Bundle Trust Board Meeting in Public Session 4 July 2023

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

1 Introduction, Welcome and Chair's Opening Remarks
Chair

2 Public Questions
Chair

3 Apologies for Absence
Chair

4 Declarations of Interest
Chair

5.1 Minutes of the meeting held on 6 June 2023
Chair

Item 5.1 Public Board Minutes June 2023V1.docx

5.2 Matters arising from the previous meeting/action log
Chair

Item 5.2 Public Action log June 2023.docx

6 Chief Executive Horizon Scan Including ICS
Chief Executive

Item 6 CEO Update, 040723.docx

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

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

8.1 Assurance and Risk Report from the Quality Governance Committee (inc MNOG appendices)

Item 8.1 QGC Upward report June 2023v1.doc
Item 8.1 Appendix 1a Maternity and Neonatal Oversight Group Terms of Reference Updated March 2023 FINAL.docx
Item 8.1 Appendix 2 20230328 ULH Pathway review letter FINAL.pdf
Item 8.1 Appendix 3 Appendix 4 MaternityActions_Results_2023_V4.pdf
Item 8.1 Appendix 5 Maternity BAME Report May 2023.docx
Item 8.1 Appendix 6 Maternity Neonatal Safety Assurance Report for May 2023 MNOG.docx
Item 8.1 Appendix 8 Bi-annual staffing report May 2023.docx
Item 8.1 Appendix 10 NED report MarchApril 2023.docx
Item 8.1 Appendix B Draft - Mixed Sex Accommodation declaration on ULH website June 23.docx

8.2 Safeguarding Annual Report
C Ferris to attend

Item 8.2 FRONT SHEET SAFEGUARDING ANNUAL REPORT JUNE 2023
Item 8.2 Safeguarding annual report 2022 - 2023 QGC Version 14th June

8.3 Complaints Annual Report

Item 8.3 Front Sheet - Annual Complaints Report 2022-23.docx
Item 8.3 ULHT Annual Complaints Report 2022-2023 v3.docx

8.4 Patient Experience Annual Report

Item 8.4 QGC PX Annual Report 2022-2023 cover June 2023.docx
Item 8.4 PXAnnual Report 2022 - 2023 AD.pdf

8.5 CQC Actions Quarterly Report
Item 8.5 Trust Board Report CQC Action Plan - Update June 2023.docx
Item 8.5 Appendix 1 - CQC action plan - June 2023.pdf

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

9.1 Assurance and Risk Report from the People and Organisational Development Committee
Item 9.1 POD - Upward Report - June 2023.docx
Item 9.1 Appendix 1a Board Report Cover Sheet EDI Annual Report 2023 (1).docx
Item 9.1 Appendix 1b EDI Annual Report 2023 Final for Trust Board.docx

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

10.1 Assurance and Risk Report from the Finance, Performance and Estates Committee
Item 10.1 FPEC Upward Report June 2023v1.docx

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

12 Integrated Performance Report
Item 12 IPR Trust Board - Front page.docx
Item 12 IPR Trust Board June 2023.pdf

13 Risk and Assurance

13.1 Risk Management Report
Item 13.1 TB - Strategic Risk Report - July 2023.docx
Item 13.1 Appendix A - Active risks rated 15-25 - June 2023.pdf

13.2 Board Assurance Framework
Item 13.2 Item BAF 2022-23 Front Cover July 2023.docx
Item 13.2 BAF 2023-2024 28.06.23.xlsx

13.3 Audit Committee Upward Report
Item 13.3 Audit Committee Upward Report June 23.docx

14 Any Other Notified Items of Urgent Business

15 The next meeting will be held on Tuesday 5 September 2023

EXCLUSION OF THE PUBLIC

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

United Lincolnshire Hospitals NHS Trust

Minutes of the Trust Board Meeting

Held on 6 June 2023

Via MS Teams Live Stream

Present

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

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

In attendance:
Mrs Jayne Warner, Trust Secretary
Mrs Karen Willey, Deputy Trust Secretary (Minutes)
Ms Jennie Negus, Head of Patient Experience
Sarah Loughton, Sister, Acute Medicine
Ms Sarah Addlesee, Associate Director of Nursing
Emma Noton, Sister, Navenby Ward
Rachel Pickering, Matron, Navenby Ward
Kathryn Helley, Deputy Director of Clinical Governance
Helen Shelton, Associate Director of Clinical Governance
Simon Hallion, Divisional Managing Director, Family Health
Suganthi Joachim, Clinical Managing Director, Family Health

Apologies
Dr Colin Farquharson, Medical Director
Mr Neil Herbert, Non-Executive Director
Mrs Rebecca Brown, Non-Executive Director
Mrs Sarah Buik, Associate Non-Executive

691/23	**Item 1 Introduction**

	The Chair welcomed Board members and members of the public, staff or interested parties who had joined the live stream to the meeting.
692/23	**Item 2 Public Questions** **Q1 from Vi King** **Please can I ask as why there is no consistent message about operations and appointments that can be done at Grantham.** **There are people being told that they can't have their elective operations at Grantham but have to go to Louth.** **Also, people who have been having ophthalmology treatment at Grantham are being sent to Louth now.** **Please can communication with letters be updated for Pre-assessment appointments at Grantham. The letters are stating that it is in outpatient's department, only then to be told on arrival it is in the Tower Block, making people late for their appointments.** **There are still issues with follow up appointments for fractures clinics. People asking for them to be had at Grantham, but being told no and having to travel all the way to Pilgrim hospital.** **Please can we have a definitive conclusion on this. As this would help Michelle Harris and her team to concentrate on other matters instead of going over the same concerns.**
693/23	The Chief Operating Officer responded: A meeting had been held with the Divisional Managing Director for Surgery, which orthopaedics and ophthalmology sat within. There was a significant amount of work undertaken during May with the clinical lead for orthopaedics trying to move forward with consistent messaging for outpatient appointments and operations. The work would be led and concluded by the clinical lead before work commences with the booking team. If a patient was a resident of Grantham, they would be offered an appointment at Grantham. If this would not be accommodated, then other sites would be offered however consistency was being resolved. With regard to operations, these were predominantly elective at Grantham however there were also semi-electives where those with trauma followed by elective care as part of the pathway, could be carried out at Grantham. Any procedure that could be undertaken at Louth can also be done at Grantham. For the preassessment letters, these were being changed however it was likely that there would be some legacy letters which had been sent out. The team at Grantham were being worked with to ensure signposting to preassessment was clear.

	The Chief Operating Officer advised that the ophthalmology run service at Grantham was for day case with large components at Louth. It was noted that ophthalmology at Louth had received national recognition for the pathways, outcomes and patient satisfaction. This was where high-volume low complexity work was undertaken and the Chief Operating Officer offered to discuss this in greater detail with Ms King during their regular correspondence. It was noted that there had been some de-skilling of the outpatient component at Grantham with work underway with the surgical team to upskill staff and ensure more comprehensive access to outpatient ophthalmology. There were however regular day cases at Grantham. The Chief Operating Officer was grateful for the comment about allowing the teams to concern themselves with other matters however it was important and actively encouraged that Ms King continued to bring questions to the Board. There was a determination to ensure equal access to services for the population of Grantham.
694/23	**Item 2.1 Ward Accreditation** The Chair welcomed the Associate Director of Nursing and Sister Noton, and Matron Pickering from Navenby Ward to the Board.
695/23	The Director of Nursing noted delight at being able to celebrate the achievements of clinical areas through the ward accreditation programme which had commenced in April 2021 and demonstrated continuous assessment and improvement across the Trust.
696/23	The Associate Director of Nursing noted that Navenby Ward had achieved a bronze diamond award, the first in the Medicine Division, having met a number of core requirements and presented a portfolio of evidence to the accreditation panel.
697/23	Sister Noton outlined the learning from a harm incident which had supported the continuous learning of the ward and achievement of the award.
698/23	The Chair noted that the Board took quality and safety of patient care seriously and was why the ward accreditation programme was supported as there was a thorough process in place to achieve.
699/23	The Director of Improvement and Integration asked, when describing the plan, do, study, act (PDSA) cycle in lessons learnt what had the biggest impact for staff to take this forward.
700/23	Sister Noton stated that this was down to team work and driving the importance of retaining quality. The training aspect of the learning had been a big improvement however noted that there was greater benefit to in-person training.
701/23	

702/23	The Chief Executive noted that patients were being encouraged to be involved in their care, particularly around fluid balance and asked what the feedback had been when patients were asked to be an active participant in looking after themselves.
703/23	Sister Noton reflected that this was dependent on the patients and how able they were to support themselves, but this was managed on an individual basis, there had been positive feedback.
704/23	Matron Pickering noted the good work of the ward noting that the ward had a number of patients who were quite acute at times meaning that there had been hard work to achieve the position. Congratulations were offered to Sister Noton and the team. The Chair congratulated the team noting that the award would be presented in person at a future date.
705/23	**Item 3 Apologies for Absence** The Chair welcomed the Director of Finance and Digital, Mr Barry Jenkins to the Trust as a member of the Board.
706/23	Apologies were received from Dr Colin Farquharson, Medical Director, Mrs Rebecca Brown, Non-Executive Director, Mrs Sarah Buik, Associate Non-Executive Director and Mr Neil Herbert, Non-Executive Director
707/23	**Item 4 Declarations of Interest** There were no new declarations of interest.
708/23	**Item 5.1 Minutes of the meeting held on 2 May 2023 for accuracy** The minutes of the meeting held on 2 May 2023 were agreed as a true and accurate record.
709/23	**Item 5.2 Matters arising from the previous meeting/action log** The Chair noted action 340/23 would be considered by the Board in private session. No other actions were due.
710/23	**Item 6 Chief Executive Horizon Scan including ICS** The Chief Executive presented the report to the Board offering the system overview to the Board and noting the number of Bank Holidays in May which had added to some of the pressure which the system found itself under.
711/23	It was noted however that the system had coped well during this period. Whilst there were no Bank Holidays during June it was noted that plans and mitigating actions were being developed ahead of the Junior Doctor strike due to take place between 14-17 June. Plans from previous actions were being refreshed to ensure all actions which could be put in place were.

712/23	The Chief Executive noted the agenda for change dispute in relation to pay and the strike action that had been taken as a result. It was noted that the National Council had approved the pay offer however not all unions were supportive of the outcome.
713/23	There had been a revised pay offer for 2022/23 and 2023/24 which was now being implemented and should be received in salaries at the end of June. It was recognised however that some unions remained in dispute with further balloting for continued action.
714/23	At the previous Board meeting discussion had been held around planning with the system having been due to submit the final draft operational plan. This had been submitted on time and a positive meeting had been held with NHS England, for which the Chief Executive attended as the Provider Chief Executive representative.
715/23	The outcome was a financial plan for the system with a planned deficit of £15.4m for the year and as at month 1 the plan was on track in respect of savings with a positive variance of just over £0.5m, against £55m.
716/23	The Chief Executive advised that the Joint Forward Plan was being coordinated by the Integrated Care Board (ICB) and was well underway in terms of the content and engagement with stakeholders and partners. The plan needed to be agreed and signed off by the end of June and, as a Board, a decision would be required as to how this was managed through governance processes. This was to ensure that the plan was owned by the system and not solely by the ICB.
717/23	A number of individuals had been involved in workshops to reach the current stage and there was a need to now share this to ensure it was understood and consistent with other plans in the system.
718/23	The Chief Executive advised the Board that, from an NHS England perspective, the Lincolnshire system was in tier 3 for Urgent and Emergency Care (UEC) in relation to the universal improvement offer. Other ICBs were in tier 1 or 2 where greater challenges were being experienced, this did not however mean there were no issues for Lincolnshire but reflected the degree of the problems being faced by systems. Support from NHS England was welcomed.
719/23	The Chief Executive noted that there were a number of personnel changes taking place at NHS England with Oliver Newbould, Director of Strategic Transformation and Director of Intensive Support handing over to the Director of Strategic Transformation and Regional Director of Service Improvement, who would be taking on the responsibilities of the Director of Intensive Support.
720/23	The Trust wished Mr Newbould well for the future noting the support and challenge offered to the Lincolnshire system. It was hoped that the positive and constructive relationship which had been built would continue.
721/23	The Chief Executive advised of the visit by the Chief Strategy Officer for NHS England who had visited on 26 May, spending the day in the system and visiting Pilgrim, Grantham and a practice in Boston. The day had been spent understanding

	rural and coastal areas and what actions were being taken to tackle local issues and implementing national issues. The Board was updated on Trust related issues with month 1 finances in line with plan with a positive position reported for month 1 savings.
722/23	
723/23	It was recognised that the Chief Strategy Officer was keen to see the plans for the new A&E at Pilgrim with building work commencing and demolition of the H block due to commence in June. This was the start of a 2-and-a-half-year programme which would result in a £45m development coming to fruition.
724/23	The NHS would be 75 in early July with the NHS arranging a series of conversations with staff about the past, here and now and the future of the NHS. A conversation had been held at the Trust with a response submitted to the NHS assembly. The conversations would be collated and fed back to the NHS as a collective and consensus view of the NHS workforce and what the future needed to be.
725/23	
726/23	Professor Van-Tam had recently visited Pilgrim to celebrate the 2nd anniversary of the complex Covid-19 vaccination service at the hospital with a number of patients and staff in attendance. More than 800 higher risk patients had received vaccinations through the service with positive feedback offered during the visit by those who would not have otherwise been able to leave their homes.
727/23	The Chief Executive advised of the Staff Network session undertaken via the Executive Leadership Team (ELT) Live where there had been sharing of the great work from the 5 existing networks and the launch of the additional network for carers. The Chief Executive also formally advised the Board of his intention to exit the Trust at the end of March 2024.
728/23	
729/23	The Chair noted the leaving date and reflected on the work undertaken by the Chief Executive in the NHS over his years of service and offered thanks for the early notice to make arrangements for a successor. The amount of work at system level was noted along with the ability for the organisation to contribute to this and enable the Trust to be a good system partner.
730/23	The Trust Board: • **Received the report and significant assurance provided**
731/23	**Item 6.1 CQC Feedback Letter following inspection 31 May 2023** The Medical Director advised the Board of an unannounced visit from the Care Quality Commission (CQC) on 31 May 2023 which had been undertaken following 2 serious incident reports on Rainforest Ward in September 2022.
732/23	The CQC offered feedback in the afternoon on the day of the visit and were assured that the actions from the serious incident had been completed and, although not the

	focus, they had observed that the staff were caring, good with the children and were a welcoming team.
733/23	The Medical Director noted that one Doctor spoken to had indicated difficulty in finding guidance on how to calculate a medication and anecdotal feedback that, although pharmacy had been part of the serious incident report, this had not been emphasised in the final investigation reports.
734/23	The staff spoken to had also raised concerns around relationships between medical and nursing staff along with there at times being a lack of communication. An incident had been raised which would be discussed at a rapid review meeting on the 7 June and action would be taken accordingly.
735/23	The Medical Director advised that, unrelated to the reason for the visit, feedback had been received from a patient regarding concerns around facilities and equipment, this would also be looked in to.
736/23	The CQC had commented that the visit was very positive, and they had been made to feel welcome and also spoke with an individual who was involved in one of the serious incidents. The staff member had welcomed the opportunity to discuss the learning with the CQC who had again emphasised how caring the staff were.
737/23	As a result of the visit, the Medical Director had been advised that there would be no change to the good rating for paediatrics. Work had commenced on developing an action plan based on the letter and feedback received however the formal outcome letter was awaited.
738/23	Once received the findings would be triangulated and reported back to the Board in due course via the normal governance mechanisms in place.
739/23	The Chair noted the overall positive visit and was pleased that the serious incidents had been followed through and actions completed. As a learning organisation this offered assurance that processes were working, and it was pleasing to see that staff had been observed as caring.
740/23	It was also pleasing to not that staff who had raised other issues whilst the CQC were here meant that further improvements could be made. This was welcomed and would be followed through in the way described. The Trust Board: • **Noted the CQC feedback letter**
741/23	**Item 7 Patient Story** The Director of Nursing introduced the patient story advising that the story was from the Medical Emergency Admissions Unit (MEAU) and about Caitlin and her support dog Clara.
742/23	

743/23	The story demonstrated what could be achieved when the Trust was flexible and inclusive and when reasonable adjustments were taken for patients to ensure the best care and experience of services offered.
744/23	The Director of Nursing welcomed the Head of Patient Experience and Sister, Acute Medicine to the Board.
745/23	The Board watched the video which detailed Caitlin's admission out of hours to the MEAU, at which time she was non-verbal. It became apparent that, whilst Clara, the autism support dog, had not attended with Caitlin she was a vital support in enabling Caitlin to feel supported and comfortable whilst in hospital.
746/23	The Chair was appreciative of the heart warming and uplifting story, noting that it was lovely to hear Caitlin's story and to see Clara and hear about how the service had been able to accommodate Caitlin's needs on the ward.
747/23	Dr Gibson noted the brilliant presentation and reflected that during this Caitlin was highly articulate and self-aware making it hard to imagine that she had been non-verbal when admitted. The impact on how she was the able to communicate and improve was clear.
748/23	Mrs Wells reflected on the reasonable adjustments that had been made and was pleased to see that signage across the Trust had been changed and asked how others would be made aware of the ability to make appropriate adjustments as described.
749/23	The Head of Patient Experience noted the work being led and driven by the sensory loss expert group and noted that there was a range of assistance dogs. Work was taking place such as providing dog walk areas which would offer something visual however it was noted that this should be linked to the carer policy.
750/23	Through person centred care and initiatives there was a need for an understanding of individual needs so that on admissions patients would be able to state what was important. Much of this work was done in partnership with the community health services and the pathways for patients being admitted. It had been suggested through the group that if it was known that a patient had an assistance dog that a flag be placed on the record.
751/23	The Director of Nursing noted the potential for the Trust to seek accreditation formally as an organisation that supported this work, and this would mean that it could be publicised as part of what the Trust offered to the wider population of Lincolnshire.
752/23	The Director of Nursing offered thanks to Caitlin and Clara for supporting the Trust with the story noting that it was only with the time offered to share the story that it was possible to understand what it was really like to be able to support the Trust in leading change and support.
	Through the story Caitlin had mentioned the lack of support in adult services for those with autism with this not appearing to be well developed. This was the right observation and some of the work that was recognised through feedback from other

753/23	patients. Work was being done around learning disabilities and autism with a specific lead in post in the organisation.
754/23	The Director of Nursing would be grateful for Caitlin's continued input to support development across the Trust as the feedback identifies if the Trust was getting this right and if not the support from a patient would be beneficial.
755/23	The Director of Nursing asked how the story could be shared widely across the organisation and how the Trust could be more proactive in this regard.
756/23	The Sister, Acute Medicine noted that this needed to be shared firstly with ward leads to disseminate to the teams. It was noted that Caitlin and been admitted over the evening and therefore there was not as much support in place at this time. There was a need for guidance to be offered to the wards so that when patients were admitted out of hours there was an awareness of what could be done. All areas needed to be informed of what could be done to support all patients.
757/23	The Chief Executive reflected that this was an uplifting story and offered thanks to Caitlin for the feedback and story which enables members of the Board to understand what goes on day to day in the Trust.
758/23	The Sister, Acute Medicine and team were commended by the Chief Executive for living the Trust values and reflecting that this had turned strategy in to something meaningful and personalised.
759/23	The Chief Operating Officer, as the executive sponsor for the new Carers Network reflected about the definition of a carer noting that this was not just about humans but any carer. It would be useful to share more widely, via the network and weekly blog the story which had been presented so more people could become aware of this. The Chair echoed the comments made by Board members and hoped that Caitlin would take up the offer to continue to work with the Trust and build on patient experience and learning. The Trust Board: • **Received the patient and staff story**
	Item 8 Objective 1 To Deliver high quality, safe and responsive patient services, shaped by best practice and our communities
760/23	**Item 8.1 Assurance and Risk Report Quality Governance Committee** Dr Gibson, on behalf of the Chair of the Quality Governance Committee, provided the assurances received by the Committee at the 23 May 2023 meeting.
761/23	A small change to the way the Trust reviewed clinical harm was noted by the Committee with regular reports offered by the Clinical Harm Oversight Group (CHOG) since Covid-19. A review of reporting was taking place with this expected to become a routine report of the Patient Safety Group. The Committee would continue to receive updates on the changes.

762/23	The Patient Safety Group was now receiving clinical harm data and the Committee was pleased to note the close down of the ophthalmology actions in response to a National Patient Safety Alert.
763/23	It was also noted that there were no outstanding actions from Never Events which was a considerable achievement to all involved in implementing the actions.
764/23	Dr Gibson noted that Covid-19 continued to be a particular issue, particularly in respect of the potential for Duty of Candour (DOC) in relation to nosocomial Covid-19. There had been national guidance received on this with the Trust conducting a thorough piece of work and it was now believed all actions required had been completed. The report was offered to the Board for consideration.
765/23	The Committee received an update from Safeguarding and Child Protection Information Sharing (CP-IS) which primarily related to issues which may become apparent to children in urgent and emergency care.
766/23	The responsibility for CP-IS had now moved to the Medicine Division however some concerns remained about the full completion of the requirements. Weekly audits were in place and actions being taken which would be monitored by the Committee.
767/23	Following the recent visit from NHS England Infection Prevention and Control team the Committee were receiving ongoing actions and it was noted that these would result in a positive outcome.
768/23	Dr Gibson advised the Board of the national approach to patient safety incidents being revised to the Patient Safety Incident Response Framework (PSIRF). The Committee received a report on the work to prepare for the biggest change in patient safety seen for a number of years.
769/23	The Trust was well underway with phase 4, having completed phase 3 and it was noted this would be a significant change for the Trust however work was on track to complete on time.
770/23	The Committee had received the ward accreditation report, which was offered to the Board for information, to demonstrate the significant achievements being made across the whole Trust. The engagement of the patient panel in the review of evidence was noted.
771/23	The Committee continued to note concerns, through the Medicines Quality Group, of staffing levels in pharmacy and the ability to provide a 7-day service however the Committee noted the recent international recruitment success with 10 new staff due to commence with the Trust.
772/23	The update from patient experience offered the Mixed Sex Accommodation (MSA) report with the Committee noting the establishment of a task and finish group in order to gain more control of systems and decision making. It was noted that, since July 2022, there had been no MSA breached which were outside of internal or national

	guidance for when these might occur. There remained work to be done however monthly reporting was in place.
773/23	The report from the Clinical Effectiveness Group indicated some concern in respect of the Trust being an outlie for early inflammatory arthritis with the Committee noting that an action plan would be presented to the group.
774/23	Dr Gibson advised the Board that the mortality group had not met for some months however the mortality statics were in a good position with one of the best Summary Hospital-Level Mortality Indicator (SHMI) reported for many years.
775/23	The Committee considered a number of routine items and received the Central Alert System and Field Safety Notices internal audit report, noting actions were in place to address the areas highlighted.
776/23	The Committee also received the Clinical Governance follow up internal audit report noting the positive outcome indicating that all actions had been taken.
777/23	Dr Gibson advised the Board that the Quality Account for 2022/23 had been received with a further draft to be shared with stakeholders for comment prior to being received by the Board for approval.
778/23	The Chair noted the comprehensive report which covered significant quality issues and was grateful to the Committee for providing due diligence to the items presented.
779/23	There were great improvements noted throughout the report with the Chair noting that the Board would consider PSIRF in due course.
780/23	The 2 appendices offered to the Board were noted. The Trust Board: • **Received the assurance report** • **Noted the ward accreditation report appended**
781/23	**Item 8.2 PSIRF Update** The Chair welcomed the Deputy Director of Clinical Governance and Assistant Director of Clinical Governance to the meeting.
782/23	The Director of Nursing advised that the report offered a general update on the position of implementing the national Patient Safety Incident Response Framework (PSIRF) with the work being primarily undertaken through the office of the Deputy Director of Clinical Governance.
783/23	This was to ensure the best position as an organisation to start to implement what was a significant change across the NHS and culturally how the Trust would manage and learn from incidents going forward.

784/23	This was a very different approach with focused work in the organisation to move from the traditional approach to the new nationally driven approach and methodology to understand learning from themes and incidents.
785/23	The Deputy Director of Clinical Governance noted that PSIRF was a fundamentally different was to approach incident management across the NHS. The framework had been published in August 2022 with a 12-month implementation process which indicated the level of change required.
786/23	The guidance document detailed a number of phases to work through with phases 1-3 having been completed and phase 4 in progress. Phase 3 related to governance and quality monitoring with appendix 2 of the report outlining the proposed reporting and meeting structures which would be implemented.
787/23	The meeting structure had been developed utilising the early adopter sites and feedback from the national implementation team with this being presented to the PSIRF implementation team, Trust Leadership Team (TLT) and Quality Governance Committee.
788/23	The Deputy Director of Clinical Governance stated that it was important to note that it was possible, even though the document had been shared, that changes would take place. Feedback from the early adopters indicated a PDSA approach to this which would have an impact. It was unlikely that this would be right first time, and this was the feedback being offered by the early adopters.
789/23	Phase 4 was underway and required the Trust to create a patient safety profile and identify areas that would want to be investigated and included within the patient safety plan.
790/23	It was noted that 2 workshops had been held, one with the PSIRF group and the other with TLT to draw up what was needed in the patient safety plan for the next year. The Board would need to sign off the plan and this would be presented at a future meeting.
791/23	The Deputy Director of Clinical Governance stated that, as agreed at TLT, the launch date for PSIRF would be 1 October 2023 at which point the Trust would move from the current serious incident framework to PSIRF.
792/23	As part of the process there was a need to consider the PSIRF requirements in relation to how this was delivered from within the central team with national guidance recommending that investigators were band 8a. Dedicated time and training would be required for the investigators.
793/23	The current structure in place did not allow for this and therefore a consultation was undertaken with the outcome being the creation of 2 band 8a investigator roles a band 7 trainee investigator and support into the divisions through a business partner model. The band 7 role within the team would allow development for the staff within the team.

794/23	The Deputy Director of Nursing advised that the Healthcare Safety Investigation Branch (HSIB) was a provider for investigation training and noted that a Board session would be offered in regard to this in July.
795/23	Both the Deputy and Assistant Directors of Clinical Governance were part of the regional and national patient safety networks with advice being taken on the work being carried out to ensure this was on track to deliver.
796/23	The Trust had reached out to the national lead for PSIRF to ask to spend some time together to update on the Trust position and proposed direction of travel. This had been agreed to and would offer a sense check on the work being done.
797/23	The Chair thanked the Deputy and Assistant Directors of Clinical Governance for the work being undertaken noting there may be more to do in the organisation about how fundamentally different this would be. A different mindset and approach would be required in the management of this, particularly how the Trust serviced the new requirements through the dedicated team, with the right skill set at high levels to conduct investigations to the highest standard.
798/23	For the Board there was a need to note how fundamentally different this would be and the arrangements in place to support this.
799/23	The Chief Executive noted the effort being undertaken to put PSIRF in place and, linked to risk management and the impact on the approach of the Trust asked if the audit report from the start of the year, where significant assurance was received, cold be impacted by the change.
800/23	Also, in respect of the people element and the changes in structures, reporting and role, the Chief Executive sought assurance that Trust process had been followed with appropriate consultation and engagement undertaken.
801/23	The Deputy Director of Clinical Governance noted that if was felt that the structure presented would strengthen the risk management approach going forward and therefore would not affect the audit outcome.
802/23	As the strategic lead for risk the structure of the team had been driven forward by the Deputy Director of Clinical Governance with the support of the Assistant Director of Clinical Governance. It was noted that the band 7 Risk and Datix manager within the structure was currently being appointed to and would have a narrowed focus. There had been other elements in this role however the change would allow for more focus on risk.
803/23	There had been an increase in the number of band 5 staff from 2 to 3 and were the posts which would work with the divisions in the structure. It was noted that the Assistant Director of Clinical Governance was currently undertaking the Institute of Risks Management, Risk Practitioner Course, which was run in conjunction with NHS Providers. This was the first course of its kind and plans were in place for all members of the risk team to undertake the course.

804/23	The Deputy Director of Clinical Governance noted, in respect of the consultation, that the work had been conducted by the Assistant Director of Clinical Governance with support from HR. The required processes had been followed to Trust policies with the engagement on union representatives prior to the commencement of the consultation. There had been work undertaken to ensure staff were supported.
805/32	There were opportunities within the structure with a new post at band 7 for a Human Factors Facilitator along with development for staff. It was hoped that appointments could be made and for this to be moved at pace.
806/23	The Director of People and Organisational Development noted there was assurance that a full and proper consultation process had been diligently followed and was aware of the thorough piece of work undertaken in this regard.
807/23	This work also linked to the plan to embed and role out just and restorative learning as this sat hand in hand with PSIRF. A dual piece of work was underway between the people and nursing directorate on the change of mindset and cultural work and the training to support staff.
808/23	The Chair was pleased to note the cross directorate working as cultural change would influence the success of implementing PSIRF.
809/23	The Deputy Director of Clinical Governance also noted that, in relation to the consultation and final structure proposed through the consultation had been influenced not only by the team but from comments received from the divisions. Ultimately this was a support service and there was a need to enable the divisions to deliver their work by offering the correct support.
810/23	Dr Gibson asked if the safety profile would interact with what was considered to be level 3 and if this would be received by the Quality Governance Committee once finalised.
811/23	The Deputy Director of Clinical Governance confirmed that level 2 and 3 would require the new style investigation. For level 2 there was a national mandate that any never event in the future would have a new style investigation. This had been allowed for in planned and the workshops that had taken place had considered data to determine areas of focus which would allow the Trust to improve for either the most patients or the most significant pieces of work.
812/23	These would then go forward through the new route and once the work was completed this would be offered to the Quality Governance Committee and on to the Board. This would outline the top 5 things that the Trust would consider in the coming year and would fall under level 3.
813/23	To note for level 4, this did not mean they would not be reviewed but that there would be different review methodologies.
814/23	The Chair thanked the Deputy Director of Clinical Governance for the update that offered the Board an understanding of the work being taken to put PSIRF in place, including the structure, policies and risk management.

815/23	It was pleasing to note that consultation and engagement with colleagues in terms of the new arrangements with good leadership in place.
816/23	The session with HSIB in July for the Board would be welcomed as would the full policy documents when these were available to come forward.
817/23	The Chair was pleased to see that a family liaison officer was included within the new arrangements as this was a role that had previously been discussed as it was essential to build relationships with families in some of the more difficult incidents. The Trust Board: • **Received the report noting the significant assurance** • **Noted the work undertaken to comply with the requirement of PSIRF, including the outcome of the structure within the risk and governance team which was endorsed**
818/23	**Item 8.3 Covid 19 Serious Incident Report** The Director of Nursing presented the report to the Board, noting this had been presented to the Quality Governance Committee, advising that this outlined the process and current position on the hospital onset Covid-19 investigation and duty of candour requirements of all organisations.
819/23	The Trust had submitted a hospital onset Covid-19 death report to the Integrated Care Board (ICB) in November 2022 following an internal governance process, with the proposal to offer written duty of candour to 59 affected patients.
820/23	The 59 patients had been identified by undertaking case note reviews of over 300 patients in order to determine if the criteria, of the guidance was met, to issue duty of candour.
821/23	The Director of Nursing advised that all relevant cases had been reviewed and it was possible to demonstrate there was clear documentation in 56 cases that duty of candour had been undertaken. The further 3 patients, since being reviewed and detailed in the report, demonstrated that the patient, or next of kin, were aware of the Covid-19 diagnosis.
822/23	The Director of Nursing noted that subsequent to this the Care Quality Commission (CQC) advised, as quoted from the report 'where providers are able to make clear at the time to the patient or their family/carer that an infection was probably or definitely acquired in the hospital – for example, through conversations with relevant clinicians while an inpatient – this should minimise or remove the need for additional follow-up communications'.
823/23	The Trust therefore believed that the requirements of the guidance had been met and in addition, a business-as-usual process was instigated, for relevant patients identified after the date pertaining to the serious incident investigation. This was to ensue that the Trust did not find itself in the position of needing to undertake further retrospective review of additional patients.

824/23	Doing this had ensured that the Trust was meeting statutory regulations in relation to Covid-19 and duty of candour.
825/23	The Board was asked to note the content of the report and note the approval of the Quality Governance Committee to stand down any further duty of candour notifications following the guidance and further clarifications of the CQC.
826/23	The Chair noted, for those who were not members of the Quality Governance Committee, that there had been a detailed conversation by the lead Committee for duty of candour which was familiar with the requirements.
827/23	The report received set out the approach take and the relevant guidance and offered clarification of what had been required of the Trust. It was the view of the Quality Governance Committee, recommending to the Board, that further notifications were stood down on this basis. The Trust Board: • **Received the report noting the significant assurance** • **Approved the closure of the duty of candour process in relation to hospital onset Covid-19**
	Item 9 Objective 2 To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT
828/23	**Item 9.1 Assurance and Risk Report People and Organisational Development Committee** The Chair of the People and Organisational Development Committee, Professor Baker, provided the assurances received by the Committee at the 9 May 2023 meeting.
829/23	Professor Baker noted the continued improvement in reporting to the Committee with reporting groups becoming more effective and highlighting key points and issues to the Committee to enable a strategic overview to be taken.
830/23	The Committee was encouraged that the groups were starting to report reliably and effectively to the Committee.
831/23	The Committee received the Workforce, Strategy and Organisational Development Group upward report with the group having reviewed the dashboard in detail. The Committee noted the lowest vacancy rate had been reported for 2 years with national recognition received for the good practice around thigs.
832/23	Professor Baker noted that improvements were not yet being seen in respect of appraisals and mandatory training but advised that this was a key directorate objective. The Committee discussed the move towards a fully established learning and education team being in place.

833/23	The Committee considered the workforce plan submission to NHS England which detailed the Trust's aim to maintain the resource level but with reduced reliance on bank and agency staff. There would be a focus on apprenticeship pathways and training Trust staff.
834/23	The safer staffing report demonstrated a stable care hours per patient day, despite a small reduction seen in fill rates.
835/23	The Committee was encouraged by the continued engagement with the Freedom to Speak Up Guardian and the new Guardian of Safe Working, Dr Sant had been welcomed to the Committee discussing positive progress around rota issues and doctors mess facilities.
836/23	The GMC Junior Doctor survey had been discussed with the Committee noting 2 alerts related to staffing, these had been addressed rapidly and the Committee had referred this to the Quality Governance Committee for information due to the potential impact on quality.
837/23	Professor Baker noted the update received in respect of Research and Innovation noting that there was encouragement with some clinical trials opening and the joint endeavour with the Trust, Integrated Care Board (ICB) and University of Lincoln around applications for training programmes.
838/23	Whilst the progress was encouraging the Committee emphasised that there was much more to be done if the Trust was to attain the levels of activity required to achieve teaching hospital status. The Committee reiterated the commitment to support the research and innovation directorate on the journey.
839/23	The Committee was pleased to hear of the improved relationship with the University of Lincoln through the upward report from the University Teaching Hospital Group. The Committee looked forward to this developing further to joint funding proposals.
840/23	Professor Baker noted that the Committee had considered 2 referrals from the Quality Governance Committee in respect of occupational health and wellbeing support and flu vaccinations and sickness levels.
841/23	The Committee discussed the support in place for staff noting the commitment to ensure this was sufficient for staff. The correlation between flu vaccine uptake and sickness levels was difficult to identify due to the pandemic and indirect effect this had had on the low efficacy of the flu vaccine. It was noted that this may be easier to consider in the coming year to determine if there was a relationship between those measures.
842/23	The Chair noted the performance regarding vacancies which was a huge achievement for the Trust which should continue to be built upon.
843/23	The comments associated with the relationship with the University of Lincoln were endorsed with progress being made. It was positive to see the cross-committee referrals which appeared to be working well.

	The Trust Board: • **Received the assurance report**
	Item 10 Objective 3 To ensure that service are sustainable, supported by technology and delivered from an improved estate
844/23	**Item 10.1 Assurance and Risk Report from the Finance, Performance and Estates Committee** Mrs Baylis, on behalf of the Chair of the Finance, Performance and Estates Governance Committee, provided the assurances received by the Committee at the 25 May 2023 meeting.
845/23	A number of reports had been received by the Committee from Estates and Facilities with the Committee noting that there remained some significant work to be done in terms of providing an upward assurance report from the Estates Group and Health and Safety Committee.
846/23	Additional support was required regarding governance, processes and procedures in order to support the Estates Group.
847/23	Mrs Baylis noted that the Health and Safety Committee was reported as having been challenging with a need for focus regarding how the feeding groups to the Committee worked to and provided support to ensure the Committee received relevant assurances.
848/23	Fire safety training was highlighted as a concern due to the downward trend and additional fire wardens were required. It was noted however that fire drills were taking place across the Trust sites.
849/23	The Committee noted the update provided in respect of Entonox usage with a need for further assurance on how the issue of ventilation would be taken forward.
850/23	Mrs Baylis noted the positive report from the Patient-Led Assessments of the Care Environment (PLACE) inspection report from 2022/23 against the previous inspection comparators from 2019.
851/23	All of the key lines of enquiry had shown a significant upward trend with the exception of condition, maintenance and appearance and Louth County being a clear outlier in the data received. The report was overall positive, and congratulations were offered to colleagues for the work undertaken to make the improvements.
852/23	The Committee received the Emergency Planning Group upward report which was clear and informative with the Committee noting the attention required on business continuity plans within the divisions and further work to be done to ensure these were robust.
853/23	As reported by the Chief Executive, the Committee considered the financial position noting that the Trust was on course in the month 1 report and offered a positive position. The Committee considered the Cost Improvement Programme (CIP)

	delivery which was £500k favourable to plan with a delivery of £1.7m against target for month 1.
854/23	This was a positive start to the year however the Committee was keen to know that all of the groundwork and foundations were in place for the schemes which were back ended or were being put in place to enable effective delivery of the CIP as this moved forward.
855/23	The Committee noted some risk to income as a result of activity and reflected the need to drive productivity. This reflected the conversations from the recent Board Development session.
856/23	Mrs Baylis noted pending admissions which demonstrated a potential reporting issue but also could be an issue impacting on quality and therefore the Committee made a referral to the Quality Governance Committee to understand what sat behind the data.
857/23	The Committee received the Capital, Revenue and Investment Group upward report and the national cost collection indices report and it was noted that there was more to do in productivity and agency reduction which was underlined by the report.
858/23	The 2023/24 Capital Plan was received as the final version with Mrs Baylis noting the conversations held in the previous Board Development sessions. This was presented to the Committee for onward referral to the Board for approval, this was agreed by the Committee.
859/23	Mrs Baylis noted that the Committee had received the strategic procurement report, which had been of concern to the Committee for some time in respect of the grip and control of contracts and when these were due for review and renewal. The Committee received a comprehensive report including expiry dates and a forward look which was more robust than previously reported. There was a need for a focused review to ensure the report met the needs of the Committee going forward.
860/23	Concern was noted by the Committee in respect of the Information Governance (IG) Group upward report which indicated that the Information Commissioners Office (ICO) was due to revisit in June. The Trust would not be able to provide full assurance that all outstanding actions had been completed to the level expected.
861/23	It was noted that a conversation would be required with the ICO to understand the implications of this with the Committee also noting the Data Security Protection Toolkit (DSPT) submission that would not meet all requirements.
862/23	This posed a potential risk however the Committee was alert to the challenges of the IG Group noting the action plans in place and the scope and scale of what was trying to be achieved. There was however some inherent risk with updates being made to the risk register in relation to this.
863/23	Mrs Baylis noted the clearly set out operational performance report with the Committee discussion the significant competing priorities that were set out in the narrative of the report against the national standards. There was a need for the Trust

	to continue to focus in the right way on the right things, particularly those areas with additional national scrutiny.
864/23	The Committee received the urgent and emergency care deep dive report and noted that whilst the principle and theory were correct this was not felt to be having the expected impact. Further consideration of the execution of the plans was required.
865/23	The CQC action plan was received with a number of item red rated, relating to estates and facilities however the verbal update provided suggested the action plan was not up to date. The Committee looked forward to this being updated ahead of the next meeting.
866/23	Mrs Baylis noted that there were no issues for escalation to the Board however advised of the 2 cross Committee referrals to the Quality Governance Committee for pending admissions and the People and Organisational Development Committee for fire safety training to ensure the right oversight and to consider the actions to be taken to improve the position.
867/23	As a consequence of the discussion the Committee agreed that objective 3b, efficient use of resources should be rated amber on the Board Assurance Framework, due to the level of confidence on the financial position, albeit only being month 1.
868/23	Objective 3d, improving cancer service access was down rated to red due to challenges in the performance position.
869/23	Mrs Baylis noted the busy meeting and agenda noting there was some work to be done to improve the governance arrangements to the Committee, particularly from estates and facilities. The Trust Board: • **Received the assurance report and annual report**
	Item 11 Objective 4 To implement integrated models of care with our partners to improve Lincolnshire's health and wellbeing
870/23	**Item 11.1 Paediatric Consultation** *The Divisional Managing Director and Divisional Clinical Director for the Family Health Division joined the meeting.*
871/23	The Divisional Managing Director advised the Board that the Equality Impact Assessment (EIA) for the paediatric consultation had been submitted noting that there was some support and advise being offered from the Equality, Diversity and Inclusion Project Manager. The Quality Impact Assessment (QIA) was being revisited and was being redrafted under the guidance of the Director of Nursing and Medical Director.

872/23	The Divisional Managing Director advised that these would be available when the consultation was launched to the public and noted that the service had been debated by the Board over the past 4 years with various iterations of the model being considered. Work had been completed to revise the original 12-hour Paediatric Assessment Unit (PAU) from 2018 into something that was thought to be a robust service.
873/23	It was noted that the consultation offered a description of the position with the view to making the model permanent with some of the history from 2018 noted within the document.
874/23	Whist a model had been put in place, by 2019 it was determined that this was not manageable and therefore amendments were being made. This was critiqued by the CQC as the Trust had not updated the description of the service.
875/23	Following this clarity of the service model was made clear with a number of iterations made and due to Covid-19 further developments were seen in the length of stay and staff were allowed to care for all children who presented regardless of length of stay.
876/23	The service had been supported with recruitment and was now fully staffed with the exception of 2 temporary staff who intended to apply for substantive consultant posts.
877/23	The Divisional Managing Director advised that the model was high with early senior assessments and consultants on site weekdays to 10pm. The focus of the ward area was for children to be seen as soon as possible on arrival with planned treatments. The length of stay was now around 22 hours with children remaining for a long as required.
878/23	The Board noted that transport off of the site was now negligible and had previously been a concern for residents in the area. Children were now only transferred out to either go to a tertiary centre or to Lincoln to access specific pathways.
879/23	The Divisional Managing Director noted that, through the consultation, it was believed that the service would meet the needs of the population which was supported by evidence of very few complaints and positive feedback from families accessing the service.
880/23	Conversations had been held with SOS Pilgrim, Health Overview Scrutiny Committee and through the Healthy Conversations work in the community which had been positive. There was a desire to move from the temporary service with a view to presenting back to Board in September/October 2023, following the consultation period, and moving to the permanent model.
881/23	Of noted the Divisional Managing Director advised the Board that in 2018 the service had moved to a gestational age of the Special Care Baby Unit (SCBU) to 36-weeks, against a national more of 32-weeks. This have been reverted 2 years ago to the 32-week gestational age and Health Education England Trainees had also returned to the site in 2021.

882/23	The Chair offered thanks were offered to the Divisional Managing Director and Clinical Managing Director and teams, for the work that had been undertaken over the past 3-4 years noting that it had taken some time to develop the model and reflecting the difficulties experienced as the start of the journey.
883/23	It was clear there had been input from families and the wider population and the paper was offered for agreement of the formal consultation process
884/23	The Board was familiar with the intention of the consultation which was fully supported however there was a need to seek the views of the community before a final decision was taken.
885/23	The Chief Executive offered thanks for moving the Trust to a positive position in respect of the service.
886/23	The work over the past few years had seen a transformation of the service with the Chief Executive keen that this went out to consultation. There was a need to ensure both the EIA and QIA were in place before the consultation was launched and anticipated that this would take place and only result in a short delay to the commencement of the consultation.
887/23	Time would be added to the end of the consultation period to ensure this ran for the full 12-weeks to enable the Trust to seek the views of both families and staff and any other interested stakeholders.
888/23	The consultation was supported by the Board however there was a need to ensure that the QIA and EIA were received once completed and signed off by the Director of Nursing and Medical Director.
889/23	The Chair requested that these were circulated to Board members before agreement of the commencement of the 12-week consultation was offered. Whilst the timeline had previously been received it was noted that there could be movement in this.
890/23	The Chair noted the recommendations stating that the progress was noted in the development of the model for paediatric care in the last 5 years and the Board was content with the consultation document presented.
891/23	The 12-week public consultation of the Pilgrim Paediatric Service would commence. The Trust Board: • **Received the report** • **Approved the plan for the 12-week public consultation to be launched subject to the completion and approval of the Quality Impact Assessment and Equality Impact Assessment**
892/23	**Item 12 Integrated Performance Report** The Chair noted the comprehensive report offered to the Board and invited questions or observations from Board members which had not been covered in the upward reports from the Committees.

893/23	There were no points raised by Board members and therefore the report was received with limited assurance with the narrative provided against each of the key metrics. The Trust Board: • **Received the report noting the limited assurance**
894/23	**Item 12.1 Integrated Improvement Plan 2023/24** The Director of Improvement and Integration presented the final version of the 2023/24 Integrated Improvement Plan (IIP) to the Board noting the bottom-up top-down design approach which had been taken.
895/23	The process had commenced in November 2022 with both clinical and corporate teams through a number of workshops as well as the views of the division being sought. A review of national guidance and triangulation to information was also undertaken in the development.
896/23	As the divisional workshops were held the divisions had created their own versions of the IIP to share with the teams which ensured the golden thread of the 4 strategic objectives.
897/23	The Director of Improvement and Integration offered an overview of the achievements made during the delivery of the 2022/23 IIP which were detailed within the report.
898/23	It was noted that Objective 2c, Well Led Services, for 23/24, required an amendment to the referenced external audit against CQC Well Led measures. The Director of Improvement and Integration would ensure the correct version was published.
899/23	The Chair noted the great piece of work that had been undertaken and reflected on the achievements that had been made following the Covid-19 pandemic and achievements over the past year. This was a celebration which the Trust should be proud of.
900/23	In terms of the plan for 23/24 the Chair noted the clarity, intent and objectives which were the best that had ever been done and appreciated that effort that had gone into this. The IIP provided absolute clarity in what the document had always intended to do.
901/23	The Chair offered thanks for the assurance on the revision that would be undertaken to objective 2c and offered thanks to the Director of Improvement and Integration for the leadership taken on this. The Trust Board: • **Received the report noting the significant assurance** • **Approved the 2023/24 Integrated Improvement Plan**

	Item 13 Risk and Assurance
902/23	**Item 13.1 Risk Management Report** The Director of Nursing presented the Risk Report to the Board noting the increased movement in the report due to a number of risks having been validated through the Risk Register Confirm and Challenge Meeting.
903/23	This had resulted in an increase of 2 quality and safety risks rated as very high, due to the paediatric risk of diabetes and epilepsy being spilt in to acute and community. There were a totally of 17 very high quality and safety risks.
904/23	The risk associated with lesson learned to improve patient safety had been closed as a specific risk. This was due to the patient safety team now being in place, as heard through the PSIRF update. Patient safety meetings were in place and risk themes had been added to the risk register, such as DKA, ophthalmology and pressure ulcer risks.
905/23	In addition to the PSIRF implementation now in place the Datix Q project manager had been recruited to support the approach to managing and holding risk with the risk register being held through the Datix system.
906/23	Patient Safety Partners had been recruited and inducted and included in established governance processes and meetings where risk was discussed. All three had attended the Quality Governance Committee in May as observers to the meeting and offered positive feedback in terms of the issues and content of the Committee and items discussed relating to risk.
907/23	The Director of Nursing noted the learning to improve the newsletter highlighting patient safety risks to include more detail in individual areas rather than having overarching risks associated with lessons learned on patient safety.
908/23	The Board was advised of 4 very high risks, an increase, for the People and Organisational Development Committee resulting in there being 7 very high risks considered by the Committee.
909/23	The 4 risks were associated to staffing levels to increase pharmacy and provide a 7-day service, pharmacy being able to withstand long staff absence, pharmacy workload demands and service reconfiguration on haematology.
910/23	There had been an increase of 1 very high risk for the Finance, Performance and Estates Committee resulting in a total of 6 very high risks. The new risk was the fabric and capacity of the mortuary service.
911/23	The Director of Nursing noted that the report offered the detail of each of the very high risks and associated risk reduction plans and demonstrated the live nature of the risk register.

912/23	The risks had been received by the Committees in month and the appendix offered the risks by each Committee which it was hoped were recognised and agreed with significant assurance being offered.
913/23	The Chair noted the layout of the report which offered additional assurance in the commentary. The Trust Board: • **Accepted the risks as presented noting the significant assurance**
914/23	**Item 13.2 Board Assurance Framework** The Trust Secretary presented the 2023/24 Board Assurance Framework (BAF) to the Board noting that this had been considered by all Committees in month.
915/23	Work continued to align the BAF with the revised IIP, which had just been considered by the Board, alongside work with the Executive Director leads in month and through the Committee process.
916/23	As noted from the update provided by the Finance, Performance and Estates Committee the recommendation had been made to the Board for objective 3b to be rated from red to amber and for objective 3d from amber to red.
917/23	The Chair invited the Board to endorse the BAF assurance ratings as presented for May noting the changes to objectives 3b and 3d as outlined during the meeting.
918/23	The development of the BAF for the 23/24 year was almost complete and following sign off of the IIP the final review could be undertaken.
919/23	The Chair noted from the Finance, Performance and Estates Committee that there was some refinement to be made on the narrative however an action was taken through the Committee by the Deputy Trust Secretary to address this. It was expected that a final version of the BAF would be received in July, having been through the Committees. The Trust Board: • **Received the report noting the moderate assurance** • **Approved the rating of Objective 3b to amber** • **Approved the rating of Objective 3d to red**
920/23	**Item 13.3 Code of Governance - update** The Trust Secretary presented the update to the Code of Governance to the Board noting that the code had been revised during 2022 and came in to affect in April 2023.
921/23	This had seen an almost 10-year-old document updated to align with changes to the Provider Licence and System Oversight Framework with the details provided to the Board.

922/23	The Trust Secretary noted the intention to complete an analysis of the revised code and offer the detail to the Audit Committee in order to identify any areas requiring alignment to corporate governance arrangements in line with the code.
923/23	It was proposed that this would be received on a quarterly basis to the Audit Committee where alignment was not felt to be in place and offer this to the Board through the upward reporting arrangements.
924/23	The Chair welcomed the suggestion of the review to identify any gaps and ensure compliance with the requirements. The changes to the Code of Governance were noted and it was suggested, in the absence of the Chair of the Audit Committee, that it was the right Committee to take oversight of the requirements.
925/23	The Chair requested that this be received by the Audit Committee as part of the quarterly compliance report to include the gap analysis. **Action: Trust Secretary, 10 July 2023** The Trust Board: • **Received the report noting the significant assurance**
926/23	**Item 13.4 Provider Licence Update and Declaration** The Trust Secretary presented the provider licence update and declaration to the Board noting that it was proposed that time would be taken through the Audit Committee to ensure that the Trust remained compliant in year.
927/23	The report offered the self-certification required of the Board on condition 6 and FT4, confirming governance arrangements were in place and the Trust was meeting the licence conditions.
928/23	The Trust Secretary advised that the assessment made as a Trust against the individual requirements be made available on the public website as there was no requirement to make a submission.
929/23	It was proposed that for year 2022/23 the Trust declared compliance against the arrangements. This had not been possible in prior years due to Care Quality Commission (CQC) notices in place as well as the Trust being in special measures.
930/23	With the removal of those conditions, it was possible for compliance for 22/23 to be proposed.
931/23	The Chair noted the important of being able to comply where previously, for the reasons outlined, this had not been possible. The report demonstrated the improvements made in the Trust over the course of the previous year.
932/23	Thanks were offered to all involved in strengthening the governance arrangements described.

	The Trust Board: • **Approved the Provider Licence update and Declaration**
933/23	**Item 14 Any Other Notified Items of Urgent Business** No items
934/23	The next scheduled meeting will be held on Tuesday 4 July 2023 via MS Teams live stream

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

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 5.2

Trust Board date	Minute ref	Subject	Explanation	Assigned to	Action due at Board	Completed
7 March 2023	340/23	Assurance and Risk Report from the Finance, Performance and Estates Committee	Update on medicines management to be offered to the Board in 3 months' time in order to ensure sight was not lost to due this having been an issue for some time	Medical Director	07/06/2023	Received to private Board
2 May 2023	613/23	Assurance and Risk Report from the Quality Governance Committee	Head of Midwifery to be invited to attend the July Board meeting to present the outcome of the review of the maternity 3-year plan	Trust Secretary	04/07/2023	Look to bring Maternity Team to Board dev session, due to number of ann reports on TB agenda
6 June 2023	925/23	Code of Governance – Update	Review of the Code of Governance and gap analysis to be reported to the Audit Committee through the quarterly compliance report	Trust Secretary	10/07/2023	

United Lincolnshire Hospitals NHS Trust

Meeting	*Public Trust Board*
Date of Meeting	*4 July 2023*
Item Number	*Item number 6*

Chief Executive's Report

Accountable Director	*Andrew Morgan, Chief Executive*
Presented by	*Professor Karen Dunderdale, Director of Nursing/Deputy Chief Executive*
Author(s)	*Andrew Morgan, Chief Executive*
Report previously considered at	*N/A*

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

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

Recommendations/ Decision Required	• *To note*

Executive Summary

System Overview

a) All parts of the system continue to operate under significant pressure. All organisations had robust plans in place for ensuring service resilience during the three day Junior Doctor strike in June. The next strike is for five days between 07.00 on Thursday 13th July through to 07.00 on Tuesday 18th July. The ballot for industrial action by Consultants closes on 27th June and the BMA has already indicated that if this vote goes in favour of industrial action, that there could be a strike by Consultants on 20th and 21st July. The ballot by the RCN for further industrial action closed on 23rd June and the result is awaited.

b) At Month 2 the system was reporting a year to date deficit of £10.1m. Taking account of the phasing of savings, the system is on track to deliver the year-end financial plan figure of a deficit of £15.4m.

c) In terms of the system Financial Recovery Plan (FRP), at Month 2 the system has delivered £6.8m of savings against a plan of £5.3m. Taking into account unidentified savings, this positive variance reduces to £1.25m.

d) There is a system financial plan delivery meeting with NHS England on 27th June. This meeting is to allow discussion on the year to date position, the expenditure run-rate, efficiency and productivity, expenditure controls, capital, and the medium-term financial plan. A summary of the outcome of the meeting will be given at the Board meeting.

e) The system has received an Operational Plan Closedown letter from NHS England following the submission of the final system Operational Plan in early May. The letter summarises the key targets and deliverables that the system has committed to deliver, covering topics such as emergency care and system resilience, elective and cancer care, mental health, learning disability and autism services, workforce, finance, as well as summarising the financial controls that are expected to be in place across the system.

f) Colleagues across the system are working with Lincolnshire Police on developing a local Right Care Right Person policy. This is a national programme designed to ensure that people in crisis and need, are signposted to the most appropriate agency.

g) Following the outcome of the public consultation on the 'Acute Services Review' (ASR), the ICB has confirmed that ULHT will run the Urgent Treatment Centre at Grantham and District Hospital. The Integrated Community and Acute Medicine beds at Grantham and District Hospital will be delivered through a collaboration between ULHT and LCHS. Work is now underway on the implementation and mobilisation plans for both of these services.

h) Over recent months NHS providers in the county have been considering how they can develop and improve the way in which they work together to integrate services. There are three immediate next steps that have been agreed. Firstly, to improve the way Primary care Networks and their community partners and stakeholders can come together to deliver integrated care. Improved structures, developed to support each locality will push more focus and resource towards prevention and self-care and care close to home. Secondly, an NHS Trust group arrangement will be established between ULHT and LCHS, with the close engagement of other NHS partners. This means that ULHT and LCHS will work even closer together in the future, with shared decision making, governance and posts where this makes sense. Thirdly, organisations will make better use of their shared expertise and experience by taking a fundamental look at how support functions come together to ensure that they deliver the best possible quality of service and value for money.

i) As part of the NHS@75 anniversary, the NHS Assembly has produced a report 'The NHS in England @75: priorities for the future.' The report sets out the need for three shifts. These cover preventing ill health, personalisation and participation, co-ordinating care closer to home. It will be for NHS England to consider the report when drawing up strategies and plans for the future.

Trust Overview

a) At Month 2, the Trust reported a year to date deficit of £4617k versus a plan of £4630k, resulting in a small positive variance of £13k. The full-year plan is for a deficit of £20.8m. Savings of £3859k have been delivered year to date, compared to the planned position of £2356k. This is a positive variance of £1503k. The full year savings plan is £28.1m.
b) The Junior Doctor strike in June resulted in the cancellation of 39 operations and 371 outpatient appointments. This is on top of the 165 operations and 1474 outpatient appointments cancelled across the previous strikes. Patients are re-booked as soon as practicable. In the financial year 2023/24, the strikes have cost the Trust circa £330k in additional staffing costs and circa £455k in lost activity income. It is hoped that this activity can be recovered at a later date. The staffing costs will need to be covered via savings in other budgets.
c) The public consultation relating to Paediatric Services at Pilgrim Hospital was launched on 12th June and runs through to 4th September. The proposal in the consultation is to make the current service provision permanent.
d) The Trust celebrated Armed Forces Week from 19th-23rd June, ahead of National Armed Forces Day on 24th June. Events included a participatory leadership event at RAF Waddington, hearing an inspirational Story of Resilience from a wounded veteran, staff wearing their uniforms and medals to work on the Wednesday and a social event.
e) The Trust also celebrated National Estates and Facilities Day on 21st June. The celebrations included Estates and Facilities Hero awards for staff.
f) The National Freedom to Speak Up Guardian has issued a report about the staff survey and speaking up in the NHS. The Trust was listed as one of the top ten most improved organisations for speaking up.
g) Colleagues from the Trust were winners in the NHS Parliamentary Awards in the Midlands. The Parliamentary Awards are for individuals and teams who have made improvements to health services. Nominations are made by MPs. There are ten award categories and the regional winners go through to the National Awards on 5th July. The Trust had winners in two of the ten categories. Martyn Staddon was the winner in the Future NHS category for his work on SUPERB, the Single Unified Patient Experience Reporting Board. Howard Straughen-Simpson was the winner in the Lifetime Achievement category having worked for the NHS for more than 60 years.
h) In line with the vast majority of NHS Trusts, ULHT is moving to holding Board meetings in public on alternate months rather than monthly. The next Board meeting will therefore be in September.

Report to:	Trust Board
Title of report:	Quality Governance Committee Assurance Report to Board
Date of meeting:	20 June 2023
Chairperson:	Rebecca Brown, Non-Executive Director
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the Quality Governance Committee (QGC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme. The Committee worked to the 2022/23 objectives.
	Assurance in respect of SO 1a Issue: Deliver high quality care which is safe, responsive and able to meet the needs of the population **Clinical Harm Oversight Group (CHOG) Upward Report** The Committee received the formal proposal to step down the group with the Committee noting the previous updates that had been offered in the respect of the development of this. Reporting of harm now takes place through the Patient Safety Group, and it was recognised that it had been demonstrated that the level of harms were low however, the impact to undertake the reviews was significant to clinical teams. The Committee was assured that the appropriate mechanisms were in place in order to review harms and reporting was taking place through Datix. Support was also offered by the Integrated Care Board who had been sighted on the proposal. The Committee supported the proposal to step down the Clinical Harm Oversight Group. **Serious Incident Summary Report inc Duty of Candour.** The Committee received the report noting the position presented and was pleased to note the ongoing position of no outstanding never event actions. Compliance continued to remain high for duty of candour with the detail of harm, as a result of delays, included. The Committee reflected that there had been an increase of other incident actions open however closure trajectories would be offered to

	the Committee in July, linked to PSIRF. **High Profile Cases** The Committee received the report noting the content. **Safeguarding Annual Report** The Committee received the safeguarding annual report noting that governance processes had been reviewed in year by internal audit with relevant actions being taken in response to the outcome. The committee continues to have concern with the delivery of the CPIS delivery The Trust continued to engage with relevant reviews for adults and children which remained static however it was noted that there was an increase in domestic homicide reviews for the county. The Committee noted the work in respect of Deprivation of Liberty which the Trust would continue with until the Liberty Protect Safeguard was brought in. It was recognised that this had been deferred for some time. The work around learning disabilities and autism was noted which was having a positive impact on staff with data having been collected for the past 2 quarters. Safeguarding DMI training was noted with the plan to roll out training from July with 830 staff identified initially for training. The Committee recommended the report to the Board for approval (appendix 3). **Medicines Quality Group Upward Report** The Committee received the report and was pleased to note that the medicines management training programme had been ratified through the Medicines Optimisation Group. Final sign off was awaited from the Chief Pharmacists. The Committee raised concern regarding the loss of dedicated support for the medicines management work from the Improvement Team noting that in order to sustain pace on progress this was required. NICE Technology Appraisals continued to remain compliant and ongoing progress was being made with e-prescribing which would be rolled out to the surgery division in the autumn. The Committee was pleased to note the increase in new pharmacists being recruited with this now at 15 new starters. It was recognised however that there would be a lead time for them onboarding. **Patient Safety Group Upward Report inc PSA Quarterly Report** The Committee received the upward report noting that the group had received and considered the incident management report. Consideration was given to a closure trajectory for open serious incident actions to ensure that these were managed. This would be offered back to the Committee once in place.

	The Patient Safety Alert report was received by the group and offered to the Committee which demonstrated a continued reduction in alerts however some had remained open for some time for which the group had requested updates for. The Committee received the Never Event summit action plan noting that a number of actions had been closed, the Committee would continue to have sight of the action plan to ensure this was completed. It was positive to note at this time that there had been no further surgical never events. **Nursing, Midwifery and Allied Health Professionals Advisory Forum Upward Report** The Committee received the upward report noting that the group had been impacted by recent strike action and therefore had not met for some time. The group had considered and approved 3 paediatric documents which would support service needs and requirements as well as addressing some CQC actions. The Committee was advised that the group had held discussions with the Chief Nursing Information Officer and reflected that the digital agenda for nursing was challenging however was assured by the early conversations which were taking place. **Maternity and Neonatal Oversight Group (MNOG) Upward Report** The Committee received the report noting the information offered, particularly that which was contained within the appendices and offered to the Board for information (appendix 1). The group had considered and revised its terms of reference which now resolved the issue of external attendees being part of the quoracy. External colleagues, whilst invited to the meeting, were not routinely attending and it was reflected that this may be due to existing supporting structures in place through which information was received. The Committee endorsed the terms of reference of the group. The Committee was pleased to note the achievement of the Clinical Negligence Scheme for Trusts Maternity, with the Trust being one of 2 organisations in the region to meet all 10 criteria. The group had considered the claims scorecard which offered a triangulated position with the Committee noting that communication was no longer highlighted as a theme. This demonstrated the huge amount of work undertaken across the service to improve. The group was focusing on minority ethnic groups with a comprehensive report received which demonstrated that overall, there were good outcomes for women from a BAME background. This work would now be

	extended for women with an Eastern European background as it was believed the Trust had a high cohort. The Committee noted the positive levels of staffing to birth rate plus and the NED Maternity and Neonatal Champion report was received by the group. The committee was pleased to receive the verbal update that The Trust had achieved all requirements of Saving Babies Lives version 2 and had commenced the work on benchmarking for Version 3, which has further criterions.
	Assurance in respect of SO 1b Issue: Improve Patient Experience **Patient Experience Group Upward Report and Annual Report** The Committee received the upward report noting the content and taking the report as read to enable a focus on the annual report. The Committee noted and commended all of the hard work that had been undertaken throughout the year and noted with interested the success of individuals in the organisation in achieving national awards. It was recognised that there was a significant piece of work being undertaken by the team to ensure that patient information leaflets were available and suitable for use. The Committee was pleased to note the development of the patient story library which was an excellent source of information, and it was hoped that this would be widely accessed. The Committee recommended the report to the Board for approval (appendix 2) **Complaints Annual Report** The Committee was attended by a number of the complaints team in order that the annual report could be offered, and feedback received directly by the team. The Committee noted the improved position in respect of complaints following revised processes being put in place and through the appointment of the Clinical Senior Complaints Case Manager role, which had seen a reduction in formal complaints as these were dealt with informally and satisfactory outcomes achieved. The Trust had received 189 more complaints for the 2022/23 year than had been received in 2021/22 with a total of 937 responded to. Focus had been given to overdue complaints and as a result there were 11 overdue at the end of March. This position had since improved further. The Committee commended the work of the complaints team and the

	achievements reported recommending the report to the Board for approval (appendix 3).
	Assurance in respect of SO 1c Issue: Improve Clinical Outcomes **Clinical Effectiveness Group Upward Report** The Committee received the report noting the VTE position which continued to be below trajectory. The VTE group would consider how this could be improved through the electronic patient record development. It was noted that outlier status for the national inflammatory arthritis audit related to timely appointments and annual reviews. The Committee requested that the actions plan being developed was shared with the Committee to gain assurance on actions being taken. The Committee noted the development of the clinical audit group which would see a more inclusive approach and include representation from audit in the forum.
	Assurance in respect of other areas: **FPEC Referral – Pending Admission data set** The Committee received the data set referral from the Finance, Performance and Estates Committee, which would be considered outside of the meeting to better understand the detail and offer an update to the Committee in July. **PODC Referral – GMC Junior Doctor Immediate Safety Alerts** The Committee received the referral from the People and Organisational Development Committee noting the content of the report, which had been offered for information. The Committee noted that the outcome of the formal report is due later this summer and agreed to wait for this report in order before considering in further detail. **Draft Terms of Reference and Work Programme 2023/24** The Committee received and approved the draft Terms of Reference noting that final revision of the work programme was required following input from the reporting groups. This would be offered back to the Committee in July for approval. **Topical, Legal and Regulatory update** The Committee received the report noting the content and reflecting that the item referring to the next version of Saving Babies Lives would be considered through MNOG. Furthermore, the Healthcare Safety Investigation Branch report into paediatric ward environments for children with complex health needs would be considered through the Children and Young People Oversight Group.

	Both would be reported to the Committee. **Integrated Improvement Plan** The Committee reflected on the layout of the report noting that this offered a clear view on the current position of the metrics and supporting narrative offered. There continued to be a number of omitted datasets however it was anticipated that these would be resolved once the CQUIN data was received at the end of Q1. The Committee noted the potential for duplication of reporting reflecting the need to ensure, if metrics were reported in other documents, that the narrative and data was correctly captured along with appropriate use of SPC charts. **Internal Audit Recommendations** The Committee received the report for information noting the position presented. The Committee reflected on the FP10 prescription pad action noting that this was being actioned through medicines management. **CQC Quarterly Action Plan** The Committee received the quarterly update of the action plan noting that work was taking place to revisit previous inspection outcomes to ensure all actions were captured. The report now included those actions relevant to surgery with other areas due to be built into the action plan. The process of including previous actions would allow for triangulation of current performance. **Quality Account 2022/23 Final** The Committee received the final version of the 2022/23 Quality Account for information noting that this had been signed by the Chair and Chief Executive. The Committee was pleased with the final outcome of the report and supported presentation to the Board. **Committee Performance Dashboard** The Committee received the report noting that discussions during the course of the Committee meeting had covered the performance items reported. It was reflected that the SPC charts within the report were not working as expected however this had been raised and was due to be resolved. **Mixed Sex Accommodation Statement** The Committee received and considered the mixed sex accommodation statement for inclusion on the Trust website, to be published in line with guidance. The Committee recommended the statement to the Board for approval.

Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	None
Committee Review of corporate risk register	The Committee noted the risk register noting those risks contained within the register.
Matters identified which Committee recommend are escalated to SRR/BAF	None
Committee position on assurance of strategic risk areas that align to committee	The Committee considered the reports, which it had received which provided assurances against the strategic risks to strategic objectives.
Areas identified to visit in dept walk rounds	None

Attendance Summary for rolling 12-month period

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

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

Maternity & Neonatal Oversight Group
Terms of Reference

1. Authority

1.1 The Maternity & Neonatal Oversight Group is appointed and established by the Quality Governance Committee. The Group holds only the powers and functions delegated to it in these Terms of Reference.

2. Purpose

2.1 Given the current national and local focus on maternity services and in accordance with good practice, the Trust has introduced a Maternity & Neonatal Oversight Group 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. The Maternity & Neonatal Oversight Group will be a key element of the Trust's 'Maternity Assurance Framework'.

2.2 The Maternity & Neonatal Oversight Group, through its membership, will bring together the Trust's maternity & neonatal safety leads / 'champions' at local and corporate level, together with relevant external stakeholders, ensuring a robust and cohesive approach to its assurance role.

2.3 The Maternity & Neonatal Oversight Group, through its membership and work programme, will give equal weight to both maternity & neonatal services as regards its challenge and oversight role.

3. Duties and Responsibilities

3.1 The duties and responsibilities of the Maternity & Neonatal Oversight Group are:

- To retain oversight of the progress of delivery the Trust's maternity & neonatal improvement plan, developed in line with the maternity transformation programme, to include the response to any external reviews or inspections and national or regulatory requirements (e.g. CQC, Ockenden).

- To receive information on quality & safety key performance indicators and national and local priorities in respect of maternity & neonatal services. This will include but not be limited to the following:

    - Maternity Quality & Safety Dashboard & Highlight Report
    - Neonatal Dashboard
    - CNST Standards – '10 Steps to Safety'
    - Saving Babies Lives
    - Outliers – 'Red Flags'
    - Service User Voice Feedback
    - Staff Feedback & Cultural Issues (including Speaking Up issues & concerns)
    - Mandatory Training Compliance
    - Safe Staffing & Escalations
    - Coroners Regulation 28: Prevention of Future Deaths Reports (PFDs).

- To receive information on numbers and themes and trends from complaints / PALS & compliments, claims, inquests, incidents & serious incidents (SIs) in order to identify and make recommendations for any further required actions with an emphasis on the prevention of future incidents and events. To receive assurance that there are mechanisms in place so that lessons learned from complaints / PALS, claims, Inquests, incidents & SIs (including HSIB investigations) are shared and timely corrective action is implemented.

- To consider national best practice, guidance and learning from other organisations ensuring dissemination of key messages and that action is taken in response to gaps identified, as appropriate.

- To review relevant audit reports and findings and the findings from ward quality reviews / accreditation etc. and retain oversight of the delivery of the agreed remedial actions.

- To review benchmarking information and ensure that, where outcomes identify that the Trust is an outlier, ensure that the appropriate actions and improvements are being identified and implemented as part of the maternity & neonatal services improvement plans.

- To receive a report from the Non-Executive Director Maternity 'Safety Champion'.

4. Membership

4.1 The members of the Maternity & Neonatal Oversight Group are:

- Director or Nursing / Deputy Chief Executive (Chair)
- Medical Director (Vice Chair)
- Divisional Triumvirate – Family Health:
  - Divisional Clinical Director – Family Health
  - Divisional Managing Director – Family Health
  - Head of Midwifery – Family Health
- Consultant Midwife
- Deputy Head of Midwifery
- Maternity & Neonatal Clinical Leads (including Antenatal Lead and other Consultants to be in attendance as the agenda dictates)
- Head of Children's Services
- Matron, Neonatal Services
- Non-Executive Director (NED) Maternity 'Safety Champion'
- LMNS Representative
- Maternity / Neonatal Voices Partnership (MVP) Representative
- CCG Representative
- Deputy Director of Clinical Governance

4.2 Attendance by other staff will be agreed as required and the agenda dictates. (It is anticipated that this will include junior doctor, midwife and neonatal nurse representatives as the work of the group is progressed.)

4.3 Where appropriate, deputies may attend to cover periods of absence of nominated members but should have the seniority and authority to represent / act on behalf of the nominated member.

5. Attendance & Quorum

5.1 A quorum will be constituted by the presence of, as a minimum:

- The Chair (In the absence of the Chair, the Vice Chair shall chair the meeting).
- One member of the Family Health Divisional Triumvirate
- One clinical representative (from maternity or neonatal services)
- A representative from the clinical governance team

6. Chair and Vice Chair

6.1 The Maternity & Neonatal Oversight Group will be chaired by the Director of Nursing as the Trust Board Executive lead / 'champion' for maternity & neonatal services.

6.2 The Vice Chair of the Maternity & Neonatal Oversight Group will be the Medical Director.

7. Frequency

7.1 Meetings will take place bi-monthly. This will remain under review.

8. Conduct of Business

8.1 The meeting will follow a core agenda. The content of the core agenda will be informed by the group's work programme with other items added as the need arises. The agenda and supporting papers for the meeting will be circulated by the meeting administrator no later than five (5) working days in advance of meetings.

8.2 Any items to be placed on the agenda are to be sent to the secretary of the meeting no later than seven (7) working days in advance of the meeting. Items which miss the deadline for inclusion on the agenda may be added on receipt with the permission of the group Chair.

8.3 Minutes will be taken at all meetings, presented according to the Trust's corporate style, circulated to members and ratified by agreement of members at the following meeting.

8.4 An action log will be maintained.

8.5 Extraordinary meetings to conduct urgent business (within the remit of the group) which cannot wait until the next routine meeting may be called with the agreement of the Chair. Any extraordinary meetings will be conducted in line with these Terms of Reference.

9. Accountability and Reporting Arrangements

9.1 The Maternity & Neonatal Oversight Group is accountable to the Quality Governance Committee.

9.2 The Chair of the Maternity & Neonatal Oversight Group will provide an upward assurance and exception report to the Quality Governance Committee after each meeting. Where issues or risks are identified that cannot be dealt with by the Maternity & Neonatal Oversight Group, such matters will be escalated through the upward report to the Quality Governance Committee or other Trust committee, as required.

9.3 The Maternity Collaborative (Delivery) Group will formally report to the Maternity & Neonatal Oversight Group and will provide a monthly upward report.

9.4 The Terms of Reference and minutes of meetings of the Maternity & Neonatal Oversight Group will be shared with the LMNS through their representative on the group. There will be a joint overview report from the LMNS / Trust to the 'system' Quality & Safety Group.

10. Review and Effectiveness

10.1 The Terms of Reference for the Maternity & Neonatal Oversight Group will be reviewed annually or sooner should the need arise. Changes will be approved by the Quality Governance Committee.

10.2 The Maternity & Neonatal Oversight Group will undertake an annual review of effectiveness. A written report detailing the outcome will be submitted to the Quality Governance Committee.

March 2021
Updated & Finalised April 2021
Updated October 2021
Updated March 2023

NHS England

Screening Quality Assurance Service

To: Libby Grooby
Divisional Head of Midwifery/Lead Nurse Family Health

United Lincolnshire Hospitals NHS Trust

By Email: Libby.Grooby@UHL.nhs.uk

12 April 2023

Dear Libby,

Re: Pathway review of the governance arrangements and incident management processes for the antenatal and newborn screening programmes at United Lincolnshire Hospitals NHS Trust

The Screening QA Service (SQAS) undertook a review of the governance pathway and incident management processes at United Lincolnshire Hospitals NHS Trust on 28 March 2023.

During the review the trust provided assurance that the governance pathway and incident management processes are effective. There were no concerns or recommendations identified.

Five actions were discussed and agreed with the trust as a service quality improvement initiative to be managed through business as usual processes:

- Review the chair arrangements of the “Antenatal and Newborn Screening Steering Group” and strengthen the terms of reference to accurately reflect the purpose of the group, account for organisational name changes, include reporting of all standards and key performance indicators and standard agenda items including inequalities
- Continue to engage with the newborn clinical lead to improve understanding of the role and the commitment expected
- Review the trusts risk management policy to make sure it contains a reference to “Managing safety incidents in NHS screening programmes”
- Ensure that key personnel have access to view e-LFH training compliance
- Complete a user survey and develop an action plan as appropriate to support the delivery of high quality screening services

It was evident that staff involved in the provision of antenatal and newborn screening are committed to improving the quality and safety of the programmes in the Trust and they should be commended.

Thank you for participating in this process and for the work done in preparation for this review.

If you have any queries, please do not hesitate to contact the SQAS team.

Yours sincerely,

Julia Waller

Quality Assurance Advisor

juliawaller@nhs.net

On behalf of Dr Helen Lewis-Parmar

Head of Quality Assurance SQAS (Midlands and East)

helenlewis-parmar@nhs.net

cc. Angela Crosby, Antenatal and Newborn Screening Coordinator

Helen Varley, Screening Support Sonographer

Stephanie Cook, Head of Public Heath Commissioning

Tim Davies, Screening and Immunisation Lead

Greta Haywood, Screening and Immunisation Manager

NHS Code	Member Number	Region Name	Member Name	NPMRT	MSDS	Transitional Care	Medical Workforce Planning	Midwifery Workforce Planning	SBL Care Bundle	Patient Feedback	In House Training	Safety Champions	ENS	No. of Actions Met
RWD	T565	MIDLANDS COMMISSIONING REGION	United Lincolnshire Hospitals NHS Trust	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10

Maternity Report

Care and outcomes for women of black and ethnic minority groups

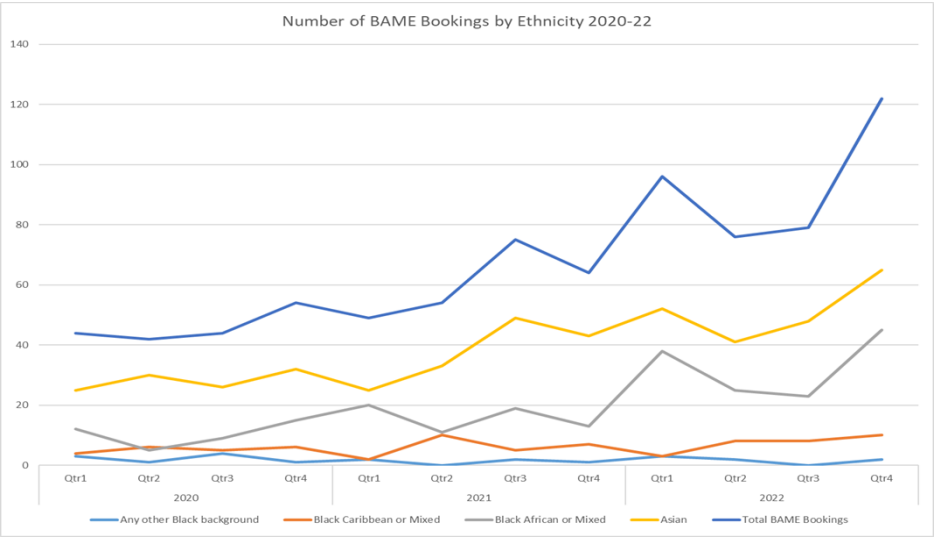
Jules Bambridge – Consultant Midwife

May 2023

UK confidential enquiries into maternal mortality and morbidities (MBRRACE-UK) as well as perinatal reviews of infant mortality have consistently identified that women from black and ethnic minority backgrounds are at a three to five times greater risk of mortality than white women in the puerperium. Black women also have significantly higher rates of re-admission, still birth and sudden infant death.

Nationally there is a drive to identify populations at risk and reduce mortality and morbidity through the Equity & Equality Framework for Maternity Services. Locally this is managed through our Better Births Transformation Team.

Historically the number of Black & Asian women using ULHT maternity services has been minimal compared to neighbouring Trusts. However, in the last three years we have seen a steady rise, particularly in the number of Black African women attending the University of Lincoln as International Students and Researchers, or staying in the UK with a partner in the same role. In Q1 2020 just over 40 women of BAME background booked their pregnancy at ULHT, whilst in Q4 2022 over 120 booked, a 200% increase.

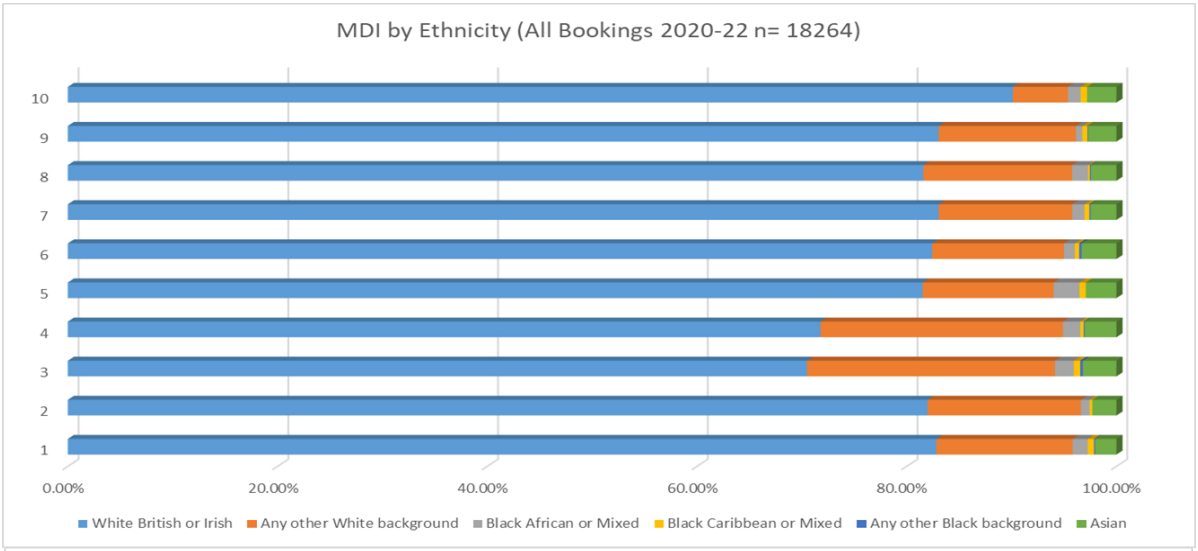


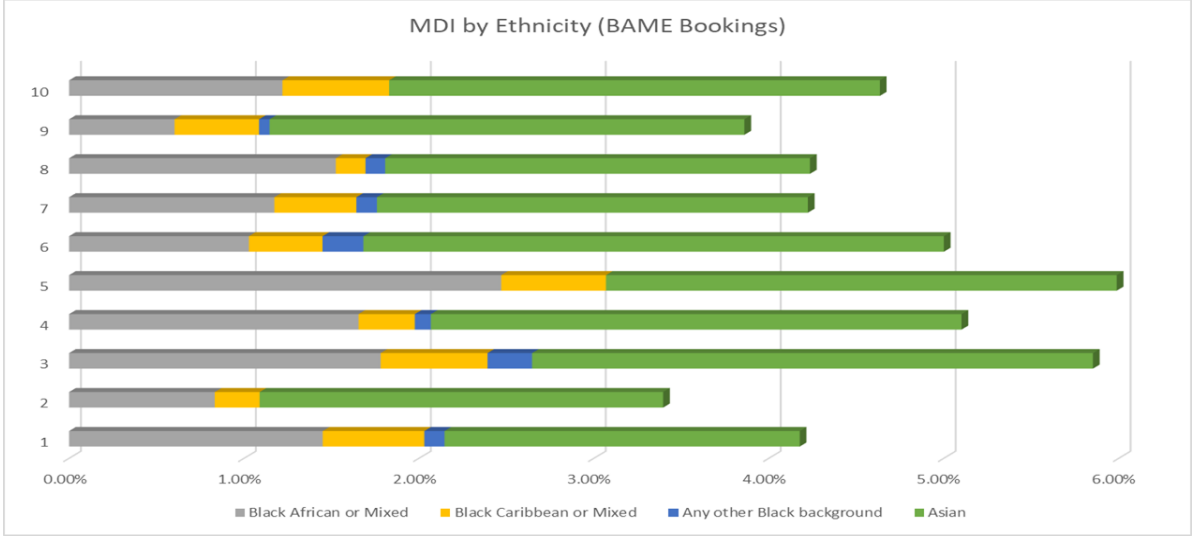
Implications for BAME women

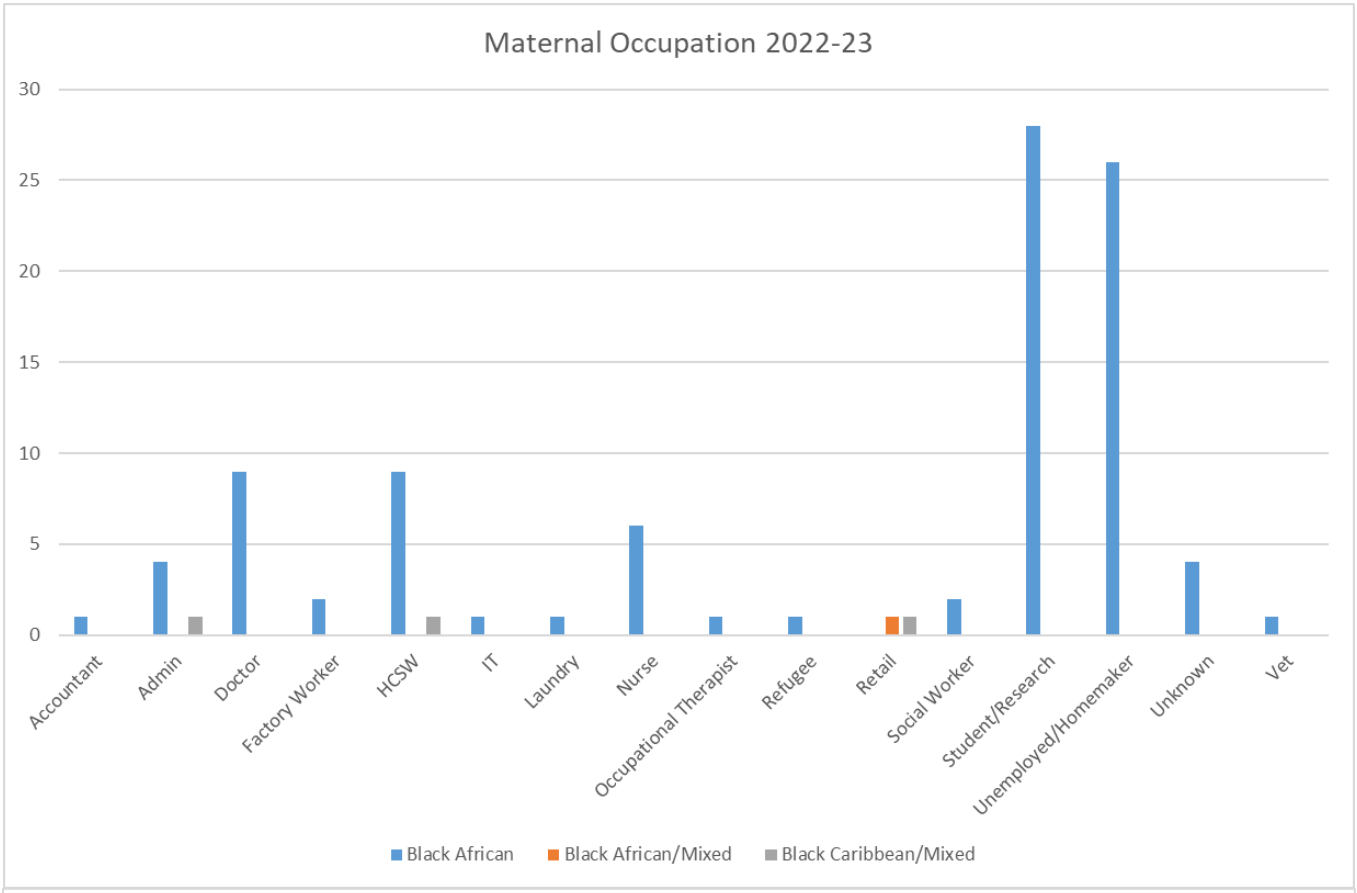
In contrast to the national picture the social demographics of women of BAME backgrounds booking at ULHT are evenly spread across all the deprivation deciles. The income and education profile of this group are significantly higher than the national average and as such we have seen no marked increase in safeguarding or mental health support required in this population. Particularly women from Black African backgrounds can be localised into student/researcher or medical staff or a partner of one of these occupations.

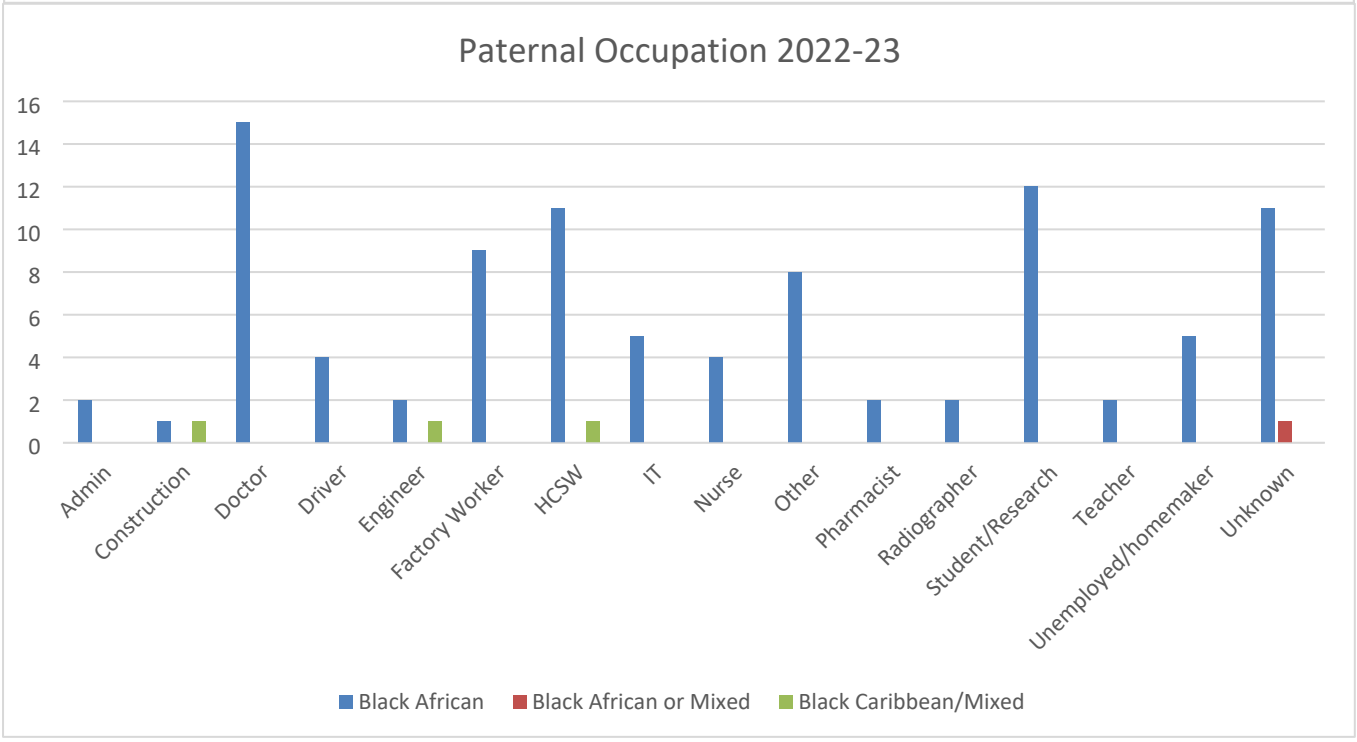
Communication within the system between the ICB, Maternity Voices Partnership, Primary care and the University have identified an increasing number of pregnant women moving to Lincoln from African countries for education and who do not necessarily understand how to access health care in Lincolnshire. The MVP is currently surveying women at the university to understand their perspectives of accessing maternity care, whilst the University and Primary care are working together to promote early access to GP and subsequent care required as part of the University induction.

At the time of report writing this data insufficient data is available for women of Asian descent.



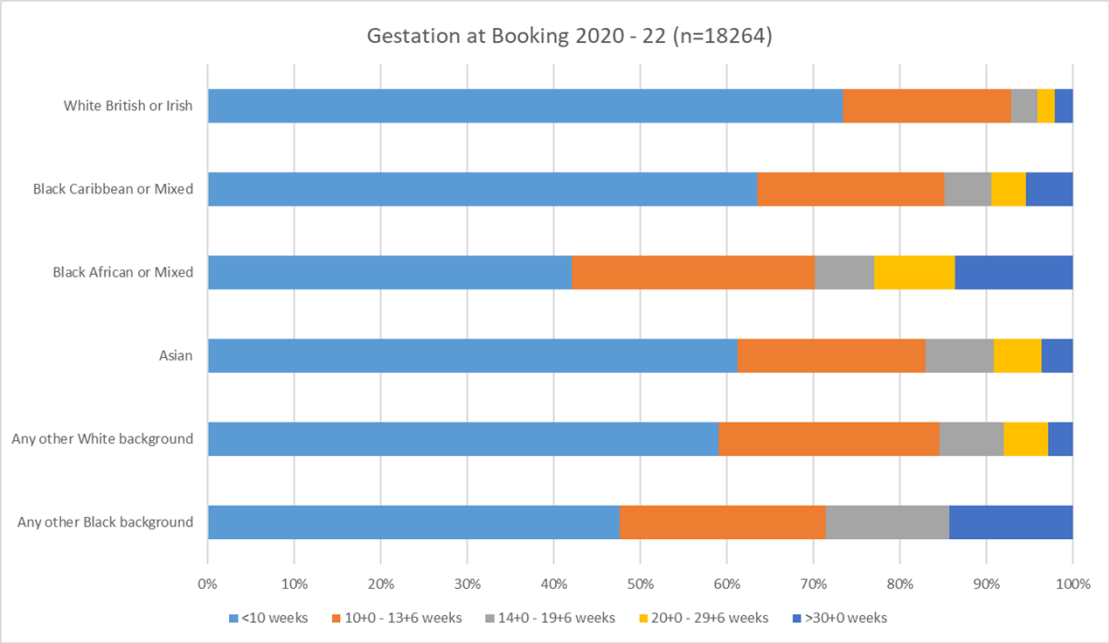




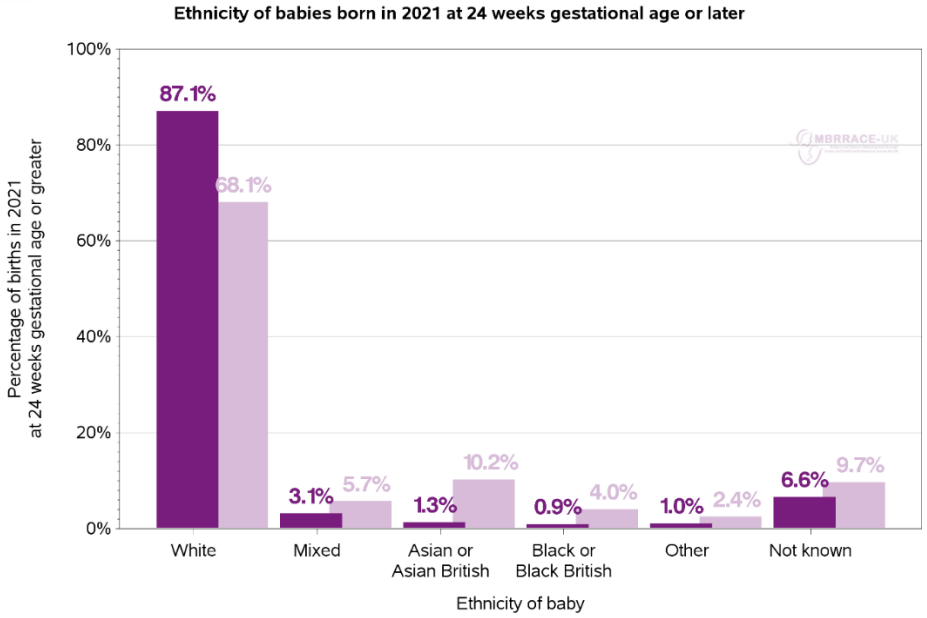


Whilst psychosocial factors are stable for this population, from a medical perspective, only 42-48% of women from a Black African/any other Black background are booking by 9+6 weeks (target 67.5%), 62-64% of Black Caribbean and Asian women book by 9+6weeks. These same groups of women are also less likely to receive first trimester screening by the 13+6 week target.

Most of the women booking late within the Trust appear to have had some antenatal care in their home country including scans however this information is not transferable or consistent so requires all offers of screening to be repeated when booking within the Trust. The Antenatal and Newborn Screening Team have seen a marked increase in haemoglobinopathy testing which includes thalassaemia and sickle cell testing for both parents and some challenges can be faced when arranging blood tests for fathers.

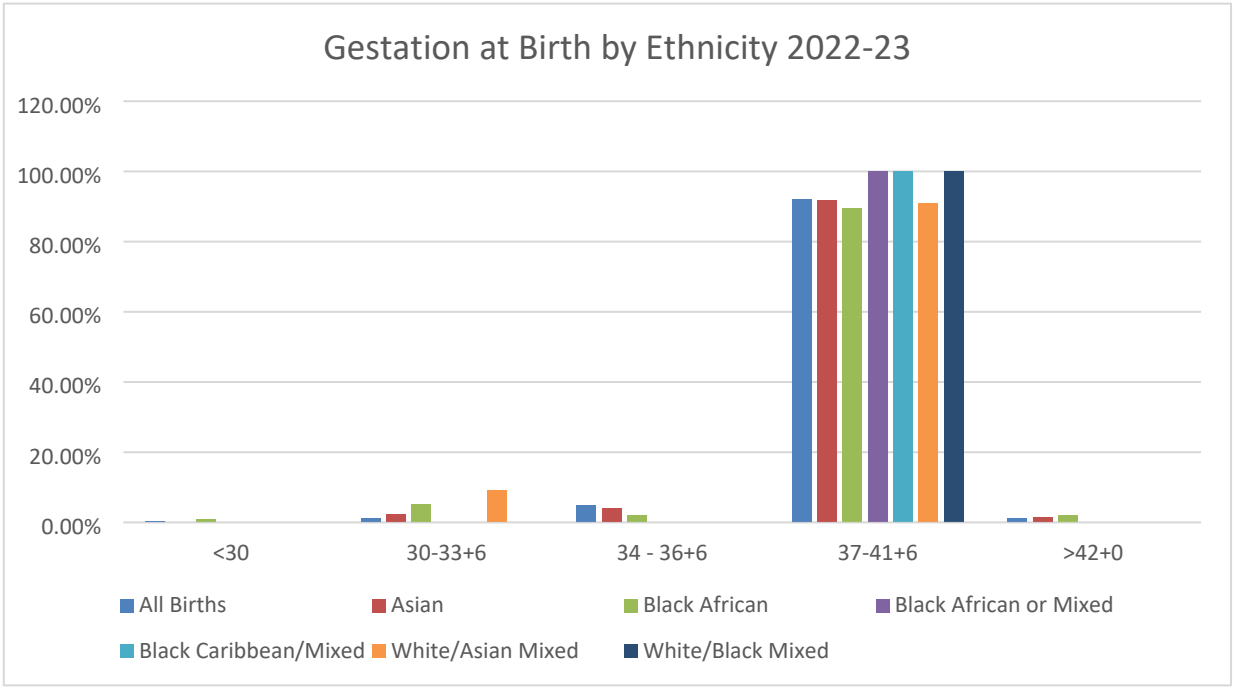


Our most recent Perinatal Mortality Reporting Tool report published to Trusts by MBRRACE on 5th May 2023 (and available to the public on 11th May 2023) indicates we have a much lower than average rate of late fetal loss, stillbirth and neonatal death across all BAME groups. However the report does highlight that 6.6% of PMRT cases do not have a recorded ethnicity. In order to ensure our data collection is robust we will need to continue improvement work to have a recorded ethnicity for all patients in ULHT.

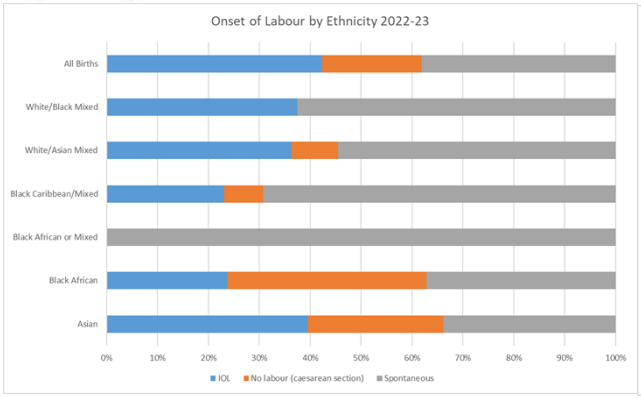


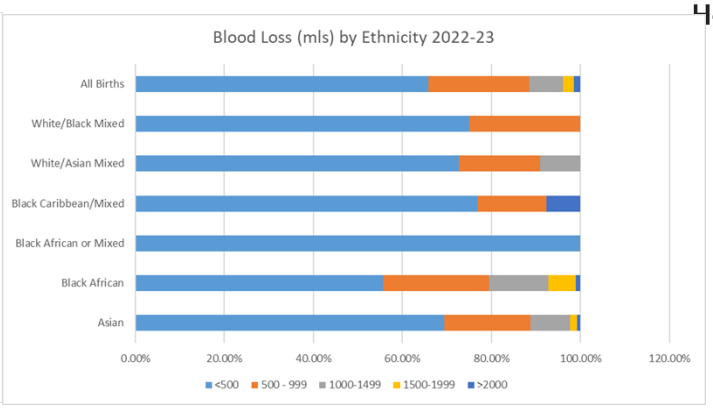
Birth outcomes

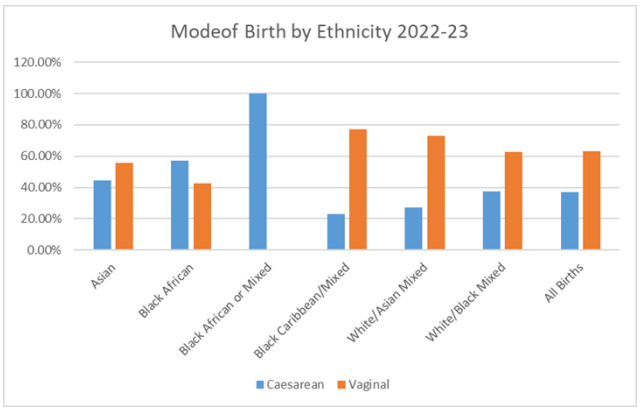
The vast majority of babies across all ethnicities were born at term with a slightly higher than average number of babies born early pre-term to women with any Asian background and also to Black African women.



Black African women are significantly more likely to have a non-labour Caesarean (this could be as a result of unsuccessful induction or elective caesarean). This primarily appears to be associated with women having had a previous caesarean in their home country but requires further data analysis. Black African women were also more likely to have a blood loss over 500ml, over 1000ml, over 1500ml and slightly less likely to have a blood loss over 2000ml than average for the Trust. This may be associated with the increased rates of caesarean birth (in which a blood loss up to 1000ml is expected) however this requires further data analysis as part of the PPH Review & Improvement group.

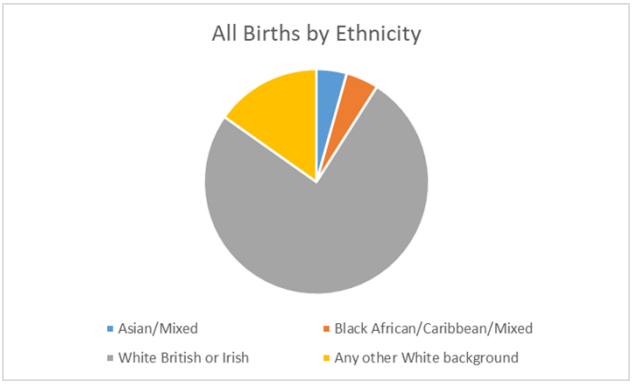




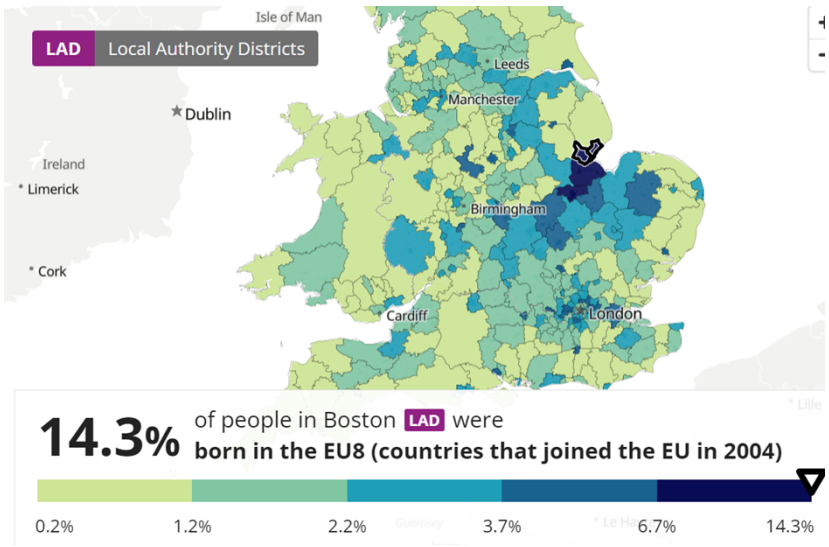


Eastern European

Whilst the national focus is predominantly on outcome for women and babies of BAME backgrounds, ULHT is in the unique position of having a very large Eastern European population which exceeds the BAME population.



This group is largely localised to the Boston region with recent ONS Census data indicating that on average, 18.1% of Boston residents were born in EU8 and EU2 countries with a density of around 30% in some areas of Boston town, the highest concentration of people originating from Eastern Europe in the UK.



Overall 23% of all Boston residents were born outside of the UK.

	Boston	South Holland
EU8 countries(Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia, Slovenia)	14.3%	8.4%
EU2 countries (Bulgaria, Romania)	3.8%	1.8%

Whilst we should not be complacent about the positive outcomes for our BAME population, it would be beneficial to undertake a similar review of our Eastern European population and the unique needs of these women, particularly those who book later in pregnancy, have limited or no English and reside in areas of increased deprivation.

Recommendations

- Digital team and Community Midwifery managers to review and ensure ethnicity is accurately recorded for all records
- ULHT to work with system partners to ensure early access to maternity services for women arriving in the UK, particularly students and dependents of Univeristy of Lincoln
- Review provision of Antenatal and Newborn Screening and ensure processes for haemoglobinopathy screening are able to meet new increased demand
- Include review of ethnicity as part of PPH Review & Improvement Group
- Include ethnicity data in any review thematic incident review, including BAME and Eastern European population data

United Lincolnshire Hospitals NHS Trust

Maternity & Neonatal Safety Assurance Report

Libby Grooby, Divisional Head of Midwifery

As at 15 May 2023

Maternity & Neonatal Safety Assurance Report – Key Highlights

Trust: United Lincolnshire Hospitals NHS Trust **Date:** As at 15 May 2023 (March data)

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

Outliers: Red Flags

KPI	National Rate	Trust Rate	Comments / Actions Being Taken
Smoking at time of delivery	<9.6%	12.10%↓	In house team appointed and now in post NRT now in use by the team Support staff recruited to
PPH ≥ 2L	<1.30%	2.42%↑	Improvement in month New guideline launched. Need to continue to monitor Maybe associated with the weighing of blood loss
PROMPT Training	>90%	89.83%↑	Drop off in month. CNST standard reached. All staff allocated onto training. Normal fluctuation, increased activity in month pulled staff from training although PROMPT is prioritised.
3rd and 4th degree tears		2.69%↓	First month red Suggest deep dive for next MNOG
No of PN admissions up to 42 days		4.03%↑	See deep dive
Sickness		5.43%↓	Second month red, driven by increased short and long term sickness, spike in covid Managed appropriately
Neonates			
Sickness - Neonates	Trust rate 4%	LCH 4.8%↑ PHB 10.3%↓	Reg'd/Unreg'd - All being managed but has been escalated to PRM
Hypothermia	0	LCH 2 - PHB 3 -	Relaunched warm bundle One BBA
QIS	70%	57% - LCH 72% - PHB	Clear trajectory and robust education programme and all new staff attend the network foundation programme for pre QIS training.

New SPC charts that sit alongside the rag rated dashboard are going to prove incredibly helpful in supporting our QI projects and areas of concern that we need to concentrate on. An example for April is attached and will be the focus for discussions in months moving forward.

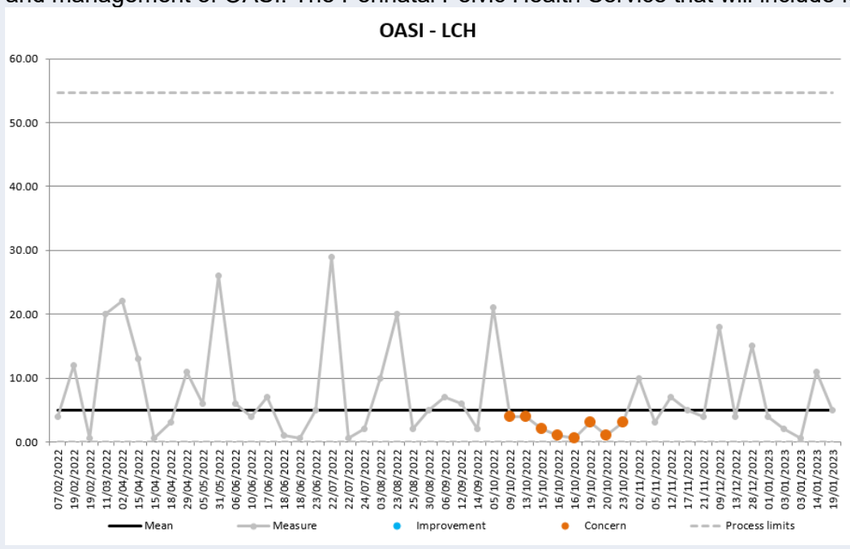
Apr 23 SPC chart narrative.docx

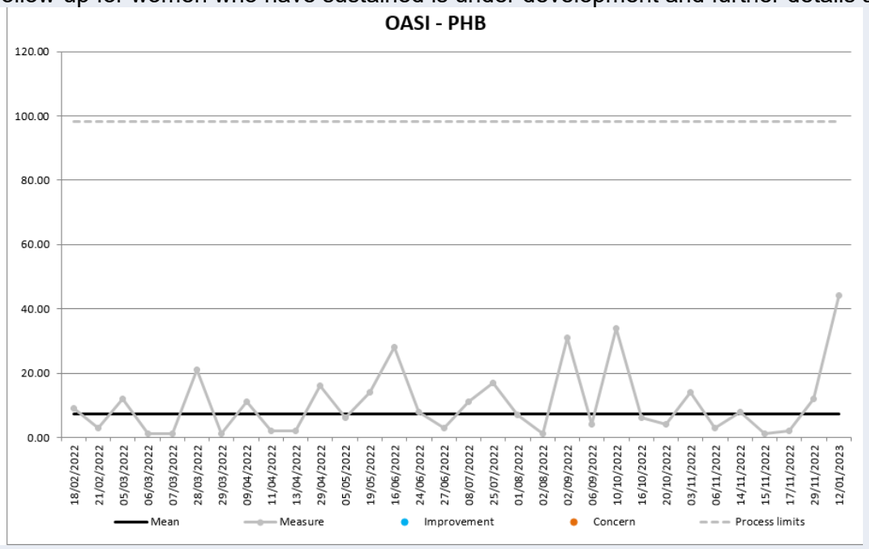
‘Deep Dives’

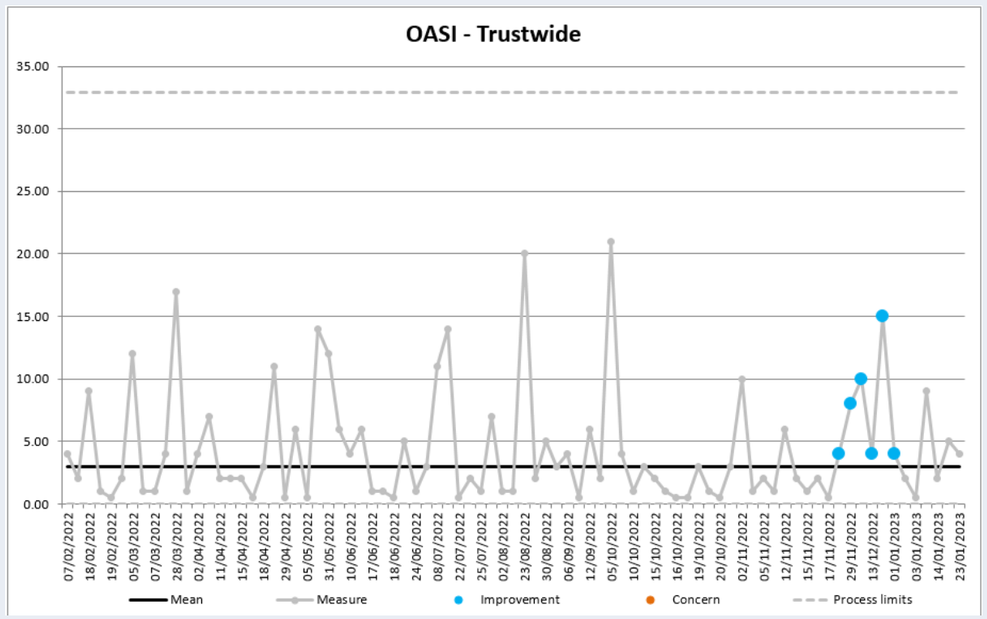
This section of the report provides high level reporting on specific ‘Deep Dives’ arising from either incidents or outliers: red flags including as requested by the Maternity & Neonatal Oversight Group.

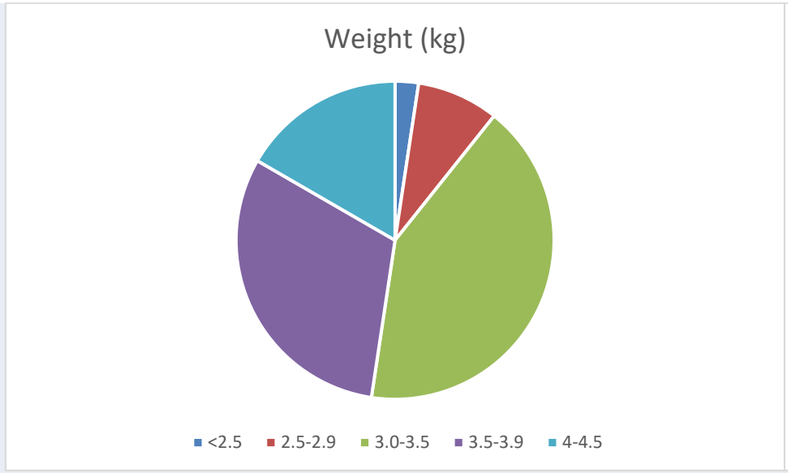
OASI Review

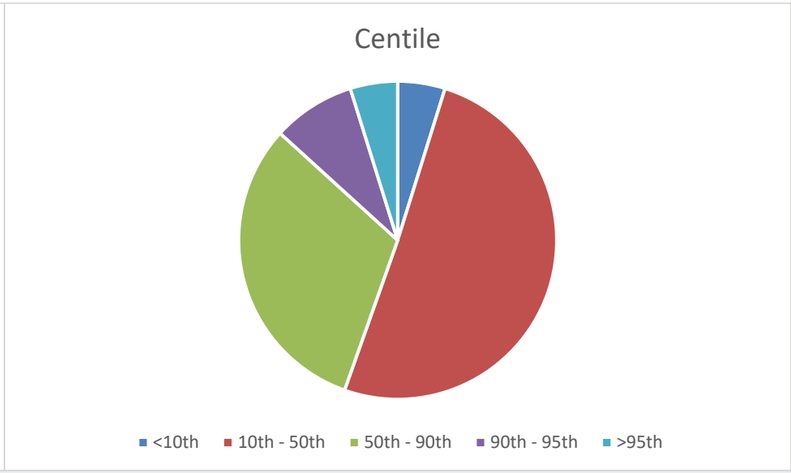
This review did not identify any trends and trust wide improvements were identified when analysed on rare events charts. Although the numbers of OASI remain well within acceptable limits, teaching continues on the prevention and management of OASI. The Perinatal Pelvic Health Service that will include follow-up for women who have sustained is under development and further details are documented in this report.

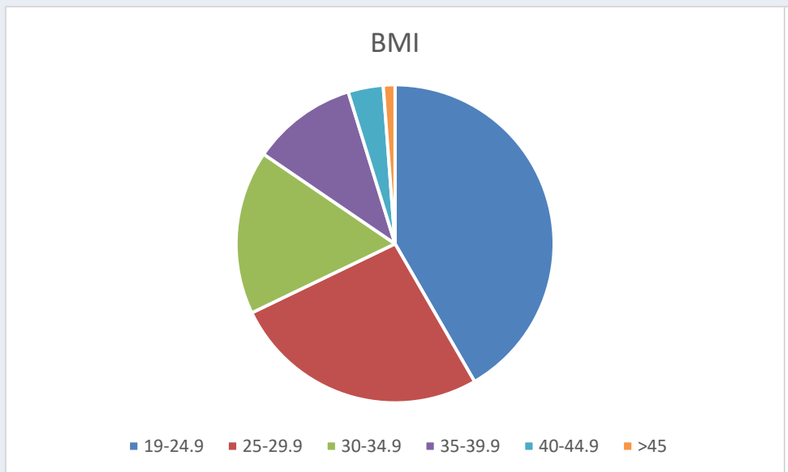


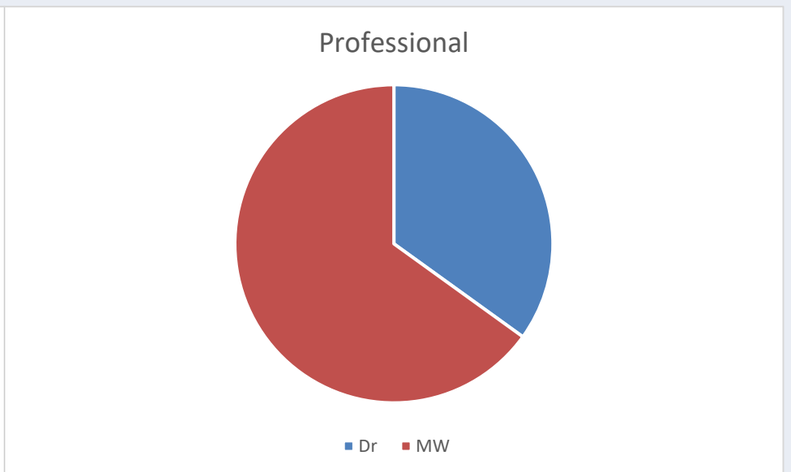












Perinatal Pelvic Health Service

The NHS Long term Plan (2019) outlined the ambition to provide Perinatal Pelvic Health Services across England. The Perinatal Pelvic Health Service has three overarching responsibilities to

- embed evidence-based practice in antenatal, intrapartum and postnatal care
- prevent and mitigate pelvic floor dysfunction resulting from pregnancy and childbirth,
- improve the rate of identification of pelvic floor issues antenatally and postnatally and to ensure timely access to NICE recommended treatment for common pelvic health issues antenatally.

The current service provision is mixed and pathways vary between sites. The proposed Perinatal Pelvic Health Service seeks to standardise the pathways of care, education for staff and education for women and birthing people.

The proposed service will be led by a multi-disciplinary team including a Women's Health Physiotherapist, Specialist Midwife and Urogynaecologist. A hub and spoke model is proposed with satellite sites across the county. This will ensure easy-access for women and birthing people with referrals for further review and follow-up as indicated. Women will be initially seen in a joint physiotherapy and midwifery led clinic and referred for further urogynaecology input as required.

We have had support from the Regional maternity team to develop and test this service. A number of test clinics have been run. Although only small numbers of women have attended feedback has been positive.

The LMNS has confirmed that £138,000 is available to support the development of this service from 23/24 transformation funding. The available funds will be used to fund a Band 7 Project Lead Specialist Midwife, a Band 6 Specialist Physiotherapist and for other equipment.

Development of guidelines and a standard operating procedure is ongoing and the plan is for the service to be fully up and running by September 2023.

Learning Lessons

Overview for the reporting period:

As at 1 May 2023, there were 97 (118 last report) open incidents for Obstetrics & Community Midwifery, 47 (42 last report) of which are overdue.

There were 13 (14 last report) open incidents in Neonates, 10 (2 last report) of which are overdue.

As at 1 May 2023, there was one (308286) Serious Incidents (SI) open in Obstetrics and none in Neonates.

6 open cases being investigated by HSIB - IDs 295891, 296364, 294094, 305131, 309592, 307455, with 3 being overdue.

There was one closed SI for Obstetrics – 303051 but none for Neonates and no closed HSIB cases.

ULHT SI Update – see below

LMNS Report May 2023.docx

SPC Charts to demonstrate data relating to Datix and SI actions

SPC Chart for MNOG May 2023.xls

Specific Requirements	Number	Details	Learning / Actions Taken
Number of incidents graded as moderate or above (reported April 2023)	1 – Obstetrics 0 - Neonates	1. 309592 – HSIB Referral. Baby sent out for cooling. HIE confirmed on MRI.	1. Agreed at SI Panel that this did meet the HSIB referral criteria as the baby required transfer to a tertiary centre for active cooling and as such this needs to be reported as a SI. No ULHT care delivery issues have been identified - it would have been reasonable to call for a Cat 1 CS on commencement of the CTG however this would unlikely have resulted in an earlier delivery and as such did not impact on patient outcome.
Other Incidents considered at SI / Rapid Review Panel **(April 2023)**	2 – Obstetrics 0- Neonates	17.4.2023 **308468** Hysterectomy- agreed this did not meet SI criteria as no care delivery issues identified. 17.4.2023 **309207** 32/40 EM LSCS PET, PPH, ICU admission - LCH **DI declared**	
Serious Incidents - New – declared April	2 - Obstetrics 0 – Neonates	1. **308286** – Gynae patient Cyst identified that is cancerous that was present in pregnancy and could have been followed up postnatally. 2. **309592** – HSIB referral accepted. Baby sent for cooling.	
Serious Incidents – Closed (April 2023)	1 – Obstetrics 0 – Neonates	1. **303051** - P0 CAT 1 section for bradycardia. 1.5l pph. Returned to theatre for EUA due to ongoing bleeding Total ebl 4800ml. DIC Transferred to ICU.	Report awaiting approval by ICB/SIRG. 1. The guidance for MEWS observations was not followed after labour. 2. There was a delay in return to theatre, delay in giving blood and delay in escalation to the consultant on call. 3. This patient is undergoing dialysis treatment and the renal function is likely to have been damaged by the PPH in a way that may not fully recover. 4. The lack of recognition, escalation and action during the patient's care surrounding blood loss and resulting lack of urine output is the likely root cause of ongoing medical concerns.

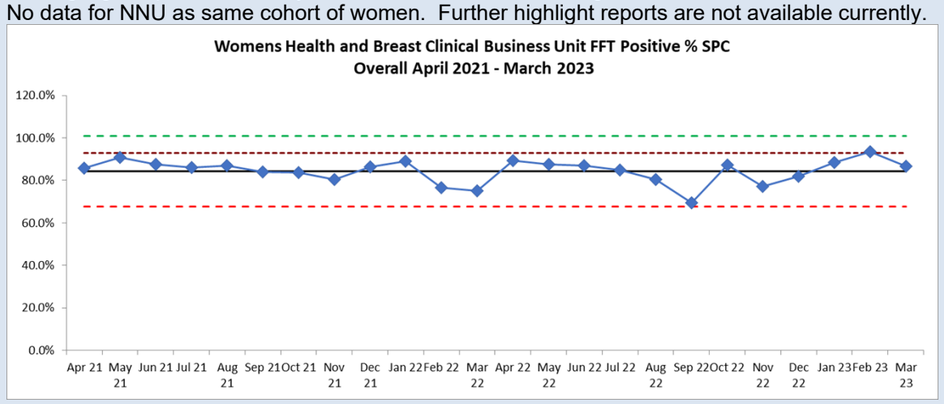
HSIB Investigations	6 current	1. 294094 - 2. 305131 - 3. 295891 - 4. 295364 - 5. 309592 - 6. 307455 -	
Key themes & trends Identified from the above incidents and any additional actions being taken		Clinical oversight CTG abnormal from admission, 20:00 hrs suspicious, then pathological Use of oxytocin on an already compromised baby – fit for labour stickers Use of interpreters Lack of holistic assessment in labour Lack of placental histology Delay in recognition and management of deteriorating patient Ongoing review of all open SI/DI/HSIB actions.	
Number of overdue actions from incidents / SIs / HSIB and actions being taken		As at 1 May 2023, in Obstetrics, there were 95 (95 last month) ongoing actions – 65 of these are overdue. In Neonates there were no outstanding actions. Weekly action plan meetings continue- teams/leads to identify any actions that may require support/resources or date extensions if unachievable.	

Service User Voice Feedback

Brief overview for the reporting period:

As at 1 May 2023, there were 9 open complaints in Obstetrics & Community Midwifery, 2 of which are overdue (including one Ombudsman case and one ongoing). There is one open complaints in Neonates.

There were 5 PALS concerns received in Obstetrics in March but currently no open PALS contacts.

Specific Requirements	Number	Details	Learning / Actions Taken
Number of complaints received in April	5 – Obstetrics 0 - Neonates	1. P36989 – 2. L36882 – 3. L36745 – 4. L36679 – 5. P36637 -	
Number of PALS received in March	5 – Obstetrics 0 - Neonates	1. 36247 2. 36370 3. 36260 4. 36116 5. 36212	
Number of compliments* ***Information taken from SUPERB (Single Unified Patient Experience Reporting Board)***	0 – Obstetrics 27 – Neonates	Compliments received on Neonates PHB	
Feedback received by Maternity & Neonatal Voices Partnerships			
Key themes & trends identified from the above activity and any additional actions being taken	Continues to be appointments and communication Divisional PEG to be commenced. This will support division in exploring patient experience and learning from themes and trends.		
Number of overdue actions from complaints / PALS and actions being taken	As at 1 May, there were 2 open Obstetric complaint actions, both overdue. There are 0 open Neonatal complaint actions.		
Friends and Family Test	The highlight report for January 2023 shows a National average recommended rate of 93%, a Trust average of 90% and Maternity have achieved 97%. No data for NNU as same cohort of women. Further highlight reports are not available currently.  We see a consistently low number of negative stories from the ‘Care Opinion’ ranging from 0-1 a month. However there is inconsistency in the positive stories ranging from 2 – 25 a month	

Staff Experience & Feedback

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

- Please also refer to the separate report from the Maternity NED 'Safety Champion.
- HoM team discussions have started on both sites monthly. Themes raised are consistent:

  Staffing in periods of high acuity
  Medway
  Environment

  Plans in place to try ways of improving both

Other in month Developments & Updates

For April/May

- Three Year Delivery Plan for Maternity and Neonatal Services

  B1915_ii_Delivery Plan for Maternity and

  B1915_Three Year Delivery Plan for mate
- Three Year Delivery Plan for Maternity and Neonatal Services

  Three Year Delivery Plan Benchmarking.xl

- Received correspondence that the Trust is in the TOP 10 Trusts for detection rates of SGA babies for Quarter 1 (January-March 2023).

Trust Q1 Detection Rate	GAP User Average Q1 Detection Rate
62.4%	43.6%

Update from Neonates –

- Workforce – Lincoln continue to recruit to the RN vacancy and have been successful in doing so. RN establishment now over recruited to following success at a recent careers fair. Agency spend should cease from June 2023 following induction and supernumerary time for all new starters. Ward Manager seconded to Boston for a period of 3 months to cover long term absence of Ward Manager, successful backfill of Ward Manager's post at Lincoln with 2 applicants – this has identified clear succession planning and robust career pathways for staff. Matron seconded into Lead Nurse role for a period of 12 months, backfill to Matron's post in progress. Boston – 1 wte RN out to advert.
- Monies received from National Team – 1 x PDN Band 7 – 22.5 hours per week, 1 x Neonatal Governance Lead, Band 7 – 22.5 hours per week. This again is exciting and much needed for career progression and service improvement. Posts to be advertised shortly following job matching and contracting.
- In process of implementing iNeed project – Trainee ANNP working on the project as part of role.
- 4Bronze accreditation achieved at Lincoln – working towards silver. Boston in process of applying for Bronze.
- AHP workforce – Physiotherapist 0.4 wte commenced in post March 2023, Clinical Psychologist 0.5wte commencing in post June 2023. Dietitian 0.4wte interviews taking place shortly.
- Mandatory training – Lincoln figures have dropped, however robust action plan in place to improve compliance.
- Qualified in Speciality (QIS) at Lincoln has dropped to 46% - training plan in place with a trajectory of reaching 70% within 18 months. Figures have dropped due increase in new starters – robust education plan in place to support all staff.
- Appraisal plan in place – staff have received this well and participating in the appraisal process
- Family Integrated Care recognised as excellent practice with new initiatives implemented. Link Nurse presenting at Best Practice Day on 11.5.23.

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

Escalations from Maternity & Neonatal Safety Collaborative –

- BFI – Lack of capacity to do skills review to support Level 3 accreditation. Extension requested and plan for safety leads to support
- Safety Improvement Plan – it was agreed that a number of embedded actions could be archived.
- New Maternity Dashboard with SPC charts for 2023/24
- Implementation of Antenatal Toolkit in partnership with Better Births.

Appendix A

ULHT Maternity & Neonatal Quality Dashboard 2022/23

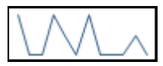
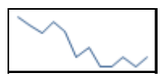
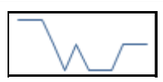
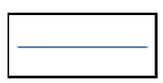
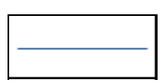
Activity Indicators ULHT

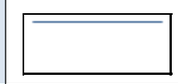
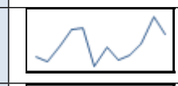
Metric	Threshold R	A	G	Data Source/ Standard	YTD	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	Total	Performance	Comments
Total Number of bookings benchmarked to 5200				Careflow Maternity (CM)		487	522	474	468	482	428	427	486	436	486	461	483	5640		
Women booked by 9+6 weeks	<67.50 %		>67.50%	CM/HES Data 2021		70.64%	67.24%	68.78%	68.16%	72.82%	73.36%	71.43%	71.81%	71.79%	67.90%	73.97%	71.84%	70.81%		
Women booked onto Continuity Pathway	<22%		>22%	CM/ULHT default plan		22.59%	20.69%	25.74%	19.44%	19.29%	24.53%	21.31%	25.31%	18.58%	24.69%	20.39%	18.22%	21.73%		
BMI >25 at Booking				CM/PHE 2018		53.18%	56.51%	55.06%	55.98%	56.22%	53.04%	53.63%	57.41%	55.50%	58.44%	55.97%	58.59%			
BMI >35 at Booking				CM/PHE 2018		12.94%	13.22%	13.50%	13.68%	12.45%	11.68%	11.94%	13.37%	13.76%	15.64%	13.88%	15.32%			
BMI >40 at Booking				CM/PHE 2018		5.95%	4.79%	5.27%	3.63%	5.19%	5.14%	4.68%	5.56%	5.50%	4.53%	4.77%	3.73%			
Total number of Births				CM		367	363	362	393	385	384	405	389	377	386	333	376	4520		
Total Number of Live Births				CM		365	363	362	391	384	384	404	389	377	384	332	374	4509		
Unassisted Vaginal Birth Rate	<57%		>57%	CM/HES Data 2020		54.22%	55.65%	51.10%	50.38%	54.55%	51.04%	53.83%	52.70%	50.13%	54.15%	58.26%	50.27%	53.02%		
Home Birth Rate	<2.40 %		>2.40%	CM/ONS 2020		1.09%	2.48%	2.76%	1.02%	1.30%	2.60%	2.22%	0.77%	2.92%	1.55%	1.20%	2.13%	1.84%		
Forceps and Ventouse	>12%		<12%	CM/HES Data 2020		10.08%	10.74%	9.67%	11.20%	9.09%	9.90%	7.90%	10.28%	11.14%	7.51%	7.21%	7.18%	9.33%		
Total Caesarean Section Rate				CM		34.88%	31.96%	38.40%	37.40%	35.58%	38.02%	37.04%	35.99%	38.20%	37.05%	32.73%	41.49%	36.56%		
Emergency Caesarean Section				CM		21.80%	20.11%	23.20%	20.36%	23.64%	21.09%	20.99%	21.34%	27.59%	23.83%	20.12%	26.33%	22.53%		
Elective Caesarean Section				CM		13.08%	11.85%	15.19%	17.05%	11.95%	16.93%	16.05%	14.65%	10.61%	13.21%	12.61%	15.16%	14.03%		
Women booked on Continuity Pathway received care in labour/birth by continuity Team	<70%		>70%	CM/NHSIE		40.00%	23.08%	34.04%	10.59%	29.41%	32.84%	34.07%	21.62%	21.69%	38.27%	20.00%	27.54%	27.76%		
Induction of Labour Rate	>40%		<40%	CM/HES Data 2021		38.46%	41.46%	38.76%	36.69%	36.13%	41.16%	33.75%	39.06%	41.71%	38.32%	39.88%	37.37%	38.56%		
Smoking at Booking				CM/MSDS 2021		13.76%	14.94%	18.99%	15.81%	13.07%	14.72%	13.58%	16.26%	12.16%	15.43%	12.36%	10.77%	14.32%		

Smoking at the time of Delivery	>9.6%		<9.6%	CM/NHSD 2021		14.29%	11.48%	14.89%	17.31%	14.40%	16.36%	15.25%	13.28%	17.91%	14.96%	12.27%	12.10%	14.54%		
GDM at delivery				CM		13.74%	14.29%	13.48%	17.05%	21.73%	13.98%	19.25%	20.83%	18.45%	19.69%	13.80%	13.80%	16.67%		

Maternal Morbidity Indicators ULHT																				
Metric	Threshold R	A	G	Data Source/ Standard	YTD	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	Total	Performance	Comments
PPH ≥1.0 litre	>8.60 %		<8.60%	CM/Obs CYMRU		7.42%	10.08%	11.52%	11.37%	10.99%	14.78%	11.25%	10.42%	12.83%	8.92%	15.34%	13.71%	11.55%		
PPH ≥1.0 litre SVB	>4.90 %		<4.90%	CM/Obs CYMRU		1.92%	3.92%	3.09%	0.78%	1.83%	2.90%	3.50%	1.56%	1.60%	2.36%	4.91%	3.49%	2.66%		
PPH ≥1.0 litre Instrumental	>18.40%		<18.40%	CM/Obs CYMRU		1.37%	0.84%	1.12%	3.10%	1.83%	3.17%	1.25%	2.08%	2.67%	1.31%	2.76%	1.08%	1.88%		
PPH ≥ 1.0litre EL/LCS	>8.50 %		<8.50%	CM/Obs CYMRU		1.37%	1.68%	1.69%	4.39%	1.57%	2.37%	3.00%	2.60%	1.07%	1.05%	3.07%	2.96%	2.24%		
PPH ≥ 1.0litre EM/LSCS	>19.80%		<19.80%	CM/Obs CYMRU		2.75%	3.64%	5.62%	3.36%	5.76%	6.33%	3.50%	4.17%	7.49%	4.20%	4.60%	6.18%	4.80%		
PPH ≥2.0 litre	>1.30 %		<1.30%	CM/Obs CYMRU		0.27%	0.84%	1.40%	0.52%	1.31%	1.06%	1.75%	2.34%	1.34%	1.84%	2.15%	2.42%	1.44%		
3rd and 4th degree Tear	>3%		<3%	CM/OASI post-bundle stats		2.47%	1.12%	2.53%	1.29%	1.57%	1.32%	3.00%	2.86%	0.80%	1.84%	3.37%	2.69%	2.07%		
Admission to ITU	>1		0	Inpatient Matron		0	1	2	0	0	0	1	0	1	0	1	2	8		
No of PN Readmissions up to 42 days of birth	>3.40 %		<3.40%	Self serve NMPA 2021		4.12%	2.24%	4.78%	3.62%	3.14%	3.69%	4.00%	2.08%	5.08%	3.15%	3.68%	4.03%	3.63%		

Neonatal Mortality & Morbidity Indicators ULHT																				
Metric	Threshold R	A	G	Data Source/ Standard	YTD	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	Total	Performance	Comments
Unexpected Term admissions to the NICU (based on Term births)	>5%		<5%	NNU/NHSIEATAIN project		6.90%	4.68%	6.34%	5.21%	5.73%	6.41%	6.90%	5.46%	9.01%	4.90%	8.22%	7.31%			Reports 1 month behind.
No. of babies transferred for therapeutic cooling	>1		0	NNU		0	0	1	0	1	1	0	0	0	0	0	0	3		

Metric	Threshold R	Threshold A	Threshold G	Data Source/ Standard	YTD	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	Total	Performance	Comments
Pre-Term Birth 23+0-36+6 wks	>6%		<6%	CM/SBL		4.90%	5.79%	8.56%	7.12%	9.35%	5.47%	5.93%	5.91%	5.84%	9.59%	6.61%	9.04%	7.01%		
No. of Antenatal stillbirths	≥1			CM		2	0	0	2	1	0	2	0	0	0	1		8		Mar 23 - 1 LCH stillbirth, awaiting PM results for whether antenatal or intrapartum
No. of Intrapartum stillbirths	≥1			CM		0	0	0	0	0	0	0	0	0	1	0		1		
Rolling stillbirth rate (12 months)	>3.8 per 1000		<3.8 per 1000	CM/ONS 2020		3.43	3.23	3.03	3.28	3.08	2.44	2.67	2.20	2.21	2.44	2.22	2.43			
No. of NND	≥1			CM and NNU		0	0	0	0	0	1	0	0	0	1	0	0	2		Sept - 21 day old baby transferred from home to ED
Rolling NND rate (12 months)	> 2.2 per 1000		<2.2 per 1000	CM and NNU/ONS 2020		0.64	0.65	0.65	0.44	0.22	0.44	0.22	0.22	0.22	0.44	0.44	0.44			
AN Steroids Eligible / Full course Administered	<100%		100%	NNU		5/1	4/1	5/3	9/2	15/5	6/1	3/2	4/1	3/1	10/3	4/4	4/2			
AN Magnesium Sulphate Eligible / Administered	<100%		100%	NNU		2/2	0/0	2/2	3/3	2/2	1/1	0/0	1/1	1/1	4/2	1/1	1/1			
SGA detection rate	< 41.2%		>41.7%	ANC/SBL Perinatal Institute		57.14%	69.38%	46.00%	55.77%	63.24%	59.18%	71.43%	50.94%	57.89%	64.71%	58.69%	54.55%	54.25%		

Workforce Indicators ULHT																					
Metric	Threshold R	Threshold A	Threshold G	Data Source/ Standard	YTD	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	Total	Performance	Comments
Midwife to Birth Ratio (funded)	01:27		01:26			01:26	01:26	01:26	01:26	01:26	01:26	01:26	01:26	01:26	01:26	01:26	01:26			
Midwife to Birth Ratio (Actual)	01:27		01:26			01:25	01:25	01:25	01:27	01:26	01:26	01:28	01:26	01:26	01:26	01:23	01:26			
1-1 in labour	<99%		>99%	CM/CNST		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	99.47%	100.00%	100.00%	100.00%	100.00%	100.00%	99.96%		
Sickness Rate	>4.3%		<4.3%	Workforce Intelligence		4.10%	3.83%	4.73%	5.65%	5.72%	3.54%	4.66%	3.95%	4.24%	4.81%	6.44%	5.43%	4.76%		
Co-ordinator Supernumerary	<96%		>99%	Inpatient Matron/CNST		90.00%	96.50%	96.00%	92.23%	93.75%	95.00%	97.55%	99.70%	100.00%	100.00%	100.00%	100.00%	96.73%		
Prompt Training Compliance	<90%		≥90%	CE team/ CNST		83.31%	81.64%	68.55%	69.54%	65.22%	69.67%	76.97%	93.44%	92.87%	90.44%	88.74%	89.83%	80.85%		
Mandatory Training Compliance	<90%		≥90%	CE team/ CNST		92.31%	83.52%	84.15%	81.58%	86.04%	84.67%	87.88%	91.29%	90.91%	90.60%	88.72%	85.98%	87.30%		

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

		Trained	Possible	%
PROMPT	Lincoln MW	149	171	87.13
	Lincoln Drs	26	31	83.87
	Lincoln Anaes	20	22	90.91
	Lincoln HCSW/MSW	40	44	90.91
	LCH Prompt	235	268	**87.69**
	Bank Only MW (Trustwide)	16	18	**88.89**
	Pilgrim MW	85	100	85.00
	Pilgrim Drs	21	23	91:30
	Pilgrim Anaes	21	22	95.45
	Pilgrim HCSW/MSW	23	24	95.83
	PHB Prompt	150	169	**88.76**
	Trust Compliance Prompt	401	455	**88.13**

Recovery Training Compliance

	LCH		**PHB**	
	Number	%	Number	%
Nov 21	85/121	70%	66/75	88%
Oct 21	24/64 Increased number of staff needing training after this to include COCOs	37.5%	20/44	45%
March 22	52/110	47%	50/67	75%
June 22	65/110	59.09%	61/67	91.04%
Sept 22	73/111	65.7%	61/67	91.04%
Feb 23	92/130	70%	62/70	89%
Apr 23	104/131	79%	68/75	90%

Postnatal Indicators ULHT																			
Metric	Threshold R	A	G	Data Source/ Standard	YTD	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	Total	Performance	Comments
Skin to Skin Contact at Birth	<80%		>80%	CM/HES 2021		78.90%	78.79%	75.41%	76.21%	80.47%	75.78%	83.17%	80.72%	82.49%	82.03%	78.92%	81.82%	79.56%		
Breastmilk at first feed	<68%		>68%	CM/HES 2021		61.64%	64.19%	66.02%	65.22%	64.58%	60.16%	70.30%	66.32%	68.70%	64.58%	65.96%	67.11%	65.40%		Jul, Sep & Oct updated Dec 22

Risk Management Indicators ULHT																			
Metric	Threshold R	A	G	Data Source/ Standard	YTD	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	Total	Performance	Comments
No. of unit closures	≥1		0	Inpatient Matron		2	1	3	2	2	2	1	0	1	1	1	2	18		
Number of incidents logged & graded as moderate or above				Risk (Datix)		3	1	3	0	0	3	3	2	1	2	1		19		
No. of SI's Maternity	≥1		0	Risk (Datix)		0	1	1	1	0	0	0	1	0	0	0	0	4		
No. of Never Events	≥1		0	Inpatient Matron		0	0	0	0	0	0	0	0	0	0	0	0	0		
No. of HSIB cases	≥1		0	Risk (Datix)		0	0	1	0	0	0	3	0	0	1	0	0	5		HSIB cases corrected Dec 22
PMRT commenced within CNST timeframe	<95%		≥95%	Bereavement Midwife		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%		
PMRT completed within CNST timeframe	<50%		≥50%	Bereavement Midwife		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%		
Duty of Candour (verbal)	<100%		100%	Risk (Datix)		100.00%	100.00%	N/A	N/A	N/A	N/A	N/A	N/A	100.00%	N/A	N/A				Reports one month behind
Duty of Candour (Written)	<100%		100%	Risk (Datix)		100.00%	100.00%	N/A	N/A	N/A	100.00%	100.00%	N/A	100.00%	N/A	N/A				Reports one month behind
No of current coroners cases / inquests pending				Legal		0	0	0	0	0	0	0	0	0	0	0	0	0		
No of coroners Regulation 28 (prevention of future death reports) made direct to the trust)				Legal		0	0	0	0	0	0	0	0	0	0	0		0		
No of Formal Complaints				Complaints		1	1	1	4	1	1	3	0	1	3	4	1	21		

Perinatal Mortality Report – March 2023

Hospital	Loss Category	Date	Gestation	Case Summary	MBRRACE Case No.	MBRRACE Notified	CNST Standards draft deadline date	DATIX Panel SI
LCH	Misc	03/03/23	16/40	P1, MCMA Twins, no fetal heart beats on USS at QMC 15+5.	N/A	N/A	N/A	No
PHB	SB	03/03/23	39+6	P2, EFW 100th centile. shoulder dystocia.	86356	06/03/23	N/A	307455 Yes HSIB
LCH	SB	12/03/23	26+5	P1, recurrent APH, spont birth at home. Circumvallate placenta found on PM	86590	20/03/23	N/A	308034 ? ?
LCH	MTOP	25/03/23	17+6	P2, T21	N/A	N/A	N/A	No
LCH	Misc	23/03/23	23+4	P1, IVF, HC<3rd centile on anomaly USS. No Fh on scan at 23/40	N/A	N/A	N/A	308829 No No
LCH	MTOP	30/03/23	19+4	P1 (Prev SB @ 25/40), essential hypertention. SROM.	N/A	N/A	N/A	No

April 2023

Hospital	Loss Category	Date	Gestation	Case Summary	MBRRACE Case No.	MBRRACE Notified	CNST Standards draft deadline date	DATIX Panel SI
LCH	MTOP	03/04/23	21+5	P0+2 Cardiac anomaly and short long bones.	N/A	N/A	N/A	No
LCH	SB	25/04/23	27/40	P0+1, HC & FL <5th centile on anomaly scan. Reduced FM at 27/40-no Fh	87242	02/05/23	N/A	310795 Not yet
PHB	Misc	19/04/23	17+3	P6+2, Prev SB @ 25+6 2021. Attened for private gender scan-no Fh.	N/A	N/A	N/A	No
External PHB	NND	01/04/23	23+5	Smoker, BMI 17.7. Pv bleeding in pregnancy. Untreated UTI and chlamydiain pregnancy. Spont labour and birth at home. Baby transferred to Leicester. RIP 3 days of age	86825	by Leicester	N/A	309189 ? ?
External LCH	MTOP	01/04/23	23+6	Multiple abnormalities	Not known	N/A	N/A	No

Maternity Dashboard 2023/24

Activity Indicators ULHT																					
Metric	Threshold			Data Source/ Standard	Link to Tab	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Average Percentage	SPC Special Cause identified	Comments
	R	A	G																		
Total Number of bookings				Careflow Maternity (CM)	Bookings	420												420			
Women booked by 9+6 weeks	<67.50%		>67.50%	CM/HES Data 2021	BookedBy9+6	69.05%													69.05%		
Women booked onto Continuity Pathway	<22%		>22%	CM/ULHT default plan	BookedToCoCo	21.67%													21.67%		
BMI >25 at Booking				CM/PHE 2018	BMIBooking	58.33%													58.33%		
BMI >35 at Booking				CM/PHE 2018		16.67%													16.67%		
BMI >40 at Booking				CM/PHE 2018		7.62%													7.62%		
Total number of Births				CM	BirthNumbers	335												335			
Total Number of Live Births				CM		334												334			
Unassisted Vaginal Birth Rate				CM/HES Data 2020	NVB	53.43%													53.43%		
Home Birth Rate	<2.40%		>2.40%	CM/ONS 2020	HomeBirth	2.09%													2.09%		
Forceps and Ventouse				CM/HES Data 2020	Forcep&Ventouse	9.85%													9.85%		
Total Caesarean Section Rate				CM	Caesarean	35.82%													35.82%		
Emergency Caesarean Section				CM		24.78%													24.78%		
Elective Caesarean Section				CM		11.04%													11.04%		
Women booked on Continuity Pathway received care in labour/birth by continuity Team	<70%		>70%	CM/NHSIE	ContinuityCare	37.68%													37.68%		
Induction of Labour Rate	>40%		<40%	CM/HES Data 2021	IoL	42.77%													42.77%		
Smoking at Booking				CM/MSDS 2021	SmokingBooking	12.86%													12.86%		
Smoking at the time of Delivery	>9.6%		<9.6%	CM/NHSD 2021	SmokingDelivery	11.45%													11.45%		

Maternal Morbidity Indicators ULHT

Metric	Threshold R	Threshold A	Threshold G	Data Source/ Standard		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Average Percentage	SPC Special Cause identified	Comments
PPH ≥1.0 litre	>8.60%		<8.60%	CM/Obs CYMRU	PPH>1l	13.25%													13.25%		
PPH ≥1.0 litre SVB	>4.90%		<4.90%	CM/Obs CYMRU	PPH>1lSVB	3.92%													3.92%		
PPH ≥1.0 litre Instrumental	>18.40%		<18.40%	CM/Obs CYMRU	PPH>1lInstrumental	1.20%													1.20%		
PPH ≥ 1.0litre EL/LCS	>8.50%		<8.50%	CM/Obs CYMRU	PPH>1lEL/LSCS	2.41%													2.41%		
PPH ≥ 1.0litre EM/LSCS	>19.80%		<19.80%	CM/Obs CYMRU	PPH>1lEM/LSCS	5.72%													5.72%		
PPH ≥2.0 litre	>1.30%		<1.30%	CM/Obs CYMRU	PPH>2l	2.41%													2.41%	H	
3rd and 4th degree Tear	>3%		<3%	CM/OASI post-bundle stats	3rd4thDegTears	1.51%													1.51%		
Admission to ITU	>1		0	Inpatient Matron	ITU	0												0			
No of PN Readmissions up to 42 days of birth	>3.40%		<3.40%	Self serve NMPA 2021	PNReadmissions	2.41%													2.41%		

Neonatal Mortality & Morbidity Indicators ULHT

Metric	Threshold R	Threshold A	Threshold G	Data Source/ Standard		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Average Percentage	SPC Special Cause identified	Comments
Unexpected Term admissions to the NICU (based on Term births)	>5%		<5%	NNU/NHSIE ATAIN project	UnexpectedNICU														#DIV/0!		Reports 1 month behind
No. of babies transferred for therapeutic cooling	>1		0	NNU	Cooling	2												2			
Pre-Term Birth 23+0-36+6 wks	>6%		<6%	CM/SBL	PreTerm	4.78%													4.78%		
No. of Antenatal stillbirths	≥1			CM	AntenatalSB	1												1			
No. of Intrapartum stillbirths	≥1			CM	IntrapartumSB	0												0			
Rolling stillbirth rate (12 months)	>3.8 per 1000		<3.8 per 1000	CM/ONS 2020	RollingSB	2.23														L	
No. of NND	≥1			CM and NNU	NoNND	0												0			
Rolling NND rate (12 months)	>2.2 per 1000		<2.2 per 1000	CM and NNU/ONS 2020	RollingNND	0.45															
AN Steroids Eligible / Full course Administered	<100%		100%	NNU	ANSteroids	33.33%													33.33%		
AN Magnesium Sulphate Eligible / Administered	<100%		100%	NNU	ANMagSulph	25.00%													25.00%		
SGA detection rate	< 41.2%		>41.7%	ANC/SBL Perintatal Institute	SGA	0.00%													0.00%		

Workforce Indicators ULHT																					
Metric	Threshold			Data Source/ Standard		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Average Percentage	SPC Special Cause identified	Comments
	R	A	G																		
Midwife to Birth Ratio (funded)	01:27		01:26			01:26															
Midwife to Birth Ratio (Actual)	01:27		01:26			01:23															
1-1 in labour	<99%		>99%	CM/CNST	1-1Labour	100.00%													100.00%		
Sickness Rate	>4.3%		<4.3%	Workforce Intelligence	Sickness	4.47%													4.47%		
Co-ordinator Supernumerary	<96%		>99%	Inpatient Matron/CNST	Co-ordinator	96.94%													96.94%		
Prompt Training Compliance	<90%		≥90%	CE team/ CNST	PROMPT	88.13%													88.13%		
Mandatory Training Compliance	<90%		≥90%	CE team/ CNST	MMTD	83.39%													83.39%		

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

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

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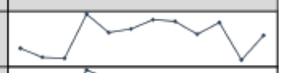
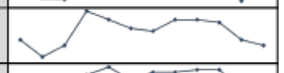
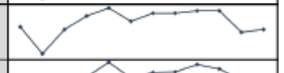
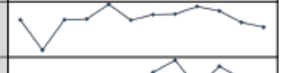
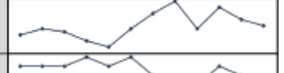
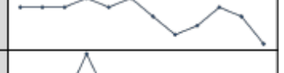
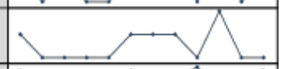
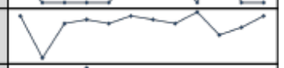
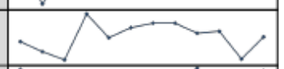
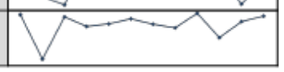
Neonatal Quality and Safety Dashboard - 2022/2023

Lincoln County Hospital

	Performance Measure	2019/20 Total	2020/21 Total	2021/22 Total	2019/20 Monthly Avg	2020/21 Monthly Avg	2021/22 Monthly Avg	YTD/ Average	Apr 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Total	
Neonatal Unit	Live Births	2909	2925	2812	242.4	243.8	234.3	233.2	220	210	209	257	237	241	251	249	235	248	207	234	2798	
	No of all NNU Admissions (including re-admissions, transfers in, etc)	345	326	371	28.8	27.2	30.9	29.8	27	21	25	37	34	31	30	34	34	33	27	25	358	
	No of First Episode Admissions	283	282	299	23.6	23.5	24.9	23.8	22	12	21	26	29	24	27	27	28	28	20	21	285	
	% of First Episode Admissions against Live Births			N/A			11%	10.1%	10.0%	5.7%	10.0%	10.1%	12.2%	10.0%	10.8%	10.8%	11.9%	11.3%	9.7%	9.0%	N/A	
	No of Admissions to TC	152	202	220	12.7	16.8	18.3	19.0	16	18	17	14	12	18	23	27	18	25	21	19	228	
	All Ex-utero transfers	73	62	69	6.1	5.2	5.8	5.3	6	6	6	7	6	7	5	3	4	6	5	2	63	
	Ex-utero transfers <27 weeks	1	2	1	0.1	0.2	0.1	0.3	0	0	0	2	0	1	0	0	0	1	0	0	4	
	In-utero transfers	4	13	11	0.4	1.1	0.9	0.8	1	0	1	0	0	1	1	2	0	2	0	1	9	
	In-utero transfers <27 weeks	0	8	6	0.0	0.7	0.5	0.5	1	0	0	0	0	1	1	1	0	2	0	0	6	
	NNU Term Admissions	143	168	170	11.9	14.0	14.2	13.8	16	5	14	15	14	16	15	14	17	11	13	16	166	
	Live Term Births	2654	2725	2584	221	227	215	216	211	200	191	241	215	226	231	231	220	222	192	216	2596	
	% NNU Term Admissions (Live Term births) - Target <5%	N/A	N/A	N/A	5.4%	6.2%	6.5%	6.4%	7.6%	2.5%	7.3%	6.2%	6.5%	7.1%	6.5%	6.1%	7.7%	5.0%	6.8%	7.4%	N/A	

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Lincoln County Hospital

	Performance Measure		2019/20 Total	2020/21 Total	2021/22 Total	2019/20 Monthly Avg	2020/21 Monthly Avg	2021/22 Monthly Avg	YTD/ Average	Apr 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Total	
Neonatal Unit - continued	Cot Occupancy - %	NNU	N/A	N/A	N/A	68%	63%	69%	71.2%	70.9%	72.5%	58.9%	57.2%	81.3%	80.4%	62.2%	70.0%	81.1%	86.9%	76.2%	56.6%	N/A	
		TC	N/A	N/A	N/A	83%	80%	45%	42.5%	38.8%	30.6%	48.3%	37.5%	40.3%	41.3%	44.0%	51.7%	44.8%	45.2%	52.7%	35.1%	N/A	
		Total (NNU & TC)	N/A	N/A	N/A		67%	61%	62.7%	59.7%	57.9%	55.2%	50.4%	67.0%	66.8%	55.8%	63.6%	86.4%	72.4%	68.0%	49.1%	N/A	
	Hypothermia on Admission - Ep.1 (<36.5ºc) (% of first episode admissions)	NNU	34	53	28	2.8	4.4	2.3	1.2	0	0	1	0	0	2	2	3	2	2	0	2	14	
		TC			15			1.3	1.9	0	3	0	1	1	3	6	1	1	5	2	0	23	
		NNU %			N/A			0.1	4.6%	0.0%	0.0%	4.8%	0.0%	0.0%	8.3%	7.4%	11.1%	7.1%	7.1%	0.0%	9.5%	N/A	
		TC %			N/A			0.1	9.6%	0.0%	16.6%	0.0%	7.1%	8.3%	16.7%	27.2%	3.7%	5.9%	20.0%	9.5%	0.0%	N/A	
	Transferred for Therapeutic Cooling		5	0	4	0.4	0	0	0.2	0	0	0	0	1	1	0	0	0	0	0	0	2	
	HIE (all grades)		8	2	6	0.7	0.2	0.5	0.3	0	0	0	1	1	1	0	0	0	0	0	0	3	
	Neonatal Deaths (following admission to NNU)		0	1	1	0	0.1	0.1	0.0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Neonatal Deaths (delivery room)								0.1	0	0	0	0	0	0	0	0	0	1		0	1	
	Unit Closures (any)		0	2	0	0	0.2	0.0	0.0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	No. of Exceptions		8	13	22	0.9	1.1	1.8	1.1	3	0	1	1	1	2	1	2	0	1	0		12	
	Medication Errors (moderate and above)															0	0		0	0	0		
	No of Serious Incidents (SI)		1	1	1	0.1	0.1	0.1	0.0	0	0	0	0	0	0	0	0	0	0	0	0	0	

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Lincoln County Hospital

	Performance Measure		2019/20 Total	2020/21 Total	2021/22 Total	2019/20 Monthly Avg	2020/21 Monthly Avg	2021/22 Monthly Avg	YTD/ Average	Apr 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Total	
Staffing	Appraisals - % (Target 100%)	Registered and unregistered	N/A	N/A	N/A			86%	89.0%	80.0%	87.2%	86.1%	86.1%	91.7%	92.0%	93.3%	89.4%	91.0%	88.9%	93.3%		N/A	
		ANNPs	N/A	N/A	N/A	75%	75%	71%	79.0%	83.0%	83.0%	71.0%	71.0%	71.0%	85.0%	85.0%	71.5%	83.0%	83.0%	83.0%		N/A	
	Sickness - % (Target - Trust avg <4%)	Registered and unregistered	N/A	N/A	N/A	6.5%	5.1%	6.8%	6.8%	10.5%	11.2%	9.6%	13.1%	6.4%	4.1%	7.2%	1.0%	4.5%	7.4%	1.9%	4.8%	N/A	
		ANNPs	N/A	N/A	N/A	4.0%	0.6%	4.9%	9.7%	3.5%	3.9%	5.7%	26.0%	2.9%	8.4%	18.9%	14.9%	10.1%	7.7%	4.6%		N/A	
	Mandatory training % (Core Learning) (Target >95%)	Registered and unregistered	N/A	N/A	N/A	94%	91%	90%	94.5%	91.0%	95.0%	96.0%	96.0%	96.0%	97.0%	92.0%	94.0%	95.0%	94.0%	93.0%		N/A	
		ANNPs	N/A	N/A	N/A	96%	97%	90%	94.0%	95.0%	93.0%	96.0%	96.0%		92.0%	94.5%	88.0%	94.5%	96.0%	95.0%		N/A	
	Mandatory training % (Core Learning Plus) (Target >95%)	Registered and unregistered	N/A	N/A	N/A	92%	86%	86%	90.1%	85.0%	86.0%	90.0%	95.0%	93.4%	93.0%	89.9%	88.0%	92.0%	90.5%	88.0%		N/A	
		ANNPs	N/A	N/A	N/A	96%	89%	86%	86.6%	90.0%	91.0%	91.0%	91.0%		80.5%	83.0%	84.5%	82.5%	83.5%	88.6%		N/A	
	BLS (Target >95%)		N/A	N/A	N/A	95%	63%	77%	82.3%	31.0%	80.0%	88.0%	88.0%	89.0%	88.0%	89.0%	91.0%	90.0%	83.0%	88.0%		N/A	
	QIS - % WTE (Target >70%)		N/A	N/A	N/A	N/A	N/A	64%	64.2%	63.6%	66.5%	68.0%	69.3%	69.5%	65.3%	63.6%	63.7%	62.8%	57.0%	57.0%		N/A	
	No. of QIS in training - WTE		N/A	N/A	N/A	3.9	4.6	2.3	1.6	2.6	1.6	1.6	1.6	1.6	1.0	1.6	1.6	1.6	1.3	1.3		N/A	
	% staff with in-date NLS (Target 100%)		N/A	N/A	N/A	100%	95%	90%	99.7%	97.2%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100.0%		N/A	

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Pilgrim Hospital, Boston

	Performance Measure	2019/20 Total	2020/21 Total	2021/22 Total	2019/20 Monthly Avg	2020/21 Monthly Avg	2021/22 Monthly Avg	YTD/ Average	Apr 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Total	
Neonatal Unit	Live Births	1762	1612	1798	146.8	134.3	149.8	142.5	145	153	153	134	147	143	152	140	142	136	125	140	1710	
	No of all NNU Admissions (including re-admissions, transfers in, etc)	209	172	218	17.4	14.3	18.2	17.1	18	19	20	10	16	14	16	9	19	18	24	22	205	
	No of First Episode Admissions	175	137	191	14.6	11.4	15.9	15.1	14	18	16	9	15	12	14	9	19	16	19	20	181	
	% of First Episode Admissions against Live Births			N/A			11%	10.6%	9.7%	11.8%	10.5%	6.7%	10.2%	8.4%	9.2%	6.4%	13.4%	11.8%	15.2%	14.3%	N/A	
	No of Admissions to TC	72	65	80	6.0	5.4	6.7	7.1	10	7	8	7	4	8	5	6	14	7	3	6	85	
	All Ex-utero transfers	30	28	23	2.5	2.3	1.9	2.1	2	2	4	1	2	2	2	1	1	3	2	3	25	
	Ex-utero transfers (<32 weeks)	12	7	9	1.0	0.6	0.8	0.6	1	0	1	0	2	0	0	0	0	2	0	1	7	
	All in-utero transfers	20	14	8	2.0	1.2	0.7	0.8	2	2	1	0	1	0	0	0	2	1	0	0	9	
	In-utero transfers (<32 weeks)	15	13	5	1.5	1.1	0.4	0.8	2	2	1	0	1	0	0	0	2	1	0	0	9	
	NNU Term Admissions	87	65	113	7.3	5.4	9.4	8.7	9	11	7	4	6	7	11	6	15	6	12	10	104	
	Live Term Births	1638	1510	1672	136.5	126	139	132	137	142	140	124	134	133	146	135	135	125	112	125	1588	
	% NNU Term Admissions (Live Term births) Target <5%	N/A	N/A	N/A	5.3%	4.3%	6.7%	6.6%	6.6%	7.7%	5.0%	3.2%	4.5%	5.3%	7.5%	4.4%	11.1%	4.8%	10.7%	8.0%	N/A	

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Neonatal Quality and Safety Dashboard - 2022/2023

Pilgrim Hospital, Boston

	Performance Measure		2019/20 Total	2020/21 Total	2021/22 Total	2019/20 Monthly Avg	2020/21 Monthly Avg	2021/22 Monthly Avg	YTD/ Average	Apr 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Total	
Neonatal Unit - continued	Cot Occupancy - %	NNU	N/A	N/A	N/A	46%	44%	42%	37.5%	34.2%	25.4%	64.2%	35.1%	40.7%	36.3%	27.4%	10.4%	20.6%	27.8%	47.3%	80.6%	N/A	
		TC	N/A	N/A	N/A	50%	39%	51%	54.6%	55.8%	80.6%	53.3%	66.1%	40.3%	36.7%	46.8%	22.5%	81.5%	58.1%	58.9%	54.8%	N/A	
		Total (NNU & TC)	N/A	N/A			42%	45%	43.2%	41.4%	43.8%	60.6%	45.4%	40.6%	36.4%	33.9%	14.4%	40.9%	37.9%	51.2%	72.0%		
	Hypothermia on Admission - Ep.1 (<36.5ºc) (% of first episode admissions)	NNU	35	39	30	2.9	3.3	2.5	1.5	4	1	1	0	0	2	1	1	2	2	1	3	18	
		TC			5			0.4	0.2	0	0	0	0	1	0	0	0	0	1	0	0	2	
		NNU %			N/A			0.2	10.8%	28.6%	16.6%	6.3%	0.0%	0.0%	16.7%	7.1%	11.1%	10.5%	12.5%	5.3%	15.0%	N/A	
		TC %			N/A			0.1	3.3%	0.0%	0.0%	0.0%	0.0%	25.0%	0.0%	0.0%	0.0%	0.0%	14.3%	0.0%	0.0%	N/A	
	Transferred for Therapeutic Cooling		2	2	1	0.2	0.2	0.1	0.1	0	0	1	0	0	0	0	0	0	0	0	0	1	
	HIE (all grades)		2	3	2	0.2	0.3	0.2	0.1	0	0	1	0	0	0	0	0	0	0	0	0	1	
	Neonatal Deaths (following admission to NNU)		0	0	2	0	0	0	0.0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Neonatal Deaths (delivery room)								0.1	1	0	0	0	0	0	0	0	0	0		0	1	
	Unit Closures (any)		0	0	0	0	0	0	0.0	0	0	0	0	0	0	0	0			0	0	0	
	No. of Exceptions		24	23	22	2.0	1.9	1.8	1.2	1	1	1	3	2	2	0	0			0	2	12	
	Medication Errors (moderate and above)															0	0			0	1		
	No of Serious Incidents (SI)		0	0	1	0	0	0	0.0	0	0	0	0	0	0	0	0			0	0	0	

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Pilgrim Hospital, Boston

	Performance Measure		2019/20 Total	2020/21 Total	2021/22 Total	2019/20 Monthly Avg	2020/21 Monthly Avg	2021/22 Monthly Avg	YTD/ Average	Apr 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Total	
Staffing	Appraisals - % (Target 100%)	NNU	N/A	N/A	N/A			83%	73.1%	89.0%	85.0%	65.0%	58.0%	70.0%	75.0%	75%	74%			82%	58.0%	N/A	
		Outreach												67.0%	67.0%	100%	100%						
	Sickness - % (Target - Trust avg <4%)	NNU	N/A	N/A	N/A	5.5%	6.3%	6.3%	10.5%	6.3%	3.9%	2.3%	11.0%	14.0%	13.8%	11.8%	15.4%	14.9%	12.0%	10.7%	10.3%	N/A	
		Outreach												0.0%	0.0%	3.2%	0.0%						
	Mandatory training % (Core Learning) (Target >95%)	NNU	N/A	N/A	N/A	95%	96%	98%	97.7%	94.6%	98.0%	98.5%	99.0%	99.0%	95.0%	99.0%	97.0%	98.0%	98.0%	98.9%	97.2%	N/A	
		Outreach												92.0%	92.0%	95.0%	97.0%						
	Mandatory training % (Core Learning Plus) (Target >95%)	NNU	N/A	N/A	N/A	92%	94%	96%	95.8%	97.0%	95.0%	93.0%	96.0%	97.0%	98.0%	99.0%	93.0%	95.5%	92.0%	97.6%	96.2%	N/A	
		Outreach												97.0%	90.0%	90.0%	90.0%						
	BLS (Target >95%)	NNU	N/A	N/A	N/A	97%	99%	96%	93.2%	95.0%	82.0%	92.0%	93.0%	93.0%	96%	96%	97%			96%	92.0%	N/A	
		Outreach												67.0%	67%	67%	67%						
	QIS - % WTE (Target >70%)		N/A	N/A	N/A	62%	67%	70%	74.1%	73.0%	73.0%	75.5%	75.5%	75.0%	75.0%	75.0%	75.0%			72.0%	72.0%	N/A	
	No. of QIS in training - WTE		N/A	N/A	N/A	2.0	0.6	1.5	1.1	2.0	2.0	1.0	2.0	1.0	1.0	1.0	1.0			0.0	0.0	N/A	
	% staff with in-date NLS (Target 100%)	NNU	N/A	N/A	N/A	96%	100%	98%	99.2%	100%	100%	100%	100.0%	92%	100%	100%	100%			100%	100%	N/A	
		Outreach							83.5%						67%		100%					N/A	

FAMILY HEALTH DIVISION

Midwifery Safe Staffing Levels – Bi-Annual Midwifery Staffing Oversight Report
May 2023

1. Executive Summary

The purpose of the report is to-

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

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

ULHT is currently staffed to the Birth rate Plus recommendations of 2021 and the local staffing review that was undertaken by the Director of Nursing in October 2022. There is also a planned further review in June 2023.

