Bundle LCHG Board Meeting in Public Session 2 July 2024

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

1 Introduction, Welcome and Chair's Opening Remarks
Chair

2 Public Questions
Chair

3 Apologies for Absence
Chair

4 Declarations of Interest
Chair

5 Minutes of the meeting held on 7th May 2024
Chair

Item 5 LCHG Public Board Minutes May 2024

5.1 Matters arising from the previous meeting/action log
Chair

6 Group Chief Executive Report
Group Chief Executive

Item 6 Group CEO update public board 2 July 2024

6.1 Infected Blood Inquiry
Chief Medical Officer

Item 6.1 Public Board July 2024 - Infected Blood Inquiry letter acknowledgement
Item 6.1 Appendix 1 Letter re Publication of the Infected Blood Inquiry final report_200524

7 BREAK

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

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

Item 8.1 Quality Committee in Common Upward Report May 2024
Item 8.1 Quality Committee in Common Upward Report June 2024v1

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

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

Item 9.1 POD - Upward Report - May 2024 v1
Item 9.1 POD - Upward Report - June 2024

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

10.1 Assurance and Risk Report from the Finance, Performance, People and Innovation Committee
Chair, Finance, Performance, People and Innovation Committee

Item 10.1 FPPIC Report to Public Board July 2024

10.2 Assurance and Risk Report from the Finance, Performance and Estates Committee
Chair, Finance, Performance and Estates Committee

Item 10.2 FPEC Upward Report May 2024v1
Item 9.1 FPEC Upward Report June 2024v1

11 Strategic Aim 4 - To collaborate with our primary care, ICS and external partners to implement new models of care, transform services and grow our culture of research and innovation
CIO/COO Update - Under Development

12 Strategic Aim 5 - To embed a population health approach to improve physical and mental health outcomes, promote well-being, and reduce health inequalities across an entire population
CIO/COO Update - Under Development

13 Integrated Performance Report ULHT/LCHS
Director of Finance and Business Intelligence/Director of Improvement and Integration
- Item 13 IPR Trust Board - Front page
- Item 13 IPR Trust Board June 2024
- Item 13 Frontsheet LCHS Integrated Performance Report
- Item 13 Appendix 1 Integrated Performance Report - May 2024 Data

14 Risk and Assurance

14.1 Group Risk Management Report
Director of Clinical Governance
- Item 14.1 LCHG Board Strategic Risk Report Exec Summary July 2024
- Item 14.1 LCHG Board LCHS Strategic Risk Report June 2024
- Item 14.1 Appendix 1 LCHS Risks
- Item 14.1 LCHG Board ULHT Strategic Risk Report - May-June 2024 (002)
- Item 14.1 LCHG Board ULHT Appendix A -Risks rated 15-25 June 2024

14.2 Board Assurance Framework
Trust Secretary/Deputy Director of Corporate Governance
- Item 14.2 LCHG Draft BAF 2024-25 Front Cover July 2024
- Item 14.2 Appendix 1 BAF

14.3 Assurance and Risk Report from the LCHS Audit Committee
Chair, Audit Committee
- Item 14.3 Audit Committee Report to Public Board July 2024
- Item 14.3 Appendix 1 - 2023-24 Annual Report of the Audit Committee

14.4 Assurance and Risk Report from the ULHT Audit Committee
Chair, Audit Committee
- Item 14.4 Audit Committee Upward Report June 24

15 Any Other Notified Items of Urgent Business

16 The next meeting will be held on Tuesday 3rd September 2024

EXCLUSION OF THE PUBLIC

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

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Hospitals NHS Trust

Minutes of the Public Board in Common Board Meeting

Held on 7 May 2024

Via MS Teams Live Stream

Present

LCHS
Voting Members:
Mrs Elaine Baylis, Group Chair
Mr Ian Orrell, Non-Executive Director
Mr Jim Connolly, Non-Executive Director
Miss Gail Shadlock, Non-Executive Director
Mr Andrew Morgan, Group Chief Executive
Professor Karen Dunderdale, Group Deputy Chief Executive / Executive Director of Nursing
Mr Sam Wilde, Director of Finance and Business Intelligence
Mrs Julie Frake-Harris, Chief Operating Officer
Dr Anne-Louise Schokker, Medical Director

LCHS
Non-Voting Members:
Mrs Rebecca Brown, Associate Non-Executive Director
Miss Claire Low, Director of People

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

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

In attendance:
Mrs Jayne Warner, Trust Secretary, ULHT
Ms Catherine Leggett, Deputy Director of Corporate Governance, LCHS
Dr Ciro Rinaldi, Deputy Medical Director, ULHT
Mrs Angie Davies, Director of Nursing, ULHT
Mrs Kathryn Helley, Director of Clinical Governance, ULHT
Mr Mike Parkhill, Director of Estates, ULHT

Mrs Rachel Lane, Trust Board Administration, LCHS (Minutes)
Ms Robyn Dalton, Midwife, ULHT (Item 2.1)
Ms Katy Carr, Ward Manager, ULHT (Item 2.1)
Ms Joana Leitao, Outpatient Clinical Service Manager, ULHT (Item 2.1)
Ms Fiona Warren, Theatre Practitioner, ULHT (Item 2.1)
Ms Sandy Crook, Play Leader, ULHT (Item 7)

Apologies
Professor Philip Baker, Non-Executive Director, ULHT
Mrs Vicki Wells, Associate Non-Executive Director, ULHT
Dr Colin Farquharson, Medical Director, ULHT

001/24	**Item 1 Introduction** The Chair welcomed Board members and members of the public, staff or interested parties who had joined the live stream, to the first public meeting of Lincolnshire Community and Hospitals NHS Group (LCHG) Board in Common, following a decision made for both Lincolnshire Community Health Services NHS Trust (LCHS) and United Lincolnshire Hospitals NHS Trust (ULHT) to come together in a Group Model arrangement to focus on improving collective service delivery.
002/24	As the meetings developed, the Chair was confident in public session, that the organisation would be able to demonstrate the benefits of integrating care to the population of Lincolnshire.
003/24	**Item 2 Public Questions** **Q1 from Vi King** **Please can I ask why peoples discharge letters are not being followed up correctly. When patients are getting their follow up appointments it is for four weeks through the portal with a different Consultant.** **After getting in touch with outpatients at Lincoln County Hospital to sort this it which was not helpful at all. The appointment was cancelled and was informed that a new one would be sent. Nothing was heard for a few days so fracture clinic at Grantham Hospital were contacted who were very helpful and tried to contact the secretary of the consultant.** **Finally the secretary rang, and an appointment was made for about 2 weeks. After looking into this concern it seems this happens very frequently. This is quite alarming especially the cost and the time that clinical staff are having to take time out of their role to sort these concerns out.**

	Please can I ask that this is rectified as soon as possible as this is not fair on the patients nor Consultants and clinical staff.
004/24	The Chief Operating Officer responded by thanking Vi for the question and agreeing that this was not good enough and it was important that all patients received the correct treatment prescribed by clinical experts. The information would help colleagues to think about how outpatient transformation work was focussing, and advised a large piece of work was being undertaken. This question would be relayed back to the team who were in the process of reviewing the way the follow up appointments worked, whilst remembering the individual patient need. New ways of working via the new outpatient hub would be commencing via this transformational work, which included patients being given all the relevant follow up information when they left their appointment.
005/24	**Item 2.1 Ward Accreditation** The Chair was pleased to be able to commence the Board meeting with the celebration of achievement of the provision of high quality, safe care through the awarding of ward accreditation.
006/24	Robyn Dalton and Katy Carr from Pilgrim Maternity Ward; Joana Leitao from Grantham Out-patients Department and Fiona Warren from Pilgrim Theatres were welcomed to the meeting to celebrate their achievements.
007/24	The Director of Nursing introduced the three teams who had successfully achieved the Silver and Bronze awards as part of the quality accreditation programme. Board members were reminded of the core requirements the departments were required to achieve against a range of quality indicators, in addition to presenting a portfolio of evidence to the Quality Accreditation Panel.
008/24	Colleagues described areas of improvement within their Wards or Department. Midwife Dalton explained that staff had been lacking confidence in wound care, for patients who had caesarean sections and following a team meeting it was agreed that there should be improved understanding of onset of infections and that wound care should better align. A review of wound care stock had been undertaken and condensed and a step-by-step guide had been produced. Tea trolley teaching covered all staff and the benefits had been far reaching. This was a vital service and expertise on wound infection training had left midwives feeling much more confident with basic wound care.
009/24	Postnatal re-admission rates had previously been increasing, however following the introduction of PCODE dressings and reaudits undertaken, this had shown that the postnatal readmission rate had reduced to 0.74% from 4.8%. Midwife Dalton was extremely proud of the work which had improved standards for women on the ward.
010/24	Clinical Service Manager Leitao explained that the out-patient team within Grantham Hospital were striving to achieve continuous service improvement with one area related to improving skin lesion assessment. This was within the dermatology clinic where patients often had to attend further appointments for adequate treatment and engage with different doctors and nurses. An option to implement a rapid review

	clinic was developed via the Business Unit which included three appointments all on the same day if treatment and surgery was determined to be required. This also reduced patient travel time and supported the reduction of the carbon footprint. The one stop clinic had now been introduced and was running efficiently. Clinical Service Manager Leitao offered thanks to Dr Schofield for being patient guided and passionate for delivering the best service for patients, and colleagues involved in this service.
011/24	Theatre Practitioner Warren explained that the team at Pilgrim Theatre were proud to have achieved a Bronze Accreditation and described details of quality improvement work surrounding care of deceased patients in theatres. There had previously been an inconsistent approach to paying final respects when patients passed away within the theatre environment and as such a comprehensive training package had been developed for all staff, including a checklist to ensure quality and consistency in the approach. A relatives room had also been developed to enable families to visit loved ones away from the theatre area. Theatre Practitioner Warren explained that this reflected the team values and the Trust's values of excellence, compassion, respect, safety and being patient centred. It was hoped that this would be rolled out across other theatres within the Trust.
012/24	The Chair thanked colleagues for their excellent examples of quality service noting that it was clear that patients were at the heart of each presentation.
013/24	Mrs Brown congratulated clinical colleagues for the excellent leadership and as maternity safety champion commented on the great achievement for maternity services. It was suggested that an article be produced from this piece of extended practice work within maternity. Mrs Brown also commented that Theatres and Outpatients were new areas to Ward accreditation and the teams had done an excellent job with their achievements and was humbled by the work that had been undertaken.
014/24	The Group Chief Executive commented that this was a good way to start a Board meeting, adding that it was good to hear from people who knew about services and clearly cared deeply about their patients and colleagues which had come across from all three services. The benefits to patients were impressive.
015/24	The Group Deputy Chief Executive / Executive Director of Nursing said that it had been good to hear a snapshot of a vast portfolio of improvements and was pleased with the achievements across maternity, theatres and outpatients and would welcome hearing of future developments within those areas.
016/24	The Chair endorsed comments received on behalf of the whole Board and added that the teams should be proud of their achievements. The Chair thanked colleagues for attending the meeting and for sharing their stories.
017/24	**Item 3 Apologies for Absence** Apologies were received from Professor Phillip Baker, Non-Executive Director, ULHT, Mrs Vicki Wells, Associate Non-Executive Director, ULHT and Dr Colin Farquharson, Medical Director, ULHT.

018/24	**Item 4 Declarations of Interest** There were no new declarations of interest.
019/24	**Item 5 Minutes of the meetings held on 5 March 2024 and 12 March 2024/ action log** The minutes of the ULHT Trust Board meeting held on 5 March 2024 were agreed as a true and accurate record, the minutes of the LCHS Trust Board held on 12 March 2024 were also agreed as a true and accurate record.
020/24	**Item 5.1 Matters arising from the previous meeting/action log** There were no outstanding matters arising.
021/24	**Item 5.2 Group Governance Arrangements** The Chair presented a paper which set out the governance arrangements for the first Public Board meeting between ULHT and LCHS and the current position. Following years of informal collaboration both organisations had agreed to form a Community and Hospital Group which became established on 1st April 2024, bringing the two organisations more closely aligned to enable further and faster working to improve patient care and more efficient use of patient resource.
022/24	The organisations had a shared Group Chief Executive and some Director roles and today marked the first meeting of both Boards together in public session. The Board would work on leading strategic delivery, overseeing performance and develop the cultures of both Trusts with a focus on improvement.
023/24	Sub-Committees of the Board would be brought together to promote greater constructive collaboration and learning across the Group and to strengthen assurance. A single Quality Committee had already been established and other Committees would be following suit. A single Audit Committee in Common would also be established as the work of the Group moved forward.
024/24	Each organisation would remain separate legal entities, under the leadership of the Chair and until work had been concluded, the Group Board would meet in line with Standing Orders and Standing Financial Instructions of each organisation in terms of quoracy and each individual Board member would retain their voting rights in line with this.
025/24	A new meeting cycle had been produced and the Lincolnshire Community and Hospitals NHS Group Board meetings in public session would be held on the first Tuesday of alternate months. Details of how to observe the meetings were documented on each Trust's website. Questions could also be posed from members of the public in advance of the meetings and details of how to do that were also available via the websites.
026/24	Meeting agendas would be structured around the Group aims and objectives and would be agreed by both organisations to provide a common agenda.

	The Trust Board: • **Noted the report**
027/24	**Item 6 Chief Executive Horizon Scan** The Group Chief Executive presented the report to the Board noting that from an operational perspective the NHS remained extremely busy; both organisations had developed good reputations for coping with pressures despite industrial action. The Group Chief Executive commented that Consultants had now agreed a pay deal with the Government, however Junior Doctors still had a mandate for strike action.
028/24	At the closedown of the 2023/24 financial year, the system had ended with a financial deficit of £19.5m against a planned deficit position of £12m. The variance had been due to the system not receiving the return of £7.5m surge funding from NHS England. Both LCHS and ULHT had delivered against their plans with LCHS ending the year with a larger surplus than anticipated.
029/24	There had been a focus over recent weeks on Operational Plans for 2024/25, both Trusts would be required to produce a plan as well as a requirement for a system plan, which had been submitted on 2nd May 2024. There had been considerable compliance with most operational targets expected for the system which had resulted in the submission of a financially breakeven plan for 2024/25. The Lincolnshire system had won considerable praise and generated confidence in reaching this position and the Group Chief Executive commended the good work from colleagues on this.
030/24	At the quarter four Quarterly System Review Meeting, the Lincolnshire system had been commended for strong operational performance over the past year and discussions had focussed on cancer, mental health targets, greater use of the NHS App, workforce figures and productivity resulting in a positive meeting.
031/24	The Group Chief Executive had recently attended an NHS CEOs leadership event where the focus had been on 2024/25 Operational Plans and the requirements around workforce hygiene factors including workforce productivity and resources, due to the significant growth in workforce numbers since the pandemic versus the return on investment. There had also been a session on the NHS Oversight Framework and how link with the Care Quality Commission (CQC) Assessment Framework.
032/24	Two Community Primary Partnership (CPP) events had been held and the next steps were being developed.
033/24	The Group had developed a 2024/25 Transition Strategy which pulled together strategic aims and objectives for the Group and was a continuation of work undertaken by both organisations in recent years. This would set out the future for the Group.
034/24	The Group Chief Executive informed those present that LCHS colleagues had recently been successful in a tendering exercise to provide sexual health services for Lincolnshire, North Lincolnshire and North East Lincolnshire.

035/24	The Group Chief Executive also took the opportunity to congratulate the Group Deputy Chief Executive / Executive Director of Nursing, who after a competitive interview process, had been appointed as the incoming Group Chief Executive and would commence in post on 1st July 2024.
036/24	The Chair thanked the Group Chief Executive for the comprehensive report. The Trust Board: • **Received the report and noted the significant assurance provided**
037/24	**Item 7 Patient/Staff Story** The Director of Nursing introduced the patient story to the Board noting this was a story about the introduction of a Kitten Scanner at Grantham Hospital, the first of its kind available within the Country which had been purchased via charitable funds. She also welcomed Play Leader Sandy Crook for this item.
038/24	A presentation had been shared with Trust Leadership Team members which outlined experiences for children when attending hospital for scans and provided reassurance when children were apprehensive. 70 children had so far, successfully had an MRI using this service since its launch in July 2023.
039/24	Board members heard of Phoebe's story who had been nervous when attending for an MRI scan, however the Matron and the Kitten Scanner had helped with the nervousness and enabling Phoebe to ask questions in advance and knew what to expect. Phoebe's father had commented that his daughter's experience had been made much better by offering this service and was extremely grateful to the staff members and the Charitable Funds Committee for being able to provide this equipment.
040/24	The Group Chief Executive asked if this could also be offered to nervous adults. Play Leader Crook explained that a booklet had been developed which outlined the journey for children and commented that it would be possible to adapt this for the benefit of adults.
041/24	As Chair of the Charitable Funds Committee, Dr Gibson said that there was further funding available for additional equipment to be provided and proposals could be submitted to the Committee. Dr Gibson asked if any problems with patient movement had been experienced in utilising this technology. The Play Leader explained that children often wriggled during the procedure however overall most children were very compliant once they felt safe.
042/24	The Chair thanked the Play Leader and colleagues for the work they had done to secure the kitten scanner and for utilising it in the ways described noting the positive view of the Board members.
045/24	The Chair offered thanks to the Play Leader for attending the meeting and to Phoebe and her father for allowing their story to be shared. Thanks were also expressed to

	the Charitable Funds Committee for providing the resource to support the purchase of a valued piece of equipment which would make a difference to younger patients. The Trust Board: • **Received the patient/staff story**
	Item 8 Strategic Aim 1 To Deliver high quality, safe and responsive patient services
046/24	**Item 8.1 Assurance and Risk Report Quality Committee in Common (inc MNOG appendices)** The Chair of the Quality Committee in Common, Mr Connolly, provided the assurances received by the Committee at the 19 March 2024 and 23 April 2024 meetings.
047/24	The Patient Safety Incident Response Plan had been submitted to the Board and had a commendation for approval from the Quality Committee in Common. Each organisations Quality Committee Annual Report for 2023/24 was also presented to the Board.
048/24	Key highlights from the Committee included Paediatric Audiology Services, the Maternity and Neonatal Oversight report which had received significant assurance and the Committee had noted the improvement journey for the service over several years which had moved from an amber to green rating. Mr Connolly explained that the Board would be aware of the Regional Heatmap where the maternity service offered by ULHT was first amongst all other services in the region and was testament to the work that had been undertaken. The Committee had also noted an increase in the number of safeguarding referrals and an increase in the workload of staff however reflected on the improvements in the leadership of the service.
049/24	Mr Connolly explained that the Board Assurance Framework (BAF) ratings had not changed since the last report had been presented and work continued in the development of the Committee. There would be a particular focus on risk and management from within the Committee from a Group and Trust perspective moving forward.
050/24	The Chair commented that the top position in the regional league for maternity services was an excellent achievement and noted that the incident response policy was comprehensive and had been well written. The Trust Board: • **Received the assurance report** • **Received the Maternity and Neonatal Oversight Group reports** • **Noted the 2023/24 Quality Committee Annual Reports for LCHS and ULHT**
051/24	**Item 8.2 Paediatric Audiology Service** The Director of Clinical Governance informed Board members that following an expert review undertaken by subject matter experts from the British Academy of

	Audiology, on behalf of NHS Lothian, failings had been identified in the standard of paediatric audiology services, resulting in delayed identification and missed treatment of children with hearing loss. Those findings had led to a review of Neonatal and diagnostic ABR services provided by NHS Trusts in England which found four with similar failings.
052/24	The Midlands region had established a paediatric audiology desktop review model and used this across the region which ULHT had participated with in full. The results had identified some gaps in documentation and audit processes at the Trust which had now been addressed. This had been upwardly reported to the Quality Committee in Common and to the Integrated Care Board (ICB) Quality Meeting and in response both the Trust and ICB had agreed the Trust's Paediatric Audiology Service met the required standards assessed by the Midlands desktop review and had been rated green.
053/24	The CQC had recently written to the Trust requesting that at the next Board meeting, consideration be given to the assurance available that children's hearing services were safe, accessible and effective and a report from the Board had been requested.
054/24	Assurance was provided to the Board that the process to achieve UKAS IQIPS (Improving Quality in Physiological Services) accreditation for paediatric audiology services had already commenced, the timescales for gaining accreditation were estimated to take between three to five years, due to the likelihood of building work being required to meet the relevant standards.
055/24	Dr Gibson asked if the IQIPS accreditation would be considered across other services. The Director of Clinical Governance responded that discussions were taking place and a similar exercise was being developed starting with a baseline assessment, despite there being financial implications to this it was anticipated that this could commence over the coming years.
056/24	Mrs Buik questioned whether waiting lists were longer than the Trust would like in relation to children's services and asked how the Trust would ensure health inequalities were not being unduly exacerbated. The Chief Operating Officer responded that the health inequality profile of waiting lists was a focal point since the pandemic with several areas of health inequalities linked through waiting lists. Within Lincolnshire it was fortunate that population health data linked through several parts of the system to be able to profile in the required way and supported optimising the patient's best health experiences. The Trust Board: • **Received the report and were assured that paediatric audiology services were safe, accessible and effective and endorsed the content of the report**
	Item 9 Strategic Aim 2 To enable our people to lead, work differently, be inclusive, motivated and proud to work within LCHG
057/24	**Item 9.1 Assurance and Risk Report People and Organisational Development Committee**

	The Deputy Chair of the People and Organisational Development Committee, Dr Gibson, provided the assurances received by the Committee at the 12 March 2024 and 16 April 2024 meetings.
058/24	The Committee had reviewed appraisal rates where there had been concerns regarding the percentage of appraisals completed within a timely manner. Assurance had been provided that the Trust would be moving to a more structured cycle of annual appraisals moving forward.
059/24	The Wellbeing Strategy had been received along with the detail of benefits offered to staff members.
060/24	An important anniversary was approaching in June 2024 when the first cohort of Lincolnshire Medical School students would graduate, which was noted as a major step forward for Lincolnshire and the Trust.
061/24	A report from the Equality Diversity and Inclusion Group had been received along with the Gender Pay Gap report.
062/24	Improved assurance had been received by the Committee under strategic objective 2b and it had been agreed to move this from an amber to green rating.
063/24	From a Teaching Hospitals perspective, under the leadership of Dr Rinaldi, Deputy Medical Director, information had been received in relation to new programmes of research.
064/24	At the April meeting concerns had been heard in relation to medical job planning and under achievement of targets and this would be added to the portfolio of the newly appointed Deputy Medical Director.
065/24	A draft workforce plan had been received which outlined an increase of circa 500 newly appointed posts, however assurance had been received that this related to the introduction of the Community Diagnostic Centres (CDC) and Electronic Patient Record (EPR). A report had also been received from the Freedom to Speak up Guardian and details were provided in relation to staff raising concerns however feeling unable to discuss issues with their manager. A plan had been shared for training to be undertaken so that it was clear individuals were approachable despite difficult circumstances.
066/24	Three clinical trials were taking place within the Trust, and there was early trial involvement of principle researchers planning and leading research.
067/24	The response to the Fuller report was received and a key action for the Trust was outlined to continue extending Disclosure and Barring Service (DBS) checks with positive progress being made. This would continue to be monitored at future meetings.
068/24	Dr Gibson drew attention to the Committee annual report for 2023/24 noting the positive year for the Committee and the changes in BAF ratings throughout were noted. Dr Gibson commented that this was testament to the leadership of the Director

	of People and OD and the team, Professor Baker for chairing the People and OD Committee meetings, and the strengthening of reporting from the groups beneath the Committee. Dr Gibson also drew attention to the improvement of the Trust's reduced vacancy, appraisal and turnover rates throughout the year.
069/24	The Chair highlighted the appraisal rates for Band 8 and above staff members, commenting that these remained low however noted that work was being undertaken on this via the Trust Leadership Team. In light of the 2024/25 Operational Plan the Chair also noted the strong focus on workforce and was pleased to see the Committee would be monitoring vacancy controls to ensure this was having the desired effect. The Trust Board: • **Received the assurance reports**
070/24	**Item 9.1.1 ULHT Gender Pay Gap Report** The Director of People and OD presented the ULHT Gender Pay Gap report and associated action plan noting that the position had improved by 1.9%, from a starting point of 14.9%. The action plan detailed the improvement work which would be undertaken.
071/24	The Chair expressed a view that the direction of travel was encouraging and that the action plan would be important moving forward. The Trust Board: • **Approved the Gender Pay Gap report**
072/24	**Item 9.1.2 ULHT Equality Delivery System Report** The Director of People and OD presented the ULHT Equality Delivery System report was received by the Board noting the three domain factors which had all achieved with an ambition to work towards an excelling rating. Several peer reviews had been undertaken across the Trust in support of the validation ratings. The Trust Board: • **Received and approved the Equality Delivery System report**
	Item 10 Strategic Aim 3 To ensure services are sustainable, supported by technology and delivered from an improved estate
073/24	**Item 10.1 Assurance and Risk Report from the LCHS Finance, Performance, People and Innovation Committee** The Chair of the Finance, Performance, People and Innovation Committee, Miss Shadlock, provided the assurances received by the Committee at the 28 March 2024 and 26 April 2024 meetings.
074/24	Miss Shadlock took the opportunity to thank the outgoing Chair of the Committee, Mr Murray Macdonald for his contribution to the meetings over several years, and for his

	rigour in terms of assurance and passion for health inequalities and wished him well in his new role.
075/24	The Committee received and approved the refreshed Terms of Reference noting that further updates would be required as a result of the new aims and objectives.
076/24	Strong performance had been received with four out of five elements of the financial plan and as a result there had been some reduction in financial risk scores.
077/24	The Committee reviewed and approved the 2024/25 budget and capital plans following delegated authority from the Trust Board. The Committee had some concerns regarding significant risks relating to the sizable CIP requirement and outstanding investment decisions.
078/24	The Committee received the Integrated Performance Report and had been informed that there were three indicators not statistically capable of achieving performance targets without redesign. These were home visiting, ethnicity recording in A&E data sets and the Better Payment Practice Code (BPPC). There were also two metrics showing signs of special cause deterioration, these were vacancy rates and operations centre calls answered within timescales.
079/24	A report from the People Executive Group outlined twelve areas reported on during the quarter, and all areas had received a green rating for assurance.
080/24	The Committee received assurance that the management of Health and Safety and Fire Safety was being supplemented by ULHT colleagues, alongside the ongoing relationship with LPFT. A workshop had also taken place to review next steps towards a Health and Safety Committee in Common which would align reporting into the Board and create improved oversight and assurance on risk and compliance areas.
081/24	The Committee Annual Report for 2023/24 was received by the Committee and offered to the Board.
082/24	The Group Deputy Chief Executive / Executive Director of Nursing requested additional information in relation to the strengthened assurance processes for health and safety and fire.
083/24	The Chief Operating Officer responded that since autumn 2023 there had been an increase in the level of concern around fire compliance at Skegness Hospital and work had commenced with Lincolnshire Fire and Rescue and NHS Property Services to ensure there was a robust action plan to ensure the facility met current and updated fire safety requirements. This had been managed weekly via an action log with confirmation offered that work was on track and risks were being reassessed. An update would be provided to the Committee at the next meeting where it was anticipated that the risk would reduce for fire for the Group. Learning was being taken across other sites to ensure there was the ability to support patients, staff and carers across the estate.

084/24	Mrs Brown commented that a deep dive on this subject had been received at the April Committee meeting and there had been assurance that this situation had been addressed well. The Trust Board: • **Received the assurance report** • **Received the 2023/24 Annual Report** • **Received and approved the ICS Financial Framework**
085/24	**Item 10.1 Assurance and Risk Report from the Finance, Performance and Estates Committee**
086/24	The Chair of the Finance, Performance and Estates Committee, Ms Cecchini, provided the assurances received by the Committee at the 21 March 2024 and 25 April 2024 meetings.
087/24	The Committee had received an update from Estates including the PLACE report showing a number of improvements and the final 6-facet survey reports which demonstrated some challenging costs to rectify infrastructure issues. An update was also offered on compartmentalisation work which had commenced within the Lincoln and Pilgrim Hospital sites. Fire door and fire alarm surveys had also been received which indicated required costs.
088/24	A report on lift status and impact on both staff and patients had also been received with the Committee noting the capital programme of works which would be dependent on affordability.
089/24	The British Safety Council had undertaken an audit across the Trust which had resulted in the achievement of a four-star rating for compliance against standards and work was underway to improve on this rating at the next audit.
090/24	The Trust had delivered its capital programme of £62.5m at the end of 2023/24 with Ms Cecchini taking the opportunity to thank finance, estates and operational colleagues for their support in delivery.
091/24	Escalation had been provided on Pilgrim Emergency Department (ED) delays in respect of high voltage work which would likely have a four - eight week delay in the programme and potential risks had been identified.
092/24	From a financial perspective the Trust had delivered the financial plan at the end of 2023/24. It was noted that inflationary pressures had not been funded however the Trust had achieved over delivery of the Cost Improvement Programme (CIP) by £6m, achieving delivery of £34.2m.
093/24	A Group Capital Plan for 2024/25 was anticipated at circa £90m and discussions would take place in respect of prioritisation of the programme and having the required resource in place to deliver the plan.
094/24	A report had been received from the Information Governance Group where three standards had not been achieved in respect of the Data Security Protection Toolkit

	(DSPT), compared to 5 the previous year. These were regarding improvement on the information asset database and multi-factoral authentication.
095/24	Regarding performance an improving picture was being seen however this was not yet being sustained within SPC charts.
096/24	There had been positive improvement in the 12-hour ambulance waits and the four-hour A&E target with the Trust achieving close to 73% against a 76% target.
097/24	An update had been received from East Midlands Acute Providers in relation to fragile services and deep dives had also been received for out-patients and stroke implementation programmes of work which would continue into 2024/25.
098/24	The Committee Annual Report for 2023/24 was also presented and Ms Cecchini highlighted an error in BAF rating 3c which ended the year on an amber, rather than red rating as stated within the report.
099/24	The Chair thanked Ms Cecchini for the comprehensive report and drew attention to the achievement of the capital programme. In relation to capacity, this would be revisited and addressed in due course. The Trust Board: • **Received the assurance report**
	Item 11 Strategic Aim 4 – To collaborate with our primary care, ICS and external partners to implement new models of care, transform services and grown our culture of research and innovation
100/24	No items.
	Item 12 Strategic Aim 5 – To embed a population health approach to improve physical and mental health outcomes, promote well-being and reduce health inequalities across an entire population
101/24	No items
102/24	**Item 13 Integrated Performance Reports** The Director of Finance and Business Intelligence presented the LCHS Integrated Performance Reporting highlighting overall improvements in sickness absence, which were achieving targets of 3% for short term and 5% for long term absence. All other areas had been reported on as part of the Finance, Performance, People and Innovation Committee assurance report.
103/24	The Director of Improvement and Integration presented the ULHT Integrated Performance Reporting noting the overall assessment level remained as moderate however reflected that the current position had improved compared to previous years.

104/24	The Chair commented that there would be a requirement to move to a joint Integrated Performance Report as soon as practicably as possible. The Trust Board: • **Received the Integrated Performance Reports noting the moderate assurance**
	Item 14 Risk and Assurance
105/24	**Item 14.1 Group Risk Management Report** The Director of Clinical Governance presented the monthly risk report to the Board noting that there had been several changes since the last update, which was a positive sign and demonstrated that the risk register was being used as a living document.
106/24	From a ULHT perspective, one Quality Committee in Common risk had increased to a very high risk and three had reduced to moderate. From a People and OD Committee perspective there had been a reduction in some risks, with one being closed and from a Finance Committee perspective two risks had closed, one relating to the AIR plant at LCHS. One new risk had also been added to the Risk Register.
107/24	From an LCHS perspective, there had been one change to a risk surrounding treatment room capacity which had increased in score to 16 from 12 and was now a significant risk. The Trust Board: • **Accepted the risks as presented noting the significant assurance**
108/24	**Item 14.2 Board Assurance Framework** The Trust Secretary presented the report noting that this had been considered by all Committees during March and April 2024. The People and OD Committee had recommended the movement of strategic objective 2b from amber to green, all other ratings remained unchanged as at the end of 2023/24.
109/24	Moving forward a draft framework for the Group was being developed and would be tested through Committees in May and June 2024.
110/24	The Deputy Director of Corporate Governance presented the LCHS report noting that this had been considered by all Committees during March and April 2024. Approval was sought on March ratings and for the closure of the 2023/24 Board Assurance Framework as presented. The Trust Board: • **Received the reports noting the moderate assurance** • **Approved the closure of 2023/24 Board Assurance Frameworks**
111/24	**Item 14.3 Assurance and Risk Report from the ULHT Audit Committee**

	The Chair of the ULHT Audit Committee, Mr Herbert, provided the assurances received by the Committee at the 26 April 2024 meeting.
112/24	An update had been received regarding Group governance arrangements and the progress made was noted.
113/24	The year end audit of Trust accounts was on track ahead of formal sign off in June with the draft accounts to be reviewed informally by the Committee during May. Proposed accounting policies had been received and approved and the accounts were being prepared on a going concern basis.
114/24	A progress report had been received from the Internal Auditors which provided significant progress made against plan with seven reports were received for review. The draft Head of Internal Audit Opinion also offered reasonable assurance.
115/24	The draft Internal Audit Plan for 2024/25 was received and approved with the Committee noting that timescales could be flexed as appropriate.
116/24	The Committee received and noted the Counter Fraud Plan and reviewed and approved the updated policy and the Local Counter Fraud Specialist was thanked for the work undertaken in this area.
117/24	The Committee considered the compliance report and noted the ongoing issues in respect of the volume of payroll overpayments, which were being monitored by the People and OD Committee, and the difficulties in implementing the required improvements in Information Governance which could result in action from the Information Commissioner.
118/24	The Committee received the final annual reports from the Assurance Committees which were noted by the Committee and would support the production of the Annual Governance Statement.
119/24	An update was received on overdue policies and guidelines, and it was noted that there was a trajectory for all divisions and progress would continue to be monitored by the Committee.
120/24	The Board Assurance Framework had been presented and objective 2c had been reviewed relating to well led. Progress was noted and with respect to Internal Audit and Counter Fraud along with the early signs of traction with policies and guidelines and the amber rating was reaffirmed for well led.
121/24	The Chair highlighted the improvements made in relation to Internal Audit and the early indications for policies and guidelines and thanked Mr Herbert for the leadership provided in these areas. The Trust Board: • **Received the assurance report**

122/24	**Item 14.4 Delegation of LCHS Governance Arrangements to Committees** The Deputy Director of Corporate Governance presented a report which outlined the arrangements for the Board to delegate authority to Committees in Common relating to the Register of Seals report, which would be delegated to the Audit Committee and the Freedom to Speak Up Guardian six monthly report which would be delegated to the Finance, Performance, People and Innovation Committee.
123/24	The LCHS 2023/24 Register of Seals report was also received by the Board which highlighted the use of the Trust Seal on four occasions. The Trust Board: • **Approved the 2023/24 Register of Seals** • **Approved the Delegations to Committees as outlined**
124/24	**Item 15 Any Other Notified Items of Urgent Business** The Chair informed those present that this would be the Group Chief Executive's final Board meeting, as he prepared to leave the Group on 30th June 2024. The Chair took the opportunity to thank him for his NHS service over 42 years outlining that he had joined the NHS in 1982, and during that time had held over 19 positions across 14 organisations in a range of different roles. In that time, the Chair commented that the Group Chief Executive had observed dedication and commitment in a way which had personally impacted on the lives of thousands of people, and he was a living example of the values of the NHS, being a strong advocate for those who required treatment.
125/24	When the Group Chief Executive commenced his role as LCHS Chief Executive in 2014 he established the values and behaviours of the LCHS Way which continued to stand the test of time and introduced a Trust wide Development Programme which led to positive culture change, this being a contributory factor to LCHS being awarded a CQC "outstanding" rating in 2018. In 2019 the Group Chief Executive took on the interim Chief Executive position at ULHT which become permanent and demonstrated testament to his personal resilience, as at that time the Trust had been placed in special measures and had been in a difficult and challenging position. Hard work and determination had resulted in the Trust exiting special measures in 2021 with the most recent CQC assessment receiving a good rating.
126/24	The Group Chief Executive had led ULHT through the pandemic and provided visible leadership, support and health and wellbeing during unprecedented times, being instrumental in the introduction of the Grantham green site for the most vulnerable patients in Lincolnshire.
127/24	In summary, the Group Chief Executive would leave the Group in an improved position, with an infrastructure benefitting patients and staff members and under his leadership had established new models of service delivery which would benefit the population. The Chair commented that it had been a pleasure to work with the Group Chief Executive over the last nine years and added that he was a true, consistent, authentic professional whose values were a shining example to all and on behalf of both Boards she thanked him for his exemplary and long service to the NHS, people and the county of Lincolnshire and she wished him well for the future.

128/24	The Group Chief Executive responded explaining that he had thoroughly enjoyed his 42 years NHS service and that he would leave both organisations in a better place than inherited. He added his delight that the Group Deputy Chief Executive / Executive Director of Nursing would be taking on the Group Chief Executive position, and he was sure she would be a success. He also offered his thanks to the Board for their friendship, support and encouragement.
129/24	The next scheduled meeting would be held on Tuesday 2 July 2024 via MS Teams live stream

Voting Members	**7 May 24**											
Elaine Baylis	X											
Andrew Morgan	X											
Karen Dunderdale	X											
Ian Orrell	X											
Jim Connolly	X											
Gail Shadlock	X											
Chris Gibson	X											
Philip Baker	A											
Neil Herbert	X											
Rebecca Brown	X											
Dani Cecchini	X											
Julie Frake-Harris	X											
Colin Farquharson	A											
Sam Wilde	X											
Anne-Louise Schokker	X											

Group Chief Executive's Report

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Hospitals NHS Trust

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*1 July 2024*
Item Number	*Item number 6*

Group Chief Executive's Report

Accountable Director	*Karen Dunderdale, Group Chief Executive*
Presented by	*Karen Dunderdale, Group Chief Executive*
Author(s)	*Karen Dunderdale, Group Chief Executive*
Recommendations/ Decision Required	*The Board is asked to note the update.*

Purpose

System Overview

a) All parts of the system remain busy, but good work continues in order to cope with the ongoing operational pressures. Planning is underway for industrial action by our junior doctor colleagues, following the outcome of the BMA ballot which extends the strike mandate until 19th September. This round of industrial action will take place from 7am on 27 June until 7am on 2 July.

b) The industrial dispute involving Consultants has been resolved after the most recent pay offer by the Government was accepted. Work is now underway at a national level to implement the outcome of this pay deal.

c) The 2024/25 system operational plan for Lincolnshire has now been submitted. This was followed by a meeting with the National team on 21 May about the system plan. This was received well by NHS England.

d) The All Parliamentary Committee on Birth Trauma was published on 13 May. ULHT has completed a benchmarked exercise against this and is compliant with most aspects of the recommendations and has specific plans and mitigations in place for Perinatal Pelvic Health services.

e) The Infected Blood Inquiry report was published on 20 May and all ICBs and Trusts received a letter from NHS England with a public apology from Amanda Pritchard, as well as setting out the steps being taken in response.

Group Overview

a) A) I commenced in the role as the substantive Group CEO yesterday (1 July). I would like to formally thank Andrew Morgan for all his support, in particular over the last few months since my appointment, which has led to a smooth transition between us. I have spent the last month recruiting to all the Group executive board level roles and will be pleased to announce the appointments made in due course.

b) The ULHT part of the Group has been successfully identified as one of the pilot sites for Marthas Rule.

c) The Group celebrated National Volunteers Week in early June, where events and awards were held to recognise the more than 270 people who have between them given over 40,000 volunteering hours to the two organisations since April 2023.

d) Three NHS teams which help to improve safety, culture and care experiences for patients in Lincolnshire have been shortlisted in this year's Health Services Journal (HSJ) Patient Safety Awards. This includes ULHT being shortlisted in the Patient Involvement in Safety category for a programme to introduce a Patient Safety Partner role across the Trust. LCHS joined with Health Innovation East Midlands for a joint entry that has also been shortlisted, recognising Lincolnshire's transforming wound care project in the Community Care Initiative of the Year category. In addition, NHS Lincolnshire ICB's Elective Activity Coordination Hub (EACH) team has been shortlisted in the Patient Safety in Elective Recovery category.

e) The Group celebrated National Estates and Facilities Day in late June, recognised the more than 1,100 estates and facilities colleagues who work behind the scenes to keep our hospitals, community settings and GP surgeries running.

f) ULHT part of the Group continues to await the outcome of its application for Teaching Hospital status.

United Lincolnshire Hospitals NHS Trust

Meeting	*Lincolnshire Community and Hospitals Group Board meeting*
Date of Meeting	*2nd July 2024*
Item Number	*6.1*

Infected Blood Inquiry

Accountable Director	*Medical Director*
Presented by	*Dr Colin Farquharson, Medical Director*
Author(s)	*Clare Frank, Business Manager to the Medical Director / Colin Farquharson, Medical Director*
Report previously considered at	*N/A*

How the report supports the delivery of the priorities within the Board Assurance Framework	
1a Deliver high quality care which is safe, responsive and able to meet the needs of the population	
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	
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	*X*
4b Becoming a university hospitals teaching trust	*X*
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	*Insert detail*
Assurance Level Assessment	*Insert assurance level* • *Significant* • *Moderate* • *Limited* • *None*

Recommendations/ Decision Required	• *To acknowledge receipt of the letter* • *To await further recommendations / actions from NHS England*

Executive Summary

Publication of the Infected Blood Inquiry final report

The Government has published the final report into the National Infected Blood Inquiry – which can be found on the website www.infectedbloodinquiry.org.uk/reports.

As a consequence, NHS England have sent the enclosed letter to all NHS Integrated Care Systems and Trusts. The Trust / Group acknowledges receipt of this letter, and will await future recommendations and actions from NHS England in due course.

The Medical Director has already issued a statement regarding the inquiry, and that the Trust remains committed to continual improvement in the care and support offered to those who utilise our services, include learning from the experiences of those involved in these impactful historical events.

To:
- All integrated care boards and NHS trusts:
  - chairs
  - chief executives
  - medical directors
  - chief nurses
  - chief operating officers
  - chief people officers
  - heads of primary care
  - directors of medical education
- Primary care networks:
  - clinical directors

cc.
- NHS England regions:
  - directors
  - chief nurses
  - medical directors
  - directors of primary care and community services
  - directors of commissioning
  - workforce leads
  - regional heads of nursing
  - regional heads of communications

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

20 May 2024

Dear colleagues,

Publication of the Infected Blood Inquiry final report

Earlier today, the Infected Blood Inquiry published its final report at: www.infectedbloodinquiry.org.uk/reports. The Prime Minister has subsequently issued an apology on behalf of successive Governments and the entire British state.

On behalf of the NHS in England, now and over previous decades, Amanda Pritchard issued a public apology, saying:

“Today’s report brings to an end a long fight for answers and understanding that those people who were infected and their families, should never have had to face.

“We owe it to all those affected by this scandal, and to the thorough work of the Inquiry team and those who have contributed, to take the necessary time now to fully understand the report’s conclusions and recommendations.

“However, what is already very clear is that tens of thousands of people put their trust in the care they got from the NHS over many years, and they were badly let down.

“I therefore offer my deepest and heartfelt apologies for the role the NHS played in the suffering and the loss of all those infected and affected.

“In particular, I want to say sorry not just for the actions which led to life-altering and life-limiting illness, but also for the failures to clearly communicate, investigate and mitigate risks to patients from transfusions and treatments; for a collective lack of openness and willingness to listen, that denied patients and families the answers and support they needed; and for the stigma that many experienced in the health service when they most needed support.

“I also want to recognise the pain that some of our staff will have experienced when it became clear that the blood products many of them used in good faith may have harmed people they cared for.

“I know that the apologies I can offer now do not begin to do justice to the scale of personal tragedy set out in this report, but we are committed to demonstrating this in our actions as we respond to its recommendations.”

The report is sobering reading, documenting failings over multiple decades, and making recommendations across a wide range of areas, including recognition, support and compensation; education and training; monitoring of and testing for Hepatitis C; the safety of blood transfusions; preventing future harm, via duty of candour and regulation; as well as giving patients a voice.

We write now to set out the initial steps we are taking in response.

Support for those affected

The Department of Health and Social Care is providing £19 million over five years to provide a bespoke Infected Blood Psychological Support Service which is expected to be rolled out later this summer.

We have listened to the experiences of those involved, including patients, their families and staff, and are working with them to design and develop this service, which will provide dedicated support for those affected, located around the country.

This service will include talking therapies, peer support, and psychosocial support, as well as access to other treatments or support for physical or mental health needs where appropriate.

In the interim, the existing England Infected Blood Support Service remains available here: www.nhsbsa.nhs.uk/england-infected-blood-support-scheme.

Further information about existing testing and support services, including those commissioned by the Government, can be found at: www.nhs.uk/infected-blood-support.

Supporting affected staff

It is important to also recognise that some of our colleagues may be affected by the publication of today's report in some way, whether through personal or professional connection to the issue.

Employers may therefore wish to increase promotion of their local health and wellbeing support for staff. Details of nationally-commissioned routes of support, including the 24/7 text helpline Shout and NHS Practitioner Health, can be found at NHS England - Support available for our NHS People.

Continuing to find and treat people with blood-borne viruses

Although it is likely that the majority of those who were directly affected have now been identified and started appropriate treatment given the time that has elapsed since the last use of infected blood products, there may be people who have not yet been identified, particularly where they are living with asymptomatic Hepatitis C.

We ask that systems continue to work with partners, including community groups and charities, as well as Hepatitis C Operational Delivery Networks, to promote local testing options for anyone at risk, or anyone who is concerned. This should include promotion of the new national service for at-home Hepatitis C self-testing kits, available via hepctest.nhs.uk.

For those who are concerned about the risk of HIV infection, further information can be found here: information on HIV diagnosis and the HIV testing services search tool.

Hepatitis B, another infection that can be linked to infected blood, usually clears up on its own without treatment; however, people concerned about Hepatitis B infection should be directed towards relevant hepatitis B information or their local sexual health clinic or GP practice.

Today's report highlights that in some cases those affected by infected blood products were told of their diagnosis in ways which were insensitive and inappropriate. We would therefore ask you to ensure that patients and their families are supported through the process of receiving test results – of whatever kind - in a compassionate and considerate way.

Ensuring patients can access the right information.

We recognise following the publication of this report, some patients may raise questions directly with their primary and/or secondary care teams, or through other points of contact with the NHS. We will be sharing materials with relevant service providers to ensure frontline clinicians and other colleagues in patient-facing roles are able to provide appropriate information or signposting.

We expect that this will be particularly relevant to:

- Providers of NHS 111 services
- GP practices and community pharmacies
- Trusts providing services where blood products are used
- Mental health providers

Maintaining confidence in current blood and blood products and related treatment

The infected blood and blood products that have been the subject of this Inquiry were withdrawn in 1991. In the intervening decades, comprehensive systems have been put in place to ensure the safety of both donors and recipients of blood and blood-derived products.

Today, blood and blood products are distributed to NHS hospitals by NHS Blood and Transplant (NHSBT), which was established in 2005 to provide a national blood and transplantation service to the NHS. NHSBT's services follow strict guidelines and testing to protect both donors and patients.

NHS Blood and Transplant has published clear information about these processes here: Infected Blood Inquiry - NHS Blood and Transplant (nhsbt.nhs.uk).

Nationally, NHS England will work with NHS Blood and Transplant and others to communicate the safety of current blood products.

Assessing further recommendations and next steps

As set out above, the final Inquiry report includes a number of important recommendations for the NHS. NHS England will be considering these in detail alongside the Department for Health and Social Care and other relevant bodies.

In addition, an Extraordinary Clinical Reference Group is being convened to inform any immediate actions which should be taken.

The next steps from this work will be shared as soon as possible, including through relevant clinical networks.

Yours sincerely,

Amanda Pritchard
NHS Chief Executive
NHS England

Professor Sir Stephen Powis
National Medical Director
NHS England

Dame Ruth May
Chief Nursing Officer England

Dr Emily Lawson DBE
Chief Operating Officer
NHS England

Quality Committee in Common Upward Report

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Hospitals NHS Trust

Meeting	*Lincolnshire Community and Hospitals Group Board meeting*
Date of Meeting	*2 July 2024*
Item Number	*8.1*

Quality Committee in Common Upward Report of the meeting held on 21 May 2024

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

Purpose

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

This assurance Committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme, for both Lincolnshire Community Health Services NHS Trust (LCHS) and United Lincolnshire Hospitals NHS Trust (ULHT). The Committee worked to the 2024/25 objectives for the Lincolnshire Community and Hospitals NHS Group (LCHG) and was attended by both ULHT and LCHS colleagues.

Upward Report

Assurance in respect of Objective 1a – Deliver high quality care, which is safe, responsive and able to meet the needs of the population

Patient Safety Group (PSG) in Common Upward Report
The Committee received the in common upward report with **assurance** noting the progress of the meeting in common with the Committee pleased to note the achievement of no overdue serious incidents.

Improvements were noted in respect of duty of candour along with an improvement in the overdue Datix position for LCHS, with support continuing to ensure further improvements.

Limited assurance had been received by the group in respect of pressure ulcers however it was recognised that a deep dive report would be offered to the Committee in June.

Significant assurance was received in respect of the work being undertaken within medicines management by LCHS over the past quarter however a **lack of assurance** was noted in respect of the work undertaken in diabetes and DKA. Additional time was afforded by the Committee for the group to receive further information and to be sighted on the work being undertaken prior to an escalation being made.

The Committee noted the inclusion of skin integrity and pressure ulcers as a patient safety incident investigation (PSII) theme due to the increase in section 42 referrals.

Communication was also noted as an area of concern by the Committee which had been identified as a theme by the Patient Experience Group with a range of work being undertaken through the group.

The C-Difficile position for ULHT continued to be reported above trajectory however remained in line with the national position. The desktop review by NHS England had not taken place however actions were in place and the position was being closely monitored.

The Committee noted and **approved** the proposal to remove falls from the Patient Safety Incident Response Framework (PSIRF) and include diabetes due to the progress made in respect of falls. The PSIRF close-down report was received for LCHS.

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

Assurance in respect of Objective 1b – Improve patient experience

Patient Experience and Involvement Group in Common Upward Report
The Committee received the Patient Experience Group upward report with **assurance** noting that this was the first meeting held in common with the opportunity taken by the group to identify what could be done differently and the opportunities for real time data collection.

Positive updates had been received in respect of complaints by the group with the quarter 4 complaints report being received. It was noted that there had been significant progress in respect of LCHS complaints since joining the

services across the Group. There had been a significant reduction in the number of overdue complaints from 34 to 7.

A workshop session would take place in June to further consider the development and opportunities of both the group and wider engagement activity. Consideration was also being given to the Patient Panel and how this could work across the Group.

Concern was noted in respect of the Patient-Led Assessments of the Care Environment (PLACE) due to three quarters of measures having worsened. Whilst trajectories and timescales were in place for improvement the group had sought further detail to ensure progress was made with the development of a comprehensive action plan.

The Committee received the urgent and emergency care report for information which offered divisional learning. This had been considered by the group and the identified themes were being addressed.

Assurance in respect of Objective 1c – Improve clinical outcomes

Clinical Effectiveness Group in Common Upward Report
The Committee received the report with **assurance** noting the positive VTE performance for ULHT, which was above 95%, and the appointment of a VTE nurse.

Limited assurance was received in respect of the National Vascular Registry report due to issues in respect of vascular surgery with work being undertaken to determine appropriate actions required.

Moderate assurance was received for both LCHS and UHT NICE reports which some actions remaining outstanding however the Committee noted appropriate trajectories were in place to address this.

The Committee was pleased to note the active approach to learning, as a result of the National Bowel Cancer Audit project, with the team seeking learning opportunities and proactively resolving identified issues.

Assurance was received from the mortality report with the Committee receiving further reassurance on the learning process through the structured judgement reviews and the robust medical examiner process.

Assurance in respect of Objective 1d – Deliver clinically led integrated services

Q4 from LCHS Emergency Planning Group
The Committee received the report with **assurance** noting that NHS England would continue to review LCHS and ULHT separately in respect of business continuity responses.

The teams across the Group were working well together with joined up on call, responses out of hours along with responses to critical incidents.

The Committee noted the internal audit report which indicated higher levels of assurances than had been offered through the self-assessment with work ongoing to ensure partial compliance could be delivered against standards at the end of quarter 4. This was an expected level of compliance against the 60 standards.

Assurance in respect of Objective 5b – Co-create a personalised care approach to integrate services for our population that are accessible and responsive

No items received.

Assurance in respect of Objective 5d – Transform key clinical pathways across the group resulting in improved clinical outcomes

No items received.

Assurance in respect of other areas

Group Board Assurance Framework 2024/25 - deferred
The Committee noted the ongoing work to develop the 2024/24 Board Assurance Framework which would be presented in draft to the June meeting.

Risk Report
The Committee received the joint report with **assurance** noting that there had been a reduction to the risk associated with echocardiograms and falls for ULHT. As a result of the reduction of the falls risk this had supported the removal from the PSIRF plan.

There had been no changes to the risk register for LCHS and it was noted that the first joint Risk Register Confirm and Challenge meeting had taken place.

The Committee noted the movement across the risk register and accepted the report.

Quality Impact Assessment Assurance Report
The Committee received the report with **assurance** noting this offered the ULHT quarterly report. Discussions had commenced with LCHS to determine how reporting could be offered across the Group.

CQC Assurance Report
The Committee received the report with **assurance** noting the ongoing work to close the final 'should do' actions with all 'must do' actions having been closed.

The Committee noted the intended changes to reporting which would move to quarterly reporting focusing on the new CQC framework.

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

It was noted that the data presented within the reports was within control limits however concern was noted in respect of the LCHS report and the data in respect of looked after children. An action was taken to ensure reporting of the data moving forward.

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

Interim ToR and Work Programme
The Committee received the interim terms of reference and work programme noting the need for updates to be made to reflect the LCHG Strategic Aims and Objectives.

Issues where assurance remains outstanding for escalation to the Board

No escalations required.

Items referred to other Committees for Assurance

No items for referral.

Attendance Summary for rolling 12-month period

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

Anne-Louise Schokker, Medical Director, LCHS	X	X	A	X	A							

X in attendance
A apologies given
D deputy attended

Quality Committee in Common Upward Report

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Hospitals NHS Trust

Meeting	*Lincolnshire Community and Hospitals Group Board meeting*
Date of Meeting	*2 July 2024*
Item Number	*8.1*

Quality Committee in Common Upward Report of the meeting held on 18 June 2024

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

Purpose

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

This assurance Committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme, for both Lincolnshire Community Health Services NHS Trust (LCHS) and United Lincolnshire Hospitals NHS Trust (ULHT). The Committee worked to the 2024/25 objectives for the Lincolnshire Community and Hospitals NHS Group (LCHG) and was attended by both ULHT and LCHS colleagues.

Upward Report

Assurance in respect of Objective 1a – Deliver high quality care, which is safe, responsive and able to meet the needs of the population

Patient Safety Group (PSG) in Common Upward Report
The Committee received the report with **assurance** noting that there remained a number of Serious Incidents awaiting ICB sign off for both UHLT and LCHS.

The group had recognised that there were no actions provided against serious incidents within the reporting for LCHS with the group requesting this be included in future reports.

Significant improvements were noted by the Committee in respect of duty of candour for both organisations with 100% achievement for both verbal and written achieved in April.

The Committee was pleased to note that there had been no Never Events reported within the financial year and that all open Never Event actions for ULHT had now been closed.

A deep dive had been undertaken in respect of incident reporting due to a number of concerns related to category use and raised incident levels. Further work would continue with oversight offered by the group.

The group received the patient safety alerts for both organisations with **moderate assurance** received for ULHT and **significant assurance** for LCHS. There were a number of overdue Central Alert System (CAS) and Field Safety Notices (FSN) overdue for ULHT however improvements were being seen and trajectories requested.

The Committee received the LCHS Infection Prevention and Control Annual Report noting the system wide approach to measles with collaborative work across the teams clearly demonstrated through the report.

The Falls and Skin Integrity Group upward reports were received with the Committee being advised that currently there were organisation specific however joint reporting would be in place in July. The thresholds for falls and skin integrity were approved by the group for ULHT.

The group received the medicine division progress on diabetes with a plan on a page offered to the group. Reporting would take place on a quarterly basis to the group to ensure traction with diabetes being within the Patient Safety Incident Response Framework (PSIRF) and a Patient Safety Incident Investigation (PSII) category.

The Committee noted the position in respect of basic life support training for children and received **reassurance** that the training places offered would be sufficient to reach the required training target.

The Committee noted the C-Difficile position which continued in line with national trajectories and also sought an update in respect of the legionella issue at LCHS. **Assurance** was received that mitigations were in place with appropriate oversight and improved relationships with NHS Property Services.

Maternity and Neonatal Oversight Group Upward Report (ULHT)
The Committee welcomed the Director of Midwifery to the meeting and received the report with **assurance** noting that the service was on track to deliver the 10 safety actions for year 6 of the Clinical Negligence Scheme for

Trusts (CNST) Maternity. It was recognised that there had been some concern on the achievement of standard 8, training, the previous year however this was being monitored.

There had been a continued significant increase seen in respect of Saving Babies Lives with overall compliance reported at 90%. An increase in assurance was being achieved at each visit that was undertaken.

The Committee noted the continuation of the 3 year delivery plan with plans in place to address the lack of support in the perinatal health service.

The service had completed the assurance templates, as a system, from the early learning taken from the Ockenden visit with a further notification reviewed of an insight visit to the system. The date for this was not yet known.

The Committee noted the neonatal workforce position with the units staffed to standards for the medical workforce however, due to the requirements of speciality qualifications for nursing this was only staff to 53% and 64% for Lincoln and Pilgrim respectively. There was ongoing work to address this with an action plan due to be presented to the next meeting.

The Birth Rate Plus report for bi-annual staffing was received by the Committee which demonstrated that the service was staffed to 2021 rates. Whilst there had not been an increase in birth rates there had been an increase in acuity rustling in the recommendation of an uplift. A new role had been appointed to within the service to review triage and antenatal assessment in order to address the deficit being seen.

The Committee noted the unsuccessful bid for a Pelvic Health Service however the service was continuing to identify other funding streams to support this. Work was taking place across the system to mitigate current risks and to support a further iteration of the business case.

The Committee received the reports and associated appendices with **assurance** recognising the significant scrutiny and oversight being given by the group to maternity and neonatal services.

Children and Young Person's Oversight Group (ULHT)
The Committee received the report with **assurance** and noting the focus given to address progress on the outstanding CQC actions with a number closed and a high level of confidence that the remaining actions would be closed in early July.

Concern was noted in respect of mandatory training for medical staff with the Committee noting the bespoke training that was in place which should address the gaps once attended by all staff.

The Committee noted that updates had been received from the Divisions with no escalations required however where concerns were noted action plans were in place.

A Safeguarding update was received by the group with concern noted in respect of the MCA training. This was due to the 3-year renewal period of the training and the high numbers of staff required to undertake the training in year. Work was taking place across the Safeguarding Team and divisions in order to address this.

Progress continued in respect of the Oliver McGowan training which was progressing inline with the national trajectory. A gap had been noted in DMI training due to 50% of staff within children and young people having lapsed training. Mitigations were in place until this could be corrected.

The Committee noted the progress being made on the transition work to support patients moving into adult services. A Transition Nurse had been recruited to support this work and to undertake a mapping exercise. The Transition Policy had been developed and considered by the group and was now being reviewed prior to approval.

There were no further updates to offer the Committee in respect of the Thirlwall Inquiry and Martha's rule.

The Committee considered the development of the group to a meeting in common with LCHS and noted that there was an appetite for this from the group with the intention to progress as soon as possible.

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

Focussed Discussion – Pressure Ulcers
The Committee undertook a focused discussion relating to pressure ulcers due to previous concerns raised in performance at LCHS. As a result, a deep dive had been undertaken, which was supported across the Group and had supported the identification of best practice, issues and actions.

The Committee was **assured** that, following the undertaking of the deep dive, the recommendations identified would support in improvements being made with **reassurance** of the learning being applied from the acute to community services to support this.

The Committee was pleased to note that the deep dive had considered informal carers and families and the support they required as well as the role they undertook. By supporting carers and families this would improve patient experience.

In order to ensure that the required changes and improvements were made the Committee requested that an update be offered in 3 months and also requested the inclusion of pressure ulcers related to children and young people.

Assurance in respect of Objective 1b – Improve patient experience

Patient Experience and Involvement Group in Common Upward Report
The Committee received the report with **assurance** noting the discussions which had taken place, with operational colleagues across the Group, regarding patient stories.

The Committee received and noted the proposal in respect of the patient story roster for the Group noting that this would ensure patient stories were heard by the Board.

The group received the Voices Survey 2023 for ULHT with previous conversations having taken place for LCHS prior to the development of the Group. Key actions were noted as well as positive feedback and development areas which included pain management, discharge processes and learning from both the acute and community services.

The joint Safeguarding and Vulnerabilities Oversight Group upward report was received by the group noting current risks including learning disabilities, clinical holding, Oliver McGowan training and safeguarding supervision. Discussions had also focused on children in care which would continue to the July meeting with a possible proposal of a focussed discussion at a further Committee meeting.

The group received the LCHS Annual Claims reporting with the Committee noting the current position which demonstrated that figures remained low however had increased to pre-Covid-19 levels. Claims continued to be managed within timeframes and discussions had commenced to algin reporting across the Group.

The year end You Care we Care to Call report was considered by the group which demonstrated the importance of the conversations being held to support patients and their families. This had also supported a reduction in avoidable complaints due to the engagement.

The group received the annual complaints reports for both ULHT and LCHS with the Committee noting the content of the reports and recommending to the Board. The reports demonstrated significant improvements across the complaints teams with 83% of ULHT complaints responded to within timescale. A significant increase on prior years.

The Committee considered the feasibility of joint annual reports moving forward as a Group and it was noted that whilst this would be the approach taken there would be clear delineation between data for both organisations.

Focussed discussion – Complaints Annual Reports (LCHS and ULHT)
Due to time constraints the Committee was unable to hold a focussed discussion on the Complaints Annual Reports however were **assured** that the reports offered a clear position of the 23/24 year and that the detail had been considered through the Patient Experience and Involvement Group in Common. The reports were recommended onwards to the Board.

Assurance in respect of Objective 1c – Improve clinical outcomes

Clinical Effectiveness Group in Common Upward Report
The Committee received the report with **assurance** noting the continued positive nature of the group meeting in common.

The Committee noted the position on the national audits with some offering limited assurance however noted that detailed reports and action plans had been requested where necessary.

The group considered the clinical audit annual reports for both LCHS and UHLT which had been offered to the Committee.

The group received a report from the Human Tissue Authority Group which highlighted concerns due to the delay in refurbishment works with further work being undertaken to understand the issues. The group received assurance on the progress of DBS checks for contractors which was being monitored through the People and OD Committee.

Focussed Discussion – Clinical Audit Annual Reports (LCHS and ULHT)
The Committee received the Clinical Audit Annual Reports with **assurance** noting that these offered a clear position of the 23/24 year and that the detail had been considered through the Clinical Effectiveness Group in Common.

The Committee noted that ULHT had achieved 100% compliance in participation with national clinical audits with 37 outcome reports published in 23/24. The Clinical Audit Team was working to strengthen governance processes and action plans would be monitored to continue to improve the position.

The reports were recommended onwards to the Board.

2024/25 Quality Accounts for LCHS and ULHT
The Committee received the Quality Accounts for both LCHS and ULHT noting that these were the final reports and included statements from local stakeholders.

The Committee noted and commended the efforts in producing the reports and was pleased to be able to recommend these to the Board.

Assurance in respect of Objective 1d – Deliver clinically led integrated services

No items received.

Assurance in respect of Objective 5b – Co-create a personalised care approach to integrate services for our population that are accessible and responsive

No items received.

Assurance in respect of Objective 5d – Transform key clinical pathways across the group resulting in improved clinical outcomes

No items received.

Assurance in respect of other areas

Group Board Assurance Framework 2024/25
The Committee received the draft Group Board Assurance Framework (BAF) with **assurance** noting the work to develop this from the LCHS Operational Plan and ULHT Integrated Improvement Plan.

During the meeting the Committee considered the RAG ratings of the objectives where assurance reports had been received and noted the ongoing work to continue to develop and populate the BAF. This would be presented to the Board in July.

Risk Report
The Committee received the joint report with **assurance** noting the dynamic nature of the risk register and the review process resulting in appropriate movement of the risks presented.

The Committee noted the ability to triangulate the risks within the risk register with the reports received and considered. The report was accepted.

Committee Performance Dashboard (ULHT and LCHS)
The Committee received the performance reports for ULHT and LCHS with **assurance,** noting that performance had been considered through the reports presented and performance was not outside of the expected control limits.

The Committee was pleased to note the positive progress of ULHT VTE performance and the improvement in LCHS sickness rates. The Committee considered medicines reconciliation and sought further detail to understand how the current variation across sites could be addressed.

CQC Assurance Report
The Committee received the report with **assurance** noting the continued improvement of actions being embedded and closed with the Family Health Division considering an appropriate trajectory to close should do actions.

The Committee noted the intention to achieve closure of all open actions by the end of June to then move to a proactive approach and progress work across the Group in respect of the new CQC Framework.

Integrated Improvement Plan: Patients Assurance Report (ULHT)
The Committee received the report for information noting the **moderate assurance** noting a number of items within the report had been considered through the group upward reports.

Interim ToR and Work Programme
The Committee received the interim terms of reference and work programme accepting the updates made to reflect the 2024/24 LCHG Strategic Aims and Objectives.

Issues where assurance remains outstanding for escalation to the Board

No escalations required.

Items referred to other Committees for Assurance

No items for referral.

Attendance Summary for rolling 12-month period

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

X in attendance
A apologies given
D deputy attended

Report to:	Lincolnshire Community and Hospitals Group Board Meeting
Title of report:	People and OD Committee Assurance Report to Board
Date of meeting:	14 May 2024
Chairperson:	Professor Phil Baker, Chair
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the People and OD Assurance Committee. The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board. This assurance committee meets monthly and takes scheduled reports according to an established work programme. The Committee worked to the 2023/24 objectives.
Assurances received by the Committee	**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. There were no escalations to the Committee and the group had considered the March performance data. The group had considered the position of Disclosure and Barring Service (DBS) checks with 3703 requests made. It was recognised that the response rate had not been as prompt as required and discussions had focused on the potential barriers with proposals to ensure support was in place for staff. The Committee noted that statutory and mandatory training compliance was just below 95% and noted the reduction in conflict resolution training availability due to staffing. E-learning was due to be launched for this which should see an increase in completion. The group had considered the absence management report which demonstrated a static position in respect of sickness and the top reasons for this. This would remain a key area of focus for the group. The Committee noted the focus on recruitment of newly qualified nurses and the move away from international recruitment recognising the transition to this position. **Committee Performance Dashboard** The Committee received the report noting that there appeared to be a plateau in respect of the completion of DBS checks.

	The Committee noted that there had been some challenges associated with DBS checks noting that there had been some delay due to funding availability. Follow up communications would also be put in place to ensure staff completed the appropriate checks. The Committee was assured on the robust process in place for new starters and noted the actions in place to support existing staff to complete DBS checks. **Workforce Planning Guidance 24/25** The Committee received the planning guidance noting that this had been published at the end of March, later than normal publication, which was reflective of the challenges currently being faced by the NHS. The Committee was pleased to note that actions were already being undertaken in response to the guidance and the productivity tool was due to be piloted. It was recognised that there was a need to ensure appropriate staffing and support was in place in respect of digital developments with the Committee noting the possible use of AI as a future approach in a number of areas. **Safer Staffing** The Committee received the report noting the positive position for Care Hours Per Patient Day (CHPPD) as a result of an increased fill rate. There was also a continued decrease in vacancies and agency usage with the temporary staffing position continuing to be positive with more bank than agency staff being utilised. Despite the continued escalation areas remaining open. The Committee noted the focused work in month in respect of agency staff and the continued move to cap rates with an expectation that all agency use would be on capped rated by July 2024. **Board Assurance Framework** The Committee agreed that the BAF assurance rating in respect of objective 2a was reflective of the assurance position.
	Assurance in respect of SO 2b **Issue: Making ULHT the best place to work** **Equality Diversity and Inclusion Group Upward Report** The Committee received the reporting noting that the group had considered its terms of reference and noted that EDI data collection had commenced with outputs due to be reported to future meetings.

The group was considering the national staff survey results from an EDI perspective alongside the OD teams to understand the results.

Work had commenced on the reviving of the 6 EDI impact actions to ensure continued progress with work due to be expanded across the Group.

The Committee noted that the gender pay gap report was now published on the Trust website with the Committee interested in the future outcome of the gender race pay gap for both medical and non-medical staff.

Just Culture Steering Group Upward Report
The Committee received the report noting that the project plans had been finalised and leads identified. Work had also commenced to review all policies which would be conducted across the Group.

A full communications plan was being supported by the Communications Team and briefing sessions for all staff had commenced and were well attended.

Guardian of Safe Working
The Committee received the quarterly report noting that there were no issues alerting from Trauma and Orthopaedics which was an improved position.

Concern was noted by the Committee regarding actions to support locally employed doctors which had not progressed at the pace required. Further updates were requested to the Committee in order to ensure appropriate action was being taken.

Improving working lives for Doctors
The Committee received an update in respect of the recent letter received from NHS England with the Committee taking oversight for the organisation in respect of this.

The Committee noted the need for metrics to be reported against associated with roster management, approval or leave and study leave. This would be reported through the dashboard to the Committee to enable confirmation of assurance against the actions required.

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

	Lack of Assurance in respect of SO 4b **Issue: To become a University Hospital Teaching Trust** **Research and Innovation Governance Group Upward Report** The Committee received the report and noted recruitment figures in excess of 1030 and 18 ongoing collaborations with project sponsors and grant applications. Work continues in respect of the collaboration with Nottingham Clinical Research Facility on the vaccine expansion with the submission of a joint bid for the Moderna expansion. The Committee noted the proactive approach to research with more phase 1 trials being opened. The Committee considered wider discussions which had been held, in respect of engagement with the National Institute for Health Research, and encouraged the Director of Research and Innovation to pursue this. **Board Assurance Framework** The Committee agreed that the BAF assurance rating in respect of objective 4b was reflective of the assurance position with evidence not sufficient to consider movement of the rating.
	Assurance in respect of other areas: **Integrated Improvement Plan** The Committee received the report for information noting the position presented. **CQC Action Plan** The Committee received the report noting the update provided and the work taking place in respect of the new CQC single assessment framework. It was recognised that there was a need to ensure evidence was provided to the compliance team to demonstrate an accurate position to be reflected within the report. **Fuller Recommendations** The Committee received the report which detailed the implications and actions as a result of the Fuller Inquiry for the Trust to consider. The Committee recognised the specific action associated with mortuary staff having up to date Disclosure and Barring Service (DBS) checks which was being addressed as a priority.

Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	None
Committee Review of corporate risk register	The Committee received the risk register noting the current risks presented with no changes to the very high and high rated risks from the previous report.
Matters identified which Committee recommend are escalated to SRR/BAF	No areas identified
Committee position on assurance of strategic risk areas that align to committee	The Committee considered the reports which it had received which provided assurances against the strategic risks to strategic objectives.
Areas identified to visit in ward walk rounds	No areas identified

Attendance Summary for rolling 12 month period

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

X in attendance
A apologies given
D deputy attended

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Report to:	Lincolnshire Community and Hospitals Group Board Meeting
Title of report:	People and OD Committee Assurance Report to Board
Date of meeting:	11 June 2024
Chairperson:	Professor Phil Baker, Chair
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the People and OD Assurance Committee. The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board. This assurance committee meets monthly and takes scheduled reports according to an established work programme. The Committee worked to the 2024/25 objectives.
Assurances received by the Committee	**Assurance is respect of SO 2a** **Issue: Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise** **Workforce Strategy and Organisational Development Group (WSODG) Upward Report** The Committee received the report noting the detailed discussions held by the group which had focused on the experience of international nurses as a result of recent concerns which had been raised through an East Midlands meeting. A meeting was due to take place to review the feedback in detail and to ensure that the Trust continued to support international recruits in the most appropriate way. Currently the Trust had no concerns regarding the wellbeing of international recruits however to provide assurance the detail would be considered. The Committee noted the change in approach to recruitment for the Trust with a move away from international recruitment. The next workforce planning round was due to be completed with the Committee noting that the additional nursing establishment would be linked to establishment reviews and escalation beds now part of the core structure. Focus continued to be given by the group to statutory and mandatory training and DBS data would now be reported into the divisional Finance, People and Activity Meetings to ensure this was reviewed at divisional level. **Committee Performance Dashboard** The Committee received the report noting the performance presented and recognising the static nature of the turnover rate at 10.9% against a target of 12.7%.

	NHS and System People Plan Quarterly Update The Committee received the report which offered the high-level activity in Q4 including the commencement of the recruitment processes for the Director of Workforce and Transformation for the ICB. The Committee noted the concerns raised in respect of culture within the People Hub with a cultural deep dive commissioned to understand the issues being experienced. **Safer Staffing** The Committee received the report with significant assurance noting the work that continued to be undertaken to deliver the strong position reported. The Committee noted that there would be benefit in the development of a similar report for non-nursing staff to receive robust assurance of staffing across the entire workforce.
	Assurance in respect of SO 2b **Issue: To be the employer of choice** **EDI Annual Report** The Committee received the report noting that this was due to be published under the 2011 Public Sector Equality Duty and recognising the work that had taken place throughout the year with the positive developments that had been seen through the EDI upward reports to the Committee. The Committee recommended the report to the Board for approval. **Guardian of Safe Working Annual Report** The Committee received the annual report from the Guardian of Safe Working offering thanks for the work that was undertaken during the year to support staff. The Committee considered in detail issues for Locally Employed Doctors (LEDs) and was pleased to note the progress in ensuring doctors had clinical supervisors. The ability to exception report had also been resolved with an addition to the Allocate system which would enable reporting. Issues continued in respect of contracts for LEDs and the issue of education opportunities as, whilst the privileges were the same as deanery doctors, this was not always realised. **Just Culture Steering Group Upward Report** The Committee received the report noting the continued delivery against the plans with the relevant policies now fully ratified and would be in place by the end of quarter 1 subject to Staffside consultation and agreement.

The briefings continued to take place across the Trust with over 1000 staff having attended. This would support the structures and processes being in place to transition to the new ways of working in terms of managing disciplinary processes.

National Staff Survey Update to inc PULSE survey results

The Committee received the results noting that the Trust had now had a full OD team in place for a year. As a result, there had been the opportunity to fully analyse the results of the surveys and take appropriate action to communicate and engage across the Trust.

Whilst the results were not as improved as would be liked there was movement being seen within these and it was hoped that the workshops and support being put in place across the organisation would show improvements in future results.

This had been the first year in which the Trust had shared the level of intelligence across the organisation which had resulted in the development of divisional action plans which would be owned locally.

The Committee considered the potential opportunity of incentives for staff should they complete the staff survey, achieve 100% on statutory and mandatory training and undertake an appraisal.

Assurance in respect of SO 4c

Issue: Grow our research and innovation through education, learning and training

Research and Innovation Update

The Committee received the report noting the additional information included which had previously been requested however it was noted that there was a need to ensure a wider focus than clinical trials.

The Committee reflected the embryonic nature of innovation within the Trust noting the new Innovation Lead post which had been appointed to. It was hoped that through this recruitment and the development of the working group innovation would progress.

Medical Education Update

The Committee received the report noting the recent interim quality visit which had taken place, identifying ongoing concerns regarding financial and governance arrangements in respect of monies into the organisation.

The Committee noted that this was an issue across the country and work was progressing to resolve the position including the establishment of a task and finish group to be chaired by the Medical Director.

Progress was also noted in respect of locally employed doctors as discussed by the Committee through the Guardian of Safe Working report.

University Teaching Hospital Group Upward Report
The Committee received the report noting the first meeting of the Clinical Academic Oversight Group has taken place, this had been chaired by the Director of Research and Innovation.

The meeting had a range of attendees from across the Group and had included a wide range of staff including medical, nursing, AHPs and scientists.

The Committee was pleased with the progress reported and noted the request for a combined report to be offered going forward for both the University progress and Research and Innovation. The Committee supported the proposal.

Assurance in respect of other areas:

Draft Board Assurance Framework (BAF) 2024/25
The Committee received and considered the draft BAF 24/25 noting this continued to be developed in terms of the content. The Committee noted the need to ensure that education was clearly represented through the BAF in order to strengthen the focus on this.

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

EDI Internal Audit Report
The Committee received the report for information noting the reasonable assurance which had been issued.

CQC Action Plan
The Committee received the report recognising the work of the Compliance Team to close actions and to work through the evidence portfolio in respect of the new framework.

It was recognised that a number of elements of the new framework were considered in detail on a monthly basis by the Committee.

Fuller Recommendations
The Committee received the report noting the ongoing work to address the actions resulting from the outcome of the inquiry.

There were a number of workforce issues being managed through competencies for relevant staff and ensuring completion of DBS checks. Work to complete DBS checks remained on track.

	The Committee noted that, in order to allow actions to have an impact, the next report would be offered in August. At this time, it was anticipated the required actions would be complete.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	None
Committee Review of corporate risk register	The Committee received the risk register noting the current risks presented with changes to the very high and high rated risks from the previous report.
Matters identified which Committee recommend are escalated to SRR/BAF	No areas identified
Committee position on assurance of strategic risk areas that align to committee	The Committee considered the reports which it had received which provided assurances against the strategic risks to strategic objectives.
Areas identified to visit in ward walk rounds	No areas identified

Attendance Summary for rolling 12 month period

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

X in attendance
A apologies given
D deputy attended

Lincolnshire Community Health Services
NHS Trust

Report to the Lincolnshire Community and Hospitals Group Board

Date of meeting	2nd July 2024	Agenda item	10.1
Title	Report on the Finance, Performance, People and Innovation Committee meetings held on 24th May 2024 and 27th June 2024.		
Report of	Gail Shadlock, Non Executive Director and Chair of FPPIC	Prepared by	Claire Low, Chief People Officer Julie Frake-Harris, Chief Operating Officer Sam Wilde, Director of Finance and Business Intelligence
Previously considered by / Date	None	Approved?	None
Summary	The FPPIC Committee met on 24th May 2024 and 27th June 2024. **Green:** Effective controls are definitely in place and the committee is satisfied that appropriate assurances are available **Amber:** Effective controls are thought to be in place but assurances are uncertain and/or possibly insufficient **Red:** Effective controls may not be in place and/or appropriate assurances are not available		

1. To deliver high quality, safe and responsive patient services	**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	
	1d. Deliver clinically led integrated services	
2. To enable our people to lead, work differently, be inclusive, motivated and proud to work within LCHG	**2a. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise**	**X**
	2b. To be the employer of choice	**X**
3. To ensure services are sustainable, supported by technology and delivered from an improved estate	**3a. Deliver financially sustainable healthcare, making the best use of resources**	**X**
	3b. Drive better decision and impactful action through insight	**X**
	3c. A modern, clean and fit for purpose environment across the Group	**X**
	3d. Reduce waits for patients who require urgent and emergency care and diagnostics and ensure we meet all constitutional standards	**X**

	3e Reducing unwarranted variation in cancer service delivery and ensure we meet all constitutional standards (ULHT)	
	3f Reducing unwarranted variation in planned service delivery and ensure we meet all constitutional standards (ULHT)	
	3g Reducing unwarranted variation in community service delivery and ensure we meet all constitutional standards (LCHS)	**X**
4. To collaborate with our primary care, ICS and external partners to implement new models of care, transform services and grow our culture of research and innovation	**4a Establish collaborative models of care with all our partners including Primary Care Network Alliance (PCNA), GPs, health and social care and voluntary sector**	**X**
	4b Successful delivery of the Acute Services Review	**X**
	4c Grow our research and innovation through education, learning and training	
	4d Enhanced data and digital capability	**X**
5. To embed a population health approach to improve physical and mental health outcomes, promote well-being, and reduce health inequalities across an entire population	**5a Develop a Population Health Management (PHM) and Health Inequalities (HI) approach for our Core20PLUS5 with our ICS**	**X**
	5b Co-create a personalised care approach to integrate services for our population that are accessible and responsive	
	5c Tackle system priorities and service transformation in partnership with our population and communities	**X**
	5d Transform key clinical pathways across the group resulting in improved clinical outcomes	

Impact of proposal/ report	*Please outline the potential impact/ expected outcome* (Quality/ Equality, Diversity/ Equality Delivery System 3/ Health Inequalities/ Financial/ People)				
CQC	**Safe**	**Caring**	**Effective**	**Responsive**	**Well-Led**
Links to risks	390, 391, 393, 418, 441, 442, 443, 444, 455, 491, 649, 651, 665, 676				
Legal/ Regulation	N/A				

Recommendations/ Actions Required

Board is asked to:
- **NOTE** the report.
- **CONSIDER** the recommendation to **APPROVE** the Annual EDI report for 2023/24

Appendices

None

Glossary

A&E – Accident and Emergency
BPPC – Better Payment Practice Code
CIP – Cost Improvement Programme
DEG – Digital Executive Group
DQIG - Data Quality Improvement Group
DSPT – Data Security and Protection Toolkit
EDI – Equality, Diversity and Inclusion
EDS3 – Equality Delivery System 3
FEG - Finance & Business Intelligence Executive Group
FPPIC – Finance, Performance, People and Innovation Committee
FRP – Financial Recovery Programme
ICS – Integrated Care System
IPR – Integrated Performance Report
LCHS – Lincolnshire Community Health Services NHS Trust
LSIIG - Lincolnshire Strategic Infrastructure and Investment Group
NCCI – National Cost Collection Index
NHS – National Health Service
NQPS – National Quarterly Pulse Survey
PEG – People Executive Group
PMR – Performance Management Review
Q3 – Quarter 3 2023/24 (October 2023 – December 2023 inclusive)
Q4 – Quarter 4 2023/24 (January 2024 – March 2024 inclusive)
QSRM – Quarterly System Review Meeting
TLT – Trust Leadership Team
ToR – Terms of Reference
UTC – Urgent Treatment Centre
WDES - Workforce Disability Equality Standard
WRES - Workforce Race Equality Standard

Report on the FPPIC meetings held on 28th March 2024 and 26th April 2024.

1. Purpose

To make the Board aware of key issues from the Finance, Performance, People and Innovation Committee (FPPIC) meetings held on 28th March 2024 and 26th April 2024.

2. Key Issues

Key issues for the Board to be aware of are as follows:

GREEN ASSURANCE

Strategic Aim 2. To enable our people to lead, work differently, be inclusive, motivated and proud to work within Lincolnshire Community and Hospitals NHS Group (LCHG):
Strategic Objective 2a. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise
Strategic Objective 2b. To be the employer of choice

Strategic Aim 3. To ensure services are sustainable, supported by technology and delivered from an improved estate:
Strategic Objective 3b. Drive better decisions and impactful action through insight

Strategic Aim 4. To collaborate with our primary care, ICS and external partners to implement new models of care, transform services and grow our culture of research and innovation:
Strategic Objective 4d. Enhanced data and digital capability

AMBER ASSURANCE

Strategic Aim 3. To ensure services are sustainable, supported by technology and delivered from an improved estate:
Strategic Objective 3a. Deliver financially sustainable healthcare, making the best use of resources
Strategic Objective 3d. Reduce waits for patients who require urgent and emergency care and diagnostics and ensure we meet all constitutional standards

Strategic Aim 4. To collaborate with our primary care, ICS and external partners to implement new models of care, transform services and grow our culture of research and innovation:
Strategic Objective 4b. Successful delivery of the Acute Services Review

RED ASSURANCE

Strategic Aim 3. To ensure services are sustainable, supported by technology and delivered from an improved estate:
Strategic Objective 3c. A modern, clean and fit for purpose environment across the Group
Strategic Objective 3g. Reduce unwarranted variation in community service delivery and ensure we meet all constitutional standards (New objective not yet rated)

Strategic Aim 4. To collaborate with our primary care, ICS and external partners to implement new models of care, transform services and grow our culture of research and innovation:
Strategic Objective 4a. Establish collaborative models of care with all our partners including Primary Care Network Alliance (PCNA), GPs, health and social care and voluntary sector (New objective not yet rated)

Strategic Aim 5. To improve physical and mental health outcomes, promote well-being, and reduce health inequalities across an entire population:
Strategic Objective 5a. Develop a Population Health Management (PHM) and Health Inequalities (HI) approach for our Core20Plus5 with our ICS (New objective not yet rated)
Strategic Objective 5c. Tackle system priorities and service transformation in partnership with our population and communities (New objective not yet rated)

Leavers Update
The Committee received the Leavers Update at the May meeting, with the report covering Q3 and Q4 of the last Financial Year. The Committee noted that a certain amount of Turnover is inevitable and at times welcome. As of 3rd May 2024, the Trust turnover figure is at 12.03% which is below the 15% threshold, but higher than we would like it to be. It was noted that the turnover figures are calculated on a 12-month rolling basis and in October 2023 the Trust had 3 staff TUPE out of the Trust and in December 2023 the Trust had 9 staff TUPE out of the Trust, which continues to impact on the figures. The Committee noted it was a real positive to see the high numbers of retire and return with an overall return rate of 91% (in Q3 out of 15 retirees 13 returned and in Q4 out of 18 retirees 17 returned). The Committee were pleased that a trend identified in previous years, of high numbers of leavers with less than 12 months service, was no longer the case and the highest number of leavers are now those with over 12 months service. Retention and flexibility continue to be a focus of the 2024-25 People Plan and each directorate/division has a plan to support areas of people promise which are drivers of retention.

Exclusions Thematic Review
The Committee received the Exclusions Thematic Review at the May meeting. This is also reported bi-monthly at the Trust Board.

NHS EDI Improvement Plan, High Impact Actions
The Committee received this report at the June meeting for assurance that the High Impact Actions within the NHS EDI Improvement Plan are being addressed across the Group. The Committee noted all the work being undertaken by our EDI teams and colleagues across People and OD and were reassured that the High Impact Actions are constantly being cross-referenced in our work to ensure we are meeting them. The Committee will receive a further update in 6-months.

People Executive Group Update

The People Executive Group Upward Report was tabled for assurance at the June meeting. The report was from the People Executive Group meeting held on 13 May and relates to Q4 of the last Financial Year. The Committee noted that no areas were rated red, three received an amber rating (up from two in Q3) and the remaining eight areas were rated green for assurance.

The three areas rated amber are:
Sickness Absence/Health & Wellbeing – remains amber as above 5% target.
Bank & Agency – remains amber but on trajectory to move to green.
Recruitment and Compliance – moved back from green to amber due to increase in overall 'time to recruit' due to the vacancy management processes that have been recently implemented.

The Committee felt that Bank and Agency and Sickness Absence/Health and Wellbeing were on trajectory to potentially be rated as green in Q1 of this Financial Year and there were no specific concerns, however, it was noted that the vacancy management process may continue to impact on overall time to recruit.

EDI Annual Report

The Committee received the EDI Annual Report at the June meeting, the production of which is a is a statutory responsibility under the Public Sector Equality Duty. The Committee noted the achievements from the previous year and the good work that has taken place. The Committee recommend the Annual Report to the Trust Board to approve the report for publication on the Trust's website in line with national reporting requirements.

National Quarterly Pulse Survey

The Committee were provided with the Quarterly Staff Survey Results from Q1 of this Financial Year at the June meeting. The survey response rate is 32%, a decrease of 1% from Q4, but much higher than the picker average at 20%. The Committee noted and was pleased to see that overall the Trust is maintaining its scoring, with the overall Staff Engagement Score remaining at 7.0 (out of 10). However, the Committee noted some 'early warning shoots' regarding small decreases in some scores and some comments within the free text feedback, particularly relating to Group, that need to be addressed at this early stage before they continue to grow. The Committee were pleased with the update on the work being undertaken by the Organisational Development team to triangulate information and develop diagnostics, initiatives and interventions to address some of the emerging themes.

Caldicott Guardian Annual Report

The committee received and reviewed the Caldicott Guardian's annual report for 2023/24 at its May meeting.

Monthly Finance Reports

The committee reviewed the months 1 and 2 finance reports at its meetings noting an improved financial position in month 2. The committee celebrated Better Payment Practice Code performance surpassing the national median. In month 2 the committee also reviewed the Lincolnshire ICS System Financial report and the Lincolnshire Financial Recovery Programme Finance report. The committee agreed with the recommended rating of amber for strategic objective 3a and the resetting of financial risk scores at the start of the new

financial year. At the end of month 2 the main contract with the ICB had not yet been signed (it has since) and there remained an element of unidentified CIP for the year (although this gap was closing).

Integrated Performance Report
The committee reviewed the Integrated Performance Reports covering April and May 2024 performance.

3 indicators were not statistically capable of achieving performance targets without redesign at the end of May 2024:

(i) Home Visiting Compliance
(ii) Ethnicity recording in A&E data sets
(iii) Better Payment Practice Code

The committee received an update that the sever/firewall issues preventing transfer of data from INFORM regarding Chlamydia Screening rates had been resolved leaving just 2 metrics showing signals of special cause deterioration in May:

(i) Vacancy Rate- Driven by the vacancy controls in place over the last 6-months including more recently the vacancy panel.
(ii) Home Visiting Compliance

7 indicators were showing special cause improvement which is a strong indication of the Trust's continuous improvement culture.

LCHS Ethnic Category Completion
At its June meeting FPPIC received a report on ethnic category completion across 3 data sets, noting the improvements already made and the plans to drive further improvement using the RINSE data quality system between November 2024 and March 2025.

National Cost Collection Index
At its June meeting FFPIC reviewed the pre-submission report for the 2023/24 National Cost Collection. It was notes that the outputs of the 2022/23 National Cost Collection are yet to be published.

12th June Final Financial Planning Submission
At its June meeting FPPIC reviewed a report regarding the final financial planning submission which had been made on 12th June. FPPIC noted the revised phasing of planned expenditure (linked to the CIP programme) and that an additional £0.7M of capital expenditure had been planned for based on the expected fair shares allocation.

Procurement Waivers
Following a request from the Audit Committee FPPIC reviewed 2 procurement waivers which had been authorised so far in 2023/24 for expenditure within the scope of the committees oversight responsibility. Neither waiver was retrospective and both were considered appropriate by the committee in the circumstances.

Finance Executive Group Report

At its May meeting the committee received and reviewed a report from the FEG meeting held on 4th April 2024 noting 2 areas were rated as green and 4 as amber.

Performance Management Review (PMR) Report
The committee reviewed the reports from the April and May PMR meetings.

Internal Audit of Core Financial Systems
At its May meeting the committee received and reviewed the internal audit review of Core Financial Systems (including payroll). The committee noted this provided 'reasonable assurance' (the second highest of the possible ratings). There were 0 urgent, 2 important and 5 routine action points. All actions were due to be complete by the end of September.

Strategic Partnerships Development
The committee reviewed a Strategic Partnership Development Update at its May meeting noting green ratings for the 2 programmes of work in this area.

Water Safety Report
The committee were updated that following repeated request to our LPFT colleagues as part of the shared service model, they were unable to give the level of assurance on water safety required. Therefore, the move to the new delivery of the Group service is being mobilised and the assurance will be gained from our teams at ULHT.

Digital Executive Group Update
The committee received the Q4 update in which, across 6 areas, all 6 were rated green: Training, Data Subject Access Requests (DSAR), Data Security and Protection Toolkit (DSPT), Data Breach Reporting, Cyber Assurance Framework and Freedom of Information (FOI) requests. The committee were conscious around the areas of Cyber security and how this is displayed in Trust Board. A request to table a conversation in Private Board as AOB has been submitted.

Electronic Patient Record Business Case
The committee received the business case for the LCHS electronic patient record. There was a discussion on the impacts, benefits, governance, integration and processes involved. Feedback was given around benefits realisation and robustness of the reporting process. The committee has reviewed the document and will be requesting it is reviewed and signed off at Trust Board private session.

Risk Assurance Report
The committee reviewed the Risk Assurance Report at each meeting noting proposed new risks, closures and changes in risk scores.

Board Assurance Framework
At its June meeting the committee reviewed its elements of the proposed draft BAF 2024/25, noting this would continue to evolve. Feedback on the document was provided. Proposed assurance ratings were agreed for the strategic objectives for which FPPIC has oversight responsibility as set out above. It was noted that where an objective has yet to be rated, it should be reported as red.

Procedural Documents Renewal Calendar

The committee reviewed the Procedural Documents Renewal Calendar report at its May meeting and was pleased to note that the Corporate Health & Safety Policy and Fire Safety Policy had now been approved.

FPPIC Self-Assessment
At its May meeting the committee reviewed the committee self-assessment which had been completed by individuals. Questions where differing responses had been given were explored and understood. The self-assessment has since been provided to and reviewed by the Audit Committee.

FPPIC Reporting Cycle
The committee reviewed its reporting cycle at each meeting.

Meeting Review
At the end of each meeting the committee had a short discussion to review how the meeting had gone and identify any opportunities for improvement going forward.

Control Issues Framework
No control framework issues were identified during the course of the meetings.

The following items were approved:
- Minutes of the meeting held on 26th April 2024 and 24th May 2024;

Issues referred to or from Audit Committee
The committee picked up the review of procurement waivers requested by the Audit Committee. The committee provided its self-assessment for 2023/24 to the Audit Committee.

Items referred to or from Quality Committee
None

Items referred to or from Trust Board
Recommendation regarding the Electronic Patient Record Business Case to be made to the Board meeting in private session.
Recommendation to approve the Annual EDI report for 2023/24.

3. Conclusion/Recommendations
Board is asked to:
- **NOTE** the report.
- **CONSIDER** the recommendation to **APPROVE** the Annual EDI report for 2023/24

Report to:	Lincolnshire Community and Hospitals Group Board Meeting
Title of report:	Finance, Performance and Estates Committee Assurance Report to Board
Date of meeting:	23 May 2024
Chairperson:	Dani Cecchini, Chair
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received, and key decisions made by the Finance, Performance and Estates Committee (FPEC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme. The Committee worked to the 2024/25 objectives.
Assurances received by the Committee	**Assurance** in respect of SO 3a Deliver financially sustainable healthcare, making best use of resources **Finance Report inc Efficiency, Contracts, Capital and CRIG Upward Report** The Committee received the report noting that the final planning submission had been made on 2 May. The submitted plan included a deficit position of £6.9m for the Trust, which formed part of the ICS breakeven plan. Month 1 delivery of the Cost Improvement Programme (CIP) was reported at £0.5m against a plan of £0.8m with the Committee noting that reporting would mature to ensure all metrics were captured. Better Payment Practice Code continued to achieve 80-90% for value and volume and the Committee noted that the cash position would start to erode throughout H1. Spend on the capital programme was noted at £2.2m against a plan of £1.8m, largely due to the spend in relation to the Community Diagnostic Centres (CDCs) with a further £88m to spend in the financial year. The Committee noted the new investments proposed for which funding had yet to be agreed with the ICB. Discussions were ongoing. Inflationary pressures were noted and it was anticipated that as the year progressed the risk of £6.4m highlighted in respect of unfunded inflation would materialise and require management. Good progress had been made in respect of contracts with an anticipation that these would be signed by the end of May.

