Bundle Trust Board Meeting in Public Session 7 November 2023

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

1 Introduction, Welcome and Chair's Opening Remarks
Chair

2 Public Questions
Chair

3 Apologies for Absence
Chair

4 Declarations of Interest
Chair

5.1 Minutes of the meeting held on 5 September 2023
Chair

Item 5.1 Public Board Minutes September 2023v1

5.2 Matters arising from the previous meeting/action log
Chair

Item 5.2 Public Action log September 2023

6 Chief Executive Horizon Scan Including ICS
Chief Executive

Item 6 CEO Update, 071123

6.1 Thirwall Inquiry - Notice of Upcoming Request for Evidence

Item 6.1 Front Cover Thirlwall Inquiry November 2023

Item 6.1 Thirlwall Inquiry_ terms of reference - GOV.UK

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

7.1 BREAK

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

8.1 Assurance and Risk Report from the Quality Governance Committee

Item 8.1 QGC Upward report September 2023

Item 8.1 Appendix PLACE Results Feedback

Item 8.1 Medical Workforce Industrial Action ULHT Response

Item 8.1 QGC Upward report October 2023

Item 8.1 Appendix 1 FINAL V.02 Ockenden Insight Visit Report LMNS June 2023

Item 8.1 Appendix 2 Triangulation Report Claims, Complaints and Incidents Qu 1 2023-24

Item 8.1 Appendix 3 Process map of the implementation of the Core Competency Framework v2 (003)

Item 8.1 Appendix 4 Maternity Neonatal Safety Assurance Report for Aug 2023 MNOG Final

Item 8.1 Appendix 5 MatSIP Headline Report September 2023

8.2 Patient Safety Incident Response Framework (PSIRF) Plan and Policy

Item 8.2 Patient-safety-incident-response-Front sheet

Item 8.2 ULHT Patient-safety-incident-response-plan-September 2023 FINAL

Item 8.2 ULHT Patient-safety-incident-response-policy-September 2023 FINAL

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

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

Item 9.1 POD - Upward Report - September 2023

Item 9.1 POD - Upward Report - October 2023

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

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

Item 10.1 FPEC Upward Report September 2023v1

Item 10.1 FPEC Upward Report October 2023v1

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

12 Integrated Performance Report

Item 12 IPR Trust Board - Front page

Item 12 Performance Report - Trust Board October 2023

13 Risk and Assurance

13.1 Risk Management Report

Item 13.1 TB - Strategic Risk Report - September-October 2023

Item 13.1 Appendix A - TB Active risks rated 15-25 - Sept-October 2023

13.2 Board Assurance Framework

Item 13.2 BAF 2022-23 Front Cover November 2023

Item 13.2 BAF 2023-2024 19.10.23

14 Any Other Notified Items of Urgent Business

15 The next meeting will be held on Thursday 11th January 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 5 September 2023

Via MS Teams Live Stream

Present

Voting Members:

Mrs Elaine Baylis, Chair
Mr Andrew Morgan, Group Chief Executive
Professor Karen Dunderdale, Director of Nursing/ Deputy Chief Executive
Dr Colin Farquharson, Medical Director
Mr Paul Dunning, Medical Director
Mrs Rebecca Brown, Non-Executive Director
Ms Michelle Harris, Chief Operating Officer
Ms Dani Cecchini, Non-Executive Director
Mr Barry Jenkins, Director of Finance and Digital
Mr Neil Herbert, Non-Executive Director

Non-Voting Members:

Dr Sameedha Rich-Mahadkar, Director of Improvement and Integration
Mrs Sarah Buik, Associate Non-Executive Director

In attendance:

Mrs Jayne Warner, Trust Secretary
Mrs Karen Willey, Deputy Trust Secretary (Minutes)
Ms Lindsay Shankland, Deputy Director of People and Organisational Development
Mrs Angie Davies, Deputy Director of Nursing – Item 2.1
Mr Jaisun Kadalikkattil, Sister/Charge Nurse Johnson Ward – Item 2.1
Ms Rebecca Lovely, Deputy Sister/Charge Nurse Lincoln Cardiac Short Stay – Item 2.1
Ms Limara Franks, Ward Manager, Pilgrim Discharge Lounge – Item 7
Ms Heather Webster, Deputy Sister/Charge Nurse Pilgrim Discharge Lounge – Item 7

Apologies

Ms Claire Low, Director of People and Organisational Development
Mrs Vicki Wells, Associate Non-Executive Director
Professor Philip Baker, Non-Executive Director
Dr Chris Gibson, Non-Executive Director

1143/23	**Item 1 Introduction** The Chair welcomed Board members and members of the public, staff or interested parties who had joined the live stream to the bi-monthly meeting of the Board.
1144/23	**Item 2 Public Questions** **Q1 from Vi King** **Please can I ask why there is no consistency between hospitals sending texts to patients reminding them of their appointments.** **It seems some sites do and some don't. This results in letters being received after the appointment date. Which then results in a Did not attend.**
1145/23	The Chief Operating Officer responded noting that there were 2 patients being directly support who were in the situation described, having been recorded as a Did Not Attend (DNA) without time correspondence from the Trust.
1146/23	There was an outpatient recovery and improvement group in place with a formal agenda item now in place to ensure the undertaking of work in respect of communications with patients, to ensure consistency.
1147/23	The Chief Operating Officer noted that this work would continue to be monitored over the coming weeks but supported the view that there was currently inconsistency in communications which required resolution.
1148/23	**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.
1149/23	Sister Kadalikkattil and Deputy Sister Lovely were welcomed to the meeting.
1150/23	The Director of Nursing noted this was one of the joys of the role occupied as the Director of Nursing, being able to celebrate the ward areas of Johnson and Cardiac Short Stay for meeting the first standards of care as part of the accreditation.
1151/23	The Deputy Director of Nursing advised that the teams had achieved the requirements of the bronze diamond award with Johnson Ward submitting evidence for the period January to December 2022 and Cardiac Short Stay for April to March 2023.
1152/23	The achievements demonstrated the quality the wards were working towards and achieving on a daily basis. The wards were required to provide a portfolio of evidence against improvement work, learning from incidents and patient or carer feedback along with staff and learner feedback.
1153/23	

1154/23	Sister Kadalikkattil shared with the Board the improvements that had been made on Johnson Ward noting the continual drive for innovation to contribute to patient well-being. There had been concerns voiced by patients about the limited information received about treatments, around the time where visiting was restricted, where families were unable to visit.
1155/23	Calls were made to the wards by family members, and it was recognised that those who were more elderly found it difficult to understand the information provided over the telephone. As a result, the team considered how the information could be offered in a better way.
1156/23	Sister Kadalikkattil explained to the Board that the ward had introduced nominated contact stickers, with patient being asked on admission who the preferred contact was. It was found, in most cases where patients were elderly, that the preferred contact was their child. A password was then set between the relative and patient and handheld phones introduced to enable patients to speak with relatives.
1157/23	This was a small initiative that reduced anxiety for the patients but also reduced the time for staff responding to phone calls, enabling more time to be spent on delivering basic patient care.
1158/23	Deputy Sister Lovely offered the improvement initiative from Cardiac Short Stay noting the ward was reconfigured since 2022 and became the first nurse led Advanced Care Practitioner (ACP) unit throughout the Trust. A number of band 6 roles were developed as co-ordinators to support staff on the ward and assist with discharges and admissions.
1159/23	The result of this was that there was improved patient flow and resulted in reduced waits from 7 days to 3 for admission to the ward, in line with national guidelines. It was also found that education of junior staff had supported the ward, particularly with the appointment of international nurses who were happy to work on the ward and felt well supported.
1160/23	Patients were happy to be able to see a consultant Monday to Friday and were assured that they could get to know the team of staff who were looking after them through the week.
1161/23	Training opportunities had been provided for staff on the ward with support for clinical education for cannulation and venepuncture. It was noted that bed managers had seen improvements in A&E waits with patient often coming straight to Cardiac Short Stay. Positive feedback had been received from both the team and patients.
1162/23	The Chair offered thanks to Sister Kadalikkattil and Deputy Sister Lovely for sharing the examples offered which demonstrated the great work that took place across the Trust.
1163/23	The Director of Improvement and Innovation noted that the innovations had been undertaken to drive improvement and asked how the staff on the wards achieved down time given the busy environments.

1164/23	Sister Kadalikkattil advised the Board of the shared decision council which was a joint venture between Johnson Ward and Cardiac Short Stay with monthly meetings in place and discussions about what was needed for the wards to support staff.
1165/23	Multicultural events were held on the ward for people from different cultures to share foods, this included the doctors and multidisciplinary teams. Bake off competitions were also held with a number of wellbeing programmes running on the ward.
1166/23	Deputy Sister Lovely described the Cardiac Short Stay team as a family noting how close they were due to the impact of Covid-19 and reflecting on a number of events that were arranged and held outside of work time, including taking walks as a team. These activities were felt to help with staff retention.
1167/23	The Director of Nursing noted that the examples offered had been delivered professionally and recognised there was a breadth of improvements undertaken, not just those presented. The shared decision council had been key to the innovation and improvements.
1168/23	The Director of Nursing asked about the impact to patients and how it was known there was an impact.
1169/23	Deputy Sister Lovely advised that, as a result of having a Tissue Viability Link Nurse who had helped to educate staff about regular repositioning, washing and dressing, there had been significant improvements found in pressure damage. The service also received Friends and Family Test results which were above 95% and cards from patients and relatives. Improvements were also captured through the matrons audits.
1170/23	The Chief Executive commended Sister Kadalikkattil and Deputy Sister Lovely for their leadership which demonstrated the values of the Trust in this being a great place to receive care and work and encouraged both to continue to role model the behaviours.
1171/23	The Chief Operating Officer reflected on the Cardiac Short Stay being the first ACP led unit which increased accountability and autonomy and asked what difference this had made to influence patient care.
1172/23	Deputy Sister Lovely noted that this had been a learning opportunity, working closely with the ACPs and being able to learn as well as implement care. The ACPs had enabled the nursing staff to build confidence and ask questions to support development as well as offering consistency of those support the patients on the ward. Staff had been empowered by the knowledge shared by the ACPs.
1173/23	The Chair reflected on the positive feedback offered through the MS Teams chart and noted the exemplary leadership which had been demonstrated to the Board. There had clearly been an impact on patients with accountability taken to improve patient care.
	The Chair noted that a formal presentation of the accreditation would be undertaken through a visit to the areas to present the plaque which would demonstrate the achievement.

1174/23	**Item 3 Apologies for Absence** Apologies were received from Ms Claire Low, Director of People and Organisational Development, Professor Philip Baker, Non-Executive Director, Mrs Vicki Wells, Associate Non-Executive Director and Dr Chris Gibson, Non-Executive Director.
1175/23	**Item 4 Declarations of Interest** There were no new declarations of interest.
1176/23	**Item 5.1 Minutes of the meeting held on 4 July 2023 for accuracy** The minutes of the meeting held on 4 July 2023 were agreed as a true and accurate record.
1177/23	**Item 5.2 Matters arising from the previous meeting/action log** 925/23 – Code of Governance update – Complete The Chair noted there were no other matters to address.
1178/23	**Item 6 Chief Executive Horizon Scan including ICS** The Chief Executive presented the report to the Board noting the appalling crimes of Lucy Letby which, understandably had caused absolute shock across the NHS and the wider country.
1179/23	For those working in the NHS and who had devoted their lives to saving lives and caring for others, the crimes committed by Lucy Letby were unimaginable. The shock waves would go through the NHS for some considerable time. An enquiry had now been set up and lessons would be learnt from this.
1180/23	The first and proper persons test was being update and within this was mention of the need for regulation of NHS managers who were not currently regulated by another route.
1181/23	The Chief Executive advised of attendance at a Chairs and Chief Executive's meeting where the case and implications for the NHS would be a key feature.
1182/23	Communications had been shared across the system to all staff when the verdict had been made, which emphasised listening to patients, families and people and trying to create a culture where on the workforce felt able to raise concerns safely, and in the knowledge that they would be listened to and receive a response.
1183/23	The Trust had also provided support to staff who had been impacted by the news and awareness of the case.
1184/23	The Chief Executive advised of other topics within the report including the ongoing industrial action with rounds in July and August with preparations underway for September and October. The Board was aware there was now some coordination

	between Junior Doctors and Consultants with a coordinated day of strikes in September and a 3-day period in October.
1185/23	This presented a different scenario to manage however the coordinated days would be treated as a Christmas day level of service which would assist in this. As the Trust moved into the winter there was no sign of industrial action ending which would further impact on patients with an increased risk. The Trust would do the best to minimise any impact from the industrial action and the impact to planned care and the waiting lists.
1186/23	The Chief Executive offered thanks to all colleagues who had gone above and beyond to try and manage and plan the industrial action and then the recovery from this.
1187/23	Good progress was being made in respect of the Recovery Support Programme (RSP) with the system making an application to exit RSP at the end of month 6. The figures were positive in terms of the progress made against the Financial Recovery Plan (FRP) with 3 areas required including a need to show a £55m FRP with a 12-month plan that all schemes against this were identified with an appropriate level of confidence on delivery. Secondly a pipeline of transformation schemes, that lived beyond the FRP, were in place and thirdly ensuring the system did not spend more than £41m on agency in the current financial year.
1188/23	The application would be submitted in October and taken through process with the decision not known until December/January. This would however be back dated to the end of September. Movement was in the right direction with a need to continue to deliver, it was important that if the exit was successful that there was not a backwards step.
1189/23	The Chief Executive noted the 4 key workstreams in the provider services with closer working with the Primary Care Networks (PCNs), a Senior Responsible Officer (SRO) was being identified for this work. Group model work was progressing with a recent constructive discussion where commitment was made to as full integration as possible, below a formal merger of the 2 Trusts.
1190/23	Work was taking place to algin corporate services, workforce and links to financial elements and transitions. There was a need to progress the culture and organisational development (OD) side to the provider services and work was underway to identify an OD partner to support this work.
1191/23	The Chief Executive was pleased to advise of the 2 new Community Diagnostic Centres (CDCs) at Skegness and Lincoln, with the Trust running these. The winter flu and Covid-19 vaccination delivery programme had been due to commence in October for adults however this had been brought forward to September following a government announcement the previous week.
1192/23	The recruitment process was underway for a new Chair of the Integrated Care Board (ICB).

1193/23	The Chief Executive offered an update on Trust issues noting that the Trust finances were on plan with progress being made on the Trust share of the system FRP.
1194/23	The Board was formally advised that the Chief Executive was now the Group Chief Executive across Lincolnshire Community Health Services NHS Trust (LCHS) and United Lincolnshire Hospitals NHS Trust (ULHT). Further work would be undertaken to appoint a substantive Group Chief Executive under the group model.
1195/23	As part of the joint role the Chief Executive was now a Board member for LCHS, ULHT and the ICB Board. The Director of People and OD was now the SRO for all people matters across the system.
1196/23	The Chief Executive noted the support being offered in the appointment of the East Midlands acute provider collaborative managing director role.
1197/23	The Trust Annual Public Meeting would be taking place on the 18 September, and it was noted that the staff awards were now closed with preparation underway for the ceremony on the 16 November.
1198/23	The Chief Executive formally welcomed Dr Farquharson back who had been on sick leave for some considerable time and was on a phased return to work.
1199/23	Mrs Buik sought an update on aerated concreate and Covid-19 rates in the hospital.
1200/23	The Chief Executive advised that Reinforced Autoclaved Aerated Concrete (RAAC) had recently been a topic in the media, this was not new to the Trust and surveys had been completed in 2020 which had confirmed there was no RAAC across the Trust.
1201/23	The Medical Director, Mr Dunning, advised of an increase in Covid-19 however noted that the peak for the year on admissions had been during February and April with 20-30 Covid-29 patients on sites at any one time. There had been periods in July where there had been not Covid-19 cases.
1202/23	The current position was offered to the Board with 3 cases at Pilgrim and 3 at Lincoln. This was expected to increase over the winter, as was seen with respiratory diseases.
1203/23	Compared to the same period for the previous year, nationally, Covid-19 figures were below those however there were indications of a more serious variant being present over the winter.
1204/23	The Board noted that the Infection Prevention and Control Group were meeting a minimum of twice a week to consider any outbreaks. The major concern was not Covid-19 however, with an increase seen in diarrhoea and vomiting in the community which could result in a norovirus outbreak and possible closure of wards in order to stop transmission. Infectious diseases were being monitored.
1205/23	The Medical Director, Dr Farquharson, thanked the Chief Executive for the welcome back to the Board and thanked Board members for the kind comments made and hoped to return full time by the end of the month.

1206/23	Dr Farquharson offered thanks to Mr Dunning and the Deputy Medical Directors for their support during the period of forced absence.
1207/23	The Chair was pleased that Dr Farquharson had returned to his role and endorsed the comments regarding the support from Mr Dunning, who had brought a different perspective to the Board, as well as the support offered by the Deputy Medical Directors. The Trust Board: • **Received the report and significant assurance provided**
1208/23	**Item 6.1 CQC Children and Young People Inspection Report** The Director of Nursing presented the inspection report noting that this had been received by the Quality Governance Committee was as a result of the Care Quality Commission (CQC) unannounced inspection of Children and Young People (CYP) services on the 31 May 2023.
1209/23	The final report was presented to the Board along with the action plan in response. The report demonstrated that good evidence had been located as part of the visit and information requested following the visit.
1210/23	Whilst the visit had not resulted in a rating change and the CQC had not reported any should do or must do actions the Family Health division had taken into account all of the feedback received and had been able to identify 4 actions.
1211/23	The action plan would feed in to the wider CQC action plan, overseen by the Quality Governance Committee, with the Director of Nursing offering moderate assurance to the Board.
1212/23	Mrs Brown confirmed that the Quality Governance Committee had received the report and noted this was recognised as support on an improvement journey. It was noted that very few issues had been raised through the unannounced visit and those areas of note had demonstrated good management in place. The Committee had noted that the division should be proud of the visit and how quickly responses had been offered and the plan was put in place.
1213/23	The Chair noted the way in which the division had responded to this and how staff had presented on the day of the inspection and to the findings which demonstrated a positive culture within the division. The action plan was clear and specific with a belief this would be completed quickly.
1214/23	The Chair offered congratulations to the Family Health Divisions on the basis of the report and the response offered noting the assurance on the grip and control over quality and safety issues. The Trust Board: • **Received the report noting the moderate assurance**

1215/23	**Item 7 Patient/Staff Story** The Director of Nursing introduced the staff story from the Pilgrim Discharge Lounge where the staff told of the significant improvement journey and improvements made for patients who were discharged from the hospital at Boston.
1216/23	The Director of Nursing thanked the Ward Manager and Deputy Sister for joining the meeting to present the story.
1217/23	The Trust Board watched the video noting the improvements that had been made to support patients who were medically fit for discharge, waiting for electronic discharge documents, medications or transport.
1218/23	The Discharge Lounge supported hospital flow by creating acute beds through having 16 patients in 2 side rooms, a 4 bedded male bay, 4 bedded female bay and 6 chairs in the ambulatory area.
1219/23	A number of improvements had been made, as detailed through the video, since leadership was in place with the Ward Manager and Deputy Sister with a recognition that there had not previously been any leadership.
1220/23	The Chair offered thanks for the story presented noting the improvements made.
1221/23	Mrs Brown noted that there had been a clear improvement in the team spirit which had improved the patient care through the amount of support and developments in place and asked if this had resulted in higher use of the discharge lounge, supporting flow.
1222/23	The Ward Manager reflected on a recent report which had compared June and July data from 2 years earlier with current figures and noted that these had increased by 100 patients for those months. This had been a significant increase with improvements in relationships across the hospital and ward now utilising the discharge lounge and communication in place with the wards and A&E to ensure appropriate patients were received.
1223/23	The Chief Operating Officer was proud of the achievements of the Ward Manager and Deputy Sister noting that over the past 2 years there had been a change in the location of the discharge lounge and the work of the team, now a 24/7 service.
1224/23	There was a recognition of the benefits of the change and work was now underway to support changes to be made at the Lincoln site to ensure a consistent approach. It was recognised that the use of the discharge lounge at Pilgrim was now custom and practice.
1225/23	The Director of Improvement and Integration commended the work undertaken noting the openness and honest about the development needed, this had provided a baseline from which to move forward. The behaviours also demonstrated the culture desired in the organisation.

1226/23	The Director of Improvement and Integration asked how this would be embedded at Lincoln and what learning could be taken from Pilgrim.
1227/23	The Ward Manager reflected that the same process would be used ensuring close working with the Ward Sister at Lincoln and ensuring that any changes were undertaken slowly to ensure staff were aware of what was taking place.
1228/23	It was noted that whilst this was mostly staffed by bank staff, this had resulted in a significant reduction in agency costs and it was hoped this could also be replicated at Lincoln.
1229/23	The Chair noted the ask in the video from the Deputy Sister regarding Doctors and the Electronic Discharge Documents (EDD) and asked how this would be attended to.
1230/23	The Chief Operating Officer noted that Lincoln currently had EDD Doctors whereas Pilgrim did not however this would be progressed to Pilgrim to support the discharge lounge. Work was underway to ensure that the practices at Lincoln could be replicated to Pilgrim with a recognition that there was a need for the Divisions to support this as the EDD Doctors currently sat within the divisions rather than corporately, as the Discharge Lounge was.
1231/23	The Chair noted the comments offered to the Ward Manager and Deputy Sister in the MS Teams Chat recognising the braveness of taking on the unknown, as described through the story. There was positive leadership in place with both the Ward Manager and Deputy Sister demonstrating they were role models for peers across the organisation. 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
1232/23	**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 18 July and 22 August 2023 meetings.
1233/23	Mrs Brown provided a focus to the August report however reflected on the July report noting that the Committee had received the ward accreditation report which offered significant assurance to the Committee. Congratulations were offered to the Director of Nursing and Deputy Director of Nursing on brining this to the Trust and embedding.
1234/23	In July the Committee received the Infection Prevention and Control (IPC) annual report which detailed the large amount of work from the dedicated IPC team with thanks offered to them.

1235/23	Mrs Brown updated the Board on the assurance received from the August meeting noting that the upward report from the IPC Group was received with the Committee noting the increase in C-Difficile cases and other targeted organisms. The Committee noted the assurance received from the team on the actions being taken which would be monitored closely by the Committee.
1236/23	The Committee was pleased to note no outstanding never event actions which was a pleasing position along with the continued improvement in duty of candour.
1237/23	The Committee received an update from the Maternity and Neonatal Oversight Group (MNOG) with 2 deep dives proactively presented, one for Easter European Women and the care received and one on Post Partum Haemorrhage (PPH). It was noted that the PPH deep dive had been undertaken due to the data presented on the SPC charts being used by the group.
1238/23	The Eastern European deep dive demonstrated some excellent work on the care provided to the women, the concerns and challenges faced, and the actions being taken.
1239/23	The Committee had noted that there may be benefit in these reports being published and further research being undertaken in these areas going forward.
1240/23	Mrs Brown noted the continued concern around IT systems within maternity services noting that, whilst connectivity within the community had improved there was a delay in the procurement of the new IT system.
1241/23	As a Board there was a need to drive this forward due to the potential impact on the achievement of the next level of Clinical Negligence Scheme for Trusts (CNST) and Saving Babies Lives version 3. Without a dedicated IT system, it would be difficult for the Trust to achieve these due to the level of detail required.
1242/23	The Committee received the Medicines Quality Group upward report noting the improvement in progress of the rollout of the Electronic Prescribing and Medicines Administration (ePMA). There had been some delay noted in the rollout to the acute medical wards however this was being addressed.
1243/23	Mrs Brown noted the direct update from the Pharmacy Team and Clinical Support Services Division around the long-term issues and concerns in medicines management. There had been some positive assurance received around recruitment and development of new roles in phase 1 of the plan.
1244/23	The Committee requested that all associated plans were brought together into a single plan and would be monitored by the Committee going forward. There was progress seen in areas of difficulty with the Committee noting the key aspect of this being leadership and motivation, with a drive for improvement being seen.
1245/23	The Patient Safety Group upward report was received along with the first draft of the Patient Safety Improvement Plan, which had identified 5 local themes which would be taken through the Patient Safety Incident Response Framework (PSIRF). The

	Committee was pleased with the themes identified and looked forward to receiving the final plan and policy which would be offered to the Board for approval.
1246/23	The Committee noted that the safeguarding upward report demonstrated the beginnings of good joint working with LCHS and noted the importance of this as the Quality Governance Committee would be the first to move forward in joint working. Some action and improvements in training figures for safeguarding were noted following this being an area of concern.
1247/23	The patient experience quarter 1 report was received with the Committee noting concern around communications beginning to be an area of concern and one which the Committee would consider in further detail at a future meeting.
1248/23	Mrs Brown was pleased to advise that the Trust was compliant with 100% of national audit requires, as reported by the Clinical Effectiveness Group, however the Trust remained an outlier in some results. Assurance was received that actions were in place to take these areas forward.
1249/23	The Committee was advised that there was some risk around achieving 2 CQUINs (Commissioning for Quality and Innovation) however plans were in place to support this.
1250/23	Mrs Brown noted that the Child Protections – Information Sharing (CPIS) had been a concern for the Committee with actions highlighted from internal audit. This had been difficult to progress with the Medicine Division attending the Committee.
1251/23	There had been strong support from the Safeguarding Team and improvements were now being seen in training and the embedding of records. Audits would continue on a weekly basis with the Committee continuing to have oversight of the position to ensure the changes were embedded. The internal audit action would not be closed until further audit results were received; this would also address issues highlighted by the Care Quality Commission (CQC).
1252/23	The Committee offered sincere thanks to Mr Andrew Simpson and Mr Paul Dunning for the support and coverage offered to the Committee in the absence of the Medical Director.
1253/23	The Director of Nursing advised that the Committee, at the September meeting would receive a CQC Action update which would address the CPIS action, for which significant progress had been seen.
1254/23	The Chair noted the level of grip on a number of areas including the pharmacy deep dive and was pleased that the Committee had been able to continue to drive this forward to receive higher levels of assurance than had previously been received.
1255/23	The IT connectivity for maternity services was noted with the Board needing to maintain oversight of this to ensure the right tools were in place to enable the service to continue to develop and deliver. A report to the Board was requested in respect of the position and progress being made.

	Action: Director of Nursing, 7 November 2023 The Trust Board: • **Received the assurance report**
1256/23	**Item 8.2 CQC Action Plan** The Director of Nursing presented the report to the Board noting that this demonstrated continued progress against the CQC must and should do actions from the formal inspection in 2022.
1257/23	There were 59 improvement actions related to the report and within those a series of underpinning sub-actions.
1258/23	At the end of August 274 of the underpinning actions, 72% of these were complete or in the process of being embedded and 5% rated as red or overdue. There had been a focus on the must do actions with 87% completed or in progress and 4% rated as red or overdue. These related to the emergency departments however progress has been made in respect of the 5 must do actions as detailed by the evidence offered to the Quality Governance Committee from the division of medicine.
1259/23	The Director of Nursing advised that work remained underway around 2 of the must do actions in respect of Child Protection Information System (CP-IS) and pre-hospital practitioners and caring for patients where ambulances were waiting to bring patients in to the emergency department.
1260/23	There had been significant progress more recently on these actions with the Director of Nursing noting that it had been helpful to have the medicine leadership team attend the Quality Governance Committee in order to understand this in more detail. The report reflected the work undertaken, monitoring of actions and the improvements or adjustments to actions where needed.
1261/23	Whilst it had taken some time to progress these actions there was confidence n the progress now being seen.
1262/23	The Director of Nursing advised that there were a number of actions of particular focus with mapping against the new single assessment framework for the CQC having been undertaken, with quality statements alongside core services.
1263/23	This was being overseen by the Quality Governance Committee with updates being offered and reporting against the transition to the new framework with the information available to the Trust.
1264/23	The Director of Nursing advised the Board that each of the Committees had reviewed the relevant aspect of the CQC action plan on a monthly basis with the full plan being offered to the Board on a quarterly basis. Moderate assurance was offered to the Board on progress and oversight.
1265/23	The Chair noted the level of assurance offered through the detail of the report and the narrative provided and was pleased to receive the mapping to the new framework

	noting this should inform how the Trust started to collect evidence for future inspections. The Trust Board: • **Received the report noting the moderate assurance**
1266/23	**BREAK**
	Item 9 Objective 2 To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT
1267/23	**Item 9.1 Assurance and Risk Report People and Organisational Development Committee** The Chair noted that apologies had been received from Professor Baker, Chair of the People and Organisational Development Committee and noted that the Board would receive the reports as presented.
1268/23	It was recognised that the responsible officer revalidation annual report would be discussed on the agenda and that there had been a strong focus by the Committee in respect of mandatory training. The Trust Board: • **Received the assurance reports**
1269/23	**Item 9.2 Workforce Race Equality Standards and Workforce Race Disability Equality Standards Action Plans** The Deputy Director of People and Organisational Development (OD) offered the Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standard (WRES) action plans to the Board noting these had been reviewed through the Workforce, Strategy and Organisational Development Group, Equality Diversity and Inclusion (EDI) Group and the People and Organisational Development Committee.
1270/23	The standard annual data collection and action plans highlighted the experience of disabled colleagues and Black, Asian and Minority Ethnic (BAME) colleagues compared to white counter parts in the organisation. The standards were required of all NHS Trusts in order to improve experiences of disabled and BAME staff.
1271/23	The Trust was required to show progress against specific metrics and suggest actions to address any disparities identified. The executive summary of the report offered key information and data against the metrics submitted to NHS England along with the action plans. There had been based on the data and took in to account the national EDI improvement plan which had been published in June 2023.
1272/23	The Deputy Director of People and OD noted that improvement was being seen in relation to WRES indicator 3 in respect of the relative likelihood of entry into formal disciplinary processes for BAME staff. This was showing that BAME staff were no more likely to enter a process and was an important change in reporting. This would continue to be monitored on a quarterly basis.

1273/23	There were also significant areas of improvement being seen in the WDES indicators with staff reporting trust, confidence, feeling valued and engagement as improving.
1274/23	Key actions were in place to address areas for improvement which aligned with retention, staff development and talent management plans for all staff with alignment to EID, Organisational Development, wellbeing and the talent academy work taking place both in the Trust and across the system.
1275/23	The Deputy Director of People and OD noted that the Board was being asked to approve the action plans for publication.
1276/23	The Chair noted the excellent reports and also thanked the EDI Project Manager for the work undertaken. This set out the position and demonstrated the progress being made along with embedding EDI in to business as usual of the Trust. The Trust Board: • **Received the reports noting the moderate assurance** • **Approved the action plans for publication**
1277/23	**Item 9.3 Responsible Officer Revalidation Annual Report** The Medical Director, Mr Dunning, presented the Responsible Officer Revalidation Annual Report noting this required the approval of the Board.
1278/23	The report summarised the statement that the Trust conformed with the responsible officer regulations and had adequate funding for this.
1279/23	It was noted that there were a number of actions that had been completed from the previous year with work continuing to complete actions from the current year which had been impacted due to capacity. Reassurance was offered that all actions would be in place ahead of the following report.
1280/23	The Chair noted the comprehensive report offered to the Board which demonstrates that actions had been taken. The Trust Board: • **Received the report** • **Approved submission to NHS England**
	Item 10 Objective 3 To ensure that service are sustainable, supported by technology and delivered from an improved estate
1281/23	**Item 10.1 Assurance and Risk Report from the Finance, Performance and Estates Committee** The Chair of the Finance, Performance and Estates Committee, Ms Cecchini, provided the assurances received by the Committee at the 20 July and 24 August 2023 meetings.
1282/23	Ms Cecchini noted that the upward report from Estates had been deferred in July however comprehensive reports had been received during August. There was

	progress reported on the savings programme with the Committee also noting the work ongoing in respect of the 6-facet survey and Health and Safety Audit. These pieces of work would support the Trust with capital and maintenance prioritisation and to demonstrate that the Trust had appropriately considered all legislative requirements. Reports would be offered to the Committee to ensure oversight.
1283/23	The Committee received the Green Plan noting that this was off plan and recognised, in order to support the ambitions of the Trust, that investment was required with consideration being given to business cases being developed to progress a number of the objectives within the green programmes.
1284/23	Ms Cecchini advised that finances were being delivered in line with plan with the cost improvement programme (CIP) delivering ahead of plan. There had been a significant impact on the delivery of the CIP plan as a result of the work to reduce agency spend.
1285/23	The Committee received and noted the capital report in July and noted in the August report that the Electronic Patient Record outline business case had been approved nationally by the Joint Investment Committee (JIC). Sign off was now awaited from Treasury.
1286/23	A letter of confirmation had been received from NHS England in respect of the operational plan and the expectations of the system to maintain focus on the delivery of the plan.
1287/23	The initial medium-term plan had been considered by the Committee with Ms Cecchini noting that the system was not yet delivering in line with requirements however it was recognised that this was an iterative process.
1288/23	The system was progressing towards exiting from the National Oversight Framework (NOF) level 4 with the criteria to deliver now known.
1289/23	The Committee received an update from procurement noting the development of the contracts register which would ensure the Committee were sighted on the pipeline of contracts due for renewal. There were a large number of pieces of work for the procurement team including capital funding which was coming through to the Trust to support renewing of estates.
1290/23	Ms Cecchini noted that the Information Governance Group upward report had been deferred in July and advised the Board that this was a challenging area for the Trust. The Information Commissioners Office (ICO) had undertaken a follow up on the previous audit and whilst some progress had been made there remained some significant outstanding actions. These were mirrored in the Data Security Protection Toolkit (DSPT) submission with the Trust awaiting further advise from the ICO on the escalation that would be taken.
1291/23	Subject Access Requests and Freedom of Information Requests also remained challenging however there was focus and work being undertaken to reduce the figures.

1292/23	The Digital Hospital Group upward report was positive however highlighted issues around staffing and the competition for good IT professionals. Going in to and understanding the progress of the Electronic Patient Record (EPR) would require sufficient and suitable staff and relevant recruitment to maintain a cohort of staff to support the EPR ambition.
1293/23	Ms Cecchini noted the significant operational report received by the Committee noting that the main area of risk was the lack of progress on some of the productivity required to support improvement on metrics.
1294/23	There was some concern on the larger improvement programmes to deliver however it was recognised there were long lead times before it would be possible to see some improvement reflected in the figures.
1295/23	Ms Cecchini noted that the Committee had been due to receive an update on the Acute Services Review (ASR) however this was deferred due to a requirement to update the paper, this would come forward to the Committee in September.
1296/23	As part of the governance improvement for the Committee, in June the Committee had received the reporting groups terms of reference with the work programmes continuing to be received to reflect the work of the reporting groups. There had been a positive update from Estates on how the governance from the directorate would be received.
1297/23	The Committee received limited assurance in July on the Integrated Improvement Plan, this reflected the concerns around productivity initiatives with work ongoing. Comprehensive reports were being received however it was noted that there as a factor of culture and changes needed, giving longer lead times than would be liked.
1298/23	The Chair reflected on the breadth of topics considered by the Committee and noted the positive indicated through the reports.
1299/23	The concerns noted in relation to productivity and performance were shared by the Board however there was a need to wait for the delivery of those programmes of work with longer lead times. The Board would need to continue to receive assurance on the movement of trajectories and the uplift in performance.
1300/23	The Chair noted the Information Governance risk noting that this may need to be considered in detail as a Board and for there to be clarity on what other actions may need to be taken in relation to this.
1301/23	The Chair congratulated the Director of Finance and Digital and Team for progressing the EPR to the Joint Investment Committee. This implications of this would be significant to the Trust with the Board aware of the detail which had been attended to in order to write the case and response to the questions from the frontline digitisation team. 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
1302/23	No items
1303/23	**Item 12 Integrated Performance Report** The Chair noted that the Integrated Performance Report offered limited assurance reflecting that the Committee reports had offered updates on the focus in each of the Committees.
1304/23	It was noted that there was nothing further to add, in addition to the considerations of the Committees, with the Board noting the improving quality and narrative to offer explanation of the position presented, along with actions where performance was off track. The Trust Board: • **Received the report noting the limited assurance**
	Item 13 Risk and Assurance
1305/23	**Item 13.1 Risk Management Report** The Director of Nursing presented the monthly risk report to the Board noting that the report remained stable from the previous month, particularly for quality and safety risks which had remained the same, along with 8 very high risks for people and organisational development.
1306/23	There were 6 very high risks in respect of finance, performance and estates with the addition of medical air plant in the maternity block and plant room 12 at the Lincoln site. These were now of an age where a risk of potential failure was present.
1307/23	The Director of Nursing advised that the mortuary services risk had reduced from very high to high as a result of mitigations in place however noted that this did not detract from the issues present which would be considered by the Board in private session.
1308/23	Risks continued to be reviewed on a monthly basis with all Committees recognising the risks received, having been reviewed through the meetings. Appendix 1 of the report offered the strategic risks with continued significant assurance offered to the Board.
1309/23	The Chair noted that the Committees had received the risk register and reflect on the dynamic nature of the report with the changes being made where necessary. The Trust Board: • **Accepted the risks as presented noting the significant assurance**

1310/23	**Item 13.2 Board Assurance Framework** The Chair noted that the Board Assurance Framework (BAF) was becoming mature and robust and offered thanks to the Executive Directors and Non-Executive Directors for the work that went into this as this was supporting the review of Board papers and directing to areas of required focus and challenge.
1311/23	The Trust Secretary confirmed that the BAF had been considered through each Committee during July and August including the Audit Committee during July.
1312/23	There had been a deep dive completed by the People and Organisational Development Committee into the relevant areas of the BAF to provide a thorough review. The Committee had agreed that further work would be completed on strengthening areas of assurance detailed within the BAF in order to progress objectives.
1313/23	The Trust Secretary noted that there were no changes made to the assurance ratings during July and August.
1314/23	It was recognised that, within the controls under well led, there was a control relating to the self-assessment process which had inadvertently been added and required removal. The Trust Board: • **Received the report noting the moderate assurance**
1315/23	**Item 13.3 Audit Committee Upward Report** The Chair of the Audit and Risk Committee, Mr Herbert, presented the report to the Board from the meeting held on 19 July 2023.
1316/23	Mr Herbert noted that the Committee had received a report from the new Internal Audit providers and advised the Board that due to the transition to the new provider the audit plan had only just commenced with little progress to date. This would be monitored to ensure this remained on track.
1317/23	Supporting processes such as action tracking being put in place which had resulted in some out-of-date reports being offered to the Audit Committee and other Committees, this issue had now been resolved.
1318/23	The Chief Operating Officer joined the meeting to provide updates on overdue actions in relation to safeguarding and data quality with significant progress noted since the update in addressing the issues.
1319/23	The Committee received the quarterly progress report and annual report from counter fraud with the Trust's progress against the counter fraud functional standards noted. All elements were reported as green with the exception of one which was expected to move to green during the current year.

1320/23	The annual report was offered to the Board for information and to reflect the work that had been undertaken.
1321/23	In respect of compliance the Trust was awaiting to hear from the Information Commissioners Officer the outcome of the follow up review and what action may be taken.
1322/23	Updated were received from the Chairs of the Board Committees and noted the actions being taken to ensure assurance and traction on medicines management from the Quality Governance Committee and mandatory training and appraisals at the People and Organisational Development Committee.
1323/23	Mr Herbert advised that following concerns raised at the previous meeting in relation to policies and guidelines, the Clinical Effectiveness Group had been engaged with the divisions agreeing to present to the September Group with a plan for addressing the concerns. The Committee would continue to closely monitor progress.
1324/23	The Committee approved its annual report to the Board which summarised the work done during the year, this had been offered for information.
1325/23	The Committee received an initial gap analysis for the Trust against the new governance code and requested some more information in supporting evidence in order to support compliance against this. This would be offered to future meetings.
1326/23	The Chair offered thanks for the comprehensive report, both through the upward report and the annual report which had set out the strong grip and control of systems and processes. Thanks were offered for the leadership of the Committee and to members of the Committee for providing the level of assurance to the Board.
1327/23	The Chair noted the counter fraud report, noting the work undertaken by the Counter Fraud Specialist and offering thanks for the support to the Trust. The Trust Board: • **Received the report noting the significant assurance**
1328/23	**Item 14 Any Other Notified Items of Urgent Business** No items
1329/23	The next scheduled meeting will be held on Tuesday 7 November 2023 via MS Teams live stream

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

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 5.2

Trust Board date	Minute ref	Subject	Explanation	Assigned to	Action due at Board	Completed
5 September 2023	1255/23	Assurance and Risk Report Quality Governance Committee	Update to be offered to the Board about the position and progress of the Maternity IT system	Director of Nursing	07/11/2023	

United Lincolnshire Hospitals NHS Trust

Meeting	*Public Trust Board*
Date of Meeting	*7 November 2023*
Item Number	*Item number 6*

Group Chief Executive's Report

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

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

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

Recommendations/ Decision Required	• *To note*

Executive Summary

System Overview

a) All parts of the system remain under significant operational pressure as we enter the autumn/winter period. No new dates for industrial action by junior doctors and consultants have been set, although the BMA is now balloting consultants and SAS doctors about additional strike action. The ballots close on 18th December.
b) Large parts of the county were affected by storm Babet during October. Business Continuity Plans were brought into use to cope with the flooding and the resultant impact on services. As usual, staff across the system went 'above and beyond' to keep patients safe and to assist colleagues. Great support was also provided by the Lincolnshire Fire and Rescue Service and by Anglian Water.
c) The Lincolnshire health system is in Tier 2 of the escalation stages for UEC. This involves increased scrutiny and support from NHS Midlands colleagues. The key issues requiring focus and improvement are the 4 hour wait standard in A&E, 12 hour waits in A&E and the Cat 2 ambulance response time. Fortnightly meetings are held with NHS Midlands in order to assess progress on these areas.
d) At M6 the system reported a year to date deficit of £38.1m compared to a plan of a £30.5m deficit. This is an adverse variance of £7.6m. The full year plan is a deficit of £15.4m, which takes account of the planned additional savings in the second half of the year.
e) At M6 the Financial Recovery Plan (FRP) for the system had delivered £25.8m of savings against a plan of £23.4m. This is a positive variance of £2.4m. The full year FRP amounts to £55m. Based on this performance and an assessment against all 15 of the exit criteria, the system has applied to exit the Recovery Support Programme (RSP). This application has been considered by NHS Midlands and is now due to be considered by the national committee on 14th November.
f) The Q2 Quarterly System Review Meeting (QSRM) was held with NHS Midlands on 18th October. The system was commended for a largely positive period alongside an acknowledgment of the challenges and risks that the system faced.
g) The 24/7 walk-in Urgent Treatment Centre (UTC) opened at Grantham and District Hospital on 31st October. This replaced the previous restricted hours A&E. This change was implemented as part of the outcome of the Acute Services Review (ASR).
h) The recruitment process for the Group Chair role across LCHS and ULHT is nearing completion. The process should conclude in week commencing 6th November.

Trust Overview

a) At M6 the Trust reported a year to date deficit of £15.463m which is in line with the year to date plan. The full-year plan is a deficit of £20.8m. At M6 the Trust reported year to date financial savings of £14.378m against a plan of £9.095m. This is a positive variance of £5.283m. The full year plan is for savings of at least £28.1m.
b) The Trust was successful in gaining approval for the Outline Business Case (OBC) for its Electronic Patient Record (EPR). Approval has now been obtained from the Department for Health and Social Care and NHS England's Joint Investment Committee (JIC) and Department for Health and Social Care Ministers and the Cabinet Office Electronic Patient Record Investment Board (EPRIB) during October. This approval

comes subject to a number of conditions, to enable the Trust to move to the procurement phase of implementing an EPR.

c) The Trust has been escalated into Tier 1 of the escalation stages for planned care and cancer. This involves national and regional scrutiny and support from NHS England. The key focus areas are clearing 78 week waits, having robust plans for getting down to a maximum 65 week wait by the end of March, improving the 62 day cancer performance and meeting the Faster Diagnosis Standard (FDS) milestones. Weekly meetings are held in order to assess progress on these areas.
d) The outcome of the public consultation on paediatric services at Pilgrim Hospital Boston will be going to a meeting of the Board of the Lincolnshire ICB on 28th November. The final decision on the way forward rests with the ICB.
e) Barry Jenkins has now left his role as Interim Director of Finance, following his successful application for a substantive Deputy CEO role of a Health Board in Scotland. We wish Barry well in his new role and thank him for his work at ULHT. Jon Young who was the Trust's Deputy Director of Finance, has stepped up into the Director of Finance role with effect from 21st October. This will be until further notice. We welcome Jon into his new role. There will be some resultant Director portfolio changes to accommodate this change and these will be confirmed shortly.

United Lincolnshire Hospitals NHS Trust

Meeting	*Public Trust Board*
Date of Meeting	*7 November 2023*
Item Number	*Item 6.1*

Thirlwall Inquiry – Advance Notification

Accountable Director	*Colin Farquharson, Medical Director*
Presented by	*Colin Farquharson, Medical Director*
Author(s)	*Colin Farquharson, Medical Director*
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	
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	*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	• *For Information*

Recommendations/ Decision Required	• *Board to note the terms of reference of the upcoming review*

Executive Summary

Thirlwall Inquiry: advance notice of an upcoming request for evidence

The Thirlwall Public Inquiry has published its terms of reference and is now starting its work.

The Public Inquiry has asked NHS England to cascade on their behalf a request for evidence to all trusts with neonatal units, so that it can better understand their work. NHS England have given advance notice of this.

The Trust will shortly receive a letter from the Public Inquiry with a request for evidence. It will comprise a set of questions to respond to in writing by mid-December. A set of FAQs will accompany the request.

NHS England requested that Boards were made aware of this forthcoming request.

Department of Health & Social Care

Guidance

Thirlwall Inquiry: terms of reference

Published 19 October 2023

Contents

This publication is available at https://www.gov.uk/government/publications/thirlwall-inquiry-terms-of-reference/thirlwall-inquiry-terms-of-reference

Introduction

On 21 August 2023, after a trial at Manchester Crown Court, Lucy Letby was sentenced to life imprisonment and a whole life order on each of 7 counts of murder and 7 counts of attempted murder. The offences took place at the Countess of Chester Hospital, part of the Countess of Chester Hospital NHS Foundation Trust.

Terms of reference

The inquiry will investigate 3 broad areas:

A. The experiences of the Countess of Chester Hospital and other relevant NHS services, of all the parents of the babies named in the indictment.

B. The conduct of those working at the Countess of Chester Hospital, including the board, managers, doctors, nurses and midwives with regard to the actions of Lucy Letby while she was employed there as a neonatal nurse and subsequently, including:

(i) whether suspicions should have been raised earlier, whether Lucy Letby should have been suspended earlier and whether the police and other external bodies should have been informed sooner of suspicions about her

(ii) the responses to concerns raised about Lucy Letby from those with management responsibilities within the trust

(iii) whether the trust's culture, management and governance structures and processes contributed to the failure to protect babies from Lucy Letby

C. The effectiveness of NHS management and governance structures and processes, external scrutiny and professional regulation in keeping babies in hospital safe and well looked after, whether changes are necessary and, if so, what they should be, including how accountability of senior managers should be strengthened. This section will include a consideration of NHS culture.

A non-exhaustive list of questions arising out of the terms of reference is set out in the annex.

Procedure

The inquiry will operate within the legal framework of the Inquiries Act 2005 (https://www.legislation.gov.uk/ukpga/2005/12/contents). The procedure and conduct of the inquiry will be directed by the inquiry chair. The terms of reference are decided by the Secretary of State after consultation with the chair.

The order in which the issues are to be considered has not yet been decided. The priority is to conduct a thorough inquiry as swiftly as possible. The length and timing of the hearings and where they take place will depend on the extent and nature of the live

evidence that is required and upon the actions of the police and Crown Prosecution Service.

Report and recommendations

The inquiry chair will provide a final report (and if appropriate, interim reports) to the Secretary of State as soon as is practically possible. She will make recommendations as she considers appropriate.

Annex: questions

This is a non-exhaustive list of questions which the inquiry intends to seek answers to. This annex does not form part of the terms of reference.

A. The experiences of all the parents whose babies were named on the indictment at the criminal trial

1. During their involvement with the Countess of Chester Hospital and elsewhere what were the parents of each child told when and by whom about the condition of their baby, what was being done to treat them and what the prognosis was?

2. How and when were deteriorations (sudden or otherwise) in their babies' conditions explained to them?

3. Where parents raised concerns about the condition and/or care of their babies, what was done and what were the parents told?

4. When were they given access to their babies' medical records?

5. What information were the parents given by the hospital regarding concerns about Letby's conduct and when? What were they told was being done about the concerns?

6. What were the parents of each child told about the likely cause of death or injuries? When and by whom?

7. When were the parents of each child told that Letby was suspected of causing the death or injury to their child? Was the trust sufficiently candid with the parents throughout?

8. What are the views of the parents of each child as to the adequacy of the information they were given at each stage?

9. What was the parents' experience of the Patient Advice and Liaison Service (PALS)?

10. What are their suggestions for keeping babies safe on the neonatal unit?

B. The conduct of those working at the Countess of Chester Hospital including the board, managers, doctors, nurses and midwives during the period from the arrival of Lucy Letby at the hospital on 4 January 2012 to date

11. What was known and what should have been known about Letby's previous work as a nurse when she began employment at the Countess of Chester Hospital?

12. What concerns were raised and when about the conduct of Letby? By whom were they raised? What was done?

13. Should concerns, including about hospital or clinical data, have been raised earlier than they were? When? What should have been done then?

14. Were existing processes and procedures for raising concerns used, including whistleblowing and freedom to speak up guardians? Were they adequate?

15. What was the culture within the hospital? To what extent did it influence the effectiveness of the processes and procedures at question 14?

16. Whether systems, including security systems relating to the monitoring of access to drugs and babies in neonatal units, would have prevented deliberate harm being caused?

17. Were existing processes used for reporting concerns to external scrutiny bodies where appropriate? If so, when and what happened? Such bodies may include NHS England (and its regional bodies), local commissioners, Monitor, NHS Improvement, child death overview panels, the Care Quality Commission, the police and the successor of any of these organisations.

18. When was consideration given to reporting Letby to the police? When was she in fact reported to the police and by whom?

19. What information about each of the deaths was provided to the coroner? Was the trust's provision of information to the coroner appropriate?

20. Did the relationship between clinicians and managers, nurses, midwives and managers and between medical professionals (doctors, nurses, midwives and others) at the Countess of Chester Hospital contribute to any failure to protect babies on the neonatal unit from the actions of Letby? How did professional relationships affect the management and governance of the hospital?

21. Did the structures and processes for the management and governance of the hospital contribute to a failure to protect the babies on the neonatal unit from the actions of Letby? Is the management structure and governance typical of neonatal settings in other hospitals?

22. What was the board's involvement in the way concerns about Letby were dealt with by the hospital?

23. What was the board's oversight of clinical and corporate governance?

24. How was Letby managed once concerns were raised about her?

25. Was Letby reported to the Nursing and Midwifery Council (NMC)? When? What information, if any, was provided to the NMC, royal colleges and any other external scrutiny bodies? What was done by the bodies to whom the actions were referred? What happened as a result?

26. What information, if any, was provided to the General Medical Council (GMC) and what information was requested by the GMC? What was the result of any referral or discussions with the GMC?

27. What happened to those who raised concerns about Letby?

C. Wider NHS

28. Whether recommendations to address culture and governance issues made by previous inquiries into the NHS have been implemented into wider NHS practice? To what effect?

29. What concerns are there about the effectiveness of the current culture, governance management structures and processes, regulation and other external scrutiny in keeping babies in hospital safe and ensuring the quality of their care? What further changes, if any, should be made to the current structures, culture or professional regulation to improve the quality of care and safety of babies? How should accountability of senior managers be strengthened?

30. Would any concerns with the conduct of the board, managers, doctors, nurses and midwives at the Countess of Chester Hospital have been addressed through changes in NHS culture, management and governance structures and professional regulation?

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Report to:	Trust Board
Title of report:	Quality Governance Committee Assurance Report to Board
Date of meeting:	19 September 2023
Chairperson:	Rebecca Brown, Non-Executive Director
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the Quality Governance Committee (QGC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme. The Committee worked to the 2022/23 objectives.
	Assurance in respect of SO 1a Issue: Deliver high quality care which is safe, responsive and able to meet the needs of the population **High Profile Cases** The Committee received the report noting the content. **Patient Safety Incident Response Framework – policy and plan** The Committee received the final Patient Safety Incident Response Framework (PSIRF) Policy and Plans noting these outlined the work associated with patient safety incidents and learning from them. The Committee noted the local themes which had been identified including patient falls, medication errors, end of life, diagnostics and DKA. The Committee recommended the policy and plan to the Board for approval noting the engagement work which had taken place both internally and across the system. **Serious Incident Summary Report inc Duty of Candour** The Committee received the report noting the detailed paper and summary offered. The Committee noted that there had been an increase in the total number of overdue actions however the number of overall actions related to SIs had decreased in preparation for the launch of the PSIRF. Reflection was made on the national high-profile case of Martha Mills with the Committee seeking to understand how the Committee would adopt Martha's Law, requesting that an update be offered at the October meeting.

	There continued to be positive progress and compliance with Duty of Candour which would continue to receive focus and support. **Infection Prevention and Control Group Upward Report** The Committee received the report noting the increase in Covid-19 infection rates for both staff and patients and recognising that the vaccination season had commenced. Progress was noted in respect of housekeeping levels of cleanliness however concern was noted around compliance with waste disposal practices in outside bins. The group had requested an update be offered to the October meeting in respect of the actions being taken and would upwardly report to the Committee. **Nursing, Midwifery and Allied Health Professional Advisory Forum Upward Report** The Committee received the report noting the positive discussion which was held regarding the EPR and the evaluation process and requirements of senior nurses, midwives and AHP colleagues to support this. The group noted the NEWS and PEWS quality metrics with a need for a change within the WebV system to address a present anomaly for NEWS recording. Mitigations were in place to correct the issue. The group agreed to support the flu and Covid-19 vaccination campaign to have 1 peer vaccination in each team to support occupational health to deliver the programme. It was also noted that there was a joined-up campaign with LCHS and a high confidence level to deliver the programme to all staff. **Patient Safety Group Upward Report inc Quarterly Patient Safety Alerts** The Committee received the report noting that the group had approved the PSIRF policy and plan which had been presented directly to the Committee. There were 3 Central Alerting System (CAS) alerts which were overdue and being oversee by the Medicines Quality Group to ensure these were closed. The Committee was pleased to note the development of the Deteriorating Patient Group which was under new stewardship and would be working to improve fluid management. **Safeguarding Group Upward Report** The Committee received the report noting the progress toward joint working and the shared training plan which was in place. The difficulties in accessing the national Oliver McGowan training were recognised by the Committee however it was noted that there were significant mitigations in place with alternative training in place as an

	interim measure. The Committee sought the support of the ICB to the system and to raise the issue of access to the training nationally. The Committee noted the continued support from the Safeguarding team in respect of DBS checks for staff in the organisation and recognised the oversight of this through the People and OD Committee. **Medicines Quality Group Upward Report** The Committee received the report and was pleased to note the downward trajectory in harm related to medicine related incidents. The group had received reports from various sub-groups with the Committee noting the work of the Chemotherapy Group in respect of patient cooling to reduce hair lost and the report from the Drugs and Therapeutics Committee in respect of the EPMA rollout. The Committee was pleased to note the assurances being received by the group through upward reporting which continued to improve. The Committee was pleased to note the triangulation between this report and other items on the agenda, associated with temperature monitoring and medical gases, which demonstrated an understanding of the issues but also the actions in place.
	Assurance in respect of SO 1b Issue: Improve Patient Experience **PLACE Annual Report** The Committee received the report (appended) which had been considered at the Patient Experience Group in July. It was noted that there had been notable improvements in all areas inspected. It was recognised that there were further improvements to be made, such as the introduction of dementia clocks, which would have a positive impact for patients. The Committee encouraged consideration of the use of charitable funds to make improvements which would impact on the patient environment and experience. The current PLACE inspection was being undertaken and would be reported to the Committee once the result were available. **Patient Experience Group Upward Report** The Committee received the report noting the assurances that had been provided to the group through the divisional mini-PEGs and the traction being achieved on the 'you care we care to call' work. Work was taking place in the EDs to support improvements following the

	outcome of the national survey with the Patient Experience Team providing support and undertaken observations of care. The outcome of which would support improvements plans alongside the implementation of a co-design group with members of the patient panel to develop ED fundamentals. **Complaints Quarterly Report** The Committee received the quarterly complaints report noting that there were 15 overdue complaints at the time of writing the report which had subsequently reduced to 6. A number of complaints had been closed within timescale and the team continued to drive improvement forward within the service with support from the divisions to support early resolution. The Committee noted the primary reasons for complaints remained communication, treatment and waiting times.
	Assurance in respect of SO 1c Issue: Improve Clinical Outcomes **Clinical Effectiveness Group Upward Report** The Committee received the report noting the positive position of the benchmarking results against NICE and Technology Appraisals. There had been significant activity in respect of clinical audit with improved engagement for both national and local audits which demonstrated the positive impact of audit. The Committee noted that the Trust remained an outliers on a number of national audits with assurance received by the group that actions were in place to address this. There were a number of challenges noted in respect of the delivery of the Stroke Sentinel National Audit Programme (SSNAP) with the team considering national benchmarking, to support an understanding of the position, which was expected to be similar to the Trust. It was recognised that the Acute Services Review would improve access to stroke beds.
	Assurance in respect of other areas: **Pending Admissions update** The Committee received a verbal update noting that work had been completed to understand the potential harm as a result of pending admissions. It was noted that whilst there was no harm associated with these processes required strengthening in respect of reconciling the waiting lists. Pending admissions would be reported, as a performance item, to FPEC.

	FPEC Response to mechanical ventilation and medicines temperature management capital funding request The Committee noted the response from FPEC in respect of the formal route to apply for capital noting that the Medicines Quality Group would move forward to seek capital funding for medicine temperatures. Feedback would be offered to the relevant individuals to advise of the process in respect of mechanical ventilation. **FPEC Referral – Nursing and Medical Representatives/Lead of Medical Gases Group** The Committee noted the referral from FPEC in respect of representatives for the Medical Gases Group from both the medical and nursing workforce to ensure appropriate oversight and ownership of actions. The Committee noted the dual reporting of the group to both Health and Safety Committee and the Medicines Quality Group. Action would be taken to review and amend the terms of reference of the Medical Gases Group to ensure representation. **Integrated Improvement Plan** The Committee received the report with moderate assurance noting that 73% of measurements were achieving target. The Committee recognised the improvements being seen in respect of medicine incidents and medication incidents causing harm. The Committee noted the areas of specific focus including timely administration of IV antibiotics for sepsis and length of stay for stoke patients. **Internal Audit Recommendations** The Committee noted that updates were being made by internal audit with an updated report due to be offered to the Committee once available. Updates were however being received through upward reports to the Committee in relation to actions related to Internal Audit with reassurance received that sufficient evidence had been submitted to close open actions. **CQC Action Plan** The Committee received the report noting the closure of a number of red actions from the previous report. Improvements had been seen in respect of the Child Protection – Information Sharing however the action would remain live until this was sufficiently embedded. The Committee noted the benchmarking that had been undertaken in respect of the CQC Single Assessment Framework to determine the current position for the Trust with further work required on the quality statements.

	Committee Performance Dashboard The Committee received the performance dashboard noting the content and the continued improvement in mortality metrics along with the improvements associated with NICE compliance. Outlier areas in respect of National Audits would be addressed through the Clinical Effectiveness Group and relevant action plans. The Committee noted the focus in the emergency departments in respect of skin integrity due to the length of stay of patients in the departments. The Committee praised the complaints team for the improved performance of responses being offered on time which had increased to 80% from 10% the previous year. **Strike Impacts and Risk** The Committee received the report (appended) noting the significant assurance offered despite the highly challenging demands placed on the NHS as a result of industrial action. It was recognised that as a result of the strike actions there had been an impact on out-patient appointments, day case procedures and elective surgeries. Cancellations had been made however all patients had been rebooked. The Committee noted the planning, rigor and learning that had taken place during the rounds of strikes with the Committee recognising the positive behaviours of the Executive Team in leading the organisation at a difficult time.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	None
Committee Review of corporate risk register	The Committee noted the risk register noting those risks contained within the register.
Matters identified which Committee recommend are escalated to SRR/BAF	None
Committee position on assurance of strategic risk areas that align to committee	The Committee considered the reports, which it had received which provided assurances against the strategic risks to strategic objectives.
Areas identified to visit in dept walk rounds	None

Attendance Summary for rolling 12-month period

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

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

United Lincolnshire Hospitals NHS Trust

PLACE 2022

Results Feedback

OUTSTANDING CARE *personally* DELIVERED

Progress from 2019 to 2022

- Increased Housekeeping resource
- Full refurbishments of Belton Ward (Grantham) and Dixon Ward (Lincoln)
- Ward enhancement programme at Lincoln incorporating disability and dementia criteria
- Corridor redecoration to improve the environment
- Introduced a PLACE Lite programme
- Training for PLACE Team Leaders
- Sought clarification from NHS Digital on some of the PLACE questions

Cleanliness

National Average for Acute Trusts	**97.99%**
National Position Against 124 Acute NHS Trusts	**75th**

2022 Results

ULHT Overall	**98.28%**
Grantham	99.50%
Lincoln	98.56%
Pilgrim	97.59%
Louth	99.63%

2019 Results

ULHT Overall	**95.16%**
Grantham	89.55%
Lincoln	95.11%
Pilgrim	96.86%
Louth	97.06%

Condition, Maintenance and Appearance

National Average for Acute Trusts	**95.81%**
National Position Against 124 Acute NHS Trusts	**85th**

2022 Results

ULHT Overall	**95.33%**
Grantham	98.71%
Lincoln	95.44%
Pilgrim	94.42%
Louth	91.04%

2019 Results

ULHT Overall	**92.29%**
Grantham	89.41%
Lincoln	90.83%
Pilgrim	95.41%
Louth	70.00%

Privacy, Dignity and Well Being

National Average for Acute Trusts	**84.90%**
National Position Against 124 Acute NHS Trusts	**57th**

2022 Results

ULHT Overall	**86.46%**
Grantham	90.98%
Lincoln	84.20%
Pilgrim	88.57%
Louth	74.14%

2019 Results

ULHT Overall	**76.03%**
Grantham	76.88%
Lincoln	76.21%
Pilgrim	75.50%
Louth	72.50%

Dementia

National Average for Acute Trusts	**79.60%**
National Position Against 124 Acute NHS Trusts	**78th**

2022 Results

ULHT Overall	**78.05%**
Grantham	80.25%
Lincoln	77.95%
Pilgrim	77.68%
Louth	63.56%

2019 Results

ULHT Overall	**65.79%**
Grantham	60.48%
Lincoln	67.64%
Pilgrim	64.44%
Louth	60.22%

Disability

National Average for Acute Trusts	**81.57%**
National Position Against 124 Acute NHS Trusts	**76th**

2022 Results

ULHT Overall	**80.69%**
Grantham	81.79%
Lincoln	81.27%
Pilgrim	79.61%
Louth	64.58%

2019 Results

ULHT Overall	**68.21%**
Grantham	59.10%
Lincoln	68.70%
Pilgrim	70.06%
Louth	58.44%

Food

National Average for Acute Trusts	**89.65%**
National Position Against 124 Acute NHS Trusts	**61st**

2022 Results

ULHT Overall	**90.72%**
Grantham	90.32%
Lincoln	89.66%
Pilgrim	92.28%

2019 Results

ULHT Overall	**89.00%**
Grantham	98.96%
Lincoln	87.93%
Pilgrim	87.80%

Plans ahead of the 2023 Collection

- Business case approved to continue the increased Housekeeping funding
- New Outpatient clinics in the old Maternity Block at Pilgrim
- New refurbished Pre-assessment Clinic at Lincoln
- New Resus Department at Lincoln ED
- Kingfisher roof repairs at Grantham
- New free of charge patient entertainment system Trust wide
- Possible source of funding for dementia clock roll out Trust wide
- Resurfacing of the visitor car park at Pilgrim and re-lining the road markings

ULHT Preparedness and Response for Medical Workforce Industrial Action

United Lincolnshire Hospitals NHS Trust

OUTSTANDING CARE personally DELIVERED

Background

Due to a continued and unrelenting demands within the NHS, many healthcare colleagues have balloted for industrial action in relation to pay and conditions and have achieved the numbers of votes required to enact strike action.

We must acknowledge that this is not a decision that is taken lightly.

The most recent professional group to vote for industrial action has been the medical workforce. Initially, this was the junior doctor workforce and subsequently the consultant workforce.

Unfortunately, no resolution has been secured in terms of pay and conditions and as a result, were find ourselves at somewhat of an impasse.

Industrial action for this group of professional continues and is occurring at regular intervals.

Currently, there have been 6 ‘rounds’ of industrial action, with a further two planned for September and october

The first of these took place at 7am on Monday 13th March and lasted until 7am Thursday 16th March

Impact

Planned industrial action has taken place monthly, with the exception of May and is set to continue with known dates in September and October.

The duration has ranged from 3 days to 5 days and whilst urgent and emergency care has been afforded ‘protection’ elective care provision as seen significant impacts over the last 6 months, will many patients treatments being postponed.

This has spanned all elements of elective care – outpatient appointments and procedures, and day case and inpatient surgery.

In total so far, this has resulted in the cancellation of c3,491 patients. This is broken down into c3,167 outpatient appointments, 206 day case procedures and 118 elective surgeries. Some of these cancellations included 2 week wait appointments and 78 week waiters.

All of these patients were rebooked in a matter of days.

The impact on our operational and administration Teams cannot be underestimated.

Impact

During the course of the Junior Doctor strikes approximately 66% of the workforce took strike action. The highest percentage of the Doctors striking was from within the Medical and Emergency Care Division and the least number was in the Family Health Division. This has been fairly consistent across the strike thus far.

During the 2 Consultant Strikes, those colleagues were asked if they would declare their intentions would be. A third confirmed they would be taking strike action, a third confirmed they would not be undertaken strike action and a third chose not to disclose.

During the Junior Doctors Strikes, safe service provision was achieved by the cancellation of activity and the Consultant workforce 'acting down' to covers essential services such the Emergency Departments and Inpatient Wards.

During the Consultant Strikes, the British Medical Association declared that service provision be like of a Christmas Day cover and that all elective activity should cease. As a Trust and acting the best interest of our patients, we chose not to following this request but accepted that some activity would undoubtably be cancelled.

It also has to be recognise the significant financial impact to the Trust.

ULHT Planning and Emergency Preparedness

- Command and Control was instigated week prior to each planned industrial action and 48 hours post industrial action.
- The Strategic response and control was led by the Chief Operating Officer and conjunction with the Medical Director's Office. The core team at strategic level also comprised of a HR Lead, Communications Lead and an EPRR Lead. Twice daily Strategic calls were put in place. The membership included Executive Team members, Divisional Leadership Teams, The Director of Estates and Facilities, Staff side and the Tactical Lead. A twice daily action log recorded all actions and decisions. This was distributed to all team members following each of the strategic calls.
- The Tactical Cell was established at the same time and comprised a Tactical Lead, Divisional Operational Teams, dedicated HR support and when required Estates and Facilities. The Tactical cell ran from 8am until 8pm. The prime functions of the Cell, were to confirm and assure that each division had robust plans in place to ensure patient safety. The cell recorded all patient activity cancellations following updates from the divisions, especially Clinical Support Services.
- Divisional Teams assessed each of their services daily and recommended where elective activity needed to be cancelled and what the impact of doing so looked like ie impact on 2 week wait clinics, patients waiting greater that 78 weeks and operative procedures. This then was shared and discussed within the Strategic call.
- Administration Teams were responsible for engaging directly with our patients to keep them fully up to date. Where possible, when a patients appointment cancelled it was rebooked in the same conversation.

System Planning, Emergency Preparedness and Reporting

- Twice daily system strategic calls and twice daily system tactical called were established.
- Information was shared in respect of the number of medical colleagues undertaking strike action and impact on services, particularly in relation to elective cancellations
- The ICB communicated with Regional Colleagues through 3 times a day calls.
- National and regional reporting structures were put in place for the duration of each strike.
- An agreed communications plan was put in place which included messages to the public, staff and where necessary, the media.

Reflections So Far

Whilst respecting our colleagues' decision to take industrial action, our focus was on patient safety and staff welfare.

Over the 6 previous strikes, we, as an organisation, have become very skilled in terms of our planning, minimising patient impact either due to cancellations of elective treatment or ensuring emergency and impatient care standards were maintained.

As an organisation and as a system, we have responded well to the demands place upon our teams, especially our administration teams and are assured that no harm has come to any of our patients.

We have established tried and tested processes that enable us to work at pace in recovering from the impact of continued industrial action.

We should be very proud all of the teams involved.

Questions

Report to:	Trust Board
Title of report:	Quality Governance Committee Assurance Report to Board
Date of meeting:	17 October 2023
Chairperson:	Rebecca Brown, Non-Executive Director
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the Quality Governance Committee (QGC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme. The Committee worked to the 2023/24 objectives. The Committee worked to a reduced length of meeting to enable a workshop to be held in support of the Group Model, therefore reports were taken as read and questions submitted ahead of the meeting to expedite the meeting.
	Assurance in respect of SO 1a Issue: Deliver high quality care which is safe, responsive and able to meet the needs of the population **Patient Safety Group Upward Report inc PSIRF Go Live update** The Committee received the report noting the go live of Datix IQ which had been successful with the Learn from Patient Safety Events (LFPSE) also launched alongside this, ahead of national timescales. The Patient Safety Incident Response Framework (PSIRF) had been launched on the 1 October with the Committee commending the launch of this and how well this had been received. The work of the Trust had been recognised across the system by the Integrated Care Board. **Infection Prevention and Control Group Upward Report** The Committee received the report noting concern in the rise of C-Difficile cases across the Trust with a deep dive to take place in order to consider themes and undertake relevant actions. It was recognised that there was a similar position nationally with the Committee noting that a review had been considered by the IPC team where it had not been identified that there was cross infection between patients.

	Medicines Quality Group Upward Report The Committee received the report noting the progress being made in respect of the closure of Central Alerting System (CAS) actions against trajectory. Concern was noted in respect of the Medical Gases Group due to quoracy however this would be reinvigorated, along with appropriate reporting. The Committee noted the immediate staffing concerns in the pharmacy team and was pleased to note that there had been some short-term improvements with recruitment which would continue to be progressed with OD support in place with the team. **Children and Young People Oversight Group Upward Report** The Committee noted that the meeting had been stood down due to Industrial Action. **Maternity and Neonatal Oversight Group Upward Report** The Committee received the upward report and a number of associated appendices (attached) including the Ockenden insight visit report, Claims triangulation report, core competency framework, saving babies lives and assurance reports. The Committee commended the outcome of the Ockenden insight visit. The Committee was pleased to note the proactive approach to deep dives noting consideration by the group of the undiagnosed breach births. This had resulted from a complaint from a member of the public with the deep dive identifying hat the Trust had a rate of 0.31% against a national rate of 1%. As a result of the deep dive a research project has commenced for point of care scanning to determine the benefit in this being implemented permanently. **Nursing, Midwifery and Allied Health Professional Advisory Forum Upward Report** The Committee received the report for information noting there were no escalations to be raised. **Ward Accreditation Quarterly Report** The Committee received the report noting the positive impact of the scheme for wards being accredited and reflected on the enhance monitoring support in place for those areas flagging as a concern. The Committee was pleased to note early support to those areas where concerns were noted before significant concerns arose with assurance on the processes to move areas in and out of enhanced monitoring. **Serious Incident Summary Report inc Duty of Candour** The Committee received the report noting that the backlog of open actions had not reduced as expected ahead of the PSIRF go live, due to

	the impact of industrial action and capacity. The overdue actions would be addressed and managed through the Patient Safety Group to ensure these were closed with trajectories in place. The Committee noted a deterioration in duty of candour however noted that, at present, this was not a trend, but work was taking place with clinical teams to ensure this was managed. **High Profile Cases** The Committee received the report noting the content.
	Assurance in respect of SO 1b Issue: Improve Patient Experience **Patient Experience Group Upward Report** The Committee received the report noting the availability of patient stories in a library on the Trust intranet site along with a number of public stories on the Trust website to share learning and experiences. The Committee reflected on the Friends and Family Test noting the work being undertaken with the Divisions not only to improve response rates but to interpret these. A sentiment analysis tool was being considered in order to better interpret and respond to narrative outputs. **Palliative and End of Life Group Upward Report** The Committee received the report noting the great progress being seen and reflected on the patient story received by the group and the support needed where carers were also health professionals to ensure professional boundaries were not crossed.
	Assurance in respect of SO 1c Issue: Improve Clinical Outcomes **Clinical Effectiveness Group Upward Report** The Committee received the report noting the progress being made on High Volume Low Complexity work. Concern was noted in respect of VTE and appropriate meetings taking place however this was being addressed. The Committee noted the significantly overdue NCEPOD actions with support being offered to the Divisions to understand the resource required to support the closure of actions.
	Assurance in respect of other areas: **Integrated Improvement Plan** The Committee received the report for information noting that there had not been any questions raised prior to the meeting.

	Quality Impact Assessments (QIA) The Committee received the report for information noting that the process was now embedded with assurance being offered. **Internal Audit Recommendations** The Committee received the report noting that this offered an up-to-date position with a number of actions closed, including CPIS and Data Quality. The Committee noted that actions associated with Field Safety Notices had been extended to 31 October to ensure all actions were completed in line with the changes to Datix. **CQC Action Plan** The Committee received the report noting that the open actions were now progressing with the Committee requesting that these be progressed with a view to close the actions by January 2024. **Committee Performance Dashboard** The Committee received the report noting the performance data presented and reflected on the improvement in the SPC charts. The Committee reflected on the level of medication incidents being low and noted that it was expected that the rollout of EMPA would further improve the position.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	None
Committee Review of corporate risk register	The Committee noted the risk register noting those risks contained within the register.
Matters identified which Committee recommend are escalated to SRR/BAF	None
Committee position on assurance of strategic risk areas that align to committee	The Committee considered the reports, which it had received which provided assurances against the strategic risks to strategic objectives.
Areas identified to visit in dept walk rounds	None

Attendance Summary for rolling 12-month period

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

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

Lincolnshire Maternity & Neonatal Programme
Better Births

NHS

Ockenden Insight Visits June 2023 FINAL

Review of Maternity Services within United Lincolnshire Hospital Trust,

Led by the LMNS

Securing the best start for women and families in Lincolnshire

Lincolnshire Maternity & Neonatal Programme
Better Births

NHS

Visit Purpose

The purpose of the visits was to provide assurance against the 7 immediate and essential actions taken from the Ockenden report which was published initially in December 2020, with then a further second and final report in March 2022. These reports outlined specific areas to focus on for assurance. The Insight Visit Team used an appreciative inquiry and learning approach to foster partnership and to aid understanding and communication of services.