The Final Ockenden Report, published March 22, highlights the need for significant investment in maternity staffing in order to deliver on the further 15 immediate and essential actions. Whilst there has been no further guidance on the impact of this report on staffing levels, the trust and the ICB have recognised the need for increased support for our vulnerable women and have supported investment in our specialist teams.

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

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

2. Background

Midwifery staffing across the UK is a challenge in terms of recruitment and retention. ULHT continues to be fortunate and has found that vacancy has been minimal across all areas. There has however been challenges with skill mix as midwives that are more senior retire and are replaced with newly qualified midwives. The Midwifery Education team have developed a detailed preceptorship programme to support

these midwives during their first 12-18 months following qualification. The trust also now has the retention midwives embedded in the team to support the preceptors in their first year.

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

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

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

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

One to One midwifery care in labour is a key safety metric that is reported via Maternity Medway and monitored on the Maternity dashboard monthly at the Divisional Governance meeting, the LMNS and the Maternity and Neonatal Oversight group. The compliance rate is consistently 99-100% on both acute sites. This has been at 100% on the Pilgrim site for 12 months and whilst this fell below 100% on 1 occasion on the Lincoln site this was just down to 99.16%.

Acuity data is also recorded using the Birth Rate Plus tool. The Labour Ward Coordinator inputs workload and staffing information every four hours as a minimum. The report in **Appendix 1** provides a detailed analysis of this data (October 22-March 23) and demonstrates that staffing is adequate for activity more frequently at PHB than at LCH. Staffing gaps are mitigated on both sites with the use of a robust escalation policy which utilises specialist midwives, managers, and in-house escalation and on call midwives to support safe staffing. The acuity data also identifies that there has been an increase in delays experienced in the IOL process. This could be attributed to the general rise in IOL however a monthly review of IOL is in place. Positively Pilgrim site have seen a decrease in the unavailability of breaks and full service closure. This is positive for staff wellbeing and patient experience.

The rosters for the Labour Wards are planned to allow one supernumerary Labour Ward Coordinator at all times. Supernumerary status of the midwifery coordinator is recorded on the Birth Rate Plus tool and reported monthly on the Maternity Dashboard. As data is recorded by the individual team members this allows for variation and potential differences in the perception and data input. This is demonstrated by the dashboard that shows 100% compliance at Lincoln with only one month dipping below the standard at Pilgrim to 96%.

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

For this period supernumerary status of the Labour Ward Coordinator was 96-100% (PHB) and 100% (LCH). Whilst 100% compliance at all times is unachievable as far as the acuity tool is utilised, the

data has been scrutinised to ensure that when the areas are recording that they are no longer supernumerary they are not providing 1:1 care. Therefore, both sites were achieving this standard at the pint of submission of compliance.

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

Overall, we are reassured by these metrics.

4. Actual Versus Planned Midwifery Staffing

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

5. BR+ Safe Midwifery Staffing Ratio

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

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

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

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

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

LCH 1:23
PHB 1:23

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

Whilst the Ockenden report questions the suitability of the Birthrate plus tool for calculating midwifery staffing, with the absence of any guidance of an alternate, this tool continues to be utilised. ULHT have also seen an uplift in specialists and the ward templates which supports a locally agreed needs

assessment for staffing as per Ockenden. There has also been a significant amount of funding received from the National team to support this specialist element.

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

ULHT CURRENT FUNDING		
Description	**Total**	**Skill Mix**
Clinical wte (including Out of scope MSW)	205.47	
RMs		220.47
MSWs in P/N Care		6
MSW - Pilgrim (outside scope of 90/10)		5.26
Non-clinical Midwifery (including matrons, consultant MW and DHoM)	33.2	
TOTAL WTE per Unit	**238.67**	

From the above ULHT has 10.91 WTE over the birth rate plus recommendation which all sits in the non-clinical midwifery budget line. However, all of the specialist have a clinical element to their roles which reduces the specialists and increases the clinical midwifery WTE. The apparent over establishment is due to:

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

This is in line with national recommendation which state; *to fund maternity and neonatal services appropriately requires a multi-year settlement to ensure the workforce is enabled to deliver consistently safe maternity and neonatal care across England.*
Minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the LMNS. This must encompass the increased

acuity and complexity of women, vulnerable families, and additional mandatory training to ensure trusts are able to safely meet organisational CNST and CQC requirements.

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

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

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

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

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

In conclusion-

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

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

- Following further development in ULHT continuity of carer teams a business case needs further work to describe the actions that need to be taken in order to achieve continuity as default.

7. Propose actions for discussion

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

Author **Libby Grooby - Divisional Head of Midwifery/Nursing**

Date May 2023

Appendix 1

MATERNITY ACUITY AND RED FLAG REPORT October 2022 – March 2023

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

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

The following data shows acuity information for the period October 2022-March 2023 and includes only scheduled data entries unless stated otherwise.

Summary

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

Pilgrim hospital's results for the period 0ctober 2022 – March 2023 showed that they were green, on average, 84% of the time, Amber 14% and red only 2% of the time.
This is an improvement on the preceding six months (Green 80%, , Amber 18%, and Red 2%).
As the smaller of the two acute settings, this unit had 828 births in this period. The volume of work is less, as reflected in their staffing templates however this also means that there are fewer midwives for redeployment and escalation during busy times. In part this is mitigated by senior and specialist presence on each site, and the allocation of specialist escalation midwives and a newly introduced pilot, the in-house on call escalation rota.

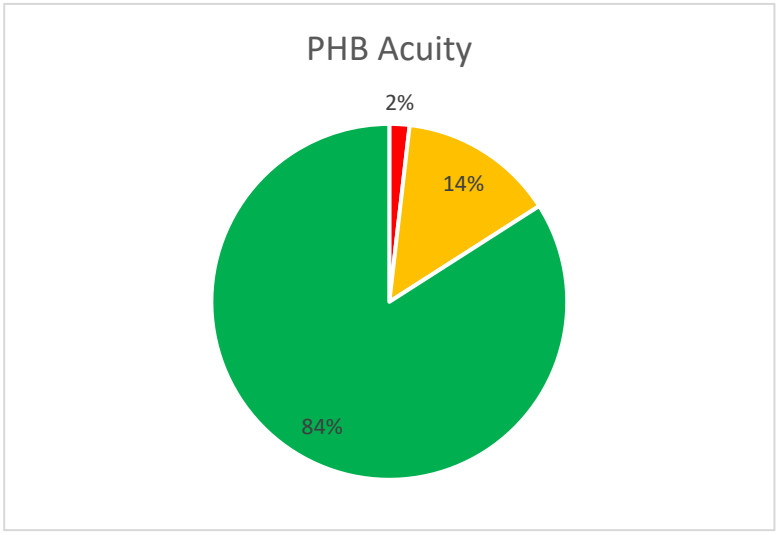
The data shows that staffing is adequate for activity more frequently at PHB than at LCH.

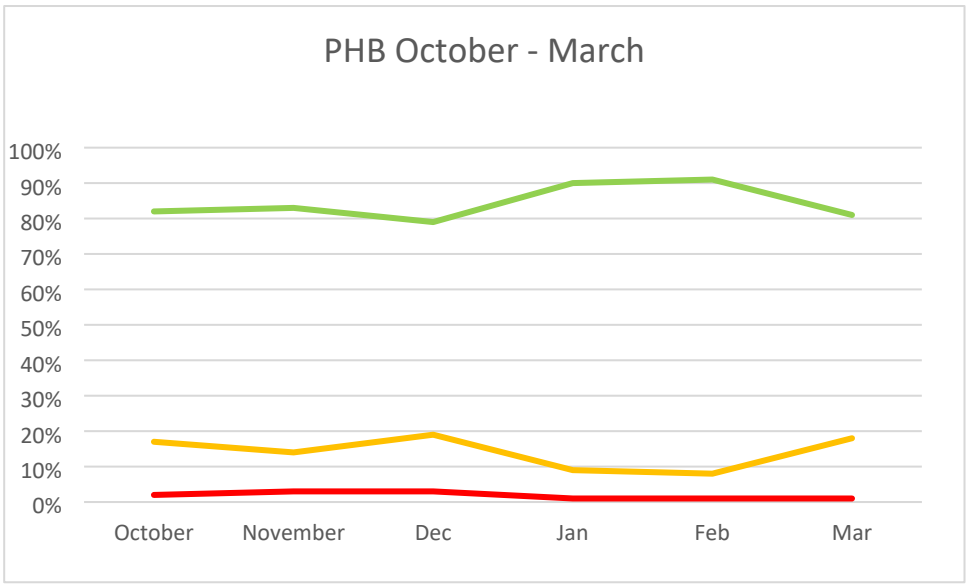
Lincoln hospital's results for the period 0ctober 2022 – March 2023 showed that they were green, on average, 58% of the time, Amber 34% and red 9% of the time. This is broadly similar to the preceding six months (Green 54%, Amber 37%, and Red 9%). As the larger of the two acute settings, this unit had 1373 births in this period. At extremely busy times, we note that the bulk of the volume of work is iatrogenic, as reflected in induction rates. Generally, the Lincoln unit does benefit from an increased number of midwives that can be redeployed/escalated when required and, like Pilgrim, benefits from specialist presence on each site, the availability of specialist escalation

midwives and to a lesser extent than Pilgrim, the newly introduced pilot in-house on call escalation rota.

Pilgrim Hospital Boston

There were 882 data entries during the period, out of a possible 1092, with compliance for data entry at pre-set timed at 86.26% (up 1%).
Acuity met on average, on 84% of data entries:





Staffing factors were recorded for 44.59 of all data entries, this includes unexpected staff absence, unfilled rosters and staff redeployed to another area or on transfer. There has been a slight increase from the last report of the availability of continuity team midwives to the ward, which could be either as a result of more women from those teams choosing to birth at this site, or increased availability of the midwives working in this model.

Breakdown of recorded staffing factors	
Unexpected staff absence	33%
No HCSW on duty	10%
Unable to fill vacant shifts	34%
No ward clerk on duty	1%
Staff redeployed to another area	10%
CoC Midwife present	10%
CoC Midwife not available	2%
Staff on transfer	1%

Clinical actions were recorded for 12.1% of data entries, with the shift leader non-supernumerary decreasing to 20% of this timeframe (but not providing 1:1 care in labour)
There was an increase in delay in ARM but this can be attributed to the general rise in induction of labour, meaning an increase in the women who are eligible for this procedure. There is an ongoing review of the ULHT induction process.

Breakdown of recorded clinical actions	
Shift leader non supernumerary	20%
Delay in ARM >4hrs	64%
Delay in commencing IOL >2hrs	13%
Delay in transferring IOL SRM to labour ward >4hrs	1%
Delay in LSCS > 4 hours	2%
Delay in transferring PROM to LW following Prostin	0%
Refusal of in utero transfers due to acuity	0%

Management actions were recorded for 18.47% of all data entries, an increase from just over 12% in previous analysis. The unavailability of breaks decreased from 35% to 28% in this analysis, and full service closure from 3% to 1%. We did see an increase of patients being transferred within the trust, and that is monitored on an ongoing monthly basis.

Breakdown of management actions	
Redeploy staff internally	27%
Staff unable to take allocated breaks	28%
Escalation to community midwives	19%
Staff stayed beyond rostered hours	7%
Management/specialist midwives supporting clinically	3%
Redeploy staff from non-clinical duties	3%
Patients transferred within Trust	11%
Full service closure	1%

Red flags were recorded on 1.27% of all data entries for the period – 12 occasions in total.

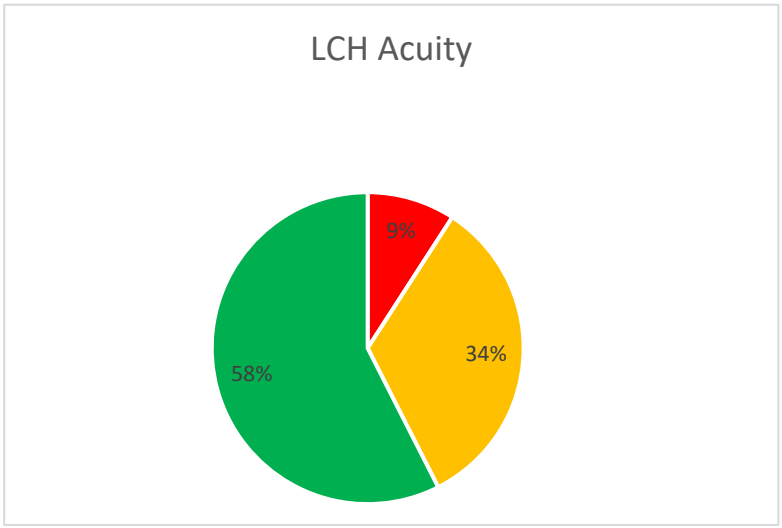
These were:

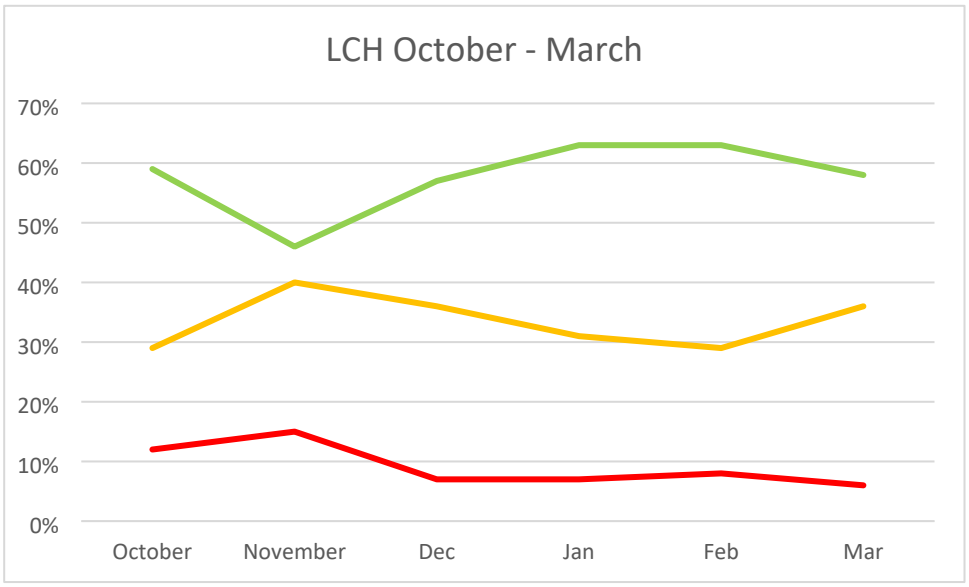
- Delayed or cancelled time critical activity (3 occasions)
- Delay between presentation and triage (1 occasion)
- Delay in suturing 1 hour post-birth (1 occasion)
- Delay between admission for induction and start of process (7 occasions)

Lincoln County Hospital

There were 882 data entries during the period, out of a possible 1082, with compliance for data entry at mandated times at 80.68 (a decrease of around 6%).

Acuity met on 57% of entries with a shortfall of up to 2 midwives on 34% of entries:





Staffing factors were recorded for >90% of entries. The most common factors were 'unexpected staff absence (28%), and 'no ward clerk on duty (23%). There was no CofC midwife available for 16% of the entries, with availability static at 11% of the time

Breakdown of recorded staffing factors	
Unexpected staff Absence	28%
No ward clerk on duty	23%
CoC Midwife not available	16%
Unable to fill vacant shifts	16%
CoC Midwife present	11%
Staff redeployed to another area	3%
Staff absence due to illness/shielding/symptoms of COVID-19	1%
No HCSW on duty	1%
Staff on transfer	1%

Clinical actions were recorded for 51% of data entries:

Breakdown of recorded clinical actions	
Delay in ARM >4hrs	82%
Delay in commencing IOL >2hrs	9%
Shift leader non-supernumerary	2%
Delay in transferring IOL SRM to labour ward >4hrs	4%
Delay in transferring PROM to LW following Prostin	2%
Refusal of in utero transfers due to acuity	0%
Delay in scheduled CS >4hrs	1%

Management actions were recorded for 36.4% of all data entries, with a reduction in full service closure and an improvement in the number of staff staying beyond rostered hours.

Breakdown of management actions	
Redeploy staff internally	32%
Staff unable to take allocated breaks	36%
Escalation to community midwives	15%
Staff stayed beyond rostered hours	8%
Full service closure	0%
Management/specialist midwives supporting clinically	4%
Patients transferred within Trust	2%
Redeploy staff from non-clinical duties	4%

Red flags were recorded on less than 1% of all data entries for the period – 8 occasions. These were:

- Delay between admission and commencement of IOL (3 occasions)
- Delayed or cancelled time critical activity (4 occasions)
- Delayed recognition and action of abnormal vital signs > 1hour (1 occasion)

United Lincolnshire Hospitals NHS Trust

NED Maternity & Neonatal Safety Champion's Report: March/April 2023

Executive summary:

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

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

are all in place.

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

Activities undertaken:

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

2nd March – MPV Meeting
7th March- Public and Private Trust Board
7th March – additional Board Development Session
8th March – LMNS PMO / NED meeting
14th March – Maternity Safety Champion Clinic
14th March – Midlands Safety Champion Discussion
21st March – Neonatal visit – Ward accreditation
21st March – Complaints Team visit
21st March – Chair Quality Committee
21st March – 1:1 with Head of Midwifery
24th March - 1:1 NED /MVP
27th March – MNOG meeting

4th April – Public and Private Trust Board
5th April – LMNS event planning meeting
11th April – Maternity Safety Champion Clinic
12th April – LMNS meeting
18th April – Board Development Session
18th April – Quality Governance Committee
21st April –1:1 NED/MVP
21st April – System QPEC meeting

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

- Estates update in readiness for the meeting with Head of Estates
- Staff drop in clinics
- Planning walk around
- Creating a Regional Community of NED Champions

Learning Lessons:	Service User Voice Feedback:	Staff Experience & Feedback:

• Building on continuity of care teams, targeting towards areas greatest need • Consolidated improvement plan and ensuring evidence objectively reviewed prior to sign off. • Wider Trust improvement projects motivating e.g. productive ward • Increased staff communications and dedicated organisational development support being provided • Wider system work on health inequalities, including weight management, diabetes, and physical exercise.	• Continued theme of Communication during labour • Sensitivity when safeguarding referral is required including documentation and communication with families • Environmental issues at both maternity sites. • Opportunity for families to weigh their babies if bottle-feeding.	• Continued concerns about the Medway IT system/ environment including storage space. Challenges especially on the Lincoln site – the need to keep staff informed of progress • Staff engagement and involvement in future IT system requirements (e.g., plug in v wireless laptops) • Strong Visibility of leadership team • Environmental issues that require progressing as a priority, Pilgrim site – Theatre provision, sanitation pipe leaks and smell, fire door on the neonatal ward • Office facilities for PMA team, Tobacco Team • Excellent Team ethos • Pride of staff • Appreciation for Specialist Midwifes and Safe Guarding Team

Good practice, improvements & innovation to share:

- Advertising new roles for Skegness Community Team
- Achievement of Bronze Ward Accreditation for Lincoln Neonatal team
- Continued support and encouragement through the LMNS team
- Excellent engagement and timely completion of complaints
- Engagement of staff from all areas in the virtual drop in clinics
- Candour of staff
- Correlation with HOM on staff issues and concerns

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

Ongoing

- Status and timing of capital plans at Lincoln site
- Status, timing, and disruption of capital works at Pilgrim site
- Status and implementation of new maternity IT system – whilst this is closer funding and implementation dates have not been agreed as yet.
- Thinking about ways to capture feedback/experience through whole perinatal pathway and across services
- Understanding the impact of COVID on pathways (e.g., vaccination take-up; preterm deliveries etc).

New this month

1. Theatre safety issues at Pilgrim
2. Fire door for the Neonatal unit at Pilgrim

Activities planned:
• Liaising with regional team re Maternity Safety Champion NED regional meeting • Maternity and Neonatal site visits (Lincoln and Pilgrim sites) including Boston Community team. • Compile a video for social media to share the role of the Maternity and Neonatal Safety Champion role and to publicise the virtual drop in clinics • Attending Maternity and Neonatal Oversight Group. • Exploring a system-wide strategic planning session for the ICB Quality Committee

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

Eliminating Mixed Sex Accommodation
Declaration of Compliance

Introduction

Each year the Trust is required to state its commitment to delivering same sex accommodation to our patients and to display this on the Trust website.

The NHS is committed to making sure that all patients receive high-quality care that is safe, effective and focused on their needs. The NHS Constitution states that all patients have the right to privacy and to be treated with dignity and respect. We believe that providing same-sex accommodation is an effective way of helping to achieve this goal and of giving all patients the best possible experience while they are in hospital.

What do we mean by mixed-sex and same-sex accommodation?

- Mixed-sex accommodation is where men and women have to share sleeping areas or toilet and washing facilities.
- Same-sex accommodation is where specific sleeping areas and toilet and washing facilities are designated as either men-only or women-only.

Same-sex accommodation can be provided in:

- Same-sex wards, where the whole ward is occupied by men or women only
- Single rooms
- Mixed-sex wards, where men and women are in separate bays or rooms.
- Toilet and washing facilities should be easily accessible and, ideally, either inside or next to the ward, bay or room. Patients should not need to go through sleeping areas or toilet and washing facilities used by the opposite sex to access their own.

Why is same-sex accommodation so important?

It is clear from what patients tell us that not being in same-sex accommodation can compromise their privacy and dignity at a time when they may already be feeling vulnerable. The most common concerns include physical exposure, being in an embarrassing or threatening situation, noise, and the possibility of other patients overhearing conversations about their condition.

Women, and elderly women in particular, are most likely to worry about this although male patients also say that they feel reluctant to talk openly and find it embarrassing to be in a mixed-sex setting. Some patients are also strongly opposed to mixed-sex accommodation for cultural or religious reasons.

Self-Declaration Statement - Declaration of Compliance

The Trust Board of United Lincolnshire Hospitals NHS Trust confirms that it is working towards eliminating mixed-sex accommodation across our hospital sites Lincoln County Hospital, Pilgrim Hospital in Boston, Grantham and District Hospital and ULHT inpatient wards at County Hospital Louth, unless in the overall best interest of the patient, or reflects their personal choice.

We have the necessary facilities, resources, operational procedures and culture to ensure that patients who are admitted to our hospitals will only share the room where they sleep with members of the same-sex, and same-sex toilets and bathrooms will be close to their bed area. Sharing with members of the opposite sex will only happen where clinically necessary (for example where patients need specialist equipment such as in ICU or cardiac ward or are admitted in an emergency to an assessment unit), or where patients actively choose to share.

If our care should fall short of the required standard, we will report it. We have a robust audit mechanism to make sure that we do not misclassify any of our reports. We will publish the results of that audit on the Trust website.

There are also several single rooms on every ward. These are normally prioritised for patients who are infectious, or are prone to infection. In addition they are used for patients who are very sick indeed or who have a greater need of privacy or may be at the end of their life.

Patients may share some communal spaces on the ward (e.g. dayrooms, dining areas).

On occasions however, clinical need and urgency will mean that patients need to share accommodation with patients of the opposite sex. Where patients require specialist treatment they may be in an area where it is mixed e.g. ITU, high dependency units, coronary care, stroke unit etc.

Where this occurs, it will be closely monitored, patient views will be sought and a plan made to resolve the situation as soon as possible. Our Trust will not turn patients away in an emergency just because a ‘right sex’ bed is not immediately available.

Children’s wards
It is accepted that for babies and small children, segregation by age and development stage can be more important than same-sex accommodation. In addition, parents of either sex are welcome to stay on the ward with their child. Once early teenage years are reached privacy becomes more important and staff on the children’s wards will endeavour to provide suitable same-sex accommodation for children in this older age group.

Staff
Male and female staff care for all patients. Where a patient requests it, or special circumstances apply, matrons will attempt to provide ‘same-sex’ staff though this may not always be possible and a Chaperone Policy is in place to support this.

United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*4th July 2023*
Item Number	*Item 8.2*

Safeguarding and Vulnerabilities Annual report 2022-2023

Accountable Director	*Professor Karen Dunderdale* *Director of Nursing*
Presented by	*Craig Ferris* *Deputy Director of Safeguarding*
Author(s)	*Craig Ferris* *Deputy Director of Safeguarding*
Report previously considered at	*Quality Governance 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	*X*
2a A modern and progressive workforce	*X*
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	*X*
3c Enhanced data and digital capability	
3d Improving cancer services access	
3e Reduce waits for patients who require planned care and diagnostics to constitutional standards	*X*
3f Urgent Care	
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	

Risk Assessment	*Insert risk register reference 4632 / 4627 5141 / 5157*
Financial Impact Assessment	*N/A*
Quality Impact Assessment	*N/A*
Equality Impact Assessment	*N/A*
Assurance Level Assessment	• *Moderate*

Recommendations/ Decision Required	• *Receive the Safeguarding Annual report* • *Approve the plans for 2023 – 2024*

Executive Summary

The purpose of the report is to provide the Trust with a Safeguarding and Vulnerabilities annual report of the work undertaken during 2022 -2023 giving assurance that the Trust is compliant with its safeguarding duties and those responsibilities specified under section 11 of the Children Act 2004, NHS Assurance Framework 2015 and current safeguarding adult legislation.

Present proposed developments for 2023 – 2024 based on local, regional, and national safeguarding agenda

The report demonstrates the continued performance of the trust within the safeguarding arena which covers Safeguarding Children (Child Protection, Domestic Abuse, FGM, County Lines, Allegations against staff), Safeguarding adults, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs), the ongoing work in relation to Learning Disability, Autism Dementia, Mental Health and the PREVENT strategy.

Whilst managed within the Nursing Directorate the safeguarding agenda threads through all aspects of the Trust business and the Trust play an active part within the wider safeguarding multiagency partnerships

Issues to note:

- Liberty Protects Safeguards is now on hold until after the next General Election
- Safeguarding training targets are still below required levels however since the move back to a face-to-face training process there has been a steady increase in compliance (April – June 2023) which should ensure compliance levels are met over the coming 12 months.
- Oliver McGowan Training will continue to be managed via the system until a suitable solution is available

Since 2020 there has been a plan to replace the current Deprivation of Liberty Safeguards with a new process entitled ‘Liberty Protects Safeguards’. Guidance has continually been delayed and currently LPS will not now be launched until after the next general election. At this present time the current Deprivation of Liberty process will continue.

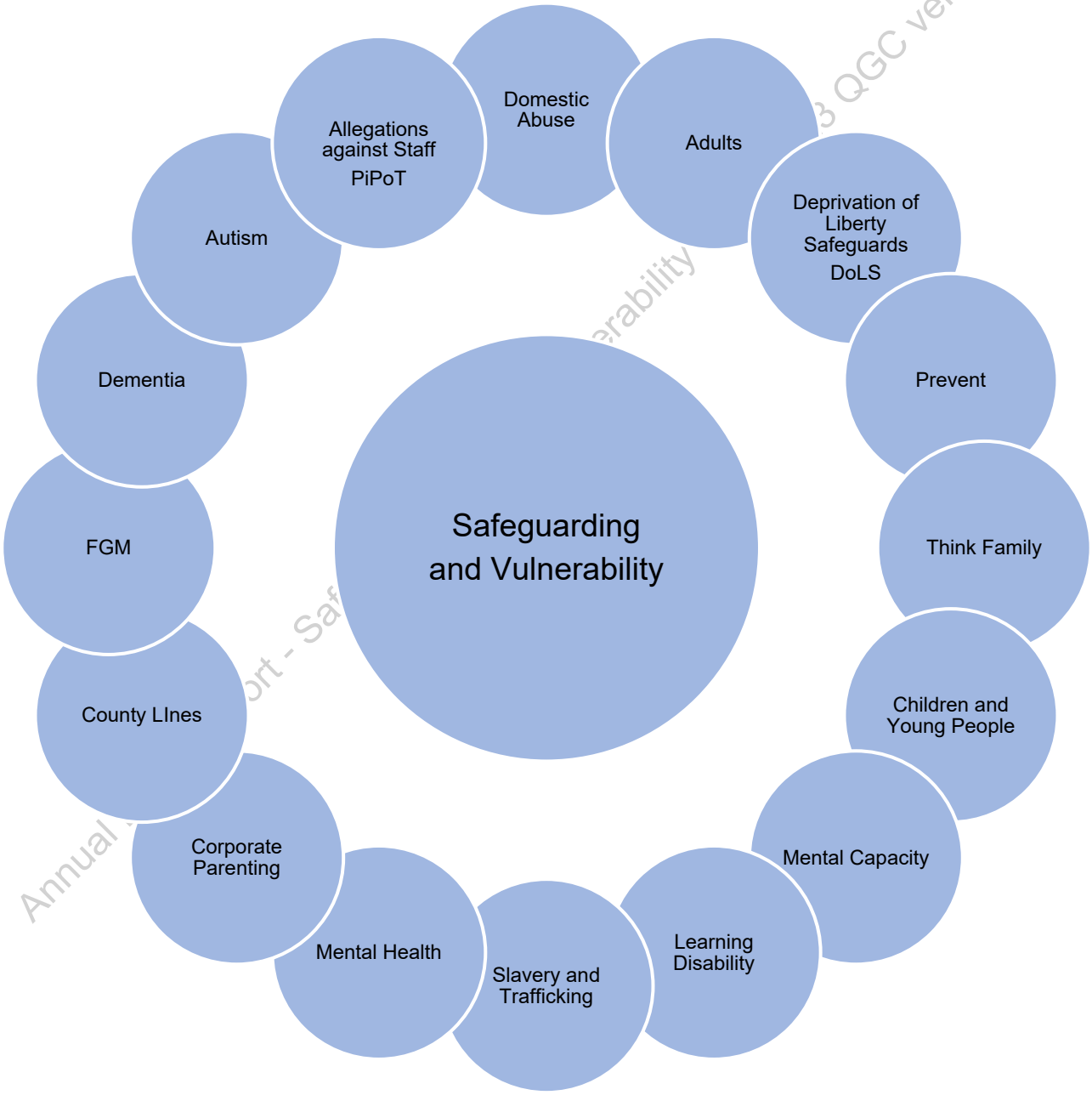
During 2022 and 2023 the team have continued to manage the vulnerabilities agenda ensuring an active involvement with many complex and challenging cases, improving care pathways, and supporting staff both across the trust and within other agencies.

Interagency working continues to be a key component of the team’s activity and ULHT are fully embedded with the multiagency frameworks within Lincolnshire ensuring that the Trust is a key partner and able to help shape the future of safeguarding and health care in the region.

NHS
United Lincolnshire Hospitals
NHS Trust

Safeguarding and Vulnerability Annual Report 2022 - 2023

OUTSTANDING CARE *personally* DELIVERED


Safeguarding and Vulnerability
Domestic Abuse
Adults
Deprivation of Liberty Safeguards DoLS
Prevent
Think Family
Children and Young People
Mental Capacity
Learning Disability
Slavery and Trafficking
Mental Health
Corporate Parenting
County LInes
FGM
Dementia
Autism
Allegations against Staff PiPoT

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Foreword

As the Executive Lead for Safeguarding, I am pleased to once again introduce United Lincolnshire Hospitals NHS Trust's Safeguarding and Vulnerabilities Annual Report for 2022/23. Over the past year, the Trust has continued to deliver quality and compassionate care and treatment across the communities in which we provide inpatient, community and emergency services. All of this is against the recovery of an unprecedented pandemic which started in March 2020.

In February 2022 the Care Quality Commission (CQC) published its inspection findings for the organisation. The Trust received an overall rating of 'requires improvement' with 'good' for Caring and Good for Well-Led. Without exception staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs. Staff also provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when needed.

The Trust continues to work towards its vision, values and strategic objectives through our integrated improvement plan. We aspire to provide outstanding care personally delivered which is of the highest quality in collaboration with everyone who uses and delivers our services. Everything we do involves and prioritises our patients, and their families and carers.

Safeguarding our people and their rights is key to all that we do as a Trust. This report highlights how we achieve this and sets out our commitment to the coming years' Safeguarding agenda.

The Trust Board of Directors are committed to ensuring all patients accessing our services are protected from harm and abuse ensuring that safeguarding remains a priority within the organisation. The Trust's **Safeguarding Statement of Intent 2021-2024** is published on our website.

The Trust has specialist Safeguarding and Mental Capacity staff who lead on and embed the practice of protecting adults and children from abuse, neglect, modern slavery, domestic abuse, and radicalisation and over the last 12 months have taken on the additional specialist areas of Learning Disability/Autism (Neuro-diversity), Dementia and Mental Health. The team work tirelessly to ensure that our frontline staff have the required skills and knowledge to protect people, uphold their human rights and assess capacity.

I would like to thank our caring and compassionate staff, volunteers and Safeguarding team for their commitment and dedication in working alongside and providing protection, guidance and support to people whose circumstances make them vulnerable to abuse, neglect or radicalisation.

Professor Karen Dunderdale

Director of Nursing/Deputy CEO and Executive Lead for Safeguarding

Statement from Lincolnshire Safeguarding Childrens Partnership (LSCP) and Lincolnshire Safeguarding Adults Board (LSAB)

A wide range of Trust staff have a vital role to play in safeguarding and promoting the welfare of children and adults including paediatricians, doctors, nurses and midwives. In addition, there are a number of designated professionals who provide expertise in this important and sensitive area. (e.g., Paediatrician for unexpected deaths in childhood)

It is clear that the Trust has a high commitment to safeguarding and this is demonstrated by their strong engagement levels within the respective partnerships. They are represented at many levels within the overall structures and contribute significantly to the work of the partnerships focussing on strategic priorities and the business plans.

During the last twelve months ULHT have been an active partner adding high value, support and challenge at all levels within the Partnership. The Trust has also made a significant contribution to our review work assisting in identifying some key learning points from individual cases.

The Lincolnshire Safeguarding Adults Board Independent Chair has attended on several occasions at the Safeguarding and Vulnerabilities meetings where they have been able to hear first-hand how ULHT are working to safeguard its patients. This displays great openness and transparency and allows independent challenge and oversight to be applied where appropriate.

We are grateful to the safeguarding team and all frontline staff for their dedication and look forward to developing this positive way of working together even further.

Mr Chris Cooke Independent Chair of LSCP

Mr Richard Proctor Independent Chair of LSAB

1.0 Purpose of Report

The purpose of the report is to provide the Board with an annual update of the work undertaken in 2022 - 2023 with regard to safeguarding children and adults, Prevent, Mental Capacity and Deprivation of Liberty Safeguards (DoLS), Learning Disability /Autism (Neurodiversity), Dementia and Mental Health and the proposed areas of development for 2023 - 2024.

2.0 Legislative Background

The NHS Outcomes Framework 2020 identifies that sustainable quality improvements are achieved when the focus is on outcomes, rather than being process driven. The DOH Outcomes Framework sets out five overarching high-level outcome domains for quality improvements.

Domain 1 Preventing people from dying prematurely.

Domain 2 Enhancing quality of life for people with long-term conditions.

Domain 3 Helping people to recover from episodes of ill health or following injury.

Domain 4 Ensuring that people have a positive experience of care; and

Domain 5 Treating and caring for people in a safe environment and protecting them from avoidable harm.

In terms of safeguarding the key domains are:

Domain 4 Ensuring people have a positive experience of care,

Domain 5 Treating and caring for people in a safe environment and protecting them from avoidable harm.

The revised guidance "Safeguarding Children, Young People and Adults at risk in the NHS: Accountability and Assurance Framework (NHS England 2022) sets out the safeguarding roles, duties and responsibilities of all NHS health care organisations.

The Trust has a range of statutory duties including safeguarding children and adults and is required to give assurance to both Local Safeguarding Partners and commissioners of service to demonstrate that we have effective safeguarding arrangements in place.

Safeguarding forms part of the NHS national contract (service condition 32 – Safety and Safeguarding - Safeguarding Children and Adults - 32.1 - 32.9) and the ICB monitors our performance via contract monitoring processes.

2.1 Safeguarding Children

Since the statutory inquiry into the death of Victoria Climbié (2003), and the first Joint Chief Inspectors' report on Safeguarding Children (2002) highlighted the lack of priority status given to safeguarding, there has been a consistent process of review and change of legislation.

In 2022 the face of safeguarding children is very different to that of the late 1990s and an emphasis on early help rather than punitive action is what currently drives the system and as such the number of children on plans continues to vary.

Whilst systems change, at a national level we continue to see tragic cases involving child abuse such as Arthur Labinjo-Hughes aged 6 (Solihull) and Star Hobson aged 1 (Keighley) who both died at the hands of the very people who were expected to protect them.

Safeguarding and promoting the welfare of children is defined in Working Together to Safeguard Children (2018 – *updated December 2020*) as

- protecting children from maltreatment.
- preventing impairment of children's health or development
- ensuring that children are growing up in circumstances consistent with the provision of safe and effective care; and
- taking action to enable all children to have the best outcomes

Safeguarding Children is everyone's responsibility, Section 11 of the Children Act 2004 places a duty on key persons and bodies to make arrangements to ensure that in discharging their functions, they have regard to the need to safeguard and promote the welfare of children.

This is a standard requirement within all ULHT contracts of employment

At an organisational or strategic level, key features which must be adopted by NHS organisations (monitored by the Local Safeguarding Children Partnerships and Commissioners) are:

- Senior management commitment to the importance of safeguarding and promoting children's welfare.
- A clear statement of the agency's responsibilities towards children for all staff.
- A clear line of accountability within the organisation for work on safeguarding and promoting the welfare of children.
- Service developments that take account of the need to safeguard and promote welfare and is informed, where appropriate, by the views of children and families.
- Staff training on safeguarding and promoting the welfare of children for all staff working with or in contact with children and families.
- Safe recruitment procedures in place.

- Effective inter-agency working to safeguard and promote the welfare of children
- Effective information sharing.
- CQC Fundamental Standards 2022 which have a safeguarding thread running through all

An audit of Section 11 duties is undertaken by the Local Safeguarding Children Partnership (LSCP) and any subsequent action plans will be monitored in line with the current governance arrangements. The most recent section 11 submission took place in February 2021 and the trust reported ***full compliance which was agreed by the LSCP***

2.2 Safeguarding Adults

The passing of the Care Act 2014 has meant significant changes in the way adult safeguarding operates across ULHT. The safeguarding process has now been placed on a statutory footing and the requirements placed on our organisation have become more clearly defined.

The term vulnerable adult has been replaced by "Adult at Risk" and the statutory guidance confirms that

> ***"Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances."***

The victim in the process is now the "adult at risk", the perpetrator "the alleged source of risk" and a written "Safeguarding Alert" is now termed a "Safeguarding Concern"

The Act recognises the need to focus on openness and transparency, in the drive to improve the quality of care individuals receive. This segues neatly with our own health service requirement for "Candour" as set down in ULHTs Incident Management Policy (C-P-43) and in line with the Trusts statutory Duty of Candour as defined in Regulation 20 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Act also places the duty on public organisations like ULHT to take action when abuse or neglect is suspected or known and underlines the duty to ensure that all staff are trained in safeguarding proportionate to their roles and responsibilities. Both are explicit in ULHTs Safeguarding Policy's and training plans.

2.2.1 Implications for Safeguarding Adults at Risk

The Act sets out the statutory framework for adult safeguarding, including local authorities' responsibilities, and those of the local partners. In many cases the requirements of the Act are already fulfilled and expand across not just safeguarding but also cover some of our more vulnerable clients such as those with dementia and learning disabilities.

Safeguarding Principles

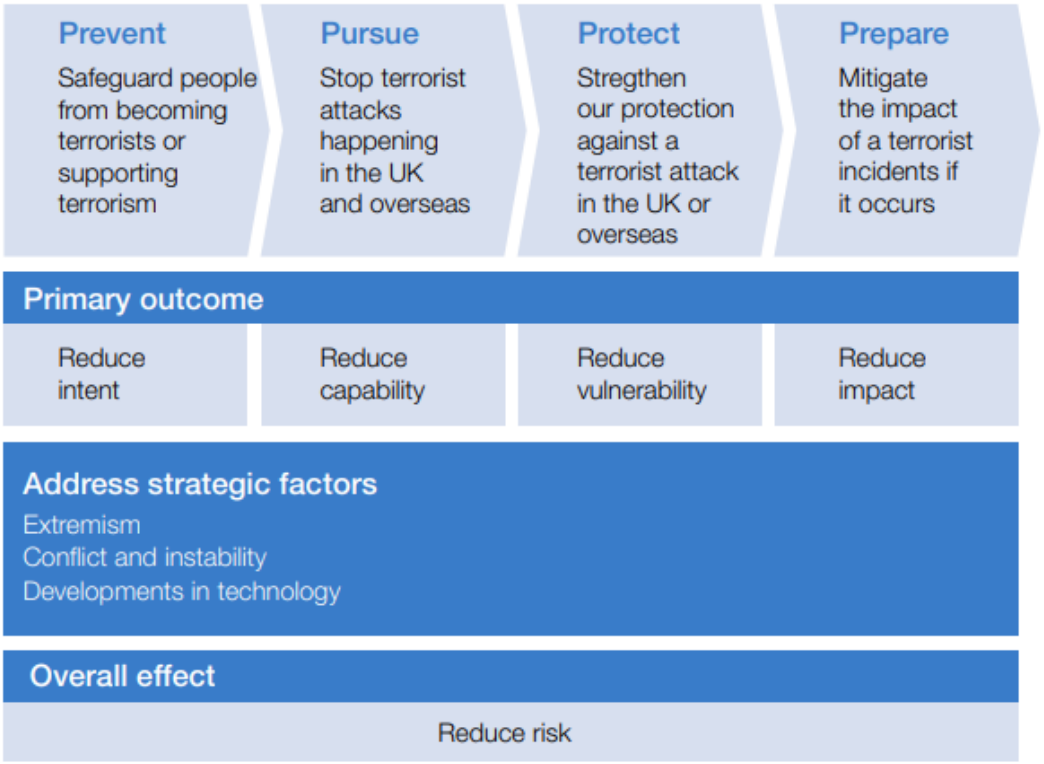
Principle 1 – Empowerment	Presumption of person led decisions and consent
Principle 2 – Protection	Support and representation for those in greatest need
Principle 3 – Prevention	Prevention of neglect harm and abuse is a primary objective.
Principle 4 – Proportionality	Proportionality and least intrusive response appropriate to the risk presented
Principle 5 – Partnership	Local solutions through services working with their communities
Principle 6 – Accountability	Accountability and transparency in delivering safeguarding

2.3 PREVENT

2.3.1 What is PREVENT?

The Counter-terrorism and Security Act 2015 placed PREVENT on a statutory footing. The Office for Security and Counter Terrorism (OSCT) in the Home Office is responsible for providing strategic direction and governance on CONTEST. As part of CONTEST, the aim of PREVENT is to stop people becoming terrorists or supporting terrorism and again transitions into vulnerable children & adults who are groomed and exploited to carry out acts of violence against others

CONTEST is primarily organised around four key principles. Work streams contribute to four programmes, each with a specific objective:



The Health Service is a key partner in PREVENT and encompasses all parts of the NHS, charitable organisations and private sector bodies which deliver health services to NHS patients.

PREVENT has 3 national objectives:

Objective 1: Tackle the causes of radicalisation and respond to the ideological challenge of terrorism

Objective 2: Safeguard and support those most at risk of radicalisation through early intervention, identifying them and offering support

Objective 3: Enable those who have already engaged in terrorism to disengage and rehabilitate

The Health Sector contribution to PREVENT will focus primarily on Objective 2.

PREVENT training is undertaken in line with the Prevent Training and Competencies Framework - Department of Health and Social Care (2021)

2.3.2 Why Health care staff?

The overall principle of health is to improve the health and wellbeing through the delivery of healthcare services while safeguarding those individuals who are vulnerable to any form of exploitation. PREVENT is also about protecting individuals.

PREVENT aims to protect those who are vulnerable to exploitation from those who seek to get people to support or commit acts of violence.

3.0 Designated and Named Professionals for the Trust and its Commissioners

3.1 Children

The terms designated and named professionals (children) are clearly defined in Working Together 2018 as professionals with specific roles and responsibilities for safeguarding children.

All Integrated Care Boards are required to have a designated doctor and nurse whose responsibility it is to take a strategic, professional lead on all aspects of the health service contribution to safeguarding children across the commissioned area, which includes all providers. The designated professionals are also in place to provide professional advice on matters relating to safeguarding children for other professionals, NHS Commissioners, Local Authority children's services and the safeguarding children partnerships. The Designated Professionals for Lincolnshire are employed within the ICB and provide this support to the Trust.

All NHS Trusts must identify a named doctor, a named nurse and a named midwife (where maternity services are provided) for safeguarding with the focus of the named professional being on safeguarding children within their own organisation. These professionals are in post within the Trust and include a lead anaesthetist for safeguarding children as recommended by the Royal College of Anaesthetists (2012)

3.2 Adults

Following the publication of Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework (July 2015) there is an expectation that Designated (ICB) and Named professionals (ULHT) for safeguarding adults are in place. Within ULHT the Deputy Director for Safeguarding holds the strategic lead for both children and adults and the Trust has a Named professional responsible for safeguarding adults and Mental Capacity Act supported by specialist nurses with responsibility for Safeguarding Adults, Learning Disability/Autism (Neurodiversity), Dementia and Mental Health

4.0 The ULHT Safeguarding and Vulnerabilities Team

The Safeguarding Team has been in place for several years and historically was responsible for Child Protection (ULHT), Adult Protection (ULHT), MCA/DOLS and the PREVENT agenda (ULHT). During 2021 to 2022 the teams remit expanded and now leads on Mental Health, Learning Disability, Autism and Dementia as well as having strong links in the development of the De-escalation, Management, and Intervention training/team. To reflect the change the team amended their name to 'Safeguarding and Vulnerabilities team'

A full structure of the current team can be found at appendix 1

From April 2023 there are no dedicated IDVA posts within the Trust

5.0 ULHT Safeguarding Governance Arrangements

The responsibility for safeguarding rests ultimately with the Chief Executive Officer, supported by the Executive Director with Board responsibility (Prof Karen Dunderdale, Director of Nursing / Deputy CEO).

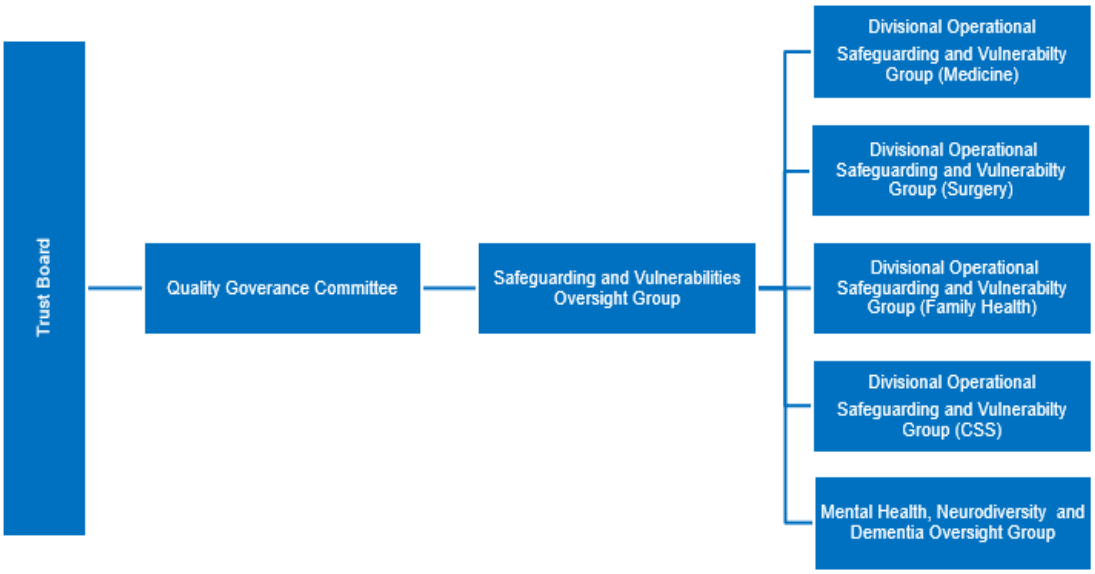
The Trust has in place the following safeguarding specific groups:

Safeguarding and Vulnerabilities Oversight Group (SVOG) which reports to the Quality Governance Committee (figure 1). The group is active in the management of the current action plans / issues within the specialist area. The group is chaired by the Deputy Director of Safeguarding and the divisional groups are chaired by a senior leader within the division.

Mental Health, Neurodiversity and Dementia Group (MHNDD) which reports to the Safeguarding and Vulnerabilities Oversight Group (figure 1). The group is active in the management of the current action plans / issues within the specialist area. The group is chaired by the Named Professional for Safeguarding Adults.

Figure 1: Safeguarding Governance Accountability and Oversight

Safeguarding Governance Accountability and Oversight 2022 -2023



5.1 Grant Thornton Report - Safeguarding Governance

During 2022 and 2023 an audit was commissioned to review the internal safeguarding governance process and its effectiveness, primarily:

Do the Safeguarding operational/divisional meetings appropriately monitor and report the safeguarding agenda?

The audit concluded that there was *Partial Assurance with improvements required.* and recommended 3 medium, 2 low and 3 improvement points

All action points in reference to the governance recommendations are complete and have been monitored via the Quality Governance committee and the Safeguarding and Vulnerabilities Oversight Group

6.0 Local Safeguarding Children Partnership Board (LSCP) and Local Safeguarding Adult Board (LSAB)

Safeguarding Children Partnerships and Safeguarding Adults Boards were set up as statutory bodies under a national model led by the local authority until a government review of their role in 2016. This led to changes in relation to Safeguarding children, bringing about a shared responsibility for safeguarding amongst the identified three lead partners (Local Authority, Police and ICB) and the change to Local Safeguarding Arrangements which allow some flexibility based on local needs.

They are a partnership of the relevant statutory, voluntary and community agencies involved in safeguarding and promoting the welfare of all children and young people /adults at risk of abuse. They do this by coordinating the safeguarding work of member agencies so that it is effective; monitoring, evaluating and when necessary, challenging the effectiveness of the work and advising on ways to improve safeguarding performance.

The Local Safeguarding Children Partnership / Adult Board within Lincolnshire both have Independent Chairs and membership has been reviewed ensuring that attendance is at the required levels and members have sufficient seniority

The Trust is represented by the Deputy Director of Safeguarding at the Partnership/Board and there is representation by other key safeguarding professionals on the subgroups.

6.1 LSCP Key areas of action

- Tackling child exploitation
- Enhancing the emotional wellbeing of children and young people
- Promoting healthy and respectful relationships
- To identify and reduce the impact of neglect on children and young people
- To identify and reduce the impact of sexual and physical harm
- Identify and reduce the impact of domestic abuse on children, young people and their families.

LSCP business plan 2022 - 2025

6.2 LSAB Key areas of action

- Prevention and Early Intervention.

- Making Safeguarding Personal (MSP)
- Learning and Shaping future practice
- Safeguarding Effectiveness

ULHT are actively involved in all the above areas by way of delivering the topic areas within training and/or sitting on operational groups to actively target the perpetrators and support the victims of abuse.

Lincolnshire Safeguarding Adult Board Strategy 2022 - 2025

7.0 Child Safeguarding Practice Reviews (Previously Serious Case Reviews - SCR) / Serious Adults Review (SAR) / Domestic Violence Homicide reviews (DHR)

7.1 Children

Child Safeguarding Reviews have been in place for many years and nationally about 100 take place every year. A review is always carried out by the Safeguarding Partnership when a child dies and abuse or neglect is known, or suspected, to be a factor in the death. Working Together (2018) guidance also states that LSCP should consider holding a review where a child has sustained a life-threatening injury through abuse or neglect, serious sexual assault, or through serious and permanent impairment of health or development through abuse or neglect. The purpose of a review is to establish what lessons can be learnt about the way professionals and organisations worked together, how they will be acted upon and what is expected to change in order to improve inter-agency working and improve safeguarding practice to children. Reviews are exercises in learning and improving policy and practice and outcomes for children and young people and are not inquiries into how a child died or who was culpable; this is the business of Coroner's and the Criminal Court.

A review is commissioned by the LSCP and involves setting up a multi-agency review panel of senior and experienced managers, with an independent chair, to ensure objectivity and impartiality. The panel must produce a report to the LSCP on lessons learnt, the LSCP then ratifies the conclusions and recommendations for actioning the lessons.

The report goes to the Trust Safeguarding and Vulnerabilities Oversight Group and Ofsted / CQC and national oversight panel for their scrutiny and response. All relevant agencies are expected to produce and implement an action plan, based on the recommendations, which is overseen by the LSCP Significant Incident Group.

The Trust is not currently involved in any new Child Safeguarding Practice Reviews (CSPRs).

During 2022 - 2023 the Trust has submitted information to support two Lincolnshire and one out of area LSCP rapid reviews. The outcome of each of the Lincolnshire rapid reviews resulted in a decision that the criteria for undertaking a CSPR had not been met. These decisions were validated by the National Panel. ULHT was not required to participate in the out of area LSCP review, due to lack of relevant in-scope involvement.

7.2 Adults

Safeguarding Adult reviews are part of the safeguarding adult's process and a statutory requirement within the Care Act 2015.

By law, a Safeguarding Adults Review (SAR) must take place when:

An adult dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

The purpose of a SAR is not to assign blame but to promote learning and improvements to prevent future deaths or serious harm.

In addition, safeguarding boards may also arrange a review where it believes there is value in doing so. This can be in any other situation involving an adult in its area with needs for care and support to promote effective learning and improvement action to prevent future deaths or serious harm occurring.

During 2022 – 2023, the Trust has been involved in one statutory serious adult review that is ongoing and one non-statutory thematic review. Three actions were identified:

- Mental capacity act (discharge related),
- Self-neglect and hoarding
- District Nurse Referral form

These are currently being reviewed and implemented within ULHT

7.3 Domestic Violence Homicide Reviews (DHR)

A DHR is very similar in nature to a children's or adults' review however takes place *when a death occurs in a young person (16 & 17 years), or an adult and the cause is linked to Domestic Violence or Abuse*.

Nationally there were 362 domestic homicides recorded by the police in the three-year period between year ending March 2018 and year ending March 2020. This represents 19% of all homicides where the victim was aged 16 years and over during this period.

Of the 362 homicides, 214 (59%) were female victims who were killed by a partner or ex-partner. In contrast 33 (9%) were male victims who were killed by a partner or ex-partner. The remaining 115 (32%) were victims killed by a suspect in a family category.

Since the introduction of the Statutory Domestic Homicide Reviews in April 2011 there have been 25 cases involving 34 deaths (including 5 alleged perpetrators) that have met the criteria for a domestic homicide review in Lincolnshire

During 2022-23 the Trust has been involved in 4 newly commissioned Domestic Homicide Reviews (DHRs) for Lincolnshire and 2 new Domestic Homicide Reviews out of area. There were 3 Domestic Homicide Reviews (DHR2018L, DHR2018Q and DHR2019F) published. All Trust actions are complete for all the published Reviews.

In total, ULHT is currently involved in nine DHRs; four of which were identified in 2021, and 2 that were ongoing prior to 2021.

In addition to the Lincolnshire, DHRs, ULHT is also involved in 2 out of County DHRs, involving submission of a chronology and report former patients who were resident in Sunderland and Rutland at the time of their death.

During 2022-2023, the Trust has also submitted information to support 2 additional Lincolnshire DHR decision-making panels at which it was determined that the criteria for undertaking a DHR had not been met

Actions for the Trust in relation to one of the newly commissioned DHRs is ongoing.

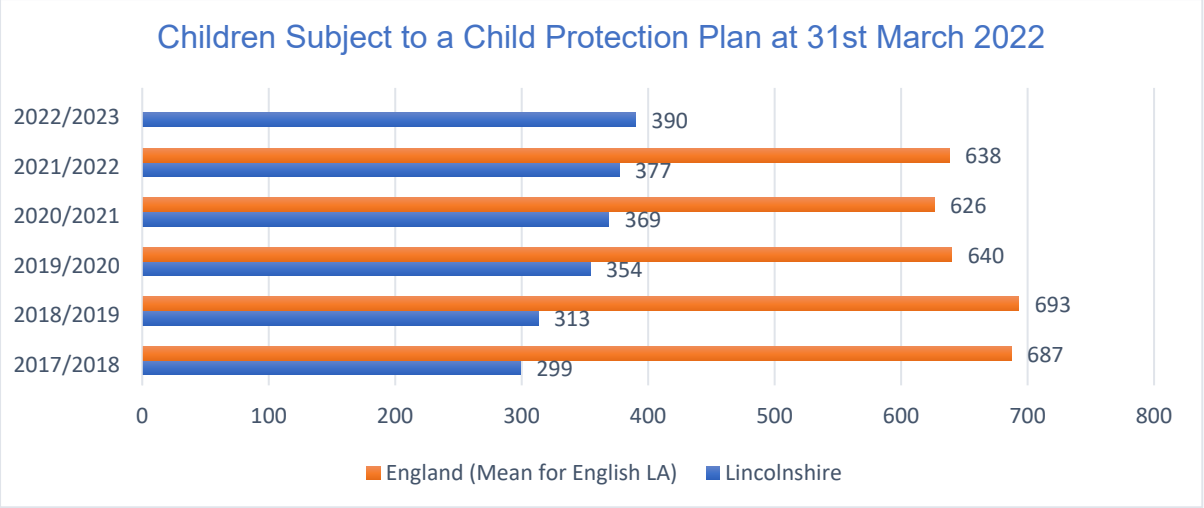
8.0 Child Protection Cases

Lincolnshire holds child protection conferences on each working day and therefore the numbers for children who currently have a child protection plan vary on a daily basis Monday to Friday and can be influenced by families moving in and out of the local authority. Overall, the numbers of children on plans (figure 2) have slowly risen over the last 5 years whereas the mean for England has demonstrated a downward trend.

Children on child protection plans are identified within the trust on Careflow and via the Lincolnshire Care Portal.

During this period there has continued to be a high number of unborn babies who have become subject to child protection / court proceedings and as such a significant impact on the midwifery workload

Figure 2: Number of children having a child protection plan within the Local Authority area who may be receiving services from ULHT (April 2017– March 2023) ***(England Mean 22/23 not available at time of report)***



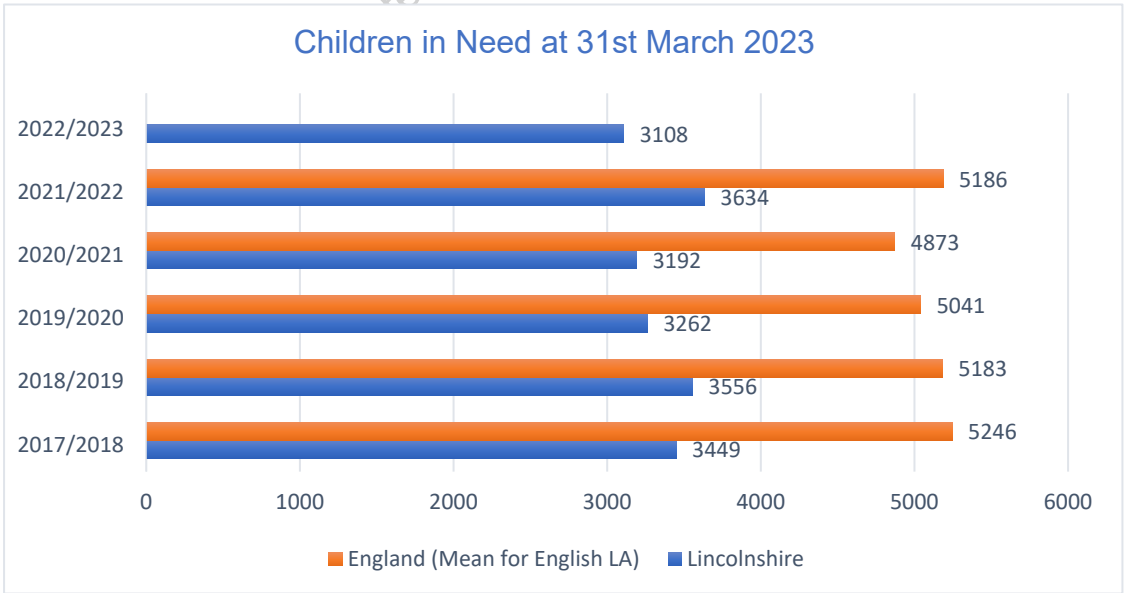
8.1 Child in Need

Some children will not meet the criteria for a child protection plan but still require a service which can be met at a lower level 'children in need' of support. The data in figure 3 demonstrates the number of children in need across Lincolnshire with an decrease in numbers over the last 12 months still remains below the England mean.

Lincolnshire has focused its support offer on 'Early Help' which is designed to assist children and family at an earlier stage and prevent them from reaching the child in need stage

Figure 3: Number of children classed as a Child in Need within the Local Authority area who may be receiving services from ULHT (April 2017 – March 2023)

(England Mean 22/23 not available at time of report)



8.2 Children in Care

Children and young people who are looked after are amongst the most socially excluded groups in England and Wales. They have profoundly increased health needs in comparison with children and young people from comparable socio-economic backgrounds who have not needed to be taken into care. These greater needs, however, often remain unmet and as a result, many children and young people who are in care continue to experience significant health inequalities and on leaving care experience very poor health, educational and social outcomes.

ULHT does not directly provide the children looked after health service however many of these children will access the services within ULHT by way of A+E or Paediatrics and research demonstrates that children in care will continue to have a high levels of Adverse Childhood Experiences (ACES) which impact on lifelong health and opportunities and therefore continue to access services long into their adult life.

Due to the demographics of Lincolnshire the Trust may also provide services to other young people who are placed in care within Lincolnshire from other Local authority areas.

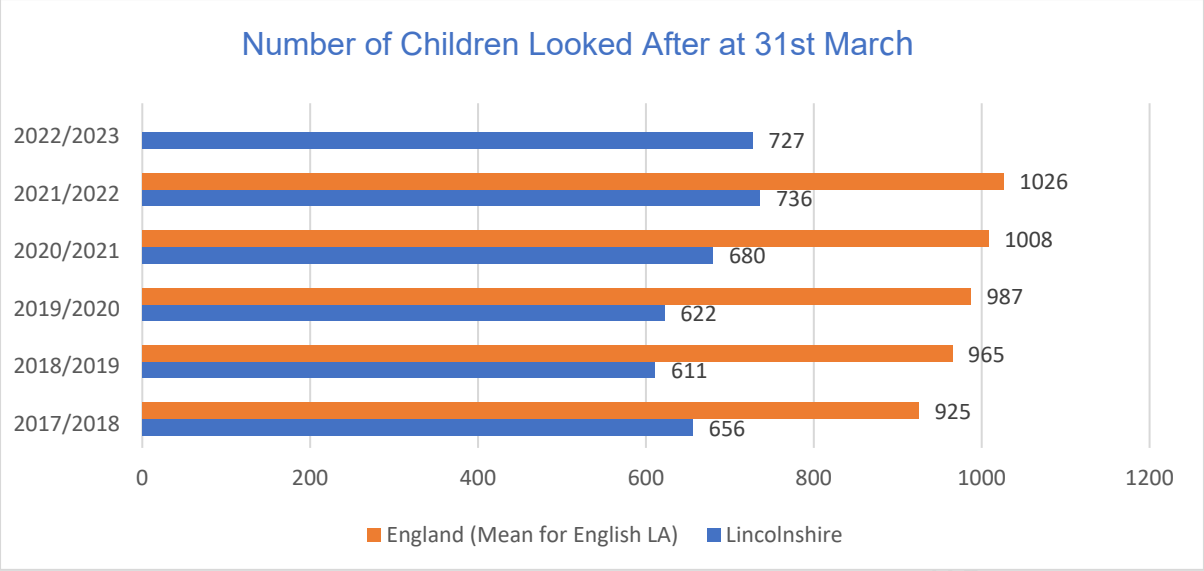
During 2022 to 2023 the Trust as provided specific care to several children who have been placed by other Local Authorities and who potentially posed a risk to themselves and others within the paediatric setting. The Trust have worked closely with our multi-agency/multi-professional partners to ensure that these children received the best possible care.

Over the last 4 years the number of children in care of Lincolnshire Local Authority has risen in line with the England mean. Although there has been a slight dip in the last 12 months.

Children within the trust are identified within Careflow and via the Lincolnshire Care Portal.

Figure 4: Number of children classed as a Child in Care within the Local Authority Area who may be receiving services from ULHT (April 2017 – March 2023)

(England Mean 22/23 not available at time of report)



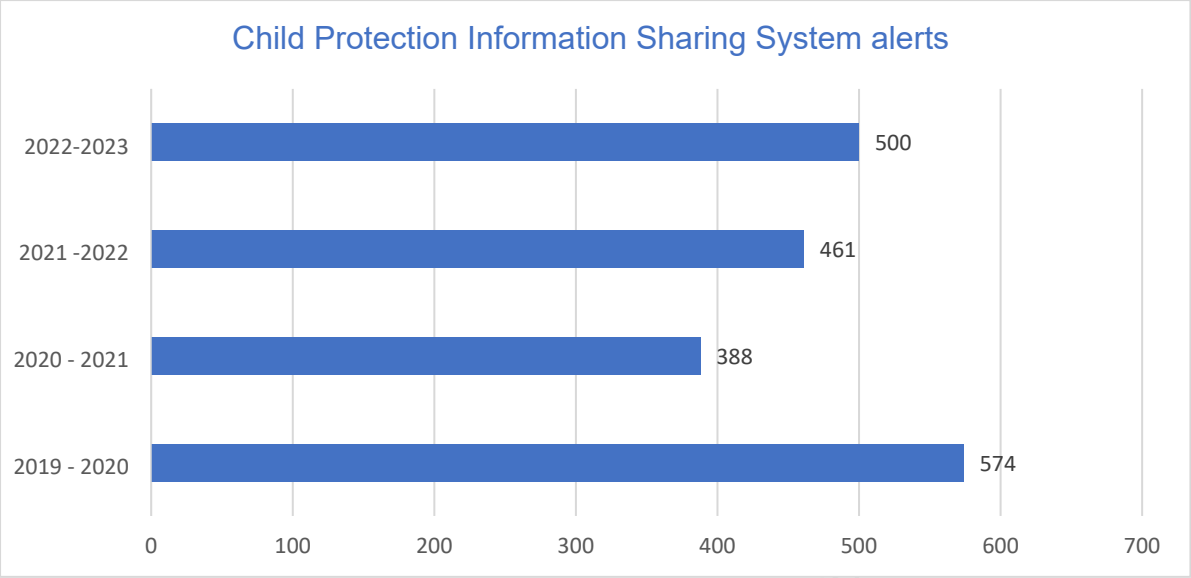
A review of the safeguarding flagging systems in the Trust continues to ensure that information is accurate and shared across as many areas as possible. Because of the large amount of data, it is expected that the process will be completed by the end of 2023

8.3 Child Protection Information Sharing System (CP-IS)

ULHT has in place systems for flagging high risk cases (e.g., Child Protection/Children Looked After/Domestic Abuse and Child Exploitation) within its Admission Systems. Following the development of the National CP-IS system, ULHT completed work with our Local Authority Partners to introduce this system into Unscheduled Care/Maternity settings Trust-wide, in line with NHS Digital's deadline of 31st March 2019. Currently, a CP-IS notification is triggered when an NHS number is entered into Careflow; with relevant information being stored within the Lincolnshire Care Portal for clinical staff to access in order for them to determine the current level of Social Care involvement and facilitate appropriate liaison. Training was provided for clinical staff in line with each of the relevant areas 'going live'; with supplementary pathways and user guides created to support usage. Upon attendance, additional Safeguarding alerts are then placed onto the patient's Careflow record to ensure non-scheduled care settings are aware of their Safeguarding status. Further work has continued in terms of audit and embedding compliance with CP-IS pathways into practice; with the focus being within our Emergency Departments.

The number of attendances for which a CP-IS alert was triggered during 2022-23 was 500 (attendances rather than children) – including plan removals/changes. For future reports, it is hoped that we will be able to demonstrate the ratio/split between CP, LAC and Unborn CP attendances.

Figure 5: The number of attendances for which a CP-IS alert was triggered during 2019 - 2023



8.3.1 Grant Thornton Report - CPIS

Between 2020 and 2021 a number of internal audits demonstrated variable compliance with the CP-IS process brought about by staff turnover, impact of the pandemic and lack of staff understanding, an issue also noted by the CQC in their 2022 report. A programme of work was undertaken to address these issues and an extended training programme for A&E staff was implemented supported by monthly audits which further demonstrated variable compliance.

As a result of this Grant Thornton were commissioned to undertake an independent audit during 2022 of the Child Protection Information Sharing system:

Are Trust staff aware and complaint with the process for reviewing, recording and appropriately escalating the information provided by the CP-IS?

The audit concluded that there was *Partial Assurance with improvements required.* and recommended 1 High, 3 medium, 3 low and 1 improvement points

Ongoing weekly monitoring audits are conducted by the Medicine division and reported to both the Children and Young Peoples Oversight Group and the Quality Governance Committee.

At the time of this report compliance remains variable and further work is required

9.0 Adult at risk

Adult Safeguarding is extremely complex and impacts on much of the day to day work of the Trust i.e.; Complaints/PALS, Serious incidents, pressure ulcers, patient safety and HR. Safeguarding is about more than simply keeping someone safe, it is about respecting and protecting an individual's needs, right, aspirations and integrity, both mental and physical. It is about making sure the environments they inhabit, and the people and services they encounter within them, reflect these same ideals. There is a fine balance to be struck regarding proportionality and the right of the individual to take risks must be balanced against the duty to protect health and wellbeing. There has been further promotion in regard to health professionals developing their professional curiosity, asking the right questions when fulfilling their safeguarding duties, and help them to enable patients to live their lives to the full, free from abuse.

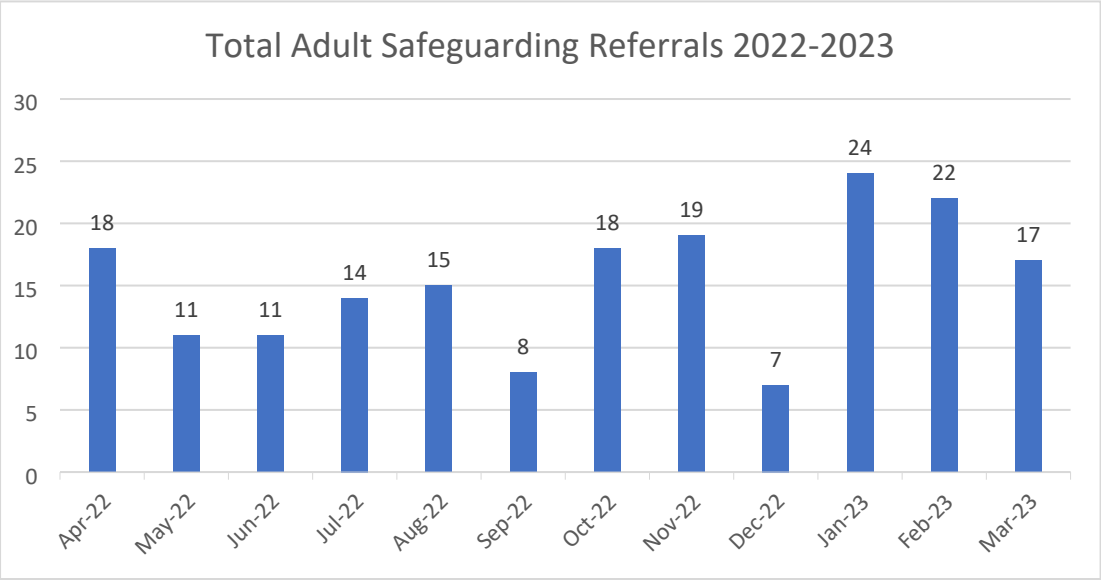
The number of referrals raised by the Trust during 2022 - 2023 was 184. Whilst this is a reduction of 35% on the previous year it is perceived as a levelling off to return to a level seen in 2020 - 2021 and does not raise concerns.

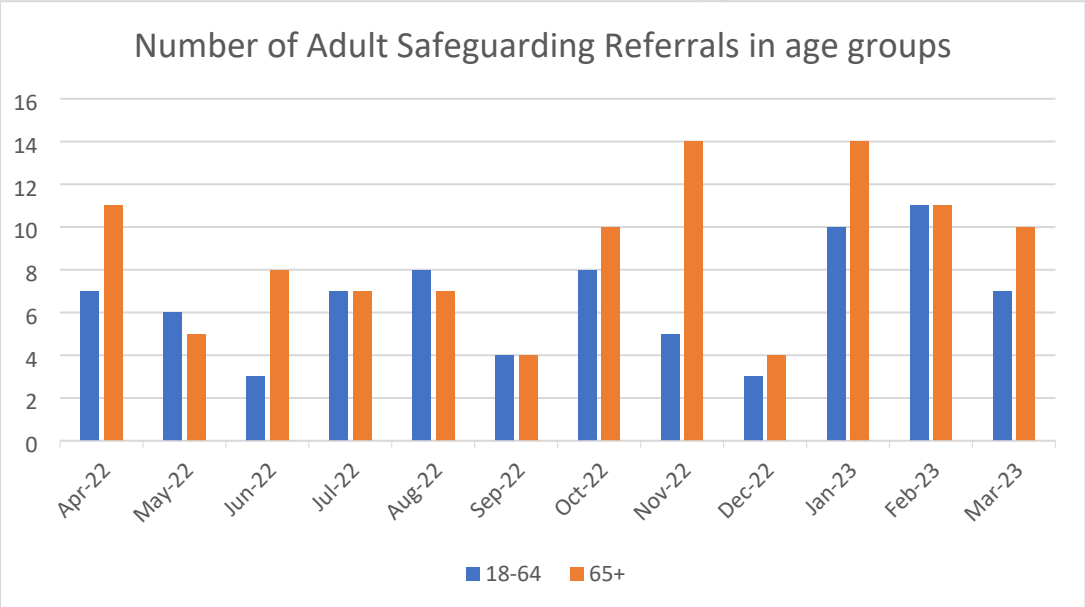
There is increased emphasis on 'making safeguarding personal' and involvement of the patient in their safeguarding decisions. Audits from the LSAB and internally continue to suggest that this is an area which requires further improvement so remains a Trust priority for 2023 - 2024.

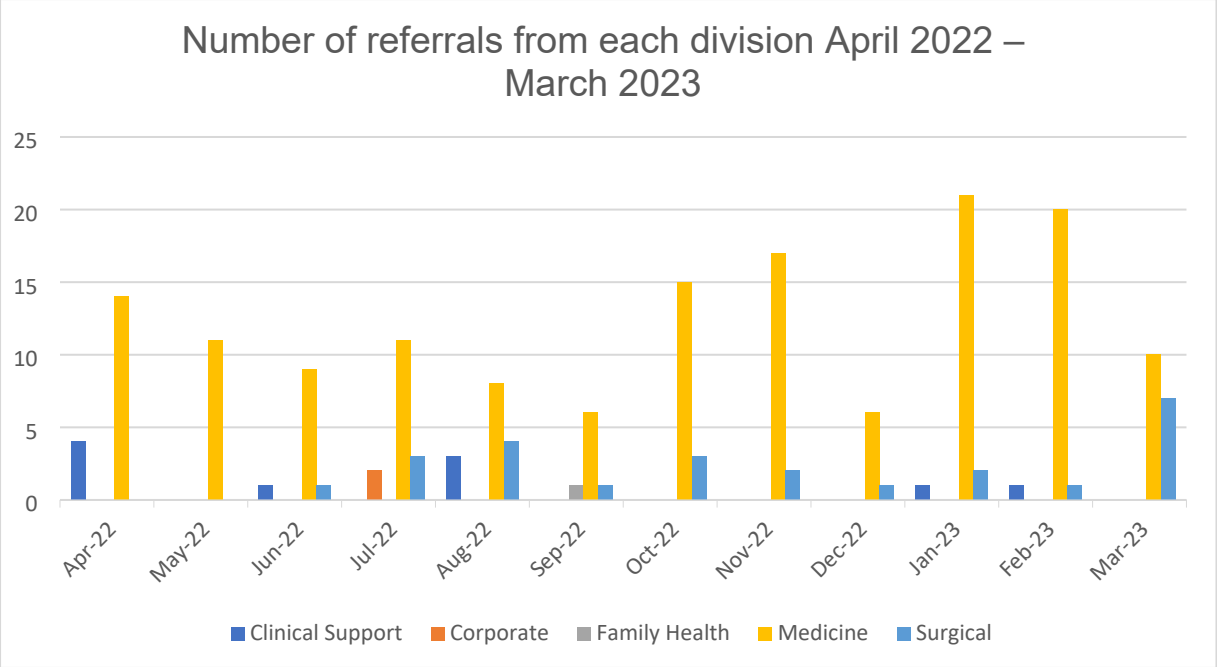
During the last year the team have seen an increase in case complexity, notably in cases of self-neglect, addictions, and disordered eating. The team have worked proactively to coordinate these cases and prevent unsafe discharges, readmissions, complaints, or safeguarding allegations against the Trust. This approach increases positive outcomes for the patients

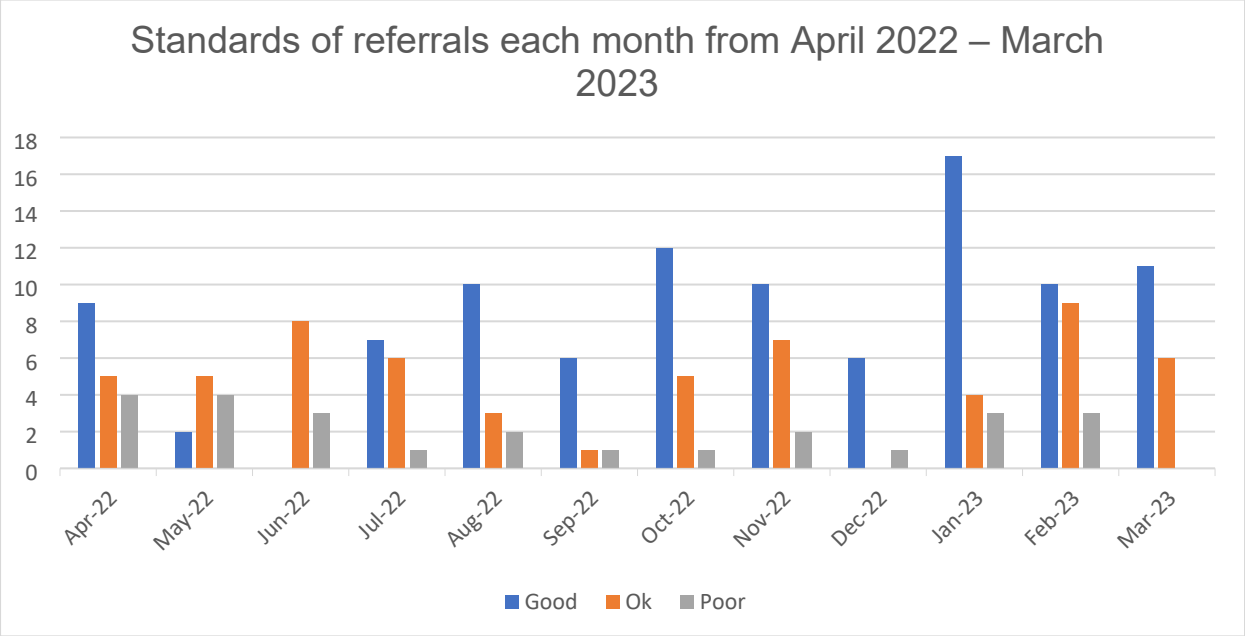
The number of safeguarding allegations raised against the Trust continues to vary however was around 40 in the past year. Trends from these investigations highlight issues of variable nursing care, lack of co-ordinated discharge and poor communication / record keeping and pertain to most staff groups. A number of lessons learnt, and actions have been put into place to minimise future risks. The Named professional meets monthly with the CQC and separately with the ICB and LA to ensure that there is an open and honest dialect maintained and works on the premise of 'no surprises.

Figure 6: Number of safeguarding adult referrals made by ULHT to the Local Authority (April 2022 – March 2023) including age breakdown and divisional breakdown









10.0 Legal statements / Court process

The safeguarding team have continued to strengthen and develop its remit of supporting staff in statement writing and court attendance. The current trend to produce more legal statements / requests for records continues and is also impacted on with the growing area of work from the Court of Protection.

The ongoing supportive relationship / process between safeguarding and the legal / data protection team continues to work well.

Other teams adversely affected by this increase are Paediatrics, Maternity and Emergency Departments across site with pressures being placed on paediatricians and frontline clinicians to provide reports and statements in greater detail and in a much shorter timescale.

The Court of Protection (CoP) is a court in England and Wales that can make decisions on behalf of people who lack the capacity to make their own decisions and the court mainly deals with decisions about a person's welfare, property, or medical treatment.

Whilst the Mental Capacity Act Code of Practice confirms some of the situations when decisions must be taken to the Court of Protection (Section 8.18), not all scenarios are covered including cases where there is a dispute about whether a particular treatment will be in a person's best interests.

The Court of Protection (CoP) has issued guidance which states that if force or restraint is required an application to court may be required and if the force or restraint amounts to a deprivation of liberty then the authority of the court will be required to make this deprivation of liberty lawful.

ULHT have taken 2 cases to the CoP in the past year and have sought legal advice on several. Whilst courts are mostly neutral, the judge in both cases congratulated the Trust for the way in which it had delivered care and the plan for clients X and Y.

During 2022 to 2023 the Trust commissioned a series of Court craft and legal updates for staff which currently continue to March 2025 and cover court skills suitable for children and family / Coroners' Courts as well as updates around the Mental Capacity Act and relevant changes in case law.

11.0 Safeguarding Clinical Supervision

11.1 Children

Effective clinical supervision is important to promote good standards of practice and support individual staff members. Supervision allows time for reflective practice and is a vital component in the protection of children. Supervisors should be available to practitioners as an important source of advice and expertise and may be required to endorse judgements at certain key points in time, and ensure each individual child has an effective plan of action. The Safeguarding team provide direct supervision to professionals (Individual and Group) which includes reflecting on, scrutinising and evaluating the work carried out, assessing the strengths and weaknesses of the practitioner and providing coaching, development and pastoral support.

Since 2021 safeguarding supervision became mandated to specific staff groups at either 3 monthly or 6 monthly periods and is managed by way of ESR (compliance/noncompliance) making the process more transparent and increasing the governance of this aspect of support.

As of 31st March 2023, compliance rates are as follows

3 Monthly - 76% (Monthly variance over 12 months 50 – 83%)

6 Monthly - 49% (Monthly variance over 12 months 41 – 53%)

Compliance figures for Safeguarding supervision are notoriously difficult to maintain due to 3 - 6-month time scales and regularly changing staff groups particularly amongst medical staff. As a trust, we use the above figures in conjunction with the Safeguarding training compliance figures to identify high-risk areas of concern and target specific staff groups.

Compliance is monitored by the team with bi-monthly reports provided to Divisional Safeguarding Operational Groups / Divisional Leads for escalation

11.2 Adults

Whilst less prescriptive, safeguarding supervision for adult protection cases is readily available and provided to staff who require it on a needs lead basis. This is often delivered at source on the clinical areas on a case-by-case basis and during the pandemic has been delivered via teams. As safeguarding adult / MCA is embedded, safeguarding supervision for adult cases is noticeably a bigger part of the work of the team and recorded via the ESR system.

12.0 Training and learning

Safeguarding training has always been a high priority to the Trust and is implicit within the National contract and Safeguarding legislation. A new training plan was introduced for safeguarding children and safeguarding adults in 2020 to accommodate restrictions imposed by the COVID-19 pandemic and bringing the trust in line with statutory guidance, adding some additional topic areas.

At the beginning of the pandemic all training stopped due to being traditionally delivered via classroom attendance and as a result compliance figures within the trust reduced by approximately 10% and for a period of 6 months remained static. During this period the safeguarding team developed and rolled out e-learning and local podcasts for all topic areas to ensure that where possible, staff could complete training and the trust was able to not only reduce the impact of the pandemic on safeguarding training but improve the level of compliance.

Despite the above and continuous monitoring, the pandemic had a significant impact on the Trusts ability to improve training compliance across all subject areas. This was further compounded by an IT issue within the Trust (July 2022 to February 2023) which prevented users from completing their training online leading to a drop in compliance rates across all subject areas

During this period, training was reviewed, and new packages were developed which were and continue to be delivered via Microsoft teams and/or classroom events.

The reported training levels with the Trust as of 31st March 2023 were as follows

KPI Description *(A measurable value that demonstrates the success of your change, to include trajectory to achieve target)*	**Measures** *(How will this be Measured)*	**Target** *(Desired level of performance)*	**Progress** *(Current progress measured month on month direction* *END March 2023 figures*	**Variation since End March 2022 ****
To reach 90% for Safeguarding children level 1	Monthly training report (MTR)	90%	88.56% ↑	-1%
To reach 90% for Safeguarding children level 2	MTR	90%	75.67% ↑	-5%
To reach 90% for Safeguarding children level 3	MTR	90%	79.43% ↑	-2%
To reach 90% for Safeguarding children level 4 **New staff member March 2023**	MTR	90%	83.33% ↓	-16%
To reach 90% for Safeguarding adults level 1	MTR	90%	88.01% ↑	0%
To reach 90% for Safeguarding adults level 2	MTR	90%	70.26% ↑	-7%
To reach 90% for Safeguarding adults level 3	MTR	90%	85.27% ↑	+3%
To reach 90 % for MCA / DOLS	MTR	90%	70.26% ↑	-10%
To reach 90% for PREVENT basic level	Quarterly training report	NHSE/I target 85% ULH target 90%	88.56% ↑	-1%
To reach 90% for PREVENT Higher level	Quarterly training report	NHSE/I target 85% ULH target 90%	79.43% ↑	-2%
To reach 90% for Mental Health	MTR	90%	88.58% ↑	-6%
To reach 90% for Dementia	MTR	90%	86.33% ↑	-8%

To reach 90% for Learning Disability / Autism Tier 1	MTR	90%	93.40% ↑	+18%
To reach 90% for Learning Disability / Autism Tier 2	MTR	90%	87.49% ↑	+15%

**** From July 2022 there was an issue within the IT system, which stopped completion of the above training via the e-learning system and was not resolved until February 2023. Whilst some reduction was mitigated with the re-introduction of face-to-face training, the above variance in compliance since March 2022 is a direct result of this technical issue**

During 2022 / 2023 Dementia training was reviewed with plans to develop three levels of training to reflect clinical need in line with national strategy and will be switched over from the current course to the new course over the next 12 months

Learning disability training was introduced in December 2021 and was a need identified across the NHS following the tragic death of Oliver McGowan in November 2016 from substandard health care and the successful campaign by Paula McGowan (Oliver's Mother)

olivermcgowan.org

Uptake and feedback has been very positive with requests for more in-depth training moving forward.

In July 2022 Oliver McGowan training was placed on a statutory footing. Due to the complexities of delivery, there is currently work ongoing across the system to explore how this will be progressed and the impact on the health economy

13.0 Safeguarding issues within Pregnant Women

The Maternity Safeguarding team consists of 2 midwives, the Named Midwife for Safeguarding and a Safeguarding Midwife based within the maternity unit on both Boston and Lincoln sites

The role of the Safeguarding Midwives is to support clinical and managerial staff in performing their safeguarding duties and responsibilities through advice, escalation of concerns to / from other agencies and effective feedback and support from safeguarding meetings and forums. They provide specialised knowledge, guidance, training and support to all staff within United Lincolnshire Hospitals NHS Trust regarding safeguarding unborn / new-born, children, young people, adults at risk and domestic abuse.

The Safeguarding Midwives maintain a Safeguarding Database that all Midwives and Neonatal staff have access to and holds information on each woman / family where there are safeguarding concerns for unborn and/or siblings in order to assist staff to safely care for women and their babies with safeguarding risks.

355 Social Care referrals were made by ULHT Maternity Services in 2022 - 2023 due to safeguarding concerns.

280 unborn babies **(an increase of 45 on the previous year)** within the safeguarding database had an allocated Social Worker, 178 were made subject to Child in Need plans **(an increase of 64 on the previous year)**, 25 subject to Child Protection plans **(a decrease of 9 on the previous year)** and the remaining 79 unborn babies were managed with the legal arena under pre-proceedings due to the severity of the safeguarding concerns with

- 31 babies being removed on discharge from their mother's care.
- 3 babies were discharged into Mother and Baby placements and a further
- 18 were discharged with their mother to a family member's address with a robust safety plan in place.

The Safeguarding Midwives attend Strategy Meetings for all unborn babies alongside the Police and Social Care in addition to representing maternity services at MARAC, Child in Need meetings, Initial Child Protection Conferences and Core groups.

The Safeguarding Midwives co-ordinate and monitor high risk cases and ensure robust birth plans are in place for all unborn who are subject to Child Protection plans and those within Pre-birth legal proceedings.

The Safeguarding Midwives have made strong working relationships with external agencies; particularly Children's Social Care and the Named Midwife for Safeguarding was instrumental in rewriting the Lincolnshire Pre-birth Protocol, alongside colleagues from the Local Authority.

Increased communication between Drug and Alcohol Services, Perinatal Mental Health Services and the Named Midwife for Safeguarding has ensured multi – professional oversight of our most vulnerable families.

The Named Midwife for Safeguarding is currently working in collaboration with partner agencies to improve and standardise the process of the management of unborn's within the legal arena, in addition to ensuring that the removal of babies from parent's care within the hospital setting is carried out as empathetically and kindly as possible.

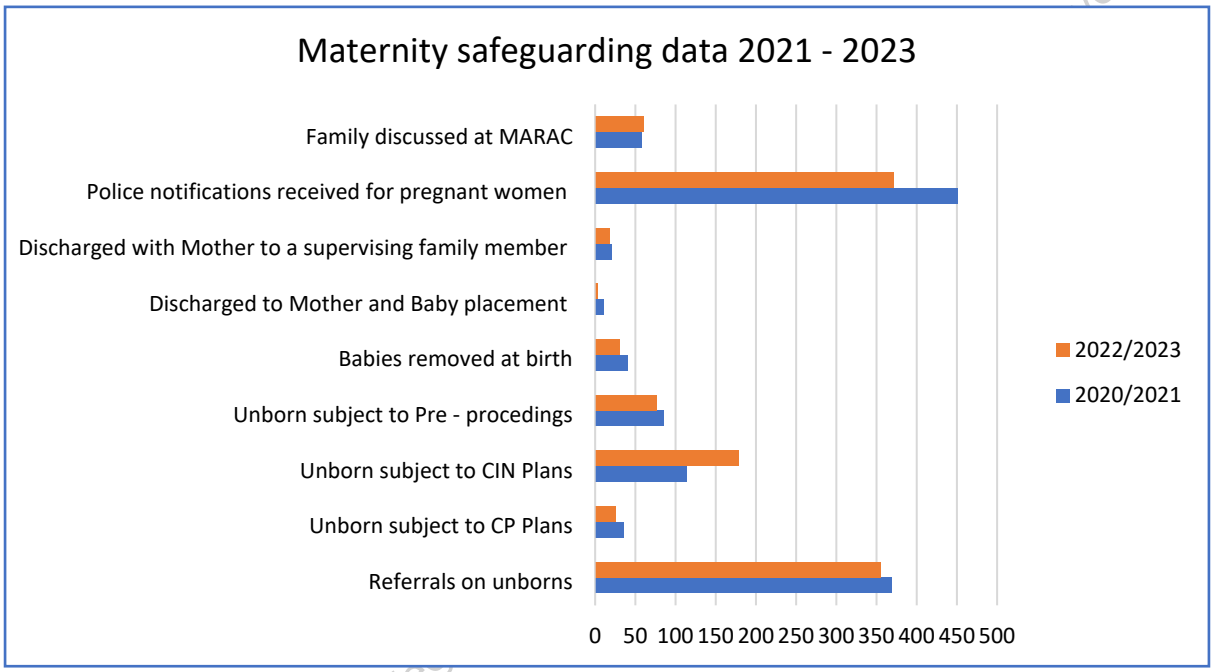
The Named Midwife for Safeguarding receives all Police incidents regarding pregnant women, 371 notifications were received in 2022/23, the majority being domestic abuse incidents with 60 pregnant women being heard at MARAC in that period due to concerns of high-risk domestic abuse.

The notifications allow the Safeguarding Midwives to ensure that any outstanding actions are completed and to monitor on-going safeguarding concerns and make any required referrals to partner agencies.

The Safeguarding Midwives provide regular Safeguarding supervision to all Midwives and also join the Neonatal Unit's safety huddle, weekly, to offer safeguarding support and advice on resident babies and their families.

There has been a noticeable increase in the complexities of safeguarding cases identified within maternity services and it has therefore been imperative that all staff work together to ensure the safest outcomes for the families whom we care for.

Figure 7: Safeguarding Specific Maternity data



14.0 Female Genital Mutilation (FGM)

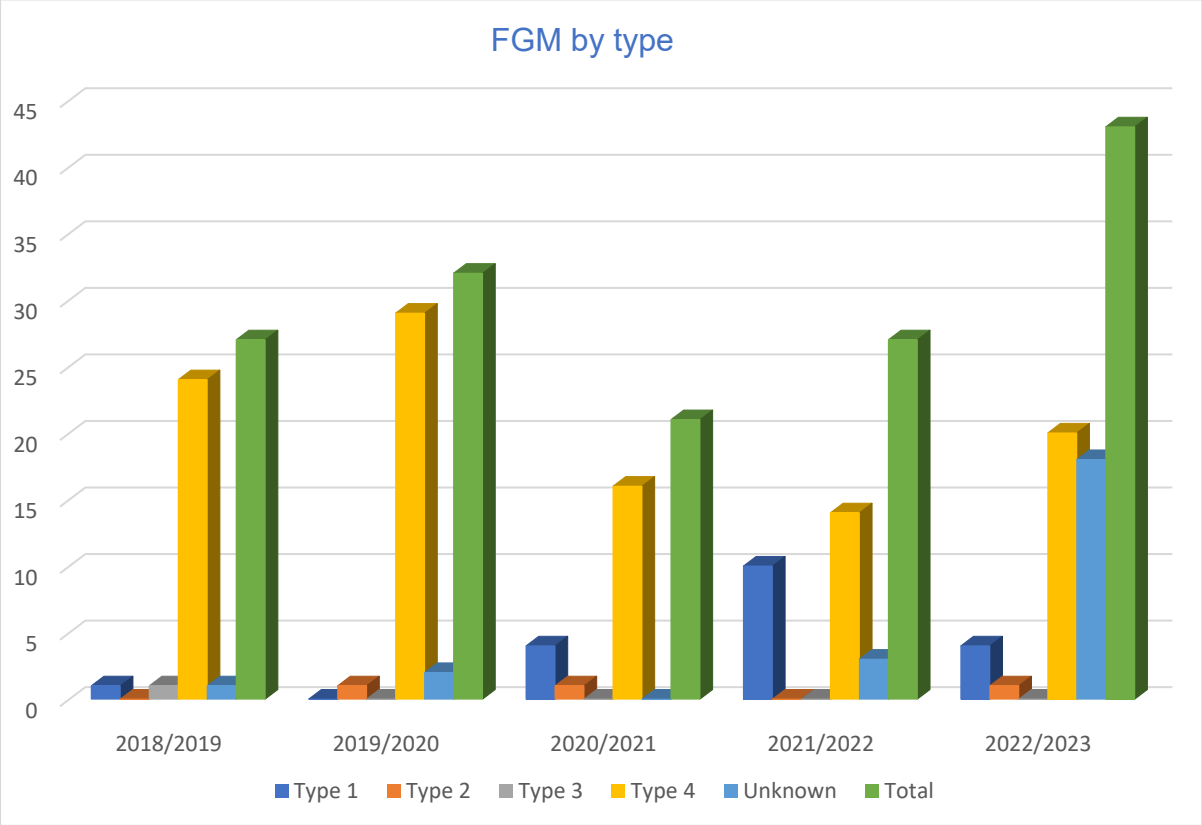
Whilst the issue of FGM affects women / girls across all operational services the midwifery and Gynaecology teams are key within early identification and reporting of this specific area of abuse. The trust has in place an FGM policy and specific working guidance for paediatrics and midwifery.

From 1st April 2015, and in line with National Guidance, the Trust began to routinely submit FGM data. This data is submitted monthly to the Trust's Information Support team for onward submission to NHS Digital.

Between April 2022 and March 2023, the Trust reported 43 cases of FGM (an increase of 60% over the last 12 months, 115% over the last 2 years): of which 20 were Type 4 (piercings); 4 were Type 1, 1 was type 2 and 18 were of an unknown type. All cases reported were reported by adults and those reporting Type 1 had undergone the FGM as children in their countries of origin.

For those Type 1 cases, appropriate safeguards were initiated in respect of the unborn: with the Trust also complying with the appropriate NHSE alerting protocols.

Figure 8: FGM specific data by WHO type classification



15.0 Domestic Violence / Multi-agency Risk Assessment Conference (MARAC)

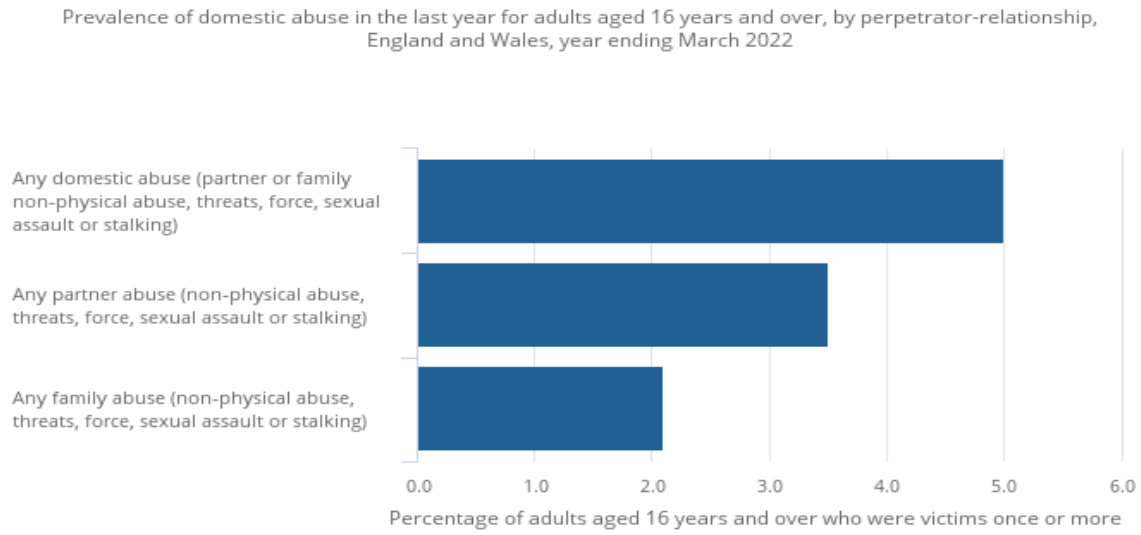
Domestic Abuse costs the country's economy £15.8 billion a year. The cost to health, housing and social services, criminal & civil legal services is estimated at 3.9 billion and of this the NHS spends £1.73 billion.

ULHT is represented at the twice-weekly MARAC meetings by the Safeguarding Specialist Nurses and Safeguarding Midwives and at the Domestic Abuse Operational and Strategic Boards by the Named Nurse for Safeguarding Children and Young People and the Deputy Director for Safeguarding, respectively.

15.1 Key Facts

The Crime Survey for England and Wales (CSEW) recorded a total of 2.4 million adults aged 16 year and over experienced domestic abuse-related incidents and crimes in England and Wales in year ending March 2022. (1.7 million women and 699,000 men). This equates to a prevalence rate of approximately 5.0% of adults (6.9% women and 3.0% men).

Figure 9: shows a higher percentage of adults experienced domestic abuse by a partner or ex-partner (3.5%) than by a family member (2.1%) in the last year. Of those who experienced partner abuse, 84.3% experienced non-physical abuse, 12.9% experienced sexual assault and 20.8% experienced stalking



Source: Office for National Statistics - Crime Survey for England and Wales

One in 20 adults experience domestic abuse in the year ending March 2022

Domestic abuse has a significant impact upon the communities and public services of Lincolnshire.

Domestic abuse remains an under reported issue. CSEW national figures suggest that only 31% of partner abuse victims told someone in an official position about their abuse (i.e., police, health professionals, or local council department). 17% of victims told the police, 18% told a health professional and 5% told a local council department. The majority of partner abuse victims instead told somebody they knew personally about their abuse. 1 in 4 partner abuse victims told nobody at all about their abuse (27%), a

much more concerning statistic amongst males where 1 in 2 (49%) told nobody about suffering abuse at the hands of their partner. (Source: Office of National Statistics)

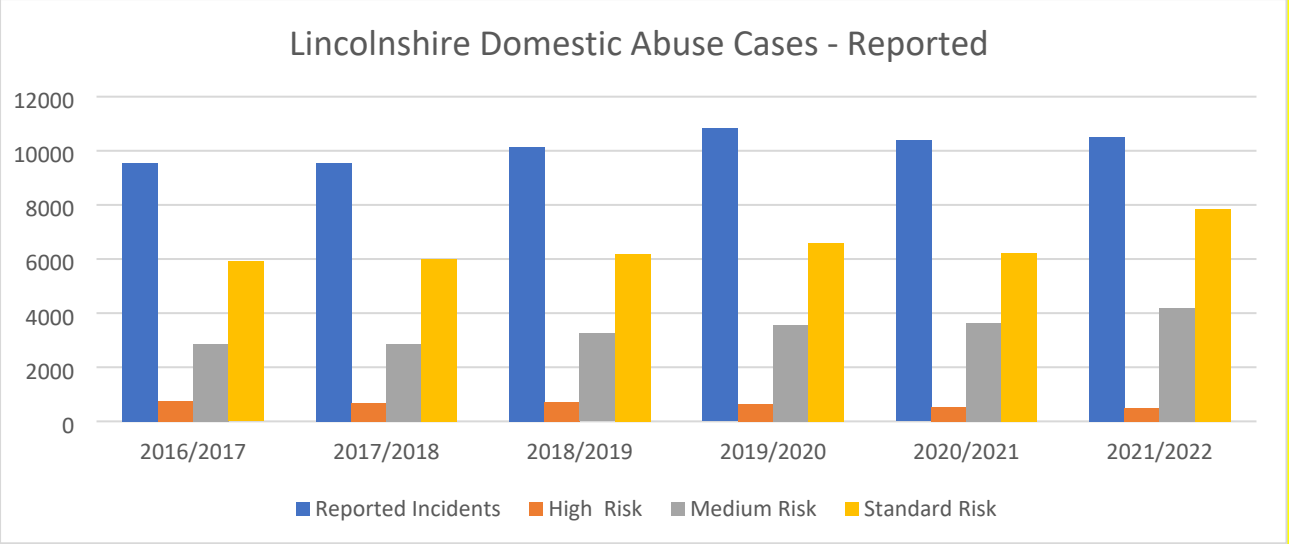
More than one in four women has experienced at least one incident of domestic violence in England and Wales since age 16 (equivalent to 4.8m women)

- On average a woman will experience **35 assaults** before going to the police
- **2 - 3 women a week** are killed by their current or former partner
- **1 in 7 males** will experience domestic violence and abuse
- Domestic violence often starts or intensifies during and after pregnancy
- 3.7 million women in England and Wales have been sexually assaulted at some point since the age of 16
- Around 2,000 women are raped each week. 34% of all rapes recorded are committed against children under 16 years of age
- Estimated 66,000 women in England and Wales have undergone Female Genital Mutilation and over 24,000 girls are estimated to be at risk
- One in four lesbian, gay, bisexual, and transgender people have experienced domestic violence and abuse in their relationship
- Disabled women are twice as likely to experience domestic violence and abuse than non-disabled women and over a longer period of time, suffering more severe injuries as a result of the violence
- Domestic violence and abuse in teen relationships is increasingly recognised as a serious issue. Research now suggests that women between the ages of 16 and 25 are at highest risk.

15.2 Domestic abuse in Lincolnshire

In the last six years, on average there are over 10,000 domestic abuse incidents reported to Lincolnshire Police every year. Of these, circa 6,500 are standard risk incidents, equivalent to around 3 in 5 domestic abuse incidents reported. The proportion of reported incidents that are graded as high risk has been falling, while the proportion graded as medium risk has continued to increase year on year. Improvements in recording practice will have contributed to this.

Figure 10: Domestic Abuse Cases



2022 – 2023 data is not yet available

15.3 Domestic abuse and children

The true number of victims of domestic abuse is likely to be higher when children are included. CSEW figures suggest that 41% of partner abuse victims suffered abuse while their children were in the house, and that 21% of victims disclosed that the children did see or hear what happened. (Source: Office of National Statistics) If only one child was present at each of the 21% of domestic abuse victimisations in Lincolnshire each year, this would mean that 5,500 children witnessed domestic abuse in their home each year. This means that the true number of Lincolnshire residents affected by domestic abuse each year is likely to be upwards of 35,700 adult victims and child witnesses.

The Domestic Abuse Act (HM Government, 2021) now recognises children and young people living within a Domestically Abusive relationship/household as being victims in their own right.

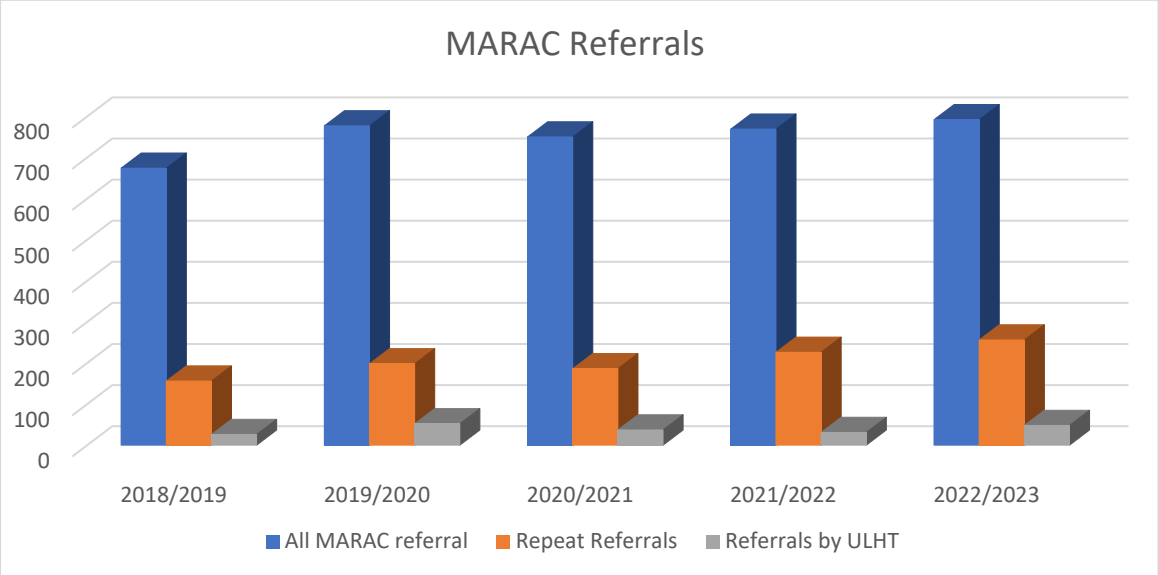
The relatively high rate at which children are present during partner abuse incidents has a number of consequences. At a basic level it places additional responsibility on those agencies encountering domestic abuse to ensure that appropriate checks, risk assessments and safeguarding referrals are being made for child witnesses as well as adult victims of domestic abuse. Domestic abuse is the single most prevalent assessment factor identified in children's social care assessments. It is more prevalent than the presence of factors such as mental health, alcohol misuse, drug misuse, disability and illness, emotional abuse, physical abuse, or sexual abuse. In Lincolnshire during 2018-19, 55.1% of assessments identified domestic abuse as an issue. This is higher than the national average of 50.6%, and places Lincolnshire 42nd among the 151 local authorities in England that supplied information. (Source: Department for Education) Domestic abuse has also specifically been identified as a factor in 54% of all serious case reviews, which investigate child deaths relating to

maltreatment, abuse, and neglect. *(S Framp, Community Safety Analyst, Lincolnshire County Council, May 2021).*

15.4 MARAC cases

There were 792 victims who were at high risk of serious harm or death referred into the Multi Agency Risk Assessment Conference (MARAC) by partner agencies in 2022-2023. On average 188 referrals are made to MARAC every quarter (last 5 years ending March 2023).

Figure 10: MARAC Referrals – all risk levels



MARAC conferences are held weekly in Lincolnshire on both a Wednesday and Thursday and during the last 12 months the team have continued to attend all MARAC meetings. More recently legislation has changes to include additional meetings to be held under Domestic Violence Disclosure Scheme. Moving into 2023 – 2024 this will place additional pressure on the team and will be monitored accordingly including exploration with the ICB with reagrds to the need for additional resources acorss the system.

Figure 11: MARAC Referrals and Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH) assessments made by ULHT Safeguarding Professionals

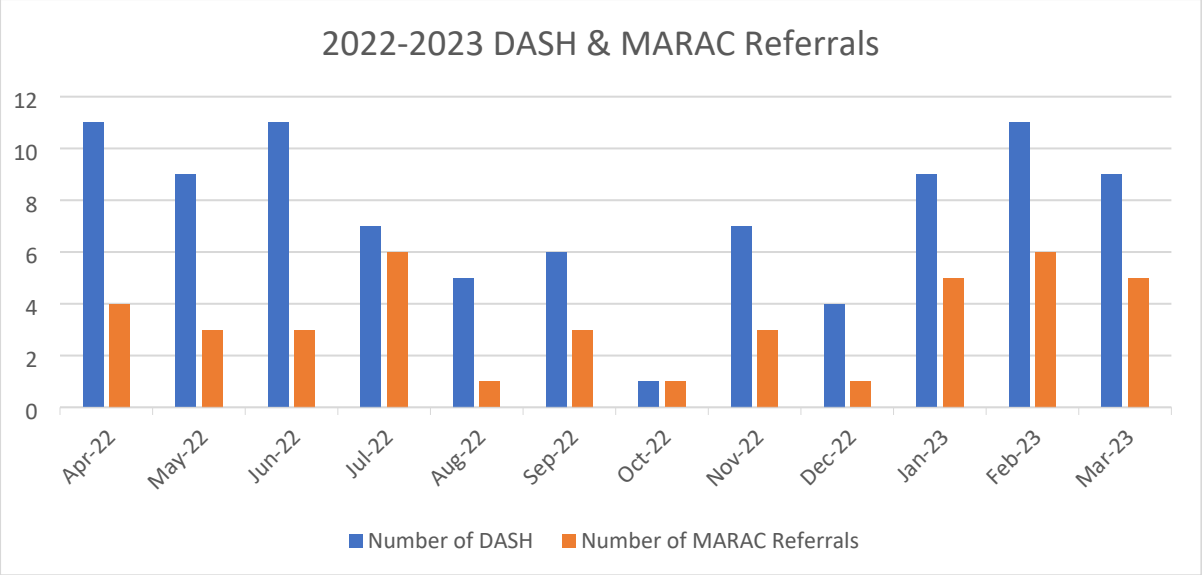
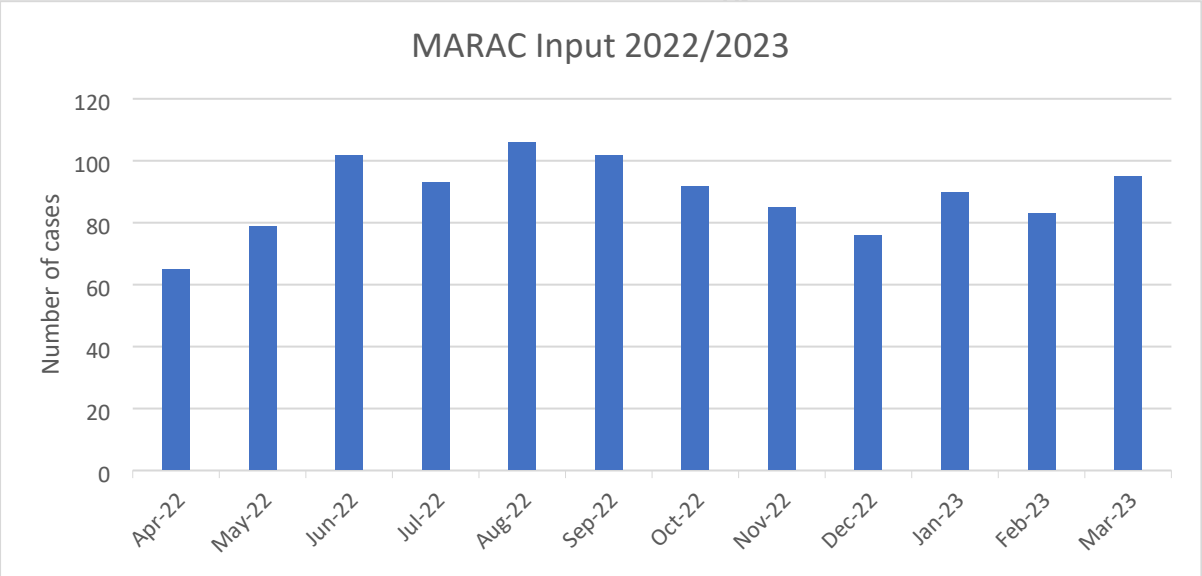


Figure 12: MARAC cases attended by ULHT Safeguarding Professionals



15.5 Domestic Abuse support

During 2022 to 2023 there were 2 Independent Domestic Violence Advocates (IDVA) employed by EDAN Lincs based within the Safeguarding and Vulnerabilities team who provided 1:1 work with victims and support staff to manage disclosures of Domestic Abuse. The IDVAs also supported staff members who make disclosures of experiencing DA in their personal lives. The IDVAs were based within Pilgrim and Lincoln County Hospitals, but also shared support for Grantham Hospital.

Across Lincolnshire there were 4962 referrals for adult victims of domestic abuse to specialist outreach support services in Lincolnshire (provided by EDAN Lincs) during 2022/2023 an increase of 42% on the previous year. As well as referrals there were a further 7759 people who contacted the EDAN Lincs helpline or online chat for one off advice regarding domestic abuse

The current service agreement with EDAN Lincs came to an end on the 31st of March 2023 and following a successful tender the new service provided by EDAN but renamed Lincolnshire Domestic Abuse Specialist Service (LDASS) was launched. Whilst providing an extensive service to clients, including online support, the new service no longer provides an hospital based IDVA service.

The effects of this are currently being monitored, a risk is recorded on the risk register (5157 - moderate) and a business case for funding is being developed with the hope of employing a dedicated ULHT domestic abuse advocate

16.0 PREVENT Lincolnshire Profile

Lincolnshire is classified as a low-level area however this does not mean that no risk exists.

There has been a drive to ensure Women be equally considered as being as capable and motivated to plan and conduct terrorist attacks as men.

The threat from Islamist extremism remains the most likely source of violent attack in the UK, despite local intelligence and referrals being much lower and within Lincolnshire Right-wing extremism occupies the majority of staff time and is the greatest risk in Lincolnshire despite the national trend.

Attacks by self-initiated terrorists (lone actors working independently to a network) is a national priority, having increased significantly in recent years and reflected a trend towards low-complexity attacks (e.g., bladed weapons and vehicles). The solitary and unpredictable nature of this type of perpetrator, combined with short planning times, means attacks can be difficult to disrupt

Lifestyle changes during the pandemic have most likely led to an increased targeting of young people online. Propaganda based on conspiracy theories can also make for complex assessments.

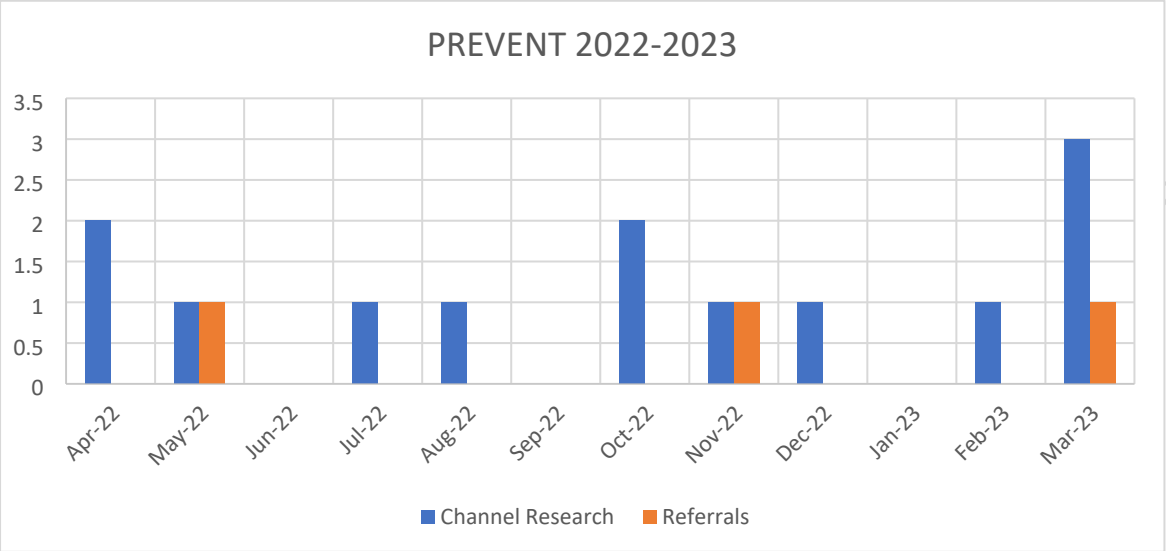
The majority of referrals (37%) related to people with a perceived vulnerability to radicalisation, due to mental ill health, age, abuse etc.

Nearly all referrals related to males, and the highest proportion of subjects were aged between 12 and 16. Female referrals are below the national average. The extent of their involvement in terrorism and extremism represents a significant intelligence gap.

Lincoln, followed closely by Boston, generated most referrals, likely due to population density. Mirroring this trend, Lincoln saw the most hate crime/incident reports

ULHT raised three Prevent referrals in this period.

Figure 13: Number of PREVENT referrals made by ULHT and data analysis cases as part of Channel Process (April 2022 – March 2023)



17.0 Multi-Agency Public Protection Panel (MAPPA)

MAPPA (Multi-Agency Public Protection Arrangements) are a set of arrangements to manage the risk posed by the most serious sexual, violent and terrorist offenders under the provisions of sections 325 to 327b the Criminal Justice Act 2003.

They bring together the Police, Probation and Prison Services and a number of other agencies are under a Duty to Co-operate (DTC) with the Responsible Authority. These include Social Services, Health Services, Youth Offending Teams, Jobcentre Plus and Local Housing and Education Authorities.

There are 3 categories of MAPPA-eligible offender:

Category 1 registered sexual offenders.

Category 2 mainly violent offenders sentenced to 12 months or more imprisonment or a hospital order; and

Category 3 offenders who do not qualify under categories 1 or 2 but who currently pose a risk of serious harm.

All MAPPA eligible offenders are presently flagged with regards to their assessed risks on Medway with processes in place for potential disclosures based on risk.

Figure 12: Lincolnshire Area MAPPA Eligible offenders on 31st March 2022 (2023 figures are not yet available) *Comparative figures 31st March 2021*

Category 1: Registered Sex offender	887	(+30)	↑
Category 2: Violent offenders	144	(-35)	↓
Category 3: Other dangerous offenders	2	(+2)	↓
Total:	1033	(-3)	↑

18.0 Persons in Positions of Trust (PiPoT)

People can be considered to be in a 'Position of Trust' where they are likely to have contact with adults and children at risk as part of their employment.

In line with the Children Act 1989 / 2004 and the Care Act 2014 the LSCP / LSAB have recently launched new PiPoT protocols. This Protocol must be followed in all cases where information (whether current or historical) is identified in connection with:

- The PiPoTs own work
- The PiPoTs life outside work which may raise concerns re contact with adults with care and support needs (for example where a son is accused of abusing his older mother and he also works as a domiciliary care worker with adults with care and support needs. Or where a woman is convicted of grievous bodily harm and works in a residential home for people with learning disabilities).

The PiPoT is admitted with drug and/or alcohol use that compromises their ability to undertake their job with children or adults

The PiPoTs admission causes concern for wider safety of vulnerable children and adults

As part of this protocol the Named Professional for Safeguarding adults has been identified as ULHT PiPoT lead and supports ward managers and HR with cases where concerns are raised. The role supports with sharing information and risk management. ULHT process and HR relations have been strengthened and there has been an increase in the safeguarding support offered, by the team thereby strengthening compliance with legislation and improving Trust assurance processes.

The PiPoT lead has positive working relationship and undertakes significant collaborative working with the Police that enables timely communication and appropriate information exchange. Support and advice have been offered in around 80 possible PiPoT issues in the past year. Of the cases identified several have resulted in a disciplinary sanction, some short of dismissal, a small number of dismissal and referral to external agencies for support.

The process as also highlighted other factors around safe recruitment (historical) for which actions have already been put in place

19.0 Mental Capacity Act and Deprivation of Liberty Safeguards - DoLS

19.1 Background

The Deprivation of Liberty Safeguards was introduced in 2009 and are part of the Mental Capacity Act 2005 (MCA). They are used to protect the rights of people who lack the ability (mental capacity) to make certain decisions for themselves.

The Mental Capacity Act provides the essential framework of guidance for people who need to make decisions on behalf of someone else. It sets out who can take decisions, in which situations, and how they should go about this – making sure they act in the person's best interests and empowering people to make their own decisions wherever possible.

The Deprivation of Liberty Safeguards is set firmly within the empowering ethos of the Mental Capacity Act (MCA). They encourage all health and social care providers to put liberty and autonomy at the heart of care planning, to avoid wherever possible the need to deprive people of their liberty.

This section of the annual report provides an update to the Trust in respect of compliance with the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) in line with the CQC's approach to regulation under the Health and Social Care Act.

19.2 Mental Capacity Act

The Mental Capacity Act 2005 (MCA) came into force in October 2007 and provides a legal framework for assessing capacity and making decisions about the care and treatment of adults who lack capacity. This could be due to a mental health condition, a severe learning disability, a brain injury, a stroke, or unconsciousness due to an anaesthetic or sudden accident. It also created new protections and powers in respect of the decision-making process. The MCA applies to young people aged 16 and over.

The Mental Capacity Act provides:

A duty to treat an incapacitated person in accordance with their best interests.

Limited ability to restrain an incapacitated person in accordance with their best interests but is only lawful where:

- It is necessary to prevent harm.
- Proportionate to the likelihood and seriousness of harm and in the least prohibitive way.

To lawfully deprive an incapacitated person of their liberty, even in their best interests, the trust must follow the statutory DoLS process and obtain an authorisation in line with the Act

When carrying out acts of care and treatment in the best interests of a person who lacks capacity, staff will be legally protected through Section 5 of the MCA against legal challenges, providing that they:

- Have taken reasonable steps to assess the person's capacity to consent to the act in question.
- Reasonably believe that the person lacks capacity to consent.
- Reasonably believe that the act they are carrying out is in the person's 'best interest'.

The Act is accompanied by a 'Code of Practice' which gives essential guidance on the implementation of the key principles.

Other provisions of the Act include:

- Appointment of Independent Mental Capacity Advocates (IMCAs) to support and represent people without capacity who have no-one to speak for them when decisions need to be made about serious medical treatment or a change in a care home or hospital accommodation.
- The Court of Protection is a specialist court with powers to deal with complex matters affecting adults who may lack capacity to take a particular decision.
- Lasting Power of Attorney (LPA) enable people to appoint one or more people they know and trust to make decisions for them on their behalf relating to Personal Welfare (including healthcare decisions) and property and affairs, an LPA must be registered with the Office of the Public Guardian before it can be used.
- Planning for future care – Advance Decisions are applicable when a person who made it does not have the capacity to consent to or refuse the treatment in question, it refers specifically to the treatment in question and the circumstances to which the refusal of treatment refers are present.

19.3 Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards came into effect in 2009 and are part of a legal framework set out in the Mental Capacity Act. They set out the principles that should guide such decisions, including the need to act in the person's best interests and to achieve the desired outcome in ways that put the least restriction on the person's rights

and freedom of action, and empowering people to make their own decisions wherever possible. The reason the Safeguards were introduced was to address the problem that arises if a person does not have the mental capacity to make an informed decision about care or treatment.

There is no simple definition of deprivation of liberty and each decision must be made on a case by case, patient-specific basis. Certain key factors can be relevant in identifying whether the steps taken in caring for a patient amount to a deprivation of liberty. These include:

- The use of restraint (including sedation)
- Staff exercising complete and effective control over the care and movement of a person for a significant period.
- Staff exercising control over assessments, treatment, contacts, and residence.
- Decisions being made that the person will not be released into the care of others or permitted to live elsewhere unless the staff considers it appropriate.
- The refusal of a request by a carer for a person to be discharged to their care.
- The person being unable to maintain social contacts because of restrictions placed on their access to other people.
- The person losing autonomy because they are under continuous supervision and control.

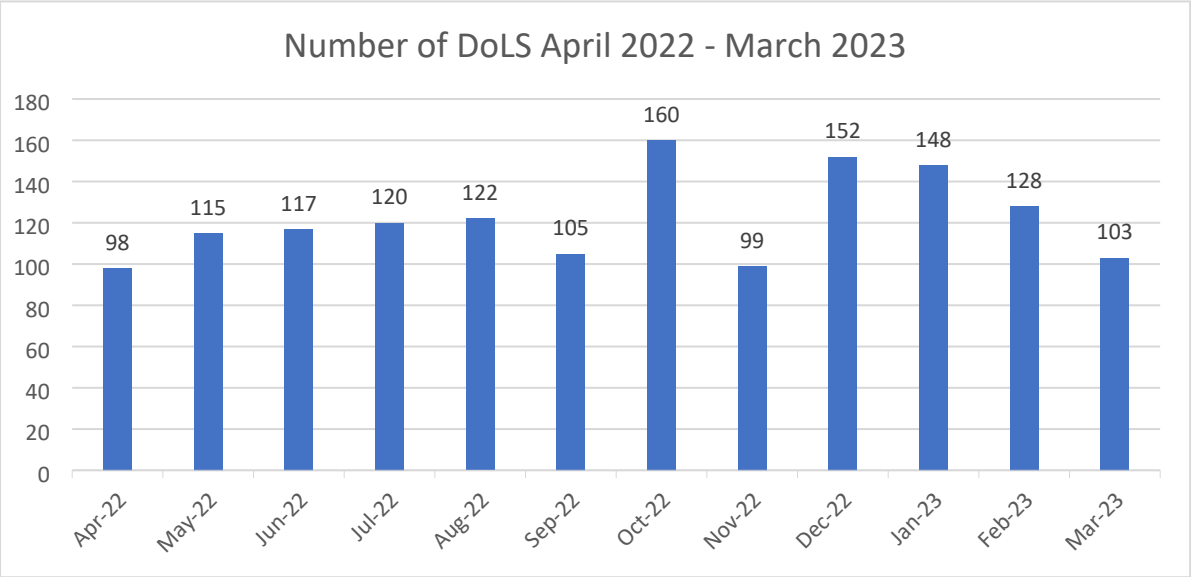
Staff must consider whether the cumulative effect of all the restrictions imposed on the person amount to a deprivation of liberty.

Staff are required to consider the following factors before considering a Deprivation of Liberty Safeguards application:

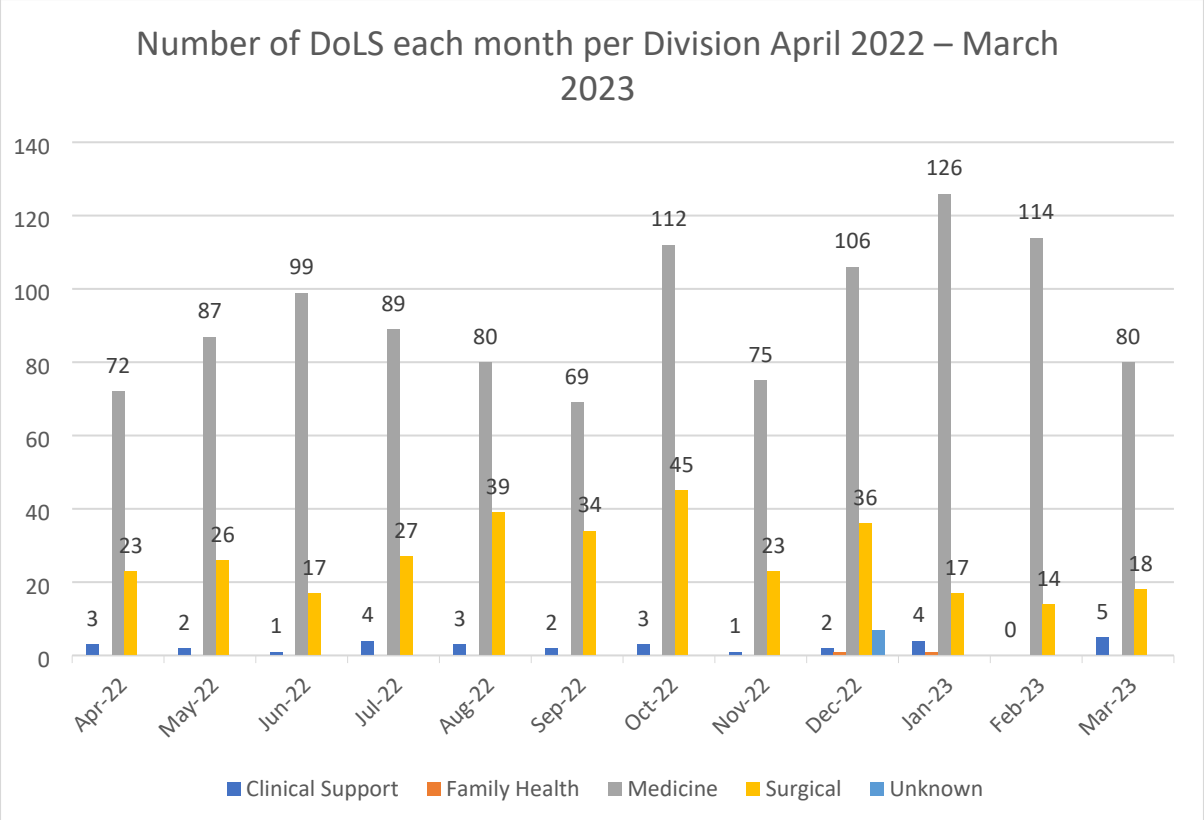
- Can the patient receive the planned care or treatment using a less restrictive but still effective care plan which avoids an unauthorised deprivation of liberty?
- Is the patient receiving treatment for a mental disorder?
- If the patient cannot receive the planned care or treatment with there being a risk of depriving them of their liberty, and all practical and reasonable steps have been taken to avoid a deprivation of liberty, an application for authorisation of deprivation of liberty must be considered.

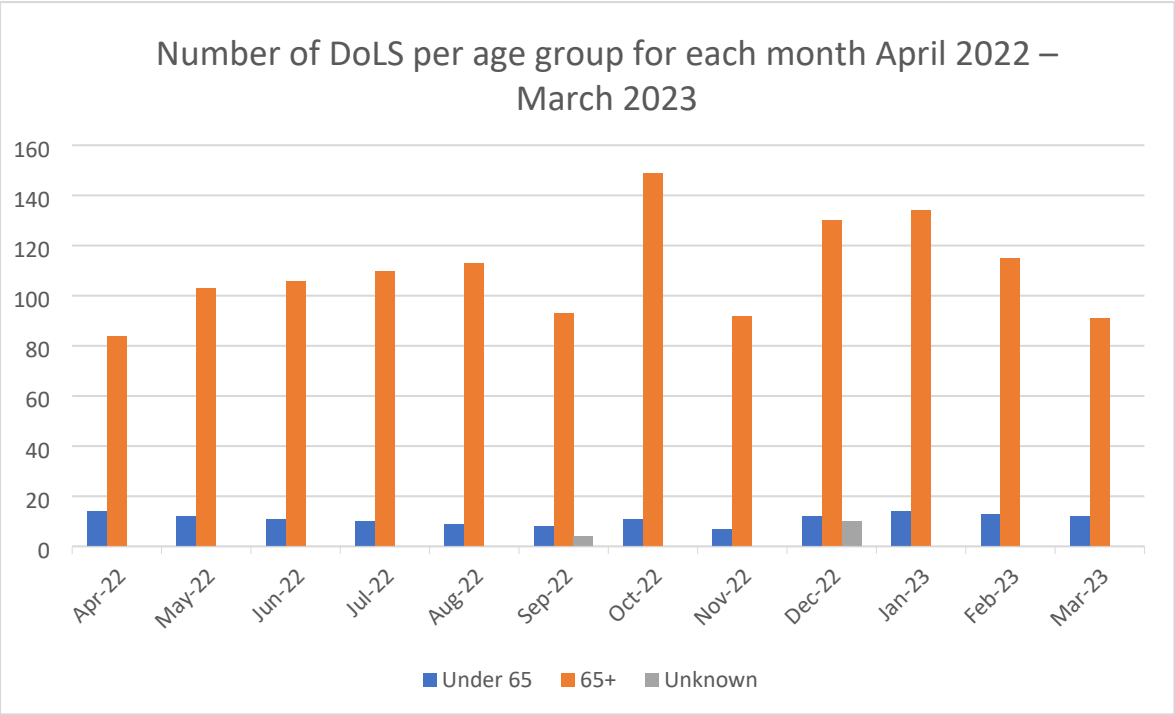
The Trust is responsible for ensuring that it does not deprive a person of their liberty without an authorisation and must comply with the law in this respect.