	Strategic Projects – Pilgrim ED Escalation The Committee received the report noting that the project was progressing well and was at internal fit out. There were some concerns noted in respect of compensation events due to delays for which the Trust would be liable. These were being managed however it was noted by the Committee that this would cause a cost pressure to the Trust.
	Assurance in respect of SO 3b Drive better decisions and impactful action through insight **No reports due**
	Assurance in respect of SO 3c A modern, clean and fit for purpose environment across the Group **Estates Upward Report** The Committee received the report noting that appropriate clinical representatives now attended the Medical Gases Group and that the Reinforced Autoclaved Aerated Concrete (RAAC) survey had been completed. Confirmation was offered to the Committee that there was no RAAC on the Trust sites. The Committee noted the commencement of the Premises Assurance Model noting a level of confidence that the levels of assurance described in previous years would remain and not decline. Concerns remained about the use of non-clinical rooms as treatment rooms with clinical assessments being completed to support services to locate to appropriate environments. Ongoing concerns were noted in respect of lift breakdowns however the repair and replacement programmes of work continued. The Committee was pleased to note the collaborative work to install a new high voltage switch at Lincoln which had improved resilience across the system. Planned Preventative Maintenance continued to improve across all sites and a reduction in priority 1 calls was noted due to the triage process through the helpdesk to eradicate misreporting. **Health and Safety Committee Upward Report** The Committee received the report and was pleased to note that the meeting had been positive. The Health and Safety annual report had been received but was not approved due to the requirement for further review to ensure this aligned with the Trust objectives and British Safety Council findings. An escalation had been made in respect of sporadic returns associated with ward hoist and lifting checklists with action to be taken to improve the returns which would evident compliance.

	Limited engagement was noted in respect of the site-based forums and as such there was a need to ensure further divisional engagement as the forums would support any identified issues. Limited assurance was offered in respect of L8 guard water flushing however it was appreciated that this could be due to ineffective engagement regarding the new system, further action would be taken. The Committee was pleased to note that the radiation protection annual dose monitoring report indicated that there were no exceeded dose limits across the Trust. Fire remained a priority for the Health and Safety Committee with the Committee noting the value of investment required in the coming years across all sites. **Emergency Planning Group Upward Report** The Committee received the report noting that assurance had been offered in respect of business continuity plans and the real time focus on these. Work had commenced to consider emergency planning across the Group which should support the teams being sustainable and resilient as these were small teams within the respective Trusts. The Committee noted the position in respect of internal lockdown and recognised the need to revisit the ask of this being in place to ensure this was done safely and appropriately.
	Assurance in respect of SO 3d Reduce waits for patients who require urgent care and diagnostics to constitutional standards **Operational Performance against National Standards** The Committee received the report noting that this offered a focus on hybrid mail which was fully live in outpatients and had resulted in an increase in the number of letters sent. Work continued on data validation which would now be undertaken internally to ensure appropriate oversight of patients waiting more than 65 and 52-weeks. This would ensure a detailed understanding of the patient tracking list. The Committee was pleased to note the increase in discharges as a result of the new discharge workstream with 13% more patient discharged. The committee noted that whilst the Trust continued to fail to comply with performance standards the SPC charts demonstrated statistically significant improvements in some areas. Whilst limited assurance continued to be received improvements were being seen.

	Urgent and Emergency Care Deep Dive The Committee received the deep dive noting the strong performance which had resulted from the actions put in place to address previous performance. The work had been undertaken across the Group with the co-creation of the improved pathway with oversight through the Urgent and Emergency Care Board. The Committee noted that there were 2 programmes of work, early supported discharge and flow and the unplanned care alliance. Together these programmes of work had focused on bed occupancy and reducing length of stay and ensuring the right support at the front door to correctly sign post patients. Positive progress had been seen in a number of areas including 4-hour waits and reduction in ambulance handover waits. There was robust governance in place to monitor and track progress through the programmes of work.
	Assurance in respect of SO 3e Reducing unwarranted variation in cancer service delivery and ensure we meet all constitutional standards **As reported at SO 3d**
	Assurance in respect of SO 3f Reducing unwarranted variation in planned service delivery and ensure we meet all constitutional standards **Operational Performance against National Standards** As reported at SO 3d **Early Supported Discharge Close Down Report** The Committee received the report noting the position.
	Assurance in respect of SO 4a Establish collaborative models of care with our partners including Primary Care Network Alliance (PCNA) **Anchor and Green Plan Update** The Committee received the report noting the update that was offered in respect of both the Anchor and Green plans. Work had commenced across the system to work in partnership to maximise the impact of the plans noting a need to reconsider the Green Plan in the context of the Group. The Committee noted the proposal to recruit a Group Sustainability Lead to support the work required to review the Green Plan and to ensure traction and delivery on associated actions. Whilst there had been some success realised this had been impacted by operational pressures.

	The Committee noted the intention to review and build governance into the Integrated Improvement Plan including the move to net zero by 2040. Work had commenced on this with all new builds working to net zero. Whilst the report offered limited assurance this would move to moderate once there was a clearer understanding of the plan in place supported by an appropriate governance structure. **Fragile Services Update** The Committee received the report noting that the work on fragile services was being undertaken as a group. The internal working group had assessed fragility to determine the support required. It was noted that there was positive support across the system with a report due to be presented to the ICB to confirm the approach being taken was right for the system. A number of improvement programmes were actively working on some fragile areas with specialty services being supported to develop action plans to address remedial actions to move out of fragility. The Committee would continue to receive quarterly reports in respect of fragile services noting that regular oversight would take place through the Group Leadership Team.
	Assurance in respect of SO 4b Successful delivery of the Acute Services Review **No reports due**
	Assurance in respect of SO 4d Enhanced data and digital capability **Information Governance Group Upward Report** The Committee received the report noting the continued progress in respect of the ICO audit recommendations which linked to the wider work associated with Information Asset Ownership. The Data Security Protection Toolkit (DSPT) submission was due to be made on the 30 June with an anticipation that 3 assertions would not be met. This was a reduction to the number not met in the previous year with one of those being a new assertion for the submission. The Committee noted the audit report which had been undertaken and offered an overall risk classification of moderate and substantial in terms of the veracity of the Trust's self-assessment. A communications campaign was taking place in response to themes identified through reported IG incidents to increase awareness and the Committee noted the continued issue with SAR performance. It was anticipated that working across the Group would strengthen the position.

	Assurance in respect of SO 5a Develop a Population Health Management (PHM) and Health Inequalities (HI) approach for our Core20PLUS5 with our ICS **No reports due**
	Assurance in respect of SO 5c Tackle system priorities and service transformation in partnership with our population and communities **No reports due**
	Assurance in respect of other areas: **Integrated Improvement Plan** The Committee received the report noting the position presented. **Improvement Steering Group Upward Report** The Committee received the report noting the intention for this to develop across the Group which would take place over the coming months. To support this further controls would be developed whilst maintaining compassion and inclusion to hold people accountable for delivery of the programmes of work. The Committee noted the reporting would commence in month 2 for the strategic aim of population health with overall assurances remaining as previously reported. **Committee Performance Dashboard** The Committee received the report noting the m12 position which demonstrated an improvement in experience and outcomes in the ED through the urgent and emergency care pathway. Positive improvement was seen in planned care with no waits over 104-weeks and work continuing on addressing 78-week waits whilst ensuring support and patient choice. The cancer position continued to be maintained with a change in the oversight to ensure this was business as usual whilst being joined up across the various specialties. Greater focus was being given to DM01 with the Committee due to receive further reports at the June meeting. **CQC Action Plan** The Committee received the report noting the progress on the closure of the should do actions and noting that future reports would focus on the new CQC framework and the proactive approach being taken.
Issues where assurance remains	None

outstanding for escalation to the Board	
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	J	A	S	O	N	D	J	F	M	A	M
Dani Cecchini, Non-Exec Director	X	X	X	X	X	X	X	X	X	X	X	X
Director of Finance	X	X	X	X	X	X	X	X	X	X	X	X
Chief Operating Officer	X	X	D	X	X	X	X	X	X	X	X	X
Director of Improvement & Integration	X	X	X	X	X	X	X	X	X	X	X	D
Sarah Buik, Associate Non-Executive Director	X	X	X	X	X	X	X	X	X	X	X	X

X in attendance
A apologies given
D deputy attended

Report to:	Lincolnshire Community and Hospitals Group Board meeting
Title of report:	Finance, Performance and Estates Committee Assurance Report to Board
Date of meeting:	20 June 2024
Chairperson:	Dani Cecchini, Chair
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received, and key decisions made by the Finance, Performance and Estates Committee (FPEC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme. The Committee worked to the 2024/25 objectives.
Assurances received by the Committee	**Assurance** in respect of SO 3a Deliver financially sustainable healthcare, making best use of resources **Finance Report inc Efficiency, Contracts, Capital and Cash Draw Down** The Committee received the suite of reports in respect of planning, finance, cost improvement programme (CIP) and cash. The Committee noted that the final financial plan had been submitted on 12 June following further refinement in relation to the profile of spend and CIP delivery undertaken across the system. No changes were made to the outturn planned. In terms of month 1 & 2 delivery, this matched the final plan budget as agreed locally and nationally. Additional capital resource was made available from NHSE with a fair share allocation of £7.6m for the ICS of which the Trust share was £6.9m. This capital resource is not cash-backed. The revenue and capital plan had been updated to reflect the revised expectation of the EPR delivery in year with a deferral of capital and profiling across future years. It was recognised that there continued to be a gap in identified CIP reflecting the additional element required for 5% total delivery. In respect of investment funding some had been agreed and was reflected in the position but there were still investments that had yet to have funding agreed. The Committee noted the possible need to reconsider affordability in respect of investments should funding not be available. The report was received with moderate assurance. The Committee noted ongoing improvement to the Better Payment Practice Code (BPPC) which was reported at 94-95% for value and volume and the cash position continued to be monitored with the current position reported at £23.4m.

	The Committee received the efficiency report with moderate assurance, noting an annual £41m CIP programme with over delivery reported at month 2 of £400k. Work had taken place to identify Senior Responsible Officers to support the programmes of work with the largest focus being medical agency. The Committee requested a deep dive into medical agency at a future meeting. The Committee received the cash draw down report noting that this was regular practice pre-Covid-19 however had not been required since Covid-19. As a result of the cash position eroding there was an expectation of a need to request cash in H2 of the year. Further discussions would take place across the system regarding cash management however there was no mechanism in place at this time to support this process. It was recognised that the borrowing of cash could impact on the Trust's National Oversight Framework (NOF) position however the actual impact of this was not yet known. The Committee received the contracting report with moderate assurance noting the national requirement to sign contracts on by noon on Friday 5 July 2024. There were no concerns to flag however it was noted that signing of the contracts had been delayed due to extended planning rounds. The Committee received and noted the capital report with moderate assurance noting that the plan was offered for approval following the Board Development session. The Committee was pleased to note that due to the submission of a breakeven plan, for the system, an additional £8.9m allocation had been received. The portion of the allocation to the Trust was £6.9m. The Committee endorsed the total capital programme of £83m for the 24/25 financial year with a £3m overcommitment to manage the position throughout the year. **Procurement Update** The Committee received the report noting the significant activity within the team and the continued training and development to support the 'grow your own' ethos. The Committee noted the work of the team in the EPR procurement exercise which continued to progress as well as the activity related to the Community Diagnostic Centres (CDCs) which were running ahead of schedule. Regulation changes were due to come in to place from October with the Committee noting the volume of work associated with this change, one primarily being the publication of procurement information and another being the impact of the limitation for the Trust to directly award contracts. This would be undertaken through a central system which was currently being developed. Training was also taking place for the team to prepare for the national changes.

	The Committee noted that the Service Level Agreements with LCHS and LPFT had now been finalised and costed to include the requirement for additional capacity within the team. **Improvement Programme Deep Dive – Nurse Agency** The Committee received the report commending the volume of work that had been undertaken to significantly improve the nurse agency position. Due to the improvements made within the Trust the intention was to roll out the programme of work and support to LCHS in order to support the reduction of usage across the community. It was recognised that the achievements had underpinned the financial delivery in the 23/24 year and was a key building block of the financial position with engagement across a number of teams. The Committee recognised the work of the Director of Nursing and Assistant Director of Nursing in the achievements and noted the learning which would be applied to medical agency and partners in the Group and system. **Strategic Projects – Pilgrim ED Escalation** The Committee received the report noting the ongoing works and concern regarding delay damages. It was noted that there was concern regarding the High Voltage installation due to changes in the contracting for the work to be completed. It was recognised that the procurement process for these works was concluding and should mitigate the delays if in place in a timely manner.
	Assurance in respect of SO 3b Drive better decisions and impactful action through insight **No reports due**
	Assurance in respect of SO 3c A modern, clean and fit for purpose environment across the Group **No reports due**
	Assurance in respect of SO 3d Reduce waits for patients who require urgent care and diagnostics to constitutional standards **Operational Performance against National Standards** The Committee received the report noting that there were continuous improvements being seen in planned care with patients receiving first outpatient appointments in a more timely manner. Validation work continues to ensure the position remains supported with a need to consider communications with patients to ensure these are received.

	28 Day FDS had shown a slight deterioration in April at 73.1% compared to a target of 75% and is no longer within the agreed trajectory however this was expected to improve for May/June. Recovery against 85% delivery of the 62 day target remains in line trajectory. The service was now working under business as usual and was embedded in operational delivery however concern was noted by the Committee that previous year's investments into the service may not be continued and therefore this could impact on the position. The Committee noted the improved DM01 reporting thanks to the support of the performance team to offer an oversight position. This was utilising the same methodology for planned and cancer performance. Concern was noted in respect of the infrastructure due to the fragility of the MRI scanners however due to the joined-up work of services these were now managed in such a way that repairs were undertaken quickly. The Committee noted the category 2 ambulance response mean time at 34 minutes compared to target of 30 minutes – there was an expectation however, that the June report would show a small deterioration due to recent pressures which had been reflected regionally. There had been significant improvement in discharge with no patients reported as waiting over 24 hours from fit to discharge to achieving this, whilst recognising that the target was 12 hours, this reflected significant improvements for the Trust. The Committee noted the benefit in receiving a deep dive into the discharge work to understand the detail of this activity and the improvements and outputs. It was anticipated this would be received to the Committee in August as this would ensure time to embed the current actions. The Committee sought assurance on the delivery of 0 patients waiting 65-weeks by September due to the deterioration in progress. It was recognised that this would be further impacted by industrial action in the coming month and the need for appropriate resource to deliver.
	Assurance in respect of SO 3e Reducing unwarranted variation in cancer service delivery and ensure we meet all constitutional standards **As reported at SO 3d**
	Assurance in respect of SO 3f Reducing unwarranted variation in planned service delivery and ensure we meet all constitutional standards **As reported at SO 3d**

	Assurance in respect of SO 4a Establish collaborative models of care with our partners including Primary Care Network Alliance (PCNA) **No reports due**
	Assurance in respect of SO 4b Successful delivery of the Acute Services Review **No reports due**
	Assurance in respect of SO 4d Enhanced data and digital capability **No reports due**
	Assurance in respect of SO 5a Develop a Population Health Management (PHM) and Health Inequalities (HI) approach for our Core20PLUS5 with our ICS **No reports due**
	Assurance in respect of SO 5c Tackle system priorities and service transformation in partnership with our population and communities **No reports due**
	Assurance in respect of other areas: **Draft Board Assurance Framework (BAF) 24/25** The Committee received the draft BAF for 24/25 noting the ongoing development of this and the alignment to the Integrated Improvement Plan. The Committee reflected on the need for further clarity and inclusion of cyber to ensure that the Board were sighted and assured on the arrangements within the Trust. **Integrated Improvement Plan** The Committee received the report noting the position presented at the end of month 2. The Committee noted that the report continued to develop in areas such as the population health objective. Patients and people continued to be rated as moderate with development of measures continuing with patients. Services and partners remained limited due to performance metrics. The Committee noted the development of the report which currently only offer quantitative measurements with work underway to develop the inclusion of qualitative measures to improve reporting. **Committee Performance Dashboard** The Committee received the report with moderate assurance noting the position presented. It was noted that a number of metrics remained

	static or were not improving as expected and therefore the Committee would consider if further information was required at a future meeting. **CQC Action Plan** The Committee received the report noting the movement within this which demonstrated the embedding of actions to move to closure. Work continued with the divisions to achieve closure of all actions by the end of June. Proactive work had commenced in respect of the new CQC framework, and the Committee would receive the first quarterly report for this at the July meeting.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	None
Committee Review of corporate risk register	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	X	X
Director of Finance	X	X	X	X	X	X	X	X	X	X	X	X
Chief Operating Officer	X	D	X	X	X	X	X	X	X	X	X	X
Director of Improvement & Integration	X	X	X	X	X	X	X	X	X	X	D	X
Sarah Buik, Associate Non-Executive Director	X	X	X	X	X	X	X	X	X	X	X	X

X in attendance
A apologies given
D deputy attended

United Lincolnshire Hospitals NHS Trust

Meeting	*Lincolnshire Community and Hospitals Group Board meeting*
Date of Meeting	*2nd July 2024*
Item Number	*13*

Integrated Performance Report for May 2024

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

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

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

Recommendations/ Decision Required	• *The Board is asked to note the current performance* • *The Board is asked to approve action to be taken where performance is below the expected target* *Key to note:* *Performance* • *Year to date activity against 2019/20 for key PODS: Daycase 118%, Electives 110%, Outpatient Firsts (including procedures) 110% Outpatient Follow ups 98%* • *The year end target for 4 hour performance was set at 78%, with May set at 76%. The full UEC combined Type 1, Type 3 (both co-located and separate sites) achieved 72.05% in May* • *21.86% of patients exceeded 12 hour wait in department in ED* • *Average response time for Cat2 ambulance conveyances in May was 34 minutes against a 30 minute target* • *Length of Stay: May NEL LoS improved to 4.74 days. Average Bed Occupancy was 96.37% for Core G&A beds, reducing to 92.31% including escalation beds* • *Long Waiters - at the end of May, the Trust reported 0 patients waiting longer than 104 weeks; 3 patients waiting over 78 weeks and 380 patients waiting over 65 weeks* • *As of 2nd June 2024, ASI sat at 749, higher than the agreed trajectory of 550, but a significant improvement overall* • *The report for DM01 in May showed a slight improvement to 73.95% compared to April's 70.63%. The primary area of concern remains Echocardiography but recent declines in MRI and Ultrasound have been observed due to capacity and availability issues* • *28-day Faster Diagnosis Standard (FDS) showed deterioration in April to 73.1%, slightly below our trajectory of 75%* • *62 day classic treatment performance for April was 58.7%, an improvement from the March position (59.9%) and against a national KPI of 85%* • *104+ day waiters increased to 49 at the end of April compared to 47 at the end of March*

Finance

- *The Trust delivered a YTD adjusted deficit of £7.9m, £3.1m adverse to the planned £4.8m deficit*
- *CIP savings of £2.5m have been delivered YTD, £0.4m favourable to £2.1m planned savings*
- *Capital delivery of £5.0m is £0.9m lower than plan of £5.9m*

Workforce

- *Mandatory training for May is 93.67% against plan of 90%*
- *May sickness rate at 5.39% against Q1 target of 5.51%*
- *Staff AfC appraisals at 75.89% for May*
- *Staff turnover at 10.09% for May against target of 12.72%*
- *Vacancies at 5.70% against Q1 target of 9.31%*

Executive Summary

Quality

Falls

There has been 1 fall resulting in severe harm during the month of May. The Trust are currently at 3 severe harm falls incidents against an improvement target of ≤17 per annum. A local falls prevention training module has been developed to compliment the national e-learning module and is currently going through a consultation process prior to approval at July's Falls Prevention Steering Group.

Pressure Ulcers

There have been 39 category 2 pressure ulcers in May. A number of actions are in place including a review of the processes undertaken when transferring patients including reassessment at handover is being conducted.

VTE

The Trust achieved 100% (target 95%) compliance with VTE assessment.

Medications

Medication incidents reported as causing harm decreased significantly this month to 7.4% against a trajectory of 10.7%. The majority of incidents are at the point of prescribing and administration of medication and the main error is omitting medicines. Improving medication incidents from omitted medicines is a work stream as part of the new Patient Safety Incident Response Framework (PSIRF).

Patient safety Alerts

100% compliance achieved for the month of May. Monthly Safety Alerts exception reports are now being presented and discussed at the Patient Safety Group. An Alerts Working Group has been implemented which meets fortnightly to discuss issues which may arise and prevent the Trust meeting the deadlines and to put plans in place to mitigate.

SHMI

The Trust SHMI has increased slightly to 104.41 for May but remains within expected limits. The date for the changes to legislation for the ME Service has now been announced for the 9 September 2024 (was expected 1 April 2024). Work is also underway to standardise the morbidity and mortality review process across the Trust.

eDD Compliance

eDD Performance continues to be below the 95% target, currently at 91.70%. There is a task and finish group chaired by the Deputy Medical Director to review processes to enable improved compliance.

Sepsis compliance – based on April data

The screening compliance for inpatient child decreased to 86.30% (target 90%) April. 38 children out of 44 that had a PEWS of 5 or above were screened within the 60 minutes. Harm reviews found that all patients with a delayed or omitted screen had either a non-bacterial cause for the raised PEWS or an illness that required oral antibiotics, no harm found.

IVAB ED Children – The administration of IVAB for children in ED decreased to 71.30% (8/11 children). Harm reviews completed for all three children and no harm found.

Duty of Candour (DoC) – April Data

Verbal and written compliance for April was at 97%% and 93% respectively against a target of 100%. A dedicated member of the incident team has been working with divisions with an aim to improve compliance. Monitoring and escalation processes will continue to improve compliance.

Operational Performance

This report pertains to the performance of May 2024. As of June 7th, the Trust has reported 6 PCR confirmed positive COVID-19 inpatients. It is worth noting that the peak for the month of May was 3 patients, and this figure has subsequently decreased in line with the local and regional trends. During May, a total of 1104 Flu tests were conducted, out of which 5 yielded positive results (0.45%). Similarly, 2 out of 341 patients tested for RSV were positive (0.59%). We are pleased to report that there are presently no active Flu/RSV patients at our sites.
ULHT experienced 8 confirmed CDIFF cases and 3 Norovirus cases on the Lincoln site during May – these affected 2 wards on "outbreaks declared" impacting capacity and flow through the site.

Tracking against ERF is not currently available. Year to date percentages against plan for key PODS are: Day case 118%, Electives 110%, Outpatient Firsts (Total) 110%, Outpatient Follow ups 98%

Increased activity trends continue into 24/25 with robust monitoring weekly and monthly to quickly identify and address dips in performance.

A & E and Ambulance Performance

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

The year-end target for 4-hour performance has been set at 78%, with a rolling monthly ambition to track achievement. However, the target for May 24 of 76% has not been met, with a negative variance of 15.25% as it has turned out at 60.75%. The SPC chart in the report shows the progress towards both the 23/24 and 24/25 targets, based on Type 1 and co-located Type 3 activities. The trajectory only reflects the performance of Type 1 and co-located Type 3 activities.

However, at the end of the month, when combining all Type 1 and Type 3 activities, the performance achieved was 72.05%. This indicates a decline compared to April 74.25% performance.

During the 23/24 performance period, there was an increase in attendance, occupancy, and acuity level of presenting cases at the department. As a response, the focus was shifted to the total time spent in the department. It was observed that 21.86% of the patients exceeded the 12-hour benchmark (T1) (4% higher than April).

The maximum response time for the Cat2 ambulance response target is 30 minutes. In May, the average response time was approximately 34 minutes per day, which is an increase of 2 minutes compared to April 2024. It should be noted that the Cat2 average includes conveyances where the patient did not attend ULHT, but their postcode was within our catchment area. The SPC chart highlights values indicating vehicles that took more than 59 minutes to reach the patient. However, it is worth noting that some of these vehicles may have been for the same patient.

Fractured Neck of Femur 48hr Pathway (#NOF)

The trust has seen a significant improvement in the compliance for #NOFs going to theatre within 48 hours. May outturn is 62.03%. This is this is a deterioration on the April outturn, largely driven by a peak in demand. Performance overall continues to be a significant improvement to that seen in September 2023 when performance was below 50%

Length of Stay

During the month of May, the Non-Elective Length of Stay demonstrated an improvement in performance of 0.08 less days when compared to April 2024. The current performance stood at 4.74 days, which is 0.24 days above the agreed target. The average bed occupancy was evaluated against the "Core G&A" and was found to be 96.37%. To ensure safe and adequate flow within the acute sites, an average of 43 escalation beds/boarding spaces were made available. The occupancy vs escalation brought a safer percentage of 92.31% against the new national standard of less than 92%.

In May 2024, System Partners faced certain impediments in providing timely assistance to facilitate discharges from the acute care setting for Pathways 1 to 3. However, it is worth noting that Pathway 3 exhibited the most significant improvement, with a marked decrease in the length of stay in May 2024 (2.7 fewer days).

System Partners were challenged with identifying timely support to facilitate discharge from the acute care setting for pathways 1 to 3. The Trust also now records and monitors the percentage of discharges within 24hrs of the predicted dated of discharge (PDD). May recorded a performance of 36.92% which continues the steep deterioration seen throughout 2024 so far.

Referral to Treatment

April performance showed a slight improvement, reporting a performance of 50.62% compared to 50.01% in March. The Trust continues to report patients waiting over 104, 78, 65 & 52 weeks. At the end of May, the Trust reported zero patients waiting longer than 104 weeks. The trust exited May with 3 patients waiting more than 78 weeks, and whilst this wasn't zero, 2 were down to patient choice that we had the capacity to treat and 1 was clinically complex and has been transferred to NUH. The national ambition of clearing patients waiting over 65-weeks by the end of March has now moved to September. May Outturn was 380 which was slightly over trajectory.

The trust was an early adopter of the Further Faster programme which is a national initiative to reduce patients waiting over 52 weeks. In April the Trust reported 3,105 patients waiting over 52 weeks. Whilst we have been performing strongly against this metric, March and April saw the first increases in backlog in 11 months.

Waiting Lists

Nationally, we are seeing increased focus on total waiting list size. Whilst the trust has made huge improvements in reducing long waiting patients, total waiting list size has remained relatively static at 72-75k since November 2022. Due to the continued focus, reduction in total waiting list size started to be evident in October 2023 with a further reduction each month. The total waiting list in April sat at 70,350 which was slightly higher than the 70,218 seen in March. The trust has committed to a timeline that will see all services return to directly bookable Outpatients slots over the next 6 months. This will give greater visibility over our waiting times to GPs and improve patient choice.

As of 2nd June 2024, ASI sat at 749. Whilst this is higher than the agreed trajectory of 550, the number fluctuates week on week and is a significant improvement overall. Additional resource has been directed to resolving missing outcomes which is having a positive effect on the bookings team being able to move the ASIs to open referrals.

DM01

The report for DM01 in May showed an improvement from March, increasing from 70.63% to 73.95%. Despite sustained improvement, performance is still significantly lower than the national target of 99%. Whilst Echo has long been the pressured area, sustained improvement is bringing performance back in line. Recent declines in MRI and Ultrasound performance have been observed due to capacity and availability issues. It should be noted that MRI has experienced an increase in demand, which has contributed to the rising breaches. A recovery trajectory has been pulled together that shows a full recovery in June 2024, but recent performance puts this at risk. A detailed piece of work is currently underway into understanding the increase in demand at a granular level.

Cancelled Ops

May outturn for cancelled operations on the day deteriorated from 1.37% in April to 2.05% in May. The main drivers for this were lack of surgical staff and equipment. Performance has been deteriorating since Mar 2023 and is an adverse effect of a drive to improve theatre utilisation.

Included in the 2.05% of on the day cancellations, 16 patients were not treated within the 28-day standard. This continues to be affected by the pressure to date patients over 78 weeks requiring surgery.

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

Cancer

28-day Faster Diagnosis Standard (FDS) showed a slight deterioration in April at 73.1%. Whilst this is below the 75% target, it is above the Forecast March position of 70.5%

62-day classic treatment performance for Apr was 58.7%, a slight deterioration from the Mar position of 59.9% but significantly lower than the national KPI of 85%.

104+ day waiters increased to 49 at the end of April compared to 47 at the end of March. The highest risk speciality is colorectal with 17 pathways greater than 104 days.

Workforce

Mandatory Training – Our May 2024 Core Learning Rate is 93.67% against a Target of 90.00%. This is a very slight decrease when compared to last month although this is minimal.

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

Work continues to ensure that all areas and individuals are given the time to complete core learning modules, with focussed support being offered to those with low compliance (50% and less) through enhanced reporting provided Divisionally by the Education & Learning Team within our People & OD Directorate. A number of support measures are being implemented in terms of ESR user support, including the provisions of 'pop-up' core learning sessions for departments and individual users requiring additional input. The Mandatory Training Action Plan has been approved, the review of all core topics has been completed and changes will be made to the core and core+ offer moving forward, with consideration as to whether training needs could be aligned individually to roles. This work is gathering momentum following some changes to the competence data and re-mapping against a number of core+ modules. There continues to be a drive for all staff groups to improve their Core Training compliance through FPAM meetings, with areas needing specific focus being highlighted by the People & OD Directorate. to ensure that we are able to maintain an above target position within 2024/25.

Sickness Absence – Our May 2024 Sickness Rate is 5.39% against a Q1 Target of 5.51%. Sickness absence rates have remained stable over across 2023/24, but is not seeing the level of percentage reduction we had planned. We are continuing to work towards further reducing our vacancy level and as such, we are hopeful this continued improvement will impact positively on our colleague's health and wellbeing throughout 2024/25.

Compliance for RTW and call backs remain low, this is having a knock on effect on the length of sickness episodes. Stress and Anxiety remains the top reason for the largest number of absence days, with Cold/Flu being the largest reason for the number of sickness episodes seen across the Trust. However, it should be noted that there has been an improvement in RTW compliance during May 2024 (76.08%) when directly compared to the previous two months.

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

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

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

Staff Appraisals – Our May 2024 Appraisal Rate is measured against a Q1 Target of 76.78%. We are awaiting our May 2024 position for Medical & Dental, but have seen further improvement in the AfC rates with a total of 75.89% completed. This is an increase and improved position when compared to performance last month. Continued focussed attention to areas who are RAG rated 'red' are being discussed with teams directly, including through FPAM discussions where relevant.

It is recognised that the overall Trust wide appraisal completion rate is consistently below our annual target of 90.00%, and it is recognised that there is further focus required for 2024/25 in improving compliance if we are to ensure that there is a Trust wide focus on our ambition to meet our Trust Target, in the coming months.

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

Staff Turnover – Our May 2024 Turnover Rate is 10.09% against a Q1 Target of 12.72% and shows a further improved position when compared to April 2024. Operational pressures, staffing and culture challenges are continued challenges, although despite this we are in line with our Turnover trajectories for the year-to-date.

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

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

Vacancies – Our May 2024 Vacancy Rate is 5.70% against a 2024/25 Q1 Target of 9.31%. This position is within target and is an improved position when compared to April 2024. We have seen a significant reduction in our Vacancy Rate since April 2022 as our levels of recruitment vacancies continue to be successful.

Our AHP Vacancy Rate has shown a further improved position in May 2024 as we start to see some of the International Recruits within Radiology commence in post to support the roll out of our Community Diagnostics Centres.
Our current Registered Nursing position shows that we have removed all vacant FTE which was outstanding as at March 2024. This is a significant achievement as April 2022 saw vacancy rates at 11% for Nursing.

AHP recruitment remains a challenge locally and nationally, and will be a focus area in 2024/25 as we further develop the Community Diagnostic Services within Lincolnshire. There is already significant work being undertaken within the Trust via the Talent Academy to support developing the Pharmacy workforce, with support using data insights into vacancies and turnover as required.

For AHP recruitment we have a dedicated Resourcing Advisor to support this recruitment with a Talent Acquisition approach, we are also looking at using one of our higher performing agencies to support this recruitment. Finance and People & OD are working closely together, with a strong focus on building the wider Workforce Plan as we continue through the Business Planning Cycle for 2024/25.

Finance

The Trust's financial plan for 2024/25 is a deficit of £6.9m inclusive of a £40.1m cost improvement programme.

The Trust delivered a YTD adjusted deficit of £7.9m which is £3.1m adverse to the planned £4.8m deficit.

Post completion of the month 2 position, the Trust submitted a revised financial plan with a revised phasing; the revised plan brought the YTD plan in line with actual spend.

CIP savings of £2.5m have been delivered YTD, which is £0.4m favourable to planned savings of £2.1m.

Capital funding levels for 2024/25 have been agreed with NHSE and system partners; the Trust delivered capital expenditure of £5.0m YTD, which is £0.9m lower than planned capital expenditure of £5.9m.

The cash balance is £23.4m (plan £26.1m); this is an decrease of £27.5m against the March year-end cash balance of £50.9m.

Sameedha Rich-Mahadkar
Director of Improvements and Integration
June 2024

Key to Variation and Assurance Icons and SPC Dots

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

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

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

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

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

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

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

Where a target has been met consistently:
Where the target has been met or exceeded for at least 3 of the most recent data points in a row, or sitting is a string of 7 of the most recent data points, at least 5 out of the 7 data points have met or exceeded.

Where a target has been missed consistently:
Where the target has been missed for at least 3 of the most recent data points in a row, or sitting is a string of 7 of the most recent data points, at least 5 out of the 7 data points have missed.

OUTSTANDING CARE personally DELIVERED

Performance Overview - Quality

NHS United Lincolnshire Hospitals NHS Trust

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Mar-24	Apr-24	May-24	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Clostridioides difficile position	Safe	Patients	Director of Nursing	9	8	6	8	14	P	
	MRSA bacteraemia	Safe	Patients	Director of Nursing	0	0	0	1	1	P	
	MSSA bacteraemia cases counts and 12-month rolling rates of hospital-onset, by reporting acute trust and month using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.01	0.01	0.01	0.01		
	E. coli bacteraemia cases counts and 12-month rolling rates, by reporting acute trust and month using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.03	0.03	0.04	0.04		
	Catheter Associated Urinary Tract Infection	Safe	Patients	Director of Nursing	1	Data Not Available	Data Not Available	Data Not Available			
	Falls per 1000 bed days resulting in moderate, severe harm & death	Safe	Patients	Director of Nursing	0.19	0.08	0.09	0.17	0.13	P	
	Pressure Ulcers category 3	Safe	Patients	Director of Nursing	4.3	0	4	3	7	P	
	Pressure Ulcers category 4	Safe	Patients	Director of Nursing	1.3	0	0	1	1	P	
	Venous Thromboembolism (VTE) Risk Assessment	Safe	Patients	Medical Director	95.00%	93.56%	95.91%	100.00%	97.96%	?	H
	Never Events	Safe	Patients	Director of Nursing	0	0	0	0	0	P	L
	Reported medication incidents per 1000 occupied bed days	Safe	Patients	Medical Director	4.30	5.51	3.84	5.64	4.74	P	

OUTSTANDING CARE personally DELIVERED

Performance Overview - Quality

NHS United Lincolnshire Hospitals NHS Trust

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Mar-24	Apr-24	May-24	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Medication incidents reported as causing harm (low /moderate /severe / death)	Safe	Patients	Medical Director	10.70%	14.10%	20.40%	7.40%	13.90%	F	
	Patient Safety Alerts responded to by agreed deadline	Safe	Patients	Medical Director	100.00%	33.33%	None due	100.00%	100.00%	F	
	Hospital Standardised Mortality Ratio - HSMR (basket of 56 diagnosis groups) (rolling year data 3 month time lag)	Effective	Patients	Medical Director	100	93.76	Not available	Not available	93.90	P	
	Summary Hospital Mortality Indicator (SHMI) (rolling year data 6 month time lag)	Effective	Patients	Medical Director	100	103.19	103.25	104.41	103.83	F	
	The Trust participates in all relevant National clinical audits	Effective	Patients	Medical Director	100.00%	100.00%	100.00%	100.00%	100.00%	P	
	eDD issued within 24 hours	Effective	Patients	Medical Director	95.00%	88.50%	91.90%	91.70%	91.80%	F	
	Sepsis screening (bundle) compliance for inpatients (adult)	Safe	Patients	Director of Nursing	90.00%	91.38%	92.00%	Data Not Available	92.00%	P	
	Sepsis screening (bundle) compliance for inpatients (child)	Safe	Patients	Director of Nursing	90.00%	92.50%	86.30%	Data Not Available	86.30%	F	
	IVAB within 1 hour for sepsis for inpatients (adult)	Safe	Patients	Director of Nursing	90.00%	97.72%	96.00%	Data Not Available	96.00%	P	
	IVAB within 1 hour for sepsis for inpatients (child)	Safe	Patients	Director of Nursing	90.00%	100.00%	100.00%	Data Not Available	100.00%	P	
	Sepsis screening (bundle) compliance in A&E (adult)	Safe	Patients	Director of Nursing	90.00%	91.00%	92.00%	Data Not Available	92.00%	P	

OUTSTANDING CARE personally DELIVERED

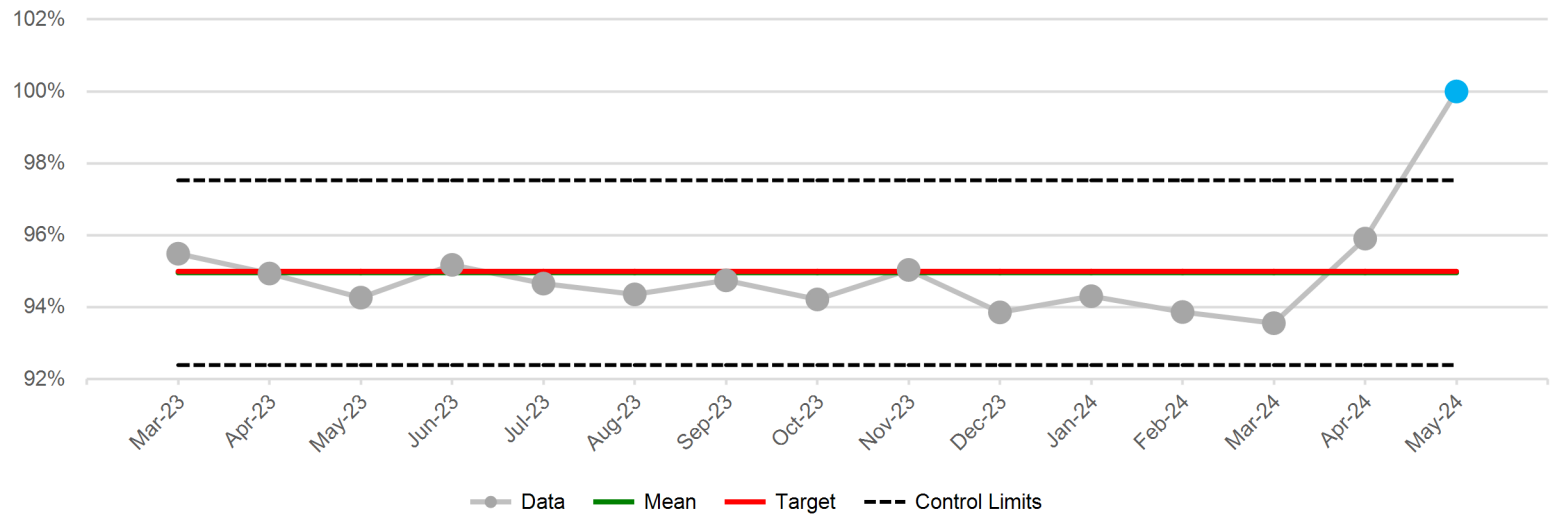
Performance Overview - Quality

NHS United Lincolnshire Hospitals NHS Trust

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Mar-24	Apr-24	May-24	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Sepsis screening (bundle) compliance in A&E (child)	Safe	Patients	Director of Nursing	90.00%	91.20%	90.67%	Data Not Available	90.67%	P	
	IVAB within 1 hour for sepsis in A&E (adult)	Safe	Patients	Director of Nursing	90.00%	95.50%	94.00%	Data Not Available	94.00%	P	
	IVAB within 1 hour for sepsis in A&E (child)	Safe	Patients	Director of Nursing	90.00%	75.00%	72.30%	Data Not Available	72.30%	F	
	Rate of stillbirth per 1000 births	Safe	Patients	Director of Nursing	3.80	2.96	2.94	2.93	2.94	P	
Improve Patient Experience	Mixed Sex Accommodation breaches	Caring	Patients	Director of Nursing	0	Submission Suspended	Submission Suspended	Submission Suspended			
	Duty of Candour compliance - Verbal	Safe	Patients	Medical Director	100.00%	100.00%	97.00%	Data Not Available	97.00%	F	
	Duty of Candour compliance - Written	Responsive	Patients	Medical Director	100.00%	86.00%	93.00%	Data Not Available	93.00%	F	

Performance Overview - Quality

Venous Thromboembolism (VTE) Risk Assessment



May-24
100.00%
Variance Type
Special cause variation - improvement (Indicator where high is good)
Target
95.00%
Achievement
Variation indicates inconsistently passing and falling short of the target
Executive Lead
Medical Director

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

What the chart tells us:
VTE risk assessment has seen significant inprovement in May 2024.

Issues:

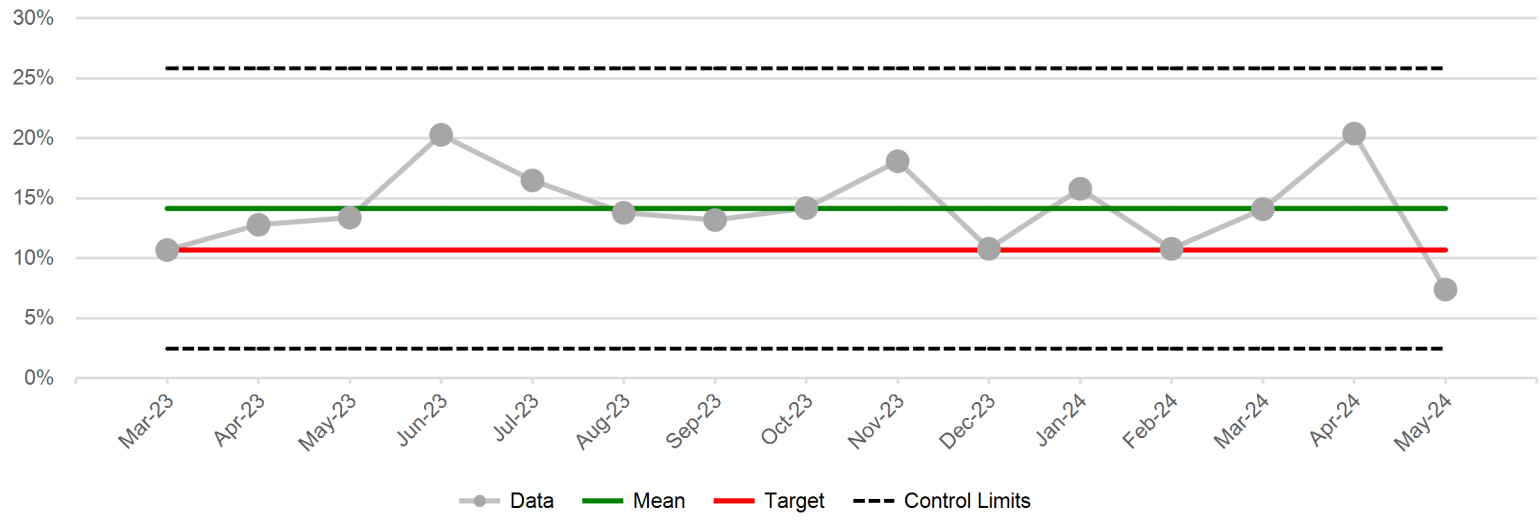
Actions:
A paper was taken to Trust Leadership Team in November 2022 proposing the reinstatement of the VTE Specialist Nurse. This was agreed and work will now take place to identify a funding stream.

No narrative owner

Mitigations:

Performance Overview - Quality

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



May-24
7.40%
Variance Type
Common cause variation
Target
10.70%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Medical Director

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

What the chart tells us:
In the month of May the number of medication incidents reported was 201. This equates to 5.64 incidents per 1000 bed days. The number of incidents causing some level of harm (low /moderate /severe / death) is 7.4% which is below the national average of 11%.

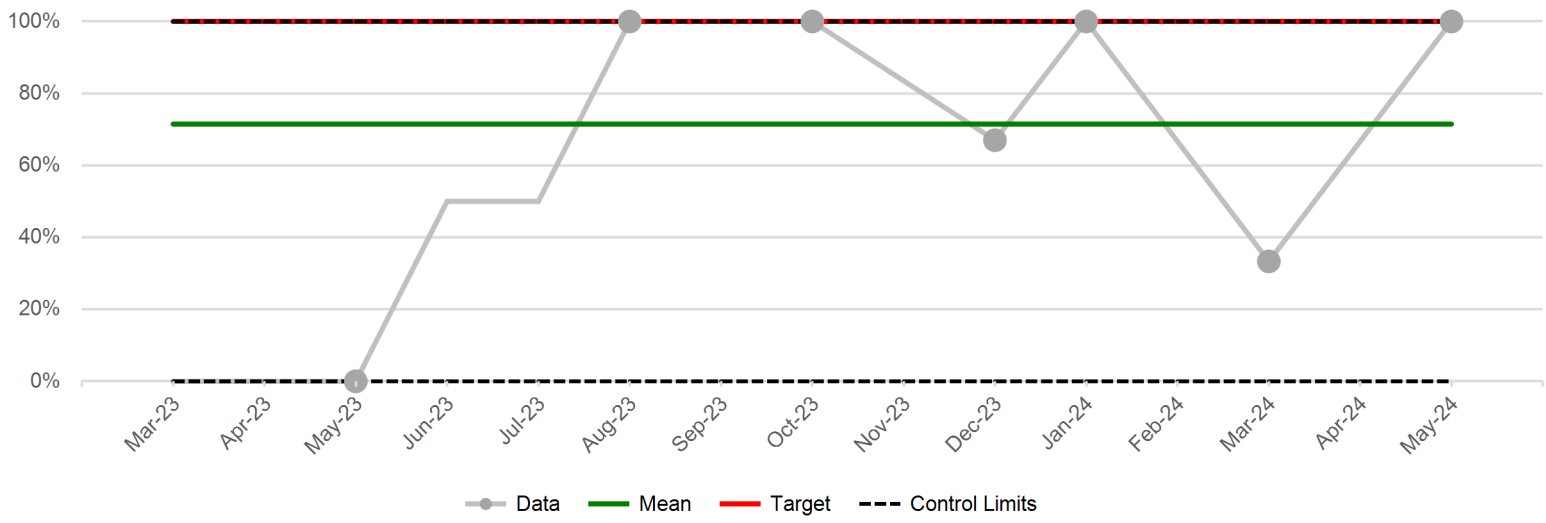
Issues:
The majority of incidents are at the point of prescribing and administration of medication and the main error is omitting medicines.

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

Mitigations:

Performance Overview - Quality

Patient Safety Alerts responded to by agreed deadline



May-24
100.00%
Variance Type
Common cause variation
Target
100.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Medical Director

Background:
Patient safety alerts responded to by agreed deadline.

What the chart tells us:
100% was compliance achieved in May 2024 although there had been deviances in December and March.

Issues:
The Trust were previously not demonstrating compliance with the target set for CAS Alerts. The performance was below the lower control limit, with non-compliance in December and March. This has improved with 100% compliance in May.

Actions:
Monthly Safety Alerts exception report is now discussed at Patient Safety Group.

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

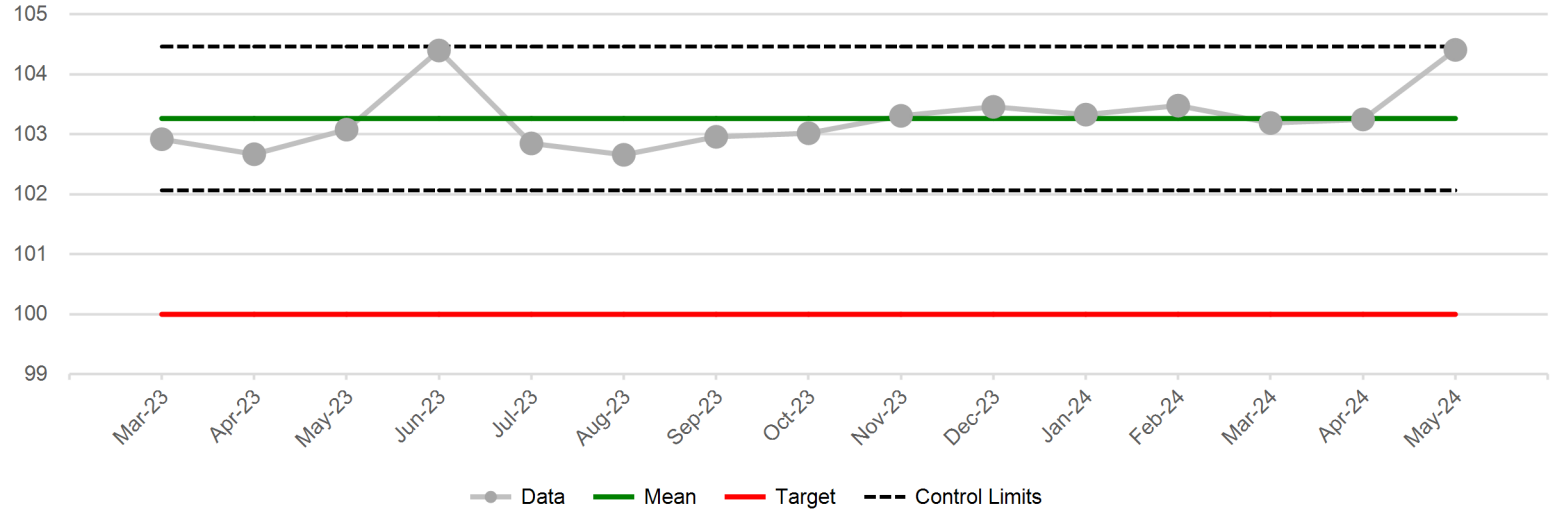
Mitigations:
Compliance to be discussed monthly at Patient Safety Group, monthly escalation report will highlight Alerts with upcoming deadlines for Leads to action.

An Alerts Working Group has been implemented which meets fortnightly to discuss issues which may arise and prevent the Trust meeting the deadlines and to put plans in place to mitigate.

Use of Dashboards for monitoring compliance on Alerts Module on DatixIQ.

Performance Overview - Quality

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



May-24
104.41
Variance Type
Common cause variation
Target
To remain in 'as expected' range
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Medical Director

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

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

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

The SHMI methodology is currently being changed – unsure what impact this will have on the data going forward.

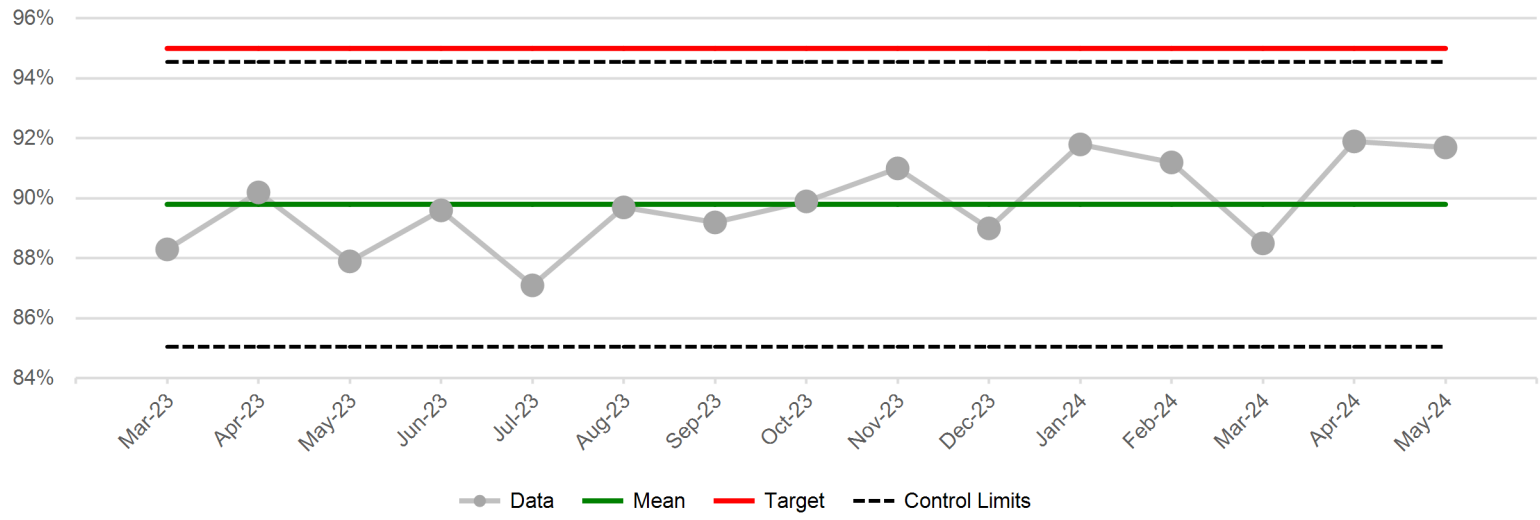
Actions:
Any diagnosis group alerting is subject to a case note review.

The Mortality Team are currently liaising with the Specialties and Business Units to implement M&Ms.

Mitigations:
The MEs have commenced reviewing some deaths in the community which will enable oversight of deaths in 30 days post discharge of which learning can be identified. Legislation will come into force from 9 September 2024 for all deaths to be reviewed by an ME.

Performance Overview - Quality

eDD issued within 24 hours



May-24
91.70%
Variance Type
Common cause variation
Target
95.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Medical Director

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

What the chart tells us:
eDD Performance continues to be below the 95% target, currently at 91.7%.

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

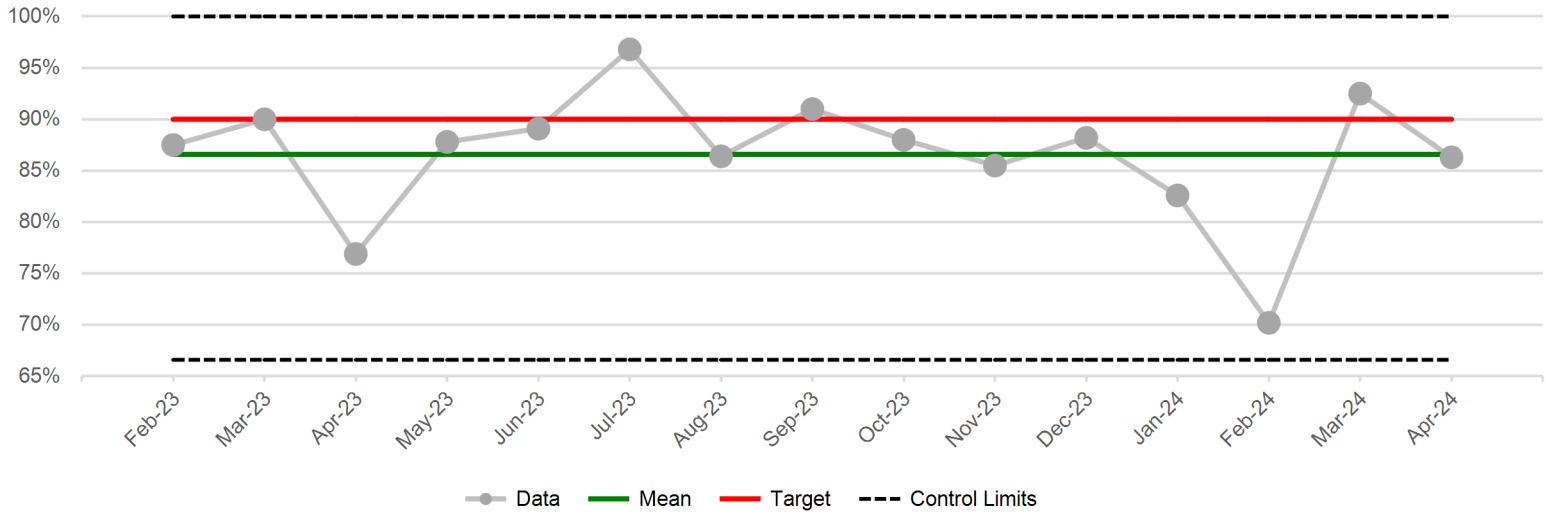
No Narrative owner

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

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

Performance Overview - Quality

Sepsis screening (bundle) compliance for inpatients (child)



Apr-24
86.30%
Variance Type
Common cause variation
Target
90.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of Nursing

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

What the chart tells us:
The data for Sepsis screening this month for Paediatric inpatients is 86.3%. This is below the 90% standard. 38 children out of 44 that had PEWS of 5 or above were screened for sepsis within 60 minutes.

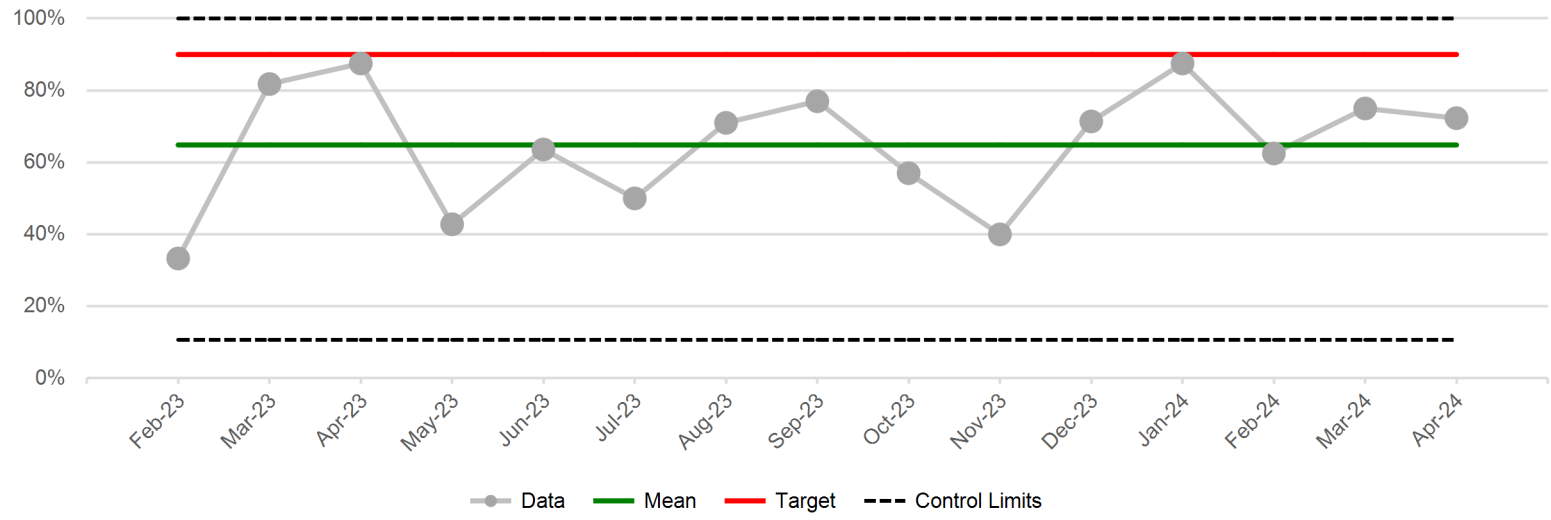
Issues:
This month six patients were not screened for sepsis within the hour. All of these had the screen added to WebV but it was not completed. The reasons given for these omissions were due to either patient workload /acuity or that they were waiting for Drs to see the patients.

Actions:
Harm reviews completed for all 6 patients and no harm found.
Simulation training held on both Lincoln and Pilgrim Site regarding Sepsis during May 24.
Staff involved have been asked to complete further harm review themselves for patients they were looking after.
Data discussed at Paediatric Governance.

Mitigations:
Harm reviews found that all patients with delayed or omitted screens had either a non-bacterial cause for raised PEWS or an illness that was treated with oral antibiotics.

Performance Overview - Quality

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



Apr-24
72.30%
Variance Type
Common cause variation
Target
90.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of Nursing

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

What the chart tells us:
The compliance for Sepsis treatment within 60 minutes in A and E was 72.3%. Eight children out of 11 were treated with IV antibiotics within the 60 minute timeframe. This is below the 90% required standard.

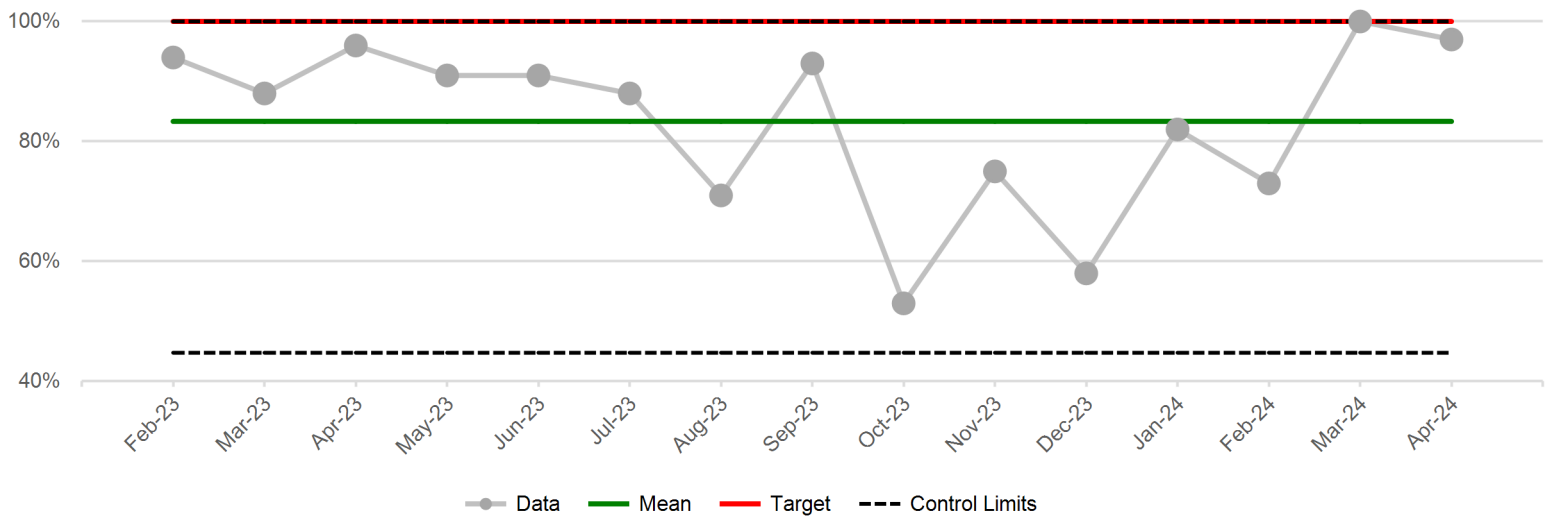
Issues:
There were 3 children this month within the ED department with delayed Sepsis treatment. All children on Lincoln site.
Two children had difficult IV access, one child had a porta Cath (no one trained to access) and the other was a baby that was difficult to cannulate due to condition. After numerous attempts at IV access IO access was achieved. The third child was delayed as waited to see Paediatric Drs before decision made to treat and then waited to be transferred to ward before IV antibiotics given.

Actions:
Urgent meetings held with both ED Nursing and Medical staff following data findings. Weekly Sepsis training now being carried out within department by Sepsis Practitioner. Lead Consultant has also done some training for medical staff. Regular Simulation training is also being arranged. Staff engagement this month to training has been positive. All cases discussed with Sepsis links.

Mitigations:
Harm reviews completed for all three patients and no harm found. Cases discussed with both ED staff at Paediatric governance as both teams involved in patient care, and involved with delays. Shared governance meetings are being planned.

Performance Overview - Quality

Duty of Candour compliance - Verbal



Apr-24
97.00%
Variance Type
Common cause variation
Target
100.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Medical Director

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

What the chart tells us:
Compliance has improved.

Issues:
From March 2024, a new parameter in DatixIQ has been used to monitor Duty of Candour compliance to ensure accuracy of data. This enables the incident team to ensure the grading of harm is accurate to enable the Duty of Candour regulation to be triggered.

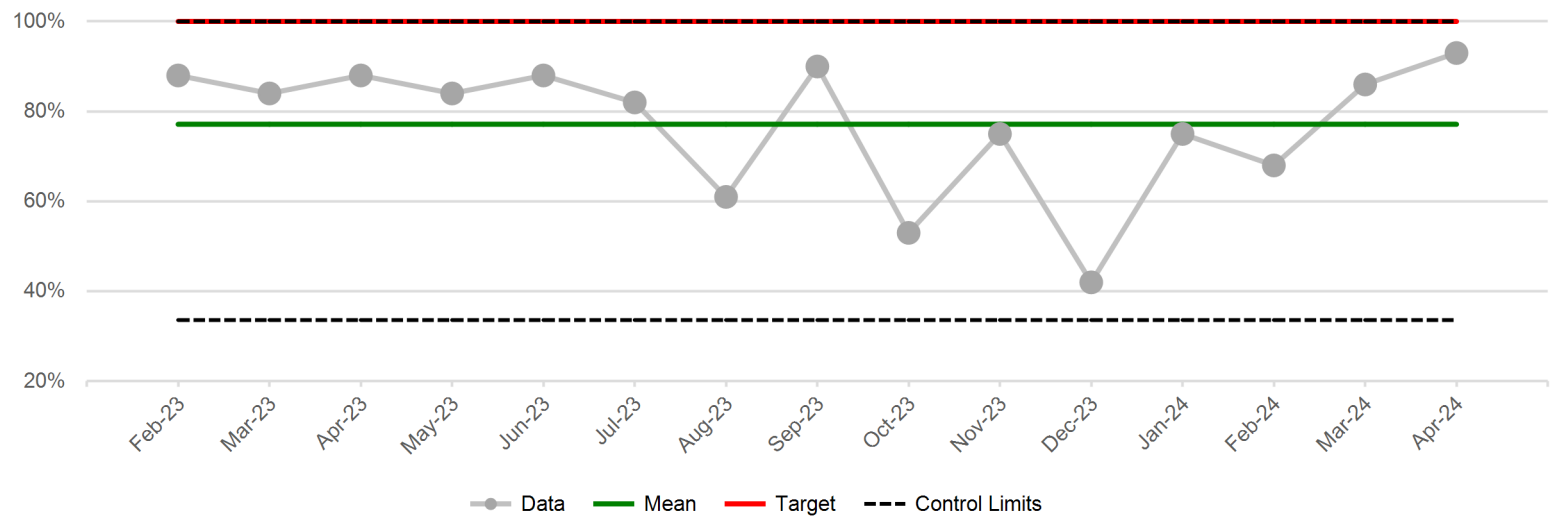
Actions:
Divisional position for each service now provided and business partners working with divisions to complete and monitor ongoing compliance.

Weekly tracking in progress by the incident team.

Mitigations:
Dedicated members of the incident team have been aligned to divisions with an aim to improve compliance.

Performance Overview - Quality

Duty of Candour compliance - Written



Apr-24
93.00%
Variance Type
Common cause variation
Target
100.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Medical Director

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

What the chart tells us:
Compliance has continued to improve.

Issues:
From March 2024, a new parameter in DatixIQ has been used to monitor Duty of Candour compliance to ensure accuracy of data. This enables the incident team to ensure the grading of harm is accurate to enable the Duty of Candour regulation to be triggered.

Actions:
Divisional position for each service now provided and business partners working with divisions to complete and monitor ongoing compliance.

Weekly tracking in progress by the incident team.

Mitigations:
Dedicated members of the incident team have been aligned to divisions with an aim to improve compliance.

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Hospitals NHS Trust

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Mar-24	Apr-24	May-24	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Patient Experience	% Triage Data Not Recorded	Effective	Patients	Chief Operating Officer	0.00%	0.40%	0.33%	0.13%	0.23%	0.00%	F	
Improve Clinical Outcomes	4hrs or less in A&E Dept	Responsive	Services	Chief Operating Officer	76.00%	60.56%	63.22%	60.75%	61.99%	76.00%	F	
	12+ Trolley waits	Responsive	Services	Chief Operating Officer	0	919	693	1,103	1,796	0	F	
	%Triage Achieved under 15 mins	Responsive	Services	Chief Operating Officer	88.50%	64.17%	75.97%	84.37%	80.17%	88.50%	F	H
	52 Week Waiters	Responsive	Services	Chief Operating Officer	2,027	3,033	3,105		3,105	4,054	F	L
	65 Week Waiters	Responsive	Services	Chief Operating Officer	0	306	284		284	0	F	L
	18 week incompletes	Responsive	Services	Chief Operating Officer	84.10%	50.01%	50.62%		50.62%	84.10%	F	
	Waiting List Size	Responsive	Services	Chief Operating Officer	58,965	70,216	70,350		N/A	N/A	F	L
	28 days faster diagnosis	Responsive	Services	Chief Operating Officer	75.00%	73.53%	73.10%		73.10%	75.00%	F	H
	62 day classic	Responsive	Services	Chief Operating Officer	85.39%	59.90%	58.70%		58.70%	85.39%	F	
	2 week wait suspect	Responsive	Services	Chief Operating Officer	93.00%	69.60%	67.00%		67.00%	93.00%	F	H

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Hospitals NHS Trust

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Mar-24	Apr-24	May-24	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Clinical Outcomes	2 week wait breast symptomatic	Responsive	Services	Chief Operating Officer	93.00%	46.50%	37.40%		37.40%	93.00%	F	H
	31 day first treatment	Responsive	Services	Chief Operating Officer	96.00%	92.70%	86.10%		86.10%	96.00%	F	
	31 day subsequent drug treatments	Responsive	Services	Chief Operating Officer	98.00%	90.60%	91.50%		91.50%	98.00%	F	
	31 day subsequent surgery treatments	Responsive	Services	Chief Operating Officer	94.00%	66.70%	68.60%		68.60%	94.00%	F	
	31 day subsequent radiotherapy treatments	Responsive	Services	Chief Operating Officer	94.00%	93.90%	85.20%		85.20%	94.00%	F	
	62 day screening	Responsive	Services	Chief Operating Officer	90.00%	71.40%	53.80%		53.80%	90.00%	F	
	62 day consultant upgrade	Responsive	Services	Chief Operating Officer	85.00%	68.30%	75.70%		75.70%	85.00%	F	
	Diagnostics achieved	Responsive	Services	Chief Operating Officer	99.00%	73.74%	70.63%	73.95%	72.29%	99.00%	F	
	Cancelled Operations on the day (non clinical)	Responsive	Services	Chief Operating Officer	0.80%	2.42%	1.37%	2.05%	1.71%	0.80%	F	
	Not treated within 28 days. (Breach)	Responsive	Services	Chief Operating Officer	0	33	37	16	53	0	F	
	#NOF 48 hrs	Responsive	Services	Chief Operating Officer	90.00%	85.54%	82.81%	62.03%	72.42%	90.00%	F	

OUTSTANDING CARE personally DELIVERED

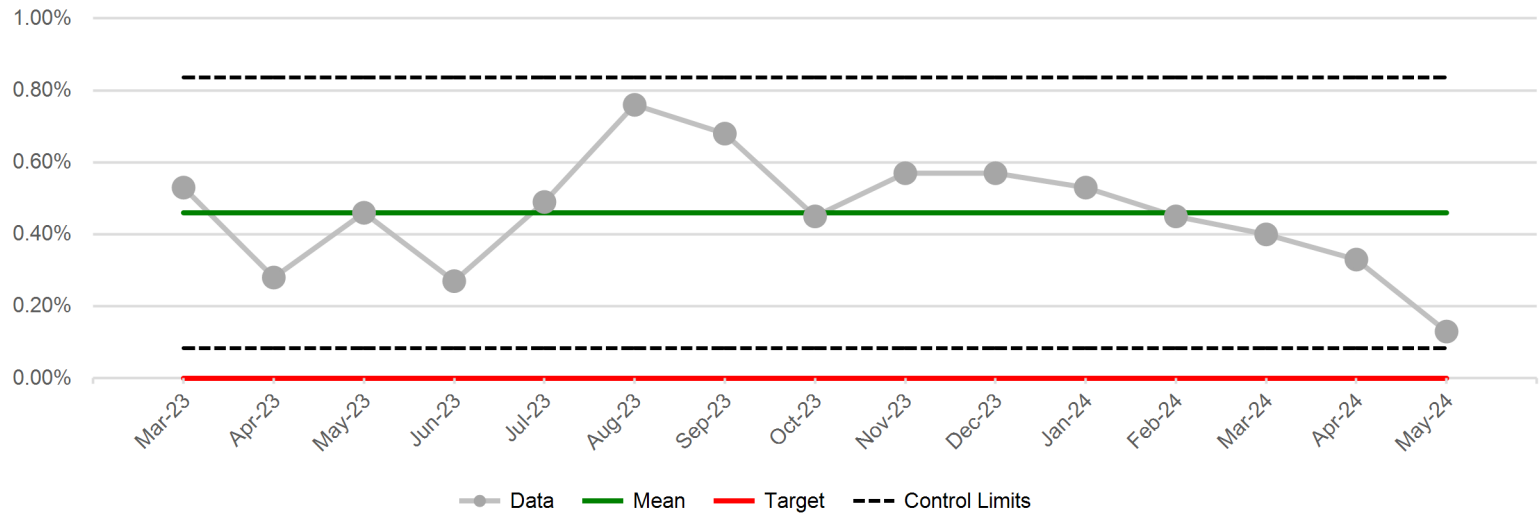
Performance Overview - Operational Performance

NHS United Lincolnshire Hospitals NHS Trust

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Mar-24	Apr-24	May-24	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Clinical Outcomes	#NOF 36 hrs	Responsive	Services	Chief Operating Officer	TBC	61.45%	57.81%	39.24%	48.53%			
	EMAS Conveyances to ULHT	Responsive	Services	Chief Operating Officer	4,657	4,779	4,628	4,924	4,776	4,657	P	H
	EMAS Conveyances Delayed >59 mins	Responsive	Services	Chief Operating Officer	0	378	210	346	278	0	F	
	104+ Day Waiters	Responsive	Services	Chief Operating Officer	10	46	47	49	96	20	F	L
	Average LoS - Elective (not including Daycase)	Effective	Services	Chief Operating Officer	2.80	2.77	2.49	3.22	2.86	2.80	?	
	Average LoS - Non Elective	Effective	Services	Chief Operating Officer	4.50	4.71	4.82	4.74	4.78	4.50	F	L
	Delayed Transfers of Care	Effective	Services	Chief Operating Officer	3.50%	Submission suspended	Submission suspended	Submission suspended		3.50%		
	Partial Booking Waiting List	Effective	Services	Chief Operating Officer	4,524	29,086	30,325	31,278	30,802	4,524	F	H
	% discharged within 24hrs of PDD	Effective	Services	Chief Operating Officer	45.00%	38.90%	37.63%	36.92%	37.28%	45.00%	F	

Performance Overview - Operational Performance

% Triage Data Not Recorded



May-24
0.13%
Variance Type
Common cause variation
Target
0.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
Percentage of triage data not recorded.

What the chart tells us:
May 24 reported a non-validated position of 0.13% of data not recorded verses target of 0%. What the chart doesn't tell us is that 89.18% of those without a triage "did not wait" to be seen. 65% of the overall missing data is on the LCH Site.

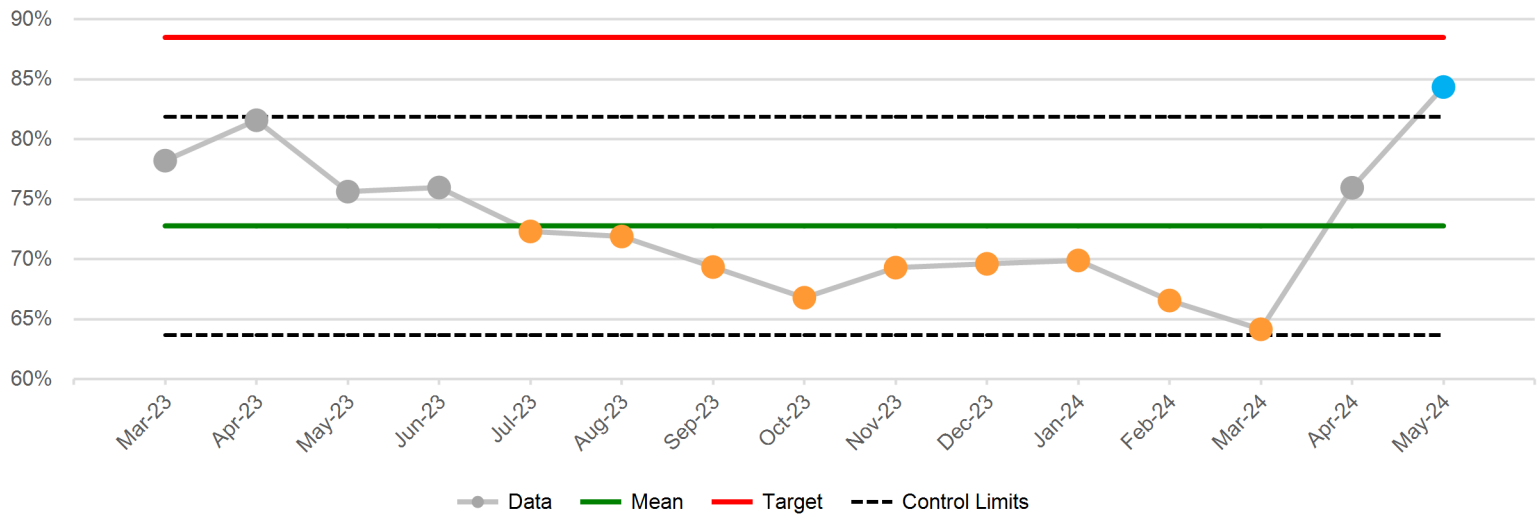
Issues:
- Identification of patients who left or refused treatment prior to triage, as well as patients who were transferred to another site for specialized care.
- It is important that the Manchester Triage trained staff operate two triage streams consistently, particularly during out-of-hours shifts. However, staffing gaps, sickness, and skill mix issues have been causing some problems that need to be addressed.

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

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

Performance Overview - Operational Performance

%Triage Achieved under 15 mins



May-24
84.37%
Variance Type
Special cause variation - improvement (Indicator where high is good)
Target
88.50%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
Percentage of triage achieved under 15 minutes.

What the chart tells us:
May outturn was 84.37% compared 75.97% in April (validated). This is a 4.13% negative variance to the target of 88.50%
Mays performance is a 17% improvement compared to 2024 Quarter 1 average. (66.88%).

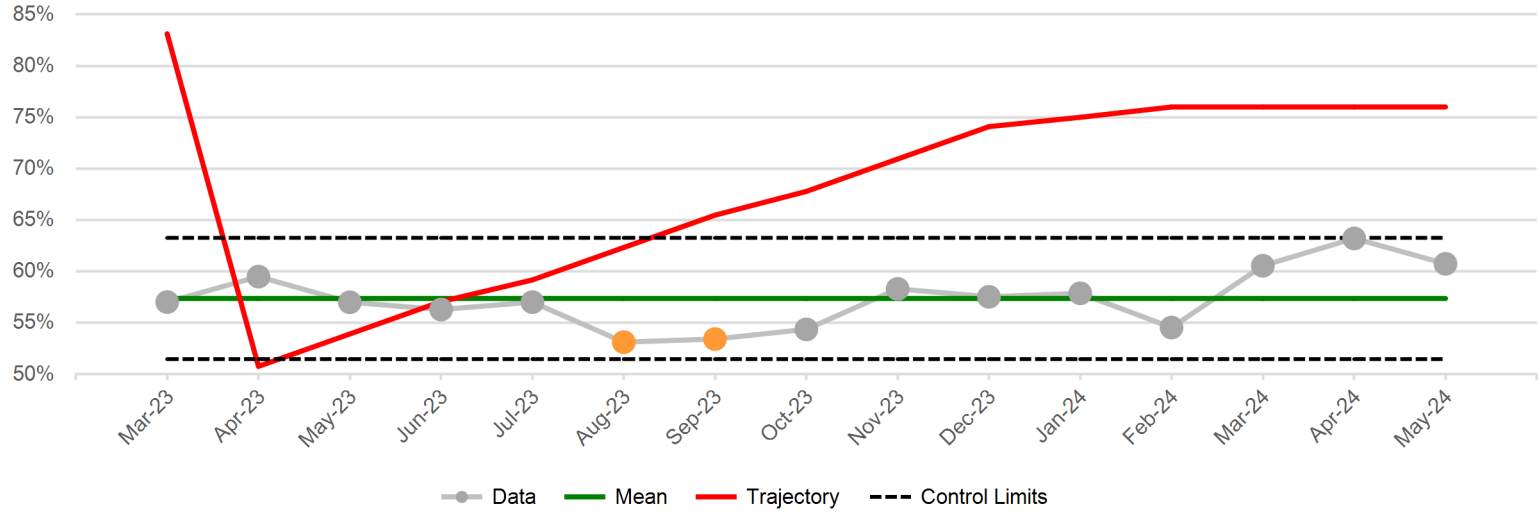
Issues:
- Consistent availability of MTS2 trained staff available per shift to ensure 2 triage streams in place 24/7 has deteriorated.
- There is a recording issue for UTC transfers of care to ED that skews that data on occasion.
- Dual department roles. For example, the second triage nurse is also the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

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

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

Performance Overview - Operational Performance

4hrs or less in A&E Dept



May-24
60.75%
Variance Type
Common cause variation
Trajectory
76.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
The 4-hour transit performance for Type 1 and co-located UTC Type 3 for has not been met.
Achieving 60.75% a negative variance of 15.25%.Mays out turn is a 2.47% decline to April performance. What the chart doesn't tell us is the 5.31% increase in daily attendances to T1 departments.

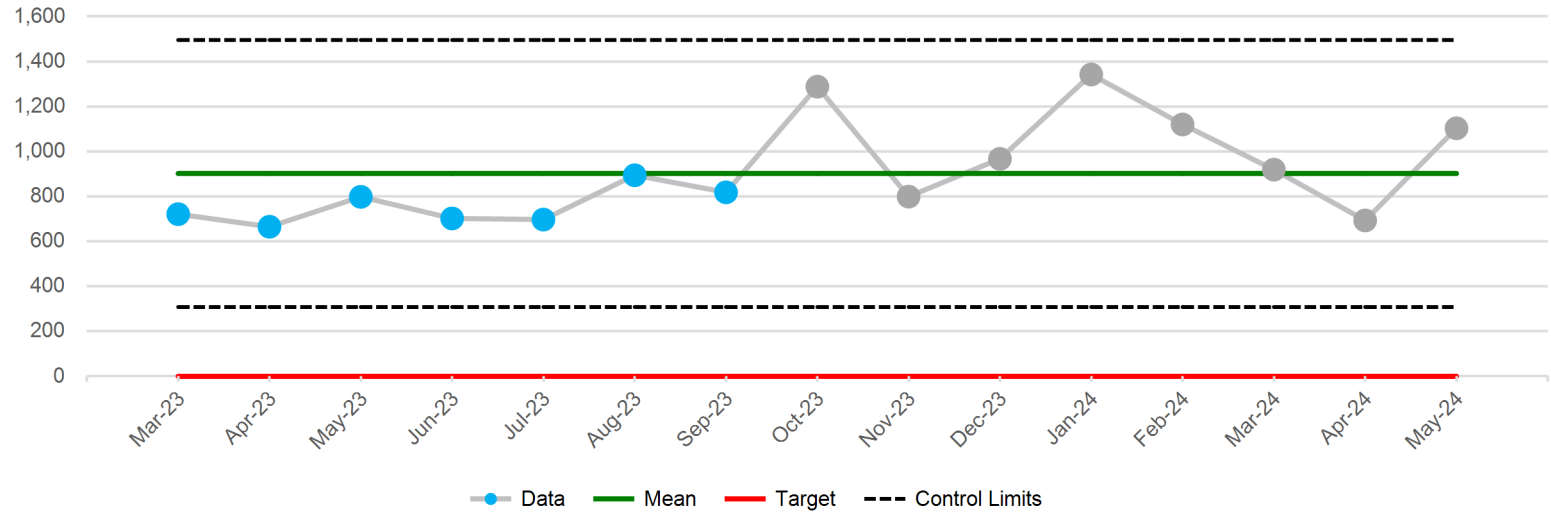
Issues:
Type 1 (ED) saw an average of 338 patients daily, which was a increase from the 320 patients seen in April 2024. However, the ED experienced a shortage of discharges from the wards, with an average of 30 fewer patients discharged daily than required to meet the demand. This resulted in longer waiting times for inpatient beds during the night. Additionally, the delayed recognition of patients who were eligible for prolonged stays in the ED, with over 60% of patients being recognized only after 4 pm daily. Furthermore, the availability of resources for movement and cleaning was affected by the closure of beds on the wards due to infection, leading to an impact on timely movements. As such, the management should consider implementing measures to address these challenges and ensure the smooth operation of the ED. These measures may include increasing the number of discharges from the wards, improving the recognition of patients who could be discharged.

Actions:
Project 76 in place which is a dedicated programme of work looking at admission avoidance, ED process, acute medicine and direct pathways to reduce overcrowding in EDs and the length of time patients are waiting to be seen.
Divisional/organisational action plans monitored weekly by senior leaders from across ULHT and LCHS.
A new Group Discharge Board has also been set up to focus on the discharge agenda and flow throughout the hospital. The group is chaired by the Chief Nurse and COO and has senior attendees from across the group.
the day.

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

Performance Overview - Operational Performance

12+ Trolley waits



May-24
1,103
Variance Type
Common cause variation
Target
0
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
There is a zero tolerance for greater than 12-hour trolley waits. These events are reported locally, regionally, and nationally.

What the chart tells us:
May experienced 1103 breaches compared to 693 in April. This is a decline of 37% (410) more patients. The 693 seen, equates to 11% of all type 1 attendances. (4% more than April).
What the chart does not highlight is the adhoc internal decisions to move focus to total time in ED to minimise exposure risk/ mortality rate.

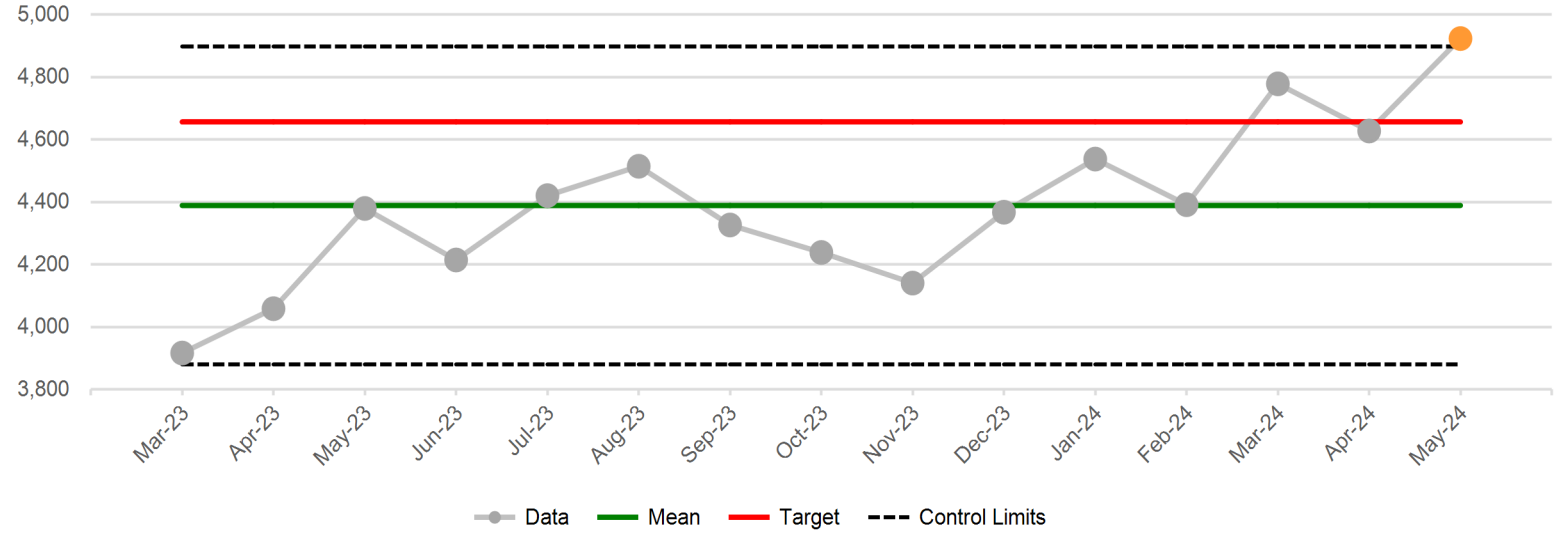
Issues:
Sub-optimal discharges to meet the known emergency demand.
All reportable 12hr trolleys were either associated with no available beds, patient deterioration or delays in transfer to other care settings.

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

Mitigations:
A System agreement remains in place to staff the Discharge Lounges 24/7 to reduce the number of patients in the Emergency Departments that are deemed 'Medically Optimised' that need onward non acute placement/support.
A Criteria to Admit Lead has been established ensuring all decisions to admit must be approved by the EPIC (Emergency Physician in Charge) with the relevant On Call Team.
An additional consultant shift was funded by winter monies to review all DTAs every day to ensure that they still require admission
Rapid Assessment and Treatment consultant shifts are in place at both ED front doors to assist with length of stay in department and appropriateness of referrals/navigation.

Performance Overview - Operational Performance

EMAS Conveyances to ULHT



May-24
4,924
Variance Type
Special cause variation - cause for concern (Indicator where high is a concern)
Target
4,657
Achievement
Variation indicates consistently passing the target
Executive Lead
Chief Operating Officer

Background:
EMAS Conveyances to ULHT.

What the chart tells us:
The total number of conveyances to ULHT in May continued to demonstrate a 15% increase in activity for 2023/24 compared to conveyance seen throughout 2022/23. What the chart does not tell is the May conversion rate of 53.15% to admission, a 2% increase compared to 2023/24. This show the higher acuity of conveyances now being seen.

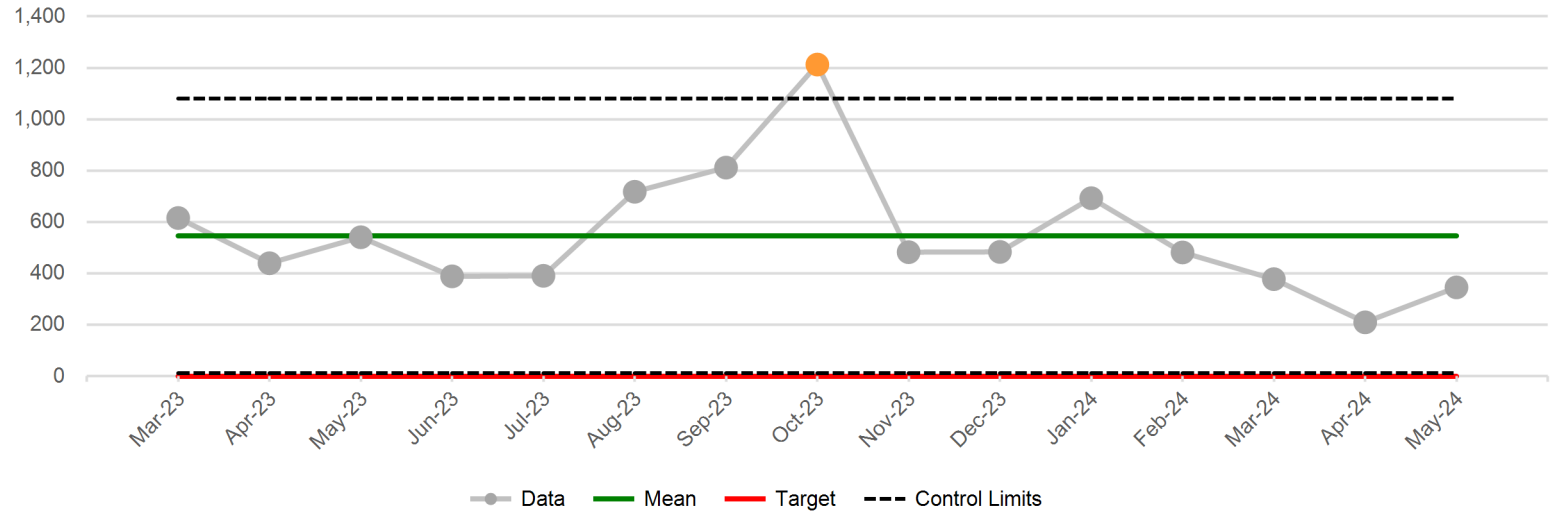
Issues:
The pattern of conveyance is such that arrivals are loaded to the late afternoon and into the evening. This also coincides with increased 'walk ins'.
The use of alternative pathways to avoid conveyance to the Trust are still not fully adhered to but progress continues to be made.
Pressure experienced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

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

Mitigations:

Performance Overview - Operational Performance

EMAS Conveyances Delayed >59 mins



May-24
346
Variance Type
Common cause variation
Target
0
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
Delays in offloading patients following a conveyance has a known impact on the ability of EMAS to respond to outstanding calls.

What the chart tells us:
May demonstrated a deterioration in ambulance handover. Notable significance with 346 arrivals over 59 minutes, representing 7.03% of all arrivals. This performance is 5% lower than that of May 23 and 6% lower than that of April 23. What the chart doesn't demonstrate is the increased daily arrivals to ULHT of 6.40%.

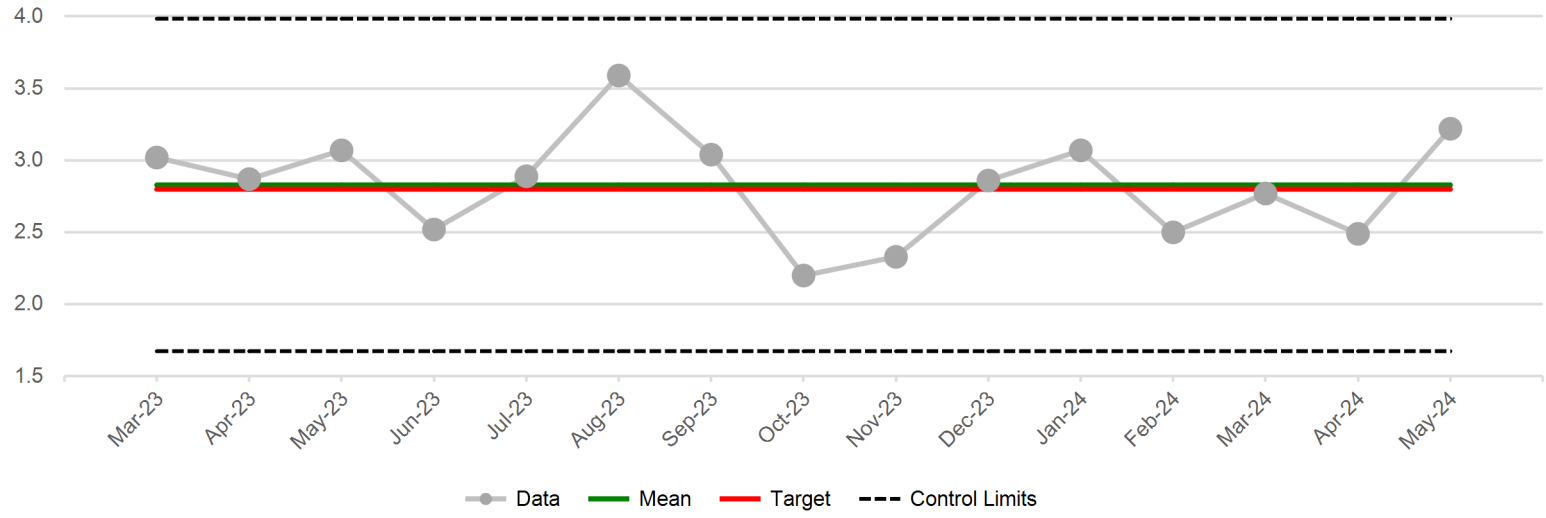
Issues:
The pattern of conveyance and prioritisation of clinical need contributes to the delays.
Increased conveyances continue to profile into the late afternoon and evening coincides with increased 'walk in' attendances causing a reduce footprint to respond to timely handover.
An increasing number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

Actions:
All ambulances approaching 30 minutes without a plan to off load are escalated to the Clinical Site Manager in hours and SOC out of hours
Daily communication with EMAS crews to sign post to alternative pathways and reduce conveyances to the acute setting.
Active monitoring of the EMAS inbound screen to ensure the departments are ready to respond.
Rapid handover protocol, designated escalation areas have been identified/confirmed to assist in reducing delays in handover.
Plus 1/2 Process active to alleviate pressure/capacity in ED.
EMAS Clinical Navigator trial imminent to test whether a dedicated senior ambulance member would be able to direct the flow of patients more successfully in conjunction with the operations centre on each site.