The visits took place on the 20th June at Lincoln County Hospital, and the 21st June at Pilgrim Hospital, Boston.

Evidence was submitted to the LMNS prior to the visits to offer compliance against the 7 IEA's. Conversations on the days further sought to demonstrate that compliance with members of the senior leadership teams as well as with acute Midwives, Obstetricians and those in Specialist roles.

The 7 areas of focus are;

1. Enhanced Safety
2. Listening to Women & Families
3. Staff Training and Working Together
4. Managing Complex Pregnancy
5. Risk Assessment Throughout Pregnancy
6. Monitoring Fetal Well-Being
7. Informed Consent
8. Workforce Planning and Guidelines

Lincolnshire Maternity & Neonatal Programme
Better Births

NHS

Insight Visit Team members

Martin Fahy – Director of Nursing & Quality ICB, Senior Responsible Officer for LMNS

Clare Brumby – Lead Midwife for the Maternity & Neonatal Programme, LMNS

Sue Jarvis – Programme Manager LMNS

Amanda Pike – Maternity Voices Chair

Chantal Knight – Senior Governance & Assurance Lead Midwife, Midlands Perinatal Team

Sarah Pemberton – Head of Quality, Maternity

Nottingham University Hospitals

Lincolnshire Maternity & Neonatal Programme
Better Births

NHS

Key Headlines
Points for celebration

- A dedicated and passionate workforce whom strives to deliver their best in each area
- A visible senior leadership team, whom is focused on engaging families and staff to improve services
- An obvious uplift of Specialist Midwives who can now focus QI projects and monitor improvements
- Fully Compliant for CNST Yr. 4, more established oversight processes were evident and a forward audit plan in place
- Fully compliant on all 5 elements of SBLCBV2
- Clear changes in environments for women and staff to be able to work more efficiently and comfortably
- Fantastic Preceptorship support for newly qualified Midwives and students, clear links with the training Universities
- Exceptional work evident and ongoing around Fetal Monitoring

Lincolnshire Maternity & Neonatal Programme
Better Births

NHS

Key Headlines
Points for consideration

- The environment, although improved in areas needs to remain a focus
- Maintaining IT connectivity is a priority, changing Maternity systems must remain the ambition in order to fully comply with PCSP's and individualised care for women
- Future job planning and specifications is not fully explored, more focus on this would ensure continued structure and succession in roles
- Consideration to explore need to appoint a DOM
- Consideration to having a Governance Lead 8a reinstated to ensure the robust processes are followed effectively and there is clear leadership in this area – (this was suggested last year also), it would also support the ever growing request in assurance compliance
- To explore further mechanisms for feedback when experiences demonstrate areas for improvement, to increase the access for women
- To consider expanding work/roles relating to Optimisation which would support IEA 7 a women's choice

Lincolnshire Maternity & Neonatal Programme
Better Births

NHS

Summary of Ockenden IEA status

IEA	Insight Visit 2022	Insight Visit 2023
1. Enhanced Safety		
2. Listening to women and families		
3. Staff Training & working together		
4. Managing Complex pregnancies		
5. Risk assessment through pregnancy	Partially met	Partially met
6. Monitoring Fetal well-being	Partially met	
7. Informed Consent		
Workforce Planning	Partially met	Partially met
Guidelines	Partially met	

Lincolnshire Maternity & Neonatal Programme
Better Births

NHS

IEA1 Enhanced Safety

IEA 1	RAG
Q 1 - Dashboards	
Q 2 - External review of SI's	
Q 3 - SI's to Board/LMNS	
Q 4 - PMRT	
Q 5 - MSDS	
Q 6 - HSIB	
Q 7 - PCQSM	
Q 8 – SI's to Board/LMNS	

Points for celebration

- PMRT process robust and well managed, now led by Safety Lead Midwife
- SI's shared at Board and LMNS level, learning is circulated
- Robust evidence of board assurance processes

Points for consideration

- To appoint a Governance Lead 8a to ensure appropriate Leadership, escalation and processes for risk and incidents
- Safety Lead Midwives to be more visible to staff on shop floor
- To ensure communications/learning to be noted by all staff groups, engage the whole MDT especially community teams whom find it more difficult to access emails on a regular basis
- To seek official 'external' reviewer for PMRT from Sherwood Forest Hosp

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IEA2 Listening to women & families

Points for celebration

- NED appears fully integrated into system working and is fully versed on all areas, both from staff and families
- Regular input and good relations between NED and MVP team which ensures consistent messages and areas for learning/improvement
- PMRT process fully embedded and each case has family input

IEA 2	RAG
Q 11 - NED	
Q 12 - PMRT	
Q 13 - Service user feedback	
Q 14 - Bi-monthly safety Champion meetings	
Q 15 - Service user feedback	
Q 16 - NED	

Points for consideration

- Continued promotion of face to face access with NED, staff have shared the desire to engage more often on site
- Review and feedback to be shared from new Patient Experience Group – inclusive of MVP
- Further progression to be considered when experiences have not been positive, more mechanisms required for families to utilise and be signposted to by staff

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IEA3 Staff Training and working together

Points for celebration

- MDT Training is well-received and welcome by all staff groups
- MDT Training is 'protected' time for all staff where possible
- Consultant twice daily ward rounds have been implemented
- Training schedule is current and robust covering all required topics
- Full implementation of Specialist Midwives in post
- Robust induction /preceptorship processes in place

IEA 3	RAG
Q 17 – MDT Training	
Q 18 – Consultant Ward rounds	
Q 19 – Ring Fenced Funding	
Q 20 -	
Q 21 – 90% MDT Training	
Q 22 – Consultant Ward Rounds	
Q 23 – MDT Training Schedule	

Points for consideration

- Training Needs Analysis is due to be repeated so that training can continue to be maintained to a high standard
- To consider including 'Consultant twice daily ward rounds' to audit programme to ensure consistent oversight of this safety measure
- To ensure that Mandatory Training and Prompt sessions compliance is monitored and actioned immediately where required due to inconsistencies in compliance month on month

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IEA4 Managing Complex Pregnancy

Points for celebration

- SBLCBV2 fully compliant on all 5 elements
- The Antenatal Care guideline instructs staff to ensure each woman has a named consultant lead
- Staff have been fully focused on supporting all elements of SBL

Points for consideration

- To strengthen process of referral to Maternal Medicine Centre by Implementation of the draft SOP being produced currently
- Consideration to include Consultant Lead review to audit programme to ensure consistent compliance
- To continue to pursue every possible avenue to securing a new IT Maternity System to ensure that future compliance is safeguarded and that data can more easily be collected

IEA 4	RAG
Q 24 – MMC Criteria	
Q 25 – Named Consultant	
Q 26 – Complex Pregnancies	
Q 27 - SBLCBV2	
Q 28 – Named Consultant Audit	
Q 29 - MMC	

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IEA5 Risk Assessment throughout pregnancy

Points for celebration

- Maternity Medway system has included RA as a mandatory field now supporting compliance
- Birth Choices Clinic is shown to be hugely effective and women who wish to birth outside guidance can attend to further discuss their choices, their risk status is then updated accordingly
- Staff are fully focused and supportive of appropriate care for women

IEA 5	RAG
Q 30 – Risk assessment	
Q 31 – Place of Birth RA	
Q 32 – SBLCBV2	
Q 33 – Risk assessment recorded with PCSP	

Points for consideration

- To establish the record keeping audit programme and to action the reviews that take place 4 monthly as detailed in the evidence record
- To ensure the application for a new IT Maternity System is upheld which will ensure a more robust and simpler way to collect data for many QI projects and risk assessments
- To ensure progress is sighted on new ways to ensure PSCP inline with women's choice

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IEA6 Monitoring Fetal well-being

Points for celebration

- SBLCBV2 is fully embedded and all staff have worked tirelessly to ensure success
- There has been a dedicated Fetal Monitoring Lead Midwife for a year now, with full action plan and dedicated capacity to achieving better outcomes
- Mandatory updates on fetal monitoring is now a full day inclusive of human factors training
- There is now dedicated Consultant Obstetric Leads to support implementation of improved fetal monitoring interpretation
- CNST Year 4 full compliance achieved

IEA 6	RAG
Q 34 – Leads in post	
Q 35 – Leads expertise	
Q 36 – SBLCBV2	
Q 37 – 90% MDT Training	
Q 38 – Leads in post	

Points for consideration

- To ensure that robust review of attendance on Mandatory Updates is continued to ensure staff maintain their clinical updates and practice in fetal monitoring

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IEA7 Informed Consent

Points for celebration

- Birth Choices Clinic is fully available and utilised by women to ensure they are included in their birth choices
- Women's feedback is sought and displayed positively in hospital areas
- The PMA service is now fully supported and 20 more staff members are to receive the training for 'Birth Trauma debrief training'
- The ULHT website has now been reviewed by the MVP team and feedback has been given
- '15 steps' has been completed and feedback given to the Trust

IEA 7	RAG
Q 39 – Accessible information, place of birth	
Q 40 – Accessible information, all care	
Q 41 – Decision making and informed consent	
Q 42 – Women's choices respected	
Q 43 – Service user feedback	
Q 44 - Website	

Points for consideration

- To ensure that neutral and unbiased information is given to women and families from medical staff groups, and that they are clear on how to signpost those who need it to further support
- To ensure that IOL counselling by medical staff remains current using up to date research and guidance, that it remains relevant and personalised to the women
- To support the reinstatement of the 'Willow Team' for Induction of Labour which previously has been well received by women and from feedback on the visits, colleagues have recognised how to improve and implement the service more effectively and wish to ensure its future success

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Workforce planning & Guidelines

Points for celebration

- Consultant Leads are now recruited to support specialist roles, ie. Fetal Monitoring and Cardiac. There are also now Obstetric and Gynae Risk Leads for the Trust to support incident review and resolution.
- There are now 2 Consultant Midwives to support safety work and quality improvement work
- The Safety Lead midwives are now fully appointed to ensure more oversight and compliance of the increased 'asks' nationally
- Robust process for management of Guidelines and NICE review

WFP & G	RAG
Q 45 - Clinical workforce planning	
Q 46 – Midwifery workforce planning	
Q 47 – D/HOM accountable to exec director	
Q 48 – Strengthening Midwifery Leadership	
Q 49 - Guidelines	

Points for consideration

- The Consultant body has been uplifted but suggest that the twice daily ward rounds need to be continually monitored to ensure compliance is met for safety.
- There is a lack of DOM and this needs to be implemented and considered further for succession planning as a priority
- To ensure that the current Safety Lead Midwives remain clinically competent and current to enable support in acute areas

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Additional points for celebration

- MVP team site visits that were performed prior to the Insight visit days were well received by staff and women, hugely positive feedback received by maternity and neonatal families
- Competent experienced NED in place who is focused on patient experience and dedicated to integrating into staff groups to understand the wider picture
- Visible and approachable senior leadership team
- Maternity is covered at every Board meeting now with representation from senior colleagues to ensure effective communication of successes and when 'calls for action' are required
- On both sites visits it was incredibly clear how proud staff are to work within the maternity and neonatal departments at ULHT. The passion for improving services and care for women was palpable and admirable
- Safety Huddles held on each day have improved vastly over the past year, they now incorporate all staff groups across the acute service which has improved communications between teams
- Estates within Maternity and Neonatal departments has seen improvements, the Bereavement Suite at Pilgrim is highly applauded by families needing it. The new ward areas are a vast improvement also for staff and families
- Collective opinion of staff groups is that there is a visible and approachable Senior Leadership team
- There appears to be strong productive relationships between midwifery staff on acute areas and consultant body
- Consultant Body now meet 3 monthly Trust wide which has improved relations and communications across sites, which will support more change going forwards

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Additional points for consideration

- The process of communication and the format could be improved further in that it 'reaches' all staff groups effectively. Community teams feel a 'disconnect' in that it is not as easy for them to access emailed updates therefore they feel slightly outdated when safety notifications have been shared
- The feedback mechanisms have improved since last visit, however there is room to improve further where experiences occur that are not positive. Staff have appeared less aware or less informed on how to signpost or what the process includes when women and/or families wish to express negative/or unhappy experiences in care
- The visibility of the newly appointed safety Leads has been queried in that 'staff' feel they need to be more present in acute areas and not appear distant or unobtainable when needed to support the workforce
- The location of the Senior teams and/or Specialist Midwives in the Whisby Suite has also come into discussion with staff groups. It is felt the distance is too great, given the lack of experience and the more obvious number of junior staff. Senior colleagues would feel more supported and more confident if senior staff were easier to access.
- There is a clear need to ascertain more direct line management and leadership within the Risk and Governance remit. A 'Team ' approach would be supported by many of the workforce, and a definite uplift with a Band 8a would be supportive of the current national agenda. There appears a slight uncertainty in the line of escalation and process, most probably due to the lack of position and structure that is lacking in this area
- There needs to be further input in developing the collaboration between the new safety leads as staff have expressed that often there is disconnect between these individuals as requests are being made from numerous areas which can be confusing and add to workload
- IT connectivity is impacting hugely the role and capacity of Community Midwives and this is really impacting staff morale some staff told us that the HR recruitment process was slow and excessive paperwork needs to be eliminated where possible (improved IT would help with this issue)
- Further work to be considered on the need for access to Translation services and tools in order to be able to communica with women more safely and easily
- Perhaps more insight into the senior escalation of issues/topics. When items have been escalated to senior medical teams it has been stressed that staff 'feel' that subjects get lost and follow up on this senior escalation does not have any outcome

Lincolnshire Maternity & Neonatal Programme
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Lastly;

The visiting team would like to express their over whelming thanks to ULHT colleagues, maternity, obstetric and neonatal for their willingness to be part of this process.

It is clear from the visits that staff are proud and willing to be at the forefront of improving care for women and families in Lincolnshire and they have shown huge growth in being able to demonstrate their ability to be open and honest in what has been achieved and what is still to be done.

Sarah Pemberton (Quality Lead for NUH) had some poignant words for us when she left and I wish to share them with you.

'I wanted to get across how lovely each and every person I came into contact with was. You can really feel their passion for improving and providing the best and safest care. The team reminded me very much of the team I worked with at SFH. They have come a long way together and have formed strong relationships with each other along the way. '

Thank you

Claims Scorecard, Complaints & Incidents – Quarter 1 2023/24: April - June 2023

Samantha Tinkler - Patient Safety Midwife
September 2023

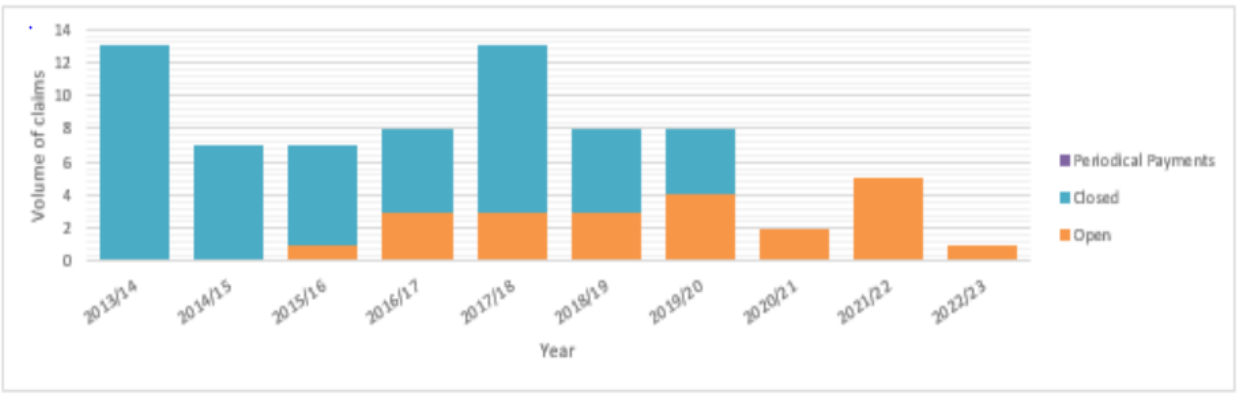
As part of the Maternity Incentive Scheme (Year 5) SA9 – Evidence that a quarterly review of the Trust's claims scorecard alongside the incident and complaint data should take place and be discussed by the Maternity, Neonatal and Trust Board level safety champions at a Trust level (Board or directorate) quality meeting. The Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trusts Patient Safety Incident Response Plan.
Therefore, this report has been produced so that the relevant information can be presented and discussed at the Maternity and Neonatal Oversight Group meeting which is held bimonthly.

Claims Data:

The most recent Trust claims scorecard was released in August 2023 - It has a ten year timescale for the period 01/04/2012-31/03/2022.

A dashboard of obstetric claims can be found here:

Copy of scorecard information for Obs



Triangulation of themes from claims with incidents and complaints remain difficult due to the fact that the data timescales and information categories are not the same and therefore incomparable. Families also have 25 years to submit a claim and are often submitted a significant amount of time after the event/incident.

Claims identify the Top 5 themes by injury and by cause of injury as shown in the tables below:

Top 5 injuries by volume for Obstetrics

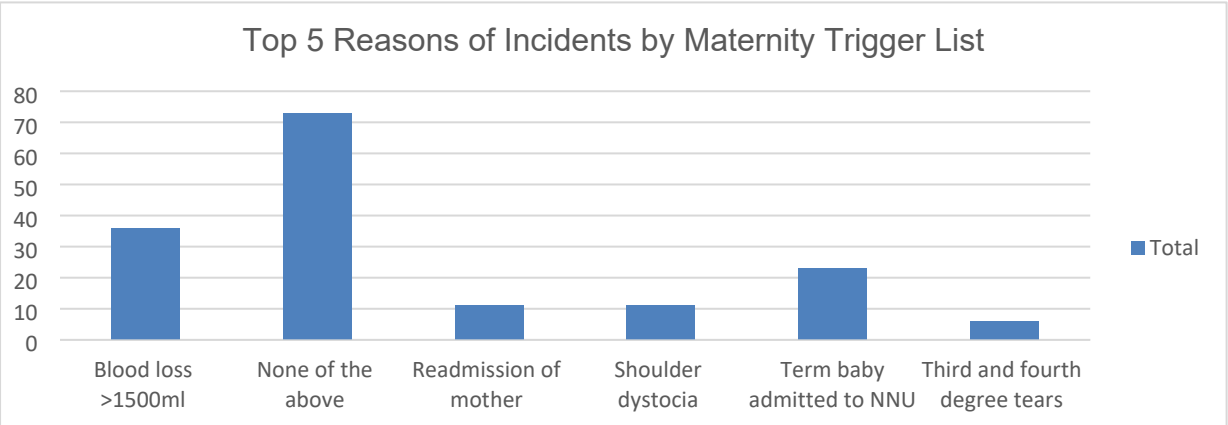
	Injury	Volume	Volume
1	Fatality	8	11%
2	Unnecessary Pain	12	16%
3	Adtnl/unnecessary Operation(s)	4	5%
4	Poor Outcome - Fractures Etc.	0	0%
5	Poor Outcome - Fractures Etc.	0	0%
Total Top 5 injuries by Volume for Obstetrics		**24**	**32%**

Top 5 causes by volume for Obstetrics

	Injury	Volume	Volume
1	Fail / Delay Treatment	19	25%
2	Failure/Delay Diagnosis	7	9%
3	Failure To Interpret X-Ray	0	0%
4	Failure To X-Ray	0	0%
5	Medication Errors	2	3%
Total Top 5 causes by Volume for Obstetrics		**28**	**37%**

Incident data:

Incident data can be categorised in a number of ways. Last quarter, it was shown how three different ways of pulling the Top 5 categories of incidents, identified how different the information can be depending on the search undertaken.
For the purpose of this report the top 5 incidents are identified by the **Maternity Trigger Lists.** This is of good value as it indicates specific issues related to Maternity Care and can highlight an increase in incidents in specific areas of care. It was also clarified that the Trusts Incident Team within the Patient Safety Team would use this criteria for the top 5 incidents if a request for this information was made. Therefore, for consistency the Maternity Trigger List for Quarter 1 2023/24 is:



Top 5 Incidents:

1. Blood Loss>1500mls
2. Readmission of Mother
3. Shoulder Dystocia
4. Term admission to the Neonatal Unit
5. Third and Fourth Degree Tears

Complaints Data:

Information received from the complaints department identified a number of reasons for complaints:

- Delay in neurology review following a caesarean section birth in October 2022 and subsequent subarachnoid haemorrhage
- Staff Attitude, patient felt that the staff had a can't be bothered and birth preference was not followed
- Clinical treatment - 3
- Clinical care and communication - 3
- Communication
- Midwifery treatment - 1
- Unhappy with the attitude of the midwife and lack of communication from the diabetic midwifery team
- Lack of consent obtained prior to procedure. Breach of confidentiality
- Unhappy with the way that they were treated throughout their pregnancy by the antenatal team
- Substandard level of maternity care, no communication

Overall Themes identified:

Claims	Complaints	Incidents
Fail / Delay Treatment	Delay in treatment/review	Blood Loss>1500mls
Failure/Delay Diagnosis	Attitude of Staff	Readmission of Mother
Failure To Interpret X-Ray	Clinical treatment	Shoulder Dystocia
Failure To X-Ray	Clinical care and communication	Term admission to the Neonatal Unit
Medication Errors	Breach of confidentiality	Third and Fourth Degree Tears

As can be highlighted from the themes identified, it remains difficult to actually triangulate specific areas without further detail of each case.
Following the reconfiguration of the Trust Patient Safety Team, in the future there will be the potential of more scope for review of individual incidents following the "After Action Reviews".
There is a new version of Datix also being launched on 1st October 2023 which may also effect the categorisation of themes and trends and potentially allow more specific trends to be identified.

Work continues to address these themes identified in all areas:

- All postpartum haemorrhages above 1500mls are individually reviewed by a Multidisciplinary Team (MDT).
- Readmissions of mothers, shoulder dystocia's and third/fourth degree tears are individually reviewed by an MDT in the Maternity weekly incident review meetings.
- All term admissions to the Neonatal Unit are reviewed as part of the National ATAIN (Avoiding term admissions to the Neonatal Unit) process.
- Ongoing work to improve education and training, including the introduction of frequent practical skills and drills procedures to address identification and escalation of clinical concerns.
- iNeed escalation project to ensure staff feel comfortable asking for help with clinical concerns and obtain timely and appropriate responses from clinicians. "Team of the Shift" is the third element to supporting escalation and is under development with an implementation date to be confirmed.
- Personalised Care and Support Planning project to improve communication with women and families, including shared decision making and improving informed consent processes and give women autonomy over their care.

Conclusion:

The barriers to effective triangulation of claims, complaints and incidents continue. Due to the nature of submissions of claims, there may be a significant time after an event or incident when the concern is highlighted as a claim and we are therefore unable to review the themes and trends of incidents occurring at the same time.
The issue with how themes and trends are identified using our Datix system for incidents can also hinder triangulation due to the number of categories available to collate themes and trends.
Further work is required to ensure themes are identified appropriately and work in collaboration with the Patient Safety Team and the work that is already being prepared with incidents and complaints.

Process map of the implementation of the Core Competency Framework v2

Introduction:

The Core Competency Framework (CCF) has since 2020, provided trusts with extended guidance for the core elements and content of mandatory training that should be provided to maternity staff.

The CCF reflects the content and requirements stipulated in Saving Babies Lives v3 and Safety Actions 6 & 8 of the Clinical Negligence Scheme for Trusts (CNST). The CCF aims to ensure the safety of service users within maternity by addressing areas of harm and standardising the inclusion of these within training. The CCF v2 has further guidance that requires implementation at the earliest opportunity.

Timing of implementation:

Mandatory Training at United Lincolnshire Hospitals Trust (ULHT), runs alongside the financial year. Training is amended and updated according to the latest available evidence, as well as, local learning as a result of audit or investigation. CCF v1 was initially released as a triennial plan with regard to dissemination of the topics stipulated in its guidance; ULHT are currently in year 3 of this plan. Due to this, some elements of the CCF v2 will be implemented by no later than the 1st April 2024. Following benchmarking which occurred on release of CCF v2, all elements have been categorised into the following options;

1. Embedded into training (stretch targets created for April 2024)
2. Requires implementation into training immediately
3. Requires implementation into training by 1st April 2024

Allocation into option 3 suggests that the implementation of this element being delayed until the new financial year will not impact on the safety of the trust, and that it will require a significant change to the facilitation and formatting of that particular topic. The benchmarking is available in Appendix 1. Allocation to option 2 suggests that that the element impacts on safety and requires immediate dissemination, or that that the element is already embedded and requires an update in either information or time allocated to that topic.

Planning and stakeholders:

Planning for Mandatory Training will commence no later than December 2023. Stakeholders include the following;

- Clinical Education Team
- Specialist Midwives
- Fetal Monitoring Leads
- Obstetric Leads
- Anaesthetic Leads
- Associated services link staff (e.g. Mental Health Nurses)
- Maternity Matrons
- Administrative Support staff

- Professional Midwifery Advocates
- Neonatal leads and Matrons

Training will be planned collaboratively to ensure compliance with all national drivers, incorporating local learning and evidence that is pertinent to the trust and maternity services. Feedback from service users will be embedded throughout each training day, ensuring their voices are heard.

Preliminary plans will be disseminated and feedback requested to ensure all specialities and facilitators are in agreement regarding content and availability to provide the training.

Training for the new financial year will be finalised and presented to the Head of Midwifery and Divisional Clinical Director no later than the 1st February 2024. Any assessments or specific training plans must be sent to local commissioners no later than 28th February 2024.

Training week currently consists of the following individual study days;

1. PROMPT –MDT skills and drills training (Face to Face)
2. Fetal Surveillance and Human Factors (Microsoft Teams)
3. Midwives Mandatory Training Day 1 (MMTD1) (Microsoft Teams)
4. Midwives Mandatory Training Day 2 (MMTD2) (Microsoft Teams)
5. E –Learning day

From April 2024 it is proposed that we include a further MDT study day in order to disseminate all essential updates to the wider team and ensure all elements of national a local drivers are included. To ensure validity and safety of staffing in the clinical setting, the training days will be allocated over two separate weeks and provisionally set out as follows;

Week one:
1. PROMPT – MDT skills and drills training (Face to Face)
2. Fetal Surveillance and Human Factors (Face to Face)
3. MDT study day (Microsoft Teams)

Week two:
1. MMTD 1 (Microsoft Teams)
2. MMTD 2 (Microsoft Teams)
3. E learning day

Modules and Content:

Please refer to the CCFv2 Process map for data on current status on implementing the entire framework. This report will contain a short summary of each module.

It can be assumed if an element is already embedded (Level 1) that plans will be implemented to achieve the stretch target

Module 1: Saving Babies Lives Care Bundle (SBLCB)

E-Learning will currently remain mandatory for Midwives on an annual basis.

1.1 Smoking in pregnancy: 50% of the elements are embedded into current training. It has been determined to achieve the remaining elements by April 2024, the MDT study day will be utilised to capture all staff groups.

1.2 Fetal Growth restriction: Further depth required to achieve elements (currently level 3). To achieve this the MDT study day will be utilised to capture all staff groups.

1.3 Reduced Fetal Movements: All elements currently at level 3 due to the need to embed service user feedback. This will be implemented in April 2024.

1.5. Preterm Birth: 75% of the elements are embedded into current training. This training will move to the MDT study day by April 2024 to capture all applicable staff groups.

1.6 Diabetes in Pregnancy: Further Depth of elements in required (All currently at level 3). All elements will be moved to the MDT study day by April 2024 to capture all applicable staff groups.

Module 2: Fetal Monitoring and Surveillance (in the antenatal and intrapartum period)

Please refer to process map of Fetal Surveillance and Human Factors day

Module 3: Maternity Emergencies and Multiprofessional training

Please refer to process map of PROMPT study day

Module 4: Equality, equity and personalised care

82% elements currently embedded in training. The majority of elements will be included in MMTDs.

Module 5: Care during labour and the immediate postnatal period

87% of elements currently embedded in training. The majority of elements will be included in MMTDs

Emergencies in the community study days will be implements from the beginning of 2024

Module 6: Neonatal basic life support (NLS)

In accordance with CNST where possible Resuscitation Council (RC) trained instructors, consultants and Advanced Neonatal Nurse Practitioners are delivering

annual NLS updates. A team of 5 RC trained instructors will be in place by April 2024.
Following an assessment on safety it was determined education on recognition of the deterioration of black and brown babies required immediate implementation and a supporting PowerPoint has been developed to present prior to commencing the practical NLS update.

Please refer to process map of PROMPT study day

United Lincolnshire Hospitals NHS Trust

Maternity & Neonatal Safety Assurance Report

Libby Grooby, Divisional Head of Midwifery

As at 18 September 2023

Maternity & Neonatal Safety Assurance Report – Key Highlights

Trust: United Lincolnshire Hospitals NHS Trust **Date:** As at 18 September 2023 (Aug data)

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

CNST Yr 5: 10 Steps-to-Safety

No	Safety Action	Predicted RAG	Comments / Actions Being Taken
1	National Perinatal Mortality Review Tool		On track, evidence in file
2	Maternity Services Data Set (MSDS)		At risk due to ethnicity data compliance – most recent 81%. Data retrospectively updated. BAME report shared with staff
3	Transitional Care Services		Action plan to review
4	Clinical Workforce Planning		Not in line with requirement for Consultant compensatory rest
5	Midwifery Workforce Planning		On track, evidence in file
6	SBLCB V3		Audit plan in place
7	Service User Feedback / Co-produced Services		Meeting in place to discuss next steps
8	Training Plan		Awaiting confirmation of standard details from NHSR
9	Safety Champions		On track, evidence in file
10	HSIB / Early Notification Scheme		On track, initial benchmarking highlighted no concerns

Saving Babies Lives Care Bundle (SBLCB) V3

CNST required to demonstrate implementation of 70% of interventions across all 6 elements overall, and implementation of at least 50% of interventions in each individual element.
Fist submission 18.09.23 with review meeting in October.

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

3 Year Delivery Plan

Theme	RAG	Comments/Actions
Theme 1: Personalised Care		Personalised care work ongoing, working towards BFI, CoC in place
Improved equity		Emerging plan to develop accessibility for resources and information, to be co-produced with MVP.
Work with service users		Some co-production underway, additional work planned
Theme 2: Grow Workforce		Workforce planning well established, Preceptorship Team in post and effective, increased administrative posts recruited to
Retain Workforce		Retention work ongoing, Student and trainee feedback being assessed, Band 7/8 mentors and succession planning being developed
Invest in skills		TNA and plan for CCFv2 in place, update required from obstetrics re: appropriate levels of supervision and management of locums.
Theme 3: Positive Safety Culture		Senior leaders undertaking Perinatal Culture Leadership Programme, plan to improve and sustain culture in development, clinical escalation processes in place, FTSU Guardian in post and three FTSU champions in Maternity, FTSU widely advertised in maternity
Learning & Improving		Duty of candour well implemented and monitored, PSIRF for maternity not yet established nationally, robust SI/DI processes in place, culture language and ethnicity considered in all reviews and reports.
Support & Oversight		Good transparency of reporting and sharing of information across Trust and LMNS, PQSM well embedded, Safety Champions in place, staff feedback regularly sought, MNVP invited to attend Patient Experience and Quality Surveillance meetings
Theme 4: Best Practice		SBLv2 fully implemented, SBLv3 on track for implementation, NEWTT2 due October 2023, MEWS not currently released by NHSE, robust risk process in place, robust guideline/NICE process in place, maternity self-assessment in process.
Data for Learning		Dashboards utilise SPC for additional data scrutiny, any reviews include deprivation and ethnicity data. MSDS submitted as required
Digital Technology		Digital maternity strategy in place, EPR system in place with plan for new system, Badgernet in place on neonatal unit.

Maternity & Neonatal Dashboard Highlight Report

ULHT dashboard continues to show Blue (good) on SPC charts for smoking at time of delivery and is green on the RAG dashboard. This shows consistent improvements and has gone from 11.45% to 8.63% in 6 months. Smoking at booking remains fairly consistent at11-13 %. This is being attributed to the in-house smoking service and will continue to be monitored.

AN steroid administration and magnesium administered are flagging as an issue. All cases are reviewed and themes are around late presentation and rapid labour.

PPH - Regionally there is a definite acknowledgement that higher intervention rates combined with other health measures (smoking and BMI predominantly) are leading to higher PPH rates. We take every step possible to prevent them occurring, but we also need to ensure we focus on the qualitative data - i.e. women's actual experiences of PPH. We have restructured our entire midwifery mandatory training plus all of our skills drills sessions to focus on the woman's experience.

‘Deep Dives’

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

- AAU & Labour Ward Waiting Times

  AAU waiting times.docx

- Quarterly PMRT Report

  Quaterly (Qu 1) Report April - June 20

- Undiagnosed Breech Birth Deep Dive

  Undiagnosed Breech highlight report.docx

- Postnatal Readmissions Deep Dive

  PN readmission Report.docx

- ATAIN Quarterly Report, Action Plan & Infographic

  ULHT Quarterly ATAIN Report Q1.doc

  2023 ATAIN and TC action plan FINAL.xlsx

  AVOIDING TERM ADMISSIONS INTO N

Learning Lessons

Overview for the reporting period:

As at 1 September 2023, there were 121 (81 last report) open incidents for Obstetrics & Community Midwifery, 67 (39 last report) of which are overdue.

There were 5 (10 last report) open incidents in Neonates, none (5 last report) of which are overdue.

As at 1 September 2023, there were 2 (309207, 315207) Serious Incidents (SI) open in Obstetrics and none in Neonates.

3 open cases being investigated by HSIB - IDs 305131 (overdue), 309592, 307455.
100% of families have received information on the role of the HSIB/EN scheme and are also compliant with regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour. This is in line and complaint with CNST standard 10.

There was one closed SI for Obstetrics (308286), no closed SIs for Neonates and one closed HSIB case (315676).

ULHT SI Update – see below

LNMS Q&S report sep.docx

SPC Charts to demonstrate data relating to Datix and SI actions

Worksheet in C Users grayner AppDa

Specific Requirements	Number	Details	Learning / Actions Taken
Number of incidents graded as moderate or above (reported Aug 2023)	1 – Obstetrics 0 - Neonates	1. **319525** – ELLSCS for 3 previous LSCS. Anticipated difficult delivery due to previous difficult delivery with adhesions +++. Total WBL 3200mls and admitted to ITU for close observations post LSCS.	1. Reviewed by the MDT and felt that no further action required. Rapid Review completed and shared with the wider MDT, no care issues identified and decided that no further investigation was required other than to be heard at the PPH review meeting.
Other Incidents considered at SI / Rapid Review Panel (Aug 2023)	10 – Obstetrics 0- Neonates	05.7.23 – **315676** – Baby transferred out for cooling – HSIB referral and SI declared. **315207** – 22+1 NND – Learning identified and agreed for SI 17.7.23 – **303051** – HSIB final report - no safety recommendations SI closed, a/w SIRG 26.7.23 – **316624** – Term ?eclamptic seizure – Concise Datix 31.7.23 – **295891** – HSIB final report – 2 safety recommendations - SI closed, a/w SIRG 07.8.23 – **314606** – Missed tubal ligation - DI declared 09.8.23 – **315308** - Information Governance Breech – Concise Datix 14.8.23 – **315676** – Re taken to panel as HSIB declined – Concise Datix 14.8.23 – **317640** – 29+6 twin pregnancy, cardiomyopathy, ITU admission – Concise Datix / PMRT twin 2 21.8.23 – **309207** – 32 Em LSCS, PPH, ITU admission - Upgraded from DI to SI	
Serious Incidents - New – declared Aug	1 - Obstetrics 0 – Neonates	1. **309207** – 32/40, Em LSCS, PPH and ITU admission originally taken to panel and declared a DI.	Following MDT review was decided to take back to panel as care issues identified regarding failure to recognise the deteriorating patient. Draft DI report sent to the ICB for external comments, awaiting response.

Serious Incidents – Closed (Aug 2023)	2 – Obstetrics 0 – Neonates	1. Obstetrics – **308286** - Faliure to provide follow up postnatally of cyst, subsequent diagnosis of CA. 2. HSIB – **315676** - Declined by HSIB as didn't meet criteria, downgraded to concise Datix as no care issues identified.	
HSIB Investigations	3 current	1. **305131** (overdue) – Term IUD – Final report back 25/8/23, no safety recommendation made, for family meeting to be arranged. 2. **307455** - Intrapartum Stillbirth – Comments for factual accuracy returned, a/w final report. 3. **309592** – Transfer out for cooling – Report back for factual accuracy.	
Key themes & trends Identified from the above incidents and any additional actions being taken	Delay in recognition and management of the deteriorating patient – New guidance to be written as currently no maternity specific guidance to follow. Failure to follow guidance when certifying NND – Review guidance regarding the attendance of the neonatal team on admission of preterm neonate and make plan of care or certify death. Failure of documentation on Medway Ongoing review of all open SI/DI/HSIB actions.		
Number of overdue actions from incidents / SIs / HSIB and actions being taken	As at 1 September 2023, in Obstetrics, there were 58 (71 last report) ongoing actions – 43 of these are overdue. In Neonates there were no outstanding actions. Weekly action plan meetings continue- teams/leads to identify any actions that may require support/resources or date extensions if unachievable.		

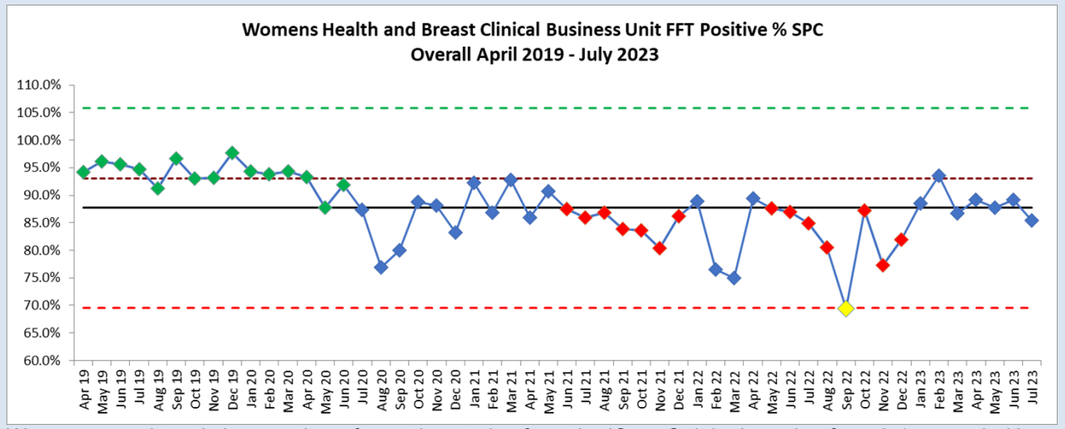
Service User Voice Feedback

Brief overview for the reporting period:

As at 1 September 2023, there were 4 open complaints in Obstetrics & Community Midwifery, none of which are overdue. There were no open complaint in Neonates.

There were 5 PALS contact received in Obstetrics in August and none in Neonates. There is one open PALS contacts for Neonates which is overdue.

Specific Requirements	Number	Details	Learning / Actions Taken
Number of complaints received in August	3 - Obstetrics 0 - Neonates	1. P38703 2. P38363 3. P38599	**RCA:** **Staff factors:** behaviours, culture, workload, language barrier, competing priorities, time constraints, work pressures, agency staff **Patient factors:** feeling rushed, unable to ask for confirmation **Environmental:** environment overall, confidential quiet rooms, capacity and demand.
Number of PALS received in Aug	5 – Obstetrics 0 - Neonates		
Number of compliments* ***Information taken from SUPERB (Single Unified Patient Experience Reporting Board)***	26 – Obstetrics 59 – Neonates	For June and July	
Feedback received by Maternity & Neonatal Voices Partnerships			
Key themes & trends identified from the above activity and any additional actions being taken		**Communication** stands out as a theme in most of the feedback the division. It is listed as a significant contributory factor in both complaints and PALS contacts. **Appointments** (access to, efficiency, experience etc) is also a regular theme in PALS **Clinical Treatment in WH –** Inadequate/inappropriate pain management. **Actions** Sharing patient experiences as patient stories; Improved liaison with MVP and NVP Ongoing work on CQC action plan Highlight to staff the new emerging theme around pain relief	
Number of overdue actions from complaints / PALS and actions being taken		As at 1 September, there were 4 open Obstetric complaint actions. There are 0 open Neonatal complaint actions.	
Friends and Family Test		The highlight report for August 2023 shows a National average recommended rate of 93%, a Trust average of 86% and Maternity have achieved 100%. No data for NNU as same cohort of women.	



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

Family Health Patient Experience Meeting Escalation	• There will be a focus on the overarching action plan and agreement to a process for updating as required. • QSIR projects to be encouraged to progress actions resulting from patient experience feedback. • List of FAB Champions to be expanded across the Division.

Staff Experience & Feedback

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

- Please also refer to the separate report from the Maternity NED 'Safety Champion.
- HoM safety clinics re launched as wall around in the hope that staff will engage more.

Other in month Developments & Updates

For July/August

Update from Maternity

- Baby Lifeline UK Mum (Maternity Unit Marvels) Awards 2023. Two of our staff Laura Fullwood and Sarah Harper were nominated and were voted as the Midlands regional winner which is amazing news. They are going down to London for a drinks reception at 11, Downing Street and then a Gala dinner the following evening.

- Translation – Cardmedic – reviewing the service with the hope of improving the translation services available to our women and families.

Equity - Translation.pptx

- MIS Yr 5 Update – July 2023. Ability to be compliant remains a challenge.

MISyear5-update-July-2023 V1.1.pdf

There have also been updates to the technical guidance:

Update from Neonates –

Workforce: Nursing
LCH. A recent trend in resignations have led to a number of vacancies across all bands. Fortunately following a robust recruitment campaign, all vacancies have now been appointed to. A deep dive into reasons for staff leaving has not led to any actions required – as these are largely due to family relocations and career promotions.

A workforce summary to be completed with the Neonatal Network October 2023 as part of the NCCR to identify gaps in meeting BAPM standards. Qualified in Speciality (QIS) nursing ratios should achieve 70% of the registered nursing workforce and whilst currently sitting at 53%, further appointment of junior staff will dilute the ratio further to sit at 40% over the coming months. Mitigations and a robust action plan in place to ensure safety of the service. The mitigations in place include sourcing further providers of QIS courses, utilising specialist nurses to back fill any gaps, and to ensure rotas are covered accordingly with oversight from Matron and senior team.

Workforce: Medical
Consultant posts fully recruited to.
Gaps identified in tier one rota, however trajectory completed demonstrating an establishment of 6wte in post by April 2024. This will be achieved through completion of courses by trainee ANNPs currently training through various course providers.

New Roles
Funding received by the national team for 0.6wte PDN and 0.6wte Neonatal Risk Lead. JDs and case of need completed. Awaiting seals of approval and CRIG authorisation.

Complaints/PALS
No complaints or PALS referrals received in August 2023.

Family Integrated Care (FIC)
Review undertaken by Network. Positive feedback received and feeding into overarching action plan for patient experience.

PEG
Working as part of the wider CYP team to embed robust actions to enhance pt/family experience and share wider learning

NNAP
Quarterly report of NNAP data to be compiled by ANNPs to identify both good practice and where improving patient outcomes required. Working closely with maternity teams to ensure data collation is accurate and deep dives are undertaken where required. Currently showing as national outlier for NEC – however deep dives into all 3 cases show no gaps in care, although now looking at implementation of donor breast milk.

NEWWT 2
Launching on 9th October 2023

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

Escalations from Maternity & Neonatal Safety Collaborative –

August –
CNST Yr 5 – Education deadlines
SBLv3 – ongoing work on audits
Co-production/design with the MVP
Connectivity

September
Concerns relating to lack of compliance by the medics with the smoking Very Brief Advice training
Concerns around compensatory rest for the medical staff
Some elements of SBL require significant work
Conversations ongoing around a System approach to progress towards BFI accreditation and improving the service moving forwards.
Positive neonatal recruitment
Connectivity is improving in the children's hubs
Huge amount of project work undertaken by IT Midwives in relation to new system
Thanks to the Neonatal Team for their support with NLS training
Funding accessed for 4 consultants to go on the CTG Masterclass
Release of IOL Journal this week
Launch of LocSSips week of 25.9.23
Maternity Newsletter to reduce the volume of individual communications to staff

Appendix A

ULHT Maternity & Neonatal Quality Dashboard 2023/24

Activity Indicators ULHT																				
Metric	Threshold			Data Source/ Standard	Link to Tab	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Average Percentage	SPC Special Cause identified	Comments
	R	A	G																		
Total Number of bookings				Careflow Maternity (CM)	Bookings	421	464	475	465	482								2307			Updated May 23
Women booked by 9+6 weeks	<67.50%		>67.50%	CM/HES Data 2021	BookedBy9+6	68.88%	72.84%	69.05%	71.83%	69.50%									70.42%		Updated May 23
Women booked onto Continuity Pathway	<22%		>22%	CM/ULHT default plan	BookedToCoCo	21.62%	26.72%	21.68%	21.08%	23.44%									22.91%		
BMI >25 at Booking				CM/PHE 2018	BMIBooking	58.19%	57.54%	57.89%	58.06%	58.71%									58.08%		
BMI >35 at Booking				CM/PHE 2018		16.63%	11.64%	11.16%	12.90%	13.07%									13.08%		
BMI >40 at Booking				CM/PHE 2018		7.60%	5.39%	4.42%	5.38%	5.81%									5.72%		
Total number of Births				CM	BirthNumbers	335	372	358	380	374								1819			
Total Number of Live Births				CM		334	370	358	380	371								1813			
Unassisted Vaginal Birth Rate				CM/HES Data 2020	NVB	53.43%	50.81%	51.68%	56.05%	47.59%									51.91%		
Home Birth Rate	<2.40%		>2.40%	CM/ONS 2020	HomeBirth	2.09%	3.49%	2.51%	1.05%	0.80%									1.99%		
Forceps and Ventouse				CM/HES Data 2020	Forcep&Ventouse	9.85%	7.26%	10.06%	6.84%	10.43%									8.89%		
Total Caesarean Section Rate				CM	Caesarean	35.82%	40.05%	36.31%	35.00%	41.44%									37.73%		
Emergency Caesarean Section				CM		24.78%	25.00%	20.11%	24.47%	25.13%									23.90%		
Elective Caesarean Section				CM		11.04%	15.05%	16.20%	10.53%	16.31%									13.83%		
Women booked on Continuity Pathway received care in labour/birth by continuity Team	<70%		>70%	CM/NHSIE	ContinuityCare	37.68%	38.81%	29.87%	38.24%	32.91%									35.50%		
Induction of Labour Rate	>40%		<40%	CM/HES Data 2021	IoL	42.77%	34.25%	35.59%	39.52%	37.74%									37.97%		
Smoking at Booking				CM/MSDS 2021	SmokingBooking	12.83%	12.72%	13.68%	13.76%	11.83%									12.96%		
Smoking at the time of Delivery	>9.6%		<9.6%	CM/NHSD 2021	SmokingDelivery	11.45%	14.25%	14.12%	9.95%	8.63%									11.68%		

Maternal Morbidity Indicators ULHT

Metric	Threshold			Data Source/ Standard		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Average Percentage	SPC Special Cause identified	Comments
	R	A	G																		
PPH ≥1.0 litre	>8.60%		<8.60%	CM/Obs CYMRU	PPH>1l	13.25%	13.15%	10.17%	10.75%	10.51%									11.57%		
PPH ≥1.0 litre SVB	>4.90%		<4.90%	CM/Obs CYMRU	PPH>1lSVB	3.92%	1.64%	3.11%	2.69%	2.96%									2.86%		
PPH ≥1.0 litre Instrumental	>18.40%		<18.40%	CM/Obs CYMRU	PPH>1lInstrumental	1.20%	1.37%	1.69%	0.27%	1.89%									1.29%		
PPH ≥ 1.0litre EL/LCS	>8.50%		<8.50%	CM/Obs CYMRU	PPH>1lEL/LSCS	2.41%	3.01%	1.13%	2.15%	1.62%									2.06%		
PPH ≥ 1.0litre EM/LSCS	>19.80%		<19.80%	CM/Obs CYMRU	PPH>1lEM/LSCS	5.72%	7.12%	4.24%	5.65%	4.04%									5.35%		
PPH ≥2.0 litre	>1.30%		<1.30%	CM/Obs CYMRU	PPH>2l	2.41%	1.92%	0.56%	1.61%	1.89%									1.68%		
3rd and 4th degree Tear	>3%		<3%	CM/OASI post-bundle stats	3rd4thDegTears	1.51%	0.82%	1.69%	1.88%	0.27%									1.23%		
Admission to ITU	≥1		0	Inpatient Matron	ITU	0	1	0	2	1								4			
No of PN Readmissions up to 42 days of birth	>3.40%		<3.40%	Self serve NMPA 2021	PNReadmissions	2.41%	5.48%	6.78%	4.57%	5.66%									4.98%		

Neonatal Mortality & Morbidity Indicators ULHT

Metric	Threshold			Data Source/ Standard		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Average Percentage	SPC Special Cause identified	Comments
	R	A	G																		
Unexpected Term admissions to the NICU (based on Term births)	>5%		<5%	NNU/NHSIE ATAIN project	UnexpectedNICU	4.84%	5.65%	4.83%	6.90%										5.56%		Reports 1 month behind
No. of babies transferred for therapeutic cooling	≥1		0	NNU	Cooling	2	0	0	1	0								3			
Pre-Term Birth 23+0-36+6 wks	>6%		<6%	CM/SBL	PreTerm	4.78%	9.68%	7.82%	8.42%	6.95%									7.53%		
No. of Antenatal stillbirths	≥1			CM	AntenatalSB	1	1	1	0	2								5			
No. of Intrapartum stillbirths	≥1			CM	IntrapartumSB	0	0	0	0	0								0			
Rolling stillbirth rate (12 months)	>3.8 per 1000		<3.8 per 1000	CM/ONS 2020	RollingSB	2.23	2.45	2.67	2.23	2.47											
No. of NND	≥1			CM and NNU	NoNND	0	0	1	2	0								3			
Rolling NND rate (12 months)	>2.2 per 1000		<2.2 per 1000	CM and NNU/ONS 2020	RollingNND	0.45	0.44	0.67	1.22	1.12											
AN Steroids Eligible / Full course Administered	<100%		100%	NNU	ANSteroids	33.33%	50.00%	57.14%	61.54%	66.67%									53.74%		
AN Magnesium Sulphate Eligible / Administered	<100%		100%	NNU	ANMagSulph	50.00%	50.00%	50.00%	100.00%	#N/A									62.50%		
SGA detection rate	< 41.2%		>41.7%	ANC/SBL Perintatal Institute	SGA	54.24%	59.57%	50.00%	54.76%										54.64%		

Workforce Indicators ULHT																				
Metric	Threshold			Data Source/ Standard		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Average Percentage	SPC Special Cause identified	Comments
	R	A	G																		
Midwife to Birth Ratio (funded)	01:27		01:26			01:26	01:26	01:26	01:26	01:26											
Midwife to Birth Ratio (Actual)	01:27		01:26			01:23	01:25	01:24	01:26	01:25											
1-1 in labour	<99%		>99%	CM/CNST	1-1Labour	100.00%	100.00%	99.68%	100.00%	99.40%									99.82%		
Sickness Rate	>4.3%		<4.3%	Workforce Intelligence	Sickness	4.47%	4.80%	4.92%	5.05%	5.53%									4.95%		
Co-ordinator Supernumerary	<96%		>99%	Inpatient Matron/CNST	Co-ordinator	96.94%	99.00%	99.75%	99.37%	97.90%									41.08%		
Prompt Training Compliance	<90%		≥90%	CE team/ CNST	PROMPT	88.13%	88.91%	89.44%	90.57%	89.01%									89.21%		
Mandatory Training Compliance	<90%		≥90%	CE team/ CNST	MMTD	83.39%	86.55%	90.07%	92.51%	93.28%									89.16%		

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

		Trained	Possible	%
PROMPT	Lincoln MW	161	168	95.83
	Lincoln Drs	20	36	55.56
	Lincoln Anaes	20	22	90.91
	Lincoln HCSW/MSW	40	44	90.91
	LCH Prompt	241	270	**89.26**
	Bank Only MW (Trustwide)	16	18	**88.89**
	Pilgrim MW	97	100	97.00
	Pilgrim Drs	18	28	64.29
	Pilgrim Anaes	17	21	80.95
	Pilgrim HCSW/MSW	24	27	88.89
	PHB Prompt	156	176	**88.64**
	Trust Compliance Prompt	413	464	**89.01**

Postnatal Indicators ULHT																				
Metric	Threshold			Data Source/ Standard		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Average Percentage	SPC Special Cause identified	Comments
	R	A	G																		
Skin to Skin Contact at Birth	<80%		>80%	CM/HES 2021	SkinToSkin	81.14%	76.76%	77.93%	78.42%	79.78%									78.81%		
Breastmilk at first feed	<68%		>68%	CM/HES 2021	FirstFeed	67.50%	71.51%	65.12%	66.85%	64.21%									67.04%		

Risk Management Indicators ULHT																				
Metric	Threshold			Data Source/ Standard		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Average Percentage	SPC Special Cause identified	Comments
	R	A	G																		
No. of unit closures	≥1		0	Inpatient Matron		3	0	1	3	2								9			
No. of SI's Maternity	≥1		0	Risk (Datix)		0	0	0	0	1								1			
No. of Never Events	≥1		0	Inpatient Matron		0	0	0	0	0								0			
No. of HSIB cases	≥1		0	Risk (Datix)		1	0	0	0	0								1			
PMRT commenced within CNST timeframe	<95%		≥95%	Bereavement Midwife		100.00%	100.00%	100.00%	100.00%	100.00%									100.00%		
PMRT completed within CNST timeframe	<50%		≥50%	Bereavement Midwife		100.00%	100.00%	100.00%	100.00%	100.00%									100.00%		
No of current coroners cases / inquests pending				Legal		0	0	0	0	0								0			
No of coroners Regulation 28 (prevention of future death reports) made direct to the trust)				Legal		0	0	0	0	0								0			
No of Formal Complaints				Complaints		5	3	3	3	0								14			

Perinatal Mortality Reports

July 2023

Hospital	Loss Category	Date	Gestation	Case Summary	MBRRACE Case No.	MBRRACE Notified	DATIX Panel SI
PHB	NND	03/07/23	21+1	P1, BMI 41, Holiday maker, spont birth in holiday accommodation. Baby born alive, RIP 1hr 4min of age.	88274	06/07/23	315833 No No
LCH	Misc	29/07/23	20+2	P1, BMI 37, LLP, APH, placental abruption	317672	N/A	317669 No No
External LCH	MTOP	28/07/23	21+3	P3, (1 prev preterm birth 25/40-NND). Major cardiac anomaly TOP @QMC	N/A	N/A	N/A
External LCH	NND	31/07/23	29+6	P3, maternal cardiomyopathy, late booker @ 26+2, DCDA twins, anhydramnios @ booking. 29+5 PV bleed, spont labour. SVD Twin 1, Twin 2 EMLSCS. 1 twin transferred to LRI- RIP @ 2 days Other twin transferred to QMC.	88787	N/A	No No No

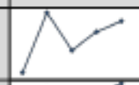
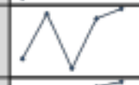
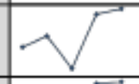
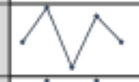
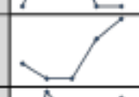
August 2023

Hospital	Loss Category	Date	Gestation	Case Summary	MBRRACE Case No.	MBRRACE Notified	DATIX Panel SI
PHB	Misc	06/08/23	19+3/40	G8 P5+2, Raised BP-medicated (also pre-pregnancy), Ex Smoker, BMI 30, DV. 1700ml APH.	n/a	n/a	318280 No No
LCH	SB	08/08/23	24+5/40	P0, IVF, small pericardial effusion noted on anomaly USS. Rpt USS 23+6 no Fh.	88794	07/08/2023	318209 Going 11/09/23
PHB	Misc	09/08/23	20+1/40	P1+0, Unbooked pregnancy, spontaneous miscarriage.	n/a	n/a	n/a
PHB	MTOP	13/08/23	18/40	P1, Spina Bifida	n/a	n/a	n/a
LCH	MTOP	13/08/23	20+6/40	P0, Spina Bifida	n/a	n/a	n/a
PHB	MTOP	15/08/23	22+6/40	P1, SROM 22+5, Sepsis	88973	18/08/2023	n/a
LCH	SB	23/08/23	33+3/40	BMI 29, Fibroids, placenta previa, C section after diagnosis of IUD	89076	24/08/2023	319560 Going 11/09/23

United Lincolnshire Hospitals NHS
NHS Trust

Neonatal Quality and Safety Dashboard - 2023/2024

Lincoln County Hospital

	Performance Measure	2019/20 Total	2020/21 Total	2021/22 Total	2019/20 Monthly Avg	2020/21 Monthly Avg	2021/22 Monthly Avg	2022/2023 Monthly Avg	YTD/ Average	Apr 2023	May 2023	June 2023	July 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Total	
Neonatal Unit	Live Births	2909	2925	2812	242.4	243.8	234.3	233.2	226.4	206	241	219	230	236								1132	
	No of all NNU Admissions (including re-admissions, transfers in, etc)	345	326	371	28.8	27.2	30.9	29.8	28.0	23	32	21	31	33								140	
	No of First Episode Admissions	283	282	299	23.6	23.5	24.9	23.8	23.2	21	23	17	27	28								116	
	% of First Episode Admissions against Live Births			N/A			11%	10%	10.2%	10.2%	9.5%	7.8%	11.7%	11.9%								N/A	
	No of Admissions to TC	152	202	220	12.7	16.8	18.3	19.0	13.2	10	17	10	15	14								66	
	All Ex-utero transfers	73	62	69	6.1	5.2	5.8	5.3	4.8	4	8	1	7	4								24	
	Ex-utero transfers <27 weeks	1	2	1	0.1	0.2	0.1	0.3	0.4	0	1	0	1	0								2	
	In-utero transfers	4	13	11	0.4	1.1	0.9	0.8	1.2	1	2	2	0	1								6	
	In-utero transfers <27 weeks	0	8	6	0.0	0.7	0.5	0.5	0.4	0	1	1	0	0								2	
	NNU Term Admissions	143	168	170	11.9	14.0	14.2	13.8	12.6	11	8	8	16	20								63	
	Live Term Births	2654	2725	2584	221	227	215	216	208	191	219	204	210	216								1040	
	% NNU Term Admissions (Live Term births) - Target <5%	N/A	N/A	N/A	5.4%	6.2%	6.5%	6.4%	6.0%	5.8%	3.7%	3.9%	7.6%	9.3%								N/A	

United Lincolnshire Hospitals NHS
NHS Trust

Neonatal Quality and Safety Dashboard - 2023/2024

Lincoln County Hospital

	Performance Measure		2019/20 Total	2020/21 Total	2021/22 Total	2019/20 Monthly Avg	2020/21 Monthly Avg	2021/22 Monthly Avg	2022/2023 Monthy Avg	YTD/ Average	Apr 2023	May 2023	June 2023	July 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Total	
Neonatal Unit - continued	Cot Occupancy - %	NNU	N/A	N/A	N/A	68%	63%	69%	71%	63.3%	72.7%	74.2%	56.7%	54.4%	58.7%								N/A	
		TC	N/A	N/A	N/A	83%	80%	45%	43%	40.9%	37.5%	29.4%	44.2%	46.4%	47.2%								N/A	
		Total (NNU & TC)	N/A	N/A	N/A		67%	61%	63%	55.5%	60.4%	58.6%	52.3%	51.6%	54.7%								N/A	
	Hypothermia on Admission - Ep.1 (<36.5ºc)	NNU	34	53	28	2.8	4.4	2.3	1.2	1.2	1	1	0	3	1								6	
		TC			15			1.3	1.9	0.2	0	1	0	0	0								1	
	(% of first episode admissions)	NNU %			N/A			0.1	4.6	4.0%	4.3%	3.1%	0.0%	9.7%	3.0%								N/A	
		TC %			N/A			0.1	9.6	1.2%	0.0%	5.9%	0.0%	0.0%	0.0%								N/A	
	Transferred for Therapeutic Cooling		5	0	4	0.4	0	0	0	0.4	2	0	0	0	0								2	
	HIE (all grades)		8	2	6	0.7	0.2	0.5	0.3	0.2	1	0	0	0	0								1	
	Neonatal Deaths (following admission to NNU)		0	1	1	0	0.1	0.1	0.0	0.0	0	0	0	0	0								0	
	Neonatal Deaths (delivery room)								0.1	0.2	0	0	1	0	0								1	
	Unit Closures (any)		0	2	0	0	0.2	0.0	0.0	0.0	0	0	0	0	0								0	
	No. of Exceptions		8	13	22	0.9	1.1	1.8	1.1	0.5		1			0								1	
	Medication Errors (moderate and above)									1.8	3	1	0	5	0								9	
	No of Serious Incidents (SI)		1	1	1	0.1	0.1	0.1	0.0	0.0	0	0	0	0	0								0	

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Neonatal Quality and Safety Dashboard - 2023/2024

Lincoln County Hospital

	Performance Measure		2019/20 Total	2020/21 Total	2021/22 Total	2019/20 Monthly Avg	2020/21 Monthly Avg	2021/22 Monthly Avg	2022/2023 Monthly Avg	YTD/ Average	Apr 2023	May 2023	June 2023	July 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Total	
Staffing	Appraisals - % (Target 100%)	Registered and unregistered	N/A	N/A	N/A			86%	89%	75.2%		64.1%	79.6%	83.0%	74.0%								N/A	
		ANNPs	N/A	N/A	N/A	75%	75%	71%	79%	50.0%	50.0%	50.0%											N/A	
	Sickness - % (Target - Trust avg <4%)	Registered and unregistered	N/A	N/A	N/A	6.5%	5.1%	6.8%	6.8%	4.6%	1.8%	3.3%	4.2%		9.0%								N/A	
		ANNPs	N/A	N/A	N/A	4.0%	0.6%	4.9%	9.7%	1.1%	0.8%	1.5%											N/A	
	Mandatory training % (Core Learning) (Target >95%)	Registered and unregistered	N/A	N/A	N/A	94%	91%	90%	95%	93.5%	91.0%	92.9%	93.3%	94.0%	96.1%								N/A	
		ANNPs	N/A	N/A	N/A	96%	97%	90%	94%	97.5%	97.0%	98.0%											N/A	
	Mandatory training % (Core Learning Plus) (Target >95%)	Registered and unregistered	N/A	N/A	N/A	92%	86%	86%	90%	87.2%	89.0%	74.0%	90.0%	90.0%	93.0%								N/A	
		ANNPs	N/A	N/A	N/A	96%	89%	86%	87%	92.0%	90.0%	94.0%											N/A	
	BLS (Target >95%)		N/A	N/A	N/A	95%	63%	77%	82%	70.4%	74.0%	57.0%	67.0%	76.0%	78.0%								N/A	
	QIS - % WTE (Target >70%)		N/A	N/A	N/A	N/A	N/A	64%	64%	47.8%	46.7%	49.0%	47.2%	48.0%	48.0%								N/A	
	No. of QIS in training - WTE		N/A	N/A	N/A	3.9	4.6	2.3	1.6	2.3	2.8	2.2	2.2	2.2	2.2								N/A	
	% staff with in-date NLS (Target 100%)		N/A	N/A	N/A	100%	95%	90%	100%	98.8%		100%	100%	98%	97%								N/A	

United Lincolnshire Hospitals NHS
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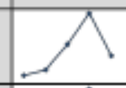
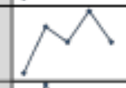
Neonatal Quality and Safety Dashboard - 2023/2024

Pilgrim Hospital, Boston

	Performance Measure	2019/20 Total	2020/21 Total	2021/22 Total	2019/20 Monthly Avg	2020/21 Monthly Avg	2021/22 Monthly Avg	2022/2023 Monthly Avg	YTD/ Average	Apr 2023	May 2023	June 2023	July 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Total	
Neonatal Unit	Live Births	1762	1612	1798	146.8	134.3	149.8	142.5	136.4	128	130	139	150	135								682	
	No of all NNU Admissions (including re-admissions, transfers in, etc)	209	172	218	17.4	14.3	18.2	17.1	17.6	11	20	17	23	17								88	
	No of First Episode Admissions	175	137	191	14.6	11.4	15.9	15.1	14.6	10	19	13	17	14								73	
	% of First Episode Admissions against Live Births			N/A			11%	11%	10.7%	7.8%	14.6%	9.4%	11.3%	10.4%								N/A	
	No of Admissions to TC	72	65	80	6.0	5.4	6.7	7.1	6.2	7	8	5	6	5								31	
	All Ex-utero transfers	30	28	23	2.5	2.3	1.9	2.1	3.4	4	5	4	3	1								17	
	Ex-utero transfers (<32 weeks)	12	7	9	1.0	0.6	0.8	0.6	1.0	1	1	1	2	0								5	
	All in-utero transfers	20	14	8	2.0	1.2	0.7	0.8	1.0	3	1	0	1	0								5	
	In-utero transfers (<32 weeks)	15	13	5	1.5	1.1	0.4	0.8	0.8	3	1	0	0	0								4	
	NNU Term Admissions	87	65	113	7.3	5.4	9.4	8.7	9.0	4	12	9	9	11								45	
	Live Term Births	1638	1510	1672	136.5	126	139	132	126	119	117	127	138	131								632	
	% NNU Term Admissions (Live Term births) Target <5%	N/A	N/A	N/A	5.3%	4.3%	6.7%	6.6%	7.1%	3.4%	10.3%	7.1%	6.5%	8.4%								N/A	

United Lincolnshire Hospitals NHS
NHS Trust

Neonatal Quality and Safety Dashboard - 2023/2024

Pilgrim Hospital, Boston

	Performance Measure		2019/20 Total	2020/21 Total	2021/22 Total	2019/20 Monthly Avg	2020/21 Monthly Avg	2021/22 Monthly Avg	2022/2023 Monthly Avg	YTD/ Average	Apr 2023	May 2023	June 2023	July 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Total	
Neonatal Unit - continued	Cot Occupancy - %	NNU	N/A	N/A	N/A	46%	44%	42%	38%	46.4%	36.3%	39.9%	60.4%	62.9%	32.7%								N/A	
		TC	N/A	N/A	N/A	50%	39%	51%	55%	47.3%	40.0%	71.0%	40.0%	43.5%	41.9%								N/A	
		Total (NNU & TC)	N/A	N/A			42%	45%	43%	46.7%	37.5%	50.3%	53.6%	56.5%	35.8%									
	Hypothermia on Admission - Ep.1 (<36.5◦c)	NNU	35	39	30	2.9	3.3	2.5	1.5	1.2	0	3	2	0	1								6	
		TC			5			0.4	0.2	0.8	0	4	0	0	0								4	
	(% of first episode admissions)	NNU %			N/A			0.2	10.8	6.5%	0.0%	15.0%	11.8%	0.0%	5.9%								N/A	
		TC %			N/A			0.1	3.3	10.0%	0.0%	50.0%	0.0%	0.0%	0.0%								N/A	
	Transferred for Therapeutic Cooling		2	2	1	0.2	0.2	0.1	0.1	0.0	0	0	0	0	0								0	
	HIE (all grades)		2	3	2	0.2	0.3	0.2	0.1	0.0	0	0	0	0	0								0	
	Neonatal Deaths (following admission to NNU)		0	0	2	0	0	0	0	0.0	0	0	0	0	0								0	
	Neonatal Deaths (delivery room)								0	0.0	0	0	0	0	0								0	
	Unit Closures (any)		0	0	0	0	0	0	0	0.0	0	0	0	0	0								0	
	No. of Exceptions		24	23	22	2.0	1.9	1.8	1.2	1.3	3	1		1	0								5	
	Medication Errors (moderate and above)									0.8	0	2	1	1	0								4	
	No of Serious Incidents (SI)		0	0	1	0	0	0	0	0.0	0	0	0	0	0								0	

United Lincolnshire Hospitals NHS
NHS Trust

Neonatal Quality and Safety Dashboard - 2023/2024

Pilgrim Hospital, Boston

	Performance Measure		2019/20 Total	2020/21 Total	2021/22 Total	2019/20 Monthly Avg	2020/21 Monthly Avg	2021/22 Monthly Avg	2022/2023 Monthly Avg	YTD/ Average	Apr 2023	May 2023	June 2023	July 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Total	
Staffing	Appraisals - % (Target 100%)	NNU	N/A	N/A	N/A			83%	73%	84.9%	69.2%	68.0%	87.5%	100.0%	100.0%								N/A	
		Outreach												60.0%	80.0%									
	Sickness - % (Target - Trust avg <4%)	NNU	N/A	N/A	N/A	5.5%	6.3%	6.3%	10.5%	7.6%	7.8%	6.0%	7.4%	8.0%	8.7%								N/A	
		Outreach								18.6%	0.0%	18.1%	22.1%	30.1%	22.6%									
	Mandatory training % (Core Learning) (Target >95%)	NNU	N/A	N/A	N/A	95%	96%	98%	98%	97.5%	97.2%	97.0%	97.5%	96.7%	99.0%								N/A	
		Outreach								89.6%	89.5%	83.3%	86.1%	92.3%	97.0%									
	Mandatory training % (Core Learning Plus) (Target >95%)	NNU	N/A	N/A	N/A	92%	94%	96%	96%	95.0%	97.2%	93.0%	97.6%	93.0%	94.0%								N/A	
		Outreach								88.8%	95.0%	87.7%	88.4%	87.0%	86.0%									
	BLS (Target >95%)	NNU	N/A	N/A	N/A	97%	99%	96%	93%	94.2%	92.0%	92.0%	95.0%	96.0%	96.0%								N/A	
		Outreach								65.4%	67.0%	33.0%	67.0%	80.0%	80.0%									
	QIS - % WTE (Target >70%)		N/A	N/A	N/A	62%	67%	70%	74%	74.5%	72.0%	72.0%	72.0%	82.0%									N/A	
	No. of QIS in training - WTE		N/A	N/A	N/A	2.0	0.6	1.5	1.1	0.0	0.0	0.0	0.0	0.0	0.0								N/A	
	% staff with in-date NLS (Target 100%)	NNU	N/A	N/A	N/A	96%	100%	98%	99%	100.0%	100%	100%	100%	100.0%	100%								N/A	
		Outreach							83.50%	100.0%	100%	100%	100%	100%	100%								N/A	

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

Naomi Plant, Patient Safety Lead Midwife
September 2023

v3.2 Maternity
Neonatal Safety Impr

The Maternity Safety Improvement Plan (MatSIP) is a dynamic live document for the collation and monitoring of improvement actions arising from national maternity reports and assurance requirements as well as internally identified improvement actions e.g. actions identified through Serious Incidents.

Following the Maternity and Neonatal Safety Collaborative meeting, including Senior Leadership and Specialist Midwives, 13 actions were closed and archived. 12 of those actions related to Induction of Labour (IOL), and it was agreed that in view of the actions taken over during this year, including gathering patient feedback, the implementation of the IOL Checklist and Patient Journal, alongside the ongoing monthly audit, it was appropriate for all actions to be removed and amalgamated in to one action whereby a quarterly IOL report will be compiled and presented at Governance. The content of this will be agreed in due course, to ensure the inclusion of all relevant archived actions.

One action relating to IOL remains in place, and it categorised as Red (see below). This is due to the Safety Lead Midwife awaiting the thematic analysis from the Patient Experience Team. Once received, this will be reviewed and findings and recommendations included in the IOL quarterly report.

Further actions will be added to the MatSIP in the coming month relating to fetal monitoring.

Section	Total Actions	**Red** Not yet completed / significantly behind agreed timescales or non-compliance expected	**Amber** In progress / on track / completion expected	**Green** Completed & ongoing and / or not yet fully embedded (awaiting evidence of embedding)	**Blue** Completed & embedded with evidence, to be signed off at MNSC prior to closure
Optimise Safety	**24** (-3)	0 (=)	21 (+3)	3	0
Optimise Experience	**11** (-6)	1 (-2)	9 (=)	1	0
Improve Leadership	**1** (=)	0 (=)	1 (=)	0	0

Choice & Personalised Care	**15** (-3)	0 (=)	12 (-3)	3	0
Provide Assurance	**6** (=)	0 (=)	6 (=)	0	0
TOTAL	**57** (-12)	**1** (-2)	**49** (=)	**7** (-9)	**0** (=)
Archived Actions	**205** (+13)	Completed, embedded and signed off by MNSC for closure			

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

	Action No	Action Milestone	Responsible Lead	Due Date	Comments
OE11	1	Mapping of the IOL patient journey including delays	IOL MW	31/05/23	Ongoing project, 296 patient experience surveys returned, being thematically analysed by data analysed. Audit of 40 patient journeys, data collected and currently being analysed. Awaiting thematic analysis results from Patient Experience, then findings will be reviewed and reported within the new IOL Quarterly Report, along with the recommendations.

United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*7 November 2023*
Item Number	*Item 8.2*

Patient Safety Incident Response Plan and Policy

Accountable Director	*Professor Karen Dunderdale, Director of Nursing / Deputy Group Chief Executive*
Presented by	*Professor Karen Dunderdale, Director of Nursing / Deputy Group Chief Executive*
Author(s)	*Helen Shelton, Assistant Director of Clinical Governance*
Report previously considered at	*PSIRF Implementation Team – 6 September 2023* *Quality Governance Committee – 19 September 2023*

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

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

Recommendations/ Decision Required	• *Note the work undertaken to develop the Patient Safety Incident Response Plan and Policy* • *Approve the Patient Safety Incident Response Plan and Patient Safety Incident Response Policy.*

Background

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

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

Current Position

General Update

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

The national guidance requires all organisations develop and publish a Patient Safety Incident Response Policy and a Patient Safety Incident Response Plan.

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

The Patient Safety Incident Response Plan and Patient Safety Incident Response Policy have been developed in line conjunction with key stakeholders and were presented and agreed at the Patient Safety Incident Response Implementation Team on 6 September 2023. These were then formally presented to the Quality Governance Committee for approval on 22 September 2023 following an opportunity at their August 2023 meeting to offer feedback and provide input into the final versions.

