Bundle Trust Board Meeting in Public Session 11 January 2024

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

1 Introduction, Welcome and Chair's Opening Remarks
Chair

2 Public Questions
Chair

2.1 Ward Accreditation
Laura Hatfield - Ward 1B - Bronze
Karen Bird - Branston Ward - Bronze

3 Apologies for Absence
Chair

4 Declarations of Interest
Chair

5.1 Minutes of the meeting held on 7 November 2023
Chair
Item 5.1 Public Board Minutes November 2023v1

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

6 Chief Executive Horizon Scan Including ICS
Chief Executive
Item 6 Group CEO Update, 110124

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 November 2023 v1
Item 8.1 QGC Upward report December 2023
Item 8.1 App 1 QGC Upward Report Dec - PSIRF Closedown Report Implementation Group November 2023
Item 8.1 App 2 QGC Upward Report Dec - Bi-annual staffing report Nov 23 V3
Item 8.1 App 3 QGC Upward Report Dec - Compensatory rest report and action plan
Item 8.1 App 4 QGC Upward Report Dec - Maternity Neonatal Safety Assurance Report for Oct 2023 MNOG FINAL
Item 8.1 App 5 QGC Upward Report Dec - MatSIP Headline Report November 2023

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

9.1 Assurance and Risk Report from the Workforce and Organisational Development Committee
Item 9.1 POD - Upward Report - November 2023
Item 9.1 POD - Upward Report - December 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 November 2023 v1
Item 10.1 FPEC Upward Report December 2023 v1

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

12 Integrated Performance Report
Director of Improvement and Intregration

Item 12 IPR Trust Board - Front page
Item 12 IPR Trust Board December 2023 Final 2

13 Risk and Assurance

13.1 Risk Management Report

Item 13.1 TB- Strategic Risk Report - November-December 2023
Item 13.1 Appendix A - TB Risks rated 15-25 - December 2023

13.2 Board Assurance Framework

Item 13.2 BAF 2022-23 Front Cover January 2024
Item 13.2 BAF 2023-2024 27.12.23

16 Any Other Notified Items of Urgent Business

17 The next meeting will be held on Tuesday 5 March 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 7 November 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
Professor Philip Baker, Non-Executive Director
Dr Chris Gibson, Non-Executive Director
Ms Michelle Harris, Chief Operating Officer
Mr Jon Young, Director of Finance
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
Ms Claire Low, Director of People and Organisational Development
Mrs Vicki Wells, Associate Non-Executive Director

In attendance:
Mrs Jayne Warner, Trust Secretary
Mrs Karen Willey, Deputy Trust Secretary (Minutes)
Mrs Sarah Addlesee, Associate Director of Nursing – Item 2.1
Carole Chapman, Senior Sister/Charge Nurse Neonatal Services, Pilgrim – Item 2.1
Joanne Coupland, Sister/Charge Nurse Bostonian – Item 2.1
Lisa Codd, Sister/Charge Nurse – Item 7
Kerry Nuttell, Deputy Sister/Charge Nurse – Item 7
Andrew Jackson-Parr, Chaplain – Item 7

Apologies
Mrs Rebecca Brown, Non-Executive Director
Ms Dani Cecchini, Non-Executive Director

1330/23	**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.
1331/23	**Item 2 Public Questions** **Q1 from Vi King**

	Why is there less clinics in ENT at Grantham than before COVID. **Holding weekend clinics when weekday clinics are not full.** **People of Grantham and areas still being told no ENT at Grantham this needs to be addressed and stopped.** The Chief Operating Officer responded: The Trust continued to have ENT clinics at Grantham with some occasions where slots were vacant during the week, as a result of late notice cancellations which could not always be filled. Some virtual clinics remained in place however work was taking place to move there back to face to face, although some patients continued to prefer virtual clinics, which would be accommodated going forward where possible. Additionally, the Trust was in the process of appointing a sixth ENT surgeon which would provide more flexibility to clinics at Grantham. An elective list for ENT had also commenced at Grantham which had not previously been in place. The weekend clinics were for first outpatient appointments only and were in place to support the backlog acquired during Covid-19. This would continue to be monitored within the Clinical Business Unit and if there were any specific escalations, the Chief Operating Officer invite Ms King to make direct contact. There was confidence that the Trust was operating ENT clinics to the same level as pre-Covid-19 however these were not all face to face.
1332/23	**Q2 from Sue McQuinn** **This is a paragraph from ULHT Dignity Pledges:** ***We will maintain your modesty and privacy and dignity during care and treatment and we will respond promptly when you call for assistance or explain reasons for any delay*** **With this in mind, I'd like to ask the following:** **1) What is the ratio of commodes to patients in ULHT hospital wards?** **2) If a commode isn't readily available for a patient who's requested one, what action should be taken?** **3) Where a patient's request is not fulfilled, resulting in soiling, are such incidents recorded? If so, is data available to show how often this is occurring?** **4) What action would you expect from staff following a soiling incident, with respect to the patient involved?**

	The Deputy Chief Executive/Director of Nursing responded: There was no national standard or ration for commodes however wards generally had between 4-6, depending on the size of the ward, as well as bed pans, urinals and ward toileting facilities for men and women. Other factors included the profile of patients on the ward with more commodes available where there were more bed bound patients. For wards, such as surgical day wards, there were less commodes required as patients would be up and about. The Director of Nursing advised that, if patients were able, they would be taken to toilet facilities on the ward however if this was not possible, they would be offered a bed pan, or urinal for med, where appropriate. This would also be dependent on the specific needs of the patient. If a patient was to soil their bed or chair, this would be recorded in the patient notes as a care episode with the nurse recording the care and actions undertaken. This was not specifically recorded as an incident as an accident could occur for specific reasons. If there was an issue with equipment or a commode this would be recorded as an incident in the Datix system. Staff would report this as an incident through regular reporting processes and this would be considered reportable data. The information captured within the patient notes, by the nursing teams, would also capture any changes in the patient condition as this could lead to the patient being incontinent and potentially result in the soiling of beds or chairs. The Director of Nursing advised that staff would ensure that the patient's skin was clean and dry with fresh dry clothing given and either the bed or chair cleaned, with fresh sheets for the bed. By recording this in the patient notes, if this had occurred due to the clinical condition of the patient then clinical staff would want to be aware as this could lead to the possible need to change the care or treatment. This would also support discussions with other colleagues to explore and support alternative solutions being in place if required. The Director of Nursing would be happy to respond to any specific queries Ms McQuinn had.
1333/23	**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.
1334/23	The Chair welcome Carole Chapman, Senior Sister/Charge Nurse, Neonatal Services, Pilgrim and Joanne Coupland, Sister/Charge Nurse, Bostonian to the Board to celebrate the achievements.

1335/23	The Associate Director of Nursing introduced the 2 teams who had successfully achieved the bronze diamond award as part of the quality accreditation programme. The Board was aware of the core requirements the departments were required to achieve against with a range of quality indicators in addition to presenting a portfolio of evidence to the Quality Accreditation Panel.
1336/23	Both the Bostonian and Neonatal Unit at Pilgrim applied and were successful in achieving the Bronze Diamond accreditation.
1337/23	Sister Coupland offered an example of the work undertaken by the shared decision council which, having initially been set up in 2019, was relaunched following staff changes and Covid-19 in September 2022. The shared decision-making council worked alongside Waddington Ward at Lincoln.
1338/23	There had been difficulty in engaging staff in the improvements identified however the Deputy Ward Manager used their enthusiasm in improving patient care and experience and leadership skills to motivate staff to become involved. Training was attended with the improvement team with areas for improvement identified.
1339/23	Sister Coupland advised that the ward had seen an increase in pressure damage with the council identifying the need for the new paperwork to be reviewed to determine if this was impacting on patient and staff experience. It was noted that both staff and patients were engaged in the improvement work ensuring that not only was the paperwork effective but that patients were able to provide feedback of their experience.
1340/23	As a result of the improvement work there was a reduction in pressure damage due to the changes in ways of working and routine on the ward and, from this, it was noted that there had also been a decrease in patient falls.
1341/23	Senior Sister Chapman advised of the learning from incidents improvement work undertaken by the Neonatal Service, following a peer review by the East Midlands Neonatal Delivery Network and Specialist Commissioners. Feedback had been offered about governance processes with a need for review identified. A significant action plan was developed following this with the Learning in Neonates (LINs) tool developed.
1342/23	The method was to share incidents and outcomes and once pulled together these where shared across the service to the Lincoln site. These were also shared with the governance group and shared with nursing and medical teams.
1343/23	The LINs considered the incident, provided a summary of what had gone wrong and what recommendations were needed. The learning was then added about the actions to be taken or known. It was noted that the team considered good practice in addition to learning from incidents which was also shared amongst colleagues.
1345/23	The Director of Nursing offered thanks to Sister Coupland and Senior Sister Chapman as well as the teams noting the achievements that had been made.

1346/23	The Director of Nursing reflected on the improvement work of Sister Coupland reflecting that this demonstrated a Plan, Do, Study, Act (PDSA) cycle with the benefit of engaging with patients as part of the process.
1347/23	The improvement work demonstrated by Senior Sister Chapman clearly offered collective working as a team with a multi-professional approach to learning, which was commended.
1348/23	The Chair noted the comments made which endorsed the feeling of the Board with Board members offered comments in the chat.
1349/23	There was clear leadership and resilience demonstrated by those involved on the wards. The inclusion of peer review and learning in a positive manner was clear and it was noted that feedback was not always received positively.
1350/23	It was clear that both Sister Coupland and Senior Sister Chapman were living the values of the Trust with the Chair offering thanks for presenting to the Trust Board.
1351/23	**Item 3 Apologies for Absence** Apologies were received from Mrs Rebecca Brown, Non-Executive Director and Ms Dani Cecchini, Non-Executive Director.
1352/23	**Item 4 Declarations of Interest** There were no new declarations of interest.
1353/23	**Item 5.1 Minutes of the meeting held on 5 September 2023 for accuracy** The minutes of the meeting held on 5 September 2023 were agreed as a true and accurate record.
1354/23	**Item 5.2 Matters arising from the previous meeting/action log** 1255/23 – Assurance and Risk Report Quality Governance Committee – The Director of Nursing advised that, through the Maternity and Neonatal Oversight Group (MNOG) and the Quality Governance Committee, the issue of the Maternity IT system had previously been raised.
1355/23	The full business case was now supported in principle and the preferred option to come forward to the investment panel in November had been identified.
1356/23	The Director of Finance and colleagues were meeting with the leadership team of the Family Health Division and the Digital Lead to source project support which had been flagged as a concern. The maternity team were developing the job description for a specific matron role to support the implementation of the maternity IT system.
1357/23	Preparation work was taking place to inform the business case so that, once approved, this could commence immediately with the procurement.

1358/23	The Director of Nursing offered reassurance to the Board that there was mitigation in place to support the maternity teams at this time however advised this was labour intensive. Oversight was held through MNOG.
1359/23	The Chair was pleased to hear that the business case was progressing and moving into procurement stages as this was something raised through visits to maternity services.
1360/23	**Item 6 Chief Executive Horizon Scan including ICS** The Chief Executive presented the report to the Board noting the continued pressures across the system. There had been further industrial action by both Junior Doctors and Consultant colleagues however there was no industrial action planned for November.
1361/23	The British Medical Association (BMA) had been balloting some members, particularly specialists and consultant members, about further industrial action. This ballot would close on 18 December with more information known following the outcome of the ballot.
1362/23	The Chief Executive noted that there had been some discussions between the Department of Health and the BMA, whilst these remained ongoing, there was an expectation that further strike action would not be announced.
1363/23	The NHS had coped well in adverse circumstances during storm Babet with the Chief Executive commending colleagues for the great work done to keep patients safe, whilst ensuring the right people were in the right place at the right time.
1364/23	Like most parts of the country there was a lot of water with a number of leaks causing issues across the Trust. Support had been received from Lincolnshire Fire and Rescue and Anglian Water to pump water out of the plant room at Pilgrim, this resulted in the site not losing hot water and heating.
1365/23	The Chief Executive offered formal thanks to the Fire and Rescue Service and Anglian Water for the way in which they responded to the request for help. A letter would be sent to both organisations to thank them. **Action: Chief Executive, 11 January 2024**
1366/23	The Board was advised of the impact that a sink hole was having at Pilgrim Hospital, outside of the Accident and Emergency Department. People had coped well with this however it was impacting on some of the work on site, particularly patient parking.
1367/23	The Chief Executive advised, from an operational issues perspective, that the Lincolnshire System was in tier 2 for Urgent and Emergency Care (UEC) due to some concerns around the 4-hour A&E wait. When type 1 and type 3 A&E and UTC attendance was considered, the System performance was above the regional average.

1368/23	The concerns in Lincolnshire were about patient waiting 12-hours or more in A&E and category 2 ambulance response times. There was significant work taking place across the system to address these concerns with a National Chief Executives meeting due to take place which would likely focus on UEC as a key topic nationally. It was accepted that improvements in performance were required.
1369/23	It was noted, in respect of finances that the system was behind plan overall however there had been positive progress on the Financial Recovery Plan (FRP). It was believed that the system had met the exit criteria for the Recovery Support Programme (RSP) with an application having been submitted to exit the RSP.
1370/23	This had been through the reginal process and was now being submitted to the National Committee to make the final decision. It was anticipated that the outcome would be heard in the second half of November.
1371/23	Despite being in the RSP and some pressures on UEC the recent Quarterly System Review meeting, for quarter 2, had been positive with NHS England. There was an awareness of risks and challenges along with actions required with confidence in the system, by NHS England, that issues would continue to be addressed.
1372/23	The Urgent Treatment Centre (UTC) at Grantham had opened at the end of October and it was hoped that this would support discussions about the future of Grantham. It was recognised that there were still individuals talking about the A&E service however, following the public consultation, it should be pleasing that there was 24/7 walk in access restored to the UTC, as part of the Acute Services Review outcome.
1373/23	The Chief Executive referred to the Group arrangements noting that the Group Chair role had been advertised nationally with the process due to conclude in the current week.
1374/23	Trust issues were discussed with the Chief Executive advising that the financial plan was on track at month 6 with the Trust ahead of plan on the FRP. The Trust contribution to the FRP had been a key part of why the system was in a position to seek to exit the RSP.
1375/23	The Chief Executive was pleased to advise that there had been national approval for the outline business case for the Electronic Patient Record (EPR) which had been a significant piece of work and achievement. There had been some conditions on the approval however this was not unexpected with the Trust addressing the conditions in order to be able to proceed to the procurement stage.
1376/23	As a Trust there had been escalation around planned and cancer care due to long waits, 78-weel waits and plans to clear the 65-week waits by the end of March, in addition to the work around the Faster Diagnosis Standard (FDS) and 62-day backlog.
1377/23	The Trust was making significant progress on this, and discussions had commenced with regional colleagues about the criteria to exit tier 1 escalation.

1378/23	The Chief Executive hoped that the Paediatric Consultation would reach conclusion, with responses having been received. The final decision would be taken by the Integrated Care Board (OCB) on 28 November, and it was hoped at this time it would be possible to move forward.
1379/23	The Chief Executive advised of the departure of Mr Barry Jenkins, who had secured a Deputy Chief Executive Officer role in Scotland. Mr Jenkins had been released quickly to his new role, partly due to the Trust being able to fill the role with Mr Jonathan Young, stepping up from Deputy Director of Finance to Director of Finance.
1380/23	Thanks were offered to Mr Jenkins for the work done whilst with the Trust and Mr Young was welcomed to the Executive Team and the Board.
1381/23	The Chair formally welcomed the Director of Finance to the Board and endorsed the comments made in respect of Mr Jenkins.
1382/23	The Chair acknowledged the strategic achievements reported regarding the UTC at Grantham and securing the finances for the EPR. It was hoped that, following difficult issues for the Board, over a number of years, that the Paediatric Consultation would conclude positively. This would enhance how the Trust provided care to patients across services and would be in an improved position. The Trust Board: • **Received the report and noted the significant assurance provided**
1383/23	**Item 6.1 Thirwell Inquiry – Notice of Upcoming Request for Evidence** The Medical Director offered and update to the Board regarding advance notice of the upcoming request for evidence as part of the national Thirwell Public Inquiry, set up in response to the Lucy Letby conviction.
1384/23	This had a wide-ranging remit and would not solely focus on activities and behaviours at the Countess of Chester Hospital NHS Foundation Trust but the wider NHS.
1385/23	The terms of reference of the inquiry had been published and evidence gathering had commenced. Whilst this would, in part be specific to the Countess of Cheshire Hospital NHS Foundation Trust, it was believed there was benefit of evidence being received from all Trusts with neonatal units. This would better inform the work and questions of the inquiry.
1386/23	The Medical Director confirmed that this was offered as an advance notice of the Trust receiving a letter from the inquiry to provide evidence pertaining to the Trust's neonatal units. It was anticipated that there would be a set of questions to respond to with an expectation this would be required by mid-December.
1387/23	Once received the questions would be scoped and oversight of the response would likely be through the Maternity and Neonatal Oversight Group and the Quality Governance Committee.

1388/23	The Medical Director confirmed that NHS England had requested that all Trust Boards were made aware of the forthcoming request.
1389/23	The Chair was confident that the Trust would send all information required and noted the need for the Trust to consider the implications of the inquiry and conviction of Letby, to take forward any learning from this and consider overall assurance functions within the Trust.
1390/23	Dr Gibson noted that the Quality Governance Committee considered a number of parameters for maternity and neonatal services on a regular basis. This included deaths in the neonatal units which, for the Trust, was fewer than 1 per year.
1391/23	The Chair noted that further information would be offered to the Board in due course. The Trust Board: • **Received the report for information**
1392/23	**Item 7 Patient/Staff Story** The Director of Nursing introduced the patient story to the Board noting this was a story, written by Pip, the wife of Stuart, regarding his stay on Acute Medical Short Stay (AMSS) at Boston. Stuart diagnosed with high grade invasive cancer which was inoperable and, since offering the story Stuart had lost his fight against cancer.
1393/23	The couple had been together over 17 years and never had time to get married. The story was of them and what staff and chaplaincy service did to support them with their wedding.
1394/23	The Trust Board watched the video which detailed the diagnosis of Stuart and the impact this had on his life, with Stuart determined to fight and remain as mobile as possible.
1395/23	The staff noted the desire for Pip and Stuart to get married and organised an emergency wedding, the first the AMSS ward had organised. It had been decided on a Wednesday at 4pm that the wedding would take place with the ward contact Chaplain Mr Jackson-Parr who attended the ward on the Thursday morning.
1396/23	The wedding took place on the Friday that week with the colour scheme being rainbow, the ward staff decorated the room used for the wedding and received donations from Waitrose and Aldi for a cake, champagne and flowers, with a photographer also being arranged.
1397/23	The Board noted that Stuart aimed to stand whilst getting married and whilst this was not done as he had hoped the staff recognised the support of Occupational Therapist Laura who support Stuart to stand with an aid.
1398/23	The video detailed the support offered by the Chaplaincy service in coordinating weddings, both faith and non-faith, with certain requirements needed for emergency situations.

1399/23	The Chair offered the sincere condolences of the Board to Pip on the loss of her beloved Stuart and also offered thanks for allowing their story to be shared. This demonstrated the care and wellbeing for patients whilst in the care of the Trust.
1400/23	Through the MS Teams Chat Board members reflected the care, compassions and can-do attitude of the staff to support the wedding.
1401/23	The Director of Nursing echoed the condolences of the Chair noting pride in the team involved in having the impact shown through the story and was pleased that the staff had not done things by halves as this had resulted in the outcome for Pip and Stuart getting married.
1402/23	The Chief Executive thanked those involved noting that this was both an uplifting and sad story with further condolences extended. The behaviours of the staff had shown the living of the Trust values with those who were touched by this, having memories of the actions of staff. Thanks were extended to the staff involved for giving the memories and experience to Pip and Stuart.
1403/23	The Chair extended thanks to the sponsors who had also supported the wedding.
1404/23	The Chaplain, Mr Jackson-Parr referred to the phrase in the video of not doing any less noting that this was a default position for staff in the Trust noting that the Chaplaincy team were only able to do what they did due to other colleagues across the Trust.
1405/23	The Chaplains were only able to support due to staff asking important questions to find out what was important to patients and their families and having a whole person approach.
1406/23	Mr Jackson-Parr noted that it was a privilege to work with colleagues across the Trust and to recognise the whole person, whilst the aim was to fix people physically, as best as possible there was so much more that could be done.
1407/23	The Chair offered thanks to Pip for sharing the story and bringing this to the Board. 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
1408/23	**Item 8.1 Assurance and Risk Report Quality Governance Committee (inc MNOG appendices)** The Deputy Chair of the Quality Governance Committee, Dr Gibson, provided the assurances received by the Committee at the 19 September and 17 October 2023 meetings.
1409/23	Dr Gibson advised the Board of the report received to the September Committee from the Infection Prevention and Control Group noting the slight rise in Covid-19 infection rates. There was an emphasis on vaccinations for both flu and Covid-19

	with peer vaccinators in place and joint working across the group, with a system approach.
1410/23	The Committee received the Patient-Led Assessment of the Care Environment (PLACE) annual report noting the significant improvements reported, with 21 of the 23 parameters improved against the 2019 report.
1411/23	The Clinical Effectiveness Group Upward report had indicated a significant improvement in audit performance however some challenges remained in respect of the Stroke National Audit Programme. It was anticipated that the implementation of the Stroke Acute Services Review would support improvement.
1412/23	The Committee also noted the significant improvement in complaints performance with the Committee commending the Complaints Team for the achievement. There had been an increase, from a previous low of 10%, to 80% of complaints responded to on time.
1413/23	Dr Gibson noted the formal report received in respect of the Industrial Action amongst the medical workforce, which was appended to the report. This demonstrated the Trust response to focus on patient safety and staff welfare with a significant financial cost, due to the cost of back filling. There had been significant effort by those involved in the planning and ensure services were in place to mitigate the potential for harm.
1414/23	The Chair noted the clear overview offered in the report and welcomed both the PLACE report and the report relating to the medical workforce industrial action. The environment improvements were noted which reflected the hard work being undertaken by colleagues across the Trust in recent years.
1415/23	Dr Gibson offered the upward report from the 17 October meeting noting the meeting was reduced in length. In order to facilitate discussion, questions had been pre-submitted by Committee members in relation to the papers.
1416/23	The Committee noted the go live of the Patient Safety Incident Response Framework (PSIRF) with the full paper offered as an agenda item to the Board. The Committee commended the process undertaken by the Patient Safety Team to reach this stage, ahead of many other Trusts.
1417/23	The Infection Prevention and Control upward report advised of the national rise in C-difficile cases with 1 MRSA case reported by the Trust in September. This would be considered at future meetings of the Committee.
1418/23	Dr Gibson noted that the Committee had received the MNOG upward report with the suite of papers appended to the report for the Board. The Committee commended the proactive approach by the maternity team taken when issues arose resulting in a deep dive being completed in to breach births. This had provided assurance that the rate of breach births was reported as 0.3% in the Trust, compared to 1% nationally.

1419/23	The Patient Experience Group Upward Report advised of the public availability of patient stories which supported the approach of being open with both positive and negative stories. These provided key learning experiences for staff.
1420/23	Through the Clinical Effectiveness Group Upward Report the Committee was alert to the National Confidential Enquiry into perioperative deaths and also noted that there were some significantly overdue National Confidential Enquiry into Patient Outcome and Death (NCEPOD) actions. The Committee noted the support being offered to the Divisions in order to address and close these actions.
1421/23	The Director of Nursing noted that the detailed MONG reported were appended to the October report from the Committee and advised of the Ockenden insight visit report from 20 June.
1422/23	Whilst there were some areas to consider, overall, the visit was excellent with the report reflecting this. The report would be shared more widely with stakeholders.
1423/23	The Director of Nursing noted the claims triangulation report and the core competence framework for the Clinical Negligence Scheme for Trusts (CNST) which the Trust would be required to meet. The Trust was now working towards the next version of Saving Babies Lives, having achieved the criterion of version 2.
1424/23	In relation to the Lucy Letby case, still births and birth rates, the Director of Nursing noted that details were offered in the reports, which were reviewed at each MONG meeting and considered in detail.
1425/23	These were offered to the Quality Governance Committee for assurance and discussion and onward to the Board for Board level oversight.
1426/23	The Chair noted the focus on maternity services with the Board being well sighted on this and recognising the process of review offered full assurance on progress.
1427/23	Congratulations were offered in respect of the Ockenden insight visit which had displayed strong performance. The Trust Board: • **Received the assurance report** • **Received the Maternity and Neonatal Oversight Group reports**
1428/23	**Item 8.2 Patient Safety Incident Response Framework (PSIRF) Plan and Policy** The Chair noted that a Board Development session had been held, in addition to information offered to the Board with the report offering the most up to date position.
1429/23	The Director of Nursing noted that the Trust had been working towards implementation for the last 12 months for PSIRF with a PSIRF implementation team in place to ensure this was done in line with national guidance.
1430/23	Updates had been offered to the Quality Governance Committee throughout the implementation alongside close down reports for each phase of the implementation.

	This had culminated in the developed PSIRF Policy and Plan which had been approved by the Quality Governance Committee.
1431/23	A requirement of the national guidance was the approval of the plan and policy by the Trust Board. Once approved by the Board these would be shared with the Integrated Care Board.
1432/23	The Director of Nursing advised that the Trust had transitioned on the 1 October 2023 with benefits being seen of not needing to follow the Serious Incident framework but having the ability to use a variety of investigation techniques. It was reflected that there may be benefit in a further session for the Board to offer a wider awareness of the process as well as considering this in a group model approach.
1433/23	The Director of Nursing also advised that the Trust had transitioned successfully to Datix IQ. There was also a new platform for information capturing with a new national reporting processes to Learning From Patient Safety Events (LFPSE). These had also been transitioned to on the 1 October. This had been done together in order to meet national requirements to progress learning.
1434/23	The LFPSE was a new national service for the recording and analysis of patient safety events in healthcare with the Trust transitioning at an early stage.
1435/23	The Director of Nursing requested approval of the PSIRF Policy and Plan.
1436/23	The Chair noted the significant work that had been undertaken which would make a fundamental difference to the way in which the Board, and Trust, understood safety requirements and where action was required.
1437/23	Dr Gibson noted within the national guidance the key change in approach to investigations noting that where an incident was well understood, due to previous incidents and a national programme of improvement, there should not be focus on investigation of this. The new process was designed to be a learning process rather than a blanket approach that saw all incidents investigated.
1438/23	The Chair noted that it would be useful for a Board discussion to be held, working as a group with Lincolnshire Community Health Services NHS Trust, to give focus on patient safety and improvement. A joint Board Development Session was proposed. **Action: Trust Secretary, 11 January 2024** The Trust Board: • **Received the report noting the moderate assurance** • **Approved the Patient Safety Incident Response Framework Policy and Plan**

	Item 9 Objective 2 To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT
1439/23	**Item 9.1 Assurance and Risk Report People and Organisational Development Committee** The Chair of the People and Organisational Development Committee, Professor Baker, provided the assurances received by the Committee at the 12 September and 10 October 2023 meetings.
1440/23	Professor Baker offered background context to the Board in respect of the establishment of the reporting groups to the Committee, which were covering much of the portfolio of the Committee. The groups were being used effectively, to help monitor and provide assurance on issues within the remit of the Committee.
1441/23	There had been some challenges in recent months in terms of reporting from the groups to the Committee.
1442/23	Whilst the Committee had met on the 12 September a number of apologies had been received from core members however, the Committee was grateful to other members of the Board for enabling the meeting to take place.
1443/23	This however had not been the case for the 10 October meeting and due to the recent service pressures, as discussed through other items, the meeting was unable to take place.
1444/23	Taking the reports as read Professor Baker noted that, at the September meeting, the Committee had been pleased to note the approval of funding of Disclosure and Barring Service (DBS) checks which were critical to the Trust complying with the Savile action plan.
1445/23	The papers for the October meeting were circulated to Committee members for consideration and it was noted that the dashboard continued to indicate a pattern of increased performance around training and compliance. There were also enhanced metrics in respect of turnover however the Committee was seeing a deterioration in sickness rates.
1446/23	This reflected the service pressures which were starting to affect all staff. Some of those issues had also been picked up in the Junior Doctor survey, where service pressures were starting to lead to frustration.
1447/23	Professor Baker noted a number of key items had been deferred to the November meeting including the Trauma and Orthopaedic Deep Dive action plan, which had previously been discussed. The Committee would also consider the progress around the Trust workforce plan.
1448/23	There was optimism that service pressures would not preclude the important work of the groups and the Committee ahead of the November meeting.
1449/23	The Chair noted the challenges in getting people to undertake the work required which reported to the Committee and noted the importance that this continued. The

	work would support staff who were experiencing the pressures and would offer some mitigation to this. Completing the work would impact on the overall position of colleagues in the Trust and therefore the importance of the Committee going ahead, wherever possible, was stressed. The Trust Board: • **Received the assurance reports**
1450/23	**BREAK**
	Item 10 Objective 3 To ensure that service are sustainable, supported by technology and delivered from an improved estate
1451/23	**Item 10.1 Assurance and Risk Report from the Finance, Performance and Estates Committee** The Deputy Chair of the Finance, Performance and Estates Committee, Mrs Buik, provided the assurances received by the Committee at the 21 September and 19 October 2023 meetings.
1452/23	Mrs Buik noted that the Pilgrim Emergency Department Upward Report had offered assurance on the project being on track with contract signatures finalised and no current concerns to delivery.
1453/23	In addition to the finance update offered by the Chief Executive, Mrs Buik noted that the Trust remained on plan for month 6, with the Committee receiving moderate assurance for the Cost Improvement Plan (CIP) achievement. This was based on the identified schemes, with additional support in place for the divisions.
1454/23	Overall, assurance remained limited for finances, mainly due to the uncertainty of the full year position as a result of inflation and industrial action. Work was underway to provide an updated forecast to consider the assurance rating.
1455/23	The Committee received moderate assurance in respect of the capital report noting that some schemes were behind plan however there was confidence on full year delivery.
1456/23	Continued improvement was being seen for Better Payment Practice Code (BPPC) performance with a revised process in place for pharmacy invoices in order for the Trust to achieve the 95% target for BPPC.
1457/23	The Committee also received the updated business case process which required a Senior Responsible Officer (SRO) to be appointed for any cases with a value of £500k.
1458/23	The Patient Level Information and Costing System (PLICS) had been received with moderate assurance with the Committee noting the potential productivity gains of £22m for future CIP schemes.
1459/23	The timescales of the 2022/23 National Cost Collection had changed due to external factors with delegated authority confirmed to the Director of Finance. The submission would then be offered to the Committee in December.

1460/23	The Committee noted progress against the scheduled digital projects with recognition of the need to ensure sufficient capacity within the team in order to deliver the full schedule of work for the year.
1461/23	Mrs Buik noted the issues reported in September around the Faster Diagnosis Standard (FDS) for breast and gynaecology services, which had seen improvement in October reports. There was a high level of confidence in the sustainability of the 62-day classic standard and funding bids had been submitted to support recovery. Limited assurance had been received however there was an expectation for improvement.
1462/23	The Committee noted the productivity in the outpatient improvement programme with the report offering a focus on 3 specialties to drive improvement. It was noted that the Trust had not yet cleared all 78-week waits with the position continuing to improve and a projection that this would be below 100 patients by the end of October.
1463/23	Work continued in parallel to clear the 65-week waits which was reported as ahead of trajectory.
1464/23	Mrs Buik noted the recent focus on Grantham Theatres and improvements in list and list utilisation, which had been recognised by Professor Briggs during his recent visit.
1465/23	Improvements in performance within diagnostics had been seen although some challenges remained. The Committee received an update on the Community Diagnostic Centres with a national requirement for programme boards to be in place, in addition to existing governance.
1466/23	Mrs Buik advised that the Committee had received an update in respect of urgent care noting that the capacity to discharge patients no longer needing treatment remained insufficient, despite the additional provision from HomeLink. Further requirements would be clarified as part of the winter plan process.
1467/23	The Committee received a specialty review update which was deferred to the November meeting in order to afford the Committee time to consider this in detail.
1468/23	An update on stroke services was also received with moderate assurance offered. This would see the consolidation of the service to a single site and a supporting business case to extend the capacity at Lincoln was being developed.
1469/23	The Chair noted that there was clarity on the areas of focus and was pleased to hear of the improvements in cancer performance for breast and 62-day as well as the improvements related to the 78 and 65-week waits.
1470/23	The comments made in relation to UEC would be revisited in the Private Board with areas of improvement noted. 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
1471/23	No items
1472/23	**Item 12 Integrated Performance Report** The Chair noted that the report set out the position of performance with each of the Committee's having reviewed the relevant sections.
1473/23	Board members were invited to flag any areas of risk or raise questions of which there were none.
1474/23	The Board took the report as read for information. The Trust Board: • **Received the report noting the limited assurance**
	Item 13 Risk and Assurance
1475/23	**Item 13.1 Risk Management Report** The Director of Nursing presented the monthly risk report to the Board noting that there continued to be stability within the report.
1476/23	There continued to be 17 very high quality and safety risks which had remained for a number of months. 6 very high risks related to people and organisational development with a further 3 risks which had changed or reduced ratings. These related to recruitment of staff with recruitment and retention now captured as 2 standalone risks following review by the People and Organisational Development Committee.
1477/23	Retention of staff, whilst a new risk following the split, was rated at 16 and the workforce culture risk had reduced to a moderate risk with a rating of 12.
1478/23	There continued to be 6 very high risks reported to the Finance, Performance and Estates Committee with risks continuing to be reviewed through the confirm and challenge meetings.
1479/23	The report offered the detail of the very high risks with the appendix providing all of the strategic risks.
1480/23	The Chair invited the Board to accept the report, with significant assurance, which represented the real and present risks recognised by the Board. The Trust Board: • **Accepted the risks as presented noting the significant assurance**

1481/23	**Item 13.2 Board Assurance Framework** The Trust Secretary presented the report noting that this had been considered by all Committees during September and October with the position against each objective shown as agreed through the Committees.
1482/23	There were no changes proposed to the ratings within the Board Assurance Framework (BAF) at this time.
1483/23	The Trust Secretary advised the Board that the Internal Audit in respect of Assurance and Risk was coming to completion following the review of the BAF, linked with the Risk Register. Confirmation of the exit meeting to discuss the findings was awaited.
1484/23	The Chair looked forward to receiving the internal audit report noting that this would offer a degree of evidence to support the well-led Care Quality Commission domain. The Trust Board: • **Received the report noting the moderate assurance**
1485/23	**Item 13.3 Report from Audit Committee** The Chair of the Audit and Risk Committee, Mr Herbert, presented the report to the Board noting that the meeting due to be held on 10 October had been cancelled due to quoracy issues. The papers had been produced and circulated to members of the Committee.
1486/23	The Committee received a report from the external auditors confirming that the 2023/24 audit planning was in progress with an outline timetable produced. A wrap up meeting for the prior year audit with the finance team would be held to identify any learning opportunities.
1487/23	A report was also received from the Trust internal auditors and, due to the concern on progress, a request was made for management of internal audit with an agreed action plan in place to being the back on track. The Committee held an informal follow up meeting at the end of October to receive the plan and was pleased to note some progress had been made against this.
1488/23	Mr Herbert noted that the Committee received a report on progress against policies and guidelines nothing that there had been concern for some time due to a large number being overdue for review. It was felt that there was a need for an action plan to be put in place to rectify this and it was agreed that an escalation would be made to the Board to ensure necessary focus and traction.
1489/23	The Chair noted the escalation for policies and guidelines noting that these were part of the governance in place to keep the Trust safe and in order. It was noted that the Executive Team would be given the opportunity to respond in due course to the escalation.
1490/23	Thanks were offered for the leadership of the Committee in the engagement with internal audit to ensure traction on delivery.

1491/23	The Chief Executive acknowledged the escalation noting this was not in the position required with some progress made on corporate policies and guidelines however the ones being referred to were, in the main, related to clinical services. The escalation was received and the action to be taken would be reported back to the Audit Committee and Board in order to improve the situation.
1492/23	The Chair offered thanks for the reassurance and would welcome the outcome of the action. The Trust Board: • **Received the report noting the significant assurance**
1493/23	**Item 14 Any Other Notified Items of Urgent Business** The Chair referred to the comments made regarding the quoracy of the Committees, appreciating that people were busy with an increase in operational matters to be seen to.
1494/23	It was important that attention was paid to due diligence and how this was exercised through the Committees. There needed to be thorough, properly constructed and quorate Committees and, whilst it was appreciated it could be difficult to attend, these did need to be prioritised and the current schedule utilised, to ensure appropriate levels of oversight and assurance.
1495/23	The Chair reflected that the meeting had been uplifting, although sad in parts, with progress being seen across the organisation. There was a number of things to celebrate with focus being given to areas of improvement with a degree of assurance received that this was being attended to in the right way and in the right timescales.
1496/23	The next scheduled meeting will be held on Thursday 11 January 2024 via MS Teams live stream

Voting Members	**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**	**7 Nov 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	A	A	X
Sarah Dunnett	A											
Paul Matthew	X	X	X	X	X	X	X					
Andrew Morgan	X	X	X	X	X	X	X	X	X	A	X	X
Simon Evans	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	A	X	X	A	X
Colin Farquharson	A	A	A	A	A	A	A	A	A	A	X	X
Gail Shadlock												

Dani Cecchini	X	X	X	X	X	X	X	A	X	X	X	A
Rebecca Brown	X	X	X	X	X	X	X	A	A	X	X	A
Neil Herbert	X	X	X	X	X	X	X	X	A	X	X	X
Paul Dunning	X	X	X	X	X	X	X	A	X	X	X	
Michelle Harris					X	A	X	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	Close
7 November 2023	1365/23	Chief Executive Horizon Scan including ICS	Letter of thanks to be offered to Lincolnshire Fire and Rescue and Anglian Water for the response to the request for help during Storm Babet	Chief Executive	11/01/2024	Complete
7 November 2023	1438/23	Patient Safety Incident Response Framework Policy and Plan	Joint Board Development Session to be scheduled with LCHS on patient safety and improvement	Trust Secretary	11/01/2024	Added to programme for joint sessions in 2024 Complete

United Lincolnshire Hospitals NHS Trust

Meeting	*Public Trust Board*
Date of Meeting	*11 January 2024*
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 coming out of the holiday period and into winter. The focus remains on ensuring patients are treated in the right place, at the right time, by the right people. This requires a continued focus on minimising ambulance handover delays, ensuring as much capacity as possible is available and maximising flow through the system. All of this continues to be addressed in partnership across the health and social care system.

b) The operational pressures are being adversely impacted by further industrial action involving junior doctors. There were three days of industrial action pre-Christmas between 07.00 on Wednesday 20th December and 07.00 on Saturday 23rd December. Six days of further industrial action is due to take place between 07.00 on Wednesday 3rd January and 07.00 on Tuesday 9th January. Industrial action impacts on both urgent and emergency care as well as planned care. Every effort is made to minimise the impact on patients.

c) The Lincolnshire system has now exited the national Recovery Support Programme (RSP) and has therefore transitioned from segment 4 to segment 3 of the NHS Oversight Framework. This follows the system having met the exit criteria related to the Financial Recovery Programme (FRP).

d) Further discussions are continuing with regional and national colleagues around the system's financial plan delivery forecast for the end of the year. This is happening in all ICB areas across the country. The Lincolnshire plan was for a year-end deficit of no more than £15.4m. The discussions are around firming up what will be the year-end deficit figure and what action is required to deliver this.

e) Following a national review of elective and cancer performance, and taking account of the good progress made locally, ULHT has been moved from Tier 1 oversight into Tier 2. This relates to both elective care and cancer care.

f) The publication of the national planning and priorities guidance for 2024/25 has been delayed, whilst further discussions continue with the government. The guidance is expected shortly. This will not prevent any planning for 2024/25, as the financial allocations and plans are already known and the service priorities will not fundamentally change.

g) The outcome of the public consultation on paediatric services at Pilgrim Hospital Boston was signed off by the ICB Board in November. The ICB approved the service change, which made the temporary service model which had been in place since March 2019 the permanent model. This is now being implemented.

h) Professor Derek Ward, Director of Public Health, has been confirmed as the Lincolnshire system lead executive for the Community Primary Partnership (CPP) programme, which is a central part of the Provider Review workstreams. Professor Ward is engaging with system leads and strategic partners to identify the scope, key drivers, strategic priorities and deliverables of the programme. Collaborative events will be held in February/March as part of this engagement work.

i) Sam Wilde, Director of Finance and Business Intelligence at LCHS, is now the SRO for the Corporate Services Transformation workstream of the Provider Review. Malcolm Burch, LCHS Chair, will be providing non-executive input to this workstream.

j) NHS England has confirmed that Elaine Baylis will be the Group Chair across LCHS and ULHT with effect from 1st April 2024. This appointment follows an open national

recruitment process. This appointment means that recruitment can now begin to the Group CEO role.

k) As part of the Chancellor's recent autumn statement, a devolution deal for Greater Lincolnshire (Lincolnshire, North Lincolnshire and North East Lincolnshire) was announced. This would see a mayoral combined authority created for Greater Lincolnshire. A briefing session is being arranged with representatives from Lincolnshire County Council to help NHS Board members better understand the devolution deal and the opportunities that it offers for the county.

Trust Overview

a) At M8 the Trust reported a year to date deficit of £15.1m which is in line with the year to date plan. The full year plan is a deficit of £20.8m. At M8 the Trust reported year to date FRP savings of £23.7m against a plan of £15.6m. This is a positive variance of £8.1m. The full year plan is for savings of at least £28.1m.

b) Michelle Harris the Trust's COO, left the Trust in early December for family reasons. I would like to thank Michelle for the great work that she did in her time at ULHT and for the dedication and commitment she has always shown. Michelle has always been a great colleague to work with and we will miss her in-depth knowledge and wise advice. We wish Michelle well for the future. LCHS COO Julie Frake-Harris, has now taken on the COO role at ULHT alongside her existing COO role at LCHS. This will continue until further notice. We welcome Julie into the ULHT part of the Group.

c) The Trust's application for Teaching Hospital status has been submitted to the Department of Health and Social Care.

d) The Trust has received the NHS Pastoral Care Quality Award in recognition of best practice care for staff recruited and onboarded from overseas. Over the last three years in excess of 780 internationally educated nurses have joined ULHT across 42 cohorts.

e) The Trust has been celebrating the work of the over 200 volunteers who provide support for staff and patients across the Trust's hospitals. Over the last year, volunteers dedicated more than 37,000 hours of support and helped over 150,000 people.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Report to:	Trust Board
Title of report:	Quality Governance Committee Assurance Report to Board
Date of meeting:	21 November 2023
Chairperson:	Chris Gibson, 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.
	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** The Committee received the report noting the internal audit in respect of Central Alert System (CAS) and Field Safety Notices (FSNs) which had been undertaken the previous year resulting in a number of required actions. The Committee was pleased to note that the actions had been completed with the group receiving the close down report and progress being noted. Concern was noted in respect of achievement of the Medical Devices Outcome Register with a requirement for this to be in place by the end of December. The Informatics Team, leading on the work would attend the group to advise of progress. It was noted that further scrutiny was required in respect of diabetic ketoacidosis (DKA) with the group agreeing to provide support to the DKA Task and Finish Group. **Serious Incident Summary Report inc Duty of Candour** The Committee received the report noting that overall reduction in the number of open actions with work taking place to close all SI actions by the end of the calendar year. The Committee noted the development of reporting due to the implementation of the Patient Safety Incident Response Framework (PSIRF) with a proposed report to be presented to the Committee in December.

	High Profile Cases The Committee received the report noting the content. **Safeguarding Group Upward Report inc Oliver McGowan training update** The Committee received the report noting the increase in cases of autism which was now a larger field of interest than learning disabilities. It was recognised that there had been positive progress with Positive Engagement Trainers (PET) training with an anticipation that the associated risk would be closed in the coming months. Oliver McGowan training continued to progress with continued use of e-learning due to the difficulties in delivery, nationally, of face-to-face training. The Committee noted concern associated with the number of staff not attending booked safeguarding training sessions. It was noted that this was not a delivery of training issue but staff being unable to attend for a number of reasons. The Committee noted that action was being taken with the Divisions to improve attendance however this was not progressing as hoped. **Infection Prevention and Control Group Upward Report** The Committee received a Chair's paper review report due to the meeting stood down as a result of capacity issues at the time of the meeting. The Committee noted that there continued to be C. Difficile cases within the Trust with a thematic analysis being completed. A deep dive would be undertaken in the medicine division for areas of concern. The group continued to receive estates and facilities reports noting that the cleanliness scores at Pilgrim were showing improvement. Work also continued in respect of waste storage in outside bins in order to sustain improved levels of compliance. **Nursing, Midwifery and Allied Health Professionals Advisory Forum Upward Report** The Committee received the report noting the discussions at the forum relating to IPC which provided assurance on the group being fully sighted on the detail. The Committee noted the issue of the overuse of Green is Clean labels noting that there was a need for a change in practice in how equipment was identified as clean without the use of a sticker. It was noted that the group were keen to further develop professional delegation, this would see the strengthening of the Daisy Award and the expansion to areas outside of nursing.

	Children and Young People Oversight Group Upward Report The Committee received the report noting the ongoing work in relation to the Child Protection Information Standard (CP-IS) to ensure processes were embedded, working alongside the Safeguarding Team. Whilst the Committee noted some concern that this was not yet embedded reassurance was offered on the progress to date and anticipation of closure of the action. Improvement was noted in the train the trainer approach for Paediatric Immediate Life Support (PILS) and it was noted that the final outcome of the Paediatric Service Public Consultation was expected to be received by the Committee at the December meeting.
	Assurance in respect of SO 1b Issue: Improve Patient Experience **Patient Experience Group Upward Report inc Patient Story** The Committee received the report and was pleased to note the positive visit to the Trust from NHS England and the Chief Nursing Officer team in respect of the work being undertaken by the Trust on Care Partners. The Trust was 1 of 9 pilot sites and following the visit the Trust had been asked to present at the National Matrons Conference to share the detail of the work. The Committee noted the work of the patient experience team to conduct observation audits within the emergency departments with a number of areas of good practice and improvement identified. The Committee recognised the ongoing positive work of the patient experience group, with work specifically noted in the ICUs to support patients who had lost periods of time during their care. **Patient Experience Quarterly Report** The Committee received the quarterly report noting the continued improvements being demonstrated through the report. It was noted that there had been some adverse responses on Friends and Family Tests and Care Opinions however these were being addressed by the Divisions. The Committee noted the caring and compassionate work demonstrated through initiatives such as the winter wardrobe which would support patients being discharged who have limited personal belongings. **Complaints Quarterly Report** The Committee received the quarterly report noting the close working of the Complaints team with the Patient Experience Team to consider themes and trends. It was noted that these remained similar as in previous months with communications, treatment and waiting times continuing to be raised.

	The Committee was pleased to note the continued improvement in response times to complaints with 83% of complaints responded to on time, compared to 10% 12-months earlier. **Palliative and End of Life Group Upward Report** The Committee received the report noting that this group was in its infancy and had taken time to consider the needs of the group and the work that would be transacted. The group had considered and identified 3 key priorities, these being timely recognition of patients at end of life, communication, and education for staff, relatives and patients. The Committee noted that funding was in place for advanced care planning which would be rolled out to nursing in the first instance, with an anticipation that, capacity allowing, this would be extended to other professions.
	Assurance in respect of SO 1c Issue: Improve Clinical Outcomes **Clinical Effectiveness Group Upward Report inc NICE & CQUINS Reports, Mortality Report and Clinical Audit Report** The Committee received the report noting the work underway to support performance associated with VTE and EDD. An EDD Task and Finish Group had been established to support progress in this area. The Committee noted 100% complaint with Technology Appraisals and 95% compliant with NICE with work continuing to address overdue actions. Mortality continued to report a stable position with this being maintained for more than a year. The position for Medical Examiner Screening and Structured Judgement Reviews was positive with data sets in place for learning lessons. The Committee noted the position of clinical audit with sharing of outcomes undertaken across the divisions. The CQUIN position was also noted with concern raised in respect of compliance against an administrative task. Action was in place to address the gap and ensure delivery.
	Assurance in respect of other areas: **Committee Performance Dashboard** The Committee received the dashboard noting that the performance had been considered through the reports presented. The Committee noted that there had been an increase in with the number of category 2 pressure ulcers with a review of the target for the coming year to be completed.

	It was recognised that the increase was associated with improved reporting of earlier pressure damage with most damage being less than 5mm in size. **Integrated Improvement Plan** The Committee received the report for information noting the position presented. **Internal Audit Recommendations** The Committee received the report and noted from the earlier reports presented that the recommendations were believed to be closed. The recommendations would be reviewed to ensure appropriate evidence had been provided. **CQC Action Plan** The Committee received the reporting noting the significant increase in embedded actions noting there was traction in actions being completed. The Committee had requested that actions were completed by the end of the year however noted the requirement for further work on actions associated with the emergency departments. The Committee would continue to monitor progress.
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	D	J	F	M	A	M	J	J	A	S	O	N
Chris Gibson Non-Executive Director	X	X	X	X	X	A	X	X	X	X	X	X
Karen Dunderdale Director of Nursing	X	D	X	X	D	X	X	D	X	X	X	X
Colin Farquharson Medical Director	D	D	D	D	D	D	D	D	X	D	X	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	A	X	X
Michelle Harris, Chief Operating Officer	A	X	X	X	X	D	X	X	D	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:	Quality Governance Committee Assurance Report to Board
Date of meeting:	19 December 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 the Quality Committee in Common to meet, 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 Patient Safety Alert Quarterly Report** The Committee received the report including the patient safety alert quarterly report and the Patient Safety Incident Response Framework (PSIRF) close down report (appendix 1). The Committee was pleased to note the achievements of PSIRF and supported the recommendation to close the Task and Finish Group. Reporting would continue to be offered, to the Committee as business as usual, through the Patient Safety Group. **Infection Prevention and Control (IPC) Group Upward Report** The Committee received the report noting the national increase in measles however reflected that currently this increase was not reflected across Lincolnshire. There continued to be monitoring of C. Difficile due to the national increase with the Trust seeing an increase in line with the national position. The Committee was pleased to note the audit which would be undertaken regarding the use of external bins across the Trust to ensure there remained compliant with IPC.

	Medicines Quality Group Upward Report The Committee received the report noting the EPMA rollout and noting the need to ensure training remained on track and areas were clear as to go live dates. The Committee raised concern regarding quoracy of the Drugs and Therapeutics Committee and noted the actions being taken to address the meeting, an update would be offered back to the Committee in January. **Children and Young People Oversight Group Upward Report** The Committee received the report noting the update offered and sought to understand if a plan was in place, with timescales, to address the concerns raised following the EMSiC visit. Reassurance was offered that this had been discussed by the Group with leads for actions identified and updates to be offered back to the Group. The Committee raised concern in respect of the Did Not Attend rates for safeguarding training noting that this was due to inappropriate attendance on the incorrect course. The Committee was pleased to note that the Trust was considering Martha's Rule and the ability to receive a second opinion and access critical outreach support. An update would be provided to a future Committee. **Maternity and Neonatal Oversight Group Upward Report** The Committee received the report noting there were no escalations. The bi-annual staffing report was received which demonstrated that the Trust was fully compliant with the management of midwifery staffing. The reports received by the Committee were offered to the Board for oversight (appendix 2 – 5). **Serious Incident Summary Report inc Duty of Candour** The Committee received the report noting that this offered the position of open Serious Incidents and reflected on the changes in incident reporting. The Trust no longer declared SIs due to the introduction of PSIRF. The Committee would continue to receive the report until all outstanding SIs were closed. A new report would be received by the Committee from February which would offer the position in terms of PSIRF reporting. **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 reporting complimenting the MSK Project 'not a health village' which was a mobile offer developed with Lincolnshire Community Health Services NHS Trust. The Committee noted the consideration of the impact of industrial action on patient experience noting that consideration was also being given to the impact on patient safety. Work was also taking place on the impact on staff. **Palliative and End of Life Group Upward Report** The Committee received the report noting that key priorities had been identified by the Group with leads also now identified. Registration was being completed for the National Audit for Care at the End of Life which would commence at the beginning of 2024. Preparations were underway to provide the appropriate data.
	Assurance in respect of SO 1c Issue: Improve Clinical Outcomes **Clinical Effectiveness Group Upward Report** The Committee received the report noting that there was now alignment of data reporting for VTE where there had been discrepancies in the times data had been run. The Committee was pleased to note the mortality position reflecting that this was the best performance for a number of years. It was reflected that work would be required on the SHMI target, moving into the new financial year, to ensure provided the correct articulation of the target. Further work would take place to develop the integrated performance report for 24/25.
	Assurance in respect of other areas: **Committee Performance Dashboard** The Committee received the report noting that performance had been considered through the reports offered to the Committee. The Committee reflected on the reported position of IV antibiotics for sepsis in ED for children noting that it would be beneficial to consider this in the wider context of model hospital and benchmarked data. **Integrated Improvement Plan** The Committee received the report for information noting the position presented and reflected that improvements were not being seen as hoped within the metrics.

	Internal Audit Recommendations The Committee received the reports noting the recommendations presented and recognised the ongoing work with internal audit to ensure appropriate evidence was submitted to enable the closure of recommendations. **CQC Action Plan – Quarterly Update** The Committee received the report noting the need to progress actions which remained open. Work continued to ensure that actions were completed and embedded prior to closing with a number of actions moving towards closure.
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	D	J	F	M	A	M	J	J	A	S	O	N	D
Chris Gibson Non-Executive Director	X	X	X	X	X	A	X	X	X	X	X	X	A
Karen Dunderdale Director of Nursing	X	D	X	X	D	X	X	D	X	X	X	X	A
Colin Farquharson Medical Director	D	D	D	D	D	D	D	D	X	D	X	X	X
Rebecca Brown, Non-Executive Director (Maternity Safety Champion)	X	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	A	X	X	X
Michelle Harris, Chief Operating Officer	A	X	X	X	X	D	X	X	D	X	X	X	
Julie Frake-Harris, Chief Operating Officer													X

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

United Lincolnshire Hospitals NHS Trust

Meeting	*PSIRF Implementation Group*
Date of Meeting	*14 November 2023*
Item Number	

Patient Safety Incident Response Framework Closedown Report

Accountable Director	*Professor Karen Dunderdale, Director of Nursing / Deputy Chief Executive*
Presented by	*Kathryn Helley, Deputy Director of Clinical Governance*
Author(s)	*Helen Shelton, Assistant Director of Clinical Governance*
Report previously considered at	*NA*

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	• *Approve the closedown the Patient Safety Incident Response Framework*

Background

In August 2022 NHS England published the Patient Safety Incident Response Framework (PSIRF). This set out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

PSIRF replaced the Serious Incident Response Framework (SIF) and removed the 'serious incident' classification.

Organisations were expected to transition to PSIRF within 12 months from September 2022. The preparation was broken down into six phases to ease transition and provide detail around discrete activities that will set strong foundations for implementation.

ULHT have successfully completed Phase 1 (PSIRF orientation), Phase 2 (Diagnostic and Discovery) and Phase 3 (Governance and Quality Monitoring), Phase 4 (Patient Safety Incident Response Planning) and Phase 5 (Curation and agreement of policy and plan) recommending closure of this final phase of implementation. As of the 1 October 2023 the Trust transitioned into the new framework delivering all six phases within the agreed timescale.

Of note, on completion of all the PSIRF phases, a close-down report was submitted to the PSIRF Implementation Group, Patient safety Group and finally the Quality Governance Committee for formal approval in line with Trust governance processes.

Overview of Implementation:

Phase 1 – PSIRF Orientation

Month's one to three, commencing in September 2022, was designed to help PSIRF leads at all levels of the system familiarise themselves with the revised framework and associated documents. This phase established an important foundation for PSIRF preparation and the subsequent implementation over the coming months.

Phase 2 – Diagnostic and Discovery

This phase commenced in December 2022 with the overall objective to enable the Trust to develop its understanding of how developed our systems and processes were to respond to patient safety incidents for the purpose of learning and improving. Several key questions were asked to establish current reporting culture, engagement of staff and patients affected by patient safety incidents, incident response capacity and training needs, Just Culture development and learning improvement. At the end of this phase there were several actions required to improve the arrangements in those areas identified which were subsequently built into a programme of work.

Phase 3 – Governance and Quality Monitoring

The aim of phase 3 was to define the oversight structures and new ways of working that would come into place once the Trust transitioned to PSIRF on 1 October 2023. Commencing in February 2023 the proposed arrangements were considered with advice taken from the National leads for PSIRF along with the early adopter sites. This resulted in the development of a flowchart outlining the proposed incident management arrangements including the agreement of the meetings and reporting structures.

Phase 4 – Patient safety Incident Response Planning

This phase commenced in March 2023 and required the Trust to:

- Map its services
- Examine patient safety incident records and safety data
- Describe the safety issues identified by the data
- Identify work underway to address contributory factors
- Agree how you intend to respond to issues listed in the patient safety incident profile.

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 Divisions to ensure that all services had been captured. The rationale for this was to ensure that the shape and structure of the plan reflected the incidents that the Trust experience and to prevent silo working.

Two years' worth of patient safety data was reviewed as part of this phase from several data sources and key stakeholders from across the Trust. The data was then grouped into themes which outlined the Trust's incident profile. These themes were discussed at two workshops, the first with the PSIRF Implementation Team and the second with the Trust Leadership Team 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 a Patient Safety Incident Investigation (PSII).

The breakdown of the agreed 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**

Phase 5 – Curation and agreement of policy and plan

Phase 5 commenced in May 2023 and focused on the curation and agreement of the Patient Safety Incident Response Policy and Plan which determines how we respond to patient safety incidents until the end of the next financial year. The Patient Safety Incident Response Plan and Patient Safety Incident Response Policy have been developed in 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 were offered to the Trust Board for approval in November 2023. Following which the documents were submitted to the ICB for its approval. The guidance specifically asked that the arrangements were developed with relevant partners and the ICB lead has been instrumental in providing advice and support to the process throughout all phases of the implementation.

Phase 6 - Transition

PSIRF will fundamentally change the way in which the organisation reviews and responds to patient safety events and requires a robust structure to be in place to support the Divisions and Directorates in the delivery of the framework. Following the successful completion and approval of the previous 5 phases, the Trust went live with the implementation of PSIRF on the 1 October 2023 as planned. Over the next 12 months the Trust will continue to review, adapt and learn as the designed systems and processes are put into place.

Conclusion/Recommendations

The work described above constitutes the requirements of the PSIRF Preparation Guide. Therefore, the PSIRF Implementation Group is asked to: -

- Approve the closedown of the implementation of the Patient Safety Incident Response Framework and therefore the closure of the Implementation Group.

Appendix 1

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

FAMILY HEALTH DIVISION

Midwifery Safe Staffing Levels – Bi-Annual Midwifery Staffing Oversight Report

November 2023

1. Executive Summary

The purpose of the report is to-

- Provide an update on Safe Midwifery staffing including evidence to support calculations of staffing.
- Update the committee on key midwifery staffing metrics
- Provide update on the specialist midwifery staffing levels to support transformation and the national Maternity agenda.
- Provide update on the plan to achieve Midwifery Continuity of carer as the default model of care
- Propose actions for discussion

The Maternity Service operates a traditional model with intrapartum service provision delivered on Pilgrim and Lincoln County sites. Despite the falling birth-rate both nationally and locally, the complexity of women and associated obstetric complications is rising for example the number of safeguarding cases, the number of women with high BMI, diabetes and smoking in pregnancy. This was reported in the last staffing report and has continued to be the case.

ULHT is currently staffed to the Birth rate Plus recommendations of 2021 and the local staffing reviews that were undertaken by the Director of Nursing in October 2022 and 2023.

Further full birth-rate plus review will be undertaken in December 2023 and we are in the early planning stages.

The Final Ockenden Report, published March 22, highlights the need for significant investment in maternity staffing in order to deliver on the further 15 immediate and essential actions. Whilst there has been no further guidance on the impact of this report on staffing levels, the trust and the ICB have recognised the need for increased support for our vulnerable women and have supported investment in our specialist teams. The Birthrate Plus team have also stated that the uplift for specialist and managers will be 12% rather than the current 9% which will further justify the investment received.

ULHT submitted full compliance for Year 4 CNST. This was again a challenging due to the training element, however, additional MDT sessions were facilitated and staff were supported to attend.

Regular six monthly reviews of safe staffing are undertaken as part of the trust establishment reviews, as well as monitoring of actual versus planned staffing by the Matrons in each area. There is a weekly ops meeting on a Monday, which is attended by all matrons and reviews safe staffing across all sites and areas. Each site then holds twice-daily staffing huddles to review this. Further huddles are undertaken when needed during the day. There is also a twice-weekly Family Health Operations meeting, chaired by the senior quad, to forward plan staffing. Out of hours, support is provided by the 'on call manager' as robust escalation policy is in place to support the areas in periods of increased activity or sudden sickness of midwives. Staffing and activity is also reported daily to the Trust and the ICB and circulated via a sit rep to the regional teams.

2. Background

Midwifery staffing across the UK is a challenge in terms of recruitment and retention. ULHT continues to be fortunate and has found that vacancy has been minimal across all areas. There has however been challenges with skill mix as midwives that are more senior retire and are replaced with newly qualified midwives. The Midwifery Education team have developed a detailed preceptorship programme to support these midwives during their first 12-18 months following qualification. The trust also now has the retention midwives embedded in the team to support the preceptors in their first year.

Due to the location of Lincolnshire, the main source of recruitment of newly qualified midwives onto our preceptorship programme has historically been students that have been on placement with us from DMU. However, October 2022 saw the first recruitment of our NQM from Lincoln University and in October 2023 we welcomed 13 newly qualified midwives to the trust. This will continue year on year. ULHT has also seen an increase in midwives from neighbouring Trusts applying for jobs. This is positive and has supported the Trust to continue to have healthy recruitment.

ULHT has a significant number of midwives who are over retirement age or are able to retire in the next 5 years. Whilst we are unable to say which of these midwives will choose to retire the numbers that are eligible are significant and continue to pose a risk to the organisation of increased vacancy.

The detailed picture of the workforce has changed very little since the last board report and still demonstrates a risk of a potential loss to retirement of around 80 midwives in the next 5-10 years. It is still anticipated that we will be successful in recruiting to this potential vacancy. However, work is ongoing to ensure that our students have the best possible experience and our preceptors are well supported in order to ensure that we have a work force that want to stay in Lincolnshire.

3. One to One care midwifery care in labour and Supernumerary Labour Ward Coordinator Status

One to One midwifery care in labour is a key safety metric that is reported via Maternity Medway and monitored on the Maternity dashboard monthly at the Divisional Governance meeting, the LMNS and the Maternity and Neonatal Oversight group. The compliance rate is consistently 99-100% on both acute sites. This has been at 100% on the Pilgrim site for 12 months and whilst this fell below 100% on 1 occasion on the Lincoln site this was just down to 99.49%. When reviewing the data the women recorded as not having 1:1 care in labour were found to be women who delivered rapidly following admission to the labour ward. CNST states that 1:1 care should be 100%. In these cases it is impossible to provided 1:1 care in labour and so the Trust submitted full compliance to CNST year 4.

Acuity data is also recorded using the Birth Rate Plus tool. The Labour Ward Coordinator inputs workload and staffing information every four hours as a minimum. The report in **Appendix 1** provides a detailed analysis of this data (April 23 – Sept 23) and demonstrates that staffing is adequate for activity more frequently at PHB than at LCH. Staffing gaps are mitigated on both sites with the use of a robust escalation policy which utilises specialist midwives, managers, and in-house escalation and on call midwives to support safe staffing. The acuity data also identifies that there has been an increase in delays experienced in the IOL process. This could be attributed to the general rise in IOL however a monthly review of IOL is in place. Positively Pilgrim site have seen a decrease in the unavailability of breaks and full service closure. This is positive for staff wellbeing and patient experience.

The rosters for the Labour Wards are planned to allow one supernumerary Labour Ward Coordinator at all times. Supernumerary status of the midwifery coordinator is recorded on the Birth Rate Plus tool and reported monthly on the Maternity Dashboard. As data is recorded by the individual team members this allows for variation and potential differences in the perception and data input. This is

demonstrated by the dashboard that shows 100% compliance at Lincoln with a couple of months dipping below the standard at Pilgrim to 93.88%.