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

Performance Overview - Operational Performance

Average LoS - Elective (not including Daycase)



May-24
3.22
Variance Type
Common cause variation
Target
2.80
Achievement
Variation indicates inconsistently passing and falling short of the target
Executive Lead
Chief Operating Officer

Background:
Average length of stay for Elective inpatients.

What the chart tells us:
The average LOS for Elective stay has increased to 3.22 days compared to 2.5 days in April. This represents a negative variance of 0.42 days against the agreed target.

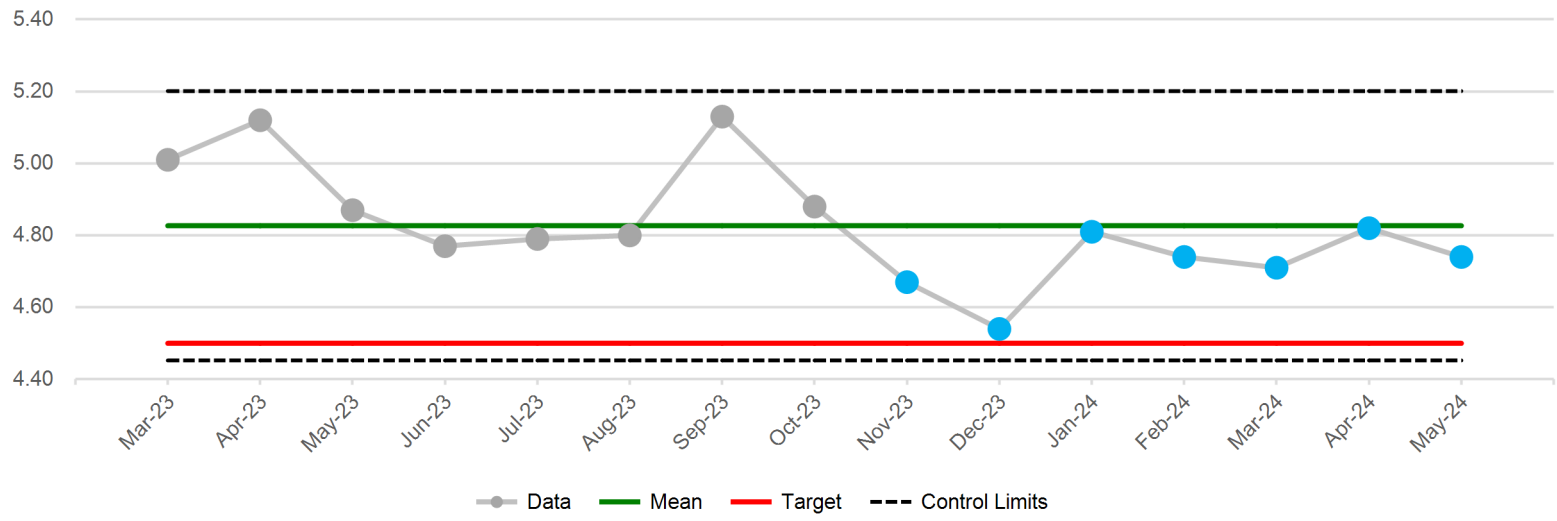
Issues:
Complexity of patients now being admitted which will impact on post-operative recovery and LOS.
Increase in Elective patients on pathways 1, 2 & 3.
Distorted figures associated with outliers in previous dedicated elective beds and coding.

Actions:
The reduction in waiting times is being monitored weekly.
Focus on speciality waiting lists where patients have been identified as having increased morbidity which will impact of increased LOS.
Timely ITU 'step down' of level 2 care to level 1 'wardable' care.
The complete review and allocation of 'P' codes. This is currently at c6weeks.
Work is in train to include an ALOS predictor against procedure normal LOS vs patient specific indicators when scheduling patients for theatre.

Mitigations:
6-4-2 weekly theatre scheduling meeting will identify those patients that will need an extended LOS and consideration for increased optimisation to reduce predicted LOS.
All elective areas are to now escalate pre-operatively any post-operative requirements that may lead to an extended LOS outside of the expected LOS.

Performance Overview - Operational Performance

Average LoS - Non Elective



May-24
4.74
Variance Type
Special cause variation - improvement (Indicator where low is good)
Target
4.50
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
May outturn of 4.74 is an improvement of 0.08 days and a 0.24-day negative variance against the agreed target.
What the chart doesn't tell us is the change by pathway:
Pathway 0 (0.1) less days
Pathway 1 (1.1) less days
Pathway 2 (2.3) more days
Pathway 3 (2.7) less days

Issues:
Stranded and Super stranded patients have decreased in daily average patients with Super reducing to 116 patients from 123 in April. Stranded reduced from 198 daily average patient to Mays 191 daily average.

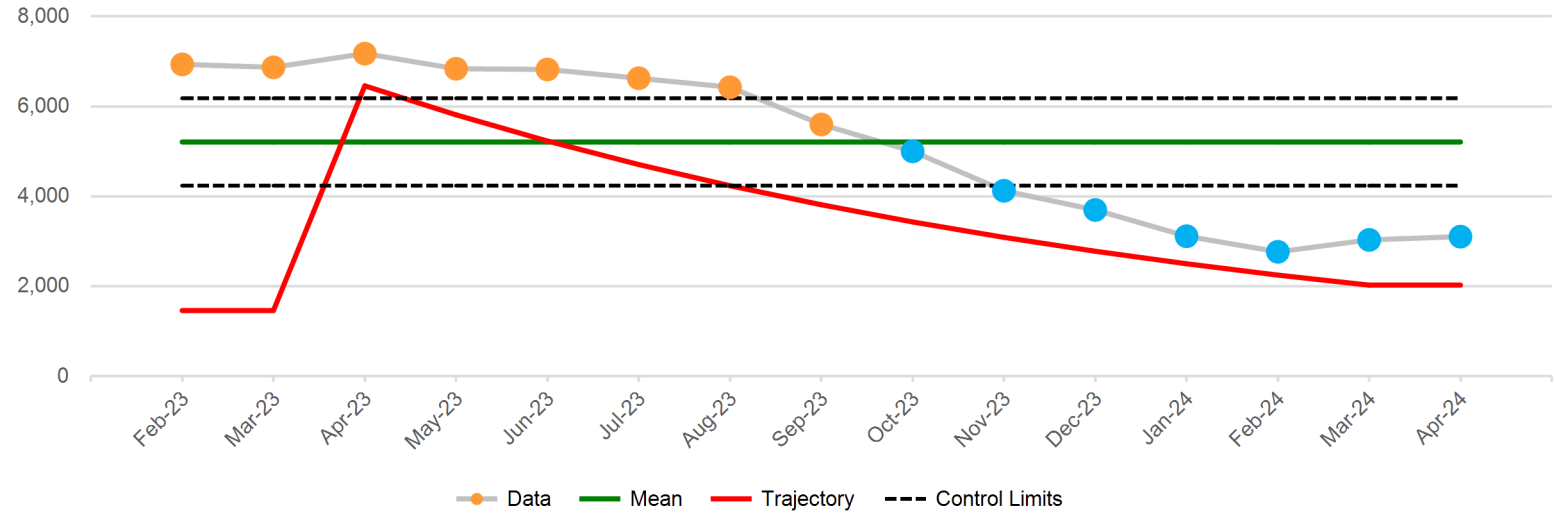
Weekend Discharges remain consistently lower than weekdays,(43% reduction/ average 60 patients) which are required to meet Emergency Admission Capacity and Demand.
But since the advent of the joint D2A process and additional funding benefits are being realised slowly but there remains insufficient capacity 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.

Actions:
Focused discharge profile through daily escalations.
Medically optimised patients discussed twice daily 7 days a week with system partners to ensure plans in place and a zero tolerance of >24hrs delay
Maximise use of all community and transitional care beds when onward care provision cannot be secured in a timely manner.
Line by line review of all pathway fully 0 patients who do not meeting the reason to reside.
Monthly face to face MADE events now commenced on each site. Reviewing all Pathways, with a greater focus on >7 days length of stay patients.

Mitigations:
Divisional Leads continue to support the escalation of exit delays.
Continued reduction in corporate and divisional meetings to allow a more proactive focus on increasing daily discharges. However, this is not sustainable.
A daily site update message is now sent at 6am alerting Key Leaders to ED position, flow and site OPEL position by Site.
The move to working 5 days over the 7 a Day period is in train.
A new rolling programme of MADE has been agreed and the frequency has been agreed as an 8-week rolling programme.

Performance Overview - Operational Performance

52 Week Waiters



Apr-24
3,105
Variance Type
Special cause variation - improvement (Indicator where low is good)
Trajectory
2,027
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
The Trust reported 3,105 incomplete 52-week breaches for April 2024, an increase of 72 from March's 3,033.

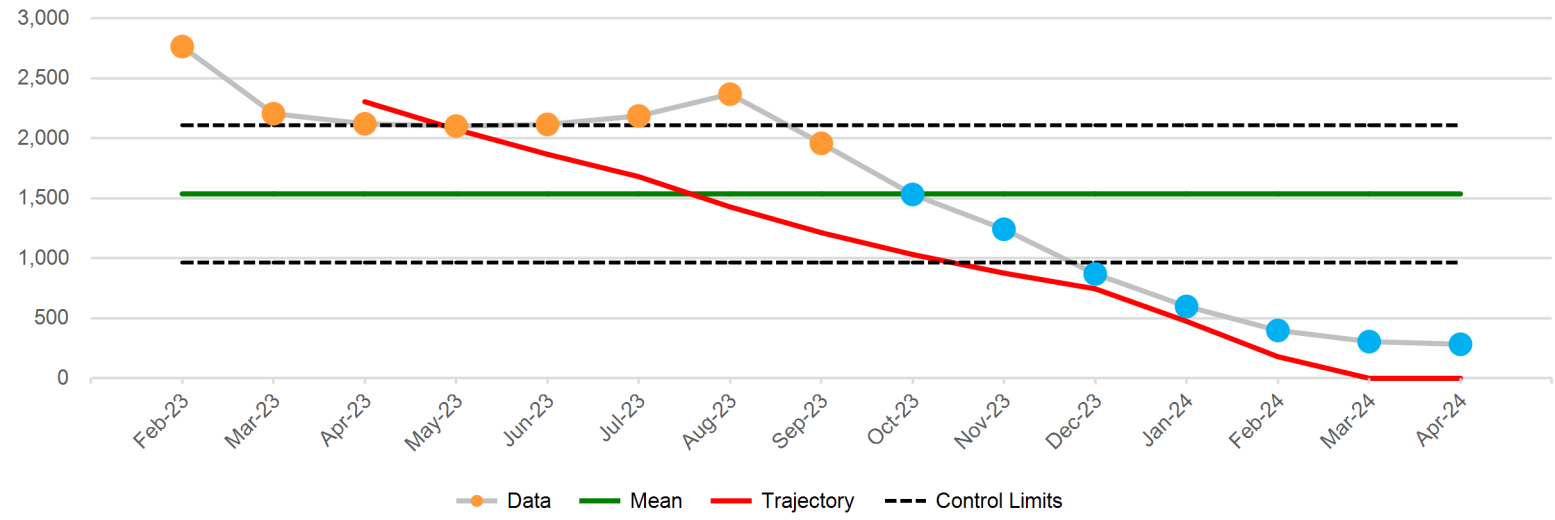
Issues:
As shown above, 52 week waiters are negatively performing against trajectory, with a slight increase on the previous month.
Both admitted and non-admitted patients sit within this wait band, however, the most significant pressure is in the non-admitted pathways.
ENT continues to be the specialty under greatest pressure.

Actions:
The Integrated Elective Care Co-Ordination Programme continues to be used for admitted patients, providing an increased efficiency of the 642 process.
Additional resource from the system Planned Care team continues to assist ENT and MaxFax, supporting man-marking of all long-waiting patients.
Additional weekend clinics are taking place for ENT patients.

Mitigations:
Due to a much improved position, ULHT have now been removed from the national tiering system for elective recovery.
ULHT 52 week position in current data (May '24) ranks 4th for this metric within the Midlands region (11 Providers).

Performance Overview - Operational Performance

65 Week Waiters



Apr-24
284
Variance Type
Special cause variation - improvement (Indicator where low is good)
Trajectory
0
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

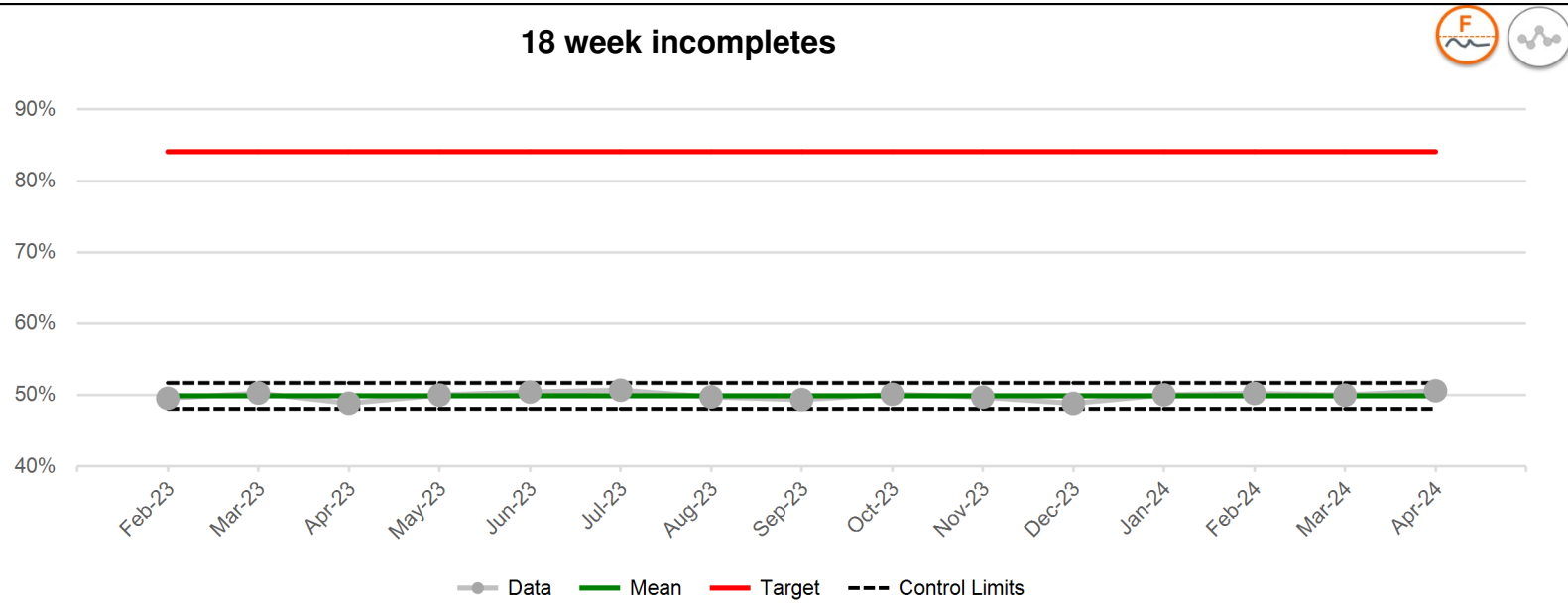
What the chart tells us:
The Trust reported 284 incomplete 65-week breaches for April 2024, a decrease of 22 from March's 306.

Issues:
ULHT's 104 week wait position was one for April. As shown above, 65 week waiters are continuing to reduce.

Actions:
Incomplete patient pathways are discussed with individual specialities weekly, through PTL meetings.
This meeting is currently focusing on patients in the 78w cohort for the current and next month, together with the 65w cohort for the current month. Due to the high volume of patients, this is being held twice a week.

Mitigations:
ORIG supports delivery of Outpatient improvements for the non-admitted pathways. To ensure Outpatient capacity is fully utilised and efficiency schemes are implemented and well used.
Current data (May '24) ranks ULHT 4th for 65w cohort metrics within the Midlands region (11 Providers).

Performance Overview - Operational Performance



Apr-24
50.62%
Variance Type
Common cause variation
Target
84.10%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
Percentage of patients on an incomplete pathway waiting less than 18 weeks:

What the chart tells us:
There is significant backlog of patients on incomplete pathways. April 2024 saw RTT performance of 50.62% against an 84.1% target, which is 0.61% up from March.

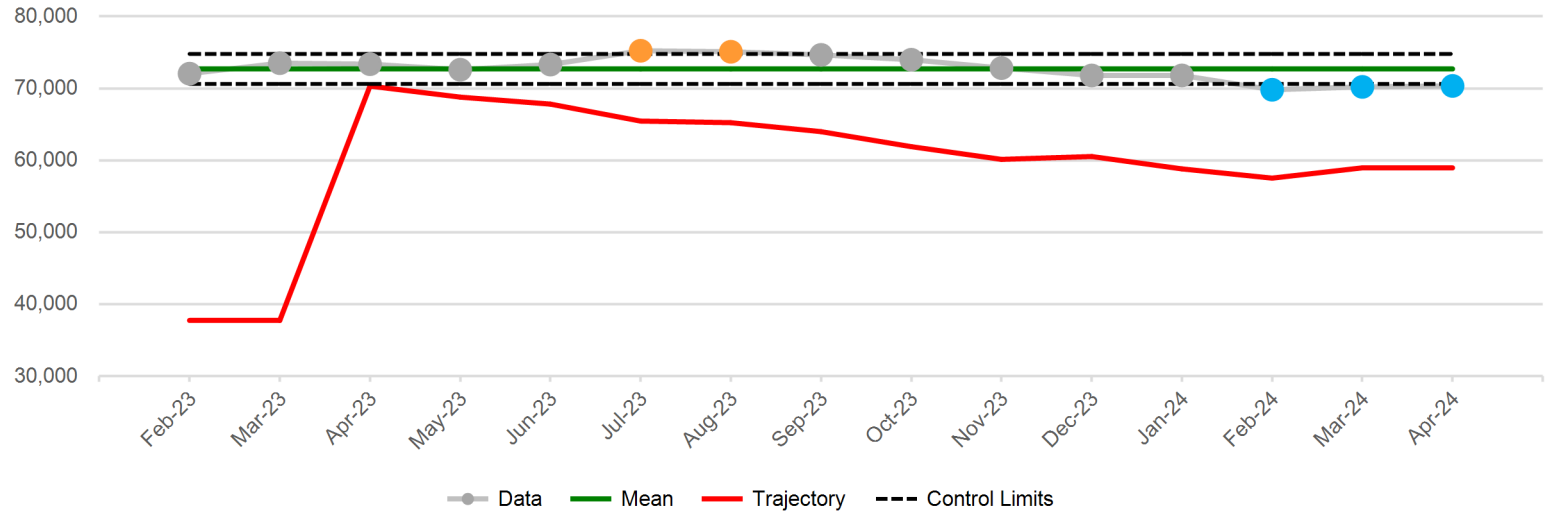
Issues:
Performance is currently below trajectory and standard. The five specialties with the highest number of 18 week breaches at the end of the month were:
ENT – 6626 (increased by 228)
Gastroenterology – 3078 (decreased by 16)
Gynaecology – 2717 (decreased by 103)
Ophthalmology – 2480 (increased by 29)
Maxillo-Facial Surgery + Ortho – 2039 (increased by 10).

Actions:
Priority remains focussed on clinically urgent and Cancer patients. National focus continues to be on patients that are waiting 78 weeks and over, with the target to achieve zero by the end of the current month. Resource is targeted at patients who have the potential to be >78 weeks.
Schemes to address the backlog include;
1. Outpatient utilisation
2. Tertiary capacity
3. Outsourcing/Insourcing
4. Use of ISPs
5. Reducing missing outcomes

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

Performance Overview - Operational Performance

Waiting List Size



Apr-24
70,350
Variance Type
Special cause variation - improvement (Indicator where low is good)
Trajectory
58,965
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
The number of patients currently on a waiting list.

What the chart tells us:
Overall waiting list size has increased from March, with April showing an increase of 134 to 70,350.
This is more than double the pre-pandemic level reported in January 2020.

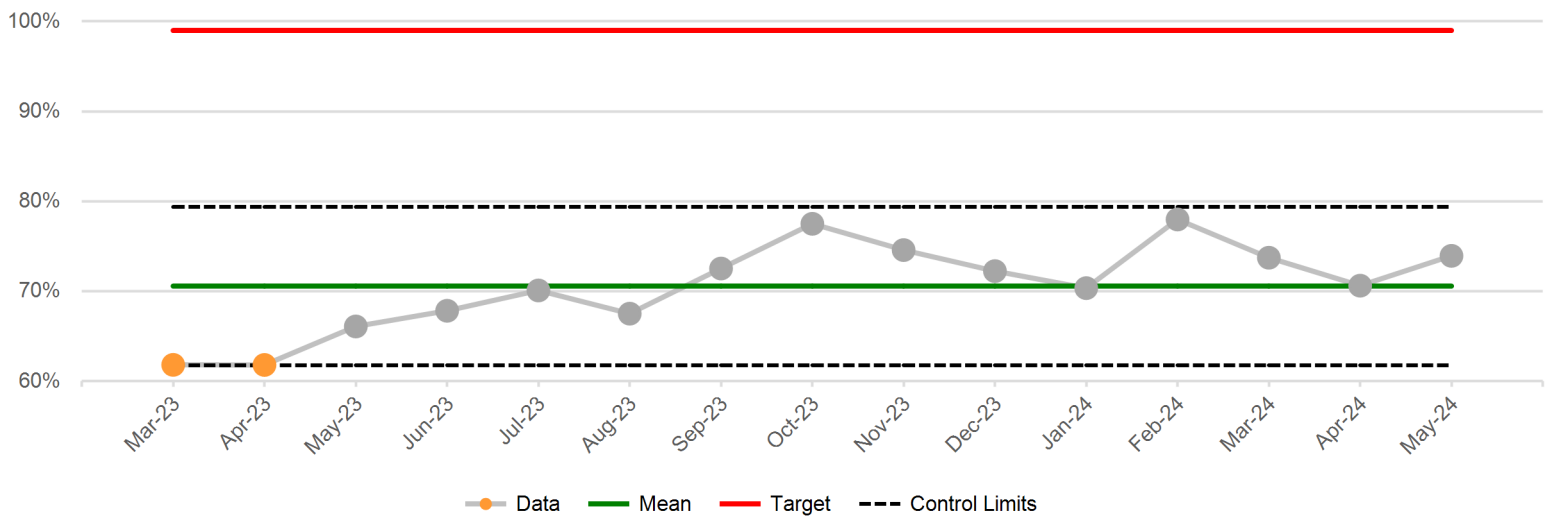
Issues:
Following the backlog increase from the pandemic, there have been additional pressures that have affected capacity, including urgent care pressures.
The five specialties with the largest waiting lists are;
ENT – 10,715
Ophthalmology – 6,443
Gastroenterology – 5,368
Gynaecology – 5,286
Urology – 4,215

Actions:
Improvement programmes as described above for RTT performance. The EACH is also supporting by contacting Dermatology, Gastroenterology, ENT and Maxillo-Facial patients to determine if a first appointment is still required.
A Business Case is being put forward for the Trust to invest in a substantive internal validation team.

Mitigations:
The number of patients waiting over 78 weeks has shown an increase of one from March. Current data (May '24) ranks ULHT 3rd for this metric within the Midlands region (11 Providers)
Appropriate admitted and non-admitted patients continue to be transferred out to ISP's or insourced, with an established process for this in place for several specialties.

Performance Overview - Operational Performance

Diagnostics achieved



May-24
73.95%
Variance Type
Common cause variation
Target
99.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
Diagnostics achieved in under 6 weeks.

What the chart tells us:
DM01 March 2024 73.95% against the 99.00% target amended target 85% by May 2024.

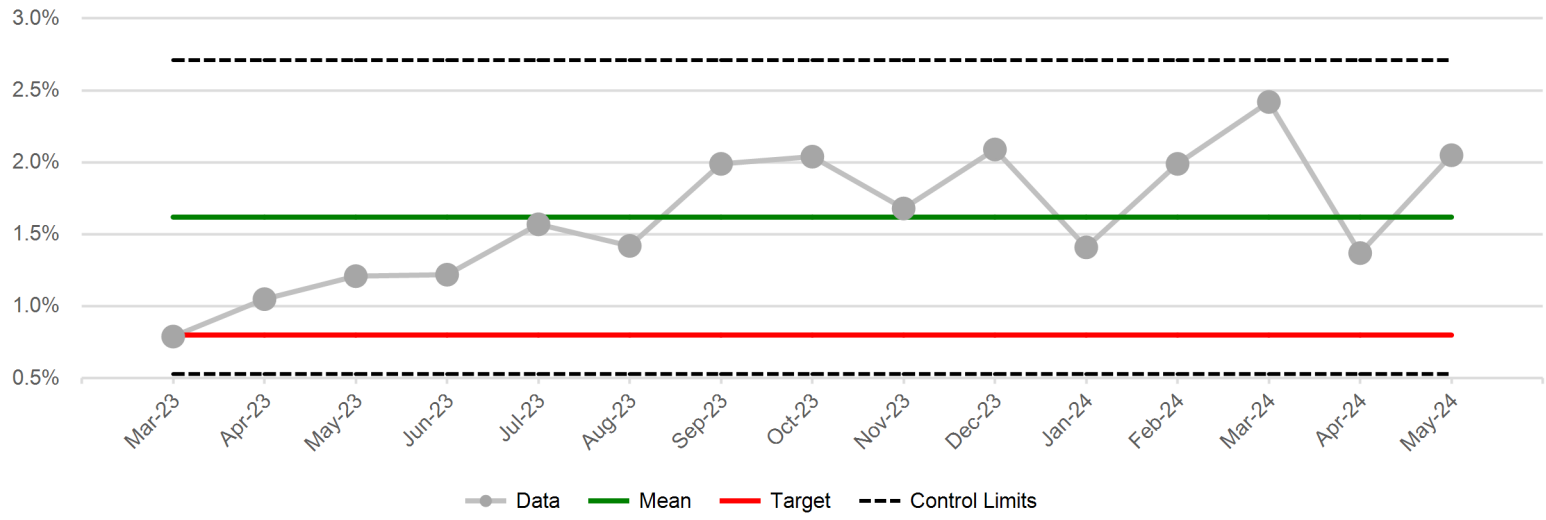
Issues:
The majority of diagnostic breaches sit in ultrasound, MRI and Dexa. A full recovery trajectory has been submitted and is being monitored closely.
MRI has an average increase of 1300 referrals from April 2023.
Demand for ultrasound is increasing and has done since the AQP provider issues 2021/22 with limited increased capacity in US and inability to recruit locums or utilise existing AQP providers.

Actions:
Radiology are working to their recovery plans that were discussed at the planned care and cancer board.
Cysto and urodynamics are reviewing the data so we have a more accurate return there will be an increase in waiting list and breaches next month after they deep dive into their systems.
Dexa has experienced significant sickness and vacancies. In the process of reprofiling staffing and training. GDH CDC DEXA will be online from June 2024 to provide additional capacity, delayed to failed installation. Recovery trajectory submitted.

Mitigations:
Patients are being seen in clinical priority.

Performance Overview - Operational Performance

Cancelled Operations on the day (non clinical)



May-24
2.05%
Variance Type
Common cause variation
Target
0.80%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
There has been a decrease in the number of non-clinical cancellations in May compared to 1.37% in April. This remains significantly above the agreed target of 0.8%.

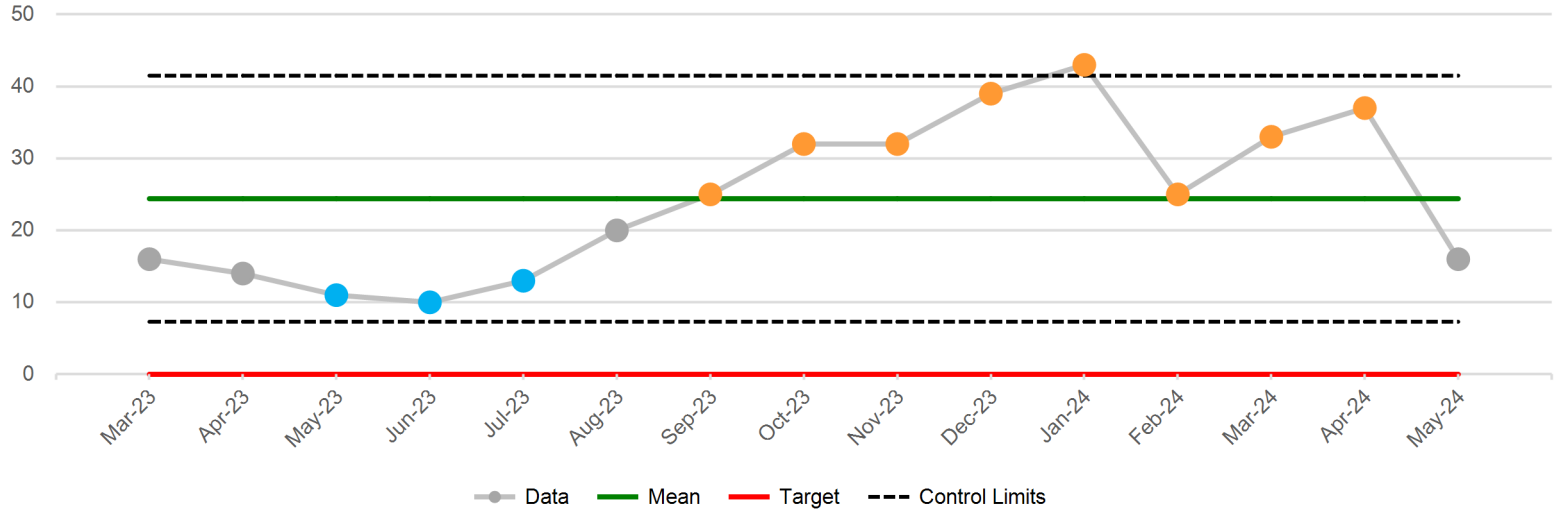
Issues:
-No Theatre Staff 24
-Lack of Time 21 (10 had previous complex cases).
-Admission Moved Back 6
-No Surgeon 5
-No Equipment 4
-More Urgent Case 4
-No Level 2 Bed 2
-Not Informed About Medication 2
-No Assistant 1
-No Notes 1
-Unaware of TCI 1

Actions:
Look Back Meeting started Wednesday 12.6.24.
Continued improved communication.
New Teams Chat commenced 10.6.24 for Equipment Issues.
Revise process for confirming a Level 2 bed.

Mitigations:
-Sickness was the underlying reason for 29 cancellations in total, significantly more than last month.
-Case complexity was the main factor behind 'lack of time' where the previous case had been much more complex than expected. This occurred in 10 of the 21 COTD due to lack of time.

Performance Overview - Operational Performance

Not treated within 28 days. (Breach)



May-24
16
Variance Type
Common cause variation
Target
0
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
The figures have decreased 16 in May compared to 37 in April. This has been the greatest improvement since July 2023. However, the target of zero has still not been achieved.

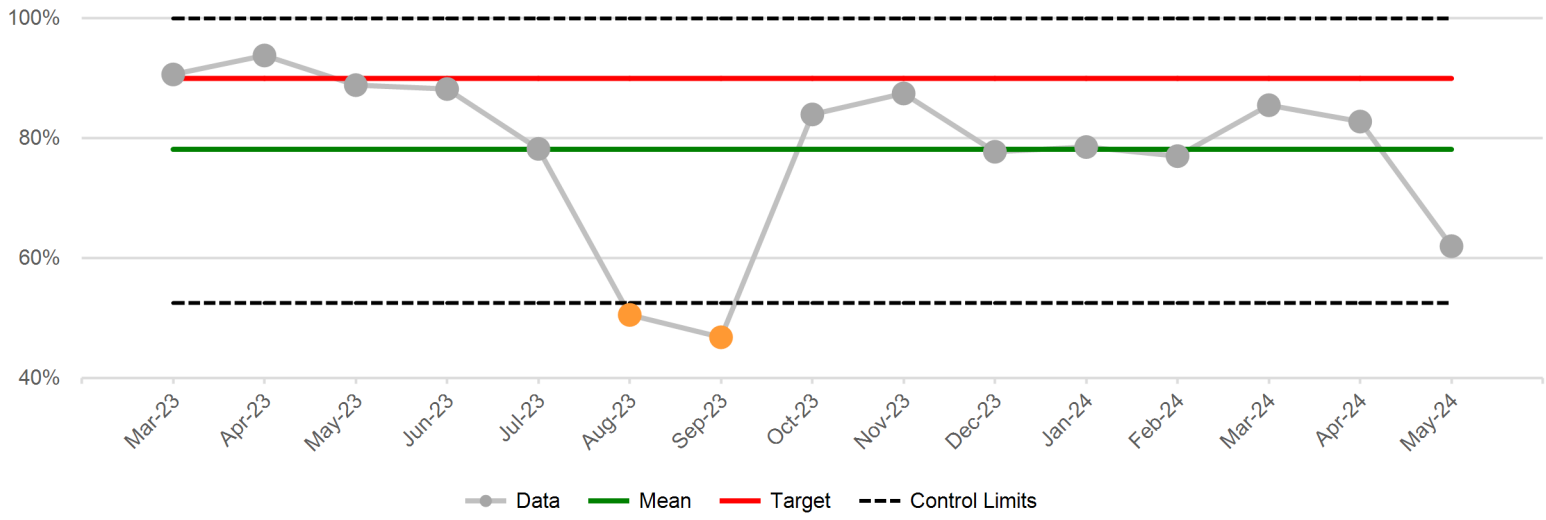
Issues:
Staffing in the Waiting List Teams remains an issue impacted by sickness and leave.

Actions:
The Family Health Waiting List Team have had their new recruit start, they are just in training.
Pre-Op clinic capacity has been increased in Pilgrim from 15.4.24 and Grantham and Lincoln from 3.6.24.
Emphasis on ensuring cancellation forms are completed on the day of cancellation.

Mitigations:
Sickness and staff shortages in the Waiting List Team remain a factor, but should improve now that recruitment has taken place.

Performance Overview - Operational Performance

#NOF 48 hrs



May-24
62.03%
Variance Type
Common cause variation
Target
90.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
The average percentage across both sites for May 2024 was 62.03%.

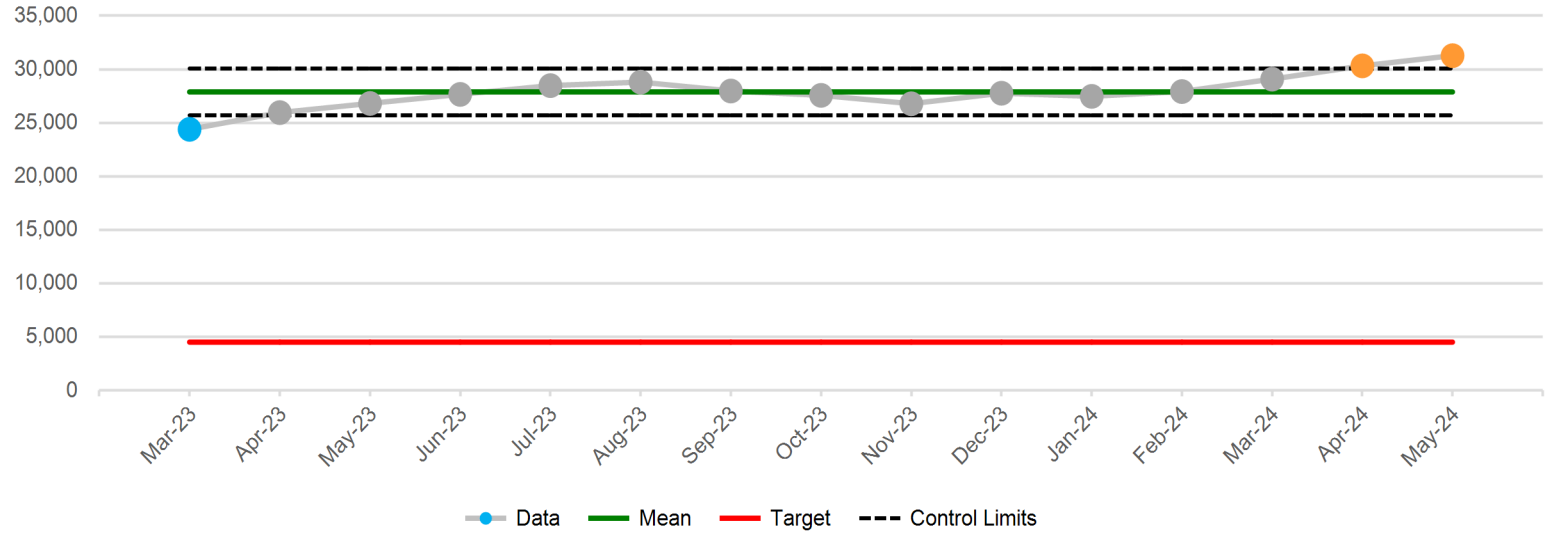
Issues:
- Lack of theatre space to accommodate Femur fractures.
- ULHT continue to have a high demand of trauma patients admitted with one trauma list planned daily on both sites.
- Specialty trauma lists on Boston and Lincoln sites not having capacity for trauma patients.
- Lack of theatre staff to provide additional trauma capacity.
- ULHT breaching the NHFD best practice tariff for femur fractures.
- Patients not being medically fit for surgery.
- KIT availability.
- Awaiting specialist surgeon.
- CBU looking at extra trauma capacity at PHB 2-3 times a week to accommodate Femur fractures.

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

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

Performance Overview - Operational Performance

Partial Booking Waiting List



May-24
31,278
Variance Type
Special cause variation - cause for concern (Indicator where high is a concern)
Target
4,524
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
The number of patients more than 6 weeks overdue for a follow up appointment.

What the chart tells us:
Currently at 31,278 against a target of 4,524. During Covid the number of patients overdue significantly increased with a slight dip in Nov 22, since when it continuously increased. We saw a steady reduction from Sept 23, increase to Dec 23, reduction in Jan 24 and a continued increase since Feb 24.

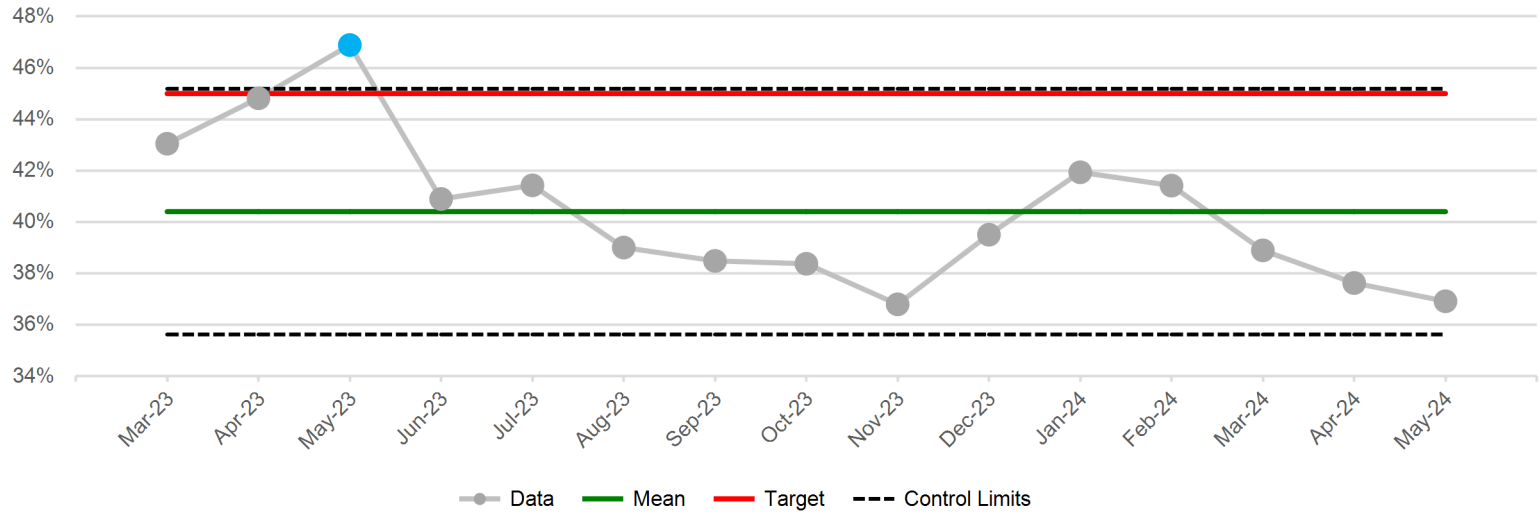
Issues:
The organisation has several competing priorities. The current focus is on the 78 and 65 week patients, and potential cancer patients. The current PBWL demand outweighs the current capacity which is being impacted by available capacity, rooms and resources.

Actions:
Regular Outpatient Waiting Lists (OWL) meeting with the CBU's includes agenda and template to improve attendance and focus. Discussions continue with CBU's regarding reducing F/ups by 25%. PIFU continues to be an area of focus and uptake has increased. 642 process currently under review to improve capacity and vacant slots. Clinic Scheduler x2 in post.
digital room booking system in procurement to improve utilisation.

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

Performance Overview - Operational Performance

% discharged within 24hrs of PDD



May-24
36.92%
Variance Type
Common cause variation
Target
45.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
% discharged within 24 hrs of PDD.

What the chart tells us:
The current performance metrics have displayed a significant downtrend, plummeting to 36.92% as against the established 45% KPI while reverting to the performance level of August 2023. This decline in performance calls for immediate attention and corrective measures to ensure the attainment of established performance objectives.

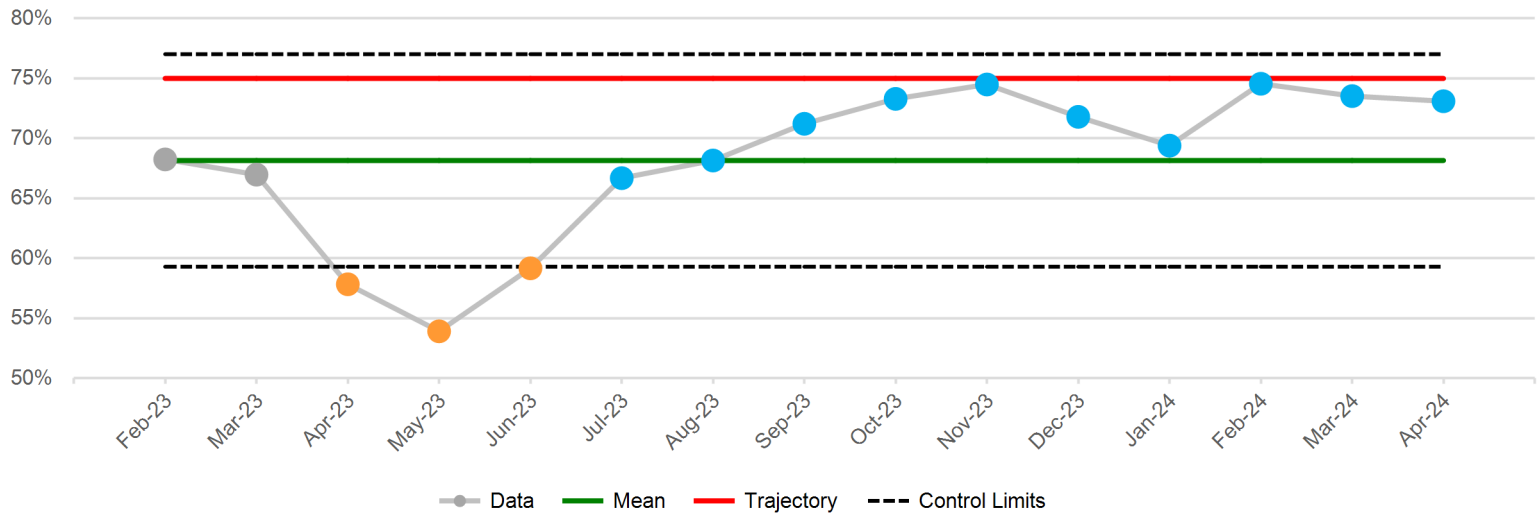
Issues:
Previously the delivery team were providing support to wards to improve WebV compliance, however when the support was withdrawn and handed over to BAU, performance dropped.

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

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

Performance Overview - Operational Performance

28 days faster diagnosis



Apr-24
73.10%
Variance Type
Special cause variation - improvement (Indicator where high is good)
Trajectory
75.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

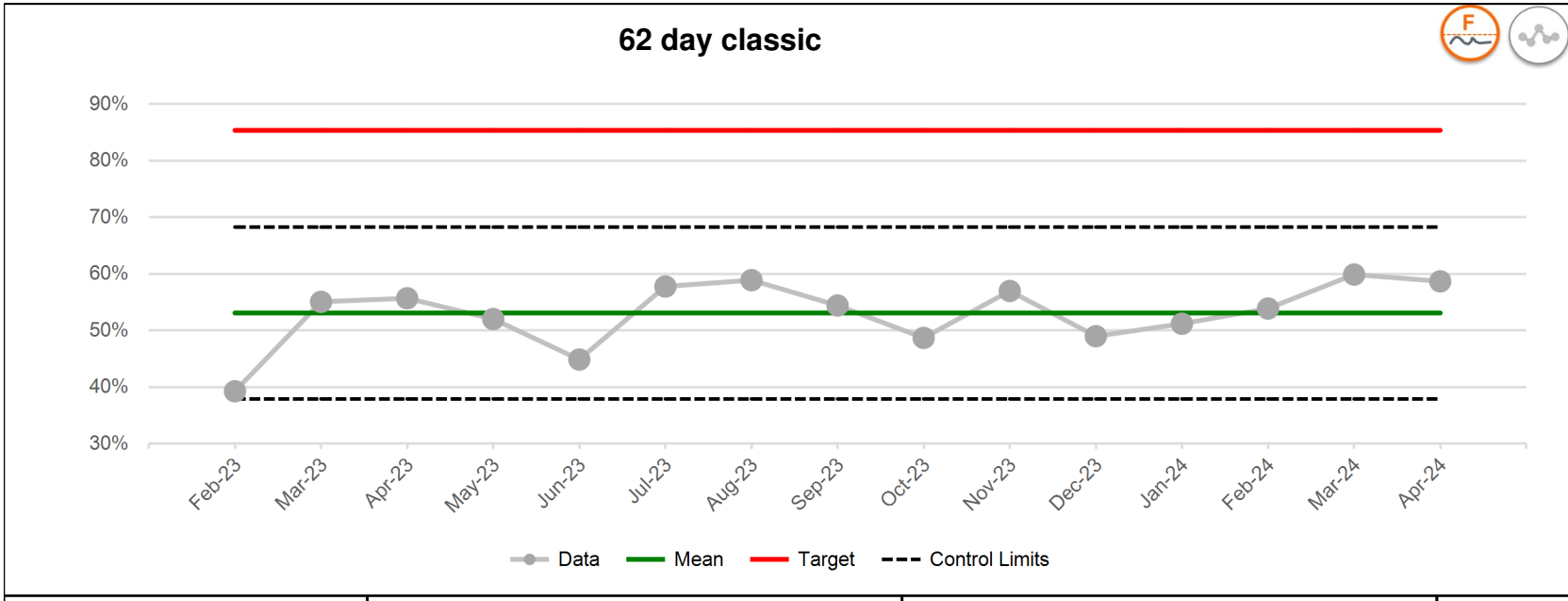
What the chart tells us:
We are currently at 73.10% against a 75% target.

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

Actions:
(Please also see Actions on 2ww suspected cancer page)
Recruitment is underway in Respiratory, ENT and Haematology specialties to improve Consultant availability and clinical review capacity.
Radiology – Bed capacity for Interventional Radiology patients at PHB. Development of OR theatre recovery unit to allow the service to recover its own patients. Constant shortfall of CTC reporting sessions.
Meetings regarding MDT streamlining support and processes for the Lung, Breast, Urology, Colorectal and Upper GI specialties are underway.
The utilisation of Narrow Band Imaging in ENT clinics to support a speedier clinic-based diagnostic process is awaiting installation of loan equipment at LCH.

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

Performance Overview - Operational Performance



Apr-24
58.70%
Variance Type
Common cause variation
Target
85.39%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
Percentage of patients to start a first treatment within 62 days combined.

What the chart tells us:
We are currently at 58.70% against a 85.39% target.

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

Please also see Issues on accompanying pages.

Actions:
Oncology Fragile Service – A piece of work on right-sizing the Oncology service workforce is ongoing. 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. Additional slots for cancer specialties to increase from 2 to 3 slots per day, awaiting confirmation of start date
Performance – Intensive Support Meetings continue to take place twice weekly to understand and resolve the themes and issues in 62 day performance in a number of tumour site specialties. Deep Dives are being undertaken by each CBU to understand how diagnostic turnaround times for positive cancers can be improved as this will be key to achieving the NHSE target of 70% by March '24.
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.

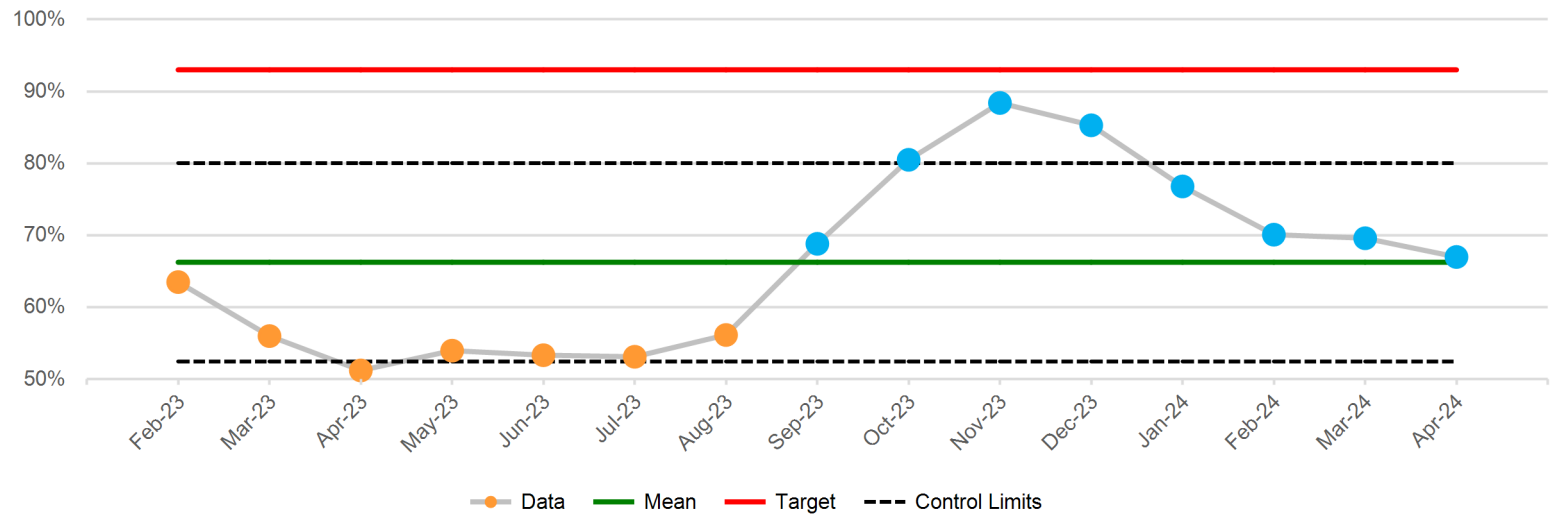
Please also see Mitigations on accompanying pages.

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Hospitals NHS Trust

2 week wait suspect



Apr-24
67.00%
Variance Type
Special cause variation - improvement (Indicator where high is good)
Target
93.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 67.00% against a 93% target.

Issues:
Patients not willing to travel to where our service and/or capacity is available.
The Trust's 14-day performance remains affected by the ongoing alignment issues in Breast Service One-Stop appointments, with 22% of the Trust's breaches occurring within that specific tumour site. Additionally, Skin tumour site accounted for 61% of the Trust's 14-day breaches, this is expected to improve for May/June performance.

Actions:
The Radiology Recruitment Strategy and intensive support meetings are in place to address the fragile Breast Service One-Stop appointment alignment issues.
Respiratory Consultant capacity is ongoing as well as the BC for an increase in consultant workforce to 10-15 consultants. 2 x Lung Cancer CNS posts (funding until March 25) for risk stratification to reduce unnecessary CT scans demand on consultant triage are now established. The Lung Rapid Access pathway will now include CT referrals to accurately reflect performance and has recently been implemented. We expect to see the impact of this in May/June performance.
Recruitment processes for the UGI Triage CNS post are under review. ICB EACH are continuing to support with 2ww referrals to reduce delays from receipt of referral to STT booking.
Processes – SOPs relating to DNAs & multiple cancellations are currently being taken through CBU Governance processes for approval.

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

The process 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 is currently being reviewed.
Please also see Mitigations on accompanying pages.

Performance Overview - Operational Performance

2 week wait breast symptomatic

Apr-24
37.40%
Variance Type
Special cause variation - improvement (Indicator where high is good)
Target
93.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 37.40% against a 93% target.

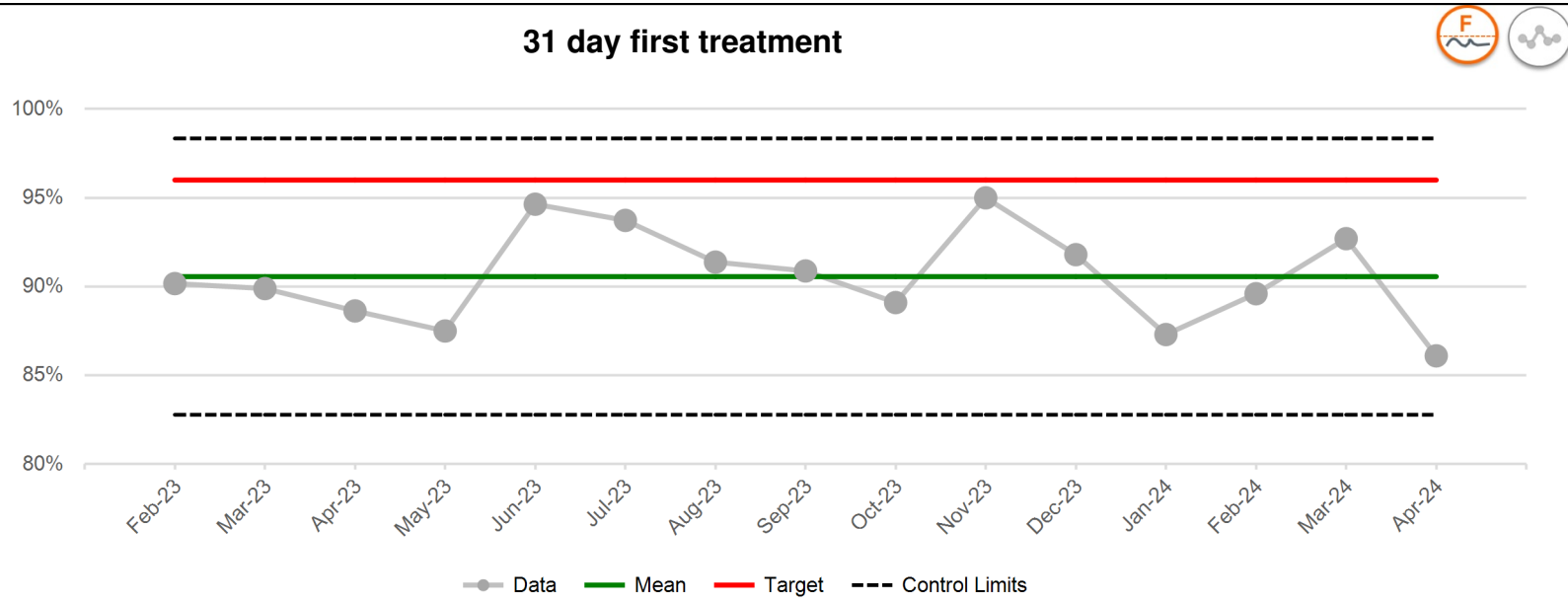
Issues:
The 14 Day Breast Symptomatic has been affected by the same impact of the Breast Service One-Stop appointment alignment issues.

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

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

Mitigations:
A mastalgia pathway is now up and running with primary care and system partners which has the potential to reduce inbound referrals by circa 15-20%. Further and more regular comms to improve utilization of this pathway within Primary Care are being supported by the ICB.

Performance Overview - Operational Performance



Apr-24
86.10%
Variance Type
Common cause variation
Target
96.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
Percentage of patients treated who began first definitive treatment within 31 days of a Decision to Treat.

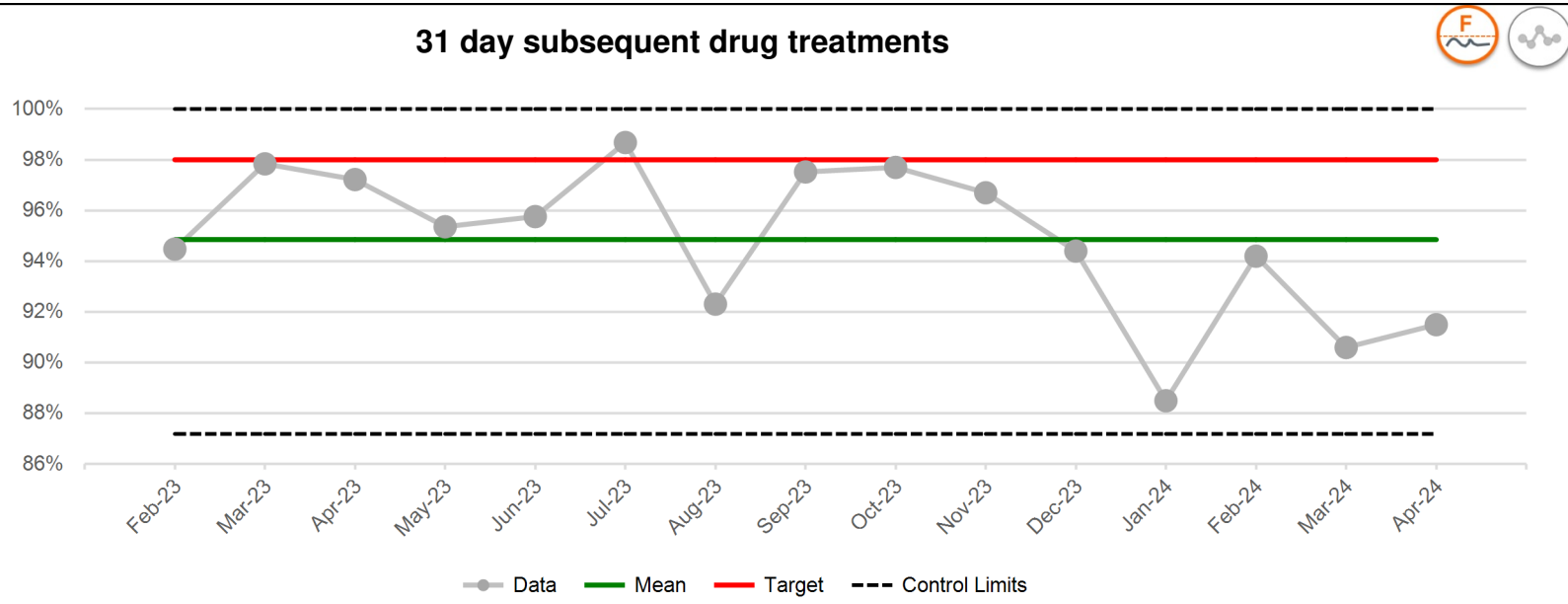
What the chart tells us:
We are currently at 86.10% against a 96% target.

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

Actions:
Oncology Fragile Service - A piece of work on right-sizing the Oncology service workforce is ongoing and recruitment is underway.
OMF Capacity issues continue to impact both Head and Neck and particularly Skin pathway performance – escalated as a risk.

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

Performance Overview - Operational Performance



Apr-24
91.50%
Variance Type
Common cause variation
Target
98.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 91.50% against a 98% target.

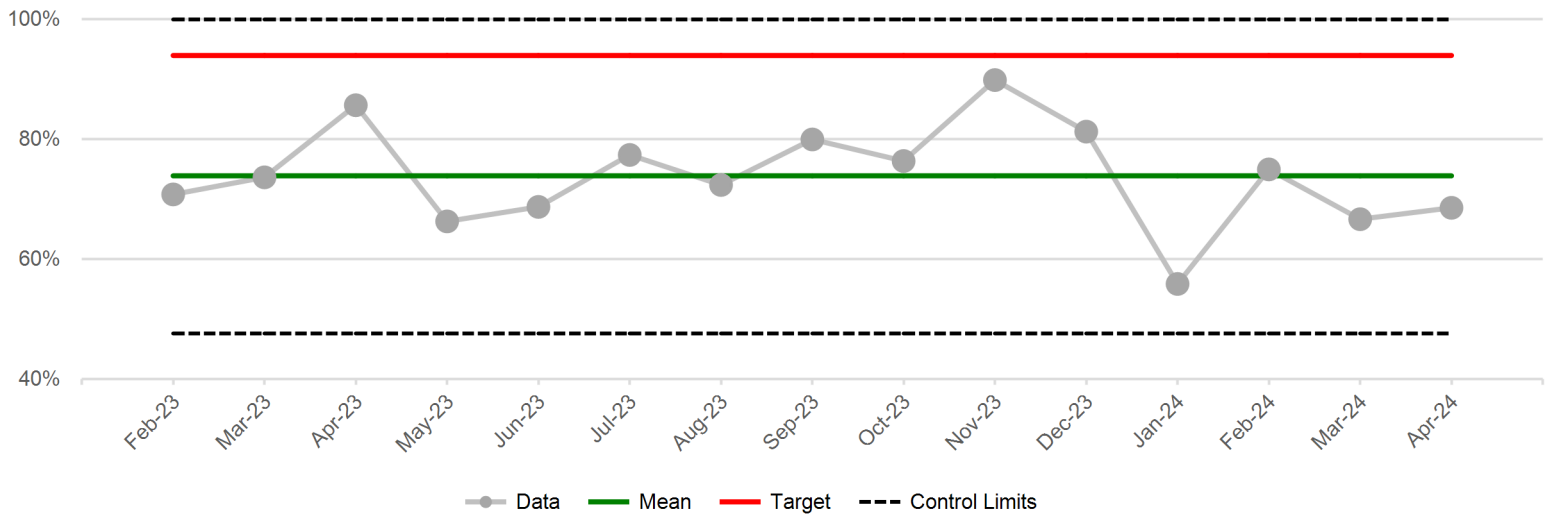
Issues:
In Chemotherapy, staffing shortages, treatment capacity and recent pharmacy staffing shortages have resulted in delayed treatment start dates.

Actions:
Oncology Fragile Service - A piece of work on right-sizing the Oncology service workforce is ongoing and recruitment is underway.
A deep dive is being undertaken to uncover any delays.

Mitigations:

Performance Overview - Operational Performance

31 day subsequent surgery treatments



Apr-24
68.60%
Variance Type
Common cause variation
Target
94.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 68.60% against a 94% target.

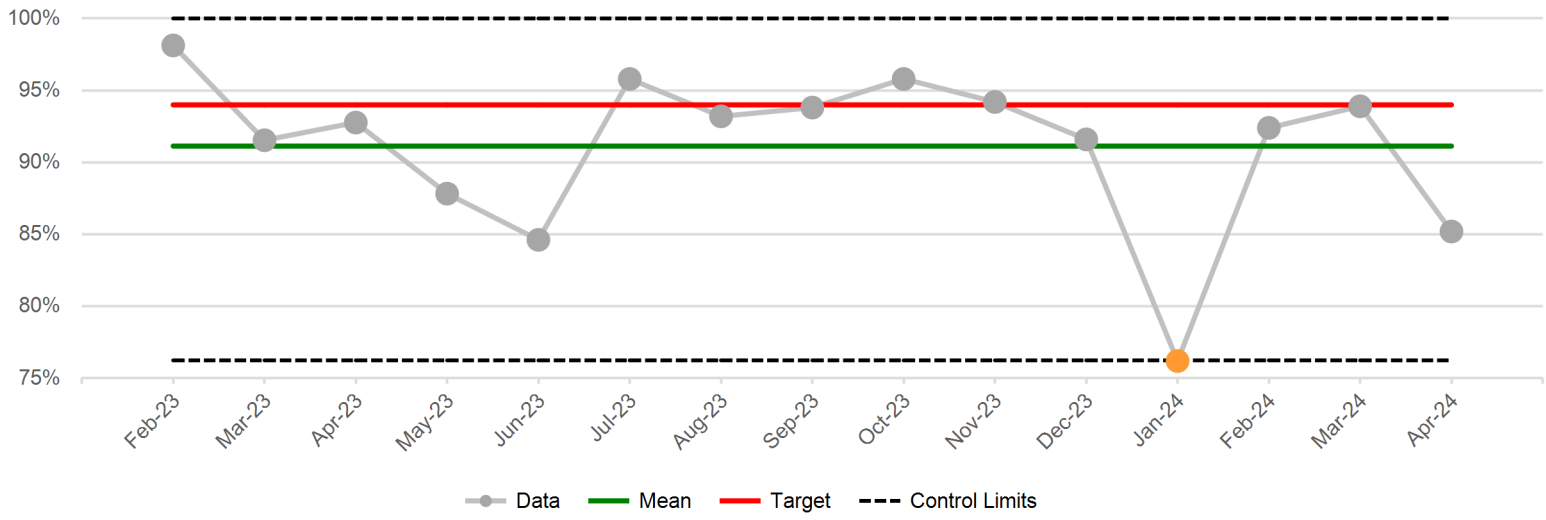
Issues:
The failure of the 31 Day surgery standard was due to limited theatre capacity and limited AA and pre-op capacity impacts the ability to be able to populate lists at short notice.
Colorectal – Current activity complexity is causing delays in allocating surgery dates, e.g. the increase in anterior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

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

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

Performance Overview - Operational Performance

31 day subsequent radiotherapy treatments



Apr-24
85.20%
Variance Type
Common cause variation
Target
94.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 85.20% against a 94% target.

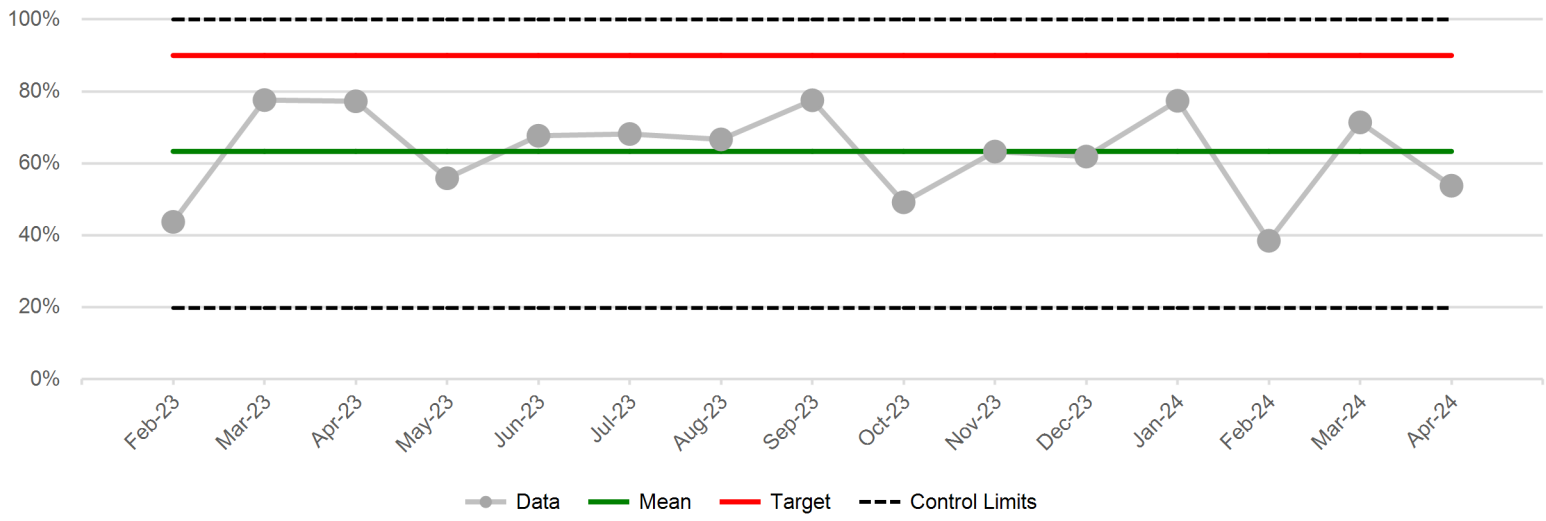
Issues:
Radiotherapy – Recent Linac breakdowns have resulted in delayed treatment start dates.

Actions:
Oncology Fragile Service - A piece of work on right-sizing the Oncology service workforce is ongoing and recruitment is underway.

Mitigations:

Performance Overview - Operational Performance

62 day screening



Apr-24
53.80%
Variance Type
Common cause variation
Target
90.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
Percentage of patients to start a first treatment within 62 days of referral from an NHS cancer screening service.

What the chart tells us:
We are currently at 53.80% against a 90% target.

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

Please also see Issues on accompanying pages.

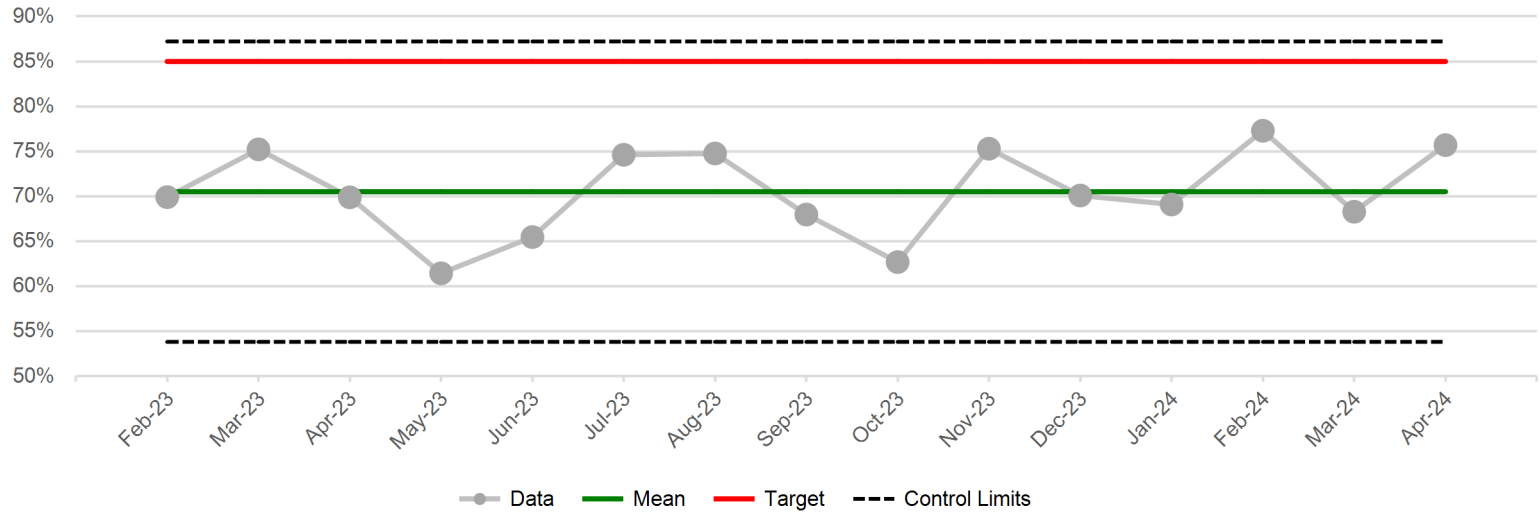
Actions:
Oncology Fragile Service – A piece of work on right-sizing the Oncology service workforce has commenced.
Robotic Lists are progressing well, though proving difficult to populate at short notice if there are cancellations due to the lack of trained staff within theatres, pre-op and anaesthetics. Tumour site specialties are working with TACC to ensure the best possible utilisation of lists, including a process for last minute cancellations. Additional slots for cancer specialties to increase from 2 to 3 slots per day, awaiting confirmation of start date.

Please also see Actions on accompanying pages.

Mitigations:
Please also see Mitigations on accompanying pages.

Performance Overview - Operational Performance

62 day consultant upgrade



Apr-24
75.70%
Variance Type
Common cause variation
Target
85.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
Percentage of patients to start a first treatment within 62 days of a consultant's decision to upgrade their priority.

What the chart tells us:
We are currently at 75.70% against a 85% target.

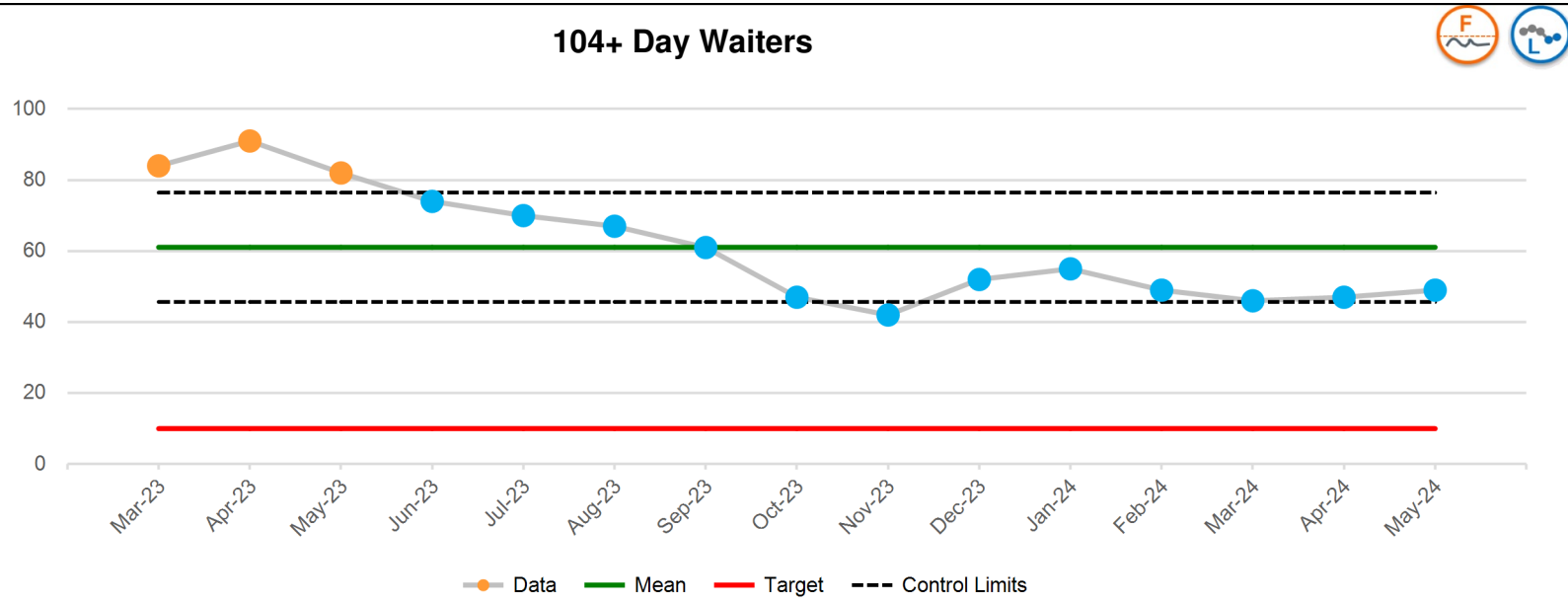
Issues:
Limited theatre capacity continues to impact cancer pathways across the Trust and limited AA and pre-op capacity impacts the ability to be able to populate lists at short notice. In Oncology, recent Linac breakdowns and pharmacy staffing shortages have resulted in delayed treatment start dates.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

Actions:
Oncology Fragile Service – A piece of work on right-sizing the Oncology service workforce has commenced.
Robotic Lists are progressing well, though proving difficult to populate at short notice if there are cancellations due to the lack of trained staff within theatres, pre-op and anaesthetics. Tumour site specialties are working with TACC to ensure the best possible utilisation of lists, including a process for last minute cancellations. Additional slots for cancer specialties to increase from 2 to 3 slots per day, awaiting confirmation of start date.

Please also see Actions on accompanying pages.

Mitigations:
Please also see Mitigations on accompanying pages.

Performance Overview - Operational Performance



May-24
49
Variance Type
Special cause variation - improvement (Indicator where low is good)
Target
10
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
Number of cancer patients waiting over 104 days.

What the chart tells us:
As of 13th June the 104 Day backlog is at 49 patients.
There is one main tumour site of concern:-

Colorectal 17

Issues:
The impact of ongoing pathway, staffing and capacity challenges.
Patients not willing to travel to where our service and / or capacity is available.
Reduced OP, diagnostic and theatre capacity across the Trust, all Specialties vying for additional sessions.
Managing backlogs significantly in excess of pre-COVID levels for Colorectal, Upper GI, Urology, Head & Neck, Gynaecology, and Lung.
Approximately 28.5% of these patients require support from the Pre-Diagnosis CNS as they have mental or social care needs that have the potential to significantly impact on the length of their pathway.

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

Please also see Actions on accompanying pages.

Mitigations:
Please also see Mitigations on accompanying pages.

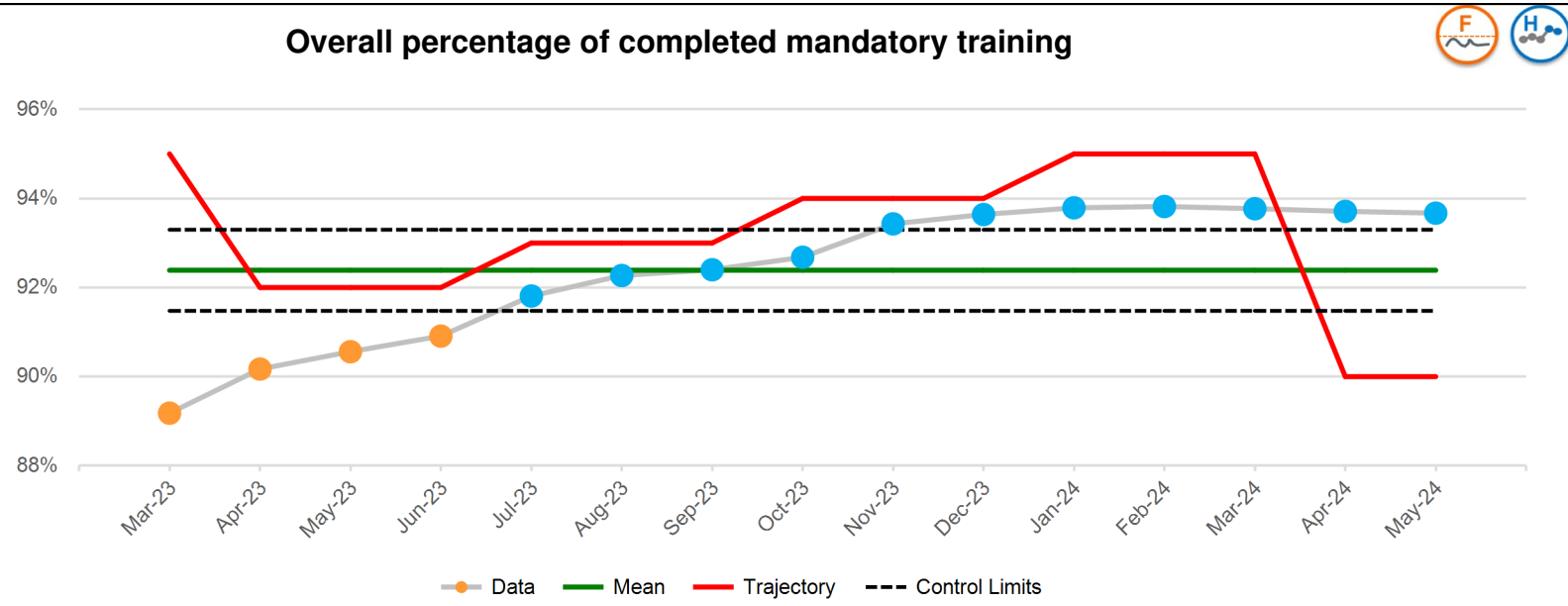
OUTSTANDING CARE personally DELIVERED

Performance Overview - Workforce

NHS United Lincolnshire Hospitals NHS Trust

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Mar-24	Apr-24	May-24	YTD	YTD Trajectory	Pass/Fail	Trend Variation
A Modern and Progressive Workforce	Overall percentage of completed mandatory training	Safe	People	Director of HR & OD	90.00%	93.77%	93.71%	93.67%	93.69%	90.00%	F	H
	Number of Vacancies	Well-Led	People	Director of HR & OD	9.31%	6.76%	6.18%	5.70%	5.94%	9.31%	F	L
	Sickness Absence	Well-Led	People	Director of HR & OD	5.51%	5.40%	5.36%	5.39%	5.38%	5.51%	F	L
	Staff Turnover	Well-Led	People	Director of HR & OD	12.72%	10.62%	10.30%	10.09%	10.20%	12.72%	P	L
	Staff Appraisals	Well-Led	People	Director of HR & OD	76.78%	74.24%	75.66%	75.89%	75.78%	76.78%	F	H

Performance Overview - Workforce



May-24
93.67%
Variance Type
Special cause variation - improvement (Indicator where high is good)
Trajectory
90.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of HR & OD

Background:
Completion is currently 93.67% against a Q1 target of 90.00%.

What the chart tells us:
Mandatory Training compliance has seen a very minimal change when compared to the previous month's position, with a stable position of above 93%.

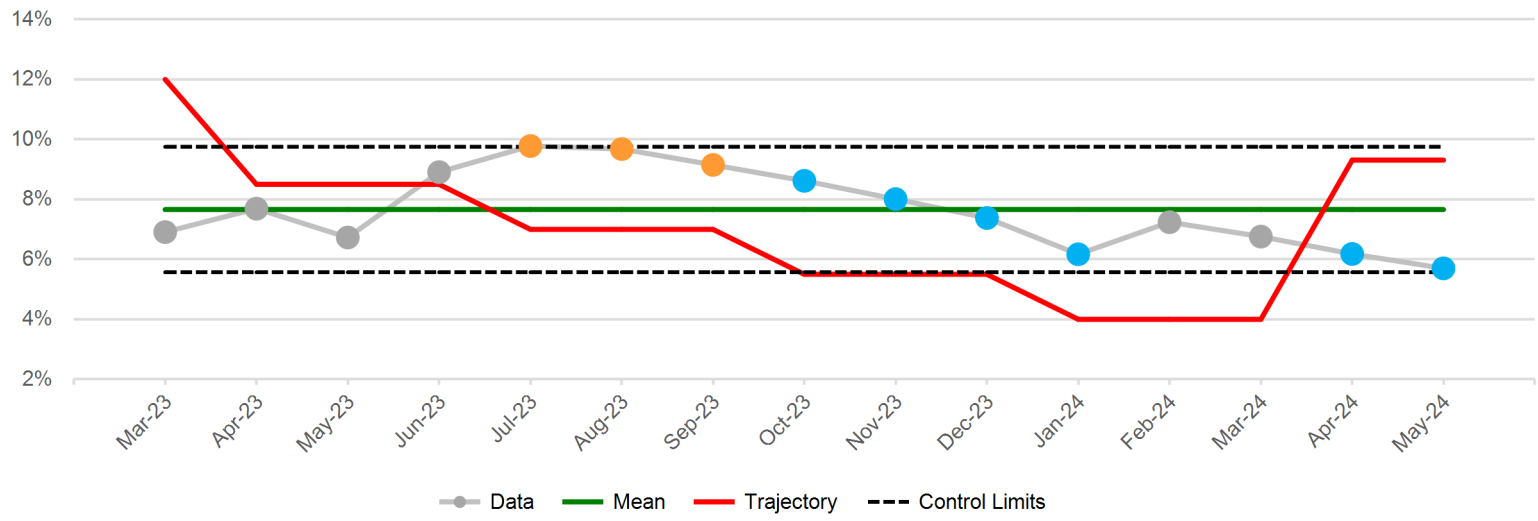
Issues:
- Protected time for core learning continues to be an issue, particularly clinical staff.
- Number of staff starting role without induction is affecting compliance.
- Training profiles being aligned to individual role profiles.

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

Mitigations:
Completion of Improvement Action Plan and targeted work with Divisions will continue to further improve our position as we move through 2024/25.

Performance Overview - Workforce

Number of Vacancies



May-24
5.70%
Variance Type
Special cause variation - improvement (Indicator where low is good)
Trajectory
9.31%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of HR & OD

Background:
May 2024 reported Vacancy Rate is 5.70% against a Q1 Target of 9.31%.

What the chart tells us:
That we are meeting our Q1 Target and remain on trajectory for the end of Q1.

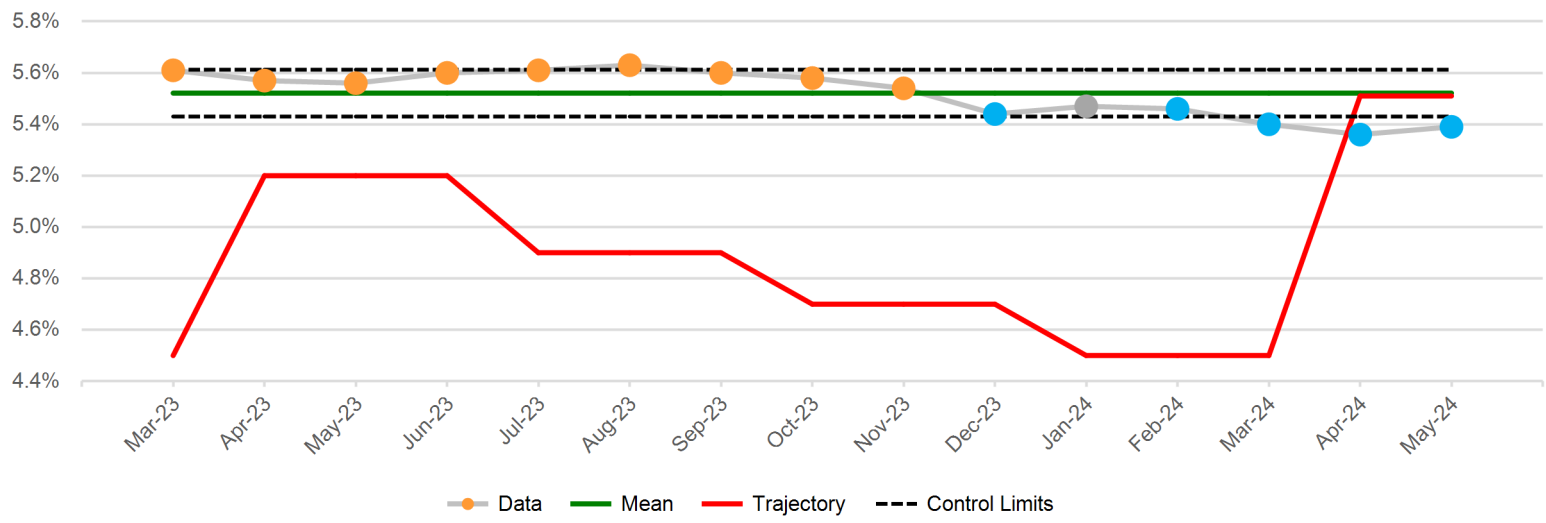
Issues:
- Sizeable business cases have been agreed which have increased our funded establishment.
- AHP recruitment remains a challenge in response to the implementation of Community Diagnostic Centres.

Actions:
- Work is in progress to review our overall establishment with our Divisional Teams as we further develop Workforce Plans in response to the Long Term Workforce Plan.
- Gap analysis being undertaken as part of the planning for 2024/25 to support identification of areas of focus for future.

Mitigations:
- Ongoing work to ensure compliance with Vacancy Rate targets, and to ensure that our establishment levels remain in line with our overall Workforce Plan.
- Our Recruitment Team have supported closing the gap between the Establishment and the number of Staff In Post.

Performance Overview - Workforce

Sickness Absence



May-24
5.39%
Variance Type
Special cause variation - improvement (Indicator where low is good)
Trajectory
5.51%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of HR & OD

Background:
5.39% of sickness absence rolling year.

What the chart tells us:
That we have exceeded our Q1 Target of 5.51%.

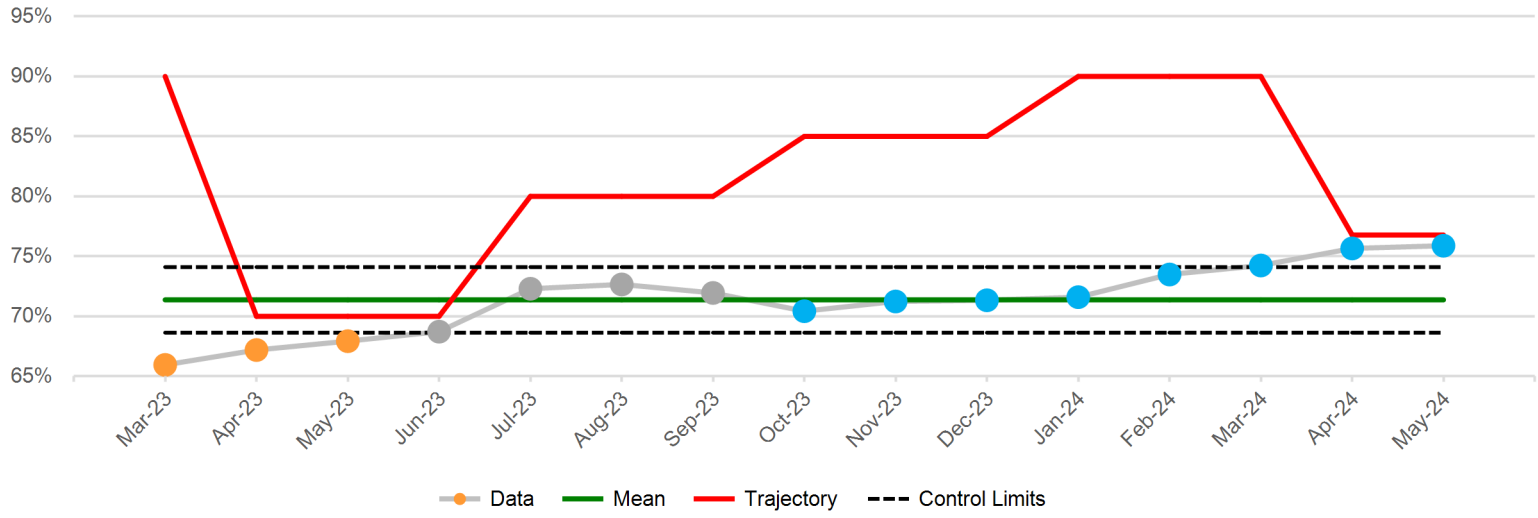
Issues:
- Sickness accounts for >75% of all unplanned absence.
- Consideration to be given to the other reasons that make up the remaining % of unplanned absence.
- AMS compliance remains a challenge.

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

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

Performance Overview - Workforce

Staff Appraisals



May-24
75.89%
Variance Type
Special cause variation - improvement (Indicator where high is good)
Trajectory
76.78%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of HR & OD

Background:
Completion is currently 77.97% (Trustwide).

What the chart tells us:
We have exceeded our Q1 Target of 76.78% and have seen further improvement compared to previous month.

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

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

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

Financial Position 2024/25

Finance Report M02

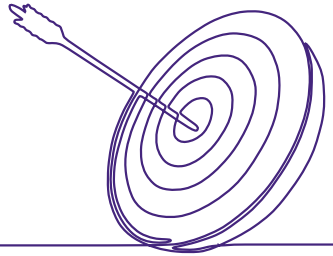
5 Year Priority – Efficient Use of Resources

NHS
United Lincolnshire Hospitals
NHS Trust

OUTSTANDING CARE
personally DELIVERED

Financial Position 2024/25

M02 Headlines - ULHT



NHS
United Lincolnshire Hospitals
NHS Trust

Adjusted financial performance	Current Month			Year to Date		
	Plan £000's	Actual £000's	Variance £000's	Plan £000's	Actual £000's	Variance £000's
Operating Income from patient care activities	61,249	63,076	1,827	122,592	124,424	1,832
Other operating Income	3,351	3,992	641	6,708	7,680	972
Employee Expenses	(42,853)	(46,706)	(3,853)	(85,940)	(92,857)	(6,917)
Operating expenses excl employee expenses	(23,345)	(22,888)	458	(46,913)	(46,246)	667
Operating Surplus/(Deficit)	**(1,598)**	**(2,526)**	**(928)**	**(3,553)**	**(6,999)**	**(3,446)**
Net finance costs	(769)	(665)	105	(1,570)	(1,267)	303
Other gains/(losses) including disposal of assets	0	(3)	(3)	0	12	12
Surplus / (Deficit) for the period	**(2,367)**	**(3,193)**	**(826)**	**(5,123)**	**(8,254)**	**(3,131)**
Remove capital donations/grants/peppercorn lease I&E impact	52	82	30	104	162	58
Adjust PFI revenue costs to UK GAAP basis	106	118	12	212	235	23
Adjusted financial performance surplus/(deficit)	**(2,209)**	**(2,994)**	**(785)**	**(4,807)**	**(7,857)**	**(3,050)**

Revenue position

- The Trust's 2024/25 financial plan is a deficit of £6.9m; the Trust's planned deficit plan is part of a break-even plan submitted by the Lincolnshire ICS.
- The accompanying table shows that the Trust's YTD position is a £7.9m deficit i.e., £3.1m adverse to the planned £4.8m deficit.
- Post completion of the month 2 financial position the Trust submitted a revised financial plan with a revised phasing. This brought the YTD plan in line with actual spend, phasing the £3.1m adverse variance in M4-M12.
- Since the April position was prepared, the Trust has had confirmation of £6.25m of investment funding for 2024/25 of which £1.3m is accrued in the YTD position. Further funding decisions are awaited from the ICS.

CIP position

- The Trust's CIP plan for 2024/25 is to deliver savings of £40.1m; the Trust YTD has delivered savings of £2.5m, or £0.4m higher than planned savings of £2.1m.

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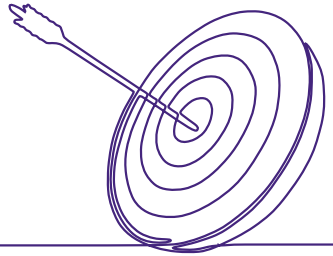
Financial Position 2024/25

Key areas of focus - Income



United Lincolnshire Hospitals NHS Trust

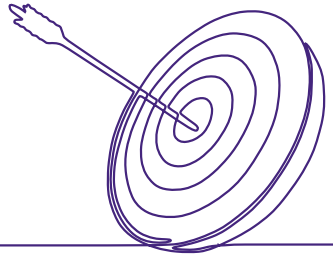
	Current Month			Year to Date		
	Plan £000's	Actual £000's	Variance £000's	Plan £000's	Actual £000's	Variance £000's
NHSE & ICB TOTAL	61,072	62,969	1,897	121,907	124,044	2,137
Injury cost recovery scheme	89	71	(18)	177	156	(21)
Non-NHS: overseas patients (non-reciprocal, chargeable to patient)	46	(11)	(57)	92	94	2
Non-NHS: private patients	16	19	3	32	30	(2)
Other Patient Care Activities Income	192	28	(164)	384	100	(284)
Sub-total - Patient Care Activities Income	**61,415**	**63,076**	**1,661**	**122,592**	**124,424**	**1,832**
Education & Training	2,030	2,059	29	4,064	4,074	10
Non-patient care services	401	435	34	795	885	90
Income in respect of employee benefits accounted on a gross basis	273	588	315	548	1,052	504
Catering income	265	270	5	529	481	(48)
Research and development	107	136	29	210	244	34
Rental revenue from operating leases	103	104	1	209	220	11
Car parking income	88	98	10	179	197	18
Other Income	42	260	218	90	443	353
Sub-total - Other Operating Income	**3,309**	**3,950**	**641**	**6,624**	**7,596**	**972**
Total - Income	64,724	67,026	2,302	129,216	132,020	2,804

- **Operating Income from Patient Care Activities**
  The YTD Patient Care Activities income position is £1.8m favourable to plan; this position includes £1.8m of additional funding from Lincolnshire ICB for which the Trust will receive contract variations in due course: £0.5m re 2023/24 consultant pay award funding & £1.3m re 2024/25 investment. Discussions about funding for other investments are ongoing [including some investments for which the Trust already has costs in the run-rate].

