Bundle Trust Board Meeting in Public Session 5 March 2024

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
Holly Gauntlet - Pilgrim SDEC - Bronze
Chelsea Spencer - Pilgrim ACU - Bronze

3 Apologies for Absence
Chair

4 Declarations of Interest
Chair

5.1 Minutes of the meeting held on 11th January 2024
Chair
Item 5.1 Public Board Minutes January 2024

5.2 Matters arising from the previous meeting/action log
Chair
Item 5.2 Public Action log January 2024

6 Chief Executive Horizon Scan Including ICS to include the Group Model Case for Change
Chief Executive
Item 6 Group CEO Update 050324
Item 6 Appendix 1 Group model Case for change vFINAL

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 Committee in Common
Item 8.1 Quality Committee in Common Upward Report January 2024
item 8.1 Quality Committee in Common Upward Report February 2024v1

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

9.1 Assurance and Risk Report from the People & Organisational Development Committee
Item 9.1 POD - Upward Report - January 2024 v1
Item 9.1 POD - Upward Report - February 2024 v1

9.2 Ward Establishments Report
Director of Nursing
Item 9.2 Establishment Review 2023 TB March 24
Item 9.2 Appendix 1 0124
Item 9.2 Appendix 2 0124
Item 9.2 Appendix 3 0124
Item 9.2 Appendix 4 0124

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

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

Item 10.1 FPEC Upward Report January 2024v1

Item 10.1 FPEC Upward Report February 2024v1

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

12 Integrated Performance Report
Director of Improvement and Integration

Item 12 IPR Trust Board Report

Item 12 Appendix 1 IPR Trust Board February 2024 Final

13 Risk and Assurance

13.1 Risk Management Report

Item 13.1 TB- Strategic Risk Report - January-February 2024

Item 13.1 Appendix A - TB Active risks rated 15-25 - Jan-Feb 2024

13.2 Board Assurance Framework

Item 13.2 BAF 2023-24 Front Cover March 2024

Item 13.2 Appendix 1 BAF 2023-2024 v27.02.24

13.3 Report from Audit Committee
Chair of Audit Committee

Item 13.3 Audit Committee Upward Report Jan 24

14 Any Other Notified Items of Urgent Business

15 The next meeting will be held on Tuesday 7th May 2024
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 12 January 2024

Via MS Teams Live Stream

Present

Voting Members:
Mrs Elaine Baylis, Chair
Mr Andrew Morgan, Group Chief Executive
Professor Karen Dunderdale, Executive Director of Nursing/Deputy Group Chief Executive
Dr Colin Farquharson, Medical Director
Professor Philip Baker, Non-Executive Director
Dr Chris Gibson, Non-Executive Director
Mrs Julie Frake-Harris, Chief Operating Officer
Mr Jon Young, Director of Finance
Mr Neil Herbert, Non-Executive Director
Mrs Rebecca Brown, Non-Executive Director
Ms Dani Cecchini, Non-Executive Director

Non-Voting Members:
Miss Claire Low, Director of People and Organisational Development
Mrs Sarah Buik, Associate Non-Executive Director
Mrs Vicki Wells, Associate Non-Executive Director

In attendance:
Mrs Jayne Warner, Trust Secretary
Mrs Karen Willey, Deputy Trust Secretary (Producer)
Mrs Rachel Lane, Corporate Administration Manager (Minutes)
Mrs Angie Davies, Director of Nursing
Mrs Kathryn Helley, Director of Clinical Governance
Mr Mike Parkhill, Director of Estates and Facilities
Ms Karen Bird, Sister, Branston Ward – Item 2.1
Ms Laura Hatfield, Sister, Ward 1B - Item 2.1
Ms Carolann Belk, Endoscopy Matron - Item 7
Ms Teri Would, Clinical Service Manager - Item 7

Apologies
Dr Sameedha Rich-Mahadkar, Director of Improvement and Integration

001/24	**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 bi-monthly meeting of the Board.
002/24	**Item 2 Public Questions** **Q1 from David Burling** **Please could you outline the capital expenditure strategy for the next 5 years and highlight the key investments in each of the hospital sites across the county?** The Director of Finance responded: Capital funding was a key enabler to improving patient experience across the various hospital sites. The Capital Strategy formed a five-year alignment alongside the Integrated Improvement Plan to support the delivery of ambitions and to continue with recent successes of securing funding through national allocations. Over the past few years key investments made via capital funding including the Emergency Department at Lincoln County Hospital (£15m), two new theatres at Grantham (£5m) and medical school facilities at Pilgrim (£2m). Further Trust wide investment would continue to be made with an additional £7m for diagnostics, £31m for medical equipment, £29m on digital equipment and £48m for estates infrastructure improvements. Over the next five years there would be continued investment across sites within the resources available to the Trust. Key improvements over a number of years would include the introduction of a Trust wide electronic patient record system at a cost of £70m, improvements to the Lincoln endoscopy unit supported by national allocation £15m - £20m and Community Diagnostic Centres (CDCs) at Grantham, Skegness and Lincoln costing approximately £40m. There would also be medical equipment replacement, improvements to the cyber and estates infrastructures and continued efforts to maximise capital resource available, year on year, with the aim to support and improve patient care.
003/24	**Q2 from Vi King** **Please can I ask why 111 are still giving the wrong information to people that the UTC at Grantham closes at 6pm.** **Please can I ask the Trust Board that 111 are told to give the correct information at all times.** **I know this has been going on for many years, but now we have a fully functioning UTC the information being given out must be correct to the people of Grantham and surrounding areas.** The Chief Operating Officer responded:

	It was important to ensure information being provided to patients was accurate which was provided by 111, via a Directory of Services (DoS), and the Chief Operating Officer provided assurance that the DoS was up to date. The Integrated Care Board (ICB) had been contacted to ensure 111 call handlers used the DoS, rather than providing advice from historical information. The Chief Operating Officer explained that the ICB had received a similar question from a member of the public and investigations were also underway regarding that query. It was reiterated that the DoS was accurate and that the learning for 111 colleagues was being taken seriously.
004/24	**Item 2.1 Ward Accreditation** The Chair was pleased to be able to commence the Board meeting with the celebration of achievement of the provision of high quality, safe care through the awarding of ward accreditation.
005/24	The Chair welcomed Sister Karen Bird and Sister Laura Hatfield, to the meeting to celebrate their achievements.
006/24	The Director of Nursing introduced the two teams who had successfully achieved the Bronze Diamond award as part of the quality accreditation programme. Board members were aware of the core requirements the departments were required to achieve against with a range of quality indicators, in addition to presenting a portfolio of evidence to the Quality Accreditation Panel. It was acknowledged that this was the first time two Ward areas providing the same service, on different sites, had been successful in achieving an accreditation award at the same time.
007/24	Sister Hatfield thanked Board members for the invitation to attend the meeting, expressing pride for the team who provided excellent services to patients and families each day. An example of nutritional work that had been undertaken on the Ward was offered, where a staff member had acknowledged that for women whose first language was not English, communication issues were being experienced and dietary requirements were being affected. One team member had photographed the breakfast trolley and printed a copy so that patients were able to visually see what was on offer which had made a great difference; the team were committed to also establishing this for snacks, lunchtime and evening meals moving forward.
008/24	Sister Bird shared details of improvement work following friends and family test feedback, where patients had found that when waiting for scans or reviews the days could be quite long. The patient ambassador for the Ward had looked at improving experiences and developed activity boxes which for example contained, sudoku, adult colouring books with pencils and crochet kits, so that patients had something to occupy them whilst waiting. This had also been replicated for in-patients on the Ward to pass the time. Sister Bird was proud of the team for implementing this to improve patient experience.
009/24	The Chair reflected that both Sisters should be extremely proud of their teams and thanked the team members for taking the initiatives forward. The Chair added that

	these examples had been provided as small things, however was certain that they were good for patients in terms of the impact on their experience.
010/24	The Group Chief Executive said that both ward accreditations should be celebrated, and the team efforts had shone through from both stories and added that the focus on patients was a credit to both teams.
011/24	The Deputy Group Chief Executive offered thanks to Sister Bird and Sister Hatfield as well as the teams, noting the achievements which had been made. The Deputy Group Chief Executive asked Sister Bird about the feedback which had been received from patients following the introduction of the activity boxes. Sister Bird responded that the patient ambassador had spoken to patients to obtain their thoughts and the majority had expressed a view that the activities available were a good distraction and helped to pass the time. They had also expressed their appreciation that staff members had wanted to put something extra in place to improve experiences.
012/24	The Chair thanked Sister Hatfield and Sister Bird for attending the meeting and for sharing their stories and reflected that these were great initiatives and asked that the Trust Board's appreciation be shared with teams.
013/24	**Item 3 Apologies for Absence** Apologies were received from Dr Sameedha Rich-Mahadkar, Director of Improvement and Integration.
014/24	**Item 4 Declarations of Interest** Mrs Rebecca Brown declared that she was an Associate Non-executive Director at Lincolnshire Community Health Services NHS Trust and the Chief Operating Officer declared that she was also undertaking the same role for Lincolnshire Community Health Services NHS Trust. The Chair commented that it was good to see the representation across both LCHS and ULHT Trust Boards ahead of the establishment of the Group Model.
015/24	**Item 5.1 Minutes of the meeting held on 7 November 2023 for accuracy** The minutes of the meeting held on 7 November 2023 were agreed as a true and accurate record.
016/24	**Item 5.2 Matters arising from the previous meeting/action log** There were no outstanding open actions.
017/24	**Item 6 Chief Executive Horizon Scan including ICS** The Chief Executive presented the report to the Board noting the continued pressures across the system. It was noted that the period following Christmas and New Year was always busy and this year had been coupled with a six-day period of

	industrial action. There had been a focus on ensuring appropriate flow and capacity so that patients were not experiencing unnecessary delays during this time, and it was reflected that there had been a good response across the system in difficult circumstances.
018/24	In relation to finances, the system had exited the Recovery Support Programme (RSP) and as a result had moved to National Oversight Framework (NOF) level 3 from level 4.
019/24	There had been similar progress around oversight in relation to cancer and planned care services where good progress having been made and the organisation moving out of tier one to tier two. The Chief Executive said that there was still a lot of work to be undertaken, however the direction of travel was good.
020/24	The Chief Executive acknowledged that the Chair had now been appointed as the Group Chair from 1st April 2024, following national recruitment. This had also enabled the recruitment of the Group Chief Executive position to be progressed with the advertisement was now live. The process would be concluded by the end of March 2024.
021/24	The Chief Operating Officer was welcomed to the Board with the Chief Executive advising that this was a being undertaken for both ULHT and LCHS which was paying dividends for urgent and emergency care services. The departure of Ms Harris was noted along with the contribution which had been made to service improvement. Thanks and well wishes for the future were extended to Ms Harris.
022/24	The Director of Finance and Business Intelligence at LCHS had been appointed as the Executive Lead for the corporate services transformation work with Mr Malcolm Burch, Chair of LCHS the Non-executive Director providing oversight for that work. Professor Derek Ward, Director of Public Health had also been confirmed as the system Executive Lead for the Community Primary Partnership (CPP) work.
023/24	The Trust's application for Teaching Hospital status had been submitted to the Department of Health and Social Care with an outcome on this awaited.
024/24	The Trust had received the NHS Pastoral Care Quality Award in recognition of best practice care for staff recruited and onboarded from overseas.
025/24	The work of over 200 volunteers was also recognised who had dedicated more than 37,000 hours of support and had helped over 150,000 people.
026/24	The Chair recognised the achievements made as a system in moving to NOF 3 and thanking colleagues who had worked hard to improve services for patients on the cancer and elective care pathways.
027/24	The Chair noted the operational position, and the contribution volunteers were making within the organisation and advised the Board of the recent opportunity to thank some of them for differences they were making for patients.

028/24	The Chair endorsed the Chief Executive's comments following the departure of Ms Harris and acknowledged the work undertaken in taking forward the operational element of the Trust and wished her well for the future.
029/24	The Chair also thanked colleagues for their support and encouragement during the application process for the position of Group Chair. The Trust Board: • **Received the report and noted the significant assurance provided**
030/24	**Item 7 Patient/Staff Story** The Director of Nursing introduced the patient story to the Board noting this was a story from Pauline and Ernie, who shared their experiences of the endoscopy service at Lincoln County Hospital. The Endoscopy Matron and Clinical Service Manager were welcomed at this point of the meeting.
031/24	The Trust Board watched a video which detailed Pauline's referral to the endoscopy service following a diagnosis of a viral infection which left her with Bell's Palsy and then required further investigations. Pauline and Ernie described how friendly, welcoming and caring the staff had been when attending the Endoscopy Unit; both had been nervous about the tests Pauline required, however the staff had been in contact in advance of the procedure to ensure she was aware of what to expect on the day. Information leaflets were shared on arrival and following the procedure the results were made available on the same day which had put Pauline and Ernie's mind at rest.
032/24	Plans to re-develop the Endoscopy Unit at Lincoln were also shared with the Trust Board, creating a facility that would enhance patient care further.
033/24	Ernie expressed his heartfelt thanks to the caring staff providing this service and explained of his concerns about the possible risks of cancer, however the staff did their best to reassure him and for that he was extremely grateful.
034/24	The Chair thanked Pauline and Ernie for sharing their story which demonstrated the overall care and experience they had received.
035/24	The Chief Operating Officer informed those present that this service was currently being delivered in a less than ideal environment and with the investment, plans would be moving forward to a purpose-built environment. It was noted that the endoscopy team had been integral to that planning process.
036/24	Mrs Wells acknowledged this positive story and said that the element of communication had really stood out which had been fantastic to hear and thanked colleagues for that.
037/24	The Clinical Service Manager thanked the Trust Board for the invitation to attend the meeting noting that it was pleasing to see the positive, direct impact, of decision making and processes put in place for those directly involved in patient care. The communication element had been further developed during the pandemic and had

	reduced the number of DNA's (did not attend), as there had been a positive impact on reducing anxieties and reassuring patients attending for tests. The benefit of patients receiving their results on the same day was also having a positive impact on both patients and staff.
038/24	The Endoscopy Sister advised of being exceptionally proud of the team of nurses who undertook a different role to ward nurses and added that it had been positive to hear that lower contact time was meaningful for patients and their loved ones. The story would now be shared with members of the team so they could see the impact on patients.
039/24	The Chair noted that the staff should be proud of their achievements and thanked Pauline and Ernie for sharing their story and positive experience with the Board. The Chair offered best wishes to Pauline for a continued recovery and to Ernie for his role in supporting his wife and for providing feedback on improvements that could be made to the service. Ernie's role as a member of the Patient Panel was also recognised and the Chair thanked him for his ongoing contributions.
040/24	In closing, the Clinical Service Manager asked if the Board could support with ensuring that GPs in the Louth area were aware that endoscopy services offered from the Louth Hospital site. The Chief Operating Officer agreed to provide support and the Board acknowledged the importance of ensuring that patients were treated as close to home as possible. **Action: Chief Operating Officer, 5 March 2024**
041/24	The Chair thanked the Endoscopy Sister and Clinical Service Manager for attending the meeting and presenting the story. The Trust Board: • **Received the patient/staff story**
	Item 8 Objective 1 To Deliver high quality, safe and responsive patient services, shaped by best practice and our communities
042/24	**Item 8.1 Assurance and Risk Report Quality Governance Committee (inc MNOG appendices)** The Chair of the Quality Governance Committee, Mrs Brown, provided the assurances received by the Committee at the 21 November 2023 and 19 December 2023 meetings, with the focus being on the December meeting.
043/24	Mrs Brown commented that this was an exciting time for the Committee as it moved into the Committee in Common and acknowledged the vast amount of work that had been and was continuing to be undertaken by governance teams from both ULHT and LCHS.
044/24	The Patient Safety Incident Response Framework (PSIRF) closedown report had been received and would be moving into business as usual; updates would be

	received as part of the update from the Patient Safety Group. Mrs Brown thanked the Deputy Chief Executive and the team for the work undertaken on this.
045/24	The update from the Infection Prevention and Control Group had been received and increases in measles cases nationally had been noted; this was not being seen within the county at present, however the team were being proactive in their approach. An increase in clostridium difficile cases was also being seen both nationally and within the organisation and assurance was provided that all corrective action was being taken.
046/24	An update from the medicines group had outlined that ePMA (Electronic Prescribing and Medicines Administration) would continue to be rolled out, this had slight challenges in terms of the focus on training and timings to ensure teams were aware of a go live date. Reassurance had been provided that this work was on track and moving forward in a timely manner.
047/24	The Children and Young People's Oversight Group report provided details that the EMSiC report and action plan would be received; several areas of action were required, and the Committee would ensure there was significant focus moving forward.
048/24	The Committee had been pleased to see that Martha's rule was being considered and further updates would be received in due course.
049/24	The Maternity and Neonatal Oversight Group upward report demonstrated through the bi-annual staffing report that the organisation was fully compliant with midwifery staffing which was not being seen elsewhere nationally; this showed the dedication and leadership of the team.
050/24	The Committee noted the consideration of industrial action within the patient experience report in terms of patient safety and patient experience and was showing a forward way of looking at this. Further reports would be received regarding the impact on staff experience. Mrs Brown expressed a view that the pressure this had on staff should not be underestimated, and the Committee were proud of the Executive Leadership Team and their teams, for the work and commitment they had demonstrated during the recent periods of industrial action.
051/24	The improved mortality position for the organisation was important for the organisation and reflections were made that the SHMI was not being illustrated appropriately within the performance dashboard which needed to be rectified. Further work on the performance dashboard was being undertaken to review the use of model hospital and benchmarking data.
052/24	Limited assurance had also been provided on the Integrated Improvement Plan (IIP) actions which had not achieved the level expected, however the challenges over the last quarter were also recognised.
053/24	The Committee had an extended discussion on the CQC action plan and recognised the need to see an increase in pace on the must do actions; the Committee had requested closure of those actions by the end of the financial year.

054/24	The Executive Director of Nursing advised the Board that the papers presented from the Maternity and Neonatal Oversight Group Upward Report supported compliance with the Clinical Negligence Scheme for Trusts (CNST) Maternity and Saving Babies lives, including the compliance status for neonatal services against the British Association of Perinatal Medicine (BAPM) standards for staffing. This demonstrated full compliance for medical staff against BAPM standards and partial compliance for nursing staff against BAPM standards.
055/24	It was confirmed that the work, in respect of the development of the Quality Committee in Common, as part of the Group Model, would see continued reporting of these papers directly to the Trust Board.
056/24	The Chair thanked Mrs Brown for the comprehensive report acknowledging that the close down of PSIRF had been a large task however it was pleasing that this was now moving into business as usual.
057/24	The Chair endorsed the comment made thanking Executive Directors and staff who had been working in particularly challenging circumstances in recent months, however the continued focus on quality and safety had been demonstrated within the reports received. The Trust Board: • **Received the assurance report** • **Received the Maternity and Neonatal Oversight Group reports**
	Item 9 Objective 2 To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT
058/24	**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 14 November and 12 December 2023 meetings.
059/24	The Committee had received an update from the Freedom to Speak up Guardian (FTSUG) at the November meeting and the increase in concerns relating to staffing and skill mix had been noted.
060/24	At the December meeting a report had been received from the Workforce Strategy and OD Group where information had been received positively in respect of low vacancy rates and mandatory training reported as over 93% across the Trust. The dashboard had been expanded to take account of Disclosure and Barring Service (DBS) checks, as a consequence of the Savile report and it was acknowledged that the organisation was ahead of schedule with the work. Detail had also been received of challenging appraisal rates and a deep dive had been commissioned by the Committee.

061/24	A report had been received on safer staffing nursing and moderate assurance had been awarded, discussion had also taken place on the revision of bandings two and three for Health Care Support Workers.
062/24	Within objective 2b a report had been received from the Guardian of Safe Working including an update on locally employed doctors who did not have supervisory initiatives in place. A report from the Equality Diversity and Inclusion Group had demonstrated that statutory reporting was on track and the annual report had been ratified. The Culture and Leadership report also detailed progress on the programme and reported that joint working with LCHS was now ongoing.
063/24	A report had been received from the University Teaching Hospital Group and the substantial amount of work to be undertaken was acknowledged. A Memorandum of Understanding (MOU) had been agreed along with principles with the University of Lincoln. The Committee also noted that there had been some upward movement in some research metrics.
064/24	The Committee had made a referral to the Finance, Performance and Estates Committee regarding personal emergency evacuation plans and assurance was requested on this.
065/24	Following debate, the Committee had agreed a change to the rating of objective 2a to green and that a similar rating was being targeted for objective 2b by the end of the financial year. It was also anticipated that objective 4b may move from red to amber shortly. Professor Baker said that this was testimony to the work the Director of People and OD and the team had undertaken.
066/24	The Chair thanked Professor Baker for the uplifting and positive report reflecting that this was a significant position with there not having previously been a green rating in relation to workforce in recent times. The amount of work that had been undertaken to get to this position was acknowledged and the comments made in relation to the Director of People and OD and team were endorsed. Thanks were offered to Professor Baker for leading the Committee, with support from Non-executive Director colleagues, in supporting the review and scrutiny of papers to have confidence to change the assurance ratings.
067/24	The Chief Executive acknowledged the achievement the Committee had made and thanked the Director of People and OD who had a significant portfolio across the system and also thanked Professor Baker for the leadership in this area.
068/23	Regarding Safer Staffing the Director of Nursing advised that staffing levels and skill mix had been triangulated through the staffing report the Committee had received and advised that actions and mitigations were in place.
069/24	The Chair noted the referral to the Finance, Performance and Estates Committee regarding emergency evacuation plans noting it was important that issue was attended to. The Trust Board: • **Received the assurance report**

	Item 10 Objective 3 To ensure that service are sustainable, supported by technology and delivered from an improved estate
070/24	**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 November and 21 December 2023 meetings.
071/24	Ms Cecchini congratulated the Director of Estates and Facilities on the general improvement in assurance around estates and health and safety over recent months.
072/24	In November the Committee received a report demonstrating that the six-facet survey was now complete, which would be helpful in terms of prioritising the capital programme. A report had also been received in relation to authorised engineers and authorised persons which provided positive assurance on statutory compliance.
073/24	The Pilgrim ED upward report was received and there were no escalations to report to the Board.
074/24	From a finance perspective, the Board had delegated authority to the Committee to submit the national cost collection return which had been completed within the required time.
075/24	The Information Governance Group upward report continued to be of concern due to lack of progress against outstanding actions in relation to the Data Protection Security Toolkit (DSPT) due to capacity, capacity was also impacting on Freedom of Information requests and Subject Access Requests not meeting required timescales.
076/24	At the November meeting, an update had been received on operational performance against national standards with reassurance received in relation to positive work in October, which was not yet seen through the metrics. Despite improvements concern remained that this was not on trajectory in respect of 78 week waits, 65 week waits and appointments being provided by the end of the calendar year.
077/24	The winter plan had been received and a risk had been noted to current bed capacity, in relation to virtual and actual within the community.
078/24	A deep dive had been received on urgent and emergency care with the speciality reviews report deferred to the December meeting.
079/24	The annual planning report had been received and there had been good assurance on processes and milestones in place for delivery of the 2024/25 plan. The Integrated Improvement Plan was also received.
080/24	The Health and Safety Annual Report was received and recommended for ratification by the Board however further redaction was required in respect of information governance, and this would be submitted to the Board in due course.

081/24	Detail was received in relation to the procurement team being shortlisted for a national healthcare supply association award and the Stores and Logistics Manager had also been shortlisted for an award.
082/24	An update had been received from the Digital Hospital Group and information was shared regarding pausing the Electronic Patient Record procurement process to undertake further market engagement, this had potential to impact on timescales.
083/24	A report had been received on the impact of industrial action and ongoing issues in maintaining services and the 78 and 65 week waits.
084/24	An update had been received from the East Midlands Provider Alliance Leadership programme with the good work noted. The Board was advised that the Managing Director for the programme was being hosted by the Trust.
085/24	The referral from People and OD Committee had been discussed and the Committee had been satisfied that procedures were in place for staff however it was more difficult to have oversight of how this had been implemented at local level. Non-executive Director discussion would be held with the Chair of the People and OD Committee to further understand the nature of the concern.
086/24	The Chair thanked Ms Cecchini for the comprehensive report noting the positive health and safety reports being seen, and welcomed sight of the health and safety annual report in due course. The Chair congratulated colleagues on their nominations and achievements for national awards and commented that it was good to see colleagues across the organisation being recognised for their work.
087/24	The Chair commented that it would be helpful for the Board to see the specialty reviews which would be useful for colleagues to engage with others across the Trust and to think about greater visibility for the Board.
088/24	It was noted that the deep dive of the nursing agency review had provided high levels of assurance with strong delivery against objectives. 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
089/24	No items.
090/24	**Item 12 Integrated Performance Report (IPR)** The Chair noted that the report set out the position of performance with each of the Committee's having reviewed the relevant sections and the report was taken as read.
091/24	The Chief Operating Officer provided an operational overview following the festive period which had been a difficult period coupled with industrial action. This had meant that there had been an impact on ambulance handover delays and length of time patients had been waiting within the Emergency Departments (ED). Work had

	been undertaken and was continuing to reduce ambulance delays and the time waiting for further treatment. It was noted that industrial action had further impacted on ambulance delays.
092/24	In terms of the national and regional picture, the organisation had remained within a positive perimeter to the credit of staff, this situation had provided an opportunity to expand group working and put additional initiatives in place around admission avoidance and the approach take to flow. This had contributed to ED activity moving back to the position it was in prior to Christmas, three days post-industrial action. There had also been improvement around cohorting, and flow though Same Day Emergency Care (SDEC) and multi-agency huddles were having the anticipated impacts. Capacity had been created outside of the acute hospital and the use of active recovery beds, community hospital beds and local authority commissioned provision had all been utilised benefiting the population of Lincolnshire.
093/24	The Chair thanked the Chief Operating Officer for the update and acknowledged the position.
094/24	Dr Gibson commented that within the IPR almost all operational performance criteria was failing on statistical process control (SPC), however when considering the detail there were some areas where recent trends were encouraging and showing signs of improvement; however overall performance was still pressured due to the challenges being faced.
095/24	Ms Cecchini agreed and reflected that this provided more confidence and sustainability than previously with optimism that the trend variation was being seen and that further improvement and sustainability could be achieved. The Trust Board: • **Received the report noting the limited assurance**
	Item 13 Risk and Assurance
096/24	**Item 13.1 Risk Management Report** The Director of Nursing presented the monthly risk report to the Board noting that there was continued stability within the report.
097/24	The number of quality and safety risks had reduced by two since the previous report had been received. One in relation to the Trust's ability to delivery of the paediatric diabetic pathway, which was now scored at 12 due to additional staffing being put in place which was positive. The other risk related to elective surgery staffing which had now been closed as staffing had reverted to full capacity since July.
098/24	Across the People and OD Committee, six very high risks remained, and Finance, Performance and Estates Committee also had six very high risks.
099/24	A risk register confirm and challenge meeting had been held to review all new, high risks and potential changes to ratings, these changes would not be submitted to the Trust Board until these had been confirmed.

100/24	The Chair asked about the pharmacy related risks with the Director of Nursing responding that a deep dive was being undertaken on pharmacy in the near future. The Trust Board: • **Accepted the risks as presented noting the significant assurance**
101/24 102/24 103/24	**Item 13.2 Board Assurance Framework** The Trust Secretary presented the report noting that this had been considered by all Committees during November and December 2023, the only proposed movement in assurance rating related to objective 2a to move from amber to green. It was noted that work had commenced with LCHS colleagues to review and align the objectives and BAF for both organisations as far as possible moving into 2024/25. Mrs Brown asked if submitting the Teaching Hospital application would move objective 4b into amber assurance. Professor Baker responded that a Board Development discussion had been requested in terms of the ambition of the organisation in relation to this. It was noted that all objectives would be revisited as part of the 2024/25 plan, and this would be included within those discussions. The Trust Board: • **Received the report noting the moderate assurance and approved the movement of objective 2a**
104/24	**Item 14 Any Other Notified Items of Urgent Business** No further items were discussed.
105/24	The next scheduled meeting will be held on Tuesday 5 March 2024 via MS Teams live stream

Voting Members	4 Oct 2022	1 Nov 2022	6 Dec 2022	7 Feb 2023	7 Mar 2023	4 Apr 2023	2 May 2023	6 June 2023	4 July 2023	5 Sept 2023	7 Nov 2023	12 Jan 2024
Elaine Baylis	X	X	X	X	X	X	X	X	X	X	X	X
Chris Gibson	X	X	X	X	X	X	X	X	A	A	X	X
Sarah Dunnett												
Paul Matthew	X	X	X	X	X	X						
Andrew Morgan	X	X	X	X	X	X	X	X	A	X	X	X
Simon Evans	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	A	X	X	A	X	X
Colin Farquharson	A	A	A	A	A	A	A	A	A	X	X	X
Gail Shadlock												
Dani Cecchini	X	X	X	X	X	X	A	X	X	X	A	X
Rebecca Brown	X	X	X	X	X	X	A	A	X	X	A	X
Neil Herbert	X	X	X	X	X	X	X	A	X	X	X	X
Paul Dunning	X	X	X	X	X	X	A	X	X	X		
Michelle Harris				X	A	X	X	X	X	X	X	
Julie Frake-Haris												X

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 5.2

Trust Board date	Minute ref	Subject	Explanation	Assigned to	Action due at Board	Completed
12 January 2023	040/23	Patient/Staff Story	GPs in the Louth area to be advised of endoscopy facilities available at Louth Hospital	Chief Operating Officer	5 March 2024	Complete - Louth Endoscopy Unit details have been added to Trust's website and shared with primary care colleagues to share with local GPs

United Lincolnshire Hospitals NHS Trust

Meeting	*Public Trust Board*
Date of Meeting	*5 March 2024*
Item Number	*6*

Group Chief Executive's Report

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

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

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

Recommendations/ Decision Required	• *To note*

OUTSTANDING CARE personally DELIVERED

Executive Summary

System Overview

a) All parts of the system remain under significant operational pressure due to the winter period and on the back of the half-term holiday period. The situation has been further impacted by the latest round of industrial action by junior doctors. Following strike action in December and January, the latest round of strike action is between 24th to 28th February. Industrial action impacts on both urgent and emergency care as well as planned care. The focus of the system remains on keeping services safe and seeking to minimise the impact on patients.

b) As the end of the 23/24 year approaches, work is continuing to ensure the best possible position at year end in relation to the key national targets. These include having zero 78 week and 65 week waiters, achieving the 76% 4 hour wait target in A&E and delivering the year end financial plan of a deficit of no more than £27.4m. All of these targets are adversely impacted by industrial action but every effort is being made to keep this impact to a minimum.

c) At M10 the system was reporting a year to date deficit of £46.9m including industrial action costs for December and January, or £44.7m excluding these costs. The full year forecast is a deficit of £29.5m including industrial action costs, or £27.4m excluding these costs. This £27.4m is in line with the financial plan agreed with NHS England.

d) NHS England has announced that the first phase of the introduction of Martha's Rule will be implemented from April 2024. Once fully implemented, patients, families, carers and staff will have round-the-clock access to a rapid review from a separate care team if they are worried about a person's condition. Martha's rule is named after Martha Mills who died in 2021 after developing sepsis in hospital. Martha's family's concerns about her deteriorating condition were not responded to promptly. NHSE will be asking for expressions of interest from at least 100 Trusts for the first phase. The Lincolnshire system is keen to express an interest.

e) The national Planning and Priorities Guidance for 2024/25 has yet to be issued. There is a briefing session with NHS England on the 6th March. In the meantime local work is continuing on planning for 24/25, based on the known local and national priorities.

f) The Q3 Quarterly System Review Meeting (QSRM) was held with NHS Midlands at the end of January. This was another positive meeting with the system commended for the progress it was making in a number of areas and an acknowledgment that the system was well sighted on those areas where further work was needed.

g) The Lincolnshire ICS has appointed Channel 3 Consulting to undertake a review of, and help create a plan for, the use of digital in health and care. Channel 3 Consulting specialise in supporting health and local authority organisations in matters such as this. The review will run from February through to April 2024 and will lead to high-level delivery plans for both health and adult social care.

h) The local system hosted a very successful visit from Dame Emily Lawson, Interim Chief Operating Officer for NHS England, on Wednesday 21st February. Dame Emily visited the Community Diagnostic Centre in Grantham and Grantham and District Hospital.

i) The appointment process for the Group CEO for LCHS and ULHT is well underway. The final interviews are on 20th March. .An engagement process is underway on the naming convention for the Group. Although this is not a merger and both Trusts will still remain as separate statutory organisations, it is felt that the Group needs a name that effectively communicates the arrangement that will be in place from 1st April 2024. A lot of work has been done over recent months to establish the Group, built around the attached Case for Change. Further work will continue beyond the 1st April.to ensure that the Group focuses on improving the care that patients receive.

Trust Overview

a) At M10 the Trust reported a year to date adjusted deficit of £20.3m. This is £2.1m adverse to plan and is attributable to the costs of industrial action in December and January. The full year financial plan is a deficit of £20.8m. Discussions are continuing with NHS England about how to deal with the costs associated with industrial action. At M10 the Trust reported year to date FRP savings of £28.8m which is £7.2m favourable to plan. The full year plan is for savings of at least £28.1m.
b) Work has now begun on the construction of the new Emergency Department at Pilgrim Hospital in Boston. This follows completion of the demolition of the building next to the existing Emergency Department. The foundations have been poured and the concrete infrastructure is being installed for the new department.
c) The Trust hosted a very successful visit by Tim Mitchell the President of the Royal College of Surgeons in February. The day focused on the surgical services at Grantham and District Hospital, including the surgical hub, the new theatres and the surgical unit. There was also an opportunity for a discussion about local surgical service developments and research.
d) A new improvement initiative called 'Give it a Go!' has been launched in the Trust. This four week initiative aims to make Quality Improvement (QI) accessible to all staff and to promote the notion that improvement is part of everyone's job. Individuals or teams are encouraged to undertake testing of new ideas, supported by colleagues from the Trust's Improvement Academy.
e) The Trust is seeking to re-invigorate it's no smoking policy. Smoking is not allowed on Trust sites but sadly this is not always adhered to. Work is underway to better enforce the policy, offer more stop smoking support to smokers, better communicate the message to the public and staff about why smoking is not permitted on Trust sites, and to be a better neighbour to those people living near our sites who face having to clear up after off-site smokers.
f) The first joint leadership event across the Group is taking place on 6th March. This Better Together leadership forum supersedes the Responsible Together leadership forum in LCHS and the Leading Together forum in ULHT.
g) I have agreed to continue as the Group CEO for LCHS and ULHT until the end of June 2024 in order to allow a smooth transition to the new Group arrangements involving a new Group CEO.

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Hospitals NHS Trust

LCHS and ULHT Group Model

November 2023

Across the NHS, we are responsible for providing safe, effective care to our populations. In Lincolnshire, whilst we have lots to be proud of, we also know that in spite of our best efforts we sometimes don't get it right for our patients or our staff.

As chairs of two of the county's NHS provider organisations, we have a statutory duty to ensure that we are taking steps to make improvements and get it right for our patients as often as we can. We cannot let historical practices and structures stand in the way of improvement and progress.

This aspiration to work in a more effective way for our patients and our staff is what has sparked discussions about forming a Group model between Lincolnshire Community Health Services NHS Trust (LCHS) and United Lincolnshire Hospitals NHS Trust (ULHT). We firmly believe that this move will bring great benefits to both organisations and more importantly to our patients. It is being done from a position of strength – both LCHS and ULHT have lots to be proud of and have achieved many impressive things in recent years. Being part of a Group will enable us to build on this and go further faster, for the benefit of our patients.

This Case for Change outlines the reasons for the change we want to make, some of the potential risks and all of the options we have considered. It also describes what we expect to be better as we form the Group. Our fundamental drivers are improving how we deliver services for our patients and making it easier for our staff to deliver the care they want to provide. Our shared commitment to delivering these benefits as a Group will keep us focused as the organisations implement the changes over the coming months.

There has never been a more opportune time for us to make this change. The time is now. As the current chairs of the two Trusts, we have been delighted to steward the organisations through their journey to this point and we look forward to what we believe will be a bright future for the Group under its new leadership.

Malcolm Burch, LCHS Acting Chair
Elaine Baylis, ULHT Chair

Background

Overview of Lincolnshire and the health and care landscape

Background to Lincolnshire and our health and care system

Population of c. 770,000 people

Highest number of adults aged 75+ in England

Nearly 80% of residents are in good or very good health

Top 5 conditions*: Hypertension, Depression, Obesity, Diabetes, Asthma

Rural, coastal county with some of the most deprived boroughs in the country

Single community trust, mental health trust, acute trust, ICB and top tier local authority

Acute provider made up of three hospitals that merged in 2000

293 care homes

14 Primary Care Networks

c. 3,500 Voluntary, Community and Social Enterprise organisations

Single place; Lincolnshire

Strong track record of collaboration between providers

*Amongst patients registered with a GP
For more information on the population of Lincolnshire and the health and care priorities, see The Integrated Care Partnership Strategy and the NHS Lincolnshire Joint Forward Plan 2023-28

Strategic context: National, regional and local

National policy direction and planning context:

- Improving health outcomes
- Narrowing health inequalities
- NHS as an attractive place to work
- More care closer to home
- UEC recovery plan
- Value for money including efficient support services
- NHS groups and collaboratives
- NHS Oversight Framework segmentation

Regional/local policy direction and planning context:

- Strong commitment to collaboration across health and care partners
- Financial Recovery Programme; systems must resolve challenges together
- Independent review of NHS provider landscape
- NHS Forward Plan 2023-28 and Integrated Care Partnership Strategy 2023

Building from a position of strength

What our trusts already do well

Organisational snapshot: LCHS

About our Trust:

- Approximately 2,500 people
- £140M income in 2022/23
- Mission: *Great care, closer to home*
- CQC rating: ‘Outstanding’ overall. Last inspected 2018
- The LCHS Way values:
  - We listen
  - We care
  - We act
  - We improve
- c. 1 million contacts delivered in 64 settings 2022/23 in including six Urgent Treatment Centres, four community hospitals, clinics, and people’s homes

Strategic Aims 2023/24:

Aim 1: Provide safe, high quality, population healthcare
Aim 2: Deliver personalised community health services that are accessible and responsive
Aim 3: Build a productive, capable and inclusive workforce
Aim 4: Ensure healthcare is financially sustainable, making best use of resources
Aim 5: Collaborate to play an action role in the Lincolnshire ICS

Organisational snapshot: ULHT

About our Trust:

- Approximately 8,700 people
- £710M income in 2022/23
- Vision: *Outstanding care, personally delivered*
- Values:
  - Patient-centred
  - Safety
  - Excellence
  - Compassion
  - Respect
- CQC rating: ‘Requires Improvement’ overall. ‘Good’ for Well-led. Last inspected 2022
- Over 916,000 patients seen in outpatients, inpatients and A&E in 2022/23
- Four main hospital sites: Lincoln, Boston, Grantham and Louth

Strategic priorities 2023/24:

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

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

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

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

What do we already do well together?

Lincolnshire providers have a long track record of collaboration. LCHS and ULHT, in particular, have worked ever closer over the last few years. Not intended to be an exhaustive list, just some of the many achievements of the Trusts working together in partnership are:

- Virtual Wards in complex neurology, cardiology, respiratory and frailty with a palliative and end-of-life virtual ward planned for implementation.
- Community Cardiology service.
- Outpatient Parenteral Antibiotic Therapy (OPAT) service.
- Frailty Pathway.
- Improved discharge and flow through an integrated discharge hub (with Adult Social Care), Discharge to Assess, and Urgent Community Response services.
- Grantham Acute Services Review (working with the Integrated Care Board).
- Shared or joint current and previous board-level roles including Chair and two Non-Executive Directors, Director of Nursing, AHPs and Quality, People Director, and Group CEO and Group Deputy CEO.
- Shared enabling services including Payroll and Procurement.
- Integration across our Safeguarding and Infection Prevention and Control teams.

So, why do we need to change?

Going further, faster, together

Benefits of even closer collaboration

- The ever-closer collaboration between LCHS and ULHT in recent years has enabled us to improve our services for patients. We have heard from our patients and staff that things are still not as integrated as they could and should be and that this affects the care we can provide.
- The Boards of both Trusts agree that closer alignment will enable us to go further, faster in making important improvements to patient care, creating a sustainable workforce, and ensuring efficient use of our collective resources.
- These moves are supported by our partners, our main commissioner, and our regulators.

Independent provider review

- In 2022, our health and care system leaders commissioned an independent review of the Lincolnshire NHS provider landscape. The intention was to identify how providers can organise health and care to better meet the considerable service and financial challenges we face.
- The review said that Lincolnshire health and care system leaders should strengthen their ability to enable shared strategic and operational decision making to improve the delivery of integrated high-quality health and care.
- Greater integration between LCHS and ULHT was one of the key recommendations. The review recommended establishing an NHS Trust Group arrangement between LCHS and ULHT, with the close engagement of other NHS partners.

Clinical case for change

Clinical evidence suggested improved outcomes for patients come from:

- Increased scope of clinical responsibility across entire pathways.
- A single approach to clinical risk.
- Reduced ‘hand-off’ of care for patients.
- Increased accountability for holistic patient care.
- Joint leadership roles equals single operating models.
- Increased resilience across providers.
- Joint focus on prevention as much as discharge.

How our Trusts are organised separately results in risk of harm to patients and staff because:

- More patients could get better care quicker if we organised things differently.
- Clinicians experience moral injury because they cannot provide the care they want to give.

Financial case for change

- In late 2021, the Lincolnshire system was placed in segment 4 of the NHS National Oversight Framework (NOF). This is the lowest performance rating and was primarily due to our overall financial performance.
- The framework recognises the interdependency between individual providers' performance and supports Trusts and systems to address their underlying problems together to build capability and make sustainable improvements.
- While the drive for greater integration between our Trusts is not primarily financial, closer working should help us to reduce duplication and waste through joint management and allocation of our collective resources.
- Lincolnshire is on track to exit NOF 4 at the end of 2023 because of our targeted, focused Financial Recovery Programme.
- The ambition is for Lincolnshire to get to a NOF 2 rating, because that is what our population should expect from us.

But why do we need to change *now*?

- There is an urgency and an opportunity now. At its heart, the review is about better integrated care for patients, families and carers, and better ways of working for our people – fundamentally clinicians want to work for the betterment of patients. To do this, we need to bring the Trusts closer together through greater integration.
- We have a significant number of executive posts across both Trusts that are not filled on a permanent basis, as well as impending changes among our Non-Executive Directors, including both Chairs. There is a need to create more certainty and stability at this level.

Why are only LCHS and ULHT changing?

- LCHS and ULHT have more patients flowing between them than other parts of the system, particularly through our integrated urgent and emergency care services. Differences in policies and management of risk and authorisations can create significant barriers to integrated care, leading to hand-offs, delays, and poor patient experience. For these reasons, the Group will initially focus on more closely integrating LCHS and ULHT.
- While LPFT will not be part of the Group now, they will support and engage with the Group as it becomes established to ensure the mental and physical health needs of our population are met in an integrated way.
- The provider review also recommended changes to the way Primary Care Networks (PCNs) and their community partners deliver integrated care, as well as work across the system to make better use of our support functions. These projects will involve other partners including the Local Authority and third sector.
- The Group model will be developed in a way that will enable other partners to join in the future if it is right for them and the Group.

The options for achieving greater integration between our Trusts

How could we deliver the change we want to see?

What options are there for making integration happen?

Degree of integration

Informal arrangements		Formal agreements		Group model		
Informal collaboration	**Strategic collaboration**	**Committees**	**Joint ventures**	**Lead provider**	**Shared or joint leadership**	**Single provider/ merger**
• May have advisory group • May have non-binding memorandum of understanding • High level shared principles for working together / collaboration • No shared decision-making - advisory / recommendations only • May make use of existing authority of individuals to make decisions for their organisation • Can be a stepping stone towards strategic collaboration	• Advisory group or leadership board • Memorandum of understanding / partnering agreement • Terms of reference for leadership board • Advisory group only or decisions through individual exercise of delegated authority • Shared information to discuss relevant matters • Joint decisions by consensus • Aligned decision making but not shared decision making	• May be statutory committees in common or statutory joint committee • Memorandum of understanding / collaboration agreement • Terms of reference for committee(s) • Collective exercise of delegated functions • Shared information to discuss relevant matters • Committees in common aligned or virtual joint decision-making • Joint committee shared decision-making by unanimous or majority voting	• Contractual or corporate • Management board • Contractual joint venture agreement or company documents • Services agreement • Principally a mechanism for service delivery • Can permit joint decision making on management board for contracted out services • Note restricted NHS trust powers for companies	• Contractual joint venture • Main contract held by lead NHS provider • Alliance / consortium agreement • Sub-contracts between lead provider and other NHS / non-NHS providers • Principally a mechanism for service delivery • Can permit joint decision making on alliance / consortium management	• Same person or people lead each provider involved • Boards of NHS Trusts or FTs appoint same person to multiple posts • Enables aligned or virtual joint decision making • May enable actual joint decision-making if combined with a joint committee	• Governance and legal advice required to determine feasibility • Must comply with NHS England transactions guidance e.g., full business case and due diligence requirements • Internal and external approvals process • Statutory transfer document and legal agreements • Results in single board for organisation

Source: Brown Jacobson LLP, *Provider Collaboration: A Practical Guide to Lawful, Well-Governed Collaboratives*, November 2023

Some simple working definitions

- **Collaboration:** Two or more providers coming together to work at scale to benefit their populations. Providers retain organisational autonomy and sovereignty, but the emphasis is on collaboration and partnership over competition. Collaborations could have some formal, contractual elements.

- **Group:** Two or more providers coming together through a joint leadership team and aligned governance and decision making whilst retaining the legal, statutory form of each organisation.

- **Merger:** Two or more providers coming together to dissolve their existing organisations and forming a new legal entity with single governance, single management structure, full pooling of assets and full pooling of risk.

The preferred option for achieving greater integration

What’s best for our patients now?

Why a Group model?

- In April 2023, the recommendations of the independent provider review were considered at a workshop attended by senior leaders.
- The Group model option received overwhelming support from NHS providers including the LCHS and ULHT provider boards, partners, commissioners and regulators.
- Leaders felt that moving to a Group model would most effectively address the issues of opportunity and urgency described above, and was the best model of provider collaboration to adopt because it would enable us to:
  - Balance greater organisational integration with the potential degree of disruption.
  - Maximise the potential to integrate services and resources for the benefit of patients and to do this at pace.
  - Address the most pressing patient harm issues and care integration opportunities.
  - Supporting better use of resources and value for money.

Why not continue our informal arrangements?

- As part of the independent provider review, the option of loose, informal arrangements was considered but discounted.
- While it was recognised the greater integration between NHS providers, particularly LCHS and ULHT, had delivered significant improvements, it was agreed that the current way our organisations are designed can get in the way of delivering great care to patients and that we could go further, faster through greater integration.
- It was also recognised that some of our system's previous informal approaches to integration have not delivered the intended benefits e.g., the Lincolnshire Health and Care Collaborative.

Why not just merge?

- As part of the independent provider review, the option of merger was considered but discounted.
- The evidence from other organisations that have moved to a Group model indicates that providers can relatively quickly deliver substantial benefits from working in collaboration at scale but without the costs, timescales and significant disruption associated with a merger.
- Providers may want to revisit the potential of a merger in the future if the situation changes. However, a Group model is judged to be the best option to deliver the intended benefits now.

What type of Group model is right for us?

Operating arrangements and internal governance recommendations

Preferred model for the Group

- There are many different models that meet the definition of a ‘Group’, with varying degrees of integration and different governance arrangements.
- Having taken the decision that a Group model was the best option to realise the intended benefits, leaders next considered what type of Group model would be best.
- On 4th September 2023, LCHS and ULHT boards met to agree some of the key operating arrangements and internal governance. Seven different types of Group model were explored.
- It was recommended that the two organisations should integrate as closely as possible. This will mean the Trusts have a joint Chair, CEO, Non-Executive Directors, and executive team. They will also move to a joint board meeting and joint committee meetings.

Preferred model for the Group – joint leadership

Informal arrangements		Formal agreements			Group model	
Informal collaboration	**Strategic collaboration**	**Committees**	**Joint ventures**	**Lead provider**	**Shared or joint leadership**	**Single provider/ merger**
• May have advisory group • May have non-binding memorandum of understanding • High level shared principles for working together / collaboration • No shared decision-making - advisory / recommendations only • May make use of existing authority of individuals to make decisions for their organisation • Can be a stepping stone towards strategic collaboration	• Advisory group or leadership board • Memorandum of understanding / partnering agreement • Terms of reference for leadership board • Advisory group only or decisions through individual exercise of delegated authority • Shared information to discuss relevant matters • Joint decisions by consensus • Aligned decision making but not shared decision making	• May be statutory committees in common or statutory joint committee • Memorandum of understanding / collaboration agreement • Terms of reference for committee(s) • Collective exercise of delegated functions • Shared information to discuss relevant matters • Committees in common aligned or virtual joint decision-making • Joint committee shared decision-making by unanimous or majority voting	• Contractual or corporate • Management board • Contractual joint venture agreement or company documents • Services agreement • Principally a mechanism for service delivery • Can permit joint decision making on management board for contracted out services • Note restricted NHS trust powers for companies	• Contractual joint venture • Main contract held by lead NHS provider • Alliance / consortium agreement • Sub-contracts between lead provider and other NHS / non-NHS providers • Principally a mechanism for service delivery • Can permit joint decision making on alliance / consortium management	• Same person or people lead each provider involved • Boards of NHS Trusts or FTs appoint same person to multiple posts • Enables aligned or virtual joint decision making • May enable actual joint decision-making if combined with a joint committee	• Governance and legal advice required to determine feasibility • Must comply with NHS England transactions guidance e.g., full business case and due diligence requirements • Internal and external approvals process • Statutory transfer document and legal agreements • Results in single board for organisation

Source: Brown Jacobson LLP, *Provider Collaboration: A Practical Guide to Lawful, Well-Governed Collaboratives*, November 2023

What will be different in a Group model?

The intended benefits of forming a Group

What improvements will we see?

- The change is about being ‘better’ not just ‘different’.
- As described earlier, significant benefits have already been realised from ever closer working between our two Trusts. The independent provider review, the clinical case for change, and the financial case for change have all identified how a Group model could deliver improved patient experience and quality, a better experience for our people, and better use of resources through greater integration.
- This section describes the ‘Why’, the ‘How’ and the ‘What’ for each of these. It also identifies some ways that we might measure the difference made as the benefits are realised.

Benefits Realisation: Patient Experience

Why	**Better experience for patients who use our services**
How	Better joined up care in local communities to meet local needs, delivered nearer to peoples' homes with reduced duplication and gaps in service provision, and more seamless transfer between providers
What	• Joint leadership roles and leaders working together across services • Joint focus on prevention and discharge • Existing pathways and services are more integrated e.g. to improve flow and winter resilience • New integrated pathways and services that build on existing initiatives e.g. virtual wards and community cardiology
We will know we have it right when?	• Improvements in patient feedback e.g. Friends and Family Test, Patient Reported Outcomes Measures • Reduced complaints

Benefits Realisation: Quality

Why	**Improved outcomes and reduced risk of harm to patients and populations**
How	Organisational arrangements support joint operational decision making, shared ownership of care and improved quality and innovation across providers
What	• A single, consistent approach to clinical risk and decision making at the right levels • Synergies across functions e.g., Infection Prevention and Control, medicines management, education, and safeguarding • Joint Quality Committee (proof-of-concept that will inform the other joint committees and joint board) • Pathway redesign e.g., Frailty and end-of-life care • Shared strategic aims and objectives across the Group
We will know we have it right when?	• Reduced delays in transfer of care within both acute and community services • Reduced length of stay • Occupancy in community services e.g. Virtual Ward utilisation and community hospital bed occupancy

Benefits Realisation: Our People

Why	Our people can consistently provide the quality of care they want to give in more rewarding and interesting roles
How	Strengthened operational relationships support clinicians to work together in new ways to provide better, joined up care through enhanced and extended roles
What	• Rotational/hybrid roles • Community-based specialist roles • Clinical academic posts • New opportunities to learn and develop together, and pursue joint research • Commitment to a set of shared values • Increased scope of clinical responsibility across entire pathways • Consistent approach to policies/authorisations to speed up decision making
We will know we have it right when?	• Staff survey ratings improved • Turnover reduced • More flexible working arrangements • Enhanced roles • Increase in research funds and joint research opportunities

Benefits Realisation: Our Resources

Why	**Our services have a sustainable future through joint stewardship and allocation of resources**
How	Greater efficiency and resilience through joint management and allocation of our collective resources
What	• Joint leadership roles (e.g. Group CEO and Chair, joint executives, and joint NEDs) • Joint planning and decision making about resource allocation and usage • Shared strategic priorities (joined up planning and priority setting) • Reduced waste and duplication • The Group operates effectively with its wider partners
We will know we have it right when?	• Improved productivity informed by benchmarking data e.g. model hospital, National Cost Collection Index and Get It Right First Time • Maximising funding spent on frontline services • National Oversight Framework rating improved

Spotlight on practice

- There have been times when ULHT's Emergency Departments have been fragile which has resulted in long waits for patients, and LCHS' UTCs could not be safely staffed leading to closures or limited services.
- Greater integration and joined-up decision making across the Trusts could provide better options to stabilise both services by looking at our resources collectively.
- This increased flexibility could create more rewarding and interesting jobs across the wider IUEC workforce including through rotations, hybrid roles, clinical academic roles and shared training opportunities.
- Greater integration could help everyone to understand the various pressures in the system with shared ownership of the patient and respecting acute and community skillsets as a powerful combination.

Risks of making the change

Although there are many benefits to us moving to a Group model, we recognise there are some potential risks. However, we believe that the risk of not making the change is greater than the risk of us doing it. Some of the risks we have considered include:

Risks	Mitigations
Low staff morale due to lack of buy in to/support for the changes	Frequent open and transparent communication focused on the benefits to patients, population and staff. Opportunities to influence the change.
Failure to invest in bringing the cultures together	An OD programme to support integration including opportunities to get to know and value each other.
The Group feels ‘acute’-centric	Clear focus on supercharging community services as part of the care closer to home strategic direction.
Implementing the Group model leads to significant disruption and distraction for the providers	The exemplar programmes through which we will deliver the change are existing workstreams e.g., virtual wards, Grantham ASR, flow. Moving to a Group will help us streamline systems and processes, creating space to deliver our priorities.

Managing the transition process

Governance and assurance

Our approach – Guiding Principles

guiding principle 1

Clinically-led and patient-centred:
Keep the focus on patients by prioritising patient safety, outcomes, satisfaction, and experience.

guiding principle 2

Plan to deliver care close to home:
Focus on place-based provision as outlined in the independent Provider Review.

guiding principle 3

Scoping:
To include transfer of delivery functions and capacity currently in the NHS Lincolnshire Integrated Care Board.

guiding principle 4

Empowerment:
Empower and support staff at all levels to take ownership and responsibility for improving the quality of care and services.

guiding principle 5

Commitment to parity in decision making and equal, mutual respect.

guiding principle 6

Values based behaviours:
Seek to understand each other in each and every encounter, ensuring key decisions are made in mutual agreement and key decisions are recorded.

guiding principle 7

Communication:
Communicating openly and transparently with our people, partners and the public as the model develops.

guiding principle 8

Collaboration:
Encourage collaboration and communication between trusts to achieve agreed goals and share best practice.

guiding principle 9

Standardisation:
Establish common standards and protocols across trusts to ensure consistency and quality of care.

guiding principle 10

Accountability:
Ensure that each trust is held accountable for its performance and that there is transparency in decision-making processes.

guiding principle 11

Continuous improvement:
Foster a culture of continuous improvement by regularly reviewing and evaluating performance.

guiding principle 12

Innovation:
Encourage innovation and the adoption of new technologies and practices to improve the quality and efficiency of care.

Governance and assurance

Implementing the transition is overseen by the Group Model Steering Group. Its responsibilities include:

- Developing change management plans based on sound change management principles and practices.
- Monitoring delivery of the work programme, identifying interdependencies, identifying early any issues likely to impede progress, managing risk and resolving issues.
- Fostering a culture of collaboration, cooperation, and shared responsibility among the key partners.

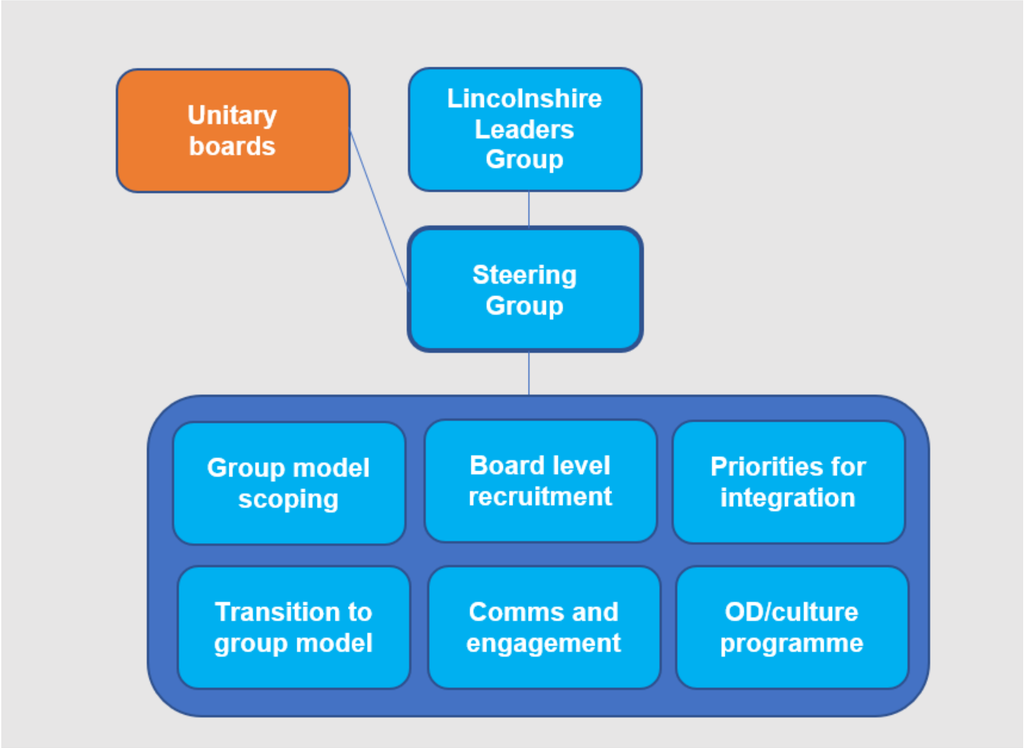
Core members:

- Chairs from LCHS and ULHT (until Group Chair is appointed)
- Group CEO
- Deputy Group CEO and Group Director of Nursing
- Medical Director
- Non-Executive Directors from LCHS and ULHT
- Governance Leads from LCHS and ULHT
- Project Lead
- Programme Director
- Communications and Engagement Lead

Other attendees:

- External governance and risk consultant

Steering Group governance and key workstreams:



- Programme workstreams supported by delivery group and legal advice as required.
- External programme assurance is provided by provider partners and the ICB through Lincolnshire Leaders Group, and NHS England.

Programme plan

- Our intention is to have a functioning Group in place by 1st April 2024.
- As with any major change programme, the transition is being underpinned by a detailed plan.
- Key deliverables and milestones are linked to key workstreams and priorities including:
  - Service delivery priorities for integration (taking the learning from a small number of exemplars to develop approaches)
  - Governance and legal
  - People and workforce
  - Culture change and OD
  - Stakeholder communication and engagement
  - Finance
  - Data and digital
  - Strategy and Planning
- Some of these areas are explore in more detail in the next slides.

Clinical priorities for integration

- Together we will identify a small number of priorities for integration that will help us to showcase the improvements we can make to patient care by working more closely as a Group. We will take the learning from these and create new approaches and models that can be applied to other developments.
- We are already doing this to great effect in some areas including virtual wards, frailty, Grantham Acute Services Review (ASR), and patient flow.
- Virtual wards have transformed the way we work together to care for our patients and our work has been recognised nationally. As an ‘exemplar’, we can build on the joint work started in 2021 go further, faster by removing some of the historical barriers between our organisations and building on the new relationships being developed across our organisations.

“Working as part of a multi-professional, multi-provider frailty virtual ward has created a team that broke historic organisational boundaries, through a ‘zero’ blame culture to agree plans that would put the patient central. Through developing trust and mutual understanding…. the team have been able to grow together through shared learning to support each other for the greater good of the patient.”

Deborah Birch, Nurse Consultant Frailty and System Integrated Frailty Lead

People and workforce

We know that a happy, well-led, well looked after, well-motivated and well engaged workforce will always deliver great patient care. We are focused on building a working environment where staff feel valued, cared for, and part of a team. The priority areas for this workstream include:

- Getting the right people, in the right roles, recruited through an open, fair and transparent process. We are starting with the Chair and CEO recruitment, and this will follow through to the Executive and NED recruitment soon after.
- Ensuring our people have the right infrastructure in place to operate in Group-level or joint roles safely, effectively and legally. For example, an agreement will be in place to enable our people to share data and information relevant to their roles.
- Having cultures and values that align is essential to the success of the Group and we are committed to ensuring that our people in both organisations have the mindset, leadership, behaviours, and culture to work in the new way. See the next slide for our approach.

Supporting our people through the transition

System OD programme	**The provider review recommended that a work programme should be created to support cultural change aimed at**: Building higher trust between organisations and leaders; Creating open and transparent sharing of data and intelligence; Better listening to patients, service users and the population: Supporting delegation of decisions to a local level; Creating a culture of clinical and care professional empowerment at the heart of the system.
Existing OD initiatives across LCHS and ULHT	**The trusts are already aligned/cooperate/coordinate on several OD initiatives:** Values frameworks; Leadership Development Programme; Leading Together/Responsible Together; Talk to TLT/TLT Live; Coaching; Exec coaching/time outs; Board development; Board to board sessions; Joint service development e.g. Stroke service; Health and Wellbeing offer; Staff networks; Talent management; Mary Seacole; 360 feedback
Support for the Group model	**A programme of OD is being developed to help create the conditions for success**: in this context, OD refers to leadership, mindset, culture, wellbeing, and engagement. This programme is being developed now because the Group model work is progressing at pace and OD is crucial to its success. The programme will sit alongside and complement the existing OD initiatives being delivered across LCHS and ULHT, and the system OD programme.

Support for Early Adopters	**Developing an Overarching Culture for the Group**	**Individual Support**	**Board Development**
Specific initiatives to help: • Foster the conditions for success including building trust, common goals, healthy conflict, shared accountability, and commitment to results. • Keep our teams safe while they are testing and experimenting with new ways of working.	Programme to create a Group culture for the future state: • Understand peoples' reality and where they are starting from. • Create a set of shared values that set the expectation in terms of behaviour. • Understand and develop the mindset needed to lead through the change.	• Support for those individuals immediately affected by the changes. • Support for those being appointed to new Group roles, both permanent and interim. • Menu of support could include coaching, career coaching, pastoral support.	Programme of joint workshops and events designed to: • Develop the board. • Support the board to develop the organisations. • Ensure the joint board and joint committees understand their responsibilities under the regulatory frameworks and provider licence.

Enablers: Local OD initiatives e.g. UTC and ED workshops; FAQs and key messages; Briefing pack for leaders; Case for change; Principles for the Group model; External support e.g. CPD Consultancy, Aqua Consultancy; Governance and risk consultancy, Legal advice; An employment contract to support Group working;

Communication and engagement

We committed at the start of the transition process to being open and transparent. Both Trusts have used a range of methods to communicate with our people and partners including:

- A Teams form for staff to ask questions and give us feedback
- Regular publication of Frequently Asked Questions
- Key messages for all leaders to share with their teams
- Joint live online Q&A events with executives from both trusts
- Q&A sessions at leadership events
- Facilitated engagement sessions for specific teams across the two trusts e.g., Urgent Treatment Centres and Emergency Departments
- All staff updates after each Steering Group meeting and workshop
- All communications shared with our provider partners and the ICB.
- Patient reps and patient involvement in service changes.

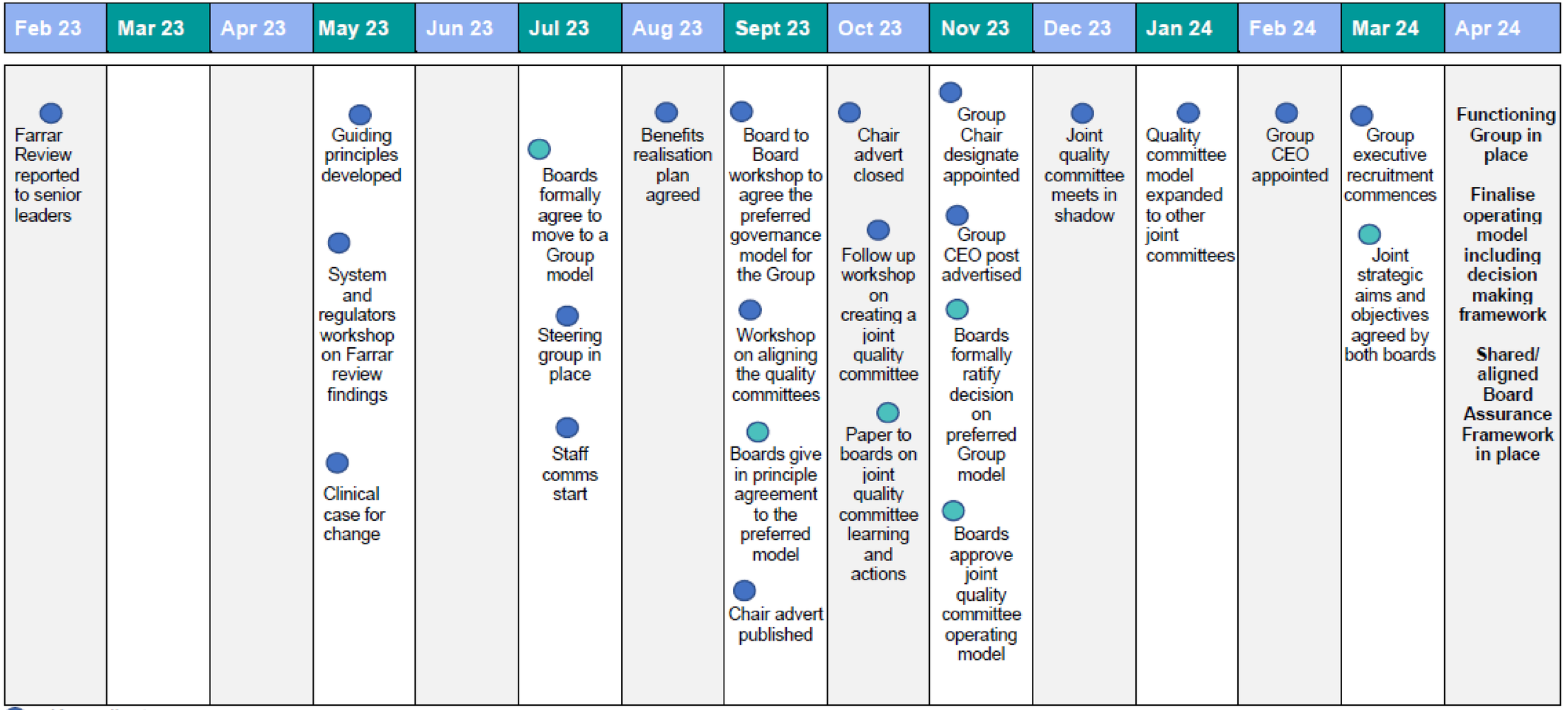
What have our partners said about the Group?

The recommendation to form a Group model was tested with some of our health and social care partners and wider stakeholders in May 2023. It received full support. This is what two of them said:

- **NHS East Midlands Regulator**: The proposed Group arrangements were seen as a strong response to the needs of Lincolnshire. The region was supportive of a more formal arrangement where lines of accountability and responsibility are clear. Joint leadership will support joint ownership of the patient and the patient pathway, and all having equal responsibility for the totality of patient care within the Group. It also benefits clinical teams and the public purse. It is recognised that the greatest immediate need and opportunity is in LCHS and ULHT, so it makes sense to focus here first.

- **Lincolnshire County Council:** The council is fully supportive of the Group. It is clearly the right thing to do for Lincolnshire. We will be delighted to be engaged with it.

High level timeline to 1st April 2024



What next?

Implementation will continue well beyond 1st April 2024. Some areas of focus will include:

- Ensuring the Group is developed in a way that supports delivery of the other provider review workstreams.
- Working with partners across the health and care system in how we implement the Group model, including involving them in our decision-making processes and structures where appropriate.
- Continuing to review membership of the Group.
- Benefits realisation plan impact measures.
- Continued work to bring the cultures together including work on shared values, behavioural expectations, and ‘how we do things around here’.

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Hospitals NHS Trust

Thank you for taking the time to read our Case for Change

Feedback can be shared with the Group Model Project Lead at Angela.Sharp6@nhs.net

Quality Committee in Common Upward Report

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Hospitals NHS Trust

Meeting	*Board in Common*
Date of Meeting	*20 February 2024*
Item Number	*7*

Quality Committee in Common Upward Report of the meeting held on 23 January 2024

Accountable Director	*Professor Karen Dunderdale, Group Deputy Chief Executive/ Executive Director of Nursing (LCHS and ULHT)*
Presented by	*Jim Connolly, Quality Committee in Common Chair*
Author(s)	*Karen Willey, Deputy Trust Secretary, (ULHT)*
Recommendations/ Decision Required	*The Board in Common is asked to:-* • *Note the discussions and assurance received by the Quality Committee in Common*

Purpose

This report summarises the assurances received and key decisions made by the Quality Committee in Common. 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, for both Lincolnshire Community Health Services NHS Trust (LCHS) and United Lincolnshire Hospitals NHS Trust (ULHT). The Committee worked to the 2023/24 objectives for both LCHS and ULHT.

The Committee was attended by both ULHT and LCHS colleagues and in order to facilitate discussion Committee members were asked to submit questions ahead of the meeting. These were responded to during the course of the meeting enabling focused discussion.

The Committee was pleased to meet formally for the first time, and throughout the discussions, the Committee was able to identify a series of reports which could be considered as the first to be combined into joint reports.

Upward Report

Assurance in respect of Objective 1a – Deliver safe services (LCHS) and Deliver harm free care (ULHT)

Patient Safety Group Upward Report to inc NatSSIPs and LocSSIPs (ULHT)
The Committee received the report noting that clinical harm data was comparative to the previous 3 months. Due to a number of harms related to delays a Structured Judgement Review was being undertaken to identify any themes.

The Committee noted the ongoing mortuary works and received assurances on the mitigations in place whilst works were completed. Outstanding Serious Incidents were also noted with a commitment from the ICB to ensure these were signed off.

Clinical Safety and Effectiveness Upward Report (LCHS)
The Committee received the report noting the issuing of a regulation 28 in December 2023, this had resulted in a recommendation to share assessments with carers and families to support patients.

The Committee noted a number of present risks including waiting lists, children and young people assessments and recruitment for children's physiotherapists. Appropriate mitigations were in place.

Challenges in respect of CQUINs was noted, particularly in relation to CQUIN13, relating to capacity and data availability. There was recognition of the need to develop templates for CQUINs in order to streamline data reporting.

Serious Incident Report to inc Duty of Candour (ULHT)
The Committee received the report noting that open SIs continued to reduce with support continuing to be in place in order to finalise actions and monitor closure trajectories.

The Committee was pleased to note that Duty of Candour compliance remained high.

Serious Incident Report to inc Overdue Datix and Duty of Candour (LCHS)
The Committee received the report noting 8 SIs declared in December associated with pressure ulcers. A review of overdue Datix incidents had been undertaken with positive progress noted over the past 6 months.

The Committee noted that Duty of Candour remained on track and as pleased to note the commencement of the Patient Safety Incident Response Framework (PSIRF) from 1 February 2024.

High Profile Cases Report (ULHT)
The Committee received the report noting the position presented.

Claims and Inquests (ULHT)
The Committee received the report noting that the position remained static with limited movement.

The Committee noted the prior request of the Quality Governance Committee for comparative data which was not yet available due to the current system. It was noted that progress was underway to move to the new Datix system which would improve reporting.

It was recognised that the changes associated with PSIRF reporting would influence the claims and inquest report.

Infection Prevention and Control (IPC) Group Upward Report (ULHT) and Infection Prevention Monthly Progress Report (LCHS)
The Committee received the reports for both ULHT and LCHS noting the blending of the IPC teams across the Trusts.

The national increase in measles cases was noted and whilst this was not prevalent within the local system, a system-wide approach was in place for contact tracing.

The rise in C-difficle was noted which aligned to the position across the East Midlands region with the intention of a desktop exercise to be completed for further evaluation.

The Committee noted the introduction of mask wearing in a number of assessment areas for LCHS due to increased respiratory illnesses. The LCHS Mass Vaccination team were supporting the provision of measles vaccinations.

Medicines Quality Group Upward Report (ULHT)
The Committee received the report noting the decrease in omitted doses and the successful implementation of the Electronic Prescribing Medicines Administration (EMPA) system.

Focused discussion was held in relation to pharmacy staffing with the Committee noting the intention of the People and OD Committee to receive a direct report from the division in respect of this concern.

In order to reduce pressures and duplicate reporting, the Quality Committee in Common requested that a single report was offered to the People and OD Committee, and an update provided back to the Committee.

Palliative Care and End of Life Oversight Group Upward Report (ULHT)
The Committee received the report noting the positive progress of the group. The Voices of Lincolnshire survey report (appendix 1) was received by the Committee which demonstrated areas for improvement, including timely recognition, communication and staff and patient education. Actions would be developed as a result of the outcome of the survey.

The Committee noted the collaborative working across the Trusts in order to improve palliative and end of life care.

Safeguarding Group Upward Report (LCHS and ULHT)
The Committee received the reports for both LCHS and ULHT noting that joint working across the Trusts being led by the Director of Safeguarding, ULHT.

Ongoing issues were noted in respect of DMI and Oliver McGowan training with actions in place to address both aspects. Concerns were also noted in respect of Mental Capacity Act training which was impacting on Deprivation of Liberties and improper use of capacity assessments.

The Committee noted concern in respect of the risk associated with Deprivation of Liberties requesting that this be reviewed in detail and updated.

Increased in children being removed from care were noted with figures being higher than the national average. Assurance on this matter was sought from the Maternity and Neonatal Oversight Group.

Nursing Midwifery and AHP Advisory Forum Upward Report (ULHT)
The Committee received the report noting the discussion held in respect of Martha's Rule noting this was not only about children but all patients. Work in this area was being developed.

The Committee noted that a number of policy documents were approved and would now be shared for medicine approval.

It was reflected that there was a desire to expand the professional leadership voice across the group with consideration and to how the group could develop.

Ward Accreditation (ULHT)
The Committee received the report detailing the ward accreditation process and noting that 1 ward area had received a silver accreditation and a number of areas had achieved bronze.

Increases in compliance of weekly spot check audits was noted along with monthly audits and quality reviews. There was also an increase in the achievement of harm free care certificates which triangulated with other data sources. There had also been achievements within ward areas previously under enhanced monitoring which demonstrated that the support in place for those areas was providing positive outcomes.

Maternity and Neonatal Oversight Group Upward Report (ULHT)
The Committee received the report and associated appendices which would be offered to the ULHT Trust Board on 6 February 2024 to support the CNST submission.

The Committee noted the positive report in respect of Eastern European women reflecting that this would likely be of national interest in the future.

Assurance in respect of Objective 1b – Improve patient experience (ULHT) and Objective 1c – Engage and involve people in their care

Stakeholder Engagement Group Upward Report (LCHS)
The Committee received the report noting the reference voices survey and the number of areas of celebration. Where areas of improvement were required, it was noted that wrap around support was in place for teams and services to focus on current themes.

The Committee noted there had been significant discussion in relation to CQC evidence, gaps and intelligence for engagement and involvement. Work was ongoing to map and track evidence required.

The Volunteer to Career programme had resulted in a number of people achieving employment as a result of the programme with a review of future engagement being undertaken.

Assurance in respect of Objective 1c – Improve clinical outcomes (ULHT) and Objective 1b – Deliver effective care (LCHS)

Clinical Effectiveness Group Upward Report to inc PROMS and Confidential Enquiries (ULHT)
The Committee received the report noting the improvements in actions related to Mortality and Morbidity Clinical Outcomes and National Confidential Enquiry into Patient Outcomes and Deaths.

Improvements were also noted in the national audit for seizures and epilepsy with the improvement associated within the work of the specialist epilepsy nurses and the impact of the orle.

The Committee noted the current staffing gap of the major trauma lead noting the formal process in place to undertake recruitment to this role.

The following items were including within the Clinical Safety and Effectiveness Upward Report:

- **Clinical Effectiveness and Safety Upward Report (LCHS)**
- **NICE Compliance (LCHS)**
- **CQUIN Delivery Update (LCHS)**
- **Clinical Audit Quarterly Report (LCHS)**

Assurance in respect of Objective 2a – Deliver clinically led integrated community services (LCHS)

The Committee noted reports for the objective would be received in February 2024.

Assurance in respect of Objective 2b – Deliver personalised health care that responds to individual need (LCHS)

The Committee noted reports for the objective would be received in February 2024.

Assurance in respect of Objective 2c – Transform clinical pathways for sustainability and improved outcomes

The Committee noted reports for the objective would be received in February 2024.

Assurance in respect of other areas

Interim ToR and Work Programme
The Committee received the interim Terms of Reference and Work Programme noting the need to ensure job titles were accurately reflected within the documents. The Committee requested that the Board allow the Committee to revise and approve the documents during the interim period.

Board Assurance Framework – ULHT and LCHS
The Committee received the Board Assurance Frameworks for both LCHS and ULHT confirming the assurance ratings as presented with no proposed changes at this time.

Risk Register – ULHT and LCHS
The Committee received the risk registers for both LCHS and ULHT noting that this was an area for consideration in respect of joint reporting to the Committee.

The Committee noted the current risks presented in the risk register requesting that the Deprivation of Liberties risk within the ULHT risk register be reviewed to ensure this was accurate.

Internal Audit Report – NCEPOD ULHT

The Committee received the ULHT Internal Audit for National Confidential Enquiry into Patient Outcomes and Deaths (NCEPOD) noting the reasonable assurance received and actions resulting from the outcome of the audit.

CQC Action Plan – ULHT
The Committee received the report noting the increase in the blue actions with the executive sign off meeting having addressed a number of areas and providing significant assurance on the embedding of actions.

The Committed noted the intention to hold an extraordinary meeting in order to enable further actions to be closed. Closure of actions would be offered to the Committee in February.

CQC Compliance Report – LCHS
The Committee received the report noting the focus on work related to the self-assessment against the new single oversight framework. Collaboration, across the group, was ongoing in respect of benchmarking against the new framework.

Committee Performance Dashboard – ULHT and LCHS

The Committee received both Committee Performance Dashboards for LCHS and ULHT noting that the reports presented had considered the relevant aspects of performance for both Trusts.

The Committee noted the need to ensure, as the Group Model developed, that a single set of indicators were developed.

Operational Plan – LCHS and Integrated Improvement Plan – ULHT

The Committee received and noted the Operational Plan and Integrated Improvement Plan reports for LCHS and ULHT respectively. The Committee noted these reports were offered for oversight of improvement programmes of work which would be developed into a single plan moving forward.

Issues where assurance remains outstanding for escalation to the Board

No escalations required.

Items referred to other Committees for Assurance

The Committee wished to refer to the ULHT People and OD Committee the issue of Pharmacy Services. It is requested that the People and OD Committee receive a full update encompassing the issues raised by the Quality Governance Committee to reduce pressures on the team reporting to two Committees.

Attendance Summary for rolling 12-month period

Voting Members	J	F	M	A	M	J	J	A	S	O	N	D
Jim Connolly Non-Executive Director (Chair)	X											
Chris Gibson Non-Executive Director	X											
Karen Dunderdale Executive Director of Nursing, ULHT/LCHS	X											
Colin Farquharson Medical Director, ULHT	X											

Rebecca Brown, Non-Executive Director (Maternity Safety Champion), ULHT/LCHS	X											
Gail Shadlock, Non-Executive Director, LCHS	X											
Julie Frake-Harris, Chief Operating Officer, ULHT/LCHS	X											
Anne-Louise Schokker, Medical Director, LCHS	X											

X in attendance
A apologies given
D deputy attended

Quality Committee in Common Upward Report

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board ULHT/LCHS*
Date of Meeting	*5 March 2024*
Item Number	

Quality Committee in Common Upward Report of the meeting held on 20 February 2024

Accountable Director	*Professor Karen Dunderdale, Group Deputy Chief Executive/ Executive Director of Nursing (LCHS and ULHT)*
Presented by	*Jim Connolly, Quality Committee in Common Chair*
Author(s)	*Karen Willey, Deputy Trust Secretary, (ULHT)*
Recommendations/ Decision Required	*The Board is asked to:-* • *Note the discussions and assurance received by the Quality Committee in Common*

Purpose

This report summarises the assurances received and key decisions made by the Quality Committee in Common. 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, for both Lincolnshire Community Health Services NHS Trust (LCHS) and United Lincolnshire Hospitals NHS Trust (ULHT). The Committee worked to the 2023/24 objectives for both LCHS and ULHT and was attended by both ULHT and LCHS colleagues.

The Committee was pleased to meet formally for the first time, and throughout the discussions, the Committee was able to identify a series of reports which could be considered as the first to be combined into joint reports.

Upward Report

Assurance in respect of Objective 1a – Deliver safe services (LCHS) and Deliver harm free care (ULHT)

Patient Safety Group Upward Report to inc National Patient Safety Strategy (ULHT)
The Committee received the upward report and the quarterly patient safety report which offered a 'report at a glance' which was well received by the Committee and demonstrated where the focus was required when considering the report.

The Committee noted the need for clarity on the actions being taken as a result of the output of the report with triangulation requested on a quarterly basis of the data presented.