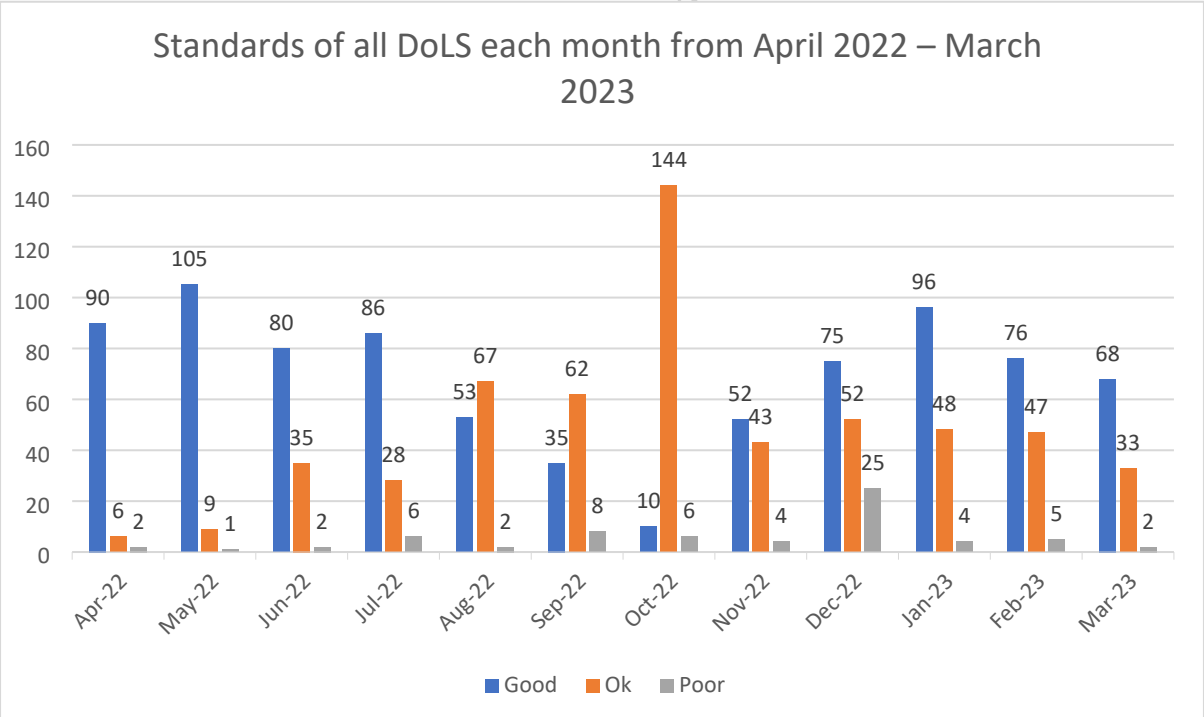
Figure 14: The number of DoLS referral made between April 2022 and March 2023 including a break down for Divisional activity, Quality of completion and Age



Over the last 3 years there has been a steady increase in DoLS application of between 35% and 42% year on year




Number of DoLS per age group for each month April 2022 – March 2023
160
140
120
100
80
60
40
20
0
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Under 65
65+
Unknown


Standards of all DoLS each month from April 2022 – March 2023
160
140
120
100
80
60
40
20
0
90
6
2
105
9
1
80
35
2
86
28
6
53
67
2
35
62
8
10
144
6
52
43
4
75
52
25
96
48
4
76
47
5
68
33
2
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Good
Ok
Poor

20.0 Dementia

20.1 What we know about dementia?

Dementia is a worldwide issue, growing significantly every year. It is estimated that over 55 million people have dementia around the world. This figure increases by 10 million annually and is estimated to reach 78 million by 2030 (World Health Organisation (WHO), 2021; Gauthier et al., 2021). In the UK there are currently 944, 000 people living with dementia, of which around 700,000 are in England, these figures are set to increase exponentially over the coming decades (Alzheimer's Research UK, 2021; Wittenberg et al., 2019b).

20.2 The impact of dementia

Dementia has significant psychological, physical, social and economic consequences for the person living with the disease as well as their families, carers, communities and society at large (WHO, 2021). Not only can dementia severely impact someone's cognitive functioning, but it also has a debilitating effect on their physical capacity, particularly later in disease progression (Alzheimer's Society, 2021b). The cost implications for health and social care are substantial, in 2019 in England alone the total cost of dementia care was £29.5 billion, of that total cost 14% is attributable to healthcare, 46% attributable to social care and 40% attributable to unpaid carers (Wittenberg et al., 2019a).

Figure 15: Projected costs of dementia for older people (£million), 2019-2040

	2019	2020	2025	2030	2040	% change
England						
Healthcare	4,100	4,300	5,300	6,700	10,600	156%
Social care	13,500	14,500	18,600	24,000	39,200	191%
Unpaid care	11,700	12,200	15,300	19,400	30,100	157%
Other	150	210	260	340	540	254%
Total	29,500	31,200	39,500	50,500	80,400	173%

20.3 Dementia in Lincolnshire

There are an estimated 12,216 people aged 65 and over living with dementia in Lincolnshire – equivalent to 6.8% of the over-65 population and 1.6% of the whole population. This is predicted to increase to 16,558 by 2030 and 18,831 by 2035 (54.15%), which is higher than the expected national increase of 51.21%. This will equate to 7.86% of the over-65 population or 2.3% of the whole population.

The number of people aged 65 or over in Lincolnshire is projected to increase by 60,000 (33.5%) between 2019 and 2035, with the highest proportion of people in this

age group who are living with dementia estimated to be in Lincoln, Boston, North Kesteven and South Holland. South Kesteven is expected to see the greatest increase in people with dementia (66.75%), given a predicted shift towards a higher proportion of older people.

The prevalence of dementia increases with age and, due to longer life expectancy, this is higher for women than for men. In 2018, an estimated 61.5% of people in Lincolnshire living with dementia were female.

There were also an estimated 211 people under the age of 65 with dementia in Lincolnshire in 2019.

In 2017, national prevalence of dementia for all ages was 0.8%. At this time, Lincolnshire East and South Lincolnshire were higher than the national figure (1.0% and 0.9% respectively), and Lincolnshire West was the same (0.8%). Southwest Lincolnshire was below the national figure. In the over 65 population, the national figure was 4.33% as at December 2018. Locally, Lincolnshire West had the highest prevalence, which was similar to the national figure (4.37%). Recorded prevalence in the other Lincolnshire areas was significantly lower, and Southwest Lincolnshire had the lowest recorded prevalence in the Central Midlands at 3.59%.

In 2018, the highest rate of dementia diagnoses was in West Lincolnshire (68%), and the lowest rate was in Southwest Lincolnshire (52.1%).

The directly age standardised rate of emergency hospital admissions of people with dementia in Lincolnshire for people aged 65+ (3,095 per 100,000 population) is significantly lower than the national rate (3,609 per 100,000 population) for 2017/18. This equates to 5,559 emergency admissions.

In 2017, there were 1,703 (948 per 100,000 population) deaths of people in Lincolnshire aged 65 and over, where dementia was mentioned either as an underlying cause of death or a contributory factor. This is a similar figure to the England rate of 903 per 100,000 population.

A number of behavioural and disease factors are known to increase the likelihood of developing dementia and many of these are more prevalent in Lincolnshire than at both regional and national levels, including physical inactivity, being overweight or obese, hypertension, stroke, diabetes, CHD and depression. These factors are not evenly spread across Lincolnshire, which creates inequalities in those populations experiencing deprivation

20.4 Progress in ULHT

In 2021 the trust started on a journey and embedded dementia within the safeguarding portfolio and governance framework and as a result appointed a Safeguarding Adults/Dementia Specialist Nurse within the team. There have been numerous projects ongoing over the last 12 months to improve and develop the services for our patients who have dementia or are likely to have an undiagnosed dementia. Work is also underway to support those who have a delirium whilst in our hospitals.

The dementia pathway was designed, piloted, and embedded and is now included in face-to-face training, TEAMS sessions and the recording of podcasts, which are available to all staff via the intranet. Staff have overall been very engaging through training; however, it is evident through audit and observation that compliance is variable. Due to this the pathways are currently being reviewed and the development of a dementia care bundle is underway. This will have a similar layout to that used with our patients who have a learning disability which should give staff the confidence to complete due to the familiarity of its design and content.

Relationships continue to be forged with Dementia Services at LPFT, so that we can work collaboratively and use skills and experience as well as tap into services which will support our patients and their families. This includes encouraging and supporting all staff to refer patients who we are concerned may have an underlying dementia directly through to the memory clinics, rather than requesting GP referral via EDD. We also refer patients with a dementia, or their carers to the Dementia Support Services who can help from the point of diagnosis all the way through to end of life. Contact has also been made with third sector services to engage and support our patients and we have improved communication with Carers First to ensure the carers of our patients are supported and advised as required. Connections are being developed with the Regional Care Providers group to discuss and build bridges with care providers where many of our patients reside.

Carers are a huge asset to our patients who have dementia, and it is critical that we work with them as care partners, as well as ensuring they are supported. To facilitate this, we have worked to develop the Carers Hub at Pilgrim Hospital which is due to open later in 2023. This will be a space staffed by volunteers who are able to offer signposting and advice to the carers as well as a space for them to have a drink and someone to talk to if things are difficult whilst in hospital. Work has also been undertaken to ensure our young carers and informal carers are included too. This will link in with the current work being undertaken to develop Carer Partners as part of the relaunch of the carers policy and carers badge.

Alongside Patient Experience, we have set up a Dementia Carer Expert Reference Group (DCERG), to be able to hear the experiences that our patients with dementia, and their carers have, when using services in ULHT. This is a really important step forward to mould services to support needs using first person experiences. We have held alternate monthly meetings and have had regular attenders, however due to their

other commitments - carer, parent, work etc. as well as sadly 2 members losing the person they care for, the group has become quite small. With discussion with the patient experience team and acknowledging the issues highlighted are the same as those raised by carers of patients without dementia we are working to open the group to carers in general. If there are any issues specifically identified as dementia a smaller task group can be arranged.

Band 4 Dementia Support Practitioners are in post at both Boston and Lincoln. They work with patients and their families early into the hospital admission to develop a one-page care plan, based around the 'All About Me' document, to give staff a snapshot of what this patient needs to have a positive experience whilst in ULHT. It also allows staff to understand the person's background; their likes and dislikes and any triggers of distress, to support reminiscence conversations as well as make reasonable adjustments to their hospital admission to reduce the distress and anxiety of being in an unfamiliar environment. The plan is to also develop activity sessions with the patient, and where appropriate family and staff, to engage and maintain skills to prevent deconditioning and aid stimulation which we often find our patients are lacking.

We now have RAPA alerts (Real-time Automated Patient Alerts) to identify patients who have dementia when admitted to ULHT to assist a quicker response during working hours. Overall, this works, however the RAPA is based on previous admission coding and therefore we are missing a number of patients which the wards are then needing to refer through.

Health Care of Older People have approached and asked for support in making spaces more dementia friendly in the hope of giving safe and relaxing areas which patients can engage in activities. This is being undertaken by a task and finish group and if successful it would be considered Trust wide.

Each ward area has a Dementia Distraction Box which are filled with various activities to distract, stimulate, and comfort our patients. We have fiddle mitts, kindly donated by various knitting groups, games such as dominoes, snap, cards. Larger building blocks and musical instruments as well as colouring packs and puzzles. We often find patients with Dementia are concerned that they cannot afford to pay for their stay or for their meals etc. available in the boxes are small purses and coins to alleviate some of these worries. Our dementia support practitioners also have access to other tools to support patients as required. The distraction boxes are also in line for a review to have tools to support other tools, such as sensory needs which can be beneficial to a wider group of patients. This will also evolve with the introduction of sensory bags within A and E departments which is another tool which is used nationally – predominately for patients with Learning Disabilities.

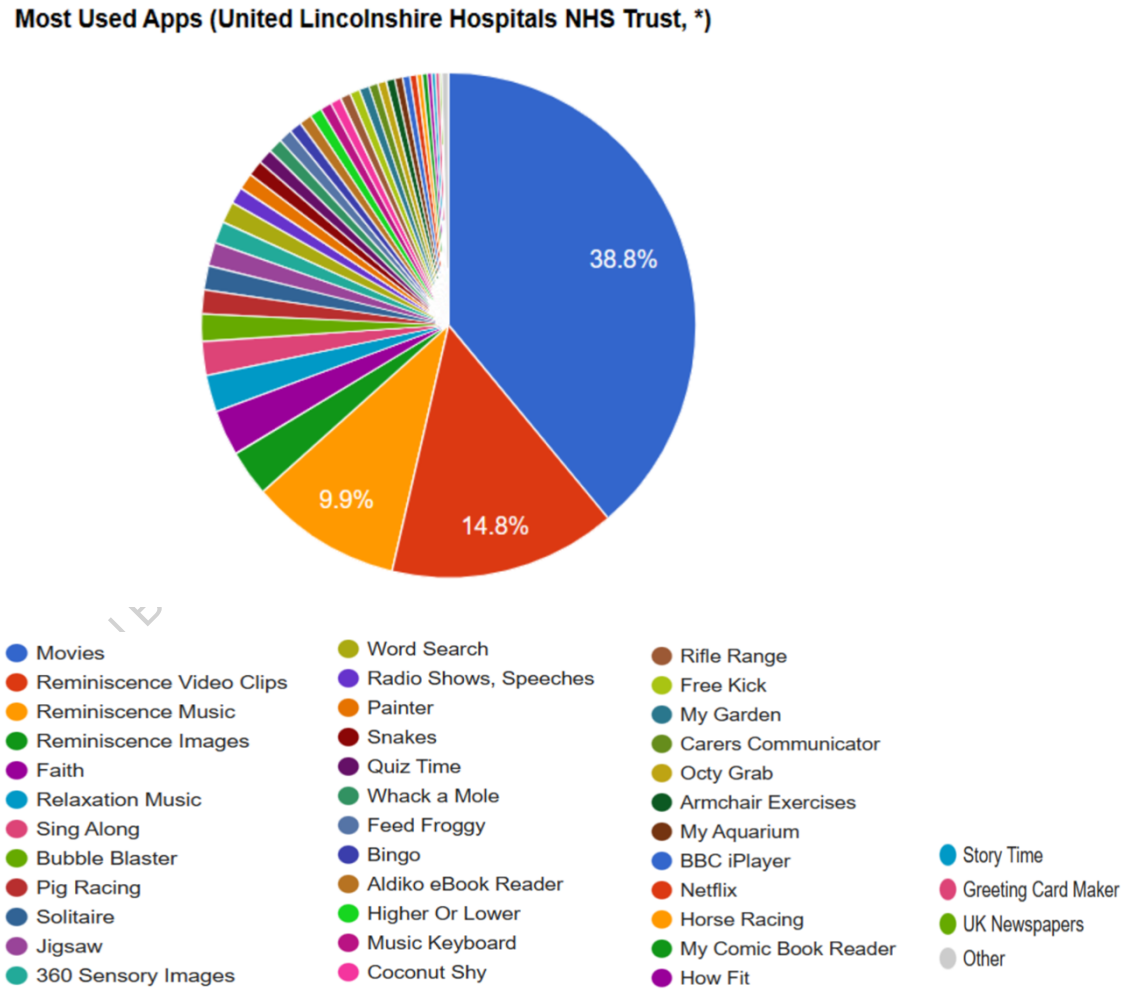
RITA (Reminiscence Interactive Therapy Activities) is a tool widely used across ULHT for our cognitively impaired patients to provide stimulation and distraction through reminiscence. The variety of films and music allows our patients to go back in time to

periods that they often have happy memories. This can then unlock communication skills and a whole world they are wanting to share with staff and their families. Our Dementia Support Practitioners, through conversations with family or carers can find out what genres they enjoy and build this into the activities, and we can watch their whole persona change. We have also found that with using RITA we can reduce the number of falls, as a patient is engaged in an activity and less likely to look for other distractions.

During 2022 with funding provided by the hospital charity, ULHT replaced and took delivery of 40 new RITA devices (20 large and 20 handheld) across the Trust. We undertook a launch week across the Trust, with Face-to-Face training which was well attended with links to training videos and podcasts on the Intranet. Staff are also invited to quarterly training on TEAMS with My Improvement Network.

We now have the ability to access usage data to see which apps are used, the time of day and how long and the clinical area. This allows for an understanding of usage, improve efficiency across the Trust and plan future developments.

Figure 16



Sessions have been developed for the HCSW induction programmes to develop their understanding of dementia and delirium and how we should be supporting our patients with Dementia. Looking at skills and trying to give staff the understanding of how these patients will feel in a strange, busy environment with different people coming and going as well as losing the routine that they all thrive on.

Dementia training is under review to make it fit for purpose and align with the national 10-year Dementia Plan ensuring all staff groups have at least an awareness of dementia and how they can support that person, or their family, from answering the phone, meeting someone in a corridor and to how we can meet their needs on our wards and clinical areas.

The Trust took part in the National Audit for Dementia across 22/23; data collection had a new format and had several challenges. Although to date we have not yet received any information from the audit we are already aware of aspects that we as a Trust need to review and will be discussing over the next year.

Nutrition and hydration have also been a focus across the Trust, and we have been keen to have a focus on our patients with dementia having enough support. We have researched and piloted a national scheme called #butfirstadrink. This initiative is every time we go to a patient, regardless of reason or discipline we offer the patient a drink – even just a sip is an improvement and has been found to improve care overall. The plan is for this to be rolled out Trustwide in the coming months.

21.0 Learning Disability and Autism

A learning disability affects the way a person learns new things throughout their lifetime by affecting the way a person understands and communicates information.

This may mean they can have difficulty with:

- Understanding new or complex information
- Learning new skills
- Coping independently

A visit to hospital can be difficult for anybody, but it is particularly challenging for people who have a learning disability or Autism. Reasonable adjustments to the hospital care of people are not only a statutory duty under the Equality Act 2010 but are also beneficial for all involved

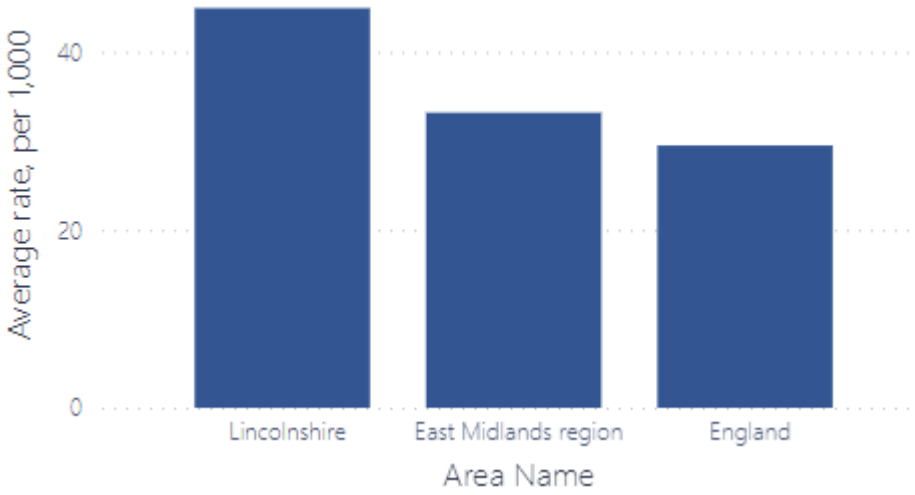
21.1 Learning Disability and Autism in Lincolnshire

21.1.1 It is estimated more than 14,000 adults with a learning disability currently live in Lincolnshire, with the number expected to increase to around 15,800 by 2035. However, only 4,500 individuals are on the Learning Disability Register maintained by County GPs. Of those who are registered, around 75% are in receipt of an annual LD Health Check, meeting the national NHS England target.

Learning disabilities are often confounded with multiple physical and mental health conditions and so there is an increased risk of developing chronic conditions from genetic and lifestyle factors. Evidence suggests rates of numerous major diseases (heart failure, epilepsy, severe mental illness, diabetes and dementia) are higher in adults with learning disability than the wider population. Consequently, average life expectancy for people with a learning disability is significantly lower than for the general population. Continuing to encourage the take-up of Annual Health Checks for people with a learning disability is a high priority to support early identification of health needs and take steps to lower risk (e.g., through modifying health behaviours or medication).

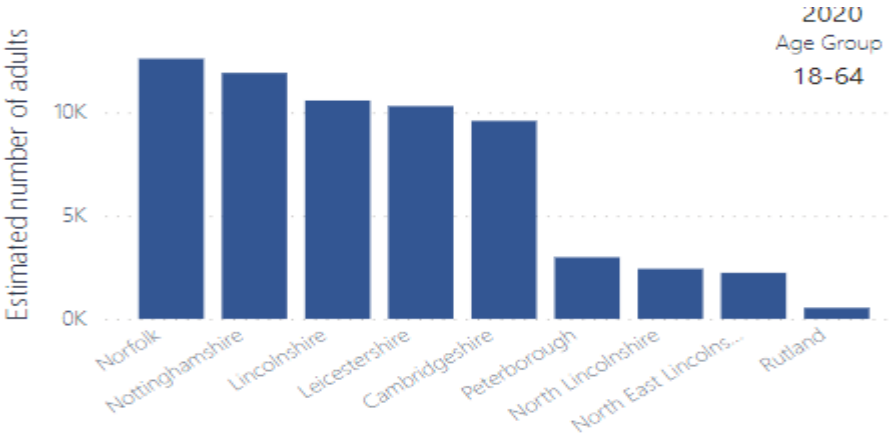
The number of people with a learning disability in Lincolnshire will continue to increase, particularly in those aged over 65. Being medically better able to sustain life, complexity of needs will increase.

Figure 16: Children with Moderate Learning Difficulties Known to Schools 2020



Lincolnshire Health Intelligence Hub 2022

Figure 17: People aged 18-64 predicted to have a learning disability



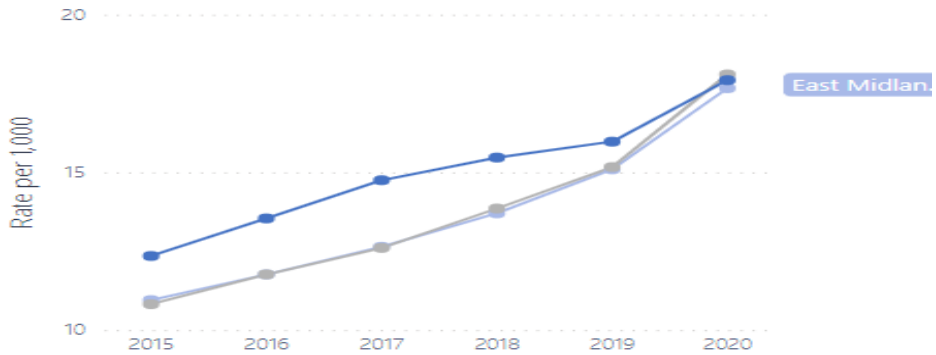
Lincolnshire Health Intelligence Hub 2022

21.1.2 Mechanisms for accurate recording of autism are not consistently available across health, education and social care systems meaning actual reliable figures are currently unavailable. For example, it may be documented that an individual is identified as having a disability within a particularly setting, but not specifically identified that they are Autistic.

In 2021-22, approximately 156 adults (aged 18+) and 192 young people (aged under 16) in Lincolnshire were diagnosed as autistic, according to Lincolnshire NHS mental health data collection. This does not include diagnosis given in private practice, by an out of area referral or by any process beyond the standard autism diagnostic pathways.

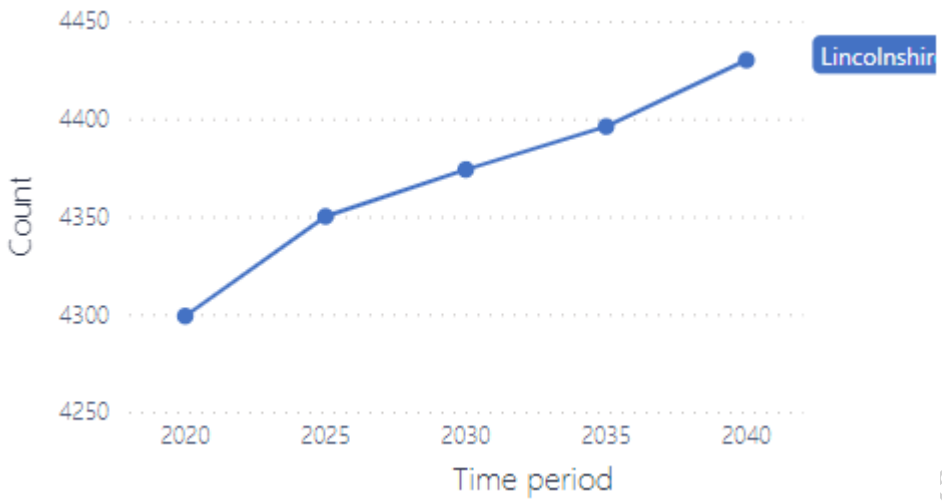
Nationally autism is underdiagnosed amongst certain groups such as older people, those who identify as females and individuals from Black, Asian and minority ethnic groups. This is due to the assessment tools used in autism diagnosis and limited awareness of the ways in which autism can present in different groups. Estimated numbers of individuals living with autism in the local community are likely to increase, as improvements to diagnostic pathways and services are made.

Figure 18: Children with Autism Known to Schools 2020



Lincolnshire Health Intelligence Hub 2022

Figure 19: People aged 18-64 predicted to have autistic disorders by 2040



Lincolnshire Health Intelligence Hub 2022

21.2 Learning Disability and Autism in ULHT

In 2021 the trust embedded Learning disability and Autism within the safeguarding portfolio and governance framework and as a result appointed a Safeguarding Adults/Learning Disability Specialist Nurse within the team who is in the process of developing and rolling out several pathways which make access to the services from ULHT more accessible (at times this will include applications to the Court of Protection).

In December 2021 Learning disability and autism training was launched for all staff groups to ensure staff have an awareness of learning disabilities and autism and know how they can support that person, or their family, from answering the phone, meeting someone in a corridor, through to how we can meet their needs on our wards and clinical areas as well as being able to support through the discharge process to ensure our patients, and their carers have support.

In July 2022 the newly legislated 'Oliver McGowan' Training** was announced as a minimum benchmark for NHS Trusts. The High standards and impact of this training across the NHS has meant that at present there is no national or local ability to fully rollout this training and as such a Lincolnshire wide partnership group is in the process of scoping out the impact and developing a possible way forward.

**** Oliver McGowan Training was added to the Trust Risk Register (5154 – moderate) in April 2023 due to the significant impact that delivering the training will have on the Trust – work is ongoing at a national and system level to try to mitigate the risk and develop a workable solution**

Since starting in post, the Specialist Learning Disability Nurse has provided additional advice, guidance, and support to patients with a learning disability, their carers/

parents, staff within the hospital as well as working collaboratively with health and social care partner agencies to ensure sure a multiagency response to those more complex patients.

The post holder has directly supported patients, and given advice made recommendations to hospital staff and or other health and social care colleagues to approx. 15-20 patients each month. This has directly improved patient care and experience and supported ward and clinical areas with understand the needs of people with Learning disabilities, educating staff and role modelling interacting with patient with alternative communication needs.

Figure 20: Patient referrals into ULHT Safeguarding and Vulnerabilities team (Learning Disability/Autism and/or Learning Difficulties Q3 and Q4

Month	**Number**
October 2022	22
November 2022	28
December 2022	10
January 2023	15
February 2023	20
March 2023	16
Total	111

The post holder has also worked with a number of other patients with learning disability and/or autism while they have been an outpatient, inpatient or as an elective admission. These have involved cases with palliative care needs, cancer patients, 2 week waits and epilepsy.

The post holder has chaired a number of Best Interest Meeting and supported staff to ensure MCA is followed and embedded for patients with learning disabilities. Cases have involved complex, finely balanced and disputed decisions along with planning for cases which have been referred to Court of Protection for approval for care and treatments.

Multi-agency and multi-disciplinary partnership working has been an essential part of the role, establishing strong partnerships with LPFT Learning disability teams especially the Acute Learning Disability Nurses and LCC Learning Disability Social care. The Trust are now involved in a number of proactive physical health meetings across the Lincolnshire services to ensure ULHT are included in plans for people with learning disabilities. This includes the Epilepsy task and finish group looking at Epilepsy services in light of the Clive Treacey Report and new Purple light took kit and

Healthy Lives working Group which is chaired and facilitated by people with learning disabilities,

Currently the team are continuing to revise the Learning Disability Care Bundle which every patient with a learning disability should have completed on admission to a ward. This supports staff to identify and plan how they can meet the needs of people with learning disabilities, including reasonable adjustments.

Bespoke training / Learning Disability awareness on the wards, departments and in Safeguarding supervision sessions continues to be provided to share knowledge, offer advice and staff.

Currently easy read documents are being developed, these have been reviewed by LPFT Experts by Experience and will be added to the External website for everyone to use and added to the Learning disability Folders each ward has.

With support from experts by experience the team have spent time producing a suite of videos which demonstrate hospital experience from a client perspective which will become available during the summer of 2023

An example of the filming is attached in the following link

https://youtu.be/W19l8wmVmxM

Figure 21: Lead Professional during hospital stay

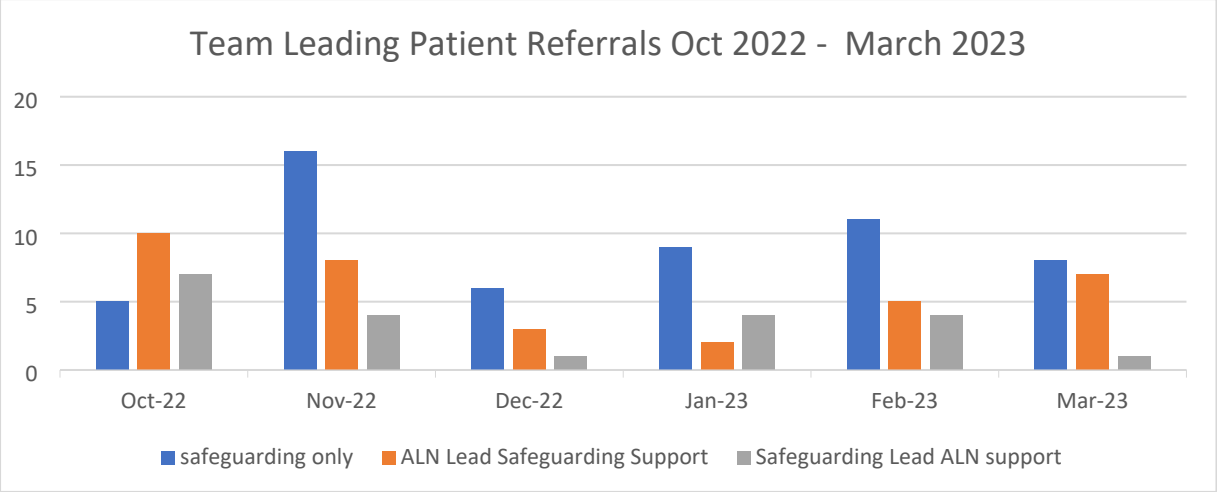
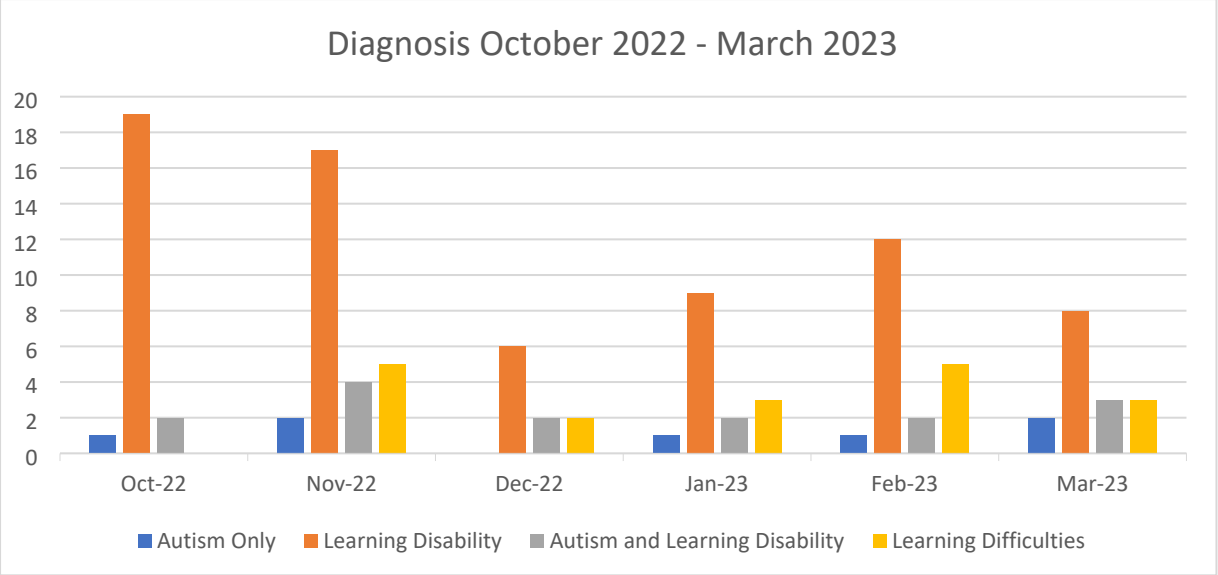


Figure 22: Patient Diagnosis at time of referral



21.3 Future plans for 2022 – 2023

There are clear challenges with elective admissions for patient with learning disabilities who have complex needs and require a number of reasonable adjustments to ensure they are fully supported on admission. The Post holder will be coordinating the development of the surgical pathway to ensure there is a consistent pathway across all ULHT sites for patients with a learning disability. This involves reviewing the current pathways at the start of the process, from listing patient for surgery, pre assessment, anaesthetics, theatre scheduling and adapting it to each hospital site with the different physical environments of theatres / admission wards etc. This will include the introduction of sensory box for theatres and recovery area.

LeDeR / SJR and mortality – Review and audit the feedback from LeDeR and the actions from governance group to look at ULHT role in improving the outcomes of people with Learning Disabilities.

Flags and alerts across the trust for people with Autism and Learning disabilities to ensure more meaningful and are ready for an Electronic Patient Record in the future.

Development of the External website to have a Learning Disability section, with resources / information. This will include accessible information about how to access our hospitals, these will include videos of people with learning disabilities acting.

Develop a funding plan to facilitate the employment of an expert by experience role within the Trust.

Explore a business case for employment of Learning Disability and Autism Support Practitioners.

22.0 Safeguarding Risks

The safeguarding team have proactively used the risk register to identify a variety of risks based on current and future predicted changes and have embedded the actions within the day-to-day business of the team.

Figure 23: Summary of current risks and risk scoring for 2022 - 2023

4628**	If the Trust is found to be in breach of the new Liberty Protection Safeguards (LPS), after they have replaced the Deprivation of Liberty Safeguards (DoLS), it could result in legal action with potential for fines and compensation awards.	MODERATE (9)
4632	If the Trust cares for patients with significant learning disabilities and complex needs in a manner that is not appropriate to their needs (e.g., because there is no pathway to achieve a General Anaesthetic for procedures such as blood tests/ MRI, etc.) it could lead to sub-optimal care and delays in diagnosis or treatment with an increased likelihood of serious harm or a poor clinical outcome.	LOW (6)
4627	If a patient becomes agitated and in response the Trust applies sedation, restraint, chemical restraint, or rapid tranquilisation inappropriately it could result in serious harm to the patient; other patients; or members of staff and could lead to subsequent legal or regulatory action	MODERATE (9)

During 2022 – 2023 the safeguarding team have been actively involved with working against these objectives which are monitored by the Safeguarding and Vulnerabilities Oversight Group

***** On the 6th of April 2023 the Department of Health and Social Care (DHSC) announced that the implementation of Liberty Protection Safeguards (LPS) will not go ahead this side of a general election (anticipated to be Autumn 2024) therefore this risk has since been closed***

23.0 A review of 2022 – 2023

The last 24 to 36 months have been a challenge for everyone across the United Kingdom in a way that no one could have envisaged. Across the safeguarding system new ways of working have been developed to help support our most vulnerable in society as well as provide a wider level of support to all staff within the trust and external safeguarding teams.

The normal pattern of safeguarding across Lincolnshire has changed and meant that some of its residents did not access services as normal during the Covid Pandemic.

During 2022 to 2023 safeguarding activity appears high particularly in relation to patients admitted due to eating disorders/disordered eating and Mental Health related issues as well as cases being more complex in nature.

As expected Nationally there have been several serious children / adult reviews which indicate the negative impact on our ability to safeguarding our most vulnerable during the pandemic and domestic homicide reviews appear to be on an increase

As we move from the Covid Pandemic the team have continued to make the following adjustments based on service and client need:

- Face to face supervision resumed; with additional sessions available via Teams to facilitate attendance
- Continued review of safeguarding and vulnerabilities pathways and processes to support staff in managing safeguarding related concerns
- Resurrection of face-to-face Level 3 Safeguarding Childrens training, thereby facilitating increased attendance, understanding and knowledge of local processes. Teams and face-to-face Level 2 Safeguarding Children and Level 2 Safeguarding Adults and MCA training also restored to facilitate increased attendance.
- Acted as first line contact for our local authority colleagues specifically in the area of MCA and DoLS due to face-to-face client contact not taking please or being limited within the hospital setting
- Maintained and increased our presence in external / partnership processes such as the LSCP / LSAB / strategy meetings / MARAC etc.
- Continue to embed and maintained the Safeguarding governance process across all divisions ensuring that safeguarding remained at the forefront of operation business
- Continued to develop policies and improvements, undertook audits to maintain safety and identify risks
- Continue to develop and expand safeguarding roles within the team to ensure that the Trust is able to deliver a safeguarding and vulnerability service (child protection / adult protection / MCA / PREVENT/learning disability / autism and mental health)
- Continued support the data protection team in delivering requests made by the judicial system
- Provided continued support with chairing complex MDT meetings and best interest meetings.
- Continue to support staff members who are required to produce statements for, or attend as a witness in, Family or Criminal Court.
- Facilitated the delivery of quarterly trust wide court craft skills training events and bi-annual Legal updates for staff who are required to attend court delivered by the trust solicitors
- Further developed and training in relation to Learning disability and Autism
- Safeguarding team actively involved in the review of complaints and Serious Incidents with a safeguarding or MCA aspect
- Continue to undertake ward spot checks for divisional leads

- Review the ligature risk assessment process and rollout the ligature cutter (QUAD) pack across clinical areas alongside refreshed ligature training
- Resurrected the production of a Safeguarding Children Activity Report – to highlight Trust-wide activity in relation to Safeguarding Children; whilst also enabling confirm and challenge within Divisional Teams.
- Re-launched the Safeguarding Champions' Network, in line with findings from the Grant Thornton audit.
- Continued to support with HR processes in relation to staff members for whom Safeguarding concerns have been raised (LADO/PiPoT)
- Amended contribution to the Divisional Safeguarding Operational Meeting Agenda, in line with the findings from Grant Thornton audit.

24.0 Safeguarding Developments and ongoing work for 2023-2024

- Maintain momentum to achieve 90% across safeguarding training areas
- Finalise and embed pathways for clients with learning disability / autism across trust services
- Continue the transition from the current Trust learning disability and autism training to the newly legislated Oliver McGowan training (3-year plan)
- Launch the trust wide dementia pathway
- Embed the training of MCA/DOLS ensuring that there is a better understanding of best interest planning, and that staff are able to more readily identify patients who require extra care and have clear plans to follow in line with legislative requirements
- Audit adult concerns submissions to ensure compliance with 'Making Safeguarding Personal'
- Identify the training cohort and embed the new De-Escalation, Management, and Intervention (DMI) training across the Trust
- Further embed RITA (Reminiscence Interactive Therapy Activities) within the clinical areas ensue data is available to demonstrate trends and effective usage.

(RITA is a stand-alone computer system that is used with dementia patients as a therapeutic aid)

- Continue to review and roll out MHA procedures
- Review and embed the new Learning Disability bundle and shared care agreements
- Develop a system of flags and alerts across the trust for people with Autism and Learning disabilities to ensure more meaningful and are ready for an Electronic Patient Record in the future.

- Development of the External website to have a Learning Disability section, with resources / information. This will include accessible information about how to access our hospitals, these will include videos of people with learning disabilities acting.
- Approve and roll out the surgical assessment process for patients with a learning disability who requiring a GA
- Continue to support A&E departments in their CQC Must-Do action to fully embed compliance with the Trust's CP-IS process.
- Fully embed the actions from the Grant Thornton Audit
- Launch and embed CP-IS phase 2 within Community Paediatrics
- Develop a business case for a post of Safeguarding Domestic Abuse Advocate to replace the gap created by the new LDASS
- Develop a business case for employment of Learning Disability and Autism Support Practitioners.
- Develop a funding plan to facilitate the employment of an expert by experience role within the Trust
- Develop in partnership with Family Health a new model of service delivery for Child Protection Medicals

25.0 Conclusion

This report demonstrates the continued development and increased awareness of safeguarding and vulnerability issues within the Trust. The Trust continues to respond to the rapid national and local pace of change as well as maintaining an input external to the Trust.

The safeguarding governance structures have been reviewed to ensure continued effectiveness, actively managing the current action plans as well as moving services forward. These will be continually reviewed to ensure that the structures remain fit for purpose.

The forthcoming year promises to be full of further developments and challenges for both the team and the Trust

26.0 Recommendations

It is recommended that the Trust Board

i) Receive the safeguarding report

ii) Approve the plans for 2023 - 2024

Appendix 1: Safeguarding Team – Structure April 2021 – March 2024

Safeguarding Team

March 2023

Portfolio:

Safeguarding Children

Safeguarding Adults

Mental Capacity and DOLS

Learning Disability / Autism

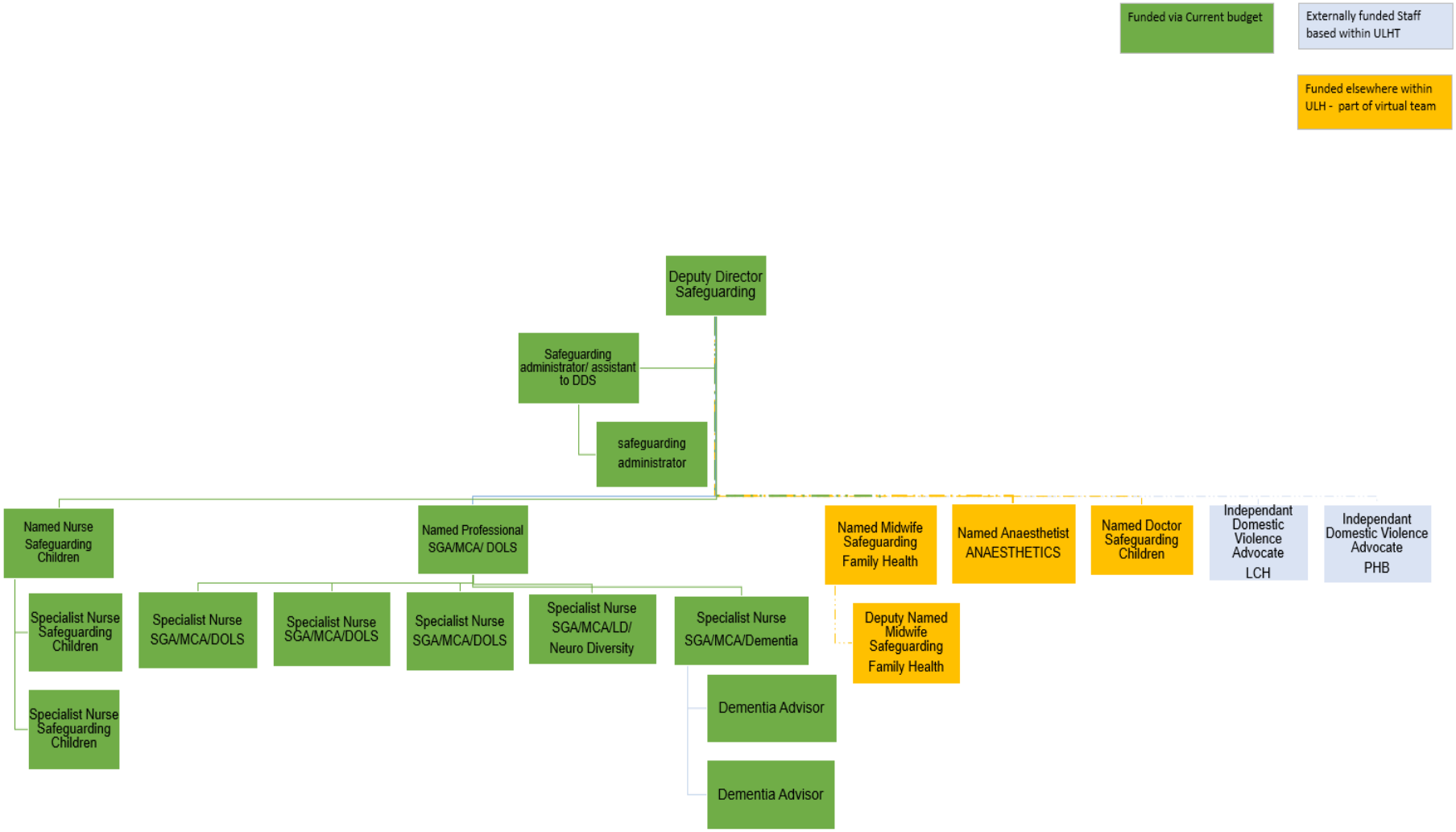
Dementia

Mental Health

PREVENT

Domestic Abuse

Safeguarding and Vulnerabilites Team - propose structure April 2021 - March 2024 (current position as at 31st March 2023)



United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*4th July 2023*
Item Number	*Item 8.3*

Complaints Annual Report 2022-23

Accountable Director	*Professor Karen Dunderdale*
Presented by	*Kathryn Helley*
Author(s)	*Claire Tarnowski*
Report previously considered at	*Patient Experience Group* *07 June 2023* *Quality Governance 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	*x*
1c Improve clinical outcomes	
2a A modern and progressive workforce	
2b Making ULHT the best place to work	
2c Well Led Services	
3a A modern, clean and fit for purpose environment	
3b Efficient use of our resources	
3c Enhanced data and digital capability	
3d Improving cancer services access	
3e Reduce waits for patients who require planned care and diagnostics to constitutional standards	
3f Urgent Care	
4a Establish collaborative models of care with our partners	
4b Becoming a university hospitals teaching trust	
4c Successful delivery of the Acute Services Review	

Risk Assessment	*3487*
Financial Impact Assessment	*N/A*
Quality Impact Assessment	*N/A*
Equality Impact Assessment	*N/A*
Assurance Level Assessment	*Insert assurance level* • *Moderate*

Recommendations/ Decision Required	• *Trust Board to note the report*

Executive Summary

This report provides information on the complaints received in the Trust between 1 April 2022 and 31 March 2023.

In 2023 the Complaints Team appointed a Clinical Senior Complaints Case Manager. The purpose of this role was to improve response times by utilising clinical expertise to work differently to address complaints.

During 2022- 2023 the Trust received 835 Complaints which was an increase of 189 from the previous financial year 2021-2022.

During 2022-2023 the Trust received 4906 PALS enquiries which is a decrease of 71 from the previous year.

There were 937 complaints responded to within 2022-2023 which is an increase of 393 from 2021-2022. This increase is reflective of the work that has been undertaken to clear the backlog of complaints.

The Trust had 115 overdue complaint responses as of the 1 October 2022. The Complaints Team developed a trajectory in conjunction with the Divisional Leads to clear the backlog by 31 March 2023. As of 31 March 2023 although we were unable to clear the backlog the Trust currently had 11 overdue cases remaining. Of these overdue cases:

- 1 meeting (booked)
- 3 awaiting Executive final sign off
- 2 awaiting Divisional Approval
- 5 with the Complaints Team being investigated

Top three primary subjects of complaints received:

- Communication
- Clinical Treatment
- Appointments

47 (5%) complainants who received their first response during 2022-2023 requested further information following their initial response.

9 complaints were referred to the PHSO.

The Trust have implemented a number of processes to improve shared learning across the Trust.

A new designated complaints room at Lincoln County Hospital has been established for families to meet and discuss their complaints.

NHS
United Lincolnshire Hospitals
NHS Trust

ANNUAL COMPLAINTS REPORT

2022-2023

OUTSTANDING CARE
personally DELIVERED

Executive Summary

This report provides information on the complaints received in the Trust between 1 April 2022 and 31 March 2023. It provides a summary of:

- The number of complaints received
- The departments the complaints relate to
- The main complaint raised
- The key trends identified
- The actions taken in response or those planned for the future

The report also reviews our performance against agreed response targets and the number of complainants who came back dissatisfied following receipt of their initial response.

Introduction

Complaints and PALS enquiries are a key source of feedback for the Trust and informs us about our patients views regarding quality of services and care provided. All staff are encouraged to respond to concerns raised by patients and relatives as soon as they become aware of them, rather than waiting to receive a formal written response and our PALS service supports this process. All formal complaints are responded to appropriately on an individual basis and are fully investigated through the Trust's complaints procedure.

If patients or relatives wish to make a formal complaint, this is dealt with by the Complaints Team. Under the NHS Constitution people have the right to have their complaint dealt with efficiently. It is the right of every health service user to bring aspects of treatment and care with which they are dissatisfied to the attention of the Trust management. They are entitled to have their complaint or concern investigated, to receive a full and prompt, open and honest explanation, as well as an apology if it is due.

ULHT treat all complaints seriously and ensure that complaints, concerns and issues raised by patients, relatives and carers are thoroughly investigated in an unbiased, non-judgmental, transparent, timely and appropriate manner. The outcome of any investigation, along with any resulting actions will be explained to the complainant by the investigating organisation.

Looking Back at the Past Year and our Achievements

We have a fantastic Complaints and PALS team and we have had some huge successes over the past year, and we are ready to build on these successes to work towards the best NHS complaints service.

New Clinical Senior Complaints Case Manager Role

In 2023 we had the opportunity to recruit to a new role. This role was a Clinical Senior Complaints Case Manager. The purpose of this role was to improve response times by utilising clinical expertise to work differently to address complaints. The Clinical Senior Complaints Case Manager reviews all of the complaints received into the Trust and identifies complaints that can be resolved through a telephone call or at a meeting with the complainant. These cases are intended to be investigated and resolved within 10 – 25 working days without the need for a full written response.

Support is still required from the Divisions to provide the Clinical Senior Complaints Case Manager with prompt information to be able to respond quickly to the complainant. If the offer of a meeting is acceptable, we still request that staff from the Division attend to give their expert opinion.

From 3 October 2022 – 15 March 2023 (5 Months) a review of the new process demonstrated the following:

- Reviewed 244 Complaints that were received by the Trust
- 8 Requested a full written response and were returned to the Complaints Facilitators
- 3 referred through to PALS
- 1 referred for Serious Incident investigation

- 1 referred for a Healthcare Professional Feedback (HPF)
- 1 referred to LCHS
- Resolved 230 complaints

Feedback from complainants regarding the Clinical Senior Complaints Case Manager role

- Thanked the team for a prompt call
- Appreciated the quick resolution
- Appreciated that someone was listening to them
- Pleased that someone got back to them in a timely fashion
- Felt listened to

The Divisional staff who have been approached for information from the Clinical Senior Complaints Case Manager have also been very helpful and receptive to help aid early closure of the complaint.

Overdue Complaints

The Trust had 115 overdue complaint responses as of the 1 October 2022. The Complaints Team developed a trajectory in conjunction with the Divisional Leads to clear the backlog by 31 March 2023. As of 31 March 2023 although we were unable to clear the backlog, however, the Trust currently has 11 overdue cases remaining. Of these overdue cases:

- 1 meeting (booked)
- 3 awaiting Executive final sign off
- 2 awaiting Divisional Approval
- 5 with the Complaints Team being investigated

The Complaints Team and the wider Teams have worked extremely hard over the past year and put in an enormous effort to clear the backlog of complaints and PALS enquiries to make it our top priority. We have focused on building strong relationships within our Divisions to ensure that we provide an open and transparent

response to our complainants. We have supported each other to achieve this goal, adapting to changes within the team and working collaboratively to resolve any issues that arise. The introduction of the Clinical Senior Complaints Case Manager has had an incredibly positive impact on our ability to resolve formal complaints quickly and efficiently thus providing early resolution. Thanks to the hard work of our team, we have made significant progress in addressing complaints and improving our overall complaint management process.

The Complaints Facilitators have been allocated a dedicated Division, they are known as the Complaints Business Partner for that Division. This helps to develop good relationships and engagement within the Division and provides consistency when supporting the co-ordination of complaints received by the Trust. Business Partners attend Speciality Governance meetings and discuss themes and trends that have been identified through their complaints.

The Divisional Triumvirate have reviewed their processes to ensure the responses are reviewed and approved within the agreed timescales to prevent any additional delays.

A weekly list of all complaint responses awaiting executive sign off are sent to the Executive Assistant to the Chief Executive to coordinate the sign off process.

Praise from Complainants

We were extremely proud to have received praise from complainants for the support the Complaints Facilitators provide throughout the investigation process. We understand that making a complaint can be a difficult and emotional experience and

our team is dedicated to making this process as easy as possible for all parties involved. Our Complaints Facilitators are trained to provide empathetic and non-judgemental support and they work tirelessly to ensure that complainant's feel heard, respected and valued throughout the investigation process. We are proud to have such a dedicated team who are committed to providing an excellent service to our patients and families.

Designated Meeting Room

We are pleased to announce that a new designated complaints room has been established for families to meet and discuss their complaints. This tranquil and calm space has been designed to provide a comfortable and private setting away from the main hospital where complainants and their families can feel at ease while discussing their concerns. The room is equipped with comfortable seating, a table, and all the necessary equipment to facilitate open and productive discussions. Our aim is to provide a supportive environment where families can feel heard and valued and where we can work together to address concerns that may arise.

Complaints Received and Outcomes

During 2022-2023, The Complaints Team have continually reviewed the processes to ensure timely and high-quality responses are formulated. Our complaints process tries to balance the need to identify actions to improve care with the ability to listen, reflect and recognise that every one of us can learn from the experiences of others. We need to be willing to make ourselves uncomfortable by listening authentically to experiences that are not good, are willing to listen, to hear and validate experiences where we find ourselves as a Trust falling short.

During 2022- 2023 the Trust received 835 Complaints which was an increase of 189 from the previous financial year 2021 -2022. The COVID-19 Pandemic may have impacted on the number of complaints received in 2021-2022 however the numbers received during 2022-2023 are higher than pre pandemic numbers. The Clinical Senior Complaints Case Manager initially responded to PALS concerns which may have resulted in the higher number of complaints, a process has been developed to

ensure all PALS concerns are responded to by the PALS Team. There were 937 complaints responded to within 2022-2023 which is an increase of 393 from 2021-22. This increase is reflective of the work that has been undertaken to clear the backlog of complaints.

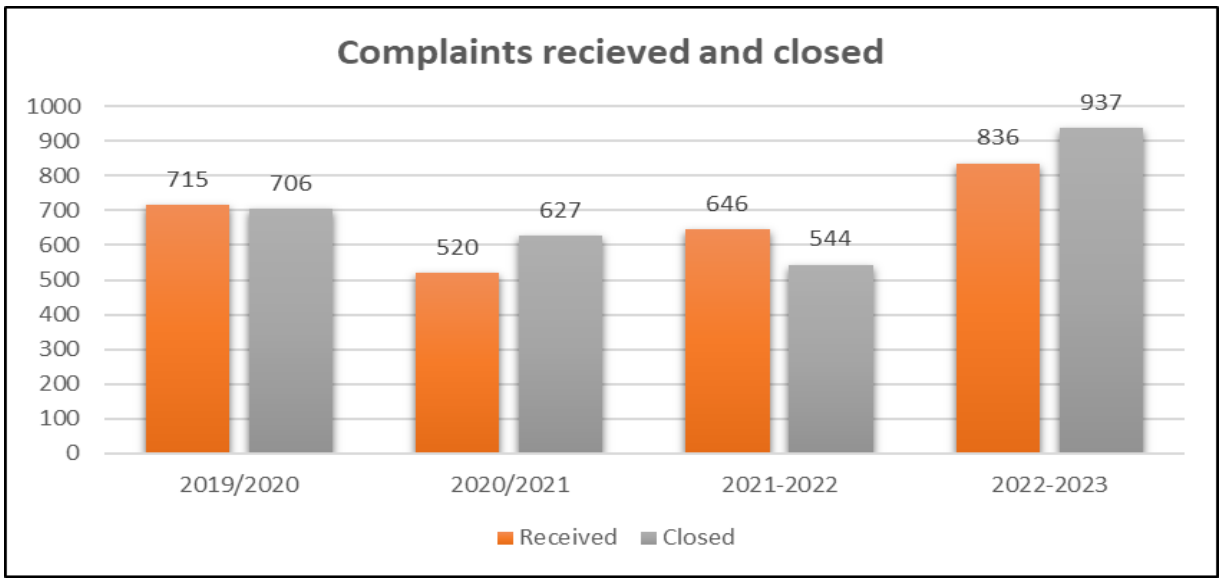
The 835 Complaints received are from a total of 916,667 emergency department, Inpatient and outpatients' episodes. This equates to a complaint ratio of 0.09% which is comparable to last 4 years.

Of the 937 complaints that were responded to:

- 384 were responded to within the agreed 50-day timescale.

100% of complaints received by the Trust were acknowledged within 3 working days. The acknowledgement is confirmed by either an email or telephone call and these are followed up by a letter.

The chart below gives a comparison of complaints received by the Trust and the number responded to for the preceding four years.

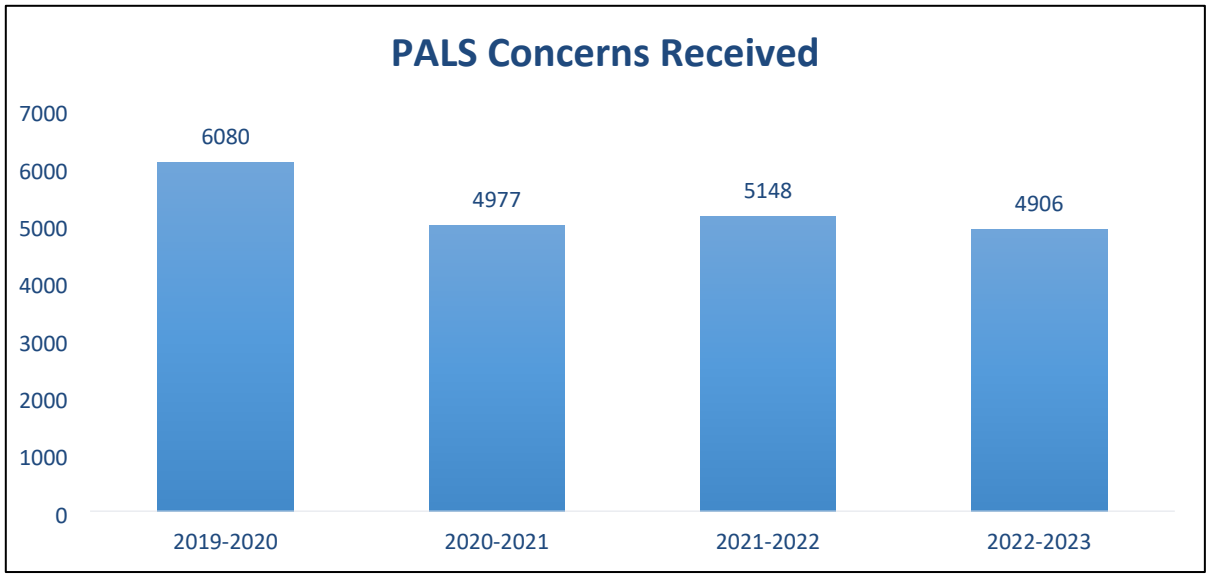


During 2022-2023, we have seen an increase in the number of complaints received by the Trust, an increase of 189 complaints in comparison to 2021-2022.

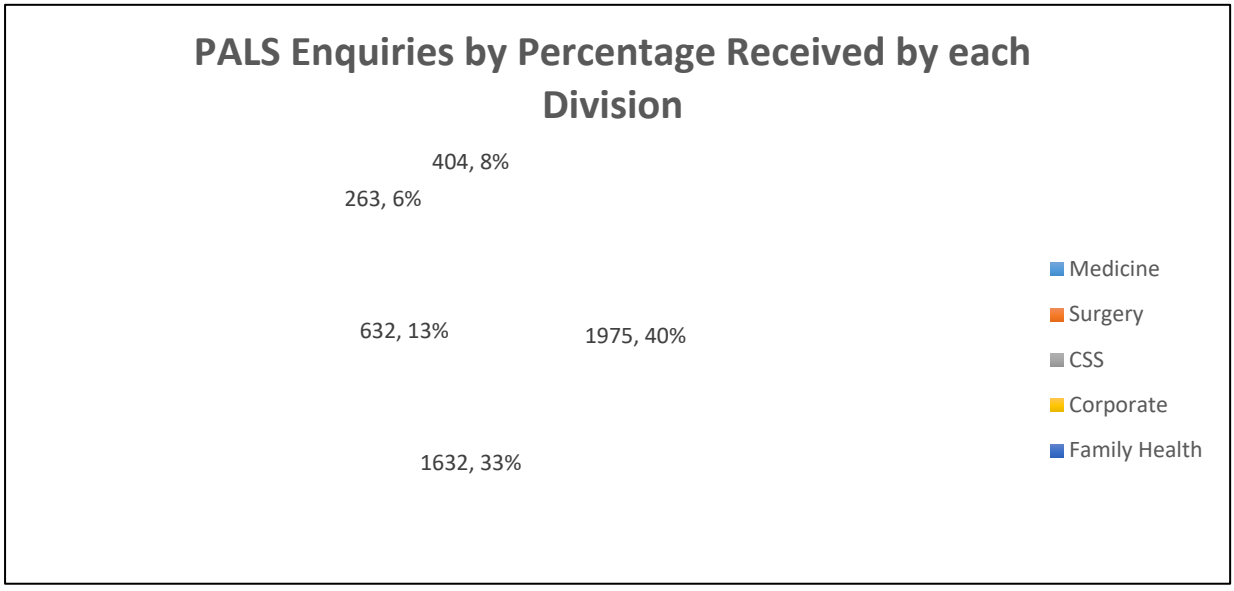
PALS Received

During 2022-2023 the Trust received 4906 PALS enquiries which is a decrease of 71 from the previous year, as previously stated this may be due to the Clinical Senior Complaints Case Manager responding to these initially.

The chart below details the number of PALS enquiries received by the Trust for the last four years.



The chart below details the number of PALS enquiries by percentage received by each Division within the Trust during 2022 – 2023.



21 PALS concerns remained open at the end of March 2023. The oldest case from 27 March 2023. The Trust aims to resolve all PALS concerns within 5 working days. During 2022-2023 94% of PALS enquiries were responded to in time.

Of the 4906 PALS enquiries received the highest number of cases were received for Outpatients, A&E and waiting Lists:

- Outpatients received 2060 PALS enquiries
- A&E received 396 PALS enquiries
- Waiting Lists received 181 PALS enquiries

Themes and Trends

Poor Communication

Poor communication is a common theme which features in all three areas above. During 2022-2023 visiting restrictions that were imposed on relatives and carers being able to visit during the COVID-19 pandemic were lifted and this allowed relatives to speak with members of staff and be provided with an update on the care and treatment being provided to their loved ones or to raise any concerns that they may have. We are still receiving PALS concerns regarding lack of communication between staff and families and the difficulties getting through to the wards by telephone. A communication working group has been developed to address these issues identified and implement actions to improve communication going forward.

Lost Property

Lost property continues to be a major concern across the Trust. The Trust has reviewed and produced a new Patient Property Policy which is awaiting ratification prior to implementation. The identified processes within the policy will help to improve safe keeping of patients' property whilst in hospital

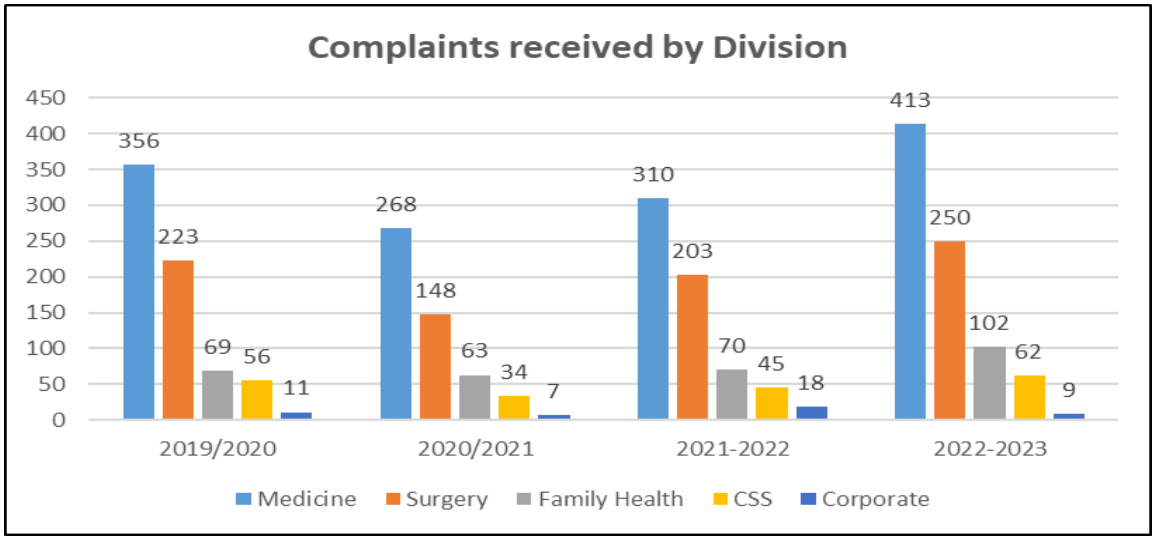
Delay/Cancellation of Appointments

Due to the COVID-19 pandemic, we are still seeing the impact of when patients' appointments required rescheduling once restrictions were relaxed. This is still having an impact as some patients continue to experience delays in receiving an appointment. Patients who are having their appointments cancelled are not receiving their letter in time or a phone call and are therefore still attending the hospital to then be advised that it is no longer going ahead.

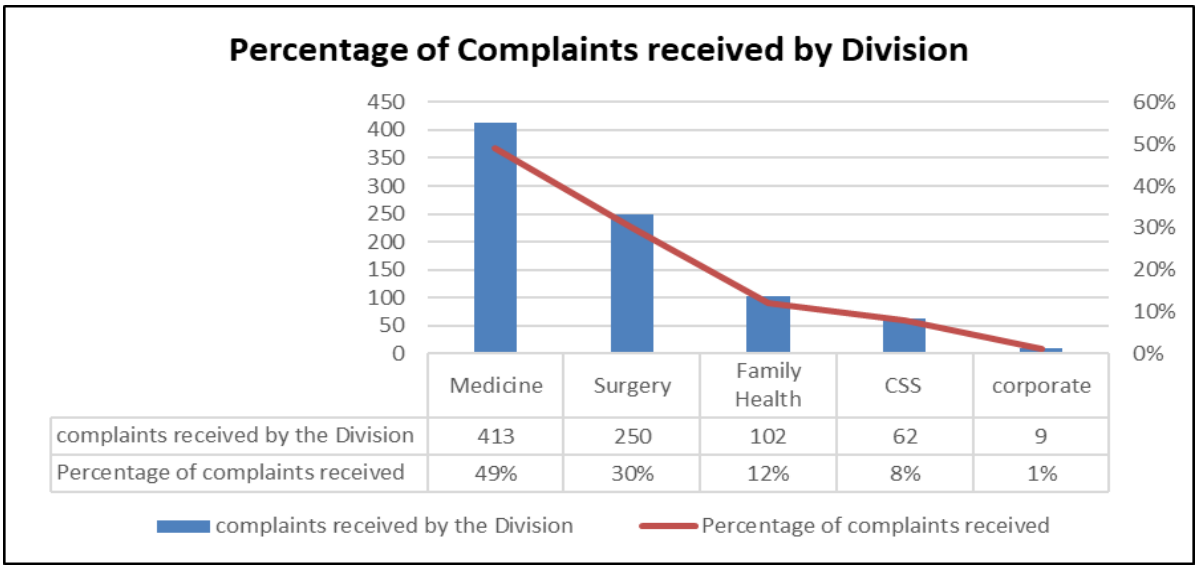
Complaints Received by Division

Complaints received by the Division during the previous four years.

The chart below highlights that Medicine Division received the highest number of complaints year on year. During 2022-2023 the Trust has had an increase in the number of complaints received in comparison to previous years.



The chart below shows the percentage of complaints received by each Division during 2022-2023.

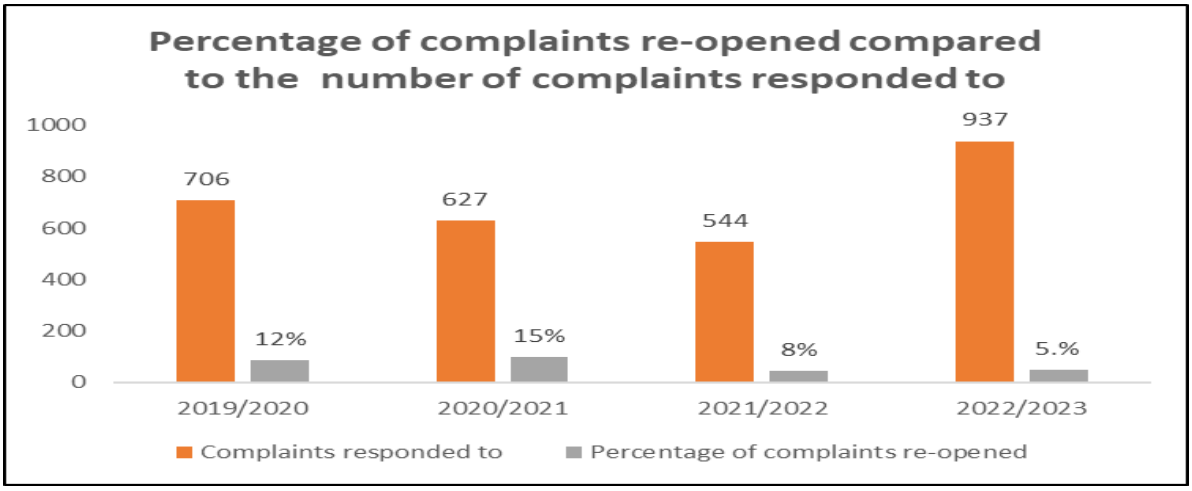


Top three primary subjects of complaints received:

Complaints category	Number received	Percentage of overall complaints
Communication	187	22%
Clinical Treatment	150	18%
Appointments	86	10%

Complaints re-opened

The chart below depicts the number and percentage of reopened cases that were closed in comparison to previous years.



Reasons detailed below why cases were referred:

- Dissatisfaction with the contents of the first response
- Requesting clarity on information provided
- Accepting an offer of a meeting
- Initial response has raised further concerns

47 (5%) complainants who received their first response during 2022-2023 requested further information following their initial response. However, the Trust have responded to a higher number of complaints during 2022-23, therefore the percentage of complainants dissatisfied with their initial response has reduced. This

compounds that thorough investigations of their concerns are being completed and the complainants are satisfied with their first response.

Complaints referred to PHSO

If complainants remain dissatisfied, they have the right to approach the Parliamentary and Health Service Ombudsman (PHSO). The PHSO will assess each case and make a decision as to whether they will provide an independent review of the complaint.

The chart below highlights the number of cases that were referred to the PHSO during 2022-2023 in comparison to the previous three financial years.

	2019/2020	2020/2021	2021/2022	2022/2023
Complaints responded	706	627	544	937
Complaints referred to the PHSO	12	9	12	9
Percentage of overall Complaints	1.69%	1.43%	2.20%	0.96%

Shared Learning and Communication

The Trust have implemented a number of processes to improve shared learning across the Trust.

Listed below are examples of how we are sharing and embedding learning and the future plans:

- Complaints and PALS workshops have been arranged to support the staff with the management and investigations of Complaints and PALS enquiries received.
- Implementation of quarterly 'Learning to Improve' Bulletins for each Division and an overarching Trust Bulletin to share learning across the Trust.
- Dedicated learning section on the Clinical Governance intranet page.

- A monthly Divisional Integrated Governance report with executive summary incorporating complaints for each Division.
- All complaints are discussed at Speciality Governance.
- The Triumvirate within each Division have oversight of all complaints as they approve the complaint response prior to the Executive Leadership Team sign off.

Learning from Complaints & PALS

- The Trust has completed a review of communication across the organisation and our Patient Experience Lead has evaluated and identified ways of making improvements. A Patient Experience Training Programme has been rolled out to all staff with the focus on communication and we have also included communication as part of our Trust core plus training. This training is for new starters and existing staff to update on a yearly basis and is based on patients' feedback and complaints.

- As a result of communication within the orthopaedic team a pilot scheme is being trialled where patients' relatives are being called every day to provide them with an update.

- Trial of 'first contact' sticker on Johnson ward to improve communication with families where Next of kin is not first contact, which is working well, and there are plans to roll this out to other areas.

- Due to feedback regarding patients not being updated on clinical test results or treatment plans. Surgery Division have plans to trial a fixed rotation, whereby each doctor stays for a month on each ward to build relationships with patients.

- All wards have implemented a communication sheet that is laminated and displayed by the nurse's station to capture communication with relatives at a time when visiting is restricted.

- Volunteers recruited with a key role to support answering the telephone to communicate with relatives.

- Some patients will be offered a Patient Initiated Follow-Up, this allows patients to arrange a follow up appointment as and when required.

Complaints & PALS Objectives 2023/24

- Assess the impact of the Clinical Senior Complaints Case Manager to agree if the pilot will become substantive.
- Complaint responses to be responded to within 35 days instead of the current 50 days (50 days will be allocated to complex complaints).
- Maintain 90% compliance for responding to complaints within agreed timescale.
- Implement Datix Cloud for complaints and PALS.
- Implement training sessions for staff in relation to PALS and complaints.
- Complaints Facilitators / PALS Officers to be more visible on ward areas to help improve patient experience.
- Audit the information inputted to Datix to ensure consistency and accuracy.

Summary

The themes from the complaints received remain similar to the previous financial year, with the most common subjects being clinical treatment, communication, and appointment issues. However, the actions outlined in this report demonstrate that trends are acted upon. The complaints received in the Trust are used to inform pieces of work aimed at improving the patient experience. The responses provided invariably outline action(s) that have been taken in response to the concerns raised or explain what is planned as a result of issues identified during the investigation.

Policy and procedures and the way in which complaints are recorded and dealt with is harmonised across Trust sites. There are systems in place to systematically review the complaints received and ensure that investigations are undertaken appropriately, in line with legislation, and escalated within the Trust as necessary.

The data collected is used to inform reports, is disseminated amongst Divisional Teams and taken to the relevant Groups and committees to inform ongoing work within the Trust.

NHS
United Lincolnshire Hospitals
NHS Trust

Meeting	*Trust Board*
Date of Meeting	*4 July 2023*
Item Number	*Item 8.4*

Patient Experience Annual Report 2022 - 2023

Accountable Director	*Karen Dunderdale. Director of Nursing*
Presented by	*Jennie Negus. Head of Patient Experience*
Author(s)	*Jennie Negus. Head of Patient Experience*
Report previously considered at	*Patient Experience Group* *07 June 2023* *Quality Governance 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	
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 new evidence based models of care	
4b Advancing professional practice with partners	
4c Becoming a university hospitals teaching trust	

Risk Assessment		
Risk ID 4629	Patient Voice	*x*
Risk ID 4980	Engagement	*x*
Risk ID 4981	Codesign	*x*
Financial Impact Assessment	*n/a*	
Quality Impact Assessment	*n/a*	
Equality Impact Assessment	*n/a*	
Assurance Level Assessment	*High*	

United Lincolnshire Hospitals NHS Trust

Recommendations/ Decision Required	• *For information* • *For assurance*

This report details the highlights and achievements of the last year within Patient Experience. It brings a Trustwide overview of patient feedback across our core datasets drawing out themes and trends and provides details on improvement actions and achievements.

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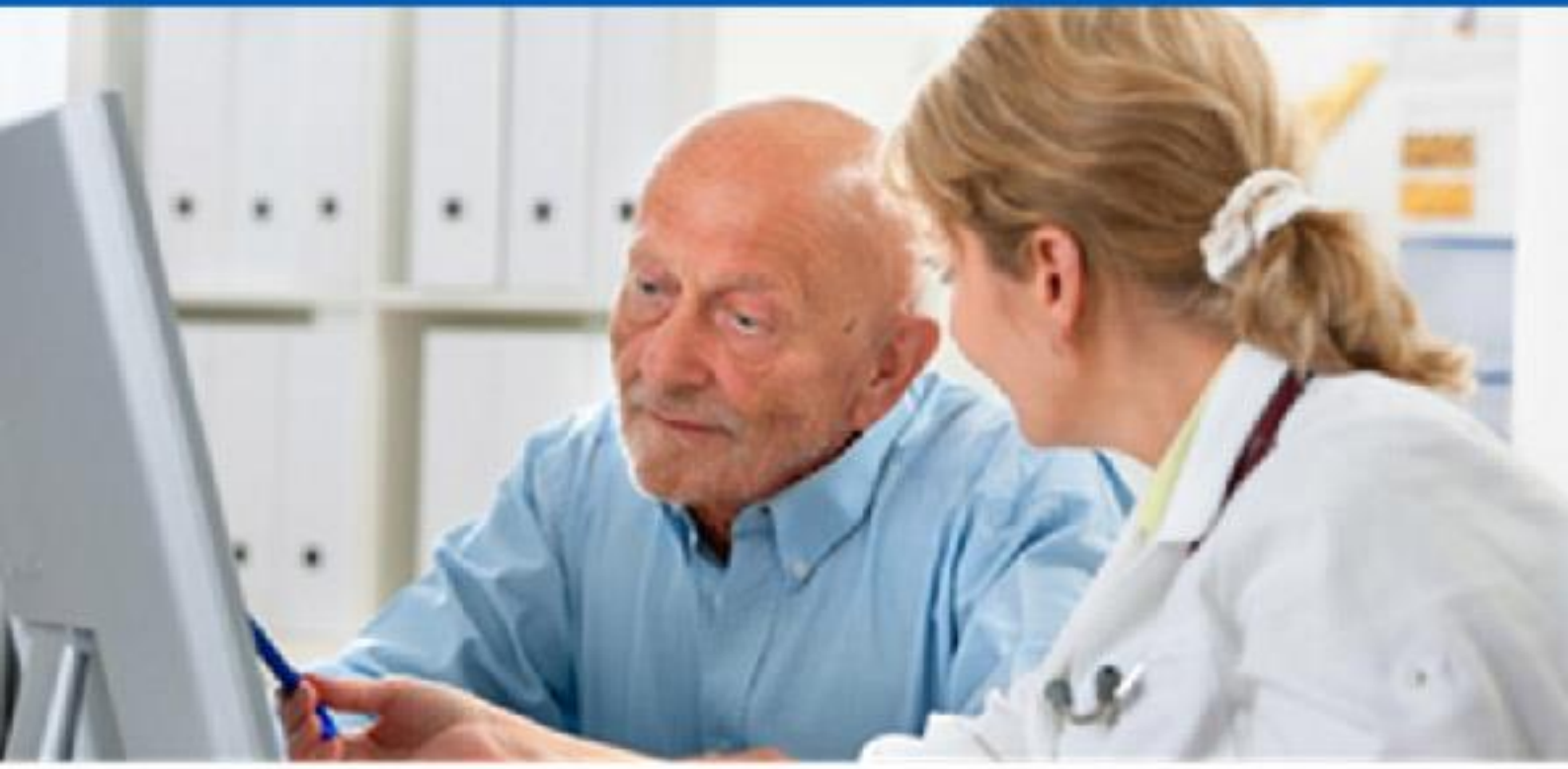
NHS Trust



Patient Experience Annual report 2022 – 2023

Prepared by: Jennie Negus. Head of Patient Experience
Endorsed by: Patient Experience Group – date

Quality Governance Committee – date

OUTSTANDING CARE
personally DELIVERED

Executive Summary

Good experience of care, treatment and support is increasingly seen as an essential part of an excellent health and social care service, alongside clinical effectiveness and safety. A person's experience starts from their very first contact with our staff and services, right through to their last, which may be years after their first treatment, and can include end-of-life care.

We are committed to delivering outstanding care, personally delivered. The use of feedback is central to ensuring delivery of these aims and we offer a variety of approaches which allow people to choose a feedback mechanism that best suits their needs. This feedback provides us with a rich picture of patient and carer experience while also offering insight into what matters to them. More importantly though it enables our organisation to build a story around all the data that we collect and the importance of triangulation to ensure our analysis and conclusions are evidenced using robust, accurate data. This helps us to move away from being 'data rich – insight poor' and have the intelligence to develop plans for improvement. The best way to improve quality in an organisation is by finding out what our patients and carers are saying through their lived experiences. We offer a number of opportunities for people to be involved including participating in our Patient Panel and emerging Expert Reference Groups, strong stakeholder engagement in Patient Experience Group, sharing stories at Trust board meetings and in other forums as well as being part of interview panels, assurance and assessment visits and volunteering.

We are reaching out across all our communities to ensure that all groups of people are included, that we hear their voices, understand their experiences and learn from their feedback.

We are seeing an increase in our clinical teams using their patient feedback through the use of triangulated data within our SUPERB dashboard. The sharing of learning and best practice through our Patient Experience Group fosters encouraging discussions around areas for continuous improvements.

This Annual Report details our performance and achievements over the last year recognising the significant challenges and extraordinary circumstances that the emergence from the COVID-19 pandemic has posed to staff and to the patients and families in our care.

Patient and carer experience plan 2022 – 2025.

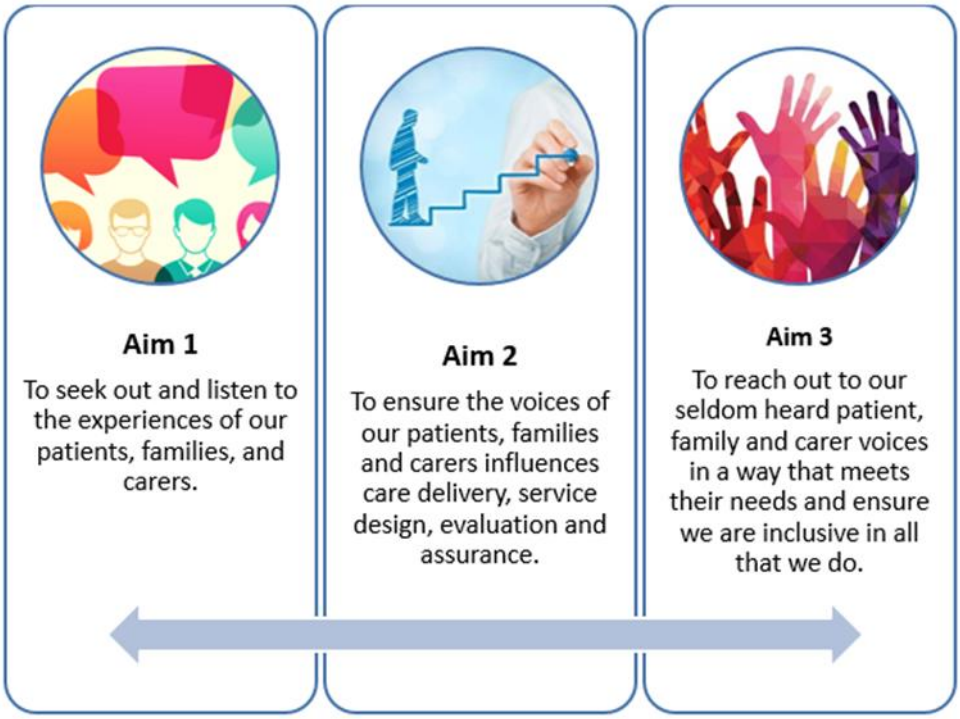
Our new Patient and Carer Experience Plan was approved and published in October 2022 and reflects the overarching Trust strategic objectives within the Integrated Improvement Plan and also the Nursing and Midwifery Framework.

We are committed to a cultural shift from ‘doing to’ patients to ‘doing with’, working in partnership with them.

The aim of the Patient and Carer Experience Plan is to support our staff and our patients to work together to achieve an outstanding care experience, delivered by compassionate and skilled staff to provide the best possible outcomes for everyone who uses our services. There are four key principles in delivering this plan:

- To listen to our patients, families and carers, including Young Carers
- To put things right if they go wrong
- To use feedback to identify opportunities for quality improvement
- To work in partnership with our patients, families and carers in co-designing services

And there are three core aims:



An associated workplan supports delivery of key priorities, progress reports have been prepared and provided to Patient Experience Group demonstrating good progress is being made. Achievements include the roll out of real time surveying and the introduction of a patient story at Trust Induction.

Patient Experience Group (PEG)

PEG is appointed and established by the Quality Governance Committee and exists to receive, review, scrutinise, challenge and respond to or escalate patient experience related data and information across the clinical activities of the organisation. PEG meets monthly, chaired by the Deputy Director of Nursing with membership from across divisions and services and stakeholders including Patient Panel, Healthwatch, Carers First and Maternity Voices. The Group has matured in its purpose and has embedded its vision for raising the importance and significance of patient experience in all that we do.

A detailed schedule of reporting is in place that encompasses patient stories, data insight, divisional assurance reports, equality, diversity and inclusion and staff experience ensuring patient voice is heard and considered. Feedback is received from and upward reports provided to Quality Governance Committee and to Nursing, Midwifery & Allied Health Professional Advisory Forum (NMAAF) and to Patient Panel.

Risks and Board Assurance Framework (BAF)

The Trust board assurance framework (BAF) brings together in one place all of the relevant information on the risks to the board's strategic objectives. It is an essential tool for Boards and provides an effective methodology for Boards so that they have real confidence that they are providing thorough oversight of strategic risk. Each month the BAF is reviewed in light of assurance received at Patient Experience Group.

PEG contributes to the Board Assurance Framework specifically in relation to 'Objective 1b Improve Patient Experience' and the risk of failing to provide a caring, compassionate service to patients and their families.

In March 2023 the patient experience section on the BAF was rated as green for the first time, indicating that Quality Governance Committee was assured that our controls were reliable and proportionate with robust evidence and reporting.

There are currently three corporate patient experience risks on the risk register:

Risk ID 4980 – Engaging with our patients. Rated as moderate risk.

Patient engagement can inform service design and evaluation as well as enhance its delivery and governance. It is the process of building the involvement of patients, families and carers, supporting their active involvement in order to enhance their care, care experience, safety, quality and patient centredness. If we do not build the expectation to engage with our patients then we will not achieve patient centred care and if we do not reach out to our 'hard to reach' groups then our intelligence will fail to be diverse and inclusive. Controls in place to mitigate this risk include:

- IIP milestone reports
- Patient Panel and expert Reference Group evaluations.
- Upward reports to Patient Experience Group
- Patient Experience training
- Stakeholder engagement and feedback at Patient Experience Group
- Evaluations and outputs from 'What Matters to You' initiative
- Evaluations and outputs from 'You Care We Care to Call' initiative.

Risk ID 4981 – Codesigning with our patients. Rated as low risk.

Codesign shifts the traditional design process where a health care team is independently coming up with ideas for problems. Co-design involves the patients in the design process and works with them to understand their met and unmet needs. If we do not involve our patients and their carers from the outset with our service design and evaluation then we will not achieve our ambition of person centred care. Controls in place to mitigate this risk include:

- Monthly patient panel meetings that considers 3 projects, service redesigns or evaluations at each meeting plus ad-hoc standalone workshops for more detailed codesign work.
- Expert reference groups: Sensory Loss, Breast Mastalgia, Cancer Patients, Dementia Carers, Improvement Academy.

Risk ID 4629 – Hearing our patient's voices. Rated as moderate risk.

If we do not listen to the voices of our patients, carers and families through not seeking out, hearing and appreciating their experiences and then acting on them, we will fail in our ambition to deliver patient centred care. Controls in place to mitigate this risk include:

- Patient and Carer Plan and associated workplan
- Patient experience metrics and reporting.
- National survey reports.
- Patient Experience Group and divisional assurance reporting.
- Patient Experience Group upwards reports to Quality Governance Committee.
- Patient Stories at Trust Board and other forums.
- PLACE reports
- Assurance and accreditation assessments.
- Care Partners Policy and Visiting Policy
- Care of the Dying Patient and Care after death procedures and guidelines.
- Patient information
- Complaints and PALs policy and reporting.

PENNA Awards 2022

Three entries were submitted for the 2022 Patient Experience Network National Awards which is widely considered the leading awards event in the field.

WINNER - Martyn Staddon, Data Insight Manager, for the development and implementation of our SUPERB Patient Experience Dashboard.

The judges said: this project showed immense leadership from the start. The project is extremely transferable and has demonstrated visible positive outcomes since launching. So much to love about this - one view, accessed by all.

RUNNER UP - Jennie Negus, Head of Patient Experience, for the development of the ULHT Patient Panel and a number of Expert Reference Groups.

The judges said: thorough approach to working in partnership with people using the Trust's services, delivering an evident shift from doing to, to doing with. If any Trust wishes to set up a similar system then in my opinion this is the model to follow.

FINALIST - Sharon Kidd, Patient Experience Manager, for the development of Swan Wedding Boxes.

The judges said: Really enjoyed this entry. It gives staff outcomes and sense of closure during managing a very difficult time. Great initiative and as a clinician I can see how this would be a very welcome scheme to support ward teams in arranging end-of-life weddings.

2022 – 2023 patient feedback received

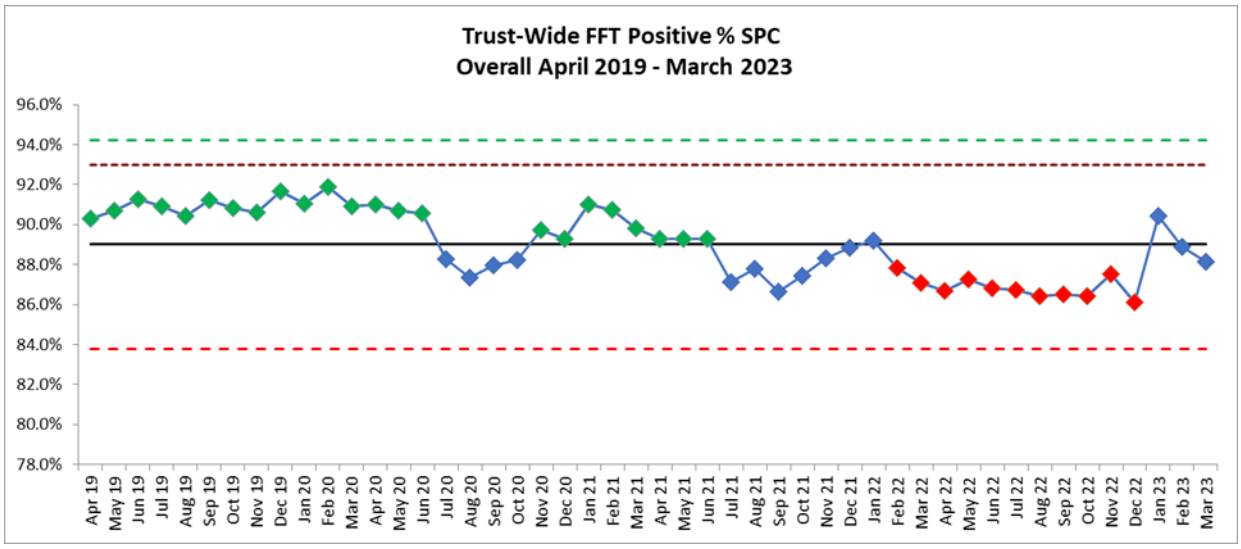
(Data sources as stated; collated via SUPERB dashboard)

1. Friends & Family Test (FFT)

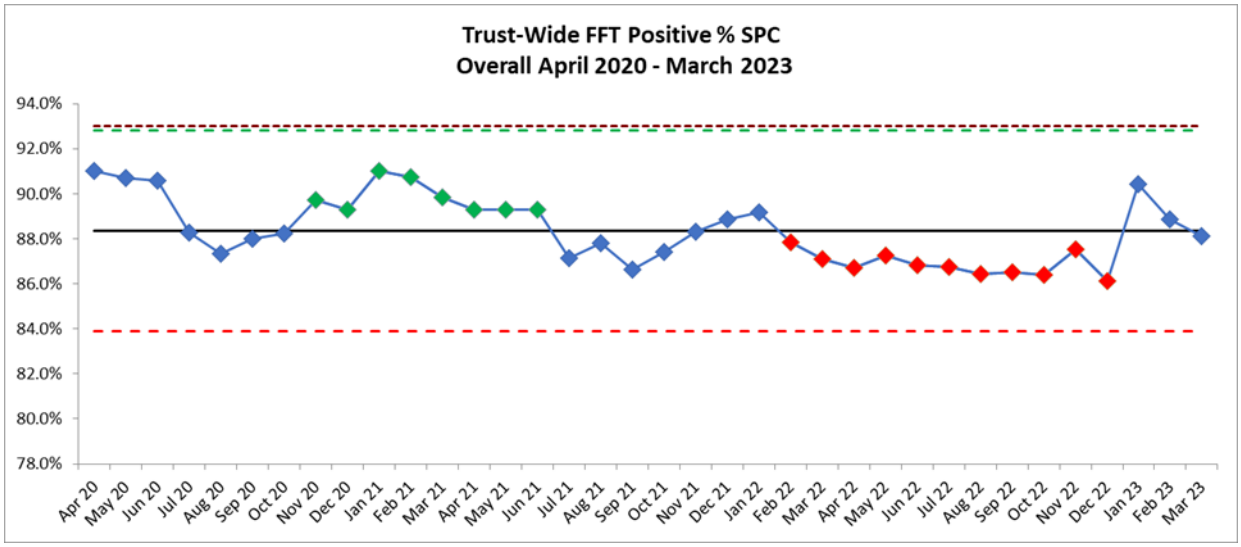
The FFT question is asked of all patients discharged from across three streams of care; inpatients, outpatients and maternity. A text or interactive voice message is sent to eligible patients asking them: “Thinking about [setting]…overall, how was your experience of our service?” and patients respond with one of the following options: very good, good, neither good nor poor, poor, very poor or don’t know. They can then provide a follow up comment to explain why they chose that particular option. Texts are free and patients are able to stop them if they wish and also indicate whether their comments are private and not for sharing.

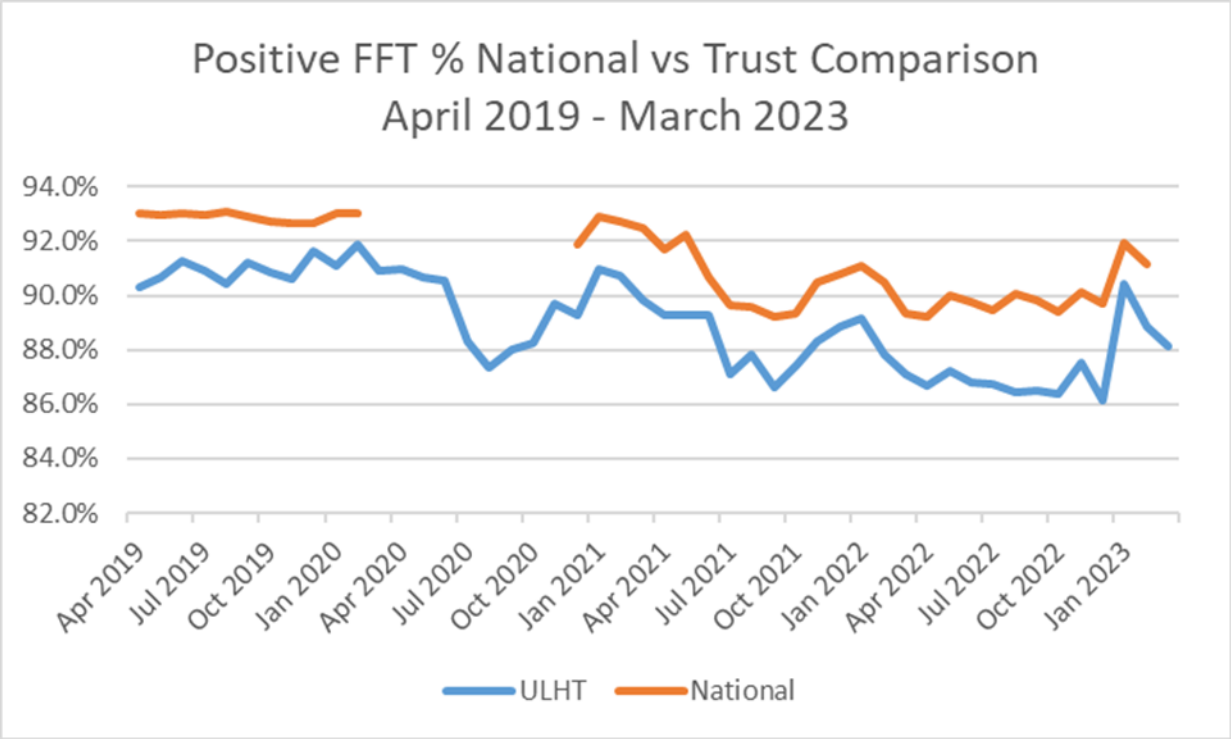
1/4/22 – 31/3/23

- 76,3137 responses were received
- 66,542 were positive, equating to 87.4%
- 5,402 were negative, 7.1%.



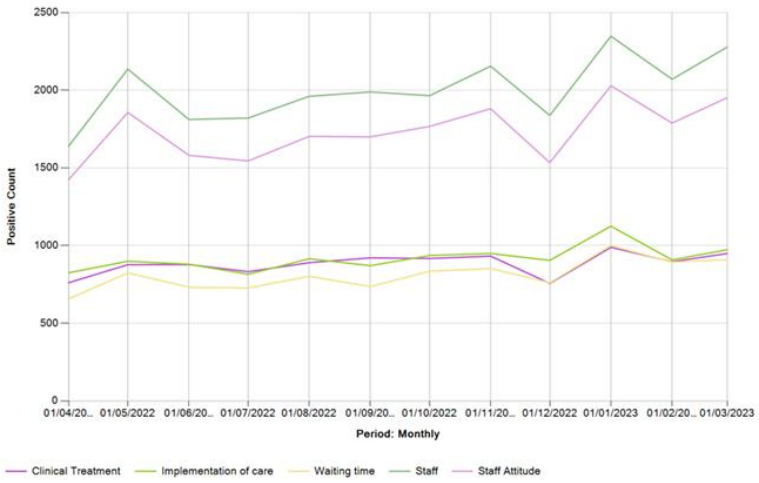
April to December 22 all showed performance sitting below average however some signs of improvement can be seen from February 2023 onwards. Some consideration needs to be given to the fact that many of the previous consecutive months above the average level pre-dated Covid and the impact that had on FFT performance both at a local and the national levels. However, the below graph (exploring April 2020-March 2023 in total) still shows the same patterns of Special Cause Variation (with 7 or more consecutive points below the average level) from February to December 2022.



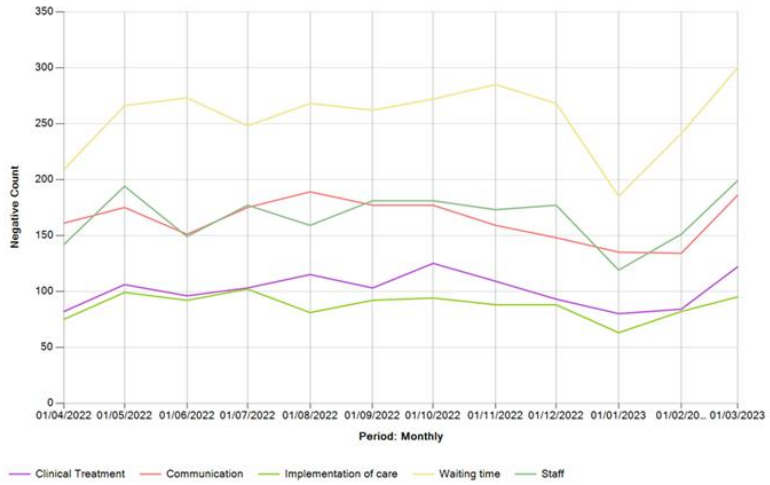


The gap in the data shown above was due to national reporting of FFT from March – November 2020 being paused, however it is clear that in general our FFT performance has followed the profile of performance seen nationally, indicating that we are still viewed in a similar position against the wider national trends.

The 5 most prevalent themes within positive follow up comments were clinical treatment, implementation of care, waiting time and staff attitude. Conversely these were the same themes within negative comments though in different orders. The relative scales of the two charts below highlight how, overall, the volume of positive experiences and positive factors far outweigh those on the negative side.

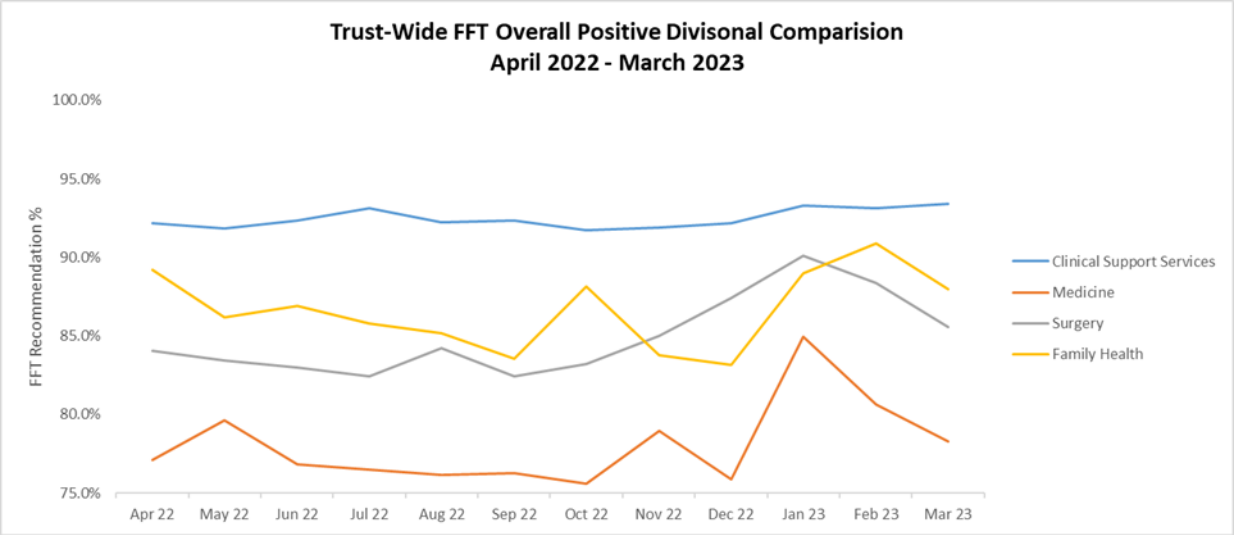


"Excellent service. The department was very busy but the team ensured everyone was served in order, babies sent through quickly as they should be too, and we were all seen regularly, I had bloods taken and good conversation with the nurse. Things appeared to me to be running like clockwork considering it was full."



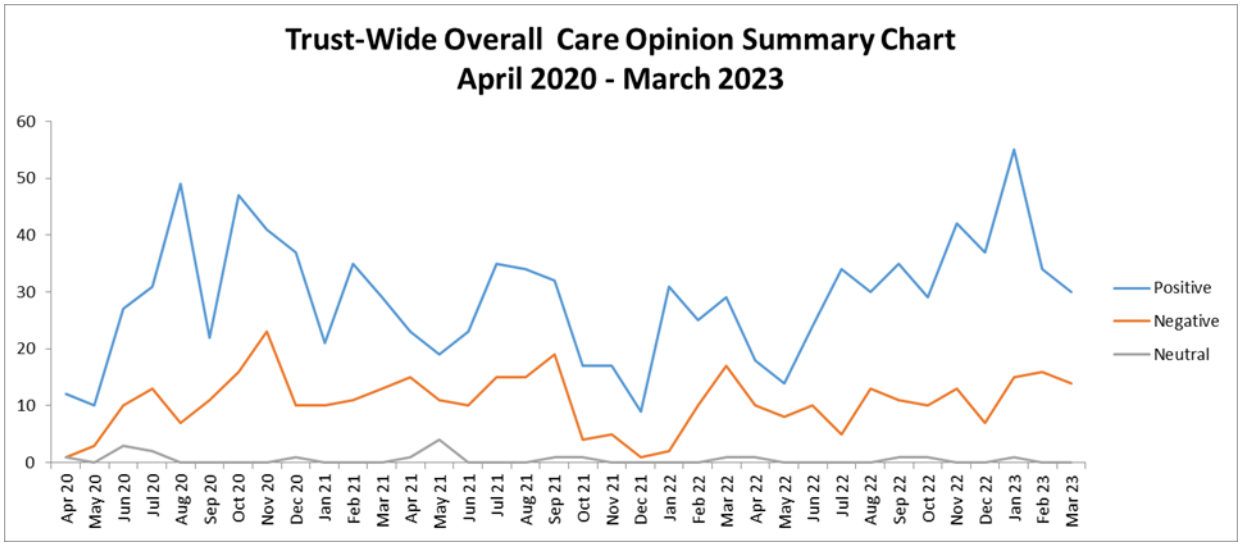
"Seating for patients was a nightmare as most people took a +1 with them and when asked to move off seats for patients most refused and I ended up standing up for over hrs. Couldn't fault the staff when I did eventually get seen. 3 hours to be seen for triage, 6.5 hours to have bloody taken and the 12 hours to be seen by a doctor to be told I needed to come back the following day for an ultrasound because they didn't work at nights."

The divisional split of FFT positivity largely reflects the operational challenges and demands within services.

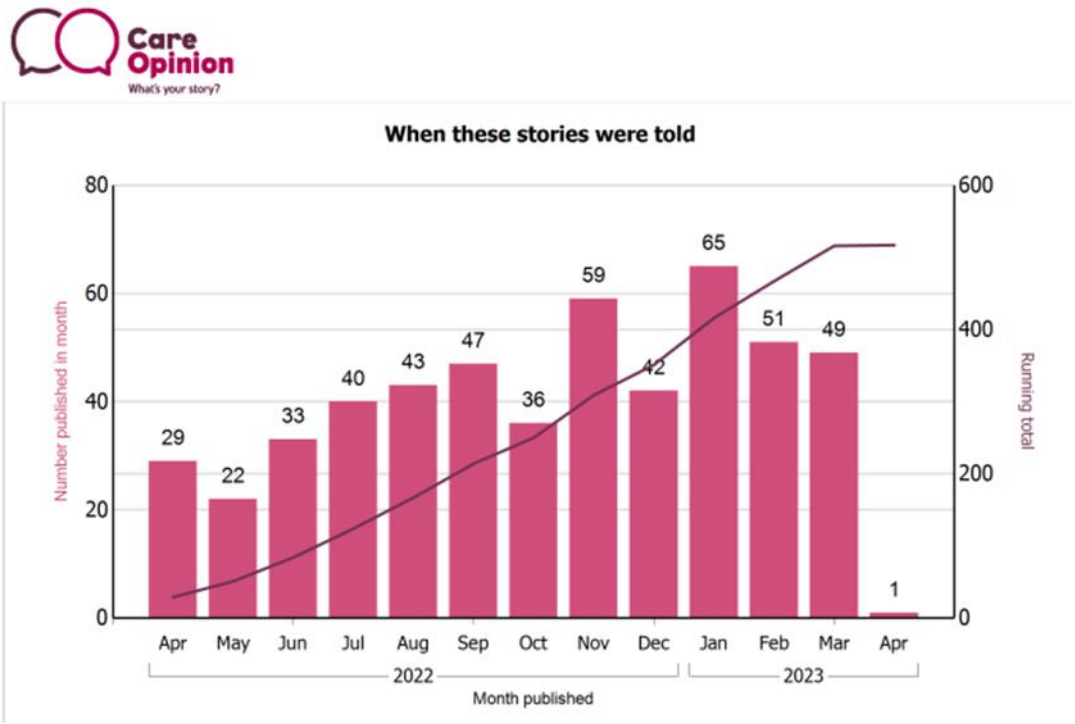


2. Care Opinion

Care Opinion is a non-profit organisation that shares people's experiences of health and care services online and enables us to engage with the storyteller and respond to their experience. The platform provides analytics and reports that are hugely valued and considered as one of our most powerful data sets.



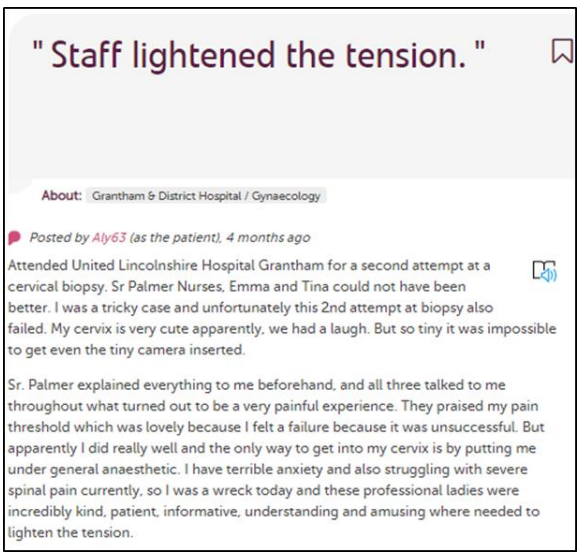
Following a dip in numbers of stories reported following on from the pandemic, as well as a general decline seen around October to December 2021 we have seen an improvement overall throughout the past year. It is encouraging to see that the bulk of these stories come from patients following on from them having had positive experiences with us. As per previous years, the bulk of stories come from within the Gynaecology Specialty, but there are also encouraging improvements seen across all other divisions.



[My care was truly outstanding | Care Opinion]

[Dedicated and caring staff | Care Opinion]

[Staff lightened the tension. | Care Opinion]



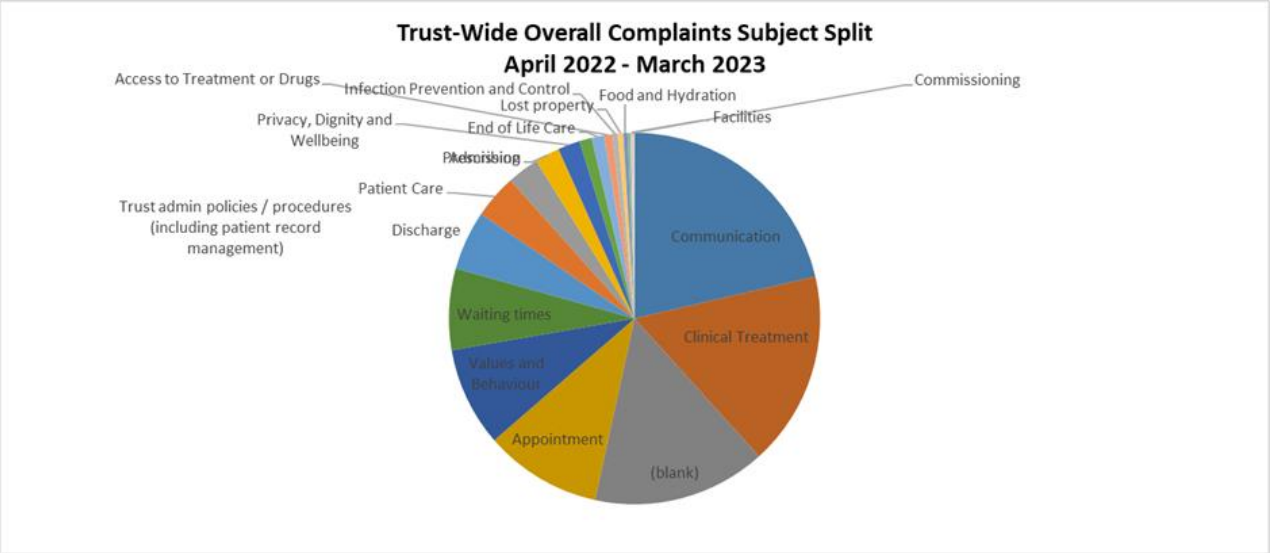
[Positive hospital experience | Care Opinion]

Most common tags added by authors to these stories

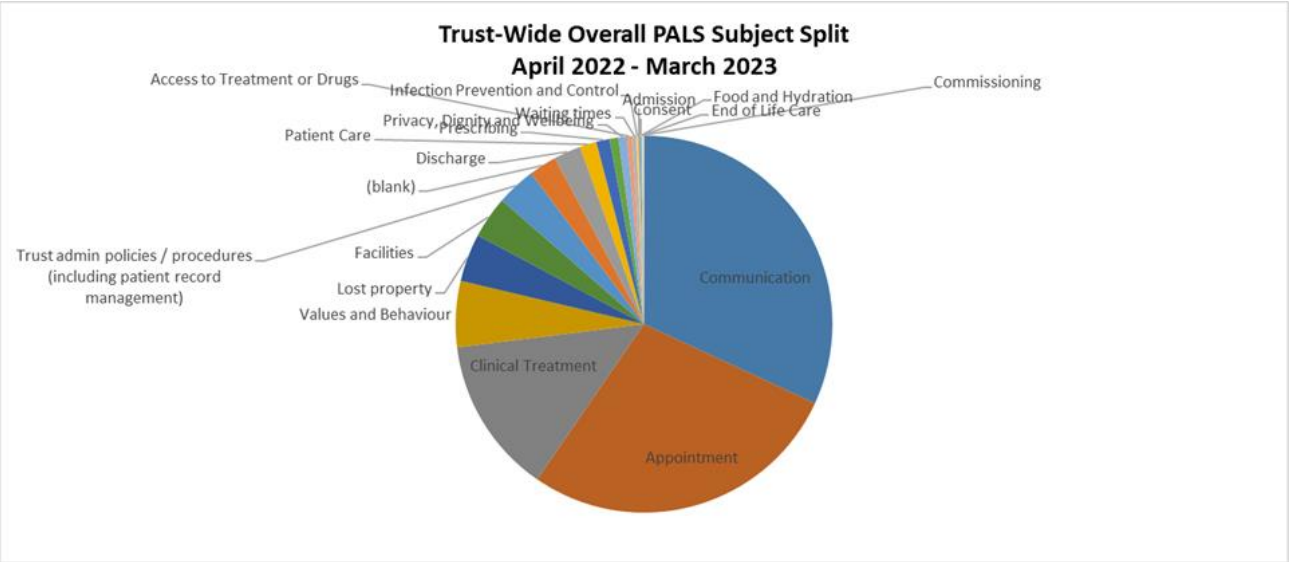
What's good?		*What could be improved?*		*Feelings*	
staff	118	communication	39	grateful	65
friendly	73	long wait	13	thank you	64
nurses	60	waiting time	12	at ease	46
professional	55	staff attitude	10	reassured	43
Care	50	information	9	cared for	39
caring	41	delays	7	put at ease	32
communication	41	food	6	comfortable	26
explanations	37	pain relief	6	relaxed	23
kind	36	Lack of care	5	safe	23
helpful	33	not being listened to	5	anxious	22
		waiting times	5		

3. Complaints & PALS

As in previous years communication is still most prevalent across complaints (account for 21% of the total, with 178 formal written complaints). Of the other more frequently reported themes from the past year, No dramatic changes or variations have been identified.

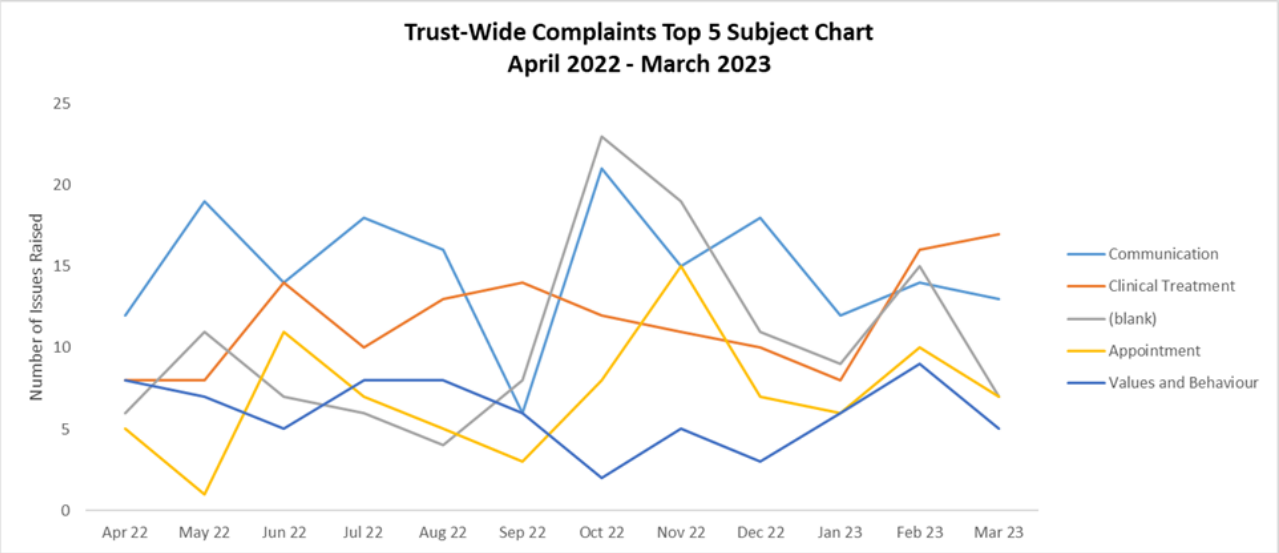


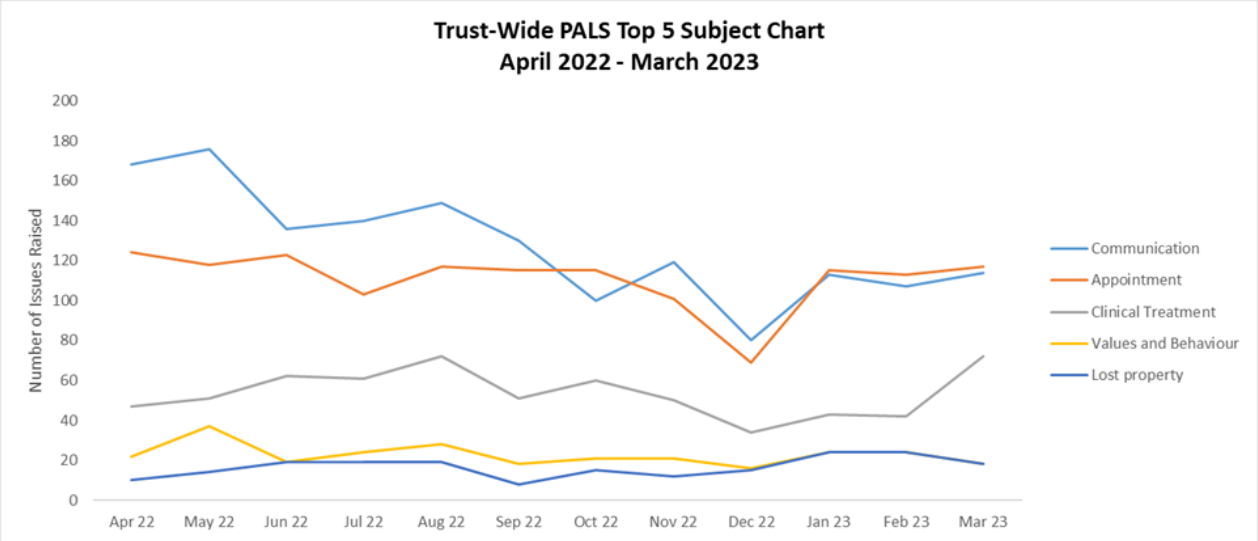
Equally, the picture when looking at PALS in isolation tells quite a similar story and again doesn't vary that much from pictures seen in past years. Communication is the stand-out theme seen with the 1532 reports made to the PALS team (32% of the total)



Across the past year, in general the top 5 high-level subjects within complaints have remained fairly constant. Whilst there is some variability looking at things on a

month-by-month basis, across the year overall we see more of a picture of consistency and a constant level of complaints within the most-prevalent themes.

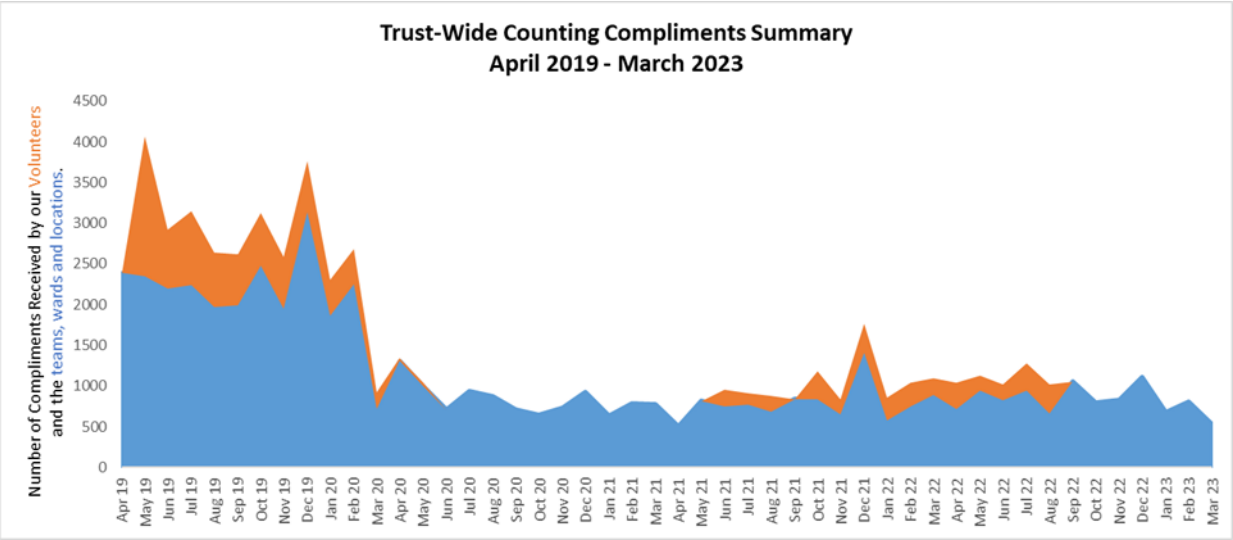




Conversely, when looking at PALS there is a clear gradual decrease in the numbers of reports made pertaining to the 5 most-prevalent themes. As such, this would appear to show some signs of improvement when it comes to Patient Experience overall.

4. Compliments

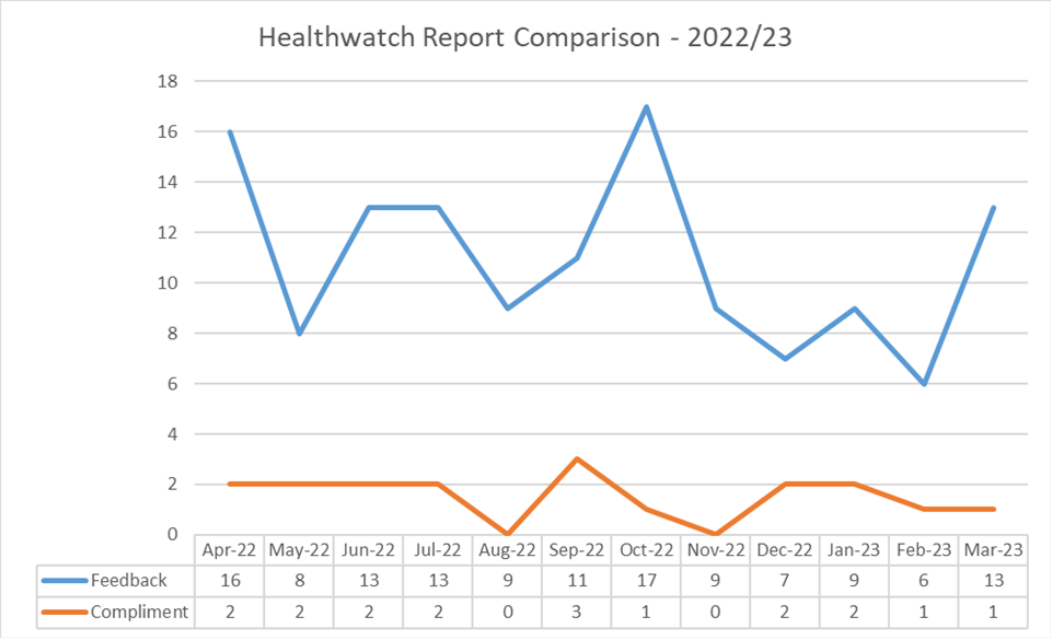
There has still not been a real recovery when it comes to the counting, collating and submitting of compliments data following on from the impacts of the pandemic. There is anecdotal evidence that the compliments are still being received, but that the issue lies instead in teams finding the capacity to record, collate and submit their compliments data. We need to find an easier mechanism to gather this data, as it feels important to celebrate the successes and bring some balance to the way in which Patient Experience data is viewed.



5. Healthwatch

Each month our partners in Healthwatch report feedback they have received through their engagement activities. Our teams treat this feedback in the same way as any feedback received and provide a response to Healthwatch We triangulate the Healthwatch report data alongside our other Patient Experience data sources. As such, much of this analysis is fairly rudimentary and high-level with the intention being that longer-term we get to the stage where Healthwatch data is considered with equal footing when compared and contrasted against other measures.

The chart below shows that overall the numbers of reports received by Healthwatch vary month by month. The bulk of the stories are negative in nature with only an average of 1.5 Healthwatch Compliments being received per month. This shows the importance of us taking this data into account, valuing it and learning from it.



	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Feedback	16	8	13	13	9	11	17	9	7	9	6	13
Compliment	2	2	2	2	0	3	1	0	2	2	1	1

Patient Stories

A patient story is an individual's personal account of their healthcare experience as described in their own words. At its simplest, it is a conversation with a patient or someone close to them, such as a relative or carer, which is recorded. Patient stories are a continuous improvement tool which help identify areas where we need to improve the quality of services and transform patient and carer experience, through listening and learning from the patient voice; they can be positive, negative, or combine elements of both. Through these stories we capture evidence of the quality of services, share the learning about what was good and what needs to be improved and the clinical teams involved take forward any improvements identified. Unlike surveys, stories can be collected face-to-face with the patient and therefore provide an opportunity to ask for more information or clarity where needed and because a story captures the experiences from the patients point of view, it helps put ourselves in their shoes and to focus on what matters most to them. Collectively, stories can help us build a picture of what it is like to be a patient or carer.

Stories are filmed and created by the Patient Experience Team. It may be a patent telling their own story or family member, or a member of staff on their behalf. Stories are also created to highlight improvement projects and where teams have developed new ideas to the benefit of our patients. This year we have launched a dedicated Patient Story library intranet page to host all of the stores we have created so far enabling them to be widely accessible for viewing and also to be used for training sessions with staff. Currently there are 24 stories published and the content of the library will continue to increase.

Stories created this year include:

Eat Well Hydrate for Health Campaign
This story showcases the campaign to raise awareness of the importance of nutrition and hydration care and a programme of quality improvements that will impact positively on patient experience and outcomes.
https://youtu.be/uMGixfD3WPc

ULHT Patient Panel - engaging and involving our patients
The story introduces our Patient Panel. The panel put our patients at the beginning and at the centre, giving them a valued voice in decision-making; engaging and involving from the outset and not just informing them afterwards.
https://youtu.be/3Md22HH3pU4

David's Story - My experience of the UK's first bilateral simultaneous Superpath Hip Replacement
This story tells of David who underwent the UK's first bilateral simultaneous Superpath Hip Replacement at Grantham Hospital.
https://youtu.be/3Je7lXB8GaU

Peter's Story
The story tells of Peter's journey of having a 2 week wait urgent CT scan. Peter is a young man with learning disabilities and autism, he lives in a supported living care home in the community, supported by care staff who know him well and has close family involvement. It details the meticulous plan for every step for a planned admission and to submit an application to the Court of Protection due to the high levels of restraint/ restriction that would be required.
https://youtu.be/6jyPc59zG9A

Same Day Emergency Care service model
The story explains the service model of SDEC areas at Pilgrim and Lincoln Hospitals and one patient's feedback on their experiences of their care.
https://youtu.be/DqLChhi4FTI

Nicky's story – my COVID-19 experience on Ward one at Pilgrim Hospital

The story tells of Nicky's personal reflections on being on ward one at Pilgrim Hospital during 2021 with COVID**.** With the help and support of the team she was eventually discharged after 8 days. She is left with PTSD and her therapist thought it would be good therapy to tell her story.

https://youtu.be/E1QzOLhWkDk

Compassionate care at the end of life

The story is told from the perspective of Vicky, a Community Cancer Nurse Specialist who highlighted the extraordinary lengths the MDT worked at Pilgrim Hospital to ensure that a married couple who were both end of life were reunited together at the Butterfly Hospice.

https://youtu.be/oTGDsGrICBc

Caring for Carers

This story relates to Caring for carers both adult and young carers and includes forthcoming plans for 2023 to help those who are carers for our patients. The story also includes the reflections of Katherine who is the main carer for her mum who was diagnosed with dementia a few years ago.

https://youtu.be/9-XPOY4jWoc

Pets as Therapy- Trevor and Clyde's story

This story tells the journey for Trevor and his dog Clyde in becoming volunteers for the national PAT Charity. The story also includes feedback from staff and patients following the visits across the sites in November 2022.

https://youtu.be/hW6ZwpW_s2g

The importance of patient centred care in Parkinson's Disease

This story tells of Mr Miles' admission to Grantham Hospital last year with pneumonia and his and his wife's experience with a focus on medications and carers.

https://youtu.be/CDGcjDuhJUw

National Survey Programme

The national survey programme is set and managed by the CQC who use surveys to find out what people think of the NHS healthcare services that they use. The results help assess NHS performance. The CQC also use them for regulatory activities such as registration, monitoring ongoing compliance and reviews.

Maternity Survey 2022 Published: January 2023

This survey looked at the experiences of women and other pregnant people who had a live birth in early 2022. Nationally the CQC found that:

- Since 2017, there has been a positive upward trend for women reporting that there was no delay with their discharge from hospital
- Support for mental health during pregnancy is improving, although there remains room for further improvement
- There has been a deterioration in the proportion of women saying they were able to get the help they needed throughout the maternity pathway
- There has been a downward trend in women being treated with kindness and understanding

Summary of findings for our Trust were:

- The majority of the Trust scores were in the middle 60% range of all Trusts surveyed.
- There are 13 scores which were in the top 20% range, with the highest scores clustered in the section around Care at home after the birth, and women saying that their midwife/midwifery team had taken their personal circumstances into account when giving advice.
- The Trust had 4 scores in the bottom 20% range and these are concerned with being involved in decisions around antenatal care; being treated with respect and dignity during antenatal care; being involved in decisions about being induced; and, where relevant, partners being able to stay as much as they wanted.

Adult inpatient survey 2021. Published: September 2022

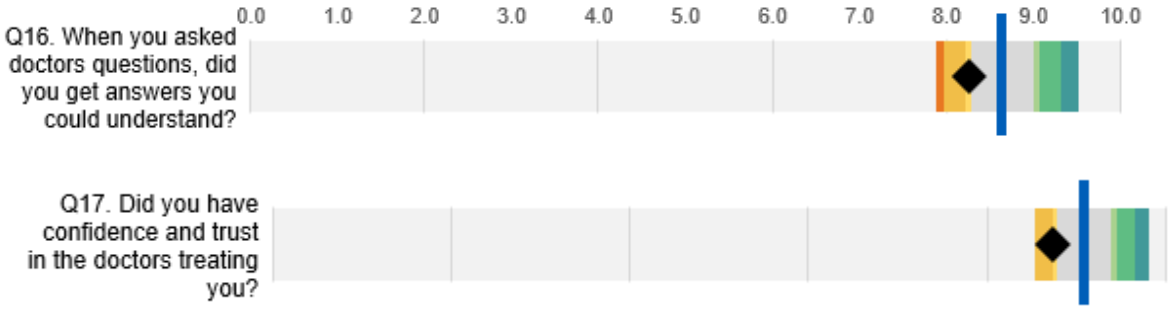
This survey looks at the experiences of people who stayed at least one night in hospital as an inpatient. Nationally the CQC found that:

- Most patients felt they were treated with dignity and respect, although results have declined
- The majority of patients reported positive interactions with doctors and nurses, although results have declined
- Less than half of respondents ‘definitely’ knew what would happen next with their care after leaving hospital
- Fewer patients said they could always get help from staff when they needed it

Summary of findings for United Lincolnshire Hospitals NHS Trust

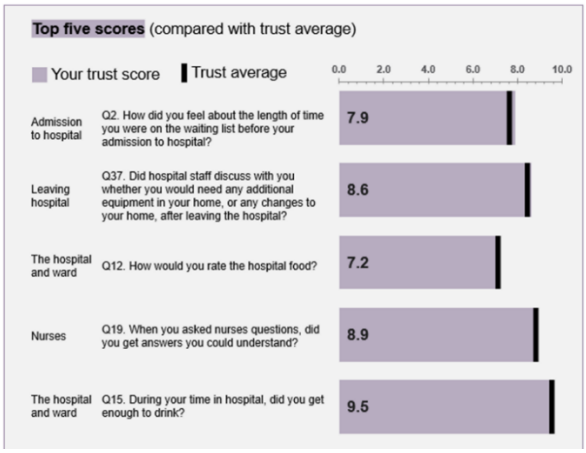
The three questions rated as worse than expected

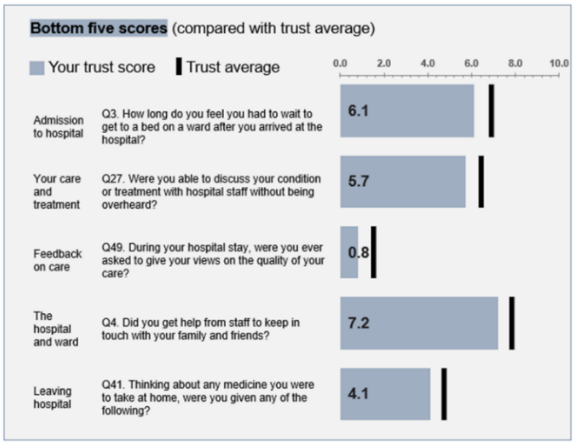
Doctors



Your care and treatment

The Picker Institute who manage the surveys determine the best and worst performance relative to the trust average. To do this five questions are calculated by comparing our trust's results to the trust average scores across England.





Overarching thematic national patient survey action plan

The Patient Experience team analysed themes from across the suite of surveys (Inpatient, Maternity, National Cancer Patient Experience, Children & Young People and Urgent & Emergency Care) and created an overarching national patient survey action plan to bring a collaborative response. Whilst divisions continue to have local action plans this overarching thematic plan provides a coordinated approach and view and reflects the fact that for many of our patients their journeys cross the survey streams. The themes identified are:

Waiting	Clinical care and treatment	Dignity, respect and kindness
Discharge arrangements	Discussing care and treatment	Environment and facilities
Involvement in decisions and discussions	Medications	Staff values and behaviours
	Tests, procedures and results.	

As new survey reports are received the overarching plan will be updated providing a continuously developing tool for driving improvements.

The 2022 Urgent and Emergency Care survey began its fieldwork in November 2022 running until February 2023 and publication anticipated in June 2023.

Communication Improvement

A review into communication concerns was undertaken in 2020 leading to a review group being convened to take forward improvement actions. A number of initiatives were implemented and work has continued since. In the last year this group has transformed into an *improvement* group recognising the need for prolonged existence and leadership of ongoing actions.

Achievements in the last 12 months include:

- Development and distribution of communication folders containing various resources to aid communication with patients who may have difficulties.
- Support for sight & hearing loss patients
- Launch of You Care We Care to Call – an initiative for proactively calling relatives to update them.
- Further highlighting of ‘What Matters to You’ initiative that encourages asking patients what is most important to them and then working to achieve that.
- A refresh of the patient experience elements within Junior doctors induction
- Support for the Trauma & Orthopaedics Hearing it My Way OSCE communication training programme.
- Updating of Ward information tablemats
- Encouraging the use of passwords for family contacts so that key information can safely be given to relatives over the phone.

A refreshed Communication Improvement Action plan has been developed that includes:

- To introduce a patient story at Trust induction illustrating and setting the scene that 'this is our business' regardless of our role.
- To provide a range of communication training opportunities suitable for all staff across all roles.
- To introduce a Communication Always Event. ‘We will ALWAYS introduce ourselves, involve our patients and carers in discussions and decisions about their care and confirm that we have communicated in a way that is understood.’

  We will do this by asking all our staff to ALWAYS start any patient interaction with ‘Hello my name is and I am….’ Introduction and to finish any patient

interaction with ‘Have you got any questions for me? and / or ‘Is there anything you didn’t understand that I can explain differently?

- Contribute to the refresh / reset of Trust Values & Behaviours ensuring that impact on patient and carer experience is showcased.
- Evaluate impact and outcomes of Dignity Pledges
- That the 'What Matters to You' principles are adopted and embedded throughout the organisation.
- Drive the communication elements within the National Survey Thematic Action Plan to demonstrate progress.
- You Care We Care to Call initiative embedded throughout the organisation.
- Develop business case for Trust wide Hearing it My Way OSCE programme

The Communication Improvement Group has strong membership including clinical representatives and colleagues from Complaints & PALS, Organisation Development and Communications Team.

You Care, We Care to Call (YCWCTC)

We knew from our patient and family feedback that there were significant issues for people trying to contact wards and departments across our hospitals with Lincoln and Pilgrim receiving the largest number of complaints. For some it was an inability to get through to a ward to enquire about a patient and for others it the challenge of reaching outpatient clinics by telephone. Our inability as a Trust to answer telephones dominates complaints about our service. The reasons were varied but evidence showed largely due to:

- Staff capacity to answer the phone
- Staff ownership of who should make a call or indeed answer a ringing phone
- A lack of appreciation of how important that call may be to a relative or a patient
- An element of reticence to make a call or answer a phone that may take some time or may be difficult.

YCWCTC is a model that puts the impetus and commitment of ward staff to proactively contact relatives to provide updates rather than relatives struggling to get through. Benefits include reduced phone traffic, greater engagement of and information from relatives and the most appropriate staff member providing the

update. For example in some cases it may be the therapist who is best placed to update family and in others the doctor.

The Patient Experience team have led this project working with wards to adopt and roll out. Transactional challenges such as telecommunications functionality have been identified and work undertaken to address, such as the introduction of a call queuing system and where wrong numbers were being advertised. Key members of the working group have been our switchboard staff.

After some initial engagement hurdles the project has gained ground and traction in year and metrics and milestones have been set to support the roll out across all wards in the coming year.

For wards who have adopted and embedded YCWCTC complaints and concerns have been significantly reduced and in some areas there have been none recorded since commencement.

#WMTY – what matters to you?

#WMTY is an international person-centred care movement that started in the United States, has spread to over 50 countries across the world and is now becoming established in the UK. The underlying principle is: ‘Ask – Listen – Do’ and at ULHT we have grasped #WMTY to help us improve our patients and families involvement in discussions and decisions about care and treatment. The intention of #WMTY is to shift the power to the person who knows best about the help or support they need, whether it be a person with a medical issue or the clinicians or staff providing care. In December 2022 a ‘#WMTY Inspiration Day was held and over 90 staff from a range of clinical and non-clinical backgrounds attended. Starting the day with the inspiration Tommy Whitelaw the national lead for #WMTY from Health and Social Care Alliance Scotland the day included staff telling their #WMTY stories from areas as diverse as A&E at Pilgrim and Waddington Ward at Lincoln and a number of workshops and discussions to inspire staff to take #WMTY back to their services. Staff ended the day with making promises for their #WMTY futures and the Patient Experience Team following these up to support as and where needed.

PX training

Designed by our Patient Experience team after consultation with nurse leaders, managers and educators within the Trust and discussion and feedback from our Patient Panel and Patient experience Group (PEG), through slides, discussion and short films the course provides elements of theory, communication styles, how data is collected, analysed and presented. Staff are also introduced to Fab Champions, #WMTY, and Dignity Pledges. The one and half hour Microsoft Teams course ran weekly over the summer and early autumn of 2022. After evaluation and review leading to some minor amendments it recommenced monthly at the beginning of 2023. It is available in several formats via face to face, Teams and recorded; the latter enabling shift staff to undertake the training at a time that is convenient to them and to the ward. Guided sessions are taught by members of the Patient Experience team and have included part of the Clinical Pillar new Trust staff/preceptorship, standalone sessions for ward training days as well as more general availability where personnel can via Teams join on the day.

By end March 2023 training has been provided to 501 staff.

Integrated Improvement Plan (IIP)

To be truly committed to designing and delivering patient centred care and patient centred services we recognised that we needed to refocus from ‘doing to’ and ‘doing for’ to ‘doing with’ our patients and public; a codesign model; this brought about a need to think differently about how we ensure our patients are genuinely involved in service design, improvement, development and evaluation.

Embedded as a Trust strategic objective within our 5-year Integrated Improvement Plan we set out to ‘Redesign our communication and engagement approaches to broaden and maximise involvement with patients and carers’ and two elements within this have been the development of our Patient Panel and establishing expert reference groups for specialist areas. We wanted our patients to be proactively involved in Trust developments and improvements through receiving, reviewing, commenting, challenging and involvement in proposals so that those individual but sometimes lone voices could collectively be louder. Strategically we have been nurturing a culture of patient engagement to ensure patient voices are sought out, listened to and incorporated in all that we do. Our panel and group members are

critical friends, experts by their own experiences, they have voices that are collectively louder and stronger and they can influence and contribute to discussions and decisions.

Since launching Patient Panel in September 2020 we have continued to meet monthly and have only missed 3 meetings during that time. There have been 90 different presentations and discussions on topics ranging from outpatient letters and appointment scheduling through to diagnostics services, developments in dermatology, protected mealtimes and Patient Safety Culture.

Panel discussions 2022 - 2023

May-22	Pilgrim ED Developments update	Nov-22	Carers First
	Shared Decision Making		Armed Forces Network
	Improvement & Integration Plan update		Protected Mealtimes
Jun-22	Safety Culture	Dec-22	Lincoln New Endoscopy
	PLACE visits		Virtual Wards/Frailty Ward
	Staff Survey		NHS Reservist Programme
Jul-22	Signage Audit Update	Jan-23	Results of Nuclear Medicine Consultation
	Hydration Initiative		Visiting Audit
	Falls & Prevention message, Never Too Busy		EMRAD PPI Group
	Draft Patient Experience Plan	Feb-23	Frailty Virtual Ward
Sep-22	CCG/EACH		Access Able
	Panel Review		Comms – NHS Joint Forward Plan
	Paediatric Update – Pilgrim	Mar-23	YCWCC
Oct-22	People Promise		Visiting Policy & Care Partners Policy
	Endoscopy Patient Facing Website		
	Update Maternity Service (Including Ockenden)		

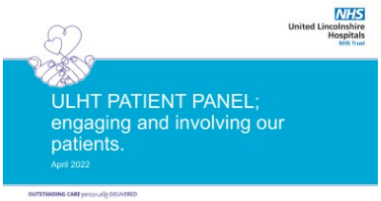
Standalone codesign workshops have also been held on topics such as Uniform Policy, Patient Moves and the Visiting Policy and a number of members played key roles in our Trustwide Signage Audit undertaking over 150 individual mapping journeys.

Alongside this a number of short life and more substantive expert reference groups have been developed including:

- Sensory Loss with 5 members who have codesigned our Supporting Patients with Assistance Dogs Policy and developed bedside symbols highlighting communication needs.
- Breast Mastalgia. This was a short life group helping with the design of a new clinical pathway through from conception to launch.
- The Cancer Patients Expert Reference Group has 8 members and whilst hosted and led by ULHT is commissioned by the Lincolnshire Cancer Board. The group has been influential in sharing the patient view on a range of issues and initiatives relating to living with cancer.

- Dementia Carers initially with 5 members; this group met 4 times and was not as successful as hoped as 3 of the members withdrew for personal reasons related to their caring role but it provided some valuable insight into the caring role in dementia care. Going forward a new Care Partners Expert Reference Group is commencing in June 2023 and the remaining dementia carers will join that.
- In March 2023 a new Patient Improvement Expert reference group was launched with 8 members. The focus of this group is to provide patient voice and views to staff undergoing training and support within the Improvement Academy.

The story of the patient panel was presented to Trust Board and can be viewed here: https://youtu.be/3Md22HH3pU4



ULHT Patient Panel - engaging and involving our patients

The story introduces our Patient Panel. The panel put our patients at the beginning and at the centre, giving them a valued voice in decision-making; engaging and involving from the outset and not just informing them afterwards. Assist us to drive, deliver and demonstrate Trust wide measurable improvement and continuous learning in outcomes, delivery, performance, sustainability and transformation in Patient Experience. They provide a diverse forum for influencing and contributing to discussions and planning of the most effective health services for the local population.

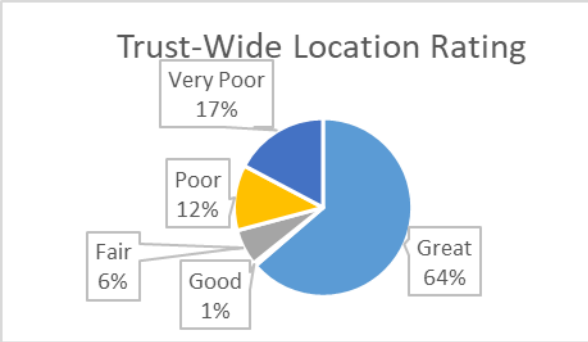
Signage Audit

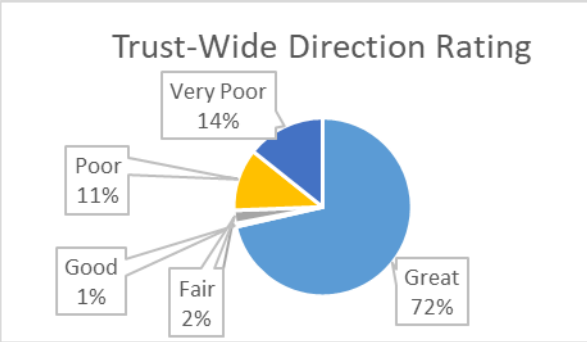
Patient Panel members raised concerns about difficulty wayfinding and signage and with other volunteers undertook an all site audit in early 2022. A survey was set up with Microsoft Forms, asking for details of the intended journey undertaken (a start and end point) as well as an overall rating of the signage for the journey as well as, where appropriate:

- Ratings of the Frequency of Signage
- Ratings of the Location of Signage
- Ratings of the Directions taken from Signage
- Ratings of the Condition of Signage

In addition there were opportunities for further detail to be added with free-text boxes relating to each of the above factors, as well as any other comments deemed necessary. A total of 168 checks were completed via the online forms. The bulk of these (108) were completed at Pilgrim, with a further 41 done at Lincoln and the remaining 19 being performed at Grantham. A full analysis and report was shared

with Patient Experience Group and with the estates and communications team leading on the new digital signage project.





- *Lincoln: "No sign in main entrance for 14/15 destinations, what level you are currently on or how to reach other levels. Need more signs at junction points. Went the wrong way and has to ask for directions"*
- *Pilgrim: At main entrance, AMU is not signed. You have to follow sign to All Wards (there are 3 boards patients are faced with, as they enter, which are advertising 19 departments but not clear you need to follow "all wards".*
- *Grantham: The sign above door to tower block entrance from main hospital does not include the surgical unit, so can be confusing for people who navigate through the hospital.*

The conclusions drawn by our patient auditors included:

- Patients and visitors can make suggestions for potential improvements and enhancements to the existing signage systems.
- There are potentially some areas of confusion around the naming of locations and difficulties in handling ward moves or relocations.
- Where signs are found within the correct locations and with appropriate frequency, they are generally considered to be very good.
- There are significant discrepancies between the signage found on the 3 different hospital sites specifically in terms of the location and frequency of signs.

Everyone involved in the audit remarked how revealing it was and the Panel continue to be involved in the ongoing improvement plans.

Visiting

As a Trust we did not have a Visiting Policy; a Visiting Procedure had been developed during the pandemic to manage the various levels of restrictions in line

with national guidance but as we emerged from the restraints it was an ideal time to review and develop a policy. To inform this, an audit was undertaken that included 51 wards across 3 hospital sites and explored public information, local arrangements, staff understanding, experience & discretion, patient and visitor experience and scoping for the future.

Findings included:

- 13 different visiting time schedules in place and most had ‘always been that way’ and to date had been reluctant to vary these times due to workload and schedules.
- 11 wards had received either complaints or PALs concerns relating to visiting.
- There was wide recognition of the Swan Scheme for end of life care but much less so for the Carers Badge initiative (though this had been paused throughout the pandemic).
- There was an appetite for change and introducing some consistency across the Trust.

The audit findings were used with staff and patient groups to codesign how visiting will be supported going forward. This included the recognition and acknowledgement that carers / care partners needed to be considered as fundamentally different to visitors and both the Visiting and Care Partners were developed in parallel using the Point of Care Foundation Codesign methodology.

Our codesigned agreements

Needed a **Visiting Policy** – had a procedure developed during the pandemic but no formal policy.

Identified our key stakeholders

Agreed definitions

Visitor	Care Partner
A family member, a friend or neighbour attending the hospital to pay a visit to a patient and will be welcomed to do so during the stated **core visiting times.**	Someone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support and will be welcomed to be with the patient so **at any time**.

Our **Carers Policy** was strong and had been heavily consulted on with key stakeholders but would need a revisit and redesign in light of Care Partners work.

Agreed Visiting times

Visiting Hours			
Adult Wards	**Paediatrics and NNU**	**Maternity**	**ICU**
14:00 – 20:00	14:00 – 20:00	14:00 – 20:00	Individual arrangements
Care Partners			
Care partners anytime	Parents or guardians anytime	Labour ward partners anytime Ante & Post-natal partners 09:00 – 21:00	Individual arrangements

We also developed a Visiting Charter; again co-written with patients and staff and clarified guidance on children visiting based upon age related risks rather than the previous arbitrary rules.

Visiting Charter

NHS
United Lincolnshire Hospitals
NHS Trust

What you can expect from us

- We will ensure that the safety and care of our patients is our priority
- We will wear our Trust photo identification badges visibly at all times
- We will ensure that masks and hand gel are accessible to you
- We believe Mealtimes Matter and we will try to avoid care delivery at mealtimes so that patients can eat their meal in a quiet and relaxed atmosphere with minimal interruption.
- We will make you feel welcome
- We will welcome any feedback you have about your hospital visit
- We may ask you to leave the bedside for a short time whilst we deliver care or to protect confidentiality
- Visitors are welcome to assist the person they are visiting at mealtimes, with their agreement. Please speak to the nurse in charge before assisting confidentiality

What we expect from our visitors

- Be polite and courteous to staff, other patients and visitors
- Respect our visiting times and precautions
- Observe confidentiality: you may see or hear things of a private nature; you must not film or photograph other patients, visitors or staff
- Be responsible for the safety and security of your belongings
- Remember that rest is important for you and the person you are visiting
- On arrival check with staff if it is ok to visit, the person you are visiting may be occupied in some way
- Have consideration for staff doing their job and for patients who need rest and privacy
- Be responsible for and in control of your children if they are visiting. Please see our guidance
- Be respectful to other patients and keep noise levels to a minimum; please put your mobile phone on silent

Infection prevention and control

- We ask you not to visit if you or any members of your household, have symptoms suggestive of COVID-19 or are unwell with other infections, for example Norovirus. If you do, you put the wellbeing of your loved one at risk and also threaten the health of other patients and our staff.
- If you are visiting a patient with an infection or a care area with infectious patients you will be made aware of any infection risks and offered appropriate personal protective equipment.
- Use hand gel when entering and leaving ward areas and wear a hospital provided mask at all times in clinical areas.
- Please help keep our hospital clean and inform staff of any cleaning concerns.
- We ask for only 2 people at the bedside at a time please though if there are particular circumstances the nurse in charge may be able to make an exception.

Aggression, violence and discrimination will not be tolerated
We will protect our staff
Thank you for your consideration and support

OUTSTANDING CARE *personally* DELIVERED

Caring for Carers

The Trust has been selected as one of 13 national pilot sites for the development of a new national Care Partners Policy. The Patient Experience Team together with Carers First and using codesign patient and staff groups have revisited and redesigned how we welcome and involve our Carers in our patients' care. The review of visiting protocols incorporated a review of how carers were welcomed and a proposal agreed that carers would be welcomed at any time and not be restricted to visiting times and that we would promote the title 'Care Partner' to reflect the importance of their role as an expert partner in care.

We have updated, rebranded and are relaunching our Care Partner Badges scheme in June 2023 and will be launching a new Care Partner Experts Reference Group to drive, deliver and demonstrate measurable improvement and continuous learning in care partners experiences. The group will be an important forum for influencing and contributing to discussions and planning of the best practice for care partners in the hospital setting

Key components of our revised Care Partners Policy are that effective liaison between Care Partners and our staff is critical to ensuring they and the patient are supported, listened to and involved in care decisions. To achieve this we have developed our 'ULHT 5 Care Partners Promises'.

