Bundle Lincolnshire Community and Hospital Group Board Meeting in Public Session 7 May 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 ULHT Ward Accreditation
Pilgrim Maternity Ward - Silver Accreditation

3 Apologies for Absence
Chair

4 Declarations of Interest
Chair

5 Minutes of the meeting of ULHT Board held on 5th March 2024 and LCHS Board held on 12th March 2024
Chair

- Item 5 ULHT Draft Public Board Minutes March 2024
- Item 5 LCHS Draft March 24 Public Board minutes

5.1 Matters arising from the previous meeting/action log
Chair

5.2 Group Governance Arrangements - To follow
Chair

6 Group Chief Executive Horizon Scan
Group Chief Executive

- Item 6 Group CEO Update 070524

7 Patient/Staff Story

7.1 BREAK

8 Strategic Aim 1 - To deliver high quality, safe and responsive patient services

8.1 Assurance and Risk Report from the Quality Committee in Common
Chair, Quality Committee in Common

- Item 8.1 Quality Committee in Common Upward Report March 2024v1
- Item 8.1 Appendix 1 ULHT LCHS Patient-safety-incident-response-policy-February 2024 DRAFT v1 (QC March)
- Item 8.1 Appendix 2 Final QandRC Annual Report 2023-24 (QC March)
- Item 8.1 Appendix 3 QGC Final Annual Report 2023-24 (QC March)
- Item 8.1 Quality Committee in Common Upward Report April 2024
- Item 8.1 Appendix 1 - Q3 Perinatal Report October - December 2023 -V0.2 (QC April)

8.2 Paediatric Audiology Service - To follow

- Item 8.2 Board front sheet - Audiology Paper
- Item 8.2 Appendix 1 IULHT Response to CQC Summary

9 Strategic Aim 2 - To enable our people to lead, work differently, be inclusive, motivated and proud to work within LCHG

9.1 Assurance and Risk Report from the ULHT People & Organisational Development Committee
Chair, People & Organisational Development Committee

- Item 9.1 POD - Upward Report - March 2024v1

Item 9.1 POD - Upward Report - April 2024v1
Item 9.1 Appendix 1 POD Final Annual Report 2023-24 (POD April)

9.1.1 ULHT Gender Pay Gap Report
Item 9.1.1. Gender Pay Gap Report Final

9.1.2 ULHT Equality Delivery System (EDS) 3 Report
Item 9.1.2. EDS2 Front Sheet
Item 9.1.2 EDS Report Final for PODC

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

10.1 Assurance and Risk Report from the LCHS Finance, Performance, People & Innovation Committee
Chair, Finance, Performance, People & Innovation Committee
Item 10.1 FPPIC Report to Public Board May 2024v1
Item 10.1 Appendix 1 FPPIC Terms of Reference - Approved March 2024
Item 10.1 Appendix 2 Proposed ICS Financial Framework - 2024_25 v2
Item 10.1 Appendix 3 FPPIC Annual Report

10.2 Assurance and Risk Report from the ULHT Finance, Performance & Estates Committee
Chair, Finance, Performance & Estates Committee
Item 10.2 FPEC Upward Report March 2024v1
Item 10.2 Appendix 1 FPEC Final Annual Report 2023-24v1 (FPEC March)
Item 10.2 FPEC Upward Report April 2024 v1

11 Strategic Aim 4 - To collaborate with our primary care, ICS and external partners to implement new models of care, transform services and grow our culture of research and innovation
No reports

12 Strategic Aim 5 - To embed a population health approach to improve physical and mental health outcomes, promote well-being, and reduce health inequalities across an entire population
No reports

13 Integrated Performance Reports
Director of Finance and Business Intelligence
Director of Improvement and Integration
Item 13 Frontsheet LCHS Integrated Performance Report - March 2024 Data
Item 13 - Appendix 1 LCHS Integrated Performance Report - March 2024 Data
Item 13 ULHT IPR Trust Board - Front page
Item 13 ULHT PR Trust Board April 2024

14 Risk and Assurance

14.1 Group Risk Management Report
Director of Clinical Governance
Item 14.1 Trust Board Strategic Risk Report Exec Summary May 2024
Item 14.1 ULHT Trust Board- Strategic Risk Report - March-April 2024
Item 14.1 Appendix A ULHT TB Very High and High Risk Summary
Item 14.1 LCHS Trust Board - Strategic Risk Report - April 2024
Item 14.1 LCHS Appendix A Datix Report

14.2 Board Assurance Framework
Trust Secretary/Deputy Director of Corporate Governance
2023/24 ULHT Board Assurance Framework
2023/24 LCHS Board Assurance Framework
Item 14.2 ULHT BAF 2023-24 Front Cover May 2024
Item 14.2 2023-24 Appendix 1 ULHT BAF Closedown Report

Item 14.2 LCHS 2023-24 BAF Closedown Report - TB May 24
Item 14.2 - LCHS 2023-24 - final ratings - May LCHG 24

14.3 Assurance and Risk Report from the ULHT Audit Committee
Chair, ULHT Audit Committee

Item 14.3 Audit Committee Upward Report April 24

14.4 Delegation of LCHS Governance Arrangements to Committees - To follow
Deputy Director of Corporate Governance

15 Any Other Notified Items of Urgent Business

16 The next meeting will be held on Tuesday 2nd July 2024

EXCLUSION OF THE PUBLIC

In accordance with Standing Order 3.1 and Section 1(2) of the Public Bodies (Admission to Meeting) Act 1960: To resolve that representatives of the press and other members of the public be excluded from this part of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

United Lincolnshire Hospitals NHS Trust

Minutes of the Trust Board Meeting

Held on 5 March 2024

Via MS Teams Live Stream

Present

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

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

In attendance:
Mrs Karen Willey, Deputy Trust Secretary (Producer)
Mrs Rachel Lane, Corporate Administration Manager (Minutes)
Mrs Angie Davies, Director of Nursing
Mrs Kathryn Helley, Director of Clinical Governance
Mr Mike Parkhill, Director of Estates and Facilities
Ms Holly Gauntlet, Sister, Pilgrim SDEC – Item 2.1
Ms Chelsea Spencer, Sister, Pilgrim ACU - Item 2.1
Ms Jennie Negus, Head of Patient Experience – Item 7

Apologies
Dr Chris Gibson, Non-Executive Director
Mrs Jayne Warner, Trust Secretary

106/24	**Item 1 Introduction** The Chair welcomed Board members and members of the public, staff or interested parties who had joined the live stream to the bi-monthly meeting of the Board.

107/24	**Item 2 Public Questions** **Q1 from Vi King** **Please can I ask why EMAS non-urgent transport are cancelling transport at last minute for appointments. This is not good for patients but also wasted appointments. What are the Trust doing about it?** The Chief Operating Officer responded:
108/24	Late cancellations were always disappointing and the Trust was working closely with EMAS and Integrated Care Board (ICB) colleagues to monitor all cancelled transport and the effect that had on patients; the reasons for the cancellations were being monitored along with timing issues and some good work had been undertaken on how the Trust booked and communicated those questions and whether EMAS had the resources required at the busiest times. Close work would continue, and learning would be fed back to EMAS with the support of ICB colleagues.
109/24	**Q2 from Peter Bell** The Chair summarised the question relating to the arrangements applied when a patient was seen in ULHT by a clinician from a partner organisation to ensure patient confidentiality, Mr Bell raised two specific areas:
110/24	**Accessing to imaging by non ULHT clinicians and cross charging for scans undertaken by ULHT for other partner organisations. Mr Bell concluded within his correspondence that by employing NHS staff to cross charge for services and not allowing images for patients being ordered simply by NHS bureaucracy needed to be addressed and eliminated from the NHS and resources should be utilised to ensure this was removed.** The Chief Operating Officer responded:
111/24	The Trust worked with partners in an integrated and joined up way for patients; Lincolnshire Partnership Foundation NHS Trust (LPfT) Doctors had access to the care portal and were able to access x-rays, medication and other shared information for patients. Doctors and other members of staff were aware of this process, however, thanked Mr Bell for reminding the Trust to ensure that colleagues were clear on this to work for patient's in an expedient way.
112/24	As a statutory organisation the Trust had to be able to see the allocation and attributed funds towards a patient pathway; however this should not get in the way of providing a seamless service. It was a statutory response to cost all elements of a pathway by each provider and it was also useful data to ensure there were no areas of duplication as well as ensuring Trusts were as efficient as possible with funds that were able to be spent on patients. The Chief Operating Officer was apologetic that this was a statutory request however, the information was used for patient centric reasons and the organisation could keep learning through the pathway.

113/24	The Chair hoped that the response answered Mr Bell's question, however if this was not the case Mr Bell was encouraged to contact the organisation and further conversations could be arranged.
114/24	**Item 2.1 Ward Accreditation** The Chair was pleased to be able to commence the Board meeting with the celebration of achievement of the provision of high quality, safe care through the awarding of ward accreditation.
115/24	The Chair welcomed Sister Holly Gauntlet and Sister Chelsea Spencer to the meeting to celebrate their achievements.
116/24	The Director of Nursing introduced the two teams who had successfully achieved the Bronze Diamond award as part of the quality accreditation programme. Board members were aware of the core requirements the departments were required to achieve against with a range of quality indicators, in addition to presenting a portfolio of evidence to the Quality Accreditation Panel.
117/24	Sister Spencer provided an example of an improvement made on the ward noting that staff members had been struggling with VIP compliance and, following some learning shared through incident huddles, a well-being huddle was implemented with the acronym BOSH. This provided staff members with the opportunity to voice anything they wished to the nurse in charge; for example to discuss patient care on the Ward or if staff members had any concerns or queries. There had been no competency in place for flushing VIP cannulas and an opportunity was provided for all staff members to feed into developing a competency. As a result of that colleagues shared their comments and were delegated appropriate jobs to significantly improve the Ward compliance rates. This embedded a positive challenge culture within the Ward area.
118/24	Sister Gauntlett explained that within Same Day Emergency Care (SDEC), packs had been developed for students as feedback had been received that students were not aware of what SDEC was. This was a relatively new service and had created confusion and apprehension in relation to which competencies could be signed off whilst they were working on the Ward. Specific work had been undertaken with one student to design an individual pack and feedback had also been received that students were not being rostered with allocated time for interviews to set out goals for their placements. Feedback was also received around confusing medical abbreviations therefore a glossary page had been included within the student pack. Sister Gauntlett was proud of the team for developing this to improve student experiences when working on the Ward.
119/24	The Chair commented that these were inspirational stories, and it was clear that both Sisters were looking after their teams and colleagues which was important in terms of working together and for the benefit of patients.
120/24	The Group Chief Executive said that both ward accreditations should be celebrated, and the team efforts had shone through from both stories.

121/24	The Deputy Group Chief Executive offered thanks for Sister Spencer and Sister Gauntlett as well as the teams who had worked collectively and collaboratively, noting the achievements which had been made.
122/24	The Deputy Group Chief Executive commented on the work which had been undertaken with students to utilise their ideas which was important for those at the beginning of their nursing careers. VIP scores were used for venous cannulas and colleagues were already aware that there had been some challenges with managing peripheral cannulas which demonstrated that the ward staff had understood the problems and taken action. This had had a positive impact on patients with the Deputy Group Chief Executive keen to see this adopted throughout the organisation.
123/24	The Chair thanked Sister Gauntlet and Sister Spencer for attending the meeting and for sharing their stories, reflecting that these were great initiatives and asked that the Trust Board's appreciation be shared with the teams.
124/24	**Item 3 Apologies for Absence** Apologies were received from Dr Chris Gibson, Non-executive Director and Mrs Jayne Warner, Trust Secretary.
125/24	**Item 4 Declarations of Interest** No new declarations of interest were made.
126/24	**Item 5.1 Minutes of the meeting held on 11 January 2024 for accuracy** The minutes of the meeting held on 11 January 2024 were agreed as a true and accurate record.
127/24	**Item 5.2 Matters arising from the previous meeting/action log** The updated action log was received; there were no outstanding open actions.
128/24	**Item 6 Chief Executive Horizon Scan including ICS** The Chief Executive presented the report to the Board noting the continued pressure within the system following the latest period of industrial action. With the approaching end of the financial year national focus remained on response times, ambulance waits and finances. The Group Chief Executive took the opportunity to thank colleagues within ULHT and across the Group and system for all their efforts in respect of operational pressures and efforts taken to minimise the impact of industrial action.
129/24	Key national priority focus this month was on the A&E four-hour standard with a target to achieve 76% and achieving the financial position, which had been significantly impacted as a result of industrial action throughout the financial year and guidance was awaited on how this should be accounted for.

130/24	Planning guidance for 2024/25 had not yet been published though it was noted that a national webinar would be taking place this week however work was being undertaken to plan for next year from a national, regional and local perspective.
131/24	Positive visits to Grantham Hospital had recently been undertaken by Dame Emily Lawson, Interim Chief Operating Officer from NHSE and Tim Mitchell, President of the National College of Surgeons.
132/24	Martha's Rule was receiving much national media attention and NHSE were seeking expressions of interest for the first phase regarding access to second opinions, when there were concerns around deteriorating conditions, which the Lincolnshire system would be participating in.
133/24	The Board was advised that a digital review for health and social care was taking place across the system.
134/24	The Group Chief Executive recruitment process was continuing, and interviews would be held on 20th March 2024, the current Group Chief Executive would remain in post until 30th June 2024 to ensure a smooth transition.
135/24	The Group Model Case for Change was also shared which outlined the benefits of establishing a Group Model for patients, staff and services as well as change management processes that both ULHT and LCHS would be going through.
136/24	Building work on Pilgrim Hospital ED was now well underway to introduce a state-of-the-art new facility.
137/24	Smoking across ULHT sites remained an issue and further active engagement with the public and staff would be undertaken soon, in line with national policy.
138/24	The "Give it a Go" campaign had recently been introduced which provided teams with an opportunity to make suggestions to improve quality improvement which was being encouraged and supported by the Executive Team.
139/24	The Group Chief Executive also highlighted the first "Better Together" event due to take place, which would bring together leaders from across the Group to talk through the benefits of the Group Model and working through the Case for Change.
140/24	The Chair thanked the Group Chief Executive for the comprehensive report which set out the context in the system and enabled colleagues to understand some of the challenges being faced. The visits from of the national leaders were noted and celebrated. The Chair explained that at a recent national event the focus had been on delivering standards and priorities across emergency services, cancer services and waiting lists. Thanks were extended to the wider organisation and Executive colleagues for working in difficult circumstances.
141/24	Mrs Brown commended leaders within the organisation for keeping patients safe during periods of industrial action. The Group Chief Executive responded that it was important for patients and staff to be kept safe during these periods whilst also delivering against national standards. At the end of February 2024 78-week waits

	had been reduced to nine patients however there was more work to do to ensure a figure of zero prior to the end of March. Colleagues were commended for the excellent work undertaken thus far.
142/24	The Trust Board: • **Received the report and noted the significant assurance provided**
143/24	**Item 7 Patient/Staff Story** The Director of Nursing introduced the patient story to the Board noting this was a story about young carers and was part of the Trust's awareness raising celebrations for Young Carers Action Day which would be held on Wednesday 13th March 2024.
144/24	A video was shared where Board members heard the stories of three young carers whose relatives had accessed the Trust's services and whose loved ones had been taken into hospital. The young carers had shared their wish to be included and involved in discussions and decisions regarding the care of the loved ones, no matter how young they were.
145/24	The presentation also detailed promotion of a Young Carers Card which would be used to help identify young carers to healthcare professionals. The Head of Patient Experience outlined some work which would be commencing shortly to identify young carer champions for each service across the organisation, to ensure their needs were always being considered.
146/24	Trust Board members found the presentation extremely powerful, poignant, and set out the challenges young carers were presented with well.
147/24	The Director of Improvement and Integration expressed a view that this linked with the quality improvement work in respect of personalisation and offered to work with the Head of Patient Experience to review what more could be done with teams to facilitate this conversation further.
148/24	Mrs Wells thanked the Head of Patient Experience and the team for the work being undertaken with young carers, commenting that work within the organisation around carers was excellent and the work staff members were doing for carers should be shared. Work across the staff networks, to support carers to remain at work, was also important and should also be shared.
149/24	The Head of Patient Experience thanked Board members for the comments and took the opportunity to ask for volunteers to participate in a young carers day in May 2024 as part of an "ask the boss" question and answer session. Many Board members volunteered to attend, and the Head of Patient Experience would liaise with them outside of the meeting.
150/24	The Chair thanked the Head of Patient Experience for attending the meeting and presenting the story from the young carers and offered thanks to the team and colleagues from the local authority.
151/24	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
152/24	**Item 8.1 Assurance and Risk Report Quality Committee in Common** The Deputy Chair of the Quality Committee in Common, Mrs Brown, provided the assurances received by the Committee at the January 2024 and February 2024 meetings. As the Committee remained in transition the Trust Board were asked to note the continued focus on the ULHT Board Assurance Framework (BAF).
153/24	The Maternity and Neonatal Oversight Group (MNOG) update had been received recognising the Clinical Negligence Scheme for Trusts (CNST) Maternity sign off, as committed to by the Trust Board at the last meeting. The palliative care upward report had featured the Voices Survey which provided a wealth of information and feedback would assist with preparing action plans going forward to improve palliative care across the county.
154/24	At the February meeting, further assurance had been received relating to the Patient Safety Incident Response Framework (PSIRF) process and the Committee were pleased with the progress being made and looked forward to receiving the learning in the coming months. There had also been a reduction in serious incidents and open actions demonstrating the good work being undertaken.
155/24	The Infection Prevention and Control (IPC) report demonstrated that the organisation was continuing to exceed the trajectory for clostridium difficile however it was noted that assurance was received, through ribotyping, that this was not being spread between patients. Work was ongoing within the team to prepare for a national tabletop exercise led by NHSE in respect of this. It was also noted that the IPC teams were working well together across the Group.
156/24	The Medicines Quality Group report had seen a reduction in harm from omitted doses which, in part, was due to the successful rollout of the Electronic Prescribing and Medicines Administration (ePMA) and the Antibiotic Surveillance and Stewardship Group had also seen a reduction in the inappropriate use of antibiotics.
157/24	The Committee had raised concerns relating to an incident in relation to controlled drugs, however had been provided with immediate assurance that actions were being undertaken to address the issues.
158/24	The quarterly complaints report provided significant assurance with the Committee noting continued positive work to address overdue complaint responses with only three outstanding.
159/24	From a clinical effectiveness perspective, the Trust was compliant with NICE Technology Appraisal and was 95% compliant for clinical guidelines.
160/24	The Mortality report demonstrated continued positive levels of reporting in respect of HSMR and SHMI, which was a positive position.

161/24	The CQC action plan had been received and four of the “must dos” had been signed off which was a step change for the action plan and further progress was expected.
162/24	The Chair commented on the clarity of the report and the governance arrangements supporting it adding that this provided clear assurance ratings in respect of the ULHT elements of the report. The Voices Survey was acknowledged as a piece of work which had been undertaken by HealthWatch. The Chair looked forward to seeing the outcomes moving into the Group arrangements which provided a good opportunity to take this forward.
163/24	The Board also noted the referral to the People and Organisational Development Committee regarding pharmacy staffing where a deep dive would be undertaken.
164/24	The Trust Board: • **Received the assurance reports**
	Item 9 Objective 2 To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT
165/24	**Item 9.1 Assurance and Risk Report People and Organisational Development Committee** The Chair of the People and Organisational Development Committee, Professor Baker, provided the assurances received by the Committee at the January 2024 and February 2024 meetings.
166/24	Mandatory training rates were increasing, however appraisal rates remained static. Good progress was being made on Disclosure and Barring Service (DBS) checks which had commenced in line with the Savile Report.
167/24	An action plan had been received relating to trauma and orthopaedics and positive outcomes were received. A communications workshop had been held and there was an intention to replicate this on a regular basis to ensure continued staff engagement. A recent visit had also been undertaken by the General Medical Council and Health Education England which had identified tangible changes in culture and behaviour.
168/24	The results of the Pulse staff survey had been received, demonstrating slight improvement, however it was recognised that this had been conducted at a time of operational pressure and industrial action.
169/24	There had been an increase in Freedom to Speak up Guardian contacts, potentially due to Speak Up month and increased issues within the Family Health division and common themes had been discussed.
170/24	An internal audit report on staff health and wellbeing had been received which offered reasonable assurance, the positive position was noted recognising that the health and wellbeing team had been established less than 12 months earlier.
171/24	The Committee also received a report on the CQC action plan and greater detail was provided in respect of assurance against progress of the eight actions, two were now

	completed, with one due to be signed off. The remaining actions continued to be progressed.
172/24	At the February meeting, a report from the Workforce Strategy and OD Group focussed on statutory and mandatory training and aligned CQC focus on medical core compliance. The existing levels of oversight would need to be increased with a focus being given in future meetings. Work was underway with the Head of Compliance to raise the levels of oversight and the approach LCHS were taking would be utilised, where there were greater levels of compliance.
173/24	The Safer Staffing report had provided moderate assurance with significant progress being made. Committee members had expressed views on the assurance rating with consideration given to what would mean this offered significant assurance.
174/24	The nursing establishment review paper had been presented relating to band two and band three posts and the process undertaken to consider this.
175/24	The pharmacy deep dive had been undertaken and there had been significant encouragement taken and assurance provided regarding the recruitment profile; this would be tracked by the Committee.
176/24	Significant discussion had taken place regarding whether an amber rating for objective 2b remained appropriate due to increased levels of assurance, this may be moved to a green rating at a future meeting.
177/24	The Committee had been encouraged by the updated financial paper relating to the application for University Teaching Hospitals status which addressed some of the previous issues raised regarding funding for clinical academics.
178/24	The Chair acknowledged the work the Committee were undertaking and for providing an increased level of assurance. The pharmacy deep dive work was acknowledged, and the Chair reiterated the requirement for the risk register to identify the risks outlined by the Committee.
179/24	The Director of People and OD drew attention to the low number of current HR cases and thanked the Committee for the continued support.
180/24	The Trust Board: • **Received the assurance report** •
181/24	**Item 9.2 Ward Establishment Report** The Director of Nursing presented the report noting that a full review of ward establishments had been completed which identified an increase in overall patient activity, acuity and dependency of patients and an increase of establishment across several areas.
182/24	Clarity and impacts of band two and three conversions and future impacts on staffing requirements had also been discussed throughout the process. It was noted that potential financial requests had not been part of the review.

183/24	There had been recent bed increases, recognising a decrease in establishment in some areas. The Director of Nursing was confident in the reduction of 13 whole time equivalents (WTE), thus creating a positive variance of £760k and the Trust Board was asked to approve the establishment changes with the report offering significant assurance regarding safer staffing levels.
184/24	The Chair acknowledged that the report had been discussed in detail by the People and OD and Finance, Performance and Estates Committees, noting the excellent due diligence which had been undertaken. There were 25 areas where changes to services had been made and it was important to recognise the impact of working differently to provide a service for patient cohorts as described within the report.
185/24	The Trust Board: • **Received the report** • **Approved the Ward establishment adjustments**
	Item 10 Objective 3 To ensure that service are sustainable, supported by technology and delivered from an improved estate
186/24	**Item 10.1 Assurance and Risk Report from the Finance, Performance and Estates Committee** The Chair of the Finance, Performance and Estates Committee, Ms Cecchini, provided the assurances received by the Committee at the January 2024 and February 2024 meetings.
187/24	In relation to estates, a sinkhole issue at Pilgrim Hospital was noted and concerns were raised regarding lift failures at both the Pilgrim and Lincoln Hospital sites. The Patient-Led Assessment of the Care Environment (PLACE) report had been received which provided overall confidence on the levels of cleanliness and patient environments. The Six Facet Survey had been received and was a helpful piece of work to support future prioritisation, however significant financial investment would be required to improve the estate.
188/24	A report had been received from the Emergency Planning Group on the level of compliance with national requirements; the assessment had been changed nationally and was more challenging than previous assessments. The Committee noted that the organisation was fully compliant with 51 of 62 standards and partially compliant for the remaining 11. Assurance relating to business continuity plans had also been received.
189/24	The finance and capital positions had been noted by the Committee along with the adverse variance relating to associated costs of industrial action. Assurance had been received on manging the capital plan and the programme was beginning to increase in terms of spending ability.
190/24	A deep dive had been received on medical contractual rates which could be impacted by industrial action and a referral had been made to the People and OD Committee in relation to medical job planning and the potential to support progression of work in this area.

191/24	The Information Governance Group upward report had been received; implementation of the actions following the Information Commissioners Office (ICO) recommendations in relation to subject access requests were pending and a Group had been established to oversee progress.
192/24	Operational performance was positive, particularly in relation to the 78 and 65 week waits. The Integrated Improvement Plan was received and in most areas there moderate assurance was offered against the patient, people and partners workstreams.
193/24	A promising report had been received in February on the Community Diagnostic Centres where good progress had been demonstrated.
194/24	Annual Planning Guidance had not yet been published however the Committee received assurance relating to teams working together to develop internal integrated plans, which would integrate with the system plan.
195/24	The Committee self-assessment was received, and the draft Committee effectiveness annual report would continue to be updated to the end of the financial year.
196/4	The Chair acknowledged the comprehensive report which demonstrated the breadth of matters covered by the Committee and acknowledged the achievement of the cost improvement plan and the impact of industrial action in terms of the adverse variance.
197/24	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
198/24	No items.
199/24	**Item 12 Integrated Performance Report (IPR)** The Director of Improvement and Integration advised that the report set out the position of performance and each of the Committee's had reviewed the relevant sections, therefore the report was taken as read.
200/24	The Trust Board: • **Received the report noting the limited assurance**
	Item 13 Risk and Assurance
201/24	**Item 13.1 Risk Management Report** The Director of Clinical Governance presented the monthly risk report to the Board noting that there was continued stability within the report. There had been a

	reduction of one risk from high to moderate relating to the delivery of the paediatric diabetic pathway where vacancies rates had improved.
202/24	Two risks had been closed relating to non-recurrent funding for cancer services where funding had now been secured and the national shortage of suction catheters.
203/24	There had been an increase in scoring to one risk in relation to the potential for regulatory action from the CQC which was due to overdue actions, however some actions had now been completed and plans were in place for the remainder to also be closed by the end of March 2024. A meeting would be taking place in March in relation to a potential reduction in the risk score.
204/24	The Chair acknowledged the response to the CQC element of the risk register and the potential reduction in risk score.
205/24	The Trust Board: • **Accepted the risks as presented noting the significant assurance**
206/24	**Item 13.2 Board Assurance Framework** The Deputy Trust Secretary presented the report noting that this had been considered by all Committees during January and February 2024, the only proposed movement in assurance rating related to objective 3d to move from red to amber, due to increase levels of assurance and the movement from tier one monitoring.
207/24	The Chair referred to the current position of the BAF and commented that this reflected the good work being undertaken within the organisation.
208/24	The Trust Board: • **Received the report noting the moderate assurance and approved the movement of objective 3d**
209/24	**Item 13.3 Report from the Audit Committee** The Chair of the Audit Committee, Mr Herbert, provided the assurances received by the Committee at the January 2024 meeting.
210/24	A report had been received from Internal Audit and the financial team regarding year end statements and reassurance was provided that plans were place. The draft timetable had been shared and work was underway to ensure the accounts could be signed off in mid-June 2024.
211/24	There was an improved position relating to the number of audits outstanding to be completed by financial year end which would provide support for the Head of Internal Audit opinion. Thanks was expressed to the Director of Finance and Trust Secretary for their leadership in this area. Significant progress had also been made in respect of closing outstanding audit actions which was now below five from a position of over 100.

212/24	The Counter Fraud report had demonstrated that the organisation was now rated green for all elements of the requirements of the Counter Fraud Functional.
213/24	From a compliance perspective, concerns had been escalated in relation to fire issues at Skegness Hospital and assurance was provided that actions had been passed to the Chief Operating Officer.
214/24	The Committed noted several salary overpayments and had requested further information to identify themes or trends.
215/24	Policies and guidance documents remained an area of concern and the lack of progress had previously been escalated to the Trust Board. All divisions except one had provided action plans to address this and further updates would be provided at the next meeting. The Trust Board would continue to be provided with updates until this was able to be referred back to the Audit Committee for ongoing monitoring.
216/24	The Committee self-assessment had been undertaken which had a positive outcome.
217/24	The Audit Committee had a role in maintaining oversight in relation to the Group Model and both organisations would initially remain with independent Audit Committees to ensure continued clarity through the transition period and into the end state.
218/24	The Chair acknowledged the breadth of the report and the improving position in relation to Internal Audit. The work in relation to salary overpayments was noted, and the Chair thanked the Audit Committee for the oversight relating to the outstanding policies.
219/24	The Trust Board: • **Received the assurance report**
220/24	**Item 14 Any Other Notified Items of Urgent Business** No further items were discussed.
221/24	The next scheduled meeting would be held on Tuesday 7 May 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	12 Jan 2024	5 Mar 2024
Elaine Baylis	X	X	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	X	A
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	X	X
Simon Evans	X	X	A	X										

Karen Dunderdale	X	X	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	X	X
Colin Farquharson	A	A	A	A	A	A	A	A	A	A	X	X	X	X
Gail Shadlock														
Dani Cecchini	X	X	X	X	X	X	X	A	X	X	X	A	X	X
Rebecca Brown	X	X	X	X	X	X	X	A	A	X	X	A	X	X
Neil Herbert	X	X	X	X	X	X	X	X	A	X	X	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		
Julie Frake-Haris													X	X

Lincolnshire Community Health Services NHS Trust

MINUTES OF THE LINCOLNSHIRE COMMUNITY HEALTH SERVICES NHS TRUST BOARD MEETING HELD ON 12th MARCH 2024 AT 10AM, MAPLE BOARDROOM, BEECH HOUSE LINCOLN

Present:	Mr M Burch	Acting Chair, LCHS
	Miss G Shadlock	Non-executive Director, LCHS
	Mrs R Brown	Associate Non-executive Director, LCHS
	Mr M Macdonald	Non-executive Director, LCHS
	Mr A Morgan	Group Chief Executive, LCHS/ULHT
	Professor K Dunderdale	Director of Nursing and Quality/Deputy Group Chief Executive, LCHS
	Mr S Wilde	Director of Finance and Business Intelligence, LCHS
	Mrs J Frake-Harris	Chief Operating Officer, LCHS
	Dr A-L Schokker	Medical Director, LCHS
In Attendance:	Ms C Leggett	Deputy Director of Corporate Governance, LCHS
	Ms L Shankland	Deputy Director of People & OD, LCHS/ULHT
	Mrs R Lane	Trust Board Administration, LCHS

1. Mr Burch welcomed those present to the meeting. He noted that there was continued pressure on the Lincolnshire system and that the recent Budget announcement would add to the focus on productivity moving forward. Mr Burch commented that this was about how the organisation worked, not simply working people harder. The work within the Group Model setting was already demonstrating that by supporting people patient outcomes could be improved. He added that the Trust Board valued and supported all staff in everything they did within the NHS, for the organisation and across the Group.

2. Mr Burch informed those present that this would be Mr Macdonald's last Trust Board meeting as he would be leaving the organisation at the end of March 2024 and he took the opportunity to thank him for his valued contributions and wished him well for his new Non-executive Director role within East Midlands Ambulance Service.

143/23 QUESTIONS FROM THE PUBLIC

3. No questions had been submitted in advance of the meeting.

144/23 APOLOGIES FOR ABSENCE

4. Apologies for absence were received from Mr Jim Connolly and Mr Ian Orrell, Non-executive Directors and Miss Claire Low, Director of People.

145/23 DECLARATIONS OF PECUNIARY OR NON-PECUNIARY INTERESTS

5. The Declarations of Interest Register was received. Mr Macdonald reported that he had recently taken up a position as a Board member for the Lincolnshire Refugee Doctor programme. Mr Orrell had also communicated that he was now a Non-executive Director for NHS Futures. The Declarations of Interest Register would be updated accordingly. **ACTION: Deputy Director of Corporate Governance**

146/23 MINUTES OF THE PREVIOUS MEETING

6. The minutes of the meeting held on 7th January 2024 were approved as an accurate record.

147/23 MATTERS ARISING FROM BOARD DECISION/ACTION LOG

7. There were no open matters arising.

148/23 FORTHCOMING BOARD PROGRAMME

8. The forthcoming meeting schedule for March 2024 was presented and the updated Board programme was noted. The Deputy Director of Corporate Governance commented that as the organisation moved towards a Board in Common from 1st April 2024, Board Forward Plans were being aligned for 2024/25.

The Trust Board:

- **Received the paper**

149/23 PATIENT STORY

9. The Chief Operating Officer introduced the patient story and welcomed the Clinical Team Lead for the Post-Covid Service, Paloma Diaz Estevez to the meeting. The Clinical Team Lead thanked Board members for inviting her to attend today's meeting which provided a good opportunity to talk about the post-covid service. This service was in place for patients to ensure they received a holistic service and approach. The referral criteria was explained, this ensured that patients were safe and that they were accessing the correct service, also ensuring that there was no duplication. Patients were able to access the service if they had symptoms for over four weeks, were able to participate in a rehabilitation programme once other medical conditions had been ruled out.

10. The Clinical Team Lead shared details of a patient's story, a 22 year old gentleman with a background of autism, learning difficulties, non-verbal communication and epilepsy who had been confirmed covid positive in April 2022, however, he was not referred into the post-covid service until September 2023. A best interest meeting had taken place regarding the patient and it was suggested that contact was made with the post-covid service for the patient to be assessed without the full pre-requisite tests. The service liaised with his GP to ensure optimised medical care, liaised with the community Occupational Therapy team and with the patients mother to agree an action plan. Following series of video consultations, where the patients care was discussed one to one input was agreed. A therapy plan was put in place for the patient, with low energy activities and the use of a wheelchair was also suggested to conserve energy. A diary was developed for the patient for each day of the week and the team would know that this was working once the patient had lower fatigue, was not going to bed early and was utilising his wheelchair less.

11. The Clinical Team Lead explained that this was still an open case, however feedback received from the patients mother was that the patient was improving, and his daily activity diary was about to be reviewed.

12. Miss Shadlock thanked the Clinical Team Lead for the presentation; she commented that the referral form appeared to be quite basic, and she wondered if that allowed the best information to be shared by GPs. The Chief Operating Officer said that this story had brought to life personalised care in a good way. She added that Board members should not lose sight of how the patients mother had felt and she expressed a view that this was about personalised care bringing out the best for all concerned. In response to Miss Shadlock's question, the Chief Operating Officer explained that relationships with primary care were being worked through currently with GP practices case by case to ensure there was confidence to put the right requirements in place. She added that this was about ensuring that relationships were working in the correct ways. A different angle on trusted assessor was also being reviewed. The Chief Operating Officer added that the post Covid service provided patients with excellent benefits. She also commented that supporting autistic patients and those with learning difficulties had to be undertaken in a respectful way.

13. The Director of Finance and Business Intelligence commented that it appeared to have been the case that the patients mother had stumbled across the service rather than the NHS directing her towards it and he expressed a view that there was some learning from that. He added that it was good that professionals were able to make judgements to flex referral criteria into the service when required.

14. The Chief Executive thanked the Clinical Team Lead for her presentation which had provided a good example of personalised care. He asked how many patients were on the caseload; he also commented that Covid was not referred to as much now within the media and he wondered if the service was likely to grow or reduce in size. The Clinical Team Lead responded there were patients not accessing the service and more education on referring into the service was required. She added that there were other autistic and patients with learning difficulties within the service, however no one with the specific requirements of this patient. The Clinical Team Lead explained that the service had been established on non-recurrent funding and therefore she was uncertain of its future however she hoped that this would continue. There were currently over 400 patients on the caseload and the team had been undertaking promotional roadshows and engagement activities recently to promote the service and many patients had come forward from those events.

15. The Deputy Chief Executive said that it had been good to hear the patient story today, and it was good to see that the Clinical Team Lead was so passionate and enthusiastic about the service. She asked what the Clinical Team Lead would like next from the service to move it to the next level. The Clinical Team Lead responded that she was currently promoting the service across schools as many school aged children were not accessing the service. She had also developed a GP pack, containing a referral form, and details of how to access the service which had been distributed across pharmacies, community hubs and GP surgeries. The Clinical Team Lead would share the pack with the Deputy Chief Executive and Chief Operating Officer who offered to promote the service further.

16. The Chief Operating Officer commented that the mass vaccination service could also provide a helpful link to the post-covid service.

17. Mr Macdonald asked if the Clinical Team Lead had reached out to carers and the voluntary sector who could be best placed to make referrals on behalf of others. The

Clinical Team Lead said that she was in contact with the voluntary sector and would also be presenting at a Forum being held by Lincolnshire County Council in June 2024.

18. Mr Burch expressed a view that this presentation fitted with his comments at the start of the meeting, and he asked how the performance of this service was measured in terms of productivity and how it would be demonstrated and articulated to the public how the service was using its resources in the best way possible. He added that this would be an important factor for the Group moving forward. The Clinical Team Lead explained that the team wanted to ensure that the service met the needs of the population, different pathways had been created along with feedback forms and each comment received was taken seriously to shape the needs of patients. Mr Burch commented that as a system and Group, population health data would need to be reflected on in detail to see how the challenges were being met.

19. Mr Burch thanked the Clinical Team Lead for attending today's meeting.

The Trust Board:

- **Received the Patient Story**

150/23 OVERVIEW REPORT OF THE GROUP CHIEF EXECUTIVE

20. The Group Chief Executive offered a national, system and Trust specific overview with the following key highlights to the Trust Board. He explained that this remained a busy time across all parts of the service as year end approached. From a financial perspective Lincolnshire was expected to come in according to plan, subject to guidance on how to account for industrial action costs. There was also increased interest in the 76% four-hour A&E standard currently. The system also had to end the financial year with zero 78 week waits.

21. Planning guidance for 2024/25 was still yet to be issued however the Trust and Group were already working on elements of this based on the current detail known. It had been communicated recently that all parts of the NHS would need to plan for a breakeven position in 2042/5. The current gap in Lincolnshire was £40m following the application of CIP and other efficiencies, however there remained a large gap to resolve. Considerable scrutiny on plans was anticipated for 2024/25.

22. The Group CEO recruitment was progressing with interviews to be held on 20th March 2024, the Group Chief Executive explained that he had agreed to remain in post until 30th June 2024 to ensure a smooth transition to his successor.

23. The Group Model Case for Change was attached to the report which demonstrated the benefits of the Group Model for patients, communities and staff and there had been a strong focus on this at a recent Better Together event which saw over 300 leaders from LCHS and ULHT come together to align leadership teams. Good progress had already been made across the Group however it was early in the process and there remained much work to do.

24. The Lincolnshire NHS Charity had a new look website and the Feature Focus this month was all about the Lincolnshire NHS Charity.

25. The Group Chief Executive advised those present that Nikki Pownall had recently been appointed as the Director of Operations.

26. Mrs Brown commented on the good appointment to the Director of Operations position. She asked for feedback from Executive Directors of their experience of the Better Together event. The Executive Directors all commented that this had been a good

event and there had been great interaction between leaders from both organisations and good evidence that patient care was at the heart of the benefits of forming the Group Model. High energy levels between teams had been noted along with enthusiasm and pace behind discissions. Mrs Brown commented that it would be important to capture these stories which would be a good testament moving forward.

27. The Deputy Director of People explained that she had also provided a 15 minute session on mindset in a VUCA world which had been well received.

28. Referring to the Group Model Case for Change Mr Burch said that a document capturing the work of the Group Model Steering Group had recently been presented and he added that the Steering Group would be moving into a new transitional Committee of the Board In Common going forward.

29. Mr Macdonald said that the planning guidance and route to zero would be a significant issue, recognising the underlying run rate in the system had not been addressed as it was hoped. He added that cherishing and growing personalisation also felt as though it would be a real issue going forward strategically for the Group and system. He commented that the Group would need to be thoughtful in terms of how that was taken forward and what the Group determined its future priorities to be. The Group Chief Executive responded that the route to zero was a large piece of work; he added that there were also mixed messages and narrative currently in terms of workforce.

30. Mr Macdonald sought clarification about Martha's Rule and how that would be implemented. The Group Chief Executive responded that there was not enough clear detail on this currently in respect of the first phase, an expression of interest for further detail had been made.

The Trust Board:

- **Received the report, noted the Feature Focus and Group Model Case for Change**

151/23 QUALITY COMMITTEE IN COMMON REPORT

31. Mrs Brown provided an update from the January and February 2024 Quality Committee in Common meetings; she added that progress was being made on the transition to one Committee meeting the requirements of both organisations which had been particularly evident at the February meeting. Key highlights from the meeting were provided:

    - There had been no changes identified to the current Board Assurance Framework (BAF) ratings
    - A Community Nursing deep dive had been undertaken and it was identified this was an area that required more work to be taken forward, recognising quality issues, pressure ulcers and waiting times which required improvement processes, recognising roles and responsibilities within the teams and skill mix
    - The Appointment of an Associate Chief Pharmacist was noted and would be important for the organisation to provide assurance from a prescribing perspective
    - Good joint working was taking place between the ULHT/LCHS Infection Prevention and Control teams, with a focus on fit testing for LCHS staff members
    - The Easter plan was also received

The Trust Board:

- **Received the reports from the January and February Quality Committee in Common meetings**

152/24 SEASONAL PLANNING REPORT

32. The Chief Operating Officer presented the seasonal planning report. She explained that planning was in place for Easter which was typically a busy time within the community and urgent treatment services. A lot had been learned from the Christmas period and there was shared learning across all parts of the group on escalating and supporting each other, weekend on call teams were now coming together across the Group for support and in the evenings.

33. Mr Macdonald commented that across the wider regional system it had been acknowledged that there was improved rigour and grip within the Lincolnshire system as the Group appeared to be addressing some of the historical issues, which was a credit to both organisations. Mr Macdonald wondered why that had not been the case previously. The Deputy Group Chief Executive expressed a view that this related to perceived organisational boundaries being in the way; however that perception was no longer there, and all teams were working for the benefit of patients.

34. Mrs Brown expressed a view that this was also down to shared executive leadership, good communication and role modelling.

The Trust Board:

- **Received the report**

153/24 NATIONAL STAFF SURVEY RESULTS

35. The Deputy Director of People shared the National Staff Survey results. The following key highlights were noted:

- The survey response rate is 56%. This is a decrease of 1% from the 2022 survey and is 4% lower than the average national response rate for CTs at 60%
- The overall Staff Engagement Score (SES) is 7.1 (out of 10) which is a decrease of 1% from 2022. This is the lower than the average score for our national benchmarking group of CTs at 7.3.
- The overall Morale score is 6.0 (out of 10) which is 1% lower than in 2022. This is the lower than the average score for our national benchmarking group of CTs at 6.2.
- Of the seven People Promise elements, we have stayed the same in six elements and have seen a marginal decrease in one element from 2022.
- In comparison to our CT benchmarking group, we were the same as the average in two of the People Promise elements and below the average in five elements.
- LCHS chose to focus on two of the People Promise elements to improve in 2023 and both elements have remained the same as last year.

36. The potential for changes to the organisation results were noted given the current period of change however the Trust Board acknowledged that previous good results had been maintained.

37. Mrs Brown expressed a view that work now needed to be undertaken on the continued focus moving to the Group and the requirement to achieve the highest response rates possible.

38. Mr Macdonald asked if next year's survey would be individual organisations or a Group survey. The Deputy Director of People explained that this was being looked at currently as a Group, however with two sets of results.

39. Miss Shadlock asked the outcomes of this for people moving forward. Mr Burch responded that there were lots of items currently in transition and there was a view the

organisation had remained steady with the staff survey results whilst in a period of significant challenge financially. Mrs Brown commented that ensuring that the right governance arrangements were in place at the present time would be important moving forward.

40. Mr Burch commented that he was pleased to see some improvement in the impoarnat area of how disabled collegues felt they were treated.

41. The Group Chief Executive commented that this part of the Group's results were in a better position than the other half, and moving into a Group there would be some internal learning undertaken.

The Trust Board:

- **Received the National Staff Survey results**

154/24 GENDER PAY GAP REPORT

42. The Gender Pay Gap report was offered to the Trust Board, which demonstrated a gender pay gap. The report shows this is as a result of the different roles and pay grades within the VSM, Medical and Dental (GP) and 'Other' staff group that show differences between nationally and locally agreed pay scales. This report shows that LCHS has seen the overall gender pay gap improve since last year. Key highlights were identified as:

    - Over the entire LCHS Trust the average pay gap is 20.55%. The gap has narrowed compared to last year and has decreased by 3.75%. The highest proportion of women are concentrated within bands 3, 5 and 6 posts. Of all the men employed within the Trust the highest proportion are employed within bands 6, 7 and 8a-d posts. In the acknowledgement that LCHS has a pay gap, it does not necessarily mean that women are paid less than men for doing the same job, but it does show that at LCHS, overall, men occupy higher-paying roles than women.
    - There have been significant decreases in the pay gap reported in the Medical and Dental categories, mostly due to the retirement of long-standing male colleagues in these positions since the 2022 report. This contributed to a decrease of 11.19% in the mean pay gap for the Medical and Dental (GP) category.
    - It is notable that the number of women within Quartile 4 roles has increased in 2023. In 2022, women made up 77.30% of those in Quartile 4 roles. In 2023 women make up 80.24% of those Quartile 4 roles.
    - There has been an increase in the number of women employed by LCHS since the last Gender Pay Gap report. Women make up 87.53% of the workforce in 2023. This figure was 86.90% in 2022.

43. There continued to be ongoing work in relation to robust recruitment and development processes along with an evidence-based approach to salaries both at the point of recruiting and pay progression as a result of appraisals.

The Trust Board:

- **Received the report**

155/24 EQUALITY DELIVERY SYSTEM 3 (EDS3) PROGRESS REPORT AND ACTION PLAN

44. The Deputy Director of People and OD presented the report and action log. She explained that work against the assessment framework to make improvements in three domains of the action plan had been completed and the Trust now had a green rating

against those three domains. The patient domain would be moving into business as usual and all services would be required to complete the assessments, working with Group focus from now on.

The Trust Board:

- **Noted the report**

156/23 FINANCE, PERFORMANCE, PEOPLE, AND INVESTMENT COMMITTEE REPORT

45. Mr Macdonald presented a report following the January and February 2024 meetings of the Finance, Performance, People, and Innovation Committee, he drew the following items to the attention of the Trust Board:

    - The Committee recommended moving strategic aim 3d and 4b of the BAF to a green rating
    - Three risks were proposed to reduce score; risks 442, 463 and 444. Risk 491 relating to health and safety was not currently being proposed to change

46. The Chief Operating Officer provided an update on health and safety issues; she explained that the sad passing of the Trust's Health and Safety Advisor had left the organisation in a vulnerable position in respect of health and safety oversight, and a plan for ULHT colleagues to provide support to oversee health and safety was now in place. There were also some fire related issues at Skegness Hospital and colleagues had been made aware of compartmentalisation issues within the roof space. NHS Property Services had put an action plan in place which was being monitored and the Chief Operating Officer assured the Board that actions had now been taken to remove the compartmentalisation. Other aspects of health and safety were in the process of being reviewed by the ULHT Health and Safety Team as the levels of assurance required were not being received as expected.

47. Mr Macdonald expressed a view that moving into the Board in Common arrangement, health and safety currently sat under the remit of the Finance, Performance, People and Investment Committee and he asked that the Board ensured that the Chief Operating Officer and team received the relevant support to see an improved position.

48. Mr Burch acknowledged the fire safety issues at Skegness Hospital and the assurance position that had been provided.

49. The Chief Operating Officer added that LCHS had now appointed a Fire Officer and she added that there was a more assured position now. The learning from Skegness would be taken into other buildings where community wards may be in a similar position. The responsiveness of learning from these issues had also been rolled out across the Wards.

The Trust Board:

- **Received the report from the January and February meetings**
- **Received the minutes from the November 2023 and January 2024 meetings**
- **Noted the proposed changes in risk ratings and BAF assurance**
- **Approved the Delegated Authority for the Committee to sign off the financial plan for 2024/25 and associated budgets at its meeting on 25th March 2024**

50. The People Promise Manager joined the meeting at this point to provide the Trust Board with a presentation on the outcome of the SWANS2 study for information only; the study had been undertaken in conjunction with the University of Lincolnshire in

relation to staff wellbeing and networks. It was noted that the report had been received by the People Executive Group and the Finance, Performance, People and Investment Committee. There were no recommendations for the Trust Board.

The Trust Board:

- **Received the presentation and thanked the People Promise Manager for attending the meeting**

156/23 AUDIT COMMITTEE

51. Miss Shadlock presented a report following the February 2024 Audit Committee meeting, she drew the following items to the attention of the Trust Board:

    - The requirement to identify a new Chair of the Finance, Performance, People and Innovation Committee had been discussed and Audit Committee members were keen to ensure that a new Chair or Interim was identified soon ensuring robust governance arrangements were in place
    - The Committee Annual Self-Assessment had been undertaken where no areas of concern had been identified
    - An update on the ongoing HMRC dispute had been received, latest advice was to potentially reduce the valuation of provision for 2023/24 with additional disclosure. Further discussion would take place at today's Private Board meeting
    - At the time of the meeting many procedural documents were out of date, however work was now underway to address these issues, which the Chair was keen for the Audit Committee to keep oversight of
    - A gap in oversight relating to strategic aim two was noted, subsequently this was being addressed by the Quality Committee in Common
    - Effectiveness Reviews had been undertaken by internal and external auditors and the Counter Fraud service; internal audit arrangements required further discussion at today's Private Board meeting.

The Trust Board:

- **Received the report**
- **Received the minutes from the meeting held in December 2023**

157/23 INTEGRATED PERFORMANCE REPORT

52. The Director of Finance and Business Intelligence presented a summary position of performance for January 2024 to the Trust Board. This provided information on the areas where there had been a significant change in performance and where it was below expected target levels.

53. Mr Burch acknowledged that this report had been reviewed in detail at the last Finance, Performance, People, and Innovation Committee meeting; he added that the report provided a positive update and some improvements were being seen.

54. Mr Macdonald explained that the 18 week wait target had been debated at the last Finance, Performance, People and Innovation Committee and he suggested that now that the Trust's approach to waiting lists had changed, to only use RTT for services which were consultant led. He expressed a view that there would be improved analysis now given the additional information.

The Trust Board:

- **Received the performance dashboard and the Integrated Performance Report**

- **Recognised that performance was positive in most areas, however where it was off track acknowledged that further work was being undertaken**
- **Agreed the 18-week RTT proposal**

158/23 RISK AND ASSURANCE REPORT

55. The Deputy Group Chief Executive provided those present with an update on progress in respect of risk and assurance and new risks and mitigations were considered. significant changes. She explained that this report was evolving moving into the Group setting in line with lesson learned from the development of the Quality Committee in Common. The report focused on the highest priority risks rated 15 – 20 aligned to strategic objectives. Quality and safety risks discussed by the Quality Committee in Common in February were outlined as below

    - Two risks had been updated in relation to the TB service capacity and demand and an increasing score from 12 to 16 due to an increase in the number of patients in the service
    - Community nursing staffing pressures had decreased from 20 to 16 however remained a significant risk for the organisation
    - Four health and safety risks rated between 15 – 20 related to John Coupland Hospital theatre and water, Skegness water safety and the fire safety risk
    - Three significant high risks sitting under FPPIC had been closed, as referred to earlier within the meeting

56. Both organisation were working to review and align risk profiles via a risk management approach, and a review of high rated risks was underway and mitigations and actions were being strengthened. Risk Confirm and Challenge meetings would also be taking place with Executive Director oversight monthly moving forward where the highest rated risks would be reviewed.

57. All risks had been reviewed through sub-committees and clear mitigations were in place as set out within the report and the Deputy Chief Executive offered a level of significant assurance relating to the risk register.

The Trust Board:

- **Received and accepted the movements within the Corporate Risk Register**

159/23 BOARD ASSURANCE FRAMEWORK REPORT

58. The Deputy Director of Corporate Governance presented the Board Assurance Framework for 2023/24 which was taken as read. The movement of strategy objectives 3d and 4b from amber to green was proposed.

59. The Deputy Director of Corporate Governance added that work was being undertaken currently preparing for the new strategic aims and objectives moving into 2024/25.

The Trust Board:

- **Approved the 2023/24 BAF proposed ratings as set out**

160/23 APPROVAL OF POLICY DOCUMENTS

60. The Deputy Director of Corporate Governance asked the Board to note the policies, standing operating procedures and guidance for ratification.

Policies for Trust Board ratification

Reference	Document Title	Approval date	Delegated Committee/Group
P_HS_19	Management of Waste Policy	13 December 2023	Health & Safety Committee
P_CS_26	Formulary of Wound Management Products (incorporating the SOP for Direct Supply of Wound Management Products)	18 December 2023	Clinical Safety & Effectiveness Group
P_HR_17	Disclosure & Barring Service Policy and Protocols	6 November 2023	Employment Policy Group / JCNC
P_HR_11	Bullying and Harassment (Your Civility Matters) Policy	6 November 2023	Employment Policy Group / JCNC
P_HR_08	Professional Registration Policy	6 November 2023	Employment Policy Group / JCNC
P_HR_44	Roster Policy	6 November 2023	Employment Policy Group / JCNC
NEW	Management of Patients with Clostridium difficile Infection (CI) / Associated Disease (CDAD) Policy	12 January 2024	Clinical Safety & Effectiveness Group
NEW	Management of Viral Gastroenteritis (including Norovirus) Policy	12 January 2024	Clinical Safety & Effectiveness Group
P_CS_32	Anaphylaxis Recognition & Treatment Policy	14 February 2024	Clinical Safety & Effectiveness Group
NEW	Enhanced Care of Adults	11 January 2024	Clinical Safety & Effectiveness Group
NEW	Clinical Records Keeping Standards Policy	14 February 2024	Clinical Safety & Effectiveness Group
NEW	Patient Access and Safe Waiting Policy	18 December 2023	Clinical Safety & Effectiveness Group
P_HR_10	Recruitment, Selection & Secondment Policy	6 February 2024	Employment Policy Group / JCNC
P_HR_58	Lease Vehicle Policy	6 February 2024	Employment Policy Group / JCNC

61. Those present also noted the policies, standard operating procedures and guidance documents which had ratified by their delegated Committee/Group or archived.

62. In light of the current position relation to overdue policies and procedures, the Deputy Director of Corporate Governance requested the Trust Board delegated authority to the Executive Leadership Team to approve policy documents currently being prioritised across the group to address overdue documents.

The Trust Board:

- **Ratified the Policies received and approved the extensions**
- **Approved the Delegation of Authority to the Executive Leadership Team**

161/23 ANY OTHER BUSINESS

63. As this was Mr Burch's last Trust Board meeting, on behalf of all Trust Board members the Group Chief Executive took the opportunity to thank him for all that he had done for the organisation and patients across Lincolnshire during his time within the organisation. He added that in each discussion he always focussed on patients, communities and colleagues along with the outcome impact to make a difference. Mr Burch responded that he had enjoyed his time within the organisation; he said he was leaving with the knowledge that the Group had got to a good stage and he expressed a view that the next steps would be exciting, however within a challenging environment.

162/23 DATE AND TIME OF NEXT MEETING

64. The next meeting would be held on Tuesday 7th May 2024.

Signed …….. Date ……

Mr M Burch, Acting Chair of LCHS NHS Trust Board

Group Chief Executive's Report

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Hospitals NHS Trust

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*7 May 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*
Recommendations/ Decision Required	*The Board is asked to note the update.*

Purpose

System Overview

a) All parts of the system remain busy, but good work continues in order to cope with the ongoing operational pressures. Since the last Board meeting, the system coped well with the Easter Bank Holiday period. Further industrial action by junior doctors is anticipated, following the outcome of the BMA ballot which extended the strike mandate until 19th September. No dates for further industrial action have been set as yet. The dispute involving Consultants has been resolved following the acceptance of the most recent pay offer by the Government. Action is now underway to implement the outcome of this pay deal.

b) The system ended the financial year 2023/24 with a financial deficit of £19.5m. The planned deficit was £12m. The variance is due to the system not receiving the return of £7.5m surge funding from NHSE. The outturn was in line with the expectations of NHS England.

c) The 2024/25 priorities and operational planning guidance was issued by NHS England towards the end of March. Work has been ongoing since then to produce the system operational plan for 2024/25. The final system plan is due to be submitted to NHS England on 2nd May. At the time of writing this report, the Lincolnshire plan was compliant with the overwhelming majority of key national operational targets. The plan was also indicating that the system would break-even financially in 2024/25. Alongside the system plan, there are operational plans for each of the Trusts in the county, including one for LCHS and one for ULHT. A review meeting about the system plan will be held with NHS England on 21st May.

d) The Q4 Quarterly System Review Meeting (QSRM) with NHS Midlands takes place on 2nd May. An update on the outcome of the meeting will be given at the Board meeting.
e) The next National CEO Leadership Event takes place in London on 1st May. An update on the key points from the event will be given at the Board meeting.
f) Two 'soft launch' events have been held about Community Primary Partnerships (CPPs), led by Professor Derek Ward who is the System Executive Lead for this work. The events were an opportunity for the key stakeholders to come together to explore their understanding of what CPPs are, what their success measures should be, how they could operate, and the potential next steps. It is anticipated that work will now progress to test the ideas in reality in a couple of geographic areas in the county.
g) NHS England has published guidance relating to the production of ICS 10 year Infrastructure Strategies. A draft strategy has to be produced by the end of May, with the final strategy being required by the end of July. These strategies will need to cover all infrastructure including estates, equipment, digital, and how these link to the workforce strategy and the system's overarching strategy.

Group Overview

a) The Group arrangement between LCHS and ULHT formally came into being at the start of April. The Group does not constitute a merger, as both Trusts retain their separate statutory names and legal obligations. The Trusts are however working together ever more closely, with the aim of integrating care for the benefit of the communities that we serve. Following extensive staff and stakeholder engagement, it has been agreed that the Group will be known as Lincolnshire Community and Hospitals NHS Group (LCHG).
b) Since the last Board meeting, it has been announced that Professor Karen Dunderdale will be the substantive Group CEO with effect from 1st July. This follows an extensive national assessment and recruitment campaign. I am retiring at the end of June and the intervening period allows for a smooth transition in leadership and accountability. I am delighted with Karen's appointment and I know she will be a huge success in her new role.
c) At the end of the financial year 2023/24, LCHS delivered a surplus of £1.38m against a plan of break-even. ULHT delivered a deficit of £20.8m which was in line with the plan. LCHS delivered CIP savings of £6.9m against a plan of £6.6m. ULHT delivered CIP savings of £34.2m against a plan of £28.1m.
d) Work has been underway to ensure that LCHG has a unified strategy for 2024/25. The strategy has strategic aims relating to patients, people, services, partners and population health. The objectives underneath each aim are predominantly Group focused, with only a small number being specific to either LCHS or ULHT.
e) From 1st April, sexual health services in Lincolnshire, North Lincolnshire and North East Lincolnshire will be delivered by the LCHS part of LCHG. The

service, known as Lincolnshire Integrated Sexual Health Services (LISH) has been delivered by LCHS in Lincolnshire for over ten years. Following a competitive tender exercise, the local authorities across Greater Lincolnshire have selected LCHS as the provider of these services in all three local authority areas.

f) The 2024 staff awards across LCHG are now open for nominations. The previous separate staff awards for LCHS and ULHT are being brought together this year into a single LCHG staff awards process and ceremony. Anyone can make a nomination in the 14 award categories, including staff, patients, and members of the public.

Quality Committee in Common Upward Report

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Hospitals NHS Trust

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*7 May 2024*
Item Number	*8.1*

Quality Committee in Common Upward Report of the meeting held on 19 March 2024

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

Purpose

This report summarises the assurances received and key decisions made by the Quality Committee in Common. The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response.

This assurance Committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme, for both Lincolnshire Community Health Services NHS Trust (LCHS) and United Lincolnshire Hospitals NHS Trust (ULHT). The Committee worked to the 2023/24 objectives for both LCHS and ULHT and was attended by both ULHT and LCHS colleagues.

Upward Report

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

Patient Safety Group Upward Report to inc Patient Safety Alerts and PSIRF (ULHT)

The Committee received and accepted the report with **assurance,** noting the decrease in the number of open serious incidents with the group receiving monthly exception reports to monitor the closure of open incidents.

Challenges in respect of the Fluid Balance Group were noted by the Committee however it was recognised that work was being undertaken to refresh the group as part of the wider work for the reporting groups to the Committee.

Clinical Safety and Effectiveness Group (CSEG) Upward Report to inc National Patient Safety Strategy Update (LCHS)
The Committee received the written report from the February meeting with the Committee noting the change to grading of pressure ulcers from ungradable to category 3 due to changes in national guidance. Therefore, an increase in category 3 pressure ulcers would be seen going forward.

The Committee noted the work of the group in respect of mitigating actions however noted the limited assurance being received due to the lack of evidence to support the ongoing work.

A deep dive into pressure ulcers would be undertaken and reported to the Committee during the first quarter.

The Committee was pleased to note the Patient Safety Incident Response Framework (PSIRF) for LCHS noting the five key areas of speech and language, diabetes, patients who are pregnant presenting at UTCs, digital safety and catheter management. These were supported by the Committee.

Discussions took place regarding end-of-life care, particularly the risk associated with unplanned palliative care and patient deaths within 24 hours of admissions. A deep dive was proposed to gain a better understanding of the challenges, this would be offered to the Committee during Q1.

Concerns regarding long waiters were raised with confirmation received that all patients had been contacted and support was in place with developments taking place across the group to strengthen support.

Serious Incident Report to inc Duty of Candour (ULHT)/Serious Incident Report to inc Overdue Datix and Duty of Candour (LCHS)
The Committee received and accepted the joint report with **assurance,** noting the position for both ULHT and LCHS.

The Committee received the Patient Safety Incident Response Framework (PSIRF) plan for ULHT and the report which outlined the LCHS activities for the coming year. The joint PSIRF policy was received by the Committee and approved for onward approval by the Board (appendix 1).

The Committee was pleased to note, from April 2024, that both LCHS and ULHT would work jointly on PSIRF to monitor and investigate incidents within the remit of PSIRF.

Concern was noted in respect of delays associated with approvals of incidents by the Integrated Care Board with assurance received that processes were in place to manage these.

High Profile Cases Report (ULHT)
The Committee received the joint report noting the position presented and **assurance** offered through both the written report and verbal updates provided.

Infection Prevention and Control (IPC) Group Upward Report inc IPC BAF and Hygiene Code (ULHT)/Infection Prevention Monthly Progress Report (LCHS)
The Committee received the Infection Prevention and Control Group Upward Report (ULHT) noting the position in respect of C. Difficile, which continued to be reported above trajectory.

A NHS England table top review was awaited to support the internal thematic analysis work which was ongoing, to identify any further actions which could be taken.

The Committee recognised that there had been occurrences of respiratory infections, influenza A and norovirus which had been effectively managed. Ongoing outside waste storage issues were noted with the Committee expressing disappointment that this had not yet been fully resolved.

The Committee received the LCHS Infection Prevention Monthly Progress Report which was taken as read.

Medicines Quality Group Upward Report (ULHT)
The Committee received and accepted the report with **assurance** noting the significant progress which had been made in managing medicines incidents with the trajectory demonstrating sustained improvements.

The Committee commended the achievement of the rollout of EPMA and noted the current discussions being held to consider rollout of this to Community services.

Concern was noted in respect of Clinician attendance at the Drugs and Therapeutics Committee however it was noted this was being addressed through job plans and wider work to consider all medicine related groups through the workshops as part of the group model work.

Safeguarding and Vulnerabilities Oversight Group Upward Report to inc MCA and DOLS compliance (ULHT and LCHS)
The Committee received and accepted the report with **assurance** noting the progress against a number of safeguarding risks including De-escalation, Management and Intervention (DMI) training and Oliver McGowan training which was being brought together across both ULHT and LCHS.

The Committee noted the ongoing work with the divisions in respect of escalated cases of children in care and the concerns about the suitability of the currently commissioned service due to changes in funding.

Detailed discussions were held regarding the current service model with the Committee receiving **assurance** that, whilst the service was safe, it did not meet national guidelines, with a desire for there to be improvements to meet guidance going forward.

Nursing Midwifery and AHP Advisory Forum Upward Report (ULHT)
The Committee received the report for information noting there were no escalations and recognised the triangulation in addressing issues across a number of areas by the group.

The Committee noted that ULHT awaited confirmation as to whether the Trust would be within the first cohort to implement Martha's Law.

The Committee noted that the group had approved a number of policies.

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

Patient Experience Group Upward Report (ULHT)/Stakeholder Engagement Group Upward Report inc 15 Steps visits (LCHS)
The Committee received and accepted both the ULHT and LCHS reports with **assurance** noting from the ULHT report that there had been updates received by the group from the divisions, including patient stories.

The Committee was pleased to note the opening of the Emerald Suite for chemotherapy patients to have a space to talk and the development of a patient feedback survey for Pharmacy at ULHT. The achievement of a reduction in letter templates outpatient and first appointment letters was also noted.

Updates were received to the LCHS meeting from all divisions regarding staff and patient engagement with the Committee noting the introduction of the new loop system for health roster for staff.

Ongoing work to address incidents in the emergency departments and urgent treatment centres was noted which was contributing to improved patient experience.

The Committee noted that data was not always accessible to staff to support work however recognised the ongoing development of a data warehouse and appointment of a Datix Manager to support improved data generated and accessibility.

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

Clinical Effectiveness Group Upward Report to inc Clinical Audit Report (ULHT)
The Committee received and accepted the report with **assurance** noting that consideration had been given during the meeting to a joint meeting with LCHS moving forward.

A number of national audits were received by the group including dementia, oesophageal cancer and asthma. Where necessary actions had been put in place to address shortfalls in the audit outcomes.

The Committee noted the continued positive position in respect of mortality and recognised the need for improvement in respect of compliance with Structured Judgement Reviews (SJRs). The timeframes for completion would be addressed through performance review meetings with the divisions.

Clinical Effectiveness and Safety Group Upward Report to inc R&D Report (LCHS)

As reported under objective 1a

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

No items received

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

No items received

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

No items received

Assurance in respect of other areas

Interim ToR and Work Programme
The Committee received the interim terms of reference and work programme noting that there were no changes required at this time. Work continued on the ToR and Work Programme for the Committee to work to in the 24/25 year.

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

Risk Register – ULHT and LCHS
The Committee received the risk register reports for both ULHT and LCHS and discussed concerns regarding the impact of a decommissioned lift. The Committee noted that, whilst mitigations were in place, these were not as effective as hoped.

The Committee noted a number of changes in risk register scores resulting in risks being downgraded due to mitigations in place.

Ongoing work was noted to achieve a collaborative approach in respect of the risk register with the Committee noting no escalations.

CQC Action Plan (ULHT)/CQC Compliance Report (LCHS)
The Committee received and accepted the report with **assurance** noting the collaborative efforts underway with plans in place to review all domains across the CQC framework by the end of quarter 2.

It was noted that a meeting was due to take place to sign off the final 2 must do actions for ULHT with evidence having been received to support this.

Internal Audit Reports – LCHS and ULHT
Mortality Internal Audit Report - ULHT
The Committee received and accepted the mortality internal audit report with **limited assurance** noting that plans were in place for mitigations and updates on actions to be shared with the Audit Committee.

It was recognised that the outcome of the audit was being utilised by the team as a learning opportunity to address the completion of structured judgement reviews and to improve the overall quality of these.

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

Committee Performance Dashboard (ULHT and LCHS)
The Committee received the performance reports noting that performance had been considered through the reports presented however noted the continued improvements seen in falls per occupied bed days, demonstrating a trend rather than an in month variation for ULHT.

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

The Committee approved the reports for presentation the Board and Audit Committees (appendix 2 (LCHS) and 3 (ULHT)).

Issues where assurance remains outstanding for escalation to the Board

No escalations required.

Items referred to other Committees for Assurance

The Committee referred to the ULHT Finance, Performance and Estates Committee, the issue of lifts within the Trust and the current issues being faced, seeking assurance on the programmes of work in place to improve the infrastructure.

Attendance Summary for rolling 12-month period

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

X in attendance
A apologies given
D deputy attended

Patient safety incident response policy

Effective date: October 2023

Estimated refresh date: April 2025

	NAME	TITLE	SIGNATURE	DATE
Author	**Helen Shelton**	**Assistant Director of Clinical Governance**		**July 2023**
Review Groups	**Patient Safety Group**			**August 2023**
Approval Groups	**Quality Governance Committee**			**September 2023**
Approval Group	**Trust Board**			**November 2023**

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

Contents

Purpose

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

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

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

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

Scope

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

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

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

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

Our patient safety culture

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

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

Patient Safety Partners (PSPs)

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

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

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

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

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

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

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

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

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

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

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

Both organisations have met the requirements of the National Patient Safety Strategy (July 2019) by introducing 6 PSPs. The post holders were recruited through the Trusts recruitment processes with an agreed job description and management infrastructure to support their transition into the organisation. It was agreed that the PSPs would enter the organisation at Level 1/3 (Framework for Involving Patients in Patient Safety 2021).

Addressing health inequalities

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

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

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

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

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

Involving Patients & Families

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

See also the trust policy on duty of candour.

Involving Staff, Colleagues and Partners

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

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

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

Patient safety incident response planning

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

Both ULHT and LCHS welcome this approach so we can focus our resources on incidents, or groups of incidents that provide the greatest opportunities for learning and improving safety. It is also recognised that our planning needs to account for other sources of feedback and intelligence such as complaints, risks, legal claims, mortality reviews and other forms of direct feedback from staff and patients. There will be one overarching policy for the Group however both ULHT and LCHS will maintain their own Patient Safety Incident Response Plans (PSIRP). PSIRF guidance specifies the following standards that our plans should reflect:

1. A thorough analysis of relevant organisational data

2. Collaborative stakeholder engagement

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

They will also be:

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

2. Published on our external facing website

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

Resources and training to support patient safety incident response

PSIRF recognises that resources and capacity to investigate and learn effectively from patient safety incidents is finite. It is therefore essential that as a group organisation we evaluate our capacity and resources to deliver our plans. The PSIRPs provide more specific details in relation to this.

Currently the Patient Safety Teams across ULHT and LCHS have several working time equivalent posts to support and facilitate the PSIRF framework:

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

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

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

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

Our patient safety incident response plan

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

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

Reviewing our patient safety incident response policy and plan

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

Updated plans will be published on our websites, replacing the previous versions.

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

Responding to patient safety incidents

PSIRF guidance states:

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

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

Patient safety incident reporting arrangements

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

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

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

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

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

Patient safety incident response decision-making

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

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

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

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

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

Timeframes for Learning Responses

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

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

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

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

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

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

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

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

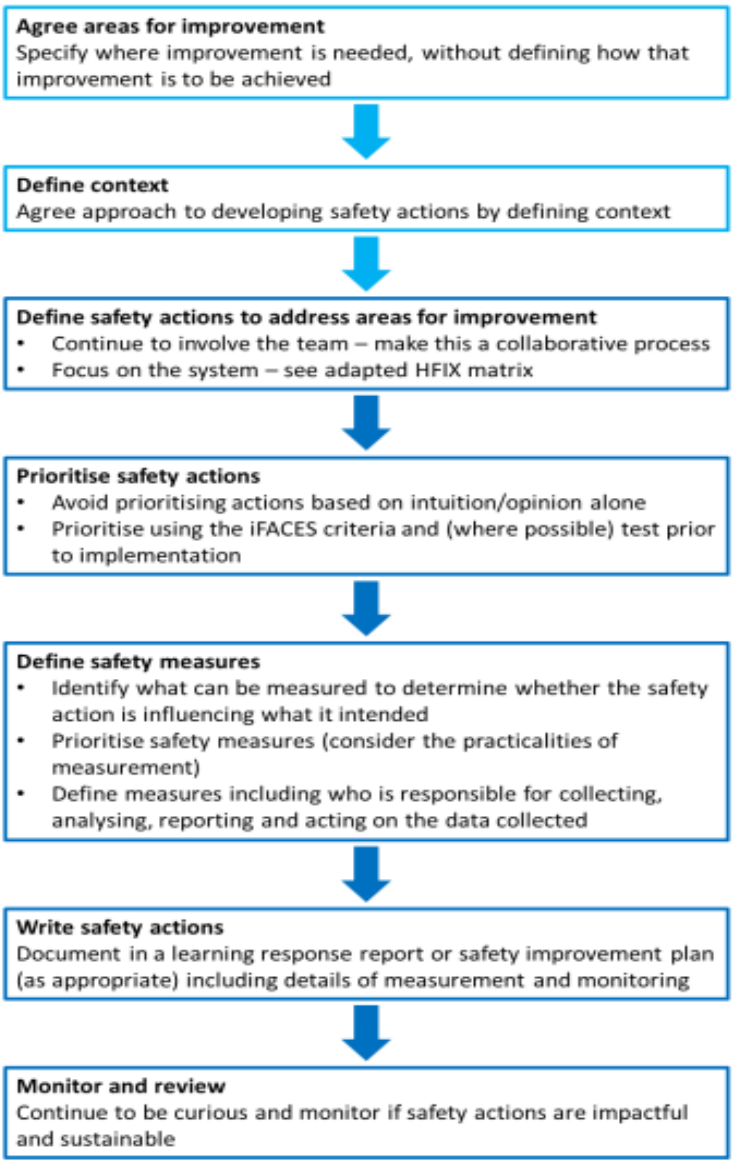
A toolkit of learning response types is available from NHSE at: https://www.england.nhs.uk/publication/patient-safety-learning-response-toolkit/

Safety action development and monitoring improvement

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

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

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



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

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

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

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

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

Safety improvement plans

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

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

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

Oversight roles and responsibilities

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

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

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

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

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

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

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

Complaints and appeals

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

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

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

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

Lincolnshire Community Health Services NHS Trust

Report to the Quality Committee in Common

Date of meeting	19 March 2024	Agenda item	
Title	Quality and Risk Committee Annual Report 2023-24		
Report of	Professor Karen Dunderdale, Group Deputy CEO, Director of Nursing, AHPs and Quality	Prepared by	Catherine Leggett, Deputy Director of Corporate Governance
Previously considered by / Date	N/A	Approved?	
Summary	The purpose of the report is to provide an overview of the Quality and Risk Committee annual plan, areas of focus and achievements for the 12-month period from the 1 April 2023 to the 31 March 2024. This report is submitted to provide assurance that the Committee has been effective in the discharge of its responsibilities as set out in the Terms of Reference.		

1. Provide safe, high quality, population healthcare	**1a. Deliver safe services**	**Cautious** approach to patient safety or harm with strong focus driven by national strategies and policies.	√
	1b. Deliver effective care	**Open** approach to effective care**.**	√
	1c. Engage and involve people in their care	**Seek** approach to engagement and involvement.	√
2. Deliver personalised community health services that are accessible and responsive	**2a. Deliver clinically led integrated community services**	**Open** approach to clinically led integrated community services.	√
	2b. Deliver personalised health care that responds to individual need	**Open** approach to personalised health care that responds to individual need.	√
	2c. Transform clinical pathways for sustainability and improved outcomes	**Seek** approach to transformation of clinical pathways for sustainability and improved outcomes.	√
3. Build a productive, capable and inclusive workforce	**3a. Grow and retain our people**	**Open** to maximising transformation opportunities and will try new and innovative ideas and ways of working to improve job satisfaction and enrichment.	
	3b. Value and develop our people	**Cautious** approach to staff safety and wellbeing and recruitment compliance**.**	
	3c. Enable a change ready workforce	**Seek** new and innovative ways of working through the use of automation and technology	

		which in turn will improve productivity and release time to care.	
	3d. Deliver Safe and Sustainable Foundations	**Cautious** approach to cyber security, health and safety and recruitment compliance. This is because we value our people as our greatest asset and we strive to keep our people, our patients and their respective information as safe as possible.	
4. Ensure healthcare is financially sustainable, making best use of resources	**4a. Deliver financially sustainable healthcare, making best use of resources**	**Open –** Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level.	
	4b. Drive better decisions and impactful action through insight	**Seek -** We will invest for the best possible return and accept the possibility of increased financial risk (with controls in place).	
5. Collaborate to play an active role in the Lincolnshire ICS	**5a. Collaborate to make a difference**	**Seek** opportunities to be innovative and collaborative, both within the organisation and the wider system environment.	
	5b. Transform services to deliver great care close to home	**Seek** opportunities to be innovative and collaborative, both within the organisation and the wider system environment.	

Impact of proposal/ report	*Quality, Patient Safety, CQC engagement and compliance, Patient engagement, People*				
CQC	**Safe**	**Caring**	**Effective**	**Responsive**	**Well-Led**
Links to risks	*Not applicable*				
Legal/ Regulation	*Not applicable*				

Recommendations/ Actions Required

The Quality Committee in Common is asked to **note** the content of the report.

Appendices

Appendix 1 – Quality and Risk Committee Terms of Reference 2023-24

Glossary

N/A

Quality and Risk Committee Annual Report 2023-24

Role of the Committee

In 2023/24, in line with all other Committees of the Board, the Terms of Reference were reviewed, amended and approved by the Trust Board, noted in Appendix 1. Under the agreed terms of reference, the Quality and Risk Committee were tasked to provide assurance to the Trust Board that appropriate and effective governance mechanisms are in place for all aspects of quality and risk including:

- safety of clinical services
- management of quality risks
- quality performance
- understanding and acting on patient engagement, involvement and experience
- clinical effectiveness including health outcomes
- learning from incidents and complaints
- delivery of the Clinical Strategy
- equality, diversity, inclusion and health inequalities (access to services, impact of change on patients and the public)
- population health management
- verbal updates, as necessary, from Non-Executive Director Champions (Freedom to Speak Up and Doctor's Disciplinary)
- compliance with national, regional and local regulatory requirements.

The role of the Committee is to seek assurance on the Trust's delivery of LCHS Strategic Aims and Objectives and will:

a) Provide assurance to the Board to inform the clinical strategic direction of the refreshed annual plan.

b) Hold Trust officers to account for delivery of actions articulated within the Board Assurance Framework relating to LCHS Strategic Aims and Objectives to include:

Strategic Aim 1: Provide safe, high quality, population healthcare

- Objective 1a - Deliver safe services
- Objective 1b – Deliver Effective Care
- Objective 1c – Engage and involve people in their care

Strategic Aim 2: Deliver personalised community health services that are accessible and responsive

- Objective 2a - Deliver clinically led integrated community services
- Objective 2b – Deliver personalised health care that responds to individual need
- Objective 2c – Transform clinical pathways for sustainability and improved outcomes

c) Agree the key priorities in terms of LCHS Strategic Objectives.

Membership and Attendees

The Committee met virtually on a monthly basis via Microsoft Teams, moving to in-person meetings as a Quality Committee in Common from December 2023 and provided an assurance report to the Trust Board bi-monthly. A summary of assurance is also presented to the Audit Committee in line with the Committee annual plan. The Medical Director attended to provide an annual statement of assurance in respect of clinical audit delivery to the Audit Committee.

The Committee is appointed by the Trust Board. During 2023-24 the Committee was chaired by Mr Jim Connolly, Non-Executive Director. Details of the core membership and attendance during the financial year are noted below.

One occasion was noted during the year, October 2023, of the Committee not being quorate resulting in the amendment to membership extending to incorporate the Chief Operating Officer, approved by Trust Board on 14th November 2023. The November meeting was deferred due to system pressures at the time and urgent escalations being reviewed by the Committee Chair and Director of Nursing, Quality and AHPs as Lead Executive. In support of the work to move to a Group Model the December workshop was cancelled to release capacity to support the first Quality Committee in Common initial meeting on 19th December 2023.

- Non-Executive Director, Chair, (Freedom to Speak Up Champion)
- Non-Executive Director (Doctor's Disciplinary Champion)
- Director of Nursing, AHPS and Quality (DIPC, CQC Nominated Individual)
- Medical Director (Caldicott Guardian, Accountable Officer for Controlled Drugs)
- Chief Operating Officer

Voting Members	27 Apr 2023	25 May 2023	29 June 2023	27 July 2023	31 Aug 2023	28 Sept 2023	26 Oct 2023	30 Nov 2023	7 Dec 2023	23 Jan 2024	20 Feb 2024	19 Mar 2024
Non-Executive Director (Mr Jim Connolly, Chair)	√	√	√	√	A	√	√	Meeting deferred	Workshop Cancelled. Initial Quality Committee in Common meeting held on 19th December	√	√	√
Non-Executive Director (Miss Gail Shadlock)	A	√	√	√	√	√	√			√	√	√
Non-Executive Director					√							
Associate Non-Executive Director (Mrs Rebecca Brown)	Appointed to ANED 12/12/23									√	√	√
Medical Director	√	√	A	√	√	√	A			√	√	A
Director of Nursing	√	√	√	A	√	√	A			√	√	A
Chief Operating Officer, Julie Frake-Harris				√ Non-voting at time	√ Non-voting at time	√ Non-voting at time	√ Non-voting at time			√	√	√
Quorate	Y	Y	Y	Y	Y	Y	N			Y	Y	Y

A denotes Apologies given
√ denotes attendance

The following officers were in attendance at the Committee

- Director of People and Innovation, or representative
- Deputy Director of Nursing, AHPs and Quality
- Deputy Medical Director
- Deputy Director of Corporate Governance
- Clinical Directors
- Divisional Leads
- Heads of Clinical Service Quality, Safety and Risk
- Deputy Director Medical Directorate (Safety & Compliance)/Chief Pharmacist
- Safeguarding Representative
- Chief AHP
- ICB representation

Review of business

The Quality and Risk annual plan for 2023-24 is noted in full in Appendix 2. The assurance received through the financial year against the LCHS Board Assurance Framework (BAF) for 2023-24 strategic aims and objectives and subsequent programmes has enabled the Committee to review, consider and propose ratings to the Trust Board for approval. The current position and movement of the BAF ratings are outlined below.

Strategic Aim	Strategic Objective	Assurance Rating 2023-24											
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
1. Provide safe, high quality, population healthcare	1a. Deliver safe services												
	1b. Deliver effective care												
	1c. Engage and involve people in their care												
2. Deliver personalised community health services that are accessible and responsive	2a. Deliver clinically led integrated co munity services												
	2b. Deliver personalised health care that responds to individual need												
	2c. Transform clinical pathways for sustainability and improved outcomes												

The Chair and Executive Lead have met monthly to agree the forthcoming committee agenda in line with the annual reporting plan.

Key risk escalations through the year

- Risk 387 Community Nursing Capacity and Demand has been a highly rated risk that the Committee has received mitigations and assurance regarding, action plans continue to be implemented for Community Nursing along with a recent position review to the Executive Leadership Team on 15th February 2024.

- Safeguarding risks were also raised in August 2023 regarding training, risk 499, establishment of the LCHS team and vacancies and capacity, risk 498, These risks have been mitigated during quarter 3.
- Risk 409 (lymphoedema service capacity) has also been a risk where the Committee has received additional assurance along with escalating this to Trust Board in-year. A number of issues had been identified which had been discussed at the system Contract Management Board and a joint options appraisal across the system would be developed. The overall score decreased following the deep dive presented to the Committee in September and October 2023 in line with the planned trajectory.
- Although not directly under the remit of the Committee estates risks related to water purity and ventilation at Skegness and Louth Community Hospital sites have been reviewed throughout the year with increased oversight and scrutiny due to the potential infection control and patient harm impact. Risk mitigation planning and action assurance have been developed and shared through Executive Leadership Team.

Summary of key areas and assurance received for strategic aims and objectives:

Strategic Aim 1: Provide safe, high quality, population healthcare

Objective 1a – Deliver safe services

- Comprehensive development of safeguarding service, resources, strengthened training, governance and assurance through group model collaborative working.
- Recognition of overall reduction in the number of serious incidents for three consecutive years along with the development of the Patient Safety Incident Response Plan (PSIRP) and ten local priorities and investigations outlined.
- The quality account priorities for 2023-24 have been progressed throughout the year for the three areas identified
    - competency framework for administration of insulin
    - care of patients who fall and sustain a possible or evident head injury
    - patient engagement / PSIRF.
- The Safer Nursing Care Tool (CNSST) successfully implemented in the Sleaford Community Nursing Team and would be rolled out across all Community Nursing Teams throughout 2024-25.
- Reduction in the number of pressure ulcers overall noted. A slight increase in Category 3 and 4 reported and thematic analysis planned to understand themes and trends. Data development in-year enabling both attributable and non-attributable pressure damage to be reviewed.
- Improving assurance received in relation to medicines management across the Trust
- Considerable progress across the trust for verbal duty of candour reporting
- The learning and trust progression against the Emergency Preparedness Resilience and Response (EPRR) Core Standards assessment outlined key areas of positive practice and developmental areas incorporated into the EPRR workplan.
- LCHS Deteriorating Patient and Medical Gases Groups met as refreshed groups from September 2023, the impact recognised through assurance provided to Committee.

Objective 1b – Deliver Effective Care

- The process for reviewing policies across the Trust was reviewed and strengthened.
- Medical Device services were successfully transferred back to the Trust with improving compliance targets noted.

- Butterfly Hospice, Boston and Scarborough Ward at Skegness Community Hospital acknowledged for good Learning from Deaths practice.
- Good practice identified as part of the National Audit of Care at the End of Life (NACEL) audit.
- The 2022-23 Infection Prevention Annual Report was received and significant progress noted. Full compliance on the Infection Prevention and Control (IPC) BAF for sections 1, 4 and 10 was acknowledged and Sections 2 and 3 and assurance regarding plans to address areas of partial compliance and gaps received.
- Robust assurance in place for NICE and Clinical Audit across the organisation with new NICE Guidance Implementation Group introduced from February 2024 to support Divisions.

Objective 1c – Engage and involve people in their care

- Continued development of the Complaints, Litigation (Claims), Incidents and PALS (CLIPS) report and triangulation of data and assurance.
- Assurance received quarterly for the two pilot areas of Cardiac Rehabilitation and Lincoln Urgent Treatment Centre for year 1 of the Equality Delivery System 3.
- Development and success of the Volunteer to Career LCHS national pilot programme with 70% of volunteers on the programme now in employed positions.
- Significant improved trajectory of patients and family member involvement and engagement in their care planning and learning from children, young people, specialised and urgent care patient and family stories shared.
- Continued work to develop trust processes and evidence for the new CQC assessment framework and 'we statements'.
- Development of web resources in response to patient asks and needs, such as the Cardiac Rehabilitation website co-production with partners based on experience.
- Received assurance of supporting patients in their self-care, cardiology services use digital resources to support healthy lifestyles and help patients access a range of services including - One You Lincolnshire, We Are With You, Lincolnshire Talking Therapies, Social prescribers, AGE UK, Wellbeing team and Neighbourhood Teams.
- The use of Clinitouch in the heart failure service supports self-management through remote monitoring of patient's observations giving the patient a more empowered active role to take ownership of their condition.
- Personalised discharged plans are being developed with a focus on highlighting long-term self-management plans.

Strategic Aim 2: Deliver personalised community health services that are accessible and responsive

Objective 2a – Deliver clinically led integrated community services

- Committee noted several mass vaccination centre developments throughout the year from the seasonal provision of covid vaccinations to the addition of community health, blood pressure checks and health promotion between seasonal vaccinations, the introduction and rollout of flu vaccinations from September 2023 to the addition of measles vaccination in February 2024.
- Commenced a pilot Intermediate Care Coordination team within the Transfer of Care hub.
- Continued substantial growth and investment in Cardiology, Respiratory, Rapid Response all Age complex Neuro Respiratory and Frailty virtual wards. Patients can be

referred onto a virtual ward either from a step-up or step-down pathway. Capacity has been increased month on month to meet anticipated demand and featured as a key component of the system winter plan.

- Sustained support to expand the clinical offer within CAS, including additional GPs, ACPs and non-medical prescribers.
- In response to significantly increased demand Children's Speech and Language Therapy revised the prioritisation system for speech sound therapy, halving the therapy list and improving wait times. Child therapy have ensured robust self-care and universal supports are in place and introduced text signposting at the point of entry into the service. Remote appointments are offered using virtual platforms and telephone consultations with 'call back slots' for families and schools to maximise accessibility.

Objective 2b – Deliver personalised health care that responds to individual need

- Development of Patient Activation Measures (PAM) along the 'what matters to me' planned journal support coproduced with patients in the Cardiac Rehabilitation, Stroke and Parkinson's pathways.
- Implementation of training has commenced based on personalisation guidance for all staff to ensure the right values, philosophies and skills are in place to support self-management and patient led care and to combat risk aversion due to the perceived complexity of the patient cohort.
- Noted developments regarding First Contact Physios (FCPs) completion of shared decision making training and aware of share decision making tools to sign post relevant patients to. AQP staff completed motivational interviewing module to improve personalises care.
- Continued progression of the post covid rehabilitation service offer to a comprehensive five-tiered system with step up / step down options, guided by Patient Activated Measures (PAM), which also helps to foster responsibility taking and acknowledges that 'one size does not fit all'. The PAM enables not only Long Covid symptoms to be assessed but also the patient's level of engagement in their own health literacy to be assessed. This in turn, enables the ability to offer a more appropriate tier of intervention.

Objective 2c – Transform clinical pathways for sustainability and improved outcomes

- Leg Ulcer Service having had problems with estates in Lincoln are now providing an additional two days in Lincoln at the Newland Health Clinic, two vacancies now filled in South. Work continues with the ICB around future service provision after submitting a service review paper highlighting investment needed to ensure the service is safe and effective going forward.
- Adult Speech and Language Therapy made three significant changes to their service delivery model which have resulted in significantly improved access to assessment and interventions.
    a) the launch of a care home pack that facilitates the management of eating and drinking concerns in care homes, significantly reducing the need for referrals for specialist assessment,
    b) utilisation of an opt in system and patient initiated follow up and

c) skill mixing to introduce more band 3 and 4 support to enable targeted therapy support.

- Waiting lists significantly reduced for both dysphagia and communication through some over-establishment of the service.
- A waiting lists dashboard has been established, increased oversight across the Trust and in divisions and robust harm reviews, renamed impact reviews, completed. Quality impact assessments completed for all patients who have waited longer than their commissioned wait time and are completed at their first clinical assessment.
- As part of the system winter projects, LCHS has set up a Healthcare Professional Single Point of Access (SPA), bolstering well-established Operations Centre and Urgent Community Response teams. The aim of this service is to reduce attendances at acute Emergency Departments, and to ensure patients are directed to the right service quicker, without the need for a long wait in Emergency Departments and/or a hospital stay.
- A significant risk has related to the Lymphoedema Service due to significant demand in excess of the commissioned service as at 2010, which is no longer sustainable. Interim measures have been put in place to see urgent patients, cancer patients and those that require intensive therapy and a full review of the caseload and waiting list has been carried out and key actions being taken forward as a result:
    - A group session clinic set up to see patients on the routine waiting list for further triage to ascertain if specialist intervention is required, inclusive of self-care and health promotion advice and assessment for a treatment plan and garments as required and safe to wait reviews.
    - Caseload mapped to Leg Ulcer clinics to scope hybrid Lower Limb clinics to encompass chronic oedema patients.
    - Lower limb summit in February 2024 in collaboration with the ICB to bring Primary Care on board with chronic oedema management.

The Quality and Risk Committee has provided direct assurance to the Trust Board in relation to the delivery against all key priorities and action plans. This is supported by a high degree of scrutiny applied at Groups, Sub-Group and service line levels by the Divisional Leads and Deputy Directors to ensure service improvement has been delivered in all aspects of patient care. The organisation will continue to contribute strongly to Lincolnshire's place-based planning, through the development of the Lincolnshire Forward Plan with the recognition of the financial challenge faced by the NHS which the trust has embraced to be safe, effective and sustainable.

Internal Audit

Lincolnshire collectively tendered and appointed TIAA for 2023-24 across the system as the Internal Auditor. The descriptions for ratings differ to previous reporting and are reflected here for information. During 2023-24 the following internal audit reviews have taken place:

- Patient flow through hospital and discharge process - [rating TBC}
- Governance, Board Assurance Framework and Risk Management - [rating TBC}

Substantial Assurance	There is a robust system of internal controls operating effectively to ensure that risks are managed and process objectives achieved.
Reasonable Assurance	The system of internal controls is generally adequate and operating effectively but some improvements are required to ensure that risks are managed and process objectives achieved.
Limited Assurance	The system of internal controls is generally inadequate or not operating effectively and significant improvements are required to ensure that risks are managed and process objectives achieved.
No Assurance	There is a fundamental breakdown or absence of core internal controls requiring immediate action.

Conclusion and Recommendations
A summary of the end of year assurance position is outlined:
The Quality and Risk Committee has continued to receive and provide assurance to the Trust Board on delivery of effective Quality Governance and sustained care quality demonstrating that the committee has effectively been able to discharge its responsibilities. In summary notable achievements and points to note this year for the committee are:

- Continued high performance and delivery of quality priorities linked to the Board Assurance Framework
- Continued improvement in management of serious incidents, progression against the patient safety and incident response framework and continued and consistent positive reporting culture, demonstrated through consistently high reporting rates, with a correlation of low harm.
- Development and success of the Volunteer to Career LCHS national pilot programme with 70% of volunteers now in employed positions.
- Significant improved trajectory of patients and family member involvement and engagement in their care planning and learning from children, young people, specialised and urgent care patient and family stories shared.
- Continued progression of triangulation and responsiveness to incidents, complaints, claims and litigation and learning implemented across the organisation.
- Developments in pharmacy provision across the trust and improved assurance of medicines management
- Butterfly Hospice, Boston and Scarborough Ward at Skegness Community Hospital acknowledged for good learning from deaths practice
- Significantly improved management of NICE which would be more robust and responsive.
- Improved performance and position of waiting lists across the trust and appropriate mitigation action plans being monitored according to ‘safe to wait’ planning.

Reporting Cycle
The reporting cycle for 2024-25 continues to develop in line with the progression to a Group.

Self assessment process
A self-assessment has been completed for all reporting groups and for Quality and Risk Committee**.**

Quality and Risk Committee are asked to note this report.

United Lincolnshire Hospitals NHS Trust

Annual Report to the Trust Board from the Quality Governance Committee 2023/24

ROLE OF THE COMMITTEE

In 2023/24, in line with all other Committees of the Board, the Terms of Reference were reviewed, amended. Under the agreed terms of reference, the Quality Governance Committee was tasked as follows:

The Quality Governance Committee will:

- Agree a set of Key Performance Indicators to be presented in the Committee Performance Dashboard monthly
- Consider the control and mitigation of quality related risks and provide assurance to the Board that such risks are being effectively controlled and managed. Whilst the committee's remit covers all of the Trust's services, the committee has a specific oversight role in relation to the quality & safety of the Trust's maternity services (reference: Ockendon)
- Provide assurance to the Board that all legal and regulatory requirements relating to quality are met, including directives, regulations, national standards, policies, reports, reviews and best practice
- Review and provide assurance on those strategic objectives within the Board Assurance Framework, identified as the responsibility of the committee seeking where necessary further action as outlined below:

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

- Developing a safety culture
- Ensuring early detection and treatment of deteriorating patients
- Ensuring safe surgical procedures
- Ensuring a robust safeguarding framework is in place to protect vulnerable patients and staff
- Maintaining HSMR and improving SHMI
- Delivering on all CQC Must Do actions and regulatory notices
- Ensure continued delivery of the hygiene code and achievement of Infection Prevention and Control (IPC) BAF
- Improve patient safety by learning from incidents, specifically:
    - Maternity services (personalised care)
    - Medication Management
    - Diabetes Management (DKA)

- Infection Prevention and Control
- Urgent and Emergency Care

Improve patient experience:

- Greater involvement in the co-design of services working closely with Healthwatch and other stakeholder patient groups
- Greater involvement in decisions about care
- Deliver year three objectives of our Inclusion Strategy
- Enhance patient experience by learning from patient feedback
- Improve delivery of care and patient discharge

Improve clinical outcomes:

- Ensuring our respiratory patients receive timely care from appropriately trained staff in the correct location
- Ensuring recommendations from Get it Right First Time (GIRFT) reviews are implemented
- Ensuring compliance with local and national clinical audit reports
- Reviewing of pharmacy model and service
- Ensuring care delivered to patients is based on evidence based best practice leading to improved clinical outcomes

MEETINGS

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

During the year, to enable the Committee to support the development of the Quality Committee in Common, meeting durations were shortened to 1 hour. The Committee continued to deliver a full agenda through the submission of questions, by Committee members, ahead of the meeting which were responded to during the meeting.

MEMBERSHIP AND ATTENDANCE

The Committee is appointed by the Board from amongst the Non-Executive Directors of the Trust. During 2023/24 the Committee was chaired by Mrs Rebecca Brown.

Details of the Committee's membership and attendance during 2023/24 is set out below:

- Non-Executive Director (Chair) (Maternity and Neonatal Safety Champion)
- Non-Executive Director (Deputy Chair)
- Associate Non-Executive Director
- Director of Nursing (DIPC, Lead Director for Safeguarding)
- Medical Director (Accountable Officer for Controlled Drugs)
- Chief Operating Officer

Voting Members	18 Apr 2023	23 May 2023	20 June 2023	18 July 2023	22 Aug 2023	19 Sept 2023	17 Oct 2023	21 Nov 2023	19 Dec 2023	23 Jan 2024	20 Feb 2024	19 Mar 2024
Non-Executive Director (Mrs Brown, Chair)	X	X	X	X	X	X	X	X	X	X	X	X
Non-Executive Director (Dr Gibson)	X	A	X	X	X	X	X	X	A	X	X	X
Medical Director	X	X	X	X	X	D	X	X	X	X	X	X
Director of Nursing	D	X	X	D	X	X	X	X	A	X	X	D
Chief Operating Officer	X	D	X	X	D	X	X	X	X	X	X	X

A denotes Apologies given
D denotes Deputy in attendance
X denotes attendance

External members including representation from the Integrated Care Board also attend the Committee to provide external challenge and review.

The Committee is regularly attended by the Deputy Director of Clinical Governance and Trust colleagues are co-opted onto the Committee to offer expert opinion and assurance when required, such as the Deputy Director of Safeguarding, Head of Patient Experience, Deputy Medical Director.

A rolling programme of reporting group chair attendance at the Committee on a monthly basis is in place allowing the Chairs to offer upward reports and raise escalations to the Committee as appropriate.

REVIEW OF BUSINESS

The Quality Governance Committee work programme for 2023/24 is set out as an appendix (1) to this report.

The Quality Governance Committee has been responsible for the oversight of the following strategic objectives of the Trust in 2023/24:

- Objective 1a Deliver high quality care which is safe, responsive and able to meet the needs of the population
- Objective 1b Improve Patient Experience
- Objective 1c Improve Clinical Outcomes

During 2023/24 the Committee has utilised the Board Assurance Framework to provide focus to the meetings and ensure alignment of the agenda to the elements of the BAF.

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

Objective 1a – **GREEN**
Objective 1b – **GREEN**
Objective 1c – **GREEN**

Through the year the Committee continued to receive reports offering assurance against the strategic objectives resulting in the objectives continuing to be rated as follows at the end of the year:

Objective 1a – **GREEN**
Objective 1b – **GREEN**
Objective 1c – **GREEN**

OVERVIEW

The Quality Governance Committee has continued to, over the last twelve months, improve the assurance it can give to the Board that there is an effective system of quality governance and internal control across the clinical activities of the Trust. The Committee has reported its progress to the Board through upward assurance reports, reporting progress against the delivery of the work plan, as defined by the terms of reference through this annual report.

The Committee continues to receive monthly assurance/exception reports from the reporting groups offering assurance on effective quality governance within the Trust.

Patient stories continued to be received by the Committee demonstrating the commitment of the Trust to deliver the best patient care however, on occasion stories of a negative nature were received. From these learning was achieved and service improvements made.

There has also been an increase in the levels of assurance received in respect of Patient Experience with positive progress being made in respect of activity within the Trust and assurances provided to the Committee.

The Committee has been well attended by members during the year with a rolling programme in place for the Chair's of the reporting groups to attend the Committee and offer assurance on the relevant aspects of work.

The Chair and Executive Lead meet monthly to agree the forthcoming committee agenda in line with the work programme.

Key areas of focus of the Committee have included:

- CQC Inspection reports and outcomes
- Mortality
- Harm Reviews
- Never Events
- Serious Incident Reviews
- Patient Safety Incident Framework
- Infection, Prevention and Control
- CNST Maternity Scheme
- Maternity and Neonatal
- Medicines management
- Safeguarding arrangements
- Palliative and End of Life Care

The Committee continued to have a focus on Maternity and Neonatal services following the introduction of the Maternity and Neonatal Oversight Group in 2021/22 due to the ongoing high level national oversight. The meeting continues to be attended by the Non-Executive Director Maternity Safety Champion which offers greater assurance to the Committee and the Trust Board.

Detailed upward reports and supporting documents continued to be received by the Committee in line with reporting from the Group with reports offered to the Board, alongside supporting documents where necessary.

During the course of the year assurances continued to be received in respect of Infection Prevention and Control with continued improvement seen across the year. Whilst there were noted increases in communicable diseases the Committee was assured that these increases were being seen in line with the national position.

The Committee continued to receive a lack of assurance in respect to Medicines Management however noted the continued development of the Medicines Quality Group and, through presentation by the Pharmacy Team, were able to gain further assurance of the actions in place to address ongoing concerns.

Significant progress on internal audit recommendations was seen with the closure of all outstanding audit recommendations achieved in year.

During the course of the year the Clinical Effectiveness Group continued to make progress with both local and national audit achievement alongside improved assurances being offered to the Committee.

Risks

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

The Committee was pleased to note the continued utilisation of the revised format of the risk register which presented a dynamic report to the Committee demonstrating movement of risks throughout the course of the year.

Performance Review

The Committee reviews performance against the agreed quality Key Performance Indicators and the actions being taken to recover where necessary. The KPIs monitored by the Committee cover harm free care, improving patient experience and improving clinical outcomes.

The Committee have actively ensured that the KPIs requiring monitoring by the Committee were reported. At each of the meetings during 2023/24 the Committee considered all aspects of the performance report and were able to identify and seek further assurance on KPIs where concerns were identified.

During 2023/24 the Committee offered oversight on the developments and introduction of the Patient Safety Incident Response Framework and was pleased to receive a number of close down reports for each stage of the work undertaken. In October 2023 the Trust implemented the Patient Safety Incident Response Framework following successful completion of the preparatory work. It was noted that reporting to the Committee would develop overtime the actions underway in year to prepare the Trust for the rollout in 2023/24.

On a monthly basis, along with all Board Committees the CQC Action plan was received and reviewed with progress noted on actions being closed and embedded. Due to the length of time actions had remained open the Committee requested that these be closed by the end of March 2024. The Committee also received, on a quarterly basis, full reports to provide governance and assurance which were offered to the Trust Board.

The Committee continued to receive reporting in respect of Duty of Candour noting that the focused approach of the Clinical Governance Team had driven forward improvements in consistency of reporting.

Due to concerns noted by the Committee in respect of progress being made by the Pharmacy Team against both risks and CQC actions, the Committee had received direct updates from the team on progress being made. Whilst it was noted that

steady progress was taking place the Committee was keen that the team consolidated a number of action plans to support further progress. International recruitment to the team was recognised as positive progress.

During 2023/24 referrals between the Board Committees were made in order to ensure that where necessary additional assurances were sought from the relevant responsible Committee in areas where responsibility for assurance extended beyond the remit of a single committee. A number of referrals to the Committee and from the Committee were made during the year offering opportunities for the Quality Governance Committee to seek further assurances.

The Quality Governance Committee is an essential element of the Trust's corporate governance structure. It works closely with the Audit Committee and the Chair of the Quality Governance Committee is also a member of the Audit Committee. The Committee received all internal audits relevant to its remit for consideration of the actions and oversight of the completion of these.

Quality Committee in Common Upward Report

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board ULHT/LCHS*
Date of Meeting	*7 May 2024*
Item Number	

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

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

Purpose

This report summarises the assurances received and key decisions made by the Quality Committee in Common. The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response.

This assurance Committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme, for both Lincolnshire Community Health Services NHS Trust (LCHS) and United Lincolnshire Hospitals NHS Trust (ULHT). The Committee worked to the 2023/24 objectives for both LCHS and ULHT and was attended by both ULHT and LCHS colleagues.

Upward Report

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

Patient Safety Group (PSG) in Common Upward Report
The Committee received and accepted the first in common upward report with **assurance** noting the positive feedback from the first meeting. A further workshop was due to be held at the end of April to support the development of the reporting groups.

Significant assurance was received by the group in respect of ULHT incident management with a verbal update offered for Duty of Candour. The

Committee noted that the position was not favourable in respect of Duty of Candour, with action being taken to ensure Divisions were completing this.

The LCHS position for Duty of Candour was positive and the Committee noted the move to the Patient Safety Incident Response Framework (PSIRF) from 1 April 2024.

Assurance was received in respect of the medical device safety position for LCHS with the Committee noting the learning being recognised by ULHT.

No assurance was received in respect of the Diabetes Task and Finish Group with the Chair of PSG writing to the Division regarding the concerns and requesting a full action plan at the next meeting.

The Committee noted the positive discussions by the Group to consider areas for consideration as deep dive topics which would support the Committee agendas.

Deep Dive Topic for discussion
The Committee considered a range of deep dive topics and the approach to identifying these for discussion noting that these would likely be identified through the reporting group upward reports.

High Profile Cases Report (ULHT)
The Committee received and accepted the joint report noting the position presented and **assurance** offered through both the written report and verbal updates provided.

Palliative and End of Life Oversight Group (ULHT)
The Committee received and accepted the report with **assurance** noting the ongoing work to ensure the deep dive has been completed for the June meeting.

Discussions at the group focused on the 3 priority areas of recognition of the dying patient, communication and education with leads being identified for each of the workstreams.

The Committee was pleased to note the completion of the NICE baseline assessment with many recommendations being met or partially met. Oversight would continue through the group.

The ability for this group to come together across the Group was noted with an open day due to take place to facilitate the development of this in the coming months.

Maternity and Neonatal Oversight Group Upward Report (UHLT)
The Committee welcomed the Director of Maternity Services to the meeting to present the report which was received with **significant assurance.**

The regional heat map presented demonstrated that Trust had improved from amber to green since January 2023 and was now placed first in the region, reflecting the improvement journey of the Trust.

The use of the Quality Improvement Library was commended by the Committee to maintain oversight of the various improvement programmes of work and to ensure there was no duplication of work.

Benchmarking against the CQC report from The Royal Surrey, who had received an outstanding rating, had been undertaken to ensure the service was able to identify areas of further focus.

Increased safeguarding referrals for unborn babies were noted resulting in an increase in workload for the service due to the significant increase. The Committee noted the quarter 3 perinatal mortality review report (appendix 1) recognising that the relevant actions would be transferred to the action log.

The Committee noted and commended the exceptional leadership within the service, reflecting on the development of the group of midwives in post to achieve the position being reported.

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

Patient Experience Group Upward Report (ULHT)/Stakeholder Engagement Group Upward Report
The Committee received and accepted the Patient Experience Group upward report with **assurance.** It was noted that the Stakeholder Engagement Group meeting was due to take place on the 29 April however had been stood down to enable the first in common meeting to take place on the 1 May.

The Patient Experience Group had received updates from the Divisions alongside patient stories relating to communication and the use of language from both positive and negative experiences.

Progress was being seen in respect of the 'hearing it your way' work with the Communications Improvement Group and the increase in the use of voluntary services was noted, along with the appointment of the Volunteer Supervisor post, funded by charitable funds.

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

Clinical Effectiveness Group in Common Upward Report
The Committee received and accepted the report with **assurance** noting the ongoing work to support the Group and the development of the reporting groups to support the Clinical Effectives Group in Common and upward reporting to the Committee.

Significant assurance was received in respect of local, regional and national audits by the group, for both ULHT and LCHS, with sustained progress being seen through the reports.

The group received the Human Tissue Authority Governance Group report which provided assurance on progress against phase 1 of the Fuller Public Inquiry. Reports would continue to be offered to the group and upwardly to the Committee.

The Committee received and approved the local and national clinal audit plans for 2024/25.

Draft Quality Account for review (ULHT/LCHS)
The Committee received the draft Quality Accounts for both ULHT and LCHS noting that these continued to be developed ahead of the publication date.

The Committee noted that the reports demonstrated the volume of work being undertaken across both Trusts to support patients.

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

Winter Overview (LCHS/UHLT)
The Committee received and accepted the report with **assurance** noting that the report offered lessons learned from the Group approach to winter planning and the continued use of this for bank holidays.

The Committee noted that this was now business as usual and moving forward a quality improvement approach would be utilised. It was recognised that whilst this was now considered business as usual, a number of the actions described had already been in place but were now being joined up across the Group.

The Committee reflected the regional feedback in relation to the Group's response to the winter period and times of pressure noting that the positive benefits of the Group were being seen.

2023-2024 Operational Plan Close Down Report and 24-25 approach (LCHS)
The Committee received the report for information noting the position presented.

2023-2024 Operational Plan March Quarter 4 Progress Update (LCHS)
The Committee received the report for information noting the position presented.

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

No items received

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

No items received

Assurance in respect of other areas

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

Risk Register – ULHT and LCHS
The Committee received and accepted the joint report with **assurance** noting that there had been a reduction to the risk associated with the risk of regulatory action, due to the closure of all 'must do' actions.

The Committee noted the movement across the risk register in a number of areas recognising the dynamic nature of the risk register and the mitigations in place for each identified risk.

CQC Assurance Report
The Committee received and accepted the report with **assurance** noting the completion of the 'must do' actions. Further work would continue on the 'should do' actions with work also underway to ensure a proactive approach to the new CQC framework.

Paediatric Audiology Services Review (ULHT)
The Committee received and accepted the report with **assurance** noting that this was due to be presented to the System Quality and Patient Experience Committee to demonstrate progress made against the review undertaken into paediatric audiology by NHS England, as a result of failings identified in standard practice in Scotland in 2023.

The Committee supported the presentation of the paper to the System Quality and Patient Experience Committee.

Topical Legal and Regulatory Update (ULHT)
The Committee received the report noting that this offered a forward view of items of interest which could be used to support future reports and discussions.

Committee Performance Dashboard (ULHT and LCHS)
The Committee received and accepted the performance reports for ULHT and LCHS with **assurance,** noting that performance had been considered through the reports presented.

Concern was noted about the appropriateness of some of the metrics and the ability to achieve the target performance however it was recognised, moving

in to the 24/25, there would be an opportunity to consider appropriate metrics and trajectories.

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

Interim ToR and Work Programme
The Committee received the interim terms of reference and work programme noting that there were no changes required at this time. Work continued on the ToR and Work Programme for the Committee to work to in the 24/25 year.

Issues where assurance remains outstanding for escalation to the Board

No escalations required.

Items referred to other Committees for Assurance

No items for referral

Attendance Summary for rolling 12-month period

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

X in attendance
A apologies given
D deputy attended

United Lincolnshire Hospitals NHS Trust

Quarterly Perinatal Mortality Review Report Qu 3 October - December 2023

Author – Samantha Tinkler – Patient Safety Lead Midwife – ULHT

Highlight Report

Continued from Quarter 2:
Year 5 CNST standards were published on 31st May 2023. These new standards came into effect for any babies that were born and died in our Trust from 30th May 2023 to 7th December 2023.

Safety Action 1:
a) All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days. For deaths from **30 May 2023,** MBRRACE-UK surveillance information should be completed within one calendar month of the death.
b) For 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from **30 May 2023** onwards.
c) For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from **30 May 2023.** 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months.
d) Quarterly reports should be submitted to the Trust Executive Board from **30 May 2023.**

Version 1.1 was published in July 2023 which included:
It is recognised that for a small number of deaths (term intrapartum stillbirths and early neonatal deaths of babies born at term) investigations will be carried out by HSIB. Your local review using the PMRT should be started but not completed until the HSIB report is complete. You should consider inviting the HSIB reviewers to attend these reviews to act as the external members of the review team, thereby enabling the learning from the HSIB review to be automatically incorporated into the PMRT review. Depending upon the timing of the HSIB report completion achieving the MIS standards for these babies may therefore be impacted by time frames beyond the Trust's control. For an individual death you can indicate in the MBRRACE-UK/PMRT case management screen that an HSIB investigation is taking place, and this will be accounted for in the external validation process.

PMRT Action Plans developed from Published reviews October – December 2023:

- Nine Perinatal Mortality Review Reports were published using the National Perinatal Mortality Review Tool (PMRT) between October and December 2023. Eight were ULHT Perinatal Mortality Reviews and one was an external review.
- One case was also declared and investigated as a Serious Incident by ULHT - ID 88151. Two were also reviewed as part of a MNSI investigation and a ULHT After Action Review (AAR). The Action Plans from theses PMRTs will be transferred into the SI/AAR Action Plans on completion.
- Six of the published reports had actions for ULHT. The issues identified which required actions are as listed below.

Main themes from reviews in which the issues raised are relevant to the death or are of concern but not directly relevant to the death:

1. The opportunity to take their baby home was not offered to the parents as there is no local policy for this in 6/9 cases.
2. This mother and her partner were not able to be cared for in either a sound proofed room or a room away from other mothers and crying babies because the necessary facilities are not available in 5/9 cases.
3. The baby had to be transferred elsewhere for the post-mortem in 3/9 cases.
4. This mother had a growth restricted baby (defined by estimated fetal weight <10th centile or reduced growth velocity on ultrasound) during her pregnancy which was not managed according to national or local guidelines in 2/9 cases.

Good practice identified from all cases:

- Identifying the need for neonatal observations following birth due to maternal medication.
- Having a clear booking plan which was made by both the Midwife and Obstetric Registrar
- Good Individualised care - Current treatment practice is Acyclovir three times a day from 36 weeks – plan to continue once a day throughout pregnancy is appropriate due to recurrence if stopped.
- A letter to GP for follow up and action the low ferritin level for clarification was sent.
- The location of appointments according to the woman's choice was arranged.
- Midwife called to check and clarify the administration of prescribed medications.
- Bloods were taken for raised CO, when reportedly not a smoker.
- Anything above 4% would require a repeat – correct practice.
- Good documentation of discussion regarding raised CO levels and sources of higher levels of carbon monoxide. Repeat bloods 3.2% - within normal limits and therefore no follow up is expected.
- Lack of translation service available however, good practice that staff did regularly continue to attempt to get a translator.
- Positive note, that the midwife used a pinnard to auscultate first.

United Lincolnshire Hospitals NHS Trust

Quarterly Report for Perinatal Mortality Cases October - December 2023

Author - Samantha Tinkler – Patient Safety Midwife – February 2024

Baby Losses Requiring Perinatal Mortality Review for October - December 2023

Hospital	Loss Category	Date	Gestation	Case Summary	MBRRACE Case No.	Mortality DATIX number	Taken to Panel Declared PSII/MNSI
PHB	Late fetal loss	04/10/23	23+4/40	P1, 39 years old, reduced FM at 20 weeks, seen again at 23+ and no fetal heart heard.	89735	42	No
LCH	Late fetal loss	06/10/23	23+5/40	P1, Laser Ablation for MCDA Twins at 17 weeks. Twin 1 passed away following deterioration in mothers clinical condition.	89749/1	341	Yes MNSI
LCH	Late fetal loss	06/10/23	23+5/40	P1, Laser Ablation for MCDA Twins at 17 weeks. Twin 2 passed away and confirmed at 22+1 weeks gestation.	89749/2	341	Yes MNSI
LCH – External.	Neonatal Death	06/10/23	21+6/40	P1+1, MCDA Twins, Laser Ablation at 20/40, Spontaneous labour and birth. Surveillance only requested for MBRRACE.	External - 89774	NA	No
PHB	Stillbirth	15/10/23	40+6/40	P1, RFM in labour, No FH on USS.	89865	907	No
LCH - External	Neonatal Death	08/10/23 received 17/11/23	23+6/40	35 years old, recent covid +ve, Extreme preterm spontaneous delivery at home, not booked at ULHT, booked at other Trust. Baby transferred – RIP.	External - 89796	493	No
LCH - External	Neonatal Death	19/10/23	37+4/40	P1, 36 years old, Known fetal abnormalities. Baby RIP – Undiagnosed cardiac abnormalities identified at birth.	External - 89998		No

		received 20/12/23					
LCH	Neonatal Death	11/11/23	23/40	P1+1, 33 years old, BMI 37.4, Previous LLETZ, Suture in at 18/40, Spontaneous labour 23+4/40. Baby RIP at 13 minutes of age.	90356	300	No
PHB - External	Neonatal Death	09/12/23 received 10/12/23	33+1/40	In-utero transfer from PHB at 33+1/40 with possible spontaneous rupture of membranes and tightening. Known fetal anomaly. Planned birth at Tertiary Centre. Covid +ve in pregnancy. Category 1 caesarean section at 33+3/40, transferred to their neonatal unit but sadly died.	External - 90765	494	No
PHB	Stillbirth	20/12/23	40/40	Concealed pregnancy, Born at home. Parents reported no signs of life. CPR performed by parents, EMAS and air ambulance.	91011		No
LCH	Stillbirth	31/12/23	24+3/40	Oligiohydrmnios, 3rd centile and abnormal UTAD at 22+6. Absent EDF at 24+1/40. Reduced fetal movements. Seen in Tertiary unit 24+2/40, No fetal heart, transferred back to LCH.	91165		No

Total Cases to Commence the Perinatal Mortality Review Process October - December 2023

Hospital	No of Stillbirths	No of Late Fetal losses	No of Neonatal Deaths	Total Perinatal Mortality Review required for ULHT	Total Perinatal Mortality Review required for External cases.	Total
Pilgrim	2	1	0	3	1	4
Lincoln	1	2	1	4	3	6
Total	3	3	1	7	4	11

Update on position of all outstanding (ULHT and External) Perinatal Mortality Reviews for 2022

Hospital	Loss Category	Gestation	Date Request Received	MBRRACE Case No.	PMRT MDT meeting held	Report Published by Lead Trust
LCH - External	SB	31+3	17/11/2022	83449	28/12/2022	Not yet published
PHB - External	NND		07/12/2022	84845	16/01/2023	Not yet published

Update on position of all ULHT Perinatal Mortality Reviews for 2023

Hospital	Loss Category	Gestation	Date of birth/death	MBRRACE Notified	MBRRACE Case No.	PMRT start date	PMRT draft date	Report Published (narrative if required)
LCH	LFL	22+	02/01/2022	03/01/2023	85298/1	19/01/2023	25/04/2023	30/06/2023
LCH	NND	22+	02/01/2022	03/01/2023	85298/2	19/01/2023	25/04/2023	30/06/2023
LCH	Intrapartum SB	38+	30/01/2022	30/01/2023	85843	27/01/2023	18/05/2023	SI and HSIB investigation PMRT published 24/07/2023
PHB	NND	Born at 37	04/02/2023	10/02/2023	86035	29/03/2023	01/06/2023	03/08/2023 Includes external input.
PHB	SB	29	09/02/2023	10/02/2023	86036	27/02/2023	19/05/2023	25/07/2023
PHB	Intrapartum SB	39	03/03/2023	06/03/2023	86356	02/05/2023	30/06/2023	05/09/2023 – 2 days overdue publication date – is not included in Year 5 CNST data. SI and HSIB investigation
LCH	SB	26+5	12/03/2023	20/03/2023	86590	04/04/2023	07/07/2023	11/09/2023
LCH	LFL	23+4	23/03/2023	29/03/2023	86720	11/04/2023	22/07/2023	22/09/2023

LCH	SB	27+0	25/04/2023	02/05/2023	87242	09/05/2023	24/08/2023	20/10/2023
PHB	SB	34+0	25/05/2023	30/05/2023	87679	30/05/2023	22/09/2023	17/11/2023
LCH MIS Year 5	SB	39+2	15/06/2023	20/06/2023	88052	03/07/2023	12/10/2023	22/11/2023
LCH MIS Year 5	NND	At 22+1	26/06/2023	28/06/2023	88151	17/07/2023	25/10/2023	31/10/2023
PHB MIS Year 5	NND	At 21+1	03/07/2023	06/07/2023	88274	07/07/2023	Due 02/11/2023 – 25/10/2023 Reassigned back to Birmingham as some data missing. Draft -21/12/2023 - Not eligible to fit criteria as more than more Trust involvement was required and assigned as appropriate.	Due 03/01/2024 Pre-published 21/12/2023 - may be published after 04/01/2024 once other Trusts have reviewed. Published 08/01/2023 PMRT not included in data as does not fit criteria for review as baby under 22 weeks gestation.
LCH MIS Year 5	SB	24+5	08/08/2023	11/08/2023	88794	26/09/2023	24/11/2023	23/01/2024
LCH MIS Year 5	SB	33+2	23/08/23	24/08/2023	89076	18/09/2023	31/10/2023	31/10/2023
LCH MIS Year 5	SB	37	03/09/2023	05/09/2023	89249	26/09/2023	15/12/2023	15/12/2023
LCH MIS Year 5	SB	34	30/09/2023	05/10/2023	89722	14/11/2023	26/01/2024	Due 29/03/2024
PHB	LFL	Confirmed at 23+4	04/10/2023	05/10/2023	89735	28/11/2023	30/01/2024	Due 03/04/2024

LCH	LFL	23+5	06/10/2023	06/10/2023	89749/1	03/12/2023	29/12/2023	29/12/2023
LCH	LFL	Confirmed at 22+1	06/10/2023	06/10/2023	89749/2	03/12/2023	29/12/2023	29/12/2023
PHB	SB	40+6	15/10/2023	16/10/2023	89865	29/11/2023	14/02/2024	Due 14/04/2024
LCH	NND	23+4	10/11/2023 – both birth and death	13/11/2023	90356	27/11/2023	Due 09/03/2024	Due 09/05/2023
PHB	SB	Estimated Term	19/12/2023	22/12/2023	91011	06/02/2024	Due 18/04/2024	Due 18/06/2024
LCH	SB	24+3	31/12/2023	03/01/2024	91165	30/01/2024	Due 30/04/2024	Due 30/06/2024

Update on position of all received External Perinatal Mortality Reviews for 2023

Hospital	Loss Category	Gestation	Date Request Received	MBRRACE Case No.	PMRT MDT meeting held	PMRT Returned	Report Published by Lead Trust
PHB	NND	Born at 27	04/01/2023	83477	30/01/2023	15/02/2023	10/03/2023
PHB	NND	Born at 23+5	06/04/2023	86825	22/05/2023	31/05/2023	Not yet published
LCH	NND	Born at 36+6	11/04/2023	86868	24/04/2023	16/05/2023	Not yet published
LCH	Stillbirth	30+6	12/07/2023	88096	31/07/2023	02/08/2023	23/11/2023
LCH	NND	Born 29+6	03/08/2023	88727	Obstetric - 18/09/2023 Neonatal – 11/10/2023	01/11/2023	Not yet published
LCH	NND	Born at 25	30/11/2023	87540	Obstetric – 11/12/2023 Neonatal – 19/12/2023	21/12/2023	Not yet published
LCH	NND	Born 23+3	17/11/2023	89796	19/11/2023	Returned automatically 12/01/2024	Not yet published
PHB	NND	Born at 33+3	10/12/2023	90765	15/01/2023	16/01/2023	Not yet published
LCH	NND		20/12/2023	89998	22/01/2024	26/01/2023	Not yet published

Compliance according to Year 5 CNST standards for Quarter 3 – October - December 2023:

Required standard for babies that were suitable for review:	Year 5 CNST required %	ULHT %
Percentage of eligible perinatal deaths reported to MBRRACE within 7 working days.	100%	100%
Percentage of surveillance completed for eligible perinatal deaths within 1 month.	100%	100%
Percentage of eligible perinatal death reviews using the PMRT started within 2 months.	95%	100%
Percentage of eligible baby deaths reviewed using the PMRT.	100%	100%
Percentage of eligible baby deaths that were reviewed by an MDT.	100%	100%
Percentage of eligible baby deaths reviewed that had a draft generated within 4 months of their death.	60%	100%
Percentage of eligible baby deaths reviewed that had a report published within 6 months of their death.	60%	100%
Percentage of babies whose parents' were informed of the review and their perspectives sought.	95%	100%

Year 5 CNST standards from MBRRACE/PMRT for the time period 30th May 2023 – 07th December 2023:

Case ID	Review status	Factual questions currently completed (%)	Eligible for CNST standards	Working days to notify	Surveillance in standard	Review in standard	Standard a surveillance complete	Standard b parents informed	Standard b parents input sought	Standard c review started	Standard c report drafted	Standard c report published
90356	Reviewing	100%	Yes	1	Yes	Yes	Met	Met	Met	Met	Not applicable	Not applicable
90352	Review not supported	Not applicable	Notification only	0								
89865	Writing report	100%	Yes	0	Yes	Yes	Met	Met	Met	Met	Met	Not applicable
89749	Review complete	100%	Yes	0	Yes	Yes	Met	Met	Met	Met	Met	Met
89749	Review complete	100%	Yes	0	Yes	Yes	Met	Met	Met	Met	Met	Met
89735	Writing report	100%	Yes	1	Yes	Yes	Met	Met	Met	Met	Met	Not applicable
89722	Writing report	100%	Yes	2	Yes	Yes	Met	Met	Met	Met	Met	Not applicable
89470	Review not supported	Not applicable	Notification only	2								
89249	Review complete	100%	Yes	1	Yes	Yes	Met	Met	Met	Met	Met	Met
89076	Review complete	100%	Yes	1	Yes	Yes	Met	Met	Met	Met	Met	Met
88973	Review not supported	Not applicable	Notification only	3								
88794	Review complete	100%	Yes	3	Yes	Yes	Met	Met	Met	Met	Met	Met
88274	Review complete	100%	Yes	3	Not eligible as surveillance assigned	Not suitable for review						
88151	Review complete	100%	Yes	2	Yes	Yes	Met	Met	Met	Met	Met	Met
88052	Review complete	100%	Yes	3	Yes	Yes	Met	Met	Met	Met	Met	Met
87986	Review not supported	Not applicable	Notification only	2								

PMRT Action Plans developed from Published reviews October – December 2023

Nine Perinatal Mortality Review Reports were published using the National Perinatal Mortality Review Tool (PMRT) between October and December 2023. Eight were ULHT Perinatal Mortality Reviews and one was an external review.

One case was also declared and investigated as Serious Incidents by ULHT - ID 88151. Two were also reviewed as part of a MNSI investigation and a ULHT, After Action Review (AAR). The Action Plans from theses PMRTs will be transferred into the SI/AAR Action Plans on completion.

Six of the published reports had actions for ULHT. The issues identified which required actions are as listed below. Further narrative can be found in Appendix 1.

ULHT Cases - issues identified as relevant to the outcome or requiring actions:

MBRRACE 87242:

Relevant but managed appropriately:

1. The opportunity to take their baby home was not offered to the parents as there is no local policy for this
2. The baby had to be transferred elsewhere for the post-mortem
3. This mother and her partner were not able to be cared for in either a sound proofed room or a room away from other mothers and crying babies because the necessary facilities are not available

Relevant and future action needed:

1. A Community Midwife visited the mother not knowing that her baby had died and spoke to the mother thinking she had her baby with her.

Not relevant to the outcome, but action is needed:

1. The Obstetric Consultant was not escalated to or requested to attend when the Registrar was busy in another birth.
2. Maternity Early Warning Score was not completed in Antenatal Clinic when a BP was abnormally raised.
3. This mother had a growth restricted baby (defined by estimated fetal weight <10th centile or reduced growth velocity on ultrasound) during her pregnancy which was not managed according to national or local guidelines
4. This mother had a pre-existing condition(s) which required specific medication which was not given
5. There was no follow up discussion regarding the compliance of taking Aspirin.
6. The mother did not have her bloods repeated postnatally when required.