The final Patient Safety Incident Response Plan and Patient Safety Incident Response Policy are offered to the Trust Board for approval.

Conclusion/Recommendations

The Trust Board is asked to:-

- Approve the Patient Safety Incident Response Plan and Patient Safety Incident Response Policy.

United Lincolnshire Hospitals NHS Trust

Patient safety incident response plan

Effective date: October 2023

Estimated refresh date: April 2025

	NAME	TITLE	SIGNATURE	DATE
Author	**Helen Shelton**	**Assistant Director of Clinical Governance**		
Reviewer				
Authoriser				

Contents

Forward

"The introduction of this framework represents a significant shift in the way the NHS responds to patient safety incidents, increasing focus on understanding how incidents happen – including the factors which contribute to them. "

Aidan Fowler, National Director of Patient Safety, NHS England

PSIRF is a different and exciting approach to how we respond to patient safety incidents. This is not a change which involves us doing the same thing but calling it something different but a cultural and system shift in our thinking and response to patient safety incidents and how we work to prevent an incident happening again. Our challenge is to shift the focus away from investigating incidents to produce a report because it might meet specific criteria in a framework and towards an emphasis on the outcomes of patient safety incident responses that support learning and improvement to prevent recurrence.

The NHS Patient Safety Strategy was published in July 2019 and describes the Patient Safety Incident Response Framework (PSIRF), a replacement for the NHS Serious Incident Framework (SIF). This document is the Patient Safety Incident Response plan (PSIRP) and describes what we have undertaken at ULHT to prepare to launch PSIRF in October 2023.

The Serious Incident Framework set the expectations for when and how the Trust should investigate Serious Incidents. However, evidence from national reviews, patients, families, carers and staff and an engagement programme in 2018 revealed that organisations struggle to deliver these. The introduction of PSIRF will support the Trust to operate systems, underpinned by behaviours, decisions and actions that assist learning and improvement, by allowing the Trust to examine incidents openly without fear of inappropriate sanction, support those affected and improve services. Unlike SIF, the PSIRF is not an investigation framework that prescribes what to investigate. Instead it:

- advocates a coordinated and data driven approach to patients' safety incident response that priorities compassionate engagement with those affected by patient safety incidents
- embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

We need to engage meaningfully with our patients, families and carers to ensure that their voice is the golden thread in any of our patient safety investigations. PSIRF sets out best principles for this engagement and our appointment to patient safety partners will ensure that the patient voice is involved at all stages of our patient safety processes.

Our recent work in moving towards a restorative and just culture underpins how we will approach our incident responses. We are fostering a culture to allow people to feel psychologically safe, enabling them to speak up and highlight safety concerns without fear or repercussions. PSIRF asks that we have conversations where people have been affected by a patient safety incident, no matter how difficult that is, and we will continue work to how we can equip and support those affected to best hear the voice of those involved. The process of reviewing an incident can help

our staff validate the decisions they made in caring for and treating a patient and facilitate psychological closure these are part of our PSIRF core objectives.

As we move into adopting this new way of managing our patient safety learning reviews, we accept that we may not get it right at the beginning, but we will continue to monitor the impact and effectiveness of our PSIRF implementation, responding and adapting as needed if our approach is not achieving what we expect it to. In this we have been supported by our commissioners, partner providers and other stakeholders to allow us to embark on this nationally driven change. Most importantly though, PSIRF offers us the opportunity to learn and improve to promote the safe, effective, and compassionate care of our patients, their families and carers whilst also protecting the well-being of our staff. We welcome PSIRF's implementation and are ready for the challenges ahead.

Introduction

This Patient Safety Incident Response Plan (PSIRP) sets out how United Lincolnshire Hospitals Trust (hereafter referred to as ULHT) intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

The plan is underpinned by our existing Trust policies on incident reporting, management, review and learning currently in redraft and the Trust Patient Safety Incident Response Policy available to all staff via our Trust's intranet.

Our services

United Lincolnshire Hospitals NHS Trust (ULHT), situated in Lincolnshire, is one of the biggest acute hospital trusts in England serving a population of over 761,224 (Office of National Statistics 2019). The trust provides acute care and specialist services to people in Lincolnshire and neighbouring counties. Lincolnshire is the second largest county in the UK. It is characterised by a dispersed population in towns, in the city of Lincoln and largely rural communities.

ULHT is registered with the Care Quality Commission (CQC) to provide services from three acute hospitals in Lincolnshire:

- Lincoln County Hospital (Acute Inpatient Beds, Maternity Unit, Emergency Department)
- Pilgrim Hospital Boston (Acute Inpatient Beds Maternity Unit, Emergency Department)
- Grantham District Hospital (Acute Inpatient Beds, Emergency Department)

The Trust also provides a wide variety of outpatient, day case and inpatient services from a range of other community hospitals operated by NHS property services. These include:

- County Hospital Louth
- John Coupland Hospital, Gainsborough
- Johnson Community Hospital, Spalding
- Skegness and District General Hospital.

In the average year, we treat more that 140,000 Emergency Department patients, over 600,000 outpatients and over 140,000 inpatients, and deliver around 4000 babies.

The Trust provides a broad range of clinical services including community services, population-screening services, and a comprehensive range of planned and unscheduled secondary services.

Defining our patient safety incident profile

The Trust has a continuous commitment to learning from patient safety incidents and has an embedded understanding and insight into patient safety matters. This is supported through the Patient Safety Group that reports into the Quality Governance Committee on a monthly basis. The role of the Patient Safety Group is to receive, review, scrutinise, challenge and respond to or escalate data and information across the clinical activities of the organisation that supports the Trust to deliver its strategic objectives.

PSIRF sets no rules or thresholds to determine what needs to be learned to inform improvement apart from the national requirements listed on p11-13 below. To fully implement the Framework the Trust has completed a review of what types of patient safety incident occur to understand what needs to be learned from to improve.

The Clinical Governance Team has engaged with key stakeholders, both internal and external and undertaken a review of data from various sources to arrive at a safety profile. This process has also involved identification and specification of the methods used to maximise learning and improvement. This has led to the development of the local focus for our PSII responses listed on p15.

Stakeholder Engagement

The Clinical Governance Team commenced planning for PSIRF following the release of the documents in August 2022. We have consulted with PSIRF early adopters to enable us to understand the practicalities of planning for and implementation of PSIRF alongside attendance at both regional and national meetings.

A PSIRF Implementation Team was established in September 2022 with key stakeholders from within the Trust also supported by the ICB and the Trust Patient Safety Partners. This was carried out with the understanding that early engagement due to the changing nature of responsibilities within PSIRF was essential and we needed to work collaboratively on this.

Internally, a number of presentations have been delivered across the Trust, divisionally and corporately, to outline the major significant differences between PSIRF and the SI Framework. A twelve-month implementation plan has been followed with a planned go live date of the 1 October 2023.

Our data sources and how they were used to define our safety profile is detailed below. Once the data was collated, we have carried out a series of workshops with our key internal and external stakeholders to review this together to finalise our local focus and priorities for review by PSII. Our engagement workshops have included presentations, group work and the use of a question-and-answer platforms to enable co-working on the development of our safety profile and response planning.

Data Sources

The Trust used a thematic analysis approach to determine which areas of patient safety activity it should focus its local patient safety priorities. Our analysis used a number of data sources and safety insights from key stakeholders both internal and external.

A review of services provided by the Trust was undertaken based on the service codes set up in the Datix Risk Management system. This was then shared with the five Divisions (Medicine, Surgery, Clinical Support Services, Family Health and Corporate areas) to ensure that all services had been captured. The rationale for this was to ensure that the shape and structure of the plan reflects the likely incidents that the Trust will experience and to prevent silo working.

It was decided that a review of two years of patient safety data (April 2021 – March 2023) would be undertaken and included the following data sources:

- Themed analysis of Datix Incident data
- Risks held on the risk register
- Key themes from clinical audit and case note reviews
- Key themes from claims
- Key themes from incidents raised with the Trust from the ICB (known as HPFs)
- Issues identified from CQC inspections and other quality surveillance processes / visits
- Issues identified through safeguarding reviews
- Complaints / PALs data
- Themes arising from mortality and medical examiner reviews
- Patient experience data
- Nursing metric data
- Themes from safety climate surveys
- Themes from the Freedom to Speak Up Guardian feedback
- Staff survey data

Incident types, recurrence and severity were explored, together with careful consideration of safety improvement opportunities and knowledge, together with plans and interventions already in place. A range of staff, including leads for each of the above data collection systems, were consulted and the review also highlighted areas which required the collation of further intelligence to inform subsequent plans.

Patient Safety Data

From the original data pull, the data was grouped into a number of broad themes which formed the Trust's patient safety incident profile. The 30 themes were reflective of the range of services the Trust provides and the types of incidents reported. These are shown in the **table 1** below:

Themes
End of Life / Respect
Communication
Fluid Management
Medication Issues
Diabetic Ketoacidosis (DKA)
Clinical Ownership
Discharge Processes
Documentation
Referral Pathways / Communication Between Specialties
Care of Vulnerable Patients
Diagnostics
Care of Children in ED
Best Interest Decisions
Administrative Processes
Obstetrics
Deteriorating Patients
Access to Health Records
Falls
Pressure Ulcers
Lost Property
Nutritional Needs
Access to Blood Products
Medical Outliers
Care Rounding
Delays in Appointments / Waiting Lists
Ligature Risks
Infection Prevention & Control (IPC)
Therapeutics
Consent
Behaviour

Two workshops were then convened to discuss the outputs of the data, the first with the Patient Safety Incident Response Framework Implementation Team, inviting additional key stakeholders from several areas such as Safeguarding, Pharmacy, Mortality, Clinical Audit etc., and the second with the Trust Leadership Team. The aim of the workshops was to identify those themes which were already being picked up through other improvement methods and those which would generate the most learning and therefore, lend themselves to local Patient Safety Incident Investigation (PSII) highlighted on page 15.

Whilst the final list has been agreed has been agreed the Trust is aware that this list is not fixed thereafter. Within our resource analysis, we have also established capacity for additional ad-hoc PSII, where a new risk emerges or learning, and improvement can be gained from investigation of a particular incident or theme.

Defining our patient safety improvement profile

In 2020, the Trust launched its five-year Integrated Improvement Plan (IIP) which is our strategic plan to help us move forward as a Trust and ensure we were focusing on the right things for our patients and our staff. Our plan recognised the considerable time and effort already taken to address some immediate improvements and urgent quality and safety issues, while supporting our ambitions to move to a more comprehensive and planned approach for the future. In 2022/23, we refreshed our plan to reflect our changed operational environment from the COVID-19 pandemic. As we continue into the fourth year of our IIP, we have renewed our annual priorities for 2023/24 to help us to achieve our vision of Outstanding Care Personally Delivered.

The Trust has existing governance processes to ensure it gains insight from patient safety incidents and this feeds into quality improvement activity. We will also continue to draw on guidance and feedback from national and regional level NHS bodies, regulators, commissioners, partner providers and other key stakeholders to identify and define the quality improvement work we need to undertake.

The Quality Governance Committee (QGC) will provide assurance that patient safety improvements, as part of PSIRF, continue to be of the highest standard. Its sub-group, the Patient Safety Group (PSG), will be responsible for the oversight of this patient safety improvement work including the robust use of quality improvement methodology.

Our clinical and corporate divisions are required to report to our PSG in order to monitor and measure patient safety activity across the organisation. This group will also provide assurance during the development of new safety improvement plans following reviews undertaken within PSIRF to ensure they have followed robust processes during development and fulfil requirements and are sufficient to allow the Trust to improve patient safety in future.

We will focus our efforts going forward on development of safety improvement plans across our most significant incident types either those within national priorities, or those we have identified locally. We will remain flexible and consider improvement planning as required where a risk or patient safety issue emerges from our own ongoing internal or external insights.

Our patient safety incident response plan: national requirements

Some events in healthcare require a specific type of response as set out in national policies or regulations. These responses may include review by or referral to another body or team, depending on the nature of the event.

Specific patient safety incidents, such as Never Events and deaths thought more likely than not due to problems in care will always require a Patient Safety Incident investigation (PSII) to learn and improve. For other types of incidents which may affect certain groups of our patients, a PSII will also be required. These have been determined nationally, but the Trust fully endorses this approach as it fits with our aim to learn and improve within a just and restorative culture. As well as PSII, some incident types require specific reporting and/or review processes to be followed.

For clarity, all types of incidents that have been nationally defined as requiring a specific response will be reviewed according to the suggested methods and are detailed in the table below. From our incident and resource analysis we estimate, due to the services we provide, we will complete approximately 23 PSII reviews where both local and national requirements have been met per annum.

Table 2 below sets out the local or national mandated responses. As ULHT does not directly provide mental health or custodial services it is more likely that the organisation will be a secondary participant rather than a lead for those incident types (8, 9, 10, and 11):

	National Priority	Required response	Anticipated improvement route
1	Incidents meeting the Never Events criteria 2018	Locally led PSII by ULHT	Create local organisational recommendations and actions and feed these into the quality improvement strategy
2	Deaths thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs))	Locally led PSII by ULHT	Create local organisational recommendations and actions and feed these into the quality improvement strategy
3	Maternity and neonatal incidents meeting HSIB criteria	Refer to HSIB for independent PSII	Respond to recommendations from external referred agency/organisation as required and feed actions into the quality improvement strategy
4	Child Deaths	Refer for Child Death Overview Panel review	Respond to recommendations from external referred

		Locally led PSII (or other response) may be required alongside the panel review	agency/organisation as required and feed actions into the quality improvement strategy
5	Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) Locally led PSII may be required alongside the LeDeR review.	Respond to recommendations from external referred agency/organisation as required and feed actions into the quality improvement strategy
6	Safeguarding incidents in which: Babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence. Adults over 18 years old are in receipt of care and support needs from their local authority. The incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence.	Refer to local authority safeguarding lead via ULHT named safeguarding lead ULHT will contribute to domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and the local safeguarding adults boards	Respond to recommendations from external referred agency/organisation as required and feed actions into the quality improvement strategy
7	Incidents in screening programmes	Refer to local Screening Quality Assurance Service for consideration of locally led learning response.	Respond to recommendations from external referred agency/organisation as required and feed actions into the quality improvement strategy
8	Deaths of patients in custody (e.g., police custody, in prison etc.) where health provision is delivered by the NHS	Refer to the Prison and Probation Ombudsman or the Independent Office for Police Conduct to carry out the relevant investigations	Respond to recommendations from external referred agency/organisation as required and feed actions into the quality improvement strategy

		Healthcare organisations must fully support these investigations where required to do so.	
9	Deaths of patients detained under the Mental Health Act (1983), or where the mental Capacity Act (2005) applies, where there is a reason to think that the death may be linked to problems in care (incidents meeting the Learning from Death criteria)	Locally led PSII by the provider in which the event occurred with ULHT participation if required	Respond to recommendations from external referred agency/organisation as required and feed actions into the quality improvement strategy
10	Mental health related homicides	Referred to the NHS England and NHS Improvement Regional Independent Investigation Team for consideration for an independent PSII Locally led PSII may be required with mental health provider as lead and ULHT participation if required	Respond to recommendations from external referred agency/organisation as required and feed actions into the quality improvement strategy
11	Domestic homicide	Identified by the police usually in partnership with the local Community Safety Partnership (CSP) with whom the overall responsibility lies for establishing review of the case.	Respond to recommendations from external referred agency/organisation as required and feed actions into the quality improvement strategy

Our patient safety incident response plan: local focus

PSIRF allows organisations to explore patient safety incidents relevant to their context and the populations served. Through our analysis of our patient safety insights, based on the review of patient safety data and engagement meetings and workshops we have determined that the Trust will undertake 23 patient safety incident investigations (PSII) over the next 18 months, 5 of which being locally defined projects. We have selected this number due to the breadth of services that the Trust provides. It is important to note that all other incidents will continue to be reviewed using alternative review methods which will be outlined later within this plan. It is not the case that only the incidents identified for a PSII will get a review of care. This includes ensuring that reviews of maternity / obstetric incidents are undertaken in line with CNST / Saving Babies Lives requirements. The breakdown of the proposed PSIIs is as follows: -

Criteria	**Number of PSIIs**
Deaths meeting the level 3 learning from deaths criteria	Estimating 8
Incidents meeting the Never Event Criteria	Estimating 5
Locally defined projects	5
Allocation for issues identified in year	5
Total	**23**

The above calculation allows for decisions to be made in year to undertake a PSII outside of the locally defined projects if it is determined that the learning from the incident warrants this. The detail of this process, how the incidents for the locally defined projects will be identified and the other review methods to be used within the Trust will be outlined in the Patient Safety Incident Response Policy. We will use the outcomes of PSII to inform our patient safety improvement planning and work.

Locally defined responses:

The following table demonstrates the criteria for selecting priorities for a PSII response:

Criteria	Considerations
Potential for learning and improvement	• Increased knowledge: potential to generate new information, novel insights, or bridge a gap in current understanding. • Likelihood of influencing: healthcare systems, professional practice, safety culture.

	• Value: extent of overlap with other improvement work; adequacy of past actions.
Systemic risk	• Complexity of interactions between different parts of the healthcare system.

Based on the analysis and selection criteria described above, local priorities for PSII have been set for the period 01 October 2023 to 31 March 2025. The 5 patient safety priorities were agreed through the PSIRF Implementation Team (attended by the Trusts commissioning team), Patient Safety Group, Trust Leadership Team and the Quality Governance Committee in July 2023 as follows:

Theme	Key Theme	Key Risks from Activity
1	Inpatient Falls	Inpatient falls continues to be in the top five incident reporting categories with evidence of patient harm. Falls is noted as a very high risk for the Trust. Although there is current improvement work taking place within the Trust it is felt that the underlying reasons for falls is not yet fully understood.
2	Medication	Medication errors, particularly omitted and delayed medications, continue to be in the top five incident reporting categories. The management of medications is noted as a very high risk for the Trust. The underlying reasons for this are not fully understood.
3	Diagnostics	Review of the data has identified a theme regarding delayed review or missed review of diagnostic test results leading to harm for patients. The systemic reasons for this are not yet understood.
4	End of Life Care and ReSpect	Recognition of end of life and the use of respect forms is a theme identified throughout incidents and complaints and is also an issue through clinical audit.
5	Diabetic Ketoacidosis (DKA)	Work has been undertaken to improve care in relation to DKA, however, a number of incidents are still being reported in relation to this area. Therefore, it is felt that the underlying reasons for this are not yet understood.

Timescales for PSIIs

Where a PSII is required (as defined in this plan for both local and national priorities), the investigation will start as soon as possible after the patient safety event is identified. PSII's will normally be completed within one to three months of their start date however, in exceptional circumstances, a longer timeframe may be required for completion of a PSII. In this case, any extended timeframe will be agreed between ULHT and the patient/family/carer.

No PSII should take longer than six months. A balance will be drawn between conducting a thorough PSII, the impact that extended timescales can have on those involved in the incident, and the risk that delayed findings may adversely affect safety or require further checks to ensure they remain relevant. Where the processes of external bodies delay access to information for longer than six months, a completed PSII can be reviewed to determine whether new information indicates the need for further investigation.

Patient Safety Reviews

Other types of response exist to deal with specific issues or concerns. Examples of such responses include complaints management, claims handling, human resource investigations into employment concerns, professional standards investigations, coroner inquests or criminal investigations. The principle aims of each of these responses differ from the aims of a patient safety response and are outside the scope of this plan.

For any incident not meeting the PSII criteria, or any other incident, different review techniques can be adopted, depending on the intended aim and required outcome as reflected below:

Patient Safety Review type	Methods	Objective
Incident recovery	Immediate safety actions	To take urgent measures to address serious and imminent: a. Discomfort, injury, or threat to life b. Damage to equipment or the environment.
	Risk Assessment	To assess the likelihood and severity of identified hazards in order that risks can be determined, prioritised and control measures apply.
Team Review	Debrief	To conduct a post incident review as a team by discussing and answering a series of questions.
	Safety Huddle – Proactive and reactive	A short multidisciplinary briefing, held at a set time and place and informed by visual feedback of data to: • Improve situational awareness • Focus on the patients most at risk

		• Share understanding of the day's focus and priorities • Agree actions • Enhance teamwork through communication and collaborative problem-solving • Celebrate successes in reducing harm.
	After ActionReview (AAR)	A structured, facilitated discussion of an incident or event to identify: • What was expected to happen? • What happened? • Why was there a difference between what was expected and what happened? • What are the lessons that can be learnt?
Systematic Reviews To determine: • The circumstances and care leading up to and surrounding the incident. • Whether there were any problems with the care provided to the patient		
	Perinatal Mortality Review Tool (PMRT)	Systematic, multidisciplinary, high-quality audit and review to determine the circumstances and care leading up to and surrounding each still birth and neonatal death, and the deaths of babies in the post-neonatal period having received neonatal care.
	Atain Review Tool	Joint review by maternity and neonatal services to identify learning points to care provision and improve understanding of potential areas of suboptimal care.
	Structured Judgement Review (SJR)	To determine whether there were any problems with the care provided to a patient by a service.
	Specialised Reviews	For example, falls, pressure ulcers, IPC reviews.
	Thematic Review	A themed review may be useful in understanding common links, themes, or issues within a cluster of investigations or incidents for example, pressure ulcers, deteriorating patient, post-partum haemorrhage, 3rd and 4th degree tears.
Monitoring	Audit	Regular review to improve the quality of care by evaluating delivered care against standards. Can be observational or include documentation review (or both).

Priorities for 'being open' conversations and Duty of Candour include:

- All patient safety incidents leading to moderate harm or above.
- All incidents for which an investigation is undertaken.

For lesser harm incidents we propose to manage these at a local level through the Datix system with ongoing thematic analysis via our existing Trust assurance processes which may lead to new or supplement existing improvement work. Further information on this and the Duty of Candour principles can be found in the ULHT Incident Management Policy.

United Lincolnshire Hospitals NHS Trust

Patient safety incident response policy

Effective date: October 2023

Estimated refresh date: April 2025

	NAME	TITLE	SIGNATURE	DATE
Author	**Helen Shelton**	**Assistant Director of Clinical Governance**		
Reviewer				
Authoriser				

Please note links to internal documents will not open, these are marked in *orange italics* but can be made available on request if required.

Contents

Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out United Lincolnshire Hospitals NHS Trust's (hereafter referred to as ULHT) approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

- compassionate engagement and involvement of those affected by patient safety incidents
- application of a range of system-based approaches to learning from patient safety incidents
- considered and proportionate responses to patient safety incidents and safety issues
- supportive oversight focused on strengthening response system functioning and improvement.

Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across all patient facing services and departments delivering NHS care at ULHT.

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a ‘person-focused’ approach where the actions or inactions of people, or ‘human error’, are stated as the cause of an incident.

There is no remit to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests and criminal investigations, exist for that purpose. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

Our patient safety culture

ULHT promotes a just culture approach (in line with the NHS Just Culture Guide) to any work planned or underway to improve safety culture. Research into organisational safety has repeatedly found that an open and transparent culture, where colleagues feel able to report incidents and raise concerns without fear of recrimination, is essential to improving safety.

The Trust encourages and supports incident reporting where any member of staff feels something has happened, or may happen, which has led to, or may lead to, harm to patients (or staff). Please refer to the *Incident Management Policy* for more information on how incidents are reported and managed in an open and transparent manner to focus on learning without blame.

Patient Safety Partners (PSPs)

The NHS Patient Safety Strategy; Safer culture, safer systems, safer patients (July 2019)

In July 2019 NHSI/E published 'The NHS Patient Safety Strategy; Safer culture, safer systems, safer patients. It had 3 strategic aims which are underpinned by the two foundations of safety systems and safety culture as follows: -

- Improving understanding of safety by drawing intelligence from multiple sources of patient safety information (Insight)
- Equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system (Involvement)
- Designing and supporting programmes that deliver effective and sustainable change in the most important areas (Improvement).

The involvement of patients in their care and in the development of safer services is a priority for the NHS. People now have a greater expectation that they will be involved in their care and in ensuring it is safe.

The Framework for involving Patients in Patient Safety (NHSE/I June 2021), sets out the key requirements for the implementation of the Patient Safety Partners (PSPs).

Supporting patients to be involved in their own safety and creating the PSP role are two important ways to make real, what Don Berwick called for when he said that patients and their carers should be present, powerful and involved at all levels of healthcare organisations from wards to the boards of trusts". (DOH 2015: *The NHS Constitution for England*).

PSPs are patients, carers, family members or other lay people (including NHS staff from another organisation working in a lay capacity) who are recruited to work in partnership with staff to influence and improve the governance and leadership of safety within an NHS organisation. As such, they perform a very different role from that of the traditional NHS volunteer who acts as, for example, a hospital guide or befriends and supports patients.

The introduction of the PSP role is clearly set out within a National Framework that describes role description, remuneration, and advisory notes on supporting the organisation to embrace the posts.

There is a recognition that this is an evolving post and the list is not exhaustive of potential opportunities for the PSP to influence: -

- Promoting openness and transparency.
- Supporting the organisation to consider how processes appear and feel to patients.
- Helping the organisation know what is important to patients.
- Helping the organisation identify risk by hearing what feels unsafe to patients.
- Supporting the prioritisation of risks that need to be addressed and subsequent improvement programmes.

- Support staff recruitment programmes.
- Promote and support equality and diversity programmes.
- Support and advice on safety governance- sitting on relevant committees to support compliance monitoring and how safety issues should be addressed.
- Supporting the organisation in developing an action plan following an investigation, particularly so that actions address the needs of patients.
- Helping the organisation produce patient information that patients understand and can access.
- Membership of safety and quality committees whose responsibilities include the review and analysis of safety data.
- Involvement in staff patient safety training.

ULHT has met the requirements of the National Patient Safety Strategy (July 2019) by introducing 3 PSPs in September 2022. The post holders were recruited through our Trust recruitment process with an agreed job description and management infrastructure to support their transition into the organisation. We agreed that the PSPs would enter the organisation at Level 1/3 (Framework for Involving Patients in Patient Safety 2021).

Addressing health inequalities

As a large provider of acute services, the Trust has a key role to play in tackling health inequalities in partnership with our local partner agencies and services. However, most of the fundamental factors driving inequalities in health are beyond the responsibility of the health care system, for example our education system; economic and community development in our most deprived neighbourhoods; employment levels; pay and conditions; and availability and quality of housing.

Through our implementation of PSIRF, we will seek to utilise data and learning from investigations to identify actual and potential health inequalities and make recommendations to our Trust Board and partner agencies on how to tackle these. The more holistic, integrated approach to patient safety under PSIRF will require the Trust to be more collaborative with the patient experience and inclusivity agenda and ensure investigations and learning do not overlook these important aspects of the wider health and societal agenda.

Our engagement with patients, families and carers following a patient safety investigation must also recognise diverse needs and ensure inclusivity for all. Any potential inclusivity or diversity issues must always be identified through the investigation process and engagement with patients and families, for example, during the duty of candour / being open process.

Engaging and involving patients, families and staff following a patient safety incident

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families and staff). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required.

Involving Patients & Families

The Trust recognises the importance of and is committed to involving patients and families following patient safety incidents, engaging them in the investigation process and to fulfil the duty of candour requirements. It is recognised from experience and research that patients and families often provide a unique, or different perspective to the circumstances around patient safety incidents, and / or may have different questions or needs to that of the organisation. This policy therefore reinforces existing guidance relating to the duty of candour and 'being open' and recognises the need to involve patients and families as soon as possible in all stages of any investigation, or improvement planning, unless they express a desire not to be involved. Further guidance in relation to involving patients and families following a patient safety incident is available from NHSE at: https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance/#heading-2

See also the trust guidance on duty of candour / being open: *Incident Management Policy*

Involving Staff, Colleagues and Partners

Similarly, involvement of staff and colleagues (including system partners) is of paramount importance when responding to a patient safety incident to ensure a holistic and inclusive approach from the outset. Again, this reinforces existing guidance such as our incident management policy, though it is recognised this approach must not be restricted to only those incidents that meet a threshold of harm or predefined categories. We will continue to promote, support and encourage our colleagues and partners to report any incident or near-misses, with a shift in focus to incidents, or groups of incidents, which provide the greatest opportunities for learning and improvement.

It is recognised that this new approach will represent a culture shift for the organisation which needs to provide support and guidance utilising the principles of good change management, so staff feel ‘part of’ rather than ‘done to’. We will therefore ensure regular communication and involvement through our communication framework and our wider organisational governance structures.

It is also recognised that staff and colleagues need to continually feel supported to speak out and openly report incidents and concerns without fear of recrimination or blame. We will continue to closely monitor incident reporting levels and continue promote an open and just culture to support this.

Patient safety incident response planning

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, organisations can explore patient safety incidents relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

As a Trust we welcome this approach so we can focus our resources on incidents, or groups of incidents that provide the greatest opportunities for learning and improving safety. It is also recognised that our planning needs to account for other sources of feedback and intelligence such as complaints, risks, legal claims, mortality reviews and other forms of direct feedback from staff and patients. PSIRF guidance specifies the following standards that our plans should reflect:

1. A thorough analysis of relevant organisational data

2. Collaborative stakeholder engagement

3. A clear rationale for the response to each identified patient safety incident type

They will also be:

1. Updated as required and in accordance with emerging intelligence and improvement efforts

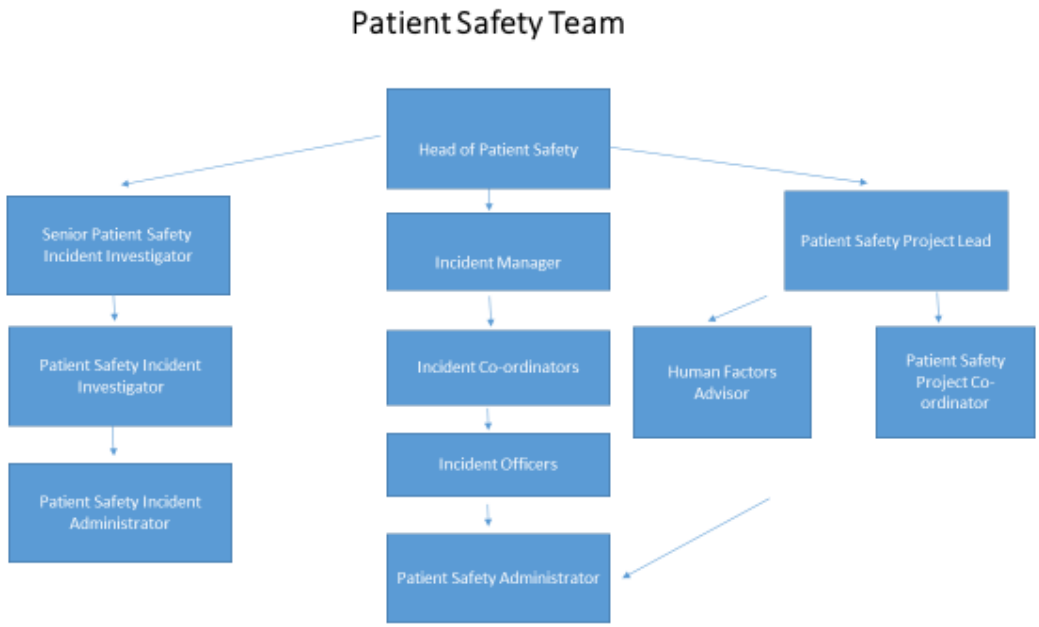
2. Published on our external facing website

Our associated Patient Safety Incident Response Plan (PSIRP) will reflect these standards and will be published alongside this overarching policy framework.

Resources and training to support patient safety incident response

PSIRF recognises that resources and capacity to investigate and learn effectively from patient safety incidents is finite. It is therefore essential that as an organisation we evaluate our capacity and resources to deliver our plan. The PSIRP provides more specific details in relation to this.

Currently the Patient Safety Team has the following working time equivalent posts to support and facilitate the PSIRF framework:



The above structure provides specific trained investigators to undertake the Patient Safety Incident Investigations (PSIIs) alongside an Incident Team who will be responsible for supporting the Divisions on all aspects of incident management that sits outside of the National and Local priorities. Again, our PSIRP will detail more specifically which incidents will require a comprehensive investigation with an indication of how many of these we expect to complete in a year.

All staff are required to complete mandatory Patient Safety Training level 1 which includes sections on:

- Listening to patients and arising concerns
- The systems approach to safety, where instead of focusing on the performance of individual members of staff, we try to improve the way we work
- Avoiding inappropriate blame when things don't go well
- Creating a just culture that prioritises safety and is open to learning about risk and safety.

It is therefore expected that Divisional managers, supported by the Incident Team, will involve all relevant staff in more routine / low risk incident reviews, though further advice and guidance can always be provided by the Patient Safety Team if required. It is important that the organisation seeks regular feedback from colleagues with regard to investigating and learning from incidents and considers whether any additional or bespoke training is required, either more widely or targeted at specific staff groups or individuals.

Our patient safety incident response plan

Our plan sets out how ULHT intends to respond to patient safety incidents over the following period of 01 October 2023 to 31 March 2025. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan.

The PSIRP is based on a thorough analysis of themes and trends from all incidents from April 2021 – March 2023 (including low harm, no harm and near misses), complaints and concerns, learning and recommendations from Serious Incidents (conducted under the previous framework), mortality reviews, legal claims and inquests, risks and risk registers and feedback from staff and patients. The priorities identified in the PSIRP will be regularly reviewed against quality governance reports and surveillance to ensure they are responsive to unforeseen or emerging risks.

Reviewing our patient safety incident response policy and plan

As referred to above, our patient safety incident response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12 to 18 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 to 18 months.

Updated plans will be published on our website, replacing the previous version.

A rigorous planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with our integrated care board (ICB)) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

Responding to patient safety incidents

PSIRF guidance states:

"Where an incident type is well understood – for example, because previous incidents of this type have been thoroughly investigated and national or local improvement plans targeted at the contributory factors are being implemented and monitored for effectiveness – resources may be better directed at improvement rather than repeat investigation (or other type of learning response)."

(PSIRF supporting guidance, Guide to responding proportionately to patient safety incidents. NHSE 2022)

Patient safety incident reporting arrangements

Patient safety incident reporting will remain in line with the Trusts Incident Management Policy. It is recognised that staff must continue to feel supported and able to report any incidents, or concerns in relation to patient safety, to promote a system of continuous improvement and a just and open culture.

In all instances, the first priority for the Trust is to ensure the needs of the individuals affected by an incident are attended to, including any urgent clinical care which may reduce the harmful impact.

Steps must be taken to ensure members of staff, visitors and patients are not put at further risk by the aftereffects of the incident. It is the responsibility of the person in charge or manager to ensure that the team takes the necessary steps needed to make the situation safe as quickly as possible and to consider the needs of the patients, visitors and staff in doing this.

Divisional managers and governance teams will ensure any incidents that require cross system or partnership engagement are identified and shared through existing channels and networks, and that system colleagues are fully engaged in investigations and learning as required. Likewise, we will ensure we are responsive to incidents reported by system colleagues that require input from the Trust, primarily by directing enquires to the relevant clinical teams or colleagues and seeking assurance that engagement, information sharing and learning has been achieved, or taken forward.

Certain incidents require external reporting to national bodies such as HSIB, HSE, RIDDOR and MHRA.

Patient safety incident response decision-making

As explained above, reporting of incidents should continue in line with existing Trust policy and guidance. The Trust also has governance and assurance systems to ensure oversight of incidents at both a Divisional and Trust level. Governance teams work with clinical and operational managers to ensure the following arrangements are in place:

- Identification and escalation of any incidents that have, or may have caused significant harm (moderate, severe or death)
- Identification of themes, trends or clusters of incidents within a specific service
- Identification of themes, trends or clusters of incidents relating to specific types of incidents
- Identification of any incidents relating to local risks and issues (e.g. – CQC concerns)
- Identification of any incidents requiring external reporting or scrutiny (e.g. – Never Events, Neonatal deaths, RIDDOR)
- Identification of any other incidents of concern, such as serious near-misses or significant failures in established safety procedures

The Patient Safety Team, with support from a Clinical Governance Analyst, also provide regular reports to the Patient Safety Group (PSG) and the Quality Governance Committee (QGC) using statistical process control (SPC) analysis on a monthly basis to identify and track emerging themes and trends outside of normal variation. This information will be reviewed regularly against our identified priorities in the PSIRP to determine whether any shift in focus is required, which will be agreed by the Quality Governance Committee if required.

As outlined in the Patient Safety Incident Response Plan (PSIRP) there are now a wider range of options for how to undertake a review as outlined in the PSIRF. The principles of proportionality and a focus on incidents that provide the greatest opportunity for learning will be central to this decision making under the Trust's PSIRP. This may often mean no further investigation is required, especially where the incident falls within one of the improvement themes identified in the PSIRP.

Attached as **Appendix 1** is a flowchart outlining the proposed incident management arrangements.

Timeframes for Learning Responses

Learning responses must balance the need for timeliness and capture of information as close to the event as possible, with thoroughness and a sufficient level of investigation to identify the key contributory factors and associated learning for improvement.

"The first step when embarking on a process to learn and improve after a patient safety incident is to make efforts to understand the context and develop a deep understanding of work processes. It can be tempting to rush to identify what needs to change, but this cannot be done without understanding work as done, and the system factors that influence this. A thorough understanding of the work system can be gained using a learning response method such as investigation, multidisciplinary team review or after action review, supplemented with a system-based framework to guide thinking (e.g.

SEIPS, Yorkshire Contributory Factors Framework, HFACS, etc)." (NHSE PSIRF Guidance: Safety Action Development, p17)

One of the most important factors in ensuring timeliness of a learning response is thorough, complete and accurate incident reporting when the circumstances are fresh in the minds of the incident reporter and the wider team. These principles are set out in the current incident reporting guidance but must be reinforced through the PSIRF.

Where a PSII is required (as defined in this plan for both local and national priorities), the investigation will start as soon as possible after the patient safety event is identified. PSII's will normally be completed within one to three months of their start date however, in exceptional circumstances, a longer timeframe may be required for completion of a PSII. In this case, any extended timeframe will be agreed between ULHT and the patient/family/carer.

No PSII should take longer than six months. A balance will be drawn between conducting a thorough PSII, the impact that extended timescales can have on those involved in the incident, and the risk that delayed findings may adversely affect safety or require further checks to ensure they remain relevant. Where the processes of external bodies delay access to information for longer than six months, a completed PSII can be reviewed to determine whether new information indicates the need for further investigation.

The PSIRP provides more detail on the types of learning response most appropriate to the circumstances of the incident. Highly prescriptive timeframes for learning responses may not be helpful so the following are included as a guideline only:

- Initial incident investigation – as soon as possible, within 5 working days of reporting
- Further learning response (e.g.: PSII, AIR, Swarm huddle) – within 20 working days of reporting

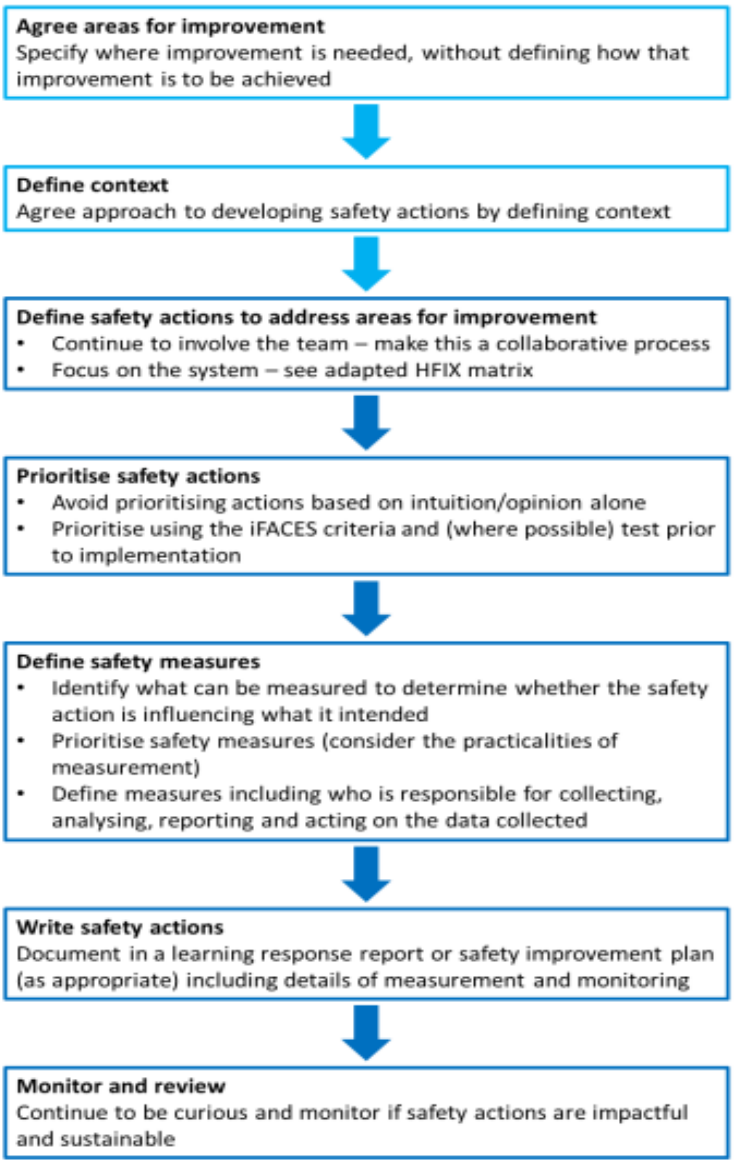
A toolkit of learning response types is available from NHSE at: https://www.england.nhs.uk/publication/patient-safety-learning-response-toolkit/

Safety action development and monitoring improvement

PSIRF moves away from the identification of 'recommendations' which may lead to an attempt to provide a solution at an early stage of the safety action development process.

"Learning response methods enable the collection of information to acquire knowledge. This is important, but it is only the beginning. A thorough human factors analysis of a patient safety incident does not always translate into better safety actions to reduce risk. You must move from identifying the learning to implementation of the lessons. Without an integrated process for designing, implementing, and monitoring safety actions, attempts to reduce risk and potential for harm will be limited."

The following diagram summarises how safety actions should be developed and overseen:



A Quality Improvement approach is valuable in this aspect of learning and improvement following a patient safety investigation. It will therefore be necessary to ensure close links are developed and maintained with the Improvement Team so their expertise and guidance can be utilised when developing the learning response and safety actions. This approach is recognised within the Trust and considerable work has taken place to educate colleagues in the principles of QI methodology. PSIRF therefore provides an opportunity to strengthen this and for the QI and Patient Safety functions to work more closely together.

Safety actions arising from a learning response should follow the SMART (Specific, Measurable, Achievable, Realistic, Time-bound) principles and thought must be given to monitoring and measures of success. Further guidance on this can be found in NHSE Guidance at

https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-Safety-action-development-v1.1.pdf

Monitoring of completion and efficacy of safety actions will be through organisational governance processes with oversight at Patient Safety Group reporting to the Quality Governance Committee. The Patient Safety Team will maintain an overview across the organisation to identify themes, trends and triangulation with other sources of information that may reflect improvements and reduction of risk.

It is important that monitoring of completion of safety actions does not become an end in and of itself, but rather a means to improve safety and quality outcomes and reduce risk. The Trust must therefore develop governance systems focused more on measuring and monitoring these outcomes, utilising subjective as well as objective measures.

Safety improvement plans

As referred to throughout the policy, the Trust has developed a PSIRP that clarifies what our improvement priorities are. The PSIRP details how we will ensure patient safety incidents are investigated in a more holistic and inclusive way, to identify learning and safety actions which will reduce risk and improve safety and quality.

These themes, as detailed in the PSIRP, are based on an extensive analysis of historic data and information from a range of sources (e.g.: incident trends, complaints, mortality reviews, risk registers, legal claims and inquests) and feedback from staff and patients. Each theme will have its own improvement plan utilising QI methodology, where appropriate, to determine what the key drivers are to patient safety risks, how improvements can be made and how these can be monitored for completion and effectiveness. Whilst the PSIRP identifies the broad organisational priorities, it is recognised there may be more specific priorities and improvements identified which although will not form part of the overarching plan, can still be approached utilising the more holistic and inclusive PSIRF approach. The Patient Safety Team will provide support and guidance, as required, to services in this regard. The QI team can also assist in these improvements and identify where there is overlap with existing and developing QI programmes across the Trust.

The Trust is reviewing governance processes in line with the PSIRF guidance so it is clear how the PSIRP improvement priorities will be overseen through the Patient Safety Group and Quality Governance Committee structures and processes.

Oversight roles and responsibilities

"When working under PSIRF, NHS providers, integrated care boards (ICBs) and regulators should design their systems for oversight "in a way that allows organisations to demonstrate [improvement], rather than compliance with prescriptive, centrally mandated measures". To achieve this, organisations must look carefully not only at what they need to improve but also what they need to stop doing (e.g., panels to declare or review Serious Incident investigations).

Oversight of patient safety incident response has traditionally included activity to hold provider organisations to account for the quality of their patient safety incident investigation reports. Oversight under PSIRF focuses on engagement and empowerment rather than the more traditional command and control."

NHSE, PSIRF Guidance 'Oversight roles and responsibilities specification and Patient safety incident response standards' (p2)

Responsibility for oversight of the PSIRF for provider organisations sits with the Trust Board. The Executive Lead is the Director of Nursing who holds responsibility for effective monitoring and oversight of PSIRF. The 'Responding to patient safety incidents' section above also describes some of the more operational principles that underpin this approach.

The Trust recognises and is committed to close working, in partnership, with the local ICB and other national commissioning bodies as required. Representatives from the ICB will sit on PSIRF implementation groups. Oversight and assurance arrangements will be developed through joint planning and arrangements must incorporate the key principles detailed in the guidance above, namely:

1. Compassionate engagement and involvement of those affected by patient safety incidents
2. Policy, planning and governance
3. Competence and capacity
4. Proportionate responses
5. Safety actions and improvement

As referred to above, it is important that under PSIRF there is a paradigm shift from monitoring of process, timescales and outputs to meaningful measures of improvement, quality and safety, and outcomes for patients. It should be noted that similarly the ICB's role will focus on oversight of PSIRF plans / priorities and monitoring progress with improvements. There will no longer be a requirement to 'declare' an SI and have individual patient safety responses 'signed off' by commissioners. However, they will wish to seek assurances that improvements and priorities under PSIRF are progressing and delivering improvements in quality and safety. The metrics, measures (objective and subjective) and evidence required to do this will need to be defined within the PSIRP for each priority which will be agreed in discussion with the ICB. Attached as **Appendix 2** are the proposed governance arrangements.

Complaints and appeals

We value the comments and compliments about the services we provide. Learning from our patients, carers and relatives experience will actively contribute to the continued development of our services.

We recognise that for our patients, carers and relatives, participation in a safety incident investigation could be a distressing time as well as being an empowering experience. Within the dynamic, it is possible the patient may raise issues regarding the process.

In the event a patient, carer or relative has concerns regarding any aspect of the investigation process, including any matters relating to the Patient Safety Incident Investigator, we will:

- If appropriate, seek to resolve the matter locally through a discussion between the patient and/or relative with the Patient safety Incident investigator and the nominated Family Liaison Officer (FLO)
- Escalate the concern to the Head of Patient Safety and the Assistant Director of Clinical Governance
- Refer the matter as a formal complaint via the Trust's Complaints Team.

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:	12 September 2023
Chairperson:	Professor Philip Baker, Chair
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the People and OD Assurance Committee. The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board. This assurance committee meets monthly and takes scheduled reports according to an established work programme. The Committee worked to the 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 inc process and timeframe for mandatory training review** The Committee received the upward report noting that the group had considered the performance dashboard in detail and looked specifically at sickness absence data. The Group had agreed this would be an area of focus given the current position. The Committee noted the work in place with the Occupational Health team to provide proactive support to staff and reflected on the soft intelligence available which indicated an impact on staff sickness as a result of industrial action. The Group had considered the winter vaccination programme in detail which launched on 11 September with the Committee noting that had taken place 2 weeks ahead of the regional date. Review of statutory and mandatory training continued with the Committee requesting a further update in respect of the progress being made to ensure that training was appropriately assigned to staff. **Committee Performance Dashboard** The Committee received the dashboard noting the information presented which had been considered in detail by the Workforce Strategy and Organisational Development Group and considered through the upward report of the group. The Committee was pleased to note the continued decrease in the turnover rate which remained below target.

Safer Staffing inc nursing additional hours
The Committee received the report noting the moderate assurance which was offered.

Medical Engagement Development Plan
The Committee received a verbal update noting that this item stemmed from the medical engagement survey with a number of areas pertaining to this, for which the Committee was alert to.

The Committee noted that work was widening in respect of medical engagement with a Clinical Managers Networking Day being held to commence this.

The Committee would receive a further update to the November meeting.

Trauma and Orthopaedic Deep Dive Action Plan
The Committee received a further update having previously been sighted on the deep dive report. It was noted that there were many themes which crossed over with the deep dive and cultural work being undertaken within the division, particularly around the management approach and key skills.

The Committee noted that the speciality had received the outcome of the report well however the action plan had not been signed off and therefore had not been offered to the Committee.

A further, more detailed update, would be offered to the Committee in October along with the action plan to ensure clear sight on the actions being taken to address areas requiring improvement.

Education Funding Update
An update paper was offered to the Committee detailing the current management of education funding which was across various departments and directors.

The new corporate education and learning team were working through the funding to understand how this was being spent and ensuring that the Training Needs Analysis (TNA) was informing the spend. Work was underway to ensure greater central oversight however there was confidence in the management of budgets with the Committee endorsing the intention of having a single leadership arrangement in place for this.

It was noted that there was circa £2.8m of education funding, circa £2m for the apprenticeship levy and £833k of Continuing Professional Development (CPD) funding. There was no Workforce Development Funding (WDF) available to the Trust in the current year however some funding was available across the Integrated Care System for which the Trust could place a bid.

	The Committee noted that the TNA process would commence in November and a Learning and Development Policy had been developed and was currently being taken through the relevant approval processes. **Education and OD Highlight Report** The Committee received the reporting noting the work of the education learning and OD team in the new Directorate structure. Current focus was being given by the team to corporate induction and statutory and mandatory training with the alignment of a core training framework. The Committee noted the creation of the mandatory training governance group which would review the training modules ensuring that there were reviewed against a set criteria. Work of the group would progress to ensure training was mapped for staff on an individualised basis, role specific rather than wider staff groups. There would be focus on raising compliance across the Trust with work taking place to provide support to those staff whose compliance was below 50%. The Committee was pleased to note that the review of the corporate induction would enable dedicated director time at the session along with time assigned for the completion of core learning. This would ensure staff completed learning at the earliest opportunity. The Committee also noted the wider work being undertaken in respect of culture and leadership and the various initiatives in place to support staff to 'do the basics brilliantly'.
	Lack of Assurance in respect of SO 2b **Issue: Making ULHT the best place to work** **National Staff Survey Action Plan 23/24 and Cultural Deep Dive Action Plan** The Committee received the action plan which included the 5 consistent themes from both the National Staff Survey results and the recent cultural deep dives which had been undertaken across a number of areas. The Committee noted that there were both Trust level plans in place as well as local action plans to address areas more specifically. Staff engagement would be key to addressing the themes and would be considered by the Executive Leadership Team. The importance of ensuring communication to staff was noted with the intention to offer a 'you said, we are doing' approach so that there was awareness of the actions in place and the progress being made.

	Further work would be undertaken to correlate other areas of staff feedback, from various forums, into the action plan to have a targeted approach in place to achieve the best outcome.
	Lack of Assurance in respect of SO 4b **Issue: To become a University Hospitals Teaching Trust** **Medical Education/Medical School Update** The Committee received the reports noting the content. **University Teaching Hospital Group Upward Report** The Committee noted the recent discussions held by the Executive Leadership Team to consider a number of possible names for the Trust when moving forward for Teaching status. It was noted that these discussions would now need to be held with LCHS to ensure clarity on the direction of travel due to the Group Model developments. Discussions continued with the University of Lincoln in respect of the financial model with the anticipation that these would be completed by the end of the year. **Research and Innovation Update** The Committee received the report noting the clarity of the information presented and reflected on the position reported in respect of the number of research participants. Whilst the Trust was off target, to achieve 2000 – 2500 by the end of the financial year there remained optimism that this would be achieved due to high recruiting trials coming online. The Committee noted the position of the Trust, as presented against comparable organisations which demonstrated the level of improvement required. Support was offered by the Committee to the Director of Research and Innovation to try to encourage the engagement of staff across all divisions to recognise the importance of research and innovation.
	Assurance in respect of other areas: **Board Assurance Framework** The Committee received the Board Assurance Framework and reflected on the significant updates that had been made following the in-depth review of the content from the previous months' discussions.

	The Committee noted that, due to a number of apologies from core Committee members, a further review of the content, and consideration of assurance ratings would be undertaken at the October meeting. **Topical, Legal and Regulatory Update** The Committee received the report noting the updates offered and reflected on the benefit of the report providing foresight of items which may wish to be considered by the Committee. **Integrated Improvement Plan** The Committee received the report noting the content and reflecting those discussions during the course of the Committee reflected the position presented within the report. **CQC Action Plan** The Committee received the report noting that discussions had taken place through the course of the meeting which addressed a number of the actions within the plan. It was recognised that further work was required in respect of paediatric competencies linked to training and pharmacy actions. Work would be undertaken to determine how these specific actions would be reported to the Committee as they were not covered in items already being received. **Savile Action Plan** The Committee were advised that the business case to support the funding for the DBS process had been received by CRIG and approval given for the cost of DBS checks. The year 2 and 3 costs would be picked up through business planning. The Committee noted that once the team was fully resourced it would be possible for timescales and milestones to be identified for the work being undertaken. The Committee would vigorously monitor the progress being made against the plan.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	None
Committee Review of corporate risk register	The Committee received the risk register noting the current risks presented.
Matters identified which Committee	No areas identified

recommend are escalated to SRR/BAF	
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	**O**	**N**	**D**	**J**	**F**	**M**	**A**	**M**	**J**	**J**	**A**	**S**
Philip Baker (Chair)	X	X	X	X	X	X	No meeting held	X	X	X	X	X
Karen Dunderdale	X	D	A	D	A	D		D	D	D	D	A
Paul Matthew	X											
Claire Low		X	X	X	X	X		X	X	X	X	X
Colin Farquharson	D	D	D	D	D	D		D	D	D	D	X
Chris Gibson	X	X	X	X	X	X		X	X	A	X	A
Vicki Wells	A	X	X	X	A	X		X	X	X	X	A

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:	10 October 2023 – Cancelled due to non-quoracy
Chairperson:	Professor Philip Baker, Chair
Author:	Claire Low, Director People and Organisational Development

Purpose	This report summarises the matters due to be considered by the People and OD Assurance Committee at the cancelled 10 October 2023 meeting. The report details the strategic risks and any matters for escalation for the Board. This assurance committee meets monthly and takes scheduled reports according to an established work programme. The Committee works to the 2022/23 objectives following approval of the BAF by the Board.
Assurances received by the Committee	**Strategic Objective 2a - A modern and progressive workforce** **Workforce Strategy and Organisational Development Group (WSODG) Upward Report** The Group did not meet in October due to quoracy issues because of industrial action taking place on the planned meeting date. A report was submitted to the Committee providing an overview of papers and progress against performance. There were no items of escalation and no concerns re: attendance at the next planned meeting in November. The Group continues to work well. **Committee Performance Dashboard** There were no items of escalation in regards the performance dashboard from the WSODG to the Committee. The main areas of focus for the WSODG and the Committee are Sickness rate, Statutory and Mandatory Training compliance rate, and Appraisal compliance rate. Improvements have been seen in the Statutory and Mandatory Training compliance rate and the Appraisal compliance rate. **Safer Staffing** There were no items of escalation in regards Safer Staffing from the WSODG to the Committee. Safer Staffing will be reviewed at the Committee meeting in November. **Trauma and Orthopaedic Deep Dive Update** This paper has been deferred for review at the November Committee meeting. **Pharmacy People Update** This paper provided an update to the Pharmacy Improvement Plan in relation to the 'people' elements. This information is also reported to the Quality Governance Committee and was shared with the People and OD

	Committee to provide assurance that the matters reported regularly within the Risk and CQC papers received at People and OD Committee are being managed with appropriate reporting and governance. **Long and Medium Term Workforce Plan Update** This paper provided an update to the Committee on the current position and work being undertaken to deliver the long and medium term workforce plan. A further paper with progress against this years workforce plan is due to be received by the Committee in November.
	Strategic Objective 2b - Making ULHT the best place to work **Culture and Leadership Group Upward Report** The meeting of the Culture and Leadership Task Force took place on the 20 September 2023. The Group considered their Terms of Reference, planning for the Leading Together Forum meeting due to be held in-person on the 25 September 2023, an update on the progress of the Just Culture Programme, and an update on the Culture and Leadership Programme and Cultural Ambassadors. There were no items of escalation. **GMC Junior Doctor Survey Update** The national training survey is the largest annual survey of doctors in the UK. Every year the GMC ask trainees about the quality of their training and the environments, where they work, and trainers about their experience as a clinical and/or educational supervisor. The paper provides a comprehensive set of results that highlights challenges in areas such as burnout and frustration with their work. Actions to address the identified issues were highlighted to be taken forward in response to the survey. The Committee are due to receive an update on medical engagement at the November meeting. **Equality, Diversity and Inclusion Group Upward Report** The meeting of the Equality, Diversity and Inclusion Group took place on the 4 September 2023. The Group considered the Workforce Race Equality Standard and Workforce Disability Equality Standard 2023 now approved by Trust Board (September Board) and published ahead of the 31st October deadline. Alongside topics such as mutual mentoring, Equality Delivery System (EDS), United Against Discrimination Action Plan, Board EDI Objectives and patient gender identity work. There were no items of escalation.
	Strategic Objective 4b - Becoming a University Hospitals Teaching Trust **Research and Innovation Update** **University Teaching Hospital Group Upward Report**

	A paper was provided for the Committee to note progress on 'Teaching' Hospital application status and further work to develop and agree the mode for clinical academic roles. Progress will be further reviewed at the Committee meeting in November. **Research, Development and Innovation Update** An update was provided, and the Committee were asked to note the risk presented by the current Finance capacity and capability and to note the risk of a 10% cut in CRN funding mid next financial year (new contract with the RRDN expected October 2024, expectations unclear at this stage). Progress will be further reviewed at the Committee meeting in November.
	Assurance in respect of other areas: **Integrated Improvement Plan** The Committee monitor progress against the plan on a monthly basis and will review at the November Committee meeting. **Risk Report including Risk Register** The Committee will review the Risk Report and Risk Register at the November Committee meeting. **Audit Recommendations** There were no audit recommendations. **Review of relevant external reports:** **CQC Action Plan** The Committee monitor progress against the action plan on a monthly basis and will review at the November Committee meeting. **Compliance against CQC should do - sufficient numbers of medical staff** This paper has been deferred for review at the November Committee meeting. **Savile Action Plan** The Committee monitor progress against the action plan on a monthly basis and will review at the November Committee meeting.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	None

Committee Review of corporate risk register	Not applicable
Matters identified which Committee recommend are escalated to SRR/BAF	No areas identified
Committee position on assurance of strategic risk areas that align to committee	The Committee position remains as at September 2023. A review of the papers due to be considered at the cancelled October 2023 Committee Meeting continues to provide assurances against the strategic risks to strategic objectives.
Areas identified to visit in ward walk rounds	No areas identified

Report to:	Trust Board
Title of report:	Finance, Performance and Estates Committee Assurance Report to Board
Date of meeting:	21 September 2023
Chairperson:	Dani Cecchini, Chair
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received, and key decisions made by the Finance, Performance and Estates Committee (FPEC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme. The Committee worked to the 2023/24 objectives.
Assurances received by the Committee	**Assurance** in respect of SO 3a A modern, clean and fit for purpose environment **Estates Group Upward Report** The Committee noted that an estates group report had been scheduled on the work programme however, recognising the significant update offered to the Committee in August, the report would be offered in line with the work programme at the appropriate time. **Emergency Department Steering Group Upward Report** The Committee received the report noting that this would provide updates on the progress of the emergency department build at Pilgrim ensuring appropriate governance was in place. The project was currently on track with no concerns escalated to the Committee, it was recognised that this was a multi-year programme with the current year spend identified and due to be delivered.
	Assurance in respect of SO 3b Efficient Use of Resources **Finance Report inc Efficiency, Capital, Contracts, CIRG Upward Report and Better Payment Practice Code (BPPC)** The Committee received the suite of finance reports noting the limited assurance that was offered in respect of the finance report due to the need for further assurances to be received for financial performance in the second half of the year. At month 5 the Trust reported a positive variance to plan with an anticipation that month 6 would also be on plan. Over performance was noted in respect of the Financial Recovery Plan by £4.4m due to the reduction of agency use in estates and bed closures which had contributed.

	Risks were noted in the delivery of activity to 116% however improvements were noted in performance at month 5. Activity under the Further Faster initiative was being considered through theatres with assurance that Grantham would move to full capacity following the conclusion of the latest round of industrial action. Capital was reported as behind plan however there was confidence, based on prior years, of delivery by year end with moderate assurance received by the Committee. The exit criteria for the National Oversight Framework (NOF) level 4 was noted which would include the need to demonstrate progress on the managed bank service. Current reporting suggested that the System would have an adverse variance to the agreed deficit plan at year end. The Committee received moderate assurance in respect of the efficiency report with good progress and delivery noted to date with the divisions being asked to ensure full delivery of their relevant elements of the plan. The Committee was pleased to note the ongoing improvement to the BPPC position of the Trust however recognised the communications received from NHS England which required further action to be taken to achieve the required 95% compliance. The Capital, Revenue and Investment Group (CRIG) upward report was received with the Committee noting the Inventory Management System, for which the Trust had been selected as one of 20 Trusts, to receive funding to support implementation. **2022/23 Cost Collection** The Committee received the update noting the moderate assurance and delegated authority from the Trust Board to sign off the submission against the relevant timelines. The process was noted and approved by the Committee with the summary of the submission due to be offered to the Committee in October for formal sign off.
	Assurance in respect of SO 3c Enhanced data and digital capability **Information Governance Group Upward Report** The Committee received the report noting the content.
	Assurance in respect of SO 3d Improving Cancer Services Performance **Operational Performance against National Standards** The Committee received the report noting that, due to the performance in urgent care, planned care and diagnostics, the moderate assurance rating would be downgraded to limited.

	The Trust continued to see an increase in ambulance handover delays with access issues also being seen to urgent treatment centres, community care provision and mental health service availability. A consistent increase in type 1 activity was being seen along with a consistent increase in attendances since Covid-19 with services working in the same footprint and workforce. As a result, the current workforce was being reviewed to ensure the staffing levels were appropriate. As part of the urgent care recovery programme an internal right sizing activity was being undertaken including the extension of Same Day Emergency Care (SDEC) hours along with further investment in place to support improvements. The Committee noted that the provision of HomeLink services in the community was insufficient due to the patient demographic and requirement for reablement support as patients came to the end of their acute care episode. It was anticipated that, as the winter plan was finalised, requirements would be clarified, and provision would be in place both in respect of HomeLink and active recovery beds. The Committee noted the planned care position recognising the outturn position of 78-week waits at 148 patients waiting at the end of August, a further trajectory was offered to NHS England. There was a high level of confidence of delivering the 65-week position which was being worked on alongside 78-weeks. Productive theatres work continued to be delivered with weekly improvements being seen in productivity at Grantham. A decrease in diagnostic performance was noted with a deep dive due to be undertaken and slippage in DM01 of 3%. There had been an issue identified in respect of the Faster Diagnostic Standard (FDS) in gynaecology which was being resolved with daily meetings in place in respect of tumour site activity. The Committee noted the achievement of the 104- week wait position across the Trust and noted the 62-week backlog which was reported as better than trajectory.
	Assurance in respect of SO 3e Reduce waits for patients who require planned care and diagnostics to constitutional standards **As reported at SO 3d** **Elective Care Priorities Check List** The Committee received the Elective Care Priorities Check list and received a further verbal update during the meeting of the work undertaken to determine the Trust position ahead of the submission.

	The Committee raised concerns over the assurance being received and noted that the report, as verbally offered, demonstrated the vehicle to provide assurance, rather than the level of assurance being received. It was recognised that the report was demonstrating where and what route assurances would be offered through to ensure that, where the Trust was not delivering activity, plans were in place which could provide assurance. The submission, due to be made, would respond to the national questions asked and following submission it was expected that this would be further refined with the Trust required to provide further responses. The Committee, on the balance of the verbal update provided, recommended the submission be approved by the Chair and Chief Executive for submission, noting that some areas required confirmation of reporting. The Committee would oversee the checklist and how assurance would be offered. **Improvement Programme Deep Dive – Outpatients** The Committee received the report accepting the limited assurance which was offered and noted concern on the assurance being received on the plans in place. The Committee reflected on the work being undertaken, noting the activities were felt to be the right ones, however there was difficulty in moving forward from transactional to transformational change. A deep dive on 4 specialities would be undertaken to determine further actions required. **Community Diagnostic Centre Update** The Committee received the update paper noting that the Trust was the chosen provider for the Community Diagnostic Centres (CDCs) across the county. The Committee noted that the governance around the CDCs recognising that there was a requirement nationally for a CDC Programme Board to be in place. The Trust was currently working through the potential impact of the CDCs on acute services and the capacity that could be released along with the activity which could be delivered from the sites. Whilst there were recognised risks in relation to staffing discussions were taking place in respect of recruitment and retention with the Committee noting that the new builds could attract staff.
	Assurance in respect of SO 3f Urgent Care

	As reported at SO 3d
	Assurance in respect of SO 4a Establish new evidence based models of care No reports
	Assurance in respect of SO 4c Successful delivery of the Acute Services Review No reports
	Assurance in respect of other areas: **Topical, Legal and Regulatory Update** The Committee noted the update offered and considered the areas raised noting the need for a review of Reinforced Autoclaved Aerated Concrete (RAAC). Whilst it was confirmed that a previous inspection at the Trust has not identified any RAAC, a further survey would be commissioned to provide assurance. **Committee Performance Dashboard** The Committee received the performance report noting that the detail of the report was considered through other agenda items presented. **Integrated Improvement Plan** The Committee received the report noting the mixed level of assurances offered across the objectives. The Committee noted the actions in place and relevant mitigations as a result of current progress noting the need to ensure that, where necessary, alternative mitigations be considered. It was recognised that, as the planning round for the next year commenced, there was a need to consider what had been effective in the current year. **Improvement Steering Group Upward Report** The Committee received the upward report noting a number of items which were reported as red however reflected that these linked to the IIP, Urgent Care and outpatient work which had already been considered by the Committee. **Internal Audit Recommendations** The Committee noted that updates were being made by the internal auditors to recommendations with a full report to be offered to a future meeting. **CQC Action Plan** The Committee received the report and update provided by the Deputy Director of Clinical Governance noting that a number of actions had oversight, from an assurance perspective, by the Committee. The Committee recognised there remained a number of sub-actions which were impacting on the overall actions being progressed and

	requested alignment of these actions to the reporting groups. This would enable the Committee to receive updates and assurance on relevant actions.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	None
Committee Review of corporate risk register	The Committee received the risk register noting the risk as presented.
Matters identified which Committee recommend are escalated to SRR/BAF	No items identified
Committee position on assurance of strategic risk areas that align to committee	The Committee considered the reports which it had received which provided assurances against the strategic risks to strategic objectives.
Areas identified to visit in dept walk rounds	None

Attendance Summary for rolling 12-month period

Voting Members	O	N	D	J	F	M	A	M	J	J	A	S
Dani Cecchini, Non-Exec Director	X	X	X	X	X	X	X	D	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	X	X	X	X	D	X	X	D	X
Director of Improvement & Integration	X	X	D	X	X	X	X	X	X	X	X	X
Sarah Buik, Associate Non-Executive Director	X	X	X	X	A	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:	19 October 2023
Chairperson:	Dani Cecchini, Chair
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received, and key decisions made by the Finance, Performance and Estates Committee (FPEC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme. The Committee worked to the 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 inc gap analysis of BCPs** Meeting cancelled due to industrial action. **Emergency Department Steering Group Upward Report** The Committee received the report noting the position and recognised the ongoing work of the Trust to align actions to the NHS England indicators. **Health and Safety Gap Analysis** Item deferred due to audit continuing to be completed.
	Assurance in respect of SO 3b Efficient Use of Resources **Finance Report inc Efficiency, Capital, Contracts and CIRG Upward Report** The Committee received the report noting the limited assurance offered due to the uncertain assurances in the second half of the year. The year-to-date position at month 6 was reported in line with plan. The Committee was pleased to note the improved Better Payment Practice Code position and the support in place within Pharmacy to further improve the position. The Trust was reporting £5.3m favourable to plan in respect of CIP and it was noted that capital spend was behind plan however assurance was received that this was being managed with a plan to achieve a full spend of £48.3m in year. The Committee noted the moderate assurance offered in respect of the capital report and was pleased to note that the contract from the

	Pilgrim ED build had been signed. Adequate resourcing to deliver the capital funding would be required. The Committee noted the moderate assurance in respect of contracting and the continued progress on the 23/24 contract with collaboration continuing with the ICB in to the 24/25 year. The Committee received the CRIG upward reporting noting the Capital Delivery Group upward reports which offered further assurance to the Committee. The business case process was also received by the Committee for information with the Committee noting the requirement for a senior SOR to be in place for anything over a value of £500k. **Patient Levels Information Costing System (PLICS) and 2022/23 Cost Collection** The Committee received the PLCIS reporting noting the moderate assurance and potential for c£22m of productivity and efficiency gains in support of future Cost Improvement Programme (CIP). The Committee noted the changes in timescales for the submission of the National Cost Collection 22/23 and agreed delegated authority to the Director of Finance to approve and make the submission. The Committee would receive the submission for information at the December Committee. **Productivity Plans** The Committee received the report with limited assurance noting the actions in place in order to improve productivity noting the focus on 4 specialties to ensure delivery. An update was offered in respect of the 78-week waits and the Trust performance with the Committee noting that whilst a 0 position had not been achieved it was anticipated that, by the end of October the position would be in double figures. Work continued to progress 65 and 52- week waits with an agreed trajectory in place with NHS England. The Committee recognised that the outpatient improvement programme offered the biggest opportunity in respect of productivity however reflected that there were a number of risks to delivery. Action was being taken to closely manage the improvement works and ensuring the right slots, in the right place with the right person was achieved. Improvement had been seen in Grantham Theatre productivity in both the list and list utilisation using the 6-4-2 approach. The improvements had been commended by Professor Briggs following a visit on the 10 October.

	The Committee, whilst recognising there had been some improvement, reflected on the need to ensure clarity on the actions and trajectories in place to enable assurance to be offered to the Board.
	Assurance in respect of SO 3c Enhanced data and digital capability **Digital Plan Update** The Committee received the report noting the current position in respect of digital programmes of work and reflected the need to ensure appropriate governance processes were followed for approvals. The Committee was pleased to note the achievement of the Electronic Patient Record (EPR) outline business case being approved by the Cabinet Office with work commencing on the tendering process. Capacity in the team was noted with a need to ensure this was sufficient in order to deliver the programmes of work.
	Assurance in respect of SO 3d Improving Cancer Services Performance **Operational Performance against National Standards** The Committee received and took the report for information noting that discussions had taken place during the Productivity Plan item. The Committee noted that Trust performance against urgent and emergency care (system) and waiting times and cancer standards (Trust) meant that the system and the Trust had been placed in escalation by NHSE at tier 2 and tier 1 respectively. The issues previously reported in respect of faster diagnosis standards for breast and gynaecology were noted as having improved with achievement above the 70% target. There was a higher level of confidence in the 62-day classic standard in respect of sustainability and resilience in the tier 1 position for planned care. The DM01 position was also reported with a positive improvement however there remained significant work to achieve further. The Committee noted that bids for funding had been submitted in respect of cancer services to support recovery of the position. The Committee noted the limited assurance.
	Assurance in respect of SO 3e Reduce waits for patients who require planned care and diagnostics to constitutional standards **As reported at SO 3d**
	Assurance in respect of SO 3f Urgent Care **As reported at SO 3d**

	Assurance in respect of SO 4a Establish new evidence based models of care **Specialty Reviews Update** The Committee deferred the Specialty Review update to ensure sufficient time was afforded to the paper.
	Assurance in respect of SO 4c Successful delivery of the Acute Services Review **Implement Stoke** The Committee received the report noting the moderate assurance and the consolidation of the service to a single site and the development of a business case in order to extend the current estates and support additional beds. The Committee recognised that the service would remain fragile until the optimum model was in place however this was developing. **Grantham ASR Implementation** The Committee received the report noting the position of the Grantham ASR implementation and recommended to the Board for approval. Work continued to ensure that communications were received by both staff and the local population to enable the implementation to be successful.
	Assurance in respect of other areas: **Committee Performance Dashboard** The Committee received the performance report noting that the detail of the report was considered through other agenda items presented. **Integrated Improvement Plan** The Committee received and took the report as read noting the updates provided. **Improvement Steering Group Upward Report** The Committee received the report noting the position reported and reflected on the continued need to ensure appropriate capacity was in place to progress improvement programmes. **Internal Audit Recommendations** The Committee received the report noting the updates which had been made and reflected on the actions which remained. **CQC Action Plan** The Committee received the report noting the red actions and the work to ensure that actions were aligned to the reporting groups of the Committee so that assurance on progress could be received.

Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	None
Committee Review of corporate risk register	The Committee received the risk register noting the risk as presented.
Matters identified which Committee recommend are escalated to SRR/BAF	No items identified
Committee position on assurance of strategic risk areas that align to committee	The Committee considered the reports which it had received which provided assurances against the strategic risks to strategic objectives.
Areas identified to visit in dept walk rounds	None

Attendance Summary for rolling 12-month period

Voting Members	N	D	J	F	M	A	M	J	J	A	S	O
Dani Cecchini, Non-Exec Director	X	X	X	X	X	X	D	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	X	X	X	D	X	X	D	X	X
Director of Improvement & Integration	X	D	X	X	X	X	X	X	X	X	X	X
Sarah Buik, Associate Non-Executive Director	X	X	X	A	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	*7th November 2023*
Item Number	*Item 12*

Integrated Performance Report for September 2023

Accountable Director	*Jonathan Young, Director of Finance*
Presented by	*Jonathan Young, Director of Finance*
Author(s)	*Sharon Parker, Performance Manager*
Report previously considered at	*N/A*

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

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

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

Executive Summary

Quality

MRSA Bacteraemia

There has been one reported case in September which is the first reported case since September 2022. The case is currently under review to establish contributory factors and potential learning.