The launch of the Patient Safety Incident Response Framework (PSIRF) had taken place in October 2023 and was progressing with the group receiving the National Patient Safety Strategy Gap Analysis which demonstrated the current position.

The Committee was assured that processes were in place to receive full assurance however in order for this to be achieved the learning from PSIRF would be required. This would come forward in due course due to the recent implementation of PSIRF.

Clinical Safety and Effectiveness Group (CSEG) Upward Report (LCHS)
The Committee received the report noting the **limited assurance** which had been received due to the increase in pressure ulcers for which benchmarking work would be completed.

An improvement plan was being developed to address the increase however there was a need to further understand the data to support this, improvement plan mitigations had been requested to be offered at the March CSEG meeting.

The Committee noted the developments within Patient Safety work with the successful recruitment of 2 Patient safety Investigation Officers who would commence in post in March.

Learning from deaths had been considered by the group with the Committee noting that structured judgment reviews had been undertaken on 87% of cases due to the gold standard approach taken by the Trust.

Safer Staffing – Community Nursing (LCHS)
The Committee received the report noting that this had been discussed with the integrated community teams and offered a clear number of themes with the reporting offering a position statement.

The Committee was assured by the work undertaken noting that there had been a number of risks associated with the staffing for community nurses which this work would look to address.

It was recognised that there was a need to undertake a job evaluation exercise for band 6 and band 7 staff in order to determine the value of the district nurse qualification.

The increase in referrals to the service was noted with a significant increase noted between January 2020 and January 2024 at circa 34% with a need to measure the workload rather than the caseload due to patient need.

The Committee noted that mitigating actions were in place however there was a need to scope the skill mix gap which had been identified along with a contractual service review and job evaluations. The Committee would receive a further report once the scoping work had been completed.

Serious Incident Report to inc Duty of Candour (ULHT)/Serious Incident Report to inc Overdue Datix and Duty of Candour (LCHS)
The Committee received the report noting that work was taking place to standardise reporting across the organisations and from 1 April 2024, LCHS would move to the Patient Safety Incident Response Framework (PSIRF).

The Committee was pleased to note the reduction in open serious incidents for ULHT with a reduction also noted in open actions.

Duty of Candour had reduced however it was noted that this was due to the reduction in harm levels due to the review of incidents but also due to the impact of industrial action, actions were in place to support the divisions to ensure compliance was achieved.

The Committee noted the open serious incidents for LCHS which were all as a result of pressure ulcers and therefore, as PSIRF was implemented, this would be a PSIRF theme.

Concern was noted about the number of pressure ulcers in the community with the Committee seeking assurance on the actions being taken to address this. **Assurance was offered** that mitigations were in place with increased visits and support for end of life and palliative patients in addition to support in place for new staff.

High Profile Cases Report (ULHT)
The Committee received the report noting the position presented with consideration being given to include LCHS information in future reports.

Infection Prevention and Control (IPC) Group Upward Report inc IPC BAF and Hygiene Code (ULHT)/Infection Prevention Monthly Progress Report (LCHS)

The Committee received the report for LCHS which demonstrated compliance with the IPC BAF and noted the focus on fit testing for masks, for which there was dedicated resource in place.

The Committee noted the appointment of Associate Chief Pharmacists who would support and lead on antimicrobial prescribing. Mitigations were in place against water safety incidents which were considered to be low risk however these would be monitored.

A norovirus outbreak was noted through the report which was dealt with effectively resulting in there being no spread of infection.

The ULHT report demonstrated that the Trust was exceeding trajectory for C-Difficile, this was not a unique position to the Trust, and ribotyping had confirmed no spread between patients.

A tabletop exercise was expected to be completed by the NHS England IPC with confirmation of the date for this awaited which would support the Trust in further gaining an understanding of the C-Difficile position.

The Committee noted the joint working across ULHT and LCHS which was further supporting learning and benefits were being seen in both organisations.

Medicines Quality Group Upward Report (ULHT)
The Committee received the report noting the continued reduction in harm from omitted doses of medication, in part due to the roll out of the Electronic Prescribing and Medicines Administration (ePMA), and the Antibiotic Surveillance and Stewardship Group had seen a reduction in the inappropriate use of antibiotics.

A recent serious incident relating to controlled drugs had seen a number of immediate actions taken, including the reclassification of the drug to ensure increased checks and balances to access.

Children and Young People Oversight Group (ULHT)
The Committee received the report with **moderate assurance** noting there were no escalations however reflected the benefit in further developments of the report to support progress on objectives.

Nursing Midwifery and AHP Advisory Forum Upward Report (ULHT)
The Committee received the report for information noting there were no escalations.

Assurance in respect of Objective 1b – Improve patient experience (ULHT) and Objective 1c – Engage and involve people in their care

Patient Experience Group Upward Report (ULHT)/Stakeholder Engagement Group Upward Report (LCHS)/Equality Delivery System 3 (LCHS)
The Committee received the report which offered and executive summary for both the LCHS and ULHT meetings with no escalations from either meeting.

Significant assurance was offered through the ULHT report with the Committee noting the ongoing engagement of the divisions through the group to demonstrate patient experience activity.

Moderate assurance was received through the LCHS report with the group receiving patient complaint information which had led to learning from a recent complaint as to how to best meet the needs of patients with learning disabilities.

The Committee noted the EDS3 pilot which had ceased and would move into business as usual with actions in place to ensure data collection was possible through System One and appropriately recorded.

The Committee noted the intentions to develop the groups and to consider, where possible, a group approach moving forward.

Quarterly Complaints Report (ULHT)
The Committee received the report with **significant assurance** noting the continued positive work to address overdue complaint responses with 3 outstanding.

The Committee noted the business partner model, which was now in place to support divisions, which was having a positive impact on concerns being raised not reaching formal Patient Advice and Liaison concerns or complaints processes.

The Committee was pleased to note the work which would take place to offer a combined LCHS and ULHT complaints reports from April.

Assurance in respect of Objective 1c – Improve clinical outcomes (ULHT) and Objective 1b – Deliver effective care (LCHS)

Clinical Effectiveness Group Upward Report to inc NICE, CQUIN & Clinical Audit Report (ULHT)/Clinical Effectiveness and Safety Upward Report inc NICE, CQUINs and Clinical Audit Report (LCHS)
The Committee received the report for ULHT noting that the group had received an update on areas below national benchmarked standards with improvements seen in the national ophthalmology audit.

ULHT was 100% compliant with NICE Technology Appraisal (TA) reports and 95% compliant for clinical guidelines. The achievement of the position was

due to the management of overdue assessments being completed whilst also addressing those more recently received.

The Committee was assured on the processes in place in respect of national audits and the support for these to be implemented and the work underway to address both the backlog and receipt of new NICE TAs.

Learning from Deaths Report (LCHS)/Mortality Report (ULHT)
The Committee received the reports for both ULHT and LCHS noting the **moderate assurance** offered and the continued positive levels of reporting in respect of HSMR and SHMI for ULHT.

The Committee noted there were no escalations from the LCHS report however it was noted that there were close working relationships across both organisations with the Committee noting the learning opportunities being identified.

Assurance in respect of Objective 2a – Deliver clinically led integrated community services (LCHS)

EPRR Q3 Report (LCHS) and Easter Plan (LCHS)
The Committee received the report noting the work being undertaken in respect of both the EPRR and Easter Plan with no escalations made to the Committee.

The EPRR function was working well with work underway to link this across both LCHS and ULHT in order to share planning and working jointly to learn lessons from the end of year review from major national incidents.

The Committee noted the recent opportunities to stress test business continuity plans throughout the winter period and the Easter Plan was shared with the Committee to demonstrate planning for the busiest period for community services.

Operations Report (LCHS)
The Committee received the report recognising the developments made in the production of the report meaning this offered a whole community view rather than specialist focus. The report would continue to develop.

The Committee noted the activity which was taking place across the organisations as presented through the report noting the need for this to reflect both activity and links to strategic objectives.

Assurance in respect of Objective 2b – Deliver personalised health care that responds to individual need (LCHS)

Operations Report (LCHS)
As reported above.

Assurance in respect of Objective 2c – Transform clinical pathways for sustainability and improved outcomes

Operations Report (LCHS)
As reported above.

Assurance in respect of other areas

Interim ToR and Work Programme
The Committee received the interim terms of reference and work programme which had been updated following the request made the previous month. The Committee confirmed the changes made and would continue to review these as the Committee developed with the documents being dynamic to support developments.

Proposals for Groups
The Committee received the report noting the work which had taken place in respect of the proposed reporting groups to the Committee including the Patient Safety Group, Clinical Effectiveness Group, Patient Experience and Involvement Group and Maternity and Neonatal Oversight Group.

The Committee noted the further work which was required to address what would site beneath each of the reporting groups with specific consideration needed for medicines management, deteriorating patients and safeguarding. Consideration was also being given to the statutory requirements of the organisations to ensure appropriate reporting.

Improvements in reporting would also be required to ensure that assurances could be offered and that there was sufficient time during the meetings for challenge and debate.

The Committee would receive an update on the proposed work programmes and terms of reference for the groups with a review of the functions to be undertaken in 6 months time.

The Committee approved the meeting structure presented and the recommendations made in respect of wider groups which were currently in place.

Board Assurance Framework – ULHT and LCHS
The Committee received the Board Assurance Frameworks for both LCHS and ULHT confirming the assurance ratings as presented with no proposed changes at this time.

Risk Register – ULHT and LCHS
The Committee received the risk registers for both LCHS and ULHT noting that work had commenced to provide a joint report.

The Committee recognised the work which was underway to review the respective policies and to consider the categorisation of risk scoring across the organisations to ensure consistency.

Significant assurance was received in respect of the ULHT risk register with the Committee noting the proposal to increase the risk associated with potential regulatory actions. This would be presented to the Risk Confirm and Challenge meeting for review and confirmation.

The Committee reflected on the changes in the LCHS risk register with a reduction of 5 risks from the previous period and an increase in the risk score for the children specialist services risk for TB demand and capacity. The Committee noted the action being taken and the discussion with the ICB to provide mitigation.

15 Steps Visits (Volunteer and NED Visits) (LCHS)
The Committee received an update through the Stakeholder Engagement Group Upward Report.

CQC Action Plan (ULHT)/CQC Compliance Report (LCHS)
The Committee received the reports noting the new assessment framework which had come into effect in January.

Both LCHS and ULHT were undertaking a review of preparedness of the framework to identify any gaps which may be present.

The Committee noted the work and progress of the open CQC must and should do actions for ULHT recognising the recent Executive Assurance Panel which had been held and resulted in 4 of the actions being signed off.

Committee Performance Dashboard (ULHT and LCHS)
The Committee received the performance reports noting that performance had been considered through the reports presented however noted the position against community acquired pressure ulcers for which the Committee sought further assurance on at the next meeting.

Integrated Improvement Plan (ULHT)
The Committee received the report for information noting the **moderate assurance.**

Quality Impact Assessments Report (LCHS)/Quality Impact Assessments Report (ULHT)
The Committee received the report for information.

Committee Self-Assessment (ULHT)/Committee Self-Assessment (LCHS)
The Committee received the self-assessments for both Trust's noting the **moderate levels of assurance** offered.

The Committee noted that these were reflective of the 2023/24 year and therefore completed for the individual quality committees of the organisations. There were no actions resulting from the completion of the self-assessments.

Annual Report – Committee Effectiveness Draft (ULHT)/ Annual Report – Committee Effectiveness Draft (LCHS)
The Committee received the draft annual reports in respect of Committee Effectiveness for the Quality and Risk Committee (LCHS) and Quality Governance Committee (ULHT).

Comments and feedback were sought on the reports for these to be offered to the Committee as final version for sign off at the March meeting. The reports would support the completion of the LCHS and ULHT Annual Governance Statements.

Issues where assurance remains outstanding for escalation to the Board

No escalations required.

Items referred to other Committees for Assurance

No items referred.

Attendance Summary for rolling 12-month period

Voting Members	J	F	M	A	M	J	J	A	S	O	N	D
Jim Connolly Non-Executive Director (Chair)	X	X										
Chris Gibson Non-Executive Director	X	X										
Karen Dunderdale Executive Director of Nursing, ULHT/LCHS	X	X										
Colin Farquharson Medical Director, ULHT	X	X										
Rebecca Brown, Non-Executive Director (Maternity Safety Champion), ULHT/LCHS	X	X										
Gail Shadlock, Non-Executive Director, LCHS	X	X										
Julie Frake-Harris, Chief Operating Officer, ULHT/LCHS	X	X										
Anne-Louise Schokker, Medical Director, LCHS	X	X										

X in attendance
A apologies given
D deputy attended

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:	16 January 2024
Chairperson:	Professor Philip Baker, Chair
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the People and OD Assurance Committee. The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board. This assurance committee meets monthly and takes scheduled reports according to an established work programme. The Committee worked to the 2023/24 objectives following approval of the BAF by the Board.
Assurances received by the Committee	**Lack of Assurance is respect of SO 2a** **Issue: A modern and progressive workforce** **Workforce Strategy and Organisational Development Group (WSODG) Upward Report** The Committee received the report noting shortened meeting to support operational pressures allowing staff to attend the Gold Command Meeting. The Committee was pleased to note that there were no escalations from the meeting and noted the current vaccine update for flu and Covid-19 reported at 37% and 27% respectively. Focused actions were taking place including visiting wards to offer vaccinations. Concern remained in respect of staff appraisal rates which remained static at 71%. The Committee was assured on the progress with statutory and mandatory training which was reported as 93.64%. The Committee was pleased to note the decrease in time to referral for occupational health services following concerns previously raised about the length of time for referrals to be responded to. The Wellbeing strategy continued to develop and was nearing completion with a Stress Management Plan also being actioned to address issues of anxiety, stress and depression which were alerting at the top 3 reasons for sickness. Additional wellbeing support, during the course of Industrial Action, such as critical incident debriefs, was noted by the Committee. **Committee Performance Dashboard** The Committee received the report noting that WSODG had considered the performance data in detail.

	The Committee was pleased to note the progress being made in respect of Disclosure and Barring Service checks with the Trust remaining on trajectory. The 2024/25 trajectory would be shared at a future meeting. Recruitment data demonstrated that there had been 163 adverts in the second half of the year with 57 having an approved start date for Q1 of 24/25. Those commencing in Q4 of 23/24 had all been through appropriate quality impact assessments. The Committee commended the recruitment team for the work undertaken to improve processes noting that the Trust currently had the lowest Band 5 vacancy rate for some time. This impacted not only on the financial position but also quality and safety for patients. **Safer Staffing** The Committee received the report which was taken as read and offered moderate assurance. **Trauma and Orthopaedic Action Plan** The Committee received the report noting that actions were in place following the review of the service and that recent feedback sessions had been well received. Due to the positive outcome from the communications workshop which had been held, there was an intention for this to be replicated on a regular basis to ensure continued staff engagement. The Committee was pleased to note the positive outcome of a recent visit by the General Medical Council and Health Education England which had identified tangible changes in culture and behaviour.
	Lack of Assurance in respect of SO 2b **Issue: Making ULHT the best place to work** **Staff Survey Upward to include Pulse Survey feedback** The Committee received the high-level position of the 2023 staff survey results, the full results would be released at a future date. The Committee noted that the survey had covered an unprecedented period of time impacted by operational pressures and industrial action. Whilst the results had seen a slight improvement further detail was awaited to understand the results in depth. **Freedom to Speak Up Quarterly Report** The Committee received the report and welcomed the Freedom to Speak Up Guardian who offered an overview of the current position. The Committee was assured by the work of the Guardian and that the increase in people speaking up was as a result of Speak Up month and the

	increase within the Family Health Division was being addressed due to the common theme. **GMC Junior Doctor Survey Update** The Committee received the report noting there were no escalations from the survey however noted the wider need for further engagement with Doctors. The Committee noted the ongoing need to support cultural development. **Board Assurance Framework** The Committee noted the positive developments within objective 2b and recognised the significant work being undertaken to provide assurances to the Committee. The Committee determined that the assurance rating would remain as amber at this time however reflected that there would be benefit in the Committee considering reporting from the staff networks to strengthen assurance associated with engagement.
	Lack of Assurance in respect of SO 4b **Issue: To become a University Hospitals Teaching Trust** **Research and Innovation Update and Upward Report** The Committee received the report noting that the recruitment to research studies had reduced during December and the Committee was keen to receive reports which offered a broader view of research and innovation. The Committee was pleased to note that, whilst funding had reduced from the Clinical Research Network this had not been as significant a reduction as expected. The opportunity for joint working with Nottingham Clinical Research Facility which would increase the opening of clinical trials, further work was required to formalise the relationship.
	Assurance in respect of other areas: **Personal Emergency Evacuation Plans (PEEPs) Referral response from FPEC** The Committee received an update on the referral made to the Finance, Performance and Estates Committee regarding PEEPs and whilst it was acknowledged that responsibility was at ward and department level the Committee was not assured that these were in use. The Committee requested an audit of the use and implementation of PEEPs to confirm that these were in place for staff, despite policies and procedures being in place.

	People Directorate Objective Upward The Committee received a verbal update on the position of the Directorate noting the restructure which had taken place with significant investment for the teams. It was noted that Just Culture was being introduced and the developments within the Directorate were also being reflected through the improvements within the Board Assurance Framework. **Internal Audit Report – Staff Health and Wellbeing** The Committee received the report noting that this offered reasonable assurance. The Committee was pleased with the level of assurance gained through the audit recognising that the Health and Wellbeing team had been established less than 12 months earlier. The actions arising from the audit would be addressed by the Health and Wellbeing team. **CQC Action Plan** The Committee received the report noting that greater detail was offered in respect of assurance against progress of the actions. It was note that the actions were monitored through other groups with the report updated to identify this. Further updates from the groups monitoring the actions would be offered to the Committee in February. The Committee noted that of the 8 actions 2 were complete and 1 was due to be signed off. The remaining actions continued to be progressed. **Integrated Improvement Plan** The Committee received the report which was taken as read noting the moderate assurance which was offered.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	
Committee Review of corporate risk register	The Committee received the risk register noting the current risks presented and the significant updates which had been made to the register.
Matters identified which Committee recommend are escalated to SRR/BAF	No areas identified

Committee position on assurance of strategic risk areas that align to committee	The Committee considered the reports which it had received which provided assurances against the strategic risks to strategic objectives.
Areas identified to visit in ward walk rounds	No areas identified

Attendance Summary for rolling 12 month period

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

X in attendance
A apologies given
D deputy attended

Report to:	Trust Board
Title of report:	People and OD Committee Assurance Report to Board
Date of meeting:	13 February 2024
Chairperson:	Dr Chris Gibson, Deputy Chair
Author:	Jayne Warner, Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the People and OD Assurance Committee. The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board. This assurance committee meets monthly and takes scheduled reports according to an established work programme. The Committee worked to the 2023/24 objectives following approval of the BAF by the Board.
Assurances received by the Committee	**Lack of Assurance is respect of SO 2a** **Issue: A modern and progressive workforce** **Workforce Strategy and Organisational Development Group (WSODG) Upward Report** The Committee received the report. The Group had focussed on the statutory and mandatory training and the CQC focus on medical core compliance. The Group reported to Committee that the existing level of oversight was not considered satisfactory and the Group would turn its focus to this. The Group had provided assurances to the Head of Compliance around a set of actions and the oversight that would be given at future meetings. The Committee noted the work that had commenced across the group, working more closely in achieving greater appraisal compliance. The Committee were advised that the Trust was examining the approach used by LCHS as the level of compliance was higher. Good practice would be shared and implemented. The Committee would receive a detailed assurance report at its meeting in March. **Committee Performance Dashboard** The Committee received the report noting that WSODG had considered the performance data in detail. The Committee was pleased to note the progress being made in respect of Disclosure and Barring Service checks with the Trust remaining on trajectory. The Committee commended the significant improvement in the level of employment cases which remained open. This had been reduced.

	Safer Staffing The Committee received the report which offered moderate assurance. The nurse staffing position continued to improve. There had been work on finalising rosters with higher levels being finalised on time for payroll, this continued to contribute to improvement in agency rates also. The Committee were advised that significant assurance from the report would be given when fill rates reached 90%. **Nurse Establishment Review** The Committee received the annual review which had been completed across 75 clinical areas and across 4 sites. The Committee noted the reported change in acuity from previous reports. The Committee noted that the work had also included consideration of the challenge relating to band 2 and band 3 posts within each clinical area. The Committee noted that the report would be shared with Trust Board. **Board Assurance Framework** The Committee agreed that the BAF assurance rating in respect of objective 2a was reflective of the assurance position.
	Lack of Assurance in respect of SO 2b **Issue: Making ULHT the best place to work** **Guardian of Safe Working Quarterly report** The Guardian of Safe Working attended Committee to present the report including safety issues highlighted and recommendations made. The Committee were concerned that T&O continued to be highlighted and the Director of People and OD suggested that the outputs of the deep dives be considered in the operational group. The allocation of clinical educati9on supervisors was noted and how this process would roll out and be reviewed. **Pharmacy Deep Dive** The Divisional Clinical and Managing Director joined the meeting to present the report. The Committee were offered assurances in relation to the latest recruitment position noting that there had been more starters than leavers in month which was helping to support staff morale. The Committee were advised that the team were beginning to own and take responsibilities for actions and improvements. The team were also being asked for regular feedback on actions and the feedback would be collated by the divisional leadership team.

A recruitment pipeline was included in the report to Committee. Assurance was given that consideration was being given to both Trust and site based roles in the recruitment taking place.

The Committee noted with concern the vacancy rate and the pressures this would bring for the teams. The Director of People and OD was asked to bring tracking data around this to the Committee routinely as achieving other aspirations in pharmacy would be difficult whilst this vacancy rate remained.

The Committee were concerned that the matters shared with Committee were not reflective of the risk register entries relating to Pharmacy and asked that this was now reviewed and addressed.

The Divisional Managing Director would bring a further assurance report to Committee mid year 2024/25.

Board Assurance Framework

The Committee noted the positive developments within objective 2b and recognised the significant work being undertaken to provide assurances to the Committee. The Committee determined that the assurance rating would remain as amber at this time but recognising that the parameters for this objective were less clear cut than 2a. The Committee would consider the position again next month.

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

University Teaching Hospital Group Upward Report

The Committee considered the updated financial model for clinical academics which had been updated after concerns had been raised at the previous committee meeting and the contributions proposed. The paper highlighted best and worst case financial positions.

The Committee noted that there had been no further update on the progress of the Trust's application for teaching hospital status post the submission.

It was agreed that the financial model would be shared with Trust Board pending further discussions. Approval of the final position would be required from Trust Board.

Research and Innovation Update and Upward Report

The Committee received the report noting the data on publications.

	Assurance in respect of other areas: **Committee Effectiveness - Annual self assessment and Annual report** The Committee received the first draft Committee Annual Report and the results of the self assessment. Comments would be shared on the report and additional time given for completion of the self assessment. **CQC Action Plan** The Committee received the report and assurance against progress of the actions. It was note that the actions were monitored through other groups with the report updated to identify this. There had been work to refresh the risks but there had been no reduction in the number of outstanding actions. **Integrated Improvement Plan** The Committee received the report which was taken as read noting the moderate assurance which was offered. The Director of People and OD advised that all IIP objectives were on target to be achieved. Work on the IIP for 24/25 was also underway.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	
Committee Review of corporate risk register	The Committee received the risk register noting the current risks presented and the significant updates which had been made to the register. 3 risks had been closed since the last meeting.
Matters identified which Committee recommend are escalated to SRR/BAF	No areas identified
Committee position on assurance of strategic risk areas that align to committee	The Committee considered the reports which it had received which provided assurances against the strategic risks to strategic objectives.
Areas identified to visit in ward walk rounds	No areas identified

Attendance Summary for rolling 12 month period

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

X in attendance
A apologies given
D deputy attended

United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*5th March 2024*
Item Number	*9.2*

Nursing Establishment Review

Accountable Director	*Dr Karen Dunderdale, Group Deputy CEO, Executive Chief Nurse*
Presented by	*Angie Davies, Director of Nursing*
Author(s)	*Angie Davies, Director of Nursing; Jon Young Director of Finance; Julie Frake-Harris, Chief Operating Officer*
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	
3a A modern, clean and fit for purpose environment	
3b Efficient use of our resources	*X*
3c Enhanced data and digital capability	
3d Improving cancer services access	
3e Reduce waits for patients who require planned care and diagnostics to constitutional standards	
3f Urgent Care	
4a Establish collaborative models of care with our partners	
4b Becoming a university hospitals teaching trust	
4c Successful delivery of the Acute Services Review	

Risk Assessment	*Insert risk register reference*
Financial Impact Assessment	The overall Establishment Review gives a reduction of 13.08 wte and a positive variance of £766.4k, excluding ED's but including the £172.8k band 3 implications. The impact of ED's at an escalation level gives an overall increase of 53.85 wte and £2,515.8k, seen in the current run rate.

	The potential budgetary impact of future business cases estimated at 97.44 wte and £4,168.7k.
Quality Impact Assessment	*Completed ahead of implementation*
Equality Impact Assessment	*Completed ahead of implementation*
Assurance Level Assessment	*Insert assurance level* • *Significant*

Recommendations/ Decision Required	• Trust Board are asked to approve the annual establishment reviews, taking into account the additional factors of the escalated ED staffing requirements; Band2/3 role conversion and potential business cases of need.

Executive Summary

As part of ensuring we have safe nursing staffing levels on all our ward and other clinical areas, an annual establishment review is undertaken. The review for 2023 was carried out across all four sites, included 4 Divisions and Operations across 75 clinical areas both for in and non-in-patient areas.

A full establishment review was undertaken, the first full establishment reviews since 2021, as tabletop establishment reviews had been undertaken through 2022.

Several areas have resulted in a template uplift due to increased clinical need shown throughout the acuity and dependency data which in turn supports professional judgment.

Several areas have resulted in a reduction to template because of bed reconfiguration, service model changes and ward relocations.

Clarity around the Nursing Associate role responsibilities was provided in that the role is not a substitution for a fully registered nurse and is a complimentary role into the nursing workforce.

Additionally, this year, 3 other factors have been considered through the establishment review process:

1. Both Emergency Departments have been experiencing increased activity and length of stay of patients in the Depts. with a correlating need for staffing to ensure patient safety. The environmental challenges both Departments face in delivering treatments in a timely and dignified way due to the patients' prolonged length of stay and thus need for treatments, has resulted in the creation of 'additional' clinical space being made available so that treatments can be delivered, as well as a seated area full of patients waiting for admission.

This has resulted in an escalated staffing template for both ED's, which is not efficient as a staffing model but required due to current environmental and flow constraints. The aim is to move to a reduced staffing template as flow, length of stay and activity improves. 2 templates for each Dept. has been supported to enable this flexibility for staffing, according to demand in the Dept and patient need. As the UEC improvement work around flow, discharges, bed reconfiguration and frailty continue in year, the staffing element of the ED's will align to that work programme to ensure a move towards the de-escalated staffing position is realised and be embedded in the work programme.

2. In November 2021, the National Job Evaluation Group reviewed the National Health Care Support Worker (HCSW) job profile creating a separate Band 2 and a separate Band 3 profile. They deemed that health care has changed to such an extent that there are essentially two levels of HCSW. The first level is a Band 2 HCSW to be responsible for delivering "person centred care" and the second level is a Band 3 HCSW to undertake "clinical care" responsibilities. The establishment reviews have clarified where and how each role is required and this is embedded within the template per area.

3. 25 areas described a change to service either through extension of hours or days, or activity, which requires a change to staffing skill mix or staffing level. Some of these changes have already been enacted due to service need, for example Theatres, whereas others are looking to develop a case of need for the new part of the service. This impact needs to be fully understood both for the current run rate and potential for investment going into 24/25, this is included within the appendix.

The paper describes the changes needed to ensure safe staffing templates and the details of the impact of these changes is shown through the 4 Appendices:

Appendix 1 – All areas - excluding both Emergency Departments LCH/PHB - templates.
Appendix 2 – Both Emergency Departments LCH/PHB templates.
Appendix 3 – HCSW Band 2 / Band 3 changes.
Appendix 4 – Potential Business cases.

Annual Nurse Establishment Review 2023

1. Nursing Review Process:

The annual nurse establishment review set out in September through to November 2023, to take forward an annual full review of establishments, the first full establishment reviews since 2021, as tabletop establishment reviews had been undertaken through 2022.

Several areas will be reviewed in three- or six-months' time with another Safer Care Nursing Tool (SNCT) acuity and dependency data collection to support decision making, due to the reconfiguration of beds and service model changes that are taking place within the Organisation currently. These areas are made clear within the report and appendix.

This annual review was undertaken to enable the Director of Nursing to satisfy herself that the current nurse establishments continue to be appropriate for the Trust.

This paper sets out a review for the Divisions of Medicine, Surgery & Critical Care, Clinical Support Services and Family Health, and the Operations Service, reflecting the core bed base.

2. Medical Areas – Reviewed:

2.1 The review covers the following areas on the *Pilgrim Hospital site:*

- Emergency Department
- SDEC (first establishment review)
- Ward 1 (new model)
- Integrated Assessment Centre
- Acute Cardiac Unit
- AMSS (new model)
- Ward 6A
- Ward 6B
- Ward 7B
- Ward 8A/PIU

2.1.1 Areas with a template change are noted below:

The Emergency Department (ED) has had a significant change to patient activity, acuity and volume since the last review was undertaken and has over time, incrementally increased the staffing template according to defined need within the Dept, all at cost pressure to the Division.
The ED establishment review therefore sets 2 templates, one that staffs the ED if flow, activity, and volume are within improved activity and flow parameters for the ED (template 1) and one that sets the escalated template based on the current pattern, should this continue (template 2).
The Dept will manage staffing to flex up and down according to patient demand and clinical need, as the Organisational UEC improvement work continues, the move towards template 1 should be the focus. Appendix 2.

SDEC PHB had its first establishment review, and the current template may be subject to change based on an extension to service hours, but this will be taken through the business case route.

Ward 1 is now a short stay ward instead of a respiratory / COVID ward and as such has a template change with a reduction in B5 staff nurse requirement and a conversion of Band 2 to Band 3 role and will be subject to a 6-month review.

IAC have seen a significant change to the acuity of their patients, moving to 81% patients of being more acutely sick and unwell from a previous 73% but within that increase of acute presentation, the balance of Safer Nursing Care Tool (SNCT) Level 2* patients (*unstable and require constant detailed observation) has doubled, in brief this means that patients are sicker and more acutely unwell than in previous years. The template change sees an increase of 0.4wte B5 to support this clinical need. A 6-month review will be undertaken with a repeated SNCT data collection.

AMSS has moved location to 9A and will operate as a 72-hour short stay ward and has seen a reduction in bed base with a resulting reduction in template requirements. This will be subject to a 6-month review.

2.2 The review covers the following areas on the *Lincoln County site*:

- Emergency Department
- SDEC (first establishment review)
- Burton and Vulcan Suite
- Clayton
- Coronary Care Unit
- Cardiac Short Stay Unit
- Cardiac Cath Lab
- Johnson
- Dixon and Saxon Suite
- Lancaster
- Neustadt Welton
- Navenby
- Stroke Unit and HASU
- Scampton
- Witham and RSU

MEAU at LCH establishment review was not included and will be reviewed in 3 months or other relevant time, when it is clear how the planned new assessment model will be utilised.

2.2.1 Areas with a template change are noted below:

As with PHB site, the Emergency Department at LCH site has had a significant change to patient activity, acuity and volume since the last review was undertaken and has over time, incrementally increased the staffing template according to defined need within the Dept, all at cost pressure to the Division.
The ED establishment review therefore sets 2 templates, one that staffs the ED if flow, activity, and volume are within improved activity and flow parameters for the ED (template 1) and one that sets the escalated template based on the current pattern, should this continue (template 2).
The Dept will manage staffing to flex up and down according to patient demand and as the Organisational UEC improvement work continues, the move towards template 1 should be the focus. Appendix 2.

SDEC LCH had its first establishment review, and the current template will be subject to change based on service hours being extended but this will be taken through the business case route.

Scampton ward has seen a significant increase in the dependency of patients from 53% in 2021 to 84% in 2023, with an aligned increase in the requirement of patient needing an enhanced level of care. This has resulted in a template increase of 1 HCSW on the Night shift to ensure safe staffing levels at night-time.

Clayton ward has also seen an increase in the enhanced level of care needs for patients and an increase of 1 HCSW on the Night shift to ensure safe staffing levels for the care required was supported.

Johnson ward has seen an increase in the number of patients requiring SNCT level 1b* care (*stable but dependant on nursing care to meet most or all care needs) from 77 per year in 2021 to 191 in 2023, almost three times as many patients due to the increase in patients with complex heart failure and those who require a long hospital stay, therefore an increase of 1 HCSW on the day shift is supported.

Cardiac Short Stay Unit (CSSU) was supported in principle to increase its B6 shift coordinator provision due to changes in the service delivery and will take this through the business case route.

Lancaster ward moved to the Clayton ward area, which resulted in a reduction in template for both registrant and unregistered staff at night-time and will be SNCT reviewed again in 6 months.

The Stroke Unit require a change from the twilight shift to a night shift due to the shortfall it left once the shift finished part way through the night, is not conducive to safe staffing levels.

Vulcan suite is developing a business case of need due to the additional work required across the wards on site, that need the specialist nursing skill set from the Burton team.

2.3 The review covers the following areas on the *Grantham site*:

- UTC Plus
- EAU
- Harrowby

No changes to establishment were required by either ward, although the conversion from band 2 to band 3 role is required for some shifts as identified within the Appendix.

The UTC Plus staffing template was agreed based on initial service assumptions and will be subject to a 6-month review. It also includes a band 3 role.

2.4 Summary

Medicine Division excluding ED departments had an overall reduction of (16.38) wte and full year effect reduction of funding of £ (1,115) k.

The ED departments at their escalation levels require an investment of 53.85 wte and £2,515.8k full year effect.

Therefore, Medicine Division including an escalated ED department at Lincoln and Pilgrim would require an increase of 37.46wte and £1,400.8k funding.

These numbers include the Band 3 financial impact, later discussed.

3. Surgical Areas– Reviewed:

3.1 This review covered the following areas on the *Pilgrim Hospital site:*

- Ward 9A – now 3A
- 7A – now 3B
- Day Case ward – Elective Surgical Unit
- Ward 5A
- Ward 5B
- ICU
- Theatres

3.1.1 Areas with a template change are noted below:

3A have a reduced template due to the reconfigured ward, with an increase to Band 6 24-hour shift coordinator cover due to an increase in occupancy from 95% in 2021 to 100% in 2023 and the increased numbers of direct admissions to the ward requiring senior nursing oversight and leadership of the ward over the 24-hour period. This will be subject to a 6-month review.

3B require an adjustment to their template due to ward relocation and an increase in beds, requiring an uplift by 1 Registrant per long day shift and an uplift of 1 HCSW per Night shift to ensure staffing ratio of 1:8 on days and 1:10 at night. This will be subject to a 6-month review.

Day Case Ward – Elective Surgical Unit has increased by 1 HCSW on the early shift and by utilising the unused unregistered B4 posts within the budget, the template change is supported in principle and is a cost borne within the Division.

5A have seen an increase from 12% in 2021 to 21% in 2023 of SNCT Level 1a* patients (*Acutely ill patients requiring intervention or those who are unstable with a greater potential to deteriorate) and take more direct admissions to support hospital flow requiring an uplift to a 4th nurse at Night-time.

PHB Theatres have additional lists and activity which require substantive staffing and will be taken through the CRIG business case route.

3.2 The review covers the following areas on the *Lincoln County site:*

- Digby
- Greetwell
- Hatton
- ICU
- SEAU
- Shuttleworth
- SAL
- Theatres

3.2.1 Areas with a template change are noted below:

SEAU have seen an increase in the number of patients at SNCT Level 2* (* unstable and require detailed observations) from 0% in 2021 to 13% in 2023 and a 4% increase in Level 1a* patients (*Acutely ill patients requiring intervention or those who are unstable with a greater potential to deteriorate) so an overall 17% increase in sick unstable patients who require a high level of nursing care. Therefore, an increase in the 24-hour Band 6 shift coordinator cover is supported to ensure senior nursing leadership and oversight is maintained through this assessment Unit.

Shuttleworth ward have a similar patient profile and expectation to the 3A ward at PHB and require Band 6 24-hour senior nursing leadership due to direct admissions to support hospital flow and the requirement to carry the Hospital site bleep for trauma, every evening, and every night. The Clinical Education role is subsumed into the B6 role within the ward.

Digby ward shift pattern was all short shifts, the change to a blended model of both long and short shifts is supported.

SAL will require a Band 3 HCSW on the long day shift, Monday through to Friday and this will be included in the Band 2 – Band 3 conversions.

LCH Theatres have additional lists and activity which require substantive staffing and will be taken through the CRIG business case route.

3.3 The review covers the following areas on the *Grantham site:*

- Combined surgical unit (ward1&2)
- Theatres

3.3.1 Areas with a template change are noted below:

GDH Surgical unit will be included within the Band 2 – Band 3 HCSW conversion for the day shift.

GDH Theatres have additional lists and activity which require substantive staffing and will be taken through the CRIG business case route.

3.4 The review covers the following areas on the *Louth site*:

- Fotherby ward
- Theatres

3.4.1 Areas with a template change are noted below:

Louth Theatres and Fotherby ward have additional lists and activity which require substantive staffing and will be taken through the CRIG business case route.

3.5 Summary

Surgery Division overall, from the establishment review reports a reduction of (5.73) wte and a full year effect reduction of funding of £ (70.6) k.

These numbers include the Band 3 financial impact, later discussed.

4. **Clinical Support Services Areas – Reviewed:**

4.1 This review covered the following areas on the *Pilgrim Hospital site:*

- Bostonian
- Chemotherapy suite

4.1.1 Areas with a template change are noted below:

PHB Chemotherapy suite have additional activity and require a service extension to hours, which require substantive staffing and will be taken through the CRIG business case route.

4.2 This review covered the following areas on the *Lincoln Hospital site:*

- Ashby
- Waddington
- OAU
- Ingham Suite

4.2.1 Areas with a template change are noted below:

Ashby ward has seen a 3% increase in the dependency of patients since 2021, but with an increase in the complexity and enhanced care needs of the patients by 11% thus requiring an additional HCSW on the long day and the long night shift.

Waddington has seen an increase in SNCT Level 1a* ((*Acutely ill patients requiring intervention or those who are unstable with a greater potential to deteriorate) from 19% in 2021 to 76% in 2023 due to the complexity of the Heamatology / oncology patient profile and complexity of the chemotherapy drug regimes. Therefore, an uplift of 1 Registrant at night-time was supported to ensure safe staffing to meet patient clinical needs.

OAU and Ingham suite will both be subject to business cases of need through the CRIG route due to additional demands on the service and staffing requirements to meet service needs.

4. 3 This review covered the following areas on the *Grantham site:*

- Emerald Suite
- Hospice in the Hospital

4.3.1 Areas with a template change are noted below:

The Hospice in the Hospital is currently reviewing its contract with St Barnabas and will review staffing requirements as part of that process.
The Emerald Suite will be included in the overall chemotherapy service review alongside the Chemotherapy suite at PHB and the Ingham Suite at LCH.

4.4 Summary

There is 7.78wte and £319.1k full year effect increase in funding requested for the Clinical Support Services Division through this establishment review.

These numbers include the Band 3 financial impact, later discussed.

5 Family Services Areas – Reviewed: CYP

5.1 This review covered the following areas on the *Pilgrim Hospital site:*

- Neonatal unit
- 4A
- Childrens Outpatients

5.1.1 Areas with a template change are noted below:

4A will look at introducing a support worker role as opposed to a healthcare support worker as a new role within the Division.

Outpatients Dept. Will have a conversion of Band 2 to Band 3 role within the service and this is included within the Appendix. Review in 3 months.

5.2 This review covered the following areas on the *Lincoln Hospital site:*

- Rainforest
- Safari
- Childrens Outpatients

5.2.1 Areas with a template change are noted below:

Rainforest will look at introducing a support worker role as opposed to a healthcare support worker as a new role within the Division.

Outpatients Dept. Will have a conversion of Band 2 to Band 3 role within the service and this is included within the Appendix. Review in 3 months.

5.3 This review covered the following areas on the *Grantham site:*

- Childrens outpatients – Kingfisher

5.3.1 Areas with a template change are noted below:

Outpatients Dept. will have a conversion of Band 2 to Band 3 role within the service and this is included within the Appendix. Review in 3 months.

Family Services Areas – Reviewed: Women and Maternity

5.4 This review covered the following areas on the *Pilgrim Hospital site:*

- 1B
- M1
- Labour Ward

5.4.1 Areas with a template change are noted below:

M1 have seen an increase in the complexity of birthing women, especially regarding diabetes care as well as re-admissions and an uplift of 1 Midwife on the late shift is supported.

Labour Ward sees a change in the HCSW shift from 1 long day to an Early / Late split.

5.5 This review covered the following areas on the *Lincoln Hospital site:*

- Branston
- Nettleham
- Bardney

5.5.1 Areas with a template change are noted below:

No Changes noted.

5.6 Summary

Family Health Division through this establishment review require 1.24 wte and £100.1k full year effect increase in funding.

These numbers include the Band 3 financial impact, later discussed.

A Summary of the financial impact of the 2023.24 Establishment Review is illustrated in the table below.

Division	Budget WTE	Budget £	Total New WTE	Total New £	Impact WTE	Impact £
CSS	108.12	4,770,900	115.90	5,090,000	7.78	319,100
Family Health	375.52	19,367,000	376.76	19,467,100	1.24	100,100
Medicine	1,008.29	45,157,550	991.91	44,042,550	-16.38	-1,115,000
Surgery	940.80	41,766,400	935.07	41,695,800	-5.73	-70,600
Grand Total	**2,432.73**	**111,061,850**	**2,419.65**	**110,295,450**	**-13.08**	**-766,400**
A&E - Escalating	236.97	11,677,700	290.82	14,193,500	53.85	2,515,800
TOTAL	**2,669.70**	**122,739,550**	**2,710.46**	**124,488,950**	**40.76**	**1,749,400**

6. Operations Service – Reviewed:

6.1 This review covered the following areas on the *Pilgrim and Lincoln sites:*

- Discharge Lounges – PHB / LCH

Discharge Lounges will both be subject to business cases of need through the CRIG route due to being an unfunded 24/7 service, but is delivering a 7day 24/7 service currently, and a staffing establishment with funded budgets to meet service needs are required. A 3-month review will take place.

7. Methodology

Each establishment review was undertaken as a full review with the divisional nurse, supported by the Director of Nursing. An objective approach using the existing model for the establishment which is configured to create both an establishment and budget for any given shift pattern was taken.

Establishments have been reviewed using the Trust's long day and long night shift pattern and where appropriate 1 short shift pattern to create flexibility in the rota, apart

from the Emergency Departments which both offer a 4-shift pattern to capture activity peaks and troughs in the 24 hour period.

The establishment model uses the following assumptions:

- Shift patterns as identified for each ward / clinical area
- Leave cover arrangements based upon standard leave entitlements (33 + 8 B/H)
- Training cover set to 8 days per WTE per year
- Sickness absence cover set at 3.65% sickness rate (bank cover) check

The calculated establishments include all nursing but exclude ward support functions and ward administration. They do include supernumerary nurse management time tied directly to the ward establishment. This has been apportioned to a 60:40 split reflecting 3 days supernumerary and 2 days clinical supervisory, therefore, legitimising actual practice and in line with the Ward Leaders handbook. Some areas have full time supernumery status for the Ward Leader where the needs of the clinical area reflect that requirement.

In addition, the review continued to assume a default position of two registered nurses on night shift as a minimum. The weighting of 0.25 WTE was offered per side room for each ward considering the geographical footprint of the ward and potential to have a reduced line of sight when in the side rooms.

Each ward was reviewed regarding the nursing workforce plan to incorporate Trainee and Nursing Associates and extended clinical placements for student nurses. Clarity around the NA role responsibilities was provided through the reviews, in that the role is not a substitution for a fully registered nurse and is a complimentary role into the nursing workforce which still requires supervision and direction, their responsibilities do not include prescribing of nursing care, but to support the nursing team with their own level of accountability.
This year further discussion ensued around the creation of a new role in several areas that will be a ward support worker role rather than a healthcare support worker role. The areas themselves will take this forward through the Trust new role pathway.

8. Band 2 / Band 3 Healthcare Support Worker role development

In November 2021, the National Job Evaluation Group reviewed the National Health Care Support Worker (HCSW) job profile creating a separate Band 2 and a separate Band 3 profile.

They deemed that health care has changed to such an extent that there are essentially two levels of HCSW. The first level is a Band 2 HCSW to be responsible for delivering “person centred care” and the second level is a Band 3 HCSW to undertake “clinical care” responsibilities.

There is no national directive regarding reviewing establishments to determine where Band 2 roles and where Band 3 roles may be required to deliver safe and effective care; this was left to the discretion of individual organisations. Within the Trust a task and finish group was established to explore this change and the impact for the Trust.

The resulting proposal has already sought support in principle through the Executive Leadership Team but has been subject to further exploration through the establishment review process.

The annual Nursing Establishment Review allowed for further conversations and clarity where needed, about skill mix and template requirements. This has allowed the Director of Nursing to 'firm' up the proposals for change to the HCSW establishment with the details of Band 2 posts to be deleted from the establishment and Band 3 posts to be created in the establishment shown in the Appendix 3.

The change to role will require a Management of Change process and a formal consultation. This is currently being developed with HR colleagues in readiness to move forwards with this change. 2 options exist regarding financial change for the individual and the impact on the Trust. This will be discussed as part of the Consultation and the impact is shown in Appendix 3. The Committee is asked to note the impact of this Organisational change.

The financial impact already reported within the overall templates is £172.8k

9. Business cases

25 clinical areas will be developing business cases to go to the Trust CRIG group, due to service extension of hours / days/ or changes that require additional or different staffing levels, over and above their current establishments. These are identified below:

- Medicine: both ED's / GDH UTC Plus / Cardiac short stay Unit / both SDEC's / Vulcan suite
- Surgery: Day case Ward Elective Surgical Unit PHB / All 4 Theatre sites / SEAU / Fotherby ward
- CSS: All 3 Chemotherapy suites
- FH: 4A / Rainforest and Safari
- Discharge Lounges - PHB/LCH.

Some of the clinical areas noted above have already implemented the changes needed as a part of their current service delivery, so are running at risk within the run rate for example Theatres / ED's, and this clarity is provided in the Appendix 4.

The Committee is asked to note the potential budgetary impact for all future business cases which may impact on 24/25 plans of 97.44wte and £4,169k.

CRIG methodology will be updated to include an expectation that any case with a staffing requirement has been supported and signed off in principle through the Director of Nursing office, as part of the case development. This will allow CRIG to be sighted on this going forwards. A method of prioritising cases will be established through the CRIG route.

10. Outcome of the Review:

Appendix 1 summaries the outcome for each ward based on the core number of beds, occupancy and acuity of patients.

Appendix 2 summarises the impact of the de-escalated template (1) and escalated template (2) for both ED's, based on current and aspirational patient need and activity, and flow through the Dept.

Appendix 3 summarises the changes from Band 2 to Band 3 for those areas requiring a role change.

Appendix 4 summarises the potential and actual impact of the 25 areas looking at a business case due to service changes.

Roster plan appendices, with the detailed calculations for each area, including the occupancy rate assumptions are available separately.

This paper reports changes in the establishments as detailed and provides the Director of Nursing, Director of Finance and Chief Operating Officer with significant assurance that the establishments are robust.

11. Recommendations:

FPEC are asked to note and support:

- the outcome of the establishment reviews
- changes to the Band 2 / Band 3 role development
- and the way forward regarding the multiple potential Business Cases of Need.
- the ED staffing templates will be aligned to the operational programmes of work around discharge / flow to steer the move towards a de-escalated staffing template.

Angie Davies
Director of Nursing

Jon Young
Director of Finance

Julie Frake-Harris
Chief Operating Officer.

January 2024

Appendix 1 – Establishment review 2023.24 Financial impact (excluding ED departments)

Division	New Ward/ Are name	Total New Proposed WTE	Total New Proposed £	Budget WTE	Budget £	Impact WTE	Impact £
Medicine	Integrated Assessment Centre	44.19	1,946,200	42.86	1,885,900	1.33	60,300
Medicine	Acute Medical Short Stay Unit	46.53	2,093,900	62.54	2,814,800	(16.01)	(720,900)
Medicine	Lin Emergency Assessment Unit	90.00	3,894,300	90.00	3,894,400	(0.00)	(100)
Medicine	EAU	39.01	1,707,500	39.02	1,700,700	(0.01)	6,800
Medicine	Ward 1 Covid	32.36	1,221,100	38.32	1,904,600	(5.96)	(683,500)
Medicine	Ward 6a	39.50	1,665,800	39.48	1,657,300	0.02	8,500
Medicine	Ward 6b	39.50	1,708,300	39.48	1,698,000	0.02	10,300
Medicine	Ward 7b Respiratory	39.28	1,710,300	39.28	1,709,700	(0.00)	600
Medicine	Ward 8a	43.82	1,856,300	43.82	1,852,900	(0.00)	3,400
Medicine	Scampton Ward	30.55	1,254,100	28.04	1,162,600	2.51	91,500
Medicine	Carlton Colbey	41.07	1,726,300	38.56	1,622,600	2.51	103,700
Medicine	Dixon Ward	34.90	1,499,200	33.29	1,429,500	1.61	69,700
Medicine	Neustadt Welton	54.33	2,268,300	54.33	2,264,500	0.00	3,800
Medicine	Harrowby Ward	30.55	1,307,900	30.55	1,307,900	0.00	0
Medicine	Clayton F.A.U	28.04	1,189,900	33.30	1,402,400	(5.26)	(212,500)
Medicine	Witham RSU	55.85	2,392,100	55.39	2,375,600	0.46	16,500
Medicine	Acute Cardiac Unit	24.38	1,019,400	24.38	1,019,400	0.00	0
Medicine	Lincoln Stroke Unit	51.59	2,451,800	51.28	2,437,600	0.31	14,200
Medicine	Pilgrim Stroke Unit	36.50	1,534,700	36.50	1,534,700	(0.00)	0
Medicine	Navenby Diabetes	38.56	1,702,700	38.56	1,699,300	(0.00)	3,400
Medicine	Johnson Ward	45.62	2,251,800	43.93	2,171,700	1.69	80,100
Medicine	Cardiac Short Stay	27.10	1,183,100	26.71	1,165,100	0.39	18,000
Medicine	Burton Ward	40.69	1,833,500	40.69	1,833,500	0.00	0
Medicine	Cardiac Catheter Lab Nursing	21.03	941,000	21.03	936,900	0.00	4,100
Medicine	Lincoln SDEC	15.69	1,223,750	15.69	1,220,550	0.00	3,200
Medicine	Pilgrim SDEC	1.26	459,300	1.26	455,400	0.00	3,900
Surgery	Ward 3A (was 9A)	38.56	1,651,200	44.96	1,871,400	(6.40)	(220,200)
Surgery	Ward 3BA (was 7A)	38.56	1,737,700	32.09	1,510,800	6.47	226,900
Surgery	Ward 5a	44.27	1,985,900	41.76	1,855,900	2.51	130,000
Surgery	Ward 5b	36.50	1,560,100	36.50	1,553,300	(0.00)	6,800
Surgery	Day Case Ward Phb	35.88	1,652,400	37.39	1,704,800	(1.51)	(52,400)
Surgery	Intensive Care Unit Nurse PHB	51.16	2,700,100	51.62	2,723,300	(0.46)	(23,200)
Surgery	Digby Ward (Orthopaedics)	35.81	1,542,200	38.10	1,630,300	(2.29)	(88,100)
Surgery	Greetwell Ward	33.30	1,470,300	33.30	1,463,500	(0.00)	6,800
Surgery	Hatton Ward	41.53	1,894,100	41.53	1,887,100	0.00	7,000
Surgery	SEAU	36.37	1,650,700	37.31	1,646,900	(0.94)	3,800
Surgery	Shuttleworth	41.76	1,837,400	41.76	1,801,500	(0.00)	35,900
Surgery	Surgical Admissions Lounge LCH	34.21	1,514,200	36.87	1,604,800	(2.66)	(90,600)
Surgery	Grantham Surgical Unit	58.23	2,674,700	58.68	2,688,000	(0.45)	(13,300)
Surgery	Intensive Care Unit Nurse LCH	78.37	4,068,600	78.37	4,068,600	0.00	0
Surgery	Theatres LCH	131.38	5,490,000	131.38	5,490,000	0.00	0
Surgery	Theatres PHB	122.50	5,195,300	122.50	5,195,300	0.00	0
Surgery	Theatres GDH	51.18	2,101,600	51.18	2,101,600	0.00	0
Surgery	Theatres CHL	14.99	559,000	14.99	559,000	0.00	0
Surgery	Fotherby Ward CHL	10.51	410,300	10.51	410,300	0.00	0
Family Health	Bardney Ward	54.99	3,249,800	54.99	3,249,800	0.00	0
Family Health	Nettleham Ward	41.28	2,276,200	41.28	2,276,200	(0.00)	0
Family Health	Labour Ward	35.01	2,201,000	34.60	2,185,200	0.41	15,800
Family Health	Ward M1 Maternity	22.98	1,279,200	22.16	1,221,700	0.82	57,500
Family Health	Branston Ward	26.21	1,134,900	26.21	1,131,200	0.00	3,700
Family Health	Ward 1B Womens Health	23.92	1,073,000	23.92	1,062,600	0.00	10,400
Family Health	Neonatal Services	46.87	2,374,000	46.87	2,374,000	(0.00)	0
Family Health	SCBU	24.28	1,246,600	24.28	1,246,600	0.00	0
Family Health	Rainforest Ward	46.93	2,293,000	46.93	2,293,000	0.00	0
Family Health	Ward 4A	34.82	1,564,900	34.82	1,564,900	0.00	0
Family Health	Safari Ward	9.33	398,000	9.33	395,400	0.00	2,600
Family Health	Kingfisher Unit	4.01	161,500	4.01	159,100	0.00	2,400
Family Health	Paediatric Clinic 5	3.24	104,500	3.24	98,800	0.00	5,700
Family Health	Pilgrim Paeds OP	2.88	110,500	2.88	108,500	0.00	2,000
CSS	Waddington Unit	43.82	1,976,900	41.30	1,851,000	2.52	125,900
CSS	Ashby Ward	35.81	1,511,300	30.55	1,325,000	5.26	186,300
CSS	Bostonian Oncology Ward	36.27	1,601,800	36.27	1,594,900	0.00	6,900
		2,419.65	**110,295,450**	**2,432.73**	**111,061,850**	**-13.08**	**-766,400**

Appendix 2 – Establishment review 2023.24 Financial impact of ED departments.

Lincoln and Pilgrim Emergency Departments financial impact.

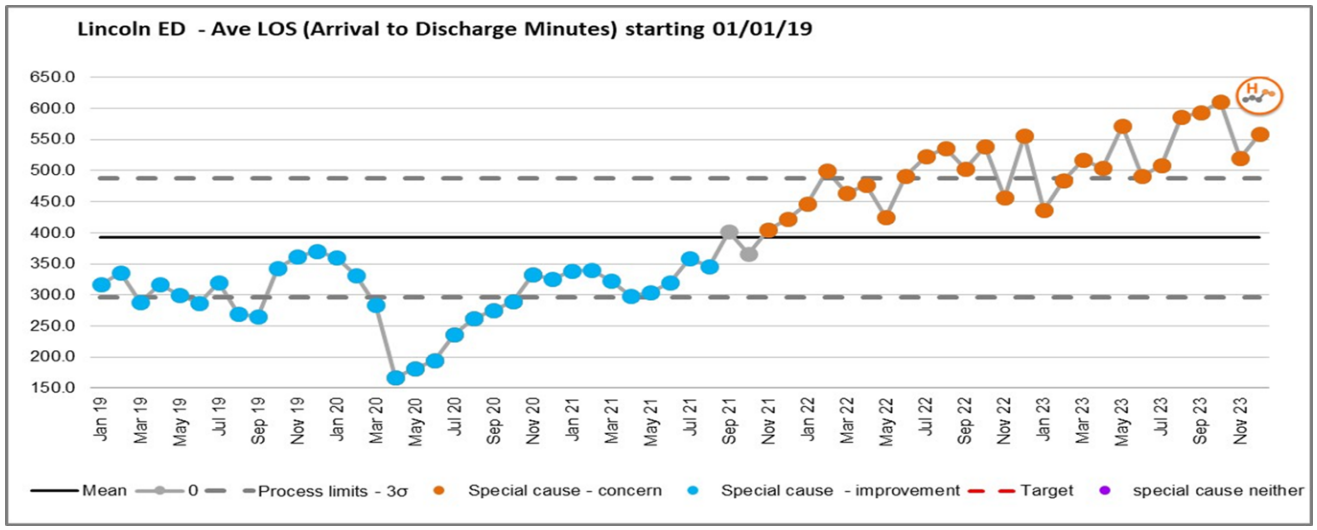
Non-Escalated Template 1

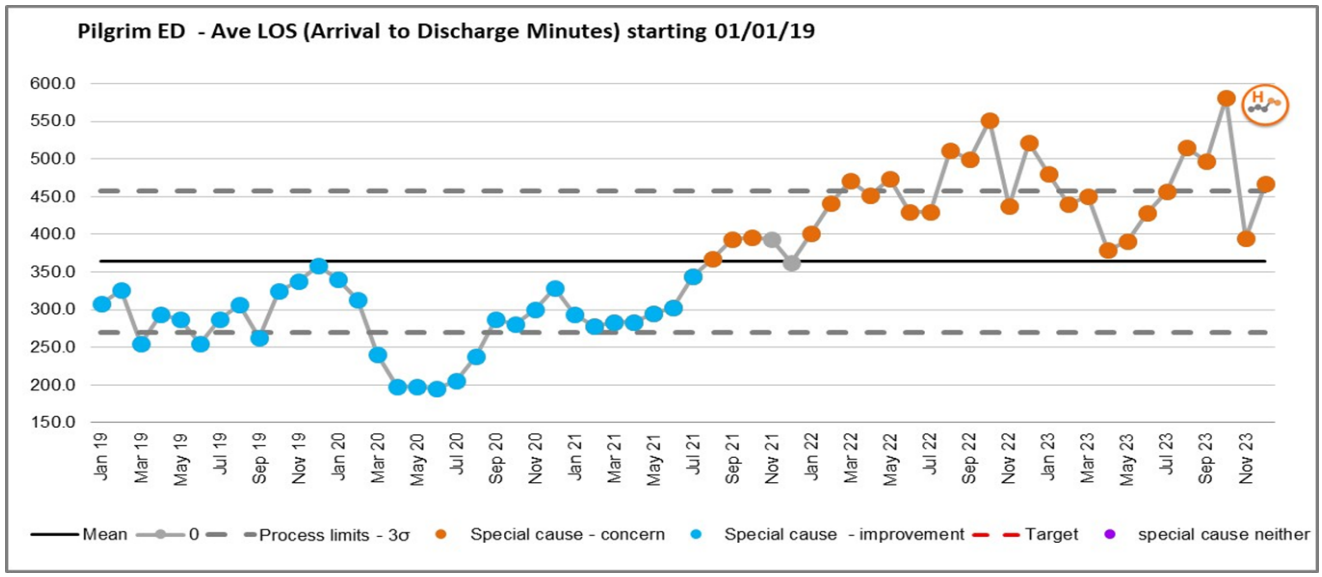
Division	New Ward/ Are name	Total New Proposed WTE	Total New Proposed £	Budget WTE	Budget £	Impact WTE	Impact £
Medicine	A&E Lincoln	129.62	6,467,500	128.05	6,270,000	1.57	197,500
Medicine	A&E Pilgrim	124.38	6,122,200	108.92	5,407,700	15.46	714,500
		254.00	**12,589,700**	**236.97**	**11,677,700**	**17.03**	**912,000**

Escalation Template 2

Division	New Ward/ Are name	Total New Proposed WTE	Total New Proposed £	Budget WTE	Budget £	Impact WTE	Impact £
Medicine	A&E Lincoln	150.66	7,385,000	128.05	6,270,000	22.61	1,115,000
Medicine	A&E Pilgrim	140.16	6,808,500	108.92	5,407,700	31.24	1,400,800
		290.82	**14,193,500**	**236.97**	**11,677,700**	**53.85**	**2,515,800**

Below charts illustrate the average length of stay changes at both ED's since January 2019





Appendix 3 – Health care support worker Band 2 to 3 changes

All the existing staffing templates have been populated to include Band 3 HCSW's if the service requires the relevant skill set, therefore all the ward financial costings already include the budgetary impact of the Band 2 to 3 change.

The summary financial impact associated with this proposed change is illustrated in the table below:

Division	Band 2 to 3 WTE	Band 2 to 3 Funding £
CSS	16.01	14,100
Family Health	19.57	25,800
Medicine	61.53	67,400
Surgery	50.43	65,500
Grand Total	**147.54**	**172,800**

The financial impact is materially lower than originally anticipated and in comparison, to the wte. This is mainly due to:

The Band 2 pay scale only has one salary; it is made up of seven scale points but all of them are the same salary. Therefore, there is no top, middle, or bottom of the scale.

Agenda for Change enhancements for a Band 3 for working an evening and weekends are lower than a Band 2, as illustrated in the table below.

Pay band	All time on Saturday (midnight to midnight) and any week day after 8 pm and before 6 am	All time on Sundays and Public Holidays (midnight to midnight)
1	Time plus 47%	Time plus 94%
2	Time plus 41%	Time plus 83%
3	Time plus 35%	Time plus 69%
4 – 9	Time plus 30%	Time plus 60%

It is not known who is going to work the enhanced shifts in a team budget, so a standard nurse shift checker is used in the finance model. This checker calculates the enhanced rate of the specific wards template using the AFC guidance and then uses this to calculate the overall % of hours for the staff group which will be enhanced, this percentage is then used to budget set for enhanced hours, across the staff group.

Calculating this for a relatively standard ward shift pattern for HCSW's of:

3 on a long day,1 on an early shift, 1 on a late shift and 3 on a long night.

The overall enhanced hours at the enhanced rate % drops from a Band 2 at 33.28% to a Band 3 at 26.31%.

The table below illustrates that the basic salary budget including on costs between a Band 2 and bottom of a Band 3 is £600, £27,400 compared to £28,000 however when the overall enhancements rates are applied, a Band 2 moves to £36,500 whilst a bottom of a Band 3 moves to £35,400, a negative variance of £1,100.

Appendix 3 – Health care support worker Band 2 to 3 changes

If we compare the same against Mid-point of a Band 3 basic salary budget including on costs difference is £2,500, whilst when enhancements are attributed the mid-point Band 3 moves to £37,800, giving an increase of £1,300.

The £1,300 budgetary impact is the increase we have assumed for our Band 2 to 3 in the model. This calculation does assume all staff on the template work a shared number of unsociable hours, given that actual salaries will be impacted differently depending on their usual shift patterns.

T/M/B	Banding	Payscale	Spine Point	Inc Point	2023/24 Salary £	Budget (including oncosts)	Variance in budget B2 to B3	New Enhanced Budget	Variance in Enhanced budget B2 to B3
	AFC Band 2	XN0207	7	6	22,383	27,400			
Top	AFC Band 2	XN0208	8	7	22,383	27,400		36,500	
Bottom	AFC Band 3	XN0301	6	1	22,816	28,000	**600**	35,400	**-1,100**
	AFC Band 3	XN0302	7	2	22,816	28,000			
Mid	AFC Band 3	XN0303	8	3	24,336	29,900	**2,500**	37,800	**1,300**
	AFC Band 3	XN0304	9	4	24,336	29,900			
	AFC Band 3	XN0305	10	5	24,336	29,900			
	AFC Band 3	XN0306	11	6	24,336	29,900			
Top	AFC Band 3	XN0307	12	7	24,336	29,900	**2,500**	37,800	**1,300**

This means for the purpose of calculating the financial impact we have assumed the £1,300 for each wte that moves from a band 2 to 3.

HR will pick up in the consultation regarding the band 2-3 role change, whether we will need to move all affected band 2's to a mid-point of a band 3 so as to not detrimentally affect their take home salary.

Appendix 4 – Potential business cases

The following tables show the areas identified through the establishment review that require a business case for change and their potential financial impact.

Some of these changes are already fully or partially within the financial position, this is in various ways, over establishments or excess bank and agency spend.

Potential business cases for CRIG in the next 6 months equate to £4,169k and 97.44wte

Business cases which are fully /partially in the run rate in 2023.24 and will continue into 2024.25.

					Total	
Division	Ward name	Are we already doing it ?	Is this New or in the runrate?	Description	Wte	£
Clinical Support Services	Ingham Suite	Yes Partially	Runrate	Rightsizing workforce for opening hours and skill mix and to cover additional services (Oral's)	-0.13	17,803
Medicine	Lincoln SDEC	Yes Partially	Runrate	To be agreed	0.00	0
Medicine	Pilgrim SDEC	Yes Partially	Runrate	To be agreed	0.00	0
Medicine	Lincoln ED	Yes Partially	Runrate	To be agreed	0.00	0
Medicine	Pilgrim ED	Yes Partially	Runrate	To be agreed	0.00	0
Medicine	Grantham UTC	Yes Partially	Runrate	To be agreed	0.00	0
Surgery	Lincoln Theatres	Yes Partially	Runrate	Increase template to reinstate closed theatres	30.00	1,057,500
Surgery	PHB Theatres	Yes Partially	Runrate	Realighn staffing between Registered and HCSW	18.00	744,400
Surgery	Grantham Theatres	Yes Partially	Runrate	Increase staffing not picked up as part of business case	5.85	228,500
Surgery	Pre Op	Yes Partially	Runrate	Increase in D&C To be agreed	0.00	0
Corporate	Discharge Lounge Lincoln	Yes Partially	Runrate	Substantively Fund new opening hours	15.60	828,800
Corporate	Discharge Lounge Pilgrim	Yes Partially	Runrate	Substantively Fund new opening hours	10.04	586,600
Medicine	Vulcan suite	Yes Partially	Runrate	To be agreed	0.00	0
					79.36	3,463,603

Business cases which will be new spend.

					Total	
Division	Ward name	Are we already doing it ?	Is this New or in the runrate?	Description	Wte	£
Family Health	Rainforest	No	New	Additional Clinical Educator and Additional Play Specialist	1.40	55,900
Family Health	4A	No	New	Additional Clinical Educator and Additional Play Specialist	1.80	70,200
Family Health	Safari	No	New	Additional Play Specialist	0.20	6,500
Clinical Support Services	Emerald Suite	No	New	Rightsizing workforce for opening hours and skill mix and to cover additional services (Oral's)	3.02	116,779
Clinical Support Services	Chemo Suite	No	New	Rightsizing workforce for opening hours and skill mix and to cover additional services (Oral's)	3.03	124,222
Clinical Support Services	Mobile Chemo Unit	No	New	Rightsizing workforce - to offset some of above	-0.40	-17,168
Clinical Support Services	OAU (Waddington)	No	New	To be agreed	0.00	0
Clinical Support Services	OAU (Bostonian)	No	New	To be agreed	0.00	0
Surgery	SEAU	No	New	Addition RN - flow coordinator	1.00	61,000
Surgery	Louth Theatres	No	New	Established for 4 days move to 5	5.78	212,500
Surgery	Fotherby	No	New	Increase in staffing	2.25	75,200
					18.08	705,133

The numbers illustrated above are indicative and will be superseded by the individual case of need.

Report to:	Trust Board
Title of report:	Finance, Performance and Estates Committee Assurance Report to Board
Date of meeting:	25 January 2024
Chairperson:	Dani Cecchini, Chair
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received, and key decisions made by the Finance, Performance and Estates Committee (FPEC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme. The Committee worked to the 2023/24 objectives.
Assurances received by the Committee	**Assurance** in respect of SO 3a A modern, clean and fit for purpose environment **Estates Upward Report** The Committee received the report which escalated a number of items including the sinkhole at Pilgrim which would require additional funding to rectify. Lift failures were also escalated for both Pilgrim and Lincoln sites with the Committee requesting a further update on the actions in place to gain assurance on the position. The Committee noted the outcome of the PLACE report which had inspected different areas to the previous report, overall the cleanliness standard had been reported as high and work was underway to ensure support was in place for food and nutrition. The outcome of the 6-facet survey was noted which confirmed the understanding of the required investments for improvement to the Trust estates which would support prioritisation of works and funding. It was recognised that the outcome of the survey offered information on the physical value of the assets of the Trust and did not identify the replacement value. The Committee noted that this could result in the potential for an increase in the costs to rectify issues identified. The results of the survey were still under review/validation by the estates teams before a final report would be issued. **Emergency Planning Group to inc NHS Core Standards EPRR** The Committee received the NHS Core Standards report for Emergency Planning Resilience and Response (EPRR) with all organisations having been assessed by NHS England.

	It was noted that the Trust had received a lower level of compliance than previously achieved however this was due to changes to the assessment and the learning from recent major incidents across the country, such as Grenfell. The Trust was fully compliant with 51 of the 62 standards and partially compliant for 11. The Committee sought further assurance on the completion and monitoring of business continuity plans which would be offered outside of the meeting. Significant assurance was received by the Committee regarding the EPRR standards.
	Assurance in respect of SO 3b Efficient Use of Resources **Finance Report inc Efficiency, Capital, Contracts, CRIG Upward Report and PLCIS Q1 and Q2** The Committee received the finance report with limited assurance noting the adverse variance to plan of circa £40k year-to-date. It was recognised that this was due to the impact of industrial action costs in December. Future guidance was anticipated at month 10 in respect of the allowability of industrial action costs within the financial position however it was noted that the financial position, at this time, remained aligned to the H2 reset plan. The Committee considered the Cost Improvement Programme (CIP) which was reported at £7.8m favourable to plan and forecast delivery for the year continuing to £31m. The cash position was noted at £36.4m which, over the coming months would reduce as the Trust moved in to the 24/25 year. The Committee noted the continuation of the Better Payment Practice Code (BPPC) improvement plan which was anticipated to show improved delivery through May and June as the pharmacy actions were embedded. Salary-overpayments were noted as a concern with the Committee supporting a referral to the People and OD Committee to ensure that the appropriate workforce actions were being undertaken to improve the position. The Committee received the capital report with moderate assurance noting the increase from month 8 as expected. The Electronic Patient record MOU was reported at £57.4m which aligned to expectations. Year-to-date capital spend for the Trust was reported at £21.2m which was behind plan by £8.2m however there were no concerns raised on the ability to deliver the full programme by year end.

	The Committee received the Capital Revenue and Investment Group (CRIG) upward report noting that the majority of cases presented were supported by ring-fenced funding streams with a number being supported by charitable funds. The Committee noted the contract position moving from Q4 of 2023/24 in to the 2024/25 year with progress on track and negotiations scheduled to commence in February. Clear governance would be required to reflect changes to contracting positions from NHS England to the ICB with regard to specialised services. The Patient Level Information and Costing System (PLICS) report was received with moderate assurance with improvements demonstrated over recent years in data collection and utilisation. **Improvement Programme Deep Dive – Extra Contractual Rate** The Committee received the deep dive with moderate assurance noting the target of £3m against the programme however recognised that achievement of this had been impacted by industrial action. The Committee reflected on the impact that job planning would have on achieving the extra contractual rate and requested that progress on this be referred to the People and OD Committee. Whilst the programme of work was not yet achieving delivery at the level anticipated the Committee was assured on the governance in place with an awareness of the limiting factors. **Further Faster Productivity Group Report** The Committee received the report with limited assurance noting that this was due to the progress seen to date but did not reflect the anticipated outcome of the work being undertaken. It was recognised that there had been an impact on productivity as a result of industrial action however due to actions taken there had been recognition of the Trust being the second most improved organisation in cohort 1. **Nurse Establishment Review** The Committee received the report noting that this was the first full review in 2 years which had considered 75 areas across 4 sites and impacted on the staffing template. The Committee was pleased to note that the review had included further check and challenge on the proposed changes to band 2 roles which would see changes to clinical skill sets and some staff re-banded to band 3. There were also a number of discussions regarding service changes and hours which would require the completion of business cases. The Committee noted the volume of work that had been undertaken through the review which offered significant assurance to the

	Committee. The favourable position of £766k was noted along with the additional £2m budget requirement for the Emergency Department which was already within the current run rate. **Strategic Projects** The Committee received the report noting that this offered a pipeline of projects, which could be overlayed in the 24/25 IIP, however deferred the item for detailed discussion to the February meeting. **Pilgrim Emergency Department Steering Group Upward Report** The Committee received the report which was taken as read noting the escalation of the sinkhole which had been discussed through the estates report. The Committee was pleased to note the awarding of the low voltage work which had resulted in a cost reduction. **ASR Operational Update** The Committee noted that this item was deferred and would be offered to the Committee at the appropriate time.
	Assurance in respect of SO 3c Enhanced data and digital capability **Information Governance Group Upward Report to inc DSPT update and FOI and SAR volume** The Committee received the report noting the ongoing discussions held by the Group in respect of the Information Commissioners Office (ICO) audit and the associated actions. Work was being undertaken in respect of the Data Security Protection Toolkit (DSPT) with specific focus on information assets. Actions for both areas were being monitored through the Group. The Committee noted concern regarding subject access requests (SAR) and freedom of information (FOI) requests and recognised the work commencing across the Group to identify shared areas of learning and resource. The Committee requested a look back of the data to seek additional oversight and assurance of the progress being made.
	Assurance in respect of SO 3d Improving Cancer Services Performance **Operational Performance against National Standards** The Committee received the report which offered limited assurance and noted the positive progress regarding the cancer faster diagnosis standard (FDS) noting that whilst there had been some deterioration in December this would be recovered through January. The Committee was pleased to note that the Trust was no longer in tier 2 monitoring for cancer services and with sustained improvements and

	statistical stability for performance agreed to propose the change of BAF rating from red to amber at this time.
	Assurance in respect of SO 3e Reduce waits for patients who require planned care and diagnostics to constitutional standards **Operational Performance against National Standards** The Committed noted the progress and focus on 65-week waits noting that, despite the changes of industrial action, the Trust had, through a quality improvement approach seen a 50% reduction in cancellations. The Committee was pleased to note that the Trust was on track to achieve zero 78-week waits by the end of January which aligned to the national standard.
	Assurance in respect of SO 3f Urgent Care **Operational Performance against National Standards** The Committee noted the report and update provided in respect of urgent care which had been considered through the IIP report and Performance Dashboard.
	Assurance in respect of SO 4a Establish new evidence based models of care **Partnership Plan – Commercial opportunities** The Committee noted that this item was deferred and would be offered to the Committee at the appropriate time. **System Anchor Plan** The Committee noted that this item was deferred and would be offered to the Committee at the appropriate time.
	Assurance in respect of SO 4c Successful delivery of the Acute Services Review **Implement Stroke** The committee received the report and noted that, whilst an assurance level had not been offered, the Committee had received a moderate level of assurance. It was noted that there was now a dedicated post in place which had resulted in robust governance in order to be able to work across the full pathway and ensure success. The Committee noted the recent national visit which would support a 1 year programme of quality improvement work around thrombolysis and recognised the achievement for the Trust in being selected for this through a competitive process. **Clinical Strategy**

	The Committee noted that this item was deferred and would be offered to the Committee at the appropriate time.
	Assurance in respect of other areas: **Integrated Improvement Plan** The Committee received the report noting that this offered moderate assurance against the patients, people and partners workstreams and limited assurance for services, due to challenges within urgent and emergency care, outpatients and theatre performance. The Committee was pleased to note the improvements in vacancy and sickness rates and noted the ongoing monitoring of actions related to non-elective care. Progress in urgent and emergency care was noted due to the integration with system partners. **Improvement Steering Group Upward Report** The Committee received the report noting the limited assurance however recognised that progress was being made in a number of areas including CIP delivery. The Committee recognised that a number of programmes in place had longer leads times meaning that these were not yet delivering however delivery was expected. The Committee commended the work of the Improvement Team reflecting that there had been no use of external agencies to support the ongoing work for improvement. **Committee Performance Dashboard** The Committee received the report with limited assurance noting the improvements reported for unplanned care. Whilst the improvements were not as desired there were clear escalations for these metrics with an awareness of the position. Developments had been made in the support for fractured neck of femur cases, with an expansion of the pathway across the group model and focus through the urgent treatment centres. Improvements in length of stay were noted which linked to the new approach to discharge which had been put in place along with the Multi-Agency Discharge Events, supported by the System Flow Director. The Committee noted the initiatives associated with increased waits in urgent and emergency care noting the impact of industrial action however further progress was expected through January and February. Changes in metrics for trolley waits were noted which would better gauge the impact on patient experience for those patients experiencing extended waits.

	CQC Action Plan The Committee received the report which was taken as read noting the anticipated closure of a number of actions once received by the Confirm and Challenge meeting. The Committee requested a review of the actions presented to ensure these were correctly aligned to the Committee.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	The Committee referred to the People and OD Committee the issue of job planning and salary overpayments to seek assurances that the actions in place would deliver.
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	The Committee recognised the improvements across cancer services and the assurances provided to the Committee and propose to the Board that Objective 3d – Improving cancer services be rated Amber from Red.
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	F	M	A	M	J	J	A	S	O	N	D	J
Dani Cecchini, Non-Exec Director	X	X	X	D	X	X	X	X	X	X	X	X
Director of Finance & Digital	X	X	X	X	X	X	X	X	X	X	X	X
Chief Operating Officer	X	X	X	D	X	X	D	X	X	X	X	X
Director of Improvement & Integration	X	X	X	X	X	X	X	X	X	X	X	X
Sarah Buik, Associate Non-Executive Director	A	X	X	X	X	X	X	X	X	X	X	X

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

Report to:	Trust Board
Title of report:	Finance, Performance and Estates Committee Assurance Report to Board
Date of meeting:	22 February 2024
Chairperson:	Dani Cecchini, Chair
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received, and key decisions made by the Finance, Performance and Estates Committee (FPEC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme. The Committee worked to the 2023/24 objectives.
Assurances received by the Committee	**Assurance** in respect of SO 3a A modern, clean and fit for purpose environment **Emergency Planning Group Upward Report** The Committee received the report noting the significant assurance received and noting the additional information which had been shared with the Committee in respect of Business Continuity Plans (BCP). The Committee was pleased to note the positive outcome of the BCP Champions, and the group had discussed the completion rate of BCPs noting that achievement of 85% with a continual renewal process was correct, ensuring there were dynamic plans in place. It was acknowledged that there was a further round of industrial action planned for 5 days with grip and oversight of this from the emergency planning team and across the system.
	Assurance in respect of SO 3b Efficient Use of Resources **Finance Report inc Efficiency, Capital and Contracts** The Committee received the finance report with continued limited assurance noting that this was due to the impact of industrial action and excess inflation, which had been contained within the position. The Committee noted that the Trust awaited confirmation of the industrial action financial impact and if this would be an allowable variation to plan. Planning was underway for the planned industrial action which was anticipated to have a material impact of circa £1.7m

	The cash position continued to be healthy, reported at £29m, however this would continue to reduce as the Trust moved to year end and capital drawdowns were made. The Committee noted that there were no improvements seen in salary overpayments and that Better Payment Practice Code (BPPC) remained static. Improvements were expected to be realised in May/June. The Committee noted the successful delivery of the whole year Cost Improvement Programme (CIP) position at month 10, at £28.8m delivered against a plan of £21.8m. The contracting report was received with moderate assurance noting that the Trust had responded to the national tariff consultation with no concerns raised against the proposals within the consultation. Contracting discussions had commenced for the 24/25 year with the Trust reaching out to the ICB to commence the process in good time. The Committee received the capital report with moderate assurance noting that the Trust remained on track to deliver the full capital programme by year end. The Committee was assured by the systems and governance in place to ensure delivery. It was noted that capital programme for the coming year was circa £88m, the largest capital programme to date for the Trust. This could potentially rise as additional funding became available throughout the year that the Trust could bid for. Due to the size of the capital programme for the coming year the Committee noted concern in respect of the capacity to deliver. It was also noted that whilst there was significant capital funding there remained a significant backlog for the Trust. **Strategic Projects** The Committee received the report noting the contents. **Community Diagnostic Centre (CDC) Update** The Committed received the report noting the recent national visit from the Interim COO at NHSE which had celebrated the Lincolnshire interpretation of the national scheme. The Committee was pleased to note the developments of the Skegness and Lincoln CDCs which were on budget and time. The Committee noted the wider piece to consider the expansion of CDCs to other areas and were supportive of exploration of this in Boston.

	Assurance in respect of SO 3c Enhanced data and digital capability **Digital Hospital Group Upward Report** The Committee received the report for information noting the progress on the procurement process of the Electronic Patient Record which remained on track against the proposed revised timelines.
	Assurance in respect of SO 3d Improving Cancer Services Performance **Operational Performance against National Standards** The Committee received the report noting that there had been a decrease in performance for cancer services however recognised that this was due to staffing issues which reflected the fragility of the service. Whilst the reduction in performance was noted the Committee was assured that this would be back on track by March.
	Assurance in respect of SO 3e Reduce waits for patients who require planned care and diagnostics to constitutional standards **Operational Performance against National Standards** The Committee noted the position of 78-week waits and the impact of industrial action on the achievement of this with an anticipated outturn of 12 patients breaching at the end of February 2024. The Trust was sighted on each patient and understood the specific reasons for the breaches with the teams working to resolve this. Where patients had been impacted as a result of industrial action focus had been given to ensure prompt rebooking. It was anticipated that there would be circa 250 65-week wait patients at the end of March 2024 with the Trust continuing to deliver against the original trajectory, to clear these waits by the end of Q1, despite the extension of the national target. The Committee noted the position in respect of DM01 and the improved reporting which had been offered. **Pathway zero and SAFER workstream update** The Committee received the report with limited assurance noting that provided oversight of the key work being undertaken across the discharge programme. Whilst there were improvements being seen to discharge it was noted that further work was required for this to be embedded, including cultural and behavioural change. It was recognised that, whilst a number of new schemes had been implemented, there was a need to ensure that these were evaluated to identify if there had been successful delivery with a request for updates to be offered to the Committee.