MBRRACE 87679:

Relevant but managed appropriately:

1. This mother lives with family members who smoke but they were not offered referral to smoking cessation services because there is no service available
2. The baby had to be transferred elsewhere for the post-mortem

Not relevant to the outcome, but action is needed:

1. It is not local guidance to advice supplementations when women are unable to tolerate Ferrous Sulphate.
2. This mother had poor/no English and family members were used as interpreters on occasions during her antenatal care
3. Obstetric Registrar Doctors caring for Sabine are not likely to have had the surgical knowledge regarding paralytic ileus and the siting of NGT.

MBRRACE 88052:

Relevant but managed appropriately:

1. The opportunity to take their baby home was not offered to the parents as there is no local policy for this
2. The baby had to be transferred elsewhere for the post-mortem

Not relevant to the outcome, but action is needed:

1. Patient documented as needle phobic incorrectly.
2. Disjointed multi-professional working in regards to the management of GDM.
3. This mother and her partner were not able to be cared for in either a sound proofed room or a room away from other mothers and crying babies because the necessary facilities are not available

MBRRACE 88151:

Relevant but managed appropriately:

1. The opportunity to take their baby home was not offered to the parents as there is no local policy for this

2. It is not possible to assess from the notes whether chest compressions were indicated and administered appropriately during the resuscitation of the baby

Relevant and future action needed:

1. This mother did not give birth in a setting appropriate to her and/or her baby's clinical needs
2. This mother had preterm labour or had preterm pre-labour rupture of membranes during her pregnancy and there was a delay in the diagnosis
3. This mother had preterm labour or had preterm pre-labour rupture of membranes during her pregnancy which was not managed according to national or local guidelines
4. During the stabilisation of the baby the stabilisation/support was not carried out appropriately
5. This mother and her partner were not able to be cared for in either a sound proofed room or a room away from other mothers and crying babies because the necessary facilities are not available

MBRRACE 89076:

Relevant but managed appropriately:

1. This mother booked late. Did this affect her care?

Relevant and future action needed:

1. This mother had a risk factor(s) for having a growth restricted baby but serial scans were not performed at correct times/intervals

Not relevant to the outcome, but action is needed:

1. The opportunity to take their baby home was not offered to the parents as there is no local policy for this
2. This mother and her partner were not able to be cared for in either a sound proofed room or a room away from other mothers and crying babies because the necessary facilities are not available

MBRRACE 89249:

Relevant and future action needed:

1. This mother had a growth restricted baby (defined by estimated fetal weight <10th centile or reduced growth velocity on ultrasound) during her pregnancy which was not managed according to national or local guidelines
2. The baby was small for gestational age at birth and had been identified as IUGR prenatally but the management was not appropriate

Not relevant to the outcome, but action is needed:

1. The opportunity to take their baby home was not offered to the parents as there is no local policy for this
2. This mother's progress in labour was not monitored on a partogram
3. This mother and her partner were not able to be cared for in either a sound proofed room or a room away from other mothers and crying babies because the necessary facilities are not available

MBRRACE 89749/1:

Relevant but managed appropriately:

1. The opportunity to take their baby home was not offered to the parents

Relevant and future action needed:

1. National and local guideline to be reviewed in relation to ablation, fetal demise and change in VTE risk.

MBRRACE 89749/2:

Not relevant to the outcome, and no action is needed:

1. The opportunity to take their baby home was not offered to the parents

Relevant and future action needed:

2. National and local guideline to be reviewed in relation to ablation, fetal demise and change in VTE risk.

External Cases - issues identified as relevant to the outcome or requiring actions:

MBRRACE 88096:

- No relevant issues or actions required from the ULHT perspective.

Good Practice identified from all cases:

- Identifying the need for neonatal observations following birth due to maternal medication.
- Having a clear booking plan which was made by both the Midwife and Obstetric Registrar
- Good Individualised care - Current treatment practice is Acyclovir three times a day from 36 weeks – plan to continue once a day throughout pregnancy is appropriate due to recurrence if stopped.
- A letter to GP for follow up and action the low ferritin level for clarification was sent.
- The location of appointments according to the woman's choice was arranged.
- Midwife called to check and clarify the administration of prescribed medications.
- Bloods were taken for raised CO, when reportedly not a smoker.
- Anything above 4% would require a repeat – correct practice.
- Good documentation of discussion regarding raised CO levels and sources of higher levels of carbon monoxide. Repeat bloods 3.2% - within normal limits and therefore no follow up is expected.
- Lack of translation service available however, good practice that staff did regularly continue to attempt to get a translator.
- Positive note, that the midwife used a pinnard to auscultate first.
- Timely instigation of the massive rapid haemorrhage policy given the clinical situation.
- Appropriate retrospective documentation given the emergency clinical situation.
- Communication and team working was excellent.
- As the mother was not able to understand English fully, her sister translated whilst still trying to get translation services – the inability to get a translator did not delay the care provided and the team worked promptly to the emergency situation and appropriately used a family member given the clinical situation.
- Timely reviews by the Registrar and escalation to Anaesthetist when patient had continued pain.
- Documentation of handovers show really good detail of the clinical situation.

Grading of care for Late Fetal Losses and Stillbirths – 7 cases:

- There were no stillbirths and late fetal losses with issues with care likely to have made a difference to the outcome of the baby.

Grading of care for Neonatal Deaths – 1 case:

- There were no neonatal and post-neonatal deaths with issues with care likely to have made a difference to the outcome for the baby.

Main themes from reviews in which the issues raised are relevant to the death or are of concern but not directly relevant to the death:

1. **The opportunity to take their baby home was not offered to the parents as there is no local policy for this in 6/9 cases:**
    - Reviewing service provision and creating a Standard Operating Procedure (SOP) to facilitate this. Current provisions enable the parents to take their babies home if they do not wish a Post Mortem and are making private funeral arrangements. However, we are unable to facilitate return of the baby to the hospital unless the parents bring their baby back themselves. This does not show compassion and consideration, we are therefore reviewing the current contract ULHT has with funeral directors to add collection of babies to the contract. The head of bereavement services is reviewing the current tender. This work is still ongoing and a SOP will be developed when finalised.

2. **This mother and her partner were not able to be cared for in either a sound proofed room or a room away from other mothers and crying babies because the necessary facilities are not available in 5/9 cases:**
    - Significant estates improvements required, ongoing work required into the provision of sufficient facilities. New development of Labour Ward at Lincoln is planned. Building work has now been complete at Pilgrim Hospital and the bereavement suite is being utilised. Bereavement fridges are in place to facilitate the babies remaining on the Labour Ward whilst mum is an inpatient. Previous provisions did not enable this and allow for parents to see their baby at any time and to keep the babies at appropriate temperatures to slow deterioration whilst not with parents. However, the bereavement fridges cannot be used at this present time. Pilgrims fridge was anticipated to be in use when the bereavement room had been completed. However, there are issues related to alarm systems which need to be resolved prior to usage and with the security access to the rooms where he fridges are stored. We are currently unsure when Lincoln's will be in use due to current plans for Labour Ward movement and development. We have delayed commissioning use at present as we do not want to allocate the financial resources required. Installing the fridge now would not be cost effective or a good use of materials and resources as it is intended the fridge will be relocated

3. **The baby had to be transferred elsewhere for the post-mortem in 3/9 cases:**
    - ULHT do not have the facility to perform post-mortem examinations and therefore these examinations are contracted out to external facilities. Although, this is relevant to the family it is managed appropriate as the service is provided externally.

4. **This mother had a growth restricted baby (defined by estimated fetal weight <10th centile or reduced growth velocity on ultrasound) during her pregnancy which was not managed according to national or local guidelines in 2/9 cases:**
    - One patient was on holiday when the scan should have taken place which delayed the growth scan and it was documented be booked on a bank holiday. This scan was never booked when the original date was suggested which would have highlighted that it was the bank holiday and then the following day could have been booked as an alternative. A process needs to be developed to prevent this from occurring. This may have made a difference to the outcome. Guidance needs to be developed around the booking of scans during a bank holiday period.
    - Antenatal management for growth restriction <3rd centile was not appropriate in one case. Referral to the fetal medicine clinic would have been appropriate given findings of fetal growth restriction < 3rd centile, in line with local guidance. This is not relevant to the outcome but an action is required as this may have been significant in other situations. Action to clarify and confirm the local pathway for women with a baby identified with an estimated fetal weight below the 3rd centile in regards to referral for local/tertiary fetal medicine review.

5. **All other issues raised occur in only 1/9 cases**

APPENDIX 1

Further information for all issues, actions and grading of care of the published reports in Quarter 3 23/24 can be found in:

Quater 3 published Issues, Actions log f

APPENDIX 2

Further information for all plans for the perinatal mortality review progress can be found in the PMRT Action Plan:

PMRT Action Plan.xlsx

United Lincolnshire Hospitals NHS Trust

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*7 May 2024*
Item Number	*8.2*

Paediatric Audiology Services within United Lincolnshire Hospitals NHS Trust

Accountable Director	*Julie Frake-Harris, Chief Operating Officer*
Presented by	*Kathryn Helley, Director of Governance* *Julie Frake-Harris, Chief Operating Officer*
Author(s)	*Jeremy Daws, Head of Compliance* *Michael Woods, Head of Service for Audiology*
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	
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	*Moderate*

Recommendations/ Decision Required	• *Trust Board are asked to note the background and assurances available in respect of Paediatric Audiology services.*

Executive Summary

Background:

- An expert review was undertaken by subject matter experts from the British Academy of Audiology (BAA) on behalf of NHS Lothian in Scotland which found failings in the standard of paediatric audiology services that resulted in delayed identification and missed treatment of children with hearing loss. This resulted in permanent, avoidable deafness for some children.
- These findings led to a review of the Neonatal and diagnostic ABR service provided by NHS trusts in England which found 4 Trusts with similar failing.
- In response to the national context, and due to many of the subject matter experts from the BAA working within the Midlands, the Midlands region established a paediatric audiology desktop review model and used this within the region. The Trust participated in full with this review.
- A paper summarising the Trust's compliance with BSA standards in response to the Midlands Region desktop review has been upwardly reported to the Trust's Quality Committee on the 23 April 2024 and to the Integrated Care Board (ICB) System Quality Meeting on the 1 May 2024. In response to this, the Trust and the ICB have agreed the Trust's Paediatric Audiology Service meets the required standards assessed by the Midlands desktop review and was therefore rated green.

CQC Request for Board Assurance:

- On the 8 April 2024, CQC wrote to the Trust requesting that at the Trust's next full Board meeting, consideration was given to the assurance available to it that children's hearing services are safe, accessible and effective. Subsequent to the Board's review of this area, CQC have requested a report from the Board.
- This paper provides a detailed response to CQC. In summary the following is reported:
    - The Trust begun the process to achieved UKAS IQIPS accreditation for paediatric audiology services and is currently at the stage of completing the IQIPS desktop analysis with a UKAS IQIPS case manager. It is being forecast that this will be complete by September 2024.
    - In the interim of full IQIPS accreditation, the Trust Board have assurances about paediatric audiology from the Midlands Region desktop review (reported to Quality Committee and ICB System Quality Meeting), and,
    - Existing work commenced already, prior to the Lothian incident, by the service to track progress against compliance with the British Academy of Audiology (BAA) Quality Standards, published in 2022. This work is transferrable to IQIPS and will support the IQIPS desktop gap analysis process.
- The expected timeline for gaining accreditation is estimated to take between 3 – 5 years due to the likelihood that building works/refurbishment will be required to meet the IQIPS standards.
- CQC have requested 'consideration by the full board at the next meeting. An initial response should be sent to CQC no later than 30 June 2024. A subsequent response should follow after the next full board meeting'. As the full board meeting is taking place on 7 Ma7 2024, this fulfils the requirement of both the initial response and subsequent response.
- Based on this, the Trust Board:-
    - is asked to note the background and assurances available in respect of Paediatric Audiology services.

United Lincolnshire Hospitals NHS Trust

Paediatric Audiology Services within United Lincolnshire Hospitals NHS Trust

National Context:

- An expert review was undertaken by subject matter experts from the British Academy of Audiology (BAA) on behalf of NHS Lothian in Scotland which found failings in the standard of paediatric audiology services that resulted in delayed identification and missed treatment of children with hearing loss. This resulted in permanent, avoidable deafness for some children.

- These findings led to a review of the Neonatal and diagnostic ABR service provided by NHS trusts in England which found 4 Trusts with similar failing.

- A Paediatric Hearing Services Improvement Programme has been established by NHS England to support providers and integrated care boards (ICBs) to improve the quality of these services. The programme is undertaking work to understand the scale of the problem and the number of children who have been affected, and to develop the strategic tools and interventions to support sustainable improvements.

- The total number of children with permanent deafness reported to be on services' caseloads has decreased by more than 7% since 2019. The incidence of permanent deafness generally remains stable, so this may suggest that some children have not yet been identified.

Local / Regional Context:

- In response to the national context, and due to many of the subject matter experts from the BAA working within the Midlands, the Midlands region established a paediatric audiology desktop review model and used this within the region. The Trust participated in full with this review.

- The findings from this were subsequently shared with NHS England. The paediatric audiology desktop review has since spread to other regions and is in use to assess the standard of paediatric audiology services within these other geographical regions.

- The findings from the Trust's review found that the Paediatric Visual Reinforcement Audiometry (VRA)[1] rooms are in line with British Society of Audiology (BSA) guidance, with the layout of the rooms meeting the base level requirements with appropriate mitigations around sound proofing.

- The desktop review identified some gaps in documentation and audit processes. These have been fully responded to and now closed.

- A paper summarising the Trust's compliance with BSA standards in response to the Midlands Region desktop review has been upwardly reported to the Trust's Quality Committee on the 23 April 2024 and to the Integrated Care Board (ICB) System Quality Meeting on the 1 May 2024. In response to this, the Trust and the ICB have agreed the Trust's Paediatric Audiology Service meets the required standards assessed by the Midlands desktop review and was therefore rated green.

Care Quality Commission (CQC) Request:

- Given the national context, CQC are working closely with NHS England to help understand the current situation across the country regarding the level of assurance boards have about the quality of hearing services for children.

- On the 8 April 2024, CQC wrote to the Trust, a copy of the correspondence is attached in **appendix 1.**

- Within this, CQC requested that at the Trust's next full Board meeting, consideration was given to the assurance available to it that children's hearing services are safe, accessible and effective. Subsequent to the Board's review of this area, CQC have requested a report from the Board that makes the following points clear:

    1. *Whether the Trust have achieved IQIPS[2] accreditation, including whether there were any improvement recommendations made.*
    2. *Whether the Trust are working towards IQIPS accreditation.*
    3. *What stage that work has reached and the assurance the Board has about paediatric audiology, using the IQIPS standards as a guide for the areas to tell us about.*

[1] VRA is a behavioural test for young children. It is central to completion of the diagnostic process for those hearing-impaired infants identified by newborn screening. A key component to the test is the adequacy of the room used to undertake VRA. The British Society of Audiology (BSA) have produced detailed guidance on this and other aspects of the diagnostic testing process.

[2] The UKAS IQIPS (Improving Quality in Physiological Services) is the only recognised accreditation standard for physiological science services inclusive of audiology services. Whilst accreditation cannot be mandated by CQC, they strongly encourage participation in UKAS diagnostic accreditation schemes, including IQIPS. Participation and performance in such schemes are evidence of good practice that is used to inform CQC's judgements about the safety and quality of care.

4. *The expected timeline for gaining accreditation.*
5. *The number and severity of incidents where a child has suffered detriment due to delayed or missed diagnosis or treatment or not received timely follow up care and support.*

- In addition, CQC have also requested:
    - *"NHS England have asked that where services that are **not** UKAS IQIPS accredited, heads of services should provide an external evidence-based assessment of their provision. If your services are not UKAS IQIPS accredited, we would like you to include a copy of that assessment report when responding to this letter.*
    - *Boards may be aware that UKAS have a benchmarking tool for provider of audiology services considering accreditation to help them understand what stage they are at and where the focus of work may need to be. Please can you supply a copy of the completed tool if you have used it."*
- CQC have clarified that this response from the Trust will be used alongside wider evidence held by CQC about providers to inform and determine risk levels. At present CQC are not planning on undertaking stand-alone inspections on this service.
- An initial response is required by CQC **no later than 30 June 2024**. A subsequent response should follow after the next full board meeting.

Update for Trust Board as at the 30 April 2024:

- ***Point 1:*** ***Whether the Trust have achieved IQIPS accreditation, including whether there were any improvement recommendations made.***

- **Trust Response:**
- The Trust has not yet achieved UKAS IQIPS accreditation for paediatric audiology services, however, the process to become accredited has commenced with the following steps having been taken already:

    - The Trust have applied for and completed registration with UKAS.
    - The Trust has received a draft contract from UKAS and has submitted this to the Trust's Contracting Team for review. Once happy, this can be signed and returned.
    - Purchase order has been submitted by the service, but has not yet been paid by the Trust, the service are waiting for ULHT accounts team to process.
    - Senior team booked to attend IQIPS assessment course on the 10 July to have a better understanding of the process / steps to be taken. A requisition has been submitted and approved for this purpose.

- Whilst the above steps have been completed, additional actions are now needed to achieve IQIPS accreditation. Some of these will require resourcing:

    - IQIPS to assign the Trust a case manager to support the next elements of the process.
    - Working with the IQIPS case manager, undertake desktop gap analysis of the ULHT service (£13k funding required to IQIPS. If budgets for 24/25 remain the same as 23/24, this will be funded by the service). The service are forecasting that this stage can be completed by September 2024. A copy of the UKAS IQIPS gap analysis document is supplied in **appendix 2** and the corresponding IQIPS standards are available as **appendix 3** with **appendix 4** providing associated help guidance.
    - Agree actions in response to gaps identified from desktop gap analysis, work through and complete.
    - Repeat desktop gap analysis and compile evidence to demonstrate compliance and submit to IQIPS.

- IQIPS undertake site visit to observe practice, review facilities and generally seek assurance of compliance following desktop reviews and review of ULHT evidence.
- IQIPS accreditation awarded (£30k annual funding required to IQIPS to retain accreditation).
- **NB:** The service are forecasting that the whole process could take between 3-5 years, given the finite staffing resource within the service and the likelihood that building works/refurbishment will be required to meet the IQIPS standards (i.e. enhancement of the Paediatric Visual Reinforcement Audiometry (VRA) rooms to ensure these meet gold standards for sound proofing). Other gaps identified by the desktop gap analysis review will also need resolution before accreditation can be granted.

- ***Point 2:* Whether the Trust are working towards IQIPS accreditation.**

- **Trust Response:**
- As described in response to point 1, the Trust are working towards IQIPS accreditation.

- ***Point 3:* What stage that work has reached and the assurance the Board has about paediatric audiology, using the IQIPS standards as a guide for the areas to tell us about.**

- **Trust Response:**
- As described in response to point 1, the Trust has reached the stage where they are ready to undertake the desktop gap analysis with a UKAS IQIPS case manager. This will be against the IQIPS standards. Further Board assurance will be available on completion of this which is forecast to be September 2024.

- In the interim of full IQIPS accreditation, the Trust Board have the following assurances about paediatric audiology:

  - The findings from the Midlands Region desktop review undertaken in comparison against the British Society of Audiology (BSA) standards. This has been upwardly reported to the Trust's Joint Quality Committee and to the ICB System Quality Meeting, during April and May 2024. The ICB agree that the Trust is now rated green.

  - Prior to the national incident and proactively in response to the publication of the British Academy of Audiology (BAA) Quality Standards in 2022, the Trust have been working towards these standards, tracking progress using an internally RAG rated

assurance document. Whilst the BAA Quality Standards are not the same as the IQIPS standards, this work is transferrable to IQIPS and will support the IQIPS desktop gap analysis process.

- Progress from this has been verbally reported as part of the Clinical Support Services (CSS) Governance Structure and included in upward reporting via the Trust's Performance reporting structure (PRM). The service will improve the assurance available from this internal work, by submitting this document in support to the verbal updates currently provided.

- ***Point 4: The expected timeline for gaining accreditation.***

- **Trust Response:**
- As described in response to point 1, the Trust are working towards IQIPS accreditation, and the steps remaining to gain accreditation, are forecast to take between 3 and 5 years. Once the gap analysis is complete, this will be reviewed to determine what actions can be taken to shorten this timescale.

- ***Point 5: The number and severity of incidents where a child has suffered detriment due to delayed or missed diagnosis or treatment or not received timely follow up care and support.***

- **Trust Response:**
- The Trust, like other Trusts throughout the UK, are challenged when it comes to children waiting. Wait times within the Paediatric Audiology Service is on the CSS risk register as risk 5235, with a risk rating of 10 (moderate risk) with the description:

- *"Audiology Paediatric waiting times. Current waits are at 27-28 weeks for paediatric appointments. This is due to a large increase in referral numbers as other services are working through backlogs and referring into Audiology for testing. Staff qualified to provide the testing are working at capacity."*

- Recognising the current waits there is a risk that children's hearing could deteriorate.

- To date there have been 14 children identified as having an incident related to waiting for treatment. In these 14 cases, the severity of the incident was deemed to be:

    - No harm: 13 cases,
    - Low harm: 1 case.

- As part of the Midlands Region desktop review, the Trust reviewed the data in relation to paediatric hearing loss. The national average for paediatric hearing loss is 1.78 per 1000 children reviewed. The ULHT rate is 1.95 per 1000 reviewed. This puts the Trust at above the national average for identifying paediatric hearing loss. The Regional Chief Healthcare Scientist for the West Midlands who has been supporting the review confirmed that the Trust were not identified as a being of concern in relation to patient harm.

- **Additional clarity sought by CQC:**

  - *"NHS England have asked that where services that are **not** UKAS IQIPS accredited, heads of services should provide an external evidence-based assessment of their provision. If your services are not UKAS IQIPS accredited, we would like you to include a copy of that assessment report when responding to this letter.*

  - **Trust Response:**
  - The Trust have participated in the Midlands Desktop Review, immediately following the Lothian incident. As described previously, the findings from this have been reported to the Joint Quality Committee and the ICB System Quality Meeting in April and May 2024 resulting in a rating of green.

- **Additional clarity sought by CQC:**

  - *Boards may be aware that UKAS have a benchmarking tool for provider of audiology services considering accreditation to help them understand what stage they are at and where the focus of work may need to be. Please can you supply a copy of the completed tool if you have used it."*

  - **Trust Response:**
  - The UKAS IQIPS benchmarking tool is attached at **appendix 2.** As previously described, the Trust are planning to use this benchmarking tool in collaboration with an IQIPS case manager to review jointly the Trust's service, as part of its accreditation journey. At this point in time, this tool has not yet been completed. The service have forecast that this will be completed by September 2024.

Next steps:

The Trust Board is asked to note the background and assurances available in respect of Paediatric Audiology services and agree for sharing with the Care Quality Commission.

Appendix 1: Letter from CQC to the Trust's CEO: 8 April 2024

The independent regulator of health and social care in England

8 April 2024

Dear colleague,

Re: Paediatric audiology services

As you may be aware, an expert review undertaken by NHS Lothian in Scotland found failings in the standard of paediatric audiology services that resulted in delayed identification and missed treatment of children with hearing loss. This resulted in permanent, avoidable deafness for some children.

These findings led to a review of the service provided by 4 NHS trusts in England which found similar failing. A Paediatric Hearing Services Improvement Programme has been established by NHS England to support providers and integrated care boards (ICBs) to improve the quality of these services. The programme is undertaking work to understand the scale of the problem and the number of children who have been affected, and to develop the strategic tools and interventions to support sustainable improvements.

Childhood deafness is a significant health and developmental risk. A National Deaf Children's Society survey in 2023 showed that:

- 527,898 children are known to the hearing services.
- In 2022 there were an estimated 8,405 children not supported by a hearing service.
- Ninety-four percent of children referred to ear nose and throat (ENT) services were missing the six-week initial appointment target, with an average waiting time of 141 days.
- More than half of respondents (52%) reported that their trusts were missing the 126-day target for grommets surgery. This was a rise of 23% since 2019. The average waiting time was now 178 days, with a maximum wait of 540 days.
- Most paediatric audiology services (79%) did not offer wax removal, and most of them referred children to ear nose and throat (ENT) services for this, leading to lengthy delays.
- Thirty-nine percent of services failed to meet the 42-day waiting list target for an initial hearing assessment for babies and children who were not referred via newborn hearing screening.
- Only 26 services (23%) reported that they were currently accredited by Improving Quality in Physiological Services (IQIPs).

The main themes identified by providers in the same survey were long waiting lists, staffing issues, increasing demands on services, barriers to gaining Improving Quality in Physiological Services (IQIPs) accreditation and other resource or funding issues.

The total number of children with permanent deafness reported to be on services' caseloads has decreased by more than 7% since 2019. The incidence of permanent deafness generally remains stable, so this may suggest that some children have not yet been identified.

CQC are working closely with NHS England to help understand the current situation across the country regarding the level of assurance boards have about the quality of hearing services for children that they commission or provide.

The UKAS IQIPS (Improving quality in physiological services) is the only recognised accreditation standard for physiological science services inclusive of audiology services. Whilst accreditation cannot be mandated by CQC, we strongly encourage participation in UKAS diagnostic accreditation schemes, including IQIPS. Participation and performance in such schemes are evidence of good practice that is used to inform CQC's judgements about the safety and quality of care. ICB's should ensure there are plans in place so that trusts can implement, achieve, and maintain accreditation using the available tools, and that there is oversight of quality management systems.

Services that are not IQIPs accredited should formally register this as a quality risk in their quality reporting system.

Please can I ask that at the next full board meeting, the board considers the assurance that they have about the safety, quality, and accessibility of your children's hearing services. Following that consideration, the board should submit a report to CQC that makes clear:

- Whether you have achieved IQUIPS accreditation, including whether there were any improvement recommendations made.
- Whether you are working towards IQIPS accreditation.
- What stage that work has reached and the assurance the board has about paediatric audiology, using the IQIPS standards as a guide for the areas to tell us about.
- The expected timeline for gaining accreditation.
- The number and severity of incidents where a child has suffered detriment due to delayed or missed diagnosis or treatment or not received timely follow up care and support.

NHS England have asked that where services that are **not** UKAS IQIPS accredited, heads of services should provide an external evidence-based assessment of their provision. If your services are not UKAS IQIPS accredited, we would like you to include a copy of that assessment report when responding to this letter.

Boards may be aware that UKAS have a benchmarking tool for provider of audiology services considering accreditation to help them understand what stage they are at and where the focus of work may need to be. Please can you supply a copy of the completed tool if you have used it.

We are keen to understand the progress made towards accreditation and how the service across the county is improving over time. We would therefore ask that further to your initial report to CQC (as outlined above), an additional review of assurance is conducted at a subsequent board meeting and a further follow up report on progress is provided to us.

The intent of this letter is information gathering and to gain a picture of service provision and the speed with which improvements are being made across the country. We are wanting to collaborate with other stakeholders to do our part in bringing about improvements in the care and treatment of this cohort of children.

Information returns from providers will be shared with operational colleagues to add to the wider information held about providers. It may be used to assist in the determination of risk levels within services for children and young people, but at this point it is not the intent to undertake stand-alone site visits based on what we are told about the service in your trust. That does not mean we will not conduct a thematic review or bespoke assessment process in

the future, but rather to reiterate that we want to focus on getting a clear picture about what is happening at provider level now.

For clarity, we require consideration by the full board at the next meeting. An initial response should be sent to CQC no later than 30 June 2024. A subsequent response should follow after the next full board meeting. If there is any reason this cannot be achieved, please do come back to us with the reasons and when you consider you might be able to tell us about your service.

Please send your responses to Terri Salt, the lead senior specialist for this work, by email to terri.salt@cqc.org.uk. Terri can also be contacted if you have any questions or queries about this letter.

Yours sincerely,

Prem Premachandran MBE
Medical Director
Care Quality Commission

Appendix 2: UKAS IQIPS Gap Analysis Desktop Review Document

Appendix 3 - UKAS IQIPS Gap Analysis Fo

Appendix 3: UKAS IQIPS Standards

Appendix 4 - IQIPS-standard-2023.

Appendix 4: UKAS IQIPS Standards with Guidance Notes

Appendix 5 - IQIPS 2023 Standard Staten

Report to:	Lincolnshire Community and Hospitals Group Board
Title of report:	People and OD Committee Assurance Report to Board
Date of meeting:	12 March 2024
Chairperson:	Professor Phil 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 to inc NHS and System People Plan update** The Committee noted that, whilst the group had not been quorate, there had been positive discussions focused on medical compliance with core training with a number of actions agreed. The group had considered sickness absence, which was above trajectory, however noted the position was being maintained. Focus was being given to the utilisation of occupational health to support staff. The completion rate of resuscitation training was noted as an area of concern by the Committee and assurance would be sought from the Medical Directors office to ensure the risk was mitigated. It was recognised that the group was alter to the concern and focus was being given to this. **Committee Performance Dashboard** The Committee received the dashboard noting this had been considered in detail by WSODG and discussion during the course of the meeting offered oversight of current performance. **Appraisal Deep Dive** The Committee received the appraisal deep dive noting that the highest completion rate of 80.59% had been achieved in January 2018, the current position was reported as 73.49%. The Committee noted the proposals from the report including moving to an annual appraisal cycle which would improve completion rates due to a focused period of time for these to be undertaken.

	Completion rates for staff were noted with band 8a and above having the lowest rates for completion. In order to address this position a report would be offered to the Trust Leadership Team. The Committee noted that work was taking place to identify a suitable system for the recording of appraisals, recognising that this needed to support staff in completing the process. **Wellbeing Strategy** The Committee welcomed the Wellbeing Manager to the meeting and received a detailed update on the wellbeing strategy and progress of the introduction of wellbeing champions. The Committee noted the significant wellbeing offer in place for staff noting the various options available. The vaccination rates for staff were noted with the Committee seeking to understand actions for the coming year to increase uptake. In order to support the uptake of vaccination rates, completion of mandatory training and appraisals the Committee were supportive of consideration and modelling for a potential additional day of leave for staff, who had completed all aspects. The positive impact of the health MOTs for staff were noted with the Committee being advised of early interventions being in place for a number of staff as a result of the outcome of the health MOTs. **Safer Staffing** The Committee received the report with moderate assurance noting there were no escalations to be made however some in-month variation was noted in respect of demand for shifts. The Committee noted the deep dive which had been undertaken in respect of safe care live and noted the plans in place for further education and training to be undertaken to support appropriate completion of the tool. **Board Assurance Framework** The Committee agreed that the BAF assurance rating in respect of objective 2a was reflective of the assurance position.
	Lack of Assurance in respect of SO 2b **Issue: Making ULHT the best place to work** **Medical Education Update** The Committee was pleased to note that the first cohort of Lincoln Medical School students were due to graduate in June 2024. The Committee noted the improvements being seen in respect of post-graduate trainees, following a visit from NHS England however recognised that there remained some work to be done to improve experiences within orthopaedics.

Equality, Diversity and Inclusion Group Upward Report to inc Gender Pay Gap and Equality Delivery System

The Committee received the upward report from the group noting the discussions held in relation to the gender pay gap. It was noted that there had been an improvement in the median for the Trust overall with a positive position for the medical workforce, there did however continue to be substantial gaps in bands 8b – 8d for those on agenda for change.

Work would be undertaken to review and better understand the position and determine appropriate actions.

The Committee received the report in respect of the Equality Delivery System.

Just Culture Steering Group Upward Report

The Committee received the report noting that work continued at pace within the organisation and the intention for a 'soft launch' of Just Culture to take place in April 2024.

Board Assurance Framework

The Committee noted the significant updates that had been made to the BAF in respect of objective 2b and, recognising the assurances this offered, proposed this be rated as green, from amber.

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

Research Group Upward Repot and monthly update

The Committee was pleased to note the ongoing work within research to improve the position of the Trust, noting the discussions being held with the ICB to widen this across the system.

Further work was being undertaken with the University of Lincoln in respect of joint academics and new programmes of research.

Work continued with the Nottingham Clinical Research Facility with the Committee noting the potential for a joint approach for the vaccine strategy. Further work would be undertaken to develop a proposal for this which, as a joint strategy, could attract additional funding.

University Teaching Hospital Group Upward Report

The Committee received the report noting this offered an update position to that offered to the Board in March.

The Committee noted the work to triangulate specialty gaps and determine areas of focus with the University and supported the establishment of a Clinical Academic Oversight Group. This would be a reporting group of the Research and Innovation Governance Group.

	Board Assurance Framework The Committee agreed that the BAF assurance rating in respect of objective 4b was reflective of the assurance position.
	Assurance in respect of other areas: **Integrated Improvement Plan** The Committee noted the report and the move to close down the 2023/24 year with significant progress having been made in a number of areas. The Committee would have an opportunity to influence measurements for vacancy rates and appraisal compliance, for the coming year in order to ensure the required focus and effect positive change. **CQC Action Plan** The Committee received the report noting that actions relevant to the Committee were considered in detail through the agenda. Whilst work was underway to develop an assurance report, linked to the recruitment plan to reduce medical agency staff, concern was noted in respect of core training for this staff group.
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 with an increase of 1 risk from the February report.
Matters identified which Committee recommend are escalated to SRR/BAF	No areas identified
Committee position on assurance of strategic risk areas that align to committee	The Committee considered the reports which it had received which provided assurances against the strategic risks to strategic objectives.
Areas identified to visit in ward walk rounds	No areas identified

Attendance Summary for rolling 12 month period

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

X in attendance
A apologies given
D deputy attended

Report to:	Lincolnshire Community and Hospitals Group Board
Title of report:	People and OD Committee Assurance Report to Board
Date of meeting:	16 April 2024
Chairperson:	Professor Phil 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 the Occupational Health review was due to conclude at the end of April with any recommendations being considered at this time to support improvements in the service. The Committee considered the half day taught session at LCHS in respect of statutory and mandatory training with developments already underway to have this in place at the Trust. Concern was noted in respect of job planning with a target completion rate of 70%, this was felt to be ambitious given the previous year's achievement of 52%. The Committee noted that a review by Job Planning Specialists had been undertaken identifying that the processes were correct and the area for development was leadership. This would be addressed through the appointment of the new Deputy Medical Director. The Committee noted the appraisal update and the proposal to move to an annual appraisal cycle, which had been approved by the Executive Leadership Team. Work was now in place to algin the process across the Group from April 2025. **Committee Performance Dashboard** The Committee received the report noting the performance and noted the detailed consideration of performance through WSODG. **Safer Staffing** The Committee noted the continued moderate assurance offered through the report noting that there were no escalations to be made to the Committee.

	In respect of Care Hours Per Patient Day, there had been an in-month variation however the Committee noted that the annual trend remained stable. Data was also demonstrating a reduction in temporary staff usage and reduced use of off-framework agency. **Workforce Plan** The Committee received an update on the submission of the draft workforce plan with the final submission due at the end of April 2024. The Committee noted the significant scrutiny of workforce plans by NHS England and recognised that, for the Trust, this demonstrated an increase in substantive posts by 530 in respect of CDCs, expected turnover and EPR related appointments. As a result of the current vacancy controls in place and the workforce plan position, the Committee requested quarterly updates on vacancy controls to maintain oversight of the position. **National Staff Survey Action Plan update** The Committee received and noted the national staff survey results which demonstrated an overall reduction in completion rates, which was reflective of other local Trusts. The Committee noted that focus groups were being held with staff to develop actions from the results of the survey and to build on the work already in place. An update on the outcome of the focus groups would be offered to the Committee in June. **Board Assurance Framework** The Committee agreed that the BAF assurance rating in respect of objective 2a was reflective of the assurance position.
	Lack of Assurance in respect of SO 2b **Issue: Making ULHT the best place to work** **Freedom to Speak Up Quarterly Report to inc FTSU National Reflection and Planning Tool** The Freedom to Speak Up Guardian presented the report to the Committee noting that disappointment had been noted in the national staff survey result with work set to continue with staff to ensure managers could be approached. FTSU training was due to be launched and it was hoped that this would support staff in feeling managers were approachable. The Committee noted that the national reflection and planning tool gap analysis had been completed for the Trust, but wider consideration would now be given due to the Group model.

GMC Junior Doctor Survey Update
The Committee received the report with moderate assurance noting the recent review of the medical education department by the NHS England Quality Team.

There remained some lack of engagement from the Divisions in responding to the survey with the medical education department keen to develop relationships.

Work continued to support the Trauma and Orthopaedic doctors in training to ensure a high-quality experience.

Culture and Leadership Group Upward Report
The Committee received the report noting the review of membership of the Leading Together Forum however reflected on the Group Better Together Forum which had met on the 6 March.

The Better Together Forum had been well received with further events scheduled however the Committee noted that the work being undertaken was through an NHS England programme and would need to be completed by ULHT before this could be linked across the Group.

Just Culture Steering Group Upward Report
The Committee received the report noting the work being undertaken in respect of a wider range of repots and policy development, whilst work was progressing there had been some delays due to the need to co-create with staffside.

The delays would not impact on the launch of Just Culture with the steering group continuing to meet on a monthly basis in quarter 1 to maintain focus on policy development. Changes in mindset and culture was already being observed within the Trust.

Board Assurance Framework
The Committee agreed that the BAF assurance rating in respect of objective 2a was reflective of the assurance position.

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

Research, Development and Innovation Update
The Committee received the report with assurance noting the launch of the R&I Hub which was part of the ICB Lincolnshire Improvement for Everyone (LIfE) with representation from the Trust at the event.

3 phase 1 clinical trials had been opened which was a milestone for the Trust with the Committee noting the need to consider communications being circulated around these.

There had been an increase in the number of colleagues from the emergency departments coming forward to discuss research opportunities with the potential for engagement in these as a result.

University Teaching Hospital Group Upward Report
The Committee received the report with assurance and noted a verbal update indicating that the first meeting of the Clinical Academic Oversight Group had been arranged with draft terms of reference developed.

Limited progress had been made with discussions in respect of the clinical academic workforce and the financial model position with the intention to develop a payment model. Once approved the memorandum of understanding will be put in place and recruitment processes commenced for which HR support was sought.

Board Assurance Framework
The Committee agreed that the BAF assurance rating in respect of objective 4b was reflective of the assurance position with evidence not sufficient to consider movement of the rating.

Assurance in respect of other areas:

Committee Effectiveness – Annual Report final
The Committee received the annual report noting that this had been updated to reflect comments offered by Committee members.

The report was approved for onward presentation to the Board and Audit Committee (Appendix 1).

Committee Self-Assessment outcome
The Committee received the outcome of the self-assessment following the extension of the response period. It was noted that there were no negative responses received with the Committee noting the outcome.

Topical, Legal and Regulatory Update
The Committee received the report noting the contents and reflecting on the usefulness of the report to ensure the Committee remained sighted on potential future areas for consideration.

Integrated Improvement Plan
The Committee received the report for information noting the position presented.

Internal Audit Report - Payroll Audit – FPEC referral
The Committee noted the payroll audit and recognised that, whilst this was a financial audit, the recommendations related to leavers and overpayments and were therefore the responsibility of the People Directorate.

	In respect of overpayments, improvements were expected to be seen due to the introduction of a single system being put in place with oversight being given through Divisional Performance Review Meetings (PRMs). **Internal Audit Report - Staff Retention** The Committee received the staff retention internal audit noting this was the third audit from a staff experience perspective. The report offered reasonable assurance however management actions, in respect of leaver feedback, were in place to triangulate data with the national staff survey and identify appropriate actions. **CQC Action Plan** The Committee received the report noting the moderate assurance and recognising that 75% of actions were complete. Of the outstanding actions the Committee recognised that these were considered through a number of reports received by the Committee with oversight being given. **Fuller Recommendations** The Committee received the report with moderate assurance noting those actions from the Fuller Inquiry, relevant to the Committee. It was noted that the inquiry had focused on mortuary arrangements and provisions. The Committee noted the need to address DBS checks with work continuing across the Trust, not just for mortuary staff but for the whole organisation, with a trajectory in place. The Committee would continue to receive regular reports to monitor progress against the outstanding recommendations.
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 with a reduction in very high and high rated risks from the March report.
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	**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**	**J**	**F**	**M**	**A**
Philip Baker (Chair)	No meeting held	X	X	X	X	X	No meeting	X	X	X	A	X	X
Karen Dunderdale		D	D	D	D	A		D	D	A	D	D	D
Claire Low		X	X	X	X	X		X	X	X	X	X	X
Colin Farquharson		D	D	D	D	X		X	D	X	D	D	D
Chris Gibson		X	X	A	X	A		X	X	X	X	A	X
Vicki Wells		X	X	X	X	A		X	X	X	A	X	X

X in attendance
A apologies given
D deputy attended

United Lincolnshire Hospitals NHS Trust

Annual Report to the Trust Board from the People and Organisational Development Committee 2023/24

ROLE OF THE COMMITTEE

In 2023/24, in line with all other Committees of the Board, the Terms of Reference were reviewed and amended. Under the agreed terms of reference the People and Organisational Development Committee was tasked as follows:

The People and Organisational Development Committee will:

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

A modern and progressive workforce:

- Embedding robust workforce planning and development of new roles
- Delivery of annual appraisals and mandatory training
- Talent Management - Creating a framework for people to achieve their full potential
- Ensuring access to the personal and professional development that enables people to deliver outstanding care and ensures ULHT becomes known as a learning organisation
- Ensuring delivery of the education agenda to all staff

Making ULHT the best place to work

- Address the concerns around equity of treatment and opportunity within ULHT, so that the Trust is seen to be an inclusive and fair organisation
- Improving the consistency and quality of leadership and line management across ULHT
- Resetting the ULHT Culture and Leadership Programme – Trust Values and Staff Charter
- Reviewing the way in which we communicate with staff and involve them in shaping our plans
- Quarterly Pulse Survey to be 'relaunched' as the main moral barometer
- Agreeing and promoting the core offer of ULHT, so our staff feel valued, supported and cared for
- Focus on junior doctor experience key roles: Freedom to Speak Up, Guardian of Safe Working and Wellbeing Guardian
- Embed a programme focused on staff wellbeing
- WRES/WDES agreed objectives and scorecard
- Top 25% of NHS Acute Organisations for indicators for recommend as a place to work

Becoming a University Teaching Hospital

- Developing a business case to support the case for change
- Increasing the number of Clinical Academic posts
- Improve the training environment for students
- Develop a portfolio of evidence to apply for membership to the University Hospitals Association
- Developing a memorandum of understanding with the University of Lincoln

MEETINGS

The Committee met monthly during the year, with the exception of April and October 2023 due to the impact of industrial action and not meeting quoracy requirements. Where the Committee did not meet reports scheduled to be received were, where required, deferred to the May and November meetings. Executive reports were offered to the Board to ensure assurance was provided.

The Committee, after each meeting held provided an assurance report to the Trust Board.

MEMBERSHIP AND ATTENDANCE

The Committee is appointed by the Board from amongst the Non-Executive Directors of the Trust. During 2023/24 the Committee was chaired by Professor Philip Baker.

Details of the Committee's membership and attendance during 2023/24 is set out below:

Non-Executive Director (Chair)
Non-Executive Director (Deputy Chair)
Director of People and Organisational Development
Director of Nursing
Medical Director

Members	**11 Apr 23**	**9 May 23**	**13 Jun 23**	**11 Jul 23**	**15 Aug 23**	**12 Sept 23**	**10 Oct 23**	**14 Nov 23**	**12 Dec 23**	**16 Jan 24**	**13 Feb 24**	**12 Mar 24**
Non-Exec Director Philip Baker (Chair)	Meeting not held	X	X	X	X	X	Meeting not held	X	X	X	X	X
Non-Executive Director (Dr Gibson)		X	X	A	X	A		X	X	X	X	A
Associate Non-Executive Director (Mrs Wells)		A	X	X	X	A		X	X	X	A	X
Director of People & Organisational Development		X	X	X	X	X		X	X	X	X	X
Medical Director		X	A	X	X	X		X	X	X	D	D
Director of Nursing		D	D	D	D	A		D	X	X	X	X

A denotes Apologies given
D denotes Deputy in attendance

REVIEW OF BUSINESS

The People and Organisational Development Committee's work programme for 2023/24 is set out as an appendix to this report.

The People and Organisational Development Committee has been responsible for the oversight of the following strategic objectives of the Trust in 2023/24:

- Objective 2a A modern and progressive workforce
- Objective 2b Making ULHT the best place to work
- Objective 4b Becoming a University Hospitals Teaching Trust

During 2023/24 the Committee has utilised the Board Assurance Framework (BAF) to provide focus to the meetings and ensure alignment of the agenda to the elements of the BAF. The strategic objectives at the beginning of the year were rated as follows:

Objective 2a – **AMBER**
Objective 2b – **AMBER**
Objective 4b – **RED**

Through the year the Committee continued to receive reports offering assurance against the strategic objectives. The Committee undertook significant reviews of the BAF and associated assurances resulting in the objectives being rated as follows at the end of the year:

Objective 2a – **GREEN**
Objective 2b – **GREEN**
Objective 4b – **RED**

OVERVIEW

The People and Organisational Development Committee has continued to, over the last twelve months, offer a level of assurance to the Board on people and organisational development. The Committee has reported its progress to the Board through upward assurance reports, reporting progress against the delivery of the work plan as defined by the terms of reference, through this annual report.

The work programme for the Committee has focused on the continued workforce challenges faced by the Trust and considered and supported the review and revision of the structure of the People and Organisational Development Directorate.

The Committee has been well attended by members throughout the year and the Chair has been actively involved in the agenda setting alongside the Director of People and Organisational Development.

Other key areas of focus of the Committee have included:

- Freedom to Speak Up
- Guardians of Safe Working
- Safer Staffing
- University Hospital Teaching Status
- Culture and Leadership Programme
- Research and Innovation

During 2023/24 the Committee saw the strengthening of the reporting groups which has resulted in the streamlining of reporting and improvements in assurances provided to the Committee. This came as a result of the work in the previous year to develop these groups. As a result, the Workforce, Strategy and Organisational Development Group has delivered strengthened reporting to the Committee including the undertaking of deep dives into areas of concern, identified by the Committee.

Increased scrutiny and further development of the Committee Performance Dashboard has also been undertaken by the Group resulting in improved reporting to the Committee. The Dashboard now incorporates areas of focus for the Committee enabling clear sight of performance and the ability to conduct further review in to any areas of concern.

The Committee has noted the strengthened reporting and refocus of the Culture and Leadership Group with the recent establishment of the Just Culture Steering Group.

Reporting continued to be received from both the Freedom to Speak Up Guardian and Guardian of Safe Working to the Committee which demonstrates the Trusts' commitment to supporting staff to be able to raise concerns to be addressed.

Regular reports are received by the Committee with attendance at the Committee meetings by both Guardians to ensure that appropriate assurances are received and where necessary escalations made. Through the reports the Committee was pleased to note the levels of reporting from staff within the organisation along with the closure of a number of concerns raised through there reporting routes.

Regular reporting continued to be received from the Equality, Diversity and Inclusion Group with the Committee noting the continued progress in this area and the strengthened annual report and associated actions which were approved in the 2023/24 year.

Continued progress was made in respect of recruitment with improved processes supporting recruiting managers and continued pipelines for international nursing

recruitment. International recruitment was also being pursued for Pharmacy vacancies.

The Committee, through the Committee Performance Dashboard noted the continued challenges with completion rates of appraisals and mandatory training however, robust actions were in place during the course of the year, resulting in incremental progress being seen.

Updates were received in respect of the National Staff Survey and following the significant improvement in results for the 2022 year, the Committee continued to oversee associated actions to drive forward further improvements. In order to gain traction in a number of areas, actions were combined with those resulting from the programme of cultural deep dives.

During the course of 2023/24 the Committee remained concerned with the progress in respect of research and innovation requesting monthly reports and representation at the meetings to gain reassurance on progress being made.

Progress in respect of the University Teaching Hospital status remained slow however the Committee was pleased to note the progress with the application for Teaching Hospital status as progress towards the overall ambition. Greater engagement and joint working with the University of Lincoln was recognised and it was hoped that this would continue to progress to support the appointment of Clinical Academics.

Risks

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

Performance Review

The Committee reviews performance against the agreed Key Performance Indicators (KPIs) and the actions being taken to recover where necessary. The KPIs monitored by the Committee cover a modern and progressive workforce and making ULHT the best place to work. The metrics presented within the report have been reviewed to ensure that the information presented offers a clear position on the performance of the Trust.

At each of the meetings held during 2023/24 the Committee considered all aspects of the performance report and were able to identify and seek further assurance on KPIs where concerns were identified.

The Committee, through the Workforce, Strategy and Organisational Development Group, have an increased level of scrutiny of the KPIs as these are considered by

the group prior to reporting to the Committee where escalations and areas of concern are highlighted.

The Committee has continued to receive and discuss regular reports in respect of Safer Staffing with moderate levels of assurance continuing to be offered to the Committee. The Trust continued to see the delivery of fill rates to an appropriate level with the Committee noting the triangulation of data with nursing and quality metrics, which demonstrates the continued quality of care being offered to patients.

Continued focus was given in respect of Disclosure and Barring Service Checks, an action following the Savile Inquiry, with positive progress noted in respect of the actions required. The Committee received updates on the trajectory which demonstrated significant progress throughout the year.

During 2023/24 referrals between the Board Committees were made in order to ensure that where necessary additional assurances were sought from the relevant responsible Committee, in areas where responsibility for assurance extended beyond the remit of a single committee. A number of referrals were made during the year offering opportunities for the Committee to seek further assurances.

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

Meeting	Lincolnshire Community and Hospitals Group Board
Date of Meeting	*7th May 2024*
Item Number	*9.1.1*

Gender Pay Gap Statement

Accountable Director	*Claire Low, Director of People & OD*
Presented by	*Lindsay Shankland, Deputy Director of HR*
Author(s)	*Alison Marriott, Head of Equality, Diversity & Inclusion (Acting)*
Report previously considered at	*EDI Operational Group* *People and Organisational Development Committee*

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

Risk Assessment	*Insert detail*
Financial Impact Assessment	*No financial impact*
Quality Impact Assessment	*Insert detail*
Equality Impact Assessment	*This report and associated action plan is to improve pay equity for the female workforce and includes associated benefits for others in the workforce.*
Assurance Level Assessment	*Insert assurance level* • *Moderate*

Recommendations/ Decision Required	• *Approve the publication of this Gender Pay Gap Report, which is due on 30 March 2024*

Executive Summary

This paper provides the Trust Board with the proposed Gender Pay Gap Statement and Action Plan to be published by the Trust as part of our statutory obligations, by the statutory deadline of 30th March 2024.

It is important to note that the Trust, and indeed the NHS nationally, has Job Evaluation and agreed, national pay systems that set the grade for a job regardless of gender. Anyone in that job would receive the grade and pay attached to it regardless of gender.

Increments, and length of time in band can influence pay gaps for men and women, particularly for Agenda for Change colleagues.

The Gender Pay Gap work is an opportunity to look at both societal and organisational factors or characteristics that may impact pay parity e.g. education, working time, occupational segregation, skills and experience. The initial data is a starting point and the action plan provides for further actions to address them.

Headlines – Improvements in Gender Pay Gap

Comparing like-for-like years, i.e. 2023 data, the national gender pay gap in the UK was 14.3%, compared to ULHT's 14.9% gap. Despite the changes in representation at the highest and lowest pay bands, the ULHT pay gap has improved to be much closer to the national median UK pay gap. The national gap has improved by 0.6%, and ULHT's gap has improved by 1.9%.

The bonus pay gap (Clinical Excellence Awards for Consultants) has improved significantly, to parity pound-(£) for-pound between men and women.

NHS EDI Improvement Plan and other Pay Gaps

A further report will be prepared for the race/ethnicity pay gap in due course, following the first race pay "snapshot" date of 31st March 2024. NHS England are currently preparing the necessary technical guidance for this, along with a dashboard in ESR once the guidance is available.

High Impact Action 3 – in the NHS EDI Improvement Plan – requires the Trust to analyse data to understand pay gaps by protected characteristic and put in place an improvement plan. This is to be tracked and monitored by NHS boards. Plans should be in place for race by 2024, disability by 2025 and other protected characteristics by 2026.

Specific actions and timescales are to:

- Implement the Mend the Gap review recommendations for medical staff and develop a plan to apply those recommendations to senior non-medical workforce (by March

2024). This report addresses this action. Mend the Gap: The Independent Review into Gender Pay Gaps in Medicine in England - December 2020 (publishing.service.gov.uk)

- Analyse data to understand pay gaps by protected characteristic and put in place an improvement plan. This will be tracked and monitored by NHS boards. Reflecting the maturity of current data sets, plans should be in place for sex and race by 2024, disability by 2025 and other protected characteristics by 2026.

- Implement an effective flexible working policy including advertising flexible working options on organisations' recruitment campaigns. (March 2024) – this action is already complete.

The success metric is a year-on-year improvement in pay gaps, via pay gap reporting.

United Lincolnshire Hospitals NHS Trust Gender Pay Gap

2023 Report – for publication no later than 30th March 2024

Executive Summary

Headlines

When reporting Gender Pay Gap data, we are working from the data as at previous 31st March, i.e. **this report is based on data from 31st March 2023**.

In this Trust, women earn 85p for every £1 that men earn when comparing median hourly pay. This is an improvement on last year's data (83p for every £1)

For women who receive a bonus, they receive £1 for every £1 men receive. In an NHS Acute Trust, bonuses are defined as the Clinical Excellence Awards (CEAs) which are only applicable to Consultants in the medical workforce.

At ULHT, women hold 83.5% of the lowest paid jobs, and 63.7% of the highest paid jobs.

There has been a slight increase (0.3%) in the number of women holding the lowest paid jobs, and also a 0.9% decrease in the number of women holding the highest paid jobs – this was the case as at the 31st March 2023 snapshot date, however changes may have occurred after this that will be reflected in the 2024 data.

Women still hold around 80% of the lower middle and upper middle-paid jobs, which has remained stable since last year.

The median is the generally-accepted main indicator across all organisations who take part in Gender Pay Gap reporting. Comparing like-for-like years, i.e. 2023 data, the national gender pay gap in the UK was 14.3%, compared to ULHT's 14.9% gap.

Despite some changes in representation at the highest and lowest pay bands in the Trust, the ULHT pay gap has improved to be much closer to the national median UK pay gap. The national gap has improved by 0.6%, and ULHT's gap has improved by 1.9%.

When comparing mean (average) hourly pay, women's mean hourly pay is 28.7% lower than men's. This is also an improvement on last year's data (29.3%)

National Sources:
Gender pay gap in the UK - Office for National Statistics (ons.gov.uk)

This report contains:

- Background to the requirements for Gender Pay Gap Reporting
- Guidance to assist understanding of the indicators and calculations used

- Narrative about the Trust's Gender Pay Gap results, in line with reporting requirements - but most importantly, to assist with the Gender Pay Gap Action Plan
- Comparison with previous year's results, which show that the Gender Pay Gap has improved (i.e. reduced)
- A proposed Action Plan to further reduce the Gender Pay Gap, incorporating the actions from the Mend the Gap report.
- Appendix with all the required data which has been submitted to the Gov.Uk Gender Pay Gap reporting portal, ahead of the 30th March 2024 deadline

This report will provide a high level of assurance in terms of compliance with Gender Pay Gap Reporting, for People and OD Committee (PODC) and Trust Board approval.

It will also provide high levels of assurance that the Trust will take action to reduce (improve) the disparity between pay for men and women, in the form of a detailed action plan. It also provides evidence for High Impact Action 3 of the NHS EDI Improvement Plan.

1. Background

Employers with 250 or more employees have been required to publish information on the pay gap between male and female employees since 31st March 2017, under the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, which can be found at: The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 (legislation.gov.uk).

Organisations in the public sector, such as NHS Trusts, are required to report against a set of six key indicators, based on data from 31st March each previous year. For example, the "snapshot date" for this report is 31st March 2023. They are then required to publish that data and narrative ("Gender Pay Gap Report") so that employees and members of the public can access it, along with an action plan to address disparities, by 31st March each year. For example, this report is to be published on Trust's website by 31st March 2024.

Separately from the report, employers are required to upload their data to the HM Government portal by 31st March at the latest. This data upload has been made already in preparation for publication of this report in March.

Private sector employers with 250 or more employees are also required to publish Gender Pay Gap information, albeit with a slightly later publication date of 5th April each year.

In preparing this report, the author has consulted and followed the NHS Employers Gender Pay Gap guide: Addressing-your-gender-pay-gap-guide.pdf (nhsemployers.org) which was co-produced with the Health and Care Women Leaders Network.

2. Understanding the Gender Pay Gap Calculations

The six key indicators that the Trust is required to report on are:

1. percentage of men and women in each hourly pay quarter (lower, lower middle, upper middle and upper quartile) by number of employees
2. mean (average) gender pay gap using hourly pay
3. median gender pay gap using hourly pay
4. percentage of men and women receiving bonus pay
5. mean (average) gender pay gap using bonus pay
6. median gender pay gap using bonus pay

The data for the report is drawn from the national Electronic Staff Record (ESR) Business Intelligence standard report.

For the purposes of these calculations, pay includes: basic pay, full paid leave, including annual, sick, maternity, paternity, adoption or parental leave, bonus pay, area and other allowances, shift premium pay, pay for piecework.

Pay does not include: overtime pay, expenses (payments made to reimburse expenditure wholly and necessarily incurred in the course of employment, e.g. mileage for use of vehicle), remuneration in lieu of leave, the value of salary sacrifice schemes, benefits in kind (e.g. child-care vouchers), redundancy pay and tax credits.

Bonus pay relates to the Clinical Excellence Awards (CEAs) to Consultants, following the NHS Employers Gender Pay Gap Guide.

We now have six years' worth of data and the opportunity is taken in this report to indicate trends in that data.

What does median mean?
This is the difference between the hourly pay of the median man and the hourly pay of the median woman. The median for each is the man or woman who is in the middle of a list of hourly pay ordered from highest to lowest paid.

Medians are useful to indicate what the 'typical' situation is. They are not distorted by very high or low hourly pay (or bonuses). However, this means that not all gender pay gap issues will be picked up. They could also fail to pick up as effectively where the gender pay gap issues are most pronounced in the lowest paid or highest paid employees.

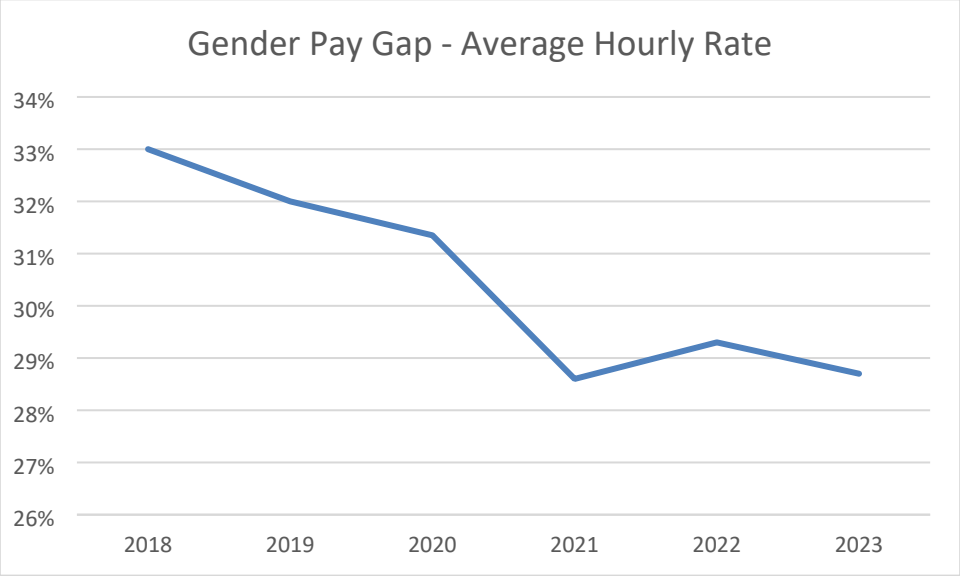
And mean?
The mean gender pay gap figure uses hourly pay of all employees to calculate the difference between the mean hourly pay of men, and the mean hourly pay of women. A mean involves adding up all of the numbers and dividing the result by how many numbers were in the list. Very high or very low pay can distort this figure.

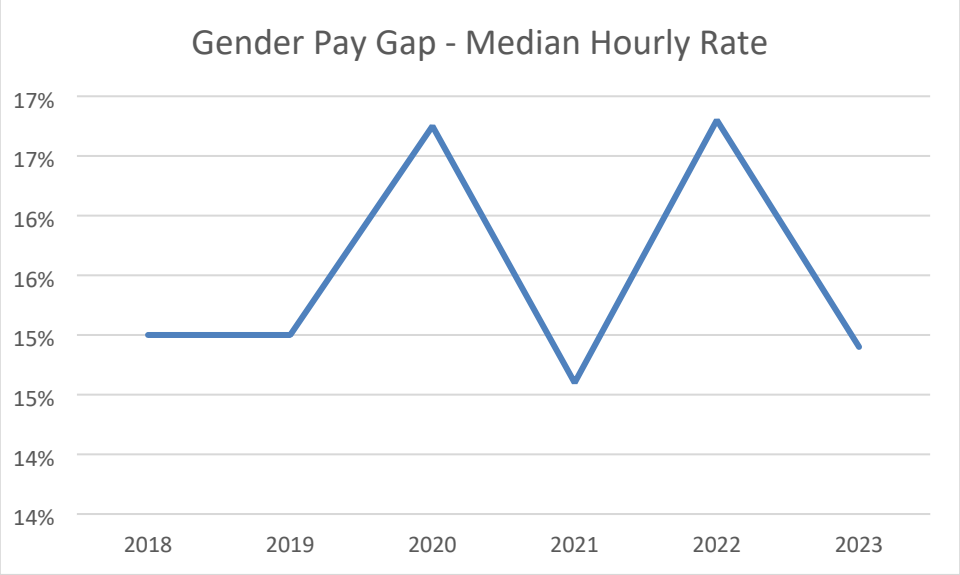
3. About our results

The Trust's Gender Pay Gap has been on a generally decreasing (i.e. improving) trend since reporting began, in line with the national trend both inside and outside of the NHS.

Compared to last year, the median is 1.9% better (smaller gender pay gap), and the average hourly rate is 0.6% better. Since reporting began, the median has fluctuated and the overall improvement since then is only around 0.1%

The trends are illustrated in the charts and tables below:





Trend 2018 when reporting began, to present data (2023)

Year	Average Hourly Rate	Median Hourly Rate
2018	33%	15%

2019	32%	15%
2020	31.35%	16.75%
2021	28.6%	14.6%
2022	29.3%	16.8%
2023	28.7%	14.9%

As with previous years, the main driver of the Trust's gender pay gap remains the structure of the NHS workforce, with female colleagues comprising the majority of the lower paid roles and men in higher paid roles including the medical workforce (especially Consultant medical staff) and Very Senior Management (VSM) roles.

Gender Disparity - Pay Quartiles
83% of the workforce in the lowest pay quartile is female. This means that women hold 83% of the lowest paid jobs. In comparison, 63% of the workforce in the top pay quartile are women. This means that women hold 63% of the highest paid jobs, disproportionately low for their representation in the lowest pay quartile (83%) and throughout the other pay quartiles (around 80%).

Gender Disparity – Mean Salary
The data in Appendix 1 highlights that below Band 8A Agenda for Change (AfC), women are paid more than men. The reasons why female colleagues are more highly-paid may relate to length of time in post, career progression and seniority in the nursing and midwifery workforce. Further investigation and actions are included in the Gender Pay Gap Action Plan.

However, from AfC Band 8A to 8D inclusive, as with last year, men are still consistently paid more than women. The reasons for this are not evident from the gender pay gap data, and may relate to length of service and gaining of higher increments.

Male Consultants and Speciality Doctors are paid more than their female colleagues, which has a specific action in the Gender Pay Gap action plan, to ensure that the "Mend the Gap" report recommendations are implemented at this Trust (NHS EDI Improvement Plan, High Impact Action 3)

Gender Disparity – Bonus Pay
Bonus pay relates to the Clinical Excellence Awards (CEAs) which only apply to Consultants.

The Trust has ensured a gender balance on the awarding panel and taken steps to encourage applications from female consultants for the CEA, and also has distributed awards equally in 2023. There is now greater equity in terms of equal bonus payments. For every £1 that male consultants receive, female consultants receive the same amount. In terms of uptake, Appendix 1 illustrates that the take-up rate is 5.4% lower for female consultants than it is for male consultants, indicating that efforts to encourage higher uptake of CEA applications need to continue.

4. How we will make progress to close the gap (Action Plan)

We have identified where we believe the Trust needs to take action. These actions will be taken forward within the context of the overall Integrated Improvement Plan (IIP), EDI Objectives 2022-2025 and the NHS EDI Improvement Plan.

The Gender Pay Gap Action Plan, proposed for further discussion, including key stakeholders such as the ULHT Women's Staff Network and the Medical Workforce, is included on the next page of this report.

Gap	Lead	Action	Timescale
Data & Analysis Supporting data and analysis, beyond the statutory reporting requirements	**EDI team** Supported by: Workforce Intelligence Team ULHT Women's Network HR	Supply further details alongside the statutory data to allow for more detailed analysis: • Include age as a factor • By team profile & role – e.g. areas where there may traditionally be over-representation/under-representation of men & women. Pay data: • Number of people asking for an uplift to their band/scale point by gender, and the outcome of their request • Colleagues at top/bottom of each band – by gender, compared to length of service in that band.	December 2024
Recruitment & Career Development Ensure that recruitment and other employment processes will increase the likelihood that a woman will a) apply for a top pay quartile role b) succeed in a job offer for the role and c) will be supported to remain and thrive in the role.	**Associate Director – Culture and OD** Supported by: Head of Recruitment HR Policy Manager EDI team ULHT Women's Network Talent Academy Medical Workforce team People Promise Manager	• Talent Academy – continue excellent work to promote the wide range of opportunities in the NHS to people of all genders, ages and other protected characteristics. • Analyse turnover and exit feedback by protected characteristic and themes (qualitative) and quantitative (as % of the workforce and absolute numbers leaving). Aim is to establish detailed picture of barriers to staying and progressing. • Grow and develop ULHT Men's Network (already in progress) – to include a range of stories and guest speakers from men working at ULHT in a wide range of roles • Establish Mutual Mentoring	Talent Academy Leads - ongoing People Promise Manager – end June 2024 Chair Men's Network, Executive Sponsor. EDI team ULHT (& LCHS)

Ensure talent pipeline is inclusive and supportive of all genders, to access all – e.g. increase male representation in lower and lower middle pay quartiles. Increase female representation in top quartile. Ensure positive trend in recruitment of female Consultants is maintained and intentionally increased.			
Flexible Working To support all colleagues, including all people with caring responsibilities, whilst recognising that women are still more likely to have these, and men are less likely to be supported or feel confident to request them.	**Head of OD** Supported by: Flexible Working Lead (People Promise Manager) Head of Recruitment EDI team Wellbeing Team Medical Workforce Team	Continue progress with: • Carers Network • Flexible working – including in patient facing and senior roles, executive roles. • Menopause support – in place, work on sustainability.	Ongoing and progress by December 2024

Medical Workforce Clinical Excellence Awards (CEAs) Mend the Gap actions	**Director of People and OD and Medical Director** Supported by: Local Negotiating Committee (LNC) CEA Task & Finish Group	Establish ULHT data as per Mend the Gap (MTG) recommendations Establish and agree an action plan, for the areas of support identified in MTG, and apply actions/support meaningfully to medical workforce at ULHT: • Flexible Working & Less Than Full Time • Mentorship – particularly in underrepresented areas • Carers • Childcare • Sexism and sexual safety Many of the Mend the Gap actions would also support Agenda for Change colleagues, in VSM/Band 9 and other senior roles. There is a separate project and working group on Sexual Safety, to meet the requirements of the NHS Sexual Safety Charter fully by end July 2024.	September 2024 November 2024

Appendix 1 – Gender Pay Gap Data on which this report is based

ULHT Overall Gender Pay Gap 2023

The mean and median hourly rates for men and women

The mean and median hourly rates for males and females

Gender	Avg. Hourly Rate	Median Hourly Rate
Male	£23.53	£17.37
Female	£16.77	£14.84
Difference	£6.75	£2.53
Pay Gap %	28.7	14.6

The proportion of male and female staff in each quartile

The proportion of male and female staff in each pay quartile

Quartile	Female	Male	Female %	Male %
1	1913	378	83.5	16.5
2	1837	456	80.1	19.9
3	1834	459	80.0	20.0
4	1461	832	63.7	36.3

Mean salary for men and women within each Agenda for Change pay band or grade 2023

Mean salary for males and females within each pay band or grade

	Gender (Fte)		Mean Salary (£)	
Pay Band/Grade	Female	Male	Female	Male
Band 1 & Apprentices	25.81	9.79	£17,349	£16,969
Band 2	1612.24	372.09	£20,964	£20,925
Band 3	566.33	137.98	£22,514	£22,412
Band 4	498.46	111.53	£24,832	£24,799
Band 5	1304.30	251.43	£29,644	£28,843
Band 6	786.83	204.65	£37,028	£36,203
Band 7	480.46	112.07	£44,372	£44,043
Band 8A	194.27	59.19	£50,260	£50,750
Band 8B	56.03	24.80	£59,809	£62,327

Band 8C	23.00	13.00	£71,059	£73,347
Band 8D	11.00	6.80	£80,701	£88,200
Band 9	9.00	10.00	£99,915	£99,437
Director	3.00	6.00	£140,930	£173,789

Mean salary for men and women within each Medical Workforce pay band or grade 2023

	Gender (Fte)		Mean Salary (£)	
Pay Band/Grade	**Female**	**Male**	**Female**	**Male**
Consultant	89.05	254.90	£104,356	£106,041
Associate Specialist	2.65	18.18	£101,072	£100,934
Staff Grade		0.78		£76,880
Specialty Doctor	53.10	152.83	£67,240	£73,174
Specialist	1.87	0.00	£83,599	
GPCA/Hospital Practitioner	1.09	0.73	£75,554	£64,626
Specialty Registrar	83.31	102.53	£45,925	£45,841
Foundation Year 2	47.36	78.94	£34,012	£34,012
Foundation Year 1	38.36	59.00	£29,384	£29,384

Bonus Payments for men and women within each Medical Workforce pay band or grade 2023

Mean & median bonus payments for males and females

Gender	Avg. Pay	Median Pay
Male	6,690.60	3,094.00
Female	4,487.26	3,094.00
Difference	2,203.34	0.00
Pay Gap %	32.93	0.00

Number of staff receiving bonus

Gender	Employees Paid Bonus	Total Relevant Employees (FTE)	%
Female	80	89.00	89.9
Male	243	255.00	95.3

END

Meeting	Lincolnshire Community and Hospitals Group Board
Date of Meeting	*7th May 2024*
Item Number	*9.1.2*

NHS Equality Delivery System (EDS)

Accountable Director	*Claire Low, Director of People & OD*
Presented by	*Lindsay Shankland, Deputy Director of HR*
Author(s)	*Claire Low, Director of People & OD*
Report previously considered at	*EDI Operational Group* *People and Organisational Development Committee*

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

Risk Assessment	*Implementation of NHS EDS and publication of the EDS report means the risk of contractual non-compliance is removed*
Financial Impact Assessment	*No financial impact identified*
Quality Impact Assessment	*EDS is a national framework and part of the NHS Standard Contract and is underpinned by a national QIA*
Equality Impact Assessment	*EDS is a national framework and part of the NHS Standard Contract and is underpinned by a national EIA. Furthermore, the EDS has equality at its core, as organisations are required to review services, workforce*

	and leadership in relation to the protected characteristics of the Equality Act 2010.
Assurance Level Assessment	*Insert assurance level* • *Moderate*

Recommendations/ Decision Required	• *The Board is asked to receive the EDS report* • *The Board is requested to approve the publication of the EDS Report and thereby fulfil the requirement of EDS, as articulated in the NHS Standard Contract*

Executive Summary

The NHS Equality Delivery System 2022 (EDS) is the revised and new version of the previous EDS and EDS2 frameworks. As part of the NHS Standard Contract, NHS organisations are required to implement the EDS and to publish their EDS report and actions on the Trust website: https://www.ulh.nhs.uk/about/equality-diversity/nhs-equality-delivery-system-eds2/. The EDS is to be completed annually.

The EDS comprises of three domains:

Domain 1: Commissioned or provided services
Domain 2: Workforce health and well-being
Domain 3: Inclusive leadership

Underneath each of the domains is a number of sub-categories which the organisation needs to review and provide an evidence-based report and resulting actions for improvement.

In domain 1 the Trust is required to identify three services and for this EDS report, a service based on each of the three primary sites has been identified and these are services of three different specialities. These services have been reviewed, reported on and actions for improvement identified.

In domain 2 the wider workforce health and well-being is reviewed, reported on and actions for improvement identified.

In domain 3 aspects appertaining to the inclusive leadership in the Trust are reviewed, reported on and actions for improvement identified.

The EDS uses a structured methodology, based around a range of metrics (including the Protected Characteristics of the Equality Act 2010) to review and interpret the data and findings and this leads to ratings for each domain and sub-domain be agreed and validated through peer review.

The rating categories are:

- Undeveloped activity
- Developing activity
- Achieving activity

- Excelling activity

Following completion of the review, data interpretation and activity ratings, the actions for improvement are identified and aligned to the local service improvement plans and the corporate ED&I Equality Objectives and High Impact Actions, respectively.

The full EDS report and action plan is in the attached document for the Trust Board's consideration and approval.

NHS
United Lincolnshire Hospitals
NHS Trust

NHS Equality Delivery System (EDS)

EDS Report and Action Plan 2024

Alison Marriott, Head of Equality, Diversity and Inclusion (acting)
Jennie Negus, Head of Patient Experience

OUTSTANDING CARE
personally DELIVERED

Contents

Introduction to the Equality Delivery System for the NHS

The EDS Reporting Template

Implementation of the Equality Delivery System (EDS) is a requirement on both NHS commissioners and NHS providers. The Trust has followed the implementation of EDS in accordance EDS guidance documents. The documents can be found at: www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/eds/

The EDS is an improvement tool for patients, staff and leaders of the NHS. It supports NHS organisations in England - in active conversations with patients, public, staff, staff networks, community groups and trade unions - to review and develop their approach in addressing health inequalities through three domains: Services, Workforce and Leadership. It is driven by data, evidence, engagement and insight.

The EDS Report is a template which is designed to give an overview of the organisation's most recent EDS implementation and grade. Once completed, the report will be submitted by the EDI team via england.eandhi@nhs.net and published on the Trust's website.

NHS Equality Delivery System (EDS) – Trust Submission Cover Sheet and Approvals

EDS Lead	Alison Marriott – Head of Equality, Diversity & Inclusion (acting)	**At what level has this been completed?** The Trust's EDS report has been completed at Trust-level for 2023. Whilst the partnership working began with Lincolnshire Community Health Services NHS Trust in Summer 2023, the two Trusts had already begun work on EDS for 2023-24. The EDI Leads at both Trusts have liaised to identify potential areas of joint-working arising from EDS, NHS EDI Improvement Plans and other statutory & mandatory action plans.	
			***List organisations**
EDS engagement date(s)	Domain 1 – Patient Experience Group, April – December 2023 Domain 2 – Staff-side (am) and Staff Networks (pm) on 9th November 2023. EDI Operational Group (EDIG) members, including Patient Experience, Staff-side	**Individual organisation**	United Lincolnshire Hospitals Trust

	and Staff Network representatives, 7th February 2024 Domain 3 – EDIG members including Staff-side and Staff Network representatives, 7th February 2024.			
			Partnership* (two or more organisations)	Not for this reporting cycle – for next reporting cycle, a group approach with Lincolnshire Community Health Services NHS Trust can be scoped. LCHS have adopted a process of self-assessment for a wide range
			Integrated Care System-wide*	Not for this reporting cycle but under regular review and discussed at Lincolnshire ICB Equalities Forum.

Date completed	31st January 2024	**Month and year published**	*March 2024*
Date authorised	Approval Schedule EDI Operational Group (EDIG) – 7th February 2024 People & OD Committee – 12th March 2024	**Revision date(s)**	*7th February 2024* *Quarterly Progress Reviews April-February 2024/25 via EDI Operational Group, in line with EDIG scheduled dates*

	Trust Board – March tbc		

Completed actions from previous EDS (2022-23)	
Action/activity	**Related equality objectives**
EDS 2022-23 Actions Retender 2023 tender for new Interpretation & Translation contract completed and now negotiating to include additional suppliers on the contract and procedures to follow when main supplier cannot provide that language in the timescale required (languages other than English). Also business case is prepared for a potential solution to non-availability of interpreters in unplanned, urgent situations, to ensure patient safety and improve both staff & patient experience.	Equality Objective 1: Person-centred care is experienced by all, with a well-informed, responsive approach to equality of patient experience and to the reduction of health inequalities Equality Objective 2 The information and communication we provide is accessible to all our patients
United against Discrimination campaign actions completed and further actions identified	Equality Objective 4: Our Trust is a safe, inclusive place for all staff
Improvements in WRES and WDES results in 2023	Equality Objective 5: The Trust is a place where staff feel a sense of belonging, are offered opportunities to develop and are supported to thrive
Menopause support service launched	Equality Objectives 4 & 5

Carers and Men's network launched	Equality Objectives 4 & 5
Progress against other identified actions outside of previous 2022 EDS: For further detail of progress against other EDI action plans during 2022- 2023, please visit the Trust's Annual EDI Report, published at: United-Lincolnshire-Hospitals-NHS-Trust-Equality-Diversity-and-Inclusion-Annual-Report.pdf (ulh.nhs.uk)	

EDS Ratings and Score Card – Including the Trust's EDS Ratings

Trusts refer to the Rating and Score Card supporting guidance document before they start to score: EDS Ratings and Score Card Guidance (england.nhs.uk). Provisional scores are included in this report, for your review and input.

Each outcome is scored, then the scores of all outcomes are added together. This then provides Trusts with their overall score, or your EDS Organisation Rating. Ratings in accordance to scores are below.

The Trust's provisional EDS Organisation Rating for 2023 is: Achieving
In 2022, it was Developing

For Domain 1 it is: Achieving
For Domain 2 it is: Achieving
For Domain 3 it is: Achieving

Each indicator for each domain has examples of how the Trust can improve its rating, and the Action Plan has been developed with this in mind.

Undeveloped activity – **organisations score out of 0** for each outcome	Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**
Developing activity – **organisations score out of 1** for each outcome	Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**

Achieving activity – **organisations score out of 2** for each outcome	Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving**
Excelling activity – **organisations score out of 3** for each outcome	Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

Domain 1: Patients (Commissioned or provided services)

Service 1 – Hospice in Hospital, Grantham & District Hospital

Service 2 – Shuttleworth Ward, Lincoln County Hospital

Service 3 – AMSS, Pilgrim Hospital, Boston

Domain outcome	Case study	Embedded
• 1B: Individual patients (service users) health needs are met • 1C: When patients (service users) use the service, they are free from harm	Hospice in Hospital	EDS 2023 Domain 1 - case study - Grantl
• 1A: Patients (service users) have required levels of access to the service • 1D: Patients (service users) report positive experiences of the service	Shuttleworth	EDS-2022-Domain-1 -case-study TAU.pdf
• 1C: When patients (service users) use the service, they are free from harm • 1D: Patients (service users) report positive experiences of the service	AMSS	EDS-2022-Domain-1 -case-study-AMSS.p

Domain 1: Commissioned or provided services

Outcome	Evidence	Rating	Owner (Dept/Lead)
1A: Patients (service users) have required levels of access to the service	Please see Shuttleworth case study above and evidence summary at Domain 1\Evidence Summary Domain 1.pdf	2 - Achieving	Patient Experience
1B: Individual patients (service users) health needs are met	Please see Hospice in Hospital case study above and evidence summary at Domain 1\Evidence Summary Domain 1.pdf	2 - Achieving	Patient Experience
1C: When patients (service users) use the service, they are free from harm	Please see evidence summary at Domain 1\Evidence Summary Domain 1.pdf	2 - Achieving	Patient Experience & Patient Safety
1D: Patients (service users) report positive experiences of the service	Please see evidence summary at Domain 1\Evidence Summary Domain 1.pdf	2 - Achieving	Patient Experience
Domain 1: Commissioned or provided services overall rating		8	Achieving

Domain 1: Commissioned or provided services

Outcome 1A: Patients (service users) have required levels of access to the service

Evidence – Please see Shuttleworth case study above and evidence summary at Domain 1\Evidence Summary Domain 1.pdf

Rating 2 - Achieving

Actions for 2024-25:

- Complete the data actions required in the NHS England statement on information on Health Inequalities:
- Complete and launch Gender Identity Policy (patients), with resources to support effective implementation
- Improve availability of patient equalities data by continuing to take part in ePatient Record (ePR) project
- Ensure appropriate resourcing (skills and time) for patient equalities across the Group model (ULHT & LCHS)
- Support Estates & Facilities team with equality impact assessments and accessibility. Include information such as ramps and hearing loops on patient maps

Please see Action Plan at end of report for full details of all Actions (SMART)

Outcome 1B: Individual patients (service users) health needs are met

Evidence – Please see Hospice in Hospital case study above and evidence summary at Domain 1\Evidence Summary Domain 1.pdf

Rating 2 - Achieving

Actions for 2024-25:

- As for 1B, plus implement a safety-net being Interpretation & Translation services (for example, clinical app-based solution) for emergency, unplanned incidences of unavailability of interpreter from main provider in timely manner.

Outcome 1C: When patients (service users) use the service, they are free from harm

Evidence – Please see evidence summary at Domain 1\Evidence Summary Domain 1.pdf

Rating 2 - Achieving

Owner (Department/Lead) – Patient Experience & Patient Safety

Actions for 2024-25:

- Ensure new Datix system is accurately and reliably reporting all EDI-related incidents and notifying the EDI team
- Continue to review risk register (EDI-related risks) through EDI Operational Group (EDIG) and establish a bi-annual review of learning from EDI-related patient incidents, via EDIG and PEG.

Outcome 1D: Patients (service users) report positive experiences of the service

Evidence – Please see evidence summary at Domain 1\Evidence Summary Domain 1.pdf

Rating 2 - Achieving

Owner (Department/Lead) – Patient Experience

Actions for 2024-25:

- As per all Domain 1 actions above, plus revisit the use of equalities monitoring in Friends and Family Test and other patient/carer feedback mechanisms to enable comparison of experiences, in conjunction with the Data Governance team, to address any previous concerns which led to this option being turned off several years ago.

Domain 1: Commissioned or provided services overall rating – 8 Achieving

Domain 2: Workforce Health & Wellbeing

Outcome	Data Sources	Evidence	Proposed Rating	Owner (Dept/Lead)
2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	Occupational Health Referral Data National Staff Survey (NSS) question 9d "My immediate manager takes a positive interest in my health & wellbeing" **Trust Average - 65.6% (Improving)** **National Average 67.4%** NSS question 11a "Organisation takes positive action on health & wellbeing". **Trust Average – 52.3% (same as previous EDS report)**	Please see evidence and data summary at Domain 2\Outcome 2A Evidence and Data by Protected Characteristic.pdf	Achieving – 2	Head of Occupational Health and Head of Equality, Diversity & Inclusion

	National Average 55.6%			
2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	q13a- Not experienced physical violence from patients/service users, their relatives or other members of the public **Overall Trust average 84% (same)** **National Average 85% (0.8% worse)** q13b- Not experienced physical violence from managers **Overall Trust average 99.1% (0.1% improved)** **National Average 99.2% (0.2% worse)** q13c- Not experienced physical violence from other colleagues **Overall Trust average 97.8% (no change)** **National Average: 98.2% (0.2% worse)** q14a- Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public **Overall Trust Average 73.8% (1% improved)**	The Trust's "United against Discrimination" programme continued in 2023. For an update and plans for 2024, please visit United Against Discrimination Update Jan 2024. The data for this indicator can be found at Domain 2\Data for Outcome 2b.pdf. This also contains an analysis by protected characteristic, which is required for EDI High Impact Action 6, and the actions in United against Discrimination provide evidence for this High Impact Action too.	Achieving- 2	Reporting: Nico Batinica, Deputy Director of HR Just Culture - Lindsay Shankland, Deputy Director of HR

	National Average 71.9% (0.7% worse) q14b- Not experienced harassment, bullying or abuse from managers **Trust Average 86.7% never (1.1% improved)** **National Average 88.4% (0.1% worse)** q14c- Not experienced harassment, bullying or abuse from other colleagues **Overall Trust Average- 78% (1.2% improved)** **National Average – 80% (0.5% worse)**			
2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	q13d- Last experience of physical violence reported **Overall Trust Average 63.4% (2.3% improved)** **"Yes, I reported it"** **National Average 68.3% (1.8% improved)** q14d- Last experience of harassment/ bullying/abuse reported **Overall Trust Average 43.7% (1.3%)** **"Yes, I reported it"**	Please see Domain 2\Data for Outcome 2c.pdf for the evidence and data summary for this outcome.	Achieving -2 To reach Excelling: The organisation facilitates pooling union representatives with partner organisations,	Chief People Officer and Staff-side Representatives

	National Average – 47.4% (0.9% improved)		to encourage independence and impartiality. It may be possible to consider this at a later stage in the Group model, with LCHS. .	
2D: Staff recommend the organisation as a place to work and receive treatment	Q23d "If a friend or relative needed treatment, would be happy with the standard of care provided by the Trust" **Trust Average: 42.7% (0.8% worse)** **National Average: 61.9% (5.1% worse)** Q23c Would recommend the Trust as a place to work **Trust Average: 44.1% (5.6% better)**	Please see Domain 2\Outcome 2D Evidence and Data by Protected Characteristic.pdf for the data summary for this outcome,	As a place to receive care, to reach Developing, the Trust average would need to increase to over 50%, as per EDS ratings & scorecard. To reach Achieving, it would need to be over 70%	Place to receive care: Dr Colin Farquharson Place to work: Deputy Directors of HR, supported by Divisional Heads of HR, Head of OD & Learning and People Promise Manager.

	National Average: 56.5% (1.9% worse)		As a place to work, the Trust is improving significantly, and if the quarterly Pulse data is considered, it very closely reaches Developing for EDS, at 49.9% for Quarter However, if the quarterly Pulse data is taken into account, it very closely reaches Developing, at 49.6% for Quarter 2 23-24, following an improving trajectory from 45.3% in Q4 22-23, and	

			47.2% in Q1 23-24. Therefore the proposed rating for outcome 2D is Developing	
Domain 2: Workforce health and well-being overall rating		Achieving	7	

Domain 2: Workforce Health & Wellbeing

2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions

Data sources
Occupational Health Referral Data

National Staff Survey (NSS) question 9d

“My immediate manager takes a positive interest in my health & wellbeing”

Trust Average - 65.6% (Improving)

National Average 67.4%

NSS question 11a “Organisation takes positive action on health & wellbeing”.
Trust Average – 52.3% (same as previous EDS report)

National Average 55.6%

Evidence – Please see evidence and data summary at Domain 2\Outcome 2A Evidence and Data by Protected Characteristic.pdf

Proposed Rating Achieving – 2

Actions for 2024-25:

- Can become Excelling if the health monitoring data which is now collated by Occupational Health and made available anonymously by all protected characteristics is used alongside anonymised absence data to increase and tailor support to all staff, including those with protected characteristics. **This will also support NHS EDI Improvement Plan High Impact Action 4**. The People Planning & Transformation team are kindly preparing a workforce, areas of deprivation and Primary Care Network map - which will indicate the most prevalent health concerns and inform this action.
- This support should both enable staff to self-manage their health and the Trust will also use it to reduce negative impacts of the working environment.

2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source

Data sources q13a- Not experienced physical violence from patients/service users, their relatives or other members of the public

Overall Trust average
84% (same)

National Average 85% (0.8% worse)

q13b- Not experienced physical violence from managers
Overall Trust average 99.1% (0.1% improved)

National Average 99.2% (0.2% worse)

q13c- Not experienced physical violence from other colleagues
Overall Trust average
97.8% (no change)

Evidence – The Trust's "United against Discrimination" programme continued in 2023. For an update and plans for 2024, please visit United Against Discrimination Update Jan 2024.

The data for this indicator can be found at Domain 2\Data for Outcome 2b.pdf. This also contains an analysis by protected characteristic, which is required for EDI High Impact Action 6, and the actions in United against Discrimination provide evidence for this High Impact Action too.

Any violence at all from managers is a significant concern in terms of leadership behaviours. In total, 42 colleagues reported experiencing at least one incident in this category, with 5 colleagues experiencing between 6 and 10 such incidents in the previous 12 months, meaning that physical violence from their manager is a regular occurrence in their workplace.

National Average: 98.2% (0.2% worse)

q14a- Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public
Overall Trust Average 73.8% (1% improved)

National Average 71.9% (0.7% worse)

q14b- Not experienced harassment, bullying or abuse from managers
Trust Average 86.7% never (1.1% improved)

National Average 88.4% (0.1% worse)
q14c- Not experienced harassment, bullying or abuse from other colleagues
Overall Trust Average-
78% (1.2% improved)

National Average – 80% (0.5% worse)

Bullying, harassment and abuse from other colleagues and peers is an area which the data suggest the Trust should focus on further, across multiple protected characteristics, along with continued support and accountability for managers in terms of their behaviours.

Proposed Rating
Achieving- 2

Actions for 2024-25:

Can achieve Excelling, if the Trust can demonstrate that it takes action to penalise those staff who abuse, harass, bully or in rare circumstances, use physical violence against other staff.

Monitoring trends of incidents will also become essential by July 2024 for full implementation of the NHS Sexual Safety Charter.

To achieve excelling, the groups experiencing poorer outcomes, as outlined in the data report, will need to be reporting an improving trend in their experiences in the NSS results

- Fully-imbedding the Just Culture Framework and One Culture – Civility & Respect will further assist improvements for this outcome.

- **NHS EDI Improvement Plan, High Impact Action 6**. • Review relevant data by protected characteristic and set year-on-year reduction targets and improvement plans • Review disciplinary and employee relation processes and where data indicates inequity, take immediate action to drive improvement. This may require insights from trust solicitors • Create an environment where staff feel able to speak out about concerns. Boards are asked to review relevant data by protected characteristic and take steps to ensure parity for all staff • Provide comprehensive psychological support to staff who report being a victim of bullying, harassment, discrimination or violence and ensure staff know how to access this by June 2024: • Have effective policies in place to support staff affected by domestic abuse and sexual violence (DASV). Support should be available for those who need it, and staff should know how to access it.

2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source

Data sources q13d- Last experience of physical violence reported
Overall Trust Average 63.4% (2.3% improved)
"Yes, I reported it"

National Average
68.3% (1.8% improved)

q14d- Last experience of harassment/ bullying/abuse reported

Overall Trust Average 43.7% (1.3%)
"Yes, I reported it"

National Average – 47.4% (0.9% improved)

Evidence – Please see Domain 2\Data for Outcome 2c.pdf for the evidence and data summary for this outcome

Proposed Rating Achieving -2

Actions for 2024-25:

- To reach Excelling, the organisation facilitates pooling union representatives with partner organisations, to encourage independence and impartiality. It may be possible to consider this at a later stage in the Group model, with LCHS.

Owner (Dept/Lead) Chief People Officer and Staff-side Representatives

2D: Staff recommend the organisation as a place to work and receive treatment

Data sources
Q23d "If a friend or relative needed treatment, would be happy with the standard of care provided by the Trust"

Trust Average:
42.7% (0.8% worse)

National Average:
61.9% (5.1% worse)

Q23c Would recommend the Trust as a place to work

Trust Average:
44.1% (5.6% better)

National Average:
56.5% (1.9% worse)

Evidence –
Please see Domain 2\Outcome 2D Evidence and Data by Protected Characteristic.pdf for the data summary for this outcome,

For both measures, the Trust proactively identifies and compares the experience of different groups with protected characteristics, through the National Staff Survey and Staff Networks, Datix and Employee Relations metrics.

The People Promise Manager and Head of EDI (acting) work closely together to improve areas of differing staff experience

Proposed Rating To reach Developing as a **place to receive care**, the Trust average would need to increase to over 50%, as per EDS ratings & scorecard. Currently it would rate as under-developed.

To reach Achieving, it would need to be over 70%

As a **place to work**, the Trust is improving significantly, and if the quarterly Pulse data is considered, it very closely reaches Developing for EDS (50%), at 49.9% for Quarter 2 23-24, and on an improving trajectory over the two previous quarters too.

Therefore the proposed rating for outcome 2D is Developing

Actions for 2024-25:

- For both measures, the Trust will continue to proactively identify and compare the experience of different groups with protected characteristics, as part of the wider work to improve National Staff Survey results for these questions. This will be achieved through the National Staff Survey data analysis, and staff networks feedback, Datix reports, Freedom to Speak Up themes and Employee Relations metrics.
- The People Promise Manager and Head of EDI will continue to work closely together to improve areas of differing staff experience

Domain 2: Workforce health and wellbeing overall rating – 7 Achieving

Domain 3: Inclusive Leadership

Outcome	Evidence	Rating	Owner (Dept/Lead)
3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	Please see data and evidence summary for Domain 3 at: Domain 3\Domain 3 Evidence.pdf	2 - Achieving	Trust Board
3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	Please see data and evidence summary for Domain 3 at: Domain 3\Domain 3 Evidence.pdf	2 - Achieving	Trust Board
3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	The Trust's WRES, WDES, EDS and Gender Pay gap reporting, along with NSS (staff survey) results showed an improving trend in 2023 and action plans were monitored by EDI Operational Group, with upward reporting to People & OD Committee.	2 - Achieving	Trust Board

	For further evidence for Domain 3c, please see: Domain 3\Domain 3 Evidence.pdf		
Domain 3: Inclusive leadership overall rating		Achieving	6

Third-party involvement in Domain 3 rating and review	
Trade Union Rep(s):	**Independent Evaluator(s)/Peer Reviewer(s):**
EDI Operational Group: Corinna Bunn	None

Domain 3: Inclusive Leadership

3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities

Evidence – Please see data and evidence summary for Domain 3 at: Domain 3\Domain 3 Evidence.pdf

Rating 2 - Achieving

Actions for 2024-25:

- To reach Excelling, Staff Networks to have more than one senior sponsor. To be proposed to Executive Leadership Team (ELT), to consider opting for deputy Executive Sponsors at e.g. Associate Director level.

3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed

Evidence – Please see data and evidence summary for Domain 3 at: Domain 3\Domain 3 Evidence.pdf

Rating 2 - Achieving

Actions for 2024-25:

- Complete the actions required in the November 2023 statement on information on Health Inequalities: NHS England » NHS England's statement on information on health inequalities (duty under section 13SA of the National Health Service Act 2006)
- Provide evidence that equalities and health inequalities are standing agenda items in all board and committee meetings.

3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients

Evidence – The Trust's WRES, WDES, EDS and Gender Pay gap reporting, along with NSS (staff survey) results showed an improving trend in 2023 and action plans were monitored by EDI Operational Group, with upward reporting to People & OD Committee.
For further evidence for Domain 3c, please see: Domain 3\Domain 3 Evidence.pdf

Rating 2 – Achieving

Actions for 2024-25:

- Board members ensure that the Trust fully implements the Leadership Framework for Health Inequalities and that the Board EDI objectives are implemented

Domain 3: Inclusive Leadership overall rating – Achieving 6

Third-party involvement in Domain 3 rating and review	
Trade Union Rep(s):	**Independent Evaluator(s)/Peer Reviewer(s):**

EDI Operational Group: Corinna Bunn	None

EDS Organisational Rating (overall rating)

EDS Organisation Rating (overall rating): Achieving/Developing

Total score is 21. 22 is required to reach Achieving overall, however each of the 3 Domains is rated as Achieving.

Organisation name(s): **United Lincolnshire Hospitals NHS Trust**

Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**

Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**

Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving**

Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

EDS Action Plan 2024

EDS Action Plan	
EDS Lead	**Year(s) active**
Alison Marriott, Head of Equality, Diversity & Inclusion (Acting)	February 2023-February 2024
EDS Sponsor	**Authorisation date**
Claire Low, Director of People & OD	Trust Board – TBC EDI Operational Group – 7th February 2024 People & OD Committee – 12th March 2024

Domain 1: Commissioned or provided services

Outcome	Objective	Action	Completion date	SRO/Responsible
1A: Patients (service users) have required levels of access to the service	To reach Excelling and fulfil duties under section 13SA of the NHS Service Act 2006 and the Public Sector Equality Duty 2011.	Complete the actions required in the November 2023 statement on information on Health Inequalities: NHS England » NHS England's statement on information on health inequalities (duty under section 13SA of the National Health Service Act 2006) Complete & launch Gender Identity Policy for patients, with learning resources to support effective implementation. Improve availability of patient equalities data by continuing to take part in	31st March 2025 (two-year cycle) September 2024	Sameedha Rich-Mahadkhar Head of EDI

		ePatient Record (ePR) process Ensure appropriate resourcing (skills and time) for patient equalities across the Group model (ULHT & LCHS) Support Estates & Facilities team with equality impact assessments and accessibility. Include information such as ramps and hearing loops on patient maps	December 2024 December 2024	C Low and K Dunderdale Head of EDI & Communications
1B: Individual patients (service users) health needs are met	To reach Excelling and fulfil duties under section 13SA of the NHS Service Act 2006 and the Public Sector Equality Duty 2011.	As above, plus implement a safety-net behind Interpretation & Translation services (for example, app-based solution), for emergency, unplanned incidences of unavailability of interpreter	Aug 2024 – pilot to be complete	Head of EDI, Deputy Chief Nursing Officer, Head of Patient Experience. Funding support required

1C: When patients (service users) use the service, they are free from harm	To reach Excelling and ensure reliability of patient safety-related EDI data	Ensure new Datix system is accurately and reliably reporting and sharing all EDI-related incidents with the EDI team. Continue to review risk register (EDI-related risks) through EDI Operational Group and establish a bi-annual review of learning from EDI-related patient incidents, via EDIG & PEG.	June 2024 Ongoing and bi-annual review in place by October 2024	Head of EDI & Head of Patient Safety Head of EDI
1D: Patients (service users) report positive experiences of the service	Person-centred care is experienced by all, with a well-informed, responsive approach to equality of patient experience and to the reduction of health inequalities	As per previous Domains, plus: Revisit the use of equalities monitoring in Friends and Family Test to enable the above, in conjunction with the Data Governance team, to address any previous	May 2024	Head of Patient Experience and Head of EDI

		concerns which led to this option being turned off several years ago.		

Domain 2: Workforce health and wellbeing

Outcome	Objective	Action	Completion date	SRO/Responsible
2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	To reach Excelling and to complete NHS EDI Improvement Plan High Impact Action 4.	Anonymised data on who is accessing the service by protected characteristic (Trustwide - for anonymity) and the reasons for accessing the service to be made available by Occupational Health. Data to be used alongside anonymised absence data to increase and tailor support to all staff, including those with protected characteristics. **This will also support NHS EDI Improvement Plan High Impact Action 4**, for which the People Planning & Transformation team are kindly preparing a workforce, areas of deprivation and Primary Care Network map, which will indicate the most prevalent health concerns in the areas where our staff live.	June 2024 August 2024	L Shankland N Batinica

		This support should both enable staff to self-manage their health & the Trust should also use it to reduce negative impacts of the working environment	December 2024	L Shankland
2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	To reach Excelling and complete NHS EDI Improvement Plan High Impact Action 6	For details of the Trust's published WRES and WDES action plans, please visit: NHS Workforce Race Equality Standard (WRES) - United Lincolnshire Hospitals (ulh.nhs.uk) and NHS Workforce Disability Equality Standard (WDES) - United Lincolnshire Hospitals (ulh.nhs.uk)	In line with WRES and WDES objectives	L Shankland
		Continued engagement with the support of the Pride + network to help understand how to best support the health & wellbeing of LGBTQIA+ colleagues, including those whose experiences are not featured in the National Staff Survey due to the data threshold. This is part of the United against Discrimination programme.	Throughout 2024, ongoing	Head of EDI & Pride+ network leads, with Communications support.
		NHS Sexual Safety Charter – work underway	July 2024	K Dunderdale & Head of EDI

		To ensure data is available demonstrating that appropriate action is taken when colleagues are found to have bullied, harassed, abused or discriminated against anyone	June 2024	N Batinica
2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	To reach Excelling	Trusts who reach Excelling facilitate the pooling of union representatives with partner organisations, to encourage independence and impartiality. It may be possible to consider this at a later stage in the Group model, with LCHS.	In line with progress with Group Model	C Low
2D: Staff recommend the organisation as a place to work and receive treatment	To reach Achieving	Measures: Over 70% of staff who live locally to services provided by the organisation do/would choose to use those services. Over 70% of staff who live locally are happy and regularly recommend the organisation as a place to work.	National Staff Survey Results 2025-26	Dr Colin Farquharson N Batinica and L Shankland, supported by Heads of Department

		Over 70% of staff who live locally to services provided by the organisation would recommend them to family and friends. Actions: To use sickness and absence data and data from end of employment exit interviews to identify and implement improvements. Head of EDI has begun to work on this with the People Promise Manager. The Trust already collates and compares the experiences of BAME, LGBT+ and Disabled staff against other staff members, and now needs to continue to ensure it acts upon the data	September 2024	People Promise Manager Head of EDI

Domain 3: Inclusive Leadership

Outcome	Objective	Action	Completion date	SRO/Responsible
3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	To achieve Excelling, to support Staff Networks further and to continue to imbed inclusion at all levels of leadership & management in the Trust	Staff networks to have more than one senior sponsor. This has been proposed to Executive Leadership Team (ELT) previously, to consider opting for deputy Exec Sponsors at e.g. Associate Director level. This will provide additional availability & support to network leads due to the expansion of Group roles in ELT and associated workload. Also, it will develop a pipeline of future executive sponsors. Further, it will strengthen staff & patient experience through their inclusive leadership at multiple levels of management & leadership.	April 2024	C Low and A Morgan

3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	To reach Excelling and fulfil duties under section 13SA of the NHS Service Act 2006 and the Public Sector Equality Duty 2011	As per 1a - Complete the actions required in the November 2023 statement on information on Health Inequalities: NHS England » NHS England's statement on information on health inequalities (duty under section 13SA of the National Health Service Act 2006) Evidence that equality and health inequalities are standing agenda items in **all** board and committee meetings.	31st March 2025 (two-year cycle)	S Rich-Mahadkar Trust Board & Trust Board Secretariat
3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	To reach Excelling and ensure that progress continues to be made with both workforce and patient EDI	Board members ensure that the Trust fully implements the Leadership Framework for Health Inequalities and that the Board EDI objectives are implemented	Ongoing	Trust Board

END

For all enquiries relating to this report, please contact: Inclusion@ulh.nhs.uk

Lincolnshire Community Health Services NHS Trust

Report to Lincolnshire Community and Hospitals Group Board

Date of meeting	7th May 2024	Agenda item	10.1
Title	Report on the Finance, Performance, People and Innovation Committee meetings held on 28th March 2024 and 26th April 2024.		
Report of	Gail Shadlock, Non Executive Director	Prepared by	Claire Low, Director of People and Innovation Julie Frake-Harris, Chief Operating Officer Sam Wilde, Director of Finance and Business Intelligence
Previously considered by / Date	None	Approved?	N/A
Summary	The FPPIC Committee met on 28th March 2024 and 26th April 2024. **Green:** Effective controls are definitely in place and the committee is satisfied that appropriate assurances are available **Amber:** Effective controls are thought to be in place but assurances are uncertain and/or possibly insufficient **Red:** Effective controls may not be in place and/or appropriate assurances are not available		

1. Provide safe, high quality, population healthcare	**1a. Deliver safe services**	**Cautious** approach to patient safety or harm with strong focus driven by national strategies and policies.	
	1b. Deliver effective care	**Open** approach to effective care**.**	
	1c. Engage and involve people in their care	**Seek** approach to engagement and involvement.	
2. Deliver personalised community health services that are accessible and responsive	**2a. Deliver clinically led integrated community services**	**Open** approach to clinically led integrated community services.	
	2b. Deliver personalised health care that responds to individual need	**Open** approach to personalised health care that responds to individual need.	
	2c. Transform clinical pathways for sustainability and improved outcomes	**Seek** approach to transformation of clinical pathways for sustainability and improved outcomes.	

3. Build a productive, capable and inclusive workforce	**3a. Grow and retain our people**	**Open** to maximising transformation opportunities and will try new and innovative ideas and ways of working to improve job satisfaction and enrichment.	√
	3b. Value and develop our people	**Cautious** approach to staff safety and wellbeing and recruitment compliance**.**	√
	3c. Enable a change ready workforce	**Seek** new and innovative ways of working through the use of automation and technology which in turn will improve productivity and release time to care.	√
	3d. Deliver Safe and Sustainable Foundations	**Cautious** approach to cyber security, health and safety and recruitment compliance. This is because we value our people as our greatest asset and we strive to keep our people, our patients and their respective information as safe as possible.	√
4. Ensure healthcare is financially sustainable, making best use of resources	**4a. Deliver financially sustainable healthcare, making best use of resources**	**Open –** Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level.	√
	4b. Drive better decisions and impactful action through insight	**Seek -** We will invest for the best possible return and accept the possibility of increased financial risk (with controls in place).	√
5. Collaborate to play an active role in the Lincolnshire ICS	**5a. Collaborate to make a difference**	**Seek** opportunities to be innovative and collaborative, both within the organisation and the wider system environment.	√
	5b. Transform services to deliver great care close to home	**Seek** opportunities to be innovative and collaborative, both within the organisation and the wider system environment.	√

Impact of proposal/ report	*N/A Assurance Report*				
CQC	**Safe**	**Caring**	**Effective**	**Responsive**	**Well-Led**
Links to risks	*388, 389, 390, 391, 393, 394, 395, 397, 405, 406, 407, 409, 415, 417, 419, 422, 424, 425, 427, 428, 435, 441, 442, 443, 444, 445, 455, 462, 489, 490, 491, 495, 501, 502, 503, 649, 658, 660, 661, 663, 665, 666, 673*				
Legal/ Regulation	*Please outline any relevant connections that need to be considered.*				

Recommendations/ Actions Required

Board is asked to:
- **NOTE** the report;
- **RECEIVE** the updated FPPIC Terms of Reference (appendix 1) and FPPIC Annual Report 2023/24 (appendix 3); and

- **CONSIDER** the recommendation to approve the Lincolnshire NHS Financial Framework for 2024/25 (appendix 2).

Appendices

Appendix 1 – FPPIC Terms of Reference approved March 2024
Appendix 2 - Lincolnshire NHS Financial Framework for 2024/25
Appendix 3 – FPPIC Annual Report 2023/24

Glossary

A&E – Accident and Emergency
BPPC – Better Payment Practice Code
CIP – Cost Improvement Programme
DEG – Digital Executive Group
DQIG - Data Quality Improvement Group
DSPT – Data Security and Protection Toolkit
EDI – Equality, Diversity and Inclusion
EDS3 – Equality Delivery System 3
FEG - Finance & Business Intelligence Executive Group
FPPIC – Finance, Performance, People and Innovation Committee
FRP – Financial Recovery Programme
ICS – Integrated Care System
IPR – Integrated Performance Report
LCHS – Lincolnshire Community Health Services NHS Trust
LSIIG - Lincolnshire Strategic Infrastructure and Investment Group
NCCI – National Cost Collection Index
NHS – National Health Service
NQPS – National Quarterly Pulse Survey
PEG – People Executive Group
PMR – Performance Management Review
Q3 – Quarter 3 2023/24 (October 2023 – December 2023 inclusive)
Q4 – Quarter 4 2023/24 (January 2024 – March 2024 inclusive)
QSRM – Quarterly System Review Meeting
TLT – Trust Leadership Team
ToR – Terms of Reference
UTC – Urgent Treatment Centre
WDES - Workforce Disability Equality Standard
WRES - Workforce Race Equality Standard

Report on the FPPIC meetings held on 28th March 2024 and 26th April 2024.

1. Purpose

To make the Board aware of key issues from the Finance, Performance, People and Innovation Committee (FPPIC) meetings held on 28th March 2024 and 26th April 2024.

2. Key Issues

Key issues for the Board to be aware of are as follows:

GREEN ASSURANCE

Strategic Aim 3. Build a productive, capable and inclusive workforce:
Strategic Objective 3a. Grow and retain our people
Strategic Objective 3b. Value and develop our people
Strategic Objective 3c. Enable a change ready workforce
Strategic Objective 3d. Deliver Safe and Sustainable Foundations

Strategic Aim 4. Ensure healthcare is financially sustainable, making best use of resources:
Strategic Objective 4a. Deliver financially sustainable healthcare, making best use of resources
Strategic Objective 4b. Drive better decisions and impactful action through insight

Strategic Aim 5. Collaborate to play an active role in the Lincolnshire ICS:
Strategic Objective 5a. Collaborate to make a difference
Strategic Objective 5b. Transform services to deliver great care close to home

AMBER ASSURANCE

There are no strategic objectives rated as amber.

RED ASSURANCE

There are no strategic objectives rated as red.

Terms of Reference Review

The committee reviewed and approved proposed updates to its Terms of Reference at its March meeting. The approved updated Terms of Reference are attached appendix 1. The committee noted that further updates would be required shortly in light of new aims and objectives.

Monthly Finance Reports

The committee reviewed the month 11 and 12 finance reports at its meetings noting continued strong performance with 4 of the 5 elements of the financial plan. The committee agreed to reduce risk scores for financial risks:
443 – The Trust fails to deliver the capital spend requirement of its financial plan - this risk materialised but with modest impact; and
445 – The Trust financial position is negatively impacted as a result of the operation of Lincolnshire System risk and gain share agreement – operation of the agreement did not have a negative impact on the Trust's financial position.
.

The committee agreed to maintain the green assurance rating for strategic objective 4a - Deliver financially sustainable healthcare, making best use of resources.

The committee also reviewed the monthly system finance report and the monthly Financial Recovery Programme (FRP) progress reports.

Budget Setting and Capital Plan

The committee reviewed the proposed 2024/25 budgets and capital plan at its March meeting and approved these using the authority that had been delegated from Board. It was noted that these would inform the draft planning submission. Any further change in the final planning submission would be transacted through budget virements. It was noted that there were significant risks with a number of investment decisions still to be made and a sizable CIP requirement. The committee also reviewed the proposed Lincolnshire NHS Financial Framework for 2024/25 (Appendix 2) noting the refinements in light of experience in 2023/24 and agreed to recommend this to Board.
The committee received a further update 2024/25 Planning Update at its April meeting noting the organisations final planning submission had been approved by Board the previous day.

Staff Exclusions

The committee received verbal updates on staff exclusions at each meeting and were assured that appropriate pastoral care was in place for excluded staff. Moving forward it was agreed that a thematic overview would be provided to offer the Committee an overview perspective rather than month on month updates.

Annual Self-Assessment

The committee launched its annual self-assessment with all members due to complete this ahead of the May meeting.

Performance Management Review (PMR) Report

The committee reviewed the report from the February PMR meetings.

Annual Report from the Performance Management Review meetings

At its March meeting the committee reviewed the annual report on the operation of the Performance Management Review (PMR) meetings and were assured the PMRs had operated effectively throughout the year.

Integrated Performance Report

The committee reviewed the Integrated Performance Reports covering February and March 2024 performance.

3 indicators are not statistically capable of achieving performance targets without redesign at the end of March 2024:

(i) Home Visiting
A 3-stage improvement plan is being implemented. Stage 1 has already been implemented and stage 2 will take effect from April.

(ii) Ethnicity recording in A&E data sets
Redesign of this process earlier in the year has driven performance up from c65% to c85%. The next stage of redesign to get to the 95% target is a new data quality system 'RINSE' to

support managers to monitor and manage where ethnicity data is not populated at source.

(iii) Better Payment Practice Code
The improvement plan approved by Audit Committee has now been fully implemented. For external reporting purposes BPPC is measured on a 12-month rolling basis, so it will take some time for the benefits of the improvement work to be fully reflected in the numbers. Statistically significant improvement has been demonstrated consistently since April 2023.

2 metrics are showing signals of special cause deterioration currently:

(i) Vacancy Rate
This measure was artificially lowered following the TUPE transfer of Mass Vaccination Centre staff into LCHS whilst work was undertaken to align budgets and establishment. That work has now been completed. This measure remains consistently capable of achieving the 8% target and is better than the national benchmark for the community sector. The signal is not therefore a cause for concern.

(ii) Operations Centre Calls Answered In Timescale
The service has seen 4 resignations since January, is currently experiencing some long term sickness and is unable to recruit to roles that would constitute a cost pressure given the vacancy approval processes. An associated risk has been captured on the register.

9 indicators were showing special cause improvement which is a strong indication of the Trust's continuous improvement culture.

The committee noted that sickness absence levels had moved within the 5% target and long-term sickness absence was within the 3% target. Both measures were signalling statistically significant improvement.

HMRC Dispute
At its April meeting the committee reviewed wording proposed to be included within the Trust's contract with Lincolnshire Integrated Care Board in respect of the dispute with HMRC. The committee were satisfied the proposed wording met the Trust's requirements.

Strategic Partnership Developments Update
At its March meeting the committee reviewed the strategic partnership developments update and agreed the recommended green ratings for the 2 programmes under strategic objective 5a.

People Executive Group Update
An overview was shared with the Committee in the January meeting offering FPPIC an update in respect of the organisation's employees.
The People Executive Group (PEG) received reports from activity in Q4 2023/24. In total 12 areas reported into PEG for this quarter. No areas were rated red, with all 12 rated green for assurance. A high-level narrative is included in the paper of green rated which encompasses all pillars of the people strategy. Work has commenced to reviewing the People objectives and key performance indicators in line with the Group aims and objectives for 2024/2025.

Risk Assurance Report
The committee reviewed the Risk Assurance Report noting proposed new risks, closures and changes in risk scores up to the end of March 2024.

Board Assurance Framework
The committee reviewed its elements of the BAF and agreed that ratings for all strategic objectives under its oversight should remain green.

Procedural Documents Renewal Report
The committee reviewed the procedural documents renewal report noting the Corporate Health & Safety Policy, Fire Safety Policy and Standard Operating Procedure for the Lone Working Application were all expected to be in place within the next month.

Operational Plan Progress Report
The committee reviewed the quarter 4 operational plan progress report and the Operational Plan Year End Close Down report at its April meeting, noting:
- The reports contained no surprises and triangulated well with other sources of assurance;
- All projects for strategic aims 3, 4 and 5 were rated as either green or blue at the end of the year (NB: Blue is used to indicate a project is paused or 'on hold'); and
. The reporting timetable for the 2024/25 Operational Plan.

FBI Strategy Quarter 3 Update
The committee received the quarter 4 update on progress implementing the FBI strategy, noting 7 green and 1 blue rating against all of the Q4 deliverables. The committee agreed to maintain the green assurance ratings for:
- Strategic objective 4a – Deliver financially sustainable healthcare, making best use of resources; and
- Strategic objective 4b – Drive better decisions and impactful action through insight.

Health & Safety Updates
The committee received the quarterly report to the April meeting and updates from the ULHT Health and Safety Department. The management of Health and Safety and Fire Safety is being supplemented by ULHT alongside the ongoing relationship with LPFT. Initial reviews and KPI audits are progressing. Any areas identified for immediate action by ULHT Teams are escalated and on conclusion of findings a collective agreement on the management of Health and Safety and Fire Safety will be presented in a Group Model approach. A workshop has taken place to review the next steps towards a Health and Safety Committee in Common. This will look to align reporting into Trust Board as well as create greater oversight and assurances on risk and compliance areas.

People & Innovation Strategy – Quarter 4 Update
The committee received the quarter 4 update on progress implementing the People and Innovation strategies, noting green ratings against all the Q4 plans. The committee agreed to green ratings on the following strategic objectives:
- 3a – Grow and retain our people.
- 3b – Value and develop our people.
- 3c – Enable a change ready workforce.
- 3d - Deliver Safe and Sustainable Foundations

Digital Executive Group Update
A paper was provided with an update in respect of the Digital Executive Group including cyber assurance, compliance reporting, reported incidents and digital strategy. All 6 domains were reported as green to the committee. The domains are Data, Security and Protection Toolkit (DSPT), cyber assurance framework, data subject access requests, freedom of information, data breach management and training. It was also noted that the LCHS Electronic Patient Record (EPR) procurement was going well with several bids submitted.

Equality Delivery System 3 Update
A paper was provided with an update in respect of the completion of the Equality Delivery System 3 Pilot. The paper offered assurance that the National Workforce Disability Equality Standards are now embedded in the broader EDI action plan. These will continue to be reported through FPPIC as progress is made and aligned to the National EDI Improvement Plan. All other elements highlighted in the paper are RAG rated as green and on track for delivery.

FPPIC Annual Report
The committee reviewed an annual report on its performance against its terms of reference (appendix 3) and with one slight amendment was content to approve this for submission to Board.

FPPIC Reporting Cycle
The committee reviewed the reporting cycle.

Meeting Review
At the end of each meeting the committee had a short discussion to review how the meeting had gone and identify any opportunities for improvement going forward.

Control Issues Framework
No control framework issues were identified during the course of the meetings.

Any Other Business
At the March meeting committee members recognised and thanked Murray Macdonald for his contribution to and leadership of the committee over many years. Committee members wished Murray every success in his new role as a Non-Executive Director of East Midlands Ambulance Service NHS Trust.

The following items were approved:
- Minutes of the meeting held on 28th February 2024 and 28th March 2024;
- FPPIC Terms of Reference;
- 2024/25 Opening budgets and capital plan; and
- FPPIC Annual Report 2023/24.

Issues referred to or from Audit Committee
None

Items referred to or from Quality Committee
None

Items referred to or from Trust Board

The committee wanted to draw Boards attention to the significant risks in the financial plan with a number of investment decisions still to be made and a sizable CIP requirement.

3. Conclusion/Recommendations

Board is asked to:
- **NOTE** the report;
- **RECEIVE** the updated FPPIC Terms of Reference (appendix 1) and FPPIC Annual Report 2023/24 (appendix 3); and
- **CONSIDER** the recommendation to approve the Lincolnshire NHS Financial Framework for 2024/25 (appendix 2).

Lincolnshire Community Health Services NHS Trust

Terms of Reference

Finance, Performance, People & Innovation Committee

Authority

The Lincolnshire Community Health Services Trust Board (Trust Board) hereby resolves to establish a committee of the Trust to be known as the Finance, Performance, People and Innovation Committee (the Committee). The Committee is a non-executive committee of the Trust and has no executive powers, other than those specifically delegated in these terms of reference.

The Committee is authorised by the Trust Board to investigate any activity within its terms of reference.

It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.

The Committee is authorised by the Trust Board to obtain outside legal or other Independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Purpose and role

The Lincolnshire Community Health Services NHS Trust Finance, Performance, People and Innovation Committee is established to provide assurance to the Trust Board that appropriate and effective governance mechanisms are in place for all aspects of:

- financial and operational strategy, policy, management and reporting
- people and innovation
- health and safety
- performance management and reporting
- procurement strategy and investment policy
- management and reporting
- integrated business planning
- associated strategies,
- digital health and cyber security
- security management
- information governance
- equality, diversity, inclusion and health inequalities
- population health management (performance, finance, data and staff aspects)
- verbal updates, as necessary, from Non-Executive Director Champions and compliance with national, regional and local regulatory requirements.

The role of the Committee is to seek assurance on the Trust's delivery of LCHS Strategic Objectives.

The Committee will:

a) Provide assurance to the Board to inform the strategic direction of the annual plan.

b) Hold Trust officers to account for delivery of actions articulated within the Board Assurance Framework relating to LCHS Strategic Aims and Objectives to include:

Aim 3: Build a productive, capable and inclusive workforce
Objectives:

- 3a. Grow and retain our people
- 3b. Value and develop our people
- 3c. Enable a change ready workforce
- 3d. Deliver Safe and Sustainable Foundations

Aim 4: Ensure healthcare is financially sustainable, making best use of resources
Objectives:

- 4a. Deliver financially sustainable healthcare, making best use of resources
- 4b. Drive better decisions and impactful action through insight

Aim 5: Collaborate to play an active role in the Lincolnshire ICS
Objectives:

- 5a. Collaborate to make a difference
- 5b. Transform services to deliver great care close to home

c) Agree the key priorities in terms of LCHS Strategic Objectives.

Membership

The Committee shall be appointed by the Trust Board and shall consist of:

- Not less than two Non-Executive Directors
- A Non-Executive Director will be designated Chair of the Committee
- Director of Finance and Business Intelligence
- Director of People and Innovation
- Chief Operating Officer

The following officers are in attendance at the Committee

- Director of Operations
- Deputy Director of People
- Deputy Director Innovation
- Deputy Director of Finance, Performance and Information
- Deputy Director of Strategy and Partnerships
- Deputy Director of Corporate Governance
- Deputy Director AHPs and Clinical Transformation

Quorum

A quorum shall be three, including at least one non-executive director and at least one executive director.

Attendance

All other members of the Trust Board shall be entitled to attend and receive papers to be considered by the Committee.

The Director of Finance and Business Intelligence shall be the Executive Director lead for the Committee.

Other officers may be invited to attend meetings as appropriate.

Observers will be permitted as agreed by the Chair.

It is the responsibility of individual members to ensure a deputy is sent to meetings if they are unable to attend and that this deputy has sufficient knowledge and authority to actively participate on their behalf.

Frequency of meetings

The Committee will meet monthly in person or by virtual means.

Duties and responsibilities

The Committee's duties/responsibilities can be categorised as follows:

Financial and Operational Strategy, Policy, Management & Reporting

(i) To consider and monitor the Trust's financial strategy, in relation to both revenue and capital
(ii) To consider and monitor the Trust's annual financial duties and targets
(iii) To consider, review and monitor delivery against annual CIP targets
(iv) To review proposals for major business cases and procurements including their respective funding sources
(v) To receive and consider as appropriate, reports on commercial activities of the Trust
(vi) Risk analysis.

People Executive Group

(i) To consider, on a quarterly basis, any items of specific concern, or which require Board approval, which will be the subject of a separate report
(ii) To consider key issues arising from the People Board Executive Group, demonstrating effective internal control and to enable the Committee to have confidence in its control systemProvide information to support the the Non-Executive Director Wellbeing Guardian in their role to assure the Board.

(iii) Provide information to support the the Non-Executive Director Freedom to Speak up Guardian in their role to assure the Board.

Health and Safety Committee

(i) To consider Health and Safety Committee activity reports for purposes of clarification and assurance that known and identified risks to the Trust are being reported upon, considered, resolved, removed and actively monitored by the committee.
(ii) To oversee and assure the Committee regarding security management measures, activity and related strategies for violence prevention and reduction.
(iii) Ensure a senior management review is undertaken twice yearly, and as required or requested, to evaluate and assess the violence prevention and reduction programme, sharing the findings with the Board.
(iv) Provide information to support the the Non-Executive Director Champion for Security Management in their role to assure the Board.

Performance Management and Reporting

(i) To consider the Trust's identification and collection and reporting of Key Performance Indicators through an Integrated Performance Report
(ii) To consider and monitor the Trust's achievement of Key Performance Indicators
(iii) To consider and review the arrangements to maintain data and to report achievement of Key Performance Indicators
(iv) To approve and keep under review the Trust's Performance through the Finance and Business Intelligence Strategy.
(v) Review and monitor the Trust's delivery of Population Health Management.

Procurement strategy, Investment Policy, Management & Reporting

(i) To approve and keep under review, on behalf of the Board of Directors, the Procurement Strategy and Investment Policy
(ii) To receive and consider major Trust Investment Plans and maintain an oversight of the Trust's investments, ensuring compliance with the Trust's policy and Monitor's requirements
(iii) To approve any innovative, commercial or investment activity e.g. proposed joint ventures.

Integrated Business Planning

(i) To review the preparation and delivery of the Trust's Integrated Business Plan.

Strategies

(i) To consider and keep under review, on behalf of the Board of Directors, the Trust's Digital Heath Strategy, People Strategy, Estates Strategy,

Finance and Business Intelligence Strategy and those elements of the relating to business relationships and related policies

(ii) To consider and approve any significant variations to the Trust's existing procurement methodology in accordance with the Standing Orders.

Digital Executive Group

(i) To maintain an oversight of the Trust's cyber security arrangements, ensuring that associated risks are appropriately mitigated and critical systems and equipment maintained.
(ii) Oversee and ensure the 10 minimum cyber security standards are followed.
(iii) Review and monitor the Trust's delivery of Information Governance, including the General Data Protection Regulations (GDOPR)
(iv) Oversee and maintain information governance systems and Trust assets.
(v) Provide the Committee and Trust Board with assurance in respect of the Registration Authority annual report
(vi) Provide information and any assurance as requested by the Non-Executive Director Champion for Security Management.

Equality, Diversity and Inclusion Group

(i) To consider and drive the Trust's approach to equality, diversity, inclusion and health inequalities.
(ii) Review and monitor the Trust's delivery of plans to reduce Health Inequalities.

Other Duties

To make arrangements as necessary to ensure that all members of the Board and senior officers of the Trust maintain an appropriate level of knowledge and understanding of key financial issues affecting the Trust.

Reporting

a) The Committee will report to theTrust Board following each meeting. Any items of specific concern, or which require Board approval, will be referred to the Board by the Chair.

b) Key Issues arising from the Committee will be provided to the Trust Board and to demonstrate effective internal control and to enable the Board to have confidence in its control system.

c) The key issues related to Committee effectiveness and internal control gaps will be referred to Audit Committee.

d) The Committee will report through the Audit Committee to Trust Board as required on its work and contribution to the Annual Governance Statement.

The Committee will refer any necessary issues arising as appropriate to the Quality and Risk Committee.

Administrative Support

The Committee shall be supported administratively by the corporate administration team. Their duties in this respect will include:

- Agreement of agendas with the chair and attendees
- Preparation, collation and circulation of papers in good time
- Ensuring that those invited to each meeting attend
- Taking the minutes and helping the chair to prepare reports to the governing body
- Keeping a record of matters arising and issues to be carried forward
- Arranging meetings for the chair - for example, with the internal/external auditors or local counter fraud specialists
- Maintaining records of members' appointments and renewal dates etc.
- Advising the committee on pertinent issues/areas of interest/policy developments
- Ensuring that action points are taken forward between meetings
- Ensuring that Committee members receive the development and training they need.

Review

The Committee will review the effectiveness and, where appropriate, revise the Committee membership and terms of reference at least annually and more frequently where required, and submit to Trust Board for approval. The Committee will also review the annual programme of all reporting groups.

Frequency of attendance by members

Members should attend at least 80% of meetings each financial year but should aim to attend all.

False and misleading information statements (Compulsory paragraph to be included in all TORs)

Under the False or Misleading Information Regulations the Trust has a responsibility to ensure that all information which is reported and published is accurate and is not presented in any way that could be considered to be misleading. All Committees must be satisfied that information which is agreed is accurate and represents a true and clear account of the facts.

March 2024

Lincolnshire NHS Financial Framework

1. This Lincolnshire NHS Financial Framework is jointly agreed by the NHS organisations based in Lincolnshire: Lincolnshire Community Health Services NHS Trust (LCHS), United Lincolnshire Hospitals NHS Trust (ULHT), Lincolnshire Partnership NHS Foundation Trust (LPFT) and Lincolnshire Integrated Care Board (LICB).
2. The Framework was agreed at the start of the 2023/24 Financial Year as part of the operational planning process and its provisions were instrumental in managing the exit from NOF4 in December 2023. The strong support and commitment to delivery throughout the year means Lincolnshire is on course to deliver the H2 reset forecast and meet all the requirements of year 1 of the Financial Recovery Plan.