CNST yr 4 states that the Trust requires evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator. The standard then goes on to state that supernumerary status will be lost if the coordinator is required to be solely responsible for any 1:1 care for a labouring women or relieve a midwife who is providing 1:1 care for a women who is requiring constant observation.

For this period supernumerary status of the Labour Ward Coordinator was 94-100% (PHB) and 100% (LCH). Whilst 100% compliance at all times is unachievable as far as the acuity tool is utilised, the data has been scrutinised to ensure that when the areas are recording that they are no longer supernumerary they are not providing 1:1 care. Therefore, both sites were achieving this standard at the point of submission of compliance.

The acuity tool also records actions taken to mitigate any red flag issues. The most common solution to the red flag issue remains 'redeployment of staff within the site' and staff unable to take breaks although as mentioned earlier this is an improving picture. There were no risk investigations where midwifery staffing was identified as a contributory factor.

Overall, we are reassured by these metrics.

4. Actual Versus Planned Midwifery Staffing

All maternity In-Patient (Including Intrapartum) areas report the actual v's planned midwifery and care staffing for day and night shifts alongside the other wards in the Trust. This is discussed twice daily at the Trust safe staffing meetings. Maternity services also have a robust escalation plan that supports the management of services in periods of increased activity and acuity.

5. BR+ Safe Midwifery Staffing Ratio

Birth Rate Plus® (BR+) is a framework for workforce planning and strategic decision-making and has been in use in UK maternity units for a significant number of years.

The principles underpinning the BR+ methodology are consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings, and have been endorsed by the RCM and RCOG. The interim NHS People Plan and the NHS Long Term Plans recommend services to be using evidence-based approaches to staffing by 2023.

Birthrate Plus (BR+) works on the assumption that all women will receive one to one care during labour with additional establishment built in depending on the acuity of the population served. The review also assumes that the service works to NICE Antenatal Care guidance (number of antenatal contacts). In addition to this BR+ will attribute a skill mix to the required workforce; the percentage for this will depend on the acuity of the population.

Case mix is categorised into five categories (1-V): 1 being a woman with a low risk pregnancy and straightforward birth with "V" being a woman with a complex pregnancy and/or birth. The acuity within the population denotes the WTE required to safely run a maternity service as it takes into consideration activity and acuity, as well as specialist midwifery services and managerial responsibilities.

The most recent report for ULHT was received in March 2021 and this showed an increase in dependency of the women who access the services on both sites. Taking the increase in dependency into account the report recommends safe staffing ratios for the maternity service are-

LCH 1:23
PHB 1:23

Current ratio for April-Sept 2023 is 1:25

The details of the BR+ report were shared in previous bi-annual reports and remain unchanged. There has been a continued decrease in the total number of births however, as previously mentioned the acuity of the women continues to increase.

Whilst the Ockenden report questions the suitability of the Birthrate plus tool for calculating midwifery staffing, with the absence of any guidance of an alternate, this tool continues to be utilised. ULHT have also seen an uplift in specialists and the ward templates which supports a locally agreed needs assessment for staffing as per Ockenden. There has also been a significant amount of funding received from the National team to support this specialist element.

BIRTH RATE PLUS RECOMENDATION		
Description	**Total**	**Skill Mix**
Clinical wte (Inc. Out of scope MSW)	205.71	
90% RMs		185.67
10% MSWs in P/N Care 90/10 ratio is recommended by BR+, although states this is a local decision		14.79
MSW - Pilgrim (outside scope of 90/10)		5.26
Non-clinical Midwifery	22.05	
TOTAL WTE per Unit	**227.76**	

ULHT CURRENT FUNDING		
Description	**Total**	**Skill Mix**
Clinical wte (including Out of scope MSW)	225.06	
RMs		199.54
MSWs in P/N Care		20.26
MSW - Pilgrim (outside scope of 90/10)		5.26
Non-clinical Midwifery (including matrons, consultant MW and DHoM)	35.26	
TOTAL WTE per Unit	**260.32**	

From the above ULHT has above the birth rate plus recommendation. Some of this sits in the non-clinical midwifery budget line. However, all of the specialist have a clinical element to their roles which reduces the specialists and increases the clinical midwifery WTE. The apparent over establishment is due to:

- the recent uplift on both postnatal wards as agreed by the establishment review
- Uplift in specialists agreed by Board to support driving forward the National agenda
- Increase in Consultant Midwives in line with Ockenden
- Increase in establishment to support uplift in training requirements as per Ockenden
- Established support for continuity of carer teams
- Nationally funded posts including, but not limited to, fetal monitoring lead, pre term birth lead, retention midwives
- Increase in MSW support for CofC Teams

This is in line with national recommendation which state; *to fund maternity and neonatal services appropriately requires a multi-year settlement to ensure the workforce is enabled to deliver consistently safe maternity and neonatal care across England.*

Minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the LMNS. This must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure trusts are able to safely meet organisational CNST and CQC requirements.

Minimum staffing levels must include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave.

Currently we have a range of different Specialist Midwives including;

- Named Midwife for Safeguarding
- Specialist Safeguarding Midwife
- Bereavement Midwife
- Mental Health Midwife
- Team of Safety Midwives
- PMA Midwife
- Risk & Governance Midwife
- Tobacco Dependence Midwife
- Pre-term birth and Multiple Pregnancy Midwife
- Fetal Monitoring Midwife
- Retention Midwives
- Antenatal and Newborn Screening Midwives
- Diabetic Midwives
- Digital Midwives
- Infant Feeding Midwives
- Audit and Guideline Midwife
- Education Midwives

6. Plan to achieve Midwifery Continuity of carer as the default model of care

Midwifery Continuity of Carer has been proven to deliver safer and more personalised maternity care. Building on the recommendations of Better Births and the commitments of the NHS Long Term Plan, the ambition for the NHS in England is for Continuity of Carer to be the default model of care for maternity services, and available to all pregnant women in England.

The role out of this has been paused, in line with Ockenden recommendations, whilst a business case is developed to uplift the staffing in order to achieve continuity as a default model. A report has been

submitted to Trust board that details the plan for achieving continuity as default and describes the need for an uplift in work force to achieve. From April 23 the ICB has agreed funding to support a specialist team of band 7 continuity of carer midwives to work in the Skegness area. This will support our most vulnerable women and is in line with the EDI work that is ongoing. There has also been agreement to fund band 2 and 3 support for each of the established continuity teams. Once these are in post a business case will be further progressed to continue role out of the teams. The Birthrate plus report stated that ULHT required an uplift of 25 WTE midwives to achieve 100% continuity. ULHT has managed to achieve 20% continuity within existing budget.

The target of March 2023 has also been removed in order to support Trusts move forward with this in a safe and measured way.

In conclusion-

- The current midwifery staffing funded establishment is in line with the recommended BR+ midwifery ratios and in line with the National reports which suggest a locally agreed uplift. Currently there is minimal vacancy across the service which is all in the recruitment process.

- The number of ICB funded specialist roles have been increased in order to meet the National Agenda and the ability to drive this forward.

- Following further development in ULHT continuity of carer teams a business case has been written and is going through CRIG processes to properly fund the existing 4 CofC teams.

- The acuity data on LCH labour ward showed to be green on 61% of occasions, which is significantly below PHB at 84.7%. This is partly because the elective caesarean pathway (ELSC) runs through the labour ward activity and is included within the data (instead of being entirely separate, not included in BR acuity and the procedure taking place in a different location at PHB). Review of the existing ELSC pathway at LCH is essential in ensuring the increase in Green compliance and patient experience at LCH.

7. Propose actions for discussion

- Note the successful recruitment and retention across the service
- Undertake a further BR+ assessment in 2024, as per recommendations.
- The committee are asked to escalate the findings of this report to Trust board.

Author **Libby Grooby - Divisional Head of Midwifery/Nursing**
Emma Upjohn – Deputy Head of Midwifery

Date November 2023

Appendix 1

MATERNITY ACUITY AND RED FLAG REPORT
April 2023 – September 2023

Acuity data is recorded using the Birth-Rate Plus tool. Workload and staffing information is input by the Labour Ward Coordinator every four hours (+/- 30 minutes) as a standard requirement. Ad-hoc entries can be submitted out with the set times and allow the Labour Ward Coordinator to input information if they have missed the mandated time frame, or to provide additional information between these times if activity/acuity is high. In practice, we find that data is less likely to be provided at the set times when the ward is busy, as the coordinators are busy managing the workload. These factors contribute to the limitations of this tool, but we recognise that this does still give us a broad of activity over a given period.

Another limitation to Birth-Rate Plus tool is that it allows for subjective data input/bias. The analysis should be interpreted with caution and considered alongside other sources of information.

The following data shows acuity information for the period April 2023 – September 2023 and includes only scheduled data entries unless stated otherwise.

Summary

The birth-rate plus acuity tool displays a RAG dashboard and displays Green when no staffing vs acuity issues, amber when an entry shows that a unit is up to 1.5 midwives short for the documented activity, then red when there is a calculated shortage of 2 or more registered staff at any data entry point.

Pilgrim hospital's results for the period April 2023 to September 2023 showed that they were green, on average, 80% of the time, Amber 18% and red only 2% of the time.

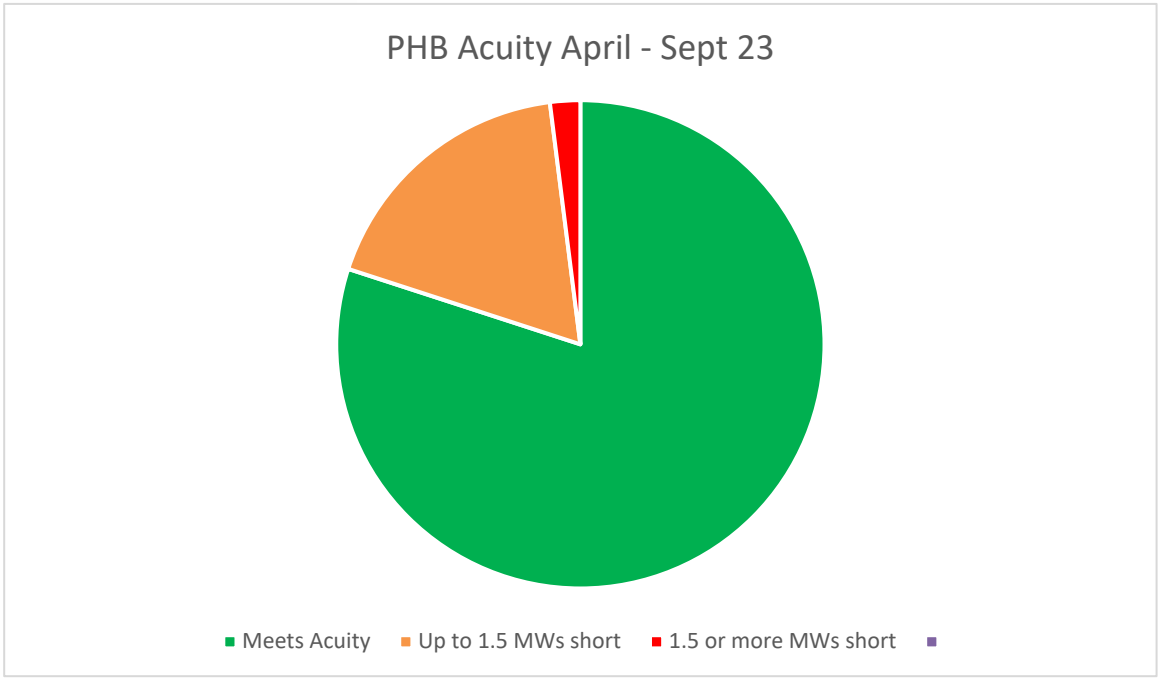
As the smaller of the two acute settings, this unit had 819 births in this period. The volume of work is less, as reflected in their staffing templates however this also means that there are fewer midwives for redeployment and escalation during busy times. In part this is mitigated by senior and specialist presence on each site, and the allocation of specialist escalation midwives and a newly introduced pilot, the in-house on call escalation rota.

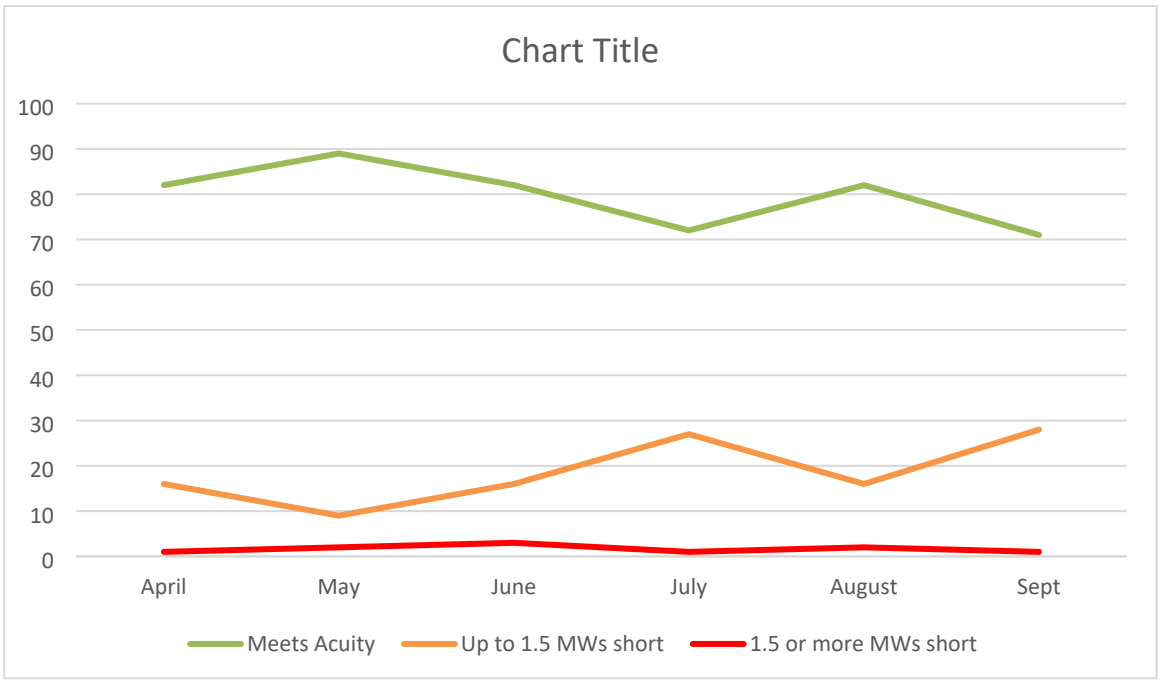
The data shows that staffing is adequate for activity more frequently at PHB than at LCH.

Lincoln hospital's results for the period April 2023 – September 2023 showed that they were green, on average, 61% of the time, Amber 35% and red 4% of the time. This is an improvement on the preceding six months (Green 54%, Amber 37%, and Red 9%). As the larger of the two acute settings, this unit had 1375 births in this period. At extremely busy times, we note that the bulk of the volume of work is iatrogenic, as reflected in induction rates. Generally, the Lincoln unit does benefit from an increased number of midwives that can be redeployed/escalated when required and, like Pilgrim, benefits from specialist presence on each site, the availability of specialist escalation midwives and to a lesser extent than Pilgrim, the newly introduced pilot in-house on call escalation rota.

Pilgrim Hospital Boston

There were 931 data entries during the period, out of a possible 1098, with compliance for data entry at pre-set timed at 84.79% (down 1%).
Acuity met on average, on 80% of data entries:





Staffing factors were recorded for 58% of all data entries, this includes unexpected staff absence, unfilled rosters and staff redeployed to another area or on transfer. There has been a slight increase from the last report of the availability of continuity team midwives to the ward, which could be either as a result of more women from those teams choosing to birth at this site, or increased availability of the midwives working in this model.

Breakdown of recorded staffing factors	
Unexpected staff absence	19%
No HCSW on duty	10%
Unable to fill vacant shifts	56%
No ward clerk on duty	4%
Staff redeployed to another area	5%
CoC Midwife present	5%
CoC Midwife not available	2%
Staff on transfer	1%

Clinical actions were recorded for 13% of data entries, with the shift leader non-supernumerary decreasing to 18% of this timeframe (but not providing 1:1 care in labour)
There was an increase in delay in ARM but this can be attributed to the general rise in induction of labour, meaning an increase in the women who are eligible for this procedure. There is an ongoing review of the ULHT induction process.

Breakdown of recorded clinical actions	
Shift leader non supernumerary	18%
Delay in ARM >4hrs	61%
Delay in commencing IOL >2hrs	17%
Delay in transferring IOL SRM to labour ward >4hrs	2%
Delay in LSCS > 4 hours	2%
Delay in transferring PROM to LW following Prostin	2%
Refusal of in utero transfers due to acuity	0%

Management actions were recorded for 20% of all data entries, an increase from just over 2% in previous analysis. The unavailability of breaks increased from 28% to 30% in this analysis, and full service closure from 1% to 5%. We did see an increase of patients being transferred within the trust, and that is monitored on an ongoing monthly basis.

Breakdown of management actions	
Redeploy staff internally	24%
Staff unable to take allocated breaks	30%
Escalation to community midwives	23%
Staff stayed beyond rostered hours	6%
Management/specialist midwives supporting clinically	5%
Redeploy staff from non-clinical duties	3%
Patients transferred within Trust	4%
Full service closure	5%

Red flags were recorded on 1% of all data entries for the period – 8 occasions in total.

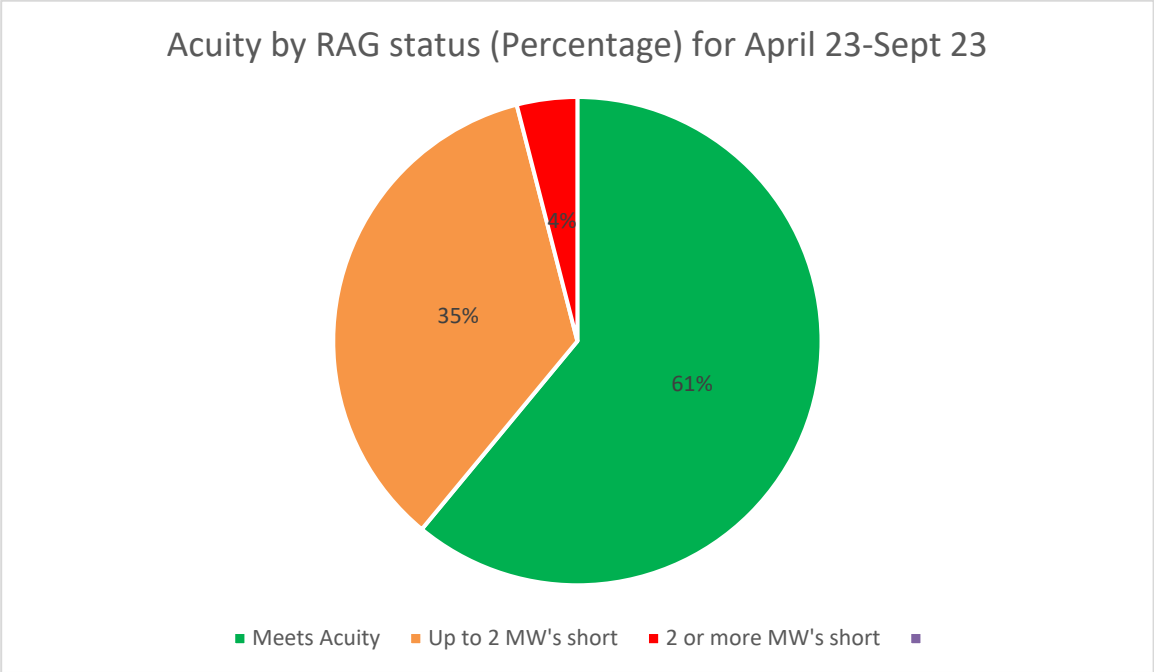
These were:

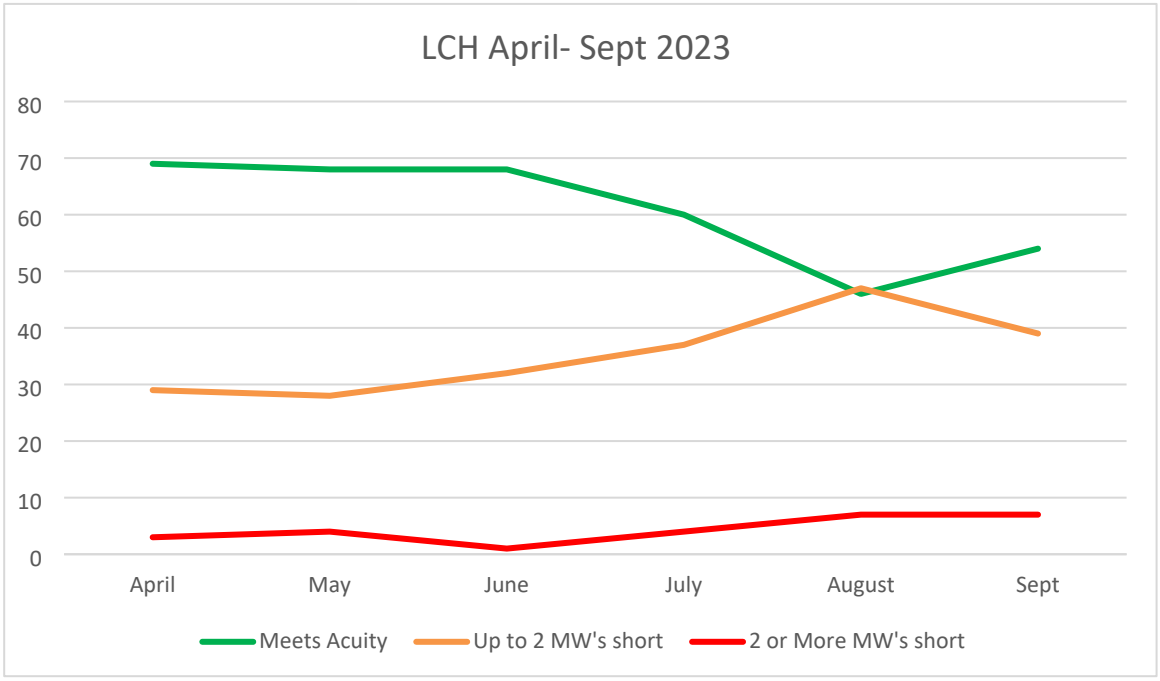
- Delayed or cancelled time critical activity (2 occasions)
- Delay between admission for induction and start of process (6 occasions)

Lincoln County Hospital

There were 817 data entries during the period, out of a possible 1098, with compliance for data entry at mandated times at 74.4% (a decrease of around 6%).

Acuity met on 61% of entries with a shortfall of up to 2 midwives on 35% of entries:





Staffing factors were recorded for 61% of entries. The most common factors were Unable to fill vacant shifts 39%, 'unexpected staff absence (11%), and 'no ward clerk on duty (16%). There was no CofC midwife available for 11% of the entries, with availability static at 18% of the time

Breakdown of recorded staffing factors	
Unexpected staff Absence	11%
No ward clerk on duty	16%
CoC Midwife not available	11%
Unable to fill vacant shifts	39%
CoC Midwife present	18%
Staff redeployed to another area	4%
Staff absence due to illness/shielding/symptoms of COVID-19	0%
No HCSW on duty	1%
Staff on transfer	0%

Clinical actions were recorded for 46% of data entries:

Breakdown of recorded clinical actions	
Delay in ARM >4hrs	87%
Delay in commencing IOL >2hrs	9%
Shift leader non-supernumerary	0%
Delay in transferring IOL SRM to labour ward >4hrs	2%
Delay in transferring PROM to LW following Prostin	0%
Refusal of in utero transfers due to acuity	0%
Delay in scheduled CS >4hrs	1%

Management actions were recorded for 82% of all data entries, with a reduction in full service closure and an improvement in the number of staff staying beyond rostered hours.

Breakdown of management actions	
Redeploy staff internally	27%
Staff unable to take allocated breaks	36%
Escalation to community midwives	13%
Staff stayed beyond rostered hours	9%
Full service closure	4%
Management/specialist midwives supporting clinically	4%
Patients transferred within Trust	1%
Redeploy staff from non-clinical duties	4%

Red flags were recorded on less than 1% of all data entries for the period – 4 occasions. These were:

- Delay between admission and commencement of IOL (2 occasions)
- Missed or delayed care – delay in suturing more than 1 hour post birth (2 occasions)

Appendix 2

United Lincolnshire Hospitals NHS Trust

Compensatory rest including action plan

CNST Safety action 4 clinical workforce

Introduction

CNST year 5 released May 30th 2023, with an updated version released on 20/07/2023. The safety action relating to clinical workforce and compensatory rest (SA4.1) can be found below.

"Trusts/organisations should implement RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. Services should provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings."

Background

RCOG and The BMA, recommends that consultants who are unable to take 11 hours of consecutive rest per day should be entitled to take compensatory rest. This reflects both in person attendance and telephone calls disrupting sleep. Compensatory rest should not be calculated on a minute-for-minute basis, with the guidance recommending it should be for the full value of 11 hours' continuous rest with the clock starting when a consultant gets back to resting

The significance of appropriate compensatory rest should not be underestimated. Compensatory rest is fundamental to patient safety and clinician wellbeing with fatigue affecting performance and decision making. Compensatory rest should be taken as soon as practically possible after the sleep disturbance in the interest of protecting the individual's health. Compensatory rest cannot be accumulated and taken as leave.

Whilst patient safety is paramount, it is recognised that these recommendations may pose challenges, particularly within smaller units. However, a mechanism to facilitate compensatory rest must be in place in all organisations and this should be actively supported by the management team, with constructive discussion between clinician and manager or clinical director rather than the decision to take rest being left to the individual consultant.

The unpredictability of activity out-of-hours poses challenges when organising compensatory rest, however, astute approaches to job planning can facilitate this. Moving to a model that would allow for full implementation of the BMA guidance will take time but we recommend that units look proactively at this issue as part of their ongoing job planning cycle. The challenge is balancing the potential need for compensatory rest versus the need to provide continuity of patient care.

While RCOG/BMA acknowledge the challenges this poses for workforce planning and that clinicians can choose to opt out of this guidance, CNST compliance is dependent on assurance that the guidance has been implemented, or, an action plan to address any shortfalls in compliance.

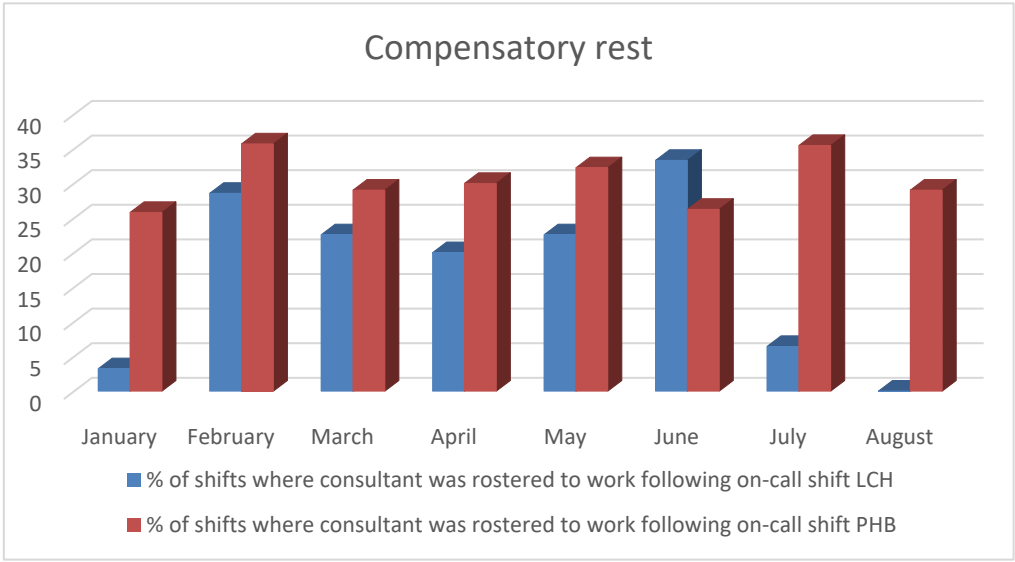
Current positon

The ULHT action card *(Calculating On-Call Payments, Compensatory Rest, Additional Unpredictable On-Call Allowance and Prospective Cover)* echoes the definition and expectations surrounding compensatory rest. CNST evidential requirement states that a 'standard operating procedures and

their implementation to assure Boards that consultants/senior SAS doctors working as non-resident on-call out of hours are not undertaking clinical duties following busy night on-calls disrupting sleep, without adequate rest. Evidence of compliance could also be demonstrated by obtaining feedback from consultants and SAS doctors about their ability to take appropriate compensatory rest in such situations.'

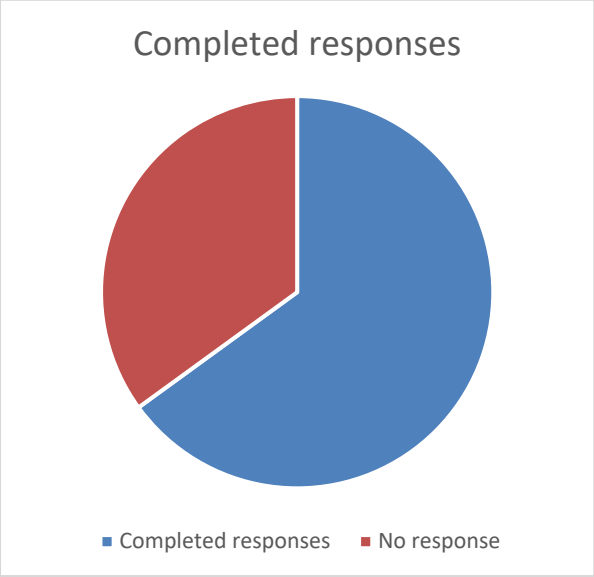
Completion of an audit of the rotas from January demonstrates that between 17% and 30% of on-call shifts occurred with the same consultant also being rostered for a clinical session the next day. The data can be found below.

Compensatory rest data.xlsx



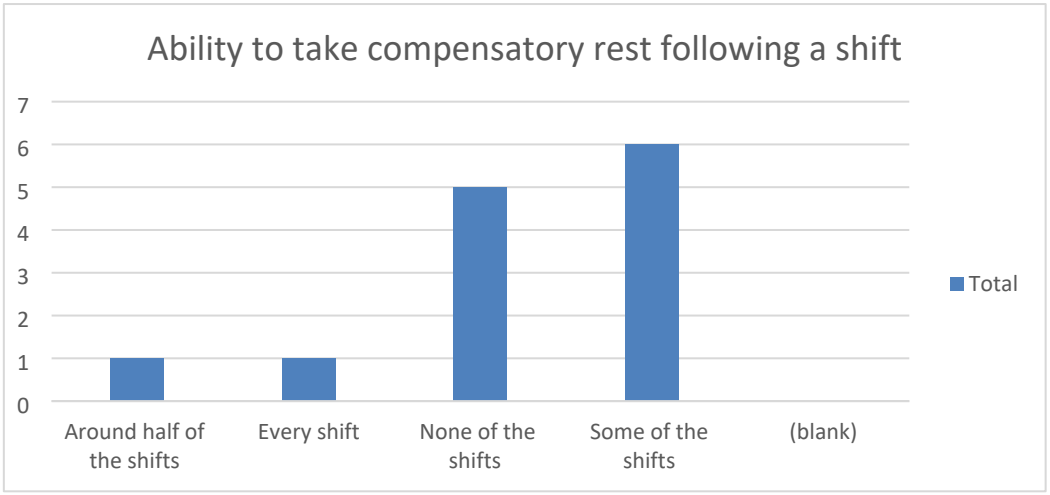
Survey results

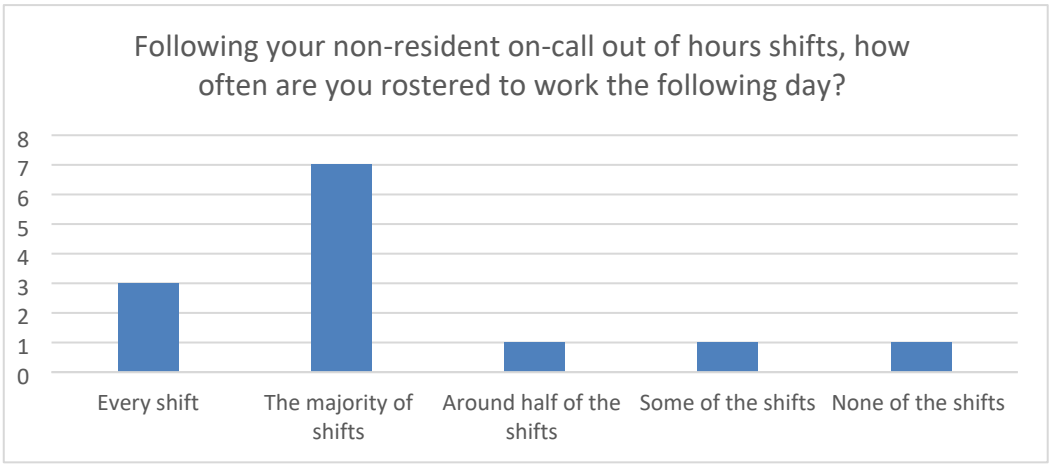
- 65% of the consultant/SAS body responded to the survey



- 100% consultants have undertaken non-resident on-call out of hours shifts since January, with 7.69% having worked 0-1 a month, 84.61% working 2-3 a month and 7.69% having worked >4 a month.

- The majority of consultants who responded were unable to take compensatory rest for all of the non-resident on-call out of hours shifts.





- Over half of the respondents reported that they were rostered to work 'every shift' or 'the majority of shifts' following their non-resident on-call out of hours shifts.

- 64% of respondents felt more supported to take compensatory rest following a weekend shift rather than a weekday shift.

- 85% of respondents answered that they felt supported to take compensatory rest if they did not feel able to work following an on-call shift.

Implications and recommendations

In addition to the financial implications of not achieving CNST compliance, serious consideration should be given to the rationale for compensatory rest and the implications on patient safety and staff well-being as fatigue and tiredness following a busy night on-call can affect performance and decision-making.

CNST states that 'services should provide assurance that they have evidence of compliance, *or an action plan to address any shortfalls in compliance*, to the Trust Board, Trust Board level safety champions and LMNS meetings.

Appendix 2

United Lincolnshire Hospitals NHS Trust

Based on survey responses, and in order to achieve CNST compliance and maintain patient safety, an action plan to address any shortfalls in compliance was recommended and created; this action plan can be found below). In order to meet the CNST timeframes, this action plan has been reviewed by the Trust Board, Trust Board level safety champions and LMNS meetings by November 2023 at the latest.

Compensatory rest action plan.xlsx

Appendix 3

United Lincolnshire Hospitals NHS Trust

Maternity & Neonatal Safety Assurance Report

Libby Grooby, Divisional Head of Midwifery

As at 20 November 2023

Maternity & Neonatal Safety Assurance Report – Key Highlights

Trust: United Lincolnshire Hospitals NHS Trust **Date:** As at 20 November 2023 (Oct 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)		Submission of MSDS in July achieved compliance
3	Transitional Care Services		Action plan to review
4	Clinical Workforce Planning		Not in line with requirement for Consultant compensatory rest but action plan in place
5	Midwifery Workforce Planning		On track, evidence in file
6	SBLCB V3		Audit plan in place and compliance improving. Close monitoring required
7	Service User Feedback / Co-produced Services		Plans in place but close monitoring required
8	Training Plan		Compliance agree now 80% - plans in place to comply however some staff groups at risk
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.
The below is compliance from October. Next submission January 24

No	Requirement	RAG	Comments / Actions Being Taken
1	Reducing Smoking	50%	Benchmarking undertaken and work ongoing. Need to update evidence
2	Fetal Growth Restriction	90%	Benchmarking undertaken and work ongoing Need to update evidence Will need to understand increase need for scan capacity
3	Reduced Fetal Movements	100%	Benchmarking undertaken and work ongoing Need to update evidence
4	Fetal Monitoring During Labour	20%	Benchmarking undertaken and work ongoing Need to update evidence. Staff training needs to be 100% across all staff groups
5	Reducing Pre-term Birth	74%	Benchmarking undertaken and work ongoing Need to update evidence
6	Diabetes	33%	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 birth rate remains varied but overall is static. Birth rate plus assessment to be undertaken in December.
Smoking at booking has decreased in month and has been green for the last 3. All women are offered smoking cessation referral which is opt out. Additional funding was secured for TDA advisors and therefore all women are now covered by the STAAR team. This should see further improvement in smoking at delivery. There is a continued trend in monitoring CO testing compliance.

PPH figures correlate with IOL and LSCS rates, PPH>2000ml particularly are a rare event and can be skewed by single cases, particularly at PHB. Deep dive recently completed for MNOG, no concerning themes identified, high risk complex cases presenting recently at PHB.

‘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.

In agenda:

- MBRRACE-UK Reports – 2021 data
- NEC
- CNST compensatory rest action plan
- Bi-annual Staffing Report
- CNST SA4 – Obstetric Workforce - documents below supports CNST requirement regarding locums and consultant attendance. This needs to be shared at Trust Board and with the board level safety champions.

- **CNST sign off** – all required documents have been shared with Trust board via the agreed route which is MNOG upto QGC and all then shared with board. HoM attends board for updates as required. MNOG chaired by DoN who is Board level safety Champion. Agreement sought that all evidence is reviewed by a nominated member of the governance team on behalf of board. Sign off process for ICB and LMNS also agreed.

- Thematic Analysis of Poor Outcomes in Relation to Fetal Monitoring – Reviews are undertaken on all term babies that were admitted to the Neonatal Unit via the ATAIN audit. All cases resulting in hypoxic ischemic encephalopathy (HIE) III, intrapartum stillbirth and early neonatal death are referred to HSIB for external review and are investigated by ULHT’s internal risk process. The results of these audits have been reviewed by the fetal monitoring team so that themes associated with failures in fetal monitoring (FM) are summarised in order to inform action plans and service improvement.

  July 2023 Thematic Analysis of Poor Outc

- Safety Lead Report –

  Monthly safety report November 2023.docx

Learning Lessons

Overview for the reporting period:

As at 1 November 2023, there were 201 (121 last report) open incidents for Obstetrics & Community Midwifery, 85 (67 last report) of which are overdue - 74 on Datix Web and 127 on Datix IQ

There were 26 (5 last report) open incidents in Neonates, 8 (none last report) of which are overdue - 4 on Datix Web and 22 on Datix IQ

The increase in the about could inpart be due to the move over to the new Datix system and staff adjusting to the change.

As at 1 November 2023, there were 2 Serious Incidents (SI) open in Obstetrics (315207 overdue) – both booked onto Panel in November. None in Neonates.

3 open cases being investigated by HSIB - IDs 305131, 309592, 307455. All are overdue
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 were no closed SIs for Obstetrics or Neonates and no closed HSIB cases.

ULHT SI Update – see below

20231017 Quality and Safety Agenda.do

Specific Requirements	Number	Details	Learning / Actions Taken
Number of incidents graded as moderate or above (reported Oct 2023)	1 – Obstetrics 0 - Neonates	1. **1347** – Cat 2 LSCS at fully dilated for malposition and high head, epidural in situ so top up given before moving to theatre. Converted to GA once procedure was commenced as patient was experiencing pain, experienced bronchial spasms – tube removed, help requested and patient re-intubated. Consultant anaesthetist requested to attend theatre but did not attend in a timely manner so help sought from ITU. Transferred to ITU for further observations.	1. Taken to the PSIRF meeting discussion around whether the patient did have sepsis, would this have been a missed opportunity. The patient was high risk and the consultant anaesthetist should have been involved at an earlier stage. It was felt that there were issues with the process and whilst the outcome for the patient was ultimately okay, a different patient on a different day could have come to serious harm. The outcome was agreed as a concise investigation within the division. To be shared at Obstetric and Anaesthetic governance.
Other Incidents considered at SI / Rapid Review Panel (Oct 2023)	0 – Obstetrics 0 - Neonates	This panel no longer exists, therefore moving forward this section will contain incidents taken to the PSIRF meeting for discussion.	
Serious Incidents - New – declared NA	NA - Obstetrics NA – Neonates	As above. Moving forward this section contain the outcomes of the incidents taken to PSIRF panel	
Serious Incidents – Closed (Oct 2023)	0 – Obstetrics 0 – Neonates		

HSIB Investigations	3 current	1. **305131** (overdue) – Term IUD – Final report back 25/8/23, no safety recommendation made, declined family meeting, to go to panel 22/11/23 for closure. 2. **307455** – (overdue) Intrapartum Stillbirth – Comments for factual accuracy returned, Final report returned, 6 recommendations, revised action plan in development. 3. **309592** – (overdue) Transfer out for cooling – Report back for factual accuracy, awaiting final report.	
Key themes & trends Identified from the above incidents and any additional actions being taken		HSIB recommendations – 1. Ensure discussion around options for mode and timing of birth and undertaken by a senior clinician. 2. Local guidance to ensure when IOL would be considered unsuccessful and supports discussion of the available options with the mother. 3. Ensure staff are supported to communicate clearly with each other if an obstetric emergency is anticipated or occurring. 4. To ensure the staff are supported to use an emergency buzzer when an obstetric emergency occurs. 5. Ensure that all the staff have an awareness of which clinicians will respond to an emergency 2222 call, and how and when to place the call. 6. Support staff to maintain a helicopter view during complex emergency situations including the verbalisation of the passage of time. Ongoing review of all open SI/DI/HSIB actions.	
Number of overdue actions from incidents / SIs / HSIB and actions being taken		As at 1 November 2023, in Obstetrics, there were 32 (58 last report) ongoing actions – 32 of these are overdue. In Neonates there were no outstanding actions. Support from the governance team to close these in place. Weekly action plan meetings continue- teams/leads to identify any actions that may require support/resources or date extensions if unachievable.	

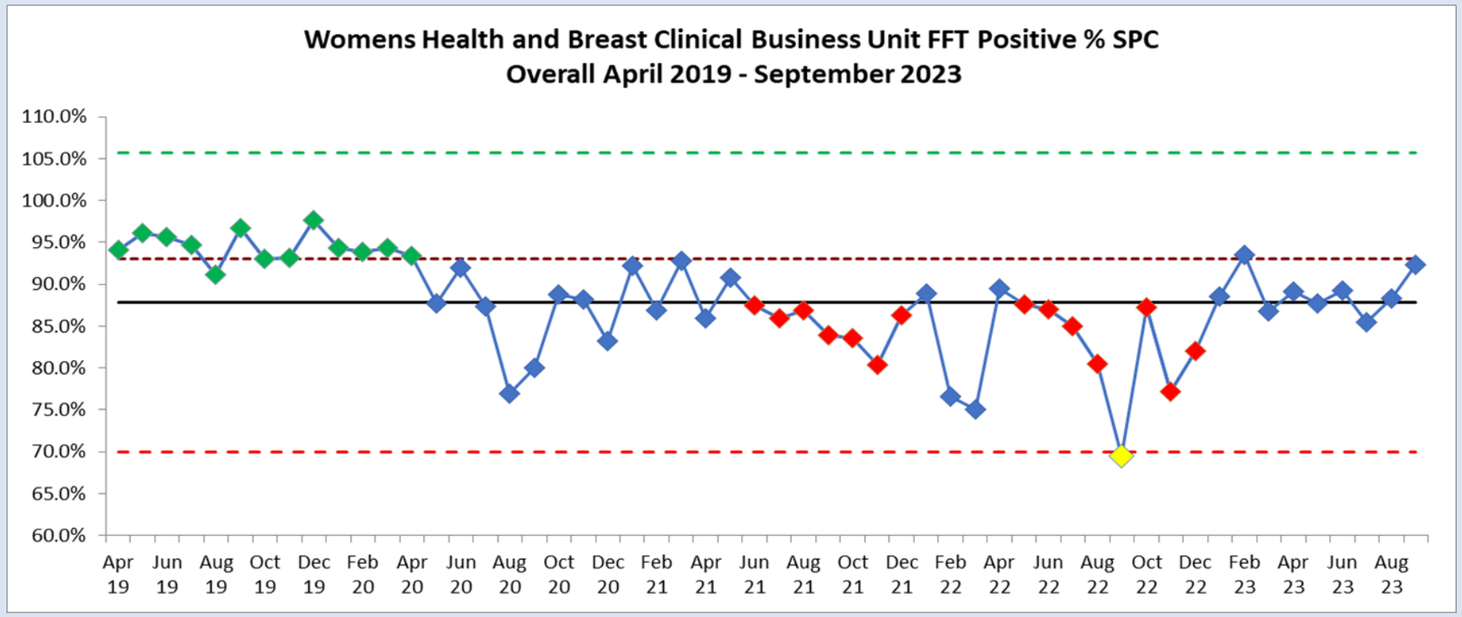
Service User Voice Feedback

Brief overview for the reporting period:

As at 1 November 2023, there were 5 open complaints in Obstetrics & Community Midwifery – 39000, 38966, 38224, 29808 33675, one of which was overdue (39000). There were no open complaint in Neonates.

There were no PALS contact received in Obstetrics or Neonates in October. There were no open PALS contacts.

Specific Requirements	Number	Details	Learning / Actions Taken
Number of complaints received in September	2 - Obstetrics 0 - Neonates	1. 38966 – 2. 33675 - with the Ombudsman which was initially received in September 2022	
Number of PALS received in October	0 – Obstetrics 0 - Neonates		
Number of compliments* ***Information taken from SUPERB (Single Unified Patient Experience Reporting Board)***	12 – Obstetrics 21 – Neonates	For August and September – need to improve compliment reporting	
Feedback received by Maternity & Neonatal Voices Partnerships			
Key themes & trends identified from the above activity and any additional actions being taken		Themes remain the same: Clinical treatment, Communication and appointment. However, in month the highest is around clinical treatment. Further work ongoing to unpick **Actions** • OD initiatives in all areas/teams; • F2F meetings with women and families; • Improved pan-division awareness of collecting compliments; • Work to support Ockenden IEA's • Sharing patient experiences as patient stories; very powerful • Weekly learning event • Improved liaison with MVP and NVP	
Number of overdue actions from complaints / PALS and actions being taken		As at 1 November, there were no open Obstetric or Neonatal complaint actions.	
Friends and Family Test		The highlight report for October 2023 shows a National average recommended rate of 93%, a Trust average of 87% and Maternity have achieved 98%. No data for NNU as same cohort of women.	



Family Health Patient Experience Meeting Escalation	October Meeting – • Positive patient stories • Card medic • Sharing some of the initiatives in another meeting • Internet pages – CYP and branding • Outlining the expectations of GAU patients – lots of documentation being trialled. Most of the work is based on patients feeding back.

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.
- SCORE survey launched and seeing some good response rates
- Staff also encouraged to complete staff survey

Other in month Developments & Updates

For September/October

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. During the Gala Diner in London they were also named as the national winner which is amazing news.

- Thirwall Enquiry – ULHT have been named as a Trust that will be interviewed. We await further guidance.

- Maternity Newsletter – launched 6.11.23 - https://lincshealthandcare.sharepoint.com/sites/Maternity/SitePages/Maternity-Newsletter.aspx. This, along with the new maternity intranet page has everything midwives need in one place. This has been well received by staff.

- Entonox – Cairn technology have now completed the sampling on the labour wards to determine staff exposure to Entonox. No staff member on the Pilgrim site breached the workplace exposure Limit (WEL) which confirmed that the changes to the ventilation had been successful.

  One staff member just breached the WEL on the Lincoln site. This demonstrates an improvement however is not in line with COSHH regulations. Discussed with Health and Safety and it was agreed that a further position statement to staff acknowledging that there is still a degree of risk and re iterating the NHSE guidance was suitable to the level of risk. The risk assessment is still on the risk register and the SoP is going through the final ratification process. Discussed with region who agreed this was suitable course of action

- Compliance with NICE Guidance in Maternity & Neonatal –

  NICE Maternity and Neonates Report V2

- Increased Number of GA C-sections at PHB for October 2023 **–** Normally 1-3. In the same time period LCH had only 1 GA LSCS. This has prompted a responsive deep dive, a high level review of Careflow Maternity data and data collection from patient notes has been compiled. This identified that there were 6 x Cat 1 LSCS and 5 x Cat 2 LSCS. Initial review indicates reasons for GA were –
  - Maternal request – 1
  - Cat 1 LSCS Pathological trace – 3
  - Cat 1 Cord prolapse, failed spinal – 1
  - Cat 1 grand multip (P14), 3 x prev LSCS, fully dilated -1
  - Spinal block too high – 1
  - Epidural not effective after KTS – 2
  - Previous spinal surgery – 1
  - Raised BMI 4 x spinal attempts – 1

  Plan is to complete a deep dive with MDT review of all cases to identify any patient safety concerns and learning opportunities.

- Quarterly PMRT Report & Newsletter

  Quaterly (Qu 2) Report July - Septemt

  PMR Newsletter - Issue 3.pdf

- Quarterly ATAIN Report

  ULHT Quarterly ATAIN Report Q2 FIN

- PMA Pulse Survey **–** Meeting with regional WTE team to discuss improvements for students. Pulse survey supported improvements. Mainly positive feedback

  Student Midwives feedback in last quart

- CQC Survey - Women's Experience of Maternity Care 2023 (action plan requested - The majority of United Lincolnshire Hospital NHS Trust's scores are in the top 20% range of all Trusts surveyed by IQVIA. Additionally, 20 scores are in the middle 60% range and only 1 score is in the bottom 20% range. The best score was achieved for "Thinking about your care during labour and birth, were you spoken to in a way you could understand?" Since 2022, 44 scores have improved and 5 have declined. Celebrate the overall positive results with staff members and embed the actions and behaviours to continue positive performance.

  Overarching action plan monitored through Divisional PEG and Trust PEG. Further action plan developed with the MVP and monitored through Divisional PEG

  5.9 - MT23 RWD United Lincolnshire H

- Compliant Triangulation Report -

  Triangulation Report Claims Complaints an

- CCF/Uplift for Training – There has been an increased in training requirements for the MDT identified in the CCF. Currently ULHT provides a 22.5% uplift to support training, mat leave, annual leave etc. The increase in training requirements necessitates the need to review this uplift with a view to increasing it. This is supported by Ockenden who recommends that the uplift is reviewed and based on the last 3 years sickness etc and the training requirements. This review was agreed at the establishment reviews and the work is ongoing.

- Supported by LMNS funding, Perihealth London delivered 3 in-depth suturing study days to over 70 midwives with excellent feedback and evaluation. Attendance at this training has supported midwives to deepen their knowledge and practice their clinical skills on very lifelike models. Comments made by midwives included "Best study day I have ever done'; "I felt the study day was so beneficial to my practice and gave me a greater understanding of assessing the perineum following delivery and suturing and I would recommend this course to all midwives."; "The training was brilliant and all the facilitators were very helpful. The training models were so brilliant, much more like skin and muscle and really useful to practice the skills. I would highly recommend the course." It is hoped to have further study days in 2024.

Update from Neonates –

Workforce: Nursing
Establishment reviews have taken place with Senior Exec team. Template for registered staff to include Nursing Associates and therefore this needs to be reflected within the nursing budget. Further work required with the Finance Team to be undertaken by December 2023. This will also contribute to the statistics of 70:30 ratio of Qualified in Speciality (QIS) as laid down by BAPM.

In addition to the above, the band 4 Nursery Nurse workforce to be reviewed as part of a larger piece of work in relation to the unregistered staffing workforce.

Vacancy position: Over recruited at Lincoln County Hospital for registered staff. Good position currently supported by Finance to enable the service to be protected during episodes of maternity leave and long term absence.
Gap in the unregistered workforce and pause in recruitment whilst work described above taking place. In order to mitigate this Nursing Associates Apprentices have been recruited to enable them to specialise in Neonatal Nursing. Slightly over recruited at PHB on the registered staff again supported by Finance for maternity and sick leave cover and again a gap in the unregistered workforce for the transition work as described.

A workforce summary was completed with the Neonatal Network in October 2023 as part of the NCCR to identify gaps in meeting BAPM standards. See attached paper Qualified in Speciality (QIS) nursing ratios should achieve 70% of the registered nursing workforce with Lincoln currently sitting at 42.6%. Separate paper attached. Mitigations and a robust action plan in place to ensure safety of the service.

QIS paper v2.docx Copy of Lincoln workforce tool.xlsx Copy of Pilgrim workforce tool (002).x

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.
ANNP paper attached.

ANNP paper (002).docx

Complaints/PALS
X 1 verbal complaint received in October 2023 dealt with at ward level complaint relates to miscommunication and following discussion with the parents some learning points taken from it to action such as appropriate channels of communication, ensuring staffing adequate for ROP day to reduce waiting times.

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 has been compiled by ANNPs to identify both good practice and where improving patient outcomes required.
See paper attached

NNAP Report Nov 2023 V2.docx

NEWWT 2
Launched on 9th October 2023

Dreams Training - A week of training for data, resus, equipment, appraisal, mandatory training and Sim.

Neonatal Dashboard -

Dashboard Paper.docx

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

Escalations from Maternity & Neonatal Safety Collaborative –

- MatSIP – PROMPT – Risk to compliance.
- Field Safety Notice – Colostrum Syringes –
- Concerns around compliance with fetal risk assessments and fresh eyes
- Training risk with regards to CNST compliance for Anaesthetic doctors/HCSW and MSWs/Neonatal Doctors
- Wi-Fi at Spalding and Grantham (Swingbridge) Children's Centres
- Business case going to CRIG for digital
- IT team's capacity to deal with all of the ongoing projects
- Fetal physiology project

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	463	503						3273			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%	70.84%	74.35%							71.04%		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%	22.46%	24.45%							23.07%		
BMI >25 at Booking				CM/PHE 2018	BMIBooking	58.19%	57.54%	57.89%	58.06%	58.71%	62.42%	59.05%							58.84%		
BMI >35 at Booking				CM/PHE 2018		16.63%	11.64%	11.16%	12.90%	13.07%	13.39%	15.11%							13.41%		
BMI >40 at Booking				CM/PHE 2018		7.60%	5.39%	4.42%	5.38%	5.81%	5.40%	7.36%							5.91%		
Total number of Births				CM	BirthNumbers	335	372	358	380	374	375	364						2558			
Total Number of Live Births				CM		334	370	358	380	371	373	364						2550			
Unassisted Vaginal Birth Rate				CM/HES Data 2020	NVB	53.43%	50.81%	51.68%	56.05%	47.59%	51.47%	45.88%							50.99%		
Home Birth Rate	<2.40%		>2.40%	CM/ONS 2020	HomeBirth	2.09%	3.49%	2.51%	1.05%	0.80%	2.13%	1.92%							2.00%		
Forceps and Ventouse				CM/HES Data 2020	Forcep&Ventouse	9.85%	7.26%	10.06%	6.84%	10.43%	7.47%	8.52%							8.63%		
Total Caesarean Section Rate				CM	Caesarean	35.82%	40.05%	36.31%	35.00%	41.44%	40.53%	43.68%							38.98%		
Emergency Caesarean Section				CM		24.78%	25.00%	20.11%	24.47%	25.13%	23.47%	27.75%							24.39%		
Elective Caesarean Section				CM		11.04%	15.05%	16.20%	10.53%	16.31%	17.07%	15.93%							14.59%		
Women booked on Continuity Pathway received care in labour/birth by continuity Team				CM/NHSIE	ContinuityCare	37.68%	38.81%	29.87%	38.24%	32.91%	42.25%	17.89%							33.95%		RAG rating removed Oct 23
Induction of Labour Rate	>40%		<40%	CM/HES Data 2021	IoL	42.77%	34.25%	35.59%	39.52%	37.74%	38.61%	35.75%							37.75%		
Smoking at Booking				CM/MSDS 2021	SmokingBooking	12.83%	12.72%	13.68%	13.76%	11.83%	12.10%	10.14%							12.44%		
Smoking at the time of Delivery	>9.6%		<9.6%	CM/NHSD 2021	SmokingDelivery	11.45%	14.25%	14.12%	9.95%	8.63%	12.06%	12.29%							11.82%		

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%	11.53%	12.57%							11.71%		
PPH ≥1.0 litre SVB	>4.90%		<4.90%	CM/Obs CYMRU	PPH>1lSVB	3.92%	1.64%	3.11%	2.69%	2.96%	2.95%	2.23%							2.79%		
PPH ≥1.0 litre Instrumental	>18.40%		<18.40%	CM/Obs CYMRU	PPH>1lInstrumental	1.20%	1.37%	1.69%	0.27%	1.89%	1.34%	2.23%							1.43%		
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%	2.14%	2.23%							2.10%		
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%	5.09%	5.87%							5.39%		
PPH ≥2.0 litre	>1.30%		<1.30%	CM/Obs CYMRU	PPH>2l	2.41%	1.92%	0.56%	1.61%	1.89%	1.34%	1.12%							1.55%		
3rd and 4th degree Tear	>3%		<3%	CM/OASI post-bundle stats	3rd4thDegTears	1.51%	0.82%	1.69%	1.88%	0.27%	1.34%	0.84%							1.19%		
Admission to ITU	≥1		0	Inpatient Matron	ITU	0	1	0	2	1	0	2						6			
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%	4.83%	4.75%							4.92%		

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%	8.93%	5.23%								6.07%		Reports 1 month behind
No. of babies transferred for therapeutic cooling	≥1		0	NNU	Cooling	2	0	0	1	0	0	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%	8.00%	5.77%							7.35%		
No. of Antenatal stillbirths	≥1			CM	AntenatalSB	1	1	1	0	2	2	1						8			
No. of Intrapartum stillbirths	≥1			CM	IntrapartumSB	0	0	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	2.46	2.91	2.72									
No. of NND	≥1			CM and NNU	NoNND	0	0	1	2	0	1	0						4			
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	1.12	1.13									
AN Steroids Eligible / Full course Administered	<100%		100%	NNU	ANSteroids	33.33%	50.00%	57.14%	61.54%	66.67%	28.57%	50.00%							49.61%		
AN Magnesium Sulphate Eligible / Administered	<100%		100%	NNU	ANMagSulph	50.00%	50.00%	50.00%	100.00%	#N/A	0.00%	33.33%							47.22%		
SGA detection rate	< 41.2%		>41.7%	ANC/SBL Perintatal Institute	SGA	54.24%	59.57%	50.00%	54.76%	60.00%	68.75%	65.91%							59.03%		

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	01:26	01:26									
Midwife to Birth Ratio (Actual)	01:27		01:26			01:23	01:25	01:24	01:26	01:25	01:25	01:25									
1-1 in labour	<99%		>99%	CM/CNST	1-1Labour	100.00%	100.00%	99.68%	100.00%	100.00%	100.00%	100.00%							99.95%		
Sickness Rate	>4.3%		<4.3%	Workforce Intelligence	Sickness	4.47%	4.80%	4.92%	5.05%	5.53%	6.20%	6.28%							5.32%		
Co-ordinator Supernumerary	<96%		>99%	Inpatient Matron/CNST	Co-ordinator	96.94%	99.00%	99.75%	99.37%	97.90%	92.00%	98.93%							56.99%		
Prompt Training Compliance	<90%		≥90%	CE team/ CNST	PROMPT	88.13%	88.91%	89.44%	90.57%	89.01%	82.12%	81.90%							87.16%		
Mandatory Training Compliance	<90%		≥90%	CE team/ CNST	MMTD	83.39%	86.55%	90.07%	92.51%	93.28%	89.30%	93.66%							89.82%		

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

		Trained	Possible	%
PROMPT	Lincoln MW	153	168	91.07
	Lincoln Drs	19	34	55.88
	Lincoln Anaes	18	22	81.82
	Lincoln HCSW/MSW	25	51	49.02
	LCH Prompt	215	275	**78.18**
	Bank Only MW (Trustwide)	16	18	**88.89**
	Pilgrim MW	98	100	98.00
	Pilgrim Drs	20	28	71.43
	Pilgrim Anaes	17	21	80.95
	Pilgrim HCSW/MSW	21	29	72.41
	PHB Prompt	156	178	**87.64**
	Trust Compliance Prompt	387	471	**82.17**

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%	79.09%	79.67%							78.97%		
Breastmilk at first feed	<68%		>68%	CM/HES 2021	FirstFeed	67.50%	71.51%	65.12%	66.85%	64.21%	65.83%	70.14%							67.31%		

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	5	0						14			
No. of SI's Maternity	≥1		0	Risk (Datix)		0	0	0	0	1	0	0						1			
No. of Never Events	≥1		0	Inpatient Matron		0	0	0	0	0	0	0						0			
No. of HSIB cases	≥1		0	Risk (Datix)		1	0	0	0	0	0	1						2			
PMRT commenced within CNST timeframe	<95%		≥95%	Bereavement Midwife		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%							100.00%		
PMRT completed within CNST timeframe	<50%		≥50%	Bereavement Midwife		100.00%	100.00%	100.00%	100.00%	100.00%	66.67%	100.00%							95.24%		
No of current coroners cases / inquests pending				Legal		0	0	0	0	0	0	0						0			
No of coroners Regulation 28 (prevention of future death reports) made direct to the trust)				Legal		0	0	0	0	0	0	0						0			
No of Formal Complaints				Complaints		5	3	3	3	0	0	6						20			

Perinatal Mortality Reports

September 2023

Hospital	Loss Category	Date	Gestation	Case Summary	MBRRACE Case No.	MBRRACE Notified	DATIX Panel SI
LCH Ext QMC	**SB**	**02/09/23**	**39+1**	**P1, 32 years old, BMI 39.6. 3 true knots and cord around neck at birth,**	**QMC**	**QMC**	**QMC**
LCH	SB	03/09/23	37/40	P1, Late booker @19/40, Prev PIH, 3.1 centile @35/40, No Fh on USS @37/40	89249	03/09/23	
LCH	Misc	08/09/23	20/40	P3, 42 years old, T18 diagnosed by NIPT, No FH on Anomaly Scan	N/A	N/A	
LCH Ext QMC	**NND**	**14/09/23**	**37+1**	**Multiple Abnormalities, Agenesis of the mandible**	**QMC**	**QMC**	**QMC**
LCH	MTOP NND	15/09/23	21/40	Cardiac Abnormalities, Declined feticide. Baby born alive, RIP at 3 hours	89470	N/A	
PHB	MTOP	18/09/23	17+5	Brain Abnormalities	N/A	N/A	
PHB	MTOP	30/09/23	20+1	P2, 42 years old, Cardiac Abnormalities, Cleft Palate	N/A	N/A	
LCH	SB	30/09/23	34+5	P5, Smoker, previous pre-term babies, previous SG involvement for DA – but denies this	89722	04/10/23	

October 2023

Hospital	Loss Category	Date	Gestation	Case Summary	MBRRACE Case No.	MBRRACE Notified	DATIX Panel PSII
PHB	Misc	04/10/23	23+4/40	P1, 39 years old, reduced FM at 20 weeks, seen again at 23+ and no FH	89735	05/10/23	42 No No
LCH	Misc	06/10/23	23+5/40	P1, Laser Ablation for MCDA Twins at 17 weeks, smaller twin passed, Larger twin passed away after mother had Cardiac Arrest and RIP in ICU.	89749	06/10/23	341 NMSI
LCH Ext - QMC	NND	06/10/23	21+6/40	P1+1, MCDA Twins, Laser Ablation at 20/40, Spont labour and birth.	External	External	
PHB	Misc	09/10/23	19+3/40	P2+3, Smoker.	n/a	n/a	595 No No
LCH	Misc	15/10/23	17/40	P1+0, BMI 37.7, Hyperthyroidism, private USS @ 16+5 slow FH. No FH on ULH conformation scan.	n/a	n/a	No
PHB	SB	15/10/23	40+6/40	P1, RFM in labour, No FH on USS.	89865	16/10/23	907 No No
LCH Ext - QMC	NND	08/10/23	23+6/40	35 years old, recent covid +ve, Extreme preterm spont delivery at home, booked under Kingsmill. Baby to QMC – RIP 20/10/23	External	External	
LCH Ext - UHL	NND	19/10/23	37+4/40	P1, 36 years old, Known fetal abnormalities with kidneys and bladder, Baby RIP 20/10/23 – Undiagnosed cardiac abnormalities identified at birth	External	External	