	Improvement Programme Deep Dive – Theatre Productivity The Committee deferred the item to the March meeting to allow time for discussion.
	Assurance in respect of SO 3f Urgent Care **Operational Performance against National Standards** The Committee received the report noting the 76% delivery requirement in urgent and emergency care (UEC) by the end of March 2024 which provides focus to the delivery of all aspects of UEC and to ensure delivery of the 4-hour target.
	Assurance in respect of SO 4a Establish new evidence based models of care No items due
	Assurance in respect of SO 4c Successful delivery of the Acute Services Review No items due
	Assurance in respect of other areas: **Committee Self-Assessment** The Committee received the self-assessment with moderate assurance noting the responses offered by Committee members. The Committee recognised the development across the Group Model which would result in changes to the Committee structure. At this time, any issues raised through the self-assessment would be considered. **Committee Effectiveness Annual Report – draft** The Committee received the draft annual report for information with comments sought from Committee members to produce a further iteration of the report to support the Trust's Annual Report and Annual Governance Statement. Committee members requested some additions to the report at this time and noted that following the final meeting of the year further updates would be made. **Annual Planning** The Committee received the report with moderate assurance noting that the report captured all planning aspects, offering a detailed executive summary and was well triangulated through the discussions held. It was noted that the Trust would work to a stretch target of 130% of (2019/20) activity, subject to operational delivery discussions. Scenario planning was required to consider the options for delivery and build this in to a 2-year plan.

	The Committee noted the financial planning position which currently reported a deficit of £55.7m before the application of Cost Improvement Programmes (CIP). The CIP programme was noted at £31.5m with an internal stretch target identified in order to ensure delivery with plans for delivery being confirmed. The Committee noted the need to ensure capacity was in place to deliver the required productivity and reflected that whilst some programmes of work would be transformational some areas would be considered improvements. The main risks against the annual planning were noted by the Committee as capacity of staff to deliver CIP, operational pressures and stretch targets. Work was being undertaken in parallel with the ICB and it was noted that a system level flash submission of the plan to NHS England was due on the 27 February. **Integrated Improvement Plan** The Committee received the report with limited assurance noting the triangulation with the Improvement Steering Group report and the identification of those KPIs and targets which had not been achieved. The Committee reflected on the lead times for a number of the programmes which were taking longer than expected to achieve delivery. The Committee noted the need to consider the programmes of work and determine if alternative actions would be required as a result of non-delivery. **Improvement Steering Group Upward Report** The Committee received the report noting the reduction in Patient Initiated Follow Up (PIFU) as part of the outpatient improvement programme with a need to embed the work being undertaken to maintain improvements. Positive outcomes were noted for the nurse agency spend in respect of CIP and the recent launch of the 'Give it a go' campaign which was supporting staff to undertake simple activities which would impact their service. The Committee noted that multi-year programmes of work would need to be continued in to the 24/25 year and proposed a Board Development session in respect of transformation schemes and CIP delivery to ensure the correct focus in the coming year. **Committee Performance Dashboard** The Committee received the report with limited assurance noting the position reported for urgent and emergency care, referral to treatment and DM01 which remained off track.

	Whilst the Committee noted some performance improvements it was recognised that pressures were reflected across the whole of the NHS. Systems and processes were in place to support improvement and to consider current plans should these not be delivering expected outcomes. **Internal Audit – Payroll** The Committee received the report noting that the Trust had received reasonable assurance. It was noted however that whilst this was a financial audit the actions which had arisen were owned by the People Directorate and therefore a referral would be made to the People and OD Committee to ensure awareness and ownership of the actions. **CQC Action Plan** The Committee received the report which was taken as read and agreed to defer discussions to the March meeting.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	The Committee wished to refer the Payroll internal audit to the People and OD Committee to ensure actions were addressed.
Committee Review of corporate risk register	The Committee received the risk register noting the risk as presented.
Matters identified which Committee recommend are escalated to SRR/BAF	No items identified
Committee position on assurance of strategic risk areas that align to committee	The Committee considered the reports which it had received which provided assurances against the strategic risks to strategic objectives.
Areas identified to visit in dept walk rounds	None

Attendance Summary for rolling 12-month period

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

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

United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*5th March 2024*
Item Number	*Item 12*

Integrated Performance Report for January 2024

Accountable Director	*Sameedha Rich-Mahadkar, Director of Improvements and Integration*
Presented by	*Sameedha Rich-Mahadkar, Director of Improvements and Integration*
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	*Moderate*

Recommendations/ Decision Required	• *The Board is asked to note the current performance.* *Key to note:* • *There has been a reduction in performance against the key performance metrics for Urgent and Emergency Care across the system, which has led to its placement in Tier 2. To achieve some "quick wins," the three main areas of focus have been identified as 4-hour performance,aggregated time of arrival (>12 hours) instead of 12+ trolley wait, and Cat2 Mean time from Ambulance Partners. All handovers within ULHTare being monitored and assessed* • *Referral to Treatment. At the end of December, the Trust reported 1 patient waiting longer than 104 weeks. This was due to complex pathways involving other Trusts for specialist input. The trust exited January with 23 patients waiting over 78 weeks. The Trust reported 870 patients waiting over 65 weeks in December compared to 1,243 in November.* • *As of 5th February 2024, ASI sat at 594, whilst this is slightly higher than the agreed trajectory of 550, this is a significant improvement overall. Additional resource has been directed to resolving missing outcomes which is having a positive effect on the bookings team being able to move the ASIs to open referrals* • *The report for DM01 in January showed a slight decline of 70.36% as compared to December's 72.25%. Despite efforts to comply with the national target of 99%, there is still a negative deviation of 28.64% from the nationally agreed target. The primary area of concern remains Echocardiography. A recovery trajectory has been pulled together that shows a full recovery in May 24.* • *28-day Faster Diagnosis Standard (FDS) showed some deterioration in December at 71.8% and was below our trajectory of 75%. The unvalidated January position is 69.3% and therefore significantly behind target* • *62 day classic treatment performance for December was 49%, a deterioration from the November position (57%) and against a national KPI of 85%.* • *104+ day waiters increased to 55 at the end of January compared to 52 at the end of December* *The Board is asked to approve action to be taken where performance is below the expected target.*

Executive Summary

Quality

Falls

There were 2 falls resulting in severe harm during the month of January 2024, with an overall increase in falls noted in month. A number of themes have been identified which will become the areas of focus for future improvement work supported by the Quality Matrons. Information team currently reviewing falls benchmarking data.

Pressure Ulcers

There have been 45 category 2 pressure ulcers and 9 unstageable reported in January 2024. A range of actions continues to be progressed in the urgent and emergency pathway routes to support early identification of skin damage. A monthly educational bulletin regarding device related pressure ulcers continues to be shared.

VTE

The Trust achieved 94.31% (target 95%) compliance with VTE assessment. Funding is now awaited to appoint a substantive VTE Nurse Specialist, however, whilst this is agreed a member of staff has been identified to commence an initial review.

Medications

Medication incidents reported as causing harm increased to 15.8% against a trajectory of 10.7%. The Terms of Reference have now been agreed to review medication errors in relation to omitted and delayed medications as part of PSIRF.

Patient safety Alerts

100% of patient safety alerts were responded to within agreed timescales. Internal audit actions are now completed resulting in an updated policy and procedures to improve governance arrangements to ensure timely management and escalation.

SHMI

The Trust SHMI has remains stable at 103.33 for January and is within expected limits. From the 1 April 2024 it will be legislation for all deaths to be reviewed by an ME service. Work is also underway to standardise the morbidity and mortality review process across the Trust.

eDD Compliance

eDD Performance continues to be below the 95% target, currently at 91.8%. There is a task and finish group chaired by the Deputy Medical Director to review processes to enable improved compliance.

Sepsis compliance – based on December data

The screening compliance for inpatient adults was at 86% and for inpatient child 88.2% for December. Screening compliance for paediatrics in ED sat at 88.3%, a slight increase from the previous reporting period. No harm has been identified as a result of the delays.

IVAB ED / Inpatient child - The administration of IVAB for children in ED increased to 71.4% (10/14 children). IVAB for paediatric inpatients dropped to 60% (3/5 children). No harm has been identified as a result of the delays.

Duty of Candour (DoC) – December Data

Verbal and written compliance for December was at 58% and 42% respectively against a 100% target. It was noted that the decline has been attributable to operational pressures and continued industrial action. Several actions have been taken by the central team to support the Medicine Division with a significant number of non-compliant incidents for a focus drive to improve compliance.

Operational Performance

This report pertains to the performance of January 2024. As of February 10th, the Trust has registered 10 PCR confirmed positive COVID-19 inpatients. In December, the peak was 14 patients, and currently, there has been an increase in line with local and regional trends. However, there is no indication of concern at present. During January, 89 of the 1336 Flu tests conducted yielded positive results (7%). Similarly, 15 (3%) of the 450 patients tested for RSV were positive. Presently, there are four patients at our Pilgrim Site and one more at Lincoln County Hospital. As per the usual winter routine, January witnessed several episodes of Clostridium difficile. Furthermore, a junior doctor strike was conducted into the new year following a previous strike just before the Christmas period.

Performance to increase activity levels to 116% of 2019/20 is now at 115.2%. Year to date percentages against 2019/20 for key PODS are: Day case 95.7%, Electives 89.3%, Outpatient Firsts (including Procedures) 121%.

Plans to increase activity levels developed in the proceeding months are starting to show signs of delivery with activity levels picking up for all pods month on month. Weekly monitoring continues in order to identify dips in performance and support a quick recovery. Further Faster work continues along with Outpatient and theatre improvement programmes.

A & E and Ambulance Performance

There has been a reduction in performance against the key performance metrics for Urgent and Emergency Care across the system, which has led to its placement in Tier 2. To achieve some "quick wins," the three main areas of focus have been identified as 4-hour performance, aggregated time of arrival (>12 hours) instead of 12+ trolley wait, and Cat2 Mean time from Ambulance Partners. All handovers within ULHT are being monitored and assessed.

The yearend target for 4-hour performance is set at 76%, with a rolling monthly ambition to track achievement. Unfortunately, the January 24 target of 75% has not been met, with a negative variance of 17.20% as it has out turned at 57.88%. The SPC chart on page 33 documents both the 22/23 and 23/24 targets to reflect performance ambition.

This trajectory is based on Type 1 and co-located Type 3 activity. Combined type 1 and type 3 activity is demonstrating an achievement of 71.56% against the overall position. It is noted that from 31st October when GDH reverted to a UTC, type recorded activity reduced as expected.

The performance in January witnessed a decline due to prolonged trolley waits that lasted for 12 hours or more. The occurrence was attributed to various factors, including augmented attendance at the departments and higher acuity of the presenting cases. In response, the focus was realigned to the aggregated time spent in the department. Patients exceeding the 12-hour benchmark (T1) amounted to 20.94%, which represents an increase compared to the 19.08% recorded in December. A daily/weekly target was established in December, which was consistently achieved during the Tier 2 meetings. ULHT managed to reduce the number of patients to an average of 77 daily in January, down from more than 100 patients. Nonetheless, further work is necessary to enhance the situation.

The Cat2 ambulance response time target mandates a maximum of 30 minutes. In January, the average response time was 44 minutes per day. It is worth noting that the Cat2 average accounts also for conveyances where the patient did not attend ULHT e.g. remained at home, but the patient's postcode was within our catchment area. Additionally, the values highlighted on the SPC chart on page 36 refer to the vehicles that took over 59 minutes to reach the patient. It is important to note that a number of these may have been for the same patient.

Fractured Neck of Femur 48hr Pathway (#NOF)

The trust has seen a significant improvement in the compliance for #NOFs going to theatre within 48 hours. January outturn is 78.57% which is a slight improvement on the December position and a significant improvement to that seen in September 2023.

Length of Stay

In January, the Non-Elective Length of Stay exhibited a decline of 0.27 days compared to December 2023, with a current performance of 4.81 days, revealing a negative variance of 0.31 against the agreed target. However, the performance has shown an improvement of 0.27 days from January 23. The average bed occupancy for January was 99.12%, evaluated against the "Core G&A." To ensure adequate and safe flow within the acute sites, an average of 50 escalation beds/boarding spaces were open. The occupancy vs escalation brought a safer percentage of 93.59% against the new national standard of less than 92%.

System Partners encountered challenges in promptly providing assistance to facilitate discharges from the acute care setting for pathways 1 to 3. Notably, in January, Pathway 3 recorded the most significant decline, exhibiting an increase in the length of stay from 22.7 days to 25.1 days. Non-Elective Length of Stay deteriorated in January with a 0.31 variance against the agreed target. Current performance is 4.81 days, showing a decline of 0.27 days compared to December 2023 but a 0.27 improvement to January 23. The average bed occupancy for January against “Core G&A” was an average of 99.12%. An average of 50 escalation beds/boarding spaces were open to maintain adequate and safe flow within the acute sites. By doing so the occupancy vs escalation brought a safer percentage of 93.59% against the new national standard of <92%.

System Partners were challenged with identifying timely support to facilitate discharge from the acute care setting for pathways 1 to 3.
In January Pathway 3 showed the biggest decline, increasing length of stay from 22.7 days to 25.1 days.

The Trust also now records and monitors the percentage of discharges within 24hrs of the predicted dated of discharge (PDD). December saw the first monthly improvement since May 2023, recording a performance of 39.51%. January has continued that trend recording a performance of 41.94%

Referral to Treatment

December demonstrated a slight deterioration in performance. November outturn was 49.72% versus 48.85% in December. The Trust is now reporting patients waiting over 104, 78, 65 & 52 weeks. At the end of December, the Trust reported 1 patient waiting longer than 104 weeks. This was due to complex pathways involving other Trusts for specialist input. The trust exited January with 23 patients waiting over 78 weeks. Whilst this was 3 over our forecast, the performance was seen in a positive light given the impact of Christmas and Industrial action. The Trust reported 870 patients waiting over 65 weeks in December compared to 1,243 in November. The trust was an early adopter of the Further Faster programme which is a national initiative to reduce patients waiting over 52 weeks. In December the trust reported 3,699 patients waiting over 52 weeks which is almost half the amount compared to December 23. Of the 20 early adopter trusts, ULHT is the second most improved to date.

Waiting Lists

Overall waiting list size decreased by more than 1000 again in December. November reported 71,805 compared to November's position of 72,832. Work continues between the outpatient department and the Clinical Business Units regarding returning better access to our bookable services for primary care and patients' choice.

As of 5th February 2024, ASI sat at 594, whilst this is slightly higher than the agreed trajectory of 550, this is a significant improvement overall. Additional resource has been directed to resolving missing outcomes which is having a positive effect on the bookings team being able to move the ASIs to open referrals.

DM01

The report for DM01 in January showed a slight decline of 70.36% as compared to December's 72.25%. Despite efforts to comply with the national target of 99%, there is still a negative deviation of 28.64% from the nationally agreed target. The primary area of concern remains Echocardiography, but recent declines in MRI and Ultrasound performance have also been observed due to capacity and availability issues. It should be noted that MRI has experienced an increase in demand, which has contributed to the rising breach. A recovery trajectory has been pulled together that shows a full recovery in May 24.

Additionally, Dexa has been affected by significant sickness and vacancies. However, GH CDC DEXA will be available from March 2024 to provide additional capacity.

Cancelled Ops

January outturn for cancelled operations on the day was 1.41% which was an improvement of 0.68% on the November position of 2.09%. Three main reasons were medically unfit, lack of time and op no longer necessary.

Included in the 1.68% of on the day cancellations, 43 patients were not treated within the 28 day standard which was 5 patients more than last month. Adherence to redating within 28 days has been deteriorating month on month since June 23, whilst some of this is impacted by the pressure to date long waiting patients, a recovery trajectory has been requested of the division.

The continuous review of the effectiveness of the 6:4:2 theatre scheduling meetings continues along with the pre-op improvement work stream, both of which are expected to drive down on the day cancellations.

Cancer

28-day Faster Diagnosis Standard (FDS) showed some deterioration in December at 71.8% and was below our trajectory of 75%. The unvalidated January position is 69.3% and therefore significantly behind target

62 day classic treatment performance for December was 49%, a deterioration from the November position (57%) and against a national KPI of 85%.

104+ day waiters increased to 55 at the end of January compared to 52 at the end of December. The highest risk speciality is colorectal with 18 pathways greater than 104 days.

Workforce

Mandatory Training – Our January 2024 Core Learning Rate is 93.79% against a Target of 95.00%. This is a further increase when compared to last month, with a continued improvement seen over recent months.

Our biggest challenge is to offer time to our colleagues to be able to complete all mandatory training as required for the role they do. As part of this it is also fundamentally important that training profiles are aligned on an individual basis to ensure there are no unnecessary asks rather than on the current wider role profiles.

Work continues to ensure that all areas and individuals are given the time to complete core learning modules, with focussed support being offered to those with low compliance (50% and less) through enhanced reporting provided Divisionally by the Education & Learning Team within our People & OD Directorate. A number of support measures are being implemented in terms of ESR user support, including the provisions of 'pop-up' core learning sessions for departments and individual users requiring additional input. The Mandatory Training Action Plan has been approved, the review of all core topics has been completed and changes will be made to the core and core+ offer moving forward, with consideration as to whether training needs could be aligned individually to roles. This work is gathering momentum following some changes to the competence data and re-mapping against a number of core+ modules. There continues to be a drive for all staff groups to improve their Core Training compliance through FPAM meetings, with areas needing specific focus being highlighted by the People & OD Directorate.

Sickness Absence –Our January 2024 Sickness Rate 5.47% against a Target of 4.50%. Sickness absence has remained stable over 2023/24 so far, but is not seeing the level of reduction we had planned. We are continuing to work towards further reducing our vacancy level and as such, we are hopeful this continued improvement will impact positively on our colleague's health and wellbeing throughout 2023/24.

Compliance for RTW and call backs remain low, this is having a knock on effect on the length of sickness episodes. Stress and Anxiety remains the top reason, followed by MSK and short term absences such as Gastrointestinal and Colds/Flu. This will be closely monitored as we continue the Winter Season. We are mindful of the impact that Industrial Action may have had on sickness levels, and also the impact that recent increases in Covid cases may have had.

Continued focus on supporting managers and leaders in absence processes and supporting our people to attend the work environment will be delivered through the mandated 'Basics brilliantly' workshops which is an action we are taking forward following the staff survey results. A further deep drive into sickness data may be required to understand key areas of focussed action over the remainder of 2023/24. There continues to be discussions as part of the Workforce & Organisational Development Group about sickness absence, and a recognition that although not within target, levels are being maintained and are not worsening. This is a key area for some benchmark reporting and potential

consideration for phased trajectories to take account of the impact of the winter months as we begin to build trajectories for 2024/25 as part of Annual Planning. Occupational Health are supporting the Trust with initial actions when a report of certain absences are flagged on the Absence Management System. This is to ensure that early support and intervention, if required, is in place to support the staff member.

Further work to support managers and leaders in absence processes and supporting our people to attend the work environment are continuing to be delivered through the mandated 'Basics Brilliantly' workshops which is one of our actions following this year's annual staff survey results. In addition, focussed work is being undertaken with Divisions where sickness absence trends have been identified so as to further our journey towards a "supporting attendance" approach as opposed to managing absence. Staff continuing to be signposted to our health and wellbeing services. We have developed and launched a new Sickness Report which will support Divisional Heads of HR to identify trends and understand, with Divisional Managers, where key areas of focus are required.

Staff Appraisals – Our January 2024 Appraisal Rate is 73.60% against a Target of 90.00%. This is an increase when compared to performance last month. There is a need to see an improved position if we are going to improve in line with the Q4 target, and meet the year end overall target. Continued focussed attention to areas who are RAG rated 'red' are being discussed with teams directly, including through FPAM discussions where relevant. Medical & Dental Appraisals rate is currently at 93.00% as at January 2024 which is above Target.

It is recognised that the overall Trust wide appraisal completion rate is consistently below our annual target of 90.00%, and it is recognised that there is further focus required for 2023/24 in improving compliance if we are to meet our Trust Target, of 90.00% by the end of March 2024.

To support continued improvement, we continue to recommend 90 minute appraisals for each colleague to ensure that staff have had an appraisal. Work continues to educate leaders on the process required to update ESR, including the use of 'how to' guides/sessions and utilising reporting to identify areas of low completion. Additionally, raising through FPAM discussions provides a further opportunity for Divisional Teams to seek support from People & OD if required, as well as raise any challenges they are facing with being able to focus attention on Appraisals. In response to the PODC request in July 2023, we are continuing to review reporting of the Trustwide Appraisal Rates to include 'all staff including Medical & Dental', however this month's reporting remains as previously reported as a Data Mapping/reporting Session is planned with People & OD and Workforce Intelligence to identify and develop reports which will allow us to easily identify trends and embed a Trust Level view which includes all Staff Groups - this work continues and will be introduced within the Scorecard once aligned and fully completed.

Following an Appraisal workshop on 22nd January 2024 a paper will be submitted to our Executive Leadership Team advocating a move to an annual appraisal cycle, bringing the Trust in line with LCHS as its Group Partner. LCHS have identified this has had a positive impact

on completion rates by having a dedicated period where objectives are set and appraisals completed in line with the workforce, strategic and financial planning cycle.

Staff Turnover – Our January 2024 Turnover Rate 11.11% against a Target of 11.50%. This is within the Trust Target and has been since M06 of 2023/24.

Operational pressures, staffing and culture challenges are continued challenges, although despite this we are in line with our Turnover trajectories for the year-to-date.

Continued focus on retention issues including flexible working. Organisational Development and our People Promise Manager continue 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 leaver's data and understand trends. People & OD are working closely with Nursing & AHP Leads to develop a Staff Experience and Retention Strategy for these Staff Groups to support a sustainable Turnover position and ensure that there are Career Pathway opportunities for these staff.

Continued strong recruitment activity and substantive positions being filled supports reducing the pressures on areas with high vacancy rates. The People & OD teams continue to work closely with Divisions, the Trust and the ICB to explore retention improvement opportunities, and bringing best practice into the organisation. We are working towards a more robust reporting process via ESR to capture leaver's data and understand trends. We will maintain a continued focus on Turnover to ensure that this remains on a positive trajectory against target throughout the year.

Vacancies – Our January 2024 Vacancy Rate is 6.17% against a Target of 4.00%. This is an improved position of 1.21% when directly compared to last month. This Vacancy rate is prior to establishment review work being fully completed, and whilst this work continues it has not yet translated into Trust Reports. We expect that when this work is complete, that our overall Trust Vacancy Rate will return to trajectory levels. Although above our Q4 Target, we have seen a continued reduction in our Vacancy Rate over the last 12 months as we have moved from a position of 11.35% in July 2022.

Our Registered Nursing (Band 5+ in line with National Registration criteria) Vacancy Rates continue to reduce when compared to 2022 data and has seen January 2024 reduce further to 1.01% which is the fourth month we have been within target. Since April 2023, there has been an increase in the number of Nurse Associates (Band 4) which supports the Trust to robustly manage and co-ordinate against safer staffing requirements.

AHP recruitment remains a challenge locally and nationally. The increase in Vacancy Rate due to the increased establishment across the Trust is an area requiring continued focus to ensure that opportunities to reduce this are identified to further support the ambitions and targets set by the Trust as part of our overall Workforce Plan for 2023/24.

We will be keeping an ongoing focus on HCSWs over the coming months to backfill those IENs achieving NMC status. For AHP recruitment we have a dedicated Resourcing Advisor to support this recruitment with a Talent Acquisition approach, we are also looking at using one of our higher performing agencies to support this recruitment. Finance and People & OD are working closely together, with a strong focus on building the wider Workforce planning as we enter the Business Planning for 2024/25.

There is a strong focus of IEN recruitment within our Recruitment Team, and we believe we are ahead of schedule to deliver the 2023/24 Workforce Plan. AHP & Pharmacy recruitment remains under significant focus but we believe we are making strong progress in both areas. We are in the process of determining our Workforce Plans for 2024/25, and AHPs will be a prominent area as we continue to support the CDC programme.

Finance

The Trust's financial plan for 2023/24 is a deficit of £20.8m inclusive of a £28.1m cost improvement programme.

The Trust delivered a YTD adjusted deficit of £20.3m or £2.1m adverse to financial plan, which is attributable to the impact of the strikes.

CIP savings of £28.8m have been delivered YTD, which is £7.2m favourable to planned savings of £21.7m.

Capital funding levels for 2023/24 have been agreed with NHSE and system partners; the Trust delivered capital expenditure of £19.0m YTD, which is £6.6m lower than planned capital expenditure of £25.6m.

The cash balance is £29.3m (plan £17.2m); this is an decrease of £12.0m against the March year-end cash balance of £41.3m.

Sameedha Rich-Mahadkar
Director of Improvements and Integration
February 2024

Key to Variation and Assurance Icons and SPC Dots

Within this report we have used XmR Statistical Process Control (SPC) charts. An SPC chart is a plot of data over time. It allows you to distinguish between common and special cause variation. It includes a mean and two process limits which are both used in the statistical interpretation of data. They also indicate whether the process is able to meet any stated target/trajectory.

To help interpret the data a number of rules can be applied. These are:

1. Any single point outside the process limits.
2. A run of 7 points above or below the mean (a shift).
3. A run of 7 points all consecutively ascending or descending (a trend).
4. 2 out of 3 points that lie beyond the two-sigma line but not beyond the three-sigma line (i.e. process limit) on a consistent side of the mean.

To highlight whether there is improvement or deterioration we use 'Variation' and 'Assurance' icons to represent this.

Variation					Assurance		
							
Special Cause Variation – Improvement (indicator where high is good)	Special Cause Variation – Improvement (indicator where low is good)	Special Cause Variation – Cause for Concern (indicator where high is a concern)	Special Cause Variation – Cause for Concern (indicator where low is a concern)	Common Cause Variation – No Significant Change	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target	Variation indicates inconsistently passing and falling short of the target

Variation icons and SPC dots: **Orange** indicates concerning **special cause variation** requiring action. **Blue** indicates where improvement appears to lie, and **Grey** indicates no significant change (**common cause variation**).

Assurance icons: **Blue** indicates that you would consistently expect to achieve a target. **Orange** indicates that you would consistently expect to miss the target. A **Grey** icon tells you that sometimes the target will be met and sometimes missed due to random variation.

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 data points have met or exceeded.

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 sitting is 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

Performance Overview - Quality

NHS United Lincolnshire Hospitals NHS Trust

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Nov-23	Dec-23	Jan-24	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Clostridioides difficile position	Safe	Patients	Director of Nursing	9	7	11	7	78	P	
	MRSA bacteraemia	Safe	Patients	Director of Nursing	0	0	0	0	1	P	
	MSSA bacteraemia cases counts and 12-month rolling rates of hospital-onset, by reporting acute trust and month using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.01	0.01	0.02	0.01		
	E. coli bacteraemia cases counts and 12-month rolling rates, by reporting acute trust and month using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.02	0.01	0.03	0.02		
	Catheter Associated Urinary Tract Infection	Safe	Patients	Director of Nursing	1	Data Not Available	Data Not Available	Data Not Available			
	Falls per 1000 bed days resulting in moderate, severe harm & death	Safe	Patients	Director of Nursing	0.19	0.09	0.09	0.08	0.07	P	
	Pressure Ulcers category 3	Safe	Patients	Director of Nursing	4.3	0	1	0	4	P	
	Pressure Ulcers category 4	Safe	Patients	Director of Nursing	1.3	0	0	0	3	P	
	Pressure Ulcers - unstageable	Safe	Patients	Director of Nursing	4.4	7	0	9	49	F	
	Venous Thromboembolism (VTE) Risk Assessment	Safe	Patients	Medical Director	95.00%	95.04%	93.86%	94.31%	94.56%	F	
	Never Events	Safe	Patients	Director of Nursing	0	0	0	0	3	P	

OUTSTANDING CARE personally DELIVERED

Performance Overview - Quality

NHS United Lincolnshire Hospitals NHS Trust

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Nov-23	Dec-23	Jan-24	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Reported medication incidents per 1000 occupied bed days	Safe	Patients	Medical Director	4.30	6.15	5.28	5.50	5.83	P	
	Medication incidents reported as causing harm (low /moderate /severe / death)	Safe	Patients	Medical Director	10.70%	18.10%	10.80%	15.80%	14.89%	F	
	Patient Safety Alerts responded to by agreed deadline	Safe	Patients	Medical Director	100.00%	None Due	66.67%	100.00%	73.33%	?	
	Hospital Standardised Mortality Ratio - HSMR (basket of 56 diagnosis groups) (rolling year data 3 month time lag)	Effective	Patients	Medical Director	100	92.36	92.71	93.22	94.06	P	
	Summary Hospital Mortality Indicator (SHMI) (rolling year data 6 month time lag)	Effective	Patients	Medical Director	100	103.31	103.46	103.33	103.17	F	
	The Trust participates in all relevant National clinical audits	Effective	Patients	Medical Director	100.00%	100.00%	100.00%	100.00%	100.00%	P	
	eDD issued within 24 hours	Effective	Patients	Medical Director	95.00%	91.00%	89.00%	91.80%	89.54%	F	
	Sepsis screening (bundle) compliance for inpatients (adult)	Safe	Patients	Director of Nursing	90.00%	88.00%	86.00%	Data Not Available	89.19%	F	
	Sepsis screening (bundle) compliance for inpatients (child)	Safe	Patients	Director of Nursing	90.00%	85.50%	88.20%	Data Not Available	87.74%	F	
	IVAB within 1 hour for sepsis for inpatients (adult)	Safe	Patients	Director of Nursing	90.00%	91.05%	91.00%	Data Not Available	93.55%	P	
	IVAB within 1 hour for sepsis for inpatients (child)	Safe	Patients	Director of Nursing	90.00%	100.00%	60.00%	Data Not Available	76.58%	?	

OUTSTANDING CARE personally DELIVERED

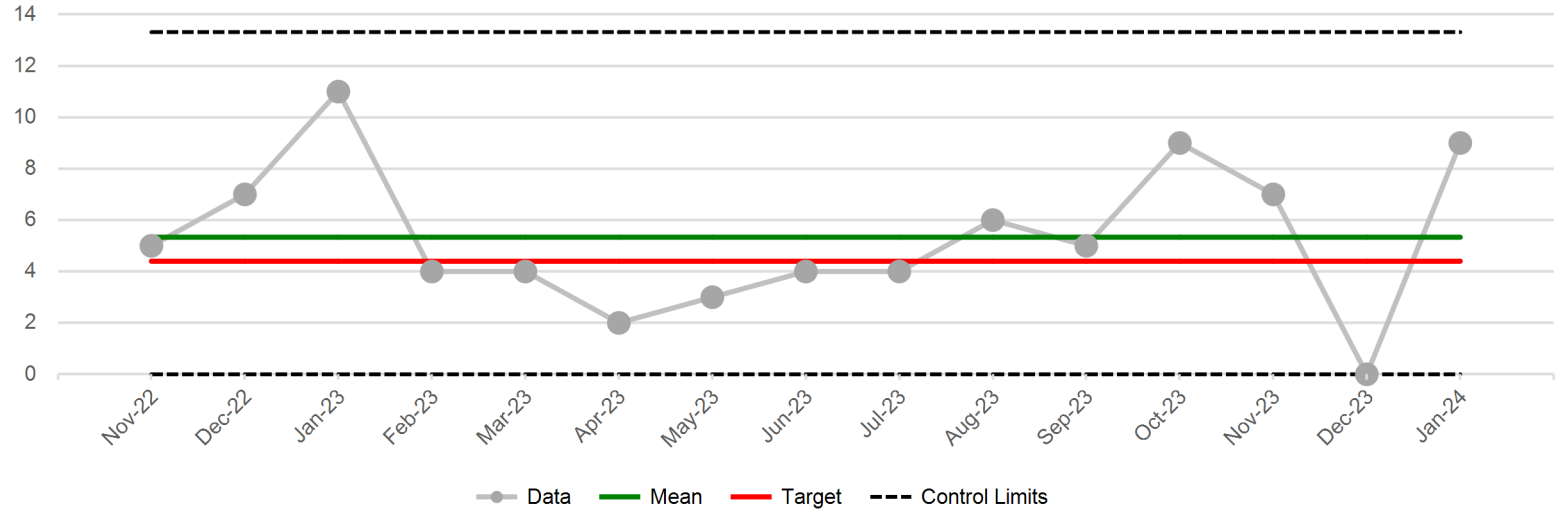
Performance Overview - Quality

NHS United Lincolnshire Hospitals NHS Trust

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Nov-23	Dec-23	Jan-24	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Sepsis screening (bundle) compliance in A&E (adult)	Safe	Patients	Director of Nursing	90.00%	92.00%	92.00%	Data Not Available	91.96%	P	
	Sepsis screening (bundle) compliance in A&E (child)	Safe	Patients	Director of Nursing	90.00%	86.10%	88.30%	Data Not Available	90.59%	?	
	IVAB within 1 hour for sepsis in A&E (adult)	Safe	Patients	Director of Nursing	90.00%	94.00%	94.00%	Data Not Available	95.40%	P	
	IVAB within 1 hour for sepsis in A&E (child)	Safe	Patients	Director of Nursing	90.00%	40.00%	71.40%	Data Not Available	62.26%	F	
	Rate of stillbirth per 1000 births	Safe	Patients	Director of Nursing	3.80	2.72	3.19	2.99	2.66	P	
Improve Patient Experience	Mixed Sex Accommodation breaches	Caring	Patients	Director of Nursing	0	Submission Suspended	Submission Suspended	Submission Suspended			
	Duty of Candour compliance - Verbal	Safe	Patients	Medical Director	100.00%	75.00%	58.00%	Data Not Available	79.56%	F	L
	Duty of Candour compliance - Written	Responsive	Patients	Medical Director	100.00%	75.00%	42.00%	Data Not Available	73.67%	F	

Performance Overview - Quality

Pressure Ulcers - unstageable



Jan-24
9
Variance Type
Common cause variation
Target
4.4
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of Nursing

Background:
Unstageable Pressure Ulcers.

What the chart tells us:
The Trust recorded 9 Unstageable incidents against a target of 4.4 per month.

Issues:
The number of Unstageable incidents increased in January with 9 incidents reported, of which 1 was device related.

Themes identified as areas to continue to focus on are:

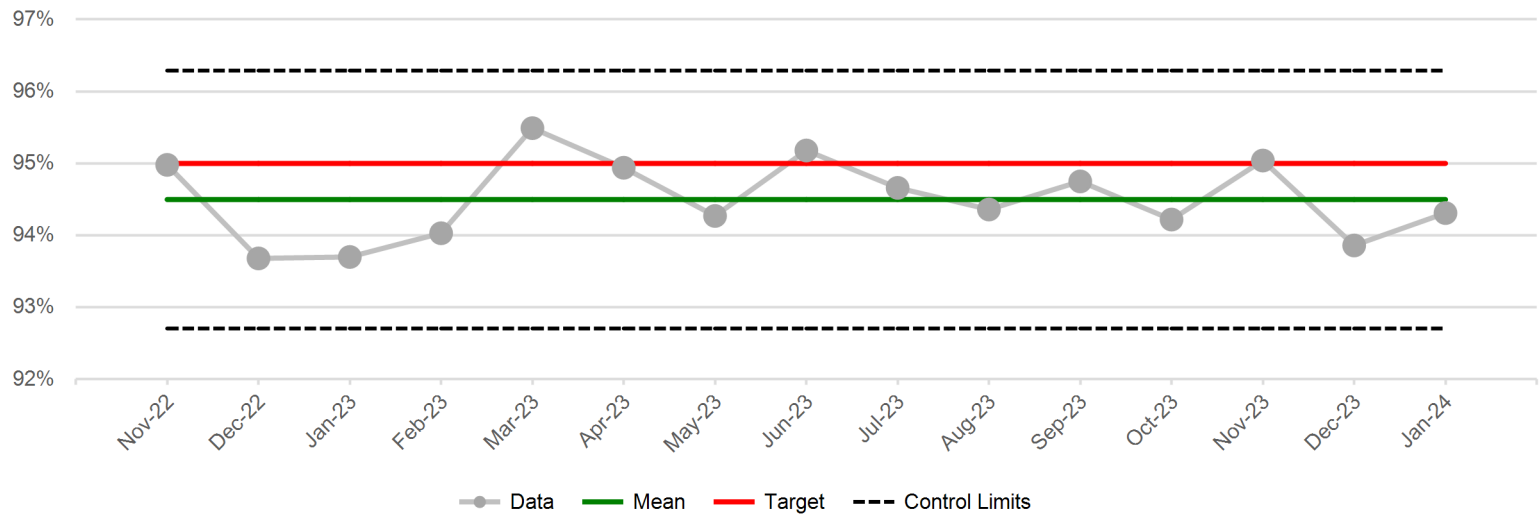
- Operational pressures resulting in extended waits in our Emergency Department
- Tissue viability care planning for patients who are recognised as being at the end of their life.

Actions:
- All Unstageable incidents will be reviewed at the weekly Patient Safety Response meeting to determine if they require an After Action Review (AAR).
- The Quality Matron and Tissue Viability team are undertaking a review of pressure ulcers and correlation with patient length of stay in the Urgent and Emergency Care departments, outcomes will be shared at Skin Integrity Group.
- A review of our current guidelines and processes relating to skin integrity priorities for patients at the end of their life

Mitigations:
Quality Matron and Tissue Viability team provide support to areas with increased number of incidents. Skin Integrity Group (SIG) provides oversight and receives Divisional performance reports, which provide assurance of the improvement actions being taken in areas reporting increased number of incidents.

Performance Overview - Quality

Venous Thromboembolism (VTE) Risk Assessment



Jan-24
94.31%
Variance Type
Common cause variation
Target
95.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Medical Director

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

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

Issues:

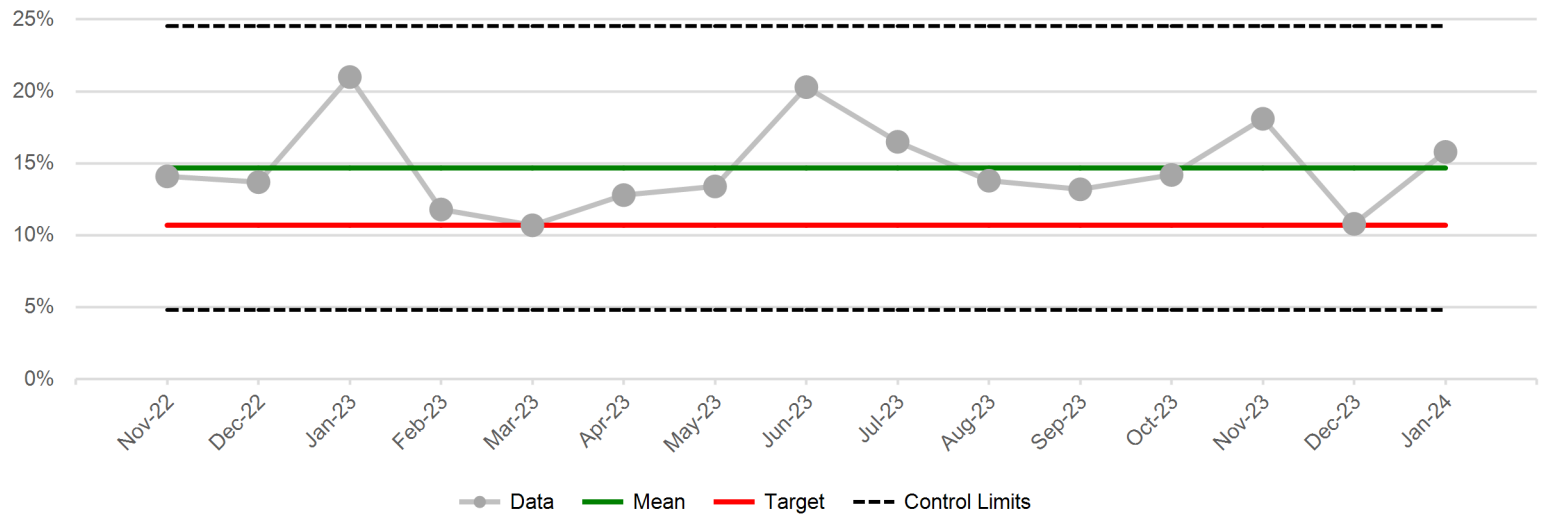
Actions:
A paper was taken to Trust Leadership Team in November 2022 proposing the reinstatement of the VTE Specialist Nurse. This was agreed and work will now take place to identify a funding stream.

No narrative owner

Mitigations:

Performance Overview - Quality

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



Jan-24
15.80%
Variance Type
Common cause variation
Target
10.70%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Medical Director

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

What the chart tells us:
In the month of January the number of incidents reported was 196. This equates to 5.50 incidents per 1000 bed days. The number of incidents causing some level of harm (low /moderate /severe / death) is 15.8% which is just above the national average of 11%.

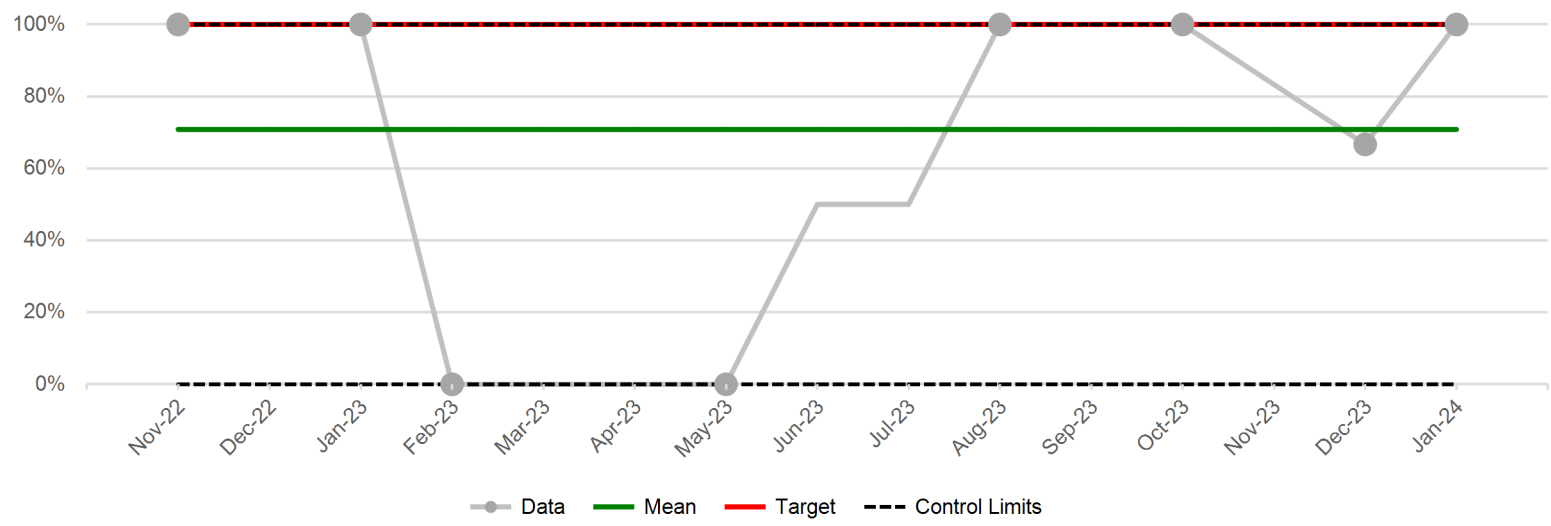
Issues:
The majority of incidents are at the point of prescribing and administration of medication and the main error is omitting medicines.

Actions:
Improving medication incidents from omitted medicines is a work stream as part of the new Patient Safety Incident Response Framework (PSIRF).

Mitigations:

Performance Overview - Quality

Patient Safety Alerts responded to by agreed deadline



Jan-24
100.00%
Variance Type
Common cause variation
Target
100.00%
Achievement
Variation indicates inconsistently passing and falling short of the target
Executive Lead
Medical Director

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

What the chart tells us:
100% compliance in number of patient safety alerts responded to within agreed deadline in January, an improvement on previous month (66.7%).

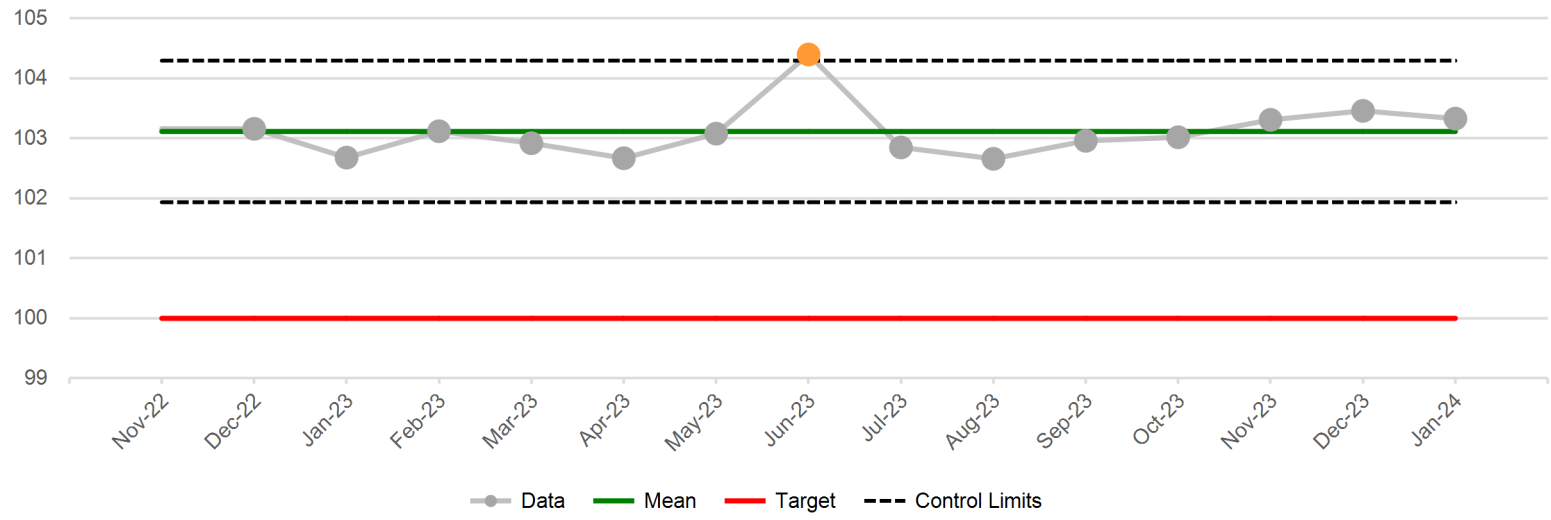
Issues:
The Trust were previously not demonstrating compliance with the target set for CAS Alerts. The performance was below the lower control limit although this has now improved.

Actions:
Patient safety alerts are now recorded on DatixIQ Alerts module, compliance will be monitored on dashboards by Risk & Datix Team and Leads with overall responsibility for the alerts.

Mitigations:
Compliance to be discussed monthly at Patient Safety Group.
Use of Dashboards for monitoring compliance on Alerts Module on DatixIQ.

Performance Overview - Quality

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



Jan-24
103.33
Variance Type
Common cause variation
Target
To remain in 'as expected' range
Achievement
Variation indicates consistently falling short of the 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 in band 2 '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.

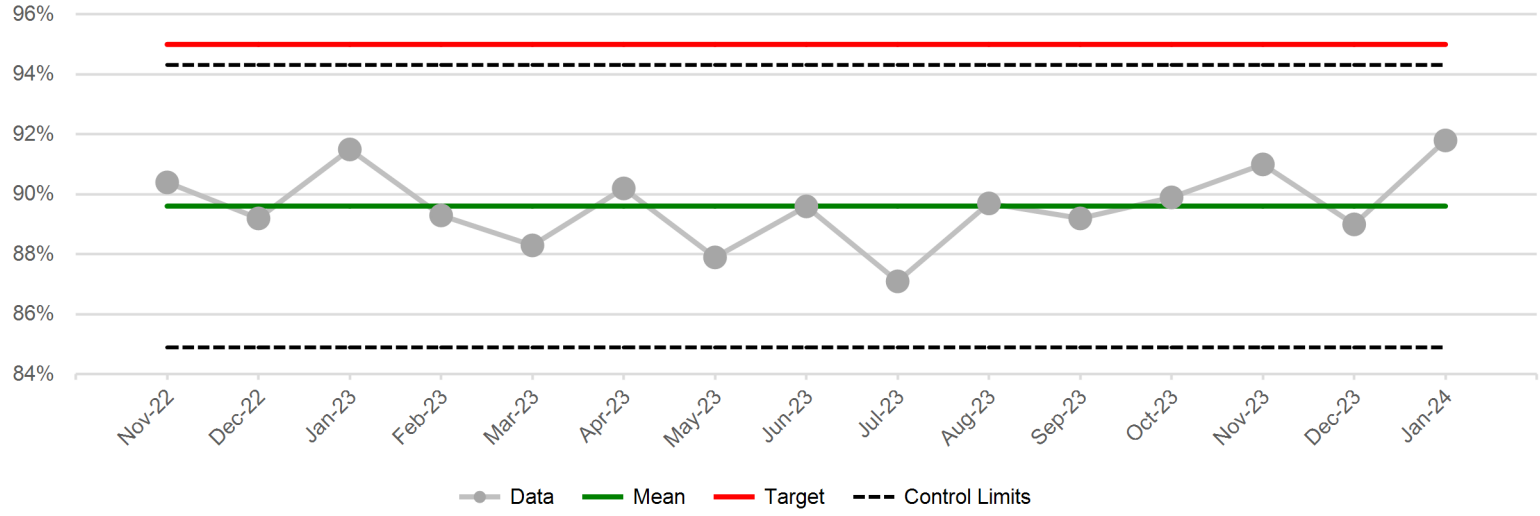
A paper was presented at MorALS to standardise M&Ms and has been agreed. The Mortality Team are currently liaising with the Specialties and Business Units to implement the M&Ms.

Mitigations:
The MEs have commenced reviewing some deaths in the community which will enable oversight of deaths in 30 days post discharge of which learning can be identified. From 1 April 2024 it will be legislation for all deaths to be reviewed by the ME service.

HSMR is 93.22 (rolling 12 months).

Performance Overview - Quality

eDD issued within 24 hours



Jan-24
91.80%
Variance Type
Common cause variation
Target
95.00%
Achievement
Variation indicates consistently falling short of 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 91.80%.

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

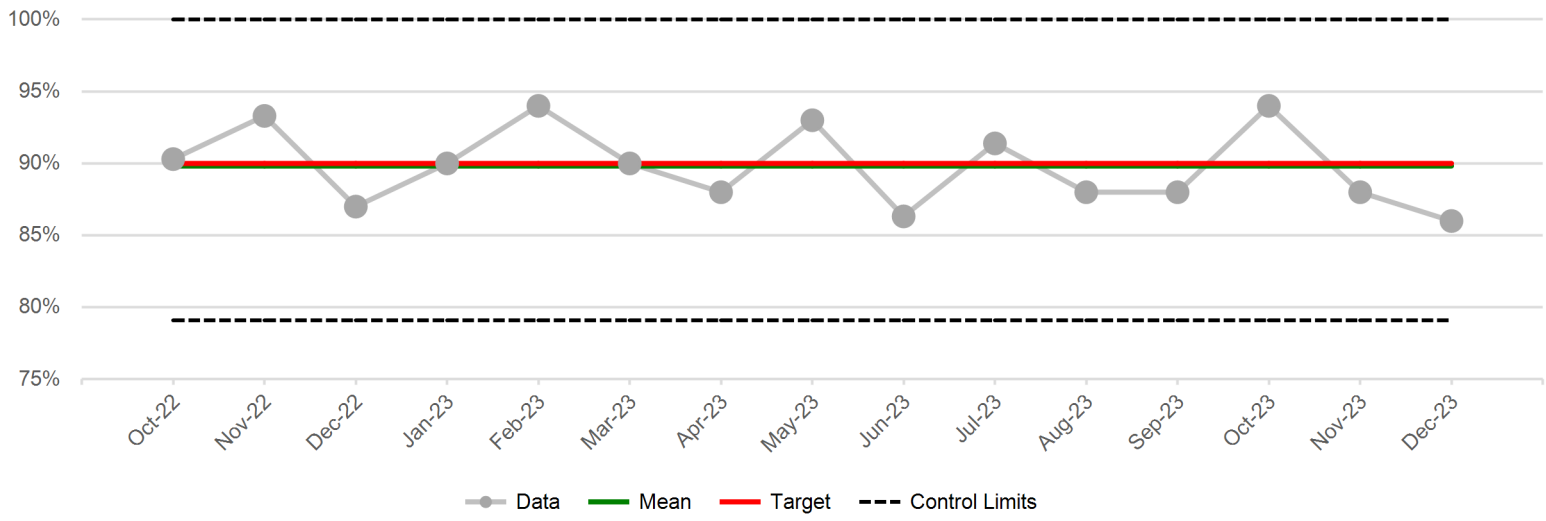
No Narrative owner

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

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

Performance Overview - Quality

Sepsis screening (bundle) compliance for inpatients (adult)



Dec-23
86.00%
Variance Type
Common cause variation
Target
90.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of Nursing

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

What the chart tells us:
Inpatient compliance is 86% for screening which is below the 90% standard.

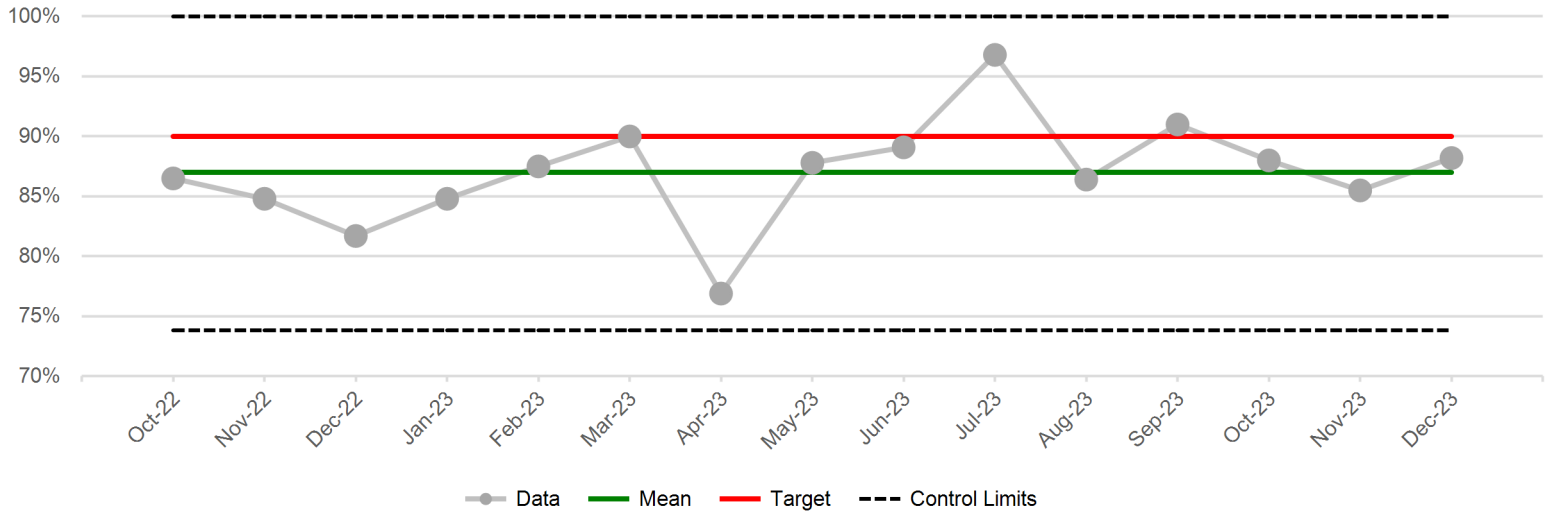
Issues:
The continued drop in compliance is attributable to medical inpatient areas which is a trend seen across the last few months. Thematic analysis provided by the ward leads suggest that the omissions are partly due to larger numbers of newly appointed staff who may require additional training and support.

Actions:
Due to the continued drop in compliance, the sepsis practitioners have moved towards a structured programme of support for inpatient areas. Previously support was provided to areas as required but the sepsis team are now rolling out bedside teaching in conjunction with the Resus officers.

Mitigations:
Ward leads provide harm reviews to identify themes that can impact on the compliances and the clinical education team have now commenced a ward ready programme that aims to prepare new starters for ward work.Sepsis screening is part of this programme and should start to improve compliance.

Performance Overview - Quality

Sepsis screening (bundle) compliance for inpatients (child)



Dec-23
88.20%
Variance Type
Common cause variation
Target
90.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of Nursing

Background:
Sepsis screening (bundle) compliance for inpatients (child)

What the chart tells us:
The Sepsis screening compliance this month was 88.2%. 60 out of 68 children were screened for Sepsis within a timely manner.

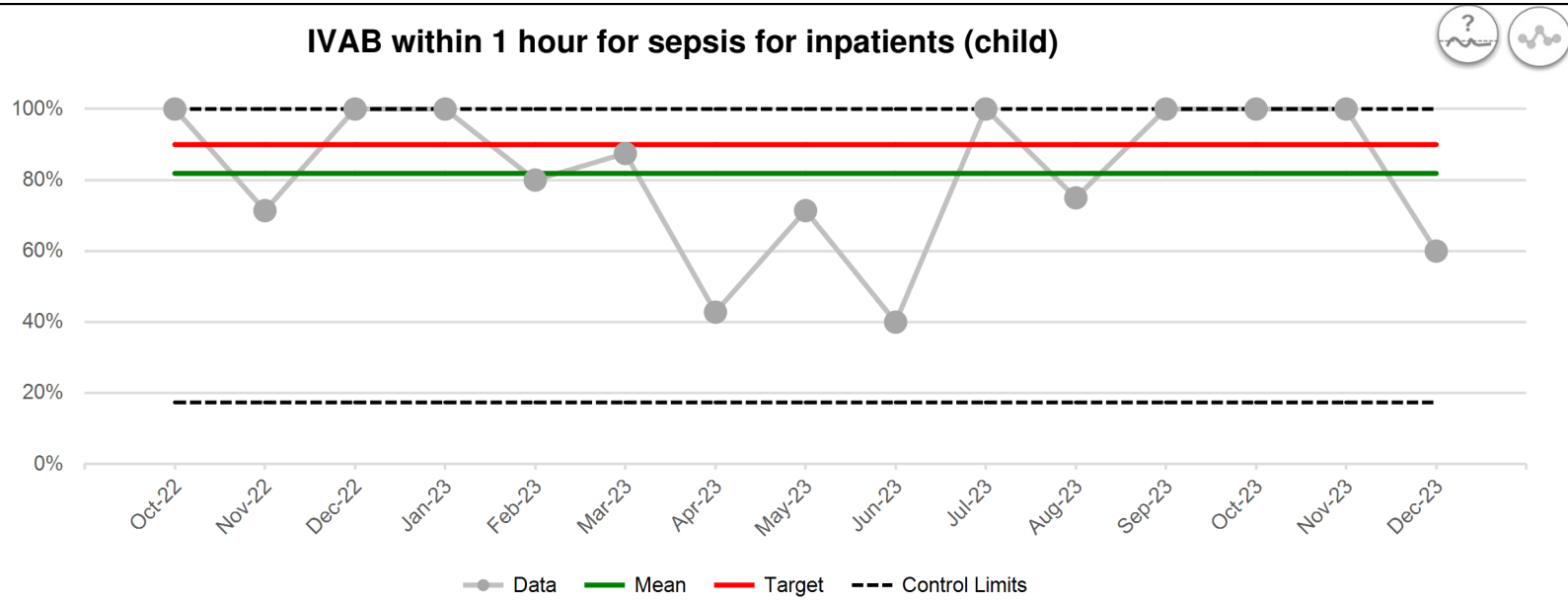
Issues:
All children with delayed Sepsis screens were either infection treated with oral antibiotics or were found to have a viral / non bacterial reason for illness.
There are a number of new members of staff on the wards that need Sepsis training.

Actions:
Staff involved have been identified and discussed with their departmental leads and Clinical Educators

Staff involved have been asked to write their own harm reviews to gain any learning opportunity.
Training has been identified and planned for any new members of staff.

Mitigations:
Harm reviews completed by Clinical Educator have not found any harm to patients from delayed or missed screens.

Performance Overview - Quality



Dec-23
60.00%
Variance Type
Common cause variation
Target
90.00%
Achievement
Variation indicates inconsistently passing and falling short of the target
Executive Lead
Director of Nursing

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

What the chart tells us:
The compliance for Sepsis treatment for inpatients was 60.0%. 3 out of 5 patients received antibiotics within the 1 hour time frame.

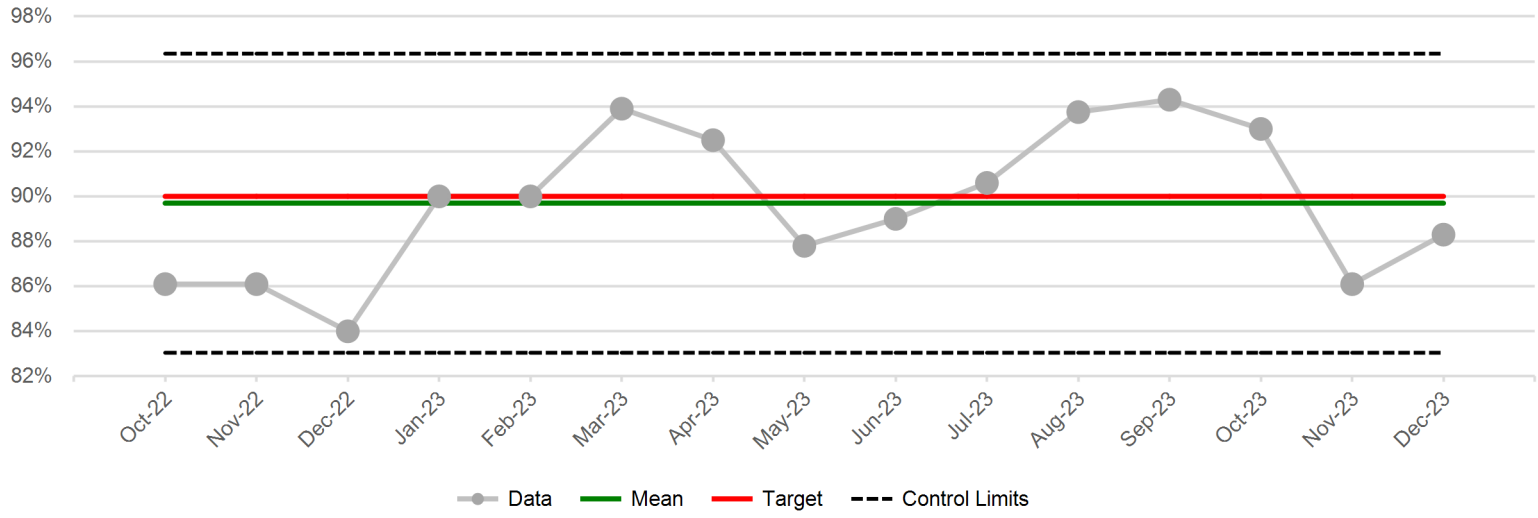
Issues:
There were 2 children who had delayed treatment with IVAB. One child was waiting to be seen by ENT team in order to make decision to treat with IVAB, Patient had a post op infection.
The second child was moved between two wards and treatment was delayed due to transfer and handover time.

Actions:
New staff identified to complete Sepsis training.
Harm Reviews completed by Sepsis Practitioner and fed back to teams.

Mitigations:
Harm reviews completed for both children and no harm found.
Clinical Educator will share any reasons / themes with ward staff.

Performance Overview - Quality

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



Dec-23
88.30%
Variance Type
Common cause variation
Target
90.00%
Achievement
Variation indicates inconsistently passing and falling short of the target
Executive Lead
Director of Nursing

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

What the chart tells us:
The sepsis screening compliance this month was 88.3%. 288 of 326 children received screening within 1 hour.

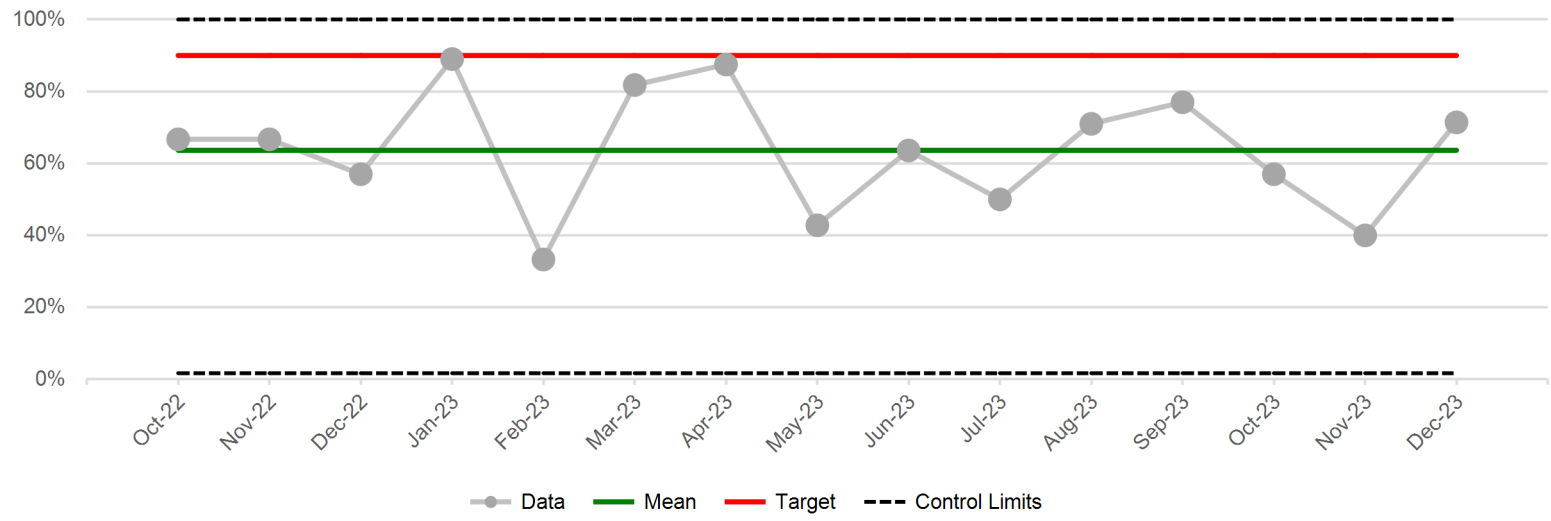
Issues:
Delayed screens appeared to be higher during busier shifts in ED.
There were some staff who had missed several screens.

Actions:
Staff involved have been identified, Sepsis Practitioner will meet with them to offer support and look at ways of completing screens more easily during these busy shifts. These staff have also been discussed with department managers.

Mitigations:
Harm reviews completed for patients found no harm due to any of the missed or delayed screens.
All missed screens were found to be non infective or infections treated with oral antibiotics.

Performance Overview - Quality

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



Dec-23
71.40%
Variance Type
Common cause variation
Target
90.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of Nursing

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

What the chart tells us:
The compliance for IVAB administration was 71.40%. 10 out of 14 children received their antibiotics in a timely manner.

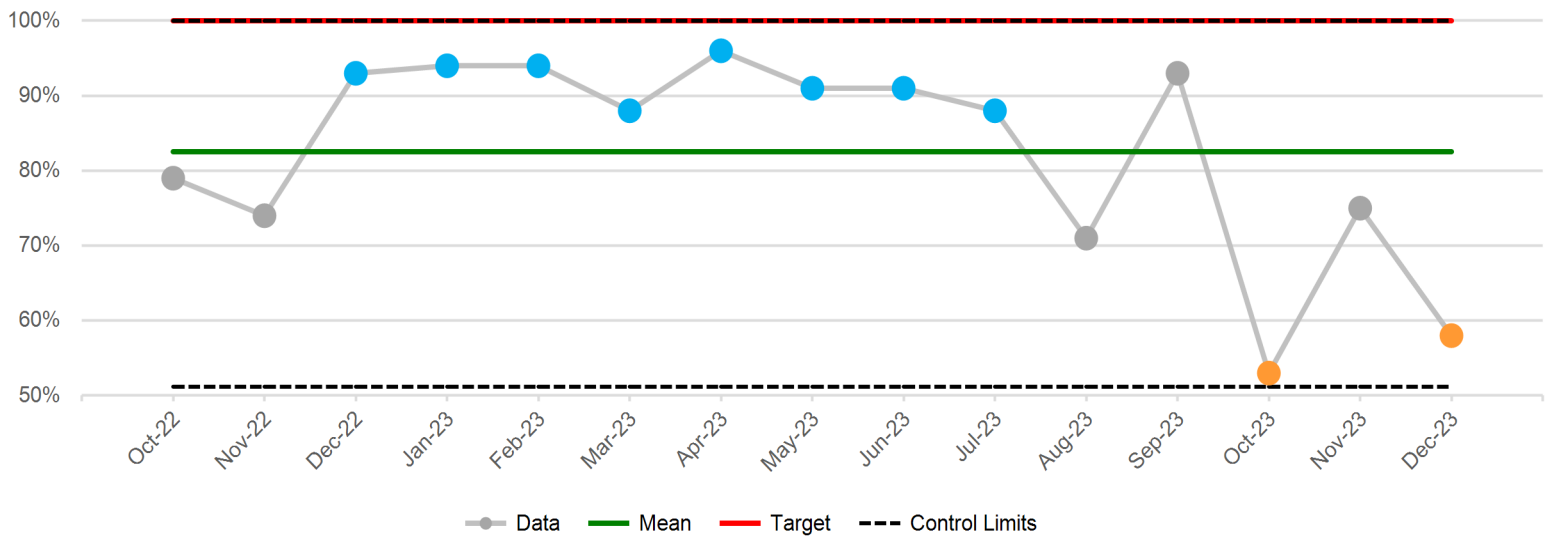
Issues:
Two children were initially treated as viral but were then treated as sepsis once arriving on the ward.
One child was very difficult to cannulate and this led to a significant delay in administration.
One child was treated for Sepsis at 86 minutes, reason for delay is not documented.

Actions:
Sepsis Practitioner to meet with A & E teams to discuss the urgency of getting IV access, bloods and giving IV antibiotics.
Alternative methods for getting IV access to children include numbing spray which can be used immediately.
Harm Reviews completed by Sepsis Practitioner and fed back to teams.

Mitigations:
Harm reviews completed for all 3 patients – no harm found
Ongoing monthly meetings with ED and Sepsis teams
Sepsis Practitioner walk rounds to increase in the departments.

Performance Overview - Quality

Duty of Candour compliance - Verbal



Dec-23
58.00%
Variance Type
Special cause variation - cause for concern (Indicator where low is a concern)
Target
100.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Medical Director

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

What the chart tells us:
Compliance has declined during December to 58%.

Issues:
A decline in the timeliness of Duty of Candour compliance following improvement in November 2023 is mainly due to the unavailability of staff over the Christmas period and compliance has since improved.

Highest non-compliance within Medicine Division.

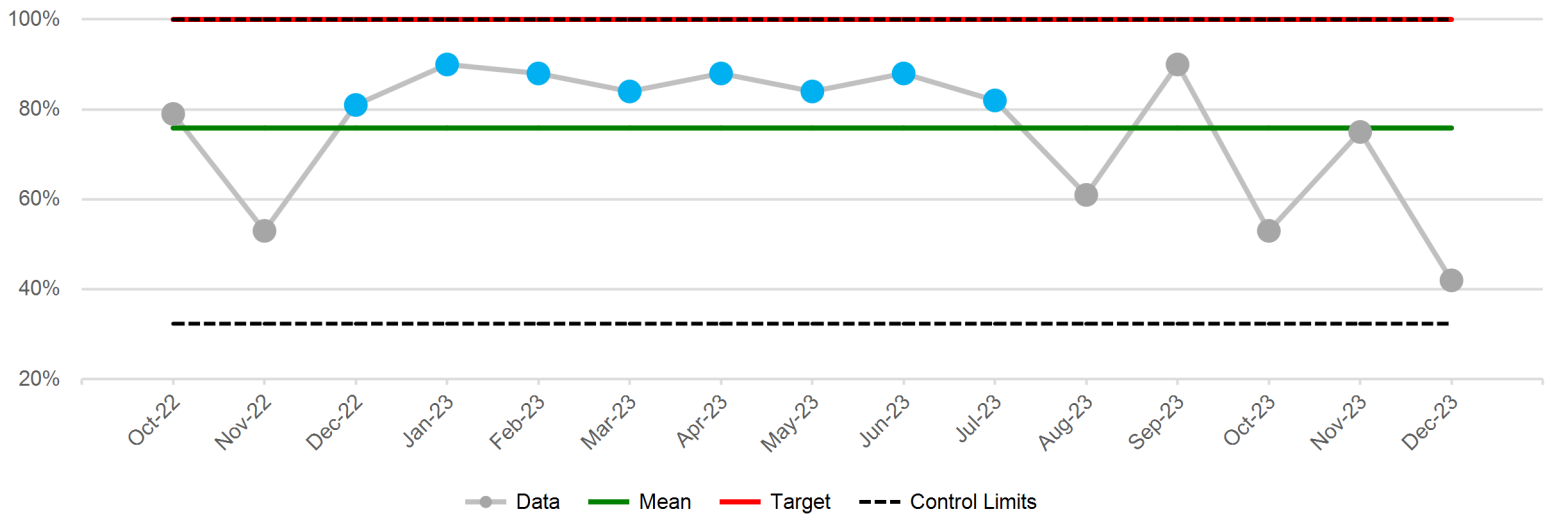
Actions:
Divisional position for each service now provided and Business Partners working with Divisions to complete outstanding and monitor ongoing compliance.

Mitigations:
Weekly tracking in progress by the incident team.

A dedicated member of the incident team is now working with divisions to improve compliance by the next report.

Performance Overview - Quality

Duty of Candour compliance - Written



Dec-23
42.00%
Variance Type
Common cause variation
Target
100.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Medical Director

Background:
Compliance with the written follow up to Duty of Candour, applies to all patient safety incidents where harm is moderate or above, is a statutory requirement.

What the chart tells us:
Compliance has declined during December to 42%

Issues:
A decline in the timeliness of Duty of Candour compliance following improvement in November 2023 is mainly due to the unavailability of staff over the Christmas period and compliance has since improved.

Actions:
Divisional position for each service now provided and Business Partners working with Divisions to complete outstanding and monitor ongoing compliance.

Mitigations:
Weekly tracking in progress by the incident team.

A dedicated member of the incident team is now working with divisions to improve compliance by the next report.

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Hospitals NHS Trust

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Nov-23	Dec-23	Jan-24	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Patient Experience	% Triage Data Not Recorded	Effective	Patients	Chief Operating Officer	0.00%	0.57%	0.57%	0.53%	0.51%	0.00%	F	
Improve Clinical Outcomes	4hrs or less in A&E Dept	Responsive	Services	Chief Operating Officer	75.00%	58.31%	57.54%	57.88%	56.45%	63.66%	F	
	12+ Trolley waits	Responsive	Services	Chief Operating Officer	0	799	967	1,342	8,970	0	F	
	%Triage Achieved under 15 mins	Responsive	Services	Chief Operating Officer	88.50%	69.31%	69.63%	69.91%	72.25%	88.50%	F	L
	52 Week Waiters	Responsive	Services	Chief Operating Officer	2,780	4,125	3,699		52,315	42,064	F	L
	65 Week Waiters	Responsive	Services	Chief Operating Officer	746	1,243	870		16,503	13,703	F	L
	18 week incompletes	Responsive	Services	Chief Operating Officer	84.10%	49.72%	48.85%		49.76%	84.10%	F	
	Waiting List Size	Responsive	Services	Chief Operating Officer	60,540	72,832	71,805		N/A	N/A	F	
	28 days faster diagnosis	Responsive	Services	Chief Operating Officer	75.00%	74.50%	71.80%		66.29%	75.00%	F	H
	62 day classic	Responsive	Services	Chief Operating Officer	85.39%	57.00%	49.00%		53.16%	85.39%	F	
	2 week wait suspect	Responsive	Services	Chief Operating Officer	93.00%	88.40%	85.30%		65.65%	93.00%	F	H

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Hospitals NHS Trust

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Nov-23	Dec-23	Jan-24	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Clinical Outcomes	2 week wait breast symptomatic	Responsive	Services	Chief Operating Officer	93.00%	79.80%	67.50%		30.70%	93.00%	F	H
	31 day first treatment	Responsive	Services	Chief Operating Officer	96.00%	95.00%	91.80%		91.41%	96.00%	F	
	31 day subsequent drug treatments	Responsive	Services	Chief Operating Officer	98.00%	96.70%	94.40%		96.18%	98.00%	F	
	31 day subsequent surgery treatments	Responsive	Services	Chief Operating Officer	94.00%	89.90%	81.30%		77.58%	94.00%	F	
	31 day subsequent radiotherapy treatments	Responsive	Services	Chief Operating Officer	94.00%	94.20%	91.60%		92.18%	94.00%	?	
	62 day screening	Responsive	Services	Chief Operating Officer	90.00%	63.30%	61.90%		65.29%	90.00%	F	
	62 day consultant upgrade	Responsive	Services	Chief Operating Officer	85.00%	75.30%	70.10%		69.15%	85.00%	F	
	Diagnostics achieved	Responsive	Services	Chief Operating Officer	99.00%	74.59%	72.25%	70.36%	70.06%	99.00%	F	H
	Cancelled Operations on the day (non clinical)	Responsive	Services	Chief Operating Officer	0.80%	1.68%	2.09%	1.41%	1.57%	0.80%	F	
	Not treated within 28 days. (Breach)	Responsive	Services	Chief Operating Officer	0	32	39	43	239	0	F	H
	#NOF 48 hrs	Responsive	Services	Chief Operating Officer	90.00%	87.50%	77.78%	78.57%	77.45%	90.00%	F	

OUTSTANDING CARE personally DELIVERED

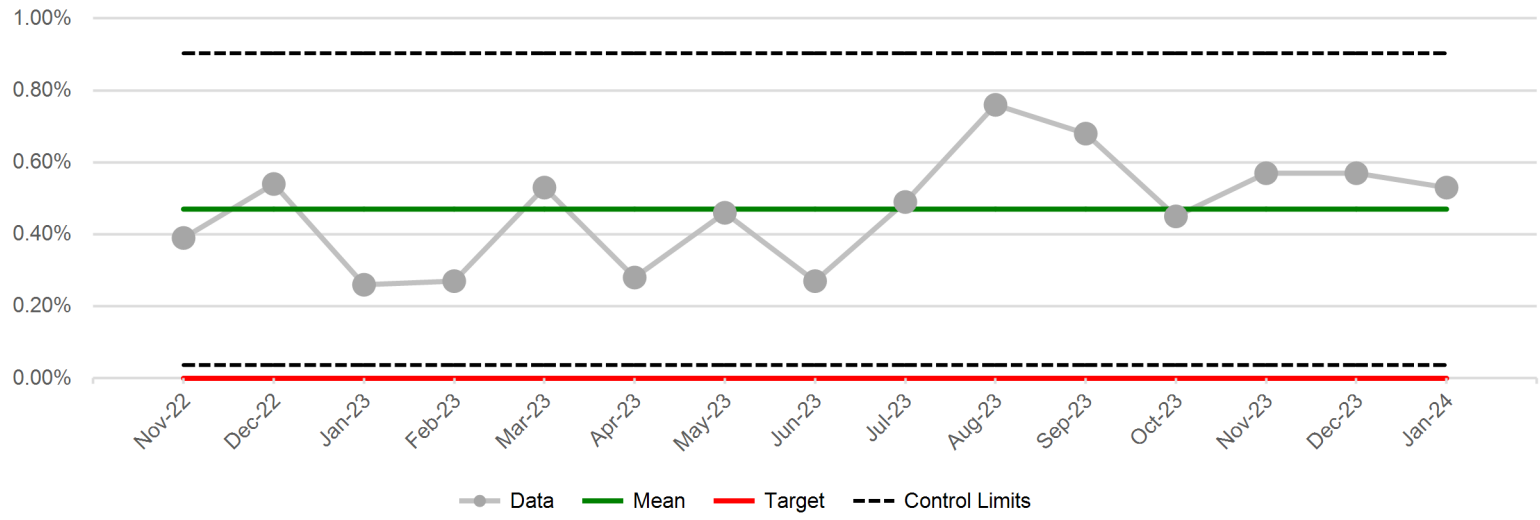
Performance Overview - Operational Performance

NHS United Lincolnshire Hospitals NHS Trust

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Nov-23	Dec-23	Jan-24	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Clinical Outcomes	#NOF 36 hrs	Responsive	Services	Chief Operating Officer	TBC	68.75%	51.85%	61.43%	54.89%			
	EMAS Conveyances to ULHT	Responsive	Services	Chief Operating Officer	4,657	4,141	4,368	4,538	4,320	4,657	P	H
	EMAS Conveyances Delayed >59 mins	Responsive	Services	Chief Operating Officer	0	483	484	693	616	0	F	
	104+ Day Waiters	Responsive	Services	Chief Operating Officer	10	42	52	55	641	100	F	L
	Average LoS - Elective (not including Daycase)	Effective	Services	Chief Operating Officer	2.80	2.33	2.86	3.07	2.84	2.80	F	
	Average LoS - Non Elective	Effective	Services	Chief Operating Officer	4.50	4.67	4.54	4.81	4.84	4.50	F	
	Delayed Transfers of Care	Effective	Services	Chief Operating Officer	3.50%	Submission suspended	Submission suspended	Submission suspended		3.50%		
	Partial Booking Waiting List	Effective	Services	Chief Operating Officer	4,524	26,789	27,771	27,479	27,532	4,524	F	H
	% discharged within 24hrs of PDD	Effective	Services	Chief Operating Officer	45.00%	36.80%	39.51%	41.94%	40.82%	45.00%	F	

Performance Overview - Operational Performance

% Triage Data Not Recorded



Jan-24
0.53%
Variance Type
Common cause variation
Target
0.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
Percentage of triage data not recorded.

What the chart tells us:
January 24 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 82.54% of those without a triage "did not wait" to be seen. 97% of the overall missing data is on the LCH Site.

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.