The Financial Recovery Plan

3. The Boards of LCHS, UHLT, LPFT and LICB agree to the Lincolnshire NHS Financial Recovery Plan (FRP) explicitly through the sign-off of the Lincolnshire NHS 2024/25 operating plan and provide material support to the delivery of the plan, and its resourcing, and reconfirm expectations of system SROs who lead system initiatives.
4. The LICB Board made a strong commitment to achieving recurrent balance at the 2023/24 planning stage and recognised this was not going to be achieved in the 2024/25 financial year when the Medium-Term Financial Plan was prepared in September 2023. It showed an expected deficit of £25m for 2024/25. Therefore, the Lincolnshire NHS FRP will need to set out the steps required to deliver system recurrent financial balance over a three-year period to 2026/27, focused on building sustained and increasing recurrent delivery which steps up in each successive financial year, based on a pipeline of improvement that delivers long term system financial sustainability. Partners agree that the system will nevertheless seek to plan based on achieving a balanced financial plan in each year using short term savings measures and non-recurrent means to do so and ensuring that the reliance on short term non-recurrent means declines year on year as recurrent delivery increases.
5. The partners agree to an FRP savings target of £64m which is equivalent to 4% of system allocations.

	2023/24	2024/25	2025/26 and 2026/27
FRP	£55m	£64m	To be confirmed through the MTFP September 2024
Underlying plan deficit at start of year	£67m	£80m	To be confirmed through the MTFP September 2024
Programme pipeline	Emerging	Established	Embedded
In year deficit ambition	£27m	£break even	£break even

6. The Lincolnshire NHS FRP will require some level of non-recurrent delivery in the 2023/24 financial year however the Lincolnshire NHS business rule will be to operate an efficiency pipeline that ensures prior to each planning cycle that recurrent savings have been identified which match every £1 of non-recurrent benefit.
7. The assurance mechanisms for the Lincolnshire NHS FRP will be through two-weekly review of delivery actions and lead indicators at the FRP Programme Board with reporting monthly to CEOs, who act as point of escalation for the system SRO for the FRP. The SRO and Programme Director will report monthly to the ICB Finance and Resource Committee for oversight and assurance and at the ICB Board and will provide updates to partner Boards as required.

Productivity

8. The Lincolnshire NHS has adopted productivity metrics to assess productivity for Community and Mental Health service delivery, which together with the Acute national measure currently reported by NHSE, builds a holistic view of Lincolnshire NHS productivity. While nationally led revisions to productivity measures are expected at some time in the 2nd half of the 2024/25 financial year, the Lincolnshire partners agree to continue the development and use of the local productivity metrics and these will be reported through the system financial report regularly, starting in Q1.
9. The FLG has worked to provide greater clarity of how the acute metric is sensitive to changes in inputs and there will be greater emphasis on forecasting productivity improvement through 2024/25.

Contracting

10. Use of results-based payments will continue in the 2024/25 financial year. For Secondary Acute partners both in and outside the Lincolnshire system there will be the continuation of Aligned Payment and Incentive contracts underpinned by the NHS Payment Scheme with built-in productivity improvement. This is primarily focused on recovery of elective backlogs and managing risk in urgent care services.
11. Contracting arrangements will place a greater emphasis on the benefits of driving elective productivity involving senior clinicians, initiated by the ICB Medical Director. This will focus on providing incentives required to drive consistent engagement with continued and sustained elective recovery.
12. The ICB will engage partners with proposals to pilot lead provider arrangements alongside delegation of expenditure.

Risk and gain arrangements

13. Allocation of resources to Lincolnshire NHS trusts will reflect the efficiency requirements agreed within the FRP and allows for contribution to a Lincolnshire NHS risk and opportunity pool commensurate with partner income levels. This will apply as a proposed 0.5% percentage reduction to all expenditure the ICB funds to provide services in Lincolnshire. It will be held at system level to provide financial headroom to deliver highest possible levels of elective recovery, mitigate any shortfalls in delivery of the FRP and support resilience in urgent and emergency care services.
14. The Lincolnshire NHS risk and gain arrangements that have been in place since 2022 to manage the consequences of system change, will continue, and are strengthened by the continuation of the Lincolnshire NHS risk and opportunity pool. The risk and gain arrangements apply a 'break glass' which necessitates all partners coming together to agree remedial actions should the FRP go off track. Practically that will happen through the FRP Board however the formality of invoking the risk and gain arrangements will continue. The risk and opportunity pool is a source of funds to facilitate swift remedial action.
15. Accountability for Planned Care delivery and Urgent and Emergency Care delivery rests with the Planned Care Board and Urgent and Emergency Care Board respectively. The Lincolnshire NHS partner boards would expect these groups to identify risks or opportunities which could be managed through deployment of the risk and opportunity pool.
16. The Finance Leaders Group will be expected to provide scrutiny of any requests to deploy the Lincolnshire NHS risk and opportunity pool, and the ICB Finance and Resource Committee (ICB F&RC) will receive and approve utilisation of the risk and opportunity pool. The ICB Finance and Resource Committee will receive reports on the use of the risk and opportunity pool quarterly.

Reporting

17. Further development of Lincolnshire NHS financial reporting will build on the good progress made in 2023/24, with the aim of further improving visibility and strengthening controls. We will seek to move toward reporting by service and population, to provide better visibility of expenditure across the system that is related.

Investment

18. The controls introduced in 2023/24 on investment decisions will continue, with 'double lock' in operation overseen by the ICB F&RC. The double lock protocol was approved by system partners in June 2022, and this will continue.
19. This control will be managed through the Financial Sustainability and Investment Panel (FSIP) and reported into the ICB F&RC regularly. The FSIP is an executive group chaired by the ICB Medical Director and its members include Lincolnshire NHS Directors of Finance, Executives representing Nursing and Operations and colleagues from NHSE regional teams.
20. Stakeholders will be engaged to feed-back on how profile and operation of the FSIP can be improved, to allow for a more visible meeting cycle and ensure that post completion reviews of investment are completed in consistently. Consideration will be given to establishing a window for business case approval restricted to a short period supporting planning cycles. This could be overridden through an 'investment break-glass' allowing approval of business case in limited situations i.e., patient safety concern, new national mandate.
21. As with the 2023/24 version of the Lincolnshire Financial Framework, the partners agree to commit to sustainable investment in line with the published annual operating plan, and to maintain expenditure within system and organisational budgets. The investments within the plan will be approved on the basis they meet Lincolnshire NHS objectives and are financially sustainable in the long term. This will establish expenditure baselines at system and organisation level, that are clearly aligned to objectives that the entire system prioritises.
22. It is unsurprising that despite the commitment to retain expenditure in line with agreed budgets this did not happen consistently throughout 2023/24, with widespread industrial action and extraordinary inflationary pressures driving significant financial pressures. This framework will allow for exploration of the drivers of financial unsustainability so that all partners are clear on cause and effect, and they are able to respond proactively and positively to current and future financial and operating risk.
23. Where a partner organisation is seeking to prioritise any new spending within that organisation that is outside of system agreed purpose, timing, or value then that organisation's Board will be asked to provide a formal update to the ICB F&RC of why that investment is required. Recognising that such action builds an unanticipated financial pressure for the whole system, the update will set out what other spending to the same quantum would plan to be discontinued and over what timeframe the investment becomes sustainably funded. This arrangement is a continuation of that agreed for the 2023/24 financial year.

Framework operation and review

24. The ICS partners will keep the Lincolnshire Financial Framework under review, and this will be led by the FLG on behalf of the ICB F&RC.

Appendix 4 – 2023/2024 Annual Report of the Finance, Performance, People and Innovation Committee

1 Membership

The Committee is appointed by the Trust Board and shall consist of:

- Not less than two Non-Executive Directors
- A Non-Executive Director will be designated Chair of the Committee
- Director of Finance and Business Intelligence
- Director of People
- Chief Operating Officer

The Director of Finance and Business Intelligence is the Executive Director lead for the committee.

Membership of the committee during 2023/24 has been as follows:

Name	Period	Chair	Role
Murray Macdonald	All Year	Yes	Non-Executive Director
Gail Shadlock	All year	No	Non-Executive Director
Rebecca Brown	January – March 24	No	Non-Executive Director
Ian Orrell	March 2024 only	No	Non-Executive Director
Sam Wilde	All year	No	Director of Finance and Business Intelligence
Reva Stewart	April – June 23	No	Chief Operating Officer
Julie Frake-Harris	July – March 24	No	Chief Operating Officer
Ceri Lennon	April 23 – August 23	No	Director of People and Innovation
Claire Low	November 23 – March 24	No	Director of People and OD
Dusty Millar covered as Deputy Director of People and Innovation September and October 23.			

2 Quorum and Membership Attendance

The quorum is at least 3 committee members including at least one non-executive director and at least one executive director. Members should attend at least 80% of meetings in the financial year (but should aim to attend all).

Member	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-23	Feb-23	Mar-23	Attendance
Murray McDonald - Non-Executive Director	Present	Present	Apologies	Apologies	Present	Present	Present	Present		Present	Present	Present	82%
Gail Shadlock - Non-Executive Director	Apologies	Present	Present	Present	Present	Present	Present	Apologies		Present	Present	Present	82%
Rebecca Brown - Non-Executive Director										Present	Present	Present	100%
Sam Wilde - Director of Finance and Business Intelligence	Present	Present	Present	Present	Present	Present	Apologies	Present		Present	Present	Present	91%
Reva Stewart - Chief Operating Officer	Present	Present											100%
Julie Frake-Harris - Chief Operating Officer				Present	Apologies	Present	Present	Apologies		Apologies	Present	Present	63%
Ceri Lennon - Director of People and Innovation	Present	Present	Present	Present	Present	Present							100%
Claire Low - Director of People and OD							Apologies	Present		Apologies	Present	Present	60%
									No Meeting				

All meetings have been quorate and most members have fulfilled the attendance requirement.

3 Other Officer Attendance

The terms of reference also require a number of other officers to be in attendance:

- Director of Operations
- Deputy Director of People
- Deputy Director Innovation
- Deputy Director of Finance, Performance and Information
- Deputy Director of Strategy and Partnerships
- Deputy Director of Corporate Governance
- Deputy Director AHPs and Clinical Transformation

Attendance of those officers was as shown:

Other Officers In Attendance	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Deputy Director of People	Present	Present	Present	Present	Present	Apologies	Present	Present		Present	Present	Apologies
Deputy Director of Innovation	Present	Present	Present	Present	Present	Present	Apologies	Present		Present	Apologies	Present
Deputy Director of Finance, Performance and Information	Present	Present	Present	Apologies	Present	Present	Present	Apologies			Present	Present
Deputy Director of Strategy and Partnerships	Present	Present	Present	Apologies	Apologies	Present	Apologies			Present	Present	Apologies
Deputy Director of Corporate Governance	Present	Present	Present	Present	Present	Apologies	Present	Present		Present	Apologies	Present
Deputy Director of Allied Health Professionals and Intergrated Community Care / Deputy Director of Operations	Present	Present	Present	Apologies	Present	Present	Present	Apologies	No Meeting	Present	Present	Apologies

Other officers may be invited to attend meetings as appropriate and observers are permitted as agreed by the chair.

4 Schedule of Meetings

The committee is required to meet monthly in person or by virtual means. The December meeting of the committee took the form of a workshop rather than a formal assurance meeting.

5 Duties and Responsibilities

Financial and Operational Strategy, Policy, Management and Reporting

The committee has received an LCHS finance report each month and also a system finance report and a system Financial Recovery Programme finance report to provide context.

The committee has received quarterly updates on the implementation on the Finance & Business Intelligence strategy.

The committee has reviewed its sections on the Board Assurance Framework and Corporate Risk Register at each of its monthly meetings.

The committee has received a regular strategic partnerships development update.

The committee has received a policy renewal calendar report on a monthly basis.

The committee has received a quarterly update from the FBI Executive Group meeting since its inception.

People Executive Group

The committee has received quarterly People Strategy updates.

The committee has received quarterly updates from the People Executive Group.

Health and Safety Committee

The committee has received quarterly updates from the Health & Safety committee.

Performance Management and Reporting

The committee has reviewed the Integrated Performance Report each month. The committee also reviewed a report on the annual operation of the Performance Management Review meetings at its March 2024 meeting.

Procurement Strategy, Investment Policy, Management and Reporting

The committee received an update on progress implementing the Lincolnshire wide NHS procurement strategy at its February 2024 meeting.

The committee approved opening 2024/25 revenue budgets and capital plan at its March 2024 meeting using delegated authority from Board. Any required updates to reflect the final planning submission will be managed through the virement process.

Integrated Business Planning

The committee has received regular updates on the progress of the development of the operational plan for the year ahead, along with the associated financial and capital plans.

The committee has reviewed a quarterly update on progress implementing the 2023/24 operational plan.

Strategies

The committee has received quarterly updates on the implementation of the strategies within its remit.

Digital Executive Group

The committee has reviewed quarterly updates on the implementation of the Digital Health strategy.

The committee had received quarterly updates from the Digital Executive Group.

Equality, Diversity and Inclusion Group

The committee has reviewed quarterly updates from the EDI Group and reviewed the gender

pay gap and WRES/WDES reports prior to consideration by Board.

Other Duties

The committee has ensured all members of the Board and senior officers of the Trust maintain an appropriate level of knowledge and understanding of key financial issues affecting the Trust through its reporting to Board.

6 Reporting

The Chair of the committee has provided a written report to the Trust Board at two monthly intervals (in line with the frequency of Board meetings). Approved minutes of committee meetings have also been made available to the Board. Where relevant key issues have been shared with Audit Committee or Quality and Risk Committee.

7 Administrative Support

Full administrative support fulfilling all requirements has been provided to the committee by the Corporate Administration Team.

8 Review

The committee's terms of reference were reviewed at the March 2024 meeting. The committee is completing its annual self-assessment at present.

Approved at FPPIC meeting 28th April 2024

Report to:	Lincolnshire Community and Hospitals Group Board
Title of report:	Finance, Performance and Estates Committee Assurance Report to Board
Date of meeting:	21 March 2024
Chairperson:	Dani Cecchini, Chair
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received, and key decisions made by the Finance, Performance and Estates Committee (FPEC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme. The Committee worked to the 2023/24 objectives.
Assurances received by the Committee	**Assurance** in respect of SO 3a A modern, clean and fit for purpose environment **Estates Report to inc H&S Specialist Gap Analysis, RAAC survey results, quarterly PAM update and Lift dilapidation/replacement status** The Committee received the suite of estates reports noting that this included the PLACE results which demonstrated some variation on previous years outcomes however this was due to different areas being assessed each year. There had been an increase in cleanliness scores which demonstrated the positive outcome of the investment in to housekeeping services 18 months prior. Commencement of fire compartmentation work was noted at Lincoln and Pilgrim for high-risk areas along with the completion of fire door and fire alarm surveys. The fire door survey had highlighted a need for further investment. The Committee was delighted to note the achievement of the 4-star audit conducted by the British Safety Council with areas for improvement noted to progress towards achieving 5-stars. The non-clinical health and safety management report was received with concern noted in respect of health and safety practices being embedded in some areas. The Lift status report was received by the Committee and the works required were noted along with the age of the lifts across all sites. The Committee was alert to the six-year capital replacement programme which was being proposed, with capital funding due to be sought, to replace and repair lifts however noted that, despite the enhanced maintenance programme in place, lift breakdowns continued to occur.

	6-Facet Survey The Committee was pleased to receive the 6-Facet survey report which had been undertaken by a specialist consultancy. The Committee noted that the outcome of the survey identified an increase in the number of buildings requiring refurbishment and an increase in the costs required to improve the status of buildings to condition B. The development of an action plan would inform the investment strategy with the Committee recognising that this should be supported through the development of an estates strategy. Where possible, external funding would be sought to support required improvements.
	Assurance in respect of SO 3b Efficient Use of Resources **Finance Report inc Efficiency, Contracts, Capital, PLIS Q1 – 3 summary** The Committee received the report with limited assurance with discussions held by the Committee in respect of the appropriate level of assurance. It was agreed that the report offered limited assurance due to the deficit plan however, the Committee recognised the work of the teams to achieve the position reported. The Trust remained on plan at month 11 which was due to the £2.6m allocation of funding to address the industrial action costs during months 9 – 11, with a continued forecast delivery of £20.8m deficit. Improved performance was noted against the Better Payment Practice Code (BPPC) achieving between 86% – 91%, continued support was in place for pharmacy with early improvements being seen. Cost Improvement Programme (CIP) delivery was reported at £31.5m, exceeding the plan by £6.6m. The Patient Level Information and Costing System (PLICS) report was received which both demonstrated areas for improvement and opportunities for advancement. The sustained decrease in nurse agency use was noted however the Committee remained concerned regarding the lack of progress for medical agency spend and the rising use of bank staff and consultants. **Procurement Update** The Committee received the report noting that the procurement team had achieved delivery of £1.6m CIP against a target of £1m. The agreed target of £1.5m for 24/25 had been set with a stretch target identified at £3m. The Committee noted the cost savings made against a number of contracts which would come in to place in the new financial year, seeing savings of circa £2m.

	Training continued to take place within the team with 2 team members achieving full qualifications and progressed the procurement team to being one of the most qualified teams in the NHS. Work was underway to develop training for the Trust in respect of the new procurement regulations which were due to come in to place on 1 October 2024. The Committee noted the forward planner for large projects and noted the changes to direct awards, which could no longer be made, meaning that pre-procurement work would need to increase to ensure work was in place to progress at pace as funding became available. **Strategic Projects – Pilgrim ED Steering Group Upward Report** The Committee received the report noting that construction continued to progress well however there had been some issues from the new drainage which had been put in place. This was being rectified by the contractor at their risk. The Committee noted the need for high voltage works to be completed, which were critical to the project, noting that any delay could impact on the timeline of the project.
	Assurance in respect of SO 3c Enhanced data and digital capability No reports due
	Assurance in respect of SO 3d Improving Cancer Services Performance **Operational Performance against National Standards** The Committee received the report noting the content and the continued improvement against cancer standards.
	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 received the report noting that there would be zero 78-week waits in March with the Trust exiting February with 9 patients. Work continued to address those patients who would enter the 78-week position with the Committee noting that this was due primarily to patient choice. 65-week waits were also noted as at their lowest level since Covid-19 however sustainability of the position continued to be challenging. **Discharge system pathway update** The Committee received the report noting this offered the Trust's performance against national best practice, both regionally and nationally.

	The system work on the national drive for joint discharge processes had been delayed due to intermediate care however this had now restarted. The progress made in respect of discharges was noted, with the continued commitment to progress activity through multi-agency work. **Improvement Programme Deep Dive – Outpatients** The Committee received the outpatient deep dive noting the four main drivers in place and the improvements that had been made, although recognised that without dedicated support these were not sustained. It was noted that there was a need to continue with the actions in place with the challenges of the winter period recognised as having impacted on performance. The Committee noted that the delivery plan for 24/25 would prioritise patient initiated follow-ups, clinic slot utilisation, diagnostics and remote consultation.
	Assurance in respect of SO 3f Urgent Care **Operational Performance against National Standards** The Committee noted that the 4-hour target stood at 73% with improvements also being seen in ambulance handovers with few taking just over 30 minutes. There had been notable improvements in the 12-hour wait in the emergency departments with a positive trend being seen following the Christmas period.
	Assurance in respect of SO 4a Establish new evidence based models of care **EMAP Leadership and Delivery Programme Update** The Committee received the report noting the recent meeting which had taken place with a focus on fragile services and the consideration of agency spend to be included as a programme of work. The establishment of the mutual aid group was noted in respect of oncology to ensure support was in place at times of pressure and discussions had also centred on the consideration of collaboration in respect of the electronic patient record. Financial commitments would continue into the new financial year for the network with a memorandum of understanding being put in place.
	Assurance in respect of SO 4c Successful delivery of the Acute Services Review **ICB Lincolnshire Service Change Process** The Committee received the report for information noting that this clarified the process to be followed in respect of future service changes.

	Assurance in respect of other areas: **People and OD Committee referral responses – Extra-contractual rates and salary overpayments** The Committee received a response from referrals made in respect of extra-contractual rates and salary overpayments noting there were specific actions and timelines in place, being monitored through business-as-usual processes. **Committee Effectiveness Annual Report – final** The Committee received and approved the Annual Report noting that feedback had been incorporated into the report which would be presented to the Board and Audit Committee (appendix 1). **Topical, Legal and Regulatory Update** The Committee received the report for information noting the content. **Annual Planning** The Committee received the ICS financial framework with moderate assurance, noting the position presented and the need for continued collaborative working within the system. A focus of the framework was noted as productivity with a need to ensure the alignment of metrics to those in the acute sector. It was noted that there was a new investment review process in place for both the Trust and system with a prioritisation panel in place for collaborative decision making. Whilst it was recognised that the process continued to evolve, the report outlines the agreed approach. The Committee noted, from a planning perspective, that the divisions had been engaged to explore triangulation of workforce, activity and finance in order to develop the Trust plan. The submission deadline for the plan to the ICB was noted as 3 May with work to continue to develop this ahead of the submission. **Integrated Improvement Plan** The Committee noted that patients, people and partners continued to be reported as moderate with limited assurance continuing to be offered in respect of services. The limited assurance was due to performance and activity KPIs not being on target. **Improvement Steering Group Upward Report** The Committee was pleased to note the successful achievement of a £31m Cost Improvement Programme (CIP) with the impact being seen as a result of a reduction in agency housekeepers and nursing staff, bed reductions and the closure of Carlton Coleby Ward ahead of schedule.

	It was recognised that due to technical delivery, ahead of plan, the Trust was forecasting to deliver £32.9m CIP by year-end. Where in year areas of non-delivery had been recorded there would be focus into the 24/25 year to determine the approach to be taken. **Committee Performance Dashboard** The Committee received the report noting the position presented and recognising discussions had taken place on performance throughout the course of the meeting. **Internal Audit – Core Financial Systems Internal Audit** The Committee received the report noting this provided significant assurance in respect of key systems and processes in place. Where necessary actions were in place to address findings from the report. **CQC Action Plan** The Committee received the report which was taken as read and noted that the final must do actions had been signed off. Work would now focus on the outstanding should do actions.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	None
Committee Review of corporate risk register	The Committee received the risk register noting the risk as presented.
Matters identified which Committee recommend are escalated to SRR/BAF	No items identified
Committee position on assurance of strategic risk areas that align to committee	The Committee considered the reports which it had received which provided assurances against the strategic risks to strategic objectives.
Areas identified to visit in dept walk rounds	None

Attendance Summary for rolling 12-month period

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

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

United Lincolnshire Hospitals NHS Trust

Annual Report to the Trust Board from the Finance, Performance and Estates Committee 2023/24

ROLE OF THE COMMITTEE

In 2023/24, in line with all other Committees of the Board, the Terms of Reference were reviewed and amended. Under the agreed terms of reference the Finance, Performance and Estates Committee was tasked as follows:

The Finance, Performance and Estates Committee will:

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

A modern, clean and fit for purpose environment:

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

Efficient use of resources:

- Delivering cost improvement programme/Financial Recovery Plan
- Delivering financial plan
- Utilising Model Hospital, Service Line Reporting and Patient Level Costing data to drive focussed improvements and productivity
- Working collaboratively to develop evidence based approach to more efficient services
- Utilisation of Capital allocation

Enhanced data and digital capability:

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

Improving Cancer Services access:

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

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

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

Urgent Care:

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

Establish collaborative models of care with our partners:

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

Successful delivery of the Acute Services Review:

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

MEETINGS

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

MEMBERSHIP AND ATTENDANCE

The Committee is appointed by the Board from amongst the Non-Executive Directors of the Trust. During 2023/24 the Committee was chaired by Ms Cecchini.

Details of the Committee's membership and attendance during 2023/24 is set out below:

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

Members	April 2023	May 2023	June 2023	July 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024
Non-Executive Director (Mrs Cecchini, Chair)	X	A	X	X	X	X	X	X	X	X	X	X
Associate Non-Executive Director Mrs Buik)	X	X	X	X	X	X	X	X	X	X	X	X
Director of Finance	X	X	X	X	X	X	X	X	X	X	X	X
Chief Operating Officer	X	D	X	X	D	X	X	X	X	X	X	X
Director of Improvement and Integration	X	X	X	X	X	X	X	X	X	X	X	X

X denotes attendance
A denotes Apologies given
D denotes Deputy in attendance

REVIEW OF BUSINESS

The Finance, Performance and Estates Committee work programme for 2023/24 is set out as an appendix to this report.

The Finance, Performance and Estates Committee has been responsible for the oversight of the following strategic objectives of the Trust in 2023/24:

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

During 2023/24 the Committee has utilised the Board Assurance Framework to provide focus to the meetings and ensure alignment of the agenda to the elements of the BAF.

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

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

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

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

During the course of, the year the Committee received assurance across a number of areas resulting in changes, in year, to the assurance ratings presented above. There has however, at the end of the year, been a static level of assurance reported.

In May 2023 the rating for Objective 3d – Improving cancer services access moved from amber to red due to the challenges being experienced by the service. In January 2024 the Committee was able to uprate the assurance from red to amber as a result of improved consistent performance. As a result of this performance the Trust had moved out of tier 1 monitoring by NSH England, supporting the change to the assurance rating.

OVERVIEW

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

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

Other key areas of focus of the Committee have included:

- Estates
- Health and Safety
- Emergency planning
- Digital services
- Procurement
- Information Governance
- Constitutional standards
- Service recovery
- Internal Audit
- Strategic projects

The Committee receives monthly assurance/exception reports from the reporting groups offering assurance on areas relevant to the remit of the Committee. There remained a continued focus in 2023/24 on reporting from the Estates Directorate with continued improvements seen in reporting, through the strengthening of the senior team within the Estates Directorate.

The Health and Safety Annual Report was received and approved by the Committee demonstrating the continued improvements and it was noted that the Trust achieved a 4-star rating from the British Safety Council in respect of the Trusts Occupational Health and Safety arrangements during the year.

The Committee monitored the requirements to achieve zero 78-week and 65-week waits in year. The Committee noted that whilst efforts were continually being made there was impact on achievement due to Industrial Action by Junior Doctors throughout the year. Despite this the Trust had achieved the targets set.

The Committee continued to monitor the delivery of the Integrated Improvement Plan noting that the delivery of projects had progressed during the course of the year with oversight provided by the Improvement Steering Group.

Strengthened management of projects was noted, particularly in relation to Cost Improvement Programmes and the Integrated Improvement Plan (IIP) projects. Whilst the Committee noted there had not been full achievement of the IIP there had been an increased level of transparency and awareness of the actions being taken.

The Committee received reports associated with strategic project, ensuring oversight and assurance on the delivery of these. Specific focus had been given to the Community Diagnostic Centres (CDCs) with a visit undertaken to the Grantham CDC by the Chief Operating Officer for NHS England, to celebrate the work of the Trust.

Work continued in the development of further CDC sites across Lincolnshire including Lincoln and Skegness.

Other strategic project considered by the Committee included the ongoing development of the Pilgrim Emergency Department works and the investment of a new Endoscopy suite at Lincoln.

Deep dives continued to be received by the Committee into a number of areas, conducted by the Improvement Team, which demonstrated positive progress on the programmes of work in place. Of particular note was the achievement of reduced Nurse Agency spend, which had significantly contributed to the Cost Improvement Programme (CIP) position for the Trust.

Throughout the year the Committee has received reports from the Digital Hospital Group with a clear focus on developments within cyber security and improvements in IT infrastructure across the Trust. The Committee was pleased to note the successful rollout of the electronic Prescribing and Medicines Administration (ePMA) across the Trust, a significant programme of work for digital services.

The Electronic Patient Record was considered by the Committee during the year with the Committee delighted to note that approval of the business case by Treasury, enabling the commencement of preparatory works and a formal procurement process.

Reporting had also been received in respect of Information Governance with the Committee noting ongoing concern with regard to Freedom of Information and Subject Access Request compliance. It was noted that there had been a significant increase in the volume of Freedom of Information requests to the Trust with increasing complexity. Focused work was noted in respect of the Data Security Protection Toolkit (DSPT) with a requirement for full review of the evidence, prior to submission to ensure an accurate submission was made, due to the changes made to the toolkit nationally.

Risks

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

Performance Review

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

The Committee have actively engaged in the development of the performance dashboard, ensuring that the KPIs requiring monitoring by the Committee were reported. At each of the meetings held during 2023/24 the Committee considered all aspects of the performance report and were able to identify and seek further assurance on KPIs where concerns were identified.

Performance discussions focused on operational performance and the Trusts' ability to increase productivity to 2019/20 levels with a focus on Further Faster to ensure delivery. It was noted however that productivity was impacted by Industrial Action with the need to manage appointments and, at times, cancel elective care in order to ensure appropriate levels of staffing.

Focus on 2024/25 productivity had commenced in the latter part of the year with the target of achieving 130% of 2019/20 activity with a need to ensure volume of delivery over financial value.

Concerns remained in respect of the continued deterioration in urgent and emergency care, due to increases in demand and continued flow and discharge issues. It was recognised that this required a System approach to address the ongoing issues with the Committee noting the support across the System which was in place. There had however been a national increase in demand for urgent and emergency care services.

The Committee noted throughout the year the financial position of the Trust, with a deficit plan submitted by the Trust of £20.8m and the Lincolnshire System of £15.4m. In year the Trust reported a deficit position, in line with the financial plan submitted, and achieved an outturn revenue position of £20.8m at year end, meeting the 23/24 plan.

Negotiations in respect of the contract position continued until the end of the first half of the year. In H1 2023/24 early delivery of the Trust CIP supported mitigating external pressures such as Industrial Action and inflation, resulting in delivery in line with plan. This also supported the Trust in meeting the exit criteria of the National Oversight Framework (NOF) level 4 and therefore enabling the Trust to move to NOF3.

Improvements were seen against performance of the Better Payment Practice Code (BPPC) in year with the implementation of No PO No Pay having a significant impact on compliance. The Committee noted the continued need for improvements to be made within Pharmacy Services to support continued improvement in BPPC.

During the year the Committee maintained oversight of the Capital Programme noting this was the largest capital plan for the Trust at circa £60m, with full delivery achieved. Capital spend spanned estates, digital and medical devices with significant improvements made across the Trust as a result of the investments, through a risk based approach.

During 2023/24 referrals between the Board Committees were made in order to ensure that where necessary additional assurances were sought from the relevant responsible Committee in areas where responsibility for assurance extended beyond the remit of a single committee. A number of referrals were made during the year offering opportunities for the Committee to seek further assurances.

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

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

Purpose	This report summarises the assurances received, and key decisions made by the Finance, Performance and Estates Committee (FPEC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme. The Committee worked to the 2023/24 objectives.
Assurances received by the Committee	**Assurance** in respect of SO 3a A modern, clean and fit for purpose environment **No reports due**
	Assurance in respect of SO 3b Efficient Use of Resources **Finance Report inc Efficiency, Contracts, Capital** The Committee received the efficiency capital and contract reports with moderate assurance noting the finance report continued to offer limited assurance. Despite the limited assurance offered the Committee noted the delivery of the 23/24 financial plan of a £20.8m deficit, supported by the over delivery of the Cost Improvement Programme (CIP) position by £6.1m, with a total delivery of £34.2m. Improvement in the Better Payment Practice Code was noted with achievement in month in the 90% range and demonstrates realisation of actions being delivered within pharmacy. The Committee noted the cash position which had deteriorated, in line with expectations, from circa £41m with the Trust commencing the 24/25 with £25m. This was higher than planned as were capital accruals. NHS patient care Contracts were expected to be signed in early May with work currently taking place to triangulate the position within the financial plan. The Committee noted the full delivery of the 23/24 capital programme at a value of circa £62.5m recognising that the coming year would see an increase in this value, for which appropriate supporting resource

	would be required to achieve delivery. A Board Development session would be arranged to discussion the 24/25 capital programme. **Strategic Projects – Pilgrim ED Escalation** The Committee received the strategic projects report for information and noted the escalation being made in respect of the high voltage work at Pilgrim ED, which could potentially result in a 4-8 week delay to the overall programme. It was recognised that this was a Trust risk.
	Assurance in respect of SO 3c Enhanced data and digital capability **Information Governance Group Upward Report** The Committee received the upward report noting the improved position compared to last year in respect of the Data Security and Protection Toolkit (DSPT) submission with an outcome of 'achieving standards' expected on formal submission. Three of the standards were not met The Committee noted the requirements of Multi-Factor Authentication (MFA) as part of the DSPT submission and recognised the actions required within the organisation to achieve this standard, which was reliant on IT system providers. **Digital Hospital Group Upward Report** The Committee received the upward report reflecting on the structure of the report which more closely aligned with the assurances being sought through the Board Assurance Framework. The Committee noted the progress in respect of the Electronic Patient Record (EPR) and the current procurement process being undertaken. The significant amount of work being undertaken by Digital Services was noted with a number of projects underway, some of which had been completed in year, such as the EPMA.
	Assurance in respect of SO 3d Improving Cancer Services Performance **Operational Performance against National Standards** The Committee noted that cancer performance continued to be positive with oversight of this moving back to business as usual due to the success of the efforts and focus of the teams.
	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 received the report noting the 78-week wait position at the end of March was 5 patients, this position was noted to be due to patient choice and support was in place. Work continued to support the 65-week wait position with a focus on ENT and continued weekend clinics would support the position being reduced.

	Theatre utilisation continued at 85% noting that this position would be maintained to ensure service delivery due to the complexity of patients. Ongoing support was needed in respect of referral to first appointment and diagnostics to continue to see positive progress with the move to hybrid mail progressing to support this.
	Assurance in respect of SO 3f Urgent Care **Operational Performance against National Standards** The Committee noted the significant progress in relation to 12 hour waits and ambulance handovers with ambulances achieving handover within the 30-minute target. 4-hour performance was reported at 73% across all types of activity which was a significant improvement from the position when the 76% target was issued.
	Assurance in respect of SO 4a Establish new evidence based models of care **No reports due**
	Assurance in respect of SO 4c Successful delivery of the Acute Services Review **Implement Stroke** The Committee received the report noting the activity taking place across the Group which had identified 8 community beds and the upskilling of staff and consolidation of space. The aim was to reduce the length of stay for stroke patients in acute beds and support recovery through pathway developments. A further options paper would be presented to the Committee in May to consider the approach to be taken to the consolidated unit. **Grantham ASR Implementation** The Committee received the report noting that this had moved into business as usual with the ability for 111 to now book directly into the team. A clinically focused learning session had taken place, due to the acuity of patients, with the surgery and medicine divisions with a number of actions identified to develop interventions to support patients through the UEC workstream. Work continued in respect of the development of the third ward and the approach to deliver this.
	Assurance in respect of other areas: **Integrated Improvement Plan**

	The Committee received the report noting the close of the position for the 23/24 year and recognised the move into year 5 of the IIP. **Improvement Steering Group Upward Report** The Committee received the close down report for the 23/24 year noting the progress that had been made, particularly focusing on the over delivery of CIP by £6.1m. Consideration was now being given to the 24/25 year and the programmes of improvement which could yield further CIP savings with a need to increase the level of savings achieved. **Committee Performance Dashboard** The Committee received the report for information, with moderate assurance, noting some concern that the data presented within the SPC charts had yet to demonstrate a sustained improvement trend in some areas but reflected the need to have confidence that the data would flow through to demonstrate improvement. The Committee noted that a programme of deep dives into areas of concern across the year would enable further assurances to be received in due course. **CQC Action Plan** The Committee received the report noting that the must do actions had been closed and the focus would now be on the progress and closure of the should do actions.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	None
Committee Review of corporate risk register	The Committee received the risk register noting the risk as presented.
Matters identified which Committee recommend are escalated to SRR/BAF	No items identified
Committee position on assurance of strategic risk areas that align to committee	The Committee considered the reports which it had received which provided assurances against the strategic risks to strategic objectives.
Areas identified to visit in dept walk rounds	None

Attendance Summary for rolling 12-month period

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

X in attendance
A apologies given
D deputy attended

Lincolnshire Community Health Services NHS Trust

Report to Lincolnshire Community and Hospitals Group Board

Date of meeting	7th May 2024	Agenda item	13.1
Title	LCHS Integrated Performance Report (March 2024 performance)		
Purpose	To provide the Trust Board and its committees with assurance that quality, risk, performance and finance are being carefully monitored and that improvement measures are being identified and implemented where necessary.		
Report of	Sam Wilde, Director of Finance and Business Intelligence		Sukesh Chandran, Business Support Technician
Previously considered by / Date	March 2024 performance considered by April FPPIC and QC meetings	Approved?	N/A
Summary	Performance up until the end of March is set out in the report. The Quality Committee and Finance, Performance, People and Innovation Committee reviewed March performance in their April meetings.		

The number of metrics in each cell in the SPC grid is as follows:

		SPC Variation		
		Special Cause Improvement	No Variation	Special Cause Deterioration
Target Capability	Consistently Capable	1	6	1
	Inconsistently Capable	3	12	2
	Not Capable	2	2	0
	No Target	3	19	0

4 indicators are not statistically capable of achieving performance targets without redesign:

1. Home Visiting

A 3-stage improvement plan is being implemented. Stage 1 has already been implemented and stage 2 will take effect from April.

2. Ethnicity recording in A&E data sets.

Redesign of this process earlier in the year has driven performance up from c65% to c85%. The next stage of redesign to get to the 95% target is a new data quality system 'RINSE' to support managers to monitor and manage where ethnicity data is not populated at source.

3. Better Payment Practice Code.

The improvement plan approved by Audit Committee has now been fully implemented. For external reporting purposes BPPC is measured on a 12-month rolling basis, so it will take some time for the benefits of the improvement

work to be fully reflected in the numbers. Statistically significant improvement has been demonstrated consistently since April 2023.

4. Friends and Family Test

Additional contractual oversight remains in place to continue to improve the roll out and reporting of the service provided.

3 indicators are showing special cause deterioration currently:

1. Vacancy Rate

This measure was artificially lowered following the TUPE transfer of Mass Vaccination Centre staff into LCHS whilst work was undertaken to align budgets and establishment. That work has now been completed. This measure remains consistently capable of achieving the 8% target and is better than the national benchmark for the community sector. The signal is not therefore a cause for concern.

Following discussion at FPPIC the control limits have been reset from September 2023 when the Mass Vaccination Centre staff budgets and establishment were aligned.

2. Ops Centre Calls: Answered in Timescale

The service has seen 4 resignations since January, is currently experiencing some long-term sickness and is unable to recruit to roles that would constitute a cost pressure given the vacancy approval processes. An associated risk has been captured on the register.

3. Length of Stay

There has been pressure on length of stay due to the 11 Enhanced care beds, without extra therapy staff. In addition, we have picked up more Stroke patients through the partnership working we have done to improve the Community Hospitals offer for Stroke to improve length of stay and bed availability in the Acute Stroke Unit. Timely access to an Acute Stroke Unit is a key indicator in patient outcomes for Stroke. However, the patients we have looked after have tended to be very complex and had longer than average lengths of stay. Our Stroke offer is a work in progress.
There has been particular concern over length of stay on one Community Hospital site and an action plan is to be put in to review this.

9 indicators are currently showing special cause improvement, which is a strong indication of our continuous improvement culture:

1. Staff Turnover
2. Sickness Absence (now achieving the 5% target)
3. Long term Sickness (now achieving the 3% target)
4. Agency Expenditure (now <2% of the total pay bill)
5. Ethnicity in A&E Data Sets (see reference to improvement plan above)
6. Better Payment Practice Code (see reference to improvement plan above)
7. UTC 15 Minute Assessment
8. Urgent Community Response - Accepted Referrals
9. UTC Activity

1. Provide safe, high quality, population healthcare	**1a. Deliver safe services**	**Cautious** approach to patient safety or harm with strong focus driven by national strategies and policies.	√
	1b. Deliver effective care	**Open** approach to effective care**.**	√
	1c. Engage and involve people in their care	**Seek** approach to engagement and involvement.	√
2. Deliver personalised community health services that are accessible and responsive	**2a. Deliver clinically led integrated community services**	**Open** approach to clinically led integrated community services.	√
	2b. Deliver personalised health care that responds to individual need	**Open** approach to personalised health care that responds to individual need.	√
	2c. Transform clinical pathways for sustainability and improved outcomes	**Seek** approach to transformation of clinical pathways for sustainability and improved outcomes.	
3. Build a productive, capable and inclusive workforce	**3a. Grow and retain our people**	**Open** to maximising transformation opportunities and will try new and innovative ideas and ways of working to improve job satisfaction and enrichment.	√
	3b. Value and develop our people	**Cautious** approach to staff safety and wellbeing and recruitment compliance**.**	√
	3c. Enable a change ready workforce	**Seek** new and innovative ways of working through the use of automation and technology which in turn will improve productivity and release time to care.	√
	3d. Deliver Safe and Sustainable Foundations	**Cautious** approach to cyber security, health and safety and recruitment compliance. This is because we value our people as our greatest asset and we strive to keep our people, our patients and their respective information as safe as possible.	
4. Ensure healthcare is financially sustainable, making best use of resources	**4a. Deliver financially sustainable healthcare, making best use of resources**	**Open –** Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level.	√
	4b. Drive better decisions and impactful action through insight	**Seek -** We will invest for the best possible return and accept the possibility of increased financial risk (with controls in place).	√

5. Collaborate to play an active role in the Lincolnshire ICS	**5a. Collaborate to make a difference**		**Seek** opportunities to be innovative and collaborative, both within the organisation and the wider system environment.			√
	5b. Transform services to deliver great care close to home		**Seek** opportunities to be innovative and collaborative, both within the organisation and the wider system environment.			
Impact of proposal/ report	N/A Assurance Report					
CQC	**Safe**	**Caring**	**Effective**	**Responsive**	**Well-Led**	
Links to risks	N/A					
Legal/ Regulation	N/A.					

Recommendations/ Actions Required

Board is asked to note the content of the report

Appendices

Appendix 1 – LCHS Integrated Performance Report on March 2024 Data

Glossary

BPPC – Better Payment Practice Code
CAS – Clinical Assessment Service
CiC – Children in Care
CIP – Cost Improvement Plan
CHPPD – Care Hours Per Patient Day
FFT – Friends and Family Test
FPPIC – Finance, Performance, People & Innovation Committee
FTE – Full-Time Equivalent
IHA – Initial Health Assessment
IPR – Integrated Performance Report
KPI – Key Performance Indicator
LAC – Looked-After Children
LoS – Length of Stay
MIU – Minor Injury Unit
MRSA - Methicillin-Resistant Staphylococcus Aureus
NHSPS – NHS Property Services
OOH – Out of Hours
PMR – Performance Management Review
PU – Pressure Ulcer
Q&RC – Quality & Risk Committee
SI – Serious Incident
SPC - Statistical Process Control
STI – Sexually Transmitted Infection
UTC – Urgent Treatment Centre

WTE – Whole Time Equivalent
YTD – Year-To-Date

Lincolnshire Community Health Services NHS Trust

INTEGRATED PERFORMANCE REPORT

March 2024 Performance Data

CONTENTS

SPC SCORECARD

Target Capability	SPC Variation: Special Cause Improvement	SPC Variation: No Variation	SPC Variation: Special Cause Deterioration
Consistently Capable	Staff Turnover	Patient Incidents Per 1000 WTE Completion Of NHS Numbers for A&E Data Sets Ops Centre Calls Abandoned Training Compliancy MRSA Environmental Cleanliness	Vacancy Rate
Inconsistently Capable	Sickness Absence LongtermSickness Agency Expenditure	15 Minute Ambulance Handover Chlamydia Screening Positivity Rate GU Patients seen within 2 working days Urgent Community Response - 2-Hour Response Compliance UTC 4 Hour Waits Community Hospital Falls per 1000 OBDs Community Hospital Discharge Summaries UTC Discharge Summaries Serious Incidents (Excluding Pressure Ulcers) Complaints - Rate per 1000 WTE Mandatory Training Compliancy Community Hospital Bed Occupancy	Average Length of Stay Ops Centre Calls Answered in Timescale
Not Capable	Ethnicity in A&E Data Sets Better Payment Practice Code	Home Visiting Compliancy Friends & Family Test	
No Target	UTC 15 minute Assessment Urgent Community Response -Accepted Referrals UTC Activity	Community Hospital Injurious Falls per 1000 OBDs Virtual Wards: Cardiology Referrals Home Visiting Activity Transitional Care Activity Out of Hours and CAS Cases Closed Discharge to Assessment: Distinct Patient Contacts Discharge to Assess Accepted Referrals Virtual Wards: Frailty Referrals CAS Activity Ops Centre Calls Answered Total Falls Concerns Compliments Complaints Total Medication Incidents CHPPD Overdue Datix Community Pressure Ulcer - Rate per 1000 contacts (C2, C3 & C4 Community Hospital Pressure Ulcers - Rate per 1000 OBDs (C2, C3 & C4)	

Executive Summary

PERFORMANCE AGAINST TARGET

Many aspects of performance achieved (or beat) target, whilst some others failed to achieve target.

Safe

✓ Total Community Hospital Falls performance rates per 1000 OBD is beating target.

✓ MRSA compliance achieving target.

✓ 0 Serious Incident (excluding pressure ulcers) reported this month.

✓ Patient Incidents Rate per 1000 WTE exceeds target reflecting a strong patient safety culture of reporting.

Caring

X FFT scores not achieving 95% target

✓ The complaints rate per 1000 WTE is above target.

Responsive

X Discharge Summaries – Community Hospitals, not achieving target.

✓ Discharge Summaries – Urgent Treatment Centres achieving target.

X UTC 4 hour waits not achieving the 95% target

X Home Visiting performance is not achieving 95% target and is not capable of doing so without redesign

X 15-minute Ambulance Handover not achieving 95% target

X Ops Centre Calls Answered in Timescale not achieving 92% target

✓ Ops Centre Calls Abandoned achieving 8% target.

X Urgent Community Response not achieving the 97% target.

Effective

✓ Chlamydia positivity rate of 15-24 years old achieving target

✓ Community Hospitals Pressure Ulcers rate per 1000 OBDs – reporting above benchmark.

✓ Environmental Cleanliness achieving target

✓Bed Occupancy rate within target range at 87.70%

X Average Length of Stay not achieving the 16 Day target.

✓ LiSH GU patients seen within 2 working days continues to meet target.

Well-Led

✓ Valid NHS Numbers for A&E Data Sets achieving the 95% target.

X Ethnicity in A&E Data Sets not achieving 95% target

✓ Staff Turnover is within the 15% target.

✓ Monthly agency expenditure is below the 3.19% level planned.

✓ Month 12 YTD Position is £1.38m surplus.

✓ Overall efficiency (CIP) on plan.

✓ Recurrent Efficiency (CIP) ahead of plan.

✓ Cash balances are £30M, which is better than plan.

X Better Payment Practice Code is not achieving the 95% target

X Capital expenditure is behind plan.

✓ Vacancy rate within the 8% target and beating the national benchmark.

✓ Training Compliance is achieving the 90% target.

✓ Total Sickness Absence is achieving the 5% target.

✓ Long-Term Sickness Absence is achieving 3% target.

Medicine-related Incidents

Background

Medication is one of the most common medical interventions. LCHS deals with medicines on a day-to-day basis. LCHS has robust polices, training programmes and audit to ensure medicines are managed safely. Due to the high volume of activity involving medicines, complexity of the procedures and the human component, some medicine-related incidents do occur.

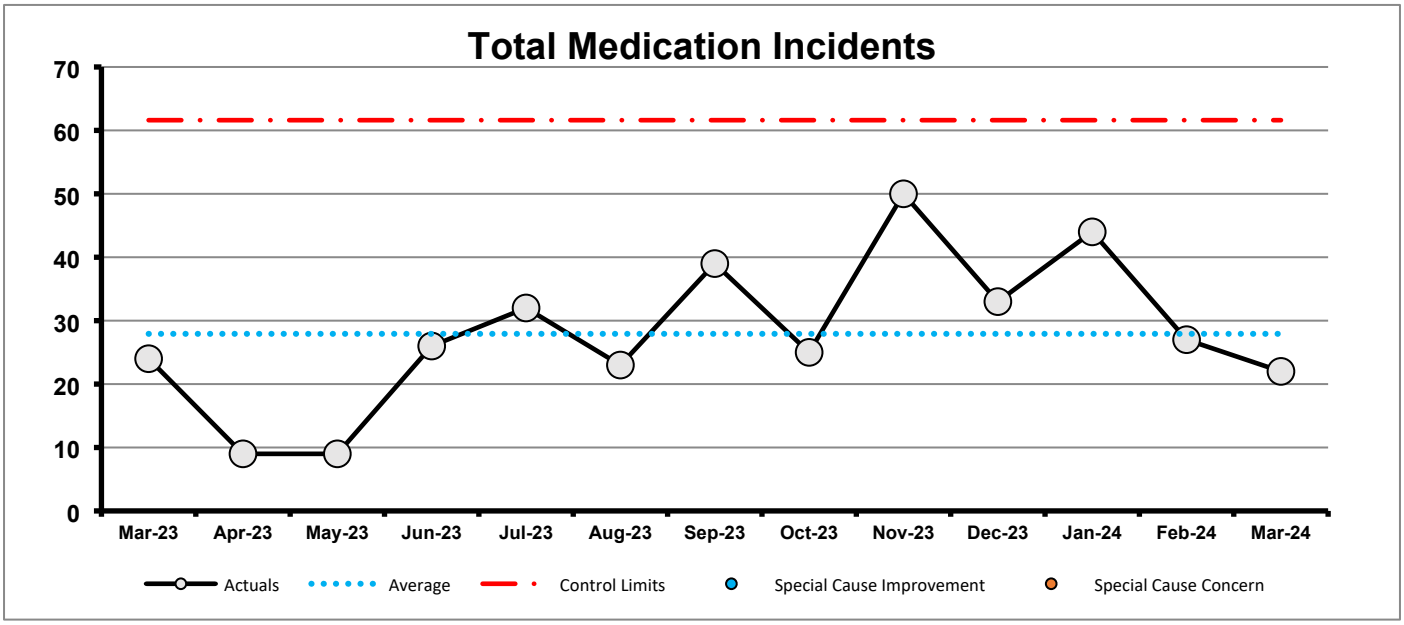
A medicine-related incident can pose a threat to the patient as well as the organisation. The member of staff who made the error can also be affected. Broadly speaking, medicine-related incidents encompass prescribing, preparation, dispensing, administration, and monitoring.

Reducing medicine-related incidents across the Trust remains an ongoing improvement priority.

Benchmark / target

NHS Benchmarking have not yet published the community dataset for the reporting period.

Current Performance



Narrative

22 LCHS related medicine incidents (a decrease from 27 in February) were recorded via Datix in March. There has been no increase in moderate or above harm related medicines incidents.

An increase in incident reporting (no/low harm incidents) is an indication of a positive safety culture with medicines incidents being employed to strengthen and embed learning across LCHS. It is important to note that the reporting of moderate harm incidents remains low, with no severe harm incidents or medicines related never events reported.

SPC

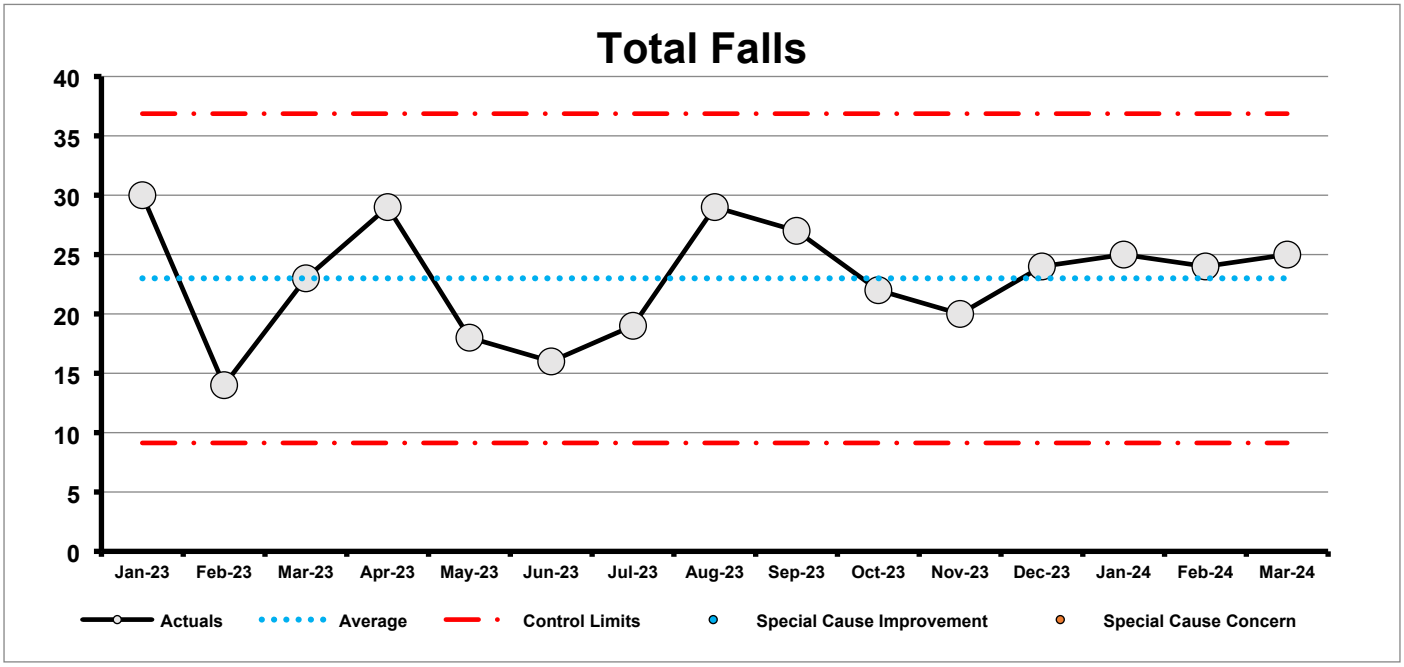
SPC shows that the Trust's total medication incidents have not varied over the period.

Total Trust Falls

Background

A fall can be devastating for a patient, not least because it can cause 'distress, pain, injury, loss of confidence, loss of independence and increased morbidity and mortality' (Source: The incidence and costs of inpatient falls in hospitals, NHS Improvement June 2017).
The graph below shows the total falls across the Trust.

Current Performance



Narrative

There has been a very consistent number of total falls in each of the last 4 months.

SPC

SPC shows that the Trust's total falls have not varied significantly over the period.

Falls in Community Hospitals

Background
Falls take place in many services, but most falls take place in our community hospitals where the patients have additional levels of frailty and health related conditions which pose additional risk of falling whilst unwell and in an unfamiliar environment.

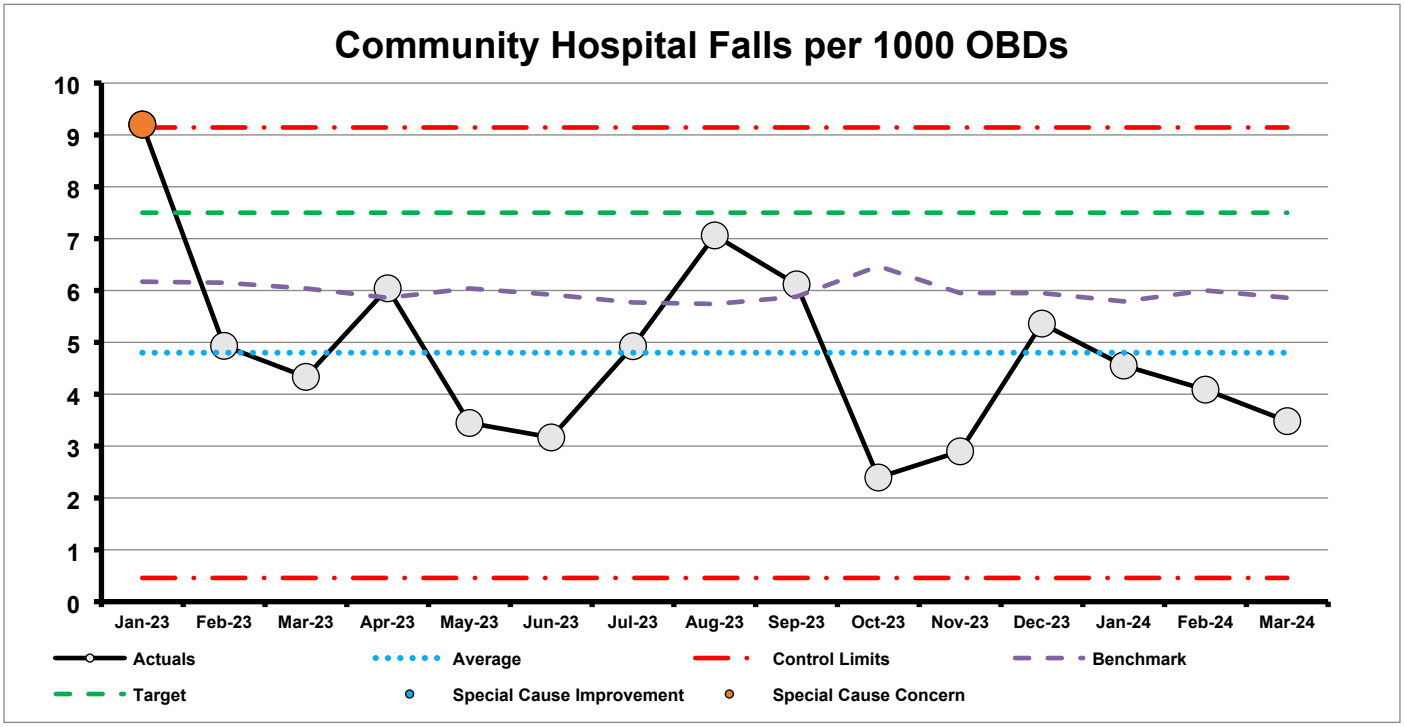
Falls are categorised and captured as the following: -

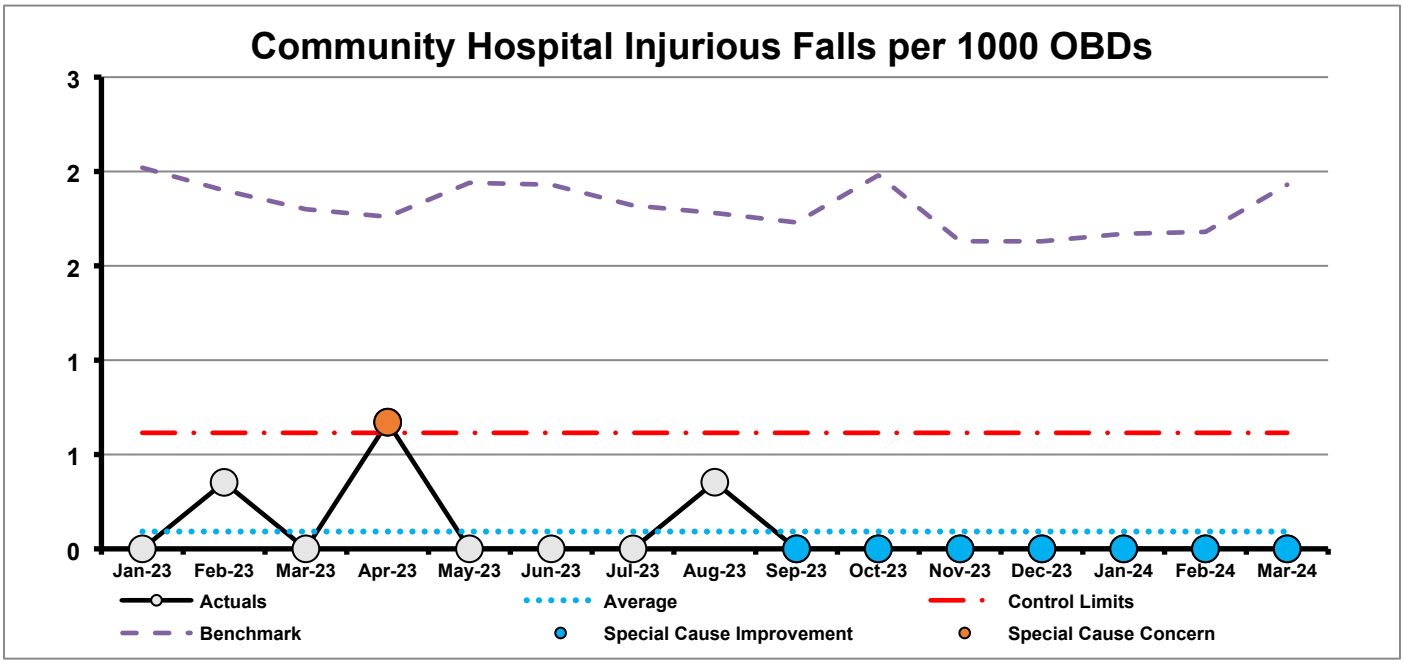
- Fall from a height / bed / chair (these falls tend to result in the highest level of injury of harm
- Slip / trip / fall on level ground.
- Supported lower to ground/ bed / chair / other (many of these are during direct patient care or therapeutic interventions)

Benchmark / target
There are 2 benchmarks available for falls within Community Hospitals. Both are measured on a 6-monthly average per 1000 OBD and are both in the Community Trust Benchmarking group.

The latest available monthly benchmark (February) for all Community Hospital falls is 5.86 The latest monthly benchmark of injurious falls is 1.69.

Current Performance





Narrative

Community Hospitals again are below average number of falls per 1000 bed days. There has been a slight increase due to a higher rate of bed occupancy this month. Benchmarking investigation is ongoing to compare against similar care delivery elsewhere. Falls improvement work continues including one falls template for the trust and mapping of the fall's 'offer' across the trust.

SPC

Community Hospital Falls per 1000 OBDs
SPC shows the Community falls per 1000 OBDs have not varied over the period.
Rate of Falls per 1000 OBD is inconsistently capable, but the target is achieved more often than not.

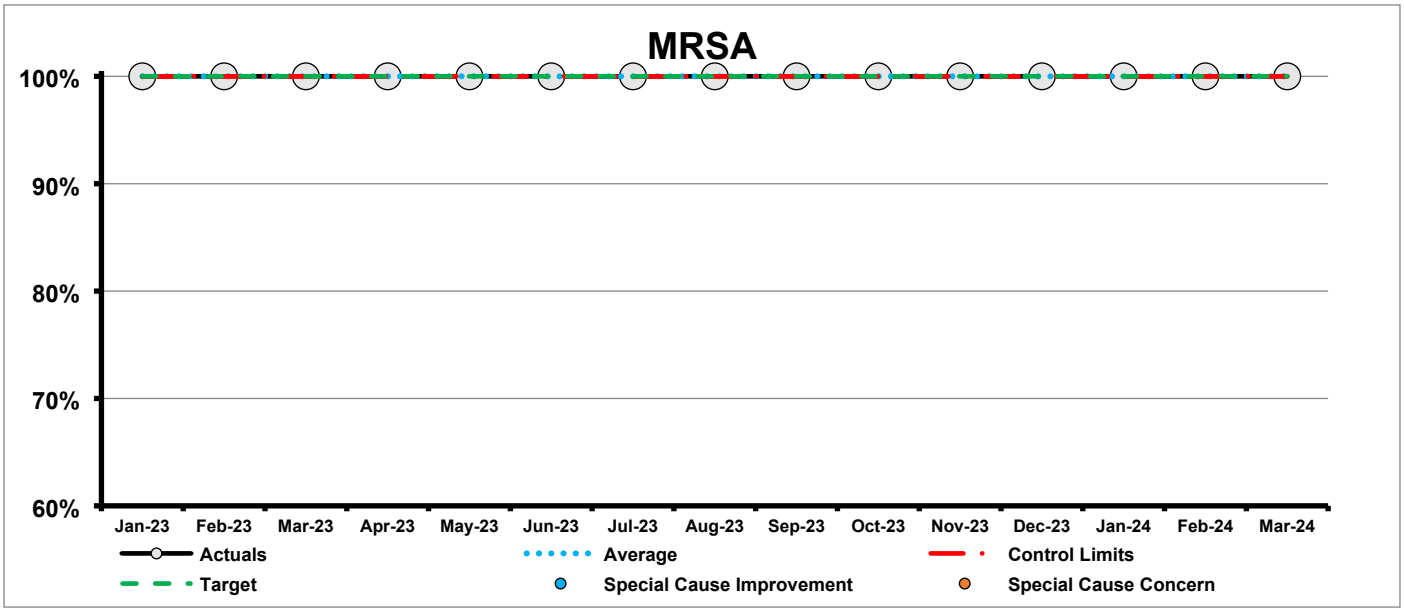
Community Hospital Injurious Falls per 1000 OBDs
SPC for Community Hospital Injurious falls per 1000 OBDs shows special cause improvement since September 2023,.remaining consistently below average.

MRSA Screening

Background
The Trust undertakes targeted MRSA colonisation screening for inpatients and surgical patients in line with the DH "Implementation of modified admission MRSA screening guidance for NHS (2014)".
The guidance advocates that those patients previously identified as MRSA positive, and those patients admitted to high-risk units are screened.
Across LCHS those patients known to be previously MRSA positive or from high-risk groups are identified on admission/or at pre-admission screening and necessary infection prevention risk management strategies applied.

Benchmark / target
The target range for screening is 100% of eligible patients.

Current Performance



Narrative

Of the 131 patients admitted across all sites, 11 patients were eligible for MRSA screening, of which all 11 were screened.

SPC

SPC shows MRSA screening compliance has not varied over the period. This metric is consistently capable of achieving the 100% target

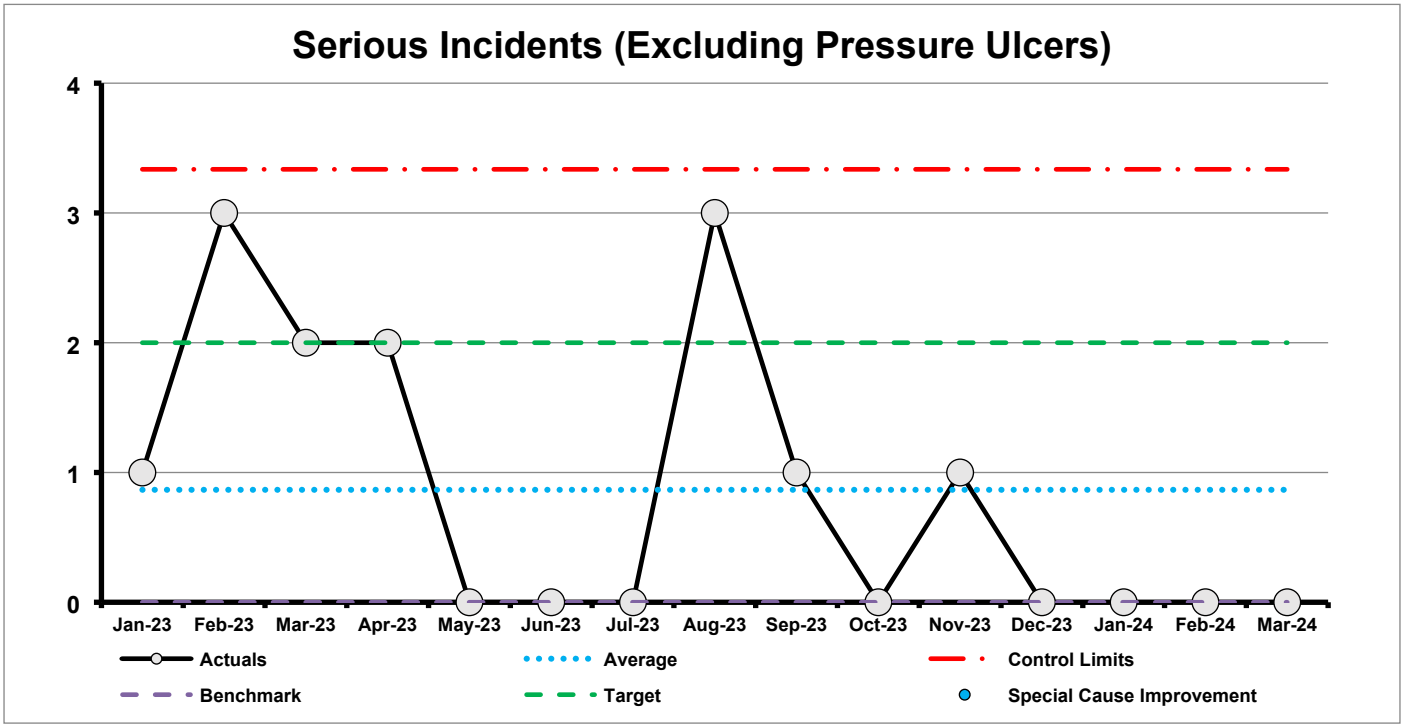
Serious Incidents

Background
Serious incidents include acts or omissions in care that result in: unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm – including those where the injury required treatment to prevent death or serious harm, abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services, and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services [NHS England 2015].

Since April 2019 pressure ulcers are not classified as avoidable or unavoidable, however all category 3s and 4s continue to be classified as serious incidents and scrutinised at the monthly thematic review.

Benchmark / target
The latest monthly value of Serious Incidents (excluding pressure ulcers) per month in the Community Trust Benchmarking group is 1 and the LCHS target is 2.

Current Performance



Narrative

There were 0 SI's (excluding Pressure Ulcers) in March.

SPC

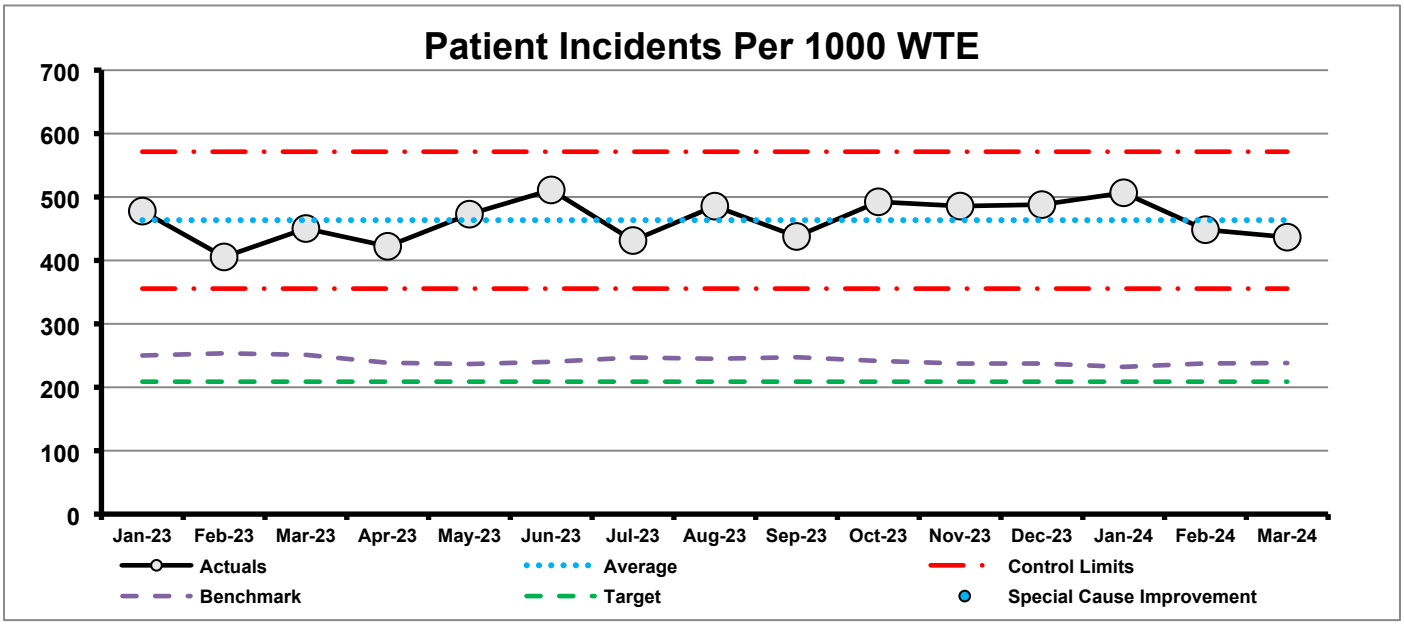
Serious Incident SPC shows there to be no significant variation over the period. This measure is inconsistently capable of achieving itarget but the target is met more often than not.

Patient Incidents

Background
From 18 June 2017 NHS Improvement moved from six monthly reporting and began publishing monthly data by reporting organisation on the numbers of incidents reported to the National Reporting and Learning System (NRLS).

Benchmarking / target
LCHS has been consistently a high reported of incidents using the Datix system.
The latest available 6 monthly average numbers of incidents per 1,000 WTE staff in the Community Trust Benchmarking group was 238.25.

Current Performance



Narrative

LCHS remains a consistently high reporter of incidents. Organisations with a higher reporting rate are more likely to have a good patient safety culture. This data also reflects the size of organisation.

Actions

Each Service Line reviews the incidents monthly at their Quality Scrutiny Group meetings to identify any trends and themes.

The themes are considered to support triangulation of themes from incidents, claims, serious incidents, complaints, and other quality datasets.

A recovery of overdue Datix management and responses within the required timescale has been developed in detail. The recovery plan is reported monthly to the Quality & Risk Committee and is achieving the agreed trajectory.

Upgrade and redevelopment of the Datix system itself is being progressed to maximise the functional use of the system, improve reporting, provide dashboards, and improve user interface for clinicians using the system.

SPC
Patient Incident SPC shows there to be no significant variation over the period. This measure is consistently capable of achieving its target. A high reporting rate is welcomed as a reflecting a good patient safety culture.

Community Pressure Ulcers – Rate per 1,000 contacts

Background
All pressure ulcers grade's 3 and 4 are classified and recorded as serious incidents. There is no distinction between avoidable and unavoidable in cause.

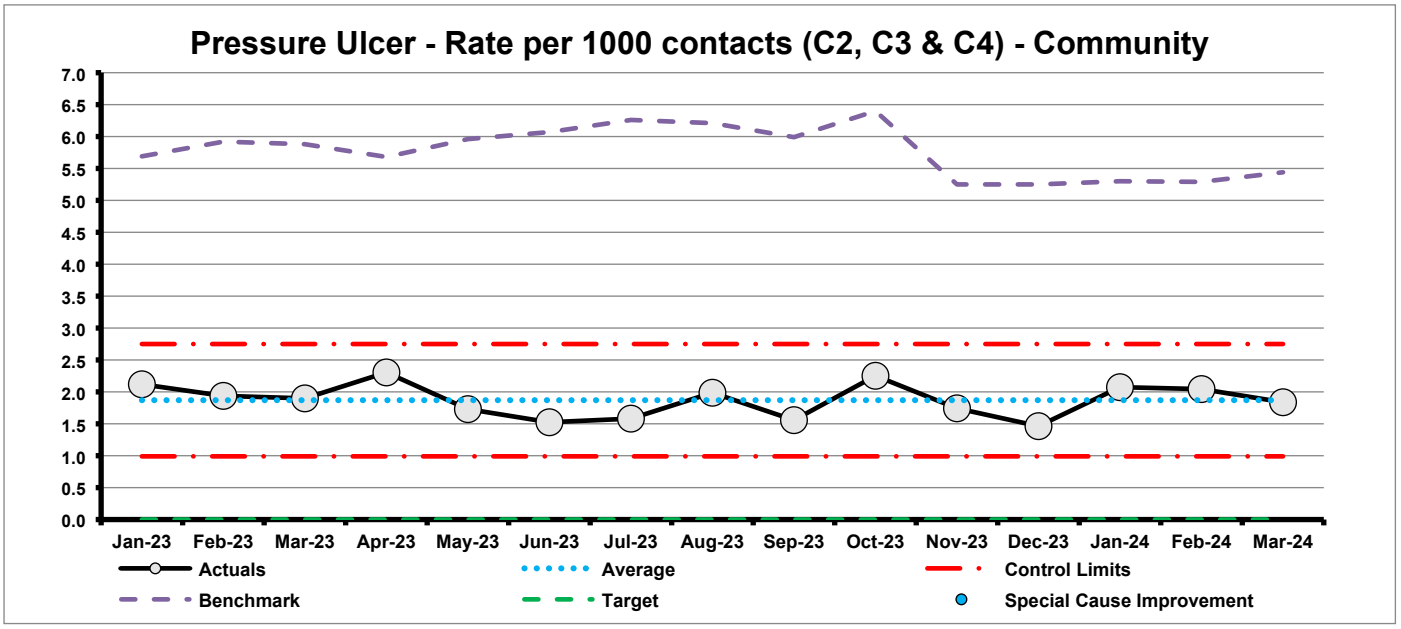
Reduction in patient harm related to pressure damage is the highest priority objective for the Lincolnshire Safeguarding Adults Board.

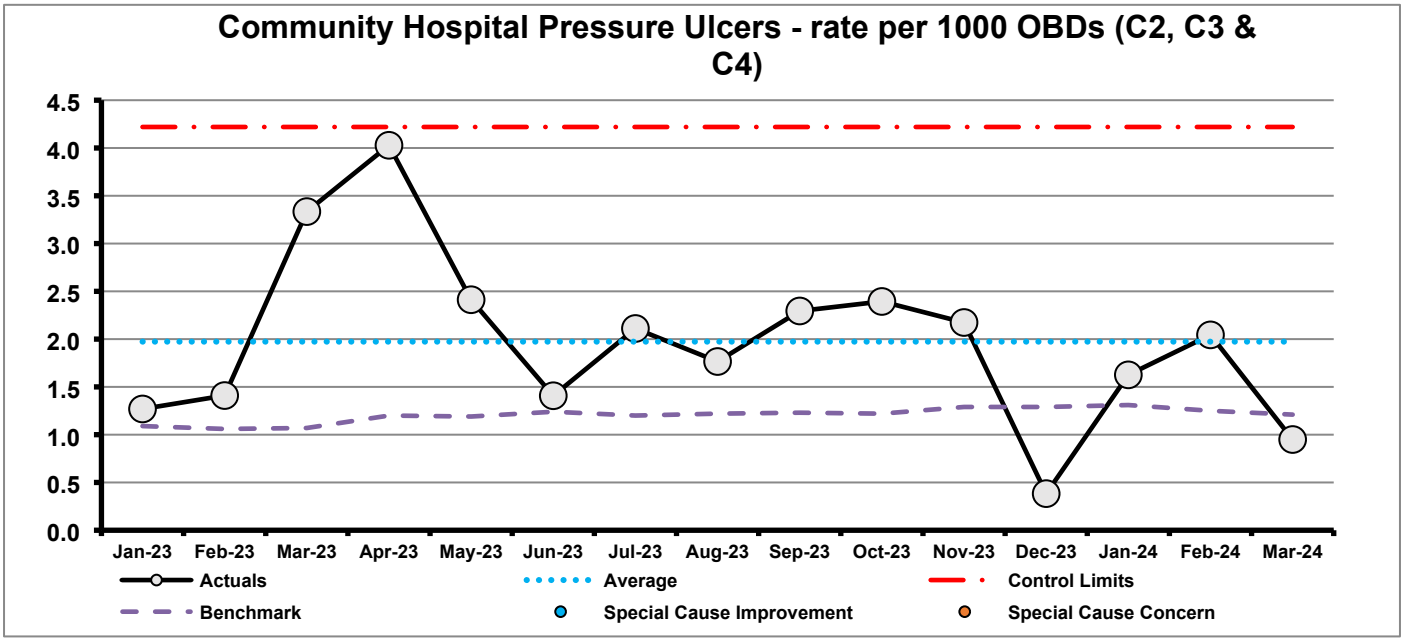
The Lincolnshire System Quality Group have agreed their first quality priority to be pressure damage – eradication of harm, standardising and improving care.

Benchmark
Benchmarking will continue to be calculated in community teams by 1,000 patient contacts – currently the national mean benchmark is 5.44.

Community Hospital benchmarking is calculated by 1000 Occupied Bed Days (OBDs) – currently the national benchmarking rate is 1.21.

Current Performance





Narrative for Community:
18 x (C3&4) and 107 x (C2) pressure ulcers were recorded within the Community for this month. There is a potential correlation between the number of deferred visits due to the vacancy factor and demand within community nursing for patients reducing visit frequency thereby impacting on Pressure Ulcer development. Thematic reviews are identifying consistent themes around pressure ulcer development including frailty recognition and identification of patients who may be in the last year of their life. A new frailty training package is being implemented from the 1st of April 2024 to support improvements in care delivery.

Narrative for Community Hospitals:
There was 3 x C2, and 0 x C3/C4 pressure ulcers recorded within Community Hospitals this month.

Actions

A database of all pressure ulcers in the Community is to be created with peer review across the county to ensure uniformity of care and to monitor effectiveness of healing.

SPC

Pressure Ulcers - rate per 1000 contacts (C2, C3 & C4) – Community
There is no significant variation over the period.

Pressure Ulcers – rate per 1000 OBDs (C2, C3 & C4) - Community Hospitals
There is no significant variation over the period.

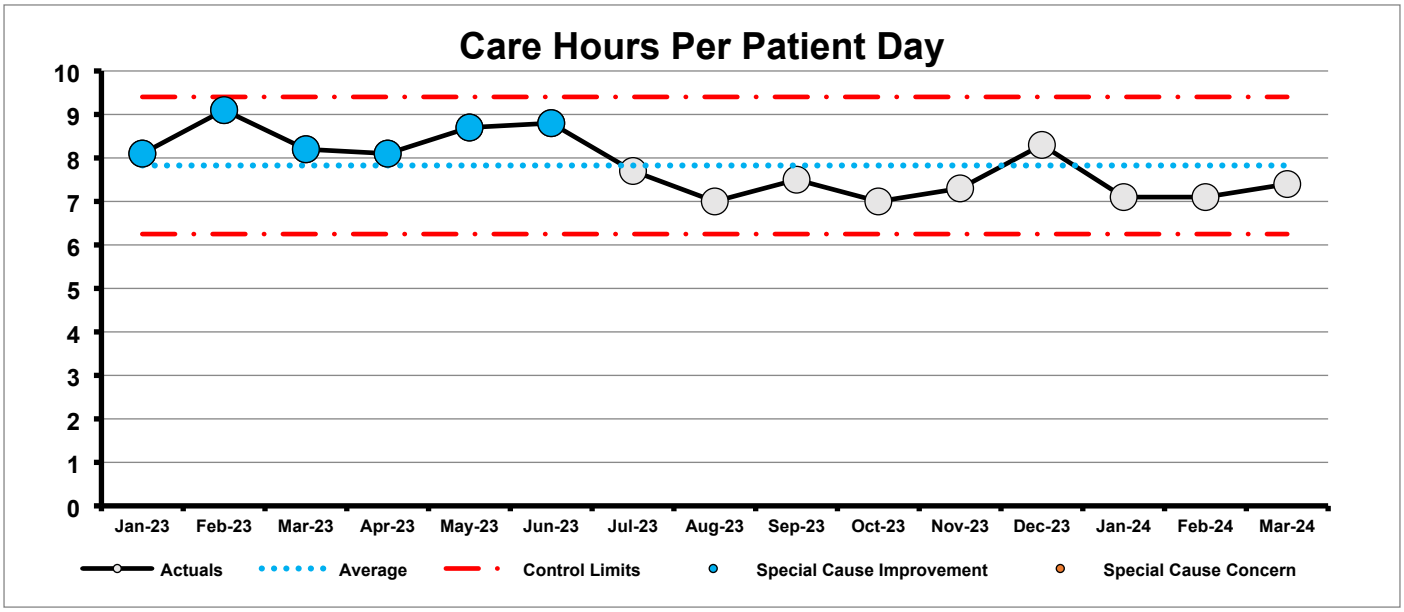
Care Hours Per Patient Day (CHPPD)

Background
Care Hours per Patient Day (CHPPD) is a simple calculation derived from dividing the number of actual care hours provided by the number of inpatients in a 24-hour period used as measure across inpatient areas.

While it is recognised that the needs of patients using these community services are often quite different, the CHPPD measure provides a representation of the number of care hours available to patients and is a measure that enables wards/units of a similar size, speciality, and patient group to be compared.

Benchmark / target
There is no available benchmark – NHSEI have confirmed this will not be progressed.
There is no agreed target, but the CHPPD rate should be considered alongside other quality and safety metrics contributing to safe staffing.

Current Performance



Narrative

CHHPD remains within the control limits. There is no current evidence to suggest a lack of staffing has led to unsafe care been delivered by the Community Hospital Team.

Actions

A full complement of registered nurse staffing is seen within Scotter ward. Reduced RN cover remains in Skegness and Louth. Planned recruitment for these areas using IEN staff is ongoing and will resolve current vacancy factor.

HCSW vacancy remains in some areas with recruitment to entry posts is challenging. There is noticeable offset in hours allocated to registrant posts in areas with lower HCSW levels. Increased hours have also been seen in Skegness secondary to the current fire precaution numbers needed. This is expected to resolve with estates work planned in the forthcoming 6 weeks.

SPC

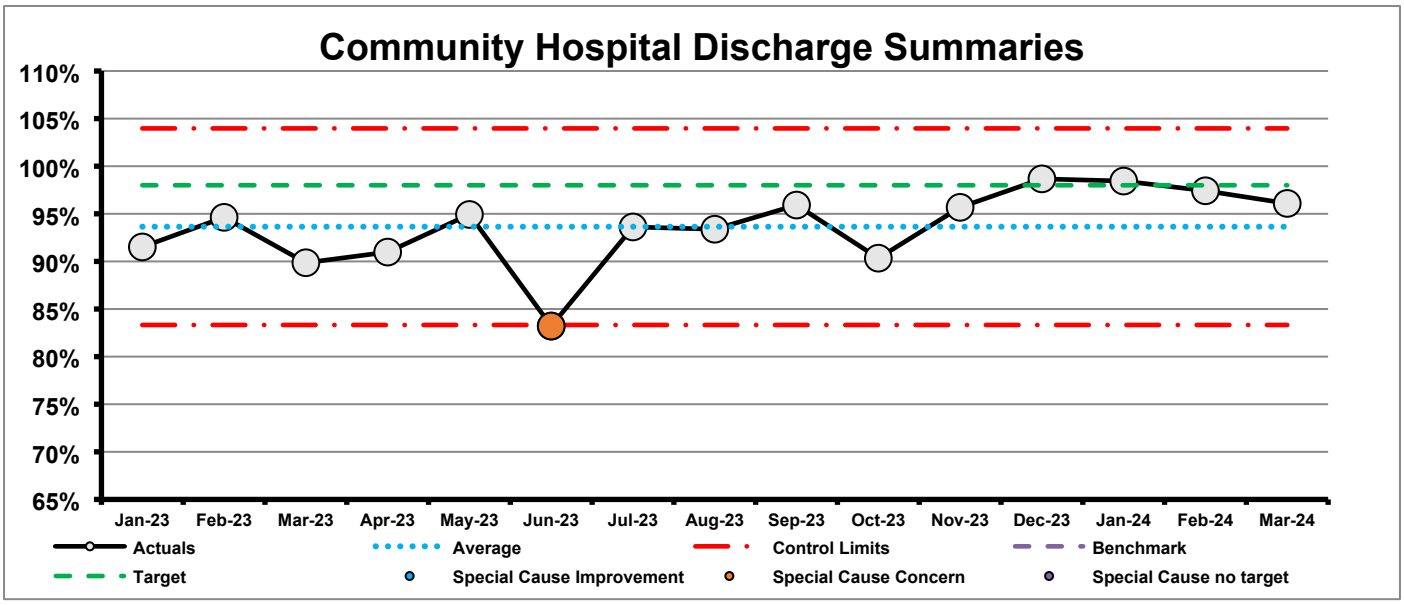
Care hours per patient day shows no significant variation since June 2023.

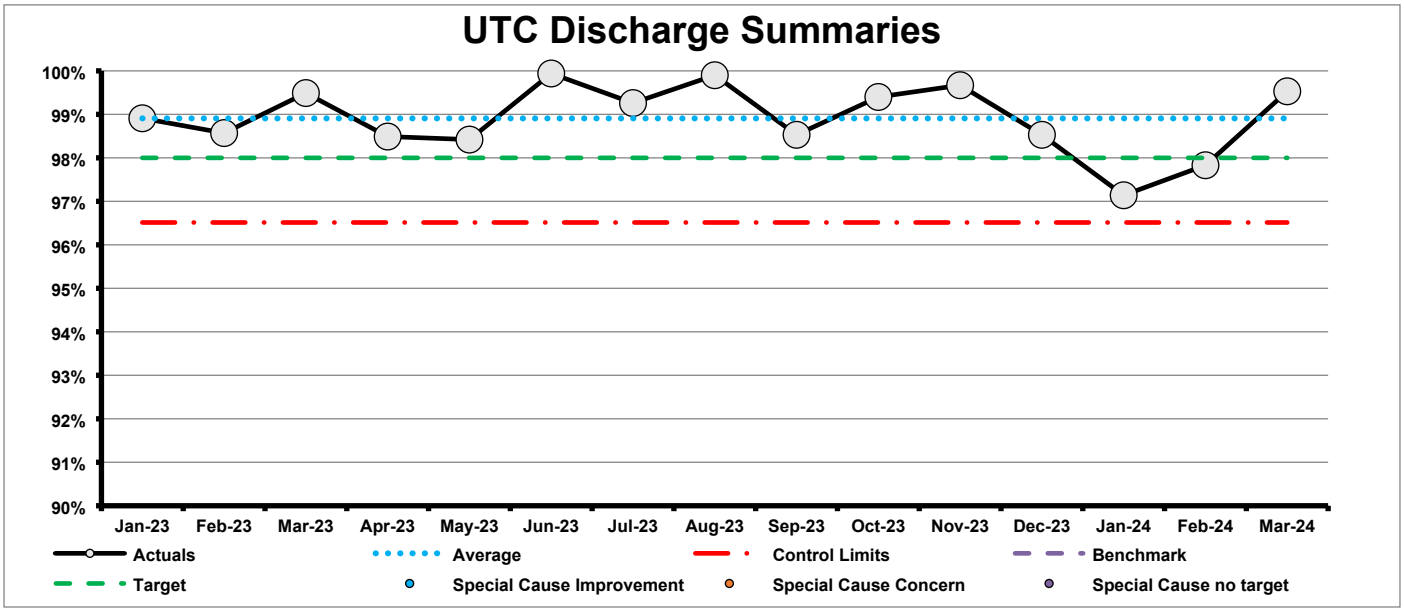
Discharge Summaries

Background
It is a requirement of the Quality Schedule part 6 to the NHS Standard Contract that discharge summaries issued by the ward doctor are issued from Community Hospitals to the patients GP within 24 hours of discharge. As the Trust medical staff currently work Monday to Friday this performance measure is adapted.

Benchmark / Target
Discharge summaries should be issued by the ward doctor in Community Hospitals to the patients GP within 24 hours of discharge – target 98%.

Current Performance





Narrative

Community Hospitals

Review of areas not achieving 100% is being audited weekly to support compliance by area CTL's. Target of 98% was not achieved this month.

Actions

Continued oversight of revised processes in place. Validation of non-compliance continues to be monitored with remedial action taken at a local level. Feedback to clinician's and teams in place for awareness and localised plan for maintenance.

Urgent Treatment Centres

Whilst not part of the Schedule 6 performance indicator – the UTCs also issue discharge summaries and compliance is 98% at 99.53% for March 2024.

SPC

Discharge Summaries - Community Hospitals
Community Hospital Discharge Summaries shows no significant variation over the period. This measure is inconsistently capable of achieving its target with the target being missed more often than not.

Discharge Summaries – Urgent Treatment Centres
UTC Discharge Summaries shows no significant variation over the period. This measure is inconsistently capable of achieving its target with the target being acheived more often than not.

Overdue & Reported Datix

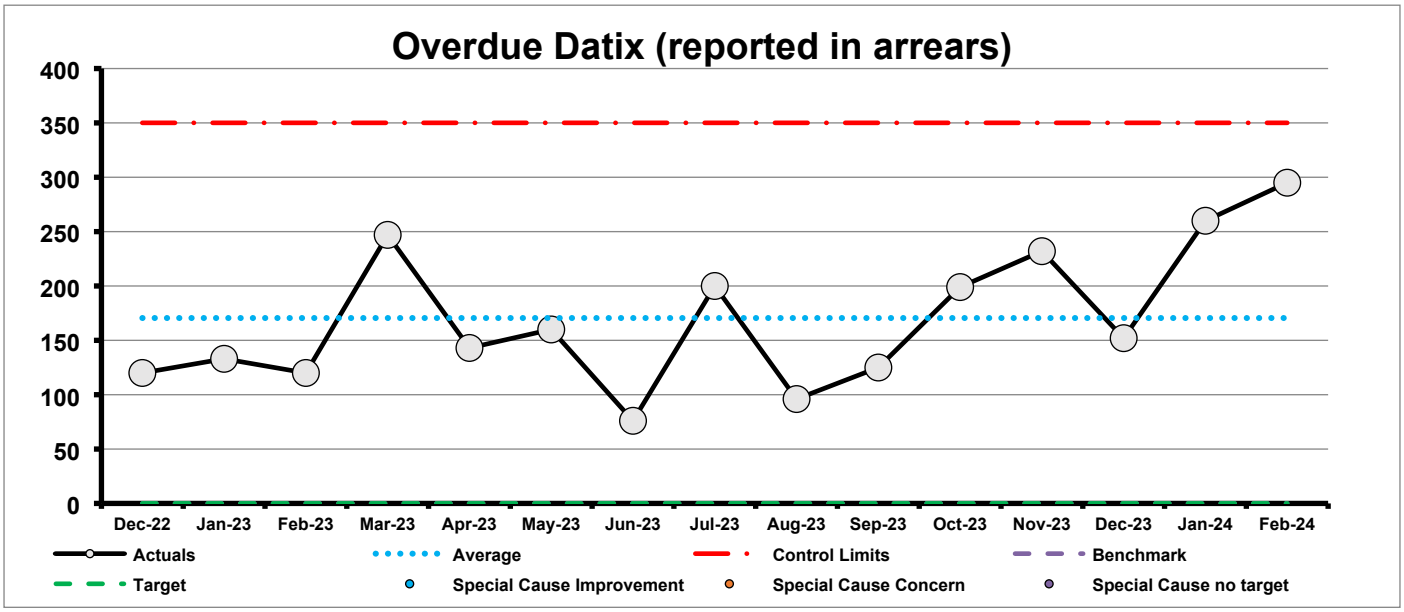
Background
When a Datix is raised to alert or escalate an incident (IR1 form) – it is imperative that the details are reviewed and considered in terms of any immediate actions that have or should be taken particularly regarding patient and staff safety.

A Datix is used as part of many governance processes and learning form the incidents when an investigation or exploration is complete should be considered, captured and changes enacted from the learning (IR2 form) A final review and closure of the Datix is completed by a senior manager where wider themes are also considered.

Benchmark/Target
The **recommended** timescale for optimum learning is 30 days.

Datix are reported as at the end of the preceding month (i.e., below is the position for February 2023). Reported Datix are reported at the end of the reporting month.

Current Performance



Narrative
The overdue Datix is taken in context of the Trust being a high reporter of Datix.

Whilst some investigations will require a longer investigation timetable than routine incidents (e.g., where incidents require statements from several staff or a formal RCA). To understand true overdue Datix - those not aligned to an investigation or planned governance process - the data has been broken down.

Actions
- A trajectory for recovery of overdue Datix has been agreed and is reported to the Quality & Risk Committee monthly- the trajectory is on target.
- Development of the Datix system is being progressed to support faster incident triage and improved oversight.
- Specific actions with the ICB are being agreed in relation to being able to close Datix relating to pressure damage.
- Training is being delivered by the quality team on the completion of IR2s.
- An online training package is under development, and the training in the recording of Datix is improving accuracy.

SPC
Overdue Datix levels have not varied significantly over the period.

Children in Care (reported one month in arrears)

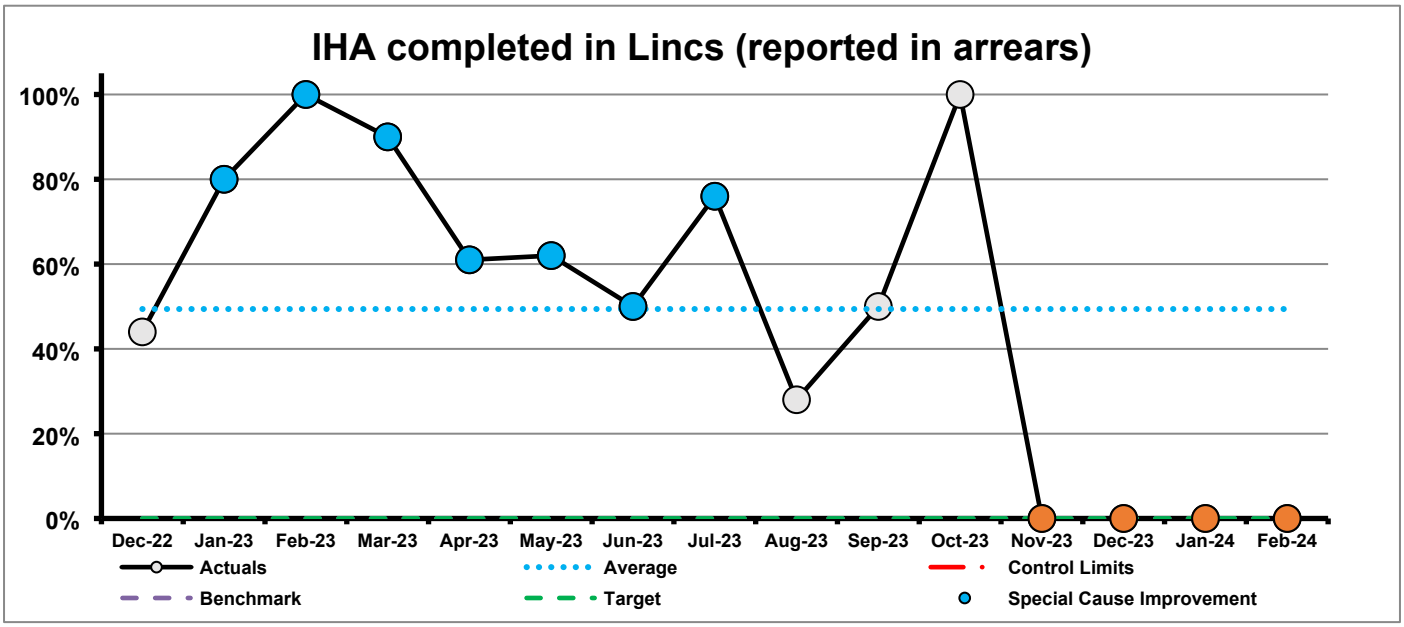
Background

From the 1st August 2019 LCHS reporting of the management and completion of Initial Health Assessments (IHA) for Children in Care (CiC) was included in this report. The performance report includes children looked after in Lincolnshire local authority and those placed in Lincolnshire by external authorities.
The quarterly and annual reports provide details on Children in Care in Lincolnshire who are placed outside of county, having their IHA with alternative providers.

Benchmarking / Target

All Children in Care are required to have an IHA undertaken and completed within 20 working days of becoming looked after. Lincolnshire County Council (LCC) has a target to complete and submit Consents and Coram BAAF forms to LCHS within 3 working days of a child becoming looked after. LCHS are required to administer the completion of an IHA within the statutory 20 working days of the child becoming looked after.

Current Performance



Narrative

Due to a change of leadership, alongside a service redesign within the Children in Care team, at the time of reporting, data was unavailable to provide accurate activity regarding Children placed in to care with Lincolnshire Local Authority and the number of IHAs completed within the target timeframe of 20 days.

The Team is working to understand the Board Reporting process and going forward a questionnaire will be published for Children in Care which will facilitate accurate reporting without a undertaking a manual trawl of the records

.

SPC

(Data currently not available).

Environmental Cleanliness

Background
The cleaning company contract with provider OCS through NHSPS shared services began in 2022.

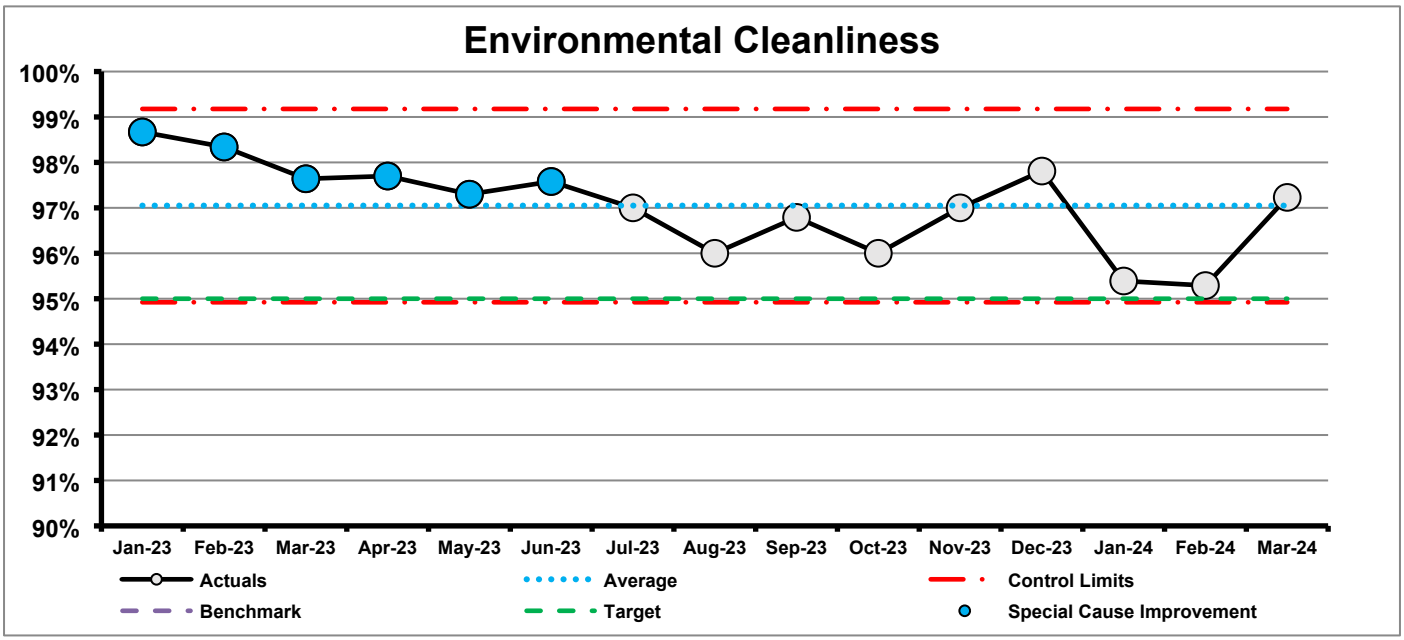
The requirements of the new National Standards of Healthcare Cleanliness that were published at the end of April 2021 have been rolled out across all LCHS community premises by OCS as well as being adopted by NHSPS and the in-house teams at the hospital sites.

Star rating posters and "Commitment to Cleanliness" posters, which include cleaning schedules, are on display in all Trust buildings.

Benchmark / Target
LCHS is required to comply and report 2 targets:

- Criterion two of the Hygiene Code requires LCHS to "provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections'' with 100% compliance.
- Completion of cleanliness audits with achievements of 5-star rating.

Current Performance



Narrative
LCHS reported 97.23% compliance of cleanliness audits and has achieved the 95% target every month. Visible improvements in the cleaning standards across all the community premises are being sustained. During the quarter, all sites achieved scores that would rate them as either 4 or 5 stars, in accordance with the new Healthcare cleaning standards.

There are currently no cleaning vacancies across the LCHS sites, and all current staff training is up to date.

Actions
Cleanliness audits and monitoring continue to facilitate appraisal of concordance with expected cleanliness standards. One area of development continues to be the cleaning contract review at Louth Urgent Care Centre.

SPC
SPC shows that cleanliness audits performance has not varied over the period. This metric is consistently capable of achieving the 95% target.

Community Hospital Bed Occupancy

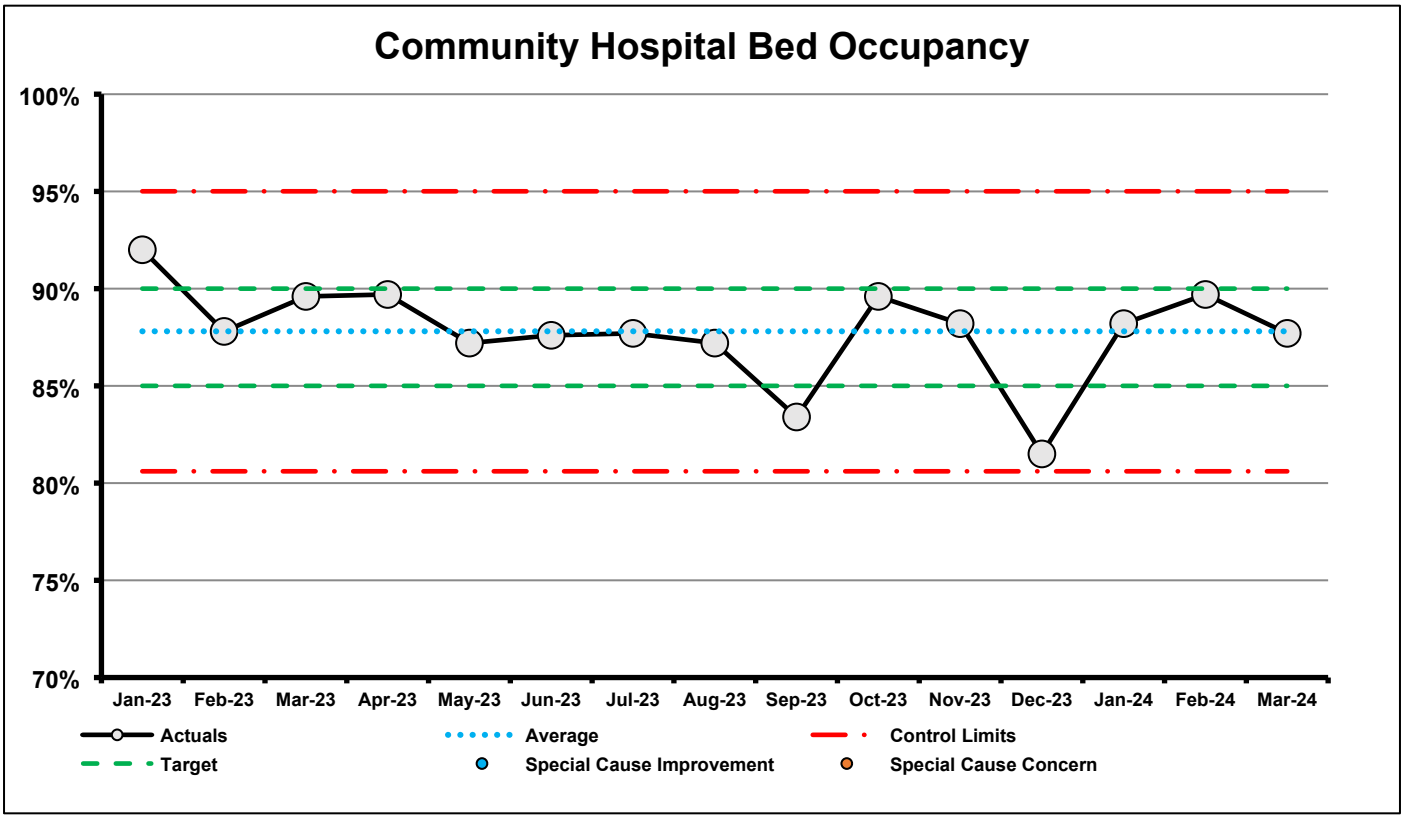
Background

Bed occupancy is measured in terms of open beds and does not include any chair-based activity.
The calculations for bed occupancy also include increases in beds at time of surge or pressure when additional beds are opened. Bed occupancy is a patient safety and patient flow measure.

Benchmark/Target

In July 2023 the bed occupancy target was moved from 90% to 85%. NHS Benchmarking have not yet published the community dataset for the reporting period. Bed occupancy target for the community hospitals is to be reviewed with a proposal for PMR that the target to be set at 85% in line with NICE guidance this proposal has been accepted and target implemented. However, from a patient flow perspective the proposed strategy is to 'fill the beds' which in practice means aiming for a bed occupancy of 95% or so.

Current Performance



Narrative

Bed occupancy for March 2024 was 87.70%.

We rely on appropriate referrals from Acute and Community partners. Responsibility for this is largely held by the multi provider Discharge Hub which coordinates Flow between ULHT and LCHS, therefore we are working closely with them to increase the number of referrals to Community Hospitals. Recently we have implemented Direct Referrals which gives Acute practitioners the ability to refer directly with the hope that a more seamless pathway would increase referrals. This pathway hasn't been utilised as frequently as we hoped as yet so we continue to work on its development.

SPC

SPC shows the Community Hospital bed occupancy performance has not varied over the period. This measure is inconsistently capable of landing within the 85%-90% target range

Average Length of Stay

Background

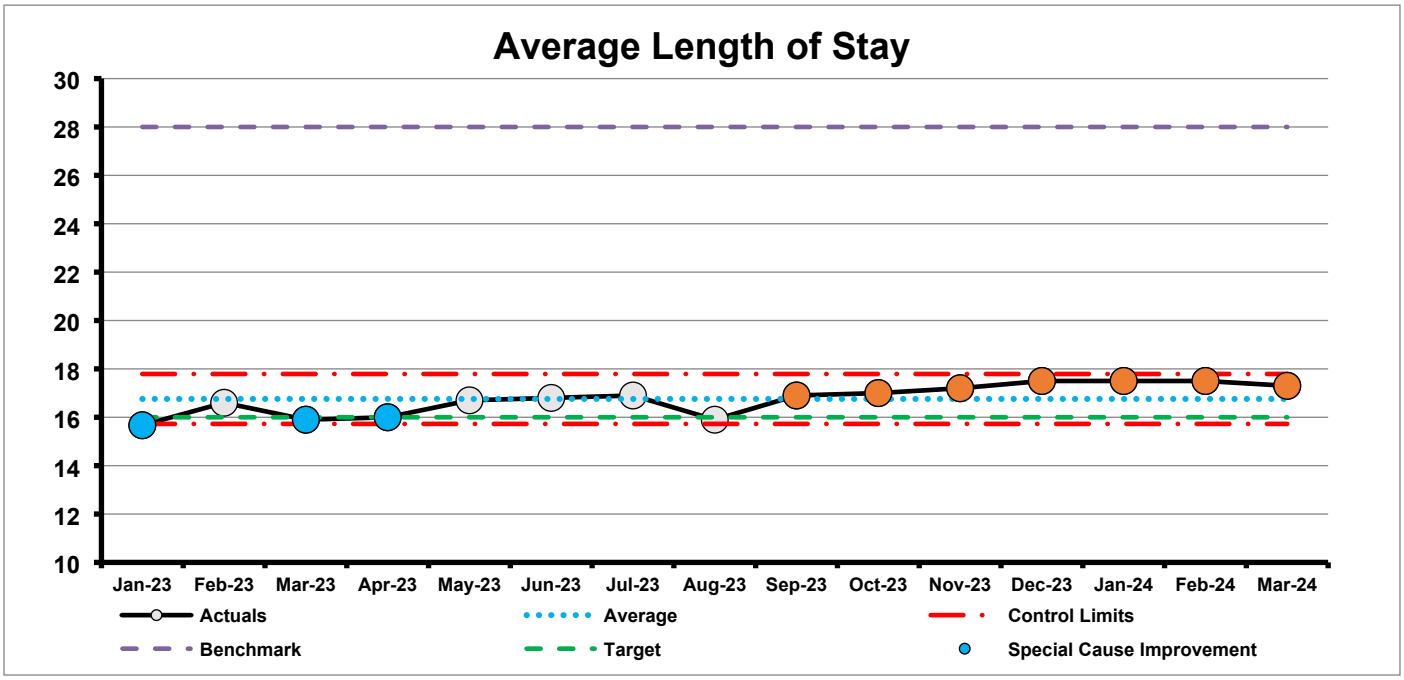
This measure is defined as the difference in days between the date the patient was discharged from the hospital, and the date they were admitted. The average time in hospital in days for all the patients who underwent a procedure in an NHS trust is then calculated (NHS Digital, 2018).

Benchmark/ Target

NHS Benchmarking have not yet published the community dataset for the reporting period.

Target length of stay is 16 days.

Current Performance



Narrative

Average length of stay in Community Hospitals has remained below the National Benchmark (currently 28 days) for over 12 months. The number of days average was 17.30 in March. This is above the target of 16 days.

Actions

There has been pressure on length of stay due to the 11 Enhanced care beds, without extra therapy staff. In addition, we have picked up more Stroke patients through the partnership working we have done to improve the Community Hospitals offer for Stroke and to assist the Acute reduce their Length of Stay and bed availability. Timely access to an Acute Stroke Unit is a key indicator in patient outcomes for Stroke. However, the patients we have looked after having tended to be very complex and had longer (than average) lengths of stay. Our Stroke offer is a work in progress. There has been particular concern over length of stay on one Community Hospital site and an action plan is to be put in to review this.

SPC

Average length of stay SPC shows special cause concern since September 2023. The SPC also shows average length of stay is inconsistently capable of achieving the local target of 16 days, the target is missed more often than not.

Friends and Family Test

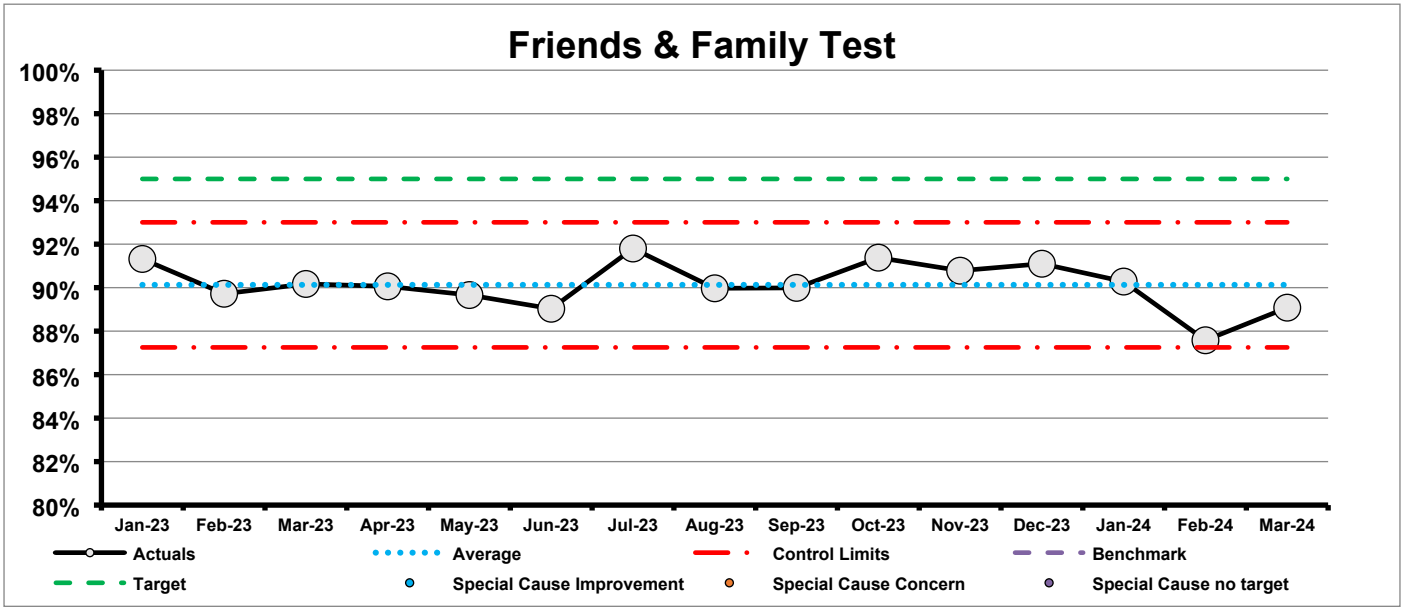
Background

The NHS Friends and Family Test was created to help service providers and commissioners understand whether their patients are happy with the service provided, and where improvements are needed. It is a quick and anonymous way to give views after receiving care or treatment across the NHS. When patients complete their treatment or are discharged from a service, they are invited to complete the FFT, they are asked to provide a score and feedback on recommending the service to friends and family. This is important because service providers can only make changes if they know exactly what is or isn't working.

Benchmark / Target

The LCHS Target is 95% of service users recommend our services.

Current Performance



Narrative

FFT figures for March (89.08%) shows an increase on last month's performance activity (87.58%).

11 FFT QR codes have been generated with bespoke alignment to the community nursing teams for patient engagement and feedback. The Patient Experience Support Officer is working within each of the 11 community nursing teams for an enrichment data collation experience. The FFT intelligence acquired will formulate a 'you said we did' feedback method - which will be incorporated into the weekly bulletin, screensaver, team meetings and QSG for dissemination.

Actions

Additional contractual oversight remains in place to continue to improve the roll out and reporting of the service provided.

SPC

SPC shows that Friends and Family performance has not varied significantly over the period. This measure is not statistically capable of achieving the 95% target without redesign.

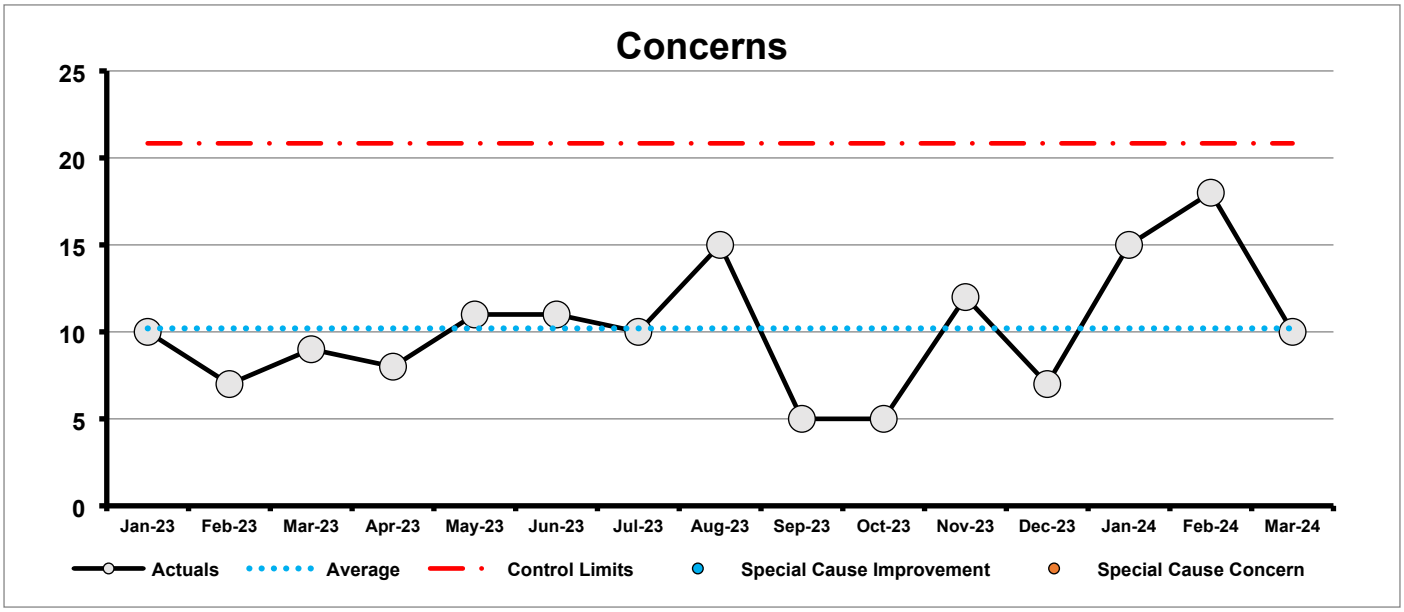
Concerns

Background
LCHS aims to resolve all concerns and issues that patients and family members raise through informal resolution through the PALS, Complaints and Claims Team with services and clinical teams directly. Actions and learning from concerns are shared with divisional and corporate teams, overseen through Quality Assurance Groups with exception reporting into the Clinical Safety and Effectiveness Group (CSEG) and the Stakeholder Engagement and Involvement Group (SEIG).

We are keen to resolve any complaints or issues, where possible, as a concern with the service and patient or family member in a prompt, personal and effective manner so that concerns do not 'time out' after 3 days and escalate to a formal complaint.

Benchmark / Target
There is no available benchmarking. The current LCHS target is to resolve as many complaints as possible through the concerns resolution 3-day route, which currently a target of 15 per month is being discussed with divisional leads.

Current Performance



Narrative

Capacity across services has been challenging, however, teams and leaders are increasingly engaging with patients and family members as they access LCHS services to ascertain whether their experience met expectations.

Significant work has been taking place since September 2022 to improve the flow of concerns, complaints, and compliments across the Trust.

Actions

Target is to increase the number of potential complaints received each month to be dealt with as a concern where possible, so improvement month on month should show an increase in complaints dealt with as concerns/ increased no of concerns.

SPC

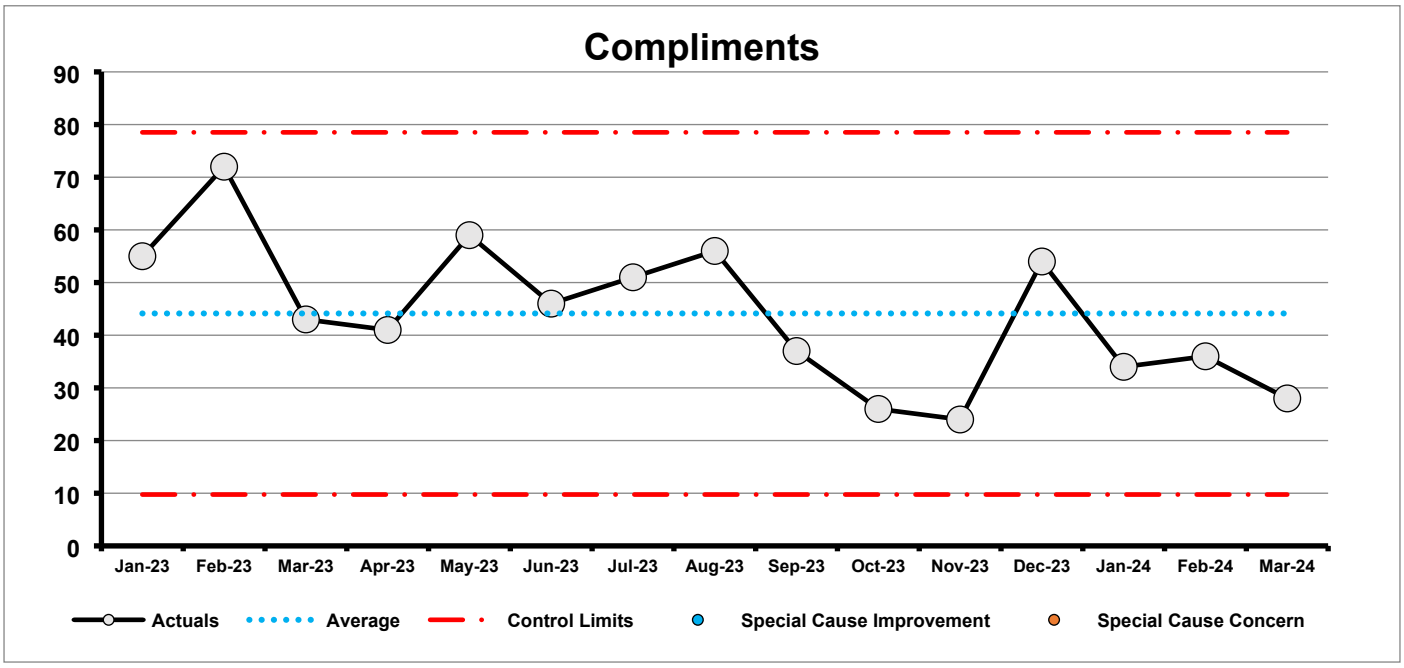
Concerns have not varied significantly over the period.

Compliments

Background
Compliments are received by the Trust through services directly which are then shared with the PALS, Complaints and Claims Team, through NHS Choices, Healthwatch, alternative partners or directly into PALS. Work continues to accurately capture the compliments received by the Trust.
Benchmark / Target

There is no available benchmarking. A proposed target of 50 compliments each month across the Trust is currently being discussed with divisions.

Current activity



Narrative

Monthly figures have varied considerably in relation to compliments received into the Trust, although consistencies are notable over a 14- month period year on year, where numbers decrease in the months of January, March, and September over the past 3 years, which are months where attendances/ use of services have increased.
March shows a slight decrease from the previous month.

SPC

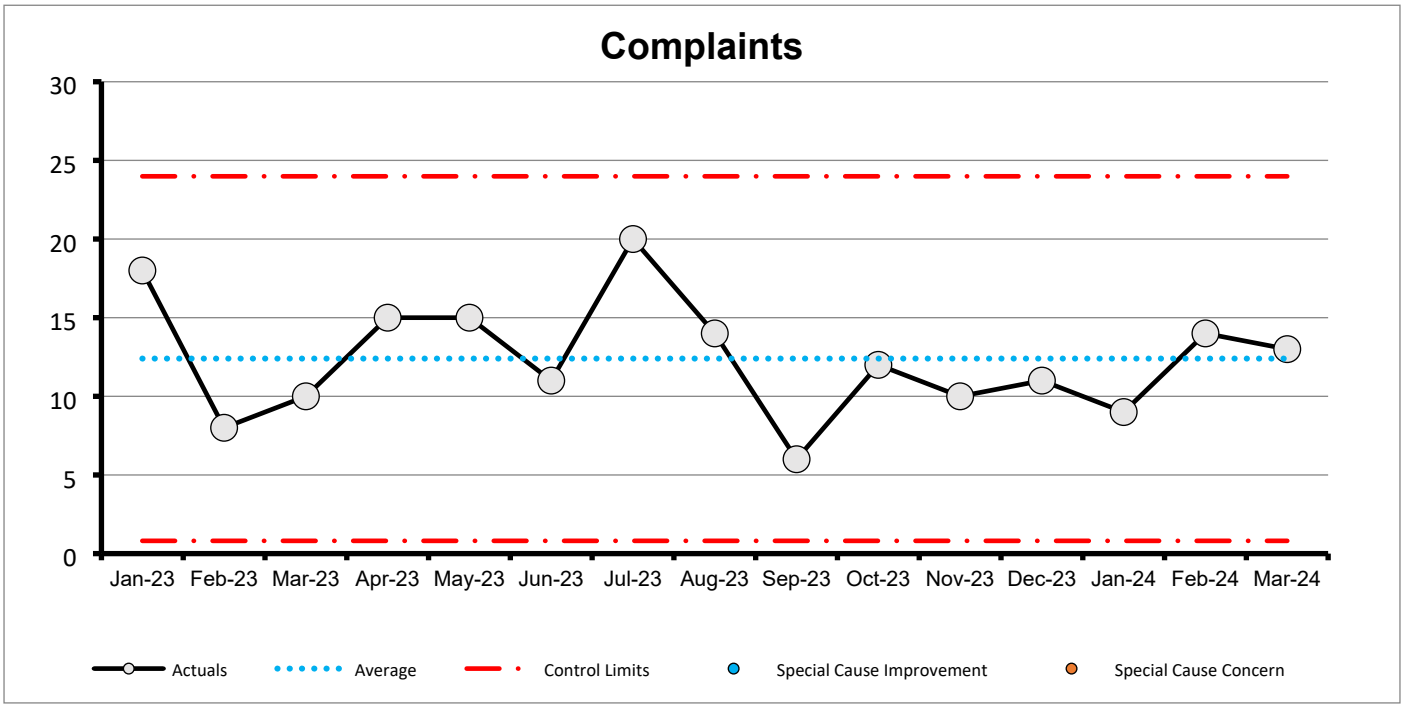
Compliments have not varied significantly over the period.