United Lincolnshire Hospitals NHS
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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	
Neonatal Unit	Live Births	2909	2925	2812	242.4	243.8	234.3	233.2	225.6	206	241	219	230	236	237	210						1579	
	No of all NNU Admissions (including re-admissions, transfers in, etc)	345	326	371	28.8	27.2	30.9	29.8	26.9	23	32	21	31	33	20	28						188	
	No of First Episode Admissions	283	282	299	23.6	23.5	24.9	23.8	21.7	21	23	17	27	28	17	19						152	
	% of First Episode Admissions against Live Births			N/A			11%	10%	9.6%	10.2%	9.5%	7.8%	11.7%	11.9%	7.2%	9.0%						N/A	
	No of Admissions to TC	152	202	220	12.7	16.8	18.3	19.0	12.7	10	17	10	15	14	11	12						89	
	All Ex-utero transfers	73	62	69	6.1	5.2	5.8	5.3	4.6	4	8	1	7	4	5	3						32	
	Ex-utero transfers <27 weeks	1	2	1	0.1	0.2	0.1	0.3	0.6	0	1	0	1	0	1	1						4	
	In-utero transfers	4	13	11	0.4	1.1	0.9	0.8	0.9	1	2	2	0	1	0	0						6	
	In-utero transfers <27 weeks	0	8	6	0.0	0.7	0.5	0.5	0.3	0	1	1	0	0	0	0						2	
	NNU Term Admissions	143	168	170	11.9	14.0	14.2	13.8	12.0	11	8	8	16	20	8	13						84	
	Term Live Births	2654	2725	2584	221	227	215	216	208	191	219	204	210	216	219	195						1454	
	% NNU Term Admissions (Live Term births) - Target <5%	N/A	N/A	N/A	5.4%	6.2%	6.5%	6.4%	5.8%	5.8%	3.7%	3.9%	7.6%	9.3%	3.7%	6.7%						N/A	

United Lincolnshire Hospitals NHS
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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	
Neonatal Unit - continued	Cot Occupancy - %	NNU	N/A	N/A	N/A	68%	63%	69%	71%	62.7%	72.7%	74.2%	56.7%	54.4%	58.7%	53.1%	69.2%						N/A	
		TC	N/A	N/A	N/A	83%	80%	45%	43%	36.7%	37.5%	29.4%	44.2%	46.4%	47.2%	24.6%	27.8%						N/A	
		Total (NNU & TC)	N/A	N/A	N/A		67%	61%	63%	53.7%	60.4%	58.6%	52.3%	51.6%	54.7%	43.2%	54.8%						N/A	
	Hypothermia on Admission - Ep.1 (<36.5ºc)	NNU	34	53	28	2.8	4.4	2.3	1.2	1.3	1	1	0	3	1	3	0						9	
		TC			15			1.3	1.9	0.1	0	1	0	0	0	0	0						1	
	(% of first episode admissions)	NNU %			N/A			0.1	4.6	5.0%	4.3%	3.1%	0.0%	9.7%	3.0%	15.0%	0.0%						N/A	
		TC %			N/A			0.1	9.6	0.8%	0.0%	5.9%	0.0%	0.0%	0.0%	0.0%	0.0%						N/A	
	Transferred for Therapeutic Cooling		5	0	4	0.4	0	0	0	0.3	2	0	0	0	0	0	0						2	
	HIE (all grades)		8	2	6	0.7	0.2	0.5	0.3	0.1	1	0	0	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	0						0	
	Neonatal Deaths (delivery room)								0.1	0.3	0	0	1	0	0	1	0						2	
	Unit Closures (any)		0	2	0	0	0.2	0.0	0.0	0.0	0	0	0	0	0	0	0						0	
	No. of Exceptions		8	13	22	0.9	1.1	1.8	1.1	0.5		1			0	0	1						2	
	Medication Errors (moderate and above)									1.4	3	1	0	5	0	0	1						10	
	No of Serious Incidents (SI)		1	1	1	0.1	0.1	0.1	0.0	0.0	0	0	0	0	0	0	0						0	

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	
Staffing	Appraisals - % (Target 100%)	Registered and unregistered	N/A	N/A	N/A			86%	89%	71.6%		64.1%	79.6%	83.0%	74.0%	67.4%	61.5%						N/A	
		ANNPs	N/A	N/A	N/A	75%	75%	71%	79%	55.0%	50.0%	50.0%	50.0%			50.0%	75.0%						N/A	
	Sickness - % (Target - Trust avg <4%)	Registered and unregistered	N/A	N/A	N/A	6.5%	5.1%	6.8%	6.8%	5.3%	1.8%	3.3%	4.2%		9.0%	5.9%	7.5%						N/A	
		ANNPs	N/A	N/A	N/A	4.0%	0.6%	4.9%	9.7%	3.3%	0.8%	1.5%	5.3%			4.6%	4.1%						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%	94.3%	92.7%						N/A	
		ANNPs	N/A	N/A	N/A	96%	97%	90%	94%	96.3%	97.0%	98.0%	97.0%			94.5%	95.0%						N/A	
	Mandatory training % (Core Learning Plus) (Target >95%)	Registered and unregistered	N/A	N/A	N/A	92%	86%	86%	90%	88.3%	89.0%	74.0%	90.0%	90.0%	93.0%	91.4%	90.5%						N/A	
		ANNPs	N/A	N/A	N/A	96%	89%	86%	87%	93.2%	90.0%	94.0%	95.0%			94.0%	93.0%						N/A	
	BLS (Target >95%)		N/A	N/A	N/A	93%	63%	77%	82%	67.9%	74.0%	57.0%	67.0%	76.0%	78.0%	49.0%	74.0%						N/A	
	QIS - % WTE (Target >70%)		N/A	N/A	N/A	N/A	N/A	64%	64%	46.1%	46.7%	49.0%	47.2%	48.0%	48.0%	41.3%	42.6%						N/A	
	No. of QIS in training - WTE		N/A	N/A	N/A	3.9	4.6	2.3	1.6	2.5	2.8	2.2	2.2	2.2	2.2	2.2	3.8						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%	98%	100%						N/A	

United Lincolnshire Hospitals NHS
NHS Trust

Neonatal Quality and Safety Dashboard - 2023/2024

Pilgrim Hospital, Boston

	Performance Measure	2019/20 Total	2020/21 Total	2021/22 Total	2019/20 Monthly Avg	2020/21 Monthly Avg	2021/22 Monthly Avg	2022/2023 Monthly Avg	YTD/ Average	Apr 2023	May 2023	June 2023	July 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Total	
Neonatal Unit	Live Births	1762	1612	1798	146.8	134.3	149.8	142.5	138.9	128	130	139	150	135	136	154						972	
	No of all NNU Admissions (including re-admissions, transfers in, etc)	209	172	218	17.4	14.3	18.2	17.1	17.9	11	20	17	23	17	20	17						125	
	No of First Episode Admissions	175	137	191	14.6	11.4	15.9	15.1	15.1	10	19	13	17	14	17	16						106	
	% of First Episode Admissions against Live Births			N/A			11%	11%	10.9%	7.8%	14.6%	9.4%	11.3%	10.4%	12.5%	10.4%						N/A	
	No of Admissions to TC	72	65	80	6.0	5.4	6.7	7.1	6.7	7	8	5	6	5	12	4						47	
	All Ex-utero transfers	30	28	23	2.5	2.3	1.9	2.1	3.1	4	5	4	3	1	3	2						22	
	Ex-utero transfers (<32 weeks)	12	7	9	1.0	0.6	0.8	0.6	1.1	1	1	1	2	0	1	2						8	
	All in-utero transfers	20	14	8	2.0	1.2	0.7	0.8	1.1	3	1	0	1	0	2	1						8	
	In-utero transfers (<32 weeks)	15	13	5	1.5	1.1	0.4	0.8	0.9	3	1	0	0	0	2	0						6	
	NNU Term Admissions	87	65	113	7.3	5.4	9.4	8.7	9.6	4	12	9	9	11	10	12						67	
	Term Live Births	1638	1510	1672	136.5	126	139	132	129	119	117	127	138	131	125	148						905	
	% NNU Term Admissions (Live Term births) Target <5%	N/A	N/A	N/A	5.3%	4.3%	6.7%	6.6%	7.4%	3.4%	10.3%	7.1%	6.5%	8.4%	8.0%	8.1%						N/A	

United Lincolnshire Hospitals NHS
NHS Trust

Neonatal Quality and Safety Dashboard - 2023/2024

Pilgrim Hospital, Boston

	Performance Measure		2019/20 Total	2020/21 Total	2021/22 Total	2019/20 Monthly Avg	2020/21 Monthly Avg	2021/22 Monthly Avg	2022/2023 Monthly Avg	YTD/ Average	Apr 2023	May 2023	June 2023	July 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Total	
Neonatal Unit - continued	Cot Occupancy - %	NNU	N/A	N/A	N/A	46%	44%	42%	38%	43.2%	36.3%	39.9%	60.4%	62.9%	32.7%	46.3%	24.2%						N/A	
		TC	N/A	N/A	N/A	50%	39%	51%	55%	50.7%	40.0%	71.0%	40.0%	43.5%	41.9%	78.3%	40.3%						N/A	
		Total (NNU & TC)	N/A	N/A			42%	45%	43%	45.7%	37.5%	50.3%	53.6%	56.5%	35.8%	56.9%	29.6%							
	Hypothermia on Admission - Ep.1 (<36.5ºc) (% of first episode admissions)	NNU	35	39	30	2.9	3.3	2.5	1.5	1.0	0	3	2	0	1	1	0						7	
		TC			5			0.4	0.2	0.9	0	4	0	0	0	2	0						6	
		NNU %			N/A			0.2	10.8	5.4%	0.0%	15.0%	11.8%	0.0%	5.9%	5.0%	0.0%						N/A	
		TC %			N/A			0.1	3.3	9.5%	0.0%	50.0%	0.0%	0.0%	0.0%	16.6%	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	0						0	
	HIE (all grades)		2	3	2	0.2	0.3	0.2	0.1	0.0	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	0						0	
	Neonatal Deaths (delivery room)								0	0.0	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	0						0	
	No. of Exceptions		24	23	22	2.0	1.9	1.8	1.2	1.0	3	1		1	0	1	0						6	
	Medication Errors (moderate and above)									0.9	0	2	1	1	0	0	2						6	
	No of Serious Incidents (SI)		0	0	1	0	0	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 Monty 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%	88.0%	69.2%	68.0%	87.5%	100.0%	100.0%	95.5%	96%						N/A	
		Outreach												60.0%	80.0%	80.0%	100%							
	Sickness - % (Target - Trust avg <4%)	NNU	N/A	N/A	N/A	5.5%	6.3%	6.3%	10.5%	7.7%	7.8%	6.0%	7.4%	8.0%	8.7%	9.4%	6.4%						N/A	
		Outreach								13.5%	0.0%	18.1%	22.1%	30.1%	22.6%	1.3%	0.0%							
	Mandatory training % (Core Learning) (Target >95%)	NNU	N/A	N/A	N/A	95%	96%	98%	98%	97.8%	97.2%	97.0%	97.5%	96.7%	99.0%	99.0%	98.0%						N/A	
		Outreach								91.9%	89.5%	83.3%	86.1%	92.3%	97.0%	95.0%	100.0%							
	Mandatory training % (Core Learning Plus) (Target >95%)	NNU	N/A	N/A	N/A	92%	94%	96%	96%	95.8%	97.2%	93.0%	97.6%	93.0%	94.0%	98.0%	98.0%						N/A	
		Outreach								90.9%	95.0%	87.7%	88.4%	87.0%	86.0%	95.0%	97.0%							
	BLS (Target >95%)	NNU	N/A	N/A	N/A	97%	98%	96%	93%	94.3%	92.0%	92.0%	95.0%	96.0%	96.0%	96.0%	93%						N/A	
		Outreach								75.3%	67.0%	33.0%	67.0%	80.0%	80.0%	100.0%	100%							
	QIS - % WTE (Target >70%)		N/A	N/A	N/A	62%	67%	70%	74%	71.9%	72.0%	72.0%	72.0%	82.0%		68.4%	65.0%						N/A	
	No. of QIS in training - WTE		N/A	N/A	N/A	2.0	0.6	1.5	1.1	0.2857	0	0	0	0	0	0	2.0						N/A	
	% staff with in-date NLS (Target 100%)	NNU	N/A	N/A	N/A	96%	100%	98%	99%	99.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95%						N/A	

Appendix 4

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

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

Naomi Plant, Patient Safety Lead Midwife
November 2023

v3.5 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.

During the Maternity and Neonatal Safety Collaborative (MNSC) a large proportion of actions were reviewed, with 10 actions being archived. Alongside this, the decision was made to develop a Patient Experience (PEX) Action Plan, which will provide oversight of all actions that are working towards improving patient experience. As a result, 8 further actions were moved from the MatSIP to the PEX Action Plan. Actions relating to placental storage, histology and reporting were added to the MatSIP, and further actions will be added in the coming months 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	**25** (+1)	1 (+1)	17 (-4)	6 (+3)	1 (+1)
Optimise Experience	**8** (-3)	0 (-1)	8 (-1)	0 (-1)	0 (=)
Improve Leadership	**1** (=)	0 (=)	1 (=)	0 (=)	0 (=)
Choice & Personalised Care	**7** (-8)	0 (=)	5 (-7)	2 (-1)	0 (=)
Provide Assurance	**3** (-3)	0 (=)	3 (-3)	0 (=)	0 (=)

Appendix 4

TOTAL	**44** (-13)	**1**	**34**	**8**	**1**
Archived Actions	**213** (+8)	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
OS46	1	90% of staff attending PROMPT	Professional Development Midwives	30/11/2023	We are required to achieve 90% compliance with PROMPT for CNST in each staff group. CNST have recently announced that they will accept a compliance rate of 80%, if an action plan if submitted alongside this. However, we are at high risk of non-compliance with both 90% and 80& for particular staff groups. The following data is correct, as of 3rd November 2023: Anaesthetists – Currently 82.6%, however, as many are due to expire, this figure is expected to drop to below 50% at the end of November, due to cancellations and non-attendance within this staff group. HCSW's and MSW's – Currently 57.5% The clinical education team are working incredibly hard and have arranged three PROMPT dates during November, however the current attendance list will not enable compliance to be achieved with the above staff groups.

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:	14 November 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** The Committee received the report noting that vaccination rates for both flu and Covid-19 which had increased to 20.26% and 31% respectively. Concern was noted in respect of the rates with the Committee noting that the deadline to receive the Covid-19 vaccination may encourage staff to be vaccinated. **Committee Performance Dashboard** The Committee received the report noting the performance reported and was pleased to note the lowest reported vacancy figure at 3%. Whilst healthcare support worker vacancies remained high there was a strong recruitment pipeline in place. **Core Training Report** The Committee received the report noting the positive progress had been made since the establishment of the team with a 9-year high in core training compliance achieved. The Committee noted that protected learning time for clinical staff had been a core issue in achievement. The People Development Policy was currently being developed which would seek to address this with protected time for staff to remain compliant. Core and Core Pus training offered had been considered in order to determine appropriate training for staff. Going forward requests for training to be included as mandatory would have to fit with the established criteria.

	Workforce Plan – review of current year position The Committee received the report noting that there had been a significant increase in the staff in post, above the planned position. There had also been a decrease in agency usage seen and, as a result, there had been an increase in bank utilisation. As a result of the movement being seen the workforce plan for the second half of the year had been reforecast. **Safer Staffing** The Committee received the report which was taken as read noting the moderate assurance which continued to be offered. **Trauma and Orthopaedic Deep Dive Report and Action Plan** The Committee received the T&O report noting that the action plan was being revised to ensure this was reflective of the position and was owned by the division. The Committee noted the recent visit from the GMC to a number of areas, in conjunction with Health Education England, which had identified a significant positive change in culture. It was recognised that a wider piece of work was ongoing to address trends identified through various deep dives and staff survey results. **Medical Engagement Update** The Committee received the report noting that work continued in respect of medical engagement to ensure this continued to develop. There had been positive engagement with Clinical Leaders and Managers following the recent workshop and whilst the 2022 medical engagement survey outcome was not as positive as hoped, consideration was being given to the repeat of this to understand the current position, following the actions enacted by the Trust.
	Lack of Assurance in respect of SO 2b **Issue: Making ULHT the best place to work** **Freedom to Speak Up Quarterly Report** The Committee received the report from the Freedom to Speak Up Guardian and noted the increase in concerns raised regarding staff and skill mix. It was noted that staff were asked and supported to speak up to their line managers where appropriate in order that concerns could be addressed at a local level. It was recognised however that this was not always possible. The Committee noted the National Reflection and Planning Tool and would welcome the output of this once considered.

	Lack of Assurance in respect of SO 4b **Issue: To become a University Hospitals Teaching Trust** **University Teaching Hospital Group Upward Report** The Committee received the report noting the position with the application for teaching status and the proposed name changes. Work had been undertaken with communications with the proposals shared with both NHS England and the Department of Health. The Committee supported the proposal presented which would be offered to the Trust Board for approval. **Research and Innovation Update** The Committee received the report noting the improvement in recruitment figures to 939 from 872 at the end of October, with the Trust having achieved better recruitment figures that competitor Trusts in the region. The Committee reflected on the performance reporting for research and innovation and requested that consideration was given to this being expended to include citations, publications and grant income.
	Assurance in respect of other areas: **Update on current workload in the Trust** The Committee received a verbal update on the current position within the Trust noting that the Trust had been awarded the Pastoral Care Award. This recognised the work of the teams involved in international nurse recruitment. Recognition had also been received, from NHS England, in respect of the improvements seen for the Trust in the 2023 National Staff Survey. The Committee noted the financial pressures across the system as a result of the impact of industrial action and recognised the increase in referrals to occupational health. The action being taken to strengthen the occupational health offering was noted. **Reporting Group Terms of Reference** The Committee received the reporting group terms of reference noting that discussions would take place with the relevant Chair's of the groups in order to ensure work programmes were developed. **Board Assurance Framework** The Committee received the Board Assurance Framework and reflected on the updates made noting that full consideration of the BAF would be undertaken at the December meeting to consider the assurance ratings.

	Integrated Improvement Plan The Committee received the report noting the continued moderate assurance offered. A number of metrics remained difficult to achieve however the Committee were sighted on these through the performance dashboard. **Internal Audit Recommendations** The Committee received the internal audit recommendations noting the position reported and reflecting the need to ensure updates were offered to internal audit for these to be closed. **CQC Action Plan** The Committee received the report noting the position presented and reflected the intrinsic link to the Integrated Improvement Plan and phased approach to achieving the set targets. The Committee noted the need for consistent reporting to ensure clear line of sight on the delivery of the actions. Ongoing meetings were taking place to ensure accountability of the outstanding actions. **CQC Medical Staffing Overview** The Committee received the report which detailed those actions being taken in regard to the specific medical staffing action noting that, whilst progress was being made, the intention would be to replicate the nursing safer staffing paper for medical staff. This would demonstrate the staffing position and provide a proactive approach to monitoring of vacancies and the workforce. **Savile Action Plan inc milestones for DBS actions** The Committee received the report noting a delay in the trajectory for DBS checks however it was anticipated that a positive change would be seen for November. The Committee noted that staff had been prioritised for checks when working in sensitive areas with processes in place to address any issues which were identified. The trajectory would be reported through the performance dashboard to future Committee meetings.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	None

Committee Review of corporate risk register	The Committee received the risk register noting the current risks presented.
Matters identified which Committee recommend are escalated to SRR/BAF	No areas identified
Committee position on assurance of strategic risk areas that align to committee	The Committee considered the reports which it had received which provided assurances against the strategic risks to strategic objectives.
Areas identified to visit in ward walk rounds	No areas identified

Attendance Summary for rolling 12 month period

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

X in attendance
A apologies given
D deputy attended

Report to:	Trust Board
Title of report:	People and OD Committee Assurance Report to Board
Date of meeting:	12 December 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** The Committee received the report noting that targeted work was required for all staff groups in respect of appraisal completion. There was recognition that a wider piece of work was needed in order to raise awareness of the benefits of conducting appraisals to ensure these were meaningful to staff. A deep dive would be conducted and reported back to the Committee. The Committee noted the current level of vaccination rates for staff noting the need for 80% achievement by January with the Trust undertaking the actions required, as detailed within the Topical, Legal and Regulatory Update paper. The Committee requested sight of the vaccination rates for Covid-19 against regional figures, as offered for flu vaccinations to determine the Trust position. Statutory and mandatory training compliance was recognised at the highest level for 10 years at 93.43% with the Committee noting the significant progress made. **Committee Performance Dashboard** The Committee received the dashboard noting this had been considered by WSODG and noted the progress with DBS checks. 188 checks had been completed, against a trajectory of 167. The Committee also considered the detail of employee relation cases noting the significant reduction in the number of open cases and the health and wellbeing and pastoral care in place to support staff.

	NHS and System People Plan Update The Committee received a verbal update noting that the ICB had undertaken a review of the people hub and it had been identified that there was a requirement for a full time Chief People Officer on the ICB Board. Following the outcome of the review workshops would be held in the New Year to consider the recommendations and actions required. The Committee noted the vacancy position across the NHS with further vacancy controls in place. Work had taken place with staffside to determine the approach to be taken in respect of the controls in place. **Safer Staffing** The Committee received the report noting the continued moderate assurance which was offered. The Committee noted the current day fill rate of 95% and received a request to endorse the night fill rate, proposed at 95%. It was noted that the Trust was consistently achieving 95-98% fill rates for night shifts and therefore the Committee endorsed the fill rate of 95%. It was recognised that the fill rates would support staff wellbeing alongside patient safety due to having appropriate numbers of staff on shift. **Centralised Temporary Staffing Service** The Committee received the report noting the developments of the service with the Trust looking to move to a centralised temporary staffing service. The Committee noted the benefits that would be realised through the centralisation of the service and improvements and widening of the existing service provision. **Healthcare Support Worker/Industrial Relations Report** The Committee received the report noting the risks associated with the band 2 and 3 job descriptions for Healthcare Support Workers and recognising the work undertaken in respect of ward establishments. This would support the move of bandings for relevant staff. It was recognised that the Trust historically had good relationships in respect of industrial relations, and it was noted that the Trust continued to support staffside representatives to further develop relationships.
	Lack of Assurance in respect of SO 2b **Issue: Making ULHT the best place to work** **Guardian of Safe Working Quarterly Report** The Committee received the report noting that the aim for locally employed Doctors to have a clinical supervisor had not yet been achieved

due to the availability of staff wishing to take on the additional responsibility.

It was noted that there had been an increase in exception reports as a result of locally employed Doctors now exception reporting. Mechanisms were in place to capture this data which would be report to future Committees.

Equality, Diversity and Inclusion Group Upward Report
The Committee received the report noting that statutory reporting remained on track, including the Equality Delivery System for which data was being gathered.

Mutual mentor programmes were considered with the Committee noting the reverse mentoring programme in place across the Trust with a desire for a more formal mentoring programme to be developed.

EDI Annual Report
The Committee received the report for information noting that this had been through the relevant approvals and was offered for ratification.

Culture and Leadership Group Upward Report
The Committee received the report noting the progress that was being made in respect of the Culture and Leadership programme with this moving from the scoping to discovery stage.

The Committee noted the noted that joint working was commencing with Lincolnshire Community Health Services NHS Trust as part of the Group Model developments.

It was recognised that the work of the Group was also focused on Just Culture and it was reflected that this was fundamentally linked with the Patient Safety Incident Response Framework with confirmation provided on the joint work across the Trust.

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

Medical Education Update
The Committee received the improvements in the quality of post-graduate training was noted following a review from Health Education England (HEEM) however there were some actions to be addressed at the Lincoln site.

It was also noted, from a recent undergraduate visit that there was limited space noted in outpatients however actions were in place to support teaching.

	University Teaching Hospital Group Upward Report The Committee received the report and memorandum of understanding which was now in place across the Trust and University of Lincoln. It was recognised that further work was required in respect of the financial model with support offered from Committee members to further develop the model. **Research and Innovation Update** The Committee received the report noting that clinical pressures continued to impact on the ability to hold research related clinics. It was recognised that work continued on wider planning events with the University of Lincoln which was supporting collaborative working alongside innovation events. Engagement with the OD team was in place to support culture and growth with a focus on doing basics brilliantly and growth of added value in the organisation. The Committee raised the issue of reporting and associated metrics making a request for the wider consideration of the metrics used in reporting to the Committee. It was recognised that this would need to be explored further before reporting could be offered to the Committee.
	Assurance in respect of other areas: **Topical, Legal and Regulatory Update** The Committee received the report for information noting that the updates contained were considered through other reports to the Committee. **Integrated Improvement Plan** The Committee received the report which was taken as read noting the moderate assurance which was offered. **Internal Audit Recommendations** The Committee received the report noting the outstanding actions which would be followed up to ensure these were closed with the auditors. **CQC Action Plan** The Committee received the report noting there was no change from the previous month and recognised the need for these to be reviewed in detail in order to ensure evidence was provided to enable traction to be demonstrated and actions to be closed.
Issues where assurance remains outstanding	None

for escalation to the Board	
Items referred to other Committees for Assurance	The Committee referred to the Finance, Performance and Estates Committee the issue of Personal Emergency Evacuation Plans, discussed under any other business, in order to seek assurance on the use and management of these plans.
Committee Review of corporate risk register	The Committee received the risk register noting the current risks presented.
Matters identified which Committee recommend are escalated to SRR/BAF	No areas identified
Committee position on assurance of strategic risk areas that align to committee	The Committee considered the reports which it had received which provided assurances against the strategic risks to strategic objectives. The Committee agreed that Objective 2a – A modern and progressive workforce should be uprated to Green as a result of the levels of controls and assurance provided to the Committee.
Areas identified to visit in ward walk rounds	No areas identified

Attendance Summary for rolling 12 month period

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

X in attendance
A apologies given
D deputy attended

Report to:	Trust Board
Title of report:	Finance, Performance and Estates Committee Assurance Report to Board
Date of meeting:	23 November 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 to inc AEs reporting schedule, 6-Facet Survey progress** The Committee received the report noting the progress on the 6-facet survey and reflected that this could be utilised to support prioritisation of capital spend. It was recognised that this could, once validated, also support the review and updating of the estates strategy. It was noted that the Patient-Led Assessments of Care Environments (PLACE) inspections continued across the Trust with Pilgrim having been completed, the outcome of the inspection would be received by the Committee. The Authorised Engineers (AEs) report was received with the Committee noting the assurances offered and action plans in place to address areas of concern. This demonstrated good compliance with AE audits and the requirements to have named AE/Aps. In addition, the committee received the annual AE-Lift and quarterly AE-Water audit reports. Improvements were also noted in the Premises Assurance Model (PAM) during the course of the year with updates continuing to be offered to the Committee on a quarterly basis. **Pilgrim Emergency Department Steering Group Upward Report** The Committee received the report which was taken as read noting that there were no escalations.

	Emergency Planning Group Upward Report – to inc BCP plan and percentage tested The Committee received the report which was taken as read however noted that the Business Continuity Plan update would be carried forward as the work was not yet complete.
	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 with limited assurance, noting that the Trust had delivered in line with plan with the deficit position reported at £15.4m, aligned to the anticipated trajectory in month 7. An over delivery in cost savings of £5.7m was reported, offsetting external pressures including inflation and industrial action. The Committee noted the focus on the contract planning for the 24/25 year with some updates to the contract expected. The Trust remained on plan to spend £50.8m of capital funding with further spending expected during November. The Trust had overcommitted on capital spend in order to ensure delivery of the programme, working to a risk-based plan. The Committee noted the risks associated with the IFRS16 (Right of Use Assets) with a potential risk of circa £1mto the Lincolnshire capital forecast in the financial year. There was a high expectation of this risk being managed. The Committee received and noted the Capital, Investment and Revenue Group upward report noting there were no major cases considered in month requiring Board approval. The position in respect of the National Cost Collection was noted with the Committee continuing to support the delegated authority to the Director of Finance to approve the submission. This would be presented to the Committee in December. The efficiency position remained at a £28.1m target, with forecasting in place for each scheme and a push for full delivery of all schemes, in order to deliver the forecast £30.2m in line with the Financial Recovery Plan.
	Assurance in respect of SO 3c Enhanced data and digital capability **Information Governance Group Upward Report** The Committee received the report noting the continued operational pressures impacting on the ability to progress actions associated with the Data Protection Security Toolkit (DSPT).

	The Committee noted that this would be raised at the Trust Leadership Team meeting at the end of November in order to ensure clarity on the actions required and the capacity required for delivery. The continued challenges were noted in respect of Subject Access and Freedom of Information Requests within the Trust.
	Assurance in respect of SO 3d Improving Cancer Services Performance **Operational Performance against National Standards** The Committee received the report noting the position on cancer services with progress being seen across a number of services. Improvement had also been seen in respect of Faster Diagnosis Standards with the Trust being above the national trajectory. The Committee noted the proposal to consider the Board Assurance Rating to amber in respect of cancer services however noted that was a need for sustained improvements to be seen before the rating could be improved.
	Assurance in respect of SO 3e Reduce waits for patients who require planned care and diagnostics to constitutional standards **Operational Performance against National Standards** The Committee noted that performance was behind trajectory for delivery of the 0 position for 78-week waits however there was clarity on achievement of 0 by December 2023. The Committee also noted confidence on the achievement of the 65-week wait position by the ned of March 2024 however concern was noted on achieving first appointments by 31 December 2023. This continued to be worked through.
	Assurance in respect of SO 3f Urgent Care **Operational Performance against National Standards inc Winter Plan** The Committee received the report noting the command-and-control structure in place to support improvements in Urgent and Emergency Care. Significant progress had been made in respect of 12-hours waits in department, 4-hour performance and ambulance handovers. The Committee received the winter plan noting the risk associated with this due to current bed capacity. The Committee noted that additional beds detailed as being required within the report were system, not Trust beds. **Improvement Programme Deep Dive – Urgent and Emergency Care** The Committee took the report as read noting the improvements made and the need to undertake a reassessment in due course.

	Assurance in respect of SO 4a Establish new evidence based models of care **Specialty Reviews Update** The Committee deferred the paper to ensure sufficient time was afforded to the paper. **EMAP Leadership and delivery programme update** The Committee deferred the paper to ensure sufficient time was afforded to the paper. **Future Models of Care with Primary Care/Dental** The Committee deferred the paper to ensure sufficient time was afforded to the paper. **Financial Impact of Grantham UTC** The Committee deferred the paper to ensure sufficient time was afforded to the paper.
	Assurance in respect of SO 4c Successful delivery of the Acute Services Review No reports due.
	Assurance in respect of other areas: **Annual Planning** The Committee received the report with moderate assurance noting the systems and processes in place for planning to be undertaken. There would be a bottom-up approach to planning with CIP workshops also being held to tie into the overall Integrated Improvement Plan. The Committee recognised the challenges in respect of productivity with risks remaining around staff morale, fatigue and capacity. **Integrated Improvement Plan** The Committee received and took the report as read noting the updates provided and the current position of assurance with patient, people and partner objectives rated as moderate and services rated as limited. The Committee noted the actions in place to recover the metrics which were not delivering with appropriate monitoring in place. Planning for the coming year would take in to account current delivery of those metrics not delivering, to consider if these remained appropriate. **Improvement Steering Group Upward Report inc Family Health Deep Dive** The Committee received the report with limited assurance based on the delivery of improvement programmes to date. The Committee noted the increase in targets for quarters 3 and 4 in respect of CIP delivery.

	It was also noted that a review of the medical staff rostering programme would be undertaken in order to understand the deteriorating position. The Committee would be sighted on the findings. The Committee received the Family Health Deep Dive for information. **Committee Performance Dashboard** The Committee received the performance report noting that there had been some significant improvements in length of stay. Some recovery of performance was also being seen in cancer services with a need to ensure that this improvement was sustained. **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 updates provided.
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	D	J	F	M	A	M	J	J	A	S	O	N
Dani Cecchini, Non-Exec Director	X	X	X	X	X	D	X	X	X	X	X	X
Director of Finance & Digital	X	X	X	X	X	X	X	X	X	X	X	X
Chief Operating Officer	X	X	X	X	X	D	X	X	D	X	X	X
Director of Improvement & Integration	D	X	X	X	X	X	X	X	X	X	X	X
Sarah Buik, Associate Non-Executive Director	X	X	A	X	X	X	X	X	X	X	X	X

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

Report to:	Trust Board
Title of report:	Finance, Performance and Estates Committee Assurance Report to Board
Date of meeting:	21 December 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 **Health and Safety Committee Upward Report** The Committee received the report noting that this had been a positive meeting. Escalation was made to the Committee in respect of fire compartmentalisation and fire safety risks with the risks recently being confirmed through the Risk Confirm and Challenge meeting which remained at 20. It was noted that whilst significant progress had been made there continued to be an underlying risk which would lead to patient safety concerns. The Committed noted ongoing concern in respect of medical and nursing officer representation at the medical gases group with an action taken by the Chief Operating Officer to address this. The draft Health and Safety Strategy was received with the Committee noting the progress that had been made in developing this and noted that further development would be undertaken to include the outcome of the British Safety Council report, once received. The Committee received the Health and Safety Annual Report for 2022/23 (appendix 1) noting the comprehensive nature of the report and agreed to recommend that the Board ratify this report. It was noted that this report had been received relatively late in the year – this was due to revisions required timing factors of the Health and safety Committee. The terms of reference for the H&S Committee were received and ratified by the Committee, subject to minor amendments.

	Pilgrim Emergency Department Steering Group Upward Report The Committee received the report noting that, whilst there were no major issues with the works, the sink hole that had appeared had caused some issues for the contractors. This was however being addressed.
	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 financial position year to date and at month 8 remained on plan. The year-to-date deficit was reported at £15.1m against the original £20.8m plan. The Committee noted the cash position at £35.4m and the Better Payment Practice Code (BPPC) performance was report at 93% and 86% for value and volume respectively. Continued improvement was being seen in respect of BPPC however it was noted that this was at a slower rate than hoped. The Trust continued to be ahead of plan in respect of Cost Improvement Plans (CIP) with delivery of £23.7m at month 8 which is £8.1m favourable to planned savings. The Committee noted the work undertaken by the ICS in respect of a revised financial position for the second half of the year however noted that there had been no confirmation of the revised plan by NHS England. Therefore, the Trust and System would continue to work to the original plan although noting that changes will be required in future months. The Committee noted the ongoing external pressures including inflation and industrial action which continued to be offset through over delivery of CIP, although delivered through technical items in month 8. The Committee received and noted the contract report and upward report from the Capital, Revenue and Investment Group. The Capital position was noted with an increase in the overall funding allocation to £51.3m as of month 8. It was noted that spend was behind plan with the Committee approving a revised over commitment of capital funding of £3m. Previously, the capital spend over commitment was in support of early spending against the EPR business case for which funding has now been approved. Whilst the capital position was behind plan the Committee noted confidence on the delivery based on historic delivery. **National Cost collection Submission** The Committee received the report noting that all files were submitted to the deadline, free of all mandatory errors. Final sign off was awaited from NHS England.

	Procurement Update The Committee received the quarterly update with significant assurance noting that there had remained a focus on CIP with delivery to date of a £1.6m saving, this was supporting the FRP. The Committee was pleased to note the shortlisting of Procurement Team members in the National Healthcare Supply Association Awards with the Stores and Logistics Manager receiving a highly commended award for materials management. Stock outs and Important Customer Notices (ICNs), which had been reported in July as an area of concern continued to have some issues however it was recognised that this was a national issue but was being managed well. The Committee noted the approval of the EPR through the cabinet office and the ongoing work in the tendering of CDCs and endoscopy equipment. The future view of contract awards was noted with a number due to be received by the Committee in quarter 4.
	Assurance in respect of SO 3c Enhanced data and digital capability **Digital Hospital Group Upward Report** The Committee received the report noting that there were no escalations. It was noted that the EPR procurement process had been stopped to enable the Trust to conduct market engagement exercises, at which point the procurement would recommence. It was noted that this would have a 3–4-month impact on the current timescales however would better support the procurement process and choice of provider. Ongoing discussions regarding Microsoft 365 and the ability for Patient Identifiable Data to be captured were noted with the creation of a task and finish group to conclude.
	Assurance in respect of SO 3d Improving Cancer Services Performance **Operational Performance against National Standards** The Committee received the report noting the substantial work that had been undertaken in order to deliver against the 2-week wait target. The further faster work was focusing on supporting patients to be treated ensuring that first outpatient appointments were offered in a timely manner.

	Assurance in respect of SO 3e Reduce waits for patients who require planned care and diagnostics to constitutional standards **Operational Performance against National Standards** The Committee noted that the Trust expected to achieve zero 78-week waits in early February and zero 65-week waits by the end of the financial year. Support had been in place by the ICB, and it was noted that the system support had helped drive the Trust's position. The Committee noted the work being undertaken on 'did not attend' patients recognising that there were improvement opportunities within the Trust to improve the position.
	Assurance in respect of SO 3f Urgent Care **Operational Performance against National Standards** The Committee received the report noting an improvement in the category 2 mean as a result of true cohorting being in place at Lincoln and the positive impact through the work undertaken via Gold Command which had focused on ensuring good patient flow across all pathways. A MADE event had been held face to face across Pilgrim and Lincoln with actions in place to discharge a number of patients in time for Christmas. **Industrial Action planning and impact on UEC and 78 and 65 week waits** The Committee received the report noting the planning which was in place to ensure appropriate actions were taken in response to industrial action which supported service delivery. It was recognised that the work had been undertaken in such a way that productivity increases had been maintained through different ways of working. The Committee noted the moderate assurance which was offered and would receive an update on the outcome of the work once the next round of industrial action concluded. The Committee noted the wider issue of capacity within the Trust and improvement activities that were underway noting that a series of reports would be offered over the coming months in respect of pathway 0, SAFER workstreams and the wider discharge system approach.

	Assurance in respect of SO 4a Establish new evidence based models of care **Specialty Reviews Update** The Committee received the report and was pleased to note that 10 specialty reviews had been completed in year and noting that 6 would be completed in the coming year. The Committee noted the reduction in the number of reviews which would be completed receiving assurance that this was to enable the team to support delivery in addition to conducting scoping and mapping. The Committee considered the assurance level of the report agreeing that this was moderate due to the processes in place. **EMAP Leadership and delivery programme update** The Committee received the report with moderate assurance, noting the work that had been undertaken to date which had identified areas of fragility against which the EMAP could focus. It was recognised that the Trust would not be able to resolve all issues in isolation due to wider regional and national issues. These specifically focused on the difficulties to recruit to Haematology and Oncology Consultants. The Committee was pleased to note that the Trust was hosting the EMAP Managing Director post which had been recruited to with opportunities to improve population health across the East Midlands. **Future Models of Care with Primary Care/Dental** The Committee received the report noting the work taking place to develop further partnership working with Primary and Dental Care. It was noted that the focus agreed by the Executive Leadership Team would be to support sustainable services in primary care. The Committee noted the moderate assurance and the need to conduct due diligence to continue to progress work. The Committee noted the immediate opportunities and agreed that progress with Dental would be put on hold due to capacity. **Financial Impact of Grantham UTC** The Committee received a verbal update noting that the financial model continued to be developed with the ICB in order to ensure a holistic view in a single system wide document.
	Assurance in respect of SO 4c Successful delivery of the Acute Services Review No reports due.

	Assurance in respect of other areas: **People and OD Referral** The Committee received a referral from the People and OD Committee in relation to Personal Emergency Evacuation Plans (PEEPs) with assurance sought on the use and monitoring of these. The Committee noted that these were in use at a local level noting that due to the confidential nature these were put in place and monitored by line managers. Policies and procedures are in place to support the use of PEEPs for staff. **Integrated Improvement Plan** The Committee received the report with overall limited assurance noting that patients, people and partner objectives continued to offer moderate assurance but assurances for objectives in respect of services remaining limited. The Committee noted national planning for the 24/25 year anticipates a target of 130% of activity against 19/20 performance. It was noted however that planning guidance had not yet been received and therefore targets could change. The Committee noted the approach taken in regard to 78, 65 and 2 week waits which had shown improvements along with the Trust being an early adopter of further faster work and the second most improved Trust in the Country for 52 week waits. The Committee specifically noted the lack of progress against research and innovation objectives which was being addressed by the People and OD Committee. **Improvement Steering Group Upward Report inc Nurse Agency Deep Dive** The Committee received the report with limited assurance noting that productive theatres and outpatient programmes were reported as amber along with the Medical workforce extra contractual rate initiative. All other programmes of work were reported as green. It was noted that the best performing programmes had ben those in estates, nurse agency spend and procurement, which were all supporting delivery of the Financial Recovery Plan. The deep dive in to nurse agency spend (appendix 2) was received and noted with the Committee recognising the hard work of the teams to deliver. Of particular note was the nomination and shortlisting of the Director of Nursing for HSJ Clinician of the Year Award in respect of the nurse agency work.

	Committee Performance Dashboard The Committee received the report, with limited assurance, which was taken as read. Improvements were noted, through the SPC charts, including 52 and 65 week waits, 28-day Faster Diagnosis Standard, 2-week breast symptomatic and 104 day waits. It was noted that there was some deterioration noting in 28-day breaches, ambulance conveyances and waiting lists. **Internal Audit Recommendations** The Committee received the report which was taken as read. **CQC Action Plan** The Committee received the report which was taken as read.
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	J	F	M	A	M	J	J	A	S	O	N	D
Dani Cecchini, Non-Exec Director	X	X	X	X	D	X	X	X	X	X	X	X
Director of Finance & Digital	X	X	X	X	X	X	X	X	X	X	X	X
Chief Operating Officer	X	X	X	X	D	X	X	D	X	X	X	X
Director of Improvement & Integration	X	X	X	X	X	X	X	X	X	X	X	X
Sarah Buik, Associate Non-Executive Director	X	A	X	X	X	X	X	X	X	X	X	X

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

United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*11th January 2024*
Item Number	*Item 12*

Integrated Performance Report for November 2023

Accountable Director	*Sameedha Rich-Mahadkar, Director of Improvements and Integration*
Presented by	*Sameedha Rich-Mahadkar, Director of Improvements and Integration*
Author(s)	*Sharon Parker, Performance Manager*
Report previously considered at	*N/A*

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

Risk Assessment	*N/A*
Financial Impact Assessment	*N/A*
Quality Impact Assessment	*N/A*
Equality Impact Assessment	*N/A*
Assurance Level Assessment	*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

Falls

There were 2 fall resulting in severe harm during the month of November. Falls Prevention Steering Group (FPSG) provides oversight, receiving Divisional performance reports providing assurance of actions being taken to improve in areas reporting increased numbers of incidents.

Pressure Ulcers

There have been 42 category 2 pressure ulcers reported in November 2023 which is a decrease of 2 from the previous month of which 9 were device related, an increase of 5 from October. A monthly educational bulletin will continue to be shared. A focus on ensuring wards/departments are utilising the SSKIN Tissue Viability Management Plan effectively to minimise the risks of patients skin deteriorating through timely interventions.

VTE

The Trust achieved 95.04% (target 95%) compliance with VTE assessment. A VTE Nurse Specialist will be appointed, however, there are ongoing discussions around the funding for this post.

Never Event

There have been no Never Events reported during the month of November 2023.

Medications – November data not yet available

For the month of October, the number of incidents reported in relation to omitted or delayed medications has decreased further to 14%, which is better than the target set (15%). There has now been a run of 7 data points below the mean average demonstrating statistically significant improvement. Medication incidents reported as causing harm increased slightly to 14.2%, which is just above the mean average and above the Trust's target of 10.7%. A medicines management project group has been established and is working 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 103.31 for November. SHMI is at the lowest levels the Trust has reported and is within the 'As expected' banding. 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. Work is also underway to standardise the morbidity and mortality review process across the Trust.

eDD Compliance

eDD Performance continues to be below the 95% target, currently at 91%. There is a task and finish group chaired by the Deputy Medical Director to help improve compliance.

Sepsis compliance – based on October data

The screening compliance for inpatient adults was at 94% and for inpatient child 88% for October. Based on the returned reviews for adult inpatients, staff appear to not document the screen on the non-infective patients that are NEWS >5. There were six children this month, that had a delayed or missed sepsis screen, all of these patients were found to have a viral illness and raised PEWS due to this. No harm found from any of the delays.

IVAB ED / Inpatient child - The administration of IVAB for children in ED decreased to 57% and inpatient children increased to 100%. The delays within ED where due to one child diagnosed bacterial meningitis, unable to obtain antibiotic administration time. Two children treated as viral initially then given IV when deteriorated.

Duty of Candour (DoC) – October Data

Verbal compliance for October reduced to 53% against a 100% target, there was also a reduction to 53% 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 November's performance.
At the time of writing this executive summary (9th December), the Trust has 11 PCR confirmed positive COVID inpatients. The November peak was 7 patients, with the current position following both local/regional trends at present of no concern. Of 1158 Flu tests conducted in November only 2 patients returned positive. However RSV is showing its seasonal peak with 152 patients returning as positive during November.

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 100.2%, Electives 91.1%, Outpatient Firsts (including Procedures) 96.1%

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. 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 3 main areas to focus quick wins were identified as 4hour performance, >12hours aggregated time of arrival rather than 12+ trolley wait and Cat 2 Mean time from Ambulance Partners.

The 23/24 4h-hour performance target has been set for yearend achieving 76% with a rolling monthly ambition to track achievement. November has not met its target of 70.94%, out turning at 58.31% a negative variance of 12.63%. The SPC chart below documents both the 22/23 and 23/24 target to reflect performance ambition.
This trajectory is based on Type 1 and co-located Type 3 activity. Combined type 1 and type 3 activity is demonstrating an achievement of 71.05% 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.

Both >12 hour aggregated time of arrival and 12+ hour trolley waits showed an improvement during November of 489 less breaches. And 9.53% less patients spending over 12 hours in total in the department. A daily/weekly ambition has been set throughout Nov/Dec with each target being met. ULHT has shown a daily reduction of >100 patients to now under 50, with further work to go or commence to aid this further.

Ambulance Response Time: Cat2 ambition is for 30 minutes maximum, with November showing an average of 42minutes daily compared to over an hour during Sept/October. To note the below values on SPC are “vehicles” that went over 59mins. A number of these will have been the same patient. But as seen the value has significantly improved from a daily average going over 59min handover of 31 to Novembers output of 16.

Fractured Neck of Femur 48hr Pathway (#NOF)

The trust has seen a significant improvement in the compliance for #NOFs going to theatre within 48 hours. November outturn is 87.5% a ~40% improvement to that seen in September 2023.

Length of Stay

Non-Elective Length of Stay is currently 0.17 against the agreed target. Current performance is 4.67 days shows an improvement of 0.21 days compared to October. The average bed occupancy for November against “Core G&A” was an average of 94.62%. An average of 23 escalation beds were open to maintain adequate and safe flow within the acute sites. By doing so the occupancy vs escalation brought a safer percentage of 92.53% against the new national standard of <92%.
System Partners were challenged with identifying timely support to facilitate discharge from the acute care setting for pathways 1 to 3. In November Pathway 2 showed the biggest improvement reducing length of stay from 21.4 days to 16.8 days.
The Trust also now records and monitors the percentage of discharges within 24hrs of the predicted dated of discharge (PDD). Current compliance is 36.8% against a target of 45%.

Referral to Treatment

October demonstrated an improvement in performance of 0.75%. September outturn was 49.38% versus 50.13% in October. The Trust is now reporting patients waiting over 65 weeks as well to 52 weeks. The Trust reported 1,533 patients waiting over 65 weeks, which is a decrease of 426 patients on the September reported position. The position has close monitoring and scrutiny.
At the end of November, 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 November at 75 >78-week waiters. This position was lower than our forecast position of 85

Waiting Lists

Overall waiting list size decreased again in October. October reported 73,992 compared to July's position of 74,662, a decrease of over 1000 in 2 months. 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 3rd December 2023, ASI recovery has demonstrated a slight deterioration at 1332 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 November reported a slight deterioration of 74.59% versus 77.51% in October. Compliance against the national target of 99%, there remains a negative variance of 24.41% against the nationally agreed target. Whilst the main area of concern remains Echocardiography, a continued month on month improvement is noted.

Cancelled Ops

November outturn for cancelled operations on the day was 1.68% which was an improvement of 0.36% on the October position of 2.04%. Three main reasons were lack of time, staff and equipment.

Included in the 1.68% of on the day cancellations, 32 patients were not treated within the 28 day standard which was the same position as last month

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 October, achieving 73.3% against a national KPI of 70%. The unvalidated November position is 75% 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.

62 day classic treatment performance for October was 48.7% a deterioration from the August position (54.43%) and against a national KPI of 85%.

104+ day waiters reduced to 42 at the end of November compared to 47 at the end of October. The highest risk speciality is colorectal with 20 pathways greater than 104 days.

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 – We moved into November 2023 with a Core Learning Rate of 93.43% against a Target of 94.00%. This is a further improved position when compared to October 2023, with a continued improvement seen over recent months.

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

Work continues to ensure that all areas and individuals are given the time to complete core learning modules, with focussed support being offered to those with low compliance (50% and less) through enhanced reporting provided Divisionally by the Education & Learning Team within our People & OD Directorate. Support measures continue to be implemented in terms of ESR user support and provision of 'pop-up' core learning sessions for departments and individual. The work to align the core and core+ offer to individual roles continues to be embedded across in line with the approved Mandatory Training Action Plan.

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 – We moved into November 2023 with a Sickness Rate of 5.54% against a Target of 4.70%. Sickness absence rates have remained stable over across 2023/24 so far, but is not seeing the level of reduction we had planned. We are continuing to work towards further reducing our vacancy level and as such, we are hopeful this continued improvement will impact positively on our colleague's health and wellbeing throughout 2023/24. New sickness absence reports have been developed and launched which will support our People & OD Teams and Divisional Managers to identify trends and areas of key focus.

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 have moved into November 2023 with an Appraisal Rate of 71.24% against a Target of 85.00%. This is a slight increase when compared to performance during October 2023. There is a need to see an improved position if we are going to improve Non-Medical Appraisals in line with the Q3 target, an d meet the year-end target overall. Continued focussed attention to areas which are

RAG rated 'red' are being discussed with teams directly, including through FPAM where relevant. Medical & Dental Appraisals for November 2023 was 94.00%, which is above the Q3 target.

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 November 2023 with a Turnover Rate of 11.30%. Although this is a slight decrease in compliance since October 2023, it is still within the year-end target of 11.50%. Turnover has continued to improve since peaking in August 2022, and we are now maintaining our Turnover position in line with trajectory and met our year-end target for 2023/24 by September 2023.

Organisational Development and our People Promise Manager continue to work with the Trust and ICB to explore retention and bring best practice into the organisation to address the challenges, planning currently underway for next year's system plan. Working towards a more robust process via ESR to capture leaver's data and understand trends. People & OD are working closely with Nursing & AHP Leads to develop a Staff Experience and Retention Strategy for these Staff Groups to support a sustainable Turnover position and ensure that there are Career Pathway opportunities for these staff.

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

Vacancies – We have moved into November 2023 with a Vacancy Rate of 8.01% against a Target of 5.50%. We have seen a continued reduction in our Vacancy Rate over the last 12 months as we have moved from a position of 11.35% in July 2022. Our Registered Nursing Vacancy Rates continue to reduce when compared to 2022 data and has seen November 2023 reduce further to 2.17% which is the third month we have been within target. Since April 2023, there has been an increase in the number of Nurse Associates which supports the Trust to robustly manage and co-ordinate against safer staffing requirements.

AHP recruitment remains a challenge locally and nationally. The increase in Vacancy Rate due to the increased establishment across the Trust is an area requiring continued focus to ensure that opportunities to reduce this are identified to further support the ambitions and

targets set by the Trust as part of our overall Workforce Plan for 2023/24. For AHP recruitment we have recruited a Resourcing Advisor to support this recruitment with a Talent

Acquisition approach, we are also looking at using one of our higher performing agencies to support this recruitment. There will also be a strong focus on the wider Workforce planning as we enter the Business Planning for 2024/25.

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 £15.1m YTD in line with plan.

CIP savings of £23.7m have been delivered YTD, which is £8.1m favourable to planned savings of £15.7m.

Capital funding levels for 2023/24 have been agreed with NHSE and system partners; the Trust delivered capital expenditure of £8.3m YTD, which is £8.7m lower than planned capital expenditure of £17.0m.

The November cash balance is £35.4m (plan £24.1m); this is an decrease of £5.9m against the March year-end cash balance of £41.3m.

Sameedha Rich-Mahadkar
Director of Improvements and Integration
December 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	Sep-23	Oct-23	Nov-23	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Clostridioides difficile position	Safe	Patients	Director of Nursing	9	14	8	7	60	P	
	MRSA bacteraemia	Safe	Patients	Director of Nursing	0	1	0	0	1	P	
	MSSA bacteraemia cases counts and 12-month rolling rates of hospital-onset, by reporting acute trust and month using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.01	0.01	0.01	0.01		H
	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	0.02	0.09	0.07	P	
	Pressure Ulcers category 3	Safe	Patients	Director of Nursing	4.3	1	0	0	3	P	
	Pressure Ulcers category 4	Safe	Patients	Director of Nursing	1.3	1	0	0	3	P	
	Pressure Ulcers - unstageable	Safe	Patients	Director of Nursing	4.4	5	9	7	40	F	
	Venous Thromboembolism (VTE) Risk Assessment	Safe	Patients	Medical Director	95.00%	94.75%	94.22%	95.04%	94.68%	F	
	Never Events	Safe	Patients	Director of Nursing	0	1	0	0	3	P	

OUTSTANDING CARE personally DELIVERED

Performance Overview - Quality

NHS United Lincolnshire Hospitals NHS Trust

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Sep-23	Oct-23	Nov-23	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Reported medication incidents per 1000 occupied bed days	Safe	Patients	Medical Director	4.30	6.16	5.56	Data Not Available	5.92	P	
	Medication incidents reported as causing harm (low /moderate /severe / death)	Safe	Patients	Medical Director	10.70%	13.20%	14.20%	Data Not Available	14.89%	F	
	Patient Safety Alerts responded to by agreed deadline	Safe	Patients	Medical Director	100.00%	None Due	100.00%	None Due	66.67%	F	
	Hospital Standardised Mortality Ratio - HSMR (basket of 56 diagnosis groups) (rolling year data 3 month time lag)	Effective	Patients	Medical Director	100	95.35	93.25	92.36	94.33	P	L
	Summary Hospital Mortality Indicator (SHMI) (rolling year data 6 month time lag)	Effective	Patients	Medical Director	100	102.96	103.02	103.31	103.12	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%	89.20%	89.90%	91.00%	89.33%	F	
	Sepsis screening (bundle) compliance for inpatients (adult)	Safe	Patients	Director of Nursing	90.00%	88.00%	94.00%	Data Not Available	89.82%	?	
	Sepsis screening (bundle) compliance for inpatients (child)	Safe	Patients	Director of Nursing	90.00%	91.00%	88.00%	Data Not Available	88.00%	F	
	IVAB within 1 hour for sepsis for inpatients (adult)	Safe	Patients	Director of Nursing	90.00%	91.00%	94.00%	Data Not Available	94.27%	P	
	IVAB within 1 hour for sepsis for inpatients (child)	Safe	Patients	Director of Nursing	90.00%	100.00%	100.00%	Data Not Available	75.60%	?	

OUTSTANDING CARE personally DELIVERED

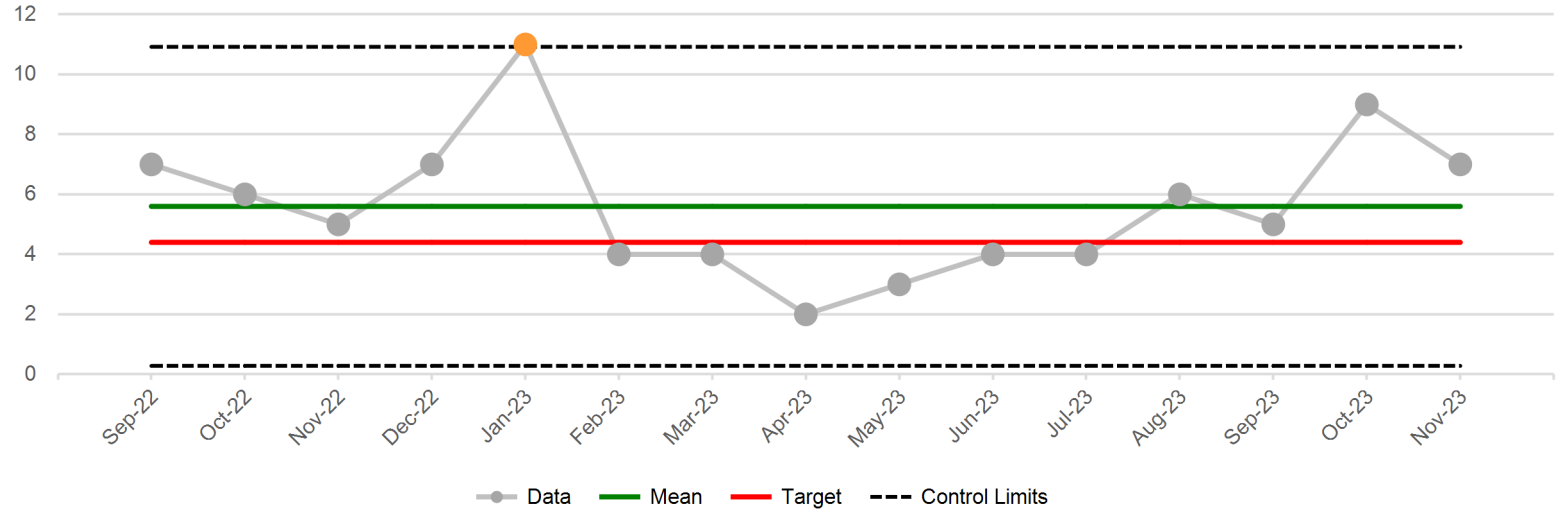
Performance Overview - Quality

NHS United Lincolnshire Hospitals NHS Trust

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Sep-23	Oct-23	Nov-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%	93.00%	92.00%	Data Not Available	91.95%	P	
	Sepsis screening (bundle) compliance in A&E (child)	Safe	Patients	Director of Nursing	90.00%	94.30%	93.00%	Data Not Available	91.56%	P	
	IVAB within 1 hour for sepsis in A&E (adult)	Safe	Patients	Director of Nursing	90.00%	96.00%	94.00%	Data Not Available	95.79%	P	
	IVAB within 1 hour for sepsis in A&E (child)	Safe	Patients	Director of Nursing	90.00%	77.00%	57.00%	Data Not Available	64.13%	F	
	Rate of stillbirth per 1000 births	Safe	Patients	Director of Nursing	3.80	2.91	2.72	2.72	2.55	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%	93.00%	53.00%	Data Not Available	83.29%	F	L
	Duty of Candour compliance - Written	Responsive	Patients	Medical Director	100.00%	90.00%	53.00%	Data Not Available	78.00%	F	

Performance Overview - Quality

Pressure Ulcers - unstageable



Nov-23
7
Variance Type
Common cause variation
Target
4.4
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of Nursing

Background:
Unstageable Pressure Ulcers.

What the chart tells us:
The Trust recorded 7 Unstageable incidents against a target of 4.4 per month.

Issues:
The number of Unstageable incidents has decreased by 2 from October 2023. 1of these incidents was device related.

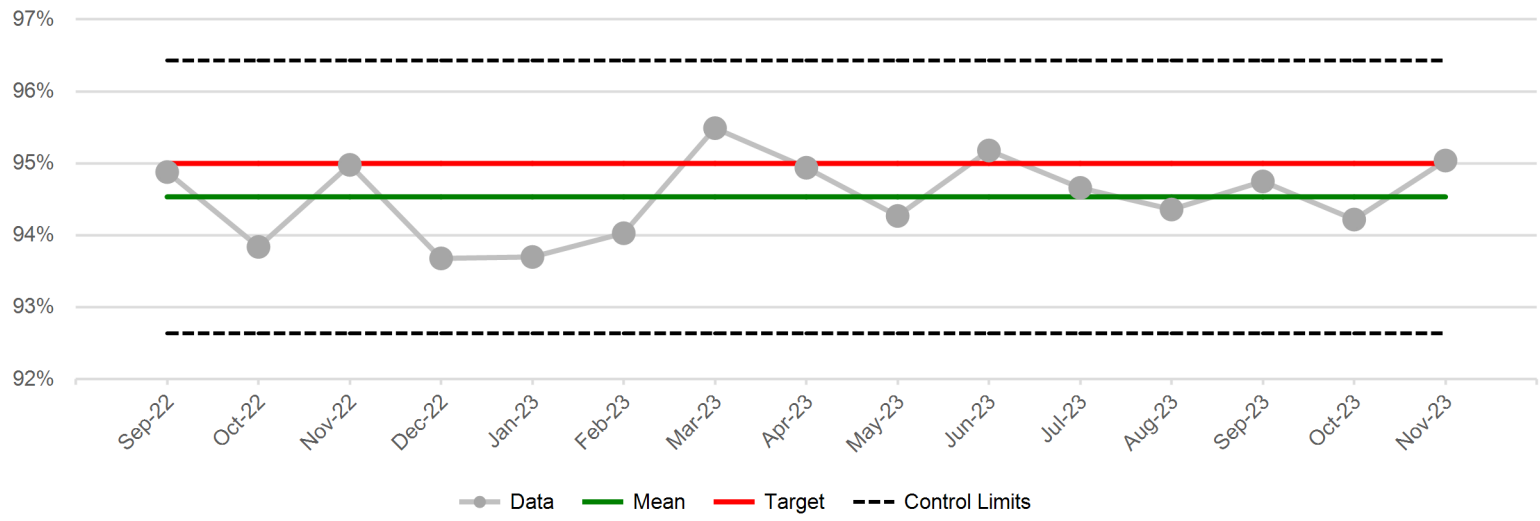
Themes identified as areas of focus to improve are:
•The majority of incidents were pressure ulcers that had deteriorated from existing pressure damage.
•Missed opportunities to request specialist collaborative support, leading to patients not obtaining the optimal preventative care plan.

Actions:
All Unstageable incidents will be reviewed at the weekly Patient Safety Response meeting to determine if they require an After Action Review (AAR).
A focus on ensuring departments are aware of how to escalate their concerns regarding patient's skin and ask for specialist advice to prevent further skin deterioration.
Education for staff regarding what equipment and management is most suitable to support patients with significant frailty or fractures.

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

Performance Overview - Quality

Venous Thromboembolism (VTE) Risk Assessment



Nov-23
95.04%
Variance Type
Common cause variation
Target
95.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Medical Director

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

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

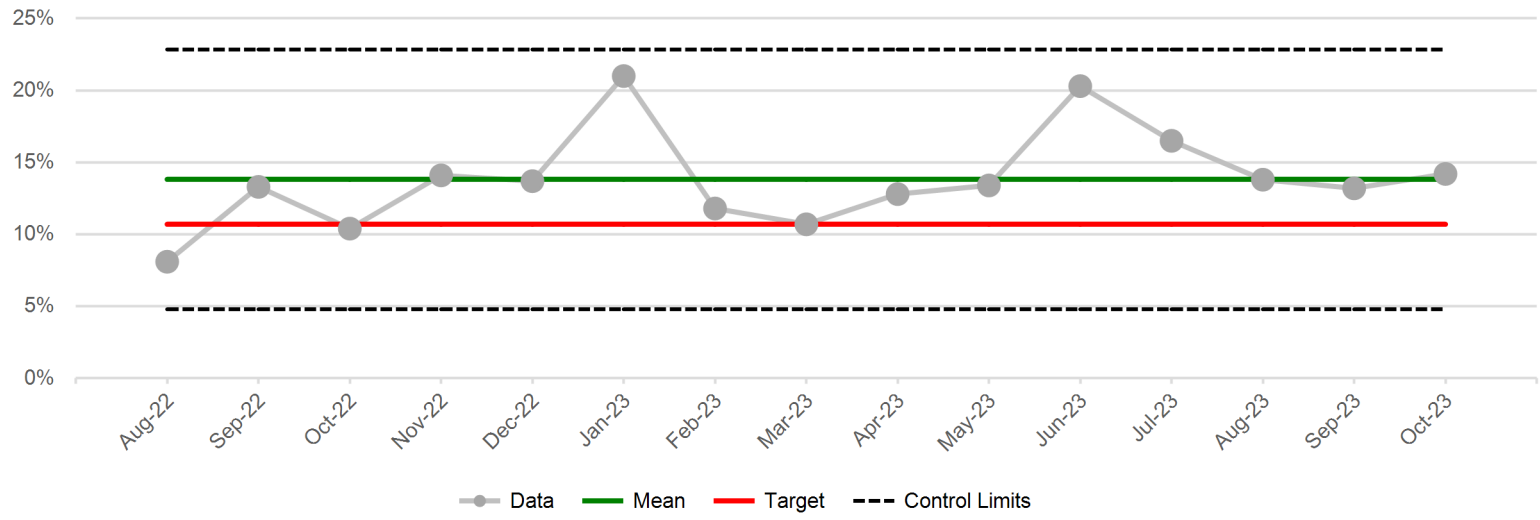
Issues:

Actions:
A paper was taken to Trust Leadership Team in November 2022 proposing the reinstatement of the VTE Specialist Nurse. This was agreed and work will now take place to identify a funding stream.
No narrative owner

Mitigations:

Performance Overview - Quality

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



Oct-23
14.20%
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 October the number of incidents reported was 196. This equates to 5.56 incidents per 1000 bed days. The number of incidents causing some level of harm (low /moderate /severe / death) is 14.2% which is above the national average of 11%.