Falls

There have been 2 falls resulting in severe harm reported in September 2023. A series of falls prevention focus groups are being facilitated by the Quality Matron and Improvement teams during October.

Pressure Ulcers

There have been 42 category 2 pressure ulcers reported in September 2023, an increase of 6 since the last reporting period. 4 of the category 2 incidents were device related. The Quality Matron and Tissue Viability teams are leading a Quality Improvement project with representation from clinical areas to raise awareness and identify barriers for prevention and management of moisture related damage.

VTE

The Trust achieved 94.75% compliance with VTE assessment, which is slightly lower than the required target of 95%. A VTE Nurse Specialist will be appointed, however, there are ongoing discussions around the funding for this post.

Never Event

There has been a further Never Event declared in September relating to the administration of wrong side regional nerve block in theatre at Lincoln. This is the third Never Event for this financial year.

Medications

For the month of September, the number of incidents reported in relation to omitted or delayed medications has decreased again to 17%. Medication incidents reported as causing harm has also reduced again this month to 13.2% from the previous reporting period. A medicines management project group has been set up to tackle on going medicines incidents. This aims to raise the profile of medicines management and reduce the number and potential severity of medicines incidents.

SHMI

The Trust SHMI has remains stable at 102.96 for September. SHMI is at the lowest level for the Trust and is 'As expected'. The Trust are currently in the process with their system partners in continuing to roll out the Medical Examiner (ME) service for community deaths. This will enable greater learning on deaths in 30 days post discharge.

Sepsis compliance – based on August data

The screening compliance for inpatient adults was at 88% and for inpatient child 86.4% for September. There were 5 children with missed / delayed sepsis screens and no harm was caused following review of the cases. The sepsis practitioners have increased their visibility on inpatient wards with more time released for this following an improvement in ED compliance and engagement.

IVAB ED / Inpatient child - The administration of IVAB for children in ED increased to 71% and inpatient children decreased to 75%. Harm reviews completed on all children involved with no harm established.

Duty of Candour (DoC) – August Data

Verbal compliance for August was at 71% against a 100% target and 61% for written against a target of 100% within the reporting period. The Clinical Governance team continue to notify clinical teams when a moderate harm or above incident is reported and supporting Duty of Candour completion. Weekly Duty of Candour compliance reports are sent to Divisional Triumvirate and CBU's and performance is included in monthly divisional governance reports.

Operational Performance

This report covers September' performance.
At the time of writing this executive summary (13th October 2023), the Trust has 29 PCR confirmed positive COVID inpatients. The September peak was 18 patients. It should be noted the numbers of COVID positive patients attending ED and inpatients have continued to increase nationally and locally.

Performance to increase activity levels to 116% of 2019/20 remains significantly under plan. Year to date percentages against 2019/20 for key PODS are: Day case 89%, Electives 69%, Outpatient Firsts (including Procedures) 91%, Outpatient Follow Ups Procedures 83% (it should be noted that Outpatient Follow Ups (excluding Procedures) is required to reduce to 75% of 2019/20 levels).

Plans to increase activity levels continue to be worked up with the Divisions, including the increased use of advice and guidance and moving patients to a patient initiated follow up pathway. Weekly meetings have been set up with Divisional Leadership Teams, Further Faster Productivity Group, to ensure more timely reviews on activity and changes are monitored. This group includes Executive Leadership attendance. Activity for the previous few weeks will be reviewed, as well as a forward look at theatre session utilisation and outpatient clinic bookings, to ensure capacity is used as effectively as possible. The group will also review workforce and finance elements of the productivity ask to ensure these align with the activity increases.

A & E and Ambulance Performance

Urgent and Emergency Care across the System has been placed in Tier 2 due the continued reduction in performance against the key performance metrics.

The 23/24 4h-hour performance target has been set for yearend achieving 76% with a rolling monthly ambition to track achievement. September has not met its target of 65.48%, out turning at 53.43% a negative variance of 12.05%. The SPC chart below documents both the 22/23 and 23/24 target to reflect performance ambition.
This trajectory is based on Type 1 and co-located Type 3 activity. Combined type 1 and type 3 activity is demonstrating an achievement of 69.21% against the overall position. The Informatics Team are working through how this is communicated more systematically within this report going forward. It is noted that from 31st October when GDH reverts to a UTC, type recorded activity will lesson.

There were 818 12-hr trolley waits, reported via the agreed process in September. This represents a decrease of 76 patients from August 2023. Also to note September saw a static performance (18.44%) of aggregated time of arrival >12hours despite an increase in daily attendances to the department (Type 1)

Performance against the 15 min triage target demonstrated a decline of 2.56% against August' performance (71.92%) compliance verses 69.36% in September. A deeper review is required of patients who leave the department or refuse treatment that compromise this performance target.

There were 812 >59 minute handover delays recorded in September, an increase of 94 from August, this is 73 less than seen in September 2022, noting the increased conveyance of 12.16% of the same periods. These handover delays represent 18.77% (27) of daily arrivals.

Fractured Neck of Femur 48hr Pathway (#NOF)

The trust has seen a significant decline in the compliance for #NOFs going to theatre within 48 hours. The average percentage across both sites for September is 46.84%, 34 fractured neck of femur patients did not go to theatre within 48hours of admission due to not having enough theatre capacity against demand.

Length of Stay

Non-Elective Length of Stay against the agreed target is not being achieved. Current performance is 5.13 days against an agreed target of 4.5 days. This is a decline of 0.33 days compared to August. The average bed occupancy for September against "Core G&A" was an average of 97.14%. September an average of 60 escalation beds open to maintain adequate and safe flow within the acute sites. By doing so the occupancy vs escalation brought a safer percentage of 91.46% against the new national standard of 92%.
PHB continues to demonstrate the highest level of occupancy against core (104.84%). September saw an average of 36 escalation beds open to maintain adequate and safe flow within the acute sites.
System Partners were challenged with identifying timely support to facilitate discharge from the acute care setting for pathways 1 to 3.
The Trust also now records and monitors the percentage of discharges within 24hrs of the predicted dated of discharge (PDD). Current compliance is 38.49% against a target of 45%.

Referral to Treatment

August demonstrated a deterioration in performance of 0.95%. July outturn was 50.70% versus 49.75% in August. The Trust is now reporting patients waiting over 65 weeks as well to 52 weeks. The Trust reported 2,369 patients waiting over 65 weeks, which is an increase of 182 patients on the July reported position. The position has close monitoring and scrutiny.

At the end of September, the Trust reported 1 patient waiting longer than 104 weeks. This was due to complex pathways involving other Trusts for specialist input. Discussions continue to take place with NHSE weekly in regard to 104 and 78-week waiters with month end figure August at 148 >78-week waiters including first definitive treatment. This position was due the impact of the Consultant and Junior Doctors strike action and patient choice.

Waiting Lists

Overall waiting list size decreased slightly in August. August reported 75,098 compared to July's position of 75,238, a decrease of 140. 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 8th October 2023, ASI recovery has demonstrated an improvement (1,456 in October verses 1,528 at the same point in September) and is not in line with the agreed trajectory of 550. Additional resource has been directed to resolving missing outcomes which is having a positive effect on the bookings team being able to move the ASIs to open referrals.

DM01

DM01 for September reported an improved position of 5.02%. 72.54% in September verses 67.52% in August. Compliance against the national target of 99%., there remains a negative variance of 26.46% against the nationally agreed target. Whilst the main area of concern remains Echocardiography, a continued month on month improvement is noted.

Cancelled Ops

September outturn for cancelled operations on the day demonstrated a deterioration at 1.99% for September versus 1.42% in August. Two main reasons were 'No Theatre Staff, primarily due to COVID and Lack of Time.

The target for not treated within 28 days of cancellation is 0.8%. September experienced 20 breaches against the standard which is a deterioration of 5 from August

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) continues to show recovery in August, achieving 68.16% against a national KPI of 70%. The unvalidated September position is 71.5% and therefore a high level of confidence that the 70% trajectory agreed with NHSE will be achieved in September following the completion of the validation.

62day classic treatment performance for August was 58.91% and improvement on the July position (57.79%) (against a national KPI of 85%).

104+ day waiters reduced to 61 at the end of September compared to 67 at the end of August. The highest risk speciality is colorectal with 20 pathways greater than 104 days, closely following by Lung at 10.

The Deputy Chief Operating Officer for Urgent Care has now assumed responsibility for Cancer Delivery. Meetings with each tumour group take place twice weekly - divisional engagement is high. The meetings are chaired by the Deputy COO with support from ICS colleagues.

Workforce

Mandatory Training – For M05 we are reporting a performance of 92.27% which is within the 2% tolerance of the Q2 plan of 93%. Since M01 the performance for this measurement has been steadily improving and has improved by 2.1%.

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 focused support being offered to those with low compliance (50% and less) through enhanced reporting provided at the Divisional level by the Education & Learning Team within our People & OD Directorate. Several 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 several core + modules.

There continues to be a drive for all staff groups to improve their Core Training compliance through monthly Finance, People and Activity Meetings (FPAM), with areas needing specific focus being highlighted by the People & OD Directorate.

Sickness Absence – During Q2 the Trust is averaging 5.62% which is within the 1% tolerance against the Q2 plan of 4.9%.

We continue work to further reduce its vacancy level and as such, we are hopeful this continued improvement will impact positively on our colleague's health and wellbeing throughout 2023/24. Compliance for Return to Work Interviews (RTW) and callbacks 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 COVID-19.

Our sickness rate is not reducing at the rates we have planned based on our trajectories for 2023/24. We have reviewed the sickness episodes for Short and Long Term absences, and have found that there has been an increase in the number of episodes since April 2023. This could potentially be linked to the wider impact of the industrial action seen over recent months. 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 to further our journey towards a "supporting attendance" approach as opposed to managing absence. Staff are continuing to be signposted to our health and wellbeing services.

Staff Appraisals – We are reporting a performance of 72.66% for M05 which is outside of the tolerance when measured against the Q2 plan of 80%. Although the appraisal compliance is steadily improving, it has not achieved the quarterly plan and is not on track to deliver the 2023/24 ambition of 90%.

Ongoing service pressures and staffing challenges continue to impact appraisal completion rates but month on month there is a slight improvement with an increase in the last month of 3.6%. There is a need to see an improved position if we are going to meet the Q2 target and focus attention on areas that are RAG-rated 'red' and are being discussed with teams directly, including through FPAM discussions where relevant. The overall Trustwide Appraisal rate is 75.27%, with Medical and Dental at 98.22% and all other Staff Groups (excluding Medical & Dental) being 72.66%.

We recognise that the overall Trustwide Appraisal completion rate is consistently below our annual target of 90.00% and that there is further focus required for 2023/24 in improving compliance if we are to meet the Trust's ambition 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.

Staff Turnover – We moved into Q2 of 2023/24 with a Turnover Rate of 12.21% against a Target of 12.50%. Turnover has continued to improve since peaking in August 2022, with our September 2023 position being 11.44% which is within the Q2 Target (12.50%) for 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.

We have a continued focus on retention issues including flexible working. The Lincolnshire System Retention Project is due to conclude shortly with specific recommendations that can be implemented. Our Organisational Development Team continue to work with the 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. There are continues to be strong recruitment activity - substantive positions being filled supports reducing pressures on areas with high vacancy rates.

Vacancies – For the past four months, we have been reporting a fluctuating performance from achieving to achieving within tolerance against the Quarterly plan. However, for M05 the Trust is reporting a deteriorating performance of 9.68% which is outside of the Q2 plan of 7%. On average, for Q2 the Trust is achieving 8.84% for this measurement which is 1.94% above the predicted quarterly ambition.

The root cause of this performance is the need to fully complete the establishment review of vacant posts. Whilst work has continued reviewing the overall establishment, this is yet to translate into Trust Reports. However, 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. As predicted, we saw an increase in in June 2023, as sizeable business cases were agreed which have increased our funded establishment.

The mitigation in place to bring this measurement back on track is that our People & OD Teams continue to work closely with Divisional Teams to ensure that our establishment levels remain in line with our 2023/24 Workforce Plan. It is expected once this review has been fully completed, that our overall Trust Vacancy Rate will return to trajectory levels.

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 deficit of £15.5m YTD in line with plan.

CIP savings of £14.4m have been delivered YTD, which is £5.3m favourable to planned savings of £9.1m.

Capital funding levels for 2023/24 have been agreed with NHSE and system partners; the Trust delivered capital expenditure of £4.3m YTD, which is £6.7m lower than planned capital expenditure of £11.0m.

The September cash balance is £36.1m; this is a reduction of £5.2m against the March year-end cash balance of £41.3m.

Jonathan Young
Director of Finance & Digital
October 2023

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	Jul-23	Aug-23	Sep-23	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Clostridioides difficile position	Safe	Patients	Director of Nursing	9	9	3	14	45	P	
	MRSA bacteraemia	Safe	Patients	Director of Nursing	0	0	0	1	1	P	H
	MSSA bacteraemia cases counts and 12-month rolling rates of hospital-onset, by reporting acute trust and month using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.01	0.01	0.01	0.01		
	E. coli bacteraemia cases counts and 12-month rolling rates, by reporting acute trust and month using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.02	0.02	0.02	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	0.09	0.07	P	
	Pressure Ulcers category 3	Safe	Patients	Director of Nursing	4.3	0	0	1	3	P	
	Pressure Ulcers category 4	Safe	Patients	Director of Nursing	1.3	1	0	1	3	P	
	Pressure Ulcers - unstageable	Safe	Patients	Director of Nursing	4.4	4	6	5	24	P	
	Venous Thromboembolism (VTE) Risk Assessment	Safe	Patients	Medical Director	95.00%	94.66%	94.36%	94.75%	94.69%	F	
	Never Events	Safe	Patients	Director of Nursing	0	0	1	1	3	?	

OUTSTANDING CARE personally DELIVERED

Performance Overview - Quality

NHS United Lincolnshire Hospitals NHS Trust

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Jul-23	Aug-23	Sep-23	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Reported medication incidents per 1000 occupied bed days	Safe	Patients	Medical Director	4.30	5.62	5.83	6.16	5.98	P	
	Medication incidents reported as causing harm (low /moderate /severe / death)	Safe	Patients	Medical Director	10.70%	16.50%	13.80%	13.20%	15.00%	F	
	Patient Safety Alerts responded to by agreed deadline	Safe	Patients	Medical Director	100.00%	None Due	None Due				
	Hospital Standardised Mortality Ratio - HSMR (basket of 56 diagnosis groups) (rolling year data 3 month time lag)	Effective	Patients	Medical Director	100	94.25	95.29	95.35	94.84	P	
	Summary Hospital Mortality Indicator (SHMI) (rolling year data 6 month time lag)	Effective	Patients	Medical Director	100	102.85	102.66	102.96	103.10	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	H
	eDD issued within 24 hours	Effective	Patients	Medical Director	95.00%	87.10%	89.70%		88.90%	F	
	Sepsis screening (bundle) compliance for inpatients (adult)	Safe	Patients	Director of Nursing	90.00%	91.39%	88.00%	Data Not Available	89.34%	?	
	Sepsis screening (bundle) compliance for inpatients (child)	Safe	Patients	Director of Nursing	90.00%	96.80%	86.40%	Data Not Available	87.40%	F	
	IVAB within 1 hour for sepsis for inpatients (adult)	Safe	Patients	Director of Nursing	90.00%	97.27%	91.00%	Data Not Available	94.97%	P	
	IVAB within 1 hour for sepsis for inpatients (child)	Safe	Patients	Director of Nursing	90.00%	100.00%	75.00%	Data Not Available	65.84%	F	

OUTSTANDING CARE personally DELIVERED

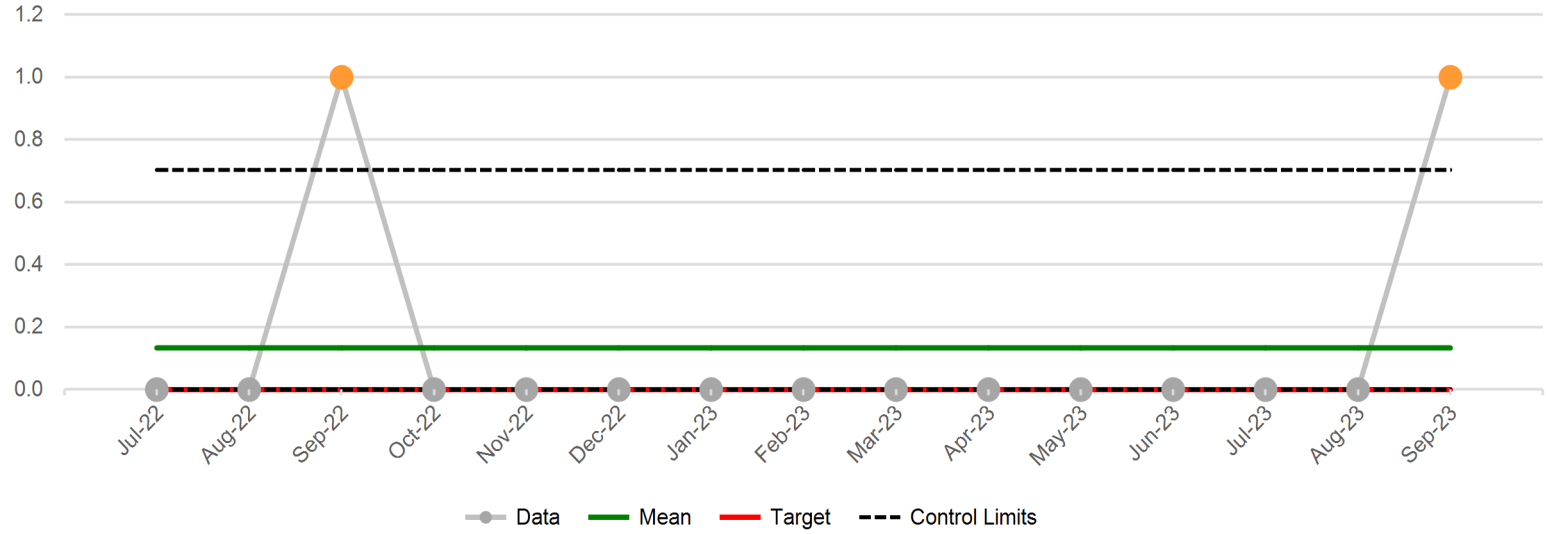
Performance Overview - Quality

NHS United Lincolnshire Hospitals NHS Trust

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Jul-23	Aug-23	Sep-23	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Sepsis screening (bundle) compliance in A&E (adult)	Safe	Patients	Director of Nursing	90.00%	91.79%	93.00%	Data Not Available	91.73%	P	
	Sepsis screening (bundle) compliance in A&E (child)	Safe	Patients	Director of Nursing	90.00%	90.60%	93.75%	Data Not Available	90.73%	P	
	IVAB within 1 hour for sepsis in A&E (adult)	Safe	Patients	Director of Nursing	90.00%	95.78%	94.00%	Data Not Available	96.11%	P	
	IVAB within 1 hour for sepsis in A&E (child)	Safe	Patients	Director of Nursing	90.00%	50.00%	71.00%	Data Not Available	62.98%	F	
	Rate of stillbirth per 1000 births	Safe	Patients	Director of Nursing	3.80	2.23	2.47	2.91	2.49	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%	88.00%	71.00%	Data Not Available	87.40%	F	
	Duty of Candour compliance - Written	Responsive	Patients	Medical Director	100.00%	82.00%	61.00%	Data Not Available	80.60%	F	

Performance Overview - Quality

MRSA bacteraemia



Sep-23
1
Variance Type
Special cause variation - cause for concern (Indicator where high is a concern)
Target
0
Achievement
Variation indicates consistently passing the target
Executive Lead
Director of Nursing

Background:
MRSA Bacteraemia

What the chart tells us:
There has been one case this month that is currently being investigated. The Trust is now over trajectory by one case.

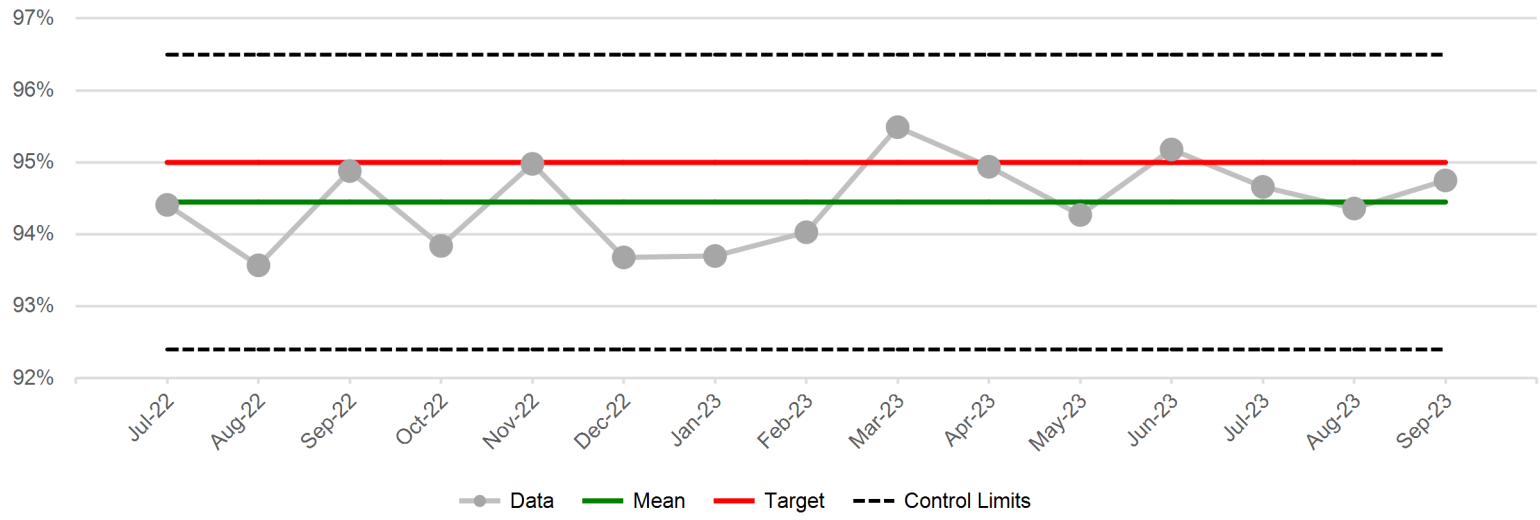
Issues:
Peripheral devices and urinary catheter documentation- not fully completed for insertion, ongoing care and removal, so difficult to establish if this contributed to the incident.

Actions:
Patient treated appropriately for MRSA bacteraemia and was a complex patient who had been very poorly and treated with multiple antibiotics during her hospital stay.

Mitigations:
Case is being fully investigated as not clear what was the cause of bacteraemia, but there will be learning identified for the ward/Trust in light of this.

Performance Overview - Quality

Venous Thromboembolism (VTE) Risk Assessment



Sep-23
94.75%
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:

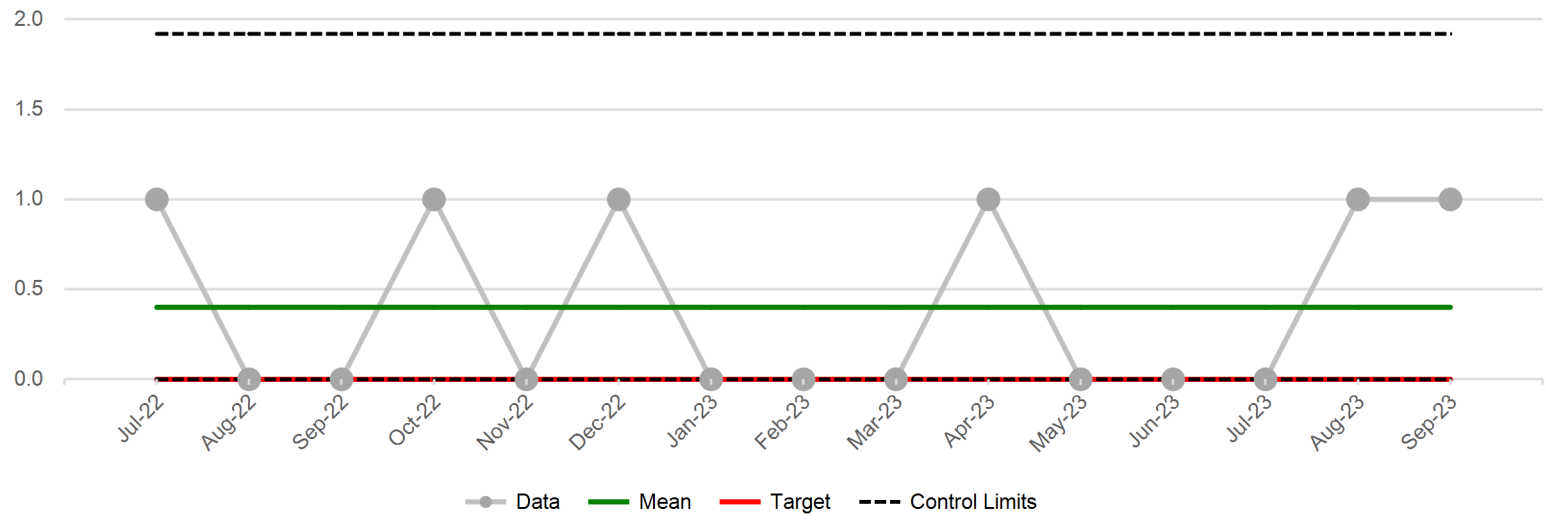
Actions:
A paper was taken to Trust Leadership Team in November 2022 proposing the reinstatement of the VTE Specialist Nurse. This was agreed and work will now take place to identify a funding stream.

No narrative owner

Mitigations:

Performance Overview - Quality

Never Events



Sep-23
1
Variance Type
Common cause variation
Target
0
Achievement
Variation indicates inconsistently passing and falling short of the target
Executive Lead
Director of Nursing

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

What the chart tells us:
There was 1 Never Event declared in April 2023 and 1 Never Event declared in August 2023 and 1 Never Event declared in September 2023.

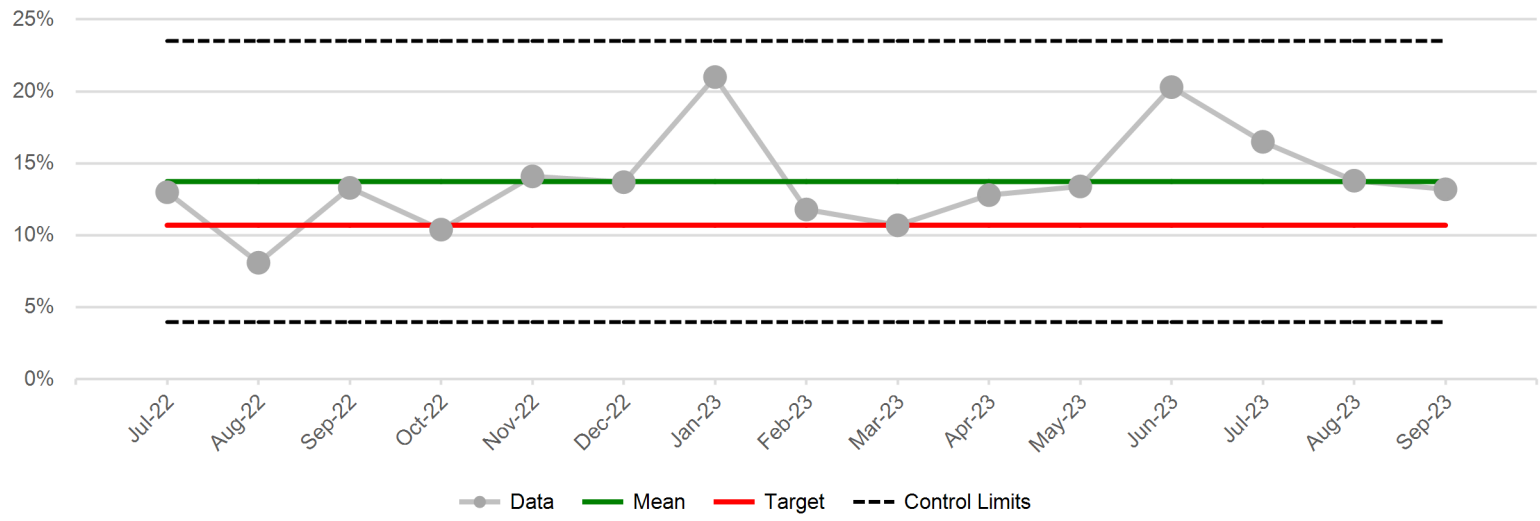
Issues:
The Never Event declared in September 2023 relates to the administration of wrong side regional nerve block in theatre at Lincoln.

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

Mitigations:
Following the initial review of each incident, immediate actions are implemented to provide mitigation where possible. At the conclusion of the investigation, recommended action plans are agreed with the Serious Incident Panel and monitored through to completion as part of divisional clinical governance arrangements.

Performance Overview - Quality

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



Sep-23
13.20%
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 September the number of incidents reported was 210. This equates to 6.16 incidents per 1000 bed days. The number of incidents causing some level of harm (low /moderate /severe / death) is 13.8% which is above the national average of 11%.

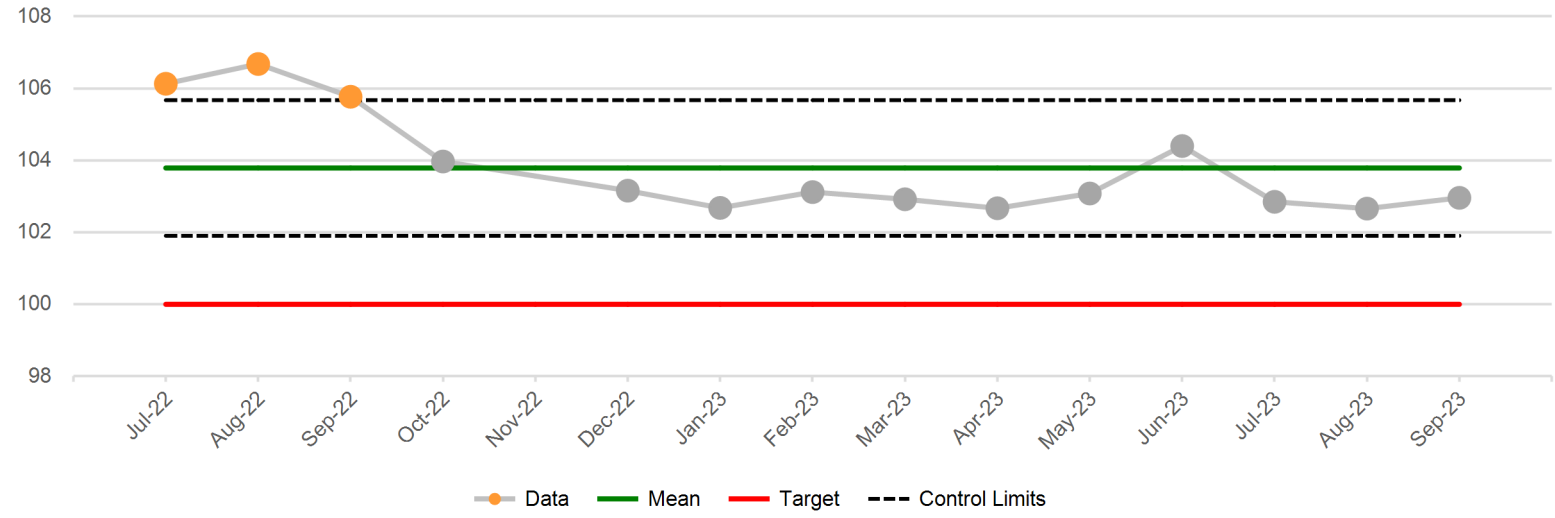
Issues:
The majority of incidents are at the point of administration of medication and the main error is omitting medicines.

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

Mitigations:

Performance Overview - Quality

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



Sep-23
102.96
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 that occur within 30-days of discharge.

What the chart tells us:
SHMI is at the lowest levels for the Trust post-pandemic and is in Band 2 with an 'As Expected SHMI'.

Issues:
The data includes deaths within 30-days of discharge.

When all GPs are participating in the Lincolnshire Medical Examiners Service, greater intelligence will be available to understand if there is any learning required.

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

The Trust are in the process with their system partners in rolling out the Medical Examiner (ME) Service for community deaths. There are 28 GPs referring their deaths. This enables greater learning on deaths in 30-days post discharge.

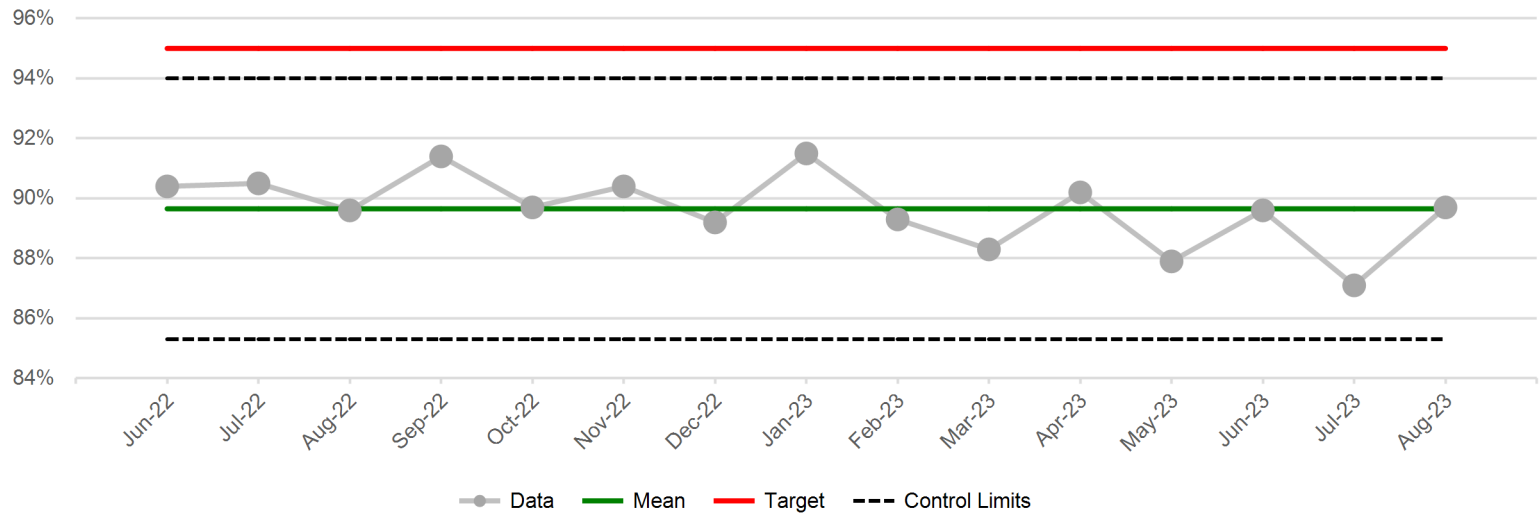
Mitigations:
The MEs have commenced reviewing community deaths which enables oversight of deaths 30-days post Acute discharge, of which learning can be identified.

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

Dr Foster also provides intelligence to the Trust which reports our in-hospital SHMI as 90.32 (Low).

Performance Overview - Quality

eDD issued within 24 hours



Aug-23
89.70%
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 89.7%.

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

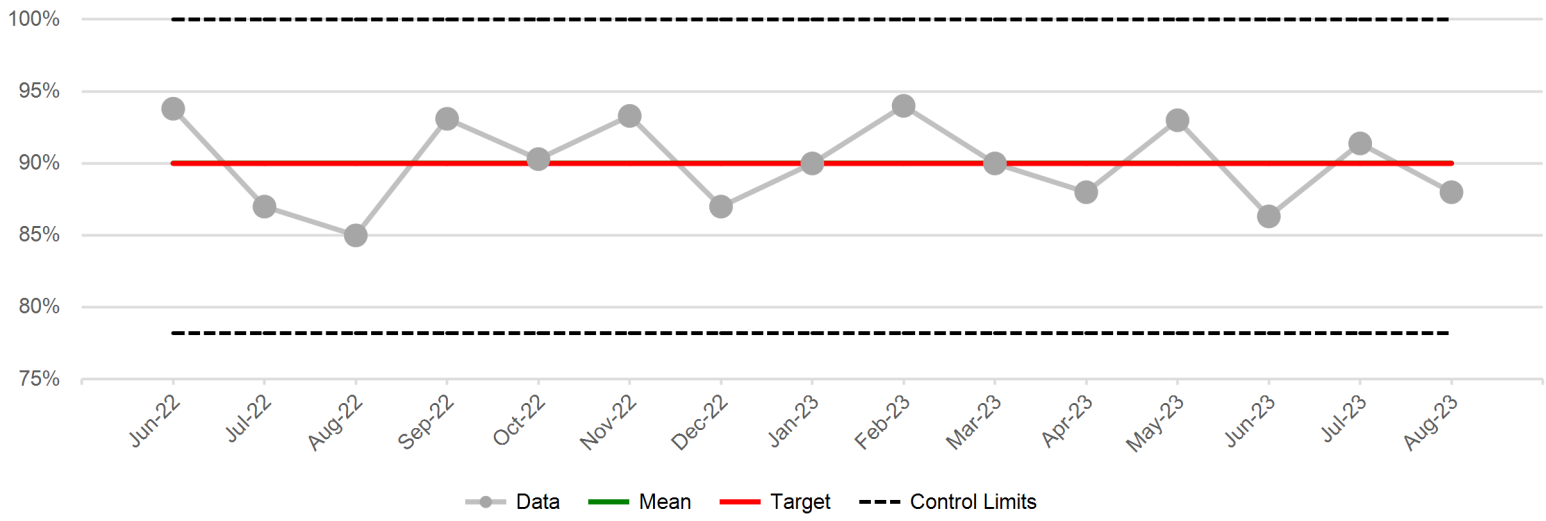
No Narrative owner

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)



Aug-23
88.00%
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:
Sepsis screening (bundle) compliance for inpatients (adult).

What the chart tells us:
The compliance for sepsis for adult inpatients has unfortunately fallen in August to 88% that represents 257 of 292 patients. The trends show a continuing difficulty in achieving this metric.

Issues:
The main areas that have seen a decline in compliance are medical inpatient areas and maternity. The main themes within medicine are a number of missed screens when the raised NEWs is attributable to non-infection causes and this is reflected in the continuing good practice and compliance for patients with red flag sepsis. There is a similar theme in maternal patients where the vast majority of patients have triggered for pre-eclampsia and not infection.

Actions:
The sepsis practitioners have increased their visibility on inpatient wards with more time released for this following an improvement in ED compliance and engagement. The wider DPG are rolling out simulation training to ward areas to include sepsis recognition. Regular teaching continues on AIM courses and DPG study days

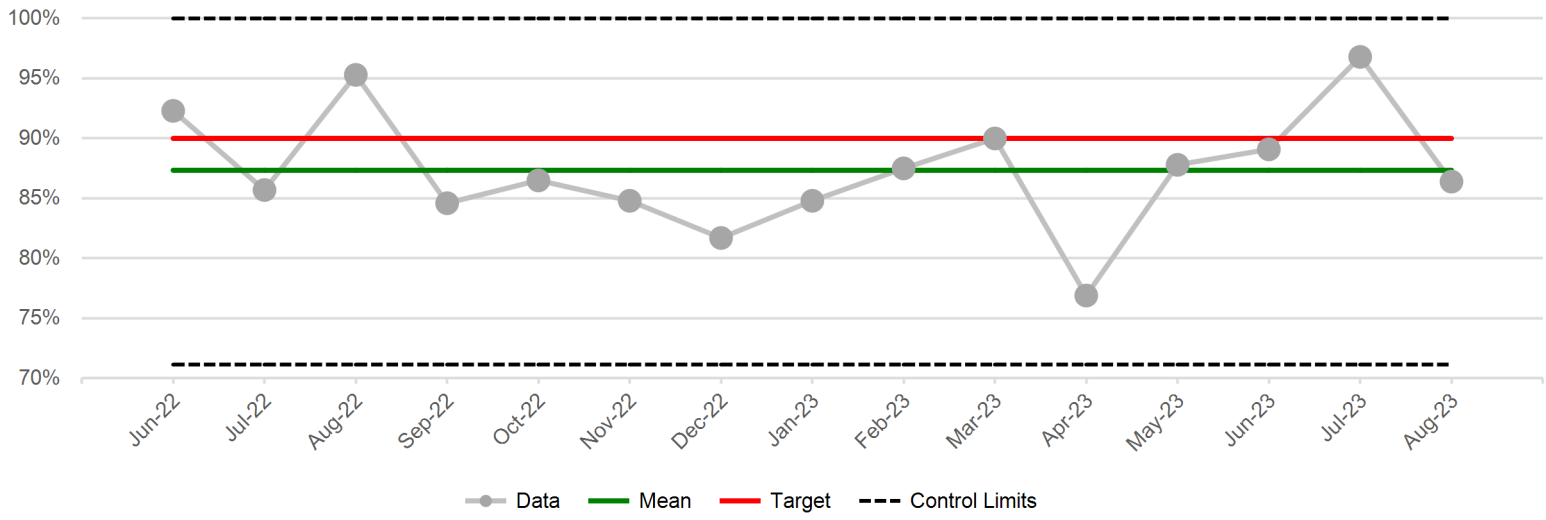
Mitigations:
Ward areas carry out harm reviews to acknowledge themes and if any harm from the sepsis omission has been caused to the patient allowing for more focussed training.

New adult Sepsis Trust e- learning package now live on ESR, which includes up to date guidance from NICE.

Sepsis workbook accessible to all staff, available on staff intranet page.

Performance Overview - Quality

Sepsis screening (bundle) compliance for inpatients (child)



Aug-23
86.40%
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)

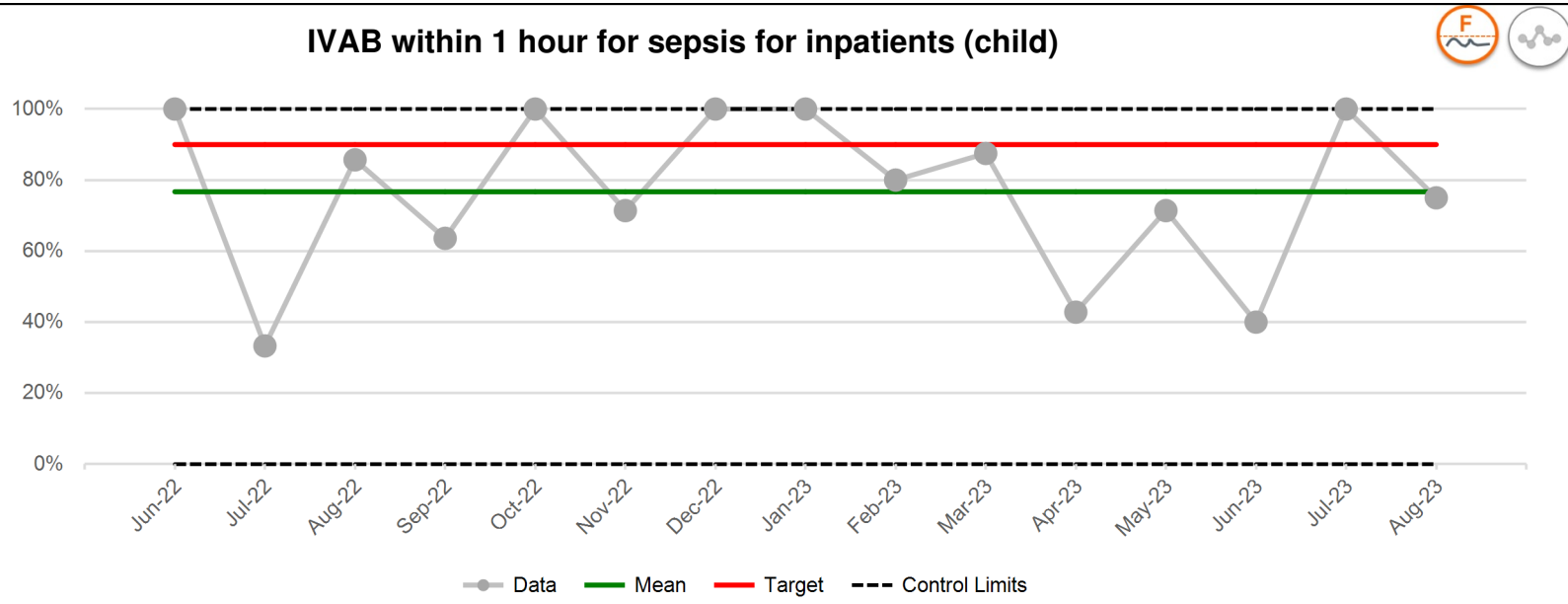
What the chart tells us:
The compliance for Sepsis screening for inpatients for children was 86.4%. This was 32 of 37 children. There were 5 children with missed / delayed sepsis screens.

Issues:
There were 3 children with delayed screens that had a viral cause for their illness. Two children were found to have an infection which was treated with oral antibiotics. Drs waited for blood results before making this decision but were not concerned about Sepsis.

Actions:
Harm reviews carried out by ward staff involved in order to learn from their practice. Sepsis compliance to be discussed at speciality governance.

Mitigations:
No harm found from any Harm reviews and all patients were treated appropriately.

Performance Overview - Quality



Aug-23
75.00%
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 for inpatients (child).

What the chart tells us:
The compliance for inpatient children for IV antibiotic administration within the hour is 75.0%. This meant that 3 of 4 children received their antibiotics in a timely manner.

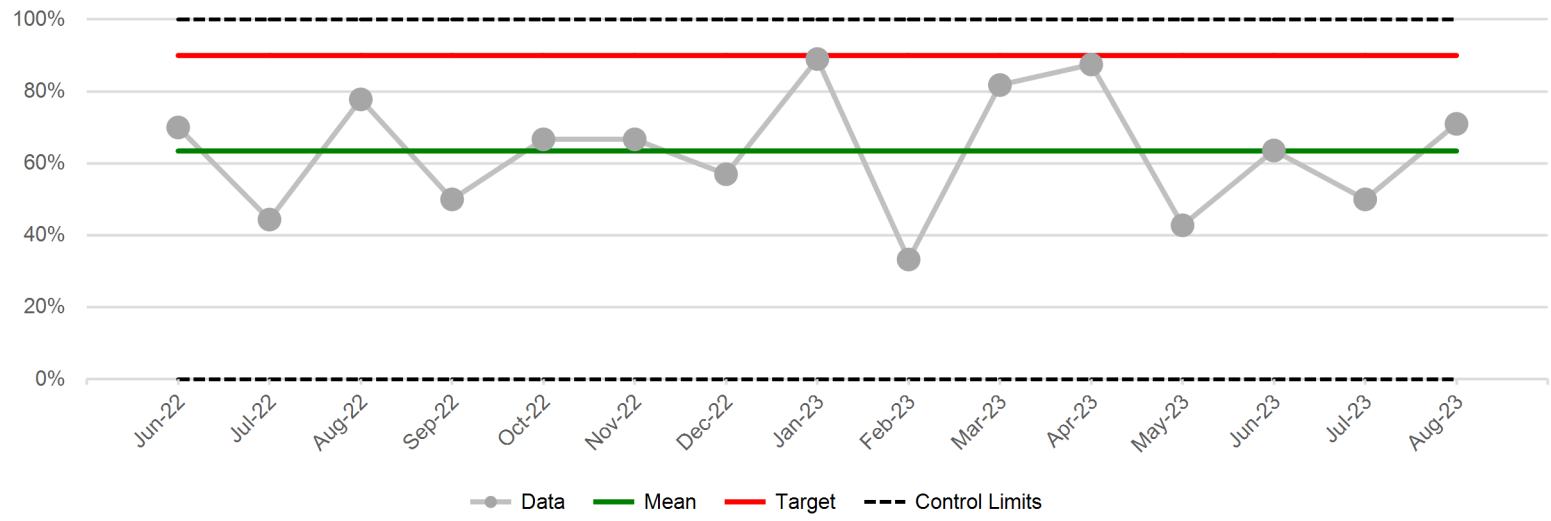
Issues:
There was one child this month in the inpatient areas with delayed antibiotic treatment. There was a delay in the child receiving a senior review, due to ward demands, and the child was also transferred between wards at this time.

Actions:
Harm review completed by ward staff in order to recognise errors / delays. IR1 completed so that medical staff can investigate this incident.

Mitigations:
No harm found from Harm review. Patient to be discussed at October speciality governance.

Performance Overview - Quality

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



Aug-23
71.00%
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 data this month shows that the IVAB compliance was 71.00%, which is 5 out of 7 patients, which is below the 90% target. There has been an increase on last month's figures.

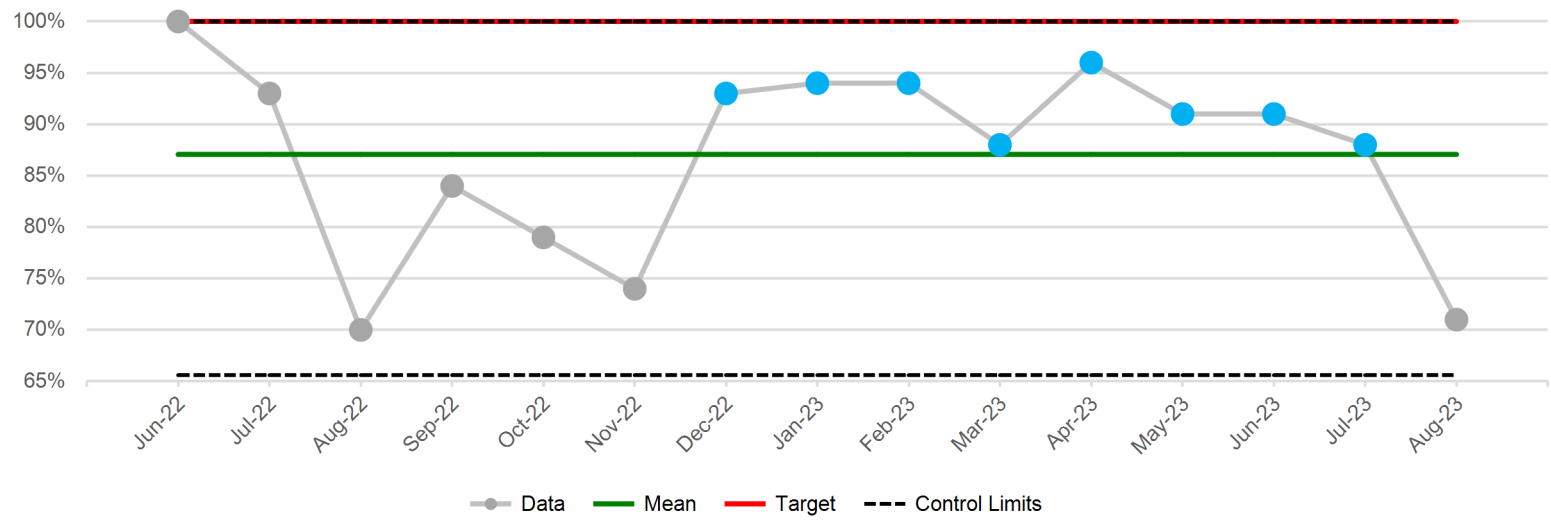
Issues:
There were 2 patients in ED this month that had delayed administration of antibiotics. One child was initially screened as a viral illness but as their condition deteriorated they were treated for Sepsis. This would have met the 3 hour timeframe. The second patient was a very young baby, ED alerted paediatric team and the child was treated for Sepsis at 82 minutes.

Actions:
Numbers requiring treatment for Sepsis in August was very low and therefore the 2 delays make a big impact on compliance numbers. Harm reviews have been shared with ED staff.

Mitigations:
Harm reviews completed for both delayed treatments and no harm found.

Performance Overview - Quality

Duty of Candour compliance - Verbal



Aug-23
71.00%
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 verbal Duty of Candour, which applies to all patient safety incidents where harm is moderate or above, is a statutory requirement.

What the chart tells us:
The Trust has not been achieving 100% compliance with Duty of Candour requirements consistently within 1 month of notification. However over previous months compliance is consistently above 90%.

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

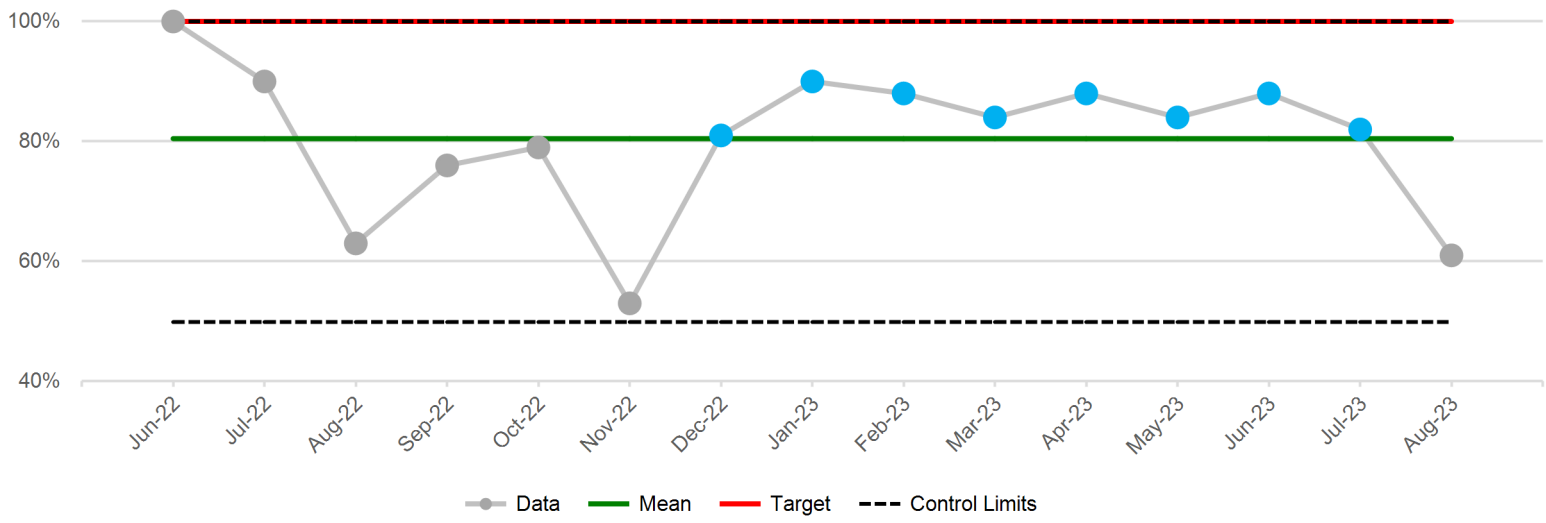
In addition, the chart above shows compliance within 1 month of an incident being reported. It does not show where Duty of Candour is completed after more than 1 month.

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

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

Performance Overview - Quality

Duty of Candour compliance - Written



Aug-23
61.00%
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, which applies to all patient safety incidents where harm is moderate or above, is a statutory requirement.

What the chart tells us:
The Trust has not been achieving 100% compliance with written follow-up Duty of Candour requirements consistently within 1 month of notification. However over previous months compliance is consistently above 85%.

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

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

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

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

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	Jul-23	Aug-23	Sep-23	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Patient Experience	% Triage Data Not Recorded	Effective	Patients	Chief Operating Officer	0.00%	0.49%	0.76%	0.68%	0.49%	0.00%	F	
Improve Clinical Outcomes	4hrs or less in A&E Dept	Responsive	Services	Chief Operating Officer	65.48%	57.02%	53.13%	53.43%	56.07%	58.13%	F	L
	12+ Trolley waits	Responsive	Services	Chief Operating Officer	0	697	894	818	4,574	0	F	
	%Triage Achieved under 15 mins	Responsive	Services	Chief Operating Officer	88.50%	72.33%	71.91%	69.36%	74.47%	88.50%	F	
	52 Week Waiters	Responsive	Services	Chief Operating Officer	4,237	6,627	6,427		33,889	30,261	F	L
	65 Week Waiters	Responsive	Services	Chief Operating Officer	1,429	2,187	2,369		10,898	10,573	F	
	18 week incompletes	Responsive	Services	Chief Operating Officer	84.10%	50.70%	49.75%		49.96%	84.10%	F	
	Waiting List Size	Responsive	Services	Chief Operating Officer	65,241	75,238	75,098		N/A	N/A	F	H
	28 days faster diagnosis	Responsive	Services	Chief Operating Officer	75.00%	66.69%	68.16%		61.16%	75.00%	F	
	62 day classic	Responsive	Services	Chief Operating Officer	85.39%	57.79%	58.91%		53.87%	85.39%	F	
	2 week wait suspect	Responsive	Services	Chief Operating Officer	93.00%	53.13%	56.16%		53.57%	93.00%	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	Jul-23	Aug-23	Sep-23	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Clinical Outcomes	2 week wait breast symptomatic	Responsive	Services	Chief Operating Officer	93.00%	13.08%	8.93%		10.45%	93.00%	F	
	31 day first treatment	Responsive	Services	Chief Operating Officer	96.00%	93.73%	91.38%		91.18%	96.00%	F	
	31 day subsequent drug treatments	Responsive	Services	Chief Operating Officer	98.00%	98.68%	92.31%		95.87%	98.00%	F	
	31 day subsequent surgery treatments	Responsive	Services	Chief Operating Officer	94.00%	77.42%	72.41%		74.12%	94.00%	F	
	31 day subsequent radiotherapy treatments	Responsive	Services	Chief Operating Officer	94.00%	95.80%	93.20%		90.84%	94.00%	F	
	62 day screening	Responsive	Services	Chief Operating Officer	90.00%	68.18%	66.67%		67.14%	90.00%	F	
	62 day consultant upgrade	Responsive	Services	Chief Operating Officer	85.00%	74.63%	74.77%		69.25%	85.00%	F	
	Diagnostics achieved	Responsive	Services	Chief Operating Officer	99.00%	70.10%	67.52%	72.54%	67.65%	99.00%	F	H
	Cancelled Operations on the day (non clinical)	Responsive	Services	Chief Operating Officer	0.80%	1.57%	1.42%	1.99%	1.41%	0.80%	F	
	Not treated within 28 days. (Breach)	Responsive	Services	Chief Operating Officer	0	13	20	25	93	0	F	
	#NOF 48 hrs	Responsive	Services	Chief Operating Officer	90.00%	78.26%	46.91%	46.84%	73.83%	90.00%	F	L

OUTSTANDING CARE personally DELIVERED

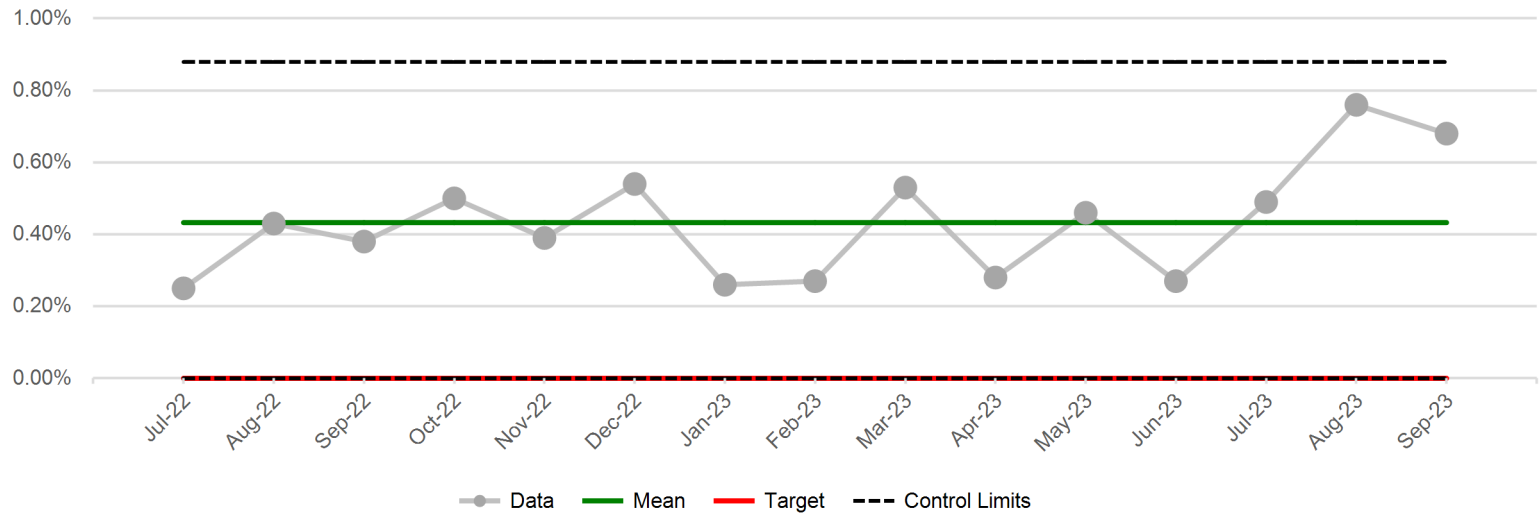
Performance Overview - Operational Performance

NHS United Lincolnshire Hospitals NHS Trust

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Jul-23	Aug-23	Sep-23	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Clinical Outcomes	#NOF 36 hrs	Responsive	Services	Chief Operating Officer	TBC	66.67%	22.22%	31.65%	49.59%			
	EMAS Conveyances to ULHT	Responsive	Services	Chief Operating Officer	4,657	4,421	4,515	4,327	4,319.5	4,657	P	
	EMAS Conveyances Delayed >59 mins	Responsive	Services	Chief Operating Officer	0	391	718	812	548.5	0	F	
	104+ Day Waiters	Responsive	Services	Chief Operating Officer	10	70	67	61	445	60	F	L
	Average LoS - Elective (not including Daycase)	Effective	Services	Chief Operating Officer	2.80	2.89	3.59	3.04	3.00	2.80	F	
	Average LoS - Non Elective	Effective	Services	Chief Operating Officer	4.50	4.79	4.80	5.13	4.91	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	28,481	28,807	27,977	27,617.7	4,524	F	H
	Outpatients seen within 15 minutes of appointment	Effective	Services	Chief Operating Officer	70.00%	32.83%	32.83%	31.52%	31.57%	70.00%	F	
	% discharged within 24hrs of PDD	Effective	Services	Chief Operating Officer	45.00%	41.43%	39.01%	38.49%	41.92%	45.00%	F	

Performance Overview - Operational Performance

% Triage Data Not Recorded



Sep-23
0.68%
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:
September 23 reported a non-validated position of 0.68% of data not recorded verses target of 0%. What the chart doesn't tell us is that 58% of those without a triage "did not wait" to be seen.

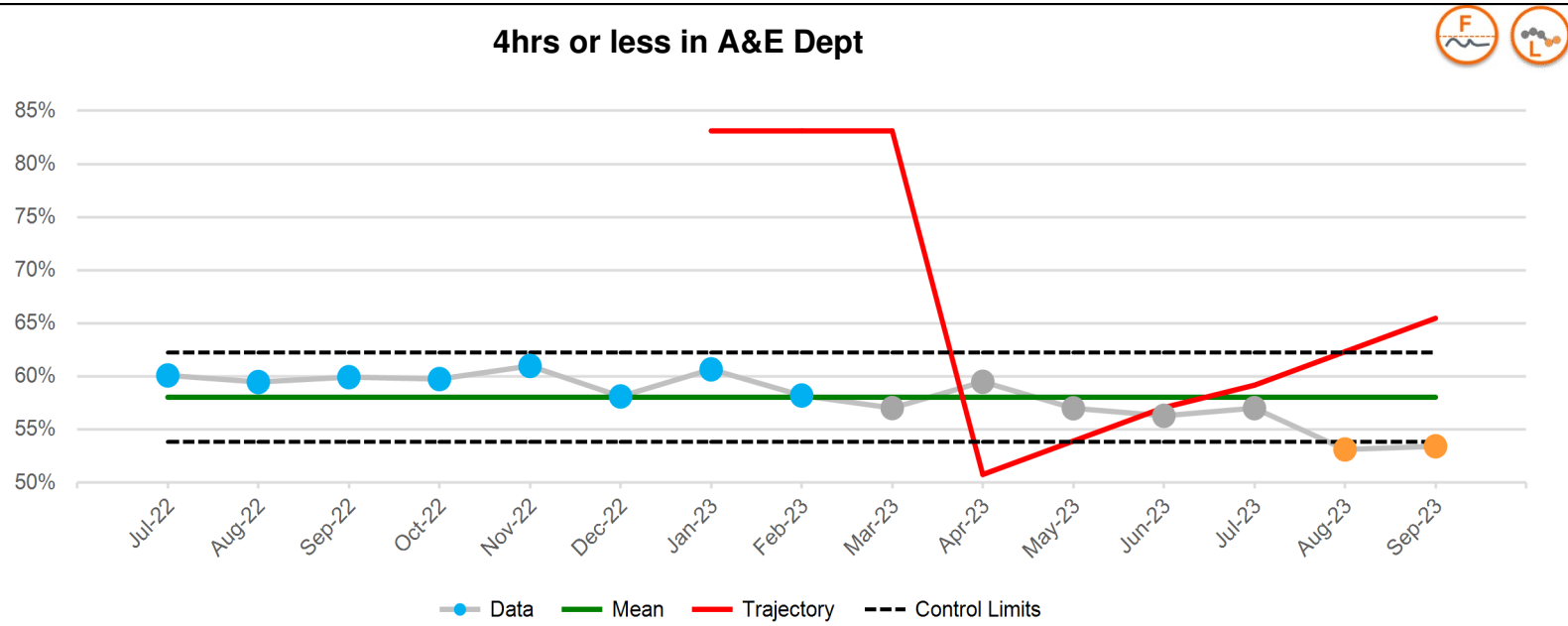
Issues:
- Recognition of patients that "Did Not Wait/Refused Treatment" prior to triage being conducted.
- Recognition of patients who were transferred from one site to another for continued emergency care/direct admission to specialty.
- Manchester Triage trained staff (MTS) to consistently operate two triage streams, especially out of hours but has been less problematic at all three sites.

Staffing gaps, sickness and skill mix issues.

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

Mitigations:
- Earlier identification of recording delays via 3 x daily capacity and performance meetings and confirmation via 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.

Performance Overview - Operational Performance



Sep-23
53.43%
Variance Type
Special cause variation - cause for concern (Indicator where low is a concern)
Trajectory
65.48%
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 target performance for Type 1 and co-located UTC Type 3 for has not been met.
What the chart doesn't tell us is the static performance with an increase attendance rate within the department.

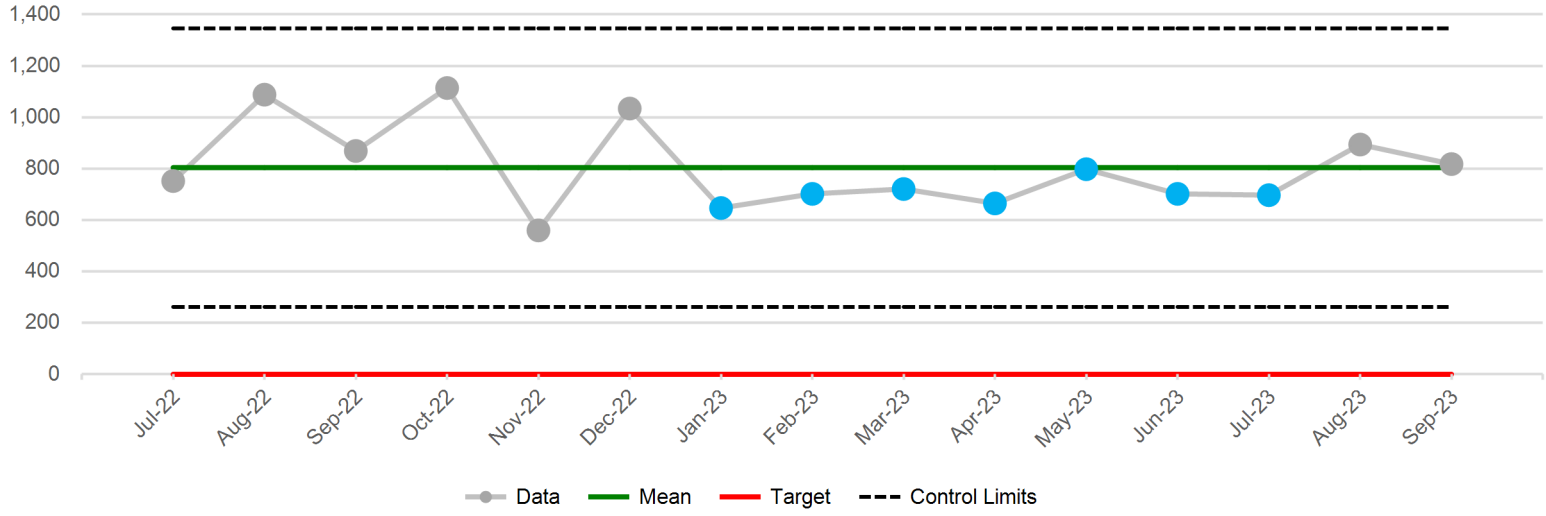
Issues:
Main factor in static performance of 53.43% compared to August 53.13% is due to increased attendances within the Emergency Departments. (3.19% more daily arrivals) equating to 2% more admissions. Ward Based Discharges were an average of 22 short to meet ED demand each day – this resulted in prolonged bed waits overnight. Early recognition of discharges also lead to the extended LOS within ED. (With 59.77% recognised after 4pm daily) Infection related closures of beds on wards impacted availability of movement and cleaning resource affected timely movements. (CDIFF& COVID19 being the predominant impacts)
Ongoing medical and nursing gaps that were not Emergency Department specific.
Inability to secure consistent 24/7 Discharge Lounge provision due increased registrant staffing gaps. Escalation of some SDEC areas into Inpatient areas was frequent.

Actions:
Reducing the burden placed upon the Emergency Departments further will be through 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 targets 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

12+ Trolley waits



Sep-23
818
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:
September experienced 818 12-hr trolley wait breaches compared to August of 894. This is decrease of 76 patients. The 818 seen, equates to 5.90% of all type 1 attendances for September.
What the chart does not explain is the internal decision to move from 12hr DTA to total time in ED to minimise exposure risk.

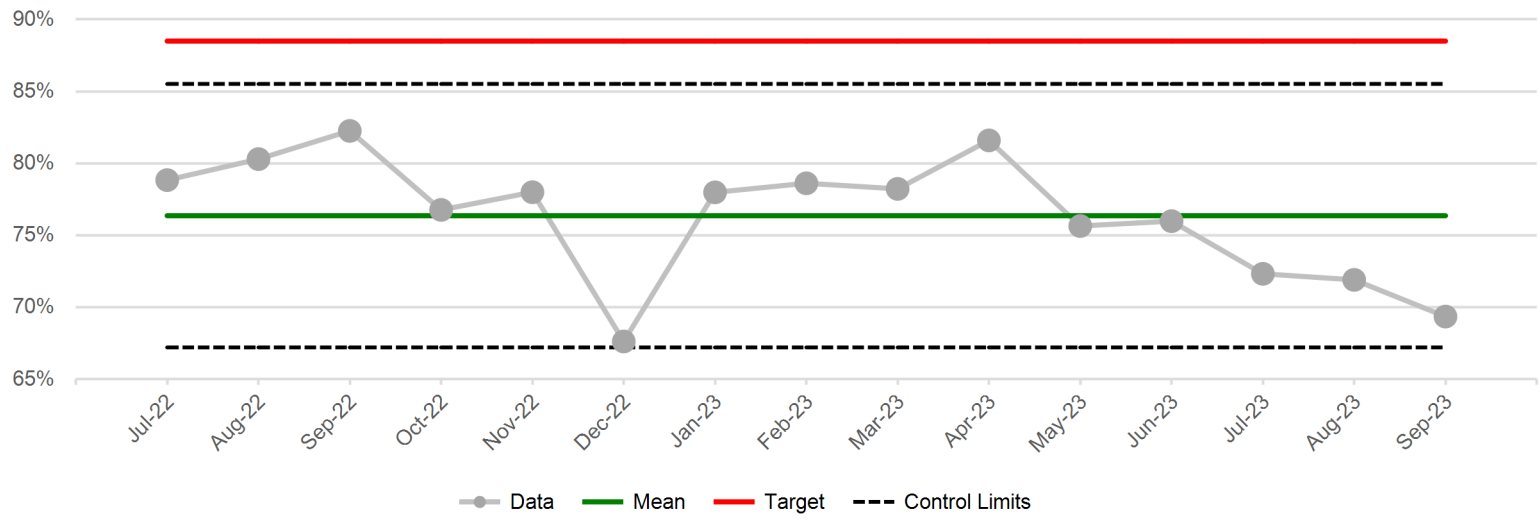
Issues:
Sub-optimal discharges to meet the known emergency demand.
All reportable 12hr trolleys were either associated with no available beds, patient deterioration or delays in transfer to other care settings.

Actions:
The Trust continues to work closely with national regulators in reviewing and reporting these breaches. Due to the number of 12hrs trolley waits breaches currently, harm reviews are completed by the UEC team, DATIX are completed and escalations to the CCG and NHSE/I are in place. A daily review of all potential 12hr trolley waits is in place and escalated to all key strategic tactical and operational leads and divisional triumvirates.
System Partners and Regulators remain actively engaged and offer practical support in situational escalations.
A substantial programme of work out of hospital is in place with system partners to reduce delayed discharges which are upwards of 15% of all beds at times.
Internal actions on admission avoidance are focussed on Same Day emergency Care.