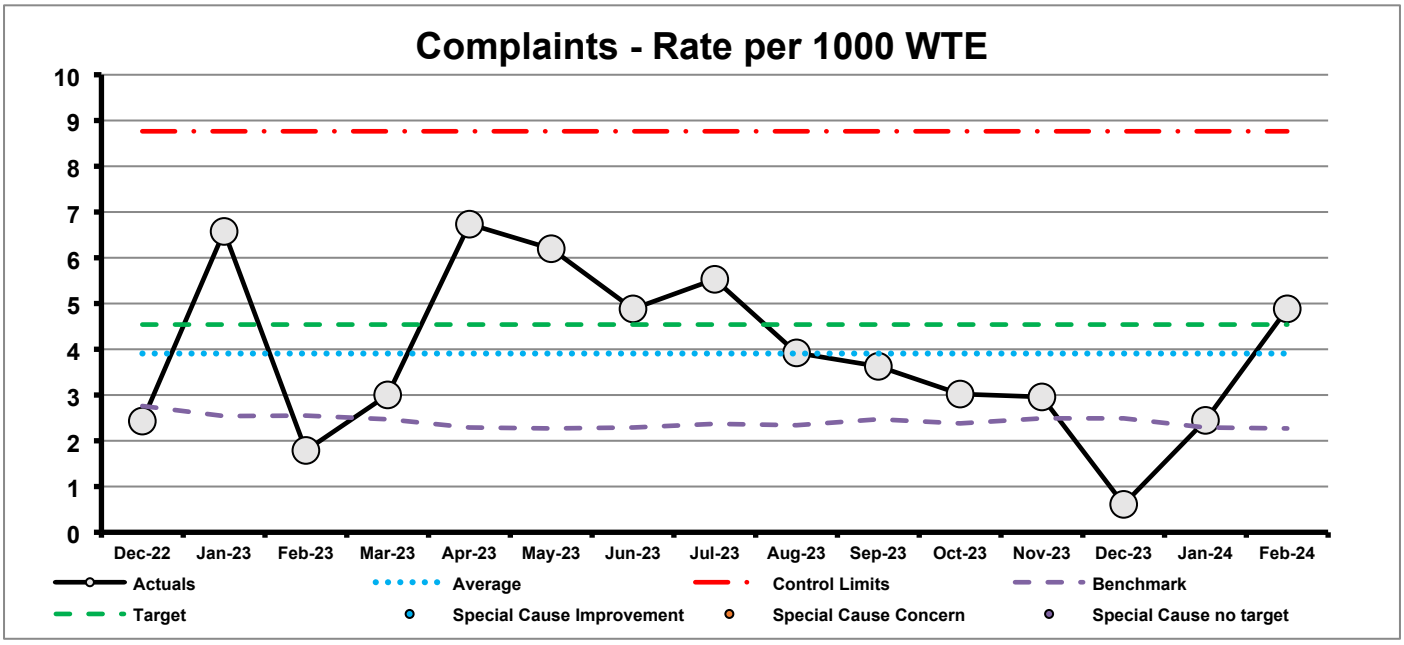
Complaints

Benchmark / Target

LCHS is benchmarked by the number of complaints reported per 1,000 WTE budgeted staff.

Current Performance





Narrative

We are keen to resolve any complaints or issues, concerned with the service and patient or family member in a prompt, personal and effective manner. This avoids the complaint reaching the 'time out' after 3 days and escalating to a formal complaint. Significant work has been taking place since September 2022 to improve the flow of concerns, complaints, and compliments across the Trust.

Actions

Through divisional leads and Quality Assurance Groups (QAGs) actions continuing to be taken forward include:

- Encouraging divisions to respond to as many complaints as possible through the informal concerns route within time to prevent escalation to a formal complaint.

Updated communication materials are in development to simplify how patients and family members can raise a concern, complaint, or feedback.

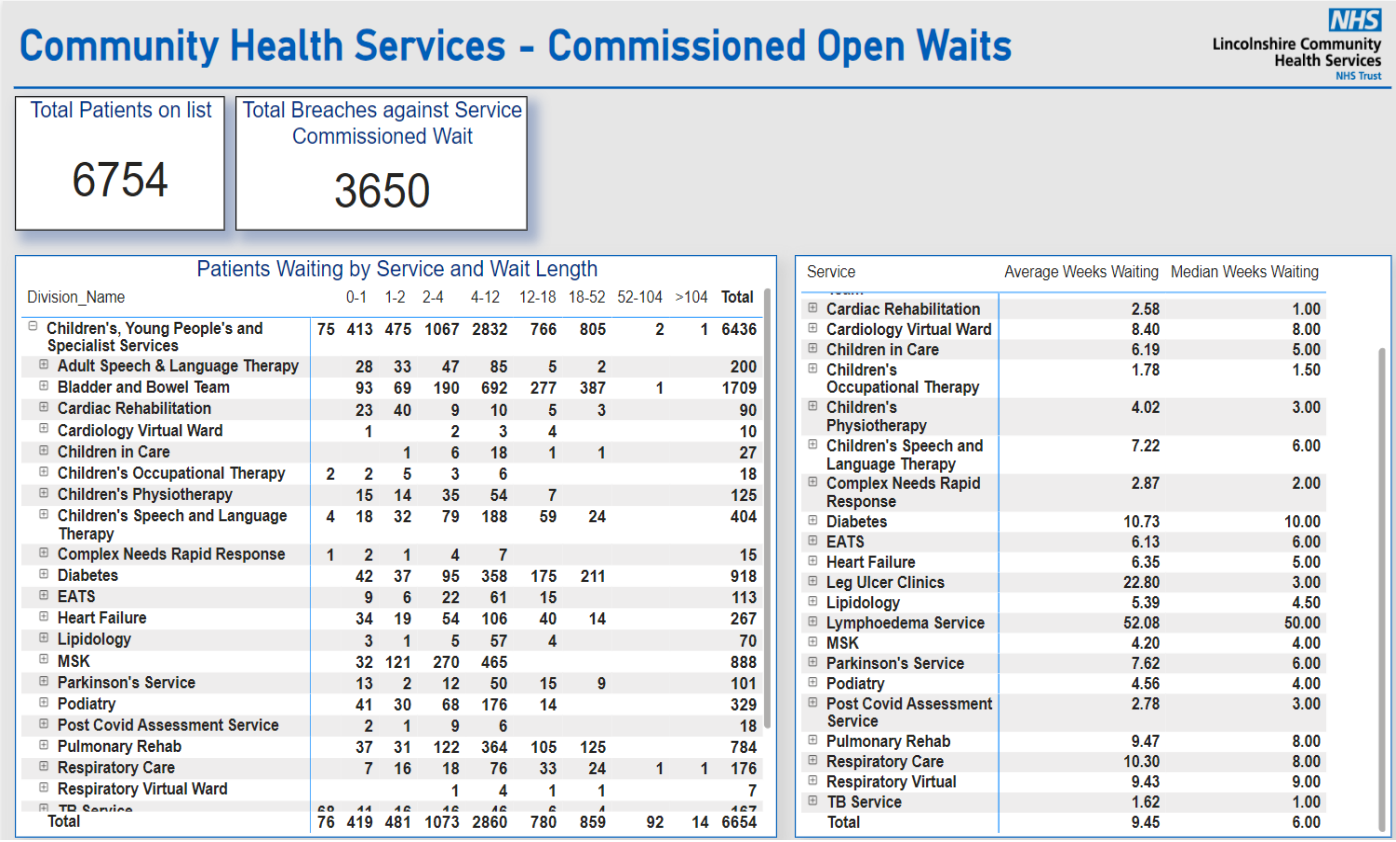
SPC

Complaints has not varied significantly over the period.
The complaints rate per 1000 WTE has not varied significantly over the period. It is inconsistently capable of achieving target but does so more often than not.

LCHS Commissioned Waits

Background

LCHS Commissioned waits are the agreed target waits set out by each service level agreement and therefore not all services will be aligned to an 18 week wait target.



Community Health Services - Commissioned Open Waits

NHS Lincolnshire Community Health Services NHS Trust

Total Patients on list	Total Breaches against Service Commissioned Wait
6754	3650

Patients Waiting by Service and Wait Length

Division_Name	0-1	1-2	2-4	4-12	12-18	18-52	52-104	>104	Total
Children's, Young People's and Specialist Services	75	413	475	1067	2832	766	805	2	1	6436
Adult Speech & Language Therapy		28	33	47	85	5	2			200
Bladder and Bowel Team		93	69	190	692	277	387	1		1709
Cardiac Rehabilitation		23	40	9	10	5	3			90
Cardiology Virtual Ward		1		2	3	4				10
Children in Care			1	6	18	1	1			27
Children's Occupational Therapy	2	2	5	3	6					18
Children's Physiotherapy		15	14	35	54	7				125
Children's Speech and Language Therapy	4	18	32	79	188	59	24			404
Complex Needs Rapid Response	1	2	1	4	7					15
Diabetes		42	37	95	358	175	211			918
EATS		9	6	22	61	15				113
Heart Failure		34	19	54	106	40	14			267
Lipidology		3	1	5	57	4				70
MSK		32	121	270	465					888
Parkinson's Service		13	2	12	50	15	9			101
Podiatry		41	30	68	176	14				329
Post Covid Assessment Service		2	1	9	6					18
Pulmonary Rehab		37	31	122	364	105	125			784
Respiratory Care		7	16	18	76	33	24	1	1	176
Respiratory Virtual Ward				1	4	1	1			7
TB Service										
Total	76	419	481	1073	2860	780	859	92	14	6654

Service	Average Weeks Waiting	Median Weeks Waiting
Cardiac Rehabilitation	2.58	1.00
Cardiology Virtual Ward	8.40	8.00
Children in Care	6.19	5.00
Children's Occupational Therapy	1.78	1.50
Children's Physiotherapy	4.02	3.00
Children's Speech and Language Therapy	7.22	6.00
Complex Needs Rapid Response	2.87	2.00
Diabetes	10.73	10.00
EATS	6.13	6.00
Heart Failure	6.35	5.00
Leg Ulcer Clinics	22.80	3.00
Lipidology	5.39	4.50
Lymphoedema Service	52.08	50.00
MSK	4.20	4.00
Parkinson's Service	7.62	6.00
Podiatry	4.56	4.00
Post Covid Assessment Service	2.78	3.00
Pulmonary Rehab	9.47	8.00
Respiratory Care	10.30	8.00
Respiratory Virtual	9.43	9.00
TB Service	1.62	1.00
Total	9.45	6.00

Narrative

This is the current LCHS Commissioned Wait position based on the data for those services currently using the clock, and where the clock has not been paused. It has been agreed across the Trust for waits to be recorded using the 18 Week Wait function on SystmOne.

Despite the NHS Operating Framework and NHS Constitution setting out rules and definitions for consultant-led waiting times, as a non-consultant-led trust, the NHS framework allows the use of the clock to make clinically sound decisions locally about applying them, in collaboration between clinicians, providers, commissioners and the patient.

This is currently in the early stages of implementation across all services recording referral to initial contact, with data quality reporting happening over the next few months, to ensure it is correct.

The agreed target waits for those services currently utilising the clock are outlined below.

Service	Target Wait
Adult Speech and Language Therapy	18 Weeks
Bladder and Bowel	6 Weeks
Cardiac Rehabilitation	10 Working Days
Child Therapy	18 Weeks
Children in Care	20 Working Days
CNS Continence	18 Weeks

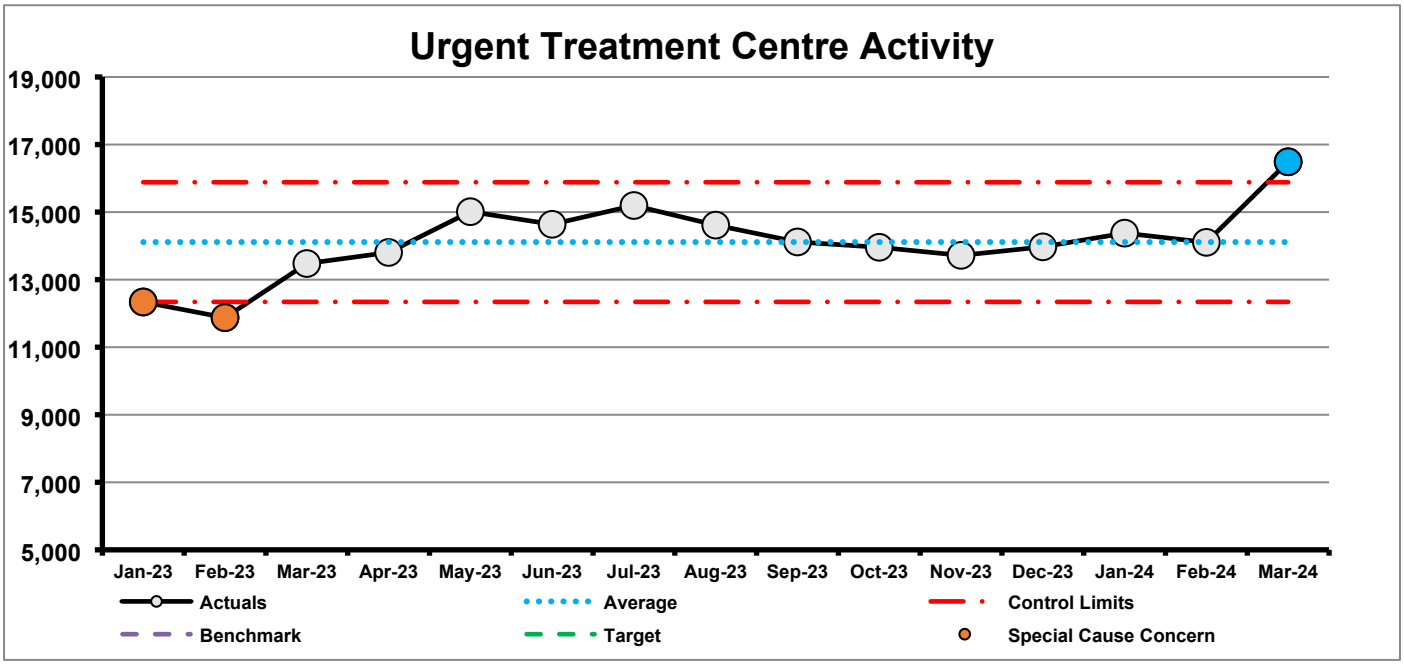
Diabetes	4 Weeks
Electronic Assistive Technology Service	6 Weeks
Heart Failure	2 Weeks
Musculoskeletal Physiotherapy	15 Working Days
Parkinson’s	18 Weeks
Podiatry	18 Weeks
Post Covid	6 Weeks
Pulmonary Rehab	10 Weeks
Complex Needs Rapid Response	18 Weeks
Respiratory (CCM, Oxygen, Physiotherapy)	4 Weeks
TB	6 Weeks

The function of the clock is to provide a true wait for those patients with a new referral awaiting an initial clinical contact and should not be confused with the Waiting Lists on SystmOne which will run alongside the clock. The Waiting Lists show the position of the patients wait but does not take into consideration where the patient has been offered an appointment they have refused and cannot be paused for any reason. This is likely to have a negative impact on the services performance.

Urgent Treatment Centre Activity

Background

This metric measures UTC activity across the Trust. Note that all LCHS Minor Injury Units (MIUs) have now transitioned to Urgent Treatment Centres, in line with national requirements. Activity from June 2021 onwards excludes Peterborough UTC after the cessation of this contract. The figures also exclude the support that LCHS provided to United Lincolnshire Hospitals at Grantham (running a UTC from July 2020 – June 2021).



Narrative

The above data shows that there has been a considerable increase in footfall across the UTC's in March 2024 compared to previous months and falls above the upper control limit. The month of March had the highest activity over the past year and around 3,000 more patients attended our UTC's compared to March 2023. Lincoln, Boston, Skegness, and Spalding have seen the most significant increases in activity although there has been an increase in all sites.

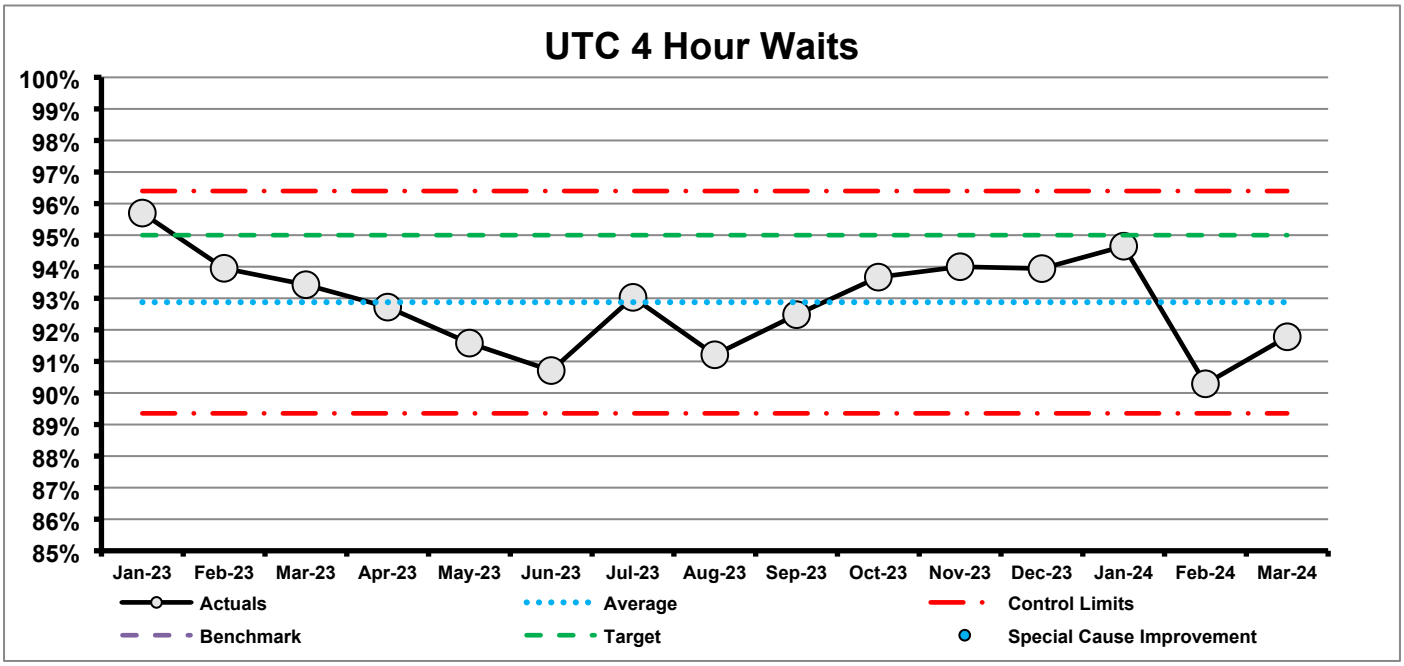
SPC

UTC activity has shown a special cause improvement in March 2024.

UTC 4 Hour Waits

Background

The Quality Schedule requires the Trust to achieve a target of 95% of UTC attendances where the Service User was admitted, transferred, or discharged within 4 hours of their arrival at an A & E department.



Narrative

Despite the drop in 4-hr performance last month there has been an improvement in performance despite the challenges from the significant increase in activity highlighted above. The UTC's where performance in 4 hour waiting times was most challenging were also where there was the greatest increase in activity. However, despite this, performance increased from just above 90% to just under 92%. Although this is below our target of 95%, it is still within the lower control limit of 89%.

It is the time to departure at our co-located sites, in particular Lincoln UTC and Boston UTC, that impacts on overall performance with delays for speciality referrals, access to x-ray and those patients requiring acute admission continue to be an ongoing challenge as we support our acute partners who also face pressures around bed availability.

Although the UTC graph shows the A&E 4-Hour Wait performance to be inconsistently capable of achieving the 95% target, we continue to work closely with our system partners to raise performance to above 76% across the system by validating breaches daily, identifying potential breaches early in the patient journey and improving pathways into specialities. As this hard work continues on reducing our 4-hour waiting times and if activity returns back down to target levels, we anticipate a significant improvement in April's data.

Continued growth in demand for UTC services reflects the hard work around pathways and system partnership working and we are now focusing on our workforce modelling for the future to ensure we continue to drive all areas of performance.

SPC

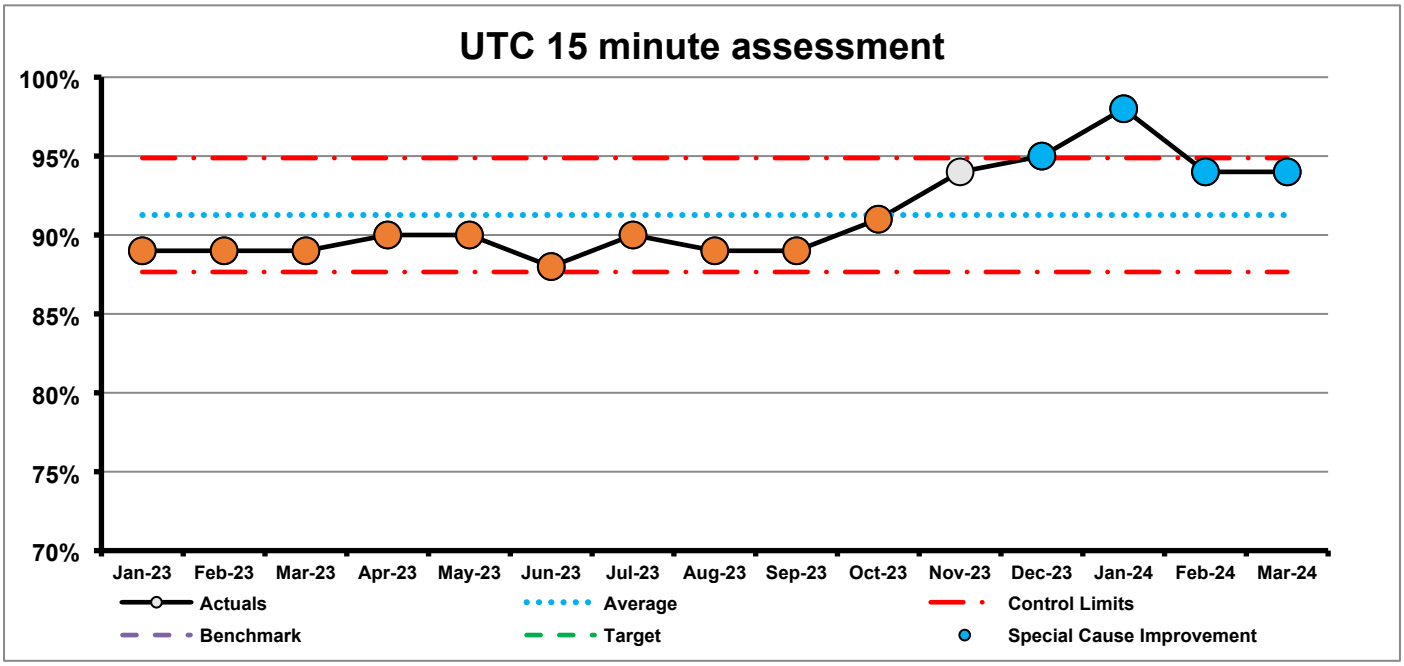
UTC 4-Hour Wait performance has not varied significantly over the period.

UTC 4-Hour Wait performance is inconsistently capable of achieving the 95% target. The target is missed more often than not.

UTC 15-Minute Assessment

Background

Urgent Treatment Centre specifications state that patients who walk-into a UTC should be clinically assessed within 15 minutes of arrival. Following a 2019/20 CQC visit it was agreed that the Trust would ensure that all patients attending A&E (for then Urgent Care Streaming services), regardless of which method of transport they used to arrive, should be assessed within 15 minutes.



Narrative

Work continues ensuring that the success achieved in the past few months continues and remains sustainable. There has been significant improvement at both Skegness and Spalding sites who were often below target. The significant improvement in our 15-minute assessment times has now been sustained for the past 5 months.

Work at Gainsborough remains ongoing and is still showing some improvement if compared historically and with potential new recruitment should only improve further.

Individual support will be given to teams that require this and daily automatic reporting now in place on ICA via the data teams.

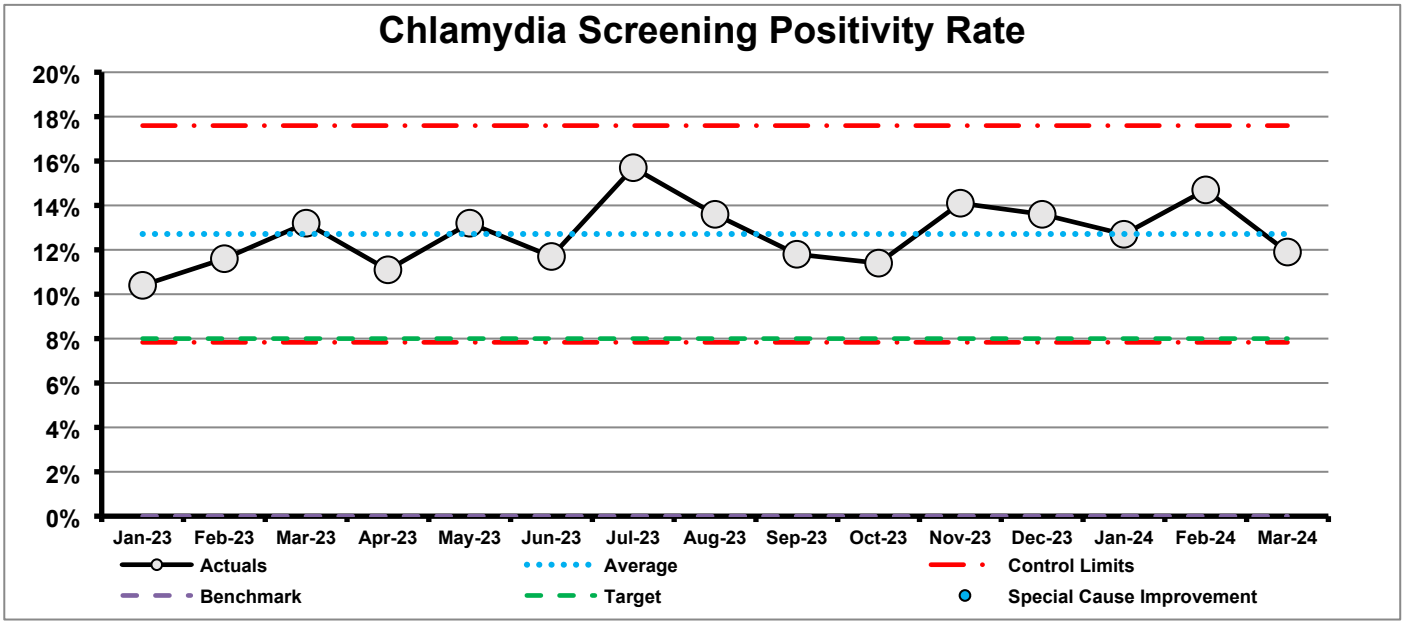
SPC

UTC 15-minute assessment shows special cause improvement since December 2023.

Chlamydia Screening Positivity Rate

Background

The Trust is commissioned with a positivity target of 8% of young adults aged 15-24 years who have accepted a screen, and to ensure that 80% of the GU patients are seen or assessed within 2 working days of first contacting the LiSH service. Both these measures have historically had financial service credits (penalties) attached in achieving the target, although these have been suspended in the Covid-19 response period and no confirmation has been made with regards to reinstatement.



Narrative

Positive screening rates have continued to exceed the target rate.

Actions

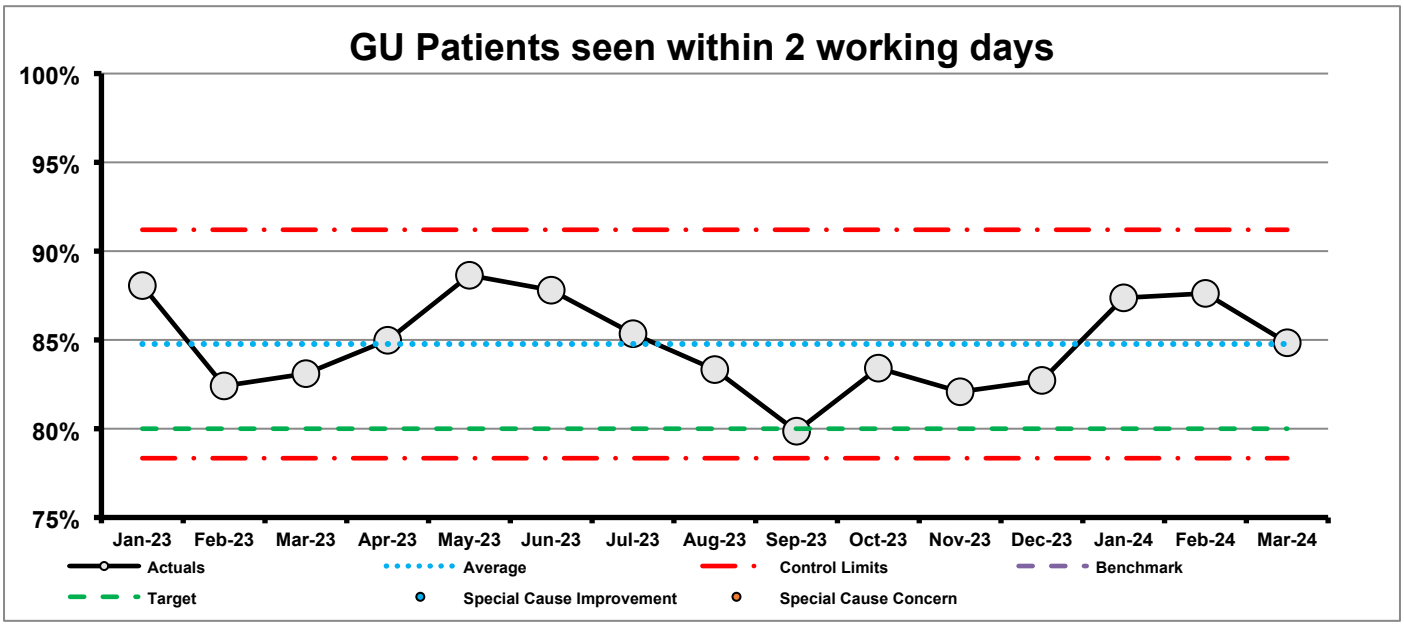
To continue developing and raising awareness of the service within the younger population.

SPC

Chlamydia screening positivity rates have not varied significantly over the period.

Chlamydia screening positivity rates are inconsistently capable of achieving the 8% target but are expected to achieve the target more often than not, as they have in each of the last 15-months.

GU Patients seen or assessed within 2 working days



Narrative

Performance levels and activity or stable for GU clients seen within two working days.

Actions

Discussions continue to understand how the team can further improve on this level of performance.

SPC

GU patients seen within 2 working days have not varied significantly over the period. This measure is inconsistently capable of achieving the 80% target but is expected to achieve target more often than not.

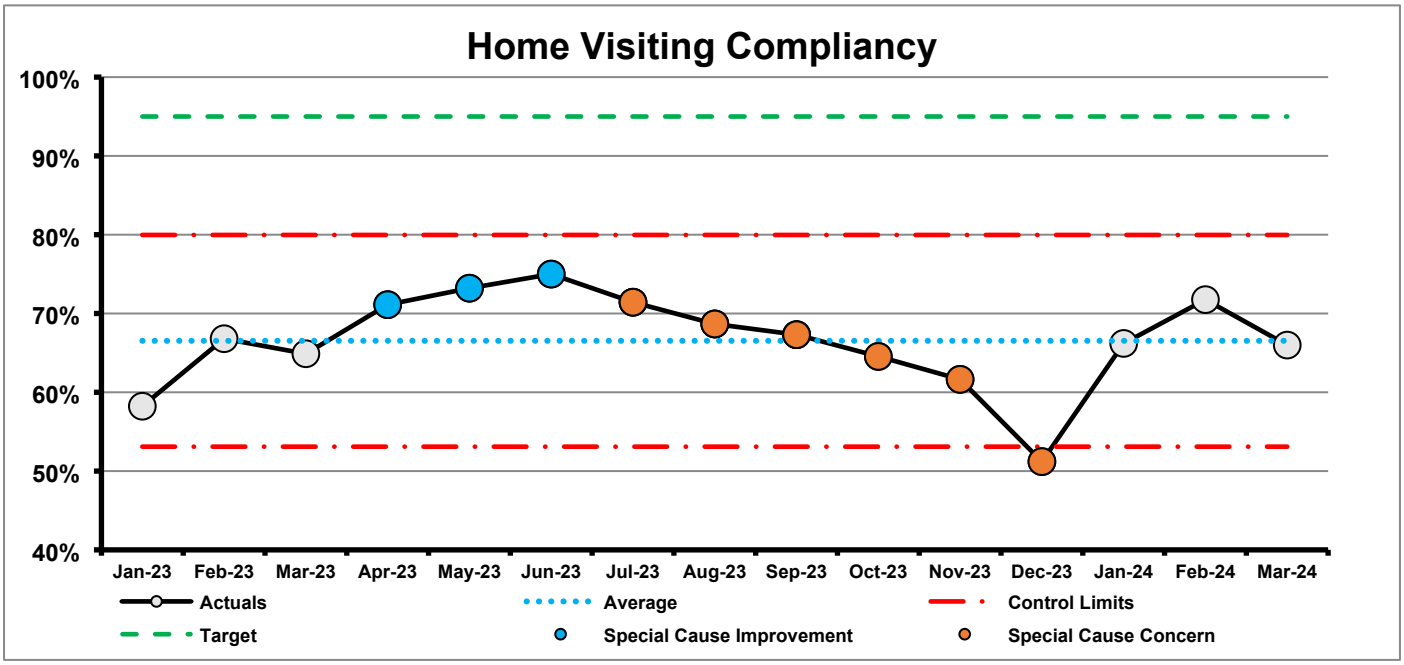
Home Visiting Report

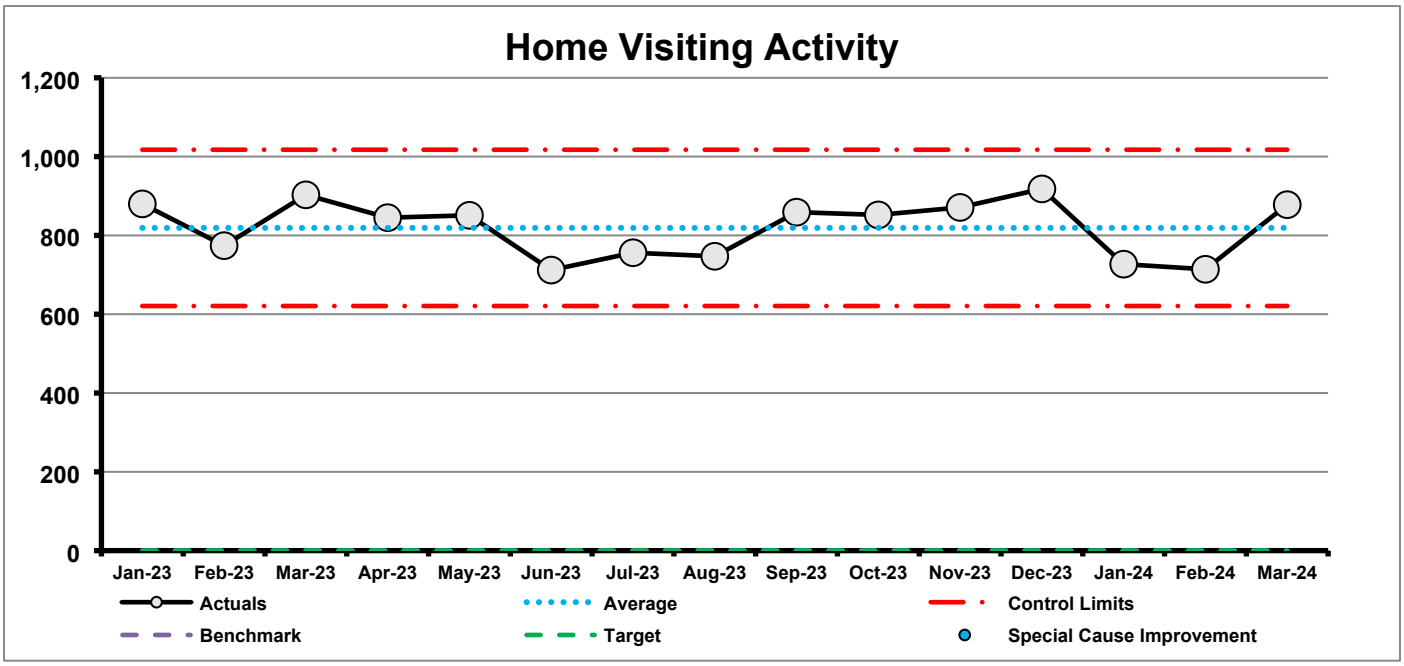
Background

Patients are offered a face-to-face consultation most appropriate to meet their needs and, where applicable, in the patient's home.

Patients are Lincolnshire citizens who become LCHS patients when triaged and accepted by the Home Visiting / Integrated Urgent Care Team and can be accessed via the 111 Service, CAS, and referrals from Community Teams.

The Service avoids admission to Emergency Departments, prevents ambulance call outs and provides reassurance for patients when GP surgeries are closed.





Narrative

For March it should be noted that although the compliance has deteriorated slightly, it has improved alongside a peak in activity (to note similar to that of November 2023 where the compliance was poor). This improvement is reflective of the work being implemented by the CTL to support in improving the operational running of the service (detailed in the January report to FFPIC and the updated report due at TLT on

18.04.24). Discussions are ongoing with regards to the responsiveness KPI as there is currently no national standard and the only standards which may be applicable are the 2023 Urgent Community Response

Standards. We are also exploring whether an additional 4hr response target may be appropriate (and evidence-based) for the acuity of patient referrals the service receives.
It should be noted that HV practitioners were utilised on at least 4 occasions to support a UTC overnight during March due to acute staffing issues. This is a practice which is a last option when all other alternatives have been explored but is sometimes unavoidable in order to keep a base open and safe. A total of 191 visits were handed over to MCRR after 20:00.

SPC

Home Visiting compliance has not varied significantly since December 2023. Home visiting compliance is not capable of achieving the 95% target without redesign.
Home Visiting activity has not varied significantly over the period.

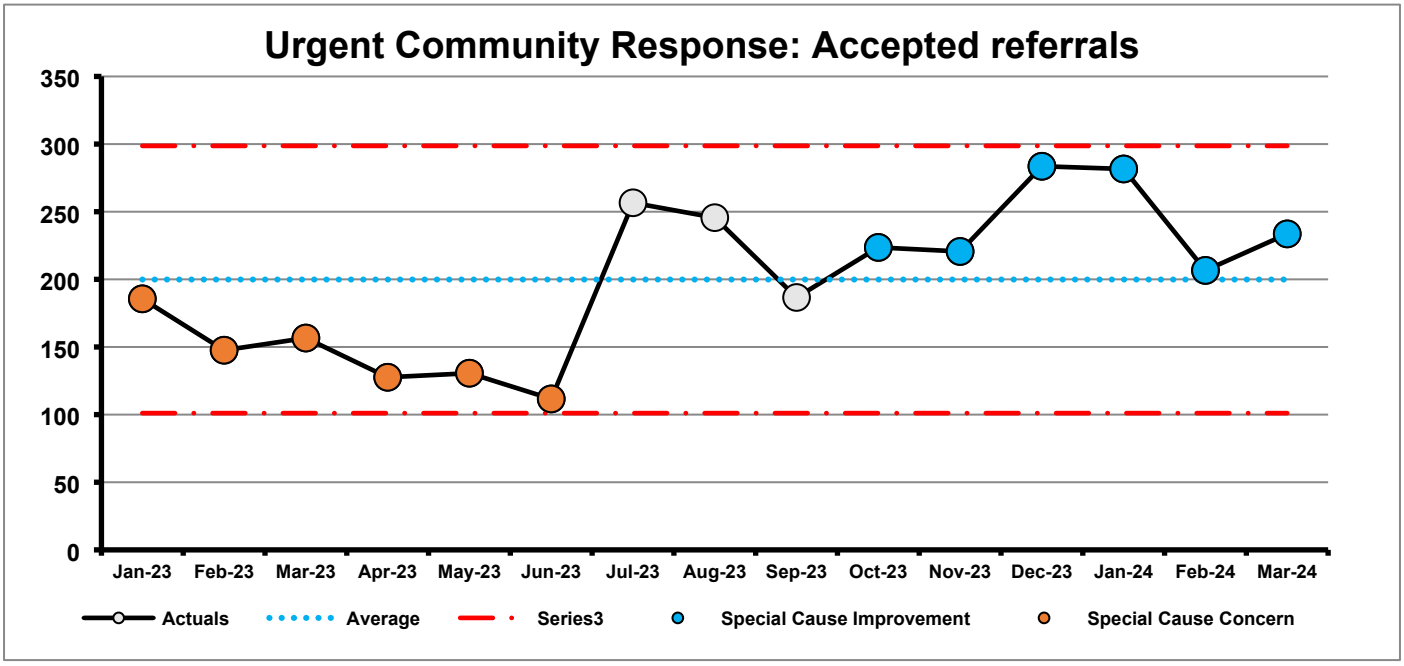
Urgent Community Response

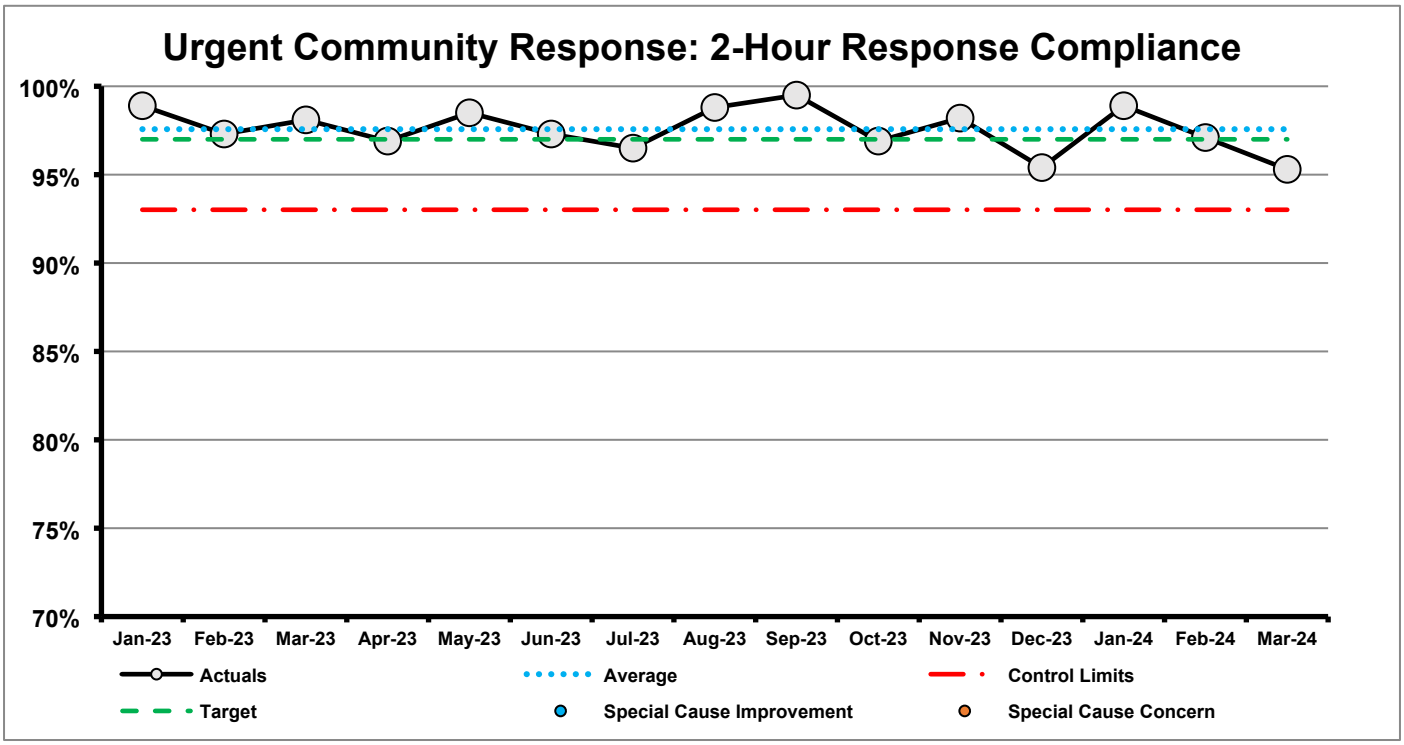
Background

Urgent Community Response is a nationally directed service. The Urgent Community Response Team receives referrals from a variety of sources to support urgent response care services.

The target for each referral is to respond and reach the patient within 2 hours.

It is a collaborative service working closely with Lincolnshire County Council and Social Care.





Narrative

For the month of March there has been an increase in referrals to UCR resulting in the compliance reducing slightly but still remaining within the expected limits (national target is a recommended minimum of 70%). The service carried 4 WTE vacancies during this month. We are continuing to work with our stakeholders to promote the use of the service and take note of the Operational Planning Guidance developed to support increasing UCR utilisation.

SPC

The number of accepted referrals for Urgent Community Response has shown special cause improvement since October 23.

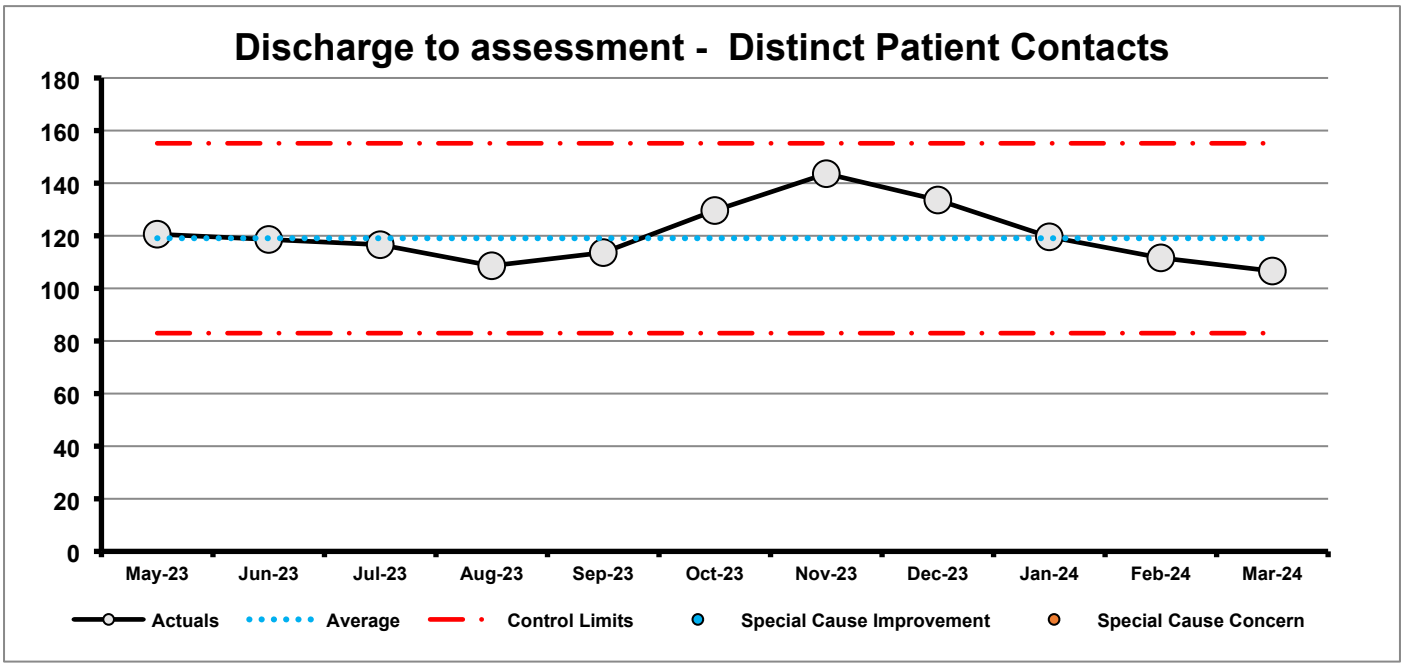
2-hour response compliance has not varied significantly over the period. The 2-hour response rate is inconsistently capable of achieving the 97% target but is expected to achieve the target more often than not.

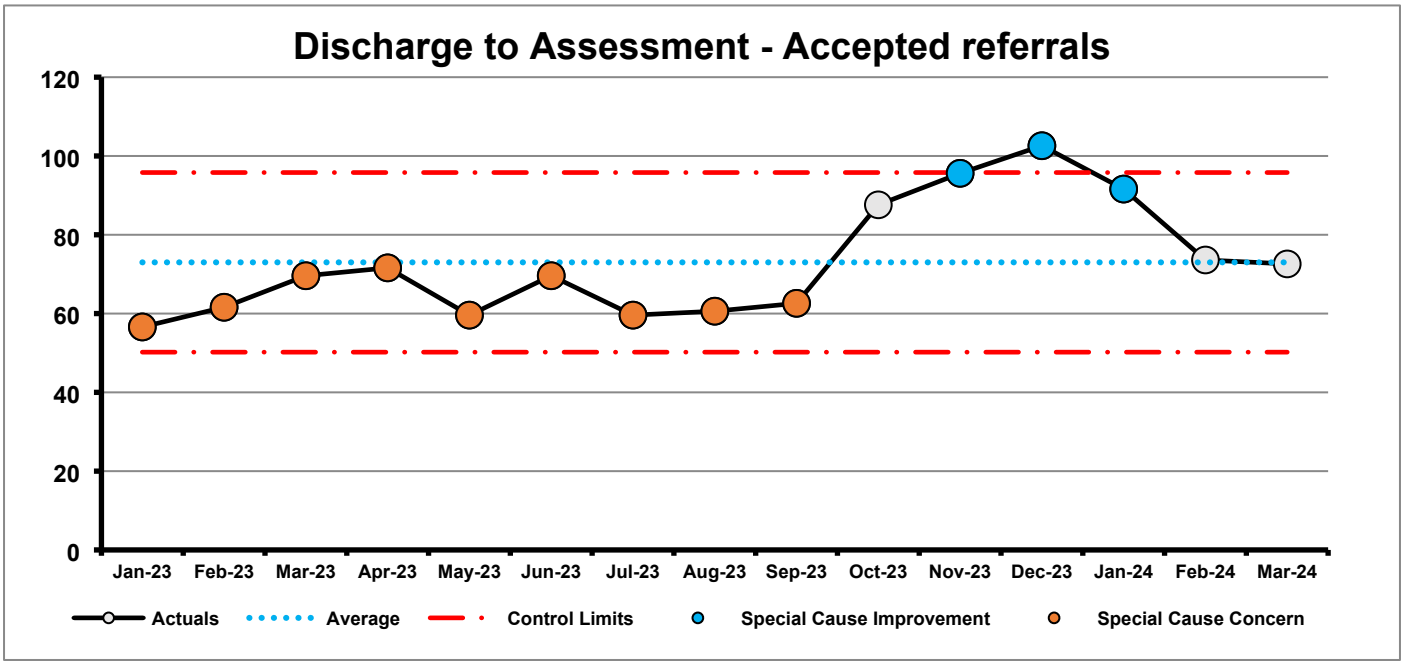
Discharge To Assessment

Background

The Discharge to Assessment programme has been introduced to expedite patients to leave acute care and return to their own home for reablement.

The service works closely with Adult Social Care and supports patients with a wide range of needs.





Narrative

The number of referrals accepted into the Pathway 1 D2A service has marginally reduced from February, however this still falls within acceptable limits, with an expected caseload of 70 per month.

The number of distinct patient contacts has also dropped slightly from February, sitting just below average.

Actions

Work alongside the transfer of care (TOC) hubs is ongoing – the aim of this is to proactively identify an increased number of patients who would benefit from D2A step-down from the acute hospital sites, where traditionally they may have been considered for step-down into a community bed.

In addition to this, collaborative discussion with the Urgent Community Response (UCR) leadership continues, with the aim of reviewing ways in which D2A and UCR can work together to safely support patients to remain at home (and therefore not inappropriately attend ED, or require a community hospital bed).

There has also been significant steps taken to recruit to therapy posts which have sat vacant for some time – with additional clinicians due to join D2A in the coming months. This will build resilience and skillset within the service, alongside better enabling opportunities to promote awareness of the service which, so increasing the number of referrals.

SPC

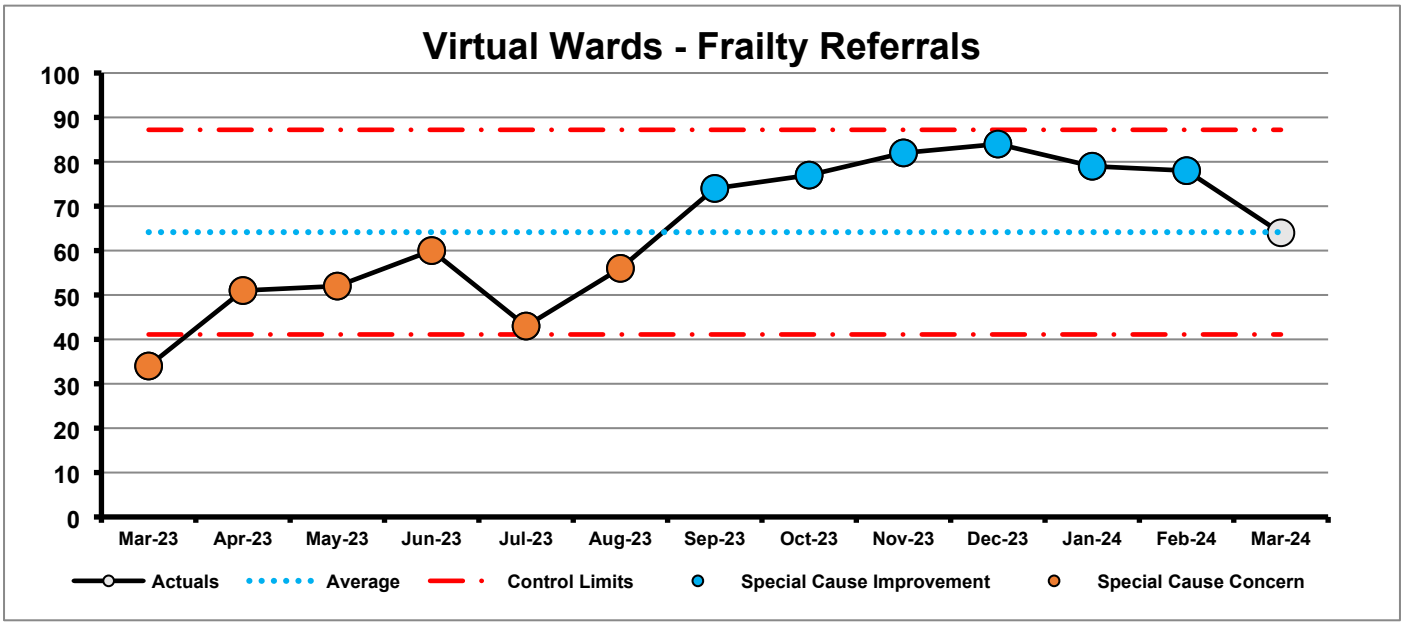
The number of distinct patient contacts has not varied significantly over the period.

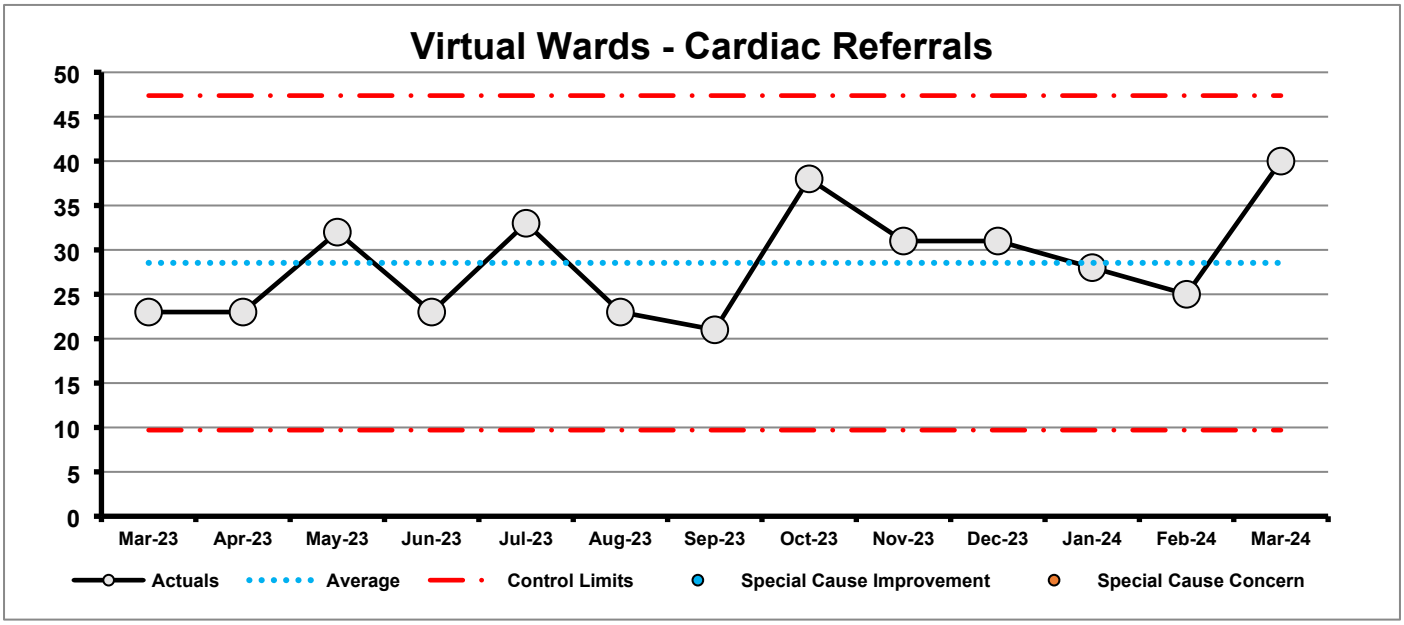
The number of D2A accepted referrals has not varied significantly since January 2024.

Virtual Wards

Background

The Trust's current virtual ward offering includes frailty, cardiology and respiratory. The service closely collaborates with ULHT, and patients are cared for in the community, with guidance from ULHT consultants.





Narrative

Reporting continues to encompass frailty, respiratory and cardiology virtual wards. OPAT & SDEC data is being progressed with ULHT. FBI are supporting the virtual ward team, cross referencing the different reporting that currently takes place (e.g., NHSE, SHREWD and internal reports) to make sure that the data is consistent and that all virtual wards are included in all our reporting.

SPC

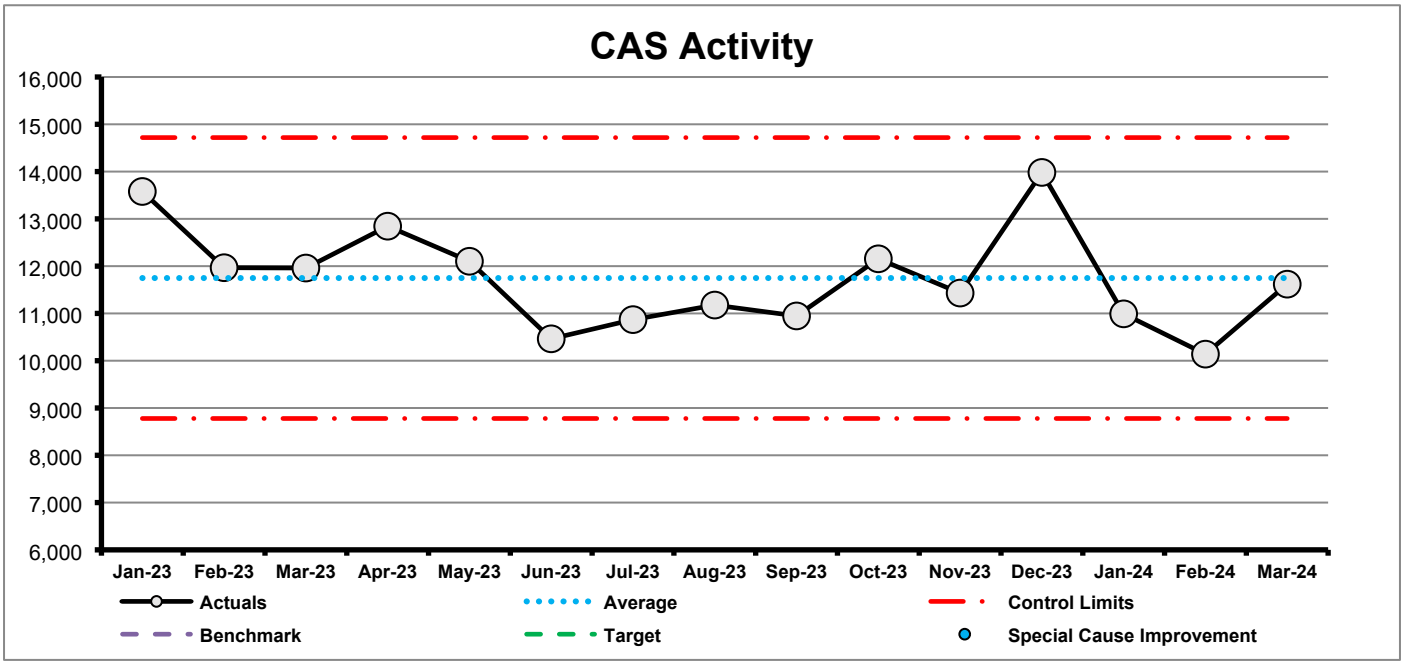
The number of referrals to the frailty virtual ward has not varied significantly since February 2024.

The number of referrals to the cardiology virtual ward has not varied significantly over the period.

CAS Activity

Background

The CAS was initially commissioned as a proof of concept and commissioners asked providers to collaborate to develop an Alliance Agreement. The service has since demonstrated significant positive system impacts in supporting and reducing A&E attendances. This is now an integral part of the LCHS and Lincolnshire System Integrated Urgent Care offer.



Narrative

Recent trends have reflected overall pressure on the Lincolnshire Urgent Care System. Following on from the huge demand across the winter of 2022/23, we have continued to see a busy period for CAS. March's figures have increased, and this is likely due to Easter being mostly in this month, which is traditionally a very busy period for CAS. Skill mix and staffing was closely monitored during this period, and this allowed us to ensure we were able to continue calling patients back in a timely manner.

Action

Continue to monitor and manage resources to meet demand across the Urgent Care Service.

The DHU contract to provide the 111 service changed as of Tuesday 9th April. Unfortunately, this was agreed at a regional level and there was not the level of engagement with the Lincolnshire system which would have been expected. This has meant that as of the 9th April, DHU are now completing all ED validations and interim dispositions which would previously have been put through to CAS. We have been monitoring the impact of this closely with the ICB and are currently seeing a reduction of approximately 100 calls per day and therefore, expect the activity for April to be significantly lower than previous months. We are reviewing the impact this is having on patient care (including any increase in conveyance to ED) and are working with the ICB to explore alternative opportunities to utilise the CAS resource.

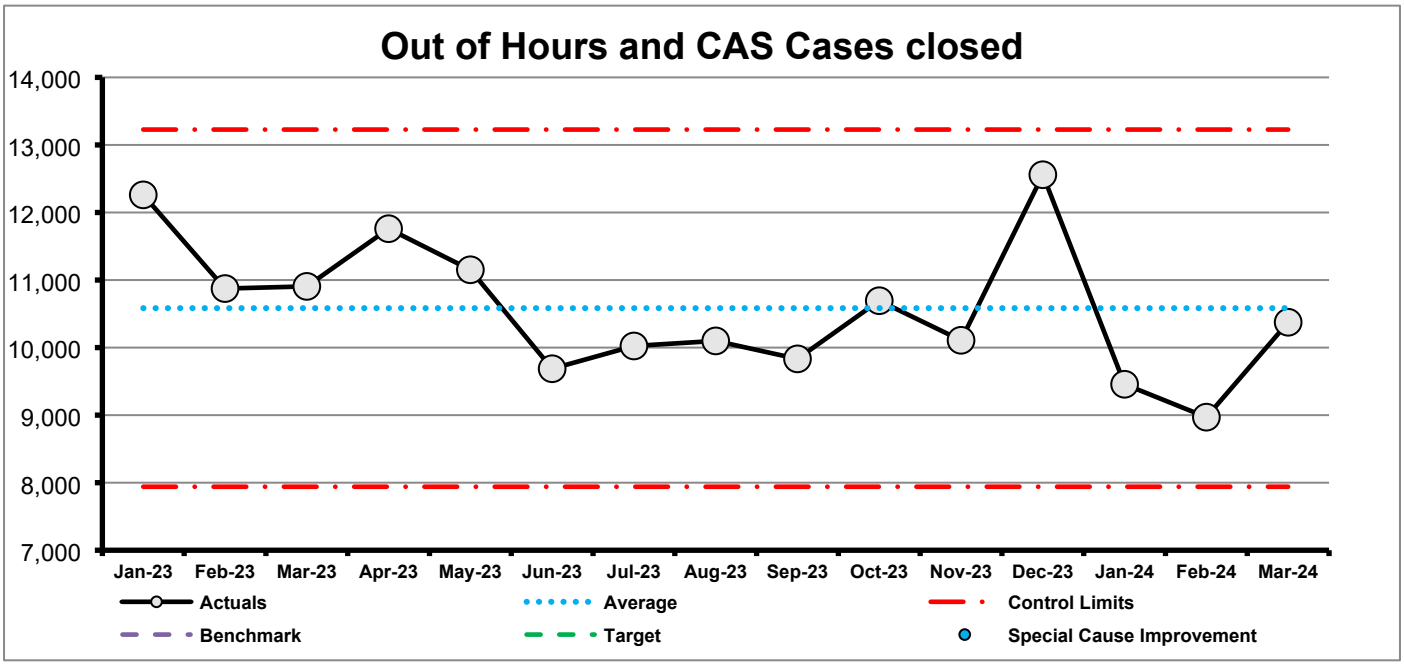
SPC

CAS activity has not varied significantly over the period.

OOH and CAS Cases Closed

Background

LCHS on average has around double the attendances of ULHT's type 1 attendances. This includes Out of Hours services and CAS.



Narrative

This metric shows the combined number of cases closed within the Stamford Out of Hours and CAS services and is directly correlated to the level of activity seen within those services (additional narrative is featured within the CAS activity). March saw a significant increase in number of cases closed, mostly attributable to the bank holiday period and increased activity through CAS. Compared to the first half of 2023, however, trends would seem to reflect the loss of Grantham UTC as these figures were previously included within this data.

Action

Ongoing discussions being held as to value of this data being included within FFPIC reporting due to Grantham OOH no longer being included.

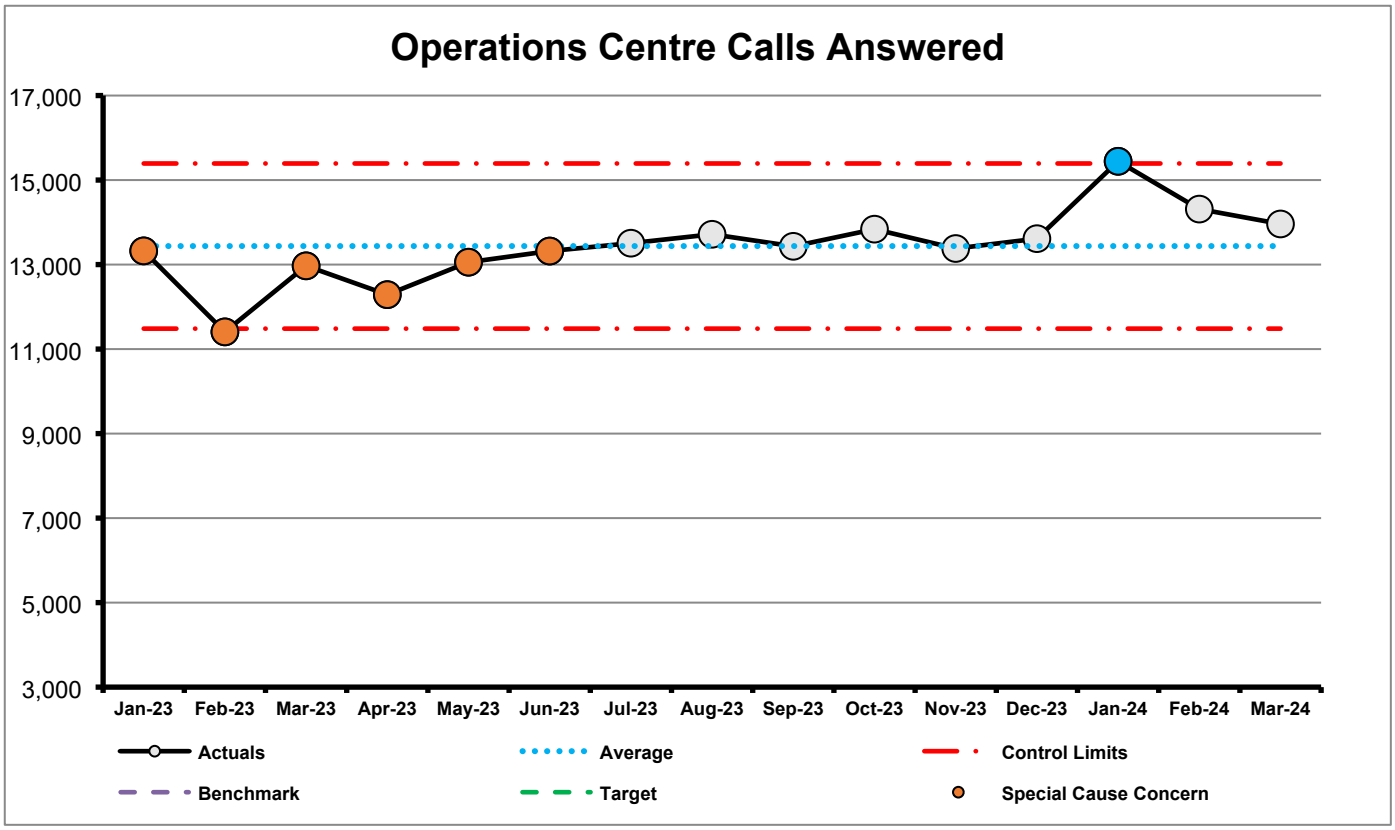
SPC

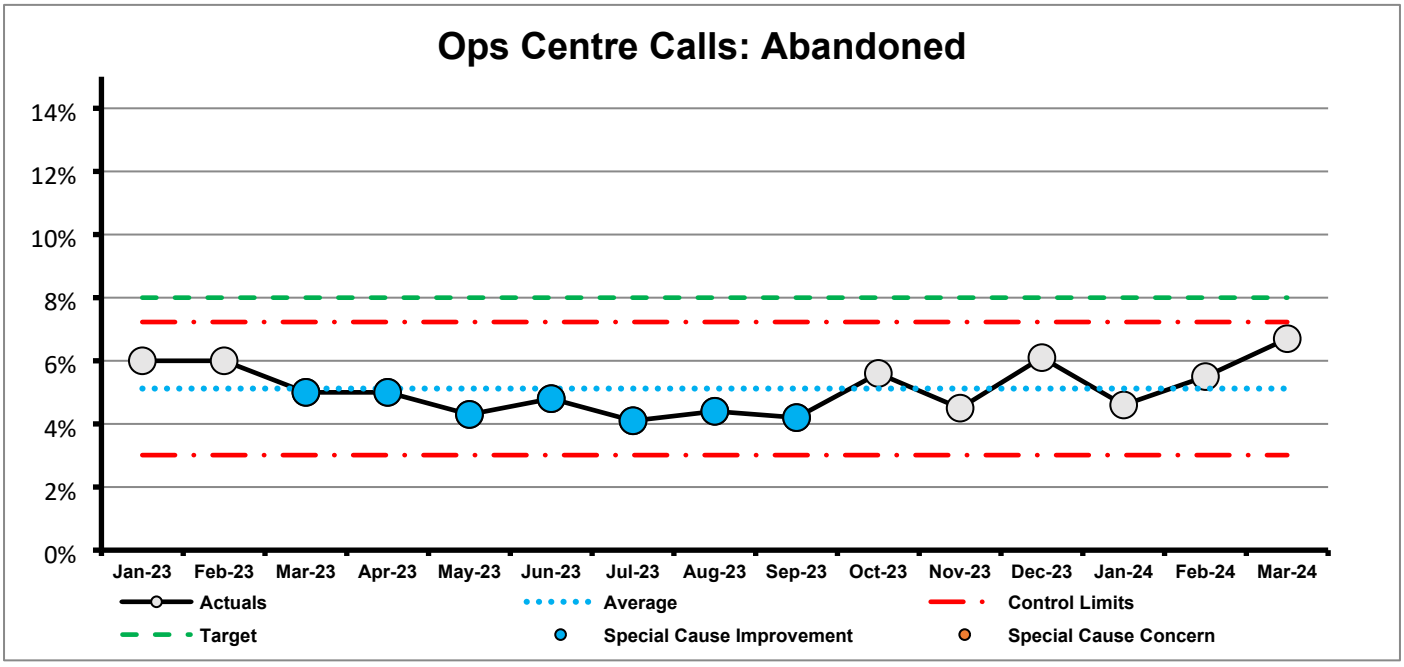
OOH & CAS Cases Closed has not varied significantly over the period.

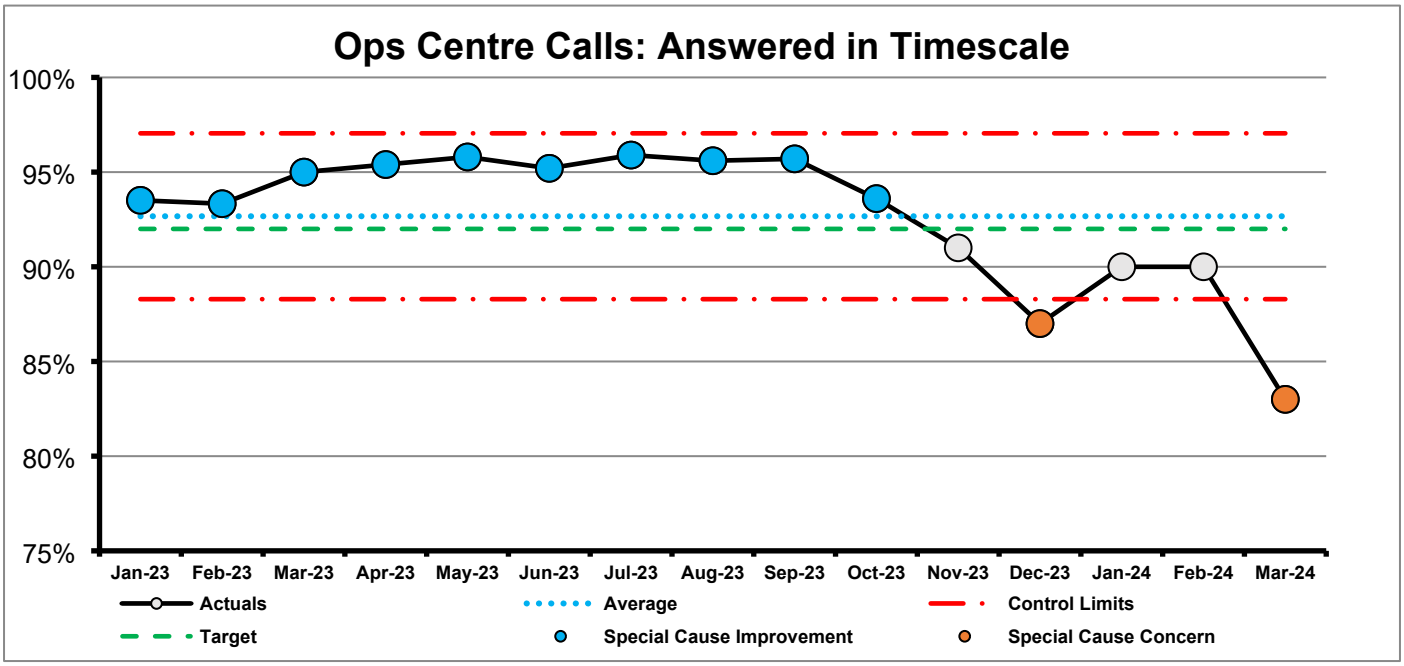
Operation Centre Calls Metrics

Background

The Operations Centre was opened in December 2016 and provides a 24/7 multi-disciplinary team for LCHS. It was developed on the principle of a 'one call does it all' model and is a critical service that holds the Trust's services together e.g., community nursing, community hospitals, urgent care, transitional care, and our Clinical Assessment Service.







Narrative

As anticipated, March was a very difficult month for the Ops Centre. The Ops centre has had a 6 WTE cost pressure since 2022 to take the community nursing calls into Ops. Recent changes to vacancy approval means that Ops can no longer recruit to this cost pressure and has seen 4 resignations since January 2024 which we have been unable to backfill. Actions taken in January and February to achieve performance are no longer sustainable, and LTS coupled with reduced headcount has impacted performance and is likely to continue to do so. This is on the risk register.

SPC

The number of calls answered within the ops centre has not varied significantly since January 2024.

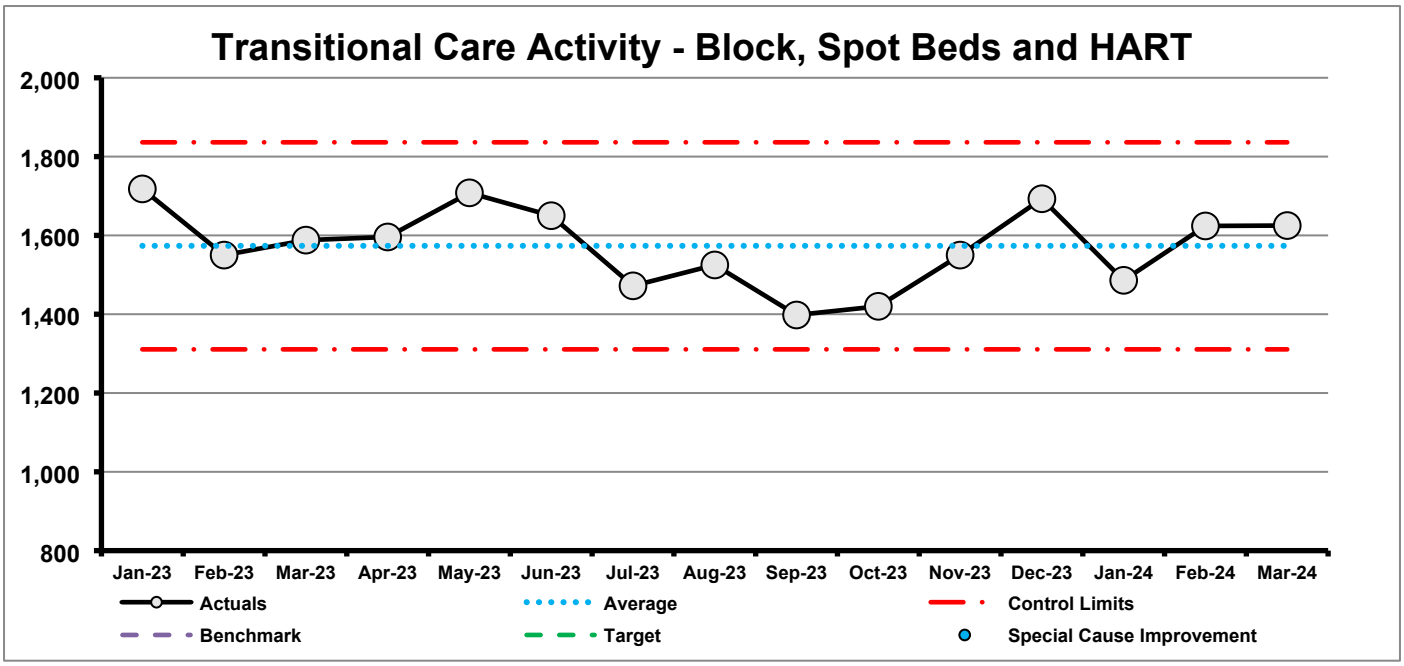
Ops Centre Calls Abandoned has not varied significantly since September 2023. It is consistently capable of achieving the 8% target.

Ops Centre Calls Answered within Timescale shows special cause deterioration in March 2024. It is inconsistently capable of achieving target but achieves target more often than not.

Transitional Care Activity

Background

LCHS has a now established and commissioned a Hospital Avoidance Response Team (HART) service, via Age UK to focus on admission avoidance and reduction of Delayed Transfers of Care (DToC). The HART service has demonstrated some excellent quality outcomes, as well as consistently achieving their targets around the number of cases managed each month. HART continue to achieve their monthly key performance indicators and work as a key system partner.



Narrative

Use of transitional care resource continues to fall within acceptable limits, remaining the same when compared with February. This is largely due to an increase in the overall use of transitional care beds (TCBs), and spot purchase beds, in line with continued demand for community hospital beds, and the regular review and 'stepping down' of patients into these community beds to release bed capacity.
In addition to this, there remains a continued demand for transitional care beds out of county, with the Peterborough in-reach team repatriating patients back into the county via this pathway.
Actions
Work is ongoing regarding the commissioned service HARTs productivity, with regular review alongside HART, business intelligence, and the ICB.
Fractured neck of femur (NOF) and clinician to clinician pathways continue to be under review, with the over-arching aim of increasing timely, clinically appropriate referrals via the transitional care & flow team, and into community hospitals. Work continues on these collaborative pathways, with ULH and LCHS colleagues working together to streamline the process.

SPC

Transitional Care Activity has not varied significantly over the period.

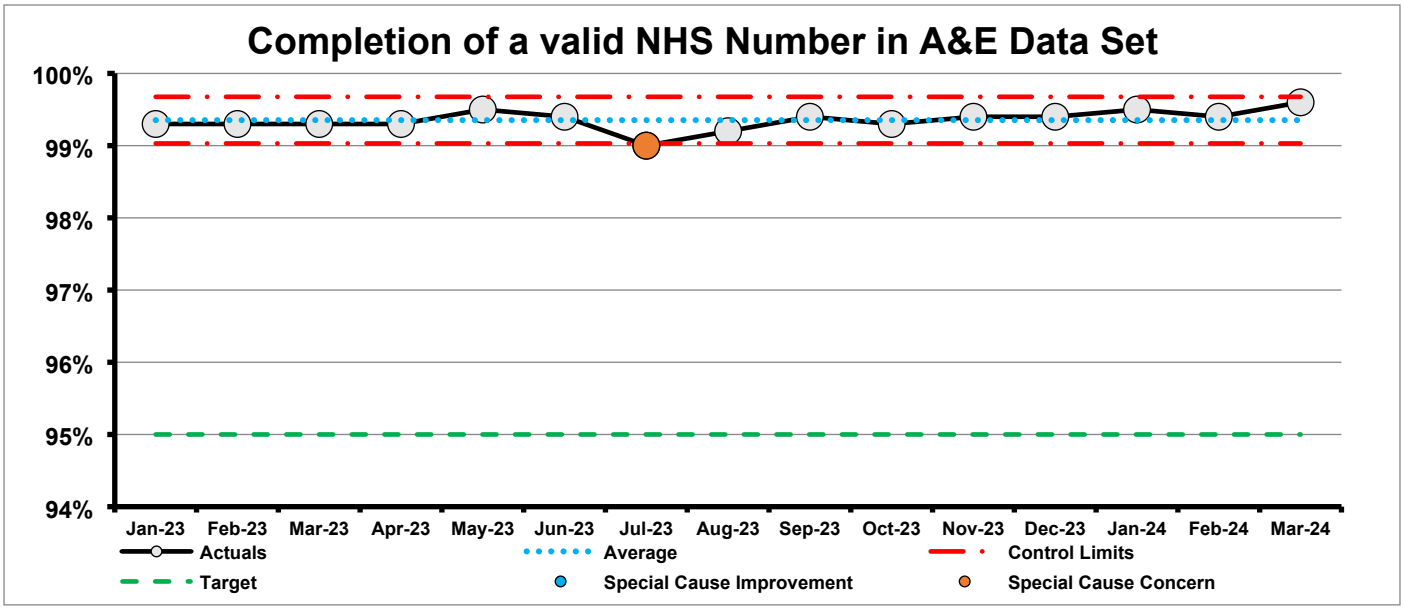
Completion of a Valid NHS Number in A&E Data Set

Background

The Data Quality Dashboards are a national resource to support the improvement and completeness of data flows by reporting on the validity of key data items in Secondary Uses Service (SUS) in accordance with published data standards. The information is provided by The Health and Social Care Information Centre and the areas applicable to LCHS are:

- Accident and emergency

The dashboards are reviewed against the national attainment and any data items that fall below the national attainment rate are highlighted for consideration and action planning.



Narrative

The latest available data demonstrates the completion of a valid NHS number for A&E Data Sets. The Trust maintains a high level of compliance – above 98% since April 2021. This is higher than the national average. Remarkably, July's figure would normally show concern, but this must be seen in context against the outstanding figures across the rest of the year.

Actions

The completions of NHS numbers within the A&E datasets continue to be raised with services, to ensure issues around data quality are addressed. The data system used is linked to the NHS Spine. Patients with no NHS number are not registered with a GP.

SPC

Completion of a valid NHS number for A&E datasets has not varied significantly since July 2023.

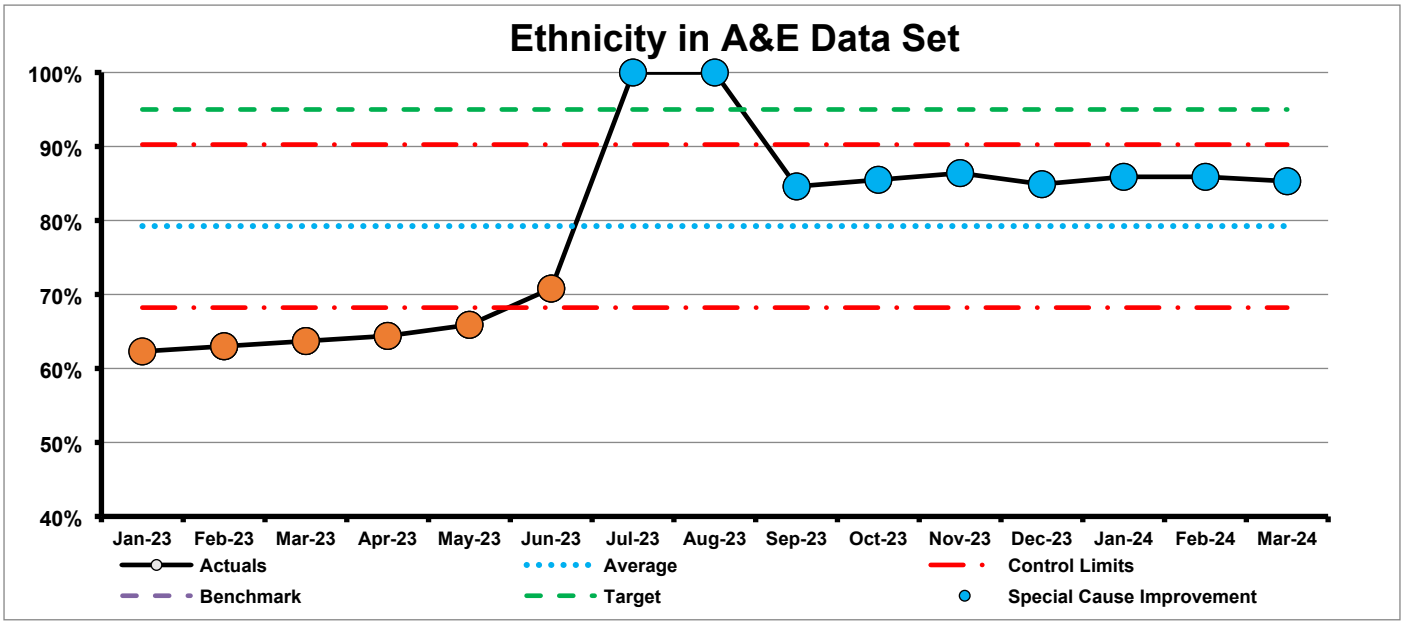
Completion of valid NHS Number for A&E Data Sets is consistently capable of achieving the 95% target.

Completion of Ethnicity in A&E data set

Background

The Data Quality Dashboards are a national resource to support the improvement and completeness of data flows by reporting on the validity of key data items in Secondary Uses Service (SUS) in accordance with published data standards. The information is provided by The Health and Social Care Information Centre and the areas applicable to LCHS are:

- Accident and emergency



Narrative

Ethnicity in A&E data shows significant improvement since June 2023. As reported previously changes to this process were being made to stop using local codes for ethnicity not stated and remove old codes.

Issues have been identified where SystmOne doesn't export patient's ethnicity if the data is not something added by the user onto the system. This has caused problems with us being unable to pull our ethnicity activity from within the extract. The months during July and august where we reported 100%, were due to a miscommunication between ourselves and NHS England during the validation period, where we were advised to reset blank ethnic codes. Since discovering these inaccuracies, we have resubmitted our activity and it is now reflected on a new download from SUS.

The increase from 67% to 85% is through a process developed to download an extra patient dataset from Systm1 which reports on Ethnicity for all patients. Following this validation process, 85% is a more reflective position on actual completion. Further work is still required with our UTC colleagues to continue to work towards improving the collating of our ethnicity data at the point of source.

We have initiated a new Data Quality system "RINSE" introduced to support managers to monitor and manage who hasn't completed ethnicity population. The FBI team continue to with digital health to ensure that any SOPs or training emphasis' the importance of completing the data.

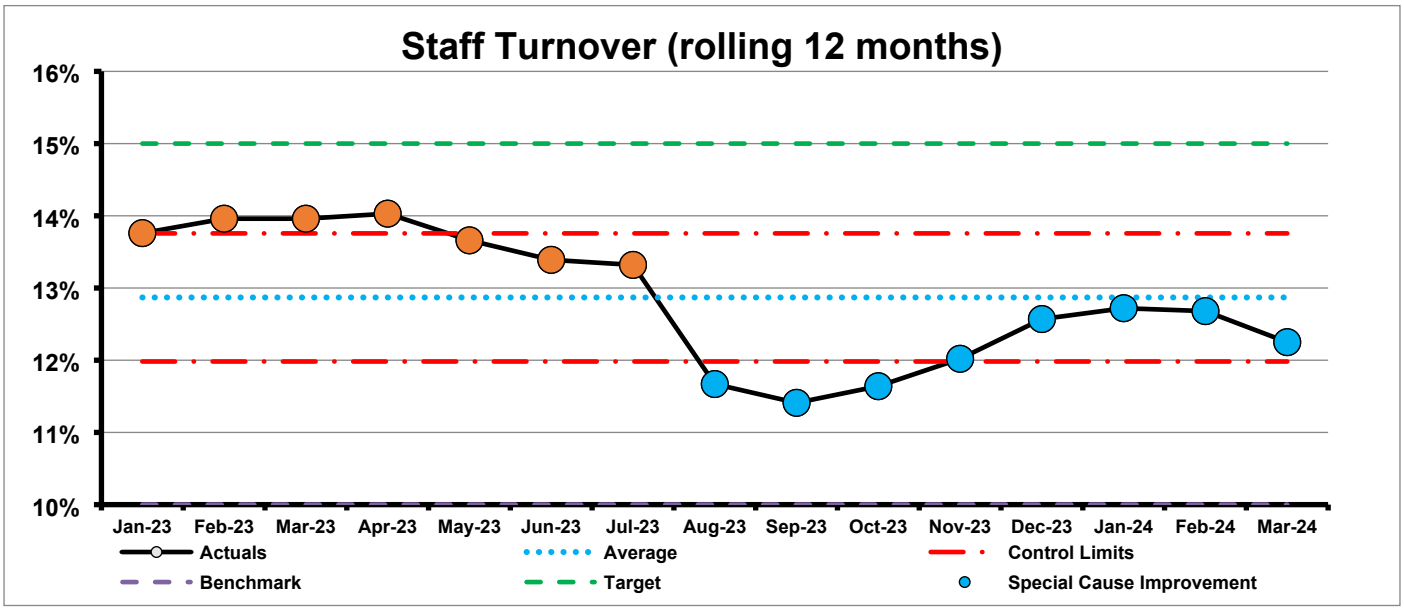
SPC

Ethnicity in A&E dataset has shown special cause improvement since July 2023. This metric is not capable of achieving the 95% target without redesign.

Staff Turnover (Rolling 12 months)

Background

The Quality Schedule requires data on staff turnover to be shared with commissioners as well as being an important barometer of service stability, sustainability, and staff satisfaction.



Narrative

The graph above shows the total staff turnover, with rolling 12-monthly turnover lower than the average at 12.25% for the period. The “target” level of 15% represents a ceiling to stay within. A healthy level of staff turnover is positive for refreshing the workforce and securing new or additional talent into the organisation, however rising turnover would be indicative of potential staff dissatisfaction and impacts on service delivery.

Actions

Staff turnover is managed by leaders at local levels with supportive frameworks to enable staff to maintain health and wellbeing, freedom to speak up and engage with changes to their service delivery.

SPC

Staff turnover has shown special cause improvement since August 2023. Staff turnover is consistently capable of achieving the 15% target.

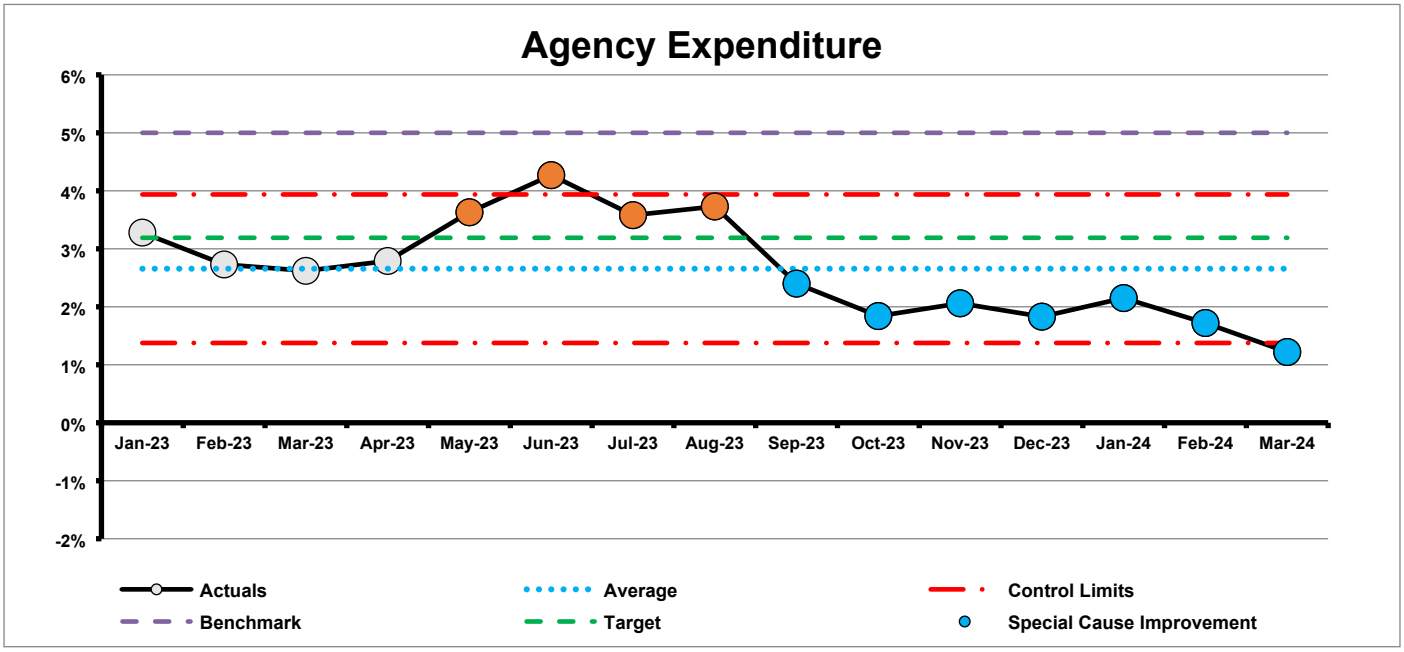
Financial Performance Summary

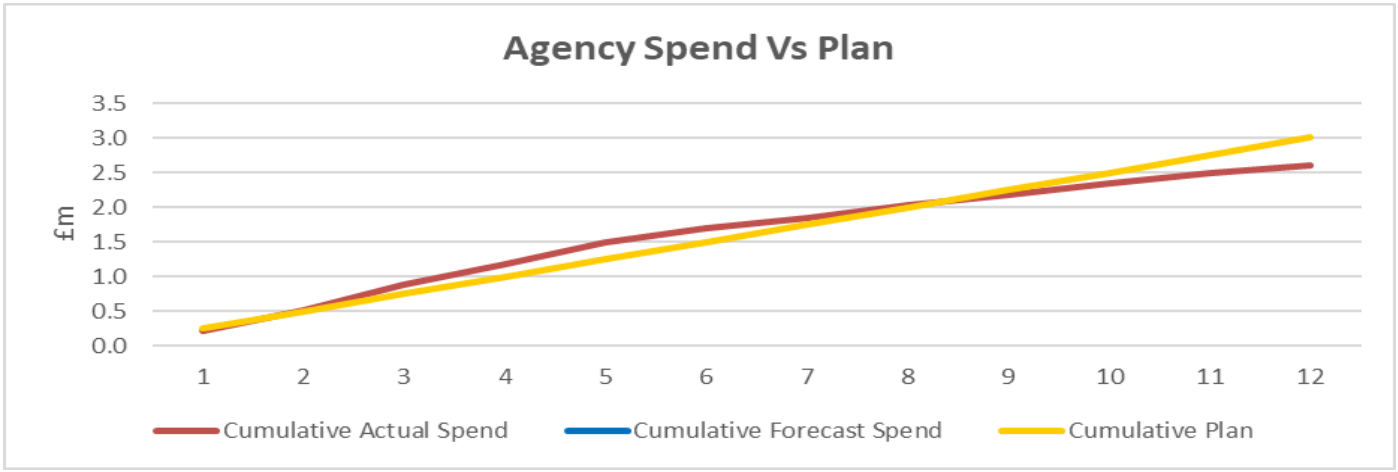
	Financial Summary Table (Month 12)
Description	**Narrative**
Position in March	£685k surplus
Position YDT	£1381k surplus
Position FYE	£1.38M surplus
CIP in March	£636k against plan of £636k
CIP YTD	£6.9M against plan of £6.6M
CIP FYE	£6.9M against plan of £6.6M
Agency in March	£101k against plan of £250k
Agency YTD	£2.6M against plan of £3M
Agency FYE	£2.6M against plan of £3M
Captial In March	£846k against plan of £172k
Captial YTD	£2.7M against a plan of £3.1M (over-delivery in Digital, shortfall in Estates and clinical equipment)
Capital FYE	£2.7M (£100k under-delivery as agreed with System, £400k excess under-delivery)
Cash	£30M against plan of £23M

Agency Expenditure

Background

Historically the Trust has set itself a target of ensuring temporary staffing costs do not exceed 4% of total pay. However, there is no requirement to do so. The Trust will not be given an agency ceiling for the year 2023/24, there is now a Lincolnshire System Ceiling. The Trust planned for a 3.19% agency level in 2023/24.





Narrative:

The agency plan has been phased evenly over 12 months. YTD Agency spend is under plan by £403k at Year End.

NHSE caps and procurement have seen improved rates and steps have been implemented to ensure more rigorous control of the volume of agency used, resulting in a decline in spending in month and more marked decline in forecasted costs, resulting in predicted underspend by the end of the year.

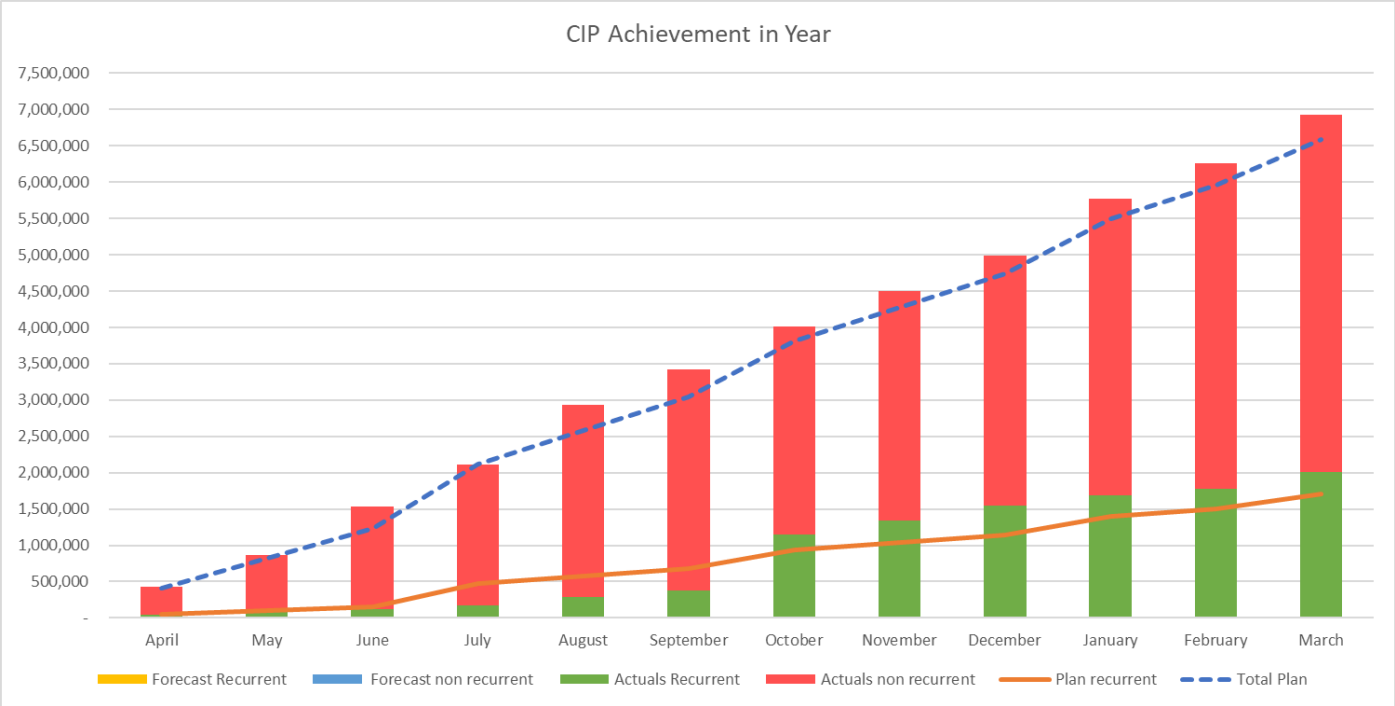
SPC

Agency expenditure shows special cause improvement since September 2023. It is inconsistently capable of achieving the 3.19% target but achieves target more often than not.

Efficiencies Plan (CIP)

Background

This information represents year-to-date delivery against the planned Cost Improvement Plan (CIP).



Narrative

Initial CIP plan was £6.6m with an improved forecast delivery of £6.9m due to additional CIP delivery from the People Hub.

£6.9m of CIP has been delivered in year.

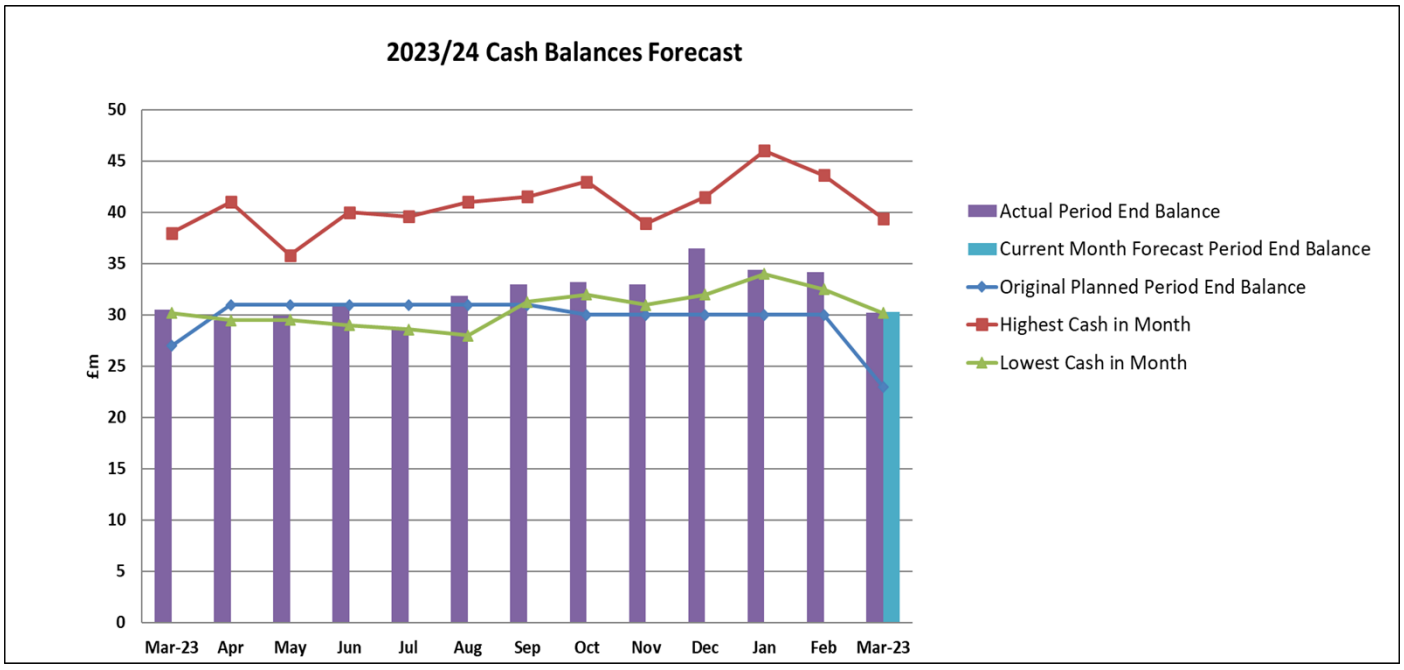
Recurrent delivery is better than planned in year, although we have £4.9m of non-recurrent savings.

Cash Balances

Background

This metric tracks the Trust performance of cash balances against planned levels of cash at each month end. Management of cash is important to ensure the Trust can adequately meet its liabilities to stakeholders. As part of the interim financial arrangements in place for Covid-19, a formal plan for cash was not mandated or collected but providers manage cash positions to remain stable.

Cash Balances for 2023/24 are as below:



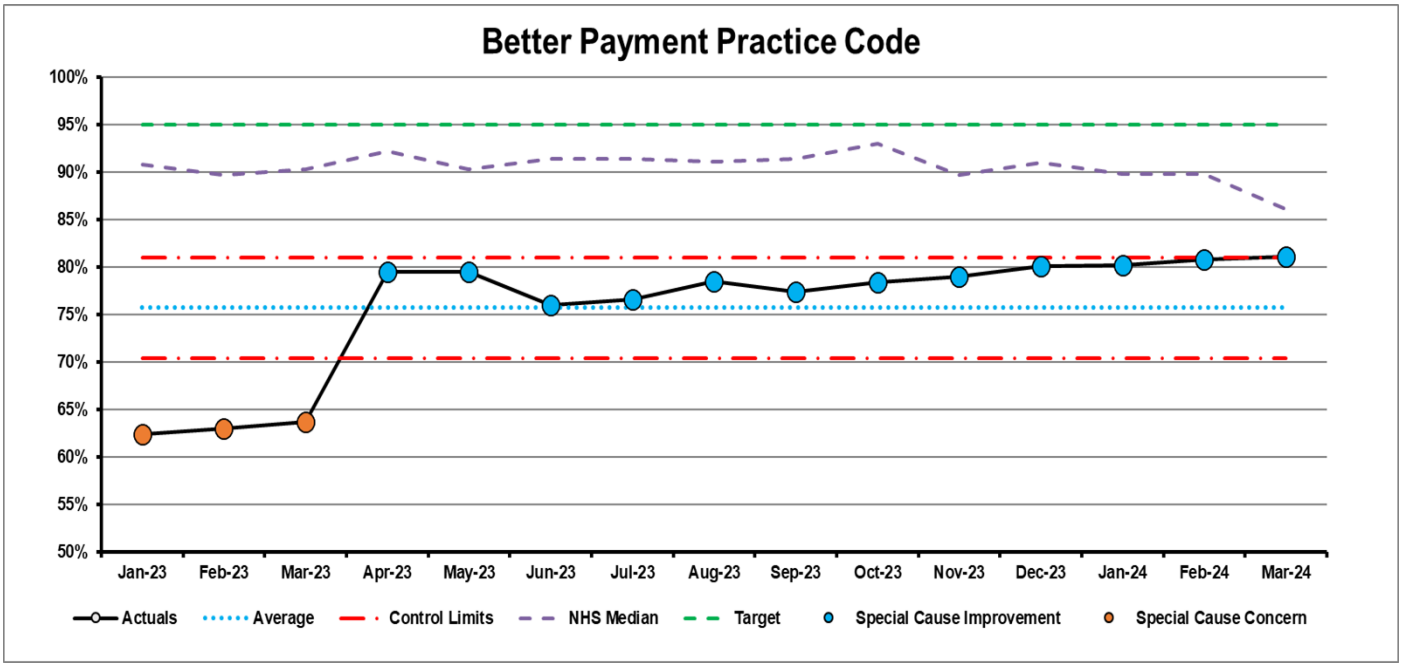
Narrative

The Trust cash balance at the end of Mar-24 has reduced by £4m, this cash outflow was anticipated and planned as part of the H2 actions relating to the HMRC provision release.

Better Payment Practice Code

Background

This metric represents the performance of our invoices paid within the agreed terms. The target Better Payment Practice Code (BPPC) is 95%.



Narrative

BPPC (by volume) score in March was 81.1% against a target of 95% showing a steady improvement as prior year impacts are falling off. This was hindered over recent months by a large number of invoices received from two organisations where purchase orders had not initially been raised. We are working on this to ensure a smoother process in 2024/25.

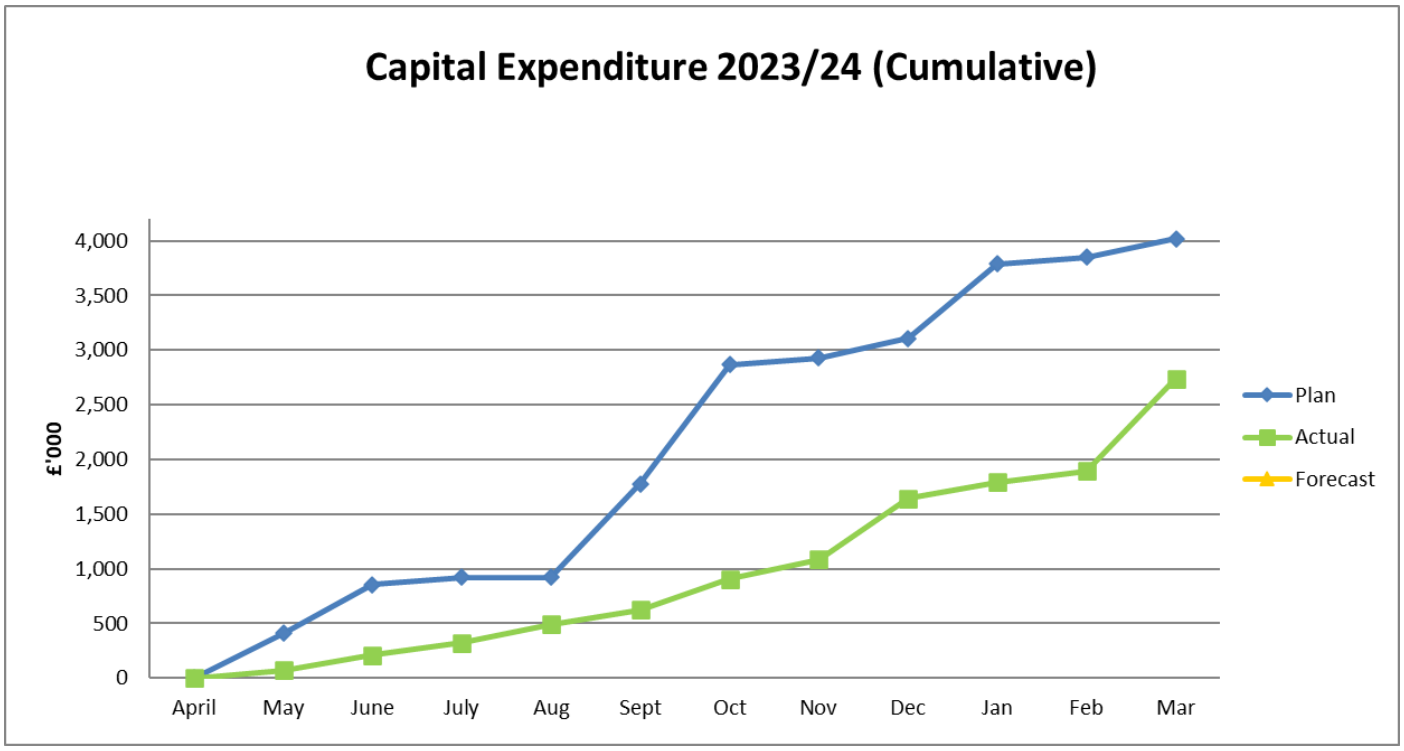
SPC

Better Payment Practice Code shows significant improvement since April 2023. This metric is not capable of achieving the 95% target without redesign. An improvement plan has now been fully implemented but it will be some time before the impact is fully reflected in the 12-month rolling average figure.

Cumulative Capital Expenditure Plan vs Actual (£000)

Background

This metric tracks year-to-date expenditure of the Trust Capital Programme against plan. Capital Expenditure includes investment in maintaining, replacing, and transforming the Trust asset base. The Trust has a capital plan of £4m for 2023/24.



Narrative

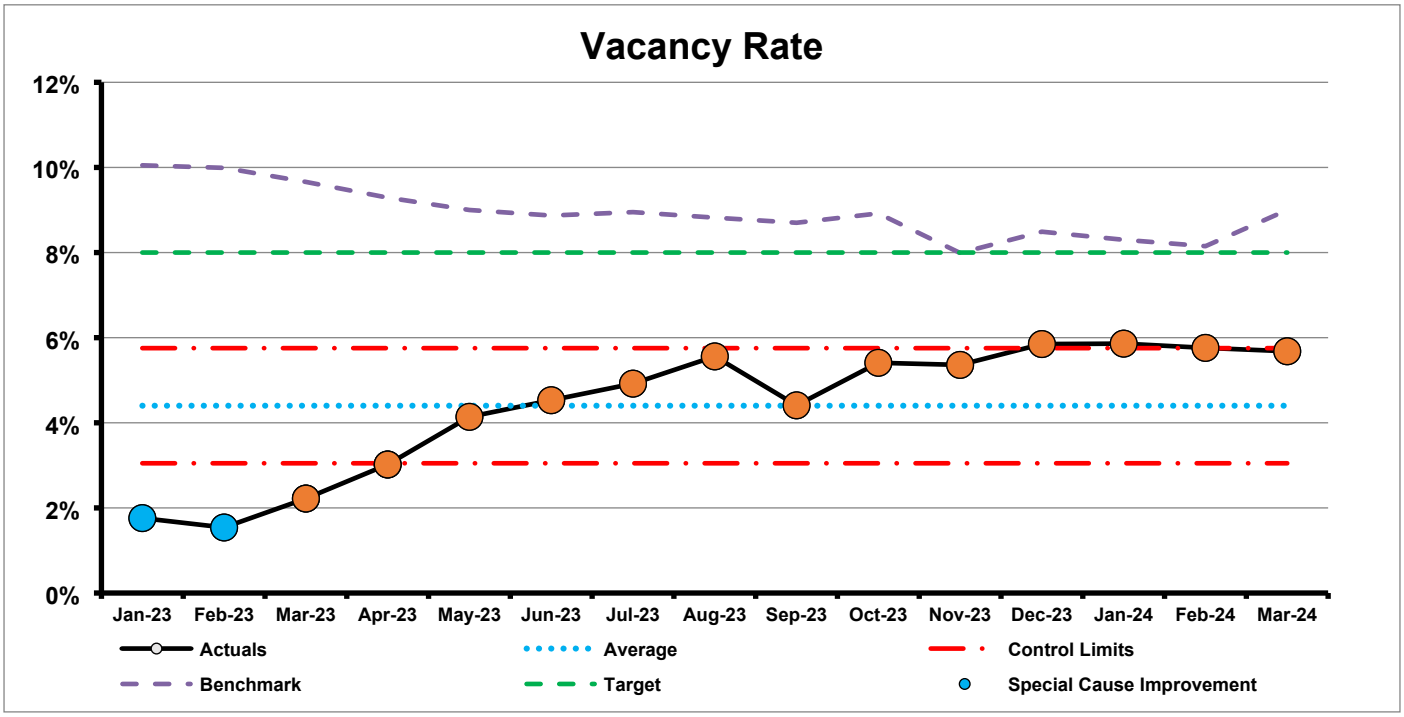
Capital spend is underspent to plan by £1.2m overall - £786k of under-delivery is IFRS16 re-measures that were not needed in year. Of capital schemes, the trust has underspent by £494k, £394k above the £100k underspend agreed with system.

This underspend is attributable to Estates schemes by £406k, partially mitigated in IM&T and Clinical Equipment/Medical Devices.

Some of this FY underspend was utilised across the ICS.

Vacancy Rate

Background
The Vacancy Rate target for LCHS is 8%.



Narrative

The vacancy rate SPC control limits have been reset from September 2023 when the mass vaccination budgets were correctly aligned.

Actions
On target – the Trust has a low overall vacancy rate compared to both the 8% target and the national benchmark figure. The national benchmark figure is published by the NHS Benchmarking Network's community indicators project monthly.

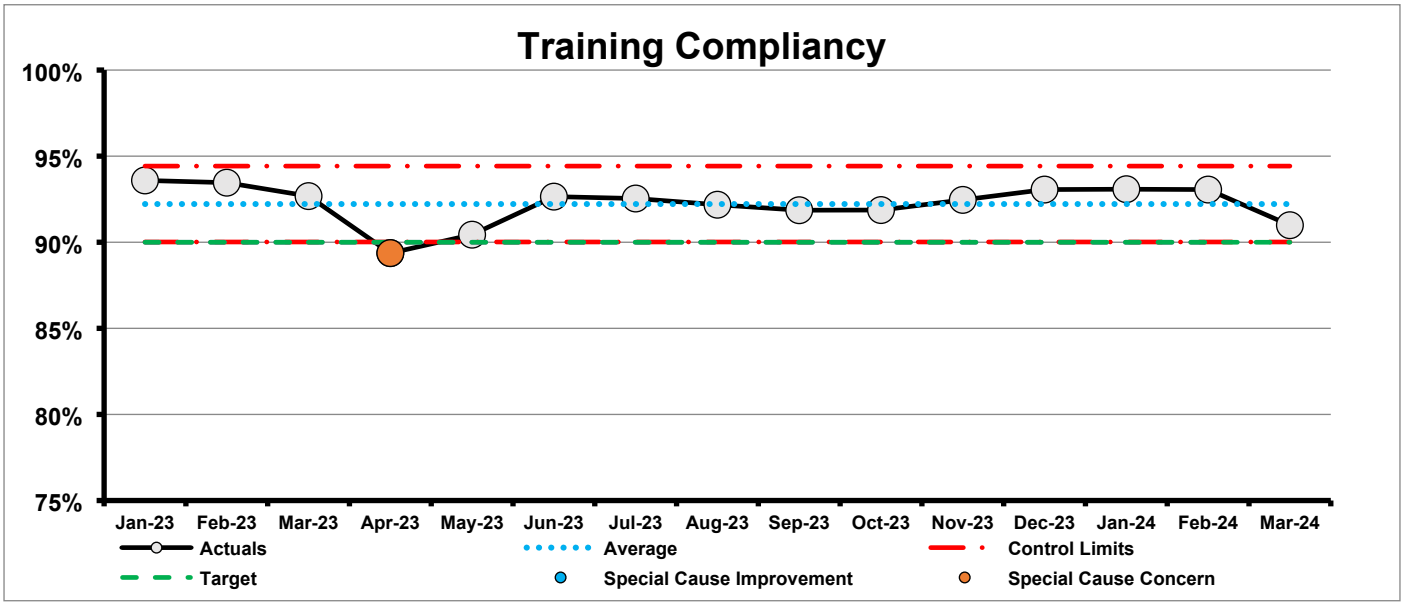
SPC

The vacancy rate shows special cause concern since March 2023 but is consistently capable of achieving the 8% target.

Mandatory Training Compliance

Background
The national benchmark for Training Compliance is 90%. In November 2022, the Trust Board approved the recommendation to reduce the target to match this. This new target of 90% is reflected within the data below.

Overall position



Overall mandatory compliance as of 31.03.2024:

The overall mandatory training compliance rate which includes all core **and** role specific modules is 93.00% which exceeds the local and national target of 90%.

Core mandatory training compliance (requirements for all staff): Overall compliance for the core mandatory modules has shown a minor reduction at 95.05% but still exceeds the national/local target of 90%

Compliance in all divisions/directorates has shown a minor reduction however still exceeds the local/national target of 90%

Children's, Young People's, and Specialist Services	97.08%
Collaborative Community Care	93.83%
Corporate Services	95.94%
Integrated Urgent and Emergency Care	93.48%
Operational Business Services	94.28%
Operational Leadership	95.69%
System	94.95%

The mandatory programme for 2024 is now live and available for staff to book on via ESR.

The programme is 2 hours for corporate/admin staff and 2.5hours for clinical staff and can be completed via a face-to-face session, MS Teams session (including evening classes) and a bespoke eLearning module which can be accessed at any time and will remain live for staff returning from long term absence after 30th June.

SPC

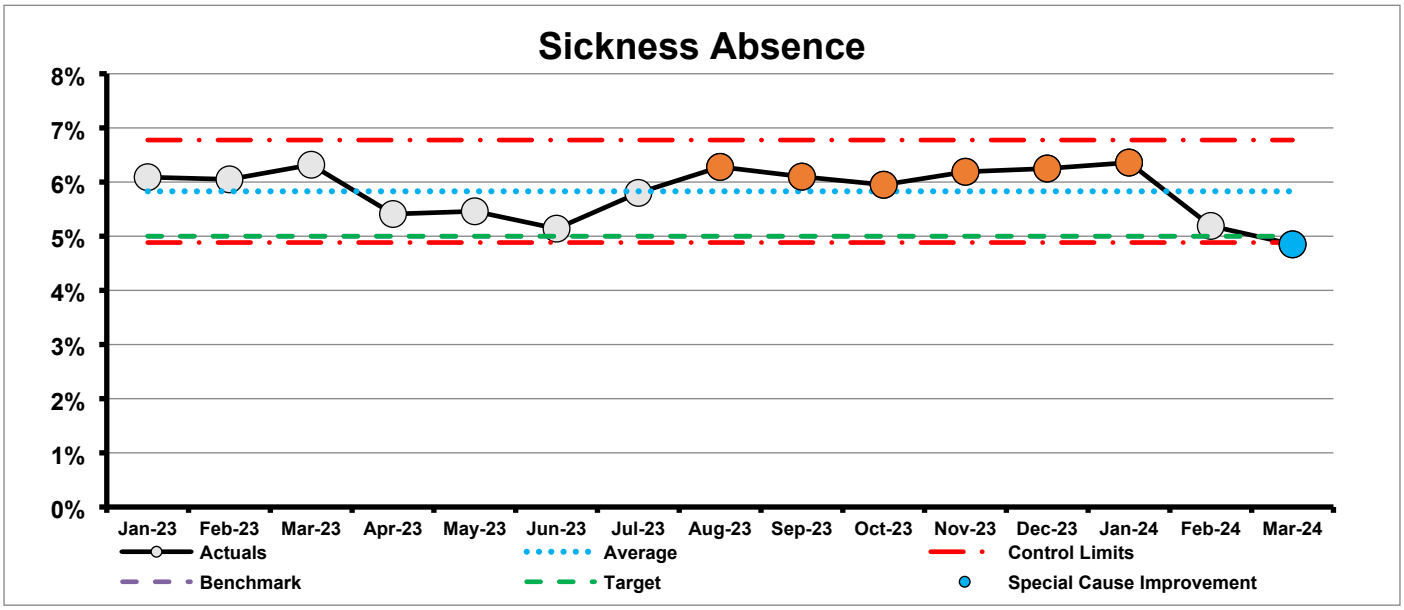
Mandatory Training compliance has not varied significantly since April 2023. The measure is consistently capable of achieving the 90% target.

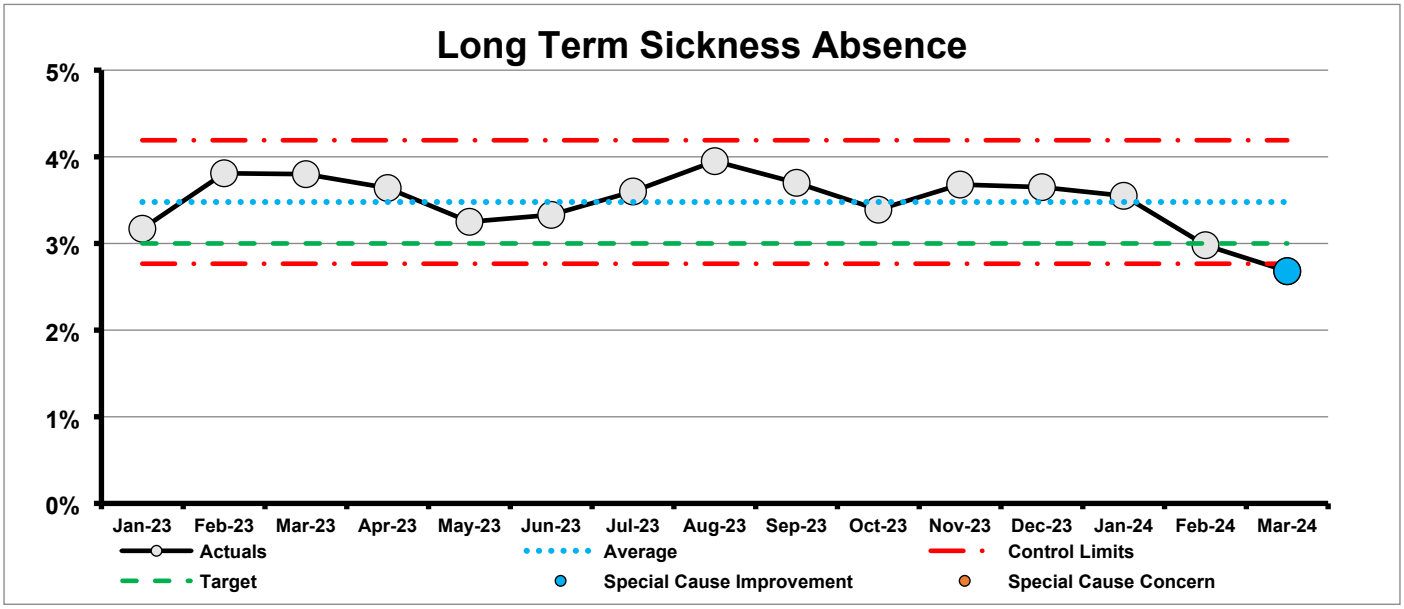
Sickness Absence

Background

The Trust target for total sickness absence is 5%.