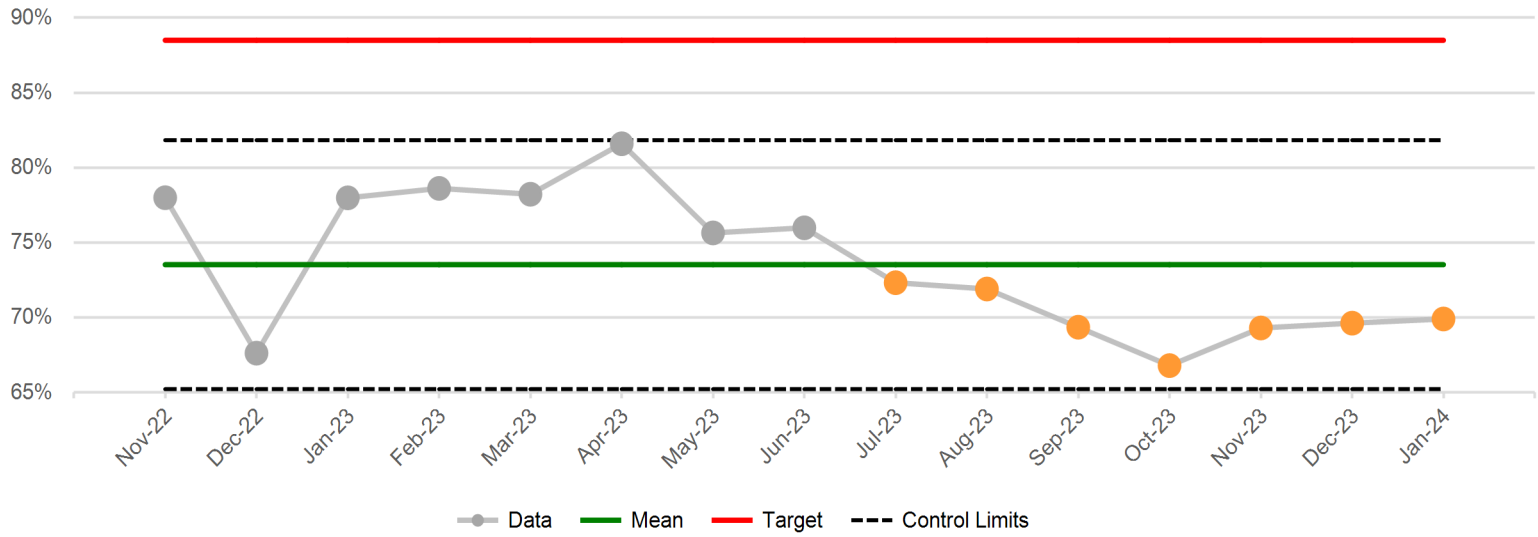
Staffing gaps, sickness, and skill mix issues.

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).

Performance Overview - Operational Performance

%Triage Achieved under 15 mins



Jan-24
69.91%
Variance Type
Special cause variation - cause for concern (Indicator where low is a concern)
Target
88.50%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
Percentage of triage achieved under 15 minutes.

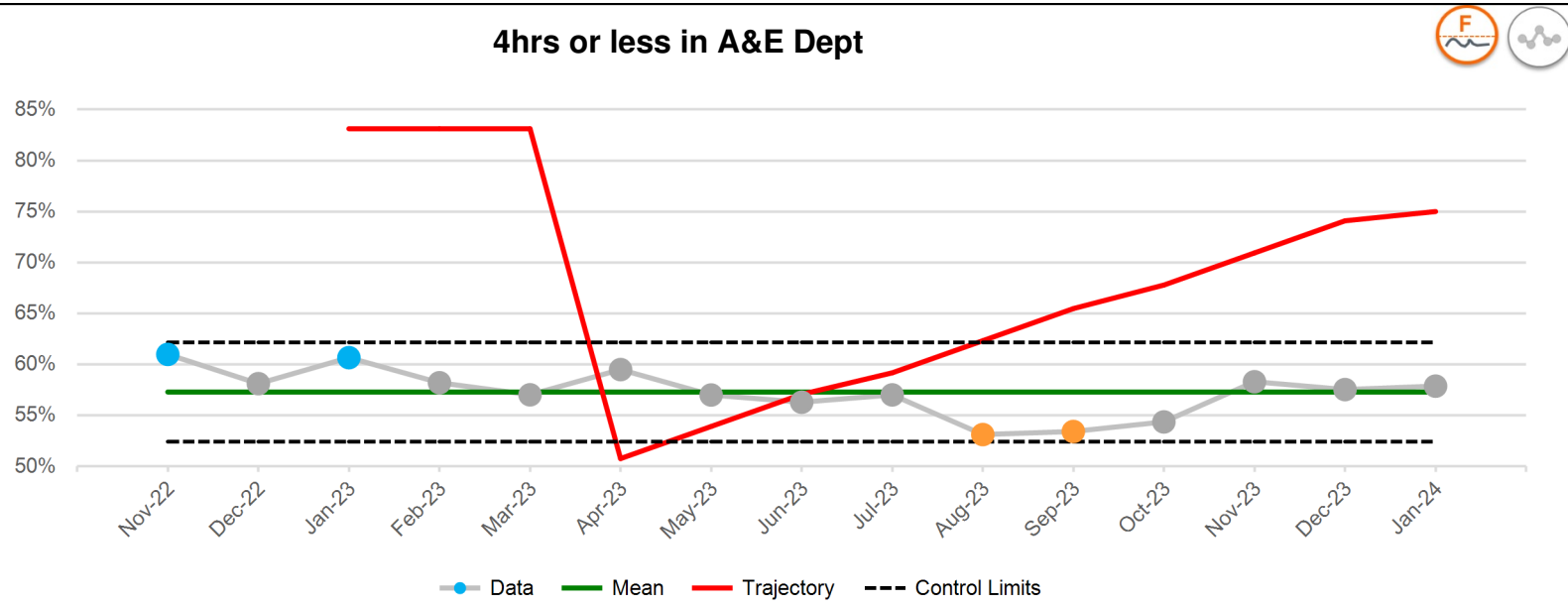
What the chart tells us:
January outturn was 69.91% compared 69.63% in Dec (validated).
What the chart doesn't tell us is the static performance is parallel with a 12% increase in daily attendances compared to January 2023. An additional 41 patients daily.

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.
• 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 3 x daily Capacity and Performance Meetings.

Mitigations:
The Senior Nurse Leads maintain oversight and support in periods of either high attendance demand or when the second triage stream is compromised due to duality of role issues.
The confirmation of 2 triage streams is ascertained at the 3 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 is in operation 7 days a week and a daily staffing forecast is also in place.

Performance Overview - Operational Performance



Jan-24
57.88%
Variance Type
Common cause variation
Trajectory
75.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
The 23/24 target has been set at 76% with a rolling trajectory by month to achieve by year end.

What the chart tells us:
The 4-hour transit performance for Type 1 and co-located UTC Type 3 for has not been met.
What the chart doesn't tell us is the improved performance with an increase attendance rate within the department.

Issues:
ED (Type 1) saw an average of 370 patients daily compared to January 2023 of 330. First assessment continues to have dips in performance overnight.

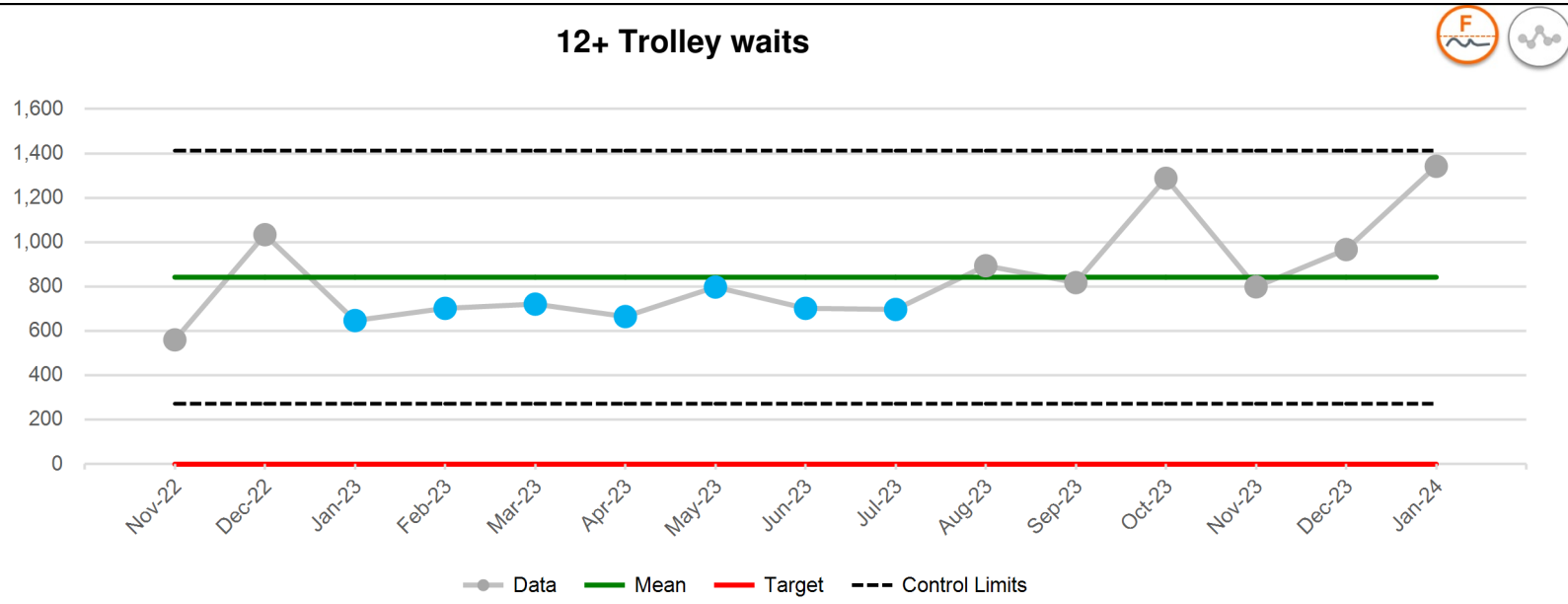
Ward Based Discharges were an average of 34 short to meet ED demand each day – this resulted in prolonged bed waits overnight. Early recognition of discharges also lead to the extended LOS within ED. (With 59.33% recognised after 4pm daily)

Infection related closures of beds on wards impacted availability of movement and cleaning resource affected timely movements.
Ongoing medical and nursing gaps that were not Emergency Department specific.

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.
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.

Performance Overview - Operational Performance



Jan-24
1,342
Variance Type
Common cause variation
Target
0
Achievement
Variation indicates consistently falling short of 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:
January experienced 1342 breaches compared to 967 in December. This is a decline of 375 more patients. The 1342 seen, equates to 12% of all type 1 attendances. (6% more than December)
What the chart does not explain is the internal decision to move focus to total time in ED to minimise exposure risk/ mortality rate.

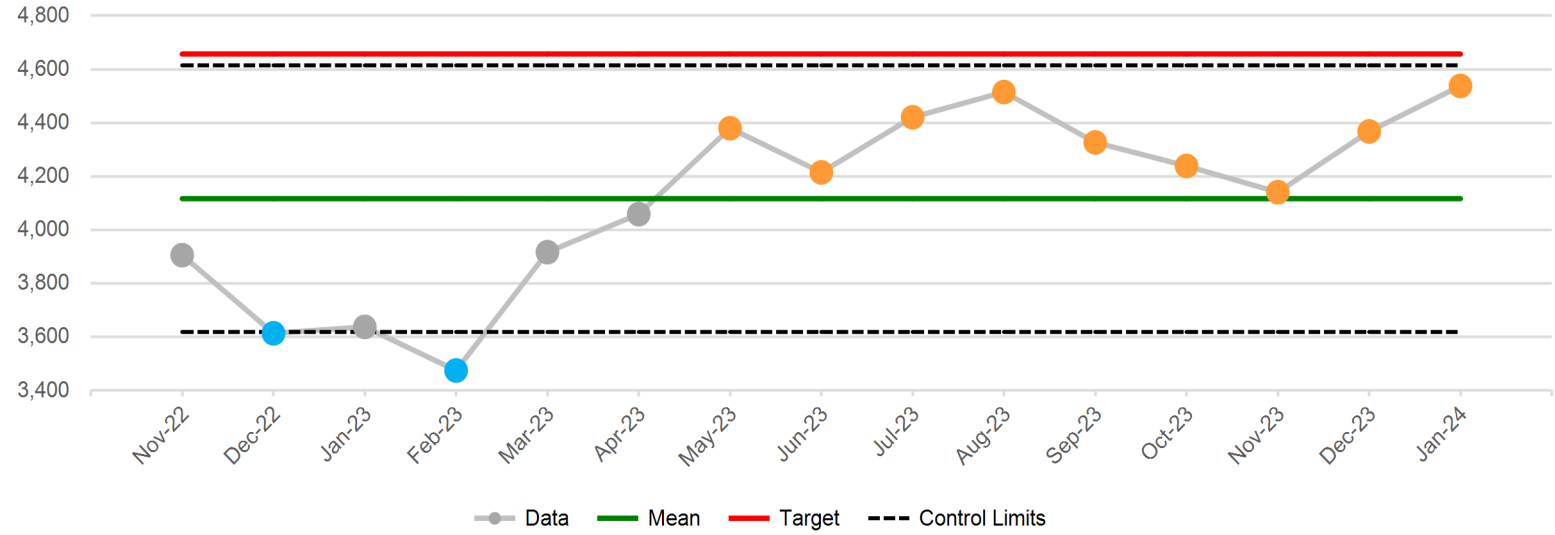
Issues:
Sub-optimal discharges to meet the known emergency demand.
All reportable 12hr trolleys were either associated with no available beds, patient deterioration or delays in transfer to other care settings.

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.

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.
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.

Performance Overview - Operational Performance

EMAS Conveyances to ULHT



Jan-24
4,538
Variance Type
Special cause variation - cause for concern (Indicator where high is a concern)
Target
4,657
Achievement
Variation indicates consistently passing the target
Executive Lead
Chief Operating Officer

Background:
EMAS Conveyances to ULHT.

What the chart tells us:
ULHT saw a total of 4538 conveyances a 170 increase to that seen in December 23.
January continued the 22/243 trend of a 10% increase in activity conveyed to ED than that of 2022.
What the chart doesn't show is the increased conversion to admission rate (4% higher) during January due to increased winter acuity being presented.

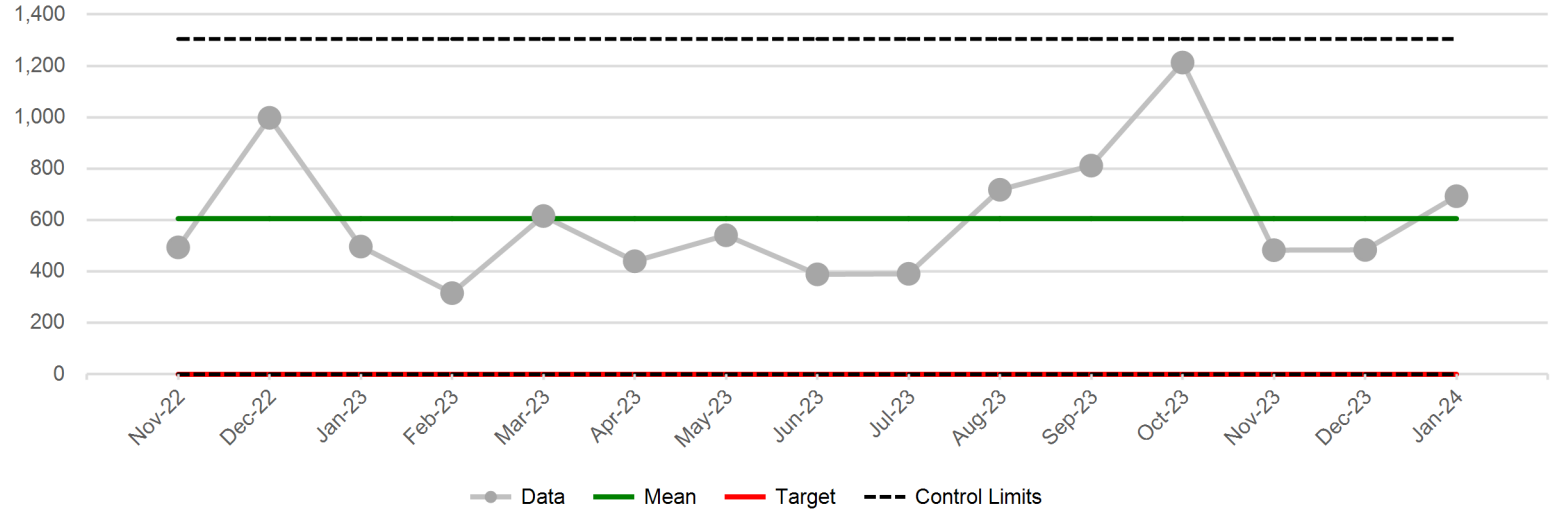
Issues:
The pattern of conveyance is such that arrivals are loaded to the late afternoon and into the evening. This also coincides with increased 'walk ins'.
The use of alternative pathways to avoid conveyance to the Trust are still not fully adhered to but progress continues to be made.
Pressure experienced by neighbouring Trusts have seen an increased ask for support. These in the main have been refused.

Actions:
Recovery plans are in place by the Trust for urgent and emergency care (UEC) which include patients being appropriately clinically managed through alternative streams to avoid large numbers of patients in the emergency department leading to possible delays in Ambulance handover. The benefits of these alternative streams have still yet to be fully realised.
Increased resourcing of CAS by LCHS which includes an extended criterion continues to develop.
Increased use of and streaming to the UTCs is in place and some benefits are being seen although the pathways and extended criterion needs to be more robust.

Mitigations:

Performance Overview - Operational Performance

EMAS Conveyances Delayed >59 mins



Jan-24
693
Variance Type
Common cause variation
Target
0
Achievement
Variation indicates consistently falling short of 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.

What the chart tells us:
January demonstrated a deteriorated performance to that seen in December 2023, however what the chart doesn't show is a 3.89% increase in conveyances to the departments.
January's performance of 693 over 59mins is a 15% of all conveyances that arrived, 4% higher than that of December 23, but only 1% higher than January 2023.

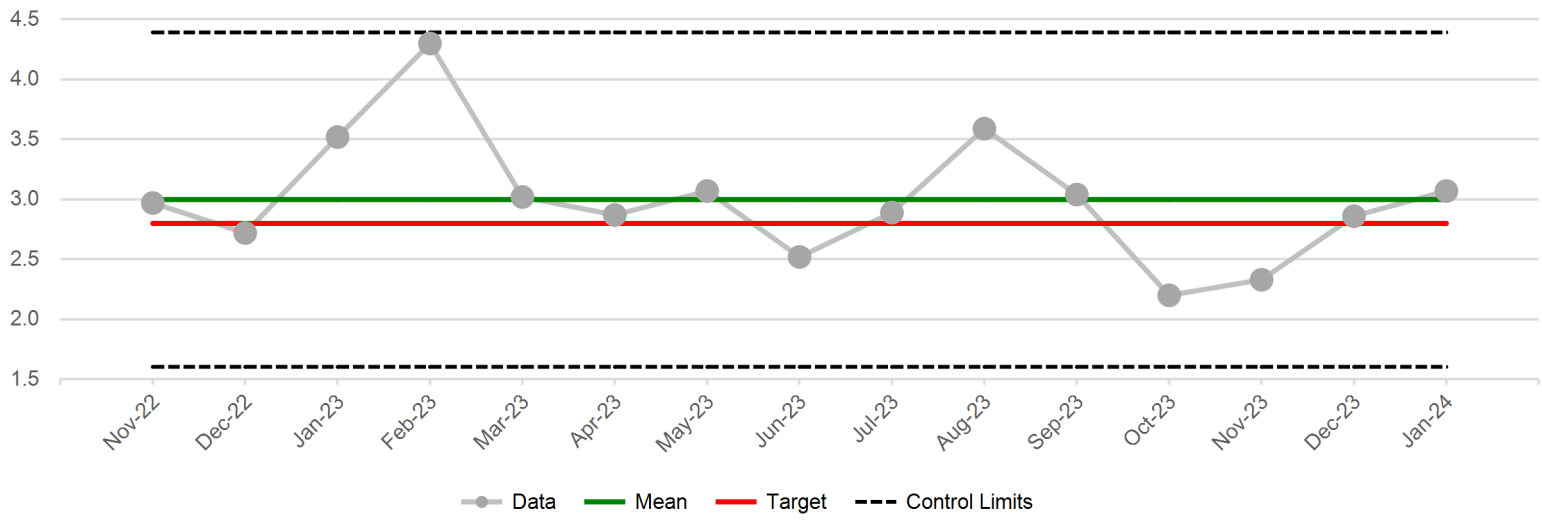
Issues:
The pattern of conveyance and prioritisation of clinical need contributes to the delays.
Increased conveyances continue to profile into the late afternoon and evening coincides with increased 'walk in' attendances causing a reduce footprint to respond to timely handover.
An increasing number 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.
Rapid handover protocol, designated escalation areas have been identified/confirmed to assist in reducing delays in handover.
Plus 1/2 Process active to alleviate pressure/capacity in ED.

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.

Performance Overview - Operational Performance

Average LoS - Elective (not including Daycase)



Jan-24
3.07
Variance Type
Common cause variation
Target
2.80
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
Average length of stay for Elective inpatients.

What the chart tells us:
The average LOS for Elective stay has increased to 3.07 days compared to 2.9 days in December. This represents a negative variance of 0.27 days against the agreed target.

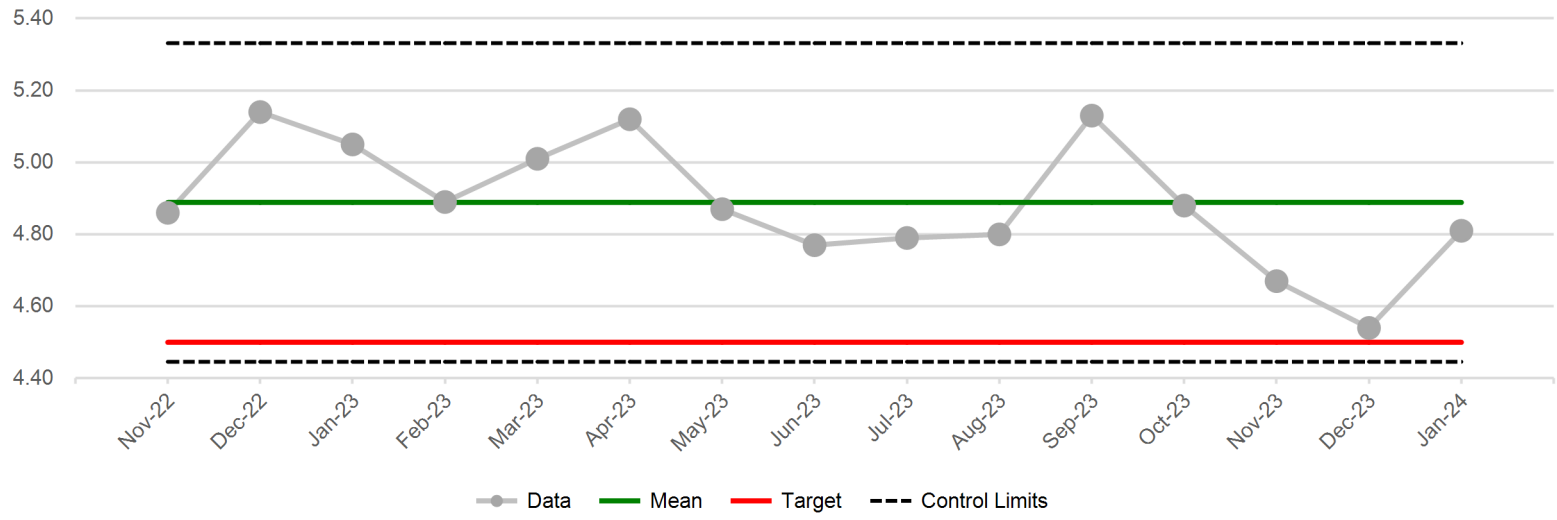
Issues:
Complexity of patients now being admitted which will impact on post-operative recovery and LOS.
Increase in Elective patients on pathways 1, 2 & 3.
Distorted figures associated with outliers in previous dedicated elective beds and coding.

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.

Performance Overview - Operational Performance

Average LoS - Non Elective



Jan-24
4.81
Variance Type
Common cause variation
Target
4.50
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
Average length of stay for non-Elective inpatients.

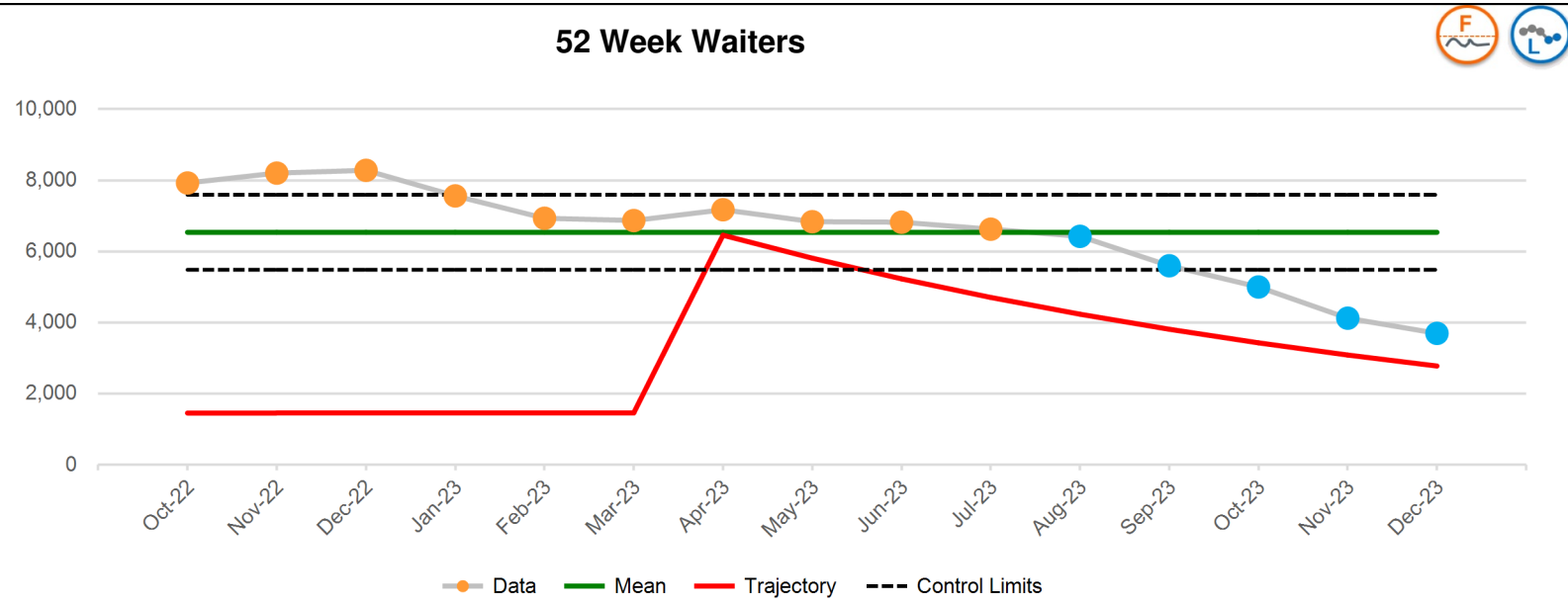
What the chart tells us:
January outturn of 4.81 is a deterioration of 0.27 days and a 0.31 day negative variance against the agreed target.
What the chart doesn't tell us is the change by pathway:
Pathway 0 (0.2) more days
Pathway 1 (0.4) more days
Pathway 2 (1.4) more days
Pathway 3 (2.4) more days

Issues:
Super stranded patients have increased in daily average 115 patients in December to 130 in January. (13% improvement) Stranded also seeing similar of 187 to 210 patients daily. (11% decline)
However both metrics are continuing the improvements seen against January 2023.
Weekend Discharges remain consistently lower than weekdays with an average of 30% 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.

Actions:
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
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.
Monthly face to face MADE events now commenced on each site. Reviewing all Pathways, with a greater focus on >7 days length of stay patients.

Mitigations:
Divisional Leads continue to support the escalation of exit delays.
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.

Performance Overview - Operational Performance



Dec-23
3,699
Variance Type
Special cause variation - improvement (Indicator where low is good)
Trajectory
2,780
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

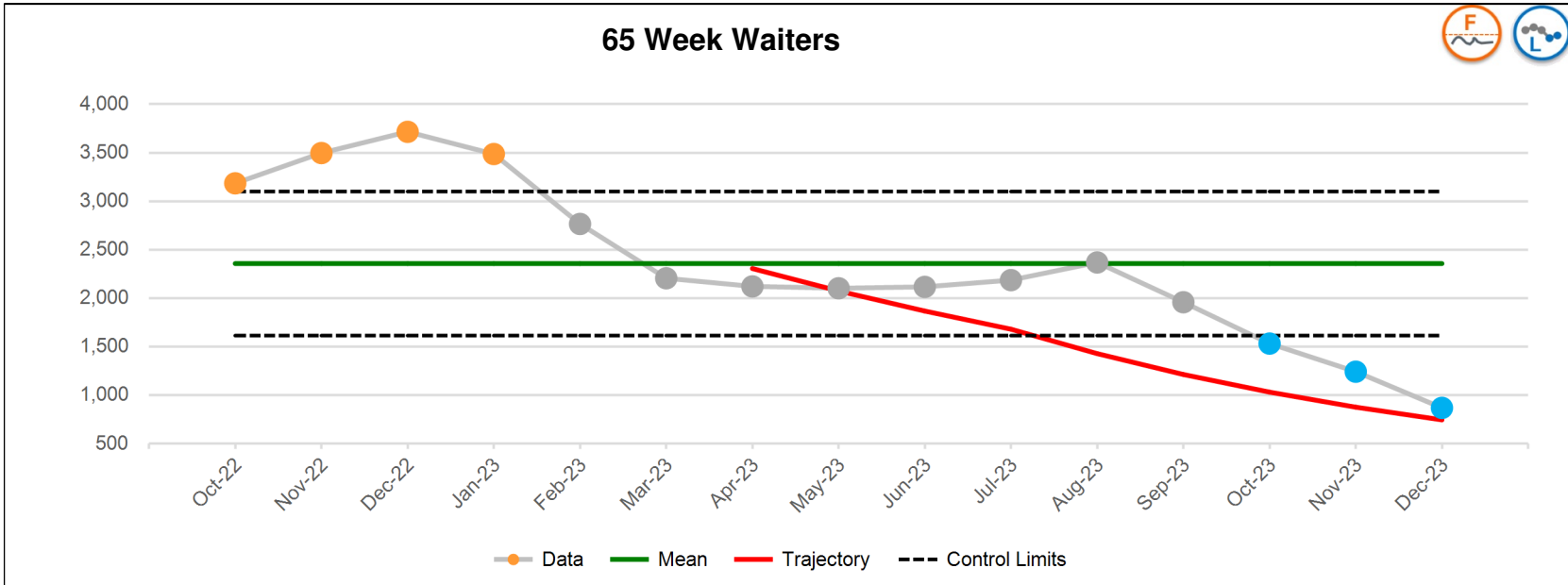
What the chart tells us:
The Trust reported 3,699 incomplete 52-week breaches for December 2023, a decrease of 426 from November 2023's 4,125.

Issues:
As shown above, 52 week waiters are negatively performing against trajectory, however, the volume continues to decrease.
Both admitted and non-admitted patients sit within this wait band, however, the most significant pressure is in the non-admitted pathways.

Actions:
The Integrated Elective Care Co-Ordination Programme continues to be used, providing a single, real time view of clinical prioritisation of patients with reduced cancellations and increased efficiency of the 642 process.

Mitigations:
ULHT have de-escalated to Tier 2 of the national tiering system for elective recovery due to an improving position. ENT remains the specialty under greatest pressure.

Performance Overview - Operational Performance



Dec-23
870
Variance Type
Special cause variation - improvement (Indicator where low is good)
Trajectory
746
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

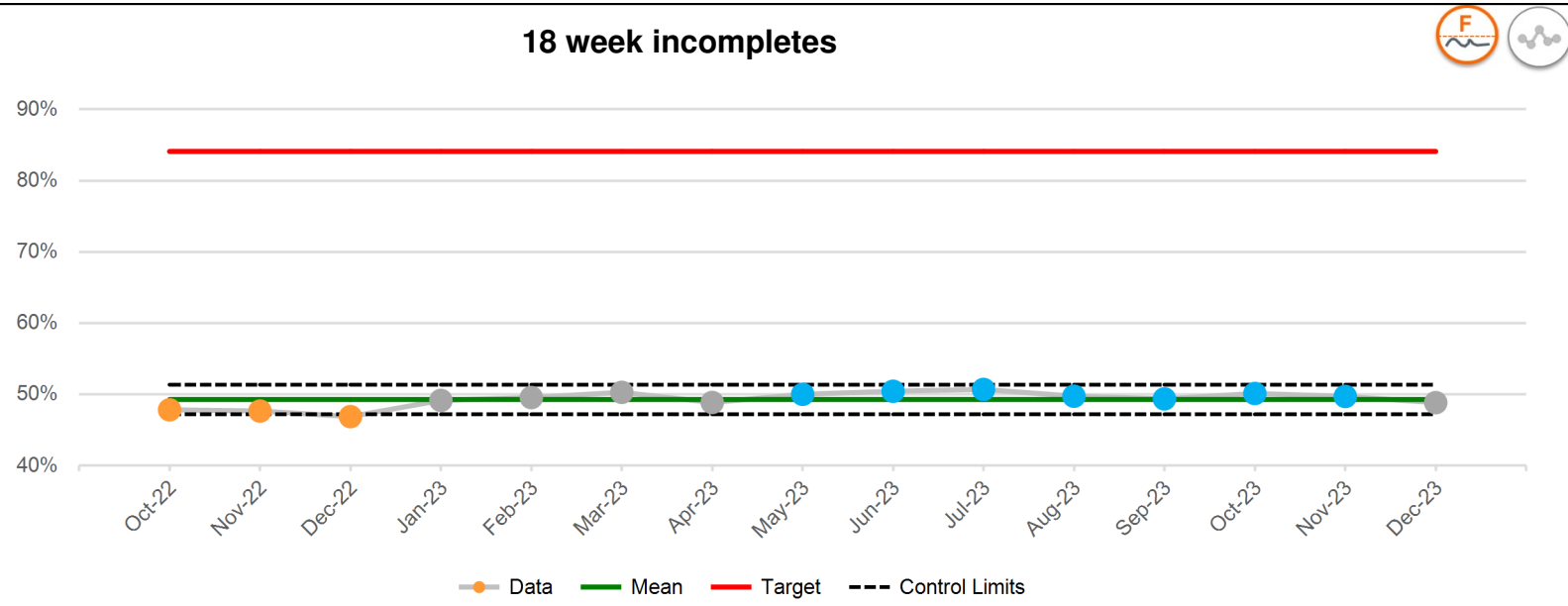
What the chart tells us:
The Trust reported 870 incomplete 65-week breaches for December 2023, a decrease of 373 from November 2023's 1,243.

Issues:
ULHT's 104 week wait patients position was five patients reported for December.
As shown above, 65 week waiters are continuing to reduce.

Actions:
Incomplete patient pathways are discussed with individual specialities weekly, through the PTL meeting.
This meeting is currently focusing on patients in the 78w cohort for the month. Due to the high volume of patients, this is being held twice a week.

Mitigations:
ORIG supports delivery of Outpatient improvements for the non-admitted pathways. To ensure Outpatient capacity is fully utilised and efficiency schemes are implemented and well used.

Performance Overview - Operational Performance



Dec-23
48.85%
Variance Type
Common cause variation
Target
84.10%
Achievement
Variation indicates consistently falling short of 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. December 2023 saw RTT performance of 48.85% against an 84.1% target, which is 0.87% down from November 2023.

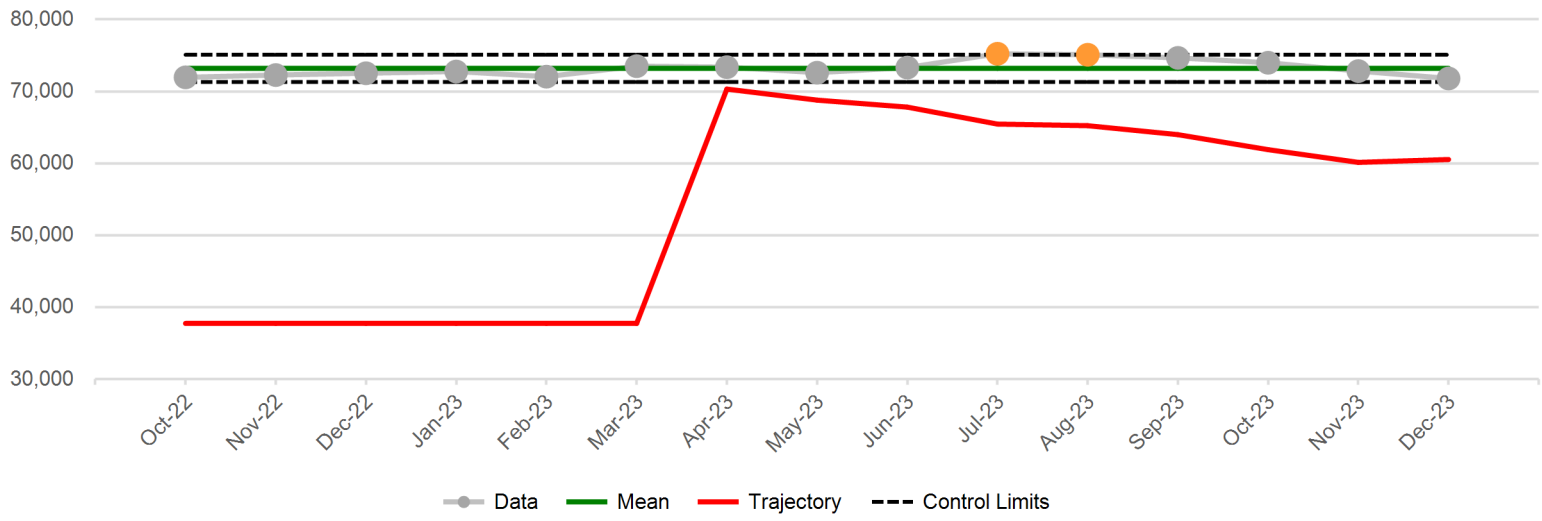
Issues:
Performance is currently below trajectory and standard. The five specialties with the highest number of 18 week breaches at the end of the month were:
ENT – 6484 (increased by 95)
Gastroenterology – 3112 (increased by 9)
Gynaecology – 2897 (decreased by 62)
Ophthalmology – 2528 (decreased by 93)
Respiratory Medicine – 2231 (decreased by 133).

Actions:
Priority remains focussed on clinically urgent and Cancer patients. National focus continues to be on patients that are waiting 78 weeks and over, with the target to achieve zero by the end of February. Resource is targeted at patients who have the potential to be >78 weeks.
Schemes to address the backlog include;
1. Outpatient utilisation
2. Tertiary capacity
3. Outsourcing/Insourcing
4. Use of ISPs
5. Reducing 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. Focus is also on capturing all activity.
Clinical prioritisation – Focusing on clinical priority of patients using theatres.

Performance Overview - Operational Performance

Waiting List Size



Dec-23
71,805
Variance Type
Common cause variation
Trajectory
60,540
Achievement
Variation indicates consistently falling short of 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 November 2023, with December showing a decrease of 1027 to 71,805.
This is more than double the pre-pandemic level reported in January 2020.

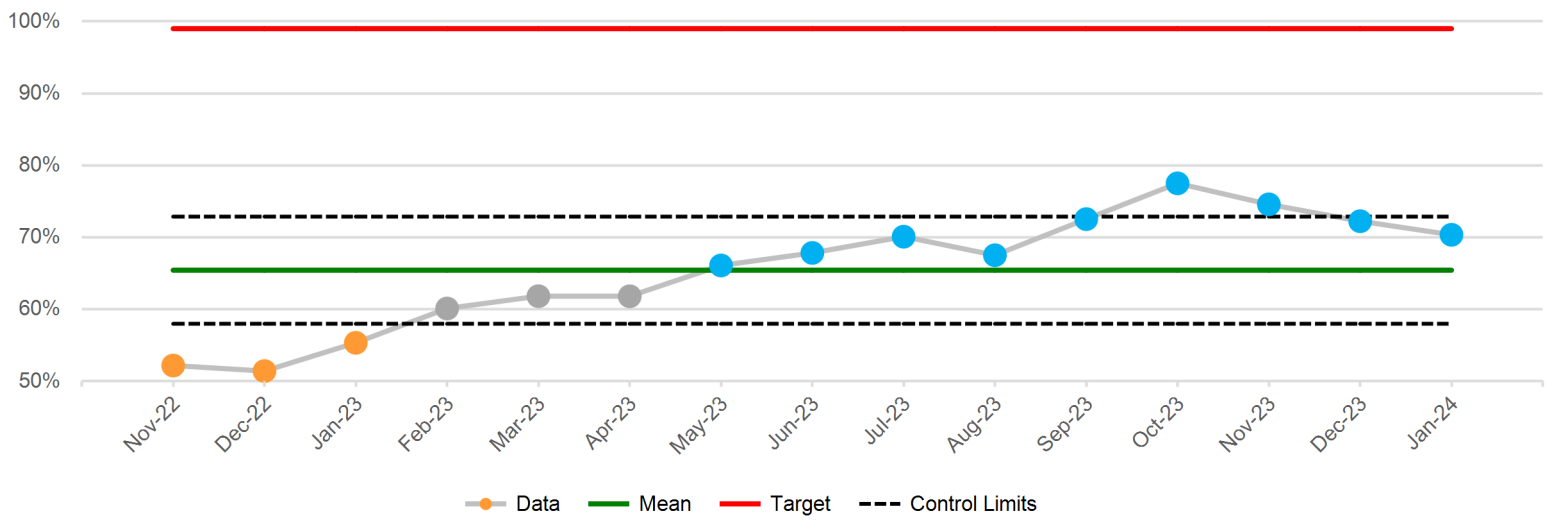
Issues:
Following the backlog increase from the pandemic, there have been additional pressures that have affected capacity, including; industrial action and urgent care pressures
The five specialties with the largest waiting lists are;
ENT – 9,919
Ophthalmology – 5,729
Gynaecology – 5,540
Gastroenterology – 5,418
Trauma & Ortho – 4,373

Actions:
Improvement programmes as described above for RTT performance. The Improving Elective Care Coordination for Patients Programme (IECCP) is in the implementation stages for use with the non-admitted waiting list and the planning stages for transition to the Federated Data Platform (FDP).

Mitigations:
The number of patients waiting over 78 weeks has shown a decrease of 40 from November.
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.

Performance Overview - Operational Performance

Diagnostics achieved



Jan-24
70.36%
Variance Type
Special cause variation - improvement (Indicator where high is good)
Target
99.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
Diagnostics achieved in under 6 weeks.

What the chart tells us:
DM01 December 2023 70.36% against the 99.00% target, amended target 85% by May.

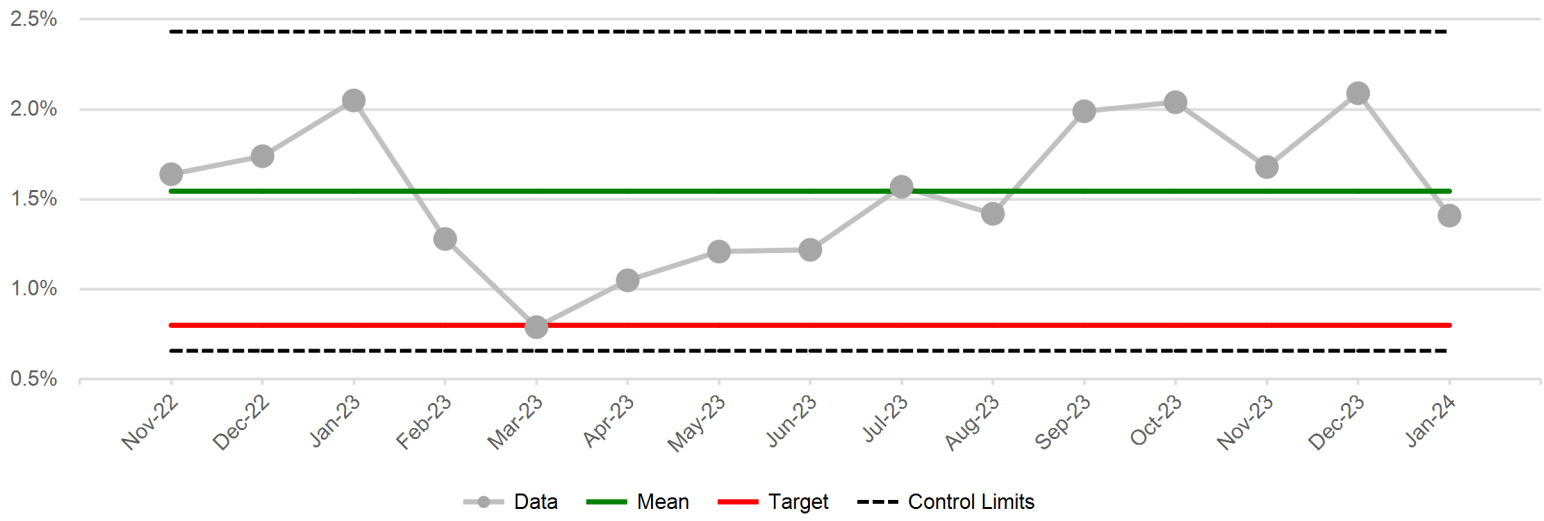
Issues:
- Slight deterioration due to worsened MRI/US performance (demand/capacity issue)
- The majority of diagnostic breaches sit in Cardiac Echo/MRI and NOUS. MRI have seen a large increase in breaches due to increase in demand .
- Audiology breaches has increased due to the increase in ENT clinics to reduce the 78-week waiters
- Cysto and urodynamics are not reporting the data correctly so we think there will be an increase in waiting list and breaches next month after they deep dive into their systems.
- Dexa has experienced significant sickness and vacancies GDH CDC DEXA will be online from March 2024 to provide additional capacity, delayed to failed installation.

Actions:
- Additional MRI CDC capacity from end of December 23 Skegness and LCH, 2nd inhouse scanner should be operational by June 2024, Skegness CDC mobile scanner funding and additional 5 days a Month from March 2024.
- Additional Ultrasounds lists.
- Additional audiology lists.
- Train additional DEXA staff.

Mitigations:
Patients are being seen in clinical priority.

Performance Overview - Operational Performance

Cancelled Operations on the day (non clinical)



Jan-24
1.41%
Variance Type
Common cause variation
Target
0.80%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
There has been a decrease in the number of patients cancelled on the day from 2.09% in December to 1.41% in January. This is an improvement, but remains significantly above the agreed target of 0.8%.

Issues:
The top 3 reasons are:
-Medically unfit/unfit on admission (39)
-Lack of time (14)
-Op no longer necessary (12)

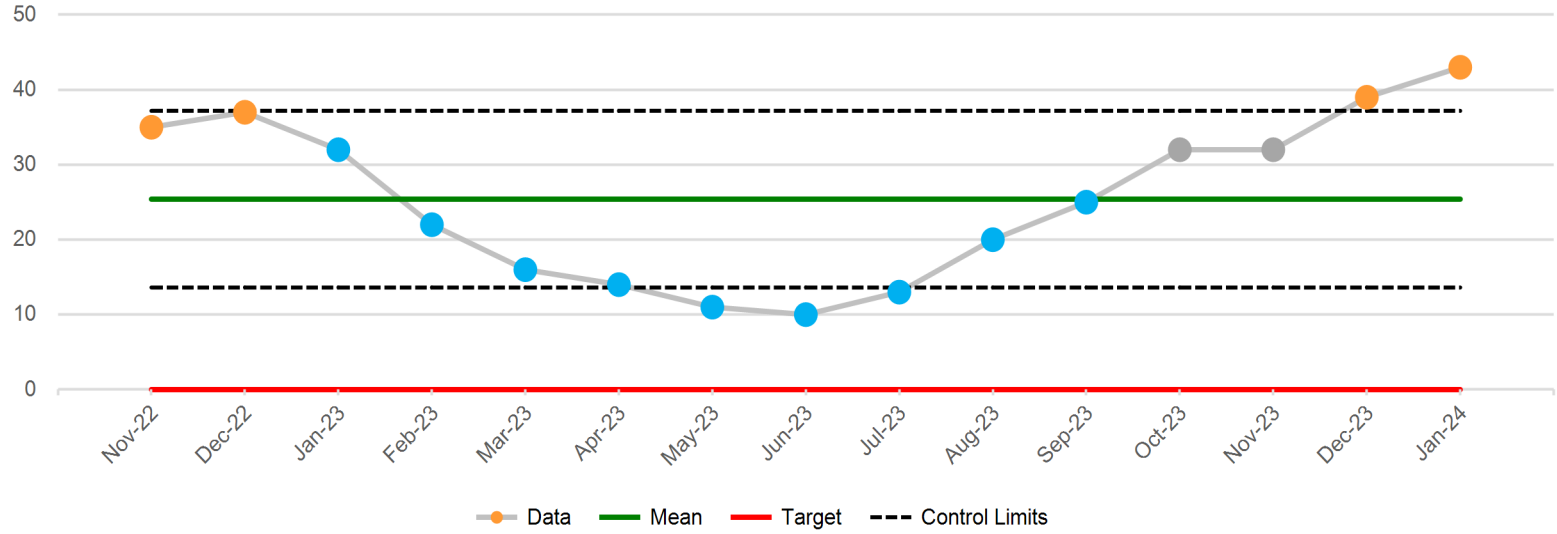
Patients are not informing the hospital when they are unwell leading up to/on the day of surgery. Issues include chest infections, urine infections, wounds or bites on the operative limb.

Actions:
The COTD SOP was implemented on 17.1.24. Documentation has been produced to capture the reason for clinical cancellations and the actions needed to address them so that the patient is not cancelled for the same reason when they are relisted.
There is now good engagement from CBUs and renewed focus.
There is now a 2pm check-in with Theatres to monitor flow.

Mitigations:
There were 2 critical incidents in Jan which led to 8 cancellations. There was a power cut and a disruption to the water supply.

Performance Overview - Operational Performance

Not treated within 28 days. (Breach)



Jan-24
43
Variance Type
Special cause variation - cause for concern (Indicator where high is a concern)
Target
0
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
The figures have increased from 39 in December to 43 in January, therefore the agreed target of zero has still not been achieved.

Issues:
Staffing in the Waiting List Teams remains an issue impacted by sickness and leave.
There remains limited capacity to re-date post-cancellation due to surgeon, staff or patient availability.
Pre-op capacity remains tight due to staffing and physical space constraints. This is being addressed.

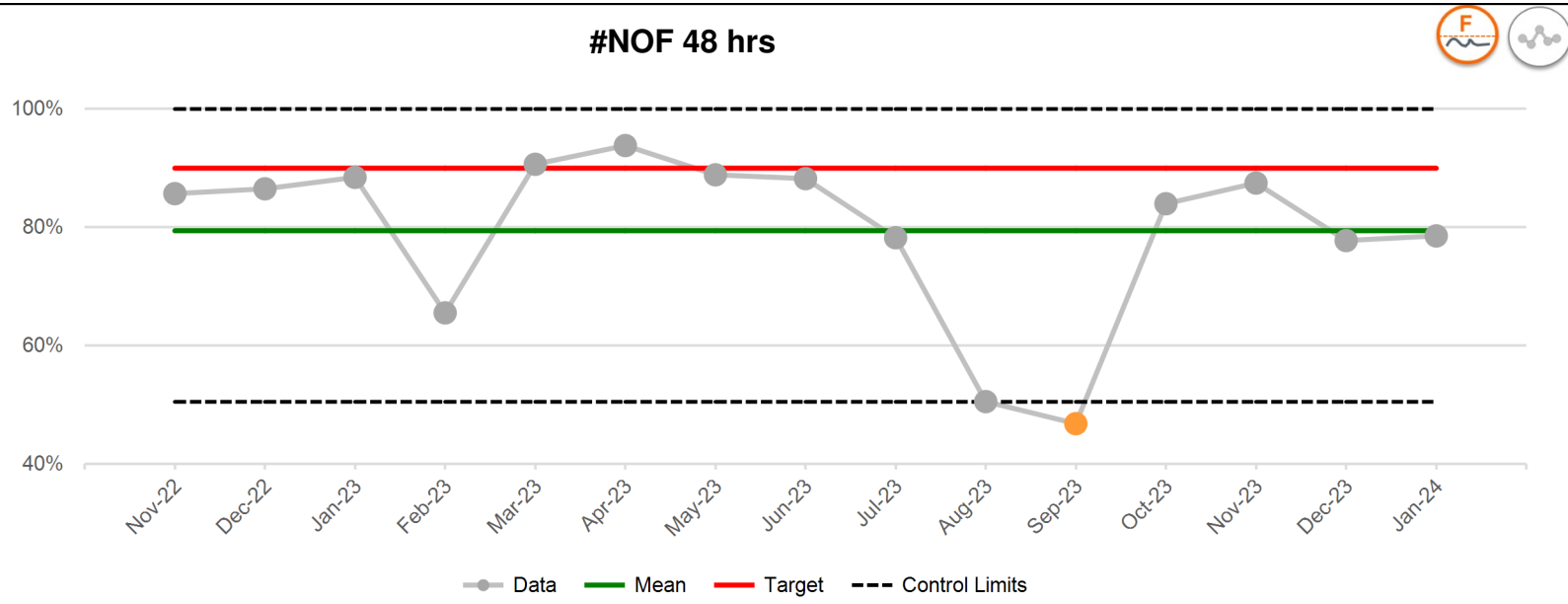
Actions:
The new Waiting List Co-Ordinator has started in post.

Pre-Op clinic capacity has been improved with the use of redeployed staff and extra clinics at Louth.

Mitigations:
Increased in-session utilisation makes it more challenging for Waiting List teams to find a suitable slot to relist a patient.

Physical space to conduct telephone clinics was a factor at LCH, however a solution was found and the clinics went ahead.

Performance Overview - Operational Performance



Jan-24
78.57%
Variance Type
Common cause variation
Target
90.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
Percentage of femur fractures patients time to theatre within 48 hours.

What the chart tells us:
The average percentage across both sites for January is 78.57%.

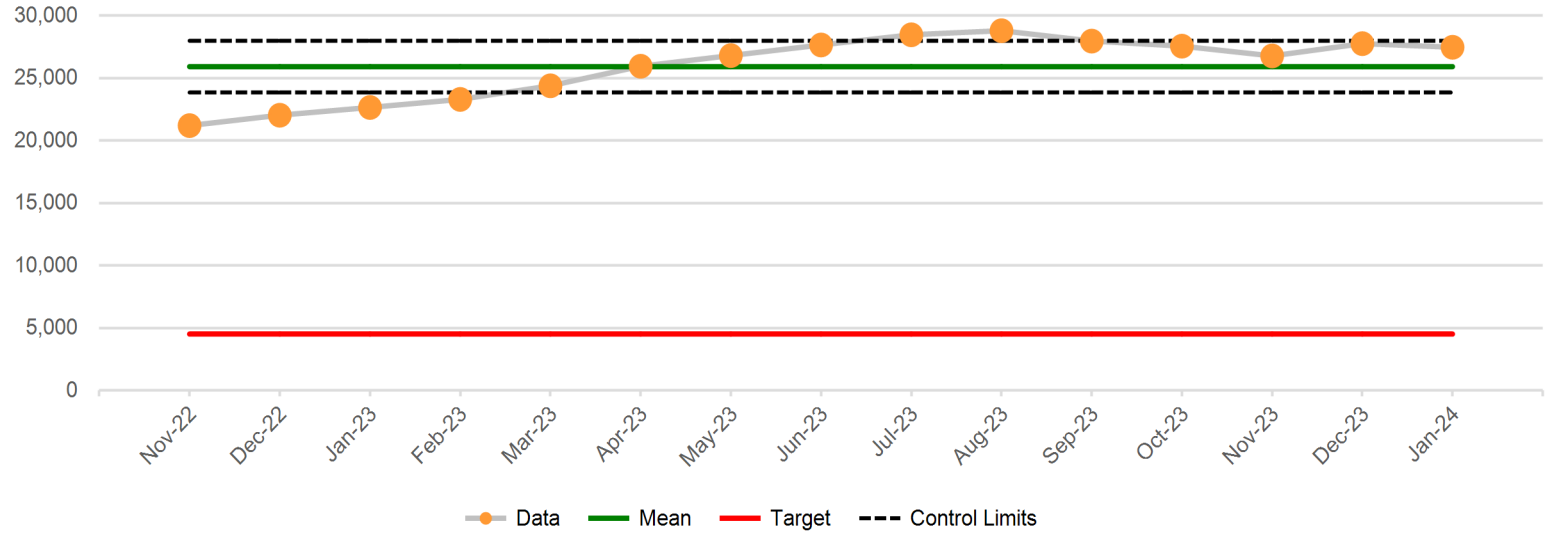
Issues:
- Lack of theatre space to accommodate Femur fractures.
- ULHT continue to have a high demand of trauma patients admitted with one trauma list planned daily on both sites.
- Specialty trauma lists on Boston and Lincoln sites not having capacity for trauma patients.
- Lack of theatre staff to provide additional trauma capacity.
- ULHT breaching the NHFD best practice tariff for femur fractures.
- Patients not being medically fit for surgery
- KIT availability
- Awaiting specialist surgeon

Actions:
- Forward planning of theatre lists required based on peaks in activity seen (adding trauma to elective lists).
- 'Golden patient' initiative to be fully implemented.
- Ensure robust processes in place to utilise Trust wide trauma capacity and beds.
- Additional Trauma lists to be planned
- Review of additional trauma lists through job planning process to see if additional trauma lists can be available for Femur fractures to avoid breaches.
- To ensure that the band 7 trauma lead continues to utilise lists and escalate high capacity of trauma cases to the CBU to see if extra theatre lists are available.
- Trauma coordinator team to ensure that femur fractures are listed on the trauma list before breaches.

Mitigations:
- Ensure trauma lists are fully optimised.
- Reduce 'on the day' change in order of the trauma list where clinically appropriate.
- Daily attendance at the trauma meeting by the clinical business unit to improve communication, visibility of current position and increased support for theatre utilisation and extra capacity needed.
- Once daily additional CBU review of trauma and plans to ensure capacity maximised for clinical priority.

Performance Overview - Operational Performance

Partial Booking Waiting List



Jan-24
27,479
Variance Type
Special cause variation - cause for concern (Indicator where high is a concern)
Target
4,524
Achievement
Variation indicates consistently falling short of 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 27,479 against a target of 4,524. During Covid the number of patients overdue significantly increased with a slight dip in Nov 22, since when it continuously increased. We saw a steady reduction from Sept 23, which increased to Dec 23 but is now showing a slight reduction in Jan 24.

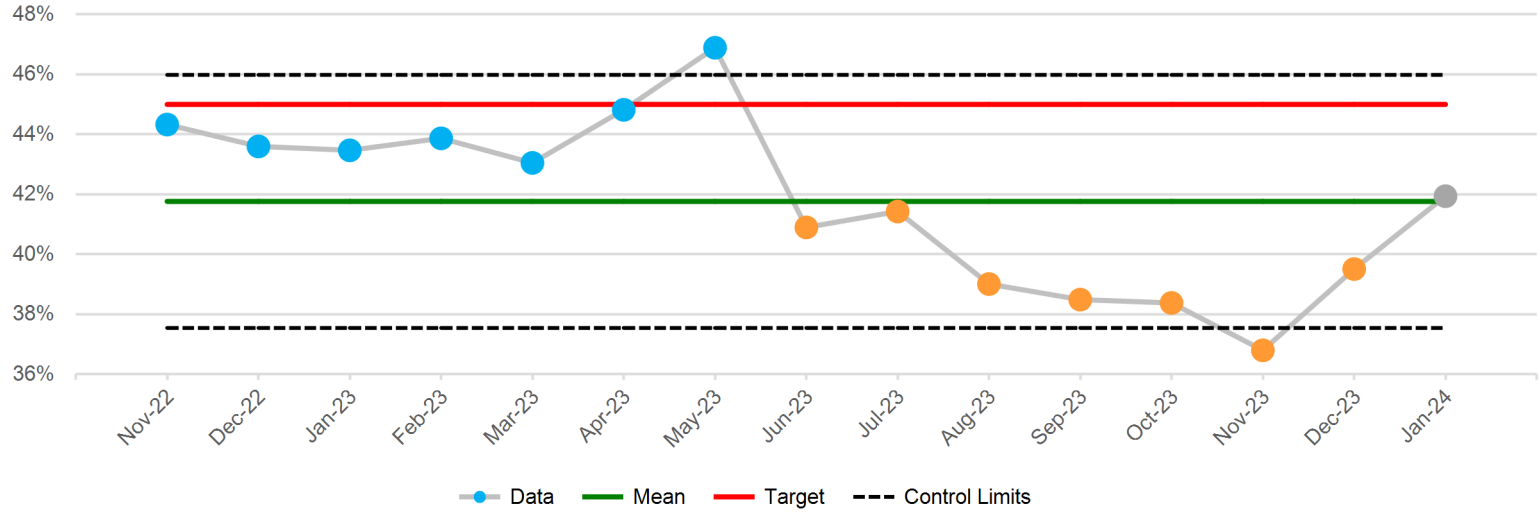
Issues:
The organisation has a number of competing priorities. The current focus is on the 78 and 65 week patients, and potential cancer patients. The current PBWL demand outweighs the current capacity which is being impacted by available capacity, rooms and resources.

Actions:
The new Outpatient Waiting Lists (OWL) meeting with the CBU's, incorporating PBWL, is now embedded and includes an agenda and template to improve attendance and focus. Discussions continue with CBU's regarding reducing F/ups by 25%. PIFU continues to be an area of focus and uptake has increased. 642 process currently under review to improve capacity and vacant slots.

Mitigations:
Clinics and patients have previously been cancelled and added to the PBWL due to industrial action. Booking team priorities are to support rebooking cancelled patients due to industrial action, the Personalised Outpatient Plan and the booking of the 78 and 65 week cohort.

Performance Overview - Operational Performance

% discharged within 24hrs of PDD



Jan-24
41.94%
Variance Type
Common cause variation
Target
45.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
The % of patients discharged within 24hours of PDD.

What the chart tells us:
There has been an improvement in performance achieving 42% against the 45% KPI and returning to July 2023 level.

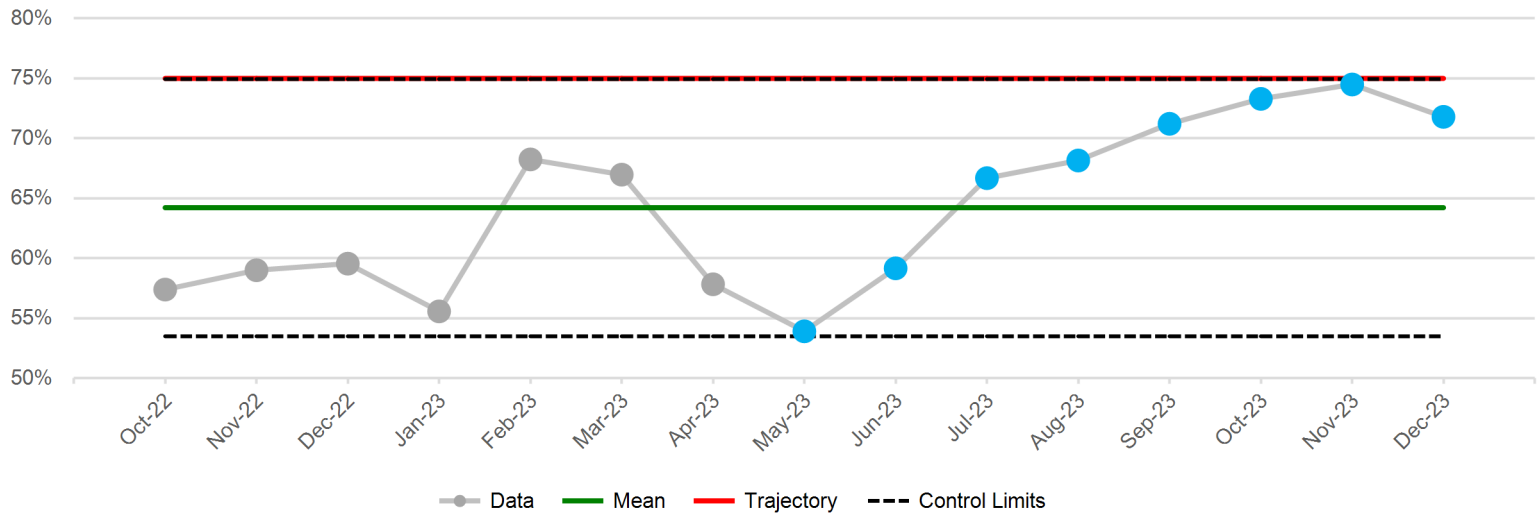
Issues:
Previously the delivery team were providing support to wards to improve WebV compliance, however when the withdrew support and handed over to BAU, performance dropped.

Actions:
The delivery team agreed to support wards from December and as a result performance improved. Weekly monitoring is in place and any areas of concern are highlighted with ward sisters and matrons to ensure performance improves.

Mitigations:
To enable a successful return to BAU, the clinical education team has been asked to include Web V compliance at the band 6 forums and the IEN ward ready programme.
Weekly monitoring and highlighting of key areas of improvement will continue. Compliance will be discussed through the SAFER workstream meetings with consideration to be given to compliance being part of Matron audits.

Performance Overview - Operational Performance

28 days faster diagnosis



Dec-23
71.80%
Variance Type
Special cause variation - improvement (Indicator where high is good)
Trajectory
75.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

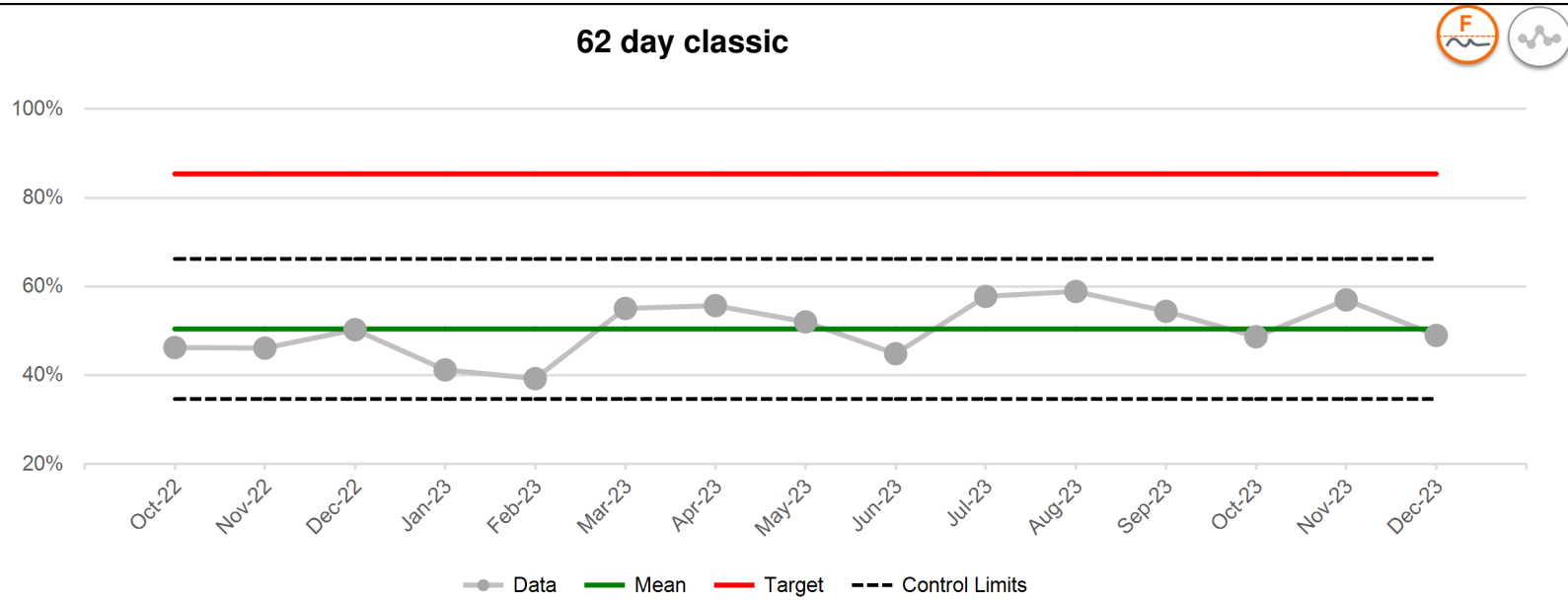
What the chart tells us:
We are currently at 71.8% against a 75% target.

Issues:
The impact of ongoing pathway, staffing and capacity challenges.
Patients not willing to travel to where our service and / or capacity is.
2ww OPA capacity issues in high volume tumour sites such as skin, breast, gynaecology and lung (see 2ww Suspect).
Diagnostic capacity challenges and clinical review capacity.
Radiology – Bed capacity for Interventional Radiology patients at PHB. Constant shortfall of CTC reporting sessions.
NHSE led target to achieve 72.5% compliance by end of 2023 and 75% by the end of March 2024.

Actions:
Recruitment is underway in Respiratory, ENT and Haematology specialties to improve Consultant availability and clinical review capacity.
Radiology – Bed capacity for Interventional Radiology patients at PHB. Development of OR theatre recovery unit to allow the service to recover its own patients. Constant shortfall of CTC reporting sessions.
Meetings regarding MDT streamlining support and processes for the Lung, Breast, Urology, Colorectal and Upper GI specialties are underway.
SOPs relating to DNAs & multiple cancellations to support patient engagement and efficient pathway management - These are currently being taken through CBU Governance processes for approval.
The utilisation of Narrow Band Imaging in ENT clinics is being reviewed to support a speedier clinic-based diagnostic process.

Mitigations:
(Please also see Actions and Mitigations on 2ww suspected cancer page)
The radiology clinical lead is looking at job plans to support and improve CTC reporting capacity with another radiologist in training to report CTCs.
Development of OR theatre recovery unit to allow the IR service to recover its own patients.
In Medicine, the EBUS and EUS BC has been stalled due to workforce challenges, but the CBU will explore interim measures.
GA hysteroscopy and truclear capacity – staff training and processes in place to introduce and maintain capacity at GK. Following a recent efficiency review, hysteroscopy and OP capacity has improved – the output of this is expected to be seen by March / April '24. A new level of referral management and educational feedback to GP's is in place through a CNS appointment.

Performance Overview - Operational Performance



Dec-23
49.00%
Variance Type
Common cause variation
Target
85.39%
Achievement
Variation indicates consistently falling short of 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 49.0% against a 85.39% target.

Issues:
Limited theatre capacity continues to impact cancer pathways across the Trust and limited AA and pre-op capacity impacts the ability to be able to populate lists at short notice. In Oncology, recent Linac breakdowns and pharmacy staffing shortages have resulted in delayed treatment start dates. NHSE led target to achieve 70% compliance in the 62 day combined standard by the end of March 2024.

Please also see Issues on accompanying pages.

Actions:
Oncology Fragile Service – 3 new consultants are set to commence clinics on 05/02/2024, 12/02/2024 and 22/02/2024. A piece of work on right-sizing the Oncology service workforce has commenced. 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. Skin – Consultant and CNS long term sickness in Dermatology will impact surgical capacity, particularly at PH .
Performance – Intensive Support Meetings continue to take place twice weekly to understand and resolve the themes and issues in 62 day performance in a number of tumour site specialties.

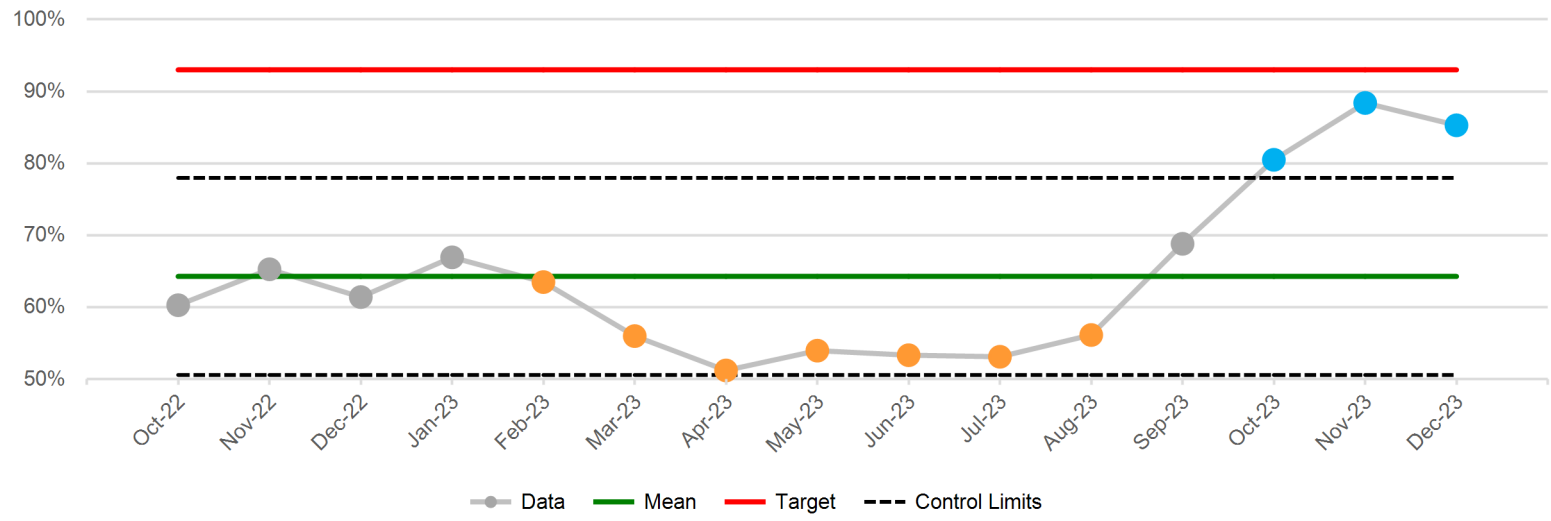
Mitigations:
Actions continued:
Deep Dives are being undertaken by each CBU to understand how diagnostic turnaround times for positive cancers can be improved as this will be key to achieving the NHSE target of 70% by March '24.

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.

Performance Overview - Operational Performance

2 week wait suspect



Dec-23
85.30%
Variance Type
Special cause variation - improvement (Indicator where high is good)
Target
93.00%
Achievement
Variation indicates consistently falling short of 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 85.3% against a 93% target.

Issues:
Patients not willing to travel to where our service and/or capacity is available.
The Trust's 14 Day performance continues to be impacted by the current Breast Service One-Stop appointment alignment issues, with 15% of the Trust's December 14 Day breaches within that tumour site.
The Gynae tumour site accounted for 22% of December breaches.
Also of concern was Skin performance which both accounted for 30% of the Trust's 14 day breaches and UGI which accounted for 10%.

Actions:
The Radiology Recruitment Strategy and intensive support meetings are in place to address the fragile Breast Service One-Stop appointment alignment issues. Respiratory Consultant capacity is ongoing as well as the BC for an increase in consultant workforce to 10-15 consultants. 2 x Lung Cancer CNS posts (funding until March 25) - risk stratification to reduce unnecessary CT scans and demand on Cons triage are going through recruitment processes. A review of current FReD pathway and the inclusion of CT referrals is being discussed and considered. Recruitment processes for the UGI Triage CNS post have been delayed but are back underway – this will support the start of UGI pathway. ICB EACH are continuing to provide support with 2ww referrals to reduce the delays from receipt of referral to STT booking.

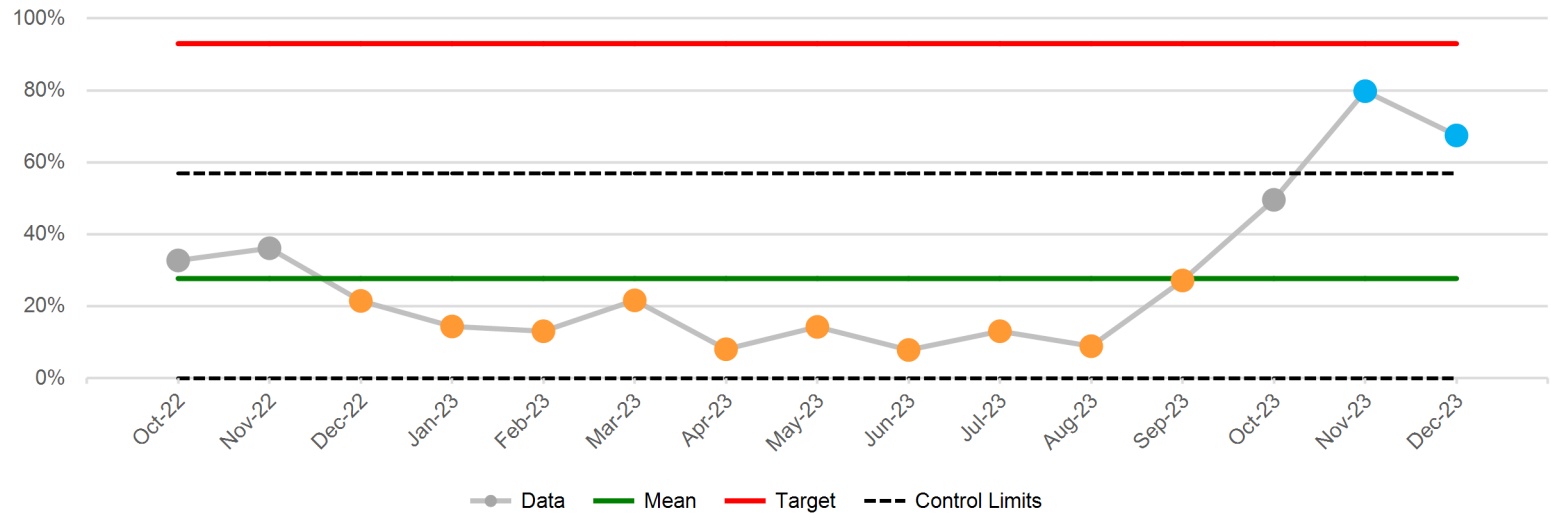
Mitigations:
Processes – SOPs relating to DNAs & multiple cancellations are being developed to support patient engagement and efficient pathway management.

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 Gynae, the urgent PMB pathway progress and impact is being monitored. An HRT programme of work is underway with support from ICB colleagues.

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.

Performance Overview - Operational Performance

2 week wait breast symptomatic



Dec-23
67.50%
Variance Type
Special cause variation - improvement (Indicator where high is good)
Target
93.00%
Achievement
Variation indicates consistently falling short of 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 67.5% against a 93% target.

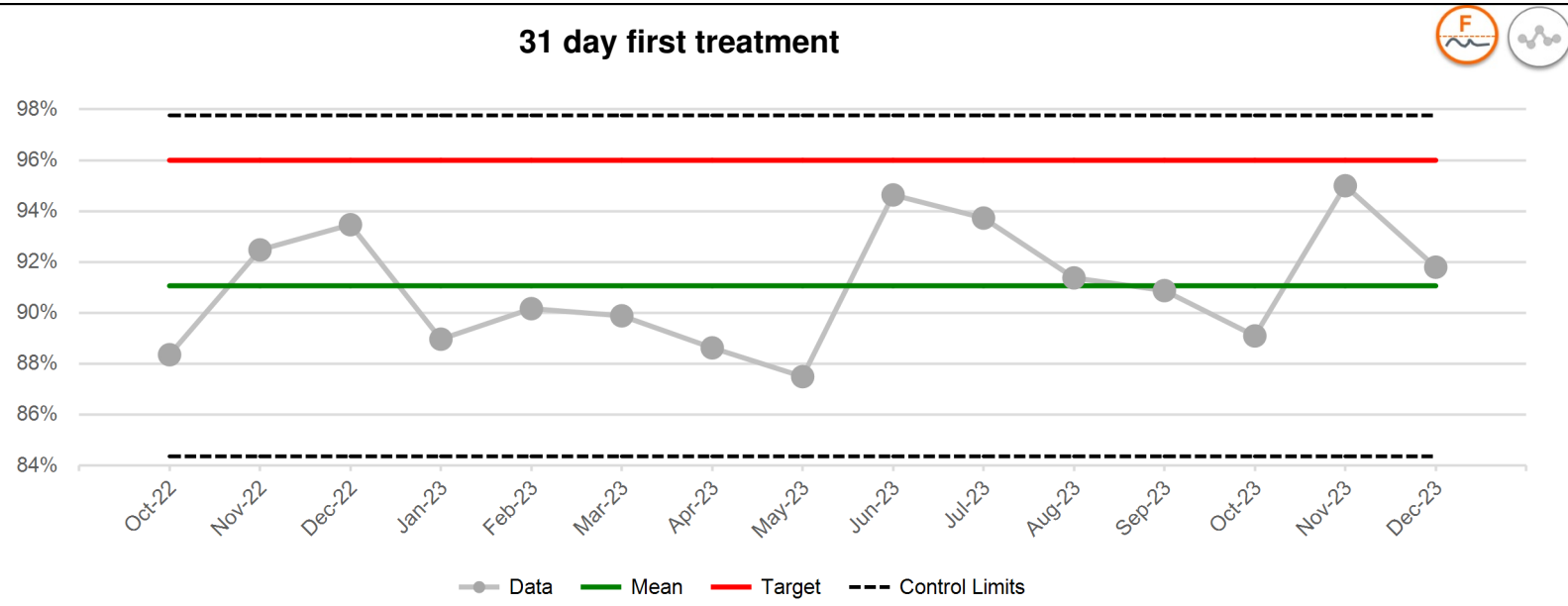
Issues:
The 14 Day Breast Symptomatic has been affected by the same impact of the Breast Service One-Stop appointment alignment issues.