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

%Triage Achieved under 15 mins



Sep-23
69.36%
Variance Type
Common cause variation
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:
September outturn was 69.36% compared to 71.92% in August (validated).
What the chart doesn't tell us is the 3.19% increase in daily attendances against August 23 and 10.24% increase against September 2022

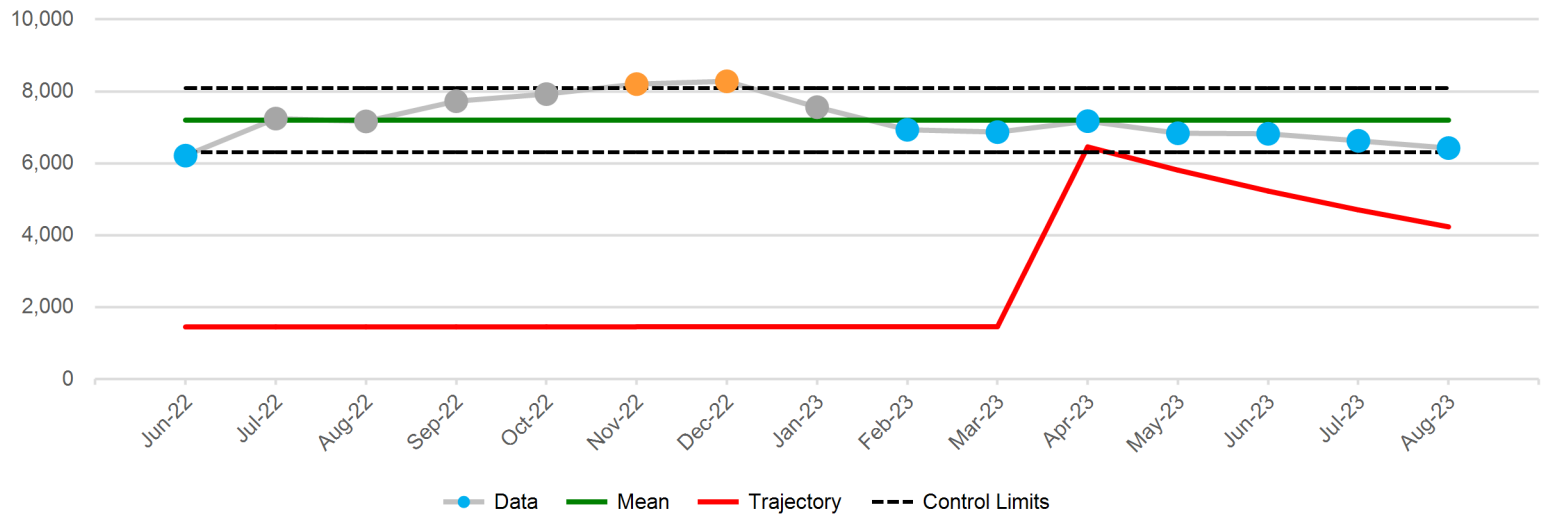
Issues:
- Consistent availability of MTS2 trained staff available per shift to ensure 2 triage streams in place 24/7 has deteriorated.
- There is a recording issue for UTC transfers of care to ED that skews that data on occasion.
- Dual department roles. For example, the second triage nurse is also the 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 4 x daily Capacity and Performance Meetings.

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

Performance Overview - Operational Performance

52 Week Waiters



Aug-23
6,427
Variance Type
Special cause variation - improvement (Indicator where low is good)
Trajectory
4,237
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.

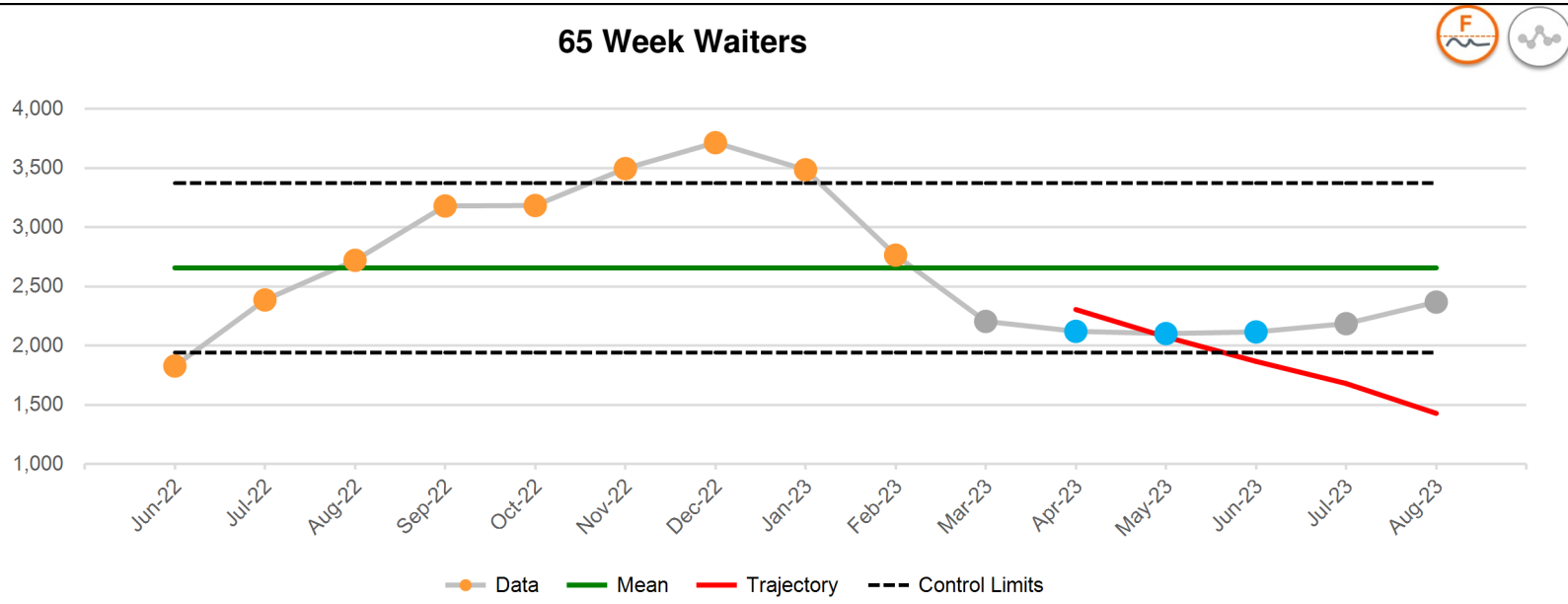
What the chart tells us:
The Trust reported 6,427 incomplete 52-week breaches for August 2023, a decrease of 200 from July's 2023's 6,627.

Issues:
As shown above, 52 week waiters are negatively performing against trajectory. Both admitted and non-admitted patients sit within this wait band, however, the most significant pressure is in the non-admitted pathways. The doctor's ongoing industrial action continues to have a detrimental effect on performance.

Actions:
Incomplete patient pathways are discussed with individual specialities weekly, through the PTL meeting.
This meeting is currently under review to assess effectiveness and to improve the monitoring of patient pathways.

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

Performance Overview - Operational Performance



Aug-23
2,369
Variance Type
Common cause variation
Trajectory
1,429
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 2,369 incomplete 65-week breaches for August 2023, an increase of 182 from July's 2023's 2,187.

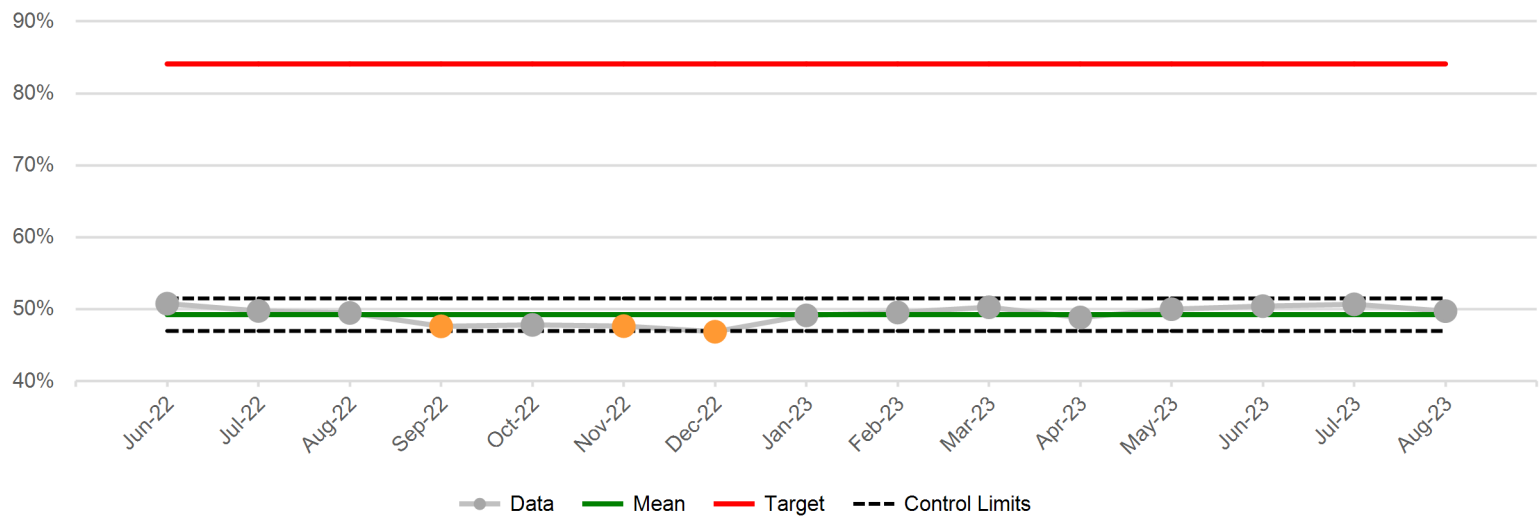
Issues:
ULHT's position is strong with 104 week wait patients, with one patient reported for August. As shown above, 65 week waiters are negatively performing against trajectory. Both admitted and non-admitted patients sit within this wait band, however, the most significant pressure is in the non-admitted pathways. The doctor's ongoing industrial action continues to have a detrimental effect on performance

Actions:
Incomplete patient pathways are discussed with individual specialities weekly, through the PTL meeting.
This meeting is currently under review to assess effectiveness and to improve the monitoring of patient pathways.

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

Performance Overview - Operational Performance

18 week incompletes



Aug-23
49.75%
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. August 2023 saw RTT performance of 49.75% against an 84.1% target, which is 0.96% down from July 2023.

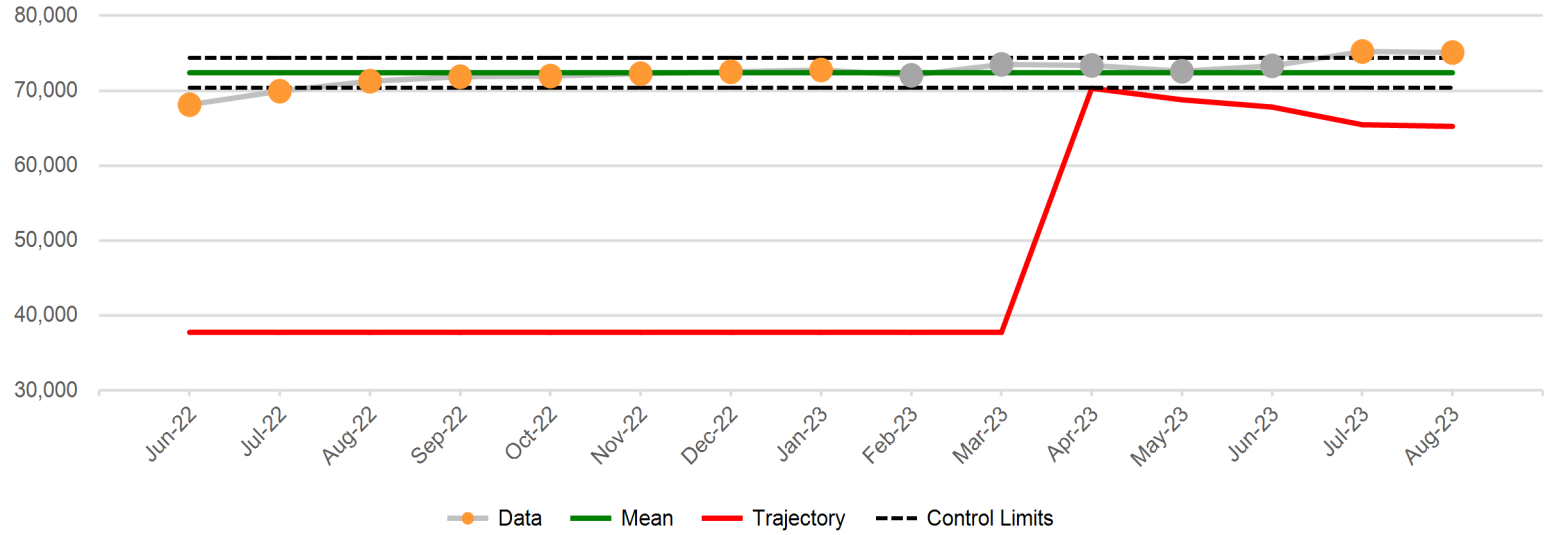
Issues:
Performance is currently below trajectory and standard. The five specialties with the highest number of 18 week breaches at the end of the month were:
ENT – 6681 (increased by 271)
Gastroenterology – 3400 (decreased by 199)
Gynaecology – 2794 (increased by 76)
Ophthalmology – 2622 (increased by 128)
Dermatology – 2545 (increased by 112).

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 November. Resource is targeted at patients who have the potential to be >78 weeks.
Schemes to address the backlog include;
1. Validation programme
2. Outpatient utilisation
3. Tertiary capacity
4. Outsourcing/Insourcing
5. Use of ISPs
6. Missing Outcomes

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

Performance Overview - Operational Performance

Waiting List Size



Aug-23
75,098
Variance Type
Special cause variation - cause for concern (Indicator where high is a concern)
Trajectory
65,241
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 July 2023, with August showing a decrease of 140 to 75,098
This is more than double the pre-pandemic level reported in January 2020.

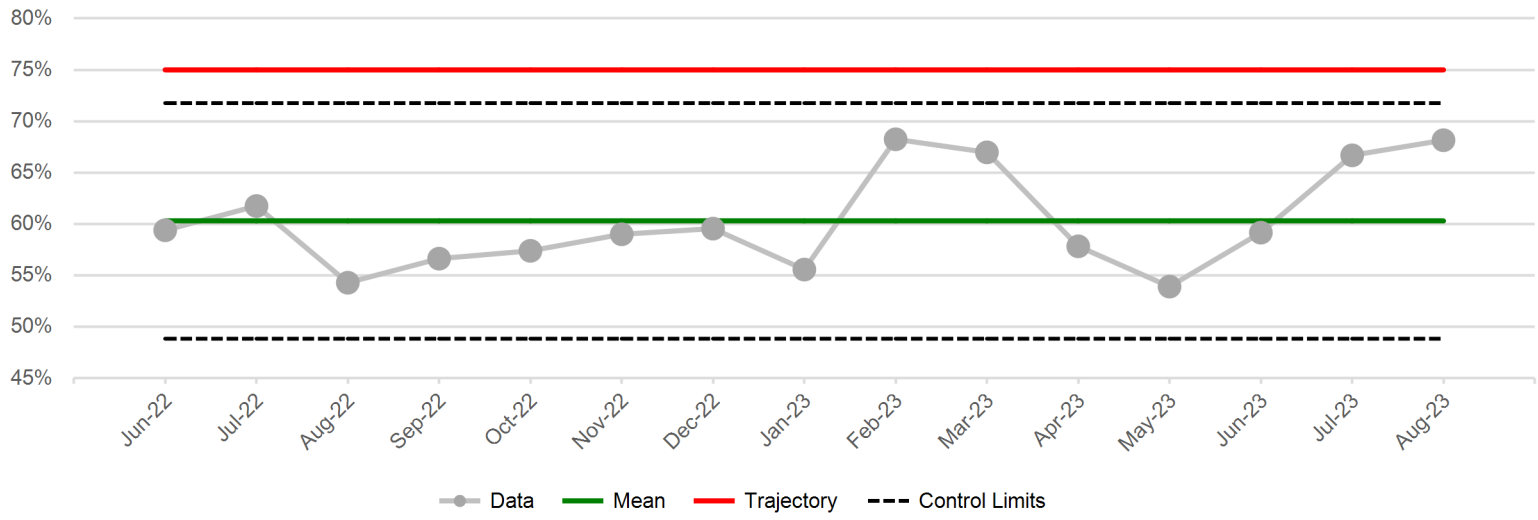
Issues:
Following the backlog increase from the pandemic, there have been additional pressures that have affected capacity, including; COVID sickness, urgent care pressures and Industrial Action.
The five specialties with the largest waiting lists are;
ENT – 10,176
Ophthalmology – 6,459
Gynaecology – 5,800
Gastroenterology – 5,680

Actions:
Improvement programmes as described above for RTT performance. In addition, all patients >52 weeks are monitored weekly by the Trusts RTT team. Phase 1 of the validation programme continues and Phase 2, the administrative review now signed off at TLT will start once their recommended changes have been implemented. The Integrated Elective Care Co-Ordination Programme is in the planning stages of implementation for use with the non-admitted waiting list.

Mitigations:
The number of patients waiting over 78 weeks has increased by 7 from July. There is a 78 week cohort meeting between the ICB and ULHT to monitor progress against target which takes place 3 times a week. Appropriate admitted and non-admitted patients continue to be transferred out to ISP's or insourced, with an established process for this now in place for several specialties.

Performance Overview - Operational Performance

28 days faster diagnosis



Aug-23
68.16%
Variance Type
Common cause variation
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.

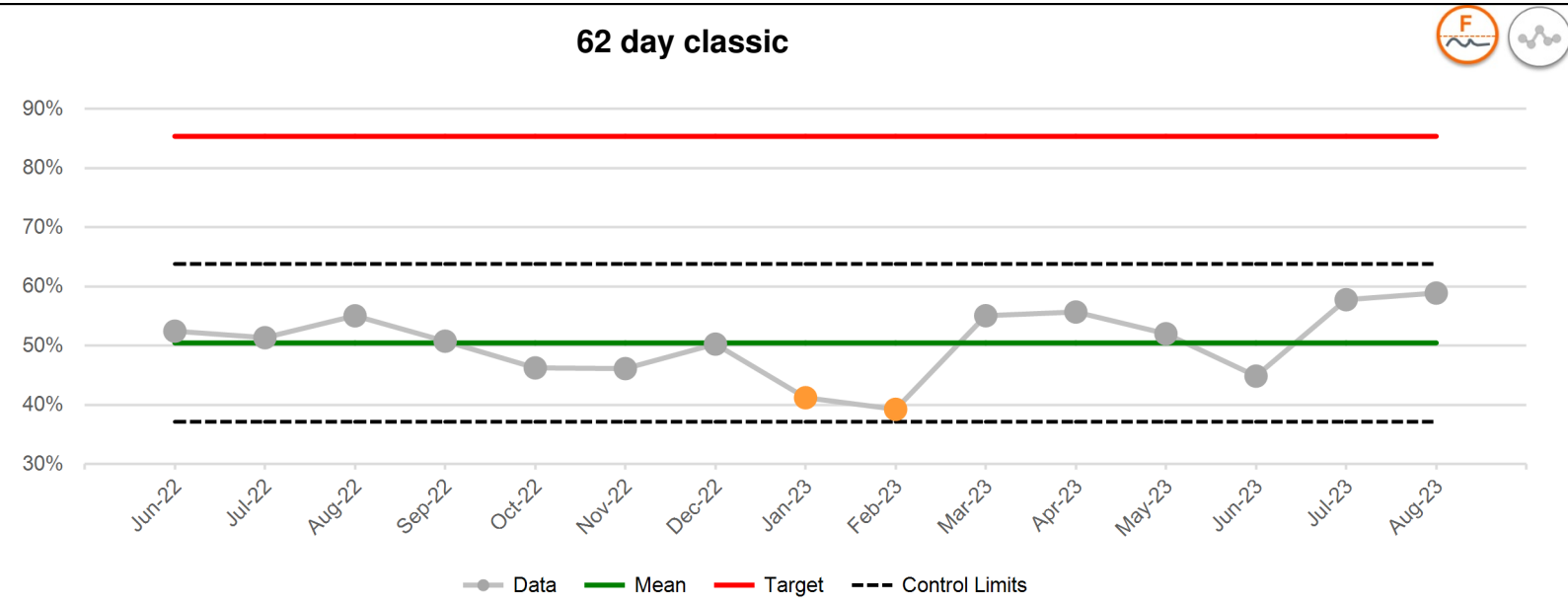
What the chart tells us:
We are currently at 68.16% against a 75% target.

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.
NHSE led target to achieve 72.5% compliance by end of 2023 and 75% by the end of March 2024.

Actions:
(Please also see Actions on 2ww suspected cancer page)
Recruitment is underway in Respiratory, ENT and Haematology specialties to improve Consultant availability and clinical review capacity.
Theatre and capacity for diagnostics in Urology – Diagnostic capacity for TPGA at Louth will be in place from October 2023. A review of the Bladder pathway is being supported by the ICB.
Radiology – Bed capacity for Interventional Radiology patients at PHB. Development of OR theatre recovery unit to allow the service to recover its own patients. Constant shortfall of CTC reporting sessions (10 sessions needed, currently running 6-7).
Meetings regarding MDT streamlining support and processes for the Lung, Breast and Upper GI specialties are underway.

Mitigations:
(Please also see Mitigations on 2ww suspected cancer page)
A process is now in place to ensure the Pre-Diagnosis CNS is made aware of patients who are likely to be non-compliant or in need of support at the time of receipt of referral to allow for early intervention / support.
The radiology clinical lead is looking at job plans to support and improve CTC reporting capacity with another radiologist in training to report CTCs.
In Medicine, the EBUS and EUS BC has been stalled due to workforce challenges, but the CBU will explore interim measures.
In order to address GA hysteroscopy and truclear capacity on the gynae pathway, staff training is in place to introduce extra capacity at GK.

Performance Overview - Operational Performance



Aug-23
58.91%
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 58.91% against an 85.4% 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 – Recruitment is ongoing to secure NHS fixed term locums. One Medical Oncologist (fixed term) has been recruited and a start date is to be confirmed. The post offered for Oncology Sp Dr is awaiting the PLAB2 exam (passed PLAB 1). 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.

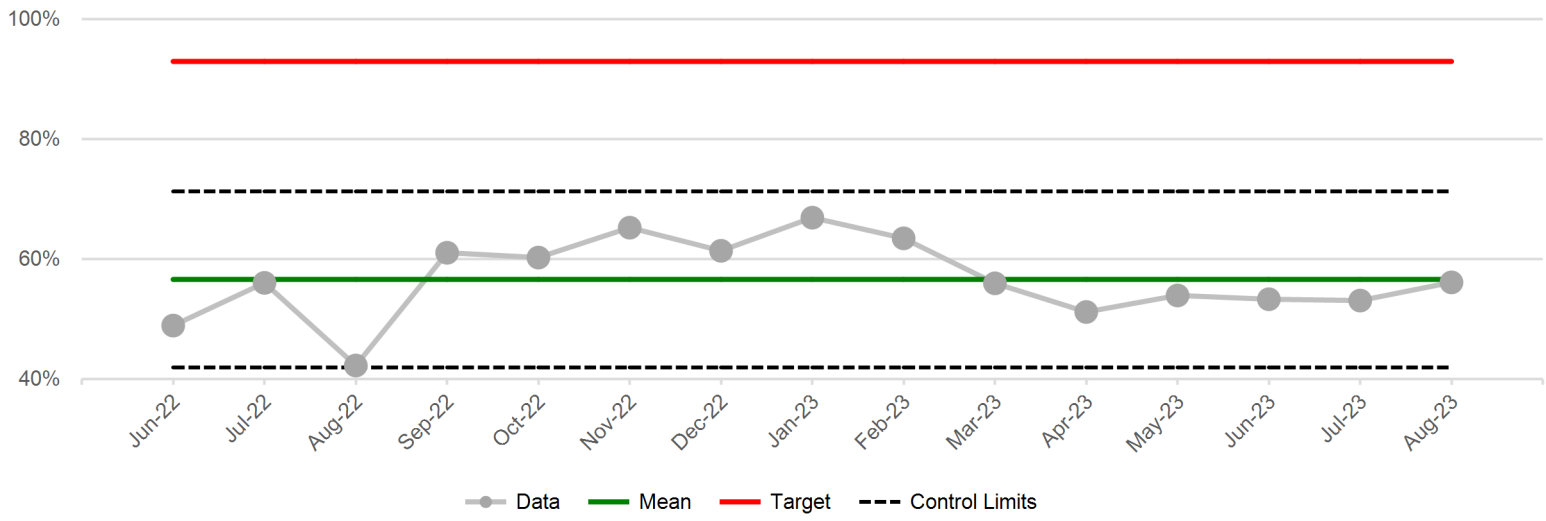
Please also see Actions on accompanying pages.

Mitigations:
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



Aug-23
56.16%
Variance Type
Common cause variation
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 56.16% 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 26% of the Trust's August 14 Day breaches within that tumour site.
Also of concern was skin performance which accounted for 42% of the Trust's 14 day breaches. The Gynae tumour site accounted for 15% of June breaches.

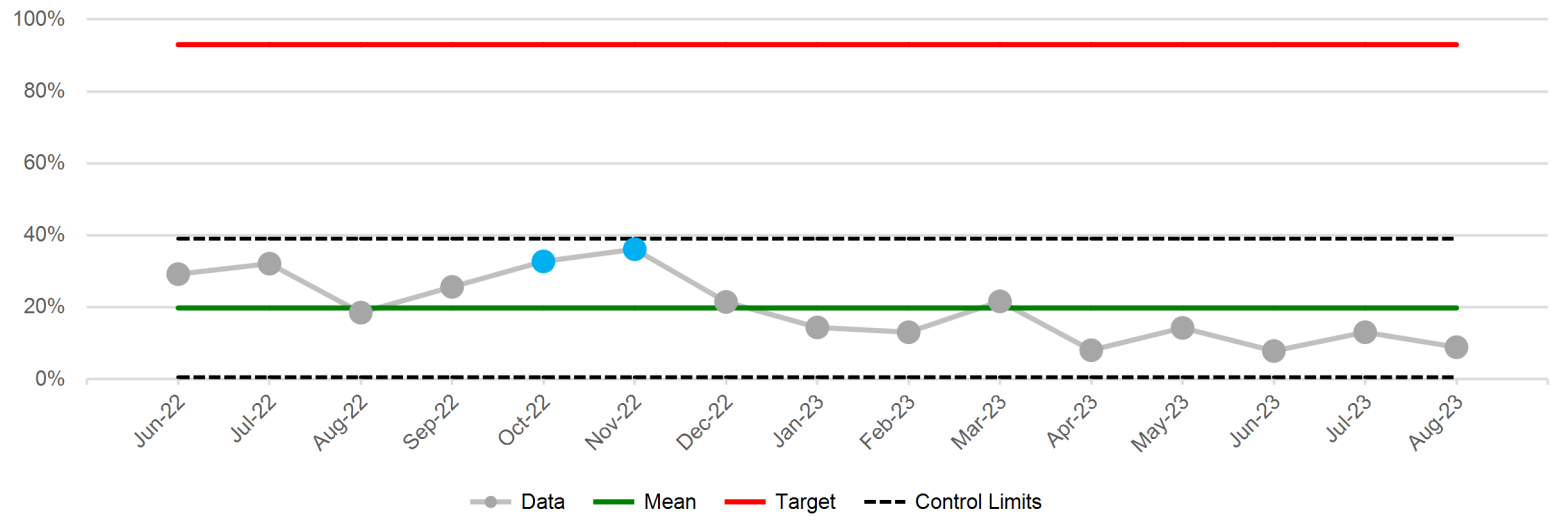
Actions:
The Radiology Recruitment Strategy and intensive support meetings are in place to address the fragile Breast Service One-Stop appointment alignment issues.
Respiratory Consultant capacity is a continuing issue and the consultant recruitment drive is ongoing as well as the BC for an increase in consultant workforce to 10-15 consultants. 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.
The UGI Triage CNS post to support the start of UGI pathway is currently awaiting an interview date to be confirmed. . ICB EACH are providing 3 months support with 2ww referrals to reduce the delays from receipt of referral to STT booking.

Mitigations:
Haematology is in fragile services due to vacancy/capacity. Issues with inappropriate referrals and GP engagement continue to be escalated and supported by the ICB. Delays in the booking and utilisation of appointment slots which continue to be addressed with C&A.
In Gynae, the urgent PMB pathway was implemented in August and the pathway improvement this is expected to bring is being closely monitored.

Please also see Mitigations on accompanying pages.

Performance Overview - Operational Performance

2 week wait breast symptomatic



Aug-23
8.93%
Variance Type
Common cause variation
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 8.93% 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.

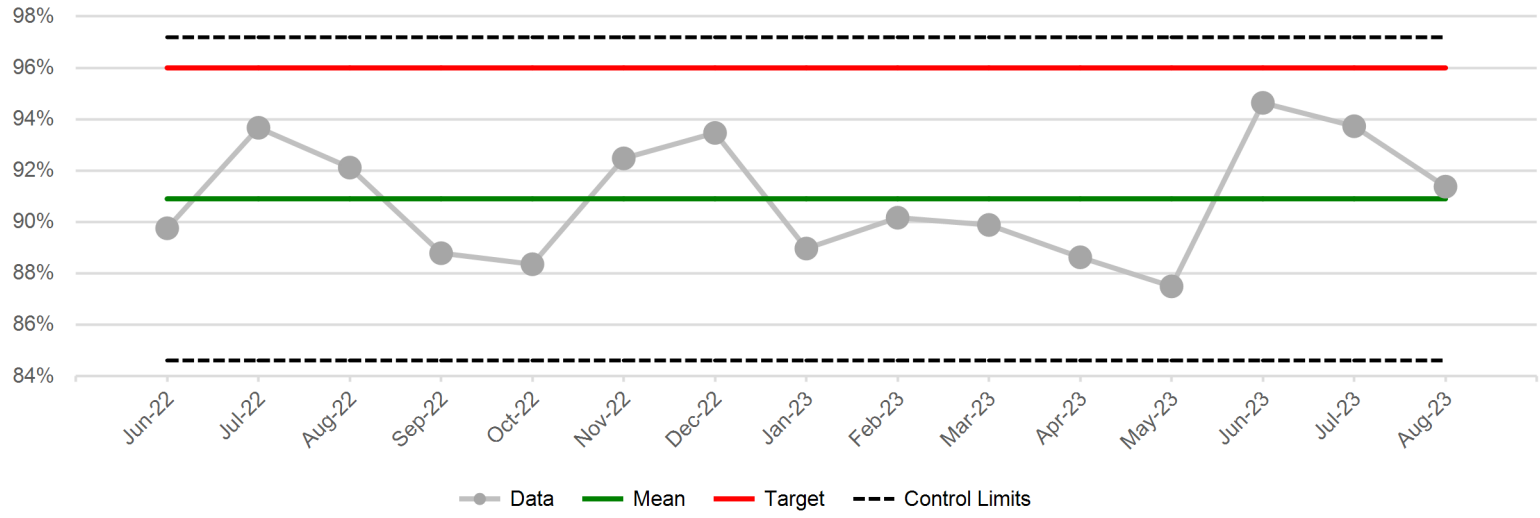
Actions:
A comprehensive review of Breast Services and consultant workload is ongoing.

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

31 day first treatment



Aug-23
91.38%
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 91.38% against a 96% target.

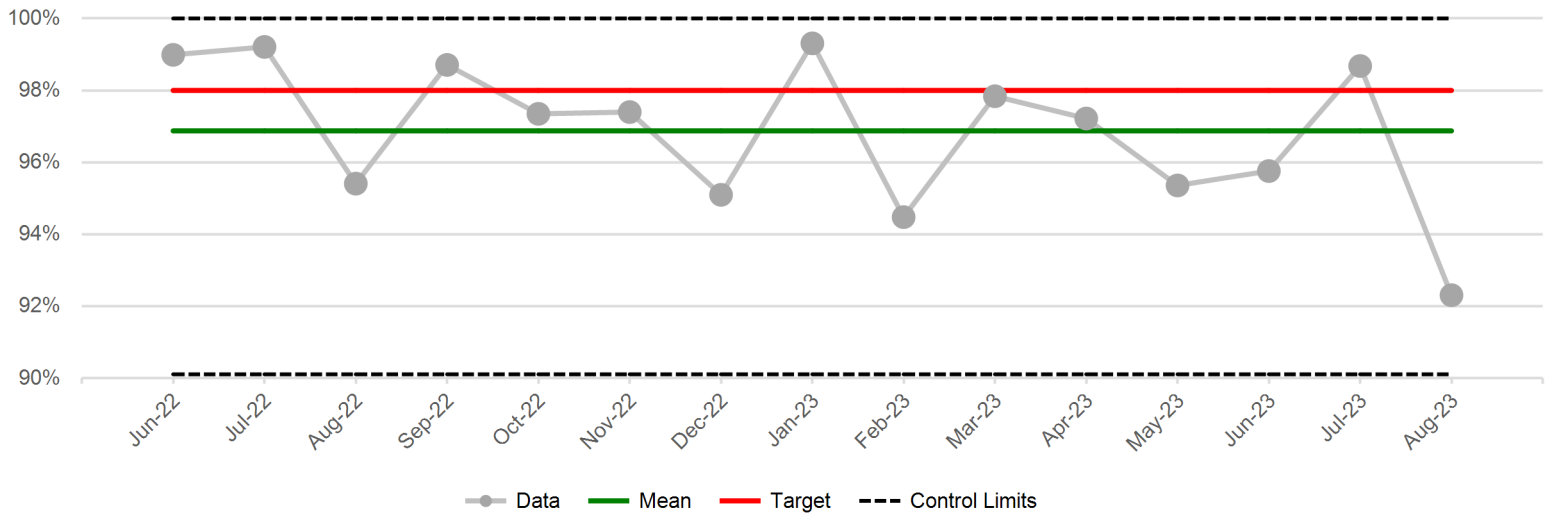
Issues:
The failure of the 31 Day standards was primarily attributed to limited theatre capacity and limited AA and pre-op capacity impacts the ability to be able to populate lists at short notice.
In Oncology, recent Linac breakdowns and pharmacy staffing shortages have resulted in delayed treatment start dates.

Actions:
Oncology Fragile Service – Recruitment is ongoing to secure NHS fixed term locums. One Medical Oncologist (fixed term) has been recruited and a start date is to be confirmed. The post offered for Oncology Sp Dr is awaiting the PLAB2 exam (passed PLAB 1). 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.
In Head and Neck, an ENT consultant has recently been recruited and a start date is pending. Locum consultant currently taking on non-cancer Thyroid cases to release capacity for cancer.

Performance Overview - Operational Performance

31 day subsequent drug treatments



Aug-23
92.31%
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.

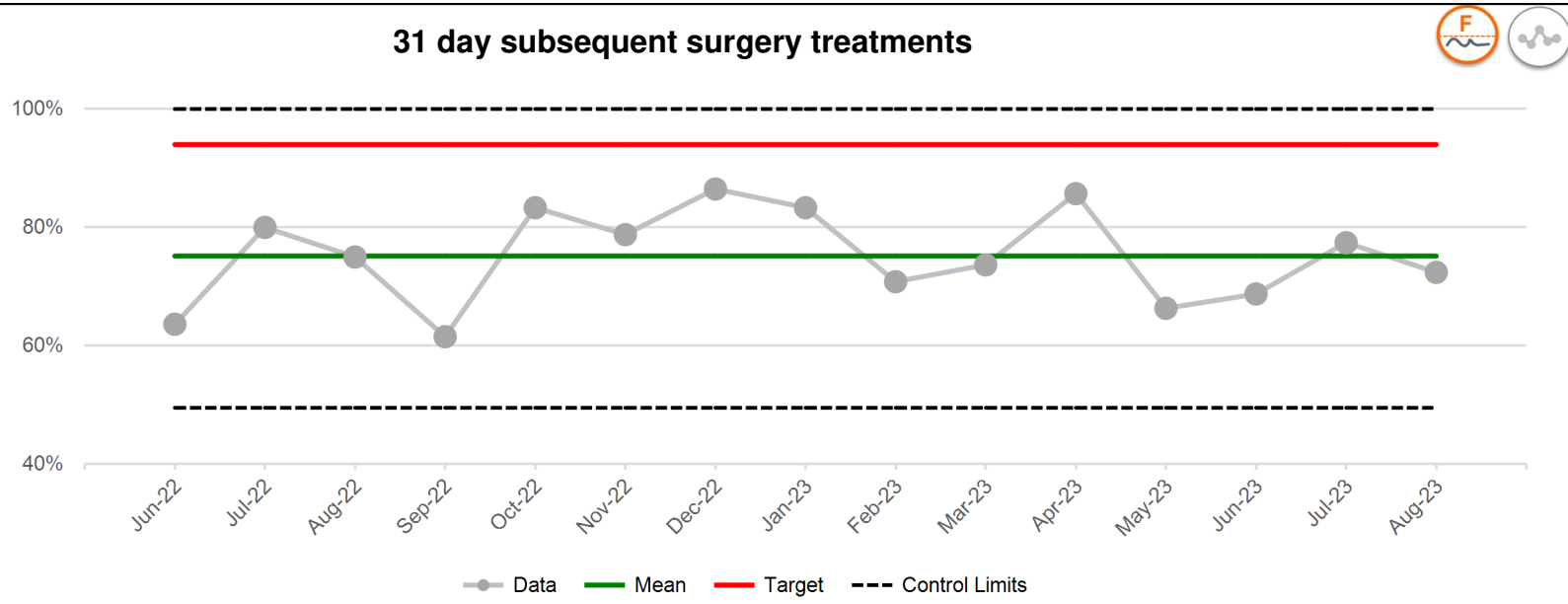
What the chart tells us:
We are currently at 92.31% against a 94% target.

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

Actions:
Oncology Fragile Service – Recruitment is ongoing to secure NHS fixed term locums. One Medical Oncologist (fixed term) has been recruited and a start date is to be confirmed. The post offered for Oncology Sp Dr is awaiting the PLAB2 exam (passed PLAB 1). A piece of work on right-sizing the Oncology service workforce has commenced.

Mitigations:

Performance Overview - Operational Performance



Aug-23
72.41%
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.

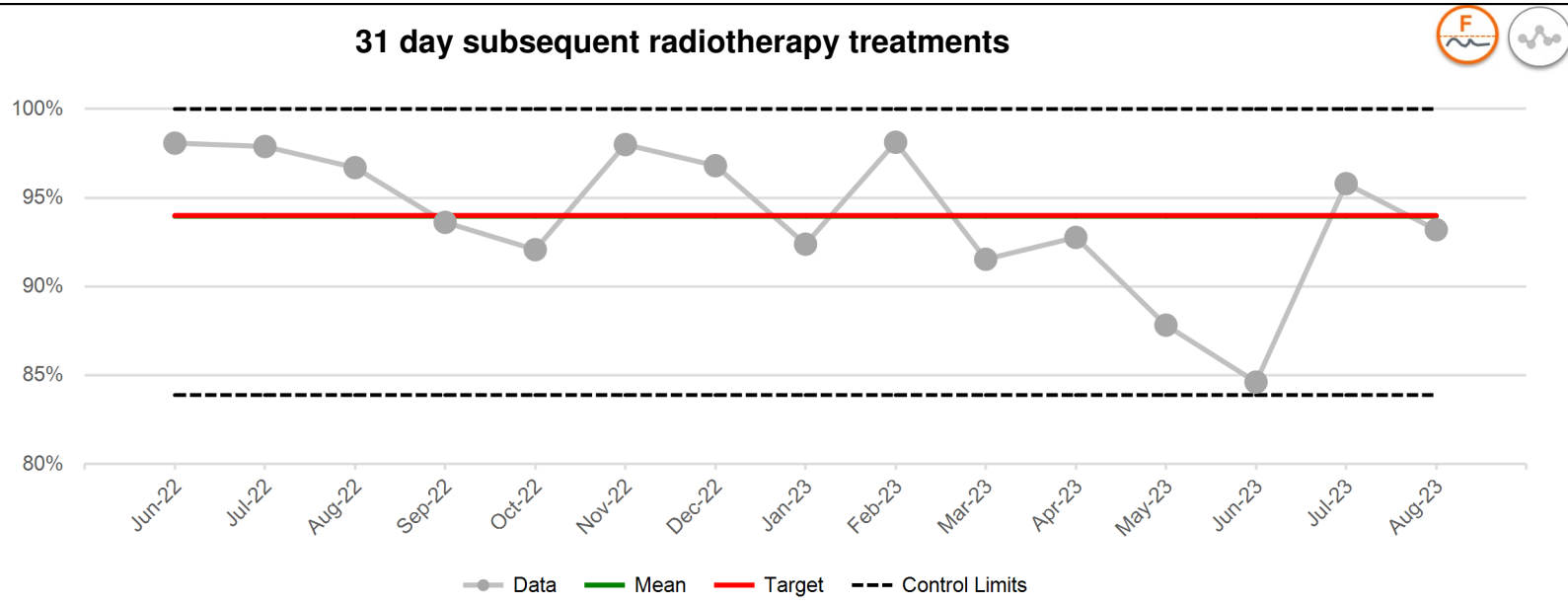
What the chart tells us:
We are currently at 72.41% against a 94% target.

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.

Actions:
Tumour site specialties are working with TACC to ensure the best possible utilisation of lists, including a process for last minute cancellations.

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.
In Head and Neck, an ENT consultant has recently been recruited and a start date is pending. Locum consultant currently taking on non-cancer Thyroid cases to release capacity for cancer.

Performance Overview - Operational Performance



Aug-23
93.20%
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 radiotherapy.

What the chart tells us:
We are currently at 93.20% against a 94% target.

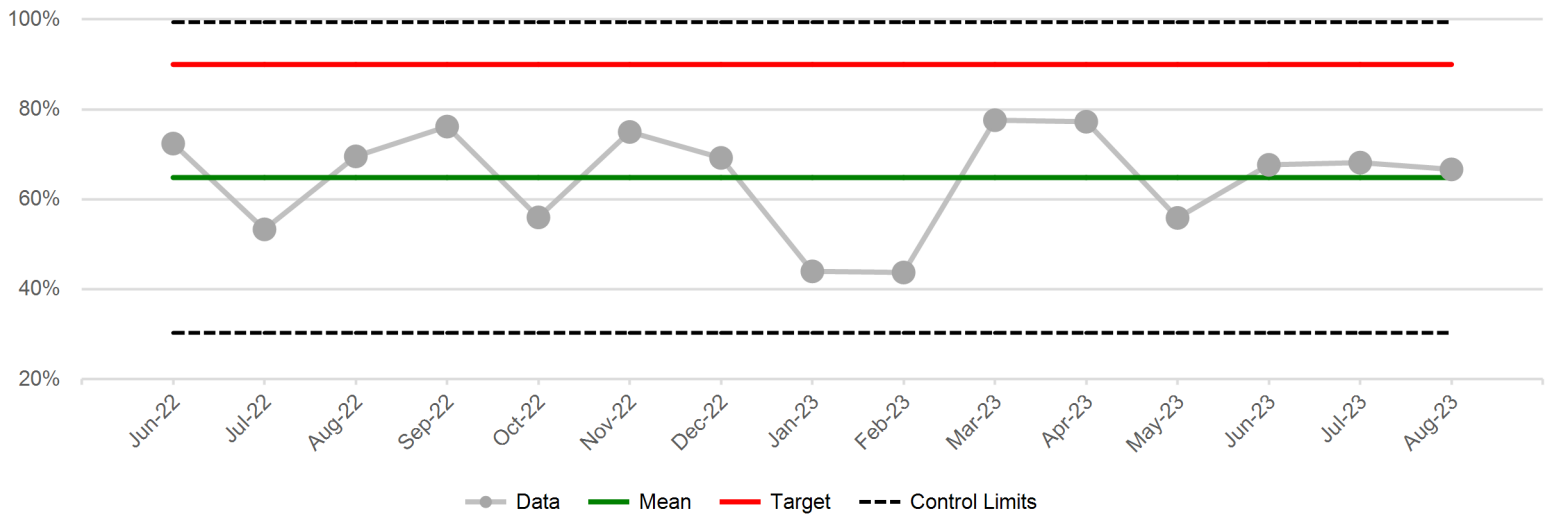
Issues:
Radiotherapy – Recent Linac breakdowns have resulted in delayed treatment start dates.

Actions:
Oncology Fragile Service – Recruitment is ongoing to secure NHS fixed term locums. One Medical Oncologist (fixed term) has been recruited and a start date is to be confirmed. The post offered for Oncology Sp Dr is awaiting the PLAB2 exam (passed PLAB 1). A piece of work on right-sizing the Oncology service workforce has commenced.

Mitigations:

Performance Overview - Operational Performance

62 day screening



Aug-23
66.67%
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 66.67% 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.

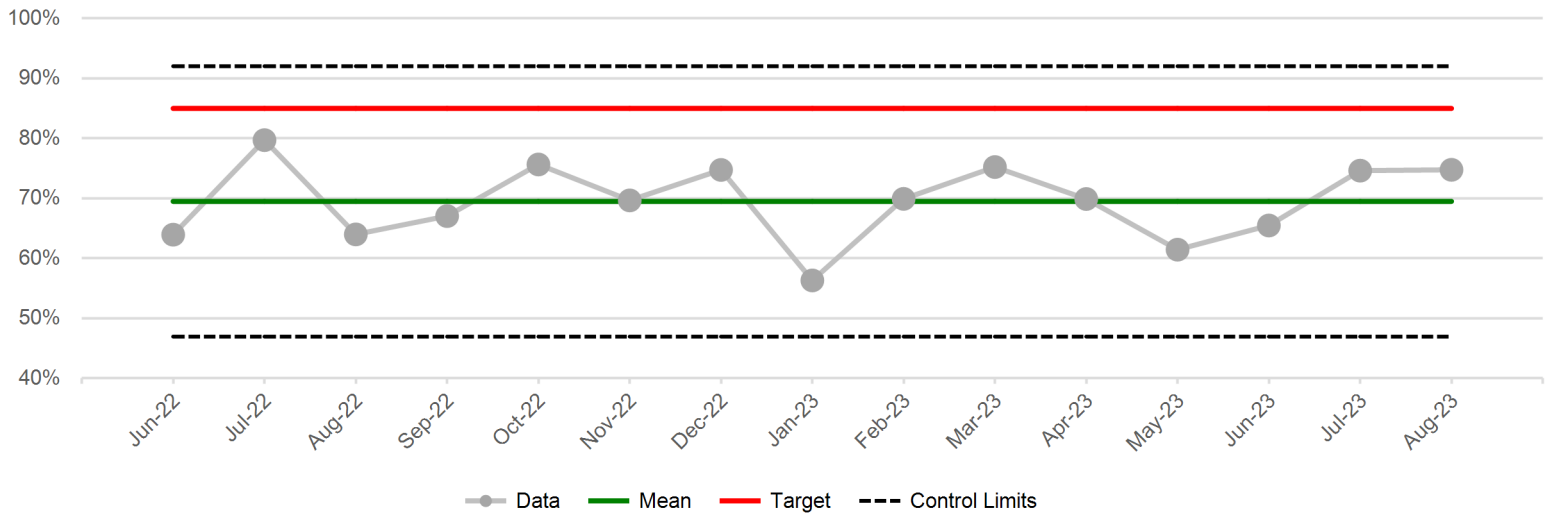
Please also see Issues on accompanying pages.

Actions:
Oncology Fragile Service – Recruitment is ongoing to secure NHS fixed term locums. One Medical Oncologist (fixed term) has been recruited and a start date is to be confirmed. The post offered for Oncology Sp Dr is awaiting the PLAB2 exam (passed PLAB 1). 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

62 day consultant upgrade



Aug-23
74.77%
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 74.77% against an 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.

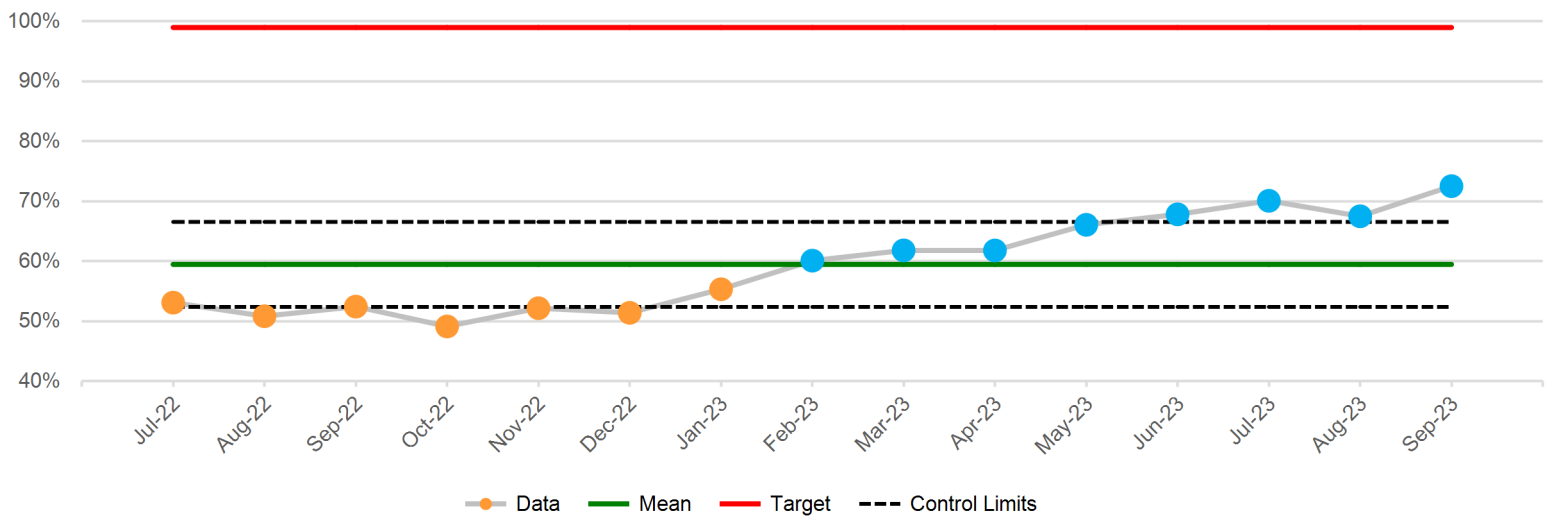
Actions:
Oncology Fragile Service – Recruitment is ongoing to secure NHS fixed term locums. One Medical Oncologist (fixed term) has been recruited and a start date is to be confirmed. The post offered for Oncology Sp Dr is awaiting the PLAB2 exam (passed PLAB 1). A piece of work on right-sizing the Oncology 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

Diagnostics achieved



Sep-23
72.54%
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:
72.54% against the 99.00% target.

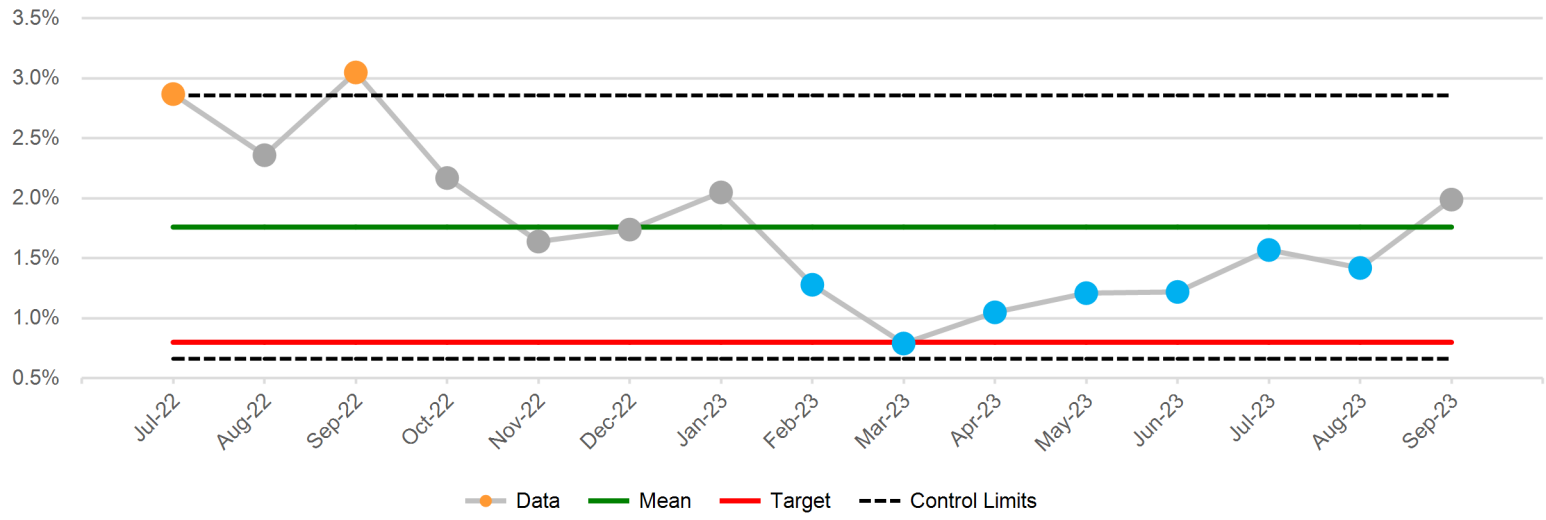
Issues:
The majority of diagnostic breaches sit in Cardiac Echo with 3068 breaches recorded in August. MRI has 816 breaches. Additional outsourcing to help reduce the backlog from January 2023. There has been an increase in Primary care demand. There is 208 Dexa Breaches as the scanner is now up and running, we should see a reduction of around 50 breaches each month due to increase in demand and staff vacancy.
Additional to the 3199 cardiac echoes there are 52 Stress/TOES and 142 echo-paediatrics.
Non-obstetric ultrasound had 445 due to annual leave and sickness with staff, also booking issues that are being addressed by the Radiology Operational Manager.

Actions:
Where demand out strips capacity additional resource is being sort. All areas have completed a recovery trajectory to NHSE. These will now be affected by the 78 weeks work. Additional lists are being undertaken for Cardiac echo and a reduction should be seen in the backlog going forward. MRI has additional outsourcing from January. Dexa steadily reducing as expected each month as now up and running.

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

Performance Overview - Operational Performance

Cancelled Operations on the day (non clinical)



Sep-23
1.99%
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 during the month of September 2023.

What the chart tells us:
There has been an increase in the number of patients cancelled on the day from 1.42% in August to 1.99% in September which is significantly above the agreed trajectory of 0.8%.

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

1. No theatre staff (29)
2. Lack of time (13)

Actions:
Monitor times of attendance and liaise directly with colleagues where there are repetitive concerns. Ensure Trust guidelines for Covid positive staff are being followed.

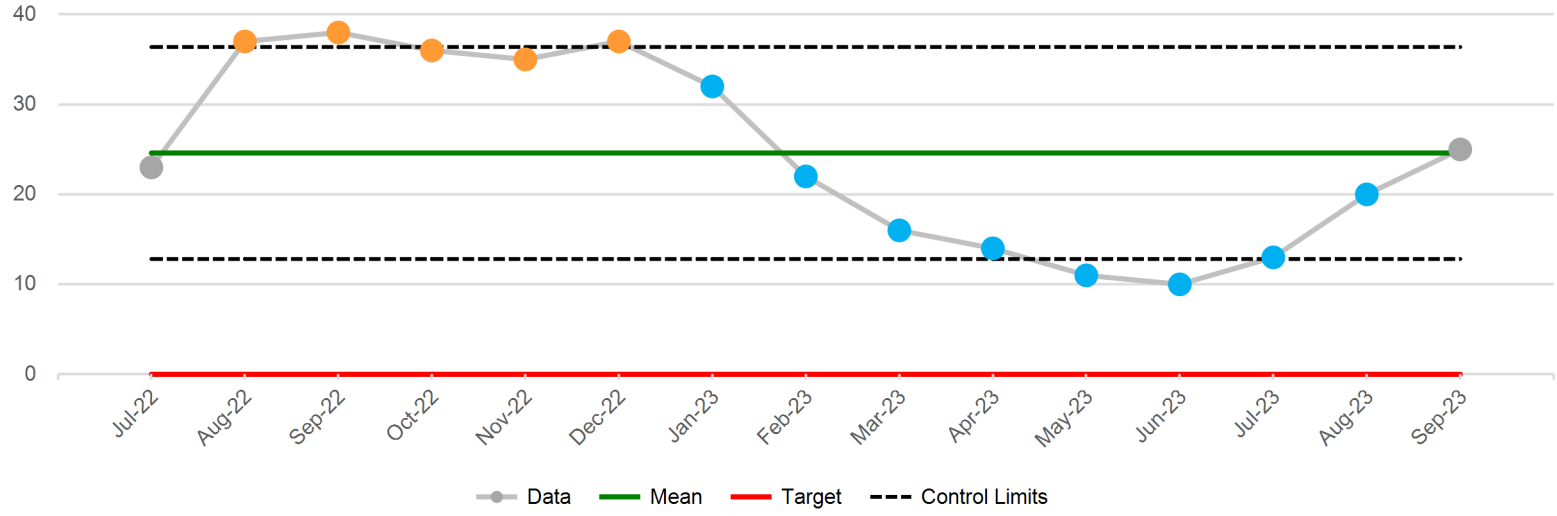
Ensure data is gathered regarding the reasons for lack of time and whether the list started on time. Theatre teams are aware of the importance of data quality.

Mitigations:
Staff were on sick leave with Covid and, had to remain off for 5 days if symptomatic.

High tier agency was not requested where a full team was needed as they cannot cover this at short notice. They may have provided 1 or 2 HCPs which would have resulted in a cost to the Trust, but would not have facilitated a list

Performance Overview - Operational Performance

Not treated within 28 days. (Breach)



Sep-23
25
Variance Type
Common cause variation
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:
There has been a significant increase in September from 20 in August to 25 and therefore the agreed target of zero has still not been achieved.

Issues:
A high number of list cancellations due to industrial action across both our consultant and junior workforce saw reduced capacity to re-date.

Theatre staffing sickness meant a significant number of patients were cancelled on the day.

Actions:
Continued and focused improvement in utilisation of all 6 theatres at our Elective Hub is increasing capacity.

CBUs to identify surgeon availability for additional lists to support.

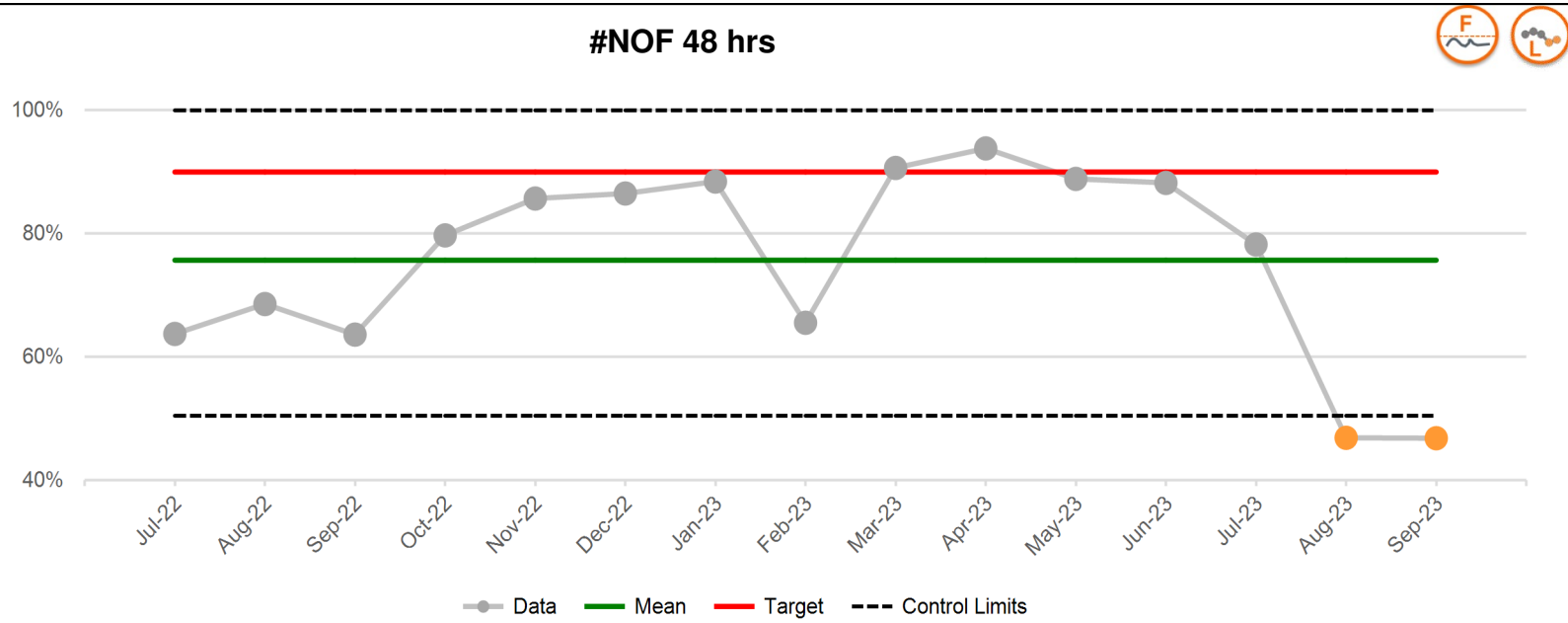
Mitigations:
Improved 642 and use of the care co-ordination solution means planned utilisation is increasing across many lists.

Staff sickness was at a significant high due, in the main to COVID, which meant a high number of cancellations. This is unusual and should be improved in October.

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Hospitals NHS Trust



Sep-23
46.84%
Variance Type
Special cause variation - cause for concern (Indicator where low is a concern)
Target
90.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
The trust have had a significant decline in the compliance for NOFs going to theatre within 48 hours
The average percentage across both sites for September is 46.84%
34 fractured neck of femur patients did not go to theatre within 48 hours of admission due to not having enough theatre capacity.

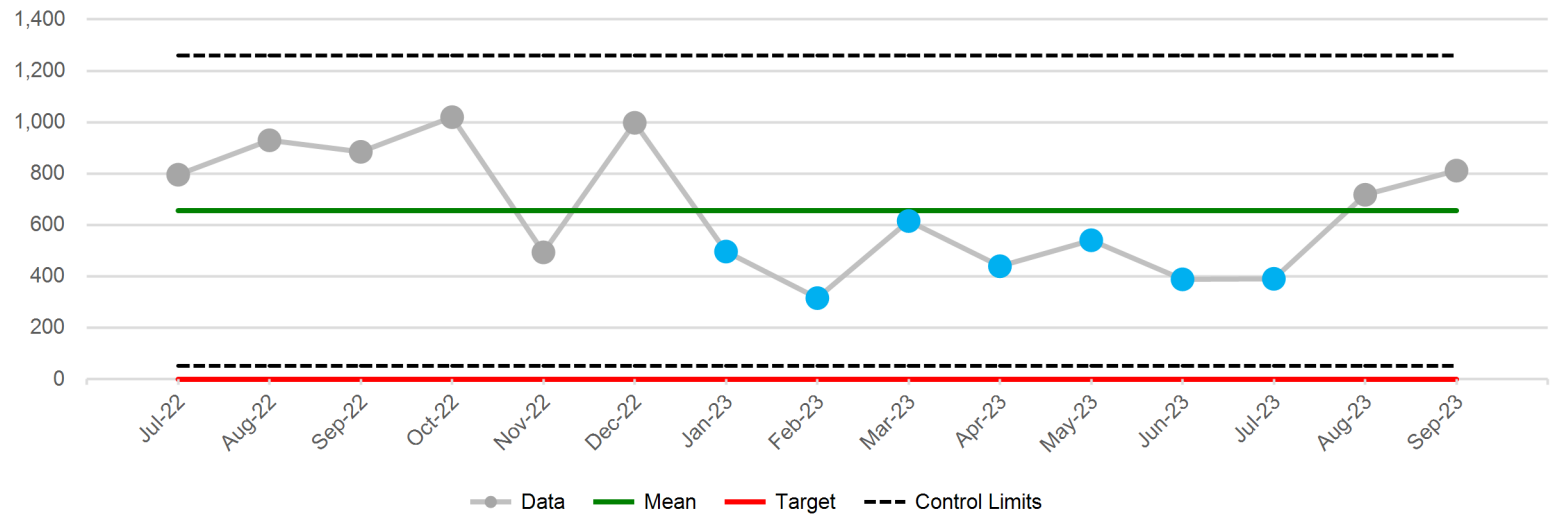
Issues:
1. Lack of theatre space to accommodate Femur fractures.
2. ULHT continue to have a high demand of trauma patients admitted with one trauma list planned daily on both sites.
3. Due to increase in trauma demand and the types of injuries seen, certain procedures have been clinically prioritised ahead of fractured femur patients.
4. Specialty trauma lists on Boston and Lincoln sites not having capacity to add trauma patients.
5. Lack of theatre staff to provide additional trauma capacity.
6. ULHT breaching the NHFD best practice tariff for femur fractures.

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

Mitigations:
1. Ensure trauma lists are fully optimised.
2. Reduce 'on the day' change in order of the trauma list where clinically appropriate.
3. 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.
4. Once daily additional CBU review of trauma and plans to ensure capacity maximised for clinical priority.

Performance Overview - Operational Performance

EMAS Conveyances Delayed >59 mins



Sep-23
812
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:
September demonstrated a declined performance to that seen in August 23, with an increase of 94.
What the chart doesn't tell us is the continued increase in conveyances throughout this year, with 12.16% more than September 2022.

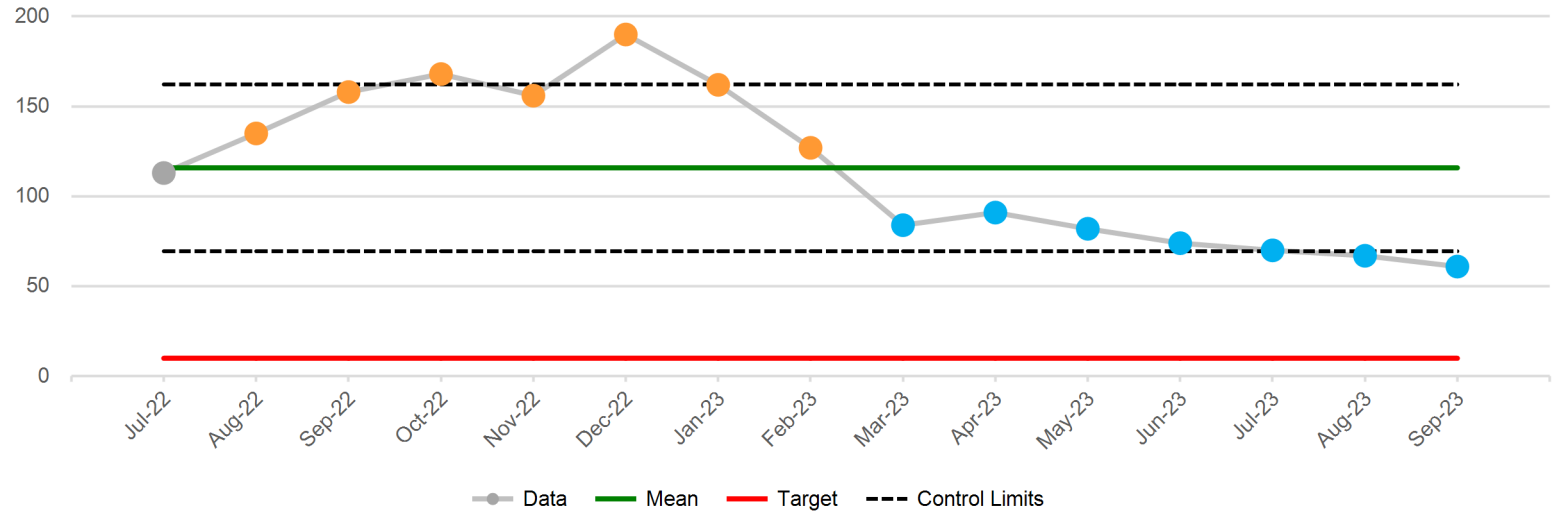
Issues:
The pattern of conveyance and prioritisation of clinical need contributes to the delays.
Increased conveyances continue to profile into the late afternoon and evening coincides with increased 'walk in' attendances causing a reduce footprint to respond to timely handover.
An increasing number of category 1 and 2 patients being conveyed.
Inadequate flow and sub-optimal discharges continue to result in the emergency departments being unable to completely de-escalate due to a number of patients waiting for admission, although this number reduced.

Actions:
All ambulances approaching 30 minutes without a plan to off load is escalated to the Clinical Site Manager and then in hours Tactical Lead to secure a resolution and plans to resolve are feedback to the DOM. Out of hours, the responsibility lies with the Tactical on Call Manager.
Daily messages to EMAS crews to sign post to alternative pathways and reduce conveyances to the acute setting.
Active monitoring of the EMAS inbound screen to ensure the departments are ready to respond.
The rapid handover protocol has now been revisited and agreed. Designated escalation areas have been identified/confirmed to assist in reducing delays in handover.

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

104+ Day Waiters



Sep-23
61
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 12th October the 104 Day backlog is at 61 patients.

There are two main tumour sites of concern:-

Colorectal 20
Lung 10

Issues:
The impact of ongoing pathway, staffing and capacity challenges.
Patients not willing to travel to where our service and / or capacity is available.
Reduced OP, diagnostic and theatre capacity across the Trust, all Specialties vying for additional sessions.
Managing backlogs significantly in excess of pre-COVID levels for Colorectal, Upper GI, Urology, Head & Neck, Gynaecology, and Lung.
Approximately 18% 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.

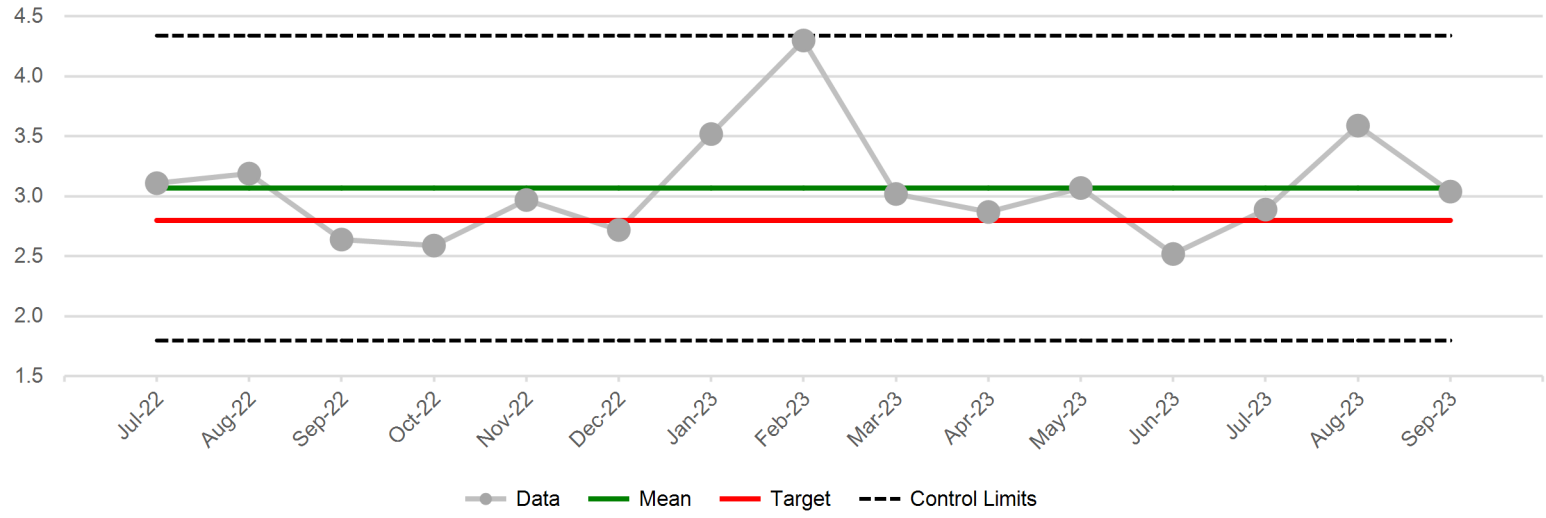
Actions:
Intensive Support Meetings in place to support Colorectal, Urology, Lung, Upper GI, Skin, Gynae and Breast recovery.

Please also see Actions on accompanying pages.

Mitigations:
Please also see Mitigations on accompanying pages.

Performance Overview - Operational Performance

Average LoS - Elective (not including Daycase)



Sep-23
3.04
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 decreased to 3.04 days compared to 3.59 days in August. This represents a negative variance of 0.24 days against the agreed target.

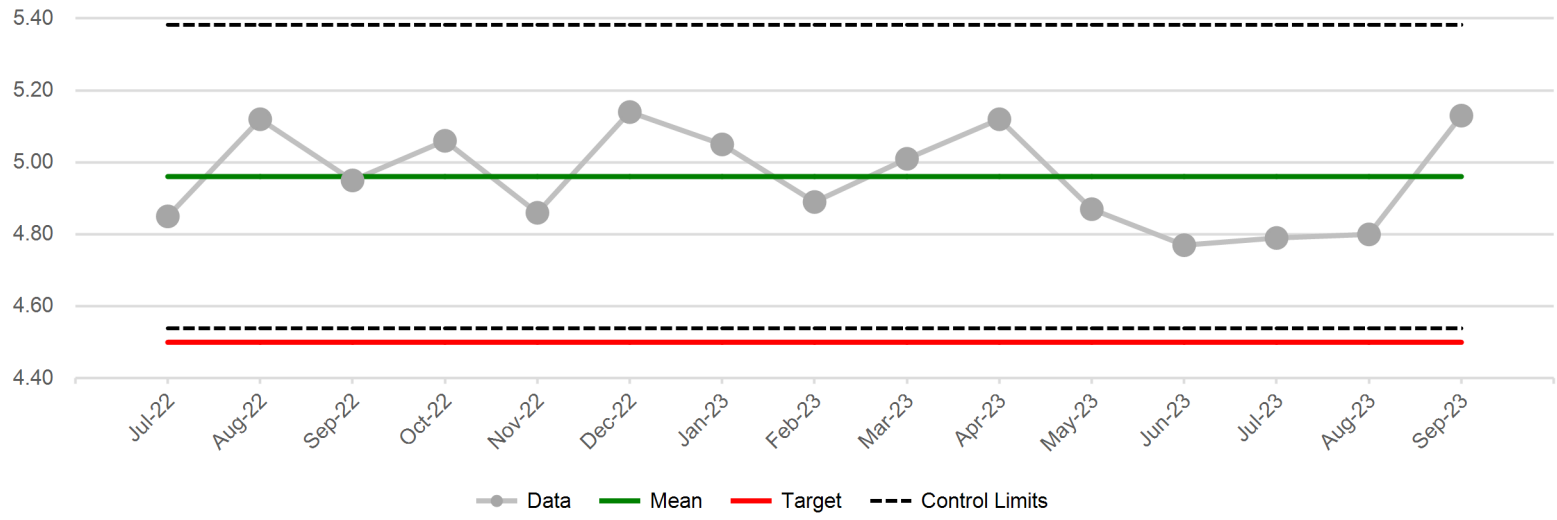
Issues:
Complexity of patients now being admitted which will impact on post-operative recovery and LOS.
Increase in Elective patients on pathways 1, 2 & 3.
Distorted figures associated with outliers in previous dedicated elective beds and coding.