Current Performance





Narrative

The overall sickness level in March have reduced to 4.85% (from 5.19% in February). This is below the agreed target of 5% and is the first time the overall sickness has achieved the target since August 2022.

For overall sickness absence, there are 2 areas that are above target as of March: Operational Business Services (6.66%) and Operations (6.06%).

The top three reasons accounting for overall sickness absence in March remain the same but in a slightly different order and are: anxiety, stress and depression, gastrointestinal problems and cold/cough/flu.

Long Term

The long-term sickness level in March have continued to reduce and are at 2.68% (2.98% in February) which is below the agreed target of 3% for the second month.

In relation to long term absence, there are 2 areas that are above target: Operational Business Services (3.56%) and Corporate (3.16%).

The top 3 reasons for long term sickness absence for March were are anxiety, stress and depression, other musculoskeletal problems and injury/fracture.

Short Term

The short-term sickness levels in March have also continued to improve at 2.17% (2.21% in February), although are still slightly above the 2% target.

In respect of short-term sickness, there are 5 areas that are above target: Operational Business Services (3.10%), Operations (3.09%), Collaborative Community Care (2.48%), Integrated Urgent and Emergency Care (2.2%), Children's, Young People and Specialist Services (2.03%).

The top 3 reasons for short term sickness absence in March are gastrointestinal problems, anxiety, stress and depression and cold/cough/flu.

Actions

- The People Strategy Group continue to focus on sickness absence including the number of return-to-work meetings taking place to support staff as well as consideration of the timescales for the various stage sickness absence meetings and whether these happen. This includes where warnings are being issued/not issued and whether this is appropriate, to ensure that the absence policy is being followed in all areas. Divisional leads and HR Business Partners have worked together to hold a number of sickness absence summits with leaders with a focus on different levels of leader's responsibilities and what support is available.
- The HR team continue to offer leaders coaching, advice and guidance in the appropriate and timely management of absence in line with the Your Attendance Matters policy and the People Fundamentals Workshop training offer is in place with further bespoke training where needed. HR are encouraging managers to hold early wellbeing conversations with individuals to identify health and wellbeing support, adjustments, and flexible arrangements as appropriate, to support individuals to remain in work and/or return to work and to reduce the number of absence cases becoming long term.
- The HR team work proactively with managers to ensure there is timely support in place for those on long term sick and to facilitate successful return to works. The HR Advisors provide monthly reporting and work with Deputy Divisional Leads and CTLs to discuss the monthly KPI reports including but not limited to absence to highlight absences and trends and discuss actions.
- A comprehensive health and wellbeing offer remains in place, relating to support for mental health and wider wellbeing which is aligned to best practice.

SPC

Overall sickness rate shows special cause improvement in March 2024 and is inconsistently capable of achieving the 5% target. The target is expected to be missed more often than achieved.

Long-Term Sickness Absence shows special cause improvement in March 2024 and is inconsistently capable of achieving the 3% target. The target is expected to be missed more often than achieved.

Workforce Dashboard

March 2024

Division	FTE Budgeted	FTE Actual	FTE Vacant	Vacancy Rate	Annual Turnover Rate	Monthly Turnover Rate	Total Absence Rate	Short Term Absence Rate	Long Term Absence Rate	Training Compliance Rate	Appraisals Rate	Supervision Rate
Children's, Young People's and Specialist Services	477.67	429.20	48.47	10.15%	9.71%	0.51%	4.86%	2.03%	2.83%	94.05%	95.13%	93.09%
Collaborative Community Care	786.25	800.43	-14.18	-1.80%	11.91%	1.42%	4.94%	2.48%	2.46%	88.75%	90.28%	85.68%
Corporate Services	258.71	241.04	17.67	6.83%	18.15%	1.83%	4.16%	1.00%	3.15%	94.24%	94.68%	93.48%
Integrated Urgent & Emergency Care	413.48	350.64	62.84	15.20%	6.44%	0.73%	4.86%	2.20%	2.66%	89.46%	93.94%	93.47%
Operational Business Services	104.17	103.32	0.85	0.82%	21.31%	0.58%	6.66%	3.10%	3.56%	95.69%	97.92%	
Operations	41.21	33.69	7.52	18.26%	21.37%	2.97%	6.06%	3.09%	2.97%	91.74%	84.62%	84.62%
System	29.20	32.47	-3.27	-11.19%	34.66%	1.85%	0.70%	0.70%		93.60%	72.00%	100.00%
Total	**2,110.69**	**1,990.78**	**119.91**	**5.68%**	**12.25%**	**1.14%**	**4.85%**	**2.17%**	**2.68%**	**90.99%**	**92.62%**	**89.45%**

Corporate Services

Division	FTE Budgeted	FTE Actual	FTE Vacant	Vacancy Rate	Annual Turnover Rate	Monthly Turnover Rate	Total Absence Rate	Short Term Absence Rate	Long Term Absence Rate	Training Compliance Rate	Appraisals Rate	Supervision Rate
Corporate Services	258.71	241.04	17.67	6.83%	18.15%	1.83%	4.16%	1.00%	3.15%	94.24%	94.68%	93.48%
Chief Exec	26.00	19.80	6.20	23.85%	27.27%	2.02%	9.81%	0.68%	9.12%	95.85%	100.00%	
Finance & Business Intelligence	52.13	48.93	3.20	6.13%	16.13%	4.09%	0.40%	0.40%		93.51%	85.29%	
Medical Directorate	46.25	34.42	11.83	25.57%	33.00%		4.06%	1.13%	2.93%	87.29%	93.75%	93.33%
People & Innovation	89.62	97.33	-7.71	-8.61%	13.15%	2.05%	3.24%	1.37%	1.87%	96.68%	96.59%	100.00%
Quality	44.71	40.55	4.16	9.31%	15.54%		8.35%	0.90%	7.46%	97.36%	97.06%	93.33%
Total	**258.71**	**241.04**	**17.67**	**6.83%**	**18.15%**	**1.83%**	**4.16%**	**1.00%**	**3.15%**	**94.24%**	**94.68%**	**93.48%**

United Lincolnshire Hospitals NHS Trust

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*7th May 2024*
Item Number	*13*

Integrated Performance Report for April 2024

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

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

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

Recommendations/ Decision Required	• *The Board is asked to note the current performance.* *Key to note:* • *Year to date activity against 2019/20 for key PODS: Daycase 103.5%, Electives 95.5%, Outpatient Firsts (including procedures) 112.8%. The ERF financial target for Lincolnshire was 100.1% with the Trust achieving 101.7%* • *The year end target for 4 hour performance was set at 78%, with March set at 76%. The full UEC combined Type 1, Type 3 (both co-located and separate sites) achieved 72.51%* • *Length of Stay: March NEL LoS improved in March to 4.71 days. Average Bed Occupancy was 98.83% for Core G&A beds, reducing to 94.35% including escalation beds* • *Referral to Treatment. At the end of March, the Trust reported 0 patients waiting longer than 104 weeks; 5 patients waiting over 78 weeks and 358 patients waiting over 65 weeks* • *As of 2nd April 2024, ASI sat at 1,005, higher than the agreed trajectory of 550, but a significant improvement overall* • *The report for DM01 in March showed a slight decline to 73.74% compared to February's 77.99%. The primary area of concern remains Echocardiography but recent declines in MRI and Ultrasound have been observed due to capacity and availability issues* • *28-day Faster Diagnosis Standard (FDS) showed improvement in February to 74.56%, slightly below our trajectory of 75%. The forecast March position is 70.5%* • *62 day classic treatment performance for February was 53.9%, an improvement from the January position (51.2%) and against a national KPI of 85%* • *104+ day waiters decreased to 46 at the end of February compared to 49 at the end of January* *The Board is asked to approve action to be taken where performance is below the expected target.*

Executive Summary

Quality

IPC

Clostridium Difficile

There have been 8 cases of confirmed clostridium difficile for the month of March, which is below the monthly trajectory for the Trust. All cases are reviewed, and the Divisions hold a programme of work for the identified themes/issues and feedback monthly to IPCG.

MRSA Bacteraemia

There has been 0 case of confirmed MRSA Bacteraemia in March. There have been 2 cases year to date.

Falls

There have been 3 falls resulting in severe harm during the month of March, an increase from February. There are currently at 24 severe harm falls incidents against an improvement target of ≤17 per annum. Falls educational bulletin will be circulated with a learning focus on application of enhanced care principles and patient education. The Quality Matron team will continue to provide support to areas with an increased number of incidents relating to commonly identified themes.

Pressure Ulcers

There have been 35 category 2 pressure ulcers and 6 unstageable reported in March, an increase of Category 2 and a decrease in unstageable. A focussed piece of work is happening in collaboration with the Palliative and End of Life Care team around the management of skin integrity for patients who are recognised at being at the end of their lives.

VTE

The Trust achieved 93.56% (target 95%) compliance with VTE assessment. Recruitment has commenced to appoint a substantive VTE Nurse Specialist. The Information Support Team are reviewing the data to ensure it is only wards that have inpatients over 24 hours are included.

Medications

Medication incidents reported as causing harm increased to 14.1% against a trajectory of 10.7%. The majority of incidents are at the point of prescribing and administration of medication and the main error is omitting medicines. Improving medication incidents from omitted medicines is a work stream as part of the new Patient Safety Incident Response Framework (PSIRF).

Patient safety Alerts

There has been a decline in compliance in March to 33.3% against a target of 100%. Monthly Safety Alerts exception reports to be discussed at Patient Safety Group commencing April 2024. Patient safety alerts are now recorded on DatixIQ Alerts module, compliance will be monitored on dashboards by Risk & Datix Team and Leads with overall responsibility for the alerts.

SHMI

The Trust SHMI remains stable at 103.19 for March and is within expected limits. The date for the changes to legislation for the ME Service has not yet been announced (was expected 1 April 2024). 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 88.5%. There is a task and finish group chaired by the Deputy Medical Director to review processes to enable improved compliance.

Sepsis compliance – based on February data

The screening compliance for inpatient adults increased to 90% (target 90%) and for inpatient child decreased to 70% for February. For the inpatient child screening, there were 14 delayed screens, harm reviews have been carried out for all patients with delayed or missed screens. All found to have a viral or non-bacterial cause. No harm found.

IVAB Inpatient Children – The administration of IVAB for inpatient children reduced to 50% (2/4 children). Harm reviews completed for both children and no harm found. Ward staff are completing harm reviews themselves in order to identify learning.

IVAB ED Child - The administration of IVAB for children in ED decreased to 62.5% (5/8 children). Harm review completed and no harm found. Monthly Sepsis meeting with ED and Sepsis Practitioners continue. Sepsis Practitioner doing regular department visits to offer support.

Duty of Candour (DoC) – February Data

Verbal and written compliance for February was at 73% and 68% respectively against a target of 100%. A dedicated member of the incident team has been working with divisions with an aim to improve compliance. Monitoring and escalation processes will continue to improve compliance.

Operational Performance

This report pertains to the performance of March 2024. As of April 14th, the Trust has registered 5 PCR confirmed positive COVID-19 inpatients. In March, the peak was 4 patients, and currently, there has been a decrease in line with local and regional trends. During March, 45 of the 1469 Flu tests conducted yielded positive results (3.06%). Similarly, 3 (0.60%) of the 500 patients tested for RSV were positive. Presently, there are zero active flu/rsv patients at our sites.

Performance to increase activity levels to 116% of 2019/20 sits at 104.2% at the end of M12 but this may change slightly when year-end is finalised Year to date percentages against 2019/20 for key PODS are: Day case 103.5%, Electives 95.5%, Outpatient Firsts (including Procedures) 112.8%. The ERF target for Lincs was 100.1% with the trust achieving 101.7%

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

A & E and Ambulance Performance

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

The yearend target for 4-hour performance was set at 78%, with a rolling monthly ambition to track achievement. Unfortunately, the March 24 target of 76% has not been met, with a negative variance of 15.44% as it has out turned at 60.56%. The SPC chart below documents both the 22/23 and 23/24 targets to reflect performance ambition.
This trajectory is based on Type 1 and co-located Type 3 activity only.

However at time of writing the paper – when the full UEC Combined type 1 and type 3 activity is merged the March 2024 performance showed an achievement of 72.51% against the overall position – a 4% improvement to February 2024 and a 2% improvement compared to April 23 – Feb 24.

The performance in March witnessed an improvement in various metrics attributed to various factors, but continued to see increase in attendance occupancy at the departments and acuity level of the presenting cases. In response, the focus was realigned to the aggregated time spent in the department. Patients exceeding the 12-hour benchmark (T1) amounted to 21.35%. A daily/weekly target was established during the Tier 2 meetings. ULHT managed to reduce the number of patients to an average of 74 daily in March, down from more than 100 patients previously. Nonetheless, further work is necessary to enhance the situation.

The Cat2 ambulance response time target mandates a maximum of 30 minutes. In March, the average response time was 39 minutes per day, 8 minutes lower than that seen in February 2024. It is worth noting that the Cat2 average accounts also for conveyances where the patient did not attend ULHT e.g. remained at home, but the patient's postcode was within our catchment area. Additionally, the values highlighted on the SPC chart refer to the vehicles that took over 59 minutes to reach the patient. It is important to note that a number of these may have been for the same patient.

Fractured Neck of Femur 48hr Pathway (#NOF)

The trust has seen a significant improvement in the compliance for #NOFs going to theatre within 48 hours. March outturn is 85.54% which is a significant improvement on the February 77% outturn, and an even more significant improvement to that seen in September 2023 when performance was below 50%

Length of Stay

In March, the Non-Elective Length of Stay exhibited an improved performance of 0.03 days compared to February 2024, with a current performance of 4.71 days, revealing a negative variance of 0.21 against the agreed target. The average bed occupancy for March was 98.83%, evaluated against the "Core G&A." To ensure adequate and safe flow within the acute sites, an average of 46 escalation beds/boarding spaces were open. The occupancy vs escalation brought a safer percentage of 94.35% against the new national standard of less than 92%.

System Partners encountered challenges in promptly providing assistance to facilitate discharges from the acute care setting for pathways 1 to 3 throughout March. Notably though in February, Pathway 3 recorded the most significant improvement, exhibiting the highest decrease in the length of stay in March from 22.2 days to its current 27.6 days.

System Partners were challenged with identifying timely support to facilitate discharge from the acute care setting for pathways 1 to 3. The Trust also now records and monitors the percentage of discharges within 24hrs of the predicted dated of discharge (PDD). March recorded a performance of 38.90% which was a steep deterioration on February.

Referral to Treatment

February performance was static, reporting a performance of 50.24% compared to 50.95% in January. The Trust continues to report patients waiting over 104, 78, 65 & 52 weeks. At the end of March, the Trust reported zero patient waiting longer than 104 weeks. The trust exited March with 5 patients waiting over 78 weeks which was within our forecast for the 2nd month running and lowest to date. The trust reported 599 patients waiting over 65 weeks in January compared to 870 in December. The national ambition was for all providers to clear their 65-week patients by the end of March, but emphasis on this has recently reduced as it is evident very few providers will meet that ambition. ULHT had submitted a revised trajectory of 337 and exited slightly higher than this at 358. 24/25 Planning guidance is now available and describes a new ambition of achieving zero patients waiting over 65 weeks by the end of September.

The trust was an early adopter of the Further Faster programme which is a national initiative to reduce patients waiting over 52 weeks. In February the trust reported 2,768 patients waiting over 52 weeks which is 347 lower than January and almost half the amount compared to December 23. Of the 20 early adopter trusts, ULHT is the second most improved to date.

Waiting Lists

Nationally, we are seeing increased focus on total waiting list size. Whilst the trust has made huge improvements in reducing long waiting patients, total waiting list size has remained relatively static at 72-75k since November 22. Due to the continued focus, reduction in total waiting list size started to be evident in October 23 with a further reduction each month. The total waiting list in February sat at 69,718, the lowest in a number of years. The trust has committed to a timeline that will see all services return to directly bookable Outpatients slots over the next 6 months. This will give greater visibility over our wating times to GPs and improve patient choice.

As of 2nd April 2024, ASI sat at 1005. Whilst this is higher than the agreed trajectory of 550, the number fluctuates week on week and is a significant improvement overall. Additional resource has been directed to resolving missing outcomes which is having a positive effect on the bookings team being able to move the ASIs to open referrals.

DM01

The report for DM01 in February showed a slight deterioration in March, reducing from from 77.99% in February to 73.74% in March. Despite sustained improvement, performance is still significantly lower than the national target of 99%. The primary area of concern remains Echocardiography, but recent declines in MRI and Ultrasound performance have also been observed due to capacity and availability issues. It should be noted that MRI has experienced an increase in demand, which has contributed to the rising breach. A

recovery trajectory has been pulled together that shows a full recovery in May 24. More detailed reporting and analysis is being worked through currently to provide more detailed assurance.

Cancelled Ops

March outturn for cancelled operations on the day saw another increase to 2.42% from 1.99% in February. The Surgical division are completing a deep dive of this metric to support a rapid improvement plan that is now required. The main drivers for this were lack of time and lack of theatre & surgical staff. Performance has been deteriorating since Mar 23 and is an adverse effect of a drive to improve theatre utilisation. The surgical division will be putting measures in place that should see this performance metric start to improve over the coming months.

Included in the 2.42% of on the day cancellations, 33 patients were not treated within the 28-day standard. This continues to be affected by the pressure to date patients over 78 weeks requiring surgery.

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

Cancer

28-day Faster Diagnosis Standard (FDS) showed an improvement in February at 74.56%, slightly below our trajectory of 75%. The Forecast March position is 70.5%

62-day classic treatment performance for February was 53.9%, an improvement from the January position of 51.2% but significantly lower than the national KPI of 85%.

104+ day waiters decreased to 46 at the end of February compared to 49 at the end of February. The highest risk speciality is colorectal with 21 pathways greater than 104 days.

Workforce

Mandatory Training – Our March 2024 Core Learning Rate is 93.77% against a Target of 95.00%. This is a slight decrease when compared to last month although this is minimal. There has been a continued improvement seen over recent months with an improvement of over 4% when March 2024 is compared to March 2023.

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

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

Sickness Absence – Our March 2024 Sickness Rate is 5.40% against a Target of 4.50%. Sickness absence has remained stable over 2023/24 so far, but is not seeing the level of reduction we had planned. We are continuing to work towards further reducing our vacancy level and as such, we are hopeful this continued improvement will impact positively on our colleague's health and wellbeing throughout 2023/24.

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

Continued focus on supporting managers and leaders in absence processes and supporting our people to attend the work environment will be delivered through the mandated 'Basics brilliantly' workshops which is an action we are taking forward following the staff survey results. There have been discussions as part of the Workforce & Organisational Development Group about sickness absence, and a recognition that although not within target, levels are being maintained and are not worsening. This is a key area for some benchmark reporting and consideration for phased trajectories.

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

In addition, focussed work is being undertaken with Divisions where sickness absence trends have been identified so as to further our journey towards a "supporting attendance" approach as opposed to managing absence. Staff continuing to be signposted to our health and wellbeing services. We have developed and launched a new Sickness Report which will support Divisional Heads of HR to identify trends and understand, with Divisional Managers, where key areas of focus are required.

Staff Appraisals – Our March 2024 Appraisal Rate is 74.24% against a Target of 90.00%. This is an increase and improved position when compared to performance last month. It is recognised that the overall Trust wide appraisal completion rate is consistently below our annual target of 90.00%, and that there is further focus required for 2024/25 in improving compliance if we are to ensure that there is a Trustwide focus on our ambition to further improve. Continued focussed attention to areas who are RAG rated 'red' are being discussed with teams directly, including through FPAM discussions where relevant.

Following an Appraisal workshop in January 2024, a paper was approved by, our Executive Leadership Team advocating a move to an annual appraisal cycle, bringing the Trust in line with LCHS as its Group Partner. LCHS have identified that this has had a positive impact on completion rates by having a dedicated period where objectives are set and appraisals completed in line with the workforce, strategic and financial planning cycle.

To support continued improvement in the meantime, 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 – Our March 2024 Turnover Rate 10.62% against a Target of 11.50%. This is within the Trust Target and has been since M06 of 2023/24.

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

Continued focus on retention issues including flexible working. Organisational Development and our People Promise Manager continue to work with the Trust and ICB to explore retention and bring best practice into the organisation to address the challenges, planning currently

underway for next year's system plan. Working towards a more robust process via ESR to capture leaver's data and understand trends. People & OD are working closely with Nursing & AHP Leads to develop a Staff Experience and Retention Strategy for these Staff Groups to support a sustainable Turnover position and ensure that there are Career Pathway opportunities for these staff.

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

Vacancies – Our March 2024 Vacancy Rate is 6.76% against a Target of 4.00%. This is an improved position when compared to last month, with the Vacancy Rate reducing from 7.24% in February 2024. This Vacancy rate is prior to establishment review work being fully completed, and whilst this work continues it has not yet translated into Trust Reports. We expect that when this work is complete, that our overall Trust Vacancy Rate will return to trajectory levels. Although above our Q4 Target, we have seen a significant reduction in our Vacancy Rate over the last 12 months as we have moved from a position of 11.35% in July 2022. The reason for this increase is due to changes in our Establishment Levels as a result of approved Business Cases which impact Workforce, and also the control measures we have in place across the Trust for vacancy approvals which have slowed the recruitment process down for some Staff Groups.

Our AHP Vacancy Rate has shown an improved position in March 2024 as we start to see some of the International Recruits within Radiology commence in post to support the roll out of our Community Diagnostics Centres.

Our Recruitment Team have supported closing the gap between the Establishment and the number of Staff In Post and there have been an additional 42 FTE staff commence in post during March 2024, the majority of which are within patient facing clinical or frontline roles.

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 met its financial plan by delivering a deficit of £20.8m in 2023/24.

The Trust exceeded its cost improvement programme plan by delivering savings of £34.2m in 2023/24.

The Trust met its capital plan by delivering capital expenditure of £62.5m in 2023/24.

The year-end cash balance is £50.9m (plan £16.2m); this is an increase of £9.6m against the previous financial year's year-end cash balance of £41.3m.

Sameedha Rich-Mahadkar
Director of Improvements and Integration
April 2024

Key to Variation and Assurance Icons and SPC Dots

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

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

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

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

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

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

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

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

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

OUTSTANDING CARE personally DELIVERED

Performance Overview - Quality

NHS United Lincolnshire Hospitals NHS Trust

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Jan-24	Feb-24	Mar-24	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Clostridioides difficile position	Safe	Patients	Director of Nursing	9	7	12	8	98	?	
	MRSA bacteraemia	Safe	Patients	Director of Nursing	0	0	1	0	2	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	0.02	0.01	0.01	0.01		
	E. coli bacteraemia cases counts and 12-month rolling rates, by reporting acute trust and month using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.03	0.04	0.03	0.02		
	Catheter Associated Urinary Tract Infection	Safe	Patients	Director of Nursing	1	Data Not Available	Data Not Available	Data Not Available			
	Falls per 1000 bed days resulting in moderate, severe harm & death	Safe	Patients	Director of Nursing	0.19	0.08	0.06	0.08	0.07	P	
	Pressure Ulcers category 3	Safe	Patients	Director of Nursing	4.3	0	1	0	5	P	
	Pressure Ulcers category 4	Safe	Patients	Director of Nursing	1.3	0	0	0	3	P	
	Pressure Ulcers - unstageable	Safe	Patients	Director of Nursing	4.4	9	7	6	62	F	
	Venous Thromboembolism (VTE) Risk Assessment	Safe	Patients	Medical Director	95.00%	94.31%	93.87%	93.56%	94.42%	F	
	Never Events	Safe	Patients	Director of Nursing	0	0	0	0	3	P	

OUTSTANDING CARE personally DELIVERED

Performance Overview - Quality

NHS United Lincolnshire Hospitals NHS Trust

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Jan-24	Feb-24	Mar-24	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Reported medication incidents per 1000 occupied bed days	Safe	Patients	Medical Director	4.30	5.50	6.60	5.51	5.87	P	
	Medication incidents reported as causing harm (low /moderate /severe / death)	Safe	Patients	Medical Director	10.70%	15.80%	10.80%	14.10%	14.48%	F	
	Patient Safety Alerts responded to by agreed deadline	Safe	Patients	Medical Director	100.00%	100.00%	None due	33.33%	66.72%	F	
	Hospital Standardised Mortality Ratio - HSMR (basket of 56 diagnosis groups) (rolling year data 3 month time lag)	Effective	Patients	Medical Director	100	93.22	92.50	93.76	93.90	P	
	Summary Hospital Mortality Indicator (SHMI) (rolling year data 6 month time lag)	Effective	Patients	Medical Director	100	103.33	103.48	103.19	103.20	F	
	The Trust participates in all relevant National clinical audits	Effective	Patients	Medical Director	100.00%	100.00%	98.00%	100.00%	99.83%	P	
	eDD issued within 24 hours	Effective	Patients	Medical Director	95.00%	91.80%	91.20%	88.50%	89.59%	F	
	Sepsis screening (bundle) compliance for inpatients (adult)	Safe	Patients	Director of Nursing	90.00%	88.74%	90.00%	Data Not Available	89.22%	F	
	Sepsis screening (bundle) compliance for inpatients (child)	Safe	Patients	Director of Nursing	90.00%	82.60%	70.20%	Data Not Available	85.68%	F	
	IVAB within 1 hour for sepsis for inpatients (adult)	Safe	Patients	Director of Nursing	90.00%	93.00%	98.27%	Data Not Available	93.93%	P	
	IVAB within 1 hour for sepsis for inpatients (child)	Safe	Patients	Director of Nursing	90.00%	100.00%	50.00%	Data Not Available	76.29%	?	

OUTSTANDING CARE personally DELIVERED

Performance Overview - Quality

NHS United Lincolnshire Hospitals NHS Trust

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Jan-24	Feb-24	Mar-24	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Sepsis screening (bundle) compliance in A&E (adult)	Safe	Patients	Director of Nursing	90.00%	93.00%	92.48%	Data Not Available	92.10%	P	H
	Sepsis screening (bundle) compliance in A&E (child)	Safe	Patients	Director of Nursing	90.00%	90.00%	93.50%	Data Not Available	90.80%	P	
	IVAB within 1 hour for sepsis in A&E (adult)	Safe	Patients	Director of Nursing	90.00%	94.30%	93.50%	Data Not Available	95.12%	P	
	IVAB within 1 hour for sepsis in A&E (child)	Safe	Patients	Director of Nursing	90.00%	87.50%	62.50%	Data Not Available	64.57%	F	
	Rate of stillbirth per 1000 births	Safe	Patients	Director of Nursing	3.80	2.99	2.97	2.96	2.71	P	H
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%	82.00%	73.00%	Data Not Available	79.18%	F	
	Duty of Candour compliance - Written	Responsive	Patients	Medical Director	100.00%	75.00%	68.00%	Data Not Available	73.27%	F	

Performance Overview - Quality

Clostridioides difficile position

Mar-24
8
Variance Type
Common cause variation
Target
9
Achievement
Variation indicates inconsistently passing and falling short of the target
Executive Lead
Director of Nursing

Background:
Clostridioides difficile position

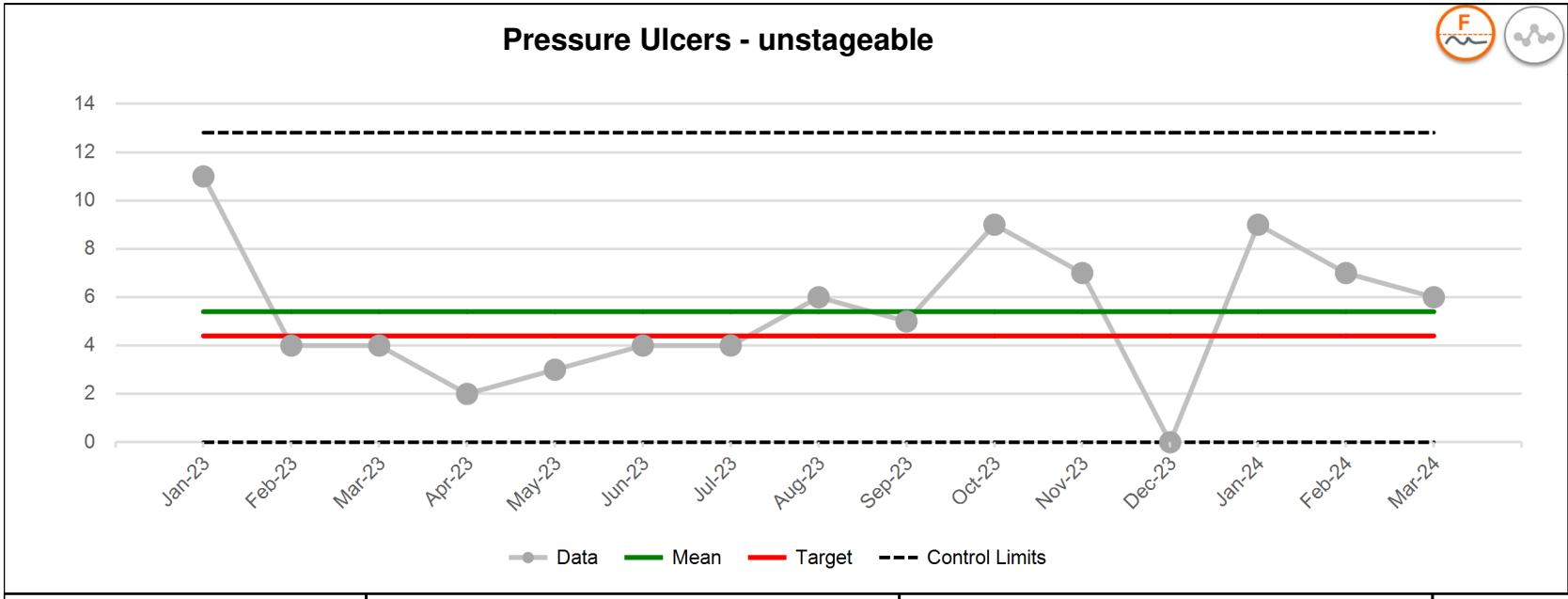
What the chart tells us:
In March there were 8 C diff infections against a target of 9. The Trust was over trajectory for the year.

Issues:

Actions:
All cases are reviewed and the Divisions hold a programme of work for the identified themes/issues and feedback monthly to IPCG.

Mitigations:

Performance Overview - Quality



Mar-24
6
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 6 Unstageable incidents against a target of 4.4 per month.

Issues:
The number of Unstageable incidents has decreased by 1 in March with 6 incidents reported, of which 1 was device related.

Theme identified as an area of focus for improvement are:

• Of the 6 incidents 5 of the patients involved were at the end of their life or had a palliative diagnosis placing them at high risk to pressure ulcer formation

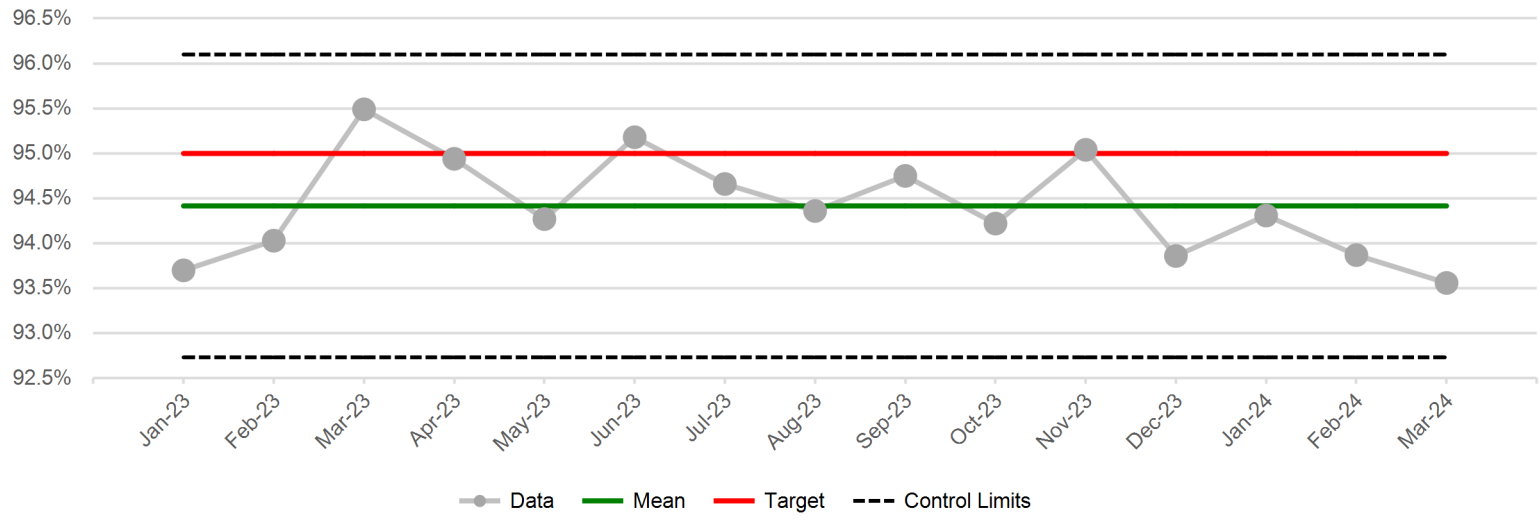
All of the incidents involved pressure ulcers that were less than a 1cm in size.

Actions:
All Unstageable incidents will be reviewed at the weekly Patient Safety Response meeting to determine if they require an After Action Review (AAR)
Conduct a focussed piece of work in collaboration with the Palliative and End of Life Care team around the management of skin integrity for patients who are recognised at being at the end of their lives.

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



Mar-24
93.56%
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:

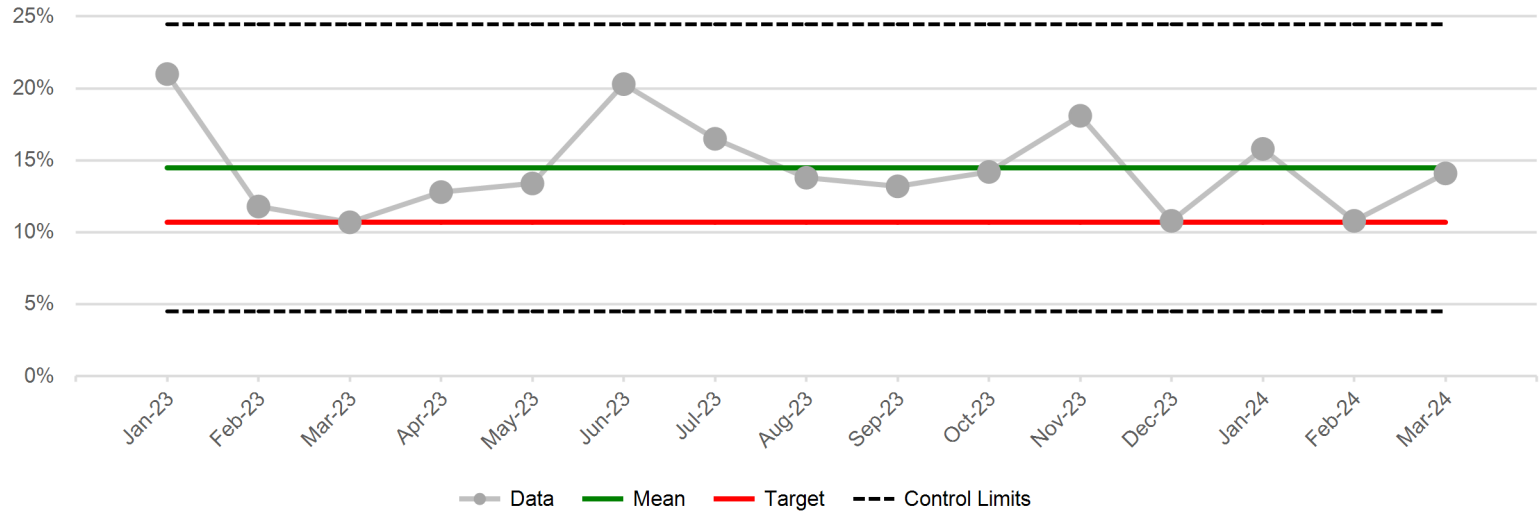
Actions:
A paper was taken to Trust Leadership Team in November 2022 proposing the reinstatement of the VTE Specialist Nurse. This was agreed and work will now take place to identify a funding stream.

No narrative owner

Mitigations:

Performance Overview - Quality

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



Mar-24
14.10%
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 March the number of incidents reported was 198. This equates to 5.51 incidents per 1000 bed days. The number of incidents causing some level of harm (low /moderate /severe / death) is 14.1% which is above the national average of 11%.

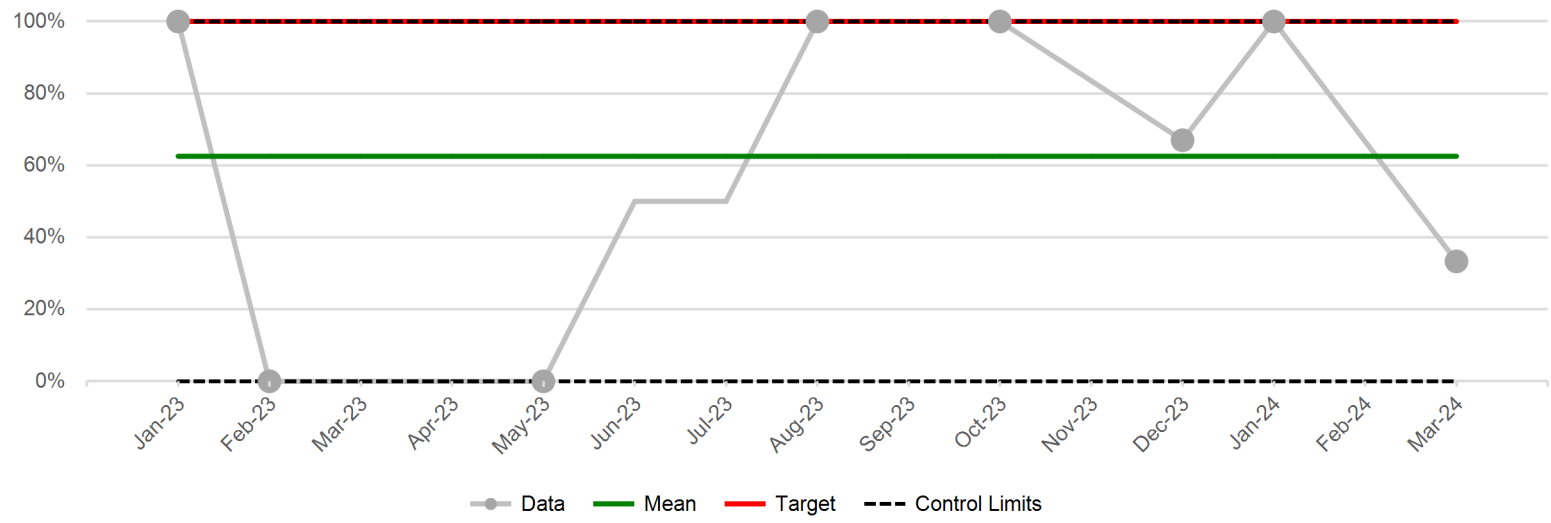
Issues:
The majority of incidents are at the point of prescribing and administration of medication and the main error is omitting medicines.

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

Mitigations:

Performance Overview - Quality

Patient Safety Alerts responded to by agreed deadline



Mar-24
33.33%
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 a decline in compliance with the set target in March to 33.3%.

Issues:
The Trust were previously not demonstrating compliance with the target set for CAS Alerts. The performance was below the lower control limit, this had improved with 100% compliance achieved in January, but a decline in compliance in March.

Actions:
Monthly Safety Alerts exception report to be discussed at Patient Safety Group commencing April 2024.

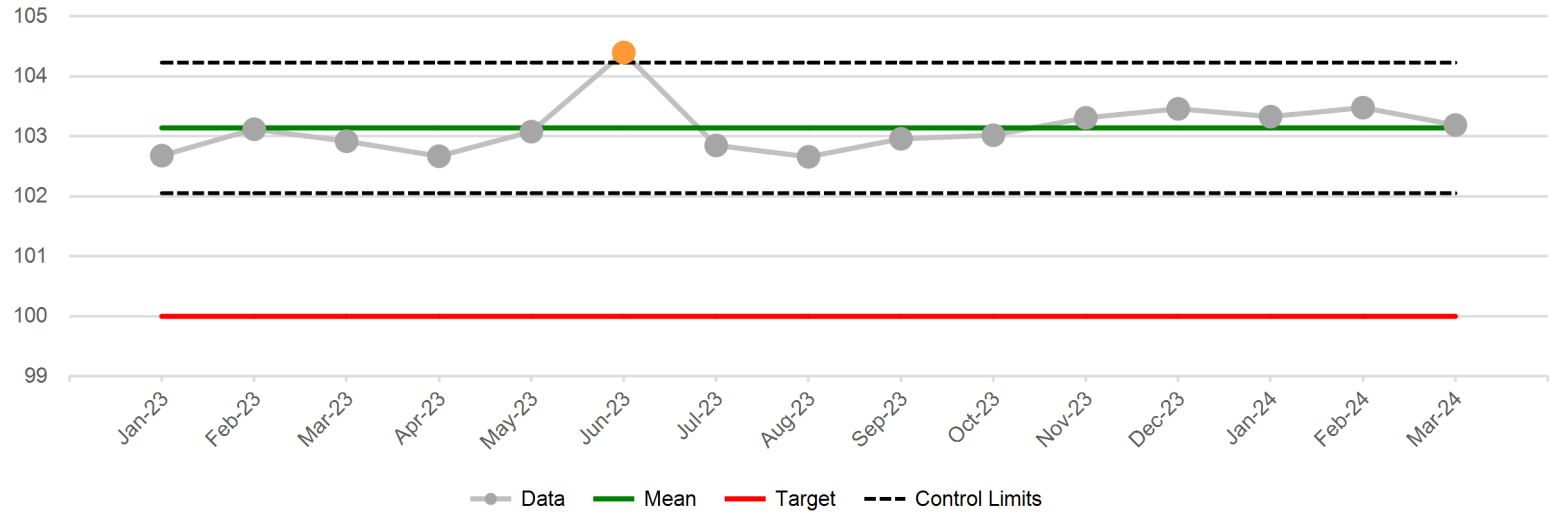
Patient safety alerts are now recorded on DatixIQ Alerts module, compliance will be monitored on dashboards by Risk & Datix Team and Leads with overall responsibility for the alerts.

Mitigations:
Compliance to be discussed monthly at Patient Safety Group, report will also escalate Alerts with upcoming deadlines for Leads to action.

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)



Mar-24
103.19
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.

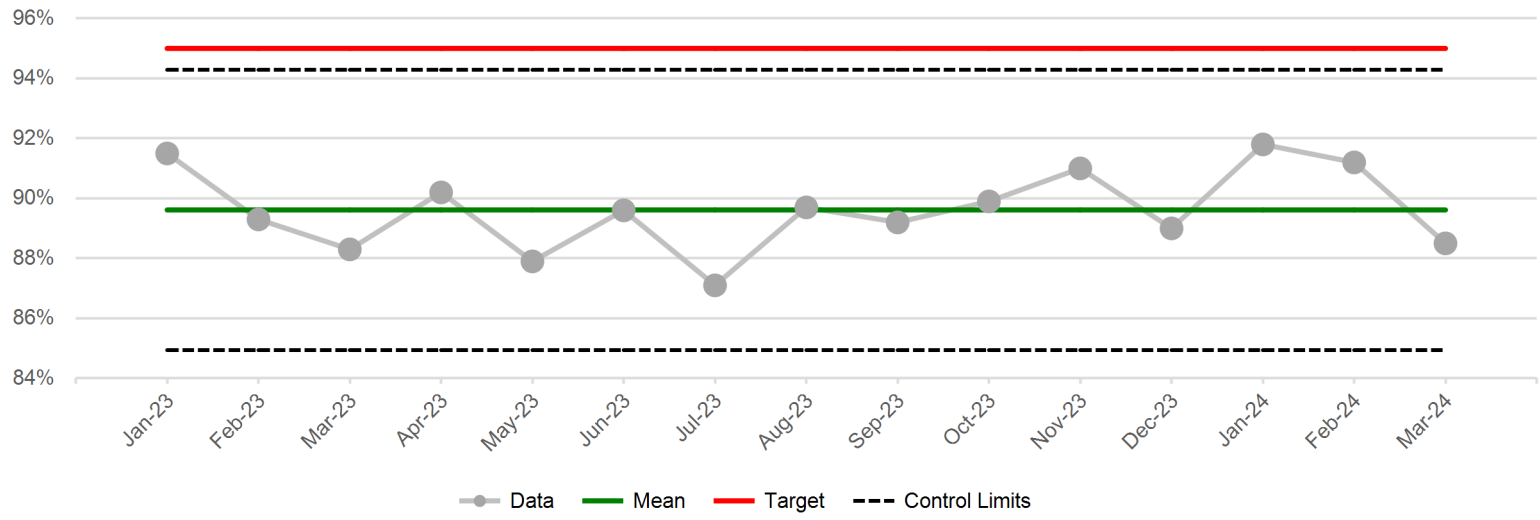
The Mortality Team are currently liaising with the Specialties and Business Units to implement M&Ms.

Mitigations:
The MEs have commenced reviewing some deaths in the community which will enable oversight of deaths in 30 days post discharge of which learning can be identified. From April 2024 (no official date released when in April) it will be legislation for all deaths to be reviewed by the ME service.

HSMR is 93.76 (rolling 12 months)

Performance Overview - Quality

eDD issued within 24 hours



Mar-24
88.50%
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 88.50%.

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

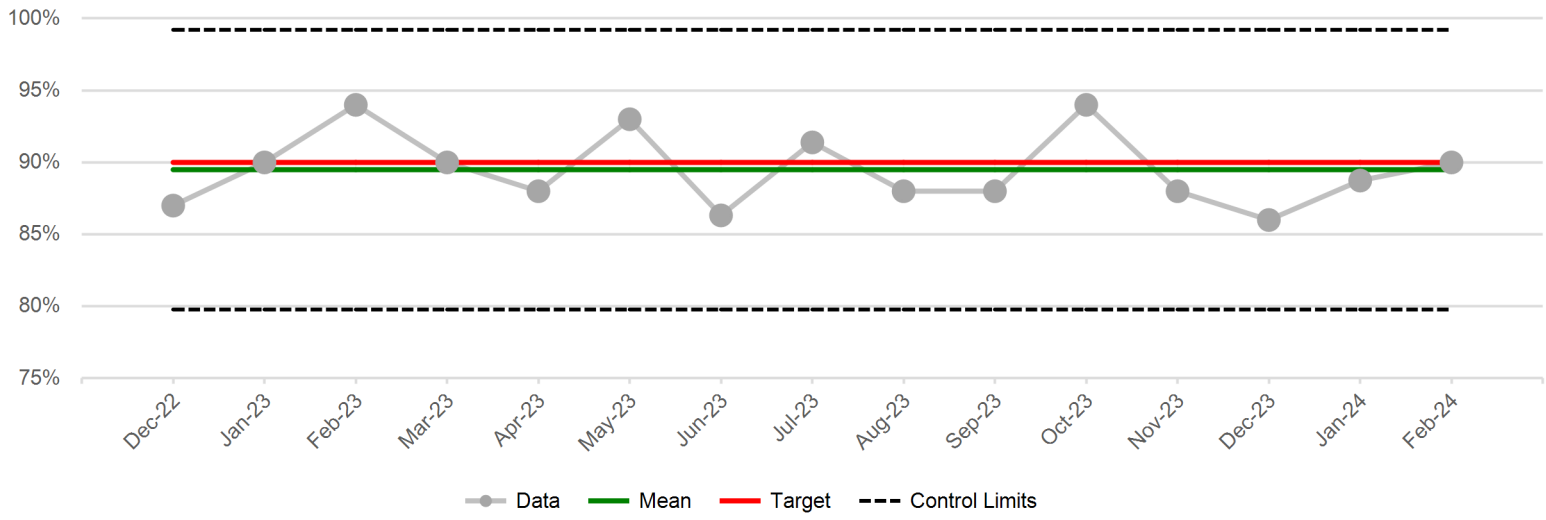
No Narrative owner

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)



Feb-24
90.00%
Variance Type
Common cause variation
Target
90.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of Nursing

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

What the chart tells us:
In the preceding months the compliance has fallen short of the 90.00% standard for sepsis screening.

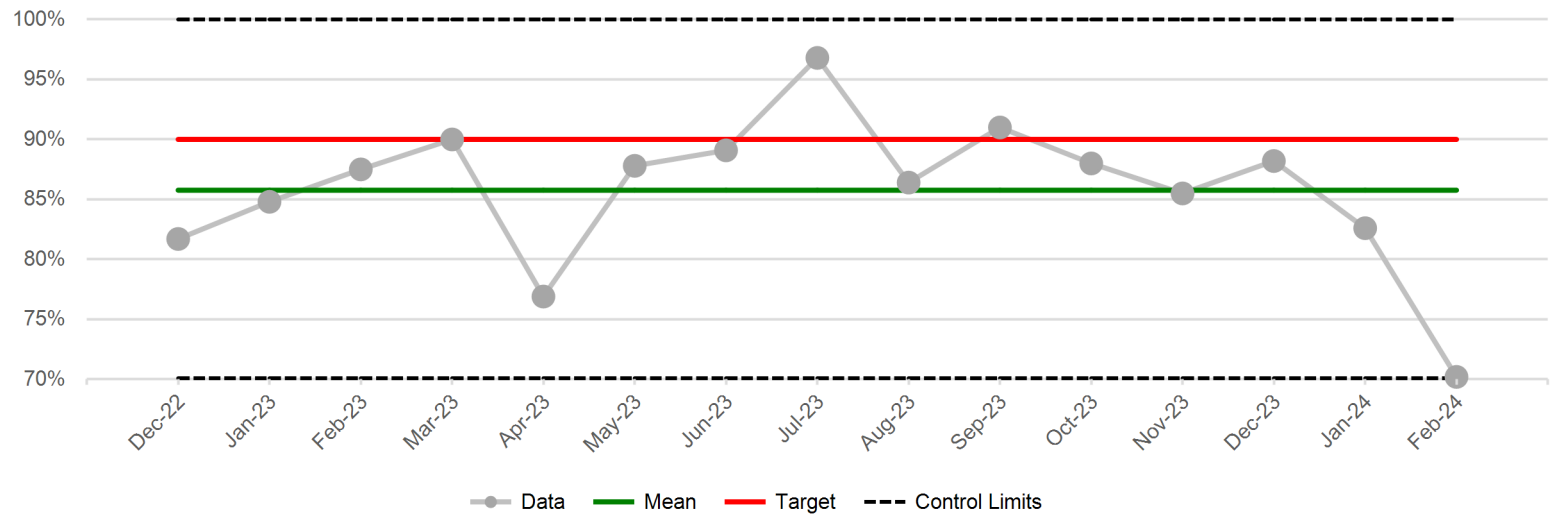
Issues:
The main areas of concern lie within the medical division with improvement seen within maternal care and consistent compliance seen in the other divisions. For context, it can be seen that there are a much greater number of unwell patients in medicine and no severe harms have resulted from the audited cases.

Actions:
The Sepsis practitioners are now offering bespoke sepsis teaching to all of the areas identified through the audit and this is in addition to the planned teaching on the AIM course, Preceptorship programme and the IEN cohort.
The clinical education team are rolling out a ward ready programme which should help bolster the confidence of new starters.

Mitigations:
The compliance for February has reached 90% and it is hoped the measures outlined will sustain this.
The harm reviews carried out have not revealed any severe harms suggesting that the main omissions occur in non infective causes for raised NEWs.

Performance Overview - Quality

Sepsis screening (bundle) compliance for inpatients (child)



Feb-24
70.20%
Variance Type
Common cause variation
Target
90.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of Nursing

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

What the chart tells us:
The compliance this month for sepsis screening of Paediatric outpatients was 70.2%. 33 of 47 patients were screened within the one hour target.

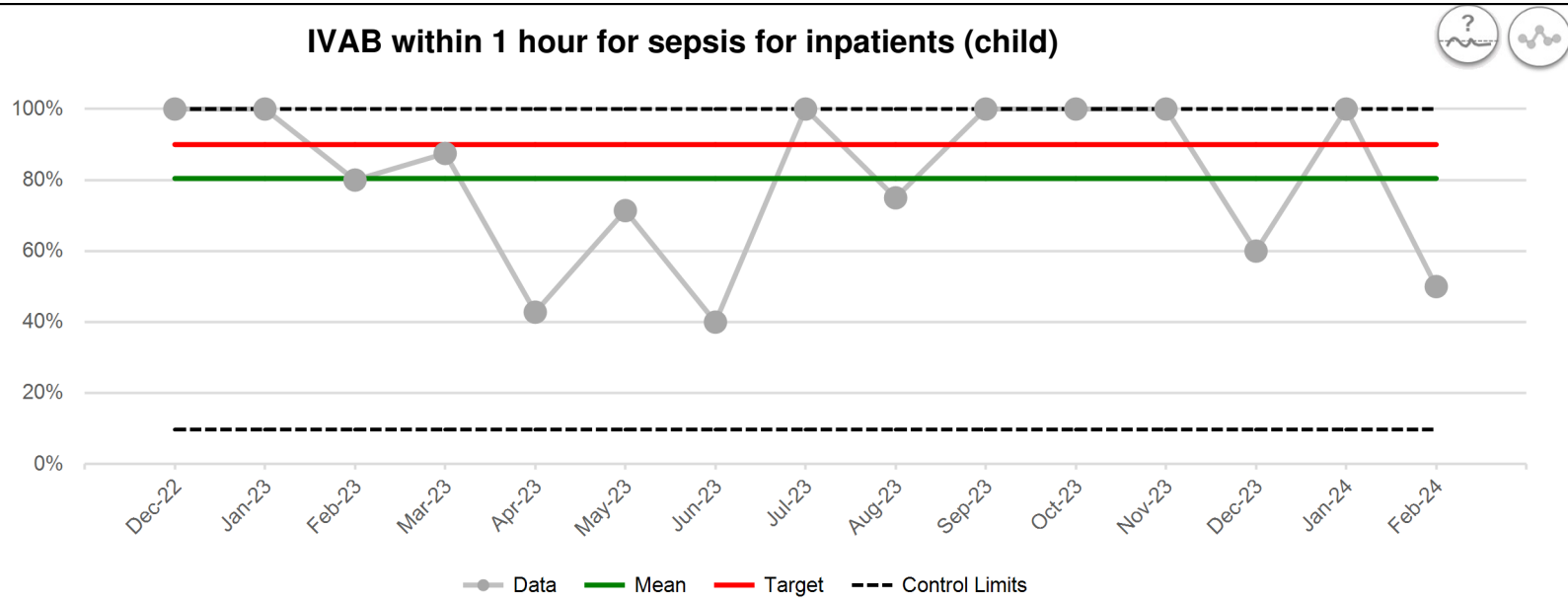
Issues:
There were 14 delayed screens, six of these were done by substantive staff.

6 were on Safari ward
6 on 4A
2 on Rainforest

Actions:
Training needs have been identified from auditing these figures and arranged with new staff. Sepsis simulation training has been carried out with ward staff and medical teams which also involved new starters.
Clinical educators will discuss with staff involved.
Harm reviews carried out by band 6 in department.

Mitigations:
Harm reviews carried out for all patients with delayed or missed screens. All found to have a viral or non-bacterial cause. No Harm found.

Performance Overview - Quality



Feb-24
50.00%
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)

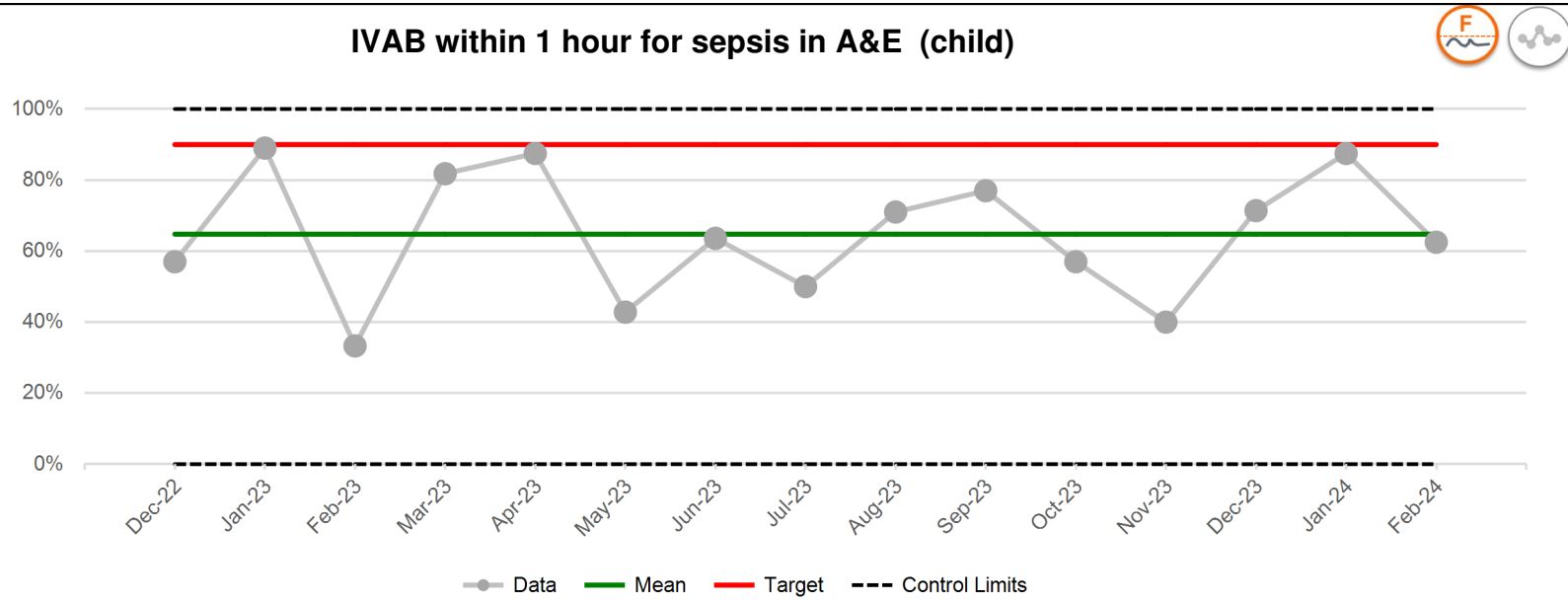
What the chart tells us:
.The Sepsis compliance for administration of antibiotics this month in inpatient areas is 50%. 2 of 4 patients received their antibiotics within a timely manner.

Issues:
Two patients in inpatient areas had a delay in IV antibiotics administration this month. Both of these patients were in one area. The Manager is aware. The first patient was a difficult cannulation, IVAB were given at 116 minutes. The second patient was delayed as the Drs wanted to do a lumbar puncture prior to giving antibiotics.

Actions:
The themes found have been discussed at Paediatric governance. Clinical lead will update Drs regarding treatment before completing full tests. Simulation for Sepsis to be done on both sites in May 2024.

Mitigations:
Harm reviews completed for both patients and no Harm found. Ward staff are completing harm reviews themselves in order to identify what went wrong.

Performance Overview - Quality



Feb-24
62.50%
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 administration of IV antibiotics this month for patients in A & E was 62.5%. 5 of 8 patients were treated with antibiotics within a timely manner.

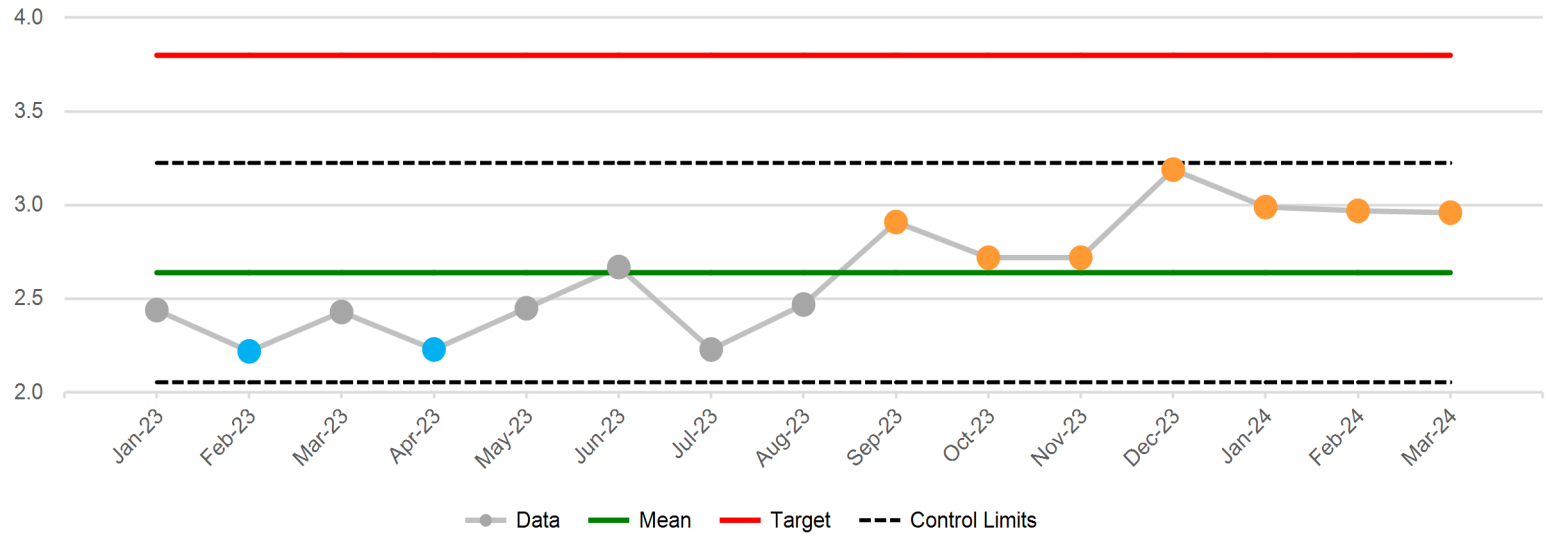
Issues:
There were 3 children this month that had a delay in the administration of IV antibiotics.
1 antibiotic was given at 76 minutes as Drs had asked for paediatric input and waited for them to come to department. The second delay was a difficult cannulation and there was no IV pump available to administer antibiotics. 1 delay was due to poor communication, drs waited for ametop to do bloods and then for results before treating.

Actions:
These cases have been discussed with Medical lead for sepsis in the department. They will discuss with Drs involved to find reason for delay. These delays will also be discussed at Sepsis meeting and speciality governance.

Mitigations:
Harm review completed and no harm found.
Monthly Sepsis meeting with ED ad Sepsis Practitioners continue. Practitioner doing regular department visits to offer support.

Performance Overview - Quality

Rate of stillbirth per 1000 births



Mar-24
2.96
Variance Type
Special cause variation - cause for concern (Indicator where high is a concern)
Target
3.80
Achievement
Variation indicates consistently passing the target
Executive Lead
Director of Nursing

Background:
Rate of stillbirth per 1000 births

What the chart tells us:
We are currently at 2.96 against a threshold of 3.8, we are consistently below the target and investigate all stiibirths that occur.

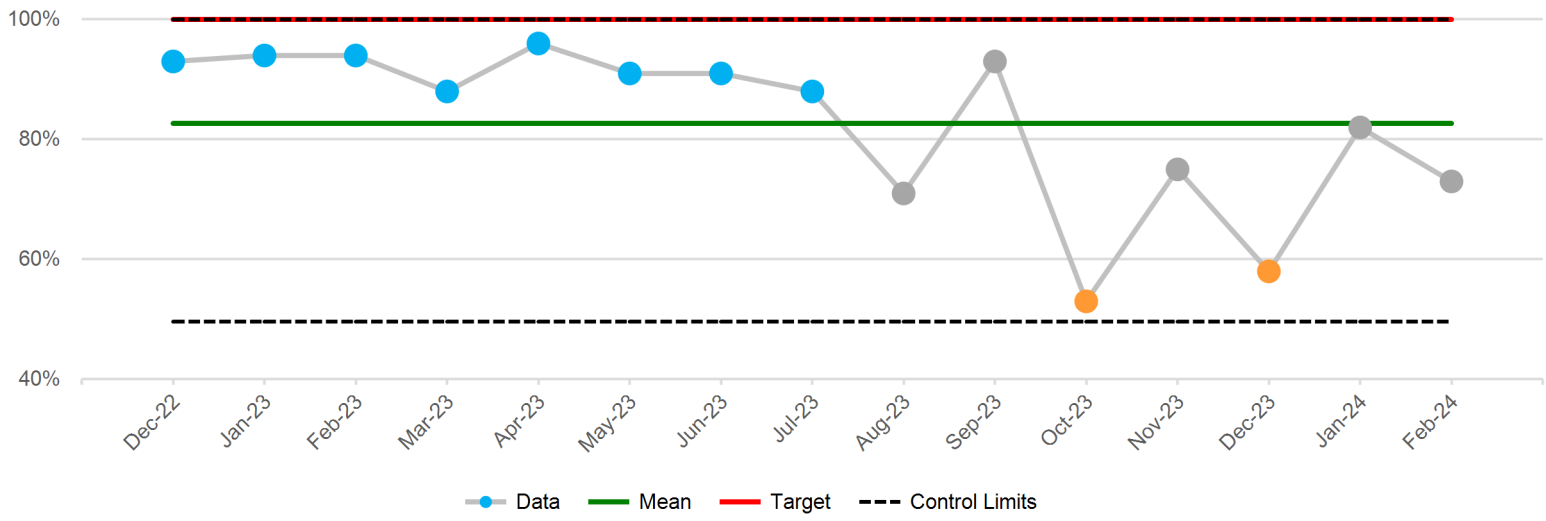
Issues:
We are consistenly below the national threshold however are aware that this is now displaying a special cause of concerning nature since Sep 23.

Actions:
All stillbirths are reviewed through the quarterly PMRT process and any outcomes are then actioned. This special cause will be highlighted to the PMRT lead who will review and include in the next quarterly report.

Mitigations:
The stillbirth rate is consistently monitored and reviewed, displayed on the maternity dashboards and outcomes of reviews are actioned.

Performance Overview - Quality

Duty of Candour compliance - Verbal



Feb-24
73.00%
Variance Type
Common cause variation
Target
100.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Medical Director

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

What the chart tells us:
Compliance has continues to vary.

Issues:
Medicine - 7 outstanding Verbal DoC - several escalations to the CBU have been made via the Incident Coordinators, now escalated to Triumvirate Divisional Team.

CSS - 1 Radiology Incident which Division seeking Trust legal advice whether it is in the patient's best interest

Surgery - 1 incident outstanding following a harm review on a PU incident.

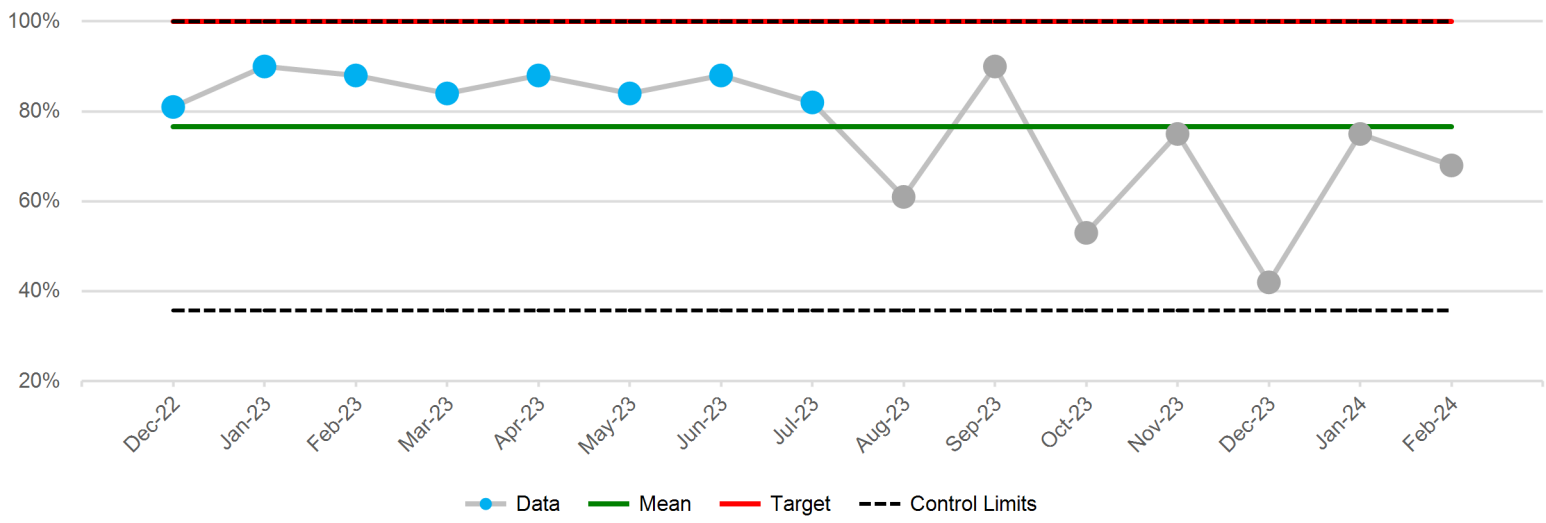
Actions:
Divisional position for each service now provided and business partners working with divisions to complete and monitor ongoing compliance.

Weekly tracking in progress by the incident team.

Mitigations:
A dedicated member of the incident team has been working with divisions with an aim to improve compliance by this report, which has been achieved. Revised monitoring and escalation processes will continue to improve compliance.

Performance Overview - Quality

Duty of Candour compliance - Written



Feb-24
68.00%
Variance Type
Common cause variation
Target
100.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Medical Director

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

What the chart tells us:
Compliance has continues to vary.

Issues:
Medicine - 7 outstanding Verbal DoC - several escalations to the CBU have been made via the Incident Coordinators, now escalated to Triumvirate Divisional Team.

CSS - 1 Radiology Incident which Division seeking Trust legal advice whether it is in the patient's best interest

Surgery - 1 incident outstanding following a harm review on a PU incident.

Actions:
Divisional position for each service now provided and business partners working with divisions to complete and monitor ongoing compliance.

Weekly tracking in progress by the incident team.

Mitigations:
A dedicated member of the incident team has been working with divisions with an aim to improve compliance by this report, which has been achieved. Revised monitoring and escalation processes will continue to improve compliance.

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	Jan-24	Feb-24	Mar-24	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Patient Experience	% Triage Data Not Recorded	Effective	Patients	Chief Operating Officer	0.00%	0.53%	0.45%	0.40%	0.49%	0.00%	F	
Improve Clinical Outcomes	4hrs or less in A&E Dept	Responsive	Services	Chief Operating Officer	76.00%	57.88%	54.55%	60.56%	56.63%	65.71%	F	
	12+ Trolley waits	Responsive	Services	Chief Operating Officer	0	1,342	1,120	919	11,009	0	F	
	%Triage Achieved under 15 mins	Responsive	Services	Chief Operating Officer	88.50%	69.91%	66.57%	64.17%	71.10%	88.50%	F	L
	52 Week Waiters	Responsive	Services	Chief Operating Officer	2,250	3,115	2,768		58,198	46,341	F	L
	65 Week Waiters	Responsive	Services	Chief Operating Officer	180	599	399		17,501	13,883	F	L
	18 week incompletes	Responsive	Services	Chief Operating Officer	84.10%	50.05%	50.24%		49.83%	84.10%	F	
	Waiting List Size	Responsive	Services	Chief Operating Officer	57,537	71,810	69,818		N/A	N/A	F	L
	28 days faster diagnosis	Responsive	Services	Chief Operating Officer	75.00%	69.40%	74.56%		67.32%	75.00%	F	H
	62 day classic	Responsive	Services	Chief Operating Officer	85.39%	51.20%	53.90%		53.05%	85.39%	F	
	2 week wait suspect	Responsive	Services	Chief Operating Officer	93.00%	76.80%	70.10%		67.07%	93.00%	F	

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Hospitals NHS Trust

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Jan-24	Feb-24	Mar-24	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Clinical Outcomes	2 week wait breast symptomatic	Responsive	Services	Chief Operating Officer	93.00%	53.80%	42.30%		33.86%	93.00%	F	
	31 day first treatment	Responsive	Services	Chief Operating Officer	96.00%	87.30%	89.60%		90.87%	96.00%	F	
	31 day subsequent drug treatments	Responsive	Services	Chief Operating Officer	98.00%	88.50%	94.20%		95.30%	98.00%	F	
	31 day subsequent surgery treatments	Responsive	Services	Chief Operating Officer	94.00%	55.90%	75.00%		75.37%	94.00%	F	
	31 day subsequent radiotherapy treatments	Responsive	Services	Chief Operating Officer	94.00%	76.20%	92.40%		90.75%	94.00%	F	
	62 day screening	Responsive	Services	Chief Operating Officer	90.00%	77.40%	38.50%		63.96%	90.00%	F	
	62 day consultant upgrade	Responsive	Services	Chief Operating Officer	85.00%	69.10%	77.30%		69.88%	85.00%	F	
	Diagnostics achieved	Responsive	Services	Chief Operating Officer	99.00%	70.36%	77.99%	73.74%	71.03%	99.00%	F	H
	Cancelled Operations on the day (non clinical)	Responsive	Services	Chief Operating Officer	0.80%	1.41%	1.99%	2.42%	1.67%	0.80%	F	
	Not treated within 28 days. (Breach)	Responsive	Services	Chief Operating Officer	0	43	25	33	297	0	F	H
	#NOF 48 hrs	Responsive	Services	Chief Operating Officer	90.00%	78.57%	77.05%	85.54%	78.09%	90.00%	F	

OUTSTANDING CARE personally DELIVERED

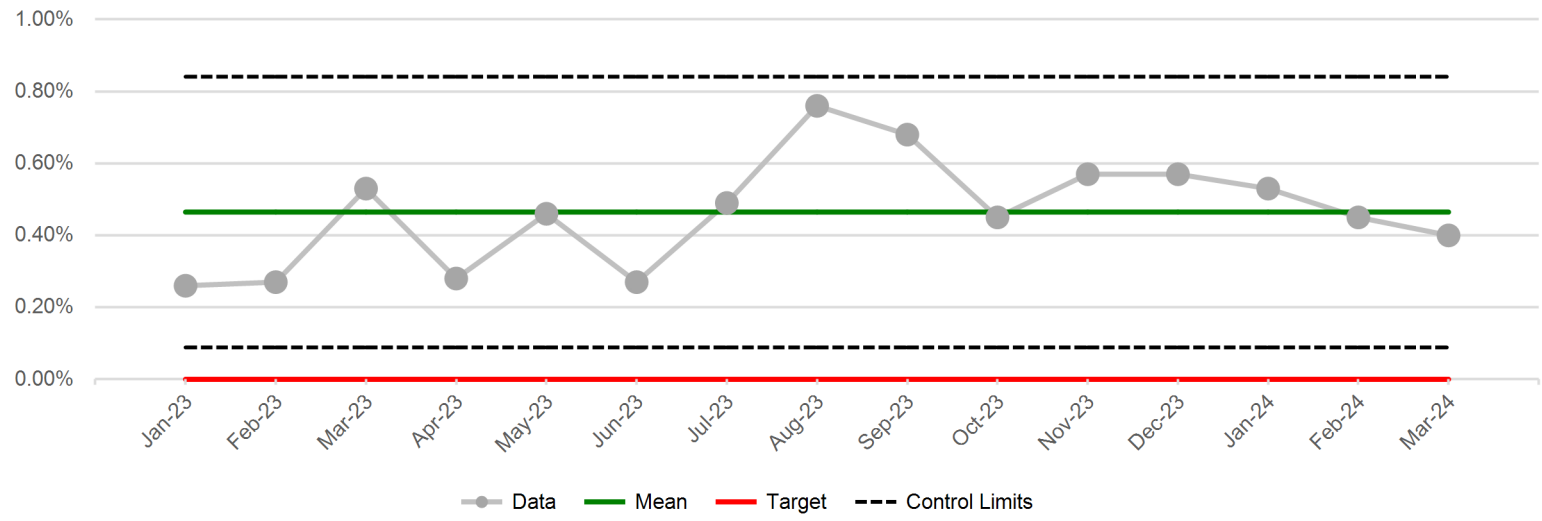
Performance Overview - Operational Performance

NHS United Lincolnshire Hospitals NHS Trust

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Jan-24	Feb-24	Mar-24	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Clinical Outcomes	#NOF 36 hrs	Responsive	Services	Chief Operating Officer	TBC	61.43%	55.74%	61.45%	55.51%			
	EMAS Conveyances to ULHT	Responsive	Services	Chief Operating Officer	4,657	4,538	4,392	4,779	4,365	4,657	P	H
	EMAS Conveyances Delayed >59 mins	Responsive	Services	Chief Operating Officer	0	693	482	378	585	0	F	
	104+ Day Waiters	Responsive	Services	Chief Operating Officer	10	55	49	46	736	120	F	L
	Average LoS - Elective (not including Daycase)	Effective	Services	Chief Operating Officer	2.80	3.07	2.50	2.77	2.81	2.80	?	
	Average LoS - Non Elective	Effective	Services	Chief Operating Officer	4.50	4.81	4.74	4.71	4.82	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	27,479	27,925	29,086	27,694	4,524	F	H
	% discharged within 24hrs of PDD	Effective	Services	Chief Operating Officer	45.00%	41.94%	41.42%	38.90%	40.71%	45.00%	F	

Performance Overview - Operational Performance

% Triage Data Not Recorded



Mar-24
0.40%
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:
March 24 reported a non-validated position of 0.40% of data not recorded verses target of 0%. What the chart doesn't tell us is that 82.22% of those without a triage "did not wait" to be seen. 91% of the overall missing data is on the LCH Site.

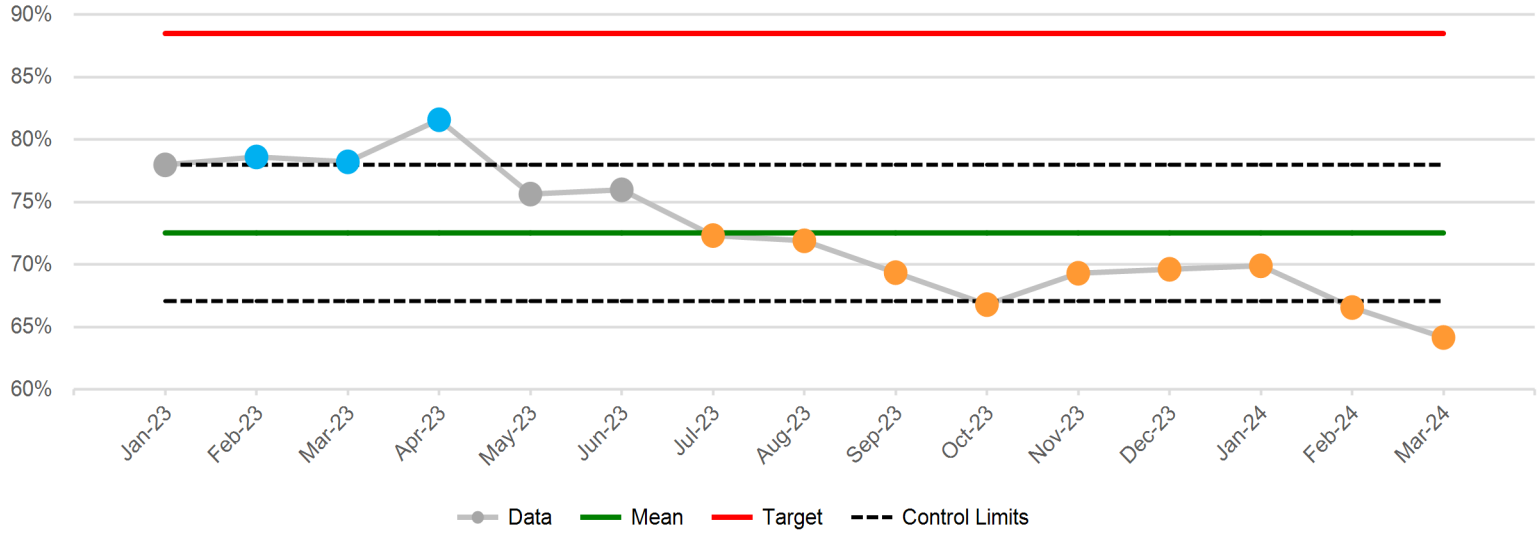
Issues:
- Identification of patients who left or refused treatment prior to triage, as well as patients who were transferred to another site for specialized care.
- It is important that the Manchester Triage trained staff operate two triage streams consistently, particularly during out-of-hours shifts. However, staffing gaps, sickness, and skill mix issues have been causing some problems that need to be addressed.

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

Performance Overview - Operational Performance

%Triage Achieved under 15 mins



Mar-24
64.17%
Variance Type
Special cause variation - cause for concern (Indicator where low is a concern)
Target
88.50%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
Percentage of triage achieved under 15 minutes.

What the chart tells us:
March outturn was 64.17% compared 66.57% in Feb (validated).
What the chart doesn't tell us is the decreased daily attendance in Type 1 from 391 patients in February to 345 in March 24.

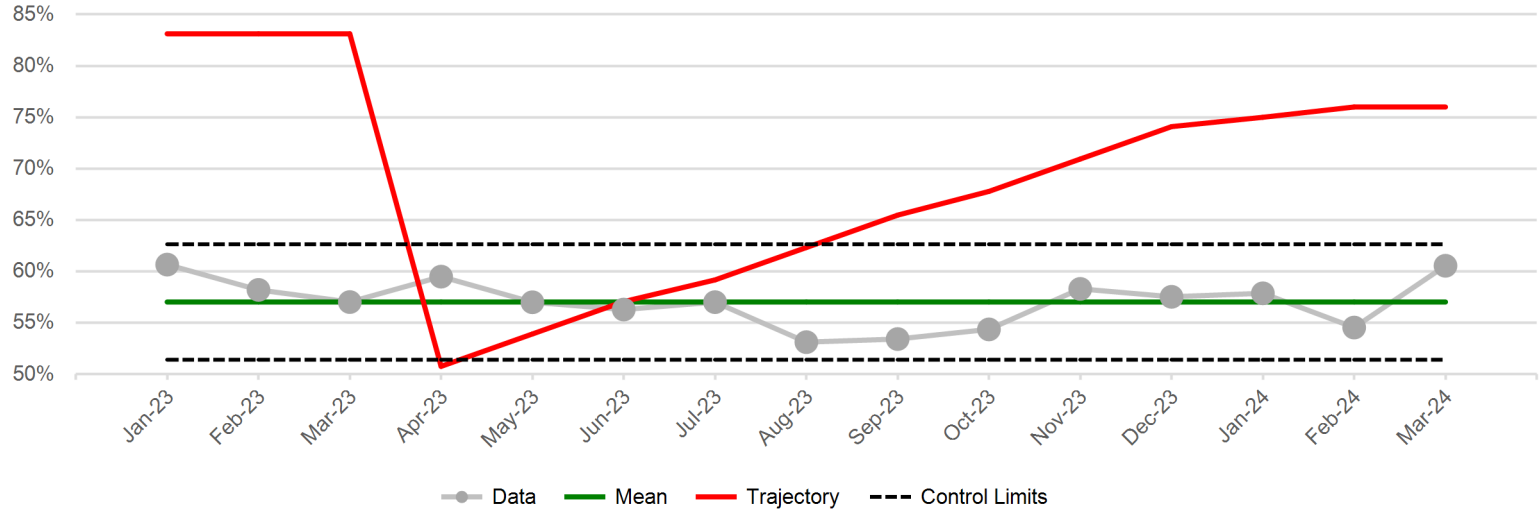
Issues:
• Consistent availability of MTS2 trained staff available per shift to ensure 2 triage streams in place 24/7 has deteriorated.
• There is a recording issue for UTC transfers of care to ED that skews that data on occasion.
• Dual department roles. For example, the second triage nurse is also the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

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



Mar-24
60.56%
Variance Type
Common cause variation
Trajectory
76.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
The 4-hour transit performance for Type 1 and co-located UTC Type 3 for has not been met.
However there has been a 6.01% improvement from the previous month. And first time the Trust hit >60% overall since January 2023.

(See appendix A at the end of the report for total Type 1 and Type 3 activity.)

Issues:
ED (Type 1) saw an average of 345 patients daily in March compared to February 2024 of 391.

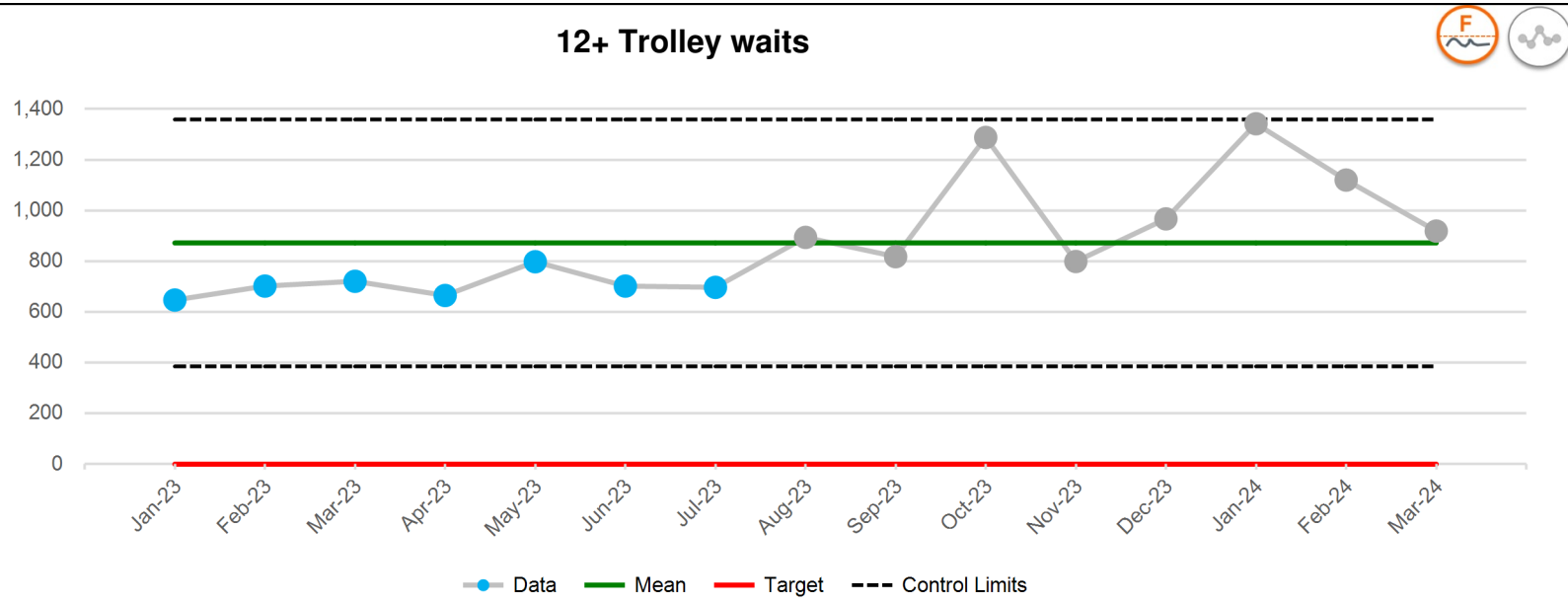
On average, there were 39 fewer discharges from the wards than what was needed to meet the demand of the (ED) each day. This resulted in longer waiting times for beds overnight. The delayed recognition of patients who could be discharged also contributed to extended stays in the ED, with 62% of patients being recognized only after 4 pm daily.

Infection-related closures of beds on the wards had an impact on the availability of resources for movement and cleaning, thereby affecting timely movements.

Actions:
Project 76 in place which is a dedicated programme of work looking at admission avoidance, ED process, acute medicine and direct pathways to reduce overcrowding in EDs and the length of time patients are waiting to be seen.
Divisional/organisational action plans monitored weekly by senior leaders from across ULHT and LCHS.
A new Group Discharge Board has also been set up to focus on the discharge agenda and flow throughout the hospital. The group is chaired by the Chief Nurse and COO and has senior attendees from across the group.
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



Mar-24
919
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:
March experienced 919 breaches compared to 1120 in February. This is an improvement of 18% (201) less patients. The 919 seen, equates to 9% of all type 1 attendances. (1% less than February)
What the chart does not highlight is the internal decision to move focus to total time in ED to minimise exposure risk/ mortality rate.

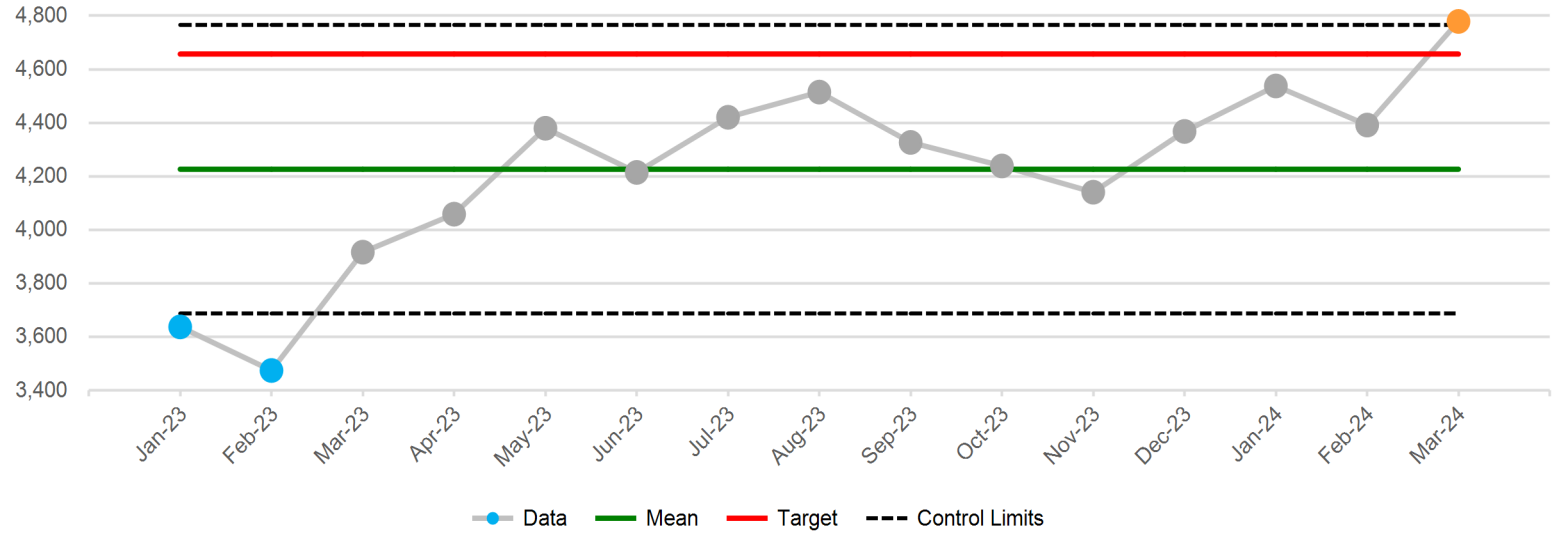
Issues:
Sub-optimal discharges to meet the known emergency demand.
All reportable 12hr trolleys were either associated with no available beds, patient deterioration or delays in transfer to other care settings.

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:
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.
An additional consultant shift was funded by winter monies to review all DTAs every day to ensure that they still require admission
Rapid Assessment and Treatment consultant shifts are in place at both ED front doors to assist with length of stay in department and appropriateness of referrals/navigation.

Performance Overview - Operational Performance

EMAS Conveyances to ULHT



Mar-24
4,779
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 number of conveyances to ULHT in March continued to demonstrate a 15% increase in activity for 2023/24 compared to conveyance seen throughout 2022/23. What the chart does not tell is the March conversion rate of 57.92% to admission, a 3% increase compared to 2023/24. This show the higher acuity of conveyances now being seen.

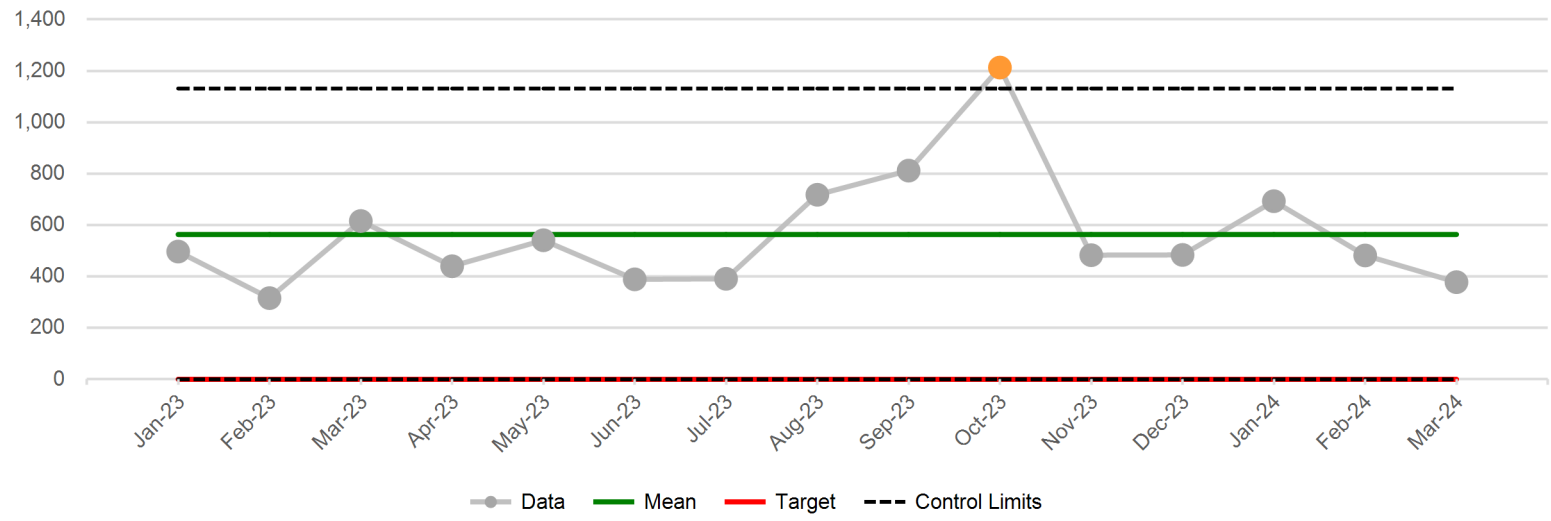
Issues:
The pattern of conveyance is such that arrivals are loaded to the late afternoon and into the evening. This also coincides with increased 'walk ins'.
The use of alternative pathways to avoid conveyance to the Trust are still not fully adhered to but progress continues to be made.
Pressure experienced 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



Mar-24
378
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:
March demonstrated a continued improvement to that seen in January 2024,
March's performance of 378 over 59mins equates to 7.91% of all conveyances that arrived, 3% lower than that of February 24, also 7.82% lower than that of March 23.

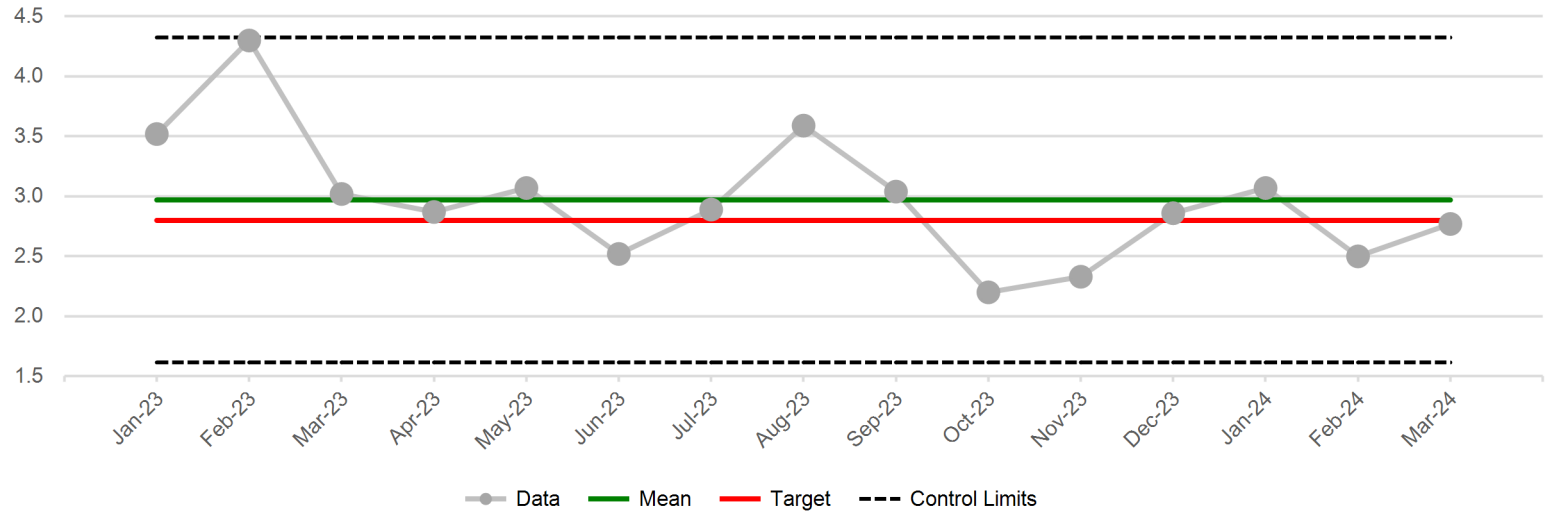
Issues:
The pattern of conveyance and prioritisation of clinical need contributes to the delays.
Increased conveyances continue to profile into the late afternoon and evening coincides with increased 'walk in' attendances causing a reduce footprint to respond to timely handover.
An increasing number 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 are escalated to the Clinical Site Manager in hours and SOC out of hours
Daily communication with 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.
EMAS Clinical Navigator trial imminent to test whether a dedicated senior ambulance member would be able to direct the flow of patients more successfully in conjunction with the operations centre on each site.

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)



Mar-24
2.77
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 increased to 2.77 days compared to 2.5 days in February. This represents a positive variance of 0.03 days against the agreed maximum threshold.

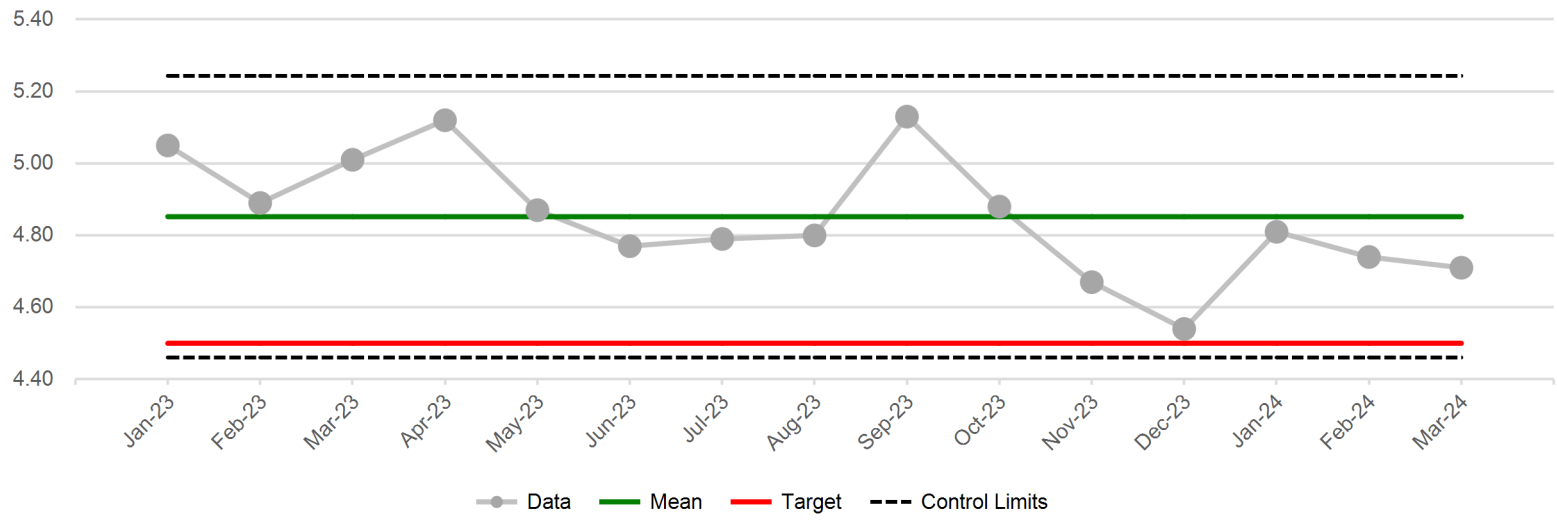
Issues:
Complexity of patients now being admitted which will impact on post-operative recovery and LOS.
Increase in Elective patients on pathways 1, 2 & 3.
Distorted figures associated with outliers in previous dedicated elective beds and coding.

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



Mar-24
4.71
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:
March outturn of 4.71 is an improvement of 0.03 days and a 0.21 day negative variance against the agreed target.
What the chart doesn't tell us is the change by pathway:
Pathway 0 (0.4) less days
Pathway 1 (1.3) more days
Pathway 2 (4.6) less days
Pathway 3 (5.4) more days

Issues:
Super stranded patients have increased in daily average 128 patients from 126 in March. Stranded however has seen an improvement from 214 to 209 daily average patients.

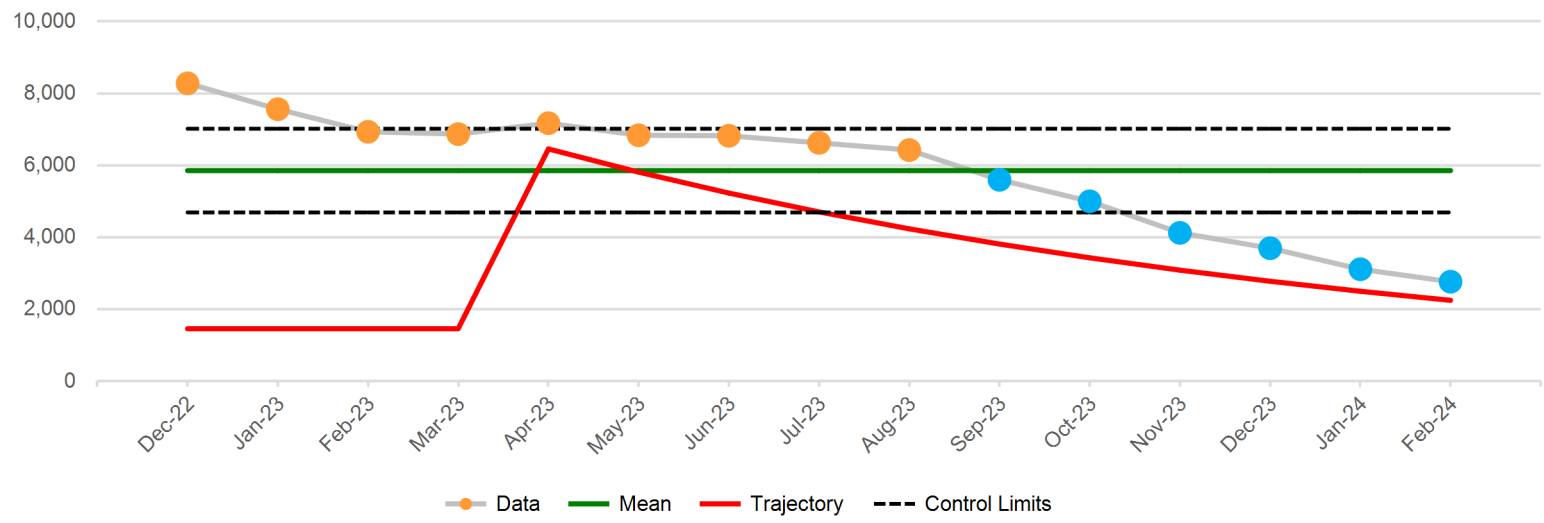
Weekend Discharges remain consistently lower than weekdays with an average of 42% less (55 patients) than required to meet Emergency Admission Demand.
But since the advent of the joint D2A process and additional funding benefits are being realised slowly but there remains insufficient capacity to meet the increasing demand.
The Transfer of Care Hub continue to gain more traction on moving discharges forward at an improved pace.
Higher acuity of patients requiring a longer period of recovery.
Increased medical outliers and reduced medical staffing leading to delays in senior reviews.

Actions:
Focused discharge profile through daily escalations.
Medically optimised patients discussed twice daily 7 days a week with system partners to ensure plans in place and a zero tolerance of >24hrs delay
Maximise use of all community and transitional care beds when onward care provision cannot be secured in a timely manner.
Line by line review of all pathway fully 0 patients who do not meeting the reason to reside.
Monthly face to face MADE events now commenced on each site. Reviewing all Pathways, with a greater focus on >7 days length of stay patients.

Mitigations:
Divisional Leads continue to support the escalation of exit delays.
Continued reduction in corporate and divisional meetings to allow a more proactive focus on increasing daily discharges. However, this is not sustainable.
A daily site update message is now sent at 6am alerting Key Leaders to ED position, flow and site OPEL position by Site.
The move to working 5 days over the 7 a Day period is in train.
A new rolling programme of MADE has been agreed and the frequency has been agreed as an 8-week rolling programme.

Performance Overview - Operational Performance

52 Week Waiters



Feb-24
2,768
Variance Type
Special cause variation - improvement (Indicator where low is good)
Trajectory
2,250
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.

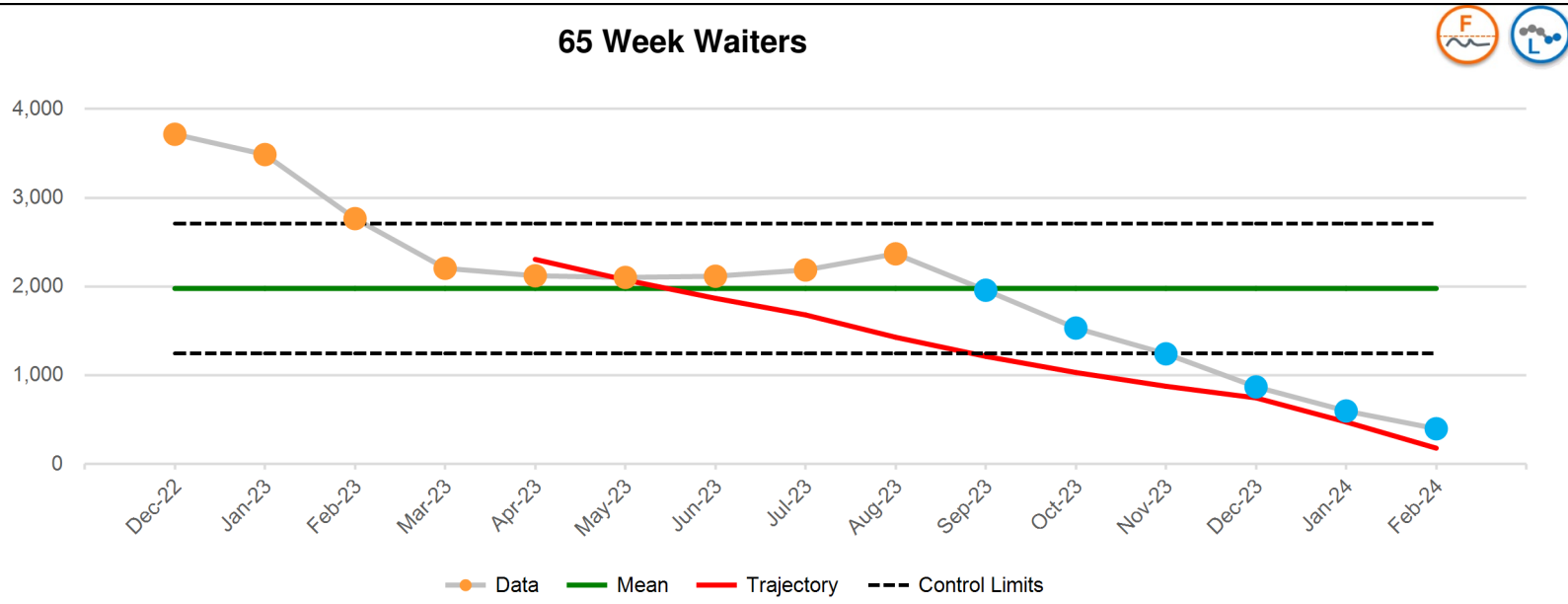
What the chart tells us:
The Trust reported 2,768 incomplete 52-week breaches for February 2024, a decrease of 347 from January's 3,115.

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

Actions:
The Integrated Elective Care Co-Ordination Programme continues to be used for admitted patients, providing an increased efficiency of the 642 process.
Additional resource from the system Planned Care team has been put into ENT and MaxFax from January to support man-marking of all long-waiting patients.

Mitigations:
ULHT remain in Tier 2 of the national tiering system for elective recovery however the position is improving. ENT remains the specialty under greatest pressure.
ULHT position has improved; current data (March 24) ranks ULHT 2nd for this metric within the Midlands region (11 Providers).

Performance Overview - Operational Performance



Feb-24
399
Variance Type
Special cause variation - improvement (Indicator where low is good)
Trajectory
180
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.

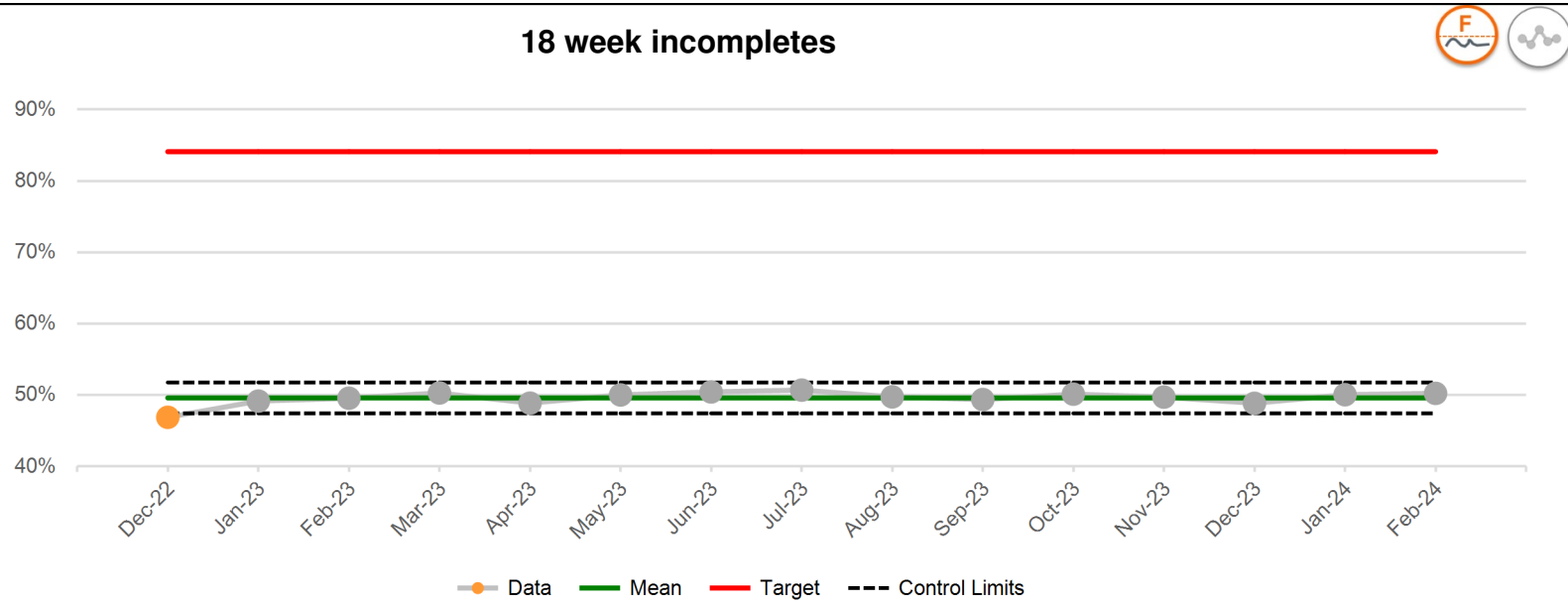
What the chart tells us:
The Trust reported 399 incomplete 65-week breaches for February 2024, a decrease of 200 from January's 599.

Issues:
ULHT's 104 week wait position was zero for February.
As shown above, 65 week waiters are continuing to reduce.

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

Mitigations:
ORIG supports delivery of Outpatient improvements for the non-admitted pathways. To ensure Outpatient capacity is fully utilised and efficiency schemes are implemented and well used.
Current data (March 24) ranks ULHT 2nd for this metric within the Midlands region (11 Providers).

Performance Overview - Operational Performance



Feb-24
50.24%
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. February 2024 saw RTT performance of 50.24% against an 84.1% target, which is 0.19% up from January.

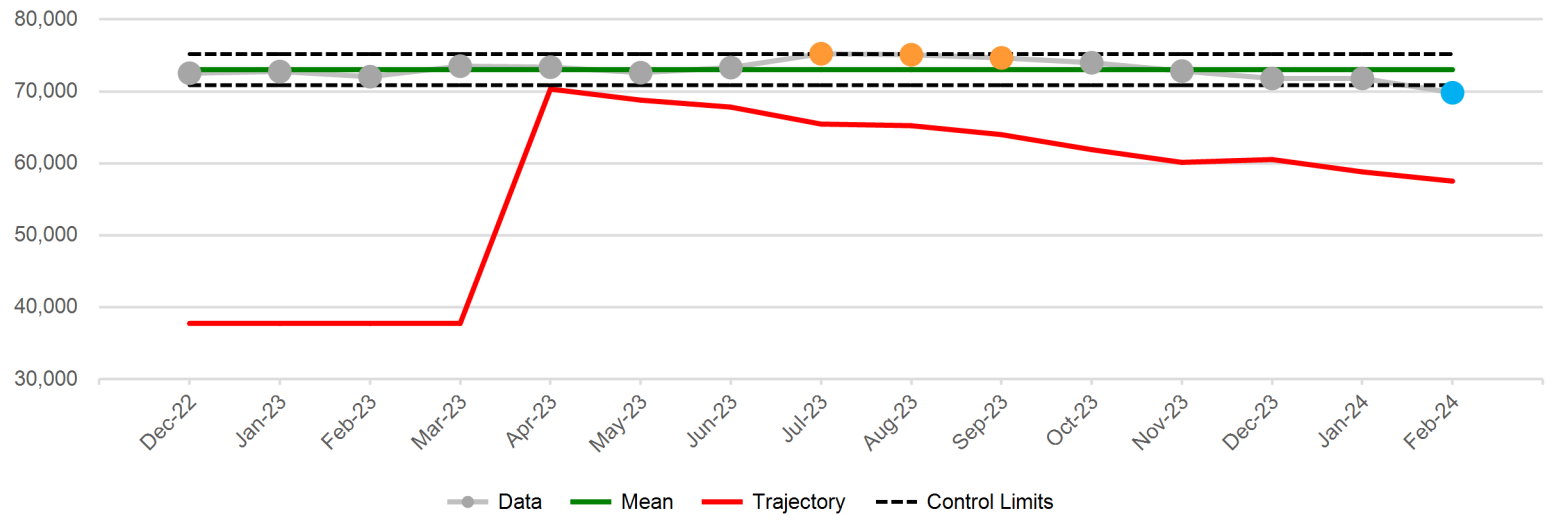
Issues:
Performance is currently below trajectory and standard. The five specialties with the highest number of 18 week breaches at the end of the month were:
ENT – 6186 (decreased by 156)
Gastroenterology – 3139 (increased by 93)
Gynaecology – 2844 (increased by 32)
Ophthalmology – 2214 (decreased by 192)
Maxillo-Facial Surgery + Ortho – 2072 (decreased by 92).

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 March. 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



Feb-24
69,818
Variance Type
Special cause variation - improvement (Indicator where low is good)
Trajectory
57,537
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 January, with February showing a decrease of 1,992 to 69,818.
This is more than double the pre-pandemic level reported in January 2020.

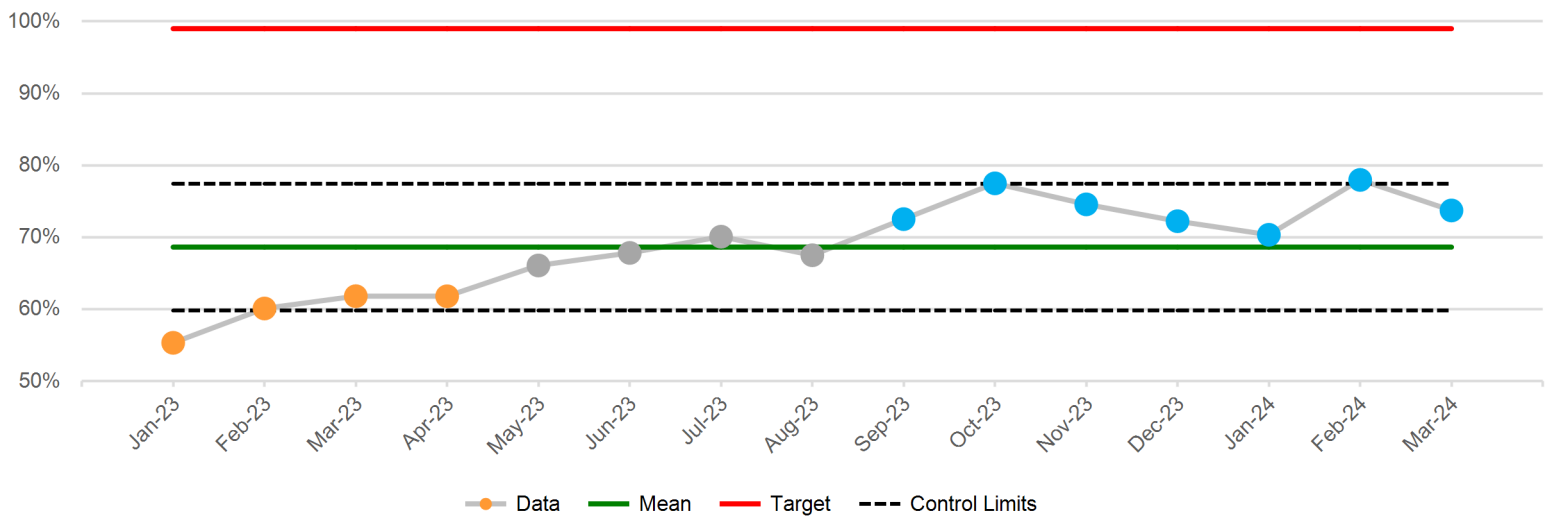
Issues:
Following the backlog increase from the pandemic, there have been additional pressures that have affected capacity, including; industrial action and urgent care pressures
The five specialties with the largest waiting lists are;
ENT – 9,958
Ophthalmology – 5,921
Gastroenterology – 5,455
Gynaecology – 5,415
Dermatology – 4,215

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

Mitigations:
The number of patients waiting over 78 weeks has shown a decrease of 11 from January. Current data (March 24) ranks ULHT 2nd for this metric within the Midlands region (11 Providers)
Appropriate admitted and non-admitted patients continue to be transferred out to ISP's or insourced, with an established process for this in place for several specialties.

Performance Overview - Operational Performance

Diagnostics achieved



Mar-24
73.74%
Variance Type
Special cause variation - improvement (Indicator where high is good)
Target
99.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
Diagnostics achieved in under 6 weeks.

What the chart tells us:
DM01 March 2024 73.74% against the 99.00% target amended target 85% by May 2024.

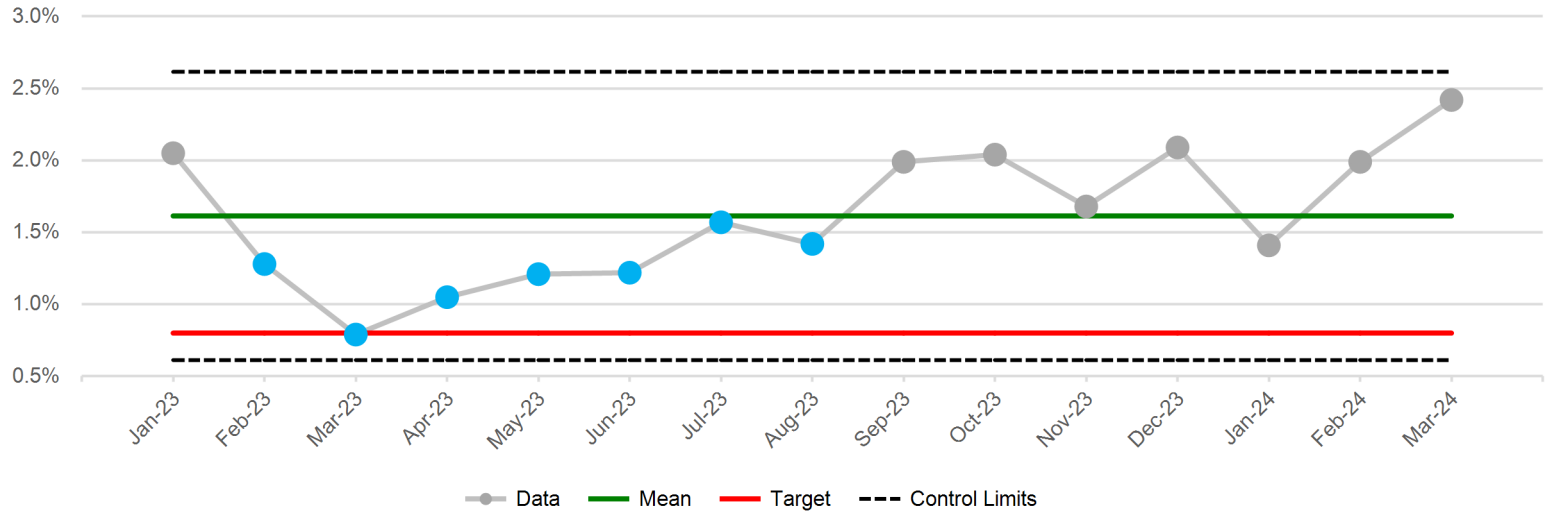
Issues:
An decrease in performance The majority of diagnostic breaches sit in ultrasound /MRI .
Ultrasound has 7 member of staff off sick and has a massive impact on capacity.
Audiology breaches has increased due to the increase in ENT clinics to reduce the 78-week waiters additional ENT Clinics have shown to produce 200 additional referrals a month
Cysto and urodynamics are not reporting the data correctly so we think there will be an increase in waiting list and breaches next month after they deep dive into their systems.
Dexa has experienced significant sickness and vacancies. In the process of reprofiling staffing and training. GDH CDC DEXA will be online from April 2024 to provide additional capacity, delayed to failed installation. Recovery trajectory submitted.

Actions:
• 1.4 WTE locums have started last week.
• RTW planned for LTS at the end of April.
• Connect with external provider for support.
• Additional MRI CDC capacity from end of December 23 Skegness and LCH, 2nd inhouse scanner should be operational by July2024, Skegness CDC mobile scanner funding and additional 5 days a Month from March 2024.

Mitigations:
Patients are being seen in clinical priority.

Performance Overview - Operational Performance

Cancelled Operations on the day (non clinical)



Mar-24
2.42%
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 an increase in the number of non-clinical cancellations on the day for March to 2.42%, this remains significantly above the agreed target of 0.8%.

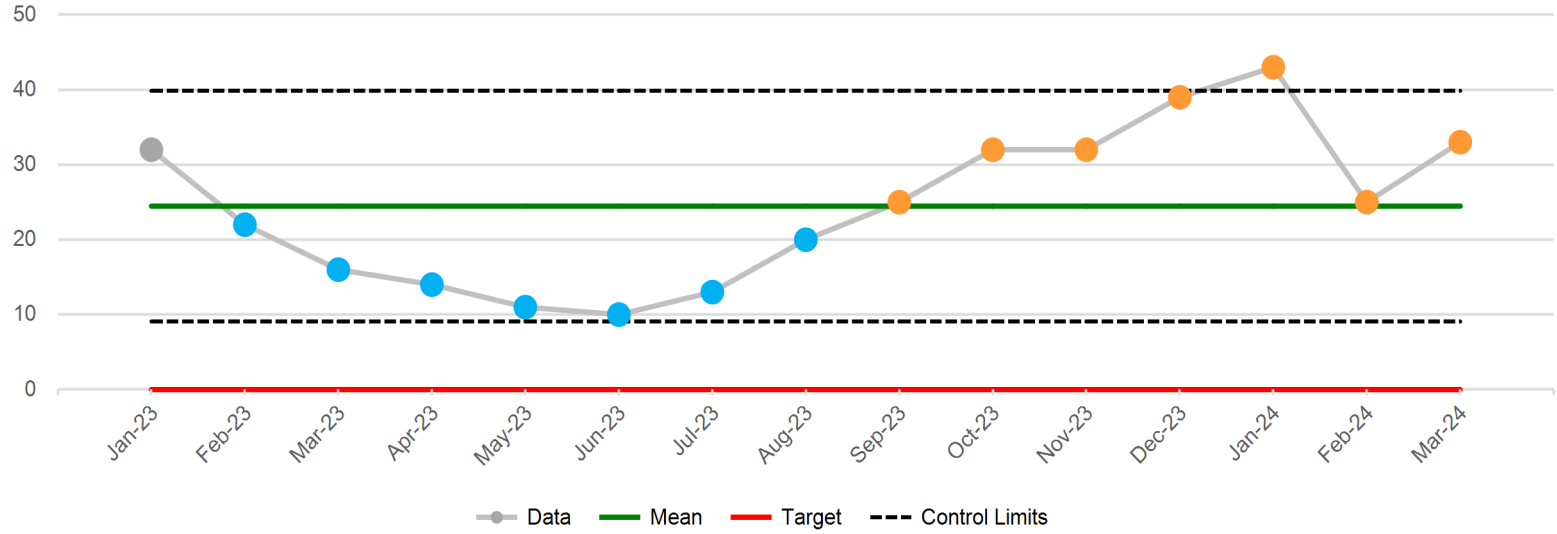
Issues:
-No Surgeon (20)
-No Theatre Staff (15)
-Lack of time (12)
-No Level 2 Beds (9)
-No Anaesthetist (4)
-Admission Moved Back (3)
-More Urgent Case (2)
-No Equipment (2)
-No General Beds (2)
-No Patient Notes (2)
-Admin Error (1)

Actions:
The COTD SOP is under review and will be recirculated this month.
There is now good engagement from CBUs and renewed focus on the reasons for COTD.
Data is presented and discussed monthly at CBU PRM.
There is now a 2pm check-in with Theatres to monitor flow in addition to the daily TACC meeting and ongoing TACC Teams chat.

Mitigations:
-Sickness was a factor in relation to cases cancelled due to no Theatre staff and no surgeon.
-ICU was over capacity throughout the month due to acute admissions. This was a regional issue.
-2 of the cases cancelled due to no anaesthetist were because the anaesthetist was called to an emergency.

Performance Overview - Operational Performance

Not treated within 28 days. (Breach)



Mar-24
33
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:
This chart shows the number of breaches where patients have not been treated within 28 days of a last-minute cancellation. This is a requirement for same day cancellations.