- **Other Operating Income**
  The YTD Other Operating income position is £1.0m favourable to plan; while there is some minor variation to plan across several categories, the overall movement is driven by favourable movements of £0.5m re Pay recharges & £0.4m re other income recognised in accordance with IFRS 15.

Financial Position 2024/25

Key areas of focus - Pay



NHS
United Lincolnshire Hospitals
NHS Trust

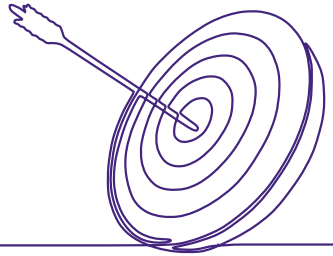
	Current Month			Year to Date		
	Plan £000's	Actual £000's	Variance £000's	Plan £000's	Actual £000's	Variance £000's
Substantive staff including on-costs	(35,253)	(38,135)	(2,882)	(70,506)	(75,723)	(5,217)
Bank staff including on-costs	(5,191)	(5,567)	(376)	(10,371)	(11,226)	(855)
Agency / contract	(2,056)	(2,623)	(567)	(4,357)	(5,152)	(795)
Other	(353)	(381)	(28)	(706)	(756)	(50)
Total - Employee Expenses	(42,853)	(46,706)	(3,853)	(85,940)	(92,857)	(6,917)

- While the YTD pay position is £6.9m adverse to plan, the Trust will receive contract variations in due course enabling it to increase its YTD I&E plan by £1.8m and reducing the reported adverse movement to plan in pay to £5.1m.
- Other investments have been agreed by the system, but funding has not yet been identified for those.

- The YTD pay position includes:
  - ❖ **Pay award** – The 2024/25 pay awards for A4C and M&D staff have been accrued in line with plan.
  - ❖ **Flowers** - The 2024/25 cost of Flowers has been accrued in line with the plan.
- **Total Pay** - Expenditure of £46.7m in May is £0.5m higher than expenditure of £46.2m in April including the impact the 2023/24 consultant pay award and an additional bank holiday in May.
- **Substantive Pay** – Substantive pay expenditure of £38.1m in May is £0.5m higher than expenditure of £37.6m in April including the impact the 2023/24 consultant pay award and an additional bank holiday in May. Contracted numbers have grown by c467wte in the last 7 months without an equivalent offset in Bank & Agency expenditure.
- **Agency Pay** – Agency pay expenditure of £2.5m in April and £2.6m in May on Agency Staffing is in unchanged from expenditure of £2.6m a month in the final months of 2023/24.
- **Bank Pay** – Bank pay expenditure of £5.7m in April & £5.6m in May is £0.4m lower than the average monthly spend in the last 5 months of 2023/24 driven by a reduction re M&D; the drivers of the reduction in spend on M&D are not fully understood so the reduction may not be sustained in future months.

Financial Position 2024/25

Key areas of focus – Non-Pay



NHS
United Lincolnshire Hospitals
NHS Trust

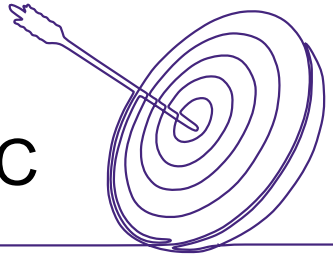
	Current Month			Year to Date		
	Plan £000's	Actual £000's	Variance £000's	Plan £000's	Actual £000's	Variance £000's
Depreciation & Amortisation	(2,602)	(2,214)	388	(5,165)	(4,426)	739
Other operating expenses	(20,743)	(20,672)	71	(41,748)	(41,820)	(72)
Total - Operating expenses excl employee expenses	(23,345)	(22,887)	458	(46,913)	(46,246)	667

- The YTD non-pay position is £0.7m favourable to plan and the overall movement can be attributed to the £0.7m favourable movement in relation to Depreciation & Amortisation.
- Non-Pay expenditure of £22.9m in May is £0.5m below plan and £0.5m lower than expenditure of £23.4m in April.

- The YTD non-pay position includes:
  - **Depreciation & Amortisation - £0.7m favourable to plan.**
    Any under spend YTD should not be expected to continue.
  - **Excess inflation – £0.5m adverse to plan**
    While the 2024/25 financial plan includes non-pay inflation as per national planning guidance, the actual level of inflation suffered was expected to be higher than planned; our estimate of the level of excess non-pay inflation suffered YTD of £0.5m is still subject to validation and the true figure may be higher as we receive actual invoices.
  - **CIP – £0.3m favourable to plan**
    The Trust has planned to deliver £15.2m of Non-Pay CIP savings in 2024/25 of which £0.7m was planned YTD and £1.0m was delivered; the planned level of CIP savings delivery increases significantly going forward as therefore does the financial impact of under delivery.
  - **Other – £0.2m favourable to plan**
    Activity volumes are lower than planned.

Financial Position 2024/25

Key areas of focus – Cash & BPPC



NHS
United Lincolnshire Hospitals
NHS Trust

Cash

- The May 2024 cash balance is £23.4m (plan: £26.1m); this is a decrease of £27.5m against the March year-end cash balance of £50.9m.
- Cash balances have reduced by £24m in May and are expected to reduce further in June as year-end capital creditors of £27m are paid / cleared. Based upon the financial plan, it is anticipated that a drawdown of revenue PDC (cash) will be required during Q2 to enable the Trust to continue paying suppliers in line with the BPPC target. A separate cash update paper is presented to FPEC.

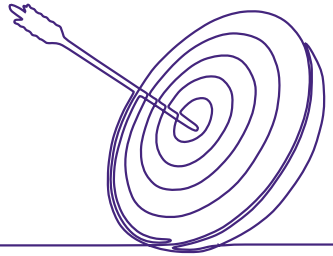
BPPC

- The BPPC performance for May was 94% / 95% by value / volume of invoices paid (appendix 5d). Year to date performance is at 92% / 94%; this compares to the full year performance in 2023/24 of 88% / 83%.
- At the end of May there were circa 800 unpaid invoices (£2.5m) over term (April 1,000 / £6.9m). These will impact future BPPC performance levels as they are paid.
- Following receipt of a letter from Julian Kelly re-iterating the 95% target and directing the Trust to improve performance from April 23, a multi-faceted improvement plan was implemented. This led to an improvement in 2023/24 which has continued into the first quarter of 2024/25. A significant element of this is due to process improvements and additional resourcing within pharmacy.

Capital position

- The Trust's capital plan for 2024/25 is anticipated to be £80m; the Trust YTD delivered capital expenditure of £5.0m, or £0.9m lower than planned capital expenditure of £5.9m

Finance Dashboard



NHS
United Lincolnshire Hospitals
NHS Trust

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

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

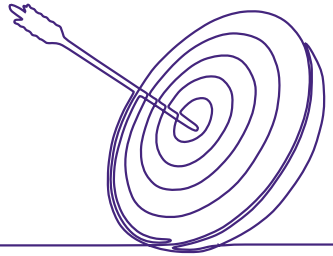
Metric	Rating Boundary			
	1	2	3	4
Capital servicing capacity	2.5	1.75	1.25	<1.25
Liquidity ratio (days)	0	-7	-14	<-14
I&E Margin	1%	0%	-1%	<=-1
I&E margin distance from plan	0%	-1%	-2%	<=-2%
Agency	0%	25%	50%	>=50%

The finance assessment seeks to answer the question: ***How effectively is the trust managing its financial resources to deliver high quality, sustainable services for patients?*** It does this at a high level using the 5 key indicators and each of which is rated 1 to 4 [which represent Outstanding, Good, Requires Improvement and Inadequate]. The rating boundaries are contained in the table above and ULHT absolute metric and rating for the last four full financial years and the current 2024/25 position are as follows

Finance and use of resources rating	Full Year ending:						Actual	Forecast
	Mar-19	Mar-20	Mar-21	Mar-22	Mar-23	Mar-24	May-24	Mar-25
Capital service cover metric	(10.40)	(1.73)	0.06	3.60	1.48	1.19	(0.98)	2.65
Capital service cover rating	4	4	4	1	3	4	4	1
Liquidity metric	(98.73)	(128.28)	3.71	2.50	(10.91)	(19.40)	(23.02)	(13.93)
Liquidity rating	4	4	1	1	3	4	4	3
I&E margin metric	(19.71%)	(7.62%)	0.38%	0.29%	(1.80%)	(2.63%)	(6.10%)	(0.89%)
I&E margin rating	4	4	2	2	4	4	4	3
Agency metric	77.00%	110.00%	113.00%	120.00%	0.00%	0.00%	0.00%	0.00%
Agency rating	4	4	4	4	1	1	1	1
I&E margin: distance from financial plan - metric	(2.80%)	0.70%	n/a	0.01%	(1.80%)	0.23%	(2.40%)	(0.89%)
I&E margin: distance from financial plan - rating	4	1	n/a	1	3	1	4	2

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

Balance Sheet



NHS
United Lincolnshire Hospitals
NHS Trust

	31-Mar-24	31-May-24			31-Mar-25	
		Plan	Actual	Variance	Plan	Forecast
	£000	£000	£000	£000	£000	£000
Intangible assets	10,924	10,204	10,208	(4)	15,064	15,043
Property, plant and equipment	333,031	336,014	334,577	1,437	383,442	382,231
Right of use assets	13,956	13,543	13,651	(108)	13,591	13,744
Receivables	2,022	2,105	2,038	67	2,105	2,105
Total non-current assets	**359,933**	**361,866**	**360,474**	**1,392**	**414,202**	**413,123**
Inventories	6,581	6,800	6,910	(110)	6,800	6,800
Receivables	19,781	28,936	31,562	(2,626)	28,616	28,616
Cash and cash equivalents	50,858	26,160	23,351	2,809	35,335	35,335
Total current assets	**77,220**	**61,896**	**61,823**	**73**	**70,751**	**70,751**
Trade and other payables	(95,425)	(82,891)	(72,872)	(10,019)	(87,425)	(87,685)
Borrowings	(3,167)	(3,167)	(3,167)	-	(3,167)	(3,167)
Provisions	(12,154)	(12,272)	(12,567)	295	(2,439)	(2,439)
Other liabilities	(1,195)	(2,930)	(17,134)	14,204	(1,130)	(1,130)
Total current liabilities	**(111,941)**	**(101,260)**	**(105,740)**	**4,480**	**(94,161)**	**(94,421)**
Total assets less current liabilities	**325,212**	**322,502**	**316,557**	**5,945**	**390,792**	**389,453**
Borrowings	(13,557)	(13,324)	(13,309)	(15)	(12,634)	(12,619)
Provisions	(5,271)	(5,242)	(5,201)	(41)	(5,624)	(5,624)
Other liabilities	(10,566)	(10,482)	(10,482)	-	(10,063)	(10,063)
Total non-current liabilities	**(29,394)**	**(29,048)**	**(28,992)**	**(56)**	**(28,321)**	**(28,306)**
Total assets employed	**295,818**	**293,454**	**287,565**	**5,889**	**362,471**	**361,147**
Financed by						
Public dividend capital	756,760	758,334	756,760	1,574	831,091	831,092
Revaluation reserve	48,454	49,448	48,253	1,195	48,498	47,314
Other reserves	190	190	190	-	190	190
Income and expenditure reserve	(509,586)	(514,518)	(517,638)	3,120	(517,308)	(517,449)
Total taxpayers' equity	**295,818**	**293,454**	**287,565**	**5,889**	**362,471**	**361,147**

Note 1: As at 31 May the balance sheet is broadly in line with plan. The exceptions being:
- Payables, where capital and other invoices have been cleared earlier than anticipated (app 5c)
- Other liabilities where cash has been received / deferred ahead of plan .

Note 2: The 2024/25 capital programme is the largest undertaken by the Trust at £89m. Depreciation is similarly significantly increased on recent years. The net impact is that Property, Plant and Equipment are expected to increase by £53m in year.

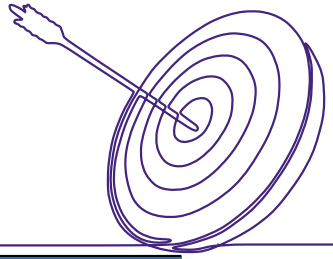
Note 3: Cash balances have reduced by £24m in May. Assuming the Trust remains on plan, a cash drawdown will be required in the during Q2.

Note 4: Receivables is predominantly a mix of invoiced debt £3.7m, accrued income £14.2m, VAT £1.2m and prepayments £13.0m, offset in part by bad debt provisions of £1.3m.

Note 5: The overall level of Trade and other payables has reduced to £72.9m including capital creditors of £14.6m.

Note 6: The level of provisions remain at March levels but are anticipated to reduce through 2024/25 as 'Flowers,' Annual Leave and Litigation issues are reviewed and resolved.

Cashflow reconciliation – April 2024– March 2025



NHS
United Lincolnshire Hospitals
NHS Trust

	31-Mar-24	31-May-24			31-Mar-25	
		Plan	Actual	Variance	Plan	Forecast
	£000	£000	£000	£000	£000	£000
Operating surplus / (deficit)	(20,954)	(3,553)	(6,999)	3,446	876	725
Depreciation and amortisation	25,768	5,165	4,425	740	35,987	35,987
Impairments and reversals	6,580	-	-	-	-	-
Income recognised in respect of capital donations	(114)	-	-	-	(50)	(50)
Amortisation of PFI deferred credit	(503)	(84)	(84)	-	(503)	(503)
(Increase) / decrease in receivables and other assets	33,556	64	(11,690)	11,754	384	(8,960)
(Increase) / decrease in inventories	(448)	-	(329)	329	-	(219)
Increase/(decrease) in trade and other payables	358	10,190	(11,881)	22,071	11,324	(479)
Increase/(decrease) in other liabilities	(65)	1,800	15,939	(14,139)	-	(65)
Increase / (decrease) in provisions	(5,390)	1,415	291	1,124	(8,036)	(9,451)
Net cash flows from / (used in) operating activities	**38,784**	**14,997**	**(10,328)**	**25,325**	**39,982**	**16,985**
Interest received	2,551	339	499	(160)	1,308	1,350
Purchase of intangible assets	(7,132)	-	-	-	(3,500)	(9,000)
Purchase of property, plant and equipment	(44,652)	(29,822)	(17,531)	(12,291)	(102,387)	(85,286)
Proceeds from sales of property, plant and equipment	59	-	18	(18)	-	12
Net cash flows from / (used in) investing activities	(49,227)	(29,483)	(17,014)	(12,469)	(104,579)	(92,924)
Public dividend capital received	32,718	1,574	-	1,574	74,331	74,331
Other loans repaid	(805)	-	-	-	(805)	(805)
Capital element of finance lease rental payments	(2,393)	(406)	(127)	(279)	(2,475)	(2,475)
Interest element of finance lease	(142)	(36)	(36)	-	(252)	(252)
PDC dividend (paid)/refunded	(9,328)	-	-	-	(10,381)	(10,381)
Cash flows from (used in) other financing activities	(9)	-	(2)	2	-	(2)
Net cash flows from / (used in) financing activities	20,032	1,132	(165)	1,297	60,418	60,416
Increase / (decrease) in cash and cash equivalents	**9,589**	**(13,354)**	**(27,507)**	**14,153**	**(4,179)**	**(15,523)**
Cash and cash equivalents at 1 April - b'f	41,269	39,514	50,858	(11,344)	39,514	50,858
Cash and cash equivalents at period end	**50,858**	**26,160**	**23,351**	**2,809**	**35,335**	**35,335**

Note 1: Cash held at 31 May was £23.4m against a plan of £26.2m. This represents a decrease of £27.5m against the March year-end cash balance of £50.9m.

Note 2: The capital programme for 2024/25 is funded through a mix of internally generated resource £26.7m and external PDC £62.3m. This will be drawn down in line with capital spend through the year. Total capital expenditure in cash terms, inclusive of March creditors will exceed £100m.

Note 3: Cash balances are expected to reduce as capital creditors are reduced. Other factors influencing cash include:
- The planned deficit of £6.9m
- Release / utilisation of provisions associated with litigation and contractual obligations – circa £8m.

Note 4: The combined impact of these factors is likely to mean the Trust will require circa £12m of cash support in year.

Lincolnshire Community Health Services NHS Trust

Report to the Lincolnshire Community and Hospitals Group Board

Date of meeting	2nd July 2024	Agenda item	13
Title	LCHS Integrated Performance Report (May 2024 performance)		
Report of	Sam Wilde, Director of Finance and Business Intelligence	Prepared by	Sukesh Chandran, Business Support Technician
Previously considered by / Date	May 2024 performance considered by June FPPIC and QC meetings	Approved?	N/A
Summary	Performance up until the end of May is set out in the report. The Quality Committee and Finance, Performance, People and Innovation Committee reviewed May performance in their June meetings. The number of metrics in each cell in the SPC grid is as follows:		

		SPC Variation		
		Special Cause Improvement	No Variation	Special Cause Deterioration
Target Capability	Consistently Capable	1	6	1
	Inconsistently Capable	2	14	1
	Not Capable	1	2	1
	No Target	3	17	0

4 indicators are not statistically capable of achieving performance targets without redesign:

1. Home Visiting

We have started to see some recovery in our responsiveness following elements of the redesign work that have been implemented so far. We have been piloting a remodel of the service delivery across a 24-hour period to support our peak times of activity. We have further work to do in addressing the appropriateness of urgent cases and the level of responsiveness required to attend these.

2. Ethnicity recording in A&E data sets.

FPPIC reviewed a paper on LCHS Ethnic Category Completion across all 3 commissioning datasets (Admitted Patient Care, Emergency Care (A&E) and Community Services). Process redesign improvements already made to the A&E dataset have seen performance rise from c65% to c85%. These have now been replicated in the Admitted Patient Care and Community Services datasets. The technical element of the next stage of redesign (the RINSE data quality system) will be completed by November and progressive monitoring and feedback thereafter should allow us to move to the 95% target by the end of the financial year.

3. Better Payment Practice Code.

This process has been redesigned and performance has improved steadily since then, reaching 91% in May 2024. Whilst this is still slightly short of the 95% target it is above the NHS median for the first time which is a cause for celebration.

4. Friends and Family Test

Additional contractual oversight remains in place to continue to improve the roll out and reporting of the service provided.

3 indicators are showing special cause deterioration currently:

1. Vacancy Rate

Additional vacancy controls have been in place since the 2023/24 H2 financial reset this work and vacancy panel approval requirements have been in place in 2024/25. These are likely to put some upward pressure on the vacancy rate and we should not be surprised by a statistical signal of special cause deterioration. Whilst this measure does show special cause deterioration since December 2023, it remains consistently capable of achieving the 8% target and also outperforms the national benchmark for community trusts.

2. Average Length of Stay

Average length of stay in Community Hospitals has remained below the National Benchmark (currently 28 days) for over 12 months. The number of days average was 17.40 in May. This is above the target of 16 days.

	3. Home Visiting Compliancy Although Home Visiting Compliancy is showing special cause deterioration since July 2023, we are starting to see a steady increase in our responsiveness. We have been piloting a remodel of the service delivery across a 24-hour period to support our peak times of activity and will now take the proposed changes through a consultation process with the team. By the end of June all our new team members will have finished their supernumerary periods. We have further work to do in addressing the appropriateness of urgent cases and the level of responsiveness required to attend these. We also intend to present options for including 2, 4, 6 and 12hr responses (in line with national practice) at the next Performance Management Review meeting. **7 indicators are currently showing special cause improvement, which is a strong indication of our continuous improvement culture:** 1. Completion of NHS Numbers for A&E data sets 2. Sickness Absence 3. Agency expenditure 4. Ethnicity in A&E data sets 5. UTC 15 Minute Assessment 6. Urgent Community Response – Accepted referrals 7. Virtual Wards – Frailty referrals	
1. To deliver high quality, safe and responsive patient services	**1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population**	X
	1b. Improve patient experience	
	1c. Improve clinical outcomes	
	1d. Deliver clinically led integrated services	**X**
2. To enable our people to lead, work differently, be inclusive, motivated and proud to work within LCHG	**2a. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise**	**X**
	2b. To be the employer of choice	
3. To ensure services are sustainable, supported by technology and delivered from an improved estate	**3a. Deliver financially sustainable healthcare, making the best use of resources**	**X**
	3b. Drive better decision and impactful action through insight	**X**
	3c. A modern, clean and fit for purpose environment across the Group	
	3d. Reduce waits for patients who require urgent and emergency care and diagnostics and ensure we meet all constitutional standards	**X**
	3e Reducing unwarranted variation in cancer service delivery and ensure we meet all constitutional standards (ULHT)	
	3f Reducing unwarranted variation in planned service delivery and ensure we meet all constitutional standards (ULHT)	
	3g Reducing unwarranted variation in community service delivery and ensure we meet all constitutional standards (LCHS)	**X**

4. To collaborate with our primary care, ICS and external partners to implement new models of care, transform services and grow our culture of research and innovation	**4a Establish collaborative models of care with all our partners including Primary Care Network Alliance (PCNA), GPs, health and social care and voluntary sector**	
	4b Successful delivery of the Acute Services Review	
	4c Grow our research and innovation through education, learning and training	
	4d Enhanced data and digital capability	
5. To embed a population health approach to improve physical and mental health outcomes, promote well-being, and reduce health inequalities across an entire population	**5a Develop a Population Health Management (PHM) and Health Inequalities (HI) approach for our Core20PLUS5 with our ICS**	
	5b Co-create a personalised care approach to integrate services for our population that are accessible and responsive	
	5c Tackle system priorities and service transformation in partnership with our population and communities	
	5d Transform key clinical pathways across the group resulting in improved clinical outcomes	

Impact of proposal/ report	*Please outline the potential impact/ expected outcome* (Quality/ Equality, Diversity/ Equality Delivery System 3/ Health Inequalities/ Financial/ People)				
CQC	**Safe**	**Caring**	**Effective**	**Responsive**	**Well-Led**
Links to risks	*N/A*				
Legal/ Regulation	*N/A*				

Recommendations/ Actions Required

Board is asked to **NOTE** the content of the report

Appendices

Appendix 1 – LCHS Integrated Performance Report on May 2024 Data

Glossary

BPPC – Better Payment Practice Code
CAS – Clinical Assessment Service
CiC – Children in Care
CIP – Cost Improvement Plan
CHPPD – Care Hours Per Patient Day
FFT – Friends and Family Test
FPPIC – Finance, Performance, People & Innovation Committee
FTE – Full-Time Equivalent
IHA – Initial Health Assessment

IPR – Integrated Performance Report
KPI – Key Performance Indicator
LAC – Looked-After Children
LoS – Length of Stay
MIU – Minor Injury Unit
MRSA - Methicillin-Resistant Staphylococcus Aureus
NHSPS – NHS Property Services
OOH – Out of Hours
PMR – Performance Management Review
PU – Pressure Ulcer
Q&RC – Quality & Risk Committee
SI – Serious Incident
SPC - Statistical Process Control
STI – Sexually Transmitted Infection
UTC – Urgent Treatment Centre
WTE – Whole Time Equivalent
YTD – Year-To-Date

Lincolnshire Community Health Services NHS Trust

INTEGRATED PERFORMANCE REPORT

May 2024 Performance Data

CONTENTS

SPC SCORECARD

Target Capability	SPC Variation: Special Cause Improvement	SPC Variation: No Variation	SPC Variation: Special Cause Deterioration
Consistently Capable	Completion Of NHS Numbers for A&E Data Sets	Staff Turnover Ops Centre Calls Abandoned Training Compliancy MRSA Environmental Cleanliness Patient Incidents Per 1000 WTE	Vacancy Rate
Inconsistently Capable	Sickness Absence Agency Expenditure	15 Minute Ambulance Handover Chlamydia Screening Positivity Rate GU Patients seen within 2 working days Urgent Community Response - 2-Hour Response Compliance UTC 4 Hour Ops Centre Calls: Answered in Timescale Community Hospital Injurious Falls per 1000 OBDs Community Hospital Falls per 1000 OBDs Community Hospital Discharge Summaries UTC Discharge Summaries Complaints - Rate per 1000 WTE Mandatory Training Compliancy Community Hospital Bed Occupancy Long Term Sickness Absence	Average Length of Stay
Not Capable	Ethnicity in A&E Data Sets	Friends & Family Test Better Payment Practice Code	Home visiting compliancy
No Target	UTC 15 minute Assessment Urgent Community Response - Accepted Referrals Virtual Wards:Frailty Referrals	Virtual Wards: Cardiology Referrals Home Visiting Activity Transitional Care Activity Out of Hours and CAS Cases Closed Discharge to Assessment: Distinct Patient Contacts Discharge to Assess Accepted Referrals CAS Activity Ops Centre Calls Answered UTC Activity Total Falls Compliments Complaints Total Medication Incidents CHPPD Overdue Datix Community Pressure Ulcer - Rate per 1000 contacts (C2, C3 & C4 Community Hospital Pressure Ulcers - Rate per 1000 OBDs (C2, C3 & C4)	

Executive Summary

Safe

✓ Patient Incidents Community Rate per 1000 WTE remains higher than target representing a strong indication of our safety culture

✓ Total Community Hospital Falls performance rates per 1000 OBD on target.

✓ Injurious Community Hospital Falls performance rates per 1000 OBD below the benchmark.

✓ MRSA compliance achieving target.

Caring

X FFT scores not achieving 95% target.

Responsive

X Performance against the UTC targets - 4 hour waits not achieving 95% target

X Home Visiting performance is not achieving 95% target and is not capable of doing so without redesign

X 15-minute Ambulance Handover not achieving 95% target

X Discharge Summaries – Community Hospitals, not achieving target.

✓ Ops Centre Calls Answered in Timescale achieving 92% target

✓ Ops Centre Calls Abandoned achieving 8% target.

✓ Urgent Community Response is achieving the 97% target.

✓ Discharge Summaries – Urgent Treatment Centres achieving target.

Effective

X Average Length of Stay not achieving the 16 Day target.

✓ Chlamydia positivity rate of 15-24 years old achieving target.

✓ LiSH GU patients seen within 2 working days continues to meet target.

✓ Environmental Cleanliness achieving target.

✓ Bed Occupancy rate achieving 85% target at 92.60%

Well-Led

X Cash balances are £28M, which is slightly worse than plan (but expected to return to planned levels in August).

X Better Payment Practice Code is not achieving the 95% target (but has passed the NHS median)

X Ethnicity in A&E Data Sets not achieving 95% target

✓ Staff Turnover is within the 15% target.

✓ Monthly agency expenditure is £99k under plan.

✓ Month 2 estimated financial YTD Position is on plan with a £522k deficit.

✓ Overall efficiency (CIP) behind plan.

✓ Recurrent Efficiency (CIP) on plan.

✓ Capital expenditure is ahead of plan.

✓ Training Compliance is achieving the 90% target.

✓ Total Sickness Absence is achieving the 5% target.

✓ Long-Term Sickness Absence is achieving 3% target.

✓ Vacancy rate within the 8% target and beating the national benchmark.

✓ Valid NHS Numbers for A&E Data Sets achieving the 95% target.

Medicine-related Incidents

Background

Medication is one of the most common medical interventions. LCHS deals with medicines on a day-to-day basis. LCHS has robust polices, training programmes and audit to ensure medicines are managed safely. Due to the high volume of activity involving medicines, complexity of the procedures and the human component, some medicine-related incidents do occur.

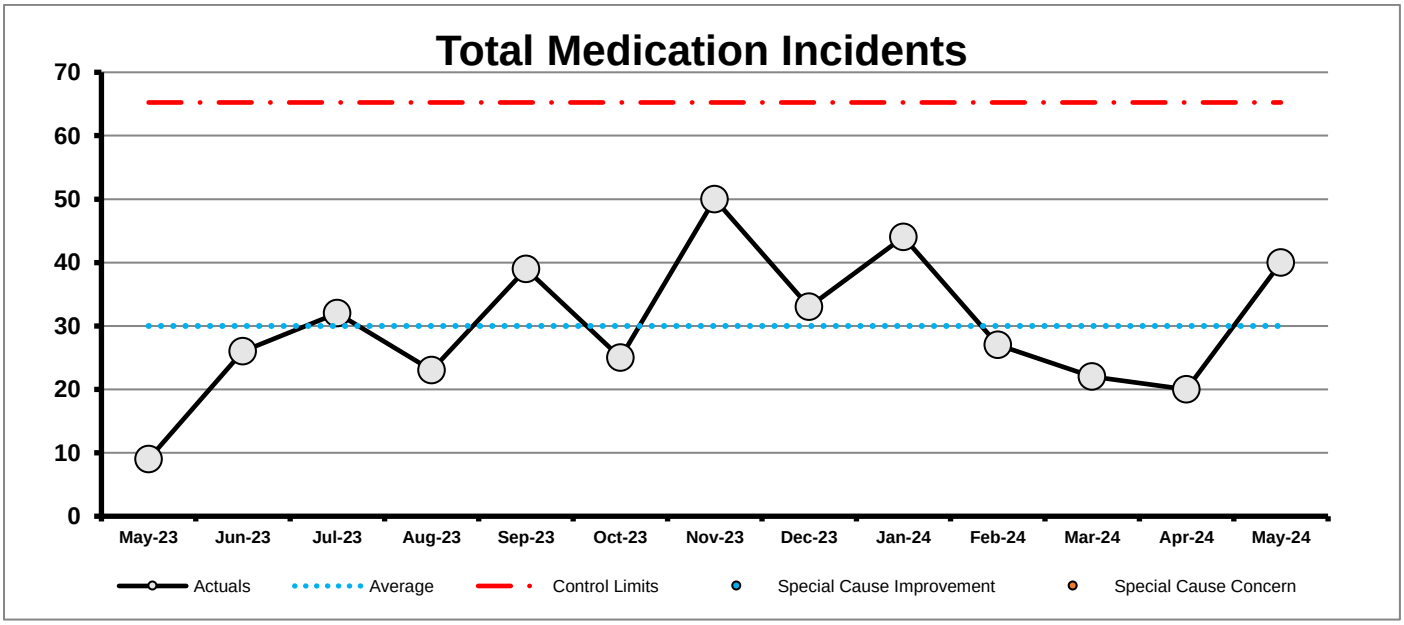
A medicine-related incident can pose a threat to the patient as well as the organisation. The member of staff who made the error can also be affected. Broadly speaking, medicine-related incidents encompass prescribing, preparation, dispensing, administration, and monitoring.

Reducing medicine-related incidents across the Trust remains an ongoing improvement priority.

Benchmark / target

NHS Benchmarking have not yet published the community dataset for the reporting period.

Current Performance



Narrative

40 LCHS related medicine incidents (an increase from 20 in April) were recorded via Datix in May. There has been no increase in moderate or above harm related medicines incidents.

An increase in incident reporting (no/low harm incidents) is an indication of a positive safety culture with medicines incidents being employed to strengthen and embed learning across LCHS. It is important to note that the reporting of moderate harm incidents remains low, with no severe harm incidents or medicines related never events reported.

SPC

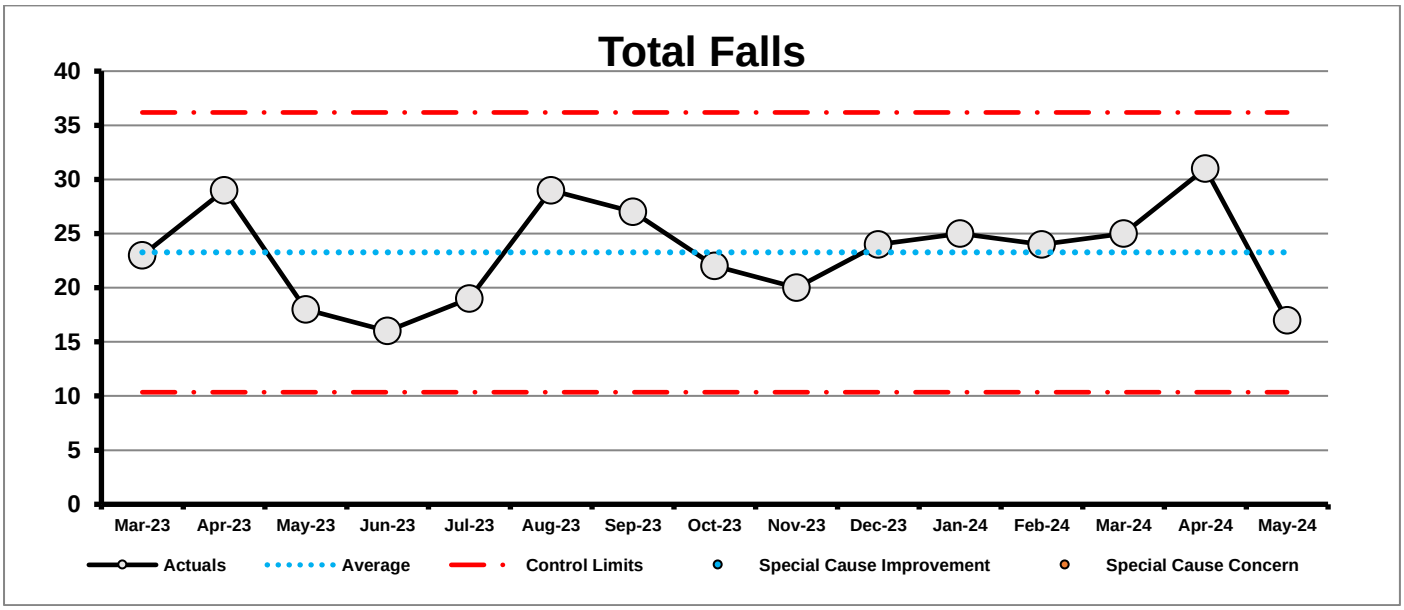
SPC shows that the Trust's total medication incidents have not varied over the period.

Total Trust Falls

Background

A fall can be devastating for a patient, not least because it can cause 'distress, pain, injury, loss of confidence, loss of independence and increased morbidity and mortality' (Source: The incidence and costs of inpatient falls in hospitals, NHS Improvement June 2017).
The graph below shows the total falls across the Trust.

Current Performance



Narrative

We have seen a slight decrease in Total falls this month, this could be partly due to the reduction in falls in our community hospitals in May.

SPC

SPC shows that the Trust's total falls have not varied significantly over the period.

Falls in Community Hospitals

Background
Falls take place in many services, but most falls take place in our community hospitals where the patients have additional levels of frailty and health related conditions which pose additional risk of falling whilst unwell and in an unfamiliar environment.

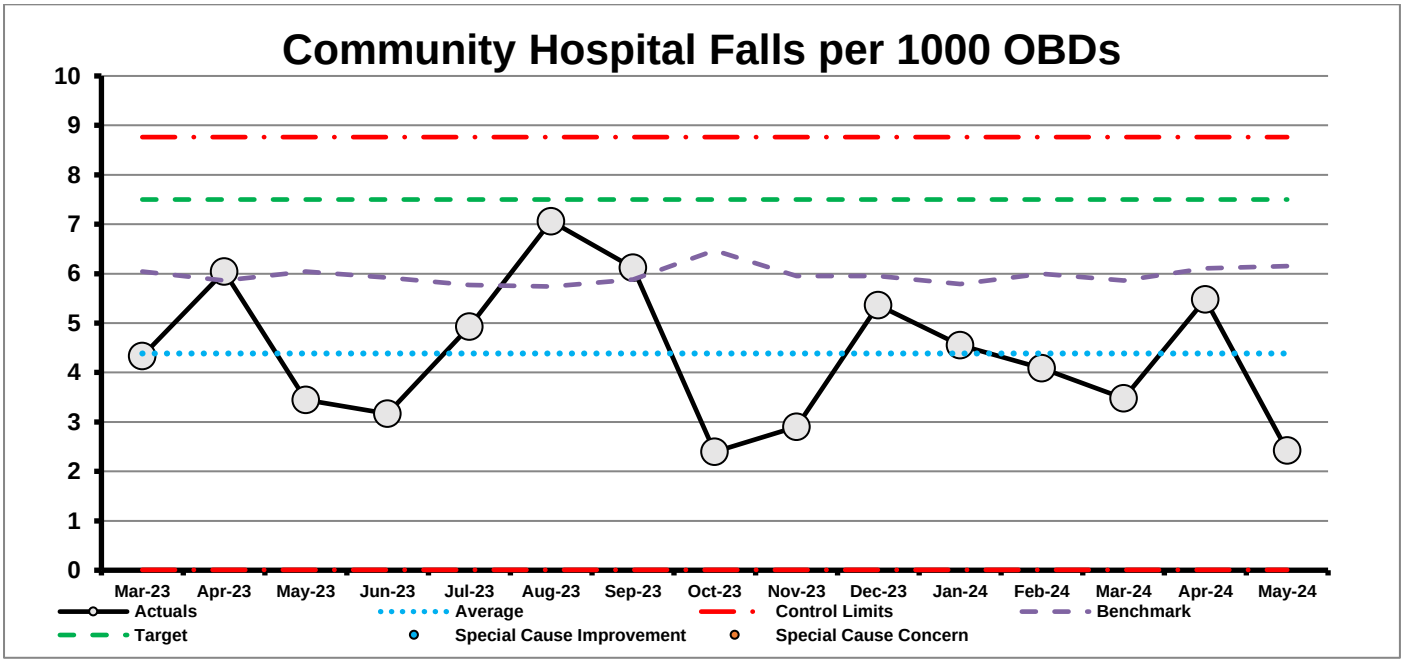
Falls are categorised and captured as the following: -

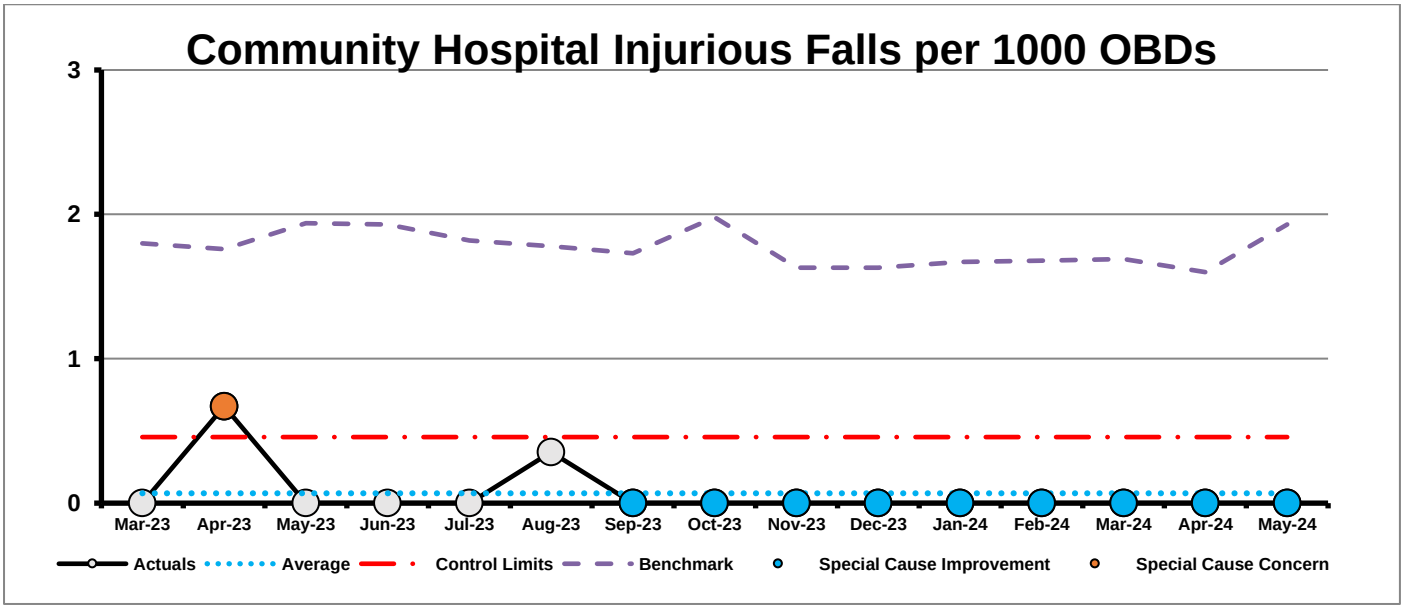
- Fall from a height / bed / chair (these falls tend to result in the highest level of injury of harm
- Slip / trip / fall on level ground.
- Supported lower to ground/ bed / chair / other (many of these are during direct patient care or therapeutic interventions)

Benchmark / target
There are 2 benchmarks available for falls within Community Hospitals. Both are measured on a 6-monthly average per 1000 OBD and are both in the Community Trust Benchmarking group.

The latest available monthly benchmark (March) for all Community Hospital falls is 6.15 The latest monthly benchmark of injurious falls is 1.57.

Current Performance





Narrative

Community Hospitals have seen a lower number of falls this month. We believe this is because the higher occupancy levels mean fewer new patients per day meaning greater time to settle them in and provide personalised care, but this will take further months of higher occupancy to link whether this is a contributing factor.'

SPC

Community Hospital Falls per 1000 OBDs
SPC shows the Community falls per 1000 OBDs have not varied over the period.
Rate of Falls per 1000 OBD is inconsistently capable, but the average being below the target means that the target is achieved more often than not.

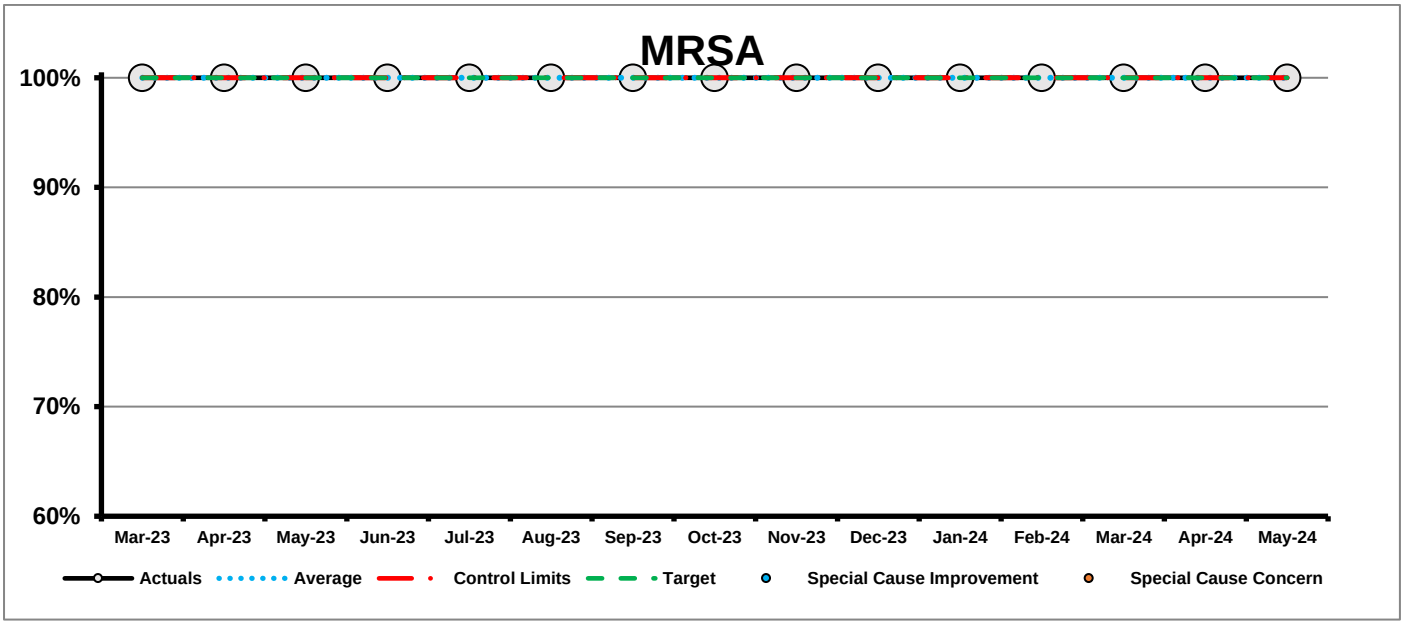
Community Hospital Injurious Falls per 1000 OBDs
SPC for Community Hospital Injurious falls per 1000 OBDs shows special cause improvement since September 2023. It remains consistently below average.

MRSA Screening

Background
The Trust undertakes targeted MRSA colonisation screening for inpatients and surgical patients in line with the DH “Implementation of modified admission MRSA screening guidance for NHS (2014)”.
The guidance advocates that those patients previously identified as MRSA positive, and those patients admitted to high-risk units are screened.
Across LCHS those patients known to be previously MRSA positive or from high-risk groups are identified on admission/or at pre-admission screening and necessary infection prevention risk management strategies applied.

Benchmark / target
The target range for screening is 100% of eligible patients.

Current Performance



Narrative

Of the 139 patients admitted across all sites, 12 patients were eligible for MRSA screening, of which all 12 were screened.

SPC

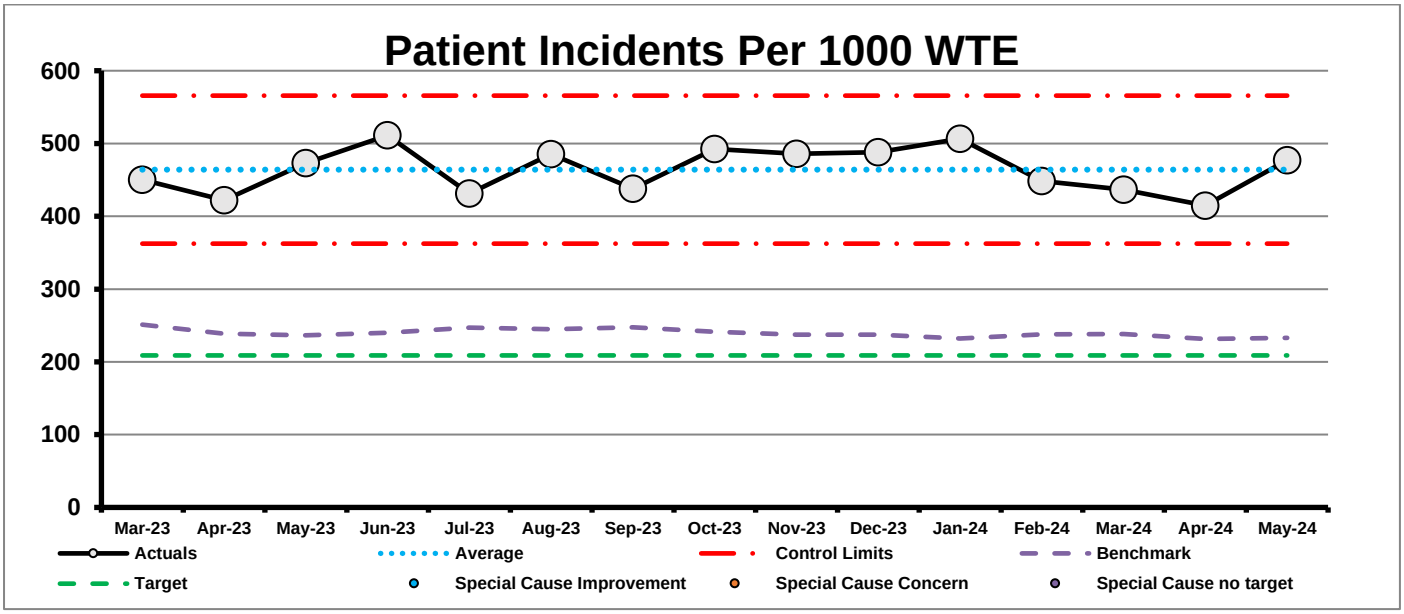
SPC shows MRSA screening compliance has not varied over the period.

Patient Incidents

Background
From 18 June 2017 NHS Improvement moved from six monthly reporting and began publishing monthly data by reporting organisation on the numbers of incidents reported to the National Reporting and Learning System (NRLS).

Benchmarking / target
LCHS has been consistently a high reported of incidents using the Datix system.
The latest available 6 monthly average numbers of incidents per 1,000 WTE staff in the Community Trust Benchmarking group was 231.46.

Current Performance



Narrative

LCHS remains a consistently high reporter of incidents. Organisations with a higher reporting rate are more likely to have a good patient safety culture. This data also reflects the size of organisation.

Actions

Each Service Line reviews the incidents monthly at their Quality Scrutiny Group meetings to identify any trends and themes.

The themes are considered to support triangulation of themes from incidents, claims, serious incidents, complaints, and other quality datasets.

A recovery of overdue Datix management and responses within the required timescale has been developed in detail. The recovery plan is reported monthly to the Quality & Risk Committee and is achieving the agreed trajectory.

Upgrade and redevelopment of the Datix system itself is being progressed to maximise the functional use of the system, improve reporting, provide dashboards, and improve user interface for clinicians using the system.

SPC

Patient Incident SPC shows there to be no significant variation over the period.

Community Pressure Ulcers – Rate per 1,000 contacts

Background
All pressure ulcers grade's 3 and 4 are classified and recorded as serious incidents. There is no distinction between avoidable and unavoidable in cause.

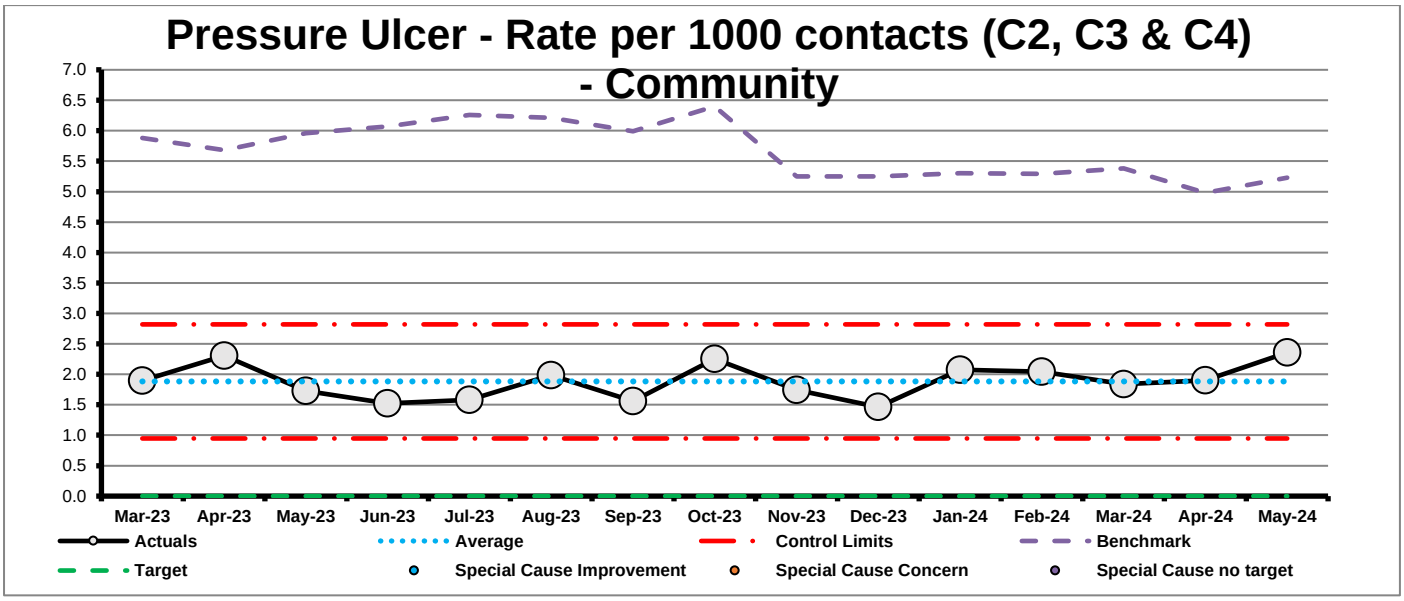
Reduction in patient harm related to pressure damage is the highest priority objective for the Lincolnshire Safeguarding Adults Board.

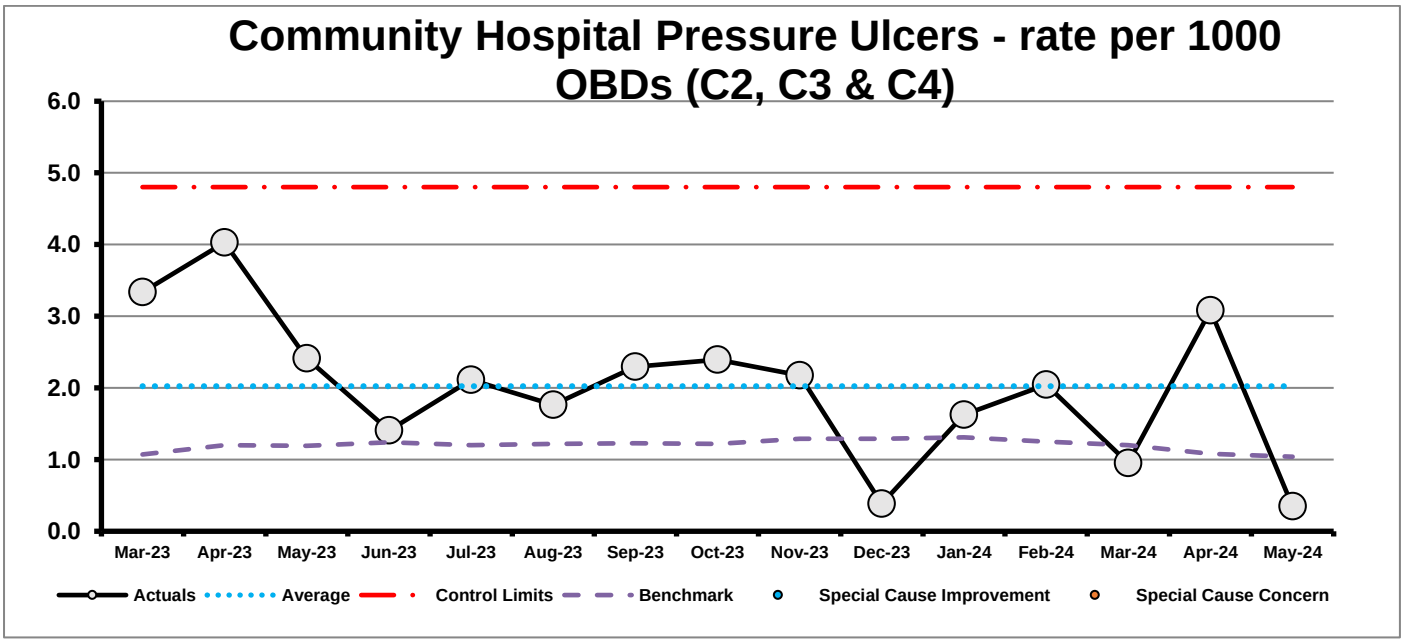
The Lincolnshire System Quality Group have agreed their first quality priority to be pressure damage – eradication of harm, standardising and improving care.

Benchmark
Benchmarking will continue to be calculated in community teams by 1,000 patient contacts – currently the national mean benchmark is 5.23.

Community Hospital benchmarking is calculated by 1000 Occupied Bed Days (OBDs) – currently the national benchmarking rate is 1.04.

Current Performance





Narrative for Community:
17 x (C3&4) and 149 x (C2) pressure ulcers were recorded within the Community for this month. There is a potential correlation between the number of deferred visits due to the vacancy factor and demand within community nursing for patients reducing visit frequency thereby impacting on Pressure Ulcer development. Thematic reviews are identifying consistent themes around pressure ulcer development including frailty recognition and identification of patients who may be in the last year of their life. A new frailty training package is being implemented from the 1st of April 2024 to support improvements in care delivery. We are currently looking at PU care across the organisation and our first workshop was completed last week.

Narrative for Community Hospitals:
There was 0 x C2, and 1x C3/C4 pressure ulcers recorded within Community Hospitals this month.

Actions

A database of all pressure ulcers in the Community is to be created with peer review across the county to ensure uniformity of care and to monitor effectiveness of healing.

SPC

Pressure Ulcers - rate per 1000 contacts (C2, C3 & C4) – Community
SPC for Pressure Ulcer rate/1000 has shown there to be no variation over the period.

Pressure Ulcers – rate per 1000 OBDs (C2, C3 & C4) - Community Hospitals
SPC shows Community Hospital Pressure Ulcers – rate per 1000 OBD has shown there to be no significant variation over the period.

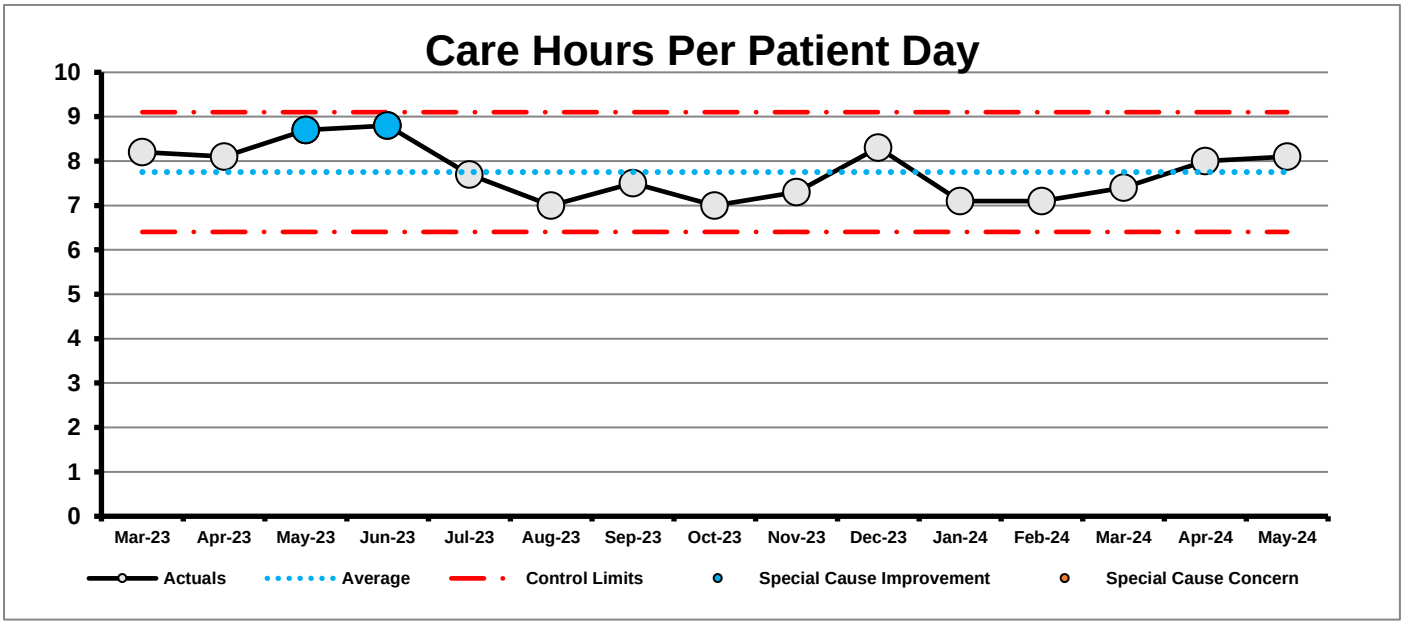
Care Hours Per Patient Day (CHPPD)

Background
Care Hours per Patient Day (CHPPD) is a simple calculation derived from dividing the number of actual care hours provided by the number of inpatients in a 24-hour period used as measure across inpatient areas.

While it is recognised that the needs of patients using these community services are often quite different, the CHPPD measure provides a representation of the number of care hours available to patients and is a measure that enables wards/units of a similar size, speciality, and patient group to be compared.

Benchmark / target
There is no available benchmark – NHSEI have confirmed this will not be progressed.
There is no agreed target, but the CHPPD rate should be considered alongside other quality and safety metrics contributing to safe staffing.

Current Performance



Narrative

CHHPD remains within the control limits. There is no current evidence to suggest a lack of staffing has led to unsafe care been delivered by the Community Hospital Team.

Actions

A full complement of registered nurse staffing is seen within Scotter ward. Reduced RN cover remains in Skegness and Louth. Planned recruitment for these areas using IEN staff has occurred with staff now being onboarded. This will resolve current vacancy factor.

HCSW vacancy remains in some areas with recruitment to entry posts challenging. There is noticeable offset in hours allocated to registrant posts in areas with lower HCSW levels. Increased hours have also been seen in areas where a number of international recruits for the community nursing services are inducted within the community hospitals.

SPC

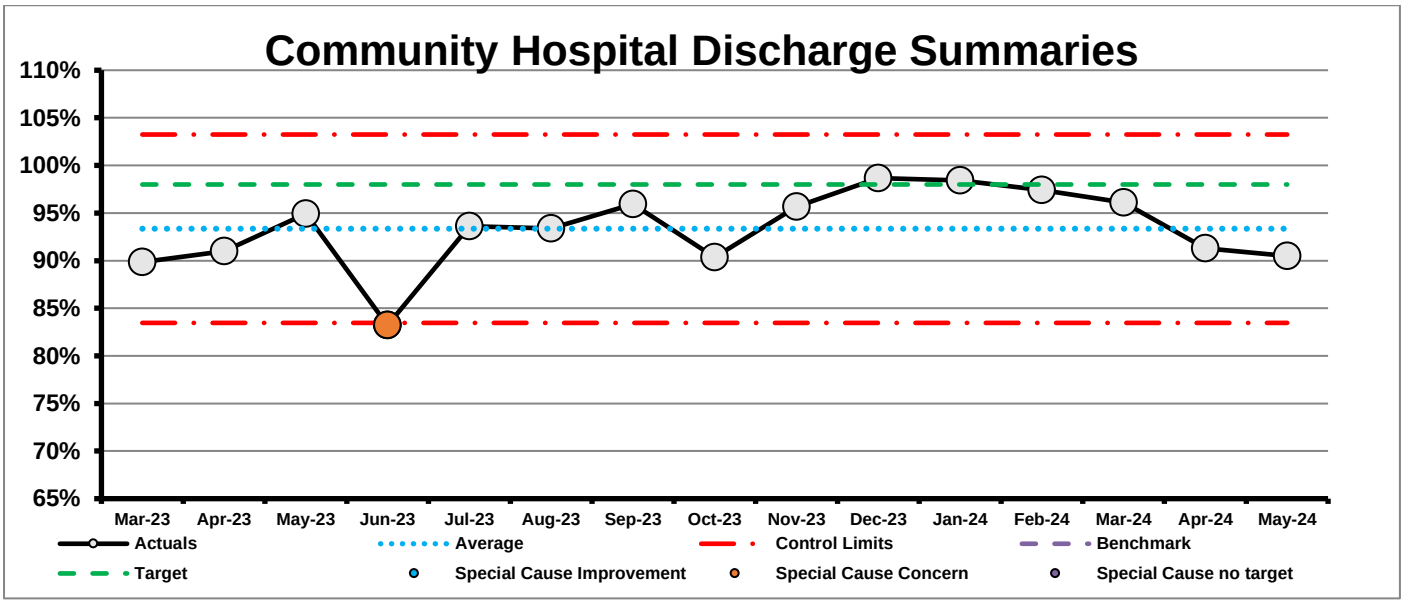
Care hours per patient day shows no significant variation since June 2023.

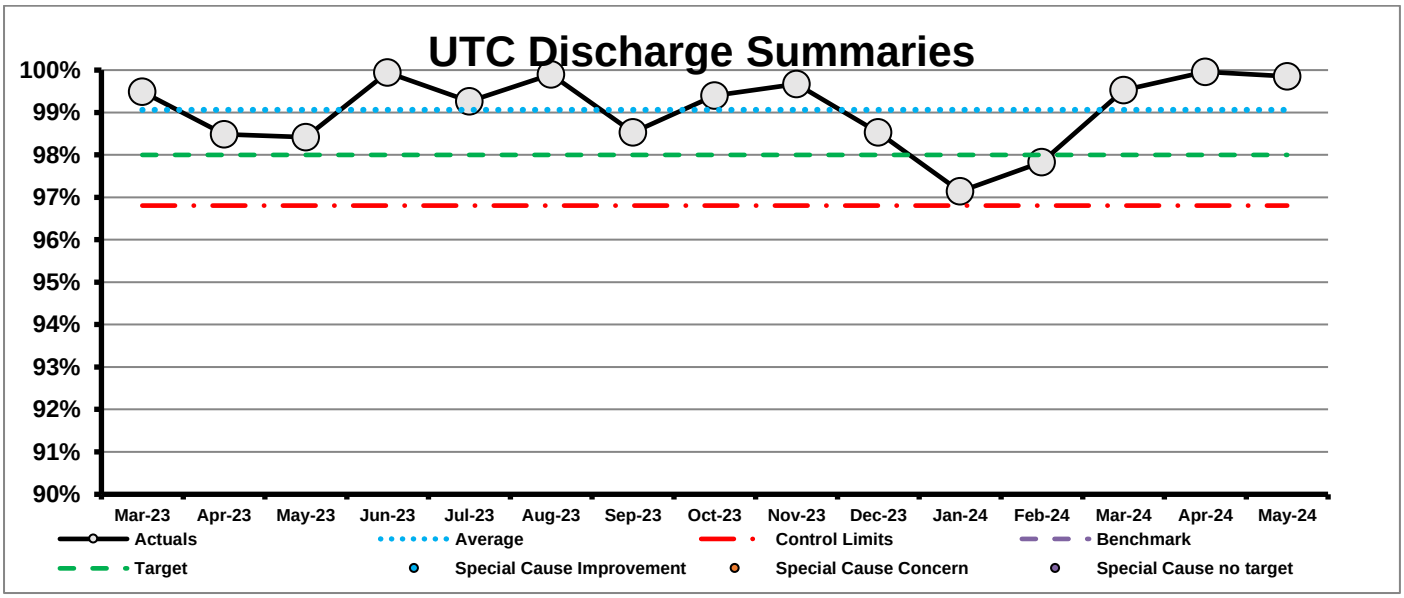
Discharge Summaries

Background
It is a requirement of the Quality Schedule part 6 to the NHS Standard Contract that discharge summaries issued by the ward doctor are issued from Community Hospitals to the patients GP within 24 hours of discharge. As the Trust medical staff currently work Monday to Friday this performance measure is adapted.

Benchmark / Target
Discharge summaries should be issued by the ward doctor in Community Hospitals to the patients GP within 24 hours of discharge – target 98%.

Current Performance





Narrative

Community Hospitals

Review of areas not achieving 100% are being audited weekly to support compliance by area CTL's. Target of 98% was not achieved this month. Clear trend with return of letters is clear for John Copland Hospital - the service is reviewing further information.

Actions

Continued oversight of revised processes in place. Validation of non-compliance continues to be monitored with remedial action taken at a local level. Feedback to clinician's and teams in place for awareness and localised plan for maintenance.

Urgent Treatment Centres

Whilst not part of the Schedule 6 performance indicator – the UTCs also issue discharge summaries and compliance is 98% at 99.85% for May 2024.

SPC

Discharge Summaries - Community Hospitals
SPC Community Hospital Discharge Summaries shows no significant variation over the period.

Discharge Summaries – Urgent Treatment Centres
UTC Discharge Summaries shows no significant variation over the period.

Overdue & Reported Datix

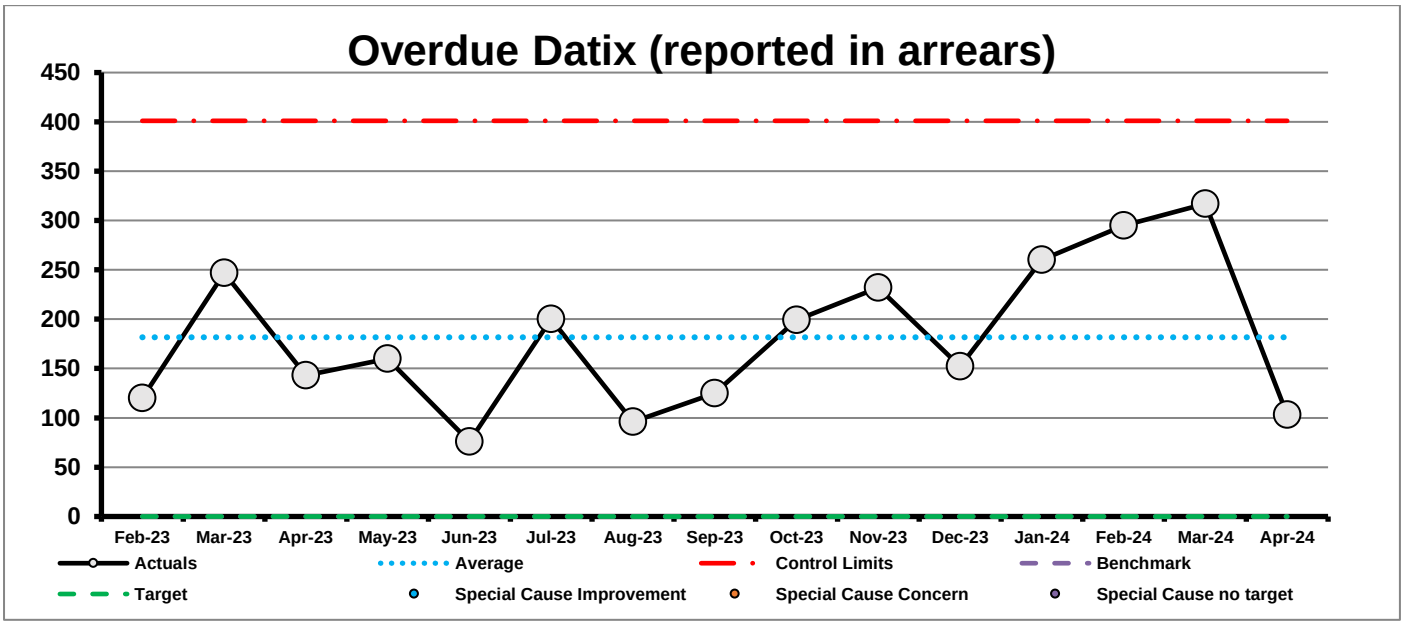
Background
When a Datix is raised to alert or escalate an incident (IR1 form) – it is imperative that the details are reviewed and considered in terms of any immediate actions that have or should be taken particularly regarding patient and staff safety.

A Datix is used as part of many governance processes and learning form the incidents when an investigation or exploration is complete should be considered, captured and changes enacted from the learning (IR2 form) A final review and closure of the Datix is completed by a senior manager where wider themes are also considered.

Benchmark/Target
The **recommended** timescale for optimum learning is 30 days.

Datix are reported as at the end of the preceding month (i.e., below is the position for April 2023). Reported Datix are reported at the end of the reporting month.

Current Performance



Narrative
The overdue Datix is taken in context of the Trust being a high reporter of Datix.

Whilst some investigations will require a longer investigation timetable than routine incidents (e.g., where incidents require statements from several staff or a formal RCA). To understand true overdue Datix - those not aligned to an investigation or planned governance process - the data has been broken down.

Actions
- A trajectory for recovery of overdue Datix has been agreed and is reported to the Quality & Risk Committee monthly- the trajectory is on target.
- Development of the Datix system is being progressed to support faster incident triage and improved oversight.
- Specific actions with the ICB are being agreed in relation to being able to close Datix relating to pressure damage.
- Training is being delivered by the quality team on the completion of IR2s.
- An online training package is under development, and the training in the recording of Datix is improving accuracy.

SPC
Overdue Datix numbers have not varied over the period.

Children in Care (reported one month in arrears)

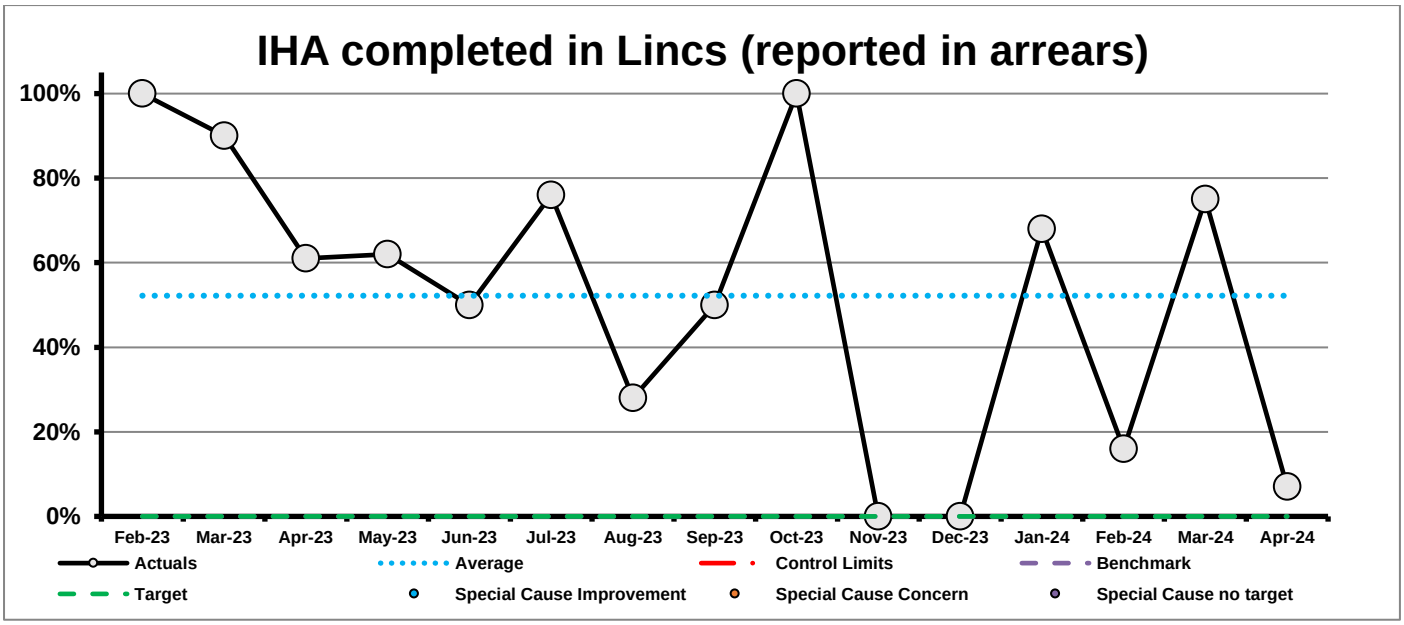
Background

From the 1st August 2019 LCHS reporting of the management and completion of Initial Health Assessments (IHA) for Children in Care (CiC) was included in this report. The performance report includes children looked after in Lincolnshire local authority and those placed in Lincolnshire by external authorities.
The quarterly and annual reports provide details on Children in Care in Lincolnshire who are placed outside of county, having their IHA with alternative providers.

Benchmarking / Target

All Children in Care are required to have an IHA undertaken and completed within 20 working days of becoming looked after. Lincolnshire County Council (LCC) has a target to complete and submit Consents and Coram BAAF forms to LCHS within 3 working days of a child becoming looked after. LCHS are required to administer the completion of an IHA within the statutory 20 working days of the child becoming looked after.

Current Performance



Narrative

SystmOne offers two reporting groups for daily extracts:

- A midnight-to-midnight extract which should be used for operational 24-hour services.
- A 17:00 – 17:00 extract for 9-5 based services and provides changes up until 17:00 the previous day.

All of our SystmOne units are currently sat within the midnight-to-midnight reporting group, however, TPP has recently stated that we need to move the non-appropriate units to the 17:00 – 17:00 reporting group. We have assured TPP that we will be moving services to the appropriate group within the last quarter of 2024 because this will require a significant amount of infrastructure development. However, we currently have no data for the Children in Care Service in the Data Warehouse since TPP have removed the unit from our midnight-to-midnight reporting group. Therefore, the data provided has been collated manually and retrospectively updated because it is not currently regularly available. We are in the process of requesting that TPP reinstates the unit in the reporting group as a temporary solution until the infrastructure development can take place, but it is likely that they will reject the request.

SPC

The SPC for IHA Performance has not varied significantly over the period.

Environmental Cleanliness

Background
The cleaning company contract with provider OCS through NHSPS shared services began in 2022.

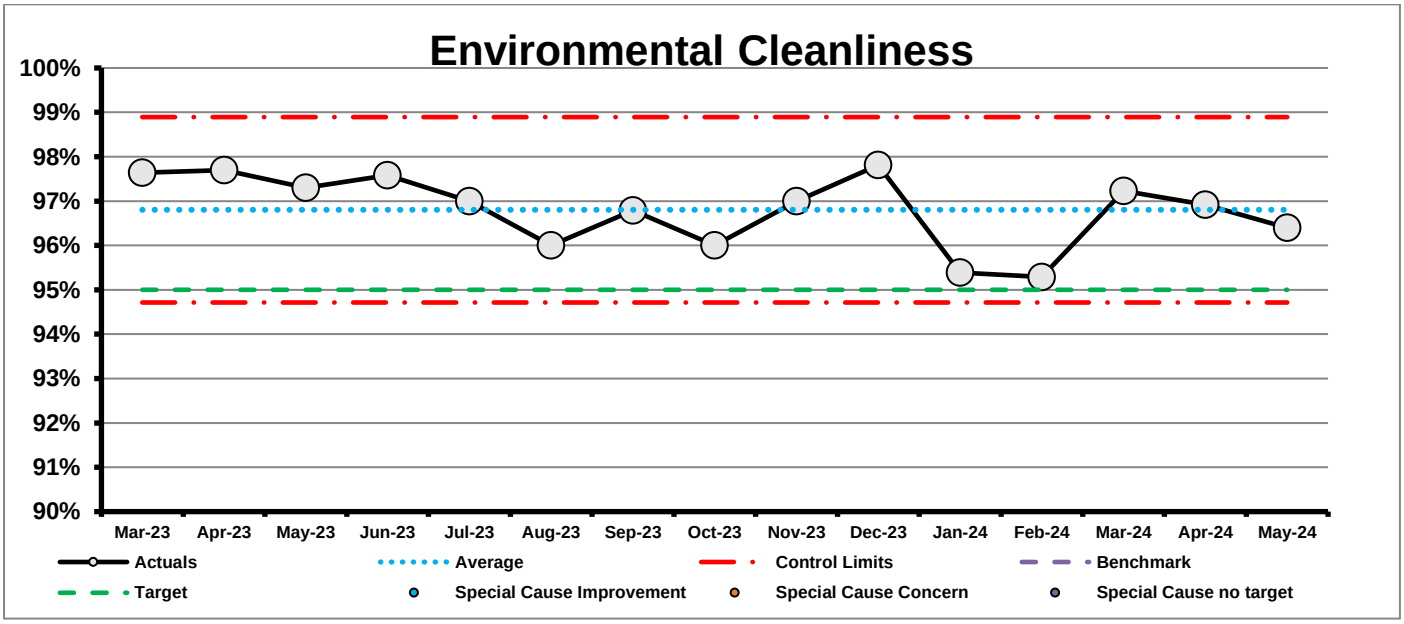
The requirements of the new National Standards of Healthcare Cleanliness that were published at the end of April 2021 have been rolled out across all LCHS community premises by OCS as well as being adopted by NHSPS and the in-house teams at the hospital sites.

Star rating posters and "Commitment to Cleanliness" posters, which include cleaning schedules, are on display in all Trust buildings.

Benchmark / Target
LCHS is required to comply and report 2 targets:

- Criterion two of the Hygiene Code requires LCHS to "provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections'' with 100% compliance.
- Completion of cleanliness audits with achievements of 5-star rating.

Current Performance



Narrative
LCHS reported 96.40% compliance of cleanliness audits and has achieved the 95% target every month. Visible improvements in the cleaning standards across all the community premises are being sustained. During the quarter, all sites achieved scores that would rate them as either 4 or 5 stars, in accordance with the new Healthcare cleaning standards.

There are currently no cleaning vacancies across the LCHS sites, and all current staff training is up to date.

Actions
Cleanliness audits and monitoring continue to facilitate appraisal of concordance with expected cleanliness standards. One area of development continues to be the cleaning contract review at Louth Urgent Care Centre.

SPC
SPC shows that cleanliness audits performance has not varied over the period.

Community Hospital Bed Occupancy

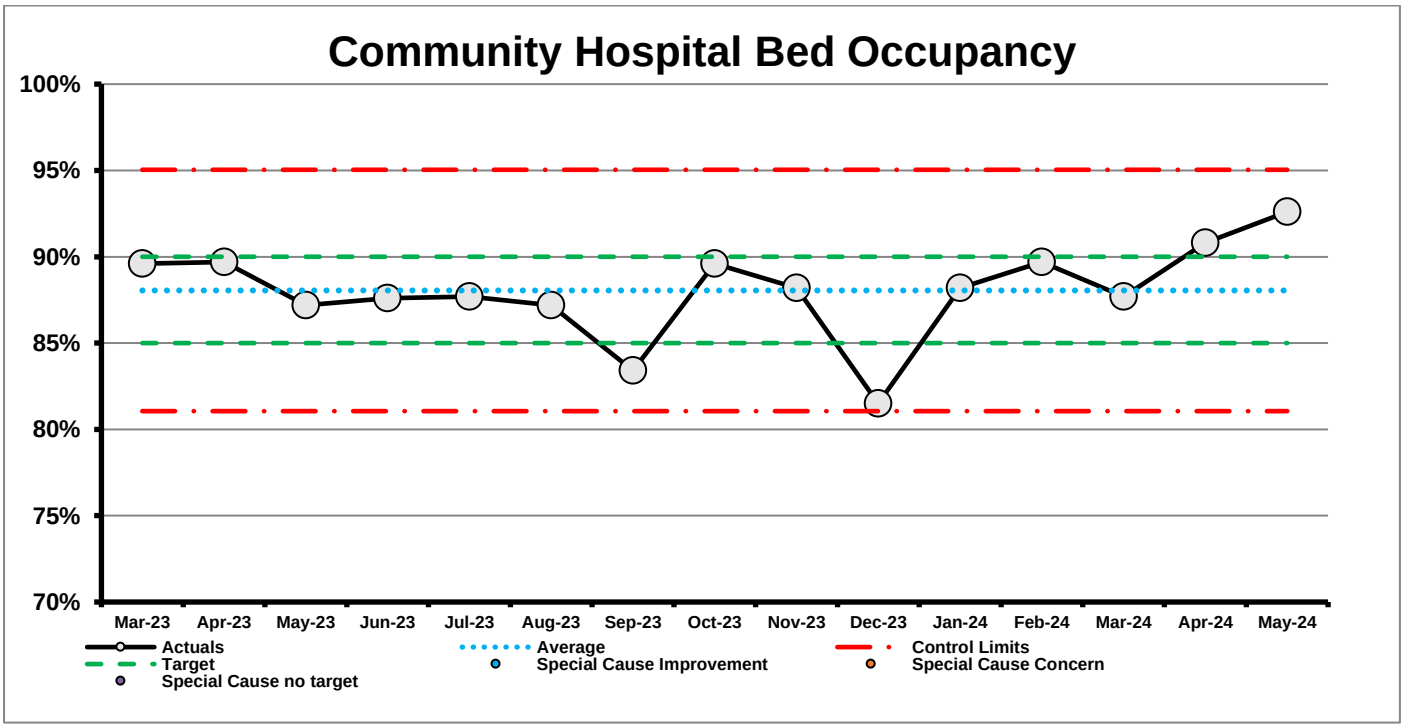
Background

Bed occupancy is measured in terms of open beds and does not include any chair-based activity.
The calculations for bed occupancy also include increases in beds at time of surge or pressure when additional beds are opened. Bed occupancy is a patient safety and patient flow measure.

Benchmark/Target

In July 2023 the bed occupancy target was moved from 90% to 85%. NHS Benchmarking have not yet published the community dataset for the reporting period. Bed occupancy target for the community hospitals is to be reviewed with a proposal for PMR that the target to be set at 85% in line with NICE guidance this proposal has been accepted and target implemented. However, from a patient flow perspective the proposed strategy is to 'fill the beds' which in practice means aiming for a bed occupancy of 95% or so.

Current Performance



Narrative

Bed occupancy for May 2024 was 92.60%, significate increase on the previous month (90.80%).

Work by the Community Hospitals teams, along with their colleagues in Transitional Care and Flow, in partnership with Acute colleagues, has enabled high bed occupancy for this month. This is an improvement we hope to sustain in future months.

SPC

Community Hospital bed occupancy performance has not varied significantly over the period.

Average Length of Stay

Background

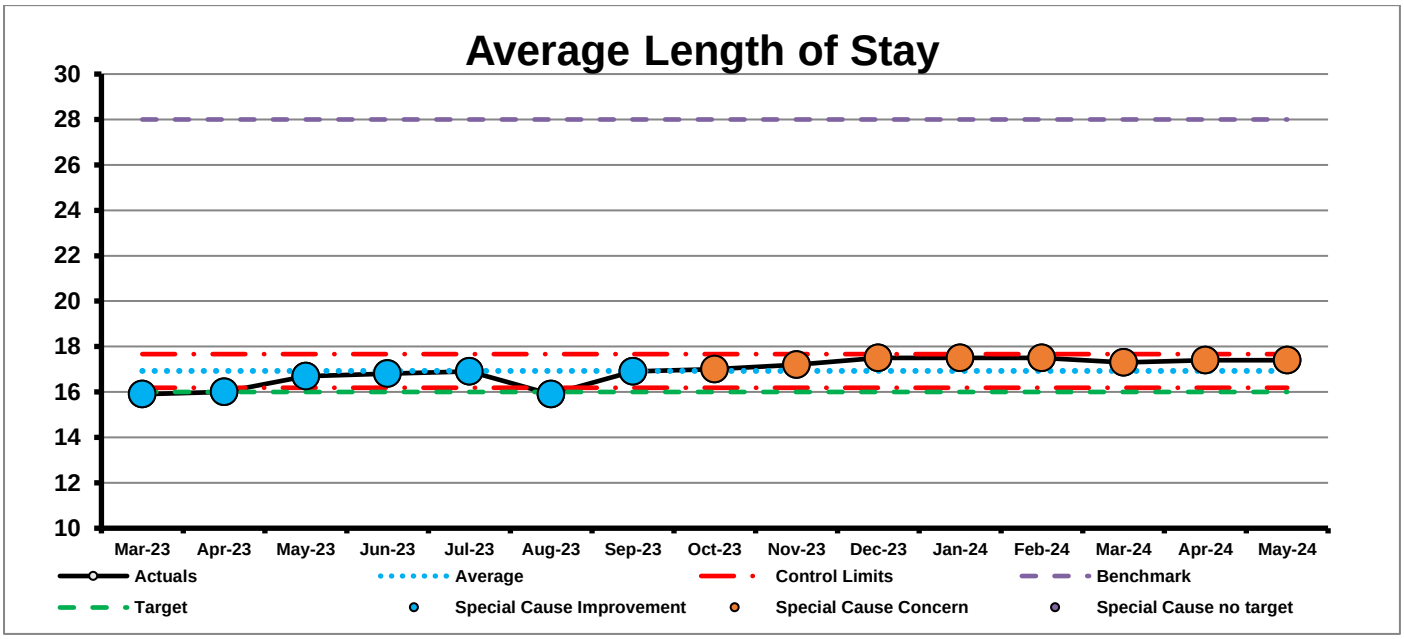
This measure is defined as the difference in days between the date the patient was discharged from the hospital, and the date they were admitted. The average time in hospital in days for all the patients who underwent a procedure in an NHS trust is then calculated (NHS Digital, 2018).

Benchmark/ Target

NHS Benchmarking have not yet published the community dataset for the reporting period.

Target length of stay is 16 days.

Current Performance



Narrative

Average length of stay in Community Hospitals has remained below the National Benchmark (currently 28 days) for over 12 months. The number of days average was 17.40 in May. This is above the target of 16 days.

Actions

With improvements made to bed occupancy the whole focus on Quality Improvement for the service can now be on Length of Stay. We hope to bring this down to the target by implementing the following: SAFER care bundle, partnership working through the 'Discharge Board', changed skill mix in therapy teams, Stroke Designated beds and continue to improve our bread-and-butter processes with regards to patient assessment, rehabilitation, and discharge.

SPC

Average length of stay SPC shows special cause concern since October 2023. Average length of stay is inconsistently capable of achieving the local target of 16, the target of 16 is missed more often than not.

Friends and Family Test

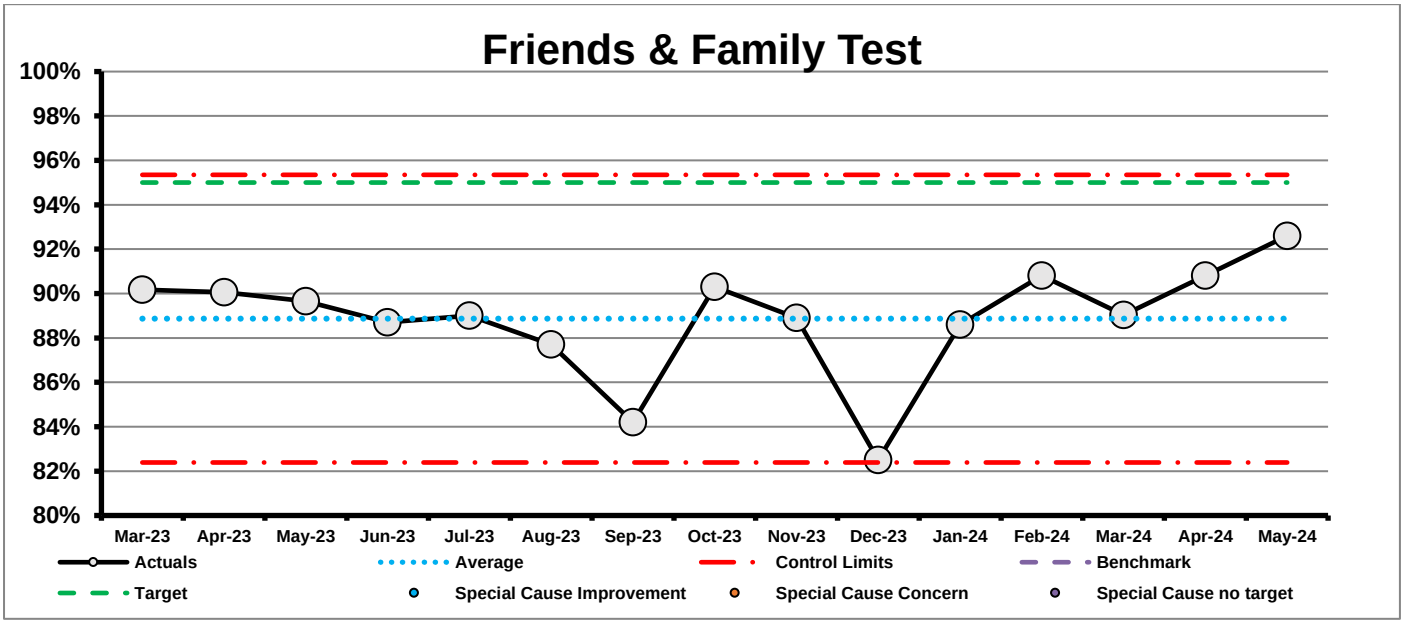
Background

The NHS Friends and Family Test was created to help service providers and commissioners understand whether their patients are happy with the service provided, and where improvements are needed. It is a quick and anonymous way to give views after receiving care or treatment across the NHS. When patients complete their treatment or are discharged from a service, they are invited to complete the FFT, they are asked to provide a score and feedback on recommending the service to friends and family. This is important because service providers can only make changes if they know exactly what is or isn't working.

Benchmark / Target

The LCHS Target is 95% of service users recommend our services.

Current Performance



Narrative

FFT figures for May (92.60%) shows an increase on last month's performance activity (90.80%).

11 FFT QR codes have been generated with bespoke alignment to the community nursing teams for patient engagement and feedback. The Patient Experience Support Officer is working within each of the 11 community nursing teams for an enrichment data collation experience. The FFT intelligence acquired will formulate a 'you said we did' feedback method - which will be incorporated into the weekly bulletin, screensaver, team meetings and QSG for dissemination.

Actions

Additional contractual oversight remains in place to continue to improve the roll out and reporting of the service provided.

SPC

Friends and Family performance has not varied significantly over the period.

Compliments

Background

Compliments are received by the Trust through services directly which are then shared with the PALS, Complaints and Claims Team, through NHS Choices, Healthwatch, alternative partners or directly into PALS. Work continues to accurately capture the compliments received by the Trust.

Benchmark / Target

There is no available benchmarking. A proposed target of 50 compliments each month across the Trust is currently being discussed with divisions.

Current activity

Narrative

Monthly figures have varied considerably in relation to compliments received into the Trust, although consistencies are notable over a 14- month period year on year, where numbers decrease in the months of January, March, and September over the past 3 years, which are months where attendances/ use of services have increased.
May shows a slight decrease from the previous month.

SPC

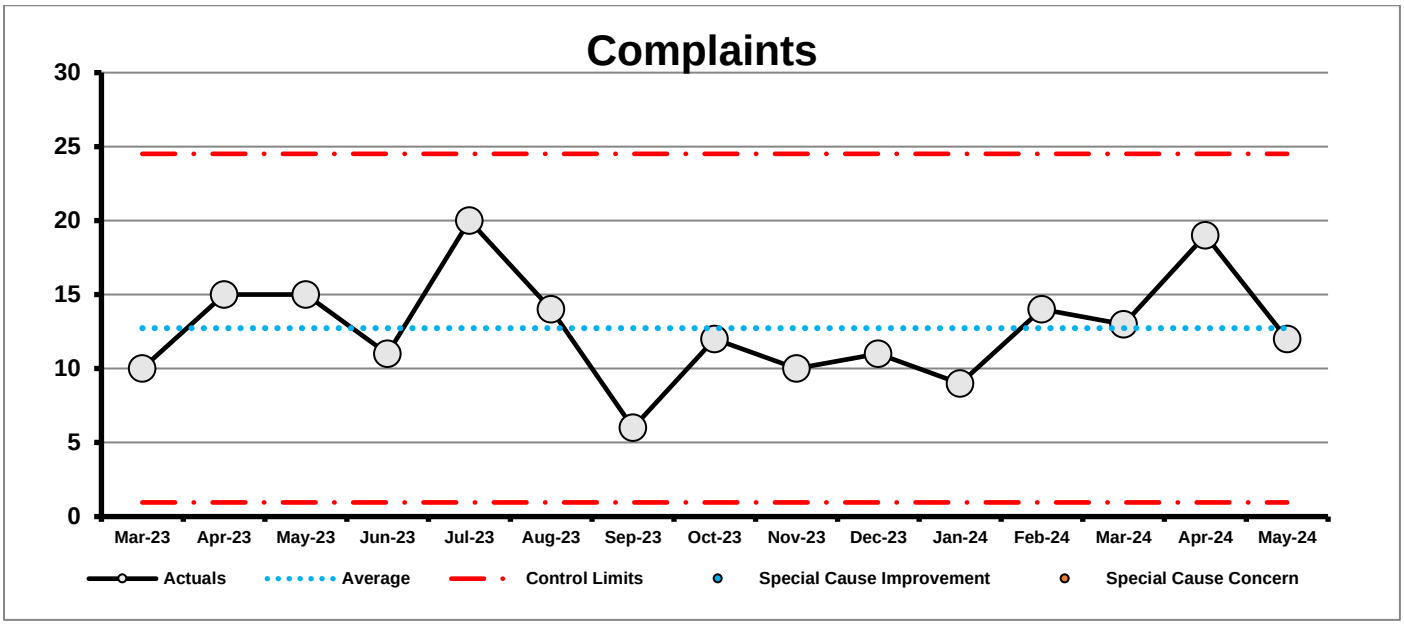
Compliments have not varied significantly since April 2024.