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



Sep-23
5.13
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:
September performance of 5.13 is a decline of 0.33 days and a 0.63-day negative variance against the agreed target.
What the chart doesn't tell us is the decrease by pathway:
Pathway 0 (0.2) days
Pathway 1 (0.2) days
Pathway 2 (0.0) days
Pathway 3 improved by 0.7 days.

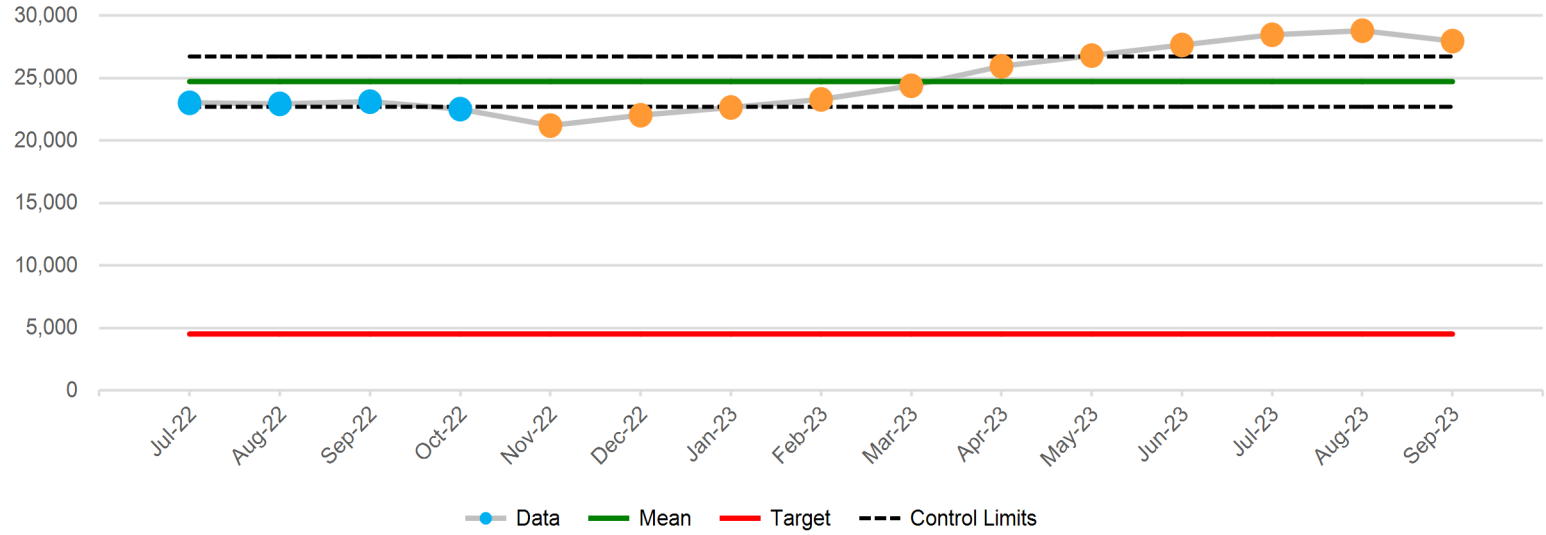
Issues:
Super stranded patients have seen a static performance compared to August daily average of 143 patients to September 146. Weekend Discharges remain consistently lower than weekdays with an average of 45% less than required to meet Emergency Admission Demand.
The Transfer of Care Hub continue to improve moving discharges forward at an improved pace.
Higher acuity of patients requiring a longer period of recovery.
Increased medical outliers and reduced medical staffing leading to delays in senior reviews.
Increased number of Industrial Strike activity has also lead to delayed discharge and impacted on improvement being realised with length of stay.

Actions:
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.
A new approach to SAFER and P0 discharges is being considered via URIG.

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

Partial Booking Waiting List



Sep-23
27,977
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.

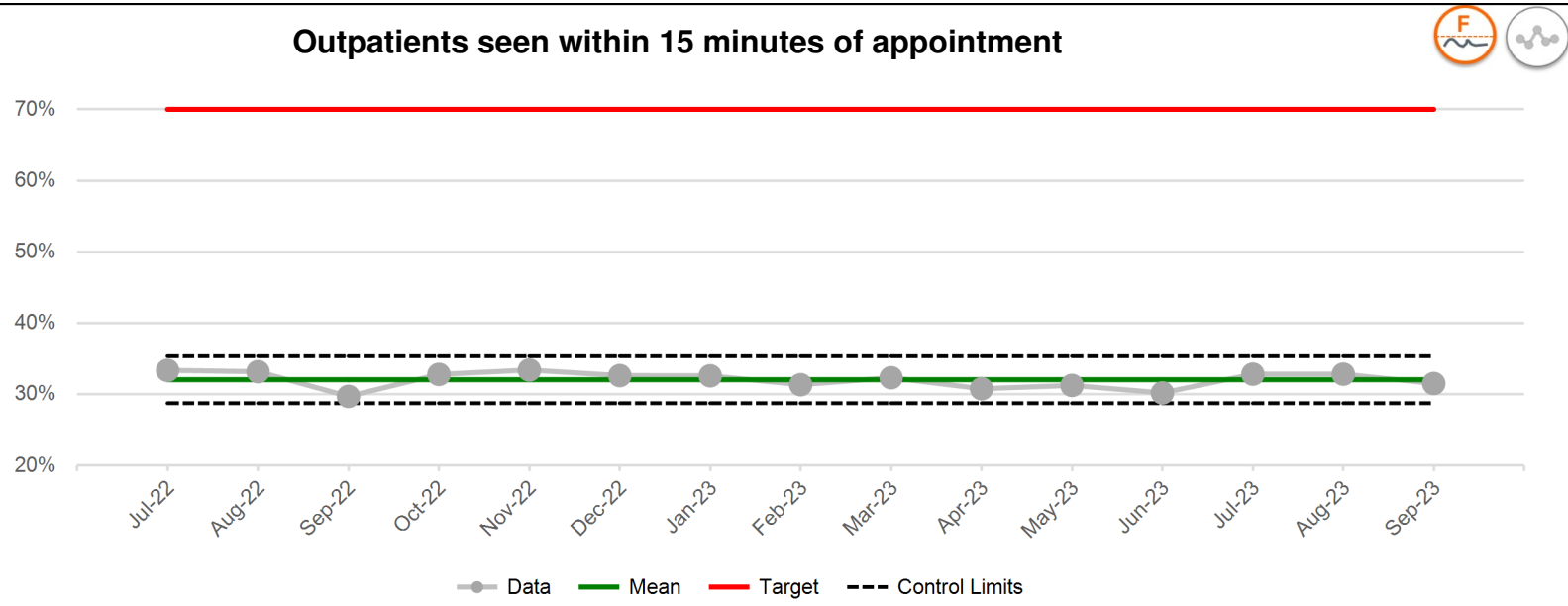
What the chart tells us:
We are currently at 27,977 against a target of 4,524. During Covid the number of patients overdue significantly increased with a slight dip in Nov 2022, since when it has continuously increased, however we have seen a slight reduction in Sept 2023.

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 industrial action and available capacity, rooms and resources.

Actions:
The PBWL meeting with the CBU's has been relaunched with a new agenda and template to improve attendance and focus. Discussions have started with CBU's regarding reducing the PBWL and reducing F/ups by 25%. PIFU continues to be an area of focus and uptake has increased. In Oct the team are reviewing the 642 process to improve outpatient 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 the industrial action plans, Personalised Outpatient Plan and supporting the booking of the 78 and 65 week cohort as a priority.

Performance Overview - Operational Performance



Sep-23
31.52%
Variance Type
Common cause variation
Target
70.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
Outpatients seen within 15 minutes of appointment.

What the chart tells us:
The percentage of patients seen within 15 mins has remained similar for the last 18 months.

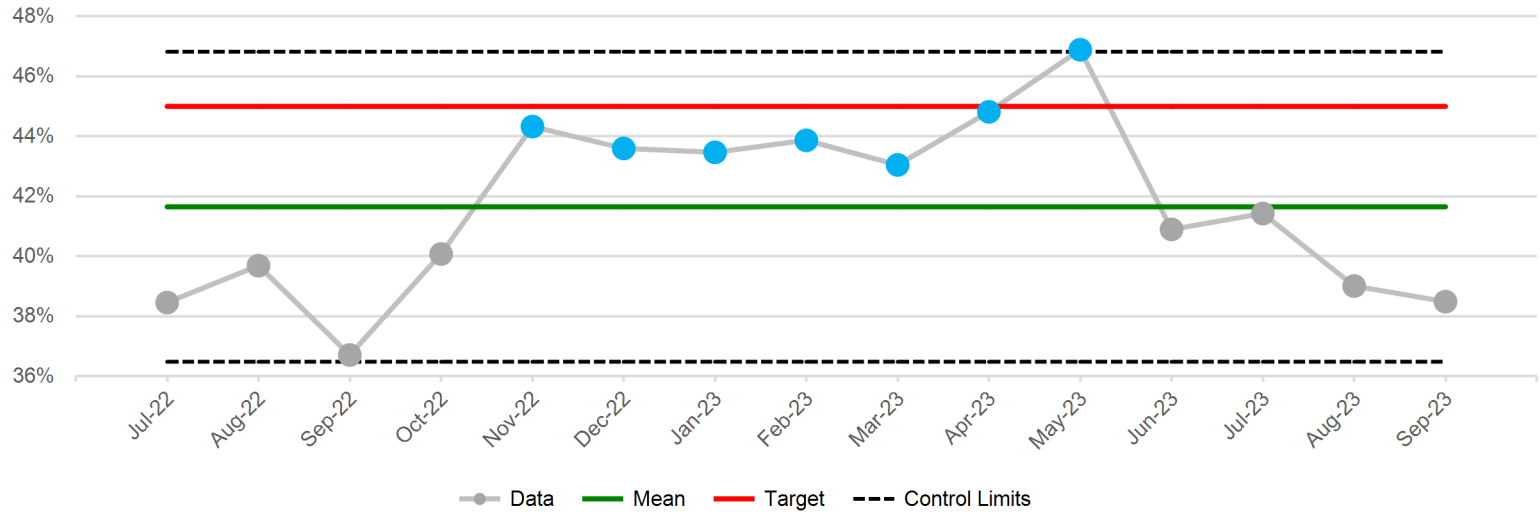
Issues:
The time seen is only recorded in approx. 10% of outpatient appointments. The interaction recorded is usually recorded by a HCA or RN for an interaction that takes place prior to a consultation.

Actions:
Further investigation, analysis and discussion needs to take place on the metric to fully understand the data and whether any actions or focus can take place to improve the performance.

Mitigations:
The data collection does not include all outpatient appointments. Further investigation needs to take place on the data source.

Performance Overview - Operational Performance

% discharged within 24hrs of PDD



Sep-23
38.49%
Variance Type
Common cause variation
Target
45.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
% of patients discharged within 24hrs of PDD.

What the chart tells us:
A deteriorating position from May 2023 after a period of stability and achievement of the 45% KPI. Since June 2023 performance has deteriorated and in September only 38.49% of patients were discharged within 24 hours of their Planned Date of Discharge as stated on Web V.

Issues:
- Limited intelligence regarding the data
- Web V Compliance has historically been low however this has improved in recent months due to targeted improvement work

Actions:
- Data to be provided at ward and Divisional level, by month, to allow analysis into causes for the deteriorating position.
- Understand if there is a correlation between improvement in Web V compliance and deterioration in PDD % within 24 hours

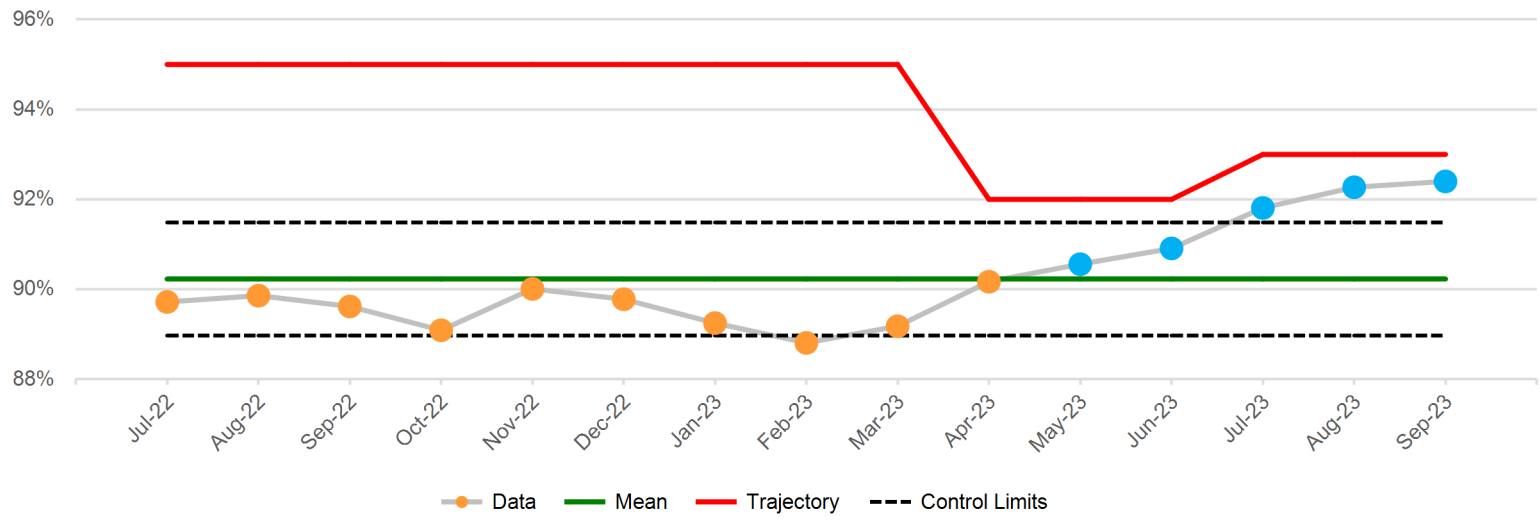
Mitigations:
Currently out to advert for x 4 B6 Clinical Coordinators SAFER. This role will support implementation of SAFER across a number of medical and trauma wards at Lincoln and Pilgrim. It is expected that this role will support and improvement in discharge planning.

Performance Overview - Workforce

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Jul-23	Aug-23	Sep-23	YTD	YTD Trajectory	Pass/Fail	Trend Variation
A Modern and Progressive Workforce	Overall percentage of completed mandatory training	Safe	People	Director of HR & OD	93.00%	91.81%	92.27%	92.40%	91.35%	92.50%	F	H
	Number of Vacancies	Well-Led	People	Director of HR & OD	7.00%	9.78%	9.68%	9.15%	8.66%	7.75%	F	
	Sickness Absence	Well-Led	People	Director of HR & OD	4.90%	5.61%	5.63%	5.60%	5.60%	5.05%	F	H
	Staff Turnover	Well-Led	People	Director of HR & OD	13.00%	12.21%	11.91%	11.44%	12.40%	13.00%	P	L
	Staff Appraisals	Well-Led	People	Director of HR & OD	80.00%	72.30%	72.66%	71.95%	70.13%	75.00%	F	H

Performance Overview - Workforce

Overall percentage of completed mandatory training



Sep-23
92.40%
Variance Type
Special cause variation - improvement (Indicator where high is good)
Trajectory
93.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of HR & OD

Background:
% completion is currently 92.40% against a Q2 target of 93.00%.

What the chart tells us:
Mandatory training compliance has seen an improvement to the previous month's position.

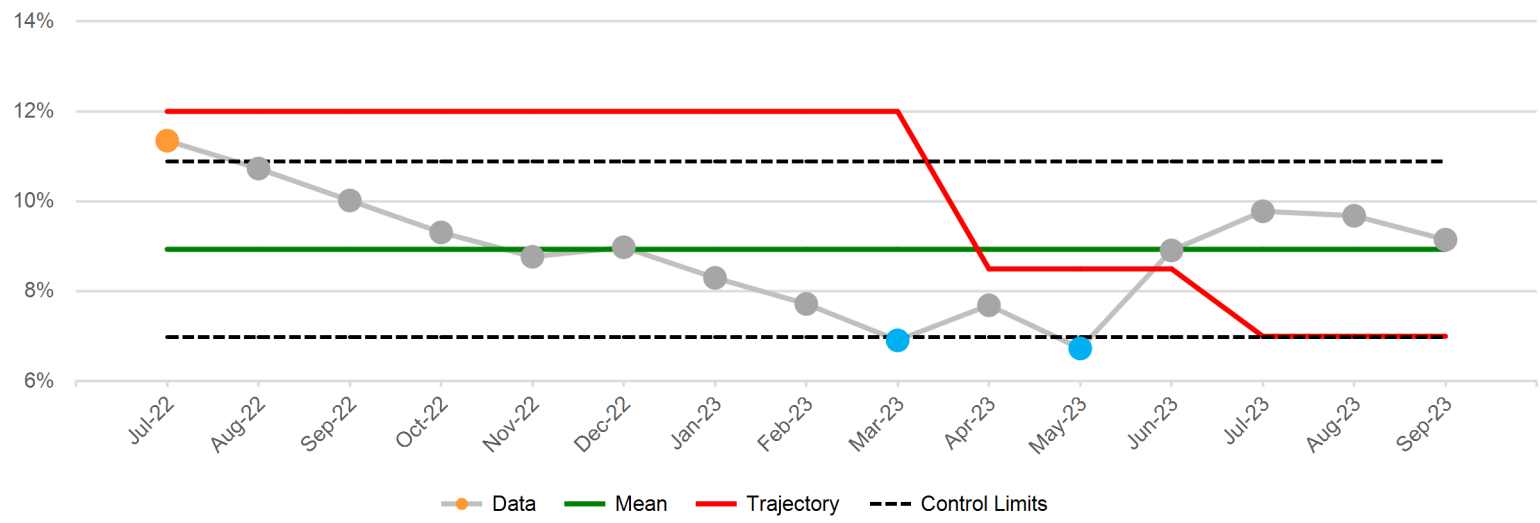
Issues:
- Protected time for core learning continues to be an issue, particularly clinical staff.
- Training profiles are not aligned on an individual/role basis meaning some staff groups are undertaking training which is not required to perform their role.
- Number of staff starting role without induction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

Actions:
- Core learning offer now aligned to the national Core Skills Training Framework (CSTF).
- Core+ offer has been reviewed. Move from position number to role level will create a more appropriate learning burden, this is underway. Work is underway to develop a mandatory training study day offered bi-weekly following approval from the MTGG. These will be online sessions covering a range of the core CSTF.

Mitigations:
Improvement Action Plan and targeted work with Divisions.

Performance Overview - Workforce

Number of Vacancies



Sep-23
9.15%
Variance Type
Common cause variation
Trajectory
7.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of HR & OD

Background:
September 2023 reported Vacancy Rate is 9.15% against a Q2 target of 7.00%.

What the chart tells us:
That we are not within the Q2 target for September 2023.

Adjusted Vacancy Rate would be closer to Target (once Establishment Review completed)

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

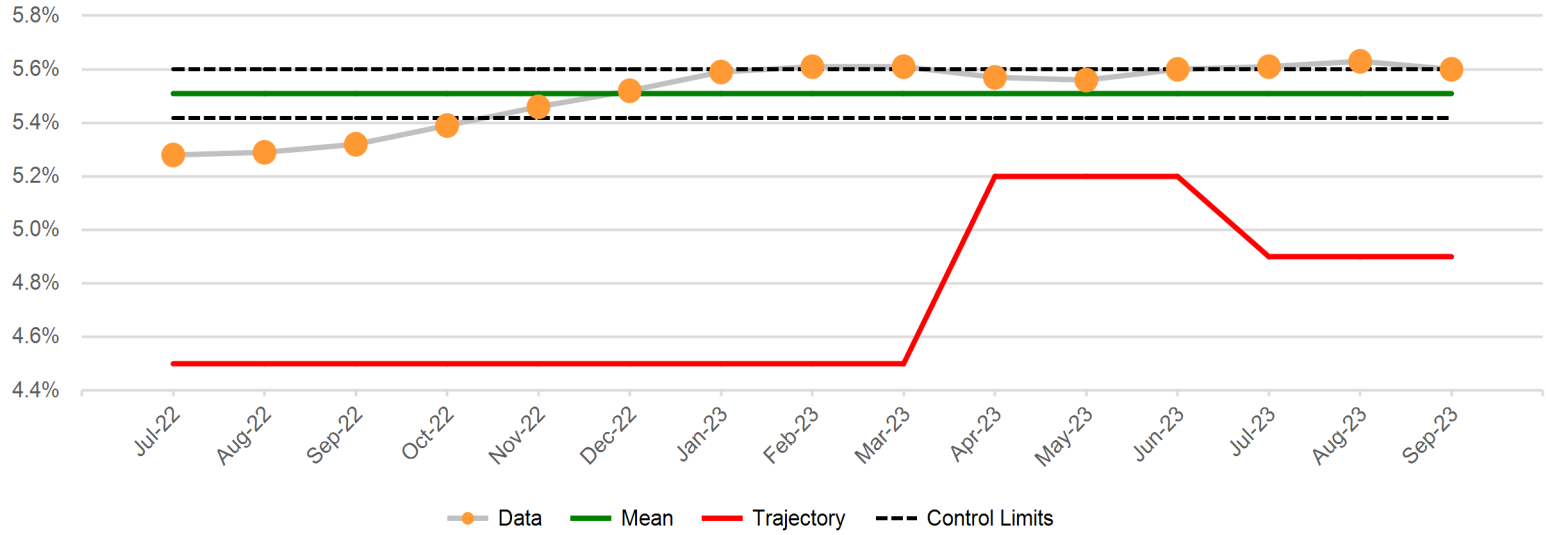
Actions:
1. Work is in progress to review our overall establishment with our Divisional Teams

NB:
It is expected when this review had been fully completed prior our overall Trust Vacancy Rate would have been approx. 2.00% less (the adjusted rate) at the end of September 2023.

Mitigations:
1. 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



Sep-23
5.60%
Variance Type
Special cause variation - cause for concern (Indicator where high is a concern)
Trajectory
4.90%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of HR & OD

Background:
5.60% of sickness absence rolling year.

What the chart tells us:
5.60% is above the Q2 target of 4.90%.

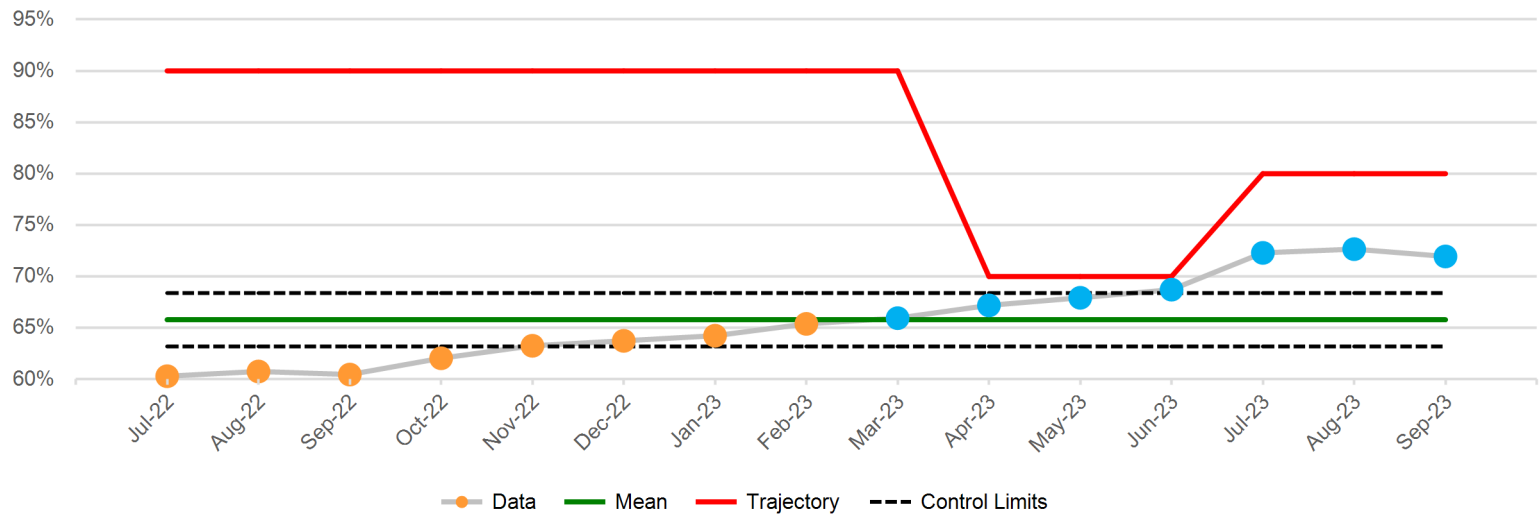
Issues:
- Sickness accounts for >75% of all unplanned absence.
- Consideration to be given to the other reasons that make up the remaining % of unplanned absence.
- AMS compliance remains a challenge.

Actions:
- People Management Essentials (PME) training to be mandated, which will provide further foundations as regards the importance/ expectations around absence management/recording within AMS.
- Consideration to be given in respect of our approach to moving away from a culture of managing attendance to one where we support attendance in the workplace, including a focus on RTW compliance.
- Occupational Health work closely with HR colleagues on the review of absence cases making recommendations to support staff to return to work in a timely manner. Continued signposting to the Wellbeing Services/Health & Well Being Champions who help to support staff to remain in the workplace.
- HR colleagues will work with Divisional Teams to identify and understand data trends.

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

Performance Overview - Workforce

Staff Appraisals



Sep-23
71.95%
Variance Type
Special cause variation - improvement (Indicator where high is good)
Trajectory
80.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of HR & OD

Background:
% completion is currently 71.95% (Trustwide).

What the chart tells us:
Despite being off track for this measure when compared to the Q2 target (80%) we have seen an improvement when compared to last year, and recent months.

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

Actions:
- Launching 90 minute appraisal 'how to' sessions to improve overall compliance.
- Ensuring that all completed appraisals have been captured in ESR.
- Raising awareness of the importance of an appraisal with a focus on areas of low compliance.

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

Financial Position Month 6 (2023/24)
Finance Report
5 Year Priority – Efficient Use of Resources

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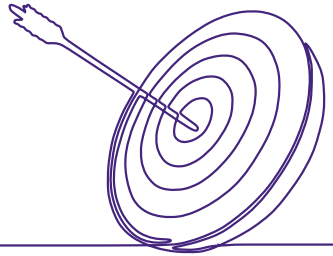
OUTSTANDING CARE
personally DELIVERED

Finance Spotlight Report (Headlines)



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Adjusted financial performance	Current Month			Year to Date		
	Plan £000's	Actual £000's	Variance £000's	Plan £000's	Actual £000's	Variance £000's
Operating Income from patient care activities	58,342	58,968	626	350,034	351,494	1,460
Other operating Income	3,449	3,571	122	20,692	21,262	570
Employee Expenses	(42,424)	(43,053)	(629)	(256,039)	(255,730)	309
Operating expenses excl employee expenses	(22,771)	(22,757)	14	(127,657)	(129,900)	(2,243)
OPERATING SURPLUS/(DEFICIT)	**(3,404)**	**(3,271)**	**133**	**(12,970)**	**(12,874)**	**96**
Net finance costs	(492)	(623)	(131)	(2,830)	(2,920)	(90)
Other Gains / Losses	0	2	2	0	52	52
Surplus / (Deficit) for the period	**(3,896)**	**(3,892)**	**4**	**(15,800)**	**(15,742)**	**58**
Below Line Adjustments	52	52	0	312	279	(33)
Adjusted financial performance surplus / (deficit)	**(3,844)**	**(3,840)**	**4**	**(15,488)**	**(15,463)**	**25**

Revenue position

- The Trust's financial plan for 2023/24 is a deficit of £20.8m; the table shows that YTD the Trust delivered an adjusted deficit of £3.8m in-month and £15.5m YTD in line with the financial plan.
- While the risk, mitigations and assumptions relating to the position are detailed in the report, the following specific risk is noted:
  - ❖ The YTD position revenue position makes no adjustment in relation to the Elective Recovery Fund for non-delivery of activity.

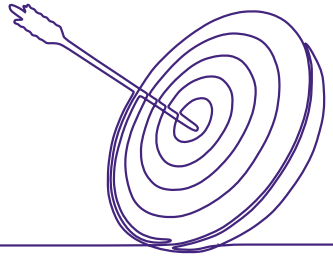
CIP position

- The Trust's CIP plan for 2023/24 is to deliver savings of £28.1m; the Trust planned £9.1m (32%) of savings delivery planned to be in H1 and £19.0m (68%) to be delivered in H2; the Trust has YTD delivered savings of £14.4m, or £5.3m favourable to planned savings of £9.1m.

Capital position

- The Trust's capital plan for 2023/24 amounts to £48.4m; YTD the Trust delivered capital expenditure of £4.3m, or £6.7m lower than planned capital expenditure of £11.0m.

Finance Spotlight Report
(Key areas of focus - Income)



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The YTD income position is £2.0m favourable to plan; this includes:

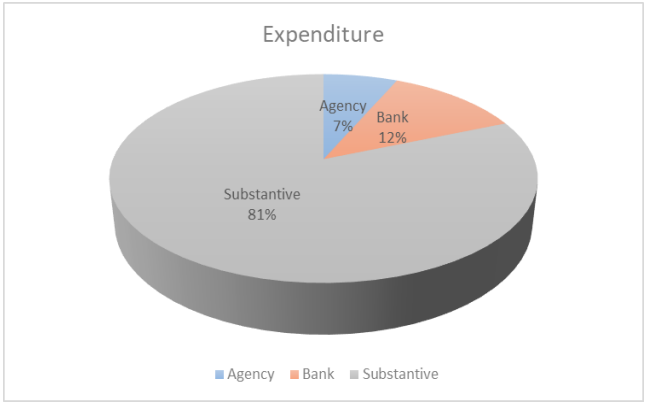
- **NHS patient care income contract – £1.2m favourable to plan**; including
  - Pass through is £1.7m favourable to plan.
  - Provision has been made for £0.6m for income risk in relation to contract activity.
- **Operating income from patient care activities - Other – £0.3m favourable to plan** driven by overseas visitor and injury cost recovery scheme over performance.
- **Other operating income - £0.6m favourable to plan; this includes:**
  - Education and training – under performance of £0.8m
  - Income in respect of employee benefits accounted on a gross basis – under performance of £0.2m.
  - Research & Development - over performance of £0.2m
  - Non-patient care services - over performance of £0.6m
  - Car Parking & Catering - over performance of £0.2m on each.
  - Retail sales over performance of £0.5m (more than offset by additional expenditure)

Finance Spotlight Report
(Key areas of focus - Pay)

United Lincolnshire Hospitals NHS Trust

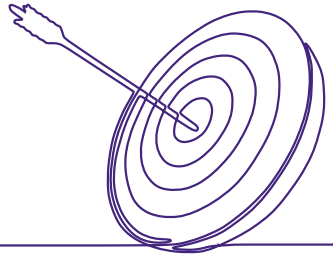
- Pay expenditure of £43.1m in September is £0.6m adverse to planned expenditure of £42.4m; the **YTD pay position is £0.3m favourable to plan**.

- YTD expenditure on Pay comprises of £207.6m (81%) on substantive staffing and £48.1m (19%) on temporary staffing.
- 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.



- 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 favourable pay position is driven by £5.2m over delivery of the FRP, although this benefit has been partly mitigated by improved recruitment and retention and other pressures (most notably £1.2m of additional pay costs re the strikes).

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



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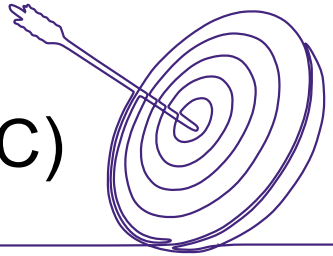
Non-Pay

- Non-pay expenditure of £22.8m in September is in line with planned expenditure of £22.8m; the **YTD non pay position is £2.2m adverse to plan**.
- The YTD non-pay position includes:
  - **Activity volumes** - Activity volumes are lower than planned; YTD the benefit of lower than planned volumes is estimated to be £2.8m, but this is in part mitigated by £0.6m of outsourcing; clinical non-pay expenditure is expected to increase as activity volumes increase.
  - **CIP** – Delivery of £3.0m of FRP non-pay savings is in line with plan.
  - **Excess inflation** – While the 2023/24 financial plan includes non-pay inflation as per national planning guidance, the actual level of inflation suffered was expected to be higher than planned; we currently estimate the level of excess non-pay inflation suffered YTD to be £2.4m, but this estimate is still subject to validation and the true figure may be higher.
  - **Other** – The balance of the adverse movement in the YTD non-pay position is driven by a number of pressures; this includes £0.2m re system digital expenditure, £0.2m re increased recruitment activity, £0.2m re bad debt provisions, £0.3m re increased depreciation costs, £0.4m in relation to retail sales expenditure, and an increased run-rate in clinical supplies, services and drugs (for some of which there is an offset in pass through income).

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



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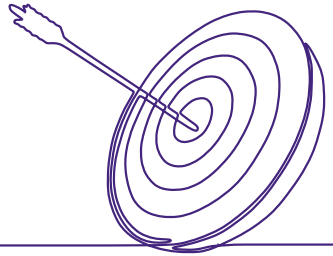
Cash

- The September 2023 cash balance is £36.1m (plan: £25.2m); this is a reduction of £5.2m 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 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 September was 89% / 79% by value / volume of invoices paid (appendix 5d).
- Year to date performance is 84% / 81% by value / volume, this compares to the full year performance in 2022/23 of 79% / 70%.
- At the end of September there were circa 1,400 unpaid invoices (£2.7m) over term (August 1,100 / £2.9m). 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



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

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

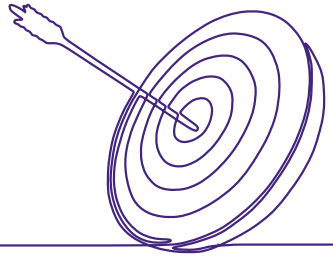
Metric	Rating Boundary			
	1	2	3	4
Capital servicing capacity	2.5	1.75	1.25	<1.25
Liquidity ratio (days)	0	-7	-14	<-14
I&E Margin	1%	0%	-1%	<=-1
I&E margin distance from plan	0%	-1%	-2%	<=-2%
Agency	0%	25%	50%	>=50%

The finance assessment seeks to answer the question: ***How effectively is the trust managing its financial resources to deliver high quality, sustainable services for patients?*** It does this at a high level using the 5 key indicators and each of which is rated 1 to 4 [which represent Outstanding, Good, Requires Improvement and Inadequate]. The rating boundaries are contained in the table above and ULHT absolute metric and rating for the last four full financial years and the current 2023/24 position are as follows

Finance and use of resources rating	Full Year ending:					Actual	Forecast
	31/03/2019	31/03/2020	31/03/2021	31/03/2022	31/03/2023	SEP 2023	31/03/2024
Capital service cover metric	(10.40)	(1.73)	0.06	3.60	1.48	0.16	1.05
Capital service cover rating	4	4	4	1	3	4	4
Liquidity metric	(98.73)	(128.28)	3.71	2.50	(10.91)	(13.52)	(20.88)
Liquidity rating	4	4	1	1	3	3	4
I&E margin metric	(19.71%)	(7.62%)	0.38%	0.29%	(1.80%)	(4.15%)	(2.79%)
I&E margin rating	4	4	2	2	4	4	4
Agency metric	77.00%	110.00%	113.00%	120.00%	[illegible]	[illegible]	0.00%
Agency rating	4	4	4	4	[illegible]	[illegible]	1
I&E margin: distance from financial plan - metric	(2.80%)	0.70%	n/a	0.01%	(1.80%)	0.11%	0.07%
I&E margin: distance from financial plan - rating	4	1	n/a	1	3	1	1

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

Balance Sheet



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	31-Mar-23	30-Sep-23			31-Mar-24	
		Plan	Actual	Variance	Plan	Forecast
	£000	£000	£000	£000	£000	£000
Intangible assets	11,383	5,164	9,204	(4,040)	4,357	7,018
Property, plant and equipment	298,860	289,605	293,937	(4,332)	306,970	328,670
Right of use assets	11,807	10,742	10,685	57	9,656	9,531
Receivables	2,157	1,848	2,112	(264)	1,848	1,848
Total non-current assets	324,207	307,359	315,938	(8,579)	322,831	347,067
Inventories	6,133	7,000	6,701	299	7,000	7,000
Receivables	52,873	29,620	27,142	2,478	30,740	29,000
Cash and cash equivalents	41,269	25,216	36,112	(10,896)	16,201	22,573
Total current assets	100,275	61,836	69,955	(8,119)	53,941	58,573
Trade and other payables	(89,905)	(70,506)	(62,136)	(8,370)	(76,995)	(86,605)
Borrowings	(3,129)	(3,016)	(3,147)	131	(2,879)	(3,161)
Provisions	(17,670)	(6,025)	(19,518)	13,493	(4,825)	(3,367)
Other liabilities	(1,260)	(1,130)	(6,020)	4,890	(1,130)	(1,130)
Total current liabilities	(111,964)	(80,677)	(90,821)	10,144	(85,829)	(94,263)
Total assets less current liabilities	312,518	288,518	295,072	(6,554)	290,943	311,377
Borrowings	(12,189)	(10,860)	(10,668)	(192)	(9,481)	(9,189)
Provisions	(5,108)	(3,142)	(5,179)	2,037	(2,992)	(4,375)
Other liabilities	(11,069)	(10,817)	(10,817)	-	(10,566)	(10,566)
Total non-current liabilities	(28,366)	(24,819)	(26,664)	1,845	(23,039)	(24,130)
Total assets employed	284,152	263,699	268,408	(4,709)	267,904	287,247
Financed by						
Public dividend capital	724,041	728,323	724,042	4,281	738,081	748,486
Revaluation reserve	42,584	28,239	42,013	(13,774)	27,891	41,443
Other reserves	190	190	190	(0)	190	190
Income and expenditure reserve	(482,663)	(493,053)	(497,836)	4,783	(498,258)	(502,871)
Total taxpayers' equity	284,151	263,699	268,408	(4,709)	267,904	287,247

Note 1: The financial plan for 2023/24 was submitted prior to the completion of the year end valuation and accounts. The net upward revaluation of circa £14m is not therefore reflected within the property plant and equipment and revaluation reserve figures quoted within the plan.

Note 2: Cash at £36.1m has reduced by £5.2m from March and is expected to reduce further as the year progresses, in line with the planned deficit and a reductions in provisions.

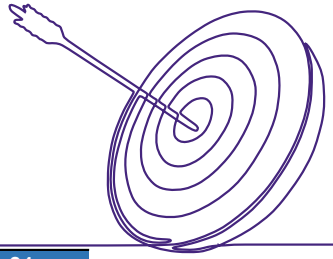
Note 3: Receivables is predominantly a mix of invoiced debt £2.4m, accrued income £13.2m and prepayments £12.1m. See Appendix 5a-b

Note 4: The overall level of Trade and other payables at £62.1m has reduced significantly from year end, driven in part by the reduction in capital creditors from the March peak of £21.2m to £2.0m. With the 2023/24 capital programme likely to be weighted towards Q4, a substantial rise is again anticipated later in the year.
BPPC and aged creditor performance is reported at Appendix 5c-d.

Note 6: The planned capital programme for 2023/24 will result in asset additions of £48.2m. This is to be funded through internal cash resources but with an injection of £24.4m PDC capital.

Note 7: The level of provisions remains high but is anticipated to reduce as 'Flowers' and Annual Leave issues are reviewed and resolved.

Cashflow reconciliation – April 2022– March 2023



United Lincolnshire Hospitals NHS Trust

	31-Mar-23	30-Sep-23			31-Mar-24	
		Plan	Actual	Variance	Plan	Forecast
	£000	£000	£000	£000	£000	£000
Operating surplus / (deficit)	(13,371)	(12,970)	(12,874)	(96)	(15,300)	(15,455)
Depreciation and amortisation	22,001	12,214	12,482	(268)	24,127	25,175
Impairments and reversals	5,079	-	-	-	-	-
Income recognised in respect of capital donations	(82)	-	(33)	33	(50)	(50)
Amortisation of PFI deferred credit	(503)	(252)	(252)	-	(503)	(503)
(Increase) / decrease in receivables and other asse	(38,148)	(1,120)	25,885	(27,005)	(2,240)	24,044
(Increase) / decrease in inventories	(127)	-	(568)	568	-	(867)
Increase/(decrease) in trade and other payables	1,593	(11,290)	(7,998)	(3,292)	(11,967)	(9,300)
Increase/(decrease) in other liabilities	130	-	4,760	(4,760)	-	(130)
Increase / (decrease) in provisions	10,861	(860)	1,882	(2,742)	(2,210)	(15,073)
Net cash flows from / (used in) operating activities	**(12,567)**	**(14,278)**	**23,284**	**(37,562)**	**(8,143)**	**7,841**
Interest received	1,175	1,260	1,366	(106)	2,100	2,938
Purchase of intangible assets	(4,142)	-	-	-	-	-
Purchase of property, plant and equipment	(42,693)	(25,795)	(23,301)	(2,494)	(45,930)	(41,403)
equipment	156	-	33	(33)	-	33
Net cash flows from / (used in) investing activities	(45,504)	(24,535)	(21,902)	(2,633)	(43,830)	(38,432)
Public dividend capital received	19,863	4,435	-	4,435	14,193	24,444
Other loans repaid	(402)	(403)	(403)	-	(805)	(805)
Capital element of finance lease rental payments	(2,416)	(1,163)	(1,200)	37	(2,319)	(2,309)
Interest element of finance lease	(121)	(55)	(54)	(1)	(104)	(104)
PDC dividend (paid)/refunded	(5,873)	(3,996)	(4,878)	882	(8,000)	(9,327)
Cash flows from (used in) other financing activities	(8)	(2)	(4)	2	(4)	(4)
Net cash flows from / (used in) financing activities	11,043	(1,184)	(6,539)	5,355	2,961	11,895
Increase / (decrease) in cash and cash equivalents	**(47,028)**	**(39,997)**	**(5,157)**	**(34,840)**	**(49,012)**	**(18,696)**
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**	**25,216**	**36,112**	**(10,896)**	**16,201**	**22,573**

Note 1: Cash held at 30 September was £36.1m against a plan of £25.2m. This represents an reduction of £5.2m against the March year-end cash balance of £41.3m.

Note 2: Cash movements have been driven significantly by reductions in receivables as 2022/23 contract variations have been cleared, offset in part by the clearance of year end capital creditors.

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

- The planned deficit of £20.7
- Release / utilisation of provisions associated with current litigation and contractual obligations – circa £15m.
- Reductions in the level of deferred income
- Utilisation of capital cash as the capital programme builds momentum in the second half of the year.

Note 4: Provided the Trust delivers the financial plan, no requirement to borrow is anticipated for 2023/24. Should the position deteriorate however, the option to move cash between Provider Organisations within the ICB should be explored.

United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*7 November 2023*
Item Number	*Item 13.1*

Strategic Risk Report

Accountable Director	*Professor Karen Dunderdale, Director of Nursing & Deputy Chief Executive*
Presented by	*Professor Karen Dunderdale, Director of Nursing & Deputy Chief Executive*
Author(s)	*Rachael Turner, Risk & 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 September and October 2023 at the point of writing.

- There were 17 quality and safety risks rated Very high (20-25) reported to the Quality Governance Committee this month, this remains stable 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 diabetes pathways-community
    - Delivery of paediatric epilepsy pathways-community
    - Quality and safety risk from inability to deliver diabetes pathways that meet National standards-Acute
    - Quality and safety risk from inability to deliver epilepsy pathways within Acute Paediatrics that meet National standards
    - Medicines reconciliation compliance;
    - Consultant capacity for Haematology outpatient appointments;
    - Non-recurrent funding in Cancer services;
    - ICU capacity for elective surgery.
    - Safety risk from Nationwide shortage of suction catheters as identified by NHS supply chain

- Following the last reporting period, a comprehensive review and update of the People & OD directorate risk register has now been undertaken. These risks were presented at the August Risk Register Confirm and Challenge meeting and have now been validated as active risks to the Trust. All updates to risk movements have been provided in bold.

- 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)

- Since the last reporting period, the following risks that are reported to the People & Organisational Development Committee were presented to Risk Register Confirm & Challenge. These risks were reduced in score:
    - Recruitment of staff (16)-**Recruitment and retention have now been split as stand-alone risks following People and OD Review**.
    - Retention of staff (16)-**New Risk now that recruitment and retention have been split.**
    - Workforce culture (Trust-wide) (12) – **This risk has now been downgraded to a Moderate risk.**

- 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.

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 426 active and approved risks reported to lead committees this month.

2.2 There were 29 risks with a current rating of Very high risk (20-25) and 44 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)

32 (+1) (7%)	87 (-8) (20%)	234 (-10) (55%)	44 (+8) (10%)	29 (-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 15 Very high risks and 13 High risks recorded in relation to this objective. This remains stable from last month. A summary of the Very high risks is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4878	If there are significant delays within the planned care non-admitted pathway (outpatients) then patients may experience extended waits for diagnosis and treatment, resulting in failure to meet national standards and and potentially reducing the likelihood of a positive clinical outcome for many patients	Very high risk (25)	- Planned care recovery plan (non-admitted / outpatients) - Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions	02/08/2023
5016	If there is not sufficient flow through the Trusts Emergency Departments, due to demand outstripping capacity and insufficient availability of beds in the hospitals leading to overcrowding. This may result in increased likelihood of long waits in the departments for patients, and an increase in the potential for patient harm, delays in care, poor patient and staff experience and impact on the reputation of the Trust .	Very high risk (25)	Capital programme ongoing at Lincoln County ED - will increase clinical space Full Business Case approved at organisational level to support new build for Pilgrim ED System support with the introduction of Breaking the cycle - to create flow in hospital supporting the reduction of ED overcrowding Increased nursing template agreed by Director of Nursing for EDs Demand and Capacity work to review medical staffing in ED.	17/10/2023
4789	If there is a significant delay in processing of Echocardiograms, which is impacted by staff shortages and inefficient processes, then it could lead to delayed assessment and treatment for patients, resulting in potential for serious harm, a poor patient experience and a poor clinical outcome	Very high risk (20)	Review and realignment of systems and processes to ensure that the team efficiency has been optimised. External company (Meridian) engaged for 10-week period to enable a deep dive and improvement plan to be implemented for the service.	16/10/2023

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4879	If there are significant delays within the planned care cancer pathway then patients may experience extended waits for diagnosis and surgery, resulting in failure to meet national standards and potentially reducing the likelihood of a positive clinical outcome for many patients	Very high risk (20)	- Planned care recovery plan (cancer) - Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions.	14/09/2023
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.	13/10/2023

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4877	If there are significant delays within the planned care admitted pathway then patients may experience extended waits for surgery, resulting in failure to meet national standards and potentially reducing the likelihood of a positive clinical outcome for many patients	Very high risk (20)	Planned care recovery plan (Admitted / HVLC / GIRFT) Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions.	02/08/2023
4932	Services will be stopped and/or disrupted due to non-recurrent funding (Macmillan/RDC/SDF funding streams). These include CNS, CCC, Waiting List Clerk, Trainee ACP's/ACP's, Advanced Practitioner Radiographer, PTL administrator, PTL Tracker, Deputy nurses-leadership roles. Services which will be stopped: transitional breast, urology and colorectal. PSA ACP monitoring service. Bone marrow nurse led clinic. Chemotherapy suite cancer care coordinator, late side effects pathway, deputy lead cancer nurse, and no Haematology ACP based at PHB. Services which will be affected due to reduction in staffing: haematology CNS team, pre diagnosis team affecting the NSS pathway. Waiting list support, cancer centre team, Radiology admin and PACS services.	Very high risk (20)	CoN's written for majority of posts to go through clinical cabinet, CRIG Workforce reviews commencing in haematology and oncology. Risk reduction plan escalated to ICB as it is a system wide impact.	14/09/2023

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
5103	Quality and safety risk from inability to deliver Community diabetes pathways that meet National standards due to resourcing and capacity factors	Very high risk (20)	Due to inadequate service, the service has been forced to be reduced and prioritising the children most in need, in doing so, not meeting BPT or audit requirements. Reduction plan: 1. Business case is being developed to address shortfall, agreed in principal at CRIG. This is for a dietician, psychologist, admin and additional nurses. 2. Multi-professional working group tasked with delivering improvements that will support achievement of audit compliance 3. An increase in clinic capacity	17/10/2023
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	17/10/2023

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4740	Demand for Haematology outpatient appointments exceeds consultant staffing capacity. High Consultant vacancy levels affecting clinic capacity, performance and review of inpatients. The areas of concern are Lymphoma, and haemostasis (there is only one consultant trust wide). PHB cover and unfilled leadership roles (in practice head of service and clinical governance lead). Due to haematology patients having long term conditions, they are required to have regular review and those on cancer treatment are time critical. If we are not able to meet the demands of the service this potentially could cause severe harm to the patients. At the end of March 2023 there are 322 overdue haem pt at phb and 597 at LCH. From 1 Oct 22 till now the haematologists have held 95 extra clinics which equates to 71 news and 813 F/U. Haemostasis in particular pt are waiting almost triple the time that they have been graded at. There are 657 pt on this consultant PBWL with 295 being overdue. The longest waiter was due an appointment around July 2022. This consultant is holding on average 3 extra clinics per month.	Very high risk (20)	Need for workforce review identified. Right sizing work force paper being written. 2 x agency consultants out to support service	14/09/2023

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4947	There is an issue in which the Trust is failing to meet NICE medicines reconciliation targets on a consistent basis and not being able to review discharges. This is caused by lack of pharmacy resource. Resulting in potential for patient harm due to incorrect or delayed medication, financial implications due to increased length of stay or unnecessary supply and risk of continuation of errors onto the discharge letter and further more into the community.	Very high risk (20)	There are many options but we are utilising these; - We have prioritised pharmacist and technician cover to acute admission areas as patient turnover is highest on these areas and gives us to best opportunity to conduct a medicines reconciliation under 24 hours - We prioritise patients which have stayed in the longest and have critical medication where known. Prioritisation of the highest risk patients decreases the risk of harm - No ward visits are divided as much as possible. To significantly reduce this risk requires additional ward based pharmacy staff cover across 7 days.	05/10/2023
5100	Quality and safety risk from inability to deliver epilepsy pathways within Acute Paediatrics that meet National standards due to resourcing and capacity factors.	Very high risk (20)	1. Multi-professional working group tasked with delivering improvements that will support achievement of audit compliance.	11/09/2023
5102	Quality and safety risk from inability to deliver diabetes pathways within Acute Paediatrics that meet National standards due to resourcing and capacity factors	Very high risk (20)	1. Multi-professional working group tasked with delivering improvements that will support achievement of audit compliance; 2. Business case being developed to address resources shortfall (e.g. dietitian, psychologist, admin support, additional nurses) - agreed in principle at CRIG meeting.	10/10/2023

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
5175	Safety risk from Nationwide shortage of respiratory supplies as identified by NHS supply chain	Very high risk (20)	1) Continue weekly meetings with Procurement leads, looking at alternative codes when stock becomes available. 2) All families to be contacted at least weekly by CCN's to identify stock levels in the home and to estimate upcoming requirement. 3) Liaise with tertiary centre clinical leads, consultants, rapid response community physio teams, long term ventilation service. 4) Identify those high risk and high demand, prioritise allocated allowance. Reassess education with families surrounding suction to ensure appropriate usage of suction catheters. 5) Devised a letter awaiting sign off to issue to families to inform families of shortage and that they will be contacted weekly. 6) Alternative equipment to be used on clinical decision if oral suction only is required.	17/10/2023
5075	Disease progress for patient's alternative treatments, change of treatment plan, poor clinical outcomes, causing patient's anxiety and worry for the patient. As a consequence of lack of ICU capacity for elective surgery patients this leads to cancellations on the day, this includes cancer patients that require level 2 post-operative care.	Very high risk (20)	The triumvirate to include surgery and TACC are planning to meet to review potential options.	25/10/2023

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.	26/09/2023
4731	If patient records are not complete, accurate, up to date and available when needed by clinicians then it could lead to delayed diagnosis and treatment, reducing the likelihood of a positive clinical outcome and possibly causing serious harm	Very high risk (20)	Design and delivery of the Electronic Document Management System (EDMS) project, incorporating Electronic Patient records (EPR). Interim strategy required to reduce the risk whilst hard copy records remain in use.	08/09/2023

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.	26/09/2023

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
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	14/09/2023

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
5093	Baseline pharmacy procurement staffing is at a level where only the basic functions can routinely be delivered and the service is not able to withstand any prolonged absence due to leave, sickness or resignation. The workforce has remained relatively stable over time; however, workforce pressures have been increasing over the last few years for a variety of reasons. There has been an increasing number of pharmaceutical shortages, many of which are complex in nature. A growing number of drugs are now being offered on an allocation basis, which requires micro management for stock ordering and distribution across the Trust. Changes in the delivery of chemotherapy have resulted in an increased demand for ordering of chemotherapy preparations. The pharmacy invoicing team have also experienced a recent increase in workload following the implementation of the Advanced finance system. The team are reporting concerns around workload and workplace stress. We are routinely reliant on existing staff working additional hours to fill gaps. If staff feel unable to come to work for any reason (including stress related) this will further increase the risk to the Trust and its patients of stock outs. This gives an associated risk to patient care, due to either a lack of personnel to raise orders, manage shortages, chase orders which are not being received, or to process invoices and manage supplier queries."	Very high risk (20)	Gap analysis highlights several areas of ongoing concern (to-follows, shortage management, invoice query management, medical gas invoicing). Occasional additional support is currently being provided to the invoicing team by a Bank Pharmacy Support Worker; we are scoping training this individual to offer procurement support in addition. This post is being paid from vacancy money elsewhere in the department and so cannot be considered a long-term fix for the procurement gaps. A case of need will be prepared to identify workforce requirements to reduce the workload stress the staff are persistently facing, and to provide a robust service which can withstand annual leave and short term sickness absence, based on the more challenging pharmaceutical market we are operating in where shortages are now a daily occurrence."	05/10/2023

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4997	Service configuration - single consultant covering both sites during weekend so cover limited if critically unwell patients on both sites	Very high risk (20)	* Workforce review * Refresher of Fragile Services Paper - NB there is a National shortage of Haematology consultants * Recruitment of further substantive consultants * Additional unfunded ST3+ for Haematology starts in August 2022	14/09/2023

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

2.7 There were 2 Very high risks, a reduction of one and 3 High risks, an increase of one recorded in relation to this objective. A summary of the Very high risks is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
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.	29/09/2023
4948	Workload demands within Pharmacy persistently exceed current staffing capacity which leads to work related stress resulting in serious and potentially long-term effects on staff health and wellbeing. Adding to this with additional workload demands with insufficient staffing, or required level of experience and skill, the risk is patients will not be reviewed by a pharmacist leading to poorer clinical outcomes, reduced flow on acute wards, delayed discharges and increased risk of omitted medicines. For staff the risk is long term absence. This may result in the failure to meet the national and local targets for KPIs	Very high risk (20)	Review current provision and identify gaps in service to inform business cases for change to support 7 day working (working with Surgery and Medicine Divisions as appropriate). Skill mix requires review due to complexity of patients.. Pragmatic management of workload & provision of management support. On-going exploration of recruitment options.	05/10/2023

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

2.8 There were 3 approved Very high risks (20-25) and 5 High risk (15-16) recorded in relation to this objective, both remaining stable form the last reporting period. 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	21/09/2023
4647	If Lincolnshire Fire & Rescue Service (LFRS) carries out an inspection and finds the Trust to be systemically non-compliant with fire safety regulations and standards it could result in regulatory action and sanctions, with the potential for financial penalties and disruption to services if sites are required to close.	Very high risk (20)	- Statutory Fire Safety Improvement Programme based upon risk - LFR involvement and oversight through the FSG - Fire safety audits being conducted by Fire Safety team - Fire wardens in place to monitor local arrangements with Fire Safety - Weekly Fire Safety Checks being undertaken - PPM reporting for FEG and FSG By Estates Teams - All areas of Trust allocated RAG rating for fire using occupancy profile, escape provision, height above ground and sleeping risk	21/09/2023

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.	03/09/2023

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	16/10/2023
5020	If there is a continued reliance on bank and agency staff for medical workforce in Urgent & Emergency Care there is a risk that there is not sufficient fill rate for medical rotas both ward / department fill and on call shifts which will impact on patient safety and have a negative impact on the CBU budget.	Very high risk (20)	Robust recruitment plan. International recruitment. Medical Workforce Management Project.	26/09/2023

Strategic objective 3c: Enhanced data and digital capability

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

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4657	If the Trust does not comply with Subject Access Requests (SARs) and Access to Health Records provisions in accordance with statutory requirements specified legislation, then it could lead to complaints to the Trust and Information Commissioner's Office (ICO). This could result in regulatory action and possibly financial penalties. Inconsistent levels of expertise outside of the IG team regarding SAR requirements. Lack of technical tools to carry out a search of emails / systems to identify personal information held. 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."	10/10/2023

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 and 1 High risk 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 17 quality and safety risks rated Very high (20-25) reported to the Quality Governance Committee this month:
  - Patient flow through Emergency Departments;
  - Recovery of planned care admitted pathways;
  - Recovery of planned care non-admitted (outpatients) pathways;
  - Recovery of planned care cancer pathways;
  - Reliance on paper medical records;
  - Reliance on manual prescribing processes;
  - Potential for serious patient harm due to a fall;
  - Processing of echocardiograms;
  - Delivery of paediatric diabetes pathways-community
  - Delivery of paediatric epilepsy pathways-community
  - Quality and safety risk from inability to deliver diabetes pathways that meet National standards-Acute
  - Quality and safety risk from inability to deliver epilepsy pathways within Acute Paediatrics that meet National standards
  - Medicines reconciliation compliance;
  - Consultant capacity for Haematology outpatient appointments;
  - Non-recurrent funding in Cancer services;
  - ICU capacity for elective surgery.
  - Safety risk from Nationwide shortage of suction catheters as identified by NHS supply chain

3.1

- Following the last reporting period, a comprehensive review and update of the People & OD directorate risk register has now been undertaken. These risks were presented at the August Risk Register Confirm and Challenge meeting and have now been validated as active risks to the Trust. All updates to risk movements have been provided in bold.

- 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	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
Strategic Objective							**1a. Deliver Harm Free Care**																			
4932	Service disruption	Lynch, Diane	Chester-Buckley, Sarah	Workforce Strategy Group		24/05/2022	16	Workforce Metrics	Clinical Support Services	Cancer Services CBU		Trust-wide	Services will be stopped and/or disrupted due to non-recurrent funding (Macmillan/RDC/SDF funding streams). These include CNS, CCC, Waiting List Clerk, Trainee ACP's/ACP's, Advanced Practitioner Radiographer, PTL administrator, PTL Tracker, Deputy nurses-leadership roles. Services which will be stopped: transitional breast, urology and colorectal. PSA ACP monitoring service. Bone marrow nurse led clinic. Chemotherapy suite cancer care coordinator, late side affects pathway, deputy lead cancer nurse, and no Haematology ACP based at PHB. Services which will be affected due to reduction in staffing: haematology CNS team, pre diagnosis team affecting the NSS pathway. Waiting list support, cancer centre team, Radiology admin and PACS services.	List of job roles provided to Finance. CoN's written for majority of posts to go through clinical cabinet, CRIG Workforce reviews commencing in haematology and oncology.	Via jo roles list	14/09/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	CoN's written for majority of posts to go through clinical cabinet, CRIG Workforce reviews commencing in haematology and oncology. Risk reduction plan escalated to ICB as it is a system wide impact.	[14/09/2023 15:00:52 Rose Roberts] Business case to be presented at ICB investment group Dec 2023. [03/08/2023 09:59:07 Rachael Turner] Following a finance quarterly review with the ICB in July there is an action to prepare for the final stage of the CRIG bids to take to Finance committee in December. There will be a follow up meeting with the ICB early September to prepare an update for the quarterly review meeting in October for the CRIG bids. The aim is to review and then prepare an overarching paper that will go to finance committee in December to get sign off for recurrent funding. At this meeting we will discuss what is required to prepare, this will include, activity/ income generated, costs for post including support costs and the gap in the plan. [02/06/2023 12:43:46 Maddy Ward] EMCA have agreed to fund all posts until March 2024. Paper being presented to ICB investment board in June/ July for recurrent funding for these posts. Awaiting outcome of board. Effected staff informed verbally and have received a letter from their line manager and EF2's have been completed. [24/04/2023 10:40:50 Maddy Ward] Business case is submitted for all posts within CSS for review by EMCA and funding from this review would be for 23/24 [03/04/2023 09:40:42 Rose Roberts] We are awaiting EMCA review to see if need the posts. McMillan posts have been funded. Reviewed at confirm and challenge confirmed as v high risk. [14/03/2023 11:21:33 Rachael Turner] Division has reviewed and have proposed that risk score is increased to a rating of 20 (Very High). This risk will be raised at RRC&C Meeting in March for validation. [30/01/2023 16:12:51 Rose Roberts] Contracts end March 2023, if not in receipt of further funding non specific symptom (NS pathway will have to stop. Pre diagnosis service will have to stop. Currently we have a tick box on all 2 ww referrals which allows complex and vulnerable patients to be identified for support from this team, circa up to 40 pt per week. The other contracts that end end of March for transitional care specifically for colorectal and urology, would stop. [15/12/2022 13:32:54 Alex Measures] case of need completed for all four divisions within the trust, paper submitted to CRIG awaiting date for presentation	8	31/10/2022		13/10/2023
4879	Physical or psychological harm	Harris, Michelle	Lynch, Diane	Patient Safety Group		28/03/2022	20	Risk assessments	Clinical Support Services	Cancer Services CBU		Trust-wide	If there are significant delays within the planned care cancer pathway then patients may experience extended waits for diagnosis and surgery, resulting in failure to meet national standards and potentially reducing the likelihood of a positive clinical outcome for many patients	National policy: - NHS standards for planned care (cancer) ULHT policy: - Cancer care pathway & booking systems / processes - Clinical Harm Review (CHR) processes ULHT governance: - Lincolnshire System Elective Recovery meeting – Monthly - Lincolnshire system RTT Cancer and Diagnostic- Weekly - ULHT Cancer Recovery and Delivery – Weekly - ULHT Clinical Business unit meetings – Weekly - Integrated Performance Report (IPR) to Trust Board - Monthly - Divisional Performance Review Meeting (PRM) process - Clinical Harm Oversight Group	Cancer patients awaiting surgery - all within 31 days New standards: 28 days for first diagnosis; 62 day max wait	14/09/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	- Planned care recovery plan (cancer) - Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions	[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. Ongoing	8	31/03/2023	31/03/2023	13/10/2023
5103	Physical or psychological harm	Rivett, Kate	Naydeva-Grigorova, Tanya	Children & Young Persons Oversight Group	Clinical Effectiveness Group	15/03/2023	20	Family Health	Children and Young Persons CBU	Children's Community Services		Trust-wide	Quality and safety risk from inability to deliver diabetes pathways within Community Paediatrics that meet National standards due to resourcing and capacity factors	1. Two Consultant Paediatricians (TN-G and AB) are currently managing all children with diabetes; 2. Team leader currently supporting provision of clinical duties across all 3 sites. 3. Prioritisation of workload to help match against available service capacity; 4. Business case in development to support expansion of diabetes services.	1. Audit of compliance with NICE guideline NG18 - Diabetes (Type 1 and Type 2) in Children and Young People: Diagnosis and Management and Adults and NICE quality standard QS125 - Diabetes in Children and Young People; 2. Results of National Paediatric Diabetes Audit	19/09/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Due to inadequate service, the service has been forced to be reduced and prioritising the children most in need, in doing so, not meeting BPT or audit requirements. Reduction plan: 1. Business case being developed to address shortfall, agreed in principal at CRIG. This is for a dietician, psychologist, admin and additional nurses. 2. Multi-professional working group tasked with delivering improvements that will support achievement of audit compliance 3. An increase in clinic capacity	[19/09/2023 14:03:37 Jasmine Kent] In recruitment stage, posts have been offered, meeting arranged with team leader for update. 75% of way through recruitment. Diabetes task and finish group ongoing with management and Consultants to monitor risk. For reduction in risk after induction of new starters. [15/08/2023 13:28:25 Jasmine Kent] Awaiting full recruitment (admin, nursing and HCSW). Progressing well. [18/07/2023 13:21:02 Jasmine Kent] Diabetes team recruitment ongoing, nursing post closed, shortlisting ongoing. To chase psychologist support. [22/06/2023 14:16:29 Jasmine Kent] Task and finish group has been established. Job descriptions have been reviewed, due to go to advert imminently. [16/05/2023 14:15:22 Jasmine Kent] Business case has been approved. Plan to increase workforce. [18/04/2023 16:32:20 Jasmine Kent] No change, nursing situation is not improving, escalated for additional support. Seeking continuity with a RN, HCSW or Admin. [15/03/2023 13:17:45 Kate Rivett] 15/03/2022 - KR 1. Risk developed to enable amalgamation of two individual risks that pertain to delivery of diabetes services (ID4974 and ID 5051)	4	15/03/2024	15/03/2024	19/10/2023

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
5101	Physical or psychological harm	Rivett, Kate	Herath, Dr Durga	Children & Young Persons Oversight Group	Clinical Effectiveness Group	14/03/2023	20		Family Health	Children and Young Persons CBU	Children's Community Services	Trust-wide	Quality and safety risk from inability to deliver epilepsy pathways within Community Paediatrics that meet National standards due to resourcing and capacity factors.	1. Single Consultant Paediatrician (DH) is currently managing all children with Epilepsy alongside a single specialist epilepsy nurse; 2. Wider consultant body supporting the care of children who are prescribed 2 antiepileptics in the absence of a consultant paediatrician with expertise in epilepsy; 3.Single Consultant Paediatrician is developing individualized care plans for each patient to optimise management of condition; 4. Liaison with ICB and regional network to support development and improvement of local services	1. Audit of compliance with NICE guideline NG217 - Epilepsies in Children, Young People and Adults and NICE quality standard QS27 - Epilepsy in Children and Young People;	15/08/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	1. Business case is being produced to enable establishment of fully funded epilepsy service 2. Agreement for spending has been obtained, moving forward. 3. In process of appointing 2 x epilepsy nurses, B6 has started, B7 was unable to start so back out to advert. 4. Epilepsy workshop with ICB	[15/08/2023 13:26:59 Jasmine Kent] 2nd nurse has now started but issues ongoing with tertiary support with Nottingham. Difficulties completing epilepsy 12 audit. Risk remains same for now. [18/07/2023 13:22:27 Jasmine Kent] New nurse starts 07/08, looking to pull together business case to increase nursing team size further. Clarifications on pathway with tertiary centre required. [22/06/2023 14:21:05 Jasmine Kent] Nursing service criteria completed for year 1 - patient cohort restricted in line with team establishment. Team only seeing newly diagnosed children, those on ketogenic diet and CBD oil until uplift in nursing staff. [16/05/2023 14:12:57 Jasmine Kent] Business case has been completed. 2 new people now in post. Risk remains the same for now, to be reviewed next month. [18/04/2023 16:07:35 Jasmine Kent] Successful recruitment 18/04. Recruited and offered post to another band 6, 2 x epilepsy nurses will be in post shortly. No current change to risk rating. [14/03/2023 11:46:07 Kate Rivett] 1. Risk developed to enable amalgamation of two individual risks that pertain to delivery of epilepsy services (ID4972 and ID 5073)	8	14/03/2024	14/03/2024	15/09/2023
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	30/08/2023	Quite likely (4) 71-90% chance	Extreme (5)	Very high risk (20-25)	20	Capital programme ongoing at Lincoln County ED - will increase clinical space Full Business Case approved at organisational level to support new build for Pilgrim ED System support with the introduction of Breaking the cycle - to create flow in hospital supporting the reduction of ED overcrowding Increased nursing template agreed by Director of Nursing for EDs Demand and Capacity work to review medical staffing in ED	[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 [22/02/2023 12:01:19 Paul White] Present at Confirm & Challenge by TW, reduction in score from 25 to 20 discussed and agree along with incorporation of details from previously separate 'surge in demand' risk. [27/01/2023 11:17:57 Helen Hartley] Risk reviewed and updated. [23/11/2022 11:28:16 Paul White] Reviewed at RRC&CG 23 Nov 2022 - current rating agreed. [10/11/2022 13:40:59 Helen Hartley] No change at governance [07/11/2022 07:03:00 Helen Hartley] Checked with Cheryl to see if there are any updates [12/10/2022 17:20:43 Helen Hartley] No changes made at governance	10	02/09/2023	31/03/2024	30/09/2023
4740	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 March 2023 there are 322 overdue haem pt at phb and 597 at LCH. From 1 Oct 22 till now the haematologists have held 95 extra clinics which equates to 71 news and 813 F/U. Haemostasis in particular pt are waiting almost triple the time that they have been graded at. There are 657 pt on this consultant PBWL with 295 being overdue. The longest waiter was due an appointment around July 2022. This consultant is holding on average 3 extra clinics per month.	Overbooking of consultant clinics (unsustainable); introduction of nurse-led clinics to manage demand. Long and short term Locum Consultant used to cover vacancies. Ad-hoc additional clinics outside of consultant job plan	Monitoring of outpatient appointments Clinical harm reviews & reported incidents	14/09/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Need for workforce review identified. Right sizing work force paper being written. 2 x agency consultants out to support service	[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	13/10/2023

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
5075	Physical or psychological harm	Capon, Mrs Catherine	Dolling, Matthew	Patient Safety Group		13/01/2023	20		Surgery	Theatres, Anaesthesia and Critical Care CBU	Critical Care	Lincoln County Hospital	Disease progress for patients alternative treatments,change of treatment plan, poor clinical outcomes,causing patients anxiety and worry for the patient. As a consequence of lack of ICU capacity for elective surgery patients this leads to cancellations on the day,this includes cancer patients that require level 2 post operative care.	Daily escalations to TACC team who endeavour to establish potential capacity through step down beds following ward rounds on ITU. Request for Anaesthetic review of the elective patients for the potential to identify patients for level 1 care rather than level 2. Patients that are cancelled are re dated as soon as possible following cancellation.	Monitoring the cancellation of elective patients - recording the reason for cancellation this includes bed capacity, due to staffing and patient need and activity at the time. Harm reviews to identify disease progression and changes in treatment plans for patients.	02/08/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	The triumvirate to include surgery and TACC are planning to meet to review potential options.	[02/08/2023 09:15:57 Rachael Turner] Update provided by Matt Dolling: This risk relates to the beds at LCH being capped at 8. The degree of risk has now decreased as plans to cap beds going forward have been suspended. Nevertheless a degree of risk Persists as whilst the consultant rota is staffed the number of appropriately competent nurses on the unit seems small. That having been said as we are in summer the unit is not being staffed to capacity from a nurse perspective but elective throughput is not being affected as it is reduced. Another way of looking at it is that we are currently staffed to need. Separately our ICUs have flagged on ICNARC as outliers nationally for non clinical transfers and this stems from the period when beds were being capped. It feels as if that has resolved now. In conclusion I do not feel as is there is no risk now but it is significantly reduced and as we plod through the rest of the year I would hope it can be removed as a risk. This risk will be presented at the RRC&C meeting in August for a reduction in score. [15/06/2023 09:01:19 Wendy Rojas] Risk continues as level 3 beds remain capped. Incidents monitored.Work in progress for recruitment. Strategy days planned. [06/04/2023 12:51:22 Paul White] Discussed at Risk Register Confirm & Challenge 29 March, risk agreed with feedback provided for consideration to clarify the risk description.	4	13/04/2023		02/09/2023
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.	05/10/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	There are many options but we are utilising these; - We have prioritised pharmacist and technician cover to acute admission areas as patient turnover is highest on these areas and gives us to best opportunity to conduct a medicines reconciliation under 24 hours - We prioritise patients which have stayed in the longest and have critical medication where known. Prioritisation of the highest risk patients decreases the risk of harm - No ward visits are divided as much as possible. To significantly reduce this risk requires additional ward based pharmacy staff cover across 7 days.	[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. [14/10/2022 16:16:26 Rachel Thackray] Business case for additional staff in progress.	8	30/06/2023	29/12/2023	02/11/2023
4624	Physical or psychological harm	Davies, Angela	Addlesee, Sarah	Patient Falls Steering Group	Nursing, Midwifery and AHP Forum	08/11/2021	16	Aggregation of Incident/Claims & Complaints/PALS	Corporate	Nursing Directorate	Corporate Nursing	Trust-wide	If patients in the care of the Trust who are at increased risk of falling are not accurately risk assessed and, where necessary appropriate preventative measures put in place, they may fall and could suffer severe harm as a result.	National policy: - NICE Clinical Guideline CG161: Assessment and prevention of falls in older people (2013) - PHE Falls and fracture consensus statement: Resource pack (2017) ULHT policy: - Falls Prevention and Management Policy (approved April 2021, due for review March 2023) ULHT governance: - Lead Quality Matron - Weekly Falls Investigation Panel / Training package tiered approach / Weekly spot check audits / Monthly Quality Metrics Dashboard meetings /ward review visits - Patient falls steering group / Nursing, Midwifery & AHP Forum / Quality Governance Committee	Frequency, location and severity of patient falls incidents reported: - The numbers of reported falls incidents are demonstrating an increasing upward trend therefore will not achieve the strategic objective to achieve harm free care. - Operational pressures have resulted in patients having prolonged periods sitting in Emergency Departments whilst waiting assessment and for inpatient beds to become available. This may contribute to an increase in some patients overall frailty level and subsequent deconditioning which increases the vulnerability to an individual falling. - Longer length of stays have demonstrated a correlation to risk of a patient falling whilst in the care of the Trust. Patient falls reported April 2021-March 2022 Total -1916 Moderate harm -22 Severe -12 Death -4 Patient falls reported April 2022-Mar 2023 Total -1958 Moderate harm -17 Severe-25 Death-1	13/10/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	• Improvement plan implemented by all Divisions, led by QM, monitored through Patient Falls Prevention Steering Group (FPSG). • Introduction and rollout of 'Think Yellow ' falls awareness visual indicators. • Patient story included within FPSG workplan. • Introduction of new falls prevention risk assessment and care plan documentation • Falls prevention training and education framework developed, delivery to commence 2022. • Analyse trends and themes in falls data to inform the need for targeted support and interventions. • Utilisation of Focus on Fundamentals programme • Enhanced care policy and associated processes review. • Revised falls investigation process and documentation. • Overarching action plan for divisional and serious incidents ,monitored through FPSG • Business case for dedicated falls team being developed • Collaborative work between Quality and Improvement teams to bring all existing falls prevention work together.	[12/10/2023 08:59:37 Sarah Addlesee] •An environmental review of toilet/bathroom environments will be concluded in October. Outcomes and recommendations will be presented to Falls Prevention Steering Group (FPSG) in November. •A series of falls prevention focus groups are being facilitated by the Quality Matron and Improvement teams during October.Outcomes will be shared at 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. •Divisions have focussed activities being undertaken to support the prevention of patients deconditioning whilst in hospital. •Falls prevention quality council continue to work collaboratively on identified quality improvements, and to join up the work being undertaken within individual falls prevention forums. Overall number of falls increased by 25 in September 2023- 2 severe and 1 moderate harm incidents. [12/07/2023 15:04:05 Sarah Addlesee] •Update July 2023 -Falls incidents continue to be analysed and trends and themes identified organisationally and reported through Falls Prevention Steering Group (FPSG). Increase in overall numbers of falls observed during June, continued to have incidents resulting in moderate and severe harm reported. •July Focus on Fundamentals is Falls Prevention, key information and guidance will be shared. Additionally a quarterly Falls Prevention newsletter will be launched in July to share learning and improvement work. •Themes from falls incident reports are discussed at monthly Divisional falls prevention forums supporting shared learning. •Quality Matron Team have commenced a review of the Safety Huddle documentation and a pilot is	4	31/12/2021	31/03/2023	30/11/2023