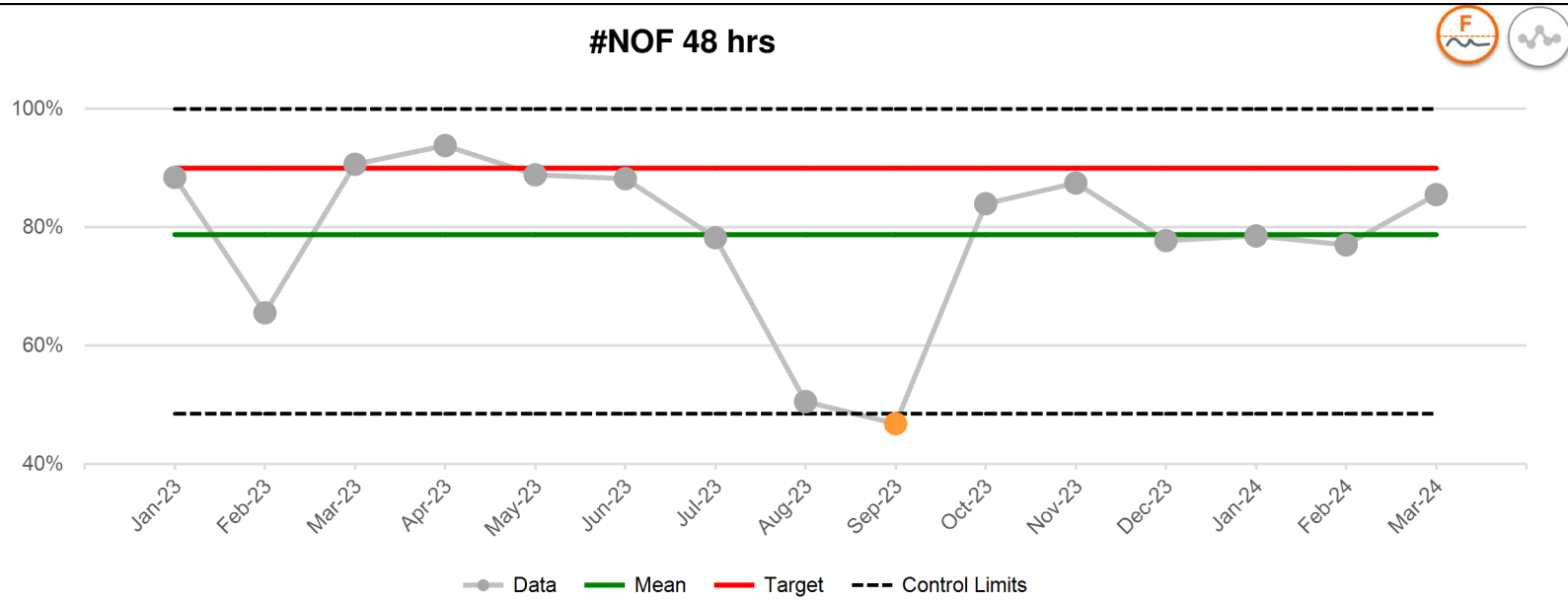
What the chart tells us:
The figures have increased to 33 in March, therefore the agreed target of zero has still not been achieved.

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

Actions:
Pre-Op clinic capacity has been improved with the latest service restructure.
Emphasis on ensuring cancellation forms are completed on the day of cancellation.

Mitigations:
Sickness and staff shortages in the Waiting List Team have been a factor.
Cross-cover has been facilitated by the Waiting List Co-ordinator to mitigate the impact of this.

Performance Overview - Operational Performance



Mar-24
85.54%
Variance Type
Common cause variation
Target
90.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
The average percentage across both sites for March was 85>54%.

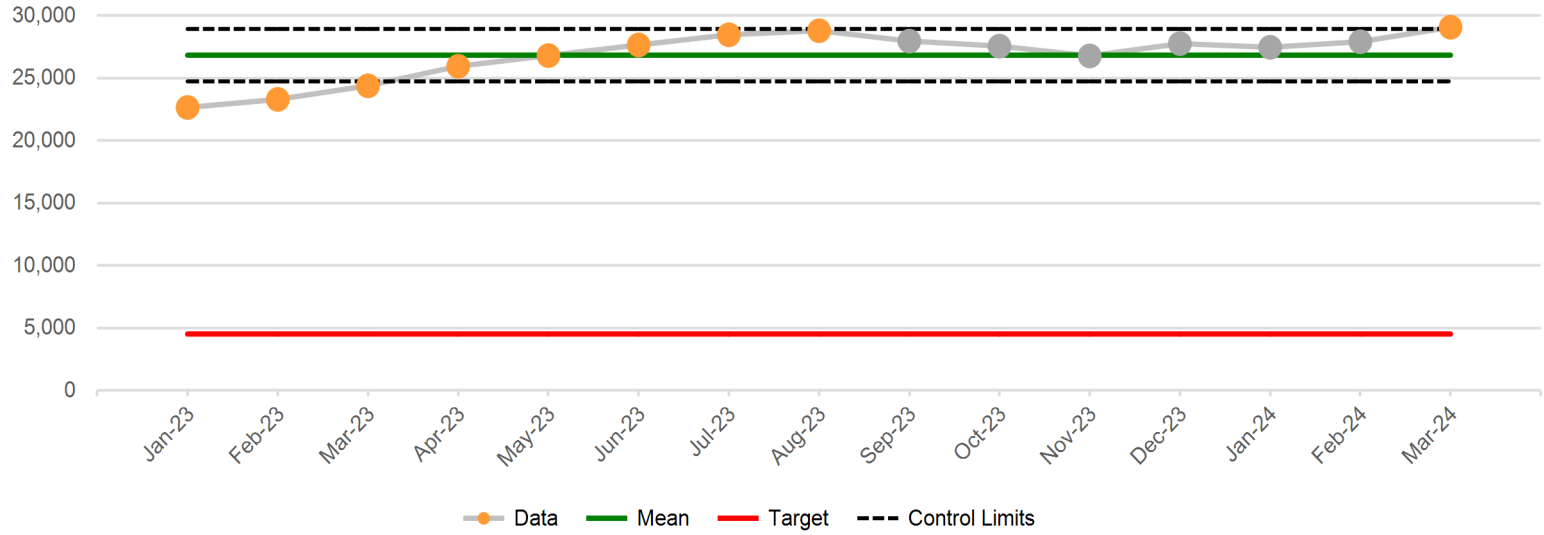
Issues:
- Lack of theatre space to accommodate Femur fractures.
- ULHT continue to have a high demand of trauma patients admitted with one trauma list planned daily on both sites.
- Specialty trauma lists on Boston and Lincoln sites not having capacity for trauma patients.
- Lack of theatre staff to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

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



Mar-24
29,086
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:
Currently at 29,086 against a target of 4,524. During Covid the number of patients overdue significantly increased with a slight dip in Nov 22, since when it continuously increased. We saw a steady reduction from Sept 23, increase to Dec 23, reduced in Jan 24 and has continued to increase since Feb 24.

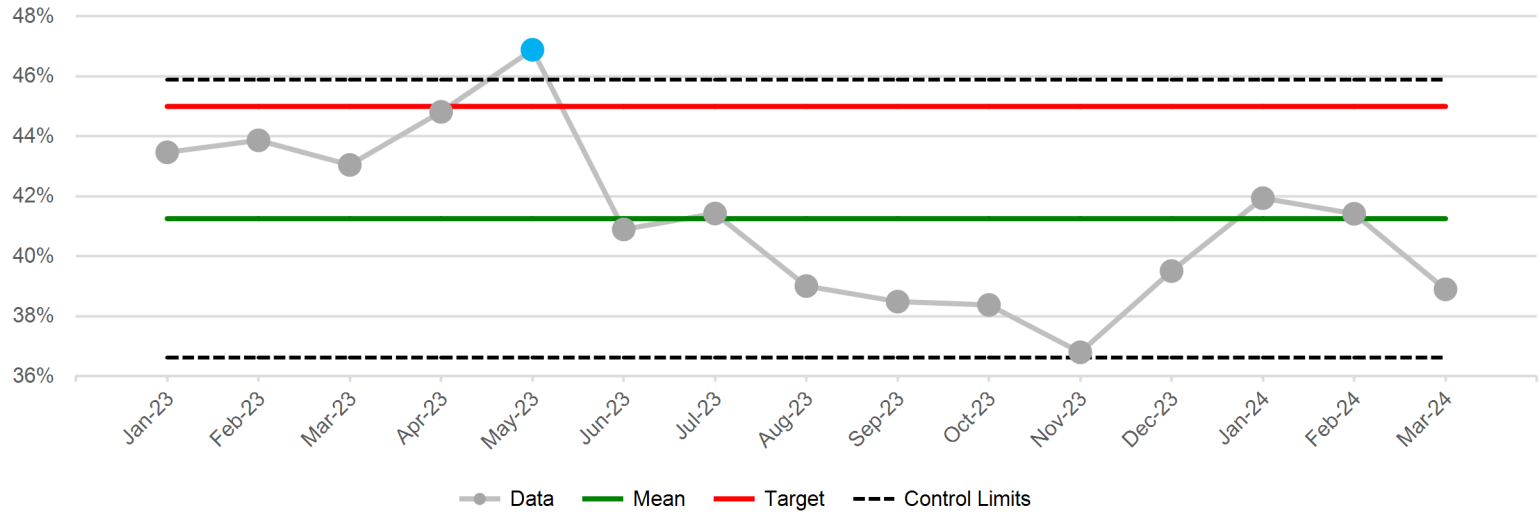
Issues:
The organisation has a number of competing priorities. The current focus is on the 78 and 65 week patients, and potential cancer patients. The current PBWL demand outweighs the current capacity which is being impacted by available capacity, rooms and resources.

Actions:
Regular Outpatient Waiting Lists (OWL) meeting with the CBU's includes agenda and template to improve attendance and focus. Discussions continue with CBU's regarding reducing F/ups by 25%. PIFU continues to be an area of focus and uptake has increased. 642 process currently under review to improve capacity and vacant slots. Clinic Scheduler x1 starts 09/04,
digital room booking system in procurement to improve utilisation.

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

Performance Overview - Operational Performance

% discharged within 24hrs of PDD



Mar-24
38.90%
Variance Type
Common cause variation
Target
45.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
% discharged within 24 hrs of PDD.

What the chart tells us:
There has been a steep decline in performance achieving 38.90% against the 45% KPI and returning to August 2023 level.

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

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

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

Performance Overview - Operational Performance

28 days faster diagnosis

Feb-24
74.56%
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.

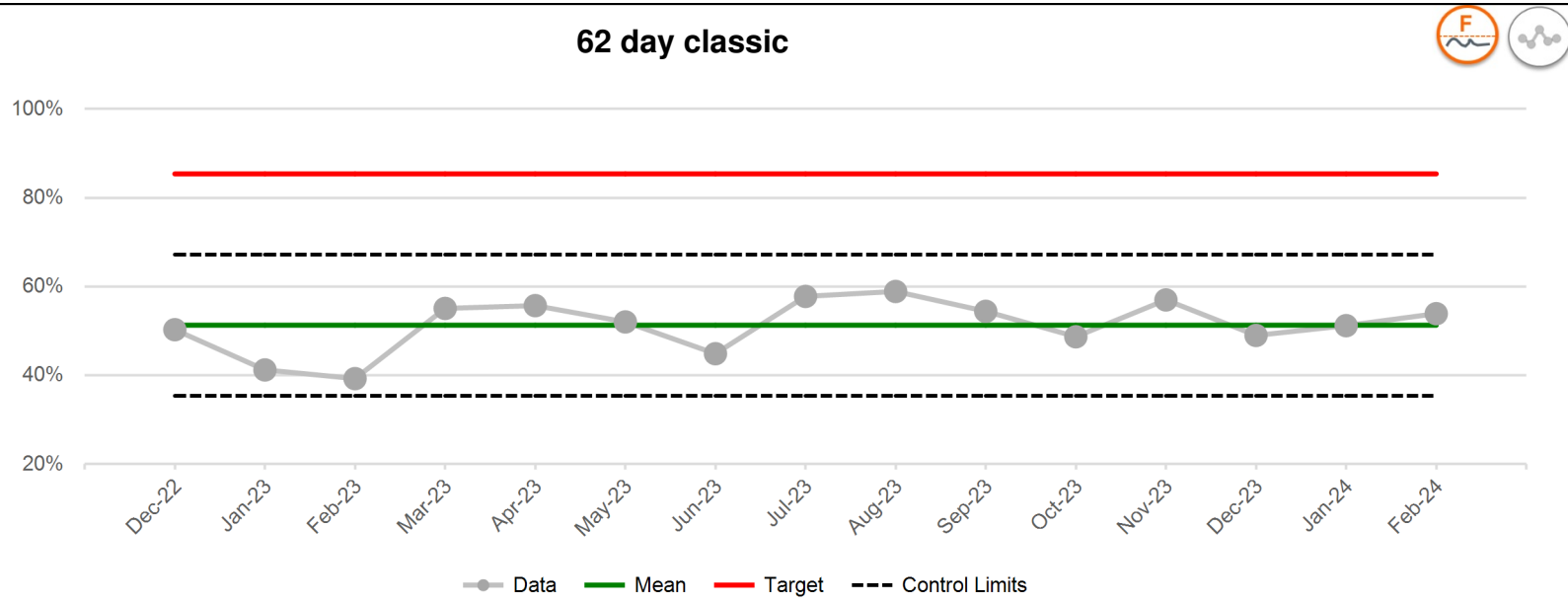
What the chart tells us:
We are currently at 74.56% against a 75% target.

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

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

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

Performance Overview - Operational Performance



Feb-24
53.90%
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 combined.

What the chart tells us:
We are currently at 53.9% against a 85.4% target.

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

Please also see Issues on accompanying pages.

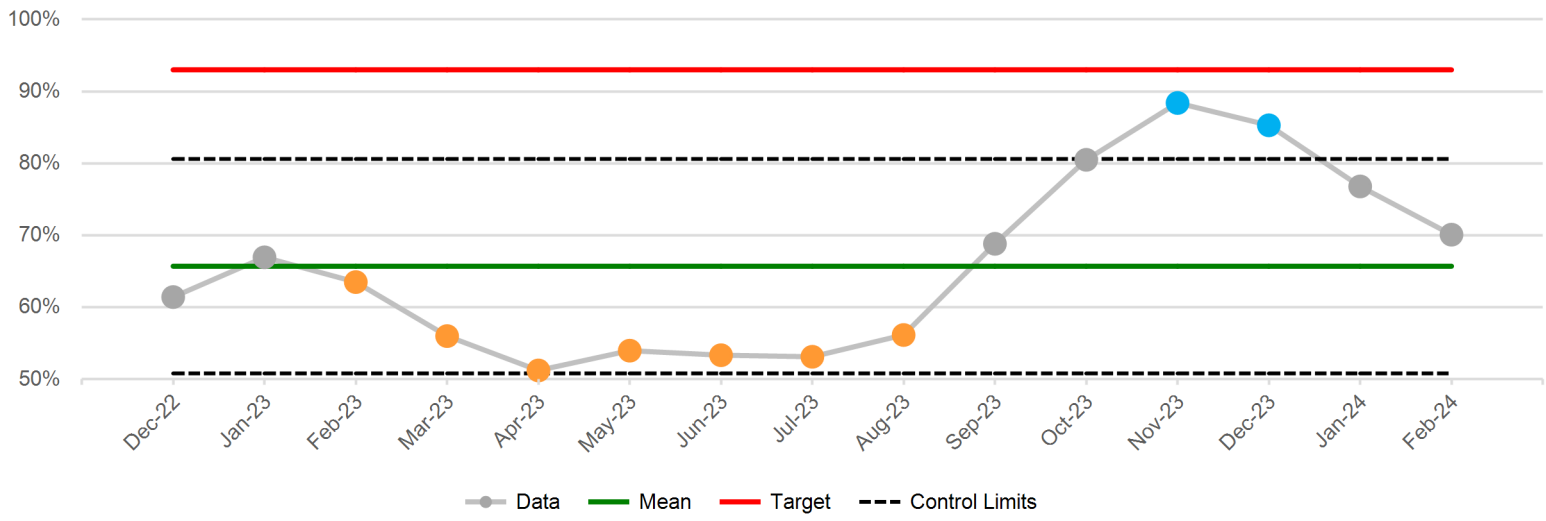
Actions:
Oncology Fragile Service – A piece of work on right-sizing the Oncology service workforce has commenced.
Robotic Lists are progressing well, though proving difficult to populate at short notice if there are cancellations due to the lack of trained staff within theatres, pre-op and anaesthetics. Tumour site specialties are working with TACC to ensure the best possible utilisation of lists, including a process for last minute cancellations.
Skin – Consultant and CNS long term sickness in Dermatology will impact surgical capacity, particularly at PH.
Performance – Intensive Support Meetings continue to take place twice weekly to understand and resolve the themes and issues in 62 day performance in a number of tumour site specialties. Deep Dives are being undertaken by each CBU to understand how diagnostic turnaround times for positive cancers can be improved as this will be key to achieving the NHSE target of 70% by March '24..

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



Feb-24
70.10%
Variance Type
Common cause variation
Target
93.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 70.1% against a 93.0% target.

Issues:
Patients not willing to travel to where our service and/or capacity is available.
The Trust's 14-day performance remains affected by the ongoing alignment issues in Breast Service One-Stop appointments, with 25% of the Trust's breaches in February occurring within that specific tumour site. Additionally, Skin tumour site accounted for 56% of the Trust's 14-day breaches, this is the impact from the previously mentioned consultant sickness.

Actions:
The Radiology Recruitment Strategy and intensive support meetings are in place to address the fragile Breast Service One-Stop appointment alignment issues. Respiratory Consultant capacity is ongoing as well as the BC for an increase in consultant workforce to 10-15 consultants. 2 x Lung Cancer CNS posts (funding until March 25) for risk stratification to reduce unnecessary CT scans demand on consultant triage are now established. The Lung Rapid Access pathway will now include CT referrals to accurately reflect performance. An approved BC for additional admin support is undergoing recruitment.
Recruitment processes for the UGI Triage CNS post are currently on hold. ICB EACH are continuing to support with 2ww referrals to reduce delays from receipt of referral to STT booking.
Processes – SOPs relating to DNAs & multiple cancellations are currently being taken through CBU Governance processes for approval.
Please also see Actions on accompanying pages.

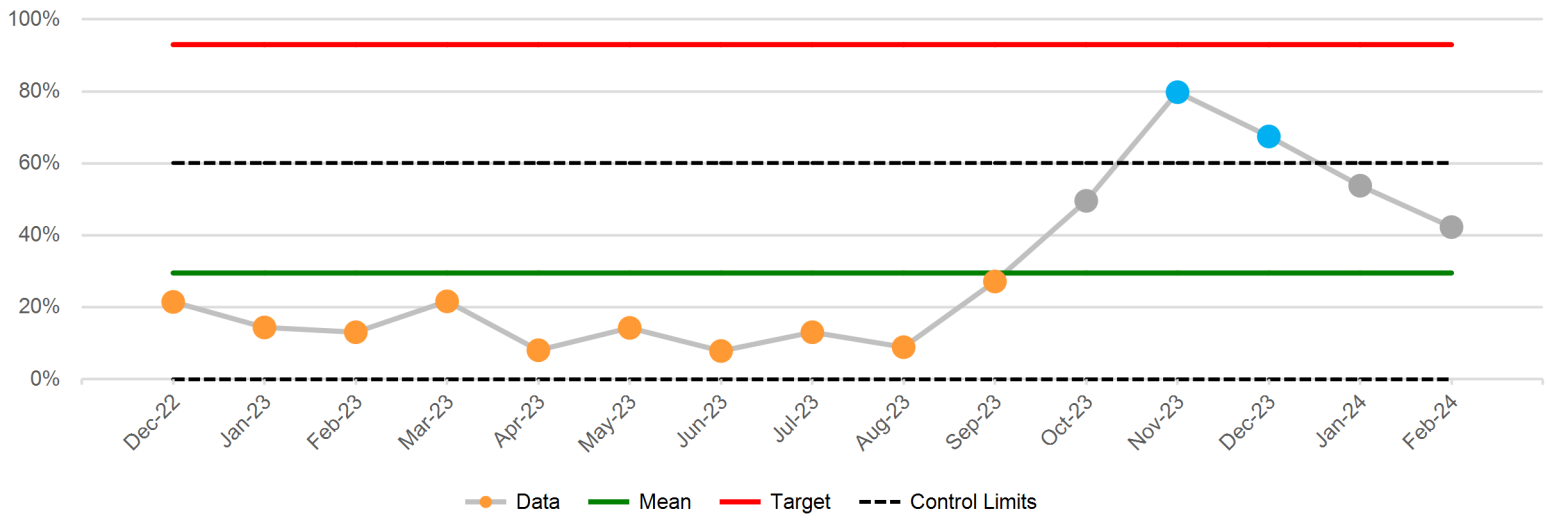
Mitigations:
Haematology is in fragile services due to vacancy/capacity. Issues with inappropriate referrals and GP engagement continue to be escalated and supported by the ICB. Delays in the booking and utilisation of appointment slots which continue to be addressed with C&A.
In Gynae, the urgent PMB pathway progress and impact is being monitored. An HRT programme of work is underway with support from ICB colleagues.

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.

Please also see Mitigations on accompanying pages.

Performance Overview - Operational Performance

2 week wait breast symptomatic



Feb-24
42.30%
Variance Type
Common cause variation
Target
93.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 42.3% against a 93.0% target.

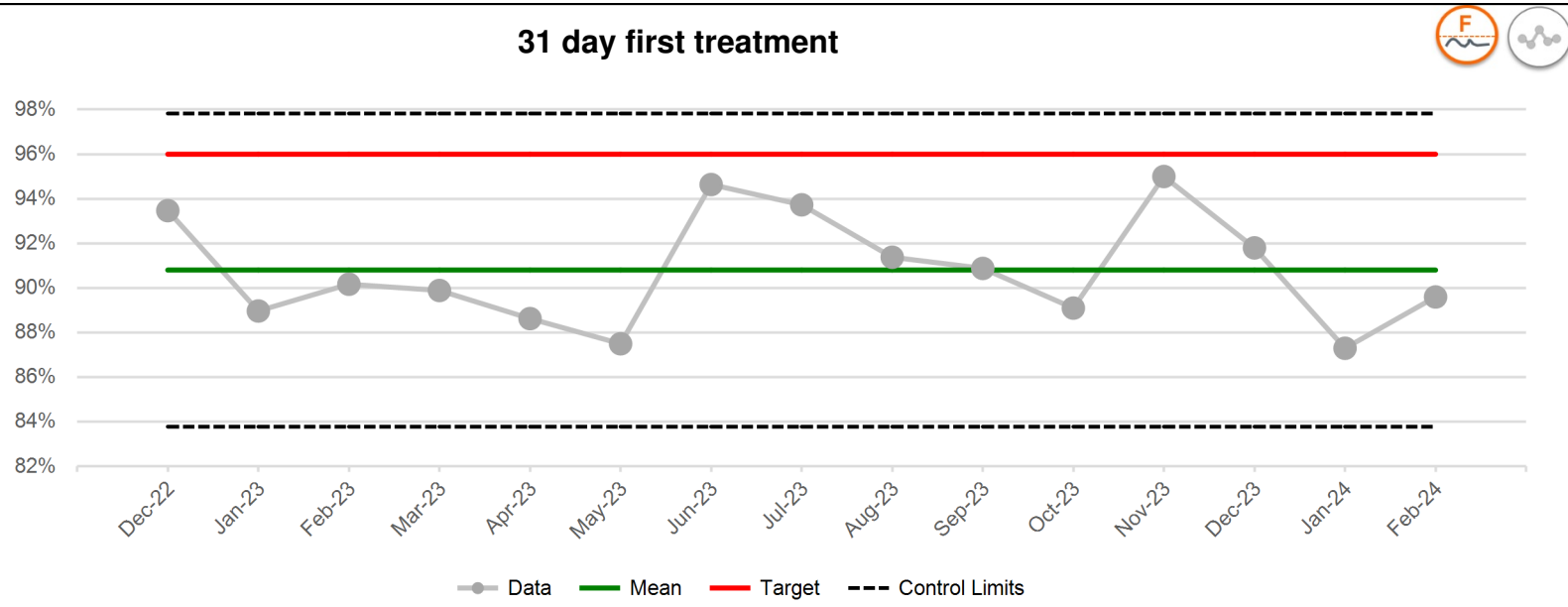
Issues:
The 14 Day Breast Symptomatic has been affected by the same impact of the Breast Service One-Stop appointment alignment issues.

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



Feb-24
89.60%
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 89.6% against a 96.0% 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 - A piece of work on right-sizing the Oncology service workforce has commenced.
OMF Capacity issues continue to impact both Head and Neck and particularly Skin pathway performance – escalated as a risk.

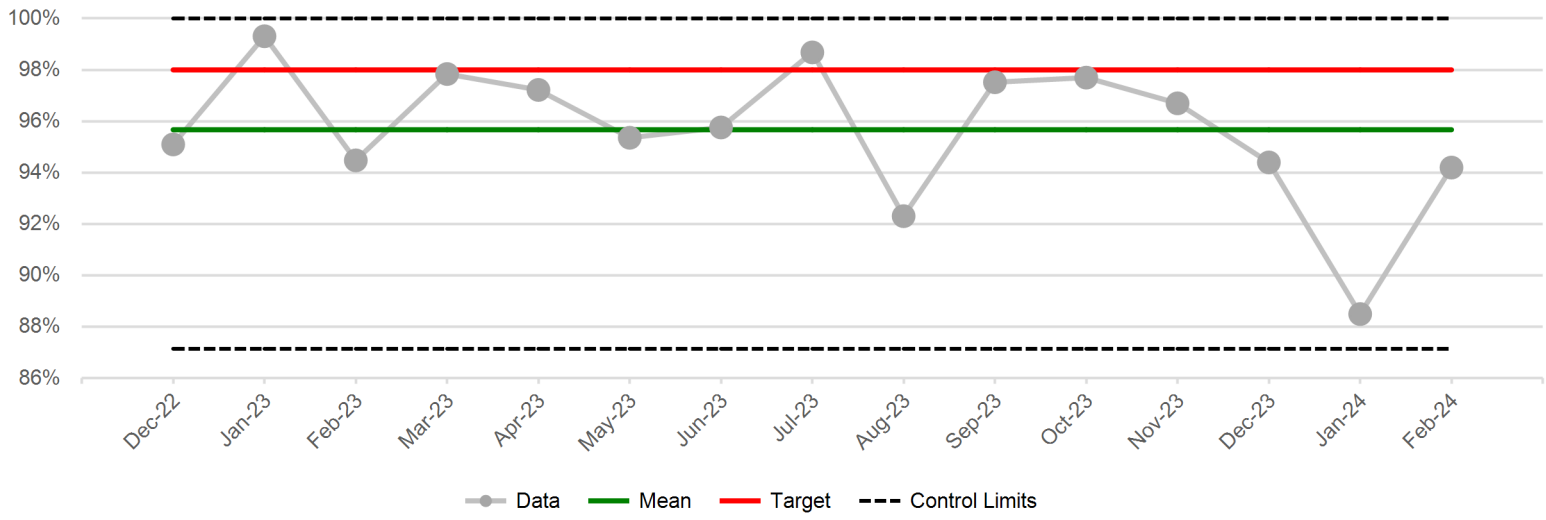
Mitigations:
Robotic Lists are progressing well, though proving difficult to populate at short notice if there are cancellations due to pre-op and anaesthetic assessment capacity. Tumour site specialties are working with TACC to ensure the best possible utilisation of lists, including a process for last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

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Hospitals NHS Trust

31 day subsequent drug treatments



Feb-24
94.20%
Variance Type
Common cause variation
Target
98.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

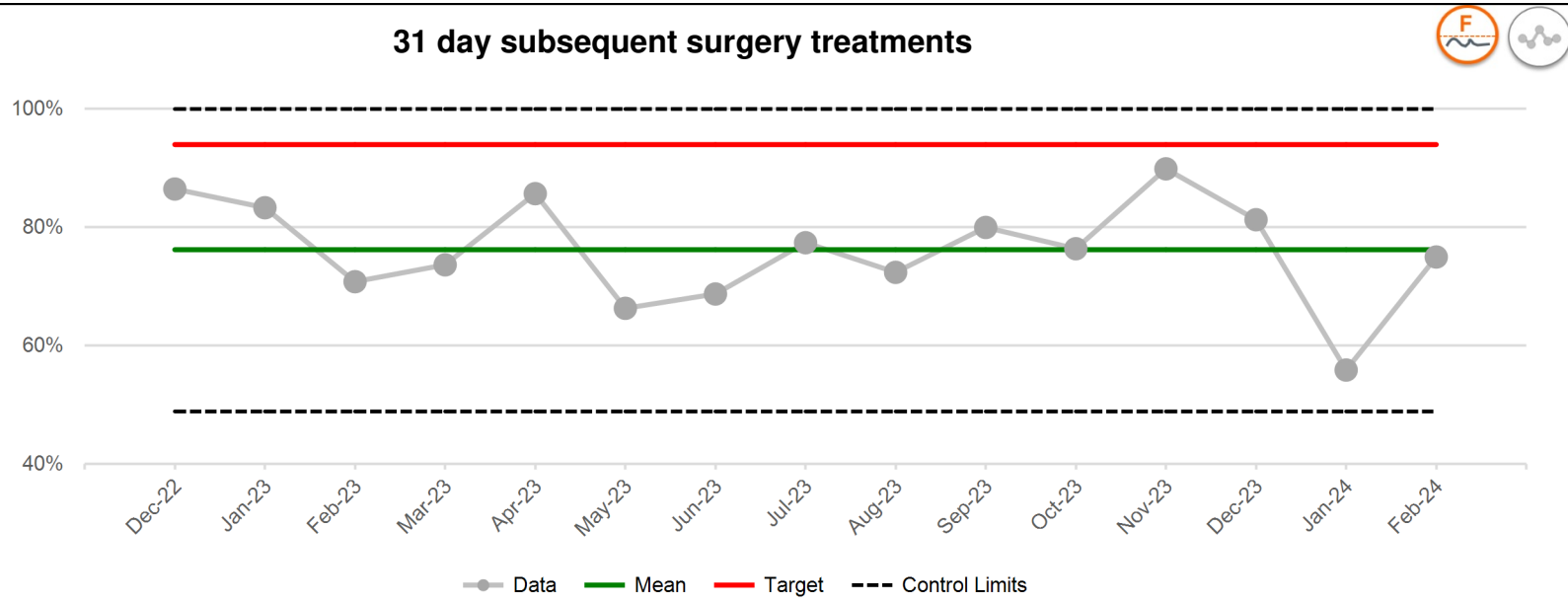
What the chart tells us:
We are currently at 94.2% against a 98.0% target.

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

Actions:
Oncology Fragile Service - A piece of work on right-sizing the Oncology service workforce has commenced.

Mitigations:

Performance Overview - Operational Performance



Feb-24
75.00%
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 75.0% against a 94.0% target.

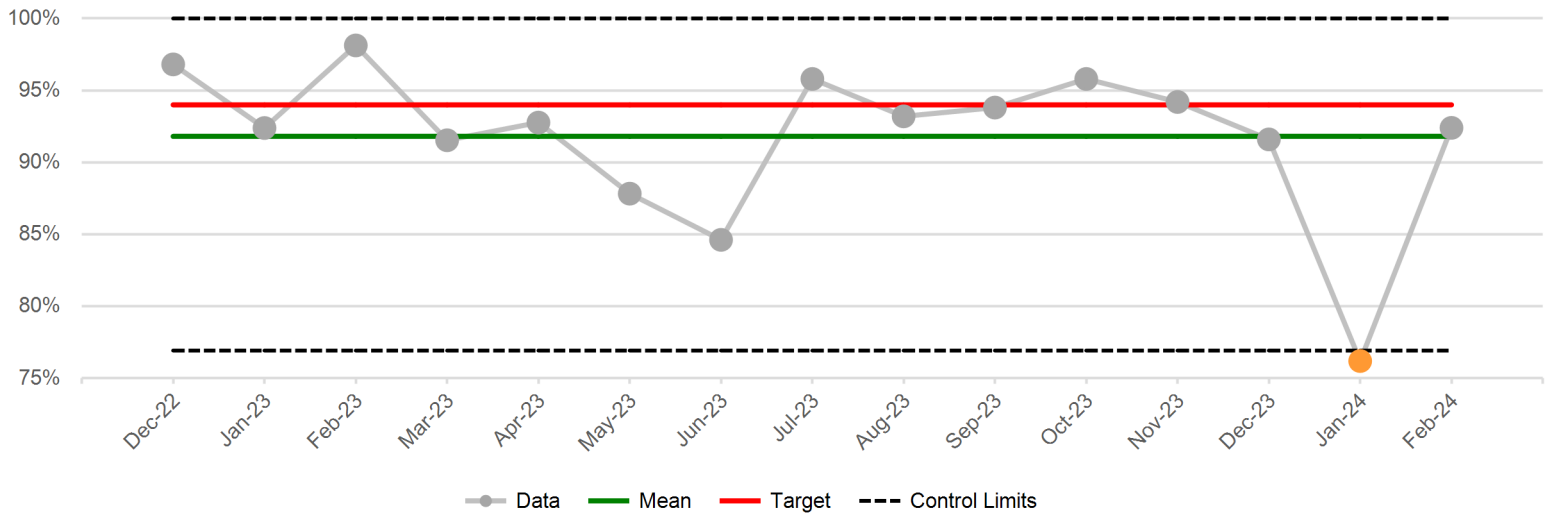
Issues:
The failure of the 31 Day surgery standard was due to limited theatre capacity and limited AA and pre-op capacity impacts the ability to be able to populate lists at short notice.
Colorectal – Current activity complexity is causing delays in allocating surgery dates, e.g. the increase in anterior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

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

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

Performance Overview - Operational Performance

31 day subsequent radiotherapy treatments



Feb-24
92.40%
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 radiotherapy.

What the chart tells us:
We are currently at 92.4% against a 94.0% target.

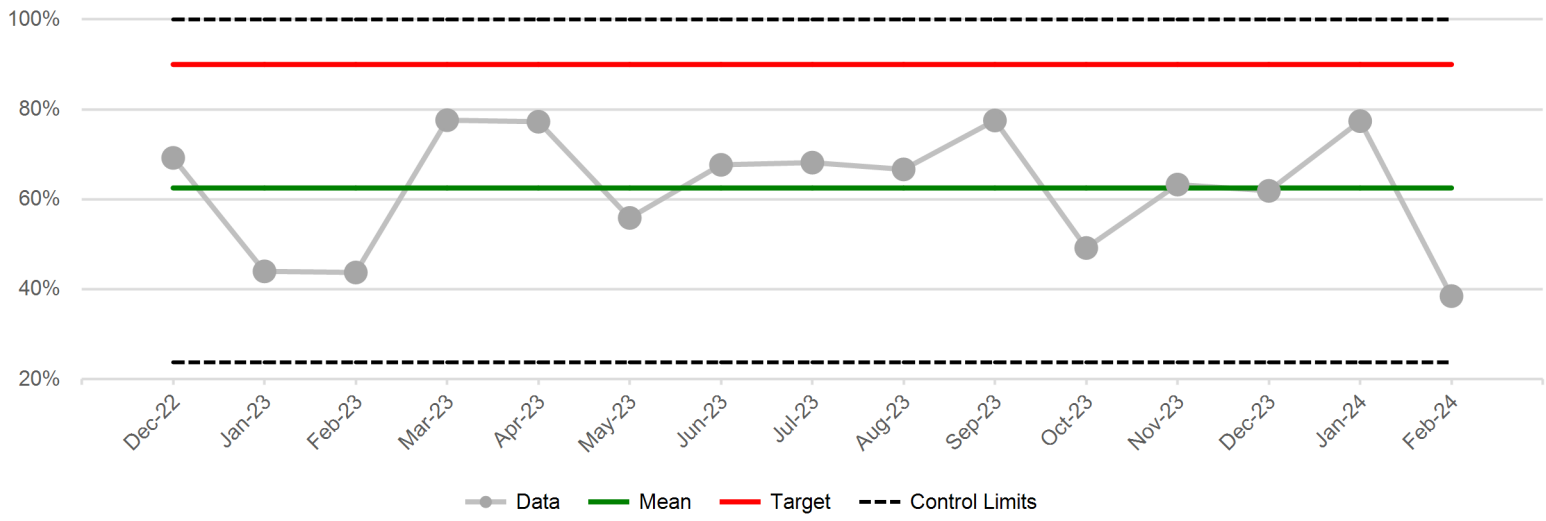
Issues:
Radiotherapy – Recent Linac breakdowns have resulted in delayed treatment start dates.

Actions:
Oncology Fragile Service - A piece of work on right-sizing the Oncology service workforce has commenced.

Mitigations:

Performance Overview - Operational Performance

62 day screening



Feb-24
38.50%
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 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 38.5% against a 90.0% 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.

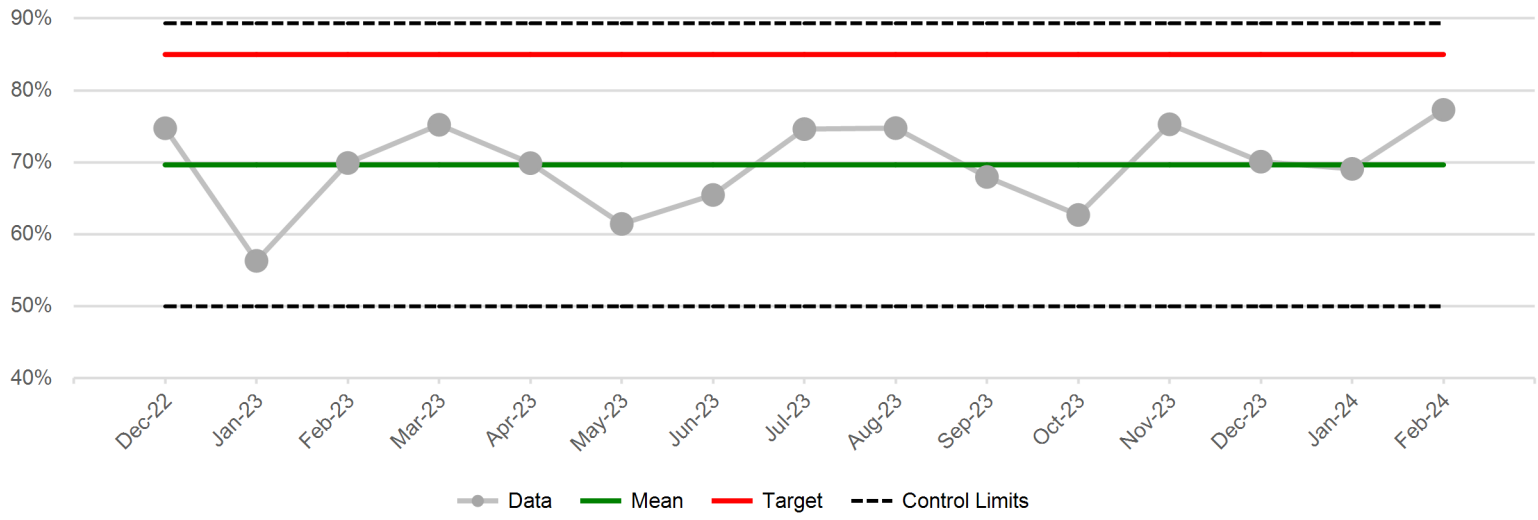
Actions:
Oncology Fragile Service – A piece of work on right-sizing the Oncology service workforce has commenced.
Robotic Lists are progressing well, though proving difficult to populate at short notice if there are cancellations due to the lack of trained staff within theatres, pre-op and anaesthetics. 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



Feb-24
77.30%
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 77.3% against a 85.0% 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.

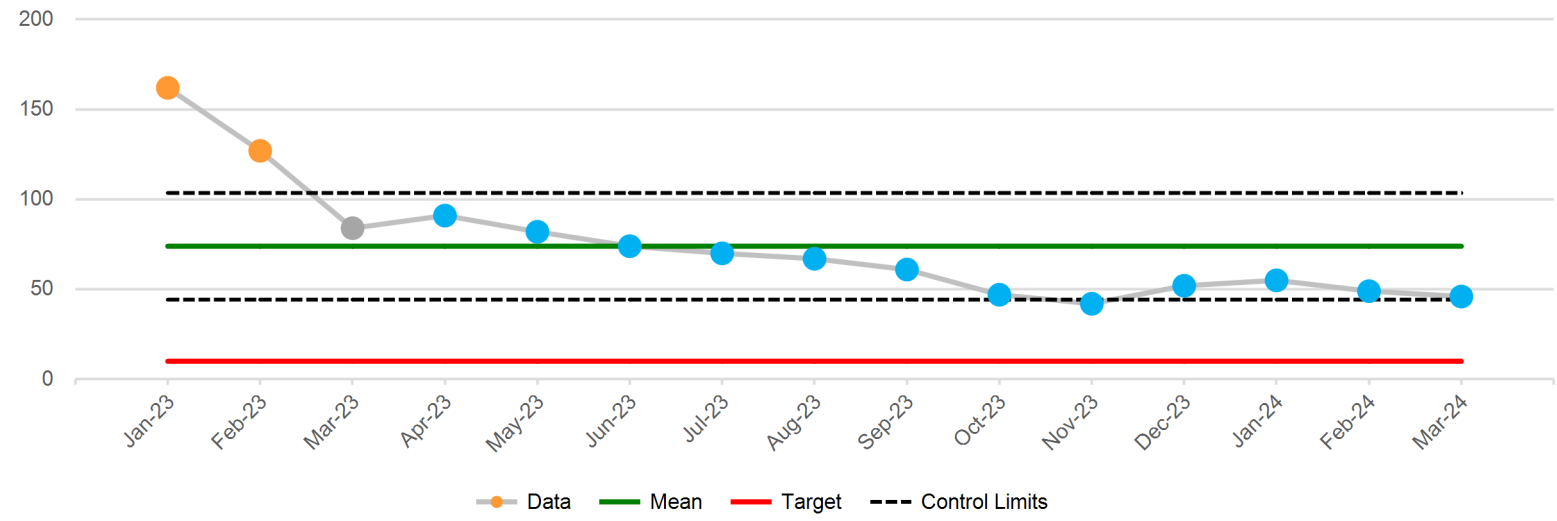
Actions:
Oncology Fragile Service – A piece of work on right-sizing the Oncology service workforce has commenced.
Robotic Lists are progressing well, though proving difficult to populate at short notice if there are cancellations due to the lack of trained staff within theatres, pre-op and anaesthetics. Tumour site specialties are working with TACC to ensure the best possible utilisation of lists, including a process for last minute cancellations.

Please also see Actions on accompanying pages.

Mitigations:
Please also see Mitigations on accompanying pages.

Performance Overview - Operational Performance

104+ Day Waiters



Mar-24
46
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 10th April the 104 Day backlog is at 46 patients.
There is one main tumour site of concern:-

Colorectal 21

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 28% of these patients require support from the Pre-Diagnosis CNS as they have mental or social care needs that have the potential to significantly impact on the length of their pathway.

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

Please also see Actions on accompanying pages.

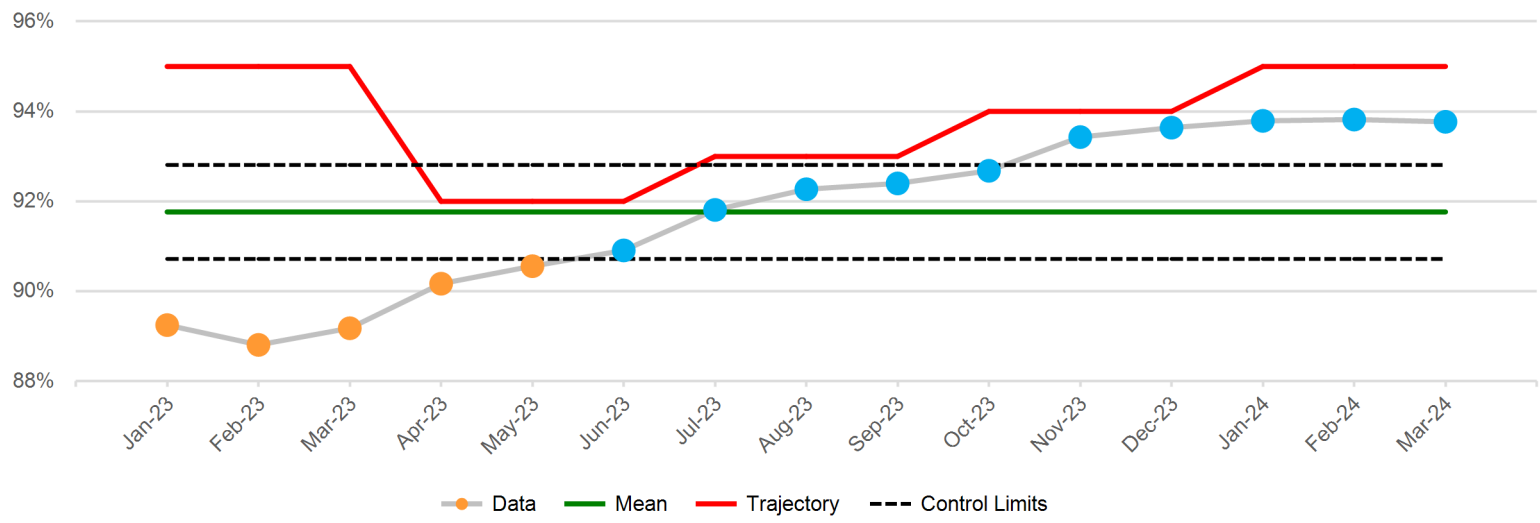
Mitigations:
Please also see Mitigations on accompanying pages.

Performance Overview - Workforce

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Jan-24	Feb-24	Mar-24	YTD	YTD Trajectory	Pass/Fail	Trend Variation
A Modern and Progressive Workforce	Overall percentage of completed mandatory training	Safe	People	Director of HR & OD	95.00%	93.79%	93.82%	93.77%	92.44%	93.50%	F	H
	Number of Vacancies	Well-Led	People	Director of HR & OD	4.00%	6.17%	7.24%	6.76%	8.01%	6.25%	F	
	Sickness Absence	Well-Led	People	Director of HR & OD	4.50%	5.47%	5.46%	5.40%	5.54%	4.83%	F	L
	Staff Turnover	Well-Led	People	Director of HR & OD	12.00%	11.11%	10.82%	10.62%	11.74%	12.50%	P	L
	Staff Appraisals	Well-Led	People	Director of HR & OD	90.00%	71.60%	73.49%	74.24%	71.09%	81.25%	F	H

Performance Overview - Workforce

Overall percentage of completed mandatory training



Mar-24
93.77%
Variance Type
Special cause variation - improvement (Indicator where high is good)
Trajectory
95.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of HR & OD

Background:
Completion is currently 93.77% against a Q4 target of 95.00%.

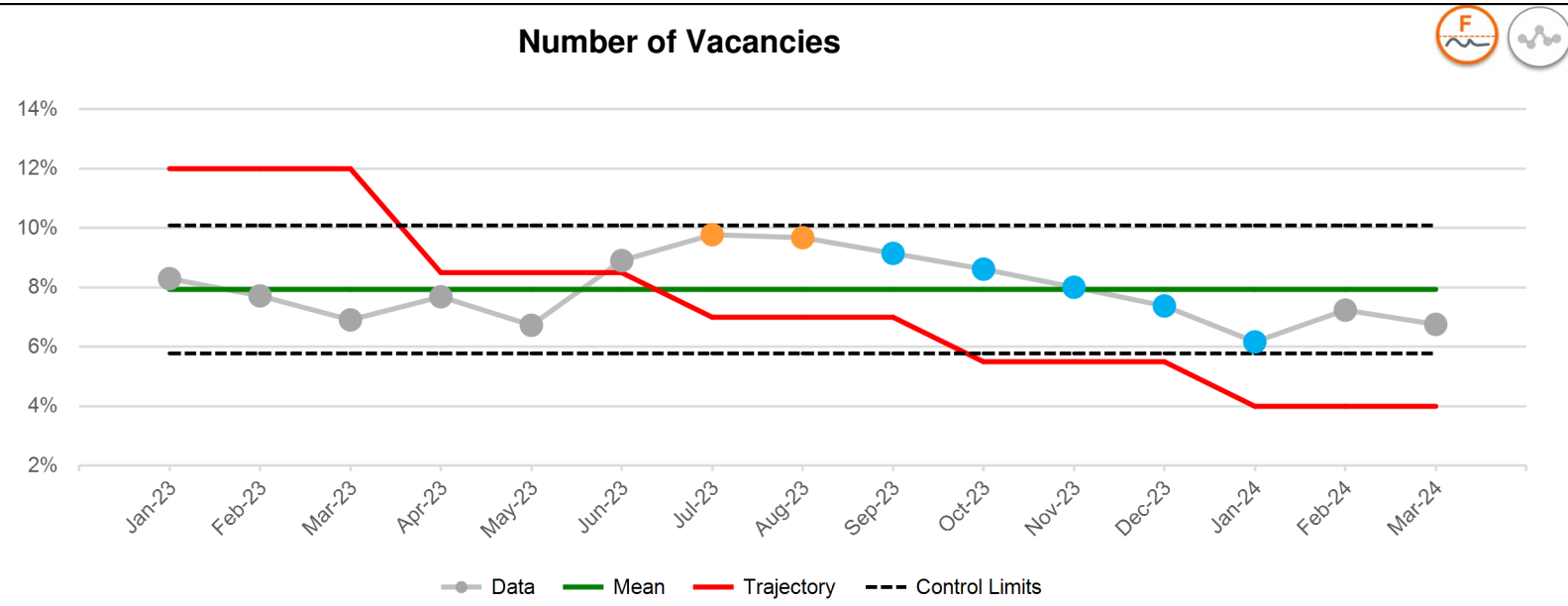
What the chart tells us:
Mandatory training compliance has seen a slight decrease when compared to the previous month's position, although this is minimal and overall remains on an upward trend.

Issues:
- Protected time for core learning continues to be an issue, particularly clinical staff.
- Number of staff starting role without induction is affecting compliance.
- Training profiles being aligned to individual role profiles.

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:
Completion of Improvement Action Plan and targeted work with Divisions will continue to further improve our position as we move into 2024/25.

Performance Overview - Workforce



Mar-24
6.76%
Variance Type
Common cause variation
Trajectory
4.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of HR & OD

Background:
March 2024 reported Vacancy Rate is 6.76% against a Q4 target of 4.00%.

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

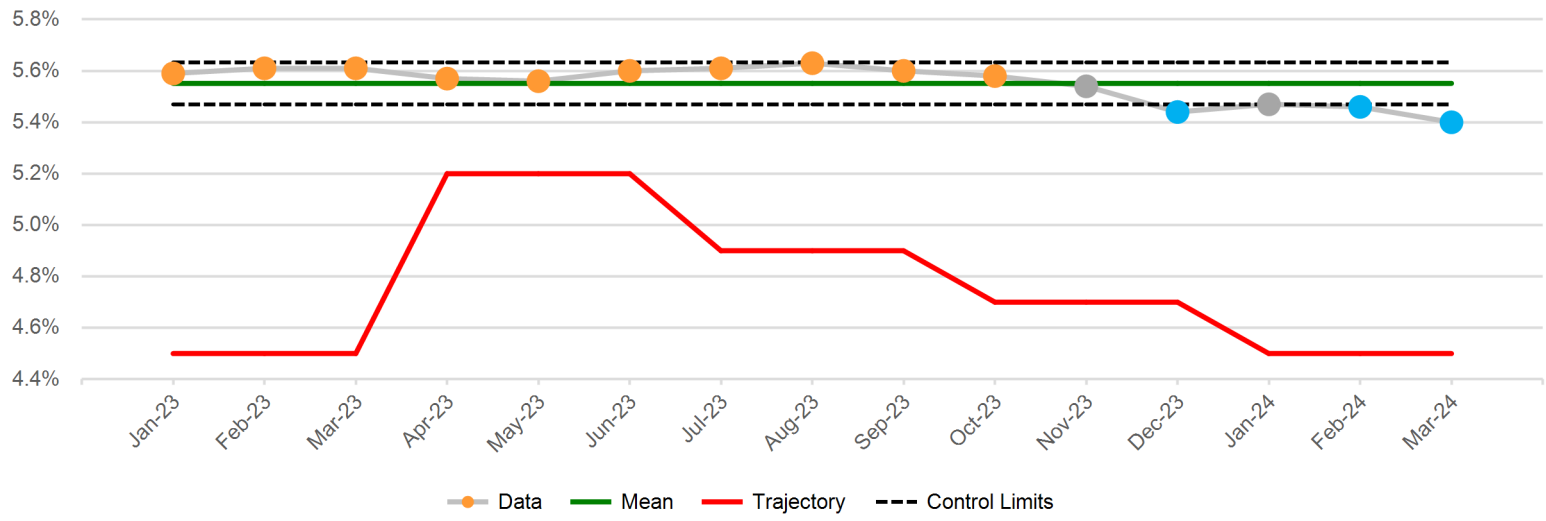
Issues:
- Sizeable business cases have been agreed which have increased our funded establishment.
- AHP recruitment remains a challenge in response to the implementation of Community Diagnostic Centres.

Actions:
- Work is in progress to review our overall establishment with our Divisional Teams as we further develop Workforce Plans in response to the Long Term Workforce Plan.
- Gap analysis being undertaken as part of the planning for 2024/25 to support identification of areas of focus for future.

Mitigations:
- Ongoing work to ensure compliance with Vacancy Rate targets, and to ensure that our establishment levels remain in line with our overall Workforce Plan.
- Our Recruitment Team have supported closing the gap between the Establishment and the number of Staff In Post.

Performance Overview - Workforce

Sickness Absence



Mar-24
5.40%
Variance Type
Special cause variation - improvement (Indicator where low is good)
Trajectory
4.50%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of HR & OD

Background:
5.40% of sickness absence rolling year.

What the chart tells us:
5.40% is above the Q4 target of 4.50%.

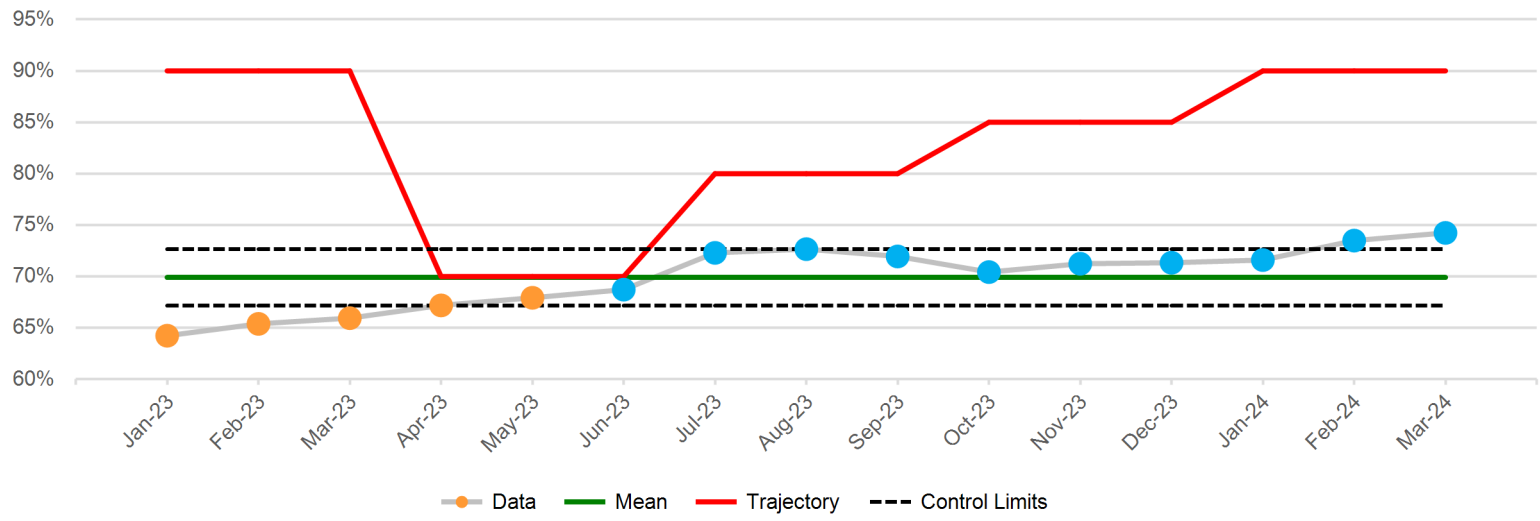
Issues:
- Sickness accounts for >75% of all unplanned absence.
- Consideration to be given to the other reasons that make up the remaining % of unplanned absence.
- AMS compliance remains a challenge.

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



Mar-24
74.24%
Variance Type
Special cause variation - improvement (Indicator where high is good)
Trajectory
90.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of HR & OD

Background:
Completion is currently 74.24% (Trustwide).

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

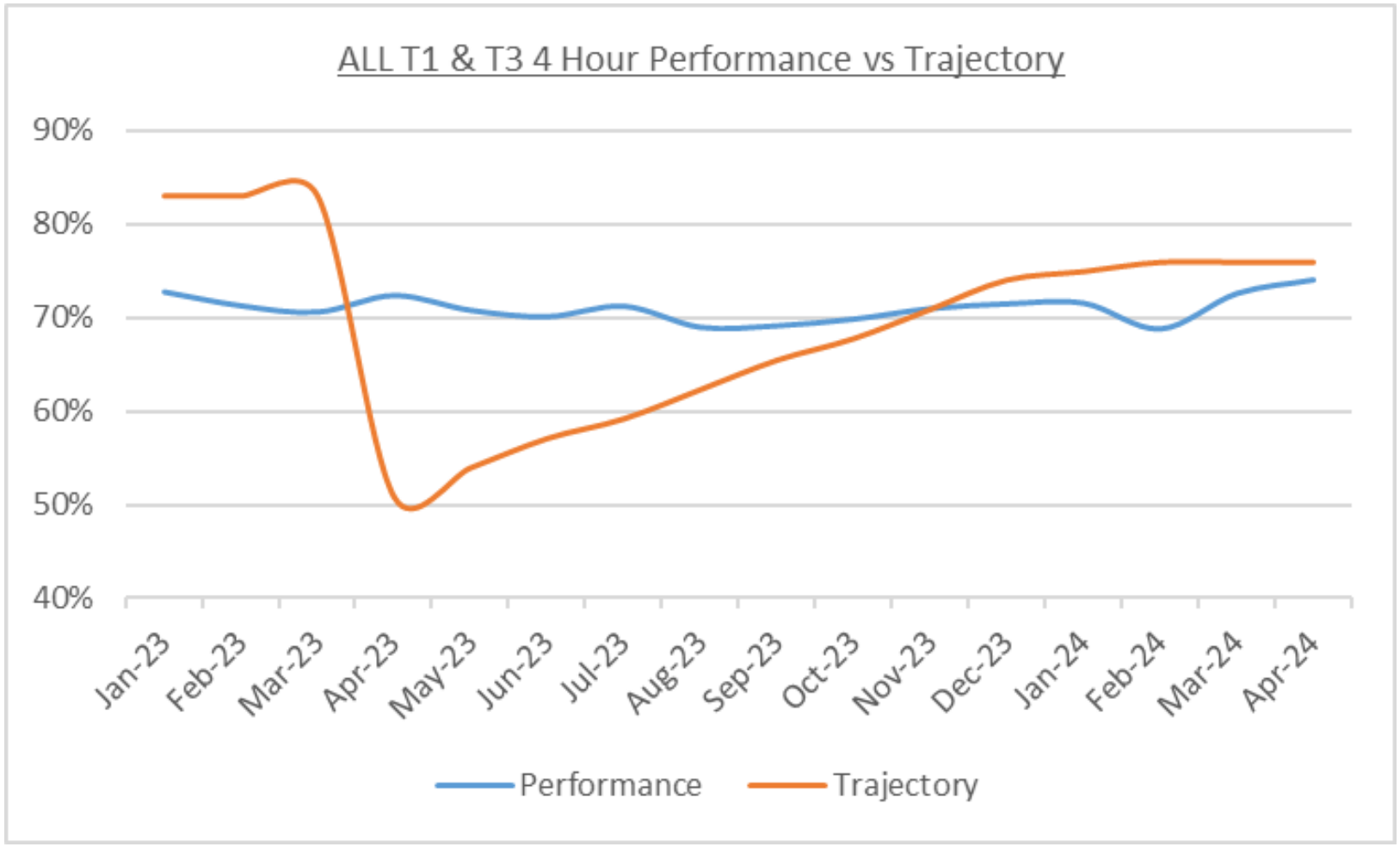
The trend is that this remains on an upward trajectory based on improvements seen to date.

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

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

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

Appendix A - 4hrs or less in A&E Dept



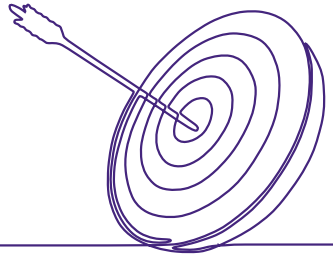
Financial Position Month 12 (2023/24)
Finance Report
5 Year Priority – Efficient Use of Resources

NHS
United Lincolnshire Hospitals
NHS Trust

OUTSTANDING CARE
personally DELIVERED

Financial Position 2023/24

M12 Headlines - System



United Lincolnshire Hospitals NHS Trust

-15.4	Original System Plan
-13.5	H2 Reset
1.5	Additional Funding Received
-27.4	H2 Reset Plan
15.4	Planned Deficit Funding Received
-12.0	Updated H2 Reset Plan

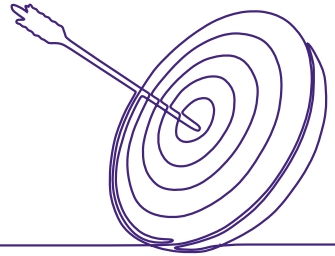
Expected year-end system position following H2 reset

	Expected Position	Actual Outturn	Variance
Lincolnshire ICB	-1.4	-8.9	-7.5
Lincolnshire Community Health Services NHS Trust	1.4	1.4	0.0
Lincolnshire Partnership NHS Foundation Trust	8.8	8.8	0.0
United Lincolnshire Hospitals NHS Trust	-20.8	-20.8	0.0
	-12.0	-19.4	-7.5

Due to non-return of surge funding (assumed in H2 reset)

Financial Position 2023/24

M12 Headlines - ULHT



NHS
United Lincolnshire Hospitals
NHS Trust

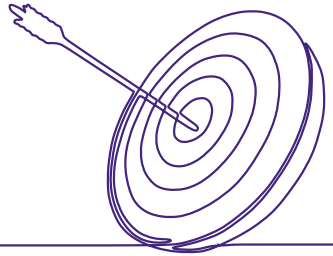
Adjusted financial performance	Current Month			Year to Date		
	Plan £000's	Actual £000's	Variance £000's	Plan £000's	Actual £000's	Variance £000's
Operating Income from patient care activities	67,617	75,423	7,806	722,224	740,456	18,232
Other operating Income	3,499	6,541	3,042	41,436	48,134	6,698
Employee Expenses	(46,804)	(57,540)	(10,736)	(516,362)	(534,287)	(17,925)
Operating expenses excl employee expenses	(26,363)	(33,361)	(6,998)	(262,598)	(275,265)	(12,667)
OPERATING SURPLUS/(DEFICIT)	**(2,051)**	**(8,937)**	**(6,886)**	**(15,300)**	**(20,962)**	**(5,662)**
Net finance costs	(561)	(320)	241	(6,045)	(5,913)	132
Other Gains / Losses	0	(4)	(4)	0	(1,189)	(1,189)
Surplus / (Deficit) for the period	**(2,612)**	**(9,261)**	**(6,649)**	**(21,345)**	**(28,064)**	**(6,719)**
Add back all I&E impairments/(reversals)	0	6,580	6,580	0	6,580	6,580
Remove net impact of consumables donated from other DHSC bodies	0	56	56	0	56	56
Remove capital donations/grants/peppercorn lease I&E impact	0	14	14	567	652	85
Adjusted financial performance surplus / (deficit)	**(2,612)**	**(2,611)**	**1**	**(20,778)**	**(20,776)**	**2**

- **Revenue Position** - The Trust's financial plan for 2023/24 is a revenue deficit of £20.8m; as the table shows, the Trust has met its financial plan.
- This outturn position includes (as per NHSE) recognition of £18.6m of notional income & expenditure for additional employers' pension contributions.
- The outturn position also includes the cost impact of excess inflation and other run-rate increases, which the Trust has been able to contain by over delivery of its FRP, through lower than planned activity levels and from non-recurrent slippage against contract income allocations.

- **CIP position** - The Trust's CIP plan for 2023/24 is to deliver savings of £28.1m; the Trust has delivered savings of £34.2m or £6.1m favourable to plan.
- **Capital position** - The Trust's capital plan for 2023/24 is £62.5m; the Trust has met its capital plan.

Financial Position 2023/24

Key areas of focus - Income



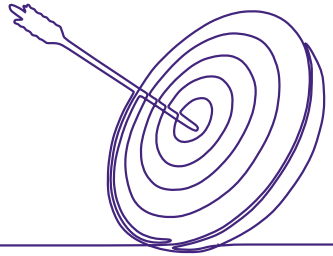
NHS
United Lincolnshire Hospitals
NHS Trust

The outturn income position is £24.9m favourable to plan; this includes:

- **Notional income for additional employers' pension contributions – £18.6m favourable variance**.
- **NHS patient care income contract – £(1.2)m adverse to plan**; including
  - ❖ Contract variations - £(6.9)m adverse to plan including £(8.6)m to Lincs ICB in March to support delivery of the system I&E position.
  - ❖ Pass through - £4.7m favourable to plan.
  - ❖ Variable & non-contract over performance & prior year income - £1.0m favourable to plan.
- **Other Operating income from patient care activities – £0.8m favourable to plan** driven by & £0.5m re overseas visitor over performance & £0.3m re the national Consultants pay offer.
- **Other operating income - £6.7m favourable to plan;** including
  - ❖ Non-patient care services - over performance of £1.7m
  - ❖ Retail sales - over performance of £1.0m (more than offset by additional expenditure)
  - ❖ Car Parking & Catering - over performance of £1.0m.
  - ❖ Income re Pilgrim Sink Hole – over performance of £0.9m.
  - ❖ Research & Development - over performance of £0.7m.
  - ❖ Education & Training – over performance of £0.4m.
  - ❖ Miscellaneous income – over performance of £1.0m.

Financial Position 2023/24

Key areas of focus - Pay



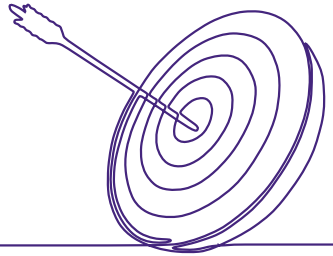
NHS
United Lincolnshire Hospitals
NHS Trust

The outturn pay position is £(17.9)m adverse to plan; this includes:

- **Notional expenditure for additional employers' pension contributions – £(18.6)m adverse to plan**; this is offset by a favourable variance to plan of £18.6m in notional income for additional employers' pension contributions.
- Excluding notional expenditure for additional employers' pension contributions, Pay is £0.7m favourable to plan as follows:
  - ❖ Substantive Pay is £(8.0)m adverse to plan.
  - ❖ Bank Pay is £5.4m favourable to plan.
  - ❖ Agency Pay is £3.0m favourable to plan.
  - ❖ Other Pay is £0.3m favourable to plan.
- **Bank Pay**
  - ❖ While the Bank pay is £5.4m favourable to plan, this includes a non-recurrent benefit of £6.1m in relation to actions to support the system's delivery of its I&E position.
  - ❖ Excluding actions to support the system's delivery of its I&E position, Bank pay expenditure of £64.5m in 2023/24 is £14.8m higher than expenditure of £49.7m in 2022/23; the adverse movement is driven by an increase of £8.7m re Medical & Dental Bank Pay [which reflects the full year impact of Extra Contractual Rates introduced in December 2022].
- **Agency Pay**
  - ❖ Agency Pay expenditure of £32.6m in 2023/34 is £18.3m lower than expenditure of £51.0m in 2022/23; the favourable movement is driven by a reduction of £13.3m re Registered Nursing agency expenditure.

Financial Position 2023/24

Key areas of focus – Non-Pay



NHS
United Lincolnshire Hospitals
NHS Trust

The outturn Non-Pay position is £(12.7)m adverse to plan; this includes

- **Activity volumes - £5.2m favourable to plan**

  Activity volumes are lower than planned; the benefit of lower than planned volumes is estimated to be £6.2m, but this is mitigated in part by £1.0m of outsourcing.

- **Excess inflation – £(5.1)m 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 in the outturn position is £5.1m.

- **Other – £(6.0)m adverse to plan**

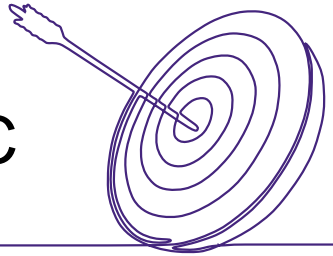
  The majority of the remaining £6.0m adverse movement is driven by £4.7m over performance on pass through drugs & devices (largely offset by over performance on pass through income). Other notable overspends include £0.6m in relation to depreciation and amortisation, £0.4m re increased recruitment costs & £0.3m in relation to unfunded system digital non pay costs.

- **Impairments & Donated Consumables – £(6.8)m adverse to plan**

  Technical adjustments made at year end, which do not count towards the adjusted deficit upon which financial performance is assessed, came to a combined total of £6.8m – this includes the recognition of £6.6m of impairments.

Financial Position 2023/24

Key areas of focus – Cash & BPPC



NHS
United Lincolnshire Hospitals
NHS Trust

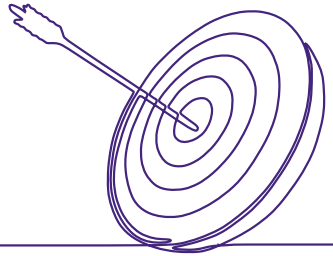
Cash

- The March 2024 cash balance is £50.9m (plan: £16.2m); this is an increase of £9.6m against the March 2023 balance of £41.3m.
- Cash balances have increased as anticipated in March with the drawdown of £32.7m PDC associated with the capital programme. Capital creditors increased to £27.1m in March, these will be cleared through Q1 2024/25.
- Cash will therefore reduce as we move into 2024/25 and will require careful management of working capital alongside external cash support.

BPPC

- The BPPC performance for March was 92% / 90% by value / volume of invoices paid (appendix 5d).
- Performance across 2023/24 was 88% / 83% by value / volume, this compares to the full year performance in 2022/23 of 79% / 70%.
- At the end of March there were circa 800 unpaid invoices (£4.2m) over term (February 900 / £2.8m). 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 2023. A multi-faceted plan has contributed to the improvement in 2023/24; elements of this are yet to be fully implemented and present opportunities for further gains. An update is contained in the final slide of this pack.

Finance Dashboard



NHS
United Lincolnshire Hospitals
NHS Trust

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

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

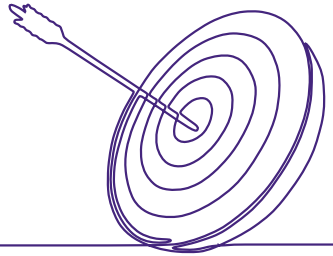
Metric	Rating Boundary			
	1	2	3	4
Capital servicing capacity	2.5	1.75	1.25	<1.25
Liquidity ratio (days)	0	-7	-14	<-14
I&E Margin	1%	0%	-1%	<=-1
I&E margin distance from plan	0%	-1%	-2%	<=-2%
Agency	0%	25%	50%	>=50%

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

Finance and use of resources rating	Full Year ending:					Actual
	31/03/2019	31/03/2020	31/03/2021	31/03/2022	31/03/2023	MAR 2023
Capital service cover metric	(10.40)	(1.73)	0.06	3.60	1.48	1.19
Capital service cover rating	4	4	4	1	3	4
Liquidity metric	(98.73)	(128.28)	3.71	2.50	(10.91)	(19.40)
Liquidity rating	4	4	1	1	3	4
I&E margin metric	(19.71%)	(7.62%)	0.38%	0.29%	(1.80%)	(2.63%)
I&E margin rating	4	4	2	2	4	4
Agency metric	77.00%	110.00%	113.00%	120.00%	[illegible]	[illegible]
Agency rating	4	4	4	4	[illegible]	[illegible]
I&E margin: distance from financial plan - metric	(2.80%)	0.70%	n/a	0.01%	(1.80%)	0.23%
I&E margin: distance from financial plan - rating	4	1	n/a	1	3	1

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

Balance Sheet



United Lincolnshire Hospitals NHS Trust

	31-Mar-23	31-Mar-24		
	£000	Plan £000	Actual £000	Variance £000
Intangible assets	11,383	4,357	10,924	(6,567)
Property, plant and equipment	298,860	306,970	333,031	(26,061)
Right of use assets	11,807	9,656	13,956	(4,300)
Receivables	2,157	1,848	2,022	(174)
Total non-current assets	**324,207**	**322,831**	**359,934**	**(37,103)**
Inventories	6,133	7,000	6,581	419
Receivables	52,873	30,740	19,780	10,960
Cash and cash equivalents	41,269	16,201	50,858	(34,657)
Total current assets	**100,275**	**53,941**	**77,220**	**(23,279)**
Trade and other payables	(89,905)	(76,995)	(95,425)	18,430
Borrowings	(3,129)	(2,879)	(3,167)	288
Provisions	(17,670)	(4,825)	(12,154)	7,329
Other liabilities	(1,260)	(1,130)	(1,195)	65
Total current liabilities	**(111,964)**	**(85,829)**	**(111,941)**	**26,112**
Total assets less current liabilities	**312,518**	**290,943**	**325,212**	**(34,269)**
Borrowings	(12,189)	(9,481)	(13,557)	4,076
Provisions	(5,108)	(2,992)	(5,271)	2,279
Other liabilities	(11,069)	(10,566)	(10,566)	-
Total non-current liabilities	**(28,366)**	**(23,039)**	**(29,394)**	**6,355**
Total assets employed	**284,152**	**267,904**	**295,818**	**(27,914)**
Financed by				
Public dividend capital	724,041	738,081	756,760	(18,679)
Revaluation reserve	42,584	27,891	48,454	(20,563)
Other reserves	190	190	190	(0)
Income and expenditure reserve	(482,663)	(498,258)	(509,585)	11,327
Total taxpayers' equity	**284,151**	**267,904**	**295,818**	**(27,914)**

Note 1: The impact of the 2023/24 revaluation is reflected within the March balance sheet. The net effect on asset values being negligible with an impairment of £6.6m charged to I&E and increase in revaluation reserve of £7.0m.

Note 2: The capital programme for 2023/24 has been delivered with PPE asset additions of £31.8m in March.

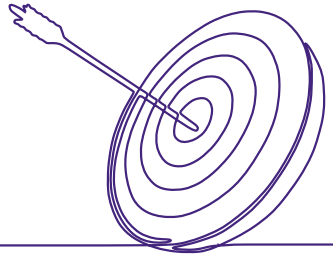
Note 3: Linked to the month 12 capital additions is a drawdown in March of £32.7m PDC capital / cash.

Note 4: Receivables is predominantly a mix of invoiced debt £6.4m, accrued income £1.8m, VAT £1.9m and prepayments £10.0m, offset in part by bad debt provisions of £1.4m.

Note 5: The overall level of Trade and other payables at £95.4m is in line with expectations. The month 12 increase driven by a rise in creditors associated with the capital programme (£27.1m). The balance of payables is made up of trade creditors (£16.1m), accruals (£32.9m) and tax, national insurance and pension contributions that will be paid over in April.

Note 6: The level of provisions remains high but have been reassessed in March in line with ongoing work to address historic 'Flowers' and annual leave issues.

Cashflow reconciliation – April 2023– March 2024



United Lincolnshire Hospitals NHS Trust

	31-Mar-23	31-Mar-24		
		Plan	Actual	Variance
	£000	£000	£000	£000
Operating surplus / (deficit)	(13,371)	(15,300)	(20,954)	5,654
Depreciation and amortisation	22,001	24,127	25,768	(1,641)
Impairments and reversals	5,079	-	6,580	(6,580)
Income recognised in respect of capital donations	(82)	(50)	(114)	64
Amortisation of PFI deferred credit	(503)	(503)	(503)	-
(Increase) / decrease in receivables and other assets	(38,148)	(2,240)	33,232	(35,472)
(Increase) / decrease in inventories	(127)	-	(448)	448
Increase/(decrease) in trade and other payables	1,593	(11,967)	677	(12,644)
Increase/(decrease) in other liabilities	130	-	(65)	65
Increase / (decrease) in provisions	10,861	(2,210)	(5,424)	3,214
Net cash flows from / (used in) operating activities	**(12,567)**	**(8,143)**	**38,749**	**(46,892)**
Interest received	1,175	2,100	2,551	(451)
Purchase of intangible assets	(4,142)	-	(9,355)	9,355
Purchase of property, plant and equipment	(42,693)	(45,930)	(42,447)	(3,483)
Proceeds from sales of property, plant and equipment	156	-	59	(59)
Net cash flows from / (used in) investing activities	(45,504)	(43,830)	(49,192)	5,362
Public dividend capital received	19,863	14,193	32,718	(18,525)
Other loans repaid	(402)	(805)	(805)	-
Capital element of finance lease rental payments	(2,416)	(2,319)	(2,393)	74
Interest element of finance lease	(121)	(104)	(142)	38
PDC dividend (paid)/refunded	(5,873)	(8,000)	(9,328)	1,328
Cash flows from (used in) other financing activities	(8)	(4)	(9)	5
Net cash flows from / (used in) financing activities	11,043	2,961	20,032	(17,071)
Increase / (decrease) in cash and cash equivalents	**(47,028)**	**(49,012)**	**9,589**	**(58,601)**
Cash and cash equivalents at 1 April - b'f	88,297	65,213	41,269	23,944
Cash and cash equivalents at period end	**41,269**	**16,201**	**50,858**	**(34,657)**

Note 1: Cash held at 31 March was £50.9m against a plan of £16.2m. This represents an increase of £9.6m against the March 2024 year-end cash balance of £41.3m.

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

Note 3: Cash balances have increased in March 2024 with the drawdown of £32.7m PDC to support the capital programme, the associated payment of suppliers being in Q1 24/25.

Note 4: The cash position is expected to deteriorate into 2024/25 where the option to move cash between Provider Organisations within the ICS may need to be explored.

Risk Reporting to the Trust Board

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Hospitals NHS Trust

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*7 May 2024*
Item Number	*14.1*

Executive Summary LCHS / ULHT Strategic Risk Reports

Accountable Director	*Professor Karen Dunderdale, Executive Director of Nursing / Deputy Chief Executive (LCHS and ULHT)*
Presented by	*Kathryn Helley, Director of Clinical Governance*
Author(s)	*Helen Shelton, Deputy Director of Clinical Governance*
Recommendations/	*The Trust Board is invited to review the content of the report, no further escalations at this time.*

Joint Executive Summary

It is evident that currently both organisations have their own Risk Strategy or Policy and both have subtle differences in the approach to risk management, risk support, risk appetite and risk scoring compounded by two sets of strategic objectives. As a result it is difficult to align risk reporting, resulting in this looking and feeling different between the two organisations. As we move towards the Group model, both ULHT and LCHS are now jointly working to review and align the Trusts risk profiles and risk management approach. The Trust Board will be provided with a joint executive summary until full alignment with reporting has been achieved.

ULHT

As of 1 April 2024, there were 546 risks recorded on the Trust risk register and aligned to the sub committees of the Trust Board; this is an increase of 82 risks from the previous report in January 2024.

There are 11 quality and safety risks rated Very high (20-25), a reduction of 4 from the previous report:

- Patient flow through Emergency Departments
- Recovery of planned care cancer pathways
- Reliance on paper medical records
- Reliance on manual prescribing processes;
- Potential for serious patient harm due to a fall
- Processing of echocardiograms
- Delivery of paediatric epilepsy pathways-community

- Quality and safety risk from inability to deliver epilepsy pathways within Acute Paediatrics that meet National standards
- Medicines reconciliation compliance
- Consultant capacity for Haematology outpatient appointments
- Removal of lift in H Block PHB affecting service delivery to patient records- **Risk presented at Risk Confirm and Challenge in February, validated for increase in score from High (15) to Very High (20)**

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

- Removal of lift in H Block PHB affecting service delivery to patient records- **presented in February, increase in score to 20 Very High Risk**
- Potential for CQC regulatory action due to open 'Must Dos'**-Risk presented in March, reduction in score validated at Moderate (12)**
- Recovery of planned care admitted pathways **- Risk reduced from Very High (20) to Moderate (12)**
- Recovery of planned care non-admitted (outpatients) pathways **- Risk reduced from Very High (20) to Moderate (12)**

There are 4 People and Organisational Development risks rated Very High (20-25) which were reported to the People & Organisational Development Committee this month, a reduction of 2 from the previous report:

- Staffing levels requiring an increase in Pharmacy to be able to provide a seven-day service.
- Pharmacy workload demands
- Service configuration (Haematology)
- Consultant workforce capacity (Haematology)

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

- Disruption to services due to potential industrial action (Trust-wide)-**Risk presented in March for reduction in score from Very High (20) to High (16).**
- Pharmacy procurement service not able to withstand prolonged staff absence- **Risk presented in March for reduction in score in from Very High (20) to High (16)**
- Core and Core Plus Learning Provisions (8)-**Risk presented in March for a reduction in score from High (16) to Moderate (8)**
- Recruitment of staff (12)- **Risk presented in March for a reduction in score from High (16) to Moderate (12)**
- Core and Core-Plus Mandatory Training not accessible to staff- **Risk presented in March validated to be closed.**

There are 5 Very high risks (20-25) reported to the Finance, Performance and Estates Committee this month, a reduction of 1 from the previous report:

- 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.

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

- Med Air Plant LCH (Medical Gas) **- Risk presented in February, validated to be closed.**
- Bone Marrow & Venesections Treatment room not compliant with HBN 00-03 due to poor ventilation (15)-**New risk presented in March, validated as High Risk (16)**

Details of all current High and Very high risks are provided in ULHT **Appendix A**.

LCHS

As of the 31st March 2024, there were 91 risks recorded on the Trust risk register aligned to the sub-committees of the Trust Board.

There are 9 Quality and Safety risks rated Significant (15-25), an increase of 1 since the February report:

- 655 - Patient Harm due to Quality of care- Sleaford
- 495 – Treatment Room Capacity
- 403 - Children Young People Therapy treatment delays
- 409 - Lymphoedema service capacity
- 395 - TB Demand and Capacity
- 489 - Community nursing staffing pressures
- 652 - Interruption to Enhanced Practitioners and FVW business as usual activity
- 654 - Patient harm and compromised quality in the South Lincs ICT
- 672 - Timely Unplanned Palliative Response 24/7

The following risks have been updated:

- 495 – Treatment room capacity – **Increased from high (12) to Significant (16) due to demand on the clinics, continued lack of clinic space, increasing demand, widening impact onto outpatients and no available funding to expand.**

There were 6 Finance, Performance, People & Innovation risks rated Significant High (15 – 25) which has remained static from the last reporting period:

- 658 - Connectivity to Live SystmOne Live Patient Records within Community Nursing
- 665 - Skegness Hospital Fire Safety
- 649 – Fire Safety Core Risk
- 390 – John Coupland Hospital Theatre Ventilation
- 391 – John Coupland Hospital Water Safety
- 393 – Skegness Hospital Water Safety

There are 0 People and Organisational Development risks rated Significant (15-25) for this reporting period.

Details of all current Significant risks are provided in LCHS **Appendix A**.

United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*7 May 2024*
Item Number	*14.1*

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	• *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 March and April at the point of writing.

There were 11 quality and safety risks rated Very High (20-25) reported to the Quality Governance Committee this month, a reduction of 2 from the previous reporting period:

- Patient flow through Emergency Departments
- Recovery of planned care cancer pathways
- Reliance on paper medical records
- Reliance on manual prescribing processes;
- Potential for serious patient harm due to a fall
- Processing of echocardiograms
- Delivery of paediatric epilepsy pathways-community
- Quality and safety risk from inability to deliver epilepsy pathways within Acute Paediatrics that meet National standards
- Medicines reconciliation compliance
- Consultant capacity for Haematology outpatient appointments
- Removal of lift in H Block PHB affecting service delivery to patient records- **Risk presented at Risk Confirm and Challenge in February, validated for increase in score from High (15) to Very High (20)**

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

- Removal of lift in H Block PHB affecting service delivery to patient records- **presented in February, increase in score to 20 Very High Risk**
- Potential for CQC regulatory action due to open 'Must Dos'-**Risk presented in March, reduction in score validated at Moderate (12)**
- Recovery of planned care admitted pathways - **Risk reduced from Very High (20) to Moderate (12)**
- Recovery of planned care non-admitted (outpatients) pathways - **Risk reduced from Very High (20) to Moderate (12)**
-

There are 4 People and Organisational Development risks rated Very High (20-25) which were reported to the People & Organisational Development Committee this month, a reduction of 2 from the previous reporting period:

- Staffing levels requiring an increase in Pharmacy to be able to provide a seven-day service.
- Pharmacy workload demands
- Service configuration (Haematology)

- Consultant workforce capacity (Haematology)

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

- Disruption to services due to potential industrial action (Trust-wide)-**Risk presented in March for reduction in score from Very High (20) to High (16).**
- Pharmacy procurement service not able to withstand prolonged staff absence- **Risk presented in March for reduction in score in from Very High (20) to High (16)**
- Core and Core Plus Learning Provisions (8)-**Risk presented in March for a reduction in score from High (16) to Moderate (8)**
- Recruitment of staff (12)- **Risk presented in March for a reduction in score from High (16) to Moderate (12)**
- Core and Core-Plus Mandatory Training not accessible to staff- **Risk presented in March validated to be closed.**

There are 5 Very high risks (20-25) reported to the Finance, Performance and Estates Committee this month, a reduction of 1 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.

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

- Med Air Plant LCH (Medical Gas) **- Risk presented in February, validated to be closed.**
- Bone Marrow & Venesections Treatment room not compliant with HBN 00-03 due to poor ventilation (15)-**New risk presented in March, validated as High Risk (16)**

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 DatixIQ Risk Management System. This report is focussed on significant risks to each objective, those with a current rating of Very High risk (a score of 20-25).

1.2 Full details of all active Very High and High risks (those with a current risk score of 15-25) are included in **Appendix A**, and a summary of Very High risks is provided in Section 2 below. Moderate and Low risks (those with a score of 12 and below) are managed at divisional level.

1.3 The Risk Register Confirm and Challenge Group continues to meet on a monthly basis, reviewing all High and Very high risks as well as receiving presentations from clinical

and corporate business areas on a rotational basis to enable constructive feedback to be provided.

2. Trust Risk Profile

2.1 There are 546 active and approved risks reported to lead committees this month, an increase of 40 since the last reporting period.

2.2 There are 20 risks with a current rating of Very High risk (20-25), a reduction of 5 since the last report, and 43 rated High risk (15-16), a reduction of 2, 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)
44 (+1) (8%)	**124 (+20)** (22%)	**315 (+26)** (57%)	**43 (-2)** (7%)	**20 (-5)** (3%)

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

2.3 There are 9 Very High risks and 10 High risks recorded in relation to this objective, a reduction of 2 since the last report. 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
5143	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.	Very high risk (20)	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 be 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.	26/03/2024
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 (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.	15/04/2024

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4789	If there is a significant delay in processing of Echocardiograms, which is impacted by staff shortages and inefficient processes, then it could lead to delayed assessment and treatment for patients, resulting in potential for serious harm, a poor patient experience and a poor clinical outcome	Very high risk (20)	Review and realignment of systems and processes to ensure that the team efficiency has been optimised. External company (Meridian) engaged for 10-week period to enable a deep dive and improvement plan to be implemented for the service.	15/04/2024 – Risk reduction plan has made a significant impact therefore plan for full review in February and potential reduction in score. This will be presented at Risk Confirm and Challenge in April.
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.	25/03/2024

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4624	If patients in the care of the Trust who are at increased risk of falling are not accurately risk assessed and, where necessary appropriate preventative measures put in place, they may fall and could suffer severe harm as a result.	Very high risk (20)	• Improvement plan implemented by all Divisions, led by QM, monitored through Patient Falls Prevention Steering Group (FPSG). • Introduction and rollout of 'Think Yellow ' falls awareness visual indicators. • Patient story included within FPSG workplan. • Introduction of new falls prevention risk assessment and care plan documentation • Falls prevention training and education framework developed, delivery to commence 2022. • Analyse trends and themes in falls data to inform the need for targeted support and interventions. • Utilisation of Focus on Fundamentals programme • Enhanced care policy and associated processes review. • Revised falls investigation process and documentation. • Overarching action plan for divisional and serious incidents ,monitored through FPSG • Business case for dedicated falls team being developed • Collaborative work between Quality and Improvement teams to bring all existing falls prevention work together.	09/04/2024- Risk currently being reviewed for potential reduction in score. This will be presented at RRC&C in April.
5101	Quality and safety risk from inability to deliver Community epilepsy pathways that meet National standards due to resourcing and capacity factors.	Very high risk (20)	1. Business case is being produced to enable establishment of fully funded epilepsy service 2. Agreement for spending has been obtained, moving forward. 3. In process of appointing 2 x epilepsy nurses, B6 has started, B7 was unable to start so back out to advert. 4. Epilepsy workshop with ICB	20/02/2024

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4740	Demand for Haematology outpatient appointments exceeds consultant staffing capacity. High Consultant vacancy levels affecting clinic capacity, performance and review of inpatients. The areas of concern are Lymphoma, and haemostasis (there is only one consultant trust wide). PHB cover and unfilled leadership roles (in practice head of service and clinical governance lead). Due to haematology patients having long term conditions, they are required to have regular review and those on cancer treatment are time critical. If we are not able to meet the demands of the service this potentially could cause severe harm to the patients. At the end of March 2023 there are 322 overdue haem pt at phb and 597 at LCH. From 1 Oct 22 till now the haematologists have held 95 extra clinics which equates to 71 news and 813 F/U. Haemostasis in particular pt are waiting almost triple the time that they have been graded at. There are 657 pt on this consultant PBWL with 295 being overdue. The longest waiter was due an appointment around July 2022. This consultant is holding on average 3 extra clinics per month.	Very high risk (20)	Need for workforce review identified. Right sizing work force paper being written. 2 x agency consultants out to support service	25/03/2024

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4947	There is an issue in which the Trust is failing to meet NICE medicines reconciliation targets on a consistent basis and not being able to review discharges. This is caused by lack of pharmacy resource. Resulting in potential for patient harm due to incorrect or delayed medication, financial implications due to increased length of stay or unnecessary supply and risk of continuation of errors onto the discharge letter and further more into the community.	Very high risk (20)	There are many options but we are utilising these; - We have prioritised pharmacist and technician cover to acute admission areas as patient turnover is highest on these areas and gives us to best opportunity to conduct a medicines reconciliation under 24 hours - We prioritise patients which have stayed in the longest and have critical medication where known. Prioritisation of the highest risk patients decreases the risk of harm - No ward visits are divided as much as possible. To significantly reduce this risk requires additional ward based pharmacy staff cover across 7 days.	04/04/2024
5100	Quality and safety risk from inability to deliver epilepsy pathways within Acute Paediatrics that meet National standards due to resourcing and capacity factors.	Very high risk (20)	1. Multi-professional working group tasked with delivering improvements that will support achievement of audit compliance.	08/04/2024

Updates since the last report

Following the February and March RRC&C meetings the following changes were agreed and validated:

Potential for CQC regulatory action due to open 'Must Dos' – Risk presented at the March RRC&C meeting, validated for reduction in score from Very High (20) to a Moderate (12). Significant progress has been made against the 'Must Do's', with all 5 'Must-Do' actions now completed following review and scrutiny of evidence at the Executive-Led CQC Assurance meeting.

H Block lift - service impact-Risk presented in February RRC&C meeting, validated for increase in score from High (15) to Very High (20). The risk rating was requested to be increased by the QIA panel due to issues with getting notes to clinics and the cancellation of patients, the health and safety risk of other areas of the hospital as notes are unable to be returned to the library, increased sets of notes that are unable to be located, the physical injuries suffered by the staff and the claim being investigated by the legal team for injury to a staff member.

Planned care pathway delays Risk & Planned care non-admitted pathway (outpatients Risk) – Both Risks presented at the February RRC&C meeting, validated for reductions in score from Very High (20) to a Moderate (12). These risks were validated for the reduction in scores due to significant reductions in waiting times for patients being seen in both planned care admitted and non-admitted pathways.

Week Wait	Dec-22 Patients waiting to be seen	Feb-24 Patients waiting to be seen
104	27	0
78	1800	31
65	3700	600
52	8000	3000

Strategic objective 1b: Improve patient experience

2.4 There are no Very High risks and 2 High risks recorded in relation to this objective, which remains stable from last month.

Strategic objective 1c: Improve clinical outcomes

2.5 There are 2 Very High risks, and 3 High risks remaining stable recorded in relation to this objective. A summary of the Very High risks is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4828	The trust currently uses a manual prescribing process across all sites, which is inefficient and restricts the timely availability of patient information when required by Pharmacists. Where information about patient medication is not accurate, up to date and available when required by Pharmacists then it could lead to delays or errors in prescribing and administration, resulting in a widespread impact on quality of care, potentially reducing the likelihood of a positive clinical outcome and/or causing serious patient harm	Very high risk (20)	Planned introduction of an auditable electronic prescribing system across the Trust. Update 4th July 22- 26th July, ePMA functionality version 10.21 will be upgraded. ePMA pilot from 13/09/22, full Trust wide roll out from mid Oct.	04/04/2024
4731	If patient records are not complete, accurate, up to date and available when needed by clinicians then it could lead to delayed diagnosis and treatment, reducing the likelihood of a positive clinical outcome and possibly causing serious harm	Very high risk (20)	Design and delivery of the Electronic Document Management System (EDMS) project, incorporating Electronic Patient records (EPR). Interim strategy required to reduce the risk whilst hard copy records remain in use.	26/03/2024

Strategic objective 2a. A modern and progressive workforce

2.6 There are 3 Very High risks, a reduction of 1; and 8 High risks, an increase of 1 recorded in relation to this objective. A summary of the Very High risks is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
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.	04/04/2024
4996	Staffing - insufficient consultant workforce to meet demand. Particular areas of concern: 1. Lymphoma tumour site cover 2. Haemostasis/haemophilia (single consultant Trust wide) 3. Pilgrim Consultant cover 4. Clinical governance lead 5. HoS/clinical lead	Very high risk (20)	* Workforce review * Refresher of Fragile Services Paper - NB there is a National shortage of Haematology consultants * Recruitment of further substantive consultants * Additional unfunded ST3+ for Haematology starts in August 2022	25/03/2024
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	25/03/2024

Updates since the last report:

Pharmacy procurement service not able to withstand prolonged staff absence (16)- Risk validated for reduction in score at RRC&C from Very High 5x4: 20 to 4x4:16 High as a number of actions taken have mitigated the risk, evidenced through further recruitment to the service which has seen an improvement in timely invoicing within 30 days. Further recruitment underway which is expected to mitigate the risk further.

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

2.7 There is 1 Very High risk, a reduction of 1; and 5 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
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.	04/04/2024

Updates since the last report

Following the February and March RRC&C meetings the following changes were agreed and validated:

Disruption to services due to potential industrial action (Trust-wide)-Risk presented in March for reduction in score from Very High (20) to High (16). Controls currently in place and managed through operational command.

Core and Core-Plus Learning Provisions -Risk presented in March for a reduction in score from High (16) to Moderate (8). The risk is always present due to system errors that can crop up with within ESR but accessibility is not a risk as such. All coordinators are trained to manage the system and any errors that occur. Attendance at the mandatory training governance group is variable however we are looking to remodel the approach using existing Teams based approval processes such as those used in CRIG.

Recruitment of staff - Risk presented in March for a reduction in score from High (16) to Moderate (12). Improvements noticed with nurse staffing recruitment, but concerns remain around the medical staffing and AHP workforces leaving this as a Moderate risk. Further reviews of this risk will continue through POD and mitigations in relation to medical and AHP workforce will be explored.

Core and Core-Plus Mandatory Training not accessible to staff- Risk presented in March, validated to be closed due to all risk reduction plans completed.

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

2.8 There are 2 approved Very High risks (20-25) a reduction of 1 and 8 High risks (15-16) an increase of 2, 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	11/04/2024
4647	If Lincolnshire Fire & Rescue Service (LFRS) carries out an inspection and finds the Trust to be systemically non-compliant with fire safety regulations and standards it could result in regulatory action and sanctions, with the potential for financial penalties and disruption to services if sites are required to close.	Very high risk (20)	- Statutory Fire Safety Improvement Programme based upon risk - LFR involvement and oversight through the FSG - Fire safety audits being conducted by Fire Safety team - Fire wardens in place to monitor local arrangements with Fire Safety - Weekly Fire Safety Checks being undertaken - PPM reporting for FEG and FSG By Estates Teams - All areas of Trust allocated RAG rating for fire using occupancy profile, escape provision, height above ground and sleeping risk	11/04/2024

Updates since the last report

Medical Air Plant-Risk was presented at RRC&C in February and closed. The Medical Air Plant has now been replaced and is fully functional. PPM as per HTM 02-01 is in place.

Bone Marrow & Venesections Treatment room not compliant with HBN 00-03 due to poor ventilation (15)-New risk presented in March, validated as High Risk (16). It has been identified that there are 11 areas across all divisions where procedures are taking place without correct ventilation due to incorrect processes being followed. The Risk Team are currently working with Estates to develop an overarching risk that will include all areas identified as a part of the risks action plan. An update for this will be provided for the next reporting period

Strategic objective 3b: Efficient use of our resources

2.9 There are 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	18/03/2024
5020	If there is a continued reliance on bank and agency staff for medical workforce in Urgent & Emergency Care there is a risk that there is not sufficient fill rate for medical rotas both ward / department fill and on call shifts which will impact on patient safety and have a negative impact on the CBU budget.	Very high risk (20)	Robust recruitment plan. International recruitment. Medical Workforce Management Project.	15/04/2024

Strategic objective 3c: Enhanced data and digital capability

2.10 There is 1 approved Very High risk, remaining stable (20-25) recorded in relation to this objective, There are also 4 High risks (15-16), a decrease of 2 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."	04/03/2024

Strategic objective 3d: Improving cancer services access

2.11 There are 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 are no approved Very High risks (20-25) or High risks (15-16) to this objective.

Strategic objective 3f: Urgent Care

2.13 There are 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 are 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 risks recorded in relation to this objective.

2.16 **Strategic objective 4c: Successful delivery of the Acute Services Review**2. There are no approved Very High risks (20-25) or High risks (15-16) to this objective.

2. Conclusions & recommendations

- There are 11 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 cancer pathways
    - Reliance on paper medical records
    - Reliance on manual prescribing processes;
    - Potential for serious patient harm due to a fall
    - Processing of echocardiograms
    - Delivery of paediatric epilepsy pathways-community
    - Quality and safety risk from inability to deliver epilepsy pathways within Acute Paediatrics that meet National standards
    - Medicines reconciliation compliance
    - Consultant capacity for Haematology outpatient appointments
    - Removal of lift in H Block PHB affecting service delivery to patient records

- There are 4 People and Organisational Development risks rated Very High (20-25) reported to the People & Organisational Development Committee this month, a reduction of 2 since the last reporting period:
    - Staffing levels requiring an increase in Pharmacy to be able to provide a seven-day service.
    - Pharmacy workload demands
    - Service configuration (Haematology)
    - Consultant workforce capacity (Haematology)

- There are 5 Very High risks (20-25) reported to the Finance, Performance and Estates Committee this month:
    - Potential for a major fire;
    - Compliance with fire safety standards, assessed by Lincolnshire Fire and Rescue Service;
    - Exceeding the agency cap due to the cost of reliance upon temporary clinical staff
    - Reliance on agency / locum medical staff in Urgent & Emergency Care
    - SAR's Compliance and access to Health records in accordance with statuary requirements.

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

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	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
2a. A modern and progressive workforce	4844	38	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.	04/04/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Pharmacy supply a limited Saturday and Sunday morning service with staff working beyond their contracted hours. An on-call pharmacist is available for EMERGENCY items only. A Business Case has been submitted to CSS CBU.	[04/04/2024 08:49:00 Lisa Hansford] no update [07/03/2024 14:20:29 Lisa Hansford] no update [13/02/2024 11:52:19 Gemma] Risk reviewed, no further update. [17/01/2024 12:06:01 Gemma] No further update [19/12/2023 13:27:34 Lisa-Marie Moore] Meeting with MD 18/12 to discuss business cases Pharmacy phase 2 improvement plan in progress [28/11/2023 12:09:20 Rachael Turner] Risk score remains, no further update. [30/10/2023 12:40:52 Rachael Turner] No changes, risk ongoing. No further updates at this time. [26/09/2023 14:05:31 Rachel Thackray] No changes as yet made, meeting to take place with Medical Director [03/08/2023 14:49:28 Lisa-Marie Moore] No further updates [27/06/2023 09:47:18 Alex Measures] Discussed in risk register review meeting- no further updates [01/06/2023 14:18:15 Lisa-Marie Moore] No change/update since previous entry [06/04/2023 12:53:22 Paul White] Discussed at Risk Register Confirm & Challenge 29 March, risk agreed with feedback provided for consideration. [09/02/2023 10:43:37 Paul White] Status changed to awaiting approval pending review by division and validation by Risk Register Confirm & Challenge Group. [22/12/2022 14:55:29 Rose Roberts] Confirmed with Paul White that the risk level can be raised here and confirm and challenge will invite the risk lead to discuss it. [20/12/2022 14:35:39 Alex Measures] Business case was not approved, currently stalled, raised to high risk today but the meeting feels it should be very high risk because it would be very likely to happen, to be taken to confirm and challenge to be upgraded 150622 ongoing business case in process of being written	4	29/10/2021	28/04/2023	03/05/2024
3c. Have enhanced data and digital capability	4557	7	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.	04/03/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Current active communications with ICO-regulator. Changes to processes are being constantly discussed and implemented. Resource needs being discussed and temporarily increased to support. Monitored through the IGG in DP KPI report. Head of IG leading on work to review and improve. Working in a more digital way where feasible. Workforce change is required which will be a much longer process. Early identifications of chasers and urgent requests to reduce the likelihood of complaints.	[04/03/2024 13:47:50 Fiona Hobday] *System has now been procured- project due to commence April 24 with an initial go live for Quarter 2. *x1 temp new starter 5/3/24 due to sickness and vacancy in dept. [25/01/2024 14:27:48 Fiona Hobday] Have extended expected completion date in light of current position- approvals have taken longer than original hoped for re solutions which impacts go live plans. Also due to lack of response from ICO to date- Trust is not aware what the outcome might be. *Agreement rec'd to procure new case mgmt solution- next step to award contract and then project to implement. *PoC for a solution re emails has concluded and a final report is being prepared which will include a recommendation. *Patient SAR compliance has fell in recent months due to vacancy- recruitment delays and current blocks on new starters means this cannot be resolved until April. Have identified x3 individuals who are fit to recruit to post if they are available come April. *Still awaiting ICO reponse. [20/12/2023 14:17:42 Fiona Hobday] *Still awaiting response from ICO-advised won't get anything for next month in recent update *Case of Need produced in relation to procuring a new solution- has gone through Seals approval and is with CRIG *Proof of concept re a e-discovery tool currently being done in relation to emails for staff related cases. *Balancing use of resource to manage urgent whilst not letting compliance drop back following work to improve. *Currently recruiting following departure of staff member. [28/11/2023 12:03:12 Fiona Hobday] *Still awaiting response from ICO *Case of Need produced in relation to procuring a new solution- includes recommended option for moving forward. To go to CRIG.	6	29/12/2023	31/08/2024	04/04/2024
2a. A modern and progressive workforce	4096	39	Service disruption	Dunning, Mr Paul	Chester-Buckley, Sarah	Workforce Strategy Group	Patient Safety Group	22/08/2022	16		Clinical Support Services	Cancer Services CBU	Haematology (Cancer Services)		Staffing - insufficient consultant workforce to meet demand. Particular areas of concern: 1. Clinical governance lead 2. Head of Service for haematology	* 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	25/03/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	* Workforce review - Now Completed (Sarah Chester-Buckley - July 2023) * Refresher of Fragile Services Paper - NB there is a National shortage of Haematology consultants - Now completed (Sarah Chester-Buckley - September 2023) * Recruitment of further substantive consultants - (Sarah Chester-Buckley - May 2024) * Additional unfunded ST3+ for Haematology starts in August 2022 - Now completed (Sarah Chester-Buckley - July 2023)	[25/03/2024 10:09:19 Gemma Staples] Haematology rightsizing SJBC presented at ICB investment panel on 15th March, still awaiting outcome. Lymphoma tumour site cover, Haemostasis/haemophilia (single consultant Trust wide), Pilgrim Consultant cover & Audit Lead have all been appointed. Head of Service due to be advertised. [26/02/2024 16:46:18 Gemma] Transfusion Lead now appointed, start date 01.02.2024. Awaiting start date for Haemostasis/Haemophilia Consultant. [31/01/2024 14:33:09 Gemma] Risk reviewed and ongoing [18/01/2024 11:10:07 Gemma] Haematology rightsizing paper taken to TLT and approved, now needs to go to the Board and ICB investment panel. [22/12/2023 08:19:28 Gemma] Haematology rightsizing paper (SBJC) presented and approved at CRIG 19/12/23. Now needs to be presented at Board and ICB investment panel. Further update to be provided at a later date. [02/11/2023 15:31:05 Vicky Dunmore] Haem rightsizing business case to be present at CRIG Nov 2023 [14/09/2023 15:01:43 Rose Roberts] Rightsizing Haem paper to be presented at CRIG Sept 2023. [03/08/2023 10:00:17 Rachael Turner] Following the briefing paper being received by ELT, weekly meetings have been set up with DL,EM,LR and MH. An action plan has been put in place. A meeting was held with the Haematology Consultants, Andrew Morgan and Michelle Harris on 31.07.2023 and it was agreed to go out to advert for 4 Haematology Consultants, 1 Haematology Secretary and 2 Secretary Assistants. [02/06/2023 12:38:22 Maddy Ward] Andrew Morgan requested a briefing paper for ELT which is now complete in conjunction with transformation and due to be circulated to execs on 05/06/2023 Making enquires if transfusion lead needs to be a consultant of if another	8	30/09/2023	01/04/2023	25/04/2024

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	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
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	4879	28	Physical or psychological harm	Frake-Harris, Julie	Lynch, Diane	Patient Safety Group		28/03/2022	20	Risk assessments	Clinical Support Services	Cancer Services CBU	Oncology		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	25/03/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	- Planned care recovery plan (cancer) - Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions	[25/03/2024 10:05:36 Gemma Staples] Haematology rightsizing SJBC presented at ICB investment panel on 15th March, still awaiting outcome. [26/02/2024 16:48:25 Gemma] Risk reviewed and ongoing [31/01/2024 14:28:50 Gemma] Risk reviewed and ongoing [19/01/2024 10:02:18 Gemma] Haematology right-sizing SJBC was approved Dec 2023 to go to TLT, FPEC, Trust Board and ICB. Oncology right-sizing CoN still under preparation. [22/12/2023 13:10:45 Gemma] Haematology right-sizing paper presented to CRIG 19/12/2023. Approved to progress to ICB / Trust Board. Oncology right-sizing being prepared for next CRIG. [27/11/2023 13:49:23 Gemma] Rightsizing haematology paper approved at CRIG to progress to SJBC. SJBC has been draft and submitted. Oncology rightsizing CoN in development. COO approved recruitment 'at risk' ahead of the investment decision outcomes. Recruitment underway for medical, nursing and admin posts to support the services. New roles in development e.g. nurse consultant. Meetings with the COO continuing for support and oversight. [14/09/2023 14:59:30 Rose Roberts] Rightsizing Haem paper to be presented at CRIG Sept 2023. [01/08/2023 15:29:44 Rachael Turner] Action plan in place July 2023, monitored by the COO weekly for Haematology. Agreements in place to start recruitment for clinical and admin staff. CEO and COO met with Haematologists and CBU Senior Team 31st July. Work will start on oncology in August. [02/06/2023 12:41:34 Maddy Ward] Andrew Morgan requested a briefing paper for ELT which is now complete in conjunction with transformation and due to be circulated to execs on 05/06/2023. [24/04/2023 10:39:20 Maddy Ward] Oncology and Haematology service review carried out in March/April in association with strategy, planning, improvement and integration directorate	8	31/03/2023	31/03/2023	25/04/2024
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5101	487	Physical or psychological harm	Rivett, Kate	Herath, Dr Durga	Children & Young Persons Oversight Group	Clinical Effectiveness Group	14/03/2023	20		Family Health	Children and Young Persons CBU	Children's Community Services	Trust-wide	Quality and safety risk from inability to deliver epilepsy pathways within Community Paediatrics that meet National standards due to resourcing and capacity factors.	1. Single Consultant Paediatrician (DH) is currently managing all children with Epilepsy alongside a single specialist epilepsy nurse; 2. Wider consultant body supporting the care of children who are prescribed 2 antiepileptics in the absence of a consultant paediatrician with expertise in epilepsy; 3.Single Consultant Paediatrician is developing individualized care plans for each patient to optimise management of condition; 4. Liaison with ICB and regional network to support development and improvement of local services	1. Audit of compliance with NICE guideline NG217 - Epilepsies in Children, Young People and Adults and NICE quality standard QS27 - Epilepsy in Children and Young People;	20/02/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	1. Business case is being produced to enable establishment of fully funded epilepsy service 2. Agreement for spending has been obtained, moving forward. 3. In process of appointing 2 x epilepsy nurses, B6 has started, B7 was unable to start so back out to advert. 4. Epilepsy workshop with ICB	[20/02/2024 13:08:27 Nicola Cornish] No change. Business case meeting is being held to progress so that bid can be submitted to ICB for funds. [17/01/2024 13:02:57 Nicola Cornish] No improvement, business case being written on new template. [21/12/2023 11:19:49 Nicola Cornish] Consultant caseload review commenced in order to apply RAG rating system to each case to enable identification of those most at risk. Reviewed 100 patients so far, 2 additional review dates to be scheduled. Nursing criteria to be changed shortly to focus on top tier most vulnerable patients. [21/11/2023 14:24:17 Kate Rivett] 21/11/23 - KR 1. Significant levels of risk remains as there are only x2 specialist nurses and x1 consultant to manage a cohort of in excess of 900 patients, some of whom have very complex epilepsy in addition to other vulnerability factors; 2. Business case being worked up in conjunction with ICB to seek additional funding to enable expansion of the team. [25/10/2023 11:47:32 Rachael Turner] Risk discussed at RRC&C meeting 25/10/2023, risk to remain at Very High risk. [17/10/2023 14:06:09 Nicola Cornish] Appointed 2 nursing staff members, service making progress in establishing numbers that can be seen, gap analysis undertaken against NICE guideline - need to break this down further into key factors required to deliver service. Benchmarking completed, need to complete NICE baseline assessment form. [15/08/2023 13:26:59 Jasmine Kent] 2nd nurse has now started but issues ongoing with tertiary support with Nottingham. Difficulties completing epilepsy 12 audit. Risk remains same for now. [18/07/2023 13:22:27 Jasmine Kent] New nurse starts 07/08, looking to pull together business case to increase nursing team size further. Clarifications on	8	14/03/2024	16/02/2024	20/03/2024
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5016	22	Physical or psychological harm	Hamer, Fiona	Smith, Charles	Workforce Strategy Group	Patient Safety Group	02/09/2022	25		Medicine	Urgent and Emergency Care CBU	Accident and Emergency		If there is not sufficient flow through the Trusts Emergency Departments, due to demand outstripping capacity and insufficient availability of beds in the hospitals leading to overcrowding; this may result in increased likelihood of long waits in the departments for patients, and an increase in the potential for patient harm, delays in care, poor patient and staff experience and impact on the reputation of the Trust .	Medical SDEC currently working 08:00 - 20:00 24 hour UTC co-located with ED at Pilgrim and Lincoln 'Are you sitting comfortably' scheme 4 x Daily Capacity meetings (08:00, 12:00, 15:00, 18:00) Clinical Operational Flow Policy Full Capacity Protocol National Criterial 2 Admit flowchart embedded in the ED's Introduction of "Pit stop" model.	ED Risk Tool - updated 4 times daily with an overview of the department Capacity Meetings to dynamically risk assess Monthly scorecard to track performance from both harm and constitutional standards Matrons Dashboard Datix Number of harm reviews	15/04/2024	Quite likely (4) 71-90% chance	Extreme (5)	Very high risk (20-25)	20	Capital programme ongoing at Lincoln County ED - will increase clinical space Full Business Case approved at organisational level to support new build for Pilgrim ED System support with the introduction of Breaking the cycle - to create flow in hospital supporting the reduction of ED overcrowding Increased nursing template agreed by Director of Nursing for EDs Demand and Capacity work to review medical staffing in ED	[15/04/2024 10:59:26 Rachael Turner] Flow is improving slightly. SAFER has been implemented. Risk currently remains with same scoring. [05/03/2024 09:09:07 Rachael Turner] Risk reviewed, no change. [07/02/2024 09:17:37 Rachael Turner] Risk reviewed, no change. [09/01/2024 15:07:09 Rachael Turner] Risk reviewed. We have introduced cohorting to offload ambulances. We are holding medical colleagues accountable for discharges. But overcrowding still stands. Risk score to remain. [13/12/2023 16:47:38 Rachael Turner] No significant update to this risk, flow expected to ramin challenging across winter. Re: implementation of SAFER process but not yet seen consistent improvement" [20/11/2023 20:22:32 Rachael Turner] No current change, risk score to remain. [17/10/2023 10:08:18 Rachael Turner] No current change, currently huge risk due to lack of flow. Increase in patients that need admitting and require treatment whilst waiting for beds. Staffing has increased in this area to decrease patient harm. The professional standards have been introduced to clinicians for them to see patients within 30 minutes, this is being audited for compliance. The continued flow policy has reintroduced but this risk still remains at the same score. [30/08/2023 11:25:49 Carl Ratcliff] To review post meeting with execs on 30th August 2023 - action plan in place to manage risk [15/08/2023 11:11:54 Helen Hartley] Continuing to look at criteria led discharge 10x10 discharges from wards Staffing model being looked into regarding Extra patients in ED to keep patients safe. Virtual wards has been discussed, has not yet started. [19/07/2023 15:52:30 Helen Hartley] There is a lot of work ongoing regarding flow, can we use virtual wards? Frailty pathways in SDEC being examined to try to move patients out of ED and into the correct places for their needs. Ongoing.	10	02/09/2023	31/03/2024	15/05/2024

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	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
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	4740	37	Physical or psychological harm	Cooper, Mrs Anita	Chester-Buckley, Sarah	Patient Safety Group	Outpatient Improvement Group	13/01/2022	15	Risk assessments	Clinical Support Services	Cancer Services CBU	Haematology (Cancer Services)	Trust-wide	Demand for Haematology outpatient appointments exceeds consultant staffing capacity. High Consultant vacancy levels affecting clinic capacity, performance and review of inpatients. The areas of concern are: 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	25/03/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	* Workforce review - Now Completed (Sarah Chester-Buckley - July 2023) * Refresher of Fragile Services Paper - NB there is a National shortage of Haematology consultants - Now completed (Sarah Chester-Buckley - September 2023) * Recruitment of further substantive consultants - (Sarah Chester-Buckley - May 2024) * Additional unfunded ST3+ for Haematology starts in August 2022 - Now completed (Sarah Chester-Buckley - July 2023)	[25/03/2024 10:12:38 Gemma Staples] Lymphoma tumour site cover, Haemostasis/haemophilia (single consultant Trust wide), Pilgrim Consultant cover & Audit Lead have all been appointed. Head of Service due to be advertised. [25/03/2024 10:10:28 Gemma Staples] Haematology rightsizing SJBC presented at ICB investment panel on 15th March, still awaiting outcome. [26/02/2024 16:51:08 Gemma] Appointed three new Consultants, one at Lincoln and two at Boston. One started on 13.02.2024, awaiting start date for Haemostasis/Haemophilia Consultant and third Consultant due to start in August. [31/01/2024 14:33:38 Gemma] Risk reviewed and ongoing [18/01/2024 11:21:10 Gemma] Haematology rightsizing paper taken to TLT and approved, now needs to go to the Board and ICB investment panel. [22/12/2023 08:21:34 Gemma] Haematology rightsizing paper (SBJC) presented and approved at CRIG 19/12/23. Now needs to be presented at Board and ICB investment panel. Further update to be provided at a later date. [06/11/2023 08:53:30 Vicky Dunmore] updated PBWL, clinic and new appt figures [14/09/2023 14:57:46 Rose Roberts] Rightsizing Haem paper to be presented at CRIG Sept 2023. [01/08/2023 15:20:30 Rachael Turner] Update provided from Lauren Rigby-we are now having weekly meetings with the COO and at risk recruitment is happening. [02/06/2023 12:40:22 Maddy Ward] Andrew Morgan requested a briefing paper for ELT which is now complete in conjunction with transformation and due to be circulated to execs on 05/06/2023. We are exploring what care could take place in primary/community setting. [24/04/2023 10:36:33 Maddy Ward] Haematology service review carried out on 20th April 2023 in association with strategy, planning, improvement and integration directorate [03/04/2023 09:34:49 Rose Roberts] Reviewed at confirm and challenge	3	01/04/2023	01/04/2023	25/04/2024
3b. Make efficient use of our resources	4664	5	Finances	Matthew, Mr Paul	Young, Jonathan	Workforce Strategy Group		11/01/2022	20	Risk assessments	Corporate	Finance and Digital	Finance	Trust-wide	The Trust has an agency cap of c£17m. The Trust is overly reliant upon a large number of temporary agency and locum staff to maintain the safety and continuity of clinical services that will lead to the Trust breaching the agency cap.	National policy: - Agency spending cap set by Government ULHT policy: - Financial plan set out the Trust limits in respect of temporary staffing spend - Annual budget setting process cascades and apportions the Trust temporary staffing spend limits to the Divisions and Directorates. - Monthly financial management & monitoring arrangements are in place to identify variation temporary staffing financial plans at all levels of expenditure from department up to Trust. - Key financial controls for the use of the break glass agency usage are in place. - Specific staff group temporary staff spend is provided to dedicated Medical and Nursing workforce oversight groups. - Financial review meetings held monthly with each Division to understand and challenge usage of temporary staffing. - Plan for every post information has been embedded to support temporary staff usage forecasts ULHT governance: - The establishment of the Improvement Steering Group will provide general oversight of Trust wide agency reduction schemes - Board assurance through Finance, Performance and Estates Committee (FPEC)	The Trust is monitored externally against an agency cap through the monthly finance return to NHSE/I The Trust monitors internally against its financial plan inclusive of specific targets for agency and bank spend by staff group The cross Trust workstreams are reported to the Improvement Steering Group The Divisional workstreams are reported to the relevant Finance, People & Activity Meeting (FPAM)	18/03/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Financial Recovery Plan schemes: - recruitment improvement; - medical job planning; - agency cost reduction; - workforce alignment	[18/03/2024 12:51:43 Rachael Turner] As at M11, agency pay expenditure of £30.0m is £3.1m lower than plan and is £17.0m lower than expenditure of £47.0m during the same period of 2022/23; while agency pay expenditure overall reduced in M11, the expenditure includes a planned increase in relation to cancer recovery for which the Trust has received funding. The reduction in agency pay expenditure is accounted for by the active management of recruitment into vacancies and movement from agency staffing to bank staffing; bank pay expenditure is £4.3m adverse to plan inclusive of the unfunded impact of industrial action. [16/02/2024 17:35:19 Rachael Turner] As at M10, agency pay expenditure of £27.4m is £3.4m lower than plan and is £16.1m lower than expenditure of £43.4m during the same period of 2022/23; while agency pay expenditure increased in M10, this includes a planned increase in relation to cancer recovery for which the Trust has received funding. The reduction in agency pay expenditure is accounted for by the active management of recruitment into vacancies and movement from agency staffing to bank staffing; bank pay expenditure is £4.1m adverse to plan inclusive of the unfunded impact of industrial action. [23/01/2024 13:16:05 Rachael Turner] Agency Pay of £24.4m is £15.2m lower than expenditure of £39.6m in 2022/23. Bank Pay of £48.2m is £12.1m higher than expenditure of £36.1m in 2022/23. This is accounted for by tX7:X8he active management of Agency staff to bank arrangements. [19/01/2024 11:41:29 Rachael Turner] Risk reviewed, no change. score to remain. [18/12/2023 16:08:27 Rachael Turner] Agency Pay of £22.1m is £13.6m lower than expenditure of £35.6m in 2022/23 Bank Pay of £41.5m is £9.7m higher than expenditure of £31.8m in 2022/23. This is accounted for by the active mangement of Agency staff to bank arrangements.	8	31/03/2023	31/03/2024	18/04/2024
3a. A modern, clean and fit for purpose environment	4647	1	Reputation	Frake-Harris, Julie	Davey, Kelron	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)	11/04/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	- Statutory Fire Safety Improvement Programme based upon risk - Policy and protocols framework and improvement plan reported into weekly Estates teams meeting - Progress reviewed by FEG and FSG monthly, to mitigate against the risk of sanctions - LFR involvement and oversight through the FSG - Regular updates with LFR provided indicating challenges during winter pressure and Covid - Fire safety audits being conducted by Fire Safety team - Fire wardens in place to monitor local arrangements with Fire Safety - Weekly Fire Safety Checks being undertaken - Improve PPM reporting for FEG and FSG By Estates Teams - Fire safety team weekly Risk assessment confirm and challenge reviews by Fire safety team - All areas of Trust allocated RAG rating for fire using using occupancy profile, escape provision, height above ground and sleeping risk - Higher rated residual risks from risk assessments being incorporated into risk	[11/04/2024 12:29:32 Rachael Turner] No change to Risk score as work continues with remedial action on compartmentation. 39 new doors on order and 2 year fire door remedial risk based programme prepared. additional joiners roles advertised. Compartmentation works ongoing based upon risk, new fire alarm and remedials works tender specification complete for marketplace April/May 2024. fire warden number continue to rise across divisions [15/03/2024 13:31:16 Rachael Turner] While works has commenced and continues regarding fire doors and compartmentation remedial actions. The risk remains until the conclusion of such remedial actions. [12/03/2024 11:05:57 Rachael Turner] Risk reviewed, no change [26/02/2024 11:29:05 Rachael Turner] Risk reviewed, no change from previous months update. [16/01/2024 13:22:28 Rachael Turner] Fire Risk Assessments are progressing based on risk priority. Review outstanding actions from previous FRA's, using FS trainer. Compartmentation (Passive): completed all 3 sites fire protection surveys, Capital teams are commencing remedial works based upon risk Fire Door Inspection: action by competent contractor, LCH and Grantham Complete. anticipated date of completion for PHB Dec 2023. Fire Alarm Systems: design of a new Pilgrim fire alarm system by capital teams. commenced 31st October with LCH and GDH to follow Storage in Corridors: security undertaking hot spot checks, completing IR1 for Managers and MyPorter. Fire Drills continue . bespoke fire safety training within higher dependency areas Fire Extinguishers concluded servicing and maintaining all 3 sites PPM Fire: Where PPM's not completed, these are escalated to the relevant Estates Lead for action.	4	30/06/2022	31/03/2024	11/05/2024

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	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
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5143	63	Service disruption	Lynch, Diane	Parkin, Mr Lee	Trust Leadership Team	Group, Information Governance Group, Outpatient Improvement Group, Patient Safety	13/04/2023	25		Clinical Support Services	Outpatients CBU	Choice, Access and Booking	Pilgrim Hospital, Boston	The demolition of H Block will remove facilities and amenities that the health records teams utilise. The impact of removing the lift will restrict the movement of patient notes and potentially the number of patients being seen in outpatients. The health records team will need to move notes in the dumbwaiters which is previously resulted in injury and legal action. With using the dumbwaiters, this will impact information governance and security of notes due to the storage and location. Staff morale will be impacted due to extra manual handling and loss of amenities required to support with mitigating this risk. This risk also has an impact on staff workload due to extra time the tasks will now take, this will also have a knock on effect to other services such as porters, secretaries. With no lift to support the department if any large items fail i.e printer or racking, replacement items will be unable to be delivered.	There is addition of dumb waiter(x2). Health & Safety risk assessment on the dumbwaiters limits the capacity to two boxes. Process in place to ensure notes are either with a member of staff or in lockable storage areas.	Patient cancellation, waiting times and waiting list increase for patients due to patient notes being unavailable or delayed. Staff survey results. Staff sickness/injury through Occupational Health and ESR.	26/03/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	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.	[26/03/2024 09:25:47 Laura Kearney] Risk as below, however new lift installation now estimated for August. Agreed that dumb waiter in clinical coding is to be upgraded and dumb waiter in outpatient office to be fixed. Gradient of ramp in health records/clinical coding to be reviewed (currently too steep). In addition 20 staff have now left the department since original lift removed, in comparison to 6 leavers during the same period prior, thus reducing the experience/knowledge in the department. [28/02/2024 11:27:56 Rachael Turner] Risk presented at RRC&C meeting 28/02/2024. Risk reduction plan has gone as far as it can go, there is a handful of temporary staff in place. This is being operated day by day. Five members of staff have been injured due to this and there are increasing staff pressures with stress. The end point is a new lift in June, the dumb waiter is also being updated as funding has been secured. Until this point risk to be increased 4x4: 20 [14/02/2024 11:29:24 Rachael Turner] The risk rating has been requested to be increased by the QIA panel (including Karen Dunderdale / Kathryn Helley / Paul Dunning) due to issues with getting notes to clinics and the cancellation of patients, the health and safety risk of other areas of the hospital as notes are unable to be returned to the library, increased sets of notes that are unable to be located, the physical injuries suffered by the staff and the claim being investigated by the legal team for injury to a staff member.Risk to be presented at Risk Register Confirm and Challenge in February. [01/02/2024 12:38:56 Gemma] [01/02/2024 10:47:42 Rachael Turner] Risk to be added to the Risk Register Confirm and Challenge agenda in February to validate increase in score. Until new risk score validated risk score to remain at 15-High Risk. [19/01/2024 10:04:46 Gemma] Funding has been agreed to replace the lift, upgrade one of the dumb waiters and to refurbish the toilets and kitchen areas - he contract has been agreed. Initially hoping to finish this project before financial	1	01/05/2023		26/04/2024
1c. Improve clinical outcomes	4828	31	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.	04/04/2024	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	[04/04/2024 08:54:58 Lisa Hansford] no update [07/03/2024 14:08:02 Lisa Hansford] Although epma has now been fully rolled out, there are new risk as a result. New risk assessment to be developed and added to RR. [13/02/2024 13:04:52 the reporter] EPMA is now rolled out across all adult inpatient areas. The risk will now be monitored and review how effective the EPMA system is. [17/01/2024 12:08:04 Gemma] EPMA is currently being rolled out. The will be in all adult inpatient areas by 22nd January. [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	4	31/12/2023	01/04/2024	03/05/2024
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	4947	27	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.	04/04/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	There are many options but we are utilising these; - We have prioritised pharmacist and technician cover to acute admission areas as patient turnover is highest on these areas and gives us to best opportunity to conduct a medicines reconciliation under 24 hours - We prioritise patients which have stayed in the longest and have critical medication where known. Prioritisation of the highest risk patients decreases the risk of harm - No ward visits are divided as much as possible. To significantly reduce this risk requires additional ward based pharmacy staff cover across 7 days.	[04/04/2024 08:45:37 Lisa Hansford] No further update [07/03/2024 14:18:16 Lisa Hansford] no further update [17/01/2024 12:05:07 Gemma] No further update [29/12/2023 13:53:23 Lisa Hansford] No further update [19/12/2023 13:26:38 Lisa-Marie Moore] phase 2 pharmacy improvement plan in development. meeting with MD 18/12 to discuss prioritisation of business cases [07/11/2023 14:13:38 Lisa Hansford] Update- DMS implementation has been affected as a consequence of low medicines reconciliation figures. Pharmacists are not clinically screening/reviewing discharges therefore this is an additional gap in the service which inhibits uptake of DMS. Core clinical pharmacy services such as medicines reconciliation and discharge screening allow additional services such as DMS to be implemented, without the former it is not possible to implement DMS [26/09/2023 14:06:35 Rachel Thackray] To meet with Medical Director to discuss lack of progress [07/09/2023 14:03:55 Lisa Hansford] 07.09.23 no changes to current situation [03/08/2023 14:48:59 Lisa-Marie Moore] No further updates [27/06/2023 09:47:37 Alex Measures] Discussed in risk register review meeting- no further updates [01/06/2023 14:17:45 Lisa-Marie Moore] No change/updates since previous entry [04/05/2023 14:12:22 Lisa Hansford] As advised at confirm and challenge meeting. Lack of compliance with national standards. [06/04/2023 13:07:13 Paul White] Discussed at Risk Register Confirm & Challenge 29 March. Risk agreed and feedback provided for consideration. [21/02/2023 08:47:37 Paul White] Note from Risk Register Confirm & Challenge Group - risk rating to be reviewed and agreed at division level prior to presentation at RRC&CG for validation.	8	30/06/2023	31/12/2024	03/05/2024