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

The Radiology Recruitment Strategy and intensive support meetings are in place to address the fragile Breast Service One-Stop appointment alignment issues.

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%. Further and more regular comms to improve utilization of this pathway within Primary Care are being supported by the ICB.

Performance Overview - Operational Performance



Dec-23
91.80%
Variance Type
Common cause variation
Target
96.00%
Achievement
Variation indicates consistently falling short of 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.

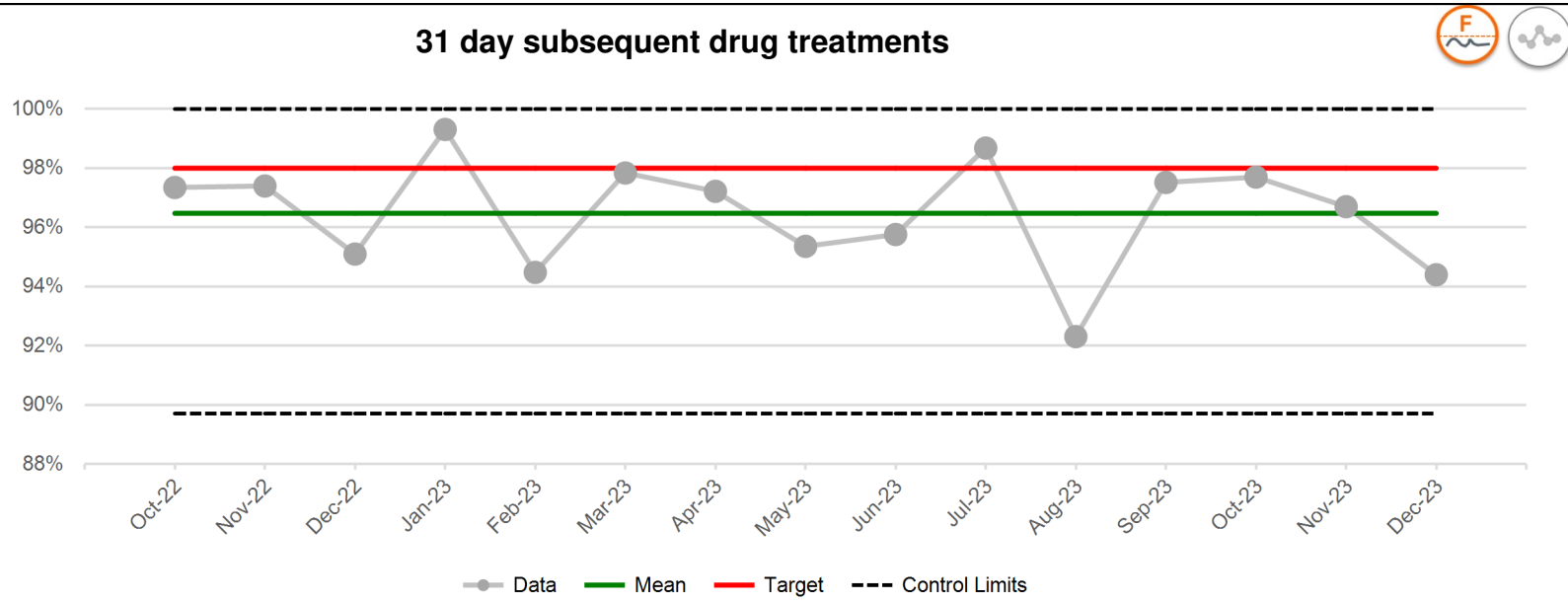
What the chart tells us:
We are currently at 91.8% against a 96% target.

Issues:
The failure of the 31 Day standards was primarily attributed to limited theatre capacity and limited AA and pre-op capacity impacts the ability to be able to populate lists at short notice.
In Oncology, recent Linac breakdowns and pharmacy staffing shortages have resulted in delayed treatment start dates.
Colorectal – Current activity complexity is causing delays in allocating surgery dates, e.g. the increase in anterior resections that require 2 surgeons.

Actions:
Oncology Fragile Service - 3 new consultants are set to commence clinics on 05/02/2024, 12/02/2024 and 22/02/2024. A piece of work on right-sizing the Oncology service workforce has commenced.
OMF Capacity issues are impacting both Head and Neck and particularly Skin pathway performance – escalated as a risk.

Mitigations:
Robotic Lists are progressing well, though proving difficult to populate at short notice if there are cancellations due to pre-op and anaesthetic assessment capacity. Tumour site specialties are working with TACC to ensure the best possible utilisation of lists, including a process for last minute cancellations.
In Dermatology, a Minor Op Clinic process review, alongside SpDr training, is underway to increase capacity. A training plan for Skin Surgery nurses to support with head and neck lesions is being developed. Current staff absence / sickness are impacting progress of this.

Performance Overview - Operational Performance



Dec-23
94.40%
Variance Type
Common cause variation
Target
98.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

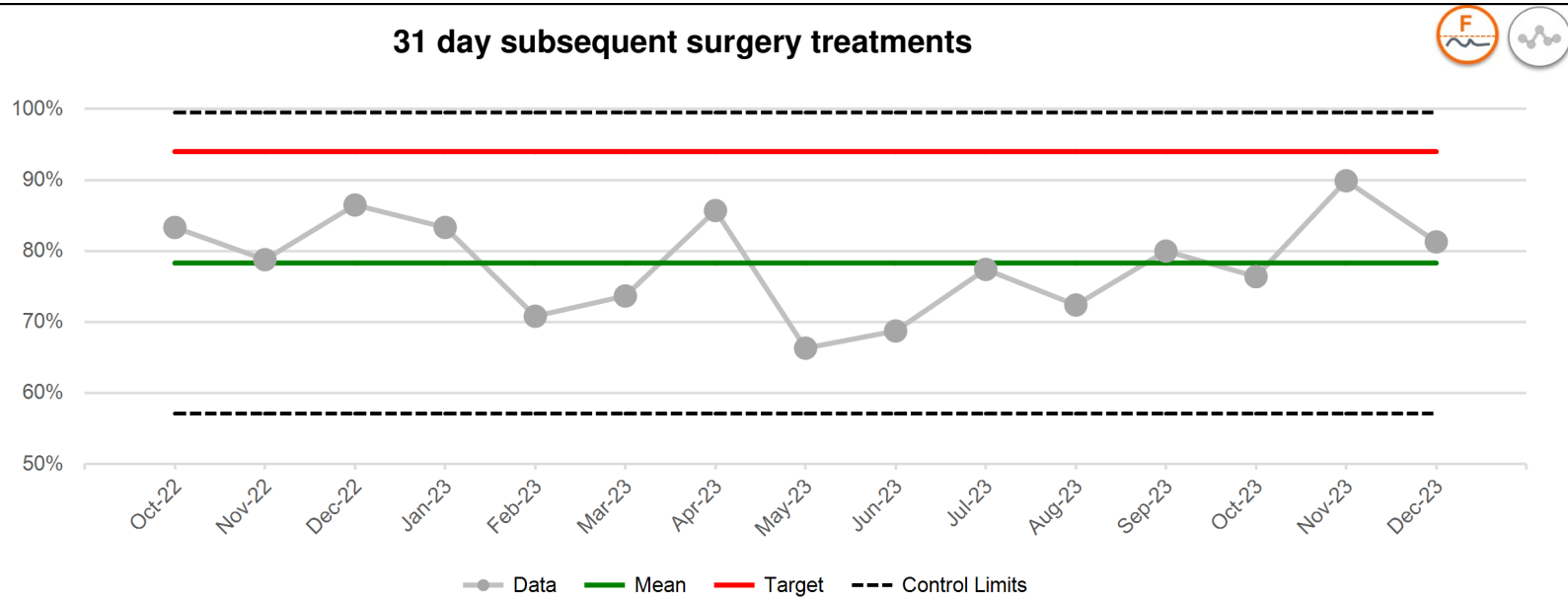
What the chart tells us:
We are currently at 94.4% against a 98% target.

Issues:
In Chemotherapy, staffing shortages, treatment capacity and recent pharmacy staffing shortages have resulted in delayed treatment start dates.

Actions:
Oncology Fragile Service - 3 new consultants are set to commence clinics on 05/02/2024, 12/02/2024 and 22/02/2024. A piece of work on right-sizing the Oncology service workforce has commenced.

Mitigations:

Performance Overview - Operational Performance



Dec-23
81.30%
Variance Type
Common cause variation
Target
94.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

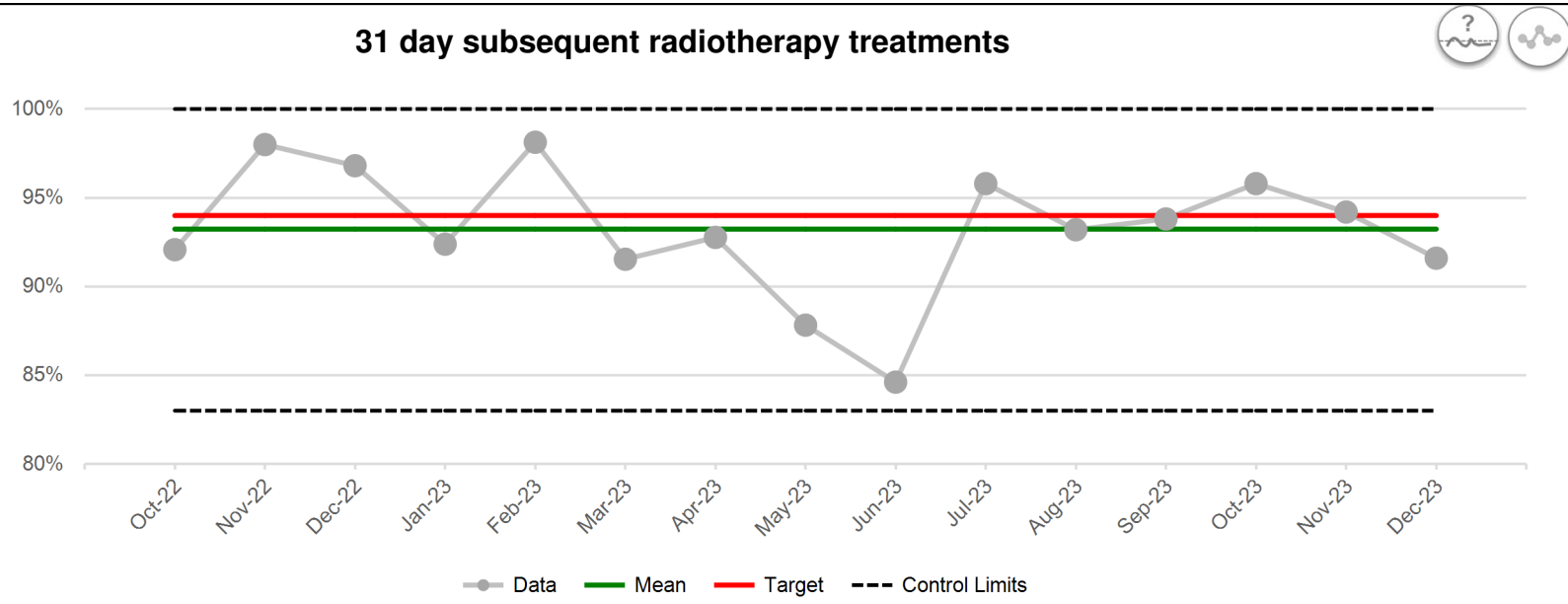
What the chart tells us:
We are currently at 81.3% against a 94% target.

Issues:
The failure of the 31 Day surgery standard was due to limited theatre capacity and limited AA and pre-op capacity impacts the ability to be able to populate lists at short notice.
Colorectal – Current activity complexity is causing delays in allocating surgery dates, e.g. the increase in anterior resections that require 2 surgeons.

Actions:
Theatre / Pre-op / AA Capacity – Tumour site specialties are working with TACC to ensure the best possible utilisation of lists, including a process for last minute cancellations. Theatre workforce issues have impacted capacity and lists remain difficult to populate at short notice if there are cancellations due to anaesthetic assessment and Pre-op capacity. These delays have been escalated and are being reviewed.

Mitigations:
In Dermatology, a Minor Op Clinic process review, alongside SpDr training, is underway to increase capacity. A training plan for Skin Surgery nurses to support with head and neck lesions is being developed. Current staff absence / sickness are impacting progress of this.
In Head and Neck, an ENT consultant has recently commenced in post. Locum consultant currently taking on non-cancer Thyroid cases to release capacity for cancer.

Performance Overview - Operational Performance



Dec-23
91.60%
Variance Type
Common cause variation
Target
94.00%
Achievement
Variation indicates inconsistently passing and falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 91.6% against a 94% target.

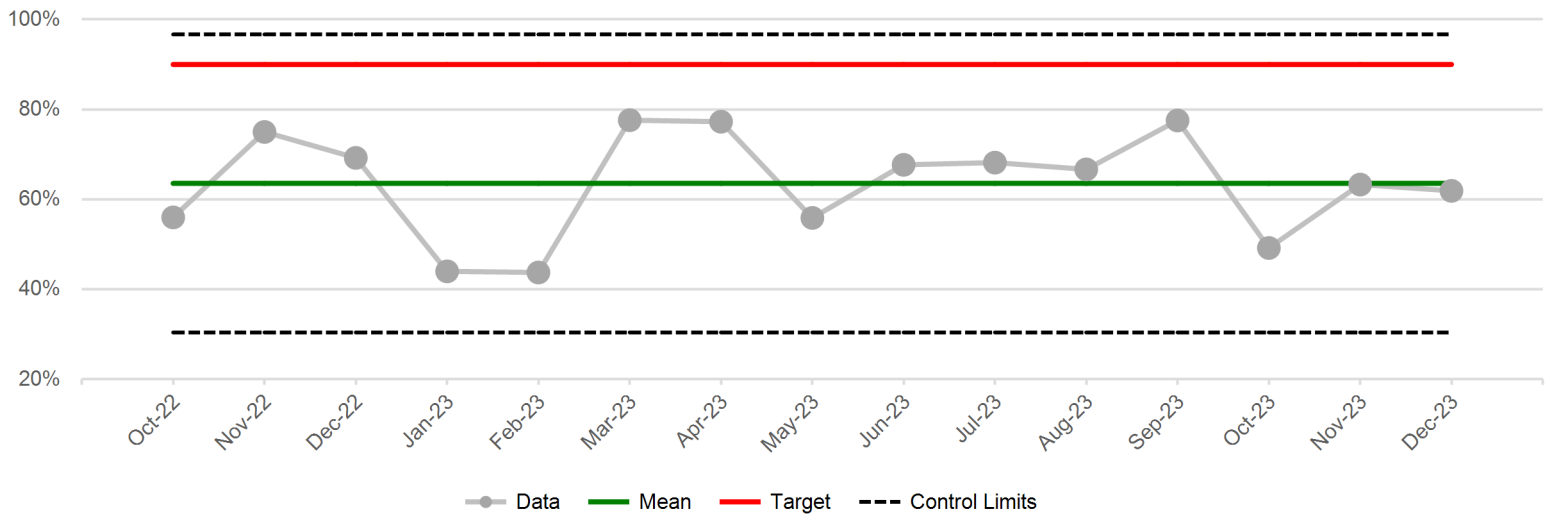
Issues:
Radiotherapy – Recent Linac breakdowns have resulted in delayed treatment start dates.

Actions:
Oncology Fragile Service - 3 new consultants are set to commence clinics on 05/02/2024, 12/02/2024 and 22/02/2024. A piece of work on right-sizing the Oncology service workforce has commenced.

Mitigations:

Performance Overview - Operational Performance

62 day screening



Dec-23
61.90%
Variance Type
Common cause variation
Target
90.00%
Achievement
Variation indicates consistently falling short of 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 61.9% against a 90% target.

Issues:
Limited theatre capacity continues to impact cancer pathways across the Trust and limited AA and pre-op capacity impacts the ability to be able to populate lists at short notice. In Oncology, recent Linac breakdowns and pharmacy staffing shortages have resulted in delayed treatment start dates. NHSE led target to achieve 70% compliance in the 62 day combined standard by the end of March 2024.

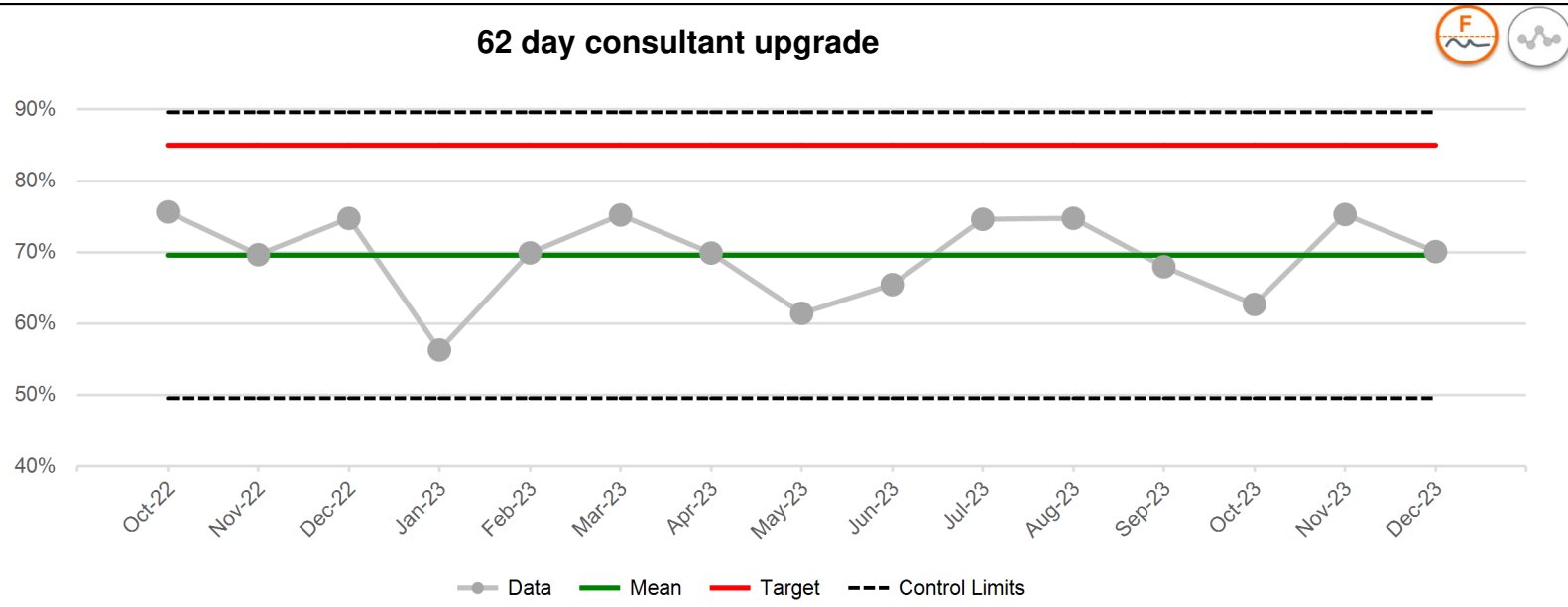
Please also see Issues on accompanying pages.

Actions:
Oncology Fragile Service – 3 new consultants are set to commence clinics on 05/02/2024, 12/02/2024 and 22/02/2024. A piece of work on right-sizing the Oncology service workforce has commenced. 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:
Please also see Mitigations on accompanying pages.

Performance Overview - Operational Performance



Dec-23
70.10%
Variance Type
Common cause variation
Target
85.00%
Achievement
Variation indicates consistently falling short of 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 70.1% against a 85% target.

Issues:
Limited theatre capacity continues to impact cancer pathways across the Trust and limited AA and pre-op capacity impacts the ability to be able to populate lists at short notice. In Oncology, recent Linac breakdowns and pharmacy staffing shortages have resulted in delayed treatment start dates. NHSE led target to achieve 70% compliance in the 62 day combined standard by the end of March 2024.
Please also see Issues on accompanying pages.

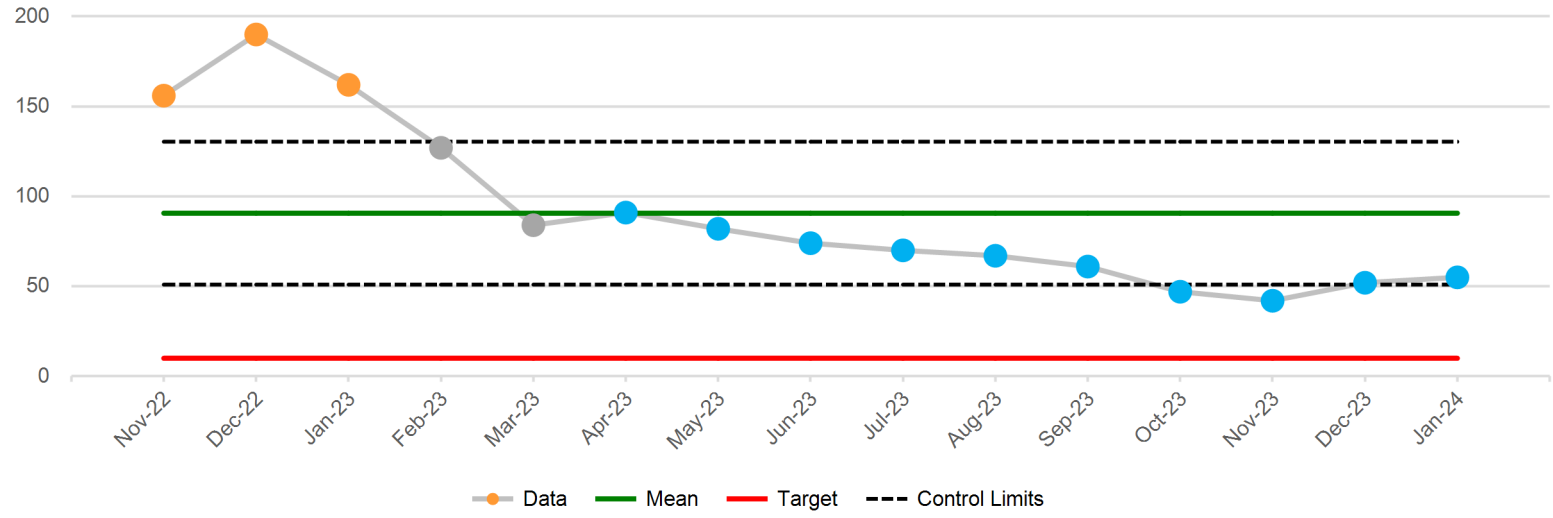
Actions:
Oncology Fragile Service – 3 new consultants are set to commence clinics on 05/02/2024, 12/02/2024 and 22/02/2024. A piece of work on right-sizing the Oncology service workforce has commenced. Robotic Lists are progressing well, though proving difficult to populate at short notice if there are 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:
Please also see Mitigations on accompanying pages.

Performance Overview - Operational Performance

104+ Day Waiters



Jan-24
55
Variance Type
Special cause variation - improvement (Indicator where low is good)
Target
10
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
Number of cancer patients waiting over 104 days.

What the chart tells us:
As of 8th February the 104 Day backlog is at 55 patients.
There is two main tumour sites of concern:-

Colorectal 18
Lung 12

Issues:
The impact of ongoing pathway, staffing and capacity challenges.
Patients not willing to travel to where our service and / or capacity is available.
Reduced OP, diagnostic and theatre capacity across the Trust, all Specialties vying for additional sessions.
Managing backlogs significantly in excess of pre-COVID levels for Colorectal, Upper GI, Urology, Head & Neck, Gynaecology, and Lung.
Approximately 29% 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:
Intensive Support Meetings in place to support Colorectal, Urology, Head & Neck, Lung, Upper GI, Skin, Gynae and Breast recovery.

Please also see Actions on accompanying pages.

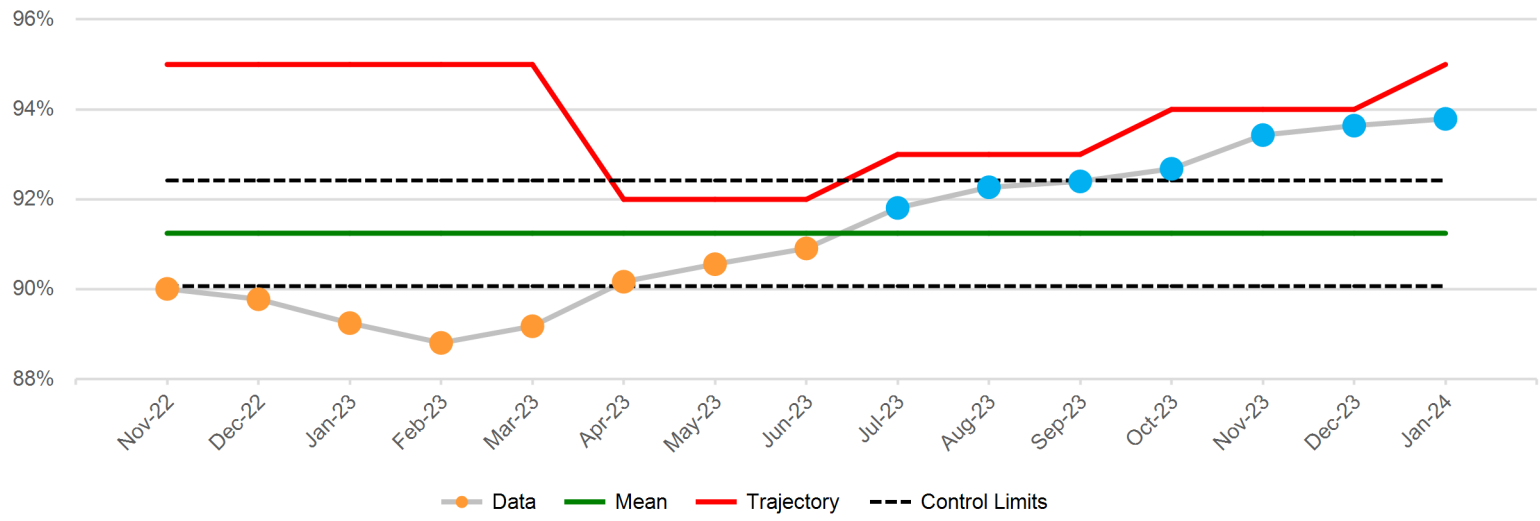
Mitigations:
Please also see Mitigations on accompanying pages.

Performance Overview - Workforce

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Nov-23	Dec-23	Jan-24	YTD	YTD Trajectory	Pass/Fail	Trend Variation
A Modern and Progressive Workforce	Overall percentage of completed mandatory training	Safe	People	Director of HR & OD	95.00%	93.43%	93.64%	93.79%	92.17%	93.20%	F	H
	Number of Vacancies	Well-Led	People	Director of HR & OD	4.00%	8.01%	7.38%	6.17%	8.21%	6.70%	F	L
	Sickness Absence	Well-Led	People	Director of HR & OD	4.50%	5.54%	5.44%	5.47%	5.56%	4.89%	F	
	Staff Turnover	Well-Led	People	Director of HR & OD	12.00%	11.30%	11.36%	11.11%	11.94%	12.60%	P	L
	Staff Appraisals	Well-Led	People	Director of HR & OD	90.00%	71.24%	71.34%	71.60%	70.54%	79.50%	F	H

Performance Overview - Workforce

Overall percentage of completed mandatory training



Jan-24
93.79%
Variance Type
Special cause variation - improvement (Indicator where high is good)
Trajectory
95.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of HR & OD

Background:
% completion is currently 93.79% against a Q4 target of 95.00%.

What the chart tells us:
Mandatory training compliance has seen an improvement to the previous month's position, and remains on an upward trend.

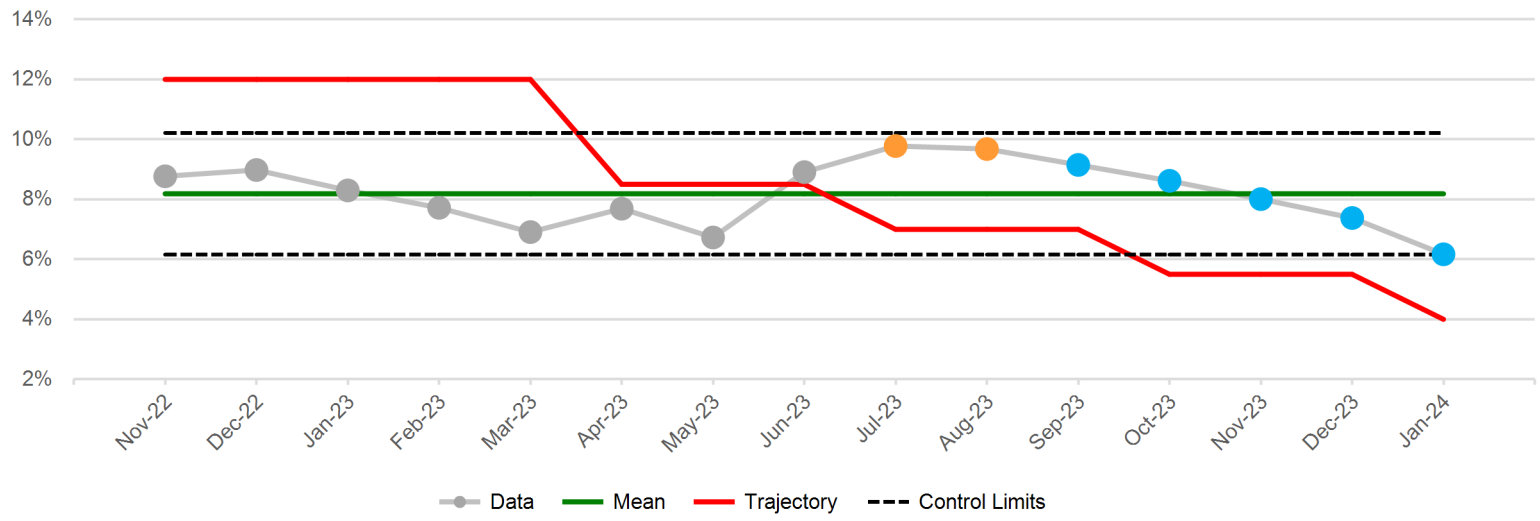
Issues:
- Protected time for core learning continues to be an issue, particularly clinical staff.
- Training profiles are not aligned on an individual/role basis meaning some staff groups are undertaking training which is not required to perform their role.
- Number of staff starting role without induction is effecting compliance.

Actions:
- Core learning offer now aligned to the national Core Skills Training Framework (CSTF).
- Focussed support being offered to those with low compliance (50% and less) through enhanced reporting provided Divisionally by the Education & Learning Team.
- ESR user support and provision of 'pop-up' core learning sessions.

Mitigations:
Improvement Action Plan and targeted work with Divisions will continue to further improve our position within 2023/24.

Performance Overview - Workforce

Number of Vacancies



Jan-24
6.17%
Variance Type
Special cause variation - improvement (Indicator where low is good)
Trajectory
4.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of HR & OD

Background:
January 2024 reported Vacancy Rate is 6.17% against a Q4 target of 4.00%.

What the chart tells us:
That we are not within the Q4 target for January 2024, although we are within our control limits.

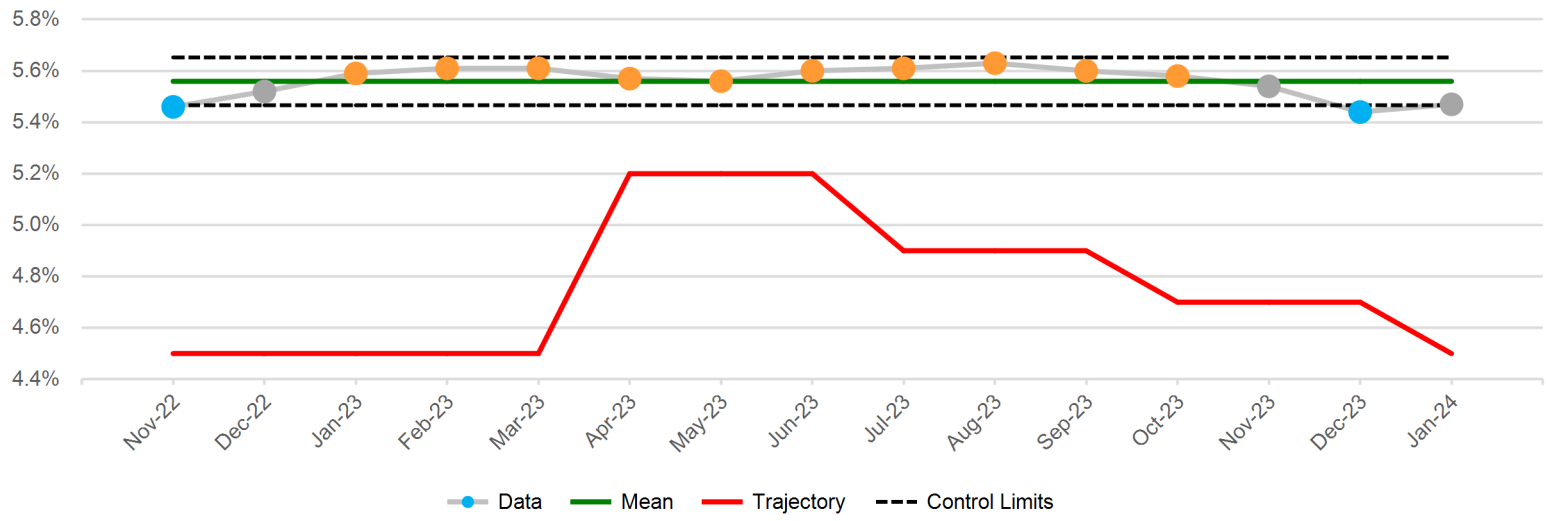
Issues:
• Sizeable business cases have been agreed which have increased our funded establishment.

Actions:
• Work is in progress to review our overall establishment with our Divisional Teams
• Gap analysis being undertaken as part of the planning for 2024/25 to support identification of areas of focus for future.

Mitigations:
Targeted work and monitoring is ongoing to ensure compliance with Vacancy Rate targets, and to ensure that our establishment levels remain in line with our overall Workforce Plan.

Performance Overview - Workforce

Sickness Absence



Jan-24
5.47%
Variance Type
Common cause variation
Trajectory
4.50%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of HR & OD

Background:
5.47% of sickness absence rolling year.

What the chart tells us:
5.47% is above the Q4 target of 4.50%, although is within our control limits.

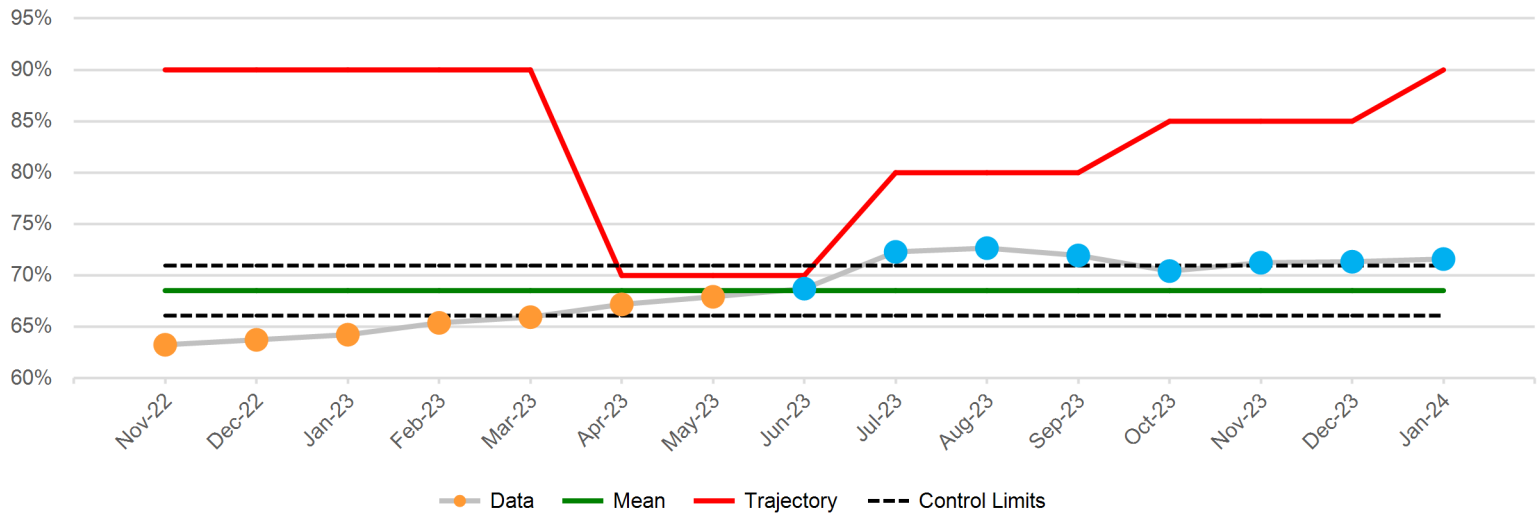
Issues:
- Sickness accounts for >75% of all unplanned absence.
- Consideration to be given to the other reasons that make up the remaining % of unplanned absence.
- AMS compliance remains a challenge.

Actions:
- People Management Essentials (PME) training to be mandated, which will provide further foundations as regards the importance/ expectations around absence management/recording within AMS.
- Consideration to be given in respect of our approach to moving away from a culture of managing attendance to one where we support attendance in the workplace, including a focus on RTW compliance.
- Occupational Health work closely with HR colleagues on the review.
- HR colleagues will work with Divisional Teams to identify and understand data trends.

Mitigations:
Robust monthly monitoring of sickness with Divisional Teams, including understanding of any trends and sharing of best practice.

Performance Overview - Workforce

Staff Appraisals



Jan-24
71.60%
Variance Type
Special cause variation - improvement (Indicator where high is good)
Trajectory
90.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of HR & OD

Background:
% completion is currently 71.60% (Trustwide).

What the chart tells us:
Despite being off track for this measure when compared to the Q4 target (90.00%) we have seen an improvement when compared to last year.

The trend is that this remains on an upward trajectory based on improvements seen to date.

Issues:
- Increased accountability with Managers is needed for appraisal compliance across the Trust's leaders.
- A lack of protected time for the completion of appraisals.
- Service pressures and staffing challenges continue to have an impact on compliance.

Actions:
- Launching 90 minute appraisal 'how to' sessions to improve overall compliance.
- Ensuring that all completed appraisals have been captured in ESR.
- Raising awareness of the importance of an appraisal with a focus on areas of low compliance.
- Paper being submitted to Executive Leadership Team to consider an annual cycle in line with other Trust Reporting and Planning.

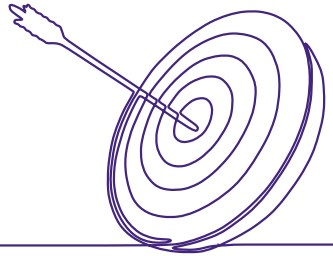
Mitigations:
See actions, and continued focus with Divisions through robust monthly monitoring.

Financial Position Month 10 (2023/24)
Finance Report
5 Year Priority – Efficient Use of Resources

NHS
United Lincolnshire Hospitals
NHS Trust

OUTSTANDING CARE
personally DELIVERED

Finance Spotlight Report (Headlines)



United Lincolnshire Hospitals NHS Trust

Revenue position

- The Trust's financial plan for 2023/24 is a deficit of £20.8m; the table shows that the Trust delivered an in-month adjusted deficit of £1.6m and a YTD adjusted deficit of £20.3m; the in-month and YTD positions are respectively £1.7m & £2.1m adverse to the financial plan.

- It is noted that the YTD revenue position makes no adjustment in relation to the Elective Recovery Fund for non-delivery of activity.

Adjusted financial performance	Current Month			Year to Date		
	Plan £000's	Actual £000's	Variance £000's	Plan £000's	Actual £000's	Variance £000's
Operating Income from patient care activities	62,794	64,958	2,164	591,149	597,505	6,356
Other operating Income	3,449	3,967	518	34,488	37,942	3,454
Employee Expenses	(43,183)	(45,518)	(2,335)	(425,555)	(431,451)	(5,896)
Operating expenses excl employee expenses	(22,492)	(23,278)	(786)	(213,913)	(218,633)	(4,720)
OPERATING SURPLUS/(DEFICIT)	**568**	**129**	**(439)**	**(13,831)**	**(14,637)**	**(806)**
Net finance costs	(540)	(591)	(51)	(4,933)	(5,060)	(127)
Other Gains / Losses	0	(1,257)	(1,257)	0	(1,192)	(1,192)
Surplus / (Deficit) for the period	**28**	**(1,719)**	**(1,747)**	**(18,764)**	**(20,889)**	**(2,125)**
Below Line Adjustments	51	79	28	517	557	40
Adjusted financial performance surplus / (deficit)	**79**	**(1,640)**	**(1,719)**	**(18,247)**	**(20,332)**	**(2,085)**

- The adverse movement to the financial plan is driven by the direct and indirect impact of industrial action in December 2023 & January 2024.

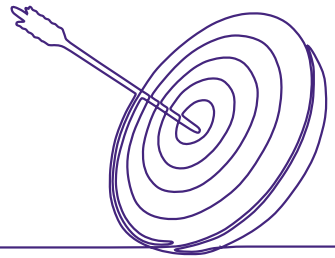
CIP position

- The Trust's CIP plan for 2023/24 is to deliver savings of £28.1m; because of early delivery, the Trust has YTD delivered savings of £28.8m, or £7.2m favourable to planned savings of £21.7m.

Capital position

- The Trust's capital plan for 2023/24 amounts to £60.8m; YTD the Trust delivered capital expenditure of £19.0m, or £6.6m lower than planned capital expenditure of £25.6m.

Finance Spotlight Report
(Key areas of focus - Income)



United Lincolnshire Hospitals NHS Trust

The YTD income position is £9.8m favourable to plan; this includes:

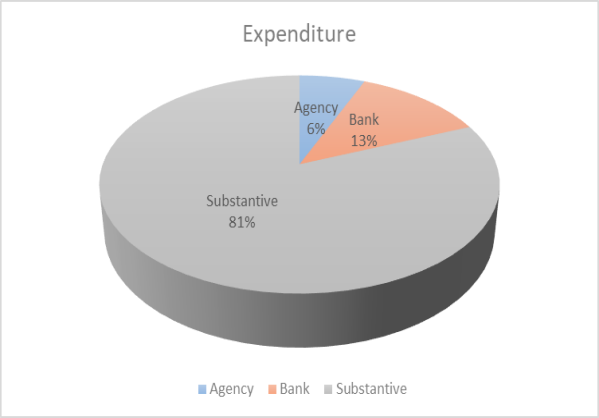
- **NHS patient care income contract – £6.1m favourable to plan**; including
  - Pass through income is £4.1m favourable to plan.
  - Contract variation income is £1.8m favourable to plan.
  - Prior year income is £0.3m favourable to plan.
- **Operating income from patient care activities - Other – £0.3m favourable to plan** driven by overseas visitor over performance.
- **Other operating income - £3.5m favourable to plan; this includes:**
  - Non-patient care services - over performance of £1.3m
  - Research & Development - over performance of £0.5m
  - Retail sales over performance of £0.8m (more than offset by additional expenditure)
  - Car Parking & Catering - over performance of £0.2m & £0.5m respectively.

Finance Spotlight Report
(Key areas of focus - Pay)

United Lincolnshire Hospitals NHS Trust

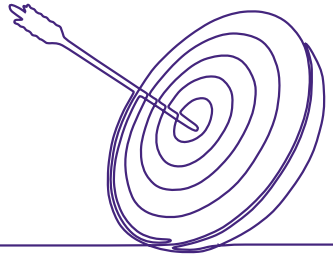
- Pay expenditure of £45.5m in January is £2.3m adverse to planned expenditure of £43.2m; the **YTD pay position is £5.9m adverse to plan**.

- YTD expenditure on Pay comprises of £349.5m (81.0%) on substantive staffing and £81.9m (19.0%) on temporary staffing.
- Compared to the same period in 2022/23:
  - ❖ Agency Pay YTD of £27.4m is £16.1m lower than expenditure of £43.5m in 2022/23.
  - ❖ Bank Pay YTD of £54.6m is £13.4m higher than expenditure of £41.1m in 2022/23.



- The YTD pay position includes:
  - ❖ **Pay award** – The 23/24 A4C pay award was paid (including arrears) in June and the pay award for medical staff was paid (including arrears) in September.
  - ❖ **Local CEA** - The 23/24 local clinical excellence award has been accrued in line with the plan.
  - ❖ **Flowers** - The costs of Flowers have been accrued in line with the plan.
- The adverse YTD pay position includes improved recruitment and retention and other pressures (most notably £1.4m of additional pay costs re the strikes) which have been offset in part by early delivery of the FRP.

Finance Spotlight Report
(Key areas of focus – Non-Pay)



United Lincolnshire Hospitals NHS Trust

Non-Pay

- Non-pay expenditure of £23.3m in January is £0.7m adverse to planned expenditure of £22.5m; the **YTD non pay position is £4.7m adverse to plan:**

  - **Excess inflation – £4.3m adverse to plan**

    While the 2023/24 financial plan includes non-pay inflation as per national planning guidance, the actual level of inflation suffered was expected to be higher than planned; our estimate of the level of excess non-pay inflation suffered YTD of £4.3m is still subject to validation and the true figure may be higher.

  - **CIP – £0.6m favourable to plan**

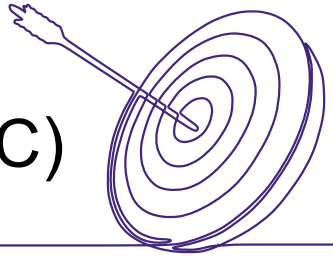
  - **Activity volumes - £3.9m favourable to plan**

    Activity volumes are lower than planned; YTD the benefit of lower than planned volumes is estimated to be £4.8m, but this is mitigated in part by £0.9m of outsourcing.

  - **Other – £4.7m adverse to plan**

    The majority of the remaining £4.7m adverse movement is driven by £4.1m over performance on pass through drugs & devices (largely offset by over performance on pass through income).

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



NHS
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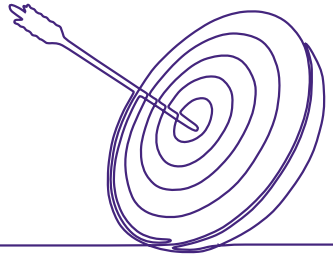
Cash

- The January 2024 cash balance is £29.3m (plan: £17.2m); this is a decrease of £12.0m against the March year-end cash balance of £41.3m.
- Whilst current cash levels remain comfortable; the position will narrow as we move towards the year end and into 2024/25 and will require careful management of cash and working capital. Key determinants of the year end cash position will be the level of capital creditors along with any variation from the planned revenue outturn.

BPPC

- The BPPC performance for January was 83% / 80% by value / volume of invoices paid (appendix 5d).
- Year to date performance is 87% / 82% by value / volume, this compares to the full year performance in 2022/23 of 79% / 70%.
- At the end of January there were circa 1,200 unpaid invoices (£6.1m) over term (December 3,600 / £3.6m). These will impact future BPPC performance levels as they are paid.
- The Trust received a letter from Julian Kelly re-iterating the 95% target and directing the Trust to improve performance from April. A multi-faceted improvement plan has since been implemented and updates contained in the final slide of this pack.

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

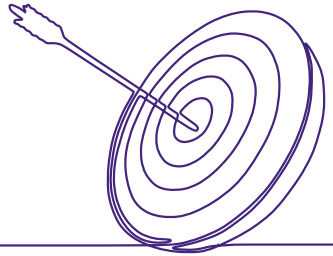
Metric	Rating Boundary			
	1	2	3	4
Capital servicing capacity	2.5	1.75	1.25	<1.25
Liquidity ratio (days)	0	-7	-14	<-14
I&E Margin	1%	0%	-1%	<=-1
I&E margin distance from plan	0%	-1%	-2%	<=-2%
Agency	0%	25%	50%	>=50%

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 four full financial years and the current 2023/24 position are as follows

Finance and use of resources rating	Full Year ending:					Actual	Forecast
	31/03/2019	31/03/2020	31/03/2021	31/03/2022	31/03/2023	JAN 2023	31/03/2024
Capital service cover metric	(10.40)	(1.73)	0.06	3.60	1.48	0.85	1.02
Capital service cover rating	4	4	4	1	3	4	4
Liquidity metric	(98.73)	(128.28)	3.71	2.50	(10.91)	(17.80)	(19.97)
Liquidity rating	4	4	1	1	3	4	4
I&E margin metric	(19.71%)	(7.62%)	0.38%	0.29%	(1.80%)	(3.20%)	(3.00%)
I&E margin rating	4	4	2	2	4	4	4
Agency metric	77.00%	110.00%	113.00%	120.00%	[illegible]	[illegible]	[illegible]
Agency rating	4	4	4	4	[illegible]	[illegible]	[illegible]
I&E margin: distance from financial plan - metric	(2.80%)	0.70%	n/a	0.01%	(1.80%)	(0.19%)	(0.14%)
I&E margin: distance from financial plan - rating	4	1	n/a	1	3	2	2

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

Balance Sheet



NHS
United Lincolnshire Hospitals
NHS Trust

	31-Mar-23	31-Jan-24			31-Mar-24	
		Plan	Actual	Variance	Plan	Forecast
	£000	£000	£000	£000	£000	£000
Intangible assets	11,383	4,635	7,802	(3,167)	4,357	7,011
Property, plant and equipment	298,860	297,386	298,405	(1,019)	306,970	334,079
Right of use assets	11,807	10,018	12,390	(2,372)	9,656	14,752
Receivables	2,157	1,848	2,176	(328)	1,848	2,105
Total non-current assets	**324,207**	**313,887**	**320,773**	**(6,886)**	**322,831**	**357,947**
Inventories	6,133	7,000	6,868	132	7,000	6,800
Receivables	52,873	30,200	30,968	(768)	30,740	29,000
Cash and cash equivalents	41,269	17,154	29,300	(12,146)	16,201	39,514
Total current assets	**100,275**	**54,354**	**67,136**	**(12,782)**	**53,941**	**75,314**
Trade and other payables	(89,905)	(71,734)	(69,987)	(1,747)	(76,995)	(98,357)
Borrowings	(3,129)	(2,926)	(3,067)	141	(2,879)	(2,894)
Provisions	(17,670)	(5,225)	(20,158)	14,933	(4,825)	(7,407)
Other liabilities	(1,260)	(4,130)	(3,632)	(498)	(1,130)	(1,130)
Total current liabilities	**(111,964)**	**(84,015)**	**(96,844)**	**12,829**	**(85,829)**	**(109,788)**
Total assets less current liabilities	**312,518**	**284,226**	**291,065**	**(6,839)**	**290,943**	**323,473**
Borrowings	(12,189)	(9,803)	(12,101)	2,298	(9,481)	(14,794)
Provisions	(5,108)	(3,042)	(5,051)	2,009	(2,992)	(5,051)
Other liabilities	(11,069)	(10,649)	(10,650)	1	(10,566)	(10,566)
Total non-current liabilities	**(28,366)**	**(23,494)**	**(27,802)**	**4,308**	**(23,039)**	**(30,411)**
Total assets employed	**284,152**	**260,732**	**263,263**	**(2,531)**	**267,904**	**293,062**
Financed by						
Public dividend capital	724,041	728,323	724,042	4,281	738,081	756,551
Revaluation reserve	42,584	28,007	41,631	(13,624)	27,891	41,443
Other reserves	190	190	190	(0)	190	190
Income and expenditure reserve	(482,663)	(495,788)	(502,599)	6,811	(498,258)	(505,121)
Total taxpayers' equity	**284,151**	**260,732**	**263,263**	**(2,531)**	**267,904**	**293,062**

Note 1: The financial plan for 2023/24 was submitted prior to the completion of the year end valuation and accounts. The net upward revaluation of circa £14m is not therefore reflected within the property plant and equipment and revaluation reserve figures quoted within the plan.

Note 2: Delays in the capital program mean that cash is expected to increase to circa £39m as PDC is drawn down in March, with high year end capital creditors anticipated.

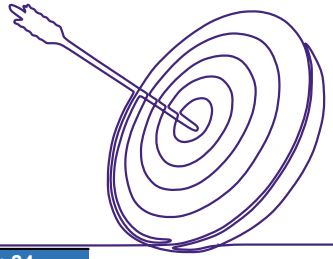
Note 3: Receivables is predominantly a mix of invoiced debt £3.6m, accrued income £13.5m and prepayments £14.4m, offset in part by bad debt provisions of £1.4m.

Note 4: The overall level of Trade and other payables at £70.0m has reduced significantly from year end, driven in part by the reduction in capital creditors from the March peak of £21.2m to £4.8m. With the 2023/24 capital programme weighted towards the back end of Q4, a substantial rise is again anticipated later in the year. BPPC and aged creditor performance is reported at

Note 5: The planned capital programme for 2023/24 will result in asset additions of £60.9m. This is to be funded through internal cash resources but with an injection of £32.5m PDC capital.

Note 6: The level of provisions remains high but are anticipated to reduce as 'Flowers' and Annual Leave issues are reviewed and resolved.

Cashflow reconciliation – April 2023– March 2024



United Lincolnshire Hospitals NHS Trust

	31-Mar-23	31-Jan-24			31-Mar-24	
		Plan	Actual	Variance	Plan	Forecast
	£000	£000	£000	£000	£000	£000
Operating surplus / (deficit)	(13,371)	(13,831)	(14,637)	806	(15,300)	(16,716)
Depreciation and amortisation	22,001	20,199	21,150	(951)	24,127	25,721
Impairments and reversals	5,079	-	-	-	-	-
Income recognised in respect of capital donations	(82)	-	(47)	47	(50)	(50)
Amortisation of PFI deferred credit	(503)	(420)	(419)	(1)	(503)	(503)
(Increase) / decrease in receivables and other assets	(38,148)	(1,700)	21,931	(23,631)	(2,240)	23,787
(Increase) / decrease in inventories	(127)	-	(735)	735	-	(667)
Increase/(decrease) in trade and other payables	1,593	(15,887)	(5,780)	(10,107)	(11,967)	(8,313)
Increase/(decrease) in other liabilities	130	3,000	2,372	628	-	(130)
Increase / (decrease) in provisions	10,861	(1,760)	2,394	(4,154)	(2,210)	(10,357)
Net cash flows from / (used in) operating activities	**(12,567)**	**(10,399)**	**26,230**	**(36,629)**	**(8,143)**	**12,772**
Interest received	1,175	1,860	2,221	(361)	2,100	2,938
Purchase of intangible assets	(4,142)	-	(5,730)	5,730	-	(5,730)
Purchase of property, plant and equipment	(42,693)	(37,126)	(26,932)	(10,194)	(45,930)	(32,100)
Proceeds from sales of property, plant and equipment	156	-	50	(50)	-	124
Net cash flows from / (used in) investing activities	(45,504)	(35,266)	(30,391)	(4,875)	(43,830)	(34,768)
Public dividend capital received	19,863	4,435	-	4,435	14,193	32,509
Other loans repaid	(402)	(805)	(805)	-	(805)	(805)
Capital element of finance lease rental payments	(2,416)	(1,936)	(2,003)	67	(2,319)	(2,283)
Interest element of finance lease	(121)	(89)	(113)	24	(104)	(135)
PDC dividend (paid)/refunded	(5,873)	(3,996)	(4,878)	882	(8,000)	(9,035)
Cash flows from (used in) other financing activities	(8)	(3)	(8)	5	(4)	(10)
Net cash flows from / (used in) financing activities	11,043	(2,394)	(7,807)	5,413	2,961	20,241
Increase / (decrease) in cash and cash equivalents	**(47,028)**	**(48,059)**	**(11,968)**	**(36,091)**	**(49,012)**	**(1,755)**
Cash and cash equivalents at 1 April - b'f	88,297	65,213	41,269	23,944	65,213	41,269
Cash and cash equivalents at period end	**41,269**	**17,154**	**29,301**	**(12,147)**	**16,201**	**39,514**

Note 1: Cash held at 31 January was £29.3m against a plan of £17.1m. This represents a decrease of £12.0m against the March year-end cash balance of £41.3m.

Note 2: The opening cash position was £24m less than planned, predominantly due to the volume / value of contract variations during March 2023 which from a cash perspective were not transacted until Q1 2023/24. This is illustrated by the significant reduction in receivables in the current year.

Note 3: Cash balances are expected to increase in March 2024 with the planned drawdown of £32.5m PDC to support the capital programme. The associated payment of suppliers however is likely to be weighted heavily into Q1 24/25. Other movements that are / will drive the cash position are:

- The forecast deficit of £23.6
- Release / utilisation of provisions associated with litigation and contractual obligations – circa £12m.

Note 4: No requirement to borrow is anticipated through the remainder of 2023/24. The cash position is expected however to deteriorate into 2024/25 where the option to move cash between Provider Organisations within the ICS may need to be explored.

United Lincolnshire Hospitals NHS Trust

Meeting	*Public Trust Board*
Date of Meeting	*5 February 2024*
Item Number	*13.1*

Strategic Risk Report

Accountable Director	*Kathryn Helley, Director of Clinical Governance*
Presented by	*Kathryn Helley, Director of Clinical Governance*
Author(s)	*Rachael Turner, Risk & Datix Facilitator*
Report previously considered at	*Lead assurance committees for each strategic objective*

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

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

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

Executive Summary

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

Due to changes in reporting timeframes this report contains data that covers January and February at the point of writing.

There were 13 quality and safety risks rated Very high (20-25) reported to the Quality Committee this month, a reduction of 2 from the previous 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
- Delivery of paediatric epilepsy pathways-community
- Quality and safety risk from inability to deliver epilepsy pathways within Acute Paediatrics that meet National standards
- Medicines reconciliation compliance
- Consultant capacity for Haematology outpatient appointments
- Potential for CQC regulatory action due to open 'Must Dos' – **Risk presented at January RRC&C meeting, validated for increase in score from Moderate (12) to a Very High (20).**

Following presentation at the Risk Confirm and Challenge Meeting during this period, the following risks have been updated:

- Delivery of paediatric diabetes pathways (community)- **Reduced to a score of 12 Moderate Risk**
- Non-recurrent funding in Cancer services - **Risk closed**
- Safety risk from nationwide shortage of suction catheters as identified by NHS supply chain – **Risk closed**.

There were 6 People and Organisational Development risks rated Very high (20-25) reported to the People & Organisational Development Committee this month, this remains stable from the previous reporting period:

- Disruption to services due to potential industrial action (Trust-wide)
- Staffing levels requiring an increase in Pharmacy to be able to provide a seven-day service.
- Pharmacy service not able to withstand prolonged staff absence.
- Pharmacy workload demands
- Service configuration (Haematology)

- Consultant workforce capacity (Haematology)

There were 6 Very high risks (20-25) reported to the Finance, Performance and Estates Committee this month, this remains stable from the previous 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.
- Med Air Plant LCH (Medical Gas)

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. **Of note progress updates against each risk within this report can be found in Appendix A.**

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 506 active and approved risks reported to lead committees this month, an increase of 42 since the last reporting period.

2.2 There were 25 risks with a current rating of Very high risk (20-25) and 45 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)
43(+8) (7%)	**104 (+9)** (20%)	**289 (+28)** (55%)	**45 (-1)** (10%)	**25 (-2)** (6%)

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

2.3 There were 11 Very high risks and 11 High risks recorded in relation to this objective. This remains stable from last month. A summary of the Very high risks is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4878	If there are significant delays within the planned care non-admitted pathway (outpatients) then patients may experience extended waits for diagnosis and treatment, resulting in failure to meet national standards and 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	26/02/2024 – a full review of this risk is due, this will be presented at Risk Confirm and Challenge in February.
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.	07/02/2024

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4789	If there is a significant delay in processing of Echocardiograms, which is impacted by staff shortages and inefficient processes, then it could lead to delayed assessment and treatment for patients, resulting in potential for serious harm, 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.	14/02/2024 – Risk reduction plan has made a significant impact therefore plan for full review in February and potential reduction in score. This will be presented at Risk Confirm and Challenge in March.
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.	27/02/2024

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.	08/01/2024
4877	If there are significant delays within the planned care admitted pathway then patients may experience extended waits for surgery, resulting in failure to meet national standards and potentially reducing the likelihood of a positive clinical outcome for many patients	Very high risk (20)	Planned care recovery plan (Admitted / HVLC / GIRFT) Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions.	26/02/2024– a full review of this risk is due with a potential to reduce – this will be presented at Risk Confirm and Challenge in February.

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4623	If an inspection by the Care Quality Commission (CQC) finds that the Trust is significantly non-compliant with regulations and standards it may result in sanctions such as a warning, improvement or prohibition notice; or a financial penalty. There is also the reputational impact of this within the local population the Trust serves.	Very high risk (20)	* Inclusion within Divisional CQC improvement plans a move to proactive compliance against new CQC framework using targeted Quality Statements as agreed at TLT workshop in October; * Ongoing support to UEC with collation of prospective data to support identification of gaps and issues and to provide assurance (i.e. paediatric ED staffing/capacity; staffing) * Completion of Compliance Team objectives around completing retrospective review of CSS actions by end of March 2024; * Ongoing 'horizon scanning' to identify and understand CQC Single Assessment Framework changed and sharing and applying these (i.e. application of Evidence Categories to ULHT proactive compliance work; * Assessment against CQC Well-Led criteria and feedback via workshop event to TLT and summary of findings reported to ELT; * Demonstrate delivery against 5 'Must-do' actions from 2021 inspection * Enhanced ability to identify areas of risk internally from triangulation of patient feedback (PALS, complaints, HealthWatch) with other indicators (i.e. performance against A&E targets)	19/02/2024
5101	Quality and safety risk from inability to deliver Community epilepsy pathways that meet National standards due to resourcing and capacity factors.	Very high risk (20)	1. Business case is being produced to enable establishment of fully funded epilepsy service 2. Agreement for spending has been obtained, moving forward. 3. In process of appointing 2 x epilepsy nurses, B6 has started, B7 was unable to start so back out to advert. 4. Epilepsy workshop with ICB	20/02/2024

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	27/02/2024

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4947	There is an issue in which the Trust is failing to meet NICE medicines reconciliation targets on a consistent basis and not being able to review discharges. This is caused by lack of pharmacy resource. Resulting in potential for patient harm due to incorrect or delayed medication, financial implications due to increased length of stay or unnecessary supply and risk of continuation of errors onto the discharge letter and further more into the community.	Very high risk (20)	There are many options but we are utilising these; - We have prioritised pharmacist and technician cover to acute admission areas as patient turnover is highest on these areas and gives us to best opportunity to conduct a medicines reconciliation under 24 hours - We prioritise patients which have stayed in the longest and have critical medication where known. Prioritisation of the highest risk patients decreases the risk of harm - No ward visits are divided as much as possible. To significantly reduce this risk requires additional ward based pharmacy staff cover across 7 days.	17/01/2024
5100	Quality and safety risk from inability to deliver epilepsy pathways within Acute Paediatrics that meet National standards due to resourcing and capacity factors.	Very high risk (20)	1. Multi-professional working group tasked with delivering improvements that will support achievement of audit compliance.	12/02/2024

Updates since the last report

Following the January RRC&C meeting the following changes were agreed and validated:

Potential for CQC regulatory action due to open 'Must Dos' – Risk presented at the January RRC&C meeting, validated for increase in score from Moderate (12) to a Very High (20). Due to the potential risk of regulatory action due to the non-completion of the 'Must Do's' the decision has been made to increase the risk score to reflect this. Significant progress is being made against the 'Must Do's' and it is anticipated that these will be closed in the next month.

Delivery of paediatric diabetes pathways (community) - Reduced from Very High (20) to a Moderate Risk (12) due to successful recruitment into vacant posts. Risk will remain as Moderate whilst a period of induction and competence development is undertaken.

Non-recurrent funding in Cancer services – Risk now closed as the ICB investment panel have agreed recurrent funding for the posts required. There are no anticipated gaps in recruitment as temporary staff in post now going through formal recruitment processes.

Safety risk from nationwide shortage of suction catheters as identified by NHS supply chain – Risk now closed as the supply issues have been resolved nationally and orders being placed as required.

Strategic objective 1b: Improve patient experience

2.4 There was no Very high risk and 2 High risks recorded in relation to this objective. This remains stable from last month.

Strategic objective 1c: Improve clinical outcomes

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

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4828	The trust currently uses a manual prescribing process across all sites, which is inefficient and restricts the timely availability of patient information when required by Pharmacists. Where information about patient medication is not accurate, up to date and available when required by Pharmacists then it could lead to delays or errors in prescribing and administration, resulting in a widespread impact on quality of care, potentially reducing the likelihood of a positive clinical outcome and/or causing serious patient harm	Very high risk (20)	Planned introduction of an auditable electronic prescribing system across the Trust. Update 4th July 22- 26th July, ePMA functionality version 10.21 will be upgraded. ePMA pilot from 13/09/22, full Trust wide roll out from mid Oct.	13/02/2024
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.	05/02/2024

Strategic objective 2a. A modern and progressive workforce

2.6 There was 4 Very high risks, a reduction of one and 7 High risks, an increase of two 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
4844	The ability to provide a seven day a week pharmacy service requires a level of staffing above the current levels. Benchmarking has taken place against peer Trusts for staffing levels. Until this is funded the seven day a week service is unobtainable and this puts patients at risk.	Very high risk (20)	Pharmacy supply a limited Saturday and Sunday morning service with staff working beyond their contracted hours. An on-call pharmacist is available for EMERGENCY items only. A Business Case has been submitted to CSS CBU.	13/02/2024
4996	Staffing - insufficient consultant workforce to meet demand. Particular areas of concern: 1. Lymphoma tumour site cover 2. Haemostasis/haemophilia (single consultant Trust wide) 3. Pilgrim Consultant cover 4. Clinical governance lead 5. HoS/clinical lead	Very high risk (20)	* Workforce review * Refresher of Fragile Services Paper - NB there is a National shortage of Haematology consultants * Recruitment of further substantive consultants * Additional unfunded ST3+ for Haematology starts in August 2022	27/02/2024

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
5093	Baseline pharmacy procurement staffing is at a level where only the basic functions can routinely be delivered and the service is not able to withstand any prolonged absence due to leave, sickness or resignation. The workforce has remained relatively stable over time; however, workforce pressures have been increasing over the last few years for a variety of reasons. There has been an increasing number of pharmaceutical shortages, many of which are complex in nature. A growing number of drugs are now being offered on an allocation basis, which requires micro management for stock ordering and distribution across the Trust. Changes in the delivery of chemotherapy have resulted in an increased demand for ordering of chemotherapy preparations. The pharmacy invoicing team have also experienced a recent increase in workload following the implementation of the Advanced finance system. The team are reporting concerns around workload and workplace stress. We are routinely reliant on existing staff working additional hours to fill gaps. If staff feel unable to come to work for any reason (including stress related) this will further increase the risk to the Trust and its patients of stock outs. This gives an associated risk to patient care, due to either a lack of personnel to raise orders, manage shortages, chase orders which are not being received, or to process invoices and manage supplier queries."	Very high risk (20)	Gap analysis highlights several areas of ongoing concern (to-follows, shortage management, invoice query management, medical gas invoicing). Occasional additional support is currently being provided to the invoicing team by a Bank Pharmacy Support Worker; we are scoping training this individual to offer procurement support in addition. This post is being paid from vacancy money elsewhere in the department and so cannot be considered a long-term fix for the procurement gaps. A case of need will be prepared to identify workforce requirements to reduce the workload stress the staff are persistently facing, and to provide a robust service which can withstand annual leave and short term sickness absence, based on the more challenging pharmaceutical market we are operating in where shortages are now a daily occurrence."	17/01/2024

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4997	Service configuration - single consultant covering both sites during weekend so cover limited if critically unwell patients on both sites	Very high risk (20)	* Workforce review * Refresher of Fragile Services Paper - NB there is a National shortage of Haematology consultants * Recruitment of further substantive consultants * Additional unfunded ST3+ for Haematology starts in August 2022	27/02/2024

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

2.7 There were 2 Very high risks, a reduction of one and 5 High risks, an increase of two 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
4439	If there is large-scale industrial action amongst Trust employees then it could lead to a significant proportion of the workforce being temporarily unavailable for work, resulting in widespread disruption to services affecting a large number of patients	Very high risk (20)	Industrial relations action plan & engagement mechanisms and arrangements with Staff Side representatives.	07/02/2024
4948	Workload demands within Pharmacy persistently exceed current staffing capacity which leads to work related stress resulting in serious and potentially long-term effects on staff health and wellbeing. Adding to this with additional workload demands with insufficient staffing, or required level of experience and skill, the risk is patients will not be reviewed by a pharmacist leading to poorer clinical outcomes, reduced flow on acute wards, delayed discharges and increased risk of omitted medicines. For staff the risk is long term absence. This may result in the failure to meet the national and local targets for KPIs	Very high risk (20)	Review current provision and identify gaps in service to inform business cases for change to support 7 day working (working with Surgery and Medicine Divisions as appropriate). Skill mix requires review due to complexity of patients.. Pragmatic management of workload & provision of management support. On-going exploration of recruitment options.	13/02/2024

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

2.8 There were 3 approved Very high risks (20-25) remaining stable and 6 High risk (15-16) an increase of 1, 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
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	26/02/2024
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	26/02/2024

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
5189	The Medical Air Plant in Maternity Block and Plantroom 12 at Lincoln County Hospital are of an age and high risk of failure. The systems are none compliant and do not comply with current triplex and quadplex installations. The installed systems or only duplex. Maternity Med Air plant has failed and currently operating with a temporary skid mount compressor plant. On 11th June the Plantroom 12 Med Air Plant failed and created significant patient Harm Risk. Both of these Med Air Plants require replacement to prevent harm to patients and staff.	Very high risk (20)	Our specialist contractors are working with the trust in order to supply temporary medical gas plant in the event of catastrophic failure to enable the impact to be as minimal as possible. The long term and only feasible strategy is to replace the medical gas air plant, upgrade to a quadplex modern and fit for purpose system, but this will require significant capital investment.	07/02/2024

Strategic objective 3b: Efficient use of our resources

2.9 There were 2 approved Very high risks (20-25), and 3 High risks (15-16), both remaining stable from the last report, recorded in relation to this objective. A summary of the Very high risks is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4664	The Trust has an agency cap of c£21m. The Trust is overly reliant upon a large number of temporary agency and locum staff to maintain the safety and continuity of clinical services that will lead to the Trust breaching the agency cap.	Very high risk (20)	Financial Recovery Plan schemes: - recruitment improvement; - medical job planning; - agency cost reduction; - workforce alignment	16/02/2024
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.	07/02/2024

Strategic objective 3c: Enhanced data and digital capability

2.10 There was 1 approved Very high risk, remaining stable (20-25) recorded in relation to this objective, There were also 6 High risks (15-16), an increase of three from the previous report. A summary of the Very High risk is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4657	If the Trust does not comply with Subject Access Requests (SARs) and Access to Health Records provisions in accordance with statutory requirements specified legislation, then it could lead to complaints to the Trust and Information Commissioner's Office (ICO). This could result in regulatory action and possibly financial penalties. Inconsistent levels of expertise outside of the IG team regarding SAR requirements. Lack of technical tools to carry out a search of emails / systems to identify personal information held. Potential financial implications."	Very high risk (20)	"Current active communications with ICO- regulator. Changes to processes are being constantly discussed and implemented. Resource needs being discussed and temporarily increased to support. Monitored through the IGG in DP KPI report. Head of IG leading on work to review and improve. Working in a more digital way where feasible. Workforce change is required which will be a much longer process. Early identifications of chasers and urgent requests to reduce the likelihood of complaints."	25/01/2024

Strategic objective 3d: Improving cancer services access

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

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

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

Strategic objective 3f: Urgent Care

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

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

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

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

2.15 There are currently no Very high 1 High risks recorded in relation to this objective. The risk relating to University Hospital Reputational risk.

2.16 **Strategic objective 4c: Successful delivery of the Acute Services Review**2.
There were no approved Very high risks (20-25) or High risks (15-16) to this objective.