1. All Care Partners will be given relevant information and support.
2. All Care Partners will be identified at point of contact.
3. All Care Partners will be treated as an equal and expert partner.
4. All Care Partners will be listened to.
5. Staff will understand the role of a Care Partner.

An exciting proposal that has been developed during the last year is to open a Carers Hub based upon the successful model of Macmillan Cancer Information hubs. A space has been identified at Pilgrim Hospital and Charitable Funds approved and work will begin in June 2023. The hub will be managed by ULHT volunteers supported by Carers First organisation who provide carer support across the county. The aim is for care partners to be able to drop in for advice and support and to call for information and signposting.

Dignity Pledges

A review of the current dignity pledge offer was undertaken following concerns raised from our patient experience data across PALs, Friends and Family Test, Care Opinion stories and results from our national surveys. The data reflected that privacy, dignity & respect was a concern and an area we need to improve on. With input from NHS colleagues, our Patient Panel members and external stakeholder

Healthwatch, we have developed a single poster to reflect our pledges to ensure we achieve outstanding care to all.

The launch of the new Dignity Pledges occurred in May 2022 to raise consciousness and mindfulness to what dignity and respect means in practice and the aim of the pledges being in a poster format is to visibly demonstrate our commitment to living those values in all that we do.

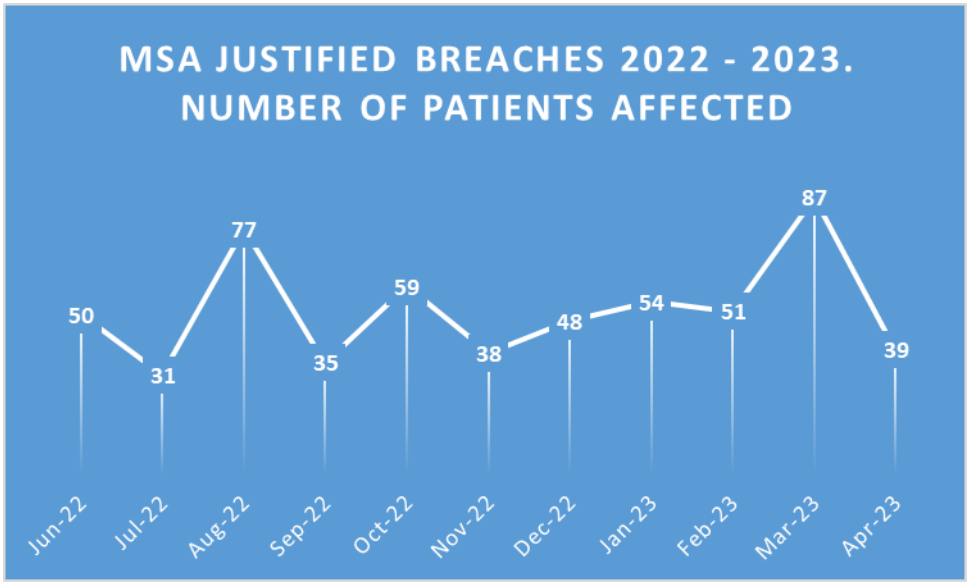
Eliminating Mixed Sex Accommodation (MSA)

In line with the Trust Eliminating Mixed Sex Accommodation Policy (C-P-25 June 2021) when a breach occurs a DATIX report is required and as part of the scrutiny a Mixed Sex Accommodation Investigation report completed to enable validation of the breach. Validation is undertaken by the Head of Patient Experience and considers the NHSI and NHSE Guidance Delivering Same Sex Accommodation 2019 definition

in order to determine whether the breach was justified or unjustified in line with the guidance. If justified it is reported internally as a breach of dignity and if unjustified is required to be reported via the NHS Strategic Data Collection Service (SDCS). Validation considers whether this was breach of sleeping area, whether is occurred within a specialist unit (Critical Care, High Dependency, Acute Stroke Units, Acute Assessment Units and Post-Operative Recovery) where there is a 4 hour window to resolve and what root cause was for the breach. This then enables a judgement to be made on whether justified or not.

Each month all incidents are examined against these parameters and a report circulated internally to key staff and any issues raised directly with the most relevant person to ensure action is taken.

There were 104 episodes of MSA breaches during 2022 - 2023 affecting 565 patients. 50 of these were considered unjustified and reported nationally on SDCS. These 50 occurred in the first quarter and were a continuance of Q4 performance of the preceding year as we emerged from the pandemic. A task and finish group convened to drive a number of actions forward to turn this around; these included a restatement to silver & gold commanders in relation to decision-making, documentation in logs, escalation, approval and plans for resolution, discussions with the Infection Prevention and Control (IPC) team in relation to use of side rooms and the development and delivery of MSA refresher training to on call commanders, operational and ward staff. Since July 2022 there have been zero breaches that have been considered as unjustified and the internal justified breaches have largely been in response to operational surges.



Patient Information

The Trust has a responsibility to ensure that the information we share with patients is evidence based, up to date and reliable. It is vital that the patient information that we produce meets strict guidelines around accuracy, accessibility and readability and that it is updated when evidence or processes change so that we can be assured that we are doing the best for our patients. It is also important that we make our patient information available in alternative formats, including other languages and accessible formats, wherever we can. A full review and refresh of all our patient information has been commenced and a new group established; the Patient Information Approval Group (PIAG). The group is currently meeting fortnightly and is in the process of reviewing approximately 600 existing leaflets as well as considering new ones being submitted. This work will take about 6 months to complete reviewing 80 leaflets each month. One of the first things PIAG has done is to look at what information is already ‘out there’. Is there a leaflet or information already available from a reputable body or organisation, a ‘Trusted Source’ that we can use? And if so does that information meet our standards in relation to authorship, evidence base, accessibility and that it is reviewed. With valuable support from our Library and Knowledge Services we have created a ULHT Trusted Source list as a basis for this work having appraised the sources against a range of criteria. The review and refresh of all our information is also, importantly considering accessibility, availability in different formats and languages and ensuring branding meets the NHS and Trust required standards.

Patient experience activities & enhancements

Time in hospital can be very boring for many patients with long days punctuated with mealtimes and medicine rounds and so in the autumn of 2022-23 we took responsibility for arranging various engagement activities and projects to provide some distraction or a bit of activity to improve the experiences and wellbeing of our patients. These covered both one-off specific celebrations as well as larger ongoing pieces of work providing a longer-lasting positive impact for our patients.

An intranet page was created and starting in October with Halloween treats and ward decorations we have had some fun initiatives alongside larger enhancements. Projects have been generously supported with charitable funds.

- Pets as Therapy dog visits across all sites.
- World Cup – learning about all the countries and a grand draw
- Christmas presents for every patient
- Chinese New Year
- Valentines Day – send a valentine to a loved one
- World Book day – a team of staff and volunteers reading to patients
- Easter around the world

Patient Experience enhancements

Christmas presents for every patient took a small army of patient experience staff to package up over 900 gift bags!

50 new wheelchairs for our volunteers to manage – all with trackers so they can be found and brought back for the next person to use. 20 each for Lincoln and Pilgrim and 10 for Grantham.

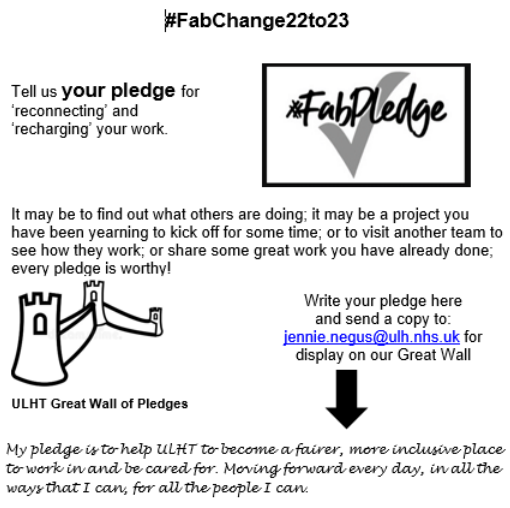
UNITED LINCOLNSHIRE HOSPITALS Charity

World Book day in March saw a team of 29 staff and volunteer 'bookworms' visiting the wards to read to patients.

The team have also been working up additional projects in year including the development of a Carers Information Hub at Pilgrim, wall decals to brighten up wards and golf buggy style transport for Lincoln and Grantham to help patients get around the sites.

Academy of Fabulous NHS Trust

This year #FabChangeDay' changed to #FabChanges22to23, so not just one day during the year but supporting and checking in throughout. The Academy of Fabulous NHS Stuff was mindful of the pressures & challenges of the last two years alongside existing and continuing operational pressures, recognising that a focus on a single day once a year, doesn't fit well with Quality Improvement models; change doesn't happen overnight. This year we went back to the beginning of Change Day history and started with pledges with the plan to check in during the following year to see how people are progressing with their pledges. We asked people to make a pledge and 33 people came forward sharing their pledges through internal communications and on social media. A #FabChanges22to23 intranet page was created to showcase the pledges.


#FabChange22to23

Tell us **your pledge** for 'reconnecting' and 'recharging' your work.

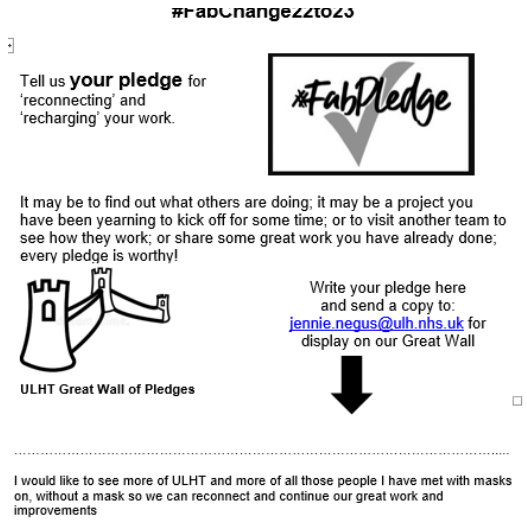
#FabPledge

It may be to find out what others are doing; it may be a project you have been yearning to kick off for some time; or to visit another team to see how they work; or share some great work you have already done; every pledge is worthy!

Write your pledge here and send a copy to: jennie.negus@ulh.nhs.uk for display on our Great Wall

ULHT Great Wall of Pledges

My pledge is to help ULHT to become a fairer, more inclusive place to work in and be cared for. Moving forward every day, in all the ways that I can, for all the people I can.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Write your pledge here and send a copy to: jennie.negus@ulh.nhs.uk for display on our Great Wall

ULHT Great Wall of Pledges

I would like to see more of ULHT and more of all those people I have met with masks on, without a mask so we can reconnect and continue our great work and improvements

Each day during the week we had a different focus. We hosted a Kindness and Positivity seminar delivered by Paul Devlin, a fab academy ambassador and a member of the NHS England and NHS Improvement elective and emergency care improvement support team; more than 50 staff attended and Roy Lilley and Terri Porrett visited and met teams and services doing #Fabulous work.

Roy Lilley & Terri Porrett, co-founders of the Academy of FAB NHS Stuff visited us on 7th July and visited some of our #FAB Teams.
Sarah Loughton on Clayton Ward

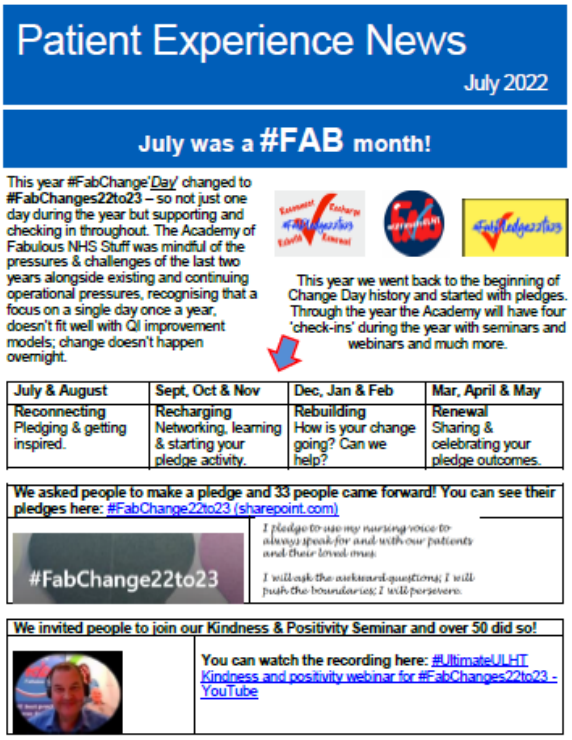

Zaynah Khan, Lauren Smith and Timothy Evans in Clinical Engineering

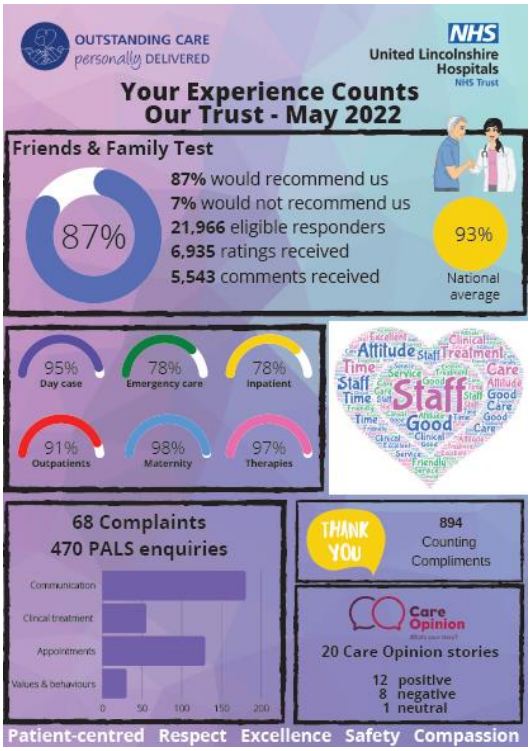


Emma Upjohn and midwifery colleagues in the Maternity Unit.


Patient Experience Newsletters & infographics

Infographics posters are shared monthly. Newsletter topics covered during the past year have included Swan Scheme, new training programme, Experience of Care week and #FABChange week.





Summary

We all recognise that patient experience is, and should be, central to all that we do. Despite considerable challenges through the last 12 months, this Patient Experience Annual Report demonstrates the continued work across the Trust to achieve the ambition of *Outstanding Care, Personally Delivered*.

Our SUPERB dashboard has been recognised nationally through the accolade of a PENNA award and demonstrates how we draw out the intelligence of the feedback we receive from our patients and their families and use this in a meaningful way to make improvements. Equally our work engaging with patients through our patient panel and expert reference groups was also recognised and is now seen as an essential forum in involving, listening to and working with our patients.

Working with colleagues from ward to board we see participation and commitment to ensuring patients are involved and partners in their care and treatment and a shared vision and aim to continue our ambition for patient centred care.

The year ahead

In the coming year we have a number of focus areas:

- Rolling out, embedding and evaluating our Care Partners work, relaunching Care Partners badges and opening our new Carers Hub.
- Rolling out real time surveying.
- Continuing the campaign of ‘What Matters to You’ as our patient centred methodology for involving our patients and carers in discussions and decisions about their care and treatment.
- Driving our Communication Improvement Plan improving how we communicate with our patients and carers, listening to what they tell us about their experience of our services and what matters to them about the way we do things.
- Expanding the adoption of ‘You Care, We Care to Call’ across all our inpatient wards.
- Strengthening the role of Fab Experience Champions and supporting them to deliver local improvements in patient experience.
- Establishing a Children and Young People patient panel
- Establishing a mini-PEG model at Divisional level.
- Increasing substantive capacity within the Patient Experience team

United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*Tuesday, 4 July 2023*
Item Number	*Item 8.5*

CQC Improvement Action Plan – Progress Update

Accountable Director	*Karen Dunderdale, Director of Nursing / Deputy Chief Executive*
Presented by	*Karen Dunderdale, Director of Nursing / Deputy Chief Executive*
Author(s)	*Jeremy Daws, Head of Compliance*
Report previously considered at	*Quality Governance Committee – 20 June 2023*

How the report supports the delivery of the priorities within the Board Assurance Framework	
1a Deliver high quality care which is safe, responsive and able to meet the needs of the population	*X*
1b Improve patient experience	*X*
1c Improve clinical outcomes	*X*
2a A modern and progressive workforce	
2b Making ULHT the best place to work	
2c Well Led Services	*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	Not Applicable
Financial Impact Assessment	Not Applicable
Quality Impact Assessment	Not Applicable
Equality Impact Assessment	Not Applicable
Assurance Level Assessment	Moderate

Recommendations/ Decision Required	• *note the achievements and progress made in achieving the actions required following the CQC inspection* • *note the areas of future action identified.*

Executive Summary

Following the unannounced CQC core-service inspection and the announced Well-Led inspection during the months of October and November 2021, the CQC published their findings on the 8 February 2022. The Trust responded to the CQC with a copy of its improvement action plan.

The CQC improvement action plan has been developed with divisions and corporate owners and is updated with owners at regular intervals.

This paper is designed to summarise for the Trust's Board, progress against the CQC improvement action plan.

Included in the scope of this paper are the actions being taken in response to the 'must-do' or 'should-do' requirements from the 2022 published inspection report.

Background/Update:

The ULHT CQC Improvement Action Plan (available in **appendix 1**) encompasses the 'Must Do' and 'Should Do' actions listed in final inspection report as well as a number of actions in response to feedback raised during the core services inspection.

Appendix 1 demonstrates the current status of the ULHT CQC Improvement Action Plan. The actions/sub-actions contained are the result of scoping work undertaken with identified action leads at an early stage and include milestones for improvement. The action plan is broken down by CBU/Division with some actions identified as having overall corporate ownership.

Each action has an accountable responsible Executive owner and is reportable to a specific Board sub-committee on a monthly basis, with Quarterly reporting to Trust Board. Additional specific 'cuts' of the action plan support oversight groups, for example the Children and Young People's Oversight Board and the Maternity & Neonatal Oversight Group's improvement plan.

The Trust's CQC Improvement Action Plan is reported on regularly using the Trust's 'BRAG' ratings. The 'BRAG' ratings can be defined as:

BRAG Rating Matrix	
Blue	Completed and embedded.
Green	Completed but not yet fully embedded/evidenced.
Amber	In progress/on track.
Red	Not yet completed/significantly behind agreed timescales

Regular reporting and escalation is through the following structures:

- Executive-led assurance process;
- Trust's Performance framework;
- Trust Leadership Team (TLT);
- Sub-committees/Trust Board.

Progress Update: As at the 8 June 2023:

CQC Update on the CQC Improvement Action Plan:																								
	Jul-22		Aug-22		Sep-22		Oct-22		Nov-22		Dec-22		Jan-23		Feb-23		Mar-23		Apr-23		May-23		Jun-23	
Number of CQC Improvement actions:	62		62		62		62		62		62		62		62		62		62		62		62	
Number of CQC sub-actions:	197		208		213		218		221		225		227		256		257		258		267		279	
BRAG Rating Matrix:																								
Blue [Completed and embedded]	32	16.2%	36	17.3%	36	16.9%	39	17.9%	41	18.6%	41	18.22%	42	18.50%	42	16.41%	48	18.68%	50	19.38%	51	19.10%	59	21.15%
Green [Completed but not yet fully embedded/evidenced]	57	28.9%	66	31.7%	89	41.8%	91	41.7%	93	42.1%	99	44.00%	100	44.05%	116	45.31%	115	44.75%	119	46.12%	126	47.19%	134	48.03%
Amber [In progress/on track]	61	31.0%	55	26.4%	58	27.2%	47	21.6%	41	18.6%	39	17.33%	28	12.33%	44	17.19%	37	14.40%	24	9.30%	27	10.11%	28	10.04%
Red [Not yet completed/significantly behind agreed timescales]	43	21.8%	43	20.7%	21	9.9%	20	9.2%	24	10.9%	24	10.67%	35	15.42%	28	10.94%	30	11.67%	38	14.73%	35	13.11%	30	10.75%

Achievements since last report:

- Linked to previously provided updates around the work underway to improve the quality of patient information available to users of ULHT services, the Trust's contract with EIDO, who specialise in provision of procedure/consent based information resources, has been reviewed and agreed to extend. This is a core part of the Trust's revised strategy which supports the aim to improve the quality and accessibility of information. Work is underway to ensure Trust staff are aware and able to access this valuable resource.

- To support the mitigation of risk around medicines being stored in hotter than ideal ambient room temperatures within Maternity. A draft standard operating procedure has been approved at the Obstetrics and Gynaecology Governance meeting to support staff within the 4 areas identified from improved temperature monitoring arrangements, to halve the manufacturer's expiry data, once medicines are received from Pharmacy. This action, as guided by the draft SOP and supported by ward stock list reviews to remove any medicines not needed to be stocked (i.e. those medicines used infrequently / reductions in the quantities being held locally) is designed to reduce the likelihood of medicines being adversely affected, by reducing the length of time medicines and fluids are stored in these locations. The SOP is scheduled for review and agreement at the next Pharmacy Governance meeting during June. Following this, a pilot of the process will be commenced.

- During June 2023, Nettleham Ward (one of the 4 wards identified as having environmental challenges leading to suboptimal conditions for storage of medicines at ambient room temperature, as described in the previous bullet point) moved locations to occupy Langton Ward, a refurbished ward within the maternity building. This has resulted in an improved environment for patients and staff alike. The ward move will now enable Nettleham ward to be refurbished as part of the ongoing plans to improve the maternity estate.

- Within Urgent and Emergency Care (UEC), as part of the expansion of facilities on the Lincoln site, the number of 'quiet rooms' available, designed to provide a location for patients assessed to be at risk to themselves, have been increased. For internal assurance, the Safeguarding Team reviewed these locations for any ligature risks that could pose a risk to safety. Following

this review, a small risk was identified which has now been resolved following contractors returning to site. Safeguarding have now approved the modification reducing the risk to safety.

Challenges being focussed on:

As illustrated in the 'BRAG' ratings, there are a number of 'Red' rated actions. A number of these relate to specific 'sub-actions' that have not been completed in line with planned timescales. In such cases progress continues and updates are obtained on a monthly basis.

Where barriers have been encountered mid-action, the regular escalation reporting via ELT/TLT, Trust Performance Framework (PRM) and the Executive-led assurance process seeks to understand barriers and mitigating actions being taken to ensure progress.

The following summarises some of the areas of strengthened oversight:

- The Trust's People and Organisational Development Committee received an update on appraisals (CQC2021-08; 'Should-do') and mandatory training (CQC2021-06; 'Should-do'). The Trust were not able to achieve the ambitious improvement targets (90% and 95%) and have reviewed the actions in place and improvement trajectories to recover this during 2023/24. Following discussion at the CQC engagement meeting in May, this will be an area the Trust provides regular updates on to CQC at future monthly meetings.
- Embedding process for checking the Child Protection Information System (CP-IS) (CQC2021/01; 'Must-do'). Whilst the improvement actions have largely been completed, with evidence that processes and oversight have improved, audit data demonstrates further improvement is required. The Trust's Quality Governance Committee have focussed on this area for assurance purposes during their meetings in January, February and May 2023. The operational teams within Urgent and Emergency care have increased the frequency of monitoring processes to weekly in order to support the Trust obtain assurance that this process remains embedded.
- Safety of patients waiting on ambulances as defined by the Pre-Hospital Practitioner (PHP) SOP (CQC2021/02; 'Must-do'). Actions agreed have been largely completed with blue/green RAGs. Whilst the Trust's 'Breaking the Cycle' initiative has supported a focus on reducing the number of patients waiting on ambulances, further process revisions have been made with the development of the 'pit stop' process which is currently being piloted. The Trust continues to face significant pressures with increased numbers of patients presenting to the department.
- Paediatric competent and skilled staff in the Emergency Department (U&E 9 & CQC21-36; 'Should-do'). Assurances are available that the Paediatric area of the ED has sufficient oversight from medical staff rotas with EPALs and designated paediatric competent nursing staff. More clarity and understanding is needed to benchmark against the RCPCH staffing standards for ED in relation to the role of Registered Sick Children's Nursing (RSCN) and Trust plans. This has been reviewed collaboratively between medicine and paediatric teams and the outcome of this is scheduled for review at the Children's and Young Persons (CYP) Board.

- The ‘should-do’ action related to the Trust’s estate is currently marked as an overdue action. This is being reviewed in detail by the Trust’s Finance, Performance and Estates Committee (FPEC) with a detailed assurance report planned for presentation to outline the actions taken to mitigate estate related risks. This will include plans around the 6-facet survey and other business as usual processes around planned and preventative maintenance (PPM) and the premises assurance model (PAM). The committee will consider if there is evidence of sufficient action in response to the ‘should-do’ and if this can move into ongoing ‘business as usual’ oversight.
- Physical condition of the maternity estate at Lincoln (Mat 3). Work remains underway to develop a business case for complete refurbishment. The first steps have now been taken with the move of Nettleham ward to Langton, providing an improved environment to support patient care. Further work is now underway for longer term capital investment.
- The Trust are not yet able to demonstrate improved Pharmacy support to ward areas identified during the 2021 inspection. There are significant challenges in recruitment to staffing gaps within the Pharmacy department. An update on this will be provided as part of the next engagement meeting with CQC

Completed Actions:

At the Executive-Led CQC Assurance meeting during May, the following actions were confirmed as having been completed and moved to ‘Blue’ since the last report, these are available in the appendices:

- CQC2021-09: The trust should ensure the requirements of duty of candour are met (Maternity and CYP).
- CQC2021-25: The trust should consider adding specific action plans to the service risk register
- CQC2021-43: Should-Do: The trust should consider giving ward managers direct access to training systems for their areas in order to monitor and action mandatory training needs of their teams on a more regular basis (Medicine).

Actions Required

The Trust Board is asked to:-

- note the achievements and progress made in achieving the actions required following the CQC inspection
- note the areas of future action identified.

NHS
United Lincolnshire Hospitals
NHS Trust

CQC Improvement Action Plan
Executive Lead: Karen Dunderdale, Director of Nursing
Senior Responsible Officer: Kathryn Helley, Deputy Director of Clinical Governance
Progress Review Date As At: 08/06/2023

BRAG Rating Matrix	
Blue	Completed and embedded.
Green	Completed but not yet fully embedded/evidenced.
Amber	In progress/on track.
Red	Not yet completed/significantly behind agreed timescales

URN	Core Service	Trust/ Site	Recommendation Source	Immediate/ Must Do/ Should Do/	CQC Must Do / Should Do / Issue	Core Service	Local action agreed to resolve the issue	Action Lead	Deadline	Completeness rating	Date action completed	Evidence available to demonstrate completion	Evidence available to track that action remains completed and embedded	On completion: Outcome - How has the action been met?	Accountable Executive Lead	Reporting to sub-committee for assurance
CQC2021-06	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure that staff complete mandatory training in line with trust targets. Including but not limited to the highest level of life support, safeguarding and mental capacity training.	All	The Trust's established process for overseeing and targeting improvement around mandatory training and appraisal rates will be strengthened as a result of an increased focus through the Performance Review Meetings (PRM) with increased assurance reporting to the People and Organisational Development Sub-Committee of the Board. Improvement trajectories will be set via the PRM process with divisions. Target to achieve is 95% to have completed mandatory training. Key performance indicators to be included to summarise progress along with highlight reporting.	Claire Low (Deputy Director of People)	31-Mar-23	Red		(1) Mandatory training reporting at Divisional PRMs; (2) Assurance reporting through to People and OD committee.	(1) Mandatory training reporting at Divisional PRMs; (2) Assurance reporting through to People and OD committee.		Claire Low, Director of People and Organisational Development (OD)	People and Organisational Development Committee (PODC)
CQC2021-07	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure they provide sufficient numbers of nursing and medical staff to safely support patients.	All	The Trust has already established work streams focussed on ensuring sufficient nursing and medical staff. The Nursing work stream includes the process for twice daily oversight arrangements, annual nurse staffing reviews for all ward areas led by the Director of Nursing and reporting through to Trust Board. This is supported by the Trust's 5-year workforce plan which includes new and emerging roles. Key performance indicators to be included to summarise progress along with highlight reporting.	Helen Clark (Assistant Director of Nursing for Workforce & Education) Claire Low (Deputy Director of People) Lisa Geraghty (HR)	31-Mar-23	Red		(1) Reporting to PODC committee on progress with workforce plans; (2) Progress with key workforce indicators.	(1) Reporting to PODC committee on progress with workforce plans; (2) Progress with key workforce indicators.		Claire Low, Director of People and Organisational Development (OD)	People and Organisational Development Committee (PODC)
CQC2021-08	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure there are mechanisms for providing all staff at every level with the development they need through the appraisal process.	All	The Trust's established process for overseeing and targeting improvement around mandatory training and appraisal rates will be strengthened as a result of an increased focus through the Performance Review Meetings (PRM) with increased assurance reporting to the People and Organisational Development Sub-Committee of the Board. Improvement trajectories will be set via the PRM process with divisions. Target to achieve is 90% to have an appraisal. Key performance indicators to be included to summarise progress along with highlight reporting.	Claire Low (Deputy Director of People)	31-Mar-23	Red		(1) Mandatory training reporting at Divisional PRMs; (2) Assurance reporting through to People and OD committee.	(1) Mandatory training reporting at Divisional PRMs; (2) Assurance reporting through to People and OD committee.		Claire Low, Director of People and Organisational Development (OD)	People and Organisational Development Committee (PODC)
CQC2021-09	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure the requirements of duty of candour are met.	All	Continue to monitor and track performance with support from the Trust's Risk & Governance team. Aim is 100% of incidents that require DoC to have evidence of written DoC. [This is a business as usual action/oversight with well-established governance oversight.]	Divisional/CBU Leads (see Divisional / CBU CQC Improvement Action Plans)	31-Dec-2022	Green	31-Mar-23	(1) DoC performance data demonstrates timescales are routinely met; (2) Performance with timescales for SI investigations are met.	(1) DoC performance data demonstrates timescales are routinely met; (2) Performance with timescales for SI investigations are met; (3) Oversight through PRM process.	Performance with Duty of Candour is overseen by the Quality Governance Committee (QGC). Divisions are provided with ongoing support from the central Clinical Governance team. Performance data demonstrates high compliance rates with Duty of Candour. Improvements made by Divisions are reflected in Trust wide compliance data.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
CQC2021-10	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure it continues to review and manage the work required to improve medicines management across the organisation.	All	The Trust have an established improvement programme of work in place to review and manage the work required to improve medicines management. Medicines management related themes and findings from the CQC inspection have been included within this programme of work. The Medical Director chairs the Medicines management T&F group to oversee delivery of this work. Key performance indicators will be scoped and included to summarise progress along with highlight reporting.	IIP Improvement Project focussing on Medicines Management	Various	Amber		(1) Assurance reporting from IIP programme of work; (2) Assurance reporting into QGC sub-committee.	(1) Assurance reporting from IIP programme of work; (2) Assurance reporting into QGC sub-committee.		Colin Farquharson, Medical Director	Quality Governance Committee (QGC)

CQC2021-11	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure they are using timely data to gain assurance at board.	All	Provide a paper to FPEC considering options available in response to CQC Should-do action. Establish additional milestones in response to actions agreed at FPEC.	Shaun Caig (Associate Director of Performance & Information)	30-Apr-2022	Green	04-Jul-22	(1) Paper to FPEC summarising options; (2) Actions agreed in response.	(1) Board reporting of performance.	Paper has been tabled outlining options and taken to FPEC.	Barry Jenkins, Director of Finance & Digital	Finance, Performance and Estates Committee (FPEC)
CQC2021-13	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure it has access to communication aids and leaflets available in other languages.	All	Update Trust provision of information to patients policy (ULHT-NUR-PPI-PDWPI) to include process for escalation to PEG should 'information owners' not update existing information resources in line with periodic, 2 yearly review dates.	Sharon Kidd (Patient Experience Manager)	31-Mar-22	Green	08-Jun-22	Revised policy in draft.	Evidence from information resource register showing ongoing work to update information with escalation to PEG for those overdue review; Evidence that overdue information is being risk stratified and escalated	The Trust policy has been updated to reference reporting through to PEG and escalation steps where steps in the Trust policy are in danger of not being followed.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						All	Approve new policy at PEG.	Sharon Kidd (Patient Experience Manager)	10-May-22	Green	08-Jun-22	(1) Minutes of PEG demonstrating approval of policy.	None.	Revised policy has been submitted to PEG and approved.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						All	Refine quarterly PEG update report regarding patient information to include escalation of specific areas/owners of overdue patient information.	Sharon Kidd (Patient Experience Manager)	30-Apr-22	[Abandon & Replace]	31-Jan-23	Revised PEG update; Minutes from PEG when update received.	Evidence from information resource register showing ongoing work to update information with escalation to PEG for those overdue review; Evidence that overdue information is being risk stratified and escalated accordingly to PEG;	The revised approach for patient information has resulted in the need for a new approach to approving patient information resources, once in place, key performance indicators will be agreed for reporting through to PEG. This is captured in a new action.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						All	Divisions to reach out to patients in their areas to determine what information resources are required that do not currently exist (including UEC and advice cards).	Divisional CQC action plan owners (with support from FAB champions).	Set with divisions.	[Abandon & Replace]	18-Oct-22	None.	None.	Corporate update on provision of patient information in different languages provided to the Executive Led CQC Assurance meeting on the 14-October-2022. It was agreed to focus on the corporate strategy presented and bring back to Divisions once further strategic actions taken.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						All	Divisions to assign 'information owners' to provide information resources in response to feedback from local patients.	Who: Divisional CQC action plan owners to nominate lead 'information owners'.	To confirm on completion of divisional scoping.	[Abandon & Replace]	18-Oct-22	None.	None.	Corporate update on provision of patient information in different languages provided to the Executive Led CQC Assurance meeting on the 14-October-2022. It was agreed to focus on the corporate strategy presented	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						All	Divisions to undertake a walk-around/audit of current patient information resource available and being provided to patients within the division and compile a register, to include what languages the information is available in.	Divisional CQC action plan owners to nominate action leads.	Set with divisions.	[Abandon & Replace]	18-Oct-22	None.	None.	Corporate update on provision of patient information in different languages provided to the Executive Led CQC Assurance meeting on the 14-October-2022. It was agreed to focus on the corporate strategy presented and bring back to Divisions once	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						All	Patient Experience team to update the Trust central register with findings from the walk-around/audit and compare and contrast with Trust standards for patient information and determine if further action is required to update the information being provided (i.e. update/refresh the information - Divisional lead required; or update the format - Patient Experience team).	Scope out action needed on completion of audit and scope of work better understood.	Set on completion of audit and scope of work better understood.	[Abandon & Replace]	18-Oct-22	None.	None.	Corporate update on provision of patient information in different languages provided to the Executive Led CQC Assurance meeting on the 14-October-2022. It was agreed to focus on the corporate strategy presented and bring back to Divisions once further strategic actions taken.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						All	Refresh Patient Experience strategy and determine KPIs relating to the provision of patient information.	Jennie Negus	30-Apr-22	[Abandon & Replace]	31-Jan-23	Refreshed patient experience strategy with KPIs to support delivery.	Update reporting on progress with strategy to PEG and measurement against agreed KPIs.	Whilst the strategy has been refined, the revised KPIs for reporting through to PEG are affected by the new approach to approving patient information and is captured in a new	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						All	Patient Experience team to work with Maxine Skinner and Denise to ensure communication aids and resource folders are available in the department and agree further actions to ensure these resources are communicated with the wider team and made use of.	Sharon Kidd (Patient Experience Manager)	31-Mar-22	Green	31-Jan-23	(1) Copies of resource available.	None.	New communication tools and resources delivered to all ward areas including the Emergency Department.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						All	Patient Experience team to determine with UEC leads how communication with patients/carers whose first language is not English is currently facilitated and determine what resources would support this to be more effective.	UEC leads with support from Patient Experience Team.	30-Apr-22	Green	31-Jan-23	(1) Evidence of communication.	None.	Equality & Diversity team have raised awareness across the Trust.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						All	Patient Experience team to liaise with specialist teams (i.e. Learning Disability CNS) and review patient/service user feedback to determine if further information in easy read is required, and scope additional milestones/timescales accordingly.	Sharon Kidd (Patient Experience Manager)	30-Mar-22	Green	31-Jan-23	(1) Evidence of communication tools.	None.	Significant work undertaken working with LD CNS and patients & carers including video communication guides & stories.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)

All	Scope out plan for translation of internal information resources into different languages.	Jennie Negus (Head of Patient Experience); Sharon Kidd (Patient Experience Manager)	30-Apr-22	Green	30-Apr-22	(1) Plan for translation of patient information resources.	None.	There is a plan to enable current information resources to be made more accessible on a public facing internet site to enable service users to access these resources, using their own devices to translate or make more accessible.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
All	Upload all known patient information resources (approximately 300) to the Trust's public facing website.	Sharon Kidd (Patient Experience Manager)	30-Sep-22	[Abandon & Replace]	18-Oct-22	None.	None.	Corporate update on provision of patient information in different languages provided to the Executive Led CQC Assurance meeting on the 14-	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
All	Develop communication plan to ensure that clinical areas know where to access information resources and are able to signpost service users to. Include within this messages relating to the use of QR codes to enable easier access.	Sharon Kidd (Patient Experience Manager)	TBC	[Abandon & Replace]	18-Oct-22	None.	None.	Corporate update on provision of patient information in different languages provided to the Executive Led CQC Assurance meeting on the 14-October-2022. It was agreed to focus	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
All	Review outcomes from the walk-around audit completed in Family Health and agree next steps to support timely information provision.	Sharon Kidd (Patient Experience Manager)	TBC	[Abandon & Replace]	18-Oct-22	None.	None.	Corporate update on provision of patient information in different languages provided to the Executive Led CQC Assurance meeting on the 14-October-2022. It was agreed to focus	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
All	Following Executive-Led meeting on the 14 October, Patient Information Task & Finish group to formalise improvement plan and quantify projected timescales.	Patient Information Task and Finish Group	30-Nov-22	Green	31-Jan-23	(1) Plan and timescales for patient information improvement actions.	None.	Revised action plan has been agreed following the Patient Information Task and Finish group reviewing and agreeing milestones.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
All	From current Trust database (n=590), triage and shortlist local information that is likely not needed: * Duplicated by EIDO /national information * Is generic information which should be in a different	Lorraine Parkin (Patient Experience Administrator)	31-Jan-23	Green	31-Jan-23	(1) Evidence of review being undertaken.	None.	Full list of existing information resources triaged. This will inform the meeting of the Information for Patients approval group.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
All	Begin to ratify triage process outcomes from a review of the information via the Information for Patients Approval Group and publish to Information repository.	Information for Patients Approvals Group	28-Feb-23	Green	28-Feb-23	(1) Agreed list of information resources to go through Patient Information Approvals group. (2) Outcome of Patient Information Approvals Group.	None.	Triage process review has begun with a trajectory to clear all information resources from the old database within 6-months.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
All	Develop process charts on which to base the Policy on, from current Trust database and triage findings: * Those information resources duplicated by EIDO / National Information - Notification to local author with	Information for Patients Approvals Group	28-Feb-23	Green	28-Feb-23	(1) Agreed process charts outlining the process - potentially there should be 3 process charts.	None.	Process charts developed and approved by group. These have formed the basis of communications to the wider Trust outlining new process.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
All	Information approval group set-up and agree TOR.	Jeremy Daws (Head of Compliance)	31-Dec-22	Green	31-Jan-23	(1) Agreed terms of reference.	(1) Evidence from meetings held.	Terms of reference have been agreed for the patient information approvals group.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
All	Develop an information for patients repository via SharePoint to serve as local register and searchable guide for other Trust staff for hosting on the Trust's hub with 'approved' content.	Anna Richards (Head of Communications)	31-Dec-22	Green	31-Jan-23	(1) Evidence of new repository.	(1) Ongoing reporting from repository.	The new repository has been developed and will be populated with the outputs from the information for patients approvals group meetings.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
All	Begin populating new patient information repository with approved patient information.	Anna Richards (Head of Communications)	28-Feb-23	Green	30-Apr-23	(1) Evidence of populated repository. (2) Evidence of comms plan to ensure staff are aware.	(1) Ongoing reporting from repository.	The new repository has had the first approved and finalised documents (n=10) uploaded and made available for staff. A comms plan is being prepared to support when more information is available to signpost to.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
All	Of the 102 information resources agreed, only 10 have been processed through to completion, with the remaining requiring actions post-approval from owners. Review escalation processes following PIAG to include PEG to escalate any instances where owners are delaying and consider PEG upward reporting on a monthly basis of owners who have delayed in taking actions post approval of information at PIAG.	Jennie Negus (Head of Patient Experience)	30-Jun-23	Amber		(1) Agreed approach to escalation following PIAG.	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
All	3. EIDO contract running out in 6-weeks' time. Urgent action for Anna/Jennie to meet with Damian Carter in Surgery to understand surgery divisions plans to do with EIDO contract. If any doubt of this to be continued, Anna/Jennie to escalated via TLT.	Jennie Negus (Head of Patient Experience); Anna Richards (Head of Communications)	31-May-23	Green	31-May-23	(1) Evidence from discussions with Surgery division.	None.	Meetings held and position understood around EIDO.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
All	Scope actions needed to ensure patient information repository is accessible to patients and service users.	Anna Richards (Head of Communications)	31-Mar-23	Green	30-Apr-23	(1) Evidence of comms plan to ensure patients and service users can access information for patients repository.	None.	The new repository has had the first approved and finalised documents (n=10) uploaded and made available for staff. A comms plan is being prepared to support when more	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
All	Identify national sources of evidence based information that we would be happy to use. Write to PEG distribution group. Share with team and approve content of message.	Jeremy Daws (Head of Compliance)	31-Dec-22	Green	31-Dec-22	(1) Email to PEG	None.	Communication to the Patient Experience Group seeking out additional sources of information to be considered as 'Trusted sources' has been issued.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)

						All	Draft interim approach to translation and making information more accessible for patient consumption.	Jeremy Daws (Head of Compliance)	28-Feb-23	Green	28-Feb-23	(1) Written up interim statement/approach to be taken.	None.	Narrative agreed by the group, to propose approach to the ED&I group on the 8 March 2023 for a steer.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						All	Draft a revised/updated policy outlining the process for creating/sourcing patient information for publishing on the new repository	Sharon Kidd (Patient Experience Manager)	30-Apr-23	Green	30-Jun-23	(1) Draft Policy based on revised process maps.	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						All	Agree strategy and approach to translation of information into 'ULHT core' languages, including how these are accessible (i.e. QR code links / or printed materials)	Information for Patients Task and Finish Group	31-Mar-23	Red		(1) Email to E&D for advice. (2) Outcome of E&D meeting in March 2023.	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						All	Draft translation and accessible access to information strategy for patient information.	Patient Information Task and Finish Group	TBC	Amber		TBC			Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						All	Undertake Easy Read training course to enable in house development of easy read documentation.	Sharon Kidd (Patient Experience Manager)	31-May-23	Green	30-Jun-23	(1) Evidence of Easy Read communication course outcomes.	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						All	Liaise with specialist teams i.e. LD to plan how information can be more accessible and available.	Information for Patients Task and Finish Group	TBC	Amber		TBC			Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						All	Identify gaps in information not being available	TBC	TBC	Amber		TBC			Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						All	Scope out process for escalation of information materials not fit for purpose (i.e. out of date, evidence being photocopied without review controls in place)	TBC	TBC	Amber		TBC			Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						All	What information is needed in ED? Jennie email and medicine update - end of Nov 22	Jennie Negus (Head of Patient Experience)	28-Feb-23	Green	28-Feb-23	(1) Evidence of plan with Medicine Division.	None.	Communication between the Patient Experience team and Medicine have been had and a task and finish group within UEC has been agreed as next steps. Milestone added to UEC Improvement Action Plan.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
CQC2021-14	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure the design, maintenance and use of facilities, premises and equipment keep patients safe.	All	Service specific actions relating to the estate (i.e. the £37m development of a new Emergency Department at Pilgrim) are outlined within the service level improvement action plans.	For further detail see the service level improvement action plans.	For further detail see the service level improvement action plans.	Amber			For further detail see the service level improvement action plans.	For further detail see the service level improvement action plans.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)
						All	Undertake a 6-facet survey to refresh the Trust's understanding of current estate conditions to further support the Trust to take a risk based approach.	Michael Parkhill (Director of Estates & Facilities)	31-Dec-2022	Red		(1) Evidence of findings from 6-facet survey; (2) Evidence of inclusion of key areas from the 6-facet survey into the Trust's estate plans.	None.		Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)

						All	The Trust is continuing to focus on strengthening its Planned Preventative Maintenance (PPM) regime with ongoing assurance reporting through the Trust's Finance, Performance and Estates Committee. This is supported by the appointed Authorising Engineers (AEs) across the Trust focussed on all aspects. The Premises Assurance Model (PAM) provides a key assurance function as part of this process. This is a business as usual action.	Michael Parkhill (Director of Estates & Facilities)	31-Mar-23	Red		(1) FPEC assurance reporting of progress with planned preventative maintenance regime; (2) FPEC assurance reporting of findings following Authorised Engineer (AEs) reviews; (3) PAM assurance reporting into FPEC; (4) FPEC assurance reporting of progress with reducing the estates backlog and controls in place to prevent backlog from developing; (5) AE reporting from key subgroups (i.e. water, fire, electrical).	(1) FPEC assurance reporting of progress with planned preventative maintenance regime; (2) FPEC assurance reporting of findings following Authorised Engineer (AEs) reviews; (3) PAM assurance reporting into FPEC; (4) FPEC assurance reporting of progress with reducing the estates backlog and controls in place to prevent backlog from developing; (5) AE reporting from key subgroups (i.e. water, fire, electrical).		Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)

NHS
United Lincolnshire Hospitals
NHS Trust

CQC Improvement Action Plan
Executive Lead: Karen Dunderdale, Director of Nursing
Senior Responsible Officer: Kathryn Helley, Deputy Director of Clinical Governance
Progress Review Date As At: 08/06/2023

BRAG Rating Matrix	
Blue	Completed and embedded.
Green	Completed but not yet fully embedded/evidenced.
Amber	In progress/on track.
Red	Not yet completed/significantly behind agreed timescales

URN	Core Service	Trust/ Site	Recommendation Source	Immediate/ Must Do/ Should Do/	CQC Must Do / Should Do / Issue	Core Service	Local action agreed to resolve the issue	Action Lead	Deadline	Completeness rating BRAG	Date action completed	Evidence available to demonstrate completion	Evidence available to track that action remains completed and embedded	On completion: Outcome - How has the action been met?	Accountable Executive Lead	Reporting to sub-committee for assurance	Notes
CQC2021-01	Urgent & Emergency Care	Lincoln County Hospital	Core services inspection	Must Do	The trust must ensure systems and processes to check nationally approved child protection information sharing systems are fully embedded and compliance is monitored. Regulation 13 Safeguarding service users from abuse and improper treatment.	UEC	The flowchart describing the correct process has been reinforced within ED. This will be supported by the Safeguarding team who have commenced education work with key staff as part of team huddles and supervision sessions. This education work will be completed by 30 November 2021. A record of staff trained will be maintained for assurance.	Elaine Todd (Named Nurse for Safeguarding Children and Young People); Holly Carter / Jemma Bowler (Senior Sister, ED); Ellie Peet and Sharon Laverton / Vikki Hoadley (ED Clinical Educators)	31-Mar-2022	Green	20-Jun-2022	(1) Training records for ED staff; (2) Evidence of this being added to UEC risk register.	(1) Monthly audit to be undertaken to test compliance; (2) Evidence this has been added to Nursing induction as a core competency.	Confirmation received from ED that all relevant staff have now completed CPIS training.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
CQC2021-04	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Must Do	The service must ensure systems and processes to check nationally approved child protection information sharing systems are fully embedded and compliance is monitored. Regulation 13 Safeguarding service users from abuse and improper treatment.	UEC	A compliance audit was already planned by the Safeguarding team, this will be undertaken as planned on this process retrospectively and will be completed by 5 November 2021. A re-audit will be undertaken following delivery of educational sessions. This will be completed by 31 January 2022.	Elaine Todd (Named Nurse for Safeguarding Children and Young People)	31-Jan-2022	Blue	31-Jan-22	(1) Audit findings / report; (2) Action plan in response.	(1) Monthly audit to be undertaken to test compliance.	A monthly schedule of audits has been agreed by which the Safeguarding team will support the ED team by undertaking these assurance audits.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	A list of those who cannot access care-portal within ED is needed and then access needs to be requested from IT.	Holly Carter / Jemma Bowler (Senior Sister, ED); Ellie and Sharon (ED Clinical Educators)	31-Mar-2022	Green	09-Jun-2022	(1) Evidence of access arrangements to Care Portal being in place for existing staff.	(1) Monthly audit to be undertaken to test compliance; (2) Evidence this has been added to Nursing induction as a core competency.	Staff automatically have access to Care Portal via their permissions provided to them once given systems access on commencing their role within the department.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Include within ED nursing competencies Safeguarding and access to the National Child Protection Register spine to ensure this training/education is provided on a routine and regular basis.	Maxine Skinner (Lead Nurse Urgent & Emergency Care) Ellie and Sharon (ED Clinical Educators)	31-Mar-2022	Green	09-Jun-2022	(1) Inclusion of Safeguarding training as part of induction programme for new starters; (2) Inclusion of access to the Care Portal system as part of the induction programme for new starters.	(1) Monthly audit to be undertaken to test compliance; (2) Evidence this has been added to Nursing induction as a core competency.	Assurance provided by the department that CP-IS training has been included within the departments local induction process to ensure new nursing/medical staff receive this training on commencement of their employment in the Department.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Implement monthly audit process to monitor compliance and to provide assurance that process is fully embedded.	Tracey Wall (Divisional Nurse); Craig Ferris (Head of Safeguarding)	31-Mar-2022	Green	31-Mar-2022	(1) Monthly audit data; (2) Action plan in response; (3) Findings from audit demonstrate compliance.	(1) Monthly audit data demonstrating compliance; (2) Reporting to appropriate UEC governance arrangements; (3) Upward report to CYP Oversight Group.	Monthly audit results are now being provided for assurance purposes to demonstrate performance with checking the Nationally Approved Child Protection Register.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Monthly audit results do not show improvement. Review performance and agree plan of improvement actions.	Denise Dodd, (UEC Matron)	31-May-2022	Blue	20-Jun-2022	(1) Agreed action plan for improvement on monthly audit findings.	None.	Standardised process agreed following pilot project supported by audit evaluation.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Undertake compliance audit of June 2022 following standardising CP-IS process across the Trust and determine action needed as appropriate from the audit findings.	Denise Dodd, (UEC Matron)	31-Jul-2022	Green	31-Aug-2022	(1) Agreed action plan for improvement on monthly audit findings.	None.	Audit findings reviewed and action plan agreed. Results demonstrated improvements annd identified areas where continued education and embedding are required.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Undertake ongoing assurance audits to track progress and agree rolling programme of actions in response to audit data.	UEC Sisters; Safeguarding team	31-Dec-2022	Green	31-Dec-2022	(1) Assurance audit data; (2) Actions in response to audit data.	None.	Audit findings reviewed and action plan agreed. CP-IS Task and Finish Group established who are taking receipt of the audit findings and overseeing actions in response.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	

						UEC	Assurance data does not demonstrate process is embedded on Lincoln site	UEC Leads.	31-Oct-2022	Red		(1) Evidence of improvements being made from the assurance audit data.	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	Assurance Data does not show evidence of improvement.
						UEC	Assurance data demonstrates process is on course for being embedded at Boston and Grantham by the end of Q1 (June 2023).	UEC Leads.	30-Jun-2023	Amber		(1) Evidence of improvements being made from the assurance audit data.	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	Assurance Data does not show evidence of improvement.
						UEC	Embed CP-IS process across all 3 sites as demonstrated by CAS card audit evidence demonstrating compliance when CP-IS is indicated.	UEC Leads.	30-Jun-2023	Amber		(1) Evidence of CP-IS process being embedded across all 3 sites.	(1) Evidence of CP-IS process being embedded across all 3 sites.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	Assurance Data does not show evidence of improvement.
CQC2021-02	Urgent & Emergency Care	Lincoln County Hospital	Core services inspection	Must Do	The trust must ensure the trust standard operating procedure for management of reducing ambulance delays is fully implemented. Regulation 12 Safe care and treatment.	UEC	Assurance data that patients waiting in ambulances are seen by a doctor.	Cheryl Thomson (General Manager)	01-Nov-2021	Green	01-Nov-2021	(1) 30-Sept-21 Information report which shows first location and time seen; (2) Ambulance handover SOP: Section 2.5; (3) 5.31 CQC full assurance report; tab 1 'drive times' tab 0-60 mins'	(1) Information reports from ED system detailing time seen and location first seen; (2) CQC full assurance documentation – tab 1 focus on triage; (3) ED 6.21 Assurance Tool focusing	The evidence supplied provides assurance that patients waiting in ambulances, due to capacity bottlenecks with the Emergency Department, are seen and assessed by a doctor whilst in the ambulance. This	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
CQC2021-05	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Must Do	The service must ensure the trust standard operating procedure for management of reducing ambulance delays is fully implemented. Patients waiting on ambulances should be reviewed by medical staff within an hour and within 30 minutes where the national early warning score is five or more or requiring prioritisation. Regulation 12 Safe care and treatment.	UEC	Inclusion of additional field into the Harm template to ensure this is more clearly evidenced from harm reviews.	Cheryl Thomson (General Manager)	01-Nov-2021	Blue	01-Nov-2021	(1) Email request for the UEC harm reviews to include a specific field to capture the time patients receive their first assessment; (2) Copy of amended harm template.	(1) Random, snapshot sample of UEC Clinical Harm reviews	This additional field makes it easier, at the time of undertaking a harm review, for harm to be accurately assessed related to waiting times/locations.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
						UEC	PHP log not felt to be best solution, amendments to CAS card instead have been made that include location of the patient when handed over.	Blanche Lentz (Clinical Services Manager UEC)	31-Aug-2022	Green	19-Sep-2022	(1) Amended casualty card.	(1) Audit evidence of the new CAS card being used in practice and recording where patient has been seen – including ambulance.	The Casualty Card has been updated to include space to record when a patient is assessed on the ambulance. This has now been approved by UEC and	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	13-May-22: Executive-led assurance review approved rebasing of this deadline from the 31-Mar-22, moving to the 31-Aug-22. This will remain as
						UEC	Develop clinically led standardised admission pathways guidance to support ED teams identify: • The primary specialty to take ownership for the ongoing care from the ED • If necessary, and additional MDT input required, this will be undertaken by the primary speciality. These have been agreed by the group, this was ratified during May and June 2021.	Urgent Emergency Care Clinical Standards Group		Blue	01-Oct-2021	(1) Copy of the standardised admission pathway guidance; (2) Minutes from the Urgent Emergency Care Clinical Standards Group evidencing approval of guidance.	(1) Copy of the standardised admission pathway guidance.	Clinically agreed guidance exists to support the Emergency Department consult and seek assistance from specialties for patients waiting in the department. The guidance includes a commitment for specialties to pull patients out of the Emergency Department.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
						UEC	Review and update the 'Management of Reducing Ambulance Delays in the Emergency Departments' SOP. Ensure this includes links to wider corporate policies and SOPs (i.e. Full Capacity Protocol and the Ambulance Turnaround Protocol) and includes all relevant roles (i.e. Pre-Hospital Practitioners (PHP) and Hospital Liaison Officers (HALO)) and makes it clear that patients are being seen regardless of location (i.e. on ambulances during extreme pressures).	Cheryl Thomson (General Manager)	31-Mar-2022	[Abandon & Replace]	05-May-2022	(1) Revised SOP completed and approved.	(1) Evidence that SOP has been added to the Trust's controlled documents procedures and is available for staff to access easily to guide them; (2) Evidence that SOP has a timely review date to ensure guidance remains updated and fit for purpose.	The Pre-Hospital Practitioner SOP has been re-written and agreed at UEC CBU Governance. This SOP outlines actions for patients waiting on ambulances and outlines when these should be reviewed by medical staff and criteria for prioritisation. This has now been added to the Trust's document control system as a corporate document with a review date of 6-months.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
						UEC	Add the Reducing Ambulance Handover Delays SOP into the Clinical Operational Flow Policy.	Michelle Harris (Chief Operating Officer)	30-Jun-2022	[Abandon & Replace]		(1) Revised SOP included within the Clinical Operational Flow Policy.	None.		Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	13-May-22: Executive-led assurance review approved rebasing of this deadline from the 31-Mar-22, moving to the 30-Jun-22. This will remain as
						UEC	Review and Update the PHP SOP following initial implementation.	Cheryl Thomson (General Manager)	31-Aug-2022	Blue	31-Aug-2022	(1) Revised PHP SOP completed and approved.	(1) Evidence that SOP has been added to the Trust's controlled documents procedures and is available for staff to access easily to guide them;	The Pre-Hospital Practitioner SOP has been re-written and agreed at UEC CBU Governance. This SOP outlines actions for patients waiting on ambulances and	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
						UEC	Draft new document to subsume the 'Full Capacity Protocol', 'Clinical Operational Flow Policy' and the 'Reducing Ambulance Handover Delays SOP'.	Michelle Harris (Chief Operating Officer)	TBC	Amber		(1) Regional guidance published for ULHT staff to access.	N/A		Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
						UEC	Revised SOP to include effectiveness measures to track progress with key metrics: (a) PHP assessment (face to face) < 15 minutes; (b) Doctor assessment < 1 hour; (c) Doctor assessment < 30 minutes if NEWS > 5; (d) Assurance that NEWS observations in the ambulance by PHP are recorded on WebV for ongoing monitoring and tracking to provide ongoing assurance against SOP.	Cheryl Thomson (General Manager)	31-Mar-2022	Green	05-Apr-2022	(1) Evidence of effectiveness measures for ongoing monitoring of performance against key metrics.	(1) Evidence that performance with key metrics, as part of revised SOP, are being used for ongoing monitoring of performance against key metrics; (2) Evidence of audit data being used for improvement purposes.	Revised SOP approved which contains key effectiveness measures.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
						UEC	In the interim, undertake monthly, matron led, snapshot assessments of patients waiting longer on ambulances to track performance with key milestones: (a) PHP assessment (face to face) ≤ 15 minutes; (b) Doctor assessment ≤ 1 hour; (c) Doctor assessment ≤ 30 minutes if NEWS > 5; (d) Assurance that NEWS observations in the ambulance by PHP are recorded on WebV for ongoing monitoring and tracking.	Maxine Skinner (Lead Nurse Urgent & Emergency Care)	31-Jul-2022	Green	04-Aug-2022	(1) Evidence of audit tool being used to collect data against key metrics as part of monthly matrons audit.	(1) Evidence of audit tool being used to collect data against key metrics as part of monthly matrons audit; (2) Evidence of audit data being used for improvement purposes.	The audit questions have now been amended and added to the Nurse in Charge booklet. This was added from the beginning of July 2022 and the data now needs collating for performance/assurance purposes.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	13-May-22: Executive-led assurance review approved rebasing of this deadline from the 31-Mar-22, moving to the 31-Jul-22. This will remain as 'RED' rated.
						UEC	Scope out the inclusion of performance with key milestones: (a) PHP assessment (face to face) < 15 minutes; (b) Doctor assessment < 1 hour; (c) Doctor assessment < 30 minutes if NEWS > 5; (d) Assurance that NEWS observations in the ambulance by PHP are recorded on WebV for ongoing monitoring and tracking as part of the Trust's Clinical Audit Programme to provide further external assurance.	Maxine Skinner (Lead Nurse Urgent & Emergency Care)	30-Apr-2022	Green	06-May-2022	(1) Development of Clinical Audit Project plan.	None.	Project plan drafted for the audit of compliance with the revised SOP and key measures.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
						UEC	Undertake first Quarterly audit project of compliance with key milestones: (a) PHP assessment (face to face) < 15 minutes; (b) Doctor assessment < 1 hour; (c) Doctor assessment < 30 minutes if NEWS > 5; (d) Assurance that NEWS observations in the ambulance by PHP are recorded on WebV.	TBC (Lead Nurse Urgent & Emergency Care)	30-Jun-2022	Green	19-Sep-2022	(1) Audit findings from first audit.	(1) Evidence of ongoing audit for assurance purposes.	PHP SOP Key measures have been included within the revised Nurse in Charge Assurance tool that will enable daily assurance reporting replacing the need for a quarterly clinical audit. Snapshot audit data has now been made available following an audit	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	

						UEC	Develop an audit tool to obtain this assurance with key milestones. Feed into monthly CBU governance reporting process (escalations to divisions and PRM).	Jeremy Daws (Head of Compliance)	31-Jul-2022	Green	09-Jun-2022	(1) Completed audit tool; (2) Evidence of audit tool being used to collect data against key metrics as part of monthly matrons audit.	(1) Evidence of audit tool being used to collect data against key metrics as part of monthly matrons audit.	The audit tool has been developed and approved at ED Governance. This has been used as part of the NIC booklet during the month of June and first data from the audit will be availble during the w/c 13 June 2022.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	13-May-22: Executive-led assurance review approved rebasing of this deadline from the 31-Mar-22, moving to the 31-Jul-22. This will remain as 'RED' rated.
						UEC	Add into Harm Review proforma - Has patient been seen within 1 hour. Review in 3 months to see if this is giving assurance needed.	Cheryl Thomson (General Manager), Maxine Skinner (Lead Nurse, UEC)	31-Mar-2022	[Abandon & Replace]	20-Jun-2022	(1) Email request for the UEC harm reviews to include a specific field to capture this; (2) Copy of amended harm template.	(1) Random, snapshot sample of UEC Clinical Harm reviews	UEC proposal to CHOG regarding a change in process in undertaking the Clinical Harm Review Process results in this sub-action relating to inclusion of ambulance wait question within the	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
						UEC	Provide a monthly overview of performance against these key milestones: (a) PHP assessment (face to face) < 15 minutes; (b) Doctor assessment < 1 hour; (c) Doctor assessment < 30 minutes if NEWS > 5; (d) Assurance that NEWS observations in the ambulance by PHP are recorded on WebV for ongoing monitoring and tracking. In addition to other related metrics (i.e. time to first assessment etc.) to Governance meeting process.	Denise Dodd (UEC Matron)	31-Jul-2022	Green	19-Sep-2022	(1) Ongoing monthly assurance reporting.	(1) Ongoing monthly assurance reporting.	PHP SOP Key measures have been included within the revised Nurse in Charge Assurance tool that will enable daily assurance reporting. Snapshot audit data has now been made available following an audit undertaken.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	13-May-22: Executive-led assurance review approved rebasing of this deadline from the 31-Mar-22, moving to the 31-Jul-22. This will remain as 'RED' rated.
						UEC	Build monthly assurance reporting of key milestones into one of the standard ED assurance processes so this becomes a standard feature of the ED assurance process.	Denise Dodd (UEC Matron)	31-May-2022	Green	19-Sep-2022	(1) Ongoing monthly assurance reporting.	(1) Ongoing monthly assurance reporting.	PHP SOP Key measures have been included within the revised Nurse in Charge Assurance tool that will enable daily assurance reporting. Date for go live with the new tool is to be	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
						UEC	In the absence of assurance data relating to compliance with the PHP SOP, develop an audit plan for Corporate Operational Management Team to undertake.	Jeremy Daws (Head of Compliance)	31-Aug-2022	Green	31-Aug-2022	(1) Copy of the audit project plan. (2) Copy of the audit tool.	N/A	Audit documentation agreed and in place to support the observational audit to be undertaken in LCH and PBH Emergency Departments.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
						UEC	In the absence of assurance data, undertake the observational audit during September and report compliace data for assurance purposes.	James Hodgkins (Operational Lead Nurse)	30-Sep-2022	Green	19-Sep-2022	(1) Findings from the audit.	N/A	Assurance audit undertaken which has now been completed providing compliance data with the PHP SOP key measures.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
						UEC	Review assurance audit data and agree next steps.	Cheryl Thompson (General Manager)	31-Oct-2022	Green	18-Oct-2022	(1) Findings from the audit.	N/A	Assurance audit undertaken which has now been completed providing compliance data with the PHP SOP key	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
						UEC	Pause actions in response to the PHP audit and evaluate the impact of the 'Breaking the Cycle' initiative that is designed to reduce ambulance handovers and therefore the number/time patients spend on ambulances.	CBU Leads	31-Dec-2022	Green	31-Dec-2022	(1) Findings from the Breaking the Cycle initiative.	N/A	Audit data collected from PHP audit process has not demonstrated the scale of improvements needed to avoid ambulance queues outside of the department.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
						UEC	Take to UEC Clinical Cabinet meeting in December for approval the plans to revise and pilot a different RAT process in case the 'Breaking the Cycle' initiative does not improve the compliance with the PHP SOP.	Blanche Lentz (Clinical Services Manager)	31-Dec-2022	Green	31-Jan-2023	(1) Evidence of discussion at UEC Clinical Cabinet meeting.	N/A	Internal approvals confirmed for a pilot of the revised PHP process designed to bring patients waiting on ambulances into the department for initial face to face assessment and triage, before, if	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
						UEC	Evaluate the pilot of the revised PHP Process using PHP audit data. Review for 3 month period. Key metrics to be measured are: (a) PHP assessment (face to face) < 15 minutes; (b) Doctor assessment < 1 hour; (c) Doctor assessment < 30 minutes if NEWS > 5; (d) Assurance that NEWS observations in the ambulance by PHP are recorded on WebV for ongoing monitoring and tracking.	UEC Leads.	30-May-2023	Red		(1) Evaluation of pilot from ongoing PHP audit data.	(1) Evaluation of pilot from ongoing PHP audit data.		Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
CQC2021-35	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Should Do	The trust should ensure deteriorating patients are identified and escalated in line with trust policy.	UEC	*(Same action above in reference to 'Must-do' action)* In the interim, whilst SOP being revised, undertake monthly, matron led, snapshot assessments of patients waiting longer on ambulances to track performance with key milestones: (a) PHP assessment (face to face) < 15 minutes; (b) Doctor assessment < 1 hour; (c) Doctor assessment < 30 minutes if NEWS > 5; (d) Assurance that NEWS observations in the ambulance by PHP are recorded on WebV for ongoing monitoring and tracking.	Denise Dodd (UEC Matron)	31-Jul-2022	Green	19-Sep-2022	(1) Monthly matrons audits of patients waiting on ambulances demonstrating performance against key metrics; (2) Performance against deteriorating patient audits (sepsis); (3) ED Daily Assurance Tool.	(1) Assurance evidence available following revision of SOP/monthly matrons audits for patients waiting on ambulances; (2) Performance against deteriorating patient audits (sepsis); (3) Ongoing monthly assurance reporting as part of S.31 response process; (4) Completed harm reviews.	PHP SOP Key measures have been included within the revised Nurse in Charge Assurance tool that will enable daily assurance reporting. Snapshot audit data has now been made available following an audit undertaken.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	13-May-22: Executive-led assurance review approved rebasing of this deadline from the 31-Mar-22, moving to the 31-Jul-22. This will remain as 'RED' rated.
						UEC	Review assurance audit data and agree next steps.	Cheryl Thompson (General Manager)	31-Oct-2022	Green	18-Oct-2022	(1) Findings from the audit.	N/A	Assurance audit undertaken which has now been completed providing compliance data with the PHP SOP key measures. Action plan agreed.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
CQC2021-33	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Should Do	The trust should ensure triage is a face to face encounter with a patient for ambulance conveyances.	UEC	*(Same action above in reference to 'Must-do' action)* In the interim, whilst SOP being revised, undertake monthly, matron led, snapshot assessments of patients waiting longer on ambulances to track performance with key milestones: (a) PHP assessment (face to face) < 15 minutes; (b) Doctor assessment < 1 hour; (c) Doctor assessment < 30 minutes if NEWS > 5; (d) Assurance that NEWS observations in the ambulance by PHP are recorded on WebV for ongoing monitoring and tracking.	Denise Dodd (UEC Matron)	31-Jul-2022	Green	19-Sep-2022	(1) Monthly matrons audits of patients waiting on ambulances demonstrating performance against key metrics; (2) Performance against deteriorating patient audits (sepsis); (3) ED Daily Assurance Tool.	(1) Assurance evidence available following revision of SOP/monthly matrons audits for patients waiting on ambulances; (2) Performance against deteriorating patient audits (sepsis); (3) Ongoing monthly assurance reporting as part of S.31 response process; (4) Completed harm reviews.	PHP SOP Key measures have been included within the revised Nurse in Charge Assurance tool that will enable daily assurance reporting. Snapshot audit data has now been made available following an audit undertaken.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	13-May-22: Executive-led assurance review approved rebasing of this deadline from the 31-Mar-22, moving to the 31-Jul-22. This will remain as 'RED' rated.
						UEC	Review assurance audit data and agree next steps.	Cheryl Thompson (General Manager)	31-Oct-2022	Green	18-Oct-2022	(1) Findings from the audit.	N/A	Assurance audit undertaken which has now been completed providing compliance data with the PHP SOP key measures. Action plan agreed.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
						UEC	Assurance data does not demonstrate process is embedded	UEC Leads.	31-Oct-2022	Red		(1) Evidence of improvements being made from the assurance audit data.	N/A		Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	Assurance Data does not show evidence of improvement.
U&E 9	Urgent & Emergency Care	Lincoln County Hospital	2021 'Interim Action'	2021 'Interim Action'	**CQC Concern: 22-Oct-21:** Concerns that there is not an appropriate number of nursing/medical staff trained in paediatric life support in paediatric ED at Lincoln County	UEC	Urgent clarification to be provided to CQC for assurance purposes.	Tracey Wall (Head of Nursing)/ Blanche Lentz (Clinical Services Manager UEC)	25-Nov-2021	Blue	25-Nov-2021	(1) Accurate training records as at Oct-21 shared with CQC	(1) Ongoing assurance reporting	The information provided assurance that the Trust's Emergency Departments did have safe levels of training competencies within its	Claire Low, Director of People and Organisational Development (OD)	People & Organisational Development Committee (PODC)	

					paediatric ED at Lincoln County). [Links to CQC2021-06]	UEC	Clear training trajectories agreed for those staff out of compliance. Submitted to CQC as part of evidence request: Pilgrim CYP 07; Pilgrim U&E 02; Pilgrim U&E 79; Lincoln CYP 07; Lincoln U&E 02	Tracey Wall (Head of Nursing)	25-Nov-2021	Blue	25-Nov-2021	(1) Accurate training records as at Oct-21 shared with CQC	(1) Improved training / competence rates in line with agreed trajectory	training competencies within its medical and nursing workforce. Improvement trajectories were provided to demonstrate plans for continued training. This identified a weakness in the central training records maintained on ESR and	Claire Low, Director of People and Organisational Development (OD)	People & Organisational Development Committee (PODC)	
						UEC	Attain compliance of 89% (PBH) and 87% (LCH) with Paediatric basic life support.	Blanche Lentz (Clinical Services Manager UEC)	31-Jan-2022	Green	19-Sep-2022	(1) ED nursing staff training compliance with Paediatric BLS.	(1) ED nursing staff training compliance with Paediatric BLS.	Assurance document collated by the Emergency Department which demonstrates that whilst the	Claire Low, Director of People and Organisational Development (OD)	People & Organisational Development Committee (PODC)	
						UEC	Attain compliance of 71% (PBH) and 83% (LCH) with European Paediatric Advanced Life Support.	Blanche Lentz (Clinical Services Manager UEC)	31-Mar-2022	Green	19-Sep-2022	(1) ED nursing staff training compliance with European Paediatric Advanced Life Support.	(1) ED nursing staff training compliance with European Paediatric Advanced Life Support.	Assurance document collated by the Emergency Department which demonstrates that whilst the	Claire Low, Director of People and Organisational Development (OD)	People & Organisational Development Committee (PODC)	
						UEC	Attain compliance of 57.8% (PBH) and 100% (LCH) with Paediatric Intermediate Life Support.	Blanche Lentz (Clinical Services Manager UEC)	31-Jan-2022	Green	19-Sep-2022	(1) ED nursing staff training compliance with Paediatric Intermediate Life Support.	(1) ED nursing staff training compliance with Paediatric Intermediate Life Support.	Assurance document collated by the Emergency Department which demonstrates that whilst the	Claire Low, Director of People and Organisational Development (OD)	People & Organisational Development Committee (PODC)	
						UEC	Agree training aim for Emergency Department staff, nursing and medical staff, for * Paediatric Basic Life Support; * Paediatric Immediate Life Support; * European Paediatric Advanced Life Support And update PODC.	Blanche Lentz (Clinical Services Manager UEC)	31-Jul-2022	Green	19-Sep-2022	(1) Document outlining staff training requirements for medical and nursing staff with training aims and targets.	None.	Assurance document collated by the Emergency Department which demonstrates that whilst the trajectories set by the Trust have not been fully met, the Emergency Department was staffed appropriately in terms of having sufficient cover from staff with paediatric life support training.	Claire Low, Director of People and Organisational Development (OD)	People & Organisational Development Committee (PODC)	
						UEC	Provide ongoing oversight and assurance reporting to the Childrens and Young People (CYP) Board.	Denise Dodd (Matron, UEC)	31-Dec-2022	Green	30-Apr-2023	(1) CYP Board Meeting Minutes.	N/A.	Monthly assurance evidence presented to CYP board on nursing competencies.	Claire Low, Director of People and Organisational Development (OD)	People & Organisational Development Committee (PODC)	
						UEC	Provide comprehensive report to Childrens and Young People (CYP) Board on competencies to care for children attending the ED department by refreshing the assurance evidence collated during 2022 for the Trust's S.31 response (including both medical and nursing workforce).	Denise Dodd (Matron, UEC)	31-Jul-2023	Amber	30-Apr-2023	(1) CYP Board Meeting Minutes; (2) Assurance paper to CYP Board.	N/A.		Claire Low, Director of People and Organisational Development (OD)	People & Organisational Development Committee (PODC)	
						UEC	Scope out ensuring central / corporate training records / systems (ESR etc.) are updated / maintained locally with accurate data to ensure corporate reporting of training level details relating to Life Support training (where external courses are accessed) is robust.	Blanche Lentz (Clinical Services Manager UEC)/Michael Durose (Organisation Dev Lead for Education)	21-Dec-2021	Blue	21-Dec-2021	(1) List of expected competencies for Medical Staff/Nursing staff in ED (2) Mapping of paediatric life support competencies to role	None.	Initial scoping completed to determine what actions are required within the Emergency Department to more accurately report on the central ESR system staffing training competencies.	Claire Low, Director of People and Organisational Development (OD)	People & Organisational Development Committee (PODC)	
						UEC	Ensure roles are correctly mapped to training needed in ED and to allow local management of records on ESR to ensure central system accuracy is maintained.	Blanche Lentz (Clinical Services Manager UEC)	TBC	Amber		(1) ED staff competencies accurately mapped and recorded. (2) Evidence that this is set at role level to ensure future proofing for when staff	(1) Improved accuracy of centrally held training records		Claire Low, Director of People and Organisational Development (OD)	People & Organisational Development Committee (PODC)	
CQC2021-16	Urgent & Emergency Care	Lincoln County Hospital	Core services inspection	Should Do	The trust should ensure, the paediatric area within the Emergency Department, nursing and medical staffing requirements meet the Royal College of Paediatrics and Child Health (RCPCH).	UEC	Provide written clarification with evidence to CQC on the following points: • The Paediatric area within the ED, whilst moved to a distinct part of the department, is retained within the UEC management and governance structure. • There is a 24/7 nominated lead doctor, detailed within the rota. • Close links with the CYP team with cross divisional learning and close working between CYP and UEC matrons.	Denise Dodd, (UEC Matron) Rebecca Thurlow (CYP Matron)	01-Dec-2021	Blue	15-Nov-2021	(1) 24/7 Paediatric named lead clinician rota; (2) Nursing rota demonstrating nurses on duty 24/7 with paediatric competencies.	(1) 24/7 Paediatric named lead clinician rota; (2) Nursing rota demonstrating nurses on duty 24/7 with paediatric competencies.	A written narrative has been provided to CQC that outlines the functionality of the Emergency Department and how it operates, how systems and controls have been established to care for children within the department. The Trust were concerned that CQC inspectors thought that the Trust had a dedicated Paediatric Emergency Department, when it does not.	Claire Low, Director of People and Organisational Development (OD)	People & Organisational Development Committee (PODC)	
CQC2021-36	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Should Do	The trust should ensure the, paediatric area within the Emergency Department, nursing and medical staffing requirements meet the Royal College of Paediatrics and Child Health (RCPCH).	UEC	Review and confirm RCPCH standards for ED departments in ULHT and staffing requirements from the guidance.	UEC CBU Leads	30-Jun-2022	Green	19-Sep-22	(1) Completed assessment of the impact on ULHT through a review and gap analysis; (2) Highlight reporting to the Children's and Young People Board.	(1) Highlight reporting to the Children's and Young People Board (and inclusion on the UEC risk register if required).	Initial review concluded. Agreed at the Executive-Led CQC Assurance meeting for a full gap analysis to be undertaken and fed back to the CYP Board along with plans for mitigation.	Michelle Harris, Chief Operating Officer	People & Organisational Development Committee (PODC)	
						UEC	Complete workforce review for nursing and medical staff on the back of the gap analysis and draft a business case for additional recruitment to close the gaps (if any).	Cheryl Thomson (General Manager)	30-Jun-2022	[Abandon & Replace]	19-Sep-22	(1) Completed assessment of the impact on ULHT through a review and gap analysis; (2) Highlight reporting to the Children's and Young People Board.	(1) Evidence of a plan to close gaps identified; (2) Clarity on mitigations in place if gaps identified; (3) Highlight reporting to Children's		Michelle Harris, Chief Operating Officer	People & Organisational Development Committee (PODC)	
						UEC	Complete gap analysis against the RCPCH standards and the CQC guidance document and present back to CYP Board with plans for mitigations.	Fiona Hamer (Divisional Nurse)	31-Dec-2022	Red				Duplicate action, the same as that described for U&E9.	Michelle Harris, Chief Operating Officer	People & Organisational Development Committee (PODC)	
CQC2021-09	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure the requirements of duty of candour are met.	All	Understand performance with DoC at CBU Level and ensure reliable data is available to feed into monthly Clinical Governance processes.	Maxine Skinner (Lead Nurse Urgent & Emergency Care)	31-Mar-2022	Green	31-Mar-2022	(1) Performance reporting of DoC for CBU (verbal and written) into monthly CBU governance arrangements; (2) Inclusion within the Divisional PRM process.	(1) Ongoing regular reporting of DoC into CBU Governance; (2) Ongoing inclusion within the Divisional PRM process.	Division have confirmed that this is a compliance issue and not a data qualtity issue. UEC performance is being monitored on an ongoing basis.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						All	Review DoC performance data and, through CBU Governance, scope additional improvement actions to be taken.	Maxine Skinner (Lead Nurse Urgent & Emergency Care)	31-Mar-2022	Green	31-Mar-2022	(1) Performance reporting of DoC for CBU (verbal and written) into monthly CBU governance arrangements.	(1) Use of data to inform improvement action plans.	Duty of candour is now brought through to the strenthened CBU governance meeting for the group's review of latest performance data and	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						All	Achieve 100% compliance within UEC with verbal and written duty of candour.	Cheryl Thomson (General Manager), Maxine Skinner (Lead Nurse, UEC)	31-Jul-2022	Green	31-Jul-2022	(1) Performance reporting of DoC compliance within UEC.	(1) Ongoing assurance of DoC performance for UEC.	No overdue duty of candour responses outstanding at the end of July 2022 in line with stated target.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						All	Summarise performance with Duty of Candour and test embedding of improvement actions taken by the CBU.	CBU Leads	31-Mar-2023	Green	31-Mar-2023	(1) Performance reporting of DoC compliance within UEC.	(1) Ongoing assurance of DoC performance for UEC.	Performance with Duty of Candour is overseen by the Quality Governance Committee (QGC). Divisions are provided with ongoing support from the central Clinical Governance team. Performance data demonstrates high compliance rates with Duty of Candour. Improvements made by Divisions are reflected in Trust wide compliance data.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	

Ph2	Pharmacy	Pilgrim Hospital	2021 'Interim Action'	2021 'Interim Action'	Prescribing within the emergency department tended to be for 'immediate' medicines with no mechanism in place to prompt staff to prescribe a patient's regular medicine. [Links to CQC2021-10]	UEC	The current ED casualty card is out for consultation on any amendments required. A reminder/prompt on this point will be included in the revised document. Reference on the CAS card has been made to prompt to prescribe a patients existing critical regular medicines.	Blanche Lentz (Clinical Services Manager UEC)	31-Aug-2022	Green	19-Sep-2022	(1) Amended Casualty card	(1) Amended Casualty card	The Casualty Card has been updated to include space to record when a patient is assessed on the ambulance. This has now been approved by UEC and Medicine Governance. The Casualty Card will now be printed for use within the department.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	13-May-22: Executive-led assurance review approved rebasing of this deadline from the 31-Mar-22, moving to the 31-Aug-22. This will remain as 'RED' rated.
U&E 6	Urgent & Emergency Care	Lincoln County Hospital	2021 'Interim Action'	2021 'Interim Action'	The medicines room door was open for the entirety of the inspection. [Links to CQC2021-10]	UEC	UEC Team reminded to prevent the door from being routinely left open.	Maxine Skinner (Lead Nurse Urgent & Emergency Care)	01-Nov-2021	Green	01-Nov-2021	(1) Communications with the team.	(1) Monthly matrons audit assessing security of medication storage ("Are drug cupboards locked at all times?").	Ongoing monitoring of medicines security is available to support CBU management team to receive assurance data on security of medicines storage.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						UEC	Nurse in Charge process at both sites to monitor and issue reminders if medicines room door seen to be open.	Denise Dodd (Matron, Urgent & Emergency Care); Jemma Bowler & Holly Carter (Senior Sister, ED)	31-Mar-2022	[Abandon & Replace]		(1) Evidence of process communicated at both ED units; (2) Monthly matrons audit assessing security of medication storage ("Are drug cupboards locked at all times?").;	(1) Monthly matrons audit assessing security of medication storage ("Are drug cupboards locked at all times?").; (2) Spot checks by NIC to determine if the medicines door is being kept closed.	31-Mar-22: This action has been abandoned. The action was based on the change in process within ED to strengthen out of hours the assurance available on key subjects. This involved the ED Managers and Matron working more out of hours shifts to support this	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						UEC	Include within the ED Assurance Tool / Band 7 audit	Denise Dodd (Matron, Urgent & Emergency Care); & Holly Carter (Senior Sister, ED)	31-Jan-2023	Green	31-May-2023	(1) Amended B7 Daily assurance proforma.	(1) Action in response to the review and inclusion as part of the B7 daily assurance process; (2) Improvements in the security of records observed.	This is an additional question which has been added to the NIC assurance tool to close the gap in assurance previously identified. Work will not continue to seek assurance of completion of this action from the newly added NIC assurance tool question.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						UEC	Request for a door closer mechanism on Medicines room door has been escalated as priority job (door currently does not close automatically).	Jemma Bowler (Senior Sister, ED)	31-Mar-2022	Blue	29-Mar-2022	(1) Evidence door closure mechanism has been fitted.	None.	Automatic door closure mechnism will prevent the door being left open unintentionally. Further work is underway linke to this, so this should be seen as a supportive additional action.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						UEC	Review assurance data (i.e. from Monthly matrons audits, ward review process) to determine compliance against Trust policy with regard to storage of medications (to include temperature monitoring) and determine if additional controls are needed.	Denise Dodd (Matron, Urgent & Emergency Care)	30-Jun-2022	Green	01-Sep-2022	(1) Paper summarising evidence of available for storage of medications in line with Trust policy.	(1) Monthly matrons audit assessing security and storage of medicines ("Are drug cupboards locked at all times?").; (2) Ward review process assessing security and storage of medicines.	Assurance report received outlining compliance with medications storage and temperature recording. This provides positive assurance.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						UEC	Review evidence from newly added question to the ED Nursing Assurance Tool: **"Are medicines being stored safely behind a locked door?"** to test if evidence from the NIC tool demonstrates this is now embedded.	Denise Dodd (Matron) & Philippa Davies (Matron)	31-Aug-2023	Amber		(1) Evidence of compliance from newly added NIC Assurance Tool question.	(1) Ongoing monitoring of compliance from NIC Assurance data.		Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
CQC2021-12	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure all patient records and other person identifiable information is kept secured at all times.	All	Matrons audits in place currently that monitor this, but this is a recurrent problem. Senior Sisters and Lead Nurse to meet to refine the contents of the B7 daily assurance process which will support proactive action to address performance issues.	Maxine Skinner (Lead Nurse); Denise Dodd (Matron, Urgent & Emergency Care); Jemma Bowler & Holly Carter (Senior Sister, ED)	31-Mar-2022	Blue	09-Jun-22	(1) Meeting to approve content of the revised NIC assurance process.	None	Paper reviewed and approved at ED Governance for inclusion of this and other topics of relevance to the 2021 inspection visit to be included in the NIC Assurance Process.	Barry Jenkins, Director of Finance & Digital	Finance, Performance and Estates Committee (FPEC)	
						All	Agreed at ED Governance for this to be added to the NIC Assurance Tool. Task and Finish group established and working with Informatics team to develop draft NIC Assurance Tool for approval and commencement within the department to obtain improved assurance of daily oversight.	Denise Dodd (Matron, Urgent & Emergency Care)	31-Jan-2023	Green	31-May-23	(1) Amended B7 Daily assurance proforma.	(1) Action in response to the review and inclusion as part of the B7 daily assurance process; (2) Improvements in the security of records observed.	This is an additional question which has been added to the NIC assurance tool to close the gap in assurance previously identified. Work will not continue to seek assurance of completion of this action from the newly added NIC assurance tool question.	Barry Jenkins, Director of Finance & Digital	Finance, Performance and Estates Committee (FPEC)	
						All	Review availability of CAS card trolleys availability at Pilgrim.	Holly Carter (Senior Sister, ED)	30-Apr-2022	Green	30-Apr-22	(1) Evidence of a review of note storage controls and identification of any gaps.	(1) Action in response to the review and inclusion as part of the B7 daily assurance process; (2) Improvements in the security of records observed.	Additional medical records storage trolley obtained for use in Fit to Sit area to support the change in process at PBH of greater assessment of patients within the area.	Barry Jenkins, Director of Finance & Digital	Finance, Performance and Estates Committee (FPEC)	
						All	Review evidence from newly added question to the ED Nursing Assurance Tool: **"Are all ED notes stored appropriately to protect the details / confidential information of each patient?"** to test if evidence from the NIC tool demonstrates this is now embedded.	Denise Dodd (Matron) & Philippa Davies (Matron)	31-Aug-2023	Amber		(1) Evidence of compliance from newly added NIC Assurance Tool question.	(1) Ongoing monitoring of compliance from NIC Assurance data.		Barry Jenkins, Director of Finance & Digital	Finance, Performance and Estates Committee (FPEC)	
CQC2021-13	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure it has access to communication aids and leaflets available in other languages.	UEC	Divisions to reach out to patients in their areas to determine what information resources are required that do not currently exist (including UEC and advice cards). Include patient information as part of the UEC Governance agenda.	Cheryl Thomson (General Manager)	31-Mar-22	Green	31-Mar-22	(1) Inclusion of patient information within the UEC Governance meeting process/schedule.	(1) Inclusion of patient information within the UEC Governance meeting process/schedule.	Review of patient information to be included with Patient Experience team programme of work.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Undertake a review of the patient information and identify any gaps where additional information is required.	Cheryl Thomson (General Manager), Maxine Skinner (Lead Nurse, UEC)	30-Jun-22	Green	31-Mar-22	(1) Evidence of undertaking review of information resources currently available; (2) Review at Governance of review and any gaps identified where further resources are required.	None.	Review of patient information to be included with Patient Experience team programme of work.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	

						UEC	Collate a register of information resources in use within UEC and submit this to the Patient Experience Team to support the strengthening of internal document control processes in relation to patient information.	Cheryl Thomson (General Manager)	30-Jun-22	[Abandon & Replace]	18-Oct-22	None.	None.	Corporate update on provision of patient information in different languages provided to the Executive Led CQC Assurance meeting on the 14-October-2022. It was agreed to focus on the corporate strategy presented and bring back to Divisions once further	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Patient Experience team to work with Maxine Skinner and Denise to ensure communication aids and resource folders are available in the department and agree further actions to ensure these resources are communicated with the wider team and made use of.	Sharon Kidd	31-Mar-22	[Abandon & Replace]	18-Oct-22	None.	None.	Corporate update on provision of patient information in different languages provided to the Executive Led CQC Assurance meeting on the 14-October-2022. It was agreed to focus on the corporate strategy presented and bring back to Divisions once further	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Patient Experience team to determine with UEC leads how communication with patients/carers whose first language is not English is currently facilitated and determine what resources would support this to be more effective.	UEC leads with support from Patient Experience Team.	30-Apr-22	[Abandon & Replace]	18-Oct-22	None.	None.	Corporate update on provision of patient information in different languages provided to the Executive Led CQC Assurance meeting on the 14-October-2022. It was agreed to focus on the corporate strategy presented and bring back to Divisions once further	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Small working group to be established to look at options for patient information to be available bespoke for ED. Consider options available from BOE. Denise / Amy / Pip to lead.	Denise Dodd (Matron) & Philippa Davies (Matron)	31-Mar-23	Red		TBC	TBC		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
CQC2021-14	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure the design, maintenance and use of facilities, premises and equipment keep patients safe. (UEC Specific)	UEC	As part of the LCH work to expand resus area, make other improvements in environment; specifically: (1) Secure paediatric area through installation of swipe card access points. This will prevent unauthorised access (i.e. from fit to sit waiting area that is in close proximity; (2) Improved segregation of Paediatric resus from adult resus areas;	CBU Leads	30-Sep-2022	Blue	31-Jan-23	(1) Evidence of improvements made to the environment.	None.	New Resus area of ED to open on Monday 6 February. Additional Mental Health Room now available increasing capacity. Improved childrens area of the Emergency Department now in place.	Michelle Harris, Chief Operating Officer (COO)	Finance, Performance and Estates Committee (FPEC)	
						UEC	Safeguarding review of new Mental Health rooms on the Lincoln site to provide guidance on additional steps needed (if any) i.e. 1:1 supervision.	Denise Dodd (LCH) (Senior Sister, ED) Craig Ferris, Head of Safeguarding.	28-Feb-2023	Green	30-May-23	(1) Evidence following review of Mental Health Rooms at Lincoln.	None.	The areas within ED at LCH designed to accommodate those patients deemed to be at risk to themselves have been reviewed with the Head of Safeguarding and additional risk factors identified (i.e. ligature risks) have been identified and resolved.	Michelle Harris, Chief Operating Officer (COO)	Finance, Performance and Estates Committee (FPEC)	
						UEC	Scope out employment for a play specialist for ED area.	TBC (LCH) (Senior Sister, ED)	30-Sep-2022	[Abandon & Replace]	04-Oct-22	(1) Scoped out plan for recruitment of a play specialist.	None.	This is to be included within the RCPCH scoping of staffing action.	Michelle Harris, Chief Operating Officer (COO)	Finance, Performance and Estates Committee (FPEC)	
						UEC	Review arrangements for 1:1 supervision of patients with mental health needs at Lincoln ED.	TBC (LCH) (Senior Sister, ED)	30-Sep-2022	Green	04-Oct-22	(1) Discussion of plans and mitigations at executive led CQC assurance meeting in September 2022.	None.	Mental health and ligature risk mitigation are included within the CQC Mental Health room action and risk assessment work following the earlier action taken by the Trust to equip Room 15 at PBH.	Michelle Harris, Chief Operating Officer (COO)	Finance, Performance and Estates Committee (FPEC)	
						UEC	Consider addition of the mental health room (location and staffing oversight) to the departmental risk register.	Jemma Bowler (Senior Sister, ED)	30-Apr-2022	Green	30-Apr-22	(1) Evidence of risk scoping and mitigation actions considered.	None.	Consideration of whether this was a risk that required inclusion within the ED risk register.	Michelle Harris, Chief Operating Officer (COO)	Finance, Performance and Estates Committee (FPEC)	
						UEC	New ED at Pilgrim which is valued at £37m and is at the full business planning stage. This is scheduled for Trust Board approval in April, and then for final approval by NHSE/I. Enabling works (included decant of staff) have begun. Build to progress over the next 2 years. Determine if dementia friendly aspects have been included in the plans.	Holly Carter (Senior Sister, ED)	31-Mar-2022	Green	31-Mar-2022	(1) Confirmation that plans for new ED include dementia friendly considerations.	(1) Evidence of dementia friendly considerations included compared with NHS planning guidance for build works.	Confirmation received from ED Manager that Dementia Friendly elements have been built into the new PBH ED plans.	Michelle Harris, Chief Operating Officer (COO)	Finance, Performance and Estates Committee (FPEC)	
						UEC	13-Apr-22: Attended meeting with ED design and building team, chaired by Grant. Designs for ED shared. Agreed to review specific details of relevance to CQC and get formal responses back to specific subjects of interest in line with the following: 1) Dementia friendly - inc. application of standard NHS Planning Guidance in the process; 2) Paediatrics area of ED - security, segregation from the adult area; RCPCH standards; 3) Anti-ligature rooms.	Grant Holley (Senior Capital Projects Manager)	TBC	Amber		(1) Confirmation of greater detail of plans in place for new ED at PBH and how they support the Trust in terms of providing care in line with CQC KLOE.	(1) Evidence of dementia friendly considerations included compared with NHS planning guidance for build works.		Michelle Harris, Chief Operating Officer (COO)	Finance, Performance and Estates Committee (FPEC)	
CQC2021-15	Urgent & Emergency Care	Lincoln County Hospital	Core services inspection	Should Do	The trust should ensure that falls and mental health risk assessments and transfer documentation are in place for patients when they are required and that completion risk assessments and transfer documentation are audited.	UEC	Process for assessing falls risk has been changed to being assessed on entry to ED by the PHP. Once identified as at risk of falling, yellow socks, yellow wristband and falls risk assessment document completed. Meeting with Senior Sisters, Matron and Lead Nurse to be held to incorporate this into the B7 daily assurance review process.	Denise Dodd (Matron, Urgent & Emergency Care); Holly Carter (Senior Sister, ED)	31-Mar-2022	Blue	09-Jun-2022	(1) Meeting to approve content of the revised NIC assurance process.	None	Paper reviewed and approved at ED Governance for inclusion of this and other topics of relevance to the 2021 inspection visit to be included in the NIC Assurance Process.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Agreed at ED Governance for falls and mental health risk assessments to be added to the NIC Assurance Tool. Task and Finish group established and working with Informatics team to develop draft NIC Assurance Tool for approval and commencement within the department to obtain improved assurance of daily oversight.	Denise Dodd (Matron) & Holly Carter (Senior Sister, ED)	31-Jan-2023	Green	31-May-2023	(1) Amended B7 Daily assurance proforma.	(1) Action in response to the review and inclusion as part of the B7 daily assurance process; (2) Improvements in performance with falls risk assessments; (3) Improvements in performance with mental health risk assessments.	This is an additional question which has been added to the NIC assurance tool to close the gap in assurance previously identified. Work will not continue to seek assurance of completion of this action from the newly added NIC assurance tool question.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	

						UEC	In the absence of assurance data from the NIC Assurance tool, undertake a snapshot review of MH risk assessments for patients presenting with MH conditions or risks.	Denise Dodd (Matron, Urgent & Emergency Care); Holly Carter (Senior Sister, PBH)	30-Sep-2022	Green	04-Oct-2022	(1) Audit findings from snapshot audit. (2) Action planned in response.	N/A	Snapshot audit undertaken and action agreed in response.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Action from review of MH risk assessment compliance snapshot audit: Clinical Education team working with Triage teams at both sites to include the completion of the mental health risk assessment at triage rather than being completed by receiving RN's. Impact to be re-audited.	Tracey Wall (Lead Nurse)	31-Oct-2022	Green	30-Nov-2022	(1) Action taken resulting in improved compliance.	(1) Ongoing evidence of compliance.	Mental health risk assessments included within the triage process.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	As agreed at the Executive-Led CQC Assurance meeting review assurance evidence available for mitigating mental health risks within the Emergency Department.	Cheryl Thompson (General Manager)	TBC	[Abandon & Replace]	31-Jan-2023			Safeguarding team have been commissioned to review MH rooms on the Lincoln site.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	In the absence of assurance data from the NIC Assurance tool, undertake an assurance review from matrons audits data relating to Falls risk assessments.	Denise Dodd (Matron, Urgent & Emergency Care)	30-Sep-2022	Red		(1) Findings from Matrons audit assurance data.	N/A		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						All	Review evidence from newly added question to the ED Nursing Assurance Tool: **"Has the falls risk assessment been completed as appropriate?"** to test if evidence from the NIC tool demonstrates this is now embedded.	Denise Dodd (Matron) & Philippa Davies (Matron)	31-Aug-2023	Amber		(1) Evidence of compliance from newly added NIC Assurance Tool question.	(1) Ongoing monitoring of compliance from NIC Assurance data.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Monitor and track compliance data for mental health risk assessments in response to actions taken already within UED specificially: * New CAS card with improved prompts (go live early 2023); * Governance meeting and huddle communications to raise awareness; * Linking MH risk assessments into the triage process.	Denise Dodd (Matron, Urgent & Emergency Care)	31-Mar-2023	Red		(1) Findings from snapshot data in the interim of the NIC Assurance Question.	N/A		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						All	Review evidence from newly added question to the ED Nursing Assurance Tool: **"Have all patients presenting to the department with mental health problems had a completed mental health risk assessment?"** to test if evidence from the NIC tool demonstrates this is now embedded.	Denise Dodd (Matron) & Philippa Davies (Matron)	31-Aug-2023	Amber		(1) Evidence of compliance from newly added NIC Assurance Tool question.	(1) Ongoing monitoring of compliance from NIC Assurance data.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						All	Review evidence from newly added question to the ED Nursing Assurance Tool: **"Has transfer documentation been completed prior to the patient leaving the department?"** to test if evidence from the NIC tool demonstrates this is now embedded.	Denise Dodd (Matron) & Philippa Davies (Matron)	31-Aug-2023	Amber		(1) Evidence of compliance from newly added NIC Assurance Tool question.	(1) Ongoing monitoring of compliance from NIC Assurance data.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
CQC2021-32	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Should Do	**Part A:** The trust should ensure patients at risk of self harm or suicide are cared for in a safe environment meeting standards recommended by the Psychiatric Liaison Accreditation network (PLAN)... (Completed - see Closed Actions) **Part B:** ... and mental health risk assessments and care plans are completed for all patients at risk. (Open)	UEC	Mental health risk assessments and care plans are completed for all patients at risk. (Open)	As above	As above	Amber					Michelle Harris, Chief Operating Officer (COO)	Finance, Performance and Estates Committee (FPEC)	
CQC2021-34	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Should Do	The trust should ensure patients at risk of falling undergo a falls risk assessment and falls preventative actions are in place.	UEC	A review of the transfer document has been held with UEC and Quality Matrons. The UEC transfer documentation has been merged with the Trust's transfer documentation and SOP. Transfer documentation has been replaced with a sticker, in SBAR format, to be applied to the CAS card and completed in ED before the patient is transferred. Limited supplies of the sticker are available, to launch pilot when there is a greater stock of stickers.	Jemma Bowler & Holly Carter (Senior Sister ED)	31-Mar-2022	Green	31-Mar-2022	(1) Launch of pilot utilising the newly fashioned transfer stickers; (2) Copy of revised sticker; (3) Evidence of communications to staff regarding pilot.	None.	The transfer sticker has been used in practice and well received by staff within the ED. No formal review or audit has been undertaken, rather the view of those using the documentation is positive. A more formal evaluation is now needed.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Review effectiveness of pilot to determine if supportive of improved documentation.	Jemma Bowler & Holly Carter (Senior Sister ED)	30-Apr-2022	Green	31-Mar-2022	(1) Evidence of performance with completion of transfer sticker documentation; (2) Additional actions if needed to	(1) Ongoing evidence of audit outcomes demonstrating improved recording and documentation of transfer information on the sticker.	The transfer sticker has been well received by staff within the ED. No formal review or audit has been undertaken, rather the view of those	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Agreed to include the transfer sticker information within the new CAS card, to scope out measuring of effectiveness.	TBC (LCH) & Holly Carter (Senior Sister ED)	31-Aug-2022	Green	19-Sep-2022	(1) Amended CAS card.	N/A.	The Casualty Card has been updated to include space to record when a patient is assessed on the ambulance. This has now been approved by UEC and Medicine Governance. The Casualty	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Agree an audit/evaluation process to review the impact and effectiveness of the transfer sticker/revised section of the CAS card. Agree process (i.e. evaluate on IAC/MEAU on arrival of the patient or undertaken snapshot compliance review within ED).	TBC (LCH) & Holly Carter (Senior Sister ED)	31-Jan-2023	Green	31-May-2023	(1) Amended B7 Daily assurance proforma.	(1) Action in response to the review and inclusion as part of the B7 daily assurance process; (2) Improvements in performance with falls risk assessments; (3) Improvements in performance with mental health risk assessments.	This is an additional question which has been added to the NIC assurance tool to close the gap in assurance previously identified. Work will not continue to seek assurance of completion of this action from the newly added NIC assurance tool question.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	

						UEC	Meeting with Senior Sisters, Matron and Lead Nurse to be held to incorporate mental health risk assessment completion into the B7 daily assurance review process.	Maxine Skinner (Lead Nurse); Denise Dodd (Matron, Urgent & Emergency Care); Jemma Bowler & Holly Carter (Senior Sister, ED)	31-Mar-2022	Blue	09-Jun-2022	(1) Meeting to approve content of the revised NIC assurance process.	None.	Paper reviewed and approved at ED Governance for inclusion of this and other topics of relevance to the 2021 inspection visit to be included in the NIC Assurance Process.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Agreed at ED Governance for falls and mental health risk assessments to be added to the NIC Assurance Tool. Task and Finish group established and working with Informatics team to develop draft NIC Assurance Tool for approval and commencement within the department to obtain improved assurance of daily oversight.	Denise Dodd (Matron, Urgent & Emergency Care)	31-Jan-2023	Green	31-May-2023	(1) Amended B7 Daily assurance proforma.	(1) Action in response to the review and inclusion as part of the B7 daily assurance process; (2) Improvements in performance with falls risk assessments; (3) Improvements in performance with mental health risk assessments.	This is an additional question which has been added to the NIC assurance tool to close the gap in assurance previously identified. Work will not continue to seek assurance of completion of this action from the newly added NIC assurance tool question.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
CQC2021-17	Urgent & Emergency Care	Lincoln County Hospital	Core services inspection	Should Do	The trust should ensure, the paediatric area within the Emergency Department, governance processes are fully implemented and aligned to the Royal College of Paediatrics and Child Health (RCPCH) standards for children in the emergency department.	UEC	Refresh CBU Governance process and arrangements for 2022/23 with renewed TOR for UEC Governance and Cabinet meetings.	Cheryl Thomson (General Manager)	31-Mar-2022	Blue	04-Apr-2022	(1) Approved TOR; (2) Minutes evidencing approval of TOR.	None.	ED Governance arrangements have been reviewed and strengthened. Assurance metrics agreed to test impact of strengthening arrangements throughout the year. This approach includes within it the governance arrangements relating to children.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
CQC2021-39	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Should Do	The trust should ensure, the paediatric area within the Emergency Department, governance processes are fully implemented and aligned to the Royal College of Paediatrics and Child Health (RCPCH) standards for children in the emergency department.	UEC	Strengthen the UEC Governance processes in line with the revised and approved TOR.	Dr David Flynn (Clinical Lead - A&E); Cheryl Thompson (General Manager)	31-Dec-2022	Green	31-Jan-23	(1) 80% of CBU governance meetings achieved; (2) 75% attendance at meetings; (3) Recognising implications of operational pressures - escalate if more than 2 meetings are cancelled to divisional governance; (4) Addition to CBU risk register if operational pressures lead to cancellation of arrangements.	(1) Evidence that Governance meetings are being held; (2) Regular highlight reporting from UEC to Children's and Young People (CYP) Board.	UEC Governance meetings have been maintained on the whole during 2022.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
						UEC	Make it clearer on the UEC Governance Meeting documentation a demarcation between agenda items focussed on CYP area and those affecting all areas of the Department.	Dr David Flynn (Clinical Lead - A&E); Cheryl Thompson (General Manager)	30-Jun-2023	Amber		(1) Clearer evidence of specific CYP items of Governance on the UEC Governance agenda.	(1) Ongoing evidence from UEC Governance meetings.		Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
CQC2021-18	Urgent & Emergency Care	Lincoln County Hospital	Core services inspection	Should Do	The trust should ensure effective systems are in place to review the service risk register.	UEC	CBU Risk Register has been refreshed. Embed regular review of risk register at strengthened Governance meeting process.	Dr David Flynn (Clinical Lead - A&E); Cheryl Thompson (General Manager)	30-Apr-2022	Blue	30-Apr-22	(1) Evidence that risks on the register have a named owner; (2) Risks should be clear and concise.	(1) Ongoing evidence of Risk Register review; (2) Evidence from meeting documentation that risk register is being reviewed and is effectively capturing risks.	CBU Risk Register has been refreshed and is regularly reviewed at the strengthened Governance meeting process.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Evaluate effectiveness of review of risks in line with Trust Policy over next 3 months: * Very high risk: Monthly review * High risk: Quarterly review * Moderate risk: Quarterly review * Low risk: 6-Monthly review	Dr David Flynn (Clinical Lead - A&E); Cheryl Thompson (General Manager)	30-Apr-2023	Blue	31-May-23	(1) Evidence that risks on the register have a named owner; (2) Risks should be clear and concise; (3) Risks should be reviewed in line with timescales within Trust (new) policy.	(1) Ongoing evidence of Risk Register review; (2) Evidence from meeting documentation that risk register is being reviewed and is effectively capturing risks.	CBU Risk Register has been refreshed and is regularly reviewed at the strengthened Governance meeting process.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
CQC2021-40	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Should Do	The trust should ensure effective systems are in place to review the service risk register.	UEC	Include within the UEC risk register the risk around the control of policies and SOPs.	Dr David Flynn (Clinical Lead - A&E); Cheryl Thompson (General Manager); Maxine Skinner (Lead Nurse)	30-Mar-2022	Blue	30-Mar-22	(1) Addition of risk to risk register.	(1) Addition of risk to risk register.	Assurance received that this has been included within the UEC risk register.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
CQC2021-31	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Should Do	The trust should ensure that policies and procedures in place to prevent the spread of infection are adhered to.	UEC	Revised cleaning checklist has been developed. To implement this on a shift by shift basis. To review how this roll-out to be communicated and completion of revised checklist to be completed.	TBC (LCH) & Holly Carter (Senior Sister ED)	31-Mar-2022	[Abandon & Replace]	19-Sep-22	(1) Flo-audit completion data; (2) Mattress audits; (3) Matrons audit contains IPC checks.	(1) Flo-audit completion data; (2) Mattress audits; (3) Matrons audit contains IPC checks.	19-Sept-22: Plan of action presented at the 12-Sept assurance meeting demonstrates this action has been superseeded.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Review completion of domestic cleaning checklist with domestic supervisor and identify any gaps that require further action.	Jemma Bowler & Holly Carter (Senior Sister ED)	30-Apr-2022	[Abandon & Replace]		TBC	TBC	20-Apr-22: On review in greater detail of the context behind this 'Should-do' action and a review of the process within ED, this action has been abandoned and replaced as it is not relevant to the bedspace cleaning process within the department, and therefore unhelpful in addressing the	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	The process for cleaning bedspaces within the department is followed, but is difficult to evidence given the throughput of patients through the ED when under pressure. Scope out and agree appropriate and realistic action in response to be able to better demonstrate and provide assurance that bedspaces are clean.	Denise Dodd (UEC Matron)	31-May-2022	Green	19-Sep-22	(1) Scoped out plan of action.	N/A.	At the Executive-Led assurance meeting the Emergency Department outlined the scoped out plan of action.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Rapid clean criteria for cubicle spaces to be undertaken.	Fiona Hamer (Divisional Nurse)	31-May-2023	Red		TBC	TBC		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	

CQC2021-37	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Should Do	The trust should ensure effective systems are in place to investigate incidents in a timely manner and identify and share learning from incidents to prevent further incidents from occurring.	UEC	Backlog of incidents has re-occurred linked to extreme operational pressures. Strengthened governance meetings will include regular ongoing oversight of this area. Theme and trend all backlog of incidents to enable sharing of lessons learnt.	Dr David Flynn (Clinical Lead - A&E); Cheryl Thompson (General Manager)	30-Jun-2022	Red		(1) Resolution of the backlog; (2) Evidence of learning from the analysis of themes and trends being shared with staff.; (3) Sustained compliance with timescales for Serious Incident Reporting and investigation.	(1) Ongoing oversight of incident reporting metrics to measure effectiveness of the process and assurance that a backlog position does not again appear; (2) Ongoing oversight of Serious Incident Reporting and investigation timescales.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	Review the effectiveness of current learning lessons processes in UEC and strengthen if needed.	Dr David Flynn (Clinical Lead - A&E); Cheryl Thompson (General Manager)	30-Jun-2022	Red		(1) Completed review and evidence of action in response.	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						UEC	A review of the mechanisms for sharing learning will be undertaken during 2022/23. As part of this work, the views of Trust staff will be sought to determine what works best for the different areas and staff groups.	Helen Shelton (Assistant Director of Clinical Governance / Patient Safety Specialist)	31-Dec-2022	Blue	31-Dec-22	(1) Trust level understanding of mechanisms in use to share learning; (2) Evidence of action in response.	None.	Review concluded that reinforced what we thought in that staff use a number of mediums to share lessons. We have therefore continued to use the following: Patient Safety Briefings Learning to Improve Divisional Newsletters quarterly Learning to Improve Trust Newsletter quarterly PSIT monthly newsletter We have discussed setting up a learning lessons forum but PSIRF is moving more towards the terminology of improvement rather than learning so we will see what comes out of the PSIRF implementation team.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
CQC2021-38	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Should Do	The trust should ensure clinical pathways and policies are updated in line with national guidance.	UEC	Undertake service by service review to identify and catalogue all SOPs and Policies currently being used or referred to within UEC.	Cheryl Thompson (General Manager)	31-Jul-2022	Green	31-Jul-22	(1) List of SOPs and Policies in use.	(1) Addition of all SOPs and Policies in use to central register for tracking and control process.	Service by service review has been undertaken and completed.	Barry Jenkins, Director of Finance & Digital	Finance, Performance and Estates Committee (FPEC)	
						UEC	Review, update and approve all UEC SOPs and Policies and ensure registered as controlled documents, in approved Trust format and stored in the CBU U drive and accessible via the intranet.	Dr David Flynn (Clinical Lead - A&E); Cheryl Thompson (General Manager)	31-Dec-2022	Red		(1) Evidence that all SOPs and Policies have been reviewed and approved; (2) Clear local policy for approval of SOPs and Policies within UEC that includes process to review documents at a scheduled and timetabled point to	(1) Ongoing process to track compliance with the control of SOPs and Policies in use with reference to Trust document control processes.		Barry Jenkins, Director of Finance & Digital	Finance, Performance and Estates Committee (FPEC)	

United Lincolnshire Hospitals NHS Trust

CQC Improvement Action Plan
Executive Lead: Karen Dunderdale, Director of Nursing
Senior Responsible Officer: Kathryn Helley, Deputy Director of Clinical Governance
Progress Review Date As At: 08/06/2023

BRAG Rating Matrix	
Blue	Completed and embedded.
Green	Completed but not yet fully embedded/evidenced.
Amber	In progress/on track.
Red	Not yet completed/significantly behind agreed timescales

URN	Core Service	Trust/ Site	Recommendation Source	Immediate/ Must Do/	CQC Must Do / Should Do / Issue	Core Service	Local action agreed to resolve the issue	Action Lead	Deadline	Completeness	Date action completed	Evidence available to demonstrate completion	Evidence available to track that action remains completed and	On completion: Outcome - How has the action been met?	Accountable Executive Lead	Reporting to sub-committee for assurance	Notes:
CQC2021-03	Maternity	Lincoln County Hospital	Core services inspection	Must Do	The trust must ensure that all medicines are stored safely and securely. Regulation 12 Safe care and treatment.	Maternity	Action taken at the time of the inspection. Trolleys with medications were moved to a secure area.	Dr Suganthi Joachim (Division Clinical Director); Libby Grooby (Divisional Head of Nursing and Midwifery); Simon Hallion (Divisional Managing Director)	31-Oct-2021	Green	31-Oct-2021	(1) Evidence submitted as part of core service evidence request; (2) Evidence of communications to team; (3) Evidence of more security for trolleys (locker type trolley).	(1) B7 Assurance process (weekly) includes an assessment of security of medications.	Action was taken at the time of the inspection to remedy the identified issues.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Maternity	Wall thermometer ordered. Daily check added to the daily check list. Staff aware of escalation process if needed.	Libby Grooby (Divisional Head of Nursing and Midwifery)	31-Oct-2021	Green	31-Oct-2021	(1) Wall thermometer in place; (2) Daily check added to the daily check list; (3) Audit of the process.	(1) Review of daily checks; (2) Survey of staff regarding action needed if temperature too high; (3) B7 Assurance process (weekly) includes an assessment of this point;	Action was taken at the time of the inspection to remedy the identified issues.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Maternity	Map out across Maternity at both sites locations where medicines (drugs rooms (inc. fluids), medication fridges, mobile trolleys) are stored	Libby Grooby (Divisional Head of Nursing and Midwifery) c/o Matrons in Maternity	15-Mar-2022	Blue	15-Mar-2022	(1) Map of locations within Maternity at both sites outlining where medicines are being stored.	(1) 6-monthly review to determine if any changes in process/location for storing medicines.	A detailed understanding of locations where medicines are stored has been completed as part of the audit process. This will support future actions relating to medicines security and storage.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Maternity	Undertake gap analysis audit against Trust's Medicines Management Policy that relates to storage and security (i.e. have locations that store medicines got digital thermometers?)	Libby Grooby (Divisional Head of Nursing and Midwifery) c/o Matrons in Maternity	15-Mar-2022	Blue	15-Mar-2022	(1) Completed audit, by location, outlining controls in place/gaps.	(1) Ongoing assurance on medicines management as gathered through daily assurance checks; B7 Spot checks; (2) 6-monthly review to determine if any changes in process for storing	A detailed gap analysis has been undertaken to understand the challenges within Maternity.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Maternity	Develop audit tool for use by Maternity Matrons to undertake gap analysis against medicines storage section of medicines management policy.	Jeremy Daws (Head of Compliance)	03-Mar-2022	Blue	04-Mar-2022	(1) Completed audit proforma.	None.	A detailed gap analysis has been undertaken to understand the challenges within Maternity. This was aided by the development of the audit tool.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Maternity	Plan out action in response to audit to close any gaps identified (i.e. order digital thermometers).	Libby Grooby (Divisional Head of Nursing and Midwifery) c/o Matrons in Maternity	31-Mar-2022	Green	29-Apr-2022	(1) Action plan collating all actions in response to gap analysis audit.	(1) Evidence that all gaps have been closed and that actions have been completed; (2) Ongoing assurance on medicines management as gathered through daily assurance checks; B7 Spot	Action plan developed in response to the gap analysis audit undertaken.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Maternity	Identify any risks from audit undertaken (i.e. rooms where ambient temperature is routinely 25 degrees or above and take advice from pharmacy around mitigations.	Libby Grooby (Divisional Head of Nursing and Midwifery) c/o Matrons in Maternity	31-Mar-2022	Green	21-Apr-2022	(1) Action plan outlining mitigations to identified risks, in line with policy with Pharmacy advice (inventory of medicines; any with specific sensitivities; stock rotation - how long kept? Insulin length	(1) Ongoing assurance on medicines management as gathered through daily assurance checks; B7 Spot checks.	Risks identified and escalated for support to mitigate the gaps/risks identified relating to ambient room temperatures.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Maternity	Ensure regular escalation reporting into PRM regarding estate issues that impact on medicines storage arrangements.	Simon Hallion (Divisional Managing Director)	31-Mar-2022	Green	29-Jun-2022	(1) Evidence of PRM escalation; (2) Addition to divisional risk registers of medicines storage matters.	(1) Ongoing escalation reporting to PRM.	Gaps/risks relating to ambient room temperatures have been escalated to PRM and ongoing work is underway to effect mitigations.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Maternity	Pilot process within Maternity where medicines and fluids to be stored at ambient temperature have their expiry date reduced. Draft SOP to support commencement of pilot.	Libby Grooby (Divisional Head of Nursing and Midwifery)	30-May-2023	Green	30-May-2023	(1) Draft SOP to support commencement of pilot.	(1) Ongoing assurance on medicines management as gathered through daily assurance checks; B7 Spot checks.	An SOP to support the manual reduction of expiry dates on receipt within maternity areas has been drafted and shared for comment. This is to be submitted to Obstetrics and Pharmacy Governance for formal approval to enable the pilot to commence, supported by this SOP.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Maternity	Pilot process within Maternity where medicines and fluids to be stored at ambient temperature have their expiry date reduced. Commence pilot on maternity ward areas.	Libby Grooby (Divisional Head of Nursing and Midwifery) c/o Matrons in Maternity	30-Jun-2023	Amber		(1) Mitigating actions scoped out in relation to environmental issues (i.e. ventilation and temperature management).	(1) Ongoing assurance on medicines management as gathered through daily assurance checks; B7 Spot checks.		Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Maternity	Review outcomes from walk-around audit undertaken within Maternity buildings at Lincoln and Pilgrim and agree actions in response.	Libby Grooby (Divisional Head of Nursing and Midwifery)	30-Jun-2023	Amber		(1) Action plan in response to the findings from the walk-around audit of the Maternity Buildings examining medicines storage.	(1) Ongoing assurance on medicines management as gathered through daily assurance checks; B7 Spot checks.		Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Maternity	Ensure regular escalation reporting into PRM regarding estate issues that impact on medicines storage arrangements.	Simon Hallion (Divisional Managing Director)	31-Mar-2022	Green	29-Jun-2022	(1) Evidence of PRM escalation; (2) Addition to divisional risk registers of medicines storage matters.	(1) Ongoing escalation reporting to PRM.	Gaps/risks relating to ambient room temperatures have been escalated to PRM and ongoing work is underway to effect mitigations.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Maternity	Ensure regular escalation reporting into PRM regarding estate issues that impact on medicines storage arrangements.	Simon Hallion (Divisional Managing Director)	31-Mar-2022	Green	29-Jun-2022	(1) Evidence of PRM escalation; (2) Addition to divisional risk registers of medicines storage matters.	(1) Ongoing escalation reporting to PRM.	Gaps/risks relating to ambient room temperatures have been escalated to PRM and ongoing work is underway to effect mitigations.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	

CYP 1	Children and young people	Pilgrim Hospital	2021 'Interim Action'	2021 'Interim Action'	There was no dedicated pharmacy service which meant staff were often taken away from clinical duties to sort discharge medicines. [Links to CQC2021-10]	CYP	There is currently insufficient resource within the Pharmacy team to provide this service at PBH. A business case would be needed for additional funding. This gap will be fed into the Trust's IIP programme of work focussed on improved medicines management. Action in response to be scoped as part of the improvement programme of work.	TBC	TBC	Amber		TBC	TBC		Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
CQC2021-12	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure all patient records and other person identifiable information is kept secured at all times.	All	Matrons audits assess security and storage of records, but main focus will be in relation to nursing documents. The Doctor's office is currently a shared room that doubles as a staff room. The doctor's office is moving to opposite the nurses station. As part of this move incorporate a door closure mechanism to ensure the door is not left open.	Carol Hogg (Ward Manager)	30-Apr-2022	Green	18-May-22	(1) Evidence of door closure device being added to the Doctors Office door.	(1) Ongoing monitoring as part of the Matron's audit process.	The Doctors office relocation to opposite the nurses station improves the ongoing oversight and assurance that medical records are stored securely. The door closure mechanism supports address the human factors elements of staff forgetting to secure the door when moving around the ward.	Barry Jenkins, Director of Finance & Digital	Finance, Performance and Estates Committee (FPEC)	
						All	Scope out with Dr Amol Chingale additional actions in relation to medical staff raised awareness regarding information governance matters and other key messages (i.e. IPC).	Rebecca Thurlow (Lead Nurse, CYP)	30-Apr-2022	Green	05-Jul-22	(1) Evidence of raising awareness with medical staff.	(1) Programme of work to raise awareness for medical staff.	Dr Chingale has raised for awareness and education purposes with medical staff within CYP.	Barry Jenkins, Director of Finance & Digital	Finance, Performance and Estates Committee (FPEC)	
						All	Obtain assurance via matron audits that IG principles - security of medical records and computer workstations - remain compliant.	Kate Rivett (Divisional Head of Children and Young Peoples Nursing)	31-Dec-2022	Red		(1) Evidence from matrons audits.	N/A.		Barry Jenkins, Director of Finance & Digital	Finance, Performance and Estates Committee (FPEC)	
CQC2021-13	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure it has access to communication aids and leaflets available in other languages.	CYP / Maternity	Divisions to reach out to patients in their areas to determine what information resources are required that do not currently exist (including UEC and advice cards).	Carol Hogg, Hayley Warner, Emma Young, Kristie Rennison, Karen O'Connor, Kay Probert (Sisters/Clinical Educators/Play	30-Apr-2022	Green	18-May-22	(1) Evidence of divisions identification of currently available information resources and any additional resources that are felt to be needed.	(1) Established schedule for reflection in future on information needs for local patients (obtained from Patient Experience Team).	Findings from the audit undertaken have been collated and shared back to the Patient Experience team to determine next step actions needed in response.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						CYP / Maternity	Divisions to undertake a walk-around/audit of current patient information resource available and being provided to patients within the division and compile a register, to include what languages the information is available in.	Carol Hogg, Hayley Warner, Emma Young, Kristie Rennison, Karen O'Connor, Kay Probert (Sisters/Clinical Educators/Play	30-Apr-2022	Green	18-May-22	(1) Register of locally held patient information resources being provided to patients.	(1) Maternity: Maternity Voices Partnership (MVP) have done a review of information provision within maternity. Track outcomes from future iterations for assurance.	Findings from the audit undertaken have been collated and shared back to the Patient Experience team to determine next step actions needed in response.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						CYP / Maternity	Divisions to assign 'information owners' to provide information resources in response to feedback of information for patient needs.	Divisional CQC action plan owners to nominate lead 'information owners'.	To confirm on completion of information availability scoping.	[Abandon & Replace]	18-Oct-22	None.	None.	Corporate update on provision of patient information in different languages provided to the Executive Led CQC Assurance meeting on the 14-October-2022. It was agreed to focus on the corporate strategy presented and bring back to Divisions once further	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						CYP	Scope out additional communication aids for use in CYP in British Sign Language and Makaton with Charitable funds.	Rebecca Thurlow (Lead Nurse, CYP)	01-Aug-22	Green	25-Jul-22	(1) Training Needs Analysis.	None.	Additional communication aid developed for use with Children.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
CQC2021-14	Trust wide	Lincoln County Hospital	Core services inspection	Should Do	The trust should ensure the design, maintenance and use of facilities, premises and equipment keep patients safe. [Family Health Specific]	CYP	Understand from Rainforest Ward if the following issues have been reported to Estates: * Entrance flooring; * Some surfaces in poor repair in bathrooms/toilets; * Worn flooring; * Broken equipment (only 1 item - Immediately repaired); * Equipment needing repair	Carol Hogg (Ward Manager)	30-Apr-2022	Green	28-Feb-23	(1) Evidence that environmental issues have been reported to Estates; (2) Evidence of Estates action in response; (3) Escalation if no action yet taken.	(1) Environmental audits evidencing that issues requiring escalation are identified and appropriately reported.	Walkaround by Matron to review completion of flooring works along with additional actions taken to remove Z beds to reduce clutter and improve the environment.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						CYP	Include within the 15 Steps audit paperwork a question clutter or broken equipment being present on the ward environment.	Kate Rivett (Divisional Head of Children and Young Peoples Nursing)	31-Jan-2023	Green	31-Jan-23	(1) Inclusion within the 15 Steps audit tool questions relating to the presence of clutter or broken equipment within the ward environment.	(1) Ongoing assurance evidence from the 15 Steps audit tool	15-Steps audit tool has been drafted which includes an assessment of clutter and broken equipment for ongoing monitoring.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						CYP	Charity funds are being secured through a major fundraising for a total refurbishment of the Rainforest Ward. Potential to incorporate Safari into ward footprint.	Rebecca Thurlow (Lead Nurse, CYP)	31-Apr-2023	Green	31-Apr-2023	(1) Refurbishment plans; (2) Evidence of completed works.	None.	Initial bid successful to support commissioning of architects to draw up plans for longer term scheme of works to encompass Safari and Ward 4a.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						CYP	Charity funds secured for commencement of architectual review. Scope out timescales for subsequent milestones following discussion at CRIG.	Simon Hallion (Divisional General Manager)	30-Nov-2023	Amber		(1) Refurbishment plans; (2) Evidence of completed works.	None.		Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						CYP	Replacement of 'Z' beds with new reclining chairs/beds to support decluttering of Rainforest ward with replacement of tables and lockers to support improved environment for patients and parents.	Rebecca Thurlow (Lead Nurse, CYP)	31-Aug-2022	Green	10-Aug-22	(1) Evidence of replacement of old equipment with new; (2) Review of the effectiveness of decluttering of ward environment.	(1) Environmental audits to identify any estates issues; (2) Evidence that environmental issues have been escalated appropriately for remedial action.	Old 'Z' beds have been replaced with new chair beds, these aid the environment by replacing additional clutter.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						CYP	Scope out the development of an internal Family Health 15-steps process to provide 'fresh eyes' on the environment.	Rebecca Thurlow (Lead Nurse, CYP)	30-Apr-2022	Green	18-May-22	(1) Evidence of plan being scoped out.	(1) Roll-out of internal 15-steps challenge methodology.	Plan agreed for how to undertake a local programme of 15-steps reviews for CYP clinical areas to better enable gaps in relation to the fabric of the environment, that affect the patient	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						CYP	Undertake phase 1 of the 15-steps roll-out plan within CYP with Healthcare Support Workers (HCSW) / Reception staff undertake review in their own areas of work and report findings to newly in post CYP Matron.	Rebecca Thurlow (Lead Nurse, CYP); Sandie White (Matron, CYP)	31-Jul-2022	[Abandon & Replace]	31-Jan-23	(1) Findings from phase 1 of the 15-steps rollout plan.	(1) Scheduled activity to ensure regular programmed events for ongoing assurance purposes.	Original plan for the 15-steps review was to undertake using staff evaluating CYP areas. Division feel it would be better use national methodology and involve service users in undertaking review.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	

						CYP	Revised approach to undertaking the 15-steps review work. Move away from undertaking review with staff to utilising the national review documentation and initiating with service users undertaking review.	Sandie White (Matron, CYP)	30-Apr-2022	[Abandon & Replace]	28-Feb-23	(1) Findings from 15-steps review.	None.	Original plan for the 15-steps review was to undertake using staff evaluating CYP areas. Division feel it would be better use national methodology and involve service users in undertaking this review. New milestone agreed with	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	03-Feb-23: Executive-led assurance review meeting on 22 February approved closure of this action and resetting timescale to new milestone action.
						CYP	Undertake revised 15-Steps process with service users undertaking the review. Receive findings and demonstrate action in response.	Sandie White (Matron, CYP)	31-May-2023	Red		(1) Findings from 15-steps review & action plan in response.	None.		Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						CYP	Understand the ULHT Trust process for undertaking, recording and frequency for undertaking ligature risk assessments.	Jeremy Daws (Head of Compliance)	30-Apr-2022	Blue	04-May-2022	(1) Clarification Trust processes.	None.	Clarity obtained in the process expected for Trust Ward areas in respect of ligature risk assessments.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						CYP	Scope out assurance available that Ligature Risk Assessments are undertaken annually in line with Trust Policy on CYP ward areas.	Rebecca Thurlow (Lead Nurse, CYP)	31-May-2022	Blue	18-May-2022	(1) Plan to obtain assurance that ligature risk assessments are a programmed activity within CYP.	None.	Agreed plan for frequency of ligature risk assessment reviews with built in reminder process.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						CYP	Scope out assurance available that Ligature Risk Assessments are undertaken annually in line with Trust Policy on CYP ward areas.	Rebecca Thurlow (Lead Nurse, CYP)	30-Nov-2022	Blue	31-Mar-2023	(1) Plan to obtain assurance that ligature risk assessments are a programmed activity within CYP.	None.	Ligature risk assessments for children's areas and neonatal areas have been completed.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						CYP	Continue to scope out additional steps for CYP in relation to risk mitigation for children with mental health concerns linking in with LPFT and ULHT Safeguarding team.	Rebecca Thurlow (Lead Nurse, CYP)	30-Apr-2022	Green	16-May-22	(1) Agree approach with system partners and stakeholders to review care and environment for children requiring Mental Health services.	TBC	Compliance team have developed a gap analysis tool to support CYP and collaborative partners to compare current practice against the GIRFT recommendations. This has been shared with CYP for use going forwards	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						CYP	The Trust have identified the latest GIRFT findings and recommendations pertaining to Children and Young People's Mental Health Services, issued in April 22. Scope out how the Trust, alongside key partners, can use this to review current service provision with a view to improving environment and care processes for CYP.	Rebecca Thurlow (Lead Nurse, CYP)	30-Jun-2022	Green	30-Jun-22	(1) Scoped out plan for next steps in reviewing current practice against GIRFT publication.	None.	Collaborative approach agreed with LPFT, ICB and Social Care. This is a proactive focus on improvements with the mental health pathway, not just ligature risks. Progress with this proactive piece of work will be monitored through Divisional oversight	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						CYP	Review and seek assurance that routine weekly fire checks are being undertaken on Safari ward.	Carol Hogg (Ward Manager)	30-Apr-2022	Green	19-Sep-22	(1) Evidence of weekly fire checks being undertaken.	(1) Assurance of processes in place to maintain this going forward; (2) Evidence of weekly fire checks (spot checks).	Evidence provided that weekly fire checks are being completed on Safari ward.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
Mat 3	Maternity	Lincoln County Hospital	2021 'Interim Action'	2021 'Interim Action'	The physical environment was in poor condition although we appreciate estates have been on site addressing our issues. [Links to CQC2021-14]	Maternity	Immediate action taken to improve privacy and dignity and replace ageing furniture.	Dr Suganthi Joachim (Division Clinical Director); Libby Grooby (Divisional Head of Nursing and Midwifery); Simon Hallion (Divisional Managing	31-Oct-2021	Blue	31-Oct-2021	(1) Assurance provided to CQC following their inspection; (2) Some interim works not able to be completed until refurbishment programme is underway which will include asbestos removal.	(1) Environmental checks & audits; (2) B7 Assurance process (weekly) includes an assessment of this point.	Specific concerns raised by CQC have been addressed during the inspection visit. Longer term refurbishment plans are also in place.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						Maternity	Formally appoint a design team to develop a business case for Maternity (and then scope additional milestones once progressed to this stage).	Simon Hallion (Divisional Managing Director)	31-Mar-2022	Blue	04-Jul-2022	(1) Confirmation that a design team have been appointed (2) Clarification on next steps.	None.	Design Team has been appointed and draft outline of next steps and timescales, that require further confirmation, have been outlined.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						Maternity	Agree a formal project plan and confirm project management structure.	Simon Hallion (Divisional Managing Director) Michael Parkhill (Director of Estates and Facilities)	31-Aug-2022	Red		(1) Formal project plan and project management structure to have been clarified. (2) Further detail on next steps and timescales.	None.		Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
CQC2021-19	Children and young people	Lincoln County Hospital	Core services inspection	Should Do	The trust should ensure ambient temperature checks are undertaken in theatres for medicine storage as per trust policy.	Surgery	Theatre safety bulletin to be devised and disseminated to all theatre staff outlining roles and responsibilities in monitoring of ambient temperatures alongside why this is a requirement.	Lisa Pim (Divisional Nurse, Surgery)	04-Mar-2022	Blue	26-May-22	(1) Completed Safety bulletin; (2) E-mail evidence of dissemination	None.	Guidance shared with Theatre teams on need to record temperatures, roles and responsibilities and action in case of temperature deviation.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Surgery	Thermometers to be ordered for all Anaesthetic Rooms	Jason Green (Matron, Surgery)	02-Mar-2022	Green	01-Sep-22	(1) Written confirmation by Theatre Matrons that Thermometers are in place; (2) Practice has been commenced.	(1) Matrons audit findings; (2) Band 7 audit findings.	Anaesthetic rooms within Theatres now have a means to record ambient temperatures and process confirmed that these are being monitored and recorded with action in line with Trust	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Surgery	Daily Temperature Checks Sheets to be installed in all Anaesthetic rooms	Jason Green (Matron, Surgery)	02-Mar-2022	Green	01-Sep-22	(1) Practice has been commenced; (2) Temperature check sheets are used to record temperatures.	(1) Matrons audit findings; (2) Band 7 audit findings.	Anaesthetic rooms within Theatres now have a means to record ambient temperatures and process confirmed that these are being monitored and recorded with action in line with Trust	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Surgery	Daily Temperature Checks to be instituted by Theatre Teams	Jason Green (Matron, Surgery)	02-Mar-2022	Green	31-Oct-22	(1) Practice has been commenced; (2) Temperature check sheets are used to record temperatures.	(1) Matrons audit findings; (2) Band 7 audit findings.	Anaesthetic rooms within Theatres now have a means to record ambient temperatures and process confirmed that these are being monitored and recorded with action in line with Trust Policy if recorded temperatures are out	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	

						Surgery	Implement remote temperature monitoring probes within Theatres with Clinical Engineering and Pharmacy input.	Jason Green (Matron, Surgery)	30-Jun-2022	Green	31-Jan-23	(1) Remote temperature probes in place.	(1) Matrons audit findings; (2) Band 7 audit findings.	Theatres are having Stanley remote temperature monitoring probes installed across all sites during February 2023.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Surgery	SOP to be devised outlining procedure to be undertaken and actions to be undertaken in the case of a temperature breach.	Lead Nurse/Matron for Health Safety	02-Mar-2022	[Abandon & Replace]	11-Apr-22			There is no need for a separate SOP as the Trust's Medicines Management policy covers off the actions required wen temperature identified as being out of range.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Surgery	Ambient temperature monitoring in Anaesthetic Rooms to be added to Band 7 Weekly Quality and Safety Audit	Matrons/Band 7 Practitioner for Theatre	02-Mar-2022	Blue	01-Sep-22	(1) Audit document with additional checks	(1) Ward accreditation process	This question is now available within the Band 7 weekly spot check audit process to monitor progress and seek ongoing assurance.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Surgery	Ambient temperature monitoring in Anaesthetic Rooms to be added to Monthly Matrons Audit	Matrons for Theatre	02-Mar-2022	Blue	30-Apr-22	(1) Audit document with additional checks	(1) Ward accreditation process	Anaesthetic rooms within Theatres now have a means to record ambient temperatures and process confirmed that these are being monitored and recorded with action in line with Trust Policy if recorded temperatures are out of range.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Surgery	As this is a new process - compliance will be reported at monthly CBU PRM	Lead Nurse TACC	01-Apr-2022	Green	01-Sep-22	(1) Monthly PRM Slide Deck	(1) CBU PRM Quality Process	Anaesthetic rooms within Theatres now have a means to record ambient temperatures and process confirmed that these are being monitored and recorded with action in line with Trust Policy if recorded temperatures are out of range.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Surgery	Track for assurance purposes compliance with temperature monitoring following roll-out of Stanley remote temperature monitoring.	Matrons/Band 7 Practitioner for Theatre	31-May-2023	Green	31-May-23	(1) Review of data from Stanley temperature probes; (2) Review of compliance with temperature monitoring policy.	(1) Matrons audit findings.	Anaesthetic rooms within Theatres now have a means to record ambient temperatures and process confirmed that these are being monitored and recorded with action in line with Trust Policy if recorded temperatures are out	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
CQC2021-20	Children and young people	Lincoln County Hospital	Core services inspection	Should Do	The trust should ensure an interpreter is used as per trust policy to ensure all young people, parents or guardians are able to consent to care and treatment and fully understand clinical conversations.	CYP	Reminders provided to staff around the availability of interpreting services.	Rebecca Thurlow (Lead Nurse, CYP)	01-Nov-2021	Blue	01-Nov-2021	(1) Communication messages shared with the team; (2) Addition (during Nov 21) of this to the monthly matrons audit.	(1) Message of the month schedule; (2) Monthly Matron Audit data.	Work undertaken to proactively remind staff of the availability of translation services for patients/families whose first language is not English.	Barry Jenkins, Director of Finance & Digital	Quality Governance Committee (QGC)	
						CYP	To include within the message of the month schedule reminders to act as an aide memoir to support staff continue to make good use of the interpreting services.	Carol Hogg (Ward Manager)	31-Dec-2021	Green	01-Mar-22	(1) Addition to the message of the month schedule.	(1) Message of the month schedule; (2) Monthly Matron Audit data.	Communications aimed at reminding staff about the process to support patients/carers with interpreting needs has been issued to staff.	Barry Jenkins, Director of Finance & Digital	Quality Governance Committee (QGC)	
						CYP	Nursing admission document being revised, currently in development by Shared Decision Group, with a prompt and space documentation relating to interpreting services booked	Rebecca Thurlow (Lead Nurse, CYP)	31-Dec-2022	Green	31-Jan-2023	(1) Completed nursing admission document.	(1) Message of the month schedule; (2) Monthly Matron Audit data.	Admission document has been finalised and is now awaiting approval by APPG before being rolled out.	Barry Jenkins, Director of Finance & Digital	Quality Governance Committee (QGC)	
						CYP	Nursing admission document finalised and needs approval via APPG before being rolled out for use.	Sandie White (Matron, CYP)	30-Apr-2023	Red		(1) Completed nursing admission document; (2) Approved via APPG.	(1) Monthly Matron Audit data.		Barry Jenkins, Director of Finance & Digital	Quality Governance Committee (QGC)	
						CYP	Section to be added in Matrons monthly assurance audit. To ensure this practise is embedded and monitored – evidence received	Rebecca Thurlow (Lead Nurse, CYP)	01-Dec-2021	Blue	01-Dec-2021	(1) Addition (during Nov 21) of this to the monthly matrons audit.	(1) Monthly Matron Audit data.	Matrons assurance audit has been updated to include assessment of interpreting service being used. This will support ongoing compliance and	Barry Jenkins, Director of Finance & Digital	Quality Governance Committee (QGC)	
CQC2021-21	Children and young people	Lincoln County Hospital	Core services inspection	Should Do	The trust should ensure cleaning records are completed as per trust policy.	CYP	Embed use of new cleaning schedules that have been introduced through Nurse In Charge taking a lead role in ensuring this is completed at the end of each day.	Rebecca Thurlow (Lead Nurse, CYP)	31-Aug-2022	Green	31-Jan-23	(1) Evidence from cleaning schedules assurance metrics; (2) Revised cleaning schedule document.	(1) Ongoing process to oversee completion of cleaning schedules and confidence this is embedded.	Revised cleaning schedules have been launched from December 2022. To track impact and monitor via matrons audit process.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
						CYP	Cleaning schedules have been approved and are in use from December 2022. To evaluate impact at 3-months from matrons audit data.	Kate Rivett (Divisional Head of Children and Young Peoples Nursing)	30-Apr-2023	Red		(1) Evidence from cleaning schedules assurance metrics.	(1) Ongoing process to oversee completion of cleaning schedules and confidence this is embedded.		Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	

						CYP	Scope out action needed in relation to Neonatal cleaning records.	Rebecca Thurlow (Lead Nurse, CYP)	31-Aug-2022	Red		(1) Evidence from cleaning schedules assurance metrics.	(1) Ongoing process to oversee completion of cleaning schedules and confidence this is embedded.	Matrons audit demonstrates that monthly audit data is available. Recent performance is 100%. To track as part of ongoing assurance metrics to evidence process is embedded.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
CQC2021-22	Children and young people	Lincoln County Hospital	Core services inspection	Should Do	The trust should consider discussing mixed sex accommodation with young people proactively rather than reactively.	CYP	Scope out further actions in response to inclusion of patients/parents in service provision whose first language is not English. Set up meeting with Lead Nurse CYP; Equality & Diversity Trust Lead and Patient Experience Lead. [Include within this availability of information for	Jeremy Daws (Head of Compliance)	30-Apr-2022	Blue	30-Apr-22	(1) Meeting held and further actions needed scoped and included within CQC Improvement Action Plan.	None.	Meeting held with Equality & Diversity team to inform next steps to support proactive mitigation of mixed sex accomodation within the unit.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						CYP	To include this and wider cultural issues to the Shared Decision Making group within CYP to scope out tangible improvement actions to support this action.	Rebecca Thurlow (Lead Nurse, CYP)	TBC	Green	19-Sep-22	(1) Agreed plan.	N/A.	The action needed has been scoped with the agreement to amend the nursing admission booklet with a prompt to ensure nursing staff are able to proactively explain mixed sex accomodation during the admission process.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						CYP	Include question(s) and prompt into the nursing admission booklet to enable a conversation to be proactively had at the point of admitting the child and their parents regarding mixed sex accomodation.	Sandie White (Matron, CYP)	21-Oct-22	Green	31-Jan-23	(1) Amended draft of the Nursing Admission Booklet.	N/A.	Admission document has been finalised and is now awaiting approval by APPG before being rolled out.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						CYP	Nursing admission document finalised and needs approval via APPG before being rolled out for use.	Sandie White (Matron, CYP)	30-Apr-23	Red		(1) Amended draft of the Nursing Admission Booklet.	N/A.	New nursing admission document has been approved by APPG and is available for use.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						CYP	Review evidence of impact of the new admission booklet through a 3-month assessment of matons audit.	Sandie White (Matron, CYP)	TBC	Amber		(1) Assurance evidence of the use of interpreters and proactive consideration of mixed sex discussions.	N/A.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
CQC2021-23	Children and young people	Lincoln County Hospital	Core services inspection	Should Do	The trust should consider the use of a communication tool to support staff working with children who have additional needs.	CYP	Work is underway in participating in the Trust trial of 'This is me' document. To be included in the next wave. Aiming to link in with CAMHS and work on this in partnership with LPFT to ensure an integrated approach. To scope out additional details and timescales.	Rebecca Thurlow (Lead Nurse, CYP)	TBC	Amber		TBC	TBC		Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
CQC2021-24	Children and young people	Lincoln County Hospital	Core services inspection	Should Do	The trust should ensure that a patient's food and fluid intake is accurately recorded.	CYP	New tool/risk assessment has been drafted specifically for CYP in collaboration with Dietetics and Clinical Education team. Awaiting ratification and approval of the document to then roll-out. Scope out additional detail and timescales and include further milestones to test implementation and	Sandie White (Matron, CYP)	30-Sep-22	Green	30-Nov-22	(1) Revised documentation for capturing food and fluid intake.	N/A.	Revised documentation has been launched to better record nutritional and flud intakes. This will be monitored via the Matrons audit.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						CYP	Monitor compliance via Matrons audits of the documentation of fluid and nutritional intake over a 3 month period.	Sandie White (Matron, CYP)	28-Feb-23	Green	30-Apr-23	(1) Revised documentation for capturing food and fluid intake.	N/A.	Revised risk assessment document has now been approved at APPG.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						CYP	Monitor compliance via Matrons audits of the documentation of fluid and nutritional intake over a 3 month period.	Sandie White (Matron, CYP)	30-Sep-23	Amber		(1) Assurance data demonstrating compliance with recording.	(1) Assurance data from matrons audit.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
CQC2021-30	Maternity	Lincoln County Hospital	Core services inspection	Should Do	The trust should improve the completion of safety, quality and performance audits to ensure these are consistently completed effectively, to enable safety and quality concerns to be identified and acted upon.	Maternity	BAU: Ongoing review and assurance that environmental audits do assess the estate and escalate appropriately into MNOG.	Libby Grooby (Divisional Head of Nursing and Midwifery)	31-Dec-2022	Green	21-Feb-22	(1) MiCad audits focus on cleanliness; (2) Matrons audits pick up estate issues.	(1) MiCad audits focus on cleanliness; (2) Matrons audits pick up estate issues; (3) Evidence of onward escalation reporting into MNOG.	This was a business as usual action. Estate deficiences are identified proactively via the FLO audits and fed upwards into the IPC committee.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
CQC2021-41	Children and young people	Pilgrim Hospital	Core services inspection	Should Do	The trust should consider all key services being available seven days a week.	CYP	Scope out and define key clinical support services needed by CYP over a 7 day period by urgency (i.e. routine management vs. seriously unwell).	Dr Suganthi Joachim (Divisional Clinical Director)	31-Mar-2022	Blue	09-Mar-22	(1) Defined list of key services and when needed in terms of urgency.	None.	A review of the Clinical Support Services not available 24/7 was undertaken to understand and quantify the gaps and risks associated.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
						CYP	Identify availability of key clinical support services over a 7 day period, by urgency and identify any gaps.	Nick Edwards (Deputy General Manager); Anita Cooper (Interim Lead Clinician)	31-May-2022	Green	10-Aug-22	(1) Key services availability and identification of any gaps.	None.	A list of clinical support services and tests, such as ultrasound, not always available at weekends has been identifed. The risks of this have been quantified and added to the risk register.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	13-May-22: Executive-led assurance review approved rebasing of this deadline from the 31-Apr-22, moving to the 31-May-22. This will remain as 'RED' rated.