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	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
2b. Making ULHT the best place to work	4948	50	Physical or psychological harm	Cooper, Mrs Anita	Walker, Helen	Health and Safety Group, Medicines Quality Group, Patient Safety Group	17/06/2022	20	Workforce Metrics	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	04/04/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Review current provision and identify gaps in service to inform business cases for change to support 7 day working (working with Surgery and Medicine Divisions as appropriate). Skill mix requires review due to complexity of patients.. Pragmatic management of workload & provision of management support. On-going exploration of recruitment options. Wellbeing team supporting staff - regular visits organised	[04/04/2024 08:44:22 Lisa Hansford] No further update [07/03/2024 14:16:19 Lisa Hansford] Current trial at Lincoln having a more comprehensive stock list on wards, focussing on TTo's and non stock item requests to manage work load. This is a back word in terms of patient safety and does not pharmacy strategy. This risk remains moderate as this approach is reactive and does not solve the issues. [13/02/2024 16:38:34 Gemma] Risk reviewed and no change [17/01/2024 12:04:24 Gemma] No further update [21/12/2023 13:30:51 Divisional Dashboards] Lisa- Marie Moore: Ongoing challenges. Demonstrable workload increase particularly on weekends across all sites. Phase 2 work plan development to review pharmacy workforce [27/11/2023 14:55:44 Rachael Turner] Risk remains with staffing challenges, no update. [26/09/2023 14:08:09 Rachel Thackray] Staffing vacancies still remain a challenge [03/08/2023 14:48:27 Lisa-Marie Moore] No further updates [27/06/2023 09:47:53 Alex Measures] Discussed in risk register review meeting- no further updates [01/06/2023 14:17:03 Lisa-Marie Moore] No change since previous entry [04/05/2023 14:07:20 Lisa Hansford] no update awaiting review on basis of reputational risk as advised at confirm and challenge meeting 29/03/23 [06/04/2023 12:52:25 Paul White] Discussed at Risk Register Confirm & Challenge 29 March, risk agreed with feedback provided for consideration. [07/02/2023 13:29:22 Rachael Turner] Risk updated to be lead by PODC committee. Requires validation at Confirm and Challenge due to current score. Division to review risk score and attend Confirm and Challenge meeting. [05/01/2023 14:05:09 Lisa-Marie Moore] No change from previous update [08/12/2022 12:33:43 Lisa-Marie Moore] Meeting with Divisional Leads and Deputy Medical Director 25/11 to discuss short and long term actions to support	8	30/06/2023	02/10/2023	03/05/2024
3a. A modern, clean and fit for purpose environment	4648	2	Physical or psychological harm	Frake-Harris, Julie	Davey, Keiron	Fire Safety Group	Emergency Planning Group, Health and Safety Group	15/12/2021	20	Risk assessments	Corporate	Estates and Facilities	Fire and Security	Trust-wide	If a fire occurs on one of the Trust's hospital sites and is not contained (due to issues with fire / smoke detection / alarm systems; compartmentation / containment) it may develop into a major fire resulting in multiple casualties and extensive property damage with subsequent long term consequences for the continuity of services.	National policy: - Regulatory Reform (Fire Safety) Order 2005 - NHS Fire safety Health Technical Memoranda (HTM 05-01 / 05-02 / 05-03) ULH policy: - Fire Policy (approved by FEG / FSG Sept 2022 - awaiting final approval / signature to be HTM compliant): # Personal Emergency Evacuation Plans (PEEPs), approved April 2017 - Fire safety training (Core Learning, annual) / Fire Warden training / Fire specialist training - review / protocol in draft, TNA in draft for Fire Safety Team review - Major Incident Plan - Estates Planned Preventative Maintenance (PPM) programme ULH governance: - Trust Board assurance through Finance, Performance & Estates Committee (FPEC) / lead Fire Safety Group (including divisional clinical representation & regulator attendance) / Fire Engineering Group - All areas within the Trust estate are individually risk rated for fire safety (based on occupancy, dependency, height, means of escape), which informs audit / monitoring activity - Local fire safety issues register (generated from local fire risk assessments) - tasks allocated to Estates / local managers, etc. as appropriate; tracked and monitored by Fire Safety Team, validation by Fire & Rescue Service - Weekly fire safety team meetings concerning risk assessments and risk register - Capital risk programme for fire - Reporting of local fire safety incidents (Datix) generated through audit programme - Authorising Engineer for Fire - Health & Safety Committee & site-based H&S committees	Results of fire safety audits & risk assessments, currently indicate: - Fire Risk assessments within Maternity Tower block Lincoln indicating substantial breaches of compartmentation requirements - Fire risk assessments indicate lack of compartmentation within some sleeping risk areas - Age of fire alarm systems at all 3 sites (beyond industry recommendations) - No compartmentation reviews undertaken to provide assurance of existing compliance (all 3 sites) - Concerns with networking of fire alarm system at Pilgrim (to notify Site Duty Manager / Switchboard of alarm activation) Reported fire safety incidents (including unwanted fire signals / false alarms)	11/04/2024	Quite likely (4) 71-90% chance	Extreme (5)	Very high risk (20-25)	20	- Capital investment programme for Fire Safety being implemented on the basis of risk - costed budget plan for FEG submission Sept 2022. - Trust-wide replacement programme for fire detectors. - Fire Doors, Fire/Smoke Dampers and Fire Compartment Barriers above ceilings in Pilgrim, Lincoln and Grantham require improvements to ensure compliant fire protection. - Fire safety protocols development and publication. - Fire drills and evacuation training for staff. - Fire Risk assessments being undertaken on basis of inherent risk priority; areas of increased residual risk to be added to the risk register for specific action required - Local weekly fire safety checks undertaken with reporting for FEG and FSG. Areas not providing assurance receive Fire safety snapshot audit. - Staff training including bespoke training for higher risk areas - Planned preventative maintenance programme by Estates	[11/04/2024 12:32:39 Rachael Turner] No change to Risk score as work continues with remedial action on compartmentation. 39 new doors on order and 2 year fire door remedial risk based programme prepared. additional joiners roles advertised. Compartmentation works ongoing based upon risk, new fire alarm and remedials works tender specification complete for marketplace April/May 2024. fire warden number continue to rise across divisions, Fire drills continue across trust areas. [15/03/2024 13:30:41 Rachael Turner] While works has commenced and continues regarding fire doors and compartmentation remedial actions. The risk remains until the conclusion of such remedial actions. [12/03/2024 11:05:16 Rachael Turner] Risk reviewed, no change [26/02/2024 11:26:38 Rachael Turner] Risk reviewed, no change from previous months update. [16/01/2024 13:25:33 Rachael Turner] Fire Risk Assessments are progressing based on risk priority. Review outstanding actions from previous FRA's, using FS trainer. Compartmentation (Passive): completed all 3 sites fire protection surveys, Capital teams are commencing remedial works based upon risk Fire Door Inspection: action by competent contractor, LCH and Grantham Complete. anticipated date of completion for PHB Dec 2023. Fire Alarm Systems: design of a new Pilgrim fire alarm system by capital teams. commenced 31st October with LCH and GDH to follow Storage in Corridors: security undertaking hot spot checks, completing IR1 for Managers and MyPorter. Arson Risk patrols by security team and warden trained Fire Drills continue . bespoke fire safety training within higher dependency areas Fire Extinguishers concluded servicing and maintaining all 3 sites	10	31/03/2022	31/03/2025	10/05/2024
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5100	487	Physical or psychological harm	Rivett, Kate	Herath, Dr Durga	Children & Young Persons Oversight Group	Clinical Effectiveness Group	14/03/2023	20	Family Health	Children and Young Persons CBU	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;	08/04/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	1. Multi-professional working group tasked with delivering improvements that will support achievement of audit compliance.	[09/04/2024 11:24:36 Nicola Cornish] A business case is being developed for expanding the epilepsy nursing team. [13/03/2024 09:12:22 Nicola Cornish] Benchmarking has been completed - initial review suggests that the outstanding gaps relate to the community service rather than acute. Further discussion required with Dr Herath to confirm this - if there are no further acute actions this risk could be closed. If Dr Herath confirms ongoing acute concerns, the risk will remain open but scoring may be reduced. [14/02/2024 14:54:26 Nicola Cornish] No change. Business case meeting this week to progress so that bid can be submitted to ICB for funds. [10/01/2024 14:26:18 Nicola Cornish] No change. Need to complete benchmarking. [16/11/2023 16:25:11 Nicola Cornish] No change as per discussion at RRC&C meeting on 07/11. [07/11/2023 11:31:43 Helen Shelton] Reviewed at the RRC&C meeting and agreed that despite the appointment of 2 epilepsy nurses the risk remains very high at 20 as A further BC is now required to improve the service further. [11/09/2023 15:33:59 Jasmine Kent] Both epilepsy nurses have started and have been asked to see newly diagnosed epilepsy patients, asked to take on cohort of complex patients so parents are receiving better support. For reduction to a 16 on both acute and community paeds. Tertiary engagement has been escalated to ICB. As agreed at RRCCG - for reduction to a 16. [14/08/2023 14:30:44 Jasmine Kent] 2 nurses now in post, risk remains very high due to difficulty engaging with tertiary neurology. [10/07/2023 13:47:04 Jasmine Kent] Requires discussion at governance and with Epilepsy service lead, no change that the team are aware of but will update following governance later this week if any further developments have been	8	14/03/2024		08/05/2024

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	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
3b. Make efficient use of our resources	5020	6	Finances	Hamer, Fiona	Smith, Charles	Workforce Strategy Group	WORK	02/09/2022	20		Medicine	Urgent and Emergency Care CBU			If there is a continued reliance on bank and agency staff for medical workforce in Urgent & Emergency Care there is a risk that there is not sufficient fill rate for medical rotas both ward / department fill and on call shifts which will impact on patient safety and have a negative impact on the CBU budget	Robust medical plan for every post meetings Close working with temporary medical staffing team Daily management of any gaps to support minimum staffing levels Fundamental overview of tier 1 and tier 2 docs in medicine and ED based on RCP safer staffing levels. Introduction of BMA rate cards This will reduce once output on medical workforce plan is in place, not due to come online in this review period.	Plan for every post meetings Budget reports	15/04/2024	Quite likely (4) 71-90% chance	Extreme (5)	Very high risk (20-25)	20	Robust recruitment plan International recruitment Medical Workforce Management Project	[15/04/2024 11:08:21 Rachael Turner] Ongoing challenge for requirement for agency and bank backfill to make department safe. T2 workforce continues, aim for completion Q3/Q4. Risk score remains. [05/03/2024 09:10:47 Rachael Turner] Risk reviewed, no change. [07/02/2024 09:16:42 Rachael Turner] Risk reviewed, no change. [09/01/2024 15:13:18 Rachael Turner] Consultation ongoing with completion due end of Feb/March. Risk currently remains the same. [13/12/2023 16:48:28 Rachael Turner] Improvement seen against Acute and GIM rotas after recruitment. However significant spend still re: ED T2 staff due to ongoing consultation. Resolution expected early 2024 with implementation Fed/March 2024. Ongoing impact of IA also to be considered." [20/11/2023 20:25:40 Rachael Turner] Work ongoing, posts waiting to be filled. Agency and bank continue to backfill. [17/10/2023 10:09:53 Rachael Turner] Consultation in place for medical workforce, funding has been agreed but remains covered by bank and agency until posts can be filled. [26/09/2023 14:44:54 Charles Smith] Risk remians the same but recruitment across Acute/GIM rotas improving over next couple of months. Ongoing impact of Strikes. Tler 1 and 2 in place for med, ongoing tier 2 consultation ED. [15/08/2023 11:14:12 Helen Hartley] Remains the same, plans for recruitment and money signed off. Stays the same until recruitment piece has happened. There is a trajectory for this, beginning 2024. Tier 1 in place Tier 2 consultation discussed in case of next steps/formal outcome. Medical workforce additional consultants signed off for RAT, positive steps happening but this will take time. [19/07/2023 15:50:48 Helen Hartley] This remains a risk, should be reduced with medical workforce management project that CS is leading. Some delays with	10	02/09/2023		15/05/2024
1c. Improve clinical outcomes	4731	33	Physical or psychological harm	Frake-Harris, Julie	Dunning, Mr Paul	Medical Records Group	Patient Safety Group	13/01/2022	20	Risk assessments	Clinical Support Services	Outpatients CBU	Choice, Access and Booking	Trust-wide	If patient records are not complete, accurate, up to date and available when needed by clinicians then it could have a widespread impact on clinical services throughout the Trust, potentially resulting in delayed diagnosis and treatment, adversely affecting patient experience and reducing the likelihood of a positive clinical outcome.	- Clinical Records Management Policy (approved June 2021, due for review December 2023) - Trust Board assurance via Finance, Performance & Estates Committee (FPEC); lead Information Governance Group / Clinical Records Group - Now led by Deputy Medical Director.	Internal audit of medical records management processes - reliance upon hard copy patient records; patients may have multiple sets of records. Reported incidents involving availability of patient records issues.	26/03/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Design and delivery of the Electronic Document Management System (EDMS) project, incorporating Electronic Patient records (EPR). Interim strategy required to reduce the risk whilst hard copy records remain in use.	[26/03/2024 09:33:18 Laura Kearney] CSS Interim GM, Lee Parkin, met with Paul Dunning, Medical Directors Office. Paul is of the opinion that any medical information held om electronic systems is not required to be printed and added into paper based notes, reducing reliance on such notes and therefore reducing the risk. Mr Dunning will take this suggestion to the Medical Director team to confirm whether required to go to MAC for sign-off, or whether this can be conveyed via a Trust communication. Once confirmation has been agreed/received the risk scoring will be reviewed. [04/03/2024 11:06:11 Gemma] Risk reviewed and no further change [05/02/2024 15:41:56 Gemma] Risk reviewed and is ongoing until an electronic health record is introduced. [23/01/2024 17:56:20 Gemma] There have been communications sent out to all clinical colleagues to remind them to ensure that patient records are and accurate and available. The Clinical Records Group Chair, will also request a quarterly report to be discussed at the meeting to ensure that any trends/issues are highlighted. [21/11/2023 08:38:09 Anita Cooper] Clinical Records Group now led by Deputy Medical Director therefore risk agreed to sit with DMD with input from Outpatients/Health records team. [30/10/2023 14:17:15 Emma Cripps] No further progress update [08/09/2023 10:45:27 Maddy Ward] Risk reviewed at Outpatients Quarterly Risk Register Review this morning. No further updates at present No further change since last review. [01/08/2023 15:35:42 Lee Parkin] No change since last review 06/06/2023 [06/06/2023 11:46:11 Maddy Ward] Still a very high risk with ongoing concerns. Will be a risk until electronic records are implemented across the trust. To mitigate the risk until that time the records management policy has been updated and communications will be sent by the Medical Director clarifying the protocols	4	30/06/2018	31/03/2025	26/04/2024
2a. A modern and progressive workforce	4997	41	Service disruption	Dunning, Mr Paul	Chester-Buckley, Sarah	Workforce Strategy Group	Patient Safety Group	22/08/2022	16		Clinical Support Services	Cancer Services CBU	Haematology (Cancer Services)		Service configuration - single consultant covering both sites during weekend so cover limited if critically unwell patients on both sites	Middle Grade cover in place from Oncology but not sustainable as Haematology is not their area of experise and therefore cannot replace consultant presents with acutely unwell patients.	* Increased Datix, Complaints and PALS * Outcome from Staff Survey results	25/03/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	* Workforce review - Now Completed (Sarah Chester-Buckley - July 2023) * Refresher of Fragile Services Paper - NB there is a National shortage of Haematology consultants - Now completed (Sarah Chester-Buckley - September 2023) * Recruitment of further substantive consultants - (Sarah Chester-Buckley - May 2024) * Additional unfunded ST3+ for Haematology starts in August 2022 - Now completed (Sarah Chester-Buckley - July 2023)	[25/03/2024 10:06:21 Gemma Staples] Haematology rightsizing SJBC presented at ICB investment panel on 15th March, still awaiting outcome. [26/02/2024 16:53:12 Gemma] Risk reviewed and ongoing [31/01/2024 14:32:33 Gemma] Risk reviewed and ongoing [18/01/2024 11:09:19 Gemma] Haematology rightsizing paper taken to TLT and approved, now needs to go to the Board and ICB investment panel. [22/12/2023 08:18:40 Gemma] Haematology rightsizing paper (SBJC) presented and approved at CRIG 19/12/23. Now needs to be presented at Board and ICB investment panel. Further update to be provided at a later date. [02/11/2023 15:21:13 Vicky Dunmore] Rightsizing haem Business Case to go to CRIG Nov 2023 [14/09/2023 15:02:19 Rose Roberts] Rightsizing Haem paper to be presented at CRIG Sept 2023. [03/08/2023 10:01:13 Rachael Turner] Following the briefing paper being received by ELT, weekly meetings have been set up with DL_EM_LR and MH. An action plan has been put in place. A meeting was held with the Haematology Consultants, Andrew Morgan and Michelle Harris on 31.07.2023 and it was agreed to go out to advert for 4 Haematology Consultants, 1 Haematology Secretary and 2 Secretary Assistants. [02/06/2023 12:39:17 Maddy Ward] Andrew Morgan requested a briefing paper for ELT which is now complete in conjunction with transformation and due to be circulated to execs on 05/06/2023 [24/04/2023 10:36:05 Maddy Ward] Haematology service review carried out on 20th April 2023 in association with strategy, planning, improvement and integration directorate [03/04/2023 09:43:59 Rose Roberts] Workforce paper for haem with triumvirate, then will start oncology workforce paper. Reviewed at confirm and challenge confirmed as v high risk.	8	01/04/2023	01/04/2023	25/04/2024

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	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
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	4779	61	Physical or psychological harm	Frake-Harris, Julie	Ratcliff, Carl		Patient Safety Group	16/01/2022	20	Risk assessments	Medicine	Cardiovascular CBU	Stroke		Increase in risk of delays to patient care/harm as a result of increasing backlog of planned care activity across stroke arising from Covid19 constraints / service restrictions/ site escalation pressures.	additional clinics/lists (cost pressure) additional staffing where feasible to increase capacity (cost pressure)	weekly monitoring of RTT and PBWL	18/03/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	-Virtual clinics in place for substantive consultants, where long overdue follow ups are giving priority. Overdue was standing at 989 patients, this was reported in October 2023. With industrial action, this will have had an impact. Trajectory of how we continue to reduce to be provided.	[18/03/2024 10:35:28 Rachael Turner] PBWL reduced to half due to carrying out virtual clinics. Work remains ongoing. [15/01/2024 14:24:35 Rachael Turner] Risk reviewed, controls in place and risk reduction plan updated. Virtual clinics currently in place to provide follow ups for long overdue patients. [13/12/2023 19:05:30 Rachael Turner] No current update, meeting to be had to combine with Risk 4780 and 4778. Due to staffing working capacity this will be done in January 24. [27/09/2023 11:31:18 Rachael Turner] Risk discussed at RRC&C as part of the Deep Dive. Since Covid this risk has moved on, this needs to be reviewed and possibly combined with risk ID 4780 and 4778. [30/08/2023 11:19:10 Carl Ratcliff] to review with COO as may be able to remove given lower COVID demand [23/07/2023 12:57:33 Carl Ratcliff] Proposal been constructed to allow better use of LCH beds - await feedback from Execs on next steps [24/04/2023 12:28:58 Carl Ratcliff] Improvement work started with team and perfect week in May will look at all opportunities for service. [27/01/2023 10:23:30 Charles Smith] 27/01/23 - CS DGM - Ongoing area of concern due to workforce and ACP gaps (being recruited to but time required to train). TIA still a concern but stable numbers. [16/12/2022 14:35:47 Carl Ratcliff] Additional work in palce to find external support / validate PWL and push patients through system [22/11/2022 17:25:10 Carl Ratcliff] Aim to have outliers back in right place and work continues to improve OPD work. Limited consultant numbers still mean there is a risk to OPD planned care work Plans in place to address backlogs across all areas. Significant area of risk for TIA. 23.08.22 Remains an issues although noting covid cases have dropped. Will be	4	31/03/2022	29/12/2023	18/06/2024
4b. Becoming a University Teaching Hospital Trust	5160		Reputation	Morgan, Mr Andrew	Rich-Mahadkar, Sameedha			21/04/2023	16		Corporate				If we don't deliver against our ambition of becoming a University Hospital Trust, this could negatively impact our organisational reputation.	Following UHA guidance Regular discussions between Executive leads from ULHT and UoL regarding financial arrangements Working closely with University of Lincoln to define and agree future collaborations Working with Research and Innovation teams and reporting into R&I groups to maintain oversight	Executive scorecard - number of clinical academics in post and number of collaborations that are developed to support research grants	29/01/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Continued discussions between ULHT and UoL Executive leads to finalise research and financial agreements Application for Teaching Hospital Status as interim step. Contact with UHA to confirm requirements for application	[18/10/2023 11:52:17 Rachael Turner] An application for Teaching Hospital Status is to be submitted to the DHSC as an interim step to recognise ULHT's significant teaching commitment. We anticipate that this will be approved before the end of 23/24 financial year. An MOU and financial model is being developed and agreed between ULHT and UoL which will support our requirement to recruit clinical academics and regular meetings are in the diary to conclude this work. A new ULHT Growth of Research Culture group has been established. [07/06/2023 12:20:47 Rachael Turner] Risk discussed at RRC&C meeting 07/06/2023.Risk needs to reflect more than getting status, such as recruitment, quality of people you attract, development and investment. Risk score 4 x 4 making it a score of 16 High Risk.	8	31/03/2025		29/04/2024
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5002	535	Service disruption	Farquharson, Colin	Edwards, Mrs Jill	Palliative / End of Life Care Oversight Group	Clinical Effectiveness Group	23/08/2022	16		Clinical Support Services	Cancer Services CBU	Specialist Palliative Care		"If the Trust is not consistently compliant with NICE Quality Standards and commissioning guidance for specialist palliative care (SPC) to identify and provide appropriate care, delays on discharge and support for people who may be at end of life, then there may be delays to accessing appropriate care and treatment provided by specialist palliative care teams, resulting in serious physical and psychological patient and family harm, with a poor patient experience of care and service. "	"National Policy - NICE Quality Standard (QS13) End of life care for adults - NICE Guideline (NG142) End of life care for adults: service delivery - NICE - Care of dying adults in the last days of life Quality standard Published: 2 March 2017 - Ambitions for Palliative and End of Life Care: A national framework for local action 2021-2026 - 'One Chance to Get it Right: improving people's experience of care in the last few days and hours of life' Leadership Alliance for the Care of Dying People. June 2014. - 'Every Moment Counts' A narrative for person centred co-ordinated care for people near the end of life (VOICES) - Commissioning guidance for Specialist Palliative Care (2016). Local Strategy - Palliative and End of Life Care (PEOL) strategy for Linconshire - PEOL Re-Design for PEOL services Lincolnshire - ULH Strategy for PEOL ULH Governance - SPC Governance/ CSS CBU/ Cancer Services/ SPC - NACEL report"	"Frequency of referrals outside SPC referral criteria Frequency of referrals that require more information for triage Number of Datix incident and complaints relating to patient care Frequency of patients died/discharged before seen Frequency of patients dying outside Preferred place of death Frequency of first assesment (over 24hrs) from service KPI's. SPC workforce review including staffing deficits and skills gap analysis MDT attendance at point of recommendations	31/01/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	"Daily caseload review and triage of caseload using PEOL OPEL reporting measures with sitrep for escalation of risks Daily palliative huddle with key partners to support demand Working as one team across sites to provide pan trust cover Increase in senior leadership for direct support to PEOL at ULHT by addition of deputy lead nurse for PEOL Completion of Workforce plan to identify gaps in alignment with national policy and guidance. Commenced Service improvement gap analysis. Internal and external ask for multi disciplinary support to the SPC team. Externally sourced Clinical Education. Development of PEOL champions developed throughout Trust. Commence update to PEOL business continuity plan. Continued involvement in systemwide PEOL Operational meeting to promote improvements across services Analysis of staff competency and supervision completed and development plans in place. Develop action plan for NACEL analysis of staff competency and supervision completed	[31/01/2024 12:36:56 Rachael Turner] Risk discussed at RRC&C meeting 31/01/2024 for increase in score. Not meeting KPI and significant delays to patients receiving care and direct patient harm. We cannot see people within 24 hours, this is currently at a week. 30% of discharges discharged with no further referral provided. Risk of patient harm due to workforce, we are working at between 5-13% currently at 1.8. There is no MDT. Currently no resource for change. Risk score reviewed and validated: 4x4:16 High risk. Also risk of regulatory action, new risk to be created to cover this. [08/12/2023 13:25:40 Gemma] Risk discussed at SPC Governance identified not able to meet KPI of 75% of referrals assessed within 24hours. This is evidence that the risk has increased and therefore would like to be considered as a high risk. Email sent to Rachel Turner to ask that this be discussed in January 2024 RRC&C [02/10/2023 10:19:22 Rachael Turner] Risk discussed at RRC&C meeting agreed to be reduced to 4x3: 12 Moderate risk. [15/09/2023 09:07:47 Rachael Turner] Risk to be presented at RRC&C to upgrade to a High risk. [14/09/2023 14:29:14 Rose Roberts] NICE quality standard for care under review by peol OG, action plan to be created. [14/09/2023 14:27:47 Rose Roberts] Case of need is now in draft form for and out for comment. Risk reduction measures are still in place. [02/06/2023 13:00:43 Maddy Ward] We have started the case of need for the SPCT. [24/04/2023 11:06:37 Maddy Ward] Reviewed at Cancer Services quarterly risk register review meeting this morning, this risk is ongoing. [03/04/2023 13:09:18 Rose Roberts] All the ongoing risk reduction measures continues. The service still operating at Opel level 2, unable to deescalate to opel 1, due to ongoing demand and available resource. Business case is being developed. This went to confirm and challenge in Sept, it was agreed it should be	4	30/12/2024		30/04/2024

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	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
2a. A modern and progressive workforce	4741	42	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	05/04/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Need to undertake a workforce review, oncology still a fragile service, continuing to work with HR to source consultants (Vicky Dunmore - March 2024)	[05/04/2024 10:41:51 Gemma Staples] Risk reviewed. No further update [05/04/2024 10:38:06 Gemma Staples] Consultant Oncologist workforce capacity [18/01/2024 11:26:42 Gemma] Oncology rightsizing paper currently being written. [14/09/2023 16:04:46 Rose Roberts] Ongoing [28/06/2023 14:43:05 Rachael Turner] Following this risk being discussed at RRC&C meeting, the question was raised around the number of patients currently waiting to be seen (including overdue) These are as follows: Oncology PBWL numbers as at 29/5/23: Lincoln County Hospital: Overdue: Clinical - 171 Medical – 55 Total number of patients on PBWL (including overdue): Clinical – 2169 Medical – 226 Pilgrim Hospital Overdue: Clinical - 30 Medical – 9 Total number of patients on PBWL (including overdue): Clinical - 531	4	31/03/2023	31/03/2023	05/07/2024
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5267	485	Physical or psychological harm	Ratcliff, Carl	Marsh, David			26/09/2023	16	Risk assessments	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	18/03/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	1. Work with imaging colleagues to develop/review need for additional imaging consultant with CMR included in Skill-set. 2. Continue to mitigate proactively at cost via current controls.	[18/03/2024 10:38:56 Rachael Turner] Reporting is massively reduced. As of last Monday there were just three to report. Longest wait was two days. This risk will be chased so that it can be agreed for a reduction and presented at RRC&C. [15/01/2024 14:28:44 Rachael Turner] There is no significant backlog. Weekly check of performance has been provided as evidence. This risk will need approval at Division in order to be reduced in score. If agreed this will go to Risk Confirm and Challenge for a reduction in score. [25/10/2023 11:12:43 Rachael Turner] Risk discussed at RRC&C meeting 25/10/2023, risk validated as 4x4:16 High Risk. [26/09/2023 15:02:00 Charles Smith] As of 11/09/23: •There are a total of 125 cardiac MRI studies awaiting reporting •The oldest scan on the reporting list is from 24 July 2023 (seven weeks) •There are 13 scans from July, 68 scans from August and 44 scans from September waiting to be reported	3	01/07/2024		18/06/2024
1c. Improve clinical outcomes	4928	89	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	18/03/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	-Weekly waiting list meeting -Weekly RTT meeting For both of these we make plans for all patients that are 45 weeks and over. This will be ongoing. -Review in place for all our pathways-this is continually at present so we can re-design with the correct cohorts.	[18/03/2024 10:44:23 Rachael Turner] Risk reviewed, waiting lists have reduced down significantly, booking up to six weeks ahead. Those on the list are being reviewed for priority and whether they require to be seen. 3563 are now currently on the waiting list. RTT position 52.54%. Risk to be looked at to be reviewed for a reduction in score. [15/01/2024 14:33:03 Rachael Turner] Waiting lists are coming down with regular monitoring and validation. We have now adopted a 6 4 2 process for booking our waiting list slots. Performance is reported through Governance PRM every month. Risk Reduction plan reviewed and updated. [16/10/2023 16:34:58 Rachael Turner] The Cardiology waiting list has been extensively validated and has been reduced. Our biggest backlog on the waiting list is loop recorders and we are holding a three day "loopathon" 14-16th November where 96 patients will be treated. New Patient appointments-they have been hampered by industrial action, we have extensive validation. We have reduced the number of 52 week breaches. Our RTT position is 49.35%. We are undertaking a review of clinic templates to make sure clinicians are seeing the correct number of new and follow up patients per clinic. Remote monitoring-we have case of need going to CRIG in November to put 500 patients a year on remote monitoring, this will make a better experience for patients. Just bid for specialised funding to reduce our backlog with tapes, currently have 2700 patients waiting. [16/10/2023 16:34:45 Rachael Turner] The Cardiology waiting list has been extensively validated and has been reduced. Our biggest backlog on the waiting list is loop recorders and we are holding a three day "loopathon" 14-16th November where 96 patients will be treated. New Patient appointments-they have been hampered by industrial action, we have extensive validation. We have reduced the number of 52 week breaches.	8	15/01/2025	01/03/2024	15/06/2024

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	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
3b. Make efficient use of our resources	4665		Finances	Matthew, Mr Paul	Young, Jonathan	Financial Turnaround Group		11/01/2022	20	Risk assessments	Corporate	Finance and Digital	Finance	Trust-wide	Updated in May 2023 to reflect 23/24. The Trust has a £28m CIP target for 23/24. If the Trust fails to deliver The CIP Plan it will have a significant adverse impact on the ability of the Trust and the Lincolnshire ICS to achieve their financial plans.	National policy: - NHS annual budget setting and monitoring processes ULHT policy: - Detailed Financial plan inclusive of the establishments and embedding of the 3 T's; Transactional, Targeted and Transformational. - Alignment of the Trust financial improvement opportunities with system partners to develop an integrated financial plan inclusive of CIP. (Transformational) - Establishment of the service framework to prioritise Speciality improvement reviews. (Transformational) - Establishment of a suite of cross cutting schemes aligned to the Trust Improvement Strategy. (Targeted) - Divisional CIP targets allocated as part of the budget setting process from 1st April. (Transactional) ULHT governance: - Detailed CIP reporting via the CIP tracker supported by QIA process - Programme Management Office (PMO) & dedicated Programme Manager. - Introduction of the Improvement Steering Group to monitor, challenge and hold accountable for the Targeted and Transformational Schemes - Refresh of the FPAMs to monitor, challenge and hold accountable for the Transactional Schemes	The Trust is monitored externally against the Trust CIP target through the monthly finance return to NHSE/I The Trust monitors internally against its CIP targets inclusive of specific Divisional and Scheme targets Divisional focus against Transactional schemes is reviewed at the relevant FPAM. Trust focus against Targeted and Transformational schemes is reviewed at the Improvement Steering Group	23/01/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	- Refresh of the CIP framework and training to all stakeholders. - Increased CIP governance & monitoring arrangements introduced. - Alignment with the Trust IIP and System objectives - CIP is embedded as part of the Trust Improvement Strategy not seen as a separate workstream.	[23/01/2024 13:18:19 Rachael Turner] The focus has now switched to pipeline opportunities for 24/25 and the ability of the trust to build a sustainable pipeline of cost improvement for the future. The Target for 24/25 is £32m. [16/10/2023 17:17:59 Rachael Turner] The Trust has over delivered each month on the FRP target months 1-6. This meets the criteria for NOF 4 of delivery in 6 consecutive months. Year to date at month 6 the FRP has overdelivered by £5.3m The trust is still forecasting to deliver a full £28.1m CIP programme for 23/24. The trajectory for savings steps up from month 7 onwards so the run rate of savings needs to increase going forwards. [14/07/2023 09:09:38 Rachael Turner] Risk reviewed, risk score to remain as current work is ongoing. The Trust has over delivered against the month 1 trajectory for the FRP by £0.5m. The trust is also forecasting to deliver a full £28.1m CIP programme for 23/24. [28/06/2023 16:16:06 Rachael Turner] Risk reviewed, targets have been reviewed to reflect where we currently stand. we have hit financial improvement target for month 1 and 2. Risk score to remain the same at 16 High Risk. [24/05/2023 13:11:53 Rachel Thackray] Updated to reflect the risk for 2023/24. The Trust has plans to deliver £28m CIP (FRP) target. In month 1 delivery exceeded plan. [02/02/2023 14:13:16 Rachel Thackray] The Trust is forecasting to deliver a £18m CIP programme for 22/23 a shortfall of £11m against its revised plan, which has been partly mitigated through the risk and gain share contractual agreement with the ICB, however this still leaves an under delivered CIP requirement that has resulted in a contribution to the forecast deficit position of the Trust. [02/02/2023 14:12:00 Rachel Thackray] The Trust is forecasting to deliver a £18m CIP programme which has been partly mitigated through the risk and gain share contractual agreement with the ICB, however this still leaves an under delivered	4	31/03/2023	31/03/2024	23/04/2024
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5095	59	Physical or psychological harm	Capon, Mrs Catherine	Chamberlain, Liz (Elizabeth)			24/02/2023	16	Risk assessments	Surgery	Surgery CBU	Vascular Surgery	Pilgrim Hospital, Boston	Due to increased demand for PICC services there is a risk that within the current establishment there is a significant delay to patients. This can delay treatment, hinder flow and cause poorer outcomes for patients. 8 years ago, venous access within the Trust was classed as central lines (internal jugular insertion) and cannulas. Peripheral central catheters (PICC) were undertaken occasionally for oncology patients and portacaths and Hickman lines were done in theatre, as they still are. The vascular ACPs started to learn how to insert picc PICC lines starting from one morning clinic on a Tuesday (supported by the Consultants). The needs for PICC increased and we went to two full day clinics in a week. They were only inserting in pilgrim at that time. It was then determined that Total Parental Nutrition (TPN) needed to be given centrally and not peripherally, and the work load increased two fold. A business case was successful for a 1.0 WTE band 6 venous access nurse to take on the clinics as the work load for the ACPs was also increasing. The Royal College of Radiologists state that a PICC line should be inserted with 72 hours. However, due to the varied nature of why a line is required particulary for urgent cases this has been deemed locally as 24 hours.	At present there is one 1.0 WTE VAN (band 6) and two 22.5 hours HCSW (band 2) covering: - Lincoln clinics (in patient only) Monday (up to and including 6 patients) and a Wednesday out/in patients - Pilgrim clinics Tuesday and Thursday, both in and outpatients - All clinics have slots for up to 6 patients, however, many late referrals are received and the clinic can increase to anything up to 12 patients. This means that the VAN goes home late most nights that incurs overtime payment. This additional activity is driven through urgent care pathways and is reliant upon a stretched team to meet this demand. As services enter a a post COVID climate there has been a recognised increase in complexity of presentations due to non-presentation at an earlier point. Case of Need has been written with final finance input outstanding to then go to CRIG ACPs are trained in this procedure but should not be relied upon as takes away from other core duties and is not a sustainable. Interventional Radiology is picking up some activity although this exposes patients to radiation and is not a sustainable option. This also require anaesthetics and theatre resources.	Volume of requests against number of staff and time taken to acquire IR1 submissions - started to see an increase in incidents being reported.	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
3c. Have enhanced data and digital capability	4641	18	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	21/03/2024	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.	[21/03/2024 11:59:38 Rachael Turner] The new Lincoln comms rooms are now largely complete and almost at the point of supplier handover, this will allow commissioning to take place during Q1/Q2 24/25. The second new comms environment at Pilgrim Hospital has been procured and will be implemented during FY 24/25. [21/03/2024 11:58:08 Rachael Turner] Propose no update to current risk score but forward view is once of reducing risk, particularly when these new facilities are onboarded. [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	21/06/2024
3c. Have enhanced data and digital capability	5245		Service disruption	Jenkins, Barry	Humber, Michael			30/08/2023	20		Corporate	Finance and Digital	Digital Services (ICT)	Trust-wide	The Trusts disaster recovery capabilities are limited. In the event of a major incident affecting the primary data centre/site the ability to restore services elsewhere is limited. This would affect the availability and data integrity of tier 1 clinical and corporate systems, leading to extended unavailability and reliance on Business Continuity Plans. In addition there is a risk of significant data loss in the event that recent backups are unavailable or compromised.	-Business Continuity Plans which the Trust is planning to exercise of a regular basis via Emergency Response. -Annual SIRO approved incident response exercise. -Protections that reduce the likelihood of various disasters, including environmental and technical controls: A number of improvements have been made in this area. We now have a dedicated ""stretched"" Metro cluster between Lincoln and Boston. We also have Standard clusters at each site which have increased capacity. -Immutable Backup system introduced to ensure organisational data is held securely and available for recovery, this includes off site cloud storage for critical data	-Annual SIRO approved incident response exercise. -Incidents reported via Datix these are backed up via an RCA and lessons learned.	30/01/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Whilst some systems still need to transition fully with VLAN/IP changes we do have new systems and system upgrades migrating to the new solution. Enabling Tech programme in place to improve the Trust Foundations from which the Digital Services will run. This requires completion prior to remobilisation of EPR. Trajectory for this is 2025/26.	[30/01/2024 11:04:10 Rachael Turner] Risk reviewed. Risk controls and reduction plan updated. Risk score to remain. [20/12/2023 09:22:32 Rachael Turner] In the process of implementing Rubrick, which will support disaster recovery and cloud back up. [30/08/2023 16:06:58 Rachael Turner] Risk discussed at RRC&C meeting 30/08/2023, score validated as: 4x4: 16 High Risk.	10	30/08/2024		30/04/2024

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	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
2b. Making ULHT the best place to work	5251		Reputation	Low, Claire	MacDonald, Damian			06/09/2023	16		Corporate	People and Organisational Development	Organisation Development	Trust-wide	If the Trust doesn't have an effective approach to employee appraisals then it could have a negative impact on morale and lead to poor performance, inappropriate behaviours, reduced productivity, non-compliance with policy, increased turnover.	1. Dedicated page for Staff Appraisals on the Intranet with a wealth of easily accessible information that sets out the process, principles, benefits, fact-sheets 2. Leading an Effective Appraisal 2-hour virtual workshop available to all managers to support them in developing their skills and confidence to undertake staff appraisals 3. Creation of an Appraisal and Career Discussion form that is simple but allows for discussion on performance, professional relationships, career and development goals, and wellbeing. It also allows for performance and development objectives to be set, an overall assessment of performance to be made and a check on completion of mandatory training to be undertaken. There are also forms to support managers to undertake regular 1:1 'check-ins' and to undertake mid-year reviews 4. Trust governance: Board assurance through People and OD Committee	1. Compliance rates reported at Divisional and Trust level in a variety of forums monthly	11/01/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	1. Creation of a Task and Finish Group to undertake a scoping/review exercise to understand current issues and barriers to completion 2. Findings of Task and Finish Group to be used to inform and develop an Improvement Action Plan 3. Complete Improvement Action Plan when drafted - to be monitored through Workforce Strategy and OD Group and reported up to People and OD Committee 4. Ensure detailed scrutiny takes place at FPAM with Divisions - Learning and Development Coordinator to provide more detailed monthly slides as part of FPAM reporting"	[11/01/2024 12:38:02 Rachael Turner] This is a reducing risk as we work through the risk reduction plan. Following a workshop in Jan 2024, we should be in a position to reassess the risk level and we will take this forward with our risk business partner [06/09/2023 14:10:25 Rachael Turner] This risk was reviewed and validated at the RRC&C meeting August 2023. Approved score 4x4:16 High Risk. [06/09/2023 14:09:45 Rachael Turner] Two priority issues identified: • Review the Staff Appraisal cycle and how this can best be aligned to business and financial planning to ensure there is a link between performance from the organisational to individual level ('golden thread') • Scope out the potential for utilising ESR for eAppraisal or whether an alternative solution would need to be found – review what system colleagues are doing and whether the Trust could use or learn from their solutions Ongoing service pressures and staffing challenges in the Trust continue to impact appraisal completion rates but month on month there is a slight improvement with an increase in June 2023 to 67.93% non-medical and an increase to 98.24% for medical. We are continuing to recommend that a 90 minute appraisal for each colleague is planned for as we enter 2023/24. Following an audit completed in Urgent & Emergency Care we identified that a number of colleague's appraisals had been completed in the past 12 months within WorkPAL, however were not recorded on ESR. Work is underway to educate leaders on the process required to update ESR, even for ones done on WorkPAL already. This will include 'how to' guides/sessions and utilising reporting to identify areas of low completion.	8	06/09/2024		11/04/2024
3a. A modern, clean and fit for purpose environment	4725	466	Physical or psychological harm	Cooper, Mrs Anita	Froggatt, Hayley	Estates investment and Environment Group	Health and Safety Group	13/01/2022	20	Risk assessments	Clinical Support Services	Therapies and Rehabilitation CBU		Lincoln County Hospital	If essential repairs and maintenance requirements at Lincoln County Hospital Occupational Therapy Department are not addressed then it may lead to accidents and injury resulting in potentially serious harm to staff, patients and visitors. There is a security risk to the building.	Legislation: - Health & Safety at Work Act 1974 -Management of Health & Safety at Work Regulations 1992 associated guidance. ULH policy: - Health & Safety Policy & related guidance - Health & safety training (Induction, Core Learning, Core Plus Learning and CPD) - Estates Planned Preventative Maintenance (PPM) / testing - Occupational Health services ULH governance: - Health & Safety Committee / site-based H&S Forums; accountable to Trust Board through Finance, Performance & Estates Committee (FPEC)	IPC flo scores, monitoring of incidents, staff satisfaction concerns, complaints / PALS Tracking of Estates work requests - The Department has a significant amount of outstanding jobs including, leaking windows, leaking roof tiles, carpeted areas, unsanitary toilet/shower & changing facilities, repeatedly broken toilets. Inability to monitor temperatures due to inappropriate fitting of radiator covers, swelling and uneven floor services following leaks.	05/02/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Daily & Weekly IPC checks, Staff well being checks, frequent monitoring of safety issues. Escalation to H&S Team via audit process. Monthly updates to MICAD system, Escalation via IPC FLO audit process.	[05/02/2024 11:05:23 Gemma] Rehabilitation Medicine will move across into the OT area as an interim measure while further suitable accommodation is sourced. [01/02/2024 13:40:16 Gemma] We will be moving to the physio therapy department as an interim measure until new premises sought within the hospital. Moving to physio hopefully before the end of the financial year. [27/09/2023 12:05:47 Rachael Turner] Risk discussed at RRC&C Meeting for an increase in score to a High Risk score of 16. There could be regulatory impact if this was not looked at and also issues reputationally. [08/09/2023 14:08:38 Maddy Ward] Likelihood of risk has been updated to quite likely in review meeting making it a high risk. Glass is falling from window frames more frequently due to rotten window frames and we have had water/rain coming into electrics. This is included in the estates escalation report. [23/06/2023 14:00:51 Rose Roberts] Flooring has been approved and has been accepted by estates. Not got a date yet. Windows etc have been escalated. [27/04/2023 14:29:26 Rose Roberts] CVR office also has a carpet - feedback from estates is quote received and awaiting go-ahead to commence work from Clinical Support Services. Rotting wooden windows - Feedback from estates is that windows are a known issue with the building but there is no funding available Changing room and Macmillan office have carpet - feedback from estates is quote received and awaiting go-ahead to commence work from Clinical Support Services. Visitor toilet - Feedback is that operative is to attend Lever taps – job raised following IPC audit that all taps need to be replaced. Feedback from estates is In order to carry out this job, isolation points need to accessed and these are underground. Accessing underground requires additional support for our operatives due to the risk involved and the Estates Team Leader	4	31/03/2022	31/03/2023	06/05/2024
2a. A modern and progressive workforce	5173		Service disruption	Morgan, Mr Andrew	Warner, Jayne	Trust Leadership Team		15/05/2023	20		Corporate	Medical Director's Office		Trust-wide	The Trust Board has a number of executive director vacancies which are currently filled by interim or acting up arrangements which may lead to instability. In some instances these appointments are for first time Director posts meaning that the Board could be seen as still developing. In addition to this the Chief Executive has recently announced his intention to stand-down on 31 March 2024, after 42 years service in the NHS.	Fit and Proper Persons Regulations. Voting rights are not impacted as interims / secondees all carry the voting rights of the role as per the Standing Orders/SFIs. Coaching and mentoring in place for those in their first appointment from the Chief Executive and the Director of Nursing/Deputy CEO. There is external coaching provision. with a plan to ensure each director has an external coach and mentor. Each executive director has a substantive deputy director. The ELT also has access to an external OD partner who works with the team on a regular basis.	Out of 6 directors only 2, the Director of Nursing and the Medcial Director are currently substantive. The Director of Nursing post is currently a shared post with LCHS. The Medical Director is currently off on long-term sick. The Chief Executive post is filled substantively but will become vacant at the end of March 2024.	20/02/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Continue with mentoring / coaching arrangements in place where appropriate. Review the succession plans for each post and ensure substantive appointments are made. Joint posts with other system providers to be considered where appropriate as part of the Lincolnshire Provider Review.	[20/02/2024 13:46:40 Rachael Turner] Risk reviewed - Medical Director is back full time and CEO has extended tenure to June 2024 to allow for recruitment to Group CEO. [07/06/2023 12:15:17 Rachael Turner] Risk discussed at RRC&C 07/06/2023 Risk score agreed as 4x4 giving a score of 16 making it a High Risk. [15/05/2023 13:41:10 Rachael Turner] Risk to be raised for validation at RRC&C Meeting in May.	10	31/03/2024		20/05/2024

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	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
3a. A modern, clean and fit for purpose environment	5104	8	Regulatory compliance	Dunning, Mr Paul	Rinaldi, Dr Ciro	Mortality and Learning Strategy (MoraLS) Group	Estates Infrastructure and Environment Group	16/03/2023	10		Clinical Support Services	Path Links (Pathology)	Mortuary (Pathology)	Trust-wide	As a result of the HTA's concerns relating to the fabric and capacity of the Trusts mortuary service and the delay in timescales by which the Trust is able to refurbish these following the HTA inspection in May 2022. There is a risk that The HTA as the regulator could impose conditions on our licence to store the body of a deceased person within the Trusts mortuary facilities.	-HTA oversight group has been established-meeting to manage the action plan. -Papers have been to CRIG for initial funding to establish planning and building work. This has been approved. -Draft business case has been developed and approved. -Initial concerns have been addressed from Lincoln site. -The Trust currently has two Titan units (temporary additional mortuary capacity) which provides additional capacity in the event of winter pressure peaks in demand and also in the event of equipment failure. -The Trust has a memorandum of understanding with Hull University Teaching Hospitals to support with the storage of bariatric bodies that require longer storage (freezer capacity).	ULHT Improvement action plan HTA Governance Group Weekly meetings to oversee mortuary refurbishment plans	01/02/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Risk reduction plan to assure HTA during March that risk controlled above mitigate their concerns over the Trusts mortuary estate. HTA have confirmed their acceptance of the Trust's plans to mitigate and have closed down their inspection process as complete.	[01/02/2024 16:05:12 Gemma] Business Case has been approved at Trust Board and work has commenced on the Trustwide Mortuary Project [19/10/2023 15:50:44 Ciro Rinaldi] -HTA oversight group has been established-meeting to manage the action plan. -Papers have been to CRIG for initial funding to establish planning and building work. This has been approved. -Draft business case has been developed and approved. -Initial concerns have been addressed from Lincoln site. -The Trust currently has two Titan units (temporary additional mortuary capacity) which provides additional capacity in the event of winter pressure peaks in demand and also in the event of equipment failure. -The Trust has a memorandum of understanding with Hull University Teaching Hospitals to support with the storage of bariatric bodies that require longer storage (freezer capacity). [19/10/2023 07:47:27 Jeremy Daws] ELT provided with an update that plans approved, and building work scheduled to commence October 2023. At recent weekly mortuary refurbishment meeting, building commencement timescales may slip back due to delays in appointing a contractor. Further update to be provided when more information known. [05/07/2023 11:06:25 Rachael Turner] Risk discussed in June RRC&C meeting, agreed to reduce risk score from 20 to a 16 High Risk [08/06/2023 13:22:36 Rachael Turner] Risk to be presented at RRC&C in June for reduction in score from 20 to 16. [31/05/2023 04:53:29 Jeremy Daws] HTA have responded to the Trust during May confirming their acceptance of the Trust's mitigation plans. HTA have confirmed they are assured enough to close down the inspection process as complete.	20	31/03/2024	31/03/2024	01/05/2024
1b. Deliver high quality care which is safe, responsive and able to meet the needs of the population	4868	64	Physical or psychological harm	Farquharson, Colin	Martinez, Francisca	Medicines Quality Group	Maternity & Neonatal Oversight Group	01/03/2022	16	Risk assessments	Clinical Support Services	Pharmacy CBU	Pharmacy		Preparation of Drugs for Lower Segment Caesarean Section (LSCS). 1. Medicines at risk of tampering as prepared in advance and left unattended. 2. Risk of microbiological contamination of the preparations. 3. Risk of wrong dose/drug/patient errors. Breach of Medicines Act: Regulation 3 of the Human Medicines Regulations 2021 permits doctors to prepare medicines for administration. The expectation would be that preparation would be in compliance with current best practice and governance expectations. Regulation 214 permits parenteral administration of medicines by or in accordance with the directions of and appropriate practitioner. This practice would constitute a risk to the patient and falls outside of expected governance arrangements detailed in Advice Note for Chief Pharmacists March 2017 NHS Pharmaceutical Quality Assurance Committee which defines acceptable practice as: administration immediately after (within 30 minutes) preparation and completed within 24 hours. It is noted the Trust Injectable Medicines Policy is in compliance with this expectation.	No current processes in place to minimise risk Policies do not support this practice	Incidents involving advance preparation of intravenous medication in clinical areas. Audits of compliance with standards / policy - The current labelling does not comply with national recommendation. Not all labels include the recommend identity (no dose/strength as per pictures). Also, no preparation date/time always included. There is no documented procedure stating the process to follow to ensure that the medicines prepared are discarded.	04/04/2024	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.	[04/04/2024 09:02:51 Lisa Hansford] NO FURTHER UPDATE [29/12/2023 13:33:55 Lisa Hansford] No further update [26/09/2023 14:17:01 Rachel Thackray] Meeting to take place to review progress [20/07/2023 10:43:27 Lisa-Marie Moore] narrative updated to reflect conversation between Fran Martinez and Regional QA about breaching medicines act regulation 3 [27/06/2023 09:45:38 Alex Measures] Discussed in risk register review meeting- no further updates [01/06/2023 14:26:57 Lisa-Marie Moore] Risk assessment resent to anaesthetists - to discuss at next MQG. If no further progress to discuss with CQC [04/05/2023 14:26:40 Lisa Hansford] needs to go back to MQG [29/03/2023 10:16:01 Maddy Ward] This risk needs to go to MOpS for escalation to medicines quality group. [21/02/2023 08:53:55 Paul White] Note from Risk Register Confirm & Challenge Group - risk to be reviewed from Family Health perspective, including current rating and where responsibility for the risk should belong. [05/01/2023 14:08:19 Lisa-Marie Moore] To be raised again at MQG and action to be taken agreed Following a Datix (ref no: 255637), it has been identified that intravenous medication required for a Lower Segment Caesarean Section (LSCS) is being prepared in advance of the procedure in case of an emergency. The Lead Obstetric Anaesthetist has discussed the practice with the team and the consensus is that for safety the drugs need to be prepared in advance for potential emergencies. The team has sourced tamper proof drug trays to store the drugs once prepared. This risk assessment has been done for Pilgrim Hospital, Boston. However, the practice seems to replicate at Lincoln County Hospital. Full risk assessment is attached to Datix. 17/5/22 No change	4	30/09/2022	31/03/2023	04/07/2024
2b. Making ULHT the best place to work	4439	49	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.	26/03/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Industrial relations action plan & engagement mechanisms and arrangements with Staff Side representatives.	[26/03/2024 13:23:38 Gemma Staples] Risk reviewed at RRC&C today and agreed for the risk to be lowered to 4x4=16 risk. [28/02/2024 12:41:33 Rachael Turner] Due to operational pressures this risk will be presented at RRC&C for validation in March 2024. [07/02/2024 13:42:52 Rachael Turner] Risk reviewed, controls currently in place and managed through operational command. Risk to be presented at RRC&C meeting in February for a reduction in score. [11/01/2024 12:27:34 Rachael Turner] LS Confirmed: Risk continues to present as an issue. All mitigations are in place and the Trust manages the issue when it presents through an operation command structure. [19/12/2023 12:29:58 Rachael Turner] Risk continues to present as an issue with medical staff undertaking periods of industrial action. Currently Junior Doctors remain in active dispute with the government and Consultants/SAS Doctors are balloting on pay proposals. In November 2022 it was necessary to increase the likelihood of this risk from low to extremely likely and this continues. Plans have been tried and tested and all mitigations are in place. Oversight and governance through the Operational/Tactical/Silver Cell, Medical Workforce Cell and Strategic/Gold Cell with reporting to the ICB. Industrial Dispute Action Plan and Risk Assessment complete and has been tested through industrial action. Currently managed within risk tolerance. EPG to consider making this risk Inactive (for annual review). [20/11/2023 20:37:44 Rachael Turner] Risk reviews, all actions and score remains appropriate. Gold and silver command continue to manage this. [30/10/2023 12:37:17 Rachael Turner] Risk reviewed and remains at current level.	4	31/03/2023	31/03/2023	26/06/2024

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	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
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	4843	57	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)	04/04/2024	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.	[04/04/2024 08:50:30 Lisa Hansford] no progress [29/12/2023 13:42:16 Lisa Hansford] No further update [26/09/2023 14:14:06 Rachel Thackray] Progress ongoing with regard to shared care [27/06/2023 09:45:04 Alex Measures] Discussed in risk register review meeting- no further updates [26/06/2023 13:55:27 Lisa Hansford] Risk discussed with Paul Dunning. Sue Leo to give PD list of patients that this effects. PD to review information and discussed with NHSE again. [01/06/2023 14:32:36 Lisa-Marie Moore] Meeting arranged to happen with Paul Dunning [04/05/2023 14:21:25 Lisa Hansford] meeting to be arranged to review the process for reviewing patients [29/03/2023 10:06:27 Maddy Ward] We have raised the risk today to quite likely and the medical director needs to review the process for review of these patients by an immunologist. [20/12/2022 14:25:21 Alex Measures] No further progress 19/07/21 - Shared care document was sent to NUH for review. However, NUH business unit manager expressed difficulties to advance on the SCA due to staff shortages in immunology division. Dr Neill Hepburn will discuss with NHS England regarding next step. 150622 ongoing until get an immunologist in the trust.	4	01/10/2021	31/07/2023	04/07/2024
3a. A modern, clean and fit for purpose environment	5334	533	Physical or psychological harm	Grooby, Mrs Libby	Carr, Katy	Patient Safety Group		26/01/2024	15		Family Health	Women's Health and Breast CBU	Obstetrics	Pilgrim Hospital, Boston	There is no second theatre within the confines of the labour ward within which to undertake any theatre based procedures when Theatre 8 is already in use. In time critical scenarios the increased time taken to transfer to Theatre 1 on ground floor and commence surgical management may impact on the health and/or wellbeing outcomes for mother and/or baby. There is a patient experience risk due to a lack of privacy and dignity for women when transferring to ground floor theatres through public corridors. There is also a potential for an increase in Caesarean Section rate as clinicians attempt to avoid late labour transfers.	Discussion with Obstetric/Anaesthetic/Theatre teams when deciding which cases to remain in theatre 8. Close monitoring of labour ward activity. Staff familiar with route to main theatres. Additional staff to support transfer. Offer Birth Afterthoughts as appropriate. Visible management and Leadership/active on call support to teams PMA support	Closely monitor all cases where woman transferred to theatre before or following birth – daily Medway report for scrutiny.	03/04/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	To inform teams of the risk controls in place. Coordinate Estates to undertake the works on Theatre 8a to minimise disruption as soon as practicably possible.	[04/04/2024 10:33:53 Nicola Cornish] Risk reviewed, no change. [31/01/2024 13:01:35 Rachael Turner] Risk discussed at RRC&C meeting 31/01/2024. Need to know frequency when this is happening. Agreed currently that this sits at a 4x4: 16 High Risk. Link to be added around regulations.	6	01/01/2025		03/07/2024
3c. Have enhanced data and digital capability	5241	518	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.	21/03/2024	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	[21/03/2024 12:00:45 Rachael Turner] The Trust and ICS partners have now procured a solution that will provide the required functionality. The procurement is now complete and the contractual issues have been resolved. The solution is expected to be rolled out to ULHT staff during Q1 24/25, planning with our ICS partners is taking place to understand how and when the solution will be implemented across our system partners. Propose no update to current risk score but forward view is once of reducing risk as a result of the technical solution being implemented. [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		21/06/2024
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	4935	58	Service disruption	Farquharson, Colin	Daniels, Mrs Samantha	Workforce Strategy Group	Patient Safety Group, WORK	26/05/2022	16	Workforce Metrics	Surgery	Theatres, Anaesthesia and Critical Care CBU	Critical Care		Insufficient medical staffing in Intensive Care Units at Lincoln and Boston. Uncovered shifts may result in Unit being decompressed. Medical staff asked to work extra hours compromising workforce directive. Unsafe cover in Unit when doctors are called to attend patients in A&E. Could result in harm to both patients and staff (in terms of wellbeing/morale).	Locums to recruit. Recruitment adverts out. Staff are being paid in TOIL in order to mitigate the financial risk to staff. Rotas are set and monitored -a Consultant formulates the rota and identifies gaps which cannot be covered in advance. Agency requests. Escalation to Divisional Triumvirate when gaps cannot be filled. Escalations are made to the medical director re payment agreements in accordance with NHSE/I policy. Business Continuity Plans are in place for both sites.	Rotas (gaps). Agency spend - financial risk. Number of Datix incidents recorded.	16/11/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Recruit to vacant posts.	[18/11/2023 21:05:16 Nicola Cornish] No change to risk score. Have an ICU oversight group with x 3 workstreams one of which is workforce. Meets weekly to look at recruitment and medical workforce. We have recruited trainee ACCP's which won't solve current issues but is future planning. [15/06/2023 09:32:33 Wendy Rojas] No change to risk status.beds capped at x8 L3 [18/04/2023 13:52:46 Caroline Donaldson] No change in risk status. Bed base number remains at x8 Level 3 beds. [09/01/2023 14:27:52 Caroline Donaldson] No change in status - still remains an issue. Bed base numbers remain reduced at x8 Level 3 beds. [29/11/2022 15:16:01 Caroline Donaldson] 17/11/2022 Discussed at TACC CBU governance meeting. Still remains an issue. [19/10/2022 15:22:43 Caroline Donaldson] 19/10/2022 CBU are looking to request an escalated rate for recruitment. Paper is currently in progress to request. Confirmed by S Daniels. Quality Impact Assessment undertaken and LCH ITU reduced to 8 x L3 bed equivalents on a temporary basis. For review Update 25.7.22 - substantive advert closes 8th August 2022. Locum advert is closed but awaiting shortlisting. Awaiting confirmation of interview date but looking like 27.9.22. Escalated to Medical Director and COO re decision to continue L3 equivalent reduction at current time.	4	31/10/2022		16/02/2024

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	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
1c. Improve clinical outcomes	5154	88	Regulatory compliance	Simpson, Mr Andrew	Hansford, Lisa	Information Governance Group	Digital Hospital Group	10/01/2022	20	Risk assessments	Corporate	Trust Headquarters	Corporate Secretary	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	04/04/2024	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.	[04/04/2024 09:01:18 Lisa Hansford] Still awaiting this package to be uploaded to ESR [29/12/2023 12:57:50 Lisa Hansford] Awaiting education and training team to upload to ESR [06/12/2023 14:55:35 Gemma] Training packs signed off through governance process Awaiting update from Education and Training team when these will be uploaded to ESR. Delay in this due to vacancy in their team [07/09/2023 14:09:00 Lisa Hansford] 7.9.23 Signed off by APPG and will go to NMAFF on 8.9.23 for final ratification [13/06/2023 12:46:40 Lisa Hansford] Training packages to be signed of by MOpS by 20th June. Then will continue through the governance process before they can go on ESR [04/05/2023 14:24:40 Lisa Hansford] No update as waiting to go through MOpS process [26/04/2023 11:14:07 Rachael Turner] Risk validated at RRC&C Meeting 26/04/2023 as a score of 16 High Risk. Risk to go to Medicines Quality Group to expedite risk.	8	17/04/2024		04/07/2024
3c. Have enhanced data and digital capability	4658	10	Reputation	Matthew, Mr Paul	Warner, Jayne	Information Governance Group	Digital Hospital Group	17/04/2023	16	Rick assessments	Corporate	Trust Headquarters	Corporate Secretary	Trust-wide	If the Trust does not have a defined records management framework/ strategy it runs the risk of not meeting national best practice and not making informed decisions in relation to Digital programmes of work. This could result in a breach of regulations and ULHT finding it difficult to meet national enquires that could lead to regulatory action and financial penalties. This risk has increased due to ongoing national enquiries and the move to a more digital way of records mgmt which whilst positive heightens the need to manage legacy and ensure expert RM support for future decision making.	The Trust has policies in place. Trust DPIA template included aspects on records mgmt and retention.	FOI compliance gives an indication of the Trusts position as compliance is linked to good records management. Reports of unmanaged records found in Trust locations.	25/01/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Requires a strategic decision from the Trust regarding a Records management lifecycle and level of expertise to advise and guide on future projects and developments. Needs to link into 365, ePR and EDMS Programme. 365 cannot be delivered with dedicated Records SME resource.	[25/01/2024 14:31:13 Fiona Hobday] *Working group has been agreed in relation to 365 following discussion at DHG- due to start in Feb 24. *Clinical Records Group has new Chair- Paul Dunning- he is now aware of concerns and issues with record retention and disposal. *Digital Programme Team are now raising lack of expert records manager in project risks and looking at how a role could be funded. *Corporate records resource needs to be reviewed in future. [04/09/2023 17:32:10 Fiona Hobday] *Little movement to date with regards to a strategy. IG have pushed in relation to ongoing future plans re EPR etc... *365 group are drafting a formal paper to go to senior staff in relation to governance as a whole and the RM work needed to do do this compliantly, linked to risks, operational ask etc... When complete IG will review and add to. [05/06/2023 17:22:19 Fiona Hobday] *Head of IG has spoken to Trust Sec re current concerns on lack of a strategic approach- linking to 365, EPR and EDMS. Need to look at whole picture and not pieces of work in isolation. *Head of IG has raised with Digital Programme Team to ensure RM is looked at strategically and in a joined up manner and they link in with Trust Secretary as the functional owner for Corporate Records. *365 Project- Records Mgmt identified now as a key deliverable and driver for the project. [08/03/2023 13:53:45 Fiona Hobday] Head of IG and DPO discussed in relation to retention of Health Records and removal of long time ban on disposing of records for Saville enquiry- this has now been lifted and Clinical Records Group to be tasked with taking discussion re record disposal forward. [02/02/2023 14:17:13 Fiona Hobday] Revise score approved at Confirm and Challenge meeting in Jan 23. [06/12/2022 15:09:53 Maria Dixon] DPO & Interim Head of IG raised with SIRO as part of O365 discussion.	4	28/06/2024	28/06/2024	25/04/2024
3a. A modern, clean and fit for purpose environment	5136	10	Physical or psychological harm	Parkhill, Michael	Pattinson, Paul	Estates Investment and Environment Group	Health and Safety Group	28/03/2023	20		Corporate	Estates and Facilities	Estates	Trust-wide	Following monitoring for Nitrous Oxide levels in Pilgrim and Lincoln (Theatre and Maternity Units), it was identified that in a number of locations, staff were exposed to higher levels of nitrous oxide where levels exceed the Workplace Exposure Limit (WEL) OF 100 ppm (8hr time weighted average (TWA)).	Following notification the following actions were undertaken: Pilgrim Hospital – Labour Ward: Estates staff checked the supply ventilation from the Air Handling Unit (AHU) to the Supply Grilles within the labour rooms. At the time of inspection, the Estates staff identified the dampers restricting airflow were not adjusted correctly. This was addressed and airflow checks were undertaken. Typical air change rates were around 6 air changes per hour (ACH) – current guidance is a minimum of 10 ACH, however the ventilation systems are circa. 1960 and the guidance is not retrospective. Following the actions undertaken, resampling commenced 15th March (15 sample tubes), 13 were within WEL limits, but 2 sample results were recorded at 255 and 407 ppm (8 h TWA) in Rooms 2/2a and Room 3, respectively and exceeded WEL limits. Estates are reviewing the current system to look at increasing air changes by upgrading the supply fans / changing pulleys / upgrading filter media or a combination of factors. Further works to increase ventilation has been completed and whilst not HTM03 compliant by design - supply ventilation has been increased to reduce the risk of WEL exceedance. Lincoln Hospital - Labour Ward: Estates staff found the ventilation system had been isolated (approximately 10 years ago). Following discussions with Estates members, the ventilation system had failed and was deemed beyond economical repair and a decision had been made not to replace (no one is aware of why this was made or by whom). Estates plan to reinstate the ventilation, where feasible, which will likely include partial refurbishment and deep clean of existing systems. N.B the use of sampling tubes to monitor Nitrous oxide levels can be highly time and place dependent, the person with the sampling equipment and their activities, can indicate exposure levels that are as a result of human error, not as a failing of the environment. As such G210 analysers specifically designed for highly accurate measurement and verification of the quality of piped N2O and O2 gases, are being sourced.	-COSHH assessments and training. -Health Safety Environmental and Welfare Operational Audit programme. -Direct involvement with Occupational Health. -Datix incident reporting.	20/03/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	The issues identified with exposure levels are not unique to ULHT, as with most NHS Trusts investment is required to upgrade Ventilation to comply with HTM 03-01. NHSEI issued guidance on the 2nd March 2023 for NHS Trusts to follow. Noting where ventilation is insufficient, human factors are critical in reducing staff exposure, such as: 1. Providing clear instructions to patients on correct use of equipment being used, including exhaling into the rebreather mask or out through the mouthpiece 2. Staff positioning relative to exhaust N2O and the direction of ventilation flow 3. Turning gas and air off when not in use 4. Unplugging regulators from outlets when not in use 5. Monitoring the condition of equipment for leakages. These factors can't directly be influenced by Estates and require the support and influence of Clinical Leads and Occupational Health. ULHT Health and Safety Team have recently implemented software to assist with COSHH assessments and training. The Team provide support with the Health Safety Environmental and Welfare Operational Audit programme. Occupational Health have been directly	[20/03/2024 14:46:36 Rachael Turner] Update from Health and Safety: PHB indicates no staff exposure exceeding values for nitrous oxide Workplace Exposure Limit. LCH does refer to x1 member of staff carried out on 29.08.2023 values cause for concern, the following day the values were no cause for concern. To date I am unaware of any referral to Occ Health relating to this employee. The work to provide a safe of work/ protocol was completed with Maternity Leads and the Cadmus system is available for department leads to provide local monitoring. It would be prudent to reduce the risk bearing in mind that this subject remains on the Maternity agenda (National Survey). The two most recent reports carried out on 30th May 2023 for PHB and 6th September 2023 LCH have been attached to this risk. Estates will undertake some further air change monitoring to ascertain if any further work is needed on the ventilation at LCH, we may then need to think about re-testing [19/03/2024 10:32:29 Rachael Turner] All workforce monitoring has been carried out. Need to confirm with H&S committee whether there have been any exposure limits for Lincoln site and if not whether this risk requires to be closed. [29/01/2024 19:35:31 Rachael Turner] The supply fans serving the recovery areas have been upgraded and airflows retested. Airflow has improved but not sufficient to meet 10 air changes per hour. Further works to be scheduled by PG/NM [25/10/2023 10:59:03 Rachael Turner] Risk reviewed and remains the same, meeting to be had tomorrow (26/10/2023) with estates to discuss progress.	10	28/03/2024		20/06/2024

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	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
1b. Improve patient experience	5234	510	Service disruption	Ratcliff, Carl	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.	19/03/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Adhoc sessions being booked for Outpatient provision where space can be found. No plan for IP on site.	[19/03/2024 10:38:03 Gemma Staples] In January we submitted a change of use form to Estates, chased this in February and March and to date have not had a response. [31/01/2024 11:37:43 Rachael Turner] Risk discussed as part of the Deep Dive at RRC&C meeting 31/01/2024. Risk score reviewed and updated to 4x4:16 High risk. [11/12/2023 13:05:50 Gemma] Risk reviewed. No change [13/09/2023 12:20:09 Maddy Ward] From an estates point of view, there is no plan to restart the service. This has been passed to project manager in estates to review clinical space (chased today). A suitable sized, permanent room is required. Started space request in September 2022 and meeting in July 2023. There has not yet been a date given for a clinical space review.	3	26/08/2024		19/06/2024
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5142	65	Physical or psychological harm	Ratcliff, Carl	Smith, Charles			12/04/2023	20		Medicine	Urgent and Emergency Care CBU	Accident and Emergency	Lincoln County Hospital	Within Lincoln and Pilgrim Emergency Departments there is a risk that, given increases in demand/footfall, the current staffing template for middle grade doctors overnight may not provide assurance to maintain patient safety.	Utilisation of on-call Consultant to support dependant on holistic risk. Specialty support and signposting to other directorates and providers. Full capacity protocol and boarding.	4 hour target/12 hour breaches. Time to first assessment. Decision to admit.	15/04/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	ED Rota and workforce review with new rotas to provide effective cover overnight in all areas at all grades. New rota templates signed off by finance, to be implemented Q3 2023. Recruitment ongoing.	[15/04/2024 11:01:21 Rachael Turner] Further delay due to job planning from medical workforce. Now expected Q3/Q4 24/25. CBU Team looking at mitigations including removal of some shifts to improve uptake across 24 hour period. [05/03/2024 15:45:12 Rachael Turner] Consultation has now ended. Expected go live date Q3/Q4, this should have gone live last October. Update to be provided in June. [09/01/2024 15:09:37 Rachael Turner] Risk remains the same. Increased winter slippage funding that lets us have extra middle grade shifts. Consultation due end of Feb/ March. [17/10/2023 10:11:32 Rachael Turner] This remain the same due the consultation in place. This remains to go out to bank and agency until staff are recruited. [26/09/2023 14:46:05 Charles Smith] Tier 2 MG consultation extended and ongoing. Mitigation via locum/bank until then. [30/08/2023 11:24:12 Carl Ratcliff] will review post meeting with exec on 30th August 2023 with action plan in place to manage more of the ED risk [15/08/2023 11:15:38 Helen Hartley] This will align into the medical workforce tier 2 recruitment process as per risk 5020 Also links into overcrowding piece. [19/07/2023 15:54:10 Helen Hartley] This has been looked at and updated, remains and will review next month [13/06/2023 11:09:55 Helen Hartley] Risk reviewed, level remains the same. Agreement for workforce plan has been given, adverts going out imminently. [07/06/2023 12:52:03 Rachael Turner] Risk discussed at RRC&C meeting 07/06/23 Risk added following three escalations. Night cover increased from 5 to 6 after funding secured. As recruitment comes on board risk will reduce. Risk score 4 x 4 at a score of 16. [24/04/2023 12:18:07 Carl Ratcliff] Review underway of short term ability to support more staffing at night by changing some shifts from day team	9	31/08/2023	01/11/2023	15/07/2024
2a. A modern and progressive workforce	5093	40	Service disruption	Simpson, Mr Andrew	Baines, Andrew	Medicines Quality Group	Workforce Strategy Group	16/02/2023	20		Clinical Support Services	Pharmacy CBU	Pharmacy		Baseline pharmacy procurement staffing is at a level where the basic functions are not routinely being delivered and the service is not able to withstand any prolonged absence due to leave, sickness or resignation. There is limited staff covering this (at times just 1 staff member).The workforce has remained relatively stable over time, however workforce pressures have been increasing over the last few years for a variety of reasons. There has been an increasing number of pharmaceutical shortages, many of which are complex in nature and need rapid action to avoid patient deaths. A growing number of drugs are now being offered on an allocation basis which requires micro management for stock ordering and distribution across the Trust. Changes in the delivery of chemotherapy have resulted in an increased demand for ordering of chemotherapy preparations. The pharmacy invoicing team have also experienced a recent increase in workload following the implementation of the Advanced finance system. This is currently 1 part time staff supported by bank staff where possible. The team are reporting concerns around workload and workplace stress. We are routinely reliant on existing staff working additional hours to fill gaps. If staff feel unable to come to work for any reason (including stress related) this will further increase the risk to the 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 to process invoices and manage supplier queries.	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	26/03/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	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.	[27/03/2024 09:51:29 Rachael Turner] Risk presented at RRC&C meeting 26/03/2024. Agreed to be reduced to a 4x4: 16 High Risk. [11/03/2024 09:59:03 Lisa Hansford] Invoicing is in a much improved position and we are now receiving monthly performance indicator from finance to show percentage of invoices paid within 30 days (as NHS target we are meant to meet), and we are performing well (overall pharmacy invoice performance is negatively impacted by homecare - we are waiting to assess the impact of their recent recruitment though, as we know they have been operating with a staffing gap. Purchasing - we have three substantive staff in Monday and Tuesday; two substantive staff Wed-Fri supplemented by bank. Risk therefore remains Wed-Fri, so position is improved and likely needs to drop from 20. Risk also remains adversely impacted until staff are fully up to speed with all processes... aiming to readvertise the Wed-Fri gap in the hope current bank member of staff may apply. [17/01/2024 12:09:36 Gemma] We have had successful recruitment but still have one remaining so still have a risk Wednesday to Friday. This is going back out to advert to help fill the gap. [17/01/2024 12:03:17 Gemma] No further update [29/12/2023 14:02:33 Lisa Hansford] No further update [18/12/2023 21:36:39 Rachael Turner] No change, recruited staff will be in post in January. Risk score to be reviewed once in post and trained. [29/11/2023 11:26:52 Rachael Turner] Risk discussed at RRC&C meeting as part of the Deep Dive. Support to fill gaps is currently in place. We have successfully recruited two posts,staff but they will not be in post until Jan 2024 and then will need to be trained. Once staff are in post this risk will need to be reviewed to look at scores. There is still a third vacancy, this post is unfunded, a business case now needs to be written to look into this. Risk reduction plan needs to be reviewed following this update.	4	16/02/2024	16/02/2024	26/06/2024

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	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
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	4646		Physical or psychological harm	Dunderdale, Karen	Gibbins, Donna	Clinical Effectiveness Group	NIV Working Group	14/12/2021	20	Policy/Protocol Issues, Risk assessments	Medicine	Specialty Medicine CBU	Respiratory Medicine	Trust-wide	If the Trust is not consistently compliant with with NICE Guidelines and BTS / GIRFT standards to support the recognition of type 2 respiratory failure then there may be delays to the provision of treatment using Non-Invasive Ventilation (NIV), resulting in serious and potentially life-threatening patient harm.	National policy: - NICE Guideline NG115 - COPD in Over-16s: diagnosis and management - NICE Quality Standard QS10 - COPD in Adults - British Thoracic Society (BTS) / Get It Right First Time (GIRFT) standards for NIV ULHT policy: - Guidelines and Care Pathway for commencing Non-invasive Ventilation (NIV) in the non-ITU setting - NIV-trained clinical staff - Dedicated NIV beds (Respiratory wards) ULHT governance: - Medicine Division clinical governance arrangements / Specialty Medicine CBU / Respiratory Medicine - Trust Board assurance through Quality Governance Committee (QGC) / lead Patient Safety Group (PSG) / NIV Group and Integrated Improvement Plan (IIP) / Improving Respiratory Services Programme	- Frequency and severity of patient safety incidents involving delayed NIV - recent history of rare but serious harm incidents - Total elapsed time from Type 2 Respiratory Failure (T2RF) suspicion to commencement of NIV <120mins - not being met at LCH or PHB as of Dec 21 - Start time for NIV <60mins from Arterial Blood Gas (ABG) - not being met at LCH or PHB as of Dec 21 - NIV progress for all patients to be reviewed (once NIV commenced) < 4hours - not being met at LCH as of Dec 21 update: There is a NIV audit captured monthly which determines both trust wide compliance and site specific- this is shared through PRM and available for cabinet and CBU governance meetings	23/01/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Delivery of the NIV Pathway project as part of the Improving Respiratory Service Programme within the Integrated Improvement Plan (IIP): 1. Understand the Trust-wide demand and capacity for Acute and Non Acute NIV. 2. Provision of ring-fenced beds for NIV. 3. Develop Trust-wide Model and Pathway for Acute and Non Acute NIV To meet BTS/GIRFT Standards. 4. Provision of NIV service (ED) which meets the BTS Quality Standards. 5. To have a trained workforce with the skills required to meet the needs of the patients and BTS standards. 6. Governance Process for NIV Demonstrating a Safe Service where Lessons are Learnt.	[23/01/2024 14:57:00 Rachael Turner] Meeting is planned in March to discuss NIV and ED, previous meeting were stepped down due to industrial action. We continue to see Datix incidents relating to NIV in ED. Meeting needs to take place before any change can be made. Support is needed for phase 2 of respiratory programme. This will be a priority for 2024. Risk score currently remains. [02/11/2023 10:11:07 Rachael Turner] Currently still do not have Trust-wide provisions- this will be picked up as part of phase 2 of respiratory programme. Whilst we have a robust process in place we continue to have issues with availability of ringfenced beds on both sites and education in ED and therefore are not consistently meeting the national standards. We have a planned meeting to discuss the last years performance. Following this, the risk will be reviewed looking at lowering the score but not remove at this point. [30/08/2023 11:21:21 Carl Ratcliff] to discuss with CBU and review ability to close or reduce [07/08/2023 17:06:10 Donna Gibbins] Funding agreed- recruited workforce continues due to agreement to ensure safe staffing Annual audit for NIV compliance complete- report to be generated and shared with Cabinet Ongoing discussions regarding provision of NIV in ED continues No SI since project commenced for NIV Full outcome of provision for Trustwide achievement not yet equal due to lack of RSU at PHB- mitigations in place to deliver a safe service Domiciliary NIV provision ongoing [23/07/2023 12:53:54 Carl Ratcliff] Funding approved for complete RSU unit in budget setting - will ask CBU for full update on project [27/04/2023 09:20:46 Silvia Tavares] update from Donna Gibbins: The risk currently remains the same. However, the following actions are being considered for June to reduce risk following the last confirm and challenge	4	30/09/2022	31/12/2024	23/04/2024
1c. Improve clinical outcomes	4866	87	Service disruption	Costello, Mr Colin	Saddick, Ahtisham	Medicines Quality Group		01/03/2022	15	Risk assessments	Clinical Support Services	Pharmacy CBU	Pharmacy		Recruitment of ULHT pharmacy technicians to ward-based clinical pharmacy roles affects the balance of the pharmacy workforce and impacts on the core pharmacy service provided	Pharmacy should be fully involved in the development and implementation of these roles. The Chief Pharmacist is accountable for the professional management of these roles, however there is not a clear understanding of the supervision and development framework for the new roles.	Monitoring of Pharmacy Technician performance	04/04/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	To develop a robust supervision, training and development framework for the new pharmacy technicians roles. 1. To undertake a quality impact assessment to evaluate the potential impact on pharmacy services. 2. To develop a robust NVQ apprenticeship training scheme to train band 2/3 staff to band 4/5 roles both on the wards and in pharmacy services to achieve a sustainable pharmacy technician workforce in order to support all pharmacy technician roles.	[04/04/2024 09:06:25 Lisa Hansford] No further update [29/12/2023 13:54:44 Lisa Hansford] No further update [07/11/2023 14:12:59 Lisa Hansford] Update- Variable ward based technician support is being provided for clinical pharmacy cover for admission areas. Risk is ongoing as there is still the possibility of staff movement to WBT roles therefore leaving gaps in core services [26/09/2023 14:15:54 Rachel Thackray] Risk remains, awaiting further update [07/09/2023 14:11:26 Lisa Hansford] 7.9.23 no further updates [27/06/2023 09:45:21 Alex Measures] Discussed in risk register review meeting- no further updates [01/06/2023 14:31:32 Lisa-Marie Moore] Discussion with CSS Division on how techs could be used to support pharmacy [28/03/2023 15:04:33 Rachael Turner] Risk proposed to be increased to a 16, this will be presented at RRC&C meeting 29th March. [20/12/2022 14:39:34 Alex Measures] no further updates Scheduled project due to commence March 2021, monthly reports will be provided. Monthly ward based technician meetings are addressing the training issue. 150622 ongoing, losing another technician to wards.	16	30/11/2021	28/04/2023	04/07/2024
2a. A modern and progressive workforce	4862		Service disruption	Thomson, Cheryl	Workforce Strategy Group	WORK		22/02/2022	16	Staff Survey	Medicine	Specialty Medicine CBU	Respiratory Medicine	Trust-wide	Consultant staffing within Respiratory Medicine at Lincoln and Boston Hospital. Currently there are only 3 Substantive consultants in place at LCH and 2 at PHB. We have a vacancy of 5 across the three sites. Various gaps are covered with Adhoc Locum. The main current risk is to the inpatient cover at Pilgrim Hospital. With only x2 Consultants over there, when we have 1 on annual leave, the risk that the other could be either sick or covid contact is extremely high. We have supported this with clinicians going over from LCH, however due to a further resignation at LCH, this is proving more difficult This combined risk on Medical staffing has now impacted the Secretarial team at LCH. There is currently 0 secretaries at work at LCH due to sickness in the team. This is mitigated through support from Agency / Other specialties supporting. We do not have the substantive staff nor the locum or agency bookings, to cover all functions of our Resp Medical Team. Inpatient risk of high acuity patients without specialist input. Outpatient risk of high activity of 2ww referrals on top of high volume OP workload, delayed pathway progress / commencing treatment such as chemotherapy. Due to lists / skillset required, there is not the ability within the organisation to cross cover between sites leading to Grantham particularly being most at risk.	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	4	30/12/2022	03/06/2024	14/02/2024
3b. Make efficient use of our resources	5389		Finances	Frake-Harris, Julie	Hodgkins, Mr James			19/02/2024	20	Corporate			Hospital at night		Risk of overspend due to current service provision being unfunded. Also overspend due to increased sickness leading to a higher requirement for bank, agency and Overtime. Increased insurance due to increased litigation. Due to patient complaints and safety aspects.	Monthly budget reviews, and recognised overspend.	Datix, through finance reviews.	28/02/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Case of Need to be heard by CRIG on the 26th March 2024, following which a business case to be submitted.	[28/02/2024 11:50:14 Rachael Turner] Risk presented at RRC&C meeting 28/02/2024. Risk validated as a 4x4:16 High risk.	6	19/02/2025		28/05/2024

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	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
2a. A modern and progressive workforce	5249		Service disruption	Low, Claire	Akhtar, Sarah			06/09/2023	16		Corporate	People and Organisational Development	Organisation Development	Trust-wide	Retention: Workforce management practices that are not in line with Trust values and expectations may have a negative impact on staff morale ultimately leading to increased turnover. Replaces current Risk 4991 (Retention element)"	1. Workforce Plan and Recruitment Plan to fill vacancies and reduce burden on current staff 2. People Promise Manager focussing on retention issues, including Exit Questionnaires and Flexible Working 3. Staff Benefit Scheme being further developed 4. Culture and Leadership Programme including Leading Together Forum and Cultural Ambassadors 5. Quarterly Staff Survey to measure leadership behaviours and engagement of staff, allowing quick time targeted interventions 6. Regular reporting through People Systems Manager 7. Onboarding process for Consultants being developed	1. Turnover Rate 2. Pulse Staff Survey (quarterly) 3. NHS Staff Survey (annual)	11/01/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	1. Development of a robust Workforce Plan with delivery against plan monitored at Workforce Strategy and OD Group on a monthly basis 2. Delivery of the People Promise Action Plan which has a clear focus on staff retention 3. Focus shift for People and Talent Academy from System to ULHT with development of clear progression pathways 4. Completion of Culture and Leadership Programme and full introduction of a Just and Restorative approach through all people management activities 5. Robust communication and action planning following quarterly and annual staff surveys to address areas of improvement and strengthen areas of good practice 6. Regular case reviews/lessons learning following employee relations issues arising 7. Career Development across staff groups in particular medical workforce 8. Retire and Return 9. Onboarding process for Consultants being developed	[11/01/2024 12:43:51 Rachael Turner] 11/1/24: Risk reduction plan continues to be worked through and is progressing well. This risk will be formally reviewed in Feb 24 with the People Promise Manager to identify if the risk level can be reduced. [06/09/2023 13:53:37 Rachael Turner] Risk was approved and validated following the RRC&C meeting in August as a new risk following the PODC risk review. Approved score of 4x4:16 High Risk. This risk was previously part of Risk ID: 4991 but has now been split so that staff retention is now a stand alone risk.	8	06/09/2024		11/04/2024
3b. Make efficient use of our resources	5215		Finances	Matthew, Mr Paul	Young, Jonathan			14/07/2023	16		Corporate	Finance and Digital	Finance	Trust-wide	23/24 introduces a new mechanism to record, calculate and apply the API contract and a System incentive / penalty linked to the Elective Recovery Fund. Actual performance/activity is taken from SUS and EROC. At present, there are some SUS/SLAM reconciliation issues and some recording issues including Missing Outcomes. The risk is twofold: 1. that without accurate ERF monitoring through SUS on actual activity delivered, the activity will look artificially low and there will be financial deductions 2. the activity plan has been built on delivery of c116% of 1920 elective, day case, outpatient first and outpatient procedure activity. Under the new regime underperformance will result in lost income	The link between activity and income has been communicated to the Trust. Monitoring is being set up to monitor activity delivery and estimate the financial impact due to the variable adjustment. Lost income through recording issues (e.g. missing outcomes) will be monitored to include a financial estimate in 23/24. An ERF baseline appeal was submitted and 95% accepted nationally. Revised national ERF baseline figure have been received and are being worked through.	Monitoring of the variable adjustment and lost income is being set up	23/01/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	"Information have been requested to reinstate SUS/SLAM reconciliation. Oversight of delivery is required through FPEC/FPAMs and any technical reporting issues reported to CFIG in the first instance. Required Trust activity delivery plan and then delivery against it."	[23/01/2024 13:21:26 Rachael Turner] National targets have been updated several times. Internal monitoring has been set up, which is consistent with national Trust level monitoring, but also shows trends by specialty and POD. SUS to SLAM monitoring undertaken by Finance as a one-off exercise identified some areas not being reported to SUS which were raised with Information Team for resolution. [16/10/2023 17:20:50 Rachael Turner] The national ERF baseline has been release twice in recent weeks. detail has been requested from the national team and is awaited in order that detailed internal monitoring can be updated [01/08/2023 14:49:23 Rachael Turner] Risk presented at RRC&C meeting in July, approved as 4 x 4 16 High Risk.	9	31/03/2024		23/04/2024
2b. Making ULHT the best place to work	4993		Service disruption	Low, Claire	Shankland, Lindsay	Equality, Diversity and Inclusion Group		08/08/2022	16		Corporate	People and Organisational Development	Organisation Development	Trust-wide	Workforce management practices that are not inclusive and equitable for people who consider themselves to have a disability may have a negative impact on the recruitment of new employees and the retention of existing ones.	1. Appointment of People Promise Manager (12 month fixed term) 2. Robust monitoring of EDI incidents/concerns 3. Equitable and EQIA 'tested' HR processes (for recruitment, reward and performance) 4. Dedicated OH service	1. Measurement of lived experience of disabled staff at ULHT via - NHS Staff Survey 2. No. EDI/disabilty related incidents reported 3. No. of EDI/disability related concerns reported	11/01/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	1. Governance and assurance for delivery of WDES action plan 2. Review of appropriate datasets to measure risk 3. Introduction of WDES annual report	[11/01/2024 12:46:15 Rachael Turner] Risk reduction plan in place and WDES action plan is being delivered. [06/09/2023 13:17:38 Rachael Turner] Risk reviewed at the RRC&C meeting 30/08/2023 following a review of the PODC risk register. This risk has been validated in score at 4x4: 16 High Risk and now replaces the previous WDES risk. [02/08/2023 10:32:59 Rachael Turner] WDES continues to be delivered and progress monitored through EDIG. Current WDES action plan assessed as good by NHSE. EDS published on Trust Website - signed off through EDIG, People and OD Committee and Trust Board. Maple Staff Network continues to be active and ran a series of events through Disability History Month. Culture and Leadership Programme continues to be delivered and Cultural Ambassadors appointed and commenced their training. Leading Together Forum continues to receive good feedback and each speaker is building on the work of the last creating consistent messaging. People Promise Manager delivering against action plan with national recognition of curent work. Funding for People Promise Manager available for Y2. National Staff Survey results available and action planning commenced. Reasonable Adjustment Policy agreed."	4	31/03/2023	31/03/2023	11/04/2024

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	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
2b. Making ULHT the best place to work	4992	55	Service disruption	Low, Claire	Shankland, Lindsay	Equality, Diversity and Inclusion Group	Estates Strategy Group, Health and Safety Group	08/02/2022	16		Corporate	People and Organisational Development	Organisation Development	Trust-wide	Workforce management practices that are not inclusive and equitable for people from all racial and cultural backgrounds may have a negative impact on the recruitment of new employees and the retention of existing ones.	1. Lincolnshire Belonging Strategy (improving equity of lived experience and representation across Lincolnshire system) 2. Appointment of People Promise Manager (12 month fixed term) 3. Robust monitoring of EDI incidents/concerns 4. Equitable and EQIA 'tested' HR processes (for recruitment, reward and performance)	1. NHS Staff Survey 2. 'Pulse Check' Staff Survey 3. No. EDI/Race incidents reported 4. No. of EDI/Race related concerns reported 5. BAME staff retention % (leave within first 3, 6 and 12 months) 6. BAME senior representation	11/01/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	1. Robust governance and assurance for ULHT direction of travel for EDI 2. Reset ULHT strategic direction for EDI (EDI objectives 2022-25) 3. Active WRES Action Plan 4. Anti-Racism strategy and delivery plan 5. Zero tolerance stance - for racist behaviour including banter 6. Improved senior level BAME representation 7. Reset Trust values (highlighting civility@work and ULHT commitment to inclusion)	[11/01/2024 12:48:20 Rachael Turner] Risk reduction plan in place and WRES action plan is being delivered. [06/09/2023 13:20:07 Rachael Turner] This risk was reviewed as part of the Deep Dive at the RRC&C meeting following the review of all PODC risks. This risk was validated with a risk score of 4x4:16 High Risk and replaces the previous WRES risk. [02/08/2023 10:35:14 Rachael Turner] WRES continues to be delivered and progress monitored through EDIG. Current WRES action plan assessed as good by NHSE. EDS published on Trust Website - signed off through EDIG, People and OD Committee and Trust Board. Anti Racism (United Against Discrimination) Working Group commenced 7 February 2023 and is delivering outputs against the plan. REACH Staff Network continues to be active and a relaunch of the Network as REACH (formerly BAME) and the See Me campaign complete. Culture and Leadership Programme continues to be delivered and Cultural Ambassadors appointed and commenced their training. Leading Together Forum continues to receive good feedback and each speaker is building on the work of the last creating consistent messaging. People Promise Manager delivering against action plan with national recognition of curent work. Funding for People Promise Manager available for Y2.	4	31/03/2023	31/03/2023	11/04/2024
3a. A modern, clean and fit for purpose environment	5383	615	Regulatory compliance	Cooper, Mrs Anita	Rigby, Lauren	Estates Investment and Environment Group	Estates Strategy Group, Health and Safety Group	13/02/2024	15		Clinical Support Services	Cancer Services CBU	Haematology (Cancer Services)	Pilgrim Hospital, Boston	Treatment room where bone marrow biopsies and venesections take place is not complaint with HBN 00-03. Due to this Bone marrow biopsies have been moved out. Currently waiting to have a meeting with the lead nurse on the ventilation project to understand if venesections can continue in there but at present they are weekly. Also do not yet have another identified area for IT chemo but this is far and few between. This is a risk of regulatory compliance and service disruption to patient treatment	Room is being decluttered Estates job logged Larger organisation piece of work being undertaken	Datix Complaints Assessment against regulations	26/03/2024	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Scoping if another area to do procedures Estates job logged to see if can increase air exchange to 10. Wider organisational piece of work.	[26/03/2024 16:04:11 Gemma Staples] Risk reviewed at the RRC&C today. Update: Suggested at last RRC&C meeting that Estates have one overarching risk but list each identified areas under this risk. Rachel Turner has met with Chris in Estates as this is one area of about 11 areas across all divisions where procedures are taking place without correct ventilation. Chris has a list of areas of which he is asking each area to review and look at areas to see what we can deal with now and then look at what is left. It was agreed that this risk be left on until the overarching risk has been added [13/03/2024 11:15:52 Gemma] Update: We have moved the bone marrow biopsies out. We are waiting to have a meeting with the lead nurse on the ventilation project to understand if venesections can continue in there but at present they are weekly. We also do not yet have another identified area for IT chemo but this is far and few between. [28/02/2024 11:41:30 Rachael Turner] Risk presented at RRC&C, we need to establish if any procedures are happening in this room as this would be a patient safety risk. Once established this will be re-presented in March.	3	13/02/2025	13/02/2025	26/06/2024
3a. A modern, clean and fit for purpose environment	4858	12	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	Trust-wide	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.	19/03/2024	Reasonably likely (3) 31-70% chance	Extreme (5)	High risk (15-16)	15	Regular inspection, automatic meter reading and telemetry for the incoming water main at all sites. Keeping components on site and regular contractors on stand by. Regular stock levels for emergency fixes. Recently undertaken a survey that looks at the condition of infrastructure. Future survey work will be taking place with Aquawave (Anglian Water) who will do a survey of all the pipework Trust-wide. Pilgrim/Watertank replacement has concluded.	[20/03/2024 15:07:19 Rachael Turner] Recently undertaken a survey that looks at the condition of infrastructure. Future survey work will be taking place with Aquawave (Anglian Water) who will do a survey of all the pipework Trust-wide. Pilgrim/Watertank replacement has concluded. [19/03/2024 10:22:50 Rachael Turner] Risk reviewed. Risk reduction plan updated. Risk score remains. [29/01/2024 19:38:32 Rachael Turner] 2 x feeds to site, one at the Hospital Exit Road, adjoining Sibsey Road & one coming in from the start of Castle Road, the access road to Progress Living. I have 2 water storage tanks, Capacity per tank is 243m³/243,000L, This is potable quality water & will supply the hospital for approx. 20 hours. [21/10/2022 09:06:00 Walter Thompson] Scheme for replacement of critical water tanks - Pilgrim HB- is being developed for the capital plan 22/23 Scheme of work and design currently being produced.	5	30/10/2020	31/03/2023	19/06/2024
2a. A modern and progressive workforce	5381		Service disruption	Frake-Harris, Julie	Markall, Amanda			09/02/2024	15		Corporate	Operations	Operations		Discharge Lounge (DL) has insufficient substantive workforce to meet current service demands. Significant RN and HCSW WTE shortfall. No B7 manager in place. B6 jnr sister post is unfunded secondment. No ward clerk. Insufficient housekeeping hours. This means that DL cannot staff each shift within budget and relys on temporary workforce and inpatient ward support. RNs and HCSWs act as ward clerk and Housekeeper. The risks are:- service is not well led on every shift contributing to delays, failed discharges, reduced patient capacity and turnover, reduced patient flow impacting on front door, omissions in care, omissions in documentation, errors, patient safety incidents, poor staff wellbeing, Poor patient notes and careflow management, poor patient experience. Improvement to practice very challenged to implement due to temporary staffing. Unable to function within current budget. Reputational damage. Inability to meet CQC requirement from 2021 audit.	Each shift has substantive, bank or ward swap nurse in charge. Staffing issues on the day managed by ops matron. Shifts go to bank and then to agency. Dynamic risk assessment; capping capacity or refusing complex patients. Strategic on call sign off required to close discharge lounge due to staffing. Orientation of temporary staff; Induction materials. limited support and advice from operations centre. RNs and HCSWs complete meal and refreshment service. RNs and HCSWs complete cleaning required outside of 2hrs allocated Housekeeper time. RNs and HCSWs complete ward clerk duties.	Healthroster, Workforce safeguard spreadsheet, 8a lead audit, flo audit, datix, PALS feedback and complaints, e-mail feedback, monthly budget, CQC assurance summary, DL patient flow dashboard, daily delays escalation, complaints, PALS feedback, TSSG, Confirm and challenge process. Sickness rates.	28/02/2024	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	1)Recruiting RNs against potential agency savings as part of TSSG. 2)Case of need in progress to fund appropriate establishment to meet demand.	[28/02/2024 11:51:43 Rachael Turner] Risk presented at RRC&C meeting 28/02/2024. Risk validated at 5x3: 15 High Risk.	4	09/02/2025		28/05/2024

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	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
1b. Improve patient experience	4701	85	Reputation	Grooby, Mrs Libby	Upjohn, Emma	Estates Investment and Environment Group	Patient Experience Group	13/01/2022	15	Risk assessments	Family Health	Women's Health and Breast CBU	Obstetrics	Trust-wide	If the quality and condition of the hospital environment and facilities used within Maternity services are poor then it may have a negative impact on patient experience and staff morale resulting in loss of confidence in the Trust and damage to reputation; there is also an increased infection risk	- Trust procedures for capital investment and Estates project management - Corporate oversight through Estates Investment & Environment Group / Finance, Performance & Estates Committee (FPEC)	Patient & staff feedback on the environment in Maternity services. Audits of infection prevention & control compliance. Reported health & safety and IPC incidents.	03/04/2024	Reasonably likely (3) 31-70% chance	Extreme (5)	High risk (15-16)	15	Plans for refurbishment of Maternity units on both sites, estimated timescales 3-5 years for LCH, PHB to be confirmed. Full Business Case required. Maternity shared decision council looking at simple solutions for improving working lives of staff.	[04/04/2024 10:32:18 Nicola Cornish] No change, awaiting trust board decision regarding the architect plans. [23/01/2024 16:04:20 Nicola Cornish] The team are continuing to work with architects to develop plans, which are expected to be submitted to the Trust board for approval by 31st March. [17/10/2023 09:30:32 Nicola Cornish] Nettleham have moved to Langton, in process of issuing purchase orders for design team and healthcare planners have visited Pilgrim. Meetings to schedule accommodation. [04/07/2023 09:11:47 Alex Measures] Risk reviewed 03/07/2023- Nettleham has decanted to 1st Floor to allow for works to commence as per plan. [04/04/2023 12:45:23 Jasmine Kent] Predicted date for decanting Nettleham to Langton 02/05/2023. While awaiting funding for refurbishment of Nettleham. Drain work at Pilgrim site is scheduled. [23/01/2023 17:04:59 Jasmine Kent] Included within capital allocation bids for next financial year. Agreement from trust board that works will take place in next financial year. Staff engagement sessions to communicate refurb plans. Issues dealt with by Estates & Facilities as they occur. 13/04/2022: Mitigation plan - full board approval to progress the business case. Require monitoring of staff surveys. CQC report demonstrates unsuitable for use - amended to 3 impact and 5 occurrence = 15 26/09/2022 - Unchanged	6	31/03/2025	31/03/2025	03/07/2024
2a. A modern and progressive workforce	4762	47	Service disruption	Capon, Mrs Catherine	Rojas, Mrs Wendy	Workforce Strategy Group	Nursing, Midwifery and AHP Forum, WORK	14/01/2022	15	Risk assessments	Surgery	Theatres, Anaesthesia and Critical Care CBU	Critical Care	Lincoln County Hospital	Issues with maintaining nurse staffing levels/skill to establishment in ICU at Lincoln.	Nursing workforce planning arrangements. Nurse recruitment / retention processes. Clinical Governance arrangements in Critical Care / Surgery Division.	Staffing vacancy rate within ICU nursing	09/02/2024	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Review of current recruitment strategy. Advertisement for vacant posts.	[26/03/2024 13:42:01 Gemma Staples] Risk reviewed at RCC&C today and it was agreed that the risk be reviewed and updated to include capacity aswell as skill and to look at if this is a service disruption risk. Once reviewed then the risk scoring should be looked at based on this. The risk scoring is to be left as it is and to be brought back to the next RRC&C meeting in April 2024. [09/02/2024 10:12:46 Nicola Cornish] Recruitment successful and minimal vacancy however due to the number of new starters skill mix remains an issue. I have reduced the risk this month as our position is improving. We have received network funding which will enable us to continue with additional clinical educators on both units. [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	6	30/06/2021	30/09/2022	09/05/2024
3a. A modern, clean and fit for purpose environment	5192	486	Service disruption	Cooper, Mrs Anita	Parriss, Helen	Estates Investment and Environment Group		14/06/2023	15		Clinical Support Services	Therapies and Rehabilitation CBU	Physiotherapy	Pilgrim Hospital, Boston	Leaking pipework under Physiotherapy Outpatient Department leading to increased humidity, water collection around windows and flooring and increased inside temperature. Risk to health and safety for staff and members of the pubic. Pre-existing problems regarding ventilation and windows (closed Risk 4296).	Physiotherapy Outpatient Department closed to staff and members of the public; relocated to gym, OT Department and consideration to hold clinics at The Johnson Hospital as needed. Face to face appointments replaced with telephone/video appointments to reduce footfall through the Department and patient treatment delay. Dehumidifiers used with the Department and an external contractor has isolated and switched off steam within the subway.	Success of repairing pipework within the subway. Continued clear asbestos results. The reopening of the Physiotherapy Outpatient Department when an acceptable level of humidity has been achieved and following a deep clean to ensure eradication of mould spores and clear ventilation ducts. Assurance from Estates Department regarding overall risk to health and safety is acceptable.	05/02/2024	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Continued liaison with Estates Department.	[05/02/2024 11:10:58 Gemma] A recent moved of Physio's into OT department due increased condensation. Physio's know back in the Physio dept - continued monitoring of condensation levels. [09/01/2024 14:25:11 Gemma] Update 10.8.23 Staff members have been off sick recently with continued chest and eye symptoms due to the high humidity levels, heat and damp within the Outpatient Physiotherapy Department. The Outpatient Gym and the Occupational Therapy Department is now being offered to staff to treat patients. Managers Occupational Health referrals are being done to support staff. Confirmation again from Estates/H&S that larger dehumidifiers would potentially increase risk of Legionairres and the only solution would be to replace the single glazed windows which cause the condensation. Risk rating has been amended to reflect this update. Continued review of asbestos risk - currently clear on all tests. Update 1.9.23 Advised by H&S that outside agency due to review further steam leak within subway under Physiotherapy Department - date to be confirmed. Staff continue to work within other areas to support their health. A further DATIX was completed due to mould spores within the Physiotherapy OPD - ID 319676 - a deep clean was arranged w.c. 21.8.23 and email request sent to Biju Biju, IPC Nurse, to request mould spore analysis. Two doors within the Physiotherapy Department were reviewed on 31.8.23 as they were not able to close due to the wood swelling. - Update given to Risk Register Confirm and Challenge Group 25.10.23	2	19/06/2023		06/05/2024

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	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
3a. A modern, clean and fit for purpose environment	5169	4830	11	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	04/04/2024	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	[04/04/2024 09:21:11 Lisa Hansford] No further update, all leaks reported to estates [29/12/2023 12:17:18 Lisa Hansford] Leak in dispensary w/c 18th December and stock had to be moved to prevent damage. [26/09/2023 14:12:47 Rachel Thackray] No further update [07/09/2023 14:20:37 Lisa Hansford] 7.9.23 no further update [01/08/2023 14:22:43 Rachael Turner] Risk discussed as RRC&C in July, risk approved to an increase in score to 5x3: 15 High Risk [27/06/2023 09:21:08 Alex Measures] meeting raised risk level to 15 Colin Costello to meet with Paul Dunning on Monday to get exec approval [01/06/2023 14:33:41 Lisa-Marie Moore] Risk ongoing no further update [29/03/2023 11:22:00 Maddy Ward] Discussed at Pharmacy Risk Register Review meeting today and risk is ongoing, no further update. [20/12/2022 14:16:17 Alex Measures] no updates - risk likely to increase in future reviewed 01/07/21 - ongoing, increase likelihood to likely 150622 ongoing. Shut down 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	04/07/2024
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5169	60	Physical or psychological harm	Ratcliff, Carl	East, Mr Sean		Estates Infrastructure and Environment Group, Medicines Quality 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 stress. General wards do not have the treatment facilities that Stroke patients need.	Stroke Therapy Team review all outliers at the cost of not seeing the Stroke ward patients as much. Stroke team will advise general ward based therapy team. Minimal basic Stroke assessment and treatment skills for general ward therapy staff. Proposal to implement Trusted Assessor Stroke Assessment.	Datixes M&H injury to staff and patient	05/02/2024	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Moving of Stroke specialist therapy staff from PHB to LCH Robust stroke training plan for general ward staff Attendance at Stroke Board to influence change and need for cohorting of outliers Review of Stroke staffing in line with latest staffing levels needed 16/10/23 funding transferred to LCH budget to help support staffing and recruitment has started	{05/02/2024 11:11:38 Gemma] Risk reviewed and is still ongoing [16/10/2023 11:12:34 Sean East] 16/10/23 funding transferred to LCH budget to help support staffing and recruitment has started [08/09/2023 14:20:40 Maddy Ward] Consultation in progress currently with the intention to move some money across to Lincoln. This links in with joint working with LCHS. [23/06/2023 14:13:54 Rose Roberts] No change, went to C&C recently and level agreed. [07/06/2023 12:45:33 Rachael Turner] Risk discussed at RRC&C meeting 07/06/2023. Hyper acute patients outlied to LCH site.Specialist staff not currently available to support these patients. Patients are at risk due not being put into priorities causing delays.This causes a risk of patient harm due not progressing or adding to disability due to not being seen in appropriate pathway. This is also impacting is discharging delays to patients. More work is also required with the community. Score agreed at 15	8	13/05/2024		06/05/2024
2a. A modern and progressive workforce	4905	48	Physical or psychological harm	Cooper, Mrs Anita	Taylor, Ruth	Workforce Strategy Group	Workforce Strategy Group	22/04/2022	12	Workforce Metrics, Risk assessments, Aggregation of Incident/Claims & Complaints/PALS	Clinical Support Services	Therapies and Rehabilitation CBU		Trust-wide	If we have insufficient staffing, or required level of experience and skill, the risk is patients will not receive assessment and rehabilitation leading to poor clinical outcome. Reduced flow on Ashby and the acute wards, delayed discharges, delayed referral to response times. Increase in avoidable harm i.e. deconditioning, PU's, constipation, delirium. Patient reviews delayed for botox treatment. Paediatric services-delayed response to new diabetes referrals and unable to see current diabetes patients in clinic- could lead to patient harm. Increase in bed stock and boarding beds without recognition of additional therapy staffing needs. Existing staff stretched to cover additional beds. Increased stress and sick leave on substantive staff.	Recruitment and retention strategies to fill vacancies. Bank staff. Requests to Locum Agencies. Skill mix Roster management. SQD data. Daily review of ward systems eg WebV. Referral guidelines and Prioritisation guidelines help to inform workloads and impact on patient flow and bed situation. Paed services are responding to direct requests for newly diagnosed children . Upskilling B5 N&D staff- (normally B6 N&D staff). Access to Staff wellbeing services. Front door therapy assessments passed to inpatient teams on admission.	Patient complaints. Fewer discharges at the weekend. Site escalation. Vacancy rates. Roster fill rates. Waiting lists for spasticity service. Staff absence. Staff survey and feedback.	05/02/2024	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Getting locums and bank staff in place. Good use of relocation allowance. Actively managing the waiting lists and dealing with urgent cases to avoid harm eg telephone contact with patients. Case of need for GDH orthopaedic staffing. Case of need for rehabilitation consultant post. Case of need for upper GI dietician. Case of need for Neuro Psychology staff on Ashby. Case of need for OT staff at PHB and LCH in ITU. Over recruitment of band 5s in dietetics. Competency frameworks and preceptorship.	[05/02/2024 11:25:33 Gemma] We are in the process of working on Therapy Strategy document and models of care document which will review current position against future planning. There is a safer staffing template for OT and Physio. Dietetics team to review use of this. [08/09/2023 14:19:33 Maddy Ward] We have made some progress in terms of recruitment but level of risk to remain the same. Grantham site is fully staffed and risk is not relevant to Grantham. [23/06/2023 14:12:17 Rose Roberts] Been asked to put in a case of need for RSU on both sites. Will be reviewed by RT to see if the risk needs to be separated out. [09/05/2023 15:14:15 Sara Blackbourn] Addition of escalation beds. Front door pilot. Referral criteria review. [10/03/2023 13:46:14 Rose Roberts] One member of staff has returned but another member is on maternity leave and there is no cover for her. Across all the services continue to be flexible and look at the skill mix to allow to deliver the best service we can. [13/01/2023 12:54:24 Lesley Bradley] 13/01/2023 Continue to review staffing levels, vacancies and reasons for sickness on a monthly basis [15/12/2022 09:55:40 Alex Measures] still looking at models of how to measure safe staffing levels, just asking each team to provide there funded establishment, what they would expect on a usual day and what is the minimum level of staffing, then we can start measuring whether we are falling below safe staffing levels, we have no method of recording that at the moment [30/11/2022 10:07:42 Rose Roberts] Continuing to look at staffing. Currently have a lot of sickness. Looking at levels of staffing so able to report whether staffing levels fall below a safe level. 130622 Looking at staffing vacancies and looking at line by line post analysis. OT IR 8 posts KPI's for Integration include reduce vacancies	9	30/09/2023	18/12/2023	06/05/2024
1b. Improve patient experience	4724	86	Physical or psychological harm	Lynch, Diane	Taylor, Ruth	Workforce Strategy Group	Patient Experience Group	13/01/2022	20	Risk assessments	Clinical Support Services	Therapies and Rehabilitation CBU		Lincoln County Hospital	If Therapies and Rehabilitation service provision is not sufficient to deliver 7 day service provision, it leaves services without cover at a weekend or with inadequate cover during the week, leading to delayed patient flow; delayed discharge; extended length of stay; impacting on patient experience with potential for serious harm. This includes the neuropsychology cover on Ashby, SLT cover for inpatients, and therapy cover on ITU.	ULH policy: - Service planning & budget setting processes - Business case decision making processes ULH governance: - Capital & Revenue Investment Group (CRIG) management of business case process - CSS Division, CBU / speciality governance arrangements	Level of cover at weekends. Length of stay, patient flow, delayed discharges. Level of funding - Some 7 day funding, but limited to orthopaedics at LCH, minimal service. Inadequate for level of service demand.	05/02/2024	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Review current provision and identify gaps in service to inform business cases for change (working with Surgery and Medicine Divisions as appropriate). Skill mix requires review due to complexity of patients. Prioritisation tool helps to identify patients with greatest acuity or importance which will directly impact patient flow and current bed situation.	[05/02/2024 11:06:18 Gemma] Risk reviewed and ongoing. [06/12/2023 13:09:39 Gemma] Conversations are currently happening in regards to appropriate staffing levels for ICU for Therapy Services. Further update to follow [25/10/2023 15:07:18 Rachael Turner] Business case being undertaken by CSS, needs to go through approval process. [08/09/2023 14:14:43 Maddy Ward] Reviewed at quarterly risk register review meeting. Risk is ongoing at present. [23/06/2023 14:07:53 Rose Roberts] Recruited into the Neuro psychology post. Increase risk in consultant cover - sickness and resignation. potential to have to stop admissions. [10/03/2023 13:43:06 Rose Roberts] Awaiting nhse results. Neuro psychology bid waiting to go to CRIG [13/01/2023 12:51:48 Lesley Bradley] 13/1/23 NHSE reviewed Ashby ward this month-await recommendations for staffing levels [15/12/2022 09:53:21 Alex Measures] No update [30/11/2022 10:04:52 Rose Roberts] Neuropsychology bid is still awaiting CRIG approval as CRIG has been stood down. Business cases completed for all areas. 130622 Neuropsychology bid is going to CRIG this mth. All others to be confirmed. Work in progress.	4	05/01/2024	31/03/2023	06/05/2024

NHS
Lincolnshire Community Health Services
NHS Trust

Report to the Lincolnshire Community and Hospitals Group Board

Date of meeting	7 May 2024	Agenda item	14.1
Title	Risk Assurance Report		
Report of	Karen Dunderdale, Director of Nursing, AHP and Quality	Prepared by	Helen Shelton, Deputy Director of Clinical Governance
Previously considered by / Date	Sub-Committees of the Trust Board	Approved?	
Summary	This report was written based on data up to and including 31st March 2024 and provides a Trust overview of strategic risks This Strategic Risk Report focuses on the highest priority risks to the Trust's strategic objectives (those with a current rating of Significant Risk, 15-25).		

1. Provide safe, high quality, population healthcare	**1a. Deliver safe services**	**Cautious** approach to patient safety or harm with strong focus driven by national strategies and policies.	✓
	1b. Deliver effective care	**Open** approach to effective care**.**	✓
	1c. Engage and involve people in their care	**Seek** approach to engagement and involvement.	✓
2. Deliver personalised community health services that are accessible and responsive	**2a. Deliver clinically led integrated community services**	**Open** approach to clinically led integrated community services.	✓
	2b. Deliver personalised health care that responds to individual need	**Open** approach to personalised health care that responds to individual need.	✓
	2c. Transform clinical pathways for sustainability and improved outcomes	**Seek** approach to transformation of clinical pathways for sustainability and improved outcomes.	✓
3. Build a productive, capable and inclusive workforce	**3a. Grow and retain our people**	**Open** to maximising transformation opportunities and will try new and innovative ideas and ways of working to improve job satisfaction and enrichment.	✓
	3b. Value and develop our people	**Cautious** approach to staff safety and wellbeing and recruitment compliance**.**	✓
	3c. Enable a change ready workforce	**Seek** new and innovative ways of working through the use of automation and technology	✓

		which in turn will improve productivity and release time to care.	
	3d. Deliver Safe and Sustainable Foundations	**Cautious** approach to cyber security, health and safety and recruitment compliance. This is because we value our people as our greatest asset and we strive to keep our people, our patients and their respective information as safe as possible.	✓
4. Ensure healthcare is financially sustainable, making best use of resources	**4a. Deliver financially sustainable healthcare, making best use of resources**	**Open –** Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level.	✓
	4b. Drive better decisions and impactful action through insight	**Seek -** We will invest for the best possible return and accept the possibility of increased financial risk (with controls in place).	✓
5. Collaborate to play an active role in the Lincolnshire ICS	**5a. Collaborate to make a difference**	**Seek** opportunities to be innovative and collaborative, both within the organisation and the wider system environment.	✓
	5b. Transform services to deliver great care close to home	**Seek** opportunities to be innovative and collaborative, both within the organisation and the wider system environment.	✓
Impact of proposal/ report	Positive impact is expected in relation to finance, performance, partnerships, people and innovation risks as well as EDI/HI.		
CQC	✓ **Safe**	✓ **Caring**	✓ **Effective**	✓ **Responsive**	✓ **Well-Led**
Links to risks	*Noted within the report*				
Legal/ Regulation	CQC regulations, NHSI, Standing Orders, Health and Social Care Act.				

Recommendations/ Actions Required

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

Appendices

Appendix A – Strategic Risks 15-25 - 31 March 2024

Glossary

NHS – National Health Service
LCHS – Lincolnshire Community Health Services NHS Trust
TLT – Trust Leadership Team
BAF – Board Assurance Framework

Risk Assurance Report to the Trust Board

1. Executive Summary

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, (those with a current rating of significant risk, 15-25). Of note detailed progress updates against each risk within this report can be found in Appendix A.

As of the 31st March 2024, there were 91 risks recorded on the Trust risk register aligned to the sub-committees of the Trust Board.

There are 9 quality and Safety risks rated Significant (15-25), an increase of 1 since the February report:

- 655 - Patient Harm due to Quality of care- Sleaford
- 495 – Treatment Room Capacity
- 403 - Children Young People Therapy treatment delays
- 409 - Lymphoedema service capacity
- 395 - TB Demand and Capacity
- 489 - Community nursing staffing pressures
- 652 - Interruption to Enhanced Practitioners and FVW business as usual activity
- 654 - Patient harm and compromised quality in the South Lincs ICT
- 672 - Timely Unplanned Palliative Response 24/7

- The following risks have been updated:
  - 495 – Treatment room capacity – **Increased from high (12) to Significant (16) due to demand on the clinics, continued lack of clinic space, increasing demand, widening impact onto outpatients and no available funding to expand.**

There were 6 Finance, Performance, People & Innovation risks rated Significant High (15 – 25) which has remained static from the last reporting period:

- 658 - Connectivity to Live SystmOne Live Patient Records within Community Nursing
- 665 - Skegness Hospital Fire Safety
- 649 – Fire Safety Core Risk
- 390 – John Coupland Hospital Theatre Ventilation
- 391 – John Coupland Hospital Water Safety
- 393 – Skegness Hospital Water Safety

There are 0 People and Organisational Development risks rated Significant (15-25) for this reporting period.

As of April 2024, a joint monthly Risk Register Confirm & Challenge meeting is now in place across the Group which will strengthen and align the current LCHS risk management processes alongside the development of a Group Risk Policy.

2. Purpose

The process to manage risks continues to be applied according to the organisation's Risk Management Strategy and Process. Risks are raised according to the strategy and are managed through risk leads across directorates. The Trust currently holds three risk registers:

- Corporate Risk Register notes all strategic risks with an overall rating of 12 or above;
- Operational Risk Register reflects all trust risks with an overall score of 4 to 11;
- Local risk register is held for all risks with an overall score or 1-3.

All risks are owned by Executive Directors, accountable for mitigating actions and progression against these. Risk Leads oversee all risks raised and review these monthly, as a minimum, and are presented to assurance groups for discussion and agreement prior to committee reporting. Risk tolerance ranges have been agreed by Trust Board to align to strategic objective appetite statements.

3. Overview of LCHS Risks

a. Open risks:

There are currently 91 open risks on the Trust risk registers an increase of 3 since the last reporting period. Current ratings are noted below:

Risk Register	Overall current score												Grand Total
	2	3	4	5	6	8	9	10	12	15	16	20	
Corporate Risk Register (12-25)									14	8	5	2	29
Operational Risk Register (4-11)	1	5											6
Local Risk Register (0-3)			5	1	12	13	15	10					56
Grand Total	1	5	5	1	12	13	15	10	14	8	5	2	91

b. Heat map/ dispersion of risk across the risk assessment matrix

Heat map/ spread of risks across the risk matrix		Consequence					
		1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic	Total
Likelihood	1 Rare: This will probably never happen	0	1	3	1	1	6
	2 Unlikely: Do not expect it to happen again but it is possible	0	3	10	8	5	26
	3 Possible: May recur occasionally	2	2	15	2	5	26
	4 Likely: Will probably recur, but is not a persistent issue	1	5	12	5	0	23
	5 Almost Certain: Will undoubtedly recur, possibly frequently	0	5	3	2	0	10
	Total	3	16	43	18	11	91

c. Movement of risks reported across Trust:

Movement of risk	Overall risk score												Grand Total
	2	3	4	5	6	8	9	10	12	15	16	20	
Decrease in score			1		2		1						4
Increase in score												1	1
New						2	1	2	1				6
Closed	1				1		1		1				4
No change	1	5	4	1	10	11	13	8	14	8	5	1	80
Grand Total	2	5	5	1	13	13	16	10	16	8	5	2	95

A summary of the significantly high risks and any movement are outlined below aligned to the strategic objectives:

Strategic objective 1 Provide safe, high quality, population healthcare:

There were 8 significantly high risks recorded in relation to this objective. A summary is provided below:

ID	Title	Risk Score	Division	Updates by reviewers	Date of review
655	Patient Harm due to Quality of care Sleaford ICT	20	Collaborative Community Care – Community Nursing	Mitigations in place to strengthen clinical leadership with the movement of EP's from 2 neighbouring teams over the next 6 months. CTL recruited and will be in post from March 2024. Daily OPEL meeting for escalation in place with CTLs and Matrons. Community Nursing risks are under review to reframe risk and actions required.	March 2024
495	Treatment room clinic capacity	20	Collaborative Community Care – Community Hospitals	Increased to 20 due to demand on the clinics. No clinic space or additional funding available. Currently working well above specification to support patient care across the system. Agreement that it would not be safe or right to reduce service offer but new specificiation and income agreement with ICB required. The capacity of the clinics is impacting on wider services such as IUEC as patients go there to be seen when appointments are unavailable.	March 2024
395	TB Demand and Capacity	16	Children's, Young People and Specialist Services	Increasing number of patients seen within the service with the new Multi drug resistant TB who will require long term follow up for 2 years. Bank staff are being used to mitigate the risk whilst an assessment of an options appraisal is undertaken in conjunction with the ICB to review the option of an additional 1xB6 and 2xHCSW. Bank Admin staff in place to support administrative processes. Video Supported Treatment has been introduced.	March 2024

				Reviewing the TB involvement in Occupational Health and whether OH could do some elements of the screening.	
489	Community nursing staffing pressures	16	Collaborative Community Care – Community nursing	Service has stepped back from OPEL 4 status and likelihood of risk has reduced due to the relocation of staff to support where skills and capacity are required. Meeting with the Director of Nursing has been undertaken to review current community nursing risks with plans underway to update the risks for the next reporting period. Daily review and escalations remain in place. Community Nursing risks are under review to reframe risk and actions required.	March 2024
403	Children Young People Therapy treatment delays (SLT)	16	Children's, Young People and Specialist Services	The downward trajectory for waiting times is slowing. Additional sickness within the team reported in March. Priority system in place & effective – face to face and virtual. The highest priority children are waiting between 9 and 16 weeks. Lower priority waits for therapy after assessment and triage is 33-51 weeks. Children have check ins and programmes of work to support during the wait - service contact details provided for escalation.	March 2024
409	Lymphoedema service capacity	16	Children's, Young People and Specialist Services	Traffic light system in caseload to determine urgency of assessment Chronic Oedema Pathway introduced and shared with Primary Care to promote early treatment of chronic oedema (Essity hosted Countywide drop-in sessions to launch in practice). Referral form updated to gather the information required to enable effective triage of referrals. An options appraisal shared with ELT and ICB for service review.	March 2024
652	Interruption to Enhanced Practitioners and FVW business as usual activity	15	Collaborative Community Care	Bank and agency support is in place, staff are working additional paid hours and a recruitment plan is in place to ensure capacity is available to support both community nursing and virtual ward patients	February 2024
654	Patient harm and compromised quality in the South Lincs ICT	15	Collaborative Community Care	Support and expertise from other teams including additional bank and agency capacity. Daily meetings for monitoring and action. Currently working to BCPs. Work has commenced in a MDT approach to develop a safety improvement plan. Community Nursing risks are under review to reframe risk and actions required.	February 2024

Strategic objective 2: Deliver personalised community health services that are accessible and responsive:

There was 1 significantly high risk recorded in relation to this objective. A summary is provided below**:**

ID	Title	Risk Score	Division	Updates by reviewers	Date of review
672	Timely Unplanned Palliative Response 24/7	16	Childrens and Specialist Services /joint risk across divisions	This currently sits on IUEC risk register as 16 (extreme risk) although this is pertinent to all Divisions and is therefore an organisational risk. Divisions are to review this risk and discuss at the April confirm and challenge meeting. Additional member of home visiting team on every day shift at present to support mitigation of risk/ reduce potential harm. ICB are leading collaborative risk mitigation work across the system. Pathway review taking and priority recruitment in train to mitigate. Comfort calls to patients in place should delays occur. Macmillan support different ways of working. A further meeting took place with ICB partners in February to review system impacts.	March 2024

Strategic objective 3: Build a productive, capable and inclusive workforce

There were significantly high risks recorded in relation to this objective. A summary is provided below:

ID	Title	Risk Score	Division	Updates by reviewers	Date of review
658	Connectivity to Live SystmOne Live Patient Records within Community Nursing	15	Collaborative Community Care	Further units now on order and being circulated as part of refresh. Targeted implementation now underway in Spalding ICT. Risk and plan discussed at Community Collaborative Care Quality Scrutiny Group Meeting 13/03/2024. Exploring further technical solutions in line with operational plans.	March 2024
665	Skegness Fire Risk	15	Estates	Fortnightly meetings are taking place with NHSPS on progress against their action plan. All actions are green and contractors will start on the removal of the old roof W/C 1st April. 1 out of 3 roof spaces have been cleared. Everything is still on track against plan. To review at the end of the month with a plan to lower the risk score in May.	March 2024
649	Fire Safety Core Risk	15	Estates	A new fire officer has been recruited into the ULHT team and is now working with LCHS on supporting with renewing the fire risk assessments. Fire officer working across the LCHS estate supporting with risk assessments, training and support. Feedback is good from operations teams on support and information provided.	March 2024

390	John Coupland Hospital Theatres ventilation	15	Estates	The technical specification for proposed design of the improved ventilation system was issued by the design consultant end of 2023. They posed several points of discussion regarding the fabric of operating theatre environment, such as door sets, ceilings, etc. which require review by our Hard FM Specialist and Ventilation AE. NHSPS confirmed the design has been approved and it is currently out to procurement. Procurement due to complete in April.	March 2024
391	John Coupland Hospital Water Safety	15	Estates	NHSPS has actively sampled throughout the hospital, then acted in response to sample results. Actions taken have included the undertaking of a new water hygiene risk and action of remedial tasks arising from that, amended flushing regimes, thermal sterilisation, chemical sterilisation, and where necessary the installation of POU filters. The last set of results returned three positive results in the three bays at the far end of Scotter Ward, and so a further chemical sterilisation is planned. NHSPS Senior Estates Manager has liaised with IPC Lead regarding results, actions, and use of POU filters. NHSPS Update – March 24 All identified dead legs have been removed and a chemical flush has been booked w/c 25th March. Filters are on positive outlet, changed monthly and documented.	March 2024
393	Skegness Hospital Water Safety	15	Estates	February 24 - NHSPS has actively sampled throughout the hospital, then acted in response to sample results. The latest results showed no legionella in most areas of the hospital, including some which had historically been problematic to resolve. Actions taken have included an Authorising Engineer audit of water safety management activities at the property, installation of a new water storage tank, review of as built water system drawings, amended flushing regimes, thermal sterilisation, chemical sterilisation, and where necessary the installation of POU filters. These actions have led to the point where there remains one area of focus, and further investigation has found previously unidentified dead legs. These are planned	March 2024

				to be removed, after which further sterilisation and then sampling will follow. In the meantime, enhanced flushing and POU filters are in use. March 24 - NHSPS Update. Further dead legs have been identified and an order has been raised to remove these ASAP. A chemical disinfection was carried out in the UTC on the 15th March. A thermal disinfection has been carried out in the rest of the hospital on the 23rd March. Resampling is taking place W/C 25th March. Filters on positive outlets replaced every month and documented.	