3. Conclusions & recommendations

There were 13 quality and safety risks rated Very high (20-25) reported to the Quality Governance Committee this month:

- Patient flow through Emergency Departments
- Recovery of planned care admitted pathways
- Recovery of planned care non-admitted (outpatients) pathways
- Recovery of planned care cancer pathways
- Reliance on paper medical records
- Reliance on manual prescribing processes;
- Potential for serious patient harm due to a fall
- Processing of echocardiograms
- Delivery of paediatric epilepsy pathways-community
- Quality and safety risk from inability to deliver epilepsy pathways within Acute Paediatrics that meet National standards
- Medicines reconciliation compliance
- Consultant capacity for Haematology outpatient appointments
- Potential for CQC regulatory action due to open 'Must Dos'

3.1

There were 6 People and Organisational Development risks rated Very high (20-25) reported to the People & Organisational Development Committee this month, this is a reduction of two since the last reporting period:

- Disruption to services due to potential industrial action (Trust-wide)
- Staffing levels requiring an increase in Pharmacy to be able to provide a seven-day service.
- Pharmacy service not able to withstand prolonged staff absence.
- Pharmacy workload demands
- Service configuration (Haematology)
- Consultant workforce capacity (Haematology)

3.2

There were 6 Very high risks (20-25) reported to the Finance, Performance and Estates Committee this month:

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

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

ID	DCIQ 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**																			
4623	225	Regulatory compliance	Helley, Kathryn	Daws, Jeremy			05/03/2018	16	Risk assessments	Corporate	Nursing Directorate	Clinical Governance		If an inspection by the Care Quality Commission (CQC) finds that the Trust is significantly non-compliant with regulations and standards it may result in sanctions such as a warning, improvement or prohibition notice; or a financial penalty. There is also the reputational impact of this within the local population the Trust serves.	* Local / ULHT policies based on national policy * Governance and oversight arrangements for CQC related matters: (1) Trust Board assurance through Quality Governance Committee (QGC) & sub-groups with monthly CQC update reports summarising compliance with divisional progress against CQC improvement plans (mainly focussed on retrospective actions) (2) Clinical governance framework within divisions (3) Divisional CQC Assurance meetings and tracking of progress against CQC action plan (mainly focussed on retrospective actions) (4) ICB oversight & assurance framework (5) Closure of 3/5 Must-Do actions during February 2024.	* Compliance data from a variety of sources * Corporate data (i.e. mandatory training, appraisal rates) * Divisional compliance reviews against CQC Action Plan * Reporting via Board sub-committees and TLT * Development of proactive process to determine compliance with new CQC framework * Patient feedback/experiences via Patient Experience Group (PEG) * Positive engagement and outcomes from ULHT working with and supporting other external agencies when visiting/assessing Trust compliance (i.e. Ockenden Insights, Neonatal peer review, Surgery in children peer review etc.) Assurance reviews: -Ward based audits undertaken weekly, monthly and to support ward accreditation with key metrics -Compliance with key measures within the Trust's IPR -Progress against CQC improvement action plan as reported to Board sub-committees, TLT and other groups (i.e. Children's and Young Person's Board) * Formerly, communication channels could have been described as frequent and open. This has now changed with routine engagement meetings moving to quarterly (from monthly) and telephone contact with local inspection team discouraged and signposted to central helpline number. This increases the risk of the Trust's relationship with CQC deteriorating.	19/02/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Move to proactive compliance against new CQC framework using two approaches: (1) Divisional focus on SAFE key question utilising Quality Statements and Evidence Categories; (2) Corporate teams focus on WELL-LED key question utilising Quality Statements and Evidence Categories, with feedback session planned at TLT and ELT before end of March 2024. Ongoing work: * Ongoing support to UEC with collation of prospective data to support identification of gaps and issues and to provide assurance (i.e. paediatric ED staffing/capacity; staffing) * Completion of Compliance Team objectives around completing retrospective review of CSS actions by end of March 2024; * Ongoing 'horizon scanning' to identify and understand CQC Single Assessment Framework changed and sharing and applying these (i.e. application of Evidence Categories to ULHT proactive compliance work; * Demonstrate delivery against 5 'Must-do' actions from 2021 inspection * Enhanced ability to identify areas of risk internally from triangulation of patient feedback (PALS, complaints, HealthWatch) with other indicators (i.e. performance against A&E targets)	[19/02/2024 09:36:27 Jeremy Daws] Risk rating increased. Controls and gaps updated, including the new gap in assurance: frequency of regular CQC meetings changed from monthly to quarterly, and less ability for the Trust to have open dialogue with CQC inspectors, move to a more generic hotline approach. [31/01/2024 12:45:31 Rachael Turner] Risk discussed at RRC&C meeting 31/01/2024. We are at risk at regulatory action due to work still do on actions that require completion from 2021. Risk score updated 5x2: 20 Very High Risk. [23/01/2024 11:25:10 Rachael Turner] Risk reviewed, still have must do actions that require completion from 2021. This has a risk of regulatory action. Risk to be presented at RRC&C in Jan for possible increase in score. [02/11/2023 10:42:02 Rachael Turner] Risk reviewed, ongoing no current update. [23/06/2023 10:51:19 Rachael Turner] Risk reviewed to include further detail of measures and controls in place. Risk score updated to 3 x 4 making it a Moderate Risk score of 12. Increase based on: -Not yet being able to demonstrate closure of 5 'Must-do' actions from 2021 -Risks around ED performance/flow through hospital and operational challenges linked to 'exit block [27/03/2023 10:48:43 Rachael Turner] Risk reviewed-no change. Removed s29a warning notice & 10 of s31 notices. Improved CQC rating. Out of Special Measures. Still Requires Improvement. Further S.31 removed in relation to time to first assessment. Positive relationship with CQC via the CQC engagement meetings.	8	31/12/2021	31/03/2023	19/03/2024
4879	28	Physical or psychological harm	Frake-Harris, Julie	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	27/02/2024	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	[26/02/2024 16:48:25 Gemma] Risk reviewed and ongoing [31/01/2024 14:28:50 Gemma] Risk reviewed and ongoing [19/01/2024 10:02:18 Gemma] Haematology right-sizing SJBC was approved Dec 2023 to go to TLT, FPEC, Trust Board and ICB. Oncology right-sizing CoN still under preparation. [22/12/2023 13:10:45 Gemma] Haematology right-sizing paper presented to CRIG 19/12/2023. Approved to progress to ICB / Trust Board. Oncology right-sizing being prepared for next CRIG. [27/11/2023 13:49:23 Gemma] Rightsizing haematology paper approved at CRIG to progress to SJBC. SJBC has been draft and submitted. Oncology rightsizing CoN in development. COO approved recruitment 'at risk' ahead of the investment decision outcomes. Recruitment underway for medical, nursing and admin posts to support the services. New roles in development e.g. nurse consultant. Meetings with the COO continuing for support and oversight. [14/09/2023 14:59:30 Rose Roberts] Rightsizing Haem paper to be presented at CRIG Sept 2023. [01/08/2023 15:29:44 Rachael Turner] Action plan in place July 2023, monitored by the COO weekly for Haematology. Agreements in place to start recruitment for clinical and admin staff. CEO and COO met with Haematologists and CBU Senior Team 31st July. Work will start on oncology in August. [02/06/2023 12:41:34 Maddy Ward] Andrew Morgan requested a briefing paper for ELT which is now complete in conjunction with transformation and due to be circulated to execs on 05/06/2023. [24/04/2023 10:39:20 Maddy Ward] Oncology and Haematology service review carried out in March/April in association with strategy, planning, improvement and integration directorate [07/03/2023 10:21:35 Rose Roberts] The cancer recovery plan is a high priority for the division. More work to do but good progress in Endoscopy and Radiotherapy. [02/03/2023 08:41:30 Maddy Ward] Risk lead changed to Diane Lynch as Lucy Rimmer has left the trust as of 02/02/2023. DL is the new interim DMD until early June [13/01/2023 15:07:01 Paul White] Closed in error - re-opened. [17/11/2022 12:24:41 Rose Roberts] 4736 can be closed as Estates have investigated everything they can and Paula is launching an education and poster campaign. Trust comms have already gone out. [16/11/2022 15:54:57 Rose Roberts] Ongoing 4/8/22 Confirmed it is an ongoing corporate risk being managed at divisional level.	8	31/03/2023	31/03/2023	27/03/2024
5101	487	Physical or psychological harm	Rivett, Kate	Herath, Dr Durga	Children & Young Persons Oversight Group	Clinical Effectiveness Group	14/03/2023	20		Family Health	Children and Young Persons CBU	Children's Community Services	Trust-wide	Quality and safety risk from inability to deliver epilepsy pathways within Community Paediatrics that meet National standards due to resourcing and capacity factors.	1. Single Consultant Paediatrician (DH) is currently managing all children with Epilepsy alongside a single specialist epilepsy nurse; 2. Wider consultant body supporting the care of children who are prescribed 2 antiepileptics in the absence of a consultant paediatrician with expertise in epilepsy; 3.Single Consultant Paediatrician is developing individualized care plans for each patient to optimise management of condition; 4. Liaison with ICB and regional network to support development and improvement of local services	1. Audit of compliance with NICE guideline NG217 - Epilepsies in Children, Young People and Adults and NICE quality standard QS27 - Epilepsy in Children and Young People;	20/02/2024	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	[20/02/2024 13:08:27 Nicola Cornish] No change. Business case meeting is being held to progress so that bid can be submitted to ICB for funds. [17/01/2024 13:02:57 Nicola Cornish] No improvement, business case being written on new template. [21/12/2023 11:19:49 Nicola Cornish] Consultant caseload review commenced in order to apply RAG rating system to each case to enable identification of those most at risk. Reviewed 100 patients so far, 2 additional review dates to be scheduled. Nursing criteria to be changed shortly to focus on top tier most vulnerable patients. [21/11/2023 14:24:17 Kate Rivett] 21/11/23 - KR 1. Significant levels of risk remains as there are only x2 specialist nurses and x1 consultant to manage a cohort of in excess of 900 patients, some of whom have very complex epilepsy in addition to other vulnerability factors; 2. Business case being worked up in conjunction with ICB to seek additional funding to enable expansion of the team. [25/10/2023 11:47:32 Rachael Turner] Risk discussed at RRC&C meeting 25/10/2023, risk to remain at Very High risk. [17/10/2023 14:06:09 Nicola Cornish] Appointed 2 nursing staff members, service making progress in establishing numbers that can be seen, gap analysis undertaken against NICE guideline - need to break this down further into key factors required to deliver service. Benchmarking completed, need to complete NICE baseline assessment form. [15/08/2023 13:26:59 Jasmine Kent] 2nd nurse has now started but issues ongoing with tertiary support with Nottingham. Difficulties completing epilepsy 12 audit. Risk remains same for now. [18/07/2023 13:22:27 Jasmine Kent] New nurse starts 07/08, looking to pull together business case to increase nursing team size further. Clarifications on pathway with tertiary centre required. [22/06/2023 14:21:05 Jasmine Kent] Nursing service criteria completed for year 1 - patient cohort restricted in line with team establishment. Team only seeing newly diagnosed children, those on ketogenic diet and CBD oil until uplift in nursing staff.	8	14/03/2024	16/02/2024	20/03/2024

ID	DCIQ ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
5016		Physical or psychological harm	Hamer, Fiona	Smith, Charles	Workforce Strategy Group	Patient Safety Group	02/09/2022	25		Medicine	Urgent and Emergency Care CBU	Accident and Emergency		If there is not sufficient flow through the Trusts Emergency Departments, due to demand outstripping capacity and insufficient availability of beds in the hospitals leading to overcrowding; this may result in increased likelihood of long waits in the departments for patients, and an increase in the potential for patient harm, delays in care, poor patient and staff experience and impact on the reputation of the Trust .	Medical SDEC currently working 08:00 - 20:00 24 hour UTC co-located with ED at Pilgrim and Lincoln 'Are you sitting comfortably' scheme 4 x Daily Capacity meetings (08:00, 12:00, 15:00, 18:00) Clinical Operational Flow Policy Full Capacity Protocol National Criterial 2 Admit flowchart embedded in the ED's Introduction of "Pit stop" model.	ED Risk Tool - updated 4 times daily with an overview of the department Capacity Meetings to dynamically risk assess Monthly scorecard to track performance from both harm and constitutional standards Matrons Dashboard Datix Number of harm reviews	07/02/2024	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	[07/02/2024 09:17:37 Rachael Turner] Risk reviewed, no change. [09/01/2024 15:07:09 Rachael Turner] Risk reviewed. We have introduced cohorting to offload ambulances. We are holding medical colleagues accountable for discharges. But overcrowding still stands. Risk score to remain. [13/12/2023 16:47:38 Rachael Turner] No significant update to this risk, flow expected to ramin challenging across winter. Re: implementation of SAFER process but not yet seen consistent improvement" [20/11/2023 20:22:32 Rachael Turner] No current change, risk score to remain. [17/10/2023 10:08:18 Rachael Turner] No current change, currently huge risk due to lack of flow. Increase in patients that need admitting and require treatment whilst waiting for beds. Staffing has increased in this area to decrease patient harm. The professional standards have been introduced to clinicians for them to see patients within 30 minutes, this is being audited for compliance. The continued flow policy has reintroduced but this risk still remains at the same score. [30/08/2023 11:25:49 Carl Ratcliff] To review post meeting with execs on 30th August 2023 - action plan in place to manage risk [15/08/2023 11:11:54 Helen Hartley] Continuing to look at criteria led discharge 10x10 discharges from wards Staffing model being looked into regarding Extra patients in ED to keep patients safe. Virtual wards has been discussed, has not yet started. [19/07/2023 15:52:30 Helen Hartley] There is a lot of work ongoing regarding flow, can we use virtual wards? Frailty pathways in SDEC being examined to try to move patients out of ED and into the correct places for their needs. Ongoing. [28/06/2023 11:22:34 Rachael Turner] Risk discussed as apart of RRC&C Deep Dive 28/06/2023. Huge demand currently, a lot of work around MEAU handover. There is not enough staff to move patients, conversation around costing at what a transfer team would look like. There is a cost implication about this but discussions are in place. CQC must do Trust initiative, there is work linking with communities looking at support that can be offered at home-use of virtual wards. Risk remains high. [26/04/2023 11:58:09 Carl Ratcliff] No change but will review at next months UC improvement group	10	02/09/2023	31/03/2024	07/03/2024
4740	37	Physical or psychological harm	Cooper, Mrs Anita	Chester-Buckley, Sarah	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 October 2023 there are 1074 overdue haem pt (237 at phb and 837 at LCH). From 1 Oct 22 until 2/11/2023 the haematologists have held 318 extra clinics which equates to 178 news and 2017 F/U. Haemostasis in particular pt are waiting almost triple the time that they have been graded at. There are 578 pt on this consultant PBWL with 232 being overdue. The longest waiter was due an appointment around March 2023. 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	27/02/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	* Workforce review - Now Completed (Sarah Chester-Buckley - July 2023) * Refresher of Fragile Services Paper - NB there is a National shortage of Haematology consultants - Now completed (Sarah Chester-Buckley - September 2023) * Recruitment of further substantive consultants - (Sarah Chester-Buckley - May 2024) * Additional unfunded ST3+ for Haematology starts in August 2022 - Now completed (Sarah Chester-Buckley - July 2023)	[26/02/2024 16:51:08 Gemma] Appointed three new Consultants, one at Lincoln and two at Boston. One started on 13.02.2024, awaiting start date for Haemostasis/Haemophilia Consultant and third Consultant due to start in August. [31/01/2024 14:33:38 Gemma] Risk reviewed and ongoing [18/01/2024 11:21:10 Gemma] Haematology rightsizing paper taken to TLT and approved, now needs to go to the Board and ICB investment panel. [22/12/2023 08:21:34 Gemma] Haematology rightsizing paper (SBJC) presented and approved at CRIG 19/12/23. Now needs to be presented at Board and ICB investment panel. Further update to be provided at a later date. [06/11/2023 08:53:30 Vicky Dunmore] updated PBWL, clinic and new appt figures [14/09/2023 14:57:46 Rose Roberts] Rightsizing Haem paper to be presented at CRIG Sept 2023. [01/08/2023 15:20:30 Rachael Turner] Update provided from Lauren Rigby-we are now having weekly meetings with the COO and at risk recruitment is happening. [02/06/2023 12:40:22 Maddy Ward] Andrew Morgan requested a briefing paper for ELT which is now complete in conjunction with transformation and due to be circulated to execs on 05/06/2023. We are exploring what care could take place in primary/community setting. [24/04/2023 10:36:33 Maddy Ward] Haematology service review carried out on 20th April 2023 in association with strategy, planning, improvement and integration directorate [03/04/2023 09:34:49 Rose Roberts] Reviewed at confirm and challenge confirmed as v high risk. [15/12/2022 13:31:29 Alex Measures] currently out to advert for second haemostasis consultant, the rest of the posts ongoing Workforce information provided to triumvirate, awaiting feedback. ACP still in training, additional vacancy for middle grades difficult to recruit to. 220622 Been identified as IIP priority for 2022/23. This includes workforce review, GIRFT review being considered.	3	01/04/2023	01/04/2023	27/03/2024
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.	17/01/2024	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.	[17/01/2024 12:05:07 Gemma] No further update [29/12/2023 13:53:23 Lisa Hansford] No further update [19/12/2023 13:26:38 Lisa-Marie Moore] phase 2 pharmacy improvement plan in development. meeting with MD 18/12 to discuss prioritisation of business cases [07/11/2023 14:13:38 Lisa Hansford] Update- DMS implementation has been affected as a consequence of low medicines reconciliation figures. Pharmacists are not clinically screening/reviewing discharges therefore this is an additional gap in the service which inhibits uptake of DMS. Core clinical pharmacy services such as medicines reconciliation and discharge screening allow additional services such as DMS to be implemented, without the former it is not possible to implement DMS [26/09/2023 14:06:35 Rachel Thackray] To meet with Medical Director to discuss lack of progress [07/09/2023 14:03:55 Lisa Hansford] 07.09.23 no changes to current situation [03/08/2023 14:48:59 Lisa-Marie Moore] No further updates [27/06/2023 09:47:37 Alex Measures] Discussed in risk register review meeting- no further updates [01/06/2023 14:17:45 Lisa-Marie Moore] No change/updates since previous entry [04/05/2023 14:12:22 Lisa Hansford] As advised at confirm and challenge meeting. Lack of compliance with national standards. [06/04/2023 13:07:13 Paul White] Discussed at Risk Register Confirm & Challenge 29 March. Risk agreed and feedback provided for consideration. [21/02/2023 08:47:37 Paul White] Note from Risk Register Confirm & Challenge Group - risk rating to be reviewed and agreed at division level prior to presentation at RRC&CG for validation. [05/01/2023 14:13:48 Lisa-Marie Moore] No change/progress since last update [08/12/2022 12:40:46 Lisa-Marie Moore] Meeting with Divisional Leads and Deputy Medical Director 25/11 to discuss business case and actions needed to be taken to support progression of it. No change to risk - currently performing under 50% on average (this is boosted by the ward based technicians who also complete med recs on patients) Many ward areas have not seen pharmacist for several weeks at LCH. [01/11/2022 15:27:25 Ahtisham Saddick] Business case has been discussed; updated and responded to comments. Trust is still performing below 50% of med recs within 24 hours.	8	30/06/2023	31/12/2024	16/02/2024

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4624		Physical or psychological harm	Davies, Angela	Addlesee, Sarah	Patient Falls Steering Group	Nursing, Midwifery and AHP Forum	08/11/2021	16	Aggregation of Incident/Claims & Complaints/PALS	Corporate	Nursing Directorate	Corporate Nursing	Trust-wide	If patients in the care of the Trust who are at increased risk of falling are not accurately risk assessed and, where necessary appropriate preventative measures put in place, they may fall and could suffer severe harm as a result.	National policy: - NICE Clinical Guideline CG161: Assessment and prevention of falls in older people (2013) - PHE Falls and fracture consensus statement: Resource pack (2017) ULHT policy: - Falls Prevention and Management Policy (approved April 2021, due for review March 2023) ULHT governance: - Lead Quality Matron - Weekly Falls Investigation Panel / Training package tiered approach / Weekly spot check audits / Monthly Quality Metrics Dashboard meetings /ward review visits - Patient falls steering group / Nursing, Midwifery & AHP Forum / Quality Governance Committee	Frequency, location and severity of patient falls incidents reported: - The numbers of reported falls incidents are demonstrating an increasing upward trend therefore will not achieve the strategic objective to achieve harm free care. - Operational pressures have resulted in patients having prolonged periods sitting in Emergency Departments whilst waiting assessment and for inpatient beds to become available. This may contribute to an increase in some patients overall frailty level and subsequent deconditioning which increases the vulnerability to an individual falling. - Longer length of stays have demonstrated a correlation to risk of a patient falling whilst in the care of the Trust. Patient falls reported April 2021-March 2022 Total -1916 Moderate harm -22 Severe -12 Death -4 Patient falls reported April 2022-Mar 2023 Total -1958 Moderate harm -17 Severe-25 Death-1	08/01/2024	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.	[23/01/2024 11:11:39 Rachael Turner] Risk reviewed. Risk is suggested that a reduction in score, meeting required with Sarah and Angela to review for reduction in score and then it will go to RRC&C in February. [20/12/2023 16:28:46 Rachael Turner] Risk reviewed, very minimal change from previous update: •Falls incidents continue to be analysed and trends and themes identified organisationally and reported through Falls Prevention Steering Group (FPSG) •The Quality Matron team will continue to provide support to areas with an increased number of incidents. •Education for teams on completing falls documentation and implementing appropriate interventions is supported by the Quality Matrons. •Themes from falls incident reports are discussed at monthly Divisional falls prevention groups supporting shared learning. •Initial outcomes from an environmental review of toilet/bathroom environments shared at FPSG .Quality Matron and Estates and Facilities Lead Nurse to meet to identify improvement opportunities and priorities. •Divisions have focussed activities being undertaken to support the prevention of patients deconditioning whilst in hospital with a plan to rollout further in the new year. •Review of training options being undertaken. •Falls prevention quality council will continue to work collaboratively on identified quality improvements, and to join up the work being undertaken within individual falls prevention forums. •Review of The 'Call Don't Fall ' communications is to be reviewed and reinvigorated. •Overall number of falls decreased by 18 in November 2023- the severity of harm increased in month with 1 moderate and 2 severe harm incidents. Most incidents continue to result in no or low harm to patients. [28/11/2023 12:48:48 Rachael Turner] •Falls incidents continue to be analysed and trends and themes identified organisationally and reported through Falls Prevention Steering Group (FPSG) •The Quality Matron team will continue to provide support to areas with an increased number of	4	31/12/2021	31/03/2023	08/02/2024
4878		Physical or psychological harm	Frake-Harris, Julie	Carter, Mr Damian	Patient Safety Group	Outpatient Improvement Group	28/03/2022	20	Risk assessments	Corporate	Operations	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	26/02/2024	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	[26/02/2024 14:11:19 Rachael Turner] At the point this risk was added. patients were waiting in excess of two years. We are currently nearly at the point at patients waiting over 18 months. Due to current waiting times reduced, risk to go to RRC&C to be validated as a 3x4: 12 Moderate risk. [20/12/2023 13:18:10 Rachael Turner] No change, risk to have full review Jan 2024 [08/11/2023 10:47:35 Helen Shelton] Verbal update from Damian - no material changes this month - full review to be undertaken in the next three weeks. [02/08/2023 14:31:41 Rachael Turner] Good progress continues to be made on reducing the time patients are waiting for Outpatient. However, Industrial action for Junior Doctors and now Consultants has significantly impacted recovery and the aim to clear all patients waiting over 78 weeks for treatment has not been met. Additional capacity and focus has been put into place to reduce numbers despite the impact of Industrial action. Numbers of patients waiting over 65 weeks for treatment continues at a rate better than expected [25/04/2023 10:38:37 Rachael Turner] Work continues, no current change to risk grading. [21/02/2023 17:44:30 Damian Carter] As Improvement plans embed, we are starting to see a reduction in number of patients waiting to be seen in Outpatients and subsequently patients are not waiting so long. Recent Outpatient Sprint to improve DNAs, missing outcomes etc. have also seen fewer patients waiting. The trust is on track to clear all incomplete patient pathways >78 weeks by the end of March 2023, with the exception of patient choice. [13/12/2022 13:31:41 Rachel Thackray] As per previous update, no change to risk grading [21/10/2022 09:42:00 Rachel Thackray] Work continues on the Outpatient Improvement Programme (ORIG) to improve clinic utilisation, reduce demand and increase activity back to 19/20 levels and above. Key progress since last update includes; 1. Contract awarded for Validation contract – Start date November 2022 2. Commencement of personalised Outpatient plan – Start date December 2022 3. Super September completed and yielded 40% reduction in non-admitted pathways that were validated	8	31/03/2023	31/03/2023	26/03/2024
4877		Physical or psychological harm	Frake-Harris, Julie	Carter, Mr Damian	Patient Safety Group		28/03/2022	20	Risk assessments	Corporate	Operations	Operations		If there are significant delays within the planned care admitted pathway then patients may experience extended waits for surgery, resulting in failure to meet national standards and potentially reducing the likelihood of a positive clinical outcome for many patients	National policy: - NHS standards for planned care ULHT policy: - Planned care admitted pathway & booking systems / processes - Clinical Harm Review (CHR) processes ULHT governance: - Lincolnshire System Elective Recovery meeting – Monthly - Integrated Performance Report (IPR) to Trust Board - Monthly - Divisional Performance Review Meeting (PRM) process - Clinical Harm Oversight Group	P2 - surgery within 31 days - currently around 6-7 weeks. Very long waiters	26/02/2024	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	[26/02/2024 14:11:54 Rachael Turner] At the point this risk was added. patients were waiting in excess of two years. We are currently nearly at the point at patients waiting over 18 months. Due to current waiting times reduced, risk to go to RRC&C to be validated as a 3x4: 12 Moderate risk. [20/12/2023 13:18:56 Rachael Turner] No change, risk to have full review Jan 2024. [08/11/2023 10:48:59 Helen Shelton] Verbal update from Damian Carter - no material change this month - full review of risk to be undertaken in three weeks. [02/08/2023 14:32:55 Rachael Turner] The Grantham site has now successfully achieved the status of a GIRFT accredited Elective hub, one of only 8 in the country. This allows the trust to use Grantham as a ringfenced elective site and gives the ability to increase elective activity without an impact from emergency demand. The 6 theatres are now established and a significant amount of elective work as moved from Pilgrim and Lincoln. Whilst patients are dated for surgery in a relatively swift manner, the delays remain in Outpatients. Mitigation is set out in risk 4878 and means the overall risk to the waiting times is significant [25/04/2023 10:41:05 Rachael Turner] Work continues, no current change to risk grading. [02/03/2023 18:51:14 Damian Carter] As Improvement plans embed, we are starting to see a reduction in number of patients waiting to be seen and subsequently patients are not waiting so long. Recent Theatre Productivity work has started to yield improvements and led to a significant reduction in late starts. This is particularly evident at Grantham through the SuperSprint and has seen lost minutes due to late starts reduce by 50% [26/01/2023 15:06:57 Corporate Dashboards] Risk moved from Surgery to Corporate as this is an operational risk, not divisional. [21/10/2022 09:40:36 Rachel Thackray] Work continues on three main improvement programmes to address capacity for Surgery 1. HVLC/GIRFT – Looking at best use of theatres by ensuring HVLC procedures are completed as daycases rather than Electives. This maximises productivity of lists and reduces length of stay to ensure bed availability for surgery. Compliance with HVLC has started to increase over recent weeks 2. Theatre efficiency/productivity – The trust deployed a company called Foureyes insight to work with the	8	31/03/2023	31/03/2023	26/03/2024

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4789	32	Physical or psychological harm	Frake-Harris, Julie	Ratcliff, Carl	Patient Safety Group	Clinical Effectiveness Group	16/01/2022	20	Risk assessments	Medicine	Cardiovascular CBU	Cardiology	Trust-wide	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 ICB 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 reducing. Booking Team are now part of the Cardiovascular Division.	14/02/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	- Set healthcare working at Grantham CDC-contract for 3000 Echoes this is to to reached by May 2024. -Continued recruitment process, which included current recruitment and retention package. This will be complete April 2025. -Direct contract award to agile services to provide physiology support at our Boston site for 3 months, this will commence the end of Jan 2024. This will mitigate the staffing issues at Pilgrim. -Two further CDC (Community Diagnostic Centres) to come online in September 2024, one in Skegness and the other in Lincoln.	[14/02/2024 14:57:54 the reporter] Risk reviewed, numbers continue to fall. Update to be provided in March, this will then go to Risk Confirm and Challenge in March for a reduction in score. [15/01/2024 14:18:13 Rachael Turner] Previously back log was 8000, this has been reduced significantly and is now currently 3576. Risk controls and risk reduction plan updated to reflect ongoing work. Risk to be reviewed for possible reduction in score in February. If agreed by Division this will be presented at Risk Confirm and Challenge. [18/12/2023 21:40:10 Rachael Turner] No update currently, risk to be reviewed in Jan 24. [20/11/2023 20:29:20 Rachael Turner] Risk reviewed, work ongoing, numbers continue to fall in the right direction. [30/10/2023 15:05:34 Rachael Turner] Weekly meetings continue with ICB. We continue to maximise the capacity at the CDC. Numbers are continuing to fall and we are basically on track with our trajectory. [16/10/2023 16:24:27 Rachael Turner] List continues to fall, all D3 are now seen within six weeks. All follow up patients with the exception of valve registry are booked when their appointment is due. Weekly ICB meetings continue to monitor progress. Clinical lead currently feels that risk score needs to remain at present. 7931 patients were previously on waiting list, currently at 4762. This will be reviewed in December. [30/08/2023 09:28:23 Carl Ratcliff] WL recovery slightly off track but still progressing in right direction / pace InHealth will stop from now from providing 40 scans a month - asked team to look at effect [23/07/2023 13:00:46 Carl Ratcliff] Progress continues - WL recovery on track with 400o pts now on list against 8700 at highest point [19/06/2023 15:35:26 Charles Smith] Charles Smith - DGM CDC work continues - Numbers improving as SET recruitment drive moves forward. Trajectories continue to be downward, slightly behind target for 6ww and 13ww cohorts due to staffing of private provider but only 1 month lost in end-point to date. Main TWL trajectory is ahead of NHSE expectations at May 2023 data point. R&R successfull, fully recruited, await new starters.	4	31/03/2022	01/02/2024	14/03/2024
5100	487	Physical or psychological harm	Rivett, Kate	Herath, Dr Durga	Children & Young Persons Oversight Group	Clinical Effectiveness Group	14/03/2023	20	Risk assessments	Family Health	Children and Young Persons CBU	Paediatric Medicine	Trust-wide	Quality and safety risk from inability to deliver epilepsy pathways within Acute Paediatrics that meet National standards due to resourcing and capacity factors.	1. Single Consultant Paediatrician (DH) is currently managing all children with Epilepsy alongside a single specialist epilepsy nurse; 2. Wider consultant body supporting the care of children who are prescribed 2 antiepileptics in the absence of a consultant paediatrician with expertise in epilepsy; 3.Single Consultant Paediatrician is developing individualized care plans for each patient to optimise management of condition; 4. Liaison with ICB and regional network to support development and improvement of local services	1. Audit of compliance with NICE guideline NG217 - Epilepsies in Children, Young People and Adults and NICE quality standard QS27 - Epilepsy in Children and Young People;	12/02/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	1. Multi-professional working group tasked with delivering improvements that will support achievement of audit compliance.	[14/02/2024 14:54:26 Nicola Cornish] No change. Business case meeting this week to progress so that bid can be submitted to ICB for funds. [10/01/2024 14:26:18 Nicola Cornish] No change. Need to complete benchmarking. [16/11/2023 16:25:11 Nicola Cornish] No change as per discussion at RRC&C meeting on 07/11. [07/11/2023 11:31:43 Helen Shelton] Reviewed at the RRC&C meeting and agreed that despite the appointment of 2 epilepsy nurses the risk remains very high at 20 as A further BC is now required to improve the service further. [11/09/2023 15:33:59 Jasmine Kent] Both epilepsy nurses have started and have been asked to see newly diagnosed epilepsy patients, asked to take on cohort of complex patients so parents are receiving better support. For reduction to a 16 on both acute and community paeds. Tertiary engagement has been escalated to ICB. As agreed at RRCCG - for reduction to a 16. [14/08/2023 14:30:44 Jasmine Kent] 2 nurses now in post, risk remains very high due to difficulty engaging with tertiary neurology. [10/07/2023 13:47:04 Jasmine Kent] Requires discussion at governance and with Epilepsy service lead, no change that the team are aware of but will update following governance later this week if any further developments have been made. [12/06/2023 15:55:12 Jasmine Kent] Discussion ongoing regarding reduction of risk level now epilepsy nurses are in post. Unsure of level of involvement with Acute Paeds at this stage, For review next month. Gap analysis to be conducted to identify risk rating and specifically where improvements need to be made. [16/05/2023 15:39:25 Jasmine Kent] Epilepsy nurses are now in place, for review next month to determine if there has been a change in risk level. [04/05/2023 09:09:17 Rachael Turner] Risk re-opened as risk is to cover acute, risk 5101 reflects community risk. [03/05/2023 15:28:19 Rachael Turner] Risk closed as duplicate of Risk ID: 5101. [18/04/2023 08:44:50 Jasmine Kent] Un-rejected, rejected by mistake, not a duplicate entry. Has already	8	14/03/2024		12/03/2024
4779		Physical or psychological harm	Frake-Harris, Julie	Ratcliff, Carl	Patient Safety Group		16/01/2022	20	Risk assessments	Medicine	Cardiovascular CBU	Stroke		Increase in risk of delays to patient care/harm as a result of increasing backlog of planned care activity across stroke arising from Covid19 constraints / service restrictions/ site escalation pressures.	additional clinics/lists (cost pressure) additional staffing where feasible to increase capacity (cost pressure)	weekly monitoring of RTT and PBWL	15/01/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	-Virtual clinics in place for substantive consultants, where long overdue follow ups are giving priority. Overdue was standing at 989 patients, this was reported in October 2023. With industrial action, this will have had an impact. Trajectory of how we continue to reduce to be provided.	[15/01/2024 14:24:35 Rachael Turner] Risk reviewed, controls in place and risk reduction plan updated. Virtual clinics currently in place to provide follow ups for long overdue patients. [13/12/2023 19:05:30 Rachael Turner] No current update, meeting to be had to combine with Risk 4780 and 4778. Due to staffing working capacity this will be done in January 24. [27/09/2023 11:31:18 Rachael Turner] Risk discussed at RRC&C as part of the Deep Dive. Since Covid this risk has moved on, this needs to be reviewed and possibly combined with risk ID 4780 and 4778. [30/08/2023 11:19:10 Carl Ratcliff] to review with COO as may be able to remove given lower COVID demand [23/07/2023 12:57:33 Carl Ratcliff] Proposal been constructed to allow better use of LCH beds - await feedback from Execs on next steps [24/04/2023 12:28:58 Carl Ratcliff] Improvement work started with team and perfect week in May will look at all opportunities for service. [27/01/2023 10:23:30 Charles Smith] 27/01/23 - CS DGM - Ongoing area of concern due to workforce and ACP gaps (being recruited to but time required to train). TIA still a concern but stable numbers. [16/12/2022 14:35:47 Carl Ratcliff] Additional work in palce to find external support / validate PWL and push patients through system [22/11/2022 17:25:10 Carl Ratcliff] Aim to have outliers back in right place and work continues to improve OPD work. Limited consultant numbers still mean there is a risk to OPD planned care work Plans in place to address backlogs across all areas. Significant area of risk for TIA. 23.08.22 Remains an issues although noting covid cases have dropped. Will be resolved once the improvement work on wards in completed to remove outliers and pts are in the correct place with appropriate bed numbers	4	31/03/2022	29/12/2023	15/04/2024

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5002		Service disruption	Farquharson, Colin	Edwards, Mrs Jill	Palliative / End of Life Care Oversight Group	Clinical Effectiveness Group	23/08/2022	16		Clinical Support Services	Cancer Services CBU	Specialist Palliative Care		"If the Trust is not consistently compliant with NICE Quality Standards and commissioning guidance for specialist palliative care (SPC) to identify and provide appropriate care, delays on discharge and support for people who may be at end of life, then there may be delays to accessing appropriate care and treatment provided by specialist palliative care teams, resulting in serious physical and psychological patient and family harm, with a poor patient experience of care and service. "	"National Policy - NICE Quality Standard (QS13) End of life care for adults - NICE Guideline (NG142) End of life care for adults: service delivery - NICE - Care of dying adults in the last days of life Quality standard Published: 2 March 2017 - Ambitions for Palliative and End of Life Care: A national framework for local action 2021-2026 - 'One Chance to Get it Right: improving people's experience of care in the last few days and hours of life' Leadership Alliance for the Care of Dying People. June 2014. - 'Every Moment Counts' A narrative for person centred co-ordinated care for people near the end of life (VOICES) - Commissioning guidance for Specialist Palliative Care (2016). Local Strategy - Palliative and End of Life Care (PEOL) strategy for Linconshire - PEOL Re-Design for PEOL services Lincolnshire - ULH Strategy for PEOL ULH Governance - SPC Governance/ CSS CBU/ Cancer Services/ SPC - NACEL report"	"Frequency of referrals outside SPC referral criteria Frequency of referrals that require more information for triage Number of Datix incident and complaints relating to patient care Frequency of patients died/discharged before seen Frequency of patients dying outside Preferred place of death Frequency of first assesment (over 24hrs) from service KPI's. SPC workforce review including staffing deficits and skills gap analysis MDT attendance at point of recommendations Start time from referral to discharge Frequency and severity of concerns relating to PEOL transition of care into community reported to CCG "	31/01/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	"Daily caseload review and triage of caseload using PEOL OPEL reporting measures with sitrep for escalation of risks Daily palliative huddle with key partners to support demand Working as one team across sites to provide pan trust cover Increase in senior leadership for direct support to PEOL at ULHT by addition of deputy lead nurse for PEOL Completion of Workforce plan to identify gaps in alignment with national policy and guidance. Commenced Service improvement gap analysis. Internal and external ask for multi disciplinary support to the SPC team. Externally sourced Clinical Education. Development of PEOL champions developed throughout Trust. Commence update to PEOL business continuity plan. Continued involvement in systemwide PEOL Operational meeting to promote improvements across services Analysis of staff competency and supervision completed and development plans in place. Develop action plan for NACEL analysis of staff competency and supervision completed and development plans in place. "	[31/01/2024 12:36:56 Rachael Turner] Risk discussed at RRC&C meeting 31/01/2024 for increase in score. Not meeting KPI and significant delays to patients receiving care and direct patient harm. We cannot see people within 24 hours, this is currently at a week. 30% of discharges discharged with no further referral provided. Risk of patient harm due to workforce, we are working at between 5-13% currently at 1.8. There is no MDT. Currently no resource for change. Risk score reviewed and validated: 4x4:16 High risk. Also risk of regulatory action, new risk to be created to cover this. [08/12/2023 13:25:40 Gemma] Risk discussed at SPC Governance identified not able to meet KPI of 75% of referrals assessed within 24hours. This is evidence that the risk has increased and therefore would like to be considered as a high risk. Email sent to Rachel Turner to ask that this be discussed in January 2024 RRC&C [02/10/2023 10:19:22 Rachael Turner] Risk discussed at RRC&C meeting agreed to be reduced to 4x3: 12 Moderate risk. [15/09/2023 09:07:47 Rachael Turner] Risk to be presented at RRC&C to upgrade to a High risk. [14/09/2023 14:29:14 Rose Roberts] NICE quality standard for care under review by peol OG, action plan to be created. [14/09/2023 14:27:47 Rose Roberts] Case of need is now in draft form for and out for comment. Risk reduction measures are still in place. [02/06/2023 13:00:43 Maddy Ward] We have started the case of need for the SPCT. [24/04/2023 11:06:37 Maddy Ward] Reviewed at Cancer Services quarterly risk register review meeting this morning, this risk is ongoing. [03/04/2023 13:09:18 Rose Roberts] All the ongoing risk reduction measures continues. The service still operating at Opel level 2, unable to deescalate to opel 1, due to ongoing demand and available resource. Business case is being developed. This went to confirm and challenge in Sept, it was agreed it should be scored higher but subject to further discussions. Risk lead has contacted Bernie/Helen S for an update. [15/12/2022 13:39:26 Alex Measures] ongoing	4	30/12/2024		01/05/2024
5267		Physical or psychological harm	Ratcliff, Carl	Marsh, David			26/09/2023	16		Medicine	Cardiovascular CBU	Cardiology		If there is a continued delay in processing of Cardiac MRIs, which is impacted by workforce limitations and an existing backlog of scans, 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 outcomes. Cardiac MRI backlog was recorded at 125 11th September, this went down to 72 2nd October, this backlog continues to be monitored.	1.Outsourcing some CMR reporting to Medica - they will be reporting ten studies per week for the foreseeable future, which is around one third of our current reporting workload. At cost. 2.Undertaking additional reporting sessions - this will help significantly with the reporting backlog but not solve causal factors. At cost.	Size of reporting backlog (number/time required) Average time for reporting of scans from date of imaging	15/01/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	1. Work with imaging colleagues to develop/review need for additional imaging consultant with CMR included in Skill-set. 2. Continue to mitigate proactively at cost via current controls.	[15/01/2024 14:28:44 Rachael Turner] There is no significant backlog. Weekly check of performance has been provided as evidence. This risk will need approval at Division in order to be reduced in score. If agreed this will go to Risk Confirm and Challenge for a reduction in score. [25/10/2023 11:12:43 Rachael Turner] Risk discussed at RRC&C meeting 25/10/2023, risk validated as 4x4:16 High Risk. [26/09/2023 15:02:00 Charles Smith] As of 11/09/23: •There are a total of 125 cardiac MRI studies awaiting reporting •The oldest scan on the reporting list is from 24 July 2023 (seven weeks) •There are 13 scans from July, 68 scans from August and 44 scans from September waiting to be reported	3	01/07/2024		15/04/2024
5095	59	Physical or psychological harm	Capon, Mrs Catherine	Sewell, Chris			24/02/2023	16		Surgery	Surgery CBU	Vascular Surgery	Pilgrim Hospital, Boston	Due to increased demand for PICC services there is a risk that within the current establishment there is a significant delay to patients. This can delay treatment, hinder flow and cause poorer outcomes for patients. 8 years ago, venous access within the Trust was classed as central lines (internal jugular insertion) and cannulas. Peripheral central catheters (PICC) were undertaken occasionally for oncology patients and portacaths and Hickman lines were done in theatre, as they still are. The vascular ACPs started to learn how to insert picc PICC lines starting from one morning clinic on a Tuesday (supported by the Consultants). The needs for PICC increased and we went to two full day clinics in a week. They were only inserting in pilgrim at that time. It was then determined that Total Parental Nutrition (TPN) needed to be given centrally and not peripherally, and the work load increased two fold. A business case was successful for a 1.0 WTE band 6 venous access nurse to take on the clinics as the work load for the ACPs was also increasing. The Royal College of Radiologists state that a PICC line should be inserted with 72 hours. However, due to the varied nature of why a line is required particulary for urgent cases this has been deemed locally as 24 hours.	At present there is one 1.0 WTE VAN (band 6) and two 22.5 hours HCSW (band 2) covering: - Lincoln clinics (in patient only) Monday (up to and including 6 patients) and a Wednesday out/in patients - Pilgrim clinics Tuesday and Thursday, both in and outpatients - All clinics have slots for up to 6 patients, however, many late referrals are received and the clinic can increase to anything up to 12 patients. This means that the VAN goes home late most nights that incurs overtime payment. This additional activity is driven through urgent care pathways and is reliant upon a stretched team to meet this demand. As services enter a a post COVID climate there has been a recognised increase in complexity of presentations due to non-presentation at an earlier point. Case of Need has been written with final finance input outstanding to then go to CRIG ACPs are trained in this procedure but should not be relied upon as takes away from other core duties and is not a sustainable. Interventional Radiology is picking up some activity although this exposes patients to radiation and is not a sustainable option. This also require anaesthetics and theatre resources.	Volume of requests against number of staff and time taken to acquire IR1 submissions - started to see an increase in incidents being reported.	19/10/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Business case established with final finance input outstanding to then go to CRIG 6 month secondment for a PICC nurse has been advertised and will require training Give consideration to training of a wider network of clinicians associated with their individual service needs	[23/10/2023 11:25:05 Nicola Cornish] Extended secondment until end of March 2024, approval and QIA for business case are ongoing [03/05/2023 10:26:45 Rachael Turner] Following further quantitative data provided this risk has now been validated as an active risk for the trust register. [26/04/2023 11:26:50 Rachael Turner] Risk needs to return to RRC&C once we have the quantitative data confirmed. Needs to look at where this risk sits as possibly more appropriate with CSS. This will be re-presented in the May RRC&C meeting. [25/04/2023 10:06:15 Chris Sewell] Due to unforeseen circumstances and long term absence the service has had to rely on the ACP and Interventional Radiology options as outlined in the risk controls. It is anticipated that they will return at the beginning of May. This has led to an increase in IR1s.	1	01/06/2023		19/01/2024

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4868		Physical or psychological harm	Farquharson, Colin	Martinez, Francisca	Medicines Quality Group	Maternity & Neonatal Oversight Group	01/03/2022	16	Risk assessments	Clinical Support Services	Pharmacy CBU	Pharmacy		Preparation of Drugs for Lower Segment Caesarean Section (LSCS). 1. Medicines at risk of tampering as prepared in advance and left unattended. 2. Risk of microbiological contamination of the preparations. 3. Risk of wrong dose/drug/patient errors. Breach of Medicines Act: Regulation 3 of the Human Medicines Regulations 2021 permits doctors to prepare medicines for administration. The expectation would be that preparation would be in compliance with current best practice and governance expectations. Regulation 214 permits parenteral administration of medicines by or in accordance with the directions of and appropriate practitioner. This practice would constitute a risk to the patient and falls outside of expected governance arrangements detailed in Advice Note for Chief Pharmacists March 2017 NHS Pharmaceutical Quality Assurance Committee which defines acceptable practice as: administration immediately after (within 30 minutes) preparation and completed within 24 hours. It is noted the Trust Injectable Medicines Policy is in compliance with this expectation.	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.	29/12/2023	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.	[29/12/2023 13:33:55 Lisa Hansford] No further update [26/09/2023 14:17:01 Rachel Thackray] Meeting to take place to review progress [20/07/2023 10:43:27 Lisa-Marie Moore] narrative updated to reflect conversation between Fran Martinez and Regional QA about breaching medicines act regulation 3 [27/06/2023 09:45:38 Alex Measures] Discussed in risk register review meeting- no further updates [01/06/2023 14:26:57 Lisa-Marie Moore] Risk assessment resent to anaesthetists - to discuss at next MQG. If no further progress to discuss with CQC [04/05/2023 14:26:40 Lisa Hansford] needs to go back to MQG [29/03/2023 10:16:01 Maddy Ward] This risk needs to go to MOpS for escalation to medicines quality group. [21/02/2023 08:53:55 Paul White] Note from Risk Register Confirm & Challenge Group - risk to be reviewed from Family Health perspective, including current rating and where responsibility for the risk should belong. [05/01/2023 14:08:19 Lisa-Marie Moore] To be raised again at MQG and action to be taken agreed Following a Datix (ref no: 255637), it has been identified that intravenous medication required for a Lower Segment Caesarean Section (LSCS) is being prepared in advance of the procedure in case of an emergency. The Lead Obstetric Anaesthetist has discussed the practice with the team and the consensus is that for safety the drugs need to be prepared in advance for potential emergencies. The team has sourced tamper proof drug trays to store the drugs once prepared. This risk assessment has been done for Pilgrim Hospital, Boston. However, the practice seems to replicate at Lincoln County Hospital. Full risk assessment is attached to Datix. 17/5/22 No change 150622 Ongoing awaiting confirmation on drugs that can be bought in. Risk is in the medical quality drugs agenda to agree and finalise.	4	30/09/2022	31/03/2023	29/03/2024
4843		Physical or psychological harm	Dunning, Mr Paul	Costello, Mr Colin	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)	29/12/2023	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.	[29/12/2023 13:42:16 Lisa Hansford] No further update [26/09/2023 14:14:06 Rachel Thackray] Progress ongoing with regard to shared care [27/06/2023 09:45:04 Alex Measures] Discussed in risk register review meeting- no further updates [26/06/2023 13:55:27 Lisa Hansford] Risk discussed with Paul Dunning. Sue Leo to give PD list of patients that this effects. PD to review information and discussed with NHSE again. [01/06/2023 14:32:36 Lisa-Marie Moore] Meeting arranged to happen with Paul Dunning [04/05/2023 14:21:25 Lisa Hansford] meeting to be arranged to review the process for reviewing patients [29/03/2023 10:06:27 Maddy Ward] We have raised the risk today to quite likely and the medical director needs to review the process for review of these patients by an immunologist. [20/12/2022 14:25:21 Alex Measures] No further progress 19/07/21 - Shared care document was sent to NUH for review. However, NUH business unit manager expressed difficulties to advance on the SCA due to staff shortages in immunology division. Dr Neill Hepburn will discuss with NHS England regarding next step. 150622 ongoing until get an immunologist in the trust.	4	01/10/2021	31/07/2023	29/03/2024
4935	58	Service disruption	Farquharson, Colin	Daniels, Mrs Samantha	Workforce Strategy Group	Patient Safety Group, WORK	26/05/2022	16	Workforce Metrics	Surgery	Theatres, Anaesthesia and Critical Care CBU	Critical Care		Insufficient medical staffing in Intensive Care Units at Lincoln and Boston. Uncovered shifts may result in Unit being decompressed. Medical staff asked to work extra hours compromising workforce directive. Unsafe cover in Unit when doctors are called to attend patients in A&E. Could result in harm to both patients and staff (in terms of wellbeing/morale).	Locums to recruit. Recruitment adverts out. Staff are being paid in TOIL in order to mitigate the financial risk to staff. Rotas are set and monitored -a Consultant formulates the rota and identifies gaps which cannot be covered in advance. Agency requests. Escalation to Divisional Triumvirate when gaps cannot be filled. Escalations are made to the medical director re payment agreements in accordance with NHSE/I policy. Business Continuity Plans are in place for both sites.	Rotas (gaps). Agency spend - financial risk. Number of Datix incidents recorded.	16/11/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Recruit to vacant posts.	[18/11/2023 21:05:16 Nicola Cornish] No change to risk score. Have an ICU oversight group with x 3 workstreams one of which is workforce. Meets weekly to look at recruitment and medical workforce. We have recruited trainee ACCP's which won't solve current issues but is future planning. [15/06/2023 09:32:33 Wendy Rojas] No change to risk status.beds capped at x8 L3 [18/04/2023 13:52:46 Caroline Donaldson] No change in risk status. Bed base number remains at x8 Level 3 beds. [09/01/2023 14:27:52 Caroline Donaldson] No change in status - still remains an issue. Bed base numbers remain reduced at x8 Level 3 beds. [29/11/2022 15:16:01 Caroline Donaldson] 17/11/2022 Discussed at TACC CBU governance meeting. Still remains an issue. [19/10/2022 15:22:43 Caroline Donaldson] 19/10/2022 CBU are looking to request an escalated rate for recruitment. Paper is currently in progress to request. Confirmed by S Daniels. Quality Impact Assessment undertaken and LCH ITU reduced to 8 x L3 bed equivalents on a temporary basis. For review Update 25.7.22 - substantive advert closes 8th August 2022. Locum advert is closed but awaiting shortlisting. Awaiting confirmation of interview date but looking like 27.9.22. Escalated to Medical Director and COO re decision to continue L3 equivalent reduction at current time.	4	31/10/2022		16/02/2024
5142		Physical or psychological harm	Ratcliff, Carl	Smith, Charles			12/04/2023	20		Medicine	Urgent and Emergency Care CBU	Accident and Emergency	Lincoln County Hospital	Within Lincoln and Pilgrim Emergency Departments there is a risk that, given increases in demand/footfall, the current staffing template for middle grade doctors overnight may not provide assurance to maintain patient safety.	Utilisation of on-call Consultant to support dependant on holistic risk. Specialty support and signposting to other directorates and providers. Full capacity protocol and boarding.	4 hour target/12 hour breaches. Time to first assessment. Decision to admit.	09/01/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	ED Rota and workforce review with new rotas to provide effective cover overnight in all areas at all grades. New rota templates signed off by finance, to be implemented Q3 2023. Recruitment ongoing.	[09/01/2024 15:09:37 Rachael Turner] Risk remains the same. Increased winter slippage funding that lets us have extra middle grade shifts. Consultation due end of Feb/ March. [17/10/2023 10:11:32 Rachael Turner] This remain the same due the consultation in place. This remains to go out to bank and agency until staff are recruited. [26/09/2023 14:46:05 Charles Smith] Tier 2 MG consultation extended and ongoing. Mitigation via locum/bank until then. [30/08/2023 11:24:12 Carl Ratcliff] will review post meeting with exec on 30th August 2023 with action plan in place to manage more of the ED risk [15/08/2023 11:15:38 Helen Hartley] This will align into the medical workforce tier 2 recruitment process as per risk 5020 Also links into overcrowding piece. [19/07/2023 15:54:10 Helen Hartley] This has been looked at and updated, remains and will review next month [13/06/2023 11:09:55 Helen Hartley] Risk reviewed, level remains the same. Agreement for workforce plan has been given, adverts going out imminently. [07/06/2023 12:52:03 Rachael Turner] Risk discussed at RRC&C meeting 07/06/23 Risk added following three escalations. Night cover increased from 5 to 6 after funding secured. As recruitment comes on board risk will reduce. Risk score 4 x 4 at a score of 16. [24/04/2023 12:18:07 Carl Ratcliff] Review underway of short term ability to support more staffing at night by changing some shifts from day team	9	31/08/2023	01/11/2023	09/04/2024

ID	DCIQ ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
4646		Physical or psychological harm	Dunderdale, Karen	Gibbins, Donna	Clinical Effectiveness Group	NIV Working Group	14/12/2021	20	Policy/Protocol Issues, Risk assessments	Medicine	Specialty Medicine CBU	Respiratory Medicine	Trust-wide	If the Trust is not consistently compliant with with NICE Guidelines and BTS / GIRFT standards to support the recognition of type 2 respiratory failure then there may be delays to the provision of treatment using Non-Invasive Ventilation (NIV), resulting in serious and potentially life-threatening patient harm.	National policy: - NICE Guideline NG115 - COPD in Over-16s: diagnosis and management - NICE Quality Standard QS10 - COPD in Adults - British Thoracic Society (BTS) / Get It Right First Time (GIRFT) standards for NIV ULHT policy: - Guidelines and Care Pathway for commencing Non-invasive Ventilation (NIV) in the non-ITU setting - NIV-trained clinical staff - Dedicated NIV beds (Respiratory wards) ULHT governance: - Medicine Division clinical governance arrangements / Specialty Medicine CBU / Respiratory Medicine - Trust Board assurance through Quality Governance Committee (QGC) / lead Patient Safety Group (PSG) / NIV Group and Integrated Improvement Plan (IIP) / Improving Respiratory Services Programme	- Frequency and severity of patient safety incidents involving delayed NIV - recent history of rare but serious harm incidents - Total elapsed time from Type 2 Respiratory Failure (T2RF) suspicion to commencement of NIV <120mins - not being met at LCH or PHB as of Dec 21 - Start time for NIV <60mins from Arterial Blood Gas (ABG) - not being met at LCH or PHB as of Dec 21 - NIV progress for all patients to be reviewed (once NIV commenced) < 4hours - not being met at LCH as of Dec 21 update: There is a NIV audit captured monthly which determines both trust wide compliance and site specific- this is shared through PRM and available for cabinet and CBU governance meetings	23/01/2024	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.	[23/01/2024 14:57:00 Rachael Turner] Meeting is planned in March to discuss NIV and ED, previous meeting were stepped down due to industrial action. We continue to see Datix incidents relating to NIV in ED. Meeting needs to take place before any change can be made. Support is needed for phase 2 of respiratory programme. This will be a priority for 2024. Risk score currently remains. [02/11/2023 10:11:07 Rachael Turner] Currently still do not have Trust-wide provisions- this will be picked up as part of phase 2 of respiratory programme. Whilst we have a robust process in place we continue to have issues with availability of ringfenced beds on both sites and education in ED and therefore are not consistently meeting the national standards. We have a planned meeting to discuss the last years performance. Following this, the risk will be reviewed looking at lowering the score but not remove at this point. [30/08/2023 11:21:21 Carl Ratcliff] to discuss with CBU and review ability to close or reduce [07/08/2023 17:06:10 Donna Gibbins] Funding agreed- recruited workforce continues due to agreement to ensure safe staffing Annual audit for NIV compliance complete- report to be generated and shared with Cabinet Ongoing discussions regarding provision of NIV in ED continues No SI since project commenced for NIV Full outcome of provision for Trustwide achievement not yet equal due to lack of RSU at PHB- mitigations in place to deliver a safe service Domiciliary NIV provision ongoing [23/07/2023 12:53:54 Carl Ratcliff] Funding approved for complete RSU unit in budget setting - will ask CBU for full update on project [27/04/2023 09:20:46 Silvia Tavares] update from Donna Gibbins: The risk currently remains the same. However, the following actions are being considered for June to reduce risk following the last confirm and challenge meeting: A full year review of NIV audit data will be captured and shared through clinical cabinet, once this is available a decision can be made of reducing further. Provision of National standards at PHB to be reviewed and formalised within the SOP.	4	30/09/2022	31/12/2024	23/04/2024
5143		Service disruption	Lynch, Diane	Parkin, Mr Lee	Trust Leadership Team, Estates, Infrastructure and Sustainability Committee, Service Improvement Group, Information Governance Group, Outpatient Improvement Group, Patient Safety Group, Information Governance Group, Outpatient Improvement Group, Patient Safety		13/04/2023	25		Clinical Support Services	Outpatients CBU	Choice, Access and Booking	Pilgrim Hospital, Boston	The demolition of H Block will remove facilities and amenities that the health records teams utilise. The impact of removing the lift will restrict the movement of patient notes and potentially the number of patients being seen in outpatients. The health records team will need to move notes in the dumbwaiters which is previously resulted in injury and legal action. With using the dumbwaiters, this will impact information governance and security of notes due to the storage and location. Staff morale will be impacted due to extra manual handling and loss of amenities required to support with mitigating this risk. This risk also has an impact on staff workload due to extra time the tasks will now take, this will also have a knock on effect to other services such as porters, secretaries. With no lift to support the department if any large items fail i.e printer or racking, replacement items will be unable to be delivered.	There is addition of dumb waiter(x2). Health & Safety risk assessment on the dumbwaiters limits the capacity to two boxes. Process in place to ensure notes are either with a member of staff or in lockable storage areas.	Patient cancellation, waiting times and waiting list increase for patients due to patient notes being unavailable or delayed. Staff survey results. Staff sickness/injury through Occupational Health and ESR.	14/02/2024	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	To reduce the impact the team will use dumb waiters, one of which is in another area with limited access. Change of processes to mitigate risk and transfer notes over a longer period. Walk around with senior individuals and project team to look at different ways of working and potential solutions. Risks to be highlighted in QIA. Risk to presented at PRM. Health and Safety guidance to be delivered to Team. Further discussions to be had regarding whether all clinicians requiring paper based notes in clinic.	[14/02/2024 11:29:24 Rachael Turner] The risk rating has been requested to be increased by the QIA panel (including Karen Dunderdale / Kathryn Helley / Paul Dunning) due to issues with getting notes to clinics and the cancellation of patients, the health and safety risk of other areas of the hospital as notes are unable to be returned to the library, increased sets of notes that are unable to be located, the physical injuries suffered by the staff and the claim being investigated by the legal team for injury to a staff member.Risk to be presented at Risk Register Confirm and Challenge in February. [01/02/2024 12:38:56 Gemma] [01/02/2024 10:47:42 Rachael Turner] Risk to be added to the Risk Register Confirm and Challenge agenda in February to validate increase in score. Until new risk score validated risk score to remain at 15-High Risk. [19/01/2024 10:04:46 Gemma] Funding has been agreed to replace the lift, upgrade one of the dumb waiters and to refurbish the toilets and kitchen areas - he contract has been agreed. Initially hoping to finish this project before financial year end. Risk score was increased to 20 following January's QIA Panel meeting. [30/10/2023 14:10:23 Emma Cripps] Funds have been found and agreement in place to build a lift directly into Health Records at Pilgrim. Existing dumb waiter to be upgraded. Both works are currently out to tender. [08/09/2023 10:41:51 Maddy Ward] An options appraisal has been completed by estates. This is being reviewed by finance in conjunction with estates to decide which option is going to be implemented. [06/06/2023 11:08:10 Maddy Ward] Since meeting on 26/04/2023, we have met with the CSS DMD, Head of Capital Projects and Estates team are going away to cost up the various works needed. To discuss with the exec team. Highlighted risk is contributing to risks across the PHB site and a number of datix have been registered highlighting health and safety risks. [26/04/2023 11:42:09 Rachael Turner] Risk presented at Risk Confirm & Challenge 26/04/2023 for validation. This was agreed as scoring as a 15-High risk. Escalation is required to look into alternative measures to support with this risk, possibly looking into Electronic records.	1	01/05/2023		19/04/2024
5169		Physical or psychological harm	Ratcliff, Carl	East, Mr Sean			09/05/2023	15		Clinical Support Services	Therapies and Rehabilitation CBU		Lincoln County Hospital	Approx 15-20 Stroke outliers at any time on the LCH site. Therefore not on the stroke unit and not receiving specialist stroke therapy at the frequency and duration required by SSNAP. Outlier patients are not cohorted on site and can be on any ward therefore Stroke staff cannot go and review and advise. Stroke patient on other non stroke ward will not be assessed as a priority as they are not medically optimised and ready for discharge. Current staffing levels are for the 28 bedded Stroke unit only. If a stroke patient is seen o a non stroke ward this is to the detriment of another patient on that ward. Increased staff stress. General wards do not have the treatment facilities that Stroke patients need.	Stroke Therapy Team review all outliers at the cost of not seeing the Stroke ward patients as much. Stroke team will advise general ward based therapy team. Minimal basic Stroke assessment and treatment skills for general ward therapy staff. Proposal to implement Trusted Assessor Stroke Assessment.	Datixes M&H injury to staff and patient	05/02/2024	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Moving of Stroke specialist therapy staff from PHB to LCH Robust stroke training plan for general ward staff Attendance at Stroke Board to influence change and need for cohorting of outliers Review of Stroke staffing in line with latest staffing levels needed 16/10/23 funding transferred to LCH budget to help support staffing and recruitment has started	[05/02/2024 11:11:38 Gemma] Risk reviewed and is still ongoing [16/10/2023 11:12:34 Sean East] 16/10/23 funding transferred to LCH budget to help support staffing and recruitment has started [08/09/2023 14:20:40 Maddy Ward] Consultation in progress currently with the intention to move some money across to Lincoln. This links in with joint working with LCHS. [23/06/2023 14:13:54 Rose Roberts] No change, went to C&C recently and level agreed. [07/06/2023 12:45:33 Rachael Turner] Risk discussed at RRC&C meeting 07/06/2023. Hyper acute patients outlied to LCH site.Specialist staff not currently available to support these patients. Patients are at risk due not being put into priorities causing delays.This causes a risk of patient harm due not progressing or adding to disability due to not being seen in appropriate pathway. This is also impacting is discharging delays to patients. More work is also required with the community. Score agreed at 15	8	13/05/2024		06/05/2024
Strategic Objective							**1b. Improve patient experience**																				
5234		Service disruption	(Historical Deleted User)	Fulloway, Mr Ian			25/08/2023	15		Clinical Support Services	Diagnostics CBU	Neurophysiology		No clinic space at Pilgrim Hospital resulting in only ad-hoc provision of outpatient nerve conduction testing at the hospital. Previous clinical space was taken from the service due to ED/UTC projects with temporary agreement for clinic room (agreed in 2020) ending in October 2022 with PHB physiologist retirement. No EEG or EMG service provided at PHB currently. No Inpatient provision for testing at PHB. Inpatients requiring tests have to be transferred by hospital transport to Lincoln County for testing. Current risk is not being able to restart the service. At the moment, this is an unequitable health offering.	Adhoc bookings of space available within Outpatients at PHB. Booked where and when possible.Recruitment of new overseas Physiologist has been undertaken and completed. The staff member is fully trained and ready to start clinics in PHB when appropriate, permanent space is provided. Space must meet IPC requirements.	Waiting times, travel times, Patient Feedback, IP LOS impacted by the service being unavailable on site.	31/01/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Adhoc sessions being booked for Outpatient provision where space can be found. No plan for IP on site.	[31/01/2024 11:37:43 Rachael Turner] Risk discussed as part of the Deep Dive at RRC&C meeting 31/01/2024. Risk score reviewed and updated to 4x4:16 High risk. [11/12/2023 13:05:50 Gemma] Risk reviewed. No change [13/09/2023 12:20:09 Maddy Ward] From an estates point of view, there is no plan to restart the service. This has been passed to project manager in estates to review clinical space (chased today). A suitable sized, permanent room is required. Started space request in September 2022 and meeting in July 2023. There has not yet been a date given for a clinical space review.	3	26/08/2024		30/04/2024

ID	DCIQ 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
4701	85	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.	22/01/2024	Reasonably likely (3) 31-70% chance	Extreme (5)	High risk (15-16)	15	Plans for refurbishment of Maternity units on both sites, estimated timescales 3-5 years for LCH, PHB to be confirmed. Full Business Case required. Maternity shared decision council looking at simple solutions for improving working lives of staff.	[23/01/2024 16:04:20 Nicola Cornish] The team are continuing to work with architects to develop plans, which are expected to be submitted to the Trust board for approval by 31st March. [17/10/2023 09:30:32 Nicola Cornish] Nettleham have moved to Langton, in process of issuing purchase orders for design team and healthcare planners have visited Pilgrim. Meetings to schedule accommodation. [04/07/2023 09:11:47 Alex Measures] Risk reviewed 03/07/2023- Nettleham has decanted to 1st Floor to allow for works to commence as per plan. [04/04/2023 12:45:23 Jasmine Kent] Predicted date for decanting Nettleham to Langton 02/05/2023. While awaiting funding for refurbishment of Nettleham. Drain work at Pilgrim site is scheduled. [23/01/2023 17:04:59 Jasmine Kent] Included within capital allocation bids for next financial year. Agreement from trust board that works will take place in next financial year. Staff engagement sessions to communicate refurb plans. Issues dealt with by Estates & Facilities as they occur. 13/04/2022: Mitigation plan - full board approval to progress the business case. Require monitoring of staff surveys. CQC report demonstrates unsuitable for use - amended to 3 impact and 5 occurrence = 15 26/09/2022 - Unchanged	6	31/03/2025	31/03/2025	22/04/2024
4724		Physical or psychological harm	Lynch, Diane	Taylor, Ruth	Workforce Strategy Group	Patient Experience Group	13/01/2022	20	Risk assessments	Clinical Support Services	Therapies and Rehabilitation CBU		Lincoln County Hospital	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.	05/02/2024	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Review current provision and identify gaps in service to inform business cases for change (working with Surgery and Medicine Divisions as appropriate). Skill mix requires review due to complexity of patients. Prioritisation tool helps to identify patients with greatest acuity or importance which will directly impact patient flow and current bed situation.	[05/02/2024 11:06:18 Gemma] Risk reviewed and ongoing. [06/12/2023 13:09:39 Gemma] Conversations are currently happening in regards to appropriate staffing levels for ICU for Therapy Services. Further update to follow [25/10/2023 15:07:18 Rachael Turner] Business case being undertaken by CSS, needs to go through approval process. [08/09/2023 14:14:43 Maddy Ward] Reviewed at quarterly risk register review meeting. Risk is ongoing at present. [23/06/2023 14:07:53 Rose Roberts] Recruited into the Neuro psychology post. Increase risk in consultant cover - sickness and resignation. potential to have to stop admissions. [10/03/2023 13:43:06 Rose Roberts] Awaiting nhse results. Neuro psychology bid waiting to go to CRIG [13/01/2023 12:51:48 Lesley Bradley] 13/1/23 NHSE reviewed Ashby ward this month-await recommendations for staffing levels [15/12/2022 09:53:21 Alex Measures] No update [30/11/2022 10:04:52 Rose Roberts] Neuropsychology bid is still awaiting CRIG approval as CRIG has been stood down. Business cases completed for all areas. 130622 Neuropsychology bid is going to CRIG this mth. All others to be confirmed. Work in progress.	4	05/01/2024	31/03/2023	06/05/2024
Strategic Objective								**1c. Improve clinical outcomes**																			
4731		Physical or psychological harm	Frake-Harris, Julie	Dunning, Mr Paul	Medical Records Group	Patient Safety Group	13/01/2022	20	Risk assessments	Clinical Support Services	Outpatients CBU		Choice, Access and Booking	Trust-wide	If patient records are not complete, accurate, up to date and available when needed by clinicians then it could have a widespread impact on clinical services throughout the Trust, potentially resulting in delayed diagnosis and treatment, adversely affecting patient experience and reducing the likelihood of a positive clinical outcome.	- Clinical Records Management Policy (approved June 2021, due for review December 2023) - Trust Board assurance via Finance, Performance & Estates Committee (FPEC); lead Information Governance Group / Clinical Records Group - Now led by Deputy Medical Director.	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.	05/02/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Design and delivery of the Electronic Document Management System (EDMS) project, incorporating Electronic Patient records (EPR). Interim strategy required to reduce the risk whilst hard copy records remain in use.	[05/02/2024 15:41:56 Gemma] Risk reviewed and is ongoing until an electronic health record is introduced. [23/01/2024 17:56:20 Gemma] There have been communications sent out to all clinical colleagues to remind them to ensure that patient records are and accurate and available. The Clinical Records Group Chair, will also request a quarterly report to be discussed at the meeting to ensure that any trends/issues are highlighted. [21/11/2023 08:38:09 Anita Cooper] Clinical Records Group now led by Deputy Medical Director therefore risk agreed to sit with DMD with input from Outpatients/Health records team. [30/10/2023 14:17:15 Emma Cripps] No further progress update [08/09/2023 10:45:27 Maddy Ward] Risk reviewed at Outpatients Quarterly Risk Register Review this morning. No further updates at present No further change since last review. [01/08/2023 15:35:42 Lee Parkin] No change since last review 06/06/2023 [06/06/2023 11:46:11 Maddy Ward] Still a very high risk with ongoing concerns. Will be a risk until electronic records are implemented across the trust. To mitigate the risk until that time the records management policy has been updated and communications will be sent by the Medical Director clarifying the protocols on current use of notes. [11/04/2023 11:47:33 Rachael Turner] Risk re-opened until electronic records are implemented. [05/04/2023 10:47:54 Rose Roberts] Email from KB - this can now be closed, updated records management policy now published. [29/03/2023 09:53:02 Anita Cooper] New ToR agreed at IG Group for CRG to become a Trust-wide group, chaired by Deputy Medical Director. Relaunch planned following approval at TLT which will require greater Divisional representation and a broader agenda. [06/03/2023 11:17:40 Maddy Ward] This risk is still ongoing, EPR not yet signed off. [02/02/2023 15:31:12 Rose Roberts] KB going to ask crg meeting if the new policy has been signed off. [15/12/2022 14:24:51 Madeline (Maddy) Ward] Ongoing, issue raised with clinical records meeting with control of health records for resolution, further meeting to be held mid-December [29/11/2022 11:04:59 Rose Roberts] Policy still awaiting final ratification so please extend by 1 month.	4	30/06/2018	31/03/2025	05/03/2024

ID	DCIQ 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	Marsh, David	Patient Safety Group		28/04/2022	16	Professional Guidance	Medicine	Cardiovascular CBU	Cardiology		Increase in risk of delays to patient care/harm as a result of increasing backlog of planned care activity across Cardiology arising from Covid19 constraints / service restrictions/ site escalation pressures.	additional clinics/lists (cost pressure) additional staffing where feasible to increase capacity (cost pressure)	weekly monitoring of RTT and PBWL	15/01/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	-Weekly waiting list meeting -Weekly RTT meeting For both of these we make plans for all patients that are 45 weeks and over. This will be ongoing. -Review in place for all our pathways-this is continually at present so we can re-design with the correct cohorts.	[15/01/2024 14:33:03 Rachael Turner] Waiting lists are coming down with regular monitoring and validation. We have now adopted a 6 4 2 process for booking our waiting list slots. Performance is reported through Governance PRM every month. Risk Reduction plan reviewed and updated. [16/10/2023 16:34:58 Rachael Turner] The Cardiology waiting list has been extensively validated and has been reduced. Our biggest backlog on the waiting list is loop recorders and we are holding a three day "loopathon" 14-16th November where 96 patients will be treated. New Patient appointments-they have been hampered by industrial action, we have extensive validation. We have reduced the number of 52 week breaches. Our RTT position is 49.35%. We are undertaking a review of clinic templates to make sure clinicians are seeing the correct number of new and follow up patients per clinic. Remote monitoring-we have case of need going to CRIG in November to put 500 patients a year on remote monitoring, this will make a better experience for patients. Just bid for specialised funding to reduce our backlog with tapes, currently have 2700 patients waiting. [16/10/2023 16:34:45 Rachael Turner] The Cardiology waiting list has been extensively validated and has been reduced. Our biggest backlog on the waiting list is loop recorders and we are holding a three day "loopathon" 14-16th November where 96 patients will be treated. New Patient appointments-they have been hampered by industrial action, we have extensive validation. We have reduced the number of 52 week breaches. Our RTT position is 49.35%. We are undertaking a review of clinic templates to make sure clinicians are seeing the correct number of new and follow up patients per clinic. Remote monitoring-we have case of need going to CRIG in November to put 500 patients a year on remote monitoring, this will make a better experience for patients. Just bid for specialised funding to reduce our backlog with tapes, currently have 2700 patients waiting. [27/09/2023 11:37:05 Rachael Turner] Risk discussed at RRC&C meeting as part of the Deep Dive risk needs a review with updates. [05/09/2023 08:39:25 Charles Smith] Service yet to recover from backlogs developed during COVID for variety of reasons. Most recently exacerbated by ongoing IA. 1xcons now in place, further to start in next 2/12. Additional clinics/ILR lists when possible.	8	15/01/2025	01/03/2024	15/04/2024
5154		Regulatory compliance	Simpson, Mr Andrew	Hansford, Lisa			17/04/2023	16		Corporate			Trust-wide	The Trust currently does not have a Medicines Management or Intravenous Drug Training package on ESR. Previous Medicines management training was removed when the ESR software was changed. Usually all new nurses will be required to complete the medicines management training as part of the mandatory training. This is to support them to be able to administer medicines to patients. Without a robust Medicines management training package staff will not have access to the r Medicines Management training that has previously been available, which is not in line with Trust standards. This could potentially lead to harm to our patients from medication incidents, we will not be adhering to CG174, NG29, SG1 and QAPPS minimising injectables risk. Risk of breaching CQC regulation 12: Safe care and treatment also	All staff will have had undertaken some level of medicines management as part of their professional qualification, however standards are inconsistent and not aligned to trust standards. National (CG174, NG29,SG1) and Local policies and guidance indicate that training should be available to staff to support in administration and safe medicines management. Additionally won't be compliant with QAPPS in relation to minimising injectable medicines risks. CQC regulation 12: Safe care and treatment all indicated training should be available. None currently in place in the Trust. There are new staff that have comenced employment with the organisation that cannot access the trust medicines management training and ward and department leads require a decision to be made as to whether or not these staff can administer medication.	Reported incidents, Staff feedback on training and support available in staff surveys. Inspection feedback	29/12/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	The Medication Safety Team have written the Medicines Management, Controlled drugs training and the Drug Administration Programme. These training documents are also to be supported by the nationally recognised eLearning for health IV therapy passport. These training packages are under review by MOpS group before they can go through the governance process. The governance process is likely to take a number of months. There is then the added task of getting the training packages put onto ESR and mapped to the correct staff. ESR team is severly understaffed which may delay the process further. As an interim measure to reduce this risk level, once the training packages have been through the relevant governance processes, there could be the option to add the training power points to the Trust intranet. This would not be mapped to staff members, however we could signpost staff to this and local training completion records could be kept by the ward/department leads.	[29/12/2023 12:57:50 Lisa Hansford] Awaiting education and training team to upload to ESR [06/12/2023 14:55:35 Gemma] Training packs signed off through governance process Awaiting update from Education and Training team when these will be uploaded to ESR. Delay in this due to vacancy in their team [07/09/2023 14:09:00 Lisa Hansford] 7.9.23 Signed off by APPG and will go to NMAFF on 8.9.23 for final ratification [13/06/2023 12:46:40 Lisa Hansford] Training packages to be signed of by MOpS by 20th June. Then will continue through the governance process before they can go on ESR [04/05/2023 14:24:40 Lisa Hansford] No update as waiting to go through MOpS process [26/04/2023 11:14:07 Rachael Turner] Risk validated at RRC&C Meeting 26/04/2023 as a score of 16 High Risk. Risk to go to Medicines Quality Group to expedite risk.	8	17/04/2024		29/03/2024
4866		Service disruption	Costello, Mr Colin	Saddick, Ahtisham	Medicines Quality Group		01/03/2022	15	Risk assessments	Clinical Support Services	Pharmacy CBU	Pharmacy		Recruitment of ULHT pharmacy technicians to ward-based clinical pharmacy roles affects the balance of the pharmacy workforce and impacts on the core pharmacy service provided	Pharmacy should be fully involved in the development and implementation of these roles. The Chief Pharmacist is accountable for the professional management of these roles, however there is not a clear understanding of the supervision and development framework for the new roles.	Monitoring of Pharmacy Technician performance	29/12/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	To develop a robust supervision, training and development framework for the new pharmacy technicians roles. 1. To undertake a quality impact assessment to evaluate the potential impact on pharmacy services. 2. To develop a robust NVQ apprenticeship training scheme to train band 2/3 staff to band 4/5 roles both on the wards and in pharmacy services to achieve a sustainable pharmacy technician workforce in order to support all pharmacy technician roles.	[29/12/2023 13:54:44 Lisa Hansford] No further update [07/11/2023 14:12:59 Lisa Hansford] Update- Variable ward based technician support is being provided for clinical pharmacy cover for admission areas. Risk is ongoing as there is still the possibility of staff movement to WBT roles therefore leaving gaps in core services [26/09/2023 14:15:54 Rachel Thackray] Risk remains, awaiting further update [07/09/2023 14:11:26 Lisa Hansford] 7.9.23 no further updates [27/06/2023 09:45:21 Alex Measures] Discussed in risk register review meeting- no further updates [01/06/2023 14:31:32 Lisa-Marie Moore] Discussion with CSS Division on how techs could be used to support pharmacy [28/03/2023 15:04:33 Rachael Turner] Risk proposed to be increased to a 16, this will be presented at RRC&C meeting 29th March. [20/12/2022 14:39:34 Alex Measures] no further updates Scheduled project due to commence March 2021, monthly reports will be provided. Monthly ward based	16	30/11/2021	28/04/2023	29/03/2024
Strategic Objective							**2a. A modern and progressive workforce**																				
4844		Service disruption	Lynch, Diane	Costello, Mr Colin	Workforce Strategy Group	Medicines Quality Group	19/01/2022	20	Risk assessments	Clinical Support Services	Pharmacy CBU	Pharmacy		The ability to provide a seven day a week pharmacy service requires a level of staffing above the current levels. Benchmarking has taken place against peer Trusts for staffing levels. Until this is funded the seven day a week service is unobtainable and this puts patients at risk.	Service planning & annual budget setting processes: Pharmacy / CSS Division	Staffing levels / budget benchmarked against other similar trusts. Reported medication incidents occurring out of hours.	13/02/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Pharmacy supply a limited Saturday and Sunday morning service with staff working beyond their contracted hours. An on-call pharmacist is available for EMERGENCY items only. A Business Case has been submitted to CSS CBU.	[13/02/2024 11:52:19 Gemma] Risk reviewed, no further update. [17/01/2024 12:06:01 Gemma] No further update [19/12/2023 13:27:34 Lisa-Marie Moore] Meeting with MD 18/12 to discuss business cases Pharmacy phase 2 improvement plan in progress [28/11/2023 12:09:20 Rachael Turner] Risk score remains, no further update. [30/10/2023 12:40:52 Rachael Turner] No changes, risk ongoing. No further updates at this time. [26/09/2023 14:05:31 Rachel Thackray] No changes as yet made, meeting to take place with Medical Director [03/08/2023 14:49:28 Lisa-Marie Moore] No further updates [27/06/2023 09:47:18 Alex Measures] Discussed in risk register review meeting- no further updates [01/06/2023 14:18:15 Lisa-Marie Moore] No change/update since previous entry [06/04/2023 12:53:22 Paul White] Discussed at Risk Register Confirm & Challenge 29 March, risk agreed with feedback provided for consideration. [09/02/2023 10:43:37 Paul White] Status changed to awaiting approval pending review by division and validation by Risk Register Confirm & Challenge Group. [22/12/2022 14:55:29 Rose Roberts] Confirmed with Paul White that the risk level can be raised here and confirm and challenge will invite the risk lead to discuss it. [20/12/2022 14:35:39 Alex Measures] Business case was not approved, currently stalled, raised to high risk today but the meeting feels it should be very high risk because it would be very likely to happen, to be taken to confirm and challenge to be upgraded 150622 ongoing business case in process of being written	4	29/10/2021	28/04/2023	13/03/2024

ID	DCIQ 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
4996	39	Service disruption	Dunning, Mr Paul	Chester-Buckley, Sarah	Workforce Strategy Group	Patient Safety Group	22/08/2022	16		Clinical Support Services	Cancer Services CBU	Haematology (Cancer Services)		Staffing - insufficient consultant workforce to meet demand. Particular areas of concern: 1. Lymphoma tumour site cover 2. Haemostasis/haemophilia (single consultant Trust wide) 3. Pilgrim Consultant cover 4. Clinical governance lead 5. Head of Service for haematology 6. Transfusion Lead from 17th July 23 (w/o this unable to run transfusion lead) 7. Audit Lead	* Completed a fragile services paper * Additional/extra clinics being undertaken where possible 1. Only 1f/t consultant and 1 p/t consultant who is covering nearly f/t hours. 2. Only 1 f/t consultant covering Trust wide. Unable to mitigate risk during a/l or unexpected absnece. Requirement to discuss with neighbouring Trust eg Notts. 3. Mitigated by high cost agency consultant cover. 4. CG lead duties shared between consultants but no one wishes to take on role. 5. HoS duties divolved to clinical lead for onc and haem and/or CD for CSS	* New referrals and PBWL show ongoing capacity issues. * RTT and cancer performance below target. * Increased PA's for substantive consultants. * Increased Datix, Complaints and PALS * Outcome from Staff Survey results	27/02/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	* Workforce review - Now Completed (Sarah Chester-Buckley - July 2023) * Refresher of Fragile Services Paper - NB there is a National shortage of Haematology consultants - Now completed (Sarah Chester-Buckley - September 2023) * Recruitment of further substantive consultants - (Sarah Chester-Buckley - May 2024) * Additional unfunded ST3+ for Haematology starts in August 2022 - Now completed (Sarah Chester-Buckley - July 2023)	[26/02/2024 16:46:18 Gemma] Transfusion Lead now appointed, start date 01.02.2024. Awaiting start date for Haemostasis/Haemophilia Consultant. [31/01/2024 14:33:09 Gemma] Risk reviewed and ongoing [18/01/2024 11:10:07 Gemma] Haematology rightsizing paper taken to TLT and approved, now needs to go to the Board and ICB investment panel. [22/12/2023 08:19:28 Gemma] Haematology rightsizing paper (SBJC) presented and approved at CRIG 19/12/23. Now needs to be presented at Board and ICB investment panel. Further update to be provided at a later date. [02/11/2023 15:31:05 Vicky Dunmore] Haem rightsizing business case to be present at CRIG Nov 2023 [14/09/2023 15:01:43 Rose Roberts] Rightsizing Haem paper to be presented at CRIG Sept 2023. [03/08/2023 10:00:17 Rachael Turner] Following the briefing paper being received by ELT, weekly meetings have been set up with DL,EM,LR and MH. An action plan has been put in place. A meeting was held with the Haematology Consultants, Andrew Morgan and Michelle Harris on 31.07.2023 and it was agreed to go out to advert for 4 Haematology Consultants, 1 Haematology Secretary and 2 Secretary Assistants. [02/06/2023 12:38:22 Maddy Ward] Andrew Morgan requested a briefing paper for ELT which is now complete in conjunction with transformation and due to be circulated to execs on 05/06/2023 Making enquires if transfusion lead needs to be a consultant of if another profession can pick this up. [24/04/2023 10:35:11 Maddy Ward] Haematology service review carried out on 20th April 2023 in association with strategy, planning, improvement and integration directorate [03/04/2023 09:42:15 Rose Roberts] Workforce paper with the triumvirate. Reviewed at confirm and challenge confirmed as v high risk. [15/12/2022 13:34:35 Alex Measures] all lead roles currently out to advert further recruitment ongoing	8	30/09/2023	01/04/2023	27/03/2024
5093	41	Service disruption	Simpson, Mr Andrew	Baines, Andrew	Medicines Quality Group	Workforce Strategy Group	16/02/2023	20		Clinical Support Services	Pharmacy CBU	Pharmacy		Baseline pharmacy procurement staffing is at a level where the basic functions are not routinely being delivered and the service is not able to withstand any prolonged absence due to leave, sickness or resignation. There is limited staff covering this (at times just 1 staff member).The workforce has remained relatively stable over time, however workforce pressures have been increasing over the last few years for a variety of reasons. There has been an increasing number of pharmaceutical shortages, many of which are complex in nature and need rapid action to avoid patient deaths. A growing number of drugs are now being offered on an allocation basis which requires micro management for stock ordering and distribution across the Trust. Changes in the delivery of chemotherapy have resulted in an increased demand for ordering of chemotherapy preparations. The pharmacy invoicing team have also experienced a recent increase in workload following the implementation of the Advanced finance system. This is currently 1 part time staff supported by bank staff where possible. The team are reporting concerns around workload and workplace stress. We are routinely reliant on existing staff working additional hours to fill gaps. If staff feel unable to come to work for any reason (including stress related) this will further increase the risk to the	The team comprises three part time procurement clerks (this has reduced from four) and one (reduced from two) part time invoice clerks working from a centralised office in Lincoln but responsible for trustwide ordering and invoicing, and 5 storekeepers who work across the sites, and is lead by a full time pharmacist and technician. All areas of the service are continuously working at or over capacity and any absence results in other staff working additional hours, or attempting to absorb additional duties over and above their own in order to maintain the basic service. There is theoretical potential to cross cover with members of the Homecare team who have a similar skill set, however that service is also under extreme pressure and so there is limited capacity to provide this cross cover – it is most often used to support the invoicing team at times of annual leave. Where staff have recently expressed concern about work related stress the associated risk assessment has been provided. From a procurement perspective the baseline staff level on a day is 2 purchasing clerks, so purely taking annual leave into account there are multiple weeks in the year where only 1 purchasing clerk is available to manage the ordering workload. This impacts adversely on the job role of the procurement technician who often has to backfill these gaps. This makes the team very susceptible to the effects of sickness absence, particularly if this occurs whilst another team member is on leave. On such days it is frequently not possible to meet the full basic demands for all pharmacy sites with the potential to see a reduction in order frequency from twice a day to once a day, and less capacity for chasing of outstanding orders, depending on staff availability – giving further rise to a risk of treatment delays if stock orders are not placed or chased in a timely manner.	Staff morale is low across the pharmacy department as per the last communicated NHS staff survey feedback, and direct feedback from staff within the procurement team highlights that morale within the team is challenged and wellbeing is impacted. An increase in workload due to product shortages can be evidenced with reference to the growing number of Medicines Shortage Notifications (MSNs) and Supply Disruption Alerts (SDAs) issued by the Department of Health and Social Care, which totalled 25 over the last 4 months of 2020 (following the launch of this scheme), 80 in 2021, and 89 in 2022. Whilst not measured, departmental feedback highlights a growing frequency out of stock scenarios which require investigation and follow-up (this may include taxi transfers of stock between sites, where stock is available in one of the other hospitals); these are often caused by a lack of time to follow-up orders which have not been received in a timely manner, and can be associated with delayed or missed doses, or impact on timely discharges.	17/01/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Gap analysis highlights several areas of ongoing concern (to-follows, shortage management, invoice query management, medical gas invoicing). Occasional additional support is currently being provided to the invoicing team by a Bank Pharmacy Support Worker; we are scoping training this individual to offer procurement support in addition. This post is being paid from vacancy money elsewhere in the department and so cannot be considered a long-term fix for the procurement gaps. A case of need will be prepared to identify workforce requirements to reduce the workload stress the staff are persistently facing, and to provide a robust service which can withstand annual leave and short term sickness absence, based on the more challenging pharmaceutical market we are operating in where shortages are now a daily occurrence.	[17/01/2024 12:09:36 Gemma] We have had successful recruitment but still have one remaining so still have a risk Wednesday to Friday. This is going back out to advert to help fill the gap. [17/01/2024 12:03:17 Gemma] No further update [29/12/2023 14:02:33 Lisa Hansford] No further update [18/12/2023 21:36:39 Rachael Turner] No change, recruited staff will be in post in January. Risk score to be reviewed once in post and trained. [29/11/2023 11:26:52 Rachael Turner] Risk discussed at RRC&C meeting as part of the Deep Dive. Support to fill gaps is currently in place. We have successfully recruited two posts,staff but they will not be in post until Jan 2024 and then will need to be trained. Once staff are in post this risk will need to be reviewed to look at scores. There is still a third vacancy, this post is unfunded, a business case now needs to be written to look into this. Risk reduction plan needs to be reviewed following this update. [05/10/2023 11:50:14 Rachael Turner] Risk reviewed, risk description and controls updated. The current procurement staffing levels are so the basic functions are not routinely being delivered and the service is not able to withstand any prolonged absence. There is very limited staffing, often just 1 member of staff are available to support. This risk is effects staff,patients and also has a knock on effect to other areas of the Trust. Pharmacy invoicing is also experiencing increased workload which is supported by 1 part time staff supported by bank staff where possible. There are currently vacancies that are out to advert for 2.0WTE purchasing clerks & 1.64 WTE invoice clerks). Risk score remains at 20 Very High but needs regular review. This risk will be added to the RRC&C agenda under AOB to advise of the updates and make members aware of the ongoing pressures. [26/09/2023 14:08:57 Rachel Thackray] Going out to recruitment for 2 x vacancies [14/09/2023 11:58:25 Lisa-Marie Moore] No update [03/08/2023 14:47:51 Lisa-Marie Moore] No further updates [27/06/2023 09:33:47 Alex Measures] proposal has been presented to Diane Lynch, questions have come back which need answering, locum member of staff supporting the team, managing with agency and bank staff at the moment [01/06/2023 14:14:06 Lisa-Marie Moore] No change/further update since April [19/04/2023 15:48:11 Andrew Baines] Colin Costello & Andrew Baines met with Diane Lynch on 18/4/23 -	4	16/02/2024	16/02/2024	16/02/2024
4997	41	Service disruption	Dunning, Mr Paul	Chester-Buckley, Sarah	Workforce Strategy Group	Patient Safety Group	22/08/2022	16		Clinical Support Services	Cancer Services CBU	Haematology (Cancer Services)		Service configuration - single consultant covering both sites during weekend so cover limited if critically unwell patients on both sites	Middle Grade cover in place from Oncology but not sustainable as Haematology is not their area of experise and therefore cannot replace consultant presents with acutely unwell patients.	* Increased Datix, Complaints and PALS * Outcome from Staff Survey results	27/02/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	* Workforce review - Now Completed (Sarah Chester-Buckley - July 2023) * Refresher of Fragile Services Paper - NB there is a National shortage of Haematology consultants - Now completed (Sarah Chester-Buckley - September 2023) * Recruitment of further substantive consultants - (Sarah Chester-Buckley - May 2024) * Additional unfunded ST3+ for Haematology starts in August 2022 - Now completed (Sarah Chester-Buckley - July 2023)	[26/02/2024 16:53:12 Gemma] Risk reviewed and ongoing [31/01/2024 14:32:33 Gemma] Risk reviewed and ongoing [18/01/2024 11:09:19 Gemma] Haematology rightsizing paper taken to TLT and approved, now needs to go to the Board and ICB investment panel. [22/12/2023 08:18:40 Gemma] Haematology rightsizing paper (SBJC) presented and approved at CRIG 19/12/23. Now needs to be presented at Board and ICB investment panel. Further update to be provided at a later date. [02/11/2023 15:21:13 Vicky Dunmore] Rightsizing haem Business Case to go to CRIG Nov 2023 [14/09/2023 15:02:19 Rose Roberts] Rightsizing Haem paper to be presented at CRIG Sept 2023. [03/08/2023 10:01:13 Rachael Turner] Following the briefing paper being received by ELT, weekly meetings have been set up with DL,EM,LR and MH. An action plan has been put in place. A meeting was held with the Haematology Consultants, Andrew Morgan and Michelle Harris on 31.07.2023 and it was agreed to go out to advert for 4 Haematology Consultants, 1 Haematology Secretary and 2 Secretary Assistants. [02/06/2023 12:39:17 Maddy Ward] Andrew Morgan requested a briefing paper for ELT which is now complete in conjunction with transformation and due to be circulated to execs on 05/06/2023 [24/04/2023 10:36:05 Maddy Ward] Haematology service review carried out on 20th April 2023 in association with strategy, planning, improvement and integration directorate [03/04/2023 09:43:59 Rose Roberts] Workforce paper for haem with triumvirate, then will start oncology workforce paper. Reviewed at confirm and challenge confirmed as v high risk. [15/12/2022 13:35:25 Alex Measures] ongoing recruitment ongoing	8	01/04/2023	01/04/2023	27/03/2024