						CYP	Outline a plan for mitigating any gaps in available clinical support services and define risks.	Nick Edwards (Deputy General Manager); Anita Cooper (Interim Lead Clinician)	31-May-2022	Green	10-Aug-22	(1) Risk stratification of gaps; (2) Plan in place to mitigate gaps.	None.	A list of clinical support services and tests, such as ultrasound, not always available at weekends has been identifed. The risks of this have been quantified and added to the risk register.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
						CYP	Add any risks to divisional risk register.	Nick Edwards (Deputy General Manager); Anita Cooper (Interim Lead Clinician)	30-Jun-2022	Green	10-Aug-22	(1) Evidence that risk has been considered and added to the risk register as necessary.	(1) Evidence of ongoing risk mitigation as part of risk register process.	A list of clinical support services and tests, such as ultrasound, not always available at weekends has been identifed. The risks of this have been quantified and added to the risk register.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
						CYP	Draft an assurance report summarising what the services where, what are the risks and what are the mitigations with the aim of discussing with clinical colleagues for internal confirm and challenge.	Kate Rivett (Divisional Head of Children and Young Peoples Nursing)	30-Nov-2022	Green	30-Apr-23	(1) Evidence that risk has been considered and added to the risk register as necessary.	(1) Evidence of ongoing risk mitigation as part of risk register process.	Summary report summarising services available over 7 days has been drafted.	Michelle Harris, Chief Operating Officer	Quality Governance Committee (QGC)	
CQC2021-42	Children and young people	Pilgrim Hospital	Core services inspection	Should Do	The trust should consider routine monitoring or auditing of waiting times for children to have a medical review as per the Royal College of Paediatrics and Child Health (RCPCH).	CYP	Review RCPCH guidance to determine specific requirement as to what waiting times need auditing and then discuss further with Lead Nurse and Clinical Lead for CYP.	Jeremy Daws (Head of Compliance)	30-Apr-2022	Green	24-Feb-22	(1) Evidence of detail for the audit being scoped out.	None.	RCPCH guidance reviewed and metrics identified that require proactive assurance monitoring against to inform the development of an audit to assess.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						CYP	Plan a prospective audit to log and record the details, a set number of times a year (to scope). Co-ordinators to collect data. Scope of wards included would be 4a/Safari/Rainforest. To be led by Dr Chingale and Becky.	Dr Chingale (Clinical Lead); Rebecca Thurlow (Lead Nurse CYP)	30-May-2022	[Abandon & Replace]	28-Feb-23	(1) Plan for the audit.	(1) Schedule for the audit to be undertaken throughout the year.	Discussed at the Executive Led - CQC Assurance meeting. Agreed that this is not an area of high risk and for the division to move to a programme of audits as opposed to continuous data collection. New action agreed to scope for inclusion within the CYP Audit programme.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	01-Mar-2023: Agreed at the Executive CQC Assurance meeting on the 28 February 2023.
						CYP	Discuss with Dr Chingale the need to include this within the Paediatric Audit Calendar and plan frequency of this audit. To include within consideration for the audit a review of incidents/complaints/PALS etc. to understand experience based feedback and if this is an area being flagged as of concern.	Suganthi Joachim (Divisional Clinical Director)	31-Mar-2023	Green	30-Apr-23	(1) Plan for the audit.	(1) Schedule for the audit to be undertaken throughout the year.	Confirmed that this has been included within the CYP audit programme.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	

NHS
United Lincolnshire Hospitals
NHS Trust

CQC Improvement Action Plan
Executive Lead: Karen Dunderdale, Director of Nursing
Senior Responsible Officer: Kathryn Helley, Deputy Director of Clinical Governance
Progress Review Date As At: 08/06/2023

BRAG Rating Matrix	
Blue	Completed and embedded.
Green	Completed but not yet fully embedded/evidenced.
Amber	In progress/on track.
Red	Not yet completed/significantly behind agreed timescales

URN	Core Service	Trust/ Site	Recommendation Source	Immediate/ Must Do/ Should Do/	CQC Must Do / Should Do / Issue	Core Service	Local action agreed to resolve the issue	Action Lead	Deadline	Completeness rating BRAG	Date action completed	Evidence available to demonstrate completion	Evidence available to track that action remains completed and embedded	On completion: Outcome - How has the action been met?	Accountable Executive Lead	Reporting to sub-committee for assurance	Notes:
CQC2021-09	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure the requirements of duty of candour are met.	All	Continue to monitor and track performance with support from the Trust's Risk & Governance team. Aim is 100% of incidents that require DoC to have evidence of written DoC. [This is a business as usual action/oversight with well-	Medicine CBU Leads	31-Dec-2022	Green	31-Mar-23	(1) DoC performance data demonstrates timescales are routinely met; (2) Performance with timescales for SI investigations are met.	(1) DoC performance data demonstrates timescales are routinely met; (2) Performance with timescales for SI investigations are met.	overseen by the Quality Governance Committee (QGC). Divisions are provided with ongoing support from the central Clinical Governance team. Performance data demonstrates high compliance rates with Duty of Candour.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
Med 4	Medical care (including older people's care)	Lincoln County Hospital	2021 'Interim Action'	2021 'Interim Action'	We saw three patients across two wards who were self-medicating with no documented risk assessment in place. [Links to CQC2021-10]	Medical	Raised awareness at the Medicine Division Ward Sisters meeting regarding using the risk assessment document.	Tracey Wall (Head of Nursing)	01-Dec-2021	Green	01-Dec-2021	(1) Matrons audit includes an assessment of medications storage; (2) Evidence from ward leads undertaken spot checks;	(1) Matrons audit includes an assessment of medications storage; (2) Ward assurance review process findings relating to medicines security and storage.	Raised awareness with ward leads following feedback from CQC.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Medical	Scope out with Pharmacy plans to update SAMPOD policy and understand assurance data to monitor impact.	Jeremy Daws (Head of Compliance)	30-Apr-2022	Green	18-May-2022	(1) Updated/Revised SAMPOD policy.	None.	Scoped out gap in greater detail and agreed a further scoping exercise to determine baseline performance against Trust's SAMPOD policy.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Medical	Review and seek approval to include SAMPOD related assurance questions to the Matrons audit tool.	Katy Mooney (Divisional Lead Nurse)	31-May-2022	Blue	20-Jun-2022	(1) Question included within Matrons audit.	(1) Ongoing reporting of compliance from Matrons Audit (additional question added in relation to	Actions required scoped. Further sub-actions to be included outlining time-bound plans.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Medical	Redistribute revised SAMPOD policy and risk assessment and ensure medical ward teams are aware of the policy and key actions.	Katy Mooney (Divisional Lead Nurse)	31-Jul-2022	Blue	19-Sep-2022	(1) Evidence of ward areas signing to demonstrate receipt and awareness of SAMPOD policy and risk assessment	None.	Medicine ward staff have read and are aware of the SAMPOD policy and associated documentation.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Medical	Standardise the ward induction programme within medicine to ensure same documentation and include SAMPOD policy/risk assessment as part of this process. Develop draft ward induction documentation for approval by 30 November 2022	Katy Mooney (Divisional Lead Nurse)	30-Nov-2022	Green	30-Nov-2022	(1) Standardised ward induction document with SAMPOD policy and risk assessment included.	None.	Draft checklist developed, now being consulted on to develop final draft for approval and implementation.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Medical	Finalise and commence in use the standardised ward induction checklist document.	Katy Mooney (Divisional Lead Nurse)	28-Feb-2023	Green	30-Apr-2023	(1) Standardised ward induction document with SAMPOD policy and risk	None.		Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Medical	Undertake an audit of new starters to medicine wards during February to assess utilisation of the standardised nursing induction checklist.	Alison Stutt (Lead Nurse, Cardiovascular); Donna Gibbins (Lead Nurse, Specialty Medicine)	31-Jul-2023	Amber		(1) Outcome from audit.	None.		Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Medical	Raise awareness across medicine wards with Medicines Management support and the use of ad-hoc audits.	Katy Mooney (Divisional Lead Nurse)	30-Nov-2022	Blue	31-Oct-2022	(1) Evidence from matrons audits focussed on SAMPOD.	(1) Ongoing reporting of compliance from Matrons Audit (additional question added in relation to SAMPOD).	Assurance data relating to SAMPOD has been included within the Matrons audit for ongoing monitoring and assurance.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Medical	Ward leads to undertake audit on the availability of SAMPOD lockers and keys within Medicine Ward Areas.	Katy Mooney (Divisional Lead Nurse)	31-Jul-2022	Blue	19-Sep-2022	(1) Audit findings on availability of SAMPOD lockers and keys.	None.	Audit of the availability of SAMPOD lockers has been undertaken.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Medical	Ensure that gaps identified from the audit of SAMPOD lockers and keys are acted upon to enable Medicine Ward areas to offer SAMPOD to applicable patients.	Alison Stutt (Lead Nurse, Cardiovascular); Donna Gibbins (Lead Nurse, Specialty Medicine)	31-Mar-2023	Red		(1) Evidence of action following audit of SAMPOD lockers.	None.		Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
Med 5	Medical care (including older people's care)	Lincoln County Hospital	2021 'Interim Action'	2021 'Interim Action'	We saw loose tablets in the clinical area on two wards. On one occasion there were approximately 25 sleeves of unsecure tablets. [Links to CQC2021-10]	Medical	Raised awareness at the Medicine Division Ward Sisters meeting.	Tracey Wall (Head of Nursing)	01-Dec-2021	Green	01-Dec-2021	None.	None.	Raised as education with matrons following the CQC inspection during	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Medical	Review findings from Matrons' Audit compliance across Medical areas to understand compliance with two questions that relate to security and storage of medicines in Medical ward areas.	Jeremy Daws (Head of Compliance)	31-May-2022	Green	24-May-2022	(1) Matrons audit includes an assessment of medications storage (including temperature monitoring); (2) Evidence from ward leads	None.	Assurance gained from a review of the Matrons audit data relating to security and storage of medicines on medical wards across all 3 sites.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Medical	Medicine Lead Nurses to review randomly medicines trolleys to ascertain if the assurance from the matrons audits is confirmed. If not and loose medicines are seen, to review and amend the matrons audit questions to ensure this is captured.	Claire Spendlove (Lead Nurse Cardiovascular); Donna Gibbbins (Lead Nurse Specialty Medicine)	30-Jun-2022	Blue	26-Jul-2022	(1) Verbal feedback of findings from snapshot review of ward practice.	None.	Feedback provided from snapshot audit review	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Medical	Amend the current question on the matrons audit (Drug trollies clean and tidy) to include specific reference to the review and checking of no loose tablets.	Donna Gibbbins (Lead Nurse Specialty Medicine)	31-Oct-2022	Blue	31-Oct-2022	(1) Evidence from matrons audits focussed on loose medications.	(1) Ongoing reporting of compliance from Matrons Audit in relation to loose medications.	Assurance data relating to loose medicines has been included within the Matrons audit for ongoing monitoring and assurance.	Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	
						Medical	Review for assurance purposes data from revised questions on Matron audits over a 3-month period, from December 2022 - February 2023.	Claire Spendlove (Lead Nurse Cardiovascular); Donna Gibbbins (Lead Nurse Specialty	28-Feb-2023	Red		(1) Evidence from matrons audits focussed on loose medications.	(1) Ongoing reporting of compliance from Matrons Audit in relation to loose medications.		Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	

CQC2021-12	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure all patient records and other person identifiable information is kept secured at all times.	All	Review assurance evidence available from existing metrics to determine if additional action is required, other than the ongoing education work resulting from ongoing assurance work.	Clare Spendlove (Lead Nurse); Donna Gibbins (Deputy Divisional Nurse)	30-Apr-2022	Green	30-Apr-22	(1) Matrons audit data in relation to security of patient records/information (systems etc.).	(1) Matrons audit data in relation to security of patient records/information (systems etc.).	Audit data reviewed and agreed that further action is required as compliance audits show room for improvements.	Barry Jenkins, Director of Finance & Digital	Finance, Performance and Estates Committee (FPEC)	
						All	Scope and agree improvement plan to support improved compliance and evidence using the matrons audits.	Katy Mooney (Divisional Lead Nurse)	31-May-2022	Green	24-May-22	(1) Agreed action plan	None.	Action plan agreed in relation to monitoring compliance with security of personal information from unsecured	Barry Jenkins, Director of Finance & Digital	Finance, Performance and Estates Committee (FPEC)	
						All	Order and put into use medical records storage trolleys within the Cath Lab.	Claire Spendlove (Lead Nurse Cardiovascular)	30-Nov-2022	Green	31-Jan-23	(1) Evidence of two notes trolleys available in Cath Lab.	None.	Confirmation received that the outstanding notes trolley has now been	Barry Jenkins, Director of Finance & Digital	Finance, Performance and Estates Committee (FPEC)	
						All	Monitor evidence from the following assurance sources to demonstrate compliance with Information Governance Requirements: * IG mandatory training compliance (reported through to Medicine PRM);	Katy Mooney (Divisional Lead Nurse)	31-Dec-2022	Red		(1) IG Training Compliance within Medicine; (2) Compliance with IG questions contained within the Matrons audit.	(1) IG Training Compliance within Medicine; (2) Compliance with IG questions contained within the Matrons audit.		Barry Jenkins, Director of Finance & Digital	Finance, Performance and Estates Committee (FPEC)	
CQC2021-13	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure it has access to communication aids and leaflets available in other languages.	All	Medicine Cabinet to scope out how to determine what information resources are required that do not currently exist (including UEC and advice cards) and catalogue information currently available and in use.	Katy Mooney (Divisional Lead Nurse)	31-Mar-2022	Green	18-May-22	(1) Agreed action plan	None.	Plan agreed within medicine on how best to approach this audit/data collection exercise.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
						All	To first undertake review of information for patients kept and provided at ward level. Discuss with weekly sisters meeting and develop clear plan to undertake this audit of information available.	Katy Mooney (Divisional Lead Nurse)		[Abandon & Replace]	18-Oct-22	None.	None.	Corporate update on provision of patient information in different languages provided to the Executive Led CQC Assurance meeting on the 14-	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	
CQC2021-14	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure the design, maintenance and use of facilities, premises and equipment keep patients safe. [Medicine specific]	Medical	Review evidence that estates issues are being identified as part of the Ward/department environmental audits and FLO audits and determine mitigations in place to safeguard quality of service provision.	Clare Spendlove (Lead Nurse); Donna Gibbins (Deputy Divisional Nurse); Maxine Skinner (UEC).	30-Apr-2022	Green	30-Nov-22	(1) Environmental audits / FLO audits demonstrating that estates issues are being identified; (2) Evidence of escalation / mitigation of estates related issues by risk.	(1) Environmental audits / FLO audits demonstrating that estates issues are being identified; (2) Evidence of escalation / mitigation of estates related issues by risk.	Meeting established between Division and Estates teams to focus on prioritising estate actions required for issues identifed on FLO audits.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						Medical	Scope out opportunities to better plan routine replacement programme for equipment with Trust's procurement team.	Clare Spendlove (Lead Nurse).	30-Apr-2022	Red		(1) Understand options available.	None.		Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
CQC2021-26	Medical care (including older people's care)	Lincoln County Hospital	Core services inspection	Should Do	The trust should ensure that safety checks of new ward environments are fully completed before moving patients.	Medical	Standardise and merge out-of-hours checklist with Divisional checklist and ensure this is accessible and version controlled as part of the Trust's documentation control processes and procedures. Katy to chair a meeting of matrons and lead nurses across divisions	Katy Mooney (Divisional Lead Nurse)	31-May-2022	Green	18-May-22	(1) Draft Revised checklist for opening a ward.	(1) Assurance evidence the checklist is in use when opening a ward.	Draft checklist developed, now being consulted on to develop final draft for approval and implementation.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						Medical	Agree final draft of the merged Surgery/Medicine checklist and agree group to approve the revised checklist and agree frequency of review (6-monthly) to ensure the document adapts in line with changing nature of the service/reflects new challenges.	Kathyrn Mayer (Matron, Surgery); Sophie Rudge (Matron, Medicine)	30-Jun-2022	Green	28-Jun-22	(1) Final draft checklist for opening a ward.	None.	Final draft checklist has been agreed and is in the process of being ratified and plans in place to implement.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
						Medical	Ratify checklist and ensure this is a controlled document with support from SOP on utilisation.	Clare Spendlove, Lead Nurse, Cardiovascular	30-Sep-2022	Red		(1) Final checklist and SOP approved as controlled Trust documents.	None.		Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	
CQC2021-27	Medical care (including older people's care)	Lincoln County Hospital	Core services inspection	Should Do	The trust should ensure national audit outcomes are continued to be monitored and any areas for improvement acted upon.	Medical	With support from the Trust's audit department, embed the process that all national audits are participated in, presented at the respective audit meetings, discussed at Governance and an action plan agreed.	National Audit leads (with support from Trust Audit Team)	31-Mar-2023	Red		(1) CEG Quarterly Report; (2) CQC Insights data.	(1) CEG Quarterly Report; (2) CQC Insights data.		Colin Farquharson, Medical Director	Quality Governance Committee (QGC)	

United Lincolnshire Hospitals NHS Trust

CQC Improvement Action Plan: Completed and Closed Action Repository
Executive Lead: Karen Dunderdale, Director of Nursing
Senior Responsible Officer: Kathryn Helley, Deputy Director of Clinical Governance

BRAG Rating Matrix	
Blue	Completed and embedded.
Green	Completed but not yet fully embedded/evidenced.
Amber	In progress/on track.
Red	Not yet completed/significantly behind agreed timescales

URN	Core Service	Trust/ Site	Recommendation Source	Immediate/ Must Do/ Should Do/	CQC Must Do / Should Do / Issue	Core Service	Local action agreed to resolve the issue	Action Lead	Deadline	Status summary and update	Completeness rating	Date action completed	Evidence available to demonstrate completion	Evidence available to track that action remains completed and embedded	On completion: Outcome - How has the action been met?	Accountable Executive Lead	Reporting to sub-committee for assurance	Notes
Mat 2	Maternity	Lincoln County Hospital	2021 'Interim Action'	2021 'Interim Action'	We were not assured staff reported all incidents appropriately.	Maternity	• Evidence of incident reporting rates comparable to peer. • Evidence that incident reporting is a regular feature of internal assurance processes. • Evidence of regular reviews of submitted incidents for learning and reporting purposes.	Libby Grooby, Head of Midwifery/Divisional Lead Nurse (Breast/Gynae)	30-Sep-22	12-Sept-22: Signed off as complete by Family Health Cabinet on 17 August 2022; Signed off as complete by Executive-Led assurance process on the 12 September 22.	Blue	30-Sep-22	(1) Evidence of incident reporting is a regular feature of internal governance processes; (2) Evidence of reviews of submitted incidents.	None.	Large amount of evidence demonstrated robust processes to ensure incidents are reported but also reviewed for the purpose of learning.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	Signed off as complete by Family Health Cabinet on 17 August 2022; Signed off as complete by Executive-Led assurance process on the 12 September 22.
CQC2021-32	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Should Do	**Part A:** The trust should ensure patients at risk of self harm or suicide are cared for in a safe environment meeting standards recommended by the Psychiatric Liaison Accreditation network (PLAN)... **Part B:** ... and mental health risk assessments and care plans are completed for all patients at risk. [OPEN still]	UEC	Room 15 has been identified as a suitable room that can be used to assess mental health patients with some modifications. The room has 2 doors meaning suitable access / egress and is situated away from the 'plaster room'.	Blanche Lentz (Clinical Services Manager UEC)	31-Jul-2022	29-Sep-22: ED Risk Tool provide context for the department resulting in the dynamic risk assessments; Patient level risk assessment. The two correlating will provide assurance. 01-Sept-22: Assurance document approved. MH Risk assessments have been split out as part B. 04-Aug-22: Assurance document completed and to be presented for internal confirm and challenge through UEC Governance processes prior to presenation to Exec assurance meeting in September 2022. 07-Jul-22: To meet with Blanche and review assuranc evidence and pull together an assurance document. 09-Jun-22: Team considered that this action is now complete, with the exception of undertaking a ligature risk assessment for the room. _____ 21-Dec: Cost code order has been sent to the contractor. Exact timescales for works to be completed to be confirmed. 15-Feb-22: Works commenced. Panic strips should be fitted. 06-Apr-22: Panic strip has been fitted in some of the room. Confirmed with	Blue	31-Jul-2022	(1) Quote for modifications; (2) Photographic evidence of modifications made to Room 15.	(1) Audit evidence of appropriate access/use by MH patients; (2) Ligature risk assessment completed for refurbished MH room.	MH Room has been modified following CQC identified concerns. UEC Governance where happy to approve this as completed.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	Part a only: Signed off as complete by UEC Governance on the 23 August 22; Signed off as complete by Executive-Led assurance process on the 12 September 22.
						UEC	In the interim, until the modifications to room 15 are complete, any patient with mental health conditions requiring use of the room will have 1:1 supervision from a sitter. The staffing template for the unit will enable this in most circumstances, and in situations where this is more challenged, escalation will be made to Site Management Team to support backfill arrangements. This arrangement has been communicated to all the team.	Denise Dodd (UEC Matron)	01-Nov-2021	Complete	Blue	01-Nov-2021	(1) Evidence of communication cascade.	(1) Audit to be undertaken in Nov-21.	The need for a 1:1 sitter for patients cared for within room 15 has been communicated to the team and assurance that this is maintained will be included in a regular assurance audit.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	Part a only: Signed off as complete by UEC Governance on the 23 August 22; Signed off as complete by Executive-Led assurance process on the 12 September 22.
						UEC	The Trust's Estates team have been contacted to fit locks to cupboard doors in the clean procedures room to ensure that there is not easy access to sharps.	Estates	01-Dec-2021	Complete	Blue	01-Dec-2021	(1) Photographic evidence of pin locks fitted and in use.	(1) Audit/walk-around visits.	The Trust's Estates team have fitted locks to cupboard doors in the clean procedures room to ensure that there is not eay access to sharps.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	Part a only: Signed off as complete by UEC Governance on the 23 August 22; Signed off as complete by Executive-Led assurance process on the 12 September 22.
						UEC	An audit will be undertaken during November 2021 to test this arrangement and the quality of record keeping. Evidence from this audit will made available for sharing with CQC.	Denise Dodd (UEC Matron)	29-Nov-2021	01-Nov: Undertake the audit, deadline: 29-Nov-21 and report back results to CQC by 31-Dec-21. 09-Dec: Project plan for the audit drafted, awaiting confirmation of the plan/progress update. Update meeting 23-Dec cancelled. 06-Jan-22: UEC CBU leads to obtain update on progress with the audit. 20-Jan-22: Audit results received. They demonstrate that room 15 has been used 11 times during December 2021 for patients with Mental Health needs and in each occasion a 1:1 sitter was present to safeguard the patient.	Blue	20-Jan-2022	(1) Audit findings / report	None	An audit has been completed which demonstrates that all patients with mental health needs who have been cared for in Room 15 within Pilgrim ED have had a 1:1 sitter with them to mitigate the fact that the room has not yet had the required alterations to make this ligature free.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	Part a only: Signed off as complete by UEC Governance on the 23 August 22; Signed off as complete by Executive-Led assurance process on the 12 September 22.
						UEC	Agree a schedule of audits to provide ongoing assurance that enhanced care is provided where needed, including for patients with identified mental health needs.	Holly Carter (Senior Sister, ED)	31-Mar-2022	01-Sep-22: Need latest audit data for the assurance document for PBH. 04-Aug-22: Assurance document for internal confirm and challenge through UEC Governance processes during August before exec assurance meeting in September 22. 07-Jul-22: To meet with Blanche and review assuranc evidence and pull together an assurance document. 09-Jun-22: Need audit data for Apr 22, May 22, Jun 22 _____ 21-Feb-22: Enhanced care is included on the Matrons audits. If gaps in UEC staffing available, escalation needed to OPS matrons to enable extra staff to cover. Lincoln now have improved access to LPFT Mental Health team. 05-Apr-22: Confirmation from Holly that Enhanced care now included on Matron's Audit. Holly also completes a separate audit on a monthly basis (reported to Nick McCauley) - Also on Huddle comms completed by NIC ahead of shift change (room utilisation for previous 12 hours - Was cubicle 15 used Y/N? Was 1:1 used? Holly reports on a monthly basis. Tracey Wall has stipulated that MH patients MUST have 1:1 sitter - There have been no breaches of this since CQC vsited (Evidence provided). 25-Apr-22: Audit data available for Dec-21, Jan-22, Feb-22, Mar-22	Blue	31-Mar-2022	(1) Evidence of scheduled audits being undertaken; (2) Appropriate action in response to the audit findings.	(1) Ongoing assurance that audits are continuing.	Audits underway monthly at PBH demonstrate that each time room 15 has been used for a patient with Mental Health conditions, a 1:1 sitter has been assigned and supervised the patient whilst in the room.	Michelle Harris, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)	Part a only: Signed off as complete by UEC Governance on the 23 August 22; Signed off as complete by Executive-Led assurance process on the 12 September 22.
Mat 7	Maternity	Trust	2021 'Interim Action'	2021 'Interim Action'	****NEW** CQC Concern: 26-Nov-21:** • 121 care during birth figures for the past year for both sites with figures for each site separately • PROMPT training compliance rates for each site separately broken down into midwifery and medical staff	Maternity	1:1 care in labour is monitored through the acuity tool and reported monthly via the dashboard. The target is 100%. Data shared with CQC demonstrating compliance figures. If 1:1 care falls below the 100% target on any occasion there is a robust escalation policy to ensure 1:1 care. This consists of reprioritising use of existing staff time, which impacts on non-direct patient care activities planned i.e. training.	Libby Grooby (Divisional Head of Nursing and Midwifery)	01-Dec-2021		Blue	01-Dec-2021	(1) Assurance evidence provided to CQC on 01-Dec-21 following their inspection.	(1) Monitoring of 1:1 care in labour via Maternity Dashboards.	Assurance provided to CQC during the time of the inspection.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	01-Mar-23: Signed off as complete by Executive-Led assurance process on the 22 February 23.
						Maternity	In response to increased sickness levels and operational pressures, staff booked on training, including PROMPT, were sometimes redeployed to help ensure patient safety, including to support with 1:1 care in labour. This had an impact on the Trust's PROMPT training rates. The Trust's trajectory to achieve 90% compliance once more with PROMPT training is by 31 March 2022.	Libby Grooby (Divisional Head of Nursing and Midwifery)	05-Jan-2023	28-Dec-22: Target achieved (90%) in line with brought forward deadline during December 22. To submit as a blue assurance area at January Exec-Led assurance meeting. 28-Oct-22: Assurance data: 61% and 72%. Risk identified from CNST bringing forward their standard target date. Risk is being managed via MNOG. Libby to share evidence around risk mitigation. 25-Jul-22: Update on PROMPT training compliance. On track. Protecting PROMPT Training. This is delivered on teams, so enables staff unable to work clinically to complete training. Confirmation from Heather Allmond that trajectory on track.	Blue	30-Nov-2022	(1) Assurance evidence provided to CQC on 01-Dec-21 following their inspection; (2) PROMPT training compliance.	(1) Monitoring of PROMPT training levels compliance.	The Trust achieved the CNST target of 90% being aimed for during December 2022. This is tracked via MNOG dashboard reporting and will feature in future CNST accreditations in the future.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	01-Mar-23: Signed off as complete by Executive-led assurance process on the 22 February 23. 13-May-22: Executive-led assurance review approved rebasing of this deadline from the 31-Mar-22, moving to the 05-Jan-23. This will remain as 'RED' rated.

CQC2021-29	Maternity	Lincoln County Hospital	Core services inspection	Should Do	The trust should continue to work towards increasing the number of midwives who are competent in theatre recovery to ensure women are recovered by appropriately skilled staff.	Maternity	Midwives whose training / sign off of competence is outstanding to have obtained competencies. In the interim, where there is a case and a midwife who has not received the training for GA recovery, the theatre recovery nurses will remain in attendance. *NB: Original action planned to have fully completed competence for those midwives outstanding by Dec-21.*	Libby Grooby (Divisional Head of Nursing and Midwifery)	30-Apr-2022 (PBH); 31-Oct-2022 (LCH).	28-Dec-22: Controls in place and linked into Health Roster. To present as closed at January CQC Assurance Meeting. 28-Oct-22: 13 new midwives will result in a fall in compliance. Action: Libby to raise with Exec-Assurance meeting based on controls in place if this action can be closed as completed. 19-Sept-22: Discussed at the executive assurance meeting. Based on assurance evidence already provided regarding process to recover women in Recovery by	Blue	19-Sep-2022	(1) Assurance provided to CQC directly; (2) Clinical Education team have all the records – reviewed each year during Mandatory training.	(1) Progress against trajectory for outstanding midwives whose training / sign off of competence is outstanding, who work on labour ward; (2) Database of competences is maintained by Education team and consultant midwife; (3) Strengthened reporting to	Assurance evidence available that demonstrates that women recovered following GA are done so in Theatre Recovery, improvement in competency rates and controls around rota planning demonstrate this action has been completed.	Michelle Harris, Chief Operating Officer	People and Organisational Development Committee (PODC)	01-Mar-23: Signed off as complete by Executive-Led assurance process on the 22 February 23.
						Maternity	Look at further strengthening, reduce the likelihood still further, by including this competency as part of roster planning. Scope out during October 2021. *Action amended subsequently to being provided to CQC:*	Libby Grooby (Divisional Head of Nursing and Midwifery)	01-Dec-2021	09-Mar-22: Clarity obtained that B6 midwives will have completed their competencies, whilst B5 will still be going through the process. Therefore Labour Ward would have a higher proportion of midwives competent to recovery women following GA. Evidence to be obtained from Heather's paper going to MNOG. This is on the agenda.	Blue	01-Dec-2021	(1) Rotas that evidence staffing on the unit and higher ratio of B6 nurses to B5.	(1) Rotas that evidence staffing on the unit and higher ratio of B6 nurses to B5.	Evidence obtained that the bulk of midwives are at B6 level ensuring higher level of competencies and therefore able to care for women post theatre.	Michelle Harris, Chief Operating Officer	People and Organisational Development Committee (PODC)	01-Mar-23: Signed off as complete by Executive-Led assurance process on the 22 February 23.
						Maternity	Monitoring of compliance and assurance through the Maternity and Neonatal Assurance Group.	Yvonne McGrath (Consultant Midwife)/ Emma Upjohn (Interim Deputy Head of Midwifery)/Lead Nurse Breast/Gynae	31-Mar-2022		Blue	31-Mar-22	(1) Update provided in the Maternity and Neonatal Assurance Report to the Maternity & Neonatal Oversight Group in November 2021.	(1) Formal reporting on compliance against the agreed trajectories to be included within the Maternity and Neonatal Assurance Report; (2) Include within next MNOG report.	Formal reporting of compliance with Recovery competencies has now been included within the monthly MNOG meeting.	Michelle Harris, Chief Operating Officer	People and Organisational Development Committee (PODC)	01-Mar-23: Signed off as complete by Executive-Led assurance process on the 22 February 23.
CQC2021-28	Maternity	Lincoln County Hospital	Core services inspection	Should Do	The trust should consider monitoring staff's compliance with the systems in place to enable learning from incidents.	Maternity	The incident 'Trigger List' has been provided to all staff and discussed at team meetings. On the back of this link in with the Trust piece of work looking at mapping of the various processes that share learning across both sites.	Paula Izod (Risk Midwife)	31-Mar-2022		Blue	31-Mar-22	(1) Copy of the trigger list.	None.	Trigger list has been shared with staff to raise awareness of incident reporting crtieria to support strenghening of current processes.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	01-Mar-23: Signed off as complete by Executive-Led assurance process on the 22 February 23.
						Maternity	A review of the mechanisms for sharing learning will be undertaken during 2022/23. As part of this work, the views of Trust staff will be sought to determine what works best for the different areas and staff groups.	Helen Shelton (Assistant Director of Clinical Governance / Patient Safety Specialist)	31-Dec-2022	31-Dec-22: Review concluded. Survey undertaken that reinforced what we thought in that staff use a number of mediums to share lessons. We have therefore continued to use the following: Patient Safety Briefings Learning to Improve Divisional Newsletters quarterly	Blue	31-Dec-22	(1) Trust level understanding of mechanisms in use to share learning; (2) Evidence of action in response.	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	01-Mar-23: Signed off as complete by Executive-Led assurance process on the 22 February 23.
						Maternity	Review the corporate assurance tools to understand what questions are regularly asked of staff and determine if further assurance relating to incidents could be included within these (i.e. ward accreditation review process).	Jeremy Daws (Head of Compliance)	30-Jun-2022	25-Jul-22: B7 and Matrons audit contain questions relating to incidents: o B7 Audit: Are harms or potential harms identified and reported and escalated? If so, has a datix been completed? o Matrons audit: (Quality Governance and Safety): Are Datix/SI's reviewed and being managed within timescale	Blue	25-Jul-22	(1) Review of corporate assurance tools.	None.	Corporate assurance questions reviewed and Matrons audit and B7 audit questions identified as having relevance to incidents and learning from. They do not provide complete assurance going forwards.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	01-Mar-23: Signed off as complete by Executive-Led assurance process on the 22 February 23.
						Maternity	Scope out with Director of Nursing process to review and refresh contents of the corporate ward assurance programme with reference to key themes identified by CQC in their 2021 inspection.	Jeremy Daws (Head of Compliance)	31-Aug-2022	08-Sept-22: Removed from Maternity action plan - not maternity specific but across the board in all areas. Not appropriate to be aligned to this action. 25-Jul-22: To discuss with Angie Davies.	[Abandon & Replace]		TBC	TBC		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	01-Mar-23: Signed off as complete by Executive-Led assurance process on the 22 February 23.
CQC2021-43	Medical care (including older people's care)	Pilgrim Hospital	Core services inspection	Should Do	The trust should consider giving ward managers direct access to training systems for their areas in order to monitor and action mandatory training needs of their teams on a more regular basis.	Medical	Scope out with HR/ESR level of access Ward managers have already to ESR which provides oversight in relation to training compliance levels within their teams.	Katy Mooney (Divisional Lead Nurse)	30-Apr-2022	4 May 2023: shared on sharedrive Ward leads access doen from hierachy form. They wil then be able to get the information. ESR report will be pulled from the month before. If new ward lead starts tomorrow would be able to get as soon as start. When have access would log into manager access on ESR and will be able to drill down to what want to look at. Part of the starter checklist - on intranet under recruitment selection policy. Recruitment send to employee?	Blue	04-Oct-22	(1) Understanding of difficulties in obtaining information from ESR; (2) Evidence of access to manager ESR.	None.	Confirmation received demonstrating that all ward leads do have the appropriate access to Manager ESR that enables them to see and access training systems and compliance of staff within their teams to action mandatory training needs of their teams on a more regular basis.	Claire Low, Director of People and Organisational Development (OD)	People and Organisational Development Committee (PODC)	Signed off as complete by Executive-Led assurance process on the 25-May-23.
CQC2021-09	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure the requirements of duty of candour are met.	All	Continue to monitor and track performance with support from the Trust's Risk & Governance team. Aim is 100% of incidents that require DoC to have evidence of written DoC. [This is a business as usual action/oversight with well-established governance oversight.]	Suganthi Joachim (Divisional Clinical Director); Simon Hallion (Divisional Managing Director); Libby Grooby (Divisional Head of Nursing and Midwifery)	31-Dec-2022	01-Mar-23: Assurance document to be written up with evidence for assurance purposes. 28-Oct-22: 100%. ______________________________ 01-Mar-22: Family Health: DoC performance: Women's health and breast services: 2021: 30 incidents; 93% verbal; 73% written 2022: 3 incidents; 100% verbal; 0% written Children and Young Persons: 2021: 4 incidents; 100% verbal; 100% written 2022: 0 incidents Team consider this to be a data quality issue where the relevant field in DATIX is not being updated. Need to check whether written DoC has taken place - Emma to check whether work has been undertaken to ensure outstanding DoC taken place.	Blue	31-Dec-22	(1) DoC performance data demonstrates timescales are routinely met; (2) Performance with timescales for SI investigations are met.	(1) DoC performance data demonstrates timescales are routinely met; (2) Performance with timescales for SI investigations are met.	Performance with Duty of Candour is overseen by the Quality Governance Committee (QGC). Divisions are provided with ongoing support from the central Clinical Governance team. Performance data demonstrates high compliance rates with Duty of Candour. Improvements made by Divisions are reflected in Trust wide compliance data.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	Signed off as complete by FH Cabinet on the 17-May-23; Signed off as complete by Executive-Led assurance process on the 25-May-23.
CQC2021-25	Children and young people	Lincoln County Hospital	Core services inspection	Should Do	The trust should consider adding specific action plans to the service risk register.	CYP	Revised risk register format now being used. Continue to embed the use of this in strengthened governance structures.	Dr Suganthi Joachim (Divisional Clinical Director); Libby Grooby (Divisional Head of Nursing and	31-Mar-2022	01-Feb-23: Assurance data. Review with Jasmine. Governance meeting evidence. 21-Feb-22: At the time of the visit, the Trust was using the previous version of the risk register which contained a list of actions. This has been replaced by a	Blue	20-Apr-22	(1) Maternity risk register in new style format and updated.	(1) Evidence of the risk register being reviewed within Maternity meeting structure and updated as per Trust policy.	The Division's risk register has been revised and strengthened.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	Signed off as complete by FH Cabinet on the 17-May-23; Signed off as complete by Executive-Led assurance process on the 25-May-23.
						CYP	Undertake review for assurance purposes that risk registers are being reviewed in line with the Trust policy timescales.	Dr Suganthi Joachim (Divisional Clinical Director); Libby Grooby (Divisional Head of Nursing and	30-Apr-2023	10-May-23: Assurance evidence demonstrates controls in place. Review with Jasmine evidence and consider assurance document. ?Move to green. 01-Mar-23: 01-Mar-23: Assurance data: CYP very high risk overdue (row 152); 6 moderate risks overdue (row 160); 3 low risks overdue (row 164);	Blue	30-Apr-23	(1) Maternity risk register in new style format and updated; (2) Evidence of the risk register being reviewed within Maternity meeting structure;	(1) Evidence of the risk register being reviewed within Maternity meeting structure and updated as per Trust policy.	Evidence demonstrates ongoing oversight and monitoring of divisional risks on the risk register.	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)	Signed off as complete by FH Cabinet on the 17-May-23; Signed off as complete by Executive-Led assurance process on the 25-May-23.

Report to:	Trust Board
Title of report:	People and OD Committee Assurance Report to Board
Date of meeting:	13 June 2023
Chairperson:	Professor Philip Baker, Chair
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the People and OD Assurance Committee. The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board. This assurance committee meets monthly and takes scheduled reports according to an established work programme. The Committee worked to the 2022/23 objectives following approval of the BAF by the Board.
Assurances received by the Committee	**Lack of Assurance is respect of SO 2a** **Issue: A modern and progressive workforce** **Workforce Strategy and Organisational Development Group (WSODG) Upward Report** The Committee received the report and was pleased to note that the meeting had been quorate with focus on discussions around statutory and mandatory training, appraisal and sickness data. The Committee noted the growth in both appraisal and training data with these being at the highest levels however the growth was slow and not to the required level. Work was in place in respect of core learning and core+ which would ensure staff were completing the appropriate training for their role. Attendance management was considered by the group due to some compliance issues associated with reporting, support was in place for staff. The Committee noted the positive position in respect of vacancies noting that there had been a reduction in the vacancy rate target, aligned to the workforce submission plan. This did not however detract from the achievement. **Committee Performance Dashboard** The Committee received the dashboard noting the information presented which had been considered in detail by the Workforce Strategy and Organisational Development Group and considered through the upward report of the group. **NHS and System People Plan update** The Committee received the quarterly plan for information noting the 9% vacancy rate for the system and the ongoing work in respect of agency spend being aligned to the financial recovery plan.

	The Committee noted the direction of travel within the plan recognising the developments with digital people and the scaling of people services. **Safer Staffing** The Committee received the report noting the moderate assurance that was offered and the continued positive position which was reported. It was noted that staffing demand during April was lower compared to March with an overall increased level of staffing availability and shift fill across all sites. There had also been a reduction in the number of shifts filled by agency staff. The Committee noted that the timing of the report needed to be considered to ensure that the Committee received the most up to date information available. **Guardian of Safe Working Annual Report** The Committee received the Guardian of Safe Working Annual Report noting the continued hard work of the Guardian. The Committee questioned the possible under reporting of hours by Junior Doctors noting that there were a number of reasons associated with this however recognised that this was a national issue and related to non-engagement with the process.
	Lack of Assurance in respect of SO 2b **Issue: Making ULHT the best place to work** **EDI Annual Report** The Committee received the Equality Diversity and Inclusion Annual Report offering feedback prior to this being presented to the Board for approval prior to publishing. The Committee noted the strengthened work across the organisation thanks to the EDI Lead with an EDI improvement plan in place and a desire across the organisation to increase the pace of patient related EDI objectives. It was noted by the Committee that there was a need to empower staff to lead on EDI actions by providing skills and tools to do so. The Committee was pleased to note the good rating from NHS Employers in respect of the EDI action plan. The Committee approved the annual report for presentation to the Board with some minor changes, the report is appended.

	Culture and Leadership Group Upward Report The Committee received the upward report noting the recent positive Leading Together Forum which had taken place and focused on restorative and just culture. The staff survey action plan was considered by the group with actions underway and the Committee noting the energy and focus on the culture and leadership work within the Trust. The Committee was pleased to note that the Trust was engaged with system work to ensure consistency and alignment and noted positively that the Trust was in a more advance position in this respect than other parts of the system.
	Lack of Assurance in respect of SO 4b **Issue: To become a University Hospitals Teaching Trust** **Medical School update** The Committee received the report noting there had been some change to recruitment from the University of Nottingham requiring all vacant posts to be taken through an approval process of which a number were being progressed. The Committee was pleased to note the successful delivery of the first rotation of AP1 for the fourth year and moving into the final year in September 2023. The curriculum for AP2 had not yet been finalised however this was anticipated to be in place by the beginning of July. The Committee noted the quality assurance visit that would be taking place on the 22 June with senior leaders invited to support. Whilst the medical school was progressing well some concern, from a delivery perspective, was noted for academic staffing. This raised concerns with the Committee in respect of the University of Lincoln becoming independent from Nottingham in the future. **Research and Innovation Update** The Committee received the update noting concern regarding the visit from the Clinical Research Network (CRN) in respect of recruitment to trial figures. Reassurance was received with 7 trials due to open with the potential to recruit 1400 participants. It was anticipated the 2000 participants would be recruited in year with a stretch target in place of 2500. The Committee noted that the CRN would revisit in December to confirm the position and determine if the Trust was delivering to trajectory. The Committee request site of the trajectory and delivery to monitor progress given the potential impact this could have on achieving Teaching Hospital status.

The Committee noted the R&I forum that was due to commence in July and noted that discussions had taken place through TLT to emphasise the importance of R&I.

Consideration was given to the engagement and involvement of staff within the new R&I forum with the Committee keen that this was broaden wider that medical staff to include nursing, midwifery and AHP colleagues.

Reflection of both the research and innovation elements with the Committee noting the need to also give focus to innovation which linked to the wider research view of service change. It was believed there were exampled of innovation taking place, such as the joint aseptic unit with the University of Lincoln. It was however recognised that more needed to be done to move this forward.

University Teaching Hospital Group Upward Report

The Committee received the report noting the progress being made in respect of the finance and model for clinical academics with meetings taking place with the University.

A number of letters of support had been received in terms of progressing the teaching status application with the communications team developing a pack of information. There would be work undertaken regarding the cost and process of transacting the name change.

The Committee reflected on the culture that would be required noting the need to embed the research and innovation culture to support this and ensure benefits were realised.

The Committee noted the need to increase the messaging to the organisation to ensure full support of staff.

Assurance in respect of other areas:

FPEC Referral – Fire Safety Training

The Committee received the referral from the Finance, Performance and Estates Committee noting the concerns raised in regard to the level of training compliance.

The Committee was reassured that the issues was being looked in to and noted that there had been some issue with session availability for staff to attend training as well as non-attendance at booked sessions.

The mandatory training group had oversight of training figures and reports would be offered from the Education and Learning Team to the FPMA meetings to hold divisions to account on a monthly basis.

	Draft Terms of Reference and Work Programme The Committee received the draft documents noting the proposed changes and the requirements for the inclusion of both medical and clinical education. This required representation through both the terms of reference and work programme to ensure suitable reporting mechanisms were in place and would be reported through objective 4b. **CQC Action Plan** The Committee received the action plan noting that work continued in respect of ensuring that the actions remained updated. The Committee considered the main areas of concern, these being statutory and mandatory training and appraisals. The Committee noted concern about the continued position of both of the actions noting that movement was required to be seen. Whilst it was recognised that work was taking place to address the actions the Committee requested divisional level data associated to both training and appraisals to determine those areas requiring focus. **Savile Action Plan** The Committee received the action plan again noting that a number of actions had not appeared to progress for some time and sought to understand the position. It was noted that there had been some impact to these due to the restructure of the directorate. Staff were now in place and therefore progress was expected in respect of the DBS checks actions. The Committee expressed the need to ensure progress was now made at pace and requested further information in respect of the figures associated with DBS checks to fully understand the scale of the action required. **Integrated Improvement Plan** The Committee received the report taking this for information and noting the alignment of the metrics to those discussions held through the agenda items of the Committee.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	None

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

Attendance Summary for rolling 12 month period

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

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

United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*4th July 2023*
Item Number	*Item 9.1*

Annual Report – Equality, Diversity & Inclusion for Patients and Colleagues

Accountable Director	*Claire Low, Director of People & OD*
Presented by	*TBC*
Author(s)	*Alison Marriott, EDI Project Manager*
Report previously considered at	*People & OD Committee, 13th June 2023*

How the report supports the delivery of the priorities within the Board Assurance Framework	
1a Deliver high quality care which is safe, responsive and able to meet the needs of the population	*X*
1b Improve patient experience	*X*
1c Improve clinical outcomes	*X*
2a A modern and progressive workforce	*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	*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	
3f Urgent Care	
4a Establish collaborative models of care with our partners	
4b Becoming a university hospitals teaching trust	
4c Successful delivery of the Acute Services Review	

Risk Assessment	*Insert risk register reference*
Financial Impact Assessment	*Insert detail*
Quality Impact Assessment	*Insert detail*
Equality Impact Assessment	*This report is designed to demonstrate progress and areas for further focus for both patient and staff equalities, in line with the Public Sector Equality Duty and the Trust's published EDI Objectives*
Assurance Level Assessment	*Insert assurance level* • *Moderate*

Recommendations/ Decision Required	• *Approve for publication on the Trust's public website* • *Support with the focus areas where progress is not keeping pace, for example patient equalities compared to workforce equalities*

Executive Summary

Purpose

The Public Sector Equality Duty (PSED) under the Equality Act 2010 applies to United Lincolnshire Hospitals NHS Trust and other public bodies who carry out public functions.

The PSED requires the Trust to have due regard (think about and act) to the:

> **"Need to eliminate discrimination, advance equality of opportunity and foster good relations for people with a protected characteristic when developing its policies, services or when carrying out day-to-day functions and activities"**

The protected characteristics covered by the Equality Act's PSED are: Age, Disability, Gender Reassignment (Gender Identity), Marriage and Civil Partnership, Pregnancy and Maternity, Race – this includes ethnic or national origins, skin colour, accent or nationality, Religion or Belief – this includes lack of belief, sex and sexual orientation.

Specific Duties

The PSED is supported by specific duties, which require public bodies to publish relevant, proportionate information demonstrating their compliance with the PSED; and to set themselves specific, measurable equality objectives. Publishing relevant equality information will make public bodies transparent about their decision-making processes, and accountable to their service users. It will give the public the information they need to hold public bodies to account for their performance on equality.

The specific duties require public bodies to:

- **Publish information to show their compliance with the Equality Duty, at least annually (i.e. this report)** ✓
- **Set and publish equality objectives, at least every four years** ✓

The Trust's current, published equality objectives can be found at Our equality objectives - United Lincolnshire Hospitals (ulh.nhs.uk) and also in Easy-Read at the same link.

These objectives run from April 2022 until April 2025. They form the basis of the Trust's EDI strategy, which was developed through data and staff & patient engagement in Quarter 4 of 2022.

The information published must include:

- **Information relating to employees who share protected characteristics (for public bodies with 150 or more employees)** ✓
- **Information relating to people affected by the Trust's policies and practices who share protected characteristics (for example, patients, service users, staff)** ✓

This EDI Annual Report provides information on the Trust's annual activity in relation to Equality Diversity and Inclusion, in compliance with all of the above and with due regard to all other statutory and mandatory reporting frameworks for NHS Trusts, with which the Trust complies.

Key Messages

- Our patient population and workforce remain different in terms of ethnicity, and our workforce is over 80% female.
- The youngest age groups in the workforce are growing, overtaking those at the middle and older ages.
- Our Staff Networks have grown substantially and have a good impact on the experiences colleagues have in the workplace, and are able to contribute to corporate objectives
- Our staff survey results and other indicators are showing the evidence of increased EDI activity, with large-scale improvements.
- We have made good progress with our workforce-related EDI objectives, but need to complete the United against Discrimination action plan fully as soon as possible.

Conclusion/Recommendations

- We need to increase the pace with our patient-related EDI objectives, with strong collaboration across teams who can help deliver on them
- We must continue the pace with workforce equalities, because it has been proven that interventions and actions do make a positive impact.
- To continue to do this, we must consider resourcing in the light of increased demands on EDI teams, and immediately collaborate more across People & OD teams, as well as with Divisional Leadership.
- A shift in gear is needed, to see EDI as part of everyone's work and increase the ability of those close to the teams to identify and eliminate risk of unlawful discrimination and to positively role-model inclusive behaviours. This needs to be adopted in all areas of the Trust to reduce the variation in staff experiences.

Appendices referred to within the report are available in the reading room

Equality, Diversity & Inclusion

Author: Alison Marriott, EDI Project Manager, United Lincolnshire Hospitals NHS Trust

Contents

✓ Denotes specific evidence to meet Public Sector Equality Duty

Foreword

2022 was a year to reset Equality, Diversity & Inclusion (EDI) at United Lincolnshire Hospitals NHS Trust - as it was for many in the NHS following the intensity of the COVID-19 pandemic in 2020 and 2021.

It was also the year that the NHS Leadership Review, the Messenger Report was published (8th June 2022) which called for inclusive leadership to be embedded as a responsibility for all leaders in the NHS:

> *"…we have much still to do to create a more diverse leadership in the NHS, but we also need tangible action and changes to ensure this happens" (Messenger, June 2022)"*

"Action and not words" was also the driving force behind equality & inclusion activities in 2022 at ULHT. The Trust published its first Anti-Racism strategy in April 2022 and all our Staff Networks grew, in leadership and active membership.

Staff have begun to see the improvements resulting from this, as reflected in the latest National Staff Survey (NSS) results, across all People Promise EDI themes, and good progress with our Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) indicators this year.

The Trust's work on equity and inclusion continues into 2023, starting from a solid foundation in 2022, to ensure the Trust continues to be a better place to work, thrive and receive person-centred care & treatment.

Our existing focus on patient equalities will increase in 2023, working closely across the Trust and with patient groups & communities in Lincolnshire, as part of the Lincolnshire Integrated Care System (ICS)

EDI is everyone's responsibility - and it is especially a leadership responsibility - to demonstrate this by actions and not just words. In 2023, our colleagues and patients can expect to see further progress, with inclusion embedded into the development of a fair and just culture.

Andrew Morgan
Chief Executive Officer

Claire Low
Director of People & OD

Duties of the Trust under the Public Sector Equality Duty (PSED)

The Equality Act's Public Sector Equality Duty (PSED) under the Equality Act 2010 applies to United Lincolnshire Hospitals NHS Trust and other public bodies who carry out public functions.

It supports good decision-making by ensuring public bodies consider how different people will be affected by their activities, helping them to deliver services which are efficient and effective; accessible to all; and which meet different people's needs.

This applies to the Trust as a service provider, an employer, and an anchor institution in our communities.

The PSED requires the Trust to have due regard (think about and act) to the:

> **"Need to eliminate discrimination, advance equality of opportunity and foster good relations for people with a protected characteristic when developing its policies, services or when carrying out day-to-day functions and activities"**

The protected characteristics covered by the Equality Act's PSED are: age, disability, sex, race, religion and belief, pregnancy and maternity, marriage and civil partnership, sexual orientation and gender reassignment.

Specific Duties

The PSED is supported by specific duties, which require public bodies to publish relevant, proportionate information demonstrating their compliance with the PSED; and to set themselves specific, measurable equality objectives. Publishing relevant equality information will make public bodies transparent about their decision-making processes, and accountable to their service users. It will give the public the information they need to hold public bodies to account for their performance on equality.

The specific duties require public bodies to:

- **Publish information to show their compliance with the Equality Duty, at least annually (i.e. this report)** ✓
- **Set and publish equality objectives, at least every four years** ✓

The Trust's current, published equality objectives can be found at Our equality objectives - United Lincolnshire Hospitals (ulh.nhs.uk) and also in Easy-Read at the same link.

These objectives run from April 2022 until April 2025. They form the basis of the Trust's EDI strategy, which was developed through data and staff & patient engagement in Quarter 4 of 2022.

The information published must include:

- **Information relating to employees who share protected characteristics (for public bodies with 150 or more employees)** ✓
- **Information relating to people affected by the Trust's policies and practices who share protected characteristics (for example, patients, service users, staff)** ✓

This EDI Annual Report provides information on the Trust's annual activity in relation to Equality Diversity and Inclusion, in compliance with all of the above and with due regard to all other statutory and mandatory reporting frameworks for NHS Trusts, with which the Trust complies.

This EDI Annual Report is currently in draft, subject to approval. Once approved by Trust Board, the final report will be published on the Trust's dedicated equality public webpage in the summer of 2023.

All other Equality Diversity and Inclusion (EDI) publications can be found on the Trust's "About Us" page on the public internet site or by clicking Equality, diversity and inclusion - United Lincolnshire Hospitals (ulh.nhs.uk)

Our Values & Inclusion at United Lincolnshire Hospitals Trust

The ULHT values underpin the Trust's commitment and approach to equality, diversity and inclusion.

As part of our EDI work, we continue to explore and refine what this means in practice from an inclusion perspective, continuously improving the day-to-day experience of our colleagues and patients, working closely with our Staff Networks and Patient Experience Group.

In 2023, we will consider further what this means in practice and act on that – a Just and Inclusive Culture go hand-in-hand, and there are excellent

examples such as the Mersey Care Model which the Trust can adopt to support this and ensure accountability and role-modelling of a Just and Inclusive culture in practice.

The success of this will depend on close working between Inclusion, Organisational Development, HR and many other areas of the Trust. We will all need to work together effectively to embed this into practical, tangible actions for everyone in the Trust, improving staff experience, positively-impacting on patient safety, and also the ability to attract and retain the workforce required to serve the population of Lincolnshire.

Patient centred	I am fully committed to providing the very highest standards of care to our patients
Safety	I do everything I can to keep my patients and my colleagues safe
	I keep my environment clean and tidy
	I recognise when something is going wrong and I have the courage to do something about it
Compassion	I show a genuine concern for my patients and my colleagues
	I communicate well with others, listening and showing an interest in what they have to say
	I am positive, approachable and friendly
Respect	I treat my patients and my colleagues with dignity and respect
	I work openly and honestly as part of an effective team
	I keep my promises and do what I say I will, when I said I will, or I will provide an explanation if I can't
Excellence	I will always go the extra mile and improve things for my patients and my colleagues
	I am competent to carry out my role and committed to my personal and professional development
	I will share good ideas and best practice and encourage my team members to do so too

Our Patient Profile ✓

The Lincolnshire population* is:

- 51% female
- In terms of ethnicity, 96% White, and 3.5% Black or Minority Ethnic (BME). The lowest number of those who identify as White is in Boston, with a significant number identifying as "Other".
- Slightly higher than the national average in terms of heterosexual orientation. Also a higher than average number not answering the question about sexual orientation, but with a sizeable LGB population (over 15,000 residents), particularly in Lincoln, but also in East Lindsey and South Kesteven.

- The largest age group (number of residents) is in the 50-64 age band, closely followed by under 20 years old. The smallest age group is 20-24 year olds.
- 25% have a disability or long-term condition which limits their day-to-day activities. The greatest numbers are within East Lindsey and South Kesteven Districts, which also have the highest number of residents aged 75 plus.
- In terms of religion, is largely Christian or has no religion. There are also around 5,000 Muslim residents, and over 2,000 Hindu residents.

*Census Data, 2021. Overall for Lincolnshire

It is very difficult to compare the patient population (those who have actually used our services) to the overall population, due to the limitations of current data collection and analysis on patient equalities. This has been attempted for this report, however the comparability of the data (episodes of care, not individuals) and the lack of any data beyond gender (male/female) and age has remained a barrier. This is highlighted as an Equality Objective with which the Trust must make progress.

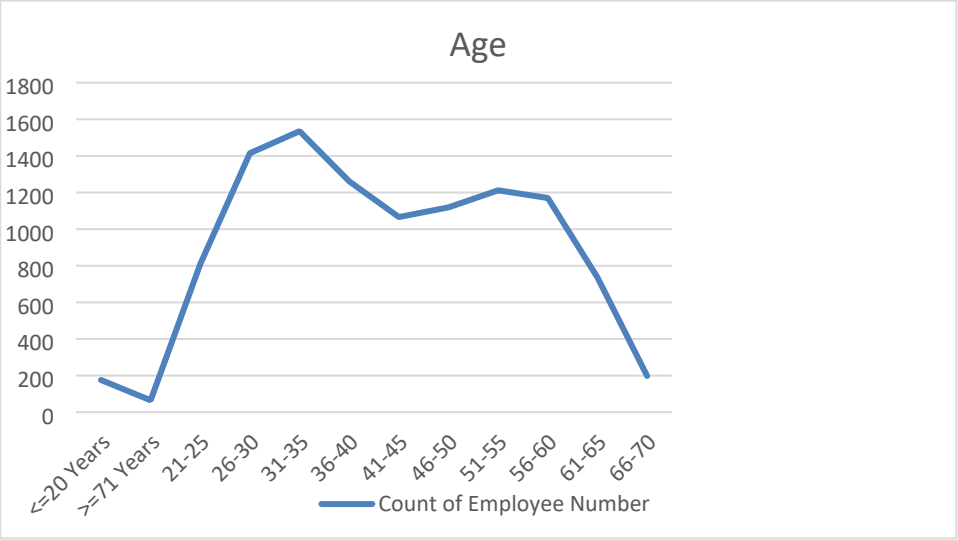
Detailed information is available at Appendix 1.

Our Workforce Profile ✓

The Trusts workforce equalities profile remains broadly the same as the 2022 EDI reporting. There has been an increase in the number of staff overall, and correspondingly in the number of female and male employees. Female employees make up over 80% of the Trust's workforce.

Nationally, the Electronic Staff Record system (ESR) still only offers the option of male or female gender, there is no option for e.g. non-binary, and nationally the NHS LGBTQ+ staff network and others are continuing to work for greater inclusion.

The age profile of the workforce continues on its growing left-shift (i.e. increasing number of younger staff), and the right-shift (staff over 50) is not as pronounced now. The middle years continue with a dip in numbers, as was seen in 2022.



The number of staff feeling confident to share in ESR (Electronic Staff Record) that they are disabled or have a long-term condition has increased, as a culture of openness and support has begun to build, as reflected in this year's improved Workforce Disability Equality Standards (WDES) data. Overall, the percentage of Disabled colleagues at ULHT (as stated in ESR) has increased during the last year and now stands at 4.22% of the workforce. In 2022, it was 3.48% and 2021 it was 3.3%.

There remains a higher number identifying as disabled or having a long-term condition in the anonymous National Staff Survey (NSS) at around 23%, which is broadly in line with the Lincolnshire population - slightly lower.

The percentage of colleagues who are lesbian, gay or bisexual is slightly higher than in the Lincolnshire population overall, and the number of bi colleagues is roughly equal to the number of lesbian or gay colleagues. There is a small but growing number of colleagues identifying with other sexual orientations.

The data is very limited in terms of gender identity and the number of colleagues who identify other than the gender assigned at birth or who are trans. The numbers are below the suppression threshold (for confidentiality) of 11.

The most marked difference between the workforce and the Lincolnshire population is in terms of ethnicity. The Trust remains typical of many rural NHS Trusts, where the workforce is significantly more diverse than the population particularly regarding ethnic background.

Overall, the percentage of Black, Asian and Minority Ethnic colleagues at ULHT has increased during the last year and now stands at 20.6%. In 2022, it

was 16.8%, and 2021 it was 13.3%. It has increased year-on-year. This is in line with increases nationally and also reflects the success of International Nursing, Medical and Allied Health Professional recruitment at ULHT.

Detailed information on workforce profiles is available at Appendix 2.

How Equality, Diversity & Inclusion works at ULHT

Structure & Scope

The People & Organisational Development (OD) Directorate structure was reviewed in 2022. The EDI team structure was not changed as a result of this.

However, the Head of EDI was seconded to work as CQ-Leading Inclusively Programme Manager from April 2022, supported by one of the EDI Assistants. The EDI Project Manager, appointed in January 2022, remained in post in the EDI team, alongside an EDI Assistant.

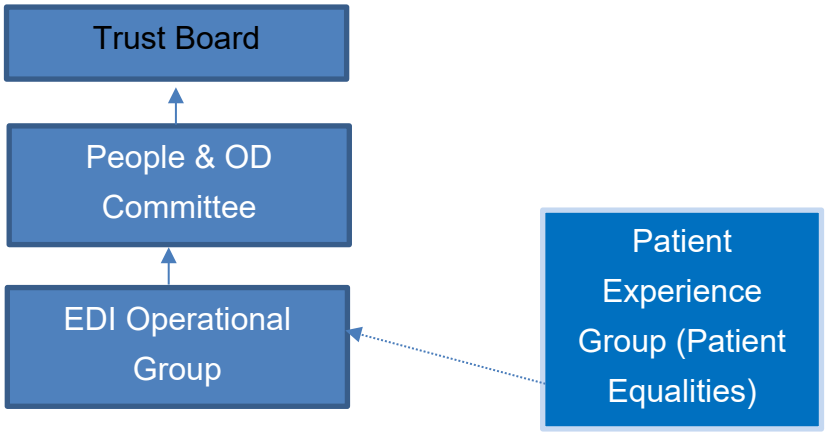
The Associate Director -OD, Wellbeing and Inclusion provided line management and oversight to the EDI team from April 2022 to present, with the substantive Associate Director currently seconded to Nottingham University Hospitals from November 2022 to date of writing.

As at February 2023, one of the EDI Assistants was successful in gaining a six-month development secondment as EDI Officer, working alongside the EDI Project Manager.

Both patient and workforce equalities remain within the remit of the EDI team at ULHT.

Governance

Oversight, assurance and governance is provided through the following structure at ULHT:



In addition, assurance is provided to the Lincolnshire Integrated Care Board (ICB) that ULHT is meeting its contractual duties under section 6 NHS

Standard Contract – Equalities & Human Rights as an NHS Service Provider and Employer.

This contractual assurance is achieved through a quarterly report from the EDI Project Manager to the Arden & GEM Senior Equality & Human Rights Manager. This restarted formally in October 2022, completed by the EDI Project Manager, and no concerns were raised at the October 2022 checkpoint or as a result of the May 2023 report.

Our partners in Inclusion at ULHT

Equality, Diversity & Inclusion is everyone's business – and to help with that, the EDI team at ULHT works closely and productively with a range of partners. Our key partners are highlighted below.

Staff Networks

United Lincolnshire Hospitals Trust has five wonderful staff networks, who are involved daily in the life and work of the Trust. In 2022, they have proven to be a "powerhouse of progress".

The Trust's Staff Networks have been instrumental in many of the improvements made in 2022. Staff networks give constructive feedback, dedicate their time to corporate objectives to support recruitment & retention, to foster greater understanding between different groups in the Trust, and provide individual support to colleagues who need a listening ear and signposting to further support, such as the Trust's Freedom to Speak Up service.

All networks meet regularly, have an Executive Sponsor (who has a role description now) and Visible Leaders. The leaders are supported with half a day per week protected time, and are paid a small honorarium in recognition of the extra time they commit to network activities beyond their normal working hours.

The Chief Executive meets with all network leads every other month, as the Council of Staff Networks. As a further development in 2022, the agenda for this forum is now set by the network leads together, bringing a stronger voice and encouraging cross-network collaboration. The Council of Staff Networks and each network now have Terms of Reference, with the network terms of reference being established in late 2022.

In addition to the five networks highlighted below, in June 2023 during national Carers' week, the Trust will be launching a new network for **ULHT Carers**

(colleagues who are unpaid carers outside of work, e.g. for a family member or loved one). In November 2023, the Trust will also be launching a **ULHT Men's Network**.

ULHT Women's Network is the largest network, with over 1400 members on the secure Facebook group. There are approximately 8,000 women working at ULHT. The group is open to all current ULHT staff who identify and/or present as female. In 2022, the Women's Network launched the Mimosa Project, providing access to sanitary products for staff, bearing in mind the long shifts, cost of living crisis and difficulty accessing shops at work. This was very well-received and the project is expanding this year.

ULHT WOMEN'S STAFF NETWORK

The Network also successfully launched a new Breastfeeding at Work policy in 2022, and prepared extensively for the approval of "Mission Menopause", which has now been approved and funded by the Trust. The network also worked in partnership with the EDI Project Manager on the Gender Pay Gap report and co-hosted the engagement workshops, developing the Gender Pay Gap action plan together.

The Women's Network organized a very successful and empowering Women's History Month program in March 2023, with exclusive access to coaching and mentoring resources ahead of Trust-wide launch and "Get to Know Me" sessions with female leaders at various bands and seniority.

This network scores very highly on the NHSE Midlands Network Maturity matrix, and with further developments expected soon with network funding from the Trust, it is on track to achieve the highest possible development rating.

The network's leaders are Sally Robinson, Head of Contracts & Partnerships

and Claire Hall, Deputy General Manager – Surgery Division. Sally and Claire are great allies and ambassadors across a wide range of EDI-related activity. Their Executive Sponsor is Karen Dunderdale, Director of Nursing.

ULHT Armed Forces Network has grown significantly in 2022 and early 2023, with over 100 members on the secure Facebook group now, compared to around 30 in early 2022.

The Armed Forces Network has also led on significant events in the calendar, such as Remembrance at our three main sites in November 2022 and Armed Forces Week in June 2022.

The Armed Forces Network successfully developed and launched the Trust's Armed Forces Reserves & Cadets policy in late 2022 and early 2023.

ULHT
ARMED FORCES
STAFF NETWORK

The Armed Forces Network successfully re-accredited the Trust as a Silver Employer under the MOD's Defence Employer Recognition Scheme in the summer of 2022. The network, supported by their new Executive Sponsor, Michelle Harris - Chief Operating Officer, is actively pursuing Gold Employer status now, building on a solid foundation established under previous leadership.

As part of this, ULHT has joined the Step Into Health program and the network has successfully gained changes to the ESR (Electronic Staff Record) and recruitment materials to further enable this, alongside organizing a recruitment open day, which was highlighted in the NHS Employers bulletin in early 2023 [Pledged to success: ULHT supports its local Armed Forces community to 'Step into Health' | NHS Employers]

This is important for any employer, but particularly for the NHS in Lincolnshire, valuing and recognising the strengths of our county - “RAF Lincolnshire” – and strong links to the Armed Forces. Also for our patients – with progress made with the Trust’s “Veteran Aware” re-accreditation in late 2022 and further work continuing in 2023.

The Armed Forces network is led by Steve Martin, Patient Safety Programme Manager and Abbi Quinn, Matron – Specialty Medicine.

ULHT Pride+ Network relaunched in 2022, under a new name and branding, with an open Facebook page for all colleagues, and a closed group for those wanting or needing greater privacy. In July 2022, the new Pride+ leadership model began, with five colleagues stepping forward to be visible leaders, unlike the traditional Chair and Vice-Chair model of the other staff networks. This is working well to date, and this leadership model is continuing beyond the initial trial period.

The support of the Executive Sponsor, Paul Matthew – Director of Digital & Finance, has been very welcome. His clear messages of the Trust’s zero

tolerance position towards anti-LGBTQ+ hate and discrimination have been appreciated. The Rainbow badge scheme continues at ULHT, and saw hundreds of new pledges of support made during June 2022, Pride month.

PRIDE+ Staff Network

Supporting equality, diversity and inclusion

During LGBTQ+ History Month, February 2023, the network's leadership circle was very active in attending and promoting the events organized system-wide by Lincolnshire Partnership Foundation Trust (LPFT). Members of the network joined the events too, with greater participation than the previous year.

There are some very exciting developments in the pipeline for 2023, building on the network's success in 2022 identifying the priorities. This includes attendance at Lincoln Pride 2023, some on-site developments which will support LGBTQ+ patients and colleagues alike, plus joint-working with other Staff Networks to raise awareness and increase understanding.

The network is also actively working with the EDI team to develop the Trust's first Gender Identity policy for patients, along with awareness resources for staff and patients. These will be launched in late 2023 following an extensive engagement program.

The leaders of this network are: Tom Evans, Chief Nursing Information Officer; Ben Petts, Charity Manager; Kat Hughes, Trainee Advanced Stroke Practitioner; Maisie Trutwein, OPAT & Antimicrobial Support Worker; and Karen Gates, Recruitment Service Manager.

ULHT RE&CH Network (formerly Black, Asian & Minority Ethnic Staff Network) has a membership of 375 on the mailing list, of which 265 were new or former Internationally-Educated Nurses, as at January 2023. At ULHT, in 2022 around 16% of the workforce was of Black, Asian or Minority Ethnic heritage – around 1600 colleagues.

The most obvious change and progress has come in the form of the new name for the network - “RE&CH”, which stands for Race, Ethnicity & Cultural Heritage. Network members selected this name in January 2023 and a new logo was designed to accompany it. This was officially-launched during Race Equality Week, February 2023.

At the same time, the EDI team launched, in partnership with the RE&CH Network, the See ME First pledge and badge scheme, as developed by Whittington Health NHS Trust originally. 153 pledges have been received to date – of support and allyship for Black, Asian and Minority Ethnic colleagues.

In March and April 2022, the network was very active in the development of the United against Racism campaign and action plan, giving honest and constructive feedback that resulted in a series of posters, along with the action plan approved by Trust Board in April 2022, which was the first Anti-Racism strategy for ULHT.

In the autumn of 2022, the network was actively engaging with members through a survey, to establish the topics that members would like the network to focus on in 2023, to review effectiveness of communication methods, the timing of meetings and to seek to clarify the purpose of staff networks with members.

RE&CH members continue to attend the bi-monthly working group to implement the full action plan, which considers and works to eliminate all forms of discrimination whilst maintaining the underlying original purpose of Anti-Racism.

Following the success of the Holi celebrations organized in March 2023 by RE&CH member Dr Deepa Agarwal, the network celebrated Africa Day in May 2023 and met more colleagues face-to-face through the “RE&CH Roadshows” in 2023, with a further 35 colleagues pledging their active support through See ME First.

The network is chaired by Trish Tsuro, Research Nurse, who started the role in August 2022. Anthonia Eberendu, Digital Specialist Nurse has recently

been appointed as Vice Chair, to cover the maternity leave of Paige Pennant, Discharge Coordinator. The network's Executive Sponsor is Claire Low, Director of People & OD.

ULHT MAPLE (Mental & Physical Lived Experience of Disability or Long-Term Condition) Network has seen substantial growth in 2022 and early 2023. The secure Facebook group now has 244 members. Around 4.5% of ULHT colleagues have a disability or long-term condition (ESR data, 2023) but this rises to over 20% in the anonymized National Staff Survey (NSS) reporting.

The network launched the Sunflower (Non-Visible Disability) campaign in the summer of 2022, with great success in enabling colleagues to come forward, join the network, gain support, and wear their sunflower badge as either a supporter or a person with a hidden disability (different badges for each).

The network leads and their Executive Sponsor took this on the road, meeting face-to-face with colleagues at Grantham, Lincoln and Boston, as well as an extensive social media and email engagement campaign.

Alongside this, the MAPLE network organized an excellent and engaging Disability History Month program throughout mid-November and early

December 2022, leading on this for the whole Lincolnshire Integrated Care System (ICS), working closely with EDI teams and Networks across the ICS.

The Disability History Month events were well-received and well-supported, increasing awareness & understanding, building confidence, and fostering closer working-relationships across staff networks and across the ICS. A copy of the programme is available at Appendix 3.

In May 2023, the network organised the program for d/Deaf Awareness month – connecting and engaging through topics such as Sign Language Team Challenges, and bite-size information. The network has also established confidential Teams channels for specific topics and conditions, to increase support, awareness and understanding. Further work is in development for "Ask Me Anything" sessions in 2023.

The network has led on the development of the Trust's first stand-alone **Reasonable Adjustments policy**, in conjunction with HR, Occupational Health and EDI colleagues. The working group looks forward to the approval of this policy in the summer of 2023.

For stage two of Reasonable Adjustments improvement objective, extensive communications and awareness-raising is planned for 2023, along with process improvements to make sure reasonable adjustments are easier to implement at ULHT. This is one of the Workforce Disability Equality Standard (WDES) Actions and an EDI objective 2022-2025. Our Staff Networks at ULHT actively deliver corporate objectives in partnership with others. Success can be measured through the WDES metric relating to reasonable adjustments and through feedback from the MAPLE network.

ULHT MAPLE STAFF NETWORK
Mental and Physical Lived Experience

Behind the scenes, the network leads and members have supported each other significantly, with listening, signposting, being a sounding-board to empower members to discuss matters with their line managers effectively, and generally ensuring that our disabled colleagues and those living with a long-term condition are able to remain in work and work towards their goals.

The MAPLE network leaders are Rosella Gugliotta (Chair), Clinical Improvement Facilitator and Yvonne Garner (Vice-Chair), EDI Officer. Their Executive Sponsor is Sameedha Rich-Mahadkar, Director of Improvement &

Integration at ULHT.

PEG (Patient Experience Group)

Patient Experience Group, chaired by Angie Davies, Deputy Director of Nursing and Patient Panel, led by Ken Gunning, are key partners in accountability and joint-working for patient equalities.

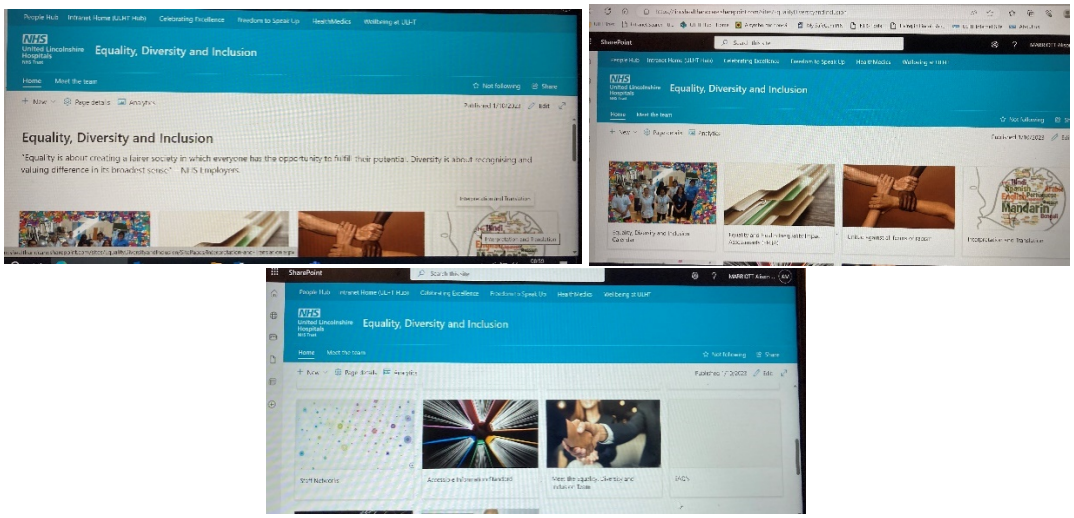
To ensure a coordinated and effective “real world” approach, PEG acts as a sounding-board and connector with the teams working directly with patients, and draws on the experience and expertise of the Patient Experience Team - led by Jennie Negus, Head of Patient Experience.

For the first time, PEG will lead on Domain 1 of the Equality Delivery System report & action plan later in 2023, in relation to equity & accessibility of services provided to patients at ULHT, with the continuing support of the EDI team.

Communications

The Communications Team at ULHT is a key partner for raising awareness and sharing EDI news, with most weeks seeing news, events and opportunities to share.

The Communications Team assisted, with the EDI Team leading (Alison Marriott, Clare Stevenson at that point), on a complete revamp and relaunch of the EDI page on the Trust’s intranet, in August – September 2022.



The Communications team was instrumental in developing the United against Racism visuals and messages in 2022.

The Communications Team provided substantial support for the development of the new-look EDI Calendar 2023, which is used regularly to plan awareness interventions and celebrate a diverse range of key dates in the year, reflecting our workforce and patient population. It also acts as a quick-reference tool for anyone in the Trust to develop their EDI knowledge.

The Communications Team also acts as an accountability partner for the EDI team, to make sure that written and other materials are accessible for a wide range of people, including those with visual and other sensory differences. The Communications Team supports our staff networks too, including logo design and the new staff networks leaflet. A copy of the Staff Networks leaflet is available at Appendix 4.

The Communications Team also provides support to each of the Staff Networks with their intranet pages and their visual identities. Thanks is extended to all members of the Communications Team, but in particular Steve Knight, Senior Communications Officer, for his work with the Staff Networks in 2022-2023.

Making EDI accessible at ULHT

To enable everyone to be part of the Trust's progress with Equality, Diversity & Inclusion, it is vital to make it accessible to everyone - increasing engagement, confidence, skills and knowledge to play their part in imbedding

inclusion into the work of the Trust.

EDI training

At ULHT, **all** colleagues undertake a mandatory EDI training module on joining the Trust, and they take a mandatory refresher every three years.

This module is due for a full review in 2023, as one of the Trust's EDI Objectives 2022-25.

The EDI Project Manager is a regular member of the Mandatory Training Group (MTG) at ULHT, advising on mandatory training requirements such as NHS Accessible Information Standard (AIS), as well as the core EDI module and Trust Induction EDI content, working closely with the Organisational Development team.

She also advises on profession-specific EDI learning, such as Cultural Competency & Awareness in Maternity, working closely with the Lincolnshire ICS Better Births team and the ULHT Family Health Division. She also provides EDI input into the Internationally-Educated Nurses (IEN) Onboarding Programme, the Inter-professional Preceptorship Programme, and new in 2023, EDI in Medicine - a Professional Development Session for Medical Students, on rotations from the University of Lincoln Medical School.

CQ – Leading Inclusively with Cultural Intelligence

In addition to this, the Trust has invested significantly in a CQ – Leading Inclusively with Cultural Intelligence programme in 2022 and early 2023, supported by Above Difference Above Difference - Cultural Intelligence and Inclusion and with a dedicated full-time Programme Manager/Facilitator at ULHT, plus administrative support and 2 part-time facilitators.

© Cultural Intelligence Center

Resulting from this significant investment by the Trust, over 400 ULHT colleagues from the "Leading Together Forum" and other areas of the Trust have benefitted from a CQ Masterclass, with further sessions planned in 2023 to reach all Divisions and Directorates. The masterclasses enable attendees to understand their profile in relation to the four areas of CQ competence (as above) and develop their personal plan, with support from the facilitators, to build on their competences and apply them in their work at ULHT.

> "*The unique combination of Cultural Intelligence (CQ) and Inclusive Leadership offers a new, innovative approach to the inclusion agenda that is rooted in academic research and based on a clear framework.*
>
> *At Above Difference, we equip leaders and organisations to move from 'managing diversity' to 'leading for inclusion'. By developing CQ and Inclusive Leadership styles in individuals and organisations, we develop individual's ability to decisively and intentionally create inclusive workplace cultures where diversity is recognised as one of the organisations' greatest assets and all cultures are valued and respected".*

© Above Difference, 2021

Raising awareness, fostering understanding

In 2022, the EDI team greatly-increased the frequency of communications around the key dates in the EDI Calendar, resetting following the Covid-19 pandemic. A copy of the 2023 EDI Calendar is available at Appendix 5.

The EDI team has used social media (Twitter, ULHT Together Facebook), the Trust Bulletins, Leader's Blogs and the History Month programmes (Black History Month, Race Equality Week, Disability History Month, LGBTQ+ History Month and Women's History Month) to increase awareness and understanding.

Engagement has increased by sharing bite-sized, clear information and by ensuring that programmes are shared and events regularly promoted throughout the History Months, with the kind help of the Communications team and the Staff Networks themselves.

The EDI team has also reached out with practical support such as the well-received Ramadhan "Breaking the Fast" packs in 2022 and again in 2023, kindly supported by the Trust's Chaplaincy and ULHT Charitable Funds. Alongside the Diwali stars and the Holi celebrations, also supported by Charitable Funds and encouraged by the EDI team, to bring people together, as part of the duty to foster good relations.

The EDI Project Manager also joined the Freedom to Speak Up Guardian, during October 2022, for Speak Up Month, visiting the restaurants at Grantham, Lincoln and Pilgrim Hospitals, to increase awareness of the Trust's Staff Networks and the support in place to speak up about discrimination, harassment, bullying or abuse.

Further work has taken place in 2023 to recruit more Freedom to Speak Up champions from the Staff Networks, providing additional trusted, relatable points of contact for those who face extra barriers in speaking up.

Building on the reset and progress in 2022, the EDI Officer is now working on a key objective of EDI engagement, with the support of ULHT's Improvement Team, making good use of the QSIR learning that she and the EDI Project Manager have completed in 2023. This work in 2023 focusses on launching a **regular staff network bulletin**, co-produced with the staff network leads.

This engagement work will also reach those who prefer or need to use paper-based and word-of-mouth communication too. As part of this, the EDI team will establish a network of **EDI champions** across the Trust to help share this information, tapping into a large pool of colleagues who have undertaken CQ – Leading Inclusively training. Also, engaging those who have pledged to any of the EDI badge schemes such as Rainbow LGBTQ+, See ME First, Sunflower or any other EDI-related scheme recognized by the Trust, plus staff network members who wish to become more active and the Trust-wide pool of Wellbeing Champions.

Another aspect of this work will be to build a "**Human Library**" of colleagues' stories on the intranet and making those available to raise awareness, learn and improve. This work will also be incorporated into some of our celebrations of 75 years of the NHS during 2023.

The success of this work can be measured in our staff survey results, EDI indicators and other key metrics such as staff retention, along with the growth of our staff networks in terms of active membership.

United against all forms of Discrimination

In this section of the EDI Annual Report, progress with the Trust's Anti-Racism (and all forms of unlawful discrimination) Action Plan, Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Gender Pay Gap, and NHS Equality Delivery System (EDS) will be considered.

Anti-Racism and WRES

In April 2022, the Trust launched its first-ever Anti-Racism Action Plan, details of which can be found here [Against racism (ulh.nhs.uk)](). Through the first year of implementation, the **poster campaign** and encouragement to report incidents of racism, has resulted in greater discussion about matters of discrimination, reporting in Datix, and signposting and support through the Staff Networks, Freedom to Speak Up and Wellbeing Champions.

The working group has also developed an alternative to the Datix reporting system, for those who would prefer to scan a **QR code** using their own smart device and report using a simple form online, which links into the Inclusion (EDI) inbox. This reporting system can also be used anonymously, for example, should a colleague wish to share a concern in a particular area, but not be named or identified individually.

Alongside this, the EDI Project Manager and working group have developed a clear **protocol for Managing Incidents of Discrimination** from patients,

relatives, guardians etc. which is due to launch in July 2023.

Quarterly anonymised reporting on incidents of discrimination reported to the Trust with a summary of outcomes & learning or changes as result, has also begun from April 2023, with the first report due to be available at the end of Quarter 1 2023 (end June).

Further work is necessary in 2023 to fulfil the actions around allyship and "bystander to up-stander" training, to ensure that everyone is equipped to safely and effectively challenge discrimination, abuse and "micro-aggressions" which can all have a deep and lasting impact. This work is positioned within the Lincolnshire ICS, for a system-wide approach.

The Trust's WRES Report and Action Plan for 2022-23 can be viewed at NHS Workforce Race Equality Standard (WRES) - United Lincolnshire Hospitals (ulh.nhs.uk). The Action Plan was developed in partnership with stakeholders, including Staff Network members and a wide range of colleagues who have influence over and can implement the identified actions. The Action Plan, led by Alison Marriott, EDI Project Manager, and supervised by Sarah Akhtar, Associate Director, OD, Wellbeing & Inclusion, was rated "Good" by NHS England WRES team.

Looking at the National Staff Survey (NSS) 2022 data, reported in January 2023, and the latest WRES data due for submission to NHS England by 31st May 2023, significant progress has been made across most indicators, and all 2022-23 actions are now complete, or are work-in-progress as described above under the Anti-Racism Action Plan.

The WRES indicators seeing greatest progress are entry into formal disciplinary investigation (Indicator 3), where equity has been reached, a closing gap between how fair recruitment and career progress is perceived and how much bullying, harassment, discrimination and abuse colleagues experience from each other, which has significantly reduced in both the NSS results and the Datix reporting internally.

Entry into Formal Disciplinary Investigation, by ethnic background

Year	Ratio
2023	0.82
2022	1.13
2021	1.47
2020	1.55

Percentage of staff experiencing discrimination at work from manager/team leader or other colleagues in the last 12 months – Trust results benchmarked with NHS national average

NSS Results:	2018	2019	2020	2021	2022
White staff: ULHT	8.5%	6.8%	7.3%	8.0%	7.4%
All other ethnic groups*: ULHT	19.1%	19.7%	19.5%	21.3%	18.6%
White staff: Average	6.3%	5.9%	6.1%	6.7%	6.5%
All other ethnic groups*: Average	14.6%	14.1%	16.8%	17.3%	17.3%

The WRES indicators of greatest concern, and therefore an area for close attention in 2023-2024 are: progression from Band 5 upwards for Agenda for Change clinical colleagues; Trust Board representation; and representation for non-clinical Agenda for Change colleagues from Band 8a upwards.

In addition, the Trust will be reporting on the new Medical WRES (MWRES) local reporting and the "First Five Priority Actions" for the first time in 2023, along with the Bank Staff WRES for the first time. At time of writing, data is being gathered and analysed.

NHS England » Medical Workforce Race Equality Standard – a commitment to collaborate; The first five

ULHT also takes part in the NHSE Midlands Workforce Race Equality Initiative, overseen for Lincolnshire by the ICB, and reports quarterly on progress with this, through the ICB to NHSE Midlands:

NHS England — Midlands » Midlands Workforce, Race, Equality and Inclusion strategy

WDES

The Trust's WDES data report and action plan for 2022-23 can be viewed at: NHS Workforce Disability Equality Standard (WDES) - United Lincolnshire Hospitals (ulh.nhs.uk). The Action Plan was developed in partnership with stakeholders, including Staff Network members and a wide range of colleagues who have influence over and can implement the identified actions.

Looking at the National Staff Survey (NSS) 2022 data, reported in January 2023, and the latest WDES data due for submission to NHS England by 31st May 2023, significant progress has been made across all WDES indicators, except Board representation.

Of particular note is the significant progress with the indicator of most concern last year, which has improved significantly and is now the best performance it has ever been:

Percentage of Staff satisfied with the extent to which the Trust values their work, with national NHS benchmarking:

	2018	2019	2020	2021	2022
Staff with a LTC or illness: Your org	28.2%	29.3%	28.5%	23.9%	31.9%
Staff without a LTC or illness: Your org	38.4%	40.5%	38.7%	33.9%	39.8%
Staff with a LTC or illness: Average	36.8%	38.1%	37.4%	32.6%	32.5%
Staff without a LTC or illness: Average	47.9%	49.9%	49.3%	43.3%	43.6%
Staff with a LTC or illness: Responses	588	723	836	934	1024
Staff without a LTC or illness: Responses	2503	2862	2964	2902	3337

The WDES indicators of greatest concern, and therefore an area for close attention in 2023-2024 are: progression from Band 5 upwards for Agenda for Change clinical colleagues; Trust Board representation; and support for medical colleagues with a disability or long-term condition, as declaration rates have improved for this group, but are still significantly lower.

NHS Confederation Framework for LGBTQ+ Patients and Staff

The Trust has reviewed this national, non-mandatory framework and identified baseline scores in early 2023, for the first time. The framework was launched

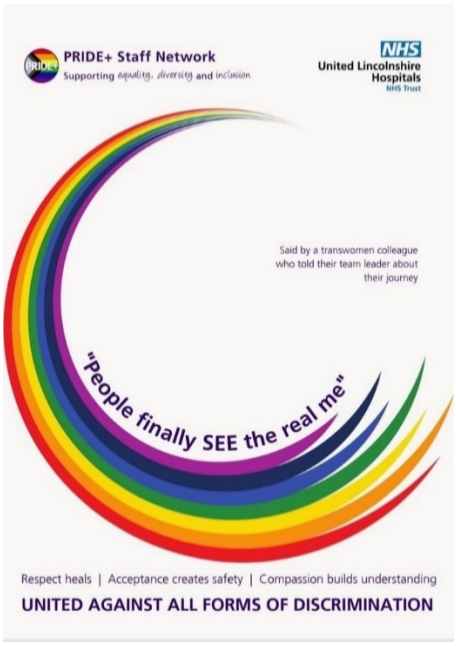
in the autumn of 2022.

Health and Care LGBTQ+ Inclusion Framework | NHS Confederation

This process has identified areas for further work in partnership with the Pride+ network. There are two “Green” rated areas, eleven are “Amber” (work nearing completion, work already planned, plus work in place but needs further imbedding), and Two are “Red”.

The priorities are:

- Fully-implement Sexual Orientation Monitoring Standard (SOMS) for patients – this is also an Equality Delivery System Domain 1 action
- Ensure that staff have access to learning materials and resources to increase their awareness and understanding of LGBTQ+ patients, and colleagues. As part of this, valuable and powerful communications assets have been developed by the network, for a bite-size approach showing the negative impact of micro-aggressions (discrimination) and the positive impact of affirmations and understanding:



Further examples of the images and messages can be found at Appendix 6.

- Increase transgender healthcare awareness in the Trust and ensure that the Trust has a clear Gender Identity policy for patients, supported by extensive and wide engagement, externally and internally, in developing this policy.
- Support and attendance at Lincoln Pride 2023, as a Lincolnshire NHS system.
- Achieve an improving score for the Trust in the 2023 National Staff Survey, for discrimination on the grounds of sexual orientation.

Gender Pay Gap

The Trust's gender pay gap (snapshot date: 31st March 2022) unfortunately saw an increase, as it did in many other Trusts:

Median Gender Pay Gap league table, Lincolnshire NHS and surrounding NHS Acute Trusts – Snapshot Date 31st March 2022

Trust	**Median Gender Pay Gap**	**Trajectory**
Nottingham (NUH)	9%	Gap wider this year
QE Kings Lynn	13.5%	Gap wider this year
Peterborough (NWAFT)	16.6%	Gap wider this year
ULHT	**16.8%**	**Gap wider this year by 2.2%**
Lincolnshire Partnership Foundation Trust (LPFT)	17.7%	Gap narrower this year
Lincolnshire Community Health Services (LCHS)	18.5%	Gap wider this year
North Lincolnshire & Goole (NLAG)	24.2%	Gap wider this year

The Trust's full gender pay gap report and action plan for 2022-23 was published at: Gender pay gap reporting - United Lincolnshire Hospitals (ulh.nhs.uk). The Trust prepared a more robust and detailed action plan this year, in partnership with the ULHT Women's Network, to seek to reverse the widening gap and begin to further close it. This action plan is still within the

implementation phase in 2023. **However, the latest indication for this year's Gender Pay Gap data (snapshot date: 31st March 2023) is that the median pay gap has improved, i.e. has reduced significantly.** Further work on this will continue in 2023 and will be reported in public before the end of March 2024, which is the next reporting deadline.

In 2023, the EDI team will also be considering how best to start reporting on the Race Pay Gap next year, following publication of non-mandatory national guidance. This had already been identified as one of the EDI Objectives 2022-2025 for the Trust. Consideration will be given to other protected characteristics as part of this, such as Disability and Sexual Orientation.

People Promise

ULHT was chosen as one of the 23 exemplar sites to pilot the People Promise Exemplar Programme, which means that the Trust had additional support for 12 months to ensure that a robust action plan has been put in place to deliver interventions in line with the People Promise. The People Promise links closely into many areas of People and OD, including Equality, Diversity & Inclusion:

All aspects of the People Promise are influenced by Equality, Diversity & Inclusion. Particularly relevant are "We are compassionate & inclusive" and "We each have a voice that counts".

Both of these People Promise scores have seen statistically-significant improvements in the 2022 (i.e. latest) National Staff Survey (NSS) results:

- **We are Compassionate & Inclusive – up from 6.7 to 6.9. This is the highest of the Trust's seven People Promise scores. 65% of colleagues who responded to the National Staff Survey in Oct/Nov 2022 said that they feel the Trust respects individual differences, up from 58% in the previous year.**

- **We each have a voice that counts – up from 6.2 to 6.3**

The NHS Staff Survey and our WRES and WDES data and Staff Networks played an important part in informing the key priorities for the People Promise programme of work.

The People Promise EDI priorities at ULHT in 2022 were:

1) Gap analysis of current International Medical Graduate Induction provision compared to new National Standards (non-mandatory) and preparation for new Trust-level Medical Workforce Race Equality Standard (MWRES): NHS Induction Programme for International Medical Graduates - elearning for healthcare (e-lfh.org.uk): **Action complete** – further action required with stakeholders to feedback and agree next steps, as there were gaps identified in current provision.

2) Removing barriers to speaking-up, particularly for those who face additional barriers because of their race, disability, sexual orientation, gender identity or other protected characteristic: Action complete: working closely with Freedom to Speak Up Guardian (FTSUG), using the national FTSUG benchmarking tool, to develop action plan for the remaining small number of gaps.

   Action complete, and ongoing: Joint Speak-Up roadshows, EDI & FTSUG; recruiting Freedom to Speak Up Champions in each staff network, moving to a business meeting and social café model for RE&CH and MAPLE networks (Race, Disability); further support to Pride+ network to ensure that colleagues can approach the Trust, or the Pride+ network (including Visible Leaders and the Executive Sponsor) with any concerns or experiences of discrimination.

3) Put in place resources to help colleagues understand what micro-aggressions are and identify them, to recognise the impact of them, and to learn how to affirm colleagues instead. Also resources to enable colleagues to move from bystander or witness, to actively standing-up for their colleagues.

   This is partially-completed a) through Lincolnshire ICS, who developed an Allyship Toolkit and b) Launching the “See ME First” badge at ULHT, during Race Equality Week 2023. The bystander training was considered by Lincolnshire ICS and the possible

programme was not judged to be suitable by those who took part in the pilot, and the search to identify a suitable programme continues in 2023.

Measuring the Impact and Progress

A significant increase in EDI activity is not a measure of success in itself, although it does help to develop understanding between different groups, and can assist minoritised people (with any protected characteristics) feel more valued and part of the Trust. It can also bring people together to begin to focus on those areas which are not yet improving.

It is important to highlight the positive impact and progress made on a larger scale, particularly for the workforce this year:

- Reduced intentionality to quit (leave employment) across all protected characteristics in National Staff Survey (NSS)
- Increased perception of fairness in recruitment and career progression across protected characteristics in NSS
- Workforce Disability Equality Standards (WDES) results are the strongest since reporting began
- Workforce Race Equality Standards (WRES) results are much improved, with many areas the strongest they have been since reporting began, including entry into formal disciplinary investigation and reduction in experiences of racism from colleagues and managers.
- We are Compassionate & Inclusive – up from 6.7 to 6.9. This is the highest of the Trust's seven People Promise scores.
- 65% of colleagues who responded to the National Staff Survey in Oct/Nov 2022 said that they feel the Trust respects individual differences, up from 58% in the previous year.
- We each have a voice that counts – up from 6.2 to 6.3

Reducing Health Inequalities

In 2022, the responsibility for Health Inequalities at ULHT was confirmed to be within the remit of the Integration & Improvement Directorate. This section of the EDI Annual Report is kindly provided by the Integration & Improvement Directorate.

Lincolnshire Population Health and Inequalities

We know that key lifestyle factors impacting on life expectancy are improving in the more affluent areas of Lincolnshire, compared to the more deprived

areas of Lincoln and Boston. North East Lincolnshire is within the top 20 local authority districts with the highest proportion of neighbourhoods in the most deprived 10% of neighbourhoods nationally.

People living in the more deprived areas of Lincolnshire (e.g. Lincoln and East Lindsey) make less healthy lifestyle choices (smoking, alcohol and less physically active) and higher levels of disability, with poorer health and wellbeing outcomes. The main causes of death of our population in Lincolnshire are cancers, heart disease, strokes and long-term conditions. Mortality rates from cardiovascular diseases and cancer have improved, but remain higher than the England average.

Emergency admissions for hip fractures are significantly above the national average for many districts and owing to the rural nature of the county, the rate of those killed or seriously injured on the county's roads is almost 60% above the national average. The birth rate in our catchment population has decreased slightly over the last three years, and this trend is anticipated to continue. However, the above average teenage conception rate, high percentage of smoking during pregnancy and low percentage of breastfeeding initiation, increases the proportion of high risk and complex pregnancies that require specialist, consultant-led care and foetal medicine. A focus on children is also required as the prevalence of obesity in children aged 10-11 is increasing within the county.

Our ageing and growing population, with multiple co-morbidities and long-term conditions, has implications for future planning and delivery of services, in order to ensure their health and wellbeing needs can be met. Hospitals are not always the best places to care for this group of patients. The introduction of the Lincolnshire Integrated Care System (ICS) has implications for our clinical services through ambitions to reduce demand on our hospitals by redesigning primary and community services, delivering more care closer to home, improving self-care, and focusing on healthy living and the prevention agenda.

Priorities for our Patients

Those priority areas of the Integrated Improvement Plan (Year 3) which relate to health equalities are highlighted below:

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

- We will deliver high-quality care which is safe, responsive and able to meet the needs of the population, leading to improved clinical outcomes.
- Ensure that care delivered to patients is based on evidence and best-practice

This will look like:

- We will have improved discharge processes
- Patients will not come to harm in our care
- Patients will receive high-quality, safe care

Priorities for our People

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

We will:

- Have a modern and progressive workforce
- Make ULHT the best place to work
- Have well-led services

What this will look like:

- We will have an improved benchmark position for vacancy and turnover rates when compared to peer and national medians
- We will have an improved position in all domains of the national NHS Staff Survey.
- We will be rated Outstanding for Well-Led by the Care Quality Commission.
- To be recognised in the top 25% of NHS acute organisations for measures relating to quality, safety and recommending the Trust as a place to work and receive care.

Priorities for our Services

By 2025, our services will be sustainable and make best use of resources, while being supported by technology and delivered from an improved estate.

We will:

- Make efficient use of our resources
- Have a modern, clean and fit for purpose environment
- Have enhanced data and digital capability
- Improve access to cancer services
- Reduce waiting times for patients who need planned care and diagnostics to constitutional standards
- Improve access for patients by reducing unwarranted variation in the services which they receive, focussing on urgent care, planned care and cancer care

What this will look like:

- Delivery of a balanced finance plan with a framework in place to identify targeted improvement schemes
- Secure capital funding to deliver Trust strategies, including the Trust Green Plan
- Our staff will have access to real-time data via electronic systems
- Our patients will be able to access services in timeframes that are safe and responsive

Priorities for our Partners

By 2025, we will work collaboratively with our partners to improve the health and wellbeing of our populations and implement new integrated models of care.

We will:

- Become a University Teaching Hospital Trust
- Have established collaborative models of care with our partners
- Have successfully delivered the Acute Services Review and our recovery support plans

What this looks like:

- We will be a leading partner for the Integrated Care System (ICS) and be making a positive impact on our population health outcomes and the local economy
- We will have embed a deeper understanding of our role to reduce health inequalities

- Develop a ULHT clinical service strategy with a focus on fragile services to provide sustainable and safe services for the future
-

Progress to date in 2023 with the highlighted actions

- Established a specific Patient Improvement Advisory Group with 9 patients providing scrutiny and voice of patients to support ULHT with our improvement ideas and specific improvement projects

- Launched our Cultural Intelligence Programme, reaching over 400 colleagues in leadership and management roles with a masterclass which gives them the tools to improve their ability to adapt, react and lead in diverse teams and organisations.

- Care closer to home/reduction in length of hospital stay: Improvement in the number of patients receiving care as a Day Case, with an increase from 67% (Mar 2022) to 68.3% (Feb 2023), through increased capacity at Grantham and Louth

- Established a Tobacco Cessation Service within the Trust

- More than 300 patients seen as a result of our expansion of our virtual ward capacity, supporting reduced waiting times and pressure on emergency services

Speciality Review Process and Health Equalities

In addition to the above progress with the Priority Areas, during 2022/23 the Specialty Review process has launched. This is a rolling programme of Specialty Reviews and the onward development of improvement plans and clinical strategy, by Specialty.

The data packs for these reviews include information on the below:-

- Population Growth
- Deprivation
- Population Density
- Working Age – Work Limiting Disability
- Lincolnshire Joint Strategic Needs Assessment
- Context of Health Inequalities in Lincolnshire
- Life Expectancy
- Health Inequalities, Lifestyle Factors and the Wider Determinants of Health
- Quality and Outcomes Framework

Integrated Improvement Plan Priorities for 2024

For the Integrated Improvement Plan (IIP) next year, which is currently in development and subject to approval, the priorities to focus on are outlined below, and are expressed as “We will” statements.

Patients

- Listen to you and improve care based on your lived experience
- Make carers feel valued as a partner in care
- Improve clinical outcomes through continuous innovation and transformation and harnessing best practice

People

- Treat all staff with kindness, compassion and respect
- Ensure our workforce is inclusive and represents the communities we serve

Services

- Improve access to cancer services to meet the needs of our population
- Enable patients to have greater involvement in decisions relating to their care

Partners

- Better understand the needs of our communities
- Improve population health and address health inequalities, through working with the System and focussing on elements of CORE20PLUS and mobilising new models of care
- Be proactive to prevent ill health
- Deliver services in the right place for patients
- Have successfully delivered our Acute Services Review in full

This concludes the section kindly provided by the Improvement Team.

Patient Equalities

Equality & Health Inequality Impact Assessments & “Due Regard”

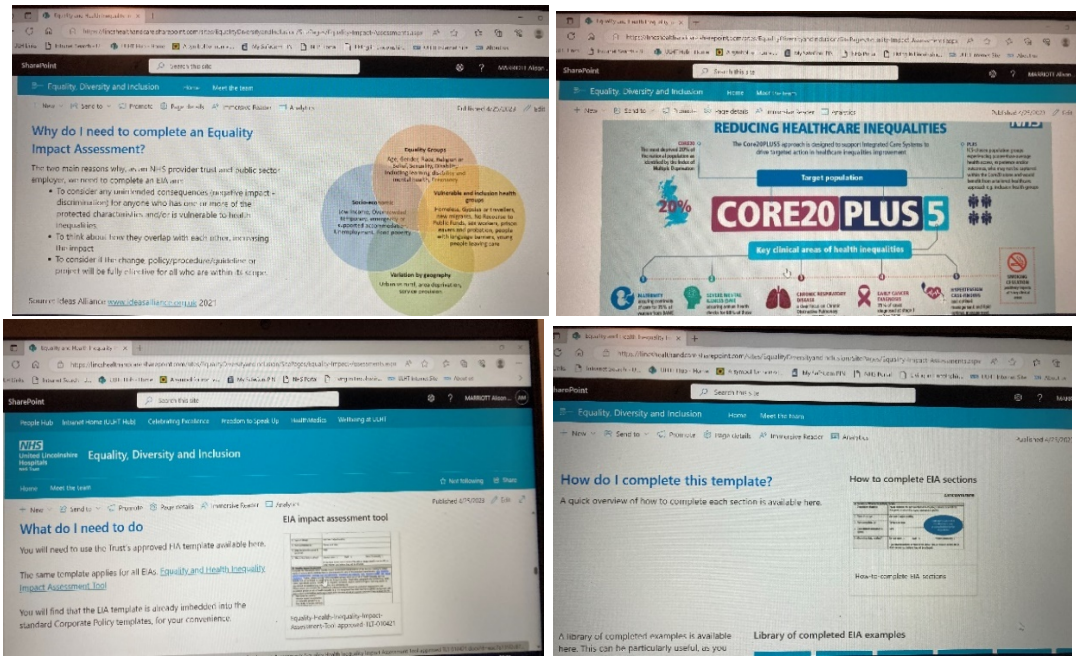
The Trust has a legal duty under the Equality Act (2010), the Public Sector Equality Duty (2011) and the NHS Constitution to have “due regard” to identifying and eliminating inequalities arising from any of the protected characteristics or health inequality themes.

An Equality Impact Assessment (EIA) is a structured, documented, evidence-based decision-making tool. It enables you carefully to consider the impact of your activity, project or decision on any protected characteristics, and health equality outcomes.

The two main reasons why, as an NHS provider trust and public sector employer, we need to complete an EIA are:

- To consider any unintended consequences (negative impact - discrimination) for anyone who has one or more of the protected characteristics and/or is vulnerable to health inequalities.
- To think about how they overlap with each other, increasing the impact
- To consider if the change, policy/procedure/guideline or project will be fully effective for all who are within its scope – equity of access to the benefits or positive impacts of the change

In 2022, the EDI Project Manager created a new EIA resource hub, on the intranet, explaining how to complete an EIA, why it is important, providing a library of completed examples and clear guidance on how to complete an EIA, and the process around the approval of it.



The new resources were well-received. In total, the EDI Project Manager had reviewed over 120 Equality Impact Assessments between January 2022 and March 2023. The majority of these were for individual Standard Operating Procedures and policies, but a major Equality Impact Assessment was completed for the Outline Business Case of the ePatient Record project.

So, after six months of piloting the self-service resources alongside individual input from EDI into each Equality Impact Assessment, the EDI Operational Group elected in March to switch to the self-service model for all EIA's, except those also requiring a QIA (Quality Impact Assessment – for patient safety following the Francis Review) which continue to be individually-reviewed by the EDI team. The full implementation of the new model has taken place in May and June 2023.

Beyond this, the EDI Project Manager suggested a panel approach to reviewing EIA's which are attached to a QIA, to ensure that the most impactful projects, changes and developments receive a deeper review. The EDI Operational Group has lent support to this, with training sessions for panel members due to begin in July/August 2023 and the panel in operation with EDI Operational Group members with immediate effect, as-and-when a QIA is developed. The intention is that training sessions for any colleagues who complete an EIA will be offered after this, at regular intervals, depending on resourcing levels of the EDI team into late 2023 and 2024.

Datix – Equality, Diversity & Inclusion themes

In 2022, the EDI Project Manager started a programme of logging, reviewing and responding to all EDI-related Datix reports. This was strengthened in terms of follow-up to incidents of all forms of discrimination, following the United against Discrimination Action Plan.

To date the top themes in 2022-23 were:

1. Patient to staff discriminatory abuse (usually verbal, racist)
   As a result of this, the full implementation of the United against Discrimination Action Plan continues, with full completion by autumn 2023

2. Lack of availability of face-to-face interpreter for planned appointments (including oncology) at times. No interpreter available immediately at times for unplanned demand on the telephone interpretation service (e.g. maternity)

   As a result of this, feedback was given to the supplier. The supplier has changed the pricing structure to incentivise face-to-face interpreters to attend in Lincolnshire. Alongside this, a piece of work has begun to identify priority areas for face-to-face interpreting, where there is a clinical need. This is in the light of high demand for interpreters across the country and the lack of available interpreters in Lincolnshire, a large

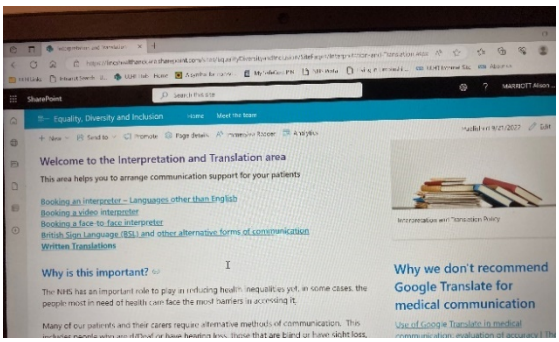
rural county. This will allow bookings to be prioritised where a face-to-face interpreter is required. For those bookings where there is not a clinical need but have been booked as face-to-face due to lack of awareness of alternatives, video remote interpreting will be offered instead.

Further work is ongoing with the ULHT Maternity and ICB Better Births teams to consider back-up options such as CardMedic App, which would provide a safety net and reassurance to both staff and parents, whilst awaiting the availability of a telephone interpreter at times of high demand. The benefits can then be explored with other areas of high, unplanned demand, such as Emergency Departments, and a safety net put in place in those areas too. Also, different ways of working for pre-planned antenatal appointments have been highlighted by the EDI team, to allow for pre-booking of video remote interpreting.

Interpretation & Translation Services

	2021*	2022	2023 to date
Interpretation – Languages other than English	£11,430.97	£91,691.28	£16,724.26
British Sign Language (BSL)	£6,667.90	£53,796.96	£4,843.60

In terms of activity and spend, the Interpretation and Translation services saw an increased demand in 2022, as more “business as usual” activity resumed in the Trust after the Covid-19 pandemic. This is in line with the increased demand nationally for Interpretation & Translation services, and particularly as the pandemic highlighted health inequalities, and this awareness has prompted greater use of interpreters both at ULHT and across the NHS nationally.



The EDI Project Manager redesigned and updated the Interpretation pages on the intranet in 2022, ensuring that all colleagues had a reliable and easy-to-use point of contact for Interpretation & Translation Services.

The top five most requested languages (other than English) across the Trust have been:

1. Polish
2. Romanian
3. Bulgarian
4. Lithuanian
5. Russian

This information is used to prioritise and plan the availability of information in different languages.

Alongside the actions in relation to Interpretation & Translation under the section titled “Datix”, the focus in 2023-24 will be to continue to increase the uptake of video remote interpreting where possible, e.g. pre-planned appointments where a face-to-face interpreter is not clinically-necessary. This will assist with greater prioritisation of face-to-face interpreting towards bookings where face-to-face is clinically-essential, to avoid delays in e.g. scans and treatment whilst awaiting a face-to-face interpreter. It is also likely to assist with spend reduction, without negatively-impacting on patient care or experience and increasing staff confidence to use the service.

Equality Delivery System – Domain 1, Commissioned Services

In 2022, the EDI team led by Alison Marriott implemented the new and extended version of the NHS Equality Delivery System (EDS), for all three Domains – Patients, Workforce and Leadership. The report is published at NHS Equality Delivery System (EDS) - United Lincolnshire Hospitals (ulh.nhs.uk)

Part of this is Domain 1, which considers equalities in terms of patient safety, access to services, patient experiences and other patient-related measures. The score in the first year was “developing” i.e. most core measures were in place, largely at Trust-wide level. However, the limitations in terms of patient equalities data were clearly highlighted and as a result, actions were developed around this, which the Trust will need to focus on implementing in 2023.

In preparation for the next EDS report, due for publication in February 2024, the Patient Experience Team will kindly be leading on Domain 1, with

continued close-working with the EDI Project Manager. It is important that the engagement with both patients, partner organisations and staff increases in October and November this year, ready for the next Equality Delivery System action plan.

Looking ahead

In 2023-2024, it is clear that progress with workforce equalities must and can continue, building on the successes of 2022-23. It has been proven that improvement is possible, and this can increase with the right collaboration and resourcing, aiming for inclusion of EDI metrics and actions for the workforce firmly within the mainstream of People and OD activities.

There is a concern around female employees, who report increased stress and risk of “burnout” in the National Staff Survey results – which is a concern in itself in terms of their wellbeing, but also because female employees represent over 80% of the workforce. It is important to address this area of risk in 2023-24.

Likewise, it is important to finish the work begun in 2022 around anti-racism and other forms of discrimination, in light of the increase in racism from patients and their relatives/visitors.

Also, representation on Trust Board is an area identified in Workforce Race Equality Standards and Workforce Disability Equality Standards where improvements are not yet seen, and with representation of Black, Asian & Minority Ethnic colleagues above Band 5 Agenda for Change (AfC) clinical roles, and across all AfC non-clinical roles. Likewise for Disabled colleagues above Band 7 AfC non-clinical roles.

The EDI team and the wider People & OD team will need to work towards the new national EDI strategy for the NHS, which has been made available in draft, whilst already taking into account new requirements such as Medical Workforce Race Equality Standard, Bank Workforce Race Equality Standard. New actions such as reducing health inequalities in the workforce and beginning to implement pay gap reporting beyond gender, into race and other protected characteristics, all demand closer working with other teams and colleagues in shared ownership of these matters, rather than EDI seen as a stand-alone function.

It is important that our **progress with patient equalities objectives** matches this progress too and a greater focus is essential, working in closer collaboration with clinical teams and with the support of the Trust Board. The

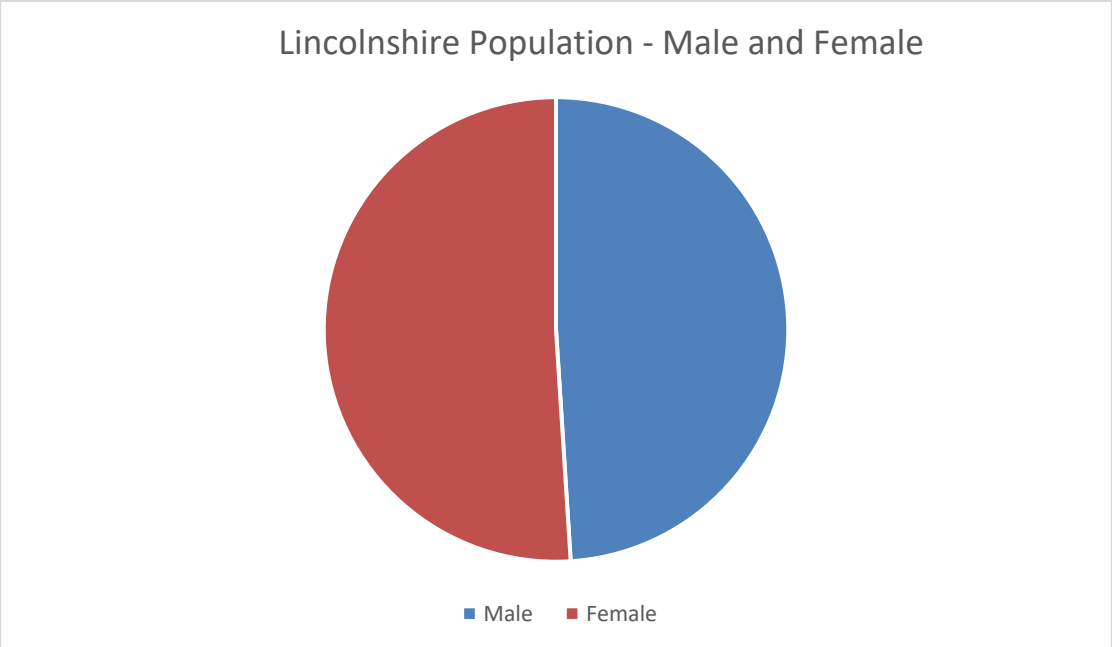
objectives to support patient equalities data – increasing the availability and completeness of it in terms of protected characteristics, along with greater imbedding of the NHS Accessible Information Standard, and improvements in the use and availability of interpretation & translation services are vital, as highlighted by this Annual Report.

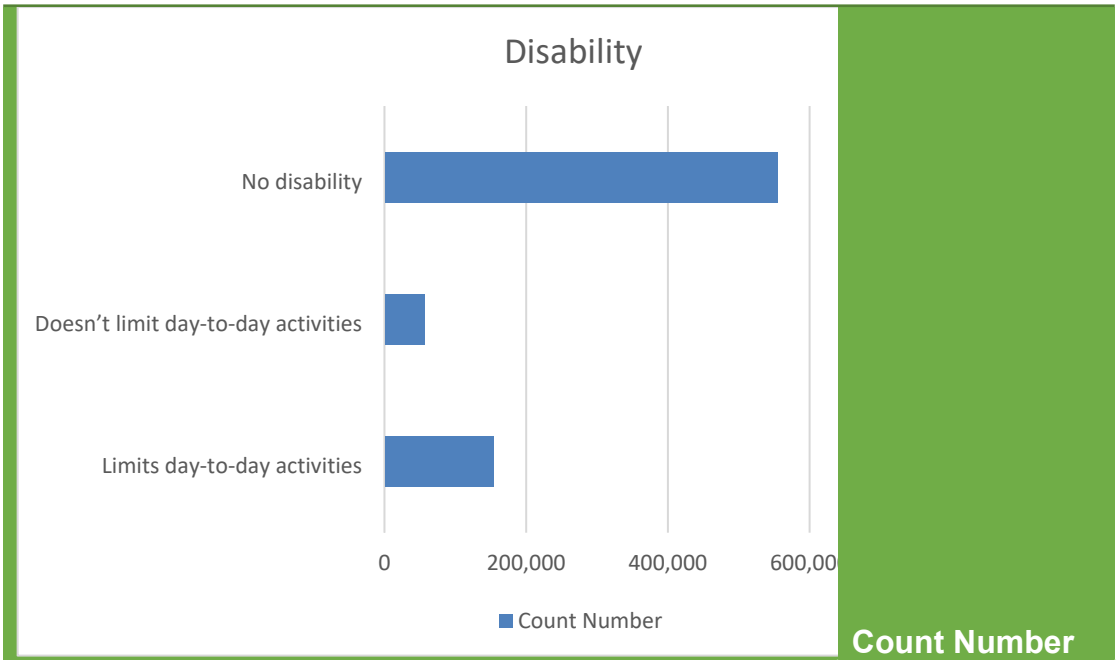
Finally, it is vital that **inclusive leadership practice reaches all areas of the Trust** too, with clear accountability, as this is the responsibility of all leaders - and that the implementation of Just and Learning Culture principles supports this.

Appendices

Appendix 1 – Lincolnshire Population Profile: Census 2021

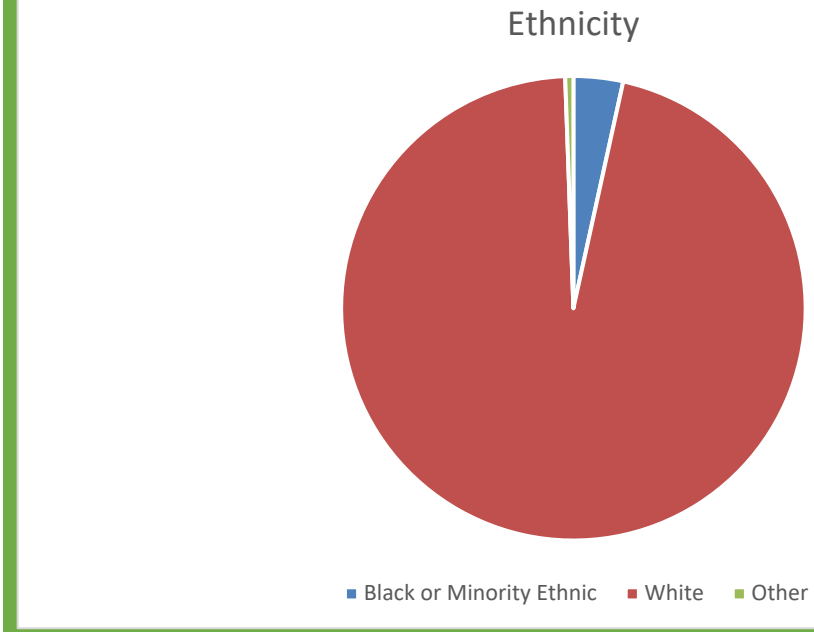
Sex	Count Number
Male	376,430
Female	391,934
Total	**768,364**



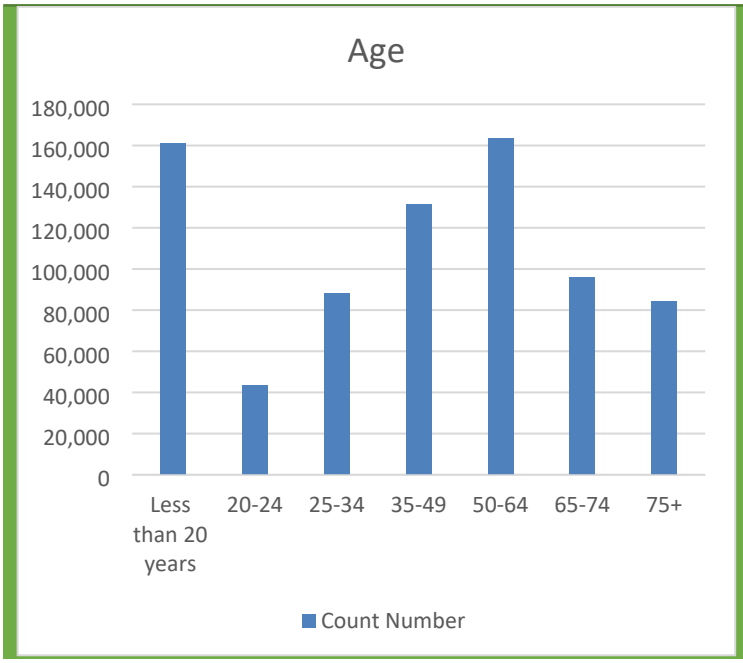


	Count Number
Limits day-to-day activities	154,573

Doesn't limit day-to-day activities	57,841
No disability	555,952
Total	**768,366**

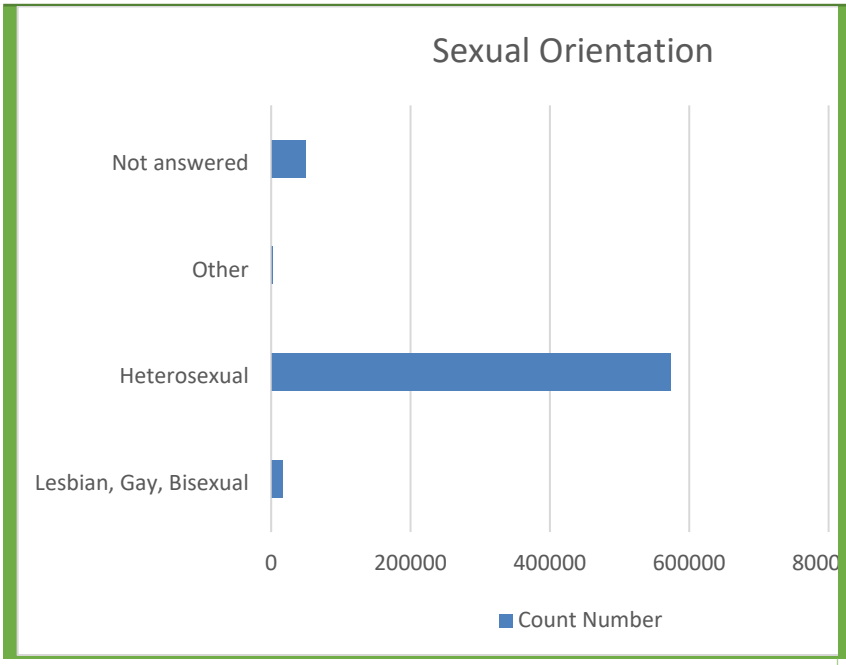


	Count Number
Black or Minority Ethnic	26,483
White	737,532
Other	4351
Total	**768,366**

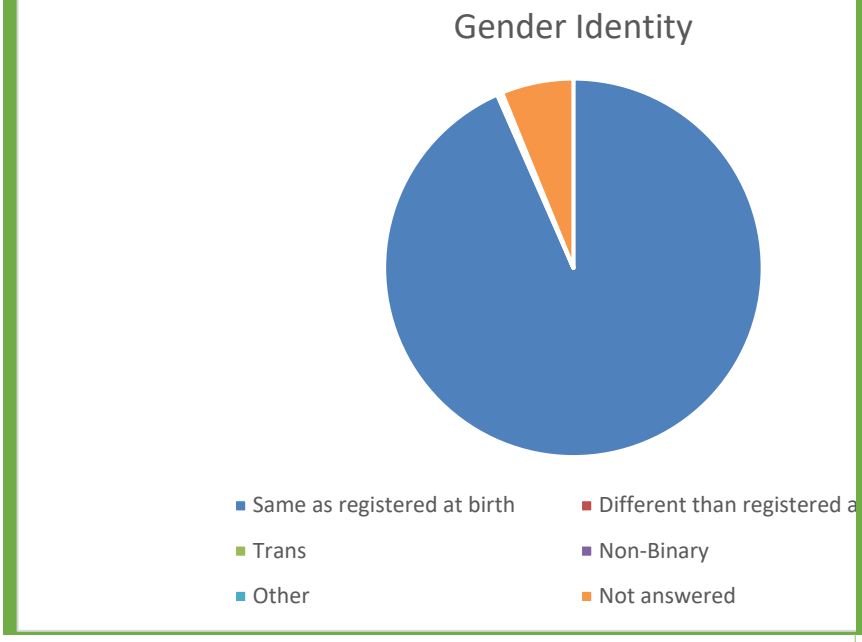


	Count Number
Less than 20 years	161,339

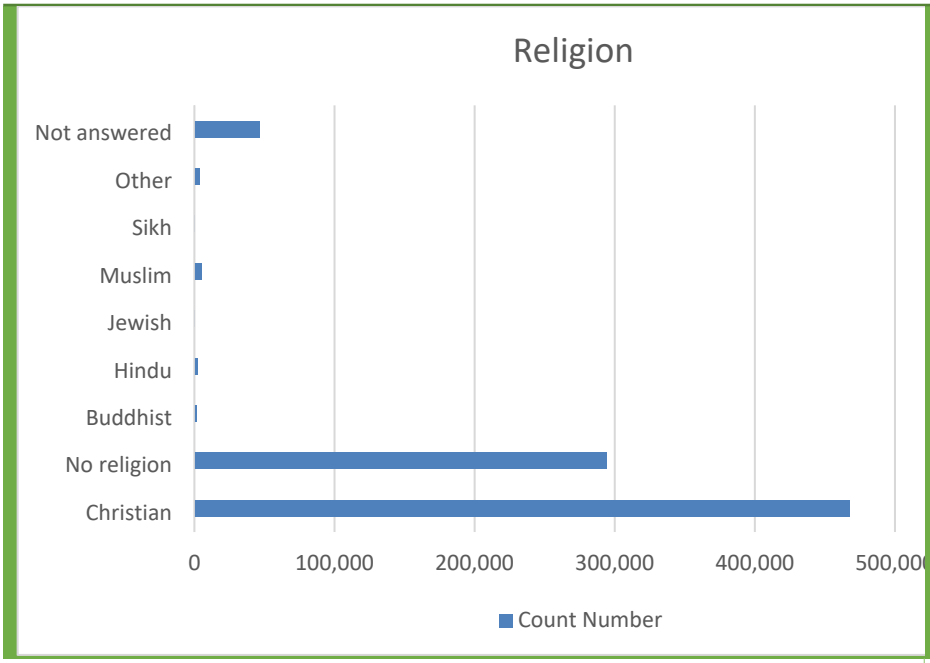
20-24	43,381
25-34	88,317
35-49	131,651
50-64	163,520
65-74	95,938
75+	84,198
Total	**768,344**



	Count Number
Lesbian, Gay, Bisexual	15865
Heterosexual	573,518
Other	1840
Not answered	48,986
Total	**640,209**



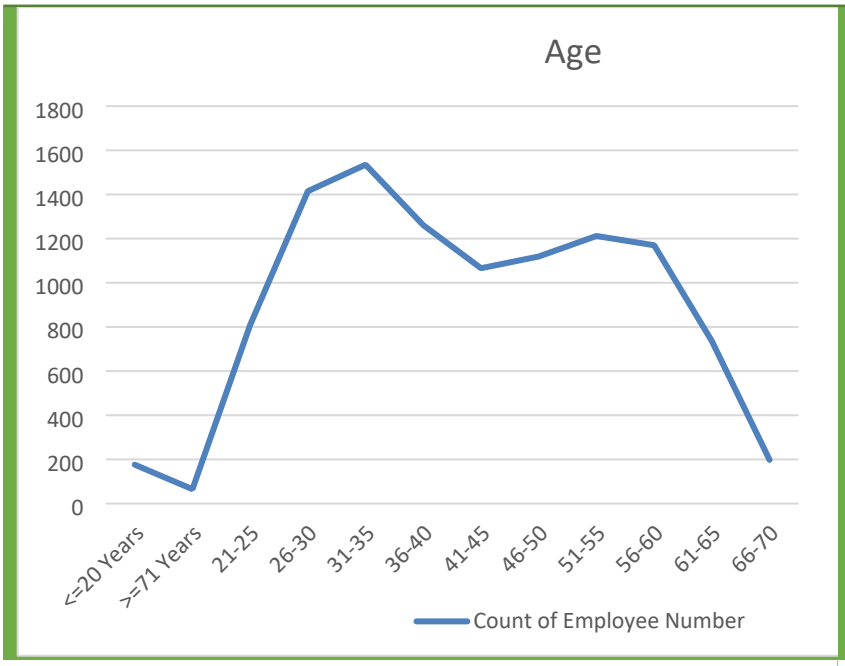
	Count Number
Same as registered at birth	598,009
Different than registered at birth	1,225
Trans	1,055
Non-Binary	340
Other	215
Not answered	39,415
Total	**640,259**



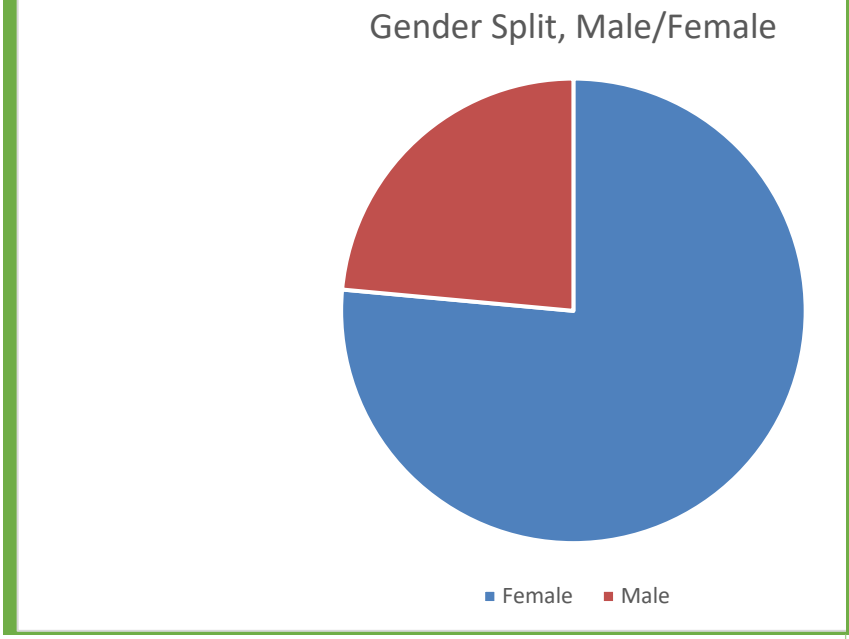
	Count Number
Christian	467,515
No religion	294,198
Buddhist	1,824

Hindu	2,494
Jewish	495
Muslim	5,411
Sikh	681
Other	3,783
Not answered	46,894
Total	**823,295**

Appendix 2 – Workforce Profiles ✓

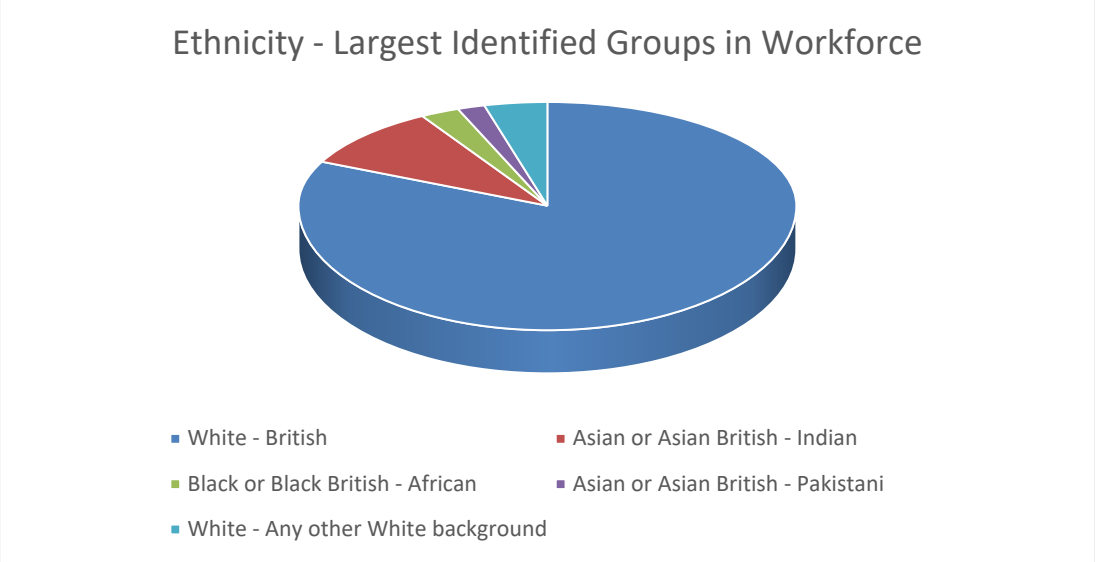


	Count of Employee Number
<=20 Years	176
>=71 Years	65
21-25	809
26-30	1415
31-35	1535
36-40	1261
41-45	1066
46-50	1119
51-55	1212
56-60	1170
61-65	736
66-70	198
Grand Total	**10762**



	Count of Employee Number
Female	8229
Male	2533
Grand Total	**10762**

NHS Electronic Staff Record (ESR) currently does not capture other gender identities, such as non-binary.



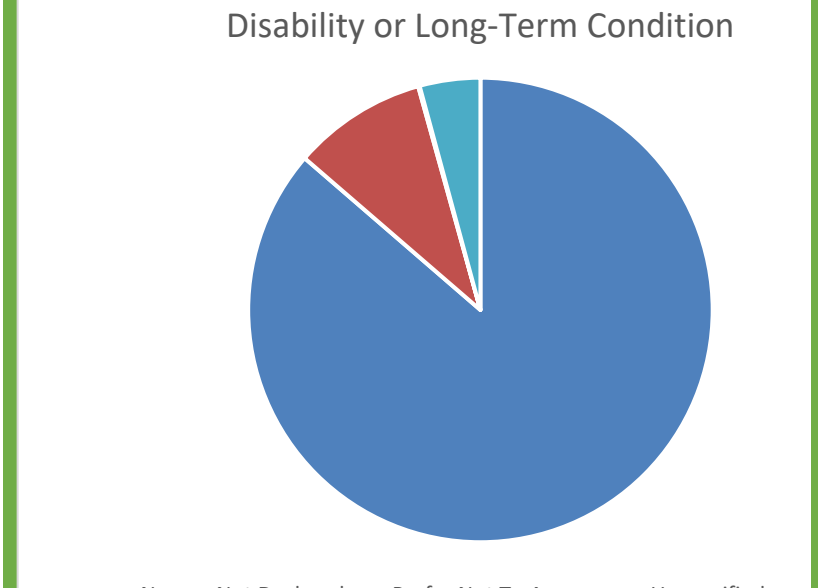
Ethnic Origin	Count of Employee Number
A White - British	7711
B White - Irish	36
C White - Any other White background	462
C3 White Unspecified	**
CA White English	38

CC White Welsh	**
CF White Greek	**
CK White Italian	**
CP White Polish	**
CQ White ex-USSR	**
CY White Other European	21
D Mixed - White & Black Caribbean	24
E Mixed - White & Black African	30
F Mixed - White & Asian	28
G Mixed - Any other mixed background	42
GE Mixed - Asian & Chinese	**
GF Mixed - Other/Unspecified	**
H Asian or Asian British - Indian	894
J Asian or Asian British - Pakistani	195
K Asian or Asian British - Bangladeshi	36
L Asian or Asian British - Any other Asian background	163
LE Asian Sri Lankan	**
LH Asian British	**
LK Asian Unspecified	**
M Black or Black British - Caribbean	25
N Black or Black British - African	267
P Black or Black British - Any other Black background	25
PC Black Nigerian	**
PD Black British	**
PE Black Unspecified	**
R Chinese	51
S Any Other Ethnic Group	213
SC Filipino	42
SE Other Specified	45
Z Not Stated	354
Unspecified	**
Grand Total	**10762**

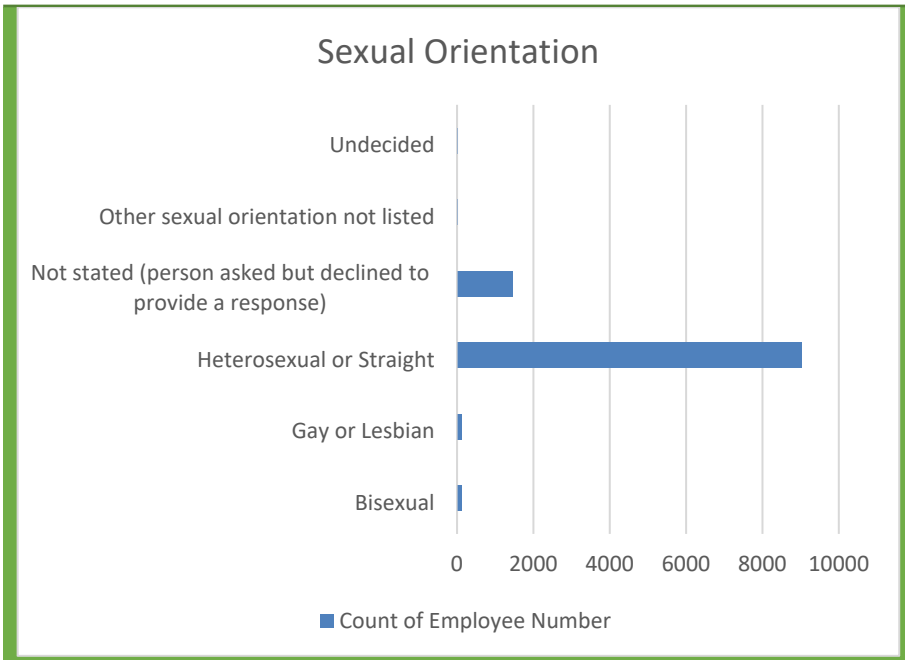
** Denotes a number less than 11, for reasons of confidentiality

Religious Belief	Count of Employee Number
Atheism	1545
Buddhism	88
Christianity	5647
Hinduism	336
I do not wish to disclose my religion/belief	1754
Islam	492
Jainism	**

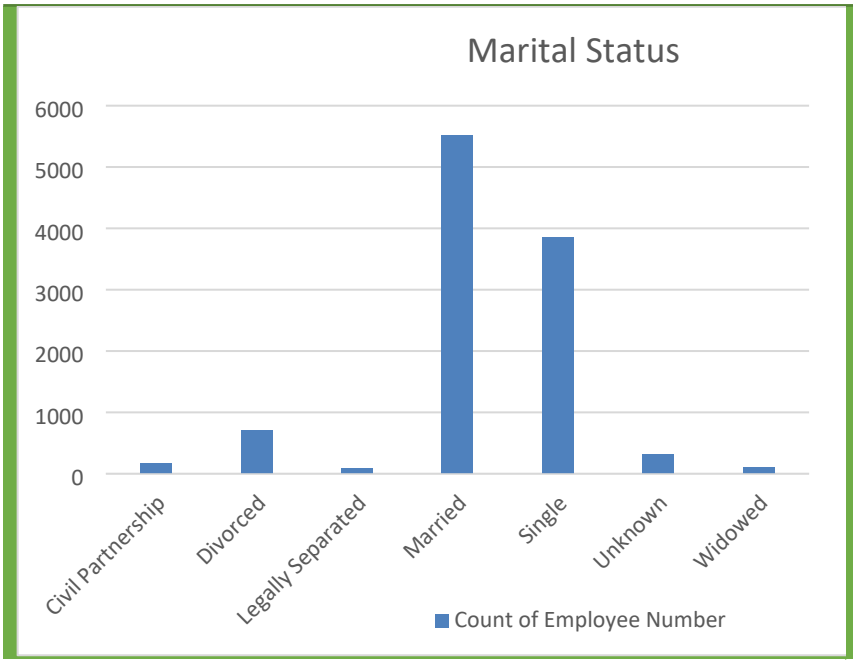
Judaism	**
Other	871
Sikhism	20
Unspecified	**
Grand Total	**10762**



	Count of Employee Number
No	9288
Not Declared	1005
Prefer Not To Answer	11
Unspecified	**
Yes	454
Grand Total	**10762**



	Count of Employee Number
Bisexual	123
Gay or Lesbian	127
Heterosexual or Straight	9025
Not stated (person asked but declined to provide a response)	1457
Other sexual orientation not listed	11
Undecided	17
Unspecified	**
Grand Total	**10762**



	Count of Employee Number
Civil Partnership	166
Divorced	715

Legally Separated	92
Married	5514
Single	3863
Unknown	311
Widowed	101
Grand Total	**10762**

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Report to:	Trust Board
Title of report:	Finance, Performance and Estates Committee Assurance Report to Board
Date of meeting:	27 June 2023
Chairperson:	Dani Cecchini, Chair
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received, and key decisions made by the Finance, Performance and Estates Committee (FPEC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme. The Committee worked to the 2022/23 objectives.
Assurances received by the Committee	**Assurance** in respect of SO 3a A modern, clean and fit for purpose environment No reports – Green Plan update was agreed to be deferred until August 2023
	Assurance in respect of SO 3b Efficient Use of Resources **Finance Report inc Efficiency, Capital, Contracts and CIRG Upward Report** The Committee received the report noting the £20.8m deficit plan for 2023/24 and was pleased to note that the Trust was on plan for month 2. The Trust had a capital plan of £37.9m for the year with £0.5m delivered to month 2 which was £1.3m behind plan. The Committee noted that this was due to Pilgrim A&E and the Community Diagnostic Centre however plans were in place for these to be brought back on track. The plan would be delivered as the Trust moved through the year and further monies would be applied for as available. The Committee noted CIP delivery of £3.9m to month 2 and was £1.5m ahead of plan. It was noted that there were income pressures due to activity levels however pay was reported as favourable to plan. The impact of industrial action by Junior Doctors was noted as impacting the Trust by £100k for each day of strikes with further action announced. It was noted by the Committee that the CIP over performance was mitigating the position in respect of income and non-pay inflation pressures as a result of excess inflation along with the cost of £100k per day that Junior Doctor strikes were held.

	The Committee noted the movement in the better payment practice code as had been advised the month prior with a slight reduction in compliance however the Trust continued to work to plan to improve the position. The PLICS report was considered in detail by the Committee noting the need to deliver the ambition of 116% however recognised the significant amount of work required to achieve this. It was clear however, through the triangulation within the report that there were opportunities to be taken forward, some of which would be transformational CIP. The Committee noted the ongoing work to ensure relevant contracts were signed for the year noting that these should be in place by the end of June. No significant financial risks were identified. The Committee received and noted the Capital, Revenue and Investment Group Upward report.
	Assurance in respect of SO 3c Enhanced data and digital capability **Digital Hospital Group Upward Report** The Committee received the report noting the content offered and the levels of assurance detailed for each of the areas discussed. It was noted that the group continued to oversee the development of the electronic patient record (EPR) and hybrid mail system. Work was underway in respect of communications for the EPR to ensure that this was socialised appropriately in the organisation before launching. The Committee noted that there had been some adjustments to the outline business case and was seeking to ensure that any changes were appropriately received and approved by the Committee and the Board where required. It was noted that there had been some issues with a software update which had had an impact on the Trust and the Committee recognised the work undertaken to not only address the issue but to develop the relationship management with the supplier to manage further updates. **Data Security Protection Toolkit (DSPT) Submission – Final position** The Committee received the report which offered the final position ahead of the DSPT submission at the end of June noting that compliance would not be met for 5 assertions as previously reported. The Committee noted that limited assurance had been offered as a result and recognised the continued improvement journey of the Trust in this area also reflecting on the requirement for specialist resource to support improvement.

	The committee requested reporting against the action plan for improvement at the regular bi monthly IG group updates.
	Assurance in respect of SO 3d Improving Cancer Services Performance **Operational Performance against National Standards** The Committee received the report noting for urgent care that there continued to be an increase in the requirement for services, some of which was impacted due to the number of bank holidays in May. Ambulance attendances had increased however there had been a reduction in the number of patients waiting greater than 59 minutes. This continued to be an issue for the Trust with work to manage the position underway. The average attendances at A&E were noted with these continuing to be significantly over the capacity for both departments at Lincoln and Pilgrim. A reduction in same day emergency care has been seen with a need to understand the position and ensure that this was working effectively. Work was also required to ensure discharges were undertaken earlier in the day to enable flow through the hospital. The Committee noted the position in respect of planned care and 78-week waits noting that the trajectory had not been achieved for March or April. The Trust was now working to a target of 125 patients waiting 78 weeks by the end of June. Work was being undertaken within the specialities to ensure that the best position was achieved with a need to ensure productivity. In respect of diagnostics the Committee noted the ranking position of the Trust at 124th out of 156. This was a significantly improved position for the Trust. The Committee noted the echocardiogram update which was offered through the report noting the improvement plan in place and the significant achievements to date which are impacting positively on the original and the revised improvement trajectory. The Committee noted the cancer performance position with an impact on faster diagnosis standards for breast. Recovery actions are being implemented to bring the position back online. An improvement had been seen in respect of the cancer backlog position with an aim to achieve 245 patients waiting by the end of June to recover the position.

	Support had been offered by the ICB for colorectal and funding had been agreed from the East Midlands Cancer Alliance to support additional posts in the Trust with a sole focus on recovery. The Committee noted the moderate assurance offered in the report reflecting that there were clear plans in place where required to deliver improvements. It was agreed however that the ratings in the BAF would remain RED until sustainable improvement was seen.
	Assurance in respect of SO 3e Reduce waits for patients who require planned care and diagnostics to constitutional standards **As reported at SO 3d**
	Assurance in respect of SO 3f Urgent Care **As reported at SO 3d**
	Assurance in respect of SO 4a Establish new evidence based models of care No reports
	Assurance in respect of SO 4c Successful delivery of the Acute Services Review No reports
	Assurance in respect of other areas: **Draft Terms of Reference and Work Programme Draft 2023/24** The Committee received the draft terms of reference and work programme accepting the proposed changes and noting further work was due to be completed on the estates and facilities reporting prior to these being approved by the Committee. **Reporting Group Terms of Reference** The Committee received the reporting group terms of reference noting the final version from the Information Governance Group would be received once approved by the group. The Committee requested that the Estates Group terms of reference be submitted to the July Committee following work to support the governance routes within estates and facilities. **Topical, Legal and Regulatory Update** The Committee received the report noting this for information and reflect that this was an informative report offering foresight on areas that should be considered. The Committee noted that the areas of interest within the report would naturally feed up to the Committee through reporting routes. This

	includes a Board checklist in respect of Elective Care Priorities for 2023/24 **Committee Performance Dashboard** The Committee received the report for information noting the limited assurance and reflecting that performance discussions had been held through the agenda items for the Committee. **Integrated Improvement Plan** The Committee received the report noting the limited assurance offered as a result of some of the measurements and trajectories for quarter 1 not yet being available. It was noted that a number of the metrics within the report did not match those within the finance report stating the need to ensure accurate and aligned reporting. Where necessary divisions were being encouraged and supported by executive directors to ensure delivery and where required escalation of areas of concern due delivery not being as expected. The Committee noted the need to remain sighted on the progress of the programmes of work reflecting that this would be considered through the report on a monthly basis. **Improvement Steering Group Upward Report inc Nurse Agency Spend Deep Dive** The Committee received the report noting that the CIP improvements had been detailed through the finance report with a number of achievements including nurse agency and bed reductions, which had been planned. The group had discussed the status of the outpatient's improvement programme which had moved from amber to red with focus to be given to the delivery of change. It was noted that the productive theatres programme was currently behind plan however work was underway to determine how the position could be recovered and mitigating actions. The Committee noted the deep dive in respect of the nurse agency spend which demonstrated a reduction in spend, the associated KPIs and what learning would be taken from this to implement this sustainably. It was noted that there was a need to strengthen the medical productivity workforce programme and there had been developments in quality improvement training to ensure this was more agile and accessible. **Internal Audit Recommendations** The Committee received the open internal audit actions focusing on those actions which were overdue and noted that these were due to be

	scrutinised by the Audit Committee to understand the position and progress. **CQC Action Plan** The Committee received the action plan and associated appendix which offered assurance of the ability to close a number of the estates actions which had remained open for some time following the submission of evidence to support this. The Committee agreed to the closure of the estates actions as detailed within the report.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	None
Committee Review of corporate risk register	The Committee received the risk register noting the risk as presented.
Matters identified which Committee recommend are escalated to SRR/BAF	No items identified
Committee position on assurance of strategic risk areas that align to committee	The Committee considered the reports which it had received which provided assurances against the strategic risks to strategic objectives.
Areas identified to visit in dept walk rounds	None

Attendance Summary for rolling 12-month period

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

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

United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*4th July 2023*
Item Number	*Item 12*

Integrated Performance Report for May 2023

Accountable Director	*Barry Jenkins, Director of Finance & Digital*
Presented by	*Barry Jenkins, Director of Finance & Digital*
Author(s)	*Sharon Parker, Performance Manager*
Report previously considered at	*N/A*

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

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

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

Executive Summary

Quality

Venous Thromboembolism Risk Assessment

Compliance against this metric has slightly decreased for the month of May and is currently at 94.27%.

Medications

For the month of May, the number of incidents reported in relation to omitted or delayed medications has decreased again from the previous three reporting periods and is at 23%. Medication incidents reported as causing harm is currently at 13.4%. A number of work programmes through the IIP continue and are currently being monitored through the Medicines Quality Group. There is a business case that has been submitted to allow 7 day working for the Pharmacy department and to provide a service to all ULHT wards. Increasing the presence of Pharmacy staff on the wards will reduce risks, improve the safety of care that the Trust provide to patients.

SHMI

The Trust SHMI has slightly increased this month and is currently at 103.08. SHMI is at the lowest level for the Trust and is 'As expected'. The Trust are currently in the process with their system partners in rolling out the Medical Examiner (ME) service for community deaths. This will enable greater learning on deaths in 30 days post discharge.

eDD

The Trust achieved 87.9% with sending eDDs within 24 hours for May 2023 against a target of 95%. A dashboard is in place to highlight compliance at both ward and consultant level with each Division now reviewing this metric at their monthly Performance Review Meeting.

Sepsis compliance – based on April data

Screening compliance Inpatient Adult / Inpatient Child – Screening compliance was at 88% for adults and 76.9% for paediatrics. Actions to recover can be seen below.

IVAB Inpatient Child - The administration of IVAB for inpatient children reduced to 42.8%. Harm reviews undertaken.

IVAB ED child - The administration of IVAB for children in ED was at 87.5% an increase from the last reporting period. Two children experienced delays however difficult cannulation was indicated in both cases.

Duty of Candour (DoC) – April Data

Verbal compliance for April was at 96% against a 100% target and 88% for written against a target of 100% within the reporting period. The Clinical Governance team continue to notify clinical teams when a moderate harm or above incident is reported and supporting Duty of Candour completion. Weekly Duty of Candour compliance reports are sent to Divisional Triumvirate and CBU's and performance is included in monthly divisional governance reports.

Operational Performance

At the time of writing this executive summary (20th June 2023), the Trust has 8 positive COVID inpatients with no patients requiring Intensive Care intervention. The May peak was 32 patients. The current Influenza inpatients are 0 with the peak in May being recorded at 2 patients versus 826 tests completed. RSV peaked at 1 patient in May versus 263 tests completed, but as of the date of this report there are zero confirmed. There are also currently 0 patients confirmed Norovirus but 5 were recorded in May.

This report covers May's performance, and it should be noted the demands of Wave 7 have now decreased with the number of positive COVID cases remaining relatively static. The teams across the organisation continue to transition to 2023/24 and the recovery of waiting times and continues to return pre-Covid access.

A & E and Ambulance Performance

The 23/24 4h-hour performance target has been set for yearend achieving 76% with a rolling monthly ambition to track achievement. May has met its target by a positive 3.09% but is a deterioration in performance of 2.49% compared to April. Overall, against the target of 57.01 against the target of 53.92%. The SPC chart below documents both the 22/23 and 23/24 target to reflect performance ambition. This trajectory is based on Type 1 and co-located Type 3 activity. Combined type 1 and type 3 activity is demonstrating an achievement of 71% against the overall position. The Informatics Team are working through how this is communicated more systematically within this report going forward.

There were 798 12-hr trolley waits, reported via the agreed process in May. This represents an increase of 133 patients from April 2023 (665). Sub-optimal discharges/timely recognition to meet emergency demand remains the root cause of these delays.

Performance against the 15 min triage target demonstrated a deterioration of 5.95% against April performance of 81.60% compliance. May reported a compliance of 75.655. This is lowest compliance since January 2023. A deeper review is required of patients who leave the department or refuse treatment that compromise this performance target.

There were 541 >59minute handover delays recorded in May, an increase of 101 from April. This represents 12.35% of arrivals waiting over this timeframe, a 1.51% deterioration to the previous month. The trust experienced an increase of 321 conveyances (4,380) compared to April (4,059). Following new standards, the <15Min handover performance for May showed an 12.07% compliance which equated to 3,831 crews waiting over the desired timeframe.

Length of Stay

Non-Elective Length of Stay against the agreed target is not being achieved. Current performance is 4.87 days against an agreed target of 4.5 days but is an improvement of 0.25 days compared to April. The average bed occupancy for May against "Core G&A" was an average of 94.13%, with PHB demonstrating the highest level of occupancy against core. May saw an average of escalation beds open to maintain adequate and safe flow within the acute sites. By doing so the occupancy vs escalation brought a safer percentage of 91.48% against the new national standard of 92%
System Partners were challenged with identifying timely support to facilitate discharge from the acute care setting for pathways 1 to 3. Pathway 1 saw a decreased length of stay by 0.3 days compared to March 2023. Pathway 2 also demonstrated a decrease in length of stay by 1.0 days but pathway 3 saw an increase of 2.3 days.

Elective Length of Stay increased to 3.07 days compared to 2.87 days in April. The target is 2.80 days.

Referral to Treatment

March demonstrated a deterioration in performance of 1,42%. April outturn was 48.87% versus 50.29% in March. The Trust is now reporting patients waiting over 65 weeks as opposed to 52 weeks. The Trust reported 2,122 patients waiting over 65 weeks, which is a decrease of 84 patients on the reported March position. The position requires close monitoring and scrutiny.

At the end of May, the Trust reported 2 patients waiting longer than 104 weeks. Both of these were due to complex pathways involving other Trusts for specialist input. Discussions are taking place with NHSE weekly in regard to 104- and 78-week waiters with month end figure May at 304 including first definitive treatment due the impact of the Junior Doctors strike action.

Waiting Lists

Overall waiting list size decreased slightly in April. April reported 73,379 compared to March's position of 73,514 an decrease of 135. Work continues between Outpatient department and the Clinical Business Units regarding returning better access to our bookable services for primary care and patients' choice.

The recovery plan for ASIs has been developed, including a recovery trajectory. As of 15th May, ASI recovery has demonstrated a slight improvement (1,225 verses 1,656 in April) and is more in line with the agreed trajectory of 550. Additional resource has been directed to resolving missing outcomes which is having an adverse effect on the bookings team being able to move the ASIs to open referrals.

DM01

DM01 for April reported an improvement of 4.34% 66.10% in May verses 61.76% in April. Compliance against the national target of 99%. A positive variation of 4.34% on the April outturn but a negative variance of 32.90% against the nationally agreed target. Whilst the main area of concern remains Echocardiography, a continued month on month improvement is noted. DEXA backlog has reduced to 593 in May compared to 617 in April. Endoscopy backlog due to outpatient recovery, in particular, colorectal. This will be supported by the continued utilisation of Medinet.

Cancelled Ops

May outturn for cancelled operations on the day demonstrated a slight deterioration at 1.21% versus 0.1.05% in April.

The target for not treated within 28 days of cancellation is zero. May experienced 11 breaches against the standard verses 14 in April. This target continues to demonstrate month on month improvement.

Again, this is the lowest position reported since December 2021. The continuous review of the effectiveness of the 6:4:2 theatre scheduling meetings continues and ICU capacity as a response to internal and external pressures is improving so it is likely that performance will continue to improve.

Cancer

Trust compliance against the 62day classic treatment standard is 55.71% (against 85.4% target.) This demonstrates an improvement of 0.63% in performance since the last reporting period and is 29.69% below the nationally agreed compliance target. This is the highest compliance against the target since August 2022. However, the position against the Trust recovery trajectory is just in line.

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

104+ day waiters have reduced and are achieving the agreed trajectory. There are currently 82 patients waiting >104 days against a target of <10. The current figure is a decrease of 16 patients since the last reporting period. The highest risk speciality is colorectal with 36 pathways greater than 104 days, this a further reduction of 16 since the last reporting period. 3 times weekly meetings are in place to offer challenge and confirm.

28-day Faster Diagnosis Standard (FDS) has declined due to specific issues related to the Breast Service. Work is in trains to recover the position, but this deterioration has been noted nationally and is a cause of concern.