4. Conclusions and Recommendations

There are 9 Quality and Safety risks rated as Significant (15 – 25) an increase of 1 since the last report:

- 655 - Patient Harm due to Quality of care- Sleaford
- 495 – Treatment Room Capacity
- 403 - Children Young People Therapy treatment delays
- 409 - Lymphoedema service capacity
- 395 - TB Demand and Capacity
- 489 - Community nursing staffing pressures
- 652 - Interruption to Enhanced Practitioners and FVW business as usual activity
- 654 - Patient harm and compromised quality in the South Lincs ICT
- 672 - Timely Unplanned Palliative Response 24/7

There were 6 Finance, Performance, People & Innovation risks rated as Significant (15 – 25), which has remained static from the last reporting period:

- 658 - Connectivity to Live SystmOne Live Patient Records within Community Nursing
- 665 - Skegness Hospital Fire Safety
- 649 – Fire Safety Core Risk
- 390 – John Coupland Hospital Theatre Ventilation
- 391 – John Coupland Hospital Water Safety
- 393 – Skegness Hospital Water Safety

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

Great care, close to home

ID	Division	Title	There is a risk that:	Caused by:	Resulting in	Controls in place	Rating (current)	Updates by reviewers
658	Collaborative Community Care	Connectivity to Live SystmOne Live Patient Records within Community Nursing	- patient safety: medication incidents relating to omitted doses/wrong doses/wrong preparations - timely access to medication - untimely doses - staff integrity & morale - capacity/demand impact	- not able to access the live patient record and check/access current prescription/A2A - inability to find patient drug history on SystmOne - incl. A2A - lack of mobile coverage in rural County - Primary Care Practices not enabling open sharing across S1 units	- patient safety: medication incidents - 45% of incidents in CoN related to A2A/connectivity (July 2023) - lack of confidence in clinical systems - reputational risk	- mobile working off line: although this may lead to increased staff workload and untimely access to records - tethering to mobile phones - paper A2A forms in patient homes: however may be out of date - staff documenting administration: not at the point of care e.g. home/out of hrs - SIMs option piloted within Bourne S.W.Lincs already. Plan to extend pilot to understand clinical impact i.e. Sleaford to start 6th Nov 2023, and potentially N.Lincoln in Jan 2024 (M.H. lead) - mobile app being considered (BRIGID) however 2 functionalities not available for CoN(appts and case load access)- no timescale identified as yet via TPP	15	18/03/2024 Further units now on order and being circulated as part of refresh. Targeted implementation now underway in Spalding ICT. Risk and plan discussed at Community Collaborative Care Quality Scrutiny Group Meeting 13/03/2024. Exploring further technical solutions in line with operational plans. 09/02/2024 Testing of initial sim modules complete and now wider roll-out of testing will commence. Working group focused on A2A and con connectivity continues to meet and explore improvements in processes. Discussed at Digital Strategy Group (16/01/2024) and Digital Executive Group (07/02/2024). 04/01/2024 Sims available. Embedded cards being ordered from Dell. Working with 3rd party to evaluate coverage. Pilot explored for Sleaford looking at mobile app for data entry/validation. Data bundle expanded. 06/12/2023 Working with AGEM to review hardware requirements for SIMs in all laptops. Reviewed data bundle for usage expansion and gained further intelligence for individual data usage when working on SystmOne Live. Digital Health have engaged with mobile networks for increasing coverage and review has taken place by Quality Team on time-in-motion study. 21/11/2023 Reviewed and discussed at Digital Strategy Group 21/11/2023. No change of score. 16/11/2023 risk discussed and approved at CSEG on the 15/11/2023 08/11/2023 Reviewed by risk owner, digital, medicines management. Plan in place.
665	Collaborative Community Care – Community Hospitals	Skegness Hospital Fire Safety	There is a risk of harm to building occupants (including patients)caused by fire.	Inadequate fire protection systems, maintenance, training and procedures	Loss of facilities, services and injuries to patients and staff.	1. urgent Skegness Working group 2. Health and Safety Committee quarterly. 3. Fire Risk Assessments 4. Fire Safety Training 5. Fire protection system tests 5. Fire Emergency Plans 6. Yearly Fire audit 7. Appointed Authorising Engineer (AE) for Fire 8. Inpatient Fire evacuation plans and tests 9. Test Fire drills. 10. Planned Preventative Maintenance PPM 11. Additional night staff on by NHSPS 12. Staff training 13. Local communications plan and SOP	15	16/04/24 1 out of 3 roof spaces have been cleared. Everything is still on track against plan. To review at the end of the month with a plan to lower the risk score in May. 14/03/2024 Fortnightly meetings are taking place with NHSPS on progress against their action plan. All actions are green and contractors will start on the removal of the old roof W/C 1st April. 14/02/2024 Discussed at risk summit with CCC & Co Ho DDLs 14/02/24: This risk is being updated by DDI DD via the H&S committee, and the most recent update on 09/02/23 notes no change of score & its rationale. Agreed that CCC Co Ho will make no change to score. Quality team aware of discussions outside QSG that confirm the score needs to remain L3 x C5 = 15. CCC to have oversight of this risk and update at QSG monthly, as some of the controls are related to staff training & staffing levels. 09/02/2024 The visit by Lincolnshire Fire and Rescue went very well and feedback about LCHS staff and procedures was greatly received. The NHSPS action plan has been shared with LFR and we are monitoring on a fortnightly basis with NHSPS. 22/01/2024 Further issues raised around condition of the compartmentation on the site. All local fire risk assessments have been refreshed in light of this and additional void detection installed in the roof spaces. 09/01/2024 No New Escalations. Evacuation plan discussed – Remains live. Evac plan - Site based walkthrough and lessons learnt to be completed for assurance. NHSPS Update - The program of works has been developed, with current focus on completion of development of the fire strategy to inform design of compartmentation works, and structural survey of the area above reception after recent findings. Completion of these was delayed by ward closures due to Norovirus. The link corridor between the 'day' part of the Hospital, and 'bedded' part of the hospital now has x2 60-minute rated fire door sets and associated curtaining in the roof void above. Lincolnshire Fire and rescue likely to attend Skegness hospital and audit the site. 22/12/2023Following some additional information about the potential roof spaces issues in Skegness hospital the following has been carried out by NHSPS, ULHT and LCHS. NHSPS confirmed a Structural Engineer commissioned to assess roof build and to feedback ASAP. Structural Engineer instructed and currently scheduled to attend site 4th JAN. NHSPS undertaking review of Landlord fire risk assessment (FRA) with ULHT fire safety advisor (FSA) reviewing Tenants FRA – Any new actions / escalation points will be shared. NHSPS reviewing void detection and to feedback ASAP. Initial investigation indicates the void above reception does not have detection. Work underway today to install temporary detection in that space. 2 additional Porters still in place to assist with evacuation. LCHS fire risk assessments and evacuation procedures for
649	Estates	Fire Safety Core Risk	There is a risk of harm to building occupants (including patients)caused by fire. There is a risk that the Trust cannot demonstrate statutory compliance in accordance with the Regulatory Reform (Fire Safety) Order 2005 (RRO).	Inadequate fire protection systems, maintenance, training and procedures	Loss of facilities, services and injuries to patients and staff.	1. Reporting of compliance in LCHS Safety and Compliance Group (SACG) monthly and Health and Safety Committee quarterly. 2. Planned Preventative Maintenance PPM 3. Fire Risk Assessments 4. Fire Safety Training 5. Fire protection system tests 5. Fire Emergency Plans 6. Yearly Fire audit 7. Appointed Authorising Engineer (AE) for Fire 8. Inpatient Fire evacuation plans and tests 9. Test Fire drills.	15	25/04/2024 Fire officer working across the LCHS estate supporting with risk assessments, training and support. Feedback is good from operations teams on support and information provided. [14/03/2024] A new fire officer has been recruited into the ULHT team and is now working with LCHS on supporting with renewing the fire risk assessments. [09/01/2024] ULHT are supporting LCHS with all elements of fire safety. Also a recruitment process has taken place to increase the capacity in the ULHT team. The LCHS Fire AE is just about to be undertaken. [08/12/2023] Paper going to ELT W/C 11th December to look to sign off additional resources to support Fire safety in LCHS.

390	Estates	John Coupland Hospital Theatres ventilation	Patient safety/ infection control / loss of service and disrupted service to patients	Theatre one - The plant in JCH theatre 1 is running inconsistently resulting in temperatures being close to or over the limit of 22c and humidity at times being close to or breaching the limit of 60.	Theatre one - The plant in JCH theatre 1 is running inconsistently resulting in temperatures being close to or over the limit of 22c and humidity at times being close to or breaching the limit of 60.	1. PPMs and recording undertaken by NHSPS. 2. Yearly survey reports on high risk equipment (theatres) undertaken by NHSPS. 3. Monitoring of compliance undertaken by Estates Shared Service. 4. Compliance information reported into LCHS Safety and Compliance Group (SACG) monthly and Health and Safety Committee Quarterly. 5. Weekly maintenance checks are being undertaken by NHSPS.	15	[25/04/2024] Risk reviewed and no change to score. Still awaiting update from NHSPS on procurement response. [27/03/2024] NHSPS Update. the design has been approved and it is currently out to procurement. Procurement due to complete in April. No change to score currently. [09/01/2024] NHSPS Update - The technical specification for proposed design of the improved ventilation system was issued by the design consultant pre-Christmas. They posed several points of discussion regarding the fabric of operating theatre environment, such as door sets, ceilings, etc. which require review by our Hard FM Specialist and Ventilation AE. Once their feedback and direction are received the design will be finalised. [08/12/2023] The M&E engineers/designers are on site again today, with commissioning engineers, to verify whether existing plant can provide services that shall be repurposed. This to include testing of LTHW & CHW flow rates, current ventilation flow rates, testing of existing pressure stabilisers, and testing of existing diffusers.
391	Estates	John Coupland Hospital Water Safety	Water supply to patients, staff and visitors has been contaminated;	The regulatory routine maintenance of the landlord (NHSPS) being ineffective;	Risk of harm from Legionella and other waterborne pathogens	1. Joint Water Safety Group 2. NHSPS planned maintenance regime 3. Reporting of compliance in LCHS Safety and Compliance Group (SACG) monthly and Health and Safety Committee quarterly. 4. Appointed Authorising Engineer (AE) for water 5. NHSPS is undertaking flushing of outlets. 6. Water sampling - with all results being sent to the Trust AE and Estates Shared Services 7. Estates shared service and AE follow up actions required on high count outlets. 8. Any positive counts have a filter fitted immediately	15	[27/03/2024] NHSPS Update. All identified dead legs have been removed and a chemical flush has been booked w/c 25th March. Filters are on positive outlet, changed monthly and documented. [09/02/2024] NHSPS has actively sampled throughout the hospital, then acted in response to sample results. Actions taken have included the undertaking of a new water hygiene risk and action of remedial tasks arising from that, amended flushing regimes, thermal sterilisation, chemical sterilisation, and where necessary the installation of POU filters. The last set of results returned three positive results in the three bays at the far end of Scotter Ward, and so a further chemical sterilisation is planned. NHSPS Senior Estates Manager has liaised with Sarah Fixter (IPC Lead) regarding results, actions, and use of POU filters. Agreed no change to score [09/01/2024] NHSPS Update - An injection point has been fitted to the pipework supplying the area which had previously returned +ve results, and an initial localised chemical disinfection completed. Subsequent sampling throughout the hospital (c.100 outlets) returned four positive results in the 50 to 150cfu range. The flushing regime has been amended accordingly, and our Senior Estates Manager has instructed retraining of cleaning colleagues to reduce likelihood of cross.
393	Estates	Skegness Hospital Water Safety	Water supply to patients, staff and visitors has been contaminated;	Water supply to patients, staff and visitors has been contaminated;	Risk of harm from Legionella and other waterborne pathogens	1. Trust Water Safety Group 2. NHSPS planned maintenance regime 3. Reporting of compliance in LCHS Safety and Compliance Group (SACG) monthly and Health and Safety Committee quarterly. 4. Appointed Authorising Engineer (AE) for water 5. NHSPS is undertaking flushing of outlets. 6. Water sampling - with all results being sent to the Trust AE and Estates Shared Services 7. Estates shared service and AE follow up actions required on high count outlets. 8. Any positive counts have a filter fitted immediately	15	[27/03/2024] NHSPS Update. Further dead legs have been identified and an order has been raised to remove these ASAP. A chemical disinfection was carried out in the UTC on the 15th March. A thermal disinfection has been carried out in the rest of the hospital on the 23rd March. Resampling is taking place W/C 25th March. Filters on positive outlets replaced every month and documented. [09/02/2024] NHSPS has actively sampled throughout the hospital, then acted in response to sample results. The latest results showed no legionella in almost areas of the hospital, including some which had historically been problematic to resolve. Actions taken have included an Authorising Engineer audit of water safety management activities at the property, installation of a new water storage tank, review of as built water system drawings, amended flushing regimes, thermal sterilisation, chemical sterilisation, and where necessary the installation of POU filters. These actions have led to the point where there remains one area of focus, and further investigation has found previously unidentified dead legs. These are planned to be removed, after which further sterilisation and then sampling will follow. In the meantime, enhanced flushing and POU filters are in use.
655	Collaborative Community Care	Patient Harm due to Quality of care- Sleaford	Patient Harm is being caused due to capacity and competency of staff in Sleaford ICT	5.4WTE Vacancies Lack of CTL Leadership - Skegness CTL covering Only 1 band 6 in work and she is in developing band 6 role, CM supporting from Grantham ICT - due to end 31st Jan 24 3.8 band 5 in recruitment process, 1 band 3 in recruitment process - will need up to 12 week inductions 4.0 WTE LTS and additional STS Limited resources to upskill junior team members and embed lessons learned	Caseload reviews not being completed Patient Harm Lack of continuity - poor patient outcome High sickness in teams both short and long term Poor staff morale Outstanding documentation Impact on other services - mutual aid requested on daily basis impacting on Boston, Grantham, 4 Counties, Lincoln Fen and Horncastle ICTs on a frequent basis. Boston reporting concerns regarding deteriorating patient safety and staff moral as a result	Cohort recruitment Staffing solution meeting resulting in movement of team members from Grantham ICT and Horncastle and Spilsby Geographical working Daily OPEL meeting for escalation Buddy system with neighbouring teams Safer staffing meeting with Karen Dunderdale - planned for 29th Jan 2024	20	Feb update - Piece of work commenced to increase leadership and clinical leadership in Sleaford, EPs moved from 2 neighbouring teams to support for the next 6 months, CTL recruited and will be in post by mid March, additional support from CMs from neighbouring teams to support RTW of Sleaford CMs This will impact teams from which mutual aid is being delivered from - this is being monitored by CTLs and matrons and reported on weekly basis 15/01/2024 Risk score not reduced as CTL is now on AL for 2 weeks and therefore ad hoc cover being provided by CTLs on a rota basis from across the ICTs. Datix not being reviewed in a timely manner due to lack of CMs, CSL having to support and working additional hours to complete. New staff members do not have confirmed start date and will need induction period. 12/01/2024 Discussed at QSG. Agreed that a quality review of Sleaford ICT will be completed with QIP 14/12/2023 no change at QSG New risk

495	Collaborative Community Care – Community Hospitals	Treatment room clinic capacity	The Treatment Room clinics are working off specification, which has led to high service demand beyond contracted obligation. Patient safety is a risk as patients with complex wound management needs are being seen in clinics staffed and set up for minor wounds. The clinics are underfunded .	Gap in service provision for ambulatory patients who have Tier 2 and 3 wounds. GP practices which opted out of the Treatment Room DCA have also been referring patients who do not meet criteria.	Time restrictions on patient assessment timeslots, risk of delayed healing/inappropriate care. Non clinic staff being pulled in to assist. The capacity of the clinics is impacting on wider services such as IUEC as patients go there to be seen when appointments are unavailable. There is no budget to expand the service to meet the need and it is a cost pressure to LCHS.	Initial service review carried out and shared with the ICB to highlight the gap in service and patient risk. Awaiting further guidance from the ICB around future service specifications. See attached risk assessment. 28/02/24: Full in-depth service review being carried out in relation to demand, capacity and cost of the service.	20	07/02/2024 No change to risk. Deep dive service review currently in progress to discuss with ICB in March. Changes have been made to the tariff with a 20% uplift for QTR 3/4 23/24 however the review should highlihght our options going forward. 12/01/2024 Reviewed at QSG. No change. AW asked to review 14/12/2023 no change at QSG 24/11/2023 [17/11/2023 Currently working well above specification to support patient care across the system. Agreement that it would not be safe or right to reduce our offer but new sepec and income agreement with ICB required. Pressure upon this workforce persists 13/10/2023 - discussed at QSG - no change in score or capacity for clinic space. Waiting on ICB decision 13/09/2023 Discussion at QSG - pending decision from commissioners - no change in risk score 10/08/2023 No change in score. Clinics being supported by Leg Ulcer Clinics.
403	Children's and Specialist Services	Children SLT Therapy treatment delays	Children / young people will wait much longer than usual for the treatment option of block of therapy intervention following assessment (6-8 months as opposed to 2-4 months pre-Covid).	During the pandemic, the Children's SLT service were initially unable to carry out therapy blocks except via Q Health, which lead to a backlog due to virtual appointments not being appropriate for all	Patient impact: treatment delays, impact on patients' mental health & social inclusion. Organisation impact: reputational (increase in complaints / concerns)	1. Advice and activities are given the patient's family and/or educational setting, ensuring they are safe to wait. 2. An appropriate skill mix is used, for example assessments are carried out by SLT and most therapy blocks completed by SLTAs. 3. Mix of face to face and virtual sessions "	16	Discussed at divisional QSG 14/03/24: the trajectory has been downwards for waiting times, but this has been slowing down and might change direction, as additional sickness within the team. No change to score. Discussed at divisional QSG 08/02/24: Good progress made with children who no longer meet the criteria, but the shift in how the service is managing its workload has only just started, so impact for more complex children is not visible yet. No change to score. Discussed at divisional QSG 11/01/24: the score of 20 proposed on the 20/12/23 update was not agreed. The waits are expected to go down in future months, and system conversations are taking place, as the system risk is separate from the service risk. Urgent patients such as dysphagia are being prioritised, and therefore score was agreed as 16, although for the system risk it should be 20. Discussed at divisional QSG 14/12/23: team working through backlog with estimated trajectory for completion in January, when the score is expected to change. Options Appraisal to be added to Datix, as well as the action plan. No change to score. Discussed at divisional QSG 09/11/23: service still working to the reduced referral criteria, no change to score. Discussed at division QSG 12/10/23. Risk score remains unchanged. OPEL 3 with OPEL 4 actions. QIA agreed and further discussions took place at the CYP Transformation Board. Comms drafted and awaiting approval for distribution from ICB to inform refers and families. Level 4 actions to be tracked through QSGs Discussed at CSEG 20/09/23 and agreed increase of score to L4 x C4 = 16. Briefing paper for rationale behind moving to OPEL 4 presented at CSEG, and QIA submitted for meeting on 24/09/23. Papers attached to this risk in the Documents section. Move into OPEL 4 being discussed with CEO JFH. Discussed at divisional QSG 14/09/23: waits for therapy still at 52 weeks and initial assessment at 26 weeks. Staff vacancies
409	Collaborative Community Care – Community Hospitals	Lymphoedema service capacity	L will be unable to effectively manage their caseload and waiting list in terms of not being able to effectively assess and treat patients especially those who are complex and/or housebound	A lack of clinic space and qualified staff to meet the demand. Increase in demand.	Increased waiting times for patients, non-routine patients not being seen in clinic due to skill mix, lack of skill development for all staff	1.Traffic light system in caseload to determine urgency of assessment 2.Chronic Oedema Pathway introduced and shared with Primary Care to promote early treatment of chronic oedema (Essity hosted Countywide drop in sessions to launch in practice). 3.Referral form updated to gather the information required to enable effective triage of referrals	16	07/02/2024 No change to score. 12/01/2024 No change at QSG 14/12/2023] No change at QSG. Significant effort from CCC leads to engage ICB re this over the past month. Options appraisal for ELT needs to progress as to supportive way forward with this 11.10.23 - discussed at QSG - there has been a lot of work done around mitigation of risk and waiting list. However score remains the same as service capacity remains unchanged 13/09/2023 Discussion at QSG - score for risk was not increased to 25 based on, staffing support for team via bank, Band 6 has now returned from sick leave, scoping additional HCSW staff, weekly lymphoedema meeting and review of current action plan which includes waiting list patient review and scoping of group sessions 10/08/2023 Currently daily waiting list meeting to ensure no patient harm and safe to wait. No change in risk score 17/07/2023 Increasing demand necessitating further increase in risk score, agreed by quality team to 25. In view of the increasing fragility of the service need to either close to referrals or only accept urgent referrals, quality team to link with DON to discuss. 23/06/2023 Risk assessment reviewed due to resignation of further staff member and agreed at CSEG on 21.06.23 for this risk score to be amended to 20 as a result of reduction in capacity. 09/06/2023 The risk has been updated to reflect the current situation. The new risk score is 20 and this will go through QSG this month. Without further review or investment, the team are unable to meet the specification and can only see urgent, cancer and primary Lymphoedema patients. They are currently in a position to see new patients in this category within 4 week however, this will change with annual leave and sickness. The situation is now affecting the health and well-being of the team. They are trying very hard to cover the service at the detriment of having breaks and dealing with unhappy
395	Children's and Specialist Services	TB Demand and Capacity	Demand is exceeding capacity within TB: the team is working at 1/3 of their capacity.	Current commissioned staffing model doesn't match the increased activity. There are 3 staff members; for 24 weeks of the year due to A/L being taken, the team is functioning at 2/3 capacity.	Increased waits.Rise of TB, LTBI, MDRTB, hospital admissions, deaths. Impact to patients' mental, social, economic&physical health. Impact on staff wellbeing.No capacity to respond timely to outbreak	1. To utilise bank staff with appropriate skills to see this patient group. 2. To ask for dedicated admin staff to support administration process to support trained staff. 3. The introduction of Video Supported Treatment is mitigation that provide case managers assurance that doses were not missed in the absence of support, but this still lacks the prompt and support elements.	16	Discussed at divisional QSG 14/03/24: 3 papers have been submitted to the ICB, 2 meetings were held with DDoN KS, request shared with LCHS to fund 1 x B6 & 2 x B3 out of fragile services list (awaiting board review). It was agreed that Occupational Health will manage latent TB recognised cases, but this is work in progress and the process is not established yet. Further work will be undertaken with the LVHIT service to support in case of outbreak. To aim to reduce the score once the Occupational Health process is in place. No change to score. Discussed at divisional QSG 08/02/24: meeting with ICB went ahead. Action with ICB KS to speak with ICB Finance about pricing up Option 2 from the Options Appraisal paper (additional 1 x B6 & 2 x HCSWs), decision awaited. Reviewing the TB involvement in Occupational Health and whether OH could do some elements of the screening, as well as there being a review of the incident declaring process & of the wrap around support around incidences (huddles being implemented). No change to score. CSEG discussed and reviewed risk 17/01/24 and proposal to increase score from 12 to 16. System risk. Further check and challenge discussion needed. Reviewed at divisional QSG on 11/01/24: the actual risk is the knock on effects of the new Multi drug resistant TB patients, who need long term follow up for 2 years from the team. To continue to use bank to mitigate the risk. Risk to be presented at steering group meeting on 24/01/24. Propose to increase score to L4 x C4 = 16. Discussed at divisional QSG 14/12/23: TB are managing with the adjusted workload, not doing the pre-emptive screening now, but a couple of outbreaks of MDR in Boston, Options Appraisal has been submitted. DL to raise this risk with CMPB on 18/12/23. No change to score. Discussed at divisional QSG 09/11/23: outcome of Options Appraisal awaited, otherwise no change to score. Discussed at Divisional QSG - No movement in score - Papers re sent 11.10.23 to ICB to support decision for options appraisal

489	Collaborative Community Care	There is a risk of community nursing staffing pressures	Patient safety may be compromised. Staff wellbeing may be affected due to increase in workload and travel time. Increase in deferred visits	Staff vacancies, maternity leave, continued sickness. Increased staff sickness levels in some teams. Rural locations of nursing teams. Staff are moving areas and teams to support Travel increase	Patient harm due to inability to provide care Increased workload for staff Increased usage of bank, agency and overtime Impact on staff mental health. Impact of care homes	1.Daily OPEL staffing calls and escalations chaired by Duty Matron 2.Early escalation to proactively identify areas of concern 3.Priority escalation sharing teams chat 4.Matrons have instigated a robust plan managing Datix to have oversight of emerging risks 5.Utilisation of agency staff with in the South of the county 6.Robust management of sickness 7.Escalation at daily operational call to explore wider organisational support with unplanned work 8.Boundaries reviewed and transfers of caseload to neighbouring teams 9.Staff being relocated to other ICT to support with staffing levels 10.Increased visibility of Matrons across the ITC	16	17/01/24 - CSEG supported decrease in score proposed. update in risk score change section: Risk reviewed. Score of 20 was initiated during OPEL 4. Service has stepped back from OPEL 4 status and likelihood of risk grading at 20 has reduced. Discussed with HP. Risk reduced to 16. 14/12/2023 Work around IEN and PCN integration should see some impact in next quarter. No change at QSG 21/11/2023 Remains unchanged currently 13/10/2023 - discussed at QSG. Score remains unchanged - movement of staff across teams pending to address more challenged teams 12/09/2023 Risk reviewed. Increase in medication incidents identified in ongoing OPEL 4. Documentation delays monitored daily. Reduction in leadership oversight to support at CSL level
652	Collaborative Community Care	Interruption to Enhanced Practitioners and FVW business as usual activity	Community Nursing caseloads are not getting the support to manage the most complex patients successfully, impacting upon quality and caseload size (approx. 25% of community nursing teams) There is also a risk, due to overall EP capacity that we don't maximise the FVW as anticipated	5 vacancies that are proving difficult to recruit to. Community EP posts to recruit too; 1WTE Lincoln North- update to go back out to advert w/b 19th FEb 0.8 WTE Louth and Wolds - update recruited to starting April 2024 0.8 WTE Sleaford - Update recrutied to and came into post 22/01/2024 0.8 WTE 18 month secondment cover for Grantham - update to go back out for recruitment 1.00 WTE Mablethorpe - recruited and starting 24/02/2024 0.8 WTE 10 month secondment H/S - recruited too start date 14/04/2024. Frailty EP's- Two qualified EP's for Frailty have handed in their notice 1.0 WTE Frailty EP for North West	Inequity in expectations and poor staff moral Patients not having access to Enhanced Practitioner service that provides complex assessments and instigates management plans and advanced care planning.	Staff working over time, bank shifts and extra hours to ensure service is covered. Posts out for recruitment 12/02/2024 - Ep's from Lincoln Fen 1.0 WTE and Boston 1.0 WTE moved to Sleaford to provide support for new EP in post for Sleaford and ICT staff. Team members working bank to cover Frailty Virtual ward at weekends	15	12/01/2024 No change at QSG 14/12/2023 no change at QSG
654	Collaborative Community Care	Patient harm and compromised quality in the South Lincs ICT	There is a risk of harm because there is not enough staff to meet the demands of the caseloads, compromising care and safety.	Band 5 staff vacancy 7.0 WTE to recruit. Maternity leave and LTS. Staff on B4 and B5 training. Lack of leadership	Lack of case management reviews Patient harm Poor staff morale Outstanding documentation Impact on other services Use of agency staff Lack of continuity of care	Movement of staff from other teams Agency and bank Safer staffing meetings held with Daily OPEL meetings Working to BCP	15	12/01/2024 Risk reviewed at QSG. No change currently. Agreed that a nominated CSL will complete a QIP for area with HON CCC 14/12/2023 no change at QSG
672	Children's and Specialist Services	Timely Unplanned Palliative Response 24/7	LCHS are not providing timely responses to palliative / EOL patients.	Continued increased demand for a timely unplanned response across all services during a 24 hours time period. Unable to meet the standard 2 hours response.	Patients are waiting longer than the recommended 2 hour for symptom control response visit (longest known wait is 11 hours, with regular waits of 5-6 hours). Poor experience for patients and their relatives. Negative impact on staff wellbeing. Increased complaints. Reputational risk.	BCP actions for comfort calls when delays take place. Unplanned pathway work (in development). Macmillan investigating different ways of working in terms of proactive management (in progress). Funding sourced to support additional recruitment into Home Visiting.	16	[24/03/2024] Discussed at CYPSS divisional QSG 14/03/24: noted insufficient data to support score of 16, and agreed with IUEC that it's the system score that is 16, with the LCHS one being 12. Propose to reduce score to L3 x C4 = 12. [18/03/2024] Discussed at IUEC Divisional QSG 12/03/24: the committee felt the score was too high, and that the mitigations need to be reviewed, with consideration that this is a system-wide risk. To further discuss at CSEG in partnership with CCC & CYPSS, as well as ICB, for consideration that local score is 12, and system score is 16. [14/02/2024] 14/02/24 update from IUEC: no change to score, meeting with ICB took place Feb'24 to discuss the fact that this is a wider system risk.

United Lincolnshire Hospitals NHS Trust

Meeting	*Lincolnshire Community and Hospitals Group Public Board*
Date of Meeting	*7 May 2024*
Item Number	*Item*

Board Assurance Framework (BAF) 2023/24
Close down report

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

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

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

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

Executive Summary

The relevant objectives of the 2023/24 BAF were presented to all Committees in March and April. The Audit Committee considered the BAF at its meeting on 26 April.

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

During the March meeting of the People and Organisational Development Committee objective 2b was considered in detail with updates made in respect of the assurances being offered to the Committee. Following review of the objective the Committee supported the rating being moved to 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 2b.

The following assurance ratings have been identified:

Objective		Rating at start of 2023/24	Assurance Rating February	Assurance Rating (Previous Board reported position) March	Assurance Rating (Current position) April
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**	**Green**	**Green**	**Green**
2b	Making ULHT the best place to work	**Amber**	**Amber**	**Amber**	**Green**
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**	**Amber**	**Amber**	**Amber**
3e	Reduce waits for patients who require planned care and diagnostics to constitutional standards	**Amber**	**Amber**	**Amber**	**Amber**
3f	Urgent Care	**Red**	**Red**	**Red**	**Red**
4a	Establish collaborative models of care with our partners	**Amber**	**Amber**	**Amber**	**Amber**
4b	Becoming a University Hospitals Teaching Trust	**Red**	**Red**	**Red**	**Red**
4c	Successful delivery of the Acute Services Review	**Amber**	**Amber**	**Amber**	**Amber**

Work is now underway to devise the 2024/25 Board Assurance Framework for the Lincolnshire Community and Hospitals Group (LCHG), which will be finalised following formal approval of the 24/25 Strategy.

Once the Strategy has received formal Board approval the draft 2024/25 Board Assurance Framework will be taken through the Committee cycle for review and update ahead of being presented to the LCHG Board in July.

It is anticipated that the Board will receive, and commence using, the 2024/25 Board Assurance Framework formally from July 2024.

United Lincolnshire Hospitals NHS Trust
Board Assurance Framework (BAF) 2023/24 - April 2024

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

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

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

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 manage blood and blood products safely Failure to manage radiation safely Failure to deliver planned improvements to quality and safety of care Failure to provide a safe hospital environment Failure to maintain the integrity and availability of patient information Failure to prevent Nosocomial spread of Covid-19	5016 4624 4877 4878 4879 4789 4932 5103 5101 4740 4947 5100 5175	CQC Safe	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.		

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
						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		

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
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.		

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
						Care after death / last offices Procedure & Guidelines Sharing information with relatives Visiting Procedure Patient information Carers Policy in place (PEG)	Audit of EOL visiting required to determine if there is a consistent approach to visiting.	Exceptions guidance re-issued. Monitor through complaints & PALs. Audit will be undertaken by the Patient Experience Team in this years schedule of work.	Report to PEG through complaints & PALs reports; upward reports were received from Visiting Review working group which has now disbanded; the planned audit will report back to PEG and propose any further recommendations. Complaint data now improved in terms of visiting issues.	Patient information currently subject to review and work is ongoing.	Work progressing well and anticipated to have completed full review by end March 2024. Audit of visiting across the Trust completed and co design workshops undertaken that subsequently produced a new Visiting Policy, Visiting Charter, standardised visiting hours across all areas and the new Care Partners Policy.		
						Inclusion Strategy in place (PEG)	Lack of diversity in patient feedback and engagement	Equality, Diversity and Inclusion Lead is member of Patient Experience Group. EDS3 Domain 1 is being piloted with 3 clinical areas.	EDI 1/4rly report to PEG;	EDI Reports will need to develop in maturity regarding patient experience	Head of Pt Experience to discuss with EDI lead to ensure data is relevant and triangulated.		
						Robust process in place for annual PLACE inspection accompanied by PLACE LITE (PEG)			PLACE report to go to Patient Experience Group quarterly and upwardly reported to QGC Annual PLACE report received at PEG	None identified	Not applicable		
						Enhance patient experience by learning from patient feedback and demonstrating our values and behaviours in the delivery of care with a specific focus on discharge of patients. (PEG)	National surveys evidence overall poor experiences in relation to discharge with a number of questions being benchmarked as worse than others Trusts.	Amalgamated survey action plan in development to identify Trust wide improvement focus. Rolling out of #WMTY initiative to ensure patients are involved in decisions and discussions about their discharge plans. Patient Experience Team working with Discharge Lounge staff facilitating understanding of discharge experience and improvements. Discharge work programme being implemtned as part of the UEC imporvment work.	Discharge experience reports to PEG quarterly.	Work required with the lead nurse for discharge to ensure experience data is collected, analysed and acted upon.	Support to be provided to the lead nurse for discharge.		
						Ensure we provide clinically safe services, through an increased number of Diamond Award Accredited Wards / Departments (PEG)	there are no identified Control gaps	Not applicable	monthly Quality metrics dashboard meeting with all clinical areas. Diamond award applications received and supported by corporate nursing team. Diamond Award Panel chaired by DoN/DepDoN. Award presented by Trust Chair. Metric included with the IIP, and measured Quarterly.	None Identified	Not applicable		

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
						Clinical Effectiveness Group in place as a sub group of QGC and meets monthly CEG works to an annual work programme and standard agenda to ensure that all business is covered appropriately. Upward reports are received from reporting groups. Role of CEG is to Improve clinical effectiveness through increased compliance with national and local standards. Quality of reporting into CEG has improved and is increasingly robust. (CEG)	Acknowledged that there is good engagement from nursing and AHPs, however work continues to encourage engagement from medics.	Invites to speakers to come direct from Mr Simpson as Chair of the Group in future. Mr Simpson to continue as Chair of the Group whilst appointment of Deputy Medical Director concluded and will commence in role of CEG chair	Effective upward reporting to QGC from reporting groups. Regular reports received from Divisions providing assurance that they understand their position with respect to clinical effectiveness	No gaps identified.	Not applicable.		
						Getting it Right First Time Programme in place with upward reports to CEG and QGC. Agreement in place recommencement of the of the GIRFT Programme (CEG)	Recognition that the Trust has made the decision that the GIRFT programme will be restricted to those areas relating to high volume, low complexity (HVLC) and areas seeking to focus on elective recovery. Reports currently tend to focus on the process of GIRFT. Further work needed to demonstrate changes in practice as a result of GIRFT work.	Quarterly reports to Clinical Effectiveness Group GIRFT team in place to support divisions and ensure that appropriate activity takes place.	Upward reports to QGC and its sub-groups KPIs in the integrated governance report Process in place for feedback to divisions	Reporting has begun to focus on outcomes but this is not yet well embedded.	Request from CEG for future reports to show improved outcomes as a result of GIRFT activity.		
						Clinical Audit Group in place and meets monthly (CAG) with monthly upward reports to CEG Refocus of CAG to focus on the learning from audit. (CEG)	There are outstanding actions from local audits Due to operational pressures, quoracy has been an issue although this is beginning to improve.	Support being provided from central team to close outstanding overdue actions Job role description for Clinical Audit Leads has been developed. Quarterly updates with Clinical Audit Leads take place with the Deputy Medical Director.	Reports generated for Clinical Audit group and CEG detailing status of local audits and number of open actions. Reports also include learning and changes in practice as a result of audit.	No gaps identfied.	Not applicable.		

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
						National and Local Audit programme in place and agreed which is signed off by QGC. Improved reporting to CEG regarding outcomes from clinical audit. Reports and process in place for any areas where the Trust is identified as an outlier. (CEG)	None identified.	Not applicable	Reports from the National Audit Programmes including outlier status where identified as such Relevant internal audit reports Reports identify where practice has improved but also where it has not improved.	None identified	Not applicable		

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
1c	Improve clinical outcomes	Medical Director	Failure to provide effective and timely diagnosis and treatment that deliver positive patient outcomes	4731 4828	CQC Responsive CQC Effective	Process for monitoring the implementation of NICE guidance and national publications in place and upwardly reported through QGC (CEG)	There are sometimes delays in the completion of the gap analysis for the Clinical Guidelines.	Process in place for escalation if required within the Clinical Divisions.	Reports on compliance with NICE / Tas demonstrating improved compliance.	None identified	Not applicable	Quality Governance Committee	**Green**
						Process in place for taking part in the Patient Related Outcome Measures (PROMs) project. (CEG)	None identified.	Not applicable	Quarterly reports to CEG and upwardly reported to QGC	Business Units not sighted on their performance due to national reporting being stood down although this is due to recommence.	National reports to be presented at Governance Meetings once produced		
						Specialised services quality dashboards (SSQD) Process in place for identifying outliers through Model Hospital. Clinical leads for outlying areas present updates to CEG quarterly. (CEG)	No gaps identified.	Not applicable.	Quarterly reports to CEG and upwardly reported to QGC. Action plans developed for all required areas.	No gaps identified.	Not applicable.		
						Process in place for implementing requirements of the CQUIN scheme. Monthly meetings take place with CQUIN leads. Quarterly reporting takes place. (CEG)	No gaps identified.	Not applicable.	Quarterly reports to CEG and upwardly reported to QGC	No gaps identfied.	Not applicable.		
						Process in place for ensuring high quality of record keeping including Medical Records Group. (CEG)	Medical Records Group not meeting regularly.	Refocus of the Medical Records Group planned by the new Chair.	Programme of record keeping audits taking place.	Audits do not demonstrate compliance with record keeping standards. Limited evidence that specialties are reviewing record keeping findings and developing actions to address.	Divisional governance leads to pick up within each area.		
						Process in place for monitoring of and implementation of NCEPOD requirements. (CEG)	None identified.	Not applicable	Quarterly reports to CEG on progress.	Some outstanding baseline assessments. Some overdue actions identified.	Work taking place with divisional leads to address.		
						Quarterly Learning Lessons Newsletter in place at both Division and Trust wide level (CEG)	Staff may not access emails to review newsletters Assurances to be received at the next meeting regarding how learning is shared within Divisions.	Programme of work commencing regarding wide ranging mechanisms for learning lessons across the Trust.	Evidence of newsletters shared is available.	No gaps identified.	Not applicable.		

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
						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	None identified	Workforce Board with oversight of the workforce CIP plans for the system	None identified	None Identified		

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
						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	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	None Identified		

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
						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 has been recruited for Yr2. Consideration to the concept of group appraisals and appraisal lite to form part of the review of people policies and procedures.	Workforce Strategy and OD Group to discuss group appraisal and appraisal lite - On Going.	Workforce, Strategy and OD Group upward report to PODC including scorecard analytics i.e. appraisal, statutory and mandatory training.	Appraisal compliance levels have improved and continue to be on target for full year effect. Mandatory Training compliance have improved and continue to be on target for full year effect.	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.		
						Embed continuous improvement methodology across the Trust	Embedding and sustaining cultural improvement change when the ability of the ULHT teams to engage is limited or constrained 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)		
		Director of		4844	CQC Safe	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.	People and	

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
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	4996 5093 4997 4997	CQC Responsive CQC Effective	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 have improved and continue to be on target for full year effect. Mandatory Training compliance have improved and continue to be on target for full year effect.	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
						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. Leading together Programme for multi disciplinary senior leaders across the Organisation.	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 Health and wellbeing Programme for staff.	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. Now at a fully recruited position within HR.	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			

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
						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			
						Reduce our staff turnover rate to 6% across all staff groups	6% turnover rate yet to be embedded as BAU in 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, specific / ad hoc pieces of OD work with individual areas, as identified that requires support / help and associated action plans agreed and owned by Clinical/Management teams. Working in conjunction with HRBP's and OD Business Partners for a joined up approach to tackle culture challenges. The OD, Education and Development Directorate was restructured as part of the redesign piece of work within People & OD Directorate and investment made to increase the workforce.	Culture shift takes time to be embedded however improvements continue to be recognised in engagement scores in the National Staff Survey results. Very strong performing staff networks now in place and being recognised nationally for awards. Investment in wellbeing manager leading the wellbeing work across the Trust under Occupational Health offering direct support for staff who may require it in addition to the Employee Assistance Programme available. Increase in the number of staff reaching out to FTSU guardian is a positive reflection of the effectiveness of the FTSU processes.	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. 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 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 formed with a full project plan and roll out being undertaken.	Culture and Leadership Group and System People Board Culture and Leadership Programme Group upward report NSS results (Feb 2023/Feb 2024) Themes from cultural deep dives presented to PODC. Patient complaints and compliments data. staff complaints data. FTSU data. External stakeholders feedback. Just and Learning Steering group offer a highlight report to PODC. Culture and Leadership Group offer a highlight report to PODC. Staff Networks and their effectiveness is measured through				

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
									the EDI action plan.				
						Effective communication mechanisms with our staff - ELT Live, managers cascade, intranet, weekly Director Blogs, twice weekly all staff communications, staff FaceBook, Public Trust Board meetings, team meetings, 1:1's.	None identified		Staff survey feedback - engagement score, recommend as place to work / recommend as a place to receive care. Pulse surveys feedback Director BLOG's, ULHT Together Facebook page and ELT Live.	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			
						Staff networks	Men's Health Network Group launched November 23	Executive sponsor for Men's Health Network to be identified Launch Network in November Additional Carers Network now launched. An ELT Network special has also been held with all Network Chairs and Executives	Council of Staff Networks covers all our networks who meet monthly with the CEO	None identified			
			Further decline in demand										

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
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	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.		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 Task and finish group to review experience of rotation, embedded practice now	None identified		People and Organisational Development Committee	**Green**
						Embed compassionate and inclusive leadership (aligned to People Promise)	System People Promise Manager recruited for Yr2 funding	None identified	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. Manager reports re: training compliance MTTG used as Gateway to core learning Mapping of core training on more individual basis.	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 allow better monitoring and reporting. Consideration of appraisal lite and group appraisal now embedded. Further work required aligned to the Quarterly Pulse survey and promotion of this. 95% compliance yet to be embedded as BAU.	HRBP support in each Division and Directorate supporting the promotion of mandatory training and appraisals, using reported data to show progress. New Appraisal paperwork embedded. Recommendations captured through the National Staff Survey.	Workforce Operational Group training report Upward reporting to People and OD Committee CQC Monthly reporting Individual core training matrix on ESR	Appraisal compliance levels not yet at expected level but is improving Mandatory Training compliance not yet at agreed level but continues to improve Limited uptake of quarterly staff survey	To be monitored through the Workforce Operational Group and FPAM meetings and will feature in the highlight report to PODC. Phased targeted approach in 23/24 KPI's as featured in the Integrated Improvement Plan has been implemented Additional monthly assurance offered to CQC through governance team regular meetings.		
						Support our Divisions to provide all staff with an appraisal and clear objectives	None identified	None identified	Workforce Operational Group reports Upward reporting to People and OD Committee CQC Monthly reporting	None identified	None identified		

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
						55% of our staff recommending ULHT as a place to work.	NSS results show a requirement to improve this recommendation	Annual NSS. Pulse surveys staff feedback through FaceBook, exit interviews, Attractive recruitment campaigns and packages; Retention strategy being developed .Attrition rates monitored	Workforce Operational Group reports Upward reporting to People and OD Committee CQC Monthly reporting National Awards e.g. Pastoral Care Award received for IEN recruitment.	None identified	None identified		
						People report that they are treated with kindness, compassion and respect.	Culture shift takes time to be embedded however positive improvements are being seen.	Annual NSS. Pulse surveys staff feedback through FaceBook, exit interviews, Attractive recruitment campaigns and packages; Retention strategy being developed .Attrition rates monitored. Feedback through appraisals. Annual staff awards ceremony. Meaningful recognitions Framework with variety of staff feedbacks and recognitions in place.	Workforce Operational Group Reports Upward reporting to People and OD Committee CQC Monthly reporting Recognition certificate and letter received for the 2022 National Staff Survey, Freedom to Speak Up Guardian post embedded.	None identified	None identified		
						53% of our staff recommending ULHT as a place to receive care	NSS results show a requirement to improve this recommendation	Further work required aligned to the Quarterly Pulse survey and promotion of this. Annual NSS. Patient feedback. National recognition for improvements in service delivery and care Eg. Maternity Service Improvements.	Workforce Operational Group Reports Upward reporting to People and OD Committee CQC Monthly reporting Recognition certificate and letter received for the 2022 National Staff Survey Patient Experience Group Staff satisfaction reports	None identified	None identified		

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
2c	Well led services	Chief Executive	Risk register configuration not fully reflective of organisations risk profile Current systems and processes for policy management are inadequate resulting in failure to review out of date or policies which are not fit for purpose	4277 4389	CQC Well Lead	Delivery of risk management training programmes Risk Register Confirm and Challenge Group meeting monthly including full risk register review Upgrade to datix system	Upgrade to Daitx due to take place October 2023		Third party assessment of well led domains Internal Audit assessments Risk Management HOIA Opinion received and Audit Committee considered in June noting 'partial assurance with improvement required can be given on the overall adequacy and effectiveness of the Trust's framework of governance, risk management and control. Completeness of risk registers Annual Governance Statement			Audit Committee	**Amber**
						Implementing a robust policy management system Additional resource identified for policy management post Reports on status by division and Directorate Updated Policy on Policies Published Guidance on intranet re policy management reviewed and updated	Divisional breakdown of policies requiring review shared with CEG and request for trajectories to update/remove all clinical policy documents requested at August meeting.	Further discssions to take place at October CEG to address shortfall in trajectories being offered	ELT report monitoring actions. Quarterly report to Audit Committee including data on in date policies CQC Report - Well Led Domain				

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
SO3	**To ensure that services are sustainable, supported by technology and delivered from an improved estate**												
	A modern, clean and fit for	Chief Operating	Longer term impact on supplier services (including raw materials) who are supporting the improvement, development, and maintenance of our	4648 - Fire Safety 4647 - Fire		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.		
						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	

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
3a	A modern, clean and fit for purpose environment	Chief Operating Officer	and maintenance of our environments. Availability of funding to support the necessary improvement of environments (capital and revenue)	4647 - Fire Safety 5189 - Med Air Plant	CQC Safe	Continued progress on improving infrastructure to meet statutory Health and Safety compliance	H&S Committee Previously not run with quoracy. However now reviewed with ToR agreed and Quorate with staffside representation	Water/Fire safety meetings are in place and review of controls are part of external validation from authorised engineers. Health and Safety Committee new terms of reference approved and now chaired by Chief Operating Officer/Director of Estates and Facilities. Upward reporting to Finance, Performance and Estates Committee Med gas, Critical ventilation, Water safety group, electrical safety group, medical gas group have all been established and include the relevant authorising engineers in attendance. These groups monitor and manage risks and report upwards any exceptions or points of escalation.	Reports from authorised engineers Response times to urgent estates requests Estates led condition inspections of the environment Response times for reactive estates repair requests Progress towards removal of enforcement notices Health and Safety Committee upward report Letter from British Safety Council on External Review			Finance, Performance and Estates Committee	**Amber**
						Implement Year 1 of our Estates Strategy	Funding gaps between overall plan of replacement vs available funding. Availability of Suppliers and Changes in market forces. Availability of raw materials and specialist components to replace/repair etc.	Business Case Development and preparation pre-empting available capital to maximise available. Use of procurement framework and liaison with NHSE to coordinate bids and larger schemes	Estates Group Upward Report				
						Refurbishment of 8 theatres, across our sites							
						Support capacity maximisation ensuring modernisation and utilisation of space, including that leased off the main acute sites							
						Reduce our net carbon footprint							
						Develop Health Master Plans to better algin wards							

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
3b	Efficient use of our resources	Director of Finance and Digital	Not identifying and then delivering the required £28m FRP of schemes The national impact of rising inflation (specifically utilities) in excess of the levels assumed in the 23/24 financial settlements The Trust is overly reliant upon a large number of temporary agency and locum staff to maintain the safety and continuity of clinical services. Failure to deliver the activity targets of 116% of 19/20 planned activity will result in a clawback of an element of the ERF allocation made to Lincolnshire.	4664 -Agency costs 5020 - UEC medical workforce	CQC Well Led CQC Use of Resources	Introduction of Aspyre for reporting all FRP schemes Refresh of the CIP framework and training to all stakeholders. Increased FRP governance & monitoring arrangements introduced. Alignment with the Trust IIP and System objectives FRP is embedded as part of the Trust Improvement Strategy not seen as a separate workstream. Internal meeting structure and reporting aligned to the ICS reporting requirements	Operational ownership and delivery of efficiency schemes Detailed delivery plans supported by clear timelines and metrics for all plans	Divisional FPAM to provide oversight of FRP reporting upward into PRMs. Trust wide oversight for FRP schemes in the Improvement Steering Group ICS oversight through the ICB Financial Recovery Board.	Delivery of the Trust FRP target Reporting through Aspyre to - FPAM PRM FPEC Financial Recovery Board	Ability of clinical and operational colleagues to engage due to service pressures. Evidence of system and Trust schemes to reduce the operational pressures and beds numbers in the Trust. Traction in year to produce cost out from cross cutting targeted and transformational schemes	Divisional - Progress is being reviewed monthly with Divisions through FPAMs. Trust wide improvement schemes - Progress is being reviewed monthly with Exec, Divisional and Corporate teams through the Improvement Steering Group. System wide - Progress is being reviewed monthly with system partners including Exec, Operational and Corporate teams through various forums.	Finance, Performance and Estates Committee	Amber
						Inflation - The Trust is working to actively manage its contracts and to flag excess inflation due to market conditions as part of the national collection process in relation to this spend area	Impact of unstable market conditions led to the Trust forecasting excess inflation of £8.1m in its 2023/24 financial plan submission - over and above national inflation funding allocations. The £8.1m (as per national instruction) sits outside of the Trust financial plan for 2023/24. Inflation pressures primarily relate to Utility costs but also impacts in other non-pay contracts. As prices continue to rise the Trust and / or ICS may be unable to mitigate these cost increases.	Financial plan set out the Trust expectation in respect of inflation aligned to the national allocations Annual budget setting process cascades and apportions the Trust inflation allocation to Divisions and Directorates. Monthly financial management & monitoring arrangements are in place to identify variation of excess inflation against financial plans at all levels of expenditure from department up to Trust. The Trust actively manages its external contracts to ensure value for money.	The Trust is monitored externally against the inflation impacts through the monthly finance return to NHSE The Trust monitors internally against its financial plan inclusive of specific inflation forecasts Divisional focus against specific contracts (e.g. Utilities) is reviewed at the relevant FPAM Excess inflation pressures will be reported internally into FPEC and externally into FLG and ICS and Finance Committee	Forward view of market conditions.	Internally through FPAMs and upwards into FPEC. Externally through greater dialogue with suppliers and proactive contract management Flagging with ICS partners and NHSE to understand if any further funding allocations will be available to offset.		
						Financial Recovery Plan schemes Recruitment improvement Medical job planning Agency price reduction Workforce alignment Service Reviews process and transformational programmes of work Budget compliance	Reliance on temporary staff to maintain services, at increased cost Management within staff departments and groups to funded levels. Maximisation of below cap framework rates Rapid ability to on-board temporary staff to substantive contracts	Proposed centralised agency & bank team. Workforce Groups to provide grip Improvement Steering Group to provide oversight Non-Clinical Agency sign off process	Delivery of the planned agency reduction target.	Granular detailed plan for every post plans Rota and job plan sign off in a timely manner	The Trust monitors internally against its financial plan inclusive of specific targets for agency and bank spend by staff group The Trust FRP workstreams are reported to the Improvement Steering Group The Divisional cut of the workstreams are reported to the relevant FPAM The staff areas of key focus - Medical and Nursing are reported through their Workforce Groups		

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
						ERF clawback - Collective ownership across the Lincolnshire ICS of the restoration and recovery of the planned care pathways leading to improved activity delivery. Trust focus to restore services to pre-COVID levels and then stretch to 116%.	Maximisation of the Trust Resources - Theatre and Outpatient productivity. Impact of the COVID patients and flow on availability of beds to provide capacity. Ability to recruit and retain staff to deliver the capacity. A production / activity delivery plan.	Divisional ownership and reporting Improved counting and coding, including data capture and missing outcome reductions. Shared risk and gain share agreements for the Lincolnshire ICS. Reporting by POD and Specialty against the delivery plan	Delivery of the 116% target	The operational pressures, specifically; sickness, excess beds open, rising acuity of patients and continuing rising demand at the front door of the acute Trust is putting at risk in year delivery of the 116% activity target.	The Trust is monitored externally against the Trust activity target through the monthly activity returns The Trust monitors internally against its activity targets inclusive of specific Divisional and Specialty plans and targets The Lincolnshire ICS is monitored externally against the system activity target through the monthly activity returns		
						Utilisation of Capital allocation based on risk to enhance our services and support efficiency improvements	Difficult to compare Estate, Digital and Equipment risks. Capacity to produce business cases to access external funds	Revised CRIG process, supported by experts. Green book training roll out. Risk rating pre & post investment required in all investment requests.	Capital, CDC and Benefits realisation upward reports into FPEC. Development of a 5 year capital programme cross referenced to risk register.	6 facet survey not completed.	Investment identified for 6 facet survey.		
						Improve utilisation of the Care Portal with increased availability of information -	Cyber Security and enhancing core infrastructure to ensure network resilience. .	Digital Services Steering Group Digital Hospital Group Operational Excellence Programme Outpatient Redesign Group	Number of staff using care portal Ranked in 4th place nationally of ICS usage of Care Portals.				
						Development and approval of Electronic Patient Record OBC	Regional and National approval of OBC Affordability of OBC	Digital Services Steering Group Digital Hospital Group e-HR Programme Steering Group Capital, Revenue and Investment Group Engagement with regional colleagues	Delivery of OBC Agreement of funding	Regional feedback on OBC	OBC approved by Frontline Digitalisation ePR Investment Board (EPRIB) on 19th July 2023. OBC approved by JIC on 28th July 2023. OBC approved by Cabinet Office Commercial Spend Controls Process on 3rd Oct 2023. ITT published 6th October 2023 with bid submission deadline on 29th November 2023 but only three bid submissions received with non of them being fully compliant. After listening to the market and involving all parties (including legal), changes have been made to the ITT, including provide increased flexibility in the approach to T&Cs and updating the wording of one of the Mandatory Compliance Questions.		

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
											ITT republished 29th February 2024 with bid submission deadline 10th April 2024. Following FBC development later this year, we estimate the contract will be signed January 2025.		
			Approval of OBC for Electronic Health Record is delayed or unsuccessful			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.		
3c	Enhanced data and digital capability	Medical Director	Major Cyber Security Attack Critical Infrastructure failure	4657 - SARs	CQC Responsive	Implement robotic process automation	Lack of expert knowledge available within and to the Trust (experts in short supply nationally) Business case development on hold due to capacity issues	Skilling up internal resource. Exploring opportunities with Northampton General Hospital who provide RPA Services LCHS and ULHT contracts being migrated to one at next renewal. Project Manager being sought to oversee / plan developments. Baselining Job Description Bandings to ensure they are competitive. Working with ICS colleagues to maximise ICS benefit.			Business case approved by CRIG. Worked scoped and started. Three year rollout of all 30+ initiatives with 'high hitters' being implemented first First Project Steering Group took place 09/04/2024.	Finance, Performance and Estates Committee	**Amber**
						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					

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
						Complete roll out of Data Quality kite mark			Ensuring every IPR metric has an associated Data Quality Kite Mark	Information improvements aligned to reporting needs of Covid-19.	A number of metrics have had a review and these are awaiting formal sign off. They will then appear in the IPR. Additional metrics have been added and reviewed, and a work plan and deadlines associated with completion is being drawn up. These will be shared with the Director of Finance & Digital for sign off.		
						Upgrade of our technological infrastructure to support technology advancements	Insufficient cap/rev to replace aging technology Insufficient capacity to deliver purchased equipment	Technical Design Authority Digital Hospital Group Information Governance Group (for cyber / info security)	Digital Maturity Assessment		Looking to procure a Technical / Implementation Partner to provide capacity as and when required Enabling infrastructure funded via FD (EPR) rollout going to plan.		
						Provide our people with real-time data to support high quality care delivery to all clinical staff							
						Enhance our organisational digital capability and skills through training	Insufficient capacity to create and deliver training materials	Digital Hospital Group			Looking to procure a Technical / Implementation Partner to provide capacity as and when required This is no well underway with 2 comms centres purchased in 23/24 and will be commissioned in 24/25, wireless network being upgraded		
						Implementation of an Electronic Prescribing system	2023/24 funding not approved yet Insufficient capacity to deliver at pace of current plan	ePMA Steering Group Digia Hospital Group	Number of wards live with ePMA		Paper written to clarify costs. Currently being worked through with Finance colleagues ePMA fully rolled out across whole trust as of 09/02/2024. Proect now closing		
						Daily reporting of all three metrics (62 day backlog, FDS and 62 day performance) Twice weekly Intensive Support meetings to review all 3 metrics and position of patients on the cancer PTL Fortnightly cancer recovery meeting System Cancer Improvement Board Weekly ICB/Group oversight through Planned Care and Cancer catch up	Capacity v demand across all tumour site pathways not completed Insufficient oversight of system partners contribution (e.g. primary care testing and workups)	Cancer Leadership Group Deep Dive Workshops (e.g. Colorectal) Intensive Support Meetings (Trust and ICS)	Cancer board assurance and performance reports Routine Performance and pathway data provided by Sommerset system Cancer Intensive Support Meetings Cancer Intensive Support Meetings Monthly Trust Board reporting for planned care and cancer	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 75% March and reduction in patients >104 days. At the end of March >62 days was 217 (aligned with trajectory), >104 was 63 patients of which 51 were tertiary patients, FDS at 74.44% (75%)		

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
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	Achievement of FDS, 104 and 62 week performance trajectory	Capacity to deliver Faster Diagnosis (FDs) for all services		Weekly system elective and cancer recovery meetings 3x weekly cancer meetings for all T Sites led by Deputy COO, Urgent Care and Cancer and ICB Cancer lead		Due to sustained improvement, NHSE de-escalated cancer from Tiering in December 2023.	Finance, Performance and Estates Committee	**Amber**
						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 RAPs at Tumour Site level available from March through which performance will be monitored		Focused piece of work in place to review Navigator role in terms of WF capacity and capability has been undertaken with a training program in place and supported PTLs as a result. Additional support from external ICB funded cancer specialist to further refine the PTL process and provide on the job coaching and trainig of the cancer team. Breast are developing a sustainability plan to be taken through CRIG in Q4 that will provide a backdrop for continuous achievement of all 3 cancer targets. Number of capacity increasing BCs have been agreed by CRIG and others dependent upon slippage. Each tumour site has worked through mitigations and impact.		
						Improve access for patients by reducing unwarranted variation in service delivery through transformation of Planned Care Integrated Improvement Programme and Assoc Governance System Planned Care and Diagnostic Group	Recovery post COVID and risk of further waves Specialty strategies in place but still in infancy Fluctuating gaps in improvement and operational teams Continued risk of capacity loss from Industrial action	Recovery plans at specialty level. To date have delivered required reductions in 104 week waits. 78 week waits now almost cleared Outpatient Improvement Group in place and is now supported by a delivery group lead by the Deputy COO for Planned Care and Diagnostics GiRFT and High Volume Low Complexity Programme Group Productive Theatres Improvement Programme Grantham Surgical Hub now established and performing well Productivity group established focused on increase of all Elective activity Early adopter of GIRFT Further Faster Programme Line by Line review twice weekly of 78 week waiting	Performance Data Planned Care Improvement and Performance Reporting Integrated Improvement Plan Highlight and Status Reports GIRFT Reports and NHSE Review data	Inconsistent approach to waiting list validation Maximum Outpatient and theatre capacity not apparent as yet. Match between job planned and delivered activity	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.		

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
								patients Outpatient letter project underway to support utilisation			Internal design, development and agreement of a 'production plan'. Review of all consultant Job Plans is in train.		
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		

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
						Clinical prioritisation Group	Ability to list appropriate mix of P2/3/4 due to effective preop Unnecessary on the day cancellations Increased non-admitted waiting list waiting to convert to admitted	Preop workstream via FEI Review and management through prioritisation group and Surgical PRM Management through ORIG/HVLC/Surgical PRM	Reporting through FPEC/HVLC				
						Meet all National asks for performance, set out in the planning guidance, for elective care							
						Maximisation of capacity and efficiencies to reduce and eliminate 78 week, 65 week waits across all specialties and moves to ambition of reducing 52 week to 700 by end of Q4 2023/2024			Trajectories for all specialties in place, weekly position statements offered to ELT and TLT Weekly planned care update meeting				
						Development of plans for seven day working, across all of our services							
						3x daily internal capacity meetings to improve discharge and flow and trouble shoot operational issues at the front door Project 76 meetings with Group/ICB stakeholders in place with weekly deep dives into divisional actions plans across both organisations and weekly project review with system partners Group Discharge Board in place (from 10/04/2024) Daily ICB UEC call to escalate issues across the system and provide support to unblock pressure areas Group UEC Board established reflecting 5 Pillars of Improvement System Urgent Care Partnership Board.	Internal professional standards not embedded Medical and Nursing WFP not reflective of 24/7 UEC service requirements Lack of understanding at ward level re SAFER leading to poor implementation Assessment areas not substantively funded Capacity Team unable to provide adequate cover 24/7 due to WFP	5 Pillars / Worstreams reflecting key cross system programs of work. Progress of the above measured through the Group UEC Board Monitoring of performance at Tiering Meetings with NHSE, although these have now been stepped back to fortnightly as UEC has moved from Tier 2 to Tier 3 External reviews including GRFT have identified gaps in services which have been included in actions plans within the relevant specialties/divisions	Improvement against 3 key metrics as agreed with NHSE and monitored via Tier 2 meetings : % of patients in Emergency Department >12 hrs (Total Time) 4 hour Type 1 performance Cat 2 Mean EMAS performance Updates full suite of metrics to ELT, TLT and Board. Updates provided to Group UEC Board and UEC System Partnership Board	Pathway 0 patients discharge is being effectiveley planned from the point of admission All PW1-3 capacity is used on a daily basis Escalation policy is not fit for purpose and not used to define triggers and actions form divisons and support services. Process and deployment of Full Capacity Protocol not clear and not used effectively as not aligned to Escalation Policy. Specialist teams are attending ED within 30 mins of request in line with IP standards	Weekly Group UEC Board from January 2024 through which x 5 pillars of cross LCHS/ULHT work are monitored Daily 76% EAS meetings taking place to monitor in-day delivery against the standard EAS discussed at every capacity meeting Daily Breach understanding is circulated along with performance MTD, previous day and in-day progress 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.		

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
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)	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. Most recent weekly performance shows: Ambulance Cat 2 ResponseTime - 30 min 34.58% (an improvement on 6 wk average of 38.22%) T1 4 hour performance - 55.7% 43.7% (Which has improved against the 6wk average of 41.6%) All Types 4 Hour performance - 76% 74.7% (which has improved against the 6wk average of 72.1%) 12 hour in dept - 559 (plan) 528 (against 6 wk average of 526)	Finance, Performance and Estates Committee	**Red**
						Maximisation of capacity and efficiencies to reduce waiting times in ED Support discharge processes, ensuring services are provided within timeframes which are safe and responsive, enabling a reduction in length of stay/bed occupancy and increased flow			Trajectories for all specialties in place, weekly position statements offered to ELT and TLT New board has a suite of metrics to measure improvments and focus divisional leadership teams on discharge target actions to ensure patients are bale to return to their usual place of residence or most fitting place of care sooner		Further rollout of SAFER will be supported by 4 B6 nurses to support discharge and flow out of wards and improve "pull" from ED. New Group Discharge Board set up to pull together workstreams that focus on discharge and flow, including SAFER priciples, criteria led discharge and divisional flow targets		
						Development of plans for seven day working, across all of our services			Requires scoping and costing for all support and direct care services				
SO4	**To implement new integrated models of care with our partners to improve Lincolnshire's health and well-being**												

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
						Supporting the implementation of new models of care across a range of specialties	Specialty strategies being developed	Specialty Review Programme has now commenced. A heat map was produced using a data driven approach to identify the first cohort of specialties to be prioritised. 15 specialties were identified and 11 have had their review workshop and have 5yr strategies now being finalised. The final 4 are planned for early 2024. A revised heat map was been sent to FPEC (Dec 2023) for approval to move forward with the 2nd phase of specialties identified. The specialty review team have also undertaken an additional 3 workshops at the request of divisional colleagues. Totalling 14 workshops delivered since the programme began in February 2023.	Reports -ELT / TLT -Committees -Board -System	Plan of how the speciality strategies will be developed	Strategy & Best Practice team now fully recruited too and all vacancies filled. Head of Strategy & Best Practice now substantively recruited to. A specialty strategy template has now been drafted and is used to create the strategy documents following review workshops. Supported by a detailed action tracker to ensure actions are captured and progress monitored. Regular update to FPEC on programme progress. All aspects of programme managed effectively.		
						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 - Complete	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 5 refresh - completed. Year 5 IIP under development and due to be completed within Apr 2024 following a robust Business Planning Session in Q4 of 2023/24 (including Divisional IIP completions).		

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
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	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 in post and will be hosted by ULHT. ULHT engagement in 3 EMAP work programmes. EMAP MOU pending Board approval. 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/MOU	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.	Finance, Performance and Estates Committee	**Amber**
						Gain a greater understanding of the Lincolnshire population and support a reduction in health inequalities	Core20PLUS dashboard not yet developed	Development of Core20PLUS dashboard by June 2023	Core20PLUS dashboard	Core20PLUS dashboard not yet developed	Dashboard due to be in place by June 2024		
						Establishment of the Tobacco Cessation service to proactively support better health for the Lincolnshire population	Service not fully recruited to	New project manager in place Jan 2024 and will lead on outstanding recruitment.	Service mobilisation of Tobacco Cessation service	Service launched end March 2024	Service to be operated by LCHS from 15th April 2024.		

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 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	JFP completed February 2024 and shared with Board	JFP triangulation with IIP Year 5	JFP completed and considered in Chief Executives Group and formally to the Board	JFP triangulation with IIP not yet completed or signed off - gaps to be identified	Year 5 IIP will include JFP triangulation for Boards prior to sign to off, April 2024		
						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	Business case needs to be developed and taken through the case of need and then full business case route of CRIG..	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. 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	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 from Research Group CRIG upward report to TLT	None identified	None identified.		
						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. Clinical Acadmic Oversight Group to oversee recruitment of clincial academic model, recruitment and delivery. *Group meetings being support discussion on performance and any adjustments to job plans* Meetings with ULHT and UOL finance/contracting teams to finalise financial model and MOU based on principles of the Selby 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/PODC	Unknown financial commitment for the Trust in relation to the clinical academic roles until the financial model is completed and recruitment commences.	Monthly meetings with ULHT and Uni of Lincoln Financial best case, most likley and worst case models reviewed by ELT and ~~to be~~ shared with Board in March 2024 to agree risk appetite		

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
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	The training and support environment for students and clinical academics will be in place. 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	People and Organisational Development Committee	**Red**
						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		
						Clear understanding of UHA requirement for University Status which requires 6% of medical workforce WTE to be clinical academics which is being used to build the ULHT/UOL model Develop a portfolio of evidence to apply for Teaching Hospital status as an interim approach towards full University Teaching Hospital status at a later stage	Financial model and clinical academic roles are not yet in place	A financial model for the appointment of clinical academics is in development that describes a timeline to achieve the required 6% of medical workforce for UHA status Portfolio of evidence is being captured for Teaching Hospital status application and is available on the shared drive Identified leads to liaise with UHA CEO (Medical Director, ULHT and System Clinical Director/Chair PCN, Lincolnshire ICS)	Financial meetings underway to develop and agree clinical academic models. Working Group meetings have been re-established and include medical, nursing, AHP and OD representation. Template for teaching Hospital submission and clear timeline in place to achieve status by end 23/24	Lack of finalised, agreed financial and contracting model for clinical academics roles currently	Meetings in diary to discuss updated financial model and MOU once approved by ELT and PODC		

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
						Develop a strong professional relationship with the University of Lincoln and the Medical School and jointly create a strategy with a focus on developing rural healthcare, medical/nursing/AHPs/Clinical Scientists/R&I staff education and other healthcare roles	Evidence bound by UHA requirements Clear plan/strategy on development of medical/nursing/SHPs/Clinical scientists/R&I staff education roles	A new R&I group has been set up, being led by Director of R&I/Deputy Medical Director. We continue active stakeholder management with Medical Director of ICS and UOL VC.	ULHT healthcare roles plan Increased recruitment/academic posts (across ICS)	The change to the UHA Guidance (20xClinical Academics) is a challenge. Received further feedback from UHA and need to have at least 20 clinical academics remain unchanged.	Working closely with University of Lincoln to develop plans for recruitment of Clinical Academic posts with a view to maximising existing research relationships where possible. Two potential candidates have been identified for the Clinical Academic recruitment.		
						Successfully recruit 6 Clinical Academics 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. Update to Trust Board shared in March 2024 to agree risk appetite and enxt steps.		
						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		CQC safe, CQC responsive, CQC well led	Develop a ULHT clinical service strategy with focus on fragile services in order to provide sustainable and safe services for the future Identify the key services to focus on for Clinical Service Review (taking into account CIP, benchmarking, GIRFT and other core data)	Divisional IIPs need to be completed to ensure links into fragile services/clinical service strategy Identify resources to implement ASR outcomes	First cohort of specialty reviews underway and on track Programme management support being identified via Provider Collaborative to help deliver ASR phase 1 Individual work streams to be established Clinical Strategy engagement period has successfully concluded - 1st draft document has been socialised for feedback from key stakeholders. Delay in launch due to resource availability - Strategy planned to be presented to Board in May 2024 for approval.	Health inequalities and core25 PLUS indicators Early Warning Discharge Indicators Rigorous engagement, both for feedback from the ASR review and further implementation	Evidence available but working on a process to bring together the information for services to aid the identification of the Top 5 areas for focus in 2022/23.	Part of the refreshed IIP Reporting processes Publish ULHT clinical service strategy April/May 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**

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
			(Level 4, Major Incident etc).			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, April 2024	Signed off specialty reviews	Governance route not yet established	Agreement of governance through ELT		
						Play an increasing leadership role within the East Midlands Acute Provider Collaborative to develop key partnerships	EMAP work programmes establishing - outcomes/deliverables not yet agreed	Programme Boards in place with monthly meetings underway Highlight reports being overseen by monthly EMAP executive meetings EMAP updates to ELT/TLT	EMAP executive meeting minutes	EMAP programme highlight reports - still in development	Verbal updates at EMAP exec meetings and ULHT representation at EMAP programme groups		
						Build a Partnership strategy to support improvements in safe and sustainable care, and harness benefits for the population of Lincolnshire	Partnership Strategy not yet in place	Associate Director of Partnerships started in post May 2023 and has started to draft Partnership Plan. Board development session 5th December 2023 and intention to have signed off by February 2024 Partnership work is already underway across the organisation and is not being delayed by the lack of formal strategy e.g opportunities emerging for the speciality review programme	Signed off Partnership Strategy	Strategy not yet completed or signed off	Work is underway to develop the strategy, which needs to align with the new IIP and ULHT clinical services strategy.		

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

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

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

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

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

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

Lincolnshire Community Health Services NHS Trust

Lincolnshire Community and Hospitals Group Board

Date of meeting	7 May 2024	Agenda item	14.2
Title	2023-24 Board Assurance Framework Closedown Report		
Report of	Catherine Leggett, Deputy Director of Corporate Governance	Prepared by	Catherine Leggett, Deputy Director of Corporate Governance
Previously considered by / Date	None.	Approved?	
Summary	This report provides the final Board Assurance Framework (BAF) ratings for 2023-24 strategic aims and objectives following Committee discussions and assurance received in March and April. The Board are asked to approve the proposed ratings for March 2024 and the closure of 2023-24 Board Assurance Framework, noted in full in appendix 1.		

1. Provide safe, high quality, population healthcare	**1a. Deliver safe services**	**Cautious** approach to patient safety or harm with strong focus driven by national strategies and policies.	√
	1b. Deliver effective care	**Open** approach to effective care**.**	√
	1c. Engage and involve people in their care	**Seek** approach to engagement and involvement.	√
2. Deliver personalised community health services that are accessible and responsive	**2a. Deliver clinically led integrated community services**	**Open** approach to clinically led integrated community services.	√
	2b. Deliver personalised health care that responds to individual need	**Open** approach to personalised health care that responds to individual need.	√
	2c. Transform clinical pathways for sustainability and improved outcomes	**Seek** approach to transformation of clinical pathways for sustainability and improved outcomes.	√
3. Build a productive, capable and inclusive workforce	**3a. Grow and retain our people**	**Open** to maximising transformation opportunities and will try new and innovative ideas and ways of working to improve job satisfaction and enrichment.	√
	3b. Value and develop our people	**Cautious** approach to staff safety and wellbeing and recruitment compliance**.**	√
	3c. Enable a change ready workforce	**Seek** new and innovative ways of working through the use of automation and technology which in turn will improve productivity and release time to care.	√

	3d. Deliver Safe and Sustainable Foundations	**Cautious** approach to cyber security, health and safety and recruitment compliance. This is because we value our people as our greatest asset and we strive to keep our people, our patients and their respective information as safe as possible.	√
4. Ensure healthcare is financially sustainable, making best use of resources	**4a. Deliver financially sustainable healthcare, making best use of resources**	**Open –** Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level.	√
	4b. Drive better decisions and impactful action through insight	**Seek -** We will invest for the best possible return and accept the possibility of increased financial risk (with controls in place).	√
5. Collaborate to play an active role in the Lincolnshire ICS	**5a. Collaborate to make a difference**	**Seek** opportunities to be innovative and collaborative, both within the organisation and the wider system environment.	√
	5b. Transform services to deliver great care close to home	**Seek** opportunities to be innovative and collaborative, both within the organisation and the wider system environment.	√

Impact of proposal/ report	N/A				
CQC	**Safe** √	**Caring** √	**Effective** √	**Responsive** √	**Well-Led** √
Links to risks	*All risks within trust scope are detailed in Appendix 1*				
Legal/ Regulation	CQC regulations, NHSI, Standing Orders, Health and Social Care Act.				

Recommendations/ Actions Required

The Board is asked to

- **Approve** the final ratings proposed for March 2024
- **Approve** the closure of the 2023 -24 Board Assurance Framework.

Appendices

Appendix 1 – 2023-24 Board Assurance Framework – proposed final ratings for March.

Glossary

NHS – National Health Service
LCHS – Lincolnshire Community Health Services NHS Trust
TLT – Trust Leadership Team
BAF – Board Assurance Framework

2023-24 Board Assurance Framework Closedown Report

1. Purpose

The Board Assurance Framework (BAF) is a key tool that the Trust uses to assess the Trust controls framework and assurance available for each strategic aim and strategic objective. The BAF notes primary, secondary and tertiary controls in place, gaps in those controls and/ or assurance and mitigations in place against gaps noted.

2. 2023-24 Board Assurance Framework.

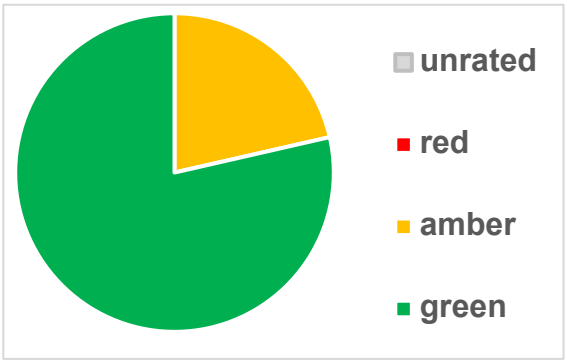
The BAF outlines the 14 strategic objectives, supported by 38 aligned programmes, for delivery in 2023-24. Current proposed ratings are noted below: The full Board Assurance Framework is noted in appendix 1.

Strategic Aim	No. of strategic objectives	Assurance ratings for strategic objectives	No of Programmes
1. Provide Safe, high quality, population healthcare	3		10
2. Deliver personalised community health services that are accessible and responsive	3		7
3. Build a productive, capable and inclusive workforce	4		13
4. Ensure healthcare is financially sustainable, making best use of resources	2		4
5. Collaborate to play an active role in the Lincolnshire ICS	2		4

a. Assurance gained – Complete 2023-24 BAF

There are a total of 14 strategic objectives, supported by 38 aligned programmes, for delivery in 2023-24 being assessed across the five Strategic Aim areas within the BAF. The summary of assurance by objectives is:

- 0 objectives are unable to be rated
- 0 objective rated as red assurance
- 3 objectives, supported by 7 programmes, rated as amber assurance (21.43%)
- 11 objectives, supported by 31 programmes, rated as green assurance (78.57%)



b. Summary of movement of 2023-24 ratings, final year-end position and proposed ratings for March 2024 for approval:

Strategic Aim	Strategic Objective	Assurance Rating 2023-24											
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
1. Provide safe, high quality, population healthcare	1a. Deliver safe services												
	1b. Deliver effective care												
	1c. Engage and involve people in their care												
2. Deliver personalised community health services that are accessible and responsive	2a. Deliver clinically led integrated community services												
	2b. Deliver personalised health care that responds to individual need												
	2c. Transform clinical pathways for sustainability and improved outcomes												
3. Build a productive, capable and inclusive workforce	3a. Grow and retain our people												
	3b. Value and develop our people												
	3c. Enable a change ready workforce												
	3d. Deliver Safe and Sustainable Foundations												
4. Ensure healthcare is financially sustainable, making best use of resources	4a. Deliver financially sustainable healthcare, making best use of resources												
	4b. Drive better decisions and impactful action through insight												
5. Collaborate to play an active role in the Lincolnshire ICS	5a. Collaborate to make a difference												
	5b. Transform services to deliver great care close to home												

3. Development of the Lincolnshire Community and Hospitals Group (LCHG) 2024-25 Board Assurance Framework

Work is now underway to devise the 2024/25 Board Assurance Framework for the Lincolnshire Community and Hospitals Group (LCHG), which will be finalised following formal approval of the 24/25 Strategy.

Once the Strategy has received formal Board approval the draft 2024/25 Board Assurance Framework will be reviewed by Committees and the LCHG Board. It is anticipated that the Board will receive, and commence using, the 2024/25 Board Assurance Framework formally from July 2024.

4. Recommendations

The Board is asked to

- **Approve** the final ratings proposed for March 2024
- **Approve** the closure of the 2023-24 Board Assurance Framework.

LCHS Board Assurance Framework 2023-24

Great Care, Close to Home

Strategic Aims	Responsible Committee
1. Provide safe, high quality, population healthcare	Quality and Risk Committee
2. Deliver personalised community health services that are accessible and responsive	
3. Build a productive, capable and inclusive workforce	Finance, Performance, People and Innovation Committee
4. Ensure healthcare is financially sustainable, making best use of resources	
5. Collaborate to play an active role in the Lincolnshire ICS	

RAG Rating

R	Effective controls may not be in place and/or appropriate assurances are not available to Board
A	Effective controls thought to be in place but assurances are uncertain and/or possibly insufficient
G	Effective controls definitely in place and Board satisfied that appropriate assurances are available

			2023-24 Operational Plan		Risk Context			Controls			Control gaps (adequate controls not in place or collectively not sufficiently effective)		Assurance			Assurance Rating										
Strategic Aim	Strategic Objective	Executive Director	Linked programmes in Operational Plan	Linked projects in Operational Plan	Risk Appetite	Current Corporate Risks (strategic risk register)	What could prevent us from meeting this objective?	First line of defence (Management/ Team/ Report/ Strategy)	Second line of defence (Review of 1st line - group/ committee/ peer review)	Third line of defence (Independent review - internal/ external audit/ survey)	What gaps exist?	How is the gap being mitigated?	Sources of assurance (see note for this cell for guidance of sources of assurance)	Are there any assurance gaps? (are all the right controls in place/ are they effective/ have we (LCHS) done all we can to deliver)	How is the gap being mitigated / addressed?	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
1. Provide safe, high quality, population healthcare	1a. Deliver safe services	Medical Director Director of Nursing Chief Operating Officer	1. Strengthen LCHS Patient Safety Culture 2. Strengthen safety through safeguarding 3. Wound care and improvement programme 4. Improve medicines related safety 5. Improve medical devices and use of in practice	1.1 Implement the National Patient Safety Strategy 1.2 Patient Safety Incident Response Framework (PSIRF) Implementation plan 1.3 Recruitment of Patient Safety Partners 2.1 Organisation approach and framework to managing waiting lists 2.2 Devising and implementing and reporting harm reviews 3.1 Implement the National wound care strategy for pressure damage 3.2 Implement the National wound care strategy for leg ulcers 3.3 Healthy IO 4.1 Delivery of the Medicines Management Improvement plan 4.2 Develop the pharmacy strategy, including gases and workforce 5.1 Review contracts for medical supplies and medical device management 5.3 Scopel introduce Point of Care Testing	Cautious approach to patient safety or harm with strong focus driven by national strategies and policies. Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward. Explore new learning to positively influence care delivery.	467 Medicines management practice 472 NHS Property Services provision of medical gases within LCHS sites. 511 Medical Devices Asset Register 519 Medicines - prescribing 524 Staff Training 536 Medicines Administration Error 554 Lincolnshire-wide Medicines Management Input 556 Medicines Management: Trust-Wide 510 LCHS Patient Waiting Lists Data	1. Lack of resources 2. Lack of skills and capability 3. Leadership capacity 4. External partnerships and ways of working 5. Patients and public behaviours 6. Mindset of leaders 7. National releases on best practice	1. Clinical Strategy 2023-28 and linked reporting of delivery 2. Integrated Care System (ICS) Strategy 3. Integrated Care Board 5-year joint forward plan 4. National Patient Safety Strategy and reporting on implementation and compliance to Q4R 5. Divisional ownership of quality safety and risk - through governance framework 6. Triangulation of data to drive implementation and improvements - dashboards 7. System approach to Patient Safety Incident Response Framework (PSIRF) 8. National Wound Care strategy and system QSG plan delivery	1. Quality Assurance groups 2. Clinical Safety and Effectiveness Group (CSEG) 3. Strategy and Planning Group (SPG) 4. Quality and Risk Committee (QRC) 5. Audit Committee 6. Trust Leadership Team (TLT) 7. Performance Management Reviews (PMRs)	1. System Patient Safety Incident Response Framework (PSIRF) group 2. Quality Surveillance Group 3 NHS England 4. Care Quality Commission new framework 5. Internal/ External Audit 6. Regional netwoks patein safety 7. CD LIN 8. Benchmarking 9 Safety plan 10 National standards and Key Performance Indicators	None	None	1.1 National Patient Safety Strategy implementation plan 1.2 Patient Safety Incident Response Framework (PSIRF) within LCHS 1.3 Patient Safety Partners embedded in posts 2.1 Organisation approach and framework to managing waiting lists 2.2 Devising and implementing and reporting harm reviews 3.1 Implement the National wound care strategy for pressure damage 3.2 Implement the National wound care strategy for leg ulcers 3.3 Healthy IO 4.1 Medicines Management Improvement plan 4.2 Pharmacy strategy, including gases and workforce 5.1 Contracts for medical supplies and medical device management 5.3 Point of Care Testing	None	None											
1. Provide safe, high quality, population healthca+A2ine	1b. Deliver effective care	Medical Director Director of Nursing Chief Operating Officer	1. Strengthen effective practice	1.1 Develop the clinical and professional workforce models across the organisation 1.2 Deliver the clinical and professional workforce models in line with the Lincolnshire ACP strategy 1.3 Expand our research portfolio 1.4 To develop the resource and structure to deliver medical directorate opportunities and medical appraisal structure as the workforce expands 1.5 Develop and implement a Ward Accreditation Framework 1.6 Improve the effective practice framework	Open approach to effective care. Willing to consider all potential delivery options while also providing an acceptable level of reward. We must always seek to make the best possible use of resources (both our own and others we have access to). Innovation is supported. Responsibility for non-critical decisions may be devolved.	442 Recruitment 470 Maintaining appropriate staffing levels could be compromised due to staff shortages 475 Timely operational performance data 481 Community Nursing Capacity 482 Community Hospital Staffing for maximum bed capacity 488 Adult Community Therapy Capacity 501 Heart Failure Team increased demand 504 Urgent Care Staffing 544 E-rostering 548 Community Nursing Staffing Shortages	1. Lack of resources 2. Lack of skills and capability 3. Leadership capacity 4. External partnerships and ways of working 5. Patients and public behaviours 6. Mindset of leaders 7. Staff health and wellbeing	1. National nursing priorities and agenda 2. People plan driven actions to support workforce 3. National nursing and AHP ACP frameworks in WF models 4 Nurse retention plan 5. Workforce models and planning programme	1. Quality Assurance groups 2. Clinical Safety and Effectiveness Group (CSEG) 3. Strategy and Planning Group (SPG) 4. Quality and Risk Committee (QRC) 5. Audit Committee 6. Trust Leadership Team (TLT) 7. Performance Management Reviews (PMRs)	1. Nursing and Midwifery Council (NMC) / National Quality Board (NQB) 2. National Communityt Nursing Plan 3 NHS England 4. Care Quality Commission new framework 5. Internal/ External Audit 6. Regional networks nursing workforce plans with priorities 7. Benchmarking 8. National standards and Key Performance Indicators	1. The nursing voice is a current gap.	1. Project to develop and implement a Ward Accreditation Framework	1.1 Clinical and professional workforce models across the organisation 1.2 Clinical and professional workforce models aligned to the Lincolnshire ACP strategy 1.3 Research portfolio expansion and delivery. 1.4 Resource and structure in place to deliver medical directorate opportunities and medical appraisal structure 1.5 Implementation update reporting against Ward Accreditation Framework 1.6 Effective practice framework delivery plan.	None	None											
1. Provide safe, high quality, population healthcare	1c. Engage and involve people in their care	Medical Director Director of Nursing Chief Operating Officer	1. Grow People Engagement 2. Improve People Involvement 3. Expand People Experience 4. Implement the Equality Delivery System 3	1.1 Develop and deliver System Statutory Engagement Team resource and plan 2.1 Co-produce an LCHS involvement plan (patient forums, digital engagement, patient expert groups, evidence based design programmes, expert patient groups/health coaching, volunteer) 2.2 Deliver an LCHS involvement plan 3.1 Co-produce an LCHS experience plan to improve service design, access and experience (FFT, 15 Steps, NHS Choices, Healthwatch, volunteers, digital mechanisms) 3.2 Deliver and monitor an LCHS experience plan to improve serice design, access and experience 4.1 Development of Divisional EDS 23/24 delivery plans for domain 1 (access, aligned to patient needs, safety and quality of services and service-specific experience)	Seek approach to engagement and involvement. Eager to be innovative and to pursue wide ranging options to involvement people who use or connect with our services to make the best use of resources (both our own and others we have access to). Innovation pursued	468 - Complaints	1. Lack of System Engagement and Comms Team/ recruitment to team/ External partnerships and ways of working 2. Inadequate resources to deliver against objective/ programmes 3. Mindset, ownership and behaviour of leaders 4. Quality improvement approach and toolkit 5. System working interdependencies 6. Patients and public behaviours 7. Lack of capacity, capability and/or skills 8. Staff health and wellbeing	1. Clinical Strategy 2023-28 and linked reporting of delivery 2. Integrated Care System (ICS) Strategy 3. Integrated Care Board 5-year joint forward plan 4. Trust Leadership Team (TLT) reports 5. LCHS Operational Plan reports 6. Lincolnshire Long Term Plan 7. Quality Team/ Patient Experience and Involvement leads 8. Complaints, Patient Advice and Liaison (PALS, and Claims Team 9. System Communications and Engagement Team 10. Volunteering Services Team 11. Triumvirate weekly complaints, incidents and claims reviews 12. Divisional monthly operational plan reporting 13. Quality Assurance Groups	1. Stakeholder Engagement and Involvement Group (SEIG) 2. Clinical Safety and Effectiveness Group (CSEG) 3. Strategy and Planning Group (SPG) 4. Quality and Risk Committee (QRC) 5. Audit Committee 6. Trust Leadership Team (TLT) 7. Performance Management Reviews (PMRs)	1. Care Quality Commission Engagement and Assessment 2. Healthwatch monthly reports 3. Patient-Led Assessments of Care Environment (PLACE) Report 4. NHS Resolution reporting 5. Audit - internal/ external 6. Patient and Public feedback/ surveys/ NHS Choices 7. Volunteering placement evaluations/ take up of opportunities 8. Complaints and Claims benchmarking data 9. Friends and Family Test data	1. System Engagement Team not currently in place and timeline not confirmed. 2. Data - not connected Datix/ Business Intelligence/ System 1 3. Equality Delivery System data not available until data warehouse can connect equality data	1. System CEOs meeting to progress decisions. 2. FBI developed rollout plan for datix being pulled into the data warehouse. 3. FBI developed rollout plan for Systemone data linkage to datix incidents/ complaints/ claims.	1.1 Recruitment and delivery of System Statutory Engagment Team resource and plan 2.1 LCHS involvement plan, feedback, improvement and delivery of plan (including national patient surveys) 3.1 LCHS experience plan, feedback, improvement and delivery of plan 3.2 Improved serice design, access and experience 4.1 Divisional EDS 23/24 delivery plans for domain 1	None	None											
2. Deliver personalised community health services that are accessible and responsive	2a.Deliver clinically led integrated community services	Medical Director Director of Nursing Chief Operating Officer	1. Maximise capacity and flow developing integrated pathways of care across frailty, palliative, respiratory and cardiology 2. Review and transformation of Intermediate Pathways of Care 3. Integrated localised community services transformation (community nursing, specialist and therapy services)	1.1 Integrated pathways of care across frailty, palliative, respiratory and cardiology including expansion of virtual wards implementation 1.2 Maximise efficiency and expand the use of technology to offer more remote appointments 1.3 Review admissions avoidance pathways and unplanned care across the division to ensure there is 24/7 coverage for the system 2.1 Intermediate Care Review 2.2 Review and development of integrated D2A, UCR and Home Visiting admission avoidance pathways 2.3 Working with system partners to review priority pathways for looked after children in Lincolnshire 3.1 Co-development of integrated community services at a PCN footprint 3.2 Implement new COBWEB Continence system and development of continence service pathway 3.3 Lincolnshire Diabetes Pathway Review	Open approach to clinically led integrated community services. Willing to consider all potential delivery options while also providing an acceptable level of reward. We must always seek to make the best possible use of resources (both our own and others we have access to). Innovation is supported. Responsibility for non-critical decisions may be devolved.	501 - Cardiology 535 - Pulmonary Rehab 547 - Virtual Wards	1. Lack of resources 2. Lack of skills and capability 3. Leadership capacity 4. External partnerships and ways of working 5. Patients and public behaviours 6. Mindset of leaders 7. Staff health and wellbeing	1. Operational services project groups 2. Operational plans 3. Clinical Strategy 4. Quality Impact Assessments and Equality Impact Assessments (EIA/EQIA)	1. Quality and Risk Committee 2. Urgent and Emergency Care Board 3. Care Closer to Home Board 5. Trust Leadership Team (TLT) 6. Transformation Delivery Group (TDG) 7. Digital Executive Group (DEG) 8. Performance Management Reviews (PMRs) 9. Stakeholder Engagement and Involvement Group (SEIG)	1. Patient and Public Involvement feedback - surveys. Patient Friends and Family Test information 2. Benchmarking data 3. National Best Practice Guidance 4. NHS England guidance 5. Clinical Audit 6. Contract Partnership Management Board	None	None	1. Year one operational plans against Clinical Strategy 2023-2028 2. Increased uptake of Virtual Ward beds across system pathways 3. Pathways of care	None	None											
2. Deliver personalised community health services that are accessible and responsive	2b.Deliver personalised health care that responds to individual need	Medical Director Director of Nursing Chief Operating Officer	1. Modernisation of Community Hospital Transformation Programme 2. Implimentation of the Lincolnshire Personalisation Strategy	1.1 Development and embed OPAT Service 1.2 Scoping and development of Outpatient Services 1.3 Scoping of community hospital spoke of CDCs 1.4 Review and redesign of the frailty pathways between acute and community services including primary care 2.1 Personalised Care and Support Plans implementation 2.2 Develop and embed strength based approaches into community hospital discharges 2.3 Expansion and implementation of Patient Activation Measures (PAMs) and other self-care measures across community based services	Open approach to clinically led integrated community services. Willing to consider all potential delivery options while also providing an acceptable level of reward. We must always seek to make the best possible use of resources (both our own and others we have access to). Innovation is supported. Responsibility for non-critical decisions may be devolved.	496 - Diabetes 548 - Community Nursing 482 - Community Hospitals 524 - Continence	1. Lack of resources 2. Lack of skills and capability 3. Leadership capacity 4. External partnerships and ways of working 5. Patients and public behaviours 6. Mindset of leaders 7. Staff health and wellbeing	1. Operational services project groups 2. Operational plans 3. Clinical Strategy 4. Quality Impact Assessments and Equality Impact Assessments (EIA/EQIA)	1. Quality and Risk Committee 2. Urgent and Emergency Care Board 3. Care Closer to Home Board 5. Trust Leadership Team (TLT) 6. Transformation Delivery Group (TDG) 7. Digital Executive Group (DEG) 8. Performance Management Reviews (PMRs) 9. Stakeholder Engagement and Involvement Group (SEIG)	1. Patient and Public Involvement feedback - surveys. Patient Friends and Family Test information 2. Benchmarking data 3. National Best Practice Guidance 4. NHS England guidance 5. Clinical Audit 6. Contract Partnership Management Board	None	None	1. Year one operational plans against Clinical Strategy 2023-2028 2. Numbers of PCSP across all services 3. Number of Patient Activation Measures (PAMs) used across relevant services 4. continence prescribing costs	None	None											
2. Deliver personalised community health services that are accessible and responsive	2c. Transform clinical pathways for sustainability and improved outcomes	Medical Director Director of Nursing Chief Operating Officer	1. Productivity and clinical effectiveness review of services 2. Co-creation of Single Point of Access and Referral Management maximisation	1.1 Review of enhanced GP packages including INR, lymphoedema and treatment rooms 1.2 Productivity review and recommendations for sustainable community services including adult community Speech and Language Therapy (SLT) service model and TB Pathway 1.3 Waiting list oversight and recovery 2.1 Development of Single Point of Access for organisation, including Clinical Assessment Service (CAS) 2.2 Maximisation of direct referral management 2.3 Review and remodel our Urgent Care offer in line with national standards	Seek approach to transformation of clinical pathways for sustainability and improved outcomes. Eager to be innovative and to pursue wide ranging opportunities to transform current provision and seek out new and innovative models for patient care to improve outcomes and make the best use of resources (both our own and others we have access to). Innovation pursued	539 - Children's therapy waiting lists 510 - Waiting lists 491 - Lymphodeama 543 - Podiatry services 466 - TB 460 - Adult SLT	1. Lack of resources 2. Lack of skills and capability 3. Leadership capacity 4. External partnerships and ways of working 5. Patients and public behaviours 6. Mindset of leaders 7. Staff health and wellbeing	1. Operational services project groups 2. Operational plans 3. Clinical Strategy 4. Quality Impact Assessments and Equality Impact Assessments (EIA/EQIA)	1. Quality and Risk Committee 2. Urgent and Emergency Care Board 3. Care Closer to Home Board 5. Trust Leadership Team (TLT) 6. Transformation Delivery Group (TDG) 7. Digital Executive Group (DEG) 8. Performance Management Reviews (PMRs) 9. Stakeholder Engagement and Involvement Group (SEIG)	1. Patient and Public Involvement feedback - surveys. Patient Friends and Family Test information 2. Benchmarking data 3. National Best Practice Guidance 4. NHS England guidance 5. Clinical Audit 6. Contract Partnership Management Board	1. Fully established data warehouse	1. Identified priorities across the Divisions	1. Year one operational plans against Clinical Strategy 2023-2028 2. Services able to provide direct referrals 3. Single Point of Access 4. Efficiencies through contracts and productivity reviews	None	None											
3. Build a productive, capable and inclusive workforce	3a. Grow and retain our people	People and Innovation	1 Workforce Planning 2. Inclusion 3. Pipeline 4. Flexibility 5. Retention	1.1. Work Planning Solution 2.1. Representative Workforce 2.2. Inclusive Recruitment 3.2. Wider Workforce 3.3. Collaborative Bank 3.4. International Recruitment 3.5. Apprenticeships 4.1. Flexibility by Default 5.1. Supporting Better Retention	We are 'Open' to maximising transformation opportunities and will try new and innovative ideas and ways of working to improve job satisfaction and enrichment. We will build a more sustainable and diverse workforce and make LCHS a great place to work and an employer of choice	442 Recruitment 470 Staffing levels	1. Lack of resources 2. Lack of skills and capability 3. Leadership capacity/capability 4. External partnerships and ways of working 5. Mindset of leaders and staff 6. Staff health and wellbeing 7. Further Industrial Relations 8. National/Region directives	1 Integrated Care System (ICS) Strategy 2. Integrated Care Board 5-year joint forward planL 3. LCHS People Strategy 2023-28 4. Clinical Strategy 2023-28 5. People Strategy Group 6. LCHS Operational PLans 7. Divisional delivery plans 8. Action Plans (eg Workforce Race Equality Scheme/Workforce Disability Equality Scheme) 9. Equality Diversity and Inclusion Lead/ Freedom to speak up guardian (FTSUG) /Staff Networks/ Health and Wellbeing Lead and Champions 10. Mental Health First Aid Champions 11. Swartz Rounds 12. Staff Networks 13. Equality Delivery System (EDS) 3 Action Plan 14. International Recruitment (IR) Project Group 15. Costs of Living Working Group	1. People Executive Group (PEG) 2. Finance, People, Performance and Investment Committee (FPPIC) 3. Lincolnshire People Board 4. Audit Committee 5. Equality, Diversity and Inclusion Group 6. Trust Well-Being Guardian 7. Lincolnshire People Plan 23/24 8. Trust Leadership Team (TLT) 9. Transformation Delivery Group (TDG) 10. Stakeholder Engagement and Involvement Group (SEIG) 11. Performance Management Reviews (PMRs) 12. Transformation Delivery Group (TDG) 13. Trust Leadership Team (TLT) 14. Quality and Risk Committee (Q&RC) 15. Lincolnshire People Hub 16. Lincolnshire Integrated Care Board	1. Audit 2. NHS National Staff Survey 3. Regional People Board 4. Equality Delivery System (EDS) 3 5. CQC 6. System Improvement Director 7. NHS People Plan 8. National/Regional Benchmarking	1. 10 Year NHSE Workforce Plan	1. The LCHS People Stragey and People Plan have been developed following NHSE 23/24 Planning Guidance and Priorities	1. Delivery of the LCHS People Strategy 23/24 Action Plan 2. Standard People Metrics (SicknessTurnover/MT/Vacancy/agency spend etc) better than LCHS targets and benchmarking 3. NHS National Staff Survey results above average in all People Promise areas 4. Delivery of the Lincs People Plan 23/24 and improved system people metrics (sickness, staff survey, turnover, agency spend etc) 5. Efficient use of Apprentice Levy funds 6. Improved NHS Freedom to Speak Up Guardian (FTSUG) Index score 7. National Quarterly Pulse Survey (Quarter 1, Quarter 2 and Quarter 4) above benchmarking 8. Improved Workforce Race Equality Scheme (WRES) and Workforce Disability Equality Scheme (WDES) Data 9. Corporate Benchmarking in the lowest quartile for People Functions 10. Delivery of the EDS3 Action Plan 23/24 11. Recruitment of 50 International Recruits (40 Nurse and 10 AHP)	1. Assurance not due to be received until July/ end of Q1. Assurance for some areas received through Q1 however not able to rate in entirity.	1. Assurance for Q1 received July.											
3. Build a productive, capable and inclusive workforce	3b. Value and develop our people	People and Innovation	1. Civility and Respect 2. Health & Well Being 3. Leadership and Talent 4. Workforce Transformation	1.1. Allyship 1.2. Active Bystander 1.3. Reverse Mentoring 2.1. Health Inequalities (staff) 2.2. Research into staff self-care/role of leadership 3.1. Talent 4.1. New Ways of Working 4.2. Develop New Roles and Skills	LCHS maintains a 'cautious' approach to staff safety and wellbeing and recruitment compliance. This is because we value our people as our greatest asset and we strive to keep our people, our patients and their respective information as safe as possible.	442 Recruitment 470 Staffing levels	1. Lack of resources 2. Lack of skills and capability 3. Leadership capacity/capability 4. External partnerships and ways of working 5. Mindset of leaders and staff 6. Staff health and wellbeing 7. Further Industrial Relations 8. National/Region directives	1 Integrated Care System (ICS) Strategy 2. Integrated Care Board 5-year joint forward planL 3. LCHS People Strategy 2023-28 4. Clinical Strategy 2023-28 5. People Strategy Group 6. LCHS Operational PLans 7. Divisional delivery plans 8. Action Plans (eg Workforce Race Equality Scheme/Workforce Disability Equality Scheme) 9. Equality Diversity and Inclusion Lead/ Freedom to speak up guardian (FTSUG) /Staff Networks/ Health and Wellbeing Lead and Champions 10. Mental Health First Aid Champions 11. Swartz Rounds 12. Staff Networks 13. EDS3 Action Plan 14. IR Project Group 15. Costs of Living Working Group	1. People Executive Group (PEG) 2. Finance, People, Performance and Investment Committee (FPPIC) 3. Lincolnshire People Board 4. Audit Committee 5. Equality, Diversity and Inclusion Group 6. Trust Well-Being Guardian 7. Lincolnshire People Plan 23/24 8. Trust Leadership Team (TLT) 9. Transformation Delivery Group (TDG) 10. Stakeholder Engagement and Involvement Group (SEIG) 11. Performance Management Reviews (PMRs) 12. Transformation Delivery Group (TDG) 13. Trust Leadership Team (TLT) 14. Quality and Risk Committee (Q&RC) 15. Lincolnshire People Hub 16. Lincolnshire Integrated Care Board	1. Audit 2. NHS National Staff Survey 3. Regional People Board 4. Equality Delivery System (EDS) 3 5. CQC 6. System Improvement Director 7. NHS People Plan 8. National/Regional Benchmarking	1. 10 Year NHSE Workforce Plan	1. The LCHS People Stragey and People Plan have been developed following NHSE 23/24 Planning Guidance and Priorities	1. Delivery of the LCHS People Strategy 23/24 Action Plan 2. Standard People Metrics (SicknessTurnover/MT/Vacancy/agency spend etc) better than LCHS targets and benchmarking 3. NHS National Staff Survey results above average in all People Promise areas 4. Delivery of the Lincs People Plan 23/24 and improved system people metrics (sickness, staff survey, turnover, agency spend etc) 5. Efficient use of Apprentice Levy funds 6. Improved NHS Freedom to Speak Up Guardian (FTSUG) Index score 7. National Quarterly Pulse Survey (Quarter 1, Quarter 2 and Quarter 4) above benchmarking 8. Improved Workforce Race Equality Scheme (WRES) and Workforce Disability Equality Scheme (WDES) Data 9. Corporate Benchmarking in the lowest quartile for People Functions 10. Delivery of the Equality Delivery System (EDS) 3 Action Plan 23/24 11. Recruitment of 50 International Recruits (40 Nurse and 10 AHP)	1. Assurance not due to be received until July/ end of Q1. Assurance for some areas received through Q1 however not able to rate in entirity.	1. Assurance for Q1 received July.											
3. Build a productive, capable and inclusive workforce	3c. Enable a change ready workforce	People and Innovation	1. Change Ready Workforce (Digital) 2. Change Ready Workforce (Estates and Transformation)	1.1. Digital Ready Workforce 1.2. Digital Leadership 2.1. Empower our People 2.2. Leadership Capability	We will 'Seek' new and innovative ways of working through the use of automation and technology which in turn will improve productivity and release time to care.	430 Cyber Security 454 NHSPS Water Supply 460 Cost of estate 461 NHSPS Maintenance of LCHS estate 483 JCH Theatre Ventillation 473 NHSPS property ventillation 551 JCH Water Purity 552 Skegness Hospital Water Purity 553 Migration from network drives to SharePoint	1. Lack of resources 2. Lack of skills and capability 3. Leadership capacity 4. External partnerships and ways of working 5. Patients and public behaviours 6. Mindset of leaders 7. Staff health and wellbeing 8. Patient and public engagement	1. Digital Health Strategy 2. Estates and Transformation Strategy 3. Clinical Strategy 4. Lincolnshire Long Term Plan 5. LCHS Operational Plan 6. Integrated Care System (ICS) Strategy 7. Integrated Care Board 5-year joint forward plan 8. Strategic Delivery Plan as part of the Recovery Support Programme 9. LCHS Green Plan 10. NHS Lincolnshire Green Plan	1. Digital Strategy Group (DSG) 2. Digital Executive Group (DEG) 3. Health and Safety Commitee 4. Finance, Performance, People and Investment Committee (FPPIC) 5. Audit Commitee 6. System Digital, Data and Technology Board (DDaT) 7. Transformation Delivery Group (TDG) 8. Trust Leadership Team (TLT) 9. Performance Management Reviews (PMRs) 10. Quality and Risk Committee (Q&RC) 11. Capital Investment Group 12. Lincolnshire Greener NHS Group	1. Estates Returns Information Collection (ERIC) Return 2. Patient-Led Assessments of Care Environment (PLACE) Report 3. Annual Network and Security Penetration Test (DSPT) 4. Data Security and Protection Toolkit 5. Internal Audit 7. CQC rating 8. Benchmarking data 9. Healthcare Information and Management Systems Society Assestment (HIMSS)	1. Patient Digital Literacy Information 2. Workforce Digital Literacy Information	1. Creation of a patient co-design group 2. Trustwide Digital skills traning needs anaylsis	1. Delivery of the Digital Health Strategy 23/24 Action Plan 2. Delivery of the Estates and Transformation Strategy 23/24 Action Plan 3. Delivery of the LCHS Green Plan action plan 23/24 4. Improved use of digital technologies 5. Delivery of LCHS Capital Plan 23/24 6. Greater uptake of digital services from the public	1. Assurance not due to be received until July/ end of Q1. Assurance for some areas received through Q1 however not able to rate in entirity.	1. Assurance for Q1 received July.											

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB
3. Build a productive, capable and inclusive workforce	3d. Deliver Safe and Sustainable Foundations	People and Innovation	1. Safe and Sustainable Foundations (Digital) 2. Safe and Susainable Foundations (Estates and Trasnformation)	1.1. Safe Practice 1.2. Technolofgy Optimisation 2.1. Safe and Compliant Spaces 2.2. Transparency in our Estates Utilisation	LCHS maintains a 'cautious' approach to cyber security, health and safety and recruitment compliance. This is because we value our people as our greatest asset and we strive to keep our people, our patients and their respective information as safe as possible.	430 Cyber Security 454 NHSPS Water Supply 460 Cost of estate 461 NHSPS Maintenance of LCHS estate 483 JCH Theatre Ventillation 473 NHSPS property ventillation 551 JCH Water Purity 552 Skegness Hospital Water Purity 553 Migration from network drives to SharePoint	1. Lack of resources 2. Lack of skills and capability 3. Leadership capacity 4. External partnerships and ways of working 5. Patients and public behaviours 6. Mindset of leaders 7. Staff health and wellbeing 8. Patient and public engagement	1. Digital Health Strategy 2. Estates and Transformation Strategy 3. Clinical Strategy 4. Lincolnshire Long Term Plan 5. LCHS Operational Plan 6. Integrated Care System (ICS) Strategy 7. Integrated Care Board 5-year joint forward plan 8. Strategic Delivery Plan as part of the Recovery Support Programme 9. LCHS Green Plan 10. NHS Lincolnshire Green Plan	1. Digital Strategy Group (DSG) 2. Estates Delivery Group 3. Digital Executive Group (DEG) 4. Health and Safety Commitee 5. Finance, Performance, People and Investment Commitee (FPPIC) 6. Audit Commitee 7. Estates Shared Service Programme Group (ESSPG) 8. System Digital, Data and Technology Board (DDaT) 9. Lincolnshire Strategic Infrastructure and Investment Group 10. Transformation Delivery Group (TDG) 11. Trust Leadership Team (TLT) 12. Performance Management Reviews (PMRs) 13. Quality and Risk Committee (Q&RC) 14. Capital Investment Group	1. Estates Returns Information Collection (ERIC) Return 2. Patient-Led Assessments of Care Environment (PLACE) Report 3. Annual Network and Security Penetration Test (DSPT) 4. Data Security and Protection Toolkit 5. Internal Audit 6. Health and Safety Executive Standards 7. CQC rating 8. Benchmarking data 9. Healthcare Information and Management Systems Society Assessment (HIMSS)	1. Fully developed Estates dashboard 2. Fully developed 3rd party compliance dashboard	1. Programme of work around information into the dashboard and further training for staff 2. Programme of work to share compliance data across organisations into a dashboard	1. Delivery of the Digital Health Strategy 23/24 Action Plan 2. Delivery of the Estates and Transformation Strategy 23/24 Action Plan 3. Delivery of the LCHS Green Plan action plan 23/24 4. Improved use of digital technologies 5. Improved Cyber security reporting and oversight 6. Increased compliance and safety 7. Robust signed off Service Level Agreements (SLAs) for the Estates Shared Service 8. Delivery of LCHS Capital Plan 23/24 9. Greater utilisation of Estate	1. Assurance not due to be received until July/ end of Q1. Assurance for some areas received through Q1 however not able to rate in entirity.	1. Assurance for Q1 received July.												
4. Ensure healthcare is financially sustainable, making best use of resources	4a. Deliver financially sustainable healthcare, making best use of resources	Finance and Business Intelligence	1.Develop foundational insight 2.Produce a multi-year financial plan including the key service transformation priorities	1.1 Develop the Population Health Management (PHM) and Health Inequalities (HI) approach 1.2 Develop regular integrated portfolio analysis 1.3 Develop and embed a multi-level performance management framework and conditions for a performance and improvement culture 2.1 Develop frameworks to identify, scope and prioritise tactical, operational and transformational efficiency opportunities	Open – Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated to capitalise on opportunities. LCHS has a proven track record of managing its finances well over several years to ensure our healthcare services are financially sustainable. This has created some headroom for investment and a reputation that we are to be trusted in financial decision making. We must always seek to make the best possible use of resources (both our own and others we have access to). The risks of financial loss should be kept	528 Breakeven Duty - Cost Control 529 Efficiency Requirement 530 System Risk and Gain Share -Financial Risk 532 Non attainment of capital plan	1.Mindset and behaviour of leaders 2.Lack of capacity 3.Lack of skills and capability 4.Leadership capacity and capability 5.A poor internal reputation 6.National guidance changes 7.System finance/data requests	1.Integrated Care System (ICS) Strategy 2.Integrated Care Board 5-year joint forward plan 3.Finance and Business Intelligence (FBI) Strategy 2023-28 4.FBI Strategy update on current year plan 5.Finance reporting to Finance Performance, People and Innovation Committee (FPPIC) 6.Trust Leadership Team (TLT) reports 7.LCHS Operational Plan reports 8.Clinical Strategy 2023-28 9.Chief Clinical Digital Information Officer (CCDIO) 10.Lincolnshire Long Term Plan 11.Strategic Delivery Plan as part of the Recovery Support Programme 12.NHSE Planning Guidance	1.LCHS Finance Performance, People and Investment Committee (FPPIC) 2.Quality and Risk Committee (Q&RC) 3.LCHS Trust Leadership Team (TLT) 4.Transformation Delivery Group (TDG) 5.Data Quality Group 6.Capital Investment Group 7.LCHS private board 8.Performance Management Reviews (PMR) 9.Lincolnshire Integrated Care Board 10.Lincolnshire Health and Care Collaborative Delivery Board 11.Strategic Delivery Plan (SDP) Programme Board 12.System Financial Assurance Group 13.System Financial Leaders Group (FLG) 14.System Digital, Data and Technology (DDAT)	1.Internal audit – Standard Financial Controls Annual Audit 2.External audit – Annual Independent Audit and Opinion on Financial Statements 3.Benchmarking data 4.National Oversight Framework rating 5.Clinical audit reports 6.National best practice data and reports 7.CQC rating 8.National Oversight Framework (NOF) rating quarterly letter	1. Skills and capability to use tools and frameworks	1 Programme of knowledge and skills development for FBI and stakeholder partners	1.Delivery of the financial plan measured through reporting and variances to planned performance 2.Deliver the required operating budget alongside leaders feeling engaged, informed and empowered to drive their service efficiency agenda 3.Delivery of the FBI Strategy plan 2023-24 4.National Oversight Framework (NOF) rating (annual and quarterly)	1. Assurance not due to be received until July/ end of Q1. Assurance for some areas received through Q1 however not able to rate in entirity.	1. Assurance for Q1 received July.												
4. Ensure healthcare is financially sustainable, making best use of resources	4b. Drive better decisions and impactful action through insight	Finance and Business Intelligence	1.Drive change, insight and direction 2.Deliver a multi-year financial plan including the key service transformation priorities	1.1 Use integrated portfolio analysis to inform strategic and tactical decision making and prioritise opportunities 1.2. Drive change, insight and direction through a business partnering approach and culture 1.3 Use performance management framework to identify key areas to maximise performance, and swiftly address areas of underperformance to ensure tangible better outcomes for patients 2.1 Support to deliver the operational efficiency initiatives and the strategic transformation/new operating models	Seek - We will invest for the best possible return and accept the possibility of increased financial risk (with controls in place). We seek to invest not only in developing better insight but also in improving our ability to utilise that in our decision making leading to action with positive impact.	529 Efficiency requirement 530 System Risk and Gain Share -Financial Risk	1.Mindset and behaviour of leaders 2.Lack of capacity 3.Lack of skills and capability 4.Leadership capacity and capability 5.A poor internal reputation	1.Integrated Care System (ICS) Strategy 2.Integrated Care Board 5-year joint forward plan 3.Finance and Business Intelligence (FBI) Strategy 2023-28 4.FBI Strategy update on current year plan 5.Finance reporting to Finance Performance, People and Innovation Committee (FPPIC) 6.Trust Leadership Team (TLT) reports 7.LCHS Operational Plan reports 8.Clinical Strategy 2023-28 9.Chief Clinical Digital Information Officer (CCDIO) 10.Lincolnshire Long Term Plan 11.Strategic Delivery Plan as part of the Recovery Support Programme 12.NHSE Planning Guidance	1.LCHS Finance Performance, People and Investment Committee (FPPIC) 2.Quality and Risk Committee (Q&RC) 3.LCHS Trust Leadership Team (TLT) 4.LCHS Strategy and Planning Group (SDP) 5.Transformation Delivery Group (TDG) 6.Performance Management Reviews (PMR) 7.Lincolnshire Integrated Care Board 8.Lincolnshire Health and Care Collaborative Delivery Board 9.Strategic Delivery Plan (SDP) Programme Board 10.System Financial Leaders Group (FLG) 11.System Digital and Data Team (DDAT)	1.Internal audit 2.External audit 3.Benchmarking data 4.Partnership satisfaction ratings 5.Clinical audit reports 6.National best practice data and reports 7.CQC rating 8.National Oversight Framework (NOF) rating quarterly letter	1. Strategic business partnering approach well-established	1. Embedding FBI structure and new ways of working	1. Partner satisfaction ratings with FBI (internal) 2. Delivery of the Finance and Business Intelligence (FBI) Strategy plan 2023-24 3. National Oversight Framework (NOF) rating (annual and quarterly)	1. Assurance not due to be received until July/ end of Q1. Assurance for some areas received through Q1 however not able to rate in entirity.	1. Assurance for Q1 received July.												
5. Collaborate to play an active role in the Lincolnshire ICS	5a. Collaborate to make a difference	Chief Executive	1.Support and provide leadership to the ICS operating framework and governance structures 2. Play an active role in collaborations that make a difference	1.1Play an active role in the governance structures of the ICS 2.1 Play an active role as a key partner in the Lincolnshire Health and Care Collaborative 2.2 Work in partnership to identify and deliver initiatives that can only succeed in collaboration	LCHS will 'Seek' opportunities to be innovative and collaborative, both within the organisation and the wider system environment. We are prepared to influence decisions that may provide greater scrutiny but could result in enabling sustainable change for those we support in the County.	444, 481, 504, 526, 530	1.Mindset and behaviour of leaders 2.Lack of capacity 3.Lack of skills and capability 4.Leadership capacity and capability 5.Commissioning practices 6.A poor external reputation	1. Integrated Care System (ICS) Strategy 2. Integrated Care Board 5-year joint forward plan 3. Lincolnshire Provider Collaborative Alliance Agreement 4. Lincolnshire Long Term Plan 5. Strategic Delivery Plan 6. Clinical Strategy 2023-28 7. LCHS Operational Plan 8. LCHS leadership through representation on system boards, committees and groups 9. NHS England Planning Guidance 10. Lincolnshire Health and Care Collaborative (LHCC) Strategy	1.LCHS Finance Performance, People and Investment Committee (FPPIC) 2.LCHS Private Board 3.LCHS Board Strategy Sessions 4.LCHS Trust Leadership Team (TLT) 5.LCHS Strategy and Planning Group (SDP) 6.Performance Management Reviews (PMR) 7.Lincolnshire Integrated Care Board 8.Lincolnshire Integrated Care Partnership 9.Lincolnshire Leaders Board 10.Better Lives Lincolnshire Leadership Team 11.Lincolnshire Health and Care Collaborative Delivery Board 12.Provider Collaborative Strategy Group (PCSG) 13.SDP Programme Board 14.System joint committees 15.System Financial Leaders Group (FLG)	1.NHSE/DHSC guidance on ICS development 2.NHSE Provider Collaborative Maturity Matrix 4.CQC assessment of system effectiveness/ICS rating 5.Quarterly System Review Meeting (QSRM) 6.National Oversight Framework (NOF) rating (annual and quarterly) 7.National Recovery Support Programme framework 8.Internal audit 9.External audit 10.Survey of partner views (e.g. survey, Deloitte review etc)	1. System Improvement Director exited support to system at end of October 23.	1. New SID commenced in post.	1.Partner satisfaction ratings with LCHS (external) 2.Delivery of the FBI Strategy plan 2023-24 3.National Oversight Framework (NOF) rating for partnership/system working (currently in development) 4.LCHS representation on system boards, committees and groups 5.Completion of a whole system segmentation model for PHM 6. ~~Sign up to Alliance Agreement~~ 7.Compliance with system mechanisms e.g. Risk/Gain Share 8.LCHS delivery of its elements of system projects	1. Assurance not due to be received until July/ end of Q1. Assurance for some areas received through Q1 however not able to rate in entirity.	1. Assurance for Q1 received July.												
5. Collaborate to play an active role in the Lincolnshire ICS	5b. Transform services to deliver great care close to home	Chief Executive	1. Care Closer to Home (Digial) 2. Care Closer to Home (Estates and Transformation)	1.1. Empowering Our Population 1.2. Technology Enabled Transformation 2.1. Supporting New Models of Care 2.2. Driving Integrated Working 2.3. Defining our Future	LCHS will 'Seek' opportunities to be innovative and collaborative, both within the organisation and the wider system environment. We are prepared to influence decisions that may provide greater scrutiny but could result in enabling sustainable change for those we support in the County.	430 Cyber Security 454 NHSPS Water Supply 460 Cost of estate 461 NHSPS Maintenance of LCHS estate 483 JCH Theatre Ventillation 473 NHSPS property ventillation 551 JCH Water Purity 552 Skegness Hospital Water Purity 553 Migration from network drives to SharePoint	1. Lack of resources 2. Lack of skills and capability 3. Leadership capacity 4. External partnerships and ways of working 5. Patients and public behaviours 6. Mindset of leaders 7. Staff health and wellbeing 8. Patient and public engagement	1. Digital Health Strategy 2. Estates and Transformation Strategy 3. Clinical Strategy 4. Lincolnshire Long Term Plan 5. LCHS Operational Plan 6. Integrated Care System (ICS) Strategy 7. Integrated Care Board 5-year joint forward plan 8. Strategic Delivery Plan as part of the Recovery Support Programme 9. LCHS Green Plan 10. NHS Lincolnshire Green Plan	1. Digital Strategy Group (DSG) 2. Estates Delivery Group 3. Digital Executive Group (DEG) 4. Health and Safety Commitee 5. Finance, Performance, People and Investment Commitee 6. Audit Commitee (FPPIC) 7. Estates Shared Service Programme Group (ESSPG) 8. System Digital, Data and Technology Board (DDaT) 9. Lincolnshire Strategic Infrastructure and Investment Group 10. Transformation Delivery Group (TDG) 11. Trust Leadership Team (TLT) 12. Performance Management Reviews (PMRs) 13. Quality and Risk Committee (Q&RC)	1. Estates Returns Information Collection (ERIC) Return 2. Patient-Led Assessments of Care Environment (PLACE) Report 3. Annual Network and Security Penetration Test (DSPT) 4. Data Security and Protection Toolkit 5. Internal Audit 6. Health and Safety Executive Standards 7. CQC rating 8. Benchmarking data 9. Healthcare Information and Management Systems Society Assessment (HIMSS)	1. Patient Digital Literacy Information 2. Workforce Digital Literacy Information 3. Fully developed Estates dashboard	1. Creation of a patient co-design group 2. Trustwide Digital skills traning needs anaylsis 3. Programme of work around information into the dashboard and further training for staff	1. Digital Health Strategy 23/24 Action Plan 2. Estates and Transformation Strategy 23/24 Action Plan 3. Delivery of the LCHS Green Plan action plan 23/24 4. Improved use of digital technologies 5. Improved Cyber security reporting and oversight 6. Increased compliance and safety 7. Robust signed off Service Level Agreements (SLAs) for the Estates Shared Service 8. Delivery of LCHS Capital Plan 23/24 9. Greater uptake of digital services from the public	1. Assurance not due to be received until July/ end of Q1. Assurance for some areas received through Q1 however not able to rate in entirity.	1. Assurance for Q1 received July.												

United Lincolnshire Hospitals NHS Trust

Meeting	*Lincolnshire Community and Hospital Group Board*
Date of Meeting	*7 May 2024*
Item Number	*Item*

Audit Committee Upward Report

Accountable Director	*Neil Herbert, Audit Committee Chair*
Presented by	*Neil Herbert, Audit Committee Chair*
Author(s)	*Jayne Warner, Trust Secretary*
Report previously considered at	*N/A*

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

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

Recommendations/ Decision Required	• *Ask the Board to note the upward report*

Executive Summary

The Audit Committee met via MS Teams on the 26th April 2024. The Committee considered the following items:

External Audit
The Committee received assurance that the year end audit had commenced and there were no concerns around the completion of the audit in line with the timetable.

The Audit Committee would meet informally in May to walk through the draft accounts with sign off at Audit Committee ahead of Board in mid June.

Accounting policies and Going Concern
The Committee received the accounting policies which would be incorporated within the financial statements, annual report and governance statement. These were based largely on the national template. The two key areas which had been tailored or adapted for the Trust were highlighted.

The Committee were advised that the accounts would be prepared on a going concern basis and the rationale for this was described

The Committee approved the accounting policies and the basis for preparing the accounts.

Internal Audit
The Committee received the report from the Internal Audit provider noting that there had been significant progress against the audit plan for 2023/24. The Committee received the draft Head of Internal Audit Opinion which reflected reasonable assurance of the risk management, control and governance processes in place.

The Committee noted that the Trust had received 7 internal audit reports since the last meeting two reviews offered substantial assurance, 4 reasonable assurance and one review (Mortality) offered limited assurance.

The Director of Finance advised that the management actions put in place to oversee the delivery of the 23/24 audit plan continued and these had been successful.

The Committee agreed the draft Audit Plan for 2024/25 noting that this could be flexed in year to allow for reviews which could be completed across the Group.

The Committee received an update of outstanding audit actions. It was noted by the Committee that there continued to be significant progress in the closing of actions.

Counter Fraud
The Committee received the quarterly progress report. It was noted that the Trust was rated GREEN for all elements of the requirements of the Counter Fraud Functional. The Trust overall rating was GREEN. Component 3 relates to Fraud Risk Assessment. Fraud risks are now included within the Trust Risk Register and during 2023/24 the management

of fraud risks had been demonstrated to be embedded allowing the final standard to move from amber to green.

The Committee received the updated Local Counter Fraud Bribery and Corruption Policy and Response Plan which was approved for publication.

Compliance Report

The Committee noted the compliance issues in relation to information governance and noted that many of the improvement actions required engagement and interventions form the divisional teams. It was noted that the Trust continued to address the actions but that the pace of completion meant that the ICO could consider regulatory action.

The Committee noted the continued significant sums in the overpayments reports and continued to review assurances in this area from the People and OD Committee.

Assurance Committee Chairs Reports

The Committee received areas for triangulation relating to controls and assurance from each of the Assurance Committee Chairs. The Committee was also in receipt of final version annual reports from each of the Assurance Committees to support the production of the Annual Report and Annual Governance Statement.

Policies and Guidelines

The Committee were advised that trajectories were in place for all policies and clinical guidelines which were out of date for review. This had been supported by the rigour given to addressing the issue within the Trust Executive Leadership Team. The review process would continue over the remainder of the year in some areas. Missed trajectories would be flagged through the Committee.

Risk Management and Board Assurance Framework

The Committee noted that work had commenced to draw together the risk management processes across the group. The meetings of a joint risk register confirm and challenge group had commenced. The Committee challenged the ability of the Trust to respond dynamically to changing risks and noted the significant progress made in relation to risk visibility.

The Committee considered the Board Assurance Framework and confirmed it remained fit for purpose noting that a draft Group BAF would be considered by the Trust Board.

Objective 2c Well Led remained Amber rated for assurance.