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4878	Physical or psychological harm	Harris, Michelle	Carter, Mr Damian	Patient Safety Group	Outpatient Improvement Group	28/03/2022	20	Risk assessments	Corporate	Operations		Trust-wide	If there are significant delays within the planned care non-admitted pathway (outpatients) then patients may experience extended waits for diagnosis and treatment, resulting in failure to meet national standards and and potentially reducing the likelihood of a positive clinical outcome for many patients	National policy: - NHS standards for planned care ULHT policy: - Planned care non-admitted pathway & booking systems / processes (outpatients) - Clinical Harm Review (CHR) processes ULHT governance: - Lincolnshire System Elective Recovery meeting – Monthly - Integrated Performance Report (IPR) to Trust Board - Monthly - Outpatient Recovery Group; Reports through Divisional PRMs (for performance), and FPEC and System Planned Care Group - Clinical Harm Oversight Group	2ww first O/Ps back within national target Urgent 1sts 90% <13 weeks by 31.03.23 Time critical follow ups (452/2657 overdue) – target to eliminate (mainly neurology, cardiology, rheumatology) by 31.03.23 RTT non-admitted: Clear >104wws by 31.03.22 Clear >78wws by 31.03.22 (with few remaining by 30.06.22) Clear >65wws by 30.09.22 Clear >52wws by 31.12.22	02/08/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	- Planned care recovery plan (non-admitted / outpatients) - Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions	[02/08/2023 14:31:41 Rachael Turner] Good progress continues to be made on reducing the time patients are waiting for Outpatient. However, Industrial action for Junior Doctors and now Consultants has significantly impacted recovery and the aim to clear all patients waiting over 78 weeks for treatment has not been met. Additional capacity and focus has been put into place to reduce numbers despite the impact of Industrial action. Numbers of patients waiting over 65 weeks for treatment continues at a rate better than expected [25/04/2023 10:38:37 Rachael Turner] Work continues, no current change to risk grading. [21/02/2023 17:44:30 Damian Carter] As Improvement plans embed, we are starting to see a reduction in number of patients waiting to be seen in Outpatients and subsequently patients are not waiting so long. Recent Outpatient Sprint to improve DNAs, missing outcomes etc. have also seen fewer patients waiting. The trust is on track to clear all incomplete patient pathways >78 weeks by the end of March 2023, with the exception of patient choice. [13/12/2022 13:31:41 Rachel Thackray] As per previous update, no change to risk grading [21/10/2022 09:42:00 Rachel Thackray] Work continues on the Outpatient Improvement Programme (ORIG) to improve clinic utilisation, reduce demand and increase activity back to 19/20 levels and above. Key progress since last update includes; 1. Contract awarded for Validation contract – Start date November 2022 2. Commencement of personalised Outpatient plan – Start date December 2022 3. Super September completed and yielded 40% reduction in non-admitted pathways that were validated 4. Plan to reinstate tertiary clinics to increase capacity 5. Dedicated support to reduce missing outcomes	8	31/03/2023	31/03/2023	02/09/2023
4877	Physical or psychological harm	Harris, Michelle	Carter, Mr Damian	Patient Safety Group		28/03/2022	20	Risk assessments	Corporate				If there are significant delays within the planned care admitted pathway then patients may experience extended waits for surgery, resulting in failure to meet national standards and potentially reducing the likelihood of a positive clinical outcome for many patients	National policy: - NHS standards for planned care ULHT policy: - Planned care admitted pathway & booking systems / processes - Clinical Harm Review (CHR) processes ULHT governance: - Lincolnshire System Elective Recovery meeting – Monthly - Integrated Performance Report (IPR) to Trust Board - Monthly - Divisional Performance Review Meeting (PRM) process - Clinical Harm Oversight Group	P2 - surgery within 31 days - currently around 6-7 weeks. Very long waiters	02/08/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Planned care recovery plan (Admitted / HVLC / GIRFT) Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions	[02/08/2023 14:32:55 Rachael Turner] The Grantham site has now successfully achieved the status of a GIRFT accredited Elective hub, one of only 8 in the country. This allows the trust to use Grantham as a ringfenced elective site and gives the ability to increase elective activity without an impact from emergency demand. The 6 theatres are now established and a significant amount of elective work as moved from Pilgrim and Lincoln. Whilst patients are dated for surgery in a relatively swift manner, the delays remain in Outpatients. Mitigation is set out in risk 4878 and means the overall risk to the waiting times is significant [25/04/2023 10:41:05 Rachael Turner] Work continues, no current change to risk grading. [02/03/2023 18:51:14 Damian Carter] As Improvement plans embed, we are starting to see a reduction in number of patients waiting to be seen and subsequently patients are not waiting so long. Recent Theatre Productivity work has started to yield improvements and led to a significant reduction in late starts. This is particularly evident at Grantham through the SuperSprint and has seen lost minutes due to late starts reduce by 50% [26/01/2023 15:06:57 Corporate Dashboards] Risk moved from Surgery to Corporate as this is an operational risk, not divisional. [21/10/2022 09:40:36 Rachel Thackray] Work continues on three main improvement programmes to address capacity for Surgery 1. HVLC/GIRFT – Looking at best use of theatres by ensuring HVLC procedures are completed as daycases rather than Electives. This maximises productivity of lists and reduces length of stay to ensure bed availability for surgery. Compliance with HVLC has started to increase over recent weeks 2. Theatre efficiency/productivity – The trust deployed a company called Foureyes insight to work with the surgical division and implement a 16 week improvement programme around best use of theatres to drive efficiency and productivity. This piece of work has now concluded and yielded improvement in utilisation and internal processes. This now needs to be embedded as business as usual 3. Clinical prioritisation – Looking at the prioritisation of patients for surgery based on their clinical need to ensure limited theatre resource is used for the patients that most need it. The output of this work has seen good list usage for our most urgent patients and an appropriate mix of lower priority	8	31/03/2023	31/03/2023	02/09/2023
4789	Physical or psychological harm	Harris, Michelle	Ratcliff, Carl	Patient Safety Group		16/01/2022	20	Risk assessments	Medicine	Cardiovascular CBU	Cardiology		If there is a significant delay in processing of Echocardiograms, which is impacted by staff shortages and inefficient processes, then it could lead to delayed assessment and treatment for patients, resulting in potential for serious harm, a poor patient experience and a poor clinical outcome	Weekly review and monitoring of OP activity /utilisation data Monthly meeting with CSS to review performance; secure any additional available capacity Escalation through CBU and Divisional governance processes / Planned Care Cancer and Diagnostic System Recovery Cell	DMO1 activity - monthly review Backlog consistently increasing C&A Team remain short-staffed due to vacancies -referrals being late added onto Medway leaving CBU with no visibility of the referrals for the first part of their pathway. - Issues with CBU not having visibility of demand to allow adequate proactive planning of additional clinic sessions. - CBU being unable to accurately forecast activity performance against standards e.g. DM01 -wasted clinic slots	30/08/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Review and realignment of systems and processes to ensure that the team efficiency has been optimised. External company (Meridian) engaged for 10 week period to enable a deep dive and improvement plan to be implemented for the service	[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. [24/04/2023 12:16:25 Carl Ratcliff] CDC work now started and also smaller service with In HEALTH Recruitment of additional staff underway with 3 joining in next month R/R now in place to prevent more staff loss Now only 44 pts behind the recovery plan extra cap for IP now also in place but does require more work [24/04/2023 12:16:07 Carl Ratcliff] CDC work now started and also smaller service with In HEALTH Recruitment of additional staff underway with 3 joining in next month R/R now in place to prevent more staff loss Now only 44 pts behind the recovery plan extra cap for IP now also in place but does require more work [27/01/2023 10:16:42 Charles Smith] 27/01/23 - Charles Smith DGM - CDC work had to go via tender, expected to start ~01/02/23. Delivery of 3000 from backlog. Midlands visit action plan/meridian recommendations largely implemented. R&R has preliminary sign-off from trust. Trajectories have total WL eradication in 2024 if no changes, 6w and 13ww cohorts within 12/12.	4	31/03/2022	01/02/2024	30/10/2023

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5102	Physical or psychological harm	Rivett, Kate	Naydeva-Grigorova, Tanya	Children & Young Persons Oversight Group	Clinical Effectiveness Group	15/03/2023	20		Family Health	Children and Young Persons CBU	Paediatric Medicine	Trust-wide	Quality and safety risk from inability to deliver diabetes pathways within Acute Paediatrics that meet National standards due to resourcing and capacity factors	1. Two Consultant Paediatricians (TN-G and AB) are currently managing all children with diabetes; 2. Team leader currently supporting provision of clinical duties across all 3 sites. 3. Prioritisation of workload to help match against available service capacity; 4. Business case in development to support expansion of diabetes services.	1. Audit of compliance with NICE guideline NG18 - Diabetes (Type 1 and Type 2) in Children and Young People: Diagnosis and Management and Adults and NICE quality standard QS125 - Diabetes in Children and Young People; 2. Results of National Paediatric Diabetes Audit	11/09/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	1. Multi-professional working group tasked with delivering improvements that will support achievement of audit compliance; 2. Business case being developed to address resources shortfall (e.g. dietitian, psychologist, admin support, additional nurses) - agreed in principle at CRIG meeting.	[11/09/2023 15:22:52 Jasmine Kent] for acute paeds, posts are funded and interviewed for, appointed HCSW and RNs and Dieticians, Psychology still a sticking point. Training and education offered to the ward once additional staff are in post. Look at reducing risk when this all in place. [14/08/2023 14:36:18 Jasmine Kent] For possible reduction next month due to shortlisting and interviews taking place for nursing, HCSW and admin recruitment. Risk remains same for now, review September 2023. [10/07/2023 13:49:10 Jasmine Kent] Requires discussion at governance and with Diabetes service lead, no change that the team are aware of but will update following governance later this week if any further developments have been made. [12/06/2023 15:51:05 Jasmine Kent] Gap analysis to be conducted to identify risk rating and specifically where improvements need to be made. [16/05/2023 15:40:38 Jasmine Kent] Business case has been approved for further recruitment. [04/05/2023 09:11:59 Rachael Turner] Risk re-opened as not a duplicate, this risk reflects risk for acute where as risk 5103 is for community. [03/05/2023 15:55:20 Rachael Turner] Risk closed as duplicate of risk ID: 5103. [18/04/2023 08:41:20 Jasmine Kent] Un-rejected. Has been approved, rejected by mistake, not a duplicate entry. [03/04/2023 15:13:44 Paul White] Duplicate entry [15/03/2023 12:50:59 Kate Rivett] 15/03/2022 - KR 1. Risk developed to enable amalgamation of two individual risks that pertain to delivery of diabetes services (ID4974 and ID 5051)	4	15/03/2024	15/03/2024	11/10/2023
5100	Physical or psychological harm	Rivett, Kate	Herath, Dr Durga	Children & Young Persons Oversight Group	Clinical Effectiveness Group	14/03/2023	20		Family Health	Children and Young Persons CBU	Paediatric Medicine	Trust-wide	Quality and safety risk from inability to deliver epilepsy pathways within Acute Paediatrics that meet National standards due to resourcing and capacity factors.	1. Single Consultant Paediatrician (DH) is currently managing all children with Epilepsy alongside a single specialist epilepsy nurse; 2. Wider consultant body supporting the care of children who are prescribed 2 antiepileptics in the absence of a consultant paediatrician with expertise in epilepsy; 3.Single Consultant Paediatrician is developing individualized care plans for each patient to optimise management of condition; 4. Liaison with ICB and regional network to support development and improvement of local services	1. Audit of compliance with NICE guideline NG217 - Epilepsies in Children, Young People and Adults and NICE quality standard QS27 - Epilepsy in Children and Young People;	11/09/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	1. Multi-professional working group tasked with delivering improvements that will support achievement of audit compliance.	[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 been approved. [03/04/2023 15:12:56 Paul White] Duplicate entry [14/03/2023 11:41:00 Kate Rivett] 14/03/2022 - KR 1. Risk developed to enable amalgamation of two individual risks that pertain to delivery of epilepsy services (ID4972 and ID 5073)	8	14/03/2024		11/10/2023
5175	Physical or psychological harm	Rivett, Kate	Flatman, Deborah		Clinical Effectiveness Group	16/05/2023	20		Family Health	Children and Young Persons CBU	Children's Community Services		Safety risk from Nationwide shortage of respiratory supplies as identified by NHS supply chain.	1) Supplies are being rationed by protect demand management within procurement department, with CCN's prioritising allocation to families based on clinical need. 19,000 a month countywide are required, allocation 9200 currently weekly meetings with procurement leads. Raised at Clinical Governance.	Datix incidents. Feedback from patients and staff. Stock check.	19/09/2023	Quite likely (4) 71-90% chance	Extreme (5)	Very high risk (20-25)	20	1) Continue weekly meetings with Procurement leads, looking at alternative codes when stock becomes available. 2) All families to be contacted at least weekly by CCN's to identify stock levels in the home and to estimate upcoming requirement. 3) Liaise with tertiary centre clinical leads, consultants, rapid response community physio teams, long term ventilation service. 4) Identify those high risk and high demand, prioritise allocated allowance. Reassess education with families surrounding suction to ensure appropriate usage of suction catheters. 5) Devised a letter awaiting sign off to issue to families to inform families of shortage and that they will be contacted weekly. 6) Alternative equipment to be used on clinical decision if oral suction only is required.	[19/09/2023 14:13:32 Jasmine Kent] Monitoring closely, no change in process. Issue ongoing re: supply issue. Receiving the right amount required at present. Weekly submission of requirements to be allocated. Alternatives have been found to be substandard. Risk reduction plan has been effective from working closely with procurement. [15/08/2023 13:36:39 Jasmine Kent] No resolution yet, ongoing concern and issue. [18/07/2023 13:19:13 Jasmine Kent] Risk persists, unable to downgrade. Concerns about going into winter due to suction catheter requirement increase. [22/06/2023 14:14:05 Jasmine Kent] Matron d/w patient supplies coordinator - Team Leaders are liaising with families and are managing suction catheters well, daily stock, adequate supply at present, 2-3 months worth of stock. [07/06/2023 12:55:43 Rachael Turner] Risk discussed at RRC&C meeting 07/06/2023. Risk score 4 x 5 20-high risk. [06/06/2023 16:06:25 Kate Rivett] 06/06/23 - KR - explanation of risk. Safety risk due to nationwide shortage of essential respiratory supplies (including suction catheters, heat moisture exchangers and naso-pharyngeal airways) as identified by NHS supply chain. Potential 6 month issue, 50 children in the community with these requirements. The unavailability of these rolling order consumables will have a direct impact on patient safety for children within the children's community team countywide. Stocks are beginning to run dangerously low, soon to be at critical levels. Without sufficient supplies in the home, there is also potential for service level disruption as patients will require 1:1 care, with unnecessary patient admission for airway management. Increased risk of chest infection, aspiration, pneumonia, and preventable child/young persons death.	5	30/11/2023		19/10/2023

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4935	Service disruption	Farquharson, Colin	Daniels, Mrs Samantha	Workforce Strategy Group	Patient Safety Group, WORK	26/05/2022	16	Workforce Metrics	Surgery	Theatres, Anaesthesia and Critical Care CBU	Critical Care		Insufficient medical staffing in Intensive Care Units at Lincoln and Boston. Uncovered shifts may result in Unit being decompressed. Medical staff asked to work extra hours compromising workforce directive. Unsafe cover in Unit when doctors are called to attend patients in A&E. Could result in harm to both patients and staff (in terms of wellbeing/morale).	Locums to recruit. Recruitment adverts out. Staff are being paid in TOIL in order to mitigate the financial risk to staff. Rotas are set and monitored -a Consultant formulates the rota and identifies gaps which cannot be covered in advance. Agency requests. Escalation to Divisional Triumvirate when gaps cannot be filled. Escalations are made to the medical director re payment agreements in accordance with NHSE/I policy. Business Continuity Plans are in place for both sites.	Rotas (gaps). Agency spend - financial risk. Number of Datix incidents recorded.	15/06/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Recruit to vacant posts.	[15/06/2023 09:32:33 Wendy Rojas] No change to risk status.beds capped at x8 L3 [18/04/2023 13:52:46 Caroline Donaldson] No change in risk status. Bed base number remains at x8 Level 3 beds. [09/01/2023 14:27:52 Caroline Donaldson] No change in status - still remains an issue. Bed base numbers remain reduced at x8 Level 3 beds. [29/11/2022 15:16:01 Caroline Donaldson] 17/11/2022 Discussed at TACC CBU governance meeting. Still remains an issue. [19/10/2022 15:22:43 Caroline Donaldson] 19/10/2022 CBU are looking to request an escalated rate for recruitment. Paper is currently in progress to request. Confirmed by S Daniels. Quality Impact Assessment undertaken and LCH ITU reduced to 8 x L3 bed equivalents on a temporary basis. For review Update 25.7.22 - substantive advert closes 8th August 2022. Locum advert is closed but awaiting shortlisting. Awaiting confirmation of interview date but looking like 27.9.22. Escalated to Medical Director and COO re decision to continue L3 equivalent reduction at current time.	4	31/10/2022		18/08/2023
5095	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	At present there is one 1.0 WTE VAN (band 6) and two 22.5 hours HCSW (band 2) covering: - Lincoln clinics (in patient only) Monday (up to and including 6 patients) and a Wednesday out/in patients - Pilgrim clinics Tuesday and Thursday, both in and outpatients - All clinics have slots for up to 6 patients, however, many late referrals are received and the clinic can increase to anything up to 12 patients. This means that the VAN goes home late most nights that incurs overtime payment. This additional activity is driven through urgent care pathways and is reliant upon a stretched team to meet this demand. As services enter a a post COVID climate there has been a recognised increase in complexity of presentations due to non-presentation at an earlier point. Case of Need has been written with final finance input outstanding to then go to CRIG ACPs are trained in this procedure but should not be relied upon as takes away from other core duties and is not a sustainable. Interventional Radiology is picking up some activity although this exposes patients to radiation and is not a sustainable option. This also require anaesthetics and theatre resources.	Volume of requests against number of staff and time taken to acquire IR1 submissions - started to see an increase in incidents being reported.	03/05/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Business case established with final finance input outstanding to then go to CRIG 6 month secondment for a PICC nurse has been advertised and will require training Give consideration to training of a wider network of clinicians associated with their individual service needs	[03/05/2023 10:26:45 Rachael Turner] Following further quantitative data provided this risk has now been validated as an active risk for the trust register. [26/04/2023 11:26:50 Rachael Turner] Risk needs to return to RRC&C once we have the quantitative data confirmed. Needs to look at where this risk sits as possibly more appropriate with CSS. This will be re-presented in the May RRC&C meeting. [25/04/2023 10:06:15 Chris Sewell] Due to unforeseen circumstances and long term absence the service has had to rely on the ACP and Interventional Radiology options as outlined in the risk controls. It is anticipated that they will return at the beginning of May. This has led to an increase in IR1s.	1	01/06/2023		03/06/2023
4779	Physical or psychological harm	Harris, Michelle	Ratcliff, Carl		Patient Safety Group	16/01/2022	20	Risk assessments	Medicine	Cardiovascular CBU	Stroke		Increase in risk of delays to patient care/harm as a result of increasing backlog of planned care activity across stroke arising from Covid19 constraints / service restrictions/ site escalation pressures.	additional clinics/lists (cost pressure) additional staffing where feasible to increase capacity (cost pressure)	weekly monitoring of RTT and PBWL	27/09/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	defined plans to address backlog for at risk areas	[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	30/12/2023

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5161	Physical or psychological harm	Rivett, Kate	Flatman, Deborah			23/04/2023	20		Family Health	Children and Young Persons CBU	Children's Community Services	Community	Quality and safety risk from non-integrated paper records.	Community matron, Team Leaders and service leads aware of the risks. Risk escalated to senior management team Meeting held with Digital Transformation Leads	To complete IR1 reports	18/07/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	1) CCNS to have access to SystemOne	[18/07/2023 13:25:46 Jasmine Kent] As we move to increase CCN team and deliver an on call service, the absence of an integrated electronic record system is going to post a larger risk, staff will be asked to provide opinion on children they do not know. [07/06/2023 13:07:24 Kate Rivett] 07/06/23 - KR - 1. Discussed at Risk Register Confirm and Challenge - panel advised score of 16 (severity of 4 x likelihood of 4) rather than the proposed 20 (severity of 4 x likelihood of 5). This was to align this risk with levels of risk across other divisions and in recognition that lack of incidents due to mitigation does not support the likelihood being= 5. [07/06/2023 13:00:51 Rachael Turner] Risk discussed at RRC&C meeting 07/06/23 Risk score agreed as 4x4 16 high risk. [06/06/2023 16:12:48 Kate Rivett] 06/06/23 - KR - explanation of risk: The children's community nursing services(CCNS) are working with a paper-based patient records system when providing direct nursing care to CYP with highly complex needs & their families within the home. There are increasing challenges for the 12 teams / specialisms when sharing information / communicating care with each other and with other professionals involved in the child's care, both within ULHT and externally with partner organisations across the ICS. 1) An individual child & family may receive care from >1 team / service within the CCS, resulting in multiple sets of records held in locked cabinets / locked offices in different locations. 2) Practicalities of sharing information when CYP may require frequent home visiting eg, daily, in various community settings / locations eg. home & school, across Lincolnshire (geography & time constraints). 3) Inability to provide contemporaneous patient healthcare information to GPs & MDT i.e.) every face-to-face & telephone contact. Including personalised care plans, complex medical & medicine management plans, PRPs / emergency healthcare plans at the end of life. Patient safety risk & poor patient experience. Risk of inappropriate treatment being delivered - actions & omissions. 4) Lack of essential information in a timely manner - GP Consultations, episodes of hospitalisations & associated CCN follow-ups, safeguarding concerns which may result in significant harm.	6	30/04/2024		18/10/2023
4868	Physical or psychological harm	Farquharson, Colin	Martinez, Francisca	Medicines Quality Group	Maternity & Neonatal Oversight Group	01/03/2022	16	Risk assessments	Clinical Support Services	Pharmacy CBU	Pharmacy		Preparation of Drugs for Lower Segment Caesarean Section (LSCS). 1. Medicines at risk of tampering as prepared in advance and left unattended. 2. Risk of microbiological contamination of the preparations. 3. Risk of wrong dose/drug/patient errors. Breach of Medicines Act: Regulation 3 of the Human Medicines Regulations 2021 permits doctors to prepare medicines for administration. The expectation would be that preparation would be in compliance with current best practice and governance expectations. Regulation 214 permits parenteral administration of medicines by or in accordance with the directions of and appropriate practitioner. This practice would constitute a risk to the patient and falls outside of expected governance arrangements detailed in Advice Note for Chief Pharmacists March 2017 NHS Pharmaceutical Quality Assurance Committee which defines acceptable practice as: administration immediately after (within 30 minutes) preparation and completed within 24 hours. It is noted the Trust Injectable Medicines	No current processes in place to minimise risk Policies do not support this practice	Incidents involving advance preparation of intravenous medication in clinical areas. Audits of compliance with standards / policy - The current labelling does not comply with national recommendation. Not all labels include the recommend identity (no dose/strength as per pictures). Also, no preparation date/time always included. There is no documented procedure stating the process to follow to ensure that the medicines prepared are discarded.	26/09/2023	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.	[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	31/12/2023
5142	Physical or psychological harm	Ratcliff, Carl	Smith, Charles			12/04/2023	20		Medicine	Urgent and Emergency Care CBU	Accident and Emergency	Lincoln County Hospital	Within Lincoln and Pilgrim Emergency Departments there is a risk that, given increases in demand/footfall, the current staffing template for middle grade doctors overnight may not provide assurance to maintain patient safety.	Utilisation of on-call Consultant to support dependant on holistic risk. Specialty support and signposting to other directorates and providers. Full capacity protocol and boarding.	4 hour target/12 hour breaches. Time to first assessment. Decision to admit.	26/09/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	ED Rota and workforce review with new rotas to provide effective cover overnight in all areas at all grades. New rota templates signed off by finance, to be implemented Q3 2023. Recruitment ongoing.	[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	26/10/2023

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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	30/08/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Delivery of the NIV Pathway project as part of the Improving Respiratory Service Programme within the Integrated Improvement Plan (IIP): 1. Understand the Trust-wide demand and capacity for Acute and Non Acute NIV. 2. Provision of ring-fenced beds for NIV. 3. Develop Trust-wide Model and Pathway for Acute and Non Acute NIV To meet BTS/GIRFT Standards. 4. Provision of NIV service (ED) which meets the BTS Quality Standards. 5. To have a trained workforce with the skills required to meet the needs of the patients and BTS standards. 6. Governance Process for NIV Demonstrating a Safe Service where Lessons are Learnt.	[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. Funding for the LCH site is currently paused awaiting budget setting and an update will be available if any concerns for escalation. Rationale for currently remaining at level of risk in addition to the above is due to recent incidents reported of NIV commenced in ED which is outside of the trusts agreed process. [26/04/2023 12:00:12 Carl Ratcliff] Await possible funding approval via BC or budget setting [13/01/2023 13:14:40 Donna Gibbins] Case of need agreed and SFBC being written following approval at establishment review for staffing establishment. Recruitment complete for LCH Respiratory wards with minimal vacancies once all staff in place.	4	30/09/2022	01/12/2023	29/09/2023
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)	26/09/2023	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.	[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	31/12/2023
5067	Reputation	Shelton, Helen	White, Paul	Patient Safety Group		23/12/2022	8		Corporate	Nursing Directorate	Clinical Governance	Trust-wide	There is a risk that the timeframe within which Serious Incidents are investigated may not meet Trust, ICB and CQC expectations in line with the 12 weeks specified in the national SI Framework, resulting in damage to reputation. This is caused by an increased number of SIs being reported and a lack of capacity in both clinical and support functions to expedite the investigation of Serious Incidents. There may also be an adverse impact on staff morale and wellbeing as a result of workload pressures.	National Serious Incident Framework ULHT Incident Management Policy & Procedures Serious Incident Panel Serparate approval process for patient falls and pressure ulcer SIs Datix system dashboard reports (live data) Divisional Clinical Governance Reports (monthly)	Currently the risk is being measured by the amount of SIs that are open and the amount that are 'overdue' the 12 week timeframe. As of 2 Dec 2022 there were: - 72 open SIs - 38 were overdue	07/06/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Weekly SI Update and Planning meetings taking place within Clinical Governance. Planning underway for transition to the new national incident framework (PSIRF) in 2023. Consideration to be given to not declaring falls and pressure ulcers as automatic serious incidents as a step towards the implementation of PSIRF. ICB / CQC not currently enforcing the 12 week timeframe (post-Covid pandemic). There is no specified timeframe in PSIRF.	[07/06/2023 12:32:58 Rachael Turner] Risk reviewed at RRC&C meeting 07/06/23 as part of the deep dive. Despite controls in place incidents continue to be raised and we have a new framework coming into place in September. Need to highlight risks that could come to other patients. Risk score to remain at a 16. [26/04/2023 15:29:22 Rachael Turner] Reviewed at clinical governance senior management team 24/04/23 current position 49 overdue SI investigations. Risk governance continue to support divisional teams with completion. Weekly update provided with oversight, SI panel panels continue but these have been recently effected by industrial action. Significant process has been made for PSERF implementation, which will eventually result in SI's being stood down and therefore risk will be closed at that stage. [27/03/2023 10:51:48 Rachael Turner] Risk reviewed-no change.	4	30/09/2023	30/09/2023	07/09/2023
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	08/09/2023	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Moving of Stroke specialist therapy staff from PHB to LCH Robust stroke training plan for general ward staff Attendance at Stroke Board to influence change and need for cohorting of outliers Review of Stroke staffing in line with latest staffing levels needed	[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		08/12/2023

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
5143	Service disruption	Lynch, Diane	Parkin, Mr Lee	Trust Leadership Team	Estates Investment and Environment Group, Patient Safety Group, Information Governance Group, Outpatient Improvement Group, Patient	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.	08/09/2023	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	To reduce the impact the team will use dumb waiters, one of which is in another area with limited access. Change of processes to mitigate risk and transfer notes over a longer period. Walk around with senior individuals and project team to look at different ways of working and potential solutions. Risks to be highlighted in QIA. Risk to presented at PRM. Health and Safety guidance to be delivered to Team. Further discussions to be had regarding whether all clinicians requiring paper based notes in clinic.	[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		08/12/2023
5232	Service disruption	Would, Teri	Woods, Mr Michael			25/08/2023	15		Clinical Support Services	Diagnostics CBU	New born hearing		Loss of clinical space for Newborn Hearing Screening due to IBS project. Due to project time line there will be a loss of 8-10 weeks of clinic space. Due to equipment and enviromental requirements specific spaces are required and capacity is short. Staffing requirements, chaperones etc. If project overruns then this will increase the risk of delayed patient pathways.	Changes in working patterns for staff to enable extra clinics over weekends in different spaces.	NBH waiting time reports	27/09/2023	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Once project complete then capacity will be restored.	[27/09/2023 12:33:56 Rachael Turner] Risk presented at RRC&C meeting. It was agreed to reduce this risk to a 4x3: 12 Moderate risk. [13/09/2023 13:44:47 Rachael Turner] Risk to be presented to RRC&C in September for reduction in score from 15 High to 12 Moderate. [13/09/2023 12:03:41 Maddy Ward] Risk reviewed at Diagnostics Quarterly Risk Register Review meeting today. No changes identified but risk has been reduced to Moderate (12) as this is most appropriate risk rating.	6	15/12/2023		30/12/2023
4688	Regulatory compliance	Hallion, Simon Chantry, Chris	Palliative / End of Life Care Oversight Group	Clinical Effectiveness Group		13/01/2022	15	Risk assessments	Family Health	Children and Young Persons CBU	Children's Community Services	Community	Quality and safety risk from non-compliance with NICE guideline NG61: End of Life Care for Infants Children and Young People with Life Limiting Conditions.	- ULHT processes for managing response to National Institute for Health and Care Excellence (NICE) pathways and guidance	Self assessment against NICE guideline NG61	18/07/2023	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Complete self assessment and implement actions required to achieve compliance Self assessment completed and details following actions: - Ensure that all parents or carers are given the information and opportunities for discussion that they need - Need more trained professionals Doctor and nurses (monitor compliance with EOL care elearning via Speciality Governance) - Manage transition from children's to adult's services in line with the NICE guideline on transition from children's to adult's services - Some groups have clear transition pathways- diabetes, oncology but there is no clear pathway for children with life threatening neuro disability or respiratory issues (D Flatman)(more specific action required) - Think about using a rapid transfer process (see recommendation 1.5.8) to allow the child or young person to be in their preferred place of death when withdrawing life-sustaining treatments, such as ventilation - Rapid Discharge pathway required (J Wooley) - The specialist paediatric palliative care team should include at a minimum: • a paediatric palliative care consultant • a nurse with expertise in paediatric palliative care • a pharmacist with expertise in specialist paediatric palliative care • experts in child and family support who have experience in end of life care (for example in providing social	[18/07/2023 13:13:40 Jasmine Kent] No change in risk, for review next quarter [18/04/2023 15:44:07 Jasmine Kent] For increase of risk. Specialist nurse is leaving, reducing capacity further. Issues with every case of end of life patients due to care not being commissioned, no 24/7 rota. Having to obtain support on a case by case basis depending who is available. [20/01/2023 11:18:34 Alison Barnes] No Paediatric palliative care consultant. Nurse with expertise, no pharmacy with expertise. [31/10/2022 15:02:43 Kate Rivett] 31/10/2022 - KR 1. 'What is the risk' updated to be more succinct to ensure that the risk is clearly articulated Self assessment completed. Actions identified have been detailed and communicated, as transcribed into this Risk Register entry	6	31/03/2022	30/11/2023	18/10/2023
Strategic Objective						**1b. Improve patient experience**																				
4701	Reputation	Grooby, Mrs Libby Upjohn, Emma	Estates Investment and Environment Group	Patient Experience Group		13/01/2022	15	Risk assessments	Family Health	Women's Health and Breast CBU	Obstetrics	Trust-wide	If the quality and condition of the hospital environment and facilities used within Maternity services are poor then it may have a negative impact on patient experience and staff morale resulting in loss of confidence in the Trust and damage to reputation; there is also an increased infection risk	- Trust procedures for capital investment and Estates project management - Corporate oversight through Estates Investment & Environment Group / Finance, Performance & Estates Committee (FPEC)	Patient & staff feedback on the environment in Maternity services. Audits of infection prevention & control compliance. Reported health & safety and IPC incidents.	03/07/2023	Reasonably likely (3) 31-70% chance	Extreme (5)	High risk (15-16)	15	Plans for refurbishment of Maternity units on both sites, estimated timescales 3-5 years for LCH, PHB to be confirmed. Full Business Case required. Maternity shared decision council looking at simple solutions for improving working lives of staff.	[04/07/2023 09:11:47 Alex Measures] Risk reviewed 03/07/2023- Nettleham has decanted to 1st Floor to allow for works to commence as per plan. [04/04/2023 12:45:23 Jasmine Kent] Predicted date for decanting Nettleham to Langton 02/05/2023. While awaiting funding for refurbishment of Nettleham. Drain work at Pilgrim site is scheduled. [23/01/2023 17:04:59 Jasmine Kent] Included within capital allocation bids for next financial year. Agreement from trust board that works will take place in next financial year. Staff engagement sessions to communicate refurb plans. Issues dealt with by Estates & Facilities as they occur. 13/04/2022: Mitigation plan - full board approval to progress the business case. Require monitoring of staff surveys. CQC report demonstrates unsuitable for use - amended to 3 impact and 5 occurrence = 15 26/09/2022 - Unchanged	6	31/03/2025	31/03/2025	03/10/2023

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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	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.	13/09/2023	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Adhoc sessions being booked for Outpatient provision where space can be found. No plan for IP on site.	[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		13/12/2023
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		Trust-wide	If Therapies and Rehabilitation service provision is not sufficient to deliver 7 day service provision, it leaves services without cover at a weekend or with inadequate cover during the week, leading to delayed patient flow; delayed discharge; extended length of stay; impacting on patient experience with potential for serious harm. This includes the neuropsychology cover on Ashby, SLT cover for inpatients, and therapy cover on ITU.	ULH policy: - Service planning & budget setting processes - Business case decision making processes ULH governance: - Capital & Revenue Investment Group (CRIG) management of business case process - CSS Division, CBU / speciality governance arrangements	Level of cover at weekends. Length of stay, patient flow, delayed discharges. Level of funding - Some 7 day funding, but limited to orthopaedics at LCH, minimal service. Inadequate for level of service demand.	08/09/2023	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Review current provision and identify gaps in service to inform business cases for change (working with Surgery and Medicine Divisions as appropriate). Skill mix requires review due to complexity of patients. Prioritisation tool helps to identify patients with greatest acuity or importance which will directly impact patient flow and current bed situation.	[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	30/11/2021	31/03/2023	08/12/2023
Strategic Objective						**1c. Improve clinical outcomes**																				
4828	Physical or psychological harm	Farquharson, Colin Costello, Mr Colin	Harris, Michelle Parkin, Mr Lee	Medicines Quality Group	Digital Hospital Group, Patient Safety Group	17/01/2022	20	Risk assessments	Clinical Support Services	Pharmacy CBU	Pharmacy	Trust-wide	The trust currently uses a manual prescribing process across all sites, which is inefficient and restricts the timely availability of patient information when required by Pharmacists. Where information about patient medication is not accurate, up to date and available when required by Pharmacists then it could lead to delays or errors in prescribing and administration, resulting in a widespread impact on quality of care, potentially reducing the likelihood of a positive clinical outcome and/or causing serious patient harm	National policy: - NICE Guideline NG5: Medicines optimisation, etc. ULHT policy: - Policy for Medicines Management: Sections 1-8 (various approval / review dates) ULHT governance: - Trust Board assurance via Quality Governance Committee (QGC) / Medicines Quality Group (MQG)	Medication incident analysis Audit / review of medicines management processes - the Trust currently uses a manual prescribing process across all sites, which is inefficient and restricts the timely availability of patient information when required by Pharmacists.	26/09/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Planned introduction of an auditable electronic prescribing system across the Trust. update 4th July 22- 26th july, empa functionality version 10.21 will be upgraded. Epma pilot from 13/09/22, full trust wide roll out- mid oct	[26/09/2023 14:04:28 Rachel Thackray] Planning to complete roll out by the end of the year. Ongoing work to implement. [03/08/2023 14:50:05 Lisa-Marie Moore] No further updates - still behind schedule [27/06/2023 09:46:58 Alex Measures] Discussed in risk register review meeting- no further updates [01/06/2023 14:19:05 Lisa-Marie Moore] Roll out continues but behind planned schedule [04/05/2023 14:22:48 Lisa Hansford] No for update roll out continues [29/03/2023 10:18:35 Maddy Ward] Due for completion in Lincoln at the end of April/ beginning of May and plan to be fully rolled out across Pilgrim by the end of September and all sites by the end of December. This excludes Paediatrics and Maternity. [02/02/2023 14:18:48 Lisa Hansford] Expected end date of implementation 31/03/23 [05/01/2023 14:07:02 Lisa-Marie Moore] Pilot phase in Cardio LCH complete. Roll out to begin on Stroke w/c 9th January [08/12/2022 12:43:26 Lisa-Marie Moore] Pilot still underway in cardiology at LCH. No update received to date on when roll out will occur. Issues external to pharmacy may hinder roll out e.g staff to add patients on careflow on admission/transfer [14/10/2022 16:05:51 Rachel Thackray] Pilot being undertaken in cardiology w/c 10 October 2022 which will take place over the next month. This will then be reviewed following completion. Funding approved for Electronic Prescribing and Medicines Administration (EPMA). Project plan has been developed, implementation from Oct / Nov 21. Reviewed at Risk Register Confirm & Challenge Group 26 Jan 22. Rating increased to 20. 17/5/22 No change 150622 Discussed that a further risk is to be added concerning accurate medicines reconciliation as defined in NICE medicine and optimisation guidance NG5. And connection to staffing. update 4th July 22- 26th july, empa functionality version 10.21 will be upgraded. Epma pilot from 13/09/22, full trust wide roll out- mid oct.	4	31/12/2023	01/04/2024	26/10/2023
4731	Physical or psychological harm	Harris, Michelle Parkin, Mr Lee	Medical Records Group Patient Safety Group			13/01/2022	20	Risk assessments	Clinical Support Services	Outpatients CBU	Choice, Access and Booking	Trust-wide	If patient records are not complete, accurate, up to date and available when needed by clinicians then it could have a widespread impact on clinical services throughout the Trust, potentially resulting in delayed diagnosis and treatment, adversely affecting patient experience and reducing the likelihood of a positive clinical outcome.	- Clinical Records Management Policy (approved June 2021, due for review June 2022) - Draft policy produced further discussion with changes required with Divisional Clinical Lead - Trust Board assurance via Finance, Performance & Estates Committee (FPEC); lead Information Governance Group / Medical Records Group - CSS Division	Internal audit of medical records management processes - reliance upon hard copy patient records; patients may have multiple sets of records. Reported incidents involving availability of patient records issues.	08/09/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Design and delivery of the Electronic Document Management System (EDMS) project, incorporating Electronic Patient records (EPR). Interim strategy required to reduce the risk whilst hard copy records remain in use.	[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. [27/10/2022 12:08:42 Rose Roberts] Ongoing OBC for EPR is being produced in line with NHSE/I guidance. Hoping to have Board sign off and funding in early 2022, with project start 2nd quarter 2022. To discuss / agree interim approach. Reviewed by Risk Register Confirm & Challenge Group, 26 Jan 22. Rating increased to 20, risk lead changed to Prof lead for Outpatients. Oversight to be via Digital Hospital Group. 120522 - Review of policy is underway – sent to h/recs managers for amendments before being sent for sign off to Lee and via the CRG 210622 Now further update until Nov. In Nov expect to get preferred bidder for it. Updates will come from Electronic records system project.	4	30/06/2018	31/03/2025	09/10/2023

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5154	Regulatory compliance	Simpson, Mr Andrew	Hansford, Lisa	Patient Safety Group		17/04/2023	16		Corporate			Trust-wide	The Trust currently does not have a Medicines Management or Intravenous Drug Training package on ESR. Previous Medicines management training was removed when the ESR software was changed. Usually all new nurses will be required to complete the medicines management training as part of the mandatory training. This is to support them to be able to administer medicines to patients. Without a robust Medicines management training package staff will not have access to the r Medicines Management training that has previously been available, which is not in line with Trust standards. This could potentially lead to harm to our patients from medication incidents, we will not be adhering to CG174, NG29, SG1 and QAPPS minimising injectables risk. Risk of breaching CQC regulation 12: Safe care and treatment also	All staff will have had undertaken some level of medicines management as part of their professional qualification, however standards are inconsistent and not aligned to trust standards. National (CG174, NG29,SG1) and Local policies and guidance indicate that training should be available to staff to support in administration and safe medicines management. Additionally won't be compliant with QAPPS in relation to minimising injectable medicines risks. CQC regulation 12: Safe care and treatment all indicated training should be available. None currently in place in the Trust. There are new staff that have comenced employment with the organisation that cannot access the trust medicines management training and ward and department leads require a decision to be made as to whether or not these staff can administer medication.	Reported incidents, Staff feedback on training and support available in staff surveys. Inspection feedback	13/06/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	The Medication Safety Team have written the Medicines Management, Controlled drugs training and the Drug Administration Programme. These training documents are also to be supported by the nationally recognised eLearning for health IV therapy passport. These training packages are under review by MOpS group before they can go through the governance process. The governance process is likely to take a number of months. There is then the added task of getting the training packages put onto ESR and mapped to the correct staff. ESR team is severly understaffed which may delay the process further. As an interim measure to reduce this risk level, once the training packages have been through the relevant governance processess, there could be the option to add the training power points to the Trust intranet. This would not be mapped to staff members, however we could signpost staff to this and local training completion records could be kept by the ward/department leads.	[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		09/10/2023
4928	Service disruption	Ratcliff, Carl	Marsh, David	Patient Safety Group		28/04/2022	16		Professional Guidance	Medicine	Cardiovascular CBU	Cardiology	Increase in risk of delays to patient care/harm as a result of increasing backlog of planned care activity across Cardiology arising from Covid19 constraints / service restrictions/ site escalation pressures.	additional clinics/lists (cost pressure) additional staffing where feasible to increase capacity (cost pressure)	weekly monitoring of RTT and PBWL	27/09/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	defined plans to address backlog for at risk areas	[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. [30/08/2023 11:22:46 Carl Ratcliff] to review with COO / CBU due to reduction in COVID [11/08/2023 12:57:38 Charles Smith] 1x Cons now in place, another to start September. Backlogs remain and impact of IA has led to reduced performance/clearance. [24/04/2023 12:57:21 Carl Ratcliff] Reduced number of covid pts in system - recruitment of locum consultant in place to cover small service gap [27/01/2023 10:20:57 Charles Smith] 27/01/2023 - CS - DGM - Further 2x Cons departures (Ads out). C&A not able to support PIFU implementation yet. Further loss of agency Cons at PHB to remove reliance on agency (cost). NHS national ask is to reduce FU work, this will have negative impact so currently negotiating via D&C process. [16/12/2022 14:40:47 Carl Ratcliff] Work underway to fill all clinics but no major concerns with perf [22/11/2022 17:29:18 Carl Ratcliff] RTT for cardiology starting to improve, however backlogs still place	8	30/06/2022	01/03/2024	30/12/2023
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	26/09/2023	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.	[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 technician meetings are addressing the training issue. 150622 ongoing, losing another technician to wards.	16	30/11/2021	28/04/2023	31/12/2023
Strategic Objective						**2a. A modern and progressive workforce**																				
4844	Service disruption	Lynch, Diane	Costello, Mr Colin	Workforce Strategy 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.	26/09/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Pharmacy supply a limited Saturday and Sunday morning service with staff working beyond their contracted hours. An on-call pharmacist is available for EMERGENCY items only. A Business Case has been submitted to CSS CBU.	[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	26/10/2023
4996	Service disruption	Dunning, Mr Paul	Chester-Buckley, Sarah	Workforce Strategy 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	14/09/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	* Workforce review * Refresher of Fragile Services Paper - NB there is a National shortage of Haematology consultants * Recruitment of further substantive consultants * Additional unfunded ST3+ for Haematology starts in August 2022	[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	13/10/2023

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
5093	Service disruption	Simpson, Mr Andrew	Baines, Andrew	Medicines Quality Group	Workforce Strategy Group	16/02/2023	20		Clinical Support Services	Pharmacy CBU	Pharmacy		Baseline pharmacy procurement staffing is at a level where 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	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.	05/10/2023	Extremely likely (5) >90% chance	Severe (4)	Very High risk (20-25)	20	Gap analysis highlights several areas of ongoing concern (to-follows, shortage management, invoice query management, medical gas invoicing). Occasional additional support is currently being provided to the invoicing team by a Bank Pharmacy Support Worker; we are scoping training this individual to offer procurement support in addition. This post is being paid from vacancy money elsewhere in the department and so cannot be considered a long-term fix for the procurement gaps. A case of need will be prepared to identify workforce requirements to reduce the workload stress the staff are persistently facing, and to provide a robust service which can withstand annual leave and short term sickness absence, based on the more challenging pharmaceutical market we are operating in where shortages are now a daily occurrence.	[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 - outcome was for a proposal to be presented to Diane for which she would find funding for necessary supporting roles. [06/04/2023 12:49:53 Paul White] Discussed at Risk Register Confirm & Challenge 29 March, risk agreed with feedback provided for consideration.	4	16/02/2024	16/02/2024	05/11/2023
4997	Service disruption	Dunning, Mr Paul	Chester-Buckley, Sarah	Workforce Strategy Group	Patient Safety Group	22/08/2022	16		Clinical Support Services	Cancer Services CBU	Haematology (Cancer Services)		Service configuration - single consultant covering both sites during weekend so cover limited if critically unwell patients on both sites	Middle Grade cover in place from Oncology but not sustainable as Haematology is not their area of experise and therefore cannot replace consultant presents with acutely unwell patients.	* Increased Datix, Complaints and PALS * Outcome from Staff Survey results	14/09/2023	Extremely likely (5) >90% chance	Severe (4)	Very High risk (20-25)	20	* Workforce review * Refresher of Fragile Services Paper - NB there is a National shortage of Haematology consultants * Recruitment of further substantive consultants * Additional unfunded ST3+ for Haematology starts in August 2022	[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	13/10/2023
4741	Service disruption	Cooper, Mrs Anita	Chester-Buckley, Sarah	Workforce Strategy Group		13/01/2022	20	Risk assessments	Clinical Support Services	Cancer Services CBU	Oncology	Trust-wide	Oncology is considered to be a fragile service due to consultant oncologist gaps. Demand vastly exceeds the capacity, requiring an increase in establishment. Tumour sites at risk (Medical oncology) - renal, breast, upper and lower GI, CUP, ovary/gynae, skin, testicular, lung, urology, HPB Clinical oncology - head and neck, skin, upper GI (RT only). Due to only consultant covering Sarcoma retiring we will no longer have consultant cover for sarcoma from July 23. Lack of cover for leadership roles: Chemotherapy Lead, and succession planning for clinical lead. Lack of continuity of care at PHB, LCH have 'hot week' for consultants, PHB have a different consultant covering for a ward round each day. If there is absence or consultant is on 'hot week' for LCH there is no cover for PHB that day and may be for several consecutive days.	Cancer services operational management processes & clinical governance arrangements Medical staff recruitment processes Agency / locum arrangements email sent to consultants to see if anyone would cover sarcoma - no capacity/specialisation	Monitoring tumour site performance data	14/09/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Need to undertake a workforce review, oncology still a fragile service, continuing to work with HR to source consultants	[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 Pilgrim Hospital Overdue: Clinical - 30 Medical – 9 Total number of patients on PBWL (including overdue): Clinical - 531 Medical - 31 [02/06/2023 13:10:49 Maddy Ward] Andrew Morgan requested a briefing paper for ELT which is now complete in conjunction with transformation and due to be circulated to execs on 05/06/2023	4	31/03/2023	31/03/2023	14/12/2023
5173	Service disruption	Morgan, Mr Andrew	Warner, Jayne	Trust Leadership Team		15/05/2023	20		Corporate	Medical Director's Office		Trust-wide	The Trust Board has a number of executive director vacancies which are currently filled by interim or acting up arrangements which may lead to instability. In some instances these appointments are for first time Director posts meaning that the Board could be seen as still developing. In addition to this the Chief Executive has recently announced his intention to stand-down on 31 March 2024, after 42 years service in the NHS.	Fit and Proper Persons Regulations. Voting rights are not impacted as interims / secondees all carry the voting rights of the role as per the Standing Orders/SFIs. Coaching and mentoring in place for those in their first appointment from the Chief Executive and the Director of Nursing/Deputy CEO. There is external coaching provision. with a plan to ensure each director has an external coach and mentor. Each executive director has a substantive deputy director. The ELT also has access to an external OD partner who works with the team on a regular basis.	Out of 6 directors only 2, the Director of Nursing and the Medcial Director are currently substantive. The Director of Nursing post is currently a shared post with LCHS. The Medical Director is currently off on long-term sick. The Chief Executive post is filled substantively but will become vacant at the end of March 2024.	07/06/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Continue with mentoring / coaching arrangements in place where appropriate. Review the succession plans for each post and ensure substantive appointments are made. Joint posts with other system providers to be considered where appropriate as part of the Lincolnshire Provider Review.	[07/06/2023 12:15:17 Rachael Turner] Risk discussed at RRC&C 07/06/2023 Risk score agreed as 4x4 giving a score of 16 making it a High Risk. [15/05/2023 13:41:10 Rachael Turner] Risk to be raised for validation at RRC&C Meeting in May.	10	31/03/2024		07/09/2023

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
4862		Ratcliff, Carl	Marsh, David	Workforce Strategy Group	WORK	22/02/2022	16	Staff Survey	Medicine	Specialty Medicine CBU	Respiratory Medicine	Trust-wide	Consultant staffing within Respiratory Medicine at Lincoln and Boston Hospital. Currently there are only 3 Substantive consultants in place at LCH and 2 at PHB. We have a vacancy of 5 across the three sites. Various gaps are covered with Adhoc Locum. The main current risk is to the inpatient cover at Pilgrim Hospital. With only x2 Consultants over there, when we have 1 on annual leave, the risk that the other could be either sick or covid contact is extremely high. We have supported this with clinicians going over from LCH, however due to a further resignation at LCH, this is proving more difficult This combined risk on Medical staffing has now impacted the Secretarial team at LCH. There is currently 0 secretaries at work at LCH due to sickness in the team. This is mitigated through support from Agency / Other specialties supporting. We do not have the substantive staff nor the locum or agency bookings, to cover all functions of our Resp Medical Team. Inpatient risk of high acuity patients without specialist input. Outpatient risk of high activity of 2ww referrals on top of high volume OP workload, delayed	Due to the severity of the risk: Currently: x 5 Consultant Gaps in Resp The impact this is having on the current workforce is stretching the team and leading to added pressure on the workforce. We are working with agency teams to work 'differently' for example Locum consultants supporting with on call work / remote clinics to release the burden on the current clinical team in respiratory. OD support in place also, along with weekly catch up meetings with the teams to explain the current state of play. The Business Unit have this week (06/09) put a bid in to the EMCA to gain funding of 250K to support a General Medicine to work in Respiratory so that our Substantive teams can be released to support Respiratory Cancer Capacity - This bid is currently being reviewed. We have worked in the background to book x 2 Agency Locum General Medicine Consultants 1 at Boston and 1 at Lincoln which will take us over budget, but supports the respiratory patients of lincolnshire and the welfare of consultant staff.	Staff Survey Results. Data Analysis through HR around recruitment and retention. Measured through Performance for patients (although this is not directly attributed towards the recruitment and retention, the longer wait times cause anxiety and unwarranted stress for the consultants in post)	30/08/2023	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.	[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 leave / sickness, we have only 1 consultant on the Pilgrim site) 2 Grantham inpatient respiratory services (Preferred) Releases x1 Agency Locum Consultant who can ?potentially? go over to Lincoln (as per previous agreement)	4	30/12/2022	03/06/2024	01/11/2023
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	30/08/2023	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	[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. Relationship with LRDP now embedded, GMC registered Drs and MSWs recruited. Agreement reached with third party supplier to support international recruitment for difficult to recruit AHP roles. " [24/04/2023 11:41:33 Rachael Turner] Work still ongoing, following PODC meeting booked in April, risk will be presented at RRC&C meeting in May.	4	31/03/2023	31/03/2023	30/09/2023
5249	Service disruption	Low, Claire	Akhtar, Sarah			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)	06/09/2023	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	[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		06/12/2023

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4762	Service disruption	Capon, Mrs Catherine	Rojas, Mrs Wendy	Workforce Strategy Group	Nursing, Midwifery and AHP Forum, WORK	14/01/2022	15	Risk assessments	Surgery	Theatres, Anaesthesia and Critical Care CBU	Critical Care	Lincoln County Hospital	Issues with maintaining nurse staffing levels/skill to establishment in ICU at Lincoln.	Nursing workforce planning arrangements. Nurse recruitment / retention processes. Clinical Governance arrangements in Critical Care / Surgery Division.	Staffing vacancy rate within ICU nursing	28/06/2023	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Review of current recruitment strategy. Advertisement for vacant posts.	[28/06/2023 11:17:28 Rachael Turner] Risk discussed at RRC&C meeting 28/06/2023, 8 level 3 beds has been abandoned, we will be aiming for 11 level 3 beds. We are in a better position staffing rates has gone up, still a risk in regards with skills. Risk will still remain high as a potential risk for nursing and medical staffing around beds. This will be reviewed along with two other risks relating to ICU and will be re-presented in July. Risk score to remain the same. [19/06/2023 11:30:56 Rachael Turner] Risk to be presented at RRC&C meeting in June 2023 for validating reduction in score. [15/06/2023 09:38:00 Wendy Rojas] Risk rating reviewed and now moderate. [15/06/2023 09:37:17 Wendy Rojas] Positive recruitment in both units. Both units nearly at full establishment. Level 3 capped at 8 which has supported training/staffing needs. Additional clinical educator both sites extended. [18/04/2023 13:54:11 Caroline Donaldson] Staffing situation remains the same. Level 3 beds are still capped at x8. [09/01/2023 14:29:40 Caroline Donaldson] Staffing position remains the same - still an issue. Advert out for posts. Second Clinical Educator post has been recruited to. Level 3 beds still capped at 8 (both sites). [29/11/2022 15:15:09 Caroline Donaldson] 17/11/2022 Discussed at TACC CBU governance meeting. Still remains an issue. No change to previous progress note. [20/10/2022 14:04:40 Caroline Donaldson] 20/10/2022 Discussed with Lead Nurse. Still ongoing workforce issues. Interviews are in progress for additional clinical educator post and approach has been made to the Clinical Education team to support with that. Individualised action plans are being drawn up and put in place for new members of nursing staff in order to support them. 16/09/2022 Skill continues to be an issue. Additional clinical educator to be appointed to support training needs of team. Level 3 beds still capped at 8. Risk continues and includes skill mix as well as numbers of staff. Mitigation - ongoing recruitment, block booking of Agency staff, daily review of staffing undertaken, liaison with University of Lincoln to	6	30/06/2021	30/09/2022	28/07/2023
4905	Physical or psychological harm	Cooper, Mrs Anita	Taylor, Ruth	Workforce Strategy Group	Workforce Strategy Group	22/04/2022	12	Workforce Metrics, Risk assessments, Aggregation of Incident/Claims & Complaints/PALS	Clinical Support Services	Therapies and Rehabilitation CBU		Trust-wide	If we have insufficient staffing, or required level of experience and skill, the risk is patients will not receive assessment and rehabilitation leading to poor clinical outcome. Reduced flow on Ashby and the acute wards, delayed discharges, delayed referral to response times. Increase in avoidable harm i.e. deconditioning, PU's, constipation, delirium. Patient reviews delayed for botox treatment. Paediatric services delayed response to new diabetes referrals and unable to see current diabetes patients in clinic- could lead to patient harm. Increase in bed stock and boarding beds without recognition of additional therapy staffing needs. Existing staff stretched to cover additional beds. Increased stress and sick leave on substantive staff.	Recruitment and retention strategies to fill vacancies. Bank staff. Requests to Locum Agencies. Skill mix Roster management. SQD data. Daily review of ward systems eg WebV. Referral guidelines and Prioritisation guidelines help to inform workloads and impact on patient flow and bed situation. Paed services are responding to direct requests for newly diagnosed children . Upskilling B5 N&D staff-(normally B6 N&D staff). Access to Staff wellbeing services. Front door therapy assessments passed to inpatient teams on admission.	Patient complaints. Fewer discharges at the weekend. Site escalation. Vacancy rates. Roster fill rates. Waiting lists for spasticity service. Staff absence. Staff survey and feedback.	08/09/2023	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Getting locums and bank staff in place. Good use of relocation allowance. Actively managing the waiting lists and dealing with urgent cases to avoid harm eg telephone contact with patients. Case of need for GDH orthopaedic staffing. Case of need for rehabilitation consultant post. Case of need for upper GI dietician. Case of need for Neuro Psychology staff on Ashby. Case of need for OT staff at PHB and LCH in ITU. Over recruitment of band 5s in dietetics. Competency frameworks and preceptorship.	[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	08/12/2023
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.	29/09/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Industrial relations action plan & engagement mechanisms and arrangements with Staff Side representatives.	[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. People and Workforce Team working with the Emergency Planning Team to ensure appropriate planning is in place. Industrial Dispute Action Plan and Risk Assessment complete and has been tested through industrial action. Industrial Action Planning Meetings. Currently managed within risk tolerance. EPG to consider making this risk Inactive (for annual review)." [10/03/2023 11:46:11 Rachael Turner] No change. Work currently in progress to provide an update in April. [31/01/2023 15:18:02 Rachel Thackray] Current risk assessment in place and working group set up to prepare for potential ongoing industrial action, links in with operational planning to ensure a joined up approach. [07/11/2022 11:13:23 Rachel Thackray] There is a likelihood that there will be some form of industrial action before the Christmas period in 2022. Therefore, it is necessary to increase the likelihood of this risk from low to extremely likely. As such he Associate Director of Workforce is working with the Emergency Planning team to revise	4	31/03/2023	29/10/2023	

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4948	Physical or psychological harm	Cooper, Mrs Anita	Moore, Lisa-Marie		Health and Safety Group, Medicines Quality Group, Patient Safety Group	17/06/2022	20	Workforce Metrics	Clinical Support Services	Pharmacy CBU			Workload demands within Pharmacy persistently exceed current staffing capacity which leads to 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	05/10/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Review current provision and identify gaps in service to inform business cases for change to support 7 day working (working with Surgery and Medicine Divisions as appropriate). Skill mix requires review due to complexity of patients.. Pragmatic management of workload & provision of management support. On-going exploration of recruitment options. Wellbeing team supporting staff - regular visits organised	[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	02/11/2023
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	06/09/2023	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"	[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		06/12/2023
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	06/09/2023	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.	[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	06/09/2024	06/12/2023
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	06/09/2023	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"	[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		06/12/2023

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
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	30/08/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	1. Governance and assurance for delivery of WDES action plan 2. Review of appropriate datasets to measure risk 3. Introduction of WDES annual report	[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 2. July 2022: ULHT review datasets, declaration rates (from 1/7/22 ULHT required to submit metrics	4	31/03/2023	31/03/2023	30/09/2023
4992	Service disruption	Low, Claire	Shankland, Lindsay	Equality, Diversity and Inclusion Group		08/08/2022	16		Corporate	People and Organisational Development	Organisation Development	Trust-wide	Workforce management practices that are not inclusive and equitable for people from all racial and cultural backgrounds may have a negative impact on the recruitment of new employees and the retention of existing ones.	1. Lincolnshire Belonging Strategy (improving equity of lived experience and representation across Lincolnshire system) 2. Appointment of People Promise Manager (12 month fixed term) 3. Robust monitoring of EDI incidents/concerns 4. Equitable and EQIA 'tested' HR processes (for recruitment, reward and performance)	1. NHS Staff Survey 2. 'Pulse Check' Staff Survey 3. No. EDI/Race incidents reported 4. No. of EDI/Race related concerns reported 5. BAME staff retention % (leave within first 3, 6 and 12 months) 6. BAME senior representation	30/08/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	1. Robust governance and assurance for ULHT direction of travel for EDI 2. Reset ULHT strategic direction for EDI (EDI objectives 2022-25) 3. Active WRES Action Plan 4. Anti-Racism strategy and delivery plan 5. Zero tolerance stance - for racist behaviour including banter 6. Improved senior level BAME representation 7. Reset Trust values (highlighting civility@work and ULHT commitment to inclusion)	[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 Board in February 2023 and published by 28 February 2023. 1. EDI Group and regular reporting established (for assurance)	4	31/03/2023	31/03/2023	30/09/2023
Strategic Objective		**3a. A modern, clean and fit for purpose environment**																								
4647	Reputation	Harris, Michelle	Davey, Keiron	Fire Safety Group	Fire Safety Group	14/12/2021	20	External inspections	Corporate	Estates and Facilities	Fire and Security	Trust-wide	If Lincolnshire Fire & Rescue Service (LFRS) carries out an inspection and finds the Trust to be systemically non-compliant with fire safety regulations and standards it could result in regulatory action and sanctions, with the potential for financial penalties and disruption to services if sites are required to close.	National policy: - Regulatory Reform (Fire Safety) Order 2005 - NHS Fire safety Health Technical Memoranda (HTM 05-01 / 05-02 / 05-03) ULH policy: - Fire Policy (approved April 2019, due for review April 2022) & related procedures / protocols / records - Fire & Security Team / Fire Safety Advisors ULH governance: - Fire Safety Group / Fire Engineering Group, accountable to Trust Board through Finance, Performance & Estates Committee (FPEC) - Health & Safety Committee & site-based H&S committees	- Compliance audits against fire safety standards - Progress with fire safety improvement plans - PPM compliance assurance (current lack of required detail for internal and regulator assurance)	21/09/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	- Statutory Fire Safety Improvement Programme based upon risk - Policy and protocols framework and improvement plan reported into weekly Estates teams meeting - Progress reviewed by FEG and FSG monthly, to mitigate against the risk of sanctions - LFR involvement and oversight through the FSG - Regular updates with LFR provided indicating challenges during winter pressure and Covid - Fire safety audits being conducted by Fire Safety team - Fire wardens in place to monitor local arrangements with Fire Safety - Weekly Fire Safety Checks being undertaken - Improve PPM reporting for FEG and FSG By Estates Teams - Fire safety team weekly Risk assessment confirm and challenge reviews by Fire safety team - All areas of Trust allocated RAG rating for fire using using occupancy profile, escape provision, height above ground and sleeping risk - Higher rated residual risks from risk assessments being incorporated into risk register	[21/09/2023 14:40:33 Rachael Turner] All higher risk areas survey completed on compartmentation surveys. Grantham completed, Pilgrim 97% completed and Pilgrim 80% completed. Higher risk areas identified for a capital spend allocation provided to capital team and identified on the basis of FRA contents to ensure higher High risks undertaken first. [18/07/2023 14:56:34 Rachael Turner] Risk areas-medium risk areas 50% completed at 3 sites. combustible material noted on ceiling within M1 at pilgrim. Action being taken by estates teams to provide remedial works by 28 July. [23/06/2023 14:25:36 Corporate Dashboards] Risk reviewed no change to report [15/05/2023 13:32:10 Rachael Turner] Progress towards the Fire Deficiency notices, Fire are currently completing inspection of the passive fire protection for ALL Higher Risk areas across the three sites, (typically patient sleeping areas). A report will be issued to the Fire safety team identifying breaches in compartmentation with associated costs. The next phase of surveys will commence June for ALL Medium-Risk areas Chubb have been appointed as a competent person to undertake extinguisher inspections. These have commenced at pilgrim and will be prioritised on the basis of compliance dates. Troup Bywaters + Anders were commissioned to undertake a site survey. A capital bid will be presented to the Capital board, to seek approval for funds to address in a phased approach in a timely manner [25/04/2023 10:09:43 Rachael Turner] Unannounced Fire Drills have now commenced in area across the trust being supervised by the fire safety team. Compartmentation surveys across 3 sites on basis of risk priority by competent contractor in accordance with Notice of deficiency received from Lincolnshire Fire and rescue. Extinguisher servicing has commenced by competent contractor. [03/03/2023 13:44:13 Rachael Turner] Fire safety team currently working with estates colleagues to identify any areas of lower assurance are included within PPM schedule. Fire Drills commencing non clinical areas March 2023 No change, risk grading remains the same	4	30/06/2022	31/03/2024	21/10/2023

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
4648	Physical or psychological harm	Harris, Michelle	Davey, Keiron	Fire Safety Group	Emergency Planning Group, Health and Safety Group	15/12/2021	20	Risk assessments	Corporate	Estates and Facilities	Fire and Security	Trust-wide	If a fire occurs on one of the Trust's hospital sites and is not contained (due to issues with fire / smoke detection / alarm systems; compartmentation / containment) it may develop into a major fire resulting in multiple casualties and extensive property damage with subsequent long term consequences for the continuity of services.	National policy: - Regulatory Reform (Fire Safety) Order 2005 - NHS Fire safety Health Technical Memoranda (HTM 05-01 / 05-02 / 05-03) ULH policy: - Fire Policy (approved by FEG / FSG Sept 2022 - awaiting final approval / signature to be HTM compliant): # Personal Emergency Evacuation Plans (PEEPs), approved April 2017 - Fire safety training (Core Learning, annual) / Fire Warden training / Fire specialist training - review / protocol in draft, TNA in draft for Fire Safety Team review - Major Incident Plan - Estates Planned Preventative Maintenance (PPM) programme ULH governance: - Trust Board assurance through Finance, Performance & Estates Committee (FPEC) / lead Fire Safety Group (including divisional clinical representation & regulator attendance) / Fire Engineering Group - All areas within the Trust estate are individually risk rated for fire safety (based on occupancy, dependency, height, means of escape), which informs audit / monitoring activity - Local fire safety issues register (generated from local fire risk assessments) - tasks allocated to Estates / local managers, etc. as appropriate; tracked and monitored by Fire Safety Team, validation by Fire & Rescue Service - Weekly fire safety team meetings concerning risk assessments and risk register - Capital risk programme for fire - Reporting of local fire safety incidents (Datix) generated through audit programme - Authorising Engineer for Fire - Health & Safety Committee & site-based H&S committees	Results of fire safety audits & risk assessments, currently indicate: - Fire Risk assessments within Maternity Tower block Lincoln indicating substantial breaches of compartmentation requirements - Fire risk assessments indicate lack of compartmentation within some sleeping risk areas - Age of fire alarm systems at all 3 sites (beyond industry recommendations) - No compartmentation reviews undertaken to provide assurance of existing compliance (all 3 sites) - Concerns with networking of fire alarm system at Pilgrim (to notify Site Duty Manager / Switchboard of alarm activation) Reported fire safety incidents (including unwanted fire signals / false alarms). Fire safety mandatory training compliance rates.	21/09/2023	Quite likely (4) 71-90% chance	Extreme (5)	Very high risk (20-25)	20	- Capital investment programme for Fire Safety being implemented on the basis of risk - costed budget plan for FEG submission Sept 2022. - Trust-wide replacement programme for fire detectors. - Fire Doors, Fire/Smoke Dampers and Fire Compartment Barriers above ceilings in Pilgrim, Lincoln and Grantham require improvements to ensure compliant fire protection. - Fire safety protocols development and publication. - Fire drills and evacuation training for staff. - Fire Risk assessments being undertaken on basis of inherent risk priority; areas of increased residual risk to be added to the risk register for specific action required - Local weekly fire safety checks undertaken with reporting for FEG and FSG. Areas not providing assurance receive Fire safety snapshot audit. - Staff training including bespoke training for higher risk areas - Planned preventative maintenance programme by Estates	[21/09/2023 14:42:06 Rachael Turner] Area on M1 material tested by AE Fire and report received to indicate a low risk. FEG requested urgent review of FRA with this knowledge. FRA continue on the basis of statutory and risk requirements [18/07/2023 14:59:14 Rachael Turner] Risk areas-combustible material highlighted on ceiling M1. Estates implementing Remedial actions by 28 July 2023 [23/06/2023 14:24:47 Corporate Dashboards] Risk reviewed no change to report. [15/05/2023 13:33:34 Rachael Turner] Competent persons are currently completing inspection of the passive fire protection for ALL Higher Risk areas across the three sites, (typically patient sleeping areas). A report will be issued to the Fire safety team identifying breaches in compartmentation with associated costs. The next phase of surveys will commence June for ALL Medium-Risk areas Troup Bywaters + Anders were commissioned to undertake a site survey. A capital bid will be presented to the Capital board, to seek approval for funds to address in a phased approach in a timely manner [25/04/2023 10:10:43 Rachael Turner] Fire door Tender for maintenance, supply and install has gone to framework by procurement teams. Fire Door inspection by competent contractor selected with anticipation of late may start up. [03/03/2023 13:47:32 Rachael Turner] Compartmentation survey commenced with remedial actions identified for inclusion within capital plan 23/24/25, Fire drills commenced in non clinical areas March 2023. [06/12/2022 14:53:59 Rachel Thackray] New security provider undertaking internal patrol routes with escalation to porters when storage discovered. [02/11/2022 12:39:13 Rachel Thackray] Regular audits conducted by fire safety team by Fire Safety team within corridors, and IR1s being submitted to line managers for action. Escalation to matrons has now begun via IR1s. Rating increased on review to 20 - combustible storage in common areas frequently found (including	10	31/03/2022	31/03/2025	21/10/2023
5189	Service disruption	Parkhill, Michael	Whitehead, Mr Stuart	Medical Gasses Working Group	Health and Safety Group	13/06/2023	25		Corporate	Estates and Facilities	Estates	Lincoln County Hospital	The Medical Air Plant in Maternity Block and Plantroom 12 at Lincoln County Hospital are of an age and high risk of failure. The systems are none compliant and do not comply with current triplex and quadplex installations. The installed systems or only duplex. Maternity Med Air plant has failed and currently operating with a temporary skid mount compressor plant. On 11th June the Plantroom 12 Med Air Plant failed and created significant patient Harm Risk. Both of these Med Air Plants require replacement to prevent harm to patients and staff.	A temporary hired medical air plant is in use at Matternity Block to maintain Medical Air provision. Plantroom 12 is operational and is under investigation and support from specialist contractors to maintain its operation.	Frequent daily inspections of plant is to be implemented immediately, this is to support the service and maintenance from the contractors as an additional monitoring activity.	03/09/2023	Quite likely (4) 71-90% chance	Extreme (5)	Very high risk (20-25)	20	Our specialist contractors are working with the trust in order to supply temporary medical gas plant in the event of catastrophic failure to enable the impact to be as minimal as possible. The long term and only feasible strategy is to replace the medical gas air plant, upgrade to a quadplex modern and fit for purpose system, but this will require significant capital investment.	[03/08/2023 10:12:04 Rachael Turner] Risk reviewed, work currently ongoing, no current update. [28/06/2023 11:48:48 Rachael Turner] Risk discussed at RRC&C meeting 28/06/2023. Risk remains at a 20 following an incident. This was declared as a Serious Incident. On 11th they lost one side of medical air vent, the ventilators stopped working. Currently running on higher sets at Lincoln. Now secured capital, looking at a Triplex. Risk score agreed as 4 x 5 at a score of 20.	5	01/03/2024		03/10/2023
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.	27/09/2023	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.	[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. [02/01/2023 13:20:55 Emma Wheatley] Updated 02/01/2023 some jobs completed. [15/12/2022 09:52:08 Alex Measures] Lucy Rimmer our CBU divisional manager did a walk around with the estates team to get some movement and actions on some of the long list and occupational therapy was on that visit	4	31/03/2022	31/03/2023	08/12/2023
5104	Regulatory compliance	Rinaldi, Dr Ciro	Dunning, Mr Paul	Mortality and Learning Strategy (MoraLS) Group	Estates Infrastructure and Environment Group	16/03/2023	10		Clinical Support Services	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 is being developed. -Initial concerns have been addressed from Lincoln site. -The Trust currently has two Titan units (temporary additional mortuary capacity) which provides additional capacity in the event of winter pressure peaks in demand and also in the event of equipment failure. -The Trust has a memorandum of understanding with Hull University Teaching Hospitals to support with the storage of bariatric bodies that require longer storage (freezer capacity).	ULHT Improvement action plan HTA Governance Group Weekly meetings to oversee mortuary refurbishment plans	21/07/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Risk reduction plan to assure HTA during March that risk controlled above mitigate their concerns over the Trusts mortuary estate. HTA have confirmed their acceptance of the Trust's plans to mitigate and have closed down their inspection process as complete.	[05/07/2023 11:06:25 Rachael Turner] Risk discussed in June RRC&C meeting, agreed to reduce risk score from 20 to a 16 High Risk [08/06/2023 13:22:36 Rachael Turner] Risk to be presented at RRC&C in June for reduction in score from 20 to 16. [31/05/2023 04:53:29 Jeremy Daws] HTA have responded to the Trust during May confirming their acceptance of the Trust's mitigation plans. HTA have confirmed they are assured enough to close down the inspection process as complete. Risk rating likelihood has been reduced from Quite likely (4) to Reasonably unlikely (3). The rationale for this is there is still a risk to the Trust if the current plans around refurbishment are not completed, even if HTA confirm that this current round of inspection/regulation is concluded. [26/04/2023 12:12:07 Rachael Turner] Risk presented at RRC&C meeting 26/04/2023 validated at a score of 20 Very High Risk. [16/03/2023 13:45:21 Rachael Turner] Risk to be presented at the RRC&C Meeting in March for validation.	20	31/03/2024		21/08/2023