ID	DCIQ 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
4741		Service disruption	Cooper, Mrs Anita	Chester-Buckley, Sarah	Workforce Strategy Group		13/01/2022	20	Risk assessments	Clinical Support Services	Cancer Services CBU	Oncology	Trust-wide	Oncology is considered to be a fragile service due to consultant oncologist gaps. Demand vastly exceeds the capacity, requiring an increase in establishment. Tumour sites at risk (Medical oncology) - renal, breast, upper and lower GI, CUP, ovary/gynae, skin, testicular, lung, urology, HPB Clinical oncology - head and neck, skin, upper GI (RT only). Due to only consultant covering Sarcoma retiring we will no longer have consultant cover for sarcoma from July 23. Lack of cover for leadership roles: Chemotherapy	Cancer services operational management processes & clinical governance arrangements Medical staff recruitment processes Agency / locum arrangements email sent to consultants to see if anyone would cover sarcoma - no capacity/specialisation	Monitoring tumour site performance data	18/01/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Need to undertake a workforce review, oncology still a fragile service, continuing to work with HR to source consultants (Vicky Dunmore - March 2024)	[18/01/2024 11:26:42 Gemma] Oncology rightsizing paper currently being written. [14/09/2023 16:04:46 Rose Roberts] Ongoing [28/06/2023 14:43:05 Rachael Turner] Following this risk being discussed at RRC&C meeting, the question was raised around the number of patients currently waiting to be seen (including overdue) These are as follows: Oncology PBWL numbers as at 29/5/23: Lincoln County Hospital: Overdue: Clinical - 171 Medical – 55 Total number of patients on PBWL (including overdue): Clinical – 2169 Medical – 226	4	31/03/2023	31/03/2023	18/04/2024
5173		Service disruption	Morgan, Mr Andrew	Warner, Jayne	Trust Leadership Team		15/05/2023	20		Corporate	Medical Director's Office		Trust-wide	The Trust Board has a number of executive director vacancies which are currently filled by interim or acting up arrangements which may lead to instability. In some instances these appointments are for first time Director posts meaning that the Board could be seen as still developing. In addition to this the Chief Executive has recently announced his intention to stand-down on 31 March 2024, after 42 years service in the NHS.	Fit and Proper Persons Regulations. Voting rights are not impacted as interims / secondees all carry the voting rights of the role as per the Standing Orders/SFIs. Coaching and mentoring in place for those in their first appointment from the Chief Executive and the Director of Nursing/Deputy CEO. There is external coaching provision with a plan to ensure each director has an external coach and mentor. Each executive director has a substantive deputy director. The ELT also has access to an external OD partner who works with the team on a regular basis.	Out of 6 directors only 2, the Director of Nursing and the Medcial Director are currently substantive. The Director of Nursing post is currently a shared post with LCHS. The Medical Director is currently off on long-term sick. The Chief Executive post is filled substantively but will become vacant at the end of March 2024.	20/02/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Continue with mentoring / coaching arrangements in place where appropriate. Review the succession plans for each post and ensure substantive appointments are made. Joint posts with other system providers to be considered where appropriate as part of the Lincolnshire Provider Review.	[20/02/2024 13:46:40 Rachael Turner] Risk reviewed - Medical Director is back full time and CEO has extended tenure to June 2024 to allow for recruitment to Group CEO. [07/06/2023 12:15:17 Rachael Turner] Risk discussed at RRC&C 07/06/2023 Risk score agreed as 4x4 giving a score of 16 making it a High Risk. [15/05/2023 13:41:10 Rachael Turner] Risk to be raised for validation at RRC&C Meeting in May.	10	31/03/2024		20/05/2024
4862		Service disruption	Ratcliff, Carl Thomson, Cheryl		Workforce Strategy Group	WORK	22/02/2022	16	Staff Survey	Medicine	Specialty Medicine CBU	Respiratory Medicine	Trust-wide	Consultant staffing within Respiratory Medicine at Lincoln and Boston Hospital. Currently there are only 3 Substantive consultants in place at LCH and 2 at PHB. We have a vacancy of 5 across the three sites. Various gaps are covered with Adhoc Locum. The main current risk is to the inpatient cover at Pilgrim Hospital. With only x2 Consultants over there, when we have 1 on annual leave, the risk that the other could be either sick or covid contact is extremely high. We have supported this with clinicians going over from LCH, however due to a further resignation at LCH, this is proving more difficult This combined risk on Medical staffing has now impacted the Secretarial team at LCH. There is currently 0 secretaries at work at LCH due to sickness in the team. This is mitigated through support from Agency / Other specialties supporting. We do not have the substantive staff nor the locum or agency bookings, to cover all functions of our Resp Medical Team. Inpatient risk of high acuity patients without specialist input. Outpatient risk of high activity of 2ww referrals on top of high volume OP workload, delayed	Due to the severity of the risk: Currently: x 5 Consultant Gaps in Resp The impact this is having on the current workforce is stretching the team and leading to added pressure on the workforce. We are working with agency teams to work 'differently' for example Locum consultants supporting with on call work / remote clinics to release the burden on the current clinical team in respiratory. OD support in place also, along with weekly catch up meetings with the teams to explain the current state of play. The Business Unit have this week (06/09) put a bid in to the EMCA to gain funding of 250K to support a General Medicine to work in Respiratory so that our Substantive teams can be released to support Respiratory Cancer Capacity - This bid is currently being reviewed. We have worked in the background to book x 2 Agency Locum General Medicine Consultants 1 at Boston and 1 at Lincoln which will take us over budget, but supports the respiratory patients of lincolnshire and the welfare of consultant staff.	Staff Survey Results. Data Analysis through HR around recruitment and retention. Measured through Performance for patients (although this is not directly attributed towards the recruitment and retention, the longer wait times cause anxiety and unwarranted stress for the consultants in post)	14/11/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Close working with Agency to try and recruit agency locums to temporarily fill gaps. Working with Advanta / Medical Resourcing to recruit long term and improve retention of current staff. Additional funding applied for from Cancer alliance/ICB for Gastro and Resp to allow for additional Gen Med Locum to reduce burden on current workforce. Remote working in place to support outpatients where possible. Agency spend supporting out of hours workload - for example, covering the substantive consultants on calls to allow them to focus on Cancer work instead of on call - supporting patient care.	[14/11/2023 14:43:19 Rachael Turner] There are 3 substantive consultants but the risks remains the same and we rely heavily on bank and agency. Score remains. Nodule ACP role, this is a permanent role, has been developed and recruited but she is still back filling the plural. [30/08/2023 09:30:26 Carl Ratcliff] Expect to be at 10 consultants at end of Nov and will review risk again in 1/12 [24/04/2023 12:25:14 Carl Ratcliff] Have recruited to Consultant ACP post in nodules to support team - will start in 1/12 Using additional external support to deliver extra capacity for OPD to allow delivery of 78ww and reduce risk for delivery of 2ww urgent work [24/02/2023 13:48:15 David Marsh] Recruitment in progress, 5 substantive consultants in post (3 x Lincoln, 2 Boston). Agency locums in place covering a variety of roles/sites. New NHS Trust Locum Respiratory Consultant from overseas started in January at Lincoln. Now working independently. Division looking at developing ACP roles and Nodule Nurse post. [01/12/2022 11:15:13 Carl Ratcliff] plan for 3 consultants now being on boarded New plan to develop ACP nodule role Most recent update: Dear Carl, Following the catch up earlier, Claudia, Ashley and I have compiled our thoughts on what could go down to support the services..... Option Take down: Benefits Risks: 1 Do Nothing None Cancer patients continue to wait prolonged periods for care. • Inpatient services at LCH and PHB continue to become extremely depleted • Welfare of current consultant workforce continues to suffer, potentially leaving to sickness / prolonged absence • Boston have only x2 Consultants, currently utilising support from already depleted LCH Team. (If annual	4	30/12/2022	03/06/2024	14/02/2024
4991		Service disruption	Low, Claire Shankland, Lindsay		Workforce Strategy Group		08/08/2022	20		Corporate	People and Organisational Development	Operational HR	Trust-wide	Recruitment: Without effective recruitment strategies and procedures the Trust may not be able to fill essential vacancies, leading to gaps in service provision affecting the care of a large number of patients and having a negative impact on existing staff. Financial risks from extra-contractual rates agreed	Policy and Strategy: 1. Agreed Workforce Plan submitted annually on 31 March with progress monitored throughout the year 2. Recruitment and Selection Policy and Procedure - approach is a mixture of Build, Buy, Borrow 3. Resource Advisors dedicated to each Division and focussed on overall recruitment targets and hard to recruit roles 4. Bank and Agency workers. Locum temporary staffing arrangements 5. Rota management systems and processes Governance: 1. FPAM and PRM scrutiny 2. Trust Board assurance through Workforce Strategy and OD Group reporting into People and Organisational Development Committee	1. Vacancy Rate 2. Temporary Staffing Spend 3. Safer Staffing Report 4. Medical Workforce Resourcing Projects 5. Fill rates reported to NHSE	02/02/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	1. Increase capacity in recruitment team to move the service from reactive to proactive 2. Reintroduce medical recruitment expertise within recruitment team 3. Development of a robust Workforce Plan with delivery against plan monitored at Workforce Strategy and OD Group on a monthly basis 4. Use of apprenticeship framework and overseas recruitment to bolster traditional recruitment pathways 5. Exploration of new staffing models, including Advanced Clinical Practitioners (ACPs), Nursing Associates and Medical Support Workers 6. Increase Agency providers across key recruitment areas 7. Develop internal agency aspect to recruitment 8. Build strong relationship with Refugee Doctor project to support MSW recruitment and GMC registered Doctors. 9. Source a third party supplier for international recruitment for hard to recruit AHP roles 10. Reservists (Winter Staffing etc.) 11. Workforce and Reporting Manager now in place 12. NHS Long-term Workforce Plan	[02/02/2024 10:11:02 Rachael Turner] Risk to be presented to RRC&C in February for validation for reduction in score. [11/01/2024 12:40:57 Rachael Turner] SB Confirmed: Now BAU, Ahead of plans, reporting and planning in place including FPAM, PRM, WFOD, PODC, signed off by board, nursing team report to NHSE - reduce score to 2. As the risk reduction plan has progressed well, this will be taken forward with our risk business partner. [06/09/2023 13:58:03 Rachael Turner] This risk is now a stand alone risk for recruitment, the retention element has now been split and can be found under risk ID: 5249. [06/09/2023 13:31:07 Rachael Turner] This risk was reviewed as part of the Deep Dive at the RRC&C meeting following a review of all PODC risks. This risk was validated as a 4x4:16 High Risk and now replaces the previous risk of recruitment and retention. [01/08/2023 09:46:03 Rachael Turner] People and OD Restructure complete. Recruitment team restructured and vacancies all filled. Dedicated medical recruitment team created. Internal agency aspect to recruitment being developed with a Talent Acquisition team of Resourcing Advisors. Workforce Plan for 2023/24 complete and submitted to the system. Recruitment Plan clearly articulated in Workforce Plan with trajectories to a 4% vacancy rate by year end 2023/24. Trust vacancy rate has consistently been under the target of 12%. New to care recruitment being extensively used for HCSW role. Nursing Associate recruitment embedded. Medical Support Worker role now looking to be embedded as business as usual. Agency providers increased to a minimum of three for key roles, rather than one previously.	4	31/03/2023	31/03/2023	02/05/2024

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5249		Service disruption	Low, Claire	Akhtar, Sarah		Workforce Strategy Group	06/09/2023	16		Corporate	People and Organisational Development	Organisation Development	Trust-wide	Retention: Workforce management practices that are not in line with Trust values and expectations may have a negative impact on staff morale ultimately leading to increased turnover. Replaces current Risk 4991 (Retention element)"	1. Workforce Plan and Recruitment Plan to fill vacancies and reduce burden on current staff 2. People Promise Manager focussing on retention issues, including Exit Questionnaires and Flexible Working 3. Staff Benefit Scheme being further developed 4. Culture and Leadership Programme including Leading Together Forum and Cultural Ambassadors 5. Quarterly Staff Survey to measure leadership behaviours and engagement of staff, allowing quick time targeted interventions 6. Regular reporting through People Systems Manager 7. Onboarding process for Consultants being developed	1. Turnover Rate 2. Pulse Staff Survey (quarterly) 3. NHS Staff Survey (annual)	11/01/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	1. Development of a robust Workforce Plan with delivery against plan monitored at Workforce Strategy and OD Group on a monthly basis 2. Delivery of the People Promise Action Plan which has a clear focus on staff retention 3. Focus shift for People and Talent Academy from System to ULHT with development of clear progression pathways 4. Completion of Culture and Leadership Programme and full introduction of a Just and Restorative approach through all people management activities 5. Robust communication and action planning following quarterly and annual staff surveys to address areas of improvement and strengthen areas of good practice 6. Regular case reviews/lessons learning following employee relations issues arising 7. Career Development across staff groups in particular medical workforce 8. Retire and Return 9. Onboarding process for Consultants being developed	[11/01/2024 12:43:51 Rachael Turner] 11/1/24: Risk reduction plan continues to be worked through and is progressing well. This risk will be formally reviewed in Feb 24 with the People Promise Manager to identify if the risk level can be reduced. [06/09/2023 13:53:37 Rachael Turner] Risk was approved and validated following the RRC&C meeting in August as a new risk following the PODC risk review. Approved score of 4x4:16 High Risk. This risk was previously part of Risk ID: 4991 but has now been split so that staff retention is now a stand alone risk.	8	06/09/2024		11/04/2024
4905		Physical or psychological harm	Cooper, Mrs Anita	Taylor, Ruth		Workforce Strategy Group	22/04/2022	12	Workforce Metrics, Risk assessments, Aggregation of Incident/Claims & Complaints/PALS	Clinical Support Services	Therapies and Rehabilitation CBU		Trust-wide	If we have insufficient staffing, or required level of experience and skill, the risk is patients will not receive assessment and rehabilitation leading to poor clinical outcome. Reduced flow on Ashby and the acute wards, delayed discharges, delayed referral to response times. Increase in avoidable harm i.e. deconditioning, PU's, constipation, delirium. Patient reviews delayed for botox treatment. Paediatric services-delayed response to new diabetes referrals and unable to see current diabetes patients in clinic-could lead to patient harm. Increase in bed stock and boarding beds without recognition of additional therapy staffing needs. Existing staff stretched to cover additional beds. Increased stress and sick leave on substantive staff.	Recruitment and retention strategies to fill vacancies. Bank staff. Requests to Locum Agencies. Skill mix Roster management. SQD data. Daily review of ward systems eg WebV. Referral guidelines and Prioritisation guidelines help to inform workloads and impact on patient flow and bed situation. Paed services are responding to direct requests for newly diagnosed children . Upskilling B5 N&D staff-(normally B6 N&D staff). Access to Staff wellbeing services. Front door therapy assessments passed to inpatient teams on admission.	Patient complaints. Fewer discharges at the weekend. Site escalation. Vacancy rates. Roster fill rates. Waiting lists for spasticity service. Staff absence. Staff survey and feedback.	05/02/2024	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.	[05/02/2024 11:25:33 Gemma] We are in the process of working on Therapy Strategy document and models of care document which will review current position against future planning. There is a safer staffing template for OT and Physio. Dietetics team to review use of this. [08/09/2023 14:19:33 Maddy Ward] We have made some progress in terms of recruitment but level of risk to remain the same. Grantham site is fully staffed and risk is not relevant to Grantham. [23/06/2023 14:12:17 Rose Roberts] Been asked to put in a case of need for RSU on both sites. Will be reviewed by RT to see if the risk needs to be separated out. [09/05/2023 15:14:15 Sara Blackbourn] Addition of escalation beds. Front door pilot. Referral criteria review. [10/03/2023 13:46:14 Rose Roberts] One member of staff has returned but another member is on maternity leave and there is no cover for her. Across all the services continue to be flexible and look at the skill mix to allow to deliver the best service we can. [13/01/2023 12:54:24 Lesley Bradley] 13/01/2023 Continue to review staffing levels, vacancies and reasons for sickness on a monthly basis [15/12/2022 09:55:40 Alex Measures] still looking at models of how to measure safe staffing levels, just asking each team to provide there funded establishment, what they would expect on a usual day and what is the minimum level of staffing, then we can start measuring whether we are falling below safe staffing levels, we have no method of recording that at the moment [30/11/2022 10:07:42 Rose Roberts] Continuing to look at staffing. Currently have a lot of sickness. Looking at levels of staffing so able to report whether staffing levels fall below a safe level. 130622 Looking at staffing vacancies and looking at line by line post analysis. OT IR 8 posts KPI's for Integration include reduce vacancies Promotional Commms for AHP week and Trac being produced to attract staff Improved recruitment strategies.	9	30/09/2023	18/12/2023	06/05/2024
Strategic Objective		**2b. Making ULHT the best place to work**																									
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.	07/02/2024	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.	[07/02/2024 13:42:52 Rachael Turner] Risk reviewed, controls currently in place and managed through operational command. Risk to be presented at RRC&C meeting in February for a reduction in score. [11/01/2024 12:27:34 Rachael Turner] LS Confirmed: Risk continues to present as an issue. All mitigations are in place and the Trust manages the issue when it presents through an operation command structure. [19/12/2023 12:29:58 Rachael Turner] Risk continues to present as an issue with medical staff undertaking periods of industrial action. Currently Junior Doctors remain in active dispute with the government and Consultants/SAS Doctors are balloting on pay proposals. In November 2022 it was necessary to increase the likelihood of this risk from low to extremely likely and this continues. Plans have been tried and tested and all mitigations are in place. Oversight and governance through the Operational/Tactical/Silver Cell, Medical Workforce Cell and Strategic/Gold Cell with reporting to the ICB. Industrial Dispute Action Plan and Risk Assessment complete and has been tested through industrial action. Currently managed within risk tolerance. EPG to consider making this risk Inactive (for annual review). [20/11/2023 20:37:44 Rachael Turner] Risk reviews, all actions and score remains appropriate. Gold and silver command continue to manage this. [30/10/2023 12:37:17 Rachael Turner] Risk reviewed and remains at current level. [29/09/2023 10:29:30 Rachael Turner] Risk reviewed-current actions remain appropriate. As it is presenting as an issue it is being managed through tactical (silver) and strategic (gold) levels of command and working groups. [01/08/2023 09:55:01 Rachael Turner] Risk has now presented as an issue with staff undertaking periods of industrial action - in November 2022 it was necessary to increase the likelihood of this risk from low to extremely likely.	4	31/03/2023	07/03/2024

ID	DCIQ 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
4948		Physical or psychological harm	Cooper, Mrs Anita	Walker, Helen		Health and Safety Group, Medicines Quality Group, Patient Safety Group	17/06/2022	20	Workforce Metrics	Corporate	Clinical Support Services	Pharmacy CBU		Workload demands within Pharmacy persistently exceed current staffing capacity which leads to longer working hours (inc weekends), work related stress resulting in serious and potentially long-term effects on staff health and wellbeing. Adding to this with additional workload demands with insufficient staffing, or required level of experience and skill, the risk is patients will not be reviewed by a pharmacist leading to poorer clinical outcomes, reduced flow on acute wards, delayed discharges and increased risk of omitted medicines. For staff the risk is long term absence. This may result in the failure to meet the national and local targets for KPIs	Business Continuity Plans on ward coverage when staffing low	Sickness rates/vacancy rates and staff turnover - highlight that retention is problematic at current. Staff survey highlights issues low staff morale within the department. Medicines reconciliation, datix incidents and omitted doses highlight that the trust is underperforming and not meeting targets at current	13/02/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Review current provision and identify gaps in service to inform business cases for change to support 7 day working (working with Surgery and Medicine Divisions as appropriate). Skill mix requires review due to complexity of patients.. Pragmatic management of workload & provision of management support. On-going exploration of recruitment options. Wellbeing team supporting staff - regular visits organised	[13/02/2024 16:38:34 Gemma] Risk reviewed and no change [17/01/2024 12:04:24 Gemma] No further update [21/12/2023 13:30:51 Divisional Dashboards] Lisa- Marie Moore: Ongoing challenges. Demonstrable workload increase particularly on weekends across all sites. Phase 2 work plan development to review pharmacy workforce [27/11/2023 14:55:44 Rachael Turner] Risk remains with staffing challenges, no update. [26/09/2023 14:08:09 Rachel Thackray] Staffing vacancies still remain a challenge [03/08/2023 14:48:27 Lisa-Marie Moore] No further updates [27/06/2023 09:47:53 Alex Measures] Discussed in risk register review meeting- no further updates [01/06/2023 14:17:03 Lisa-Marie Moore] No change since previous entry [04/05/2023 14:07:20 Lisa Hansford] no update awaiting review on basis of reputational risk as advised at confirm and challenge meeting 29/03/23 [06/04/2023 12:52:25 Paul White] Discussed at Risk Register Confirm & Challenge 29 March, risk agreed with feedback provided for consideration. [07/02/2023 13:29:22 Rachael Turner] Risk updated to be lead by PODC committee. Requires validation at Confirm and Challenge due to current score. Division to review risk score and attend Confirm and Challenge meeting. [05/01/2023 14:05:09 Lisa-Marie Moore] No change from previous update [08/12/2022 12:33:43 Lisa-Marie Moore] Meeting with Divisional Leads and Deputy Medical Director 25/11 to discuss short and long term actions to support staff, current vacancies and support business case. BCP to be enacted when required. [06/10/2022 14:12:57 Lisa-Marie Moore] Business case still in progress No change	8	30/06/2023	02/10/2023	13/03/2024
5250		Service disruption	Low, Claire	Shankland, Lindsay			06/09/2023	16		Corporate	People and Organisational Development	Organisation Development	Trust-wide	If our employees are not provided with appropriate statutory and mandatory Core and Core Plus learning provision it could lead to unsafe and inconsistent practices that increase the potential for harm to patients, staff and visitors; financial loss; or damage to property.	1. Creation of an Education and Learning Team through the People and OD restructure and the appointment of an Education and Learning Manager and Statutory and Mandatory Training Coordinator 2. Improvement Action Plan 3. Creation of Mandatory Training Governance Group 4. National policy: Health Education England (HEE) Core Skills Training Framework (England), October 2020 5. Trust policy: Induction and Core Learning Training Policy, approved January 2015, due for review January 2020 6. Trust governance: Board assurance through People and OD Committee	1. Compliance rates reported at Divisional and Trust level in a variety of forums monthly	02/02/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	"1. Align Trust Core Training Framework to Skills for Health Core Skills Framework 2. Put in place a robust process for deciding what topics form part of the Trust Core Plus Training Framework 3. Align compliance reporting with Core Training and Core Plus Training 4. Complete Improvement Action Plan - to be monitored through Mandatory Training Governance Group (MTGG) and reported up to Workforce Strategy and OD Group and People and OD Committee"	[02/02/2024 10:07:47 Rachael Turner] Risk reviewed, scoring looking to be adjusted score 2x4: 8 Moderate risk. Risk to be presented at RRC&C meeting in February for validation of score. [11/01/2024 12:30:23 Rachael Turner] MDR confirmed: The risk is always present due to system errors that can crop up with within ESR but accessibility is not a risk a such. All coordinators trained to manage the system and any errors that occur. Attendance at the mandatory training governance group is variable however we are looking to remodel the approach using existing Teams based approval processes such as those used in CRIG. Risk should be reassigned to medium. This will be taken forward with our risk business partner [06/09/2023 14:05:15 Rachael Turner] Risk was reviewed and validated at the RRC&C meeting in August. Approved score of 4x4:16 High Risk [06/09/2023 14:04:13 Rachael Turner] ICT technology issues addressed – ESR moved out of IE mode and into Edge on 8 February 2023. Education and Learning function within People and Organisational Development created with all posts recruited to. Proposed new approach for defining Core and Core Plus Training across the Trust and agreement for proposed process to be put in place for deciding what topics form part of the Trust's Core and Core Plus Training Framework implemented. Improvement Action Plan created and will be monitored through MTGG and Workforce Strategy and OD Group with upward reporting to People and OD Committee.	8	06/09/2024		02/05/2024
5248		Service disruption	Low, Claire	Shankland, Lindsay			06/09/2023	20		Corporate	People and Organisational Development	Organisation Development	Trust-wide	There is a risk that the core and core plus training modules are not available for staff to complete due to acceptability issues with the E-Learning system and/or ESR.	1) Mandatory Training Governance Group. 2) All educational learning coordinators trained to upload and manage the system.	Compliance rates reported at Divisional and Trust level in a variety of forums monthly	02/02/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Ensuring there is no single point of failure in regards with maintaining and managing the system. Regular review by mandatory training governance group. Interim solutions applied as required and in response with presenting issue.	[02/02/2024 10:09:43 Rachael Turner] Risk to go to RRC&C in February as risk is requested to be closed due to completion of risk reduction plan. [11/01/2024 12:35:27 Rachael Turner] MDR confirmed: Risk reduction plan nearly fully implemented. Can be closed, only thing outstanding is the policy – this will be the new People Development Policy, it has been to policy group, just needs to go back to JNF in Feb for approval. This will be taken forward with our risk business partner. [06/09/2023 13:45:39 Rachael Turner] Risk was reviewed and validated with a score of 4x4:16 High risk at the RRC&C meeting in August as a new risk following a review of all PODC risks.	8	06/09/2024		02/05/2024

ID	DCIQ 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
5251		Reputation	Low, Claire	MacDonald, Damian			06/09/2023	16		Corporate	People and Organisational Development	Organisation Development	Trust-wide	If the Trust doesn't have an effective approach to employee appraisals then it could have a negative impact on morale and lead to poor performance, inappropriate behaviours, reduced productivity, non-compliance with policy, increased turnover.	1. Dedicated page for Staff Appraisals on the Intranet with a wealth of easily accessible information that sets out the process, principles, benefits, fact-sheets 2. Leading an Effective Appraisal 2-hour virtual workshop available to all managers to support them in developing their skills and confidence to undertake staff appraisals 3. Creation of an Appraisal and Career Discussion form that is simple but allows for discussion on performance, professional relationships, career and development goals, and wellbeing. It also allows for performance and development objectives to be set, an overall assessment of performance to be made and a check on completion of mandatory training to be undertaken. There are also forms to support managers to undertake regular 1:1 'check-ins' and to undertake mid-year reviews 4. Trust governance: Board assurance through People and OD Committee	1. Compliance rates reported at Divisional and Trust level in a variety of forums monthly	11/01/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	1. Creation of a Task and Finish Group to undertake a scoping/review exercise to understand current issues and barriers to completion 2. Findings of Task and Finish Group to be used to inform and develop an Improvement Action Plan 3. Complete Improvement Action Plan when drafted - to be monitored through Workforce Strategy and OD Group and reported up to People and OD Committee 4. Ensure detailed scrutiny takes place at FPAM with Divisions - Learning and Development Coordinator to provide more detailed monthly slides as part of FPAM reporting"	[11/01/2024 12:38:02 Rachael Turner] This is a reducing risk as we work through the risk reduction plan. Following a workshop in Jan 2024, we should be in a position to reassess the risk level and we will take this forward with our risk business partner [06/09/2023 14:10:25 Rachael Turner] This risk was reviewed and validated at the RRC&C meeting August 2023. Approved score 4x4:16 High Risk. [06/09/2023 14:09:45 Rachael Turner] Two priority issues identified: • Review the Staff Appraisal cycle and how this can best be aligned to business and financial planning to ensure there is a link between performance from the organisational to individual level ('golden thread') • Scope out the potential for utilising ESR for eAppraisal or whether an alternative solution would need to be found – review what system colleagues are doing and whether the Trust could use or learn from their solutions 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 in June 2023 to 67.93% non-medical and an increase to 98.24% for medical. We are continuing to recommend that a 90 minute appraisal for each colleague is planned for as we enter 2023/24. Following an audit completed in Urgent & Emergency Care we identified that a number of colleague's appraisals had been completed in the past 12 months within WorkPAL, however 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. This will include 'how to' guides/sessions and utilising reporting to identify areas of low completion. During June 2023 our OD Managers will be writing to staff who have not had an appraisal and pro-actively encouraging them to approach their Line Manager to ensure one is planned/completed.	8	06/09/2024		11/04/2024
4993		Service disruption	Low, Claire	Shankland, Lindsay	Equality, Diversity and Inclusion Group		08/08/2022	16		Corporate	People and Organisational Development	Organisation Development	Trust-wide	Workforce management practices that are not inclusive and equitable for people who consider themselves to have a disability may have a negative impact on the recruitment of new employees and the retention of existing ones.	1. Appointment of People Promise Manager (12 month fixed term) 2. Robust monitoring of EDI incidents/concerns 3. Equitable and EQIA 'tested' HR processes (for recruitment, reward and performance) 4. Dedicated OH service	1. Measurement of lived experience of disabled staff at ULHT via - NHS Staff Survey 2. No. EDI/disabilty related incidents reported 3. No. of EDI/disability related concerns reported	11/01/2024	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	[11/01/2024 12:46:15 Rachael Turner] Risk reduction plan in place and WDES action plan is being delivered. [06/09/2023 13:17:38 Rachael Turner] Risk reviewed at the RRC&C meeting 30/08/2023 following a review of the PODC risk register. This risk has been validated in score at 4x4: 16 High Risk and now replaces the previous WDES risk. [02/08/2023 10:32:59 Rachael Turner] WDES continues to be delivered and progress monitored through EDIG. Current WDES action plan assessed as good by NHSE. EDS published on Trust Website - signed off through EDIG, People and OD Committee and Trust Board. Maple Staff Network continues to be active and ran a series of events through Disability History Month. Culture and Leadership Programme continues to be delivered and Cultural Ambassadors appointed and commenced their training. Leading Together Forum continues to receive good feedback and each speaker is building on the work of the last creating consistent messaging. People Promise Manager delivering against action plan with national recognition of curent work. Funding for People Promise Manager available for Y2. National Staff Survey results available and action planning commenced. Reasonable Adjustment Policy agreed." [31/01/2023 15:22:04 Rachel Thackray] WDES action plan continues to be delivered and monitored through EDIG. Recently completed national Equality Delivery System (EDS) audit, being reported to Trust Board in February 2023 and published by 28 February 2023. 1. WDES action plan prioritised for engagement, development and delivery	4	31/03/2023	31/03/2023	11/04/2024
4992	55	Service disruption	Low, Claire	Shankland, Lindsay	Equality, Diversity and Inclusion Group		08/08/2022	16		Corporate	People and Organisational Development	Organisation Development	Trust-wide	Workforce management practices that are not inclusive and equitable for people from all racial and cultural backgrounds may have a negative impact on the recruitment of new employees and the retention of existing ones.	1. Lincolnshire Belonging Strategy (improving equity of lived experience and representation across Lincolnshire system) 2. Appointment of People Promise Manager (12 month fixed term) 3. Robust monitoring of EDI incidents/concerns 4. Equitable and EQIA 'tested' HR processes (for recruitment, reward and performance)	1. NHS Staff Survey 2. 'Pulse Check' Staff Survey 3. No. EDI/Race incidents reported 4. No. of EDI/Race related concerns reported 5. BAME staff retention % (leave within first 3, 6 and 12 months) 6. BAME senior representation	11/01/2024	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)	[11/01/2024 12:48:20 Rachael Turner] Risk reduction plan in place and WRES action plan is being delivered. [06/09/2023 13:20:07 Rachael Turner] This risk was reviewed as part of the Deep Dive at the RRC&C meeting following the review of all PODC risks. This risk was validated with a risk score of 4x4:16 High Risk and replaces the previous WRES risk. [02/08/2023 10:35:14 Rachael Turner] WRES continues to be delivered and progress monitored through EDIG. Current WRES action plan assessed as good by NHSE. EDS published on Trust Website - signed off through EDIG, People and OD Committee and Trust Board. Anti Racism (United Against Discrimination) Working Group commenced 7 February 2023 and is delivering outputs against the plan. REACH Staff Network continues to be active and a relaunch of the Network as REACH (formerly BAME) and the See Me campaign complete. Culture and Leadership Programme continues to be delivered and Cultural Ambassadors appointed and commenced their training. Leading Together Forum continues to receive good feedback and each speaker is building on the work of the last creating consistent messaging. People Promise Manager delivering against action plan with national recognition of curent work. Funding for People Promise Manager available for Y2. National Staff Survey results available and action planning commenced. [31/01/2023 15:23:43 Rachel Thackray] WRES action plan continues to be delivered and monitored through EDIG. Recently completed national Equality Delivery System (EDS) audit, being reported to Trust	4	31/03/2023	31/03/2023	11/04/2024
Strategic Objective		**3a. A modern, clean and fit for purpose environment**																									

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4647	1	Reputation	Frake-Harris, Julie	Whitehead, Mr Stuart	Medical Gasses Working 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)	26/02/2024	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	[26/02/2024 11:29:05 Rachael Turner] Risk reviewed, no change from previous months update. [16/01/2024 13:22:28 Rachael Turner] Fire Risk Assessments are progressing based on risk priority. Review outstanding actions from previous FRA's, using FS trainer. Compartmentation (Passive): completed all 3 sites fire protection surveys, Capital teams are commencing remedial works based upon risk Fire Door Inspection: action by competent contractor, LCH and Grantham Complete. anticipated date of completion for PHB Dec 2023. Fire Alarm Systems: design of a new Pilgrim fire alarm system by capital teams. commenced 31st October with LCH and GDH to follow Storage in Corridors: security undertaking hot spot checks, completing IR1 for Managers and MyPorter. Fire Drills continue . bespoke fire safety training within higher dependency areas Fire Extinguishers concluded servicing and maintaining all 3 sites PPM Fire: Where PPM's not completed, these are escalated to the relevant Estates Lead for action. compartmentation surveys complete and capital commencement with remedials on tower blocks. Block priority spreadsheet being developed to ensure risk based approach. fire alarm surveys complete on all 3 sites and tender specification being drafted [19/12/2023 15:06:16 Rachael Turner] Risk reviewed, no current change, risk score remains. [27/11/2023 14:50:37 Rachael Turner] Fire Risk Assessments are progressing based on risk priority. Review outstanding actions from previous FRA's, using FS trainer. Compartmentation (Passive): completed all 3 sites fire protection surveys, Capital teams are commencing remedial works based upon risk Fire Door Inspection: action by competent contractor, LCH and Grantham Complete. anticipated date of completion for PHB Dec 2023. Fire Alarm Systems: design of a new Pilgrim fire alarm system by capital teams. commenced 31st October with LCH and GDH to follow Storage in Corridors: security undertaking hot spot checks, completing IR1 for Managers and MyPorter.	4	30/06/2022	31/03/2024	26/03/2024
5189		Service disruption	Parkhill, Michael	Davey, Keiron	Fire Safety Group	Fire Safety Group	13/06/2023	25		Corporate	Estates and Facilities	Estates	Lincoln County Hospital	The Medical Air Plant in Maternity Block and Plantroom 12 at Lincoln County Hospital are of an age and high risk of failure. The systems are none compliant and do not comply with current triplex and quadplex installations. The installed systems or only duplex. Maternity Med Air plant has failed and currently operating with a temporary skid mount compressor plant. On 11th June the Plantroom 12 Med Air Plant failed and created significant patient Harm Risk. Both of these Med Air Plants require replacement to prevent harm to patients and staff.	A temporary hired medical air plant is in use at Matternity Block to maintain Medical Air provision. Plantroom 12 is operational and is under investigation and support from specialist contractors to maintain its operation.	Frequent daily inspections of plant is to be implemented immediately, this is to support the service and maintenance from the contractors as an additional monitoring activity.	07/02/2024	Quite likely (4) 71-90% chance	Extreme (5)	Very High risk (20-25)	20	Our specialist contractors are working with the trust in order to supply temporary medical gas plant in the event of catastrophic failure to enable the impact to be as minimal as possible. The long term and only feasible strategy is to replace the medical gas air plant, upgrade to a quadplex modern and fit for purpose system, but this will require significant capital investment.	[07/02/2024 16:24:15 Rachael Turner] No change, risk to be discussed at RRC&C in February. [29/01/2024 19:32:56 Rachael Turner] Medical Air Plant has now been replaced and is fully functional. PPM as per HTM 02-01 is in place - Action can be closed. Risk to be presented at Risk Confirm and Challenge in February for confirmation of closure of risk. [14/11/2023 17:18:33 Rachael Turner] Risk reviewed, score remains, work ongoing. [03/08/2023 10:12:04 Rachael Turner] Risk reviewed, work currently ongoing, no current update. [28/06/2023 11:48:48 Rachael Turner] Risk discussed at RRC&C meeting 28/06/2023. Risk remains at a 20 following an incident. This was declared as a Serious Incident. On 11th they lost one side of medical air vent, the ventilators stopped working. Currently running on higher sets at Lincoln. Now secured capital, looking at a Triplex. Risk score agreed as 4 x 5 at a score of 20.	5	01/03/2024		07/03/2024
4648	2	Physical or psychological harm	Frake-Harris, Julie	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.	26/02/2024	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	[26/02/2024 11:26:38 Rachael Turner] Risk reviewed, no change from previous months update. [16/01/2024 13:25:33 Rachael Turner] Fire Risk Assessments are progressing based on risk priority. Review outstanding actions from previous FRA's, using FS trainer. Compartmentation (Passive): completed all 3 sites fire protection surveys, Capital teams are commencing remedial works based upon risk Fire Door Inspection: action by competent contractor, LCH and Grantham Complete. anticipated date of completion for PHB Dec 2023. Fire Alarm Systems: design of a new Pilgrim fire alarm system by capital teams. commenced 31st October with LCH and GDH to follow Storage in Corridors: security undertaking hot spot checks, completing IR1 for Managers and MyPorter. Arson Risk patrols by security team and warden trained Fire Drills continue . bespoke fire safety training within higher dependency areas Fire Extinguishers concluded servicing and maintaining all 3 sites Fire Alarm Systems: Where PPM's not completed, these are escalated to the relevant Estates Lead for action. Staff training access to courses made flexible. out of date staff emailed by FS team Div. leads provided with fire warden and training statistics for FSG scrutiny Compartmentation surveys completed and remedial capital works commence Jan 2024 on risk basis fire alarm survey complete and tender technical survey underway. New additional FSA commencing Feb 2024 to assist in FRA reviews and provide competent advice based at Pilgrim. [19/12/2023 15:04:37 Rachael Turner] Risk reviewed, no current change, risk score remains. [27/11/2023 14:53:16 Rachael Turner] Fire Risk Assessments are progressing based on risk priority. Review outstanding actions from previous FRA's, using FS trainer. Compartmentation (Passive): completed all 3 sites fire protection surveys, Capital teams are commencing remedial works based upon risk Fire Door Inspection: action by competent contractor, LCH and Grantham Complete. anticipated date of	10	31/03/2022	31/03/2025	26/03/2024

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4725		Physical or psychological harm	Cooper, Mrs Anita	Froggatt, Hayley	Estates Investment and Environment Group	Health and Safety Group	13/01/2022	20	Risk assessments	Clinical Support Services	Therapies and Rehabilitation CBU		Lincoln County Hospital	If essential repairs and maintenance requirements at Lincoln County Hospital Occupational Therapy Department are not addressed then it may lead to accidents and injury resulting in potentially serious harm to staff, patients and visitors. There is a security risk to the building.	Legislation: - Health & Safety at Work Act 1974 -Management of Health & Safety at Work Regulations 1992 associated guidance. ULH policy: - Health & Safety Policy & related guidance - Health & safety training (Induction, Core Learning, Core Plus Learning and CPD) - Estates Planned Preventative Maintenance (PPM) / testing - Occupational Health services ULH governance: - Health & Safety Committee / site-based H&S Forums; accountable to Trust Board through Finance, Performance & Estates Committee (FPEC)	IPC flo scores, monitoring of incidents, staff satisfaction concerns, complaints / PALS Tracking of Estates work requests - The Department has a significant amount of outstanding jobs including, leaking windows, leaking roof tiles, carpeted areas, unsanitary toilet/shower & changing facilities, repeatedly broken toilets. Inability to monitor temperatures due to inappropriate fitting of radiator covers, swelling and uneven floor services following leaks.	05/02/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Daily & Weekly IPC checks, Staff well being checks, frequent monitoring of safety issues. Escalation to H&S Team via audit process. Monthly updates to MICAD system, Escalation via IPC FLO audit process.	[05/02/2024 11:05:23 Gemma] Rehabilitation Medicine will move across into the OT area as an interim measure while further suitable accommodation is sourced. [01/02/2024 13:40:16 Gemma] We will be moving to the physio therapy department as an interim measure until new premises sought within the hospital. Moving to physio hopefully before the end of the financial year. [27/09/2023 12:05:47 Rachael Turner] Risk discussed at RRC&C Meeting for an increase in score to a High Risk score of 16. There could be regulatory impact if this was not looked at and also issues reputationally. [08/09/2023 14:08:38 Maddy Ward] Likelihood of risk has been updated to quite likely in review meeting making it a high risk. Glass is falling from window frames more frequently due to rotten window frames and we have had water/rain coming into electrics. This is included in the estates escalation report. [23/06/2023 14:00:51 Rose Roberts] Flooring has been approved and has been accepted by estates. Not got a date yet. Windows etc have been escalated. [27/04/2023 14:29:26 Rose Roberts] CVR office also has a carpet - feedback from estates is quote received and awaiting go-ahead to commence work from Clinical Support Services. Rotting wooden windows - Feedback from estates is that windows are a known issue with the building but there is no funding available Changing room and Macmillan office have carpet - feedback from estates is quote received and awaiting go-ahead to commence work from Clinical Support Services. Visitor toilet - Feedback is that operative is to attend Lever taps – job raised following IPC audit that all taps need to be replaced. Feedback from estates is In order to carry out this job, isolation points need to accessed and these are underground. Accessing underground requires additional support for our operatives due to the risk involved and the Estates Team Leader will organise for this support so the work can be carried out. Several windows allow a lot of sun through into office space and clinic rooms. This reduces visibility when using computer and risk patient/staff getting overheated. Requested antiglare UV film for the window – this has been agreed and allocated to an operative to attend. [10/03/2023 13:41:03 Rose Roberts] Continue to liaise with estates about the outstanding work.	4	31/03/2022	31/03/2023	06/05/2024
5104	533	Regulatory compliance	Dunning, Mr Paul	Rinaldi, Dr Ciro	Mortality and Learning Strategy (MoraLS) Group	Estates Infrastructure and Environment Group	16/03/2023	10		Clinical Support Services	Path Links (Pathology)	Mortuary (Pathology)	Trust-wide	As a result of the HTA's concerns relating to the fabric and capacity of the Trusts mortuary service and the delay in timescales by which the Trust is able to refurbish these following the HTA inspection in May 2022. There is a risk that The HTA as the regulator could impose conditions on our licence to store the body of a deceased person within the Trusts mortuary facilities.	-HTA oversight group has been established-meeting to manage the action plan. -Papers have been to CRIG for initial funding to establish planning and building work. This has been approved. -Draft business case has been developed and approved. -Initial concerns have been addressed from Lincoln site. -The Trust currently has two Titan units (temporary additional mortuary capacity) which provides additional capacity in the event of winter pressure peaks in demand and also in the event of equipment failure. -The Trust has a memorandum of understanding with Hull University Teaching Hospitals to support with the storage of bariatric bodies that require longer storage (freezer capacity).	ULHT Improvement action plan HTA Governance Group Weekly meetings to oversee mortuary refurbishment plans	01/02/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Risk reduction plan to assure HTA during March that risk controlled above mitigate their concerns over the Trusts mortuary estate. HTA have confirmed their acceptance of the Trust's plans to mitigate and have closed down their inspection process as complete.	[01/02/2024 16:05:12 Gemma] Business Case has been approved at Trust Board and work has commenced on the Trustwide Mortuary Project [19/10/2023 15:50:44 Ciro Rinaldi] -HTA oversight group has been established-meeting to manage the action plan. -Papers have been to CRIG for initial funding to establish planning and building work. This has been approved. -Draft business case has been developed and approved. -Initial concerns have been addressed from Lincoln site. -The Trust currently has two Titan units (temporary additional mortuary capacity) which provides additional capacity in the event of winter pressure peaks in demand and also in the event of equipment failure. -The Trust has a memorandum of understanding with Hull University Teaching Hospitals to support with the storage of bariatric bodies that require longer storage (freezer capacity). [19/10/2023 07:47:27 Jeremy Daws] ELT provided with an update that plans approved, and building work scheduled to commence October 2023. At recent weekly mortuary refurbishment meeting, building commencement timescales may slip back due to delays in appointing a contractor. Further update to be provided when more information known. [05/07/2023 11:06:25 Rachael Turner] Risk discussed in June RRC&C meeting, agreed to reduce risk score from 20 to a 16 High Risk [08/06/2023 13:22:36 Rachael Turner] Risk to be presented at RRC&C in June for reduction in score from 20 to 16. [31/05/2023 04:53:29 Jeremy Daws] HTA have responded to the Trust during May confirming their acceptance of the Trust's mitigation plans. HTA have confirmed they are assured enough to close down the inspection process as complete. Risk rating likelihood has been reduced from Quite likely (4) to Reasonably unlikely (3). The rationale for this is there is still a risk to the Trust if the current plans around refurbishment are not completed, even if	20	31/03/2024	31/03/2024	01/05/2024
5334		Physical or psychological harm	Grooby, Mrs Libby	Carr, Katy	Patient Safety Group		26/01/2024	15		Family Health	Women's Health and Breast CBU	Obstetrics	Pilgrim Hospital, Boston	There is no second theatre within the confines of the labour ward within which to undertake any theatre based procedures when Theatre 8 is already in use. In time critical scenarios the increased time taken to transfer to Theatre 1 on ground floor and commence surgical management may impact on the health and/or wellbeing outcomes for mother and/or baby. There is a patient experience risk due to a lack of privacy and dignity for women when transferring to ground floor theatres through public corridors. There is also a potential for an increase in Caesarean Section rate as clinicians attempt to avoid late labour transfers.	Discussion with Obstetric/Anaesthetic/Theatre teams when deciding which cases to remain in theatre 8. Close monitoring of labour ward activity. Staff familiar with route to main theatres. Additional staff to support transfer. Offer Birth Afterthoughts as appropriate. Visible management and Leadership/active on call support to teams PMA support	Closely monitor all cases where woman transferred to theatre before or following birth – daily Medway report for scrutiny.	31/01/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	To inform teams of the risk controls in place. Coordinate Estates to undertake the works on Theatre 8a to minimise disruption as soon as practicably possible.	[31/01/2024 13:01:35 Rachael Turner] Risk discussed at RRC&C meeting 31/01/2024. Need to know frequency when this is happening. Agreed currently that this sits at a 4x4: 16 High Risk. Link to be added around regulations.	6	01/01/2025	31/03/2024	30/04/2024

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5136		Physical or psychological harm	Parkhill, Michael	Pattinson, Paul	Estates Investment and Environment Group	Health and Safety Group	28/03/2023	20		Corporate	Estates and Facilities	Estates	Trust-wide	Following monitoring for Nitrous Oxide levels in Pilgrim and Lincoln (Theatre and Maternity Units), it was identified that in a number of locations, staff were exposed to higher levels of nitrous oxide where levels exceed the Workplace Exposure Limit (WEL) OF 100 ppm (8hr time weighted average (TWA)).	Following notification the following actions were undertaken: Pilgrim Hospital – Labour Ward: Estates staff checked the supply ventilation from the Air Handling Unit (AHU) to the Supply Grilles within the labour rooms. At the time of inspection, the Estates staff identified the dampers restricting airflow were not adjusted correctly. This was addressed and airflow checks were undertaken. Typical air change rates were around 6 air changes per hour (ACH) – current guidance is a minimum of 10 ACH, however the ventilation systems are circa. 1960 and the guidance is not retrospective. Following the actions undertaken, resampling commenced 15th March (15 sample tubes), 13 were within WEL limits, but 2 sample results were recorded at 255 and 407 ppm (8 h TWA) in Rooms 2/2a and Room 3, respectively and exceeded WEL limits. Estates are reviewing the current system to look at increasing air changes by upgrading the supply fans / changing pulleys / upgrading filter media or a combination of factors. Further works to increase ventilation has been completed and whilst not HTM03 compliant by design - supply ventilation has been increased to reduce the risk of WEL exceedance. Lincoln Hospital - Labour Ward: Estates staff found the ventilation system had been isolated (approximately 10 years ago). Following discussions with Estates members, the ventilation system had failed and was deemed beyond economical repair and a decision had been made not to replace (no one is aware of why this was made or by whom). Estates plan to reinstate the ventilation, where feasible, which will likely include partial refurbishment and deep clean of existing systems. N.B the use of sampling tubes to monitor Nitrous oxide levels can be highly time and place dependent, the person with the sampling equipment and their activities, can indicate exposure levels that are as a result of human error, not as a failing of the environment. As such G210 analysers specifically designed for highly accurate measurement and verification of the quality of piped N2O and O2 gases, are being sourced.	-COSHH assessments and training. -Health Safety Environmental and Welfare Operational Audit programme. -Direct involvement with Occupational Health. -Datix incident reporting.	29/01/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	The issues identified with exposure levels are not unique to ULHT, as with most NHS Trusts investment is required to upgrade Ventilation to comply with HTM 03-01. NHSEI issued guidance on the 2nd March 2023 for NHS Trusts to follow. Noting where ventilation is insufficient, human factors are critical in reducing staff exposure, such as: 1. Providing clear instructions to patients on correct use of equipment being used, including exhaling into the rebreather mask or out through the mouthpiece 2. Staff positioning relative to exhaust N2O and the direction of ventilation flow 3. Turning gas and air off when not in use 4. Unplugging regulators from outlets when not in use 5. Monitoring the condition of equipment for leakages. These factors can't directly be influenced by Estates and require the support and influence of Clinical Leads and Occupational Health. ULHT Health and Safety Team have recently implemented software to assist with COSHH assessments and training. The Team provide support with the Health Safety Environmental and Welfare Operational Audit programme. Occupational Health have been directly involved with the implementation of sampling and post sampling. Following sample results, Occupational Health were contacted to advise that staff may require support. To date no Datix reports have been raised and no concerns re: ill-health have been escalated in relation to Entonox use/levels to the Health and Safety Team,. Estates will continue to look at improving the current	[29/01/2024 19:35:31 Rachael Turner] The supply fans serving the recovery areas have been upgraded and airflows retested. Airflow has improved but not sufficient to meet 10 air changes per hour. Further works to be scheduled by PG/NM [25/10/2023 10:59:03 Rachael Turner] Risk reviewed and remains the same, meeting to be had tomorrow (26/10/2023) with estates to discuss progress. [28/06/2023 11:49:31 Rachael Turner] Risk discussed at RRC&C meeting 28/06/2023. Pilgrim from a Estates point of view, all mitigation has been put into place. At Lincoln we are still in the same position. This now sits under two separate risks with two separate scoring. 20 score for Lincoln, 12 for Pilgrim. These risks will go to division to agree to be split. [19/06/2023 11:14:32 Rachael Turner] Since the last review, sampling has been carried out for Pilgrim. WEL exposure limits were not exceeded in the last Pilgrim sampling reports with a few caveats: •Sampling was undertaken but use of Entonox was recorded as low •Due to works undertaken by Estates Supply Air was increased to exceed 10ac/hr, although it should be noted extract is via corridor extract so not in full compliance with HTM03. Occupational Health have reviewed this risk with the following findings: Following recent monitoring, we have established there is a tentative but almost certainly very low level of risk to midwives caring for labouring women using Entonox (nitrous oxide, otherwise known as "gas and air"). The theoretical risk is mainly to pregnant staff. There are significant gaps in the knowledge base about adverse health effects of Entonox, but adverse health effects are likely confined to when it is used as a recreational drug. Nevertheless,it is important that there is adherence to protocols associated with Entonox use. Guidance has been reviewed and is in alignment with NHS England current guidance. Pending further advice and investigations NHS England guidance must be followed: •Provide clear instructions to patients on correct use of equipment being used, including exhaling into the rebreather mask or out through the mouthpiece.	10	28/03/2024		29/04/2024
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.	29/01/2024	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.	[29/01/2024 19:38:32 Rachael Turner] 2 x feeds to site, one at the Hospital Exit Road, adjoining Sibsey Road & one coming in from the start of Castle Road, the access road to Progress Living. I have 2 water storage tanks, Capacity per tank is 243m³/243,000L, This is potable quality water & will supply the hospital for approx. 20 hours. [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	29/04/2024
5192		Service disruption	Cooper, Mrs Anita	Parriss, Helen	Estates Investment and Environment Group		14/06/2023	15		Clinical Support Services	Therapies and Rehabilitation CBU	Physiotherapy	Pilgrim Hospital, Boston	Leaking pipework under Physiotherapy Outpatient Department leading to increased humidity, water collection around windows and flooring and increased inside temperature. Risk to health and safety for staff and members of the pubic. Pre-existing problems regarding ventilation and windows (closed Risk 4296).	Physiotherapy Outpatient Department closed to staff and members of the public; relocated to gym, OT Department and consideration to hold clinics at The Johnson Hospital as needed. Face to face appointments replaced with telephone/video appointments to reduce footfall through the Department and patient treatment delay. Dehumidifiers used with the Department and an external contractor has isolated and switched off steam within the subway.	Success of repairing pipework within the subway. Continued clear asbestos results. The reopening of the Physiotherapy Outpatient Department when an acceptable level of humidity has been achieved and following a deep clean to ensure eradication of mould spores and clear ventilation ducts. Assurance from Estates Department regarding overall risk to health and safety is acceptable.	05/02/2024	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Continued liaison with Estates Department.	[05/02/2024 11:10:58 Gemma] A recent moved of Physio's into OT department due increased condensation. Physio's know back in the Physio dept - continued monitoring of condensation levels. [09/01/2024 14:25:11 Gemma] Update 10.8.23 Staff members have been off sick recently with continued chest and eye symptoms due to the high humidity levels, heat and damp within the Outpatient Physiotherapy Department. The Outpatient Gym and the Occupational Therapy Department is now being offered to staff to treat patients. Managers Occupational Health referrals are being done to support staff. Confirmation again from Estates/H&S that larger dehumidifiers would potentially increase risk of Legionairres and the only solution would be to replace the single glazed windows which cause the condensation. Risk rating has been amended to reflect this update. Continued review of asbestos risk - currently clear on all tests. Update 1.9.23 Advised by H&S that outside agency due to review further steam leak within subway under Physiotherapy Department - date to be confirmed. Staff continue to work within other areas to support their health. A further DATIX was completed due to mould spores within the Physiotherapy OPD - ID 319676 - a deep clean was arranged w.c. 21.8.23 and email request sent to Biju Biju, IPC Nurse, to request mould spore analysis. Two doors within the Physiotherapy Department were reviewed on 31.8.23 as they were not able to close due to the wood swelling. - Update given to Risk Register Confirm and Challenge Group 25.10.23 Pre-existing problems regarding ventilation and windows (closed Risk 4296). Acute problem - leaking pipework within subway under Physiotherapy Outpatient Department leading to	2	19/06/2023		06/05/2024

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4830		Service disruption	Cooper, Mrs Anita	Myers, Joseph		Estates Infrastructure and Environment Group, Medicines Quality Group	17/01/2022	15	Risk assessments	Clinical Support Services	Pharmacy CBU	Pharmacy	Pilgrim Hospital, Boston	The area above Pharmacy at Pilgrim Hospital contains estates plant and pipes that are prone to blockage and overflow, which could cause extensive damage to medicines; computer equipment and aseptic facilities that disrupts service continuity.	ULHT policy: - Estates maintenance / repair arrangements - Business continuity plans ULHT governance: - Trust Board assurance via Quality Governance Committee (QGC) / Medicines Quality Group (MQG) / Pharmacy CBU / CSS Division	Reported incidents of service disruption	29/12/2023	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Discussions with Estates to identify potential solutions to the blockage / overflow issues. Contingency plan - medicines and equipment are moved to a temporary location in the event of overflow into Pharmacy. 7.9.23 there are no ongoing conversations with estates. JM will open up discussions again with estates and facilities	[29/12/2023 12:17:18 Lisa Hansford] Leak in dispensary w/c 18th December and stock had to be moved to prevent damage. [26/09/2023 14:12:47 Rachel Thackray] No further update [07/09/2023 14:20:37 Lisa Hansford] 7.9.23 no further update [01/08/2023 14:22:43 Rachael Turner] Risk discussed as RRC&C in July, risk approved to an increase in score to 5x3: 15 High Risk [27/06/2023 09:21:08 Alex Measures] meeting raised risk level to 15 Colin Costello to meet with Paul Dunning on Monday to get exec approval [01/06/2023 14:33:41 Lisa-Marie Moore] Risk ongoing no further update [29/03/2023 11:22:00 Maddy Ward] Discussed at Pharmacy Risk Register Review meeting today and risk is ongoing, no further update. [20/12/2022 14:16:17 Alex Measures] no updates - risk likely to increase in future reviewed 01/07/21 - ongoing, increase likelihood to likely 150622 ongoing. Shut down asceptic facility at PHB and put in a modular unit at PHB as consequence. Colin considers the risk level should be increased, to be discussed at confirm and challenge meeting next week.	6	30/09/2021	31/03/2022	29/03/2024
Strategic Objective								**3b. Make efficient use of our resources**																			
4664	5	Finances	Matthew, Mr Paul	Young, Jonathan	Workforce Strategy Group		11/01/2022	20	Risk assessments	Corporate	Finance and Digital	Finance	Trust-wide	The Trust has an agency cap of c£17m. The Trust is overly reliant upon a large number of temporary agency and locum staff to maintain the safety and continuity of clinical services that will lead to the Trust breaching the agency cap.	National policy: - Agency spending cap set by Government ULHT policy: - Financial plan set out the Trust limits in respect of temporary staffing spend - Annual budget setting process cascades and apportions the Trust temporary staffing spend limits to the Divisions and Directorates. - Monthly financial management & monitoring arrangements are in place to identify variation temporary staffing financial plans at all levels of expenditure from department up to Trust. - Key financial controls for the use of the break glass agency usage are in place. - Specific staff group temporary staff spend is provided to dedicated Medical and Nursing workforce oversight groups. - Financial review meetings held monthly with each Division to understand and challenge usage of temporary staffing. - Plan for every post information has been embedded to support temporary staff usage forecasts ULHT governance: - The establishment of the Improvement Steering Group will provide general oversight of Trust wide agency reduction schemes - Board assurance through Finance, Performance and Estates Committee (FPEC)	The Trust is monitored externally against an agency cap through the monthly finance return to NHSE/I The Trust monitors internally against its financial plan inclusive of specific targets for agency and bank spend by staff group The cross Trust workstreams are reported to the Improvement Steering Group The Divisional workstreams are reported to the relevant Finance, People & Activity Meeting (FPAM)	16/02/2024	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	[16/02/2024 17:35:19 Rachael Turner] As at M10, agency pay expenditure of £27.4m is £3.4m lower than plan and is £16.1m lower than expenditure of £43.4m during the same period of 2022/23; while agency pay expenditure increased in M10, this includes a planned increase in relation to cancer recovery for which the Trust has received funding. The reduction in agency pay expenditure is accounted for by the active management of recruitment into vacancies and movement from agency staffing to bank staffing; bank pay expenditure is £4.1m adverse to plan inclusive of the unfunded impact of industrial action. [23/01/2024 13:16:05 Rachael Turner] Agency Pay of £24.4m is £15.2m lower than expenditure of £39.6m in 2022/23. Bank Pay of £48.2m is £12.1m higher than expenditure of £36.1m in 2022/23. This is accounted for by tX7:X8he active management of Agency staff to bank arrangements. [19/01/2024 11:41:29 Rachael Turner] Risk reviewed, no change. score to remain. [18/12/2023 16:08:27 Rachael Turner] Agency Pay of £22.1m is £13.6m lower than expenditure of £35.6m in 2022/23 Bank Pay of £41.5m is £9.7m higher than expenditure of £31.8m in 2022/23. This is accounted for by the active mangement of Agency staff to bank arrangements. [20/11/2023 20:12:46 Rachael Turner] Risk reviewed, no change or update to report. [16/10/2023 17:16:29 Rachael Turner] The YTD pay position is £0.3m favourable to plan. Compared to the same period in 2022/23: •Agency Pay of £17.1m is £9.9m lower than expenditure of £27.0m in 2022/23. •Bank Pay of £31.0m is £7.1m higher than expenditure of £23.9m in 2022/23. This is accounted for by the active management of Agency staff to bank arrangements. [14/07/2023 09:07:10 Rachael Turner] Risk reviewed, score to remain at 20. Work ongoing. [28/06/2023 16:13:10 Rachael Turner] The Trust has hit its own agency plan. This is our internal plan. Score to remain the same at this time. [24/05/2023 13:24:21 Rachel Thackray] Updated to reflect the risk for 2023/24. Cap reduced from £21m to £17m. The Trust's CIP plan for 23/24 is heavily focussed on agency reduction, risks to delivery include; excess beds, winter pressures and not delivering recruitment trajectories. [24/04/2023 13:17:23 Rachael Turner] No change currently, update to be provided next month when	8	31/03/2023	31/03/2024	16/03/2024
5020		Finances	Hamer, Fiona	Smith, Charles	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	07/02/2024	Quite likely (4) 71 -90% chance	Extreme (5)	Very high risk (20-25)	20	Robust recruitment plan International recruitment Medical Workforce Management Project	[07/02/2024 09:16:42 Rachael Turner] Risk reviewed, no change. [09/01/2024 15:13:18 Rachael Turner] Consultation ongoing with completion due end of Feb/March. Risk currently remains the same. [13/12/2023 16:48:28 Rachael Turner] Improvement seen against Acute and GIM rotas after recruitment. However significant spend still re: ED T2 staff due to ongoing consultation. Resolution expected early 2024 with implementation Fed/March 2024. Ongoing impact of IA also to be considered." [20/11/2023 20:25:40 Rachael Turner] Work ongoing, posts waiting to be filled. Agency and bank continue to backfill. [17/10/2023 10:09:53 Rachael Turner] Consultation in place for medical workforce, funding has been agreed but remains covered by bank and agency until posts can be filled. [26/09/2023 14:44:54 Charles Smith] Risk remians the same but recruitment across Acute/GIM rotas improving over next couple of months. Ongoing impact of Strikes. Tier 1 and 2 in place for med, ongoing tier 2 consultation ED. [15/08/2023 11:14:12 Helen Hartley] Remains the same, plans for recruitment and money signed off. Stays the same until recruitment piece has happened. There is a trajectory for this, beginning 2024. Tier 1 in place Tier 2 consultation discussed in case of next steps/formal outcome. Medical workforce additional consultants signed off for RAT, positive steps happening but this will take time. [19/07/2023 15:50:48 Helen Hartley] This remains a risk, should be reduced with medical workforce management project that CS is leading. Some delays with recruitment and HR, a few resignations due to deanery positions. Mitigations in place. [28/06/2023 11:24:27 Rachael Turner] Risk discussed at RRC&C as part of the Deep Dive 28th June 2023. Putting money into medical workforce to increase medical staffing by 2 on each shift. Also looking at people on the agency how we can recruit into substantive posts.Work remains ongoing. This risk remains the same. [13/06/2023 11:13:13 Helen Hartley] Robust recruitment plan and international recruitment plan in place and ongoing. The uplift to meet demand and capacity has been approved and agreed, adverts are going	10	02/09/2023		07/03/2024

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4665		Finances	Matthew, Mr Paul	Young, Jonathan	Financial Turnaround Group		11/01/2022	20	Risk assessments	Corporate	Finance and Digital	Finance	Trust-wide	Updated in May 2023 to reflect 23/24. The Trust has a £28m CIP target for 23/24. If the Trust fails to deliver The CIP Plan it will have a significant adverse impact on the ability of the Trust and the Lincolnshire ICS to achieve their financial plans.	National policy: - NHS annual budget setting and monitoring processes ULHT policy: - Detailed Financial plan inclusive of the establishments and embedding of the 3 T's; Transactional, Targeted and Transformational. - Alignment of the Trust financial improvement opportunities with system partners to develop an integrated financial plan inclusive of CIP. (Transformational) - Establishment of the service framework to prioritise Speciality improvement reviews. (Transformational) - Establishment of a suite of cross cutting schemes aligned to the Trust Improvement Strategy. (Targeted) - Divisional CIP targets allocated as part of the budget setting process from 1st April. (Transactional) ULHT governance: - Detailed CIP reporting via the CIP tracker supported by QIA process - Programme Management Office (PMO) & dedicated Programme Manager. - Introduction of the Improvement Steering Group to monitor, challenge and hold accountable for the Targeted and Transformational Schemes - Refresh of the FPAMs to monitor, challenge and hold accountable for the Transactional Schemes	The Trust is monitored externally against the Trust CIP target through the monthly finance return to NHSE/I The Trust monitors internally against its CIP targets inclusive of specific Divisional and Scheme targets Divisional focus against Transactional schemes is reviewed at the relevant FPAM. Trust focus against Targeted and Transformational schemes is reviewed at the Improvement Steering Group	23/01/2024	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.	[23/01/2024 13:18:19 Rachael Turner] The focus has now switched to pipeline opportunities for 24/25 and the ability of the trust to build a sustainable pipeline of cost improvement for the future. The Target for 24/25 is £32m. [16/10/2023 17:17:59 Rachael Turner] The Trust has over delivered each month on the FRP target months 1-6. This meets the criteria for NOF 4 of delivery in 6 consecutive months. Year to date at month 6 the FRP has overdelivered by £5.3m The trust is still forecasting to deliver a full £28.1m CIP programme for 23/24. The trajectory for savings steps up from month 7 onwards so the run rate of savings needs to increase going forwards. [14/07/2023 09:09:38 Rachael Turner] Risk reviewed, risk score to remain as current work is ongoing. The Trust has over delivered against the month 1 trajectory for the FRP by £0.5m. The trust is also forecasting to deliver a full £28.1m CIP programme for 23/24. [28/06/2023 16:16:06 Rachael Turner] Risk reviewed, targets have been reviewed to reflect where we currently stand. we have hit financial improvement target for month 1 and 2. Risk score to remain the same at 16 High Risk. [24/05/2023 13:11:53 Rachel Thackray] Updated to reflect the risk for 2023/24. The Trust has plans to deliver £28m CIP (FRP) target. In month 1 delivery exceeded plan. [02/02/2023 14:13:16 Rachel Thackray] The Trust is forecasting to deliver a £18m CIP programme for 22/23 a shortfall of £11m against its revised plan, which has been partly mitigated through the risk and gain share contractual agreement with the ICB, however this still leaves an under delivered CIP requirement that has resulted in a contribution to the forecast deficit position of the Trust. [02/02/2023 14:12:00 Rachel Thackray] The Trust is forecasting to deliver a £18m CIP programme which has been partly mitigated through the risk and gain share contractual agreement with the ICB, however this still leaves an under delivered CIP requirement that has resulted in a contribution to the forecast deficit position of the Trust. The Trust has delivered its CIP plan for the past 3 years, albeit a reduced requirement during the 2 financial years that cover COVID. The Trust is embedding a new Improvement framework with CIP included within it and is also working with system partners to make financial improvements due to	4	31/03/2023	31/03/2024	23/04/2024
5215		Finances	Matthew, Mr Paul	Young, Jonathan			14/07/2023	16		Corporate	Finance and Digital	Finance	Trust-wide	23/24 introduces a new mechanism to record, calculate and apply the API contract and a System incentive / penalty linked to the Elective Recovery Fund. Actual performance/activity is taken from SUS and EROC. At present, there are some SUS/SLAM reconciliation issues and some recording issues including Missing Outcomes. The risk is twofold: 1. that without accurate ERF monitoring through SUS on actual activity delivered, the activity will look artificially low and there will be financial deductions 2. the activity plan has been built on delivery of c116% of 1920 elective, day case, outpatient first and outpatient procedure activity. Under the new regime underperformance will result in lost income	The link between activity and income has been communicated to the Trust. Monitoring is being set up to monitor activity delivery and estimate the financial impact due to the variable adjustment. Lost income through recording issues (e.g. missing outcomes) will be monitored to include a financial estimate in 23/24. An ERF baseline appeal was submitted and 95% accepted nationally. Revised national ERF baseline figure have been received and are being worked through.	Monitoring of the variable adjustment and lost income is being set up	23/01/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	"Information have been requested to reinstate SUS/SLAM reconciliation. Oversight of delivery is required through FPEC/FPAMs and any technical reporting issues reported to CFIG in the first instance. Required Trust activity delivery plan and then delivery against it."	[23/01/2024 13:21:26 Rachael Turner] National targets have been updated several times. Internal monitoring has been set up, which is consistent with national Trust level monitoring, but also shows trends by specialty and POD. SUS to SLAM monitoring undertaken by Finance as a one-off exercise identified some areas not being reported to SUS which were raised with Information Team for resolution. [16/10/2023 17:20:50 Rachael Turner] The national ERF baseline has been release twice in recent weeks. detail has been requested from the national team and is awaited in order that detailed internal monitoring can be updated [01/08/2023 14:49:23 Rachael Turner] Risk presented at RRC&C meeting in July, approved as 4 x 4 16 High Risk.	9	31/03/2024		23/04/2024
Strategic Objective							**3c. Have enhanced data and digital capability**																				
4657		Reputation	Matthew, Mr Paul	Hobday, Fiona	Information Governance Group	Digital Hospital Group	10/01/2022	12	Risk assessments	Corporate	Trust Headquarters	Corporate Secretary		If the Trust does not comply with Subject Access Requests (SARs) and Access to Health Records provisions in accordance with statutory requirements specified legislation, then it could lead to complaints to the Trust and Information Commissioner's Office (ICO). This could result in regulatory action and possibly financial penalties. Inconsistent levels of expertise outside of the IG team regarding SAR requirements. Lack of technical tools to carry out a search of emails / systems to identify personal information held. Implementation of digital systems which don't include a disclosure process. Potential financial implications.	ULHT policy in place. Monitoring through IGG and at exec level. Temporary additional resource has been put in place to oversee. Proposal made to ELT and IGG regarding process which has removed reliance on clinical staff to review all cases. Increased training provided to team.	Monthly reporting completed. Compliance rate is monitored by the Supervisor and reports taken to IGG in our KPI report. Volume of ICO complaints and Trust complaints received.	25/01/2024	Extremely likely (5) >90% chance	Severe (4)	Very High risk (20-25)	20	Current active communications with ICO- regulator. Changes to processes are being constantly discussed and implemented. Resource needs being discussed and temporarily increased to support. Monitored through the IGG in DP KPI report. Head of IG leading on work to review and improve. Working in a more digital way where feasible. Workforce change is required which will be a much longer process. Early identifications of chasers and urgent requests to reduce the likelihood of complaints.	[25/01/2024 14:27:48 Fiona Hobday] Have extended expected completion date in light of current position- approvals have taken longer than original hoped for re solutions which impacts go live plans. Also due to lack of response from ICO to date- Trust is not aware what the outcome might be. *Agreement rec'd to procure new case mgmt solution- next step to award contract and then project to implement. *PoC for a solution re emails has concluded and a final report is being prepared which will include a recommendation. *Patient SAR compliance has fell in recent months due to vacancy- recruitment delays and current blocks on new starters means this cannot be resolved until April. Have identified x3 individuals who are fit to recruit to post if they are available come April. *Still awaiting ICO reponse. [20/12/2023 14:17:42 Fiona Hobday] *Still awaiting response from ICO-advised won't get anything for next month in recent update *Case of Need produced in relation to procuring a new solution- has gone through Seals approval and is with CRIG *Proof of concept re a e-discovery tool currently being done in relation to emails for staff related cases. *Balancing use of resource to manage urgent whilst not letting compliance drop back following work to improve. *Currently recruiting following departure of staff member. [28/11/2023 12:03:12 Fiona Hobday] *Still awaiting response from ICO *Case of Need produced in relation to procuring a new solution- includes recommended option for moving forward. To go to CRIG. *Proof of concept re a e-discovery tool being done in Dec 23 in relation to emails for staff related cases. [10/10/2023 15:54:52 Fiona Hobday] *Still awaiting response from ICO *Case of Need produced in relation to procuring a new solution- includes recommended option for moving forward. With Trust Sec to review and seek funding. *Awaiting Digital to recruit additional resource to support completion of backlog searches. *Completion date extended due to delays in procurement work, Digital recruitment and lack of response	6	29/12/2023	31/08/2024	29/02/2024

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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	20/12/2023	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.	[20/12/2023 09:39:41 Rachael Turner] Risk reviewed, no current change. Risk score remains. [20/09/2023 14:27:49 Rachael Turner] Risk reviewed as a part of the digital risk review. Score remains the same. 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	20/03/2024
5245		Service disruption	Jenkins, Barry	Humber, Michael			30/08/2023	20		Corporate	Finance and Digital	Digital Services (ICT)	Trust-wide	The Trusts disaster recovery capabilities are limited. In the event of a major incident affecting the primary data centre/site the ability to restore services elsewhere is limited. This would affect the availability and data integrity of tier 1 clinical and corporate systems, leading to extended unavailability and reliance on Business Continuity Plans. In addition there is a risk of significant data loss in the event that recent backups are unavailable or compromised.	-Business Continuity Plans which the Trust is planning to exercise of a regular basis via Emergency Response. -Annual SIRO approved incident response exercise. -Protections that reduce the likelihood of various disasters, including environmental and technical controls: A number of improvements have been made in this area. We now have a dedicated ""stretched"" Metro cluster between Lincoln and Boston. We also have Standard clusters at each site which have increased capacity. -Immutable Backup system introduced to ensure organisational data is held securely and available for recovery, this includes off site cloud storage for critical data	-Annual SIRO approved incident response exercise. -Incidents reported via Datix these are backed up via an RCA and lessons learned.	30/01/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Whilst some systems still need to transition fully with VLAN/IP changes we do have new systems and system upgrades migrating to the new solution. Enabling Tech programme in place to improve the Trust Foundations from which the Digital Services will run. This requires completion prior to remobilisation of EPR. Trajectory for this is 2025/26.	[30/01/2024 11:04:10 Rachael Turner] Risk reviewed. Risk controls and reduction plan updated. Risk score to remain. [20/12/2023 09:22:32 Rachael Turner] In the process of implementing Rubrick, which will support disaster recovery and cloud back up. [30/08/2023 16:06:58 Rachael Turner] Risk discussed at RRC&C meeting 30/08/2023, score validated as: 4x4: 16 High Risk.	10	30/08/2024		30/04/2024
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)	ULHT policy: - Information Governance Policy and supporting appendices -Privacy by Design Procedure (NEW 2023) -Data Protection and Conf Policy 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. Data breaches- reports to IGG.	15/01/2024	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.	[15/01/2024 16:41:44 Fiona Hobday] *Data Protection and Conf Policy updated- approved at Jan 24 IGG. *Work with Procurement- initial work to review future work programmes completed and process agreed to do on a 6 monthly basis moving forward. Risk of non compliant contracts or lack of due diligence has been greatly reduced. *IG Comms Campaign- scheduled to start Jan 24; agreed via IGG and in collaborations with Comms Team. *Work re IAO ongoing- discussions to be had with COO re divisional input and support. [04/09/2023 17:22:52 Fiona Hobday] *Work ongoing with Procurement- update given at July IGG. *Further comms planned as part of IG Comms Campaign agreed within Trust- Comms currently producing proposals. *Procurement element part of DSPT Improvement Plan and ICO Audit follow up. [05/06/2023 17:25:59 Fiona Hobday] *Privacy by Design Procedure approved and live. *Contracts and IG Guidance document approved and live. *Ongoing comms to staff on a monthly basis. *Head of IG delivered awareness training session to Procurement Managers in 03/23. *Regular monthly meetings now in place with IG/ Digital and IG/ Programme & Project Team. [08/03/2023 13:50:25 Fiona Hobday] 08/03/23- New DPIA template live and published on intranet. Supporting procedure written and due to be ratified at IGG in March 23. Awareness session planned with Procurement Dept 16/3/23 by Head of IG. New 3rd Party Due Diligence in use and due to be published on intranet shortly. Annual comms plan for IG commenced in Jan 23. [06/12/2022 15:00:16 Maria Dixon] Developed new template to go live this month. Strategy is drafted going to IGG for escalation in Jan 2023. Interim Head of IG currently in post. Process and documentation reviewed and updated; these are now GDPR compliant. Further action required to address governance issues.	6	31/03/2024	29/03/2024	28/03/2024
5241		Service disruption	Jenkins, Barry	Gay, Nigel			30/08/2023	16		Corporate	Finance and Digital	Digital Services (ICT)	Trust-wide	SSL Inspection on Internet Traffic: There is significant risk that a malicious cyber event may occur as a result that encrypted Internet traffic is not inspected at the Trust external facing network boundaries. As a result malicious payloads may enter the Trust network and attack staff and IT Service endpoints resulting a breach of C, I or A. (e.g. link to a compromised website or C2C server connection due to a phishing event.)	Web-proxy/filter, boundary firewalls	As above.	20/12/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Introduction of web-proxy with capability for SSL inspection. Proxy procurement continues and is a ULH focused procurement activity in the hope that apartner organisations will be onboarded in 2024 - agreed May 2023 at DDaT	[20/12/2023 09:37:57 Rachael Turner] Risk reviewed, currently no no change risk to be reviewed in March 2024 for update. The functionality is yet to be switched on due ongoing security discussions. [30/08/2023 15:26:12 Rachael Turner] Risk discussed at RRC&C Meeting 30/08/2023. Controls are currently in place but this not mitigate the risk. Risk validated with an agreed score of 4x4: 16 High Risk.	4	30/08/2024		20/03/2024

ID	DCIQ 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/ strategy it runs the risk of not meeting national best practice and not making informed decisions in relation to Digital programmes of work. This could result in a breach of regulations and ULHT finding it difficult to meet national enquires that could lead to regulatory action and financial penalties. This risk has increased due to ongoing national enquiries and the move to a more digital way of records mgmt which whilst positive heightens the need to manage legacy and ensure expert RM support for future decision making.	The Trust has policies in place. Trust DPIA template included aspects on records mgmt and retention.	FOI compliance gives an indication of the Trusts position as compliance is linked to good records management. Reports of unmanaged records found in Trust locations.	25/01/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Requires a strategic decision from the Trust regarding a Records management lifecycle and level of expertise to advise and guide on future projects and developments. Needs to link into 365, ePR and EDMS Programme. 365 cannot be delivered with dedicated Records SME resource.	[25/01/2024 14:31:13 Fiona Hobday] *Working group has been agreed in relation to 365 following discussion at DHG- due to start in Feb 24. *Clinical Records Group has new Chair- Paul Dunning- he is now aware of concerns and issues with record retention and disposal. *Digital Programme Team are now raising lack of expert records manager in project risks and looking at how a role could be funded. *Corporate records resource needs to be reviewed in future. [04/09/2023 17:32:10 Fiona Hobday] *Little movement to date with regards to a strategy. IG have pushed in relation to ongoing future plans re EPR etc... *365 group are drafting a formal paper to go to senior staff in relation to governance as a whole and the RM work needed to do do this compliantly, linked to risks, operational ask etc... When complete IG will review and add to. [05/06/2023 17:22:19 Fiona Hobday] *Head of IG has spoken to Trust Sec re current concerns on lack of a strategic approach- linking to 365, EPR and EDMS. Need to look at whole picture and not pieces of work in isolation. *Head of IG has raised with Digital Programme Team to ensure RM is looked at strategically and in a joined up manner and they link in with Trust Secretary as the functional owner for Corporate Records. *365 Project- Records Mgmt identified now as a key deliverable and driver for the project. [08/03/2023 13:53:45 Fiona Hobday] Head of IG and DPO discussed in relation to retention of Health Records and removal of long time ban on disposing of records for Saville enquiry- this has now been lifted and Clinical Records Group to be tasked with taking discussion re record disposal forward. [02/02/2023 14:17:13 Fiona Hobday] Revise score approved at Confirm and Challenge meeting in Jan 23. [06/12/2022 15:09:53 Maria Dixon] DPO & Interim Head of IG raised with SIRO as part of O365 discussion. Development of health records retention & disposal policy in progress. Discussed at Risk Register Confirm & Challenge Group, 23 March 2022. Currently the Trust is storing paper records for longer than it should and there remains a lot of unknowns as to where records are stored. Likelihood should be increased, severity may possibly be lower.	4	28/06/2024	28/06/2024	25/04/2024
5242		Service disruption	Jenkins, Barry	Gay, Nigel			30/08/2023	20		Corporate	Finance and Digital	Digital Services (ICT)	Trust-wide	Risk of ULHT staff falling victim to a malicious Phish exploit.	Enhanced monitoring using technical tools (Ironscales O365 mail filtering) Alerts in place to support early intervention by Digital Services and E&F. Cyber security Baseline control set measures. Phishing simulation programmes on an ongoing basis, this includes training for staff that have been targeted.	Output from phishing simulation programmes is reported to Technical Design Authority and Information Governance Group (monthly basis). This identifies key trends.	30/01/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Continued improvements to Ironscales and O365 Email filtering capability (New rules\engagement with vendor for new controls or AI detection routines.) Continued development for training to staff. Implementation of new Secure Web Gateway solution as part of 23/24 capital programme.	[30/01/2024 11:31:50 Rachael Turner] Risk reviewed, risk control, measures and risk reduction plan updated. Due to mitigation currently in place (training, multi factor authentication on accounts used for accessing Microsoft services) risk score to be reduced to 4x3: 12 Moderate risk. Risk to be presented at Risk Confirm and Challenge in February for reduction in score. [20/12/2023 09:29:04 Rachael Turner] Tools in place to mitigate risk. Ironscales currently in place. Anti virus software has recently been updated which includes phishing tools. 500,000 phishing attacks were prevented from the Trust during October/November which has increased drastically from early summer. [30/08/2023 15:34:45 Rachael Turner] Risk discussed at RRC&C meeting 30/08/2023. Although there are very good controls in place we cannot mitigate all of the risk. NHS mail have had issues with phishing emails which staff fall fowl of. Expedition in traffic will also help with this. Risk was validated with an agreed score of 4x4: 16 High Risk.	1	30/08/2024		30/04/2024
5244		Service disruption	Jenkins, Barry	Humber, Michael			30/08/2023	20		Corporate	Finance and Digital	Digital Services (ICT)	Trust-wide	The most important challenge regarding legacy software is the risk to the 'cyber security\information security' posture of the organisation with the potential impact being the loss of clinical and digital services\data. A typical incident is likely to be due to a successful malicious exploit event regarding vulnerabilities that can be found in all unsupported legacy software. There is a risk that exploited security vulnerabilities present within unmanaged and out of date applications will result in a breach of Confidentiality, Integrity, and Availability and likely result in loss of availability of access to these services. The operation of legacy software that is not maintained by the vendor means that the likelihood of successful attack is increased, due to unsupported software containing many known and exploitable vulnerabilities. The Trust has a large complex estate that has developed over many years, while the current approach is to adopt an 'evergreen' approach to software, this has not historically been the case. The replacement of legacy software is a remediation activity the MUST completed, but may take time. Currently, the Trust's clinical reliance(s) are expected to be in place for some years to come whilst significant Digital Delivery Programmes of development and innovation come to fruition, for example E-HR, ERMA, EDMS. Therefore	Monitoring. Trend Deep Security applied to legacy Windows Operating systems ongoing projects to reduce legacy reliance, upgrading and replacing where possible. Implemented system to catalogue medical devices connected to the network.	Data analysis and ongoing daily monitoring.	30/01/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	While the aspiration is avoidance it is recognised that mitigation prevents the most reasonable short/medium term approach as there is expected to be a continued reliance on legacy systems and software for a considerable time. The Trust should prioritise and continue to implement base line security controls as detailed that support the ability to run required legacy software in the most secure an appropriate manner possible. While the risk is not eliminated the aim is to ensure the status of this risk is aligned and agreed to the risk appetite of the SIRO. As part of the EPR Enabling technologies programme the Trust is undertaking a re-design of its network, this will include new technologies including Network Access Control and segmentation. This will be further progressed and understood during 24/25. The Trust is currently procuring an EPR solution, expected to start to go live from 25/26 this will reduce the reliance on legacy applications.	[30/01/2024 11:19:06 Rachael Turner] Risk reviewed, controls and reduction plan updated. Risk score reviewed, to be reduced to a 3x4: 12 Moderate risk. This risk will be presented to Risk Confirm and Challenge to validate reduction in score. [20/12/2023 09:25:19 Rachael Turner] Currently implementing Celera. Meetings currently ongoing within digital within clinical and digital engineering. [30/08/2023 15:57:37 Rachael Turner] Risk discussed at RRC&C meeting 30/08/2023, validated risk score: 4x4: 16 Moderate risk. [30/08/2023 15:56:47 Rachael Turner] Update : 06/06/23 The recent completion of Dell VMware/Metro/NSX has provided new capabilty around segmentation within our Virtual estate. Whilst a futher 6 months of work will enhase this and embed within the infastructure we do now have the capabilty to apply firewall rules between VMs on the same network segment. IF needed we can apply mitigation against ULH Metro, Standard, MGMT and the ICB clusters within VMware."	10	30/08/2024		30/04/2024
Strategic Objective		**4b. Becoming a University Teaching Hospital Trust**																									
5160		Reputation	Morgan, Mr Andrew	Rich-Mahadkar, Sameedha			21/04/2023	16		Corporate				If we don't deliver against our ambition of becoming a University Hospital Trust, this could negatively impact our organisational reputation.	Following UHA guidance Regular discussions between Executive leads from ULHT and UoL regarding financial arrangements Working closely with University of Lincoln to define and agree future collaborations Working with Research and Innovation teams and reporting into R&I groups to maintain oversight	Executive scorecard - number of clinical academics in post and number of collaborations that are developed to support research grants	29/01/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Continued discussions between ULHT and UoL Executive leads to finalise research and financial agreements Application for Teaching Hospital Status as interim step. Contact with UHA to confirm requirements for application	[18/10/2023 11:52:17 Rachael Turner] An application for Teaching Hospital Status is to be submitted to the DHSC as an interim step to recognise ULHT's significant teaching commitment. We anticipate that this will be approved before the end of 23/24 financial year. An MOU and financial model is being developed and agreed between ULHT and UoL which will support our requirement to recruit clinical academics and regular meetings are in the diary to conclude this work. A new ULHT Growth of Research Culture group has been established. [07/06/2023 12:20:47 Rachael Turner] Risk discussed at RRC&C meeting 07/06/2023.Risk needs to reflect more than getting status, such as recruitment, quality of people you attract, development and investment. Risk score 4 x 4 making it a score of 16 High Risk.	8	31/03/2025		29/04/2024

United Lincolnshire Hospitals NHS Trust

Meeting	*Public Trust Board*
Date of Meeting	*5 March 2024*
Item Number	*Item 13.2*

Board Assurance Framework (BAF) 2023/24

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

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

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

Recommendations/ Decision Required	• *Board to consider assurances provided in respect of Trust objectives noting that framework has been reviewed through committee structure* • *Confirm the assurance rating of objective 3d moving from red to amber*

Executive Summary

The relevant objectives of the 2023/24 BAF were presented to all Committees in January and February. The Audit Committee considered the BAF at its meeting on 12 January.