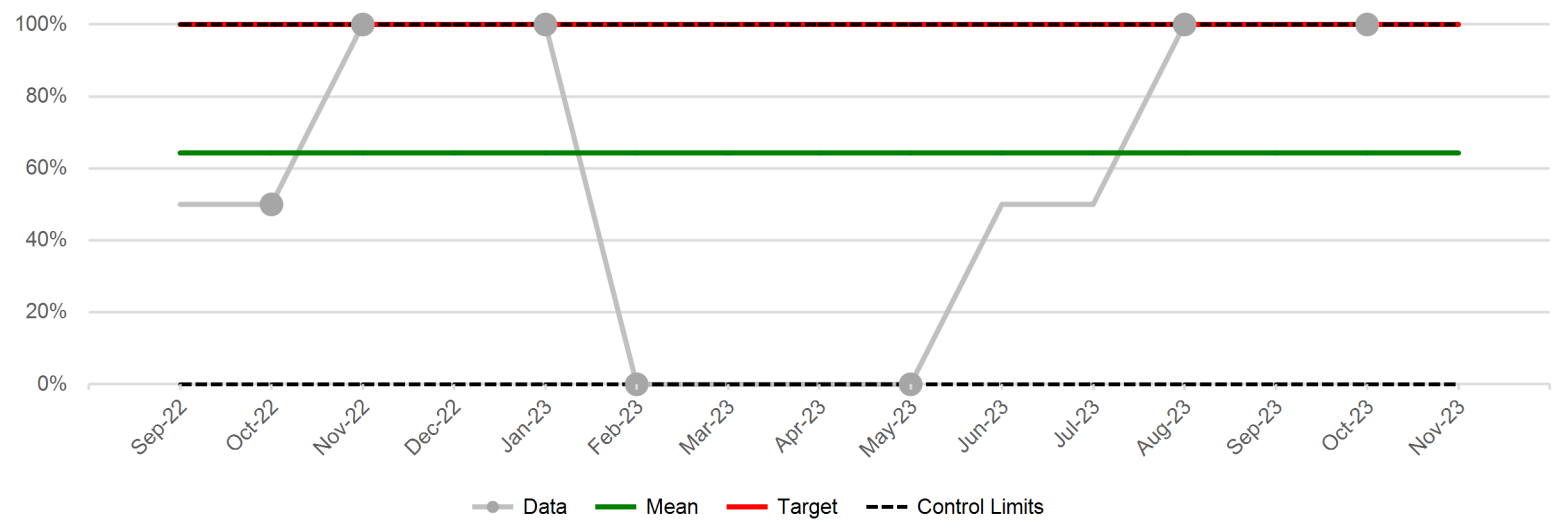
Issues:
The majority of incidents are at the point of administration of medication and the main error is omitting medicines

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

Patient Safety Alerts responded to by agreed deadline



Nov-23
None Due
Variance Type
Common cause variation
Target
100.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Medical Director

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

What the chart tells us:
There has been an improvement with compliance since May 2023.

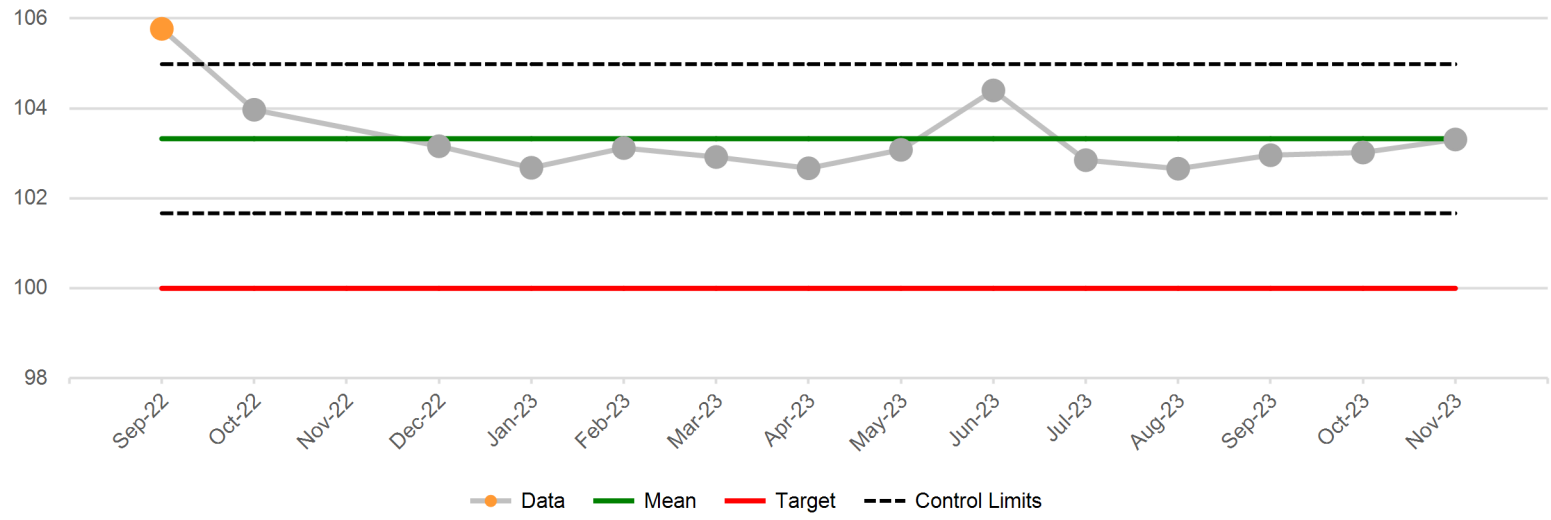
Issues:
The Trust were not demonstrating compliance with the target set for CAS Alerts. The performance has been below the lower control limit although this has now improved.

Actions:
An internal audit was undertaken this highlighted 8 recommendations, which have now been addressed. A new CAS/FSN Alerts Policy has been implemented. Alerts are now submitted onto the new DatixIQ Alerts Module, compliance will be monitored via Dashboards.

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

Performance Overview - Quality

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



Nov-23
103.31
Variance Type
Common cause variation
Target
To remain in 'as expected' range
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Medical Director

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

What the chart tells us:
SHMI is in band 2 'as expected'.

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

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

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

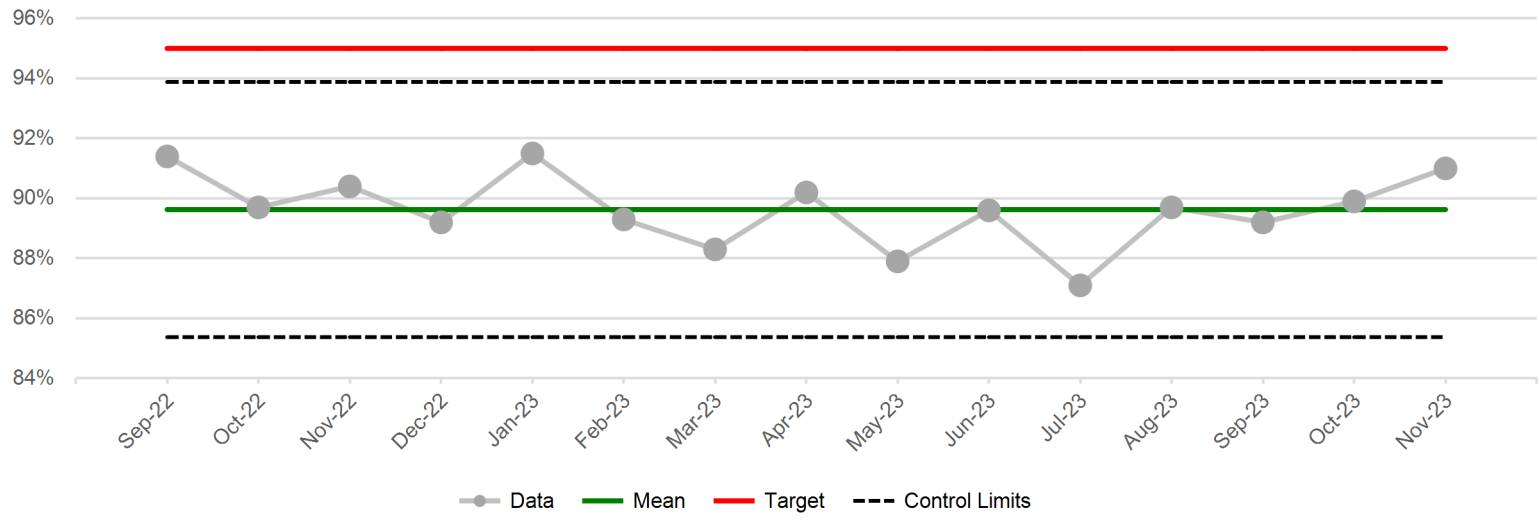
Mitigations:
The MEs have commenced reviewing deaths in the community which will enable oversight of deaths in 30 days post discharge of which learning can be identified.

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

HSMR is 92.36 (rolling 12 months)

Performance Overview - Quality

eDD issued within 24 hours



Nov-23
91.00%
Variance Type
Common cause variation
Target
95.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Medical Director

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

What the chart tells us:
eDD Performance continues to be below the 95% target, currently at 91%.

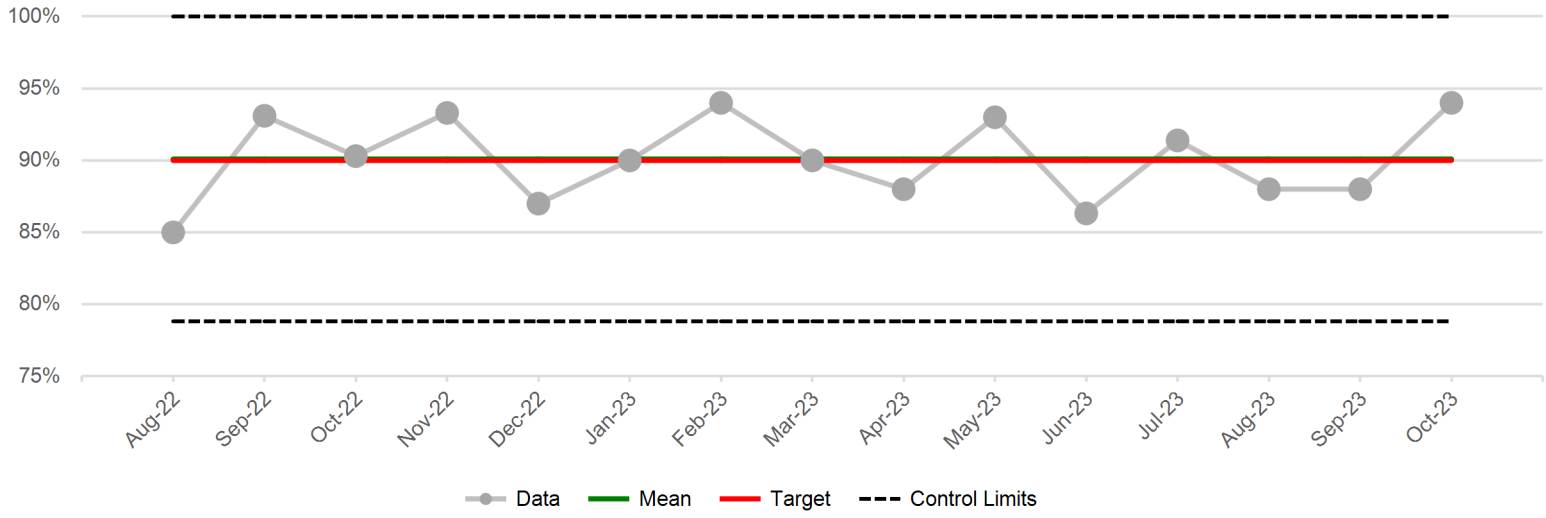
Issues:
Ownership of completion of the EDD remains an issue, including the timely completion.
No Narrative owner

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)



Oct-23
94.00%
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:
Sepsis screening compliance in adult inpatients has achieved and exceeded the 90% target.

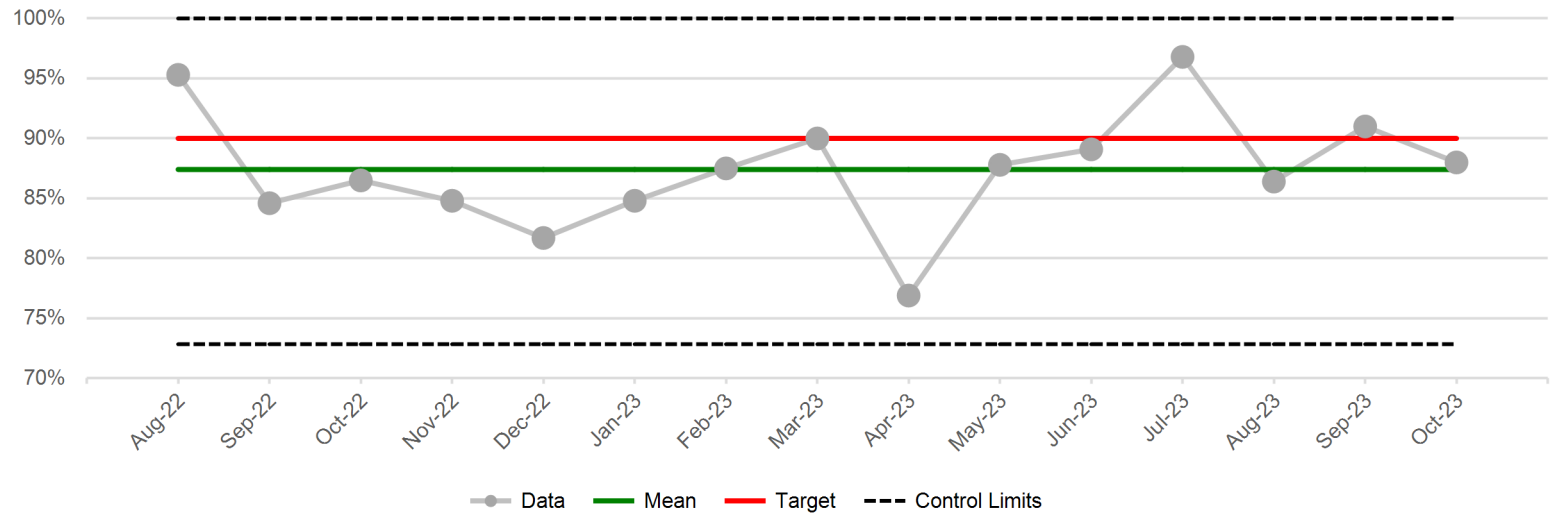
Issues:
Medical wards appear to be the most fragile trust wide.
Based on the returned reviews staff appear to not document the screen on the non-infective patients that are NEWS >5, however with targeted ward training appears to have improved results in the month of October.

Actions:
The sepsis practitioners continue to have increased 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 deteriorating patient study days.

Mitigations:
Await implementation of new NICE guidelines that emphasise amber flag actions for patients with a NEWs score of 5 and 6 which will allow for time to consider clinical presentation and reduce pressure on nursing staff to instigate treatment.

Performance Overview - Quality

Sepsis screening (bundle) compliance for inpatients (child)



Oct-23
88.00%
Variance Type
Common cause variation
Target
90.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of Nursing

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

What the chart tells us:
The compliance for Sepsis screening this month was 88.0%. 44 children out of 50 were screened for Sepsis within the 1 hour timeframe

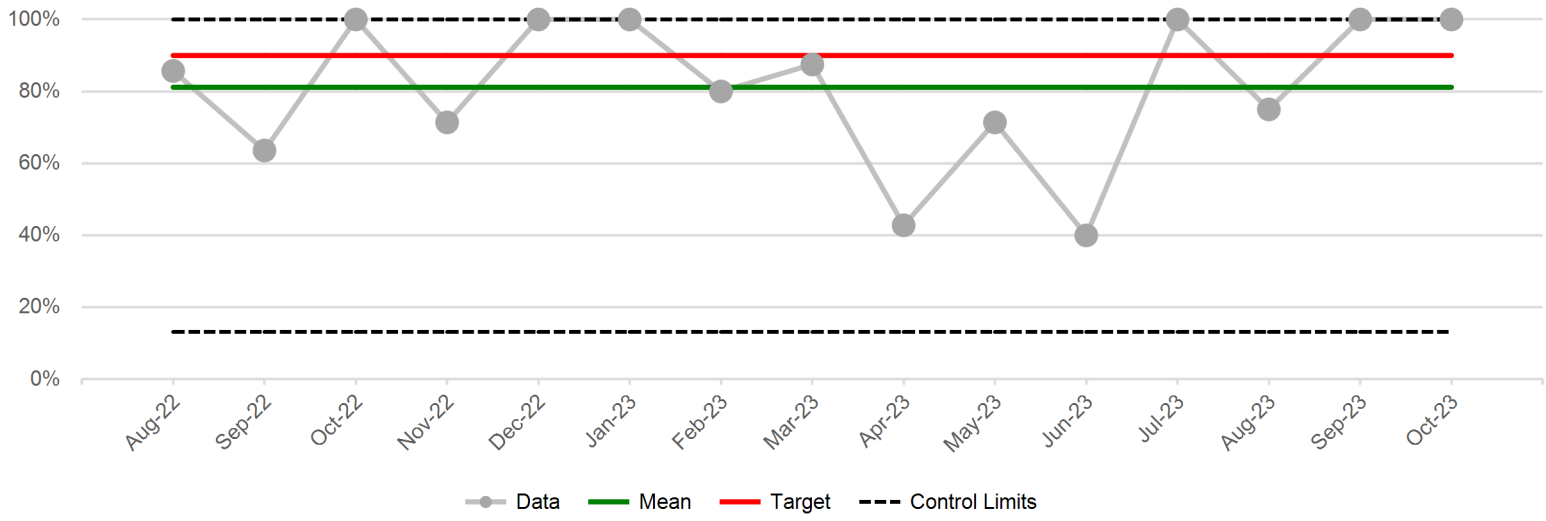
Issues:
There were six children this month, within inpatient areas that had a delayed or missed sepsis screen. All 6 of these patients were found to have a viral illness and raised PEWS due to this. No harm found from any of the delays

Actions:
There are some new staff in inpatient areas that have been identified as needing sepsis training. Sepsis Practitioner and clinical Educator working together to deliver this.

Mitigations:
Harm reviews completed for all 6 of the patients and no harm found, Data sent to ward managers and clinical educators to do internal harm reviews also and identify their own learning needs.

Performance Overview - Quality

IVAB within 1 hour for sepsis for inpatients (child)



Oct-23
100.00%
Variance Type
Common cause variation
Target
90.00%
Achievement
Variation indicates inconsistently passing and falling short of the target
Executive Lead
Director of Nursing

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

What the chart tells us:
The compliance for IV antibiotics within 1 hour as treatment for Sepsis was 100% this month. There were 2 children that were treated for Sepsis and they were both treated within 1 hour.

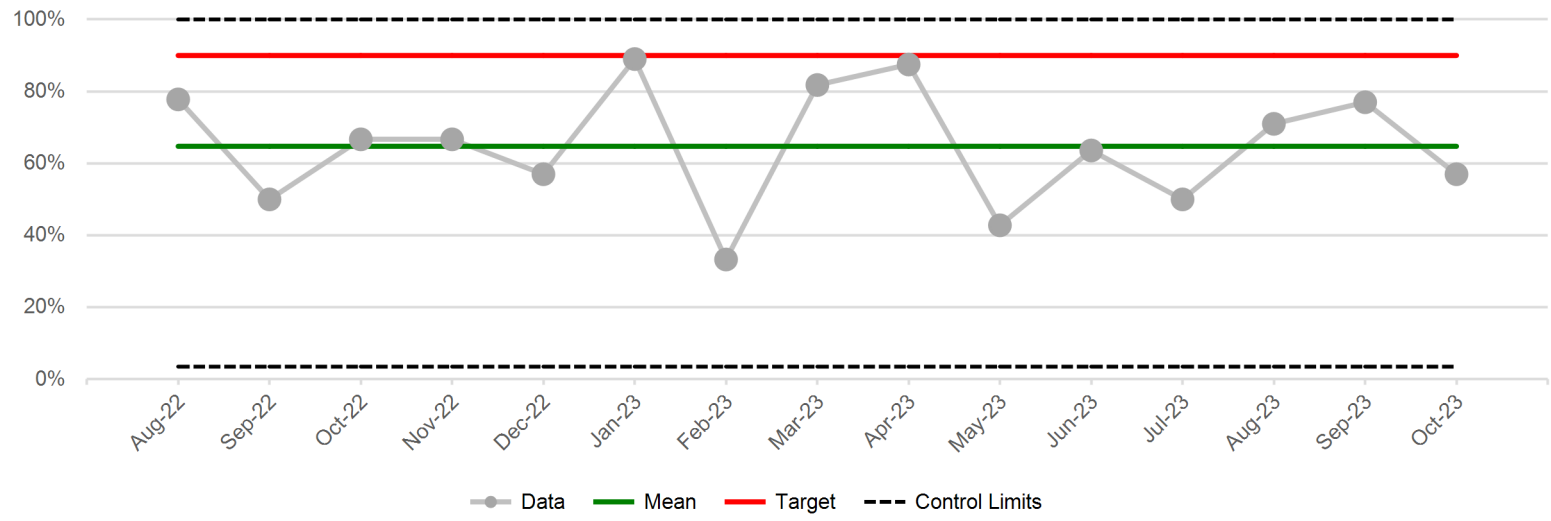
Issues:
Both children that required treatment for Sepsis this month received this in a timely manner within 1 hour.

Actions:
Sepsis practitioner continues to visit inpatient areas to offer support if needed. Sepsis training offered to all new staff.

Mitigations:
To continue to monitor compliance and act accordingly if anything changes.

Performance Overview - Quality

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



Oct-23
57.00%
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 compliance for IV antibiotic treatment within 1 hour for children with suspected sepsis in A & E was 57.0%. This is well below the 90.0% target. 4 children out of 7 received their antibiotics within a timely manner.

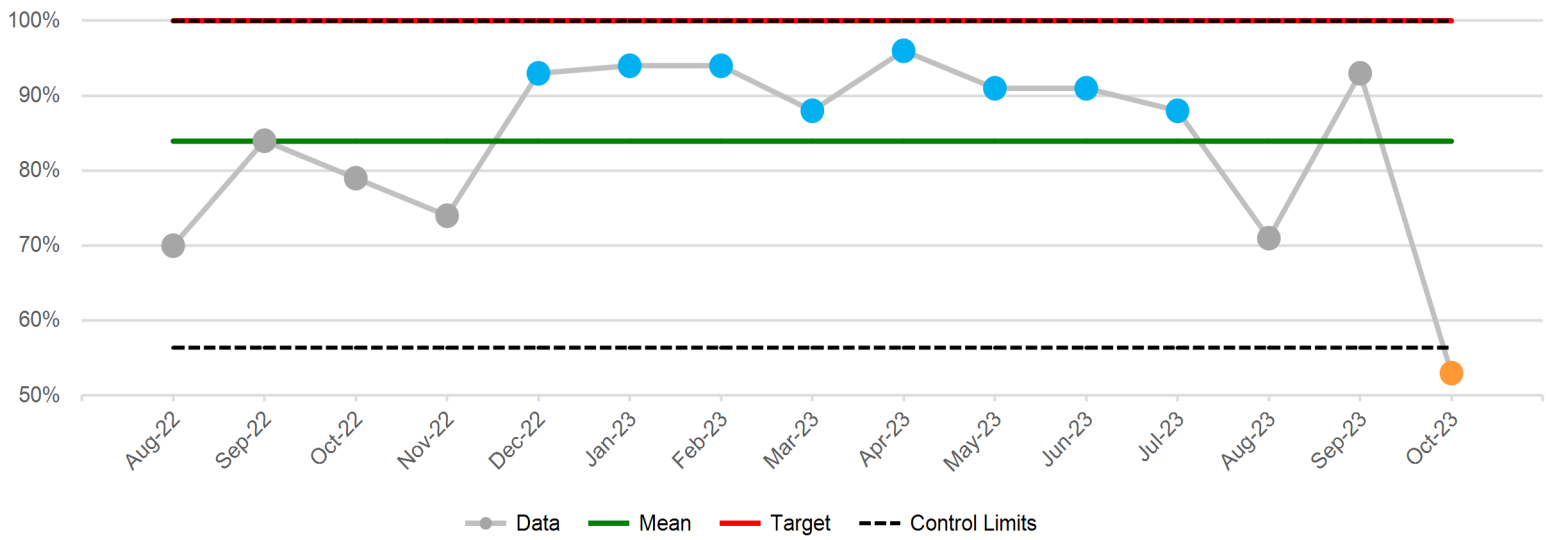
Issues:
The data for ED was raw data as there was an issue with the WEBV system. All three delayed treatments were on the Lincoln site. Due to the ED department rearranging notes it has also been difficult to obtain patient notes for harm reviews. One child diagnosed bacterial meningitis – unable to obtain antibiotic administration time. Two children treated as viral initially then given IV when deteriorated.

Actions:
To continue to try to obtain notes and data will be adapted accordingly if any changes to treatment / administration times.

Mitigations:
No harm found from the harm reviews that could be completed.

Performance Overview - Quality

Duty of Candour compliance - Verbal



Oct-23
53.00%
Variance Type
Special cause variation - cause for concern (Indicator where low is a concern)
Target
100.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Medical Director

Background:
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:
Compliance has reduced during from Sept to October to 53%.

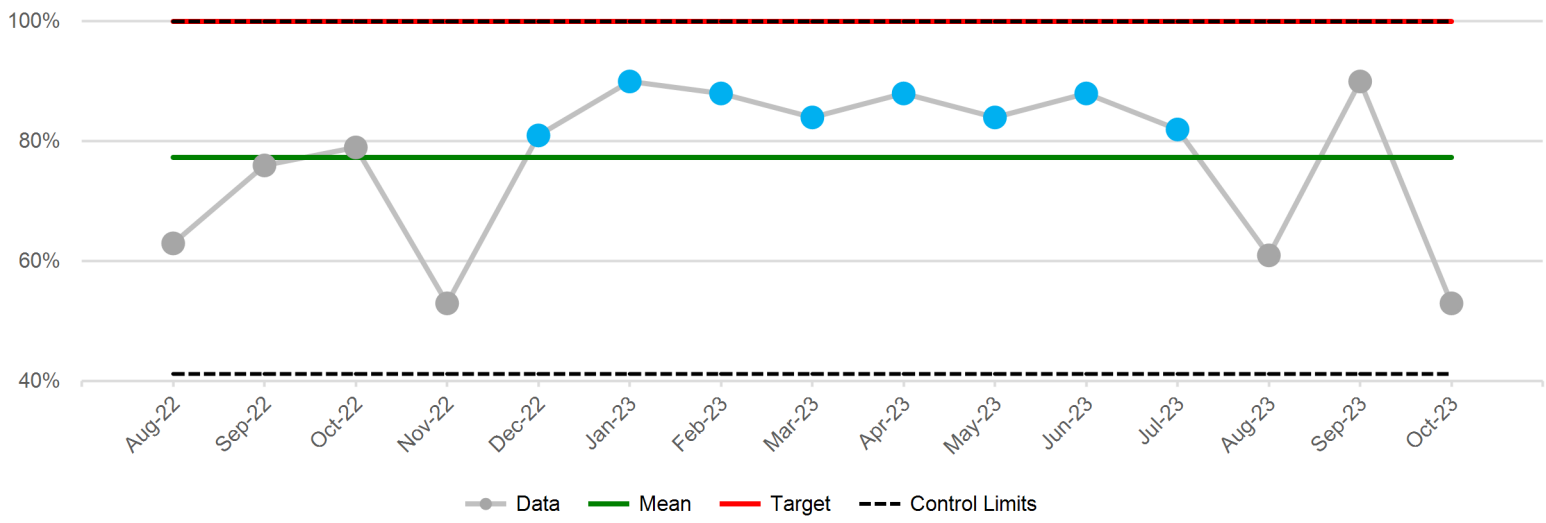
Issues:
Number of issues with tracking compliance with the transition of DatixIQ.
Some divisional reviews in regrades of reviewing grading of incidents which has led to downgrade of harm.
Highest non-compliance within Medicine Division.

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

Mitigations:
Weekly tracking in progress by the incident team.

Performance Overview - Quality

Duty of Candour compliance - Written



Oct-23
53.00%
Variance Type
Common cause variation
Target
100.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Medical Director

Background:
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:
Compliance has reduced during from Sept to October to 53%.

Issues:
Number of issues with tracking compliance with the transition of DatixIQ.
Some divisional reviews in regrades of reviewing grading of incidents which has led to downgrade of harm.
Highest non-compliance within Medicine Division.

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

Mitigations:
Weekly tracking in progress by the incident team.

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	Sep-23	Oct-23	Nov-23	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Patient Experience	% Triage Data Not Recorded	Effective	Patients	Chief Operating Officer	0.00%	0.68%	0.45%	0.59%	0.50%	0.00%	F	
Improve Clinical Outcomes	4hrs or less in A&E Dept	Responsive	Services	Chief Operating Officer	70.94%	53.43%	54.37%	58.31%	56.13%	60.94%	F	
	12+ Trolley waits	Responsive	Services	Chief Operating Officer	0	818	1,288	799	6,661	0	F	
	%Triage Achieved under 15 mins	Responsive	Services	Chief Operating Officer	88.50%	69.36%	66.80%	69.22%	72.86%	88.50%	F	
	52 Week Waiters	Responsive	Services	Chief Operating Officer	3,432	5,600	5,002		44,491	36,782	F	L
	65 Week Waiters	Responsive	Services	Chief Operating Officer	1,032	1,959	1,533		14,390	12,482	F	L
	18 week incompletes	Responsive	Services	Chief Operating Officer	84.10%	49.38%	50.13%		49.90%	84.10%	F	
	Waiting List Size	Responsive	Services	Chief Operating Officer	61,910	74,662	73,992		N/A	N/A	F	
	28 days faster diagnosis	Responsive	Services	Chief Operating Officer	75.00%	71.22%	73.30%		64.33%	75.00%	F	H
	62 day classic	Responsive	Services	Chief Operating Officer	85.39%	54.43%	48.70%		53.21%	85.39%	F	
	2 week wait suspect	Responsive	Services	Chief Operating Officer	93.00%	68.83%	80.50%		59.60%	93.00%	F	H

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Hospitals NHS Trust

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Sep-23	Oct-23	Nov-23	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Clinical Outcomes	2 week wait breast symptomatic	Responsive	Services	Chief Operating Officer	93.00%	27.19%	49.60%		18.43%	93.00%	F	H
	31 day first treatment	Responsive	Services	Chief Operating Officer	96.00%	90.88%	89.10%		90.84%	96.00%	F	
	31 day subsequent drug treatments	Responsive	Services	Chief Operating Officer	98.00%	97.52%	97.70%		96.36%	98.00%	F	
	31 day subsequent surgery treatments	Responsive	Services	Chief Operating Officer	94.00%	80.00%	76.40%		75.29%	94.00%	F	
	31 day subsequent radiotherapy treatments	Responsive	Services	Chief Operating Officer	94.00%	93.81%	95.80%		91.98%	94.00%	F	
	62 day screening	Responsive	Services	Chief Operating Officer	90.00%	77.55%	49.20%		66.06%	90.00%	F	
	62 day consultant upgrade	Responsive	Services	Chief Operating Officer	85.00%	67.98%	62.70%		68.13%	85.00%	F	
	Diagnostics achieved	Responsive	Services	Chief Operating Officer	99.00%	72.54%	77.51%	74.59%	69.75%	99.00%	F	H
	Cancelled Operations on the day (non clinical)	Responsive	Services	Chief Operating Officer	0.80%	1.99%	2.04%	1.68%	1.52%	0.80%	F	
	Not treated within 28 days. (Breach)	Responsive	Services	Chief Operating Officer	0	25	32	32	157	0	F	H
	#NOF 48 hrs	Responsive	Services	Chief Operating Officer	90.00%	46.84%	84.00%	87.50%	77.27%	90.00%	F	

OUTSTANDING CARE personally DELIVERED

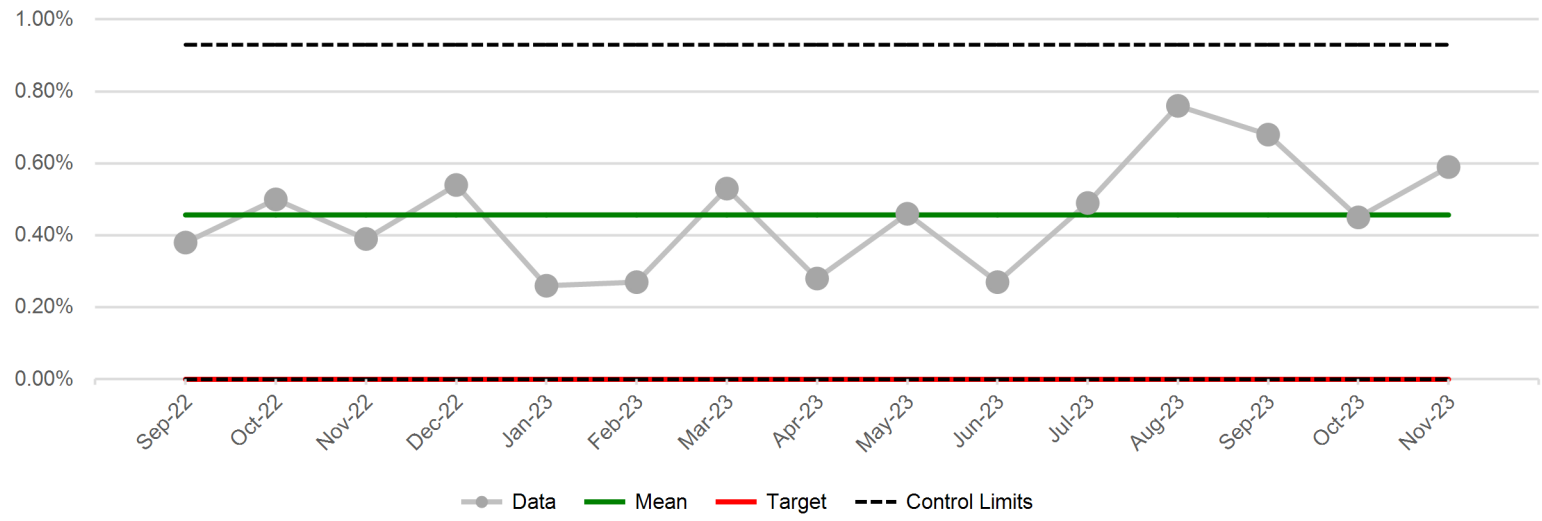
Performance Overview - Operational Performance

NHS United Lincolnshire Hospitals NHS Trust

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Sep-23	Oct-23	Nov-23	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Clinical Outcomes	#NOF 36 hrs	Responsive	Services	Chief Operating Officer	TBC	31.65%	64.00%	68.75%	54.46%			
	EMAS Conveyances to ULHT	Responsive	Services	Chief Operating Officer	4,657	4,327	4,239	4,141	4,287	4,657	P	H
	EMAS Conveyances Delayed >59 mins	Responsive	Services	Chief Operating Officer	0	812	1,213	483	623	0	F	
	104+ Day Waiters	Responsive	Services	Chief Operating Officer	10	61	47	42	534	80	F	L
	Average LoS - Elective (not including Daycase)	Effective	Services	Chief Operating Officer	2.80	3.04	2.20	2.33	2.81	2.80	?	
	Average LoS - Non Elective	Effective	Services	Chief Operating Officer	4.50	5.13	4.88	4.67	4.88	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	27,977	27,570	26,789	27,508	4,524	F	H
	Outpatients seen within 15 minutes of appointment	Effective	Services	Chief Operating Officer	70.00%	31.52%	34.42%	35.32%	32.39%	70.00%	F	
	% discharged within 24hrs of PDD	Effective	Services	Chief Operating Officer	45.00%	38.49%	38.38%	36.80%	40.84%	45.00%	F	

Performance Overview - Operational Performance

% Triage Data Not Recorded



Nov-23
0.59%
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:
November 23 reported a non-validated position of 0.59% of data not recorded verses target of 0%. What the chart doesn't tell us is that 62% of those without a triage "did not wait" to be seen. 91% of the overall missing data is on the LCH Site.

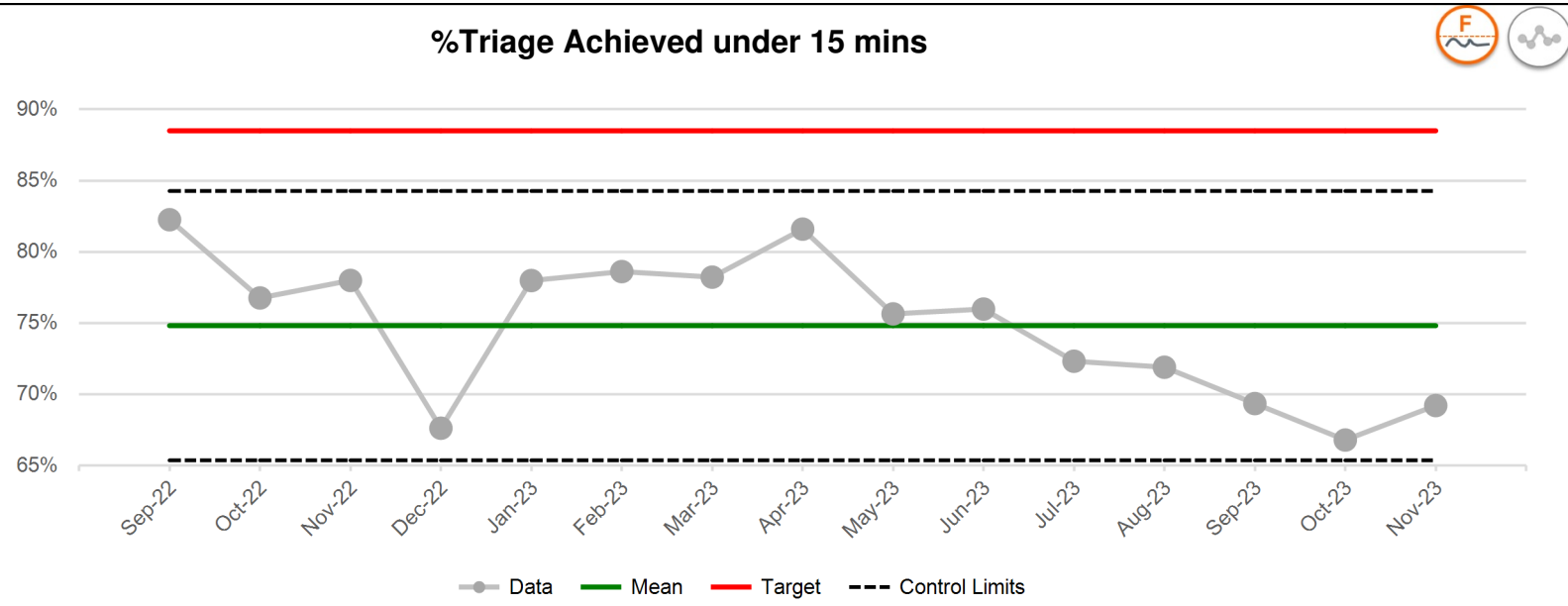
Issues:
- Recognition of patients that "Did Not Wait/Refused Treatment" prior to triage being conducted.
- Recognition of patients who were transferred from one site to another for continued emergency care/direct admission to specialty.
- Manchester Triage trained staff (MTS) to consistently operate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

Staffing gaps, sickness and skill mix issues.

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

Mitigations:
- Earlier identification of recording delays via 3 x daily Capacity and performance meetings and confirmation via a bespoke UEC daily updates.
- Increased nursing workforce following a targeted recruitment campaign has been successful and supernumerary period, has, in the main come to an end.
- Twice daily staffing reviews to ensure appropriate allocation of the ED workforce to meet this indicator.
- The Urgent and Emergency Care Clinical Business Unit continue to undertake daily interventions regarding compliance (recording and undertaking).

Performance Overview - Operational Performance



Nov-23
69.22%
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:
November outturn was 69.22% compared 66.80% in Oct (validated).
What the chart doesn't tell us is the 5% increase in daily attendances compared to November 2022. An additional 20 patients daily.

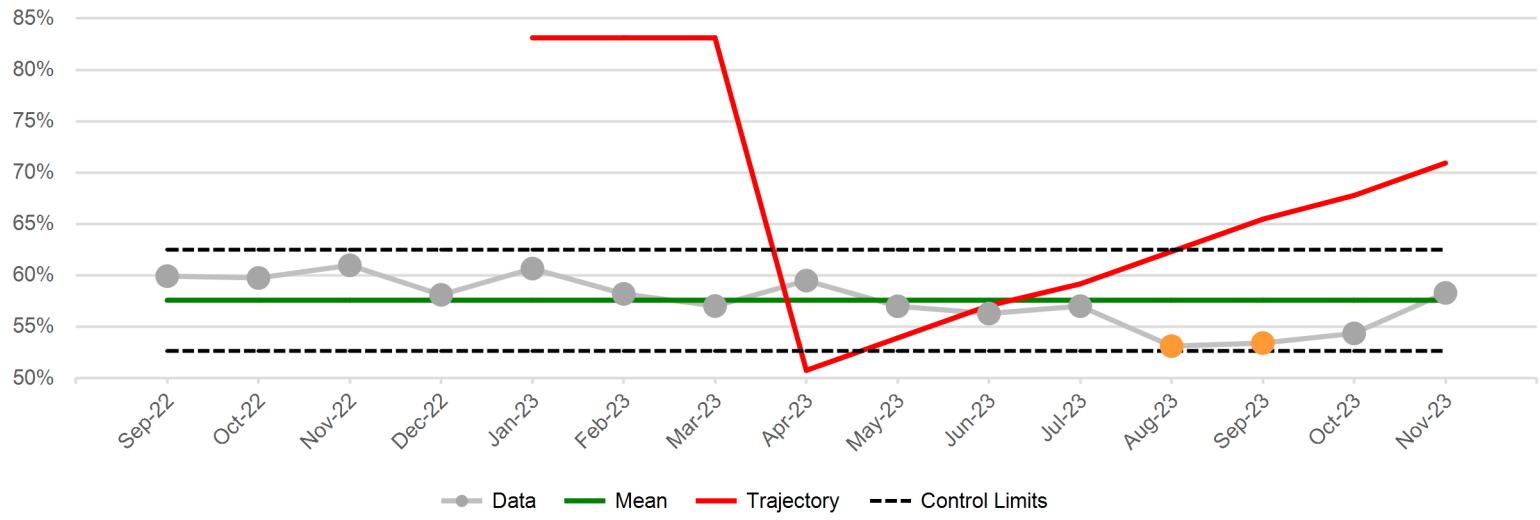
Issues:
- Consistent availability of MTS2 trained staff available per shift to ensure 2 triage streams in place 24/7 has deteriorated.
- There is a recording issue for UTC transfers of care to ED that skews that data on occasion.
- Dual department roles. For example, the second triage nurse is also the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

Actions:
Most actions are repetitive but remain relevant.
Increased access to MTS2 training.
Increased registrant workforce to support 2 triage streams to be in place via Emergency Department recruitment campaign.
To move to a workforce model with Triage dedicated registrants and remove the dual role component.
The metric forms part of the Emergency Department safety indicators and is monitored/scrutinised at 3 x daily Capacity and Performance Meetings.

Mitigations:
The Senior Nurse Leads maintain oversight and support in periods of either high attendance demand or when the second triage stream is compromised due to duality of role issues.
The confirmation of 2 triage streams is ascertained at the 3 x daily Capacity meetings.
Early escalation and rectification are also managed through the Emergency Department Teams Chat and Staffing Cell.
A twice daily staffing meeting is in operation 7 days a week and a daily staffing forecast is also in place.

Performance Overview - Operational Performance

4hrs or less in A&E Dept



Nov-23
58.31%
Variance Type
Common cause variation
Trajectory
70.94%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

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

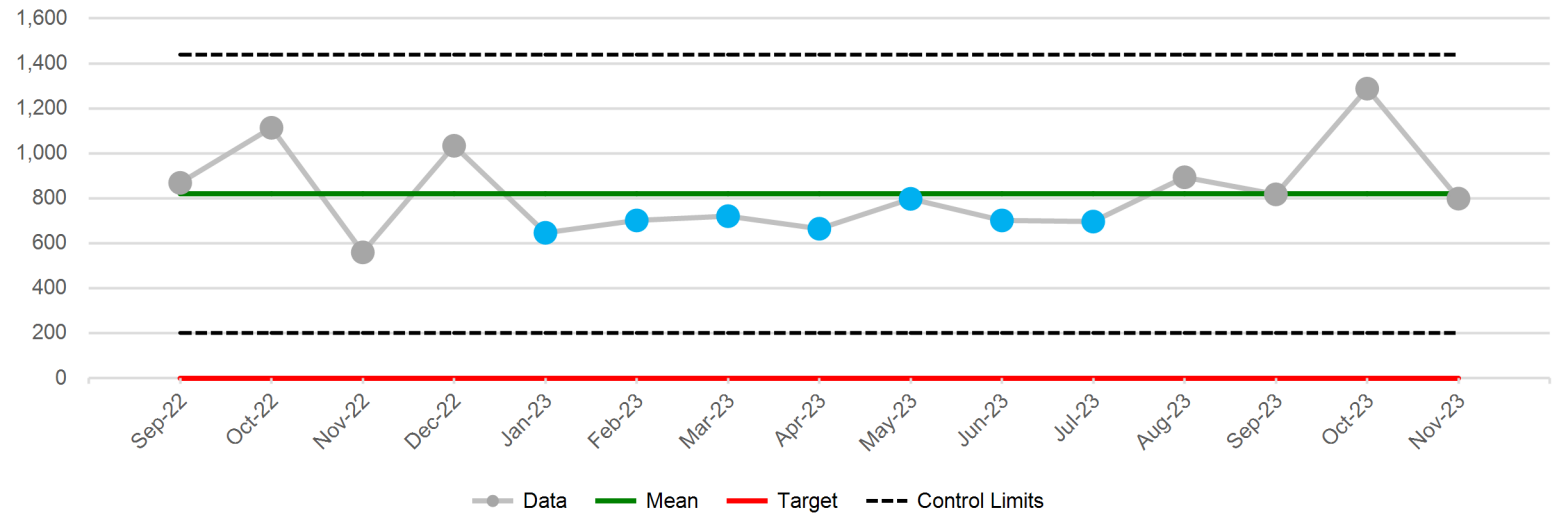
Issues:
ED (Type 1) saw an average of 370 patients daily compared to October 2023 of 388. First assessment continues to have dips in performance overnight. However monthly average for each site shows an improved time of 20 minutes quicker at Lincoln and 33 minutes at Pilgrim.
Ward Based Discharges were an average of 47 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 58.33% recognised after 4pm daily)
Infection related closures of beds on wards impacted availability of movement and cleaning resource affected timely movements.
Ongoing medical and nursing gaps that were not Emergency Department specific.

Actions:
Reducing the burden placed upon the Emergency Departments further will be though the continued expansion of Same Day Emergency Care (SDEC) Services, maximising the Right to Reside (R2R) information to ensure timely and effective discharges for all pathway zero patients, the System flow and discharge improvements to increase access pathway 1 (D2A) capacity and the 'Care Closer to Home' programme.
Breaking the Cycle initiative experienced a reduced benefit during December so has been re-launched and daily discharge target have been set for the organisation and marked through the course of the day.

Mitigations:
EMAS continue to enact a targeted admission avoidance process, including no Cat 4 conveyances should arrive at the Emergency Department.
The Discharge Lounge at LCH and PHB continues operating, where possible, a 24/7 service provision to release the burden placed on the Emergency Departments in terms of patients awaiting AIR/CIR and transport home.
Increased CAS and 111 support especially out of hours.
EPIC to Specialty Consultant reviews to ensure DTA applied appropriately.
Clinical Operational Flow Policy adherence and compliance and Full Capacity Protocol activation when OPEL 3 reached.

Performance Overview - Operational Performance

12+ Trolley waits



Nov-23
799
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:
October experienced 799 breaches compared to 1288 in October. This is an improvement of 489 less patients. The 799 seen, equates to 7% of all type 1 attendances. (1% less than October)
What the chart does not explain is the internal decision to move focus to total time in ED to minimise exposure risk/ mortality rate.

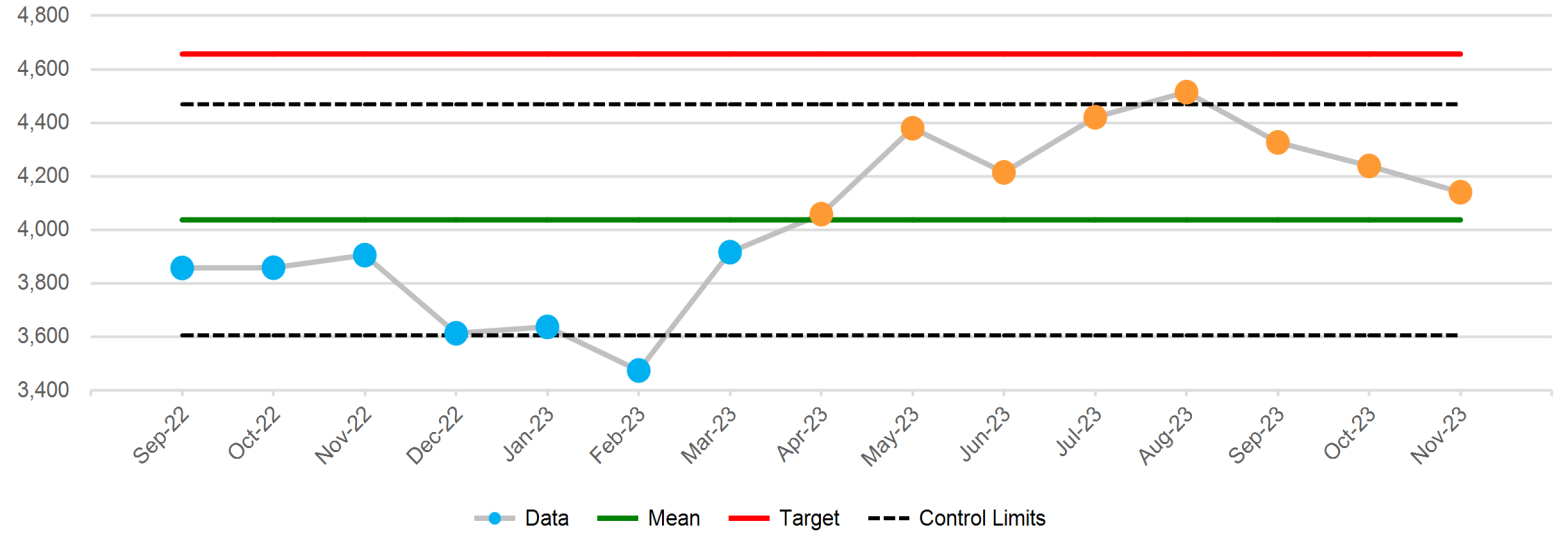
Issues:
Sub-optimal discharges to meet the known emergency demand.
All reportable 12hr trolleys were either associated with no available beds, patient deterioration or delays in transfer to other care settings.

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

Mitigations:
All potential DTA risks are escalated at 8hrs to the Daytime Tactical Lead, out of hours Tactical Lead on Call Manager and CCG Tactical Lead – in and out of hours. Rectification plans are agreed with all CBU teams in hours.
A System agreement remains in place to staff the Discharge Lounges 24/7 to reduce the number of patients in the Emergency Departments that are deemed 'Medically Optimised' that need onward non acute placement/support.
A Criteria to Admit Lead has been established ensuring all decisions to admit must be approved by the EPIC (Emergency Physician in Charge) with the relevant On Call Team.

Performance Overview - Operational Performance

EMAS Conveyances to ULHT



Nov-23
4,141
Variance Type
Special cause variation - cause for concern (Indicator where high is a concern)
Target
4,657
Achievement
Variation indicates consistently passing the target
Executive Lead
Chief Operating Officer

Background:
EMAS Conveyances to ULHT.

What the chart tells us:
The total conveyances to ULHT in November continues a 9% increase in activity for 2023 compared to 2022.
What the chart does not tell is following Grantham converting to a UTC – Conveyances are no longer reported against this site so will have contributed to the drop seen.

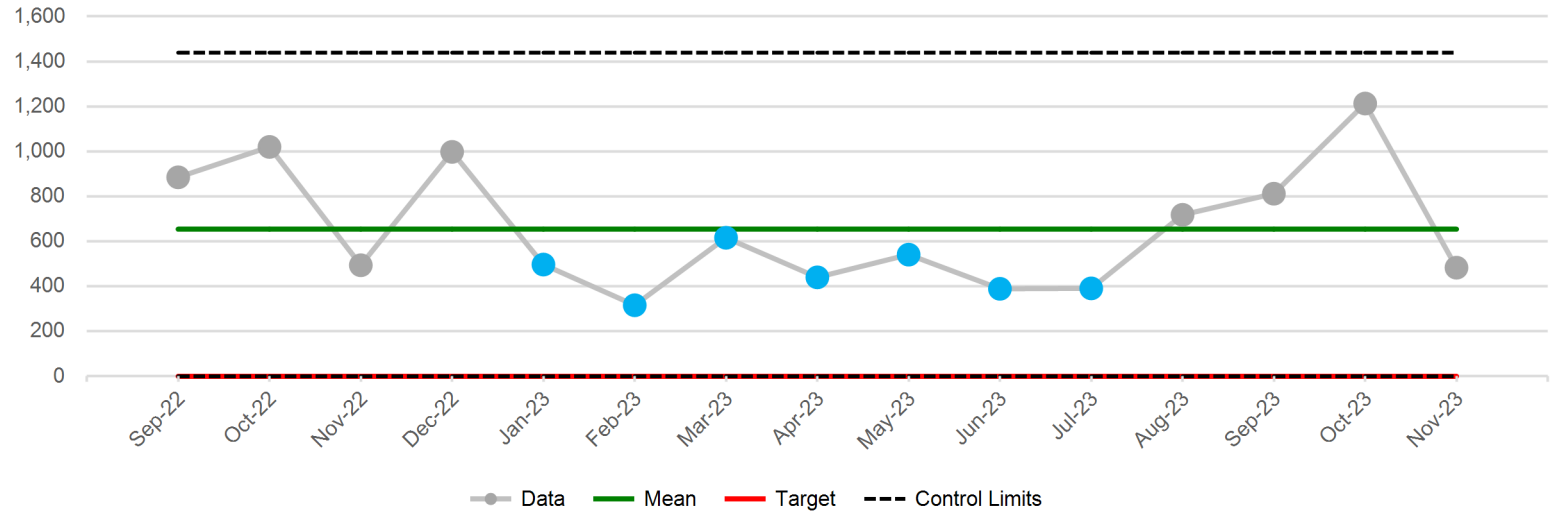
Issues:
The pattern of conveyance is such that arrivals are loaded to the late afternoon and into the evening. This also coincides with increased 'walk ins'.
The use of alternative pathways to avoid conveyance to the Trust are still not fully adhered to but progress continues to be made.
Pressure experienced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

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

Mitigations:

Performance Overview - Operational Performance

EMAS Conveyances Delayed >59 mins



Nov-23
483
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:
November demonstrated an improved performance to that seen in August – October 23, with a decrease of 730 ambulances. What the chart doesn't tell is the continued increase in conveyances throughout this year, with 9% more than 2022 monthly average.

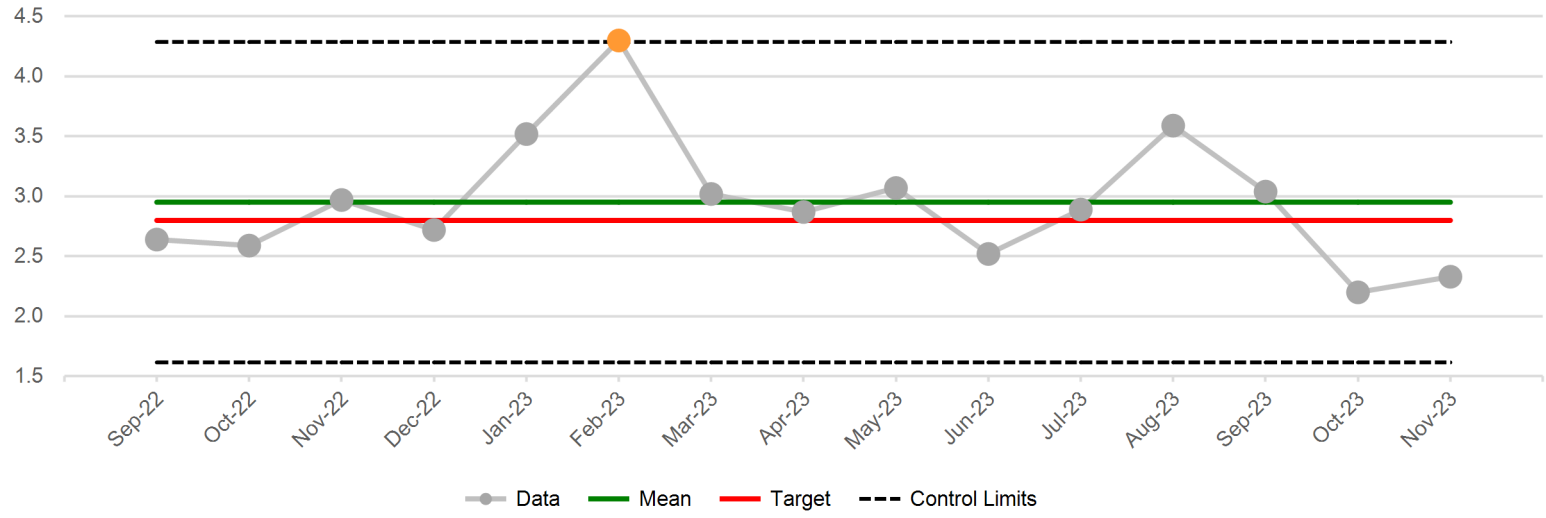
Issues:
The pattern of conveyance and prioritisation of clinical need contributes to the delays.
Increased conveyances continue to profile into the late afternoon and evening coincides with increased 'walk in' attendances causing a reduce footprint to respond to timely handover.
An increasing number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

Actions:
All ambulances approaching 30 minutes without a plan to off load is escalated to the Clinical Site Manager and then in hours Tactical Lead to secure a resolution and plans to resolve are feedback to the DOM. Out of hours, the responsibility lies with the Tactical on Call Manager.
Daily messages to EMAS crews to sign post to alternative pathways and reduce conveyances to the acute setting.
Active monitoring of the EMAS inbound screen to ensure the departments are ready to respond.
Rapid handover protocol, designated escalation areas have been identified/confirmed to assist in reducing delays in handover.
Plus 1/2 Process active to alleviate pressure/capacity in ED.

Mitigations:
Early intelligence of increasing EMAS demand has allowed for planning and preparedness to receive and escalate.
Contact points throughout the day and night with the Clinical Site Manager and Tactical Lead (in and out of hours) to appreciate EMAS on scene (active calls) and calls waiting by district and potential conveyance by site.

Performance Overview - Operational Performance

Average LoS - Elective (not including Daycase)



Nov-23
2.33
Variance Type
Common cause variation
Target
2.80
Achievement
Variation indicates inconsistently passing and 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 2.33 days compared to 2.30 days in October. This represents a negative variance of 0.03 days against the agreed target.

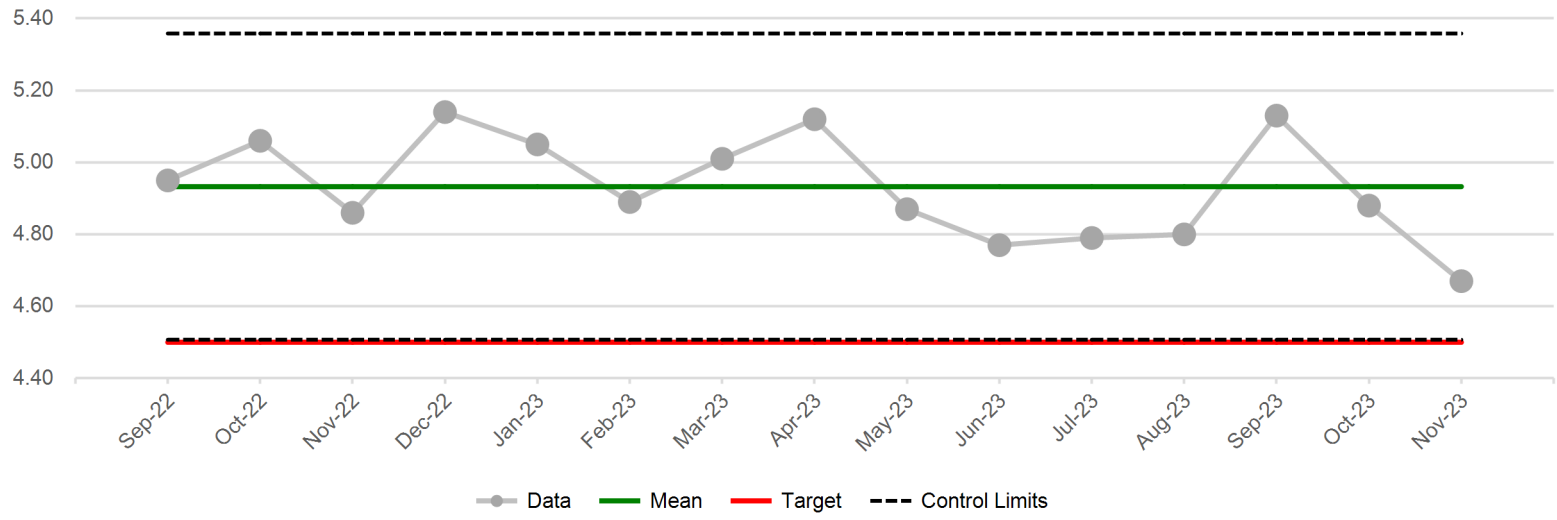
Issues:
Complexity of patients now being admitted which will impact on post-operative recovery and LOS.
Increase in Elective patients on pathways 1, 2 & 3.
Distorted figures associated with outliers in previous dedicated elective beds and coding.

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



Nov-23
4.67
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.