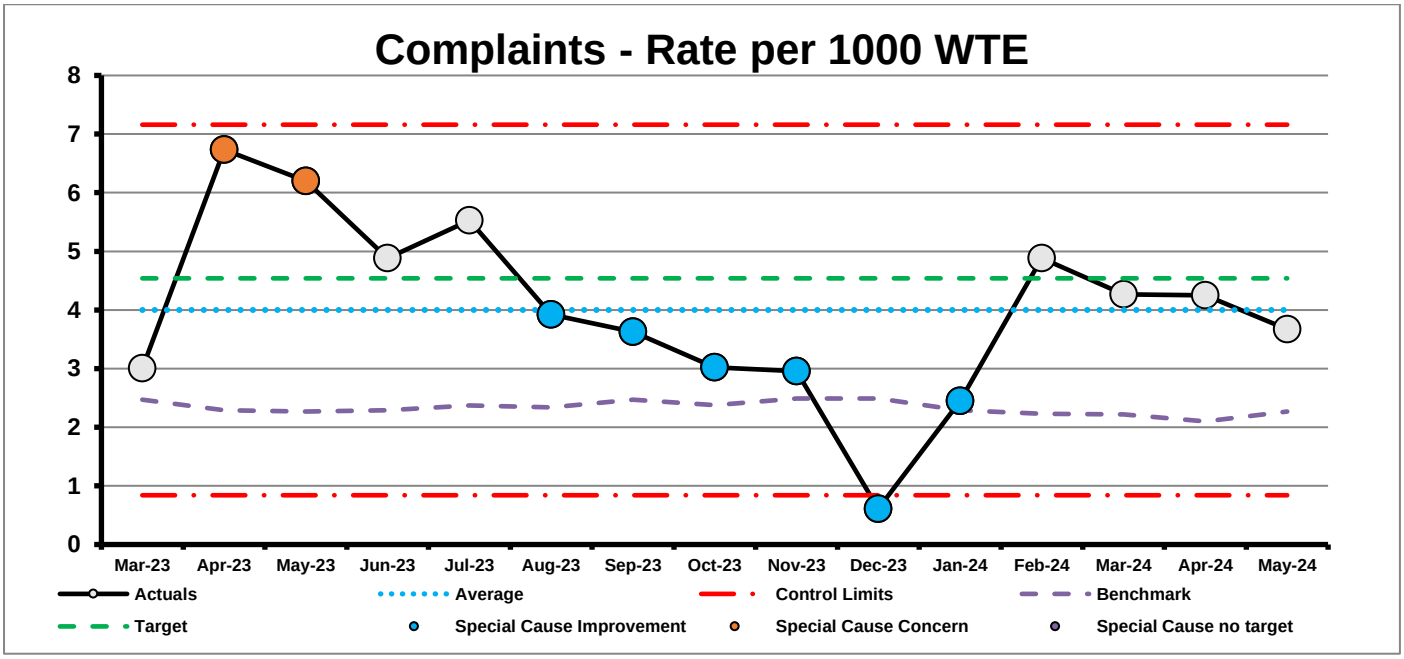
Complaints

Benchmark / Target

LCHS is benchmarked by the number of complaints reported per 1,000 WTE budgeted staff.

Current Performance





Narrative

We are keen to resolve any complaints or issues, concerned with the service and patient or family member in a prompt, personal and effective manner. This avoids the complaint reaching the 'time out' after 3 days and escalating to a formal complaint. Significant work has been taking place since September 2022 to improve the flow of concerns, complaints, and compliments across the Trust.

Actions

Through divisional leads and Quality Assurance Groups (QAGs) actions continuing to be taken forward include:

- Encouraging divisions to respond to as many complaints as possible through the informal concerns route within time to prevent escalation to a formal complaint.

Updated communication materials are in development to simplify how patients and family members can raise a concern, complaint, or feedback.

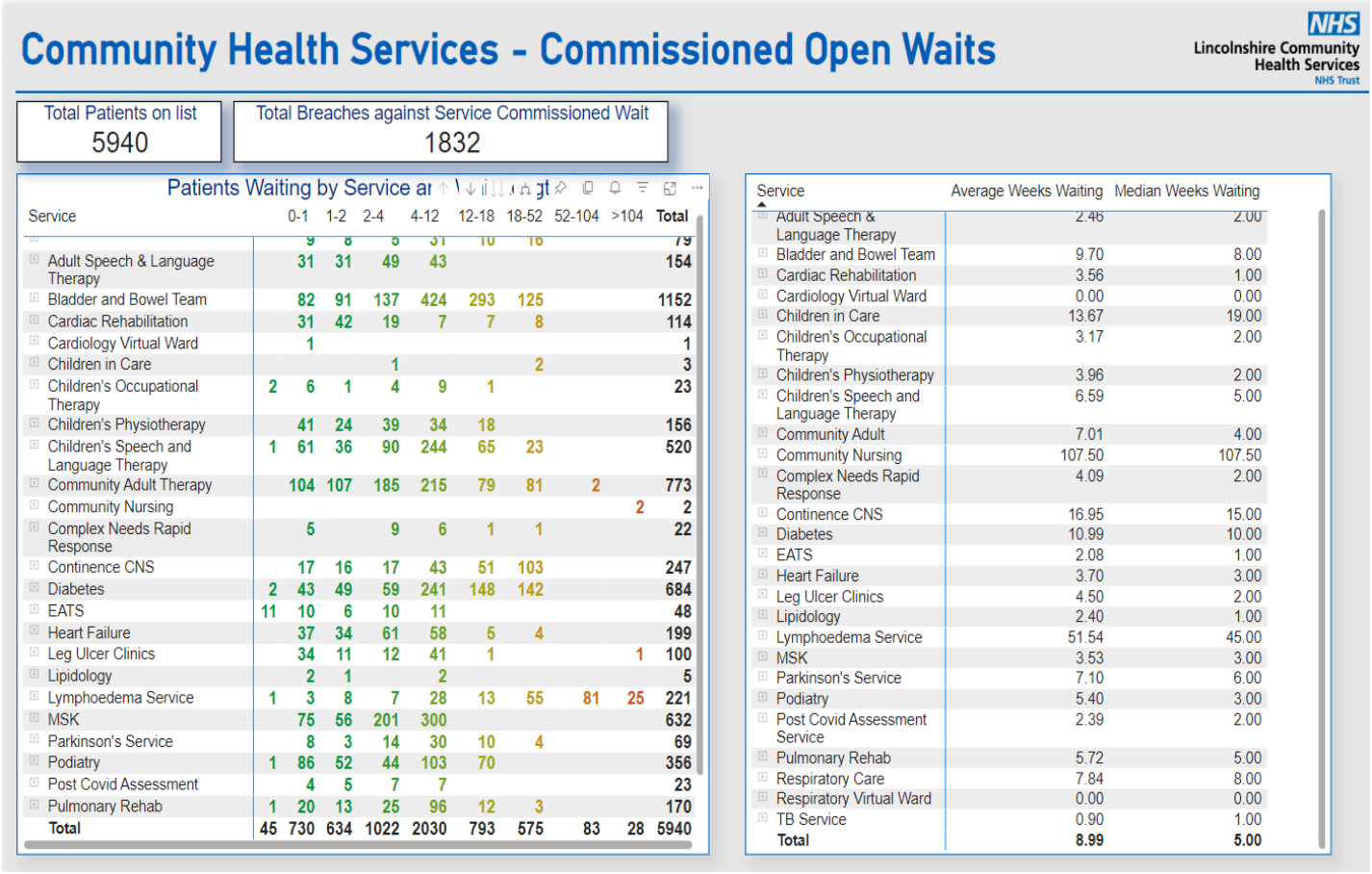
SPC

Both complaints, and complaints rate per 1000 WTE have not varied significantly over the period..

LCHS Commissioned Waits

Background

LCHS Commissioned waits are the agreed target waits set out by each service level agreement and therefore not all services will be aligned to an 18 week wait target.



Community Health Services - Commissioned Open Waits

NHS Lincolnshire Community Health Services NHS Trust

Total Patients on list	Total Breaches against Service Commissioned Wait
5940	1832

Patients Waiting by Service ar...gt

Service	0-1	1-2	2-4	4-12	12-18	18-52	52-104	>104	Total
Adult Speech & Language Therapy		31	31	49	43				154
Bladder and Bowel Team		82	91	137	424	293	125		1152
Cardiac Rehabilitation		31	42	19	7	7	8		114
Cardiology Virtual Ward		1							1
Children in Care				1			2		3
Children's Occupational Therapy	2	6	1	4	9	1			23
Children's Physiotherapy		41	24	39	34	18			156
Children's Speech and Language Therapy	1	61	36	90	244	65	23		520
Community Adult Therapy		104	107	185	215	79	81	2	773
Community Nursing								2	2
Complex Needs Rapid Response		5		9	6	1	1		22
Continence CNS		17	16	17	43	51	103		247
Diabetes	2	43	49	59	241	148	142		684
EATS	11	10	6	10	11				48
Heart Failure		37	34	61	58	5	4		199
Leg Ulcer Clinics		34	11	12	41	1		1	100
Lipidology		2	1		2				5
Lymphoedema Service	1	3	8	7	28	13	55	81	25	221
MSK		75	56	201	300				632
Parkinson's Service		8	3	14	30	10	4		69
Podiatry	1	86	52	44	103	70			356
Post Covid Assessment		4	5	7	7				23
Pulmonary Rehab	1	20	13	25	96	12	3		170
Total	45	730	634	1022	2030	793	575	83	28	5940

Service	Average Weeks Waiting	Median Weeks Waiting
Adult Speech & Language Therapy	2.46	2.00
Bladder and Bowel Team	9.70	8.00
Cardiac Rehabilitation	3.56	1.00
Cardiology Virtual Ward	0.00	0.00
Children in Care	13.67	19.00
Children's Occupational Therapy	3.17	2.00
Children's Physiotherapy	3.96	2.00
Children's Speech and Language Therapy	6.59	5.00
Community Adult	7.01	4.00
Community Nursing	107.50	107.50
Complex Needs Rapid Response	4.09	2.00
Continence CNS	16.95	15.00
Diabetes	10.99	10.00
EATS	2.08	1.00
Heart Failure	3.70	3.00
Leg Ulcer Clinics	4.50	2.00
Lipidology	2.40	1.00
Lymphoedema Service	51.54	45.00
MSK	3.53	3.00
Parkinson's Service	7.10	6.00
Podiatry	5.40	3.00
Post Covid Assessment Service	2.39	2.00
Pulmonary Rehab	5.72	5.00
Respiratory Care	7.84	8.00
Respiratory Virtual Ward	0.00	0.00
TB Service	0.90	1.00
Total	**8.99**	**5.00**

Narrative

This is the current LCHS Commissioned Wait position based on the data for those services using the clock, and where the clock has not been paused. It has been agreed across the Trust for waits to be recorded using the 18 Week Wait function on SystmOne. However, each individual service will be working and recording Harm reviews within their own commissioned wait KPIs which maybe outside the 18 weeks.

Despite the NHS Operating Framework and NHS Constitution setting out rules and definitions for consultant-led waiting times, as a non-consultant-led trust, the NHS framework allows the use of the clock to make clinically sound decisions locally about applying them, in collaboration between clinicians, providers, commissioners and the patient.

All services in May 2024 have now implemented this process, recording referral to initial contact. Data quality reporting target to ensure this is correct is in progress and will be completed by the end of Q1.

The agreed target waits for those services currently utilising the clock are outlined below.

Service	**Target Wait**
Adult Speech and Language Therapy	18 Weeks
Bladder and Bowel	6 Weeks
Cardiac Rehabilitation	10 Working Days

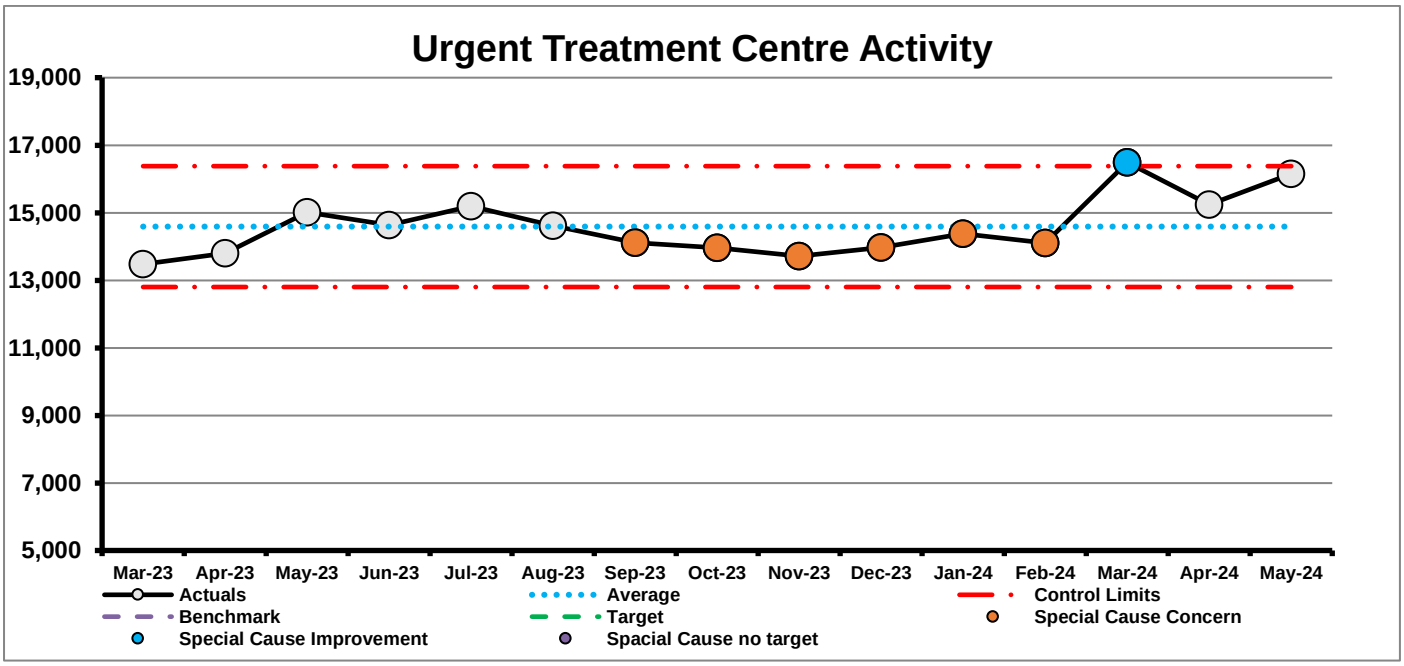
Child Therapy	18 Weeks
Children in Care	20 Working Days
CNS Continence	18 Weeks
Diabetes	4 Weeks
Electronic Assistive Technology Service	6 Weeks
Heart Failure	2 Weeks
Musculoskeletal Physiotherapy	15 Working Days
Parkinson's	18 Weeks
Podiatry	18 Weeks
Post Covid	6 Weeks
Pulmonary Rehab	10 Weeks
Complex Needs Rapid Response	18 Weeks
Respiratory (CCM, Oxygen, Physiotherapy)	4 Weeks
TB	6 Weeks

The function of the clock is to provide a true wait for those patients with a new referral awaiting an initial clinical contact and should not be confused with the Waiting Lists on SystmOne which will run alongside the clock. The Waiting Lists show the position of the patients wait but does not take into consideration where the patient has been offered an appointment they have refused and cannot be paused for any reason. This is likely to have a negative impact on the services performance.

Urgent Treatment Centre Activity

Background

This metric measures UTC activity across the Trust. Note that all LCHS Minor Injury Units (MIUs) have now transitioned to Urgent Treatment Centres, in line with national requirements. Activity from June 2021 onwards excludes Peterborough UTC after the cessation of this contract. The figures also exclude the support that LCHS provided to United Lincolnshire Hospitals at Grantham (running a UTC from July 2020 – June 2021).



Narrative

The above data shows the footfall in May 2024 rose to just below the upper control limit. The month of May showed approximately 1,500 more patients attended our UTC's compared to May 2023 and approximately 1,000 more patients than last month.

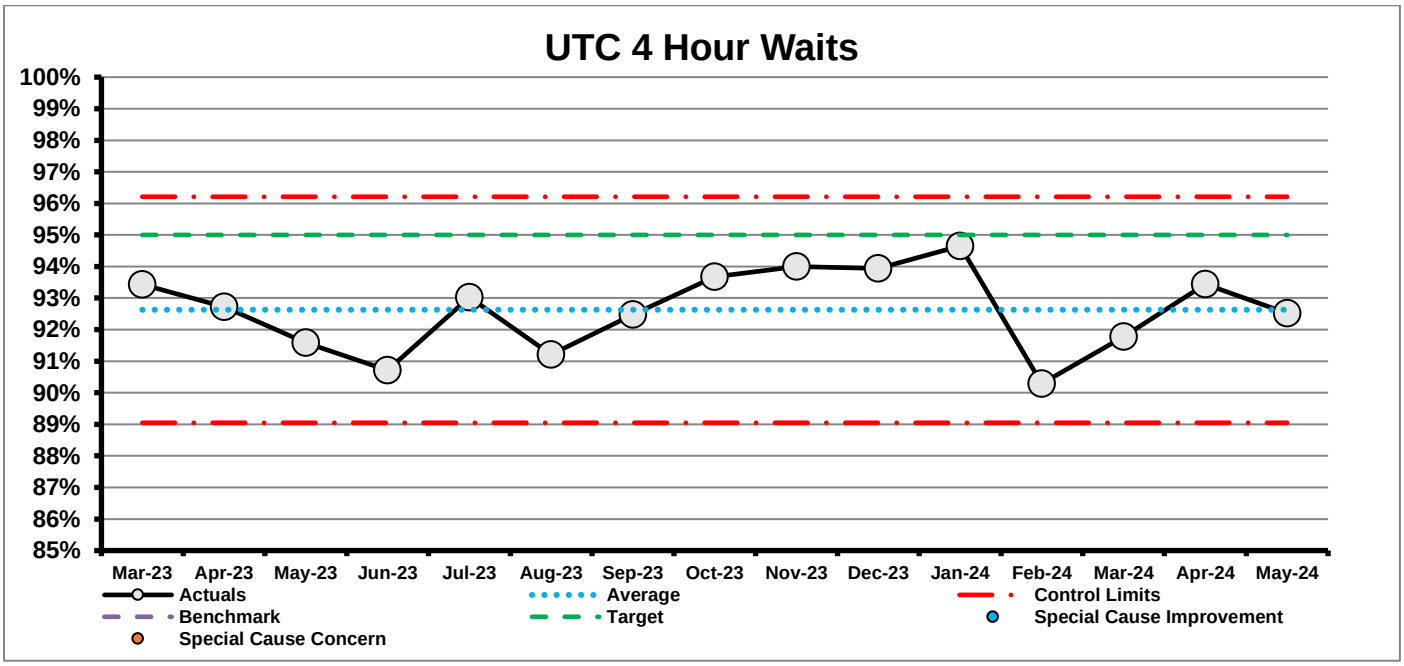
SPC

UTC activity has not varied significantly since March 2024.

UTC 4 Hour Waits

Background

The Quality Schedule requires the Trust to achieve a target of 95% of UTC attendances where the Service User was admitted, transferred, or discharged within 4 hours of their arrival at an A & E department.



Narrative

May 2024 shows a significant improvement in 4-hour waits compared to May 2023.

There has been a slight drop in performance compared to last month however as the above data shows activity has increased which may have contributed to this. The UTC's where performance in 4 hour waiting times was most challenging were also where there was the greatest increase in activity. However, despite this, performance has only dropped by less than 1%.

It is the time to departure at our co-located sites, in particular Lincoln UTC and Boston UTC, that impacts on overall performance with delays for speciality referrals, access to x-ray and those patients requiring acute admission continue to be an ongoing challenge as we support our acute partners who also face pressures around bed availability.

Although the UTC 4-Hour Wait performance data shows that we have been inconsistent in achieving the 95% target, it is important to consider the significant sustained increase in activity we have seen this year. We continue to work closely with our system partners to raise performance to above 76% across the system by validating breaches daily, identifying potential breaches early in the patient journey and improving pathways into specialities. As this hard work continues on reducing our 4-hour waiting times and if activity returns back down to target levels, we anticipate further improvements to June data.

Continued growth in demand for UTC services reflects the hard work around pathways and system partnership working and we are now focusing on our workforce modelling for the future to ensure we continue to drive all areas of performance.

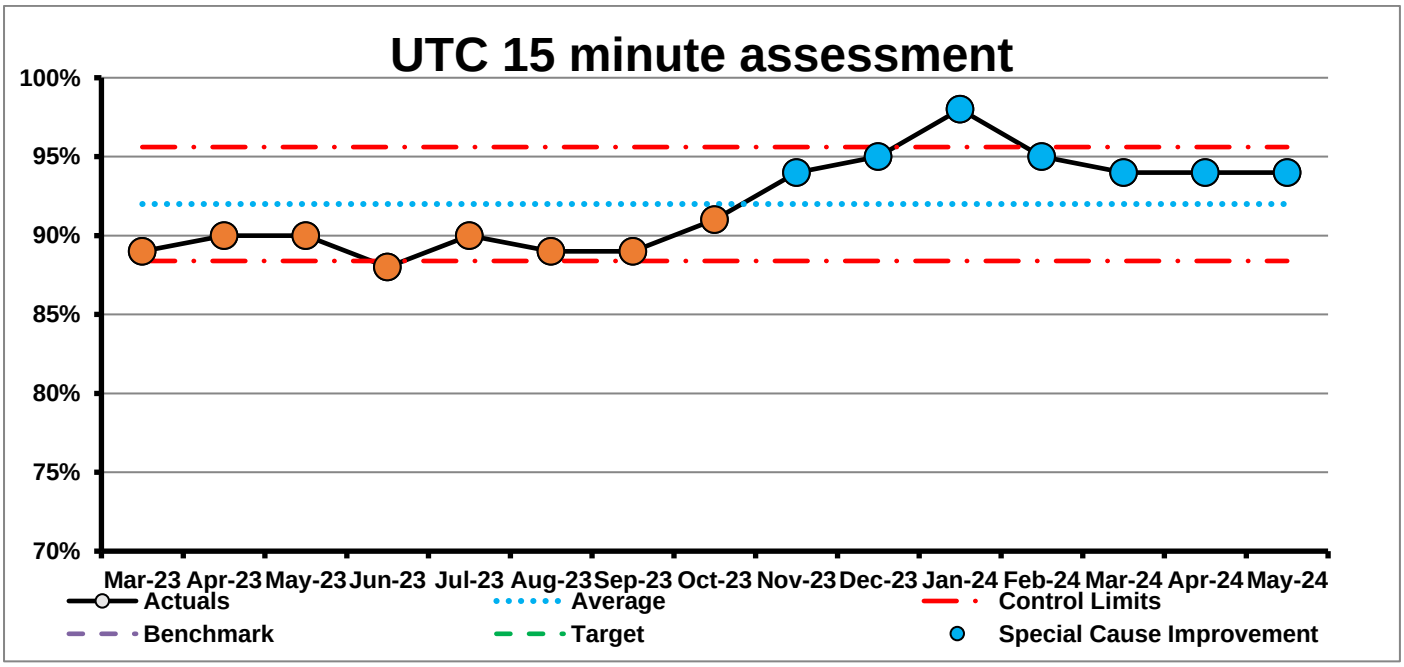
SPC

UTC 4-Hour Wait performance has not varied significantly over the period. UTC 4-Hour Wait performance is inconsistently capable of achieving the 95% target. The target is missed more often than not.

UTC 15-Minute Assessment

Background

Urgent Treatment Centre specifications state that patients who walk-into a UTC should be clinically assessed within 15 minutes of arrival. Following a 2019/20 CQC visit it was agreed that the Trust would ensure that all patients attending A&E (for then Urgent Care Streaming services), regardless of which method of transport they used to arrive, should be assessed within 15 minutes.



Narrative

Work continues ensuring that the success achieved in the past few months continues and remains sustainable. There has been significant improvement at both Skegness and Spalding sites who were often below target. The significant improvement in our 15-minute assessment times has now been sustained for the past 6 months and sits just below 95% for the past 3 months in a row.

Work at Gainsborough remains ongoing and is still showing some improvement if compared historically and with potential new recruitment, should only improve further.

Individual support will be given to teams that require this and daily automatic reporting now in place on ICA via the data teams.

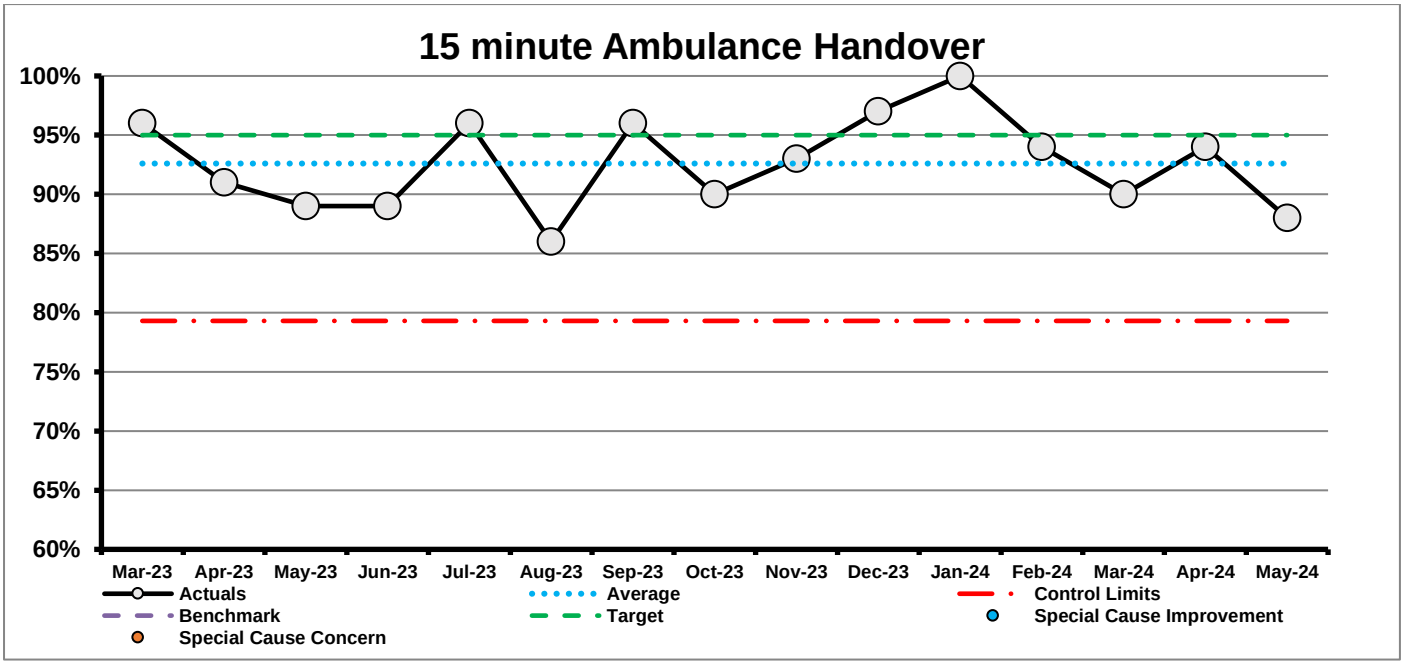
SPC

UTC 15-minute assessment shows special cause improvement since November 2023.

15-Minute Ambulance Handover

Background

The NHS standard contract requires that handovers between ambulances and A & E must take place within 15 minutes with no patient waiting more than 30 minutes. Locally the 95% target is used to indicate and highlight where this is not delivered.



Narrative

15-minute Ambulance Handover performance has not varied significantly over the period. However, there has been a slight decrease in May which may have been a result of the increase in activity compared to last month. We continue to work closely and meet regularly with EMAS partners to enhance admission avoidance pathways.

SPC

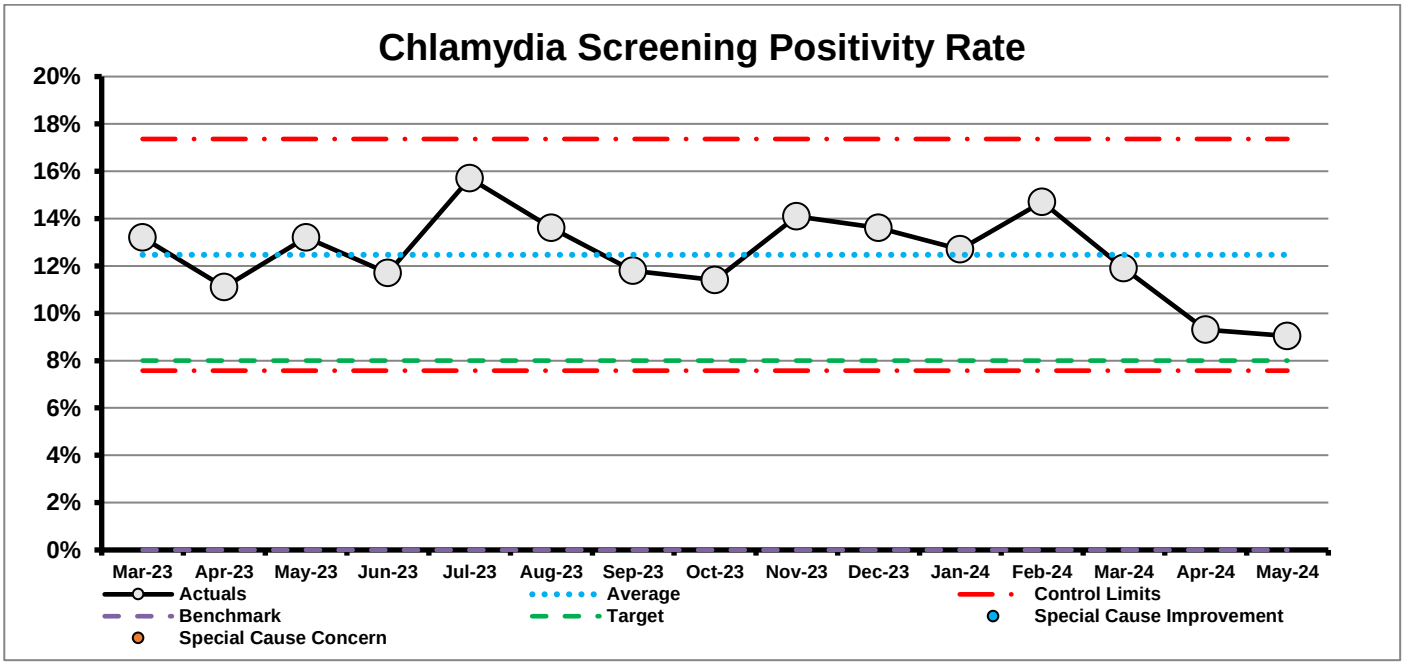
15-minute Ambulance Handover performance has not varied significantly over the period.

15-minute Ambulance Handover is inconsistently capable of achieving the 95% target. This target is missed more often, than not.

Chlamydia Screening Positivity Rate

Background

The Trust is commissioned with a positivity target of 8% of young adults aged 15-24 years who have accepted a screen, and to ensure that 80% of the GU patients are seen or assessed within 2 working days of first contacting the LiSH service. Both these measures have historically had financial service credits (penalties) attached in achieving the target, although these have been suspended in the Covid-19 response period and no confirmation has been made with regards to reinstatement.



Narrative

Positive screening rates have continued to exceed the target rate.

Actions

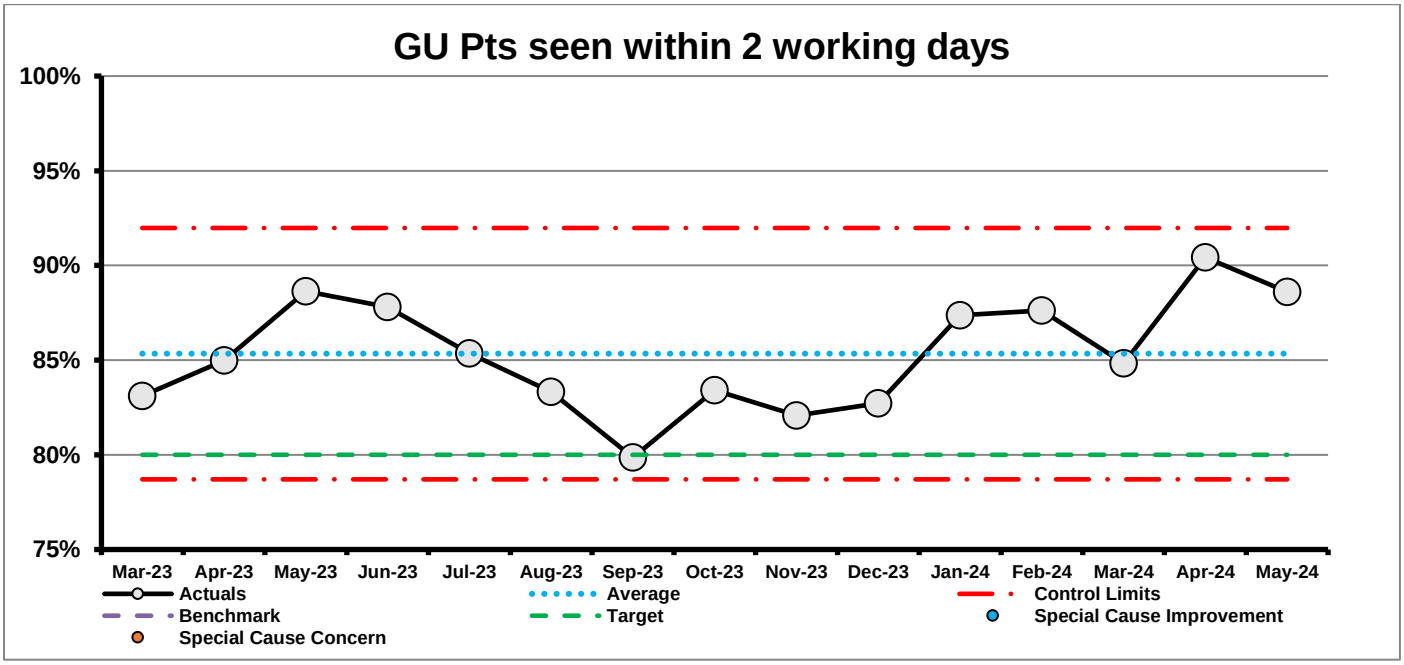
To continue developing and raising awareness of the service within the younger population.

SPC

Chlamydia screening positivity rates have not varied significantly over the period.

Chlamydia screening positivity rates are inconsistently capable of achieving the 8% target but are expected to achieve the target more often than not, as they have in each of the last 15-months.

GU Patients seen or assessed within 2 working days



Narrative

Performance levels and activity or stable for GU clients seen within two working days.

Actions

Discussions continue to understand how the team can further improve on this level of performance.

SPC

GU patients seen within 2 working days have not varied significantly over the period. This measure is inconsistently capable of achieving the 80% target but is expected to achieve target more often than not.

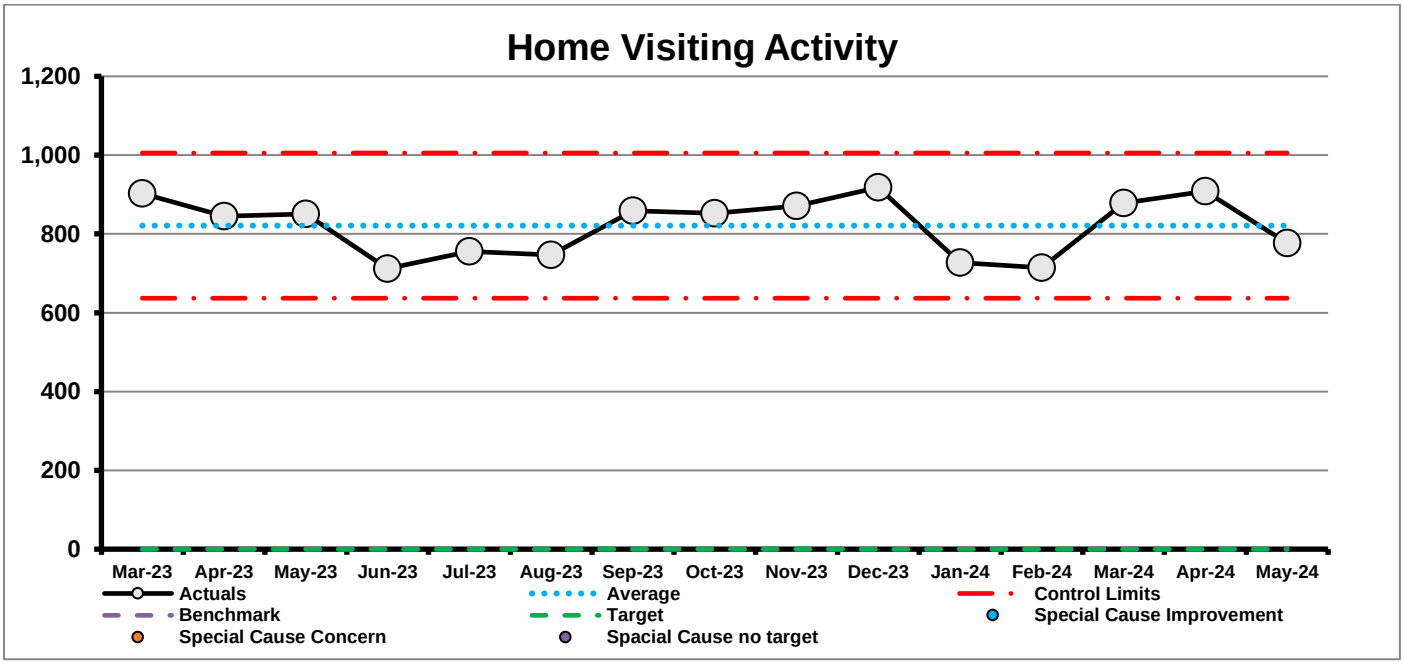
Home Visiting Report

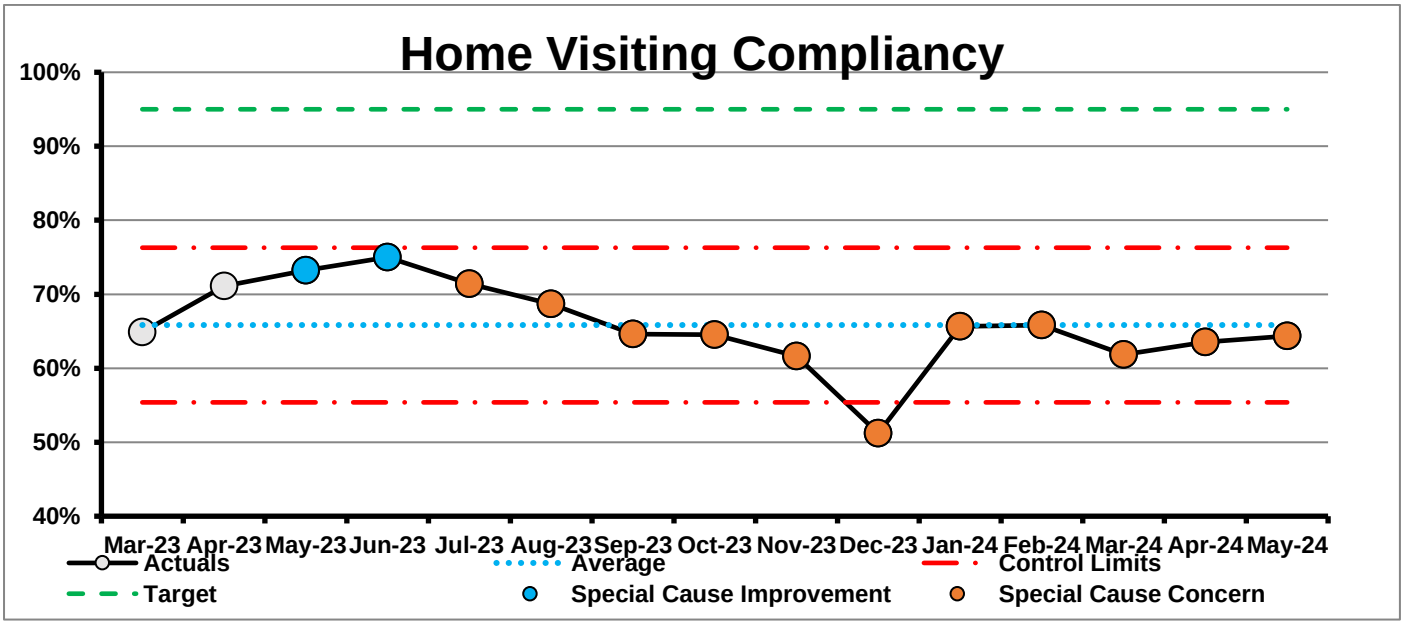
Background

Patients are offered a face-to-face consultation most appropriate to meet their needs and, where applicable, in the patient's home.

Patients are Lincolnshire citizens who become LCHS patients when triaged and accepted by the Home Visiting / Integrated Urgent Care Team and can be accessed via the 111 Service, CAS, and referrals from Community Teams.

The Service avoids admission to Emergency Departments, prevents ambulance call outs and provides reassurance for patients when GP surgeries are closed.





Narrative

We are starting to see a steady increase in our responsiveness. We have been piloting a remodel of the service delivery across a 24-hour period to support our peak times of activity and will now take the proposed changes through a consultation process with the team. By the end of June all our new team members will have finished their supernumerary periods. We have further work to do in addressing the appropriateness of urgent cases and the level of responsiveness required to attend these. We also intend

to present options for including 2, 4, 6 and 12hr responses (in line with national practice) at the next Performance Management Review.

SPC

Home Visiting compliance shows statistically significant deterioration since July 2023 and is not capable of achieving the 95% target without redesign.

Home Visiting activity has not varied significantly over the period.

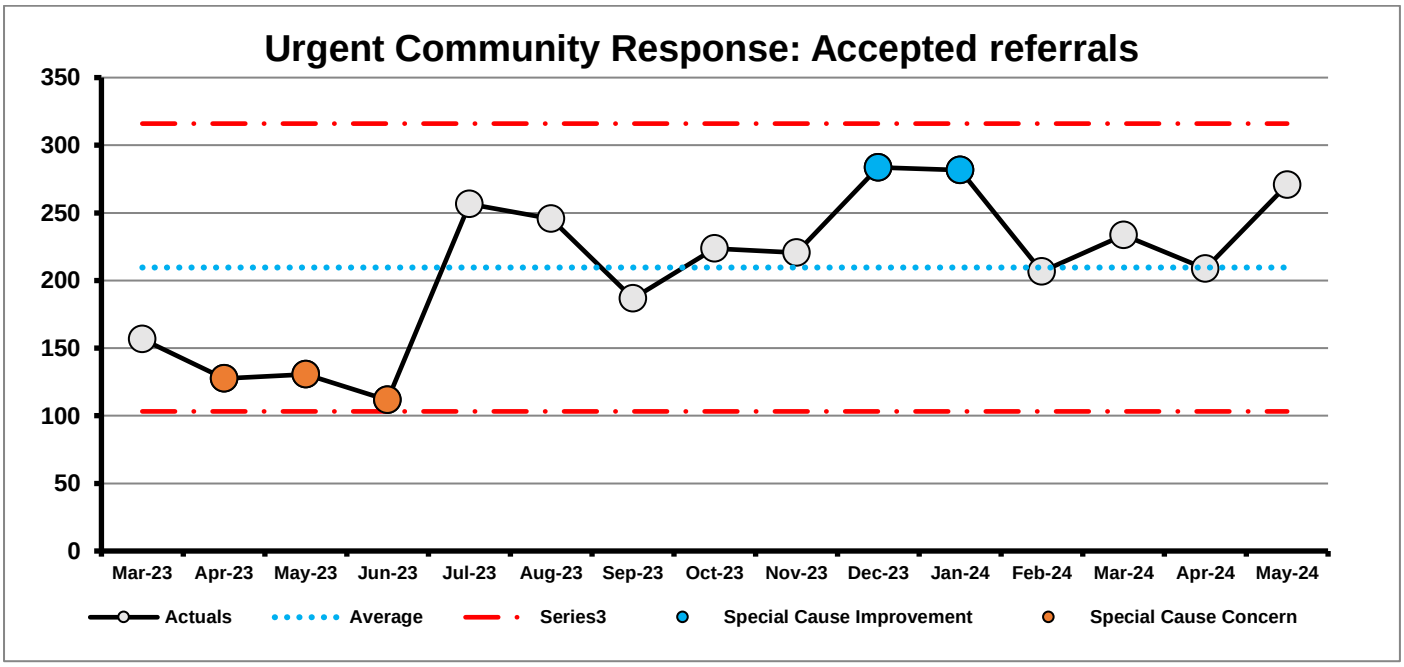
Urgent Community Response

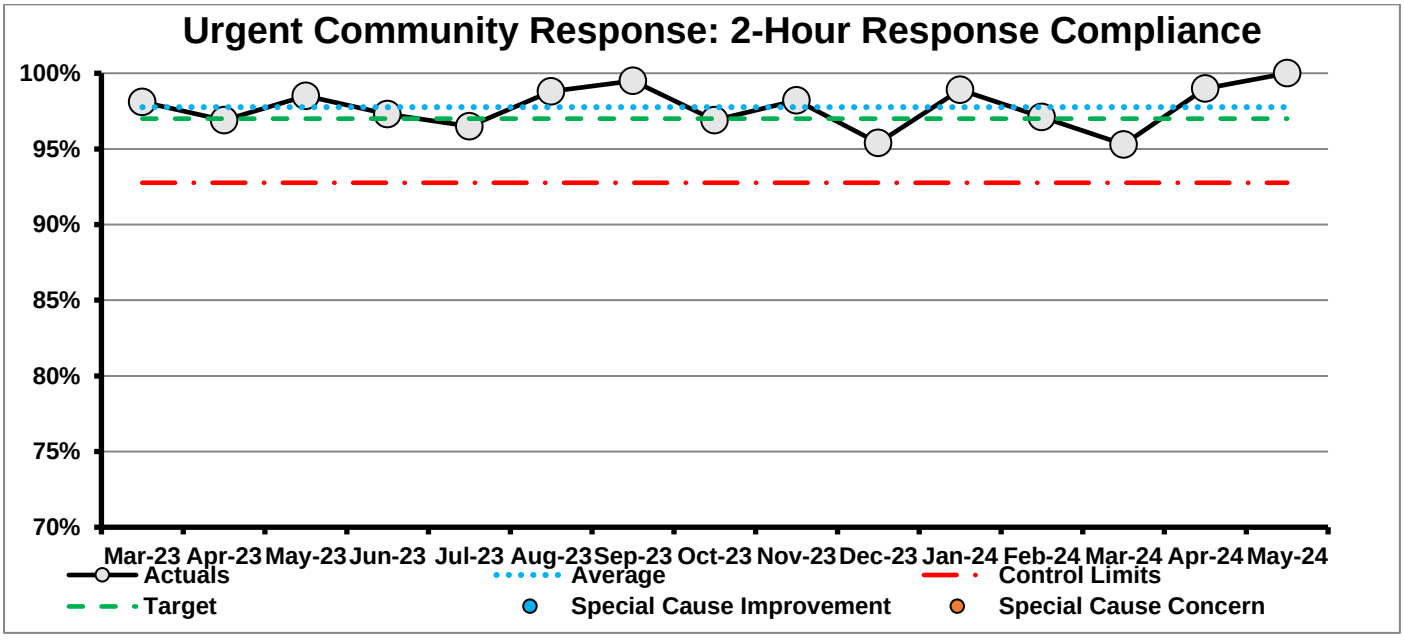
Background

Urgent Community Response is a nationally directed service. The Urgent Community Response Team receives referrals from a variety of sources to support urgent response care services.

The target for each referral is to respond and reach the patient within 2 hours.

It is a collaborative service working closely with Lincolnshire County Council and Social Care.





Narrative

UCR have seen a spike in activity during May, receiving 298 referrals. Compliance remains above target and is not an area for concern. We have been promoting increased use of the service through stakeholder engagement and will continue with this to ensure compliance with trajectory. A new clinical triage tool is currently being trialled to support safe and effective triage of referrals into the service and will be presented at the next Quality Scrutiny Group. We recently held a UCR summit with key partners to review our quality improvement plans for the coming year and plans for continued collaborative working with Home Visiting and the CAS service.

SPC

The number of accepted referrals for Urgent Community Response has not varied significantly since January 2024.

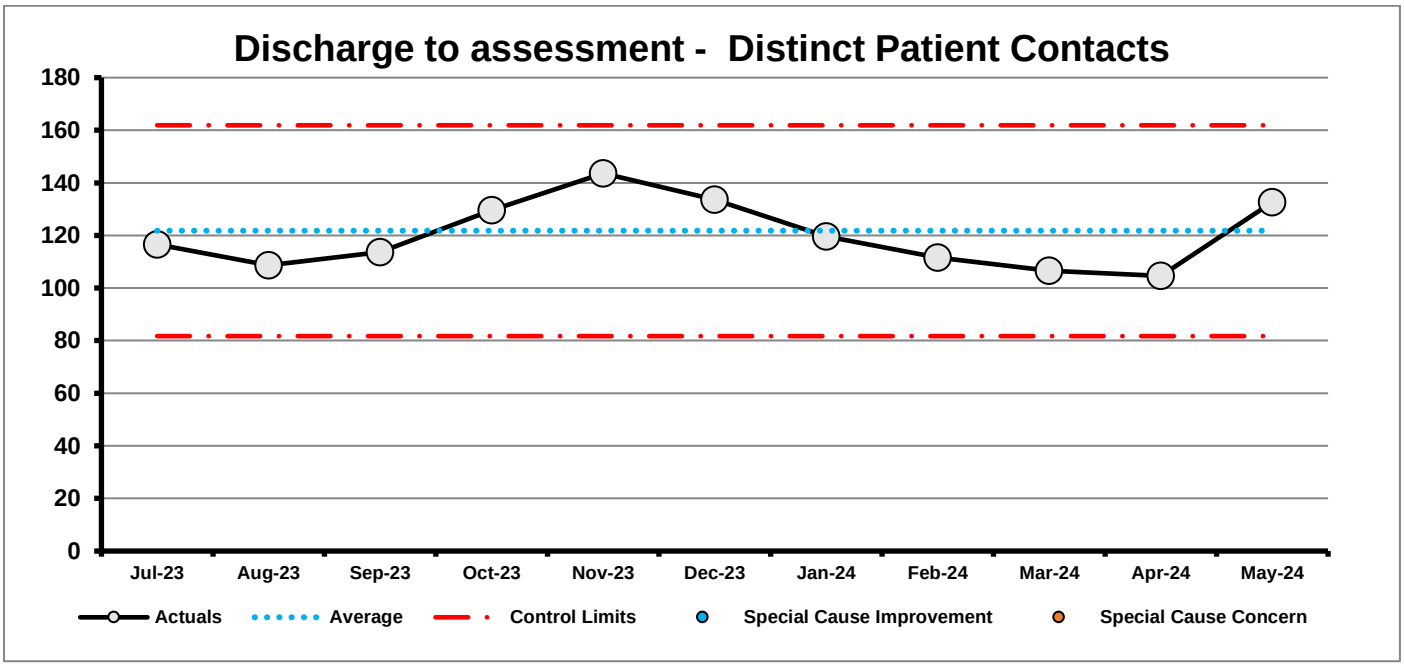
2-hour response compliance has not varied significantly over the period. The 2-hour response rate is inconsistently capable of achieving the 97% target but is expected to achieve the target more often than not.

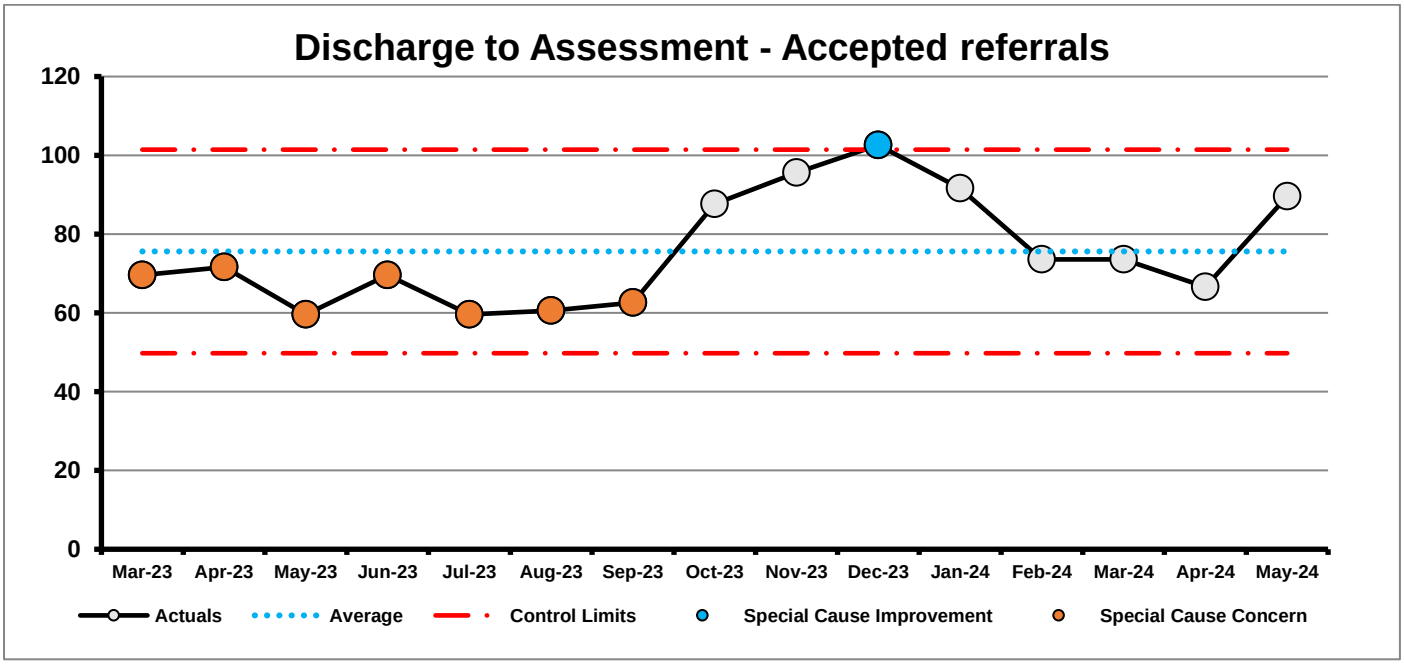
Discharge To Assessment

Background

The Discharge to Assessment programme has been introduced to expedite patients to leave acute care and return to their own home for reablement.

The service works closely with Adult Social Care and supports patients with a wide range of needs.





Narrative

The number of referrals accepted has increased from April and is above the average for the service.

The number of distinct patient contacts has also increased and currently above average, this has been reflected in the caseload numbers with hitting target caseload of 70 on a consistent basis for the month.

Actions

Continue work alongside the transfer of care (TOC) hubs is ongoing – from this work we have seen an increase in referrals and reduced number of failed starts due to increased communication and enhanced triaging.

Work continues with Urgent Community Response to support admission avoidance where capacity allows.

Recruitment to Therapist posts now coming into effect with x1 band 6 starting in the month of May and undertaking local inductions, further x2 Therapists to join service over the months of June and July. Further focus on recruitment to further round the skillsets of the service with plans to re-advertise Nursing posts.

SPC

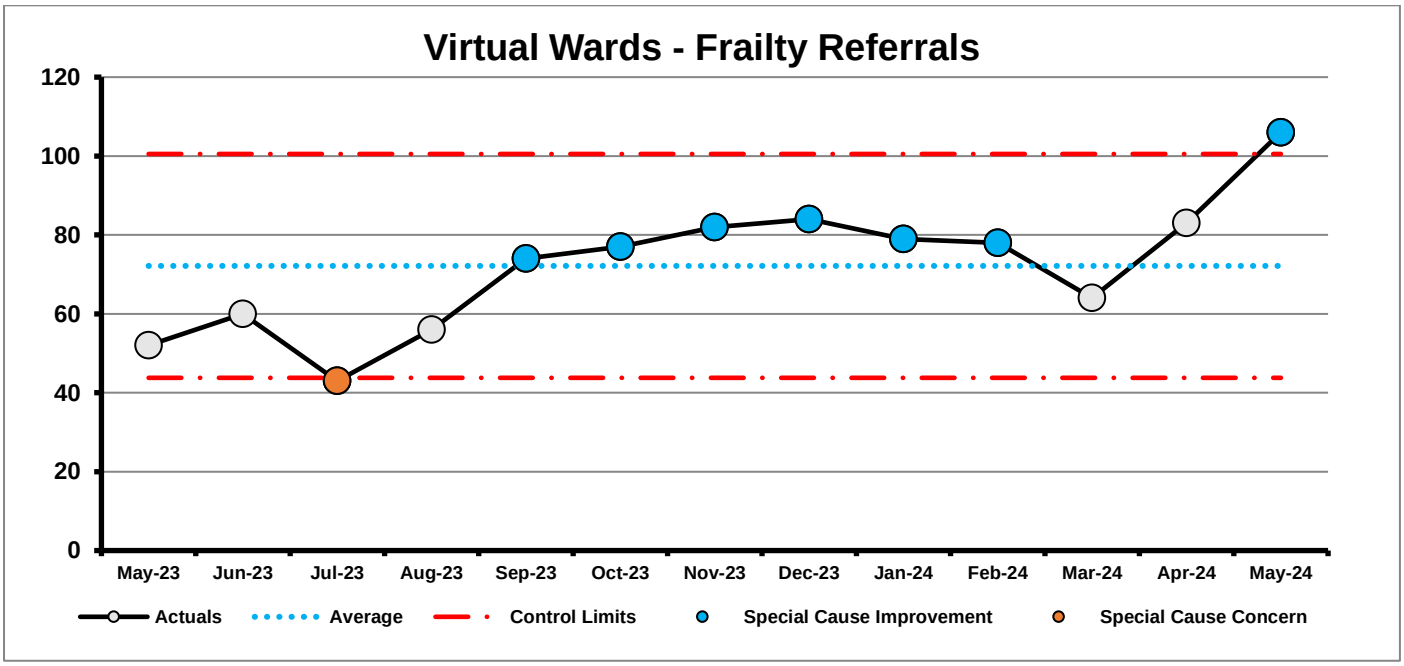
The number of distinct patient contacts has not varied significantly over the period.

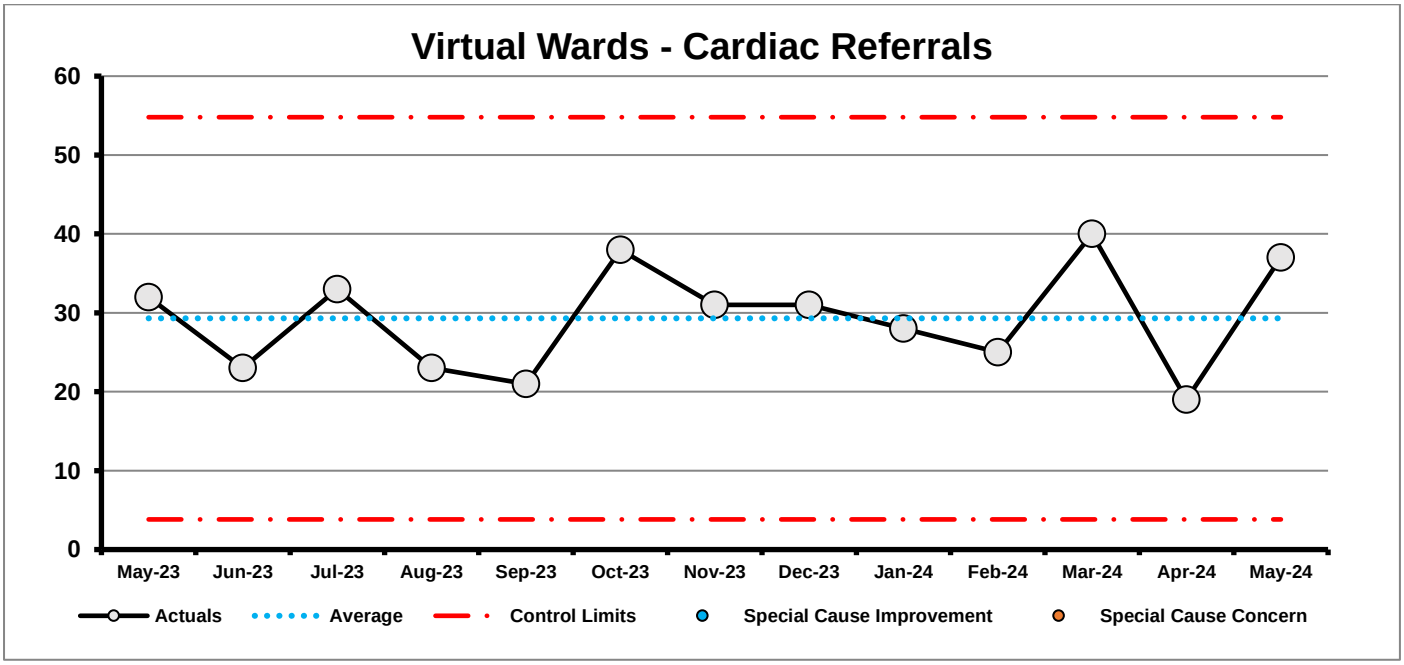
The number of D2A accepted referrals has not varied significantly since January 2024.

Virtual Wards

Background

The Trust's current virtual ward offering includes frailty, cardiology and respiratory. The service closely collaborates with ULHT, and patients are cared for in the community, with guidance from ULHT consultants.





Narrative

Reporting continues to encompass frailty, respiratory and cardiology virtual wards. OPAT & SDEC data is being progressed with ULHT. FBI are supporting the virtual ward team, cross referencing the different reporting that currently takes place (e.g., NHSE, SHREWD and internal reports) to make sure that the data is consistent and that all virtual wards are included in all our reporting.

SPC

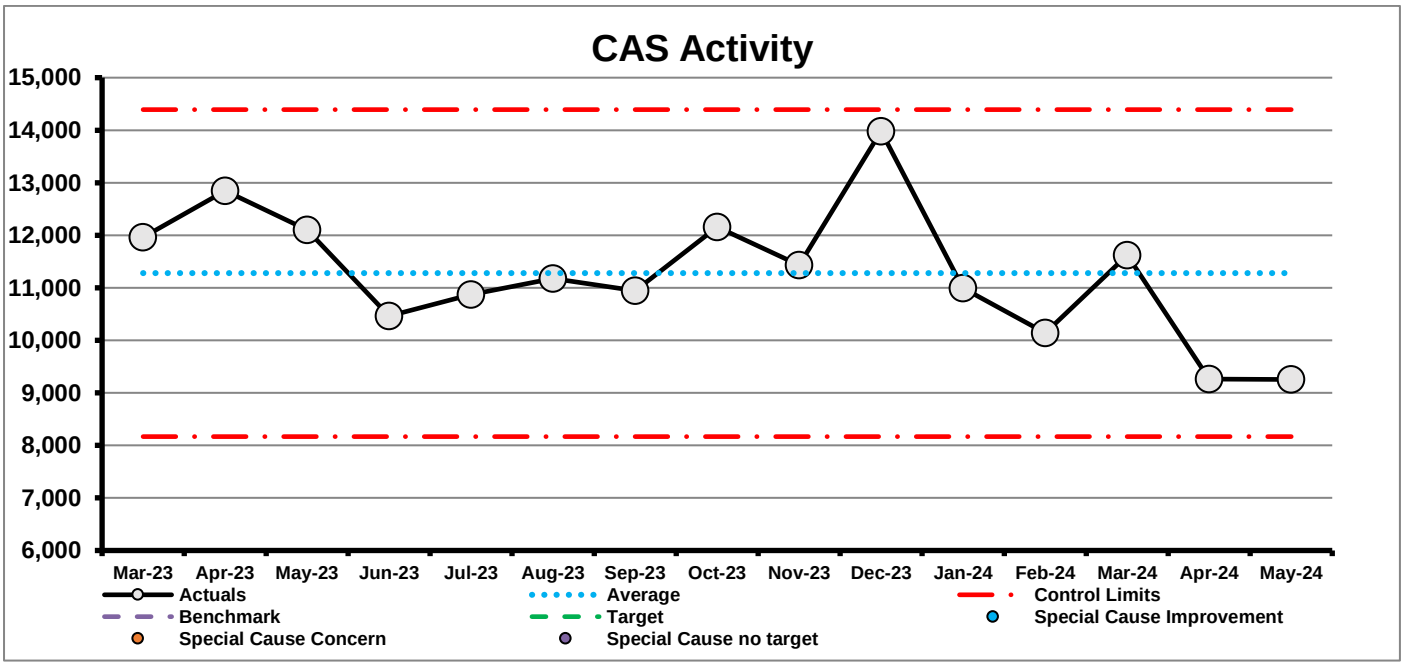
The number of referrals to the frailty virtual ward has shown special cause improvement in May 2024.

The number of referrals to the cardiology virtual ward has not varied significantly over the period.

CAS Activity

Background

The CAS was initially commissioned as a proof of concept and commissioners asked providers to collaborate to develop an Alliance Agreement. The service has since demonstrated significant positive system impacts in supporting and reducing A&E attendances. This is now an integral part of the LCHS and Lincolnshire System Integrated Urgent Care offer.



Narrative

April's figures were significantly decreased due to the 111 contract changes from the 9th of April and equates to a loss of approximately 100 calls per day. This trend has continued with number of referrals remaining similar for May. This activity is being closely monitored and other options are being considered to increase referrals into the service. A paper is being presented at TLT on 27th June on the wider impact of the new contract on both the system and also on patient experience and outcomes.

Action

Continue to monitor and manage resources to meet demand across the Urgent Care Service. The DHU contract change has meant that DHU are now completing ED validations and interim dispositions. The numbers being received are being actively monitored alongside general volume of referrals. The impact and risks are being monitored closely for patients, staff, and the system (such as increased referrals to EMAS and conveyances) A risk round UTCs across the county receiving having seen an increase in referrals in line with this call volume is merging and this is also being actively monitored. Appropriately trained members of the CAS team are looking into ways to support the UTCs with this increase in volume. There are also options being actively pursed in agreement with the ICB to increase call volume.

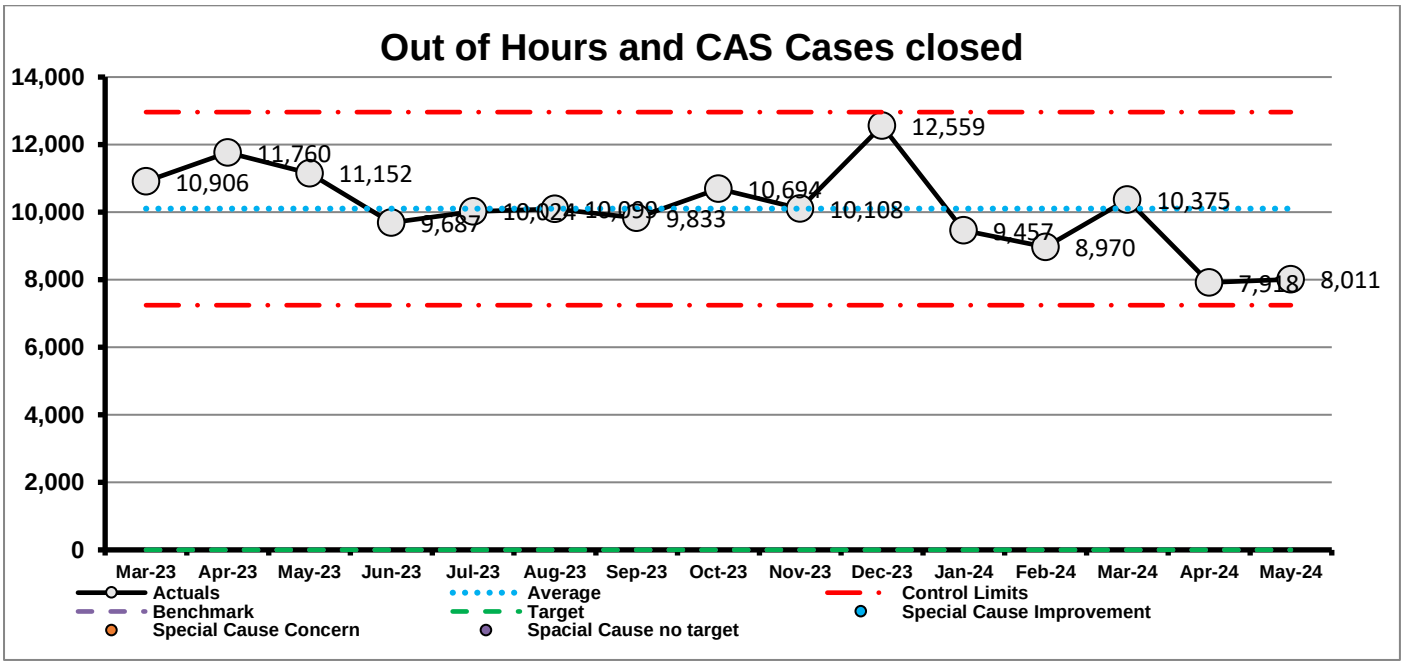
SPC

CAS activity has not varied significantly over the period.

OOH and CAS Cases Closed

Background

LCHS on average has around double the attendances of ULHT's type 1 attendances. This includes Out of Hours services and CAS.



Narrative

This metric shows the combined number of cases closed within the Stamford Out of Hours and CAS services and is directly correlated to the level of activity seen within those services. (Additional narrative is featured within the CAS activity). April saw a significant decrease likely due to the change in the DHU contract and the reduction in call volume to CAS and therefore a decrease in booking appointments. This has only increased slightly in May so will require monitoring closely.

Action

Ongoing discussions were being held as to the value of this data being included within FFPIC reporting due to Grantham OOH no longer being included. However, due to the drop of referrals it seems prudent to continue monitoring this data.

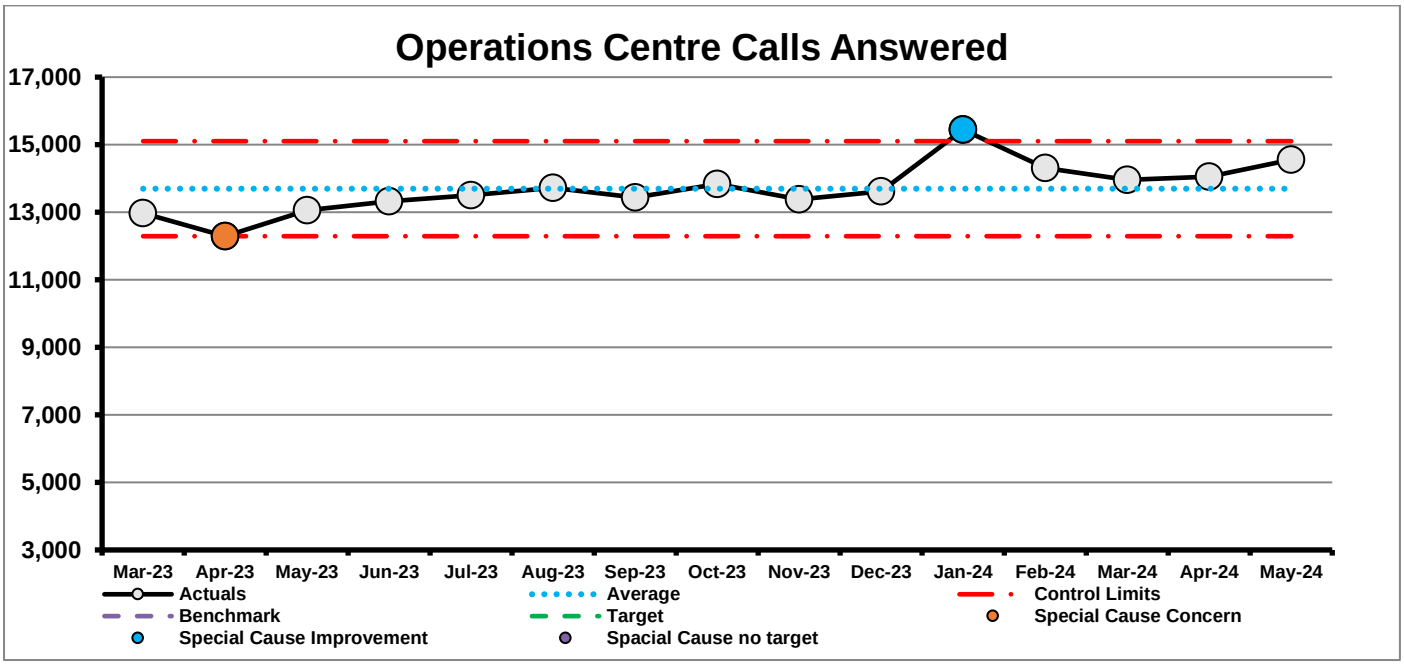
SPC

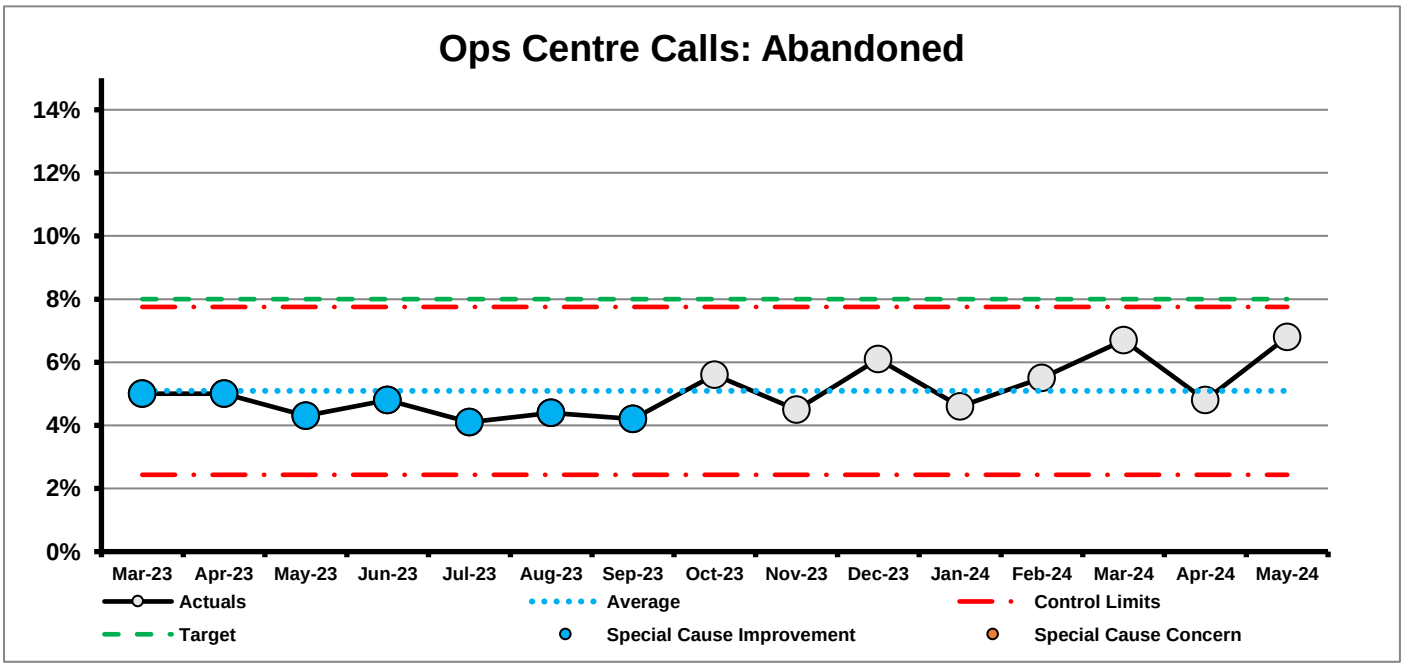
OOH & CAS Cases Closed has not varied significantly over the period.

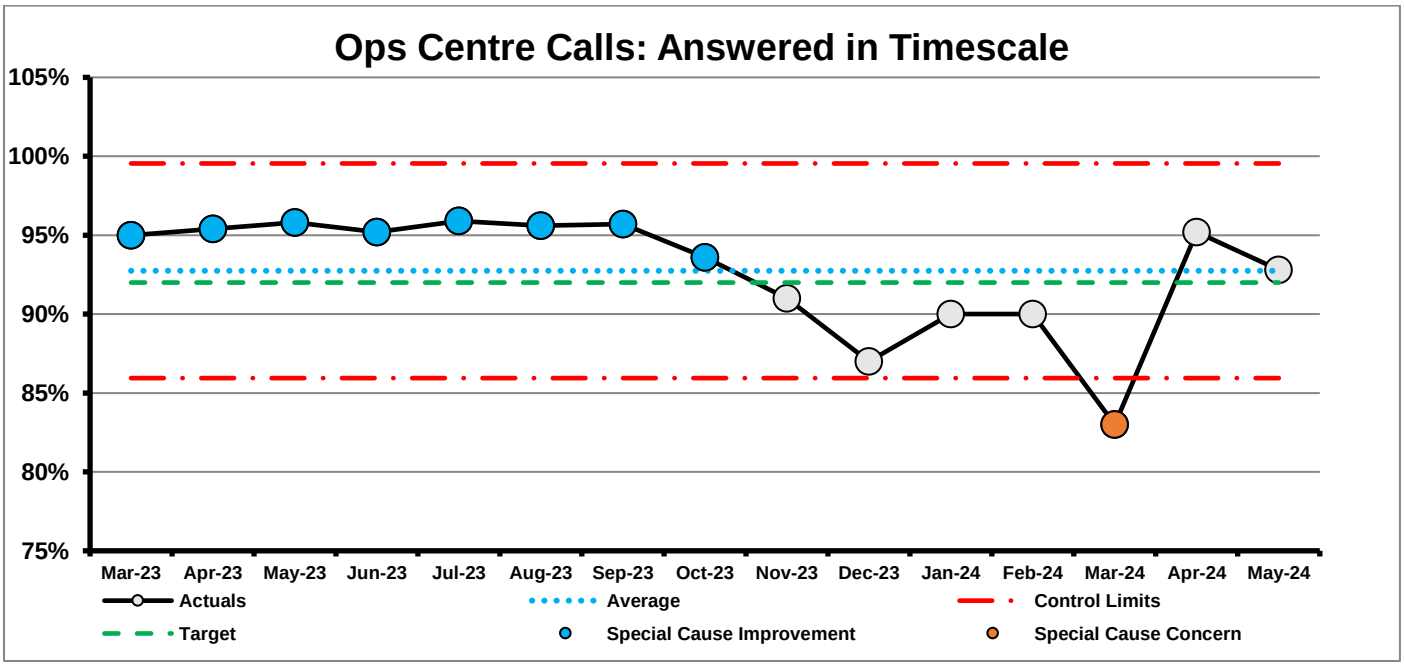
Operation Centre Calls Metrics

Background

The Operations Centre was opened in December 2016 and provides a 24/7 multi-disciplinary team for LCHS. It was developed on the principle of a 'one call does it all' model and is a critical service that holds the Trust's services together e.g., community nursing, community hospitals, urgent care, transitional care, and our Clinical Assessment Service.







Narrative

The impact of lower resource continued in May, though reduced staffing unavailability and favourable call profile mitigated the impact somewhat. However we saw a further 3 resignations received in May and are unfortunately still unable to recruit to as cost pressure remains, consequently performance is at risk of continued deterioration. Until the matter of resolving the cost pressure is resolved I fear this will continue to be the narrative.

A plus point to highlight is that the abandon rate remains low. We continue to see increase in demand and I note that the call centre calls have reached a new high record this month.

SPC

The number of calls answered within the ops centre has not varied significantly since January 2024.

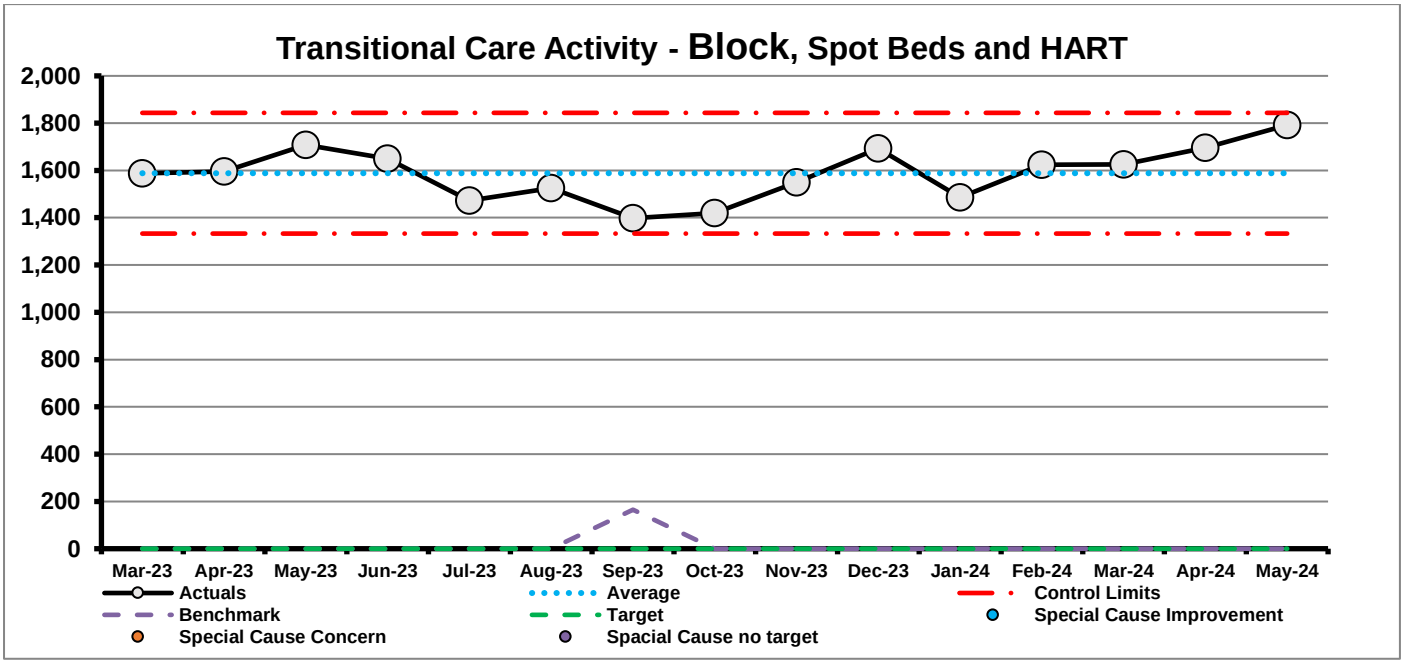
Ops Centre Calls Abandoned has not varied significantly since September 2023. It is consistently capable of achieving the 8% target.

Ops Centre Calls Answered within Timescale has not varied significantly since March 2024. It is inconsistently capable of achieving target but achieves target more often than not.

Transitional Care Activity

Background

LCHS has a now established and commissioned a Hospital Avoidance Response Team (HART) service, via Age UK to focus on admission avoidance and reduction of Delayed Transfers of Care (DToC). The HART service has demonstrated some excellent quality outcomes, as well as consistently achieving their targets around the number of cases managed each month. HART continue to achieve their monthly key performance indicators and work as a key system partner.



Narrative

Use of transitional care resource continues to rise during May. The service has supported a significant amount of step-downs from the community hospital beds in an attempt to alleviate system pressures and free up beds for the acute. The demand for spot purchase beds continues (dependent on system pressure) and this is being monitored closely to ensure the service continues to flex as required but remain within budget.

Actions

Our Commissioned service HART's productivity is being regularly scrutinised to ensure the service is being utilised effectively, with regular review alongside HART, business intelligence, and the ICB.

Our two new pathways (Fractured neck of femur (NOF) and clinician to clinician) continue to be regularly reviewed. We have started to adapt these pathways to increase the productivity with the over-arching aim of increasing timely, clinically appropriate referrals via the transitional care & flow team, and into community hospitals.

SPC

Transitional care activity has not varied significantly over the period.

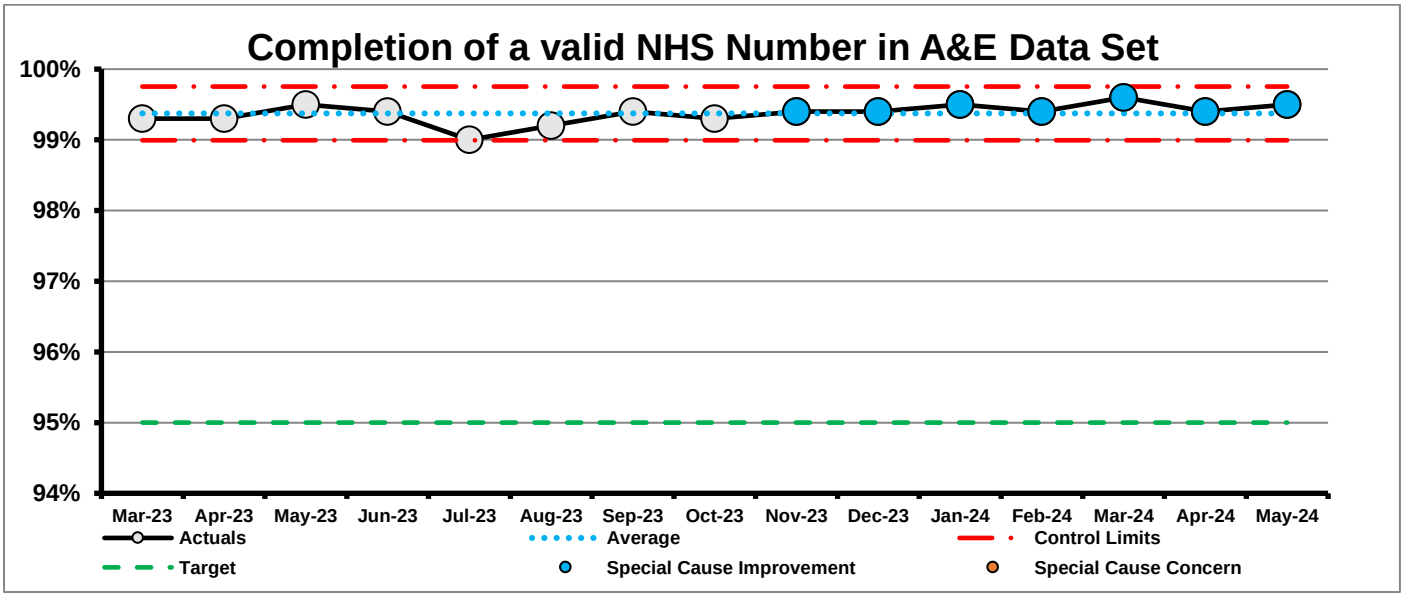
Completion of a Valid NHS Number in A&E Data Set

Background

The Data Quality Dashboards are a national resource to support the improvement and completeness of data flows by reporting on the validity of key data items in Secondary Uses Service (SUS) in accordance with published data standards. The information is provided by The Health and Social Care Information Centre and the areas applicable to LCHS are:

- Accident and emergency

The dashboards are reviewed against the national attainment and any data items that fall below the national attainment rate are highlighted for consideration and action planning.



Narrative

The latest available data demonstrates the completion of a valid NHS number for A&E Data Sets. The Trust maintains a high level of compliance – above 98% since April 2021. This is higher than the national average. Remarkably, July's figure would normally show concern, but this must be seen in context against the outstanding figures across the rest of the year.

Actions

The completions of NHS numbers within the A&E datasets continue to be raised with services, to ensure issues around data quality are addressed. The data system used is linked to the NHS Spine. Patients with no NHS number are not registered with a GP.

SPC

Completion of a valid NHS number for A&E datasets shows special cause improvement since November 2023.

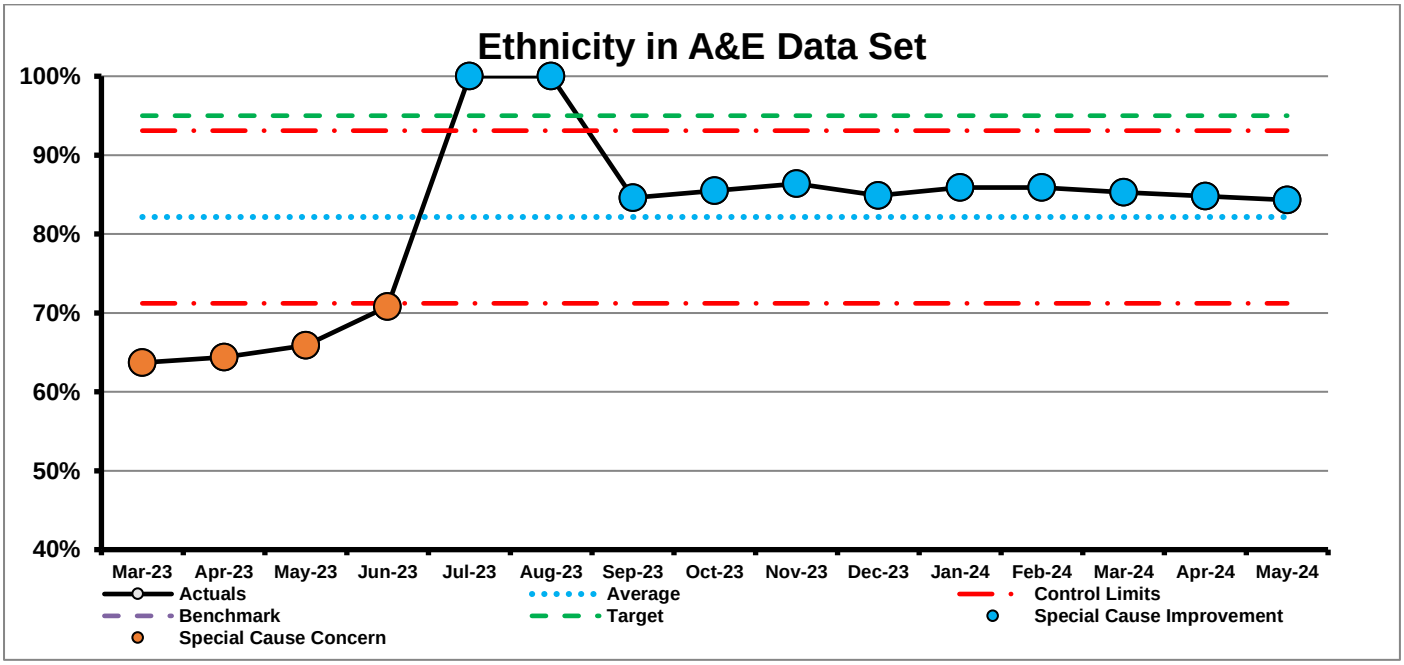
SPC also shows Completion of valid NHS Number for A&E Data Sets to be consistently capable of achieving the 95% target.

Completion of Ethnicity in A&E data set

Background

The Data Quality Dashboards are a national resource to support the improvement and completeness of data flows by reporting on the validity of key data items in Secondary Uses Service (SUS) in accordance with published data standards. The information is provided by The Health and Social Care Information Centre and the areas applicable to LCHS are:

- Accident and emergency



Narrative

Ethnicity in A&E data shows significant improvement since June 2023. As reported previously changes to this process were being made to stop using local codes for ethnicity not stated and remove old codes.

Issues have been identified where SystmOne doesn't export patient's ethnicity if the data is not something added by the user onto the system. This has caused problems with us being unable to pull our ethnicity activity from within the extract. The months during July and august where we reported 100%, were due to a miscommunication between ourselves and NHS England during the validation period, where we were advised to reset blank ethnic codes. Since discovering these inaccuracies, we have resubmitted our activity and it is now reflected on a new download from SUS.

The increase from 67% to 85% is through a process developed to download an extra patient dataset from Systm1 which reports on Ethnicity for all patients. Following this validation process, 85% is a more reflective position on actual completion. Further work is still required with our UTC colleagues to continue to work towards improving the collating of our ethnicity data at the point of source.

We have initiated a new Data Quality system "RINSE" introduced to support managers to monitor and manage who hasn't completed ethnicity population. The FBI team continue to with digital health to ensure that any SOPs or training emphasis' the importance of completing the data.

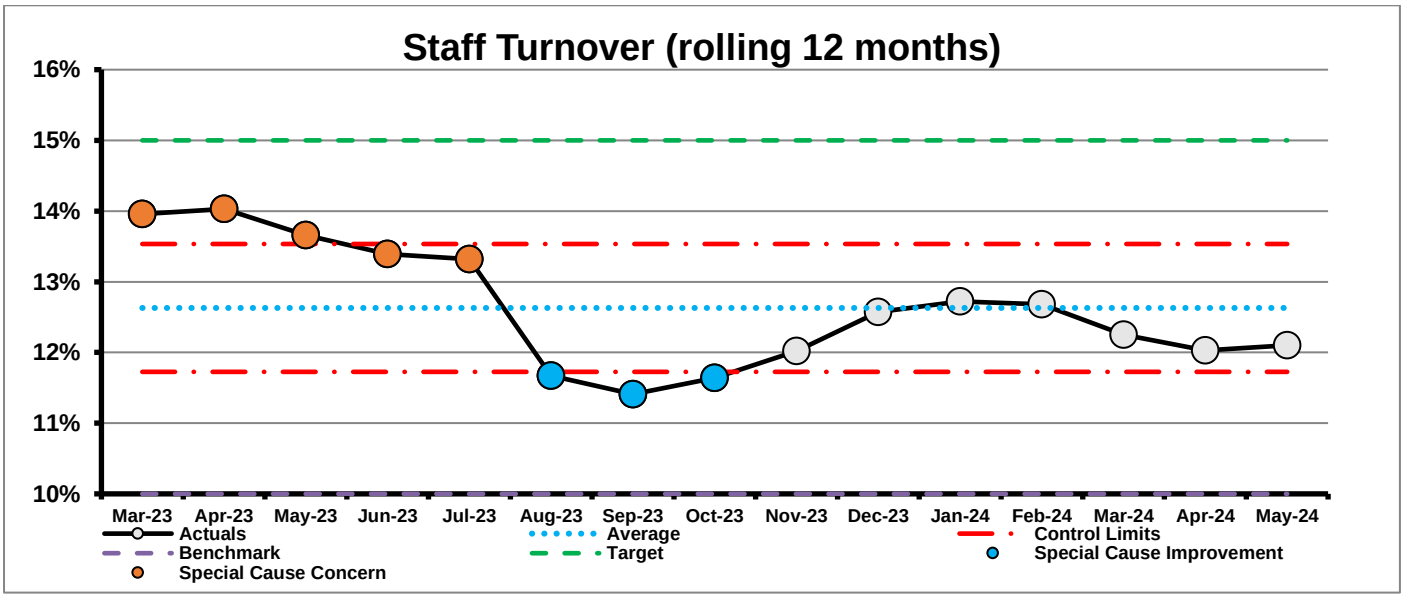
SPC

Ethnicity in A&E dataset has shown special cause improvement since July 2023. This metric is not capable of achieving the 95% target without redesign.

Staff Turnover (Rolling 12 months)

Background

The Quality Schedule requires data on staff turnover to be shared with commissioners as well as being an important barometer of service stability, sustainability, and staff satisfaction.



Narrative

The graph above shows the total staff turnover, with rolling 12-monthly turnover lower than the average at 12.10% for the period. The “target” level of 15% represents a ceiling to stay within. A healthy level of staff turnover is positive for refreshing the workforce and securing new or additional talent into the organisation, however rising turnover would be indicative of potential staff dissatisfaction and impacts on service delivery.

Actions

Staff turnover is managed by leaders at local levels with supportive frameworks to enable staff to maintain health and wellbeing, freedom to speak up and engage with changes to their service delivery.

SPC

Staff turnover has not varied significantly since October 2023..

Staff turnover is consistently capable of achieving the 15% target.