Workforce

Mandatory Training – The mandatory training rate for May 2023 has seen a slight increase when compared to April 2023 (by 0.39%) to 90.56%, against a 95% target. Work is ongoing to ensure that all areas and individuals are given the time to complete core learning modules. Work is being undertaken to support low compliance, particularly those at 50% and less. This has been communicated Divisionally and action is being taken to address locally, with the aid of a new report produced by the Education & Learning Team within our People & OD Directorate. A number of support measures are being implemented in terms of ESR user support, including the provisions of 'pop-up' core learning sessions for departments and individual users requiring additional input. The Mandatory Training Action Plan has been approved and work is underway to improve our mandatory training compliance. The review of all core and topics has been completed and changes will be made to the core and core + offer moving forward, with consideration as to whether training needs could be aligned individually to roles.

Sickness Absence – Sickness absence rates have remained stable over April 2023 (5.57%) and May 2023 (5.56%), but remains above the target of 4.50%. The Trust is approaching its lowest vacancy level over the past two years and as such, we are hopeful this continued improvement will impact positively on our colleagues health and wellbeing. Nonetheless, our sickness average remains above target, consideration in respect of this target being achievable needs discussion and consideration. Further work to support managers and leaders in absence processes and supporting our people to attend the work environment will be delivered through the mandated 'Basics Brilliantly' workshops which is one of our actions following this year's annual staff survey results. We are hopeful to commence our journey towards a "supporting attendance" approach as opposed to managing absence by continuing to signpost staff to health and wellbeing services and working closely with Divisions to understand absence trends.

Staff Appraisals – Ongoing service pressures and staffing challenges in the Trust continue to impact appraisal completion rates but month on month there is a slight improvement with an increase this month to 67.93% non-medical and an increase to 98.24% for medical. We are continuing to recommend that a 90 minute appraisal for each colleague is planned for as we enter 2023/24. Following an audit completed in Urgent & Emergency Care we identified that a number of colleague's appraisals had been completed in the past 12 months within WorkPAL, however were not recorded on ESR. Work is underway to educate leaders on the process required to update ESR, even for ones done on WorkPAL already. This will include 'how to' guides/sessions and utilising reporting to identify areas of low completion. During June 2023 our OD Managers will be writing to staff who have not had an appraisal and pro-actively encouraging them to approach their Line Manager to ensure one is planned/completed.

Staff Turnover – Turnover has seen a slight decrease in May 2023 (13.01%) when compared to April 2023 (13.23%) against a target of 12%. The increase in April 2023 was expected due to the impact of financial year end leavers e.g. fixed term contracts etc. Operational pressures, staffing and culture challenges mean that a regular proportion of staff are looking for other avenues outside the Trust. The People Promise Manager continues to work with the Trust and ICB to explore retention and bring best practice into the organisation to address the challenges in support of the System Plans. We are working towards a more robust reporting process via ESR to capture leavers data and understand trends.

Vacancies – We have seen a continued reduction in our vacancy rate since its highest rate in June 2022 (12.0%). May 2023 saw a 0.96% decrease in our vacancy rate to 6.73%. We need to keep an ongoing focus on HCSWs over the coming months to backfill those IENs achieving NMC status. We may see an increase in our vacancy factor over the next month due to sizeable business cases for Community Diagnostics and Housekeeping being signed off which will increase our funded establishment, however despite this due to significant recruitment our net staffing position will continue to grow. Our Medical & Dental Vacancy is now as low as 2.1%, and our nursing vacancy factor is at 7% and we are on target to completely remove these vacancy factor by September 2023.

Finance

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

The Trust delivered a deficit of £4.6m YTD in line with plan.

CIP savings of £3.9m have been delivered YTD, which is £1.5m favourable to planned savings of £2.4m.

Capital funding levels for 2023/24 have been agreed with NHSE and system partners; the Trust delivered capital expenditure of £0.5m YTD which is £1.3m lower than planned capital expenditure of £1.8m.

The May cash balance is £51.0m; this is an increase of £9.7m against the March year-end cash balance of £41.3m

Barry Jenkins
Director of Finance & Digital
June 2023

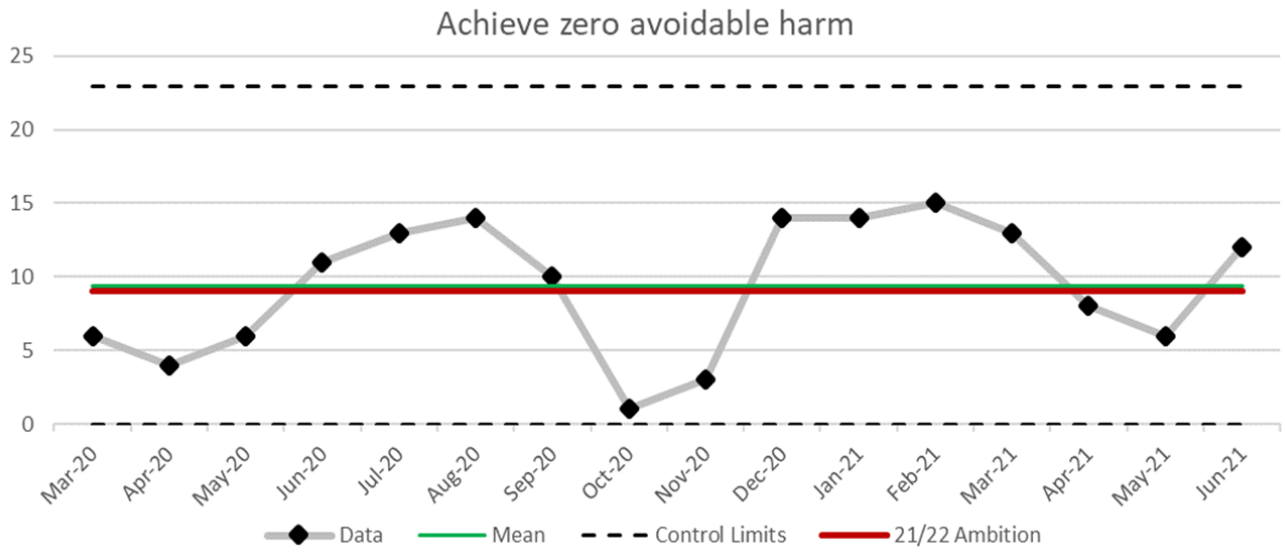
Statistical Process Control Charts

Statistical Process Control (SPC) charts are an analytical tool that plot data over time. They help us understand variation which guides us to make appropriate decisions.

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

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

An example chart is below:



Statistical Process Control Charts

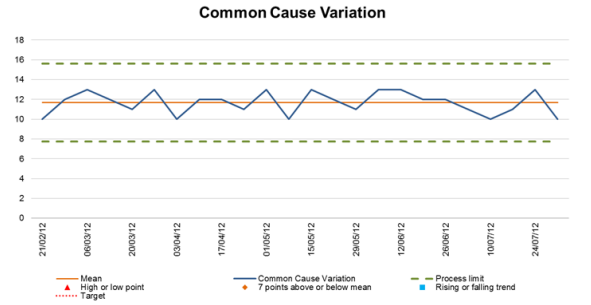
Normal variations in performance across time can occur randomly- without a direct cause, and should not be treated as a concern, or a sign of improvement, and is unlikely to require investigation unless one of the patterns defined below applies.

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

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

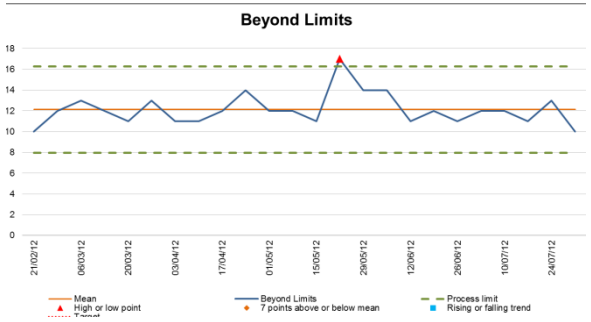
Icons are used throughout this report either complementing or as a substitute for SPC charts. The guidance below describes each icon:

Normal Variation



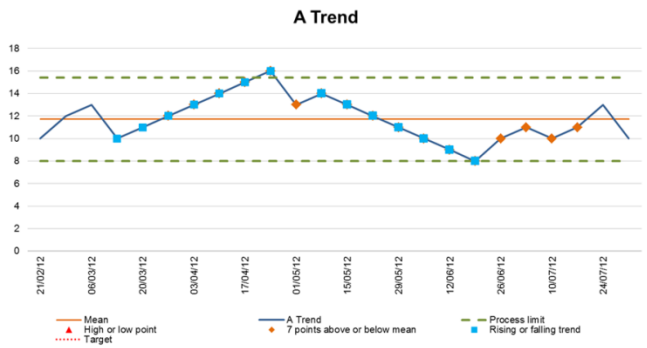
Extreme Values

There is no Icon for this scenario.

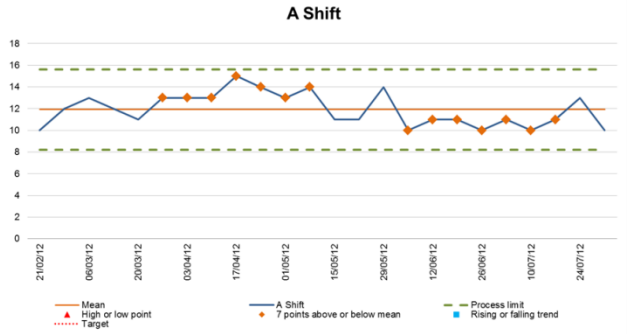


Statistical Process Control Charts

A Trend (upward or downward)



A Trend (a run above or below the mean)



Where a target has been met consistently

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

Where a target has been missed consistently

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

EXECUTIVE SCORECARD

Measure ID	Domain	Measure	Measure Definition	SRO	2022/23 Ambition	Tolerance	£'000	Mar-23	Apr-23	May-23	Latest month pass/fail to ambition/ tolerance	Trend variation
1	Patients	Implementation of SAFER Bundle – LOS > 7 Days pathway 0	Non-elective stranded patients with LoS over 7 days as a percentage of total non-elective LoS, just for pathway 0 patients.	COO	10.00%	1.00%		12.50%	12.30%	10.41%	P	
2	Patients	SHMI performance	Summary Hospital-level Mortality Indicator. National data published by NHS Digital is for rolling 36 month period ending 5 months prior to current month	MD	100	5 points		3rd Quartile (102.92 (69th of 121)	3rd Quartile (102.67 (67th of 121)	3rd Quartile (103.08 (72nd of 120)	P	
3	Patients	Reduction in moderate and severe harm and death incidents	Serious incidents (including Never Events) of harm - Moderate, severe and death - per 1000 OBD	DoN	0	0.17		0.34	0.33	0.12	P	
5	Patients	Reduction in medication incidents leading to moderate & severe harm or death	Total number of Medication incidents reported as causing harm (moderate /severe / death) - per 1000 OBD	DoN	0	0.07		0.03	0.03	0.15	F	
6	Patients	Reduction in DKA incidents resulting in moderate & severe harm or death	Total number of DKA incidents reported as causing harm (moderate /severe / death) - per 1000 OBD	MD	TBD	TBD		0.00	0.00	0.00		
7	Patients	Achievement of the IPC BAF	% of green/compliant items from the IPC COVID BAF C1501 v1.8 (quarterly)	DoN	95.00%	1.00%					P	
8	Services	Financial Plan	Variance aganst plan (£'000)	DoF	£0	£0	£'000	(258)	10	3	P	
9	Services	Percentage of patients spending more than 12 hours in department	Number of Patient ED attendances waiting more than 12 hours from arrival to transfer, admission or discharge as a percentage of ED attendances.	COO	1.00%	5.00%		15.45%	12.43%	14.57%	F	
10a	Services	Patients waiting 52 weeks or more	Number of patients waiting 52 weeks or more (RTT pathways)	COO	503	100		6,870	7,174		F	
10b	Services	Patients waiting 65 weeks or more	Number of patients waiting 65 weeks or more (RTT pathways)	COO	TBD	TBD		2,206	2,122			
11	Services	28 days faster diagnosis	Number of patients diagnosed within 28 days or less of referral as a percentage of total Cancer pathways.	COO	75.00%	5.00%		66.98%	57.84%		F	
12	People	Improved vacancy rates	Total vacancy rates including all staff groups.	DoPOD	8.50%	1.00%		6.91%	7.69%	6.73%	P	
13a	People	Appraisal rates and training development **(Appraisal Rates)**	Total appraisal rates including all staff groups.	DoPOD	90.00%	2.00%		65.95%	67.19%	67.93%	F	
13b	People	Appraisal rates and training development **(Core Learning)**	Overall Core learning including all staff groups	DoPOD	95.00%	2.00%		89.18%	90.17%	90.56%	F	
14	People		Improvement in the % of people rating their likelihood of referring the Trust to Friends and Family (Agree & Strongly Agree)	DoPOD	55.00%	5.00%						
16	Partners	Increased recruitment/academic posts (across the ICS)	Number of posts appointed	DII	10	2						
18	Partners	Early Warning Discharge Indicators	Non-elective stranded patients with LoS over 7 days as a percentage of total non-elective LoS, for pathway 1-3 patients.	COO	50%	10.00%		74.90%	74.85%	73.07%	F	

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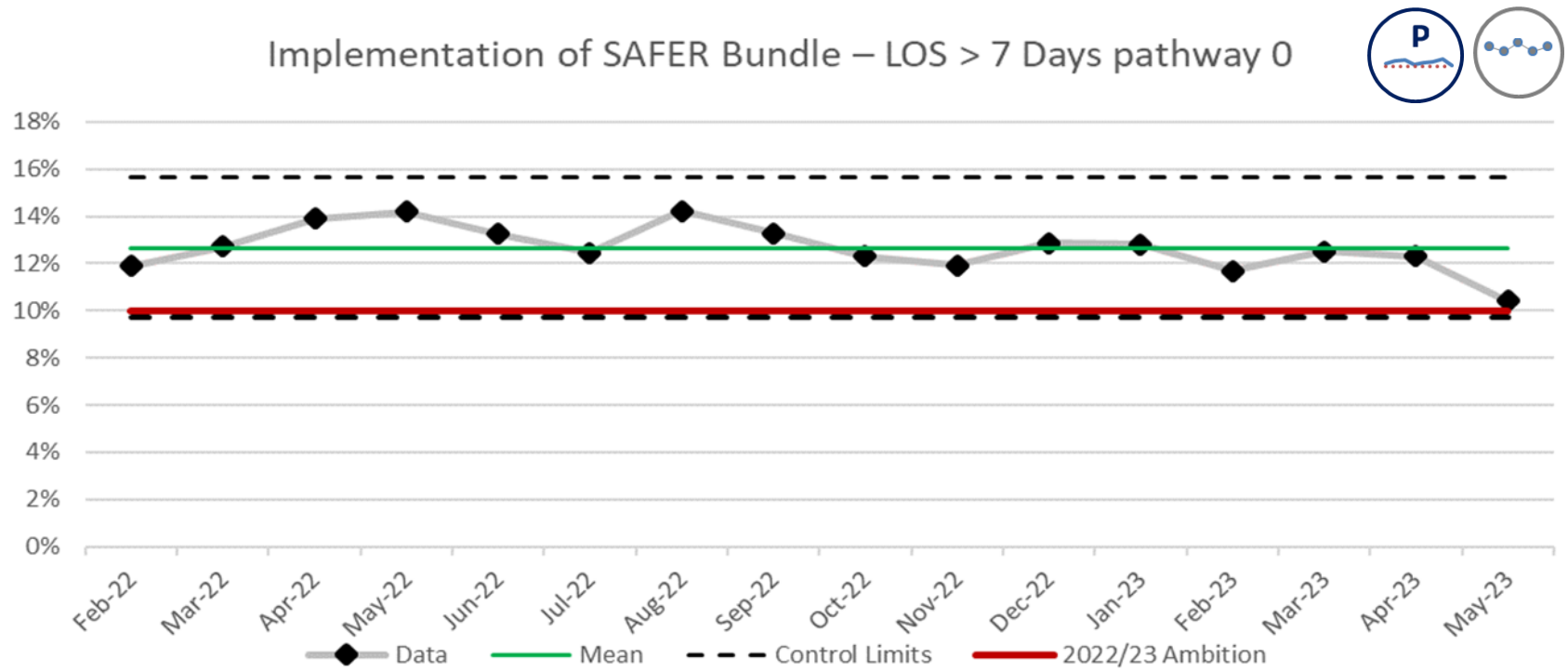

May-23
10.41%
Variance Type
Metric is currently experiencing Common Cause Variation
2022/23 Ambition/Tolerance
10% with 1% tolerance
Achievement
Metric has passed within tolerance but failing to ambition
Executive Lead
Chief Operating Officer

Background:

Non-elective stranded patients with LoS over 7 days as a percentage of total non-elective LoS, just for pathway 0 patients.

What the chart tells us:

Whilst not achieving the ambition of 10%, improvements are being realised and currently reports at 10.41% which is a marked improvement.
What the chart isn't telling is that the average time from medically Optimised to discharge for Pathway 0 in May was 0.1 days

Issues:

Numbers of stranded and super stranded patients has increased across all 3 Acute Sites.
Higher acuity of patients requiring a longer period of recovery post Winter Impact, and complexity of post hospital care.
Medical outliers have reduced overall but reduced medical staffing has led to delays in senior reviews.
During April ULHT saw a number of areas impacted due to IPC intervention against Norovirus – delaying review/discharge.

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

Actions:

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

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

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

Mitigations:

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

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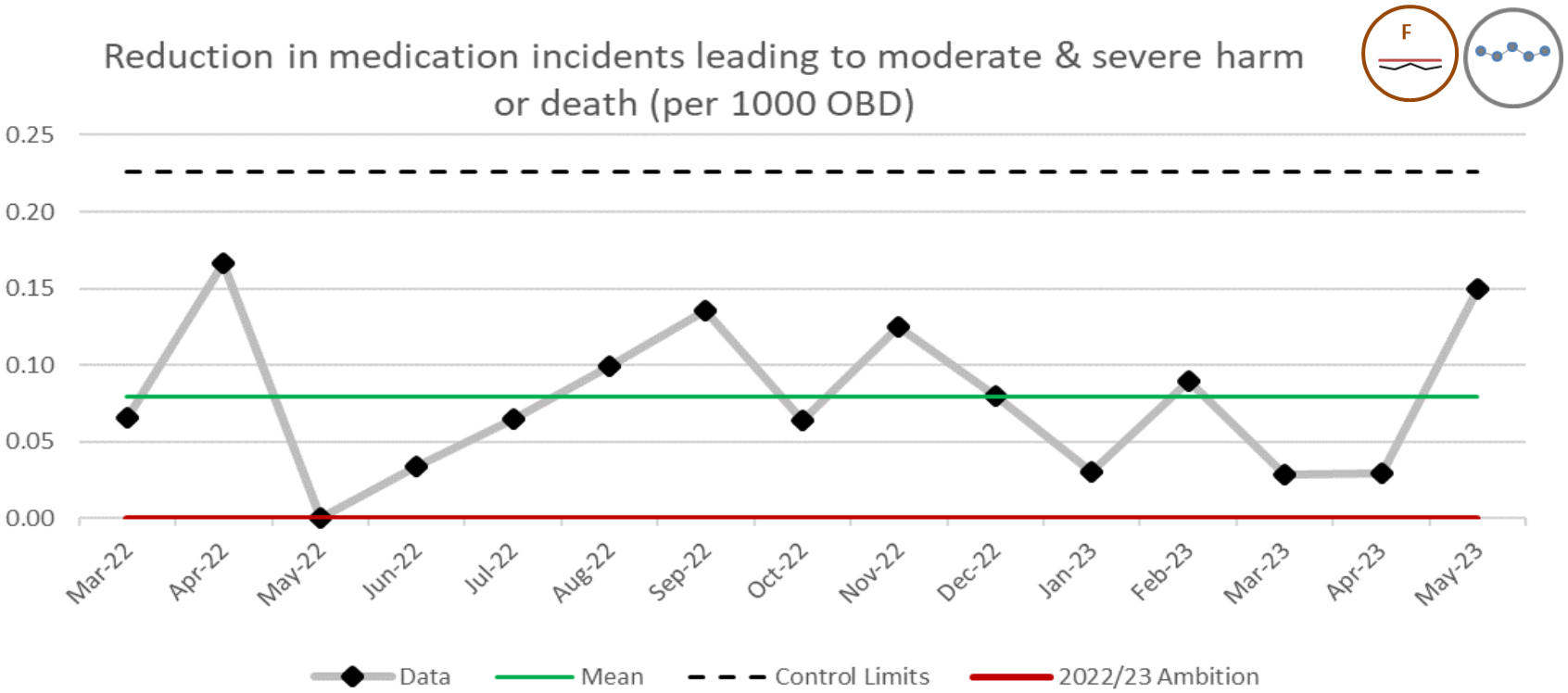

May-23
0.15
Variance Type
Metric is currently experiencing Common Cause Variation
2022/23 Ambition/Tolerance
0 with a 0.07 tolerance
Achievement
Metric is failing to ambition
Executive Lead
Director of Nursing

Background:
Total number of Medication incidents reported as causing harm (moderate /severe / death) - per 1000 OBD

What the chart tells us:
In the month of May the number of Medication incidents per 1000 bed days was 0.15. This is an increase from the April figure of 0.06

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

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

Mitigations:

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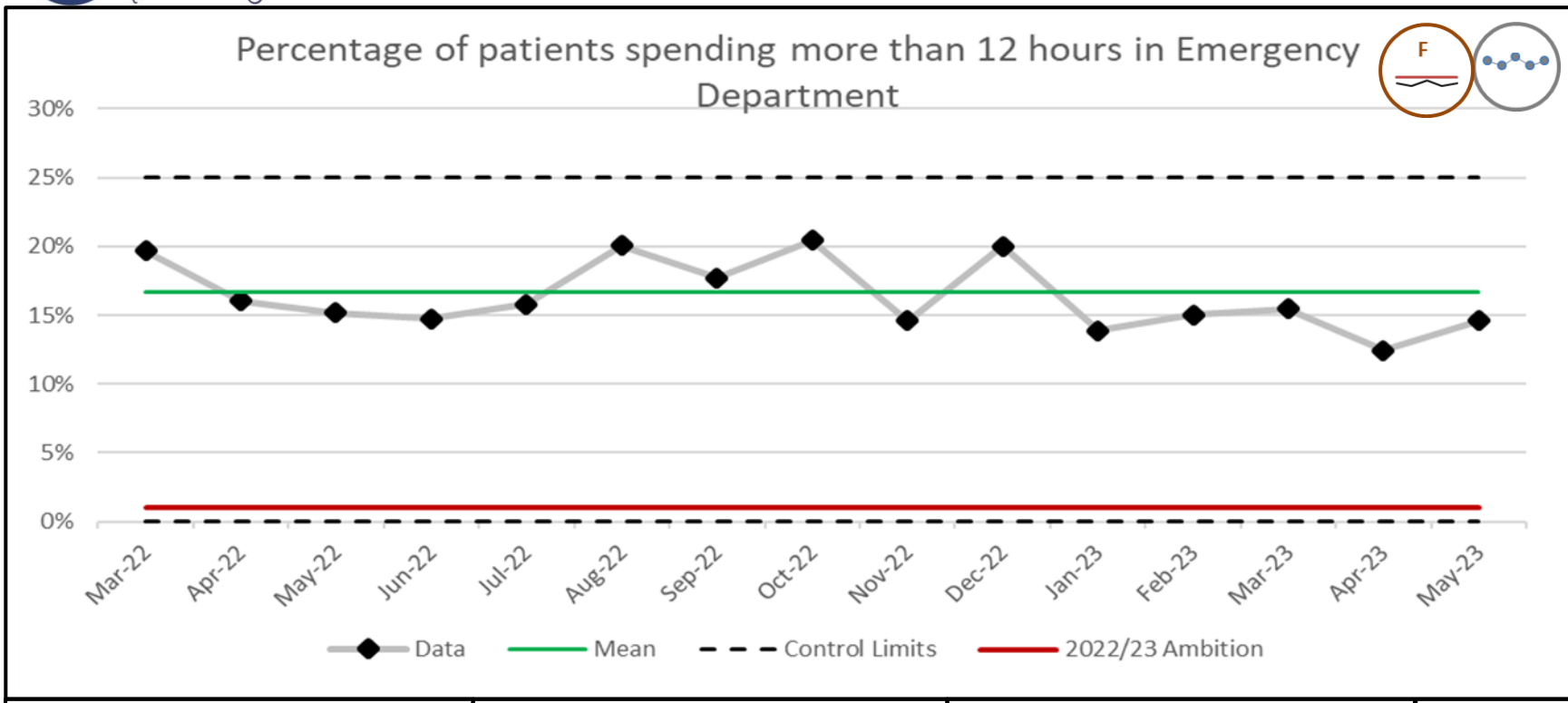

May-23
14.57%
Variance Type
Metric is currently experiencing Common Cause Variation
2022/23 Ambition/Tolerance
1% with 5% tolerance
Achievement
Metric is consistently failing to ambition
Executive Lead
Chief Operating Officer

Background:

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

What the chart tells us:

May experienced an increase in the numbers of patients with an aggregated time of arrival greater than 12 hours against total attendance. 1,759 compared to 1,486 in April.
What the chart doesn't tell us is that 628 went over 24hrs, with the longest at 47.17hrs hours. Compared to 463 over 24hrs in April 23 and longest at 43 hours.

Issues:

May experienced a 6.37% increase in Type 1 attendances to ED compared to April 23. This increase in Emergency Department attendances resulted in 151 more non-elective admissions. However the main factor contributing to the delays still seen, is due to inadequate discharges from exit block/ timely recognition of discharges to meet the demand and flow. Increased number of patients experiencing an elongated LOS due to requiring non acute admission but requiring access to an alternative health care setting such as domiciliary care, transitional care, community hospital and Adult Social Care. The establishment of a joint health and social care off for domiciliary care is in place and capacity to access this is increasing.
Delays in time to first assessment contribute to the clear formulation of a treatment plan, especially out of hours.

Actions:

Reduce the burden on the Emergency Department through maximising discharges in the morning to create flow and reduce exit block.
Implementation of the revised Full Capacity Protocol (+1on every adult inpatient area)
Use of alternative pathways such as the UTC, CAS, SDEC, FAU and SAU.
Direct access via EMAS to Community and transitional care facilities established and now in place to SDEC, FAU, SAU, GAU and Virtual Wards
Zero tolerance to escalate any and all SDEC areas
The impact will be monitored through the Capacity Meetings and Executive oversight.

Mitigations:

EMAS have enacted a targeted admission avoidance process which includes non-conveyance of any Category 4.
The Discharge Lounge at LCH and PHB continue to operate a 24/7 service provision to release the burden placed on the Emergency Department at in terms of patients awaiting AIR/CIR, failure to resolve +1 and transport home. Although planned closures of the Discharges Lounges were put in place in October, to support the 'Breaking the Cycle' a 24/7 provision has remained in place.
Increased CAS and 111 support especially out of hours have been further enhanced.
Clinical Operational Flow Policy adherence and compliance and Full Capacity Protocol activation against a revised protocol.

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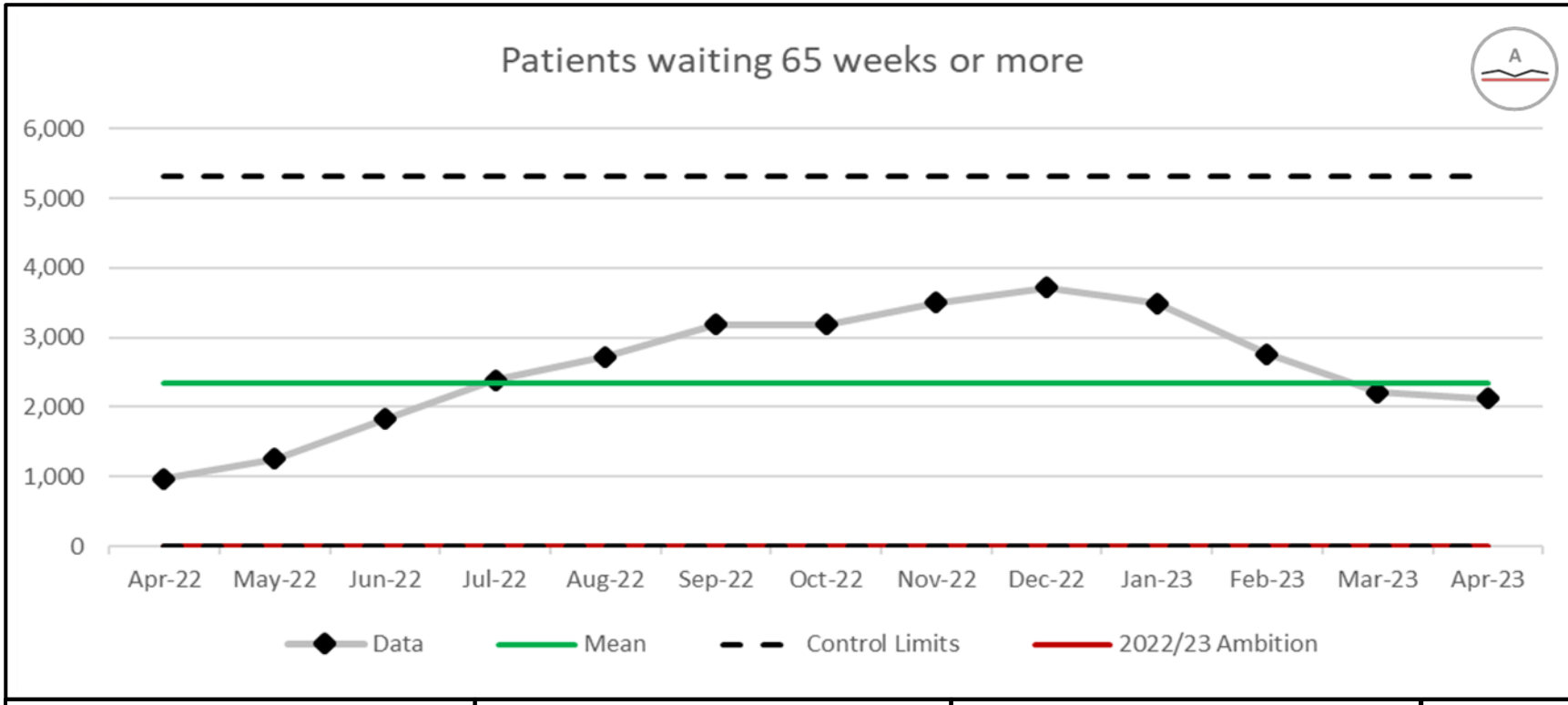

Apr-23
2,122
Variance Type
Metric is currently experiencing Special Cause Variation – Above the mean
2022/23 Ambition/Tolerance
TBD
Achievement
Executive Lead
Chief Operating Officer

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

What the chart tells us:
The Trust reported 2,122 incomplete 65-week breaches for April 2023, a decrease of 84 from March 2023's 2,206.

Issues:
Whilst ULHT's position is strong with 104 week wait patients, with 5 patients reported for April; performance is less assured with 65 week waiters. Both admitted and non-admitted patients sit within this backlog, however, the most significant pressure remains in the non-admitted pathways. The doctors scheduled industrial action will have a detrimental effect on performance.

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

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

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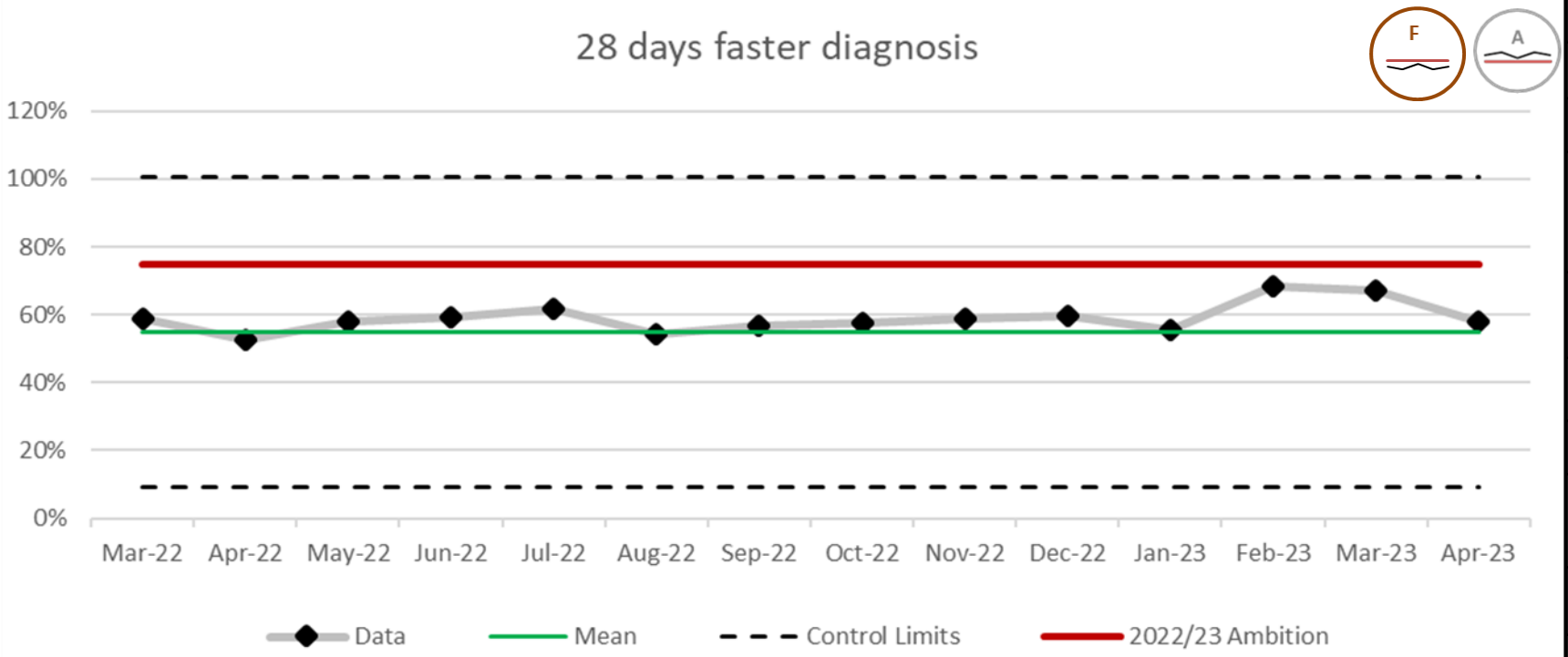

Apr-23
57.84%
Variance Type
Metric is currently experiencing Special Cause Variation – Above the mean
2022/23 Ambition/Tolerance
75% with 5% tolerance
Achievement
Metric is consistently failing to ambition
Executive Lead
Chief Operating Officer

Background:

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

What the chart tells us:

We are currently at 57.84% against a 75% 2022/23 ambition with a 5% tolerance.

Issues:

The impact of ongoing pathway, staffing and capacity challenges.
Patients not willing to travel to where our service and / or capacity is.
2ww OPA capacity in high volume tumour sites such as skin, breast, gynaecology and lung (see 2ww Suspect).
Diagnostic capacity challenges and clinical review capacity.

Actions:

28 Day standard identified as Trust's cancer performance work stream in the Integrated Improvement Program.
Recruitment to vacant CNP post focus on clinical reviews below 28 days is currently on hold until potential re-banding and substantive funding is in place.
Recruitment is underway in Respiratory, ENT and Haematology specialties to improve Consultant availability and clinical review capacity.
Theatre capacity for Urology diagnostics remains a challenge – work to increase this capacity and reduce bottlenecks is ongoing. Daily Diagnostic Huddles have been implemented within the Urology CBU.
Diagnostic capacity for TPGA is due to implemented at GK imminently now that equipment has been relocated and in Louth from June 2023.
Radiology – Bed capacity for Interventional Radiology patients at PHB.
Development of OR theatre recovery unit to allow the service to recover its own patients. Constant shortfall of CTC reporting sessions (10 sessions needed, currently running 6-7).

Mitigations:

Haematuria Pathway – One-Stop has not improved but GK STT slots have been offered and are pending a start date.
A process is now in place to ensure the Pre-Diagnosis CNS is made aware of patients who are likely to be non-compliant or in need of support at the time of receipt of referral to allow for early intervention / support. However, the Pre-Diagnosis Team workload continues to be impacted by an increasing backlog.
Intensive Support Meetings are taking place twice weekly to understand and resolve the themes and issues in 28 day FDS performance in a number of tumour site specialties.
The radiology clinical lead is looking at job plans to support and improves CTC reporting capacity.
Navigator SOP being developed in conjunction with Colorectal CBU that can and will be introduced and utilised by other Divisional specialties to support escalation processes.

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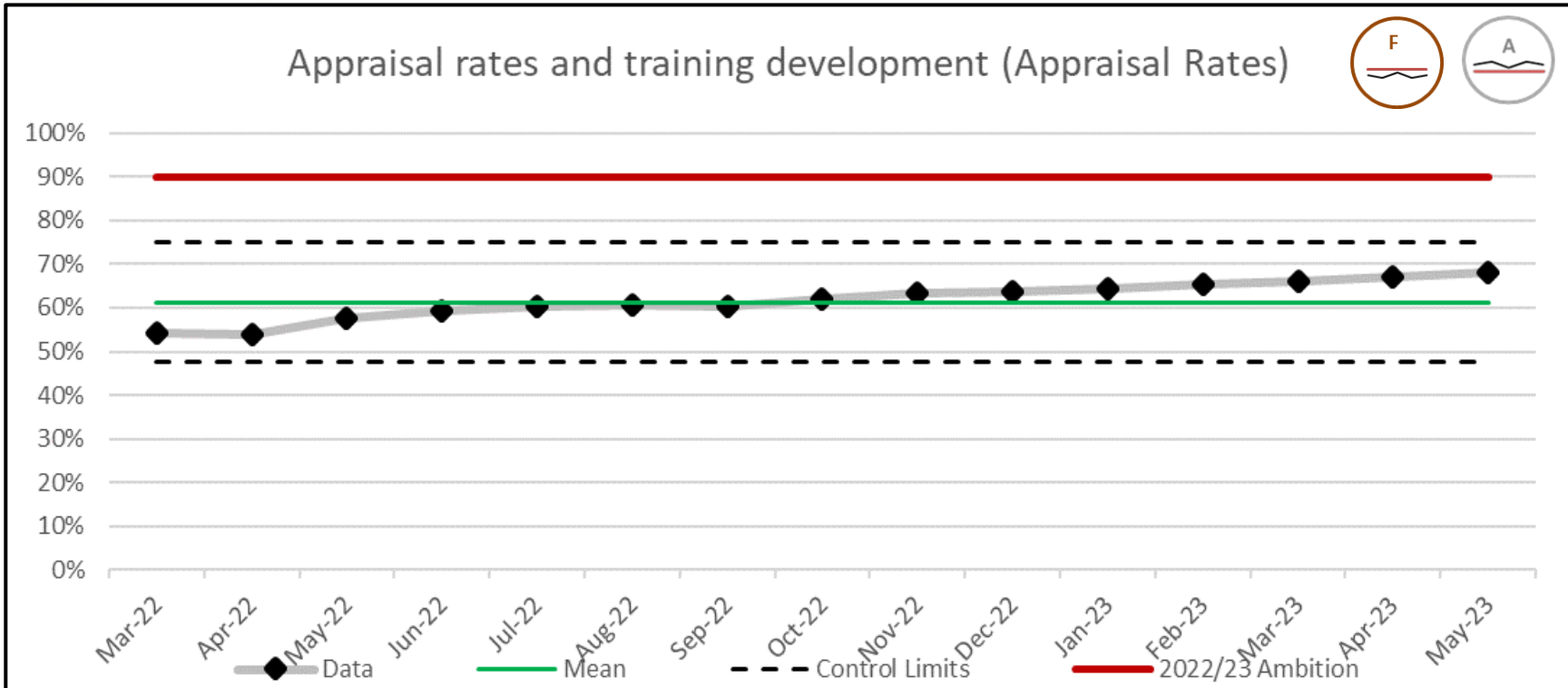

May-23
67.93%
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
2022/23 Ambition/Tolerance
90% with 2% tolerance
Achievement
Metric is consistently failing to target
Executive Lead
Director of People and OD

Background:
% completion is currently 67.93% **(non-medical)**

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

Issues:

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

Actions:

- Launching 90 minute appraisal 'how to' sessions to improve overall compliance.
- Ensuring that all completed appraisals have been captured in ESR.
- Raising awareness of the importance of an appraisal with a focus on areas of low compliance.
- During June 2023 OD Managers will write to staff without a completed appraisal asking them to raise with their line manager.

Mitigations:
See actions

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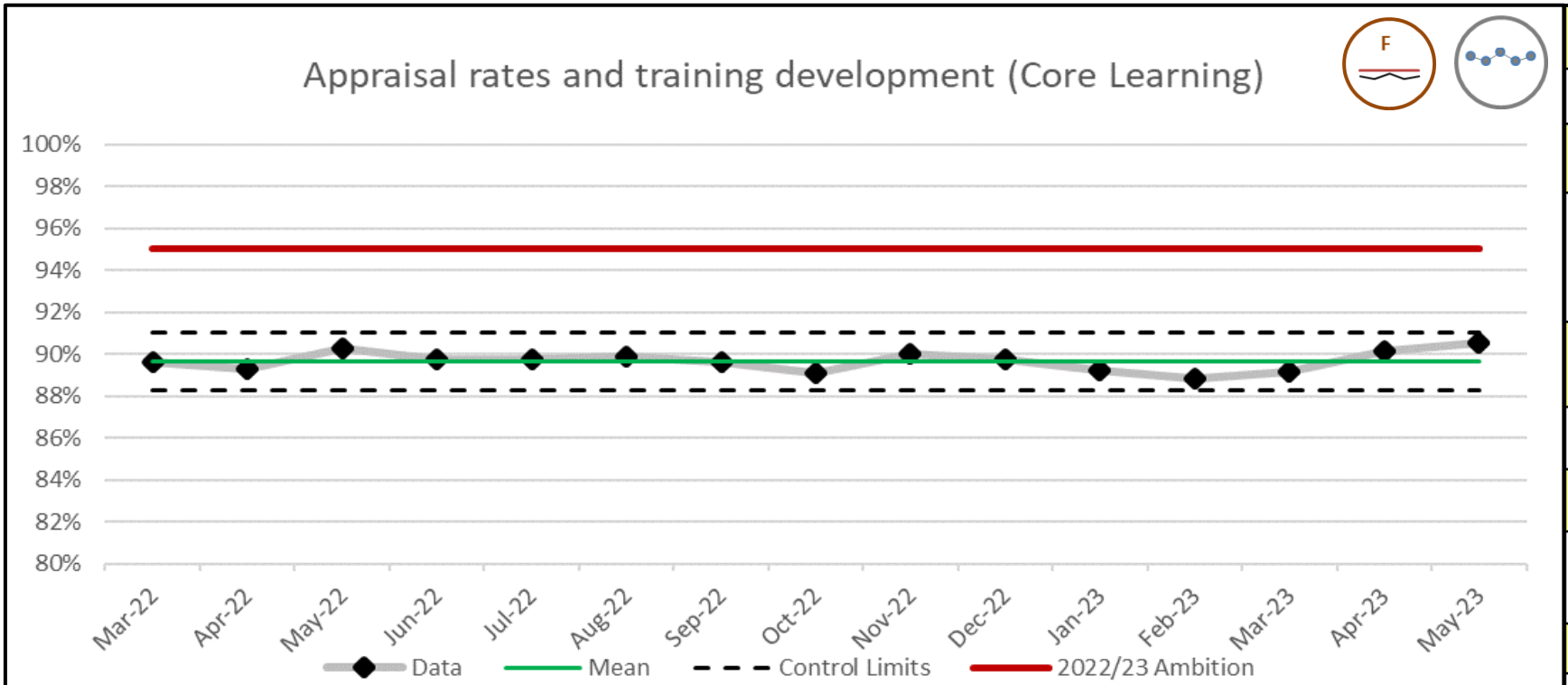

May-23
90.56%
Variance Type
Metric is currently experiencing Common Cause Variation
2022/23 Ambition/Tolerance
95% with 2% tolerance
Achievement
Metric is consistently failing to target
Executive Lead
Director of People and OD

Background:
% completion is currently 90.56%

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

Issues:
- Protected time for core learning continues to be an issues, particularly clinical staff.
- Junior Doctor Induction different to that of all other staff affecting overall core compliance.
- Training profiles are not aligned on an individual/role basis meaning some staff groups are undertaking training which is not required to perform their role.

Actions:
- A protected learning time policy is being created to support the completion of appraisals and core learning, in turn also increasing the associated compliance rates.
- Core learning offer now aligned to the national Core Skills Training Framework (CSTF).
- Core + offer has been reviewed.
- Each core + module is now being remapped as appropriate to role as opposed to position level.

Mitigations:
Improvement Action Plan

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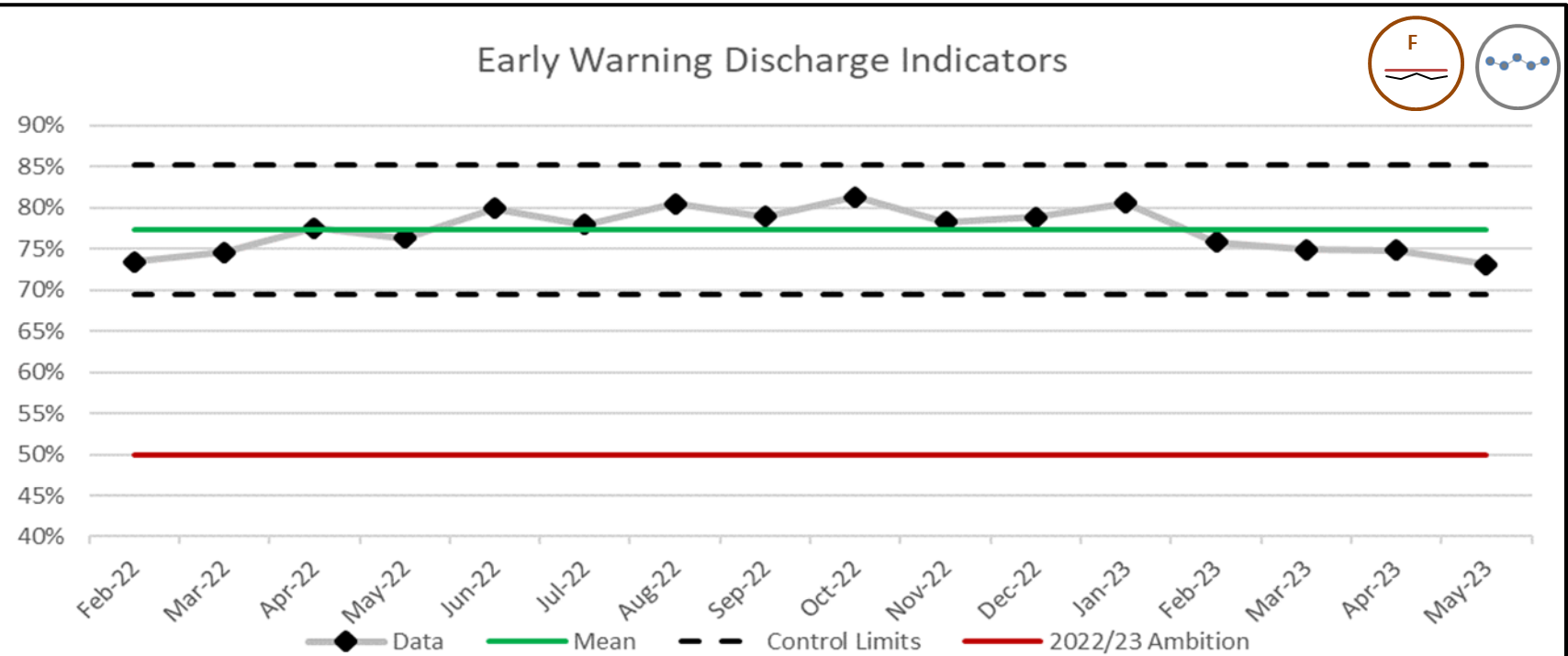

May-23
73.07%
Variance Type
Metric is currently experiencing Common Cause Variation
2022/23 Ambition/Tolerance
50% with 10% tolerance
Achievement
Metric is consistently failing to ambition
Executive Lead
Chief Operating Officer

Background:

Non-elective stranded patients with LoS over 7 days as a percentage of total non-elective LoS, for pathway 1-3 patients.

What the chart tells us:

The Trust is currently at 73.07% against a 50% 2022/23 ambition. This is a increase in performance of 1.78% compared to April 23, but a 23.07% negative variance against the ambition.

What the chart doesn't tell us is that the most improvement seen is within Pathway 1 and 2. Pathway 1 capacity had increased since the on boarding of Homelink.

Issues:

Numbers of stranded and super stranded patients demonstrated a slight decrease.
Super by 0.79% and stranded by 1.29%

The decrease in volume of bed days is Pathway 1 and is attributed to increased access due to additional funding and capacity benefits but there remains insufficient capacity to meet the increasing demand.
The Transfer of Care Hub continue to gain more traction on moving discharges forward at an improved pace.

Actions:

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

Mitigations:

A rolling programme of MADE has been agreed and the frequency has been agreed as an 8-week rolling programme. This is working well.

Increased Transfer of Care Hub workforce has been approved and recruitment has been successful to apply a continued focus across the 7 day period.

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PERFORMANCE OVERVIEW - QUALITY

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target per month	Mar-23	Apr-23	May-23	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Clostridioides difficile position	Safe	Patients	Director of Nursing	9	5	2	9	11	P	
	MRSA bacteraemia	Safe	Patients	Director of Nursing	0	0	0	0	0	P	
	MSSA bacteraemia cases counts and 12-month rolling rates of hospital-onset, by reporting acute trust and month using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.01	0.02	0.01	0.02		
	E. coli bacteraemia cases counts and 12-month rolling rates, by reporting acute trust and month using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.01	0.04	0.01	0.03		
	Catheter Associated Urinary Tract Infection	Safe	Patients	Director of Nursing	1						
	Falls per 1000 bed days resulting in moderate, severe harm & death	Safe	Patients	Director of Nursing	0.19	0.04	0.04	0.04	0.04	P	
	Pressure Ulcers category 3	Safe	Patients	Director of Nursing	4.3	0	0	1	1	P	
	Pressure Ulcers category 4	Safe	Patients	Director of Nursing	1.3	0	1	0	1	P	
	Pressure Ulcers - unstageable	Safe	Patients	Director of Nursing	4.4	4	2	3	5	P	
	Venous Thromboembolism (VTE) Risk Assessment	Safe	Patients	Medical Director	95%	95.49%	94.94%	94.27%	94.61%	F	
	Never Events	Safe	Patients	Director of Nursing	0	0	1	0	1	P	
	Reported medication incidents per 1000 occupied bed days	Safe	Patients	Medical Director	4.3	5.85	5.77	6.06	5.92	P	
	Medication incidents reported as causing harm (low /moderate /severe / death)	Safe	Patients	Medical Director	10.7%	10.70%	12.80%	13.4%	13.10%	F	

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PERFORMANCE OVERVIEW - QUALITY

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Mar-23	Apr-23	May-23	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Patient Safety Alerts responded to by agreed deadline	Safe	Patients	Medical Director	100%	None due	None due				
	Hospital Standardised Mortality Ratio - HSMR (basket of 56 diagnosis groups) (rolling year data 3 month time lag)	Effective	Patients	Medical Director	100	94.03	95.22	95.07	95.15		
	Summary Hospital Mortality Indicator (SHMI) (rolling year data 6 month time lag)	Effective	Patients	Medical Director	100	102.92	102.67	103.08	102.88		
	The Trust participates in all relevant National clinical audits	Effective	Patients	Medical Director	100%	100.00%	100.00%	100.00%	100.00%		
	eDD issued within 24 hours	Effective	Patients	Medical Director	95%	88.30%	90.20%	87.90%	89.05%		
	Sepsis screening (bundle) compliance for inpatients (adult)	Safe	Patients	Director of Nursing	90%	90.00%	88.00%		88.00%		
	Sepsis screening (bundle) compliance for inpatients (child)	Safe	Patients	Director of Nursing	90%	90.00%	76.90%		76.90%		
	IVAB within 1 hour for sepsis for inpatients (adult)	Safe	Patients	Director of Nursing	90%	95.00%	98.00%		98.00%		
	IVAB within 1 hour for sepsis for inpatients (child)	Safe	Patients	Director of Nursing	90%	87.50%	42.80%		42.80%		
	Sepsis screening (bundle) compliance in A&E (adult)	Safe	Patients	Director of Nursing	90%	92.00%	91.00%		91.00%		
	Sepsis screening (bundle) compliance in A&E (child)	Safe	Patients	Director of Nursing	90%	93.90%	92.50%		92.50%		
	IVAB within 1 hour for sepsis in A&E (adult)	Safe	Patients	Director of Nursing	90%	97.00%	97.00%		97.00%		
	IVAB within 1 hour for sepsis in A&E (child)	Safe	Patients	Director of Nursing	90%	81.80%	87.50%		87.50%		
	Rate of stillbirth per 1000 births	Safe	Patients	Director of Nursing	3.80	2.43	2.23	2.45	2.34		
Improve Patient Experience	Mixed Sex Accommodation breaches	Caring	Patients	Director of Nursing	0	Submission suspended during Covid					
	Duty of Candour compliance - Verbal	Safe	Patients	Medical Director	100%	88.00%	96.0%	Data not yet available	96.00%		
	Duty of Candour compliance - Written	Responsive	Patients	Medical Director	100%	84.00%	88.0%	Data not yet available	88.00%		

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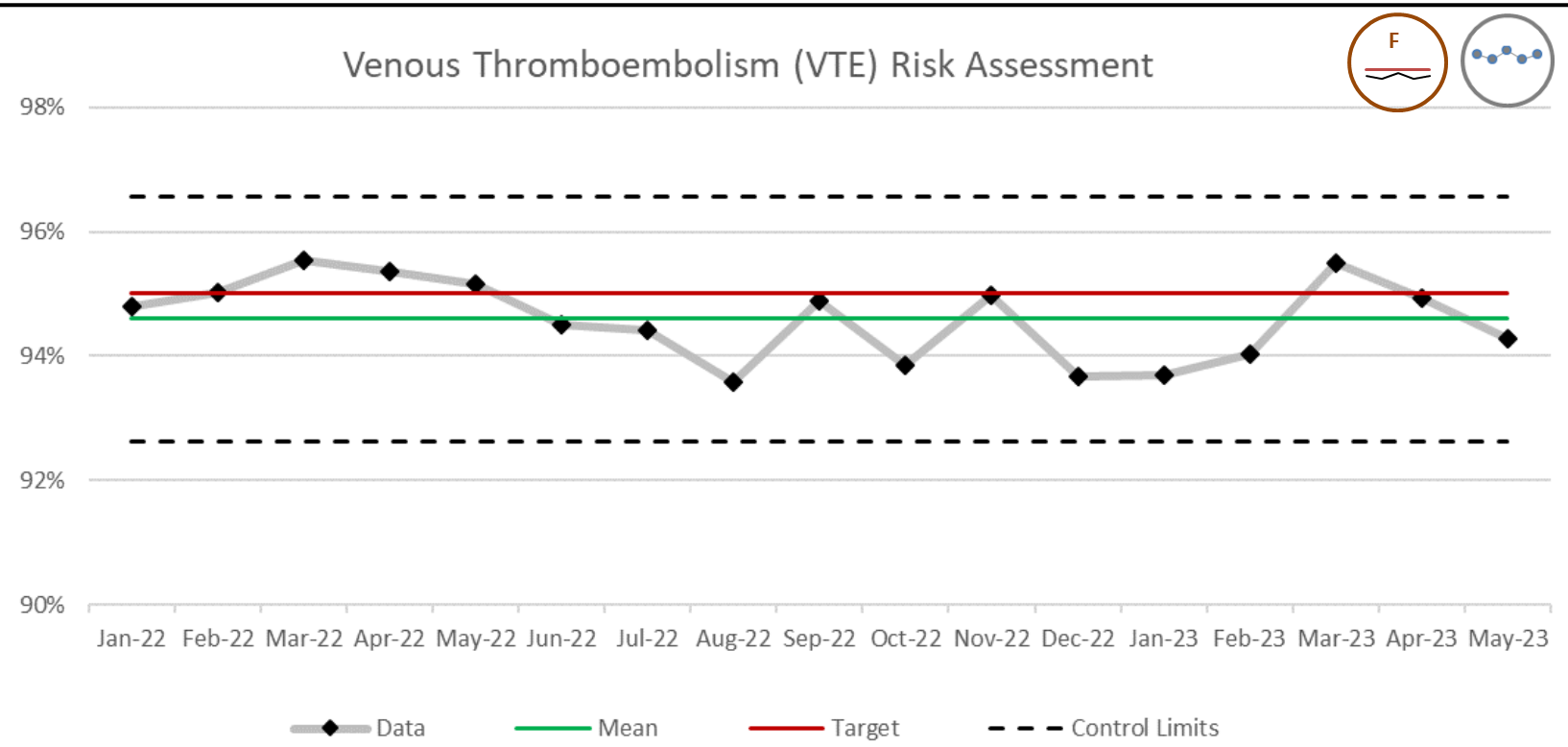

May-23
94.27%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
95%
Target Achievement
Metric is failing the target
Executive Lead
Medical Director

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.

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

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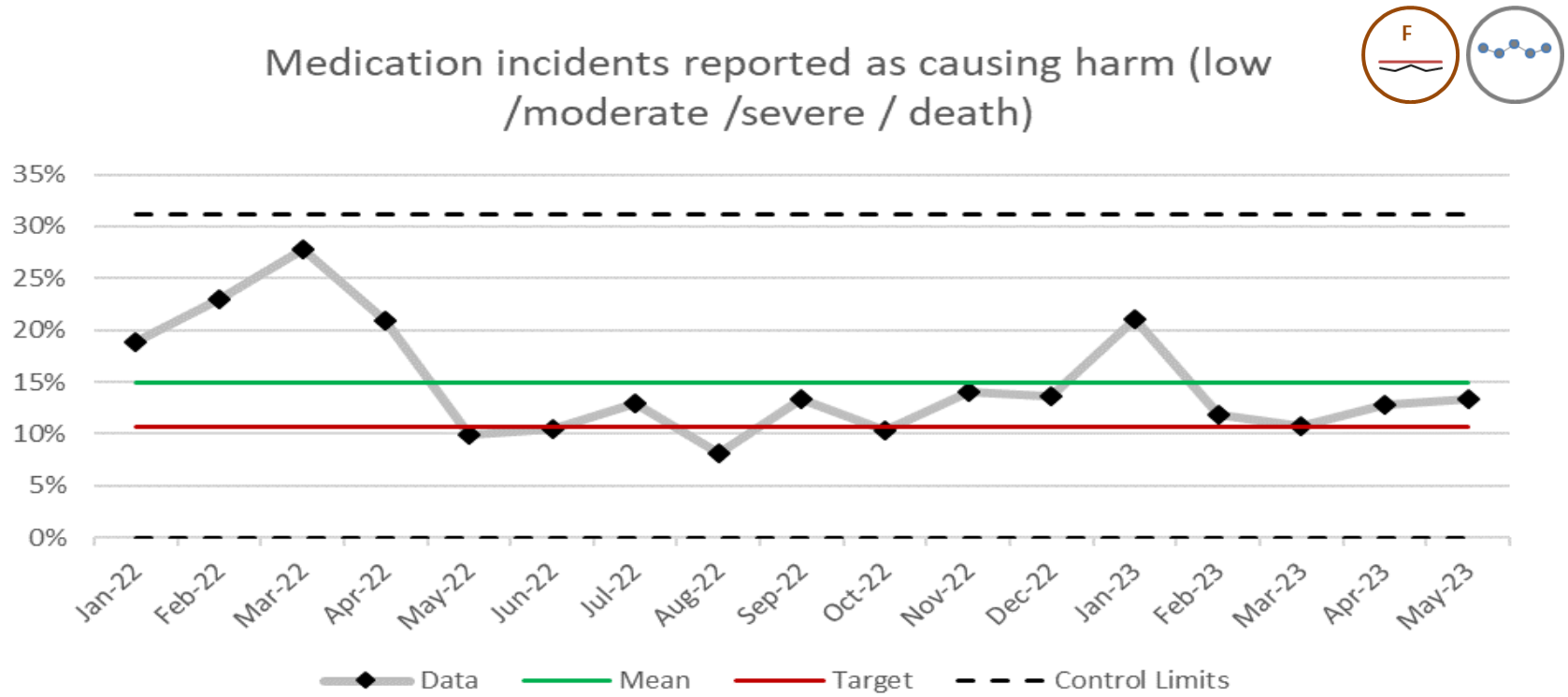

May-23
13.4%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
10.7%
Target Achievement
Metric is consistently failing the target
Executive Lead
Medical Director

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

What the chart tells us:
In the month of May the number of incidents reported was 208. This equates to 6.06 incidents per 1000 bed days. The number of incidents causing some level of harm (low /moderate /severe / death) is 13.4% which is above the national average of 11%.

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

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

Mitigations:

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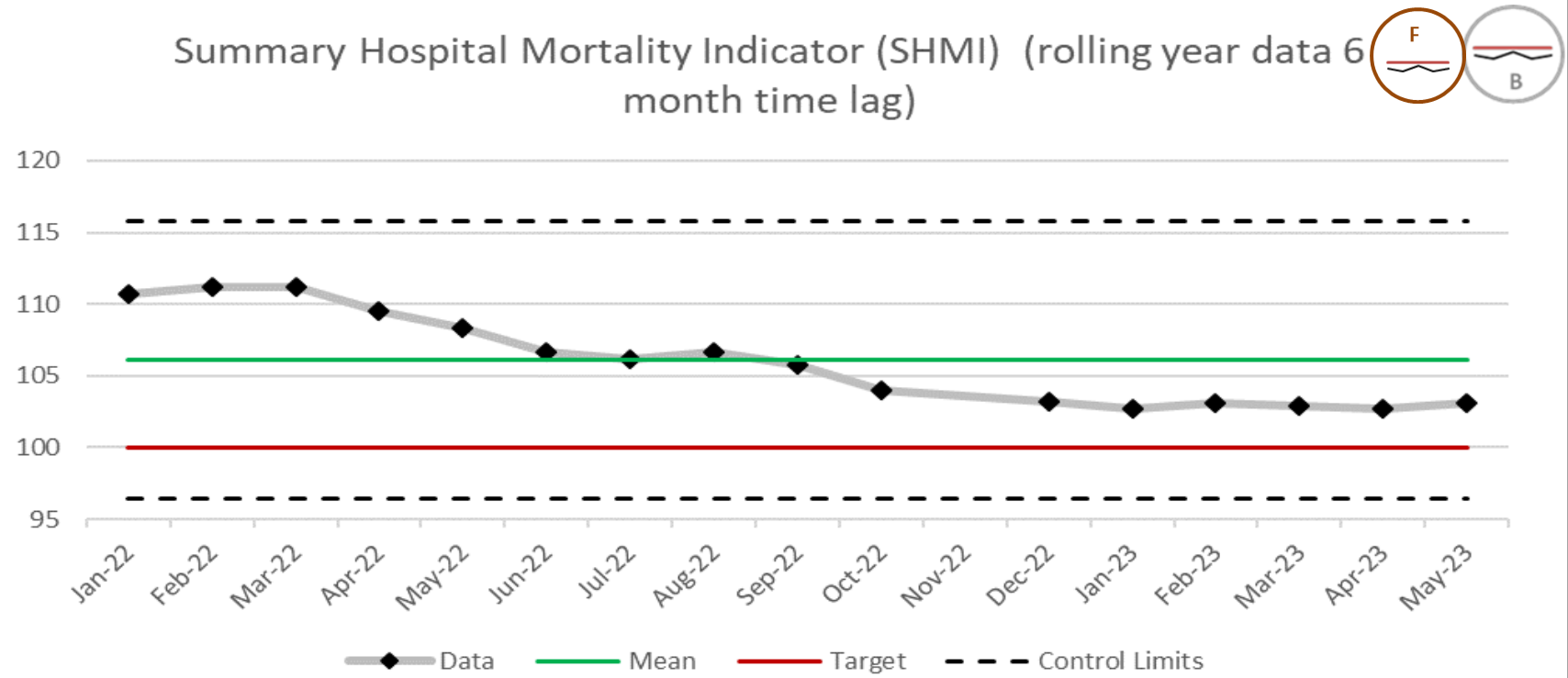


May-23
103.08
Variance Type
Metric is currently experiencing Special Cause Variation – below the mean
Target
To remain in "as expected" range
Target Achievement
The metric has consistently failed to target
Executive Lead
Medical Director

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

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

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

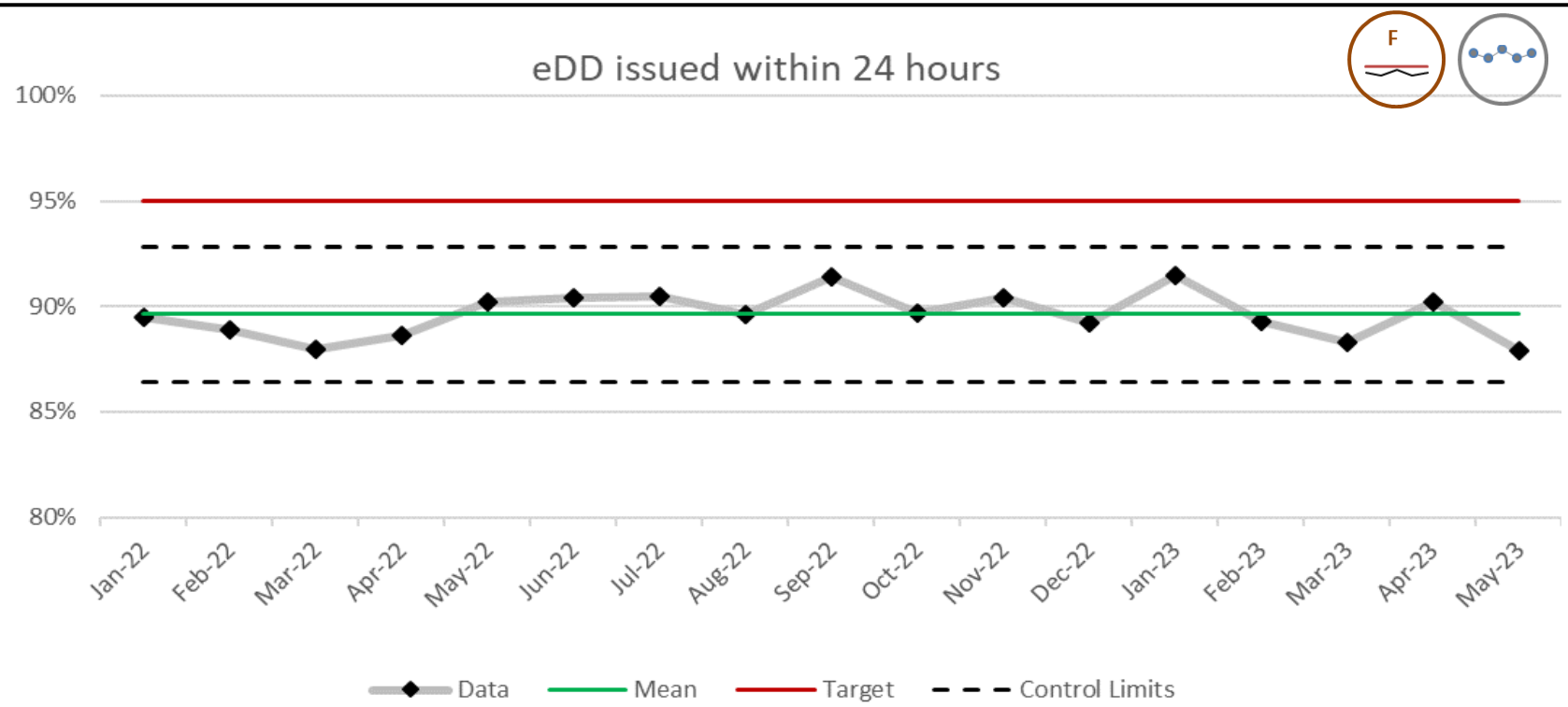
Actions:
Any diagnosis group alerting is subject to a case note review.

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

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

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

HSMR is 95.07 (rolling 12 months)



May-23
87.90%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
95%
Target Achievement
Metric is consistently failing the target
Executive Lead
Medical Director

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

What the chart tells us:
eDD Performance continues to be below the 95% target, currently at 87.90%.

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.

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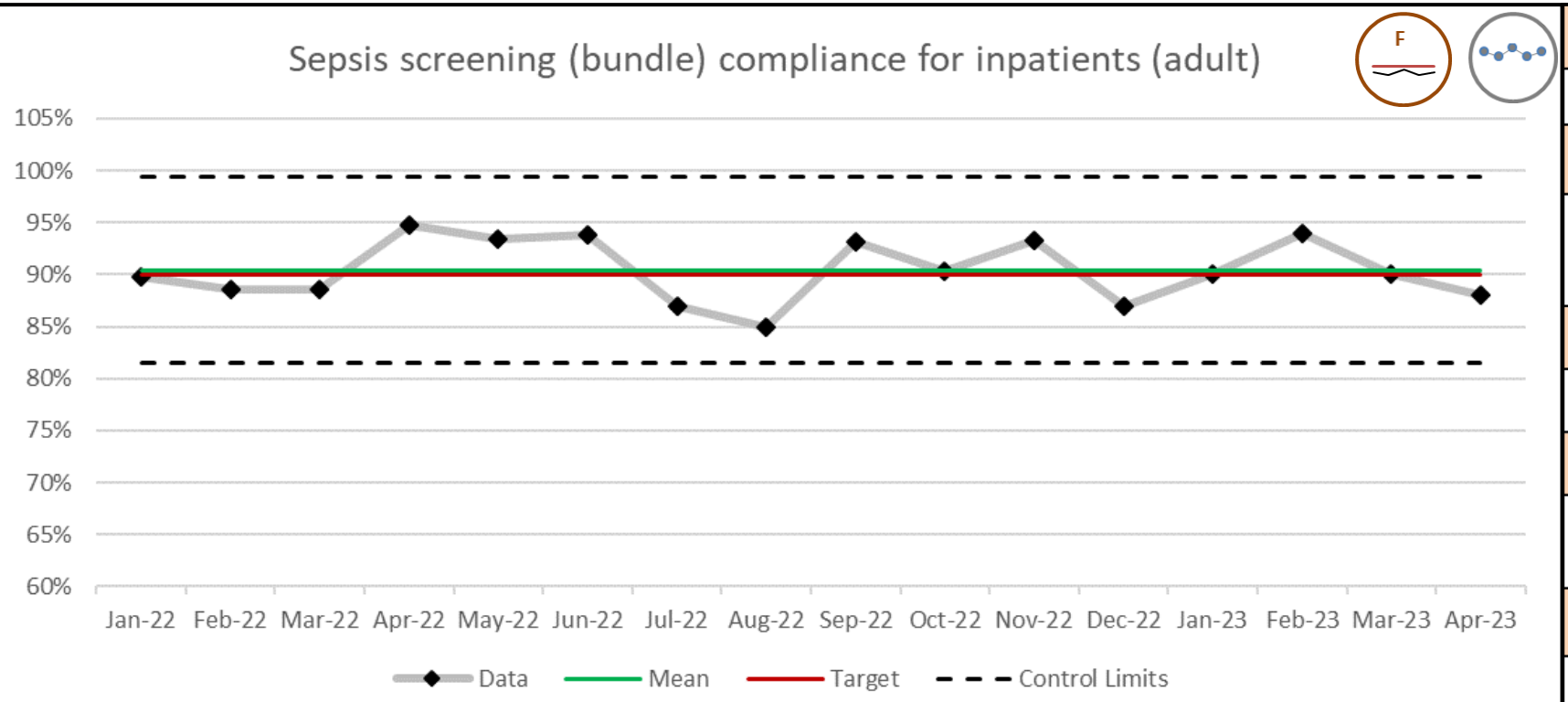

Apr-23
88.00%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
The compliance for sepsis for adult inpatients has unfortunately fallen in the month of April to 88% that represents 231/ 262 patients.

Issues:
The reduced compliance is mainly a reflection of the number of missed screens across both the Lincoln and Pilgrim sites; Grantham continues to maintain achieving compliance.

There does not appear to be any clear themes throughout the data with the wards that have reduced compliance in April, with many having been achieving for months previously. Majority of the omissions were non-infective in nature.

Actions:
Ad hoc teaching continues to areas falling short of the 90% target with the focus of the training being in medical directorate accounting for 22 of the 31 omissions. Regular teaching provided on AIM courses concerning the deteriorating patient including sepsis.

Sepsis team beginning to work collaboratively with primary in the hope to provide community sepsis training to release some on the pressure on our hospitals.

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

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

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

Quality | Operational Performance | Workforce | Finance

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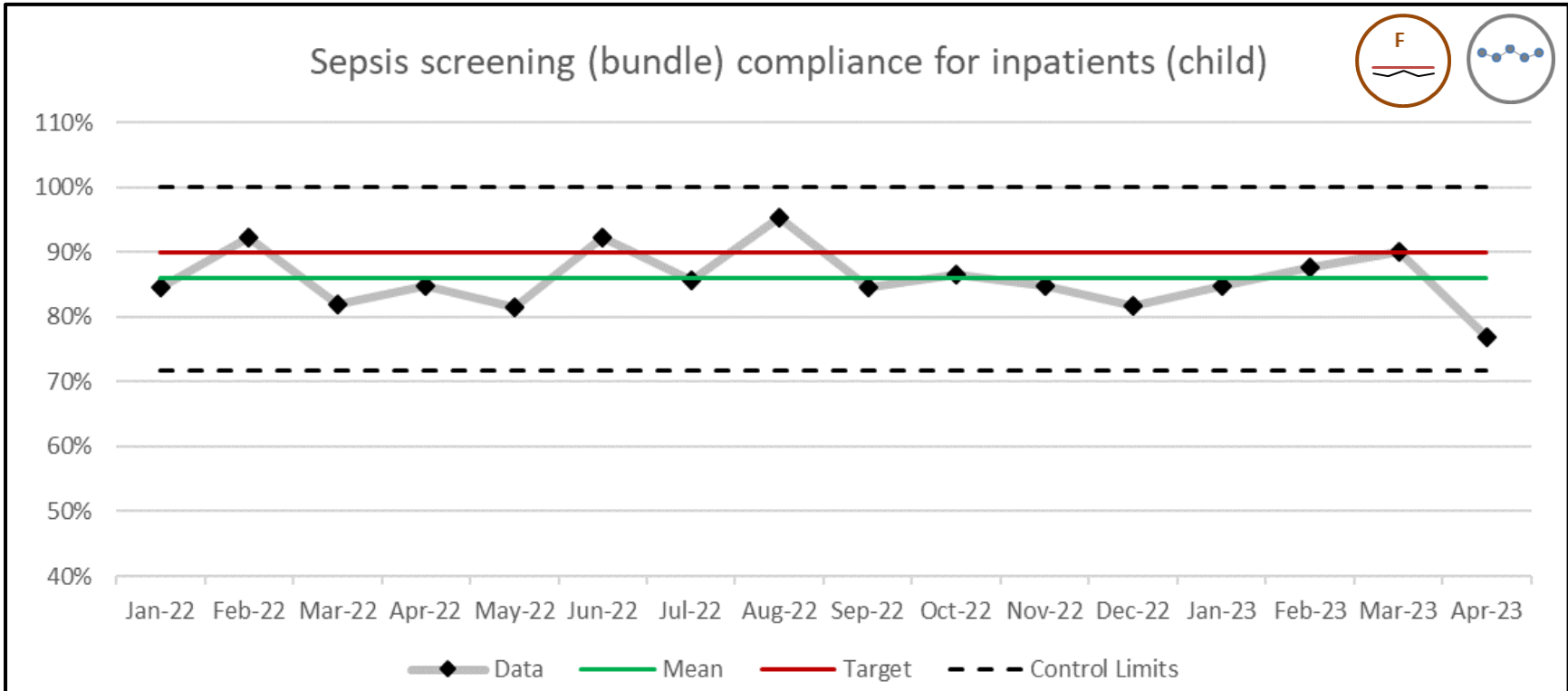

Apr-23
76.90%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
Sepsis screening compliance for this month was 76.9%. 40 out of 52 patients received their Sepsis screening within the 1 hour time limit.

Issues:
10 of the children with delayed screens had an underlying cause for the raised PEWS that was either non/infective or viral in nature. 1 child had a delayed screen and had a bacterial infection – Datix completed and 1 set of observations were done by an unregistered member of staff and not escalated to a registered nurse.

Actions:
Sepsis practitioner has attended wards on both sites and had discussions with non-registered members of staff. Reminder given to escalate a PEWS of 5 or above to nurse in charge. Also advised to add a note to WEBV about who they have escalated to. No harm found from any delayed screens.

Mitigations:
Datix completed for the screen that was done incorrectly as viral – Ward manager will lead the investigation into this.
There have been some problems with receiving harm reviews from one site but this has now been resolved so all areas are completing their own.

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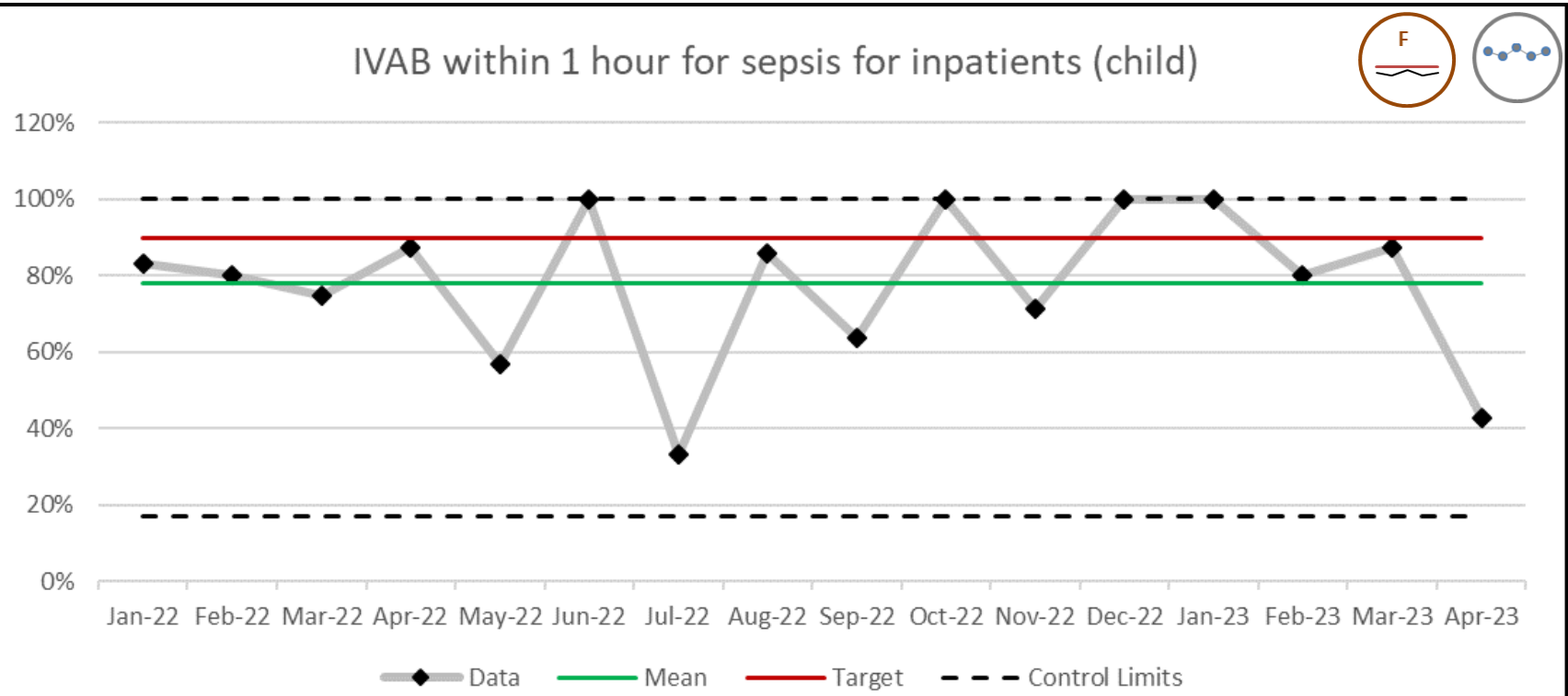

Apr-23
42.80%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
Only 3 out of 7 children requiring treatment received this in a timely manner. 4 children had delayed antibiotics.

Issues:
One child had a very complex background so Ward Drs wanted to discuss with their tertiary centre before starting antibiotics, this caused a short delay but they were treated with IVAB following this discussion. Two children were delayed being seen and cannulated. 1 Child was screened as viral but had an infection and was treated for Sepsis but delayed.

Actions:
The Sepsis link nurses for each ward have completed harm reviews for these patients and no harm has been found from delays.
Sepsis practitioner has met with ward managers on both sites to discuss the delays and wards are putting actions in to place.

Mitigations:
Simulation training is taking place monthly involving both nursing and medical staff. This is embedded at Lincoln and now focusing on getting this running at Pilgrim Clinical Educator and Sepsis Practitioner are doing Sepsis training with new starters. New E-learning package for Paediatric Sepsis to be rolled out by the end of June.

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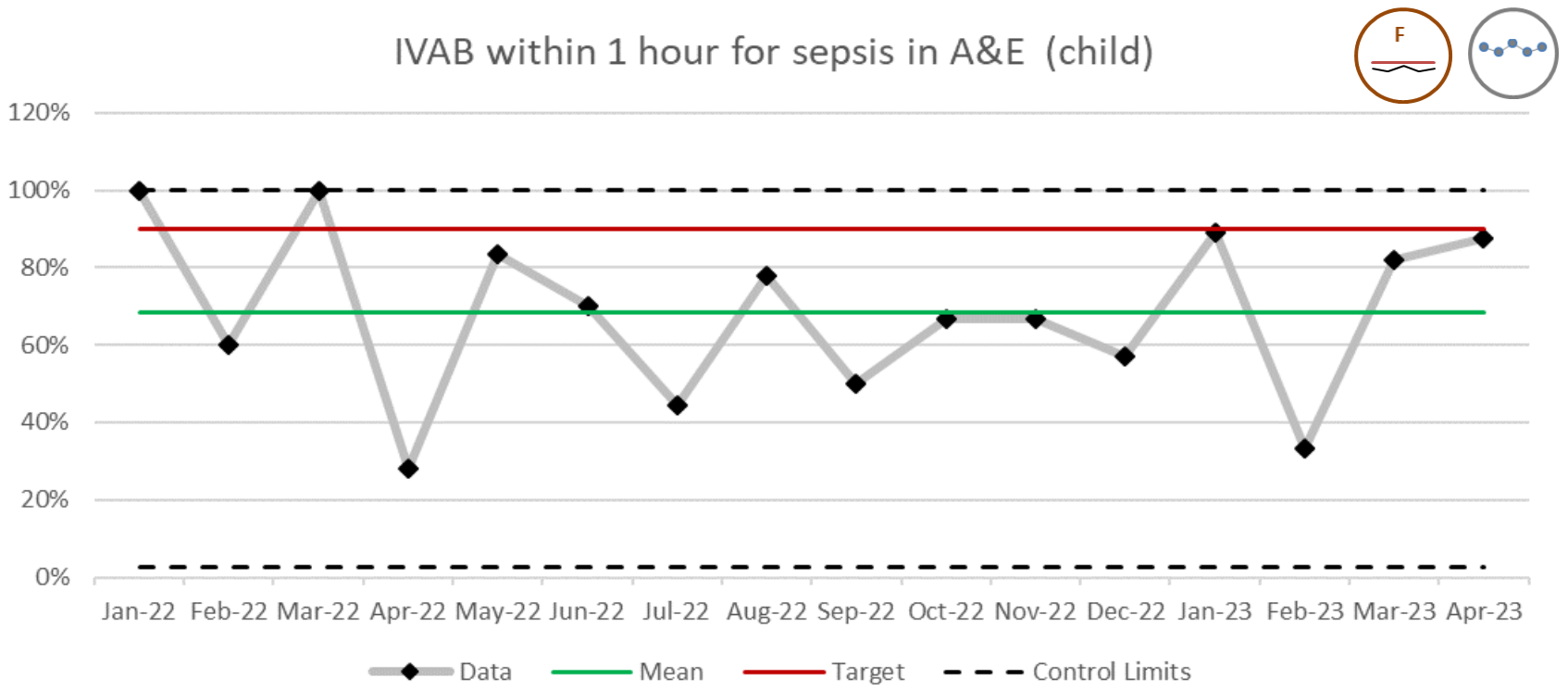

Apr-23
87.50%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is consistently failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
The data this month shows that the IVAB compliance was 87.5%, which is 14 of 16 patients, which is below the 90% target. There is a good improvement on last month's figures but 2 children were delayed receiving antibiotics.

Issues:
There were 2 patients in ED this month that were delayed in receiving antibiotics. . Both of the delays were on one site. The first child was very difficult to cannulate, this was done within the hour but prescription was done outside the hour. When Nurse went to give antibiotics cannula had tissued. IM ceftriaxone was then given. The second child was waiting to be seen by paediatric team and for them to cannulate child.

Actions:
Harm reviews have been completed for all delayed treatment and no harm has been found.
IM administration is to be discussed at the next Focus group meeting.
Delays also discussed at Paediatric governance.
Issues around cannulation of children also to be explored further by Sepsis practitioner as this is a common theme.

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

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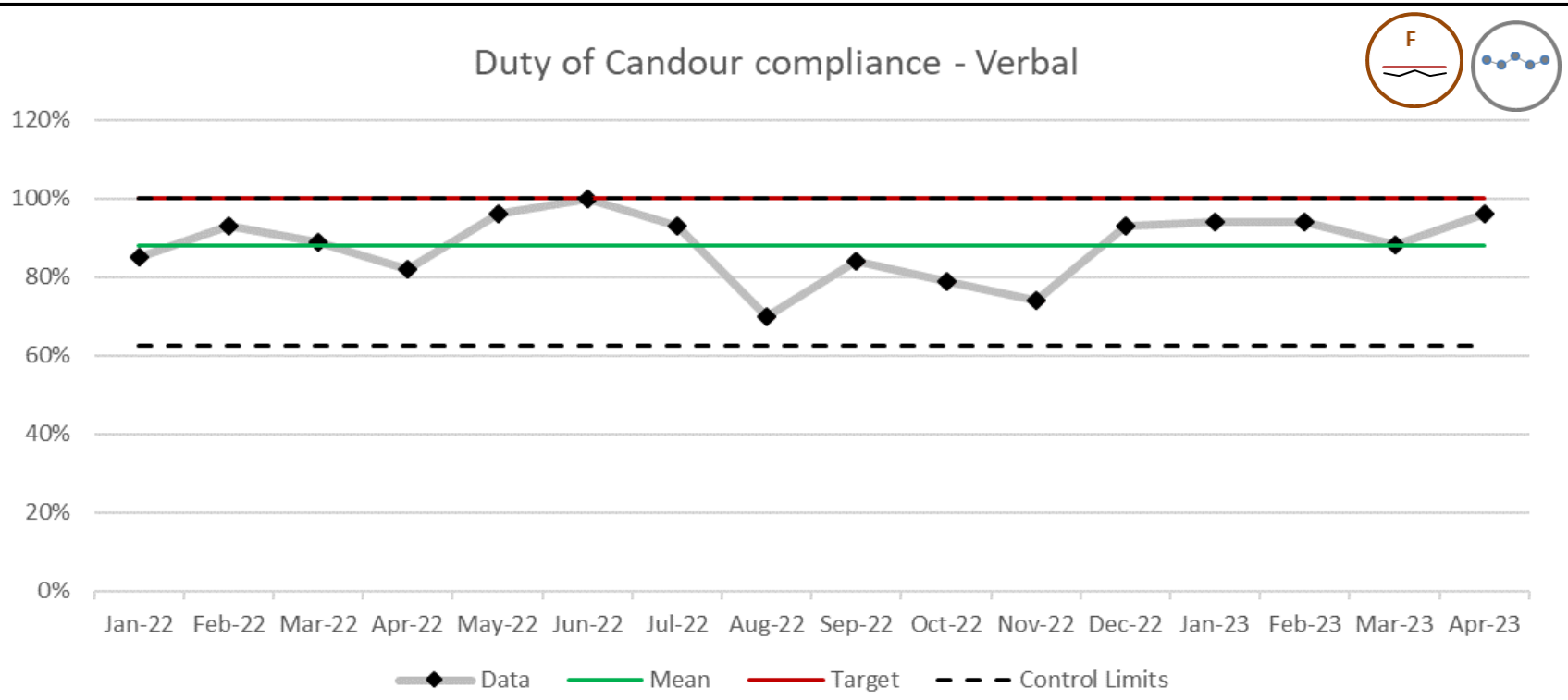

Apr-23
96.00%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
100%
Target Achievement
Metric is consistently failing the target
Executive Lead
Director of Nursing

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

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

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

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

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

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

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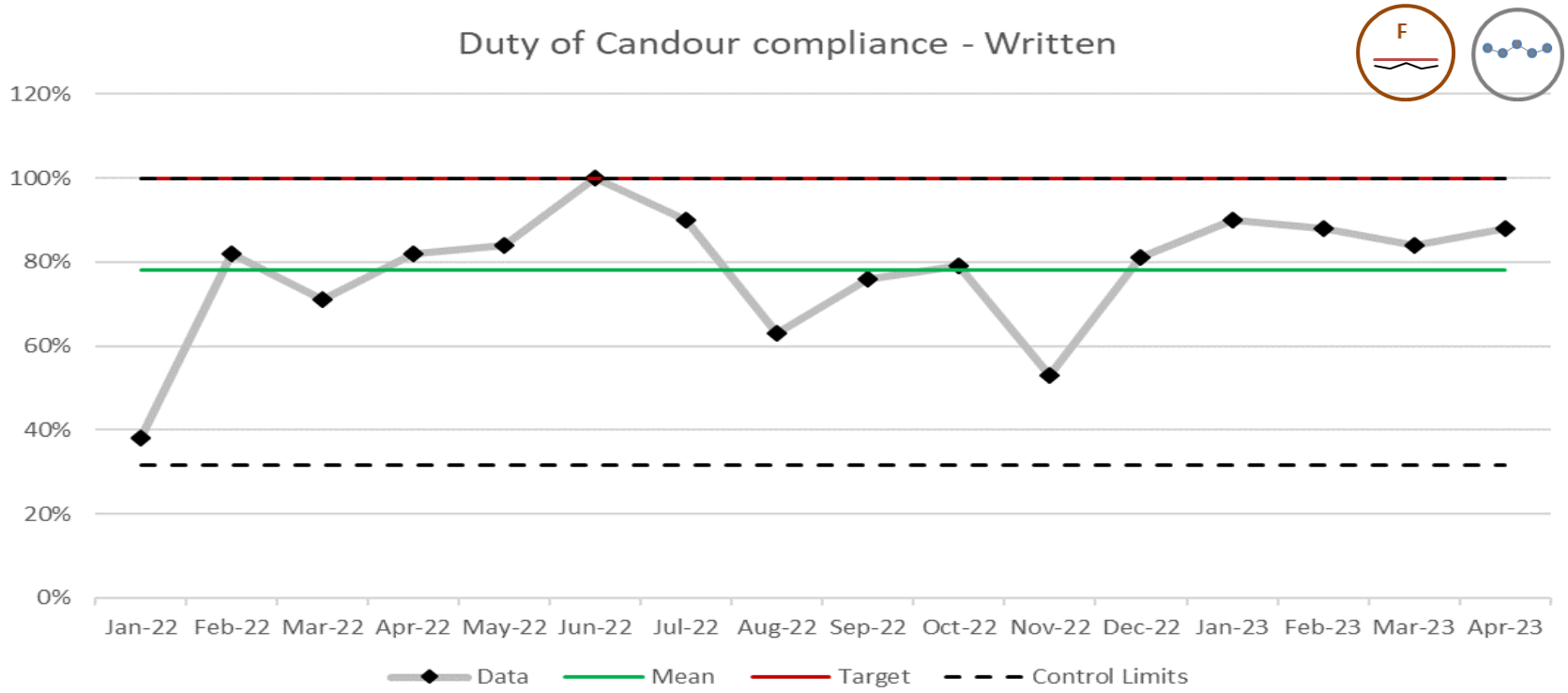

Apr-23
88.00%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
100%
Target Achievement
Metric is consistently failing the target
Executive Lead
Director of Nursing

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

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

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

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

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

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

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PERFORMANCE OVERVIEW – OPERATIONAL PERFORMANCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Feb-23	Mar-23	Apr-23	May-23	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Improve Patient Experience	% Triage Data Not Recorded	Effective	Patients	Chief Operating Officer	0%	0.27%	0.53%	0.28%	0.46%	0.37%				
Improve Clinical Outcomes	4hrs or less in A&E Dept	Responsive	Services	Chief Operating Officer	53.92%	58.21%	57.03%	59.50%	57.01%	58.25%	52.35%			
	12+ Trolley waits	Responsive	Services	Chief Operating Officer	0	702	721	665	798	1463	0			
	%Triage Achieved under 15 mins	Responsive	Services	Chief Operating Officer	88.5%	78.62%	78.23%	81.60%	75.65%	78.63%	88.50%			
	65 Week Waiters	Responsive	Services	Chief Operating Officer	TBC	2766	2206	2122		33,326				
	18 week incompletes	Responsive	Services	Chief Operating Officer	84.1%	49.56%	50.29%	48.87%		49.25%	84.10%			
	Waiting List Size	Responsive	Services	Chief Operating Officer	70,327	72,055	73,514	73,379		n/a	n/a			
	62 day classic	Responsive	Services	Chief Operating Officer	85.4%	39.27%	55.08%	55.71%		49.04%	85.39%			
	2 week wait suspect	Responsive	Services	Chief Operating Officer	93.0%	63.51%	56.01%	51.23%		59.47%	93.00%			
	2 week wait breast symptomatic	Responsive	Services	Chief Operating Officer	93.0%	13.08%	21.67%	8.08%		22.23%	93.00%			
	31 day first treatment	Responsive	Services	Chief Operating Officer	96.0%	90.17%	89.89%	88.63%		90.60%	96.00%			
	31 day subsequent drug treatments	Responsive	Services	Chief Operating Officer	98.0%	94.48%	97.84%	97.22%		97.34%	98.00%			
	31 day subsequent surgery treatments	Responsive	Services	Chief Operating Officer	94.0%	70.83%	73.68%	85.71%		75.20%	94.00%			
	31 day subsequent radiotherapy treatments	Responsive	Services	Chief Operating Officer	94.0%	98.13%	91.54%	92.77%		95.35%	94.00%			
	62 day screening	Responsive	Services	Chief Operating Officer	90.0%	43.75%	77.61%	77.27%		65.47%	90.00%			

PERFORMANCE OVERVIEW – OPERATIONAL PERFORMANCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Feb-23	Mar-23	Apr-23	May-23	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Improve Clinical Outcomes	62 day consultant upgrade	Responsive	Services	Chief Operating Officer	85.0%	69.92%	75.23%	69.90%		69.41%	85.00%			
	Diagnostics achieved	Responsive	Services	Chief Operating Officer	99.0%	60.12%	61.83%	61.82%	66.10%	63.96%	99.00%			
	Cancelled Operations on the day (non clinical)	Responsive	Services	Chief Operating Officer	0.8%	1.28%	0.79%	1.05%	1.21%	1.13%	0.80%			
	Not treated within 28 days. (Breach)	Responsive	Services	Chief Operating Officer	0	22	16	14	11	25	0			
	#NOF 48 hrs	Responsive	Services	Chief Operating Officer	90%	65.56%	90.67%	93.83%	88.89%	91.36%	90%			
	#NOF 36 hrs	Responsive	Services	Chief Operating Officer	TBC	37.78%	80.00%	53.09%	63.89%	58.49%				
	EMAS Conveyances to ULHT	Responsive	Services	Chief Operating Officer	4,657	3,475	3,917	4,059	4,380	4,220	4,657			
	EMAS Conveyances Delayed >59 mins	Responsive	Services	Chief Operating Officer	0	316	616	440	541	491	0			
	104+ Day Waiters	Responsive	Services	Chief Operating Officer	10	127	84	91	82	173	20			
	Average LoS - Elective (not including Daycase)	Effective	Services	Chief Operating Officer	2.80	4.30	3.02	2.87	3.07	2.97	2.80			
	Average LoS - Non Elective	Effective	Services	Chief Operating Officer	4.50	4.89	5.01	5.12	4.87	5.00	4.5			
	Delayed Transfers of Care	Effective	Services	Chief Operating Officer	3.5%	Submission suspended					3.5%			
	Partial Booking Waiting List	Effective	Services	Chief Operating Officer	4,524	23,309	24,397	25,962	26,816	26,389	4,524			
	Outpatients seen within 15 minutes of appointment	Effective	Services	Chief Operating Officer	70.0%	31.35%	32.33%	30.78%	31.25%	31.01%	70.00%			
	% discharged within 24hrs of PDD	Effective	Services	Chief Operating Officer	45.0%	43.87%	43.05%	44.82%	46.89%	45.85%	45.00%			

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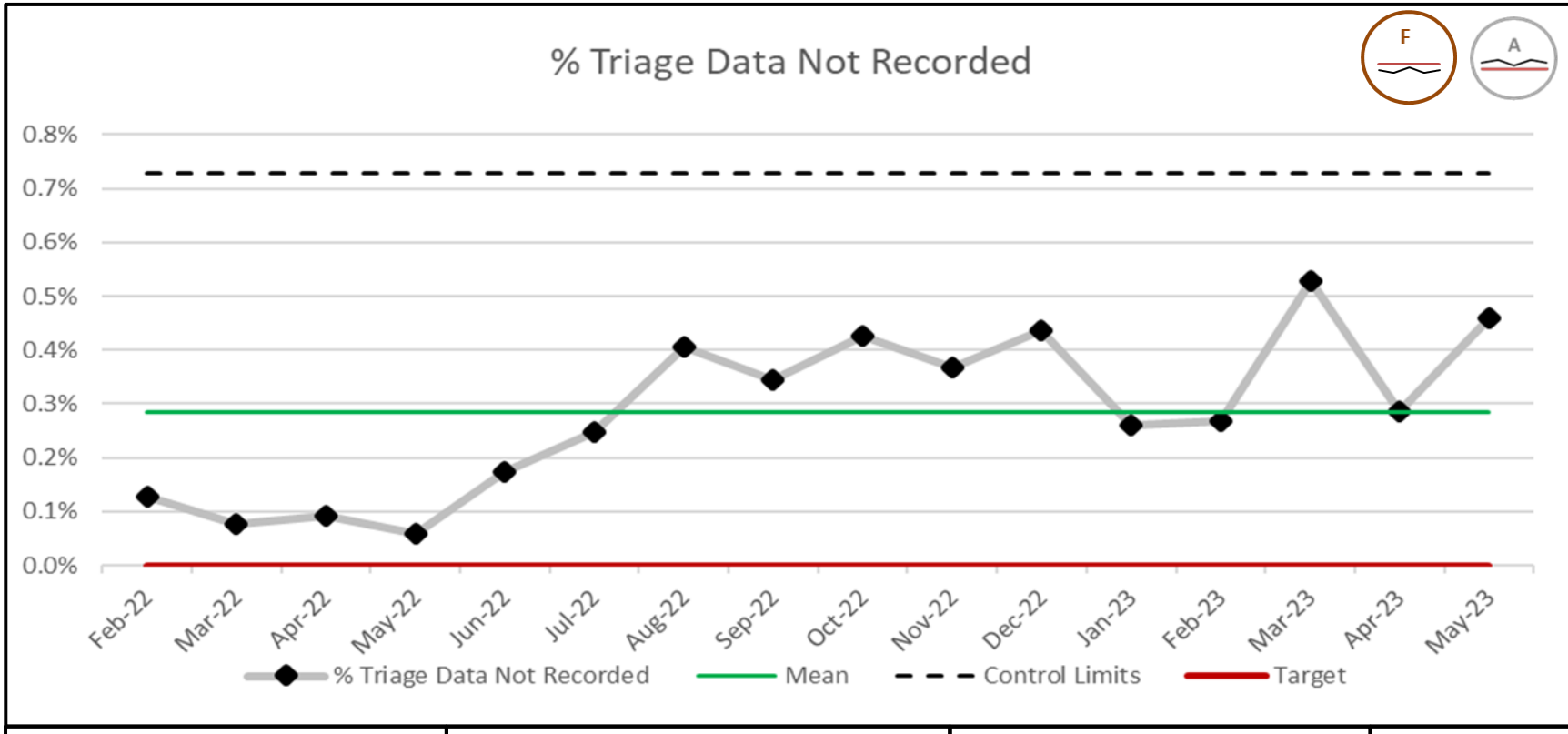

May-23
0.46%
Variance Type
Metric is currently experiencing Special Cause Variation – Above the mean
Target
0%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Percentage of triage data not recorded.

What the chart tells us:
May 23 reported a non-validated position of 0.46% of data not recorded verses target of 0%. This is the second worse performance since February 2022.
What the chart doesn't tell us is that 63.16% of those without a triage recorded "did not wait" to be seen.

Issues:

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

Actions:

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

Mitigations:

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

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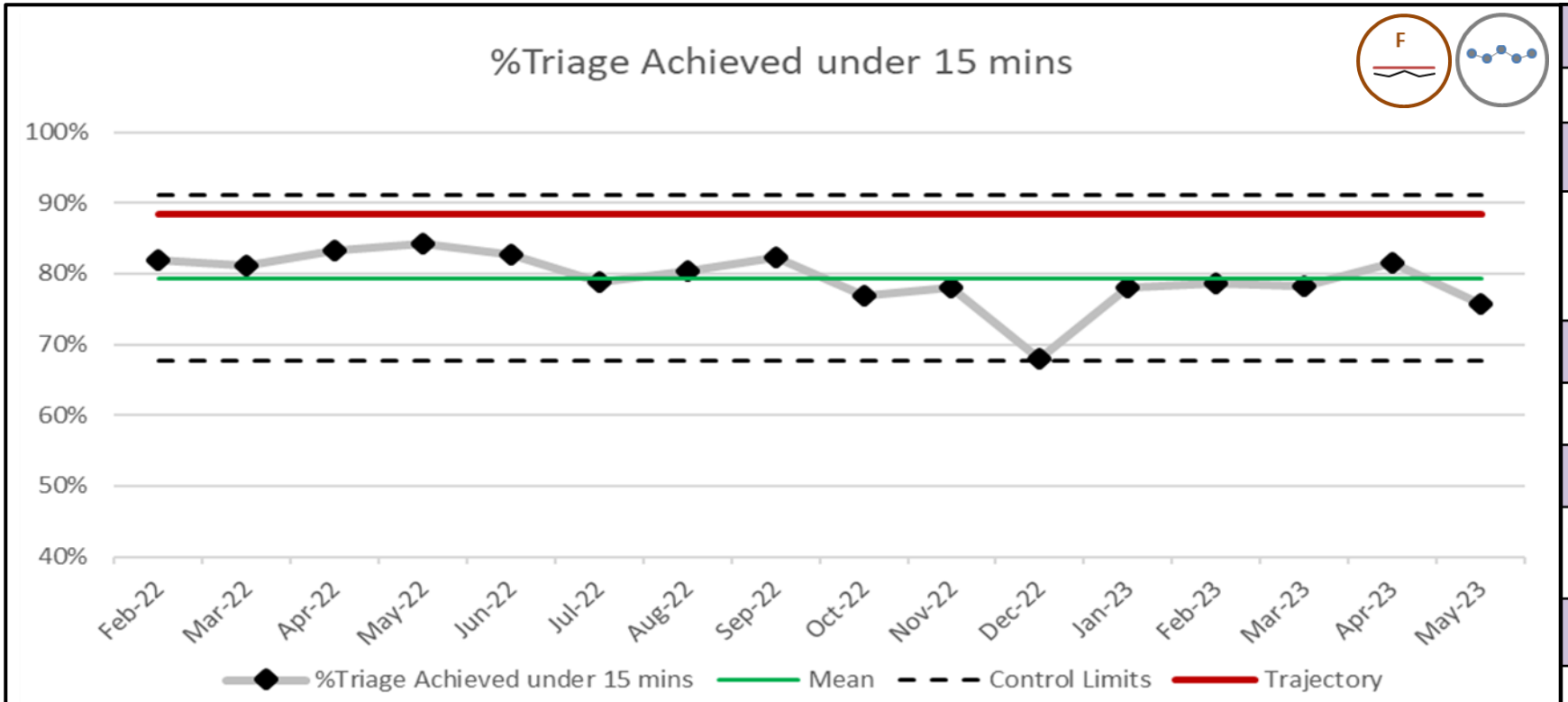

May-23
75.65%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
88.5%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

Percentage of triage achieved under 15 minutes.

What the chart tells us:

The compliance against this target is 88.50%.
May outturn was 75.65% compared to 81,60% in April (validated).
This target has not been met.
What the chart doesn't tell us, is that the ED attendances increased by 788 patients in May compared to April 23. This is lowest performance since January 23 proportionate to attendances.

Issues:

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

Actions:

Most actions are repetitive but remain relevant.
Increased access to MTS2 training.
Increased registrant workforce to support 2 triage streams to be in place via Emergency Department recruitment campaign.
To move to a workforce model with Triage dedicated registrants and remove the dual role component.
The metric forms part of the Emergency Department safety indicators and is monitored/scrutinised at 4 x daily Capacity and Performance Meetings.

Mitigations:

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

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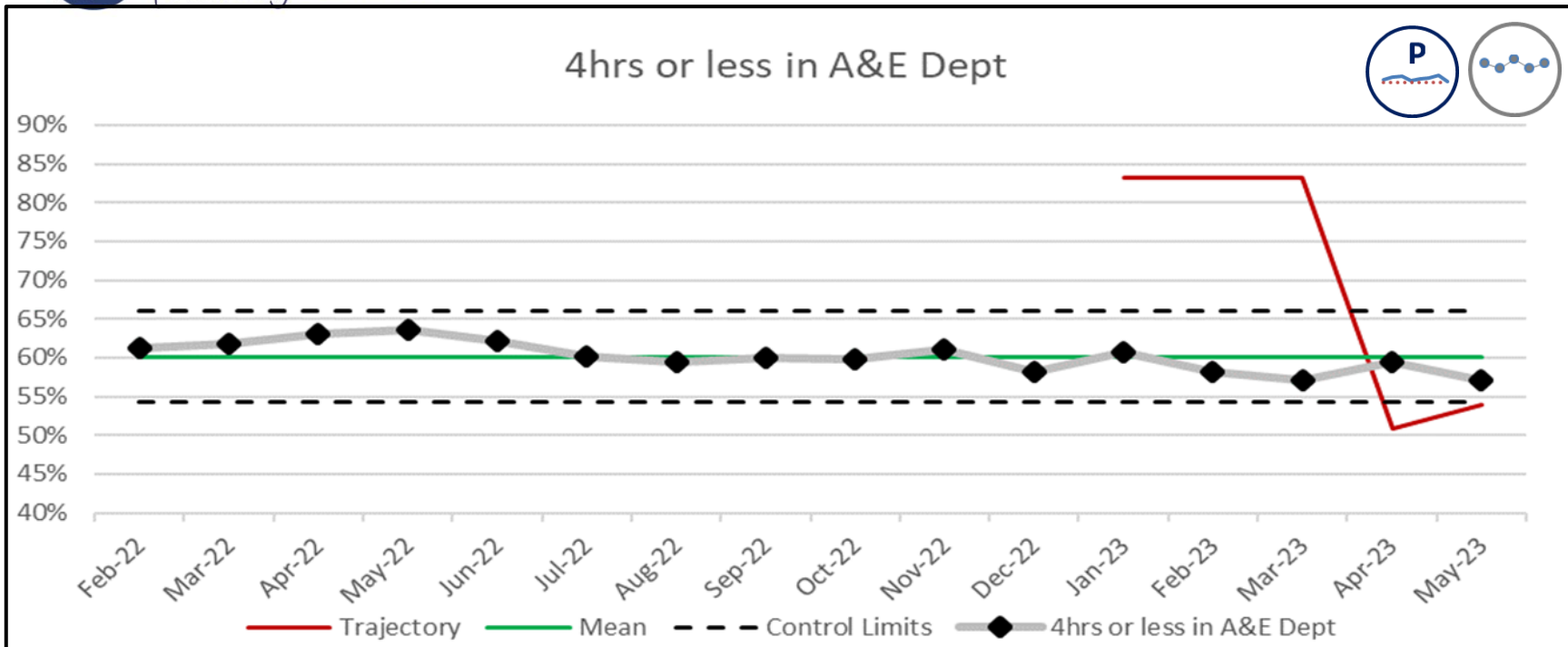

May-23
57.01%
Variance Type
Metric is currently experiencing Common Cause Variation
Recovery Trajectory
50.77%
Trajectory Achievement
Metric is passing recovery trajectory
Executive Lead
Chief Operating Officer

Background:

The 23/24 target has been set at 76% with a rolling trajectory by month to achieve by year end. The ULHT improvement trajectory is based on Type 1 and co-located UTC Type 3 attendances.
With May 2023 set at a 53.92% ambition

What the chart tells us:

The 4-hour transit target performance for Type 1 and co-located UTC Type 3 for May was 57.01% against a target of 53.92%. April was 59.50%, Whilst the improvement trajectory has bee met, there was a deterioration in performance of 5.58%.
The Type 1 and combined Type 3 position is >70%

Issues:

Main factor in improvement due to reduction of attendances within the Emergency Departments experienced in April of 935 patients compared to March. 27,453 combined attendances (in ED and UTC) compared to 26,518 combined attendances (ED and UTC) in March 23.

Ward Based Discharges were an average of 35 short to meet ED demand each day – this resulted in prolonged bed waits overnight. Early recognition of discharges also lead to the extended LOS within ED. (With >65% recognised after 4pm daily)

Ongoing medical and nursing gaps that were not Emergency Department specific.
Inability to secure consistent 24/7 Discharge Lounge provision due increased registrant staffing gaps.
Escalation of some SDEC areas into Inpatient areas was frequent.

Actions:

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

Mitigations:

EMAS continue to enact a targeted admission avoidance process, including no Cat 4 conveyances should arrive at the Emergency Department.
The Discharge Lounge at LCH and PHB continues operating, where possible, a 24/7 service provision to release the burden placed on the Emergency Departments in terms of patients awaiting AIR/CIR and transport home. The closure of the Discharge Lounges due to inadequate staffing sits solely with the Chief Operating Officer and the Director of Nursing but can be delegated to Dep Chief Operating Officer/ Gold Commander "Out of Hours"
Increased CAS and 111 support especially out of hours.
EPIC to Specialty Consultant reviews to ensure DTA applied appropriately.
Clinical Operational Flow Policy adherence and compliance and Full Capacity Protocol activation when OPEL 3 reached.

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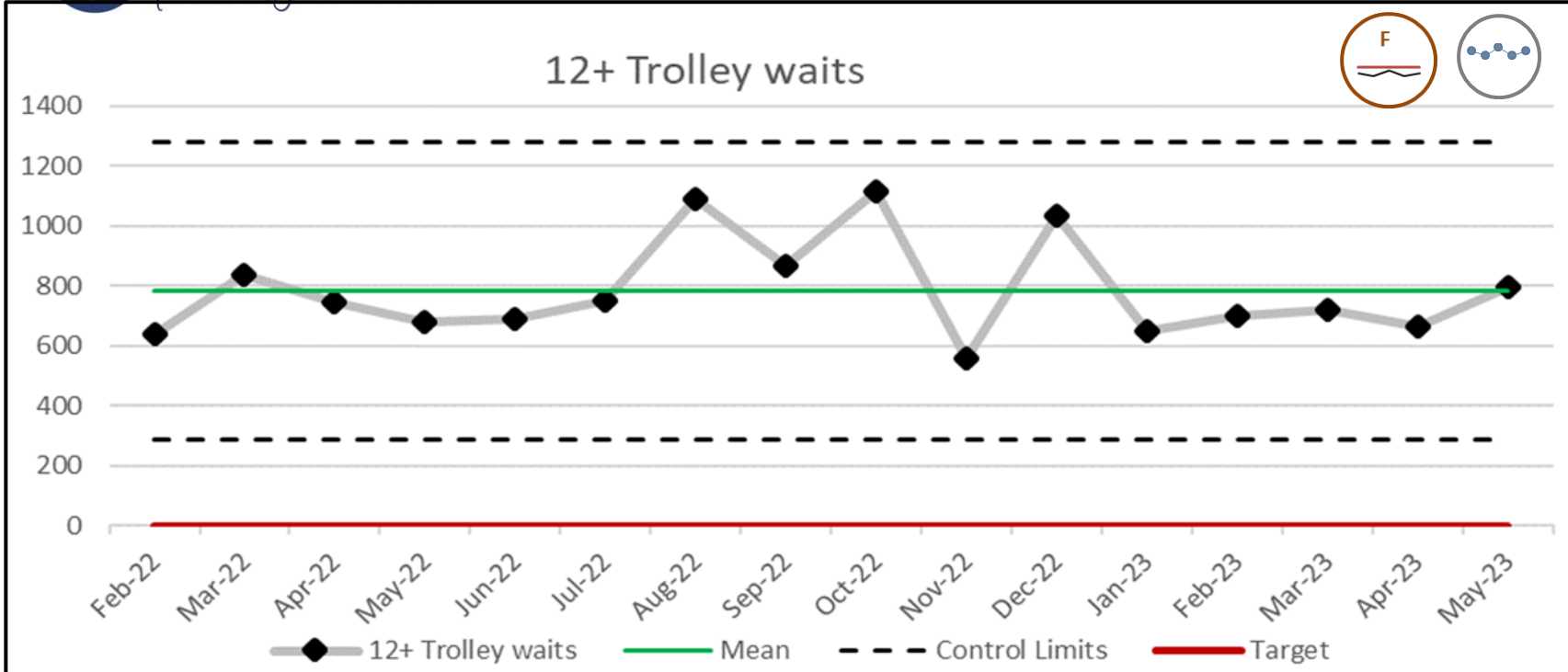

May-23
798
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

There is a zero tolerance for greater than 12-hour trolley waits. These events are reported locally, regionally, and nationally.

What the chart tells us:

May experienced 798 12-hr trolley wait breaches compared to April of 665. This is an increase of 133.
The 798 seen, equates to 6.44% of all type 1 attendances for May
What the chart does not explain is the internal decision to move from 12hr DTA to total time in ED to minimise exposure risk.

Issues:

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

The 12hr trolleys were anticipated against flow predictions
There remains some complacency in terms of 12hr trolley waits following the winter peak of 84.64% increase seen.

Actions:

The Trust continues to work closely with national regulators in reviewing and reporting these breaches.
Due to the number of 12hrs trolley waits breaches currently, harm reviews are completed by the UEC team, DATIX are completed and escalations to the CCG and NHSE/I are in place.
A daily review of all potential 12hr trolley waits is in place and escalated to all key strategic tactical and operational leads and divisional triumvirates.
System Partners and Regulators remain actively engaged and offer practical support in situational escalations.
A substantial programme of work out of hospital is in place with system partners to reduce delayed discharges which are upwards of 15% of all beds at times.
Internal actions on admission avoidance are focussed on Same Day emergency Care and recent developments have shown a 100% increase in some areas when not escalated into.

Mitigations:

All potential DTA risks are escalated at 8hrs to the Daytime Tactical Lead, out of hours Tactical Lead on Call Manager and CCG Tactical Lead – in and out of hours. Rectification plans are agreed with all CBU teams in hours.
A System agreement remains in place to staff the Discharge Lounges 24/7 to reduce the number of patients in the Emergency Departments that are deemed 'Medically Optimised' that need onward non acute placement/support. This demonstrates a positive impact but due to staffing gaps, there is an increased request to close this facility. Permission to close these areas now sits solely with the Chief Operating Officer and Director of Nursing or delegated officer
A Criteria to Admit Lead has been established ensuring all decisions to admit must be approved by the EPIC (Emergency Physician in Charge) with the relevant On Call Team.

OUTSTANDING CARE personally DELIVERED

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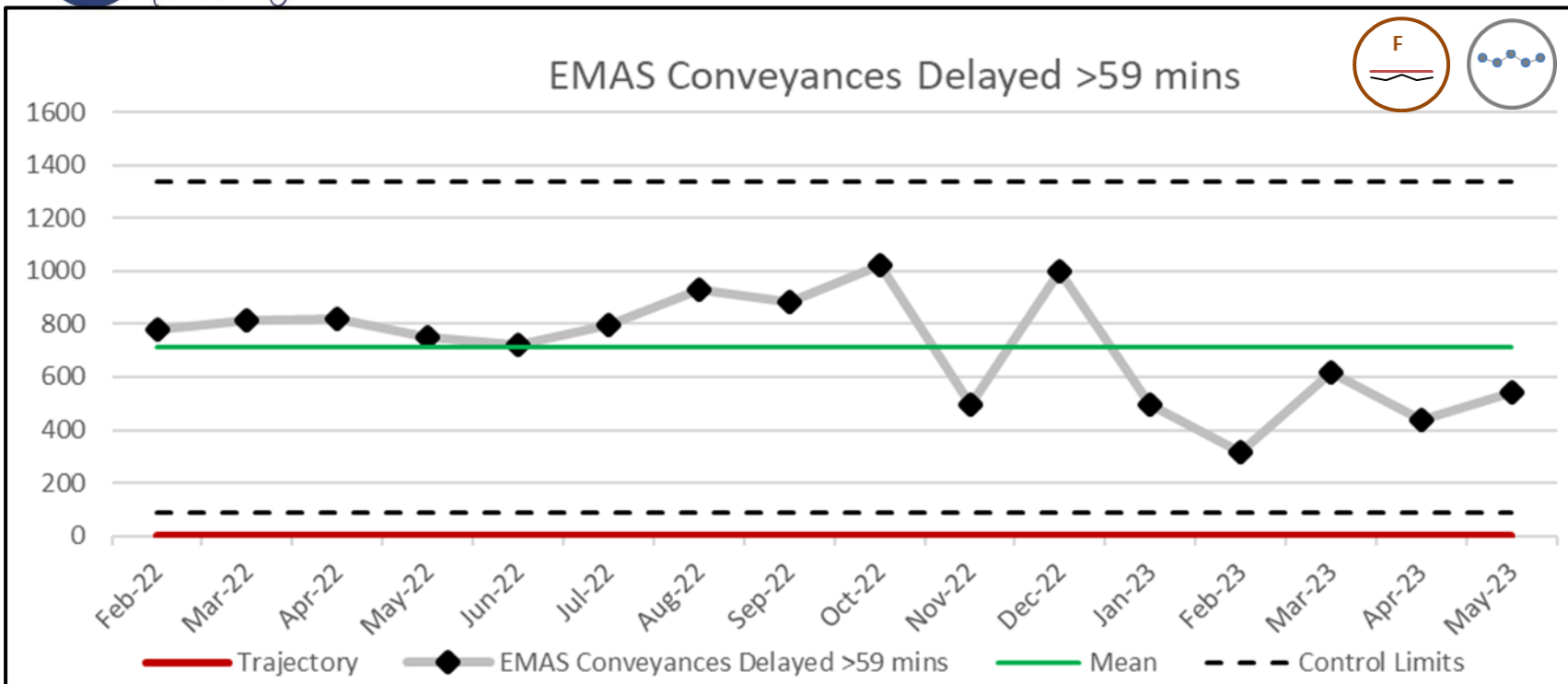

May-23
541
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

Delays in offloading patients following a conveyance has a known impact on the ability of EMAS to respond to outstanding calls. Any delays greater than 59 minutes is reportable to the ICB. There is local and national Ambulance handover delay escalation protocol.

What the chart tells us:

May demonstrated a deterioration in performance waits greater than 59 minutes' to that seen in April 23. 541 compared to 440. This represents a 18.67% deterioration.
What the chart does not tell us is that ULHT actually saw 7.33% more ambulance arrivals to ED in May than that of April.
What the chart does not tell us that LCH saw the largest delays in >59mins, >120 mins, >120mins – 240mins and >240mins

Issues:

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

Actions:

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

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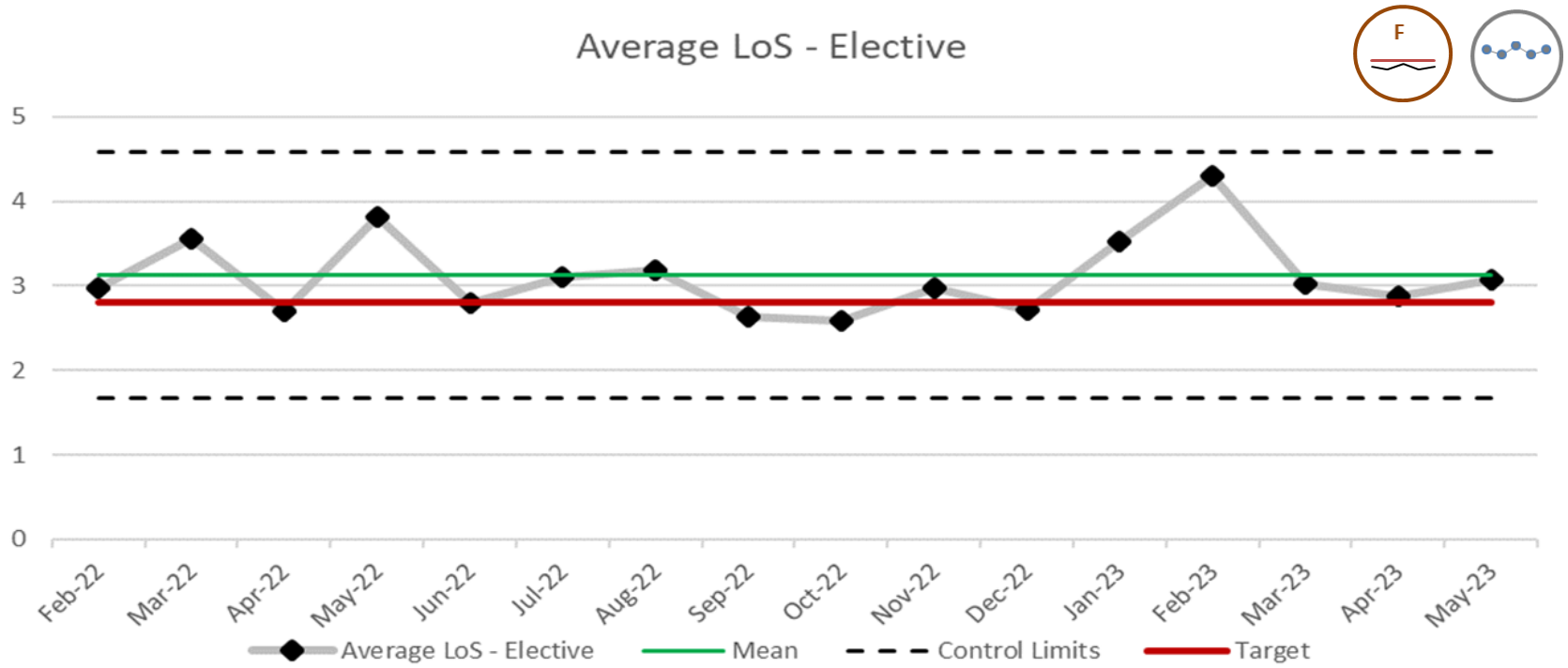

May-23
3.07
Variance Type
Metric is currently experiencing Common Cause Variation
Target
2.80
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Average length of stay for Elective inpatients.

What the chart tells us:
The average LOS for Elective stay has increased to 3.07 days compared to 2.87 days in April. This is a deterioration of 0.2 days and represents a negative variance of days against the agreed target of 0.27 days

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.

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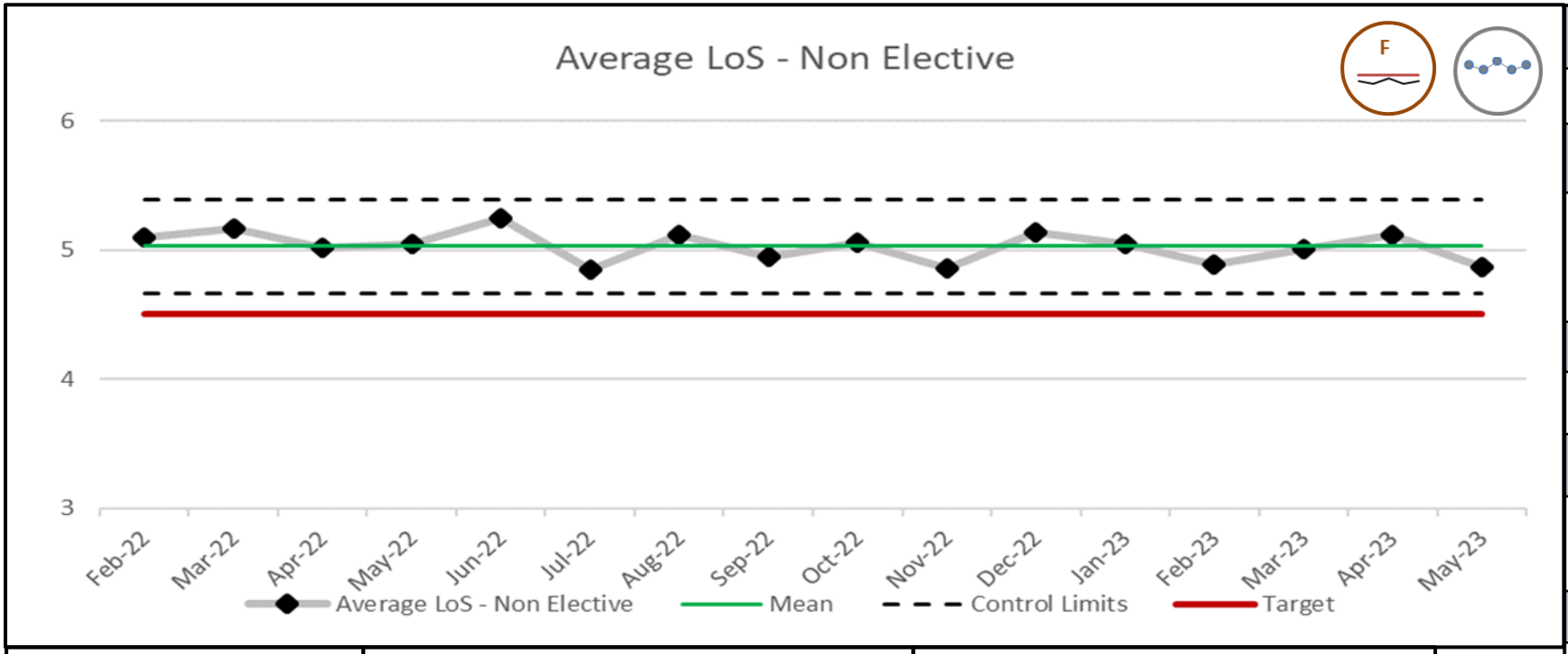

May-23
4.87
Variance Type
Metric is currently experiencing Common Cause Variation
Target
4.5
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

Average length of stay for non-Elective inpatients.

What the chart tells us:

The agreed target is 4.5 days verses the actual of 4.87 days in May
This is an improvement of 0.25 days and a 0.37 days negative variance against the agreed target.

What the chart doesn't tell us is that the decline is against Pathway 3 only, whereas the other groups were improvements (days)
P0 – 0.1
P1 0.3
P2 – 1.0
P3 – - 2.3

Issues:

Numbers of stranded and super stranded patients have decreased.
Super by 3.15% and stranded by 1.71%. With an average of 154 super daily and 381 standard stranded daily.

Weekend Discharges remain consistently lower than weekdays with an average of 40% less than required to meet Emergency Admission Demand.
But since the advent of the joint D2A process and additional funding benefits are being realised slowly but there remains insufficient capacity to meet the increasing demand.
The Transfer of Care Hub continue to gain more traction on moving discharges forward at an improved pace.
Higher acuity of patients requiring a longer period of recovery.
Increased medical outliers and reduced medical staffing leading to delays in senior reviews.
Increased number of Industrial Strike activity has also lead to delayed discharge and impacted on improvement being realised with length of stay.

Actions:

These actions are repetitive but still appropriate
Focused discharge profile through daily escalations.
Medically optimised patients discussed twice daily 7 days a week with system partners to ensure plans in place and a zero tolerance of >24hrs delay
The move to Lateral Flow Testing as opposed to PCR testing for access to onward non acute care is proving beneficial once Community and social care is secured.
Maximise use of all community and transitional care beds when onward care provision cannot be secured in a timely manner.
Line by line review of all pathway fully 0 patients who do not meeting the reason to reside.
A new approach to SAFER and P0 discharges is being considered via URIG.

Mitigations:

Divisional Bronze Lead continues to support the escalation of exit delays to the relevant Divisions and Clinical Business Units.
Continued reduction in corporate and divisional meetings to allow a more proactive focus on increasing daily discharges. However, this is not sustainable.
A daily site update message is now sent at 6am alerting Key Leaders to ED position, flow and site OPEL position by Site.
The move to working 5 days over the 7 a Day period is in train.
A new rolling programme of MADE has been agreed and the frequency has been agreed as an 8-week rolling programme.

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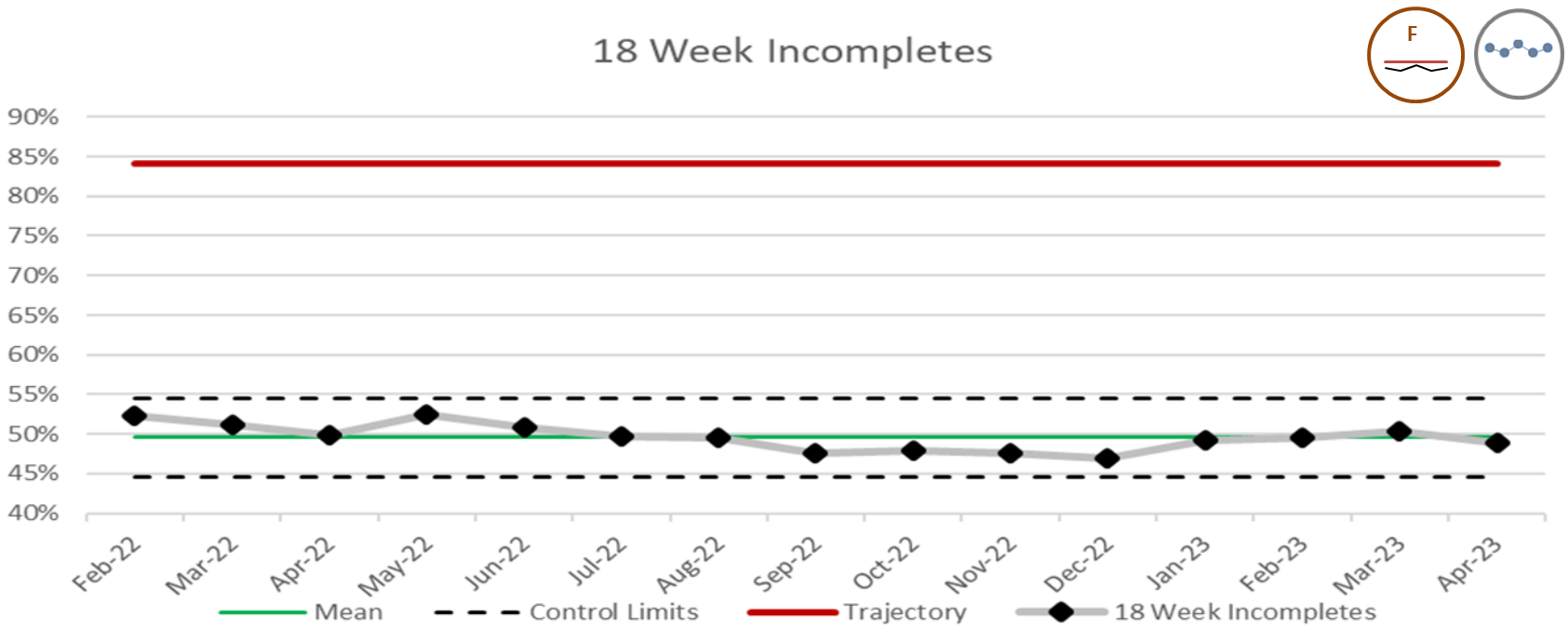

Apr-23
48.87%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
84.1%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background

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

What the chart tells us:

There is significant backlog of patients on incomplete pathways. April 2023 saw RTT performance of 48.87% against a 84.1% target, which is 1.42% down from March 2023.

Issues:

Performance is currently below trajectory and standard. The five specialties with the highest number of 18 week breaches at the end of the month were:

- ENT – 5804 (increased by 146)
- Gastroenterology – 3902 (increased by 64)
- Dermatology – 2820 (decreased by 101)
- Ophthalmology – 2753 (increased by 223)
- Gynaecology – 2661 (increased by 67).

Actions:

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

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

Mitigations:

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

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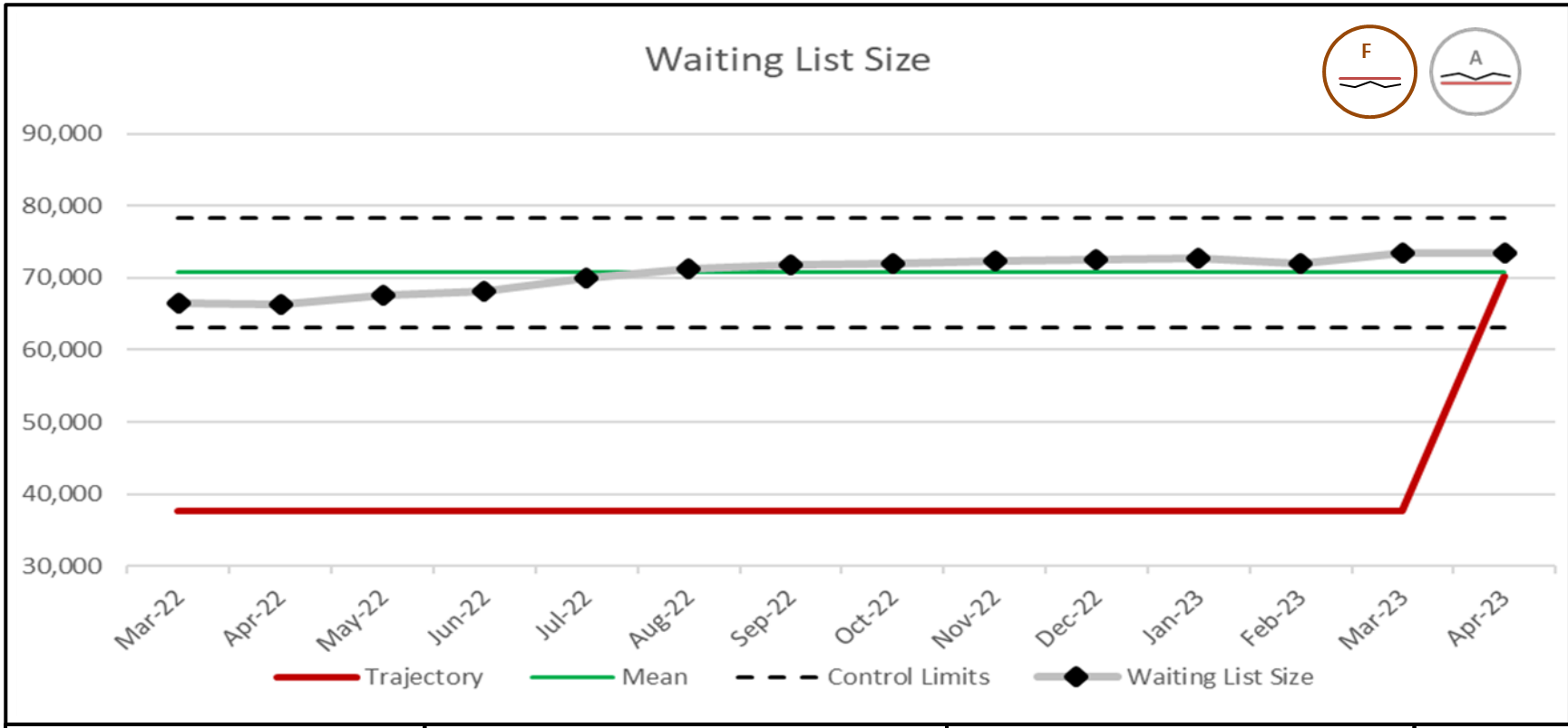

Apr-23
73,379
Variance Type
Metric is currently experiencing Special Cause Variation – Above the mean
Target
37,762
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
The number of patients currently on a waiting list.

What the chart tells us:
Overall waiting list size has decreased from March 2023, with April showing a decrease of 135 to 73,379
This is more than double the pre-pandemic level reported in January 2020.

Issues:
Following the backlog increase from the pandemic, there have been additional pressures that have affected capacity, including; COVID sickness and urgent care pressures
The five specialties with the largest waiting lists are;

- ENT – 9234
- Ophthalmology – 6256
- Gastroenterology – 6027
- Gynaecology – 5342
- Dermatology – 5185

Actions
Improvement programmes as described above for RTT performance. In addition, all patients >52 weeks are monitored weekly by the Trusts RTT team. Phase 1 of the validation programme has started. This will be followed by phase 2, an administrative review; involving contacting patients to review the need for treatment.

Mitigations:
The number of patients waiting over 78 weeks has increased by 38 from March. There is a 78 week cohort meeting between the ICB and ULHT to monitor progress against target which takes place 3 times a week. Appropriate admitted and non-admitted patients continue to be transferred out to ISP's or insourced, with an established process for this now in place for several specialties.

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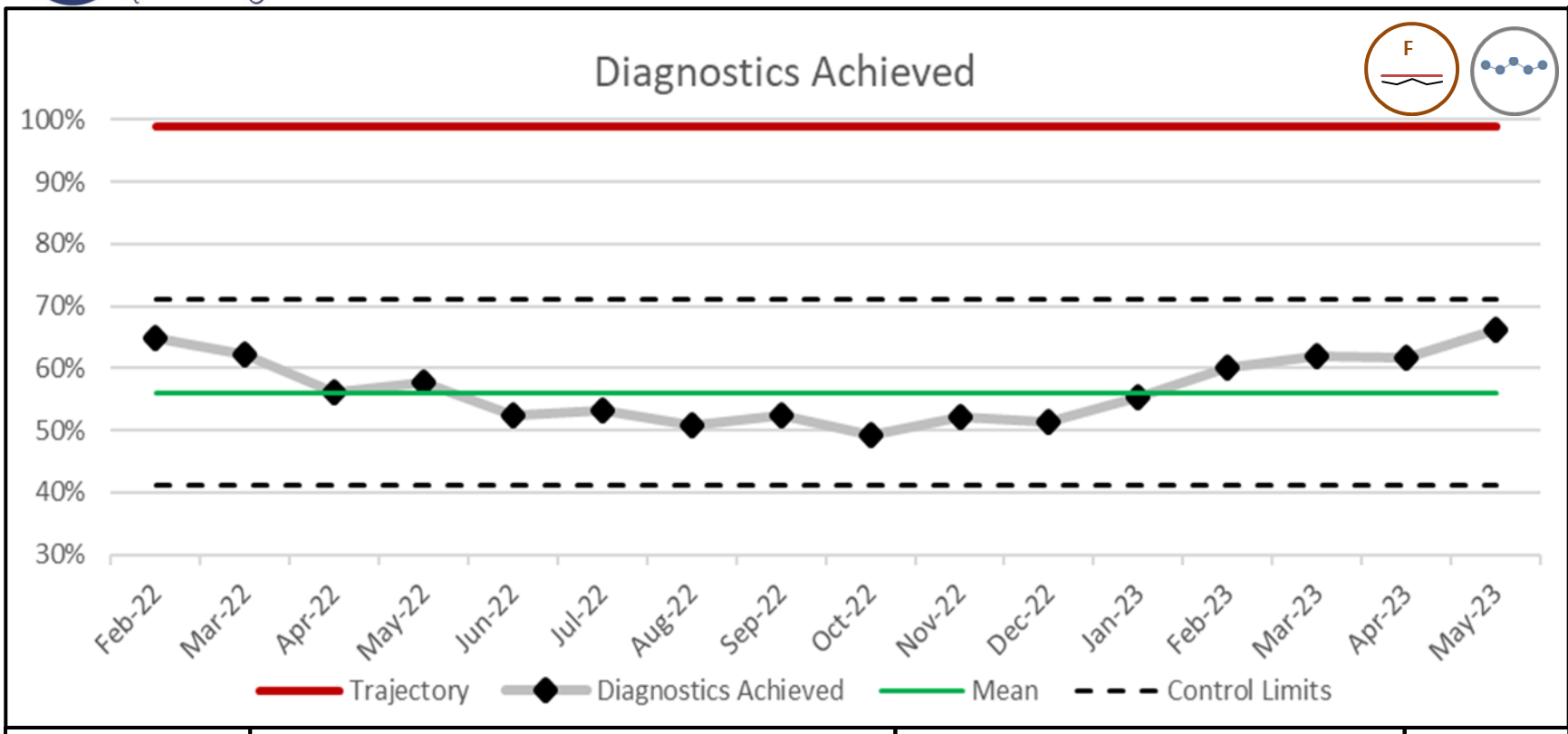


May-23
66.10%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
99.00%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Diagnostics achieved in under 6 weeks.

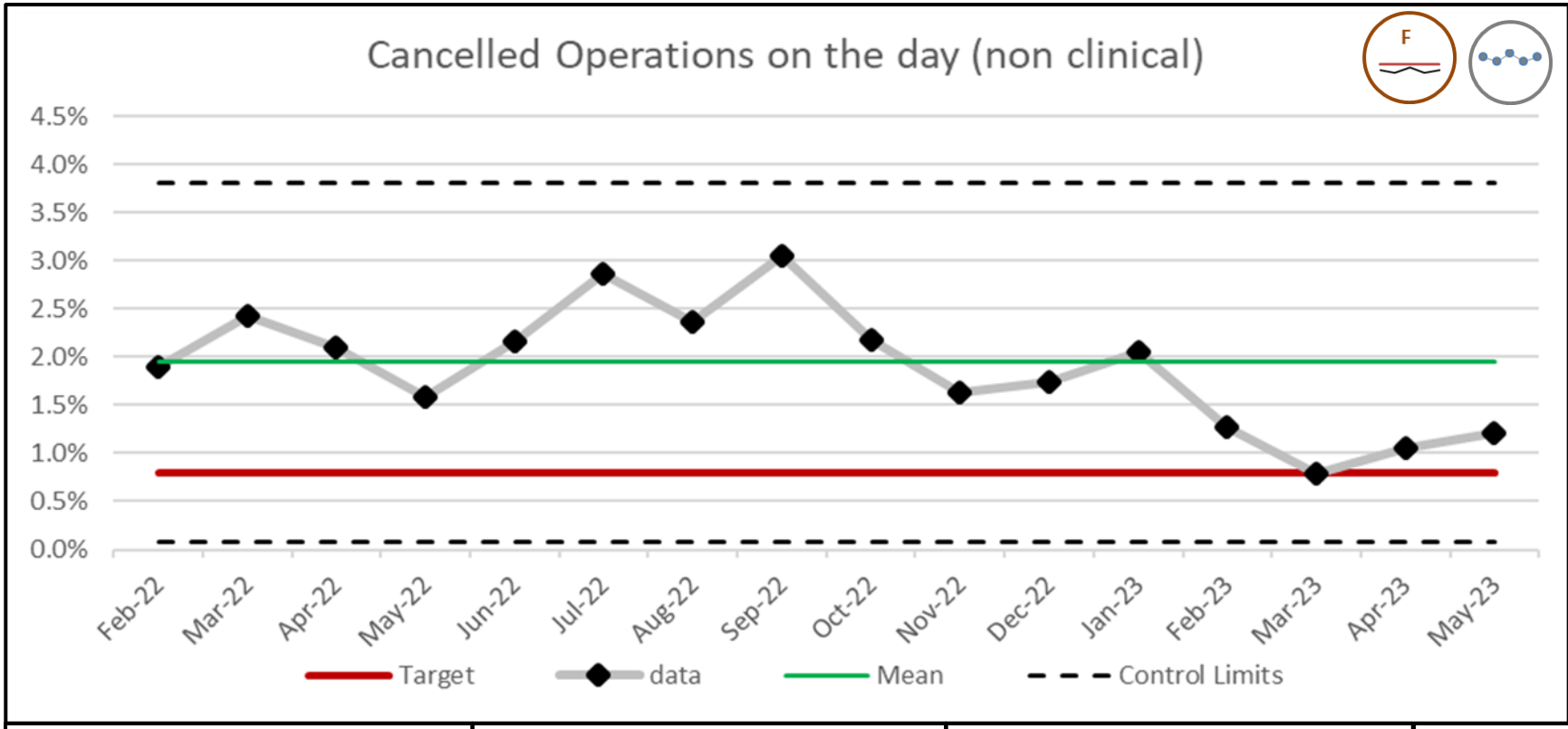
What the chart tells us:
We are currently at 66.10% against the 99.00% target.

Issues:

- The majority of diagnostic breaches sit in Cardiac Echo with 4670 breaches recorded in April.
- MRI has 446 breaches. Additional outsourcing to help reduce the backlog from January 2023 hopefully reducing breaches to within limits by September
- There is 593 Dexa Breaches as the scanner is now up and running we should see a reduction of around 200 breaches each month but slowed down due to increase in demand not activity
- Additional to the 4670 cardiac echoes there are additional 109 Stress/TOES and 170 echo-paediatrics.

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

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



May-23
1.21%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0.8%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us
There has been further increase in number of patients cancelled on the day from 1.05% in April to 1.21% in May which is above the agreed trajectory of 0.8%.

Issues:
The top 3 reasons for same day non-clinical theatre cancellations for May have been identified as:

1. Lack of time
2. No equipment available
3. No surgeon

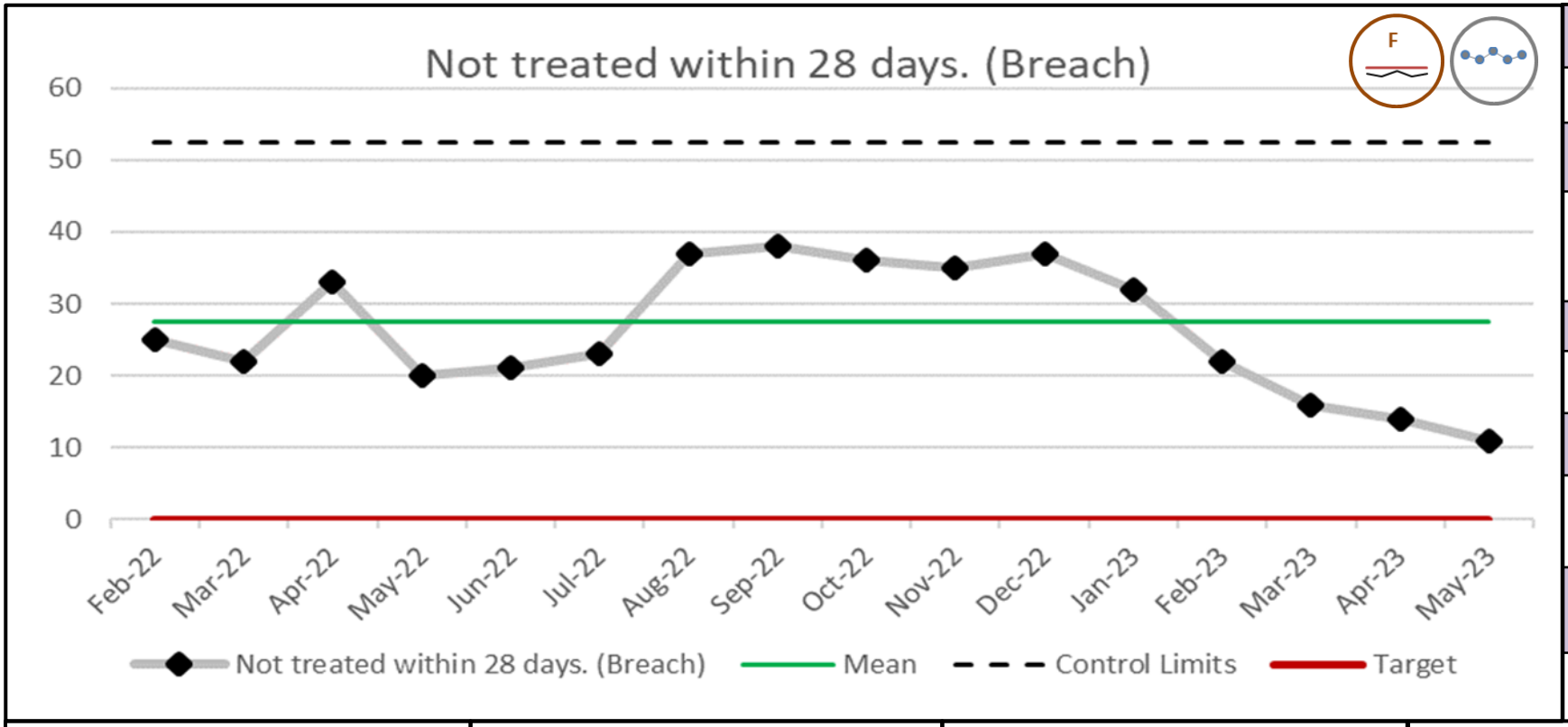
Actions:
Ensuring theatres start on time alongside reduced down time between cases will reduce the possibility of cancellations for lack of time due to late starts.

Super Sprint rolled out to Lincoln and Pilgrim on 5th June so there is an expectation this will improve further.

Improve recording

Mitigations:
On the day sickness for staff and an issue with the Grantham laser were the cause for nearly 50% of Mays' on the day cancellations.

A further 8% were down to mis-recorded cancellations which were actually cancelled prior to the day of surgery.



May-23
11
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
There have been further reductions in May, with the total number of breaches now at 11 which is a continuing reduction, though the agreed target of zero has not been achieved.

Issues:
There has been reduced availability of lists due to the school holidays during May which reduced list availability.

Actions:
Waiting List teams continue to work to maintain planned list activity at a minimum of 90%.

Grantham utilisation is being pushed with all CBUs to provide an increase

Mitigations:
The Productive Theatre/Super Sprint initiative has now also rolled out to Pilgrim and Lincoln and provides increased focus on list utilisation and therefore this has supported ensuring lists are fuller, providing ability to reduce breaches which is evident in the reduction of breaches.