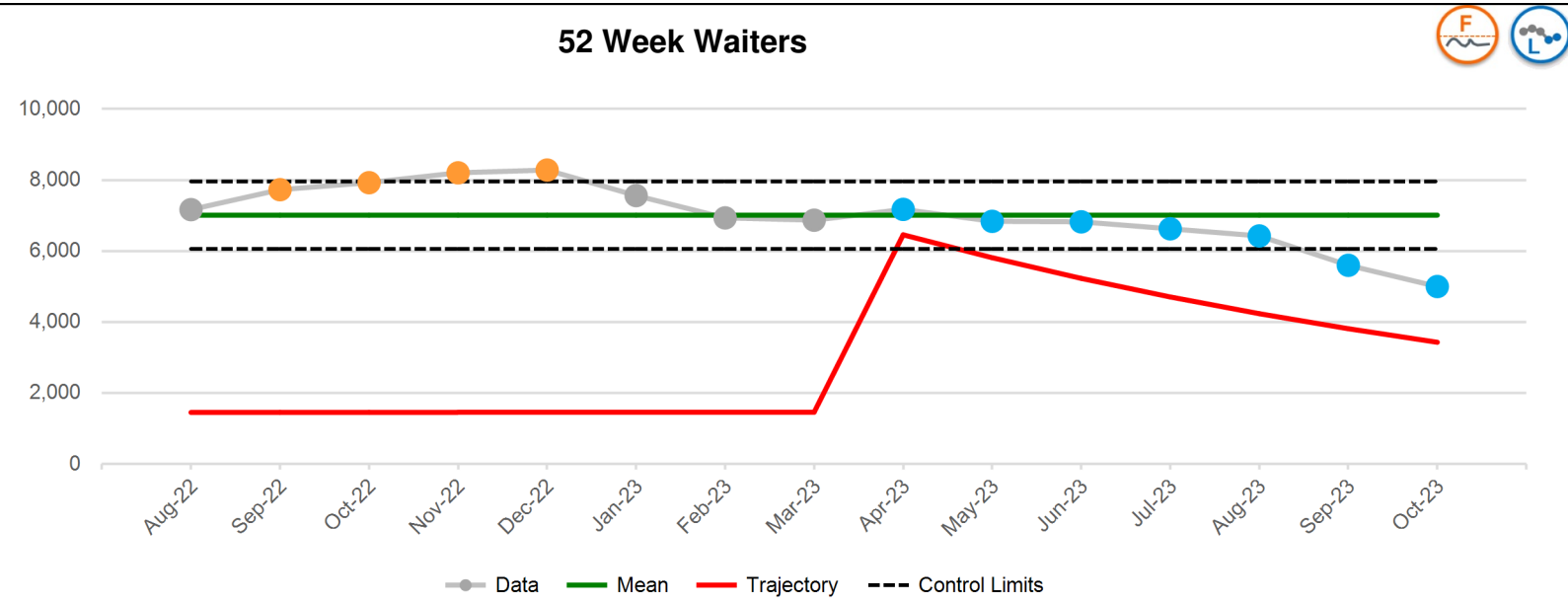
What the chart tells us:
November outturn of 4.67 is a continued improvement of 0.28 days and a 0.17-day negative variance against the agreed target.
What the chart doesn't tell us is the change by pathway:
Pathway 0 (0.2) additional days
Pathway 1 (0.2) less days
Pathway 2 (0.8) additional days
Pathway 3 (0.5) less days

Issues:
Super stranded patients have seen an improved performance of daily average 133 patients in October to 121 in November. (9% improvement)
Stranded also seeing improvements of 222 to 204 patients daily. (8% improvement).
Weekend Discharges remain consistently lower than weekdays with an average of 46% less than required to meet Emergency Admission Demand.
But since the advent of the joint D2A process and additional funding benefits are being realised slowly but there remains insufficient capacity to meet the increasing demand.
The Transfer of Care Hub continue to gain more traction on moving discharges forward at an improved pace.
Higher acuity of patients requiring a longer period of recovery.
Increased medical outliers and reduced medical staffing leading to delays in senior reviews.

Actions:
Focused discharge profile through daily escalations.
Medically optimised patients discussed twice daily 7 days a week with system partners to ensure plans in place and a zero tolerance of >24hrs delay
Maximise use of all community and transitional care beds when onward care provision cannot be secured in a timely manner.
Line by line review of all pathway fully 0 patients who do not meeting the reason to reside.
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



Oct-23
5,002
Variance Type
Special cause variation - improvement (Indicator where low is good)
Trajectory
3,432
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 5,002 incomplete 52-week breaches for October 2023, a decrease of 598 from September 2023's 5,600.

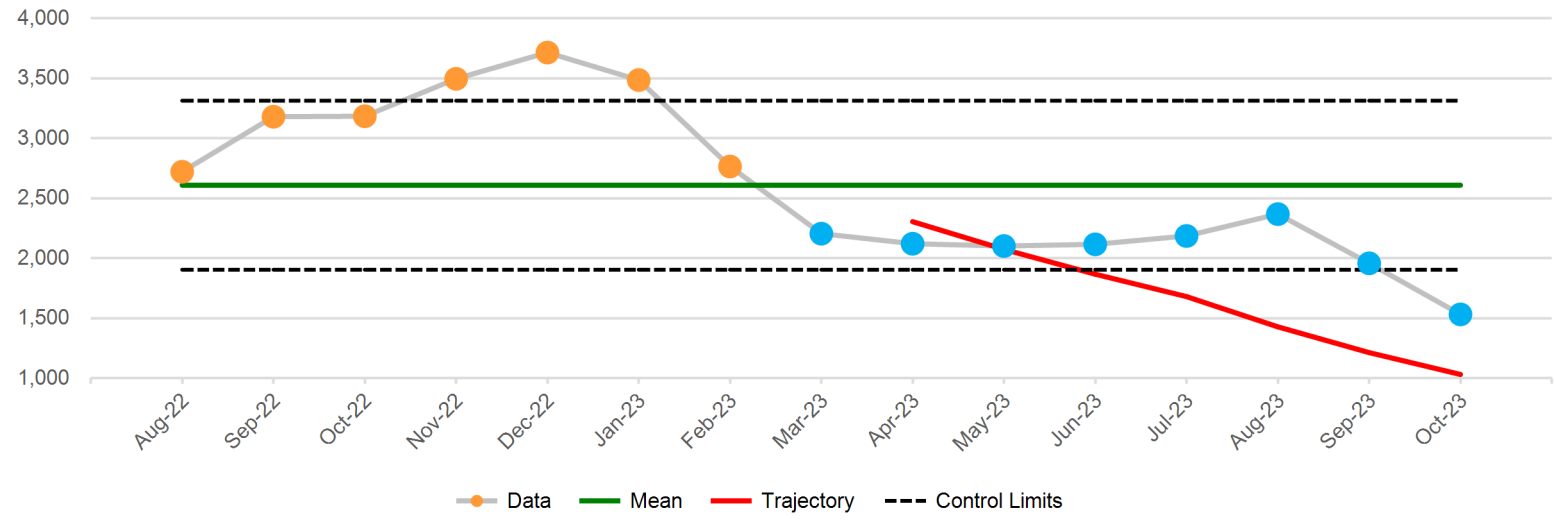
Issues:
As shown above, 52 week waiters are negatively performing against trajectory. ULHT are showing as 5th of 11 Trusts regionally.
Both admitted and non-admitted patients sit within this wait band, however, the most significant pressure is in the non-admitted pathways.

Actions:
In line with the national PIDMAS programme, the first cohort of patients, those waiting 40w and over; have been offered choice of alternative provider, where appropriate. Alternative providers have been found for 0.33% of these patients. No further cohorts of patients have been identified as the PIDMAS programme is currently paused.

Mitigations:
Theatre productivity and HVLC compliance are worked through by the theatres group to support admitted pathways. The Integrated Elective Care Co-Ordination Programme is now embedded as business as usual for admitted patients, providing a single, real time view of clinical prioritisation of patients with reduced cancellations and increased efficiency of the 642 process.

Performance Overview - Operational Performance

65 Week Waiters



Oct-23
1,533
Variance Type
Special cause variation - improvement (Indicator where low is good)
Trajectory
1,032
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.

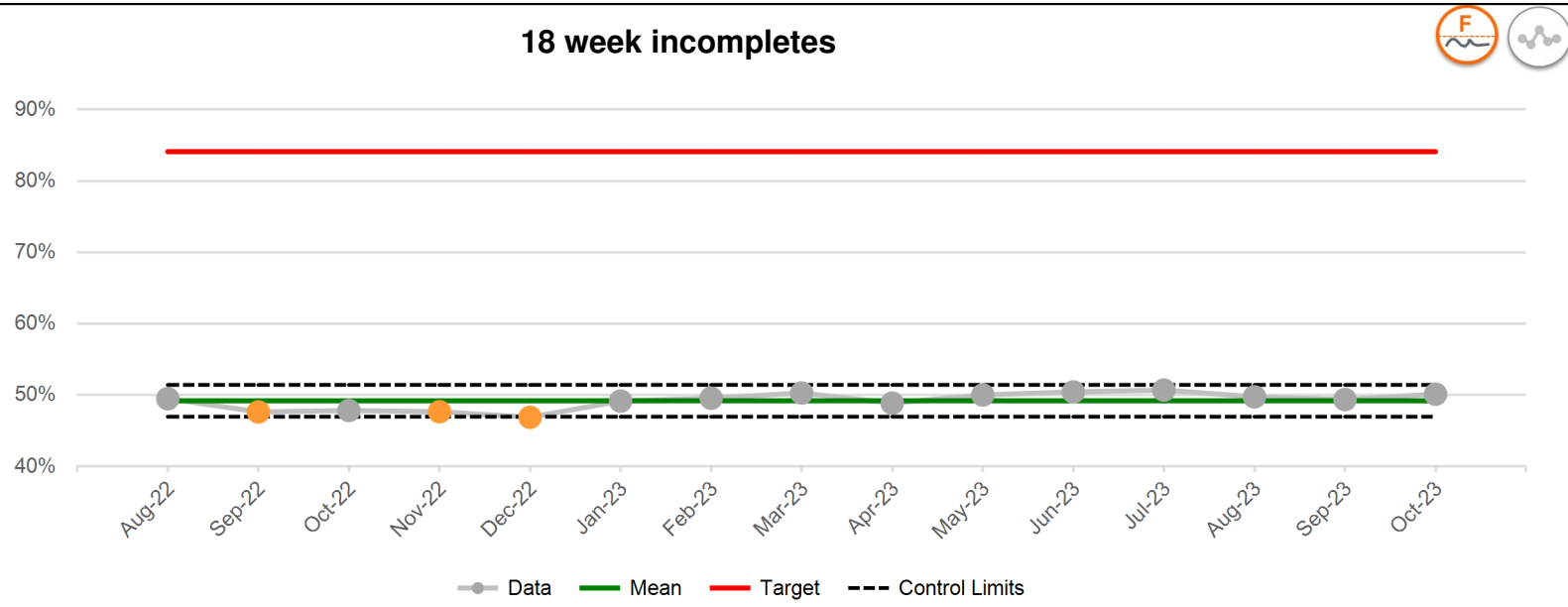
What the chart tells us:
The Trust reported 1,533 incomplete 65-week breaches for October 2023, a decrease of 426 from September 2023's 1,959.

Issues:
ULHT's position is strong with 104 week wait patients, with one patient reported for October. As shown above, 65 week waiters are continuing to reduce.
ULHT are showing as 6th of 11 Trusts regionally.

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

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

Performance Overview - Operational Performance



Oct-23
50.13%
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. October 2023 saw RTT performance of 50.13% against an 84.1% target, which is 0.75% up from September 2023.

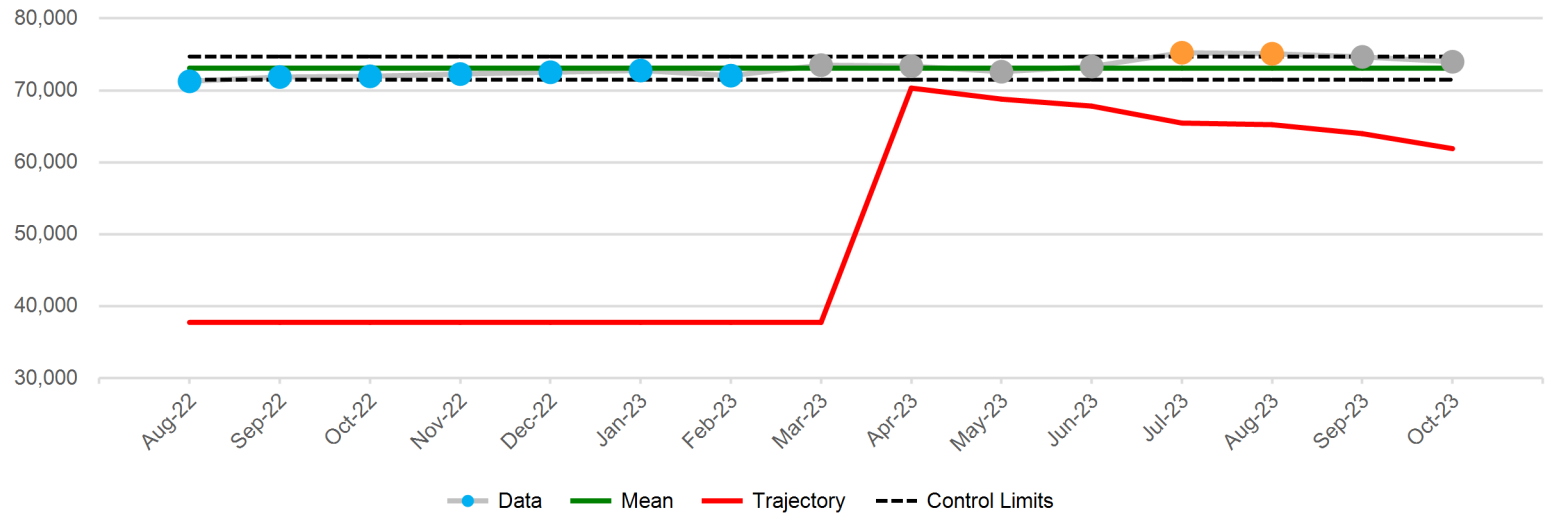
Issues:
Performance is currently below trajectory and standard. The five specialties with the highest number of 18 week breaches at the end of the month were:
ENT – 6495 (decreased by 119)
Gastroenterology – 3217 (decreased by 184)
Gynaecology – 3052 (increased by 100)
Maxillo-Facial + Orthodontics – 2634 (decreased by 26)
Ophthalmology – 2469 (decreased by 171).

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 December. Resource is targeted at patients who have the potential to be >78 weeks.
Schemes to address the backlog include;
1. Outpatient utilisation
2. Tertiary capacity
3. Outsourcing/Insourcing
4. Use of ISPs
5. Reducing missing outcomes

Mitigations:
Improvement programmes established to support delivery of actions and maintain focus on recovery.
HVLC/Theatre Productivity – To ensure best use of theatres and compliance with HVLC procedures. Focus is also on capturing all activity.
Clinical prioritisation – Focusing on clinical priority of patients using theatres.

Performance Overview - Operational Performance

Waiting List Size



Oct-23
73,992
Variance Type
Common cause variation
Trajectory
61,910
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 September 2023, with October showing a decrease of 670 to 73,992
This is more than double the pre-pandemic level reported in January 2020.

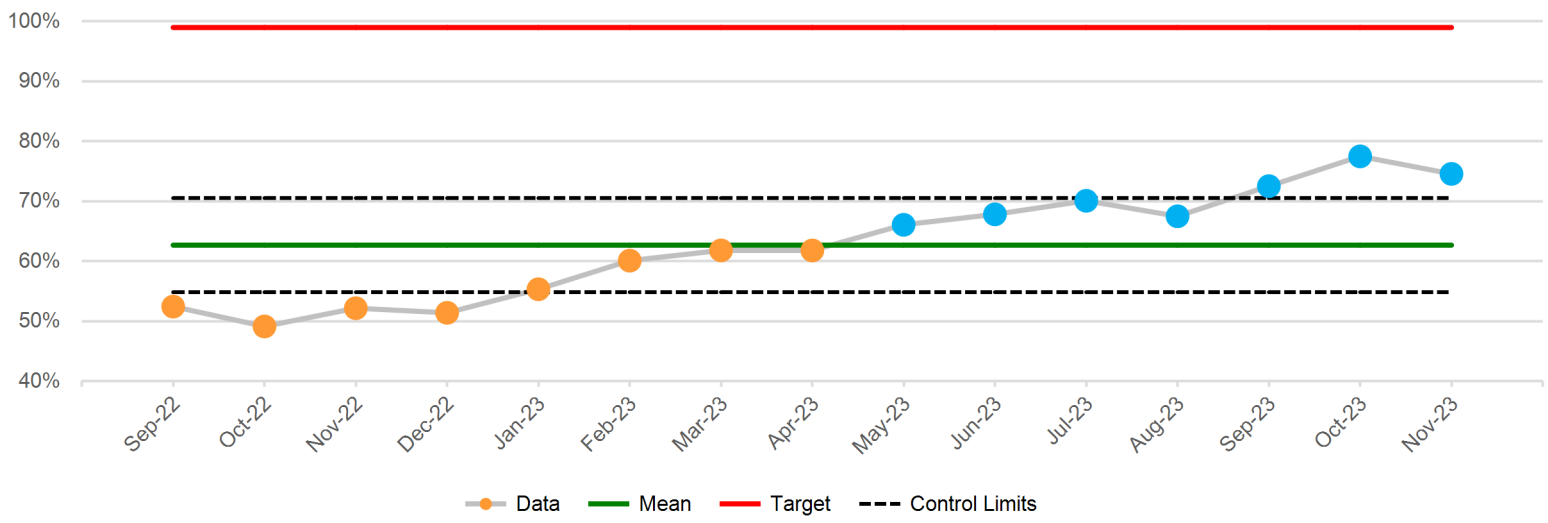
Issues:
Following the backlog increase from the pandemic, there have been additional pressures that have affected capacity, including; COVID sickness and urgent care pressures
The five specialties with the largest waiting lists are;
ENT – 9,917
Gynaecology – 6,024
Ophthalmology – 5,943
Gastroenterology – 5,445
Trauma & Ortho – 4,534

Actions:
Improvement programmes as described above for RTT performance. Phase 1 of the validation programme has been completed. Phase 2, the administrative review has been paused due to the national PIDMAS work. 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 shown a decrease of 64 from September. Appropriate admitted and non-admitted patients continue to be transferred out to ISP's or insourced, with an established process for this now in place for several specialties.

Performance Overview - Operational Performance

Diagnostics achieved



Nov-23
74.59%
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:
We are currently at 74.59% against a 99% target.

Issues:
- The majority of diagnostic breaches sit in Cardiac Echo/MRI.
- MRI and Ultrasound have seen a large increase in breaches due to increase in GP demand Additional MRI.
- Audiology breaches has increased due to the increase in ENT clinics to reduce the 78-week waiters.

Actions:
Additional MRI CDC capacity from end of December 23 .

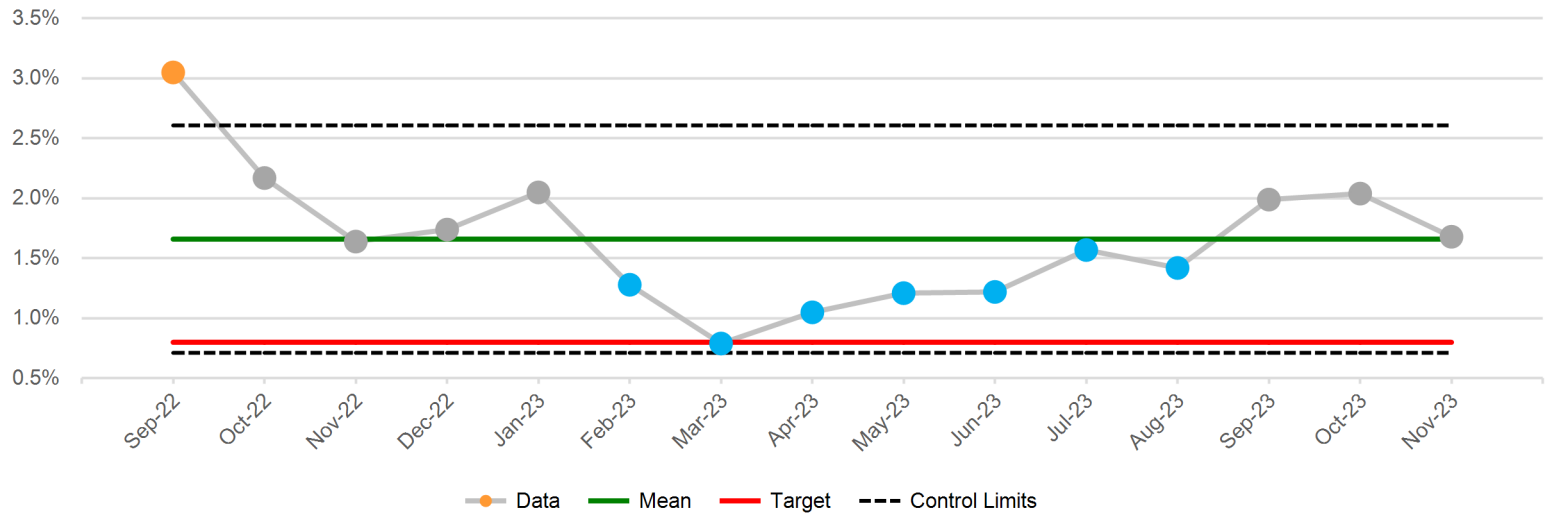
Additional Ultrasounds lists

Additional audiology lists

Mitigations:
Patients are being seen in clinical priority.

Performance Overview - Operational Performance

Cancelled Operations on the day (non clinical)



Nov-23
1.68%
Variance Type
Common cause variation
Target
0.80%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
There has been a decrease in the number of patients cancelled on the day from 2.04% in October to 1.68% in November. Although a fall this is significantly above the agreed trajectory of 0.8%.

Issues:
Top 3 non-clinical reasons for COTD are:

- Lack of time (25)
- Lack of staff (13)
- No Equipment available (6)

Lack of time as list are booked into the 100% + is resulting in a greater number of cancellations.

Lack of staff is a result of sickness.

Poor equipment continuing issues with Steris.

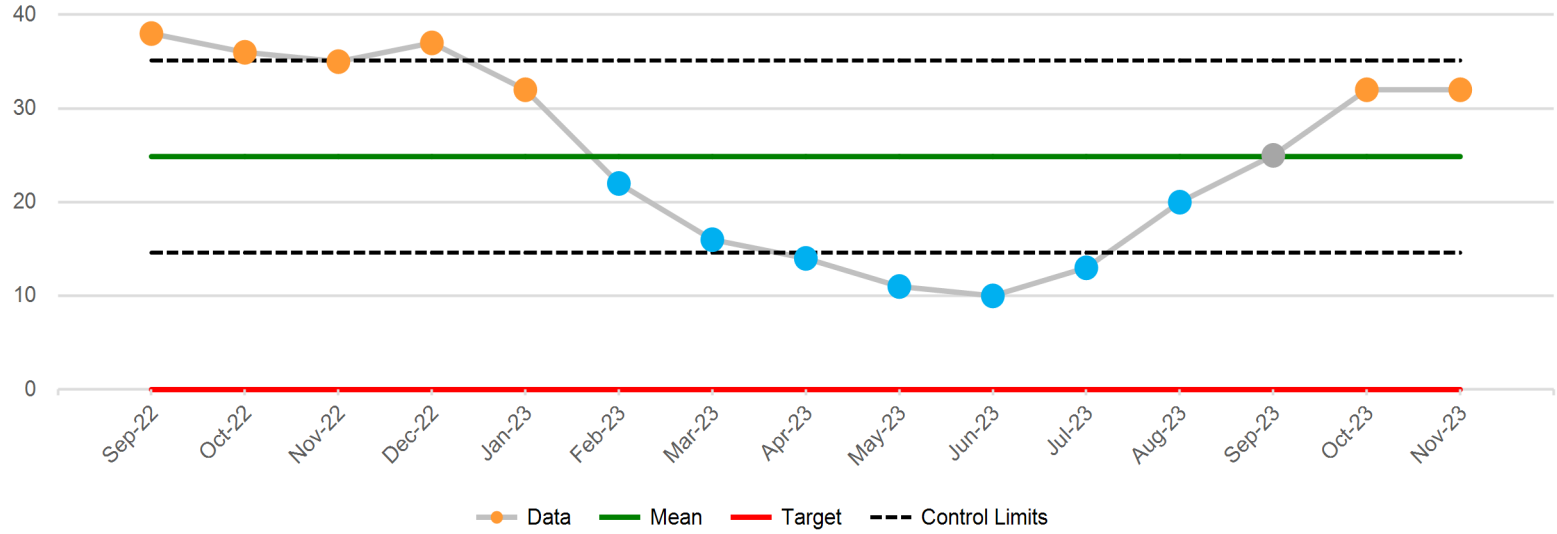
Actions:
A Working Group commences 17.11.23 to address key issues and will establish an equitable approach for managing a potential COTD across the Trust. This will include:

- MDT discussion of process.
- Formal process flowchart agreed with all key stakeholders.
- Appropriate and timely escalation to TACC, Surgical CBUs and Triumvirate.

Mitigations:
A backlog of instrument processing at Steris has resulted in late starts and COTD –This was addressed. But further cleaning issues have arisen. Issues around over utilisation of list resulting in COTD this is being addressed in 642. Significant staff sickness remains a factor although no themes have been identified.

Performance Overview - Operational Performance

Not treated within 28 days. (Breach)



Nov-23
32
Variance Type
Special cause variation - cause for concern (Indicator where high is a concern)
Target
0
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
The figures are stagnant from 32 in October to 32 in November and therefore the agreed target of zero has still not been achieved.

Issues:
Waiting List teams report increased workload due to staff vacancies, sickness and leave.

There remains limited capacity to re-date post-cancellation due to surgeon, staff or patient availability.

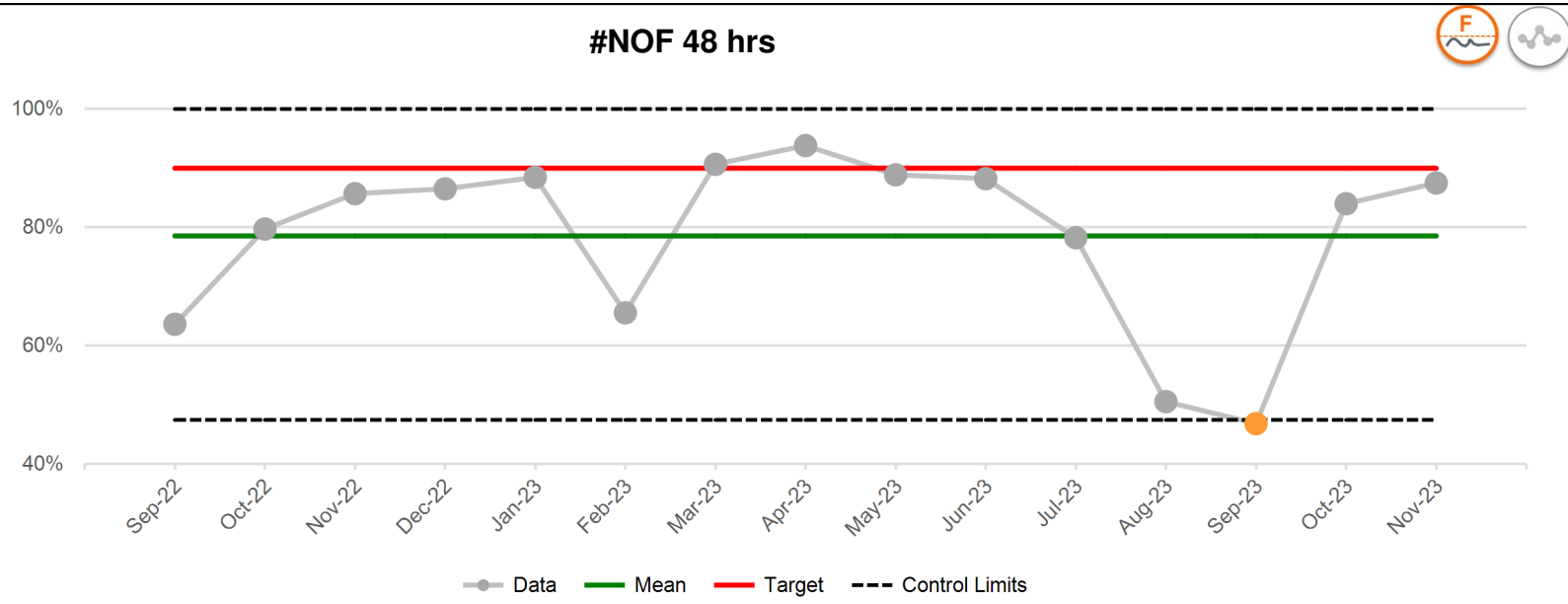
Pre-op capacity to review re-booked patients is limited due to demand on service.

Actions:
A Waiting List co-ordinator is being recruited which should reduce pressure on the Waiting List team. They will link into TACC.

There is an ongoing high-level restructure of pre-op services currently being undertaken which will improve pre-op capacity.

Mitigations:
Significantly more list are being undertaken across the Trust following the new 6-4-2,
Theatre Increased in-session utilisation makes it more challenging for Waiting List teams to find a suitable slot to relist a patient. We are also seeing a rise in demand for 2ww and long waiters.

Performance Overview - Operational Performance



Nov-23
87.50%
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 fracture neck of femur patient's time to theatre within 48 hours.

What the chart tells us:
The average percentage across both sites for November is 87.50% which is an improvement compared to the last 3 months but still not above target.

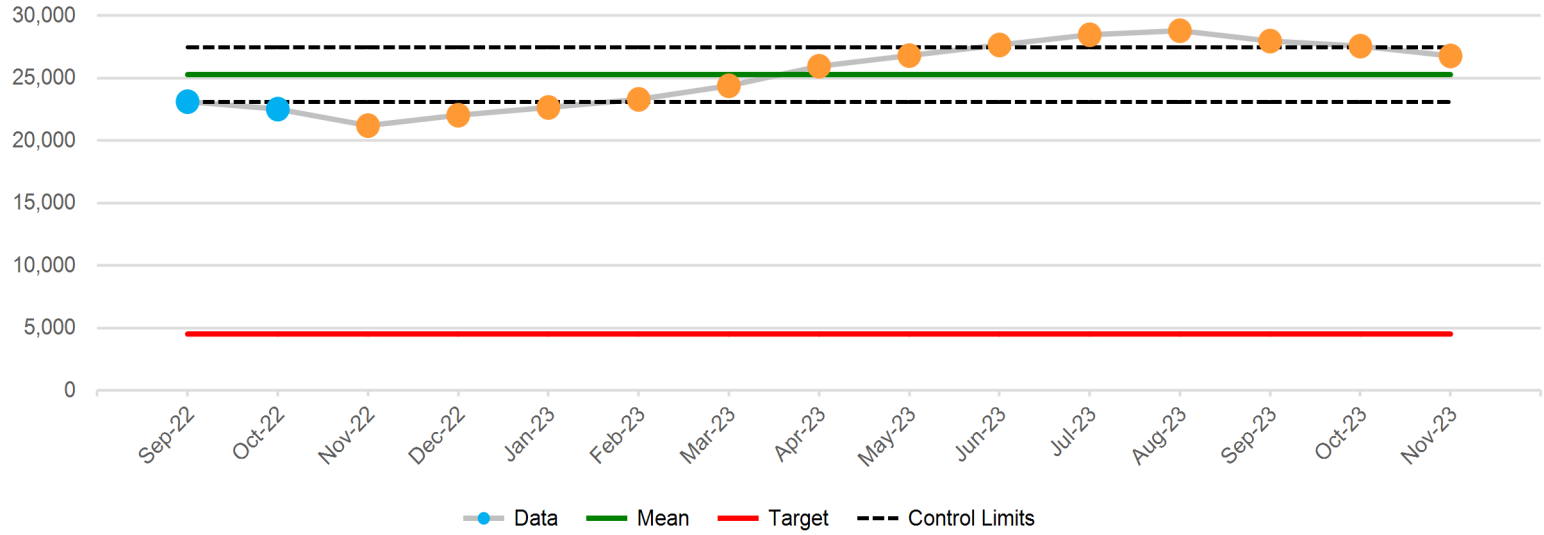
Issues:
- Lack of theatre space to accommodate Femur fractures.
- ULHT continue to have a high demand of trauma patients admitted with one trauma list planned daily on both sites.
- Specialty trauma lists on Boston and Lincoln sites not having capacity to add trauma patients.
- Lack of theatre staff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

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

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

Performance Overview - Operational Performance

Partial Booking Waiting List



Nov-23
26,789
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 26,789 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 steady reduction from Sept 2023.

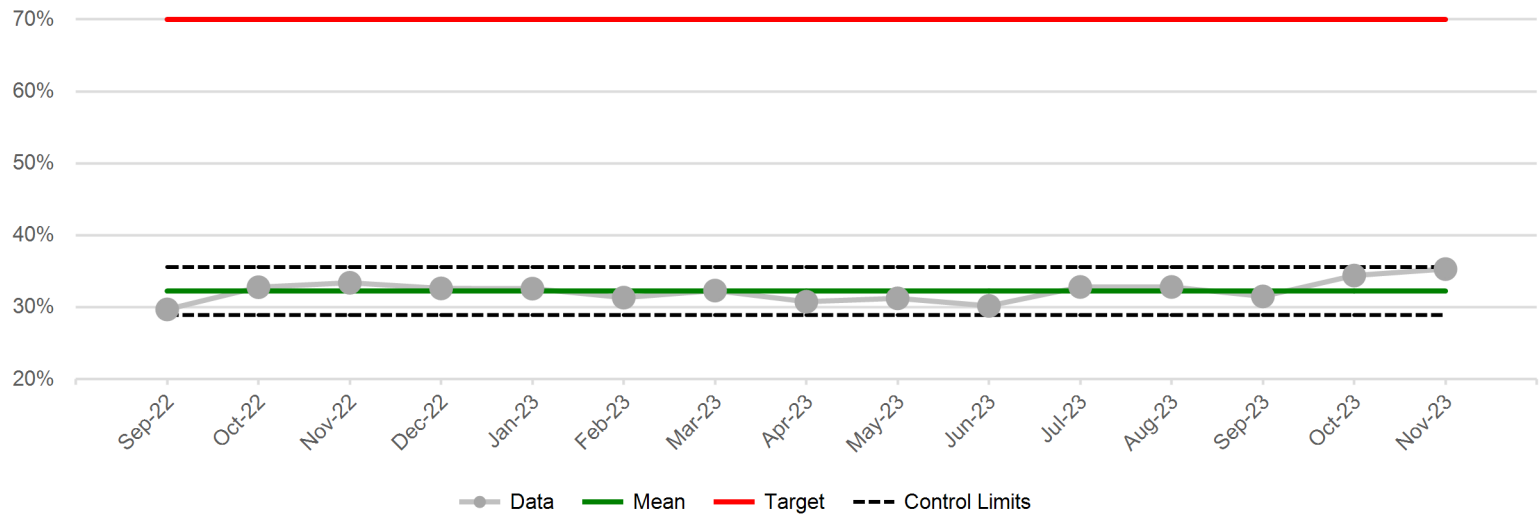
Issues:
The organisation has a number of competing priorities. The current focus is on the 78 and 65 week patients, and potential cancer patients. The current PBWL demand outweighs the current capacity which is being impacted by available capacity, rooms and resources.

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

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

Performance Overview - Operational Performance

Outpatients seen within 15 minutes of appointment

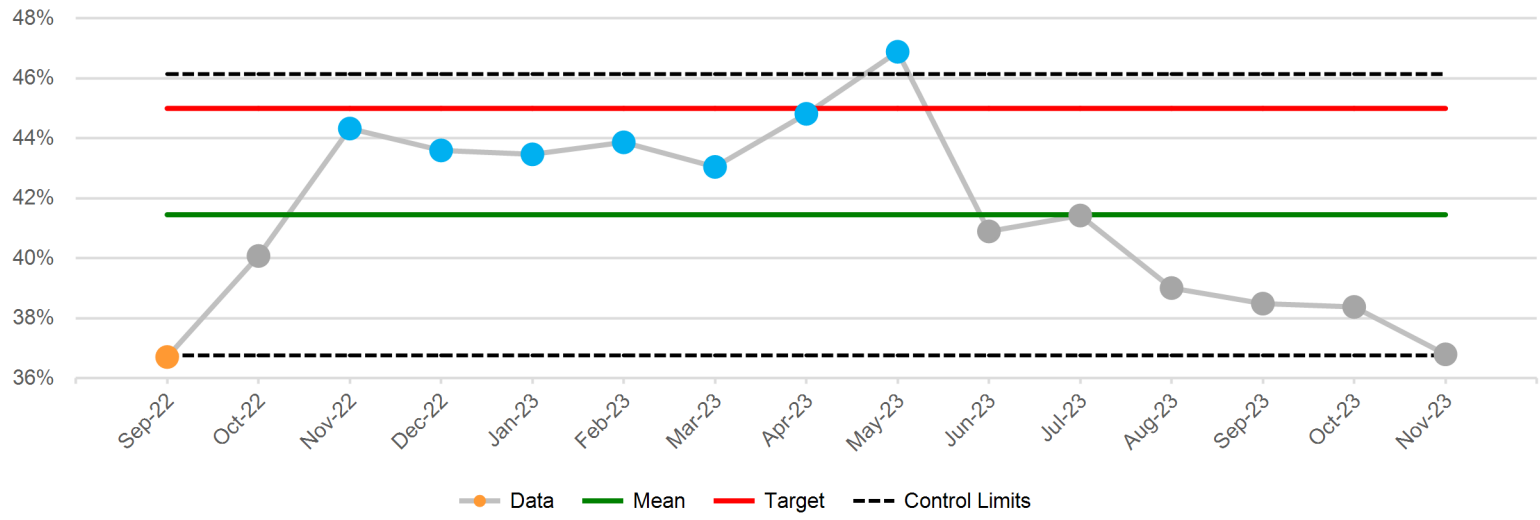


Nov-23
35.32%
Variance Type
Common cause variation
Target
70.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:	Issues:	Actions:	Mitigations:
What the chart tells us: .			

Performance Overview - Operational Performance

% discharged within 24hrs of PDD

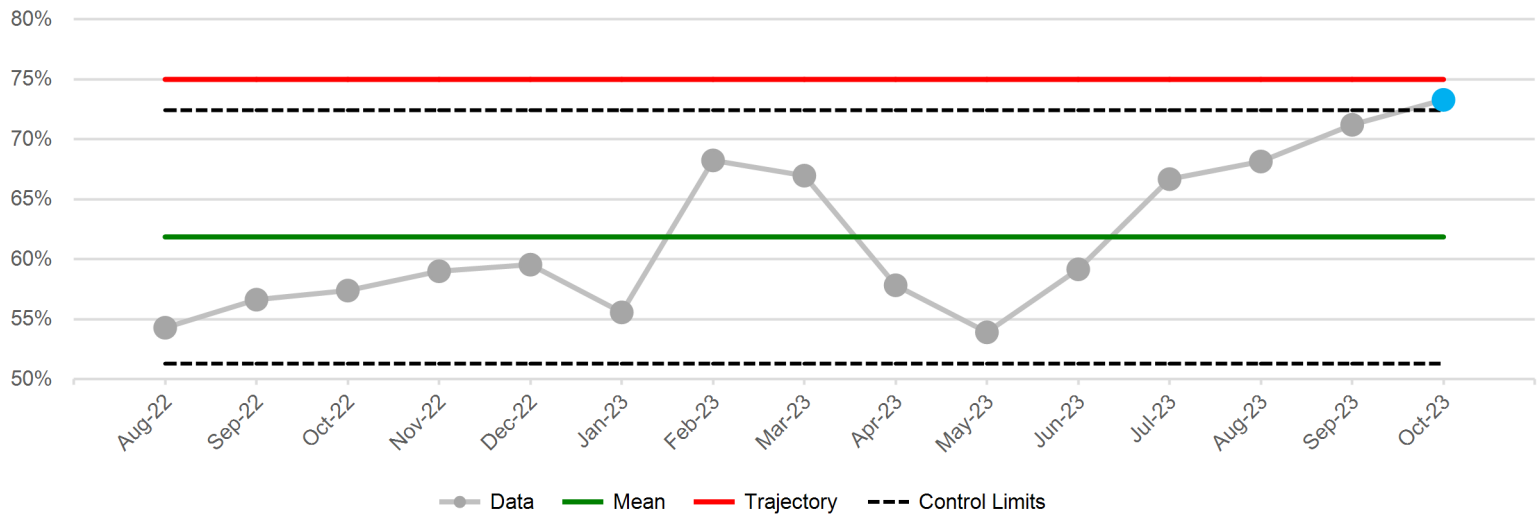


Nov-23
36.80%
Variance Type
Common cause variation
Target
45.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:	Issues:	Actions:	Mitigations:
What the chart tells us:			

Performance Overview - Operational Performance

28 days faster diagnosis



Oct-23
73.30%
Variance Type
Special cause variation - improvement (Indicator where high is good)
Trajectory
75.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 73.3% against a 75% target.

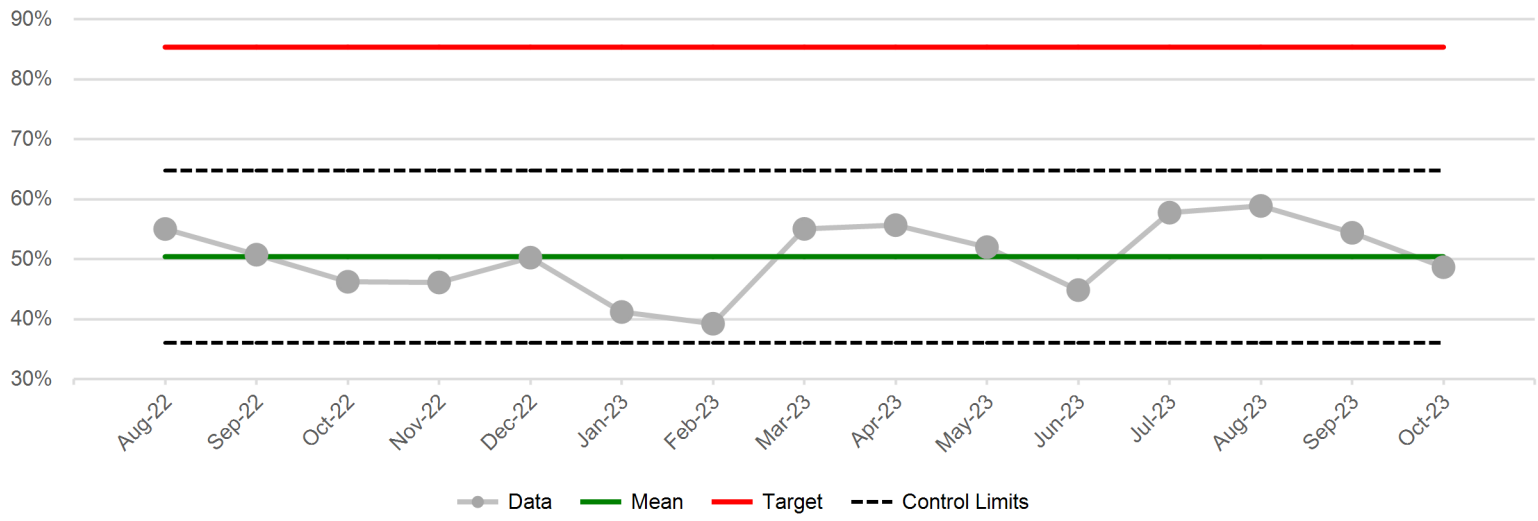
Issues:
The impact of ongoing pathway, staffing and capacity challenges.
Patients not willing to travel to where our service and / or capacity is.
2ww OPA capacity issues in high volume tumour sites such as skin, breast, gynaecology and lung (see 2ww Suspect).
Diagnostic capacity challenges and clinical 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 – A review of the Bladder and prostate pathways is underway and 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, Urology, Colorectal 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. Cancer navigators - A review of this role has been completed and recommendations are being fed back. A mandated Cancer Navigator Education session took place on 23/11/2023.

Performance Overview - Operational Performance

62 day classic



Oct-23
48.70%
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 48.7% against a 85.39% target.

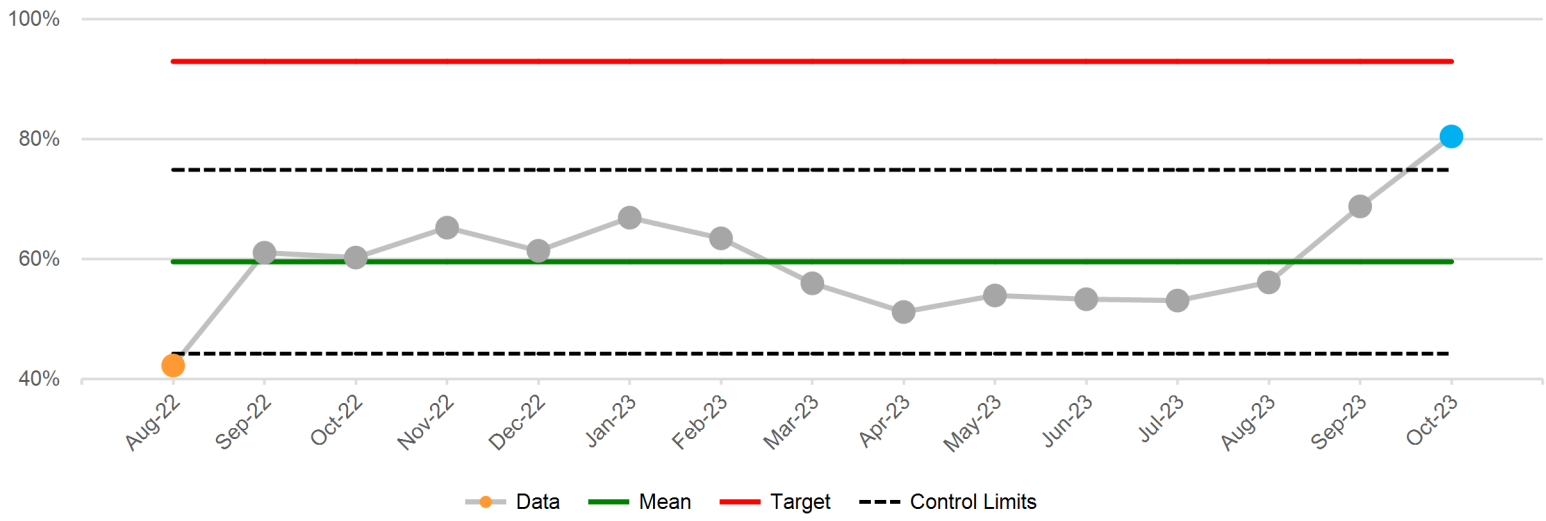
Issues:
Limited theatre capacity continues to impact cancer pathways across the Trust and limited AA and pre-op capacity impacts the ability to be able to populate lists at short notice. In Oncology, recent Linac breakdowns and pharmacy staffing shortages have resulted in delayed treatment start dates.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

Actions:
Oncology Fragile Service – One Med Onc Locum consultant commenced in post in November and is completing a 4 week induction. Another Med Onc locum consultant is due to commence their induction in January 2024. The post offered for Oncology Sp Dr has passed both PLAB1 and 2 exams and is awaiting a start date. A further Sp Dr commences in post in February 2024. A piece of work on right-sizing the Oncology service workforce has commenced.
Robotic Lists are progressing well, though proving difficult to populate at short notice if there are cancellations due to the lack of trained staff within theatres, pre-op and anaesthetics. Tumour site specialties are working with TACC to ensure the best possible utilisation of lists, including a process for last minute cancellations.
Please also see Actions on accompanying pages.

Mitigations:
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



Oct-23
80.50%
Variance Type
Special cause variation - improvement (Indicator where high is good)
Target
93.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 80.5% against a 93% target.

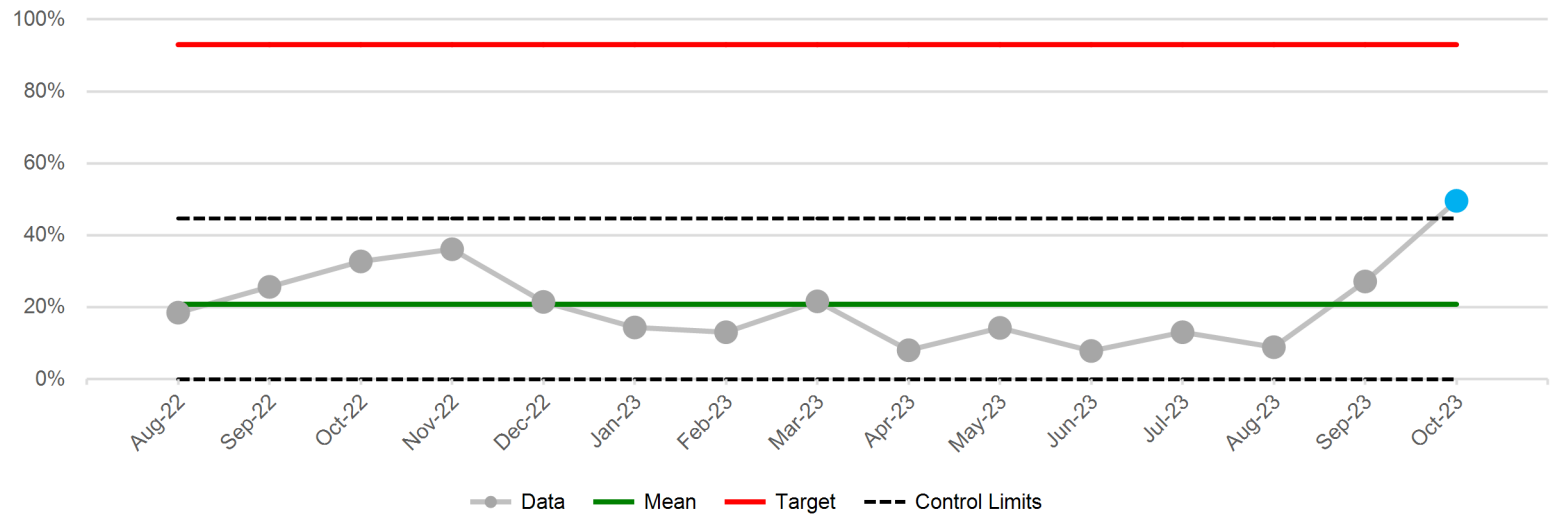
Issues:
Patients not willing to travel to where our service and/or capacity is available.
The Trust's 14 Day performance continues to be impacted by the current Breast Service One-Stop appointment alignment issues, with 41% of the Trust's October 14 Day breaches within that tumour site.
Also of concern was skin performance which accounted for 25% of the Trust's 14 day breaches. The Gynae tumour site accounted for 18% of October 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.
Recruitment processes for the UGI Triage CNS post have been delayed but are back underway – this will support the start of UGI pathway. ICB EACH are continuing to provide support with 2ww referrals to reduce the delays from receipt of referral to STT booking.
Please also see Actions on accompanying pages.

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 progress and impact is being monitored. An HRT programme of work is underway with support from ICB colleagues.
Please also see Mitigations on accompanying pages.

Performance Overview - Operational Performance

2 week wait breast symptomatic



Oct-23
49.60%
Variance Type
Special cause variation - improvement (Indicator where high is good)
Target
93.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 49.6% 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.

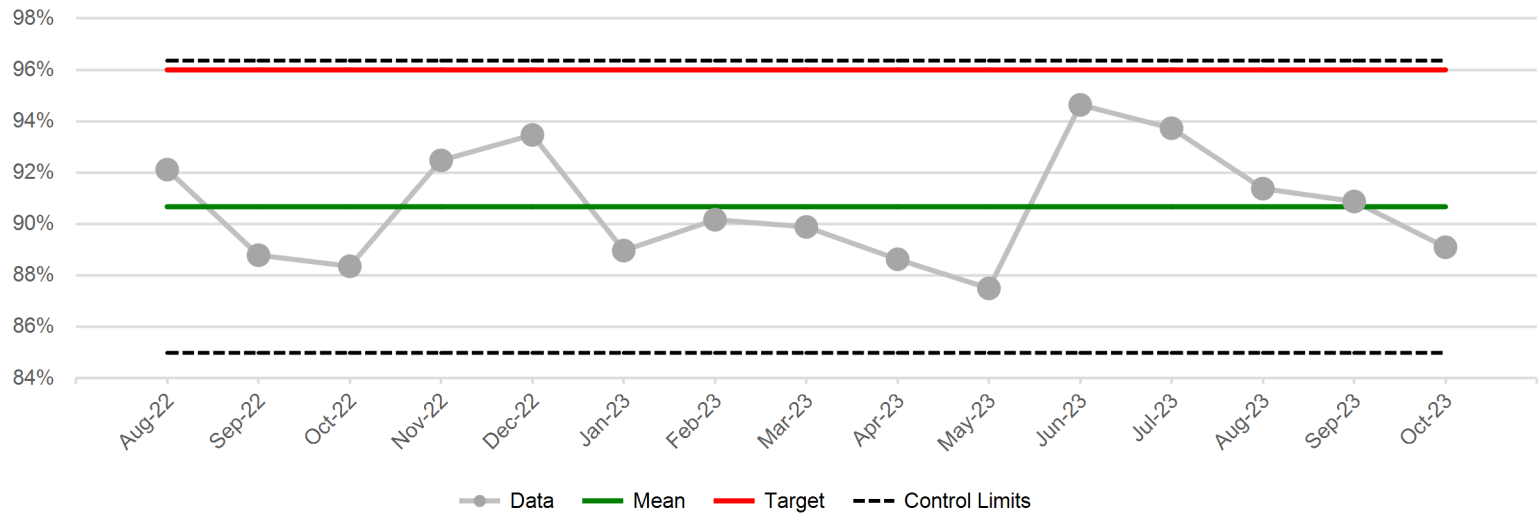
Actions:
A comprehensive review of Breast Services and consultant workload is ongoing.

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



Oct-23
89.10%
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 89.1% against a 96% target.

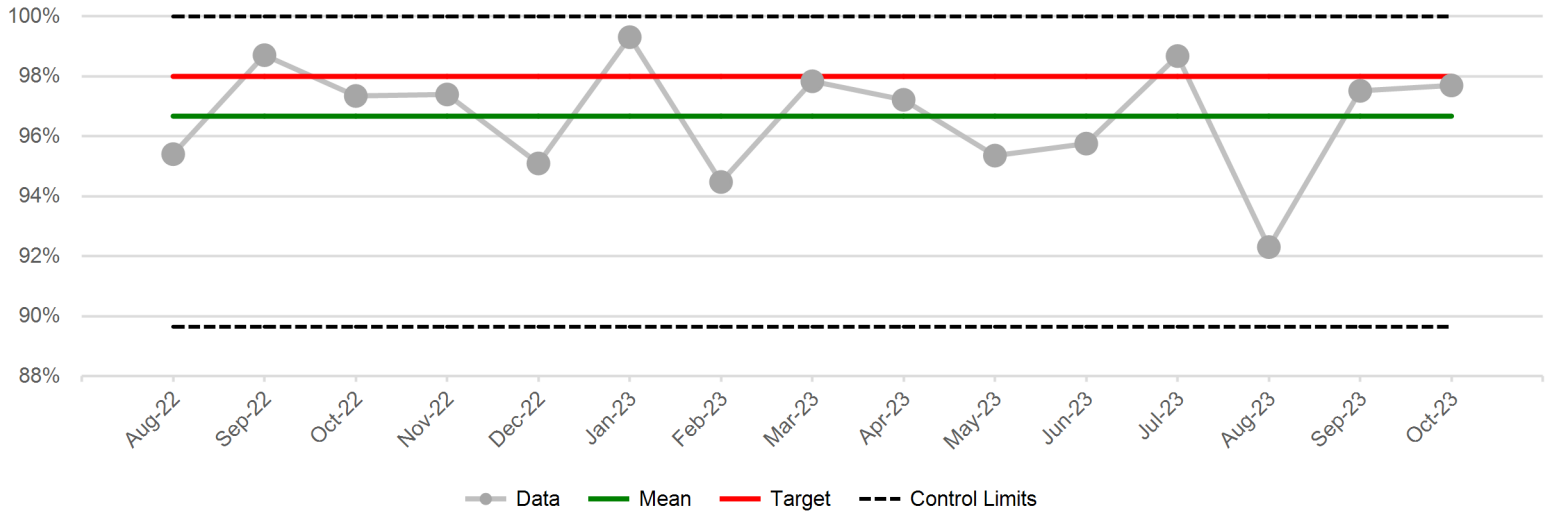
Issues:
The failure of the 31 Day standards was primarily attributed to limited theatre capacity and limited AA and pre-op capacity impacts the ability to be able to populate lists at short notice.
In Oncology, recent Linac breakdowns and pharmacy staffing shortages have resulted in delayed treatment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

Actions:
Oncology Fragile Service - One Med Onc Locum consultant commenced in post in November and is completing a 4 week induction. Another Med Onc locum consultant is due to commence their induction in January 2024. The post offered for Oncology Sp Dr has passed both PLAB1 and 2 exams and is awaiting a start date. A further Sp Dr commences in post in February 2024. A piece of work on right-sizing the Oncology service workforce has commenced.
OMF Capacity issues are impacting both Head and Neck and particularly Skin pathway performance – escalated as a risk.

Mitigations:
Robotic Lists are progressing well, though proving difficult to populate at short notice if there are cancellations due to pre-op and anaesthetic assessment capacity. Tumour site specialties are working with TACC to ensure the best possible utilisation of lists, including a process for last minute cancellations.
In Dermatology, a Minor Op Clinic process review, alongside SpDr training, is underway to increase capacity. A training plan for Skin Surgery nurses to support with head and neck lesions is being developed.
In Head and Neck, an ENT consultant has recently commenced in post. Locum consultant currently taking on non-cancer Thyroid cases to release capacity for cancer

Performance Overview - Operational Performance

31 day subsequent drug treatments



Oct-23
97.70%
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 97.7% against a 98% target.

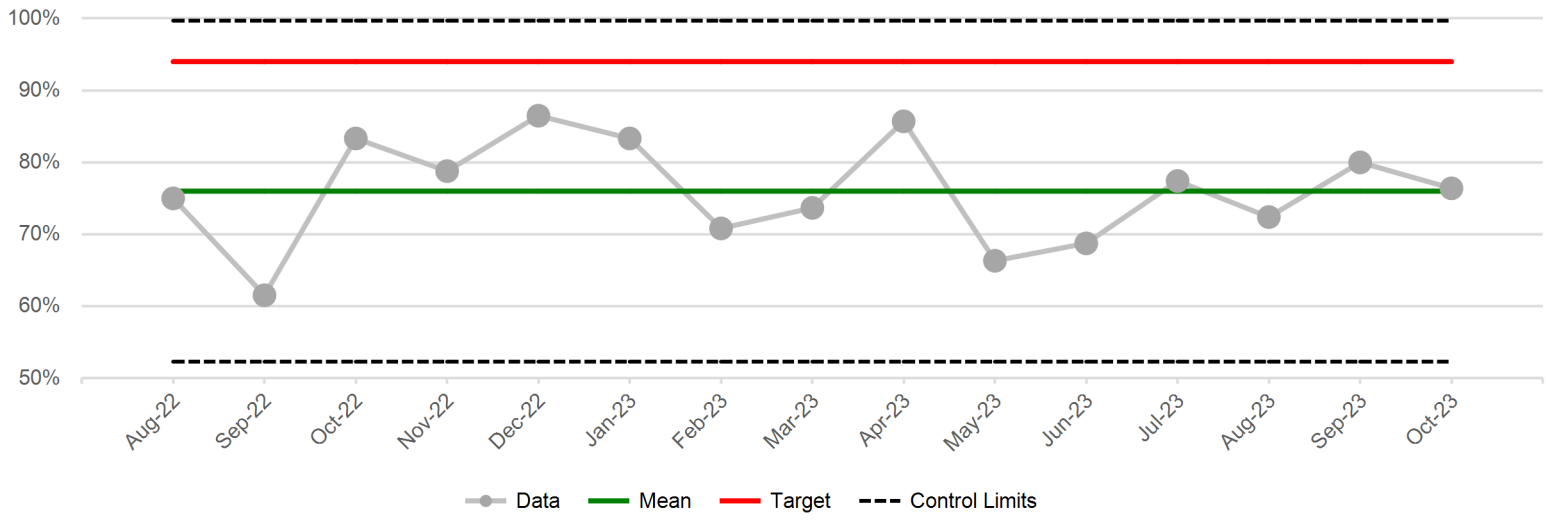
Issues:
In Chemotherapy, staffing shortages, treatment capacity and recent pharmacy staffing shortages have resulted in delayed treatment start dates.

Actions:
Oncology Fragile Service - One Med Onc Locum consultant commenced in post in November and is completing a 4 week induction. Another Med Onc locum consultant is due to commence their induction in January 2024. The post offered for Oncology Sp Dr has passed both PLAB1 and 2 exams and is awaiting a start date. A further Sp Dr commences in post in February 2024. A piece of work on right-sizing the Oncology service workforce has commenced.

Mitigations:

Performance Overview - Operational Performance

31 day subsequent surgery treatments



Oct-23
76.40%
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 76.4% against a 94% target.

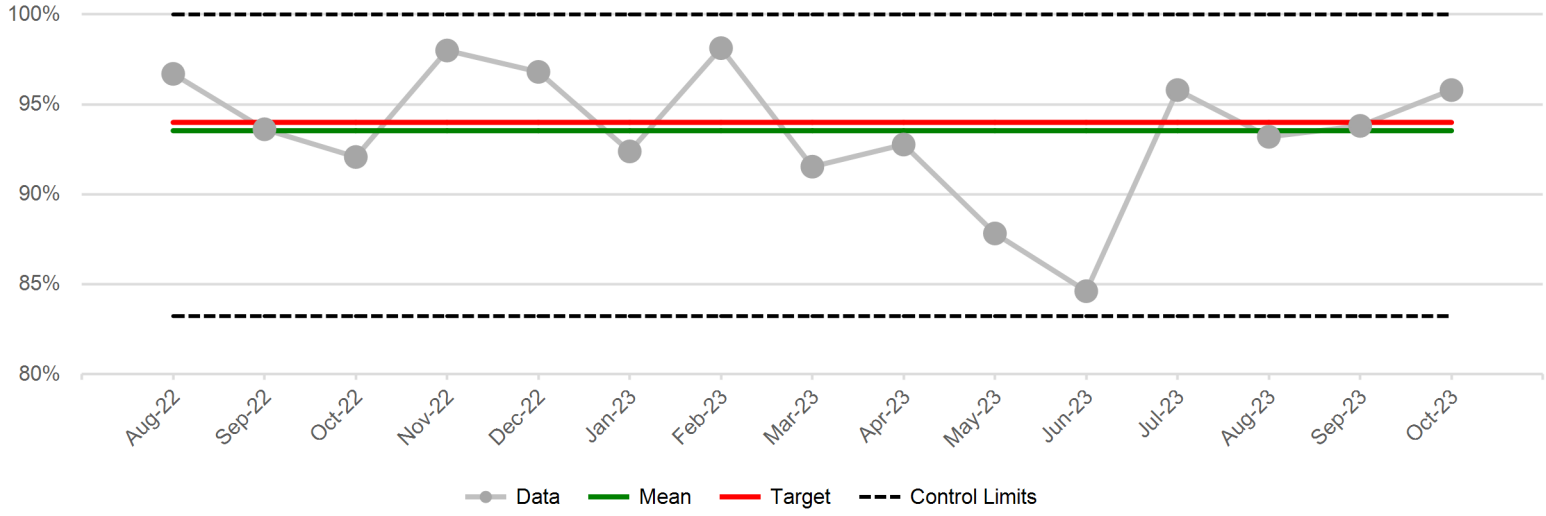
Issues:
The failure of the 31 Day surgery standard was due to limited theatre capacity and limited AA and pre-op capacity impacts the ability to be able to populate lists at short notice.
Colorectal – Current activity complexity is causing delays in allocating surgery dates, e.g. the increase in anterior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

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

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

Performance Overview - Operational Performance

31 day subsequent radiotherapy treatments



Oct-23
95.80%
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 95.8% against a 94% target.

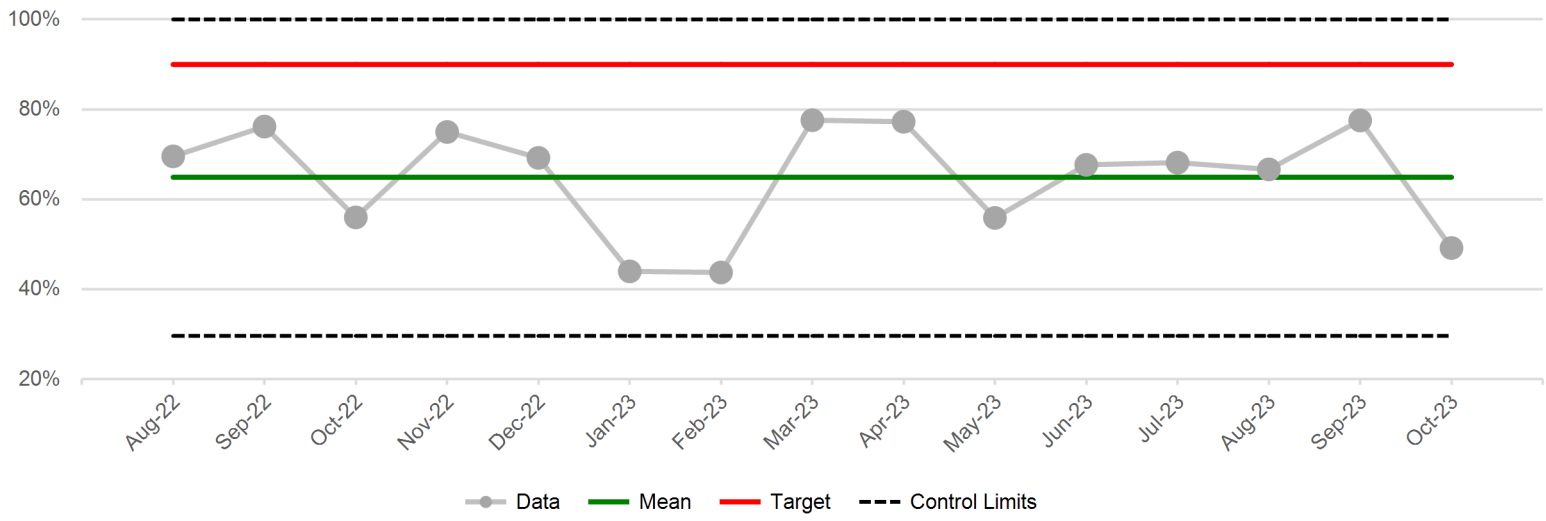
Issues:
Subs RT Standard achieved in October 2023. Radiotherapy – Recent Linac breakdowns have resulted in delayed treatment start dates.