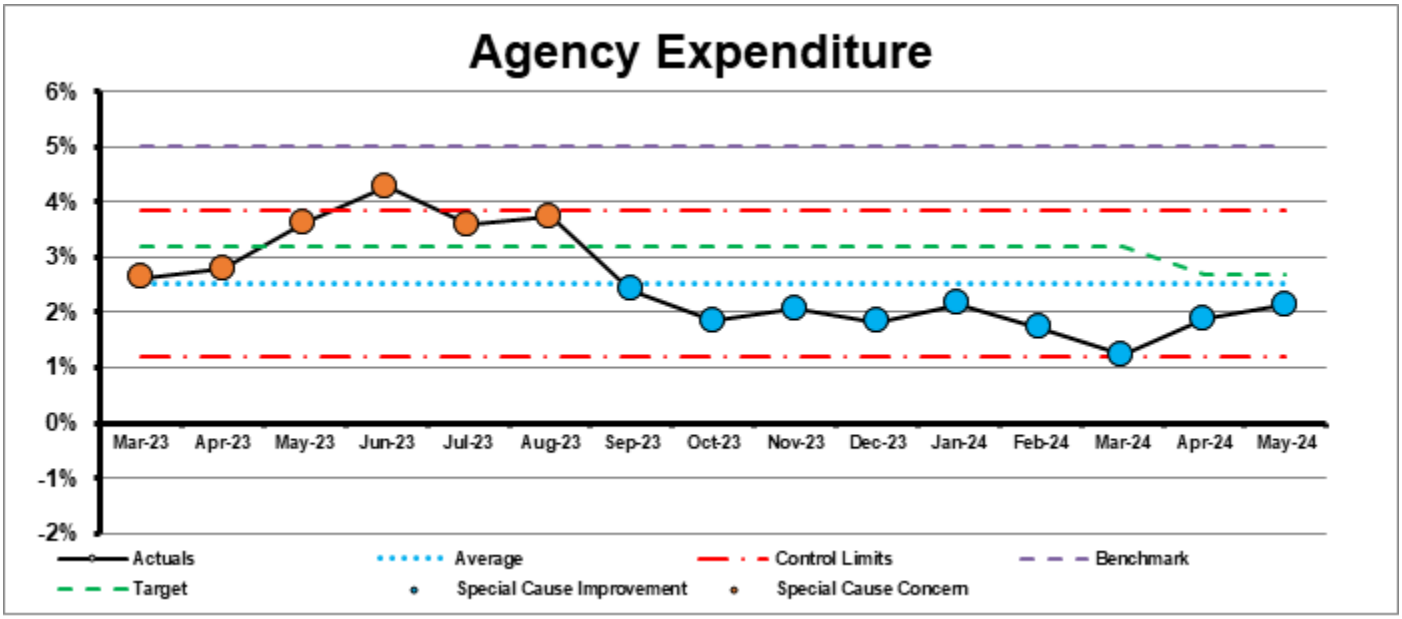
Financial Performance Summary

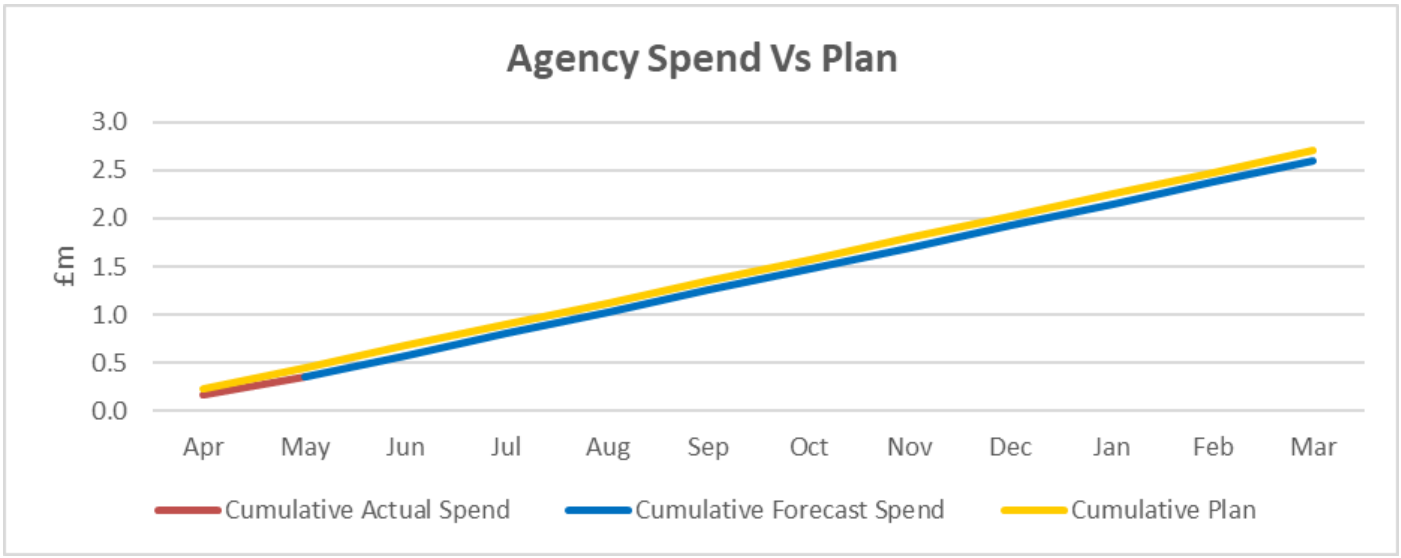
Financial Summary Table (Month 2)	
Description	**Narrative**
Position in May	£314k surplus
Position YTD	£552k deficit
Position FOT	Breakeven
CIP in May	£280k against plan of £280k
CIP YTD	£560k against plan of £560k
CIP FOT	£7m against plan of £7m
Agency in May	£184k against plan of £225k
Agency YTD	£351k against plan of £450k
Agency FOT	£2.6m against plan of £2.7m
Capital in May	£247k against plan of £0k
Capital YTD	£265k against plan of £0k
Capital FOT	£2M against plan of £2M
Cash	£28M against plan of £30M

Agency Expenditure

Background

Historically the Trust has set itself a target of ensuring temporary staffing costs do not exceed 4% of total pay. However, there is no requirement to do so. The Trust will not be given an agency ceiling for the year 2023/24, there is now a Lincolnshire System Ceiling. The Trust planned for a 3.19% agency level in 2023/24.





Narrative

The agency plan has been phased evenly over 12 months. Agency expenditure is £99k under plan in Month 2.

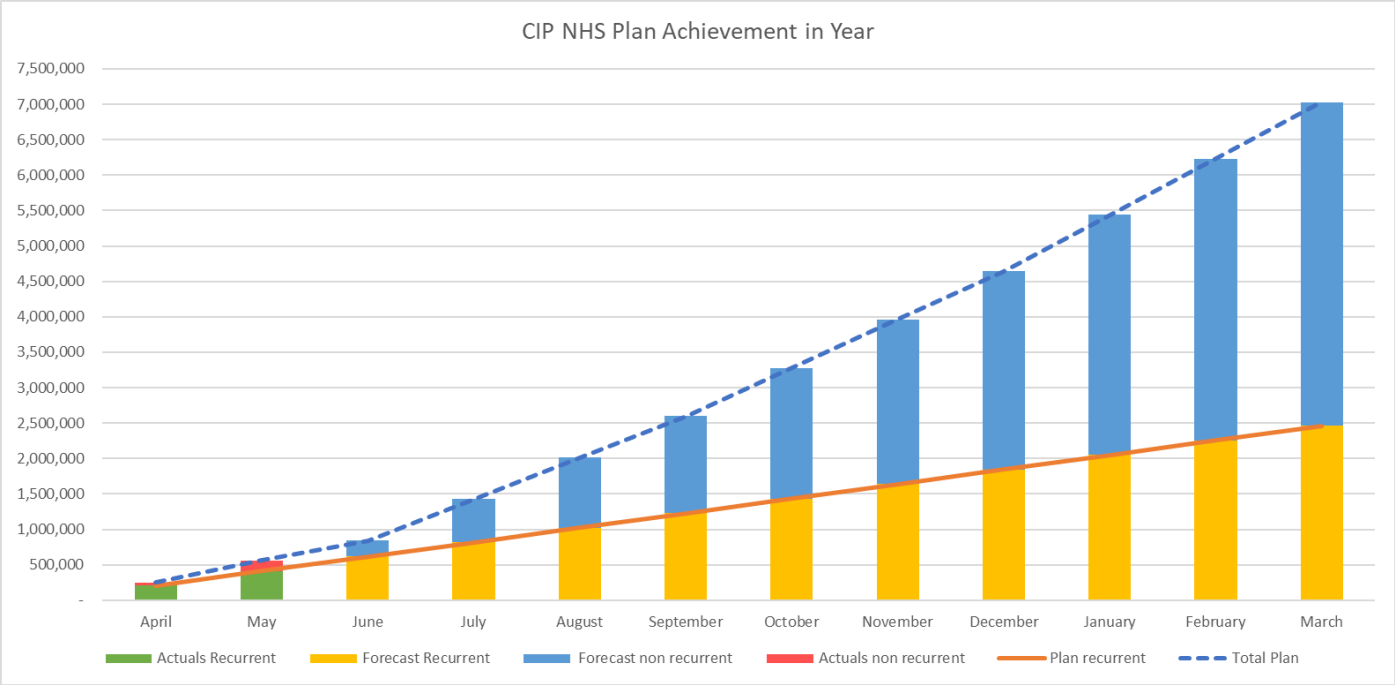
SPC

Agency expenditure shows special cause improvement since September 2023. It is inconsistently capable of achieving the 2.7% target but achieves target more often than not.

Efficiencies Plan (CIP)

Background

This information represents year-to-date delivery against the planned Cost Improvement Plan (CIP).



Narrative

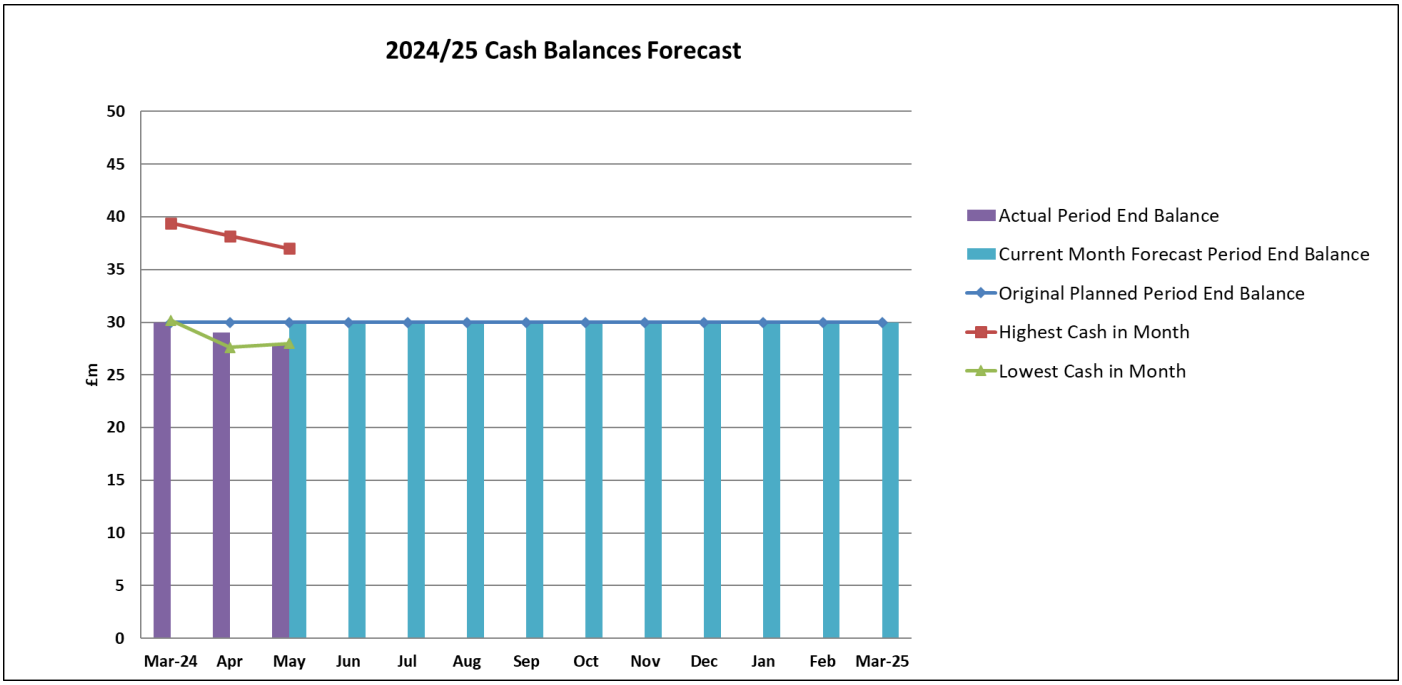
The recurrent CIP requirement is £7m. At the time this report was written, £2.459m of CIP schemes have been identified with further work being undertaken to identify further schemes. Delivery is phased to increase as schemes are identified throughout the year.

Cash Balances

Background

This metric tracks the Trust performance of cash balances against planned levels of cash at each month end. Management of cash is important to ensure the Trust can adequately meet its liabilities to stakeholders. As part of the interim financial arrangements in place for Covid-19, a formal plan for cash was not mandated or collected but providers manage cash positions to remain stable.

Cash Balances for 2023/24 are as below:



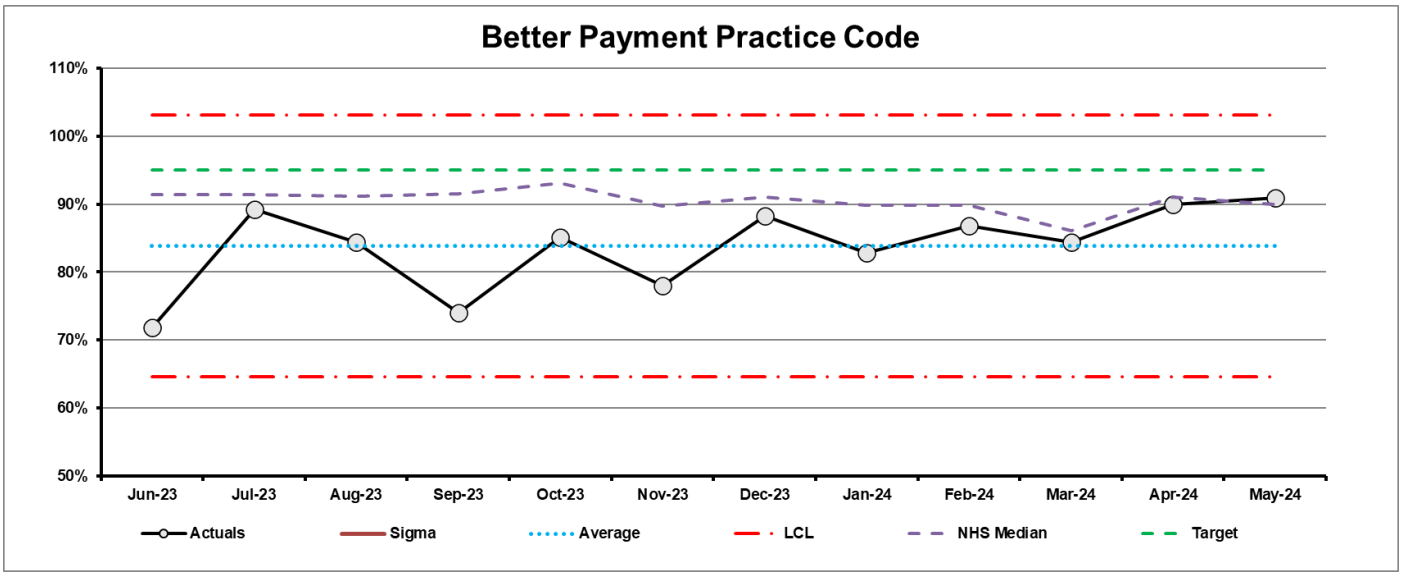
Narrative

The Trust cash balance at the end of May stood at £28m, a small decrease from April due to Lincolnshire ICB paying the Trust old year values pending final signing of contract.

Better Payment Practice Code

Background

This metric represents the performance of our invoices paid within the agreed terms. The target Better Payment Practice Code (BPPC) is 95%.



Narrative

No. of invoices - 91% for may against a target of 95%, a small improvement from prior month.

LCHS is now performing ahead of the NHS Median BPPC performance.

This graph now shows the actual monthly performance and shows a gradual upward trend in our performance although more work still needs to be done to ensure improvements in the process and performance in 2024/25.

SPC

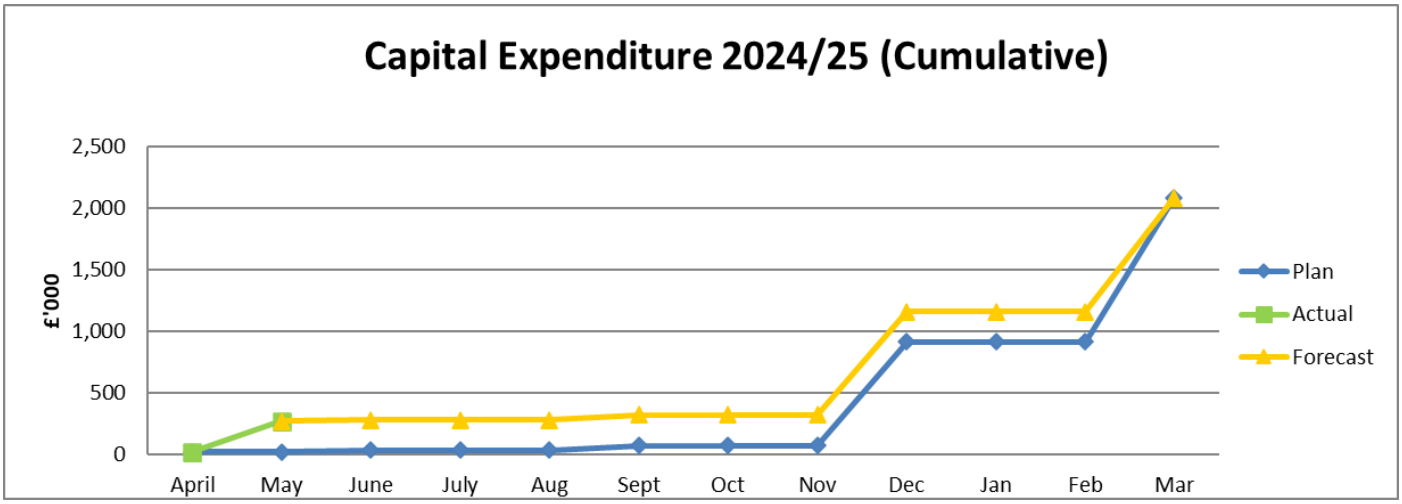
Monthly Better Payment Practice Performance by volume has not varied significantly over the period.

This metric is not capable of achieving the 95% target without redesign. An improvement plan has now been fully implemented.

Cumulative Capital Expenditure Plan vs Actual (£000)

Background

This metric tracks year-to-date expenditure of the Trust Capital Programme against plan. Capital Expenditure includes investment in maintaining, replacing, and transforming the Trust asset base. The Trust has a capital plan of £4m for 2023/24.



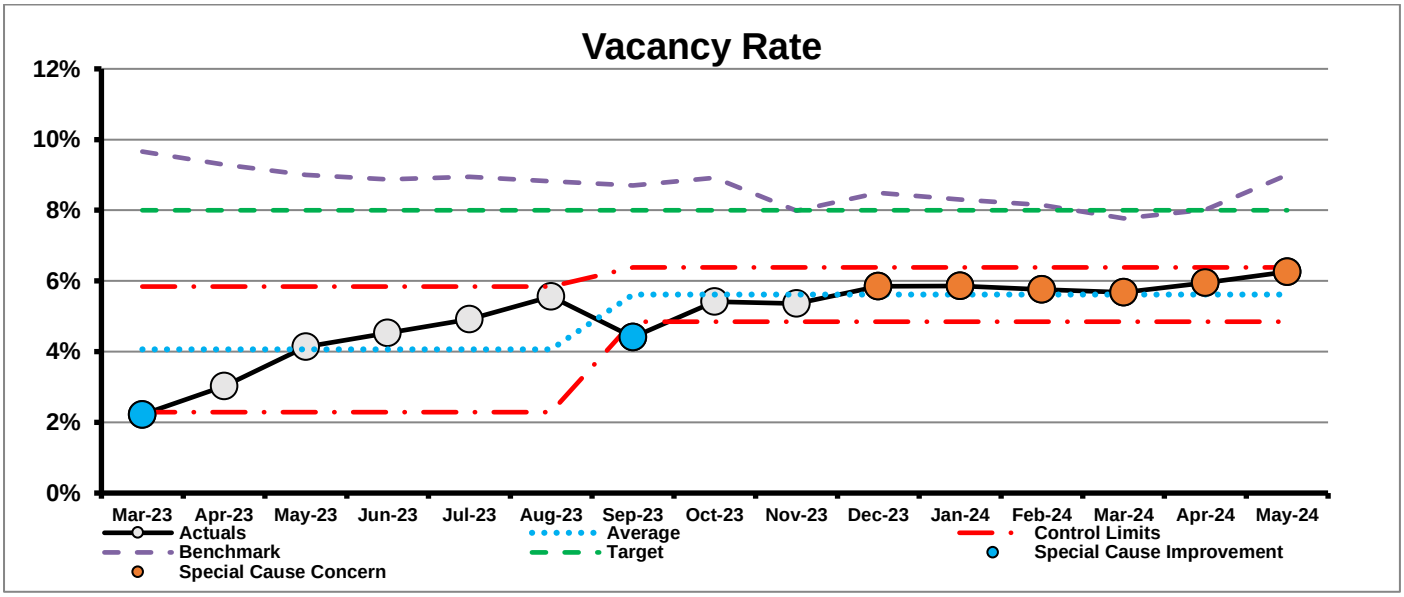
Narrative

Capital expenditure in Month 2 is £247k against a nil plan, bringing YTD expenditure to £265k. Capital schemes are currently being assessed, prioritised and scheduled.

Vacancy Rate

Background

The Vacancy Rate target for LCHS is 8%.



Narrative

Following the TUPE transfer of the Mass Vaccination Centre staff into LCHS from the ICB, this affected the Trust vacancy rate bringing this artificially lower whilst work was undertaken to align the budgets and establishment. This work has now been completed and the budget/finance system and ESR have been fully balanced.

Actions

On target – the Trust has a low overall vacancy rate compared to both the 8% target and the national benchmark figure. The national benchmark figure is published by the NHS Benchmarking Network's community indicators project monthly.

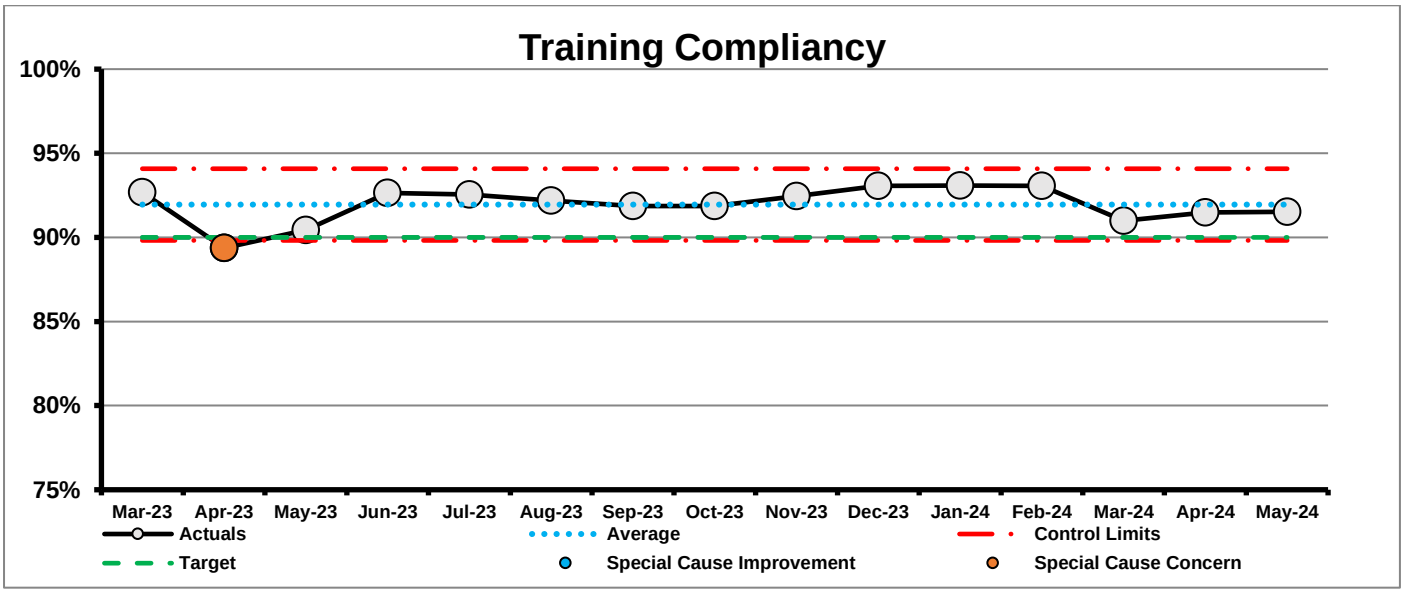
SPC

The vacancy rate has shown special cause concern since December 2023 and is consistently capable of achieving the 8% target.

Training Compliancy

Background

The national benchmark for Training Compliance is 90%. In November 2022, the Trust Board approved the recommendation to reduce the target to match this. This new target of 90% is reflected within the data below.



Overall mandatory compliance as of 31.05.2024:

The overall mandatory training compliance rate which includes all core **and** role specific modules is 91.51% which exceeds the local and national target of 90%.

Core mandatory training compliance (requirements for all staff): Overall compliance for the core mandatory modules is 92.95% which exceeds the national/local target of 90%

There has been an expected dip in compliance with the annual core modules which have all dropped below the 90% target.

LCHS overall compliance with annual modules:

Infection Prevention and Control - Level 2 - 1 Year	83.72%
Information Governance and Data Security - 1 Year	85.52%
Resuscitation - Level 1 - 1 Year	86.43%
Resuscitation - Level 2 - Adult Basic Life Support - 1 Year	86.25%
Resuscitation - Level 2 - Paediatric Basic Life Support	85.95%

This is due to the 2024 programme having launched on 1st April and naturally compliance for some staff will have expired prior to this year's refresher being completed.

All divisions/directorates except 'System' are amber with the annual requirements however have overall compliance remaining above the national/local target of 90%

Children's, Young People's, and Specialist Services	93.67%
Collaborative Community Care	90.47%
Corporate Services	93.49%
Integrated Urgent and Emergency Care	90.00%
Operational Business Services	94.37%
Operational Leadership	92.32%
System	94.61%

The mandatory programme for 2024 which includes all annual modules is live and available for staff to book on via ESR until 30th June 2024, after this time a bespoke eLearning package is available to access at any time to enable any non-compliant staff to update.

Divisional Leads/HOS have been informed of the current position for action and escalation.

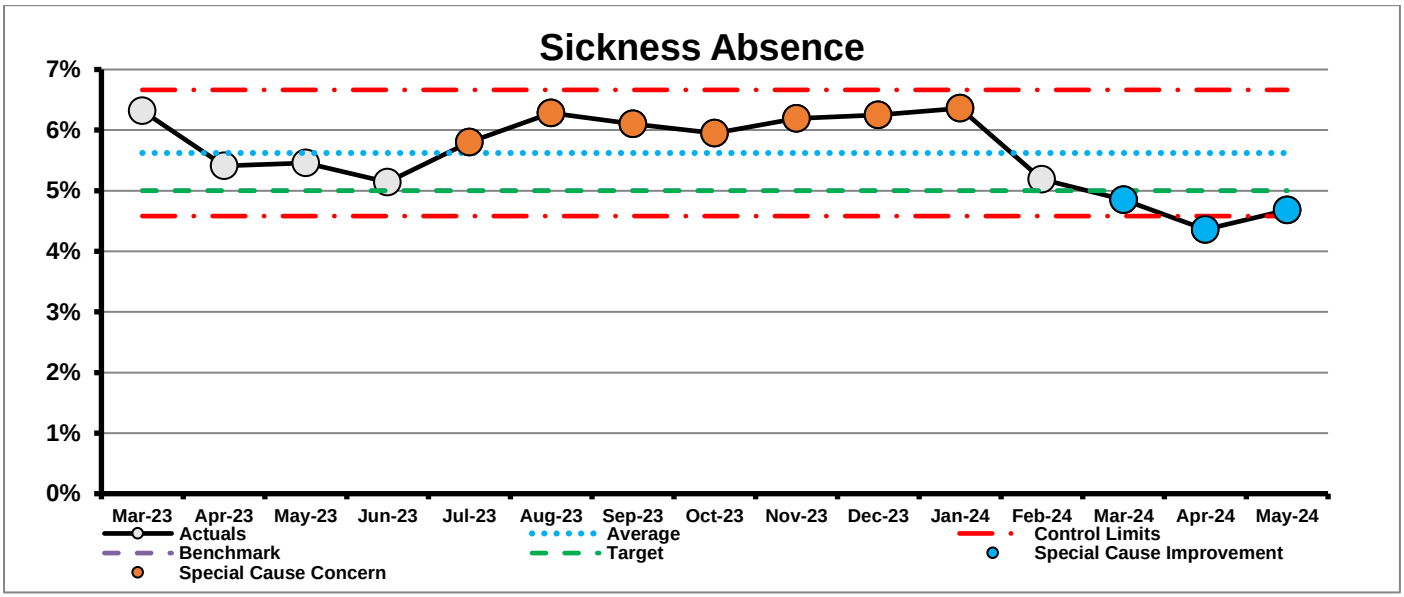
SPC

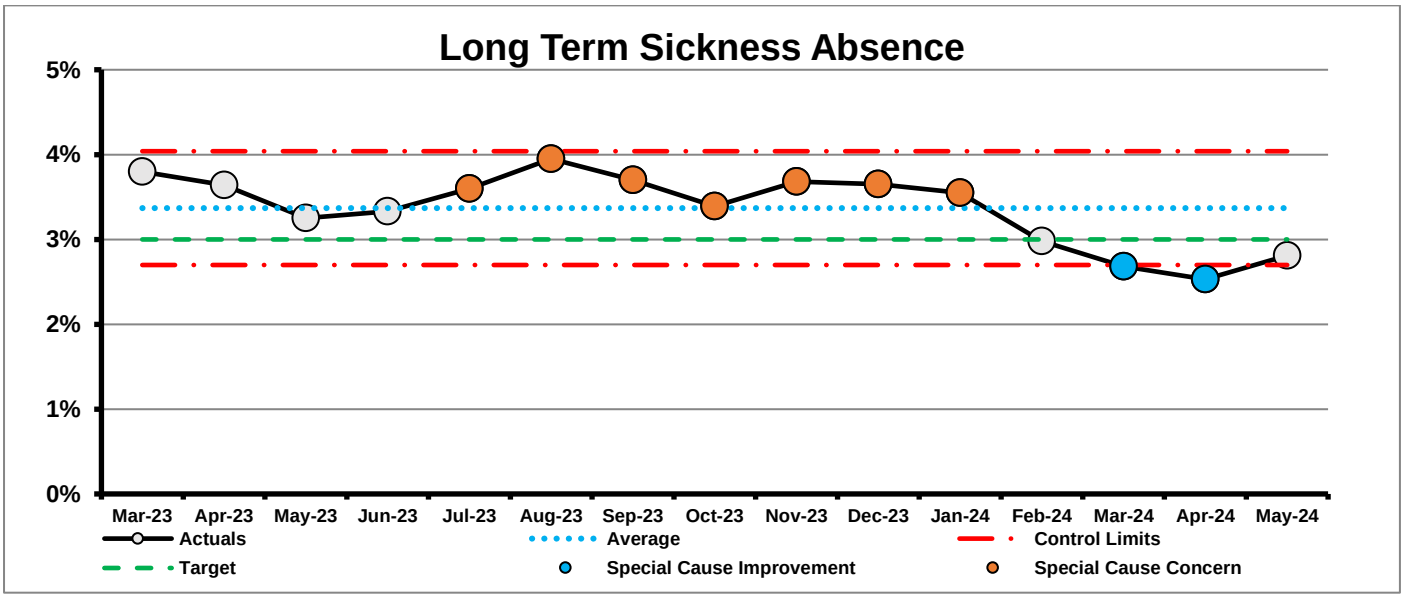
Mandatory Training compliance has not varied significantly since April 2023. The measure is consistently capable of achieving the 90% target.

Sickness Absence

Background

The Trust target for total sickness absence is 5%.





Narrative

The overall sickness level in May have remained relatively stable at 4.68%, from 4.36% in April. This remains below the agreed target of 5%.

For overall sickness absence, there are two areas above target as of May: System (8.40%) and Operations (6.94%).

The top three reasons accounting for overall sickness absence in May are: anxiety, stress and depression, gastrointestinal problems and other musculoskeletal problems.

Long Term

The long-term sickness level in May have remained below the agreed target of 3% at 3.81%.

In relation to long term absence, there is one area above target: Children's, Young People and Specialist Services (3.52%).

The top 3 reasons for long term sickness absence for May were: anxiety, stress and depression, other musculoskeletal problems and gastrointestinal problems.

Short Term

The short-term sickness level in May have remained consistent at 1.87% (1.83% in April), and are below the 2% target.

In respect of short-term sickness, there are 5 areas that are above target: System (5.53%), Operations (4.95%), Integrated Urgent and Emergency Care (2.15%), Collaborative Community Care (2.09%) and Operational Business Services (2.03%).

The top 3 reasons for short term sickness absence in May remain the same as in April at: anxiety, stress and depression, gastrointestinal problems and cold/cough/flu.

Actions

- The People Strategy Group continue to focus on sickness absence including the number of return-to-work meetings taking place to support staff as well as consideration of the timescales for the various stage sickness absence meetings and whether these happen. This includes where warnings are being issued/not issued and whether this is appropriate, to ensure that the absence policy is being followed in all areas. Divisional leads and HR Business Partners have worked together to hold a number of sickness absence summits with leaders with a focus on different levels of leader's responsibilities and what support is available.

- The HR team continue to offer leaders coaching, advice and guidance in the appropriate and timely management of absence in line with the Your Attendance Matters policy and the People Fundamentals Workshop training offer is in place with further bespoke training where needed. HR are encouraging managers to hold early wellbeing conversations with individuals to identify health and wellbeing support, adjustments, and flexible arrangements as appropriate, to support individuals to remain in work and/or return to work and to reduce the number of absence cases becoming long term.

- The HR team work proactively with managers to ensure there is timely support in place for those on long term sick and to facilitate successful return to works. The HR Advisors provide monthly reporting and work with Deputy Divisional Leads and CTLs to discuss the monthly KPI reports including but not limited to absence to highlight absences and trends and discuss actions.

- A comprehensive health and wellbeing offer remains in place, relating to support for mental health and wider wellbeing which is aligned to best practice.

SPC

Overall sickness rate shows special cause improvement since May 2024 and is inconsistently capable of achieving the 5% target. The target is expected to be missed more often than achieved.

Long-Term Sickness Absence has not varied significantly since May 2024 and is inconsistently capable of achieving the 3% target. The target is expected to be missed more often than achieved.

Workforce Dashboard

May 2024

Division	FTE Budgeted	FTE Actual	FTE Vacant	Vacancy Rate	Annual Turnover Rate	Monthly Turnover Rate	Total Absence Rate	Short Term Absence Rate	Long Term Absence Rate	Training Compliance Rate	Appraisals Rate	Supervision Rate
⊞ Children's, Young People's and Specialist Services	483.59	451.83	31.76	6.57%	10.00%	1.14%	4.74%	1.23%	3.52%	92.92%	41.19%	95.65%
⊞ Collaborative Community Care	792.73	785.48	7.25	0.91%	11.23%	0.20%	4.92%	2.09%	2.84%	90.47%	35.60%	85.49%
⊞ Corporate Services	229.33	235.75	-6.42	-2.80%	19.24%	1.70%	2.48%	0.86%	1.62%	93.49%	29.02%	95.45%
⊞ Integrated Urgent & Emergency Care	421.92	357.41	64.51	15.29%	5.22%		4.89%	2.15%	2.74%	89.74%	43.11%	92.46%
⊞ Operational Business Services	104.74	100.77	3.97	3.79%	24.39%	3.54%	4.77%	2.03%	2.74%	94.47%	44.04%	
⊞ Operations	40.90	34.79	6.11	14.95%	17.82%		6.94%	4.95%	1.99%	92.55%	9.76%	81.58%
⊞ System	19.00	34.77	-15.77	-83.02%	32.32%	2.88%	8.40%	5.53%	2.88%	94.61%	12.90%	93.75%
Total	**2,092.21**	**2,000.81**	**91.40**	**4.37%**	**11.97%**	**0.77%**	**4.68%**	**1.87%**	**2.81%**	**91.45%**	**37.19%**	**89.78%**

Corporate Services

Division	FTE Budgeted	FTE Actual	FTE Vacant	Vacancy Rate	Annual Turnover Rate	Monthly Turnover Rate	Total Absence Rate	Short Term Absence Rate	Long Term Absence Rate	Training Compliance Rate	Appraisals Rate	Supervision Rate
⊟ **Corporate Services**	229.33	235.75	-6.42	-2.80%	19.24%	1.70%	2.48%	0.86%	1.62%	93.49%	29.02%	95.45%
⊞ Chief Exec	21.35	14.60	6.75	31.62%	36.99%		3.00%	3.00%		94.79%	42.86%	
⊞ Finance & Business Intelligence	56.00	50.53	5.47	9.76%	17.60%	1.98%	0.40%	0.40%		94.48%	10.00%	
⊞ Medical Directorate	22.25	33.29	-11.04	-49.61%	32.32%		5.00%	0.84%	4.16%	87.33%	37.50%	87.50%
⊞ People & Innovation	86.77	96.93	-10.16	-11.71%	13.20%	2.06%	2.60%	1.11%	1.49%	94.76%	36.84%	100.00%
⊞ Quality	42.96	40.40	2.56	5.96%	18.56%	2.48%	2.57%	0.08%	2.49%	96.17%	24.39%	100.00%
Total	**229.33**	**235.75**	**-6.42**	**-2.80%**	**19.24%**	**1.70%**	**2.48%**	**0.86%**	**1.62%**	**93.49%**	**29.02%**	**95.45%**

Risk Reporting to the Group Board

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Hospitals NHS Trust

Meeting	*Lincolnshire Community and Hospitals Group Board meeting*
Date of Meeting	*2 July 2024*
Item Number	*14.1*

Executive Summary LCHS / ULHT Strategic Risk Reports

Accountable Director	*Professor Karen Dunderdale, Executive Director of Nursing / Deputy Chief Executive (LCHS and ULHT)*
Presented by	*Kathryn Helley, Director of Clinical Governance*
Author(s)	*Helen Shelton, Deputy Director of Clinical Governance*
Recommendations/	*The Group Board is invited to review the content of the report, no further escalations at this time.*

Joint Executive Summary

It is evident that currently both organisations have their own Risk Strategy or Policy and both have subtle differences in the approach to risk management, risk support, risk appetite and risk scoring compounded by two sets of strategic objectives. As a result it is difficult to align risk reporting, resulting in this looking and feeling different between the two organisations. Both ULHT and LCHS are now jointly working to review and align the Trusts risk profiles and risk management approach. The Group Board will be provided with a joint executive summary until full alignment with reporting has been achieved.

ULHT

As of June 2024, there were 565 risks recorded on the Trust risk register and aligned to the sub committees of the Trust Board; this is an increase of 19 risks from the previous report in May 2024.

There are 9 quality and safety risks rated Very high (20-25), a reduction of 2 from the previous report:

- Patient flow through Emergency Departments
- Recovery of planned care cancer pathways
- Reliance on paper medical records
- Reliance on manual prescribing processes;
- Delivery of paediatric epilepsy pathways-community
- Quality and safety risk from inability to deliver epilepsy pathways within Acute Paediatrics that meet National standards
- Medicines reconciliation compliance

- Consultant capacity for Haematology outpatient appointments
- Removal of lift in H Block PHB affecting service delivery to patient records.

Following presentation at the Risk Confirm and Challenge Meetings during this period, the following risks aligned with Quality Committee have been updated:

- Potential for serious patient harm due to a fall - **Risk presented in April, reduction in score from Very High (20) to Moderate (12)**
- Processing of echocardiograms - **Risk presented in April, reduction in score validated from Very High (20) to High (16)**

There are 4 People and Organisational Development risks rated Very High (20-25) which were reported to the People & Organisational Development Committee this month, remaining stable from the previous report:

- Staffing levels requiring an increase in Pharmacy to be able to provide a seven-day service.
- Pharmacy workload demands
- Service configuration (Haematology)
- Consultant workforce capacity (Haematology).

There are 6 Very high risks (20-25) reported to the Finance, Performance and Estates Committee this month, a increase of 1 from the previous report:

- Potential for a major fire
- Compliance with fire safety standards, assessed by Lincolnshire Fire and Rescue Service
- Exceeding the agency cap due to the cost of reliance upon temporary clinical staff
- Reliance on agency / locum medical staff in Urgent & Emergency Care
- SAR's Compliance and access to Health records in accordance with statuary requirements.
- Grantham Medical Air Plant Fault/Failure – **Risk presented at Risk Confirm and Challenge in April and validated as Very High Risk (20).**

Details of all current High and Very high risks are provided in ULHT **Appendix A**.

<u>LCHS</u>

As of the 31 May 2024, there were 93 risks recorded on the Trust risk register aligned to the sub-committees of the Trust Board.

There are 9 Quality and Safety risks rated Significant (15-25), reported to the Quality Committee in Common, remaining static in number since the last report noting that 3 significantly high risks have closed and 3 opened during this reporting period.:

- 495 – Treatment Room Capacity
- 403 – Children Young People Therapy treatment delays
- 409 – Lymphoedema service capacity
- 395 – TB Demand and Capacity
- 652 – Interruption to Enhanced Practitioners and FVW business as usual activity

- 672 – Timely Unplanned Palliative Response 24/7
- 695 – Lack of District Nurse Specialist Practice qualified staff in community nursing affecting the quality of care (**New risk presented at Risk Register Confirm and Challenge in May 2024**)
- 714 – Delivery of pressure ulcer care in the community (**New risk presented at Risk Register Confirm and Challenge in May 2024**)
- 715 – Community nursing lacks capacity and skill set to meet community demand (**New risk presented at Risk Register Confirm and Challenge in May 2024)**

The following risks have been updated:

- 655 – Patient Harm due to Quality of care Sleaford. **This risk has been replaced with revised risks – 695 and 715. Closed.**
- 489 – Community nursing staffing pressures. **This risk has been replaced with revised risks – 695 and 715. Closed.**
- 654 – Patient harm and compromised quality in the South Lincs ICT. **This risk has been replaced with revised risks – 695 and 715**. **Closed.**

There were 9 Finance, Performance, People & Innovation risks rated Significant High (15 – 25) an increase of 3 from the last reporting period:

- 442 – Efficiency Requirement 2024 / 2025 – **Increased risk from Moderate to Significant (20) awaiting validation at June Risk Register Confirm and Challenge.**
- 455 – Failure to deliver the financial plan – Income - **Increased risk from Moderate to Significant (20) awaiting validation at June Risk Register Confirm and Challenge.**
- 444 – Failure to deliver the financial plan – cost - **Increased risk from Moderate to Significant (20) awaiting validation at June Risk Register Confirm and Challenge.**
- 665 – Skegness Hospital Fire Safety Risk.
- 418 – Medical Gases Compliance - **Increased risk from High to Significant (20) awaiting validation at June Risk Register Confirm and Challenge.**
- 390 – John Coupland Hospital Theatres Ventilation
- 391 – John Coupland Hospital Water Safety
- 393 – Skegness Hospital Water Safety
- 649 – Fire Safety Core Risk

The following risks have been updated:

- Risk 658 - Connectivity to Live SystmOne Live Patient Records within Community Nursing – This risk has changed due to successful implementation of laptop trials. Risk closed and replaced by Risk 709 to reflect current patient safety risk with lack of funding to replace laptops across community nursing (score 12).
- Risk 418 - Medical Gases Compliance – increased risk score to 16 due to the need for robust arrangements & contract for ordering medical gas cylinders (previously 12).
- Risk 770 – Butterfly Hospice Fire Risk - All the work on the fire doors has been completed. Risk closed. This was a new significant risk in April however due to completion of works on the fire doors was subsequently closed in May.

There are 0 People and Organisational Development risks rated Significant (15-25) for this reporting period.

Details of all current Significant risks are provided in LCHS **Appendix A**.

Lincolnshire Community Health Services NHS Trust

Report to the Board of Directors

Date of meeting	2nd July 2024	Agenda item	14.1
Title	Risk Assurance Report		
Report of	Karen Dunderdale, Director of Nursing, AHP and Quality	Prepared by	Lorna Adlington, Head of Patient Safety and Quality Governance
Previously considered by / Date	Sub-Committees of the Trust Board.	Approved?	
Summary	This report was written based on data up to and including 31st May 2024 and provides a Trust overview of strategic risks. This Strategic Risk Report focuses on the highest priority risks to the Trust's strategic objectives (those with a current rating of Significant Risk, 15-20).		

1. To deliver high quality, safe and responsive patient services	**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	√
	1d. Deliver clinically led integrated services	√
2. To enable our people to lead, work differently, be inclusive, motivated and proud to work within LCHG	**2a. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise**	√
	2b. To be the employer of choice	√
3. To ensure services are sustainable, supported by technology and delivered from an improved estate	**3a. Deliver financially sustainable healthcare, making the best use of resources**	√
	3b. Drive better decision and impactful action through insight	√
	3c. A modern, clean and fit for purpose environment across the Group	√
	3d. Reduce waits for patients who require urgent and emergency care and diagnostics and ensure we meet all constitutional standards	√
	3e Reducing unwarranted variation in cancer service delivery and ensure we meet all constitutional standards (ULHT)	
	3f Reducing unwarranted variation in planned service delivery and ensure we meet all constitutional standards (ULHT)	

	3g Reducing unwarranted variation in community service delivery and ensure we meet all constitutional standards (LCHS)	√
4. To collaborate with our primary care, ICS and external partners to implement new models of care, transform services and grow our culture of research and innovation	**4a Establish collaborative models of care with all our partners including Primary Care Network Alliance (PCNA), GPs, health and social care and voluntary sector**	√
	4b Successful delivery of the Acute Services Review	√
	4c Grow our research and innovation through education, learning and training	√
	4d Enhanced data and digital capability	√
5. To embed a population health approach to improve physical and mental health outcomes, promote well-being, and reduce health inequalities across an entire population	**5a Develop a Population Health Management (PHM) and Health Inequalities (HI) approach for our Core20PLUS5 with our ICS**	√
	5b Co-create a personalised care approach to integrate services for our population that are accessible and responsive	√
	5c Tackle system priorities and service transformation in partnership with our population and communities	√
	5d Transform key clinical pathways across the group resulting in improved clinical outcomes	√

Impact of proposal/ report	*Please outline the potential impact/ expected outcome* (Quality/ Equality, Diversity/ Equality Delivery System 3/ Health Inequalities/ Financial/ People)				
CQC	**Safe** √	**Caring** √	**Effective** √	**Responsive** √	**Well-Led** √
Links to risks	Noted within the report				
Legal/ Regulation	CQC regulations, NHSI, Standing Orders, Health and Social Care Act.				

Recommendations/ Actions Required

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

Appendices

Appendix A – Strategic Risks (15 – 20) - 31 May 2024

Glossary

NHS – National Health Service
LCHS – Lincolnshire Community Health Services NHS Trust
LCHG – Lincolnshire Community and Hospitals NHS Group
TLT – Trust Leadership Team
BAF – Board Assurance Framework

Risk Assurance Report to the Trust Board

1. Executive Summary

The purpose of this report is to enable the Group Board to review the management of significant risks to strategic objectives and consider the overall extent of risk exposure within the Trust at this time, (those with a current rating of significant risk, 15-20). Of note detailed progress updates against each risk within this report can be found in Appendix A.

As of the 31st May 2024, there were 93 risks recorded on the Trust risk register aligned to the sub-committees of the Trust Board.

There are 9 quality and safety risks rated Significant (15-20) reported to the Quality Committee in Common. There have been 3 significantly high risks closed and 3 opened during this reporting period. These 9 risks relate to:

- 495 – Treatment Room Capacity
- 403 – Children Young People Therapy treatment delays
- 409 – Lymphoedema service capacity
- 395 – TB Demand and Capacity
- 652 – Interruption to Enhanced Practitioners and FVW business as usual activity
- 672 – Timely Unplanned Palliative Response 24/7
- 695 – Lack of District Nurse Specialist Practice qualified staff in community nursing affecting the quality of care (**New risk presented at Risk Register Confirm and Challenge in May 2024**)
- 714 – Delivery of pressure ulcer care in the community (**New risk presented at Risk Register Confirm and Challenge in May 2024**)
- 715 – Community nursing lacks capacity and skill set to meet community demand (**New risk presented at Risk Register Confirm and Challenge in May 2024)**

- The following risks have been updated:
    - 655 – Patient Harm due to Quality of care Sleaford. **This risk has been replaced with revised risks – 695 and 715. Closed.**
    - 489 – Community nursing staffing pressures. **This risk has been replaced with revised risks – 695 and 715. Closed.**
    - 654 – Patient harm and compromised quality in the South Lincs ICT. **This risk has been replaced with revised risks – 695 and 715**. **Closed.**

There were 9 risks rated significantly High (15 – 20) reported to the Finance, Performance, People & Innovation Committee which is an increase of 3 from the last reporting period. These 9 risks relate to:

- 442 – Efficiency Requirement 2024 / 2025 – **Increased risk from Moderate to Significant (20) awaiting validation at June Risk Register Confirm and Challenge.**

- 455 – Failure to deliver the financial plan – Income - **Increased risk from Moderate to Significant (20) awaiting validation at June Risk Register Confirm and Challenge.**
- 444 – Failure to deliver the financial plan – cost - **Increased risk from Moderate to Significant (20) awaiting validation at June Risk Register Confirm and Challenge.**
- 665 – Skegness Hospital Fire Safety Risk.
- 418 – Medical Gases Compliance - **Increased risk from High to Significant (20) awaiting validation at June Risk Register Confirm and Challenge.**
- 390 – John Coupland Hospital Theatres Ventilation
- 391 – John Coupland Hospital Water Safety
- 393 – Skegness Hospital Water Safety
- 649 – Fire Safety Core Risk

The following risks have been updated:

- Risk 658 - Connectivity to Live SystmOne Live Patient Records within Community Nursing – This risk has changed due to successful implementation of laptop trials. Risk **closed and replaced by Risk 709** to reflect current patient safety risk with lack of funding to replace laptops across community nursing (score 12).
- Risk 418 - Medical Gases Compliance – **increased risk score to 16** due to the need for robust arrangements & contract for ordering medical gas cylinders (previously 12).
- Risk 770 – Butterfly Hospice Fire Risk - All the work on the fire doors has been completed. Risk **closed.** This was a new significant risk in April however due to completion of works on the fire doors was subsequently closed in May.

There are 0 People and Organisational Development risks rated Significant (15-20) for this reporting period.

As of April 2024, a joint monthly Risk Register Confirm & Challenge meeting is now in place across the Group which will strengthen and align the current LCHS risk management processes alongside the development of a Group Risk Policy.

2. Purpose

The process to manage risks continues to be applied according to the organisation's Risk Management Strategy and Process. Risks are raised according to the strategy and are managed through risk leads across directorates. The Trust currently holds three risk registers:

- Corporate Risk Register notes all strategic risks with an overall rating of 12 or above;
- Operational Risk Register reflects all trust risks with an overall score of 4 to 11;
- Local risk register is held for all risks with an overall score or 1-3.

All risks are owned by Executive Directors, accountable for mitigating actions and progression against these. Risk Leads oversee all risks raised and review these monthly, as a minimum, and are presented to assurance groups for discussion and agreement prior to committee reporting.

3. Overview of LCHS Risks

a. Open risks:

There are currently 93 open risks on the Trust risk registers an increase of 2 since the last reporting period. Current ratings are noted below:

Risk Register	Overall current score												Grand Total
	2	3	4	5	6	8	9	10	12	15	16	20	
Corporate Risk Register (12-25)									16	7	8	3	34
Operational Risk Register (4-11)	1	5											6
Local Risk Register (0-3)			5	1	13	12	15	7					53
Grand Total	1	5	5	1	13	12	15	7	16	7	8	3	93

b. Heat map/ dispersion of risk across the risk assessment matrix

Heat map/ spread of risks across the risk matrix		Consequence					
		1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic	Total
Likelihood	1 Rare: This will probably never happen	0	1	2	1	1	5
	2 Unlikely: Do not expect it to happen again but it is possible	0	3	8	6	4	21
	3 Possible: May recur occasionally	3	5	15	2	6	31
	4 Likely: Will probably recur, but is not a persistent issue	1	6	14	8	1	30
	5 Almost Certain: Will undoubtedly recur, possibly frequently	0	3	1	2	0	6
	Total	4	18	40	19	12	93

c. Movement of risks reported across Trust:

Movement of risk	Overall risk score												Grand Total
	2	3	4	5	6	8	9	10	12	15	16	20	
Decrease in score			1		1	1	2						5
Increase in score					1		1		1	1	1	2	7
Closed			2		2		1	1	2	3	1	1	13
New					1		1	2	4		3		11
No change	1	5	4	1	10	11	11	5	11	6	4	1	70
Grand Total	1	5	7	1	15	12	16	8	18	10	9	4	106

A summary of the significantly high risks and any movement are outlined below aligned to the strategic objectives:

Strategic objective 1. To deliver high quality, safe and responsive patient services

There were 9 significantly high risks recorded in relation to this objective. A summary is provided below:

ID	Title	Risk Score	Division	Updates by reviewers	Date of review
495	Treatment room clinic capacity	20	Collaborative Community Care – Community Hospitals	The risk to the service remains unchanged. The demand on the service is high and there are not enough appointments at times to meet demand. The service continues to work above the agreed specification delivering support to patients across the system. Further review and deep dive information shared with ICB pending further review. The capacity of the clinics continues to impact on wider services such as IUEC as patients go there to be seen when appointments are unavailable.	May QSG
395	TB Demand and Capacity	16	Children's, Young People and Specialist Services	New secondment staff being recruited and trained which should improve the position over the next month. Conversation in relation to LTB for Occ Health continuing. No referrals now being accepted for LTBI from OH unless symptomatic – ICB is aware of this position.	May QSG
403	Children Young People Therapy treatment delays (SLT)	16	Children's, Young People and Specialist Services	Waits increasing due to vacancies and demand which is impacting on staff morale. Health and wellbeing support is in place. Review of model is expected at CYP Board in July.	May QSG
409	Lymphoedema service capacity	16	Children's, Young People and Specialist Services	Details of risk changed to reflect the risk of MSK injury to staff due to moving and handling of patients with large heavy limbs. Waiting list has reduced as a direct result of the work that has been completed with Honorary contract team members. Work is ongoing with the ICB in regards to supporting Primary Care with the application of the Chronic Oedema pathways.	May QSG

695	Collaborative Community Care	16	Lack of District Nurse Specialist Practice qualified (DNSPQ) staff in community nursing affecting the quality of care	**New Risk.** This is one of two new risks that replace 654, 655 and 489. Insufficient levels of qualified Specialist practice qualified district nurses to support staff within community nursing teams. This impacts on lack of oversight for complex case management, lack of professional support and guidance for team development and links directly to the safe management of caseloads. A service evaluation of DNSPQ role has commenced.	May QSG and Risk Register confirm and challenge meeting.
714	Collaborative Community Care	16	Patients are not always receiving the correct level of care for pressure ulcers within community nursing settings	**New Risk.** Variability in the delivery of care for pressure ulcers across community settings. Service action plan to improve pressure ulcer care implemented and an educational training plan has been initiated for all community clinicians.	May QSG and Risk Register confirm and challenge meeting.
715	Collaborative Community Care	16	The community nursing service is unable to meet the demand of patients within Lincolnshire	**New Risk**. This is one of two new risks that replace 654, 655 and 489. Increased demand for service of 8%. The care unit allocation is currently above the agreed maximum of 15 care units daily. Twice daily matron led safety huddles take place. Senior leaders have been allocated to risk areas for oversight. Support from UCR and CYPSS services is in place to support unplanned demand when required	May QSG and Risk Register confirm and challenge meeting.
672	Timely Unplanned Palliative Response 24/7	16	Childrens and Specialist Services /joint risk across divisions	Patients are still waiting outside wait times. In particular between 4 - 8pm due to inability of and capacity of community nursing and home visiting. Advice and specialist guidance is provided by Macmillan via PSPA Additional member of home visiting team on everyday shift at present to support mitigation of risk/ reduce potential harm. ICB are leading collaborative risk mitigation work across the system. Pathway review taking and priority recruitment in train to mitigate. Comfort calls to patients in place should delays occur. Macmillan support different ways	May QSGs

				of working. A further meeting took place with ICB partners in February to review system impacts.	
652	Interruption to Enhanced Practitioners and FVW business as usual activity	15	Collaborative Community Care	Bank and agency support is in place, staff are working additional paid hours and a recruitment plan is in place to ensure capacity is available to support both community nursing and virtual ward patients.	May QSG

Strategic objective 3. To ensure services are sustainable, supported by technology and delivered from an improved estate

There were 9 significantly high risks (15 – 20) recorded in relation to this objective. A summary is provided below:

ID	Title	Risk Score	Division	Updates by reviewers	Date of review
442	Efficiency Requirement 24/25	20	Finance	LCHG have agreed to adopt a common approach to improvement programmes in 24/25. Current start of year position.	May 2024 - **Increased risk from Moderate to Significant (20) awaiting validation at June Risk Register Confirm and Challenge.**
455	Failure to deliver financial plan 24/25 - Income	20	Finance	245k shortfall for Lincs vaccination and health improvement team. Conversations with commissioners of N and NE Lincs integrated sexual health services continuing before that contract is signed.	May 2024 - **Increased risk from Moderate to Significant (20) awaiting validation at June Risk Register Confirm and Challenge.**
418	Medical Gases Compliance	16	Medical	Chief Pharmacist met with ULHT Dir of Estates & Facilities and Interim Ass Director of Estates & Facilities on the 18/04/2024 to explore options for joint working and strengthening assurance relating to the management of medical gases. Action plan developed to track actions. Risk score increased to reflect current risk regarding limited assurance in this area i.e., no AE annual report, no AP in place, no	May 2024 - **Increased risk from High to Significant (20) awaiting validation at June Risk Register**

				quality control assurances relating to identity and purity of medical gases received.	**Confirm and Challenge.**
665	Skegness Fire Risk	15	Estates	All roof void work has been completed. All local fire risk assessments are going to be reviewed and then this score can be amended. Fortnightly meetings are taking place with NHSPS on progress against their action plan.	May 2024
444	Failure to deliver financial plan 24/25 - Cost	15	Finance	Revised financial position at the beginning of the finance year 2024 / 2025. Unknown or unforeseen system pressures for the financial year ahead	May 2024 - **Increased risk from Moderate to Significant (20) awaiting validation at June Risk Register Confirm and Challenge.**
390	John Coupland Hospital Theatres ventilation	15	Corporate	Risk reviewed and no change to score – still awaiting update from NHSPS on procurement response. The design was approved in March 2024 and procurement processes commenced due to complete in April 2024.	May 2024
391	John Coupland Hospital Water Safety	15	Corporate	May 2024 - NHSPS Update - All bacteria counts are zero and now awaiting new test results post the flushes that have taken place. Filters fitted on any outlet that previously returned a count to protect staff and patients.	May 2024
393	Skegness Hospital Water Safety	15	Corporate	May 2024 - NHSPS Update - 2 Outlets are still displaying significant counts after flushes have taken place. pipework to now be removed and replaced. Work has already commenced on this. UTC still returning small counts. Flushes planned. All outlets with counts returning have got filters fitted to reduce risks to staff and patients.	May 2024
649	Fire Safety Core Risk	15	Corporate	A new fire officer has been recruited into the ULHT team and is now working with LCHS supporting with renewing the fire risk assessments, training, and providing expertise. Feedback is good from operations teams on support and information provided.	May 2024

4. Conclusions and Recommendations

There are 9 quality and Safety risks rated Significant (15-20) reported to the Quality Committee in Common. This number has remained static since the May report noting three new risks which have replaced existing risks:

- 495 – Treatment Room Capacity
- 403 - Children Young People Therapy treatment delays
- 409 - Lymphoedema service capacity
- 395 - TB Demand and Capacity
- 652 - Interruption to Enhanced Practitioners and FVW business as usual activity
- 672 - Timely Unplanned Palliative Response 24/7
- 695 - Lack of District Nurse Specialist Practice qualified staff in community nursing affecting the quality of care **(New)**
- 714 - Delivery of pressure ulcer care in the community **(New)**
- 715 - Community nursing lacks capacity and skill set to meet community demand **(New)**

There were 9 risks rated Significantly High (15 – 20) reported to the Finance, Performance, People & Innovation Committee which is an increase of 3 from the last reporting period.

There are 9 risks with a current rating of 12 – 20. These relate to:

- 442 – Efficiency Requirement 2024 / 2025
- 455 – Failure to deliver the financial plan - Income
- 444 – Failure to deliver the financial plan – cost
- 655 – Skegness Hospital Fire Safety Risk.
- 418 – Medical Gases Compliance
- 390 – John Coupland Hospital Theatres Ventilation
- 391 – John Coupland Hospital Water Safety
- 393 – Skegness Hospital Water Safety
- 649 – Fire Safety Core Risk

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

ID	Division	Title	There is a risk that:	Caused by:	Resulting in	Controls in place	Likelihood (current)	Consequence (current)	Rating (current)	Updates by reviewers	Risk level (current)
495	Collaborative Community Care – Community Hospitals	Treatment room clinic capacity	The Treatment Room clinics are working off specification, which has led to high service demand beyond contracted obligation. Patient safety is a risk as patients with complex wound management needs are being seen in clinics staffed and set up for minor wounds. The clinics are underfunded .	Gap in service provision for ambulatory patients who have Tier 2 and 3 wounds. GP practices which opted out of the Treatment Room DCA have also been referring patients who do not meet criteria.	Time restrictions on patient assessment timeslots, risk of delayed healing/inappropriate care. Non clinic staff being pulled in to assist. The capacity of the clinics is impacting on wider services such as IUEC as patients go there to be seen when appointments are unavailable. There is no budget to expand the service to meet the need and it is a cost pressure to LCHS.	Initial service review carried out and shared with the ICB to highlight the gap in service and patient risk. Awaiting further guidance from the ICB around future service specifications. See attached risk assessment. 28/02/24: Full in-depth service review being carried out in relation to demand, capacity and cost of the service.	5 Almost Certain: Will undoubtedly recur, possibly frequently	4 Major	20	April 2024 - The risk to the service remains unchanged. The demand on the service is high and there are not enough appointments at times to meet demand. The service continues to work above the agreed specification delivering support to patients across the system. Further review and deep dive information shared with ICB pending further review. The capacity of the clinics continues to impact on wider services such as IUEC as patients go there to be seen when appointments are unavailable.	Extreme
442	Corporate	Efficiency Requirement 24/25	The Trust fails to deliver the efficiency requirement aspect of its financial plan	Lack of identified efficiency plans; Non delivery of identified schemes; delays in implementing efficiency savings of increased complexity due to system implications	Reputational damage including reduction in the SOF rating and/or lack of financial sustainability going forward, and a failure to meet statutory financial duties	1. Financial plan and budgets approved and delegated. 2. Financial control systems in place 3. Executive oversight at TLT with Executive owned targets for efficiency delivery. Cost improvement planning process overseen by TLT and FPPIC. 4. Benchmarking actively used in identifying opportunities across clinical and corporate areas including estates.	5 Almost Certain: Will undoubtedly recur, possibly frequently	4 Major	20	**Risk score increase to be agreed at June risk register confirm and challenge meeting** 20/05/2024 LCHG have agreed to adopt a common approach to improvement programmes in 24/25 14/05/2024 Risk decrease from 12 in December 2023 to 6. Risk updated on 29/04/2024 with Mike Pockett. 13/02/2024 updates by reviewers - Commentary to be added following FPPIC approval on 19/02/24 24/11/2023 Likelihood reduced from 4 to 3 (overall 16 to 12) to reflect movement of £1.1m in respect of 'red rated schemes' moving from non recurrent to recurrent	Extreme
455	Corporate	Failure to deliver financial plan 24/25 - Income	The Trust fails to deliver the breakeven duty aspect of its financial plan by not achieving planned levels of income	Restriction of in year funding; Service pressures, continued pressure in the system and the level of demand being experienced, and/or failure to manage performance effectively or unforeseen events;	Reputational damage including reduction in the SOF rating and/or lack of financial sustainability going forward, and a failure to meet statutory financial duties	1. Financial plan and budgets approved and delegated. 2. Financial control systems in place 3. Executive oversight at TLT 4. LCHS embedded in system planning and Financial Leadership Group (FLG) and maintain a high profile and active participation in ICS discussions; 5. Monitored at PMR, monthly via FPPIC and , monthly contract meetings with Commissioners. LCHS aligned to system plan but maintaining own business and governance assurance. 6. Agreement of principles with the CCGs prior to any sharing of information. 7. Discussions with CCGs changing focus from input based commissioning to focus on the patient outcomes achieved/delivered 8. Contractual notice periods for any disinvestments	4 Likely: Will probably recur, but is not a persistent issue	5 Catastrophic	20	**Risk score increase to be agreed at June risk register confirm and challenge meeting** 20/05/2024 £245k shortfall for Lincs vaccination and health improvement team at present. Conversations with commissioners of N and NE Lincs integrated sexual health services continuing before that contract is signed. 27/04/2024 Score decreased from L3 x C3 = 9 to L2 x C3 = 6 as per slide deck presented at FPPIC. Narrative awaited. 24/11/2023 LCHS have secured the resources of £421k non recurrently in respect of additional activity and Gainsboro and Spalding UTC from the System risk and opportunity pool. The risk likelihood has therefore been reduced to 2 (2x3 =6 Overall) 24/10/2023 no change in risk or score	Extreme
403	Children's and Specialist Services	Children SLT Therapy treatment delays	Children / young people will wait much longer than usual for the treatment option of block of therapy intervention following assessment (6-8 months as opposed to 2-4 months pre-Covid).	During the pandemic, the Children's SLT service were initially unable to carry out therapy blocks except via Q Health, which lead to a backlog due to virtual appointments not being appropriate for all	Patient impact: treatment delays, impact on patients' mental health & social inclusion. Organisation impact: reputational (increase in complaints / concerns)	1. Advice and activities are given the patient's family and/or educational setting, ensuring they are safe to wait. 2. An appropriate skill mix is used, for example assessments are carried out by SLT and most therapy blocks completed by SLTAs. 3. Mix of face to face and virtual sessions "	4 Likely: Will probably recur, but is not a persistent issue	4 Major	16	16/05/2024 Waits increasing due to vacancies and demand. Impacting on staff morale. HWB support provided by CSL. Paper expected at CYP Board July to review the model Discussed at divisional QSG 11/04/24: All vacancies are out to advert, with waiting times expected to be impacted over the next few weeks, as AP, B5, and 2 x B6 have left or are in the process of leaving the service. Anticipated deterioration due to further staff resignations, but score remains the same this month. Discussed at divisional QSG 14/03/24: the trajectory has been downwards for waiting times, but this has been slowing down and might change direction, as additional sickness within the team. No change to score. Discussed at divisional QSG 08/02/24: Good progress made with children who no longer meet the criteria, but the shift in how the service is managing its workload has only just started, so impact for more complex children is not visible yet. No change to score. Discussed at divisional QSG 11/01/24: the score of 20 proposed on the 20/12/23 update was not agreed. The waits are expected to go down in future months, and system conversations are taking place, as the system risk is separate from the service risk. Urgent patients such as dysphagia are being prioritised, and therefore score was agreed as 16, although for the system risk it should be 20.	Extreme

409	Collaborative Community Care – Community Hospitals	Lymphoedema service capacity	L will be unable to effectively manage their caseload and waiting list in terms of not being able to effectively assess and treat patients especially those who are complex and/or housebound	A lack of clinic space and qualified staff to meet the demand. Increase in demand.	Increased waiting times for patients, non-routine patients not being seen in clinic due to skill mix, lack of skill development for all staff	1.Traffic light system in caseload to determine urgency of assessment 2.Chronic Oedema Pathway introduced and shared with Primary Care to promote early treatment of chronic oedema (Essity hosted Countywide drop in sessions to launch in practice). 3.Referral form updated to gather the information required to enable effective triage of referrals	4 Likely: Will probably recur, but is not a persistent issue	4 Major	16	17/05/2024 Details on risk changed to reflect the risk of MSK injury to staff due to the moving and handling of patients with large heavy limbs. Staff member had LTS absence last year having injured back due to unpredictable load. Moving and handling protocol was used to mitigate risk. No change to risk score. 18/04/2024- No change to risk. Waiting list has reduced because of the work that has been completed with Honorary contract team members. Patients who do did not respond are being discharged. Work ongoing with ICB in regard to onboarding Primary Care with using the Chronic Oedema pathways. Arrangements being made for education amongst primary care teams. 07/02/2024 No change to score. 12/01/2024 No change at QSG 14/12/2023] No change at QSG. Significant effort from CCC leads to engage ICB re this over the past month. Options appraisal for ELT needs to progress as to supportive way forward with this 11.10.23 - discussed at QSG - there has been a lot of work done around mitigation of risk and waiting list. However score remains the same as service capacity remains unchanged	Extreme
395	Children's and Specialist Services	TB Demand and Capacity	Demand is exceeding capacity within TB: the team is working at 1/3 of their capacity.	Current commissioned staffing model doesn't match the increased activity. There are 3 staff members; for 24 weeks of the year due to A/L being taken, the team is functioning at 2/3 capacity.	Increased waits.Rise of TB, LTBI, MDRTB, hospital admissions, deaths. Impact to patients' mental, social, economic&physical health. Impact on staff wellbeing.No capacity to respond timely to outbreak	1. To utilise bank staff with appropriate skills to see this patient group. 2. To ask for dedicated admin staff to support administration process to support trained staff. 3. The introduction of Video Supported Treatment is mitigation that provide case managers assurance that doses were not missed in the absence of support, but this still lacks the prompt and support elements.	4 Likely: Will probably recur, but is not a persistent issue	4 Major	16	16/05/2024 LTBI patients not being started on treatment due to lack of capacity to case manage. TB and MDRTB being prioritised. OH identified LTBI patients await handover to OH team and have not been started on treatment. Ongoing discussions with ICB regarding this who are aware. No referrals now being accepted for LTBI from OH unless symptomatic, OH aware of this and ICB. Discussed at divisional QSG 11/04/24: the risk's content changes (staffing impact's on updating procedural documents and responding to outbreaks) were noted. Confirmed that 1 x B6 and 2 x B3 vacancies had been authorised. No change to score. Discussed at divisional QSG 14/03/24: 3 papers have been submitted to the ICB, 2 meetings were held with DDoN KS, request shared with LCHS to fund 1 x B6 & 2 x B3 out of fragile services list (awaiting board review). It was agreed that Occupational Health will manage latent TB recognised cases, but this is work in progress and the process is not established yet. Further work will be undertaken with the LVHIT service to support in case of outbreak. To aim to reduce the score once the Occupational Health process is in place. No change to score. Discussed at divisional QSG 08/02/24: meeting with ICB went ahead. Action with ICB KS to speak with ICB Finance about pricing up Option 2 from the Options Appraisal paper (additional 1 x B6 & 2 x HCSWs), decision awaited. Reviewing the TB involvement in Occupational Health and whether OH could do some elements of the screening, as well as there being a review of the incident declaring process & of the wrap around support around incidences (huddles being implemented). No change to score.	Extreme
672	Children's and Specialist Services	Timely Unplanned Palliative Response 24/7	LCHS are not providing timely responses to palliative / EOL patients.	Continued increased demand for a timely unplanned response across all services during a 24 hours time period. Unable to meet the standard 2 hours response.	Patients are waiting longer than the recommended 2 hour for symptom control response visit (longest known wait is 11 hours, with regular waits of 5-6 hours). Poor experience for patients and their relatives. Negative impact on staff wellbeing. Increased complaints. Reputational risk.	BCP actions for comfort calls when delays take place. Unplanned pathway work (in development). Macmillan investigating different ways of working in terms of proactive management (in progress). Funding sourced to support additional recruitment into Home Visiting.	4 Likely: Will probably recur, but is not a persistent issue	4 Major	16	16/05/2024 Discussed at CYP SS Quality meeting 16.5.24 Patients are still waiting outside wait times. In particular between 4 - 8pm due to inability ofand capacity of community nursing and home visiting. Advice and specialist guidance is provided by Macmillan via PSPA 15/04/2024 Discussed at divisional QSG 09/04/24: Score remains 16. To involve palliative care strategic work in further conversations. Refreshing all data for HV paper to TLT should provide additional information. Score remains the same. 14/04/2024 Discussed at CYPSS divisional QSG 11/04/24: acknowledged that CSEG did not agree decrease of score to 12. Incidents are still being submitted for delays to providing palliative care. Score remains the same. 04/04/2024 Unplanned palliative care risk. This currently sits on IUEC risk register as 16 (extreme risk) although this is pertinent to all Divisions and is therefore an organisational risk. The joint monthly risk register confirm and challenge meetings are to begin imminently. Divisions are asked to review this risk, which will then be discussed within the confirm and challenge meeting. Decrease of score not agreed. 24/03/2024 Discussed at CYPSS divisional QSG 14/03/24: noted insufficient data to support score of 16, and agreed with IUEC that it's the system score that is 16, with the LCHS one being 12. Propose to reduce score to L3 x C4 = 12. 18/03/2024 Discussed at IUEC Divisional QSG 12/03/24: the committee felt the score was too high, and that the mitigations need to be reviewed, with consideration that this is a system-wide risk. To further discuss at CSEG in partnership with CCC & CYPSS, as well as ICB, for consideration that local score is 12, and system score is 16. 14/02/2024 update from IUEC: no change to score, meeting with ICB took place Feb'24 to discuss the fact that this is a wider system risk. 14/02/2024 Discussed at divisional QSG 08/02/24: meeting around hybrid	Extreme

695	Collaborative Community Care	Lack of District Nurse Specialist Practice qualified staff in community nursing affecting the quality of care	Community nursing teams fail to provide high quality care due to reduced levels of District Nurse Qualified staff within the team structure	Lack of value placed upon the importance of the DNSPQ qualification within community nursing teams Failure to reimburse staff undertaking the role relevant to their responsibilities and thereby retaining them Failure to train sufficient number of DNSPQ qualified staff Lack of standard use of the Enhanced Practitioner role in community nursing teams and defined role Lack of qualified DN	Insufficient levels of qualified DNSPQ support for junior members of teams Lack of oversight for complex case management. Identified theme in case of patient harm Reduced safe management of caseload sizes in community nursing teams Lack of professional support and guidance for team development	BSAFE initiated for daily oversight of safe care BSAFE audits by CSL level staff Reallocation of qualified DNSPQ staff to teams with low levels to aid safety Identification of new assessors for DNSPQ trainees Allocation of trainers to training places for increased trajectory of DNSPQ training Recovery trajectory and commitment to model of care for excellence to be submitted to ELT as part of a wider strategy for service	4 Likely: Will probably recur, but is not a persistent issue	4 Major	16	30/05/2024 **New risk** agreed at Risk Register Confirm & Challenge Group 29/05/2024	Extreme
714	Collaborative Community Care	Delivery of pressure ulcer care in the community	Patients are not always receiving the correct level of care for pressure ulcers within community nursing settings	Variability in the delivery of care for pressure ulcers across community Lack of consistent senior clinical case review Variable clinical skill set of team members in delivering pressure ulcer care	Deterioration in pressure ulcers Increasing referrals for S42 safeguarding responses Poor patient and family/carer experience ICB/CQC oversight of pressure ulcer care	Daily BeSafe reviews of patient care Service action plan to improve pressure ulcer care implemented ICB oversight Educational training plan for all community clinicians initiated Assurance programme commenced Monthly thematic review of pressure ulcers highlighting themes and risks in care	4 Likely: Will probably recur, but is not a persistent issue	4 Major	16	30/05/2024 **New risk** agreed at Risk Register Confirm & Challenge Group 29/05/2024	Extreme
715	Collaborative Community Care	There is a risk that the Community nursing lacks capacity and skill set to meet community demand	The community nursing service is unable to meet the demand of patients within Lincolnshire	Increased demand for service of 8% Care unit allocation above the maximum of 15 care units daily Case load levels above 150 max levels Reduced numbers of DNSPQ qualified staff	Variance in care delivery Ineffective case load management Poor patient experience Reduced complex caseload efficiency Task based service provision with a lack of holistic care planning	Daily BSafe - escalation/oversight review Twice daily matron led safety huddles Re allocation of senior resource to at risk areas Operational oversight of risk daily Service evaluation of DNSPQ role Support from UCR and CYPSS services to aid meeting unplanned demand when required	4 Likely: Will probably recur, but is not a persistent issue	4 Major	16	30/05/2024 **New risk** agreed at Risk Register Confirm & Challenge Group 29/05/2024	Extreme
418	Medical	Medical Gases Compliance	MGPS does not meet the requirements of HTM-02. Systems/ plant/ equipment are not maintained/serviced to the requirements of HTM-02.	Liquid Oxygen bund 'VIE' not being adequately inspected and maintained by NHSPS	Loss of supply. Potential for serious incident (fire) at VIE. The trust cannot be assured of the quality of its piped oxygen. Harm to patients and staff.	has had overview of systems. Estates team are undertaking weekly checks of VIE and local pipework to it at Louth until NHSPS implement PPMs. NHSPS have been made aware of the requirement by the shared service. 2. Liaison with ULHT for Louth and NHSPS at Spalding regarding pharmacy quality assurance for LCHS purposes as we do not order the oxygen directly. Both providers have been made aware of the issue by the shared service. 3. Staff general awareness training on medical gasses (piped and cylinders) has been produced and is available via the internet. Extensive LCHS medical gasses SOPS in place including emergency actions which were recently reviewed and updated. 4. Training for designated Medical/Nursing Officers has been sourced. Funding will be required to initiate. 5. The pipework on our wards in Louth was recently improved with new bed head units and certification as part of the fire improvements scheme.	4 Likely: Will probably recur, but is not a persistent issue	4 Major	16	**Risk score increase to be agreed at June risk register confirm and challenge meetin**g 23/05/2024 Awaiting responses from Estates ULHT (agreed at ELT that a Group approach would be employed to manage this risk) and LPFT Shared Services. Chased up again on the 23/05/2024. See associated action plan. Also, require a robust arrangement & contract for ordering medical gas cylinders - needs a Group approach. 19/04/2024 Lack of AE input into new clinical areas where piped medical gases may be required. 19/04/2024 Also, some related SOPs new reviewing. Previous lead on medical gases for LCHS retired in April 2024. Last 2 medical gas meetings were cancelled by TB due to lack of attendance. Chief pharmacist (SB) asked for lack of support within this area to be escalated to ELT. A Group approach was agreed at ELT (April 2024). Chief Pharmacist met with ULHT Dir of Estates & Facilities (MP) and Interim Ass Director of Estates & Facilities (MS, Estates Shared Services) on the 18/04/2024 to explore options for joint working and strengthening assurance relating to the management of medical gases. Action plan developed to track actions agreed between SB, MS, and MP.SB to request risk to be closed and new one opened to reflect current risks. Risk score increased to reflect current risk regarding limited assurance in this area ie no AE annual report, no AP in place, no quality control assurances relating to identity and purity of medical gases received, no DNO/DMO in place & no associated training, last 2 LCHS medical gas meetings cancelled due to lack of attendance, working through Group governance structure and reporting arrangements for LCHS medical gases group - to report to Group Health & Safety committee in future (in discussion with MP).	Extreme

652	Collaborative Community Care	Interruption to Enhanced Practitioners and FVW business as usual activity	Community Nursing caseloads are not getting the support to manage the most complex patients successfully, impacting upon quality and caseload size (approx. 25% of community nursing teams) There is also a risk, due to overall EP capacity that we don't maximise the FVW as anticipated	5 vacancies that are proving difficult to recruit to. Community EP posts to recruit too; 1WTE Lincoln North- update to go back out to advert w/b 19th FEb 0.8 WTE Louth and Wolds - update recruited to starting April 2024 0.8 WTE Sleaford - Update recrutied to and came into post 22/01/2024 0.8 WTE 18 month secondment cover for Grantham - update to go back out for recruitment 1.00 WTE Mablethorpe - recruited and starting 24/02/2024 0.8 WTE 10 month secondment H/S - recruited too start date 14/04/2024. Frailty EP's- Two qualified EP's for Frailty have handed in their notice 1.0 WTE Frailty EP for North West Quadrant to go out for recruitment 0.8 WTE Frailty EP for North East Quadrant to go out for recruitment, both posts sent for authorisation 15/02/2024.	Inequity in expectations and poor staff moral Patients not having access to Enhanced Practitioner service that provides complex assessments and instigates management plans and advanced care planning.	Staff working over time, bank shifts and extra hours to ensure service is covered. Posts out for recruitment 12/02/2024 - Ep's from Lincoln Fen 1.0 WTE and Boston 1.0 WTE moved to Sleaford to provide support for new EP in post for Sleaford and ICT staff. Team members working bank to cover Frailty Virtual ward at weekends	5 Almost Certain: Will undoubtedly recur, possibly frequently	3 Moderate	15	April 2024 - Bank and agency support is in place, staff are working additional paid hours and a recruitment plan is in place to ensure capacity is available to support both community nursing and virtual ward patients. The risk was reviewed in April and a revised position is to be considered by the May risk confirm and challenge meeting. 12/01/2024 No change at QSG 14/12/2023 no change at QSG	Extreme
444	Corporate	Failure to deliver financial plan 24/25 - Cost	The Trust fails to deliver breakeven duty aspect of its financial plan by failing to contain costs within planned levels	Service pressures, continued pressure in the system and level of demand being experienced, and/or failure to manage performance effectively or unforeseen events; Inflationary 'cost of living pressures	Reputational damage including reduction in the SOF rating and/or lack of financial sustainability going forward, and a failure to meet statutory financial duties.	1. Financial plan and budgets approved, including the capital plan 2. Financial control system 3. Executive oversight at TLT, through to FPPIC. 4. Monthly capital group meeting internal to LCHS 5. Monitored at PMR, monthly via FPPIC and , monthly contract meetings with Commissioners. LCHS aligned to system plan but maintaining own business and governance assurance. 6. Cost of living increase pressures funding influenced at Lincolnshire system and national levels.	3 Possible: May recur occasionally	5 Catastrophic	15	**Risk score increase to be agreed at June risk register confirm and challenge meeting** 20/05/2024 Decisions regarding cost pressures need to be made by ELT. 14/05/2024 Risk decrease from 12 in December 2023 to 6. Risk updated on 29/04/2024 with Mike Pockett. 27/04/2024 Retrospective decrease of score noted following FPPIC report 26/04/24. Narrative to follow on 29/04/24. 13/02/2024 Commentary to be added following FPPIC approval on 19/02/24 24/11/2023 no change to score following monthly review.	Extreme
390	Corporate	John Coupland Hospital Theatres ventilation	Patient safety/ infection control / loss of service and disrupted service to patients	Theatre one - The plant in JCH theatre 1 is running inconsistently resulting in temperatures being close to or over the limit of 22c and humidity at times being close to or breaching the limit of 60.	Creating a patient safety risk if not effectively monitored, theatre lists have had to be cancelled for patient safety at short notice, a risk to service delivery and LCHS reputation.	1. PPMs and recording undertaken by NHSPS. 2. Yearly survey reports on high risk equipment (theatres) undertaken by NHSPS. 3. Monitoring of compliance undertaken by Estates Shared Service. 4. Compliance information reported into LCHS Safety and Compliance Group (SACG) monthly and Health and Safety	3 Possible: May recur occasionally	5 Catastrophic	15	10/05/2024 Risk reviewed and no change to score 25/04/2024 Risk reviewed and no change to score. Still awaiting update from NHSPS on procurement response. 27/03/2024 NHSPS Update. the design has been approved and it is currently out to procurement. Procurement due to complete in April. No change to score currently. 09/01/2024 NHSPS Update - The technical specification for proposed design of the improved ventilation system was issued by the design consultant pre-Christmas. They posed several points of discussion regarding the fabric of operating theatre environment, such as door sets, ceilings, etc, which require	Extreme
391	Corporate	John Coupland Hospital Water Safety	Water supply to patients, staff and visitors has been contaminated;	The regulatory routine maintenance of the landlord (NHSPS) being ineffective;	Risk of harm from Legionella and other waterborne pathogens	1. Joint Water Safety Group 2. NHSPS planned maintenance regime 3. Reporting of compliance in LCHS Safety and Compliance Group (SACG) monthly and Health and Safety Committee quarterly. 4. Appointed Authorising Engineer (AE) for water 5. NHSPS is undertaking flushing of outlets. 6. Water sampling - with all results being sent to the Trust AE and Estates Shared Services 7. Estates shared service and AE follow up actions required on high count outlets. 8. Any positive counts have a filter fitted immediately	3 Possible: May recur occasionally	5 Catastrophic	15	10/05/2024 NHSPS Update. All bacteria counts are zero and now awaiting new test results post the flushes that have taken place. Filters fitted on any outlet that previously returned a count to protect staff and patients. 27/03/2024 NHSPS Update. All identified dead legs have been removed and a chemical flush has been booked w/c 25th March. Filters are on positive outlet, changed monthly and documented. 09/02/2024 NHSPS has actively sampled throughout the hospital, then acted in response to sample results. Actions taken have included the undertaking of a new water hygiene risk and action of remedial tasks arising from that, amended flushing regimes, thermal sterilisation, chemical sterilisation, and where necessary the installation of POU filters. The last set of results returned three positive results in the three bays at the far end of Scotter Ward, and so a further chemical sterilisation is planned. NHSPS Senior Estates Manager has liaised with Sarah Fixter (IPC Lead) regarding results, actions, and use of POU filters. Agreed no change to score	Extreme

393	Corporate	Skegness Hospital Water Safety	Water supply to patients, staff and visitors has been contaminated;	The regulatory routine maintenance of the landlord (NHSPS) being ineffective	Risk of harm from Legionella and other waterborne pathogens	1. Trust Water Safety Group 2. NHSPS planned maintenance regime 3. Reporting of compliance in LCHS Safety and Compliance Group (SACG) monthly and Health and Safety Committee quarterly. 4. Appointed Authorising Engineer (AE) for water 5. NHSPS is undertaking flushing of outlets. 6. Water sampling - with all results being sent to the Trust AE and Estates Shared Services 7. Estates shared service and AE follow up actions required on high count outlets. 8. Any positive counts have a filter fitted immediately	3 Possible: May recur occasionally	5 Catastrophic	15	10/05/2024 NHSPS Update - 2 Outlets are still displaying significant counts after flushes have taken place. pipework to now be removed and replaced. Work has already commenced on this. UTC still returning small counts. Flushes planned. All outlets with counts returning have got filters fitted to reduce risks to staff and patients. 27/03/2024 NHSPS Update. Further dead legs have been identified and an order has been raised to remove these ASAP. A chemical disinfection was carried out in the UTC on the 15th March. A thermal disinfection has been carried out in the rest of the hospital on the 23rd March. Resampling is taking place W/C . 25th March. Filters on positive outlets replaced every month and documented. 09/02/2024 NHSPS has actively sampled throughout the hospital, then acted in response to sample results. The latest results showed no legionella in almost areas of the hospital, including some which had historically been problematic to resolve. Actions taken have included an Authorising Engineer audit of water safety management activities at the property, installation of a new water storage tank, review of as built water system drawings, amended flushing regimes, thermal sterilisation, chemical sterilisation, and where necessary the installation of POU filters. These actions have led to the point where there remains one area of focus, and further investigation has found previously unidentified dead legs. These are planned to be removed, after which further sterilisation and then sampling will follow. In the meantime, enhanced flushing and POU filters are in use. Agreed no change to score	Extreme
649	Corporate	Fire Safety Core Risk	There is a risk of harm to building occupants (including patients)caused by fire. There is a risk that the Trust cannot demonstrate statutory compliance in accordance with the Regulatory Reform (Fire Safety) Order 2005 (RRO).	Inadequate fire protection systems, maintenance, training and procedures	Loss of facilities, services and injuries to patients and staff.	1. Reporting of compliance in LCHS Safety and Compliance Group (SACG) monthly and Health and Safety Committee quarterly. 2. Planned Preventative Maintenance PPM 3. Fire Risk Assessments 4. Fire Safety Training 5. Fire protection system tests 5. Fire Emergency Plans 6. Yearly Fire audit 7. Appointed Authorising Engineer (AE) for Fire 8. Inpatient Fire evacuation plans and tests 9. Test Fire drills.	3 Possible: May recur occasionally	5 Catastrophic	15	10/05/2024 No change to score and it continues to be monitored and reviewed. 25/04/2024 Fire officer working across the LCHS estate supporting with risk assessments, training and support. Feedback is good from operations teams on support and information provided. 14/03/2024 A new fire officer has been recruited into the ULHT team and is now working with LCHS on supporting with renewing the fire risk assessments. 09/01/2024 ULHT are supporting LCHS with all elements of fire safety. Also a recruitment process has taken place to increase the capacity in the ULHT team. The LCHS Fire AE is just about to be undertaken.	Extreme
665	Collaborative Community Care – Community Hospitals	Skegness Hospital Fire Safety	There is a risk of harm to building occupants (including patients)caused by fire.	Inadequate fire protection systems, maintenance, training and procedures	Loss of facilities, services and injuries to patients and staff.	1. urgent Skegness Working group 2. Health and Safety Committee quarterly. 3. Fire Risk Assessments 4. Fire Safety Training 5. Fire protection system tests 5. Fire Emergency Plans 6. Yearly Fire audit 7. Appointed Authorising Engineer (AE) for Fire 8. Inpatient Fire evacuation plans and tests 9. Test Fire drills. 10. Planned Preventative Maintenance PPM 11. Additional night staff on by NHSPS 12. Staff training 13. Local communications plan and SOP	3 Possible: May recur occasionally	5 Catastrophic	15	10/05/2024 All roof void work has been completed. All local fire risk assessments are going to be reviewed and then this score can be amended. 25/04/2024 Work has been completed in the roof void 1 and 3 with work due to complete on roof void 2 by the 10th May. Post the work in the roof voids all risk assessments will be reviewed. 14/03/2024 Fortnightly meetings are taking place with NHSPS on progress against their action plan. All actions are green and contractors will start on the removal of the old roof W/C 1st April. 14/02/2024 Discussed at risk summit with CCC & Co Ho DDLs 14/02/24: This risk is being updated by DDI DD via the H&S committee, and the most recent update on 09/02/23 notes no change of score & its rationale. Agreed that CCC Co Ho will make no change to score. Quality team aware of discussions outside QSG that confirm the score needs to remain L3 x C5 = 15. CCC to have oversight of this risk and update at QSG monthly, as some of the controls are related to staff training & staffing levels. 09/02/2024 The visit by Lincolnshire Fire and Rescue went very well and feedback about LCHS staff and procedures was greatly received. The NHSPS action plan has been shared with LFR and we are monitoring on a fortnightly basis with NHSPS.	Extreme

United Lincolnshire Hospitals NHS Trust

Meeting	*Lincolnshire Community and Hospitals Group Board meeting*
Date of Meeting	*2 July 2024*
Item Number	*14.1*

Strategic Risk Report

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

How the report supports the delivery of the priorities within the LCHG Board Assurance Framework	
1a Deliver high quality care which is sae, responsive and able to meet the needs of the population	*X*
1b Improve patient experience	*X*
1c Improve clinical outcomes	*X*
1d Deliver clinically led integrated services	*X*
2a Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	*X*
2b To be the employer of choice	*X*
3a Deliver financially sustainable healthcare, making the best use of resources	*X*
3b Drive better decision and impactful action through insight	*X*
3c A modern, clean and fit for purpose environment across the Group	*X*
3d Reduce waits for patients who require urgent and emergency care and diagnostics and ensure we meet all constitutional standards	*X*
3e Reducing unwarranted variation in cancer service delivery and ensure we meet all constitutional standards (ULHT)	*X*
3f Reducing unwarranted variation in planned service delivery and ensure we meet all constitutional standards (ULHT)	*X*
3g Reducing unwarranted variation in community service delivery and ensure we meet all constitutional standards (LCHS)	*X*
4a Establish collaborative models of care with all our partners including Primary Care Network Alliance (PCNA), GPs, health and social care and voluntary sector	*X*
4b Successful delivery of the Acute Services Review	*X*
4c Grow our research and innovation through education, learning and training 4d Enhanced data and digital capability	*X*
5a Develop a Population Health Management (PHM) and Health Inequalities (HI) approach for our Core20PLUS5 with our ICS	*X*

5b Co-create a personalised care approach to integrate services for our population that are accessible and responsive	*X*
5c Tackle system priorities and service transformation in partnership with our population and communities	*X*
5d Transform key clinical pathways across the group resulting in improved clinical outcomes	*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 Group Board are 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.

- This report contains data that covers May 2024.

- There were 9 quality and safety risks rated Very High (20-25) reported to the Quality Committee in Common this month, a reduction of 2 from the previous reporting period:
  - Patient flow through Emergency Departments
  - Recovery of planned care cancer pathways
  - Reliance on paper medical records
  - Reliance on manual prescribing processes;
  - Processing of echocardiograms
  - Delivery of paediatric epilepsy pathways-community
  - Quality and safety risk from inability to deliver epilepsy pathways within Acute Paediatrics that meet National standards
  - Medicines reconciliation compliance
  - Consultant capacity for Haematology outpatient appointments
  - Removal of lift in H Block PHB affecting service delivery to patient records

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

  - Potential for serious patient harm due to a fall, Risk presented in April, reduction in score validated to Moderate (12)
  - Processing of echocardiograms-Risk presented in April, reduction in score validated at High (16)

- There are 4 People and Organisational Development risks rated Very High (20-25) which were reported to the People & Organisational Development Committee this month, this remains in a stable position from the previous reporting period:

    - Staffing levels requiring an increase in Pharmacy to be able to provide a seven-day service.
    - Pharmacy workload demands
    - Service configuration (Haematology)
    - Consultant workforce capacity (Haematology)

- There are 6 Very high risks (20-25) reported to the Finance, Performance and Estates Committee this month, an increase of 1 from the previous reporting period:
    - Potential for a major fire;
    - Compliance with fire safety standards, assessed by Lincolnshire Fire and Rescue Service;
    - Exceeding the agency cap due to the cost of reliance upon temporary clinical staff
    - Reliance on agency / locum medical staff in Urgent & Emergency Care
    - SAR's Compliance and access to Health records in accordance with statuary requirements.
    - Grantham Medical Air Plant Fault/Failure –**Risk presented at Risk Confirm and Challenge in April and validated as Very High Risk (20)**

- Following presentation at the Risk Confirm and Challenge Meeting during this period, the following risks aligned with FPEC have been updated:
    - Integration of data protection / privacy impact assessments within decision making-presented at Risk Confirm and Challenge in May and validated for reduction in score to Moderate (12)

Purpose

The purpose of this report is to enable the Group 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. **Please note full alignment with the updated Group Strategic Objectives will occur in the next reporting period due to the work required on the DatixIQ system to migrate these across.**

1. Introduction

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

1.2 Full details of all active Very High and High risks (those with a current risk score of 15-25) are included in **Appendix A**, and a summary of Very High risks is provided in Section 2 below. Moderate and Low risks (those with a score of 12 and below) are managed at divisional level.

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

2. Trust Risk Profile

2.1 There are 565 active and approved risks reported to lead committees this month, an increase of 19 risks since the last report.