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

During the January meeting of the Finance, Performance and Estates Committee discussions were held regarding objective 3d and the assurance rating provided. Following review of the objective over a number of months and the increased levels of assurance provided to the Committee, along with the stable performance and move out of tier 1 support for cancer services, the Committee supported the rating being moved to Amber.

This proposal has been made to the Board and reflected in the BAF with the Board asked to approve the change in the rating for objective 3d.

The following assurance ratings have been identified:

Objective		**Rating at start of 2023/24**	**Assurance Rating** **December**	**Assurance Rating (Previous Board reported position)** **January**	**Assurance Rating (Current position)** **February**
1a	Deliver harm free care	**Green**	**Green**	**Green**	**Green**
1b	Improve patient experience	**Green**	**Green**	**Green**	**Green**
1c	Improve clinical outcomes	**Green**	**Green**	**Green**	**Green**
2a	A modern and progressive workforce	**Amber**	**Amber**	**Green**	**Green**
2b	Making ULHT the best place to work	**Amber**	**Amber**	**Amber**	**Amber**
2c	Well led services	**Amber**	**Amber**	**Amber**	**Amber**
3a	A modern, clean and fit for purpose environment	**Amber**	**Amber**	**Amber**	**Amber**
3b	Efficient use of resources	**Red**	**Amber**	**Amber**	**Amber**

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

United Lincolnshire Hospitals NHS Trust
Board Assurance Framework (BAF) 2023/24 - February 2024

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

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

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

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						Policies are developed and updated in line with national and local guidance and in line with the National IPC Manual for England IPCG will retain oversight of the relevant IIP programme of work. (IPCG)	Some Estates and Facilities IPC-related. Some Estates and Facilities IPC-related policies not in line with the requirements of the Hygiene Code and some have not been reviewed and updated.	Estates and Facilities Policy Schedule has been presented to the IPCG containing dates for completion. Each policy is approved by the IPCG. Water, Ventilation and Decontamination IPCG sub groups have oversight of policy development	The IPCG is the primary source of assurance with each policy being an agenda item IPC programmes of surveillance and audit are in place to monitor policy requirements. Divisional audit processes with progress and exception reporting to IPCG, IPC Site meetings and IPC related Divisional forums. Associated action and development plan documentation.	None Identified	Not applicable		
						Process in place to monitor delivery of and compliance with The Health and Social Care Act (2008). Code of Practice on the prevention and control of infections and related guidance (IPCG). Infection Prevention and Control BAF in place and reviewed quarterly (IPCG)	Non-compliance with some aspects of the Hygiene Code in respect of criterion 2, (provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections) with specific concern relating to decrease in standards of environmental cleanliness (PHB), poor environmental infrastructure (water and ventilation), impact on planned preventative maintenance programme, breach of waste regulations for the safe storage of clinical waste and some aspects of in house decontamination processes	Good monitoring of standards of environmental cleanliness with auditing and process for remedial action. Recruitment of additional housekeeping staff at PHB. Water and ventilation safety groups are established. Planned preventative maintenance subject to assessment of risk and prioritisation processes. Increased waste audits and inspections. Storage capital programme work is progressing. Decontamination remedial work has progresses and Trust-wide audit of compliance is planned. Monthly reporting to the IPCG with upward reporting to the QGC	IPC programmes of surveillance and audit are in place to monitor policy requirements. Divisional audit processes with progress and exception reporting to IPCG, IPC Site meetings and IPC related Divisional forums. Associated action and development plan documentation	None applicable	Not applicable		

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						Process in place to ensure safe use of surgical procedures (NatSIPs/LocSIPs) NatSIPs 2 in the process of being launched to include 8 steps to safer surgery rather than 5. (PSG)	Improvement seen across all divisions in terms of development of NatSIPs/LocSIPs, however audit is required in order to provide assurance of implementation. Lack of reporting whilst transitioning to the new way of working	Individual Divisional meetings now in place; quarterly reporting to PSG Additional support provided to medicine from the Patient Safety Improvement Team NatSIPS' T&F group currently being established to address the necessary changes	Audit of compliance Upward reporting of the T&F group into PSG.	Reporting into PSG needs to become more robust.	Review occurring through the Divisional meetings with quarterly reporting to PSG. Reporting into PSG will be picked up as part of the T&F group.		
						Medicines Quality Group in place with a focus on improving medication safety / appropriate prescribing / appropriate management of drugs and controlled drugs Robust medicines management policies and procedures in place Improving the safety of medicines management / review of Pharmacy model and service are key projects within the IIP. Improvement actions reflect the challenges identified from a number of sources e.g. CQC, internal audit. The Medicines Management Action group in place to oversee the programme of works from the IIP programme. MQG will retain oversight of the relevant IIP programme of work (MQG)	Lack of e-prescribing leading to increase in patient safety incidents due to medication errors Gaps identified within the recent internal audit undertaken by Grant Thornton Lack of adherence to Medicines management policy and procedures Lack of 7 day clinical pharmacy service	Replacement of manual prescribing processes with an electronic prescribing system; improvements to medication storage facilities; strengthening of Pharmacy involvement in discharge processes. Deputy Medical Director led Action / Delivery Group in place meeting monthly to progress actions and reporting to the MQG.	Upward Report from the Medicines Quality Group to QGC Routine analysis and reporting of medication incidents and outcomes from medicines audits in to Medicines Quality Group Omitted doses audit Prescribing Quality reports Robust Divisional reporting and attendance into MQG monthly IIP upward report into MQG monthly Internal Audit report Upward reporting from DTC and the Chemotherapy Group has commenced.	Lack of upward reporting from the Medical Gases, Sedation Group Pharmacy audits only occurring in areas they are providing a clinical service to.	Divisional representation at Medicines Quality Group reinforced by Medical Director and Director of Nursing and template for divisional reporting of BAU medication safety activities in to Medicines Quality Group developed and in place		

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1a	Deliver high quality care which is safe, responsive and able to meet the needs of the population	Director of Nursing/Medical Director	Failure to manage demand safely Failure to provide safe care Failure to provide timely care Failure to use medical devices and equipment safely Failure to use medicines safely Failure to control the spread of infections Failure to safeguard vulnerable adults and children Failure to manage blood and blood products safely Failure to manage radiation safely Failure to deliver planned improvements to quality and safety of care Failure to provide a safe hospital environment Failure to maintain the integrity and availability of patient information Failure to prevent Nosocomial spread of Covid-19	5016 4624 4877 4878 4879 4789 4932 5103 5101 4740 4947 5100 5175	CQC Safe	Maternity & Neonatal Oversight Group (MNOG) in place to have oversight of the quality of maternity & neonatal services and to provide assurance that these services are safe and in line with the National Safety Ambition / Transformation programme. Thematic review of SIs and complaints undertaken - recommendations being progressed as part of the Maternity & Neonatal Improvement Plan. External independent input in to SI process. MNOG will retain oversight of the implementation of the relevant IIP programme of work. (MNOG)	Issues with the environment. Ongoing difficulties with the Maternity Medway system which has the potential to impact on compliance with the CNST Year 4 Safety Actions.	Improvements to the environment to be completed as part of planned ward refurbishment. Team to continue to liaise with E&F to resolve and immediate issues as they arise ensuring escalation where delays are encountered. Issues with the Medway system being progressed at local and system level.	Monthly Maternity & Neonatal Assurance Report. Maternity & Neonatal Improvement Plan. Executive & NED Safety Champions in place and work closely with local Safety Champions. NHSE/I appointed MIA in place and supporting the Trust - monthly reports of progress to MNOG. Validation of the implementation & embedding of the Ockenden IEAs has been provided by the regional maternity team. There is a process in place for ongoing testing through supported site visits. Training compliance data.	None Identified	Not applicable.	Quality Governance Committee	**Green**
						Appropriate policies and procedures in place to recognise and treat the deteriorating patient, reported to deteriorating patient group and upwardly to PSG and QGC. Deteriorating Patient Group set up as a sub group of the Patient Safety Group to identify actions taken to improve; has its own sub-groups covering AKI; sepsis (Ensuring early detection and treatment of deteriorating patients) (PSG)	Work required to develop the maturity of the group. New Chair identified and full review of membership and remit required. Maturity of some of the sub-groups of DPG not yet realised. This will be considered as part of the review of DPG.	Observation policy ready to go to next NMAAF Fluid management policy approved by DPG/PSG and awaiting approval at NMAAF Deteriorating Patient Group set up as a sub group of the Patient Safety Group to identify actions taken to improve; has its own sub-groups covering AKI; sepsis; CCOT	Audit of response to triage, NEWS, MEWS and PEWS Sepsis Six compliance data Audit of compliance for all cardiac arrests Upward reports into DPG from all areas Number of incidents occurring regarding lack of recognition of the deteriorating patient Robust upward reports recieved monthly into PSG	Fluid Management group has not been meeting and therefore concerns through PSG have been raised.	The chair of DPG is undertaking a relaunch of the Fluid Management group with revised attendance and reporting into DPG		

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						A robust safeguarding framework is in place to protect vulnerable patients and staff Safeguarding and Vulnerabilties Oversight Group (SVOG) strategically leads on the overall safeguarding goverance, reporting up to QGC Bi Monthly. Mental Health, Neuro-diversityand Dementia Group (MHNDD) have a topic focus and feed into SVOG (Bi-Monthly). Safeguarding and Vulnerabilty Operational groups within the 4 divisions lead on operational issues and action plans - feeding up to SVOG Safeguarding and Domestic Homicide reviews are monitored and quality assured Via SVOG Safeguarding related policies are Monitored and commissioned by SVOG in line with national and local requirements Safeguarding audits (internal and system) are monitored and commissioned by SVOG Safeguarding training topics /compliance are monitored and commissioned by SVOG	Further system work required in relation to delivering against Oliver McGowan Training risk (ID 5141). Business case and funding required in relation to IDVA service gap to ensure efective DV service provision for patients and staff. Rollout of DMI training needs to be embedded across operational teams	Risk 5114 being monitored via SVOG / MHNDD group with ongoing work via System meetings. LD training tier one and two (internal) rolled out to ensure staff have upto date knowledge accepting this is not Oliver McGowan training. Transition from ULHT training to O.Mc as system Domestic abuse workload being monitored via safeguarding team and SVOG Staff groups for DMI identified and PET group in place - full rollout from August 2023 being monitored via SVOG and Health and Security group	Upward reporting from SG operational groups and MHNDD group to SVOG Learning disabilty training figures monitored monthly by Deputy Director of Safeguarding feeding into system meetings and via SVOG. Clinical Holding / restraint Datix being monitored by safeguarding team to ensure review of any restraint incidents with update paper to SVOG Domestic abuse workload monitored via safeguarding team and adjustments to workload made as necessary with paper to SVOG	None Identified	Not applicable		

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						Appropriate policies in place to ensure CAS alerts and Field Safety Notices are implemented as appropriate. One central monitoring process now in place. (PSG)	Review of compliance metrics required. Internal audit of CAS/FSN process found limited assurance with current processes.	New group meeting to address CAS/FSN policy implementation with key stakeholders. Any relevant alerts are also discussed at gold as appropriate. Action plan in place to adress issues identified in internal audit report.	Quarterly report to PSG with escalation to QGC as necessary. Compliance included in the integrated governance report for Divisions.	Furtther work required on the reporting process for CAS / FSNs.	To be incorporated into the action plan following the internal audit.		
						Appropriate policies and procedures in place to reduce the prevalence of pressure ulcers, including a Skin Integrity Group Monthly SIG meeting, with highlight report to NMAAF. Patient information booklet shared with patients Annual Stop the Pressure conference and other learning events in week. Quality Improvements overseen by SIG and outputs through the overarching action plan (NMAAF)	None identified.	Not applicable.	Monthly skin integrity performance report to SIG.	None identified.	Not applicable.		
						Formal governance processes in place within divisions, including regular meetings and reporting, supported by a central governance team Formal role description and network in place for Clinical Governance Leads (CG)	Training provision for Divisional Clinical Governance Leads	Role based TNA being devised for Clinical Governance leads	Minutes of Divisional Clinical Governance meetings with upward reporting within the Division Divisional Integrated Governance Report Support Offer in place from the central CG team for the Divisions	Minutes demonstrate some Divisional Clinical Governance meetings need strengthening	Implementation of standard ToR, agendas and reporting		
						Robust process in place to monitor delivery against the CQC Must Do and Should Do actions and regulatory notices (Delivering on all CQC Must Do actions and regulatory notices). Includes regular meetings with divisions, CQC action plan which goes to relevant committees, TLT, etc. Regular executive challenge meetings on delivery. Escalation routes into PRM and TLT. (CG)	No gaps identified.	Not applicable.	Monthly reporting to sub-committees with the relevant extract of the action plan. CYC and TLT receive monthly reports. QGC receive quarterly update on the entire plan. Quarterly updates Trust Board. Feedback to CQC on achievements at monthly engagement meeting. CQC assurance data.	CQC assurance data not yet complete. CQC assurance data not yet shared with committees. Output from PRM is not clear. Escalations not always acted upon promptly.	Use of exec led meeting to pick up escalations which may not occur via other routes. Additional resource identified for compliance team to support with sourcing levels of assurance.		

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						Embrace both internal and external assessments of patient experience and safety and triangulate information in order to drive a culture of safety - Ensure you do not come to harm under our care (PSG)							
						Embedded processes to address risk of hidden child and support transition across all services (CYP)							
						Maximise safety of patients in our care, through learning from incidents, reducing incidents causing harm and reviewing external reports and assessments of our services (PSG)							
						Well established Patient Experience Group, which is a sub-group of the Quality Governance Committee, in place meeting monthly Robust Complaints and PALS process in place The Group meets monthly and has a work plan and schedule. (PEG)	There are no identified control gaps.	Not applicable.	Upward reports to QGC monthly and responds to feedback Review of ToR annually as part of the work schedule. Quarterly Complaints reports identifying themes and trends presented at the Patient Experience Group Patient Experience Group upward report Divisional Reports have developed in reporting maturity and include a patient story / risks and issues / actions. This is a well embedded part of the PEG meeting.	Themes from the Divisional assurance reports and the Complaints reports and others sources of information are being triangulated, so oversight across the themes is clear, this is work in progress.	Overall report being developed and monitored through PEG.		
						Patient and Carer Experience (PACE) plan 2022 - 2025 The PACE Delivery Plan is actioned and embedded over the life of the delivery plan. (PEG)	There are no identified control gaps.	Not applicable	Patient Experience & Carer Plan progress report to Patient Experience Group as per schedule. Ongoing assurances provided to PEG re: actions.	There are no assurance gaps identified.	Not applicable		

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1b	Improve patient experience	Director of Nursing	Failure to provide a caring, compassionate service to patients and their families Failure to provide a suitable quality of hospital environment		CQC Caring	Quality Accreditation and assurance programme which includes weekly and monthly audits which include feedback on patient experience from patients in the clinical areas. (PEG)	Further development of alignment of findings in audit data to patient experience surveys overarching plan and other sources of patient experience information.	Head of pt experience can access the audit date. Deep dives into areas of concern as identified in quality metrics dashboard meetings Update reports to PEG and QGC as required. Weekly and monthly audits continue to take place including during times of extremis.	Reports to PEG and upwardly to QGC	There are no assurance gaps identified.	Not applicable.	Quality Governance Committee	**Green**
						Communication and engagement approaches to broaden and maximise involvement with patients and carers Expert by Experience Groups are well embedded (one of which relates to discharge) Patient Panel has agenda and representatives that attend Patient Experience group to feedback and ensure continuity of messaging. Sensory Loss group upwardly reports to Patient Panel. Communications task and finish group in place (PEG)	Reaching out project (Hard to Reach groups) still in development. Diversity of current patient representatives and panel members is narrow;.C Contact still to be made with some community groups.	Recruitment for new panel members continues. You Care - We Care to Call (YCWCC) Campaign being used in several wards to test out a variety of ways to improve communication with families / loved ones of in-patients. Communication engagement group set up as a subgroup of Patient Experience Group to look at a range of communication issues affecting patient experience.	Upward reports and minutes to the Patient Experience Group	Diversity of the patients engaging and involving themselves limited meaning that is is not represenative of the local population.	Partnership working established with Healthwatch to reach out to Eastern European community. Early attempts to reach local groups have not been successful and consideration now to work alongside existing agencies such as healthwatch to hear the voices of this community. Staff BAME network approached for community links and contacts. Breast mastalgia group has completed its co-design but will meet again in the future as part of service evaluation. Dementia Carers Expert Reference Group ran for 4 months but membership dropped. Now being redesigned to be a Care Partners Expert Reference group. Advert out for members. New expert reference groups established for Improvement Academy and Digital Transformation. Cancer Expert reference group continues to meet quarterly, hosted by ULHT and reporting to Lincolnshire Cancer Board.		

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						Care after death / last offices Procedure & Guidelines Sharing information with relatives Visiting Procedure Patient information Carers Policy in place (PEG)	Audit of EOL visiting required to determine if there is a consistent approach to visiting.	Exceptions guidance re-issued. Monitor through complaints & PALs. Audit will be undertaken by the Patient Experience Team in this years schedule of work.	Report to PEG through complaints & PALs reports; upward reports were received from Visiting Review working group which has now disbanded; the planned audit will report back to PEG and propose any further recommendations. Complaint data now improved in terms of visiting issues.	Patient information currently subject to review and work is ongoing.	Work progressing well and anticipated to have completed full review by end March 2024. Audit of visiting across the Trust completed and co design workshops undertaken that subsequently produced a new Visiting Policy, Visiting Charter, standardised visiting hours across all areas and the new Care Partners Policy.		
						Inclusion Strategy in place (PEG)	Lack of diversity in patient feedback and engagement	Equality, Diversity and Inclusion Lead is member of Patient Experience Group. EDS3 Domain 1 is being piloted with 3 clinical areas.	EDI 1/4rly report to PEG;	EDI Reports will need to develop in maturity regarding patient experience	Head of Pt Experience to discuss with EDI lead to ensure data is relevant and triangulated.		
						Robust process in place for annual PLACE inspection accompanied by PLACE LITE (PEG)			PLACE report to go to Patient Experience Group quarterly and upwardly reported to QGC Annual PLACE report received at PEG	None identified	Not applicable		
						Enhance patient experience by learning from patient feedback and demonstrating our values and behaviours in the delivery of care with a specific focus on discharge of patients. (PEG)	National surveys evidence overall poor experiences in relation to discharge with a number of questions being benchmarked as worse than others Trusts.	Amalgamated survey action plan in development to identify Trust wide improvement focus. Rolling out of #WMTY initiative to ensure patients are involved in decisions and discussions about their discharge plans. Patient Experience Team working with Discharge Lounge staff facilitating understanding of discharge experience and improvements. Discharge work programme being implemtned as part of the UEC imporvment work.	Discharge experience reports to PEG quarterly.	Work required with the lead nurse for discharge to ensure experience data is collected, analysed and acted upon.	Support to be provided to the lead nurse for discharge.		
						Ensure we provide clinically safe services, through an increased number of Diamond Award Accredited Wards / Departments (PEG)	there are no identified Control gaps	Not applicable	monthly Quality metrics dashboard meeting with all clinical areas. Diamond award applications received and supported by corporate nursing team. Diamond Award Panel chaired by DoN/DepDoN. Award presented by Trust Chair. Metric included with the IIP, and measured Quarterly.	None Identified	Not applicable		

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						Clinical Effectiveness Group in place as a sub group of QGC and meets monthly CEG works to an annual work programme and standard agenda to ensure that all business is covered appropriately. Upward reports are received from reporting groups. Role of CEG is to Improve clinical effectiveness through increased compliance with national and local standards. Quality of reporting into CEG has improved and is increasingly robust. (CEG)	Acknowledged that there is good engagement from nursing and AHPs, however work continues to encourage engagement from medics.	Invites to speakers to come direct from Mr Simpson as Chair of the Group in future. Mr Simpson to continue as Chair of the Group whilst appointment of Deputy Medical Director concluded and will commence in role of CEG chair	Effective upward reporting to QGC from reporting groups. Regular reports received from Divisions providing assurance that they understand their position with respect to clinical effectiveness	No gaps identified.	Not applicable.		
						Getting it Right First Time Programme in place with upward reports to CEG and QGC. Agreement in place recommencement of the of the GIRFT Programme (CEG)	Recognition that the Trust has made the decision that the GIRFT programme will be restricted to those areas relating to high volume, low complexity (HVLC) and areas seeking to focus on elective recovery. Reports currently tend to focus on the process of GIRFT. Further work needed to demonstrate changes in practice as a result of GIRFT work.	Quarterly reports to Clinical Effectiveness Group GIRFT team in place to support divisions and ensure that appropriate activity takes place.	Upward reports to QGC and its sub-groups KPIs in the integrated governance report Process in place for feedback to divisions	Reporting has begun to focus on outcomes but this is not yet well embedded.	Request from CEG for future reports to show improved outcomes as a result of GIRFT activity.		
						Clinical Audit Group in place and meets monthly (CAG) with monthly upward reports to CEG Refocus of CAG to focus on the learning from audit. (CEG)	There are outstanding actions from local audits Due to operational pressures, quoracy has been an issue although this is beginning to improve.	Support being provided from central team to close outstanding overdue actions Job role description for Clinical Audit Leads has been developed. Quarterly updates with Clinical Audit Leads take place with the Deputy Medical Director.	Reports generated for Clinical Audit group and CEG detailing status of local audits and number of open actions. Reports also include learning and changes in practice as a result of audit.	No gaps identfied.	Not applicable.		
						National and Local Audit programme in place and agreed which is signed off by QGC. Improved reporting to CEG regarding outcomes from clinical audit. Reports and process in place for any areas where the Trust is identified as an outlier. (CEG)	None identified.	Not applicable	Reports from the National Audit Programmes including outlier status where identified as such Relevant internal audit reports Reports identify where practice has improved but also where it has not improved.	None identified	Not applicable		

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1c	Improve clinical outcomes	Medical Director	Failure to provide effective and timely diagnosis and treatment that deliver positive patient outcomes	4731 4828	CQC Responsive CQC Effective	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	Quality Governance Committee	**Green**
						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) Process in place for identifying outliers through Model Hospital. Clinical leads for outlying areas present updates to CEG quarterly. (CEG)	No gaps identified.	Not applicable.	Quarterly reports to CEG and upwardly reported to QGC. Action plans developed for all required areas.	No gaps identified.	Not applicable.		
						Process in place for implementing requirements of the CQUIN scheme. Monthly meetings take place with CQUIN leads. Quarterly reporting takes place. (CEG)	No gaps identified.	Not applicable.	Quarterly reports to CEG and upwardly reported to QGC	No gaps identfied.	Not applicable.		
						Process in place for ensuring high quality of record keeping including Medical Records Group. (CEG)	Medical Records Group not meeting regularly.	Refocus of the Medical Records Group planned by the new Chair.	Programme of record keeping audits taking place.	Audits do not demonstrate compliance with record keeping standards. Limited evidence that specialties are reviewing record keeping findings and developing actions to address.	Divisional governance leads to pick up within each area.		
						Process in place for monitoring of and implementation of NCEPOD requirements. (CEG)	None identified.	Not applicable	Quarterly reports to CEG on progress.	Some outstanding baseline assessments. Some overdue actions identified.	Work taking place with divisional leads to address.		
						Quarterly Learning Lessons Newsletter in place at both Division and Trust wide level (CEG)	Staff may not access emails to review newsletters Assurances to be received at the next meeting regarding how learning is shared within Divisions.	Programme of work commencing regarding wide ranging mechanisms for learning lessons across the Trust.	Evidence of newsletters shared is available.	No gaps identified.	Not applicable.		
						Improve clinical effectiveness and best practice principles by prioritising Cardiovascular pathways							

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						Monthly MorALS meeting chaired by the Deputy Medical Director and attended by a representative of the Triumvirate for each division. Member of systemwide Mortality Collaborative Group. Divisional M&M meetings in place. Business Partner Model approach in place. Monthly mortality report in place to track achievement of SHMI/Mortality targets (Maintaining our HSMR and improving our SHMI) reporting in to monthly mortality group and upwardly to PSG. Training has been delivered to approximately 40 members of staff to undertake SJR's. Bespoke training and support offered from the Mortality team to the Divisions. (CEG)	Gaps in the number of structured judgement reviews undertaken - this is not across all Divisions, good practice exists and is demonstrated through the mortality group. Not all specialties have recommenced M&M meetings since Covid - work is taking place to support them with this.	Following the success in UTOO for ACP's contributing to the SJR reviews, further training is going to be rolled out to the MDT. Standardised process being developed for M&M meetings.	National Clinical Audits Dr Foster alerts HSMR and SHMI data Medical Examiner screening compliance and feedback Dr Foster data on depth of coding. Divisional updates at MorALs by the Triumvirate.	Gap identified in the ability to draw learning from SJR's due to ongoing delays with completion	Local data sources are used where possible. Gaps in learning mitigated by ME process and escalation of concerns via incident management processes.		
SO2	**To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT**												
						NHS people plan & system people plan & five themes:- - Looking after our people - Belonging in the NHS - New ways of working & delivering care - Growing for the future - Leadership and Lifelong Learning (from 2022/23)	None identified		Workforce Board with oversight of the workforce CIP plans for the system	None identified			
						Workforce planning and workforce plans Recruitment to agreed roles - plan for every post, for Agenda for Change, Medical and Dental Workforce 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. Reported through to the Operational Workforce and Strategy Group and then included within the highlight report for People & OD Committee highlight report to Board	None identified		Workforce plans submitted for 2023/24 Operational Planning. Recruitment plans are in place. Divisional Recruitment Pipeline Reports are refreshed regularly for each division working with each of the SHRBP's and are reporting through to FPAM in terms of pipeline linked to reducing agency spend.	None identified			

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2a	A modern and progressive workforce	Director of People and Organisational Development	Possible disruption caused by system wide strike action and capacity of Pillar leads	4844 4996 5093 4997	CQC Safe CQC Responsive CQC Effective	Focus on retention of staff - creating positive working environment and integration of People Promise 'themes' System retention role established and in place for 2023/24. People Promise Y1 work complete with funding for Y2 agreed. Education and Learning Team in place and actively working to improve compliance with Statutory and Mandatory Training. Organisational Development Team in place and actively working to improve completion rates for Appraisals.	System People Promise Manager to be recruited for Yr2 Consideration to the concept of group appraisals and appraisal lite	OD picking up retention/flexible working whilst People Promise Manager not yet recruited to Workforce Strategy and OD Group to discuss group appraisal and appraisal lite Sept 2023	Workforce, Strategy and OD Group upward report to PODC including scorecard analytics i.e. appraisal, statutory and mandatory training	Appraisal compliance levels not at expected level Mandatory Training compliance not at agreed level	To be monitored through the Workforce Operational Group and FPAM meetings and will feature in the highlight report to PODC. Phased targeted approach in 23/24 KPI's as featured in the Integrated Improvement Plan.	People and Organisational Development Committee	Green
						Embed continuous improvement methodology across the Trust	Embedding and sustaining cultural change when the ability of the ULHT teams to engage when we are operationally challenged Ability to demonstrate quick impact on the cultural change due to various interventions will be limited (as these are multi year/multi factorial projects)	Improvement Academy now report all training & associated activity to embed continuous improvement through Improvement Steering Group for oversight and escalations Working with each improvement programme and Divisions to develop identify and align improvement plans	Internal training reports produced by Improvement academy Improvement programmes identifying personalised training needs for ULHT staff Divisions training plan (aligned to the IIP) presented at FPAM	Information is reported to ISG - Low uptake of our various training offers despite general and targeted comms through various platforms. Services are struggling to release staff for QI training due to pressures. Plan for a QI relaunch in the new financial year. Use of virtual training option via MS Teams.	Weekly meetings with Improvement Academy to increase offer with more agile training methods to meet the needs of the varied staff. Developing communications & engagement strategy for on-going awareness of Improvement Academy to enable improvement culture change (not just limited to sending email updates but being creative and being on site on wards to talk about quality improvement)		
						Reducing sickness absence - Absence Management System	Manager call back compliance and return to work interview	Compliance with use of AMS being addressed through People Management Essential Training and AMS training from HRBPs Early Occupational Health led interventions are being explored for top two reasons for sickness absence	Sickness/absence data Deep dive by Workforce Strategy and OD Group into absence data Internal Audit Report Actions	Various reports through Heads of HR to Divisions Output from WSOD Group deep dive into absence data	Work continues with the completion of the audit actions and work/training with the departmental managers and HR. To be monitored through the Workforce Operational Group and FPAM meetings and will feature in the highlight report to PODC. Phased targeted approach in 23/24 KPI's as featured in the Integrated Improvement Plan. A deep dive is being undertaken of the full utilisation of the AMS management system as early indications show improvement is needed.		
						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 Promote benefits and	None identified		WSODG, FPAM and PODC data Workforce, Strategy and OD Group upward report to PODC including scorecard analytics i.e. appraisal, statutory and mandatory training	Appraisal compliance levels not at expected level Mandatory Training compliance not at agreed level	To be monitored through the Workforce Operational Group and FPAM meetings and will feature in the highlight report to PODC. Phased targeted approach in 23/24 KPI's as featured in the Integrated Improvement Plan.		

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						opportunities of Apprenticeships							
						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	New Training and Development department in place with full recruitment programme now complete	Dedicated capacity and project leadership identified for Culture and Leadership Programme	WSODG, FPAM and PODC data Culture and Leadership Task Force Reports to PODC	None identified		
						Proactively support staff to remain well and at work, however should the need arise, supporting them through illness and their return to work Staff Vaccination Programme	Improvement in sickness rate in 23/34 full year affect of 4.5% required. Continue to fill vacancies within the HR department to support Divisions with sickness management	Continue to fill vacancies within the HR department to support Divisions with sickness management As at Aug 23 almost at fully recruited position within HR structure	Health and wellbeing Manager and Health and Wellbeing Group/Wellbeing Champions Upward reporting to WSODG from H&WB Group Board level HWB Guardian change enacted Vaccination Programme updates through WSOD Group	None identified		
						Employee Assistance Programme implemented May 2022 - embedded as business as usual	None identified		PODC Scorecard reporting to PODC	None identified		
						Vacancy levels below 4% across all staff groups Aligned to the plan for every post, recruitment plans for each division and aligned to the workforce submission plan for 23/24.	None identified		Key Performance indicators have been identified as part of the IIP and will be monitored through the scorecard at Workforce Operational and Strategy Group. Pastoral care award received for recruitment and on-boarding of international nurses	None identified		

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						Reduce our staff turnover rate to 6% across all staff groups	Aligned to the continued work under the People Promise Manager role and plans for 23/24 to continue to improve work life balance, flexible working requests, flexible retirement/retire and return options. People Promise Mgr funding identified for Yr2		Key Performance indicators have been identified as part of the IIP and will be monitored through the scorecard at Workforce Operational and Strategy Group. Pastoral care award received for recruitment and on-boarding of international nurses	None identified			
						Compliance with National agency utilisation target of 3.7% agency and locum workforce	None identified		FRP and ISG	None identified			
						Reset ULH Culture and Leadership through delivery and implementation of Culture and Leadership Programme and Restorative and Just Culture Programme. Cultural deep dives	Comprehensive follow up and prioritisation of NSS results - key areas of concern identified for action 7 point action plan presented and agreed to ELT/TLT	Leading Together Forum - regular bi-monthly leadership event Delivery Plan and actions to be confirmed further to results of Leadership Survey LTF Forward Plan Leadership SkillsLAB - essentials in management and leadership for existing managers	Culture and Leadership Group and System People Board Culture and Leadership Programme Group upward report NSS results (Feb 2023) Themes from cultural deep dives presented to PODC	Delivery of agreed output	Paper presented to ELT in August to offer a plan in terms of 23/24 National Staff Survey plans and individual priorities being taken forward in preparation for the next NSS. Restorative Just and Learning Culture project team has been created to scope out the plans to roll out in the Trust.		
						Effective communication mechanisms with our staff - ELT Live, managers cascade, intranet etc.	None identified		Staff survey feedback - engagement score, recommend as place to work / recommend as a place to receive care Director BLOG's	None Identified			
						Leadership & Management training. (Improving the consistency and quality of leadership and line management across ULHT) Leadership SkillsLab - Re-launched July 2023	None identified		National Quarterly Pulse surveys (mandated from July'22) Number of staff attending leadership courses	Limited uptake of quarterly staff survey	Work on-going in terms of uptake and analysis		
						Lincs Belonging Strategy EDI Delivery Plan 2022-25	None identified		Council of Staff Networks Internal Audit - Equality, Diversity and Inclusion NHS NSS EDI/EDS objectives	None identified			

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2b	Making ULHT the best place to work	Director of People and Organisational Development	Further decline in demand Weak structure (to support delivery) Lack of resource and expertise Failure to address examples bullying & poor behaviour Lack of investment or engagement in leadership & management training Perceived lack of listening to staff voice Under-investing in staff engagement with wellbeing programme Failure to respond to GMC survey Ineffectiveness of key roles Staff networks not strong	4439 4948	CQC Well Led	Staff networks	Men's Health Network Group due to be launched November 23 Additional Carers Network now launched. An ELT Network special has also been held with all Network Chairs and Executives	Executive sponsor for Men's Health Network to be identified Launch Network in November	Council of Staff Networks	None identified			**Amber**
						Focus on junior doctor experience key roles:- - Freedom to speak up Guardian - Guardian of safe working - Well-being Guardian	Additional resources are now in place within the OD Department to help support culture and engagement within the Medical Workforce.	Task and finish group to review experience of rotation	Dedicated resource in place for GOSW and FTSUG. NED 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)	System People Promise Manager to be recruited for Yr2 funding identified	OD picking up retention/flexible working whilst People Promise Manager not yet recruited to	Culture and Leadership Group to PODC	None identified			
						Support Divisions to achieve 95% of our people having completed all relevant statutory and mandatory training by March 2024 Trust aligned to National Core Skills Training Framework Mandatory Training Governance Group in place MTTG used as Gateway to core learning Mapping of core training on more individual basis		Support and training from new Education Department	Workforce Operational Group Upward reporting to People and OD Committee CQC Monthly reporting				
						Support our Divisions to provide all staff with an appraisal and clear objectives	Newly created dedicated Education Department now in place as part of the restructure. Aligned to the People Promise continued work for 23/24 Updates to ESR system to	Support and training from new Education Department	Workforce Operational Group Upward reporting to People and OD Committee CQC Monthly reporting	Appraisal compliance levels not at expected level	To be monitored through the Workforce Operational Group and FPAM meetings and will feature in the highlight report to PODC. Phased targeted approach in 23/24 KPI's as featured in the Integrated		

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						55% of our staff recommending ULHT as a place to work and an improved position with regards to our people feeling that they are treated with kindness, compassion and respect.	allow better monitoring and reporting Consideration of appraisal lite and group appraisal Further work required aligned to the Quarterly Pulse survey and promotion of this.		Workforce Operational Group Upward reporting to People and OD Committee CQC Monthly reporting Recognition certificate and letter received for the 2022 National Staff Survey	Mandatory Training compliance not at agreed level Limited uptake of quarterly staff survey	Improvement Plan. Additional monthly assurance offered to CQC through governance team regular meetings		
						53% of our staff recommending ULHT as a place to receive care		Further work required aligned to the Quarterly Pulse survey and promotion of this.	Workforce Operational Group Upward reporting to People and OD Committee CQC Monthly reporting Recognition certificate and letter received for the 2022 National Staff Survey				
2c	Well led services	Chief Executive	Risk register configuration not fully reflective of organisations risk profile Current systems and processes for policy management are inadequate resulting in failure to review out of date or policies which are not fit for purpose	4277 4389	CQC Well Lead	Delivery of risk management training programmes Risk Register Confirm and Challenge Group meeting monthly including full risk register review Upgrade to datix system	Upgrade to Daitx due to take place October 2023		Third party assessment of well led domains Internal Audit assessments Risk Management HOIA Opinion received and Audit Committee considered in June noting 'partial assurance with improvement required can be given on the overall adequacy and effectiveness of the Trust's framework of governance, risk management and control. Completeness of risk registers Annual Governance Statement			Audit Committee	**Amber**

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						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	Divisional breakdown of policies requiring review shared with CEG and request for trajectories to update/remove all clinical policy documents requested at August meeting.	Further discssions to take place at October CEG to address shortfall in trajectories being offered	ELT report monitoring actions. Quarterly report to Audit Committee including data on in date policies CQC Report - Well Led Domain				
SO3	**To ensure that services are sustainable, supported by technology and delivered from an improved estate**												
						Develop business cases to demonstrate capital requirement in line with Estates Strategy	Business Cases require level of capital development that cannot be rectified in any single year.	Estates Strategy sets out a framework of responding to issues and management of risk. Capital Delivery Group has oversight of the delivery of key capital schemes. External Specialist Advisor working jointly NHSE & ULHT providing external guidance and validation. Use of the premises assurance model PAM will help identify gaps and subsequent actions or schemes of improvements.	Capital Delivery Group Highlight Reports Compliance report to Finance, Performance and Estates Committee Updates on progress above linked to the estates strategy. PAM Quarterly internal review and annual submission.	Funding gap when considering the full £100m+ backlog in first year. Future years will at most tackle £20m of backlog in any given year 6 Facet Surveys used to quantify and identify schemes are out of date and need reviewing.	Estates improvement and Estates Group review compliance and key statutory areas. Progress against Estates Strategy/Delivery Plan and IIP via sub groups upward reports. Delivery of 2022/23 Capital Programme will continue to ensure progress against remaining backlog of critical infrastructure. Capital Delivery Group will monitor the delivery of key capital programmes and ensure robust programme governance. Structure review including upward reports are being reviewed by specialist advisor with recommendations of reporting lines.		
						Continual improvement towards meeting PLACE assessment outcomes	PLACE assessments have been suspended and delayed for a period during COVID	Use of PLACE Light assessments and other intelligence reports.	PLACE Light Assessments PLACE Full assessments starting in September 22	PLACE/Light do not provide as deep an assurance review as PLACE with limited input.	Combination of PLACE Light and other intelligence (IPC Group/Compliance Reports and Capital Delivery Group) will help triangulate areas of concern and response. With PLACE Full assessments starting in September gaps will be closed further.		

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3a	A modern, clean and fit for purpose environment	Director of Improvement and Integration	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 5189 - Med Air Plant	CQC Safe	Review and improve the quality and value for money of Facility services including catering and housekeeping	Value for Money schemes have been delayed during COVID	Improvement teams have started in 2022/23 working through value for money and financial efficiency schemes included development of Housekeeping, Security and Portering Business Cases for future models	MiC4C cleaning inspections Staff and user surveys 6 Facet Surveys	6 Facet Survey are not recent and require updating.	Cleanliness is reported through IPC Group to QGC. Water Safety and Fire Safety Groups will report through to relevant sub-committees and provide a more comprehensive view offering assurance were it is possible and describing improvement where it is not with Annual Reporting providing assurance and gap analysis on all AE domains.	Finance, Performance and Estates Committee	**Amber**
						Continued progress on improving infrastructure to meet statutory Health and Safety compliance	H&S Committee Previously not run with quoracy. However now reviewed with ToR agreed and Quorate with staffside representation	Water/Fire safety meetings are in place and review of controls are part of external validation from authorised engineers. Health and Safety Committee new terms of reference approved and now chaired by Chief Operating Officer/Director of Estates and Facilities. Upward reporting to Finance, Performance and Estates Committee Med gas, Critical ventilation, Water safety group, electrical safety group, medical gas group have all been established and include the relevant authorising engineers in attendance. These groups monitor and manage risks and report upwards any exceptions or points of escalation.	Reports from authorised engineers Response times to urgent estates requests Estates led condition inspections of the environment Response times for reactive estates repair requests Progress towards removal of enforcement notices Health and Safety Committee upward report Letter from British Safety Council on External Review				
						Implement Year 1 of our Estates Strategy	Funding gaps between overall plan of replacement vs available funding. Availability of Suppliers and Changes in market forces. Availability of raw materials and specialist components to replace/repair etc.	Business Case Development and preparation pre-empting available capital to maximise available. Use of procurement framework and liaison with NHSE to coordinate bids and larger schemes	Estates Group Upward Report				
						Refurbishment of 8 theatres, across our sites							
						Support capacity maximisation ensuring modernisation and utilisation of space, including that leased off the main acute sites							
						Reduce our net carbon footprint							
						Develop Health Master Plans to better algin wards							

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3b	Efficient use of our resources	Director of Finance and Digital	Not identifying and then delivering the required £28m FRP of schemes The national impact of rising inflation (specifically utilities) in excess of the levels assumed in the 23/24 financial settlements The Trust is overly reliant upon a large number of temporary agency and locum staff to maintain the safety and continuity of clinical services. Failure to deliver the activity targets of 116% of 19/20 planned activity will result in a clawback of an element of the ERF allocation made to Lincolnshire.	4664 -Agency costs 5020 - UEC medical workforce	CQC Well Led CQC Use of Resources	Introduction of Aspyre for reporting all FRP schemes Refresh of the CIP framework and training to all stakeholders. Increased FRP governance & monitoring arrangements introduced. Alignment with the Trust IIP and System objectives FRP is embedded as part of the Trust Improvement Strategy not seen as a separate workstream. Internal meeting structure and reporting aligned to the ICS reporting requirements	Operational ownership and delivery of efficiency schemes Detailed delivery plans supported by clear timelines and metrics for all plans	Divisional FPAM to provide oversight of FRP reporting upward into PRMs. Trust wide oversight for FRP schemes in the Improvement Steering Group ICS oversight through the ICB Financial Recovery Board.	Delivery of the Trust FRP target Reporting through Aspyre to - FPAM PRM FPEC Financial Recovery Board	Ability of clinical and operational colleagues to engage due to service pressures. Evidence of system and Trust schemes to reduce the operational pressures and beds numbers in the Trust. Traction in year to produce cost out from cross cutting targeted and transformational schemes	Divisional - Progress is being reviewed monthly with Divisions through FPAMs. Trust wide improvement schemes - Progress is being reviewed monthly with Exec, Divisional and Corporate teams through the Improvement Steering Group. System wide - Progress is being reviewed monthly with system partners including Exec, Operational and Corporate teams through various forums.	Finance, Performance and Estates Committee	Amber
						Inflation - The Trust is working to actively manage its contracts and to flag excess inflation due to market conditions as part of the national collection process in relation to this spend area	Impact of unstable market conditions led to the Trust forecasting excess inflation of £8.1m in its 2023/24 financial plan submission - over and above national inflation funding allocations. The £8.1m (as per national instruction) sits outside of the Trust financial plan for 2023/24. Inflation pressures primarily relate to Utility costs but also impacts in other non-pay contracts. As prices continue to rise the Trust and / or ICS may be unable to mitigate these cost increases.	Financial plan set out the Trust expectation in respect of inflation aligned to the national allocations Annual budget setting process cascades and apportions the Trust inflation allocation to Divisions and Directorates. Monthly financial management & monitoring arrangements are in place to identify variation of excess inflation against financial plans at all levels of expenditure from department up to Trust. The Trust actively manages its external contracts to ensure value for money.	The Trust is monitored externally against the inflation impacts through the monthly finance return to NHSE The Trust monitors internally against its financial plan inclusive of specific inflation forecasts Divisional focus against specific contracts (e.g. Utilities) is reviewed at the relevant FPAM Excess inflation pressures will be reported internally into FPEC and externally into FLG and ICS and Finance Committee	Forward view of market conditions.	Internally through FPAMs and upwards into FPEC. Externally through greater dialogue with suppliers and proactive contract management Flagging with ICS partners and NHSE to understand if any further funding allocations will be available to offset.		
						Financial Recovery Plan schemes Recruitment improvement Medical job planning Agency price reduction Workforce alignment Service Reviews process and transformational programmes of work Budget compliance	Reliance on temporary staff to maintain services, at increased cost Management within staff departments and groups to funded levels. Maximisation of below cap framework rates Rapid ability to on-board temporary staff to substantive contracts	Proposed centralised agency & bank team. Workforce Groups to provide grip Improvement Steering Group to provide oversight Non-Clinical Agency sign off process	Delivery of the planned agency reduction target.	Granular detailed plan for every post plans Rota and job plan sign off in a timely manner	The Trust monitors internally against its financial plan inclusive of specific targets for agency and bank spend by staff group The Trust FRP workstreams are reported to the Improvement Steering Group The Divisional cut of the workstreams are reported to the relevant FPAM The staff areas of key focus - Medical and Nursing are reported through their Workforce Groups		

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						ERF clawback - Collective ownership across the Lincolnshire ICS of the restoration and recovery of the planned care pathways leading to improved activity delivery. Trust focus to restore services to pre-COVID levels and then stretch to 116%.	Maximisation of the Trust Resources - Theatre and Outpatient productivity. Impact of the COVID patients and flow on availability of beds to provide capacity. Ability to recruit and retain staff to deliver the capacity. A production / activity delivery plan.	Divisional ownership and reporting Improved counting and coding, including data capture and missing outcome reductions. Shared risk and gain share agreements for the Lincolnshire ICS. Reporting by POD and Specialty against the delivery plan	Delivery of the 116% target	The operational pressures, specifically; sickness, excess beds open, rising acuity of patients and continuing rising demand at the front door of the acute Trust is putting at risk in year delivery of the 116% activity target.	The Trust is monitored externally against the Trust activity target through the monthly activity returns The Trust monitors internally against its activity targets inclusive of specific Divisional and Specialty plans and targets The Lincolnshire ICS is monitored externally against the system activity target through the monthly activity returns		
						Utilisation of Capital allocation based on risk to enhance our services and support efficiency improvements	Difficult to compare Estate, Digital and Equipment risks. Capacity to produce business cases to access external funds	Revised CRIG process, supported by experts. Green book training roll out. Risk rating pre & post investment required in all investment requests.	Capital, CDC and Benefits realisation upward reports into FPEC. Development of a 5 year capital programme cross referenced to risk register.	6 facet survey not completed.	Investment identified for 6 facet survey.		
						Improve utilisation of the Care Portal with increased availability of information -	Cyber Security and enhancing core infrastructure to ensure network resilience. .	Digital Services Steering Group Digital Hospital Group Operational Excellence Programme Outpatient Redesign Group	Number of staff using care portal Ranked in 4th place nationally of ICS usage of Care Portals.				
						Development and approval of Electronic Patient Record OBC	Regional and National approval of OBC Affordability of OBC	Digital Services Steering Group Digital Hospital Group e-HR Programme Steering Group Capital, Revenue and Investment Group Engagement with regional colleagues	Delivery of OBC Agreement of funding	Regional feedback on OBC	OBC approved by Frontline Digitalisation ePR Investment Board (EPRIB) on 19th July 2023. OBC approved by JIC on 28th July 2023. OBC approved by Cabinet Office Commercial Spend Controls Process on 3rd Oct 2023. ITT published 6th October 2023. Despite multiple clarification questions only received three bids all of which did not meet our minimum threshold criteria. Commercial review carried out in conjunction with legal, the LPP framework and FD as well as external advisors supporting this work. Making some changes to the ITT to ensure that we are able to include as many suppliers as possible. Changes have been made to the commercial terms and		

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											conditions, as well as small changes to the mandatory pass / fail questions in line with wider advice. These changes are currently going through the steering group approval process and being finalised by legal and will go out later in February with the aim of getting more (and much stronger) bids back from the market.		
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	4657 - SARs	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. Project Manager being sought to oversee / plan developments. Baselining Job Description Bandings to ensure they are competitive. Working with ICS colleagues to maximise ICS benefit.			Business case approved by CRIG. Worked scoped and started. Three year rollout of all 30+ initiatives with 'high hitters' being implemented first		
						Improve end user utilisation of electronic systems	Business case for additional staff under development	Digital team providing advice and guidance hoc to address pressure points					

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						Complete roll out of Data Quality kite mark			Ensuring every IPR metric has an associated Data Quality Kite Mark	Information improvements aligned to reporting needs of Covid-19.	A number of metrics have had a review and these are awaiting formal sign off. They will then appear in the IPR. Additional metrics have been added and reviewed, and a work plan and deadlines associated with completion is being drawn up. These will be shared with the Director of Finance & Digital for sign off.		
						Upgrade of our technological infrastructure to support technology advancements	Insufficient cap/rev to replace aging technology Insufficient capacity to deliver purchased equipment	Technical Design Authority Digital Hospital Group Information Governance Group (for cyber / info security)	Digital Maturity Assessment		Looking to procure a Technical / Implementation Partner to provide capacity as and when required Enabling infrastructure funded via FD (EPR) rollout going to plan.		
						Provide our people with real-time data to support high quality care delivery to all clinical staff							
						Enhance our organisational digital capability and skills through training	Insufficient capacity to create and deliver training materials	Digital Hospital Group			Looking to procure a Technical / Implementation Partner to provide capacity as and when required		
						Implementation of an Electronic Prescribing system	2023/24 funding not approved yet Insufficient capacity to deliver at pace of current plan	ePMA Steering Group Digia Hospital Group	Number of wards live with ePMA		Paper written to clarify costs. Currently being worked through with Finance colleagues ePMA fully rolled out across whole trust as of 09/02/2024. Proect now closing		
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	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	Capacity v demand across all tumour site pathways not completed Insufficient oversight of system partners contribution (e.g. primary care testing and workups)	Cancer Leadership Group Deep Dive Workshops (e.g. Colorectal) East Midlands Cancer Alliance Increased Oversight Intensive Support Meetings (Trust and ICS)	Cancer board assurance and performance reports Deep Dive information and reports on gap analysis Routine Performance and pathway data provided by Sommerset system Cancer Intensive Support Meetings	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	Trajectories in place agreed with all tumour sites, to achieve a reduction in number patients >62 days, achievement FDS 70% end of Sept, 72.5% Dec and 75% March and reduction in patients >104 days. The response to the Intensive Support Meetings has been effective, at the end of December >62 days was 191 patients, >104 was 70 pateints, FDS at 72/82%	Finance, Performance and Estates Committee	**Amber**
						Achievement of 104 and 62 week performance trajectory	Capacity to deliver Faster Diagnosis (FDs) for all services	Additional support secured through mutual aid to provide focus on cancer recovery	Weekly system elective and cancer recovery meetings 3x weekly cancer meetings led by Deputy COO, Urgent Care and Cancer and ICB Cancer lead		Due to sustained improvement, NHSE de-escalated cancer from Tiering in December 2023.		

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			access or level of service Trust in tier 1 due to delivery of FDs		FDS	Maximisation of capacity and efficiencies to reduce waiting times and support discharge processes, ensuring services are provided within timeframes which are safe and responsive, enabling a reduction in length of stay/bed occupancy			Trajectories for all specialties in place, weekly position statements offered to ELT and TLT		Focused piece of work in place to review Navigator role in terms of WF capacity and capability has been undertaken with a training program in place and supported PTLs as a result. Breast are developing a sustainability plan to be taken through CRIG in Q4 that will provide a backdrop for continuous achievement of all 3 cancer targets.		
						Development of plans for seven day working, across all of our services							
						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 in place but still in infancy Fluctuating gaps in improvement and operational teams Continued risk of capacity loss from Industrial action	Recovery plans at specialty level. To date have delivered required reductions in 104 week waits. 78 week waits now almost cleared Outpatient Improvement Group in place and is now supported by a delivery group lead by the Deputy COO for Planned Care and Diagnostics GiRFT and High Volume Low Complexity Programme Group Productive Theatres Improvement Programme Grantham Surgical Hub now established and performing well Productivity group established focused on increase of all Elective activity Early adopter of GIRFT Further Faster Programme Line by Line review twice weekly of 78 week waiting patients Outpatient letter project underway to support utilisation	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 Maximum Outpatient and theatre capacity not apparent as yet. Demonstration of change at pace is lacking. Time and oversight from senior divisional teams	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.		

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3e	Reduce waits for patients who require planned care and diagnostics to constitutional standards	Chief Operating Officer	Insufficient clinical or physical capacity, insufficiently optimised pathways Trust in tier 1 due to delivery of FDs		Referral to Treatment (18week wait) Standards Diagnostic 6week (DM01)	Outpatient Recovery & Improvement Programme (ORIG)	Focused on 3 activities to support outpatient specialties to be able to reduce backlogs and provide enough capacity to meet demand 1. Clinic slot utilisation key metric being tracked to drive up access to outpatient services and reduce the backlogs 2. e-RS -All directory of services (DOS) reviewed and services to be uploaded to ensure polling for primary care 3. Missing outcomes backlog addressed and reduced with sustainable plans OP Sprint above completed - next phase of OP work in Q4 to continue to address slot utilisation, improve Patient Initiated Follow Up , no patients waiting over 78 week & root cause issues of missing outcomes & DNA in Trauma & Orthopaedics	ORIG working with division to get back to pre-covid clinic templates and develop recovery plans Specialty based capacity and demand modelling to ensuring outpatient resource focused in correct areas-focus on division specific areas of improvement required. This now supported with a delivery group that focuses on 'Further Faster'.	OP Data Activity tacker from Performance Team reviewed weekly monthly in divisional FPAM	Escalations & issues through ISG when required	Reporting through Improvement Steering Group & FPEC	Finance, Performance and Estates Committee	**Amber**
						HVLC/GIRFT Programme - Theatre productivity and efficiency	Ability of the ULHT teams to engage in the programme Emergency pressures resulting in elective cancellations Culture mindset change takes time.	Full robust Theatre programme with focus on KPIs now meeting weekly to oversee and drive changes	Theatre dashboard has been created and reviewed by operational teams for booking & scheduling - aim for 90% 6-4-2/scheduling now in place and now has a Senior Leader attendance rota. Weekly Capacity meetings held to ensure theatre utilisation	Increased in NEL demand may impact staffing levels, elective bed capacity, and therefore could impact on elective activity. KPIs potentially impacted: OTD cancellations and actual utilisation against planned levels	Reporting through Improvement Steering Group/FPEC/HVLC		
						Clinical prioritisation Group	Ability to list appropriate mix of P2/3/4 due to effective preop Unnecessary on the day cancellations Increased non-admitted waiting list waiting to convert to admitted	Preop workstream via FEI Review and management through prioritisation group and Surgical PRM Management through ORIG/HVLC/Surgical PRM	Reporting through FPEC/HVLC				
						Meet all National asks for performance, set out in the planning guidance, for elective care							

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						Maximisation of capacity and efficiencies to reduce and eliminate 78 week, 65 week waits across all specialties and moves to ambition of reducing 52 week to 700 by end of Q4 2023/2024			Trajectories for all specialties in place, weekly position statements offered to ELT and TLT Weekly planned care update meeting				
						Development of plans for seven day working, across all of our services							
						Twice Daily System control meetings in collaboration with 3x daily internal capacity meetings. Group UEC Board established reflecting 5 Pillars of Improvement System Urgent Care Partnership Board.	Internal professional standards not embedded Medical and Nursing WFP not reflective of 24/7 UEC service requirements Lack of understanding at ward level re SAFER leading to poor implementation Assessment areas not substantively funded Capacity Team unable to provide adequate cover 24/7 due to WFP	5 Pillars / Worstreams reflecting key cross system programs of work. Progress of the above measured through the Group UEC Board Monitoring of performance at Tier 2 Meetings with NHSE External reviews including GRFT have identified gaps in services	Improvement against 3 key metrics as agreed with NHSE and monitored via Tier 2 meetings : % of patients in Emergency Department >12 hrs (Total Time), 4 hour Type 1 performance, Cat 2 Mean EMAS performance Updates full suite of metrics to ELT, TLT and Board. Updates provided to Group UEC Board and UEC System Partnership Board	Assurance that PW0 patients discharge is being effectiveley planned at pace. Assurance that all PW1-3 capacity is used on a daily basis Full Capacity protocol implemented as per guidance Discharge is being planned in line with SAFER principles Specialist teams are attending ED within 30 mins of request in line with IP standards	Revised capacity meetings implemented from Sept 2023 and led by COO Office x 4 days a week and Divisions 1 day a week. Full capacity protocol including +1 and +2 on wards has been updated and implemented from September 2023. Commencement of the Perfect Week Model from Oct 2023. Daily UEC Strategic and Tactical Meetingsfrom Nov 2023. Weekly Group UEC Board from January 2024 through which x 5 pillars of cross LCHS/ULHT work are monitored		

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3f	Urgent Care	Chief Operating Officer	Insufficient clinical capacity or expertise, inefficiently configured services, failure of system partners to provide capacity or reduce demand to pathway and excessive demand above capacity available		Emergency Care Clinical Indicators (12hr, 4 hour CRTP, 60 minute decision and 15 minute triage)	Urgent Care Recovery Improvement Steering Group which oversees a programme of work linked to increase capacity, flow and discharge through the Trust Wide Emergency Departments, Urgent Treatment Centres and Same Day Emergency Care Breaking the cycle pilot has now ended and lesson learnt document shared and agreed recommendations for embedded changes agreed at UCRIG	Large complex programme which required system working to reduce pathway 0 waits and deliver right care right time principals	Large programme of work so additional resource had been provided through a consultancy Impower & ECIST to assist in identification of areas to improve and on the ground support. This has now ceased. ED 'risk' summit undertaken on 8 August 2023 to support ongoing recovery.	Metrics dashboard developed for discharge and flow linked to bed reductions trajectory	Data metrics to demonstrate impact on of the interventions is being developed. There is a risk to the delivery of non-elective length of stay target and increase in daily discharges due to the reliance of other specialties and external agencies outside of the control of the hospital There is a risk that winter pressures and will outstrip length of stay and occupancy gains preventing delivery of discharge/ bed closures.	Reporting through Urgent Care Improvement& Recovery Steering Group and Improvement Steering Group monthly. Working with System Partners to ensure maximum use of all external capacity and an increase in capacity where there is unmet demand (PW 1 in particular - c 50-60 patients per day) Perfect week was introduced in October 2023 with supporting strategic and tactical governance structure in place to support rapid improvement in UEC performance	Finance, Performance and Estates Committee	**Red**
						Recovery Support Plans	Risk of further waves, increased emergency demand and covid related sickness	Urgent and Emergency Care Board.	Daily review via Capacity and performance meetings Weekly reporting to ELT Fortnightly reporting to TLT		ED Intensive Support meetings established in August 2023. Exec led and attended by CD Urgent Care, Divisional Lead Nurses etc. 5 key priorities identified, delivery monitored via this meeting weekly.		
						Meet all National asks for performance, set out in the planning guidance, for non-elective care					NHSE are monitoring the Trust on 3 key metrics: (i) Ambulance Response Time Cat 2: 30 min national standard. Achieved historically but performance in Sept has deteriorated. (ii)4 hour performance: currently overperforming against trajectory (iii) 12 hour in dept: the number of patients that wait >12 hours in ED was c2900 in September. The Trust is one of the worst nationally in terms of this metric.		
						Maximisation of capacity and efficiencies to reduce waiting times in ED and support discharge processes, ensuring services are provided within timeframes which are safe and responsive, enabling a reduction in length of stay/bed occupancy			Trajectories for all specialties in place, weekly position statements offered to ELT and TLT		Further rollout of SAFER will be supported by 4 B6 nurses to support discharge and flow out of wards and improve "pull" from ED.		
						Development of plans for seven day working, across all of our services							
SO4	**To implement new integrated models of care with our partners to improve Lincolnshire's health and well-being**												

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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 being developed	Specialty Review Programme has now commenced. A heat map was produced using a data driven approach to identify the first cohort of specialties to be prioritised. 15 specialties were identified and 11 have had their review workshop and have 5yr strategies now being finalised. The final 4 are planned for early 2024. A revised heat map was been sent to FPEC (Dec 2023) for approval to move forward with the 2nd phase of specialties identified. The specialty review team have also undertaken an additional 3 workshops at the request of divisional colleagues. Totalling 14 workshops delivered since the programme began in February 2023.	Reports -ELT / TLT -Committees -Board -System	Plan of how the speciality strategies will be developed	Strategy & Best Practice team now fully recruited too and all vacancies filled. Head of Strategy & Best Practice now substantively recruited to. A specialty strategy template has now been drafted and is used to create the strategy documents following review workshops. Supported by a detailed action tracker to ensure actions are captured and progress monitored. Regular update to FPEC on programme progress. All aspects of programme managed effectively.	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 Lincolnshire ICS anchor organisation plan not yet in place Wider regional governance to provide East Midlands oversight of population need and outcomes not yet finalised (via East Midlands Acute Provider Collaborative (EMAP)) ULHT have not embedded a culture of contributing towards population health across the whole organisation and a further understanding of health inequalities and mitigating actions.	Map key stakeholders and priorities for a partnership strategy focussing on addressing health inequalities and prevention Board and senior leadership team sessions on understanding the new ICS landscape and ULHT role within this Lincolnshire System Anchor Workshops underway to align areas of focus and develop system Anchor Plan - looking to agree priorities and exploring opportunties associated with Greater Lincolsnhire devolution EMAP Governance structure now agreed, EMAP Managing Director starts 27th Novemebr 2023 and will be hosted by ULHT. ULHT engagement in 3 EMAP work programmes. Scope what a good effective partnership look like.	ULHT Green Plan Risk and Gain share (provider collaborative) Early Warning Discharge Indicators/development a common set of agreed metrics for flow and discharge across the system ICB delegation agreement ULHT Partnership Strategy EMAP governance structures	Green Pan under-delivery 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	Green PLan assurance - governance and PMO plan 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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								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.					
						Gain a greater understanding of the Lincolnshire population and support a reduction in health inequalities	Core20PLUS dashboard not yet developed	Development of Core20PLUS dashboard by June 2023	Core20PLUS dashboard	Core20PLUS dashboard not yet developed	Dashboard due to be in place by June 2023		
						Establishment of the Tobacco Cessation service to proactively support better health for the Lincolnshire population	Service not fully recruited to	New project manager in place Jan 2024 and will lead on outstanding recruitment.	Service mobilisation of Tobacco Cessation service	Service not yet mobilised	Project Manager and 1 x Tobacco advisor recruited and started. 1 x Tobacco urse starting in February 2024. This will form a Lincoln site based team to mobilise Lincoln service by end of March 2024.		
						A Joint Forward Plan by June 2023 and continued utilisation of Joint Strategic Needs Assessment (JSNA), population health data from Optum and the health and wellbeing strategy, to influence our collective approach	Final plan not yet in place	Plan being considered by relevant Boards prior to sign to off, expected July 2023	Plan to be considered in Chief Executives Group and formally to the Board	Final plan not yet in place	Plan being considered by relevant Boards prior to sign to off, expected July 2023		
						Joint working with system partners, maximising care homes, virtual wards and admission avoidance schemes, such as the frailty programme	Investment Business Cases not yet in place (SDEC frailty assessment, ED Paed Hub, Community Child Nurse, Rapid Assessment and Triage (RAT), Hospital at Night, SAFER)	Business Cases being presented to CRIG in July	Business Cases Shared Performance Dashboard - frequent attenders	Business Cases in development Dashboard in development	Business Cases being presented to CRIG in July Joint work with Optum to create dashboard		
						Developing a business case to support achievement of University Hospital Teaching Trust Status through development of fit for purpose R&I estate	R&I Team require investment and growth to create sustainable department	The case of need was approved at CRIG (September 2021) and now needs to return to CRIG as FBC. R&I team working closely with Strategic Projects to develop full business case for the growth of R&I department.	Progress with application for University Hospital Trust status R&I Team reporting in to ULHT Hospital Steering group as key stakeholder. Upward report to P&OD Committee	Further understanding of the costs involved to increase size of R&I department and also to develop an R&I facility - options appraisal in development	R&I team reworking business case with a phased approach		

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4b	Becoming a university hospitals teaching trust	Director of Improvement and Integration	Failure to develop research and innovation programme Failure to develop relationship with university of Lincoln and University of Nottingham Failure to meet the current UHA requirements to become member of university hospital association		CQC Caring CQC Responsive CQC Well Led	Shared understanding and implications of the UHA guidance and identify relationship management of key stakeholders nationally (DH, UHA) Agree contract with UOL, R&I team to Increase the number of Clinical Academic posts	Funding for Clinical Academic posts and split with UOL to be agreed	Monthly meetings with ULHT and Uni of Lincoln to discuss funding position and agree MOU - ULHT to fully fund clinical academic posts until research grant income starts to be generated - agreed approach for joint oversight of clinical academics to support discussion on performance and any adjustments to job plans Meetings with ULHT and UOL finance/contracting teams have taken place to develop the full financial model including risk share approach. Next meeting planned MOU aligned to early outputs from the commissioned working group with the full report expected early 2024.	Contract agreed with UOL for Clinical academic posts. UoL and ULHT have draft contracts and offer letters ready for use. Increase in numbers of Clinical Academic posts - agreed to prioritise on clinical specialities where there are workforce gaps/high agency spend to mitigate ULHT cost pressure RD&I Strategy and implementation plan agreed by Trust Board Upward reporting and approval sought through TLT/ELT	Unknown financial commitment for the Trust in relation to the clinical academic roles until the financial model is completed.	Monthly meetings with ULHT and Uni of Lincoln Financial model will be updated in line with new risk share proposals for review and approval by ELT	People and Organisational Development Committee	Red
						Improve the training and support environment for students and clinical academics ULHT Library and training facilities improvements are now complete.	Lack of a model for research training and support for new clinical academics as they start to be employed No current agreement between ULHT/UoL in relation to clinical academic accommodation and resources model	Clinical Academic Model financial model and contract will include facilities and resource provision. Exploratory work underway to understand package of support e.g. via clinical rails unit, UoL	Clinical academic financial model once complete GMC training survey Stock check against checklist Internal Audit - Education Funding	Clinical Academic financial model not yet agreed	A new R&I group has been set up being led by Director of R&I/Deputy Medical Director, this will provide more oversight and rigor in developing an R&I agenda with representation from key stakeholders and clear milestones for delivery		
						Develop a joint research strategy with the UoL by September 2023, which identified shared research focus areas which is needed to meet UHA requirements	A joint MOU is in place at a Lincolnshire System level as agreed in April 2022, and the Steering Group and ELT has agreed that this should be used as the overarching MOU A draft ULHT/UOL MOU has been prepared but this has not been signed off as ideally it will need be combined with the final clinical academic model into a shared contract. Draft priorities based on initial dialogue with vice dean of the medical school has been created, further work to develop UOL strategy is being undertaken.	Working closely with the University of Lincoln, monthly meetings. Through these meetings have completed first draft of the Joint Strategy. There is an existing ULHT R&I Strategy in place and a new version will be developed for 24/25 as the current one is it its final year. The Lincolnshire ICS have commenced work on a system wide R&I strategy - UHLT Director of R&I is engaged with this process. As ULHT are not currently in a position to apply for UHA status due to the lack of clinical academics employed, the shared Strategy is not required currently. However it will need to be in place ahead of a UHA application.	RD&I Strategy and implementation plan agreed by Trust Board	Clinical Academic Model is required to support shared Strategy development UoL have refreshed their Research Strategy and as at end Oct 2022 ULHT are awaiting a copy of this to then align to joint strategy between the two organisations.	Monthly meetings with ULHT and Uni of Lincoln and through ULHT Steering Group Shared Strategy is a requirement for UHA application and not Teaching Hospital Status		

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
						Clear understanding of UHA requirement for University Status which requires 6% of medical workforce WTE to be clinical academics which is being used to build the ULHT/UOL model Develop a portfolio of evidence to apply for Teaching Hospital status as an interim approach towards full University Teaching Hospital status at a later stage	Financial model and clinical academic roles are not yet in place	A financial model for the appointment of clinical academics is in development that describes a timeline to achieve the required 6% of medical workforce for UHA status Portfolio of evidence is being captured for Teaching Hospital status application and is available on the shared drive Identified leads to liaise with UHA CEO (Medical Director, ULHT and System Clinical Director/Chair PCN, Lincolnshire ICS)	Financial meetings underway to develop and agree clinical academic models. Working Group meetings have been re-established and include medical, nursing, AHP and OD representation. Template for teaching Hospital submission and clear timeline in place to achieve status by end 23/24	Lack of finalised, agreed financial and contracting model for clinical academics roles currently	Meetings in diary to discuss updated financial model and MOU once approved by ELT and PODC		
						Develop a strong professional relationship with the University of Lincoln and the Medical School and jointly create a strategy with a focus on developing rural healthcare, medical/nursing/AHPs/Clinical Scientists/R&I staff education and other healthcare roles	Evidence bound by UHA requirements Clear plan/strategy on development of medical/nursing/SHPs/Clinical scientists/R&I staff education roles	A new R&I group has been set up, being led by Director of R&I/Deputy Medical Director. We continue active stakeholder management with Medical Director of ICS and UOL VC.	ULHT healthcare roles plan Increased recruitment/academic posts (across ICS)	The change to the UHA Guidance (20xClinical Academics) is a challenge. Received further feedback from UHA and need to have at least 20 clinical academics remain unchanged.	Working closely with University of Lincoln to develop plans for recruitment of Clinical Academic posts with a view to maximising existing research relationships where possible. Two potential candidates have been identified for the Clinical Academic recruitment.		
						Successfully recruit 6 Clinical Academics within the first year of agreement of the UoL/ULHT model	Agreed clinical academic financial model	A financial model for the appointment of clinical academics is in development that describes a timeline to achieve the required 6% of medical workforce for UHA status	Working group Meetings, ULHT/UOL Exec meetings and R&I meetings	The financial model is not yet agreed which is delaying appointment of clinical academic roles Identified early adopter Clinical Academic roles once model agreed	Ongoing meetings between ULHT and UoL, commissioned working group developing final proposal which will be used to inform the financial model and MOU.		
						Improve research and innovation activities and culture through new ULHT Growth of Research Culture Steering group	Workplan not agreed or implemented as yet	R&I held a session with TLT 6th July and steering group meetings are taking place. To develop the workplan and inform the strategy development	Steering group Meetings underway, meeting minutes and actions	Wider engagement and awareness across ULHT	Head of R&I and Director of R&I planning research culture engagement events		

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4c	Successful delivery of the Acute Services Review	Director of Improvement and Integration	Limited capacity to hold regular scheduled ASR meetings with ULHT Divisional Teams due to ongoing operational pressures (Level 4, Major Incident etc).		CQC safe, CQC responsive, CQC well led	Develop a ULHT clinical service strategy with focus on fragile services in order to provide sustainable and safe services for the future Identify the key services to focus on for Clinical Service Review (taking into account CIP, benchmarking, GIRFT and other core data)	Divisional IIPs need to be completed to ensure links into fragile services/clinical service strategy Identify resources to implement ASR outcomes	First cohort of specialty reviews underway and on track Programme management support being identified via Provider Collaborative to help deliver ASR phase 1 Individual work streams to be established Clinical Strategy engagement period has successfully concluded - 1st draft document has been socialised for feedback from key stakeholders. Delay in launch due to resource availability - Strategy planned to be presented to Board in March 2024 for approval.	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 Publish ULHT clinical service strategy March/April 2024 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 - pressures remain in length of stay and outliers but capital build planning is progressing. GDH ASR: UTC is mobilised and open with integrated community model being completed early 2024.	Finance, Performance and Estates Committee	**Amber**
						Establishment of a rolling programme of service reviews, with 12 completed in year	Sign off of specialty review strategies and governance route not yet known	To be agreed with ELT, July 2023	Signed off specialty reviews	Governance route not yet established	Agreement of governance through ELT		
						Play an increasing leadership role within the East Midlands Acute Provider Collaborative to develop key partnerships	EMAP work programmes establishing - outcomes/deliverables not yet agreed	Programme Boards in place with monthly meetings underway Highlight reports being overseen by monthly EMAP executive meetings EMAP updates to ELT/TLT	EMAP executive meeting minutes	EMAP programme highlight reports - still in development	Verbal updates at EMAP exec meetings and ULHT representation at EMAP programme groups		
						Build a Partnership strategy to support improvements in safe and sustainable care, and harness benefits for the population of Lincolnshire	Partnership Strategy not yet in place	Associate Director of Partnerships started in post May 2023 and has started to draft Partnership Plan. Board development session 5th December 2023 and intention to have signed off by February 2024 Partnership work is already underway across the organisation and is not being delayed by the lack of formal strategy e.g opportunities emerging for the speciality review programme	Signed off Partnership Strategy	Strategy not yet completed or signed off	Work is underway to develop the strategy, which needs to align with the new IIP and ULHT clinical services strategy.		

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating

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

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

United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*5 March 2024*
Item Number	*Item 13.3*

Audit Committee Upward Report

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

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

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

Recommendations/ Decision Required	• *Ask the Board to note the upward report*

Executive Summary

The Audit Committee met via MS Teams on the 12th January 2024. The Committee considered the following items:

External Audit

Changes within the Trust Audit Team were highlighted to the Committee. The Committee would receive the full audit plan once the interim audit work was completed.

The Committee received assurance that there were no concerns around the completion of the audit at year end. The Trust timetable was shared and the Director of Finance provided assurance that capacity within the Finance Teams was in place to respond to the audit and would be kept under review.

The Audit Committee would meet informally in May to walk through the draft accounts with sign off at Audit Committee ahead of Board in mid June.

Internal Audit

The Committee received the report from the Internal Audit provider noting that there had been some progress against the audit plan for 2023/24. The Committee expressed concern that there were still a significant number of reports to be published before year end and in support of the reporting of the Head of Internal Audit Opinion.

The Internal Audit Provider advised that there had been issues in late 2023 with the publication of reports but this was being addressed and a number of reports were now ready to publish in January.

The Director of Finance advised that management actions had been put in place to oversee the delivery of the 23/24 audit plan. These included regular meetings with the audit provider at both organisation and system level. Work had started to produce the plan for 24/25 with an aim to agree this at the April Audit Committee meeting.

The Committee received an update of outstanding audit actions. It was noted by the Committee that there had been significant progress in the closing of actions. Evidence had been provided for the remaining actions and it was anticipated that these would be closed imminently. The reduction of over 100 outstanding actions to a position now below 5 was celebrated. This would continue to be an area of focus.

Counter Fraud

The Committee received the quarterly progress report. It was noted that the Trust was rated GREEN for all elements of the requirements of the Counter Fraud Functional. The Trust overall rating was GREEN. Component 3 relates to Fraud Risk Assessment. Fraud risks are now included within the Trust Risk Register and during 2023/24 the management of fraud risks had been demonstrated to be embedded allowing the final standard to move from amber to green.

Compliance Report

The Committee noted that fire issues had been flagged by the fire service in relation to the Skegness site. The site was owned by NHS Property Services and the Trust had sought legal advice in relation to the latest position.

The Committee noted the compliance issues in relation to information governance and noted that many of the improvement actions required engagement and interventions form the divisional teams. The Committee sought assurance that these areas had been highlighted as part of the handover with the Chief Operating Officer.

The Committee noted some significant sums in the overpayments reports and asked for more details break down in future reports to identify themes or trends.

Assurance Committee Chairs Reports

The Committee received areas for triangulation relating to controls and assurance from each of the Assurance Committee Chairs. The Chair of Finance, Performance and Estates Committee stated that the assurances being received in respect of Estates continued to improve. The Chair of the Quality Governance Committee highlighted that bringing the committees of the two organisations together as the group was formed would present challenges which would need to be monitored by the Audit Committee.

Policies and Guidelines

The Committee were advised that the Clinical Effectiveness Group had received trajectories to update all outstanding policies from all but one division. The Committee would continue to receive updates at each meeting and the action had been flagged on the Board agenda.

Audit Committee Self Assessment Checklist

The Committee noted the positive outcome of the self assessment checklist which had been completed by members and those in attendance at the Committee. The Committee acknowledged the areas in which it would continue to provide focus – implementation of audit actions, policy review and governance code compliance.

Group Model Governance

The Committee acknowledged its role as the Group Model transition progressed to provide assurance to the Trust Board. Both sovereign organisations would initially maintain an independent Audit Committee whilst the assurance committees of each organisation were brought together.