Actions:
Oncology Fragile Service - One Med Onc Locum consultant commenced in post in November and is completing a 4 week induction. Another Med Onc locum consultant is due to commence their induction in January 2024. The post offered for Oncology Sp Dr has passed both PLAB1 and 2 exams and is awaiting a start date. A further Sp Dr commences in post in February 2024. A piece of work on right-sizing the Oncology service workforce has commenced.

Mitigations:

Performance Overview - Operational Performance

62 day screening



Oct-23
49.20%
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 49.2% against a 90% target.

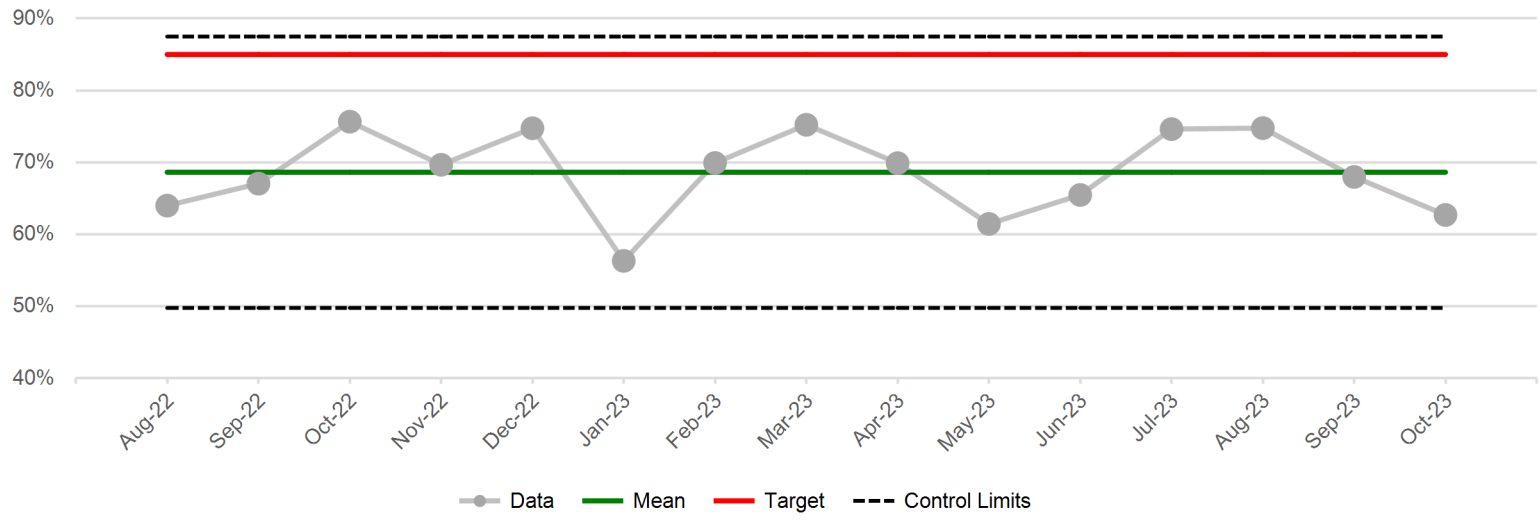
Issues:
Limited theatre capacity continues to impact cancer pathways across the Trust and limited AA and pre-op capacity impacts the ability to be able to populate lists at short notice. In Oncology, recent Linac breakdowns and pharmacy staffing shortages have resulted in delayed treatment start dates.
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 – One Med Onc Locum consultant commenced in post in November and is completing a 4 week induction. Another Med Onc locum consultant is due to commence their induction in January 2024. The post offered for Oncology Sp Dr has passed both PLAB1 and 2 exams and is awaiting a start date. A further Sp Dr commences in post in February 2024. A piece of work on right-sizing the Oncology service workforce has commenced.
Robotic Lists are progressing well, though proving difficult to populate at short notice if there are cancellations due to the lack of trained staff within theatres, pre-op and anaesthetics. Tumour site specialties are working with TACC to ensure the best possible utilisation of lists, including a process for last minute cancellations.
Please also see Actions on accompanying pages.

Mitigations:
Please also see Mitigations on accompanying pages.

Performance Overview - Operational Performance

62 day consultant upgrade



Oct-23
62.70%
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.

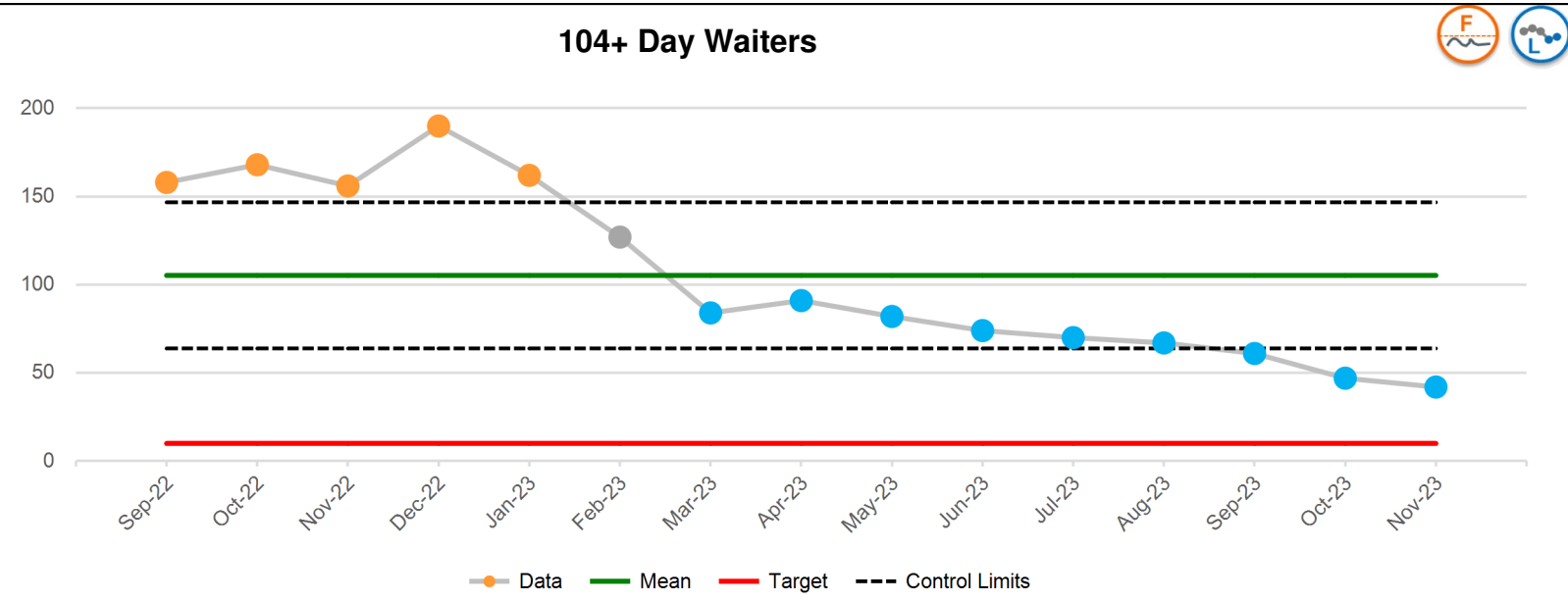
What the chart tells us:
We are currently at 62.7% against a 85% target.

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

Actions:
Oncology Fragile Service – One Med Onc Locum consultant commenced in post in November and is completing a 4 week induction. Another Med Onc locum consultant is due to commence their induction in January 2024. The post offered for Oncology Sp Dr has passed both PLAB1 and 2 exams and is awaiting a start date. A further Sp Dr commences in post in February 2024. A piece of work on right-sizing the Oncology service workforce has commenced.
Robotic Lists are progressing well, though proving difficult to populate at short notice if there are cancellations due to the lack of trained staff within theatres, pre-op and anaesthetics. Tumour site specialties are working with TACC to ensure the best possible utilisation of lists, including a process for last minute cancellations.
Please also see Actions on accompanying pages.

Mitigations:
Please also see Mitigations on accompanying pages.

Performance Overview - Operational Performance



Nov-23
42
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 14th December the 104 Day backlog is at 42 patients.

There is one main tumour site of concern:-

Colorectal 20

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 12% of these patients require support from the Pre-Diagnosis CNS as they have mental or social care needs that have the potential to significantly impact on the length of their pathway.

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

Please also see Actions on accompanying pages.

Mitigations:
Please also see Mitigations on accompanying pages.

OUTSTANDING CARE personally DELIVERED

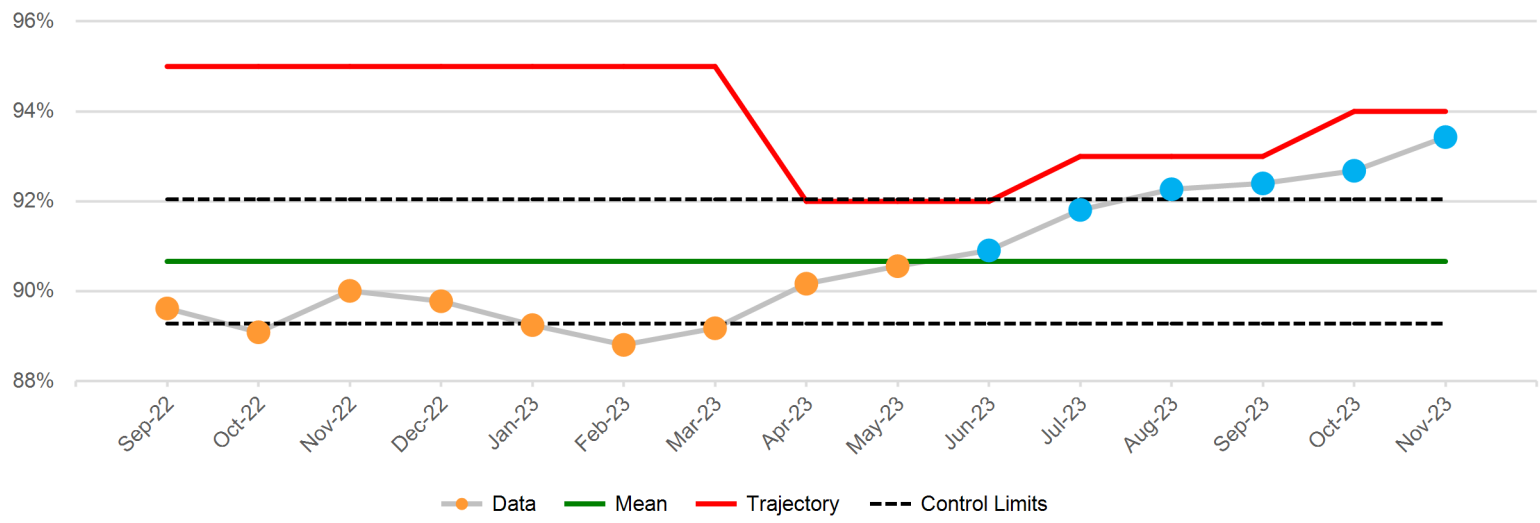
Performance Overview - Workforce

NHS United Lincolnshire Hospitals NHS Trust

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Sep-23	Oct-23	Nov-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	94.00%	92.40%	92.68%	93.43%	91.78%	92.88%	F	H
	Number of Vacancies	Well-Led	People	Director of HR & OD	5.50%	9.15%	8.62%	8.01%	8.57%	7.19%	F	
	Sickness Absence	Well-Led	People	Director of HR & OD	4.70%	5.60%	5.58%	5.54%	5.59%	4.96%	F	
	Staff Turnover	Well-Led	People	Director of HR & OD	12.00%	11.44%	11.20%	11.30%	12.12%	12.75%	P	L
	Staff Appraisals	Well-Led	People	Director of HR & OD	85.00%	71.95%	70.43%	71.24%	70.30%	77.50%	F	H

Performance Overview - Workforce

Overall percentage of completed mandatory training



Nov-23
93.43%
Variance Type
Special cause variation - improvement (Indicator where high is good)
Trajectory
94.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of HR & OD

Background:
% completion is currently 93.43% against a Q3 target of 94.00%.

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

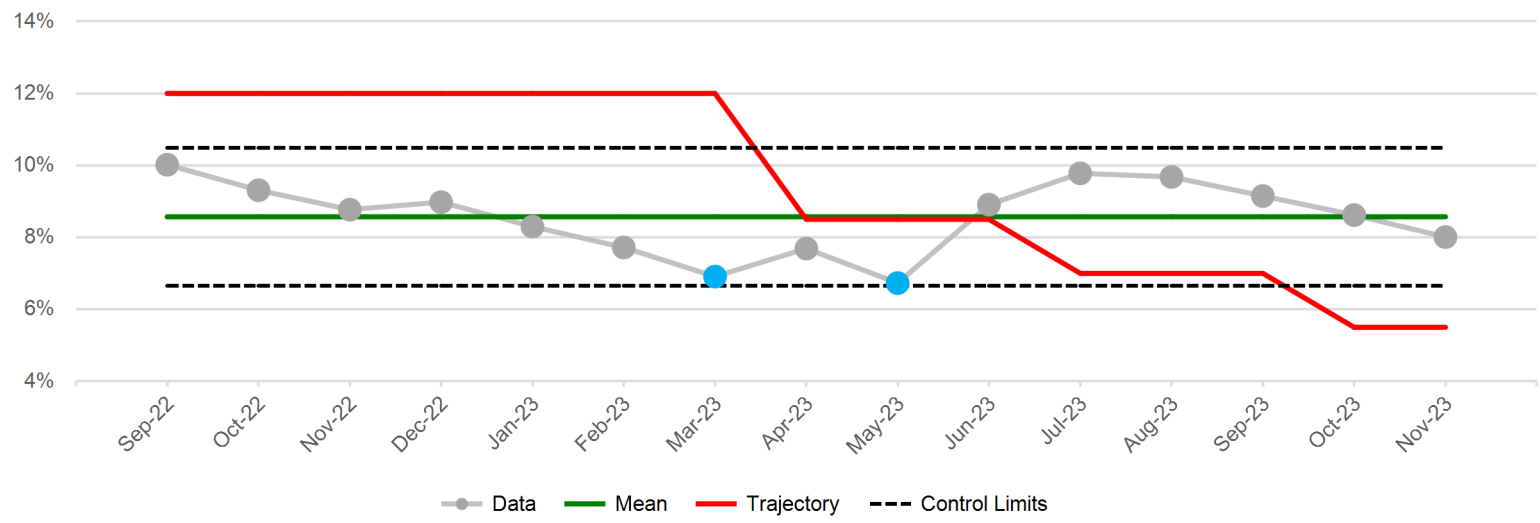
Issues:
- Protected time for core learning continues to be an issue, particularly clinical staff.
- Training profiles are not aligned on an individual/role basis meaning some staff groups are undertaking training which is not required to perform their role.
- Number of staff starting role without induction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

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

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

Performance Overview - Workforce

Number of Vacancies



Nov-23
8.01%
Variance Type
Common cause variation
Trajectory
5.50%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of HR & OD

Background:
November 2023 reported Vacancy Rate is 8.01% against a Q3 target of 5.50%.

What the chart tells us:
That we are not within the Q3 target for November 2023, although we are within our control limits.

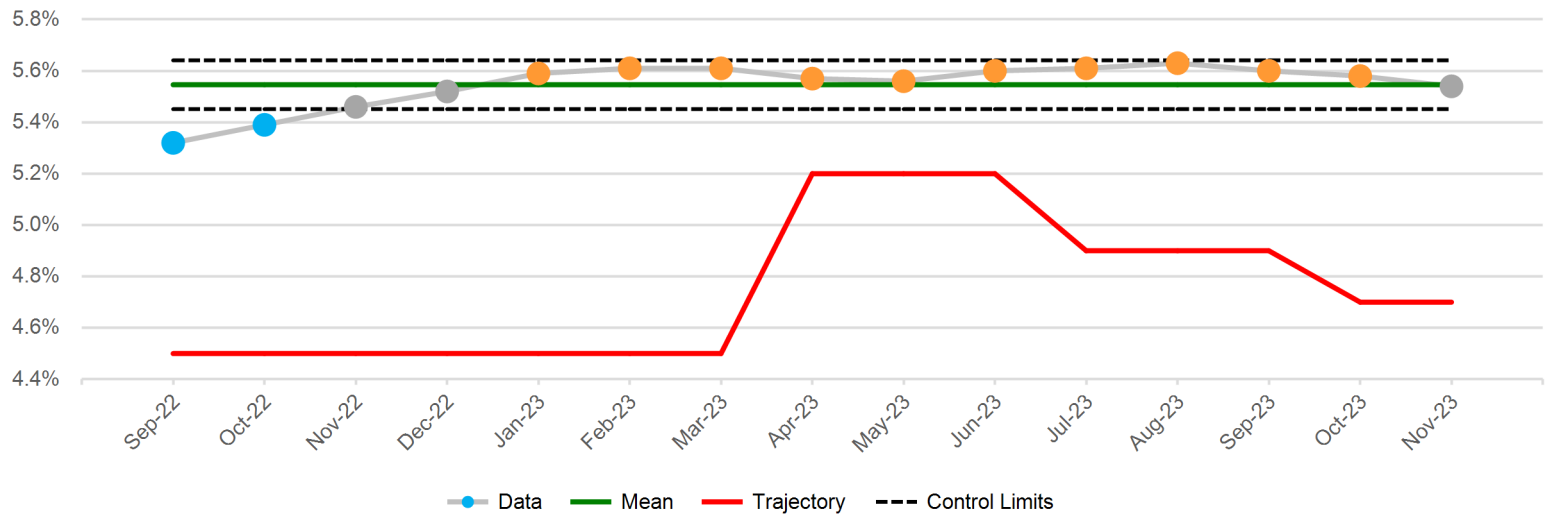
Issues:
• Sizeable business cases have been agreed which have increased our funded establishment.

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

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

Performance Overview - Workforce

Sickness Absence



Nov-23
5.54%
Variance Type
Common cause variation
Trajectory
4.70%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of HR & OD

Background:
5.54% of sickness absence rolling year.

What the chart tells us:
5.54% is above the Q3 target of 4.70%, although is within our control limits.

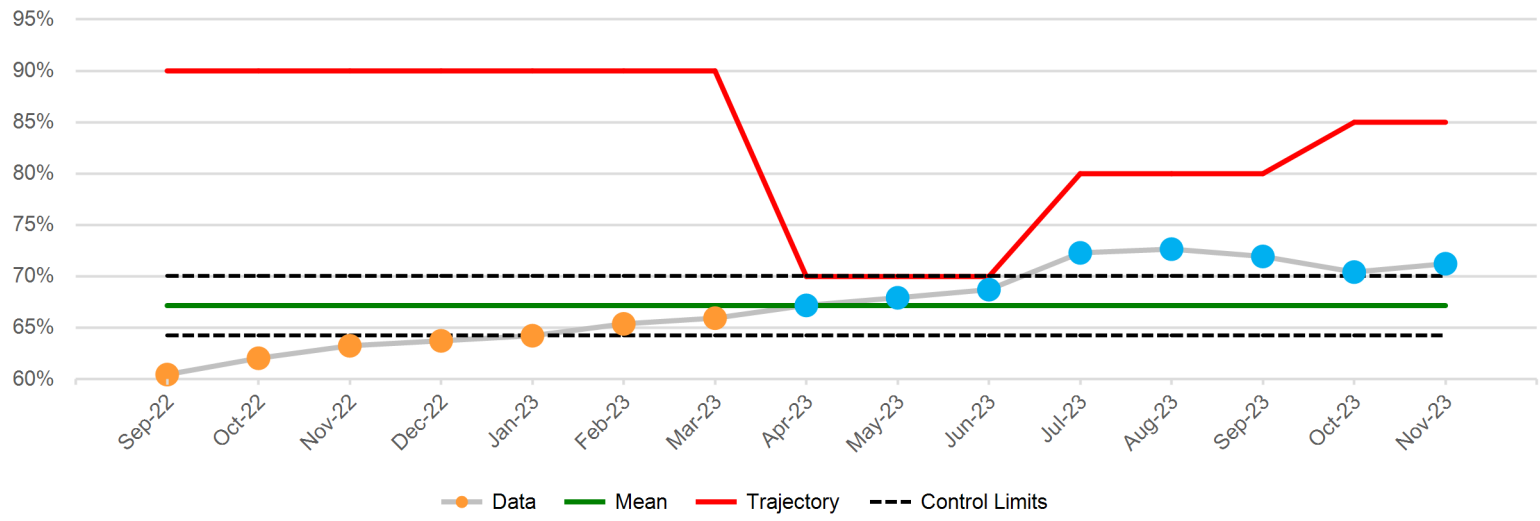
Issues:
- Sickness accounts for >75% of all unplanned absence.
- Consideration to be given to the other reasons that make up the remaining % of unplanned absence.
- AMS compliance remains a challenge

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

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

Performance Overview - Workforce

Staff Appraisals



Nov-23
71.24%
Variance Type
Special cause variation - improvement (Indicator where high is good)
Trajectory
85.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of HR & OD

Background:
% completion is currently 71.24% (Trustwide)

What the chart tells us:
Despite being off track for this measure when compared to the Q3 target (85%) we have seen an improvement when compared to last year.

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

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

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

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

Financial Position Month 8 (2023/24)
Finance Report
5 Year Priority – Efficient Use of Resources

NHS
United Lincolnshire Hospitals
NHS Trust

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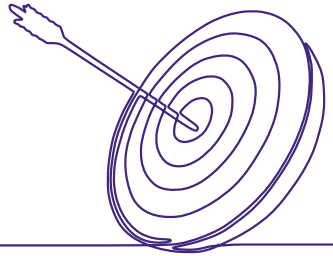
Finance Spotlight Report (Headlines)



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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	59,662	61,422	1,760	468,665	472,720	4,055
Other operating Income	3,449	4,029	580	27,590	29,793	2,203
Employee Expenses	(42,179)	(42,011)	168	(340,002)	(340,607)	(605)
Operating expenses excl employee expenses	(20,249)	(22,808)	(2,559)	(167,969)	(173,563)	(5,594)
OPERATING SURPLUS/(DEFICIT)	**683**	**632**	**(51)**	**(11,716)**	**(11,657)**	**59**
Net finance costs	(521)	(490)	31	(3,862)	(3,934)	(72)
Other Gains / Losses	0	9	9	0	61	61
Surplus / (Deficit) for the period	**162**	**151**	**(11)**	**(15,578)**	**(15,530)**	**48**
Below Line Adjustments	52	68	16	415	398	(17)
Adjusted financial performance surplus / (deficit)	**214**	**219**	**5**	**(15,163)**	**(15,132)**	**31**

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 surplus of £0.2m in-month and an adjusted deficit of £15.1m YTD in line with the financial plan.
- While the risk, mitigations and assumptions relating to the position are detailed in the report, it is specifically noted that the YTD revenue position makes no adjustment in relation to the Elective Recovery Fund for non-delivery of activity.

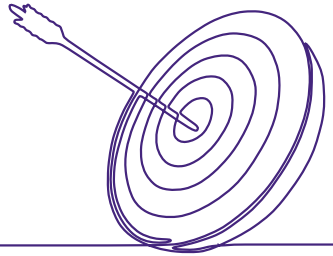
CIP position

- The Trust's CIP plan for 2023/24 is to deliver savings of £28.1m; the Trust planned 32% of savings delivery to be in H1 and 68% to be in H2; because of early delivery, the Trust has YTD delivered savings of £23.7m, or £8.1m favourable to planned savings of £15.7m.

Capital position

- The Trust's capital plan for 2023/24 amounts to £51.3m; YTD the Trust delivered capital expenditure of £8.3m, or £8.7m lower than planned capital expenditure of £17.0m.

Finance Spotlight Report
(Key areas of focus - Income)



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United Lincolnshire Hospitals
NHS Trust

The YTD income position is £6.3m favourable to plan; this includes:

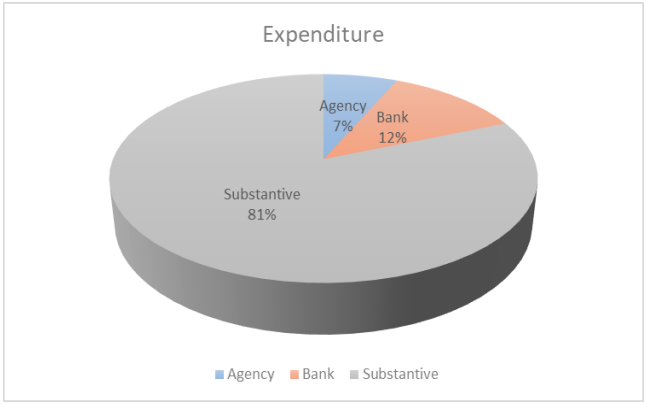
- **NHS patient care income contract – £3.9m favourable to plan**; including
  - Pass through is £3.4m favourable to plan.
  - Prior year income is £0.3m favourable to plan.
- **Operating income from patient care activities - Other – £0.2m favourable to plan** driven by overseas visitor and injury cost recovery scheme over performance.
- **Other operating income - £2.2m favourable to plan; this includes:**
  - Education and training – under performance of £0.3m
  - Income in respect of employee benefits accounted on a gross basis – under performance of £0.1m.
  - Research & Development - over performance of £0.3m
  - Non-patient care services - over performance of £0.8m
  - Car Parking & Catering - over performance of £0.2m & £0.4m respectively.
  - Retail sales over performance of £0.7m (more than offset by additional expenditure)

Finance Spotlight Report
(Key areas of focus - Pay)

United Lincolnshire Hospitals NHS Trust

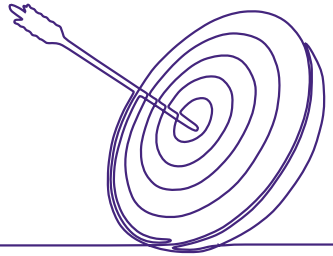
- Pay expenditure of £42.0m in November is £0.2m favourable to planned expenditure of £42.2m; the **YTD pay position is £0.6m adverse to plan**.

- YTD expenditure on Pay comprises of £277.0m (81.3%) on substantive staffing and £63.6m (18.7%) on temporary staffing.
- Compared to the same period in 2022/23:
  - ❖ Agency Pay of £22.1m is £13.6m lower than expenditure of £35.6m in 2022/23.
  - ❖ Bank Pay of £41.5m is £9.7m higher than expenditure of £31.8m in 2022/23.



- The YTD pay position includes:
  - ❖ **Pay award** – The 23/24 A4C pay award was paid (including arrears) in June and the pay award for medical staff was paid (including arrears) in September.
  - ❖ **Local CEA** - The 23/24 local clinical excellence award has been accrued in line with the plan.
  - ❖ **Flowers** - The costs of Flowers have been accrued in line with the plan.
- The adverse YTD pay position includes improved recruitment and retention and other pressures (most notably £1.0m of additional pay costs re the strikes) which have been offset in the main by early delivery of the FRP.

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



United Lincolnshire Hospitals NHS Trust

Non-Pay

- Non-pay expenditure of £22.8m in November is £2.6m adverse to planned expenditure of £20.2m; the **YTD non pay position is £5.6m adverse to plan:**

  - **Activity volumes - £2.2m favourable to plan**

    Activity volumes are lower than planned; YTD the benefit of lower than planned volumes is estimated to be £2.9m, but this is mitigated in part by £0.7m of outsourcing.

  - **CIP – £0.6m favourable to plan**

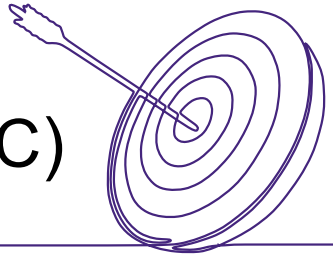
  - **Excess inflation – £3.4m adverse to plan**

    While the 2023/24 financial plan includes non-pay inflation as per national planning guidance, the actual level of inflation suffered was expected to be higher than planned; our estimate of the level of excess non-pay inflation suffered YTD of £2.8m is still subject to validation and the true figure may be higher.

  - **Other – £5.0m adverse to plan**

    The balance of the adverse movement is driven by over performance on pass through drugs & devices (largely offset by over performance on pass through income) and other non-pay pressures; the other pressures include £0.3m re increased recruitment activity, £0.3m re system digital expenditure, £0.7m re bad debt provisions, and £0.5m in relation to retail sales expenditure.

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



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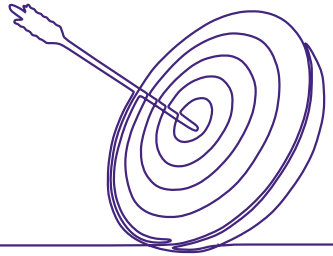
Cash

- The November 2023 cash balance is £35.4m (plan: £24.1m); this is a decrease of £5.9m against the March year-end cash balance of £41.3m.
- Whilst current cash levels remain comfortable; the position will narrow as we move towards the year end and into 2024/25 and will require careful management of cash and working capital. Key determinants of the year end cash position will be the level of capital creditors along with any variation from the planned revenue outturn.

BPPC

- The BPPC performance for November was 93% / 86% by value / volume of invoices paid (appendix 5d).
- Year to date performance is 86% / 82% by value / volume, this compares to the full year performance in 2022/23 of 79% / 70%.
- At the end of November there were circa 798 unpaid invoices (£1.3m) over term (October 1,360 / £2.7m). 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



United Lincolnshire Hospitals NHS Trust

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

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

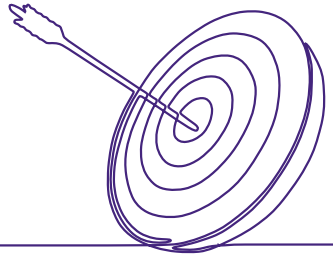
Metric	Rating Boundary			
	1	2	3	4
Capital servicing capacity	2.5	1.75	1.25	<1.25
Liquidity ratio (days)	0	-7	-14	<-14
I&E Margin	1%	0%	-1%	<=-1
I&E margin distance from plan	0%	-1%	-2%	<=-2%
Agency	0%	25%	50%	>=50%

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

Finance and use of resources rating	Full Year ending:					Actual	Forecast
	31/03/2019	31/03/2020	31/03/2021	31/03/2022	31/03/2023	NOV 2023	31/03/2024
Capital service cover metric	(10.40)	(1.73)	0.06	3.60	1.48	0.82	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)	(13.45)	(19.12)
Liquidity rating	4	4	1	1	3	3	4
I&E margin metric	(19.71%)	(7.62%)	0.38%	0.29%	(1.80%)	(3.01%)	(2.76%)
I&E margin rating	4	4	2	2	4	4	4
Agency metric	77.00%	110.00%	113.00%	120.00%	~~0.00%~~	~~0.00%~~	0.00%
Agency rating	4	4	4	4	~~.~~	~~.~~	1
I&E margin: distance from financial plan - metric	(2.80%)	0.70%	n/a	0.01%	(1.80%)	0.12%	0.10%
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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United Lincolnshire Hospitals
NHS Trust

	31-Mar-23	30-Nov-23			31-Mar-24	
		Plan	Actual	Variance	Plan	Forecast
	£000	£000	£000	£000	£000	£000
Intangible assets	11,383	4,912	8,666	(3,754)	4,357	7,244
Property, plant and equipment	298,860	292,256	294,272	(2,016)	306,970	326,392
Right of use assets	11,807	10,380	10,565	(185)	9,656	14,190
Receivables	2,157	1,848	2,090	(242)	1,848	1,848
Total non-current assets	**324,207**	**309,396**	**315,594**	**(6,198)**	**322,831**	**349,674**
Inventories	6,133	7,000	6,893	107	7,000	7,000
Receivables	52,873	29,660	32,204	(2,544)	30,740	29,000
Cash and cash equivalents	41,269	24,134	35,404	(11,270)	16,201	22,573
Total current assets	**100,275**	**60,794**	**74,501**	**(13,707)**	**53,941**	**58,573**
Trade and other payables	(89,905)	(70,687)	(60,673)	(10,014)	(76,995)	(78,578)
Borrowings	(3,129)	(2,973)	(3,198)	225	(2,879)	(2,894)
Provisions	(17,670)	(5,625)	(20,218)	14,593	(4,825)	(8,049)
Other liabilities	(1,260)	(2,630)	(10,937)	8,307	(1,130)	(1,130)
Total current liabilities	**(111,964)**	**(81,915)**	**(95,026)**	**13,111**	**(85,829)**	**(90,651)**
Total assets less current liabilities	**312,518**	**288,275**	**295,068**	**(6,793)**	**290,943**	**317,596**
Borrowings	(12,189)	(10,530)	(10,547)	17	(9,481)	(14,157)
Provisions	(5,108)	(3,092)	(5,166)	2,074	(2,992)	(5,165)
Other liabilities	(11,069)	(10,733)	(10,734)	1	(10,566)	(10,566)
Total non-current liabilities	**(28,366)**	**(24,355)**	**(26,447)**	**2,092**	**(23,039)**	**(29,888)**
Total assets employed	**284,152**	**263,920**	**268,621**	**(4,701)**	**267,904**	**287,708**
Financed by						
Public dividend capital	724,041	728,323	724,042	4,281	738,081	748,947
Revaluation reserve	42,584	28,123	41,820	(13,697)	27,891	41,443
Other reserves	190	190	190	(0)	190	190
Income and expenditure reserve	(482,663)	(492,716)	(497,431)	4,715	(498,258)	(502,871)
Total taxpayers' equity	**284,151**	**263,920**	**268,621**	**(4,701)**	**267,904**	**287,708**

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 £35.4m is expected to reduce as the year progresses, in line with the planned deficit and a reductions in provisions.

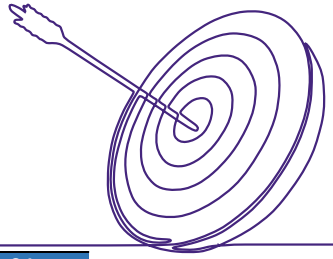
Note 3: Receivables is predominantly a mix of invoiced debt £3.2m, accrued income £12.5m and prepayments £16.9m. See Appendix 5a-b

Note 4: The overall level of Trade and other payables at £60.7m 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-f.

Note 6: The planned capital programme for 2023/24 will result in asset additions of £51.0m. 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 2023– March 2024



NHS
United Lincolnshire Hospitals
NHS Trust

	31-Mar-23	30-Nov-23			31-Mar-24	
		Plan	Actual	Variance	Plan	Forecast
	£000	£000	£000	£000	£000	£000
Operating surplus / (deficit)	(13,371)	(11,716)	(11,657)	(59)	(15,300)	(15,462)
Depreciation and amortisation	22,001	16,226	16,772	(546)	24,127	25,175
Impairments and reversals	5,079	-	-	-	-	-
Income recognised in respect of capital donations	(82)	-	(47)	47	(50)	(50)
Amortisation of PFI deferred credit	(503)	(336)	(335)	(1)	(503)	(503)
(Increase) / decrease in receivables and other assets	(38,148)	(1,160)	20,831	(21,991)	(2,240)	24,044
(Increase) / decrease in inventories	(127)	-	(760)	760	-	(867)
Increase/(decrease) in trade and other payables	1,593	(13,590)	(10,856)	(2,734)	(11,967)	(19,727)
Increase/(decrease) in other liabilities	130	1,500	9,677	(8,177)	-	(130)
Increase / (decrease) in provisions	10,861	(1,310)	2,569	(3,879)	(2,210)	(9,601)
Net cash flows from / (used in) operating activities	**(12,567)**	**(10,386)**	**26,194**	**(36,580)**	**(8,143)**	**2,879**
Interest received	1,175	1,580	1,826	(246)	2,100	2,938
Purchase of intangible assets	(4,142)	-	(226)	226	-	(226)
Purchase of property, plant and equipment	(42,693)	(30,684)	(26,741)	(3,943)	(45,930)	(36,700)
equipment	156	-	33	(33)	-	33
Net cash flows from / (used in) investing activities	(45,504)	(29,104)	(25,108)	(3,996)	(43,830)	(33,955)
Public dividend capital received	19,863	4,435	-	4,435	14,193	24,905
Other loans repaid	(402)	(403)	(403)	-	(805)	(805)
Capital element of finance lease rental payments	(2,416)	(1,550)	(1,585)	35	(2,319)	(2,283)
Interest element of finance lease	(121)	(73)	(78)	5	(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)	(6)	4	(4)	(6)
Net cash flows from / (used in) financing activities	11,043	(1,589)	(6,950)	5,361	2,961	12,380
Increase / (decrease) in cash and cash equivalents	**(47,028)**	**(41,079)**	**(5,864)**	**(35,215)**	**(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**	**24,134**	**35,405**	**(11,271)**	**16,201**	**22,573**

Note 1: Cash held at 30 November was £35.4m against a plan of £24.1m. This represents a decrease of £5.9m against the March year-end cash balance of £41.3m.

Note 2: The opening cash position was £24m higher than planned predominantly due to the volume / value of contract variations during March which from a cash perspective were not transacted until Q1 2023/24. This is illustrated by the significant reduction in receivables in the current year.

Note 3: Although a number of factors are contributing to the cash balance being higher than plan, a significant contributor is the income received in advance, which from an I&E perspective is deferred.

Note 3: Cash balances are expected to reduce during Q4. Principle drivers being:

- The planned deficit of £20.7
- Release / utilisation of provisions associated with litigation and contractual obligations – circa £12m.
- Reductions in the level of deferred income
- Utilisation of capital cash as the capital programme builds momentum through Q4

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

United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*11 January 2023*
Item Number	*Item 13.1*

Strategic Risk Report

Accountable Director	*Kathryn Helley, Director of Clinical Governance*
Presented by	*Kathryn Helley, Director of Clinical Governance*
Author(s)	*Rachael Turner, Risk & Datix Facilitator*
Report previously considered at	*Lead assurance committees for each strategic objective*

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

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

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

Executive Summary

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

- Due to changes in reporting timeframes this report contains data that covers November and December 2023 at the point of writing.

- There were 15 quality and safety risks rated Very high (20-25) reported to the Quality Governance Committee this month, a reduction of two 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 epilepsy pathways within Acute Paediatrics that meet National standards
    - Medicines reconciliation compliance;
    - Consultant capacity for Haematology outpatient appointments;
    - Non-recurrent funding in Cancer services;
    - Safety risk from Nationwide shortage of suction catheters as identified by NHS supply chain

- Following presentation at the Risk Confirm and Challenge Meeting during this period, the following risks have been updated:

    - ICU capacity for elective surgery- **This risk is now closed as ICU have been back to full capacity since July.**
    - Quality and safety risk from inability to deliver diabetes pathways that meet National standards-Acute-**Due to staffing now in place this risk has been reduced to a Moderate risk (12)**

- There were 6 People and Organisational Development risks rated Very high (20-25) reported to the People & Organisational Development Committee this month, this remains stable from the previous reporting period:

    - Disruption to services due to potential industrial action (Trust-wide)
    - Staffing levels requiring an increase in Pharmacy to be able to provide a seven-day service.
    - Pharmacy service not able to withstand prolonged staff absence.

- Pharmacy workload demands
- Service configuration (Haematology)
- Consultant workforce capacity (Haematology)

- There were 6 Very high risks (20-25) reported to the Finance, Performance and Estates Committee this month, this remains stable from the previous reporting period:
  - Potential for a major fire;
  - Compliance with fire safety standards, assessed by Lincolnshire Fire and Rescue Service;
  - Exceeding the agency cap due to the cost of reliance upon temporary clinical staff
  - Reliance on agency / locum medical staff in Urgent & Emergency Care
  - SAR's Compliance and access to Health records in accordance with statuary requirements.
  - Med Air Plant LCH (Medical Gas)

Purpose

The purpose of this report is to enable the Trust Board to review the management of significant risks to strategic objectives and consider the overall extent of risk exposure within the Trust at this time.

1. Introduction

1.1 The Trust's risk registers are recorded on the Datix Risk Management System. This report is focussed on significant risks to each objective, those with a current rating of Very high risk (a score of 20-25).

1.2 Full details of all active Very High and High risks (those with a current risk score of 15-25) are included in **Appendix A**, and a summary of Very High risks is provided in Section 2 below. Moderate and Low risks (those with a score of 12 and below) are managed at divisional level. **Of note progress updates against each risk within this report can be found in Appendix A.**

1.3 The Risk Register Confirm and Challenge Group continues to meet on a monthly basis, reviewing all High and Very high risks as well as receiving presentations from clinical and corporate business areas on a rotational basis to enable constructive feedback to be provided.

2. Trust Risk Profile

2.1 There were 464 active and approved risks reported to lead committees this month, an increase of 38 since the last reporting period.

2.2 There were 27 risks with a current rating of Very high risk (20-25) and 46 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)
35(+3) (7%)	**95 (+8)** (20%)	**261 (+27)** (55%)	**46 (+2)** (10%)	**27 (-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 13 Very high risks (reduction of 2) and 14 (increase of 1) High risks recorded in relation to this objective. A summary of the Very high risks is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4878	If there are significant delays within the planned care non-admitted pathway (outpatients) then patients may experience extended waits for diagnosis and treatment, resulting in failure to meet national standards and 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	20/12/2023
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.	13/12/2023
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.	18/12/2023

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.	22/12/2023
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.	20/12/2023

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.	20/12/2023
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.	22/12/2023

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	19/12/2023
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	19/12/2023

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	22/12/2023

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.	11/12/2023
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.	13/11/2023

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.	19/12/2023

2.3.1 Following the Risk Confirm and Challenge meetings for this reporting period, the following risks were presented:

- **Quality and safety risk from inability to deliver paediatric diabetes pathways that meet National standards-Acute (12)**

The risk reduction plan that was in place has resulted in an increase in team size following successful recruitment which has improved delivery of diabetes service to CYP within the county. Further work is required to update NG18 baseline assessment to identify how close the team is to delivering service in line with National standards. Agreement was made that this would reduce from a **Very high to a Moderate risk**.

- **ICU capacity for elective surgery- This risk is now closed as ICU have been back to full capacity since July.**

The Division presented the risk at the RRC&C meeting were it was confirmed that ICU capacity had increased to full capacity at 11 level 3 beds following both medical and nurse staffing recruitment. Agreement was made that this risk could now be closed.

Strategic objective 1b: Improve patient experience

2.4 There was no Very high risk and 3 High risks (increase of 1) recorded in relation to this objective.

Strategic objective 1c: Improve clinical outcomes

2.5 There were 2 Very high risks, and 3 High risks remaining stable 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.	21/12/2023
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.	21/11/2023

Strategic objective 2a. A modern and progressive workforce

2.6 There was 4 Very high risks, a reduction of one and 7 High risks, remaining stable 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.	11/12/2023

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	22/12/2023

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."	18/12/2023

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	22/12/2023

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

2.7 There were 2 Very high risks and 5 High risks (increase of 2), 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.	19/12/2023
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.	21/12/2023

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

2.8 There were 3 approved Very high risks (20-25) remaining stable and 6 High risk (15-16) 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
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	19/12/2023
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	19/12/2023

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.	14/11/2023

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	18/12/2023

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
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.	13/12/2023

Strategic objective 3c: Enhanced data and digital capability

2.10 There was 1 approved Very high risk, remaining stable (20-25) recorded in relation to this objective, There were also 6 High risks (15-16), an increase of three from the previous report. A summary of the Very High risk is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4657	If the Trust does not comply with Subject Access Requests (SARs) and Access to Health Records provisions in accordance with statutory requirements specified legislation, then it could lead to complaints to the Trust and Information Commissioner's Office (ICO). This could result in regulatory action and possibly financial penalties. Inconsistent levels of expertise outside of the IG team regarding SAR requirements. Lack of technical tools to carry out a search of emails / systems to identify personal information held. Potential financial implications."	Very high risk (20)	"Current active communications with ICO- regulator. Changes to processes are being constantly discussed and implemented. Resource needs being discussed and temporarily increased to support. Monitored through the IGG in DP KPI report. Head of IG leading on work to review and improve. Working in a more digital way where feasible. Workforce change is required which will be a much longer process. Early identifications of chasers and urgent requests to reduce the likelihood of complaints."	20/12/2023

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 15 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 epilepsy pathways within Acute Paediatrics that meet National standards
- Medicines reconciliation compliance;
- Consultant capacity for Haematology outpatient appointments;
- Non-recurrent funding in Cancer services;
- Safety risk from Nationwide shortage of suction catheters as identified by NHS supply chain

3.1 There were 6 People and Organisational Development risks rated Very high (20-25) reported to the People & Organisational Development Committee this month, this is a reduction of two since the last reporting period:

- Disruption to services due to potential industrial action (Trust-wide)
- Staffing levels requiring an increase in Pharmacy to be able to provide a seven-day service.
- Pharmacy service not able to withstand prolonged staff absence.
- Pharmacy workload demands
- Service configuration (Haematology)
- Consultant workforce capacity (Haematology)

3.2 There were 6 Very high risks (20-25) reported to the Finance, Performance and Estates Committee this month:

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

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

ID	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**																			
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.	16/11/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Recruit to vacant posts.	[18/11/2023 21:05:16 Nicola Cornish] No change to risk score. Have an ICU oversight group with x 3 workstreams one of which is workforce. Meets weekly to look at recruitment and medical workforce. We have recruited trainee ACCP's which won't solve current issues but is future planning. [15/06/2023 09:32:33 Wendy Rojas] No change to risk status.beds capped at x8 L3 [18/04/2023 13:52:46 Caroline Donaldson] No change in risk status. Bed base number remains at x8 Level 3 beds. [09/01/2023 14:27:52 Caroline Donaldson] No change in status - still remains an issue. Bed base numbers remain reduced at x8 Level 3 beds. [29/11/2022 15:16:01 Caroline Donaldson] 17/11/2022 Discussed at TACC CBU governance meeting. Still remains an issue. [19/10/2022 15:22:43 Caroline Donaldson] 19/10/2022 CBU are looking to request an escalated rate for recruitment. Paper is currently in progress to request. Confirmed by S Daniels. Quality Impact Assessment undertaken and LCH ITU reduced to 8 x L3 bed equivalents on a temporary basis. For review Update 25.7.22 - substantive advert closes 8th August 2022. Locum advert is closed but awaiting shortlisting. Awaiting confirmation of interview date but looking like 27.9.22. Escalated to Medical Director and COO re decision to continue L3 equivalent reduction at current time.	4	31/10/2022		16/02/2024
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 deemed locally as 24 hours.	At present there is one 1.0 WTE VAN (band 6) and two 22.5 hours HCSW (band 2) covering: - Lincoln clinics (in patient only) Monday (up to and including 6 patients) and a Wednesday out/in patients - Pilgrim clinics Tuesday and Thursday, both in and outpatients - All clinics have slots for up to 6 patients, however, many late referrals are received and the clinic can increase to anything up to 12 patients. This means that the VAN goes home late most nights that incurs overtime payment. This additional activity is driven through urgent care pathways and is reliant upon a stretched team to meet this demand. As services enter a a post COVID climate there has been a recognised increase in complexity of presentations due to non-presentation at an earlier point. Case of Need has been written with final finance input outstanding to then go to CRIG ACPs are trained in this procedure but should not be relied upon as takes away from other core duties and is not a sustainable. Interventional Radiology is picking up some activity although this exposes patients to radiation and is not a sustainable option. This also require anaesthetics and theatre resources.	Volume of requests against number of staff and time taken to acquire IR1 submissions - started to see an increase in incidents being reported.	19/10/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Business case established with final finance input outstanding to then go to CRIG 6 month secondment for a PICC nurse has been advertised and will require training Give consideration to training of a wider network of clinicians associated with their individual service needs	[23/10/2023 11:25:05 Nicola Cornish] Extended secondment until end of March 2024, approval and QIA for business case are ongoing [03/05/2023 10:26:45 Rachael Turner] Following further quantitative data provided this risk has now been validated as an active risk for the trust register. [26/04/2023 11:26:50 Rachael Turner] Risk needs to return to RRC&C once we have the quantitative data confirmed. Needs to look at where this risk sits as possibly more appropriate with CSS. This will be re-presented in the May RRC&C meeting. [25/04/2023 10:06:15 Chris Sewell] Due to unforeseen circumstances and long term absence the service has had to rely on the ACP and Interventional Radiology options as outlined in the risk controls. It is anticipated that they will return at the beginning of May. This has led to an increase in IR1s.	1	01/06/2023		19/01/2024
5169	Physical or psychological harm	Ratcliff, Carl	East, Mr Sean		Patient Safety Group	09/05/2023	15	Risk assessments	Clinical Support Services	Therapies and Rehabilitation CBU		Lincoln County Hospital	Approx 15-20 Stroke outliers at any time on the LCH site. Therefore not on the stroke unit and not receiving specialist stroke therapy at the frequency and duration required by SSNAP. Outlier patients are not cohorted on site and can be on any ward therefore Stroke staff cannot go and review and advise. Stroke patient on other non stroke ward will not be assessed as a priority as they are not medically optimised and ready for discharge. Current staffing levels are for the 28 bedded Stroke unit only. If a stroke patient is seen o a non stroke ward this is to the detriment of another patient on that ward. Increased staff	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	16/10/2023	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 16/10/23 funding transferred to LCH budget to help support staffing and recruitment has started	[16/10/2023 11:12:34 Sean East] 16/10/23 funding transferred to LCH budget to help support staffing and recruitment has started [08/09/2023 14:20:40 Maddy Ward] Consultation in progress currently with the intention to move some money across to Lincoln. This links in with joint working with LCHS. [23/06/2023 14:13:54 Rose Roberts] No change, went to C&C recently and level agreed. [07/06/2023 12:45:33 Rachael Turner] Risk discussed at RRC&C meeting 07/06/2023. Hyper acute patients outlied to LCH site.Specialist staff not currently available to support these patients. Patients are at risk due not being put into priorities causing delays.This causes a risk of patient harm due not progressing or adding to disability due to not being seen in appropriate pathway. This is also impacting is discharging delays to patients. More work is also required with the community. Score agreed at 15	8	13/05/2024		08/12/2023
4779	Physical or psychological harm	Harris, Michelle	Ratcliff, Carl		Patient Safety Group	16/01/2022	20		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	13/12/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	defined plans to address backlog for at risk areas	[13/12/2023 19:05:30 Rachael Turner] No current update, meeting to be had to combine with Risk 4780 and 4778. Due to staffing working capacity this will be done in January 24. [27/09/2023 11:31:18 Rachael Turner] Risk discussed at RRC&C as part of the Deep Dive. Since Covid this risk has moved on, this needs to be reviewed and possibly combined with risk ID 4780 and 4778. [30/08/2023 11:19:10 Carl Ratcliff] to review with COO as may be able to remove given lower COVID demand [23/07/2023 12:57:33 Carl Ratcliff] Proposal been constructed to allow better use of LCH beds - await feedback from Execs on next steps [24/04/2023 12:28:58 Carl Ratcliff] Improvement work started with team and perfect week in May will look at all opportunities for service. [27/01/2023 10:23:30 Charles Smith] 27/01/23 - CS DGM - Ongoing area of concern due to workforce and ACP gaps (being recruited to but time required to train). TIA still a concern but stable numbers. [16/12/2022 14:35:47 Carl Ratcliff] Additional work in palce to find external support / validate PWL and push patients through system [22/11/2022 17:25:10 Carl Ratcliff] Aim to have outliers back in right place and work continues to improve OPD work. Limited consultant numbers still mean there is a risk to OPD planned care work Plans in place to address backlogs across all areas. Significant area of risk for TIA. 23.08.22 Remains an issues although noting covid cases have dropped. Will be resolved once the improvement work on wards in completed to remove outliers and pts are in the correct place with appropriate bed numbers	4	31/03/2022	29/12/2023	13/03/2024
5301	Physical or psychological harm	Cooper, Mrs Anita	Richardson, Carol	Hospital Transfusion Group	Patient Safety Group	28/11/2023	16		Clinical Support Services	Cancer Services CBU	Blood Transfusion	Grantham & District Hospital	Potential harm to patients. Platelets used in massive haemorrhage unable to be stored correctly in line with Blood Safety Quality Regulations (BSQR 2005)- No facility to incubate and agitate blood product due to failure of blood storage device.	Currently no controls in place that meet BSQR Although the device is condemned, service is being supported by temporarily directing a large stand up fan to blow cold air over the platelet incubator condenser in order to try and keep it cool. This is obviously not ideal and would not pass an MHRA or UKAS inspection.	audit	28/11/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	replace blood storage device		4	29/01/2024		20/12/2023

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
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	21/11/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	1) CCNS to have access to SystemOne	[21/11/2023 13:35:58 Kate Rivett] 21/11/23 - KR 1. Reviewed at monthly Risk Register Review meeting; 2. Meeting held between representatives from ULHT, LCHS (local hosts for SystmOne) and ICB; 3. LCHS unable to commit to supporting team with SystmOne access at the moment due to capacity constraints. ULHT would also need to provide funding to enable delivery of SystmOne to the organisation; 4. Meeting to be scheduled between TV (Lincs ICB) and SH (Divisional MD) to discuss possible options. [17/10/2023 14:25:52 Nicola Cornish] Met with Digital transformation team, 3 options considered but SystemOne is the only viable option and some colleagues are already using this system. [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	6	30/04/2024		17/01/2024
5267	Physical or psychological harm	Ratcliff, Carl	Marsh, David			26/09/2023	16		Medicine	Cardiovascular CBU	Cardiology		If there is a continued delay in processing of Cardiac MRIs, which is impacted by workforce limitations and an existing backlog of scans, then it could lead to delayed assessment and treatment for patients, resulting in potential for serious harm, a poor patient experience and a poor clinical outcomes. Cardiac MRI backlog was recorded at 125 11th September, this went down to 72 2nd October, this backlog continues to be monitored.	1.Outsourcing some CMR reporting to Medica - they will be reporting ten studies per week for the foreseeable future, which is around one third of our current reporting workload. At cost. 2.Undertaking additional reporting sessions - this will help significantly with the reporting backlog but not solve causal factors. At cost.	Size of reporting backlog (number/time required) Average time for reporting of scans from date of imaging	25/10/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	1. Address reporting productivity across workforce. 2. Work with imaging colleagues to develop/review need for additional imaging consultant with CMR included in Skill-set. 3. Continue to mitigate proactively at cost via current controls.	[25/10/2023 11:12:43 Rachael Turner] Risk discussed at RRC&C meeting 25/10/2023, risk validated as 4x4:16 High Risk. [26/09/2023 15:02:00 Charles Smith] As of 11/09/23: •There are a total of 125 cardiac MRI studies awaiting reporting •The oldest scan on the reporting list is from 24 July 2023 (seven weeks) •There are 13 scans from July, 68 scans from August and 44 scans from September waiting to be reported	3	01/07/2024		25/01/2024
4879	Physical or psychological harm	Harris, Michelle	Lynch, Diane	Patient Safety Group		24/03/2022	20	Risk assessments	Clinical Support Services	Cancer Services CBU			If there are significant delays within the planned care cancer pathway then patients may experience extended waits for diagnosis and surgery, resulting in failure to meet national standards and potentially reducing the likelihood of a positive clinical outcome for many patients	National policy: - NHS standards for planned care (cancer) ULHT policy: - Cancer care pathway & booking systems / processes - Clinical Harm Review (CHR) processes ULHT governance: - Lincolnshire System Elective Recovery meeting – Monthly - Lincolnshire system RTT Cancer and Diagnostic- Weekly - ULHT Cancer Recovery and Delivery – Weekly - ULHT Clinical Business unit meetings – Weekly - Integrated Performance Report (IPR) to Trust Board - Monthly - Divisional Performance Review Meeting (PRM) process - Clinical Harm Oversight Group	Cancer patients awaiting surgery - all within 31 days New standards: 28 days for first diagnosis; 62 day max wait	22/12/2023	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	[22/12/2023 13:10:45 Gemma] Haematology right-sizing paper presented to CRIG 19/12/2023. Approved to progress to ICB / Trust Board. Oncology right-sizing being prepared for next CRIG. [27/11/2023 13:49:23 Gemma] Rightsizing haematology paper approved at CRIG to progress to SJBC. SJBC has been draft and submitted. Oncology rightsizing CoN in development. COO approved recruitment 'at risk' ahead of the investment decision outcomes. Recruitment underway for medical, nursing and admin posts to support the services. New roles in development e.g. nurse consultant. Meetings with the COO continuing for support and oversight. [14/09/2023 14:59:30 Rose Roberts] Rightsizing Haem paper to be presented at CRIG Sept 2023. [01/08/2023 15:29:44 Rachael Turner] Action plan in place July 2023, monitored by the COO weekly for Haematology. Agreements in place to start recruitment for clinical and admin staff. CEO and COO met with Haematologists and CBU Senior Team 31st July. Work will start on oncology in August. [02/06/2023 12:41:34 Maddy Ward] Andrew Morgan requested a briefing paper for ELT which is now complete in conjunction with transformation and due to be circulated to execs on 05/06/2023. [24/04/2023 10:39:20 Maddy Ward] Oncology and Haematology service review carried out in March/April in association with strategy, planning, improvement and integration directorate [07/03/2023 10:21:35 Rose Roberts] The cancer recovery plan is a high priority for the division. More work to do but good progress in Endoscopy and Radiotherapy. [02/03/2023 08:41:30 Maddy Ward] Risk lead changed to Diane Lynch as Lucy Rimmer has left the trust as of 02/02/2023. DL is the new interim DMD until early June [13/01/2023 15:07:01 Paul White] Closed in error - re-opened. [17/11/2022 12:24:41 Rose Roberts] 4736 can be closed as Estates have investigated everything they can and Paula is launching an education and poster campaign. Trust comms have already gone out. [16/11/2022 15:54:57 Rose Roberts] Ongoing 4/8/22 Confirmed it is an ongoing corporate risk being managed at divisional level. Ongoing	8	31/03/2023	31/03/2023	22/01/2024
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	19/12/2023	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	[21/12/2023 11:17:23 Nicola Cornish] 19/12 - January start date for most new staff, one will be in April. Review again once staff are in post, completed induction and orientation etc. [21/11/2023 14:31:10 Kate Rivett] 21/11/23 - KR 1. Discussed at monthly Risk Register Review meeting; 2. Increase in team size following successful recruitment has improved delivery of diabetes service to CYP within the county; 3. To update NG18 baseline assessment to identify how close team is to delivering delivering service in line with National standards; 4. To arrange review of grading via Risk Register Confirm and Challenge as there is potential to reduce the Likelihood of the risk occurring thus reducing the overall risk level. [17/10/2023 14:02:46 Nicola Cornish] Recruitment process ongoing, induction 6-8 weeks. Risk rating can be reviewed following completion of this. Business case is completed and funding secured for all posts, LPFT query about funding for psychologist post. Regular T&F group meetings to monitor progress. Clinic capacity remains an ongoing problem. [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	4	15/03/2024	15/03/2024	19/01/2024
5101	Phys	Rivett	Hera	Child	Clini cal Effec	####	20		Fami	Child	Child	Trust	Quality and safety risk from inability to deliver epilepsy pathways within Community Paediatrics that meet	1. Single Consultant Paediatrician (DH) is currently managing all children with Epilepsy alongside a single specialist epilepsy nurse;	1. Audit of compliance with NICE guideline NG217 - Epilepsies in Children, Young People and Adults and	####	Extre	Seve	Very	20	1. Business case is being produced to enable establishment of fully funded epilepsy service	[21/12/2023 11:19:49 Nicola Cornish] Consultant caseload review commenced in order to apply RAG rating system to each case to enable identification of those most at risk. Reviewed 100 patients so far. 2	8	####	####	####

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (Initial)	Source of Risk	Division	Clinical business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
5016	Physical or psychological harm	Hamer, Fiona	Smith, Charles	Workforce Strategy Group	Patient Safety Group	02/09/2021	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	13/12/2023	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	[13/12/2023 16:47:38 Rachael Turner] No significant update to this risk, flow expected to ramin challenging across winter. Re: implementation of SAFER process but not yet seen consistent improvement" [20/11/2023 20:22:32 Rachael Turner] No current change, risk score to remain. [17/10/2023 10:08:18 Rachael Turner] No current change, currently huge risk due to lack of flow. Increase in patients that need admitting and require treatment whilst waiting for beds. Staffing has increased in this area to decrease patient harm. The professional standards have been introduced to clinicians for them to see patients within 30 minutes, this is being audited for compliance. The continued flow policy has reintroduced but this risk still remains at the same score. [30/08/2023 11:25:49 Carl Ratcliff] To review post meeting with execs on 30th August 2023 - action plan in place to manage risk [15/08/2023 11:11:54 Helen Hartley] Continuing to look at criteria led discharge 10x10 discharges from wards Staffing model being looked into regarding Extra patients in ED to keep patients safe. Virtual wards has been discussed, has not yet started. [19/07/2023 15:52:30 Helen Hartley] There is a lot of work ongoing regarding flow, can we use virtual wards? Frailty pathways in SDEC being examined to try to move patients out of ED and into the correct places for their needs. Ongoing. [28/06/2023 11:22:34 Rachael Turner] Risk discussed as apart of RRC&C Deep Dive 28/06/2023. Huge demand currently, a lot of work around MEAU handover. There is not enough staff to move patients, conversation around costing at what a transfer team would look like. There is a cost implication about this but discussions are in place. CQC must do Trust initiative, there is work linking with communities looking at support that can be offered at home-use of virtual wards. Risk remains high. [26/04/2023 11:58:09 Carl Ratcliff] No change but will review at next months UC improvement group [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.	10	02/09/2021	31/03/2024	13/01/2024
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 October 2023 there are 1074 overdue haem pt (237 at phb and 837 at LCH). From 1 Oct 22 until 2/11/2023 the haematologists have held 318 extra clinics which equates to 178 news and 2017 F/U. Haemostasis in particular pt are waiting almost triple the time that they have been graded at. There are 578 pt on this consultant PBWL with 232 being overdue. The longest waiter was due an appointment around March 2023. This consultant is holding on average 3 extra clinics per month.	Overbooking of consultant clinics (unsustainable); introduction of nurse-led clinics to manage demand. Long and short term Locum Consultant used to cover vacancies. Ad-hoc additional clinics outside of consultant job plan	Monitoring of outpatient appointments Clinical harm reviews & reported incidents	22/12/2023	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	[22/12/2023 08:21:34 Gemma] Haematology rightsizing paper (SBJC) presented and approved at CRIG 19/12/23. Now needs to be presented at Board and ICB investment panel. Further update to be provided at a later date. [06/11/2023 08:53:30 Vicky Dunmore] updated PBWL, clinic and new appt figures [14/09/2023 14:57:46 Rose Roberts] Rightsizing Haem paper to be presented at CRIG Sept 2023. [01/08/2023 15:20:30 Rachael Turner] Update provided from Lauren Rigby-we are now having weekly meetings with the COO and at risk recruitment is happening. [02/06/2023 12:40:22 Maddy Ward] Andrew Morgan requested a briefing paper for ELT which is now complete in conjunction with transformation and due to be circulated to execs on 05/06/2023. We are exploring what care could take place in primary/community setting. [24/04/2023 10:36:33 Maddy Ward] Haematology service review carried out on 20th April 2023 in association with strategy, planning, improvement and integration directorate [03/04/2023 09:34:49 Rose Roberts] Reviewed at confirm and challenge confirmed as v high risk. [15/12/2022 13:31:29 Alex Measures] currently out to advert for second haemostasis consultant, the rest of the posts ongoing Workforce information provided to triumvirate, awaiting feedback. ACP still in training, additional vacancy for middle grades difficult to recruit to. 220622 Been identified as IIP priority for 2022/23. This includes workforce review, GIRFT review being considered.	3	01/04/2023	01/04/2023	22/01/2024
5143	Service disruption	Lynch, Diane	Parkin, Mr Lee	Trust Leadership Team	Estates Infrastructure and Environment Group, Estates Strategy Group, Health and Safety Group , Information Governance Group, Outpatient Improvement Group, Patient Safety Group	13/04/2023	25		Clinical Support Services	Outpatients CBU	Choice, Access and Booking	Pilgrim Hospital, Boston	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.	30/10/2023	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.	[30/10/2023 14:10:23 Emma Cripps] Funds have been found and agreement in place to build a lift directly into Health Records at Pilgrim. Existing dumb waiter to be upgraded. Both works are currently out to tender. [08/09/2023 10:41:51 Maddy Ward] An options appraisal has been completed by estates. This is being reviewed by finance in conjunction with estates to decide which option is going to be implemented. [06/06/2023 11:08:10 Maddy Ward] Since meeting on 26/04/2023, we have met with the CSS DMD, Head of Capital Projects and Estates team are going away to cost up the various works needed. To discuss with the exec team. Highlighted risk is contributing to risks across the PHB site and a number of datix have been registered highlighting health and safety risks. [26/04/2023 11:42:09 Rachael Turner] Risk presented at Risk Confirm & Challenge 26/04/2023 for validation. This was agreed as scoring as a 15-High risk. Escalation is required to look into alternative measures to support with this risk, possibly looking into Electronic records.	1	01/05/2023		29/12/2023