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
5136	Physical or psychological harm	Parkhill, Michael	Pattinson, Paul	Estates Investment and Environment Group	Health and Safety Group	28/03/2023	20		Corporate	Estates and Facilities	Estates	Trust-wide	Following monitoring for Nitrous Oxide levels in Pilgrim and Lincoln (Theatre and Maternity Units), it was identified that in a number of locations, staff were exposed to higher levels of nitrous oxide where levels exceed the Workplace Exposure Limit (WEL) OF 100 ppm (8hr time weighted average (TWA)).	Following notification the following actions were undertaken: Pilgrim Hospital – Labour Ward: Estates staff checked the supply ventilation from the Air Handling Unit (AHU) to the Supply Grilles within the labour rooms. At the time of inspection, the Estates staff identified the dampers restricting airflow were not adjusted correctly. This was addressed and airflow checks were undertaken. Typical air change rates were around 6 air changes per hour (ACH) – current guidance is a minimum of 10 ACH, however the ventilation systems are circa. 1960 and the guidance is not retrospective. Following the actions undertaken, resampling commenced 15th March (15 sample tubes), 13 were within WEL limits, but 2 sample results were recorded at 255 and 407 ppm (8 h TWA) in Rooms 2/2a and Room 3, respectively and exceeded WEL limits. Estates are reviewing the current system to look at increasing air changes by upgrading the supply fans / changing pulleys / upgrading filter media or a combination of factors. Lincoln Hospital - Labour Ward: Estates staff found the ventilation system had been isolated (approximately 10 years ago). Following discussions with Estates members, the ventilation system had failed and was deemed beyond economical repair and a decision had been made not to replace (no one is aware of why this was made or by whom). Estates plan to reinstate the ventilation, where feasible, which will likely include partial refurbishment and deep clean of existing systems. N.B the use of sampling tubes to monitor Nitrous oxide levels can be highly time and place dependent, the person with the sampling equipment and their activities, can indicate exposure levels that are as a result of human error, not as a failing of the environment. As such G210 analysers specifically designed for highly accurate measurement and verification of the quality of piped N2O and O2 gases, are being sourced.	-COSHH assessments and training. -Health Safety Environmental and Welfare Operational Audit programme. -Direct involvement with Occupational Health. -Datix incident reporting.	28/06/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	The issues identified with exposure levels are not unique to ULHT, as with most NHS Trusts investment is required to upgrade Ventilation to comply with HTM 03-01. NHSEI issued guidance on the 2nd March 2023 for NHS Trusts to follow. Noting where ventilation is insufficient, human factors are critical in reducing staff exposure, such as: 1. Providing clear instructions to patients on correct use of equipment being used, including exhaling into the rebreather mask or out through the mouthpiece 2. Staff positioning relative to exhaust N2O and the direction of ventilation flow 3. Turning gas and air off when not in use 4. Unplugging regulators from outlets when not in use 5. Monitoring the condition of equipment for leakages. These factors can't directly be influenced by Estates and require the support and influence of Clinical Leads and Occupational Health. ULHT Health and Safety Team have recently implemented software to assist with COSHH assessments and training. The Team provide support with the Health Safety Environmental and Welfare Operational Audit programme. Occupational Health have been directly involved with the implementation of sampling and post sampling. Following sample results, Occupational Health were contacted to advise that staff may require support. To date no Datix reports have been raised and no concerns re: ill-health have been escalated in relation to Entonox use/levels to	[28/06/2023 11:49:31 Rachael Turner] Risk discussed at RRC&C meeting 28/06/2023. Pilgrim from a Estates point of view, all mitigation has been put into place. At Lincoln we are still in the same position. This now sits under two separate risks with two separate scoring. 20 score for Lincoln, 12 for Pilgrim. These risks will go to division to agree to be split. [19/06/2023 11:14:32 Rachael Turner] Since the last review, sampling has been carried out for Pilgrim. WEL exposure limits were not exceeded in the last Pilgrim sampling reports with a few caveats: •Sampling was undertaken but use of Entonox was recorded as low •Due to works undertaken by Estates Supply Air was increased to exceed 10ac/hr, although it should be noted extract is via corridor extract so not in full compliance with HTM03. Occupational Health have reviewed this risk with the following findings: Following recent monitoring, we have established there is a tentative but almost certainly very low level of risk to midwives caring for labouring women using Entonox (nitrous oxide, otherwise known as "gas and air"). The theoretical risk is mainly to pregnant staff. There are significant gaps in the knowledge base about adverse health effects of Entonox, but adverse health effects are likely confined to when it is used as a recreational drug. Nevertheless,it is important that there is adherence to protocols associated with Entonox use. Guidance has been reviewed and is in alignment with NHS England current guidance. Pending further advice and investigations NHS England guidance must be followed: •Provide clear instructions to patients on correct use of equipment being used, including exhaling into the rebreather mask or out through the mouthpiece. •Be aware of your positioning relative to exhaust nitrous oxide and the direction of ventilation flow •Turn nitrous oxide off when not in use. •Unplug regulators from outlets when not in use. •Monitor the condition of equipment for leakages. •Ventilate rooms by opening doors and windows when able and when rooms are not in use.	10	28/03/2024		28/07/2023
4858	Service disruption	Parkhill, Michael	Whitehead, Mr Stuart	Water Safety Group	Emergency Planning Group, Estates Infrastructure and Environment Group	10/02/2022	25	Risk assessments	Corporate	Estates and Facilities	Estates	Pilgrim Hospital, Boston	If there is a critical failure of the water supply to one of the Trust's hospital sites then it could lead to unplanned closure of all or part of the hospital, resulting in significant disruption to multiple services affecting a large number of patients, visitors and staff	Estates Infrastructure and Environment Committee (EIEC). Estates risk governance & compliance monitoring process. Emergency Planning Group / Major Incident Plan and departmental business continuity plans.	Surveys of water supply infrastructure - Pilgrim Hospital is served by only one incoming water main. This is in very poor condition and has burst on several occasions causing loss of supply to the site.	21/10/2022	Reasonably likely (3) 31-70% chance	Extreme (5)	High risk (15-16)	15	Regular inspection, automatic meter reading and telemetry for the incoming water main at Pilgrim Hospital. Install additional supply to provide resilience.	[21/10/2022 09:06:00 Walter Thompson] Scheme for replacement of critical water tanks - Pilgrim HB- is being developed for the capital plan 22/23 Scheme of work and design currently being produced.	5	30/10/2020	31/03/2023	21/01/2023
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	26/09/2023	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	[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 aseptic facility at PHB and put in a modular unit at PHB as consequence. Colin considers the risk level should be increased, to be discussed at confirm and challenge meeting next week.	6	30/09/2021	31/03/2022	31/12/2023
Strategic Objective					**3b. Make efficient use of our resources**																					

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
4664	Finances	Matthew, Mr Paul	Young, Jonathan	Workforce Strategy Group		11/01/2022	20	Risk assessments	Corporate	Finance and Digital	Finance	Trust-wide	The Trust has an agency cap of c£17m. The Trust is overly reliant upon a large number of temporary agency and locum staff to maintain the safety and continuity of clinical services that will lead to the Trust breaching the agency cap.	National policy: - Agency spending cap set by Government ULHT policy: - Financial plan set out the Trust limits in respect of temporary staffing spend - Annual budget setting process cascades and apportions the Trust temporary staffing spend limits to the Divisions and Directorates. - Monthly financial management & monitoring arrangements are in place to identify variation temporary staffing financial plans at all levels of expenditure from department up to Trust. - Key financial controls for the use of the break glass agency usage are in place. - Specific staff group temporary staff spend is provided to dedicated Medical and Nursing workforce oversight groups. - Financial review meetings held monthly with each Division to understand and challenge usage of temporary staffing. - Plan for every post information has been embedded to support temporary staff usage forecasts ULHT governance: - The establishment of the Improvement Steering Group will provide general oversight of Trust wide agency reduction schemes - Board assurance through Finance, Performance and Estates Committee (FPEC)	The Trust is monitored externally against an agency cap through the monthly finance return to NHSE/I The Trust monitors internally against its financial plan inclusive of specific targets for agency and bank spend by staff group The cross Trust workstreams are reported to the Improvement Steering Group The Divisional workstreams are reported to the relevant Finance, People & Activity Meeting (FPAM)	01/08/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Financial Recovery Plan schemes: - recruitment improvement; - medical job planning; - agency cost reduction; - workforce alignment	[14/07/2023 09:07:10 Rachael Turner] Risk reviewed, score to remain at 20. Work ongoing. [28/06/2023 16:13:10 Rachael Turner] The Trust has hit its own agency plan. This is our internal plan. Score to remain the same at this time. [24/05/2023 13:24:21 Rachel Thackray] Updated to reflect the risk for 2023/24. Cap reduced from £21m to £17m. The Trust's CIP plan for 23/24 is heavily focussed on agency reduction, risks to delivery include; excess beds, winter pressures and not delivering recruitment trajectories. [24/04/2023 13:17:23 Rachael Turner] No change currently, update to be provided next month when financial plan is complete. [02/03/2023 10:14:50 Rachel Thackray] No update this month. [02/02/2023 14:17:26 Rachel Thackray] The Trust is forecasting a 52.8m agency usage in 22/23 this is driven by increased volume requirements due to the number of beds open and significant breach of the agency price caps due to market conditions. The Trust has significant oversight and plans to control and manage in a phased and safe way agency reductions in Q4 22/23 and into 23/24. [02/11/2022 11:06:31 Rachel Thackray] The Trust agency spend continues on a similar trajectory driven by significant and increased demand for patient services – primarily in the NEL pathway and pressures in ED. This has resulted in additional beds being required above those planned and subsequently a need to staff the beds with temporary and high cost nursing and medical staff to remain safe. The Trust has introduced a financial improvement plan that is heavily focused on increased agency oversight across all staff groups with a number of Exec lead schemes. The Trust has exited the 21/22 financial year with an agency spend of c£44m. This has in part been driven by COVID pressures and a large number of escalation beds open increasing the requirement for temporary staff. The Trust has agreed an ambitious CIP programme that is heavily focused on agency reductions through the recruitment of staff and reducing the number of NEL beds required. This will take time to embed. Reviewed at RRC&CG - score increased from 16 to 20.	8	31/03/2023	31/03/2024	01/09/2023
5020	Finances	Hamer, Fiona	Smith, Charles	Workforce Strategy Group	WORK	02/09/2022	20		Medicine	Urgent and Emergency Care CBU			If there is a continued reliance on bank and agency staff for medical workforce in Urgent & Emergency Care there is a risk that there is not sufficient fill rate for medical rotas both ward / department fill and on call shifts which will impact on patient safety and have a negative impact on the CBU budget	Robust medical plan for every post meetings Close working with temporary medical staffing team Daily management of any gaps to support minimum staffing levels Fundamental overview of tier 1 and tier 2 docs in medicine and ED based on RCP safer staffing levels. Introduction of BMA rate cards This will reduce once output on medical workforce plan is in place, not due to come online in this review period.	Plan for every post meetings Budget reports	26/09/2023	Quite likely (4) 71-90% chance	Extreme (5)	Very high risk (20-25)	20	Robust recruitment plan International recruitment Medical Workforce Management Project	[26/09/2023 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. Tler 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 out next week. [26/04/2023 11:58:59 Carl Ratcliff] No update [14/03/2023 13:58:09 Rachael Turner] Robust recruitment plan and international recruitment plan in place. Ongoing work with medical workforce plan. Well ahead of schedule. Agency cost. Proposal for the score to be reduced to a 16 (High) this risk to be presented at RRC&C Meeting. [27/01/2023 11:36:10 Helen Hartley] Reviewed today, will be discussed further on 6 Feb to potentially lower. [23/11/2022 11:25:30 Paul White] Reviewed at RRC&CG 23 Nov 2022 - current rating agreed but may	10	02/09/2023		16/10/2023
5215	Finances	Matthew, Mr Paul	Young, Jonathan			14/07/2023	16		Corporate	Finance and Digital	Finance	Trust-wide	23/24 introduces a new mechanism to record, calculate and apply the API contract and a System incentive / penalty linked to the Elective Recovery Fund. Actual performance/activity is taken from SUS and EROC. At present, there are some SUS/SLAM reconciliation issues and some recording issues including Missing Outcomes. The risk is twofold: 1. that without accurate ERF monitoring through SUS on actual activity delivered, the activity will look artificially low and there will be financial deductions 2. the activity plan has been built on delivery of c116% of 1920 elective, day case, outpatient first and outpatient procedure activity. Under the new regime underperformance will result in lost income	The link between activity and income has been communicated to the Trust. Monitoring is being set up to monitor activity delivery and estimate the financial impact due to the variable adjustment. Lost income through recording issues (e.g. missing outcomes) will be monitored to include a financial estimate in 23/24. An ERF baseline appeal was submitted and 95% accepted nationally. This will reduce the baseline by £5.8m, final confirmation of the revised baseline is awaited.	Monitoring of the variable adjustment and lost income is being set up	14/07/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	"Information have been requested to reinstate SUS/SLAM reconciliation. Oversight of delivery is required through FPEC/FPAMs and any technical reporting issues reported to CFIG in the first instance. Required Trust activity delivery plan and then delivery against it."	[01/08/2023 14:49:23 Rachael Turner] Risk presented at RRC&C meeting in July, approved as 4 x 4 16 High Risk.	9	31/03/2024		14/11/2023

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
4665	Finances	Matthew, Mr Paul	Young, Jonathan	Financial Turnaround Group	WORK	11/01/2022	20	Risk assessments	Corporate	Finance and Digital	Finance	Trust-wide	Updated in May 2023 to reflect 23/24. The Trust has a £28m CIP target for 23/24. If the Trust fails to deliver The CIP Plan it will have a significant adverse impact on the ability of the Trust and the Lincolnshire ICS to achieve their financial plans.	National policy: - NHS annual budget setting and monitoring processes ULHT policy: - Detailed Financial plan inclusive of the establishments and embedding of the 3 T's; Transactional, Targeted and Transformational. - Alignment of the Trust financial improvement opportunities with system partners to develop an integrated financial plan inclusive of CIP. (Transformational) - Establishment of the service framework to prioritise Speciality improvement reviews. (Transformational) - Establishment of a suite of cross cutting schemes aligned to the Trust Improvement Strategy. (Targeted) - Divisional CIP targets allocated as part of the budget setting process from 1st April. (Transactional) ULHT governance: - Detailed CIP reporting via the CIP tracker supported by QIA process - Programme Management Office (PMO) & dedicated Programme Manager. - Introduction of the Improvement Steering Group to monitor, challenge and hold accountable for the Targeted and Transformational Schemes - Refresh of the FPAMs to monitor, challenge and hold accountable for the Transactional Schemes	The Trust is monitored externally against the Trust CIP target through the monthly finance return to NHSE/I The Trust monitors internally against its CIP targets inclusive of specific Divisional and Scheme targets Divisional focus against Transactional schemes is reviewed at the relevant FPAM. Trust focus against Targeted and Transformational schemes is reviewed at the Improvement Steering Group	14/07/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	- Refresh of the CIP framework and training to all stakeholders. - Increased CIP governance & monitoring arrangements introduced. - Alignment with the Trust IIP and System objectives - CIP is embedded as part of the Trust Improvement Strategy not seen as a separate workstream.	[14/07/2023 09:09:38 Rachael Turner] Risk reviewed, risk score to remain as current work is ongoing. The Trust has over delivered against the month 1 trajectory for the FRP by £0.5m. The trust is also forecasting to deliver a full £28.1m CIP programme for 23/24. [28/06/2023 16:16:06 Rachael Turner] Risk reviewed, targets have been reviewed to reflect where we currently stand. we have hit financial improvement target for month 1 and 2. Risk score to remain the same at 16 High Risk. [24/05/2023 13:11:53 Rachel Thackray] Updated to reflect the risk for 2023/24. The Trust has plans to deliver £28m CIP (FRP) target. In month 1 delivery exceeded plan. [02/02/2023 14:13:16 Rachel Thackray] The Trust is forecasting to deliver a £18m CIP programme for 22/23 a shortfall of £11m against its revised plan, which has been partly mitigated through the risk and gain share contractual agreement with the ICB, however this still leaves an under delivered CIP requirement that has resulted in a contribution to the forecast deficit position of the Trust. [02/02/2023 14:12:00 Rachel Thackray] The Trust is forecasting to deliver a £18m CIP programme which has been partly mitigated through the risk and gain share contractual agreement with the ICB, however this still leaves an under delivered CIP requirement that has resulted in a contribution to the forecast deficit position of the Trust. The Trust has delivered its CIP plan for the past 3 years, albeit a reduced requirement during the 2 financial years that cover COVID. The Trust is embedding a new Improvement framework with CIP included within it and is also working with system partners to make financial improvements due to pathway changes. This will take time to embed and alongside the operational pressures, specifically; sickness, excess beds open, rising acuity of patients and continuing rising demand at the front door of the acute Trust is putting at risk in year delivery of the CIP target. Reviewed at RRC&CG - agreed score of 16.	4	31/03/2023	31/03/2024	14/10/2023
4965	Finances	Hallion, Simon	Chantry, Chris	Workforce Strategy Group	WORK	11/07/2022	9	Workforce Metrics	Family Health	Children and Young Persons CBU	Paediatric Medicine	Trust-wide	Financial risk due to reliance upon temporary staff (nursing and medical) to cover vacancies in Paediatrics.	1. Scrutiny of rosters to ensure optimal use of existing staffing resources; 2. Review of all shifts that are placed with either Nursing or Medical Bank to ensure these are required; 3. Use of bank staff in preference to agency staff in view of potential cost savings; 4. Utilisation of tier 1 and 2 agencies in view of potential cost savings; 5. Use of long line agency in view of potential cost savings and increased assurance that shifts are safely staffed.	1. Reviewed via temporary staffing expenditure and safe staffing metrics; 2. Agency spend reviewed via at FPAM	11/09/2023	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	1. Robust recruitment and retention plan for nursing and medical staff across Children and Young People Clinical Business Unit.	[11/09/2023 15:41:26 Jasmine Kent] Nursing improved temporarily, medically short, recent rotation has shown an improvement but increased consultant required. Winter planning meeting required. [14/08/2023 14:41:07 Jasmine Kent] Nursing risk reducing, less reliance on temp staff. Spend reducing, closing vacancies. ?Possible reduction, for discussion at governance. [12/06/2023 15:59:14 Jasmine Kent] Overseas nursing recruitment ongoing, jobs are out to advert. Looking at role development. [13/03/2023 16:09:39 Jasmine Kent] No improvements, despite efforts, lack of traction with filling vacancies. [13/12/2022 14:40:14 Alison Barnes] No change [18/11/2022 11:42:37 Alison Barnes] Positive feedback around nursing recruitment. Start dates for medical staff currently delayed beyond predictions impacting on higher than anticipated use of agency staff. Agency spend closely monitored at trust level. 09/08/22 - KR 1. Risk discussed at acute paediatrics governance meeting - agreed that risk should be added to the risk register and initial rating agreed via discussion. 24/08/22 - KR Discussed at Risk Register Confirm and Challenge meeting. Confirmed that risk is solely financial as there is mitigation in place to ensure quality and safety are maintained (eg long line booking of regular agency staff). Some discussion about whether this risk should sit on the divisional risk register or whether it is captured in the corporate risk that focuses on the impacts of vacancies. To discuss at forthcoming risk meeting.	3	31/07/2023		11/12/2023
Strategic Objective							**3c. Have enhanced data and digital capability**																			
4657	Reputation	Matthew, Mr Paul	Warner, Jayne	Information Governance Group	Digital Hospital Group	10/01/2022	12	Risk assessments	Corporate	Trust Headquarters	Corporate Secretary		If the Trust does not comply with Subject Access Requests (SARs) and Access to Health Records provisions in accordance with statutory requirements specified legislation, then it could lead to complaints to the Trust and Information Commissioner's Office (ICO). This could result in regulatory action and possibly financial penalties. Inconsistent levels of expertise outside of the IG team regarding SAR requirements. Lack of technical tools to carry out a search of emails / systems to identify personal information held. 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.	10/10/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Current active communications with ICO- regulator. Changes to processes are being constantly discussed and implemented. Resource needs being discussed and temporarily increased to support. Monitored through the IGG in DP KPI report. Head of IG leading on work to review and improve. Working in a more digital way where feasible. Workforce change is required which will be a much longer process. Early identifications of chasers and urgent requests to reduce the likelihood of complaints.	[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 from ICO to date. [04/09/2023 17:26:05 Fiona Hobday] *Still awaiting response from ICO, advised this is still being considered. Has been a complaint to ICO re a staff SAR which is being managed currently. *Case of need for new solution has been drafted and is awaiting review. *Temp additional resource has been agreed for Cyber in Digital due to ongoing delays with searches being ran for staff related SARs. [03/08/2023 10:14:11 Rachael Turner] Still awaiting response from ICO, this is being chased as no outcome as of yet. [03/07/2023 11:47:54 Fiona Hobday] *Still awaiting response from ICO following Feb 22 meeting. AS follow up question was asked- but no outcome as yet. *Escalated re Procurement of new solution for SARs- rough idea of cost identified. *Focus on clearing backlog emails and identifying gaps to resolve prior to escalating to complaint or ICO. [05/06/2023 17:17:35 Fiona Hobday] *Still awaiting response from ICO to Feb meeting *Escalated re Procurement of new solution for SARs *Focus on complaints, and clearing requests from Feb. March currently. *More requests being disclose digitally which is positive. [25/04/2023 12:45:53 Fiona Hobday] *Resource remains prioritised to requests post Jan 23 to minimise the risk of a complaint to the ICO. *Considerable movement was made of backlog (Pre Dec 22) and the majority of the oldest requests were completed. Oldest currently dates to August 22. *Work is re-starting on the procurement of a dedicated solution as it has been identified again that DATIX cannot meet our needs (4 month delay in work as a result).	6	29/12/2023	29/03/2024	02/10/2023

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
4661	Reputation	Warner, Jayne	Warner, Jayne	Information Governance Group	Digital Hospital Group	10/01/2022	20	Risk assessments	Corporate	Trust Headquarters	Corporate Secretary		If the required data protection / privacy impact assessment process and subsequent contractual requirements is not followed consistently at the start of a system/ process change project, then results may not be available to inform decision-making and system development resulting in an increased likelihood of a future data breach or third-party non compliance that could expose the Trust to regulatory action by the Information Commissioner's Office (ICO)	National policy: - Data Protection Act 2018 & General Data Protection Regulation - NHS Digital Data Security & Protection Toolkit ULHT policy: - Information Governance Policy and supporting appendices -Privacy by Design Procedure (NEW 2023) ULHT governance: - Trust Board assurance via Finance, Performance & Estates Committee (FPEC); lead Information Governance Group - Senior Information Risk Owner (SIRO) / Caldicott Guardian / Data Protection Officer (DPO) / Chief Information Officer (CIO) roles	Monitoring of IG project tracker into IG Group. Internal audit review of data protection / PIA processes. Number of escalated issues in relation to project work.	04/09/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Review of the data protection / privacy impact assessment process and governance, to include education and communication to raise staff awareness of the required process. Work to review and implement a formal process with procurement/ contracting. Work to develop and implement the IAO strategy.	[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. Reference to DPIAs in Data Security and Awareness mandatory training. Long standing issue of IG not being made aware of new systems or changes in processes that require assessment under Data Protection legislation. Educating staff across the Trust is required. Changes to legislation due to Brexit means that any data leaving the UK has greater risks associated. If a DPIA is not conducted then this could have an impact on availability of that data.	6	31/03/2024	29/12/2023	06/11/2023
4658	Reputation	Matthew, Mr Paul	Warner, Jayne	Information Governance Group	Digital Hospital Group	10/01/2022	20	Risk assessments	Corporate	Trust Headquarters	Corporate Secretary	Trust-wide	If the Trust does not have a defined records management framework/ strategy it runs the risk of not meeting national best practice and not making informed decisions in relation to Digital programmes of work. This could result in a breach of regulations and ULHT finding it difficult to meet national enquires that could lead to regulatory action and financial penalties. This risk has increased due to ongoing national enquiries and the move to a more digital way of records mgmt which whilst positive heightens the need to manage legacy and ensure expert RM support for future decision making.	The Trust has policies in place. Trust DPIA template included aspects on records mgmt and retention.	FOI compliance gives an indication of the Trusts position as compliance is linked to good records management. Reports of unmanaged records found in Trust locations.	04/09/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Requires a strategic decision from the Trust regarding a Records management lifecycle and level of expertise to advise and guide on future projects and developments. Needs to link into 365, ePR and EDMS Programme. 365 cannot be delivered with dedicated Records SME resource.	[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	04/12/2023
4641	Service disruption	Humber, Michael	Gay, Nigel	Digital Hospital Group	Emergency Planning Group	23/11/2021	16	Risk assessments	Corporate	Finance and Digital	Digital Services (ICT)	Trust-wide	If the Trust's digital infrastructure or systems experience an unplanned outage then the availability of essential information for multiple clinical and corporate services may be disrupted for a prolonged period of time, resulting in a significant impact on patient care, productivity and costs	National policy: - NHS Digital Data Security Protection Toolkit (DSPT) and Guidance ULHT policy: - Telecoms infrastructure maintenance arrangements - ICT hardware & software upgrade programme - Corporate and local business continuity plans for loss of access to ICT systems & system recovery ULHT governance: - Digital Hospital Group / Information Governance Group (IGG), accountable to the Finance, Performance & Estates Committee (FPEC) - 5 year capital plan -	- Network performance monitoring - Digital Services reported issues / incidents - Monitoring delivery of digital capital programme - Horizon scanning across the global digital market / supply chain to identify availability issues	20/09/2023	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.	[20/09/2023 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	20/12/2023
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 Protections that reduce the likelihood of various disasters, including environmental and technical controls.	As above.	30/08/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	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. 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. Network wise we now have the cienna link fully operational between LCH and PHB and are near to testing BGP failover for ingress/egress via MLL."	[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		30/11/2023

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
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.	30/08/2023	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	[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		30/11/2023
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.	As above.	30/08/2023	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.)	[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		30/11/2023
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	Monitoring. Trend Deep Security applied to legacy Windows Operating systems ongoing projects to reduce legacy reliance, upgrading and replacing where possible."	Data analysis and ongoing monitoring.	30/08/2023	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.	[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		30/11/2023
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	07/06/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Continued discussions between ULHT and UoL Executive leads to finalise research and financial agreements Contact with UHA to confirm requirements for application	[07/06/2023 12:20:47 Rachael Turner] Risk discussed at RRC&C meeting 07/06/2023.Risk needs to reflect more than getting status, such as recruitment, quality of people you attract, development and investment. Risk score 4 x 4 making it a score of 16 High Risk.	8	31/03/2025		07/07/2023

United Lincolnshire Hospitals NHS Trust

Meeting	*Public Trust Board*
Date of Meeting	*7 November 2023*
Item Number	*Item 13.2*

Board Assurance Framework (BAF) 2023/24

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

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

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

Recommendations/ Decision Required	• *Board to consider assurances provided in respect of Trust objectives noting that framework has been reviewed through committee structure*

Executive Summary

The relevant objectives of the 2023/24 BAF were presented to all Committees in September and to the Quality Governance and Finance, Performance and Estates Committee's during October.

The Audit and People and Organisational Development Committees did not meet in October.

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

It should be noted that there have been no proposals to amend assurance ratings from the Committees during either the September or October meetings.

The following assurance ratings have been identified:

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

3e	Reduce waits for patients who require planned care and diagnostics to 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 - October 2023

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

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

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

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
						Policies are developed and updated in line with national and local guidance and in line with the National IPC Manual for England IPCG will retain oversight of the relevant IIP programme of work. (IPCG)	Some Estates and Facilities IPC-related. Some Estates and Facilities IPC-related policies not in line with the requirements of the Hygiene Code and some have not been reviewed and updated.	Estates and Facilities Policy Schedule has been presented to the IPCG containing dates for completion. Each policy is approved by the IPCG. Water, Ventilation and Decontamination IPCG sub groups have oversight of policy development	The IPCG is the primary source of assurance with each policy being an agenda item IPC programmes of surveillance and audit are in place to monitor policy requirements. Divisional audit processes with progress and exception reporting to IPCG, IPC Site meetings and IPC related Divisional forums. Associated action and development plan documentation.	None Identified	Not applicable		
						Process in place to monitor delivery of and compliance with The Health and Social Care Act (2008). Code of Practice on the prevention and control of infections and related guidance (IPCG). Infection Prevention and Control BAF in place and reviewed quarterly (IPCG)	Non-compliance with some aspects of the Hygiene Code in respect of criterion 2, (provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections) with specific concern relating to decrease in standards of environmental cleanliness (PHB), poor environmental infrastructure (water and ventilation), impact on planned preventative maintenance programme, breach of waste regulations for the safe storage of clinical waste and some aspects of in house decontamination processes	Good monitoring of standards of environmental cleanliness with auditing and process for remedial action. Recruitment of additional housekeeping staff at PHB. Water and ventilation safety groups are established. Planned preventative maintenance subject to assessment of risk and prioritisation processes. Increased waste audits and inspections. Storage capital programme work is progressing. Decontamination remedial work has progresses and Trust-wide audit of compliance is planned. Monthly reporting to the IPCG with upward reporting to the QGC	IPC programmes of surveillance and audit are in place to monitor policy requirements. Divisional audit processes with progress and exception reporting to IPCG, IPC Site meetings and IPC related Divisional forums. Associated action and development plan documentation	None applicable	Not applicable		

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
						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		

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
1a	Deliver high quality care which is safe, responsive 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 5102 5175 5075	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		

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
						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		

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
						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. (PEG)	Reaching out project (Hard to Reach groups) still in development. Diversity of current patient representatives and panel members is narrow;.C Contact still to be made with some community groups.	Recruitment for new panel members continues. You Care - We Care to Call (YCWCC) Campaign being used in several wards to test out a variety of ways to improve communication with families / loved ones of in-patients. Communication working group set up to look at a range of communication issues affecting patient experience.	Upward reports and minutes to the Patient Experience Group	Diversity of the patients engaging and involving themselves limited meaning that is is not represenative of the local population.	Partnership working established with Healthwatch to reach out to Eastern European community. Staff BAME network approached for community links and contacts. Breast mastalgia group has completed its co-design but will meet again in the future as part of service evaluation. Dementia Carers group has had first meeting and will meet alternate months. Cardiology and QI groups being developed		
						Care after death / last offices Procedure & Guidelines Sharing information with relatives Visiting Procedure Patient information (PEG)	Audit of EOL visiting required to determine if there is a consistent approach to visiting.	Exceptions guidance re-issued. Monitor through complaints & PALs. Audit will be undertaken by the Patient Experience Team in this years schedule of work.	Report to PEG through complaints & PALs reports; upward reports were received from Visiting Review working group which has now disbanded; the planned audit will report back to PEG and propose any further recommendations. Complaint data now improved in terms of visiting issues.	Patient information currently subject to review and work is ongoing.	Audit of visiting experience planned which will provide an understanding across all aspects of visiting now that all COVID precautions have been stepped down. This will also tie in with national work on Care Partners and visiting guidance under the Health & Care Advisory Board which the Head of Patient Experience is a member of.		
						Inclusion Strategy in place (PEG)	Lack of diversity in patient feedback and engagement	Equality, Diversity and Inclusion Lead is member of Patient Experience Group.	EDI 1/4rly report to PEG;	EDI Reports will need to develop in maturity regarding patient experience	Head of Pt Experience to discuss with EDI lead to ensure data is relevant and triangulated.		

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						Robust process in place for annual PLACE inspection accompanied by PLACE LITE (PEG)	PLACE Lite Process needs to be embedded as Business as Usual	PLACE Lite visits are being scheduled for the year across the organisation.	PLACE report to go to Patient Experience Group quarterly and upwardly reported to QGC	National PLACE programme currently paused due to pandemic; national programme recommenced September 22	PLACE Lite continues & reports to PEG plus the annual report will be received at PEG, due Jan 23		
						Enhance patient experience by learning from patient feedback and demonstrating our values and behaviours in the delivery of care with a specific focus on discharge of patients. (PEG)	National surveys evidence overall poor experiences in relation to discharge with a number of questions being benchmarked as worse than others Trusts.	Amalgamated survey action plan in development to identify Trust wide improvement focus. Rolling out of #WMTY initiative to ensure patients are involved in decisions and discussions about their discharge plans. Patient Experience Team working with Discharge Lounge staff facilitating understanding of discharge experience and improvements.	Discharge experience reports to PEG quarterly.	Work required with the lead nurse for discharge to ensure experience data is collected, analysed and acted upon.	Support to be provided to the lead nurse for discharge.		
						Ensure we provide clinically safe services, through an increased number of Diamond Award Accredited Wards / Departments (PEG)	there are no identified Control gaps	Not applicable	monthly Quality metrics dashboard meeting with all clinical areas. Diamond award applications received and supported by corporate nursing team. Diamond Award Panel chaired by DoN/DepDoN. Award presented by Trust Chair. Metric included with the IIP, and measured Quarterly.	None Identified	Not applicable		
						Clinical Effectiveness Group in place as a sub group of QGC and meets monthly CEG works to an annual work programme and standard agenda to ensure that all business is covered appropriately. Upward reports are received from reporting groups. Role of CEG is to Improve clinical effectiveness through increased compliance with national and local standards. Quality of reporting into CEG has improved and is increasingly robust. (CEG)	Acknowledged that there is good engagement from nursing and AHPs, however work continues to encourage engagement from medics.	Invites to speakers to come direct from Mr Simpson as Chair of the Group in future.	Effective upward reporting to QGC from reporting groups. Regular reports received from Divisions providing assurance that they understand their position with respect to clinical effectiveness	No gaps identified.	Not applicable.		

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						Getting it Right First Time Programme in place with upward reports to CEG and QGC. Agreement in place recommencement of the of the GIRFT Programme (CEG)	Recognition that the Trust has made the decision that the GIRFT programme will be restricted to those areas relating to high volume, low complexity (HVLC) and areas seeking to focus on elective recovery. Reports currently tend to focus on the process of GIRFT. Further work needed to demonstrate changes in practice as a result of GIRFT work.	Quarterly reports to Clinical Effectiveness Group GIRFT team in place to support divisions and ensure that appropriate activity takes place.	Upward reports to QGC and its sub-groups KPIs in the integrated governance report Process in place for feedback to divisions	Reporting has begun to focus on outcomes but this is not yet well embedded.	Request from CEG for future reports to show improved outcomes as a result of GIRFT activity.		
						Clinical Audit Group in place and meets monthly (CAG) with quarterly reports to QGC Refocus of CAG to focus on the learning from audit. (CEG)	There are outstanding actions from local audits Due to operational pressures, quoracy has been an issue although this is beginning to improve.	Support being provided from central team to close outstanding overdue actions Job role description for Clinical Audit Leads has been developed. Quarterly updates with Clinical Audit Leads take place with the Deputy Medical Director.	Reports generated for Clinical Audit group and CEG detailing status of local audits and number of open actions. Reports also include learning and changes in practice as a result of audit.	No gaps identfied.	Not applicable.		
						National and Local Audit programme in place and agreed which is signed off by QGC. Improved reporting to CEG regarding outcomes from clinical audit. Quarterly reports and process in place for any areas where the Trust is identified as an outlier. (CEG)	None identified.	Not applicable	Reports from the National Audit Programmes including outlier status where identified as such Relevant internal audit reports Reports identify where practice has improved but also where it has not improved.	None identified	Not applicable		
						Process for monitoring the implementation of NICE guidance and national publications in place and upwardly reported through QGC (CEG)	There are sometimes delays in the completion of the gap analysis for the Clinical Guidelines.	Process in place for escalation if required within the Clinical Divisions.	Reports on compliance with NICE / Tas demonstrating improved compliance.	None identified	Not applicable		
						Process in place for taking part in the Patient Related Outcome Measures (PROMs) project. (CEG)	None identified.	Not applicable	Quarterly reports to CEG and upwardly reported to QGC	Business Units not sighted on their performance due to national reporting being stood down although this is due to recommence.	National reports to be presented at Governance Meetings once produced		
			Failure to provide effective and	4731	CQC								

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1c	Improve clinical outcomes	Medical Director	timely diagnosis and treatment that deliver positive patient outcomes	4731 4828	CQC Responsive CQC Effective	Specialised services quality dashboards (SSQD) Process in place for identifying outliers through Model Hospital. Clinical leads for outlying areas present updates to CEG quarterly. (CEG)	No gaps identified.	Not applicable.	Quarterly reports to CEG and upwardly reported to QGC. Action plans developed for all required areas.	No gaps identified.	Not applicable.	Quality Governance Committee	**Green**
						Process in place for implementing requirements of the CQUIN scheme. Monthly meetings take place with CQUIN leads. Quarterly reporting takes place. (CEG)	No gaps identified.	Not applicable.	Quarterly reports to CEG and upwardly reported to QGC	No gaps identfied.	Not applicable.		
						Process in place for ensuring high quality of record keeping including Medical Records Group. (CEG)	Medical Records Group not meeting regularly.	Refocus of the Medical Records Group planned by the new Chair.	Programme of record keeping audits taking place.	Audits do not demonstrate compliance with record keeping standards. Limited evidence that specialties are reviewing record keeping findings and developing actions to address.	Divisional governance leads to pick up within each area.		
						Process in place for monitoring of and implementation of NCEPOD requirements. (CEG)	None identified.	Not applicable	Quarterly reports to CEG on progress.	Some outstanding baseline assessments. Some overdue actions identified.	Work taking place with divisional leads to address.		
						Quarterly Learning Lessons Newsletter in place at both Division and Trust wide level (CEG)	Staff may not access emails to review newsletters Assurances to be received at the next meeting regarding how learning is shared within Divisions.	Programme of work commencing regarding wide ranging mechanisms for learning lessons across the Trust.	Evidence of newsletters shared is available.	No gaps identified.	Not applicable.		
						Improve clinical effectiveness and best practice principles by prioritising Cardiovascular pathways							

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						Monthly MorALS meeting chaired by the Deputy Medical Director and attended by a representative of the Triumvirate for each division. Member of systemwide Mortality Collaborative Group. Divisional M&M meetings in place. Business Partner Model approach in place. Monthly mortality report in place to track achievement of SHMI/Mortality targets (Maintaining our HSMR and improving our SHMI) reporting in to monthly mortality group and upwardly to PSG. Training has been delivered to approximately 40 members of staff to undertake SJR's. Bespoke training and support offered from the Mortality team to the Divisions. (CEG)	Gaps in the number of structured judgement reviews undertaken - this is not across all Divisions, good practice exists and is demonstrated through the mortality group. Not all specialties have recommenced M&M meetings since Covid - work is taking place to support them with this.	Following the success in UTOO for ACP's contributing to the SJR reviews, further training is going to be rolled out to the MDT. Standardised process being developed for M&M meetings.	National Clinical Audits Dr Foster alerts HSMR and SHMI data Medical Examiner screening compliance and feedback Dr Foster data on depth of coding. Divisional updates at MorALs by the Triumvirate.	Gap identified in the ability to draw learning from SJR's due to ongoing delays with completion	Local data sources are used where possible. Gaps in learning mitigated by ME process and escalation of concerns via incident management processes.		
SO2	**To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT**												
						NHS people plan & system people plan & five themes:- - Looking after our people - Belonging in the NHS - New ways of working & delivering care - Growing for the future - Leadership and Lifelong Learning (from 2022/23)	None identified		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	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	4362 & new high risk on POD register	CQC Safe CQC Responsive CQC Effective	Focus on retention of staff - creating positive working environment and integration of People Promise 'themes' System retention role established 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	**Amber**
						Embed continuous improvement methodology across the Trust	Embedding and sustaining cultural change when the ability of the ULHT teams to engage when we are operationally challenged Ability to demonstrate quick impact on the cultural change due to various interventions will be limited (as these are multi year/multi factorial projects)	Improvement Academy now report all training & associated activity to embed continuous improvement through Improvement Steering Group for oversight and escalations Working with each improvement programme and Divisions to develop identify and align improvement plans	Internal training reports produced by Improvement academy Improvement programmes identifying personalised training needs for ULHT staff Divisions training plan (aligned to the IIP) presented at FPAM	Information is reported to ISG - Low uptake of our various training offers despite general and targeted comms through various platforms. Services are struggling to release staff for QI training due to pressures. Plan for a QI relaunch in the new financial year. Use of virtual training option via MS Teams.	Weekly meetings with Improvement Academy to increase offer with more agile training methods to meet the needs of the varied staff. Developing communications & engagement strategy for on-going awareness of Improvement Academy to enable improvement culture change (not just limited to sending email updates but being creative and being on site on wards to talk about quality improvement)		
						Reducing sickness absence - Absence Management System	Manager call back compliance and return to work interview	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.		

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		Development				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 opportunities of Apprenticeships	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.		
						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	Turnover and leadership capacity within OD Team hampering progress with NHSE Culture and Leadership Programme	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			

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						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.	None identified			
						Reduce our staff turnover rate to 6% across all staff groups	Aligned to the continued work under the People Promise Manager role and plans for 23/24 to continue to improve work life balance, flexible working requests, flexible retirement/retire and return options. 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.	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	4083	CQC Well Led	Staff networks	Men's Health Network Group due to be launched November 23	Executive sponsor for Men's Health Network to be identified Launch Network in November	Council of Staff Networks	None identified			**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	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 to 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.	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 Mandatory Training compliance not at agreed level Limited uptake of quarterly staff survey	To be monitored through the Workforce Operational Group and FPAM meetings and will feature in the highlight report to PODC. Phased targeted approach in 23/24 KPI's as featured in the Integrated Improvement Plan. Additional monthly assurance offered to CQC through governance team regular meetings		
						Support our Divisions to provide all staff with an appraisal and clear objectives		Support and training from new Education Department	Workforce Operational Group Upward reporting to People and OD Committee CQC Monthly reporting				
						55% of our staff recommending ULHT as a place to work and an improved position with regards to our people feeling that they are treated with kindness, compassion and respect.			Workforce Operational Group Upward reporting to People and OD Committee CQC Monthly reporting				

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						53% of our staff recommending ULHT as a place to receive care			Workforce Operational Group Upward reporting to People and OD Committee CQC Monthly reporting				
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**
						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				

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SO3	**To ensure that services are sustainable, supported by technology and delivered from an improved estate**												
	A modern, clean and fit for	Chief Operating	Longer term impact on supplier services (including raw materials) who are supporting the improvement, development, and maintenance of our	4648 - Fire Safety		Develop business cases to demonstrate capital requirement in line with Estates Strategy	Business Cases require level of capital development that cannot be rectified in any single year.	Estates Strategy sets out a framework of responding to issues and management of risk. Capital Delivery Group has oversight of the delivery of key capital schemes. External Specialist Advisor working jointly NHSE & ULHT providing external guidance and validation. Use of the premises assurance model PAM will help identify gaps and subsequent actions or schemes of improvements.	Capital Delivery Group Highlight Reports Compliance report to Finance, Performance and Estates Committee Updates on progress above linked to the estates strategy. PAM Quarterly internal review and annual submission.	Funding gap when considering the full £100m+ backlog in first year. Future years will at most tackle £20m of backlog in any given year 6 Facet Surveys used to quantify and identify schemes are out of date and need reviewing.	Estates improvement and Estates Group review compliance and key statutory areas. Progress against Estates Strategy/Delivery Plan and IIP via sub groups upward reports. Delivery of 2022/23 Capital Programme will continue to ensure progress against remaining backlog of critical infrastructure. Capital Delivery Group will monitor the delivery of key capital programmes and ensure robust programme governance. Structure review including upward reports are being reviewed by specialist advisor with recommendations of reporting lines.	Finance, Performance	
						Continual improvement towards meeting PLACE assessment outcomes	PLACE assessments have been suspended and delayed for a period during COVID	Use of PLACE Light assessments and other intelligence reports.	PLACE Light Assessments PLACE Full assessments starting in September 22	PLACE/Light do not provide as deep an assurance review as PLACE with limited input.	Combination of PLACE Light and other intelligence (IPC Group/Compliance Reports and Capital Delivery Group) will help triangulate areas of concern and response. With PLACE Full assessments starting in September gaps will be closed further.		
						Review and improve the quality and value for money of Facility services including catering and housekeeping	Value for Money schemes have been delayed during COVID	Improvement teams have started in 2022/23 working through value for money and financial efficiency schemes included development of Housekeeping, Security and Portering Business Cases for future models	MiC4C cleaning inspections Staff and user surveys 6 Facet Surveys	6 Facet Survey are not recent and require updating.	Cleanliness is reported through IPC Group to QGC. Water Safety and Fire Safety Groups will report through to relevant sub-committees and provide a more comprehensive view offering assurance were it is possible and describing improvement where it is not with Annual Reporting providing assurance and gap analysis on all AE domains.		

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3a	A modern, clean and fit for purpose environment	Chief Operating Officer	and maintenance of our environments. Availability of funding to support the necessary improvement of environments (capital and revenue)	4647 - Fire Safety 4858 - Water	CQC Safe	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			Finance, Performance and Estates Committee	**Amber**
						Implement Year 1 of our Estates Strategy	Funding gaps between overall plan of replacement vs available funding. Availability of Suppliers and Changes in market forces. Availability of raw materials and specialist components to replace/repair etc.	Business Case Development and preparation pre-empting available capital to maximise available. Use of procurement framework and liaison with NHSE to coordinate bids and larger schemes	Estates Group Upward Report				
						Refurbishment of 8 theatres, across our sites							
						Support capacity maximisation ensuring modernisation and utilisation of space, including that leased off the main acute sites							
						Reduce our net carbon footprint							
						Develop Health Master Plans to better algin wards							

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3b	Efficient use of our resources	Director of Finance and Digital	Not identifying and then delivering the required £28m FRP of schemes The national impact of rising inflation (specifically utilities) in excess of the levels assumed in the 23/24 financial settlements The Trust is overly reliant upon a large number of temporary agency and locum staff to maintain the safety and continuity of clinical services. Failure to deliver the activity targets of 116% of 19/20 planned activity will result in a clawback of an element of the ERF allocation made to Lincolnshire.	4665 - FRP delivery 4666 - Inflation pressures 4664 -Agency costs 4384 - ERF Clawback (116% activity delivery risk) NEW Risk to be added to the risk register - Availability of Capital	CQC Well Led CQC Use of Resources	Introduction of Aspyre for reporting all FRP schemes Refresh of the CIP framework and training to all stakeholders. Increased FRP governance & monitoring arrangements introduced. Alignment with the Trust IIP and System objectives FRP is embedded as part of the Trust Improvement Strategy not seen as a separate workstream. Internal meeting structure and reporting aligned to the ICS reporting requirements	Operational ownership and delivery of efficiency schemes Detailed delivery plans supported by clear timelines and metrics for all plans	Divisional FPAM to provide oversight of FRP reporting upward into PRMs. Trust wide oversight for FRP schemes in the Improvement Steering Group ICS oversight through the ICB Financial Recovery Board.	Delivery of the Trust FRP target Reporting through Aspyre to - FPAM PRM FPEC Financial Recovery Board	Ability of clinical and operational colleagues to engage due to service pressures. Evidence of system and Trust schemes to reduce the operational pressures and beds numbers in the Trust. Traction in year to produce cost out from cross cutting targeted and transformational schemes	Divisional - Progress is being reviewed monthly with Divisions through FPAMs. Trust wide improvement schemes - Progress is being reviewed monthly with Exec, Divisional and Corporate teams through the Improvement Steering Group. System wide - Progress is being reviewed monthly with system partners including Exec, Operational and Corporate teams through various forums.	Finance, Performance and Estates Committee	Amber
						Inflation - The Trust is working to actively manage its contracts and to flag excess inflation due to market conditions as part of the national collection process in relation to this spend area	Impact of unstable market conditions led to the Trust forecasting excess inflation of £8.1m in its 2023/24 financial plan submission - over and above national inflation funding allocations. The £8.1m (as per national instruction) sits outside of the Trust financial plan for 2023/24. Inflation pressures primarily relate to Utility costs but also impacts in other non-pay contracts. As prices continue to rise the Trust and / or ICS may be unable to mitigate these cost increases.	Financial plan set out the Trust expectation in respect of inflation aligned to the national allocations Annual budget setting process cascades and apportions the Trust inflation allocation to Divisions and Directorates. Monthly financial management & monitoring arrangements are in place to identify variation of excess inflation against financial plans at all levels of expenditure from department up to Trust. The Trust actively manages its external contracts to ensure value for money.	The Trust is monitored externally against the inflation impacts through the monthly finance return to NHSE The Trust monitors internally against its financial plan inclusive of specific inflation forecasts Divisional focus against specific contracts (e.g. Utilities) is reviewed at the relevant FPAM Excess inflation pressures will be reported internally into FPEC and externally into FLG and ICS and Finance Committee	Forward view of market conditions.	Internally through FPAMs and upwards into FPEC. Externally through greater dialogue with suppliers and proactive contract management Flagging with ICS partners and NHSE to understand if any further funding allocations will be available to offset.		
						Financial Recovery Plan schemes Recruitment improvement Medical job planning Agency price reduction Workforce alignment Service Reviews process and transformational programmes of work Budget compliance	Reliance on temporary staff to maintain services, at increased cost Management within staff departments and groups to funded levels. Maximisation of below cap framework rates Rapid ability to on-board temporary staff to substantive contracts	Proposed centralised agency & bank team. Workforce Groups to provide grip Improvement Steering Group to provide oversight Non-Clinical Agency sign off process	Delivery of the planned agency reduction target.	Granular detailed plan for every post plans Rota and job plan sign off in a timely manner	The Trust monitors internally against its financial plan inclusive of specific targets for agency and bank spend by staff group The Trust FRP workstreams are reported to the Improvement Steering Group The Divisional cut of the workstreams are reported to the relevant FPAM The staff areas of key focus - Medical and Nursing are reported through their Workforce Groups		

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						ERF clawback - Collective ownership across the Lincolnshire ICS of the restoration and recovery of the planned care pathways leading to improved activity delivery. Trust focus to restore services to pre-COVID levels and then stretch to 116%.	Maximisation of the Trust Resources - Theatre and Outpatient productivity. Impact of the COVID patients and flow on availability of beds to provide capacity. Ability to recruit and retain staff to deliver the capacity. A production / activity delivery plan.	Divisional ownership and reporting Improved counting and coding, including data capture and missing outcome reductions. Shared risk and gain share agreements for the Lincolnshire ICS. Reporting by POD and Specialty against the delivery plan	Delivery of the 116% target	The operational pressures, specifically; sickness, excess beds open, rising acuity of patients and continuing rising demand at the front door of the acute Trust is putting at risk in year delivery of the 116% activity target.	The Trust is monitored externally against the Trust activity target through the monthly activity returns The Trust monitors internally against its activity targets inclusive of specific Divisional and Specialty plans and targets The Lincolnshire ICS is monitored externally against the system activity target through the monthly activity returns		
						Utilisation of Capital allocation based on risk to enhance our services and support efficiency improvements	Difficult to compare Estate, Digital and Equipment risks. Capacity to produce business cases to access external funds	Revised CRIG process, supported by experts. Green book training roll out. Risk rating pre & post investment required in all investment requests.	Capital, CDC and Benefits realisation upward reports into FPEC. Development of a 5 year capital programme cross referenced to risk register.	6 facet survey not completed.	Investment identified for 6 facet survey.		
						Improve utilisation of the Care Portal with increased availability of information -	Cyber Security and enhancing core infrastructure to ensure network resilience. .	Digital Services Steering Group Digital Hospital Group Operational Excellence Programme Outpatient Redesign Group	Number of staff using care portal Ranked in 4th place nationally of ICS usage of Care Portals.				
						Development and approval of Electronic Patient Record OBC	Regional and National approval of OBC Affordability of OBC	Digital Services Steering Group Digital Hospital Group e-HR Programme Steering Group Capital, Revenue and Investment Group Engagement with regional colleagues	Delivery of OBC Agreement of funding	Regional feedback on OBC	OBC approved by Frontline Digitalisation ePR Investment Board (EPRIB) on 19th July 2023. OBC approved by JIC on 28th July 2023. OBC approved by Cabinet Office Commercial Spend Controls Process on 3rd Oct 2023. ITT will now be published.		

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3c	Enhanced data and digital capability	Director of Finance and Digital	Approval of OBC for Electronic Health Record is delayed or unsuccessful Major Cyber Security Attack Critical Infrastructure failure	4641 - Digital infrastructure 4661 - DPIA	CQC Responsive	Rollout of PowerBI as Business Intelligence Platform during 2022/23			Delivering improved information and reports Implement a refreshed IPR Rollout increasing, having replaced QlikView dashboards. New dashboards in place to support Vaccination reporting and HR EF3 processes. Work underway to automate IPR production for Trust Board and Committees, as well as Divisional PRMs.	IPR refresh for 22/23. Completed for Jan 2022	Steady implementation of PowerBI through specific bespoke dashboards and requests.	Finance, Performance and Estates Committee	**Amber**
						Implement robotic process automation	Lack of expert knowledge available within and to the Trust (experts in short supply nationally) Business case development on hold due to capacity issues	Skilling up internal resource. Exploring opportunities with Northampton General Hospital who provide RPA Services LCHS and ULHT contracts being migrated to one at next renewal. 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.					
						Improve end user utilisation of electronic systems	Business case for additional staff under development	Digital team providing advice and guidance hoc to address pressure points					
						Complete roll out of Data Quality kite mark			Ensuring every IPR metric has an associated Data Quality Kite Mark	Information improvements aligned to reporting needs of Covid-19.	A number of metrics have had a review and these are awaiting formal sign off. They will then appear in the IPR. Additional metrics have been added and reviewed, and a work plan and deadlines associated with completion is being drawn up. These will be shared with the Director of Finance & Digital for sign off.		
						Upgrade of our technological infrastructure to support technology advancements	Insufficient cap/rev to replace aging technology Insufficient capacity to deliver purchased equipment	Technical Design Auhority Digital Hospital Group Information Governance Group (for cyber / info security)	Digital Marurity Assessment		Looking to procure a Technical / Implemenation Parner to provide capacity as and when required		

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						Provide our people with real-time data to support high quality care delivery to all clinical staff							
						Enhance our organisational digital capability and skills through training	Insufficient capacity to create and deliver training materials	Digital Hospital Group			Looking to procure a Technical / Implemenation Parner to provide capacity as and when required		
						Implementation of an Electronic Prescribing system	2023/24 funding not approved yet Insufficient capacity to deliver at pace of current plan	ePMA Steering Group Digia Hospital Group	Number of wards live with ePMA		Paper written to clarify costs. Currently being worked through with Finance colleagues Looking to procure a Technical / Implemenation Parner to provide capacity as and when required		
3d	Improving cancer services access	Chief Operating Officer	Insufficient clinical capacity, insufficiently optimised pathways, Dependency on services (primary care, pathology) that are unable to deliver required access or level of service Trust in tier 1 due to delivery of FDs		Cancer Standards 62 day, 14 day and 28 Day FDS	Improve access for patients by reducing unwarranted variation in service delivery through transformation of Cancer Care Integrated Improvement Programme and Assoc Governance System Cancer Improvement Board	Recovery post COVID and risk of further waves Specialty Capacity strategies not in place Insufficient oversight of system partners contribution (e.g. primary care testing and workups)	Requirement for specialty strategies now part of strategy deployment and will commence Q1 22/23 Cancer Leadership Group Deep Dive Workshops (e.g. Colorectal) East Midlands Cancer Alliance Increased Oversight	Cancer board assurance and performance reports Deep Dive information and reports on gap analysis Routine Performance and pathway data provided by Sommerset system 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 September >62 days was 219 v 350 trajectory, >104 was 73 v 80 trajectory and FDS at 71% v 70% trajectory.	Finance, Performance and Estates Committee	**Red**
						Achievment of 104 and 62 week perofmrnace trajectory	Capacity to deliver Faster Diagnosis (FDs) for all services	Additional support secured through mutual aid to provide focus on cancer recovery	Weekly system elective and cancer recovery meetings 3x weekly cancer meeitngs led by Deputy COO, Urgent Care and Cancer and ICB Cancer lead				
						Maximisation of capacity and efficiencies to reduce waiting times and support discharge processes, ensuring services are provided within timeframes which are safe and responsive, enabling a reduction in length of stay/bed occupancy			Trajectories for all specialties in place, weekly position statements offered to ELT and TLT		Focused piece of work in place to review Navigator role in terms of WF capacity and capability will be concluded at end of October. Breast are commencing a sustainability plan in December that will provide a backdrop for continuous achievement of all 3 cancer targets however this is likely to require investment.		
						Development of plans for seven day working, across all of our services							

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						Improve access for patients by reducing unwarranted variation in service delivery through transformation of Planned Care Integrated Improvement Programme and Assoc Governance System Planned Care and Diagnostic Group	Recovery post COVID and risk of further waves Specialty strategies not in place Elective Theatre Programme Transformation team is now established and a delivery group is also in train. Continued risk of capacity loss from Industrial action	Requirement for specialty strategies now part of strategy deployment and for complation in Q1 23/24 Recovery plans at specialty level. To date have delivered required reductions in 104 week waits Outpatient Improvement Group in place and is now supported by a delvery group lead by the Deputy COO for Planned Care and Diagnostics GiRFT and High Volume Low Complexity Programme Group Productive Theatres Improvement Programme Grantham Surgical Hub now established with Focused utilisation plan Productivity group established focused on increase of all Elective activity Early adopter of GIRFT Further Faster Programme	Performance Data Planned Care Improvement and Performance Reporting Integrated Improvement Plan Highlight and Status Reports GIRFT Reports and NHSE Review data Weekly update on Productivity into ELT	Inconsistent approach to waiting list validation CBUs do not have traction or insight into the non admitted or admitted waiting lists Maximum Outpatient and theatre capacity not apparent as yet. Demonstration of change at pace is lacking.	National edict to see and treat all patient waiting greater then 78 weeks by 31 March 2023 in place. Twice daily monitoring and reporting is now in place. The largest DM01 risk is Echo Cardiology. A plan is now in place to offer and recruitment and retention premium. The recommendations and action plans suggested following the Regional Diagnostic Team external review is realising some benefits. Local, System, Regional and national assurance meetings in place to monitor progress and delivery. Use of independent sector, mutual aid and insourcing/outsourcing providers to ensure delivery. ICB and COO holding the Trust to account for delivery against national deadline. Internal design, development and agreement of a 'production plan'. Review of all consultant Job Plans is in train. The ULHT COO is now System SRO for Planned Care and Diagnostics. The System SRO for cancer is now the ICB COO		

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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							
						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				

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						Development of plans for seven day working, across all of our services							
3f	Urgent Care	Chief Operating Officer	Insufficient clinical capacity or expertise, inefficiently configured services, failure of system partners to provide capacity or reduce demand to pathway and excessive demand above capacity available		Emergency Care Clinical Indicators (12hr, 4 hour CRTP, 60 minute decision and 15 minute triage)	Daily System control meetings in collaboration with 3x daily internal capacity meetings. Integrated Improvement plan for urgent care and Urgent Care improvement Group. System Urgent Care Partnership Board. LHCC Improvement Programme Board and LHCC Board	Recovery post COVID and risk of further waves Internal professional standards not embedded External dependencies lack of visibility of capacity and system control to move risk/capacity between services. E.g. community care hours, care home ,assessment capacity etc.	External reviews used to identify gaps in services and assess capacity shortfalls. Emergency Care Intensive Support Team, IMPOWER specialist consultants and Dr Ian Sturgess specialist consultant reviews identify control and process and capacity gaps. Development of clinical vision for Urgent and Emergency Care	Improvement against strategic metrics Suite of performance metrics and benchmarking % of patients in Emergency Department >12 hrs (Total Time) Reports produced by ECIST IMPOWER and Improvement Consultants Breaking the cycle updates (as delivery of the clinical vision) A revised 4hr transit target of 76% agreed nationally and improvement trajectories being confirmed.	Gaps in Early Warning Dashboard Pathway 1 capacity admission avoidance impact, waits and capacity for primary care. Clear Treatment plans for P0 patients to support exit. Assurance in regard to Bed closure plan.	LHCC Programme Board reviewing Early Warning Dashboard - additional reports on progress. The System have now adopted SHREWD as the method of actual position and early warning 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. . Offsite meeting led by Medical Directors office and to be attended by the CDs to discuss Internal Professional Standards is taking place on 6/10.	Finance, Performance and Estates Committee	**Red**
						Urgent Care Recovery Improvement Steering Group which oversees a programme of work linked to increase capacity, flow and discharge through the Trust Wide Emergency Departments, Urgent Treatment Centres and Same Day Emergency Care Breaking the cycle pilot has now ended and lesson learnt document shared and agreed recommendations for embedded changes agreed at UCRIG	Large complex programme which required system working to reduce pathway 0 waits and deliver right care right time principals	Large programme of work so additional resource had been provided through a consultancy Impower & ECIST to assist in identification of areas to improve and on the ground support. This has now ceased. ED 'risk' summit underatlen on 8 August 2023 to support ongoing recovery.	Metrics dashboard developed for discharge and flow linked to bed reductions trajectory	Data metrics to demonstrate impact on of the interventions is being developed. There is a risk to the delivery of non-elective length of stay target and increase in daily discharges due to the reliance of other specialties and external agencies outside of the control of the hospital There is a risk that winter pressures and will outstrip length of stay and occupancy gains preventing delivery of discharge/ bed closures.	Reporting through Urgent Care Improvement& Recovery Steering Group and Improvement Steering Group monthly. 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)		
						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.		

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						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**												
						Supporting the implementation of new models of care across a range of specialties	Specialty strategies not in place	Requirement for specialty strategies now part of strategy deployment and will commence Q1 22/23	Reports -ELT / TLT -Committees -Board -System	No plan of how the speciality strategies will be developed	New Improvement programme framework aligned to the CIP framework is being developed. Draft Heat Map is almost complete to support the identification of priority specialities for service reviews by July 2022. Heat Map finalised and used to identify the Specialties that were to be prioritised first for Specialty Review. Initial 17 data packs completed in readiness for Specialty Reviews during Feb/Mar 2023. Pilot within Cardiology undertaken in Nov 2022.		
			Failure of specialty teams to			Implementing the Outstanding Care Together Programme to support the Organisation to focus on high priority improvements in 22/23- (1) continued improvements in patient safety and experience (2) reduce long waiting times for treatment (3)make our people feel valued and supported by improving our culture and leadership	Embedding and sustaining cultural change when we remain operationally challenged with staffing issues etc. Ability to demonstrate quick impact on the cultural change due to various interventions as part of our Outstanding Care Together programme will be limited (as these are multi year/multi factorial projects)	ELT/TLT oversight Board / system reporting	Updated IIP reported at relevant Board Committees	Impact of Outstanding Care together programme on any of the key deliverables	Outstanding care together programme is being refreshed as part of the IIP year 3 refresh - completed. Year 4 IIP under development and due to be completed within Mar 2023 following a robust Business Planning Session in Q4 of 2022/23 (including Divisional IIP completions).		

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4a	Establish collaborative models of care with our partners	Director of Improvement and Integration	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	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 develope system Anchor Plan - next workshop 15th September 2023 EMAP Governance structure and propsal in development, recruitment of EMAP Managing Director, to be hosted by ULHT. Scope what a good effective partnership look like. Stakeholder mapping & engagement plan. Develop appropriate comms for the Lincolnshire ICS and our provider collaborative Agreements to support the development of the Provider Collaborative have been designed and shared. The Provider Collaborative is undertaking a stock take of services.	ULHT Green Plan Risk and Gain share (provider collaborative) Early Warning Discharge Indicators/development a common set of agreed metrics for flow and discharge across the system ICB delegation agreement ULHT Partnership Strategy	A better understanding of effective partnerships and what good looks like Clarity around role/accountability of partners within the Provider Collaborative Clarity around system improvement plan and provider collaborative plan and what outcomes each seeks to achieve Shared understanding and implications of the early warning discharge indicators, risk and gain share agreement within ULHT	Part of the refreshed IIP Reporting processes Regular updates to ELT/TLT/TB on Provider Collaborative, Health Inequalities, EMAP and our ICS Evidence and intelligence gathered from Service Reviews, Business Planning, Population Health and all other aspects of work will be pulled into this strategy to support the wider considerations of partnership working and future opportunities (commercial and non-commercial) The process of building the Trust Clinical Strategy has commenced taking information from Specialty Reviews to inform accordingly, and building on outputs from the Business Planning process.	Finance, Performance and Estates Committee	**Amber**
						Gain a greater understanding of the Lincolnshire population and support a reduction in health inequalities	Core20PLUS dashboard not yet developed	Development of Core20PLUS dashboard by June 2023	Core20PLUS dashboard	Core20PLUS dashboard not yet developed	Dashboard due to be in place by June 2023		
						Establishment of the Tobacco Cessation service to proactively support better health for the Lincolnshire population	Staff not yet in place to deliver and lead service	Job descriptions being job matched to support mobilisation by August 2023	Service mobilisation of Tobacco Cessation serivce	Service not yet mobilised	Job descriptions being job matched to support mobilisation by August 2023		
						A Joint Forward Plan by June 2023 and continued utilisation of Joint Strategic Needs Assessment (JSNA), population health data from Optum and the health and wellbeing strategy, to influence our collective approach	Final plan not yet in place	Plan being considered by relevant Boards priro to sign to off, expected July 2023	Plan to be considered in Chief Executives Group and formally to the Board	Final plan not yet in place	Plan being considered by relevant Boards priro to sign to off, expected July 2023		

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						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		
						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 clincial academic posts until research grant income starts to be generated - agreed approach for joint oversight of clincial academics to support discussionon perfomance 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 2 November 2023 where we will look to agree the finanical model, hosting arrangements and MOU	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 Agreement to produce financial model week beginning 2nd October 2023 for agreement at meeting on 2nd November 2023		
						Improve the training and support environment for students and clinical academics ULHT Library and training facilities improvements are now complete.	Lack of a model for research training and support for new clinical academics as they start to be employed No current agreement between ULHT/UoL in relation to clinical academic accommodation and resources model	Clinical Academic Model financial model and contract will include facilities and resource provision. Exploratory work underway to understand package of support e.g. via clinical rails unit, UoL	Clinical academic financial model once complete GMC training survey Stock check against checklist Internal Audit - Education Funding	Clinical Academic financial model not yet agreed	A new R&I group has been set up being led by Director of R&I/Deputy Medical Director, this will provide more oversight and rigor in developing an R&I agenda with representation from key stakeholders and clear milestones for delivery		

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4b	Becoming a university hospitals teaching trust	Director of Improvement and Integration	Failure to develop research and innovation programme Failure to develop relationship with university of Lincoln and University of Nottingham Failure to meet the current UHA requirements to become member of university hospital association		CQC Caring CQC Responsive CQC Well Led	Develop a joint research strategy with the UoL by September 2023, which identified shared research focus areas which is needed to meet UHA requirements	A joint MOU is in place at a Lincolnshire System level as agreed in April 2022, and the Steering Group and ELT has agreed that this should be used as the overarching MOU A draft ULHT/UOL MOU has been prepared but this has not been signed off as ideally it will need be combined with the final clinical academic model into a shared contract. Draft priorities based on initial dialogue with vice dean of the medical school has been created, further work to develop UOL strategy is being undertaken.	Working closely with the University of Lincoln, monthly meetings. Through these meetings have completed first draft of the Joint Strategy. There is an existing ULHT R&I Strategy in place and a new version will be developed for 24/25 as the current one is it its final year. The Lincolnshire ICS have commenced work on a system wide R&I strategy - UHLT Director of R&I is engaged with this process. As ULHT are not currently in a position to apply for UHA status due to the lack of clinical academics employed, the shared Strategy is not required currently. However it will need to be in place ahead of a UHA application.	RD&I Strategy and implementation plan agreed by Trust Board	Clinical Academic Model is required to support shared Strategy development UoL have refreshed their Research Strategy and as at end Oct 2022 ULHT are awaiting a copy of this to then align to joint strategy between the two organisations.	Monthly meetings with ULHT and Uni of Lincoln and through ULHT Steering Group Shared Strategy is a requirement for UHA application and not Teaching Hospital Status	People and Organisational Development Committee	**Red**
						Clear understanding of UHA requirement for University Status which requires 6% of medical workforce WTE to be clinical academics which is being used to build the ULHT/UOL model Develop a portfolio of evidence to apply for Teaching Hospital status as an interim approach towards full University Teaching Hospital status at a later stage	Financial model and clinical academic roles are not yet in place	A financial model for the appointment of clinical academics is in development that describes a timeline to achieve the required 6% of medical workforce for UHA status Portfolio of evidence is being captured for Teaching Hospital status application and is available on the shared drive Identified leads to liaise with UHA CEO (Medical Director, ULHT and System Clinical Director/Chair PCN, Lincolnshire ICS)	Financial meetings underway to develop and agree clinical academic models. Working Group meetings have been 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	Meeting held 12th July between ULHT and UOL finance/ contracting teams. Next meeting 23rd August 2023 to agree revised model.		
						Develop a strong professional relationship with the University of Lincoln and the Medical School and jointly create a strategy with a focus on developing rural healthcare, medical/nursing/AHPs/Clinical Scientists/R&I staff education and other healthcare roles	Evidence bound by UHA requirements Clear plan/strategy on development of medical/nursing/SHPs/Clinical scientists/R&I staff education roles	A new R&I group has been set up, being led by Director of R&I/Deputy Medical Director. We continue active stakeholder management with Medical Director of ICS and UOL VC.	ULHT healthcare roles plan Increased recruitment/academic posts (across ICS)	The change to the UHA Guidance (20xClinical Academics) is a challenge. Received further feedback from UHA and need to have at least 20 clinical academics remain unchanged.	Working closely with University of Lincoln to develop plans for recruitment of Clinical Academic posts with a view to maximising existing research relationships where possible. Two potential candidates have been identified for the Clinical Academic recruitment.		

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						Successfully recruit 6 Clinical Academics within the first year of agreement of the UoL/ULHT model	Agreed clinical academic financial model	A financial model for the appointment of clinical academics is in development that describes a timeline to achieve the required 6% of medical workforce for UHA status	Working group Meetings, ULHT/UOL Exec meetings and R&I meetings	The financial model is not yet agreed which is delaying appointment of clinical academic roles	Meeting held 12th July between ULHT and UOL finance/ contracting teams. Next meeting 23rd August 2023 to agree revised model.		
						Improve research and innovation activities and culture through new ULHT Growth of Research Culture Steering group	First meeting end June 2023 so has not yet established	R&I held a session with TLT 6th July and further meetings of the Steering Group are being scheduled		No confirmed dates in diaries yet for ongoing meetings	Head of R&I and Director of R&I to confirm forward meeting schedule		
4c	Successful delivery of the Acute Services Review	Director of Improvement and Integration	Limited capacity to hold regular scheduled ASR meetings with ULHT Divisional Teams due to ongoing operational pressures (Level 4, Major Incident etc).		CQC safe, CQC responsive, CQC well led	Develop a ULHT clinical service strategy with focus on fragile services in order to provide sustainable and safe services for the future Identify the key services to focus on for Clinical Service Review (taking into account CIP, benchmarking, GIRFT and other core data) Engage with services to develop plans as to how best to approach a clinical review, First Implementation Oversight Group meeting scheduled for September	Heat maps now drafted, with service reviews linked with improvement and clinical strategy development Divisional IIPs need to be completed to ensure links into fragile services/clinical service strategy Identify resources to implement ASR outcomes	Process being developed to identify services for review. This includes the development of a HEAT Tool to identify areas where services are not meeting targets, such as RTT, Cancer, Finance data. Initial discussions with divisions have been had with a view to ensure that the services most needing priority review are identified. Programme management support being identified via Provider Collaborative to help deliver ASR phase 1 Individual work streams to be established	Heatmap of fragility Plan for development of a clinical service strategy Health inequalities and core25 PLUS indicators Early Warning Discharge Indicators Rigorous engagement, both for feedback from the ASR review and further implementation	Evidence available but working on a process to bring together the information for services to aid the identification of the Top 5 areas for focus in 2022/23.	Part of the refreshed IIP Reporting processes HEAT Map for identification of services being created within Strategy & Planning at TLT on 13/10/22 for review and sign off. Publish ULHT clinical service strategy end of 2022/23 Working with Divisions to identify ASR implementation requirements with draft outline plans in place for Orthopaedics and Stroke. Stroke Capital/Estates Group meetings now diarised and being led by the Business Case Team. Orthopaedics ASR taken to HOSC in Dec 2022 and confirmed as complete through ULT upward reporting. Stroke ASR are working on a 'Perfect Week' to further progress and have commenced relevant staff consultation processes required.	Finance, Performance and Estates Committee	**Amber**
						Establishment of a rolling programme of service reviews, with 12 completed in year	Sign off of speciaty review strategies and governance route not yet known	To be agreed with ELT, July 2023	Signed off specialty reviews	Governance route not yet established	Agreement of governance through ELT		
						Play an increasing leadership role within the East Midlands Acute Provider Collaborative to develop key partnerships							
						Build a Partnership strategy to support improvements in safe and sustainable care, and harness benefits for the population of Lincolnshire	Partnership Startegy not yet in place	Associate Director of Partnerships started in post May 2023 and has started to draft Partnership Plan with intention to have signed off by December 2023	Signed off Partnership Strategy	Strategy not yet completed or sgned off	Work is underway to develop the strategy, which needs to align with the current IIP and new ULHT clincial services strategy.		

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

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