OUTSTANDING CARE personally DELIVERED

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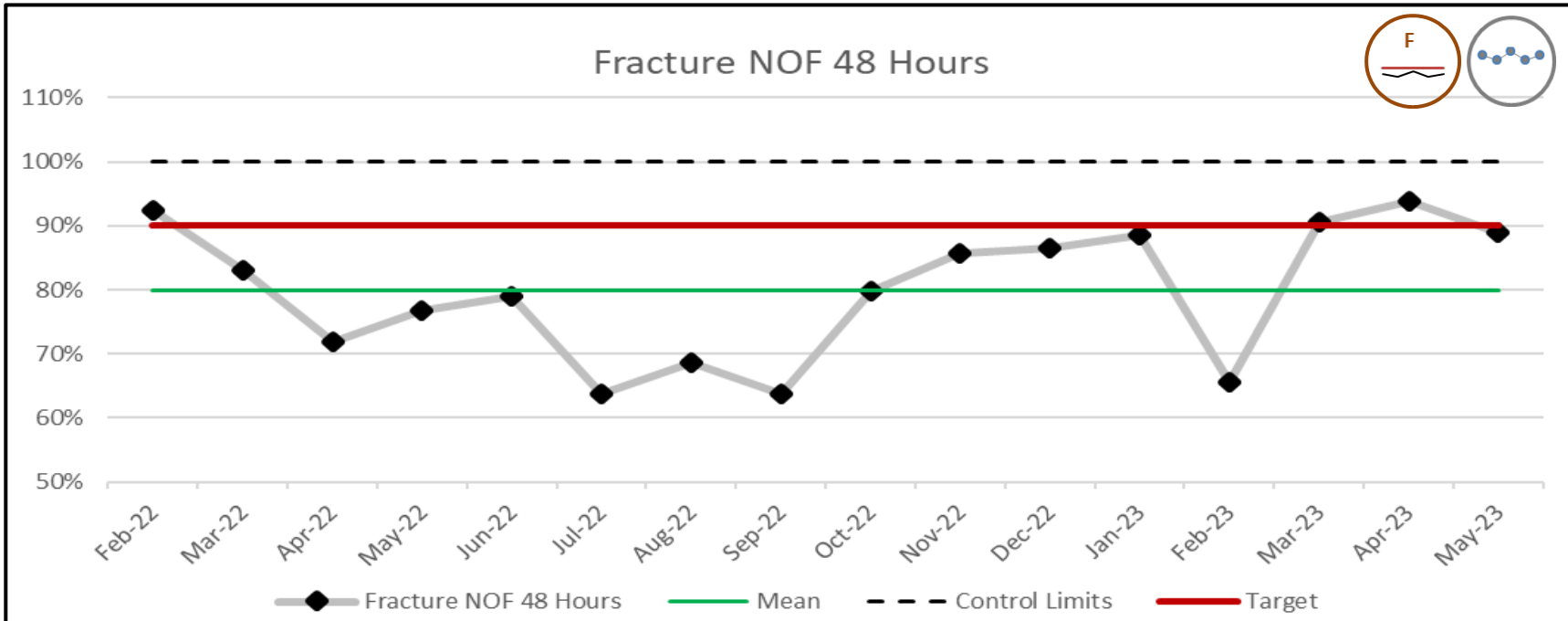

May-23
88.89%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
Metric is failing the target
Executive Lead
Chief Operating Officer

Background:

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

What the chart tells us:

March and April has achieved the target of getting fractured femurs patients to theatre within 48 hours.

In May LCH percentage was 75% and PHB was 97.22%.

The average percentage across both sites was 88.89%, just under target.

Issues:

- LCH admitted 8 fractured femur patients over a period of 48 hours which have caused breaches due to no theatre capacity
- Due to increase in trauma demand and the types of injuries seen, certain procedures have been clinically prioritised ahead of fractured femur patients.
- Delays for fractured femur patients included reduced theatre capacity, patients medically unfit to proceed and the need for specialist surgeon availability due to complexities.
- Specialty trauma lists on Boston and Lincoln sites not having capacity to add trauma patients
- Lack of anaesthetic or theatre staff to provide additional trauma capacity.
- Elective patients given priority over trauma cases.

Actions:

1. NOF pathway project to commence with the multidisciplinary team complying with the best practice tariff for femur fractures
2. Forward planning of theatre lists required based on peaks in activity seen (adding trauma to elective lists)
3. 'Golden patient' initiative to be fully implemented.
4. Ensure robust processes in place to utilise Trust wide trauma capacity and beds.
4. Additional Specialty Trauma lists identified to Theatre to ensure prioritisation of cases.
5. Review of additional trauma lists through job planning process
6. To ensure that the band 7 trauma lead continues to the utilisation of lists and escalate high capacity of trauma cases to the CBU to see if extra theatre lists are available
7. Trauma coordinator team to ensure that femur fractures are listed on the trauma list before breaches

Mitigations:

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

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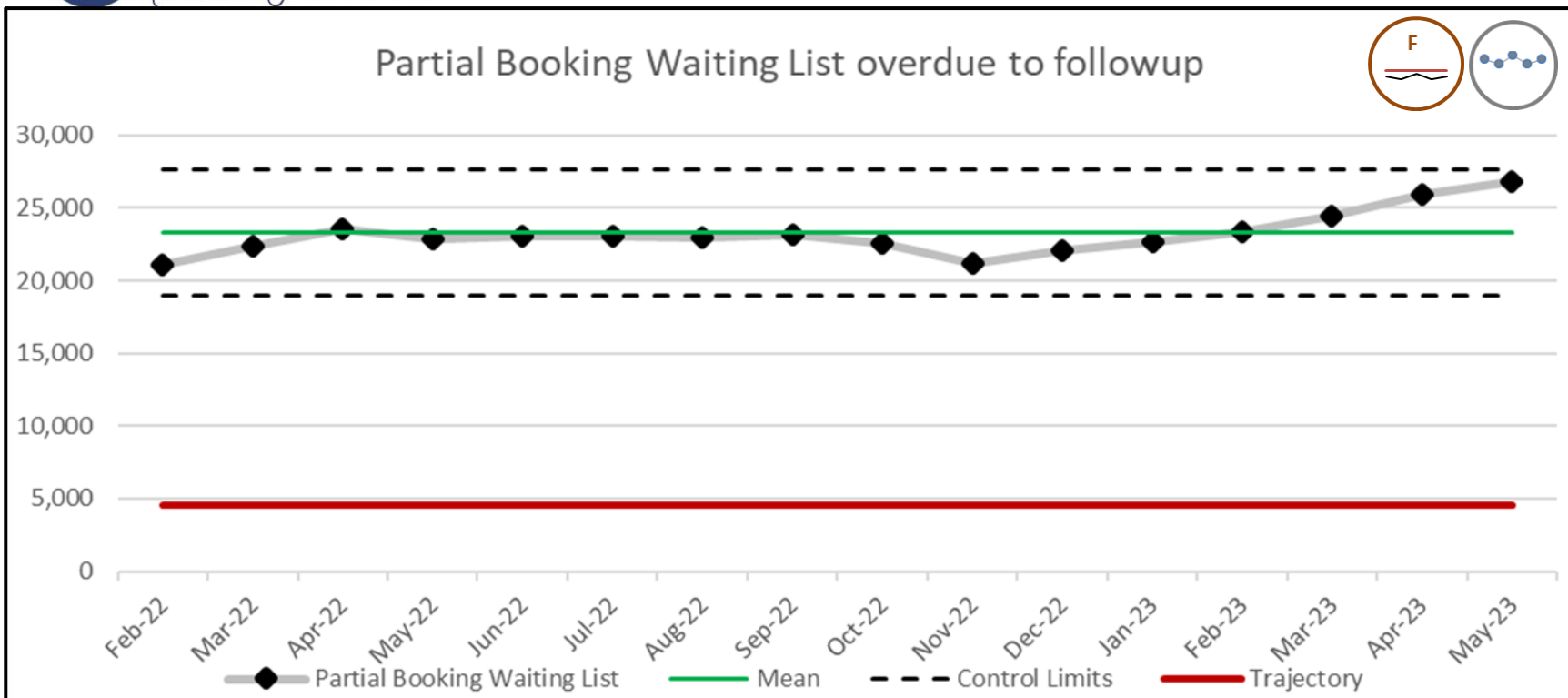

May-23
26,816
Variance Type
Metric is currently experiencing Common Cause Variation
Target
4,524
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
The number of patients more than 6 weeks overdue for a follow up appointment.

What the chart tells us:
We are currently at 26,816 against a target of 4,524.
During Covid the number of patients overdue significantly increased until April 2022, at which point it remained stable. Since November 2022 the PBWL has steadily been increasing.

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

Actions:
The PBWL meeting with the CBU's has been relaunched with a new agenda and template to improve attendance and focus. Outpatients have met with the GM / DGM's to launch the new format. PIFU implementation has been refreshed and continues to be an area of focus to reduce PBWL.

Mitigations:
Clinics and patients have previously been cancelled and added to the PBWL due to industrial action. Booking team priorities are to support the industrial action plans and supporting the booking of the 78 week cohort.

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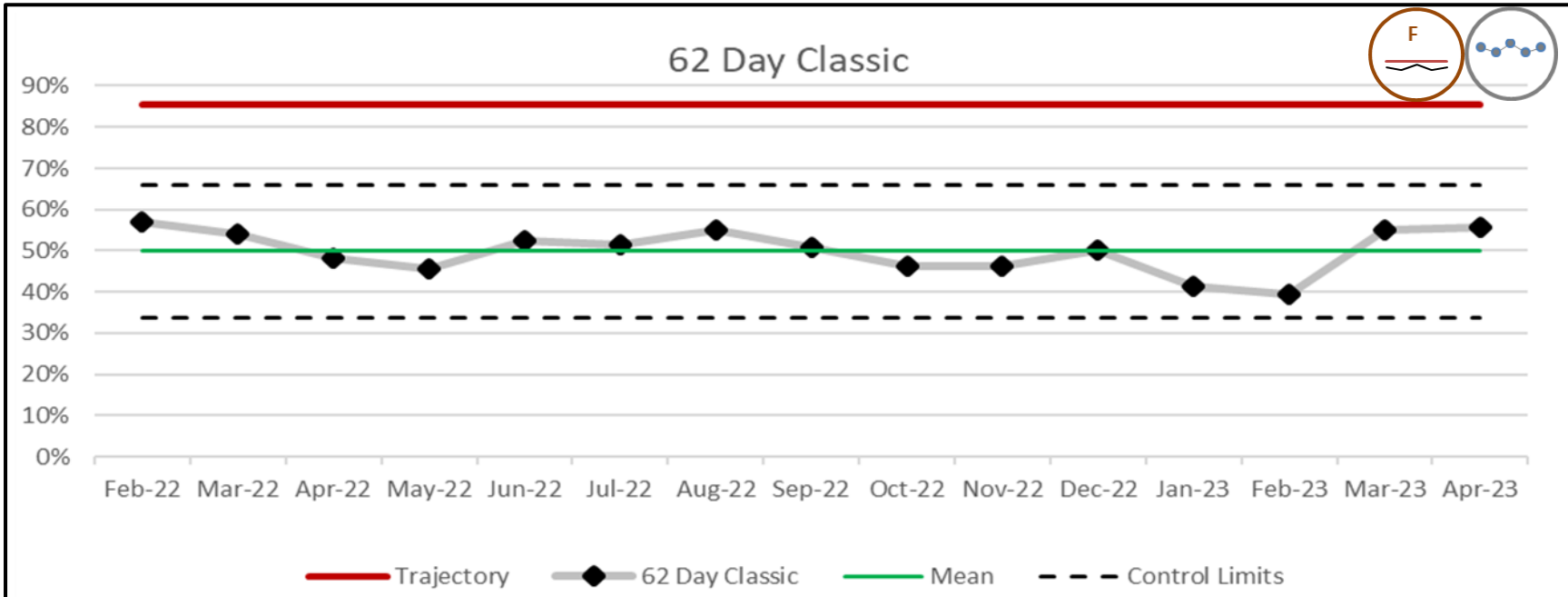


Apr-23
55.71%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
85.4%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

Percentage of patients to start a first treatment within 62 days of a 2ww GP referral.

What the chart tells us:

We are currently at 55.71% against an 85.4% target.

Issues:

The impact of ongoing pathway, staffing and capacity challenges.
Patients not willing to travel to where our service and / or capacity is.
Managing backlogs significantly in excess of pre-COVID levels for Colorectal, Upper GI, Urology, Head & Neck, Gynaecology and Lung.
Limited theatre capacity continues to impact cancer pathways across the Trust.
Anaesthetic assessment capacity is also limited and impacts the ability to be able to populate lists at short notice.

Actions:

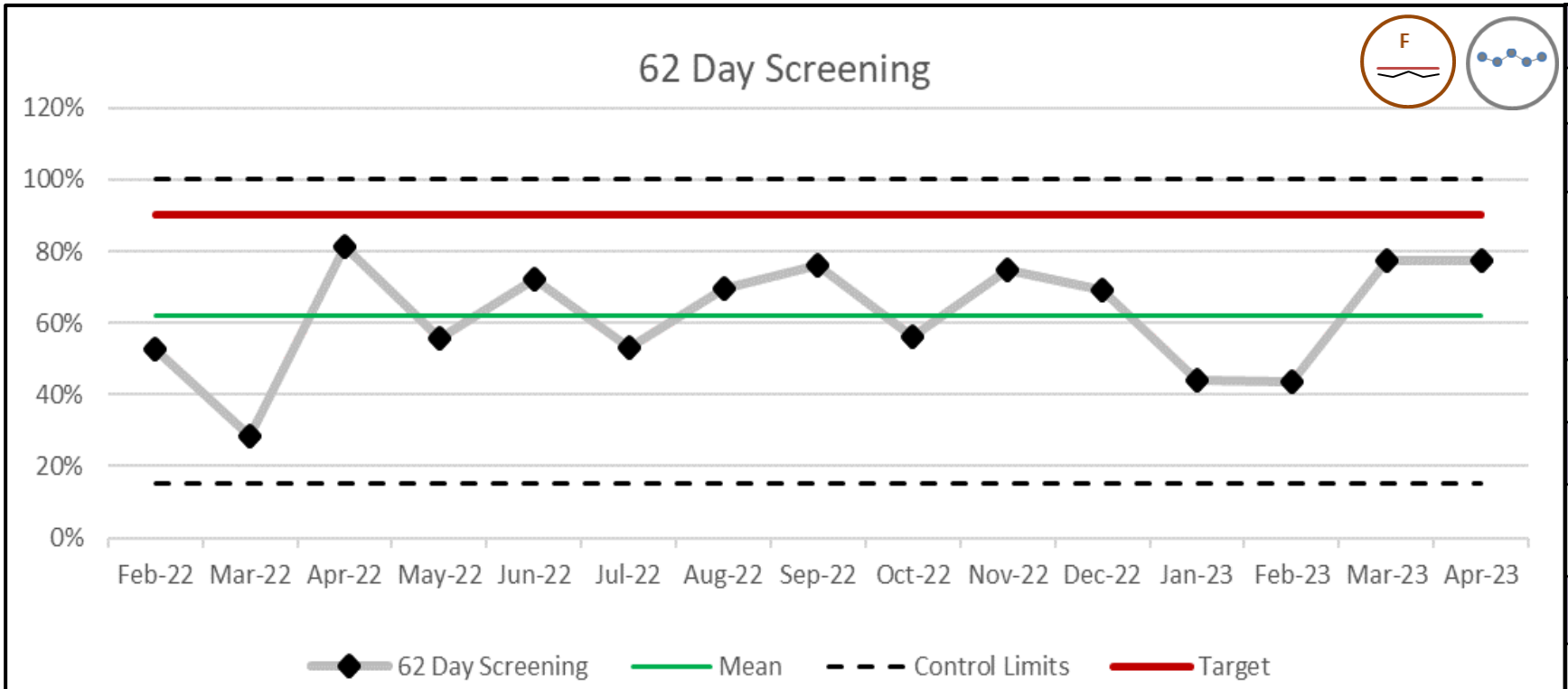
In Oncology, recruitment is ongoing to secure locums, NHS locums or substantive posts. 2 Medical Oncologist posts are out to advert as locums. We appointed to one post and area awaiting a start date. A 6 month Oncology SpDr post went out to advert from which we have 2 appointable candidates. One has already started and one is awaiting the PLAB2 exam.
Robotic Lists are progressing well, though proving difficult to populate at short notice if there are cancellations due to the lack of trained staff within theatres, pre-op and anaesthetics. Tumour site specialties are working with TACC to ensure the best possible utilisation of lists, including a process for last minute cancellations.

Please also see Actions on accompanying pages.

Mitigations:

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

Please also see Mitigations on accompanying pages.



Apr-23
77.27%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

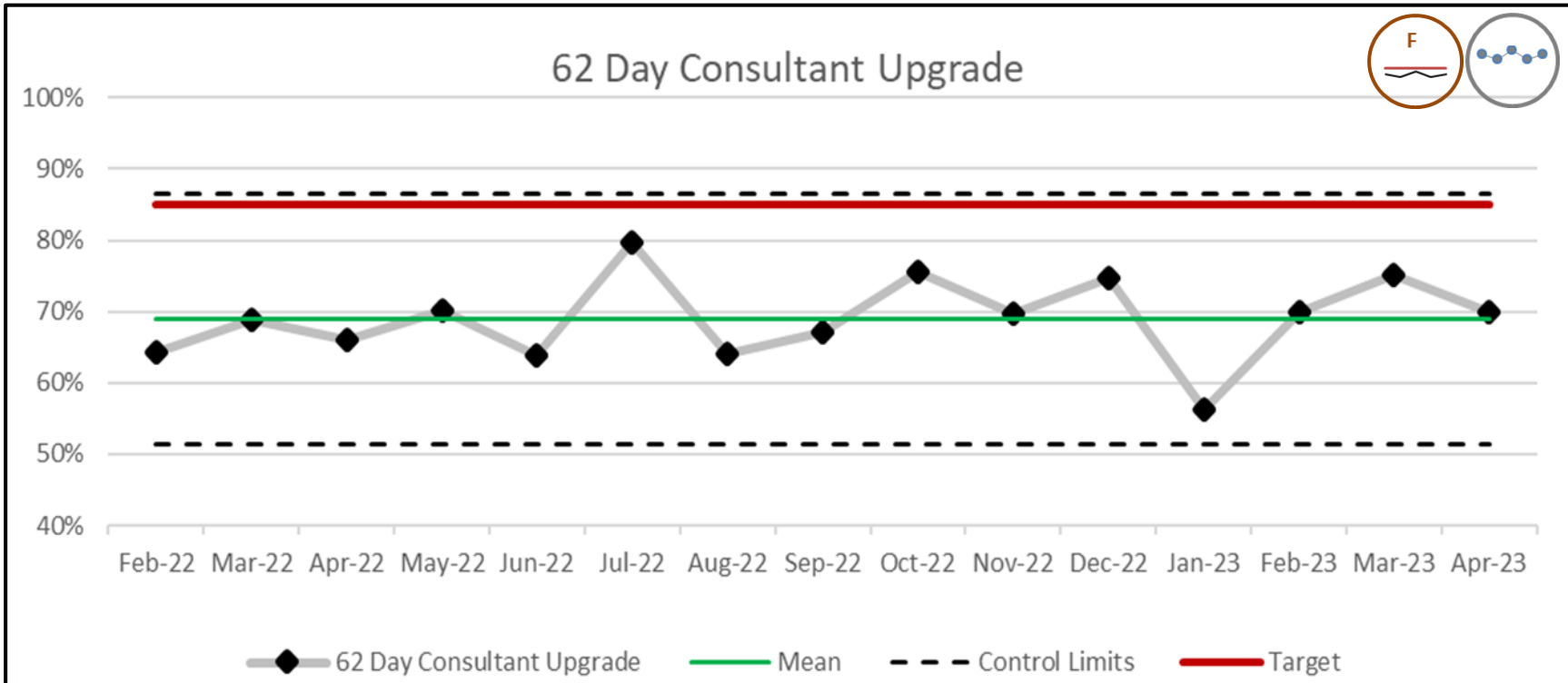
Background:
Percentage of patients to start a first treatment within 62 days of referral from an NHS cancer screening service.

What the chart tells us:
We are currently at 77.27% against a 90% target.

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

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

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



Apr-23
69.90%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
85%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 69.90% against an 85% target.

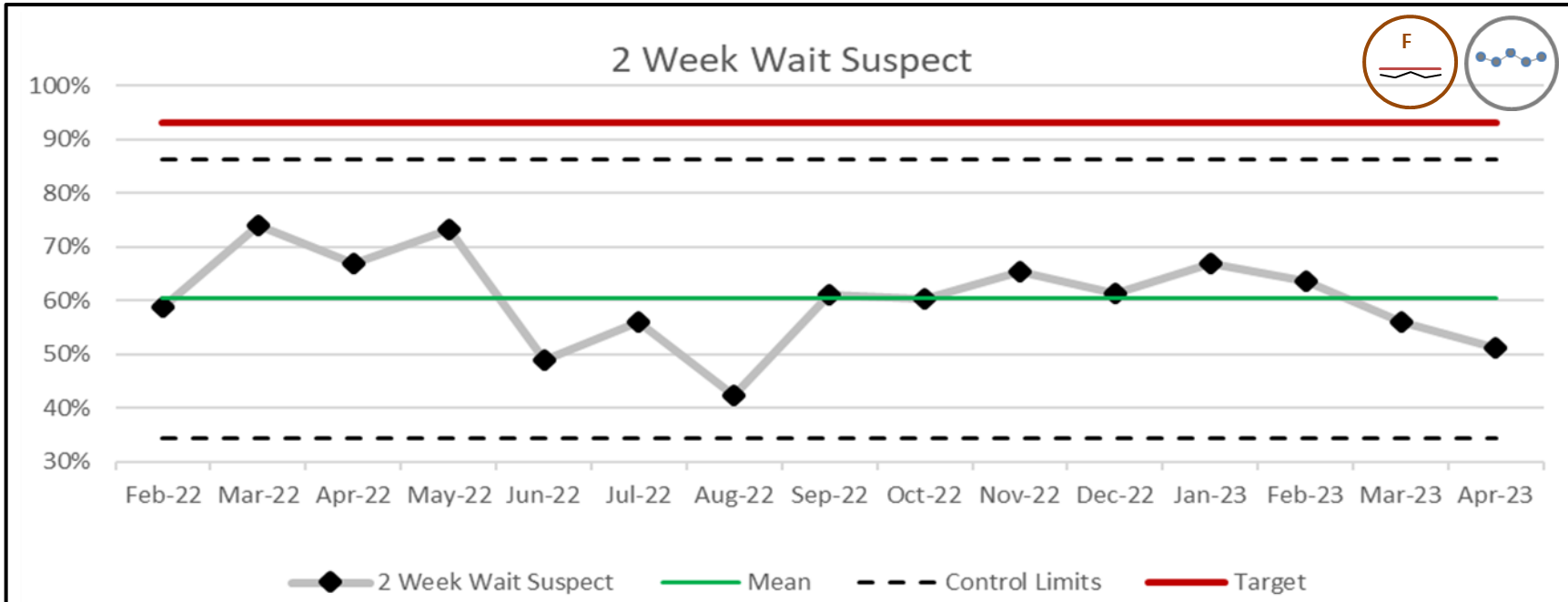
Issues:
See issues on previous page – 62 day classic.

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

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Apr-23
51.23%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
93%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

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

What the chart tells us:

We are currently at 51.23% against a 93% target.

Issues:

Patients not willing to travel to where our service and/or capacity is available.
Nurse Triage / CNP capacity issues in colorectal specialty.
The Trust's 14 Day performance continues to be impacted by the current Breast Service One-Stop appointment alignment issues, with 30% of the Trust's April 14 Day breaches within that tumour site.
Also of concern was skin performance which accounted for 38% of the Trust's 14 day breaches.
The Gynae tumour site accounted for 13% of April breaches.

Actions:

In Gynaecology, a number of work streams have been identified through the oncology strategy meetings. Referral triage by the CNS team and referral redesign work is still underway to address 1st OPA capacity challenges.
The Radiology Recruitment Strategy and intensive support meetings are in place to address the fragile Breast Service One-Stop appointment alignment issues.
Respiratory consultant capacity is a continuing issue alongside an increased number of referrals. ICB Analysis of the FReD Referrals is in progress and an ongoing BC for an increase in consultant workforce to 10-15 consultants is ongoing.
UGI Referral and Triage processes are being reviewed and a Gap Analysis supported by the ICB has been completed. The ICB is supporting discussions regarding the management of incomplete referrals. A bid is being developed for UGI CNS to triage at the start of UGI pathway and discussions are underway with Endoscopy and Outpatient teams to streamline processes at the front of the pathway and support effective triage and booking of appointments.
These and other key action progress are tracked through the Urgent Care Cancer group chaired by the Medical Director and run with full system partner involvement.

Mitigations:

Haematology is in fragile services due to vacancy/capacity. Issues with inappropriate referrals and GP engagement continue to be escalated and supported by the ICB.
Delays in the booking and utilisation of appointment slots which continue to be addressed with C&A.
In Dermatology, the seasonal increase in referrals is already evident. A Demand and Capacity deep dive has resulted in a number of improvements being adopted to smooth out booking processes and increase capacity.
In Urology Poor quality referrals without PSA/DRE/MSU are causing delays - the ICB are working with PC to improve comms and referral quality.

OUTSTANDING CARE personally DELIVERED

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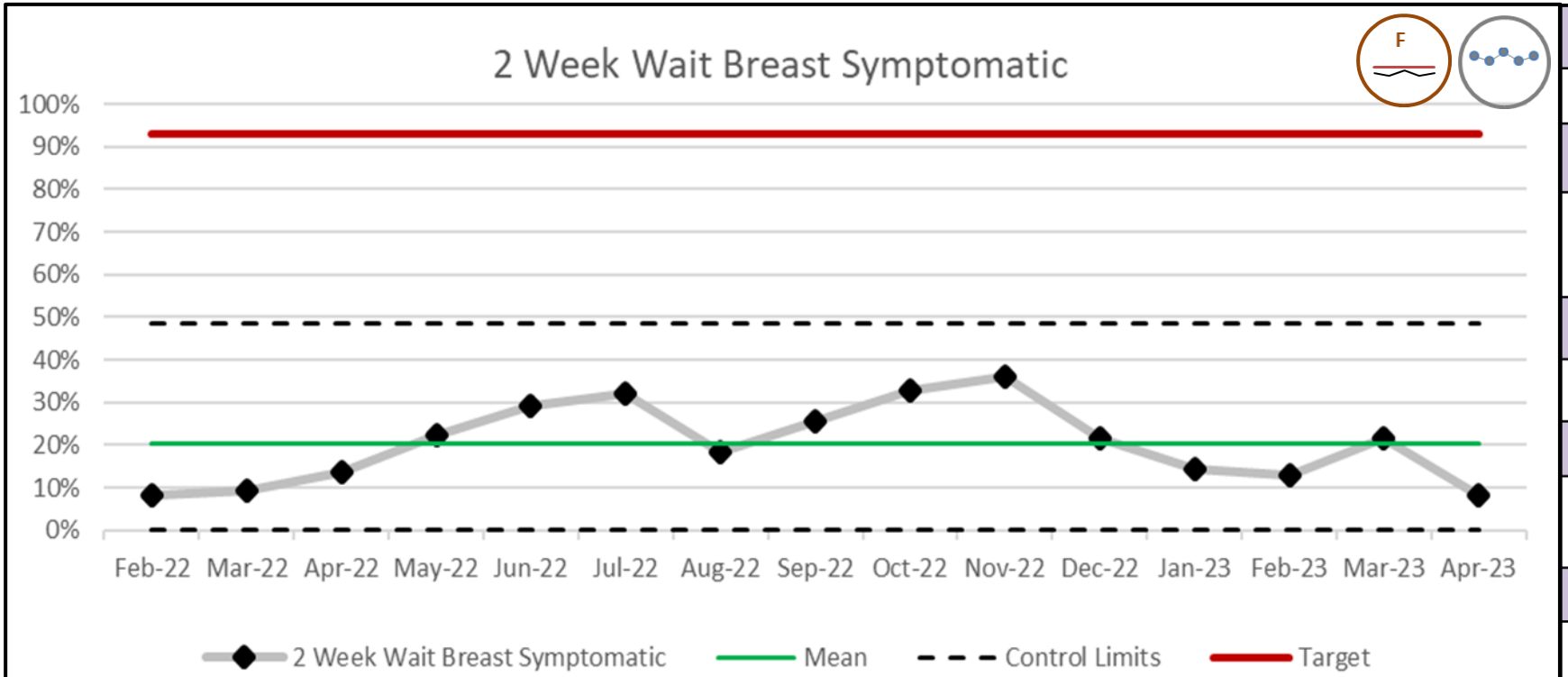

Apr-23
8.08%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
93%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 8.08% against a 93% target.

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

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

Mitigations:
A mastalgia pathway is now up and running with primary care and system partners which has the potential to reduce inbound referrals by circa 15-20%.

OUTSTANDING CARE personally DELIVERED

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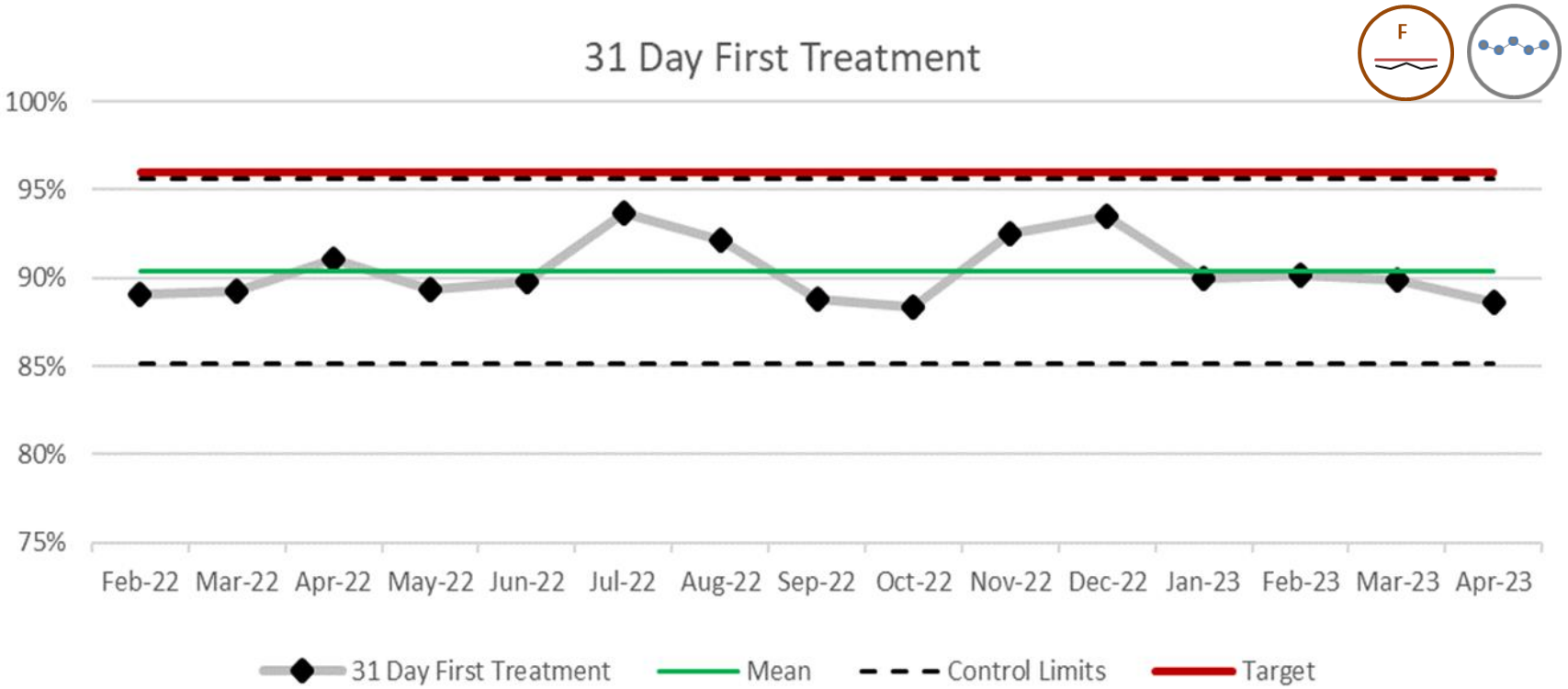


Apr-23
88.63%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
96%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

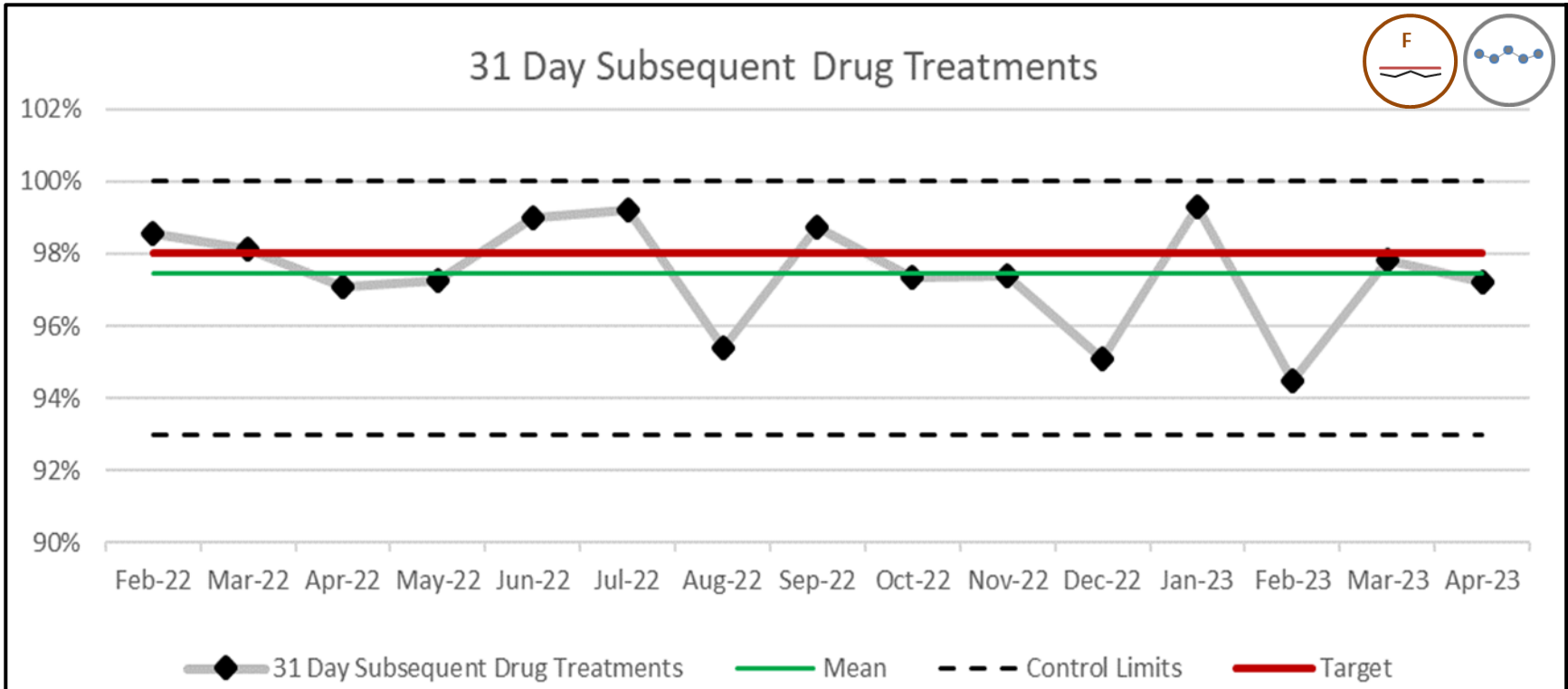
Background:
Percentage of patients treated who began first definitive treatment within 31 days of a Decision to Treat.

What the chart tells us:
We are currently at 88.63% against a 96% target.

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

Actions:
Recruitment in Oncology is ongoing to secure locums, NHS locums or substantive posts. 2 Medical Oncologist posts are out to advert as locums. We appointed to one post and area awaiting a start date. A 6 month Oncology SpDr post went out to advert from which we have 2 appointable candidates. One has already started and one is awaiting the PLAB2 exam.
OMF Capacity issues are impacting both Head and Neck and particularly Skin pathway performance – escalated as a risk.
Radiotherapy & Brachytherapy – Recent Linac breakdowns have resulted in delayed treatment start dates. Multiple Bank Holidays have resulted in reduced Brachy capacity – work is underway with theatre teams with an aim to provide a Tuesday service.

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



Apr-23
97.22%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
98%
Target Achievement
Metric is failing the target
Executive Lead
Chief Operating Officer

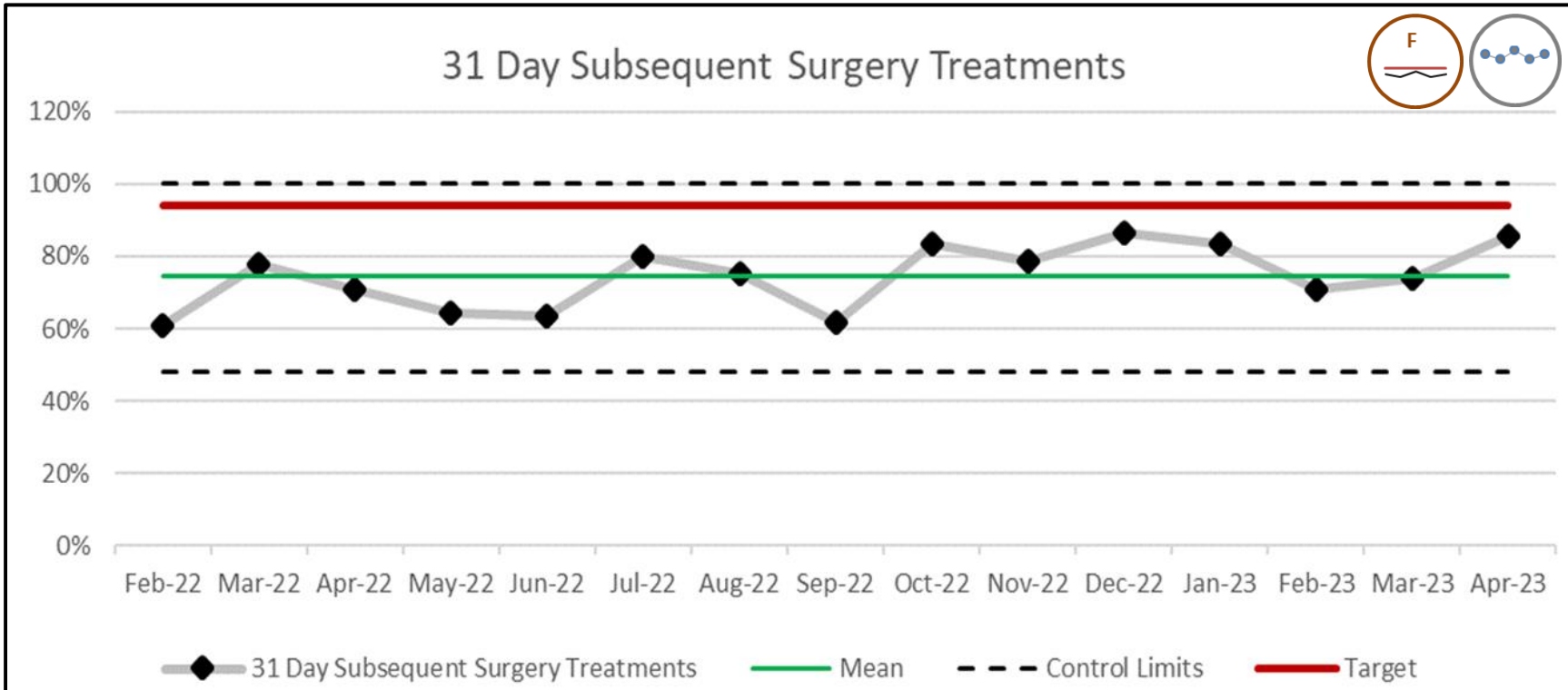
Background:
Percentage of patients who began treatment within 31 days where the subsequent treatment was drugs.

What the chart tells us:
We are currently at 97.22% against a 98% target.

Issues:
The failure of the 31 Day standards was primarily attributed to lack of AA and theatre capacity.
In March, the Trust only narrowly missed achieving the standard for Drug.

Actions:
See actions on previous page – 31 day first treatment.

Mitigations:
See mitigations on previous page – 31 day first treatment.



Apr-23
85.71%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
94%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

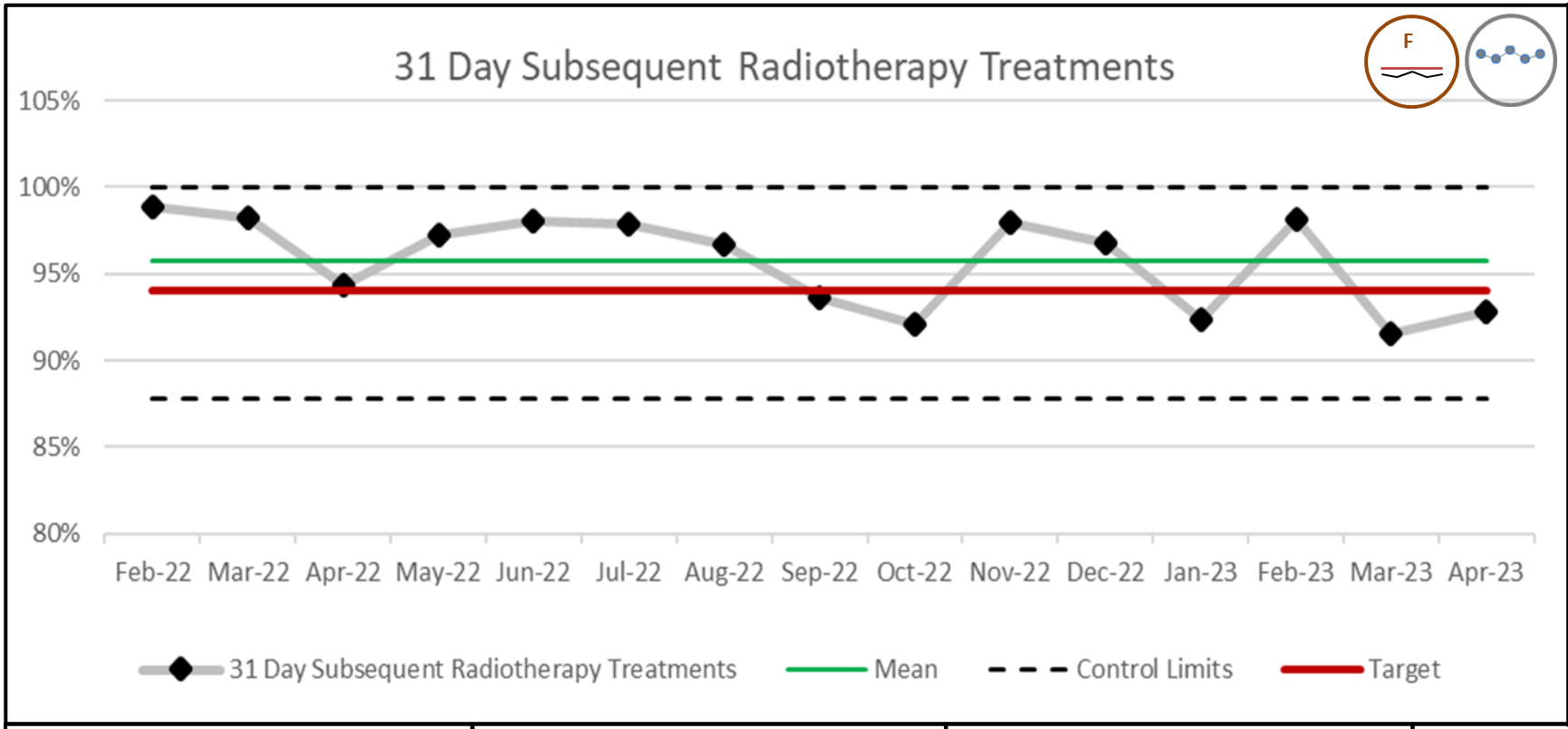
Background:
Percentage of patients who began treatment within 31 days where the subsequent treatment was surgery.

What the chart tells us:
We are currently at 85.71% against a 94% target.

Issues:
The failure of the 31 Day standards was primarily attributed to lack of AA and theatre capacity.
In February, for the subsequent standards the Trust achieved the RT standard, only narrowly missing the standard for Drug.

Actions:
See actions on previous page – 31 day first treatment.

Mitigations:
See mitigations on previous page – 31 day first treatment.



Apr-23
92.77%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
94%
Target Achievement
Metric is failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 92.77% against a 94% target.

Issues:
Radiotherapy & Brachytherapy – Recent Linac breakdowns have resulted in delayed treatment start dates. Multiple Bank Holidays have resulted in reduced Brachy capacity – work is underway with theatre teams with an aim to provide a Tuesday service.

Actions:
See actions on previous page – 31 day first treatment.

Mitigations:
See mitigations on previous page – 31 day first treatment.

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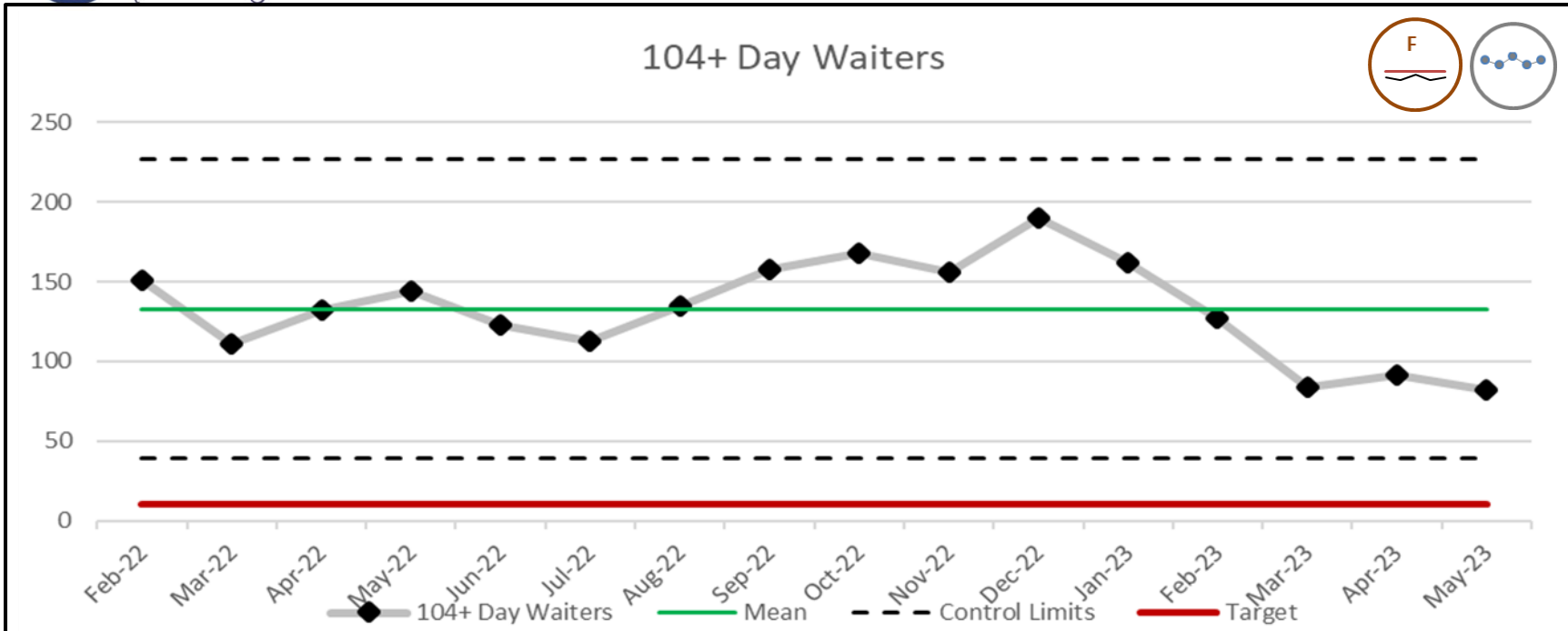

May-23
82
Variance Type
Metric is currently experiencing Common Cause Variation
Target
10
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

Number of cancer patients waiting over 104 days.

What the chart tells us:

As of 8th June the 104 Day backlog was at 82 patients. The agreed target is <10.

There are three tumour sites of concern:-
Colorectal 30 (majority awaiting diagnostics, outpatients and clinical review)
Upper GI 12
Head & Neck 10

Issues:

The impact of ongoing pathway, staffing and capacity challenges.
Patients not willing to travel to where our service and / or capacity is available.
Reduced OP, diagnostic and theatre capacity across the Trust, all Specialties vying for additional sessions.
Managing backlogs significantly in excess of pre-COVID levels for Colorectal, Upper GI, Urology, Head & Neck, Gynaecology, and Lung.
Approximately 21% of these patients require support from the Pre-Diagnosis CNS as they have mental or social care needs that have the potential to significantly impact on the length of their pathway.

Actions:

See Actions on previous pages

Mitigations:

See Mitigations on previous pages

Intensive Support Meetings in place to support Colorectal, Urology, Lung, Upper GI and Breast recovery. Other tumour site specialties are being monitored as appropriate.

PERFORMANCE OVERVIEW - WORKFORCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Feb-23	Mar-23	Apr-23	May-23	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
A Modern and Progressive Workforce	Overall percentage of completed mandatory training	Safe	People	Director of HR & OD	95%	88.81%	89.18%	90.17%	90.56%	90.37%		F		
	Number of Vacancies	Well-Led	People	Director of HR & OD	8.5%	7.72%	6.91%	7.69%	6.73%	7.21%		P		
	Sickness Absence	Well-Led	People	Director of HR & OD	4.5%	5.61%	5.61%	5.57%	5.56%	5.56%		F	A	
	Staff Turnover	Well-Led	People	Director of HR & OD	12%	13.55%	12.82%	13.23%	13.01%	13.12%		F		
	Staff Appraisals	Well-Led	People	Director of HR & OD	90%	65.39%	65.95%	67.19%	67.93%	67.56%		F	A	

See Executive Scorecard section for relevant failing metrics above.

OUTSTANDING CARE personally DELIVERED

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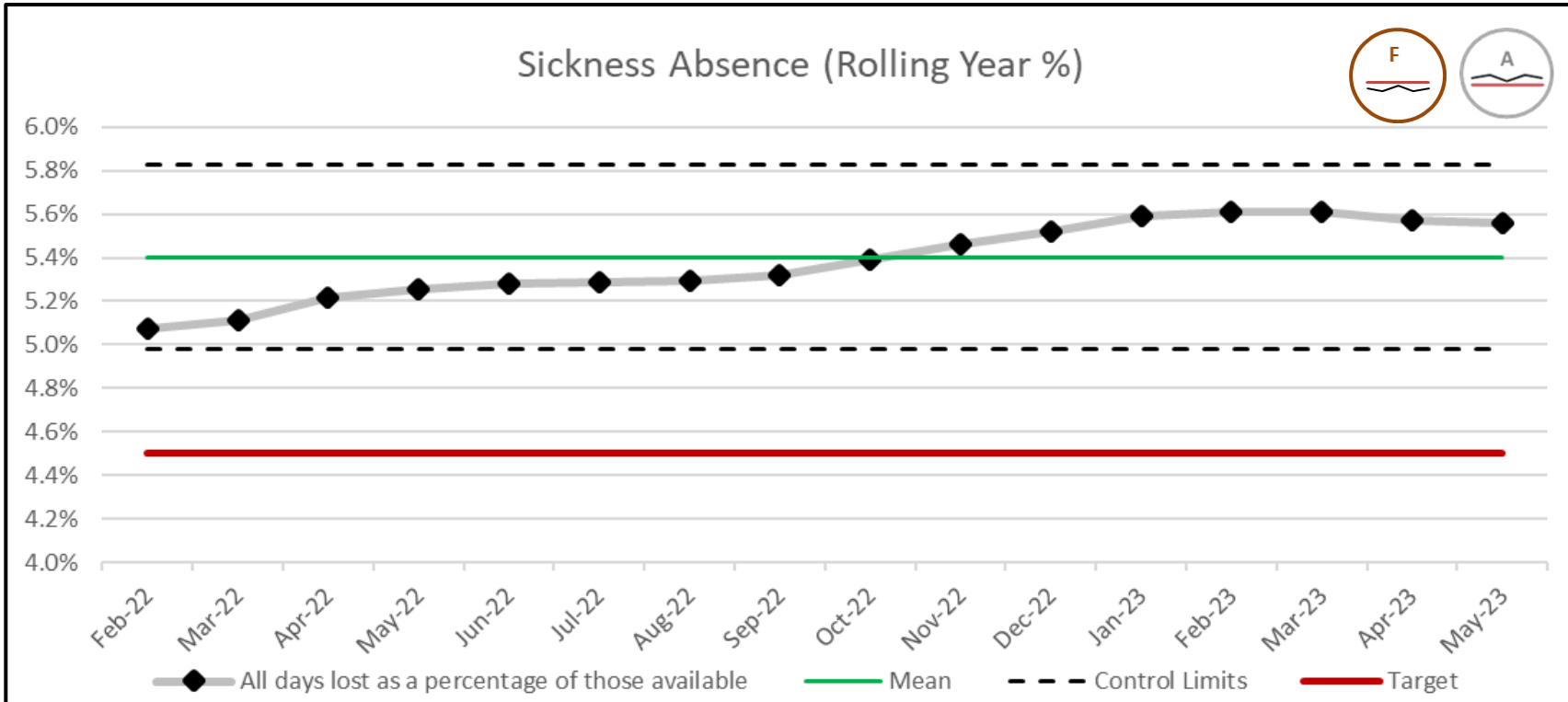

May-23
5.56%
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
4.5%
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of People and OD

Background:
5.56% of sickness absence rolling year.

What the chart tells us:
5.56% is above the target of 4.5%.

Issues:

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

Actions:

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

Mitigations:
Please note that by gaining full engagement in the use of AMS, we will see an increase in the absence rate before we see an improvement due to accurate, full reporting.

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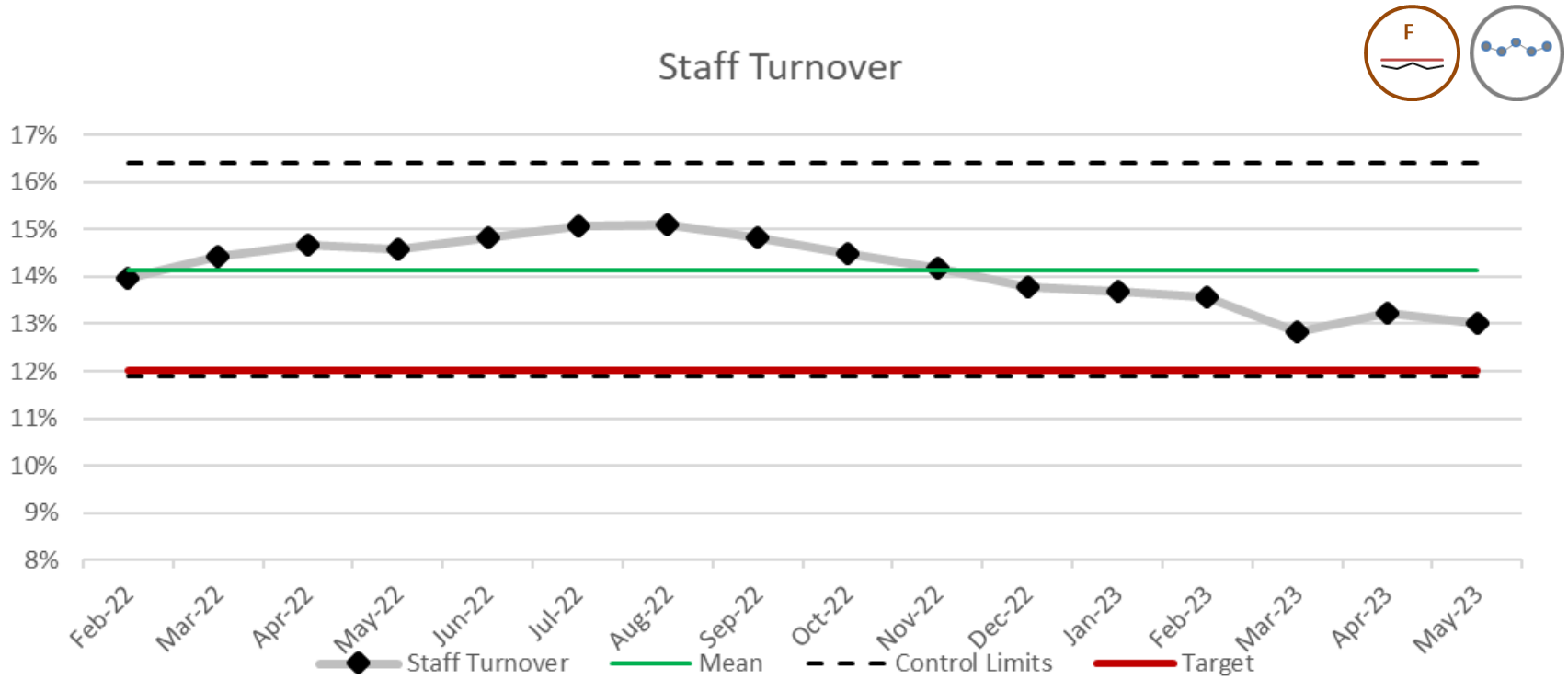

May-23
13.01%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
12%
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of People and OD

Background:
13.01% of turnover over a rolling 12 month period.

What the chart tells us:
Turnover rates have stabilised and decreased slightly month on month but are still higher than 12% target. There has been a small increase in April 2023 which was expected due to the financial year end leavers e.g. Fixed-Term contracts etc.

Issues:
Turnover rate was expected to increase in April 2023 due to year end leavers (fixed term contracts) and retirements.

Recent Analysis of exit survey data shows reasons as follows

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

Actions:

- Recruitment of a dedicated ULHT People Promise Manager focussing on retention issues including career conversations and flexible working.
- Recruitment/Induction of 16 Culture Ambassadors who have commenced their development programme.
- Recruitment levels are on track to reduce vacancies which will assist with retention

Mitigations:
Staff survey results are being disseminated across the Trust and focus groups have been arranged to gain feedback on the findings and establish Divisional action plans to address any of the areas of concerns highlighted and share best practice. This should help improve employee engagement levels by undertaking a 'you said we did' campaign which in turn should help reduce turnover.

Financial Position Month 2 (2023/24)
Finance Report
5 Year Priority – Efficient Use of Resources

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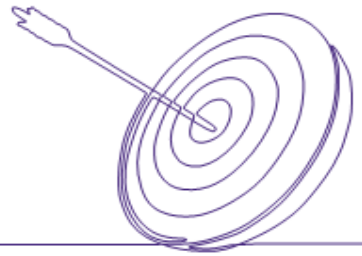
OUTSTANDING CARE
personally DELIVERED

Quality | Operational Performance | Workforce | **Finance**

Finance Spotlight Report (Headlines)



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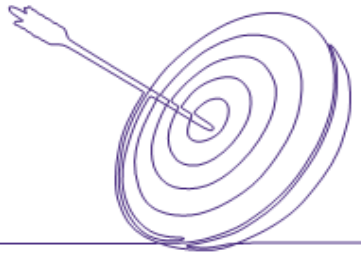
Adjusted financial performance	Current Month			Year to Date		
	Plan £000's	Actual £000's	Variance £000's	Plan £000's	Actual £000's	Variance £000's
Operating Income from patient care activities	58,794	58,807	13	115,945	115,526	(419)
Other operating Income	3,449	3,550	101	6,896	7,139	243
Employee Expenses	(43,671)	(42,883)	788	(85,226)	(84,241)	985
Operating expenses excl employee expenses	(20,680)	(21,588)	(908)	(41,425)	(42,291)	(866)
OPERATING SURPLUS/(DEFICIT)	**(2,108)**	**(2,114)**	**(6)**	**(3,810)**	**(3,867)**	**(57)**
Net finance costs	(451)	(464)	(13)	(925)	(906)	19
Other Gains / Losses	0	22	22	0	51	51
Surplus / (Deficit) for the period	**(2,559)**	**(2,556)**	**4**	**(4,735)**	**(4,722)**	**13**
Below Line Adjustments	53	53	0	105	105	0
Adjusted financial performance surplus / (deficit)	**(2,506)**	**(2,503)**	**4**	**(4,630)**	**(4,617)**	**13**

- **Revenue position** - The Trust's financial plan for 2023/24 is a deficit of £20.8m; the table above shows that YTD the Trust delivered an adjusted deficit of £4.6m i.e. the reported revenue position is in line with the planned deficit of £4.6m
- **Capital position** - The Trust's capital plan for 2023/24 amounts to £37.9m; YTD the Trust delivered capital expenditure of £0.5m, or £1.3m lower than planned capital expenditure of £1.8m.
- **CIP position** - The Trust's CIP plan for 2023/24 is to deliver savings of £28.1m; YTD the Trust delivered savings of £3.9m, or £1.5m (62.7%) favourable to planned savings of £2.4m.
- **Reporting** – Financial reporting for Month 2 reflects national guidance that providers will accrue for the full cost (YTD & FOT) of the AfC pay award in Month 2 (the medical pay award should be accrued in line with planning assumptions at this stage).

Finance Spotlight Report
(Key areas of focus - Income)



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The YTD income position is £180k adverse to plan; this includes:

- **NHS patient care income contract – £470k adverse to plan**; including
  - Pass through is £292k adverse to plan.
  - Provision has been made for £200k for income risk in relation to contract activity.
- **Other operating income from patient care activities – £51k favourable to plan**
- **Other operating income - £243k favourable to plan**; including
  - Non-patient care services income over performance of £189k.
  - Research & Development income over performance of £60k.
  - Car Parking income over performance of £41k.
  - Catering Income over performance of £36k.
  - Miscellaneous over performance of £16k.
  - Education & Training under performance of £97k.
  - Pay recharges under performance of £111k

Finance Spotlight Report
(Key areas of focus - Pay)

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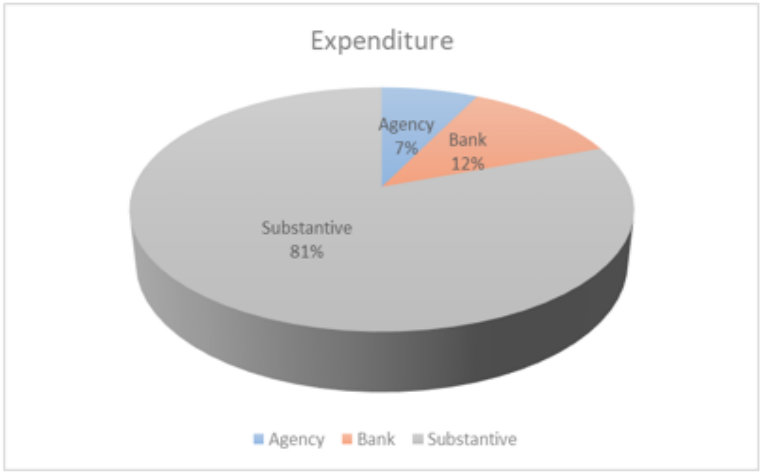
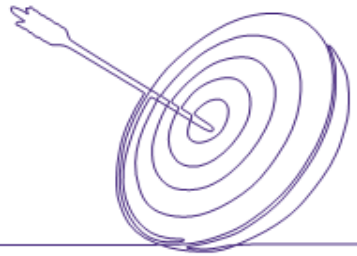
- Pay expenditure of £42.9m in May is £0.8m favourable to planned expenditure of £43.7m; the May position includes £1.6m in relation to the increased A4C pay award [providers were required to accrue in May for the full YTD cost of the award]; the **YTD pay position is £1.0m favourable to plan**.

- YTD expenditure on Pay comprised £68.4m (81%) on substantive staffing and £15.8m (19%) on temporary staffing:
  - £6.1m on agency staffing (down by £2.0m on expenditure of £8.1m in the same period of 2022/23).
  - £9.7m on bank staffing (up by £1.8m on expenditure of £7.9m in the same period of 2022/23).



- **The pay position includes**:
  - **Pay award** - An accrual for the full cost of the 2023/24 A4C pay award.
  - **Bank holiday enhancements** - An accrual re outstanding bank holiday enhancements for substantive staff (paid a month in arrears) and bank staff (paid a week in arrears).
  - **Local CEA** - An accrual in line with the financial plan for the 23/24 local clinical excellence award.
  - **Flowers** - An accrual for the costs of Flowers; these costs will be ongoing.

Finance Spotlight Report
(Key areas of focus - Other)



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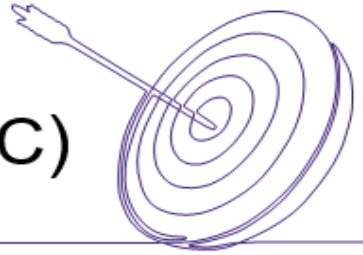
Non Pay

- Non pay expenditure of £21.6m is £0.9m adverse to plan both in-month and YTD; the YTD variance is driven by drugs being £0.8m adverse to plan due to the plan phasing re drugs expenditure; drugs expenditure is expected to be breakeven to plan at the end of each quarter.
- Actual non pay expenditure of £21.6m in May is £0.9m higher than expenditure of £20.7m in April; the key drivers of the overall increase in Non Pay expenditure include the following movements:
  - ❖ Increase across a number of expenditure lines e.g. £0.5m re drugs expenditure, £0.3m re International recruitment (partly offset by income), & £0.1m re Medical and Surgical supplies.
  - ❖ Increase of £0.8m in Estates & Facilities across food provisions, postage, building & engineering, and energy & utilities.
  - ❖ Decreases across a number of expenditure lines e.g. £0.1m on bad debt provisions re overseas visitors, and £0.1m re non recurrent Injury Benefit expenditure.
  - ❖ Overall movement partly mitigated by release of accruals made in M1 for activity/inflation.
- The YTD non pay position includes:
  - ❖ Lower than planned activity volumes, noting that clinical non pay expenditure will increase as activity volumes increase.
  - ❖ The levels of inflation suffered are expected to be higher than national planning guidance advised for 23/24; the level of excess inflation suffered is to be reviewed at the end of Q1.

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



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Cash

- The May 2023 cash balance is £51.0m; this is an increase of £9.7m against the March year-end cash balance of £41.3m.

- Whilst current cash levels remain comfortable; the position will narrow as we move into 2023/24 and will require careful management of cash and working capital.

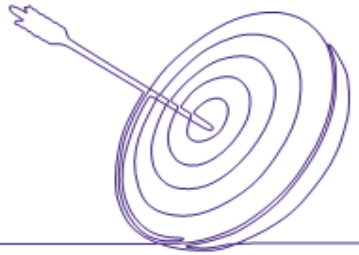
BPPC

- The BPPC performance for May was 84% / 78% by value / volume of invoices paid (appendix 5d).
- Year to date performance is 90% / 79% by value / volume, this compares to the full year performance in 2022/23 of 79% / 70%.

- At the end of May there were circa 2,247 unpaid invoices (£8.6m) over term. These will impact future BPPC performance levels as they are paid.

- The Trust received a letter from Julian Kelly re-iterating the 95% target and directing the Trust to improve performance from April. A multi-faceted improvement plan has since been implemented.

Finance Dashboard



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

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

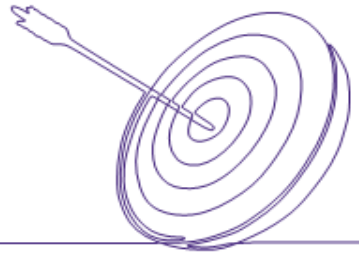
Metric	Rating Boundary			
	1	2	3	4
Capital servicing capacity	2.5	1.75	1.25	<1.25
Liquidity ratio (days)	0	-7	-14	<-14
I&E Margin	1%	0%	-1%	<=-1
I&E margin distance from plan	0%	-1%	-2%	<=-2%
Agency	0%	25%	50%	>=50%

The finance assessment seeks to answer the question: ***How effectively is the trust managing its financial resources to deliver high quality, sustainable services for patients?*** It does this at a high level using the 5 key indicators and each of which is rated 1 to 4 [which represent Outstanding, Good, Requires Improvement and Inadequate]. The rating boundaries are contained in the table above and ULHT absolute metric and rating for the last three full financial years and the current 2022/23 position are as follows

Finance and use of resources rating	Full Year ending:					Actual	Forecast
	31/03/2019	31/03/2020	31/03/2021	31/03/2022	31/03/2023	MAY 2023	31/03/2024
Capital service cover metric	(10.40)	(1.73)	0.06	3.60	1.48	0.26	1.00
Capital service cover rating	4	4	4	1	3	4	4
Liquidity metric	(98.73)	(128.28)	3.71	2.50	(10.91)	(9.77)	(22.27)
Liquidity rating	4	4	1	1	3	3	4
I&E margin metric	(19.71%)	(7.62%)	0.38%	0.29%	(1.80%)	(3.80%)	(2.82%)
I&E margin rating	4	4	2	2	4	4	4
Agency metric	77.00%	110.00%	113.00%	120.00%	[illegible]	[illegible]	0.00%
Agency rating	4	4	4	4	[illegible]	[illegible]	1
I&E margin: distance from financial plan - metric	(2.80%)	0.70%	n/a	0.01%	(1.80%)	0.00%	0.04%
I&E margin: distance from financial plan - rating	4	1	n/a	1	3	1	1

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

Balance Sheet



NHS
United Lincolnshire Hospitals
NHS Trust

	31-Mar-23	31-May-23		31-Mar-24	
		Plan	Actual	Plan	Forecast
	£000	£000	£000	£000	£000
Intangible assets	11,383	5,730	10,675	4,357	7,095
Property, plant and equipment	298,860	286,715	296,340	306,970	319,051
Right of use assets	11,807	11,465	11,393	9,656	9,391
Receivables	2,157	1,848	2,130	1,848	1,848
Total non-current assets	**324,207**	**305,758**	**320,538**	**322,831**	**337,385**
Inventories	6,133	7,000	6,316	7,000	7,000
Receivables	52,873	28,540	42,803	30,740	26,375
Cash and cash equivalents	41,269	49,928	50,977	16,201	16,201
Total current assets	**100,275**	**85,468**	**100,096**	**53,941**	**49,576**
Trade and other payables	(89,905)	(82,303)	(86,104)	(76,995)	(78,281)
Borrowings	(3,129)	(3,095)	(3,099)	(2,879)	(3,161)
Provisions	(17,670)	(6,825)	(18,398)	(4,825)	(4,825)
Other liabilities	(1,260)	(2,630)	(5,789)	(1,130)	(1,130)
Total current liabilities	**(111,964)**	**(94,853)**	**(113,390)**	**(85,829)**	**(87,397)**
Total assets less current liabilities	**312,518**	**296,373**	**307,244**	**290,943**	**299,564**
Borrowings	(12,189)	(11,932)	(11,795)	(9,481)	(9,007)
Provisions	(5,108)	(3,124)	(5,035)	(2,992)	(2,992)
Other liabilities	(11,069)	(10,985)	(10,985)	(10,566)	(10,566)
Total non-current liabilities	**(28,366)**	**(26,041)**	**(27,815)**	**(23,039)**	**(22,565)**
Total assets employed	**284,152**	**270,332**	**279,429**	**267,904**	**276,999**
Financed by					
Public dividend capital	724,041	723,888	724,042	738,081	738,236
Revaluation reserve	42,584	28,471	42,393	27,891	41,888
Other reserves	190	190	190	190	190
Income and expenditure reserve	(482,663)	(482,217)	(487,196)	(498,258)	(503,314)
Total taxpayers' equity	**284,151**	**270,332**	**279,429**	**267,904**	**276,999**

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

Note 2: Cash at £51.0m has increased £9.7m from March but is expected to reduce during the year in line with the planned deficit and a reductions in creditors / provisions.

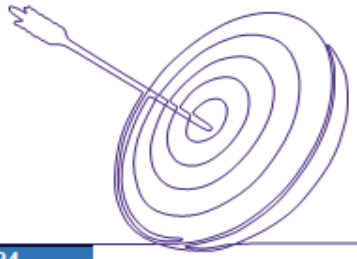
Note 3: Receivables remain higher than for much of 2022/23 with payment for the non-consolidated element of the 2022/23 pay award (£14.6m) due to be received in June.

Note 4: The overall level of Trade and other payables at £86.1m remains above historic levels. This includes the estimated cost of the pay award circa £14.9m. Capital makes up £5.7m of this, having reduced from the year end peak of £21.2m.
BPPC and aged creditor performance is reported at

Note 6: The planned capital programme for 2023/24 will result in asset additions of £38.0m. This is to be funded through internal cash resources but with an injection of £14.2m PDC capital.

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

Cashflow reconciliation – April 2022– March 2023



United Lincolnshire Hospitals NHS Trust

	31-Mar-23	31-May-23		31-Mar-24	
		Plan	Actual	Plan	Forecast
	£000	£000	£000	£000	£000
Operating surplus / (deficit)	(13,371)	(3,810)	(3,867)	(15,300)	(15,351)
Depreciation and amortisation	22,001	4,091	4,128	24,127	24,557
Impairments and reversals	5,079	-	-	-	-
Income recognised in respect of capital donations	(82)	-	-	(50)	(50)
Amortisation of PFI deferred credit	(503)	(84)	(84)	(503)	(503)
(Increase) / decrease in receivables and other assets	(38,148)	(40)	10,168	(2,240)	26,669
(Increase) / decrease in inventories	(127)	-	(183)	-	(867)
Increase/(decrease) in trade and other payables	1,593	(4,592)	10,374	(11,967)	(2,966)
Increase/(decrease) in other liabilities	130	1,500	4,529	-	(130)
Increase / (decrease) in provisions	10,861	(78)	617	(2,210)	(14,999)
Net cash flows from / (used in) operating activities	**(12,567)**	**(3,013)**	**25,683**	**(8,143)**	**16,360**
Interest received	1,175	459	413	2,100	2,238
Purchase of intangible assets	(4,142)	-	-	-	-
Purchase of property, plant and equipment	(42,693)	(12,325)	(16,001)	(45,930)	(45,930)
Proceeds from sales of property, plant and equipment	156	-	29	-	29
Net cash flows from / (used in) investing activities	(45,504)	(11,866)	(15,559)	(43,830)	(43,663)
Public dividend capital received	19,863	-	-	14,193	14,193
Other loans repaid	(402)	-	-	(805)	(805)
Capital element of finance lease rental payments	(2,416)	(387)	(398)	(2,319)	(2,319)
Interest element of finance lease	(121)	(19)	(18)	(104)	(104)
PDC dividend (paid)/refunded	(5,873)	-	1	(8,000)	(8,727)
Cash flows from (used in) other financing activities	(8)	-	(1)	(4)	(4)
Net cash flows from / (used in) financing activities	11,043	(406)	(416)	2,961	2,234
Increase / (decrease) in cash and cash equivalents	**(47,028)**	**(15,285)**	**9,708**	**(49,012)**	**(25,069)**
Cash and cash equivalents at 1 April - brought forward	88,297	65,213	41,269	65,213	41,269
Cash and cash equivalents at period end	**41,269**	**49,928**	**50,977**	**16,201**	**16,200**

Note 1: Cash held at 31 May was £50.9m against a plan of £49.9m. This represents an increase of £9.7m against the March year-end cash balance of £41.3m.

Note 2: Whilst the overall variance against plan is negligible there are differences within working capital payables and receivables driven predominantly by the 2022/23 non-consolidated pay award funding and liability.

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

- The planned deficit of £20.7
- Release / utilisation of provisions associated with current litigation and contractual obligations – circa £15m.
- A general reduction in payables as the Trust seeks improved compliance with the Better Payments Performance Target.
- A potential increase in the underlying level of receivables as ICBs move away from the block contract arrangements that have been in place for the last two years,

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

United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*4th July 2023*
Item Number	*Item 13.1*

Strategic Risk Report

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

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

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

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

Executive Summary

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

- There were 17 quality and safety risks rated Very high (20-25) reported to the Quality Governance Committee this month:
    - Patient flow through Emergency Departments;
    - Recovery of planned care admitted pathways;
    - Recovery of planned care non-admitted (outpatients) pathways;
    - Recovery of planned care cancer pathways;
    - Reliance on paper medical records;
    - Reliance on manual prescribing processes;
    - Potential for serious patient harm due to a fall;
    - Processing of echocardiograms;
    - Delivery of paediatric diabetes pathways-community
    - Delivery of paediatric epilepsy pathways-community
    - Quality and safety risk from inability to deliver diabetes pathways that meet National standards-Acute
    - Quality and safety risk from inability to deliver epilepsy pathways within Acute Paediatrics that meet National standards
    - Medicines reconciliation compliance;
    - Consultant capacity for Haematology outpatient appointments;
    - Non-recurrent funding in Cancer services;
    - ICU capacity for elective surgery.
    - Safety risk from Nationwide shortage of suction catheters as identified by NHS supply chain

- There were 8 People and Organisational Development risks rated Very high (20-25) reported to the People & Organisational Development Committee this month:

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

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

- Fabric and capacity of the mortuary service

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

1. Introduction

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

1.2 Full details of all active Very High and High risks (those with a current risk score of 15-25) are included in **Appendix A**, and a summary of Very High risks is provided in Section 2 below. Moderate and Low risks (those with a score of 12 and below) are managed at divisional level.

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

2. Trust Risk Profile

2.1 There were 378 active and approved risks reported to lead committees this month.

2.2 There were 31 risks with a current rating of Very high risk (20-25) and 33 rated High risk (15-16) reported to lead committees this month. **Table 1** below shows the number of active risks by current risk rating and proportion of the overall Trust risk profile:

Very low (1-3)	**Low** (4-6)	**Moderate** (8-12)	**High** (15-16)	**Very high** (20-25)
24 (7%)	**71** (19%)	**219** (57%)	**33** (7%)	**31** (9%)

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

2.3 There were 14 Very high risks and 13 High risks recorded in relation to this objective. A summary of the Very high risks is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4878	If there are significant delays within the planned care non-admitted pathway (outpatients) then patients may experience extended waits for diagnosis and treatment, resulting in failure to meet national standards and and potentially reducing the likelihood of a positive clinical outcome for many patients	Very high risk (25)	- Planned care recovery plan (non-admitted / outpatients) - Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions	25/04/2023
5016	If there is not sufficient flow through the Trusts Emergency Departments, due to demand outstripping capacity and insufficient availability of beds in the hospitals leading to overcrowding. This may result in increased likelihood of long waits in the departments for patients, and an increase in the potential for patient harm, delays in care, poor patient and staff experience and impact on the reputation of the Trust .	Very high risk (25)	Capital programme ongoing at Lincoln County ED - will increase clinical space Full Business Case approved at organisational level to support new build for Pilgrim ED System support with the introduction of Breaking the cycle - to create flow in hospital supporting the reduction of ED overcrowding Increased nursing template agreed by Director of Nursing for EDs Demand and Capacity work to review medical staffing in ED.	26/04/2023
4789	If there is a significant delay in processing of Echocardiograms, which is impacted by staff shortages and inefficient processes, then it could lead to delayed assessment and treatment for patients, resulting in potential for serious harm, a poor patient experience and a poor clinical outcome	Very high risk (20)	Review and realignment of systems and processes to ensure that the team efficiency has been optimised. External company (Meridian) engaged for 10-week period to enable a deep dive and improvement plan to be implemented for the service.	24/04/2023
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.	02/06/2023

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4624	If patients in the care of the Trust who are at increased risk of falling are not accurately risk assessed and, where necessary appropriate preventative measures put in place, they may fall and could suffer severe harm as a result.	Very high risk (20)	• Improvement plan implemented by all Divisions, led by QM, monitored through Patient Falls Prevention Steering Group (FPSG). • Introduction and rollout of 'Think Yellow ' falls awareness visual indicators. • Patient story included within FPSG workplan. • Introduction of new falls prevention risk assessment and care plan documentation • Falls prevention training and education framework developed, delivery to commence 2022. • Analyse trends and themes in falls data to inform the need for targeted support and interventions. • Utilisation of Focus on Fundamentals programme • Enhanced care policy and associated processes review. • Revised falls investigation process and documentation. • Overarching action plan for divisional and serious incidents ,monitored through FPSG • Business case for dedicated falls team being developed • Collaborative work between Quality and Improvement teams to bring all existing falls prevention work together.	05/06/2023
4877	If there are significant delays within the planned care admitted pathway then patients may experience extended waits for surgery, resulting in failure to meet national standards and potentially reducing the likelihood of a positive clinical outcome for many patients	Very high risk (20)	Planned care recovery plan (Admitted / HVLC / GIRFT) Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions.	25/04/2023

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4932	Services will be stopped and/or disrupted due to non-recurrent funding (Macmillan/RDC/SDF funding streams). These include CNS, CCC, Waiting List Clerk, Trainee ACP's/ACP's, Advanced Practitioner Radiographer, PTL administrator, PTL Tracker, Deputy nurses-leadership roles. Services which will be stopped: transitional breast, urology and colorectal. PSA ACP monitoring service. Bone marrow nurse led clinic. Chemotherapy suite cancer care coordinator, late side effects pathway, deputy lead cancer nurse, and no Haematology ACP based at PHB. Services which will be affected due to reduction in staffing: haematology CNS team, pre diagnosis team affecting the NSS pathway. Waiting list support, cancer centre team, Radiology admin and PACS services.	Very high risk (20)	CoN's written for majority of posts to go through clinical cabinet, CRIG Workforce reviews commencing in haematology and oncology. Risk reduction plan escalated to ICB as it is a system wide impact.	02/06/2023
5103	Quality and safety risk from inability to deliver Community diabetes pathways that meet National standards due to resourcing and capacity factors	Very high risk (20)	Due to inadequate service, the service has been forced to be reduced and prioritising the children most in need, in doing so, not meeting BPT or audit requirements. Reduction plan: 1. Business case is being developed to address shortfall, agreed in principal at CRIG. This is for a dietician, psychologist, admin and additional nurses. 2. Multi-professional working group tasked with delivering improvements that will support achievement of audit compliance 3. An increase in clinic capacity	16/05/2023

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
5101	Quality and safety risk from inability to deliver 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	16/05/2023
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	02/06/2023

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4947	There is an issue in which the Trust is failing to meet NICE medicines reconciliation targets on a consistent basis and not being able to review discharges. This is caused by lack of pharmacy resource. Resulting in potential for patient harm due to incorrect or delayed medication, financial implications due to increased length of stay or unnecessary supply and risk of continuation of errors onto the discharge letter and further more into the community.	Very high risk (20)	There are many options but we are utilising these; - We have prioritised pharmacist and technician cover to acute admission areas as patient turnover is highest on these areas and gives us to best opportunity to conduct a medicines reconciliation under 24 hours - We prioritise patients which have stayed in the longest and have critical medication where known. Prioritisation of the highest risk patients decreases the risk of harm - No ward visits are divided as much as possible. To significantly reduce this risk requires additional ward based pharmacy staff cover across 7 days.	01/06/2023
5100	Quality and safety risk from inability to deliver epilepsy pathways within Acute Paediatrics that meet National standards due to resourcing and capacity factors.	Very high risk (20)	1. Multi-professional working group tasked with delivering improvements that will support achievement of audit compliance.	16/05/2023
5102	Quality and safety risk from inability to deliver diabetes pathways within Acute Paediatrics that meet National standards due to resourcing and capacity factors	Very high risk (20)	1. Multi-professional working group tasked with delivering improvements that will support achievement of audit compliance; 2. Business case being developed to address resources shortfall (e.g. dietitian, psychologist, admin support, additional nurses) - agreed in principle at CRIG meeting.	16/05/2023

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
5175	Safety risk from Nationwide shortage of respiratory supplies as identified by NHS supply chain	Very high risk (20)	1) Continue weekly meetings with Procurement leads, looking at alternative codes when stock becomes available. 2) All families to be contacted at least weekly by CCN's to identify stock levels in the home and to estimate upcoming requirement. 3) Liaise with tertiary centre clinical leads, consultants, rapid response community physio teams, long term ventilation service. 4) Identify those high risk and high demand, prioritise allocated allowance. Reassess education with families surrounding suction to ensure appropriate usage of suction catheters. 5) Devised a letter awaiting sign off to issue to families to inform families of shortage and that they will be contacted weekly. 6) Alternative equipment to be used on clinical decision if oral suction only is required.	07/06/2023

Strategic objective 1b: Improve patient experience

2.4 There was no Very high risk and 2 High risks recorded in relation to this objective. The Very high risk in relation to Outpatient appointment processes in Haematology was reduced at the June RRC&C meeting to a Moderate (12) due to the reduction in the number of outstanding letters and recruitment into vacant posts.

Strategic objective 1c: Improve clinical outcomes

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

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
5075	Disease progress for patient's alternative treatments, change of treatment plan, poor clinical outcomes, causing patient's anxiety and worry for the patient. As a consequence of lack of ICU capacity for elective surgery patients this leads to cancellations on the day, this includes cancer patients that require level 2 post-operative care.	Very high risk (20)	The triumvirate to include surgery and TACC are planning to meet to review potential options.	06/04/2023
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.	01/06/2023
4731	If patient records are not complete, accurate, up to date and available when needed by clinicians then it could lead to delayed diagnosis and treatment, reducing the likelihood of a positive clinical outcome and possibly causing serious harm	Very high risk (20)	Design and delivery of the Electronic Document Management System (EDMS) project, incorporating Electronic Patient records (EPR). Interim strategy required to reduce the risk whilst hard copy records remain in use.	06/06/2023

Strategic objective 2a. A modern and progressive workforce

2.6 There was 5 Very high risk and 4 High risks recorded in relation to this objective. A summary of the Very high risk is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4991	If the Trust is unable to recruit and retain sufficient numbers of staff with the required skills and experience then it may not be possible to provide a full range of services, resulting in widespread disruption with potential delays to diagnosis and treatment and a negative impact on patient experience	Very high risk (20)	1. Focus staff engagement & structuring development pathways. 2. Use of apprenticeship framework to provide a way in to a career in NHS careers. 3. Exploration of new staffing models, including nursing associates and Medical Support Workers. 4. Increase Agency providers across key recruitment areas. 5. Increase capacity in recruitment team to move the service from reactive to proactive. 6. Develop internal agency aspect to recruitment. 7. Reintroduce medical recruitment expertise within Recruitment Team. 8. Build strong relationship with Refugee Doctor project to support MSW recruitment and GMC registered Doctors. 9. Source a third party supplier for Philippines recruitment for hard to recruit AHP roles.	01/06/2023
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.	01/06/2023
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	02/06/2023

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
5093	Baseline pharmacy procurement staffing is at a level where only the basic functions can routinely be delivered and the service is not able to withstand any prolonged absence due to leave, sickness or resignation. The workforce has remained relatively stable over time; however, workforce pressures have been increasing over the last few years for a variety of reasons. There has been an increasing number of pharmaceutical shortages, many of which are complex in nature. A growing number of drugs are now being offered on an allocation basis, which requires micro management for stock ordering and distribution across the Trust. Changes in the delivery of chemotherapy have resulted in an increased demand for ordering of chemotherapy preparations. The pharmacy invoicing team have also experienced a recent increase in workload following the implementation of the Advanced finance system. The team are reporting concerns around workload and workplace stress. We are routinely reliant on existing staff working additional hours to fill gaps. If staff feel unable to come to work for any reason (including stress related) this will further increase the risk to the Trust and its patients of stock outs. This gives an associated risk to patient care, due to either a lack of personnel to raise orders, manage shortages, chase orders which are not being received, or to process invoices and manage supplier queries."	Very high risk (20)	Gap analysis highlights several areas of ongoing concern (to-follows, shortage management, invoice query management, medical gas invoicing). Occasional additional support is currently being provided to the invoicing team by a Bank Pharmacy Support Worker; we are scoping training this individual to offer procurement support in addition. This post is being paid from vacancy money elsewhere in the department and so cannot be considered a long-term fix for the procurement gaps. A case of need will be prepared to identify workforce requirements to reduce the workload stress the staff are persistently facing, and to provide a robust service which can withstand annual leave and short term sickness absence, based on the more challenging pharmaceutical market we are operating in where shortages are now a daily occurrence."	01/06/2023
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	02/06/2023

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

2.7 There were 3 Very high risks and 2 High risks recorded in relation to this objective. A summary of the Very high risks is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4990	Poor culture within the Trust resulting in poor behaviours, increased ER cases, turnover, retention issues and ability to recruit and increased sickness absence. ULHT 'Pulse' Survey (quarterly): poor/low uptake; staff survey fatigue; lack of motivation and confidence amongst staff that results are anonymised and are meaningful to ULHT Results affects ULHT standing as an employer of choice and employer brand within NHS - may therefore result in reputational risk and create difficulties when recruiting/attracting talent and retention of workforce locally, regionally and nationally	Very high risk (20)	1. National mandate for NHS organisations to run Pulse Survey every quarter (1,2&4) 2. Comprehensive and robust positioning to complement NHS Staff Survey and part of a wider staff listening and engagement plan 3. You said campaign to drip feed/communicate how staff intelligence is improving working environment and services - now live	01/06/2023
4439	If there is large-scale industrial action amongst Trust employees then it could lead to a significant proportion of the workforce being temporarily unavailable for work, resulting in widespread disruption to services affecting a large number of patients	Very high risk (20)	Industrial relations action plan & engagement mechanisms and arrangements with Staff Side representatives.	06/04/2023
4948	Workload demands within Pharmacy persistently exceed current staffing capacity which leads to work related stress resulting in serious and potentially long-term effects on staff health and wellbeing. Adding to this with additional workload demands with insufficient staffing, or required level of experience and skill, the risk is patients will not be reviewed by a pharmacist leading to poorer clinical outcomes, reduced flow on acute wards, delayed discharges and increased risk of omitted medicines. For staff the risk is long term absence. This may result in the failure to meet the national and local targets for KPIs	Very high risk (20)	Review current provision and identify gaps in service to inform business cases for change to support 7 day working (working with Surgery and Medicine Divisions as appropriate). Skill mix requires review due to complexity of patients.. Pragmatic management of workload & provision of management support. On-going exploration of recruitment options.	01/06/2023

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

2.8 There were 3 approved Very high risks (20-25), an increase of 1 from last month and 2 High risk (15-16) recorded in relation to this objective, also an increase of 1 from last month. A summary of the Very high risks is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
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	15/05/2023
4647	If Lincolnshire Fire & Rescue Service (LFRS) carries out an inspection and finds the Trust to be systemically non-compliant with fire safety regulations and standards it could result in regulatory action and sanctions, with the potential for financial penalties and disruption to services if sites are required to close.	Very high risk (20)	- Statutory Fire Safety Improvement Programme based upon risk - LFR involvement and oversight through the FSG - Fire safety audits being conducted by Fire Safety team - Fire wardens in place to monitor local arrangements with Fire Safety - Weekly Fire Safety Checks being undertaken - PPM reporting for FEG and FSG By Estates Teams - All areas of Trust allocated RAG rating for fire using occupancy profile, escape provision, height above ground and sleeping risk	15/05/2023
5104	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.	Very high risk (20)	Risk reduction plan to assure HTA during March that risk controlled above mitigate their concerns over the Trusts mortuary estate.	31/05/2023

Strategic objective 3b: Efficient use of our resources

2.9 There were 2 approved Very high risks (20-25), and 4 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	24/05/2023
5020	If there is a continued reliance on bank and agency staff for medical workforce in Urgent & Emergency Care there is a risk that there is not sufficient fill rate for medical rotas both ward / department fill and on call shifts which will impact on patient safety and have a negative impact on the CBU budget.	Very high risk (20)	Robust recruitment plan. International recruitment. Medical Workforce Management Project.	26/04/2023

Strategic objective 3c: Enhanced data and digital capability

2.10 There was 1 approved Very high risk (20-25) recorded in relation to this objective, There were also 3 High risks (15-16), both remaining stable from the previous report. A summary of the Very High risk is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4657	If the Trust does not comply with Subject Access Requests (SARs) and Access to Health Records provisions in accordance with statutory requirements specified legislation, then it could lead to complaints to the Trust and Information Commissioner's Office (ICO). This could result in regulatory action and possibly financial penalties. Inconsistent levels of expertise outside of the IG team regarding SAR requirements.	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.	25/04/2023

	Lack of technical tools to carry out a search of emails / systems to identify personal information held. Potential financial implications."		Early identifications of chasers and urgent requests to reduce the likelihood of complaints."	

Strategic objective 3d: Improving cancer services access

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

Strategic objective 3e: Reduce waits for patients who require planned care and diagnostics to constitutional standards

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

Strategic objective 3f: Urgent Care

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

Strategic objective 4a: Establish new evidence based models of care

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

Strategic objective 4b. To become a University Hospitals Teaching Trust

2.15 There are currently no Very high or High risks recorded in relation to this objective. However, the Director of Improvement and Integration has asked for the risk to delivery of this objective to be assessed and added to the risk register this month, an update will be provided in next months report.

2.16 A comprehensive review and update of the People & OD directorate risk register is currently taking place, with support from the Clinical Governance risk team. A workshop has taken place to review risks and we are currently waiting to receive the final report of PODC's updated risk register. This work is likely to result in a more detailed breakdown of specific workforce risks, providing clearer links between the risk register and planned work on workforce planning; leadership and management; and equality and inclusion.

2.17 **Strategic objective 4c: Successful delivery of the Acute Services Review**2. There were no approved Very high risks (20-25) or High risks (15-16) to this objective.

3. Conclusions & recommendations

3.1 There were 17 quality and safety risks rated Very high (20-25) reported to the Quality Governance Committee this month:

- Patient flow through Emergency Departments;
- Recovery of planned care admitted pathways;
- Recovery of planned care non-admitted (outpatients) pathways;
- Recovery of planned care cancer pathways;
- Reliance on paper medical records;
- Reliance on manual prescribing processes;
- Potential for serious patient harm due to a fall;
- Processing of echocardiograms;
- Delivery of paediatric diabetes pathways-community
- Delivery of paediatric epilepsy pathways-community
- Quality and safety risk from inability to deliver diabetes pathways that meet National standards-Acute
- Quality and safety risk from inability to deliver epilepsy pathways within Acute Paediatrics that meet National standards
- Medicines reconciliation compliance;
- Consultant capacity for Haematology outpatient appointments;
- Non-recurrent funding in Cancer services;
- ICU capacity for elective surgery.
- Safety risk from Nationwide shortage of suction catheters as identified by NHS supply chain

3.2 There were 8 People and Organisational Development risks rated Very high (20-25) reported to the People & Organisational Development Committee this month:

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

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

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

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

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
Strategic Objective							**1a. Deliver Harm Free Care**																			
4932	Service disruption	Lynch, Diane	Chester-Buckley, Sarah	Workforce Strategy Group		24/05/2022	16	Workforce Metrics	Clinical Support Services	Cancer Services CBU		Trust-wide	Services will be stopped and/or disrupted due to non-recurrent funding (Macmillan/RDC/SDF funding streams). These include CNS, CCC, Waiting List Clerk, Trainee ACP's/ACP's, Advanced Practitioner Radiographer, PTL administrator, PTL Tracker, Deputy nurses-leadership roles. Services which will be stopped: transitional breast, urology and colorectal. PSA ACP monitoring service. Bone marrow nurse led clinic. Chemotherapy suite cancer care coordinator, late side affects pathway, deputy lead cancer nurse, and no Haematology ACP based at PHB. Services which will be affected due to reduction in staffing: haematology CNS team, pre diagnosis team affecting the NSS pathway. Waiting list support, cancer centre team, Radiology admin and PACS services.	List of job roles provided to Finance. CoN's written for majority of posts to go through clinical cabinet, CRIG Workforce reviews commencing in haematology and oncology.	Via jo roles list	02/06/2023	Extremely likely (5)	>90% chance	Severe (4)	Very high risk (20-25)	20	CoN's written for majority of posts to go through clinical cabinet, CRIG Workforce reviews commencing in haematology and oncology. Risk reduction plan escalated to ICB as it is a system wide impact.	[02/06/2023 12:43:46 Maddy Ward] EMCA have agreed to fund all posts until March 2024. Paper being presented to ICB investment board in June/ July for recurrent funding for these posts. Awaiting outcome of board. Effected staff informed verbally and have received a letter from their line manager and EF2's have been completed. [24/04/2023 10:40:50 Maddy Ward] Business case is submitted for all posts within CSS for review by EMCA and funding from this review would be for 23/24 [03/04/2023 09:40:42 Rose Roberts] We are awaiting EMCA review to see if need the posts. McMillan posts have been funded. Reviewed at confirm and challenge confirmed as v high risk. [14/03/2023 11:21:33 Rachael Turner] Division has reviewed and have proposed that risk score is increased to a rating of 20 (Very High). This risk will be raised at RRC&C Meeting in March for validation. [30/01/2023 16:12:51 Rose Roberts] Contracts end March 2023, if not in receipt of further funding non specific symptom (NS pathway will have to stop. Pre diagnosis service will have to stop. Currently we have a tick box on all 2 ww referrals which allows complex and vulnerable patients to be identified for support from this team, circa up to 40 pt per week. The other contracts that end end of March for transitional care specifically for colorectal and urology, would stop. [15/12/2022 13:32:54 Alex Measures] case of need completed for all four divisions within the trust, paper submitted to CRIG awaiting date for presentation Reduced to moderate as finance are now fully aware of the situation. Ongoing	8	31/10/2022		03/07/2023
4879	Physical or psychological harm	Harris, Michelle	Lynch, Diane	Patient Safety Group		28/03/2022	20	Risk assessments	Clinical Support Services	Cancer Services CBU		Trust-wide	If there are significant delays within the planned care cancer pathway then patients may experience extended waits for diagnosis and surgery, resulting in failure to meet national standards and potentially reducing the likelihood of a positive clinical outcome for many patients	National policy: - NHS standards for planned care (cancer) ULHT policy: - Cancer care pathway & booking systems / processes - Clinical Harm Review (CHR) processes ULHT governance: - Lincolnshire System Elective Recovery meeting – Monthly - Lincolnshire system RTT Cancer and Diagnostic- Weekly - ULHT Cancer Recovery and Delivery – Weekly - ULHT Clinical Business unit meetings – Weekly - Integrated Performance Report (IPR) to Trust Board - Monthly - Divisional Performance Review Meeting (PRM) process - Clinical Harm Oversight Group	Cancer patients awaiting surgery - all within 31 days New standards: 28 days for first diagnosis; 62 day max wait	02/06/2023	Extremely likely (5)	>90% chance	Severe (4)	Very high risk (20-25)	20	- Planned care recovery plan (cancer) - Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions	[02/06/2023 12:41:34 Maddy Ward] Andrew Morgan requested a briefing paper for ELT which is now complete in conjunction with transformation and due to be circulated to execs on 05/06/2023. [24/04/2023 10:39:20 Maddy Ward] Oncology and Haematology service review carried out in March/April in association with strategy, planning, improvement and integration directorate [07/03/2023 10:21:35 Rose Roberts] The cancer recovery plan is a high priority for the division. More work to do but good progress in Endoscopy and Radiotherapy. [02/03/2023 08:41:30 Maddy Ward] Risk lead changed to Diane Lynch as Lucy Rimmer has left the trust as of 02/02/2023. DL is the new interim DMD until early June [13/01/2023 15:07:01 Paul White] Closed in error - re-opened. [17/11/2022 12:24:41 Rose Roberts] 4736 can be closed as Estates have investigated everything they can and Paula is launching an education and poster campaign. Trust comms have already gone out. [16/11/2022 15:54:57 Rose Roberts] Ongoing 4/8/22 Confirmed it is an ongoing corporate risk being managed at divisional level. Ongoing	8	31/03/2023	31/03/2023	03/07/2023
5103	Physical or psychological harm	Rivett, Kate	Naydeva-Grigorova, Tanya	Children & Young Persons Oversight Group		15/03/2023	20		Family Health	Children and Young Persons CBU	Children's Community Services	Trust-wide	Quality and safety risk from inability to deliver diabetes pathways within Community Paediatrics that meet National standards due to resourcing and capacity factors	1. Two Consultant Paediatricians (TN-G and AB) are currently managing all children with diabetes; 2. Team leader currently supporting provision of clinical duties across all 3 sites. 3. Prioritisation of workload to help match against available service capacity; 4. Business case in development to support expansion of diabetes services.	1. Audit of compliance with NICE guideline NG18 - Diabetes (Type 1 and Type 2) in Children and Young People: Diagnosis and Management and Adults and NICE quality standard QS125 - Diabetes in Children and Young People; 2. Results of National Paediatric Diabetes Audit	16/05/2023	Extremely likely (5)	>90% chance	Severe (4)	Very high risk (20-25)	20	Due to inadequate service, the service has been forced to be reduced and prioritising the children most in need, in doing so, not meeting BPT or audit requirements. Reduction plan: 1. Business case being developed to address shortfall, agreed in principal at CRIG. This is for a dietician, psychologist, admin and additional nurses. 2. Multi-professional working group tasked with delivering improvements that will support achievement of audit compliance 3. An increase in clinic capacity	[16/05/2023 14:15:22 Jasmine Kent] Business case has been approved. Plan to increase workforce. [18/04/2023 16:32:20 Jasmine Kent] No change, nursing situation is not improving, escalated for additional support. Seeking continuity with a RN, HCSW or Admin. [15/03/2023 13:17:45 Kate Rivett] 15/03/2022 - KR 1. Risk developed to enable amalgamation of two individual risks that pertain to delivery of diabetes services (ID4974 and ID 5051)	4	15/03/2024	15/03/2024	16/06/2023
5101	Physical or psychological harm	Rivett, Kate	Herath, Dr Durga	Children & Young Persons Oversight 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;	16/05/2023	Extremely likely (5)	>90% chance	Severe (4)	Very high risk (20-25)	20	1. Business case is being produced to enable establishment of fully funded epilepsy service 2. Agreement for spending has been obtained, moving forward. 3. In process of appointing 2 x epilepsy nurses, B6 has started, B7 was unable to start so back out to advert. 4. Epilepsy workshop with ICB	[16/05/2023 14:12:57 Jasmine Kent] Business case has been completed. 2 new people now in post. Risk remains the same for now, to be reviewed next month. [18/04/2023 16:07:35 Jasmine Kent] Successful recruitment 18/04. Recruited and offered post to another band 6, 2 x epilepsy nurses will be in post shortly. No current change to risk rating. [14/03/2023 11:46:07 Kate Rivett] 1. Risk developed to enable amalgamation of two individual risks that pertain to delivery of epilepsy services (ID4972 and ID 5073)	8	14/03/2024	14/03/2024	16/06/2023
5016	Physical or psychological harm	Wall, Mrs Tracey	Thomson, Cheryl	Workforce Strategy Group	Patient Safety Group	02/09/2022	25		Medicine	Urgent and Emergency Care CBU	Accident and Emergency		If there is not sufficient flow through the Trusts Emergency Departments, due to demand outstripping capacity and insufficient availability of beds in the hospitals leading to overcrowding; this may result in increased likelihood of long waits in the departments for patients, and an increase in the potential for patient harm, delays in care, poor patient and staff experience and impact on the reputation of the Trust .	Medical SDEC currently working 08:00 - 20:00 24 hour UTC co-located with ED at Pilgrim and Lincoln 'Are you sitting comfortably' scheme 4 x Daily Capacity meetings (08:00, 12:00, 15:00, 18:00) Clinical Operational Flow Policy Full Capacity Protocol National Criterial 2 Admit flowchart embedded in the ED's Introduction of "Pit stop" model.	ED Risk Tool - updated 4 times daily with an overview of the department Capacity Meetings to dynamically risk assess Monthly scorecard to track performance from both harm and constitutional standards Matrons Dashboard Datix Number of harm reviews	13/06/2023	Quite likely (4)	71-90% chance	Extreme (5)	Very high risk (20-25)	20	Capital programme ongoing at Lincoln County ED - will increase clinical space Full Business Case approved at organisational level to support new build for Pilgrim ED System support with the introduction of Breaking the cycle - to create flow in hospital supporting the reduction of ED overcrowding Increased nursing template agreed by Director of Nursing for EDs Demand and Capacity work to review medical staffing in ED	[26/04/2023 11:58:09 Carl Ratcliff] No change but will review at next months UC improvement group [22/02/2023 12:01:19 Paul White] Present at Confirm & Challenge by TW, reduction in score from 25 to 20 discussed and agree along with incorporation of details from previously separate 'surge in demand' risk. [27/01/2023 11:17:57 Helen Hartley] Risk reviewed and updated. [23/11/2022 11:28:16 Paul White] Reviewed at RRC&CG 23 Nov 2022 - current rating agreed. [10/11/2022 13:40:59 Helen Hartley] No change at governance [07/11/2022 07:03:00 Helen Hartley] Checked with Cheryl to see if there are any updates [12/10/2022 17:20:43 Helen Hartley] No changes made at governance	10	02/09/2023	31/03/2024	12/07/2023

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
4740	Physical or psychological harm	Cooper, Mrs Anita	Rigby, Lauren	Patient Safety Group	Outpatient Improvement Group	13/01/2022	15	Risk assessments	Clinical Support Services	Cancer Services CBU	Haematology (Cancer Services)	Trust-wide	Demand for Haematology outpatient appointments exceeds consultant staffing capacity. High Consultant vacancy levels affecting clinic capacity, performance and review of inpatients. The areas of concern are Lymphoma, and haemostasis (there is only one consultant trust wide). PHB cover and unfilled leadership roles (in practice head of service and clinical governance lead). Due to haematology patients having long term conditions, they are required to have regular review and those on cancer treatment are time critical. If we are not able to meet the demands of the service this potentially could cause severe harm to the patients. At the end of March 2023 there are 322 overdue haem pt at phb and 597 at LCH. From 1 Oct 22 till now the haematologists have held 95 extra clinics which equates to 71 news and 813 F/U. Haemostasis in particular pt are waiting almost triple the time that they have been graded at. There are 657 pt on this consultant PBWL with 295 being overdue. The longest waiter was due an appointment around July 2022. This consultant is holding on average 3 extra clinics per month.	Overbooking of consultant clinics (unsustainable); introduction of nurse-led clinics to manage demand. Long and short term Locum Consultant used to cover vacancies. Ad-hoc additional clinics outside of consultant job plan	Monitoring of outpatient appointments Clinical harm reviews & reported incidents	02/06/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Need for workforce review identified. Right sizing work force paper being written. 2 x agency consultants out to support service	[02/06/2023 12:40:22 Maddy Ward] Andrew Morgan requested a briefing paper for ELT which is now complete in conjunction with transformation and due to be circulated to execs on 05/06/2023. We are exploring what care could take place in primary/community setting. [24/04/2023 10:36:33 Maddy Ward] Haematology service review carried out on 20th April 2023 in association with strategy, planning, improvement and integration directorate [03/04/2023 09:34:49 Rose Roberts] Reviewed at confirm and challenge confirmed as v high risk. [15/12/2022 13:31:29 Alex Measures] currently out to advert for second haemostasis consultant, the rest of the posts ongoing Workforce information provided to triumvirate, awaiting feedback. ACP still in training, additional vacancy for middle grades difficult to recruit to. 220622 Been identified as IIP priority for 2022/23. This includes workforce review, GIRFT review being considered.	3	01/04/2023	01/04/2023	03/07/2023
4947	Physical or psychological harm	Simpson, Mr Andrew	Saddick, Ahtisham	Medicines Quality Group	Clinical Effectiveness Group	17/06/2022	20	Policy/Protocol Issues	Clinical Support Services	Pharmacy CBU			There is an issue in which the Trust is failing to meet NICE medicines reconciliation targets on a consistent basis and not being able to review discharges. This is caused by lack of pharmacy resource. Resulting in potential for patient harm due to incorrect or delayed medication, financial implications due to increased length of stay or unnecessary supply and risk of continuation of errors onto the discharge letter and further more into the community.	NICE guidance NG5 states that in an acute setting, that we should accurately list all of the patient's medicines (including prescribed, over-the-counter and complementary medicines) and carry out medicines reconciliation within 24 hours or sooner if clinically necessary, when the person moves from one care setting to another – for example, if they are admitted to hospital.	We conduct monthly medicines reconciliation audits, which consistently have shown us failing to meet NICE targets and we are operating significantly below the national average. This audit is presented at the MQG.	01/06/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	There are many options but we are utilising these; - We have prioritised pharmacist and technician cover to acute admission areas as patient turnover is highest on these areas and gives us to best opportunity to conduct a medicines reconciliation under 24 hours - We prioritise patients which have stayed in the longest and have critical medication where known. Prioritisation of the highest risk patients decreases the risk of harm - No ward visits are divided as much as possible. To significantly reduce this risk requires additional ward based pharmacy staff cover across 7 days.	[01/06/2023 14:17:45 Lisa-Marie Moore] No change/updates since previous entry [04/05/2023 14:12:22 Lisa Hansford] As advised at confirm and challenge meeting. Lack of compliance with national standards. [06/04/2023 13:07:13 Paul White] Discussed at Risk Register Confirm & Challenge 29 March. Risk agreed and feedback provided for consideration. [21/02/2023 08:47:37 Paul White] Note from Risk Register Confirm & Challenge Group - risk rating to be reviewed and agreed at division level prior to presentation at RRC&CG for validation. [05/01/2023 14:13:48 Lisa-Marie Moore] No change/progress since last update [08/12/2022 12:40:46 Lisa-Marie Moore] Meeting with Divisional Leads and Deputy Medical Director 25/11 to discuss business case and actions needed to be taken to support progression of it. No change to risk - currently performing under 50% on average (this is boosted by the ward based technicians who also complete med recs on patients) Many ward areas have not seen pharmacist for several weeks at LCH. [01/11/2022 15:27:25 Ahtisham Saddick] Business case has been discussed; updated and responded to comments. Trust is still performing below 50% of med recs within 24 hours. [14/10/2022 16:16:26 Rachel Thackray] Business case for additional staff in progress.	8	30/06/2023	29/12/2023	06/07/2023
4624	Physical or psychological harm	Davies, Angela	Addlesee, Sarah	Patient Falls Steering Group	Nursing, Midwifery and AHP Forum	08/11/2021	16	Aggregation of Incident/Claims & Complaints/PALS	Corporate	Nursing Directorate	Corporate Nursing	Trust-wide	If patients in the care of the Trust who are at increased risk of falling are not accurately risk assessed and, where necessary appropriate preventative measures put in place, they may fall and could suffer severe harm as a result.	National policy: - NICE Clinical Guideline CG161: Assessment and prevention of falls in older people (2013) - PHE Falls and fracture consensus statement: Resource pack (2017) ULHT policy: - Falls Prevention and Management Policy (approved April 2021, due for review March 2023) ULHT governance: - Lead Quality Matron - Weekly Falls Investigation Panel / Training package tiered approach / Weekly spot check audits / Monthly Quality Metrics Dashboard meetings /ward review visits - Patient falls steering group / Nursing, Midwifery & AHP Forum / Quality Governance Committee	Frequency, location and severity of patient falls incidents reported: - The numbers of reported falls incidents are demonstrating an increasing upward trend therefore will not achieve the strategic objective to achieve harm free care. - Operational pressures have resulted in patients having prolonged periods sitting in Emergency Departments whilst waiting assessment and for inpatient beds to become available. This may contribute to an increase in some patients overall frailty level and subsequent deconditioning which increases the vulnerability to an individual falling. - Longer length of stays have demonstrated a correlation to risk of a patient falling whilst in the care of the Trust. Patient falls reported April 2021-March 2022 Total -1916 Moderate harm -22 Severe -12 Death -4 Patient falls reported April 2022-May 2022 Total -344 Moderate harm -7 Severe-4 Death-1	07/06/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	• Improvement plan implemented by all Divisions, led by QM, monitored through Patient Falls Prevention Steering Group (FPSG). • Introduction and rollout of 'Think Yellow ' falls awareness visual indicators. • Patient story included within FPSG workplan. • Introduction of new falls prevention risk assessment and care plan documentation • Falls prevention training and education framework developed, delivery to commence 2022. • Analyse trends and themes in falls data to inform the need for targeted support and interventions. • Utilisation of Focus on Fundamentals programme • Enhanced care policy and associated processes review. • Revised falls investigation process and documentation. • Overarching action plan for divisional and serious incidents ,monitored through FPSG • Business case for dedicated falls team being developed • Collaborative work between Quality and Improvement teams to bring all existing falls prevention work together.	[07/06/2023 12:28:16 Rachael Turner] Risk reviewed at RRC&C as part of the Deep Dive 07/06/2023. Analysis on tends and themes has taken place. Risk assessments are being updated and monitored. Risk score to remain at 5 x 4 at a score of 20. [05/06/2023 17:43:08 Sarah Addlesee] Update May 2023 Falls incidents continue to be analysed and trends and themes identified organisationally and reported through Falls Prevention Steering Group (FPSG). Decrease in overall numbers of falls observed during May, continued to have incidents resulting in moderate and above harm reported. Monthly Falls Prevention Quality Council meeting and improvement priorities identified based on themes of incidents being observed. Business Case for Falls Prevention Service update in progress with additional option being explored prior to resubmitting to CRIG. Audit of practice against the Falls Prevention and Management Policy is in progress. Outcomes and recommendations will be presented to FPSG. [24/04/2023 13:05:08 Sarah Addlesee] •Update April 2023 Falls incidents continue to be analysed and trends and themes identified organisationally and reported through Falls Prevention Steering Group (FPSG). •A monthly Falls Prevention Quality Council has commenced as part of the collaborative working across Quality, Divisional and Improvement teams to ensure an integrated approach to falls prevention work. •An audit of practice against the Falls Prevention and Management Policy is planned to be undertaken during May 2023 supported by the Audit and Clinical Effectiveness team. Outcomes and recommendations will be presented to FPSG. •Divisional falls prevention forums are in place to support shared learning. •Business Case for Falls Prevention Service to be further developed and resubmitted following feedback from CRIG. •Falls Prevention and Management Policy and Enhanced Care Policy are being reviewed and	4	31/12/2021	31/03/2023	07/07/2023

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
4878	Physical or psychological harm	Harris, Michelle	Carter, Mr Damian	Patient Safety Group	Outpatient Improvement Group	28/03/2022	20	Risk assessments	Corporate	Operations		Trust-wide	If there are significant delays within the planned care non-admitted pathway (outpatients) then patients may experience extended waits for diagnosis and treatment, resulting in failure to meet national standards and and potentially reducing the likelihood of a positive clinical outcome for many patients	National policy: - NHS standards for planned care ULHT policy: - Planned care non-admitted pathway & booking systems / processes (outpatients) - Clinical Harm Review (CHR) processes ULHT governance: - Lincolnshire System Elective Recovery meeting – Monthly - Integrated Performance Report (IPR) to Trust Board - Monthly - Outpatient Recovery Group; Reports through Divisional PRMs (for performance), and FPEC and System Planned Care Group - Clinical Harm Oversight Group	2ww first O/Ps back within national target Urgent 1sts 90% <13 weeks by 31.03.23 Time critical follow ups (452/2657 overdue) – target to eliminate (mainly neurology, cardiology, rheumatology) by 31.03.23 RTT non-admitted: Clear >104wws by 31.03.22 Clear >78wws by 31.03.22 (with few remaining by 30.06.22) Clear >65wws by 30.09.22 Clear >52wws by 31.12.22	25/04/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	- Planned care recovery plan (non-admitted / outpatients) - Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions	[25/04/2023 10:38:37 Rachael Turner] Work continues, no current change to risk grading. [21/02/2023 17:44:30 Damian Carter] As Improvement plans embed, we are starting to see a reduction in number of patients waiting to be seen in Outpatients and subsequently patients are not waiting so long. Recent Outpatient Sprint to improve DNAs, missing outcomes etc. have also seen fewer patients waiting. The trust is on track to clear all incomplete patient pathways >78 weeks by the end of March 2023, with the exception of patient choice. [13/12/2022 13:31:41 Rachel Thackray] As per previous update, no change to risk grading [21/10/2022 09:42:00 Rachel Thackray] Work continues on the Outpatient Improvement Programme (ORIG) to improve clinic utilisation, reduce demand and increase activity back to 19/20 levels and above. Key progress since last update includes; 1. Contract awarded for Validation contract – Start date November 2022 2. Commencement of personalised Outpatient plan – Start date December 2022 3. Super September completed and yielded 40% reduction in non-admitted pathways that were validated 4. Plan to reinstate tertiary clinics to increase capacity 5. Dedicated support to reduce missing outcomes 210622 No change due to major pressure on the system due to covid backlog. 230922 An externally procured validation team have been identified and they are due to start end of October. Risk transferred to Operations from Outpatients following discussion re ownership.	8	31/03/2023	31/03/2023	25/05/2023
4877	Physical or psychological harm	Harris, Michelle	Carter, Mr Damian	Patient Safety Group		28/03/2022	20	Risk assessments	Corporate				If there are significant delays within the planned care admitted pathway then patients may experience extended waits for surgery, resulting in failure to meet national standards and potentially reducing the likelihood of a positive clinical outcome for many patients	National policy: - NHS standards for planned care ULHT policy: - Planned care admitted pathway & booking systems / processes - Clinical Harm Review (CHR) processes ULHT governance: - Lincolnshire System Elective Recovery meeting – Monthly - Integrated Performance Report (IPR) to Trust Board - Monthly - Divisional Performance Review Meeting (PRM) process - Clinical Harm Oversight Group	P2 - surgery within 31 days - currently around 6-7 weeks. Very long waiters	25/04/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Planned care recovery plan (Admitted / HVLC / GIRFT) Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions	[25/04/2023 10:41:05 Rachael Turner] Work continues, no current change to risk grading. [02/03/2023 18:51:14 Damian Carter] As Improvement plans embed, we are starting to see a reduction in number of patients waiting to be seen and subsequently patients are not waiting so long. Recent Theatre Productivity work has started to yield improvements and led to a significant reduction in late starts. This is particularly evident at Grantham through the SuperSprint and has seen lost minutes due to late starts reduce by 50% [26/01/2023 15:06:57 Corporate Dashboards] Risk moved from Surgery to Corporate as this is an operational risk, not divisional. [21/10/2022 09:40:36 Rachel Thackray] Work continues on three main improvement programmes to address capacity for Surgery 1. HVLC/GIRFT – Looking at best use of theatres by ensuring HVLC procedures are completed as daycases rather than Electives. This maximises productivity of lists and reduces length of stay to ensure bed availability for surgery. Compliance with HVLC has started to increase over recent weeks 2. Theatre efficiency/productivity – The trust deployed a company called Foureyes insight to work with the surgical division and implement a 16 week improvement programme around best use of theatres to drive efficiency and productivity. This piece of work has now concluded and yielded improvement in utilisation and internal processes. This now needs to be embedded as business as usual 3. Clinical prioritisation – Looking at the prioritisation of patients for surgery based on their clinical need to ensure limited theatre resource is used for the patients that most need it. The output of this work has seen good list usage for our most urgent patients and an appropriate mix of lower priority patient in order to maximise list utilisation Risk lead updated to Head of Operations.	8	31/03/2023	31/03/2023	25/05/2023
4789	Physical or psychological harm	Harris, Michelle	Ratcliff, Carl	Patient Safety Group		16/01/2022	20	Risk assessments	Medicine	Cardiovascular CBU	Cardiology		If there is a significant delay in processing of Echocardiograms, which is impacted by staff shortages and inefficient processes, then it could lead to delayed assessment and treatment for patients, resulting in potential for serious harm, a poor patient experience and a poor clinical outcome	Weekly review and monitoring of OP activity /utilisation data Monthly meeting with CSS to review performance; secure any additional available capacity Escalation through CBU and Divisional governance processes / Planned Care Cancer and Diagnostic System Recovery Cell	DMO1 activity - monthly review Backlog consistently increasing C&A Team remain short-staffed due to vacancies -referrals being late added onto Medway leaving CBU with no visibility of the referrals for the first part of their pathway. - Issues with CBU not having visibility of demand to allow adequate proactive planning of additional clinic sessions. - CBU being unable to accurately forecast activity performance against standards e.g. DM01 -wasted clinic slots	24/04/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Review and realignment of systems and processes to ensure that the team efficiency has been optimised. External company (Meridian) engaged for 10 week period to enable a deep dive and improvement plan to be implemented for the service	[24/04/2023 12:16:25 Carl Ratcliff] CDC work now started and also smaller service with In HEALTH Recruitment of additional staff underway with 3 joining in next month R/R now in place to prevent more staff loss Now only 44 pts behind the recovery plan extra cap for IP now also in place but does require more work [24/04/2023 12:16:07 Carl Ratcliff] CDC work now started and also smaller service with In HEALTH Recruitment of additional staff underway with 3 joining in next month R/R now in place to prevent more staff loss Now only 44 pts behind the recovery plan extra cap for IP now also in place but does require more work [27/01/2023 10:16:42 Charles Smith] 27/01/23 - Charles Smith DGM - CDC work had to go via tender, expected to start ~01/02/23. Delivery of 3000 from backlog. Midlands visit action plan/meridian recommendations largely implemented. R&R has preliminary sign-off from trust. Trajectories have total WL eradication in 2024 if no changes, 6w and 13ww cohorts within 12/12. FUrther workforce challenges with Mat leave and new resignations. Position remains difficult in terms of capacity and fragility of workfoce. [01/12/2022 10:58:41 Carl Ratcliff] New working group in place lead by COO Plans being worked up to open CDC when contract agreed Extra room now found at LCH - start to sue next week R/R paper submitted to COO for approval Need to obtain recovery graph to show impacts of each / all action [04/11/2022 12:28:16 Carl Ratcliff] Approval now in place to use CDC at Grantham to cover 300 pts in back log. Process being agreed with procurement / operations to start. Plan for other half of waiting list being worked up for agreement. Booking team now transferred to Cardiology team to manage. Deep dive	4	31/03/2022	01/02/2024	31/05/2023

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5102	Physical or psychological harm	Rivett, Kate	Nayzeva-Grigorova, Tanya	Children & Young Persons Oversight Group	Clinical Effectiveness Group	15/03/2023	20		Family Health	Children and Young Persons CBU	Paediatric Medicine	Trust-wide	Quality and safety risk from inability to deliver diabetes pathways within Acute Paediatrics that meet National standards due to resourcing and capacity factors	1. Two Consultant Paediatricians (TN-G and AB) are currently managing all children with diabetes; 2. Team leader currently supporting provision of clinical duties across all 3 sites. 3. Prioritisation of workload to help match against available service capacity; 4. Business case in development to support expansion of diabetes services.	1. Audit of compliance with NICE guideline NG18 - Diabetes (Type 1 and Type 2) in Children and Young People: Diagnosis and Management and Adults and NICE quality standard QS125 - Diabetes in Children and Young People; 2. Results of National Paediatric Diabetes Audit	12/06/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	1. Multi-professional working group tasked with delivering improvements that will support achievement of audit compliance; 2. Business case being developed to address resources shortfall (e.g. dietitian, psychologist, admin support, additional nurses) - agreed in principle at CRIG meeting.	[12/06/2023 15:51:05 Jasmine Kent] Gap analysis to be conducted to identify risk rating and specifically where improvements need to be made. [16/05/2023 15:40:38 Jasmine Kent] Business case has been approved for further recruitment. [04/05/2023 09:11:59 Rachael Turner] Risk re-opened as not a duplicate, this risk reflects risk for acute where as risk 5103 is for community. [03/05/2023 15:55:20 Rachael Turner] Risk closed as duplicate of risk ID: 5103. [18/04/2023 08:41:20 Jasmine Kent] Un-rejected. Has been approved, rejected by mistake, not a duplicate entry. [03/04/2023 15:13:44 Paul White] Duplicate entry [15/03/2023 12:50:59 Kate Rivett] 15/03/2022 - KR 1. Risk developed to enable amalgamation of two individual risks that pertain to delivery of diabetes services (ID4974 and ID 5051)	4	15/03/2024	15/03/2024	12/07/2023
5100	Physical or psychological harm	Rivett, Kate	Herath, Dr Durga	Children & Young Persons Oversight Group	Clinical Effectiveness Group	14/03/2023	20		Family Health	Children and Young Persons CBU	Paediatric Medicine	Trust-wide	Quality and safety risk from inability to deliver epilepsy pathways within Acute Paediatrics that meet National standards due to resourcing and capacity factors.	1. Single Consultant Paediatrician (DH) is currently managing all children with Epilepsy alongside a single specialist epilepsy nurse; 2. Wider consultant body supporting the care of children who are prescribed 2 antiepileptics in the absence of a consultant paediatrician with expertise in epilepsy; 3.Single Consultant Paediatrician is developing individualized care plans for each patient to optimise management of condition; 4. Liaison with ICB and regional network to support development and improvement of local services	1. Audit of compliance with NICE guideline NG217 - Epilepsies in Children, Young People and Adults and NICE quality standard QS27 - Epilepsy in Children and Young People;	12/06/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	1. Multi-professional working group tasked with delivering improvements that will support achievement of audit compliance.	[12/06/2023 15:55:12 Jasmine Kent] Discussion ongoing regarding reduction of risk level now epilepsy nurses are in post. Unsure of level of involvement with Acute Paeds at this stage, For review next month. Gap analysis to be conducted to identify risk rating and specifically where improvements need to be made. [16/05/2023 15:39:25 Jasmine Kent] Epilepsy nurses are now in place, for review next month to determine if there has been a change in risk level. [04/05/2023 09:09:17 Rachael Turner] Risk re-opened as risk is to cover acute, risk 5101 reflects community risk. [03/05/2023 15:28:19 Rachael Turner] Risk closed as duplicate of Risk ID: 5101. [18/04/2023 08:44:50 Jasmine Kent] Un-rejected, rejected by mistake, not a duplicate entry. Has already been approved. [03/04/2023 15:12:56 Paul White] Duplicate entry [14/03/2023 11:41:00 Kate Rivett] 14/03/2022 - KR 1. Risk developed to enable amalgamation of two individual risks that pertain to delivery of epilepsy services (ID4972 and ID 5073)	8	14/03/2024		12/07/2023
5175	Physical or psychological harm	Rivett, Kate	Flatman, Deborah			16/05/2023	20		Family Health	Children and Young Persons CBU	Children's Community Services		Safety risk from Nationwide shortage of respiratory supplies as identified by NHS supply chain	1) Supplies are being rationed by protect demand management within procurement department, with CCN's prioritising allocation to families based on clinical need. 19,000 a month countywide are required, allocation 9200 currently weekly meetings with procurement leads. Raised at Clinical Governance.	Datix incidents. Feedback from patients and staff. Stock check.	07/06/2023	Quite likely (4) 71-90% chance	Extreme (5)	Very high risk (20-25)	20	1) Continue weekly meetings with Procurement leads, looking at alternative codes when stock becomes available. 2) All families to be contacted at least weekly by CCN's to identify stock levels in the home and to estimate upcoming requirement. 3) Liaise with tertiary centre clinical leads, consultants, rapid response community physio teams, long term ventilation service. 4) Identify those high risk and high demand, prioritise allocated allowance. Reassess education with families surrounding suction to ensure appropriate usage of suction catheters. 5) Devised a letter awaiting sign off to issue to families to inform families of shortage and that they will be contacted weekly. 6) Alternative equipment to be used on clinical decision if oral suction only is required.	[07/06/2023 12:55:43 Rachael Turner] Risk discussed at RRC&C meeting 07/06/2023. Risk score 4 x 5 20-high risk. [06/06/2023 16:06:25 Kate Rivett] 06/06/23 - KR - explanation of risk. Safety risk due to nationwide shortage of essential respiratory supplies (including suction catheters, heat moisture exchangers and naso-pharyngeal airways) as identified by NHS supply chain. Potential 6 month issue, 50 children in the community with these requirements. The unavailability of these rolling order consumables will have a direct impact on patient safety for children within the children's community team countywide. Stocks are beginning to run dangerously low, soon to be at critical levels. Without sufficient supplies in the home, there is also potential for service level disruption as patients will require 1:1 care, with unnecessary patient admission for airway management. Increased risk of chest infection, aspiration, pneumonia, and preventable child/young persons death.	5	30/11/2023		07/07/2023
4843	Physical or psychological harm	Cooper, Mrs Anita	Hansford, Lisa	Medicines Quality Group	Patient Safety Group, WORK	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)	01/06/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Single staff reliance for local panels, 1x haematology consultant, 1x neurology consultant and 1x chief pharmacist only. Antimicrobial and High Cost Drugs Management Pharmacist undertaking administrative functions to ensure all referrals are screened and are done so in a timely manner. Shared care arrangements and prescribing accountabilities are unclear and need review.	[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	28/04/2023	07/09/2023
4935	Service disruption	Farquharson, Colin	Daniels, Mrs Samantha	Workforce Strategy Group		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.	18/04/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Recruit to vacant posts.	[15/06/2023 09:32:33 Wendy Rojas] No change to risk status.beds capped at x8 L3 [18/04/2023 13:52:46 Caroline Donaldson] No change in risk status. Bed base number remains at x8 Level 3 beds. [09/01/2023 14:27:52 Caroline Donaldson] No change in status - still remains an issue. Bed base numbers remain reduced at x8 Level 3 beds. [29/11/2022 15:16:01 Caroline Donaldson] 17/11/2022 Discussed at TACC CBU governance meeting. Still remains an issue. [19/10/2022 15:22:43 Caroline Donaldson] 19/10/2022 CBU are looking to request an escalated rate for recruitment. Paper is currently in progress to request. Confirmed by S Daniels. Quality Impact Assessment undertaken and LCH ITU reduced to 8 x L3 bed equivalents on a temporary basis. For review Update 25.7.22 - substantive advert closes 8th August 2022. Locum advert is closed but awaiting shortlisting. Awaiting confirmation of interview date but looking like 27.9.22. Escalated to Medical Director and COO re decision to continue L3 equivalent reduction at current time.	4	31/10/2022		18/08/2023

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5095	Physical or psychological harm	Capon, Mrs Catherine	Sewell, Chris			24/02/2023	16		Surgery	Surgery CBU	Vascular Surgery	Pilgrim Hospital, Boston	Due to increased demand for PICC services there is a risk that within the current establishment there is a significant delay to patients. This can delay treatment, hinder flow and cause poorer outcomes for patients. 8 years ago, venous access within the Trust was classed as central lines (internal jugular insertion) and cannulas. Peripheral central catheters (PICC) were undertaken occasionally for oncology patients and portacaths and Hickman lines were done in theatre, as they still are. The vascular ACPs started to learn how to insert picc PICC lines starting from one morning clinic on a Tuesday (supported by the Consultants). The needs for PICC increased and we went to two full day clinics in a week. They were only inserting in pilgrim at that time. It was then determined that Total Parental Nutrition (TPN) needed to be given centrally and not peripherally, and the work load increased two fold. A business case was successful for a 1.0 WTE band 6 venous access nurse to take on the clinics as the work load for the ACPs was also increasing. The Royal College of Radiologists state that a PICC line should be inserted with 72 hours. However, due to the varied nature of why a line is required particulary for urgent cases this has been	At present there is one 1.0 WTE VAN (band 6) and two 22.5 hours HCSW (band 2) covering: - Lincoln clinics (in patient only) Monday (up to and including 6 patients) and a Wednesday out/in patients - Pilgrim clinics Tuesday and Thursday, both in and outpatients - All clinics have slots for up to 6 patients, however, many late referrals are received and the clinic can increase to anything up to 12 patients. This means that the VAN goes home late most nights that incurs overtime payment. This additional activity is driven through urgent care pathways and is reliant upon a stretched team to meet this demand. As services enter a a post COVID climate there has been a recognised increase in complexity of presentations due to non-presentation at an earlier point. Case of Need has been written with final finance input outstanding to then go to CRIG ACPs are trained in this procedure but should not be relied upon as takes away from other core duties and is not a sustainable. Interventional Radiology is picking up some activity although this exposes patients to radiation and is not a sustainable option. This also require anaesthetics and theatre resources.	Volume of requests against number of staff and time taken to acquire IR1 submissions - started to see an increase in incidents being reported.	03/05/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Business case established with final finance input outstanding to then go to CRIG 6 month secondment for a PICC nurse has been advertised and will require training Give consideration to training of a wider network of clinicians associated with their individual service needs	[03/05/2023 10:26:45 Rachael Turner] Following further quantitative data provided this risk has now been validated as an active risk for the trust register. [26/04/2023 11:26:50 Rachael Turner] Risk needs to return to RRC&C once we have the quantitative data confirmed. Needs to look at where this risk sits as possibly more appropriate with CSS. This will be re-presented in the May RRC&C meeting. [25/04/2023 10:06:15 Chris Sewell] Due to unforeseen circumstances and long term absence the service has had to rely on the ACP and Interventional Radiology options as outlined in the risk controls. It is anticipated that they will return at the beginning of May. This has led to an increase in IR1s.	1	01/06/2023		03/06/2023
5161	Physical or psychological harm	Rivett, Kate	Flatman, Deborah			23/04/2023	20		Family Health	Children and Young Persons CBU	Children's Community Services	Community	Quality and safety risk from non-integrated paper records.	Community matron, Team Leaders and service leads aware of the risks. Risk escalated to senior management team Meeting held with Digital Transformation Leads	To complete IR1 reports	07/06/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	1) CCNS to have access to SystemOne	[07/06/2023 13:07:24 Kate Rivett] 07/06/23 - KR - 1. Discussed at Risk Register Confirm and Challenge - panel advised score of 16 (severity of 4 x likelihood of 4) rather than the proposed 20 (severity of 4 x likelihood of 5). This was to align this risk with levels of risk across other divisions and in recognition that lack of incidents due to mitigation does not support the likelihood being= 5. [07/06/2023 13:00:51 Rachael Turner] Risk discussed at RRC&C meeting 07/06/23 Risk score agreed as 4x4 16 high risk. [06/06/2023 16:12:48 Kate Rivett] 06/06/23 - KR - explanation of risk: The children's community nursing services(CCNS) are working with a paper-based patient records system when providing direct nursing care to CYP with highly complex needs & their families within the home. There are increasing challenges for the 12 teams / specialisms when sharing information / communicating care with each other and with other professionals involved in the child's care, both within ULHT and externally with partner organisations across the ICS. 1) An individual child & family may receive care from >1 team / service within the CCS, resulting in multiple sets of records held in locked cabinets / locked offices in different locations. 2) Practicalities of sharing information when CYP may require frequent home visiting eg, daily, in various community settings / locations eg. home & school, across Lincolnshire (geography & time constraints). 3) Inability to provide contemporaneous patient healthcare information to GPs & MDT i.e.) every face-to-face & telephone contact. Including personalised care plans, complex medical & medicine management plans, PRPs / emergency healthcare plans at the end of life. Patient safety risk & poor patient experience. Risk of inappropriate treatment being delivered - actions & omissions. 4) Lack of essential information in a timely manner - GP Consultations, episodes of hospitalisations & associated CCN follow-ups, safeguarding concerns which may result in significant harm. 5) Management of person identifiable and sensitive information - carrying nursing records & medical management plans, loss/theft/damage of nursing practitioner patient records. Receiving & sending of patient sensitive information via email. 6) Increase in risk parallel to increase in complexity of CYP needs due to healthcare advancement &	6	30/04/2024		07/09/2023
4779	Physical or psychological harm	Harris, Michelle	Ratcliff, Carl	Patient Safety Group		16/01/2022	20	Risk assessments	Medicine	Cardiovascular CBU	Stroke		Increase in risk of delays to patient care/harm as a result of increasing backlog of planned care activity across stroke arising from Covid19 constraints / service restrictions/ site escalation pressures.	additional clinics/lists (cost pressure) additional staffing where feasible to increase capacity (cost pressure)	weekly monitoring of RTT and PBWL	24/04/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	defined plans to address backlog for at risk areas	[24/04/2023 12:28:58 Carl Ratcliff] Improvement work started with team and perfect week in May will look at all opportunities for service. [27/01/2023 10:23:30 Charles Smith] 27/01/23 - CS DGM - Ongoing area of concern due to workforce and ACP gaps (being recruited to but time required to train). TIA still a concern but stable numbers. [16/12/2022 14:35:47 Carl Ratcliff] Additional work in palce to find external support / validate PWL and push patients through system [22/11/2022 17:25:10 Carl Ratcliff] Aim to have outliers back in right place and work continues to improve OPD work. Limited consultant numbers still mean there is a risk to OPD planned care work Plans in place to address backlogs across all areas. Significant area of risk for TIA. 23.08.22 Remains an issues although noting covid cases have dropped. Will be resolved once the improvement work on wards in completed to remove outliers and pts are in the correct place with appropriate bed numbers	4	31/03/2022	29/12/2023	30/06/2023
5142	Physical or psychological harm	Ratcliff, Carl	Thomson, Cheryl			12/04/2023	20		Medicine	Urgent and Emergency Care CBU	Accident and Emergency	Lincoln County Hospital	If there is a continued increase in footfall within Lincoln Emergency Department there is a risk that 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.	13/06/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	ED Rota and workforce review with new rotas to provide effective cover overnight in all areas at all grades	[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	12/07/2023

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4868	Physical or psychological harm	Farquharson, Colin	Martinez, Francisca	Medicines Quality Group	Maternity & Neonatal Oversight Group	01/03/2022	16	Risk assessments	Clinical Support Services	Pharmacy CBU	Pharmacy		Preparation of Drugs for Lower Segment Caesarean Section (LSCS). 1. Medicines at risk of tampering as prepared in advance and left unattended. 2. Risk of microbiological contamination of the preparations. 3. Risk of wrong dose/drug/patient errors.	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.	01/06/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	1. Use of tamper proof boxes/trays being purchased. 2. The only control to prevent the risk is to prepare the injections prior to administration (within 30 minutes) as per guidance (National and Trust). 3. If the practice is to continue, the prepared products should be labelled to include the recommended information. A procedure should be developed indicating the process to follow to ensure the medicines drawn up are discarded at the end of the day.	[01/06/2023 14:26:57 Lisa-Marie Moore] Risk assessment resent to anaesthetists - to discuss at next MQG. If no further progress to discuss with CQC [04/05/2023 14:26:40 Lisa Hansford] needs to go back to MQG [29/03/2023 10:16:01 Maddy Ward] This risk needs to go to MOpS for escalation to medicines quality group. [21/02/2023 08:53:55 Paul White] Note from Risk Register Confirm & Challenge Group - risk to be reviewed from Family Health perspective, including current rating and where responsibility for the risk should belong. [05/01/2023 14:08:19 Lisa-Marie Moore] To be raised again at MQG and action to be taken agreed Following a Datix (ref no: 255637), it has been identified that intravenous medication required for a Lower Segment Caesarean Section (LSCS) is being prepared in advance of the procedure in case of an emergency. The Lead Obstetric Anaesthetist has discussed the practice with the team and the consensus is that for safety the drugs need to be prepared in advance for potential emergencies. The team has sourced tamper proof drug trays to store the drugs once prepared. This risk assessment has been done for Pilgrim Hospital, Boston. However, the practice seems to replicate at Lincoln County Hospital. Full risk assessment is attached to Datix. 17/5/22 No change 150622 Ongoing awaiting confirmation on drugs that can be bought in. Risk is in the medical quality drugs agenda to agree and finalise.	4	30/09/2022	31/03/2023	07/09/2023
4646	Physical or psychological harm	Dunderdale, Karen	Gibbins, Donna	Clinical Effectiveness Group	NIV Working Group	14/12/2021	20	Policy/Protocol Issues, Risk assessments	Medicine	Specialty Medicine CBU	Respiratory Medicine	Trust-wide	If the Trust is not consistently compliant with with NICE Guidelines and BTS / GIRFT standards to support the recognition of type 2 respiratory failure then there may be delays to the provision of treatment using Non-Invasive Ventilation (NIV), resulting in serious and potentially life-threatening patient harm.	National policy: - NICE Guideline NG115 - COPD in Over-16s: diagnosis and management - NICE Quality Standard QS10 - COPD in Adults - British Thoracic Society (BTS) / Get It Right First Time (GIRFT) standards for NIV ULHT policy: - Guidelines and Care Pathway for commencing Non-invasive Ventilation (NIV) in the non-ITU setting - NIV-trained clinical staff - Dedicated NIV beds (Respiratory wards) ULHT governance: - Medicine Division clinical governance arrangements / Specialty Medicine CBU / Respiratory Medicine - Trust Board assurance through Quality Governance Committee (QGC) / lead Patient Safety Group (PSG) / NIV Group and Integrated Improvement Plan (IIP) / Improving Respiratory Services Programme	- Frequency and severity of patient safety incidents involving delayed NIV - recent history of rare but serious harm incidents - Total elapsed time from Type 2 Respiratory Failure (T2RF) suspicion to commencement of NIV <120mins - not being met at LCH or PHB as of Dec 21 - Start time for NIV <60mins from Arterial Blood Gas (ABG) - not being met at LCH or PHB as of Dec 21 - NIV progress for all patients to be reviewed (once NIV commenced) < 4hours - not being met at LCH as of Dec 21 update: There is a NIV audit captured monthly which determines both trust wide compliance and site specific- this is shared through PRM and available for cabinet and CBU governance meetings	27/04/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Delivery of the NIV Pathway project as part of the Improving Respiratory Service Programme within the Integrated Improvement Plan (IIP): 1. Understand the Trust-wide demand and capacity for Acute and Non Acute NIV. 2. Provision of ring-fenced beds for NIV. 3. Develop Trust-wide Model and Pathway for Acute and Non Acute NIV To meet BTS/GIRFT Standards. 4. Provision of NIV service (ED) which meets the BTS Quality Standards. 5. To have a trained workforce with the skills required to meet the needs of the patients and BTS standards. 6. Governance Process for NIV Demonstrating a Safe Service where Lessons are Learnt.	[27/04/2023 09:20:46 Silvia Tavares] update from Donna Gibbins: The risk currently remains the same. However, the following actions are being considered for June to reduce risk following the last confirm and challenge meeting: A full year review of NIV audit data will be captured and shared through clinical cabinet, once this is available a decision can be made of reducing further. Provision of National standards at PHB to be reviewed and formalised within the SOP. Funding for the LCH site is currently paused awaiting budget setting and an update will be available if any concerns for escalation. Rationale for currently remaining at level of risk in addition to the above is due to recent incidents reported of NIV commenced in ED which is outside of the trusts agreed process. [26/04/2023 12:00:12 Carl Ratcliff] Await possible funding approval via BC or budget setting [13/01/2023 13:14:40 Donna Gibbins] Case of need agreed and SFBC being written following approval at establishment review for staffing establishment. Recruitment complete for LCH Respiratory wards with minimal vacancies once all staff in place. Task and finish group arranged for phase 2 of the respiratory project to review NIV standards at PHB and additional areas of focus including domiciliary NIV. To commence end of January 23. Monthly NIV audit continues-Timeliness of the commencement of NIV is improving, issues relating to availability of NIV bed and appropriate referrals a current issue to bed pressures. Escalated and reported through escalation structure. Agreed risk remains high but reduced, requires to remain at 16 until for confirmation of Trust wide achievement of BTS standards. New Specialist Respiratory Unit with adjoining Respiratory ward now open at LCH. Plans for development of the facility at PHB are on hold with provisions in place to allow NIV to be delivered in the bay where there are x 4 monitored beds (IPC agreed) Risk discussed at Risk Register Confirm & Challenge Group in May 2022. Still inconsistencies with timeliness against BTS standards, particularly at Lincoln, and inability to ring-fence beds but an	4	30/09/2022	31/12/2022	27/07/2023
5067	Reputation	Shelton, Helen	White, Paul	Patient Safety Group	Patient Safety Group, WORK	23/12/2022	8	Corporate	Nursing Directorate	Clinical Governance		Trust-wide	There is a risk that the timeframe within which Serious Incidents are investigated may not meet Trust, ICB and CQC expectations in line with the 12 weeks specified in the national SI Framework, resulting in damage to reputation. This is caused by an increased number of SIs being reported and a lack of capacity in both clinical and support functions to expedite the investigation of Serious Incidents. There may also be an adverse impact on staff morale and wellbeing as a result of workload pressures.	National Serious Incident Framework ULHT Incident Management Policy & Procedures Serious Incident Panel Serparate approval process for patient falls and pressure ulcer SIs Datix system dashboard reports (live data) Divisional Clinical Governance Reports (monthly)	Currently the risk is being measured by the amount of SIs that are open and the amount that are 'overdue' the 12 week timeframe. As of 2 Dec 2022 there were: - 72 open SIs - 38 were overdue	07/06/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Weekly SI Update and Planning meetings taking place within Clinical Governance. Planning underway for transition to the new national incident framework (PSIRF) in 2023. Consideration to be given to not declaring falls and pressure ulcers as automatic serious incidents as a step towards the implementation of PSIRF. ICB / CQC not currently enforcing the 12 week timeframe (post-Covid pandemic). There is no specified timeframe in PSIRF.	[07/06/2023 12:32:58 Rachael Turner] Risk reviewed at RRC&C meeting 07/06/23 as part of the deep dive. Despite controls in place incidents continue to be raised and we have a new framework coming into place in September. Need to highlight risks that could come to other patients. Risk score to remain at a 16. [26/04/2023 15:29:22 Rachael Turner] Reviewed at clinical governance senior management team 24/04/23 current position 49 overdue SI investigations. Risk governance continue to support divisional teams with completion. Weekly update provided with oversight, SI panel panels continue but these have been recently effected by industrial action. Significant process has been made for PSERF implementation, which will eventually result in SI's being stood down and therefore risk will be closed at that stage. [27/03/2023 10:51:48 Rachael Turner] Risk reviewed-no change.	4	30/09/2023	30/09/2023	07/09/2023
4722	Physical or psychological harm	Cooper, Mrs Anita	Ogunyemi, Olubuyni			13/01/2022	20	Risk assessments	Clinical Support Services	Therapies and Rehabilitation CBU		Lincoln County Hospital	If there is insufficient enhanced care support available at the level required for the number of patients on Ashby Ward who require it (the ward has a high level of complex rehabilitation patients and regularly has 3 or more patients requiring enhanced care due to high risk of falls; cognitive impairment; wandering - security of self and other patients) then it may lead to safety and security incidents resulting in serious harm to patients	ULH policy: - Service planning & budget setting processes - Business case decision making processes ULH governance: - Quality Governance Committee (QGC) assurance through lead Patient Safety Group (PSG) - CSS Division, CBU / speciality governance arrangements - Capital & Revenue Investment Group (CRIG) management of business case process	Patients requiring enhanced care on Ashby Ward Patient falls incidents on Ashby Ward Patient security incidents on Ashby Ward	21/03/2023	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Business case written and submitted for additional Band 2 HCSW staff for the ward to ensure enhanced care requirements can be met and within the ward budget rather than regularly overspending on Bank and Agency staff. Review by Specialised Commissioners.	[10/03/2023 13:25:31 Rose Roberts] Meant to only have 4 enhanced pt, last 2 weeks they have had 7. Pt safety compromised. Have asked for increased agency staff. Considered raising risk level, left as is but monitor. [15/12/2022 09:42:18 Alex Measures] They have not been recruited, still some vacancies, have got the funding so should improve Business case written and submitted for additional Band 2 HCSW staff. Funding in place and posts being recruited to Support from Specialised commissioners for staffing review. Some recruitment complete but further vacancies have arisen therefore process still in progress. 130622 ongoing not up to establishment yet.	3	31/10/2021	21/09/2022	30/06/2023
5169	Physical or psychological harm	Ratcliff, Carl	East, Mr Sean			09/05/2023	15		Clinical Support Services	Therapies and Rehabilitation CBU		Lincoln County Hospital	Approx 15-20 Stroke outliers at any time on the LCH site. Therefore not on the stroke unit and not receiving specialist stroke therapy at the frequency and duration required by SSNAP. Outlier patients are not cohorted on site and can be on any ward therefore Stroke staff cannot go and review and advise. Stroke patient on other non stroke ward will not be assessed as a priority as they are not medically optimised and ready for discharge. Current staffing levels are for the 28 bedded Stroke unit only. If a stroke patient is seen o a non stroke ward this is to the detriment of another patient on that ward. Increased staff stress. General wards do not have the treatment facilities that Stroke patients need.	Stroke Therapy Team review all outliers at the cost of not seeing the Stroke ward patients as much. Stroke team will advise general ward based therapy team. Minimal basic Stroke assessment and treatment skills for general ward therapy staff. Proposal to implement Trusted Assessor Stroke Assessment.	Datixes M&H injury to staff and patient	09/05/2023	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Moving of Stroke specialist therapy staff from PHB to LCH Robust stroke training plan for general ward staff Attendance at Stroke Board to influence change and need for cohorting of outliers Review of Stroke staffing in line with latest staffing levels needed	[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		13/11/2023