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4868	Physical or psychological harm	Farquharson, Collin	Martinez, Francisca	Medicines Quality Group	Maternity & Neonatal Oversight Group	01/03/2022	16	Risk assessments	Clinical Support Services	Pharmacy CBU	Pharmacy		Preparation of Drugs for Lower Segment Caesarean Section (LSCS). 1. Medicines at risk of tampering as prepared in advance and left unattended. 2. Risk of microbiological contamination of the preparations. 3. Risk of wrong dose/drug/patient errors. Breach of Medicines Act: Regulation 3 of the Human Medicines Regulations 2021 permits doctors to prepare medicines for administration. The expectation would be that preparation would be in compliance with current best practice and governance expectations. Regulation 214 permits parenteral administration of medicines by or in accordance with the directions of and appropriate practitioner. This practice would constitute a risk to the patient and falls outside of expected governance arrangements detailed in Advice Note for Chief Pharmacists March 2017 NHS Pharmaceutical Quality Assurance Committee which defines acceptable practice as: administration immediately after (within 30 minutes) preparation and completed within 24 hours. It is noted the Trust Injectable Medicines Policy is in compliance with this expectation.	No current processes in place to minimise risk Policies do not support this practice	Incidents involving advance preparation of intravenous medication in clinical areas. Audits of compliance with standards / policy - The current labelling does not comply with national recommendation. Not all labels include the recommend identity (no dose/strength as per pictures). Also, no preparation date/time always included. There is no documented procedure stating the process to follow to ensure that the medicines prepared are discarded.	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
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.	11/12/2023	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.	[19/12/2023 13:26:38 Lisa-Marie Moore] phase 2 pharmacy improvement plan in development. meeting with MD 18/12 to discuss prioritisation of business cases [07/11/2023 14:13:38 Lisa Hansford] Update- DMS implementation has been affected as a consequence of low medicines reconciliation figures. Pharmacists are not clinically screening/reviewing discharges therefore this is an additional gap in the service which inhibits uptake of DMS. Core clinical pharmacy services such as medicines reconciliation and discharge screening allow additional services such as DMS to be implemented, without the former it is not possible to implement DMS [26/09/2023 14:06:35 Rachel Thackray] To meet with Medical Director to discuss lack of progress [07/09/2023 14:03:55 Lisa Hansford] 07.09.23 no changes to current situation [03/08/2023 14:48:59 Lisa-Marie Moore] No further updates [27/06/2023 09:47:37 Alex Measures] Discussed in risk register review meeting- no further updates [01/06/2023 14:17:45 Lisa-Marie Moore] No change/updates since previous entry [04/05/2023 14:12:22 Lisa Hansford] As advised at confirm and challenge meeting. Lack of compliance with national standards. [06/04/2023 13:07:13 Paul White] Discussed at Risk Register Confirm & Challenge 29 March. Risk agreed and feedback provided for consideration. [21/02/2023 08:47:37 Paul White] Note from Risk Register Confirm & Challenge Group - risk rating to be reviewed and agreed at division level prior to presentation at RRC&CG for validation. [05/01/2023 14:13:48 Lisa-Marie Moore] No change/progress since last update [08/12/2022 12:40:46 Lisa-Marie Moore] Meeting with Divisional Leads and Deputy Medical Director 25/11 to discuss business case and actions needed to be taken to support progression of it. No change to risk - currently performing under 50% on average (this is boosted by the ward based technicians who also complete med recs on patients) Many ward areas have not seen pharmacist for several weeks at LCH. [01/11/2022 15:27:25 Ahtisham Saddick] Business case has been discussed; updated and responded to comments. Trust is still performing below 50% of med recs within 24 hours. [14/10/2022 16:16:26 Rachel Thackray] Business case for additional staff in progress.	8	30/06/2023	31/12/2024	11/01/2024
4932	Physical or psychological harm	Ratcliff, Carl	Smith, Charles	Wor		12/04/2023	20	Wor Kforc	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.	List of job roles provided to Finance. CoN's written for majority of posts to go through clinical cabinet, CRIG	Via jo roles list	17/10/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	CoN's written for majority of posts to go through clinical cabinet, CRIG New rota templates signed off by finance, to be implemented Q3 2023. Recruitment ongoing.	[22/12/2023 08:21:06 Gemma] ICB investment panel agreed to fund all posts. Paper now needs to go to CRIG for Governance purposes [17/10/2023 10:11:32 Rachael Turner] This remain the same due the consultation in place. This remains to go out to bank and agency until staff are recruited. [26/09/2023 14:46:05 Charles Smith] Tier 2 MG consultation extended and ongoing. Mitigation via locum/bank until then. [30/08/2023 11:24:12 Carl Ratcliff] will review post meeting with exec on 30th August 2023 with action plan in place to manage more of the ED risk [15/08/2023 11:15:38 Helen Hartley] This will align into the medical workforce tier 2 recruitment process as per risk 5020!! Also links into overcrowding piece. [19/07/2023 15:54:10 Helen Hartley] This has been looked at and updated, remains and will review next month [13/06/2023 11:09:55 Helen Hartley] Risk reviewed, level remains the same. Agreement for workforce plan has been given, adverts going out imminently. [07/06/2023 12:52:03 Rachael Turner] Risk discussed at RRC&C meeting 07/06/23 Risk added following three escalations. Night cover increased from 5 to 6 after funding secured. As recruitment comes on board risk will reduce. Risk score 4 x 4 at a score of 16. [24/04/2023 12:18:07 Carl Ratcliff] Review underway of short term ability to support more staffing at night by changing some shifts from day team	8 9	#### 31/08/2023	#### 01/11/2023	#### 17/01/2024

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
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	20/12/2023	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.	[20/12/2023 16:28:46 Rachael Turner] Risk reviewed, very minimal change from previous update: •Falls incidents continue to be analysed and trends and themes identified organisationally and reported through Falls Prevention Steering Group (FPSG) •The Quality Matron team will continue to provide support to areas with an increased number of incidents. •Education for teams on completing falls documentation and implementing appropriate interventions is supported by the Quality Matrons. •Themes from falls incident reports are discussed at monthly Divisional falls prevention groups supporting shared learning. •Initial outcomes from an environmental review of toilet/bathroom environments shared at FPSG .Quality Matron and Estates and Facilities Lead Nurse to meet to identify improvement opportunities and priorities. •Divisions have focussed activities being undertaken to support the prevention of patients deconditioning whilst in hospital with a plan to rollout further in the new year. •Review of training options being undertaken. •Falls prevention quality council will continue to work collaboratively on identified quality improvements, and to join up the work being undertaken within individual falls prevention forums. •Review of The 'Call Don't Fall ' communications is to be reviewed and reinvigorated. •Overall number of falls decreased by 18 in November 2023- the severity of harm increased in month with 1 moderate and 2 severe harm incidents. Most incidents continue to result in no or low harm to patients. [28/11/2023 12:48:48 Rachael Turner] •Falls incidents continue to be analysed and trends and themes identified organisationally and reported through Falls Prevention Steering Group (FPSG) •The Quality Matron team will continue to provide support to areas with an increased number of incidents. •Education for teams on completing falls documentation and implementing appropriate interventions is	4	31/12/2023	31/03/2023	22/01/2024
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	20/12/2023	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	[20/12/2023 13:18:10 Rachael Turner] No change, risk to have full review Jan 2024 [08/11/2023 10:47:35 Helen Shelton] Verbal update from Damian - no material changes this month - full review to be undertaken in the next three weeks. [02/08/2023 14:31:41 Rachael Turner] Good progress continues to be made on reducing the time patients are waiting for Outpatient. However, Industrial action for Junior Doctors and now Consultants has significantly impacted recovery and the aim to clear all patients waiting over 78 weeks for treatment has not been met. Additional capacity and focus has been put into place to reduce numbers despite the impact of Industrial action. Numbers of patients waiting over 65 weeks for treatment continues at a rate better than expected [25/04/2023 10:38:37 Rachael Turner] Work continues, no current change to risk grading. [21/02/2023 17:44:30 Damian Carter] As Improvement plans embed, we are starting to see a reduction in number of patients waiting to be seen in Outpatients and subsequently patients are not waiting so long. Recent Outpatient Sprint to improve DNAs, missing outcomes etc. have also seen fewer patients waiting. The trust is on track to clear all incomplete patient pathways >78 weeks by the end of March 2023, with the exception of patient choice. [13/12/2022 13:31:41 Rachel Thackray] As per previous update, no change to risk grading [21/10/2022 09:42:00 Rachel Thackray] Work continues on the Outpatient Improvement Programme (ORIG) to improve clinic utilisation, reduce demand and increase activity back to 19/20 levels and above. Key progress since last update includes; 1.EContract awarded for Validation contract – Start date November 2022 2.ECommencement of personalised Outpatient plan – Start date December 2022 3.SSuper September completed and yielded 40% reduction in non-admitted pathways that were validated 4.PPlan to reinstate tertiary clinics to increase capacity	8	31/03/2023	31/03/2023	20/01/2024
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	20/12/2023	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	[20/12/2023 13:18:56 Rachael Turner] No change, risk to have full review Jan 2024. [08/11/2023 10:48:59 Helen Shelton] Verbal update from Damian Carter - no material change this month - full review of risk to be undertaken in three weeks. [02/08/2023 14:32:55 Rachael Turner] The Grantham site has now successfully achieved the status of a GIRFT accredited Elective hub, one of only 8 in the country. This allows the trust to use Grantham as a ringfenced elective site and gives the ability to increase elective activity without an impact from emergency demand. The 6 theatres are now established and a significant amount of elective work as moved from Pilgrim and Lincoln. Whilst patients are dated for surgery in a relatively swift manner, the delays remain in Outpatients. Mitigation is set out in risk 4878 and means the overall risk to the waiting times is significant [25/04/2023 10:41:05 Rachael Turner] Work continues, no current change to risk grading. [02/03/2023 18:51:14 Damian Carter] As Improvement plans embed, we are starting to see a reduction in number of patients waiting to be seen and subsequently patients are not waiting so long. Recent Theatre Productivity work has started to yield improvements and led to a significant reduction in late starts. This is particularly evident at Grantham through the SuperSprint and has seen lost minutes due to late starts reduce by 50% [26/01/2023 15:06:57 Corporate Dashboards] Risk moved from Surgery to Corporate as this is an operational risk, not divisional. [21/10/2022 09:40:36 Rachel Thackray] Work continues on three main improvement programmes to address capacity for Surgery 1.HHVLC/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.TTheatre 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	8	31/03/2023	31/03/2023	20/01/2024

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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	18/12/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (15-25)	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	[18/12/2023 21:40:10 Rachael Turner] No update currently, risk to be reviewed in Jan 24. [20/11/2023 20:29:20 Rachael Turner] Risk reviewed, work ongoing, numbers continue to fall in the right direction. [30/10/2023 15:05:34 Rachael Turner] Weekly meetings continue with ICB. We continue to maximise the capacity at the CDC. Numbers are continuing to fall and we are basically on track with our trajectory. [16/10/2023 16:24:27 Rachael Turner] List continues to fall, all D3 are now seen within six weeks. All follow up patients with the exception of valve registry are booked when their appointment is due. Weekly ICB meetings continue to monitor progress. Clinical lead currently feels that risk score needs to remain at present. 7931 patients were previously on waiting list, currently at 4762. This will be reviewed in December. [30/08/2023 09:28:23 Carl Ratcliff] WL recovery slightly off track but still progressing in right direction / pace InHealth will stop from now from providing 40 scans a month - asked team to look at effect [23/07/2023 13:00:46 Carl Ratcliff] Progress continues - WL recovery on track with 400o pts now on list against 8700 at highest point [19/06/2023 15:35:26 Charles Smith] Charles Smith - DGM CDC work continues - Numbers improving as SET recruitment drive moves forward. Trajectories continue to be downward, slightly behind target for 6ww and 13ww cohorts due to staffing of private provider but only 1 month lost in end-point to date. Main TWL trajectory is ahead of NHSE expectations at May 2023 data point. R&R successfull, fully recruited, await new starters. [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	4	31/03/2023	01/02/2024	18/01/2024
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	02/11/2023	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.	[02/11/2023 10:11:07 Rachael Turner] Currently still do not have Trust-wide provisions- this will be picked up as part of phase 2 of respiratory programme. Whilst we have a robust process in place we continue to have issues with availability of ringfenced beds on both sites and education in ED and therefore are not consistently meeting the national standards. We have a planned meeting to discuss the last years performance. Following this, the risk will be reviewed looking at lowering the score but not remove at this point. [30/08/2023 11:21:21 Carl Ratcliff] to discuss with CBU and review ability to close or reduce [07/08/2023 17:06:10 Donna Gibbins] Funding agreed- recruited workforce continues due to agreement to ensure safe staffing Annual audit for NIV compliance complete- report to be generated and shared with Cabinet Ongoing discussions regarding provision of NIV in ED continues No SI since project commenced for NIV Full outcome of provision for Trustwide achievement not yet equal due to lack of RSU at PHB- mitigations in place to deliver a safe service Domiciliary NIV provision ongoing [23/07/2023 12:53:54 Carl Ratcliff] Funding approved for complete RSU unit in budget setting - will ask CBU for full update on project [27/04/2023 09:20:46 Silvia Tavares] update from Donna Gibbins: The risk currently remains the same. However, the following actions are being considered for June to reduce risk following the last confirm and challenge meeting: A full year review of NIV audit data will be captured and shared through clinical cabinet, once this is available a decision can be made of reducing further. Provision of National standards at PHB to be reviewed and formalised within the SOP. 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.	4	30/09/2022	01/12/2023	02/02/2024
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;	13/11/2023	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.	[16/11/2023 16:25:11 Nicola Cornish] No change as per discussion at RRC&C meeting on 07/11. [07/11/2023 11:31:43 Helen Shelton] Reviewed at the RRC&C meeting and agreed that despite the appointment of 2 epilepsy nurses the risk remains very high at 20 as A further BC is now required to improve the service further. [11/09/2023 15:33:59 Jasmine Kent] Both epilepsy nurses have started and have been asked to see newly diagnosed epilepsy patients, asked to take on cohort of complex patients so parents are receiving better support. For reduction to a 16 on both acute and community paeds. Tertiary engagement has been escalated to ICB. As agreed at RRCCG - for reduction to a 16. [14/08/2023 14:30:44 Jasmine Kent] 2 nurses now in post, risk remains very high due to difficulty engaging with tertiary neurology. [10/07/2023 13:47:04 Jasmine Kent] Requires discussion at governance and with Epilepsy service lead, no change that the team are aware of but will update following governance later this week if any further developments have been made. [12/06/2023 15:55:12 Jasmine Kent] Discussion ongoing regarding reduction of risk level now epilepsy nurses are in post. Unsure of level of involvement with Acute Paeds at this stage, For review next month. Gap analysis to be conducted to identify risk rating and specifically where improvements need to be made. [16/05/2023 15:39:25 Jasmine Kent] Epilepsy nurses are now in place, for review next month to determine if there has been a change in risk level. [04/05/2023 09:09:17 Rachael Turner] Risk re-opened as risk is to cover acute, risk 5101 reflects community risk. [03/05/2023 15:28:19 Rachael Turner] Risk closed as duplicate of Risk ID: 5101. [18/04/2023 08:44:50 Jasmine Kent] Un-rejected, rejected by mistake, not a duplicate entry. Has already been approved. [03/04/2023 15:12:56 Paul White] Duplicate entry	8	14/03/2024		13/12/2023

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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	21/11/2023	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Complete self assessment and implement actions required to achieve compliance Self assessment completed and details following actions: - Ensure that all parents or carers are given the information and opportunities for discussion that they need - Need more trained professionals Doctor and nurses (monitor compliance with EOL care elearning via Speciality Governance) - Manage transition from children's to adult's services in line with the NICE guideline on transition from children's to adult's services - Some groups have clear transition pathways- diabetes, oncology but there is no clear pathway for children with life threatening neuro disability or respiratory issues (D Flatman)(more specific action required) - Think about using a rapid transfer process (see recommendation 1.5.8) to allow the child or young person to be in their preferred place of death when withdrawing life sustaining treatments, such as ventilation - Rapid Discharge pathway required (J Wooley) - The specialist paediatric palliative care team should include at a minimum: • a paediatric palliative care consultant • a nurse with expertise in paediatric palliative care • a pharmacist with expertise in specialist paediatric palliative care • experts in child and family support who have experience in end of life care (for example in providing social, practical,	[21/11/2023 13:30:00 Kate Rivett] 21/11/23 - KR 1. Discussion at Risk Register Review meeting; 2. Current compliance with NICE guideline NG61: End of Life Care for Infants Children and Young People with Life Limiting Conditions is unclear; 3. To review NG61 Baseline Assessment to ascertain if compliance has improved or not - this will enable a refocus on those areas that are non-compliant and will give a better overall position of current level of compliance and hence the level of risk that is being carried. [17/10/2023 14:28:39 Nicola Cornish] No change, need to redo benchmarking. Met with St Andrews Hospice and ICB to look at closer working, their doctor has remit to cover all of Lincolnshire. [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	17/01/2024
4843	Physical or psychological harm	Dunning, Mr Paul	Costello, Mr Colin	Medicines Quality Group		19/01/2022	20	Risk assessments	Clinical Support Services	Pharmacy CBU	Pharmacy		Screening, management and review mechanisms of patients requiring or in receipt of Intravenous Immunoglobulin (IVIg) is inadequate.	National policy: - NICE Guideline NG5: Medicines optimisation, etc. ULHT policy: - Policy for Medicines Management: Sections 1-8 (various approval / review dates) ULHT governance: - Trust Board assurance via Quality Governance Committee (QGC) / Medicines Quality Group (MQG)	Reported incidents involving use of Intravenous Immunoglobulin (IVIg)	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	Shelton, Helen	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 Separate 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	02/11/2023	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.	[05/12/2023 16:18:15 Helen Shelton] Risk reviewed as part of the CG SMT. As of the 1 December 2023 there are 39 open Serious Incidents of which 33 are overdue their completion date. A closure trajectory has been set with the Divisions to have all open SI closed completed by the end of December 2023. Additional sign off panels are being put in place to ensure enough capacity to achieve and oversight is provided through the PSG. Once all SIs have been approved this risk will be closed. [02/11/2023 10:56:59 Rachael Turner] Risk reviewed, score to remain. No further update. [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	31/12/2023	31/12/2023
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.	17/10/2023	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.	[17/10/2023 09:30:32 Nicola Cornish] Nettleham have moved to Langton, in process of issuing purchase orders for design team and healthcare planners have visited Pilgrim. Meetings to schedule accommodation. [04/07/2023 09:11:47 Alex Measures] Risk reviewed 03/07/2023- Nettleham has decanted to 1st Floor to allow for works to commence as per plan. [04/04/2023 12:45:23 Jasmine Kent] Predicted date for decanting Nettleham to Langton 02/05/2023. While awaiting funding for refurbishment of Nettleham. Drain work at Pilgrim site is scheduled. [23/01/2023 17:04:59 Jasmine Kent] Included within capital allocation bids for next financial year. Agreement from trust board that works will take place in next financial year. Staff engagement sessions to communicate refurb plans. Issues dealt with by Estates & Facilities as they occur. 13/04/2022: Mitigation plan - full board approval to progress the business case. Require monitoring of staff surveys. CQC report demonstrates unsuitable for use - amended to 3 impact and 5 occurrence = 15 26/09/2022 - Unchanged	6	31/03/2025	31/03/2025	02/01/2024

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 (current)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
5234	Service disruption	(Historical Deleted User)	Fulloway, Mr Ian			25/08/2023	15		Clinical Support Services	Diagnostics CBU	Neurophysiology		No clinic space at Pilgrim Hospital resulting in only ad-hoc provision of outpatient nerve conduction testing at the hospital. Previous clinical space was taken from the service due to ED/UTC projects with temporary agreement for clinic room (agreed in 2020) ending in October 2022 with PHB physiologist retirement. No EEG or EMG service provided at PHB currently. No Inpatient provision for testing at PHB. Inpatients requiring tests have to be transferred by hospital transport to Lincoln County for testing. Current risk is not being able to restart the service. At the moment, this is an unequitable health offering.	Adhoc bookings of space available within Outpatients at PHB. Booked where and when possible.Recruitment of new overseas Physiologist has been undertaken and completed. The staff member is fully trained and ready to start clinics in PHB when appropriate, permanent space is provided. Space must meet IPC requirements.	Waiting times, travel times, Patient Feedback, IP LOS impacted by the service being unavailable on site.	11/12/2023	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.	[11/12/2023 13:05:50 Gemma] Risk reviewed. No change [13/09/2023 12:20:09 Maddy Ward] From an estates point of view, there is no plan to restart the service. This has been passed to project manager in estates to review clinical space (chased today). A suitable sized, permanent room is required. Started space request in September 2022 and meeting in July 2023. There has not yet been a date given for a clinical space review.	3	26/08/2024		01/06/2024
4724	Physical or psychological harm	Lynch, Diane	Taylor, Ruth	Workforce Strategy Group	Patient Experience Group	13/01/2022	20	Risk assessments	Clinical Support Services	Therapies and Rehabilitation CBU		Lincoln County Hospital	If Therapies and Rehabilitation service provision is not sufficient to deliver 7 day service provision, it leaves services without cover at a weekend or with inadequate cover during the week, leading to delayed patient flow; delayed discharge; extended length of stay; impacting on patient experience with potential for serious harm. This includes the neuropsychology cover on Ashby, SLT cover for inpatients, and therapy cover on ITU.	ULH policy: - Service planning & budget setting processes - Business case decision making processes ULH governance: - Capital & Revenue Investment Group (CRIG) management of business case process - CSS Division, CBU / speciality governance arrangements	Level of cover at weekends. Length of stay, patient flow, delayed discharges. Level of funding - Some 7 day funding, but limited to orthopaedics at LCH, minimal service. Inadequate for level of service demand.	06/12/2023	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.	[06/12/2023 13:09:39 Gemma] Conversations are currently happening in regards to appropriate staffing levels for ICU for Therapy Services. Further update to follow [25/10/2023 15:07:18 Rachael Turner] Business case being undertaken by CSS, needs to go through approval process. [08/09/2023 14:14:43 Maddy Ward] Reviewed at quarterly risk register review meeting. Risk is ongoing at present. [23/06/2023 14:07:53 Rose Roberts] Recruited into the Neuro psychology post. Increase risk in consultant cover - sickness and resignation. potential to have to stop admissions. [10/03/2023 13:43:06 Rose Roberts] Awaiting nhse results. Neuro psychology bid waiting to go to CRIG [13/01/2023 12:51:48 Lesley Bradley] 13/1/23 NHSE reviewed Ashby ward this month-await recommendations for staffing levels [15/12/2022 09:53:21 Alex Measures] No update [30/11/2022 10:04:52 Rose Roberts] Neuropsychology bid is still awaiting CRIG approval as CRIG has been stood down. Business cases completed for all areas. 130622 Neuropsychology bid is going to CRIG this mth. All others to be confirmed. Work in progress.	4	05/01/2024	31/03/2023	05/01/2024
Strategic Objective							**1c Improve Clinical outcomes**																			
5154	Regulatory compliance	Simpson, Mr Andrew	Hansford, Lisa			17/04/2023	16		Corporate			Trust-wide	The Trust currently does not have a Medicines Management or Intravenous Drug Training package on ESR. Previous Medicines management training was removed when the ESR software was changed. Usually all new nurses will be required to complete the medicines management training as part of the mandatory training. This is to support them to be able to administer medicines to patients. Without a robust Medicines management training package staff will not have access to the r Medicines Management training that has previously been available, which is not in line with Trust standards. This could potentially lead to harm to our patients from medication incidents, we will not be adhering to CG174, NG29, SG1 and QAPPS minimising injectables risk. Risk of breaching CQC regulation 12: Safe care and treatment also	All staff will have had undertaken some level of medicines management as part of their professional qualification, however standards are inconsistent and not aligned to trust standards. National (CG174, NG29,SG1) and Local policies and guidance indicate that training should be available to staff to support in administration and safe medicines management. Additionally won't be compliant with QAPPS in relation to minimising injectable medicines risks. CQC regulation 12: Safe care and treatment all indicated training should be available. None currently in place in the Trust. There are new staff that have comenced employment with the organisation that cannot access the trust medicines management training and ward and department leads require a decision to be made as to whether or not these staff can administer medication.	Reported incidents, Staff feedback on training and support available in staff surveys. Inspection feedback	06/12/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	The Medication Safety Team have written the Medicines Management, Controlled drugs training and the Drug Administration Programme. These training documents are also to be supported by the nationally recognised eLearning for health IV therapy passport. These training packages are under review by MOpS group before they can go through the governance process. The governance process is likely to take a number of months. There is then the added task of getting the training packages put onto ESR and mapped to the correct staff. ESR team is severly understaffed which may delay the process further. As an interim measure to reduce this risk level, once the training packages have been through the relevant governance procesess, 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.	[06/12/2023 14:55:35 Gemma] Training packs signed off through governance process Awaiting update from Education and Training team when these will be uploaded to ESR. Delay in this due to vacancy in their team [07/09/2023 14:09:00 Lisa Hansford] 7.9.23 Signed off by APPG and will go to NMAFF on 8.9.23 for final ratification [13/06/2023 12:46:40 Lisa Hansford] Training packages to be signed of by MOpS by 20th June. Then will continue through the governance process before they can go on ESR [04/05/2023 14:24:40 Lisa Hansford] No update as waiting to go through MOpS process [26/04/2023 11:14:07 Rachael Turner] Risk validated at RRC&C Meeting 26/04/2023 as a score of 16 High Risk. Risk to go to Medicines Quality Group to expedite risk.	8	17/04/2024		06/03/2024
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	16/10/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	defined plans to address backlog for at risk areas	[16/10/2023 16:34:58 Rachael Turner] The Cardiology waiting list has been extensively validated and has been reduced. Our biggest backlog on the waiting list is loop recorders and we are holding a three day "loopathon" 14-16th November where 96 patients will be treated. New Patient appointments-they have been hampered by industrial action, we have extensive validation. We have reduced the number of 52 week breaches. Our RTT position is 49.35%. We are undertaking a review of clinic templates to make sure clinicians are seeing the correct number of new and follow up patients per clinic. Remote monitoring-we have case of need going to CRIG in November to put 500 patients a year on remote monitoring, this will make a better experience for patients. Just bid for specialised funding to reduce our backlog with tapes, currently have 2700 patients waiting. [16/10/2023 16:34:45 Rachael Turner] The Cardiology waiting list has been extensively validated and has been reduced. Our biggest backlog on the waiting list is loop recorders and we are holding a three day "loopathon" 14-16th November where 96 patients will be treated. New Patient appointments-they have been hampered by industrial action, we have extensive validation. We have reduced the number of 52 week breaches. Our RTT position is 49.35%. We are undertaking a review of clinic templates to make sure clinicians are seeing the correct number of new and follow up patients per clinic. Remote monitoring-we have case of need going to CRIG in November to put 500 patients a year on remote monitoring, this will make a better experience for patients. Just bid for specialised funding to reduce our backlog with tapes, currently have 2700 patients waiting. [27/09/2023 11:37:05 Rachael Turner] Risk discussed at RRC&C meeting as part of the Deep Dive risk needs a review with updates. [05/09/2023 08:39:25 Charles Smith] Service yet to recover from backlogs developed during COVID for variety of reasons. Most recently exacerbated by ongoing IA. 1xcons now in place, further to start in next 2/12. Additional clinics/ILR lists when possible. [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	8	30/06/2022	01/03/2024	16/01/2024

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4828	Physical or psychological harm	Farquharson, Colin	Costello, Mr Colin	Medicines Quality Group	Digital Hospital Group, Patient Safety Group	17/01/2022	20	Risk assessments	Clinical Support Services	Pharmacy CBU	Pharmacy	Trust-wide	The trust currently uses a manual prescribing process across all sites, which is inefficient and restricts the timely availability of patient information when required by Pharmacists. Where information about patient medication is not accurate, up to date and available when required by Pharmacists then it could lead to delays or errors in prescribing and administration, resulting in a widespread impact on quality of care, potentially reducing the likelihood of a positive clinical outcome and/or causing serious patient harm	National policy: - NICE Guideline NG5: Medicines optimisation, etc. ULHT policy: - Policy for Medicines Management: Sections 1-8 (various approval / review dates) ULHT governance: - Trust Board assurance via Quality Governance Committee (QGC) / Medicines Quality Group (MQG)	Medication incident analysis Audit / review of medicines management processes - the Trust currently uses a manual prescribing process across all sites, which is inefficient and restricts the timely availability of patient information when required by Pharmacists.	29/12/2023	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	[21/12/2023 13:28:32 Divisional Dashboards] Lisa-Marie Moore: epma roll out currently in final stages for inpatients with only pilgrim surgical areas left and due to be rolled out from 15th January (delayed roll out due to Drs strikes) will then be reflection and review of implementing to further areas - outpatients and maternity. paediatric electronic prescribing not currently supported by the current epma system to meet mhra requirements [29/11/2023 11:12:37 Rachael Turner] Risk discussed at RRC&C meeting 29/11/2023 roll out to sites has taken place. This risk needs to be reviewed as risk reduction plan needs updating. This risk needs a full review to whether it needs reducing and/or making a site risk. [01/11/2023 13:10:29 Rachael Turner] Work ongoing to be rolled out by the end of the year. [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	4		31/12/2023	01/04/2024	22/01/2024
4866	Service disruption	Costello, Mr Colin	Saddick, Ahtsham	Medicines Quality Group	Medicines Quality Group	01/03/2022	15	Risk assessments	Clinical Support Services	Pharmacy CBU	Pharmacy	Trust-wide	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	02/11/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-18)	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.	[07/11/2023 14:12:59 Lisa Hansford] Update- Variable ward based technician support is being provided for clinical pharmacy cover for admission areas. Risk is ongoing as there is still the possibility of staff movement to WBT roles therefore leaving gaps in core services [26/09/2023 14:15:54 Rachel Thackray] Risk remains, awaiting further update [07/09/2023 14:11:26 Lisa Hansford] 7.9.23 no further updates [27/06/2023 09:45:21 Alex Measures] Discussed in risk register review meeting- no further updates [01/06/2023 14:31:32 Lisa-Marie Moore] Discussion with CSS Division on how techs could be used to support pharmacy [28/03/2023 15:04:33 Rachael Turner] Risk proposed to be increased to a 16, this will be presented at RRC&C meeting 29th March. [20/12/2022 14:39:34 Alex Measures] no further updates Scheduled project due to commence March 2021, monthly reports will be provided. Monthly ward based technician meetings are addressing the training issue. 150622 ongoing, losing another technician to wards.	16	30/11/2021	28/04/2023	31/12/2023
4731	Physical or psychological harm	Harris, Michelle	Dunning, Mr Paul	Medical Records Group	Digital Hospital Group, Information Governance Group, Patient Experience Group, Patient Safety Group	13/01/2022	20	Risk assessments	Clinical Support Services	Outpatients CBU	Choice, Access and Booking	Trust-wide	If patient records are not complete, accurate, up to date and available when needed by clinicians then it could have a widespread impact on clinical services throughout the Trust, potentially resulting in delayed diagnosis and treatment, adversely affecting patient experience and reducing the likelihood of a positive clinical outcome.	- Clinical Records Management Policy (approved June 2021, due for review December 2023) - Trust Board assurance via Finance, Performance & Estates Committee (FPEC); lead Information Governance Group / Clinical Records Group - Now led by Deputy Medical Director.	Internal audit of medical records management processes - reliance upon hard copy patient records; patients may have multiple sets of records. Reported incidents involving availability of patient records issues.	21/11/2023	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.	[21/11/2023 08:38:09 Anita Cooper] Clinical Records Group now led by Deputy Medical Director therefore risk agreed to sit with DMD with input from Outpatients/Health records team. [30/10/2023 14:17:15 Emma Cripps] No further progress update [08/09/2023 10:45:27 Maddy Ward] Risk reviewed at Outpatients Quarterly Risk Register Review this morning. No further updates at present No further change since last review. [01/08/2023 15:35:42 Lee Parkin] No change since last review 06/06/2023 [06/06/2023 11:46:11 Maddy Ward] Still a very high risk with ongoing concerns. Will be a risk until electronic records are implemented across the trust. To mitigate the risk until that time the records management policy has been updated and communications will be sent by the Medical Director clarifying the protocols on current use of notes. [11/04/2023 11:47:33 Rachael Turner] Risk re-opened until electronic records are implemented. [05/04/2023 10:47:54 Rose Roberts] Email from KB - this can now be closed, updated records management policy now published. [29/03/2023 09:53:02 Anita Cooper] New ToR agreed at IG Group for CRG to become a Trust-wide group, chaired by Deputy Medical Director. Relaunch planned following approval at TLT which will require greater Divisional representation and a broader agenda. [06/03/2023 11:17:40 Maddy Ward] This risk is still ongoing, EPR not yet signed off. [02/02/2023 15:31:12 Rose Roberts] KB going to ask crg meeting if the new policy has been signed off. [15/12/2022 14:24:51 Madeline (Maddy) Ward] Ongoing, issue raised with clinical records meeting with control of health records for resolution, further meeting to be held mid-December [29/11/2022 11:04:59 Rose Roberts] Policy still awaiting final ratification so please extend by 1 month. [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	4	30/06/2018	31/03/2025	31/01/2024
Strategic Objective		**2c A modern and progressive workforce**																								

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
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	16/11/2023	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Review of current recruitment strategy. Advertisement for vacant posts.	[18/11/2023 21:08:13 Nicola Cornish] No change to risk score. Part of ICU workforce group that meets weekly. Minimal vacancy across both sites but skill mix remains diluted. Additional clinical education support on both sites and additional funding from network to support training and development. [25/10/2023 11:21:03 Rachael Turner] Risk reviewed at RRC&C still a high risk, score remains the same. [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. [6/09/2023 Still continues to be an issue. Additional clinical educator to be recruited to support	6	30/06/2021	30/09/2022	16/02/2024
4844	Service disruption	Lynch, Diane	Costello, Mr Colin	Workforce Strategy Group	Medicines Quality Group	19/01/2022	20	Risk assessments	Clinical Support Services	Pharmacy CBU	Pharmacy		The ability to provide a seven day a week pharmacy service requires a level of staffing above the current levels. Benchmarking has taken place against peer Trusts for staffing levels. Until this is funded the seven day a week service is unobtainable and this puts patients at risk.	Service planning & annual budget setting processes: Pharmacy / CSS Division	Staffing levels / budget benchmarked against other similar trusts. Reported medication incidents occurring out of hours.	11/12/2023	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.	[19/12/2023 13:27:34 Lisa-Marie Moore] Meeting with MD 18/12 to discuss business cases Pharmacy phase 2 improvement plan in progress [28/11/2023 12:09:20 Rachael Turner] Risk score remains, no further update. [30/10/2023 12:40:52 Rachael Turner] No changes, risk ongoing. No further updates at this time. [26/09/2023 14:05:31 Rachel Thackray] No changes as yet made, meeting to take place with Medical Director [03/08/2023 14:49:28 Lisa-Marie Moore] No further updates [27/06/2023 09:47:18 Alex Measures] Discussed in risk register review meeting- no further updates [01/06/2023 14:18:15 Lisa-Marie Moore] No change/update since previous entry [06/04/2023 12:53:22 Paul White] Discussed at Risk Register Confirm & Challenge 29 March, risk agreed with feedback provided for consideration. [09/02/2023 10:43:37 Paul White] Status changed to awaiting approval pending review by division and validation by Risk Register Confirm & Challenge Group. [22/12/2022 14:55:29 Rose Roberts] Confirmed with Paul White that the risk level can be raised here and confirm and challenge will invite the risk lead to discuss it. [20/12/2022 14:35:39 Alex Measures] Business case was not approved, currently stalled, raised to high risk today but the meeting feels it should be very high risk because it would be very likely to happen, to be taken to confirm and challenge to be upgraded 150622 ongoing business case in process of being written	4	29/10/2021	28/04/2023	11/01/2024
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 [24/04/2023 10:37:37 Maddy Ward] Oncology service review carried out in March in association with	4	31/03/2023	31/03/2023	14/12/2023

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
4996	Service disruption	Dunning, Mr Paul	Chester-Buckley, Sarah	Workforce Strategy Group	Patient Safety Group	22/08/2022	16		Clinical Support Services	Cancer Services CBU	Haematology (Cancer Services)	Trust-wide	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	22/12/2023	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	[22/12/2023 08:19:28 Gemma] Haematology rightsizing paper (SBJC) presented and approved at CRIG 19/12/23. Now needs to be presented at Board and ICB investment panel. Further update to be provided at a later date. [02/11/2023 15:31:05 Vicky Dunmore] Haem rightsizing business case to be present at CRIG Nov 2023 [14/09/2023 15:01:43 Rose Roberts] Rightsizing Haem paper to be presented at CRIG Sept 2023. [03/08/2023 10:00:17 Rachael Turner] Following the briefing paper being received by ELT, weekly meetings have been set up with DL,EM,LR and MH. An action plan has been put in place. A meeting was held with the Haematology Consultants, Andrew Morgan and Michelle Harris on 31.07.2023 and it was agreed to go out to advert for 4 Haematology Consultants, 1 Haematology Secretary and 2 Secretary Assistants. [02/06/2023 12:38:22 Maddy Ward] Andrew Morgan requested a briefing paper for ELT which is now complete in conjunction with transformation and due to be circulated to execs on 05/06/2023 Making enquires if transfusion lead needs to be a consultant of if another profession can pick this up. [24/04/2023 10:35:11 Maddy Ward] Haematology service review carried out on 20th April 2023 in association with strategy, planning, improvement and integration directorate [03/04/2023 09:42:15 Rose Roberts] Workforce paper with the triumvirate. Reviewed at confirm and challenge confirmed as v high risk. [15/12/2022 13:34:35 Alex Measures] all lead roles currently out to advert further recruitment ongoing	8		30/09/2023	01/04/2023	22/01/2024
5173	Service disruption	Morgan, Mr Andrew	Warner, Jayne	Trust Leadership Team	Workforce Strategy Group	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		
5093	Service disruption	Simpson, Mr Andrew	Baines, Andrew	Medicines Quality Group	Workforce Strategy Group	16/02/2023	20	Staff Survey	Clinical Support Services	Pharmacy CBU	Pharmacy		Baseline pharmacy procurement staffing is at a level where the basic functions are not routinely being delivered and the service is not able to withstand any prolonged absence due to leave, sickness or resignation. There is limited staff covering this (at times just 1 staff member).The workforce has remained relatively stable over time, however workforce pressures have been increasing over the last few years for a variety of reasons. There has been an increasing number of pharmaceutical shortages, many of which are complex in nature and need rapid action to avoid patient deaths. A growing number of drugs are now being offered on an allocation basis which requires micro management for stock ordering and distribution across the Trust. Changes in the delivery of chemotherapy have resulted in an increased demand for ordering of chemotherapy preparations. The pharmacy invoicing team have also experienced a recent increase in workload following the implementation of the Advanced finance system. This is currently 1 part time staff supported by bank staff where possible. The team are reporting concerns around workload and workplace stress. We are routinely reliant on existing staff working additional hours to fill gaps. If staff feel unable to come to work for any reason (including stress related) this will further increase the risk to the Trust and its patients of stock outs, with an associated risk to patient care, due to either a lack of personnel to raise orders, manage shortages, chase orders which are not being received, or	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.	18/12/2023	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.	[18/12/2023 21:36:39 Rachael Turner] No change, recruited staff will be in post in January. Risk score to be reviewed once in post and trained. [29/11/2023 11:26:52 Rachael Turner] Risk discussed at RRC&C meeting as part of the Deep Dive. Support to fill gaps is currently in place. We have successfully recruited two posts,staff but they will not be in post until Jan 2024 and then will need to be trained. Once staff are in post this risk will need to be reviewed to look at scores. There is still a third vacancy, this post is unfunded, a business case now needs to be written to look into this. Risk reduction plan needs to be reviewed following this update. [05/10/2023 11:50:14 Rachael Turner] Risk reviewed, risk description and controls updated. The current procurement staffing levels are so the basic functions are not routinely being delivered and the service is not able to withstand any prolonged absence. There is very limited staffing, often just 1 member of staff are available to support. This risk is effects staff,patients and also has a knock on effect to other areas of the Trust. Pharmacy invoicing is also experiencing increased workload which is supported by 1 part time staff supported by bank staff where possible. There are currently vacancies that are out to advert for 2.0WTE purchasing clerks & 1.64 WTE invoice clerks). Risk score remains at 20 Very High but needs regular review. This risk will be added to the RRC&C agenda under AOB to advise of the updates and make members aware of the ongoing pressures. [26/09/2023 14:08:57 Rachel Thackray] Going out to recruitment for 2 x vacancies [14/09/2023 11:58:25 Lisa-Marie Moore] No update [03/08/2023 14:47:51 Lisa-Marie Moore] No further updates [27/06/2023 09:33:47 Alex Measures] proposal has been presented to Diane Lynch, questions have come back which need answering, locum member of staff supporting the team, managing with agency and bank staff at the moment [01/06/2023 14:14:06 Lisa-Marie Moore] No change/further update since April [19/04/2023 15:48:11 Andrew Baines] Colin Costello & Andrew Baines met with Diane Lynch on 18/4/23 - 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	18/01/2024
4862		Ratcliff, Carl Thomson, Cheryl	Workforce Strategy Group		WORK	22/02/2022	16		Medicine	Specialty Medicine CBU	Respiratory Medicine	Trust-wide	Consultant staffing within respiratory Medicine at Lincoln and Boston Hospital. Currently there are only 3 Substantive consultants in place at LCH and 2 at PHB. We have a vacancy of 5 across the three sites. Various gaps are covered with Adhoc Locum. The main current risk is to the inpatient cover at Pilgrim Hospital. With only x2 Consultants over there, when we have 1 on annual leave, the risk that the other could be either sick or covid contact is extremely high. We have supported this with clinicians going over from LCH, however due to a further resignation at LCH, this is proving more difficult This combined risk on Medical staffing has now impacted the Secretarial team at LCH. There is currently 0 secretaries at work at LCH due to sickness in the team. This is mitigated through support from Agency / Other specialties supporting. We do not have the substantive staff nor the locum or agency bookings, to cover all functions of our Resp Medical Team. Inpatient risk of high acuity patients without specialist input. Outpatient risk of high activity of 2ww referrals on top of high volume OP workload, delayed pathway progress / commencing treatment such as chemotherapy. Due to lists / skillset required, there is not the ability within the organisation to cross cover between	Due to the severity of the risk: Currently: x 5 Consultant Gaps in Resp The impact this is having on the current workforce is stretching the team and leading to added pressure on the workforce. We are working with agency teams to work 'differently' for example Locum consultants supporting with on call work / remote clinics to release the burden on the current clinical team in respiratory. OD support in place also, along with weekly catch up meetings with the teams to explain the current state of play. The Business Unit have this week (06/09) put a bid in to the EMCA to gain funding of 250K to support a General Medicine to work in Respiratory so that our Substantive teams can be released to support Respiratory Cancer Capacity - This bid is currently being reviewed. We have worked in the background to book x 2 Agency Locum General Medicine Consultants 1 at Boston and 1 at Lincoln which will take us over budget, but supports the respiratory patients of lincolnshire and the welfare of consultant staff.	Staff Survey Results. Data Analysis through HR around recruitment and retention. Measured through Performance for patients (although this is not directly attributed towards the recruitment and retention, the longer wait times cause anxiety and unwarranted stress for the consultants in post)	14/11/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Close working with Agency to try and recruit agency locums to temporarily fill gaps. Working with Advanta / Medical Resourcing to recruit long term and improve retention of current staff. Additional funding applied for from Cancer alliance/ICB for Gastro and Resp to allow for additional Gen Med Locum to reduce burden on current workforce. Remote working in place to support outpatients where possible. Agency spend supporting out of hours workload - for example, covering the substantive consultants on calls to allow them to focus on Cancer work instead of on call - supporting patient care.	[14/11/2023 14:43:19 Rachael Turner] There are 3 substantive consultants but the risks remains the same and we rely heavily on bank and agency. Score remains. Nodule ACP role, this is a permanent role, has been developed and recruited but she is still back filling the plural. [30/08/2023 09:30:26 Carl Ratcliff] Expect to be at 10 consultants at end of Nov and will review risk again in 1/12 [24/04/2023 12:25:14 Carl Ratcliff] Have recruited to Consultant ACP post in nodules to support team - will start in 1/12 Using additional external support to deliver extra capacity for OPD to allow delivery of 78ww and reduce risk for delivery of 2ww urgent work [24/02/2023 13:48:15 David Marsh] Recruitment in progress, 5 substantive consultants in post (3 x Lincoln, 2 Boston). Agency locums in place covering a variety of roles/sites. New NHS Trust Locum Respiratory Consultant from overseas started in January at Lincoln. Now working independently. Division looking at developing ACP roles and Nodule Nurse post. [01/12/2022 11:15:13 Carl Ratcliff] plan for 3 consultants now being on boarded New plan to develop ACP nodule role Most recent update: Dear Carl, Following the catch up earlier, Claudia, Ashley and I have compiled our thoughts on what could go down to support the services..... Option Take down Benefits Risks: 1 Do Nothing None Cancer patients continue to wait prolonged periods for care. • Inpatient services at LCH and PHB continue to become extremely depleted • Welfare of current consultant workforce continues to suffer, potentially leaving to sickness / prolonged absence • Boston have only x2 Consultants, currently utilising support from already depleted LCH Team. (If annual	4		30/12/2022	03/06/2024	14/02/2023

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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	22/12/2023	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	[22/12/2023 08:18:40 Gemma] Haematology rightsizing paper (SBJC) presented and approved at CRIG 19/12/23. Now needs to be presented at Board and ICB investment panel. Further update to be provided at a later date. [02/11/2023 15:21:13 Vicky Dunmore] Rightsizing haem Business Case to go to CRIG Nov 2023 [14/09/2023 15:02:19 Rose Roberts] Rightsizing Haem paper to be presented at CRIG Sept 2023. [03/08/2023 10:01:13 Rachael Turner] Following the briefing paper being received by ELT, weekly meetings have been set up with DL,EM,LR and MH. An action plan has been put in place. A meeting was held with the Haematology Consultants, Andrew Morgan and Michelle Harris on 31.07.2023 and it was agreed to go out to advert for 4 Haematology Consultants, 1 Haematology Secretary and 2 Secretary Assistants. [02/06/2023 12:39:17 Maddy Ward] Andrew Morgan requested a briefing paper for ELT which is now complete in conjunction with transformation and due to be circulated to execs on 05/06/2023 [24/04/2023 10:36:05 Maddy Ward] Haematology service review carried out on 20th April 2023 in association with strategy, planning, improvement and integration directorate [03/04/2023 09:43:59 Rose Roberts] Workforce paper for haem with triumvirate, then will start oncology workforce paper. Reviewed at confirm and challenge confirmed as v high risk. [15/12/2022 13:35:25 Alex Measures] ongoing recruitment ongoing	8	01/04/2023	01/04/2023	22/01/2024
4991	Service disruption	Low, Claire	Shankland, Lindsay	Workforce Strategy Group		08/09/2022	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	06/09/2023	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. [14/03/2023 13:54:10 Rachael Turner] Increase in headcount, 7.7% now and plans to get this over	4	31/03/2023	31/03/2023	06/12/2023
5249	Service disruption	Low, Claire	Akhtar, Sarah			06/09/2024	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

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
4905	Physical or psychological harm	Cooper, Mrs Anita	Taylor, Ruth		Workforce Strategy Group	22/04/2022	12	Workforce Metrics, Risk assessments, Aggregation of Incident/Claims & Complaints/PALS	Clinical Support Services	Therapies and Rehabilitation CBU		Trust-wide	If we have insufficient staffing, or required level of experience and skill, the risk is patients will not receive assessment and rehabilitation leading to poor clinical outcome. Reduced flow on Ashby and the acute wards, delayed discharges, delayed referral to response times. Increase in avoidable harm i.e. deconditioning, PU's, constipation, delirium. Patient reviews delayed for botox treatment. Paediatric services-delayed response to new diabetes referrals and unable to see current diabetes patients in clinic-could lead to patient harm. Increase in bed stock and boarding beds without recognition of additional therapy staffing needs. Existing staff stretched to cover additional beds. Increased stress and sick leave on substantive staff.	Recruitment and retention strategies to fill vacancies. Bank staff. Requests to Locum Agencies. Skill mix Roster management. SQD data. Daily review of ward systems eg WebV. Referral guidelines and Prioritisation guidelines help to inform workloads and impact on patient flow and bed situation. Paed services are responding to direct requests for newly diagnosed children . Upskilling B5 N&D staff-(normally B6 N&D staff). Access to Staff wellbeing services. Front door therapy assessments passed to inpatient teams on admission.	Patient complaints. Fewer discharges at the weekend. Site escalation. Vacancy rates. Roster fill rates. Waiting lists for spasticity service. Staff absence. Staff survey and feedback.	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**																			
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		06/12/2023
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
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.	19/12/2023	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.	[19/12/2023 12:29:58 Rachael Turner] Risk continues to present as an issue with medical staff undertaking periods of industrial action. Currently Junior Doctors remain in active dispute with the government and Consultants/SAS Doctors are balloting on pay proposals. In November 2022 it was necessary to increase the likelihood of this risk from low to extremely likely and this continues. Plans have been tried and tested and all mitigations are in place. Oversight and governance through the Operational/Tactical/Silver Cell, Medical Workforce Cell and Strategic/Gold Cell with reporting to the ICB. Industrial Dispute Action Plan and Risk Assessment complete and has been tested through industrial action. Currently managed within risk tolerance. EPG to consider making this risk Inactive (for annual review). [20/11/2023 20:37:44 Rachael Turner] Risk reviews, all actions and score remains appropriate. Gold and silver command continue to manage this. [30/10/2023 12:37:17 Rachael Turner] Risk reviewed and remains at current level. [29/09/2023 10:29:30 Rachael Turner] Risk reviewed-current actions remain appropriate. As it is presenting as an issue it is being managed through tactical (silver) and strategic (gold) levels of command and working groups. [01/08/2023 09:55:01 Rachael Turner] Risk has now presented as an issue with staff undertaking periods of industrial action - in November 2022 it was necessary to increase the likelihood of this risk from low to extremely likely. 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	4		31/03/2023	19/01/2024
4948	Physical or psychological harm	Cooper, Mrs Anita	Moore, Lisa-Marie		Health and Safety Group, Medicines Quality Group, Patient Safety Group	17/08/2022	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	21/12/2023	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	[21/12/2023 13:30:51 Divisional Dashboards] Lisa- Marie Moore: Ongoing challenges. Demonstrable workload increase particularly on weekends across all sites. Phase 2 work plan development to review pharmacy workforce [27/11/2023 14:55:44 Rachael Turner] Risk remains with staffing challenges, no update. [26/09/2023 14:08:09 Rachel Thackray] Staffing vacancies still remain a challenge [03/08/2023 14:48:27 Lisa-Marie Moore] No further updates [27/06/2023 09:47:53 Alex Measures] Discussed in risk register review meeting- no further updates [01/06/2023 14:17:03 Lisa-Marie Moore] No change since previous entry [04/05/2023 14:07:20 Lisa Hansford] no update awaiting review on basis of reputational risk as advised at confirm and challenge meeting 29/03/23 [06/04/2023 12:52:25 Paul White] Discussed at Risk Register Confirm & Challenge 29 March, risk agreed with feedback provided for consideration. [07/02/2023 13:29:22 Rachael Turner] Risk updated to be lead by PODC committee. Requires validation at Confirm and Challenge due to current score. Division to review risk score and attend Confirm and Challenge meeting. [05/01/2023 14:05:09 Lisa-Marie Moore] No change from previous update [08/12/2022 12:33:43 Lisa-Marie Moore] Meeting with Divisional Leads and Deputy Medical Director 25/11 to discuss short and long term actions to support staff, current vacancies and support business case. BCP to be enacted when required. [06/10/2022 14:12:57 Lisa-Marie Moore] Business case still in progress No change	8	30/06/2023	02/10/2023	22/01/2024
4993	Service disruption	Low, Claire	Shankland, Lindsay	Equality, Diversity and Inclusion Group		08/08/2022	16		Corporate	People and Organisational Development	Organisation Development	Trust-wide	Workforce management practices that are not inclusive and equitable for people who consider themselves to have a disability may have a negative impact on the recruitment of new employees and the retention of existing ones.	1. Appointment of People Promise Manager (12 month fixed term) 2. Robust monitoring of EDI incidents/concerns 3. Equitable and EQIA 'tested' HR processes (for recruitment, reward and performance) 4. Dedicated OH service	1. Measurement of lived experience of disabled staff at ULHT via - NHS Staff Survey 2. No. EDI/disabilty related incidents reported 3. No. of EDI/disability related concerns reported	06/09/2023	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 and narrative data via the DCF online platform by Aug'22). 3. End October 2022: deadline for ULHT to publish WDES 2022 annual report (include metrics report and WDES action plan)	4	31/03/2023	31/03/2023	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
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	06/09/2023	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) 2. Anti racism strategy and delivery plan socialised with stakeholders and live	4	31/03/2023	31/03/2023	06/12/2023
Strategic Objective							**3a. A modern, clean and fit for purpose environment**																			
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
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	21/01/2024

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
5104	Regulatory compliance	Dunning, Mr Paul	Rinaldi, Dr Ciro	Mortality and Learning Strategy (MoraLS) Group	Estates Infrastructure and Environment Group	16/03/2023	10		Clinical Support Services	Path Links (Pathology)	Mortuary (Pathology)	Trust-wide	As a result of the HTA's concerns relating to the fabric and capacity of the Trusts mortuary service and the delay in timescales by which the Trust is able to refurbish these following the HTA inspection in May 2022. There is a risk that The HTA as the regulator could impose conditions on our licence to store the body of a deceased person within the Trusts mortuary facilities.	-HTA oversight group has been established-meeting to manage the action plan. -Papers have been to CRIG for initial funding to establish planning and building work. This has been approved. -Draft business case has been developed and approved. -Initial concerns have been addressed from Lincoln site. -The Trust currently has two Titan units (temporary additional mortuary capacity) which provides additional capacity in the event of winter pressure peaks in demand and also in the event of equipment failure. -The Trust has a memorandum of understanding with Hull University Teaching Hospitals to support with the storage of bariatric bodies that require longer storage (freezer capacity).	ULHT Improvement action plan HTA Governance Group Weekly meetings to oversee mortuary refurbishment plans	19/10/2023	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.	[19/10/2023 15:50:44 Ciro Rinaldi] -HTA oversight group has been established-meeting to manage the action plan. -Papers have been to CRIG for initial funding to establish planning and building work. This has been approved. -Draft business case has been developed and approved. -Initial concerns have been addressed from Lincoln site. -The Trust currently has two Titan units (temporary additional mortuary capacity) which provides additional capacity in the event of winter pressure peaks in demand and also in the event of equipment failure. -The Trust has a memorandum of understanding with Hull University Teaching Hospitals to support with the storage of bariatric bodies that require longer storage (freezer capacity). [19/10/2023 07:47:27 Jeremy Daws] ELT provided with an update that plans approved, and building work scheduled to commence October 2023. At recent weekly mortuary refurbishment meeting, building commencement timescales may slip back due to delays in appointing a contractor. Further update to be provided when more information known. [05/07/2023 11:06:25 Rachael Turner] Risk discussed in June RRC&C meeting, agreed to reduce risk score from 20 to a 16 High Risk [08/06/2023 13:22:36 Rachael Turner] Risk to be presented at RRC&C in June for reduction in score from 20 to 16. [31/05/2023 04:53:29 Jeremy Daws] HTA have responded to the Trust during May confirming their acceptance of the Trust's mitigation plans. HTA have confirmed they are assured enough to close down the inspection process as complete. Risk rating likelihood has been reduced from Quite likely (4) to Reasonably unlikely (3). The rationale for this is there is still a risk to the Trust if the current plans around refurbishment are not completed, even if 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	20	31/03/2024	31/03/2024	19/01/2024
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)	19/12/2023	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	[19/12/2023 15:06:16 Rachael Turner] Risk reviewed, no current change, risk score remains. [27/11/2023 14:50:37 Rachael Turner] Fire Risk Assessments are progressing based on risk priority. Review outstanding actions from previous FRA's, using FS trainer. Compartmentation (Passive): completed all 3 sites fire protection surveys, Capital teams are commencing remedial works based upon risk Fire Door Inspection: action by competent contractor, LCH and Grantham Complete. anticipated date of completion for PHB Dec 2023. Fire Alarm Systems: design of a new Pilgrim fire alarm system by capital teams. commenced 31st October with LCH and GDH to follow Storage in Corridors: security undertaking hot spot checks, completing IR1 for Managers and MyPorter. Fire Drills continue . bespoke fire safety training within higher dependency areas Fire Extinguishers concluded servicing and maintaining all 3 sites PPM Fire: Where PPM's not completed, these are escalated to the relevant Estates Lead for action. [25/10/2023 09:41:17 Rachael Turner] Risk reviewed-extinguishers serviced, all fire doors to be inspected (completion end Nov 23) compartmentation survey complete pilgrim, Grantham, 80% complete Lincoln [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	4	30/06/2022	31/03/2024	19/01/2024
5192	Service disruption	Cooper, Mrs Anita	Parriss, Helen	Estates Investment and Environment Group		14/06/2023	15		Clinical Support Services	Therapies and Rehabilitation CBU	Physiotherapy	Pilgrim Hospital, Boston	Leaking pipework under Physiotherapy Outpatient Department leading to increased humidity, water collection around windows and flooring and increased inside temperature. Risk to health and safety for staff and members of the pubic. Pre-existing problems regarding ventilation and windows (closed Risk 4296).	Physiotherapy Outpatient Department closed to staff and members of the public; relocated to gym, OT Department and consideration to hold clinics at The Johnson Hospital as needed. Face to face appointments replaced with telephone/video appointments to reduce footfall through the Department and patient treatment delay. Dehumidifiers used with the Department and an external contractor has isolated and switched off steam within the subway. Update 10.8.23 Staff members have been off sick recently with continued chest and eye symptoms due to the high humidity levels, heat and damp within the Outpatient Physiotherapy Department. The Outpatient Gym and the Occupational Therapy Department is now being offered to staff to treat patients. Managers Occupational Health referrals are being done to support staff. Confirmation again from Estates/H&S that larger dehumidifiers would potentially increase risk of Legionairres and the only solution would be to replace the single glazed windows which cause the condensation. Risk rating has been amended to reflect this update. Continued review of asbestos risk - currently clear on all tests. Update 1.9.23 Advised by H&S that outside agency due to review further steam leak within subway under Physiotherapy Department - date to be confirmed. Staff continue to work within other areas to support their health. A further DATIX was completed due to mould spores within the Physiotherapy OPD - ID 319676 - a deep clean was arranged w.c. 21.8.23 and email request sent to Biju Biju, IPC Nurse, to request mould spore analysis. Two doors within the Physiotherapy Department were reviewed on 31.8.23 as they were not able to close due to the wood swelling.	Success of repairing pipework within the subway. Continued clear asbestos results. The reopening of the Physiotherapy Outpatient Department when an acceptable level of humidity has been achieved and following a deep clean to ensure eradication of mould spores and clear ventilation ducts. Assurance from Estates Department regarding overall risk to health and safety is acceptable.	25/10/2023	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Continued liaison with Estates Department.	[25/10/2023 11:37:57 Rachael Turner] Risk discussed at RRC&C meeting 25/10/23. Risk validated as 5x3: 15 High risk. [23/06/2023 14:02:21 Rose Roberts] Leak been dealt with but still got high humidity levels.	2	19/06/2023		25/01/2024