2.2 There are 19 risks with a current rating of Very High risk (20-25) and 43 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)
47 (+3) (8%)	**129 (+5)** (22%)	**325 (+10)** (57%)	**45 (+2)** (8%)	**19 (-1)** (3%)

Strategic objective 1a: Deliver high quality care which is safe, responsive and able to meet the needs of the population

2.3 There are 7 Very High risks, a reduction of 2 and 12 High risks, remaining stable recorded in relation to this objective. A summary of the Very high risks is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
5143	The demolition of H Block will remove facilities and amenities that the health records teams utilise. The impact of removing the lift will restrict the movement of patient notes and potentially the number of patients being seen in outpatients. The health records team will need to move notes in the dumbwaiters which is previously resulted in injury and legal action. With using the dumbwaiters, this will impact information governance and security of notes due to the storage and location. Staff morale will be impacted due to extra manual handling and loss of amenities required to support with mitigating this risk. This risk also has an impact on staff workload due to extra time the tasks will now take, this will also have a knock on effect to other services such as porters, secretaries. With no lift to support the department if any large items fail i.e printer or racking, replacement items will be unable to be delivered.	Very high risk (25)	To reduce the impact the team will use dumb waiters, one of which is in another area with limited access. Change of processes to mitigate risk and transfer notes over a longer period. Walk around with senior individuals and project team to look at different ways of working and potential solutions. Risks to be highlighted in QIA. Risk to be presented at PRM. Health and Safety guidance to be delivered to Team. Further discussions to be had regarding whether all clinicians requiring paper based notes in clinic.	03/06/2024
5016	If there is not sufficient flow through the Trusts Emergency Departments, due to demand outstripping capacity and insufficient availability of beds in the hospitals leading to overcrowding. This may result in increased likelihood of long waits in the departments for patients, and an increase in the potential for patient harm, delays in care, poor patient and staff experience and impact on the reputation of the Trust .	Very high risk (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.	06/06/2024

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4879	If there are significant delays within the planned care cancer pathway then patients may experience extended waits for diagnosis and surgery, resulting in failure to meet national standards and potentially reducing the likelihood of a positive clinical outcome for many patients	Very high risk (20)	- Planned care recovery plan (cancer) - Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions.	14/06/2024
5101	Quality and safety risk from inability to deliver Community epilepsy pathways that meet National standards due to resourcing and capacity factors.	Very high risk (20)	1. Business case is being produced to enable establishment of fully funded epilepsy service 2. Agreement for spending has been obtained, moving forward. 3. 2 x epilepsy nurses now in post 4. Epilepsy workshop with ICB	21/05/2024

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4740	Demand for Haematology outpatient appointments exceeds consultant staffing capacity. High Consultant vacancy levels affecting clinic capacity, performance and review of inpatients. The areas of concern are Lymphoma, and haemostasis (there is only one consultant trust wide). PHB cover and unfilled leadership roles (in practice head of service and clinical governance lead). Due to haematology patients having long term conditions, they are required to have regular review and those on cancer treatment are time critical. If we are not able to meet the demands of the service this potentially could cause severe harm to the patients. At the end of March 2023 there are 322 overdue haem pt at phb and 597 at LCH. From 1 Oct 22 till now the haematologists have held 95 extra clinics which equates to 71 news and 813 F/U. Haemostasis in particular pt are waiting almost triple the time that they have been graded at. There are 657 pt on this consultant PBWL with 295 being overdue. The longest waiter was due an appointment around July 2022. This consultant is holding on average 3 extra clinics per month.	Very high risk (20)	Need for workforce review identified. Right sizing work force paper being written. 2 x agency consultants out to support service	29/05/2024

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4947	There is an issue in which the Trust is failing to meet NICE medicines reconciliation targets on a consistent basis and not being able to review discharges. This is caused by lack of pharmacy resource. Resulting in potential for patient harm due to incorrect or delayed medication, financial implications due to increased length of stay or unnecessary supply and risk of continuation of errors onto the discharge letter and further more into the community.	Very high risk (20)	There are many options but we are utilising these; - We have prioritised pharmacist and technician cover to acute admission areas as patient turnover is highest on these areas and gives us to best opportunity to conduct a medicines reconciliation under 24 hours - We prioritise patients which have stayed in the longest and have critical medication where known. Prioritisation of the highest risk patients decreases the risk of harm - No ward visits are divided as much as possible. To significantly reduce this risk requires additional ward based pharmacy staff cover across 7 days.	11/06/2024
5100	Quality and safety risk from inability to deliver epilepsy pathways within Acute Paediatrics that meet National standards due to resourcing and capacity factors.	Very high risk (20)	1. Multi-professional working group tasked with delivering improvements that will support achievement of audit compliance.	10/06/2024

Updates since the last report

Following the April and May RRC&C meetings the following changes were agreed and validated:

- **Potential for serious patient harm due to a fall**, Risk presented in April, reduction in score validated to Moderate (12) Significant improvement work undertaken over past 2 years and improvement actions are ongoing. Overall number of falls and falls per 1000 occupied bed days have reduced year on year. Have achieved 14 of 17 targets for moderate harm falls. Different oversight arrangements in place now so confident that improvements will be sustained and increased. Agreed reduction in scoring to 12 (3x4).
- **Processing of echocardiograms**-Risk presented in April, reduction in score validated at High (16) In the last 18 months reduced waiting list from 8000 patients to 1800 patients, overdue is now around 600 patients. Previously worst performing Trust in the country and now in the top 10. Predict that by June 2024 no patients will be waiting for more than 13 weeks. Agreed reduction in scoring to 16 (4x4).

Strategic objective 1b: Improve patient experience

2.4 There are no Very High risks and 2 High risks recorded in relation to this objective, which remains stable from last month.

Strategic objective 1c: Improve clinical outcomes

2.5 There are 2 Very High risks, and 3 High risks remaining stable recorded in relation to this objective. A summary of the Very High risks is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4828	The trust currently uses a manual prescribing process across all sites, which is inefficient and restricts the timely availability of patient information when required by Pharmacists. Where information about patient medication is not accurate, up to date and available when required by Pharmacists then it could lead to delays or errors in prescribing and administration, resulting in a widespread impact on quality of care, potentially reducing the likelihood of a positive clinical outcome and/or causing serious patient harm	Very high risk (20)	Planned introduction of an auditable electronic prescribing system across the Trust. Update 4th July 22- 26th July, ePMA functionality version 10.21 will be upgraded. ePMA pilot from 13/09/22, full Trust wide roll out from mid Oct. Full roll out now complete – risk assessment currently underway to review any potential new risks in relation to ePMA with a plan to close this risk in due course.	11/06/2024
4731	If patient records are not complete, accurate, up to date and available when needed by clinicians then it could lead to delayed diagnosis and treatment, reducing the likelihood of a positive clinical outcome and possibly causing serious harm	Very high risk (20)	Design and delivery of the Electronic Document Management System (EDMS) project, incorporating Electronic Patient records (EPR). Interim strategy required to reduce the risk whilst hard copy records remain in use.	18/06/2024

Strategic objective 2a. A modern and progressive workforce

2.6 There are 3 Very High risks and 8 High risks, both remaining in a stable position recorded in relation to this objective. A summary of the Very High risks is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4844	The ability to provide a seven day a week pharmacy service requires a level of staffing above the current levels. Benchmarking has taken place against peer Trusts for staffing levels. Until this is funded the seven day a week service is unobtainable and this puts patients at risk.	Very high risk (20)	Pharmacy supply a limited Saturday and Sunday morning service with staff working beyond their contracted hours. An on-call pharmacist is available for EMERGENCY items only. A Business Case has been submitted to CSS CBU.	11/06/2024
4996	Staffing - insufficient consultant workforce to meet demand. Particular areas of concern: 1. Lymphoma tumour site cover 2. Haemostasis/haemophilia (single consultant Trust wide) 3. Pilgrim Consultant cover 4. Clinical governance lead 5. HoS/clinical lead	Very high risk (20)	* Workforce review * Refresher of Fragile Services Paper - NB there is a National shortage of Haematology consultants * Recruitment of further substantive consultants * Additional unfunded ST3+ for Haematology starts in August 2022	29/05/2024
4997	Service configuration - single consultant covering both sites during weekend so cover limited if critically unwell patients on both sites	Very high risk (20)	* Workforce review * Refresher of Fragile Services Paper - NB there is a National shortage of Haematology consultants * Recruitment of further substantive consultants * Additional unfunded ST3+ for Haematology starts in August 2022	29/05/2024

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

2.7 There is 1 Very High risk and 4 High risks, remaining stable recorded in relation to this objective. A summary of the Very High risks is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
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.	11/06/2024

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

2.8 There are 3 approved Very High risks (20-25) an increase of 1 and 7 High risks (15-16) a reduction of 1, recorded in relation to this objective. A summary of the Very High risks is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4648	If a fire occurs on one of the Trust's hospital sites and is not contained (due to issues with fire / smoke detection / alarm systems; compartmentation / containment) it may develop into a major fire resulting in multiple casualties and extensive property damage with subsequent long term consequences for the continuity of services.	Very high risk (20)	- Statutory Fire Safety Improvement Programme based upon risk. - Fire safety protocols development and publication. - Fire drills and evacuation training. - Fire Risk assessments being undertaken on basis of inherent risk priority; areas of increased residual risk to be added to the risk register for specific action required - Local weekly fire safety checks undertaken with reporting for FEG and FSG. Areas not providing assurance receive Fire safety snapshot audit. - Planned preventative maintenance programme by Estates	13/06/2024

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
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	13/06/2024
5415	Grantham Site Medical Air Plant failure/limited functionality. The current medical air plant has 2 associated compressors of which are of an age where failure is likely, the units are MIM manufacturer who no longer are trading. one compressor has failed and the site is operating on one compressor only supported by an emergency manifold cylinder. The compressors are beyond life and obsolete, at this time there are no abilities to repair the failed unit and replacement is required. at present if the only remaining unit fails, the site will be operating on a cylinder manifold designed only for emergency use with limited time capacity. This failure will impact on all surgical services	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	14/06/2024

Updates since the last report

- **Grantham Medical Air Plant Fault/Failure** –Risk presented at Risk Confirm and Challenge in April and validated as Very High Risk (20)

Strategic objective 3b: Efficient use of our resources

2.9 There are 2 approved Very High risks (20-25), and 3 High risks (15-16), both remaining stable from the last report, recorded in relation to this objective. A summary of the Very High risks is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4664	The Trust has an agency cap of c£21m. The Trust is overly reliant upon a large number of temporary agency and locum staff to maintain the safety and continuity of clinical services that will lead to the Trust breaching the agency cap.	Very high risk (20)	Financial Recovery Plan schemes: - recruitment improvement; - medical job planning; - agency cost reduction; - workforce alignment	13/06/2024
5020	If there is a continued reliance on bank and agency staff for medical workforce in Urgent & Emergency Care there is a risk that there is not sufficient fill rate for medical rotas both ward / department fill and on call shifts which will impact on patient safety and have a negative impact on the CBU budget.	Very high risk (20)	Robust recruitment plan. International recruitment. Medical Workforce Management Project.	06/06/2024

Strategic objective 3c: Enhanced data and digital capability

2.10 There is 1 approved Very High risk, remaining stable (20-25) recorded in relation to this objective, There are also 3 High risks (15-16), a decrease of 1 from the previous report. A summary of the Very High risk is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4657	If the Trust does not comply with Subject Access Requests (SARs) and Access to Health Records provisions in accordance with statutory requirements specified legislation, then it could lead to complaints to the Trust and Information Commissioner's Office (ICO). This could result in regulatory action and possibly financial penalties. Inconsistent levels of expertise outside of the IG team regarding SAR requirements. Lack of technical tools to carry out a search of emails / systems to identify personal information held. Potential financial implications."	Very high risk (20)	"Current active communications with ICO- regulator. Changes to processes are being constantly discussed and implemented. Resource needs being discussed and temporarily increased to support. Monitored through the IGG in DP KPI report. Head of IG leading on work to review and improve. Working in a more digital way where feasible. Workforce change is required which will be a much longer process. Early identifications of chasers and urgent requests to reduce the likelihood of complaints."	17/06/2024

Updates since the last report:

Following presentation at the Risk Confirm and Challenge Meeting during this period, the following risks aligned with FPEC under strategic objective 3C have been updated:

- **Integration of data protection / privacy impact assessments within decision making**-presented at Risk Confirm and Challenge in May and validated for reduction in score to Moderate (12)

Strategic objective 3d: Improving cancer services access

2.11 There are no approved Very High risks (20-25) or High risks (15-16) to this objective.

Strategic objective 3e: Reduce waits for patients who require planned care and diagnostics to constitutional standards

2.12 There are no approved Very High risks (20-25) or High risks (15-16) to this objective.

Strategic objective 3f: Urgent Care

2.13 There are no approved Very High risks (20-25) or High risks (15-16) to this objective.

Strategic objective 4a: Establish new evidence based models of care

2.14 There are no approved Very High risks (20-25) or High risks (15-16) to this objective.

Strategic objective 4b. To become a University Hospitals Teaching Trust

2.15 There are currently no Very High risks recorded in relation to this objective.

2.16 **Strategic objective 4c: Successful delivery of the Acute Services Review**2. There are no approved Very High risks (20-25) or High risks (15-16) to this objective.

3. Conclusions & recommendations

- There are 9 quality and safety risks rated Very High (20-25) reported to the Quality Committee this reporting period:

    - Patient flow through Emergency Departments
    - Recovery of planned care cancer pathways
    - Reliance on paper medical records
    - Reliance on manual prescribing processes;
    - Delivery of paediatric epilepsy pathways-community
    - Quality and safety risk from inability to deliver epilepsy pathways within Acute Paediatrics that meet National standards
    - Medicines reconciliation compliance
    - Consultant capacity for Haematology outpatient appointments
    - Removal of lift in H Block PHB affecting service delivery to patient records

- There are 4 People and Organisational Development risks rated Very High (20-25) reported to the People & Organisational Development Committee this reporting period:

    - Staffing levels requiring an increase in Pharmacy to be able to provide a seven-day service.
    - Pharmacy workload demands
    - Service configuration (Haematology)
    - Consultant workforce capacity (Haematology)

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

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

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
2a. A modern and progressive workforce	4844	38	Service disruption	Lynch, Diane	Costello, Mr Colin	Workforce Strategy Group	Medicines Quality Group	19/01/2022	20	Risk assessments	Clinical Support Services	Pharmacy CBU	Pharmacy		The ability to provide a seven day a week pharmacy service requires a level of staffing above the current levels. Benchmarking has taken place against peer Trusts for staffing levels. Until this is funded the seven day a week service is unobtainable and this puts patients at risk.	Service planning & annual budget setting processes: Pharmacy / CSS Division	Staffing levels / budget benchmarked against other similar trusts. Reported medication incidents occurring out of hours.	11/06/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Pharmacy supply a limited Saturday and Sunday morning service with staff working beyond their contracted hours. An on-call pharmacist is available for EMERGENCY items only. A Business Case has been submitted to CSS CBU.	[11/06/2024 10:38:30 Lisa Hansford] Risk reviewed and remains the same [09/05/2024 08:55:00 Gemma Staples] Risk reviewed and remains the same. [04/04/2024 08:49:00 Lisa Hansford] no update [07/03/2024 14:20:29 Lisa Hansford] no update [13/02/2024 11:52:19 Gemma] Risk reviewed, no further update. [17/01/2024 12:06:01 Gemma] No further update [19/12/2023 13:27:34 Lisa-Marie Moore] Meeting with MD 18/12 to discuss business cases Pharmacy phase 2 improvement plan in progress [28/11/2023 12:09:20 Rachael Turner] Risk score remains, no further update. [30/10/2023 12:40:52 Rachael Turner] No changes, risk ongoing. No further updates at this time. [26/09/2023 14:05:31 Rachel Thackray] No changes as yet made, meeting to take place with Medical Director [03/08/2023 14:49:28 Lisa-Marie Moore] No further updates [27/06/2023 09:47:18 Alex Measures] Discussed in risk register review meeting- no further updates [01/06/2023 14:18:15 Lisa-Marie Moore] No change/update since previous entry [06/04/2023 12:53:22 Paul White] Discussed at Risk Register Confirm & Challenge 29 March, risk agreed with feedback provided for consideration. [09/02/2023 10:43:37 Paul White] Status changed to awaiting approval pending review by division and validation by Risk Register Confirm & Challenge Group. [22/12/2022 14:55:29 Rose Roberts] Confirmed with Paul White that the risk level can be raised here and confirm and challenge will invite the risk lead to discuss it. [20/12/2022 14:35:39 Alex Measures] Business case was not approved, currently stalled, raised to high risk today but the meeting feels it should be very high risk because it would be very likely to happen, to be taken to confirm and challenge to be upgraded	4	29/10/2021	28/04/2023	11/07/2024
3c. Have enhanced data and digital capability	4657	7	Reputation	Matthew, Mr Paul	Hobday, Fiona	Information Governance Group	Digital Hospital Group	10/01/2022	12	Risk assessments	Corporate	Trust Headquarters	Corporate Secretary		If the Trust does not comply with Subject Access Requests (SARs) and Access to Health Records provisions in accordance with statutory requirements specified legislation, then it could lead to complaints to the Trust and Information Commissioner's Office (ICO). This could result in regulatory action and possibly financial penalties. Inconsistent levels of expertise outside of the IG team regarding SAR requirements. Lack of technical tools to carry out a search of emails / systems to identify personal information held. Implementation of digital systems which don't include a disclosure process. Potential financial implications.	ULHT policy in place. Monitoring through IGG and at exec level. Temporary additional resource has been put in place to oversee. Proposal made to ELT and IGG regarding process which has removed reliance on clinical staff to review all cases. Increased training provided to team.	Monthly reporting completed. Compliance rate is monitored by the Supervisor and reports taken to IGG in our KPI report. Volume of ICO complaints and Trust complaints received.	17/06/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Current active communications with ICO-regulator. Changes to processes are being constantly discussed and implemented. Resource needs being discussed and temporarily increased to support. Monitored through the IGG in DP KPI report. Head of IG leading on work to review and improve. Working in a more digital way where feasible. Workforce change is required which will be a much longer process. Early identifications of chasers and urgent requests to reduce the likelihood of complaints.	[17/06/2024 15:53:00 Fiona Hobday] *Still awaiting outcome from ICO *New system- have drafted the config for the new system- Corestream to now build. Completion date for risk adjusted linked to system. *Have seen an increase in complex cases and Maternity related in last couple of months. [24/04/2024 13:26:16 Nicola Cornish] Discussed at RRC&C meeting on 24/04/24 - backlog has reduced significantly but compliance still not in line with legal requirement and still potential for regulatory action from the ICO. [23/04/2024 09:05:15 Fiona Hobday] ICO requested further information- supplied 18/04/24 Meeting arranged with Corestream re planning system config April 2024- draft spec produced ready for discussion. [04/03/2024 13:47:50 Fiona Hobday] *System has now been procured- project due to commence April 24 with an initial go live for Quarter 2. *x1 temp new starter 5/3/24 due to sickness and vacancy in dept. [25/01/2024 14:27:48 Fiona Hobday] Have extended expected completion date in light of current position- approvals have taken longer than original hoped for re solutions which impacts go live plans. Also due to lack of response from ICO to date- Trust is not aware what the outcome might be. *Agreement rec'd to procure new case mgmt solution- next step to award contract and then project to implement. *PoC for a solution re emails has concluded and a final report is being prepared which will include a recommendation.	6	29/12/2023	31/10/2024	17/07/2024
2a. A modern and progressive workforce	4996	39	Service disruption	Rinaldi, Dr Ciro	Chester-Buckley, Sarah	Workforce Strategy Group	Patient Safety Group	22/08/2022	16		Clinical Support Services	Cancer Services CBU	Haematology (Cancer Services)		Staffing - insufficient consultant workforce to meet demand. Particular areas of concern: 1. Clinical governance lead 2. Head of Service for haematology	* Completed a fragile services paper * Additional/extra clinics being undertaken where possible 1. Only 1f/t consultant and 1 p/t consultant who is covering nearly f/t hours. 2. Only 1 f/t consultant covering Trust wide. Unable to mitigate risk during a/l or unexpected absnece. Requirement to discuss with neighbouring Trust eg Notts. 3. Mitigated by high cost agency consultant cover. 4. CG lead duties shared between consultants but no one wishes to take on role. 5. HoS duties divolved to clinical lead for onc and haem and/or CD for CSS	* New referrals and PBWL show ongoing capacity issues. * RTT and cancer performance below target. * Increased PA's for substantive consultants. * Increased Datix, Complaints and PALS * Outcome from Staff Survey results	29/05/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	* Workforce review - Now Completed (Sarah Chester-Buckley - July 2023) * Refresher of Fragile Services Paper - NB there is a National shortage of Haematology consultants - Now completed (Sarah Chester-Buckley - September 2023) * Recruitment of further substantive consultants - (Sarah Chester-Buckley - May 2024) * Additional unfunded ST3+ for Haematology starts in August 2022 - Now completed (Sarah Chester-Buckley - July 2023)	[29/05/2024 09:01:54 Gemma Staples] Risk reviewed, ICB investment panel not to fund the Right Sizing Business Case in 2024/2025. A reduced Business case has been put forward for funding to the SDF panel. [24/04/2024 13:22:37 Nicola Cornish] Discussed at RRC&C on 24/04/24 - not in a position to reduce scoring yet despite recent appointments to vacant posts as this is still a very fragile service. Once new staff are in post and embedded, the score will be reviewed. [23/04/2024 13:06:20 Gemma Staples] Risk reviewed and still awaiting outcome of ICB investment panel [25/03/2024 10:09:19 Gemma Staples] Haematology rightsizing SJBC presented at ICB investment panel on 15th March, still awaiting outcome. Lymphoma tumour site cover, Haemostasis/haemophilia (single consultant Trust wide), Pilgrim Consultant cover & Audit Lead have all been appointed. Head of Service due to be advertised. [26/02/2024 16:46:18 Gemma] Transfusion Lead now appointed, start date 01.02.2024. Awaiting start date for Haemostasis/Haemophilia Consultant. [31/01/2024 14:33:09 Gemma] Risk reviewed and ongoing [18/01/2024 11:10:07 Gemma] Haematology rightsizing paper taken to TLT and approved, now needs to go to the Board and ICB investment panel. [22/12/2023 08:19:28 Gemma] Haematology rightsizing paper (SBJC) presented and approved at CRIG 19/12/23. Now needs to be presented at Board and ICB investment panel. Further update to be provided at a later date. [02/11/2023 15:31:05 Vicky Dunmore] Haem rightsizing business case to be present at CRIG Nov 2023 [14/09/2023 15:01:43 Rose Roberts] Rightsizing Haem paper to be presented at CRIG Sept 2023. [03/08/2023 10:00:17 Rachael Turner] Following the briefing paper being received	8	30/09/2023	01/04/2023	28/06/2024

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	4879	28	Physical or psychological harm	Frake-Harris, Julie	Lynch, Diane	Patient Safety Group		28/03/2022	20	Risk assessments	Clinical Support Services	Cancer Services CBU	Oncology		If there are significant delays within the planned care cancer pathway then patients may experience extended waits for diagnosis and surgery, resulting in failure to meet national standards and potentially reducing the likelihood of a positive clinical outcome for many patients	National policy: - NHS standards for planned care (cancer) ULHT policy: - Cancer care pathway & booking systems / processes - Clinical Harm Review (CHR) processes ULHT governance: - Lincolnshire System Elective Recovery meeting – Monthly - Lincolnshire system RTT Cancer and Diagnostic- Weekly - ULHT Cancer Recovery and Delivery – Weekly - ULHT Clinical Business unit meetings – Weekly - Integrated Performance Report (IPR) to Trust Board - Monthly - Divisional Performance Review Meeting (PRM) process - Clinical Harm Oversight Group	Cancer patients awaiting surgery - all within 31 days New standards: 28 days for first diagnosis; 62 day max wait	14/06/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	- Planned care recovery plan (cancer) - Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions	[14/06/2024 13:10:53 Gemma Staples] CSS requested advice at PRM for way forward. DL and AC subsequently met with JY on 6 June 2024. JY has asked for an update on where the Division is in relation to agency, temporary and substantive recruitment 'at risk' which had previously been approved by the COO in Spring 2023. Division will respond with this by 21 June 2024. [17/05/2024 13:32:32 Gemma Staples] Information received that this has not yet been supported at ICB investment panel. CSS will now review to see if the benefits realisation can provide a funding stream to enable some / all of the case to be supported to fit with the recently modified system business case process. [23/04/2024 13:03:48 Gemma Staples] Risk reviewed and still awaiting outcome of ICB investment panel [25/03/2024 10:05:36 Gemma Staples] Haematology rightsizing SJBC presented at ICB investment panel on 15th March, still awaiting outcome. [26/02/2024 16:48:25 Gemma] Risk reviewed and ongoing [31/01/2024 14:28:50 Gemma] Risk reviewed and ongoing [19/01/2024 10:02:18 Gemma] Haematology right-sizing SJBC was approved Dec 2023 to go to TLT, FPEC, Trust Board and ICB. Oncology right-sizing CoN still under preparation. [22/12/2023 13:10:45 Gemma] Haematology right-sizing paper presented to CRIG 19/12/2023. Approved to progress to ICB / Trust Board. Oncology right-sizing being prepared for next CRIG. [27/11/2023 13:49:23 Gemma] Rightsizing haematology paper approved at CRIG to progress to SJBC. SJBC has been draft and submitted. Oncology rightsizing CoN in development. COO approved recruitment 'at risk' ahead of the investment decision outcomes. Recruitment underway for medical, nursing and admin posts to support the services. New roles in development e.g. nurse consultant. Meetings with the COO continuing for support and oversight. [14/09/2023 14:59:30 Rose Roberts] Rightsizing Haem paper to be presented at	8	31/03/2023	31/03/2023	15/07/2024
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5101	487	Physical or psychological harm	Rivett, Kate	Herath, Dr Durga	Patient Safety 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;	21/05/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	1. Business case is being produced to enable establishment of fully funded epilepsy service 2. Agreement for spending has been obtained, moving forward. 3. In process of appointing 2 x epilepsy nurses, B6 has started, B7 was unable to start so back out to advert. 4. Epilepsy workshop with ICB	[21/12/2023 11:19:49 Nicola Cornish] Consultant caseload review commenced in order to apply RAG rating system to each case to enable identification of those most at risk. Reviewed 100 patients so far, 2 additional review dates to be scheduled. Nursing criteria to be changed shortly to focus on top tier most vulnerable patients. [21/11/2023 14:24:17 Kate Rivett] 21/11/23 - KR 1. Significant levels of risk remains as there are only x2 specialist nurses and x1 consultant to manage a cohort of in excess of 900 patients, some of whom have very complex epilepsy in addition to other vulnerability factors; 2. Business case being worked up in conjunction with ICB to seek additional funding to enable expansion of the team. [25/10/2023 11:47:32 Rachael Turner] Risk discussed at RRC&C meeting 25/10/2023, risk to remain at Very High risk. [17/10/2023 14:06:09 Nicola Cornish] Appointed 2 nursing staff members, service making progress in establishing numbers that can be seen, gap analysis undertaken against NICE guideline - need to break this down further into key factors required to deliver service. Benchmarking completed, need to complete NICE baseline assessment form. [15/08/2023 13:26:59 Jasmine Kent] 2nd nurse has now started but issues ongoing with tertiary support with Nottingham. Difficulties completing epilepsy 12 audit. Risk remains same for now.	8	14/03/2024	16/02/2024	21/06/2024
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5016	22	Physical or psychological harm	Hamer, Fiona	Smith, Charles	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	06/06/2024	Quite likely (4) 71-90% chance	Extreme (5)	Very high risk (20-25)	20	Capital programme ongoing at Lincoln County ED - will increase clinical space Full Business Case approved at organisational level to support new build for Pilgrim ED System support with the introduction of Breaking the cycle - to create flow in hospital supporting the reduction of ED overcrowding Increased nursing template agreed by Director of Nursing for EDs Demand and Capacity work to review medical staffing in ED	{06/06/2024 11:51:02 Rachael Turner] Ongoing work in place for long lengths in stay. There is a discharge work progress team in place. 78% performance project currently in place which is supported by the improvement team. [10/05/2024 12:02:11 Rachael Turner] Risk reviewed, following presentation at RRC&C there have been no further updates. Risk score to remain. [24/04/2024 13:30:50 Nicola Cornish] Discussed at RRC&C meeting on 24/04/24 - have been improvements but not in a position to reduce the scoring yet. Need to review controls and actions to reflect the work that has been done and is still ongoing. [15/04/2024 10:59:26 Rachael Turner] Flow is improving slightly. SAFER has been implemented. Risk currently remains with same scoring. [05/03/2024 09:09:07 Rachael Turner] Risk reviewed, no change. [07/02/2024 09:17:37 Rachael Turner] Risk reviewed, no change. [09/01/2024 15:07:09 Rachael Turner] Risk reviewed. We have introduced cohorting to offload ambulances. We are holding medical colleagues accountable for discharges. But overcrowding still stands. Risk score to remain. [13/12/2023 16:47:38 Rachael Turner] No significant update to this risk, flow expected to ramin challenging across winter. Re: implementation of SAFER process but not yet seen consistent improvement" [20/11/2023 20:22:32 Rachael Turner] No current change, risk score to remain. [17/10/2023 10:08:18 Rachael Turner] No current change, currently huge risk due to lack of flow. Increase in patients that need admitting and require treatment whilst waiting for beds. Staffing has increased in this area to decrease patient harm. The professional standards have been introduced to clinicians for them to see patients within 30 minutes, this is being audited for compliance. The continued flow policy has reintroduced but this risk still remains at the same score. [30/08/2023 11:25:49 Carl Ratcliff] To review post meeting with execs on 30th	10	02/09/2023	31/03/2024	06/07/2024

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	4740	37	Physical or psychological harm	Cooper, Mrs Anita	Chester-Buckley, Sarah	Patient Safety Group	Outpatient Improvement Group	13/01/2022	15	Risk assessments	Clinical Support Services	Cancer Services CBU	Haematology (Cancer Services)	Trust-wide	Demand for Haematology outpatient appointments exceeds consultant staffing capacity. High Consultant vacancy levels affecting clinic capacity, performance and review of inpatients. The areas of concern are: unfilled leadership roles (in practice head of service and clinical governance lead). Due to haematology patients having long term conditions, they are required to have regular review and those on cancer treatment are time critical. If we are not able to meet the demands of the service this potentially could cause severe harm to the patients. At the end of October 2023 there are 1074 overdue haem pt (237 at phb and 837 at LCH). From 1 Oct 22 until 2/11/2023 the haematologists have held 318 extra clinics which equates to 178 news and 2017 F/U. Haemostasis in particular pt are waiting almost triple the time that they have been graded at. There are 578 pt on this consultant PBWL with 232 being overdue. The longest waiter was due an appointment around March 2023. This consultant is holding on average 3 extra clinics per month.	Overbooking of consultant clinics (unsustainable); introduction of nurse-led clinics to manage demand. Long and short term Locum Consultant used to cover vacancies. Ad-hoc additional clinics outside of consultant job plan	Monitoring of outpatient appointments Clinical harm reviews & reported incidents	29/05/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	* Workforce review - Now Completed (Sarah Chester-Buckley - July 2023) * Refresher of Fragile Services Paper - NB there is a National shortage of Haematology consultants - Now completed (Sarah Chester-Buckley - September 2023) * Recruitment of further substantive consultants - (Sarah Chester-Buckley - May 2024) * Additional unfunded ST3+ for Haematology starts in August 2022 - Now completed (Sarah Chester-Buckley - July 2023)	[29/05/2024 09:03:11 Gemma Staples] Risk reviewed, ICB investment panel not to fund the Right Sizing Business Case in 2024/2025. A reduced Business case has been put forward for funding to the SDF panel. [24/04/2024 14:58:48 Nicola Cornish] Discussed at RRC&C - oncology is still a fragile service and not in a position to reduce scoring yet. [23/04/2024 13:06:42 Gemma Staples] Risk reviewed and still awaiting outcome of ICB investment panel [25/03/2024 10:12:38 Gemma Staples] Lymphoma tumour site cover, Haemostasis/haemophilia (single consultant Trust wide), Pilgrim Consultant cover & Audit Lead have all been appointed. Head of Service due to be advertised. [25/03/2024 10:10:28 Gemma Staples] Haematology rightsizing SJBC presented at ICB investment panel on 15th March, still awaiting outcome. [26/02/2024 16:51:08 Gemma] Appointed three new Consultants, one at Lincoln and two at Boston. One started on 13.02.2024, awaiting start date for Haemostasis/Haemophilia Consultant and third Consultant due to start in August. [31/01/2024 14:33:38 Gemma] Risk reviewed and ongoing [18/01/2024 11:21:10 Gemma] Haematology rightsizing paper taken to TLT and approved, now needs to go to the Board and ICB investment panel. [22/12/2023 08:21:34 Gemma] Haematology rightsizing paper (SBJC) presented and approved at CRIG 19/12/23. Now needs to be presented at Board and ICB investment panel. Further update to be provided at a later date. [06/11/2023 08:53:30 Vicky Dunmore] updated PBWL, clinic and new appt figures [14/09/2023 14:57:46 Rose Roberts] Rightsizing Haem paper to be presented at CRIG Sept 2023. [01/08/2023 15:20:30 Rachael Turner] Update provided from Lauren Rigby-we are now having weekly meetings with the COO and at risk recruitment is happening. [02/06/2023 12:40:22 Maddy Ward] Andrew Morgan requested a briefing paper	3	01/04/2023	01/04/2023	28/06/2024
3b. Make efficient use of our resources	4664	5	Finances	Young, Jonathan	Picken, David	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)	13/06/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Financial Recovery Plan schemes: - recruitment improvement; - medical job planning; - agency cost reduction; - workforce alignment	[13/06/2024 13:54:04 Rachael Turner] In 2023/24, agency pay expenditure of £32.6m was £3.0m lower than plan and £18.4m lower than expenditure of £51.0m in 2022/23. The reduction in agency pay expenditure was achieved through the active management of recruitment into vacancies and movement from agency staffing to bank staffing. In 2024/25, the Trust's financial plan requires a further, similar sized reduction in agency expenditure to that delivered in 2023/24 i.e., the Trust requires to make a reduction of £18.2m in 2024/25 compared to the reduction of £18.4m it made in 2023/24. In 2023/24, £13.3m (72%) of the reduction related to registered nursing and midwifery and only £1.4m (7%) related to medical & dental. However, with medical & dental accounting for £19.2m (59%) of the spend in 2023/24, the focus for savings in 2024/25 is now more in relation medical & dental than any other staff group. The 2024/25 financial plan requires agency expenditure to reduce: •From £6.3m in the first financial quarter of the year [from £2.3m in April 2024 down to £2.0m in June 2024]. •To £3.7m in the second financial quarter of the year [from £1.3m in July 2024 to £1.2m in September 2024]. •To £2.7m in the third financial quarter of the year [from £1.0m in October 2024 to £0.8m in December 2024]. •To £1.8m in the final quarter of the year [from £0.7m in January 2025 to £0.4m in March 2025]. Agency expenditure YTD of £5.2m is £1.0m lower than spend of £6.1m in the	8	31/03/2023	31/03/2024	13/07/2024
3a. A modern, clean and fit for purpose environment	4647	1	Reputation	Frake-Harris, Julie	Davey, Kelron	Fire Safety Group	Fire Safety Group	14/12/2021	20	External Inspections	Corporate	Estates and Facilities	Fire and Security	Trust-wide	If Lincolnshire Fire & Rescue Service (LFRS) carries out an inspection and finds the Trust to be systemically non-compliant with fire safety regulations and standards it could result in regulatory action and sanctions, with the potential for financial penalties and disruption to services if sites are required to close.	National policy: - Regulatory Reform (Fire Safety) Order 2005 - NHS Fire safety Health Technical Memoranda (HTM 05-01 / 05-02 / 05-03) ULH policy: - Fire Policy (approved April 2019, due for review April 2022) & related procedures / protocols / records - Fire & Security Team / Fire Safety Advisors ULH governance: - Fire Safety Group / Fire Engineering Group, accountable to Trust Board through Finance, Performance & Estates Committee (FPEC) - Health & Safety Committee & site-based H&S committees	- Compliance audits against fire safety standards - Progress with fire safety improvement plans - PPM compliance assurance (current lack of required detail for internal and regulator assurance)	13/06/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	- Statutory Fire Safety Improvement Programme based upon risk - Policy and protocols framework and improvement plan reported into weekly Estates teams meeting - Progress reviewed by FEG and FSG monthly, to mitigate against the risk of sanctions - LFR involvement and oversight through the FSG - Regular updates with LFR provided indicating challenges during winter pressure and Covid - Fire safety audits being conducted by Fire Safety team - Fire wardens in place to monitor local arrangements with Fire Safety - Weekly Fire Safety Checks being undertaken - Improve PPM reporting for FEG and FSG By Estates Teams - Fire safety team weekly Risk assessment confirm and challenge reviews by Fire safety team - All areas of Trust allocated RAG rating for fire using using occupancy profile, escape provision, height above ground and sleeping risk - Higher rated residual risks from risk assessments being incorporated into risk	[13/06/2024 14:18:00 Rachael Turner] Risks are presented to FEG for confirm, challenge and review. following the meeting the risks are escalated to FSG and presented to trust health and Safety committee. [13/06/2024 13:57:11 Rachael Turner] No change risk score remains. [10/05/2024 14:39:55 Rachael Turner] No change mapping exercise continues on fire doors and work to commence shortly on Damper mapping. survey of new fire doors undertaken at Pilgrim and Lincoln [11/04/2024 12:29:32 Rachael Turner] No change to Risk score as work continues with remedial action on compartmentation. 39 new doors on order and 2 year fire door remedial risk based programme prepared. additional joiners roles advertised. Compartmentation works ongoing based upon risk, new fire alarm and remedials works tender specification complete for marketplace April/May 2024. fire warden number continue to rise across divisions [15/03/2024 13:31:16 Rachael Turner] While works has commenced and continues regarding fire doors and compartmentation remedial actions. The risk remains until the conclusion of such remedial actions. [12/03/2024 11:05:57 Rachael Turner] Risk reviewed, no change [26/02/2024 11:29:05 Rachael Turner] Risk reviewed, no change from previous months update. [16/01/2024 13:22:28 Rachael Turner] Fire Risk Assessments are progressing based on risk priority. Review outstanding actions from previous FRA's, using FS trainer. Compartmentation (Passive): completed all 3 sites fire protection surveys, Capital teams are commencing remedial works based upon risk Fire Door Inspection: action by competent contractor, LCH and Grantham Complete. anticipated date of completion for PHB Dec 2023. Fire Alarm Systems: design of a new Pilgrim fire alarm system by capital teams.	4	30/06/2022	31/03/2024	15/07/2024

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
3a. A modern, clean and fit for purpose environment	5415	626	Service disruption	Parkhill, Michael	Whitehead, Mr Stuart	Medical Gasses Working Group		10/04/2024	12		Corporate	Estates and Facilities	Estates	Grantham & District Hospital	Grantham Site Medical Air Plant failure/limited functionality. The current medical air plant has 2 associated compressors of which are of an age where failure is likley, the units are MIM manufacturer who no longer are trading. one compressor has failed and the site is operating on one compressor only supported by an emergency manifold cylinder. The compressors are beyond life and obsolete, at this time there are no abilities to repair the failed unit and replacement is required. at present if the only remaining unit fails, the site will be operating on a cylinder manifold designed only for emergency use with limited time capacity. This failure will impact on all surgical services	one compressor still functioning with increased service support and back up emergency manifold, along with back flow feed kits available, but this is not sufficient to reduce risk enough.	inspection and service monitoring	14/06/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	short term solution is to provide a hire set medical gas compressor system in replacement of the existing unit, this is at a substantial cost and not a long term effective strategy. long term plan is for a medical gas compressor plant replacement.	[14/06/2024 11:14:16 Rachael Turner] Risk reviewed, no change at present. Risk score remains the same. [16/05/2024 18:06:34 Rachael Turner] Replacement costs received and capital scheme in process of being developed for replacement following 1 compressor failure. Plant needs to be added to capital list for 2024/25. [24/04/2024 12:54:04 Nicola Cornish] Discussed at RRC&C meeting on 24/04/24. Need to add potential timescales for replacement of plant. Agreed for this to be added to register with a score of 20.	4	10/07/2024		14/07/2024
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5143	63	Service disruption	Lynch, Diane	Parkin, Mr Lee	Trust Leadership Team	Group, Information Governance Group, Outpatient Improvement Group, Patient Safety	13/04/2023	25		Clinical Support Services	Outpatients CBU	Choice, Access and Booking	Pilgrim Hospital, Boston	The demolition of H Block will remove facilities and amenities that the health records teams utilise. The impact of removing the lift will restrict the movement of patient notes and potentially the number of patients being seen in outpatients. The health records team will need to move notes in the dumbwaiters which is previously resulted in injury and legal action. With using the dumbwaiters, this will impact information governance and security of notes due to the storage and location. Staff morale will be impacted due to extra manual handling and loss of amenities required to support with mitigating this risk. This risk also has an impact on staff workload due to extra time the tasks will now take, this will also have a knock on effect to other services such as porters, secretaries. With no lift to support the department if any large items fail i.e printer or racking, replacement items will be unable to be delivered.	There is addition of dumb waiter(x2). Health & Safety risk assessment on the dumbwaiters limits the capacity to two boxes. Process in place to ensure notes are either with a member of staff or in lockable storage areas.	Patient cancellation, waiting times and waiting list increase for patients due to patient notes being unavailable or delayed. Staff survey results. Staff sickness/injury through Occupational Health and ESR.	03/06/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	To reduce the impact the team will use dumb waiters, one of which is in another area with limited access. Change of processes to mitigate risk and transfer notes over a longer period. Walk around with senior individuals and project team to look at different ways of working and potential solutions. Risks to be highlighted in QIA. Risk to presented at PRM. Health and Safety guidance to be delivered to Team. Further discussions to be had regarding whether all clinicians requiring paper based notes in clinic.	[03/06/2024 11:03:37 Gemma Staples] We have a new date of September of the lift being installed and the dumb waiter being upgraded. We have lost further staff due to the environment. [23/05/2024 16:33:23 Gemma Staples] In discussion with estates and facilities, the project manager has left the Trust, lift in danger of being delayed further due to issues accessing room for surveys. Continued issues accessing room and until resolved there is a risk to timeframes for the lift being installed. Continued discussions with project team. [26/04/2024 10:22:29 Gemma Staples] Risk presented at RRC&C 26/03 and agreed to stay at 20. Support from Trust COO, must be no slippage on planned installation date (Aug 2024). [26/03/2024 09:25:47 Laura Kearney] Risk as below, however new lift installation now estimated for August. Agreed that dumb waiter in clinical coding is to be upgraded and dumb waiter in outpatient office to be fixed. Gradient of ramp in health records/clinical coding to be reviewed (currently too steep). In addition 20 staff have now left the department since original lift removed, in comparison to 6 leavers during the same period prior, thus reducing the experience/knowledge in the department. [28/02/2024 11:27:56 Rachael Turner] Risk presented at RRC&C meeting 28/02/2024. Risk reduction plan has gone as far as it can go, there is a handful of temporary staff in place. This is being operated day by day. Five members of staff have been injured due to this and there are increasing staff pressures with stress. The end point is a new lift in June, the dumb waiter is also being updated as funding has been secured. Until this point risk to be increased 4x4: 20 [14/02/2024 11:29:24 Rachael Turner] The risk rating has been requested to be increased by the QIA panel (including Karen Dunderdale / Kathryn Helley / Paul Dunning) due to issues with getting notes to clinics and the cancellation of patients, the health and safety risk of other areas of the hospital as notes are	1	01/05/2023		03/07/2024
1c. Improve clinical outcomes	4828	31	Physical or psychological harm	Farquharson, Colin	Costello, Mr Colin	Medicines Quality Group	Digital Hospital Group, Patient Safety Group	17/01/2022	20	Risk assessments	Clinical Support Services	Pharmacy CBU	Pharmacy	Trust-wide	The trust currently uses a manual prescribing process across all sites, which is inefficient and restricts the timely availability of patient information when required by Pharmacists. Where information about patient medication is not accurate, up to date and available when required by Pharmacists then it could lead to delays or errors in prescribing and administration, resulting in a widespread impact on quality of care, potentially reducing the likelihood of a positive clinical outcome and/or causing serious patient harm	National policy: - NICE Guideline NG5: Medicines optimisation, etc. ULHT policy: - Policy for Medicines Management: Sections 1-8 (various approval / review dates) ULHT governance: - Trust Board assurance via Quality Governance Committee (QGC) / Medicines Quality Group (MQG)	Medication incident analysis Audit / review of medicines management processes - the Trust currently uses a manual prescribing process across all sites, which is inefficient and restricts the timely availability of patient information when required by Pharmacists.	11/06/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Planned introduction of an auditable electronic prescribing system across the Trust. update 4th July 22- 26th july, empa functionality version 10.21 will be upgraded. Epma pilot from 13/09/22, full trust wide roll out- mid oct	[11/06/2024 09:59:34 Gemma Staples] Risk reviewed and confirmed to be reassigned to Digital Team. Rachel Turner to discuss with Digital Team and confirm who to assign as the handler. [09/05/2024 08:56:06 Gemma Staples] Risk reviewed and remains the same. [04/04/2024 08:54:58 Lisa Hansford] no update [07/03/2024 14:08:02 Lisa Hansford] Although epma has now been fully rolled out, there are new risk as a result. New risk assessment to be developed and added to RR. [13/02/2024 13:04:52 the reporter] EPMA is now rolled out across all adult inpatient areas. The risk will now be monitored and review how effective the EPMA system is. [17/01/2024 12:08:04 Gemma] EPMA is currently being rolled out. The will be in all adult inpatient areas by 22nd January. [21/12/2023 13:28:32 Divisional Dashboards] Lisa-Marie Moore: epma roll out currently in final stages for inpatients with only pilgrim surgical areas left and due to be rolled out from 15th January (delayed roll out due to Drs strikes) will then be reflection and review of implementing to further areas - outpatients and maternity. paediatric electronic prescribing not currently supported by the current epma system to meet mhra requirements [29/11/2023 11:12:37 Rachael Turner] Risk discussed at RRC&C meeting 29/11/2023 roll out to sites has taken place. This risk needs to be reviewed as risk reduction plan needs updating. This risk needs a full review to whether it needs reducing and/or making a site risk. [01/11/2023 13:10:29 Rachael Turner] Work ongoing to be rolled out by the end of the year. [26/09/2023 14:04:28 Rachel Thackray] Planning to complete roll out by the end of the year. Ongoing work to implement.	4	31/12/2023	01/04/2024	11/07/2024

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	4947	27	Physical or psychological harm	Sakthivel, Mr Kulandaivel	Saddick, Ahtisham	Medicines Quality Group	Clinical Effectiveness Group	17/06/2022	20	Policy/Protocol Issues	Clinical Support Services	Pharmacy CBU			There is an issue in which the Trust is failing to meet NICE medicines reconciliation targets on a consistent basis and not being able to review discharges. This is caused by lack of pharmacy resource. Resulting in potential for patient harm due to incorrect or delayed medication, financial implications due to increased length of stay or unnecessary supply and risk of continuation of errors onto the discharge letter and further more into the community.	NICE guidance NG5 states that in an acute setting, that we should accurately list all of the patient's medicines (including prescribed, over-the-counter and complementary medicines) and carry out medicines reconciliation within 24 hours or sooner if clinically necessary, when the person moves from one care setting to another – for example, if they are admitted to hospital.	We conduct monthly medicines reconciliation audits, which consistently have shown us failing to meet NICE targets and we are operating significantly below the national average. This audit is presented at the MQG.	11/06/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	There are many options but we are utilising these; - We have prioritised pharmacist and technician cover to acute admission areas as patient turnover is highest on these areas and gives us to best opportunity to conduct a medicines reconciliation under 24 hours - We prioritise patients which have stayed in the longest and have critical medication where known. Prioritisation of the highest risk patients decreases the risk of harm - No ward visits are divided as much as possible. To significantly reduce this risk requires additional ward based pharmacy staff cover across 7 days.	[11/06/2024 10:39:16 Lisa Hansford] risk reviewed and remains the same [09/05/2024 08:53:19 Gemma Staples] Risk reviewed and remains the same. [04/04/2024 08:45:37 Lisa Hansford] No further update [07/03/2024 14:18:16 Lisa Hansford] no further update [17/01/2024 12:05:07 Gemma] No further update [29/12/2023 13:53:23 Lisa Hansford] No further update [19/12/2023 13:26:38 Lisa-Marie Moore] phase 2 pharmacy improvement plan in development. meeting with MD 18/12 to discuss prioritisation of business cases [07/11/2023 14:13:38 Lisa Hansford] Update- DMS implementation has been affected as a consequence of low medicines reconciliation figures. Pharmacists are not clinically screening/reviewing discharges therefore this is an additional gap in the service which inhibits uptake of DMS. Core clinical pharmacy services such as medicines reconciliation and discharge screening allow additional services such as DMS to be implemented, without the former it is not possible to implement DMS [26/09/2023 14:06:35 Rachel Thackray] To meet with Medical Director to discuss lack of progress [07/09/2023 14:03:55 Lisa Hansford] 07.09.23 no changes to current situation [03/08/2023 14:48:59 Lisa-Marie Moore] No further updates [27/06/2023 09:47:37 Alex Measures] Discussed in risk register review meeting- no further updates [01/06/2023 14:17:45 Lisa-Marie Moore] No change/updates since previous entry [04/05/2023 14:12:22 Lisa Hansford] As advised at confirm and challenge meeting. Lack of compliance with national standards. [06/04/2023 13:07:13 Paul White] Discussed at Risk Register Confirm & Challenge 29 March. Risk agreed and feedback provided for consideration. [21/02/2023 08:47:37 Paul White] Note from Risk Register Confirm & Challenge	8	30/06/2023	31/12/2024	11/07/2024
2b. Making ULHT the best place to work	4948	50	Physical or psychological harm	Cooper, Mrs Anita	Walker, Helen	Health and Safety Group, Medicines Quality Group, Patient Safety Group		17/06/2022	20	Workforce Metrics	Clinical Support Services	Pharmacy CBU			Workload demands within Pharmacy persistently exceed current staffing capacity which leads to longer working hours (inc weekends), work related stress resulting in serious and potentially long-term effects on staff health and wellbeing. Adding to this with additional workload demands with insufficient staffing, or required level of experience and skill, the risk is patients will not be reviewed by a pharmacist leading to poorer clinical outcomes, reduced flow on acute wards, delayed discharges and increased risk of omitted medicines. For staff the risk is long term absence. This may result in the failure to meet the national and local targets for KPIs	Business Continuity Plans on ward coverage when staffing low	Sickness rates/vacancy rates and staff turnover - highlight that retention is problematic at current. Staff survey highlights issues low staff morale within the department. Medicines reconciliation, datix incidents and omitted doses highlight that the trust is underperforming and not meeting targets at current	11/06/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Review current provision and identify gaps in service to inform business cases for change to support 7 day working (working with Surgery and Medicine Divisions as appropriate). Skill mix requires review due to complexity of patients.. Pragmatic management of workload & provision of management support. On-going exploration of recruitment options. Wellbeing team supporting staff - regular visits organised	[11/06/2024 10:37:25 Lisa Hansford] Risk reviewed and remains the same [09/05/2024 08:51:41 Gemma Staples] Risk reviewed and remains the same. [04/04/2024 08:44:22 Lisa Hansford] No further update [07/03/2024 14:16:19 Lisa Hansford] Current trial at Lincoln having a more comprehensive stock list on wards, focussing on TTo's and non stock item requests to manage work load. This is a back word in terms of patient safety and does not pharmacy strategy. This risk remains moderate as this approach is reactive and does not solve the issues. [13/02/2024 16:38:34 Gemma] Risk reviewed and no change [17/01/2024 12:04:24 Gemma] No further update [21/12/2023 13:30:51 Divisional Dashboards] Lisa- Marie Moore: Ongoing challenges. Demonstrable workload increase particularly on weekends across all sites. Phase 2 work plan development to review pharmacy workforce [27/11/2023 14:55:44 Rachael Turner] Risk remains with staffing challenges, no update. [26/09/2023 14:08:09 Rachel Thackray] Staffing vacancies still remain a challenge [03/08/2023 14:48:27 Lisa-Marie Moore] No further updates [27/06/2023 09:47:53 Alex Measures] Discussed in risk register review meeting- no further updates [01/06/2023 14:17:03 Lisa-Marie Moore] No change since previous entry [04/05/2023 14:07:20 Lisa Hansford] no update awaiting review on basis of reputational risk as advised at confirm and challenge meeting 29/03/23 [06/04/2023 12:52:25 Paul White] Discussed at Risk Register Confirm & Challenge 29 March, risk agreed with feedback provided for consideration. [07/02/2023 13:29:22 Rachael Turner] Risk updated to be lead by PODC committee. Requires validation at Confirm and Challenge due to current score. Division to review risk score and attend Confirm and Challenge meeting. [05/01/2023 14:05:09 Lisa-Marie Moore] No change from previous update	8	30/06/2023	02/10/2023	11/07/2024
3a. A modern, clean and fit for purpose environment	4648	2	Physical or psychological harm	Frake-Harris, Julie	Davey, Keiron	Fire Safety Group	Emergency Planning Group, Health and Safety Group	15/12/2021	20	Risk assessments	Corporate	Estates and Facilities	Fire and Security	Trust-wide	If a fire occurs on one of the Trust's hospital sites and is not contained (due to issues with fire / smoke detection / alarm systems; compartmentation / containment) it may develop into a major fire resulting in multiple casualties and extensive property damage with subsequent long term consequences for the continuity of services.	National policy: - Regulatory Reform (Fire Safety) Order 2005 - NHS Fire safety Health Technical Memoranda (HTM 05-01 / 05-02 / 05-03) ULH policy: - Fire Policy (approved by FEG / FSG Sept 2022 - awaiting final approval / signature to be HTM compliant): # Personal Emergency Evacuation Plans (PEEPs), approved April 2017 - Fire safety training (Core Learning, annual) / Fire Warden training / Fire specialist training - review / protocol in draft, TNA in draft for Fire Safety Team review - Major Incident Plan - Estates Planned Preventative Maintenance (PPM) programme ULH governance: - Trust Board assurance through Finance, Performance & Estates Committee (FPEC) / lead Fire Safety Group (including divisional clinical representation & regulator attendance) / Fire Engineering Group - All areas within the Trust estate are individually risk rated for fire safety (based on occupancy, dependency, height, means of escape), which informs audit / monitoring activity - Local fire safety issues register (generated from local fire risk assessments) - tasks allocated to Estates / local managers, etc. as appropriate; tracked and monitored by Fire Safety Team, validation by Fire & Rescue Service - Weekly fire safety team meetings concerning risk assessments and risk register - Capital risk programme for fire - Reporting of local fire safety incidents (Datix) generated through audit programme - Authorising Engineer for Fire - Health & Safety Committee & site-based H&S committees	Results of fire safety audits & risk assessments, currently indicate: - Fire Risk assessments within Maternity Tower block Lincoln indicating substantial breaches of compartmentation requirements - Fire risk assessments indicate lack of compartmentation within some sleeping risk areas - Age of fire alarm systems at all 3 sites (beyond industry recommendations) - No compartmentation reviews undertaken to provide assurance of existing compliance (all 3 sites) - Concerns with networking of fire alarm system at Pilgrim (to notify Site Duty Manager / Switchboard of alarm activation) Reported fire safety incidents (including unwanted fire signals / false alarms)	13/06/2024	Quite likely (4) 71-90% chance	Extreme (5)	Very high risk (20-25)	20	- Capital investment programme for Fire Safety being implemented on the basis of risk - costed budget plan for FEG submission Sept 2022. - Trust-wide replacement programme for fire detectors. - Fire Doors, Fire/Smoke Dampers and Fire Compartment Barriers above ceilings in Pilgrim, Lincoln and Grantham require improvements to ensure compliant fire protection. - Fire safety protocols development and publication. - Fire drills and evacuation training for staff. - Fire Risk assessments being undertaken on basis of inherent risk priority; areas of increased residual risk to be added to the risk register for specific action required - Local weekly fire safety checks undertaken with reporting for FEG and FSG. Areas not providing assurance receive Fire safety snapshot audit. - Staff training including bespoke training for higher risk areas - Planned preventative maintenance programme by Estates	[13/06/2024 14:18:49 Rachael Turner] Fire door assurance review being conducted by Fire safety team. compartmentation ventilation damper mapping exercise being undertaken by fire safety and CAFM team [13/06/2024 13:56:21 Rachael Turner] No change, risk score remains. [10/05/2024 14:42:03 Rachael Turner] No change in score as work continues on fire doors, compartmentation and damper mapping. new door surveyed at Pilgrim and Lincoln. [11/04/2024 12:32:39 Rachael Turner] No change to Risk score as work continues with remedial action on compartmentation. 39 new doors on order and 2 year fire door remedial risk based programme prepared. additional joiners roles advertised. Compartmentation works ongoing based upon risk, new fire alarm and remedials works tender specification complete for marketplace April/May 2024. fire warden number continue to rise across divisions, Fire drills continue across trust areas. [15/03/2024 13:30:41 Rachael Turner] While works has commenced and continues regarding fire doors and compartmentation remedial actions. The risk remains until the conclusion of such remedial actions. [12/03/2024 11:05:16 Rachael Turner] Risk reviewed, no change [26/02/2024 11:26:38 Rachael Turner] Risk reviewed, no change from previous months update. [16/01/2024 13:25:33 Rachael Turner] Fire Risk Assessments are progressing based on risk priority. Review outstanding actions from previous FRA's, using FS trainer. Compartmentation (Passive): completed all 3 sites fire protection surveys, Capital teams are commencing remedial works based upon risk Fire Door Inspection: action by competent contractor, LCH and Grantham Complete. anticipated date of completion for PHB Dec 2023.	10	31/03/2022	31/03/2025	15/07/2024

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5100	487	Physical or psychological harm	Rivett, Kate	Herath, Dr Durga	Patient Safety 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;	10/06/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	1. Multi-professional working group tasked with delivering improvements that will support achievement of audit compliance.	[10/06/2024 15:10:51 Nicola Cornish] No change [21/05/2024 13:15:59 Nicola Cornish] Risk reviewed, no further progress. [09/04/2024 11:24:36 Nicola Cornish] A business case is being developed for expanding the epilepsy nursing team. [13/03/2024 09:12:22 Nicola Cornish] Benchmarking has been completed - initial review suggests that the outstanding gaps relate to the community service rather than acute. Further discussion required with Dr Herath to confirm this - if there are no further acute actions this risk could be closed. If Dr Herath confirms ongoing acute concerns, the risk will remain open but scoring may be reduced. [14/02/2024 14:54:26 Nicola Cornish] No change. Business case meeting this week to progress so that bid can be submitted to ICB for funds. [10/01/2024 14:26:18 Nicola Cornish] No change. Need to complete benchmarking. [16/11/2023 16:25:11 Nicola Cornish] No change as per discussion at RRC&C meeting on 07/11. [07/11/2023 11:31:43 Helen Shelton] Reviewed at the RRC&C meeting and agreed that despite the appointment of 2 epilepsy nurses the risk remains very high at 20 as A further BC is now required to improve the service further. [11/09/2023 15:33:59 Jasmine Kent] Both epilepsy nurses have started and have been asked to see newly diagnosed epilepsy patients, asked to take on cohort of complex patients so parents are receiving better support. For reduction to a 16 on both acute and community paeds. Tertiary engagement has been escalated to ICB. As agreed at RRCCG - for reduction to a 16. [14/08/2023 14:30:44 Jasmine Kent] 2 nurses now in post, risk remains very high due to difficulty engaging with tertiary neurology. [10/07/2023 13:47:04 Jasmine Kent] Requires discussion at governance and with	8	14/03/2024		10/07/2024
3b. Make efficient use of our resources	5020	6	Finances	Hamer, Fiona	Smith, Charles	Workforce Strategy Group	WORK	02/09/2022	20		Medicine	Urgent and Emergency Care CBU			If there is a continued reliance on bank and agency staff for medical workforce in Urgent & Emergency Care there is a risk that there is not sufficient fill rate for medical rotas both ward / department fill and on call shifts which will impact on patient safety and have a negative impact on the CBU budget	Robust medical plan for every post meetings Close working with temporary medical staffing team Daily management of any gaps to support minimum staffing levels Fundamental overview of tier 1 and tier 2 docs in medicine and ED based on RCP safer staffing levels. Introduction of BMA rate cards This will reduce once output on medical workforce plan is in place, not due to come online in this review period.	Plan for every post meetings Budget reports	06/06/2024	Quite likely (4) 71-90% chance	Extreme (5)	Very high risk (20-25)	20	Robust recruitment plan International recruitment Medical Workforce Management Project	[06/06/2024 11:52:13 Rachael Turner] This is being monitored by TSSG and ongoing recruitment and retention plans as a CBU. [10/05/2024 12:04:33 Rachael Turner] Risk reviewed.Ongoing challenge. For ED T2 workforce rota implementation going through job planning process. Acute staffing plan dependent on outcome of budget setting process for 2024/25, awaiting update as of 10/05. [15/04/2024 11:08:21 Rachael Turner] Ongoing challenge for requirement for agency and bank backfill to make department safe. T2 workforce continues, aim for completion Q3/Q4. Risk score remains. [05/03/2024 09:10:47 Rachael Turner] Risk reviewed, no change. [07/02/2024 09:16:42 Rachael Turner] Risk reviewed, no change. [09/01/2024 15:13:18 Rachael Turner] Consultation ongoing with completion due end of Feb/March. Risk currently remains the same. [13/12/2023 16:48:28 Rachael Turner] Improvement seen against Acute and GIM rotas after recruitment. However significant spend still re: ED T2 staff due to ongoing consultation. Resolution expected early 2024 with implementation Fed/March 2024. Ongoing impact of IA also to be considered." [20/11/2023 20:25:40 Rachael Turner] Work ongoing, posts waiting to be filled. Agency and bank continue to backfill. [17/10/2023 10:09:53 Rachael Turner] Consultation in place for medical workforce, funding has been agreed but remains covered by bank and agency until posts can be filled. [26/09/2023 14:44:54 Charles Smith] Risk remians the same but recruitment across Acute/GIM rotas improving over next couple of months. Ongoing impact of Strikes. Tler 1 and 2 in place for med, ongoing tier 2 consultation ED. [15/08/2023 11:14:12 Helen Hartley] Remains the same, plans for recruitment and money signed off. Stays the same until recruitment piece has happened. There is a trajectory for this, beginning 2024.	10	02/09/2023		10/07/2024
1c. Improve clinical outcomes	4731	33	Physical or psychological harm	Frake-Harris, Julie	Dunning, Mr Paul	Medical Records Group	Patient Safety Group	13/01/2022	20	Risk assessments	Corporate	Operations	Operations	Trust-wide	If patient records are not complete, accurate, up to date and available when needed by clinicians then it could have a widespread impact on clinical services throughout the Trust, potentially resulting in delayed diagnosis and treatment, adversely affecting patient experience and reducing the likelihood of a positive clinical outcome.	- Clinical Records Management Policy (approved June 2021, due for review December 2023) - Trust Board assurance via Finance, Performance & Estates Committee (FPEC); lead Information Governance Group / Clinical Records Group - Now led by Deputy Medical Director.	Internal audit of medical records management processes - reliance upon hard copy patient records; patients may have multiple sets of records. Reported incidents involving availability of patient records issues.	26/04/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Design and delivery of the Electronic Document Management System (EDMS) project, incorporating Electronic Patient records (EPR). Interim strategy required to reduce the risk whilst hard copy records remain in use.	[26/04/2024 10:19:13 Gemma Staples] Lee Parkin met with Paul Dunning. Medical directors office to review if patient clinical information is stored on an electronic system is it necessary to add to paper notes, await update. This risk will significantly reduce one EDMS (digital records) introduced. [25/04/2024 14:08:17 Gemma Staples] Following a review of the risk with Colin Farquharson it was agreed that the risk sit under COO instead of Outpatients CBU. Risk now updated. [26/03/2024 09:33:18 Laura Kearney] CSS Interim GM, Lee Parkin, met with Paul Dunning, Medical Directors Office. Paul is of the opinion that any medical information held om electronic systems is not required to be printed and added into paper based notes, reducing reliance on such notes and therefore reducing the risk. Mr Dunning will take this suggestion to the Medical Director team to confirm whether required to go to MAC for sign-off, or whether this can be conveyed via a Trust communication. Once confirmation has been agreed/received the risk scoring will be reviewed. [04/03/2024 11:06:11 Gemma] Risk reviewed and no further change [05/02/2024 15:41:56 Gemma] Risk reviewed and is ongoing until an electronic health record is introduced. [23/01/2024 17:56:20 Gemma] There have been communications sent out to all clinical colleagues to remind them to ensure that patient records are and accurate and available. The Clinical Records Group Chair, will also request a quarterly report to be discussed at the meeting to ensure that any trends/issues are highlighted. [21/11/2023 08:38:09 Anita Cooper] Clinical Records Group now led by Deputy Medical Director therefore risk agreed to sit with DMD with input from Outpatients/Health records team. [30/10/2023 14:17:15 Emma Cripps] No further progress update [08/09/2023 10:45:27 Maddy Ward] Risk reviewed at Outpatients Quarterly Risk	4	30/06/2018	31/03/2025	24/05/2024

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2a. A modern and progressive workforce	4997	41	Service disruption	Rinaldi, Dr Ciro	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	29/05/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	* Workforce review - Now Completed (Sarah Chester-Buckley - July 2023) * Refresher of Fragile Services Paper - NB there is a National shortage of Haematology consultants - Now completed (Sarah Chester-Buckley - September 2023) * Recruitment of further substantive consultants - (Sarah Chester-Buckley - May 2024) * Additional unfunded ST3+ for Haematology starts in August 2022 - Now completed (Sarah Chester-Buckley - July 2023)	[29/05/2024 09:00:34 Gemma Staples] Risk reviewed, ICB investment panel not to fund the Right Sizing Business Case in 2024/2025. A reduced Business case has been put forward for funding to the SDF panel. [23/04/2024 13:05:45 Gemma Staples] Risk reviewed and still awaiting outcome of ICB investment panel [25/03/2024 10:06:21 Gemma Staples] Haematology rightsizing SJBC presented at ICB investment panel on 15th March, still awaiting outcome. [26/02/2024 16:53:12 Gemma] Risk reviewed and ongoing [31/01/2024 14:32:33 Gemma] Risk reviewed and ongoing [18/01/2024 11:09:19 Gemma] Haematology rightsizing paper taken to TLT and approved, now needs to go to the Board and ICB investment panel. [22/12/2023 08:18:40 Gemma] Haematology rightsizing paper (SBJC) presented and approved at CRIG 19/12/23. Now needs to be presented at Board and ICB investment panel. Further update to be provided at a later date. [02/11/2023 15:21:13 Vicky Dunmore] Rightsizing haem Business Case to go to CRIG Nov 2023 [14/09/2023 15:02:19 Rose Roberts] Rightsizing Haem paper to be presented at CRIG Sept 2023. [03/08/2023 10:01:13 Rachael Turner] Following the briefing paper being received by ELT, weekly meetings have been set up with DL,EM,LR and MH. An action plan has been put in place. A meeting was held with the Haematology Consultants, Andrew Morgan and Michelle Harris on 31.07.2023 and it was agreed to go out to advert for 4 Haematology Consultants, 1 Haematology Secretary and 2 Secretary Assistants. [02/06/2023 12:39:17 Maddy Ward] Andrew Morgan requested a briefing paper for ELT which is now complete in conjunction with transformation and due to be circulated to execs on 05/06/2023 [24/04/2023 10:36:05 Maddy Ward] Haematology service review carried out on	8	01/04/2023	01/04/2023	28/06/2024
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	4779	61	Physical or psychological harm	Frake-Harris, Julie	Marsh, David	Patient Safety Group		16/01/2022	20	Risk assessments	Medicine	Cardiovascular CBU	Stroke		Increase in risk of delays to patient care/harm as a result of increasing backlog of planned care activity across stroke arising from Covid19 constraints / service restrictions/ site escalation pressures.	additional clinics/lists (cost pressure) additional staffing where feasible to increase capacity (cost pressure)	weekly monitoring of RTT and PBWL	18/03/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	-Virtual clinics in place for substantive consultants, where long overdue follow ups are giving priority. Overdue was standing at 989 patients, this was reported in October 2023. With industrial action, this will have had an impact. Trajectory of how we continue to reduce to be provided.	[18/03/2024 10:35:28 Rachael Turner] PBWL reduced to half due to carrying out virtual clinics. Work remains ongoing. [15/01/2024 14:24:35 Rachael Turner] Risk reviewed, controls in place and risk reduction plan updated. Virtual clinics currently in place to provide follow ups for long overdue patients. [13/12/2023 19:05:30 Rachael Turner] No current update, meeting to be had to combine with Risk 4780 and 4778. Due to staffing working capacity this will be done in January 24. [27/09/2023 11:31:18 Rachael Turner] Risk discussed at RRC&C as part of the Deep Dive. Since Covid this risk has moved on, this needs to be reviewed and possibly combined with risk ID 4780 and 4778. [30/08/2023 11:19:10 Carl Ratcliff] to review with COO as may be able to remove given lower COVID demand [23/07/2023 12:57:33 Carl Ratcliff] Proposal been constructed to allow better use of LCH beds - await feedback from Execs on next steps [24/04/2023 12:28:58 Carl Ratcliff] Improvement work started with team and perfect week in May will look at all opportunities for service. [27/01/2023 10:23:30 Charles Smith] 27/01/23 - CS DGM - Ongoing area of concern due to workforce and ACP gaps (being recruited to but time required to train). TIA still a concern but stable numbers. [16/12/2022 14:35:47 Carl Ratcliff] Additional work in palce to find external support / validate PWL and push patients through system [22/11/2022 17:25:10 Carl Ratcliff] Aim to have outliers back in right place and work continues to improve OPD work. Limited consultant numbers still mean there is a risk to OPD planned care work Plans in place to address backlogs across all areas. Significant area of risk for TIA. 23.08.22 Remains an issues although noting covid cases have dropped. Will be	4	31/03/2022	29/12/2023	18/06/2024
4b. Becoming a University Teaching Hospital Trust	5160		Reputation	Morgan, Mr Andrew	Rich-Mahadkar, Sameedha	Corporate		21/04/2023	16						If we don't deliver against our ambition of becoming a University Hospital Trust, this could negatively impact our organisational reputation.	Following UHA guidance Regular discussions between Executive leads from ULHT and UoL regarding financial arrangements Working closely with University of Lincoln to define and agree future collaborations Working with Research and Innovation teams and reporting into R&I groups to maintain oversight	Executive scorecard - number of clinical academics in post and number of collaborations that are developed to support research grants	29/01/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Continued discussions between ULHT and UoL Executive leads to finalise research and financial agreements Application for Teaching Hospital Status as interim step. Contact with UHA to confirm requirements for application	[18/10/2023 11:52:17 Rachael Turner] An application for Teaching Hospital Status is to be submitted to the DHSC as an interim step to recognise ULHT's significant teaching commitment. We anticipate that this will be approved before the end of 23/24 financial year. An MOU and financial model is being developed and agreed between ULHT and UoL which will support our requirement to recruit clinical academics and regular meetings are in the diary to conclude this work. A new ULHT Growth of Research Culture group has been established. [07/06/2023 12:20:47 Rachael Turner] Risk discussed at RRC&C meeting 07/06/2023.Risk needs to reflect more than getting status, such as recruitment, quality of people you attract, development and investment. Risk score 4 x 4 making it a score of 16 High Risk.	8	31/03/2025		29/04/2024

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1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5002	535	Service disruption	Farquharson, Colin	Edwards, Mrs Jill	Patient Safety Group	Clinical Effectiveness Group, Palliative/End of Life Care Oversight Group	23/08/2022	16		Clinical Support Services	Cancer Services CBU	Specialist Palliative Care		"If the Trust is not consistently compliant with NICE Quality Standards and commissioning guidance for specialist palliative care (SPC) to identify and provide appropriate care, delays on discharge and support for people who may be at end of life, then there may be delays to accessing appropriate care and treatment provided by specialist palliative care teams, resulting in serious physical and psychological patient and family harm, with a poor patient experience of care and service. "	"National Policy - NICE Quality Standard (QS13) End of life care for adults - NICE Guideline (NG142) End of life care for adults: service delivery - NICE - Care of dying adults in the last days of life Quality standard Published: 2 March 2017 - Ambitions for Palliative and End of Life Care: A national framework for local action 2021-2026 - 'One Chance to Get it Right: improving people's experience of care in the last few days and hours of life' Leadership Alliance for the Care of Dying People. June 2014. - 'Every Moment Counts' A narrative for person centred co-ordinated care for people near the end of life (VOICES) - Commissioning guidance for Specialist Palliative Care (2016). Local Strategy - Palliative and End of Life Care (PEOL) strategy for Linconshire - PEOL Re-Design for PEOL services Lincolnshire - ULH Strategy for PEOL ULH Governance - SPC Governance/ CSS CBU/ Cancer Services/ SPC - NACEL report"	"Frequency of referrals outside SPC referral criteria Frequency of referrals that require more information for triage Number of Datix incident and complaints relating to patient care Frequency of patients died/discharged before seen Frequency of patients dying outside Preferred place of death Frequency of first assesment (over 24hrs) from service KPI's. SPC workforce review including staffing deficits and skills gap analysis MDT attendance at point of recommendations	25/04/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	"Daily caseload review and triage of caseload using PEOL OPEL reporting measures with sitrep for escalation of risks Daily palliative huddle with key partners to support demand Working as one team across sites to provide pan trust cover Increase in senior leadership for direct support to PEOL at ULHT by addition of deputy lead nurse for PEOL Completion of Workforce plan to identify gaps in alignment with national policy and guidance. Commenced Service improvement gap analysis. Internal and external ask for multi disciplinary support to the SPC team. Externally sourced Clinical Education. Development of PEOL champions developed throughout Trust. Commence update to PEOL business continuity plan. Continued involvement in systemwide PEOL Operational meeting to promote improvements across services Analysis of staff competency and supervision completed and development plans in place. Develop action plan for NACEL analysis of staff competency and supervision completed	[25/04/2024 11:33:45 Gemma Staples] Risk reviewed and remains the same. A regulatory risk is being drafted and will be taken to the division for approval and will be taken back to RRC&C. Macmillan in reach role support has been reduced from 5 days to approx 3 days per week. Ongoing conversations with LCHS and options appraisal being completed. [31/01/2024 12:36:56 Rachael Turner] Risk discussed at RRC&C meeting 31/01/2024 for increase in score. Not meeting KPI and significant delays to patients receiving care and direct patient harm. We cannot see people within 24 hours, this is currently at a week. 30% of discharges discharged with no further referral provided. Risk of patient harm due to workforce, we are working at between 5-13% currently at 1.8. There is no MDT. Currently no resource for change. Risk score reviewed and validated: 4x4:16 High risk. Also risk of regulatory action, new risk to be created to cover this. [08/12/2023 13:25:40 Gemma] Risk discussed at SPC Governance identified not able to meet KPI of 75% of referrals assessed within 24hours. This is evidence that the risk has increased and therefore would like to be considered as a high risk. Email sent to Rachel Turner to ask that this be discussed in January 2024 RRC&C [02/10/2023 10:19:22 Rachael Turner] Risk discussed at RRC&C meeting agreed to be reduced to 4x3: 12 Moderate risk. [15/09/2023 09:07:47 Rachael Turner] Risk to be presented at RRC&C to upgrade to a High risk. [14/09/2023 14:29:14 Rose Roberts] NICE quality standard for care under review by peol OG, action plan to be created. [14/09/2023 14:27:47 Rose Roberts] Case of need is now in draft form for and out for comment. Risk reduction measures are still in place. [02/06/2023 13:00:43 Maddy Ward] We have started the case of need for the SPCT. [24/04/2023 11:06:37 Maddy Ward] Reviewed at Cancer Services quarterly risk	4	30/12/2024		25/07/2024
2a. A modern and progressive workforce	4741	42	Service disruption	Cooper, Mrs Anita	Chester-Buckley, Sarah	Workforce Strategy Group		13/01/2022	20	Risk assessments	Clinical Support Services	Cancer Services CBU	Oncology	Trust-wide	Oncology is considered to be a fragile service due to consultant oncologist gaps. Demand vastly exceeds the capacity, requiring an increase in establishment. Tumour sites at risk (Medical oncology) - renal, breast, upper and lower GI, CUP, ovary/gynae, skin, testicular, lung, urology, HPB Clinical oncology - head and neck, skin, upper GI (RT only). Due to only consultant covering Sarcoma retiring we will no longer have consultant cover for sarcoma from July 23. Lack of cover for leadership roles: Chemotherapy Lead, and succession planning for clinical lead. Lack of continuity of care at PHB, LCH have 'hot week' for consultants, PHB have a different consultant covering for a ward round each day. If there is absence or consultant is on 'hot week' for LCH there is no cover for PHB that day and may be for several consecutive days.	Cancer services operational management processes & clinical governance arrangements Medical staff recruitment processes Agency / locum arrangements email sent to consultants to see if anyone would cover sarcoma - no capacity/specialisation	Monitoring tumour site performance data	23/04/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Need to undertake a workforce review, oncology still a fragile service, continuing to work with HR to source consultants (Vicky Dunmore - March 2024)	[23/04/2024 13:04:41 Gemma Staples] Risk reviewed and no further update [05/04/2024 10:41:51 Gemma Staples] Risk reviewed. No further update [05/04/2024 10:38:06 Gemma Staples] Consultant Oncologist workforce capacity [18/01/2024 11:26:42 Gemma] Oncology rightsizing paper currently being written. [14/09/2023 16:04:46 Rose Roberts] Ongoing [28/06/2023 14:43:05 Rachael Turner] Following this risk being discussed at RRC&C meeting, the question was raised around the number of patients currently waiting to be seen (including overdue) These are as follows: Oncology PBWL numbers as at 29/5/23: Lincoln County Hospital: Overdue: Clinical - 171 Medical – 55 Total number of patients on PBWL (including overdue): Clinical – 2169 Medical – 226 Pilgrim Hospital Overdue: Clinical - 30 Medical – 9 Total number of patients on PBWL (including overdue):	4	31/03/2023	31/03/2023	23/07/2024
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5267	485	Physical or psychological harm	Ratcliff, Carl	Marsh, David	Patient Safety Group		26/09/2023	16		Medicine	Cardiovascular CBU	Cardiology		If there is a continued delay in processing of Cardiac MRIs, which is impacted by workforce limitations and an existing backlog of scans, then it could lead to delayed assessment and treatment for patients, resulting in potential for serious harm, a poor patient experience and a poor clinical outcomes. Cardiac MRI backlog was recorded at 125 11th September, this went down to 72 2nd October, this backlog continues to be monitored.	1.Outsourcing some CMR reporting to Medica - they will be reporting ten studies per week for the foreseeable future, which is around one third of our current reporting workload. At cost. 2.Undertaking additional reporting sessions - this will help significantly with the reporting backlog but not solve causal factors. At cost.	Size of reporting backlog (number/time required) Average time for reporting of scans from date of imaging	18/03/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	1. Work with imaging colleagues to develop/review need for additional imaging consultant with CMR included in Skill-set. 2. Continue to mitigate proactively at cost via current controls.	[18/03/2024 10:38:56 Rachael Turner] Reporting is massively reduced. As of last Monday there were just three to report. Longest wait was two days. This risk will be chased so that it can be agreed for a reduction and presented at RRC&C. [15/01/2024 14:28:44 Rachael Turner] There is no significant backlog. Weekly check of performance has been provided as evidence. This risk will need approval at Division in order to be reduced in score. If agreed this will go to Risk Confirm and Challenge for a reduction in score. [25/10/2023 11:12:43 Rachael Turner] Risk discussed at RRC&C meeting 25/10/2023, risk validated as 4x4:16 High Risk. [26/09/2023 15:02:00 Charles Smith] As of 11/09/23: •There are a total of 125 cardiac MRI studies awaiting reporting •The oldest scan on the reporting list is from 24 July 2023 (seven weeks) •There are 13 scans from July, 68 scans from August and 44 scans from September waiting to be reported	3	01/07/2024		19/06/2024

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1c. Improve clinical outcomes	4928	89	Service disruption	Ratcliff, Carl	Marsh, David	Patient Safety Group		28/04/2022	16	Professional Guidance	Medicine	Cardiovascular CBU	Cardiology		Increase in risk of delays to patient care/harm as a result of increasing backlog of planned care activity across Cardiology arising from Covid19 constraints / service restrictions/ site escalation pressures.	additional clinics/lists (cost pressure) additional staffing where feasible to increase capacity (cost pressure)	weekly monitoring of RTT and PBWL	18/03/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	-Weekly waiting list meeting -Weekly RTT meeting For both of these we make plans for all patients that are 45 weeks and over. This will be ongoing. -Review in place for all our pathways-this is continually at present so we can re-design with the correct cohorts.	[18/03/2024 10:44:23 Rachael Turner] Risk reviewed, waiting lists have reduced down significantly, booking up to six weeks ahead. Those on the list are being reviewed for priority and whether they require to be seen. 3563 are now currently on the waiting list. RTT position 52.54%. Risk to be looked at to be reviewed for a reduction in score. [15/01/2024 14:33:03 Rachael Turner] Waiting lists are coming down with regular monitoring and validation. We have now adopted a 6 4 2 process for booking our waiting list slots. Performance is reported through Governance PRM every month. Risk Reduction plan reviewed and updated. [16/10/2023 16:34:58 Rachael Turner] The Cardiology waiting list has been extensively validated and has been reduced. Our biggest backlog on the waiting list is loop recorders and we are holding a three day "loopathon" 14-16th November where 96 patients will be treated. New Patient appointments-they have been hampered by industrial action, we have extensive validation. We have reduced the number of 52 week breaches. Our RTT position is 49.35%. We are undertaking a review of clinic templates to make sure clinicians are seeing the correct number of new and follow up patients per clinic. Remote monitoring-we have case of need going to CRIG in November to put 500 patients a year on remote monitoring, this will make a better experience for patients. Just bid for specialised funding to reduce our backlog with tapes, currently have 2700 patients waiting. [16/10/2023 16:34:45 Rachael Turner] The Cardiology waiting list has been extensively validated and has been reduced. Our biggest backlog on the waiting list is loop recorders and we are holding a three day "loopathon" 14-16th November where 96 patients will be treated. New Patient appointments-they have been hampered by industrial action, we have extensive validation. We have reduced the number of 52 week breaches.	8	15/01/2025	01/03/2024	15/06/2024
3b. Make efficient use of our resources	4665	14	Finances	Young, Jonathan	Sargeant, Paula	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	18/04/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	- Refresh of the CIP framework and training to all stakeholders. - Increased CIP governance & monitoring arrangements introduced. - Alignment with the Trust IIP and System objectives - CIP is embedded as part of the Trust Improvement Strategy not seen as a separate workstream.	[18/04/2024 16:54:00 Rachael Turner] The Trust has committed to do 5% CIP in 2024-25 as part of the financial plan. This has moved the target from the previously planned £32m to £40.1m plus any investments that are required to deliver the savings will need to be covered off with more CIP delivery. The increase in target is to support the trust to decrease its underlying deficit and build towards a sustainable pipeline of cost improvement for the future. The Target for 24/25 is £40.1m There is currently a £9.8m GAP to delivery and of the £30.3m of opportunities identified, granular plans are still in the process of being worked up. [23/01/2024 13:18:19 Rachael Turner] The focus has now switched to pipeline opportunities for 24/25 and the ability of the trust to build a sustainable pipeline of cost improvement for the future. The Target for 24/25 is £32m. [16/10/2023 17:17:59 Rachael Turner] The Trust has over delivered each month on the FRP target months 1-6. This meets the criteria for NOF 4 of delivery in 6 consecutive months. Year to date at month 6 the FRP has overdelivered by £5.3m The trust is still forecasting to deliver a full £28.1m CIP programme for 23/24. The trajectory for savings steps up from month 7 onwards so the run rate of savings needs to increase going forwards. [14/07/2023 09:09:38 Rachael Turner] Risk reviewed, risk score to remain as current work is ongoing. The Trust has over delivered against the month 1 trajectory for the FRP by £0.5m. The trust is also forecasting to deliver a full £28.1m CIP programme for 23/24. [28/06/2023 16:16:06 Rachael Turner] Risk reviewed, targets have been reviewed to reflect where we currently stand. we have hit financial improvement target for month 1 and 2. Risk score to remain the same at 16 High Risk. [24/05/2023 13:11:53 Rachel Thackray] Updated to reflect the risk for 2023/24. The Trust has plans to deliver £28m CIP (FRP) target. In month 1 delivery	4	31/03/2023	31/03/2024	19/07/2024
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5095	59	Physical or psychological harm	Capon, Mrs Catherine	Chamberlain, Liz (Elizabeth)	Patient Safety Group		24/02/2023	16		Surgery	Surgery CBU	Vascular Surgery	Pilgrim Hospital, Boston	Due to increased demand for PICC services there is a risk that within the current establishment there is a significant delay to patients. This can delay treatment, hinder flow and cause poorer outcomes for patients. 8 years ago, venous access within the Trust was classed as central lines (internal jugular insertion) and cannulas. Peripheral central catheters (PICC) were undertaken occasionally for oncology patients and portacaths and Hickman lines were done in theatre, as they still are. The vascular ACPs started to learn how to insert picc PICC lines starting from one morning clinic on a Tuesday (supported by the Consultants). The needs for PICC increased and we went to two full day clinics in a week. They were only inserting in pilgrim at that time. It was then determined that Total Parental Nutrition (TPN) needed to be given centrally and not peripherally, and the work load increased two fold. A business case was successful for a 1.0 WTE band 6 venous access nurse to take on the clinics as the work load for the ACPs was also increasing. The Royal College of Radiologists state that a PICC line should be inserted with 72 hours. However, due to the varied nature of why a line is required particulary for urgent cases this has been deemed locally as 24 hours.	At present there is one 1.0 WTE VAN (band 6) and two 22.5 hours HCSW (band 2) covering: - Lincoln clinics (in patient only) Monday (up to and including 6 patients) and a Wednesday out/in patients - Pilgrim clinics Tuesday and Thursday, both in and outpatients - All clinics have slots for up to 6 patients, however, many late referrals are received and the clinic can increase to anything up to 12 patients. This means that the VAN goes home late most nights that incurs overtime payment. This additional activity is driven through urgent care pathways and is reliant upon a stretched team to meet this demand. As services enter a a post COVID climate there has been a recognised increase in complexity of presentations due to non-presentation at an earlier point. Case of Need has been written with final finance input outstanding to then go to CRIG ACPs are trained in this procedure but should not be relied upon as takes away from other core duties and is not a sustainable. Interventional Radiology is picking up some activity although this exposes patients to radiation and is not a sustainable option. This also require anaesthetics and theatre resources.	Volume of requests against number of staff and time taken to acquire IR1 submissions - started to see an increase in incidents being reported.	31/05/2024	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	[31/05/2024 12:07:02 Nicola Cornish] Business case needs to be reviewed before presentation to CRIG. Looking at funding sources across other divisions as it is a Trust wide service. 6 month secondment has been extended to end of March 2025. [28/05/2024 14:48:51 Nicola Cornish] No further update [23/10/2023 11:25:05 Nicola Cornish] Extended secondment until end of March 2024, approval and QIA for business case are ongoing [03/05/2023 10:26:45 Rachael Turner] Following further quantitative data provided this risk has now been validated as an active risk for the trust register. [26/04/2023 11:26:50 Rachael Turner] Risk needs to return to RRC&C once we have the quantitative data confirmed. Needs to look at where this risk sits as possibly more appropriate with CSS. This will be re-presented in the May RRC&C meeting. [25/04/2023 10:06:15 Chris Sewell] Due to unforeseen circumstances and long term absence the service has had to rely on the ACP and Interventional Radiology options as outlined in the risk controls. It is anticipated that they will return at the beginning of May. This has led to an increase in IR1s.	1	01/06/2023		31/08/2024

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3c. Have enhanced data and digital capability	4641	18	Service disruption	Humber, Michael	Gay, Nigel	Digital Hospital Group	Emergency Planning Group	23/11/2021	16	Risk assessments	Corporate	Finance and Digital	Digital Services (ICT)	Trust-wide	If the Trust's digital infrastructure or systems experience an unplanned outage then the availability of essential information for multiple clinical and corporate services may be disrupted for a prolonged period of time, resulting in a significant impact on patient care, productivity and costs	National policy: - NHS Digital Data Security Protection Toolkit (DSPT) and Guidance ULHT policy: - Telecoms infrastructure maintenance arrangements - ICT hardware & software upgrade programme - Corporate and local business continuity plans for loss of access to ICT systems & system recovery ULHT governance: - Digital Hospital Group / Information Governance Group (IGG), accountable to the Finance, Performance & Estates Committee (FPEC) - 5 year capital plan -	- Network performance monitoring - Digital Services reported issues / incidents - Monitoring delivery of digital capital programme - Horizon scanning across the global digital market / supply chain to identify availability issues	21/03/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	- Prioritisation of available capital and revenue resources to essential projects through the business case approval process. - Working with suppliers and application vendors to understand upgrade and support roadmaps. - Assurance mechanisms in place with key suppliers for business continuity purposes - Comprehensive risk assessments to be completed for local service / site specific vulnerabilities so that appropriate action can be taken to manage those risks. - Contingency plans - data centres protected from overheating, fire and flood / water damage risks: Portable air con units kept on site for when needed. Estates work has addressed some leakage issues at Pilgrim. Fire retardant systems in all data centre rooms, routinely serviced by Estates.	[21/03/2024 11:59:38 Rachael Turner] The new Lincoln comms rooms are now largely complete and almost at the point of supplier handover, this will allow commissioning to take place during Q1/Q2 24/25. The second new comms environment at Pilgrim Hospital has been procured and will be implemented during FY 24/25. [21/03/2024 11:58:08 Rachael Turner] Propose no update to current risk score but forward view is once of reducing risk, particularly when these new facilities are onboarded. [20/12/2023 09:39:41 Rachael Turner] Risk reviewed, no current change. Risk score remains. [20/09/2023 14:27:49 Rachael Turner] Risk reviewed as a part of the digital risk review. Score remains the same. Risk reviewed, description amended to reflect broader range of threats to the digital infrastructure. Current score increased to 16. Have purchased a significant number of Radios, to allow communication in the event of failure. We've completed a Network Core Switch replacement at Pilgrim new Data (DC3) at Pilgrim to provide resilience at site backup across site has been improved. Recovery Vault is in the process of implementation The Metro-Cluster is in the process of implementation.	4	31/03/2023	31/03/2023	21/06/2024
3c. Have enhanced data and digital capability	5245	19	Service disruption	Jenkins, Barry	Humber, Michael			30/08/2023	20		Corporate	Finance and Digital	Digital Services (ICT)	Trust-wide	The Trusts disaster recovery capabilities are limited. In the event of a major incident affecting the primary data centre/site the ability to restore services elsewhere is limited. This would affect the availability and data integrity of tier 1 clinical and corporate systems, leading to extended unavailability and reliance on Business Continuity Plans. In addition there is a risk of significant data loss in the event that recent backups are unavailable or compromised.	-Business Continuity Plans which the Trust is planning to exercise of a regular basis via Emergency Response. -Annual SIRO approved incident response exercise. -Protections that reduce the likelihood of various disasters, including environmental and technical controls: A number of improvements have been made in this area. We now have a dedicated ""stretched"" Metro cluster between Lincoln and Boston. We also have Standard clusters at each site which have increased capacity. -Immutable Backup system introduced to ensure organisational data is held securely and available for recovery, this includes off site cloud storage for critical data	-Annual SIRO approved incident response exercise. -Incidents reported via Datix these are backed up via an RCA and lessons learned.	16/05/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Whilst some systems still need to transition fully with VLAN/IP changes we do have new systems and system upgrades migrating to the new solution. Enabling Tech programme in place to improve the Trust Foundations from which the Digital Services will run. This requires completion prior to remobilisation of EPR. Trajectory for this is 2025/26.	[17/05/2024 10:42:15 Rachael Turner] Implementation of Rubrick continues. Risk score currently remains. [30/01/2024 11:04:10 Rachael Turner] Risk reviewed. Risk controls and reduction plan updated. Risk score to remain. [20/12/2023 09:22:32 Rachael Turner] In the process of implementing Rubrick, which will support disaster recovery and cloud back up. [30/08/2023 16:06:58 Rachael Turner] Risk discussed at RRC&C meeting 30/08/2023, score validated as: 4x4: 16 High Risk.	10	30/08/2024		16/08/2024
2b. Making ULHT the best place to work	5251		Reputation	Low, Claire	MacDonald, Damian			06/09/2023	16		Corporate	People and Organisational Development	Organisation Development	Trust-wide	If the Trust doesn't have an effective approach to employee appraisals then it could have a negative impact on morale and lead to poor performance, inappropriate behaviours, reduced productivity, non-compliance with policy, increased turnover.	1. Dedicated page for Staff Appraisals on the Intranet with a wealth of easily accessible information that sets out the process, principles, benefits, fact-sheets 2. Leading an Effective Appraisal 2-hour virtual workshop available to all managers to support them in developing their skills and confidence to undertake staff appraisals 3. Creation of an Appraisal and Career Discussion form that is simple but allows for discussion on performance, professional relationships, career and development goals, and wellbeing. It also allows for performance and development objectives to be set, an overall assessment of performance to be made and a check on completion of mandatory training to be undertaken. There are also forms to support managers to undertake regular 1:1 'check-ins' and to undertake mid-year reviews 4. Trust governance: Board assurance through People and OD Committee	1. Compliance rates reported at Divisional and Trust level in a variety of forums monthly	11/01/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	1. Creation of a Task and Finish Group to undertake a scoping/review exercise to understand current issues and barriers to completion 2. Findings of Task and Finish Group to be used to inform and develop an Improvement Action Plan 3. Complete Improvement Action Plan when drafted - to be monitored through Workforce Strategy and OD Group and reported up to People and OD Committee 4. Ensure detailed scrutiny takes place at FPAM with Divisions - Learning and Development Coordinator to provide more detailed monthly slides as part of FPAM reporting"	[11/01/2024 12:38:02 Rachael Turner] This is a reducing risk as we work through the risk reduction plan. Following a workshop in Jan 2024, we should be in a position to reassess the risk level and we will take this forward with our risk business partner [06/09/2023 14:10:25 Rachael Turner] This risk was reviewed and validated at the RRC&C meeting August 2023. Approved score 4x4:16 High Risk. [06/09/2023 14:09:45 Rachael Turner] Two priority issues identified: • Review the Staff Appraisal cycle and how this can best be aligned to business and financial planning to ensure there is a link between performance from the organisational to individual level ('golden thread') • Scope out the potential for utilising ESR for eAppraisal or whether an alternative solution would need to be found – review what system colleagues are doing and whether the Trust could use or learn from their solutions Ongoing service pressures and staffing challenges in the Trust continue to impact appraisal completion rates but month on month there is a slight improvement with an increase in June 2023 to 67.93% non-medical and an increase to 98.24% for medical. We are continuing to recommend that a 90 minute appraisal for each colleague is planned for as we enter 2023/24. Following an audit completed in Urgent & Emergency Care we identified that a number of colleague's appraisals had been completed in the past 12 months within WorkPAL, however were not recorded on ESR. Work is underway to educate leaders on the process required to update ESR, even for ones done on WorkPAL already. This will include 'how to' guides/sessions and utilising reporting to identify areas of low completion.	8	06/09/2024		11/04/2024