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5143	Service disruption	Lynch, Diane	Parkin, Mr Lee	Trust Leadership Team	Safety Group, Information Governance Group, Outpatient Improvement Group, Patient	13/04/2023	25		Clinical Support Services	Outpatients CBU	Choice, Access and Booking	Pilgrim Hospital, Boston	The demolition of H Block will remove facilities and amenities that the health records teams utilise. The impact of removing the lift will restrict the movement of patient notes and potentially the number of patients being seen in outpatients. The health records team will need to move notes in the dumbwaiters which is previously resulted in injury and legal action. With using the dumbwaiters, this will impact information governance and security of notes due to the storage and location. Staff morale will be impacted due to extra manual handling and loss of amenities required to support with mitigating this risk. This risk also has an impact on staff workload due to extra time the tasks will now take, this will also have a knock on effect to other services such as porters, secretaries. With no lift to support the department if any large items fail i.e printer or racking, replacement items will be unable to be delivered.	There is addition of dumb waiter(x2). Health & Safety risk assessment on the dumbwaiters limits the capacity to two boxes. Process in place to ensure notes are either with a member of staff or in lockable storage areas.	Patient cancellation, waiting times and waiting list increase for patients due to patient notes being unavailable or delayed. Staff survey results. Staff sickness/injury through Occupational Health and ESR.	06/06/2023	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	To reduce the impact the team will use dumb waiters, one of which is in another area with limited access. Change of processes to mitigate risk and transfer notes over a longer period. Walk around with senior individuals and project team to look at different ways of working and potential solutions. Risks to be highlighted in QIA. Risk to presented at PRM. Health and Safety guidance to be delivered to Team. Further discussions to be had regarding whether all clinicians requiring paper based notes in clinic.	[06/06/2023 11:08:10 Maddy Ward] Since meeting on 26/04/2023, we have met with the CSS DMD, Head of Capital Projects and Estates team are going away to cost up the various works needed. To discuss with the exec team. Highlighted risk is contributing to risks across the PHB site and a number of datix have been registered highlighting health and safety risks. [26/04/2023 11:42:09 Rachael Turner] Risk presented at Risk Confirm & Challenge 26/04/2023 for validation. This was agreed as scoring as a 15-High risk. Escalation is required to look into alternative measures to support with this risk, possibly looking into Electronic records.	1	01/05/2023		06/09/2023
4688	Regulatory compliance	Hallion, Simon	Chantry, Chris	Palliative / End of Life Care Oversight Group	Clinical Effectiveness Group	13/01/2022	15	Risk assessments	Family Health	Children and Young Persons CBU	Children's Community Services	Community	Quality and safety risk from non-compliance with NICE guideline NG61: End of Life Care for Infants Children and Young People with Life Limiting Conditions.	- ULHT processes for managing response to National Institute for Health and Care Excellence (NICE) pathways and guidance	Self assessment against NICE guideline NG61	18/04/2023	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Complete self assessment and implement actions required to achieve compliance Self assessment completed and details following actions: - Ensure that all parents or carers are given the information and opportunities for discussion that they need - Need more trained professionals Doctor and nurses (monitor compliance with EOL care elearning via Speciality Governance) - Manage transition from children's to adult's services in line with the NICE guideline on transition from children's to adult's services - Some groups have clear transition pathways- diabetes, oncology but there is no clear pathway for children with life threatening neuro disability or respiratory issues (D Flatman)(more specific action required) - Think about using a rapid transfer process (see recommendation 1.5.8) to allow the child or young person to be in their preferred place of death when withdrawing life-sustaining treatments, such as ventilation - Rapid Discharge pathway required (J Wooley) - The specialist paediatric palliative care team should include at a minimum: • a paediatric palliative care consultant • a nurse with expertise in paediatric palliative care • a pharmacist with expertise in specialist paediatric palliative care • experts in child and family support who have experience in end of life care (for example in providing social	[18/04/2023 15:44:07 Jasmine Kent] For increase of risk. Specialist nurse is leaving, reducing capacity further. Issues with every case of end of life patients due to care not being commissioned, no 24/7 rota. Having to obtain support on a case by case basis depending who is available. [20/01/2023 11:18:34 Alison Barnes] No Paediatric palliative care consultant. Nurse with expertise, no pharmacy with expertise. [31/10/2022 15:02:43 Kate Rivett] 31/10/2022 - KR 1. 'What is the risk' updated to be more succinct to ensure that the risk is clearly articulated Self assessment completed. Actions identified have been detailed and communicated, as transcribed into this Risk Register entry	6	31/03/2022	30/11/2023	18/07/2023
Strategic Objective						**1b. Improve patient experience**																				
4701	Reputation	Grooby, Mrs Libby	Upjohn, Emma	Estates Investment and Environment Group	Patient Experience Group	13/01/2022	15	Risk assessments	Family Health	Women's Health and Breast CBU	Obstetrics	Trust-wide	If the quality and condition of the hospital environment and facilities used within Maternity services are poor then it may have a negative impact on patient experience and staff morale resulting in loss of confidence in the Trust and damage to reputation; there is also an increased infection risk	- Trust procedures for capital investment and Estates project management - Corporate oversight through Estates Investment & Environment Group / Finance, Performance & Estates Committee (FPEC)	Patient & staff feedback on the environment in Maternity services. Audits of infection prevention & control compliance. Reported health & safety and IPC incidents.	03/04/2023	Reasonably likely (3) 31-70% chance	Extreme (5)	High risk (15-16)	15	Plans for refurbishment of Maternity units on both sites, estimated timescales 3-5 years for LCH, PHB to be confirmed. Full Business Case required. Maternity shared decision council looking at simple solutions for improving working lives of staff.	[04/04/2023 12:45:23 Jasmine Kent] Predicted date for decanting Nettleham to Langton 02/05/2023. While awaiting funding for refurbishment of Nettleham. Drain work at Pilgrim site is scheduled. [23/01/2023 17:04:59 Jasmine Kent] Included within capital allocation bids for next financial year. Agreement from trust board that works will take place in next financial year. Staff engagement sessions to communicate refurb plans. Issues dealt with by Estates & Facilities as they occur. 13/04/2022: Mitigation plan - full board approval to progress the business case. Require monitoring of staff surveys. CQC report demonstrates unsuitable for use - amended to 3 impact and 5 occurrence = 15 26/09/2022 - Unchanged	6	31/03/2025	31/03/2025	03/07/2023
4724	Physical or psychological harm	Rimmer, Lucy	LES (Deleted User)	Workforce Strategy Group	Patient Experience Group	13/01/2022	20	Risk assessments	Clinical Support Services	Therapies and Rehabilitation CBU		Trust-wide	If Therapies and Rehabilitation service provision is not sufficient to deliver 7 day service provision, it leaves services without cover at a weekend or with inadequate cover during the week, leading to delayed patient flow; delayed discharge; extended length of stay; impacting on patient experience with potential for serious harm. This includes the neuropsychology cover on Ashby, SLT cover for inpatients, and therapy cover on ITU.	ULH policy: - Service planning & budget setting processes - Business case decision making processes ULH governance: - Capital & Revenue Investment Group (CRIG) management of business case process - CSS Division, CBU / speciality governance arrangements	Level of cover at weekends. Length of stay, patient flow, delayed discharges. Level of funding - Some 7 day funding, but limited to orthopaedics at LCH, minimal service. Inadequate for level of service demand.	10/03/2023	Extremely likely (5) >90% chance	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.	[10/03/2023 13:43:06 Rose Roberts] Awaiting nhse results. Neuro psychology bid waiting to go to CRIG [13/01/2023 12:51:48 Lesley Bradley] 13/1/23 NHSE reviewed Ashby ward this month-await recommendations for staffing levels [15/12/2022 09:53:21 Alex Measures] No update [30/11/2022 10:04:52 Rose Roberts] Neuropsychology bid is still awaiting CRIG approval as CRIG has been stood down. Business cases completed for all areas. 130622 Neuropsychology bid is going to CRIG this mth. All others to be confirmed. Work in progress.	4	30/11/2021	31/03/2023	28/04/2023
Strategic Objective						**1c. Improve clinical outcomes**																				

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
4828	Physical or psychological harm	Farquharson, Colin	Costello, Mr Colin	Medicines Quality Group	Digital Hospital Group, Patient Safety Group	17/01/2022	20	Risk assessments	Clinical Support Services	Pharmacy CBU	Pharmacy	Trust-wide	The trust currently uses a manual prescribing process across all sites, which is inefficient and restricts the timely availability of patient information when required by Pharmacists. Where information about patient medication is not accurate, up to date and available when required by Pharmacists then it could lead to delays or errors in prescribing and administration, resulting in a widespread impact on quality of care, potentially reducing the likelihood of a positive clinical outcome and/or causing serious patient harm	National policy: - NICE Guideline NG5: Medicines optimisation, etc. ULHT policy: - Policy for Medicines Management: Sections 1-8 (various approval / review dates) ULHT governance: - Trust Board assurance via Quality Governance Committee (QGC) / Medicines Quality Group (MQG)	Medication incident analysis Audit / review of medicines management processes - the Trust currently uses a manual prescribing process across all sites, which is inefficient and restricts the timely availability of patient information when required by Pharmacists.	01/06/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Planned introduction of an auditable electronic prescribing system across the Trust. update 4th July 22- 26th july, empa functionality version 10.21 will be upgraded. Epma pilot from 13/09/22, full trust wide roll out- mid oct	[01/06/2023 14:19:05 Lisa-Marie Moore] Roll out continues but behind planned schedule [04/05/2023 14:22:48 Lisa Hansford] No for update roll out continues [29/03/2023 10:18:35 Maddy Ward] Due for completion in Lincoln at the end of April/ beginning of May and plan to be fully rolled out across Pilgrim by the end of September and all sites by the end of December. This excludes Paediatrics and Maternity. [02/02/2023 14:18:48 Lisa Hansford] Expected end date of implementation 31/03/23 [05/01/2023 14:07:02 Lisa-Marie Moore] Pilot phase in Cardio LCH complete. Roll out to begin on Stroke w/c 9th January [08/12/2022 12:43:26 Lisa-Marie Moore] Pilot still underway in cardiology at LCH. No update received to date on when roll out will occur. Issues external to pharmacy may hinder roll out e.g staff to add patients on careflow on admission/transfer [14/10/2022 16:05:51 Rachel Thackray] Pilot being undertaken in cardiology w/c 10 October 2022 which will take place over the next month. This will then be reviewed following completion. Funding approved for Electronic Prescribing and Medicines Administration (EPMA). Project plan has been developed, implementation from Oct / Nov 21. Reviewed at Risk Register Confirm & Challenge Group 26 Jan 22. Rating increased to 20. 17/5/22 No change 150622 Discussed that a further risk is to be added concerning accurate medicines reconciliation as defined in NICE medicine and optimisation guidance NG5. And connection to staffing. update 4th July 22- 26th july, empa functionality version 10.21 will be upgraded. Epma pilot from 13/09/22, full trust wide roll out- mid oct.	4	31/12/2023	29/12/2023	06/07/2023
5075	Physical or psychological harm	Capon, Mrs Catherine	Dolling, Matthew	Patient Safety Group	Estates Infrastructure and Environment Group	13/01/2023	20	Surgery	Theatres, Anaesthesia and Critical Care CBU	Critical Care	Lincoln County Hospital		Disease progress for patients alternative treatments,change of treatment plan, poor clinical outcomes,causing patients anxiety and worry for the patient. As a consequence of lack of ICU capacity for elective surgery patients this leads to cancellations on the day,this includes cancer patients that require level 2 post operative care.	Daily escalations to TACC team who endeavour to establish potential capacity through step down beds following ward rounds on ITU. Request for Anaesthetic review of the elective patients for the potential to identify patients for level 1 care rather than level 2. Patients that are cancelled are re dated as soon as possible following cancellation.	Monitoring the cancellation of elective patients - recording the reason for cancellation this includes bed capacity, due to staffing and patient need and activity at the time. Harm reviews to identify disease progression and changes in treatment plans for patients.	06/04/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	The triumvirate to include surgery and TACC are planning to meet to review potential options.	[15/06/2023 09:01:19 Wendy Rojas] Risk continues as level 3 beds remain capped. Incidents monitored.Work in progress for recruitment. Strategy days planned. [06/04/2023 12:51:22 Paul White] Discussed at Risk Register Confirm & Challenge 29 March, risk agreed with feedback provided for consideration to clarify the risk description.	4	13/04/2023		15/07/2023
4731	Physical or psychological harm	Harris, Michelle	Parkin, Mr Lee	Medical Records Group	Digital Hospital Group, Patient Safety Group	13/01/2022	20	Risk assessments	Clinical Support Services	Outpatients CBU		Choice, Access and Booking	If patient records are not complete, accurate, up to date and available when needed by clinicians then it could have a widespread impact on clinical services throughout the Trust, potentially resulting in delayed diagnosis and treatment, adversely affecting patient experience and reducing the likelihood of a positive clinical outcome.	- Clinical Records Management Policy (approved June 2021, due for review June 2022) - Draft policy produced further discussion with changes required with Divisional Clinical Lead - Trust Board assurance via Finance, Performance & Estates Committee (FPEC); lead Information Governance Group / Medical Records Group - CSS Division	Internal audit of medical records management processes - reliance upon hard copy patient records; patients may have multiple sets of records. Reported incidents involving availability of patient records issues.	06/06/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Design and delivery of the Electronic Document Management System (EDMS) project, incorporating Electronic Patient records (EPR). Interim strategy required to reduce the risk whilst hard copy records remain in use.	[06/06/2023 11:46:11 Maddy Ward] Still a very high risk with ongoing concerns. Will be a risk until electronic records are implemented across the trust. To mitigate the risk until that time the records management policy has been updated and communications will be sent by the Medical Director clarifying the protocols on current use of notes. [11/04/2023 11:47:33 Rachael Turner] Risk re-opened until electronic records are implemented. [05/04/2023 10:47:54 Rose Roberts] Email from KB - this can now be closed, updated records management policy now published. [29/03/2023 09:53:02 Anita Cooper] New ToR agreed at IG Group for CRG to become a Trust-wide group, chaired by Deputy Medical Director. Relaunch planned following approval at TLT which will require greater Divisional representation and a broader agenda. [06/03/2023 11:17:40 Maddy Ward] This risk is still ongoing, EPR not yet signed off. [02/02/2023 15:31:12 Rose Roberts] KB going to ask crg meeting if the new policy has been signed off. [15/12/2022 14:24:51 Madeline (Maddy) Ward] Ongoing, issue raised with clinical records meeting with control of health records for resolution, further meeting to be held mid-December [29/11/2022 11:04:59 Rose Roberts] Policy still awaiting final ratification so please extend by 1 month. [27/10/2022 12:08:42 Rose Roberts] Ongoing OBC for EPR is being produced in line with NHSE/I guidance. Hoping to have Board sign off and funding in early 2022, with project start 2nd quarter 2022. To discuss / agree interim approach. Reviewed by Risk Register Confirm & Challenge Group, 26 Jan 22. Rating increased to 20, risk lead changed to Prof lead for Outpatients. Oversight to be via Digital Hospital Group. 120522 - Review of policy is underway – sent to h/recs managers for amendments before being sent for sign off to Lee and via the CRG 210622 Now further update until Nov. In Nov expect to get preferred bidder for it. Updates will come from Electronic records system project. 23/09/2022 - No further updates	4	30/06/2018	31/03/2025	06/07/2023
4866	Service disruption	Costello, Mr Colin	Saddick, Ahtisham	Medicines Quality Group	Patient Safety 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	01/06/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	To develop a robust supervision, training and development framework for the new pharmacy technicians roles. 1. To undertake a quality impact assessment to evaluate the potential impact on pharmacy services. 2. To develop a robust NVQ apprenticeship training scheme to train band 2/3 staff to band 4/5 roles both on the wards and in pharmacy services to achieve a sustainable pharmacy technician workforce in order to support all pharmacy technician roles.	[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	07/09/2023

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
4928	Service disruption	Ratcliff, Carl	Smith, Charles	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	24/04/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	defined plans to address backlog for at risk areas	[24/04/2023 12:57:21 Carl Ratcliff] Reduced number of covid pts in system - recruitment of locum consultant in place to cover small service gap [27/01/2023 10:20:57 Charles Smith] 27/01/2023 - CS - DGM - Further 2x Cons departures (Ads out). C&A not able to support PIFU implementation yet. Further loss of agency Cons at PHB to remove reliance on agency (cost). NHS national ask is to reduce FU work, this will have negative impact so currently negotiating via D&C process. [16/12/2022 14:40:47 Carl Ratcliff] Work underway to fill all clinics but no major concerns with perf [22/11/2022 17:29:18 Carl Ratcliff] RTT for cardiology starting to improve, however backlogs still place and risk not yet reduced. Specialty review work will lead t plan to bring RTT performance back into line but could take 6/12 Discussed at Risk Register Confirm & Challenge Group 25 May 2022. Additional details to be added to risk reduction plan. 10.08.2022- New consultant starting September 2022- 2 x clinics per week for new patients only Existing new patients currently being validated by support manager. TOE list capacity being utilised for PBWL patients. Plans in plan for PIFU for cardiology (next meeting end of August 2022).	8	30/06/2022	31/07/2023	27/04/2023
Strategic Objective						**2a. A modern and progressive workforce**																				
4844	Service disruption	Lynch, Diane	Costello, Mr Colin	Workforce Strategy Group	Medicines Quality Group	19/01/2022	20	Risk assessments	Clinical Support Services	Pharmacy CBU	Pharmacy		The ability to provide a seven day a week pharmacy service requires a level of staffing above the current levels. Benchmarking has taken place against peer Trusts for staffing levels. Until this is funded the seven day a week service is unobtainable and this puts patients at risk.	Service planning & annual budget setting processes: Pharmacy / CSS Division	Staffing levels / budget benchmarked against other similar trusts. Reported medication incidents occurring out of hours.	01/06/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Pharmacy supply a limited Saturday and Sunday morning service with staff working beyond their contracted hours. An on-call pharmacist is available for EMERGENCY items only. A Business Case has been submitted to CSS CBU.	[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	06/07/2023
4996	Service disruption	Dunning, Mr Paul	Chester-Buckley, Sarah	Workforce Strategy Group	Patient Safety Group	22/08/2022	16		Clinical Support Services	Cancer Services CBU	Haematology (Cancer Services)		Staffing - insufficient consultant workforce to meet demand. Particular areas of concern: 1. Lymphoma tumour site cover 2. Haemostasis/haemophilia (single consultant Trust wide) 3. Pilgrim Consultant cover 4. Clinical governance lead 5. Head of Service for haematology 6. Transfusion Lead from 17th July 23 (w/o this unable to run transfusion lead) 7. Audit Lead	* Completed a fragile services paper * Additional/extra clinics being undertaken where possible 1. Only 1f/t consultant and 1 p/t consultant who is covering nearly f/t hours. 2. Only 1 f/t consultant covering Trust wide. Unable to mitigate risk during a/l or unexpected absnece. Requirement to discuss with neighbouring Trust eg Notts. 3. Mitigated by high cost agency consultant cover. 4. CG lead duties shared between consultants but no one wishes to take on role. 5. HoS duties divolved to clinical lead for onc and haem and/or CD for CSS	* New referrals and PBWL show ongoing capacity issues. * RTT and cancer performance below target. * Increased PA's for substantive consultants. * Increased Datix, Complaints and PALS * Outcome from Staff Survey results	02/06/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	* Workforce review * Refresher of Fragile Services Paper - NB there is a National shortage of Haematology consultants * Recruitment of further substantive consultants * Additional unfunded ST3+ for Haematology starts in August 2022	[02/06/2023 12:38:22 Maddy Ward] Andrew Morgan requested a briefing paper for ELT which is now complete in conjunction with transformation and due to be circulated to execs on 05/06/2023 Making enquires if transfusion lead needs to be a consultant of if another profession can pick this up. [24/04/2023 10:35:11 Maddy Ward] Haematology service review carried out on 20th April 2023 in association with strategy, planning, improvement and integration directorate [03/04/2023 09:42:15 Rose Roberts] Workforce paper with the triumvirate. Reviewed at confirm and challenge confirmed as v high risk. [15/12/2022 13:34:35 Alex Measures] all lead roles currently out to advert further recruitment ongoing	8	30/09/2023	01/04/2023	03/07/2023
5093	Service disruption	Simpson, Mr Andrew	Baines, Andrew	Medicines Quality Group	Workforce Strategy Group	16/02/2023	20		Clinical Support Services	Pharmacy CBU	Pharmacy		Baseline pharmacy procurement staffing is at a level where only the basic functions can routinely be delivered and the service is not able to withstand any prolonged absence due to leave, sickness or resignation. The workforce has remained relatively stable over time, however workforce pressures have been increasing over the last few years for a variety of reasons. There has been an increasing number of pharmaceutical shortages, many of which are complex in nature. A growing number of drugs are now being offered on an allocation basis which requires micro management for stock ordering and distribution across the Trust. Changes in the delivery of chemotherapy have resulted in an increased demand for ordering of chemotherapy preparations. The pharmacy invoicing team have also experienced a recent increase in workload following the implementation of the Advanced finance system. The team are reporting concerns around workload and workplace stress. We are routinely reliant on existing staff working additional hours to fill gaps. If staff feel unable to come to work for any reason (including stress related) this will further increase the risk to the Trust and its patients of stock outs, with an associated risk to patient care, due to either a lack of personnel to raise	The team comprises four part time procurement clerks and two part time invoice clerks working from a centralised office in Lincoln but responsible for trustwide ordering and invoicing, and 5 storekeepers who work across the sites, and is lead by a full time pharmacist and technician. All areas of the service are continuously working at or over capacity and any absence results in other staff working additional hours, or attempting to absorb additional duties over and above their own in order to maintain the basic service. There is theoretical potential to cross cover with members of the Homecare team who have a similar skill set, however that service is also under extreme pressure and so there is limited capacity to provide this cross cover – it is most often used to support the invoicing team at times of annual leave. Where staff have recently expressed concern about work related stress the associated risk assessment has been provided. From a procurement perspective the baseline staff level on a day is 2 purchasing clerks, so purely taking annual leave into account there are multiple weeks in the year where only 1 purchasing clerk is available to manage the ordering workload. This impacts adversely on the job role of the procurement technician who often has to backfill these gaps. This makes the team very susceptible to the effects of sickness absence, particularly if this occurs whilst another team member is on leave. On such days it is frequently not possible to meet the full basic demands for all pharmacy sites with the potential to see a reduction in order frequency from twice a day to once a day, and less capacity for chasing of outstanding orders, depending on staff availability – giving further rise to a risk of treatment delays if stock orders are not placed or chased in a timely manner.	Staff morale is low across the pharmacy department as per the last communicated NHS staff survey feedback, and direct feedback from staff within the procurement team highlights that morale within the team is challenged and wellbeing is impacted. An increase in workload due to product shortages can be evidenced with reference to the growing number of Medicines Shortage Notifications (MSNs) and Supply Disruption Alerts (SDAs) issued by the Department of Health and Social Care, which totalled 25 over the last 4 months of 2020 (following the launch of this scheme), 80 in 2021, and 89 in 2022. Whilst not measured, departmental feedback highlights a growing frequency out of stock scenarios which require investigation and follow-up (this may include taxi transfers of stock between sites, where stock is available in one of the other hospitals); these are often caused by a lack of time to follow-up orders which have not been received in a timely manner, and can be associated with delayed or missed doses, or impact on timely discharges.	01/06/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Gap analysis highlights several areas of ongoing concern (to-follows, shortage management, invoice query management, medical gas invoicing). Occasional additional support is currently being provided to the invoicing team by a Bank Pharmacy Support Worker; we are scoping training this individual to offer procurement support in addition. This post is being paid from vacancy money elsewhere in the department and so cannot be considered a long-term fix for the procurement gaps. A case of need will be prepared to identify workforce requirements to reduce the workload stress the staff are persistently facing, and to provide a robust service which can withstand annual leave and short term sickness absence, based on the more challenging pharmaceutical market we are operating in where shortages are now a daily occurrence.	[01/06/2023 14:14:06 Lisa-Marie Moore] No change/further update since April [19/04/2023 15:48:11 Andrew Baines] Colin Costello & Andrew Baines met with Diane Lynch on 18/4/23 - outcome was for a proposal to be presented to Diane for which she would find funding for necessary supporting roles. [06/04/2023 12:49:53 Paul White] Discussed at Risk Register Confirm & Challenge 29 March, risk agreed with feedback provided for consideration.	4	16/02/2024	16/02/2024	06/07/2023

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
4991	Service disruption	Low, Claire	Shankland, Lindsay	Workforce Strategy Group	Workforce Strategy Group	08/08/2022	20		Corporate	People and Organisational Development	Operational HR	Trust-wide	If the Trust is unable to recruit and retain sufficient numbers of staff with the required skills and experience then it may not be possible to provide a full range of services, resulting in widespread disruption with potential delays to diagnosis and treatment and a negative impact on patient experience.	ULHT policy: - Workforce planning processes - Recruitment & Selection Policy & Procedure - Rota management systems & processes - Locum temporary staffing arrangements - Workforce management information - Core learning / Core+ programmes? ULHT governance: - Trust Board assurance through People & OD Committee / lead Workforce Strategy Group - Divisional workforce governance arrangements	Vacancies & turnover rate. Staff survey results relating to job satisfaction / retention. Core learning compliance rates?	01/06/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	1. Focus staff engagement & structuring development pathways. 2. Use of apprenticeship framework to provide a way in to a career in NHS careers. 3. Exploration of new staffing models, including nursing associates and Medical Support Workers. 4. Increase Agency providers across key recruitment areas. 5. Increase capacity in recruitment team to move the service from reactive to proactive. 6. Develop internal agency aspect to recruitment. 7. Reintroduce medical recruitment expertise within Recruitment Team. 8. Build strong relationship with Refugee Doctor project to support MSW recruitment and GMC registered Doctors. 9. Source a third party supplier for Philippines recruitment for hard to recruit AHP roles.	[24/04/2023 11:41:33 Rachael Turner] Work still ongoing, following PODC meeting booked in April, risk will be presented at RRC&C meeting in May. [14/03/2023 13:54:10 Rachael Turner] Increase in headcount, 7.7% now and plans to get this even lower. Roughly 4% improvement. 450 more staff increase and cicra 300 net extra are clinical. Agency providers are now across 4 key areas. Talent acquisition team are now in place to help recruit to difficult to recruit roles. Refugee doctor project still in place. Due to work taking place, proposal for the risk score to be reduced to a score of 12 (moderate). This will go to RRC&C meeting for validation. [10/03/2023 11:43:15 Rachael Turner] No change this month, work currently underway for progress update in April. [31/01/2023 15:11:35 Rachel Thackray] Developing workforce planning report to be submitted to HEE by 31 March 2023, this has a monthly breakdown of anticipated recruitment plans across staff groups with an aim to take us to a vacancy factor of approx 2%. This will be monitored at an organisational and system level monthly. Staff survey results from November 2022 show increased positive scores across all factors which should influence retention issues. Risk reduction plan - Presentation to ELT on 10/11/22 to update international recruitment plan, revised projection on increasing nurse recruitment to get to zero vacancy position by March 2023 Currently 250 nurse vacancies - task and finish group created by Head of Recruitment to work in conjunction with divisional leads to pull together a recruitment activity plan for the remainder of 2022/23 and 2023/24. Plan for recruitment of 285 nurses by the end of the financial year. 1. New to care recruitment being extensively used for HCSW role with 14 appointed & a further 40 offered. 2. Nursing associate recruitment embedded 3. Medical Support Worker role now	4	31/03/2023	31/03/2023	01/07/2023
4997	Service disruption	Dunning, Mr Paul	Chester-Buckley, Sarah	Workforce Strategy Group	Patient Safety Group	22/08/2022	16		Clinical Support Services	Cancer Services CBU	Haematology (Cancer Services)		Service configuration - single consultant covering both sites during weekend so cover limited if critically unwell patients on both sites	Middle Grade cover in place from Oncology but not sustainable as Haematology is not their area of experise and therefore cannot replace consultant presents with acutely unwell patients.	* Increased Datix, Complaints and PALS * Outcome from Staff Survey results	02/06/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	* Workforce review * Refresher of Fragile Services Paper - NB there is a National shortage of Haematology consultants * Recruitment of further substantive consultants * Additional unfunded ST3+ for Haematology starts in August 2022	[02/06/2023 12:39:17 Maddy Ward] Andrew Morgan requested a briefing paper for ELT which is now complete in conjunction with transformation and due to be circulated to execs on 05/06/2023 [24/04/2023 10:36:05 Maddy Ward] Haematology service review carried out on 20th April 2023 in association with strategy, planning, improvement and integration directorate [03/04/2023 09:43:59 Rose Roberts] Workforce paper for haem with triumvirate, then will start oncology workforce paper. Reviewed at confirm and challenge confirmed as v high risk. [15/12/2022 13:35:25 Alex Measures] ongoing recruitment ongoing	8	01/04/2023	01/04/2023	03/07/2023
4741	Service disruption	Cooper, Mrs Anita	Chester-Buckley, Sarah	Workforce Strategy Group		13/01/2022	20	Risk assessments	Clinical Support Services	Cancer Services CBU	Oncology	Trust-wide	Oncology is considered to be a fragile service due to consultant oncologist gaps. Demand vastly exceeds the capacity, requiring an increase in establishment. Tumour sites at risk (Medical oncology) - renal, breast, upper and lower GI, CUP, ovary/gynae, skin, testicular, lung, urology, HPB Clinical oncology - head and neck, skin, upper GI (RT only). Due to only consultant covering Sarcoma retiring we will no longer have consultant cover for sarcoma from July 23. Lack of cover for leadership roles: Chemotherapy Lead, and succession planning for clinical lead. Lack of continuity of care at PHB, LCH have 'hot week' for consultants, PHB have a different consultant covering for a ward round each day. If there is absence or consultant is on 'hot week' for LCH there is no cover for PHB that day and may be for several consecutive days.	Cancer services operational management processes & clinical governance arrangements Medical staff recruitment processes Agency / locum arrangements email sent to consultants to see if anyone would cover sarcoma - no capacity/specialisation	Monitoring tumour site performance data	02/06/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Need to undertake a workforce review, oncology still a fragile service, continuing to work with HR to source consultants	[02/06/2023 13:10:49 Maddy Ward] Andrew Morgan requested a briefing paper for ELT which is now complete in conjunction with transformation and due to be circulated to execs on 05/06/2023 [24/04/2023 10:37:32 Maddy Ward] Oncology service review carried out in March in association with strategy, planning, improvement and integration directorate [03/04/2023 09:37:11 Rose Roberts] workforce paper to be started after haem have been reviewed, discussed at risk confirm and challenge, confirmed as high risk. [16/01/2023 12:13:46 Sarah Chester-Buckley] Interviews being set up for leadership role. [15/12/2022 13:42:46 Alex Measures] leadership posts out to advert [16/11/2022 15:56:34 Rose Roberts] Posts being mitigated by employing high cost locums, risk with this mitigation is that locums need only give one weeks notice. Raised at Cancer delivery and performance (CCG present). CSM spoken with Advanta re requirements. 220622 Agency Clinical oncologists recruited. So improved cover for Head and neck and melanoma. Ongoing	4	31/03/2023	31/03/2023	04/09/2023

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
4862	Physical or psychological harm	Cooper, Mrs Anita (Historical Deleted User)	Ratcliff, Carl Marsh, David	Workforce Strategy Group	Workforce Strategy Group WORK	22/02/2022	16	Staff Survey	Medicine	Specialty Medicine CBU	Respiratory Medicine	Trust-wide	Consultant staffing within Respiratory Medicine at Lincoln and Boston Hospital. Currently there are only 3 Substantive consultants in place at LCH and 2 at PHB. We have a vacancy of 5 across the three sites. Various gaps are covered with Adhoc Locum. The main current risk is to the inpatient cover at Pilgrim Hospital. With only x2 Consultants over there, when we have 1 on annual leave, the risk that the other could be either sick or covid contact is extremely high. We have supported this with clinicians going over from LCH, however due to a further resignation at LCH, this is proving more difficult This combined risk on Medical staffing has now impacted the Secretarial team at LCH. There is currently 0 secretaries at work at LCH due to sickness in the team. This is mitigated through support from Agency / Other specialties supporting. We do not have the substantive staff nor the locum or agency bookings, to cover all functions of our Resp Medical Team. Inpatient risk of high acuity patients without specialist input. Outpatient risk of high activity of 2ww referrals on top of high volume OP workload, delayed	Due to the severity of the risk: Currently: x 5 Consultant Gaps in Resp The impact this is having on the current workforce is stretching the team and leading to added pressure on the workforce. We are working with agency teams to work 'differently' for example Locum consultants supporting with on call work / remote clinics to release the burden on the current clinical team in respiratory. OD support in place also, along with weekly catch up meetings with the teams to explain the current state of play. The Business Unit have this week (06/09) put a bid in to the EMCA to gain funding of 250K to support a General Medicine to work in Respiratory so that our Substantive teams can be released to support Respiratory Cancer Capacity - This bid is currently being reviewed. We have worked in the background to book x 2 Agency Locum General Medicine Consultants 1 at Boston and 1 at Lincoln which will take us over budget, but supports the respiratory patients of lincolnshire and the welfare of consultant staff.	Staff Survey Results. Data Analysis through HR around recruitment and retention. Measured through Performance for patients (although this is not directly attributed towards the recruitment and retention, the longer wait times cause anxiety and unwarranted stress for the consultants in post)	24/04/2023	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.	[24/04/2023 12:25:14 Carl Ratcliff] Have recruited to Consultant ACP post in nodules to support team - will start in 1/12 Using additional external support to deliver extra capacity for OPD to allow delivery of 78ww and reduce risk for delivery of 2ww urgent work [24/02/2023 13:48:15 David Marsh] Recruitment in progress, 5 substantive consultants in post (3 x Lincoln, 2 Boston). Agency locums in place covering a variety of roles/sites. New NHS Trust Locum Respiratory Consultant from overseas started in January at Lincoln. Now working independently. Division looking at developing ACP roles and Nodule Nurse post. [01/12/2022 11:15:13 Carl Ratcliff] plan for 3 consultants now being on boarded New plan to develop ACP nodule role Most recent update: Dear Carl, Following the catch up earlier, Claudia, Ashley and I have compiled our thoughts on what could go down to support the services..... Option Take down: Benefits Risks: 1 Do Nothing None Cancer patients continue to wait prolonged periods for care. • Inpatient services at LCH and PHB continue to become extremely depleted • Welfare of current consultant workforce continues to suffer, potentially leaving to sickness / prolonged absence • Boston have only x2 Consultants, currently utilising support from already depleted LCH Team. (If annual leave / sickness, we have only 1 consultant on the Pilgrim site) 2 Grantham inpatient respiratory services (Preferred) Releases x1 Agency Locum Consultant who can ?potentially? go over to Lincoln (as per previous agreement) • Releases a consultant to cover the rota to a 'safe' level Non-compliance with ASR due to taking out inpatient respiratory services at GDH	4	30/12/2022	30/06/2023	31/05/2023
4905	Physical or psychological harm	Cooper, Mrs Anita (Historical Deleted User)	Ratcliff, Carl Marsh, David	Workforce Strategy Group	Workforce Strategy Group	22/04/2022	12	Workforce Metrics, Risk assessments, Aggregation of Incident/Claims & Complaints/PALS	Clinical Support Services	Therapies and Rehabilitation CBU		Trust-wide	If we have insufficient staffing, or required level of experience and skill, the risk is patients will not receive assessment and rehabilitation leading to poor clinical outcome. Reduced flow on Ashby and the acute wards, delayed discharges, delayed referral to response times. Increase in avoidable harm i.e. deconditioning, PU's, constipation, delirium. Patient reviews delayed for botox treatment. Paediatric services delayed response to new diabetes referrals and unable to see current diabetes patients in clinic- could lead to patient harm. Increase in bed stock and boarding beds without recognition of additional therapy staffing needs. Existing staff stretched to cover additional beds. Increased stress and sick leave on substantive staff.	Recruitment and retention strategies to fill vacancies. Bank staff. Requests to Locum Agencies. Skill mix Roster management. SQD data. Daily review of ward systems eg WebV. Referral guidelines and Prioritisation guidelines help to inform workloads and impact on patient flow and bed situation. Paed services are responding to direct requests for newly diagnosed children . Upskilling B5 N&D staff-(normally B6 N&D staff). Access to Staff wellbeing services. Front door therapy assessments passed to inpatient teams on admission.	Patient complaints. Fewer discharges at the weekend. Site escalation. Vacancy rates. Roster fill rates. Waiting lists for spasticity service. Staff absence. Staff survey and feedback.	08/05/2023	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Getting locums and bank staff in place. Good use of relocation allowance. Actively managing the waiting lists and dealing with urgent cases to avoid harm eg telephone contact with patients. Case of need for GDH orthopaedic staffing. Case of need for rehabilitation consultant post. Case of need for upper GI dietician. Case of need for Neuro Psychology staff on Ashby. Case of need for OT staff at PHB and LCH in ITU. Over recruitment of band 5s in dietetics. Competency frameworks and preceptorship.	[09/05/2023 15:14:15 Sara Blackbourn] Addition of escalation beds. Front door pilot. Referral criteria review. [10/03/2023 13:46:14 Rose Roberts] One member of staff has returned but another member is on maternity leave and there is no cover for her. Across all the services continue to be flexible and look at the skill mix to allow to deliver the best service we can. [13/01/2023 12:54:24 Lesley Bradley] 13/01/2023 Continue to review staffing levels, vacancies and reasons for sickness on a monthly basis [15/12/2022 09:55:40 Alex Measures] still looking at models of how to measure safe staffing levels, just asking each team to provide there funded establishment, what they would expect on a usual day and what is the minimum level of staffing, then we can start measuring whether we are falling below safe staffing levels, we have no method of recording that at the moment [30/11/2022 10:07:42 Rose Roberts] Continuing to look at staffing. Currently have a lot of sickness. Looking at levels of staffing so able to report whether staffing levels fall below a safe level. 130622 Looking at staffing vacancies and looking at line by line post analysis. OT IR 8 posts KPI's for Integration include reduce vacancies Promotional Commms for AHP week and Trac being produced to attract staff Improved recruitment strategies.	9	30/09/2023	18/12/2023	14/08/2023
Strategic Objective						**2b. Making ULHT the best place to work**																				
4990	Reputation	Low, Claire	Shankland, Lindsay	Workforce Strategy Group		08/08/2022	20		Corporate	People and Organisational Development	Organisation Development	Trust-wide	Poor culture within the Trust resulting in poor behaviours, increased ER cases, turnover, retention issues and ability to recruit and increased sickness absence. ULHT 'Pulse' Survey (quarterly): poor/low uptake; staff survey fatigue; lack of motivation and confidence amongst staff that results are anonymised and are meaningful to ULHT Results affects ULHT standing as an employer of choice and employer brand within NHS - may therefore result in reputational risk and create difficulties when recruiting/attracting talent and retention of workforce locally, regionally and nationally.	1. National and local lessons learnt for engaging staff effectively with surveys 2. Dedicated 'staff experience/engagement' role proposed to lead programme of work (including corporate and local action planning)	1. Pulse Staff Survey response rate (quarterly) 2. NHS Staff Survey response rate (annual)	01/06/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	1. National mandate for NHS organisations to run Pulse Survey every quarter (1,2&4) 2. Comprehensive and robust positioning to complement NHS Staff Survey and part of a wider staff listening and engagement plan 3. You said campaign to drip feed/communicate how staff intelligence is improving working environment and services - now live	[24/04/2023 11:39:46 Rachael Turner] No change, currently awaiting response rates from next reviews. [14/03/2023 14:01:55 Rachael Turner] Staff survey results demonstrate significant improvement, the Trust are now second nationally in improving. Update to be provided at next reviews [10/03/2023 11:44:40 Rachael Turner] No change. Work currently underway to provide an update in April. [31/01/2023 15:15:19 Rachel Thackray] Staff survey responses from November 2022 indicate a perceptible positive shift across most questions. Improvement evident in position within our group on Picker moving from last place to 57/65. [09/11/2022 14:55:58 Rachel Thackray] Staff survey currently live with a good uptake and comms on a daily basis. HRBPs working with divisional leads to promote areas with low uptake. Promise Manager now in post from September 2022 working on staff retention. 1. Pulse Staff Survey - Q2 (July'22) 2. Reset approach (communication, engagement of and management) for sign off - ELT (June'22) 3. Local action planning process - now live 4. 7 Big Ticket Priorities proposed following NHS Staff Survey	4	31/03/2023	31/03/2023	01/07/2023
4439	Service disruption	Low, Claire	Shankland, Lindsay	Emergency Planning Group	WORK	16/11/2018	20		Corporate	People and Organisational Development	Operational HR		If there is large-scale industrial action amongst Trust employees then it could lead to a significant proportion of the workforce being temporarily unavailable for work, resulting in widespread disruption to services affecting a large number of patients	Workforce plans & rota management procedures. Temporary staffing arrangements. Business Continuity Policy with associated procedures & guidelines. Local service-specific business continuity plans & recovery procedures. Executive oversight (Chief Operating Officer) through Emergency Planning Group.	Frequency of industrial action events. Publicised staff polls / surveys by professional bodies on possible industrial action.	01/06/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Industrial relations action plan & engagement mechanisms and arrangements with Staff Side representatives.	[10/03/2023 11:46:11 Rachael Turner] No change. Work currently in progress to provide an update in April. [31/01/2023 15:18:02 Rachel Thackray] Current risk assessment in place and working group set up to prepare for potential ongoing industrial action, links in with operational planning to ensure a joined up approach. [07/11/2022 11:13:23 Rachel Thackray] There is a likelihood that there will be some form of industrial action before the Christmas period in 2022. Therefore, it is necessary to increase the likelihood of this risk from low to extremely likely. As such he Associate Director of Workforce is working with the Emergency Planning team to revise the current action plan in place involving staff side reps and the Senior Management Team. The communications team will also be involved. There is a meeting taking place on the 8 November 2022 to implement a Task and Finish group. Currently managed within risk tolerance. EPG to consider making this risk Inactive (for annual review).	4	31/03/2023	31/03/2023	01/07/2023

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
4948	Physical or psychological harm	Cooper, Mrs Anita	Moore, Lisa-Marie	Equality, Diversity and Inclusion Group	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 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	01/06/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Review current provision and identify gaps in service to inform business cases for change to support 7 day working (working with Surgery and Medicine Divisions as appropriate). Skill mix requires review due to complexity of patients.. Pragmatic management of workload & provision of management support. On-going exploration of recruitment options. Wellbeing team supporting staff - regular visits organised	[01/06/2023 14:17:03 Lisa-Marie Moore] No change since previous entry [04/05/2023 14:07:20 Lisa Hansford] no update awaiting review on basis of reputational risk as advised at confirm and challenge meeting 29/03/23 [06/04/2023 12:52:25 Paul White] Discussed at Risk Register Confirm & Challenge 29 March, risk agreed with feedback provided for consideration. [07/02/2023 13:29:22 Rachael Turner] Risk updated to be lead by PODC committee. Requires validation at Confirm and Challenge due to current score. Division to review risk score and attend Confirm and Challenge meeting. [05/01/2023 14:05:09 Lisa-Marie Moore] No change from previous update [08/12/2022 12:33:43 Lisa-Marie Moore] Meeting with Divisional Leads and Deputy Medical Director 25/11 to discuss short and long term actions to support staff, current vacancies and support business case. BCP to be enacted when required. [06/10/2022 14:12:57 Lisa-Marie Moore] Business case still in progress No change	8	30/06/2023	02/10/2023	06/07/2023
4993	Regulatory compliance	Low, Claire	Shankland, Lindsay	Equality, Diversity and Inclusion Group		08/08/2022	16	Corporate	People and Organisational Development	Organisation Development		Trust-wide	WDES (Workforce Disability Equality Standard): limited awareness and implementation of reasonable adjustments and other forms of support which results in limited equality and equity of opportunity for staff classified as having a 'disability'; impedes Trust's ambitions to create an inclusive culture and foster belonging; difficulties in attracting as well as retaining talent	1. Appointment of People Promise Manager (12 month fixed term) 2. Robust monitoring of EDI incidents/concerns 3. Equitable and EQIA 'tested' HR processes (for recruitment, reward and performance) 4. Dedicated OH service	1. Measurement of lived experience of disabled staff at ULHT via - NHS Staff Survey 2. No. EDI/disabilty related incidents reported 3. No. of EDI/disability related concerns reported	31/01/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	1. Governance and assurance for delivery of WDES action plan 2. Review of appropriate datasets to measure risk 3. Introduction of WDES annual report	[31/01/2023 15:22:04 Rachel Thackray] WDES action plan continues to be delivered and monitored through EDIG. Recently completed national Equality Delivery System (EDS) audit, being reported to Trust Board in February 2023 and published by 28 February 2023. 1. WDES action plan prioritised for engagement, development and delivery 2. July 2022: ULHT review datasets, declaration rates (from 1/7/22 ULHT required to submit metrics and narrative data via the DCF online platform by Aug'22). 3. End October 2022: deadline for ULHT to publish WDES 2022 annual report (include metrics report and WDES action plan)	4	31/03/2023	31/03/2023	28/04/2023
4992	Regulatory compliance	Low, Claire	Shankland, Lindsay	Equality, Diversity and Inclusion Group		08/08/2022	16	Corporate	People and Organisational Development	Organisation Development		Trust-wide	WRES (Workforce Race Equality Standard): low compliance/ limited improvement and action to address indicators i.e. increase senior representation and better lived experience of BAME staff working in ULHT. Risk is this results in low number of applications for vacancies which then remain unfilled (difficulty attracting talent); poor turnover rates (difficulty in retaining talent) and a poor employer brand locally, regionally, nationally and overseas. This will impact on the culture of the organisation and the ability to recruit with increased turnover. Wider risk with regards to broader protected characteristics linked to the delivery of the EDI objectives.	1. Lincolnshire Belonging Strategy (improving equity of lived experience and representation across Lincolnshire system) 2. Appointment of People Promise Manager (12 month fixed term) 3. Robust monitoring of EDI incidents/concerns 4. Equitable and EQIA 'tested' HR processes (for recruitment, reward and performance)	1. NHS Staff Survey 2. 'Pulse Check' Staff Survey 3. No. EDI/Race incidents reported 4. No. of EDI/Race related concerns reported 5. BAME staff retention % (leave within first 3, 6 and 12 months) 6. BAME senior representation	31/01/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	1. Robust governance and assurance for ULHT direction of travel for EDI 2. Reset ULHT strategic direction for EDI (EDI objectives 2022-25) 3. Active WRES Action Plan 4. Anti-Racism strategy and delivery plan 5. Zero tolerance stance - for racist behaviour including banter 6. Improved senior level BAME representation 7. Reset Trust values (highlighting civility@work and ULHT commitment to inclusion)	[31/01/2023 15:23:43 Rachel Thackray] WRES action plan continues to be delivered and monitored through EDIG. Recently completed national Equality Delivery System (EDS) audit, being reported to Trust Board in February 2023 and published by 28 February 2023. 1. EDI Group and regular reporting established (for assurance) 2. Anti racism strategy and delivery plan socialised with stakeholders and live 3. NHS Staff Survey results - deep dive and analysis of lived experience of staff with protected characteristics 4. Draft EDI objectives 2022-25 - socialised and ready for sign off (end June) 5. ULHT workstream lead - addressing BAME disciplinary gap (Lincs Belonging Strategy) 6. People Promise Manager successfully appointed from end May'22	4	31/03/2023	31/03/2023	28/04/2023
Strategic Objective					**2c. Have well led services**																					
5154	Regulatory compliance	Simpson, Mr Andrew	Hansford, Lisa	Trust Leadership Team		17/04/2023	16	Corporate				Trust-wide	The Trust currently does not have a Medicines Management or Intravenous Drug Training package on ESR. Previous Medicines management training was removed when the ESR software was changed. Usually all new nurses will be required to complete the medicines management training as part of the mandatory training. This is to support them to be able to administer medicines to patients. Without a robust Medicines management training package staff will not have access to the r Medicines Management training that has previously been available, which is not in line with Trust standards. This could potentially lead to harm to our patients from medication incidents, we will not be adhering to CG174, NG29, SG1 and QAPPS minimising injectables risk. Risk of breaching CQC regulation 12: Safe care and treatment also	All staff will have had undertaken some level of medicines management as part of their professional qualification, however standards are inconsistent and not aligned to trust standards. National (CG174, NG29,SG1) and Local policies and guidance indicate that training should be available to staff to support in administration and safe medicines management. Additionally won't be compliant with QAPPS in relation to minimising injectable medicines risks. CQC regulation 12: Safe care and treatment all indicated training should be available. None currently in place in the Trust. There are new staff that have comenced employment with the organisation that cannot access the trust medicines management training and ward and department leads require a decision to be made as to whether or not these staff can administer medication.	Reported incidents, Staff feedback on training and support available in staff surveys. Inspection feedback	17/04/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	The Medication Safety Team have written the Medicines Management, Controlled drugs training and the Drug Administration Programme. These training documents are also to be supported by the nationally recognised eLearning for health IV therapy passport. These training packages are under review by MOpS group before they can go through the governance process. The governance process is likely to take a number of months. There is then the added task of getting the training packages put onto ESR and mapped to the correct staff. ESR team is severly understaffed which may delay the process further. As an interim measure to reduce this risk level, once the training packages have been through the relevant governance processess, there could be the option to add the training power points to the Trust intranet. This would not be mapped to staff members, however we could signpost staff to this and local training completion records could be kept by the ward/department leads.	[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		01/07/2023
5173	Service disruption	Morgan, Mr Andrew	Warner, Jayne	Trust Leadership Team		15/05/2023	20	Corporate	Medical Director's Office			Trust-wide	The Trust Board has a number of executive director vacancies which are currently filled by interim or acting up arrangements which may lead to instability. In some instances these appointments are for first time Director posts meaning that the Board could be seen as still developing. In addition to this the Chief Executive has recently announced his intention to stand-down on 31 March 2024, after 42 years service in the NHS.	Fit and Proper Persons Regulations. Voting rights are not impacted as interims / secondees all carry the voting rights of the role as per the Standing Orders/SFIs. Coaching and mentoring in place for those in their first appointment from the Chief Executive and the Director of Nursing/Deputy CEO. There is external coaching provision. with a plan to ensure each director has an external coach and mentor. Each executive director has a substantive deputy director. The ELT also has access to an external OD partner who works with the team on a regular basis.	Out of 6 directors only 2, the Director of Nursing and the Medcial Director are currently substantive. The Director of Nursing post is currently a shared post with LCHS. The Medical Director is currently off on long-term sick. The Chief Executive post is filled substantively but will become vacant at the end of March 2024.	15/05/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Continue with mentoring / coaching arrangements in place where appropriate. Review the succession plans for each post and ensure substantive appointments are made. Joint posts with other system providers to be considered where appropriate as part of the Lincolnshire Provider Review.	[07/06/2023 12:15:17 Rachael Turner] Risk discussed at RRC&C 07/06/2023 Risk score agreed as 4x4 giving a score of 16 making it a High Risk. [15/05/2023 13:41:10 Rachael Turner] Risk to be raised for validation at RRC&C Meeting in May.	10	31/03/2024		15/06/2023
Strategic Objective					**3a. A modern, clean and fit for purpose environment**																					

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
5104	Regulatory compliance	Rinaldi, Dr Ciro	Dunning, Mr Paul	Mortality and Learning Strategy (MoraLS) Group	Estates Infrastructure and Environment Group	16/03/2023	10		Clinical Support Services			Trust-wide	As a result of the HTA's concerns relating to the fabric and capacity of the Trusts mortuary service and the delay in timescales by which the Trust is able to refurbish these following the HTA inspection in May 2022. There is a risk that the HTA as the regulator could impose conditions on our licence to store the body of a deceased person within the Trusts mortuary facilities.	-HTA oversight group has been established-meeting to manage the action plan. -Papers have been to CRIG for initial funding to establish planning and building work. This has been approved. -Draft business case is being developed. -Initial concerns have been addressed from Lincoln site. -The Trust currently has two Titan units (temporary additional mortuary capacity) which provides additional capacity in the event of winter pressure peaks in demand and also in the event of equipment failure. -The Trust has a memorandum of understanding with Hull University Teaching Hospitals to support with the storage of bariatric bodies that require longer storage (freezer capacity).	ULHT Improvement action plan HTA Governance Group Weekly meetings to oversee mortuary refurbishment plans	31/05/2023	Quite likely (4) 71-90% chance	Extreme (5)	Very high risk (20-25)	20	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.	[08/06/2023 13:22:36 Rachael Turner] Risk to be presented at RRC&C in June for reduction in score from 20 to 16. [31/05/2023 04:53:29 Jeremy Daws] HTA have responded to the Trust during May confirming their acceptance of the Trust's mitigation plans. HTA have confirmed they are assured enough to close down the inspection process as complete. Risk rating likelihood has been reduced from Quite likely (4) to Reasonably unlikely (3). The rationale for this is there is still a risk to the Trust if the current plans around refurbishment are not completed, even if HTA confirm that this current round of inspection/regulation is concluded. [26/04/2023 12:12:07 Rachael Turner] Risk presented at RRC&C meeting 26/04/2023 validated at a score of 20 Very High Risk. [16/03/2023 13:45:21 Rachael Turner] Risk to be presented at the RRC&C Meeting in March for validation.	20	31/03/2024		#####
4647	Reputation	Harris, Michelle	Davey, Keiron	Fire Safety Group	Fire Safety Group	14/12/2021	20		External Inspections	Corporate	Estates and Facilities	Fire and Security	Trust-wide	If Lincolnshire Fire & Rescue Service (LFRS) carries out an inspection and finds the Trust to be systemically non-compliant with fire safety regulations and standards it could result in regulatory action and sanctions, with the potential for financial penalties and disruption to services if sites are required to close.	National policy: - Regulatory Reform (Fire Safety) Order 2005 - NHS Fire safety Health Technical Memoranda (HTM 05-01 / 05-02 / 05-03) ULH policy: - Fire Policy (approved April 2019, due for review April 2022) & related procedures / protocols / records - Fire & Security Team / Fire Safety Advisors ULH governance: - Fire Safety Group / Fire Engineering Group, accountable to Trust Board through Finance, Performance & Estates Committee (FPEC) - Health & Safety Committee & site-based H&S committees	- Compliance audits against fire safety standards - Progress with fire safety improvement plans - PPM compliance assurance (current lack of required detail for internal and regulator assurance)	15/05/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	- Statutory Fire Safety Improvement Programme based upon risk - Policy and protocols framework and improvement plan reported into weekly Estates teams meeting - Progress reviewed by FEG and FSG monthly, to mitigate against the risk of sanctions - LFR involvement and oversight through the FSG - Regular updates with LFR provided indicating challenges during winter pressure and Covid - Fire safety audits being conducted by Fire Safety team - Fire wardens in place to monitor local arrangements with Fire Safety - Weekly Fire Safety Checks being undertaken - Improve PPM reporting for FEG and FSG By Estates Teams - Fire safety team weekly Risk assessment confirm and challenge reviews by Fire safety team - All areas of Trust allocated RAG rating for fire using using occupancy profile, escape provision, height above ground and sleeping risk - Higher rated residual risks from risk assessments being incorporated into risk register	[15/05/2023 13:32:10 Rachael Turner] Progress towards the Fire Deficiency notices, Fire are currently completing inspection of the passive fire protection for ALL Higher Risk areas across the three sites, (typically patient sleeping areas). A report will be issued to the Fire safety team identifying breaches in compartmentation with associated costs. The next phase of surveys will commence June for ALL Medium-Risk areas Chubb have been appointed as a competent person to undertake extinguisher inspections. These have commenced at pilgrim and will be prioritised on the basis of compliance dates. Troup Bywaters + Anders were commissioned to undertake a site survey. A capital bid will be presented to the Capital board, to seek approval for funds to address in a phased approach in a timely manner [25/04/2023 10:09:43 Rachael Turner] Unannounced Fire Drills have now commenced in area across the trust being supervised by the fire safety team. Compartmentation surveys across 3 sites on basis of risk priority by competent contractor in accordance with Notice of deficiency received from Lincolnshire Fire and rescue. Extinguisher servicing has commenced by competent contractor. [03/03/2023 13:44:13 Rachael Turner] Fire safety team currently working with estates colleagues to identify any areas of lower assurance are included within PPM schedule. Fire Drills commencing non clinical areas March 2023 No change, risk grading remains the same [06/12/2022 14:55:09 Rachel Thackray] Fire safety team currently working with estates colleagues to identify any areas of lower assurance are included within PPM schedule [02/11/2022 12:40:28 Rachel Thackray] No change, risk grading remains the same LFR previously served ULH with an Enforcement notice and action plan (since removed) in which the storage of items within corridors was highlighted: "Article 14(2) Emergency Routes and Exits There are combustible materials and items that pose an ignition risk are located on escape routes	4	30/06/2022	31/03/2024	#####
4648	Physical or psychological harm	Harris, Michelle	Davey, Keiron	Fire Safety Group	Emergency Planning Group, Health and Safety Group	15/12/2021	20		Risk assessments	Corporate	Estates and Facilities	Fire and Security	Trust-wide	If a fire occurs on one of the Trust's hospital sites and is not contained (due to issues with fire / smoke detection / alarm systems; compartmentation / containment) it may develop into a major fire resulting in multiple casualties and extensive property damage with subsequent long term consequences for the continuity of services.	National policy: - Regulatory Reform (Fire Safety) Order 2005 - NHS Fire safety Health Technical Memoranda (HTM 05-01 / 05-02 / 05-03) ULH policy: - Fire Policy (approved by FEG / FSG Sept 2022 - awaiting final approval / signature to be HTM compliant): # Personal Emergency Evacuation Plans (PEEPs), approved April 2017 - Fire safety training (Core Learning, annual) / Fire Warden training / Fire specialist training - review / protocol in draft, TNA in draft for Fire Safety Team review - Major Incident Plan - Estates Planned Preventative Maintenance (PPM) programme ULH governance: - Trust Board assurance through Finance, Performance & Estates Committee (FPEC) / lead Fire Safety Group (including divisional clinical representation & regulator attendance) / Fire Engineering Group - All areas within the Trust estate are individually risk rated for fire safety (based on occupancy, dependency, height, means of escape), which informs audit / monitoring activity - Local fire safety issues register (generated from local fire risk assessments) - tasks allocated to Estates / local managers, etc. as appropriate; tracked and monitored by Fire Safety Team, validation by Fire & Rescue Service - Weekly fire safety team meetings concerning risk assessments and risk register - Capital risk programme for fire - Reporting of local fire safety incidents (Datix) generated through audit programme - Authorising Engineer for Fire - Health & Safety Committee & site-based H&S committees	Results of fire safety audits & risk assessments, currently indicate: - Fire Risk assessments within Maternity Tower block Lincoln indicating substantial breaches of compartmentation requirements - Fire risk assessments indicate lack of compartmentation within some sleeping risk areas - Age of fire alarm systems at all 3 sites (beyond industry recommendations) - No compartmentation reviews undertaken to provide assurance of existing compliance (all 3 sites) - Concerns with networking of fire alarm system at Pilgrim (to notify Site Duty Manager / Switchboard of alarm activation) Reported fire safety incidents (including unwanted fire signals / false alarms). Fire safety mandatory training compliance rates.	15/05/2023	Quite likely (4) 71-90% chance	Extreme (5)	Very high risk (20-25)	20	- Capital investment programme for Fire Safety being implemented on the basis of risk - costed budget plan for FEG submission Sept 2022. - Trust-wide replacement programme for fire detectors. - Fire Doors, Fire/Smoke Dampers and Fire Compartment Barriers above ceilings in Pilgrim, Lincoln and Grantham require improvements to ensure compliant fire protection. - Fire safety protocols development and publication. - Fire drills and evacuation training for staff. - Fire Risk assessments being undertaken on basis of inherent risk priority; areas of increased residual risk to be added to the risk register for specific action required - Local weekly fire safety checks undertaken with reporting for FEG and FSG. Areas not providing assurance receive Fire safety snapshot audit. - Staff training including bespoke training for higher risk areas - Planned preventative maintenance programme by Estates	[15/05/2023 13:33:34 Rachael Turner] Competent persons are currently completing inspection of the passive fire protection for ALL Higher Risk areas across the three sites, (typically patient sleeping areas). A report will be issued to the Fire safety team identifying breaches in compartmentation with associated costs. The next phase of surveys will commence June for ALL Medium-Risk areas Troup Bywaters + Anders were commissioned to undertake a site survey. A capital bid will be presented to the Capital board, to seek approval for funds to address in a phased approach in a timely manner [25/04/2023 10:10:43 Rachael Turner] Fire door Tender for maintenance, supply and install has gone to framework by procurement teams. Fire Door inspection by competent contractor selected with anticipation of late may start up. [03/03/2023 13:47:32 Rachael Turner] Compartmentation survey commenced with remedial actions identified for inclusion within capital plan 23/24/25, Fire drills commenced in non clinical areas March 2023. [06/12/2022 14:53:59 Rachel Thackray] New security provider undertaking internal patrol routes with escalation to porters when storage discovered. [02/11/2022 12:39:13 Rachel Thackray] Regular audits conducted by fire safety team by Fire Safety team within corridors, and IR1s being submitted to line managers for action. Escalation to matrons has now begun via IR1s. Rating increased on review to 20 - combustible storage in common areas frequently found (including life lobbys); emerging lessons learned from recent arson incident at LCH (including spread of smoke beyond the room of origin). Actions undertaken recently - IR1s issued to local managers and owners of storage risk, including escalation to senior managers. Setting up task & finish group to look at storage issues. Reviewed all fire risk assessments in Diagnostics across all 3 sites; other FRAs for public areas have also been reviewed. Reviewed all external security patrols and implemented alterations to routes to ensure	10	31/03/2022	31/03/2025	#####

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
5136	Physical or psychological harm	Parkhill, Michael	Pattinson, Paul	Estates Investment and Environment Group	Health and Safety Group	28/03/2023	20	Risk assessments	Corporate	Estates and Facilities	Estates	Trust-wide	Following monitoring for Nitrous Oxide levels in Pilgrim and Lincoln (Theatre and Maternity Units), it was identified that in a number of locations, staff were exposed to higher levels of nitrous oxide where levels exceed the Workplace Exposure Limit (WEL) OF 100 ppm (8hr time weighted average (TWA)).	Following notification the following actions were undertaken: Pilgrim Hospital – Labour Ward: Estates staff checked the supply ventilation from the Air Handling Unit (AHU) to the Supply Grilles within the labour rooms. At the time of inspection, the Estates staff identified the dampers restricting airflow were not adjusted correctly. This was addressed and airflow checks were undertaken. Typical air change rates were around 6 air changes per hour (ACH) – current guidance is a minimum of 10 ACH, however the ventilation systems are circa. 1960 and the guidance is not retrospective. Following the actions undertaken, resampling commenced 15th March (15 sample tubes), 13 were within WEL limits, but 2 sample results were recorded at 255 and 407 ppm (8 h TWA) in Rooms 2/2a and Room 3, respectively and exceeded WEL limits. Estates are reviewing the current system to look at increasing air changes by upgrading the supply fans / changing pulleys / upgrading filter media or a combination of factors. Lincoln Hospital - Labour Ward: Estates staff found the ventilation system had been isolated (approximately 10 years ago). Following discussions with Estates members, the ventilation system had failed and was deemed beyond economical repair and a decision had been made not to replace (no one is aware of why this was made or by whom). Estates plan to reinstate the ventilation, where feasible, which will likely include partial refurbishment and deep clean of existing systems. N.B the use of sampling tubes to monitor Nitrous oxide levels can be highly time and place dependent, the person with the sampling equipment and their activities, can indicate exposure levels that are as a result of human error, not as a failing of the environment. As such G210 analysers specifically designed for highly accurate measurement and verification of the quality of piped N2O and O2 gases, are being sourced.	-COSHH assessments and training. -Health Safety Environmental and Welfare Operational Audit programme. -Direct involvement with Occupational Health. -Datix incident reporting.	26/04/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	The issues identified with exposure levels are not unique to ULHT, as with most NHS Trusts investment is required to upgrade Ventilation to comply with HTM 03-01. NHSEI issued guidance on the 2nd March 2023 for NHS Trusts to follow. Noting where ventilation is insufficient, human factors are critical in reducing staff exposure, such as: 1. Providing clear instructions to patients on correct use of equipment being used, including exhaling into the rebreather mask or out through the mouthpiece 2. Staff positioning relative to exhaust N2O and the direction of ventilation flow 3. Turning gas and air off when not in use 4. Unplugging regulators from outlets when not in use 5. Monitoring the condition of equipment for leakages. These factors can't directly be influenced by Estates and require the support and influence of Clinical Leads and Occupational Health. ULHT Health and Safety Team have recently implemented software to assist with COSHH assessments and training. The Team provide support with the Health Safety Environmental and Welfare Operational Audit programme. Occupational Health have been directly involved with the implementation of sampling and post sampling. Following sample results, Occupational Health were contacted to advise that staff may require support. To date no Datix reports have been raised and no concerns re: ill-health have been escalated in relation to Entonox use/levels to the Health and Safety Team.	[26/04/2023 12:02:44 Rachael Turner] This is a risk to midwives. Pilgrim is currently in progress and re-sampling is in place. In Lincoln the ventilation is a big issue due to asbestos. This risk may need to be split. Looking at improving the monitoring at both sites to provide assurance and measure levels. This risk was validated at Risk Register Confirm and Challenge at a score of 16 High Risk. [06/04/2023 12:48:08 Paul White] Presented by Estates at Risk Register Confirm & Challenge 29 March. Agreed that perspectives from other areas is required before bringing back to April meeting for validation.	10	28/03/2024		####
4858	Service disruption	Parkhill, Michael	Whitehead, Mr Stuart	Water Safety Group	Emergency Planning Group, Estates Infrastructure and Environment Group	10/02/2022	25	Risk assessments	Corporate	Estates and Facilities	Estates	Pilgrim Hospital, Boston	If there is a critical failure of the water supply to one of the Trust's hospital sites then it could lead to unplanned closure of all or part of the hospital, resulting in significant disruption to multiple services affecting a large number of patients, visitors and staff	Estates Infrastructure and Environment Committee (EIEC). Estates risk governance & compliance monitoring process. Emergency Planning Group / Major Incident Plan and departmental business continuity plans.	Surveys of water supply infrastructure - Pilgrim Hospital is served by only one incoming water main. This is in very poor condition and has burst on several occasions causing loss of supply to the site.	21/10/2022	Reasonably likely (3) 31-70% chance	Extreme (5)	High risk (15-16)	15	Regular inspection, automatic meter reading and telemetry for the incoming water main at Pilgrim Hospital. Install additional supply to provide resilience.	[21/10/2022 09:06:00 Walter Thompson] Scheme for replacement of critical water tanks - Pilgrim HB- is being developed for the capital plan 22/23 Scheme of work and design currently being produced.	5	30/10/2020	31/03/2023	####
Strategic Objective							**3b. Make efficient use of our resources**																			
4664	Finances	Matthew, Mr Paul	Young, Jonathan	Workforce Strategy Group		11/01/2022	20	Risk assessments	Corporate	Finance and Digital	Finance	Trust-wide	The Trust has an agency cap of c£17m. The Trust is overly reliant upon a large number of temporary agency and locum staff to maintain the safety and continuity of clinical services that will lead to the Trust breaching the agency cap.	National policy: - Agency spending cap set by Government ULHT policy: - Financial plan set out the Trust limits in respect of temporary staffing spend - Annual budget setting process cascades and apportions the Trust temporary staffing spend limits to the Divisions and Directorates. - Monthly financial management & monitoring arrangements are in place to identify variation temporary staffing financial plans at all levels of expenditure from department up to Trust. - Key financial controls for the use of the break glass agency usage are in place. - Specific staff group temporary staff spend is provided to dedicated Medical and Nursing workforce oversight groups. - Financial review meetings held monthly with each Division to understand and challenge usage of temporary staffing. - Plan for every post information has been embedded to support temporary staff usage forecasts ULHT governance: - The establishment of the Improvement Steering Group will provide general oversight of Trust wide agency reduction schemes - Board assurance through Finance, Performance and Estates Committee (FPEC)	The Trust is monitored externally against an agency cap through the monthly finance return to NHSE/I The Trust monitors internally against its financial plan inclusive of specific targets for agency and bank spend by staff group The cross Trust workstreams are reported to the Improvement Steering Group The Divisional workstreams are reported to the relevant Finance, People & Activity Meeting (FPAM)	24/05/2023	Extremely likely (5) >90% chance	Severe (4)	Very High risk (20-25)	20	Financial Recovery Plan schemes: - recruitment improvement; - medical job planning; - agency cost reduction; - workforce alignment	[24/05/2023 13:24:21 Rachel Thackray] Updated to reflect the risk for 2023/24. Cap reduced from £21m to £17m. The Trust's CIP plan for 23/24 is heavily focussed on agency reduction, risks to delivery include; excess beds, winter pressures and not delivering recruitment trajectories. [24/04/2023 13:17:23 Rachael Turner] No change currently, update to be provided next month when financial plan is complete. [02/03/2023 10:14:50 Rachel Thackray] No update this month. [02/02/2023 14:17:26 Rachel Thackray] The Trust is forecasting a 52.8m agency usage in 22/23 this is driven by increased volume requirements due to the number of beds open and significant breach of the agency price caps due to market conditions. The Trust has significant oversight and plans to control and manage in a phased and safe way agency reductions in Q4 22/23 and into 23/24. [02/11/2022 11:06:31 Rachel Thackray] The Trust agency spend continues on a similar trajectory driven by significant and increased demand for patient services – primarily in the NEL pathway and pressures in ED. This has resulted in additional beds being required above those planned and subsequently a need to staff the beds with temporary and high cost nursing and medical staff to remain safe. The Trust has introduced a financial improvement plan that is heavily focused on increased agency oversight across all staff groups with a number of Exec lead schemes. The Trust has exited the 21/22 financial year with an agency spend of c£44m. This has in part been driven by COVID pressures and a large number of escalation beds open increasing the requirement for temporary staff. The Trust has agreed an ambitious CIP programme that is heavily focused on agency reductions through the recruitment of staff and reducing the number of NEL beds required. This will take time to embed. Reviewed at RRC&CG - score increased from 16 to 20.	8	31/03/2023	31/03/2024	26/06/2023

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
5020	Finances	Wall, Mrs Tracey	Thomson, Cheryl	Workforce Strategy Group	WORK	02/09/2022	20	Professional Guidance	Medicine	Urgent and Emergency Care CBU		Trust-wide	If there is a continued reliance on bank and agency staff for medical workforce in Urgent & Emergency Care there is a risk that there is not sufficient fill rate for medical rotas both ward / department fill and on call shifts which will impact on patient safety and have a negative impact on the CBU budget	Robust medical plan for every post meetings Close working with temporary medical staffing team Daily management of any gaps to support minimum staffing levels Fundamental overview of tier 1 and tier 2 docs in medicine and ED based on RCP safer staffing levels. Introduction of BMA rate cards This will reduce once output on medical workforce plan is in place, not due to come online in this review period.	Plan for every post meetings Budget reports	13/06/2023	Quite likely (4) 71-90% chance	Extreme (5)	Very high risk (20-25)	20	Robust recruitment plan International recruitment Medical Workforce Management Project	[13/06/2023 11:13:13 Helen Hartley] Robust recruitment plan and international recruitment plan in place and ongoing. The uplift to meet demand and capacity has been approved and agreed, adverts are going out next week. [26/04/2023 11:58:59 Carl Ratcliff] No update [14/03/2023 13:58:09 Rachael Turner] Robust recruitment plan and international recruitment plan in place. Ongoing work with medical workforce plan. Well ahead of schedule. Agency cost. Proposal for the score to be reduced to a 16 (High) this risk to be presented at RRC&C Meeting. [27/01/2023 11:36:10 Helen Hartley] Reviewed today, will be discussed further on 6 Feb to potentially lower. [23/11/2022 11:25:30 Paul White] Reviewed at RRC&CG 23 Nov 2022 - current rating agreed but may be reduced on next review taking account of mitigating controls. [10/11/2022 13:40:37 Helen Hartley] No change at governance [07/11/2022 07:03:07 Helen Hartley] Checked with Cheryl to see if there are any updates [12/10/2022 17:24:16 Helen Hartley] No changes made at governance	10	02/09/2023		13/07/2023
4957	Finances	Young, Jonathan	Young, Jonathan			28/06/2022	16	Professional Guidance	Corporate	Finance and Digital	Finance	Trust-wide	The lack of ability of the Trust to eradicate / reduce the costs that were introduced as a consequence of COVID. The national planning assumption is that all COVID costs incurred in Acute settings in relation to COVID will cease from 1st June 2022 aligned to the anticipated reduction in COVID patients to extremely low levels.	National policy: - Government financial planning assumptions due to COVID ULHT policy: - Financial plan set out the Trust Budget allocations in respect of COVID spend - Annual budget setting process cascades and apportions the Trust COVID budgets to the Divisions and Directorates (phased April - May 2022 / 2 months only). ULHT governance: - Monthly financial management & monitoring arrangements are in place to identify variation of COVID spend to financial plans at all levels of expenditure from department up to Trust. - Financial review meetings held monthly with each Division to understand and challenge of COVID services impacts on the cost base. - The Planning and Recovery Steering group will provide oversight of the COVID costs.	The Trust is monitored externally against the COVID impacts through the monthly finance return to NHSE/I The Trust monitors internally against its financial plan inclusive of specific COVID costs into FPEC and onto Trust Board Divisional focus against specific COVID costs is reviewed at the relevant FRM.	24/05/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Alignment of the Directorate and Divisional budgets to the national strategy for the removal of COVID costs from 1st June 20222. By exception reporting of all COVID costs not removed from financial positions.	[08/06/2023 13:26:33 Rachael Turner] Risk to be presented at RRC&C meeting in June for validation for reduction in score. [24/05/2023 13:18:28 Rachel Thackray] The remaining costs from the COVID pandemic have been built in to the 23/24 financial plan based on the exit run rate. There is a risk of a further wave of COVID which would result in an adverse financial variance to plan. Likelihood reduced to quite unlikely (4) from quite likely (2). [02/02/2023 14:25:19 Rachel Thackray] The Trust is forecasting £5.8m COVID related costs for 22/23. This is a much improved position from the 21/22 spend however this is still a pressure, although much reduced, in the financial position. All schemes that have been reduced or ceased have been through a QIA assessment. Risk to be reassessed in April 2023. The Trust incurred c£13m of direct costs in relation to COVID with a further indirect cost e.g. staff sickness. The national expectation is that the costs of COVID cease from 1st June 2022. This is a significant risk to the delivery of the Trust financial position as the costs have become embedded in the Trust way of working in number of services. E.g. Housekeeping services to improve IPC.	8	31/03/2023	31/03/2023	24/08/2023
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	24/05/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	- Refresh of the CIP framework and training to all stakeholders. - Increased CIP governance & monitoring arrangements introduced. - Alignment with the Trust IIP and System objectives - CIP is embedded as part of the Trust Improvement Strategy not seen as a separate workstream.	[24/05/2023 13:11:53 Rachel Thackray] Updated to reflect the risk for 2023/24. The Trust has plans to deliver £28m CIP (FRP) target. In month 1 delivery exceeded plan. [02/02/2023 14:13:16 Rachel Thackray] The Trust is forecasting to deliver a £18m CIP programme for 22/23 a shortfall of £11m against its revised plan, which has been partly mitigated through the risk and gain share contractual agreement with the ICB, however this still leaves an under delivered CIP requirement that has resulted in a contribution to the forecast deficit position of the Trust. [02/02/2023 14:12:00 Rachel Thackray] The Trust is forecasting to deliver a £18m CIP programme which has been partly mitigated through the risk and gain share contractual agreement with the ICB, however this still leaves an under delivered CIP requirement that has resulted in a contribution to the forecast deficit position of the Trust. The Trust has delivered its CIP plan for the past 3 years, albeit a reduced requirement during the 2 financial years that cover COVID. The Trust is embedding a new Improvement framework with CIP included within it and is also working with system partners to make financial improvements due to pathway changes. This will take time to embed and alongside the operational pressures, specifically; sickness, excess beds open, rising acuity of patients and continuing rising demand at the front door of the acute Trust is putting at risk in year delivery of the CIP target. Reviewed at RRC&CG - agreed score of 16.	4	31/03/2023	31/03/2024	24/08/2023
5019	Finances	Wall, Mrs Tracey	Spendlove, Mrs Clare			02/09/2022	20	Risk assessments	Medicine	Urgent and Emergency Care CBU	Accident and Emergency		If there is a continued reliance on bank and agency staff for nursing workforce in Urgent & Emergency Care there is a risk that there not sufficient fill rate in each department which will impact on patient safety and have a negative impact on the CBU budget	Robust nursing plan for every post meetings Daily operational matrons identified for Lincoln and Pilgrim Daily safer staffing lead identified for escalation Establishment review DON Monthly roster clinics / workforce dashboard Daily staffing meetings 3x day Monthly director of nursing quality dashboards. Temporary staffing solutions group - purpose is to reduce agency spend attendance.	Plan for every post meetings Budget reports	13/06/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Robust recruitment plan International recruitment	[13/06/2023 11:08:11 Helen Hartley] The risk level remains the same, ongoing recruitment and training unlikely to stabilise until the earliest Autumn 2023. [24/04/2023 12:58:59 Carl Ratcliff] Recruitment plan in place and continues - will plan when next risk reduction can take place [06/03/2023 13:55:09 Rachael Turner] RRC&C members in agreement of risk score reduction to a High Risk (16). [22/02/2023 16:47:51 the reporter] -Establishment reviews have taken place -Fill rates have improved into temporary staffing therefore the likelihood of not having nursing staffing in both Pilgrim and Lincoln is reduced -The organisation has taken ownership that a rapid handover is available. -Divisional approval of risk reduction confirmed. -Email sent to RCRC&C members for approval of risk score reduction. [22/02/2023 14:03:50 Paul White] Improvement in fill rates when shifts are put out. Reduced likelihood because of existing mitigations in place affecting staffing and there is a proposed end . Presented at Confirm & Challenge meeting 22 Feb by TW. Agreed in principle with reduction in score from 20 to 16. Group members to be given until 1 March to raise any concerns. [09/02/2023 16:12:57 Helen Hartley] Met with Tracey Wall, Cheryl Thomson and Rachel Thackray - reduced to 16 and added mitigations [27/01/2023 11:39:06 Helen Hartley] Reviewed today but another meeting in diary early February to discuss in more detail potential to lower. [23/11/2022 11:25:56 Paul White] Reviewed at RRC&CG 23 Nov 2022 - current rating agreed but may be reduced on next review taking account of mitigating controls. [10/11/2022 13:40:02 Helen Hartley] No change at governance [07/11/2022 07:03:20 Helen Hartley] Checked with Cheryl to see if there are any updates	8	02/09/2023	30/09/2023	13/07/2023

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
4965	Finances	Hallion, Simon	Chantry, Chris	Workforce Strategy Group	WORK	11/07/2022	9	Workforce Metrics	Family Health	Children and Young Persons CBU	Paediatric Medicine	Trust-wide	Financial risk due to reliance upon temporary staff (nursing and medical) to cover vacancies in Paediatrics.	1. Scrutiny of rosters to ensure optimal use of existing staffing resources; 2. Review of all shifts that are placed with either Nursing or Medical Bank to ensure these are required; 3. Use of bank staff in preference to agency staff in view of potential cost savings; 4. Utilisation of tier 1 and 2 agencies in view of potential cost savings; 5. Use of long line agency in view of potential cost savings and increased assurance that shifts are safely staffed.	1. Reviewed via temporary staffing expenditure and safe staffing metrics; 2. Agency spend reviewed via at FPAM	12/06/2023	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	1. Robust recruitment and retention plan for nursing and medical staff across Children and Young People Clinical Business Unit.	[12/06/2023 15:59:14 Jasmine Kent] Overseas nursing recruitment ongoing, jobs are out to advert. Looking at role development. [13/03/2023 16:09:39 Jasmine Kent] No improvements, despite efforts, lack of traction with filling vacancies. [13/12/2022 14:40:14 Alison Barnes] No change [18/11/2022 11:42:37 Alison Barnes] Positive feedback around nursing recruitment. Start dates for medical staff currently delayed beyond predictions impacting on higher than anticipated use of agency staff. Agency spend closely monitored at trust level. 09/08/22 - KR 1. Risk discussed at acute paediatrics governance meeting - agreed that risk should be added to the risk register and initial rating agreed via discussion. 24/08/22 - KR Discussed at Risk Register Confirm and Challenge meeting. Confirmed that risk is solely financial as there is mitigation in place to ensure quality and safety are maintained (eg long line booking of regular agency staff). Some discussion about whether this risk should sit on the divisional risk register or whether it is captured in the corporate risk that focuses on the impacts of vacancies. To discuss at forthcoming risk meeting.	3	31/07/2023		12/09/2023
Strategic Objective							**3c. Have enhanced data and digital capability**																			
4657	Reputation	Matthew, Mr Paul	Warner, Jayne	Information Governance Group	Digital Hospital Group	10/01/2022	12	Risk assessments	Corporate	Trust Headquarters	Corporate Secretary		If the Trust does not comply with Subject Access Requests (SARs) and Access to Health Records provisions in accordance with statutory requirements specified legislation, then it could lead to complaints to the Trust and Information Commissioner's Office (ICO). This could result in regulatory action and possibly financial penalties. Inconsistent levels of expertise outside of the IG team regarding SAR requirements. Lack of technical tools to carry out a search of emails / systems to identify personal information held. Potential financial implications.	ULHT policy in place. Monitoring through IGG and at exec level. Temporary additional resource has been put in place to oversee. Proposal made to ELT and IGG regarding process which has removed reliance on clinical staff to review all cases. Increased training provided to team.	Monthly reporting completed. Compliance rate is monitored by the Supervisor and reports taken to IGG in our KPI report. Volume of ICO complaints and Trust complaints received.	25/04/2023	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Current active communications with ICO- regulator. Changes to processes are being constantly discussed and implemented. Resource needs being discussed and temporarily increased to support. Monitored through the IGG in DP KPI report. Head of IG leading on work to review and improve. Working in a more digital way where feasible. Workforce change is required which will be a much longer process. Early identifications of chasers and urgent requests to reduce the likelihood of complaints.	[05/06/2023 17:17:35 Fiona Hobday] *Still awaiting response from ICO to Feb meeting *Escalated re Procurement of new solution for SARs *Focus on complaints, and clearing requests from Feb. March currently. *More requests being disclose digitally which is positive. [25/04/2023 12:45:53 Fiona Hobday] *Resource remains prioritised to requests post Jan 23 to minimise the risk of a complaint to the ICO. *Considerable movement was made of backlog (Pre Dec 22) and the majority of the oldest requests were completed. Oldest currently dates to August 22. *Work is re-starting on the procurement of a dedicated solution as it has been identified again that DATIX cannot meet our needs (4 month delay in work as a result). *New process documents have been developed and released to service; these will aid consistency, assurance and training of new staff- currently being tested. *Still awaiting response from ICO following Feb 22 meeting. Expected completion date has been changed in light of system work and staff departures- this impacts delivery. [29/03/2023 13:01:02 Fiona Hobday] *A work plan has been developed by the Head of IG and Disclosure Supervisor to provide greater oversight. *The spec for the new case mgmt system has been started and the next step is to meet with the project Mgr. *Current reduction in resource due to staff leaving- plans in place to replace. *Fortnightly meeting with HR are taking place re staff SARs. *Resource currently directed at new requests to minimise risk of complaints for requests from 2023 onwards as this would impact ICO involvement. [01/03/2023 16:45:25 Fiona Hobday] Risk updated following Confirm and Challenge meeting. Meeting with ICO 6/2/22 with Trust Secretary, SIRO and Head of IG- overall regulator were comfortable with position explained to them and work ongoing to resolve backlog issue. Staff resource has been reallocated to split between backlog and new requests- performance being	6	30/06/2023	30/09/2023	03/07/2023
4661	Reputation	Warner, Jayne	Warner, Jayne	Information Governance Group	Digital Hospital Group	10/01/2022	20	Risk assessments	Corporate	Trust Headquarters	Corporate Secretary		If the required data protection / privacy impact assessment process and subsequent contractual requirements is not followed consistently at the start of a system/ process change project, then results may not be available to inform decision-making and system development resulting in an increased likelihood of a future data breach or third-party non compliance that could expose the Trust to regulatory action by the Information Commissioner's Office (ICO)	National policy: - Data Protection Act 2018 & General Data Protection Regulation - NHS Digital Data Security & Protection Toolkit ULHT policy: - Information Governance Policy and supporting appendices -Privacy by Design Procedure (NEW 2023) ULHT governance: - Trust Board assurance via Finance, Performance & Estates Committee (FPEC); lead Information Governance Group - Senior Information Risk Owner (SIRO) / Caldicott Guardian / Data Protection Officer (DPO) / Chief Information Officer (CIO) roles	Monitoring of IG project tracker into IG Group. Internal audit review of data protection / PIA processes. Number of escalated issues in relation to project work.	08/03/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Review of the data protection / privacy impact assessment process and governance, to include education and communication to raise staff awareness of the required process. Work to review and implement a formal process with procurement/ contracting. Work to develop and implement the IAO strategy.	[05/06/2023 17:25:59 Fiona Hobday] *Privacy by Design Procedure approved and live. *Contracts and IG Guidance document approved and live. *Ongoing comms to staff on a monthly basis. *Head of IG delivered awareness training session to Procurement Managers in 03/23. *Regular monthly meetings now in place with IG/ Digital and IG/ Programme & Project Team. [08/03/2023 13:50:25 Fiona Hobday] 08/03/23- New DPIA template live and published on intranet. Supporting procedure written and due to be ratified at IGG in March 23. Awareness session planned with Procurement Dept 16/3/23 by Head of IG. New 3rd Party Due Diligence in use and due to be published on intranet shortly. Annual comms plan for IG commenced in Jan 23. [06/12/2022 15:00:16 Maria Dixon] Developed new template to go live this month. Strategy is drafted going to IGG for escalation in Jan 2023. Interim Head of IG currently in post. Process and documentation reviewed and updated; these are now GDPR compliant. Further action required to address governance issues. Reference to DPIAs in Data Security and Awareness mandatory training. Long standing issue of IG not being made aware of new systems or changes in processes that require assessment under Data Protection legislation. Educating staff across the Trust is required. Changes to legislation due to Brexit means that any data leaving the UK has greater risks associated. If a DPIA is not conducted then this could have an impact on availability of that data.	6	31/03/2024	30/06/2023	07/08/2023

ID	Risk Type	Executive lead	Risk lead	Lead Oversight Group	Reportable to	Opened	Rating (initial)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
4658	Reputation	Matthew, Mr Paul	Warner, Jayne	Information Governance Group	Digital Hospital Group	10/01/2022	20	Risk assessments	Corporate	Trust Headquarters	Corporate Secretary	Trust-wide	If the Trust does not have a defined records management framework/ strategy it runs the risk of not meeting national best practice and not making informed decisions in relation to Digital programmes of work. This could result in a breach of regulations and ULHT finding it difficult to meet national enquires that could lead to regulatory action and financial penalties. This risk has increased due to ongoing national enquiries and the move to a more digital way of records mgmt which whilst positive heightens the need to manage legacy and ensure expert RM support for future decision making.	The Trust has policies in place. Trust DPIA template included aspects on records mgmt and retention.	FOI compliance gives an indication of the Trusts position as compliance is linked to good records management. Reports of unmanaged records found in Trust locations.	08/03/2023	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Requires a strategic decision from the Trust regarding a Records management lifecycle and level of expertise to advise and guide on future projects and developments. Needs to link into 365, ePR and EDMS Programme. 365 cannot be delivered with dedicated Records SME resource.	[05/06/2023 17:22:19 Fiona Hobday] *Head of IG has spoken to Trust Sec re current concerns on lack of a strategic approach- linking to 365, EPR and EDMS. Need to look at whole picture and not pieces of work in isolation. *Head of IG has raised with Digital Programme Team to ensure RM is looked at strategically and in a joined up manner and they link in with Trust Secretary as the functional owner for Corporate Records. *365 Project- Records Mgmt identified now as a key deliverable and driver for the project. [08/03/2023 13:53:45 Fiona Hobday] Head of IG and DPO discussed in relation to retention of Health Records and removal of long time ban on disposing of records for Saville enquiry- this has now been lifted and Clinical Records Group to be tasked with taking discussion re record disposal forward. [02/02/2023 14:17:13 Fiona Hobday] Revise score approved at Confirm and Challenge meeting in Jan 23. [06/12/2022 15:09:53 Maria Dixon] DPO & Interim Head of IG raised with SIRO as part of O365 discussion. Development of health records retention & disposal policy in progress. Discussed at Risk Register Confirm & Challenge Group, 23 March 2022. Currently the Trust is storing paper records for longer than it should and there remains a lot of unknowns as to where records are stored. Likelihood should be increased, severity may possibly be lower.	4	28/06/2024	28/06/2024	03/07/2023
4641	Service disruption	Humber, Michael	Gay, Nigel	Digital Hospital Group	Emergency Planning Group	23/11/2021	16	Risk assessments	Corporate	Finance and Digital	Digital Services (ICT)	Trust-wide	If the Trust's digital infrastructure or systems experience an unplanned outage then the availability of essential information for multiple clinical and corporate services may be disrupted for a prolonged period of time, resulting in a significant impact on patient care, productivity and costs	National policy: - NHS Digital Data Security Protection Toolkit (DSPT) and Guidance ULHT policy: - Telecoms infrastructure maintenance arrangements - ICT hardware & software upgrade programme - Corporate and local business continuity plans for loss of access to ICT systems & system recovery ULHT governance: - Digital Hospital Group / Information Governance Group (IGG), accountable to the Finance, Performance & Estates Committee (FPEC) - 5 year capital plan -	- Network performance monitoring - Digital Services reported issues / incidents - Monitoring delivery of digital capital programme - Horizon scanning across the global digital market / supply chain to identify availability issues	19/05/2022	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	- Prioritisation of available capital and revenue resources to essential projects through the business case approval process. - Working with suppliers and application vendors to understand upgrade and support roadmaps. - Assurance mechanisms in place with key suppliers for business continuity purposes - Comprehensive risk assessments to be completed for local service / site specific vulnerabilities so that appropriate action can be taken to manage those risks. - Contingency plans - data centres protected from overheating, fire and flood / water damage risks: Portable air con units kept on site for when needed. Estates work has addressed some leakage issues at Pilgrim. Fire retardant systems in all data centre rooms, routinely serviced by Estates.	Risk reviewed, description amended to reflect broader range of threats to the digital infrastructure. Current score increased to 16. Have purchased a significant number of Radios, to allow communication in the event of failure. We've completed a Network Core Switch replacement at Pilgrim new Data (DC3) at Pilgrim to provide resilience at site backup across site has been improved. Recovery Vault is in the process of implementation The Metro-Cluster is in the process of implementation.	4	31/03/2023	31/03/2023	18/08/2022

United Lincolnshire Hospitals NHS Trust

Meeting	*Public Trust Board*
Date of Meeting	*4 July 2023*
Item Number	*Item 13.2*

Board Assurance Framework (BAF) 2023/24

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

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

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

Recommendations/ Decision Required	• *Board to consider assurances provided in respect of Trust objectives noting that framework has been reviewed through committee structure*

Executive Summary

The relevant objectives of the 2023/24 BAF were presented to all Committees during May with the exception of the Audit Committee in draft format having been updated to reflect the Integrated Improvement Plan.

The Board are asked to note the updates provided within the BAF identified by green text. Work continues to be undertaken to ensure appropriate inclusion and alignment of the relevant aspects of the Year 4 Integrated Improvement Plan (IIP) for the 2023/24 with a further round of review to be undertaken during July ahead of the July Committee meetings.

The following assurance ratings have been identified:

Objective		Rating at start of 2023/24	Assurance Rating (May)	Assurance Rating (June)
1a	Deliver harm free care	**Green**	**Green**	**Green**
1b	Improve patient experience	**Green**	**Green**	**Green**
1c	Improve clinical outcomes	**Green**	**Green**	**Green**
2a	A modern and progressive workforce	**Amber**	**Amber**	**Amber**
2b	Making ULHT the best place to work	**Amber**	**Amber**	**Amber**
2c	Well led services	**Amber**	**Amber**	**Amber**
3a	A modern, clean and fit for purpose environment	**Amber**	**Amber**	**Amber**
3b	Efficient use of resources	**Red**	**Amber**	**Amber**
3c	Enhanced data and digital capability	**Amber**	**Amber**	**Amber**
3d	Improving cancer services access	**Amber**	**Red**	**Red**
3e	Reduce waits for patients who require planned care and diagnostics to constitutional standards	**Amber**	**Amber**	**Amber**
3f	Urgent Care	**Red**	**Red**	**Red**

4a	Establish collaborative models of care with our partners	**Amber**	**Amber**	**Amber**
4b	Becoming a University Hospitals Teaching Trust	**Red**	**Red**	**Red**
4c	Successful delivery of the Acute Services Review	**Amber**	**Amber**	**Amber**

United Lincolnshire Hospitals NHS Trust
Board Assurance Framework (BAF) 2023/24 - June 2023

Strategic Objective	Board Committee
Patients: To deliver high quality, safe and responsive **patient** services, shaped by best practice and our communities	Quality Governance Committee
People: To enable our **people** to lead, work differently and to feel valued, motivated and proud to work at ULHT	People and Organisational Development Committee
Services: To ensure that **services** are sustainable, supported by technology and delivered from an improved estate	Finance, Performance and Estates Committee
Partners: To implement new integrated models of care with our **partners** to improve Lincolnshire's health and well-being	Trust Board

Assurance Rating Key:	
Red	Effective controls may not be in place and/or appropriate assurances are not available to the Board
Amber	Effective controls are thought to be in place but assurances are uncertain and/or possibly insufficient
Green	Effective controls are definitely in place and Board are satisfied that appropriate assurances are available

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
SO1	**To deliver high quality, safe and responsive patient services, shaped by best practice and our communities**												
						Developing a Safety Culture - Programme of work in place to implement the requirements of the National Patient Safety Strategy (culture and systems) Human Factors faculty in place and face to face training restarted. Commencing next steps of cultural work with external agency. Pascale survey work continues to be undertaken. Safe to Say Campaign launched. (PSG)	Further work required in conjunction with People and OD to develop the Just Culture framework. Issues linking National Patient Safety Training to ESR are impacting on our ability to meet National training requirement.	To be considered as part of the Trust Culture and Leadership Programme	Safety Culture Surveys Action plans from focus groups and Pascal survey findings. Regular update reports to the Patient Safety Group and upwardly reported to QGC and through TLT. Theatre Safety Group reporting progress against a Quality Improvement plan to PSG. Regular upward reports received from Divisions.	None identified	Not applicable		
						Robust Quality Governance Committee, which is a sub-group of the Trust Board, in operation with appropriate reporting from sub-groups. (CG)	None identified.	Not applicable	Upward reports from QGC sub-groups 6 month review of sub-group function Annual review of QGC takes place.	None identified	Not applicable		
						Effective sub-group structure and reporting to QGC in place (CG)	None identified.	Not applicable	Sub-Group upward reports to QGC	None identified.	Not applicable		

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
						IPC policies and procedures are in place in line with the requirements of The Health and Social Care Act (2008). Code of Practice on the prevention and control of infections and related guidance "Hygiene Code" IPCG will retain oversight of the relevant IIP programme of work. (IPCG)	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.	Planned programme of IPC policy development and update in line with Hygiene Code requirements.	IPC programmes of surveillance and audit are in place to monitor policy requirements. Divisional audit processes with progress and exception reporting to IPCG, IPC Site meetings and IPC related Divisional forums. Associated action and development plan documentation. Very good progress with monthly IPC ratification. Work on decontamination and other estates- related policies. This will lead to compliance of policy aspects of the Hygiene Code	Some aspects of reporting require further development.	Estates and Facilities policy schedule document to be presented to the IPCG		
						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 with specific concern relating to poor environmental infrastructure such as ventilation systems	IPC policies have been updated / developed / written in line with the timetable. •Estates and Facilities/Decontamination Lead has made good progress continued to progress work including a Decontamination sub group of the IPCG • Good progress with achieving and sustaining standards of environmental cleanliness as well as audit and monitoring processes to achieve compliance with the National Standards of Healthcare Cleanliness 2021 Provision of suitable hand hygiene products installed across the Trust	IPC programmes of surveillance and audit are in place to monitor policy requirements. Divisional audit processes with progress and exception reporting to IPCG, IPC Site meetings and IPC related Divisional forums. Associated action and development plan documentation	Some aspects of reporting continue to be subject to further development	Reporting to and monitoring by the IPCG and other related forums		

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

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1a	Deliver high quality care which is safe, responsive and able to meet the needs of the population	Director of Nursing/Medical Director	Failure to manage demand safely Failure to provide safe care Failure to provide timely care Failure to use medical devices and equipment safely Failure to use medicines safely Failure to control the spread of infections Failure to safeguard vulnerable adults and children Failure to manage blood and blood products safely Failure to manage radiation safely Failure to deliver planned improvements to quality and safety of care Failure to provide a safe hospital environment Failure to maintain the integrity and availability of patient information Failure to prevent Nosocomial spread of Covid-19	5016 4624 4877 4878 4879 4789 4932 5103 5101 4740 4947 5100 5102 5175	CQC Safe	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	Lack of upward reporting from the DTC, Medical Gases, Sedation and Chemotherapy Group. Limited 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	Quality Governance Committee	**Green**
						Maternity & Neonatal Oversight Group (MNOG) in place to have oversight of the quality of maternity & neonatal services and to provide assurance that these services are safe and in line with the National Safety Ambition / Transformation programme. MNOG will retain oversight of the implementation of the relevant IIP programme of work. (MNOG)	Issues with the environment. Ongoing difficulties with the Maternity Medway system which has the potential to impact on compliance with the CNST Year 4 Safety Actions.	External independent input in to SI process. Thematic review of SIs and complaints undertaken - recommendations being progressed as part of the Maternity & Neonatal Improvement Plan. Improvements to the environment to be completed as part of planned ward refurbishment. Team to continue to liaise with E&F to resolve and immediate issues as they arise ensuring escalation where delays are encountered. Issues with the Medway system being progressed at local and system level.	Monthly Maternity & Neonatal Assurance Report. Maternity & Neonatal Improvement Plan. Executive & NED Safety Champions in place and work closely with local Safety Champions. NHSE/I appointed MIA in place and supporting the Trust - monthly reports of progress to MNOG. Validation of the implementation & embedding of the Ockenden IEAs has been provided by the regional maternity team. There is a process in place for ongoing testing through supported site visits.	Additional assurance required in respect of training compliance (recovery of women following GA) - trajectory agreed.	Monitoring of compliance against trajectory for recovery training occurs through MNOG.		

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						Appropriate policies and procedures in place to recognise and treat the deteriorating patient, reported to deteriorating patient group and upwardly to PSG and QGC. Deteriorating Patient Group set up as a sub group of the Patient Safety Group to identify actions taken to improve; has its own sub-groups covering NIV; AKI; sepsis; VTE;DKA (Ensuring early detection and treatment of deteriorating patients) (PSG)	Work required to develop the maturity of the group. New Chair identified and full review of membership and remit required. Maturity of some of the sub-groups of DPG not yet realised. This will be considered as part of the review of DPG.	Observation policy ready to go to next NMAAF Fluid management policy approved by DPG/PSG and awaiting approval at NMAAF Deteriorating Patient Group set up as a sub group of the Patient Safety Group to identify actions taken to improve; has its own sub-groups covering NIV; AKI; sepsis; VTE; DKA	Audit of response to triage, NEWS, MEWS and PEWS Sepsis Six compliance data Audit of compliance for all cardiac arrests Upward reports into DPG from all areas Number of incidents occurring regarding lack of recognition of the deteriorating patient	DPG meeting not meeting as frequently due to loss of Chair. New Chair identified and commenced in post October 2022.			
						Ensuring a robust safeguarding framework is in place to protect vulnerable patients and staff (Ensuring a robust safeguarding framework is in a place to protect vulnerable patients and staff) (SVOG)	Paper presented to CRIG and funding agreed - currently sat in reserves and awaiting drawdown by Estates and Facilities who will manage the trainers	Updated policy & training in use of chemical restraint / sedation; strengthening of pathways & training to support patients with mental health issues	Upward reporting to Mental Health, Neuro Diversity and Autism group	DMI training to commence delivery in November 2022. 05.01.2023 - Training commenced delivery in November but not fully rolled out as only 1 trainer in post. New Training jobs are out to advert this month with a view to being in post for March / April 2023 when full rollout will begin	Datix being monitored by safeguarding team to ensure review of any restraint incidents Funding agreed by CRIG. new roles to be managed within Estates and Facilities. 05.01.2023 - New Training jobs are out to advert this month with a view to being in post for March / April 2023 when full rollout will begin 07.02.23 - all posts now advertised and shortlisted - interviews early March - likely appointment dates May 2023 3 posts in place undergoing indcution - one final post currently out to advert. staff requiring DMI training now identified and the team are in the process of adding the data to the ESR training Matrix		
						Appropriate policies in place to ensure CAS alerts and Field Safety Notices are implemented as appropriate. (PSG) One central monitoring process now in place.	Review of compliance metrics required.	New group meeting to address CAS/FSN policy implementation with key stakeholders. Any relevant alerts are also discussed at gold as appropriate.	Quarterly report to PSG with escalation to QGC as necessary. Compliance included in the integrated governance report for Divisions.				
						Appropriate policies and procedures in place to reduce the prevalence of pressure ulcers, including a Skin Integrity Group (NMAAF)							

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						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) (CG)			Monthly report to QGC and Trust Board on Must and Should dos				
						Maximise safety of patients in our care, through learning from incidents, reducing incidents causing harm and reviewing external reports and assessments of our services							
						Improve our medication management safety and reduce medication related incidents resulting in harm, supported by implementation of an e-Prescribing system							
						Establish an open and honest patient safety culture rather than attributing blame and liability, which will enable improved clinical outcomes, through implementation of PSIRF by September 2023							

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						Patient Experience Group, which is a sub-group of the Quality Governance Committee, in place meeting monthly Robust Complaints and PALS process in place (PEG)	Patient Experience Group - the group continues to develop its maturity Meeting may be stood down due to operational pressures at time of operational extremis.	The Group meets monthly and has a work plan and schedule. If the meeting is stood down, then the papers are reviewed and Chairs report provided.	Upward reports to QGC monthly and responds to feedback Review of ToR in May 2022 and annually as part of the work schedule. Quarterly Complaints reports identifying themes and trends presented at the Patient Experience Group Patient Experience Group upward report Divisional Reports have developed in reporting maturity and include a patient story / risks and issues / actions. This is a well embedded part of the PEG meeting.	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 (PEG)	The PACE Delivery Plan to be actioned and embedded over the life of the delivery plan.		Patient Experience & Carer Plan progress report to Patient Experience Group as per schedule.	Ongoing assurances provided to PEG re: actions. Assurance is variable due to the number of actions being delivered. But overall oversight of the plan = moderate assurance	The delivery plan will be monitored through PEG		
						Quality Accreditation and assurance programme which includes weekly and monthly audits which include feedback on patient experience from patients in the clinical areas.(PEG)	Further development of alignment of findings in audit data to patient experience surveys overarching plan and other sources of patient experience information. Annual Ward / Dept quality review visits may be paused due to operational pressures in times of extremis.	Head of pt experience can access the audit 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	Ward / Dept review Visits are cancelled when the organisation is in surge. However, weekly spot checks and matron audits continue.	Scheduled review visits for the year, which include the patient experience team as part of the visit team. Pt Experience team to have sight of hotspots / concerns and can in-reach to provide support.		

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1b	Improve patient experience	Director of Nursing	Failure to provide a caring, compassionate service to patients and their families Failure to provide a suitable quality of hospital environment		CQC Caring	Redesign our communication and engagement approaches to broaden and maximise involvement with patients and carers (PEG)	Reaching out project (Hard to Reach groups) still in development; diversity of current patient representatives and panel members is narrow; 15 new panel members recruited; contact still to be made with some community groups. Experts by Experience group slow to gain traction and engagement.	Patient Panel has agenda and representatives that attend Patient Experience group to feedback and ensure continuity of messaging. Recruitment for new panel members will happen through Nov / Dec 22. Sensory Loss group upwardly reports to Patient Panel. You Care - We Care to Call (YCWCC) Campaign pilot being used in several wards to test out a variety of ways to improve communication with families / loved ones of in-patients. Communication working group set up to look at a range of communication issues affecting patient experience.	Upward reports and minutes to the Patient Experience Group	Diversity of patient engagement and involvement is limited.	Partnership working established with Healthwatch to reach out to Eastern European community; staff BAME network approached for community links and contacts. Expert reference groups progressing well: Breast mastalgia group has completed its co-design but will meet again in the future as part of service evaluation, Cancer group meeting quarterly, Dementia Carers group has had first meeting and will meet alternate months. Cardiology and QI groups being developed	Quality Governance Committee	**Green**
						Care after death / last offices Procedure & Guidelines Sharing information with relatives Visiting Procedure Patient information (PEG)	Audit of EOL visiting required to determine if there is a consistent approach to visiting. Audit planned for Jan 23 and to report to PEG in Feb/March 23	Exceptions guidance re-issued. Monitor through complaints & PALs. Audit will be undertaken by the Patient Experience Team in this years schedule of work. Audit planned for Jan 23 combined with EOL visiting audit.	Report to PEG through complaints & PALs reports; upward reports were received from Visiting Review working group which has now disbanded; the planned audit will report back to PEG and propose any further recommendations. With visiting restrictions now removed the previous issues cited within complaints and PALs have not been seen. This will continue to be monitored through the winter months. from Visiting Review working group.	Patient information currently subject to review and work is ongoing.	Audit of visiting experience planned for Jan 23 will provide an understanding across all aspects of visiting now that all COVID precautions have been stepped down. This will also tie in with national work on Care Partners and visiting guidance under the Health & Care Advisory Board which the Head of Patient Experience is a member of.		

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						Inclusion Strategy in place (PEG)	Lack of diversity in patient feedback and engagement	Equality, Diversity and Inclusion Lead is member of Patient Experience Group.	EDI 1/4rly report to PEG;	EDI Reports will need to develop in maturity regarding patient experience	Head of Pt Experience to discuss with EDI lead to ensure data is relevant and triangulated.		
						Robust process in place for annual PLACE inspection accompanied by PLACE LITE (PEG)	PLACE Lite Process needs to be embedded as Business as Usual	PLACE Lite visits are being scheduled for the year across the organisation.	PLACE report to go to Patient Experience Group quarterly and upwardly reported to QGC	National PLACE programme currently paused due to pandemic; national programme recommenced September 22	PLACE Lite continues & reports to PEG plus the annual report will be received at PEG, due Jan 23		
						Enhance patient experience by learning from patient feedback and demonstrating our values and behaviours in the delivery of care with a specific focus on discharge of patients	National surveys evidence overall poor experiences in relation to discharge with a number of questions being benchmarked as worse than others Trusts.	Amalgamated survey action plan in development to identify Trust wide improvement focus. Rolling out of #WMTY initiative to ensure patients are involved in decisions and discussions about their discharge plans. Patient Experience Team working with Discharge Lounge staff facilitating understanding of discharge experience and improvements.	Discharge experience reports to PEG quarterly.	Lead Nurse for discharge to attend PEG in October. Deferred to Nov. Deferred to Dec.	Patient Experience Team to meet with Lead Nurse for Discharge to support and ensure experience data is collected, analysed and acted upon.		
						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							
						Implementation of our 'you care, we care to call' programme across 38 wards							
						Improved learning from patient feedback, with a focus on addressing discharge processes and inclusion of 'experts by experience'							
						Embedded processes to address risk of hidden child and support transition across all services							

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

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						Specialised services quality dashboards (SSQD)	SSQD data collection now commenced again post Covid. Areas with outliers identified with some plans for improvement, however not all required areas currently have plans.	Continued support from the Clinical Effectiveness Team and requirement to attend CEG and provide update on progress.	Quarterly reports to CEG and upwardly reported to QGC. Action plans developed for all required areas.	Actions plans not yet received for all necessary areas.	Continued requirement to attend CEG to provide updates.		
						Process in place for implementing requirements of the CQUIN scheme.	Plans now in place for delivery of 2022/23 CQUINs, although assurances not yet received that these are fully implemented.	CQUIN delivery group commenced again.	Quarterly reports to CEG and upwardly reported to QGC	Some gaps identified in reporting processes.	Being dealt with via the CQUIN delivery group		
						Process in place for ensuring high quality of record keeping including Medical Records Group.	Medical Records Group not meeting regularly.	Refocus of the Medical Records Group planned by the new Chair.	Programme of record keeping audits taking place.	Audits do not demonstrate compliance with record keeping standards.	Divisional governance leads to pick up within each area.		
						Process in place for monitoring of and implementation of NCEPOD requirements.	None identified.	Not applicable	Quarterly reports to CEG on progress.	Some outstanding baseline assessments. Some overdue actions identified.	Work taking place with divisional leads to address.		
						Quarterly Learning Lessons Newsletter in place at both Division and Trust wide level (CEG)	Staff may not access emails to review newsletters Assurances to be received at the next meeting regarding how learning is shared within Divisions.	Programme of work commencing regarding wide ranging mechanisms for learning lessons across the Trust.	Evidence of newsletters shared is available.				
						Ensure we provide clinically safe services, through an increased volume of Diamond Accredited Wards							
						Improve clinical effectiveness through increased compliance with national and local standards							
						Improve clinical effectiveness and best practice principles by prioritising Cardiovascular pathways							
						Relaunch and embed our CQUIN programme to ensure best practice and improve clinical outcomes							
SO2	**To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT**												
						NHS people plan & system people plan & five themes:- - Looking after our people - Belonging in the NHS - New ways of working & delivering care - Growing for the future - Leadership and Lifelong Learning (from 2022/23)			System PP - Each 'pillar assigned system lead Progress/assurance reported to People Board (quarterly) Reported progress on the implementation of	None identified	A new sub committtee of the Finance Recovery Board called Workforce Board has now been created and is chaired by the LPFT CEO. This group will have oversight of the workforce CIP plans from the system and feed into the FRB on a regular basis. Work has also been		

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									the NHS People Plan and the Lincolnshire System Workforce Plan Priorities agreed for 2022/23		commenced to create a number of task and finish groups to review the opportunities to streamline and deliver in a collbrative way moving forward back office services including recruitment, OD, Education and HR processes.		
						Workforce planning and workforce plans	Overall vacancy rate declining	A new pillar for workforce planning and transformation is being created as part of the People Directorate restructure. The Trust have an Associate Director of Transformation and Workforce planning in post who is leading workforce planning in conjunction with HRBP's, finance and improvement team. This is established and regular reviews are now in place.	Workforce plans submitted for H2 2021/22 Operational Planning. Recruitment plans are in place. Divisional Recruitment Pipeline Reports are refreshed regularly for each division working with each of the SHRBP's and are reporting through to FPAM in terms of pipeline linked to reducing agency spend.	Some areas remain hard to fill however full and comprehensive workforce plans are in place 'plan for every post' and workforce scorecards are in place and are reported through to the Operational Workforce and Strategy Group and then included within the highlight report for People & OD Committee highlight report to Board.	Final submission has been completed with a headline that our baseline establishment headcount will not change. Work continues with recruitment and Divisions to ensure recruitment is on track with projected pipeline to continue to fill our existing vacancies.		
						Recruitment to agreed roles - plan for every post	Availability of workforce	Pipeline report shows future vacancy position International nurse recruitment & cohort recruitment	Internal Audit - Recruitment follow up and completion of actions. Recruitment key performance metrics feature as part of the People & OD scorecard which is tabled at the Workforce Strategy and Operational meeting and then is reported upwards by expectation to People & OD Committee via the highlight report.	None identified			
						Focus on retention of staff - creating positive working environment and integration of People Promise 'themes' System retention role established (8B - 12 month) Temp/12 month fixed term People Promise Manager appointed (Liz Smith - ULHT) from end May 2022 Task and Finish Group Statutory and Mandatory Training Task and Finish Group Appraisal	Talent management - on hold	Restructure and resource in to People and OD Directorate	Executive CQC Assurance Panel Workforce, Strategy and OD Group upward report to PODC including scorecard analytics i.e. appraisal, statutory and mandatory training	Appraisal compliance levels not at expected level Mandatory Training compliance not at agreed level	To be monitored through the Workforce Operational Group and FPAM meetings and will feature in the highlight report to PODC. Phased targeted approach in 23/24 KPI's as featured in the Integrated Improvement Plan.		

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2a	A modern and progressive workforce	Director of People and Organisational Development	Possible disruption caused by system wide strike action and capacity of Pillar leads	4362 & new high risk on POD register	CQC Safe CQC Responsive CQC Effective	Embed continuous improvement methodology across the Trust	Embedding and sustaining cultural change when the ability of the ULHT teams to engage when we are operationally challenged Ability to demonstrate quick impact on the cultural change due to various interventions will be limited (as these are multi year/multi factorial projects)	Improvement Academy now report all training & associated activity to embed continuous improvement through Improvement Steering Group for oversight and escalations Working with each improvement programme and Divisions to develop identify and align improvement plans	Internal training reports produced by Improvement academy Improvement programmes identifying personalised training needs for ULHT staff Divisions training plan (aligned to the IIP) presented at FPAM	Information is reported to ISG - Low uptake of our various training offers despite general and targeted comms through various platforms. Services are struggling to release staff for QI training due to pressures. Plan for a QI relaunch in the new financial year. Use of virtual training option via MS Teams.	Weekly meetings with Improvement Academy to increase offer with more agile training methods to meet the needs of the varied staff. Developing communications & engagement strategy for on-going awareness of Improvement Academy to enable improvement culture change (not just limited to sending email updates but being creative and being on site on wards to talk about quality improvement)	People and Organisational Development Committee	**Amber**
						Reducing sickness absence - Absence Management System	Manager call back compliance and return to work interview	Support and training from HRBPs External consultancy briefings with divisional leads	Sickness/absence data	Various reports (Sitrep, Gold, STP) unable to offer absolute assurance due to both the national picture and the Critical level the Trust is operating under.	Work continues with the completion of the audit actions and work/training with the departmental managers and HR. To be monitored through the Workforce Operational Group and FPAM meetings and will feature in the highlight report to PODC. Phased targeted approach in 23/24 KPI's as featured in the Integrated Improvement Plan. A deep dive is being undertaken of the full utilisation of the AMS management system as early indications show improvement is needed.		
						Ensuring access to the personal and professional development that enables people to deliver outstanding care and ensures ULHT becomes known as a learning organisation Establish ULHT Education and Learning service (pending P&OD restructure)	Training and Development department	Subject area/work programme under review. Work underway to 'scope' requirements, including interface with Education Recruitment to Head of Education and Training infrastructure. Interim resource in place	System LEAD (Learning, Education and Development) Board to provide system oversight (agreed) Apprenticeship uptake and utilisation of levy through WSODG	None identified			
						Creation of robust Workforce Plan •Values based recruitment and retention •Maximising talent management opportunities •Create an environment where there is investment in training and a drive towards a career escalator culture – 'earn and learn' Promote benefits and opportunities of Apprenticeships		Associate Director of People Planning and Workforce Transformation commenced March 2023. Task and Finish Group established	Improved vacancy rates reported through WSODG	None identified			

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						Improve the consistency and quality of leadership through:- Reset leadership development offer and support (Leadership SkillsLab and PME) •Improved mandatory training compliance •Improved appraisals rates using the WorkPal system •Developing clear communication mechanisms within teams and departments	New Training and Development department in place with full recruitment programme now complete	Recruitment to Head of Education and Training infrastructure. Interim resource in place. Realignment of OD priorities in line with the restructure have gone live in April 2023	Workforce and OD Group IPR - Appraisal compliance Culture and Leadership Group Priority updates to PODC	None identified			
						Providing a stable and sustainable workforce by:- •Ensuring we have the right roles in the right place through strong workforce planning •Reducing vacancy rates and ensuring that posts are filled through a positive and values recruitment approach •Reducing our agency staffing levels/spend •Strengthening the Medical Workforce Job Planning processes	Work continue to recruit to all new vacancies within the newly formed central Medical Staffing Function to offer more support for job planning compliance.	System support being considered for job planning	WSODG TSSG Medical Staffing Group	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	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	Health and wellbeing Manager appointment and the creation of a Health and Wellbeing Group has been completed and their first meeting was held end of April. This will feed into the Workforce Operational Group. On going training and support for Health and Wellbeing champions.		Nearly at a fully recruited position witthin the newly restructured HR department.		
						Employee Assistance Programme implemented May 2022	Aligned to reduction in sickness work in partnership with Heads of HR and Divisional Management	Through local Health and Wellbeing group and HR casework reviews.	System Health & Wellbeing Board Linc People Board (NB. Wellbeing Pillar)	Wellbeing activity (for reporting to Workforce, Strategy and OD Group)	Core data is now included in the POD scorecard which is tabled at the Operational working group.		
						Develop and support our people and the wider system, maximising access to training opportunities, making full use of the apprenticeship levy	Working in collabration with the system to ensure we continue to support where appropriate the transfer of ULHT levy in line with the regulations and guidelines to do so.	Not applicable	Key Performance indicators have been identified as part of the IIP and will be monitored through the scorecard at Workforce Operational and Strategy Group. Aligned to restructure of the Talent Academy within the POD broader restructure.	None identified			

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						Vacancy levels below 4% across all staff groups	Aligned to the plan for every post, recruitment plans for each divison and aligned to the workforce submission plan for 23/24.	Not applicable	Key Performance indicators have been identified as part of the IIP and will be monitored through the scorecard at Workforce Operational and Strategy Group.	None identified			
						Reduce our staff turnover rate to 6% across all staff groups	Aligned to the continued work under the People Promise Manager role and plans for 23/24 to continue to improve work life balance, flexible working requests, flexible retirement/retire and return options.	Not applicable	Key Performance indicators have been identified as part of the IIP and will be monitored through the scorecard at Workforce Operational and Strategy Group.	None identified			
						Compliance with National agency utilisation target of 3.7% agency and locum workforce	Aligned to the cost improvement programmes reported through the IIP updates						
						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 futureAlignment with People Promise Reset and alignment of Trust values & staff charter (with safe culture) Reset ULH Culture & Leadership	Comprehensive follow up and prioritisation of NSS results - key areas of concern identified for action 7 point action plan presented and agreed to ELT/TLT	Leading Together Forum - regular bi-monthly leadership event Delivery Plan and actions to be confirmed further to results of Leadership Survey LTF Forward Plan Leadership SkillsLAB - essentials in management and leadership for existing managers	Culture and Leadership Group and System People Board Culture and Leadership Programme Group upward report NSS results (Feb 2023)	Delivery of agreed output	Paper being presented to Board in May to offer a plan in terms of 23/24 National Staff Survey plans and individual priorities being taken forward in preparation for the next NSS. Restorative Just and Learning Culture project team has been created to scope out the plans to roll out in the Trust further update will follow meeting being held in May.		
						Effective communication mechanisms with our staff - ELT Live, managers cascade, intranet etc.	Director BLOG's	The BLOG's pick up and highlight areas of focus supporting the staff survey action plan for 23/24.	Staff survey feedback - engagement score, recommend as place to work / recommend as a place to receive care	None Identified	Regular timetable of Director Blog's		
						Leadership & Management training. (Improving the consistency and quality of leadership and line management across ULHT) Leadership SkillsLab - launched June'22	Training and Development department	Leadership SkillsLab - launched June'22	National Quarterly Pulse surveys (mandated from July'22) Number of staff attending leadership courses	Limited oversight of outputs of Pulse Surveys	Work on-going in terms of launch of next pulse survey and promotion.		
						Lincs Belonging Strategy EDI Delivery Plan 2022-25	Aligned to ULHT Equality and Diversity annual plan	Not applicable	Council of Staff Networks Internal Audit - Equality, Diversity and Inclusion NHS NSS EDI/EDS objectives	None identified	None Identified		

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						Staff networks	Additional Carers Network now launched. An ELT Network special has also been held with all Network Chairs and Executives	Not applicable	Council of Staff Networks	None identified	None Identified		
						Focus on junior doctor experience key roles:- - Freedom to speak up Guardian - Guardian of safe working - Well-being Guardian	Additiona resources are now in place within the OD Department to help support culture and engagement within the Medical Workforce.	not applicable	Dedicated resource in place for GOSW and FTSUG. Trust Chair has taken role of Well being Guardian. Reports being provided from GOSW and FTSUG. JNR doctor survey findings being seen at Committee. GOSW and FTSUG invited in person to Committee	None identified	None Identified		
						Embed compassionate and inclusive leadership (aligned to People Promise)	Training and Development department, part of the embedding of the Restortive Just and Learning Programme	Task and finish group has been created with SRO's, programme leads which reports into the Culture and Leadership Group	Culture and Leadership Group	None identified			
						Support Divisions to achieve 95% of our people having completed all relevant statutory and mandatory training by March 2024	Newly created dedicated Education Department now in place as part of the restructure. Aligned to the People Promise continued work for 23/24	Support and training from new Education Department	Workforce Operational Group	Delivery of agreed output	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.		
						Support our Divisions to provide all staff with an appraisal and clear objectives		Support and training from new Education Department	Workforce Operational Group				
						55% of our staff recommending ULHT as a place to work and an improved position with regards to our people feeling that they are treated with kindness, compassion and respect.		Further work required aligned to the Quarterly Pulse survey and promotion of this.	Workforce Operational Group				
						53% of our staff recommending ULHT as a place to receive care		Further work required aligned to the Quarterly Pulse survey and promotion of this.	Workforce Operational Group				

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2c	In year improvement within Quality and Safety, with an ambition by 2025 to increase by 5% on our current league table for NHS Acute Organisations for indicators	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 4 sessions during Oct / Nov 21 Risk Register Confirm and Challenge Group ToRs Upgrade to datix system Full Risk Register review	Policy and Strategy document updated	Complete	Third party assessment of well led domains Internal Audit assessments Risk Management HOIA Opinion received and Audit Committee considered in June noting 'partial assurance with improvement required can be given on the overall adequacy and effectiveness of the Trust's framework of governance, risk management and control. Completeness of risk registers Annual Governance Statement			Audit Committee	**Amber**
						Shared Decision making framework			Number of Shared decision making councils in place	8 councils established. Target for 2021 was 6			
						Implementing a robust policy management system Additional resource identified for policy management post Reports on status by division and Directorate Updated Policy on Policies Published Guidance on intranet re policy management reviewed and updated	Move of policies in to SharePoint reliant on progress with Trust intranet. Timeline delayed through Covid Divisional breakdown of policies requiring review being shared with PRMs	Review of document management processes - Complete New document management system - SharePoint - In place Reports generated form existing system - Complete All policies aligned to division and directorates - Complete Single process for all polices clinical and corporate - Complete	Fortnightly ELT report monitoring actions. Quarterly report to Audit Committee including data on in date policies CQC Report - Well Led Domain				
						Ensure system alignment with improvement activity							
						Complaince with National agency utilisation target of 3.7% agency and locum workforce							
						Reduce our staff turnover rate to 6% acorss all staff groups							

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						An external audit agaisnt CQC Well Led measures, to be completed by September 2023 and an action plan to be developed for futher improvements							
						53% of our staff recommending ULHT as a place to receive care							
SO3	**To ensure that services are sustainable, supported by technology and delivered from an improved estate**												
	A modern, clean and fit for	Chief Operating	Longer term impact on supplier services (including raw materials) who are supporting the improvement, development, and maintenance of our	4648 - Fire Safety		Develop business cases to demonstrate capital requirement in line with Estates Strategy	Business Cases require level of capital development that cannot be rectified in any single year.	Estates Strategy sets out a framework of responding to issues and management of risk. Capital Delivery Group has oversight of the delivery of key capital schemes. External Specialist Advisor working jointly NHSE & ULHT providing external guidance and validation. Use of the premises assurance model PAM will help identify gaps and subsequent actions or schemes of improvements.	Capital Delivery Group Highlight Reports Compliance report to Finance, Performance and Estates Committee Updates on progress above linked to the estates strategy. PAM Quarterly internal review and annual submission.	Funding gap when considering the full £100m+ backlog in first year. Future years will at most tackle £20m of backlog in any given year 6 Facet Surveys used to quantify and identify schemes are out of date and need reviewing.	Estates improvement and Estates Group review compliance and key statutory areas. Progress against Estates Strategy/Delivery Plan and IIP via sub groups upward reports. Delivery of 2022/23 Capital Programme will continue to ensure progress against remaining backlog of critical infrastructure. Capital Delivery Group will monitor the delivery of key capital programmes and ensure robust programme governance. Structure review including upward reports are being reviewed by specialist advisor with recommendations of reporting lines.		
						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	

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3a	A modern, clean and fit for purpose environment	Chief Operating Officer	and maintenance of our environments. Availability of funding to support the necessary improvement of environments (capital and revenue)	4647 - Fire Safety 4858 - Water	CQC Safe	Continued progress on improving infrastructure to meet statutory Health and Safety compliance	H&S Committee Previously not run with quoracy. However now reviewed with ToR agreed and Quorate with staffside representation	Water/Fire safety meetings are in place and review of controls are part of external validation from authorised engineers. Health and Safety Committee new terms of reference approved and now chaired by Chief Operating Officer/Director of Estates and Facilities. Upward reporting to Finance, Performance and Estates Committee Med gas, Critical ventilation, Water safety group, electrical safety group, medical gas group have all been established and include the relevant authorising engineers in attendance. These groups monitor and manage risks and report upwards any exceptions or points of escalation.	Reports from authorised engineers Response times to urgent estates requests Estates led condition inspections of the environment Response times for reactive estates repair requests Progress towards removal of enforcement notices Health and Safety Committee upward report Letter from British Safety Council on External Review			Finance, Performance and Estates Committee	**Amber**
						Implement Year 1 of our Estates Strategy	Funding gaps between overall plan of replacement vs available funding. Availability of Suppliers and Changes in market forces. Availability of raw materials and specialist components to replace/repair etc.	Business Case Development and preparation pre-empting available capital to maximise available. Use of procurement framework and liaison with NHSE to coordinate bids and larger schemes	Estates Group Upward Report				
						Refurbishment of 8 theatres, across our sites							
						Support capacity maximisation ensuring modernisation and utilisation of space, including that leased off the main acute sites							
						Reduce our net carbon footprint							
						Develop Health Master Plans to better algin wards							

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

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						ERF clawback - Collective ownership across the Lincolnshire ICS of the restoration and recovery of the planned care pathways leading to improved activity delivery. Trust focus to restore services to pre-COVID levels and then stretch to 116%.	Maximisation of the Trust Resources - Theatre and Outpatient productivity. Impact of the COVID patients and flow on availability of beds to provide capacity. Ability to recruit and retain staff to deliver the capacity. A production / activity delivery plan.	Divisional ownership and reporting Improved counting and coding, including data capture and missing outcome reductions. Shared risk and gain share agreements for the Lincolnshire ICS. Reporting by POD and Specialty against the delivery plan	Delivery of the 116% target	The operational pressures, specifically; sickness, excess beds open, rising acuity of patients and continuing rising demand at the front door of the acute Trust is putting at risk in year delivery of the 116% activity target.	The Trust is monitored externally against the Trust activity target through the monthly activity returns The Trust monitors internally against its activity targets inclusive of specific Divisional and Specialty plans and targets The Lincolnshire ICS is monitored externally against the system activity target through the monthly activity returns		
						Utilisation of Capital allocation based on risk to enhance our services and support efficiency improvements	Difficult to compare Estate, Digital and Equipment risks. Capacity to produce business cases to access external funds	Revised CRIG process, supported by experts. Green book training roll out. Risk rating pre & post investment required in all investment requests.	Capital, CDC and Benefits realisation upward reports into FPEC. Development of a 5 year capital programme cross referenced to risk register.	6 facet survey not completed.	Investment identified for 6 facet survey.		
						Improve utilisation of the Care Portal with increased availability of information -	Cyber Security and enhancing core infrastructure to ensure network resilience. .	Digital Services Steering Group Digital Hospital Group Operational Excellence Programme Outpatient Redesign Group	Number of staff using care portal Ranked in 4th place nationally of ICS usage of Care Portals.				
						Development and approval of Electronic Patient Record OBC	Regional and National approval of OBC Affordability of OBC	Digital Services Steering Group Digital Hospital Group e-HR Programme Steering Group Capital, Revenue and Investment Group Engagement with regional colleagues	Delivery of OBC Agreement of funding	Regional feedback on OBC	EPR OBC to be approved by Frontline Digitalisation NHSE/I OBC requirements (including financial) being worked through with Frontline Digitalisation NHSE/I OBC approved at Aug FPEC and Sept Board Updated 'affordable' OBC to go to Jan / Feb 2023 FPEC / Board FPEC supported new version of OBC on 1st Feb. Now going to Trust Board for approval on 7th Feb. OBC now with Regional / Frontline Digitalisation Fundamental Criteria Review.		

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3c	Enhanced data and digital capability	Director of Finance and Digital	Approval of OBC for Electronic Health Record is delayed or unsuccessful Major Cyber Security Attack Critical Infrastructure failure	4641 - Digital infrastructure 4661 - DPIA	CQC Responsive	Rollout of PowerBI as Business Intelligence Platform during 2022/23			Delivering improved information and reports Implement a refreshed IPR Rollout increasing, having replaced QlikView dashboards. New dashboards in place to support Vaccination reporting and HR EF3 processes. Work underway to automate IPR production for Trust Board and Committees, as well as Divisional PRMs.	IPR refresh for 22/23. Completed for Jan 2022	Steady implementation of PowerBI through specific bespoke dashboards and requests.	Finance, Performance and Estates Committee	**Amber**
						Implement robotic process automation	Lack of expert knowledge available within and to the Trust (experts in short supply nationally) Business case development on hold due to capacity issues	Skilling up internal resource. Exploring opportunities with Northampton General Hospital who provide RPA Services LCHS and ULHT contracts being migrated to one at next renewal.					
						Improve end user utilisation of electronic systems	Business case for additional staff under development	Digital team providing advice and guidance hoc to address pressure points					
						Complete roll out of Data Quality kite mark			Ensuring every IPR metric has an associated Data Quality Kite Mark	Information improvements aligned to reporting needs of Covid-19.	A number of metrics have had a review and these are awaiting formal sign off. They will then appear in the IPR. Additional metrics have been added and reviewed, and a work plan and deadlines associated with completion is being drawn up. These will be shared with the Director of Finance & Digital for sign off.		
						Upgrade of our technological infrastructure to support technology advancements	Insufficient cap/rev to replace aging technology Insufficient capacity to deliver purchased equipment	Technical Design Auhority Digital Hospital Group Information Governance Group (for cyber / info security)	Digital Marurity Assessment		Looking to procure a Technical / Implemenation Parner to provide capacity as and when required		
						Provide our people with real-time data to support high quality care delivery to all clinical staff							
						Enhance our organisational digital capability and skills through training	Insufficient capacity to create and deliver training materials	Digital Hospital Group			Looking to procure a Technical / Implemenation Parner to provide capacity as and when required		

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						Implementation of an Electronic Prescribing system	2023/24 funding not approved yet Insufficient capacity to deliver at pace of current plan	ePMA Steering Group Digia Hospital Group	Number of wards live with ePMA		Paper written to clarify costs. Currently being worked through with Finance colleagues Looking to procure a Technical / Implemenation Parner to provide capacity as and when required		
3d	Improving cancer services access	Chief Operating Officer	Insufficient clinical capacity, insufficiently optimised pathways, Dependency on services (primary care, pathology) that are unable to deliver required access or level of service Trust in tier 1 due to delivery of FDs		Cancer Standards 62 day, 14 day and 28 Day FDS	Improve access for patients by reducing unwarranted variation in service delivery through transformation of Cancer Care Integrated Improvement Programme and Assoc Governance System Cancer Improvement Board	Recovery post COVID and risk of further waves Specialty Capacity strategies not in place Insufficient oversight of system partners contribution (e.g. primary care testing and workups)	Requirement for specialty strategies now part of strategy deployment and will commence Q1 22/23 Cancer Leadership Group Deep Dive Workshops (e.g. Colorectal) East Midlands Cancer Alliance Increased Oversight	Cancer board assurance and performance reports Deep Dive information and reports on gap analysis Routine Performance and pathway data provided by Sommerset system	Process information below the cancer stages are not always captured Some digital systems are not linked and not all wait information is recorded e.g. MIME system	Targeted Improvement (3 x weekly) of key concern specialties increase the scrutiny of reporting and pathway performance led by COO Colorectal now seeing a well managed recovery and the Surgical Division is now reviewing the Prostate Cancer Pathway. Breast continues to see improvement. The 62 day backlog continues to be aligned to the agreed recovery trajectory.	Finance, Performance and Estates Committee	**Red**
						Achievment of 104 and 72 week perofmrnace trajectory	Capacity to deliver Faster Diagnosis (FDs) for all services	Additional support secured through mutual aid to provide focus on cancer recovery	Weekly system elective and cancer recovery meetings 3x weekly cancer				
						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				
						Development of plans for seven day working, across all of our services							

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3e	Reduce waits for patients who require planned care and diagnostics to constitutional standards	Chief Operating Officer	Insufficient clinical or physical capacity, insufficiently optimised pathways		Referral to Treatment (18week wait) Standards Diagnostic 6week (DM01)	Improve access for patients by reducing unwarranted variation in service delivery through transformation of Planned Care Integrated Improvement Programme and Assoc Governance System Planned Care and Diagnostic Group	Recovery post COVID and risk of further waves Specialty strategies not in place Elective Theatre Programme Transformation team not yet established.	Requirement for specialty strategies now part of strategy deployment and will commence Q1 22/23 Recovery plans at specialty level. To date have delivered required reductions in 104 week waits Outpatient Improvement Group Foureyes Theatre Improvement Programme GiRFT and High Volume Low Complexity Programme Group	Performance Data Planned Care Improvement and Performance Reporting Integrated Improvement Plan Highlight and Status Reports GIRFT Reports and NHSE Review data	Inconsistent approach to waiting list validation CBUs do not have traction or insight into the non admitted or admitted waiting lists Maximum Outpatient and theatre capacity not apparent as yet. Demonstration of change at pace is lacking.	National edict to see and treat all patient waiting greater then 78 weeks by 31 March 2023 in place. Twice daily monitoring and reporting is now in place. The largest DM01 risk is Echo Cardiology. A plan is now in place to offer and recruitment and retention premium. The recommendations and action plans suggested following the Regional Diagnostic Team external review is realising some benefits. Local, System, Regional and national assurance meetings in place to monitor progress and delivery. Use of independent sector, mutual aid and insourcing/outsourcing providers to ensure delivery. ICB and COO holding the Trust to account for delivery against national deadline. Internal design, development and agreement of a 'production plan'. Review of all consultant Job Plans is in train.	Finance, Performance and Estates Committee	**Amber**
						Outpatient Recovery & Improvement Programme (ORIG)	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	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		

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						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 Weekly Capacity meetings held to ensure theatre utilisation	Increased in NEL demand may impact staffing levels, elective bed capacity, and therefore could impact on elective activity. KPIs potentially impacted: OTD cancellations and actual utilisation against planned levels	Reporting through Improvement Steering Group/FPEC/HVLC		
						Clinical prioritisation Group	Ability to list appropriate mix of P2/3/4 due to effective preop Unnecessary on the day cancellations Increased non-admitted waiting list waiting to convert to admitted	Preop workstream via FEI Review and management through prioritisation group and Surgical PRM Management through ORIG/HVLC/Surgical PRM			Reporting through FPEC/HVLC		
						Meet all National asks for performance, set out in the planning guidance, for elective care							

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						Maximisation of capacity and efficiencies to reduce and elimination 65 week waits across all specialties			Trajectories for all specialties in place, weekly position statements offered to ELT and TLT Weekly planned care update meeting				
						Development of plans for seven day working, across all of our services							
3f	Urgent Care	Chief Operating Officer	Insufficient clinical capacity or expertise, inefficiently configured services, failure of system partners to provide capacity or reduce demand to pathway and excessive demand above capacity available		Emergency Care Clinical Indicators (12hr, 4 hour CRTP, 60 minute decision and 15 minute triage)	Daily System control meetings in collaboration with 3x daily internal capacity meetings. Integrated Improvement plan for urgent care and Urgent Care improvement Group. System Urgent Care Partnership Board. LHCC Improvement Programme Board and LHCC Board	Recovery post COVID and risk of further waves Internal professional standards not embedded External dependencies lack of visibility of capacity and system control to move risk/capacity between services. E.g. community care hours, care home ,assessment capacity etc.	External reviews used to identify gaps in services and assess capacity shortfalls. Emergency Care Intensive Support Team, IMPOWER specialist consultants and Dr Ian Sturgess specialist consultant reviews identify control and process and capacity gaps. Development of clinical vision for Urgent and Emergency Care	Improvement against strategic metrics Suite of performance metrics and benchmarking % of patients in Emergency Department >12 hrs (Total Time) Reports produced by ECIST IMPOWER and Improvement Consultants Breaking the cycle updates (as delivery of the clinical vision) A revised 4hr transit target of 76% agreed nationally and improvement trajectories being confirmed.	Gaps in Early Warning Dashboard Pathway 1 capacity admission avoidance impact, waits and capacity for primary care. Clear Treatment plans for P0 patients to support exit. Assurance in regard to Bed closure plan.	LHCC Programme Board reviewing Early Warning Dashboard - additional reports on progress. The System have now adopted SHREWD as the method of actual position and early warning LHCC Programme Board reviewing progress Weekly CEO Forum review where evidence is and any gaps supplemented with twice weekly CEO and COO calls.	Finance, Performance and Estates Committee	**Red**
						Urgent Care Recovery Improvement Steering Group which oversees a programme of work linked to increase capacity, flow and discharge through the Trust Wide Emergency Departments, Urgent Treatment Centres and Same Day Emergency Care Breaking the cycle pilot has now ended and lesson learnt document shared and agreed recommendations for embedded changes agreed at UCRIG	Large complex programme which required system working to reduce pathway 0 waits and deliver right care right time principals	Large programme of work so additional resource has been provided through a consultancy Impower & ECIST to assist in identification of areas to improve and on the ground support	Metrics dashboard developed for discharge and flow linked to bed reductions trajectory	Data metrics to demonstrate impact on of the interventions is being developed. There is a risk to the delivery of non-elective length of stay target and increase in daily discharges due to the reliance of other specialties and external agencies outside of the control of the hospital There is a risk that winter pressures and will outstrip length of stay and occupancy gains preventing delivery of discharge/ bed closures.	Reporting through Urgent Care Improvement& Recovery Steering Group and Improvement Steering Group monthly		
						Recovery Support Plans	Risk of further waves, increased emergency demand and covid related sickness	Urgent and Emergency Care Board.			Daily review via Capacity and performance meetings Weekly reporting to ELT Fortnightly reporting to TLT		

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						Meet all National asks for performance, set out in the planning guidance, for non-elective care							
						Maximisation of capacity and efficiencies to reduce waiting times in ED and support discharge processes, ensuring services are provided within timeframes which are safe and responsive, enabling a reduction in length of stay/bed occupancy			Trajectories for all specialties in place, weekly position statements offered to ELT and TLT				
						Development of plans for seven day working, across all of our services							

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SO4	**To implement new integrated models of care with our partners to improve Lincolnshire's health and well-being**												
4a	Establish collaborative models of care with our partners	Director of Improvement and Integration	Failure of specialty teams to design and adopt new pathways of care Failure to support system working Failure to design and implement improvement methodology Operational pressures and other planning priorities puts an added constraint on time, capacity and headspace to engage with the ICS agenda. Thus, being unable to fully support system working and play an active role in the development of the Provider Collaborative. Challenge to get wider organisation and partner engaged in enhancing our collective roles as Anchor institutions		CQC Caring CQC Responsive CQC Well Led	Supporting the implementation of new models of care across a range of specialties	Specialty strategies not in place	Requirement for specialty strategies now part of strategy deployment and will commence Q1 22/23	Reports -ELT / TLT -Committees -Board -System	No plan of how the speciality strategies will be developed	New Improvement programme framework aligned to the CIP framework is being developed. Draft Heat Map is almost complete to support the identification of priority specialities for service reviews by July 2022. Heat Map finalised and used to identify the Specialties that were to be prioritised first for Specialty Review. Initial 17 data packs completed in readiness for Specialty Reviews during Feb/Mar 2023. Pilot within Cardiology undertaken in Nov 2022.	Finance, Performance and Estates Committee	**Amber**
						Implementing the Outstanding Care Together Programme to support the Organisation to focus on high priority improvements in 22/23- (1) continued improvements in patient safety and experience (2) reduce long waiting times for treatment (3)make our people feel valued and supported by improving our culture and leadership	Embedding and sustaining cultural change when we remain operationally challenged with staffing issues etc. Ability to demonstrate quick impact on the cultural change due to various interventions as part of our Outstanding Care Together programme will be limited (as these are multi year/multi factorial projects)	ELT/TLT oversight Board / system reporting	Updated IIP reported at relevant Board Committees	Impact of Outstanding Care together programme on any of the key deliverables	Outstanding care together programme is being refreshed as part of the IIP year 3 refresh - completed. Year 4 IIP under development and due to be completed within Mar 2023 following a robust Business Planning Session in Q4 of 2022/23 (including Divisional IIP completions).		
						Lead the Lincolnshire ICS and Provider Collaborative as an Anchor Institution and play an increasing leadership role within the East Midlands Acute Services Collaborative	Governance arrangements for Provider Collaborative, Integrated Care Board still in development Clarity on accountability of partners in integration/risk and gain ULHT anchor organisation plan not yet in place Wider regional governance to provide East Midlands oversight of population need and outcomes not yet finalised (via East Midlands Acute Provider Collaborative (EMAP)) ULHT have not embedded a culture of contributing towards population health across the whole organisation and a further understanding of health inequalities and mitigating actions.	Map key stakeholders and priorities for a partnership strategy focussing on addressing health inequalities and prevention Board and senior leadership team sessions on understanding the new ICS landscape and ULHT role within this Scope what a good effective partnership look like. Stakeholder mapping & engagement plan. Develop appropriate comms for the Lincolnshire ICS and our provider collaborative Agreements to support the development of the Provider Collaborative have been designed and shared. The Provider Collaborative is undertaking a stock take of services.	ULHT anchor institution plan Risk and Gain share (provider collaborative) Early Warning Discharge Indicators/development a common set of agreed metrics for flow and discharge across the system ICB delegation agreement ULHT Partnership Strategy	A better understanding of effective partnerships and what good looks like Clarity around role/accountability of partners within the Provider Collaborative Clarity around system improvement plan and provider collaborative plan and what outcomes each seeks to achieve Shared understanding and implications of the early warning discharge indicators, risk and gain share agreement within ULHT	Part of the refreshed IIP Reporting processes Regular updates to ELT/TLT/TB on Provider Collaborative, Health Inequalities, EMAP and our ICS Evidence and intelligence gathered from Service Reviews, Business Planning, Population Health and all other aspects of work will be pulled into this strategy to support the wider considerations of partnership working and future opportunities (commercial and non-commercial) The process of building the Trust Clinical Strategy has commenced taking information from Specialty Reviews to inform accordingly, and building on outputs from the Business Planning process.		

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						Gain a greater understanding of the Lincolnshire population and support a reduction in health inequalities	Core20PLUS dashboard not yet developed	Development of Core20PLUS dashboard by June 2023	Core20PLUS dashboard	Core20PLUS dashboard not yet developed	Dashboard due to be in place by June 2023		
						Establishment of the Tobacco Cessation service to proactively support better health for the Lincolnshire population	Staff not yet in place to deliver and lead service	Job descriptions being job matched to support mobilisation by August 2023	Service mobilisation of Tobacco Cessation serivce	Service not yet mobilised	Job descriptions being job matched to support mobilisation by August 2023		
						A Joint Forward Plan by June 2023 and continued utilisation of Joint Strategic Needs Assessment (JSNA), population health data from Optum and the health and wellbeing strategy, to influence our collective approach	Final plan not yet in place	Plan being considered by relevant Boards priro to sign to off, expected July 2023	Plan to be considered in Chief Executives Group and formally to the Board	Final plan not yet in place	Plan being considered by relevant Boards priro to sign to off, expected July 2023		
						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		

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						Developing a business case to support achievement of University Hospital Teaching Trust Status	R&I Team require investment and growth to create sustainable department	The case of need was approved at CRIG (September 2021) and now needs to return to CRIG as FBC. R&I team working closely with Strategic Projects to develop full business case for the growth of R&I department.	Progress with application for University Hospital Trust status R&I Team reporting in to ULHT Hospital Steering group as key stakeholder. Upward report to P&OD Committee	Further understanding of the costs involved to increase size of R&I department and also to develop an R&I facility	R&I team reworking business case with a phased approach		
						Shared understanding and implications of the UHA guidance and identify relationship management of key stakeholders nationally (DH, UHA) Agree contract with UOL, R&I team to Increase the number of Clinical Academic posts	With the criteria change in June 2021 we are no require to demonstrated increase clinical academics by 20 and RCF funding worth £200k within the last 2yrs Further clarification and implications of the changed guidance on univ hospital status required. Funding for Clinical Academic posts and split with UOL to be agreed	Working through the potential options presented by the Medicine Clinical Academics pilot and understanding whether this can be deployed across other divisions. Monthly meetings with ULHT and Uni of Lincoln to discuss funding position	Contract agreed with UOL for Clinical academic posts. UoL have draft contracts and offer letters ready for use. Increase in numbers of Clinical Academic posts - linked to roadmap and Research Event to identify specialties. RD&I Strategy and implementation plan agreed by Trust Board Upward reporting and approval sought through TLT/ELT	Unknown financial commitment for the Trust	Monthly meetings with ULHT and Uni of Lincoln to discuss funding position - now amalgamated into the monthly Steering Group with ad hoc meetings between SRO's where needed to discuss funding for Clinical Academics. ULHT have a recruitment roadmap in place which will include some pump prime from vacancies. Additionally a joint Research Event is being planned for Q3 of 2022/23 with the University to identify future areas of collaboration with research and Clinical Academic recruitment. Event planned for Q3 of 2022/23 cancelled by the University as they wanted to review outputs from a previous event they hosted in August 2022 to understand if there was any potential alignments that could be made for onward joint collaborations.		
						Improve the training environment for students	Understanding of our offer of the facilities required for a functioning clinical academic department	Revision of the library and training facilities to ensure that facilities are fit for purpose for all staff who will require access to training facilities, library, ICT equipment to be able to perform their role. This will be aligned to the UHA Guidance, and will include those within UGME/PGME and access for Clinical Academics.	GMC training survey Stock check against checklist Internal Audit - Education Funding	Unknown timescales of completion	A new R&I group has been set up being led by Director of R&I/Deputy Medical Director, this will provide more oversight and rigor in developing an R&I agenda with representation from key stakeholders and clear milestones for delivery		
4b	Develop a strong professional relationship with the University of Lincoln (UoL) and the Medical School	Director of Improvement and Integration	Failure to develop research and innovation programme Failure to develop relationship with university of Lincoln and University of Nottingham Failure to become member of university hospital association		CQC Caring CQC Responsive CQC Well Led	Developing a joint research strategy with the University of Lincoln Develop a joint research strategy by September 2023, which identified shared research focus areas	A joint MOU is in place at a Lincolnshire System level as agreed in April 2022, and the Steering Group and ELT has agreed that this should be used as the overarching MOU, with a local version between ULHT and UoL created as we move forward and understand the finer details of the partnership. Draft priorities based on initial dialogue with vice dean of the medical school has been created, further work to develop UOL strategy is being undertaken.	Working closely with the University of Lincoln, monthly meetings. Through these meetings have completed first draft of the Joint Strategy.	RD&I Strategy and implementation plan agreed by Trust Board	Drafts in place which broadly cover joint research and teaching approach across the organisations, unable to outline in strategy financial commitment. UoL have refreshed their Research Strategy and as at end Oct 2022 ULHT are awaiting a copy of this to then align to joint strategy between the two organisations.	Monthly meetings with ULHT and Uni of Lincoln and through ULHT Steering Group	People and Organisational Development Committee	**Red**

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						Develop a portfolio of evidence to apply for membership to the University Hospitals Association	Evidence bound by UHA requirements	Portfolio of evidence is being captured and is available on the shared drive Identified leads to liaise with UHA CEO (Medical Director, ULHT and System Clinical Director/Chair PCN, Lincolnshire ICS)	Roadmap developed to identify required evidence for portfolio	Clear understanding of rigidity of UHA requirements Letter to CEO of UHA agreed at TLT on 15/09/2022 and being sent by IID Director to ask for meeting to discuss approach.	Discussions being held to clearly identify opportunity for movement within guidance and steps being taken for a name change application		
						Develop a strong professional relationship with the University of Lincoln and the Medical School and jointly create a strategy with a focus on developing rural healthcare, medical/nursing/AHPs/Clinical Scientists/R&I staff education and other healthcare roles	Evidence bound by UHA requirements Clear plan/strategy on development of medical/nursing/SHPs/Clinical scientists/R&I staff education roles	A new R&I group has been set up, being led by Director of R&I/Deputy Medical Director. We continue active stakeholder management with Medical Director of ICS and UOL VC.	ULHT healthcare roles plan Increased recruitment/academic posts (across ICS)	The change to the UHA Guidance (20xClinical Academics) is a challenge. Received further feedback from UHA and need to have at least 20 clinical academics remain unchanged.	Working closely with University of Lincoln to develop plans for recruitment of Clinical Academic posts with a view to maximising existing research relationships where possible. Two potential candidates have been identified for the Clinical Academic recruitment.		
						Successfully recruit 6 Clinical Academics							
						Improve research and innovation throuhg 4 collaborative research projects							
						Develop a joint future workforce plan for resources to enable development of future clinicla workofrce, including the trianing of principle investigators							

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4c	Successful delivery of the Acute Services Review	Director of Improvement and Integration	Limited capacity to hold regular scheduled ASR meetings with ULHT Divisional Teams due to ongoing operational pressures (Level 4, Major Incident etc).		CQC safe, CQC responsive, CQC well led	Develop a ULHT clinical service strategy with focus on fragile services in order to provide sustainable and safe services for the future Identify the key services to focus on for Clinical Service Review (taking into account CIP, benchmarking, GIRFT and other core data) Engage with services to develop plans as to how best to approach a clinical review, First Implementation Oversight Group meeting scheduled for September	Heat maps now drafted, with service reviews linked with improvement and clinical strategy development Divisional IIPs need to be completed to ensure links into fragile services/clinical service strategy Identify resources to implement ASR outcomes	Process being developed to identify services for review. This includes the development of a HEAT Tool to identify areas where services are not meeting targets, such as RTT, Cancer, Finance data. Initial discussions with divisions have been had with a view to ensure that the services most needing priority review are identified. Programme management support being identified via Provider Collaborative to help deliver ASR phase 1 Individual work streams to be established	Heatmap of fragility Plan for development of a clinical service strategy Health inequalities and core25 PLUS indicators Early Warning Discharge Indicators Rigorous engagement, both for feedback from the ASR review and further implementation	Evidence available but working on a process to bring together the information for services to aid the identification of the Top 5 areas for focus in 2022/23.	Part of the refreshed IIP Reporting processes HEAT Map for identification of services being created within Strategy & Planning at TLT on 13/10/22 for review and sign off. Publish ULHT clinical service strategy end of 2022/23 Working with Divisions to identify ASR implementation requirements with draft outline plans in place for Orthopaedics and Stroke. Stroke Capital/Estates Group meetings now diarised and being led by the Business Case Team. Orthopaedics ASR taken to HOSC in Dec 2022 and confirmed as complete through ULT upward reporting. Stroke ASR are working on a 'Perfect Week' to further progress and have commenced relevant staff consultation processes required.	Finance, Performance and Estates Committee	**Amber**
						Establishment of a rolling programme of service reviews, with 12 completed in year	Sign off of specialty review strategies and governance route not yet known	To be agreed with ELT, July 2023	Signed off specialty reviews	Governance route not yet established	Agreement of governance through ELT		
						Play an increasing leadership role within the East Midlands Acute Provider Collaborative to develop key partnerships							
						Build a Partnership strategy to support improvements in safe and sustainable care, and harness benefits for the population of Lincolnshire							

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

Red	Effective controls may not be in place and/or appropriate assurances are not available to the Board
Amber	Effective controls are thought to be in place but assurances are uncertain and/or possibly insufficient
Green	Effective controls are definitely in place and Board are satisfied that appropriate assurances are available

United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*20 June 2023*
Item Number	*Item 13.3*

Audit Committee Upward Report

Accountable Director	*Neil Herbert, Audit Committee Chair*
Presented by	*Neil Herbert, Audit Committee Chair*
Author(s)	*Jayne Warner, Trust Secretary*
Report previously considered at	*N/A*

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

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

Recommendations/ Decision Required	• *Ask the Board to note the upward report and the recommendation to approve the annual accounts and annual report*

Executive Summary

The Audit Committee met via MS Teams on the 20th June 2023. The Committee considered the following items:

Internal Audit

The Committee received the final reports relating to the 2022/23 Internal Audit Plan. This completed all work planned for the year. The Trust received significant assurance with some improvement required for the Clinical Governance Follow Up review and the Core Financial Controls Host Ledger review. The Host Payroll report gave partial assurance and the Committee noted that the incumbent Internal Audit providers would conduct a full review and provide more details assurance in this area.

The Committee received the final Annual Internal Audit Report including the Head of Internal Audit Opinion for 2022/23. The Internal Audit Provider recognised that the Trust had directed the planned work to areas of risk. The basis of the opinion was the design and operation of the Board Assurance Framework and supporting processes, assessment of the individual assurances from audit reports and the extent to which audit recommendations had been responded to. The Opinion gave an overall rating of Partial Assurance with Improvement Required. The Internal Auditor highlighted to the Committee the improvements made within the triangulated opinion and the Trust had moved closer to achieving significant assurance with the improvements made to the control environment.

The Committee thanked the outgoing Internal Audit Team from Grant Thornton for their work throughout the contract period.

External Audit

The Committee received the External Audit Completion Report and the Auditors Annual Report. The Committee were advised by the External Auditor that there had been no significant issues identified and that the Trust had been given an unqualified Internal Audit Opinion.

The Committee were advised that the audit had produced one medium rating internal control recommendation which related to a vesting certificate. The Trust had responded adding that this was an isolated issues and action had been taken around the use in future.

The External Audit provider commended the team for the way they had responded to the process. The Committee were advised that the audit process recognised the positive steps being taken by the Trust and that some of the remaining issues were systemic. It was noted that these were clearly captured within the Board Assurance Framework and that the Board were sighted on the challenges faced.

The Committee received the Audit Completion Report.

Annual Accounts and Annual Report 2022/23

The Committee received and recommended to the Board for final approval the Annual Accounts and Annual Report.

It was noted that the Committee had spent some time outside of the Committee meeting completing a page turn exercise.

Draft Internal Audit Plan 2023/24

The Committee received the latest version of the proposed Internal Audit Plan, recognising the challenges that had been encountered as the contract was awarded to a new provider.

The Committee Chair asked for an adjustment to be made to allow for a review of procurement as this had been raised as an area in which the Board would like to seek further assurance.

The Internal Audit Providers advised that the plan could be kept under review during the year and flexed to meet the needs of the organisation. The reviews planned for the early part of 2023/24 were approved and the final version of the plan would be presented to Committee in July.