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (Initial)	Source of Risk	Division	Clinical business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
5189	Service disruption	Parkhill, Michael	Whitehead, Mr Stuart	Medical Gases 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.	14/11/2023	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.	[14/11/2023 17:18:33 Rachael Turner] Risk reviewed, score remains, work ongoing. [03/08/2023 10:12:04 Rachael Turner] Risk reviewed, work currently ongoing, no current update. [28/06/2023 11:48:48 Rachael Turner] Risk discussed at RRC&C meeting 28/06/2023. Risk remains at a 20 following an incident. This was declared as a Serious Incident. On 11th they lost one side of medical air vent, the ventilators stopped working. Currently running on higher sets at Lincoln. Now secured capital, looking at a Triplex. Risk score agreed as 4 x 5 at a score of 20.	5	01/09/2024	14/12/2023	14/12/2023
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 of the following actions were undertaken: Pilgrim Hospital – Labour Ward: Estates staff checked the supply ventilation from the Air Handling Unit (AHU) to the Supply Grilles within the labour rooms. At the time of inspection, the Estates staff identified the dampers restricting airflow were not adjusted correctly. This was addressed and airflow checks were undertaken. Typical air change rates were around 6 air changes per hour (ACH) – current guidance is a minimum of 10 ACH, however the ventilation systems are circa. 1960 and the guidance is not retrospective. Following the actions undertaken, resampling commenced 15th March (15 sample tubes), 13 were within WEL limits, but 2 sample results were recorded at 255 and 407 ppm (8 h TWA) in Rooms 2/2a and Room 3, respectively and exceeded WEL limits. Estates are reviewing the current system to look at increasing air changes by upgrading the supply fans / changing pulleys / upgrading filter media or a combination of factors. Further works to increase ventilation has been completed and whilst not HTM03 compliant by design - supply ventilation has been increased to reduce the risk of WEL exceedance. Lincoln Hospital - Labour Ward: Estates staff found the ventilation system had been isolated (approximately 10 years ago). Following discussions with Estates members, the ventilation system had failed and was deemed beyond economical repair and a decision had been made not to replace (no one is aware of why this was made or by whom). Estates plan to reinstate the ventilation, where feasible, which will likely include partial refurbishment and deep clean of existing systems. N.B the use of sampling tubes to monitor Nitrous oxide levels can be highly time and place dependent, the person with the sampling equipment and their activities, can indicate exposure levels that are as a result of human error, not as a failing of the environment. As such G210 analysers specifically designed for highly accurate measurement and verification of the quality of piped N2O and O2 gases, are being sourced.	-COSHH assessments and training. -Health Safety Environmental and Welfare Operational Audit programme. -Direct involvement with Occupational Health. -Datix incident reporting.	25/10/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	The issues identified with exposure levels are not unique to ULHT, as with most NHS Trusts investment is required to upgrade Ventilation to comply with HTM 03-01. NHSEI issued guidance on the 2nd March 2023 for NHS Trusts to follow. Noting where ventilation is insufficient, human factors are critical in reducing staff exposure, such as: 1. Providing clear instructions to patients on correct use of equipment being used, including exhaling into the rebreather mask or out through the mouthpiece 2. Staff positioning relative to exhaust N2O and the direction of ventilation flow 3. Turning gas and air off when not in use 4. Unplugging regulators from outlets when not in use 5. Monitoring the condition of equipment for leakages. These factors can't directly be influenced by Estates and require the support and influence of Clinical Leads and Occupational Health. ULHT Health and Safety Team have recently implemented software to assist with COSHH assessments and training. The Team provide support with the Health Safety Environmental and Welfare Operational Audit programme. Occupational Health have been directly involved with the implementation of sampling and post sampling. Following sample results, Occupational Health were contacted to advise that staff may require support. To date no Datix reports have been raised and no concerns re: ill-health have been escalated in relation to Entonox use/levels to the [illegible]	[25/10/2023 10:59:03 Rachael Turner] Risk reviewed and remains the same, meeting to be held tomorrow (26/10/2023) with estates to discuss progress. [28/06/2023 11:49:31 Rachael Turner] Risk discussed at RRC&C meeting 28/06/2023. Pilgrim from a Estates point of view, all mitigation has been put into place. At Lincoln we are still in the same position. This now sits under two separate risks with two separate scoring. 20 score for Lincoln, 12 for Pilgrim. These risks will go to division to agree to be split. [19/06/2023 11:14:32 Rachael Turner] Since the last review, sampling has been carried out for Pilgrim. WEL exposure limits were not exceeded in the last Pilgrim sampling reports with a few caveats: •Sampling was undertaken but use of Entonox was recorded as low •Due to works undertaken by Estates Supply Air was increased to exceed 10ac/hr, although it should be noted extract is via corridor extract so not in full compliance with HTM03. Occupational Health have reviewed this risk with the following findings: Following recent monitoring, we have established there is a tentative but almost certainly very low level of risk to midwives caring for labouring women using Entonox (nitrous oxide, otherwise known as "gas and air"). The theoretical risk is mainly to pregnant staff. There are significant gaps in the knowledge base about adverse health effects of Entonox, but adverse health effects are likely confined to when it is used as a recreational drug. Nevertheless,it is important that there is adherence to protocols associated with Entonox use. Guidance has been reviewed and is in alignment with NHS England current guidance. Pending further advice and investigations NHS England guidance must be followed: •Provide clear instructions to patients on correct use of equipment being used, including exhaling into the rebreather mask or out through the mouthpiece. •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. •[illegible]	10	28/03/2024	25/01/2023	25/01/2023
4880	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
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.	19/12/2023	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	[19/12/2023 15:54:37 Rachael Turner] Risk reviewed, no current change, risk score remains. [27/11/2023 14:53:16 Rachael Turner] Fire Risk Assessments are progressing based on risk priority. Review outstanding actions from previous FRA's, using FS trainer. Compartmentation (Passive): completed all 3 sites fire protection surveys, Capital teams are commencing remedial works based upon risk Fire Door Inspection: action by competent contractor, LCH and Grantham Complete. anticipated date of completion for PHB Dec 2023. Fire Alarm Systems: design of a new Pilgrim fire alarm system by capital teams. commenced 31st October with LCH and GDH to follow Storage in Corridors: security undertaking hot spot checks, completing IR1 for Managers and MyPorter. Arson Risk patrols by security team and warden trained Fire Drills continue . bespoke fire safety training within higher dependency areas Fire Extinguishers concluded servicing and maintaining all 3 sites PPM Fire: Where PPM's not completed, these are escalated to the relevant Estates Lead for action. Staff training access to courses made flexible. out of date staff emailed by FS team Div. leads provided with fire warden and training statistics for FSG scrutiny [25/10/2023 09:48:02 Rachael Turner] Extinguishers serviced at all 3 sites, Fire door inspections underway, compartmentation surveys complete at pilgrim and Grantham [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 [illegible]	10	31/03/2022	31/03/2025	19/01/2024
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
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 QJA 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	16/10/2023	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.	[16/10/2023 17:17:59 Rachael Turner] The Trust has over delivered each month on the FRP target months 1-6. This meets the criteria for NOF 4 of delivery in 6 consecutive months. Year to date at month 6 the FRP has overdelivered by £5.3m The trust is still forecasting to deliver a full £28.1m CIP programme for 23/24. The trajectory for savings steps up from month 7 onwards so the run rate of savings needs to increase going forwards. [14/07/2023 09:09:38 Rachael Turner] Risk reviewed, risk score to remain as current work is ongoing. The Trust has over delivered against the month 1 trajectory for the FRP by £0.5m. The trust is also forecasting to deliver a full £28.1m CIP programme for 23/24. [28/06/2023 16:16:06 Rachael Turner] Risk reviewed, targets have been reviewed to reflect where we currently stand. we have hit financial improvement target for month 1 and 2. Risk score to remain the same at 16 High Risk. [24/05/2023 13:11:53 Rachel Thackray] Updated to reflect the risk for 2023/24. The Trust has plans to deliver £28m CIP (FRP) target. In month 1 delivery exceeded plan. [02/02/2023 14:13:16 Rachel Thackray] The Trust is forecasting to deliver a £18m CIP programme for 22/23 a shortfall of £11m against its revised plan, which has been partly mitigated through the risk and gain share contractual agreement with the ICB, however this still leaves an under delivered CIP requirement that has resulted in a contribution to the forecast deficit position of the Trust. [02/02/2023 14:12:00 Rachel Thackray] The Trust is forecasting to deliver a £18m CIP programme which has been partly mitigated through the risk and gain share contractual agreement with the ICB, however this still leaves an under delivered CIP requirement that has resulted in a contribution to the forecast deficit position of the Trust. The Trust has delivered its CIP plan for the past 3 years, albeit a reduced requirement during the 2 financial years that cover COVID. The Trust is embedding a new Improvement framework with CIP included within it and is also working with system partners to make financial improvements due to 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.	4	31/03/2023	31/03/2024	16/01/2024
4664	Finances	Matthew, Mr Paul	Young, Jonathan	Workforce Strategy Group	WORK	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)	18/12/2023	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	[18/12/2023 16:08:27 Rachael Turner] Agency Pay of £22.1m is £13.6m lower than expenditure of £35.6m in 2022/23 Bank Pay of £41.5m is £9.7m higher than expenditure of £31.8m in 2022/23. This is accounted for by the active mangement of Agency staff to bank arrangements. [20/11/2023 20:12:46 Rachael Turner] Risk reviewed, no change or update to report. [16/10/2023 17:16:29 Rachael Turner] The YTD pay position is £0.3m favourable to plan. Compared to the same period in 2022/23: ▪Agency Pay of £17.1m is £9.9m lower than expenditure of £27.0m in 2022/23. ▪Bank Pay of £31.0m is £7.1m higher than expenditure of £23.9m in 2022/23. This is accounted for by the active management of Agency staff to bank arrangements. [14/07/2023 09:07:10 Rachael Turner] Risk reviewed, score to remain at 20. Work ongoing. [28/06/2023 16:13:10 Rachael Turner] The Trust has hit its own agency plan. This is our internal plan. Score to remain the same at this time. [24/05/2023 13:24:21 Rachel Thackray] Updated to reflect the risk for 2023/24. Cap reduced from £21m to £17m. The Trust's CIP plan for 23/24 is heavily focussed on agency reduction, risks to delivery include; excess beds, winter pressures and not delivering recruitment trajectories. [24/04/2023 13:17:23 Rachael Turner] No change currently, update to be provided next month when 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.	8	31/03/2023	31/03/2024	18/01/2024
5020	Finances	Hamer, Fiona	Smith, Charles	Workforce Strategy Group	WORK	02/09/2022	20	Risk assessments	Medicine	Urgent and Emergency Care CBU			If there is a continued reliance on bank and agency staff for medical workforce in Urgent & Emergency Care there is a risk that there is not sufficient fill rate for medical rotas both ward / department fill and on call shifts which will impact on patient safety and have a negative impact on the CBU budget	Robust medical plan for every post meetings Close working with temporary medical staffing team Daily management of any gaps to support minimum staffing levels Fundamental overview of tier 1 and tier 2 docs in medicine and ED based on RCP safer staffing levels. Introduction of BMA rate cards This will reduce once output on medical workforce plan is in place, not due to come online in this review period.	Plan for every post meetings Budget reports	13/12/2023	Quite likely (4) 71-90% chance	Extreme (5)	Very high risk (20-25)	20	Robust recruitment plan International recruitment Medical Workforce Management Project	[13/12/2023 16:48:28 Rachael Turner] Improvement seen against Acute and GIM rotas after recruitment. However significant spend still re: ED T2 staff due to ongoing consultation. Resolution expected early 2024 with implementation Fed/March 2024. Ongoing impact of IA also to be considered." [20/11/2023 20:25:40 Rachael Turner] Work ongoing, posts waiting to be filled. Agency and bank continue to backfill. [17/10/2023 10:09:53 Rachael Turner] Consultation in place for medical workforce, funding has been agreed but remains covered by bank and agency until posts can be filled. [26/09/2023 14:44:54 Charles Smith] Risk remians the same but recruitment across Acute/GIM rotas improving over next couple of months. Ongoing impact of Strikes. Tier 1 and 2 in place for med, ongoing tier 2 consultation ED. [15/08/2023 11:14:12 Helen Hartley] Remains the same, plans for recruitment and money signed off. Stays the same until recruitment piece has happened. There is a trajectory for this, beginning 2024. Tier 1 in place Tier 2 consultation discussed in case of next steps/formal outcome. Medical workforce additional consultants signed off for RAT, positive steps happening but this will take time. [19/07/2023 15:50:48 Helen Hartley] This remains a risk, should be reduced with medical workforce management project that CS is leading. Some delays with recruitment and HR, a few resignations due to deanery positions. Mitigations in place. [28/06/2023 11:24:27 Rachael Turner] Risk discussed at RRC&C as part of the Deep Dive 28th June 2023. Putting money into medical workforce to increase medical staffing by 2 on each shift. Also looking at people on the agency how we can recruit into substantive posts.Work remains ongoing. This risk remains the same. [13/06/2023 11:13:13 Helen Hartley] Robust recruitment plan and international recruitment plan in place and ongoing. The uplift to meet demand and capacity has been approved and agreed, adverts are going out next week.	10	02/09/2023		13/01/2024

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
4965	Finances	Hallion, Simon	Chantry, Chris	Workforce Strategy Group	WORK	11/07/2022	9	Workforce Metrics	Family Health	Children and Young Persons CBU	Paediatric Medicine	Trust-wide	Financial risk due to reliance upon temporary staff (nursing and medical) to cover vacancies in Paediatrics.	1. Scrutiny of rosters to ensure optimal use of existing staffing resources; 2. Review of all shifts that are placed with either Nursing or Medical Bank to ensure these are required; 3. Use of bank staff in preference to agency staff in view of potential cost savings; 4. Utilisation of tier 1 and 2 agencies in view of potential cost savings; 5. Use of long line agency in view of potential cost savings and increased assurance that shifts are safely staffed.	1. Reviewed via temporary staffing expenditure and safe staffing metrics; 2. Agency spend reviewed via at FPAM	13/11/2023	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.	[16/11/2023 16:29:53 Nicola Cornish] Recruited to some posts. Nursing agency expense has improved significantly but still have challenge with medical staffing. Long line request to be submitted. [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		13/02/2024
5215	Finances	Matthew, Mr Paul	Young, Jonathan			14/07/2023	16	Corporate	Finance and Digital	Finance		Trust-wide	23/24 introduces a new mechanism to record, calculate and apply the API contract and a System incentive / penalty linked to the Elective Recovery Fund. Actual performance/activity is taken from SUS and EROC. At present, there are some SUS/SLAM reconciliation issues and some recording issues including Missing Outcomes. The risk is twofold: 1. that without accurate ERF monitoring through SUS on actual activity delivered, the activity will look artificially low and there will be financial deductions 2. the activity plan has been built on delivery of c116% of 1920 elective, day case, outpatient first and outpatient procedure activity. Under the new regime underperformance will result in lost income	The link between activity and income has been communicated to the Trust. Monitoring is being set up to monitor activity delivery and estimate the financial impact due to the variable adjustment. Lost income through recording issues (e.g. missing outcomes) will be monitored to include a financial estimate in 23/24. An ERF baseline appeal was submitted and 95% accepted nationally. Revised national ERF baseline figure have been received and are being worked through.	Monitoring of the variable adjustment and lost income is being set up	16/10/2023	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."	[16/10/2023 17:20:50 Rachael Turner] The national ERF baseline has been release twice in recent weeks. detail has been requested from the national team and is awaited in order that detailed internal monitoring can be updated [01/08/2023 14:49:23 Rachael Turner] Risk presented at RRC&C meeting in July, approved as 4 x 4 16 High Risk.	9	31/03/2024		16/01/2024
Strategic Objective						**3c. Have enhanced data and digital capability**																				
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

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
4657	Reputation	Matthew, Mr Paul	Hobday, Fiona	Information Governance Group	Digital Hospital Group	10/01/2022	12	Risk assessments	Corporate	Trust Headquarters	Corporate Secretary		If the Trust does not comply with Subject Access Requests (SARs) and Access to Health Records provisions in accordance with statutory requirements specified legislation, then it could lead to complaints to the Trust and Information Commissioner's Office (ICO). This could result in regulatory action and possibly financial penalties. Inconsistent levels of expertise outside of the IG team regarding SAR requirements. Lack of technical tools to carry out a search of emails / systems to identify personal information held. Implementation of digital systems which don't include a disclosure process. Potential financial implications.	ULHT policy in place. Monitoring through IGG and at exec level. Temporary additional resource has been put in place to oversee. Proposal made to ELT and IGG regarding process which has removed reliance on clinical staff to review all cases. Increased training provided to team.	Monthly reporting completed. Compliance rate is monitored by the Supervisor and reports taken to IGG in our KPI report. Volume of ICO complaints and Trust complaints received.	20/12/2023	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.	[20/12/2023 14:17:42 Fiona Hobday] *Still awaiting response from ICO-advised won't get anything for next month in recent update *Case of Need produced in relation to procuring a new solution- has gone through Seals approval and is with CRIG *Proof of concept re a e-discovery tool currently being done in relation to emails for staff related cases. *Balancing use of resource to manage urgent whilst not letting compliance drop back following work to improve. *Currently recruiting following departure of staff member. [28/11/2023 12:03:12 Fiona Hobday] *Still awaiting response from ICO *Case of Need produced in relation to procuring a new solution- includes recommended option for moving forward. To go to CRIG. *Proof of concept re a e-discovery tool being done in Dec 23 in relation to emails for staff related cases. [10/10/2023 15:54:52 Fiona Hobday] *Still awaiting response from ICO *Case of Need produced in relation to procuring a new solution- includes recommended option for moving forward. With Trust Sec to review and seek funding. *Awaiting Digital to recruit additional resource to support completion of backlog searches. *Completion date extended due to delays in procurement work, Digital recruitment and lack of response 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	6	29/12/2023	29/03/2024	26/01/2024
4641	Service disruption	Humber, Michael	Gay, Nigel	Digital Hospital Group	Emergency Planning Group	23/11/2021	16	Risk assessments	Corporate	Finance and Digital	Digital Services (ICT)	Trust-wide	If the Trust's digital infrastructure or systems experience an unplanned outage then the availability of essential information for multiple clinical and corporate services may be disrupted for a prolonged period of time, resulting in a significant impact on patient care, productivity and costs	National policy: - NHS Digital Data Security Protection Toolkit (DSPT) and Guidance ULHT policy: - Telecoms infrastructure maintenance arrangements - ICT hardware & software upgrade programme - Corporate and local business continuity plans for loss of access to ICT systems & system recovery ULHT governance: - Digital Hospital Group / Information Governance Group (IGG), accountable to the Finance, Performance & Estates Committee (FPEC) - 5 year capital plan -	- Network performance monitoring - Digital Services reported issues / incidents - Monitoring delivery of digital capital programme - Horizon scanning across the global digital market / supply chain to identify availability issues	20/12/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	- Prioritisation of available capital and revenue resources to essential projects through the business case approval process. - Working with suppliers and application vendors to understand upgrade and support roadmaps. - Assurance mechanisms in place with key suppliers for business continuity purposes - Comprehensive risk assessments to be completed for local service / site specific vulnerabilities so that appropriate action can be taken to manage those risks. - Contingency plans - data centres protected from overheating, fire and flood / water damage risks: Portable air con units kept on site for when needed. Estates work has addressed some leakage issues at Pilgrim. Fire retardant systems in all data centre rooms, routinely serviced by Estates.	[20/12/2023 09:39:41 Rachael Turner] Risk reviewed, no current change. Risk score remains. [20/09/2023 14:27:49 Rachael Turner] Risk reviewed as a part of the digital risk review. Score remains the same. Risk reviewed, description amended to reflect broader range of threats to the digital infrastructure. Current score increased to 16. Have purchased a significant number of Radios, to allow communication in the event of failure. We've completed a Network Core Switch replacement at Pilgrim new Data (DC3) at Pilgrim to provide resilience at site backup across site has been improved. Recovery Vault is in the process of implementation The Metro-Cluster is in the process of implementation.	4	31/03/2023	31/03/2023	20/03/2024
5245	Service disruption	Jenkins, Barry	Humber, Michael			30/08/2023	20		Corporate	Finance and Digital	Digital Services (ICT)	Trust-wide	The Trusts disaster recovery capabilities are limited. In the event of a major incident affecting the primary data centre/site the ability to restore services elsewhere is limited. This would affect the availability and data integrity of tier 1 clinical and corporate systems, leading to extended unavailability and reliance on Business Continuity Plans. In addition there is a risk of significant data loss in the event that recent backups are unavailable or compromised.	Business Continuity Plans Protections that reduce the likelihood of various disasters, including environmental and technical controls.	As above.	20/12/2023	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."	[20/12/2023 09:22:32 Rachael Turner] In the process of implementing Rubrick, which will support disaster recovery and cloud back up. [30/08/2023 16:06:58 Rachael Turner] Risk discussed at RRC&C meeting 30/08/2023, score validated as: 4x4: 16 High Risk.	10	30/08/2024		20/03/2024
5241	Service disruption	Jenkins, Barry	Gay, Nigel			30/08/2023	16		Corporate	Finance and Digital	Digital Services (ICT)	Trust-wide	SSL Inspection on Internet Traffic: There is significant risk that a malicious cyber event may occur as a result that encrypted Internet traffic is not inspected at the Trust external facing network boundaries. As a result malicious payloads may enter the Trust network and attack staff and IT Service endpoints resulting a breach of C, I or A. (e.g. link to a compromised website or C2C server connection due to a phishing event.)	Web-proxy/filter, boundary firewalls	As above.	20/12/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Introduction of web-proxy with capability for SSL inspection. Proxy procurement continues and is a ULH focused procurement activity in the hope that apartner organisations will be onboarded in 2024 - agreed May 2023 at DDaT	[20/12/2023 09:37:57 Rachael Turner] Risk reviewed, currently no no change risk to be reviewed in March 2024 for update. The functionality is yet to be switched on due ongoing security discussions. [30/08/2023 15:26:12 Rachael Turner] Risk discussed at RRC&C Meeting 30/08/2023. Controls are currently in place but this not mitigate the risk. Risk validated with an agreed score of 4x4: 16 High Risk.	4	30/08/2024		20/03/2024

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (Initial)	Source of Risk	Division	Clinical business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
4658	Reputation	Matthew, Mr Paul	Warner, Jayne	Information Governance Group	Digital Hospital Group	10/01/2022	20	Risk assessments	Corporate	Trust Headquarters	Corporate Secretary	Trust-wide	If the Trust does not have a defined records management framework/ strategy it runs the risk of not meeting national best practice and not making informed decisions in relation to Digital programmes of work. This could result in a breach of regulations and ULHT finding it difficult to meet national enquires that could lead to regulatory action and financial penalties. This risk has increased due to ongoing national enquiries and the move to a more digital way of records mgmt which whilst positive heightens the need to manage legacy and ensure expert RM support for future decision making.	The Trust has policies in place. Trust DPIA template included aspects on records mgmt and retention.	FOI compliance gives an indication of the Trusts position as compliance is linked to good records management. Reports of unmanaged records found in Trust locations.	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	28/06/2034	04/12/2023
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.	20/12/2023	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.)	[20/12/2023 09:29:04 Rachael Turner] Tools in place to mitigate risk. Ironscales currently in place. Anti virus software has recently been updated which includes phishing tools. 500,000 phishing attacks were prevented from the Trust during October/November which has increased drastically from early summer. [30/08/2023 15:34:45 Rachael Turner] Risk discussed at RRC&C meeting 30/08/2023. Although there are very good controls in place we cannot mitigate all of the risk. NHS mail have had issues with phishing emails which staff fall fowl of. Expedition in traffic will also help with this. Risk was validated with an agreed score of 4x4: 16 High Risk.	1	30/08/2024		20/03/2024
5244	Service disruption	Jenkins, Barry	Humber, Michael			30/08/2023	20		Corporate	Finance and Digital	Digital Services (ICT)	Trust-wide	The most important challenge regarding legacy software is the risk to the 'cyber security\information security' posture of the organisation with the potential impact being the loss of clinical and digital services\data. A typical incident is likely to be due to a successful malicious exploit event regarding vulnerabilities that can be found in all unsupported legacy software. There is a risk that exploited security vulnerabilities present within unmanaged and out of date applications will result in a breach of Confidentiality, Integrity, and Availability and likely result in loss of availability of access to these services. The operation of legacy software that is not maintained by the vendor means that the likelihood of successful attack is increased, due to unsupported software containing many known and exploitable vulnerabilities. The Trust has a large complex estate that has developed over many years, while the current approach is to adopt an 'evergreen' approach to software, this has not historically been the case. The replacement of legacy software is a remediation activity the MUST completed, but may take time. Currently, the Trust's clinical reliance(s) are expected to be in place for some years to come whilst significant Digital Delivery Programmes of development and innovation come to fruition, for example E-HR, EPMA, EDMS. Therefore, appropriate risk remediation\mitigation of identified vulnerability will always be the key to protecting vital services.	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.	20/12/2023	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.	[20/12/2023 09:25:19 Rachael Turner] Currently implementing Celera. Meetings currently ongoing within digital within clinical and digital engineering. [30/08/2023 15:57:37 Rachael Turner] Risk discussed at RRC&C meeting 30/08/2023, validated risk score: 4x4: 16 Moderate risk. [30/08/2023 15:56:47 Rachael Turner] Update : 06/06/23 The recent completion of Dell VMware/Metro/NSX has provided new capabilty around segmentation within our Virtual estate. Whilst a futher 6 months of work will enhase this and embed within the infastructure we do now have the capabilty to apply firewall rules between VMs on the same network segment. IF needed we can apply mitigation against ULH Metro, Standard, MGMT and the ICB clusters within VMware."	10	30/08/2024		20/03/2024
Strategic Objective							**4b. Becoming a University Teaching Hospital Trust**																			
5160	Reputation	Morgan, Mr Andrew	Rich-Mahadkar, Sameedha			21/04/2023	16		Corporate				If we don't deliver against our ambition of becoming a University Hospital Trust, this could negatively impact our organisational reputation.	Following UHA guidance Regular discussions between Executive leads from ULHT and UoL regarding financial arrangements Working closely with University of Lincoln to define and agree future collaborations Working with Research and Innovation teams and reporting into R&I groups to maintain oversight	Executive scorecard - number of clinical academics in post and number of collaborations that are developed to support research grants	18/10/2023	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 Application for Teaching Hospital Status as interim step. Contact with UHA to confirm requirements for application	[18/10/2023 11:52:17 Rachael Turner] An application for Teaching Hospital Status is to be submitted to the DHSC as an interim step to recognise ULHT's significant teaching commitment. We anticipate that this will be approved before the end of 23/24 financial year. An MOU and financial model is being developed and agreed between ULHT and UoL which will support our requirement to recruit clinical academics and regular meetings are in the diary to conclude this work. A new ULHT Growth of Research Culture group has been established. [07/06/2023 12:20:47 Rachael Turner] Risk discussed at RRC&C meeting 07/06/2023.Risk needs to reflect more than getting status, such as recruitment, quality of people you attract, development and investment. Risk score 4 x 4 making it a score of 16 High Risk.	8	31/03/2025		18/01/2024

United Lincolnshire Hospitals NHS Trust

Meeting	*Public Trust Board*
Date of Meeting	*11 January 2024*
Item Number	*Item 13.2*

Board Assurance Framework (BAF) 2023/24

Accountable Director	*Andrew Morgan, Chief Executive*
Presented by	*Jayne Warner, Trust Secretary*
Author(s)	*Karen Willey, Deputy Trust Secretary*
Report previously considered at	*N/A*

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

Risk Assessment	*Objectives within BAF referenced to Risk Register*
Financial Impact Assessment	*N/A*
Quality Impact Assessment	*N/A*
Equality Impact Assessment	*N/A*
Assurance Level Assessment	• *Moderate*

Recommendations/ Decision Required	• *Board to consider assurances provided in respect of Trust objectives noting that framework has been reviewed through committee structure* • *Confirm the assurance rating of objective 2a moving from amber to green*

Executive Summary

The relevant objectives of the 2023/24 BAF were presented to all Committees in November and December with the exception of the Audit Committee which is not due to meet until 12 January.

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

During the December meeting of the People and Organisational Development Committee discussions were held regarding objective 2a and the assurance rating provided. Following significant scrutiny of the objective and associated assurances provided to the Committee there was agreement that the objective should be rated Green.

This proposal has been made to the Board and reflected in the BAF with the Board asked to approve the change in the rating for objective 2a.

The following assurance ratings have been identified:

Objective		**Rating at start of 2023/24**	**Assurance Rating** **October**	**Assurance Rating (Previous Board reported position)** **November**	**Assurance Rating (Current position)** **December**
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**	**Green**
2b	Making ULHT the best place to work	**Amber**	**Amber**	**Amber**	**Amber**
2c	Well led services	**Amber**	**Amber**	**Amber**	**Amber**
3a	A modern, clean and fit for purpose environment	**Amber**	**Amber**	**Amber**	**Amber**
3b	Efficient use of resources	**Red**	**Amber**	**Amber**	**Amber**

3c	Enhanced data and digital capability	**Amber**	**Amber**	**Amber**	**Amber**
3d	Improving cancer services access	**Amber**	**Red**	**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 - December 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
						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.		
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 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	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	Quality Governance Committee	**Green**

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. Communications task and finish group in place (PEG)	Reaching out project (Hard to Reach groups) still in development. Diversity of current patient representatives and panel members is narrow;.C Contact still to be made with some community groups.	Recruitment for new panel members continues. You Care - We Care to Call (YCWCC) Campaign being used in several wards to test out a variety of ways to improve communication with families / loved ones of in-patients. Communication engagement group set up as a subgroup of Patient Experience Group to look at a range of communication issues affecting patient experience.	Upward reports and minutes to the Patient Experience Group	Diversity of the patients engaging and involving themselves limited meaning that is is not represenative of the local population.	Partnership working established with Healthwatch to reach out to Eastern European community. Early attempts to reach local groups have not been successful and consideration now to work alongside existing agencies such as healthwatch to hear the voices of this community. Staff BAME network approached for community links and contacts. Breast mastalgia group has completed its co-design but will meet again in the future as part of service evaluation. Dementia Carers Expert Reference Group ran for 4 months but membership dropped. Now being redesigned to be a Care Partners Expert Reference group. Advert out for members. New expert reference groups established for Improvement Academy and Digital Transformation. Cancer Expert reference group continues to meet quarterly, hosted by ULHT and reporting to Lincolnshire Cancer Board.		

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						Care after death / last offices Procedure & Guidelines Sharing information with relatives Visiting Procedure Patient information Carers Policy in place (PEG)	Audit of EOL visiting required to determine if there is a consistent approach to visiting.	Exceptions guidance re-issued. Monitor through complaints & PALs. Audit will be undertaken by the Patient Experience Team in this years schedule of work.	Report to PEG through complaints & PALs reports; upward reports were received from Visiting Review working group which has now disbanded; the planned audit will report back to PEG and propose any further recommendations. Complaint data now improved in terms of visiting issues.	Patient information currently subject to review and work is ongoing.	Work progressing well and anticipated to have completed full review by end March 2024. Audit of visiting across the Trust completed and co design workshops undertaken that subsequently produced a new Visiting Policy, Visiting Charter, standardised visiting hours across all areas and the new Care Partners Policy.		
						Inclusion Strategy in place (PEG)	Lack of diversity in patient feedback and engagement	Equality, Diversity and Inclusion Lead is member of Patient Experience Group.	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 Annual PLACE report received at PEG	None identified	Not applicable		
						Enhance patient experience by learning from patient feedback and demonstrating our values and behaviours in the delivery of care with a specific focus on discharge of patients. (PEG)	National surveys evidence overall poor experiences in relation to discharge with a number of questions being benchmarked as worse than others Trusts.	Amalgamated survey action plan in development to identify Trust wide improvement focus. Rolling out of #WMTY initiative to ensure patients are involved in decisions and discussions about their discharge plans. Patient Experience Team working with Discharge Lounge staff facilitating understanding of discharge experience and improvements.	Discharge 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. Mr Simpson to continue as Chair of the Group whilst appointment of Deputy Medical Director concluded and will commence in role of CEG chair	Effective upward reporting to QGC from reporting groups. Regular reports received from Divisions providing assurance that they understand their position with respect to clinical effectiveness	No gaps identified.	Not applicable.		

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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	QGC								

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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 report for People & OD Committee highlight report to Board	None identified		Workforce plans submitted for 2023/24 Operational Planning. Recruitment plans are in place. Divisional Recruitment Pipeline Reports are refreshed regularly for each division working with each of the SHRBP's and are reporting through to FPAM in terms of pipeline linked to reducing agency spend.	None identified			

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2a	A modern and progressive workforce	Director of People and Organisational Development	Possible disruption caused by system wide strike action and capacity of Pillar leads	4844 4996 5093 4997	CQC Safe CQC Responsive CQC Effective	Focus on retention of staff - creating positive working environment and integration of People Promise 'themes' System retention role established and in place for 2023/24. People Promise Y1 work complete with funding for Y2 agreed. Education and Learning Team in place and actively working to improve compliance with Statutory and Mandatory Training. Organisational Development Team in place and actively working to improve completion rates for Appraisals.	System People Promise Manager to be recruited for Yr2 Consideration to the concept of group appraisals and appraisal lite	OD picking up retention/flexible working whilst People Promise Manager not yet recruited to Workforce Strategy and OD Group to discuss group appraisal and appraisal lite Sept 2023	Workforce, Strategy and OD Group upward report to PODC including scorecard analytics i.e. appraisal, statutory and mandatory training	Appraisal compliance levels not at expected level Mandatory Training compliance not at agreed level	To be monitored through the Workforce Operational Group and FPAM meetings and will feature in the highlight report to PODC. Phased targeted approach in 23/24 KPI's as featured in the Integrated Improvement Plan.	People and Organisational Development Committee	Green
						Embed continuous improvement methodology across the Trust	Embedding and sustaining cultural change when the ability of the ULHT teams to engage when we are operationally challenged Ability to demonstrate quick impact on the cultural change due to various interventions will be limited (as these are multi year/multi factorial projects)	Improvement Academy now report all training & associated activity to embed continuous improvement through Improvement Steering Group for oversight and escalations Working with each improvement programme and Divisions to develop identify and align improvement plans	Internal training reports produced by Improvement academy Improvement programmes identifying personalised training needs for ULHT staff Divisions training plan (aligned to the IIP) presented at FPAM	Information is reported to ISG - Low uptake of our various training offers despite general and targeted comms through various platforms. Services are struggling to release staff for QI training due to pressures. Plan for a QI relaunch in the new financial year. Use of virtual training option via MS Teams.	Weekly meetings with Improvement Academy to increase offer with more agile training methods to meet the needs of the varied staff. Developing communications & engagement strategy for on-going awareness of Improvement Academy to enable improvement culture change (not just limited to sending email updates but being creative and being on site on wards to talk about quality improvement)		
						Reducing sickness absence - Absence Management System	Manager call back compliance and return to work interview	Compliance with use of AMS being addressed through People Management Essential Training and AMS training from HRBPs Early Occupational Health led interventions are being explored for top two reasons for sickness absence	Sickness/absence data Deep dive by Workforce Strategy and OD Group into absence data Internal Audit Report Actions	Various reports through Heads of HR to Divisions Output from WSOD Group deep dive into absence data	Work continues with the completion of the audit actions and work/training with the departmental managers and HR. To be monitored through the Workforce Operational Group and FPAM meetings and will feature in the highlight report to PODC. Phased targeted approach in 23/24 KPI's as featured in the Integrated Improvement Plan. A deep dive is being undertaken of the full utilisation of the AMS management system as early indications show improvement is needed.		
						Ensuring access to the personal and professional development that enables people to deliver outstanding care and ensures ULHT becomes known as a learning organisation Establish ULHT Education and Learning service Promote benefits and 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.		

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						Opportunities of Apprenticeships							
						Improve the consistency and quality of leadership through:- Reset leadership development offer and support (Leadership SkillsLab and PME) •Improved mandatory training compliance •Improved appraisals rates using the WorkPal system •Developing clear communication mechanisms within teams and departments	New Training and Development department in place with full recruitment programme now complete	Dedicated capacity and project leadership identified for Culture and Leadership Programme	WSODG, FPAM and PODC data Culture and Leadership Task Force Reports to PODC	None identified			
						Proactively support staff to remain well and at work, however should the need arise, supporting them through illness and their return to work Staff Vaccination Programme	Improvement in sickness rate in 23/34 full year affect of 4.5% required. Continue to fill vacancies within the HR department to support Divisions with sickness management	Continue to fill vacancies within the HR department to support Divisions with sickness management As at Aug 23 almost at fully recruited position within HR structure	Health and wellbeing Manager and Health and Wellbeing Group/Wellbeing Champions Upward reporting to WSODG from H&WB Group Board level HWB Guardian change enacted Vaccination Programme updates through WSOD Group	None identified			
						Employee Assistance Programme implemented May 2022 - embedded as business as usual	None identified		PODC Scorecard reporting to PODC	None identified			
						Vacancy levels below 4% across all staff groups Aligned to the plan for every post, recruitment plans for each division and aligned to the workforce submission plan for 23/24.	None identified		Key Performance indicators have been identified as part of the IIP and will be monitored through the scorecard at Workforce Operational and Strategy Group. Pastoral care award received for recruitment and on-boarding of international nurses	None identified			

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						Reduce our staff turnover rate to 6% across all staff groups	Aligned to the continued work under the People Promise Manager role and plans for 23/24 to continue to improve work life balance, flexible working requests, flexible retirement/retire and return options. People Promise Mgr funding identified for Yr2		Key Performance indicators have been identified as part of the IIP and will be monitored through the scorecard at Workforce Operational and Strategy Group. Pastoral care award received for recruitment and on-boarding of international nurses	None identified			
						Compliance with National agency utilisation target of 3.7% agency and locum workforce	None identified		FRP and ISG	None identified			
						Reset ULH Culture and Leadership through delivery and implementation of Culture and Leadership Programme and Restorative and Just Culture Programme. Cultural deep dives	Comprehensive follow up and prioritisation of NSS results - key areas of concern identified for action 7 point action plan presented and agreed to ELT/TLT	Leading Together Forum - regular bi-monthly leadership event Delivery Plan and actions to be confirmed further to results of Leadership Survey LTF Forward Plan Leadership SkillsLAB - essentials in management and leadership for existing managers	Culture and Leadership Group and System People Board Culture and Leadership Programme Group upward report NSS results (Feb 2023) Themes from cultural deep dives presented to PODC	Delivery of agreed output	Paper presented to ELT in August to offer a plan in terms of 23/24 National Staff Survey plans and individual priorities being taken forward in preparation for the next NSS. Restorative Just and Learning Culture project team has been created to scope out the plans to roll out in the Trust.		
						Effective communication mechanisms with our staff - ELT Live, managers cascade, intranet etc.	None identified		Staff survey feedback - engagement score, recommend as place to work / recommend as a place to receive care Director BLOG's	None Identified			
						Leadership & Management training. (Improving the consistency and quality of leadership and line management across ULHT) Leadership SkillsLab - Re-launched July 2023	None identified		National Quarterly Pulse surveys (mandated from July'22) Number of staff attending leadership courses	Limited uptake of quarterly staff survey	Work on-going in terms of uptake and analysis		
						Lincs Belonging Strategy EDI Delivery Plan 2022-25	None identified		Council of Staff Networks Internal Audit - Equality, Diversity and Inclusion NHS NSS EDI/EDS objectives	None identified			

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2b	Making ULHT the best place to work	Director of People and Organisational Development	Further decline in demand Weak structure (to support delivery) Lack of resource and expertise Failure to address examples bullying & poor behaviour Lack of investment or engagement in leadership & management training Perceived lack of listening to staff voice Under-investing in staff engagement with wellbeing programme Failure to respond to GMC survey Ineffectiveness of key roles Staff networks not strong	4439 4948	CQC Well Led	Staff networks	Men's Health Network Group due to be launched November 23 Additional Carers Network now launched. An ELT Network special has also been held with all Network Chairs and Executives	Executive sponsor for Men's Health Network to be identified Launch Network in November	Council of Staff Networks	None identified			**Amber**
						Focus on junior doctor experience key roles:- - Freedom to speak up Guardian - Guardian of safe working - Well-being Guardian	Additional resources are now in place within the OD Department to help support culture and engagement within the Medical Workforce.	Task and finish group to review experience of rotation	Dedicated resource in place for GOSW and FTSUG. NED has taken role of Well being Guardian. Reports being provided from GOSW and FTSUG. JNR doctor survey findings being seen at Committee. GOSW and FTSUG invited in person to Committee	None identified			
						Embed compassionate and inclusive leadership (aligned to People Promise)	System People Promise Manager to be recruited for Yr2 funding identified	OD picking up retention/flexible working whilst People Promise Manager not yet recruited to	Culture and Leadership Group to PODC	None identified			
						Support Divisions to achieve 95% of our people having completed all relevant statutory and mandatory training by March 2024 Trust aligned to National Core Skills Training Framework Mandatory Training Governance Group in place MTTG used as Gateway to core learning Mapping of core training on more individual basis		Support and training from new Education Department	Workforce Operational Group Upward reporting to People and OD Committee CQC Monthly reporting				
						Support our Divisions to provide all staff with an appraisal and clear objectives	Newly created dedicated Education Department now in place as part of the restructure. Aligned to the People Promise continued work for 23/24 Updates to ESR system to	Support and training from new Education Department	Workforce Operational Group Upward reporting to People and OD Committee CQC Monthly reporting	Appraisal compliance levels not at expected level	To be monitored through the Workforce Operational Group and FPAM meetings and will feature in the highlight report to PODC. Phased targeted approach in 23/24 KPI's as featured in the Integrated		

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						55% of our staff recommending ULHT as a place to work and an improved position with regards to our people feeling that they are treated with kindness, compassion and respect.	allow better monitoring and reporting Consideration of appraisal lite and group appraisal Further work required aligned to the Quarterly Pulse survey and promotion of this.		Workforce Operational Group Upward reporting to People and OD Committee CQC Monthly reporting Recognition certificate and letter received for the 2022 National Staff Survey	Mandatory Training compliance not at agreed level Limited uptake of quarterly staff survey	Improvement Plan. Additional monthly assurance offered to CQC through governance team regular meetings		
						53% of our staff recommending ULHT as a place to receive care		Further work required aligned to the Quarterly Pulse survey and promotion of this.	Workforce Operational Group Upward reporting to People and OD Committee CQC Monthly reporting Recognition certificate and letter received for the 2022 National Staff Survey				
2c	Well led services	Chief Executive	Risk register configuration not fully reflective of organisations risk profile Current systems and processes for policy management are inadequate resulting in failure to review out of date or policies which are not fit for purpose	4277 4389	CQC Well Lead	Delivery of risk management training programmes Risk Register Confirm and Challenge Group meeting monthly including full risk register review Upgrade to datix system	Upgrade to Daitx due to take place October 2023		Third party assessment of well led domains Internal Audit assessments Risk Management HOIA Opinion received and Audit Committee considered in June noting 'partial assurance with improvement required can be given on the overall adequacy and effectiveness of the Trust's framework of governance, risk management and control. Completeness of risk registers Annual Governance Statement			Audit Committee	**Amber**

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						Implementing a robust policy management system Additional resource identified for policy management post Reports on status by division and Directorate Updated Policy on Policies Published Guidance on intranet re policy management reviewed and updated	Divisional breakdown of policies requiring review shared with CEG and request for trajectories to update/remove all clinical policy documents requested at August meeting.	Further discssions to take place at October CEG to address shortfall in trajectories being offered	ELT report monitoring actions. Quarterly report to Audit Committee including data on in date policies CQC Report - Well Led Domain				
SO3	**To ensure that services are sustainable, supported by technology and delivered from an improved estate**												
						Develop business cases to demonstrate capital requirement in line with Estates Strategy	Business Cases require level of capital development that cannot be rectified in any single year.	Estates Strategy sets out a framework of responding to issues and management of risk. Capital Delivery Group has oversight of the delivery of key capital schemes. External Specialist Advisor working jointly NHSE & ULHT providing external guidance and validation. Use of the premises assurance model PAM will help identify gaps and subsequent actions or schemes of improvements.	Capital Delivery Group Highlight Reports Compliance report to Finance, Performance and Estates Committee Updates on progress above linked to the estates strategy. PAM Quarterly internal review and annual submission.	Funding gap when considering the full £100m+ backlog in first year. Future years will at most tackle £20m of backlog in any given year 6 Facet Surveys used to quantify and identify schemes are out of date and need reviewing.	Estates improvement and Estates Group review compliance and key statutory areas. Progress against Estates Strategy/Delivery Plan and IIP via sub groups upward reports. Delivery of 2022/23 Capital Programme will continue to ensure progress against remaining backlog of critical infrastructure. Capital Delivery Group will monitor the delivery of key capital programmes and ensure robust programme governance. Structure review including upward reports are being reviewed by specialist advisor with recommendations of reporting lines.		
						Continual improvement towards meeting PLACE assessment outcomes	PLACE assessments have been suspended and delayed for a period during COVID	Use of PLACE Light assessments and other intelligence reports.	PLACE Light Assessments PLACE Full assessments starting in September 22	PLACE/Light do not provide as deep an assurance review as PLACE with limited input.	Combination of PLACE Light and other intelligence (IPC Group/Compliance Reports and Capital Delivery Group) will help triangulate areas of concern and response. With PLACE Full assessments starting in September gaps will be closed further.		

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3a	A modern, clean and fit for purpose environment	Director of Improvement and Integration	Longer term impact on supplier services (including raw materials) who are supporting the improvement, development, and maintenance of our environments. Availability of funding to support the necessary improvement of environments (capital and revenue)	4648 - Fire Safety 4647 - Fire Safety 4858 - Water	CQC Safe	Review and improve the quality and value for money of Facility services including catering and housekeeping	Value for Money schemes have been delayed during COVID	Improvement teams have started in 2022/23 working through value for money and financial efficiency schemes included development of Housekeeping, Security and Portering Business Cases for future models	MiC4C cleaning inspections Staff and user surveys 6 Facet Surveys	6 Facet Survey are not recent and require updating.	Cleanliness is reported through IPC Group to QGC. Water Safety and Fire Safety Groups will report through to relevant sub-committees and provide a more comprehensive view offering assurance were it is possible and describing improvement where it is not with Annual Reporting providing assurance and gap analysis on all AE domains.	Finance, Performance and Estates Committee	**Amber**
						Continued progress on improving infrastructure to meet statutory Health and Safety compliance	H&S Committee Previously not run with quoracy. However now reviewed with ToR agreed and Quorate with staffside representation	Water/Fire safety meetings are in place and review of controls are part of external validation from authorised engineers. Health and Safety Committee new terms of reference approved and now chaired by Chief Operating Officer/Director of Estates and Facilities. Upward reporting to Finance, Performance and Estates Committee Med gas, Critical ventilation, Water safety group, electrical safety group, medical gas group have all been established and include the relevant authorising engineers in attendance. These groups monitor and manage risks and report upwards any exceptions or points of escalation.	Reports from authorised engineers Response times to urgent estates requests Estates led condition inspections of the environment Response times for reactive estates repair requests Progress towards removal of enforcement notices Health and Safety Committee upward report Letter from British Safety Council on External Review				
						Implement Year 1 of our Estates Strategy	Funding gaps between overall plan of replacement vs available funding. Availability of Suppliers and Changes in market forces. Availability of raw materials and specialist components to replace/repair etc.	Business Case Development and preparation pre-empting available capital to maximise available. Use of procurement framework and liaison with NHSE to coordinate bids and larger schemes	Estates Group Upward Report				
						Refurbishment of 8 theatres, across our sites							
						Support capacity maximisation ensuring modernisation and utilisation of space, including that leased off the main acute sites							
						Reduce our net carbon footprint							
						Develop Health Master Plans to better algin wards							

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3b	Efficient use of our resources	Director of Finance and Digital	Not identifying and then delivering the required £28m FRP of schemes The national impact of rising inflation (specifically utilities) in excess of the levels assumed in the 23/24 financial settlements The Trust is overly reliant upon a large number of temporary agency and locum staff to maintain the safety and continuity of clinical services. Failure to deliver the activity targets of 116% of 19/20 planned activity will result in a clawback of an element of the ERF allocation made to Lincolnshire.	4665 - FRP delivery 4666 - Inflation pressures 4664 -Agency costs 4384 - ERF Clawback (116% activity delivery risk) NEW Risk to be added to the risk register - Availability of Capital	CQC Well Led CQC Use of Resources	Introduction of Aspyre for reporting all FRP schemes Refresh of the CIP framework and training to all stakeholders. Increased FRP governance & monitoring arrangements introduced. Alignment with the Trust IIP and System objectives FRP is embedded as part of the Trust Improvement Strategy not seen as a separate workstream. Internal meeting structure and reporting aligned to the ICS reporting requirements	Operational ownership and delivery of efficiency schemes Detailed delivery plans supported by clear timelines and metrics for all plans	Divisional FPAM to provide oversight of FRP reporting upward into PRMs. Trust wide oversight for FRP schemes in the Improvement Steering Group ICS oversight through the ICB Financial Recovery Board.	Delivery of the Trust FRP target Reporting through Aspyre to - FPAM PRM FPEC Financial Recovery Board	Ability of clinical and operational colleagues to engage due to service pressures. Evidence of system and Trust schemes to reduce the operational pressures and beds numbers in the Trust. Traction in year to produce cost out from cross cutting targeted and transformational schemes	Divisional - Progress is being reviewed monthly with Divisions through FPAMs. Trust wide improvement schemes - Progress is being reviewed monthly with Exec, Divisional and Corporate teams through the Improvement Steering Group. System wide - Progress is being reviewed monthly with system partners including Exec, Operational and Corporate teams through various forums.	Finance, Performance and Estates Committee	Amber
						Inflation - The Trust is working to actively manage its contracts and to flag excess inflation due to market conditions as part of the national collection process in relation to this spend area	Impact of unstable market conditions led to the Trust forecasting excess inflation of £8.1m in its 2023/24 financial plan submission - over and above national inflation funding allocations. The £8.1m (as per national instruction) sits outside of the Trust financial plan for 2023/24. Inflation pressures primarily relate to Utility costs but also impacts in other non-pay contracts. As prices continue to rise the Trust and / or ICS may be unable to mitigate these cost increases.	Financial plan set out the Trust expectation in respect of inflation aligned to the national allocations Annual budget setting process cascades and apportions the Trust inflation allocation to Divisions and Directorates. Monthly financial management & monitoring arrangements are in place to identify variation of excess inflation against financial plans at all levels of expenditure from department up to Trust. The Trust actively manages its external contracts to ensure value for money.	The Trust is monitored externally against the inflation impacts through the monthly finance return to NHSE The Trust monitors internally against its financial plan inclusive of specific inflation forecasts Divisional focus against specific contracts (e.g. Utilities) is reviewed at the relevant FPAM Excess inflation pressures will be reported internally into FPEC and externally into FLG and ICS and Finance Committee	Forward view of market conditions.	Internally through FPAMs and upwards into FPEC. Externally through greater dialogue with suppliers and proactive contract management Flagging with ICS partners and NHSE to understand if any further funding allocations will be available to offset.		
						Financial Recovery Plan schemes Recruitment improvement Medical job planning Agency price reduction Workforce alignment Service Reviews process and transformational programmes of work Budget compliance	Reliance on temporary staff to maintain services, at increased cost Management within staff departments and groups to funded levels. Maximisation of below cap framework rates Rapid ability to on-board temporary staff to substantive contracts	Proposed centralised agency & bank team. Workforce Groups to provide grip Improvement Steering Group to provide oversight Non-Clinical Agency sign off process	Delivery of the planned agency reduction target.	Granular detailed plan for every post plans Rota and job plan sign off in a timely manner	The Trust monitors internally against its financial plan inclusive of specific targets for agency and bank spend by staff group The Trust FRP workstreams are reported to the Improvement Steering Group The Divisional cut of the workstreams are reported to the relevant FPAM The staff areas of key focus - Medical and Nursing are reported through their Workforce Groups		

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						ERF clawback - Collective ownership across the Lincolnshire ICS of the restoration and recovery of the planned care pathways leading to improved activity delivery. Trust focus to restore services to pre-COVID levels and then stretch to 116%.	Maximisation of the Trust Resources - Theatre and Outpatient productivity. Impact of the COVID patients and flow on availability of beds to provide capacity. Ability to recruit and retain staff to deliver the capacity. A production / activity delivery plan.	Divisional ownership and reporting Improved counting and coding, including data capture and missing outcome reductions. Shared risk and gain share agreements for the Lincolnshire ICS. Reporting by POD and Specialty against the delivery plan	Delivery of the 116% target	The operational pressures, specifically; sickness, excess beds open, rising acuity of patients and continuing rising demand at the front door of the acute Trust is putting at risk in year delivery of the 116% activity target.	The Trust is monitored externally against the Trust activity target through the monthly activity returns The Trust monitors internally against its activity targets inclusive of specific Divisional and Specialty plans and targets The Lincolnshire ICS is monitored externally against the system activity target through the monthly activity returns		
						Utilisation of Capital allocation based on risk to enhance our services and support efficiency improvements	Difficult to compare Estate, Digital and Equipment risks. Capacity to produce business cases to access external funds	Revised CRIG process, supported by experts. Green book training roll out. Risk rating pre & post investment required in all investment requests.	Capital, CDC and Benefits realisation upward reports into FPEC. Development of a 5 year capital programme cross referenced to risk register.	6 facet survey not completed.	Investment identified for 6 facet survey.		
						Improve utilisation of the Care Portal with increased availability of information -	Cyber Security and enhancing core infrastructure to ensure network resilience. .	Digital Services Steering Group Digital Hospital Group Operational Excellence Programme Outpatient Redesign Group	Number of staff using care portal Ranked in 4th place nationally of ICS usage of Care Portals.				
						Development and approval of Electronic Patient Record OBC	Regional and National approval of OBC Affordability of OBC	Digital Services Steering Group Digital Hospital Group e-HR Programme Steering Group Capital, Revenue and Investment Group Engagement with regional colleagues	Delivery of OBC Agreement of funding	Regional feedback on OBC	OBC approved by Frontline Digitalisation ePR Investment Board (EPRIB) on 19th July 2023. OBC approved by JIC on 28th July 2023. OBC approved by Cabinet Office Commercial Spend Controls Process on 3rd Oct 2023. ITT will now be published and progressing through clarification etc.		

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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 Authority Digital Hospital Group Information Governance Group (for cyber / info security)	Digital Maturity Assessment		Looking to procure a Technical / Implementation Partner to provide capacity as and when required		

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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 / Implementation Partner to provide capacity as and when required		
						Implementation of an Electronic Prescribing system	2023/24 funding not approved yet Insufficient capacity to deliver at pace of current plan	ePMA Steering Group Digia Hospital Group	Number of wards live with ePMA		Paper written to clarify costs. Currently being worked through with Finance colleagues Looking to procure a Technical / Implementation Partner 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**
						Achievement of 104 and 62 week performance trajectory	Capacity to deliver Faster Diagnosis (FDs) for all services	Additional support secured through mutual aid to provide focus on cancer recovery	Weekly system elective and cancer recovery meetings 3x weekly cancer meetings led by Deputy COO, Urgent Care and Cancer and ICB Cancer lead				
						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 completion 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 delivery group lead by the Deputy COO for Planned Care and Diagnostics GiRFT and High Volume Low Complexity Programme Group Productive Theatres Improvement Programme Grantham Surgical Hub now established with Focused utilisation plan Productivity group established focused on increase of all Elective activity Early adopter of GIRFT Further Faster Programme Line by Line review twice weekly of 78 week waiting patients Weekly monitoring of Outpatient capacity to support 1st OPA booking for 65 week waiting paitents	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 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							

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						Maximisation of capacity and efficiencies to reduce and eliminate 78 week, 65 week waits across all specialties and moves to ambition of reducing 52 week to 700 by end of Q4 2023/2024			Trajectories for all specialties in place, weekly position statements offered to ELT and TLT Weekly planned care update meeting				
						Development of plans for seven day working, across all of our services							
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 undertaken on 8 August 2023 to support ongoing recovery.	Metrics dashboard developed for discharge and flow linked to bed reductions trajectory	Data metrics to demonstrate impact on of the interventions is being developed. There is a risk to the delivery of non-elective length of stay target and increase in daily discharges due to the reliance of other specialties and external agencies outside of the control of the hospital There is a risk that winter pressures and will outstrip length of stay and occupancy gains preventing delivery of discharge/ bed closures.	Reporting through Urgent Care Improvement& Recovery Steering Group and Improvement Steering Group monthly. Working with System Partners to ensure maximum use of all external capacity and an increase in capacity where there is unmet demand (PW 1 in particular - c 50-60 patients per day) Perfect week was introduced in October 2023 with supporting strategic and tactical governance structure in place to support rapid improvement in UEC performance		

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						Recovery Support Plans	Risk of further waves, increased emergency demand and covid related sickness	Urgent and Emergency Care Board.	Daily review via Capacity and performance meetings Weekly reporting to ELT Fortnightly reporting to TLT		ED Intensive Support meetings established in August 2023. Exec led and attended by CD Urgent Care, Divisional Lead Nurses etc. 5 key priorities identified, delivery monitored via this meeting weekly.		
						Meet all National asks for performance, set out in the planning guidance, for non-elective care					NHSE are monitoring the Trust on 3 key metrics: (i) Ambulance Response Time Cat 2: 30 min national standard. Achieved historically but performance in Sept has deteriorated. (ii)4 hour performance: currently overperforming against trajectory (iii) 12 hour in dept: the number of patients that wait >12 hours in ED was c2900 in September. The Trust is one of the worst nationally in terms of this metric.		
						Maximisation of capacity and efficiencies to reduce waiting times in ED and support discharge processes, ensuring services are provided within timeframes which are safe and responsive, enabling a reduction in length of stay/bed occupancy			Trajectories for all specialties in place, weekly position statements offered to ELT and TLT		Further rollout of SAFER will be supported by 4 B6 nurses to support discharge and flow out of wards and improve "pull" from ED.		
						Development of plans for seven day working, across all of our services							
SO4	**To implement new integrated models of care with our partners to improve Lincolnshire's health and well-being**												
						Supporting the implementation of new models of care across a range of specialties	Specialty strategies being developed	Specialty Review Programme has now commenced. A heat map was produced using a data driven approach to identify the first cohort of specialties to be prioritised. 15 specialties were identified and 11 have had their review workshop and have 5yr strategies now being finalised. The final 4 are planned for early 2024. A revised heat map is now being worked on to identify the 2nd cohort of specialties to be looked at during 2024. The specialty review team have also undertaken an additional 3 workshops at the request of divisional colleagues. Totalling 14 workshops delivered since the programme began in February 2023.	Reports -ELT / TLT -Committees -Board -System	Plan of how the speciality strategies will be developed	Strategy & Best Practice team now fully recruited too and all vacancies filled. Head of Strategy & Best Practice now substantively recruited to. A specialty strategy template has now been drafted and is used to create the strategy documents following review workshops. Supported by a detailed action tracker to ensure actions are captured and progress monitored. Regular update to FPEC on programme progress. All aspects of programme managed effectively.		

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4a	Establish collaborative models of care with our partners	Director of Improvement and Integration	Failure of specialty teams to design and adopt new pathways of care Failure to support system working Failure to design and implement improvement methodology Operational pressures and other planning priorities puts an added constraint on time, capacity and headspace to engage with the ICS agenda. Thus, being unable to fully support system working and play an active role in the development of the Provider Collaborative. Challenge to get wider organisation and partner engaged in enhancing our collective roles as Anchor institutions		CQC Caring CQC Responsive CQC Well Led	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).	Finance, Performance and Estates Committee	**Amber**
						Lead the Lincolnshire ICS and Provider Collaborative as an Anchor Institution and play an increasing leadership role within the East Midlands Acute Services Collaborative	Governance arrangements for Provider Collaborative, Integrated Care Board still in development Clarity on accountability of partners in integration/risk and gain Lincolnshire ICS anchor organisation plan not yet in place Wider regional governance to provide East Midlands oversight of population need and outcomes not yet finalised (via East Midlands Acute Provider Collaborative (EMAP)) ULHT have not embedded a culture of contributing towards population health across the whole organisation and a further understanding of health inequalities and mitigating actions.	Map key stakeholders and priorities for a partnership strategy focussing on addressing health inequalities and prevention Board and senior leadership team sessions on understanding the new ICS landscape and ULHT role within this Lincolnshire System Anchor Workshops underway to align areas of focus and develop system Anchor Plan - looking to agree priorities and exploring opportunties associated with Greater Lincolsnhire devolution EMAP Governance structure now agreed, EMAP Managing Director starts 27th Novemebr 2023 and will be hosted by ULHT. ULHT engagement in 3 EMAP work programmes. Scope what a good effective partnership look like. 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 EMAP governance structures	Green Pan under-delivery A better understanding of effective partnerships and what good looks like Clarity around role/accountability of partners within the Provider Collaborative Clarity around system improvement plan and provider collaborative plan and what outcomes each seeks to achieve Shared understanding and implications of the early warning discharge indicators, risk and gain share agreement within ULHT	Green PLan assurance - governance and PMO plan Part of the refreshed IIP Reporting processes Regular updates to ELT/TLT/TB on Provider Collaborative, Health Inequalities, EMAP and our ICS Evidence and intelligence gathered from Service Reviews, Business Planning, Population Health and all other aspects of work will be pulled into this strategy to support the wider considerations of partnership working and future opportunities (commercial and non-commercial) The process of building the Trust Clinical Strategy has commenced taking information from Specialty Reviews to inform accordingly, and building on outputs from the Business Planning process.		
						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 service	Service not yet mobilised	Job descriptions being job matched to support mobilisation by August 2023		

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						A Joint Forward Plan by June 2023 and continued utilisation of Joint Strategic Needs Assessment (JSNA), population health data from Optum and the health and wellbeing strategy, to influence our collective approach	Final plan not yet in place	Plan being considered by relevant Boards prior to sign to off, expected July 2023	Plan to be considered in Chief Executives Group and formally to the Board	Final plan not yet in place	Plan being considered by relevant Boards prior to sign to off, expected July 2023		
						Joint working with system partners, maximising care homes, virtual wards and admission avoidance schemes, such as the frailty programme	Investment Business Cases not yet in place (SDEC frailty assessment, ED Paed Hub, Community Child Nurse, Rapid Assessment and Triage (RAT), Hospital at Night, SAFER)	Business Cases being presented to CRIG in July	Business Cases Shared Performance Dashboard - frequent attenders	Business Cases in development Dashboard in development	Business Cases being presented to CRIG in July Joint work with Optum to create dashboard		
						Developing a business case to support achievement of University Hospital Teaching Trust Status through development of fit for purpose R&I estate	R&I Team require investment and growth to create sustainable department	The case of need was approved at CRIG (September 2021) and now needs to return to CRIG as FBC. R&I team working closely with Strategic Projects to develop full business case for the growth of R&I department.	Progress with application for University Hospital Trust status R&I Team reporting in to ULHT Hospital Steering group as key stakeholder. Upward report to P&OD Committee	Further understanding of the costs involved to increase size of R&I department and also to develop an R&I facility - options appraisal in development	R&I team reworking business case with a phased approach		
						Shared understanding and implications of the UHA guidance and identify relationship management of key stakeholders nationally (DH, UHA) Agree contract with UOL, R&I team to Increase the number of Clinical Academic posts	Funding for Clinical Academic posts and split with UOL to be agreed	Monthly meetings with ULHT and Uni of Lincoln to discuss funding position and agree MOU - ULHT to fully fund clinical academic posts until research grant income starts to be generated - agreed approach for joint oversight of clinical academics to support discussion on performance and any adjustments to job plans Meetings with ULHT and UOL finance/contracting teams have taken place to develop the full financial model including risk share approach. Next meeting planned MOU aligned to early outputs from the commissioned working group with the full report expected early 2024.	Contract agreed with UOL for Clinical academic posts. UoL and ULHT have draft contracts and offer letters ready for use. Increase in numbers of Clinical Academic posts - agreed to prioritise on clinical specialities where there are workforce gaps/high agency spend to mitigate ULHT cost pressure RD&I Strategy and implementation plan agreed by Trust Board Upward reporting and approval sought through TLT/ELT	Unknown financial commitment for the Trust in relation to the clinical academic roles until the financial model is completed.	Monthly meetings with ULHT and Uni of Lincoln Financial model will be updated in line with new risk share proposals for review and approval by ELT		
						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.		
						Successfully recruit 6 Clinical Academics within the first year of agreement of the UoL/ULHT model	Agreed clinical academic financial model	A financial model for the appointment of clinical academics is in development that describes a timeline to achieve the required 6% of medical workforce for UHA status	Working group Meetings, ULHT/UOL Exec meetings and R&I meetings	The financial model is not yet agreed which is delaying appointment of clinical academic roles Identified early adopter Clinical Academic roles once model agreed	Ongoing meetings between ULHT and UoL, commissioned working group developing final proposal which will be used to inform the financial model and MOU.		

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						Improve research and innovation activities and culture through new ULHT Growth of Research Culture Steering group	Workplan not agreed or implemented as yet	R&I held a session with TLT 6th July and steering group meetings are taking place. To develop the workplan and inform the strategy development	Steering group Meetings underway, meeting minutes and actions	Wider engagement and awareness across ULHT	Head of R&I and Director of R&I planning research culture engagement events		
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)	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	First cohort of specialty reviews underway and on track Programme management support being identified via Provider Collaborative to help deliver ASR phase 1 Individual work streams to be established Clinical Strategy engagement period has successfully concluded - draft strategy now being developed in line with January 2024 launch deadline.	Health inequalities and core25 PLUS indicators Early Warning Discharge Indicators Rigorous engagement, both for feedback from the ASR review and further implementation	Evidence available but working on a process to bring together the information for services to aid the identification of the Top 5 areas for focus in 2022/23.	Part of the refreshed IIP Reporting processes Publish ULHT clinical service strategy Jan 2024 Working with Divisions to identify ASR implementation requirements with draft outline plans in place for Orthopaedics and Stroke. Stroke Capital/Estates Group meetings now diarised and being led by the Business Case Team. Orthopaedics ASR taken to HOSC in Dec 2022 and confirmed as complete through ULT upward reporting. Stroke ASR are working on a 'Perfect Week' to further progress and have commenced relevant staff consultation processes required - pressures remain in length of stay and outliers but capital build planning is progressing. GDH ASR: UTC is mobilised and open with integrated community model being completed early 2024.	Finance, Performance and Estates Committee	**Amber**
						Establishment of a rolling programme of service reviews, with 12 completed in year	Sign off of specialty review strategies and governance route not yet known	To be agreed with ELT, July 2023	Signed off specialty reviews	Governance route not yet established	Agreement of governance through ELT		
						Play an increasing leadership role within the East Midlands Acute Provider Collaborative to develop key partnerships							

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						Build a Partnership strategy to support improvements in safe and sustainable care, and harness benefits for the population of Lincolnshire	Partnership Strategy not yet in place	Associate Director of Partnerships started in post May 2023 and has started to draft Partnership Plan. Board development session 5th December 2023 and intention to have signed off by February 2024 Partnership work is already underway across the organisation and is not being delayed by the lack of formal strategy e.g opportunities emerging for the speciality review programme	Signed off Partnership Strategy	Strategy not yet completed or signed off	Work is underway to develop the strategy, which needs to align with the new IIP and ULHT clinical services strategy.		

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