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3a. A modern, clean and fit for purpose environment	4725	466	Physical or psychological harm	Cooper, Mrs Anita	Froggatt, Hayley	Estates Investment and Environment Group	Health and Safety Group	13/01/2022	20	Risk assessments	Clinical Support Services	Therapies and Rehabilitation CBU		Lincoln County Hospital	If essential repairs and maintenance requirements at Lincoln County Hospital Occupational Therapy Department are not addressed then it may lead to accidents and injury resulting in potentially serious harm to staff, patients and visitors. There is a security risk to the building.	Legislation: - Health & Safety at Work Act 1974 -Management of Health & Safety at Work Regulations 1992 associated guidance. ULH policy: - Health & Safety Policy & related guidance - Health & safety training (Induction, Core Learning, Core Plus Learning and CPD) - Estates Planned Preventative Maintenance (PPM) / testing - Occupational Health services ULH governance: - Health & Safety Committee / site-based H&S Forums; accountable to Trust Board through Finance, Performance & Estates Committee (FPEC)	IPC flo scores, monitoring of incidents, staff satisfaction concerns, complaints / PALS Tracking of Estates work requests - The Department has a significant amount of outstanding jobs including, leaking windows, leaking roof tiles, carpeted areas, unsanitary toilet/shower & changing facilities, repeatedly broken toilets. Inability to monitor temperatures due to inappropriate fitting of radiator covers, swelling and uneven floor services following leaks.	07/05/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Daily & Weekly IPC checks, Staff well being checks, frequent monitoring of safety issues. Escalation to H&S Team via audit process. Monthly updates to MICAD system, Escalation via IPC FLO audit process.	[07/05/2024 11:15:24 Gemma Staples] OT have moved into Physio now and Rehab Medicine are moving into the better part of the dept on 9/05/2024. The riskiest corridor will then be secured and locked and the other corridor will be storage only and limited access. Staff are reporting an impact on wellbeing capacity to do their job. There is ongoing lack of office space to be able to do none clinical work effectively and lack of space to accommodate lunch breaks. There is a clear drive for us to consider off site premises with the support of the Estates team. [05/02/2024 11:05:23 Gemma] Rehabilitation Medicine will move across into the OT area as an interim measure while further suitable accommodation is sourced. [01/02/2024 13:40:16 Gemma] We will be moving to the physio therapy department as an interim measure until new premises sought within the hospital. Moving to physio hopefully before the end of the financial year. [27/09/2023 12:05:47 Rachael Turner] Risk discussed at RRC&C Meeting for an increase in score to a High Risk score of 16. There could be regulatory impact if this was not looked at and also issues reputationally. [08/09/2023 14:08:38 Maddy Ward] Likelihood of risk has been updated to quite likely in review meeting making it a high risk. Glass is falling from window frames more frequently due to rotten window frames and we have had water/rain coming into electrics. This is included in the estates escalation report. [23/06/2023 14:00:51 Rose Roberts] Flooring has been approved and has been accepted by estates. Not got a date yet. Windows etc have been escalated. [27/04/2023 14:29:26 Rose Roberts] CVR office also has a carpet - feedback from estates is quote received and awaiting go-ahead to commence work from Clinical Support Services. Rotting wooden windows - Feedback from estates is that windows are a known issue with the building but there is no funding available	4	31/03/2022	31/03/2023	07/08/2024
2a. A modern and progressive workforce	5173	43	Service disruption	Morgan, Mr Andrew	Warner, Jayne	Trust Leadership Team	Corporate	15/05/2023	20		Corporate	Trust Headquarters	Corporate Secretary	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.	24/04/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Continue with mentoring / coaching arrangements in place where appropriate. Review the succession plans for each post and ensure substantive appointments are made. Joint posts with other system providers to be considered where appropriate as part of the Lincolnshire Provider Review.	[24/04/2024 14:15:27 Nicola Cornish] Discussed at RRC&C on 24/04/24 - risk moved under CEO/Trust Secretary as this is beyond the scope of the MD role. [20/02/2024 13:46:40 Rachael Turner] Risk reviewed - Medical Director is back full time and CEO has extended tenure to June 2024 to allow for recruitment to Group CEO. [07/06/2023 12:15:17 Rachael Turner] Risk discussed at RRC&C 07/06/2023 Risk score agreed as 4x4 giving a score of 16 making it a High Risk. [15/05/2023 13:41:10 Rachael Turner] Risk to be raised for validation at RRC&C Meeting in May.	10	31/03/2024		24/07/2024
3a. A modern, clean and fit for purpose environment	5104	8	Regulatory compliance	Dunning, Mr Paul	Rinaldi, Dr Ciro	Mortality and Learning Strategy (MoraLS) Group	Estates Infrastructure and Environment Group	16/03/2023	10		Clinical Support Services	Path Links (Pathology)	Mortuary (Pathology)	Trust-wide	As a result of the HTA's concerns relating to the fabric and capacity of the Trusts mortuary service and the delay in timescales by which the Trust is able to refurbish these following the HTA inspection in May 2022. There is a risk that The HTA as the regulator could impose conditions on our licence to store the body of a deceased person within the Trusts mortuary facilities.	-HTA oversight group has been established-meeting to manage the action plan. -Papers have been to CRIG for initial funding to establish planning and building work. This has been approved. -Draft business case has been developed and approved. -Initial concerns have been addressed from Lincoln site. -The Trust currently has two Titan units (temporary additional mortuary capacity) which provides additional capacity in the event of winter pressure peaks in demand and also in the event of equipment failure. -The Trust has a memorandum of understanding with Hull University Teaching Hospitals to support with the storage of bariatric bodies that require longer storage (freezer capacity).	ULHT Improvement action plan HTA Governance Group Weekly meetings to oversee mortuary refurbishment plans	17/05/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Risk reduction plan to assure HTA during March that risk controlled above mitigate their concerns over the Trusts mortuary estate. HTA have confirmed their acceptance of the Trust's plans to mitigate and have closed down their inspection process as complete.	[17/05/2024 10:54:44 Gemma Staples] Risk remains the same as work is ongoing [01/02/2024 16:05:12 Gemma] Business Case has been approved at Trust Board and work has commenced on the Trustwide Mortuary Project [19/10/2023 15:50:44 Ciro Rinaldi] -HTA oversight group has been established-meeting to manage the action plan. -Papers have been to CRIG for initial funding to establish planning and building work. This has been approved. -Draft business case has been developed and approved. -Initial concerns have been addressed from Lincoln site. -The Trust currently has two Titan units (temporary additional mortuary capacity) which provides additional capacity in the event of winter pressure peaks in demand and also in the event of equipment failure. -The Trust has a memorandum of understanding with Hull University Teaching Hospitals to support with the storage of bariatric bodies that require longer storage (freezer capacity). [19/10/2023 07:47:27 Jeremy Daws] ELT provided with an update that plans approved, and building work scheduled to commence October 2023. At recent weekly mortuary refurbishment meeting, building commencement timescales may slip back due to delays in appointing a contractor. Further update to be provided when more information known. [05/07/2023 11:06:25 Rachael Turner] Risk discussed in June RRC&C meeting, agreed to reduce risk score from 20 to a 16 High Risk [08/06/2023 13:22:36 Rachael Turner] Risk to be presented at RRC&C in June for reduction in score from 20 to 16. [31/05/2023 04:53:29 Jeremy Daws] HTA have responded to the Trust during May confirming their acceptance of the Trust's mitigation plans. HTA have confirmed they are assured enough to close down the inspection process as complete.	20	31/03/2024	31/03/2024	16/08/2024

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1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	4868	64	Physical or psychological harm	Farquharson, Colin	Martinez, Francisca	Medicines Quality Group	Maternity & Neonatal Oversight Group	01/03/2022	16	Risk assessments	Clinical Support Services	Pharmacy CBU	Pharmacy		Preparation of Drugs for Lower Segment Caesarean Section (LSCS). 1. Medicines at risk of tampering as prepared in advance and left unattended. 2. Risk of microbiological contamination of the preparations. 3. Risk of wrong dose/drug/patient errors. Breach of Medicines Act: Regulation 3 of the Human Medicines Regulations 2021 permits doctors to prepare medicines for administration. The expectation would be that preparation would be in compliance with current best practice and governance expectations. Regulation 214 permits parenteral administration of medicines by or in accordance with the directions of and appropriate practitioner. This practice would constitute a risk to the patient and falls outside of expected governance arrangements detailed in Advice Note for Chief Pharmacists March 2017 NHS Pharmaceutical Quality Assurance Committee which defines acceptable practice as: administration immediately after (within 30 minutes) preparation and completed within 24 hours. It is noted the Trust Injectable Medicines Policy is in compliance with this expectation.	No current processes in place to minimise risk Policies do not support this practice	Incidents involving advance preparation of intravenous medication in clinical areas. Audits of compliance with standards / policy - The current labelling does not comply with national recommendation. Not all labels include the recommend identity (no dose/strength as per pictures). Also, no preparation date/time always included. There is no documented procedure stating the process to follow to ensure that the medicines prepared are discarded.	04/04/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	1. Use of tamper proof boxes/trays being purchased. 2. The only control to prevent the risk is to prepare the injections prior to administration (within 30 minutes) as per guidance (National and Trust). 3. If the practice is to continue, the prepared products should be labelled to include the recommended information. A procedure should be developed indicating the process to follow to ensure the medicines drawn up are discarded at the end of the day.	[04/04/2024 09:02:51 Lisa Hansford] NO FURTHER UPDATE [29/12/2023 13:33:55 Lisa Hansford] No further update [26/09/2023 14:17:01 Rachel Thackray] Meeting to take place to review progress [20/07/2023 10:43:27 Lisa-Marie Moore] narrative updated to reflect conversation between Fran Martinez and Regional QA about breaching medicines act regulation 3 [27/06/2023 09:45:38 Alex Measures] Discussed in risk register review meeting- no further updates [01/06/2023 14:26:57 Lisa-Marie Moore] Risk assessment resent to anaesthetists - to discuss at next MQG. If no further progress to discuss with CQC [04/05/2023 14:26:40 Lisa Hansford] needs to go back to MQG [29/03/2023 10:16:01 Maddy Ward] This risk needs to go to MOpS for escalation to medicines quality group. [21/02/2023 08:53:55 Paul White] Note from Risk Register Confirm & Challenge Group - risk to be reviewed from Family Health perspective, including current rating and where responsibility for the risk should belong. [05/01/2023 14:08:19 Lisa-Marie Moore] To be raised again at MQG and action to be taken agreed Following a Datix (ref no: 255637), it has been identified that intravenous medication required for a Lower Segment Caesarean Section (LSCS) is being prepared in advance of the procedure in case of an emergency. The Lead Obstetric Anaesthetist has discussed the practice with the team and the consensus is that for safety the drugs need to be prepared in advance for potential emergencies. The team has sourced tamper proof drug trays to store the drugs once prepared. This risk assessment has been done for Pilgrim Hospital, Boston. However, the practice seems to replicate at Lincoln County Hospital. Full risk assessment is attached to Datix. 17/5/22 No change	4	30/09/2022	31/03/2023	04/07/2024
2b. Making ULHT the best place to work	4439	49	Service disruption	Low, Claire	Shankland, Lindsay	Emergency Planning Group	WORK	16/11/2018	20	Corporate	People and Organisational Development	Operational HR			If there is large-scale industrial action amongst Trust employees then it could lead to a significant proportion of the workforce being temporarily unavailable for work, resulting in widespread disruption to services affecting a large number of patients	Workforce plans & rota management procedures. Temporary staffing arrangements. Business Continuity Policy with associated procedures & guidelines. Local service-specific business continuity plans & recovery procedures. Executive oversight (Chief Operating Officer) through Emergency Planning Group.	Frequency of industrial action events. Publicised staff polls / surveys by professional bodies on possible industrial action.	26/03/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Industrial relations action plan & engagement mechanisms and arrangements with Staff Side representatives.	[26/03/2024 13:23:38 Gemma Staples] Risk reviewed at RRC&C today and agreed for the risk to be lowered to 4x4=16 risk. [28/02/2024 12:41:33 Rachael Turner] Due to operational pressures this risk will be presented at RRC&C for validation in March 2024. [07/02/2024 13:42:52 Rachael Turner] Risk reviewed, controls currently in place and managed through operational command. Risk to be presented at RRC&C meeting in February for a reduction in score. [11/01/2024 12:27:34 Rachael Turner] LS Confirmed: Risk continues to present as an issue. All mitigations are in place and the Trust manages the issue when it presents through an operation command structure. [19/12/2023 12:29:58 Rachael Turner] Risk continues to present as an issue with medical staff undertaking periods of industrial action. Currently Junior Doctors remain in active dispute with the government and Consultants/SAS Doctors are balloting on pay proposals. In November 2022 it was necessary to increase the likelihood of this risk from low to extremely likely and this continues. Plans have been tried and tested and all mitigations are in place. Oversight and governance through the Operational/Tactical/Silver Cell, Medical Workforce Cell and Strategic/Gold Cell with reporting to the ICB. Industrial Dispute Action Plan and Risk Assessment complete and has been tested through industrial action. Currently managed within risk tolerance. EPG to consider making this risk Inactive (for annual review). [20/11/2023 20:37:44 Rachael Turner] Risk reviews, all actions and score remains appropriate. Gold and silver command continue to manage this. [30/10/2023 12:37:17 Rachael Turner] Risk reviewed and remains at current level.	4	01/10/2021	31/03/2023	26/06/2024
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	4843	57	Physical or psychological harm	Dunning, Mr Paul	Costello, Mr Colin	Medicines Quality Group	Medicines Quality Group	19/01/2022	20	Risk assessments	Clinical Support Services	Pharmacy CBU	Pharmacy		Screening, management and review mechanisms of patients requiring or in receipt of Intravenous Immunoglobulin (IVIg) is inadequate.	National policy: - NICE Guideline NG5: Medicines optimisation, etc. ULHT policy: - Policy for Medicines Management: Sections 1-8 (various approval / review dates) ULHT governance: - Trust Board assurance via Quality Governance Committee (QGC) / Medicines Quality Group (MQG)	Reported incidents involving use of Intravenous Immunoglobulin (IVIg)	04/04/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Single staff reliance for local panels, 1x haematology consultant, 1x neurology consultant and 1x chief pharmacist only. Antimicrobial and High Cost Drugs Management Pharmacist undertaking administrative functions to ensure all referrals are screened and are done so in a timely manner. Shared care arrangements and prescribing accountabilities are unclear and need review.	[04/04/2024 08:50:30 Lisa Hansford] no progress [29/12/2023 13:42:16 Lisa Hansford] No further update [26/09/2023 14:14:06 Rachel Thackray] Progress ongoing with regard to shared care [27/06/2023 09:45:04 Alex Measures] Discussed in risk register review meeting- no further updates [26/06/2023 13:55:27 Lisa Hansford] Risk discussed with Paul Dunning. Sue Leo to give PD list of patients that this effects. PD to review information and discussed with NHSE again. [01/06/2023 14:32:36 Lisa-Marie Moore] Meeting arranged to happen with Paul Dunning [04/05/2023 14:21:25 Lisa Hansford] meeting to be arranged to review the process for reviewing patients [29/03/2023 10:06:27 Maddy Ward] We have raised the risk today to quite likely and the medical director needs to review the process for review of these patients by an immunologist. [20/12/2022 14:25:21 Alex Measures] No further progress 19/07/21 - Shared care document was sent to NUH for review. However, NUH business unit manager expressed difficulties to advance on the SCA due to staff shortages in immunology division. Dr Neill Hepburn will discuss with NHS England regarding next step. 150622 ongoing until get an immunologist in the trust.	4	01/10/2021	31/07/2023	04/07/2024
3a. A modern, clean and fit for purpose environment	5334	533	Physical or psychological harm	Crosby, Mrs Libby	Carr, Katy	Patient Safety Group	Patient Safety Group	26/01/2024	15	Risk assessments	Family Health	Women's Health and Breast CBU	Obstetrics	Pilgrim Hospital, Boston	There is no second theatre within the confines of the labour ward within which to undertake any theatre based procedures when Theatre 8 is already in use. In time critical scenarios the increased time taken to transfer to Theatre 1 on ground floor and commence surgical management may impact on the health and/or wellbeing outcomes for mother and/or baby. There is a patient experience risk due to a lack of privacy and dignity for women when transferring to ground floor theatres through public corridors. There is also a potential for an increase in Caesarean Section rate as clinicians attempt to avoid late labour transfers.	Multi-professional discussions in relation to plans of care. Out of hours – on call maternity manager available for support. Dedicated theatre available in ground floor theatre. Close monitoring of labour ward activity. Publication of Standard Operating Procedure (SoP) Labour Ward Manager / Matron / Labour Ward Obstetric Lead to have an awareness of all theatre cases. Visible management and Leadership/active on call support to teams PMA support	Closely monitor all cases where woman transferred to theatre before or following birth – daily Medway report for scrutiny. Regular review of Incident reporting system.	03/04/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	To inform teams of the risk controls in place. Coordinate Estates to undertake the works on Theatre 8a to minimise disruption as soon as practicably possible.	[04/04/2024 10:33:53 Nicola Cornish] Risk reviewed, no change. [31/01/2024 13:01:35 Rachael Turner] Risk discussed at RRC&C meeting 31/01/2024. Need to know frequency when this is happening. Agreed currently that this sits at a 4x4: 16 High Risk. Link to be added around regulations.	6	01/01/2025		03/07/2024

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3c. Have enhanced data and digital capability	5241	518	Service disruption	Jenkins, Barry	Gay, Nigel			30/08/2023	16		Corporate	Finance and Digital	Digital Services (ICT)	Trust-wide	SSL Inspection on Internet Traffic: There is significant risk that a malicious cyber event may occur as a result that encrypted Internet traffic is not inspected at the Trust external facing network boundaries. As a result malicious payloads may enter the Trust network and attack staff and IT Service endpoints resulting a breach of C, I or A. (e.g. link to a compromised website or C2C server connection due to a phishing event.)	Web-proxy/filter, boundary firewalls	As above.	21/03/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Introduction of web-proxy with capability for SSL inspection. Proxy procurement continues and is a ULH focused procurement activity in the hope that apartner organisations will be onboarded in 2024 - agreed May 2023 at DDaT	[21/03/2024 12:00:45 Rachael Turner] The Trust and ICS partners have now procured a solution that will provide the required functionality. The procurement is now complete and the contractual issues have been resolved. The solution is expected to be rolled out to ULHT staff during Q1 24/25, planning with our ICS partners is taking place to understand how and when the solution will be implemented across our system partners. Propose no update to current risk score but forward view is once of reducing risk as a result of the technical solution being implemented. [20/12/2023 09:37:57 Rachael Turner] Risk reviewed, currently no no change risk to be reviewed in March 2024 for update. The functionality is yet to be switched on due ongoing security discussions. [30/08/2023 15:26:12 Rachael Turner] Risk discussed at RRC&C Meeting 30/08/2023. Controls are currently in place but this not mitigate the risk. Risk validated with an agreed score of 4x4: 16 High Risk.	4	30/08/2024		21/06/2024
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	4935	58	Service disruption	Farquharson, Colin	Sewell, Chris	Patient Safety Group	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.	13/06/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Recruit to vacant posts.	[14/06/2024 13:17:32 Nicola Cornish] The JD has now been approved and the consultant post is currently out to advert. [28/05/2024 14:47:03 Nicola Cornish] No further update [23/04/2024 14:15:23 Nicola Cornish] No change. ICU oversight group continues with x 3 workstreams. Have x 3 TACCP's in post [18/11/2023 21:05:16 Nicola Cornish] No change to risk score. Have an ICU oversight group with x 3 workstreams one of which is workforce. Meets weekly to look at recruitment and medical workforce. We have recruited trainee ACCP's which won't solve current issues but is future planning. [15/06/2023 09:32:33 Wendy Rojas] No change to risk status.beds capped at x8 L3 [18/04/2023 13:52:46 Caroline Donaldson] No change in risk status. Bed base number remains at x8 Level 3 beds. [09/01/2023 14:27:52 Caroline Donaldson] No change in status - still remains an issue. Bed base numbers remain reduced at x8 Level 3 beds. [29/11/2022 15:16:01 Caroline Donaldson] 17/11/2022 Discussed at TACC CBU governance meeting. Still remains an issue. [19/10/2022 15:22:43 Caroline Donaldson] 19/10/2022 CBU are looking to request an escalated rate for recruitment. Paper is currently in progress to request. Confirmed by S Daniels. Quality Impact Assessment undertaken and LCH ITU reduced to 8 x L3 bed equivalents on a temporary basis. For review Update 25.7.22 - substantive advert closes 8th August 2022. Locum advert is closed but awaiting shortlisting. Awaiting confirmation of interview date but looking like 27.9.22. Escalated to Medical Director and COO re decision to continue L3 equivalent reduction at current time.	4	31/10/2022		13/09/2024
1c. Improve clinical outcomes	5154	88	Regulatory compliance	Simpson, Mr Andrew	Hansford, Lisa			17/04/2023	16		Corporate			Trust-wide	The Trust currently does not have a Medicines Management or Intravenous Drug Training package on ESR. Previous Medicines management training was removed when the ESR software was changed. Usually all new nurses will be required to complete the medicines management training as part of the mandatory training. This is to support them to be able to administer medicines to patients. Without a robust Medicines management training package staff will not have access to the r Medicines Management training that has previously been available, which is not in line with Trust standards. This could potentially lead to harm to our patients from medication incidents, we will not be adhering to CG174, NG29, SG1 and QAPPS minimising injectables risk. Risk of breaching CQC regulation 12: Safe care and treatment also	All staff will have had undertaken some level of medicines management as part of their professional qualification, however standards are inconsistent and not aligned to trust standards. National (CG174, NG29,SG1) and Local policies and guidance indicate that training should be available to staff to support in administration and safe medicines management. Additionally won't be compliant with QAPPS in relation to minimising injectable medicines risks. CQC regulation 12: Safe care and treatment all indicated training should be available. None currently in place in the Trust. There are new staff that have comenced employment with the organisation that cannot access the trust medicines management training and ward and department leads require a decision to be made as to whether or not these staff can administer medication.	Reported incidents, Staff feedback on training and support available in staff surveys. Inspection feedback	04/04/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	The Medication Safety Team have written the Medicines Management, Controlled drugs training and the Drug Administration Programme. These training documents are also to be supported by the nationally recognised eLearning for health IV therapy passport. These training packages are under review by MOpS group before they can go through the governance process. The governance process is likely to take a number of months. There is then the added task of getting the training packages put onto ESR and mapped to the correct staff. ESR team is severly understaffed which may delay the process further. As an interim measure to reduce this risk level, once the training packages have been through the relevant governance procesess, there could be the option to add the training power points to the Trust intranet. This would not be mapped to staff members, however we could signpost staff to this and local training completion records could be kept by the ward/department leads.	[04/04/2024 09:01:18 Lisa Hansford] Still awaiting this package to be uploaded to ESR [29/12/2023 12:57:50 Lisa Hansford] Awaiting education and training team to upload to ESR [06/12/2023 14:55:35 Gemma] Training packs signed off through governance process Awaiting update from Education and Training team when these will be uploaded to ESR. Delay in this due to vacancy in their team [07/09/2023 14:09:00 Lisa Hansford] 7.9.23 Signed off by APPG and will go to NMAFF on 8.9.23 for final ratification [13/06/2023 12:46:40 Lisa Hansford] Training packages to be signed of by MOpS by 20th June. Then will continue through the governance process before they can go on ESR [04/05/2023 14:24:40 Lisa Hansford] No update as waiting to go through MOpS process [26/04/2023 11:14:07 Rachael Turner] Risk validated at RRC&C Meeting 26/04/2023 as a score of 16 High Risk. Risk to go to Medicines Quality Group to expedite risk.	8	17/04/2024		04/07/2024

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
3c. Have enhanced data and digital capability	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.	23/04/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Requires a strategic decision from the Trust regarding a Records management lifecycle and level of expertise to advise and guide on future projects and developments. Needs to link into 365, ePR and EDMS Programme. 365 cannot be delivered with dedicated Records SME resource.	[23/04/2024 09:19:54 Fiona Hobday] Little progress: *Corporate- Action with Digital to identify all available funding in different project pots so Trust can look at options for RM roles. *Clinical- Current action with Lee Perkin and EDMS PM to develop JD/PS. Potential move to national tenant adds further priority to this exercise. Have moved expected completion date as can't progress until SME role sorted and in post. [25/01/2024 14:31:13 Fiona Hobday] *Working group has been agreed in relation to 365 following discussion at DHG- due to start in Feb 24. *Clinical Records Group has new Chair- Paul Dunning- he is now aware of concerns and issues with record retention and disposal. *Digital Programme Team are now raising lack of expert records manager in project risks and looking at how a role could be funded. *Corporate records resource needs to be reviewed in future. [04/09/2023 17:32:10 Fiona Hobday] *Little movement to date with regards to a strategy. IG have pushed in relation to ongoing future plans re EPR etc... *365 group are drafting a formal paper to go to senior staff in relation to governance as a whole and the RM work needed to do do this compliantly, linked to risks, operational ask etc... When complete IG will review and add to. [05/06/2023 17:22:19 Fiona Hobday] *Head of IG has spoken to Trust Sec re current concerns on lack of a strategic approach- linking to 365, EPR and EDMS. Need to look at whole picture and not pieces of work in isolation. *Head of IG has raised with Digital Programme Team to ensure RM is looked at strategically and in a joined up manner and they link in with Trust Secretary as the functional owner for Corporate Records. *365 Project- Records Mgmt identified now as a key deliverable and driver for the project. [08/03/2023 13:53:45 Fiona Hobday] Head of IG and DPO discussed in relation to	4	28/06/2024	30/09/2024	28/06/2024
3a. A modern, clean and fit for purpose environment	5136	10	Physical or psychological harm	Parkhill, Michael	Pattinson, Paul	Estates investment and Environment Group	Health and Safety Group	28/03/2023	20		Corporate	Estates and Facilities	Estates	Trust-wide	Following monitoring for Nitrous Oxide levels in Pilgrim and Lincoln (Theatre and Maternity Units), it was identified that in a number of locations, staff were exposed to higher levels of nitrous oxide where levels exceed the Workplace Exposure Limit (WEL) OF 100 ppm (8hr time weighted average (TWA)).	Following notification the following actions were undertaken: Pilgrim Hospital – Labour Ward: Estates staff checked the supply ventilation from the Air Handling Unit (AHU) to the Supply Grilles within the labour rooms. At the time of inspection, the Estates staff identified the dampers restricting airflow were not adjusted correctly. This was addressed and airflow checks were undertaken. Typical air change rates were around 6 air changes per hour (ACH) – current guidance is a minimum of 10 ACH, however the ventilation systems are circa. 1960 and the guidance is not retrospective. Following the actions undertaken, resampling commenced 15th March (15 sample tubes), 13 were within WEL limits, but 2 sample results were recorded at 255 and 407 ppm (8 h TWA) in Rooms 2/2a and Room 3, respectively and exceeded WEL limits. Estates are reviewing the current system to look at increasing air changes by upgrading the supply fans / changing pulleys / upgrading filter media or a combination of factors. Further works to increase ventilation has been completed and whilst not HTM03 compliant by design - supply ventilation has been increased to reduce the risk of WEL exceedance. Lincoln Hospital - Labour Ward: Estates staff found the ventilation system had been isolated (approximately 10 years ago). Following discussions with Estates members, the ventilation system had failed and was deemed beyond economical repair and a decision had been made not to replace (no one is aware of why this was made or by whom). Estates plan to reinstate the ventilation, where feasible, which will likely include partial refurbishment and deep clean of existing systems. N.B the use of sampling tubes to monitor Nitrous oxide levels can be highly time and place dependent, the person with the sampling equipment and their activities, can indicate exposure levels that are as a result of human error, not as a failing of the environment. As such G210 analysers specifically designed for highly accurate measurement and verification of the quality of piped N2O and O2 gases, are being sourced.	-COSHH assessments and training. -Health Safety Environmental and Welfare Operational Audit programme. -Direct involvement with Occupational Health. -Datix incident reporting.	20/03/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	The issues identified with exposure levels are not unique to ULHT, as with most NHS Trusts investment is required to upgrade Ventilation to comply with HTM 03-01. NHSEI issued guidance on the 2nd March 2023 for NHS Trusts to follow. Noting where ventilation is insufficient, human factors are critical in reducing staff exposure, such as: 1. Providing clear instructions to patients on correct use of equipment being used, including exhaling into the rebreather mask or out through the mouthpiece 2. Staff positioning relative to exhaust N2O and the direction of ventilation flow 3. Turning gas and air off when not in use 4. Unplugging regulators from outlets when not in use 5. Monitoring the condition of equipment for leakages. These factors can't directly be influenced by Estates and require the support and influence of Clinical Leads and Occupational Health. ULHT Health and Safety Team have recently implemented software to assist with COSHH assessments and training. The Team provide support with the Health Safety Environmental and Welfare Operational Audit programme. Occupational Health have been directly	[20/03/2024 14:46:36 Rachael Turner] Update from Health and Safety: PHB indicates no staff exposure exceeding values for nitrous oxide Workplace Exposure Limit. LCH does refer to x1 member of staff carried out on 29.08.2023 values cause for concern, the following day the values were no cause for concern. To date I am unaware of any referral to Occ Health relating to this employee. The work to provide a safe of work/ protocol was completed with Maternity Leads and the Cadmus system is available for department leads to provide local monitoring. It would be prudent to reduce the risk bearing in mind that this subject remains on the Maternity agenda (National Survey). The two most recent reports carried out on 30th May 2023 for PHB and 6th September 2023 LCH have been attached to this risk. Estates will undertake some further air change monitoring to ascertain if any further work is needed on the ventilation at LCH, we may then need to think about re-testing [19/03/2024 10:32:29 Rachael Turner] All workforce monitoring has been carried out. Need to confirm with H&S committee whether there have been any exposure limits for Lincoln site and if not whether this risk requires to be closed. [29/01/2024 19:35:31 Rachael Turner] The supply fans serving the recovery areas have been upgraded and airflows retested. Airflow has improved but not sufficient to meet 10 air changes per hour. Further works to be scheduled by PG/NM [25/10/2023 10:59:03 Rachael Turner] Risk reviewed and remains the same, meeting to be had tomorrow (26/10/2023) with estates to discuss progress.	10	28/03/2024		20/06/2024
1b. Improve patient experience	5234	510	Service disruption	(Historical Deleted User)	Fullaway, Mr Ian			25/08/2023	15		Clinical Support Services	Diagnostics CBU	Neurophysiology		No clinic space at Pilgrim Hospital resulting in only ad-hoc provision of outpatient nerve conduction testing at the hospital. Previous clinical space was taken from the service due to ED/UTC projects with temporary agreement for clinic room (agreed in 2020) ending in October 2022 with PHB physiologist retirement. No EEG or EMG service provided at PHB currently. No Inpatient provision for testing at PHB. Inpatients requiring tests have to be transferred by hospital transport to Lincoln County for testing. Current risk is not being able to restart the service. At the moment, this is an unequitable health offering.	Adhoc bookings of space available within Outpatients at PHB. Booked where and when possible.Recruitment of new overseas Physiologist has been undertaken and completed. The staff member is fully trained and ready to start clinics in PHB when appropriate, permanent space is provided. Space must meet IPC requirements.	Waiting times, travel times, Patient Feedback, IP LOS impacted by the service being unavailable on site.	17/06/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Adhoc sessions being booked for Outpatient provision where space can be found. No plan for IP on site.	[17/06/2024 10:08:42 Gemma Staples] It has been agreed - we are waiting for Estates to confirm the costs and dates for the enabling works. IPC have reviewed and are happy with the plan [19/03/2024 10:38:03 Gemma Staples] In January we submitted a change of use form to Estates, chased this in February and March and to date have not had a response. [31/01/2024 11:37:43 Rachael Turner] Risk discussed as part of the Deep Dive at RRC&C meeting 31/01/2024. Risk score reviewed and updated to 4x4:16 High risk. [11/12/2023 13:05:50 Gemma] Risk reviewed. No change [13/09/2023 12:20:09 Maddy Ward] From an estates point of view, there is no plan to restart the service. This has been passed to project manager in estates to review clinical space (chased today). A suitable sized, permanent room is required. Started space request in September 2022 and meeting in July 2023. There has not yet been a date given for a clinical space review.	3	26/08/2024		17/09/2024

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5142	65	Physical or psychological harm	Ratcliff, Carl	Smith, Charles	Patient Safety Group		12/04/2023	20		Medicine	Urgent and Emergency Care CBU	Accident and Emergency	Lincoln County Hospital	Within Lincoln and Pilgrim Emergency Departments there is a risk that, given increases in demand/footfall, the current staffing template for middle grade doctors overnight may not provide assurance to maintain patient safety.	Utilisation of on-call Consultant to support dependant on holistic risk. Specialty support and signposting to other directorates and providers. Full capacity protocol and boarding.	4 hour target/12 hour breaches. Time to first assessment. Decision to admit.	15/04/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	ED Rota and workforce review with new rotas to provide effective cover overnight in all areas at all grades. New rota templates signed off by finance, to be implemented Q3 2023. Recruitment ongoing.	[15/04/2024 11:01:21 Rachael Turner] Further delay due to job planning from medical workforce. Now expected Q3/Q4 24/25. CBU Team looking at mitigations including removal of some shifts to improve uptake across 24 hour period. [05/03/2024 15:45:12 Rachael Turner] Consultation has now ended. Expected go live date Q3/Q4, this should have gone live last October. Update to be provided in June. [09/01/2024 15:09:37 Rachael Turner] Risk remains the same. Increased winter slippage funding that lets us have extra middle grade shifts. Consultation due end of Feb/ March. [17/10/2023 10:11:32 Rachael Turner] This remain the same due the consultation in place. This remains to go out to bank and agency until staff are recruited. [26/09/2023 14:46:05 Charles Smith] Tier 2 MG consultation extended and ongoing. Mitigation via locum/bank until then. [30/08/2023 11:24:12 Carl Ratcliff] will review post meeting with exec on 30th August 2023 with action plan in place to manage more of the ED risk [15/08/2023 11:15:38 Helen Hartley] This will align into the medical workforce tier 2 recruitment process as per risk 5020 Also links into overcrowding piece. [19/07/2023 15:54:10 Helen Hartley] This has been looked at and updated, remains and will review next month [13/06/2023 11:09:55 Helen Hartley] Risk reviewed, level remains the same. Agreement for workforce plan has been given, adverts going out imminently. [07/06/2023 12:52:03 Rachael Turner] Risk discussed at RRC&C meeting 07/06/23 Risk added following three escalations. Night cover increased from 5 to 6 after funding secured. As recruitment comes on board risk will reduce. Risk score 4 x 4 at a score of 16. [24/04/2023 12:18:07 Carl Ratcliff] Review underway of short term ability to support more staffing at night by changing some shifts from day team	9	31/08/2023	01/11/2023	15/07/2024
2a. A modern and progressive workforce	5093	40	Service disruption	Sakthivel, Mr Kulandaivel	Baines, Andrew	Medicines Quality Group	Workforce Strategy Group	16/02/2023	20		Clinical Support Services	Pharmacy CBU	Pharmacy		Baseline pharmacy procurement staffing is at a level where the basic functions are not routinely being delivered and the service is not able to withstand any prolonged absence due to leave, sickness or resignation. There is limited staff covering this (at times just 1 staff member).The workforce has remained relatively stable over time, however workforce pressures have been increasing over the last few years for a variety of reasons. There has been an increasing number of pharmaceutical shortages, many of which are complex in nature and need rapid action to avoid patient deaths. A growing number of drugs are now being offered on an allocation basis which requires micro management for stock ordering and distribution across the Trust. Changes in the delivery of chemotherapy have resulted in an increased demand for ordering of chemotherapy preparations. The pharmacy invoicing team have also experienced a recent increase in workload following the implementation of the Advanced finance system. This is currently 1 part time staff supported by bank staff where possible. The team are reporting concerns around workload and workplace stress. We are routinely reliant on existing staff working additional hours to fill gaps. If staff feel unable to come to work for any reason (including stress related) this will further increase the risk to the Trust and its patients of stock outs, with an associated risk to patient care, due to either a lack of personnel to raise orders, manage shortages, chase orders which are not being received, or to process invoices and manage supplier queries.	The team comprises three part time procurement clerks (this has reduced from four) and one (reduced from two) part time invoice clerks working from a centralised office in Lincoln but responsible for trustwide ordering and invoicing, and 5 storekeepers who work across the sites, and is lead by a full time pharmacist and technician. All areas of the service are continuously working at or over capacity and any absence results in other staff working additional hours, or attempting to absorb additional duties over and above their own in order to maintain the basic service. There is theoretical potential to cross cover with members of the Homecare team who have a similar skill set, however that service is also under extreme pressure and so there is limited capacity to provide this cross cover – it is most often used to support the invoicing team at times of annual leave. Where staff have recently expressed concern about work related stress the associated risk assessment has been provided. From a procurement perspective the baseline staff level on a day is 2 purchasing clerks, so purely taking annual leave into account there are multiple weeks in the year where only 1 purchasing clerk is available to manage the ordering workload. This impacts adversely on the job role of the procurement technician who often has to backfill these gaps. This makes the team very susceptible to the effects of sickness absence, particularly if this occurs whilst another team member is on leave. On such days it is frequently not possible to meet the full basic demands for all pharmacy sites with the potential to see a reduction in order frequency from twice a day to once a day, and less capacity for chasing of outstanding orders, depending on staff availability – giving further rise to a risk of treatment delays if stock orders are not placed or chased in a timely manner.	Staff morale is low across the pharmacy department as per the last communicated NHS staff survey feedback, and direct feedback from staff within the procurement team highlights that morale within the team is challenged and wellbeing is impacted. An increase in workload due to product shortages can be evidenced with reference to the growing number of Medicines Shortage Notifications (MSNs) and Supply Disruption Alerts (SDAs) issued by the Department of Health and Social Care, which totalled 25 over the last 4 months of 2020 (following the launch of this scheme), 80 in 2021, and 89 in 2022. Whilst not measured, departmental feedback highlights a growing frequency out of stock scenarios which require investigation and follow-up	26/03/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Gap analysis highlights several areas of ongoing concern (to-follows, shortage management, invoice query management, medical gas invoicing). Occasional additional support is currently being provided to the invoicing team by a Bank Pharmacy Support Worker; we are scoping training this individual to offer procurement support in addition. This post is being paid from vacancy money elsewhere in the department and so cannot be considered a long-term fix for the procurement gaps. A case of need will be prepared to identify workforce requirements to reduce the workload stress the staff are persistently facing, and to provide a robust service which can withstand annual leave and short term sickness absence, based on the more challenging pharmaceutical market we are operating in where shortages are now a daily occurrence.	[27/03/2024 09:51:29 Rachael Turner] Risk presented at RRC&C meeting 26/03/2024. Agreed to be reduced to a 4x4: 16 High Risk. [11/03/2024 09:59:03 Lisa Hansford] Invoicing is in a much improved position and we are now receiving monthly performance indicator from finance to show percentage of invoices paid within 30 days (as NHS target we are meant to meet), and we are performing well (overall pharmacy invoice performance is negatively impacted by homecare - we are waiting to assess the impact of their recent recruitment though, as we know they have been operating with a staffing gap. Purchasing - we have three substantive staff in Monday and Tuesday; two substantive staff Wed-Fri supplemented by bank. Risk therefore remains Wed-Fri, so position is improved and likely needs to drop from 20. Risk also remains adversely impacted until staff are fully up to speed with all processes... aiming to readvertise the Wed-Fri gap in the hope current bank member of staff may apply. [17/01/2024 12:09:36 Gemma] We have had successful recruitment but still have one remaining so still have a risk Wednesday to Friday. This is going back out to advert to help fill the gap. [17/01/2024 12:03:17 Gemma] No further update [29/12/2023 14:02:33 Lisa Hansford] No further update [18/12/2023 21:36:39 Rachael Turner] No change, recruited staff will be in post in January. Risk score to be reviewed once in post and trained. [29/11/2023 11:26:52 Rachael Turner] Risk discussed at RRC&C meeting as part of the Deep Dive. Support to fill gaps is currently in place. We have successfully recruited two posts,staff but they will not be in post until Jan 2024 and then will need to be trained. Once staff are in post this risk will need to be reviewed to look at scores. There is still a third vacancy, this post is unfunded, a business case now needs to be written to look into this. Risk reduction plan needs to be reviewed following this update.	4	16/02/2024	16/02/2024	26/06/2024
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	4789	32	Physical or psychological harm	Frake-Harris, Julie	Venuggopal, Mr Vinod	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 ICB to review performance; secure any additional available capacity Escalation through CBU and Divisional governance processes / Planned Care Cancer and Diagnostic System Recovery Cell	DMO1 activity - monthly review Backlog consistently reducing. Booking Team are now part of the Cardiovascular Division.	24/04/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	- Set healthcare working at Grantham CDC-contract for 3000 Echoes this is to to reached by May 2024. -Continued recruitment process, which included current recruitment and retention package. This will be complete April 2025. -Direct contract award to agile services to provide physiology support at our Boston site for 3 months, this will commence the end of Jan 2024. This will mitigate the staffing issues at Pilgrim. -Two further CDC (Community Diagnostic Centres) to come online in September 2024, one in Skegness and the other in Lincoln.	[24/04/2024 14:25:46 Nicola Cornish] Discussed at RRC&C on 24/04/24 - in last 18 months, reduced waiting list from 8,000 patients to 1800 patients so backlog is now around 600 patients. Were previously worst performing Trust in the country and we are now in the top 10. Predict that by June 2024, no one will be waiting for more than 13 weeks. Agreed reduction in scoring to 16 (4x4). [09/04/2024 19:54:33 Rachael Turner] Representative not available to present at RRC&C in March, this will be presented in April for reduction in score. [05/03/2024 09:12:58 Rachael Turner] Risk reviewed, will be presented at the Risk Register Confirm and Challenge Meeting in March for request for reduction in score. [14/02/2024 14:57:54 the reporter] Risk reviewed, numbers continue to fall. Update to be provided in March, this will then go to Risk Confirm and Challenge in March for a reduction in score. [15/01/2024 14:18:13 Rachael Turner] Previously back log was 8000, this has been reduced significantly and is now currently 3576. Risk controls and risk reduction plan updated to reflect ongoing work. Risk to be reviewed for possible reduction in score in February. If agreed by Division this will be presented at Risk Confirm and Challenge. [18/12/2023 21:40:10 Rachael Turner] No update currently, risk to be reviewed in Jan 24. [20/11/2023 20:29:20 Rachael Turner] Risk reviewed, work ongoing, numbers continue to fall in the right direction. [30/10/2023 15:05:34 Rachael Turner] Weekly meetings continue with ICB. We continue to maximise the capacity at the CDC. Numbers are continuing to fall and we are basically on track with our trajectory. [16/10/2023 16:24:27 Rachael Turner] List continues to fall, all D3 are now seen within six weeks. All follow up patients with the exception of valve registry are booked when their appointment is due. Weekly ICB meetings continue to	4	31/03/2022	01/02/2024	24/07/2024

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1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	4646	66	Physical or psychological harm	Dunderdale, Karen	Gibbins, Donna	Patient Safety Group	Clinical Effectiveness 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	26/04/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Delivery of the NIV Pathway project as part of the Improving Respiratory Service Programme within the Integrated Improvement Plan (IIP): 1. Understand the Trust-wide demand and capacity for Acute and Non Acute NIV. 2. Provision of ring-fenced beds for NIV. 3. Develop Trust-wide Model and Pathway for Acute and Non Acute NIV To meet BTS/GIRFT Standards. 4. Provision of NIV service (ED) which meets the BTS Quality Standards. 5. To have a trained workforce with the skills required to meet the needs of the patients and BTS standards. 6. Governance Process for NIV Demonstrating a Safe Service where Lessons are Learnt.	[26/04/2024 14:32:58 Rachael Turner] Risk currently remains at 16 due to lack of equitable service to comply against BTS at Pilgrim. The Monthly NIV audit has demonstrated that there are educational shortfalls with ED and delays in type 2 respiratory failure and escalation. An initial meeting has taken place with respiratory and ED to discuss and review the NIV in a non-ITU setting Sop due in august 24 to consider any contributory factors for commencing NIV in ED. The availability of the ringfenced remains an improved position against the standard. [23/01/2024 14:57:00 Rachael Turner] Meeting is planned in March to discuss NIV and ED, previous meeting were stepped down due to industrial action. We continue to see Datix incidents relating to NIV in ED. Meeting needs to take place before any change can be made. Support is needed for phase 2 of respiratory programme. This will be a priority for 2024. Risk score currently remains. [02/11/2023 10:11:07 Rachael Turner] Currently still do not have Trust-wide provisions- this will be picked up as part of phase 2 of respiratory programme. Whilst we have a robust process in place we continue to have issues with availability of ringfenced beds on both sites and education in ED and therefore are not consistently meeting the national standards. We have a planned meeting to discuss the last years performance. Following this, the risk will be reviewed looking at lowering the score but not remove at this point. [30/08/2023 11:21:21 Carl Ratcliff] to discuss with CBU and review ability to close or reduce [07/08/2023 17:06:10 Donna Gibbins] Funding agreed- recruited workforce continues due to agreement to ensure safe staffing Annual audit for NIV compliance complete- report to be generated and shared with Cabinet Ongoing discussions regarding provision of NIV in ED continues No SI since project commenced for NIV Full outcome of provision for Trustwide achievement not yet equal due to lack of	4	30/09/2022	31/12/2024	26/07/2024
1c. Improve clinical outcomes	4866	87	Service disruption	Costello, Mr Colin	Saddick, Ahtisham	Medicines Quality Group	Risk assessments	01/03/2022	15	Risk assessments	Clinical Support Services	Pharmacy CBU	Pharmacy	Trust-wide	Recruitment of ULHT pharmacy technicians to ward-based clinical pharmacy roles affects the balance of the pharmacy workforce and impacts on the core pharmacy service provided	Pharmacy should be fully involved in the development and implementation of these roles. The Chief Pharmacist is accountable for the professional management of these roles, however there is not a clear understanding of the supervision and development framework for the new roles.	Monitoring of Pharmacy Technician performance	04/04/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	To develop a robust supervision, training and development framework for the new pharmacy technicians roles. 1. To undertake a quality impact assessment to evaluate the potential impact on pharmacy services. 2. To develop a robust NVQ apprenticeship training scheme to train band 2/3 staff to band 4/5 roles both on the wards and in pharmacy services to achieve a sustainable pharmacy technician workforce in order to support all pharmacy technician roles.	[04/04/2024 09:06:25 Lisa Hansford] No further update [29/12/2023 13:54:44 Lisa Hansford] No further update [07/11/2023 14:12:59 Lisa Hansford] Update- Variable ward based technician support is being provided for clinical pharmacy cover for admission areas. Risk is ongoing as there is still the possibility of staff movement to WBT roles therefore leaving gaps in core services [26/09/2023 14:15:54 Rachel Thackray] Risk remains, awaiting further update [07/09/2023 14:11:26 Lisa Hansford] 7.9.23 no further updates [27/06/2023 09:45:21 Alex Measures] Discussed in risk register review meeting- no further updates [01/06/2023 14:31:32 Lisa-Marie Moore] Discussion with CSS Division on how techs could be used to support pharmacy [28/03/2023 15:04:33 Rachael Turner] Risk proposed to be increased to a 16, this will be presented at RRC&C meeting 29th March. [20/12/2022 14:39:34 Alex Measures] no further updates Scheduled project due to commence March 2021, monthly reports will be provided. Monthly ward based technician meetings are addressing the training issue. 150622 ongoing, losing another technician to wards.	16	30/11/2021	28/04/2023	04/07/2024
2a. A modern and progressive workforce	4862		Staffing	Ratcliff, Carl	Thomson, Cheryl	Workforce Strategy Group	WORK	22/02/2022	16	Staff Survey	Medicine	Specialty Medicine CBU	Respiratory Medicine	Trust-wide	Consultant staffing within Respiratory Medicine at Lincoln and Boston Hospital. Currently there are only 3 Substantive consultants in place at LCH and 2 at PHB. We have a vacancy of 5 across the three sites. Various gaps are covered with Adhoc Locum. The main current risk is to the inpatient cover at Pilgrim Hospital. With only x2 Consultants over there, when we have 1 on annual leave, the risk that the other could be either sick or covid contact is extremely high. We have supported this with clinicians going over from LCH, however due to a further resignation at LCH, this is proving more difficult This combined risk on Medical staffing has now impacted the Secretarial team at LCH. There is currently 0 secretaries at work at LCH due to sickness in the team. This is mitigated through support from Agency / Other specialties supporting. We do not have the substantive staff nor the locum or agency bookings, to cover all functions of our Resp Medical Team. Inpatient risk of high acuity patients without specialist input. Outpatient risk of high activity of 2ww referrals on top of high volume OP workload, delayed pathway progress / commencing treatment such as chemotherapy. Due to lists / skillset required, there is not the ability within the organisation to cross cover between sites leading to Grantham particularly being most at risk.	Due to the severity of the risk: Currently: x 5 Consultant Gaps in Resp The impact this is having on the current workforce is stretching the team and leading to added pressure on the workforce. We are working with agency teams to work 'differently' for example Locum consultants supporting with on call work / remote clinics to release the burden on the current clinical team in respiratory. OD support in place also, along with weekly catch up meetings with the teams to explain the current state of play. The Business Unit have this week (06/09) put a bid in to the EMCA to gain funding of 250K to support a General Medicine to work in Respiratory so that our Substantive teams can be released to support Respiratory Cancer Capacity - This bid is currently being reviewed. We have worked in the background to book x 2 Agency Locum General Medicine Consultants 1 at Boston and 1 at Lincoln which will take us over budget, but supports the respiratory patients of lincolnshire and the welfare of consultant staff.	Staff Survey Results. Data Analysis through HR around recruitment and retention. Measured through Performance for patients (although this is not directly attributed towards the recruitment and retention, the longer wait times cause anxiety and unwarranted stress for the consultants in post)	09/05/2024	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.	[09/05/2024 14:35:19 Rachael Turner] There is going to be a clinical strategy review for Respiratory. This will require significant financial investment and currently we are restricted. Risk remains the same. ACP work will continue. [14/11/2023 14:43:19 Rachael Turner] There are 3 substantive consultants but the risks remains the same and we rely heavily on bank and agency. Score remains. Nodule ACP role, this is a permanent role, has been developed and recruited but she is still back filling the plural. [30/08/2023 09:30:26 Carl Ratcliff] Expect to be at 10 consultants at end of Nov and will review risk again in 1/12 [24/04/2023 12:25:14 Carl Ratcliff] Have recruited to Consultant ACP post in nodules to support team - will start in 1/12 Using additional external support to deliver extra capacity for OPD to allow delivery of 78ww and reduce risk for delivery of 2ww urgent work [24/02/2023 13:48:15 David Marsh] Recruitment in progress, 5 substantive consultants in post (3 x Lincoln, 2 Boston). Agency locums in place covering a variety of roles/sites. New NHS Trust Locum Respiratory Consultant from overseas started in January at Lincoln. Now working independently. Division looking at developing ACP roles and Nodule Nurse post. [01/12/2022 11:15:13 Carl Ratcliff] plan for 3 consultants now being on boarded New plan to develop ACP nodule role Most recent update: Dear Carl, Following the catch up earlier, Claudia, Ashley and I have compiled our thoughts on what could go down to support the services….. Option Take down: Benefits Risks:	4	30/12/2022	03/06/2024	09/08/2024
3b. Make efficient use of our resources	5389		Finances	Frake-Harris, Julie	Hodgkins, Mr James			19/02/2024	20	Corporate			Hospital at night		Risk of overspend due to current service provision being unfunded. Also overspend due to increased sickness leading to a higher requirement for bank, agency and Overtime. Increased insurance due to increased litigation. Due to patient complaints and safety aspects.	Monthly budget reviews, and recognised overspend.	Datix, through finance reviews.	14/06/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Case of Need to be heard by CRIG on the 26th March 2024, following which a business case to be submitted.	[14/06/2024 11:12:21 Rachael Turner] Risk reviewed, no change at present. Risk score remains the same. [28/02/2024 11:50:14 Rachael Turner] Risk presented at RRC&C meeting 28/02/2024. Risk validated as a 4x4:16 High risk.	6	19/02/2025		19/09/2024

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1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5227	439	Regulatory compliance	Lynch, Diane	Hughes, Robert	Clinical Effectiveness Group		02/08/2023	12		Clinical Support Services	Path Links (Pathology)	Mortuary (Pathology)	Trust-wide	Due to the limited security measures in place there is significant risk of unauthorised entry into the Trust's mortuary departments and/or temporary body stores. The risk is based on the following security gaps: Lincoln: Temporary body store: No alarm, Swipecard access Lincoln: Main mortuary: Alarm system in place, but not connected to Switchboard Boston: Temporary body store: No alarm, Swipecard access Boston: Main mortuary: No alarm system In the event of a break in, not only would the dignity of patients be compromised but there is a high probability that damage could be inflicted on patients either deliberately or as a consequence of a failure in the control of the environment. The scenario is reportable to both CQC and HTA as regulators. In addition, criminal investigations would be initiated. As regulators, CQC and HTA can issues fines, sanctions or even revoke the licence to operate mortuaries. It would be highly likely that complaints and claims from families of the deceased would ensue having lasting reputational damage to the Trust.	24 hour site security: Walkarounds in place, with security tags fitted to exterior of mortuary buildings; additional security patrols at night CCTV: On entrance to Mortuary departments and the temporary body stores (inside also) Access Control: Swipecard access to main mortuary departments (governed by SOPs). No swipecard access to Temporary body stores, this is key operated locks only. Single key set only accessible by mortuary staff held in the mortuary which is access controlled. Boston: Temporary Body store: Not currently in use, likely to be no longer needed when refurbishment work completed at the end of April 2024. Access is via a locked gated yard.	The frequency and extended use of the temporary body store at Lincoln has increased the risk.	24/04/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Actions being taken: * Assess security vulnerability (on the back of recent incident at NLAG/DPoW) with NLAG/ULHT/Police review of security: Date tbc * Boston main mortuary: Quotation obtained and authorisation approved for alarm system to be fitted to department with autodialler to call Switchboard at event of alarm operating (to install same autodialler to existing alarm system in Lincoln main mortuary). Date: TBC Action to be taken now: *Lincoln temporary body store: Obtain Quotation for alarm system and seek authorisation: Action: K. Davey * Grantham Alarm: Quotation to be obtained for alarm system: Action: K Davey	[24/04/2024 13:12:25 Nicola Cornish] Discussed at RRC&C on 24/04/24. Likelihood has increased due to longer use of the temporary units but the severity has also increased due to the current acute focus on mortuary security following well publicised local and national incidents. Agreed to increase in score to 16 (4x4). [03/04/2024 16:03:33 Jeremy Daws] As a result of the refurbishment programme of work taking longer than first planned (Paper to ELT submitted) and the demolition of B Store to enable refurbishment work at Lincoln, the use of the Temporary Body Store at Lincoln has increased and will be in use for much longer than first planned (?End of September 2024). There has been a security near miss incident at Boston which was reported to the HTA. There has been a well publicised security incident at Grimsby which has increased the focus on security. The Fuller inquiry has also focussed on security. Given this context, it has been proposed to increase the risk to a 4 x 4 (16) risk. It is requested for this to be approved at next Risk Register confirm and challenge meeting. [27/02/2024 16:17:34 Gemma] The risk has been reviewed at the HTA Governance meeting. An upward report has been submitted to CSS Governance as to whether are willing to accept this risk given the planned refurbishment of the Lincoln & Boston mortuaries which is due to commence within the next few months, which will eradicate the need for the Titan temporary body stores with increased capacity provided as a result of the completed refurbishment.	6	02/08/2024		24/07/2024
2a. A modern and progressive workforce	5249	13	Service disruption	Low, Claire	Akhtar, Sarah			06/09/2023	16		Corporate	People and Organisational Development	Organisation Development	Trust-wide	Retention: Workforce management practices that are not in line with Trust values and expectations may have a negative impact on staff morale ultimately leading to increased turnover. Replaces current Risk 4991 (Retention element)"	1. Workforce Plan and Recruitment Plan to fill vacancies and reduce burden on current staff 2. People Promise Manager focussing on retention issues, including Exit Questionnaires and Flexible Working 3. Staff Benefit Scheme being further developed 4. Culture and Leadership Programme including Leading Together Forum and Cultural Ambassadors 5. Quarterly Staff Survey to measure leadership behaviours and engagement of staff, allowing quick time targeted interventions 6. Regular reporting through People Systems Manager 7. Onboarding process for Consultants being developed	1. Turnover Rate 2. Pulse Staff Survey (quarterly) 3. NHS Staff Survey (annual)	11/01/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	1. Development of a robust Workforce Plan with delivery against plan monitored at Workforce Strategy and OD Group on a monthly basis 2. Delivery of the People Promise Action Plan which has a clear focus on staff retention 3. Focus shift for People and Talent Academy from System to ULHT with development of clear progression pathways 4. Completion of Culture and Leadership Programme and full introduction of a Just and Restorative approach through all people management activities 5. Robust communication and action planning following quarterly and annual staff surveys to address areas of improvement and strengthen areas of good practice 6. Regular case reviews/lessons learning following employee relations issues arising 7. Career Development across staff groups in particular medical workforce 8. Retire and Return 9. Onboarding process for Consultants being developed	[11/01/2024 12:43:51 Rachael Turner] 11/1/24: Risk reduction plan continues to be worked through and is progressing well. This risk will be formally reviewed in Feb 24 with the People Promise Manager to identify if the risk level can be reduced. [06/09/2023 13:53:37 Rachael Turner] Risk was approved and validated following the RRC&C meeting in August as a new risk following the PODC risk review. Approved score of 4x4:16 High Risk. This risk was previously part of Risk ID: 4991 but has now been split so that staff retention is now a stand alone risk.	8	06/09/2024		11/04/2024
3b. Make efficient use of our resources	5215	13	Finances	Young, Jonathan	Chilengwe, Leah			14/07/2023	16		Corporate	Finance and Digital	Finance	Trust-wide	23/24 introduces a new mechanism to record, calculate and apply the API contract and a System incentive / penalty linked to the Elective Recovery Fund. Actual performance/activity is taken from SUS and EROC. At present, there are some SUS/SLAM reconciliation issues and some recording issues including Missing Outcomes. The risk is twofold: 1. that without accurate ERF monitoring through SUS on actual activity delivered, the activity will look artificially low and there will be financial deductions 2. the activity plan has been built on delivery of c116% of 1920 elective, day case, outpatient first and outpatient procedure activity. Under the new regime underperformance will result in lost income	The link between activity and income has been communicated to the Trust. Monitoring is being set up to monitor activity delivery and estimate the financial impact due to the variable adjustment. Lost income through recording issues (e.g. missing outcomes) will be monitored to include a financial estimate in 23/24. An ERF baseline appeal was submitted and 95% accepted nationally. Revised national ERF baseline figure have been received and are being worked through.	Monitoring of the variable adjustment and lost income is being set up	18/04/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	"Information have been requested to reinstate SUS/SLAM reconciliation. Oversight of delivery is required through FPEC/FPAMs and any technical reporting issues reported to CFIG in the first instance. Required Trust activity delivery plan and then delivery against it."	[18/04/2024 17:00:20 Rachael Turner] The Finance Team negotiated a block contract with Lincolnshire ICB to remove the underperformance risk of not hitting the 116% plan. The Improvement Team undertook a piece of work to resolve the missing outcomes issue. The Finance Department undertook a reconciliation of SUS to SLAM data and the issues were raised with the Information Team to be resolved - ongoing. Local monitoring of ERF now matches the national ERF monitoring and is also available by specialty, this is shared with Trust managerial teams regularly. Early indications are that based on the draft year end data the Trust hit the national ERF target but materially underperformed against the Plan. [23/01/2024 13:21:26 Rachael Turner] National targets have been updated several times. Internal monitoring has been set up, which is consistent with national Trust level monitoring, but also shows trends by specialty and POD. SUS to SLAM monitoring undertaken by Finance as a one-off exercise identified some areas not being reported to SUS which were raised with Information Team for resolution. [16/10/2023 17:20:50 Rachael Turner] The national ERF baseline has been release twice in recent weeks. detail has been requested from the national team and is awaited in order that detailed internal monitoring can be updated [01/08/2023 14:49:23 Rachael Turner] Risk presented at RRC&C meeting in July, approved as 4 x 4 16 High Risk.	9	31/03/2024		18/07/2024

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2b. Making ULHT the best place to work	4993		Service disruption	Low, Claire	Shankland, Lindsay	Equality, Diversity and Inclusion Group		08/08/2022	16		Corporate	People and Organisational Development	Organisation Development	Trust-wide	Workforce management practices that are not inclusive and equitable for people who consider themselves to have a disability may have a negative impact on the recruitment of new employees and the retention of existing ones.	1. Appointment of People Promise Manager (12 month fixed term) 2. Robust monitoring of EDI incidents/concerns 3. Equitable and EQIA 'tested' HR processes (for recruitment, reward and performance) 4. Dedicated OH service	1. Measurement of lived experience of disabled staff at ULHT via - NHS Staff Survey 2. No. EDI/disabilty related incidents reported 3. No. of EDI/disability related concerns reported	11/01/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	1. Governance and assurance for delivery of WDES action plan 2. Review of appropriate datasets to measure risk 3. Introduction of WDES annual report	[11/01/2024 12:46:15 Rachael Turner] Risk reduction plan in place and WDES action plan is being delivered. [06/09/2023 13:17:38 Rachael Turner] Risk reviewed at the RRC&C meeting 30/08/2023 following a review of the PODC risk register. This risk has been validated in score at 4x4: 16 High Risk and now replaces the previous WDES risk. [02/08/2023 10:32:59 Rachael Turner] WDES continues to be delivered and progress monitored through EDIG. Current WDES action plan assessed as good by NHSE. EDS published on Trust Website - signed off through EDIG, People and OD Committee and Trust Board. Maple Staff Network continues to be active and ran a series of events through Disability History Month. Culture and Leadership Programme continues to be delivered and Cultural Ambassadors appointed and commenced their training. Leading Together Forum continues to receive good feedback and each speaker is building on the work of the last creating consistent messaging. People Promise Manager delivering against action plan with national recognition of curent work. Funding for People Promise Manager available for Y2. National Staff Survey results available and action planning commenced. Reasonable Adjustment Policy agreed."	4	31/03/2023	31/03/2023	11/04/2024
2b. Making ULHT the best place to work	4992	55	Service disruption	Low, Claire	Shankland, Lindsay	Equality, Diversity and Inclusion Group		08/08/2022	16		Corporate	People and Organisational Development	Organisation Development	Trust-wide	Workforce management practices that are not inclusive and equitable for people from all racial and cultural backgrounds may have a negative impact on the recruitment of new employees and the retention of existing ones.	1. Lincolnshire Belonging Strategy (improving equity of lived experience and representation across Lincolnshire system) 2. Appointment of People Promise Manager (12 month fixed term) 3. Robust monitoring of EDI incidents/concerns 4. Equitable and EQIA 'tested' HR processes (for recruitment, reward and performance)	1. NHS Staff Survey 2. 'Pulse Check' Staff Survey 3. No. EDI/Race incidents reported 4. No. of EDI/Race related concerns reported 5. BAME staff retention % (leave within first 3, 6 and 12 months) 6. BAME senior representation	11/01/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	1. Robust governance and assurance for ULHT direction of travel for EDI 2. Reset ULHT strategic direction for EDI (EDI objectives 2022-25) 3. Active WRES Action Plan 4. Anti-Racism strategy and delivery plan 5. Zero tolerance stance - for racist behaviour including banter 6. Improved senior level BAME representation 7. Reset Trust values (highlighting civility@work and ULHT commitment to inclusion)	[11/01/2024 12:48:20 Rachael Turner] Risk reduction plan in place and WRES action plan is being delivered. [06/09/2023 13:20:07 Rachael Turner] This risk was reviewed as part of the Deep Dive at the RRC&C meeting following the review of all PODC risks. This risk was validated with a risk score of 4x4:16 High Risk and replaces the previous WRES risk. [02/08/2023 10:35:14 Rachael Turner] WRES continues to be delivered and progress monitored through EDIG. Current WRES action plan assessed as good by NHSE. EDS published on Trust Website - signed off through EDIG, People and OD Committee and Trust Board. Anti Racism (United Against Discrimination) Working Group commenced 7 February 2023 and is delivering outputs against the plan. REACH Staff Network continues to be active and a relaunch of the Network as REACH (formerly BAME) and the See Me campaign complete. Culture and Leadership Programme continues to be delivered and Cultural Ambassadors appointed and commenced their training. Leading Together Forum continues to receive good feedback and each speaker is building on the work of the last creating consistent messaging. People Promise Manager delivering against action plan with national recognition of curent work. Funding for People Promise Manager available for Y2.	4	31/03/2023	31/03/2023	11/04/2024
3a. A modern, clean and fit for purpose environment	5383	615	Regulatory compliance	Cooper, Mrs Anita	Rigby, Lauren	Estates Investment and Environment Group	Estates Strategy Group, Health and Safety Group	13/02/2024	15		Clinical Support Services	Cancer Services CBU	Haematology (Cancer Services)	Pilgrim Hospital, Boston	Treatment room where bone marrow biopsies and venesections take place is not complaint with HBN 00-03. Due to this Bone marrow biopsies have been moved out. Currently waiting to have a meeting with the lead nurse on the ventilation project to understand if venesections can continue in there but at present they are weekly. Also do not yet have another identified area for IT chemo but this is far and few between. This is a risk of regulatory compliance and service disruption to patient treatment	Room is being decluttered Estates job logged Larger organisation piece of work being undertaken	Datix Complaints Assessment against regulations	23/04/2024	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Scoping if another area to do procedures Estates job logged to see if can increase air exchange to 10. Wider organisational piece of work.	[23/04/2024 13:12:50 Gemma Staples] BM biopsies moved, Karen Bailey confirmed venesections do not require the air exchanges, only IT chemo will be administered in this room being discussed with IT lead and pharmacy lead around options. [26/03/2024 16:04:11 Gemma Staples] Risk reviewed at the RRC&C today. Update: Suggested at last RRC&C meeting that Estates have one overarching risk but list each identified areas under this risk. Rachel Turner has met with Chris in Estates as this is one area of about 11 areas across all divisions where procedures are taking place without correct ventilation. Chris has a list of areas of which he is asking each area to review and look at areas to see what we can deal with now and then look at what is left. It was agreed that this risk be left on until the overarching risk has been added [13/03/2024 11:15:52 Gemma] Update: We have moved the bone marrow biopsies out. We are waiting to have a meeting with the lead nurse on the ventilation project to understand if venesections can continue in there but at present they are weekly. We also do not yet have another identified area for IT chemo but this is far and few between. [28/02/2024 11:41:30 Rachael Turner] Risk presented at RRC&C, we need to establish if any procedures are happening in this room as this would be a patient safety risk. Once established this will be re-presented in March.	3	13/02/2025	13/02/2025	23/07/2024

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3a. A modern, clean and fit for purpose environment	4858	12	Service disruption	Parkhill, Michael	Whitehead, Mr Stuart	Water Safety Group	Emergency Planning Group, Estates Infrastructure and Environment Group	10/02/2022	25	Risk assessments	Corporate	Estates and Facilities	Estates	Trust-wide	If there is a critical failure of the water supply to one of the Trust's hospital sites then it could lead to unplanned closure of all or part of the hospital, resulting in significant disruption to multiple services affecting a large number of patients, visitors and staff	Estates Infrastructure and Environment Committee (EIEC). Estates risk governance & compliance monitoring process. Emergency Planning Group / Major Incident Plan and departmental business continuity plans.	Surveys of water supply infrastructure - Pilgrim Hospital is served by only one incoming water main. This is in very poor condition and has burst on several occasions causing loss of supply to the site.	19/03/2024	Reasonably likely (3) 31-70% chance	Extreme (5)	High risk (15-16)	15	Regular inspection, automatic meter reading and telemetry for the incoming water main at all sites. Keeping components on site and regular contractors on stand by. Regular stock levels for emergency fixes. Recently undertaken a survey that looks at the condition of infrastructure. Future survey work will be taking place with Aquawave (Anglian Water) who will do a survey of all the pipework Trust-wide. Pilgrim/Watertank replacement has concluded.	[20/03/2024 15:07:19 Rachael Turner] Recently undertaken a survey that looks at the condition of infrastructure. Future survey work will be taking place with Aquawave (Anglian Water) who will do a survey of all the pipework Trust-wide. Pilgrim/Watertank replacement has concluded. [19/03/2024 10:22:50 Rachael Turner] Risk reviewed. Risk reduction plan updated. Risk score remains. [29/01/2024 19:38:32 Rachael Turner] 2 x feeds to site, one at the Hospital Exit Road, adjoining Sibsey Road & one coming in from the start of Castle Road, the access road to Progress Living. I have 2 water storage tanks, Capacity per tank is 243m³/243,000L, This is potable quality water & will supply the hospital for approx. 20 hours. [21/10/2022 09:06:00 Walter Thompson] Scheme for replacement of critical water tanks - Pilgrim HB- is being developed for the capital plan 22/23 Scheme of work and design currently being produced.	5	30/10/2020	31/03/2023	19/06/2024
2a. A modern and progressive workforce	5381		Service disruption	Frake-Harris, Julie	Markall, Amanda	Workforce Strategy Group	Nursing, Midwifery and AHP Forum, WORK	09/02/2024	15	Risk assessments	Corporate	Operations	Operations		Discharge Lounge (DL) has insufficient substantive workforce to meet current service demands. Significant RN and HCSW WTE shortfall. No B7 manager in place. B6 jnr sister post is unfunded secondment. No ward clerk. Insufficient housekeeping hours. This means that DL cannot staff each shift witihin budget and relys on temporary workforce and inpatient ward support. RNs and HCSWs act as ward clerk and Housekeeper. The risks are:- service is not well led on every shift contributing to delays, failed discharges, reduced patient capacity and turnover, reduced patient flow impacting on front door, omissions in care, omissions in documentation, errors, patient safety incidents, poor staff wellbeing, Poor patient notes and careflow management, poor patient experience. Improvement to practice very challenged to implement due to temporary staffing. Unable to function within current budget. Reputational damage. Inability to meet CQC requirement from 2021 audit.	Each shift has substantive, bank or ward swap nurse in charge. Staffing issues on the day managed by ops matron. Shifts go to bank and then to agency. Dynamic risk assessment; capping capacity or refusing complex patients. Strategic on call sign off required to close discharge lounge due to staffing. Orientation of temporary staff; Induction materials. limited support and advice from operations centre. RNs and HCSWs complete meal and refreshment service. RNs and HCSWs complete cleaning required outside of 2hrs allocated Housekeeper time. RNs and HCSWs complete ward clerk duties.	Healthroster, Workforce safeguard spreadsheet, 8a lead audit, flo audit, datix, PALS feedback and complaints, e-mail feedback, monthly budget, CQC assurance summary, DL patient flow dashboard, daily delays escalation, complaints, PALS feedback, TSSG, Confirm and challenge process. Sickness rates.	28/02/2024	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	1)Recruiting RNs against potential agency savings as part of TSSG. 2)Case of need in progress to fund appropriate establishment to meet demand.	[28/02/2024 11:51:43 Rachael Turner] Risk presented at RRC&C meeting 28/02/2024. Risk validated at 5x3: 15 High Risk.	4	09/02/2025		28/05/2024
1b. Improve patient experience	4701	85	Reputation	Grooby, Mrs Libby	Upjohn, Emma	Estates Investment and Environment Group	Patient Experience Group	13/01/2022	15	Risk assessments	Family Health	Women's Health and Breast CBU	Obstetrics	Trust-wide	If the quality and condition of the hospital environment and facilities used within Maternity services are poor then it may have a negative impact on patient experience and staff morale resulting in loss of confidence in the Trust and damage to reputation; there is also an increased infection risk	- Trust procedures for capital investment and Estates project management - Corporate oversight through Estates Investment & Environment Group / Finance, Performance & Estates Committee (FPEC)	Patient & staff feedback on the environment in Maternity services. Audits of infection prevention & control compliance. Reported health & safety and IPC incidents.	03/04/2024	Reasonably likely (3) 31-70% chance	Extreme (5)	High risk (15-16)	15	Plans for refurbishment of Maternity units on both sites, estimated timescales 3-5 years for LCH, PHB to be confirmed. Full Business Case required. Maternity shared decision council looking at simple solutions for improving working lives of staff.	[04/04/2024 10:32:18 Nicola Cornish] No change, awaiting trust board decision regarding the architect plans. [23/01/2024 16:04:20 Nicola Cornish] The team are continuing to work with architects to develop plans, which are expected to be submitted to the Trust board for approval by 31st March. [17/10/2023 09:30:32 Nicola Cornish] Nettleham have moved to Langton, in process of issuing purchase orders for design team and healthcare planners have visited Pilgrim. Meetings to schedule accommodation. [04/07/2023 09:11:47 Alex Measures] Risk reviewed 03/07/2023- Nettleham has decanted to 1st Floor to allow for works to commence as per plan. [04/04/2023 12:45:23 Jasmine Kent] Predicted date for decanting Nettleham to Langton 02/05/2023. While awaiting funding for refurbishment of Nettleham. Drain work at Pilgrim site is scheduled. [23/01/2023 17:04:59 Jasmine Kent] Included within capital allocation bids for next financial year. Agreement from trust board that works will take place in next financial year. Staff engagement sessions to communicate refurb plans. Issues dealt with by Estates & Facilities as they occur. 13/04/2022: Mitigation plan - full board approval to progress the business case. Require monitoring of staff surveys. CQC report demonstrates unsuitable for use - amended to 3 impact and 5 occurrence = 15 26/09/2022 - Unchanged	6	31/03/2025	31/03/2025	03/07/2024
2a. A modern and progressive workforce	4762	47	Service disruption	Capon, Mrs Catherine	Rojas, Mrs Wendy	Workforce Strategy Group	Nursing, Midwifery and AHP Forum, WORK	14/01/2022	15	Risk assessments	Surgery	Theatres, Anaesthesia and Critical Care CBU	Critical Care	Lincoln County Hospital	Issues with maintaining nurse staffing levels/skill to establishment in ICU at Lincoln.	Nursing workforce planning arrangements. Nurse recruitment / retention processes. Clinical Governance arrangements in Critical Care / Surgery Division.	Staffing vacancy rate within ICU nursing	13/06/2024	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Review of current recruitment strategy. Advertisement for vacant posts.	[14/06/2024 13:15:32 Nicola Cornish] All substantive posts have now been recruited to but the staff are not yet not fully skilled yet. Additional funding for the clinical educator continues in order to support staff development. [09/05/2024 12:15:19 Nicola Cornish] Risk reviewed as felt needed to stay at 15 due to increased capacity in ICU, increased vacancy and poor skill mix. As of 8th May we currently have 8.91 wte vacancy at Lincoln and 0 vacancy at PHB. We are interviewing this month and hope to fill all vacancies. Skill mix will remain an issue but we have recruited some nurses with critical care experience. It will be several months before skill issues improve. We continue to have an additional clinical educator funded by the network. [26/03/2024 13:42:01 Gemma Staples] Risk reviewed at RCC&C today and it was agreed that the risk be reviewed and updated to include capacity aswell as skill and to look at if this is a service disruption risk. Once reviewed then the risk scoring should be looked at based on this. The risk scoring is to be left as it is and to be brought back to the next RRC&C meeting in April 2024. [09/02/2024 10:12:46 Nicola Cornish] Recruitment successful and minimal vacancy however due to the number of new starters skill mix remains an issue. I have reduced the risk this month as our position is improving. We have received network funding which will enable us to continue with additional clinical educators on both units. [18/11/2023 21:08:13 Nicola Cornish] No change to risk score. Part of ICU workforce group that meets weekly. Minimal vacancy across both sites but skill mix remains diluted. Additional clinical education support on both sites and additional funding from network to support training and development. [25/10/2023 11:21:03 Rachael Turner] Risk reviewed at RRC&C still a high risk, score remains the same.	6	30/06/2021	30/09/2022	13/09/2024

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
3a. A modern, clean and fit for purpose environment	4830	11	Service disruption	Cooper, Mrs Anita	Myers, Joseph		Estates Infrastructure and Environment Group, Medicines Quality Group	17/01/2022	15	Risk assessments	Clinical Support Services	Pharmacy CBU	Pharmacy	Pilgrim Hospital, Boston	The area above Pharmacy at Pilgrim Hospital contains estates plant and pipes that are prone to blockage and overflow, which could cause extensive damage to medicines; computer equipment and aseptic facilities that disrupts service continuity.	ULHT policy: - Estates maintenance / repair arrangements - Business continuity plans ULHT governance: - Trust Board assurance via Quality Governance Committee (QGC) / Medicines Quality Group (MQG) / Pharmacy CBU / CSS Division	Reported incidents of service disruption	04/04/2024	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Discussions with Estates to identify potential solutions to the blockage / overflow issues. Contingency plan - medicines and equipment are moved to a temporary location in the event of overflow into Pharmacy. 7.9.23 there are no ongoing conversations with estates. JM will open up discussions again with estates and facilities	[04/04/2024 09:21:11 Lisa Hansford] No further update, all leaks reported to estates [29/12/2023 12:17:18 Lisa Hansford] Leak in dispensary w/c 18th December and stock had to be moved to prevent damage. [26/09/2023 14:12:47 Rachel Thackray] No further update [07/09/2023 14:20:37 Lisa Hansford] 7.9.23 no further update [01/08/2023 14:22:43 Rachael Turner] Risk discussed as RRC&C in July, risk approved to an increase in score to 5x3: 15 High Risk [27/06/2023 09:21:08 Alex Measures] meeting raised risk level to 15 Colin Costello to meet with Paul Dunning on Monday to get exec approval [01/06/2023 14:33:41 Lisa-Marie Moore] Risk ongoing no further update [29/03/2023 11:22:00 Maddy Ward] Discussed at Pharmacy Risk Register Review meeting today and risk is ongoing, no further update. [20/12/2022 14:16:17 Alex Measures] no updates - risk likely to increase in future reviewed 01/07/21 - ongoing, increase likelihood to likely 150622 ongoing. Shut down aseptic facility at PHB and put in a modular unit at PHB as consequence. Colin considers the risk level should be increased, to be discussed at confirm and challenge meeting next week.	6	30/09/2021	31/03/2022	04/07/2024
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5169	60	Physical or psychological harm	Ratcliff, Carl	East, Mr Sean	Patient Safety Group		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	07/05/2024	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Moving of Stroke specialist therapy staff from PHB to LCH Robust stroke training plan for general ward staff Attendance at Stroke Board to influence change and need for cohorting of outliers Review of Stroke staffing in line with latest staffing levels needed 16/10/23 funding transferred to LCH budget to help support staffing and recruitment has started	{07/05/2024 11:25:01 Gemma Staples] Increased staffing - additional full time band 6 Physio and a rotational band 6. x 2 Band 6 OT's increase. Extra x1 band 4. Currently collecting data on Stroke and Neurological outliers to consider an outlier team. [05/02/2024 11:11:38 Gemma] Risk reviewed and is still ongoing [16/10/2023 11:12:34 Sean East] 16/10/23 funding transferred to LCH budget to help support staffing and recruitment has started [08/09/2023 14:20:40 Maddy Ward] Consultation in progress currently with the intention to move some money across to Lincoln. This links in with joint working with LCHS. [23/06/2023 14:13:54 Rose Roberts] No change, went to C&C recently and level agreed. [07/06/2023 12:45:33 Rachael Turner] Risk discussed at RRC&C meeting 07/06/2023. Hyper acute patients outlied to LCH site.Specialist staff not currently available to support these patients. Patients are at risk due not being put into priorities causing delays.This causes a risk of patient harm due not progressing or adding to disability due to not being seen in appropriate pathway. This is also impacting is discharging delays to patients. More work is also required with the community. Score agreed at 15	8	13/05/2024		07/08/2024
2a. A modern and progressive workforce	4905	48	Physical or psychological harm	Cooper, Mrs Anita	Taylor, Ruth	Workforce Strategy Group		22/04/2022	12	Workforce Metrics, Risk assessments, Aggregation of Incident/Claims & Complaints/PALS	Clinical Support Services	Therapies and Rehabilitation CBU		Trust-wide	If we have insufficient staffing, or required level of experience and skill, the risk is patients will not receive assessment and rehabilitation leading to poor clinical outcome. Reduced flow on Ashby and the acute wards, delayed discharges, delayed referral to response times. Increase in avoidable harm i.e. deconditioning, PU's, constipation, delirium. Patient reviews delayed for botox treatment. Paediatric services-delayed response to new diabetes referrals and unable to see current diabetes patients in clinic- could lead to patient harm. Increase in bed stock and boarding beds without recognition of additional therapy staffing needs. Existing staff stretched to cover additional beds. Increased stress and sick leave on substantive staff.	Recruitment and retention strategies to fill vacancies. Bank staff. Requests to Locum Agencies. Skill mix Roster management. SQD data. Daily review of ward systems eg WebV. Referral guidelines and Prioritisation guidelines help to inform workloads and impact on patient flow and bed situation. Paed services are responding to direct requests for newly diagnosed children . Upskilling B5 N&D staff- (normally B6 N&D staff). Access to Staff wellbeing services. Front door therapy assessments passed to inpatient teams on admission.	Patient complaints. Fewer discharges at the weekend. Site escalation. Vacancy rates. Roster fill rates. Waiting lists for spasticity service. Staff survey and feedback.	07/05/2024	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Getting locums and bank staff in place. Good use of relocation allowance. Actively managing the waiting lists and dealing with urgent cases to avoid harm eg telephone contact with patients. Case of need for GDH orthopaedic staffing. Case of need for rehabilitation consultant post. Case of need for upper GI dietician. Case of need for Neuro Psychology staff on Ashby. Case of need for OT staff at PHB and LCH in ITU. Over recruitment of band 5s in dietetics. Competency frameworks and preceptorship.	[07/05/2024 11:37:33 Gemma Staples] The position remains the same however we are looking at capacity and demand reviews. We have also looked at were there is a known risk and been able to recruit to those areas against the matched establishment. Potential challenges to putting forward cases of need in the current financial restrictions and processes. [05/02/2024 11:25:33 Gemma] We are in the process of working on Therapy Strategy document and models of care document which will review current position against future planning. There is a safer staffing template for OT and Physio. Dietetics team to review use of this. [08/09/2023 14:19:33 Maddy Ward] We have made some progress in terms of recruitment but level of risk to remain the same. Grantham site is fully staffed and risk is not relevant to Grantham. [23/06/2023 14:12:17 Rose Roberts] Been asked to put in a case of need for RSU on both sites. Will be reviewed by RT to see if the risk needs to be separated out. [09/05/2023 15:14:15 Sara Blackbourn] Addition of escalation beds. Front door pilot. Referral criteria review. [10/03/2023 13:46:14 Rose Roberts] One member of staff has returned but another member is on maternity leave and there is no cover for her. Across all the services continue to be flexible and look at the skill mix to allow to deliver the best service we can. [13/01/2023 12:54:24 Lesley Bradley] 13/01/2023 Continue to review staffing levels, vacancies and reasons for sickness on a monthly basis [15/12/2022 09:55:40 Alex Measures] still looking at models of how to measure safe staffing levels, just asking each team to provide there funded establishment, what they would expect on a usual day and what is the minimum level of staffing, then we can start measuring whether we are falling below safe staffing levels, we have no method of recording that at the moment [30/11/2022 10:07:42 Rose Roberts] Continuing to look at staffing. Currently have	9	30/09/2023	18/12/2023	07/08/2024

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
1b. Improve patient experience	4724	86	Physical or psychological harm	Lynch, Diane	Taylor, Ruth	Workforce Strategy Group	Patient Experience Group	13/01/2022	20	Risk assessments	Clinical Support Services	Therapies and Rehabilitation CBU		Lincoln County Hospital	If Therapies and Rehabilitation service provision is not sufficient to deliver 7 day service provision, it leaves services without cover at a weekend or with inadequate cover during the week, leading to delayed patient flow; delayed discharge; extended length of stay; impacting on patient experience with potential for serious harm. This includes the neuropsychology cover on Ashby, SLT cover for inpatients, and therapy cover on ITU.	ULH policy: - Service planning & budget setting processes - Business case decision making processes ULH governance: - Capital & Revenue Investment Group (CRIG) management of business case process - CSS Division, CBU / speciality governance arrangements	Level of cover at weekends. Length of stay, patient flow, delayed discharges. Level of funding - Some 7 day funding, but limited to orthopaedics at LCH, minimal service. Inadequate for level of service demand.	07/05/2024	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Review current provision and identify gaps in service to inform business cases for change (working with Surgery and Medicine Divisions as appropriate). Skill mix requires review due to complexity of patients. Prioritisation tool helps to identify patients with greatest acuity or importance which will directly impact patient flow and current bed situation.	[07/05/2024 11:16:36 Gemma Staples] Risk reviewed and remains the same. Increased extra ward cover at Lincoln. [05/02/2024 11:06:18 Gemma] Risk reviewed and ongoing. [06/12/2023 13:09:39 Gemma] Conversations are currently happening in regards to appropriate staffing levels for ICU for Therapy Services. Further update to follow [25/10/2023 15:07:18 Rachael Turner] Business case being undertaken by CSS, needs to go through approval process. [08/09/2023 14:14:43 Maddy Ward] Reviewed at quarterly risk register review meeting. Risk is ongoing at present. [23/06/2023 14:07:53 Rose Roberts] Recruited into the Neuro psychology post. Increase risk in consultant cover - sickness and resignation. potential to have to stop admissions. [10/03/2023 13:43:06 Rose Roberts] Awaiting nhse results. Neuro psychology bid waiting to go to CRIG [13/01/2023 12:51:48 Lesley Bradley] 13/1/23 NHSE reviewed Ashby ward this month-await recommendations for staffing levels [15/12/2022 09:53:21 Alex Measures] No update [30/11/2022 10:04:52 Rose Roberts] Neuropsychology bid is still awaiting CRIG approval as CRIG has been stood down. Business cases completed for all areas. 130622 Neuropsychology bid is going to CRIG this mth. All others to be confirmed. Work in progress.	4	05/01/2024	31/03/2023	07/08/2024

Board Assurance Framework 2024/25

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Hospitals NHS Trust

Meeting	*Lincolnshire Community and Hospitals Group Board meeting*
Date of Meeting	*2 July 2024*
Item Number	*14.2*

Lincolnshire Community and Hospitals Group Draft Board Assurance Framework 2024/25

Accountable Director	*Andrew Morgan, Chief Executive*
Presented by	*Jayne Warner, Trust Secretary* *Catherine Leggett, Deputy Director of Corporate Governance*
Author(s)	*Karen Willey, Deputy Trust Secretary*
Recommendations/ Decision Required	*The Board is asked to:- Consider and approve the draft Board Assurance Framework for 2024-25*

Purpose

The Board Assurance Framework (BAF) enables the Board to maintain effective oversight of its strategic objectives with assurance being provided by the relevant Committees. The development of the Lincolnshire Community and Hospitals Group (LCHG) BAF is being completed alongside the development of the 2024/25 Strategy for the Group.

The draft 2024/25 framework has been further populated and developed following the approval of the 2024/25 Strategy and the Integrated Improvement Plan (ULHT) and Operational Plan (LCHS).

Following the population of the BAF this was presented to all Committees, with the exception of the Audit Committees, for both organisations during June. The Committees considered the narrative provided and, where possible, offered initial RAG ratings for the month of June.

Further population of the BAF is required and further requests were made through the Committees for this to be undertaken. A number of updates have been offered to the document and are presented to the Board however it is recognised that further work is required to ensure the current position is offered through the BAF.

Once work has concluded in respect of the programmes and projects of work within the Integrated Improvement Plan for ULHT these will be added to the document to provide oversight of the work in place to support the delivery of the strategic objectives.

A meeting has taken place to consider the alignment of risk within the BAF however it should be noted that work is required within Datix to algin the system with the new strategic objectives for 2024/25. Therefore, it is anticipated that the inclusion of risks linked to the risk register, within the BAF, will be available in August.

Process will now be followed to ensure monthly review and update of the BAF which will enable the Committees to consider the content and assurance ratings with bi-monthly reporting to the Board. Reporting to the Audit Committees will continue on a quarterly basis.

Lincolnshire Community and Hospitals Group
Board Assurance Framework (BAF) 2024/25

Strategic Aims	Board Committee
Patients - To deliver high, quality, safe and responsive patient services	Quality Committee
People - To enable our people to lead, work differently, be inclusive, motivated and proud to work within LCHG	People and Organisational Development Committee
Services - To ensure services are sustainable, supported by technology and delivered from an improved estate	Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee
Partners - To collaborate with our primary care, ICS and external partners to implement new models of care, transform services and grow our culture of research and innovation	Transformation and Integration Committee
Population Health - To embed a population health approach to improve physical and mental health outcomes, promote well-being, and reduce health inequalities across an entire population	Quality Committee / Transformation and Integration Committee

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

Objective alignment
Lincolnshire Community Health Services NHS Trust objectives
United Lincolnshire Hospitals NHS Trust objective

Ref	Objective	Executive Lead	Linked programmes in Integrated Improvement Plan/Operational Plan	Linked projects in Integrated Improvement Plan/Operational Plan	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
SA1 To deliver high, quality, safe and responsive patient services															
1a	Deliver high quality care which is safe, responsive and able to meet the needs of the population	Group Chief Nurse/Group Chief Medical Officer	1. Improve medical devices and use of in practice	1.1. Develop in house maintenance programme 1.2. Review contracts for medical supplies and medical device management 1.3. Support implementation of Point of Care (POC) testing at Urgent Treatment Centres 1.4. Modernising and innovating use of technology to improve quality of patient care 1.5. Virtual Ward Programme Support	1. Lack of resources 2. Lack of skills and capability 3. Leadership capacity 4. External partnerships and ways of working 5. Patients and public behaviours 6. Mindset of leaders 7. National releases on best practice	467 Medicines management practice 472 NHS Property Services provision of medical gases within LCHS sites. 511 Medical Devices Asset Register 519 Medicines - prescribing 524 Staff Training 536 Medicines Administration Error 554 Lincolnshire-wide Medicines Management Input 556 Medicines Management: Trust-Wide 510 LCHS Patient Waiting Lists Data							Quality Committee	G
			2. Wound care and improvement management	2.1. Implement the National wound care strategy for pressure damage 2.2. Implement the National wound care strategy for leg ulcers 2.3. Introduction of a digital application											
			3. Improve medicines related safety	3.1. Develop the pharmacy strategy, including gases and workforce											
			4. Strengthen LCHS Patient Safety Culture	4.1. Embed the Just Culture principals and a full programme of training as part of the PSIRF response. 4.2. Strengthen a learning culture across LCHS through the introduction of the Patient Safety Incident Response Framework. 4.3. Recruitment of Patient Safety Partners											
			5. Strengthen Effective Practice	5.1. Develop clear nursing competencies, from band 2-6, aligned to clinical pathways and best practice within community nursing and community hospitals 5.2.Expand our current research portfolio 5.3. Aim to be top recruiter in GP trials in East Midlands in 2023 5.4. Start participating in commercial trials 5.5. Work with the Medicine Management Team on medicines related research 5.6. Modernising and innovating use of technology to improve quality of patient care 5.7. Develop workforce plans for clinical services across the organisation 5.8. Support the delivery the clinical and professional workforce models in line											

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				with the Lincolnshire ACP strategy with regards to job plan implementation, workforce modelling and 3-5 year workforce training plans 5.9. Implement a Ward Accreditation Framework over the next 2 years to include all clinical teams in a phased approach											
1b	Improve patient experience	Group Chief Nurse	1. Grow People Engagement	1.1. Co-produce an LCHS statutory engagement plan and trajectory for informing decision-making and service delivery collaboratively across the group	1. Lack of System Engagement and Comms Team/ recruitment to team/ External partnerships and ways of working 2. Inadequate resources to deliver against objective/ programmes 3. Mindset, ownership and behaviour of leaders 4. Quality improvement approach and toolkit 5. System working interdependencies 6. Patients and public behaviours 7. Lack of capacity, capability and/or skills 8. Staff health and wellbeing	468 - Complaints		Primary: 1. Clinical Strategy 2023-28 and linked reporting of delivery 2. Integrated Care System (ICS) Strategy 3. Integrated Care Board 5-year joint forward plan 4. Trust Leadership Team (TLT) reports 5. LCHS Operational Plan reports 6. Lincolnshire Long Term Plan 7. Quality Team/ Patient Experience and Involvement leads 8. Complaints, Patient Advice and Liaison (PALS, and Claims Team 9. System Communications and Engagement Team 10. Volunteering Services Team 11. Triumvirate weekly complaints, incidents and claims reviews 12. Divisional monthly operational plan reporting 13. Quality Assurance Groups Secondary: 1. Stakeholder Engagement and Involvement Group (SEIG) 2. Clinical Safety and Effectiveness Group (CSEG) 3. Strategy and Planning Group (SPG) 4. Quality and Risk Committee (QRC) 5. Audit Committee 6. Trust Leadership Team (TLT) 7. Performance Management Reviews (PMRs) Tertiary: 1. Care Quality Commission Engagement and Assessment 2. Healthwatch monthly reports 3. Patient-Led Assessments of Care Environment (PLACE) Report 4. NHS Resolution reporting 5. Audit - internal/ external 6. Patient and Public feedback/ surveys/ NHS Choices 7. Volunteering placement evaluations/ take up of opportunities 8. Complaints and Claims benchmarking data 9. Friends and Family Test data	1. System Engagement Team not currently in place and timeline not confirmed. 2. Data - not connected Datix/ Business Intelligence/ System 1	1. System CEOs meeting to progress decisions. 2. FBI developed rollout plan for datix being pulled into the data warehouse. 3. FBI developed rollout plan for Systemone data linkage to datix incidents/ complaints/ claims.	1.1 Recruitment and delivery of System Statutory Engagement Team resource and plan 2.1 LCHS involvement plan, feedback, improvement and delivery of plan (including national patient surveys) 3.1 LCHS experience plan, feedback, improvement and delivery of plan 3.2 Improved service design, access and experience			Quality Committee	G
1c	Improve clinical outcomes	Group Chief Nurse/Group Chief Medical Officer	1. Quality Assurance and Accreditation Programme	1.1 Develop a quality assurance assessment methodology 1.2 Develop a quality accreditation programme										Quality Committee	G
			2. In collaboration develop a quality dashboard and infrastructure to provide best evidence to demonstrate quality of care	2.1. Develop an overarching infrastructure to ensure quality improvement and performance can be continually monitored, evidenced and understood from ward to Board ensuring that evidence can easily be collated for CQC assessments											

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			3. Improve People Involvement	3.1. Develop a programme of assurance with effectiveness of clinical procedural documents											
1d	Deliver clinically led integrated services	Group Chief Nurse/Group Chief Medical Officer	1. Review and transformation of Intermediate Pathways of Care Review	1.1. Working with system partners to review priority pathways for looked after children in Lincolnshire 1.2. Links to system Intermediate Care Review. This is currently paused so will be picked up again once this has been reinstated. 1.3. Maximising the use, occupancy and pathways in to our Community Hospitals and Transitional Care Beds- review of the Integrated Discharge Hub										Quality Committee	
			2. Frailty Pathways	2.1. Community Hospitals being recognised as Frailty specialists within our Lincolnshire system 2.2. Adult Community Therapy Frailty Rebranding 2.3. Delivering a population health needs based service that maximises the potential of our estate from Archer Assessment Unit										
			3. Childrens Services Transformation	3.1. Child to adult transition of services - Business Cases and Case for Change being prepared nationally - where do these children go - for example Asthma - there is no adult service for this										
			4. Palliative Pathways	4.1. Review the palliative pathways across LCHS to meet the needs of all palliative patients and their families.										

Ref	Objective	Executive Lead	Linked programmes in Integrated Improvement Plan/Operational Plan	Linked projects in Integrated Improvement Plan/Operational Plan	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
SA2 To enable our people to lead, work differently, be inclusive, motivated and proud to work within LCHG															
2a	Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	Group Chief People Officer	1. Transforming Nursing in the Community	1. Keeping, Developing Our People	1. Lack of resources 2. Lack of skills and capability 3. Leadership capacity/capability 4. External partnerships and ways of working 5. Mindset of leaders and staff 6. Staff health and wellbeing 7. Further Industrial Relations 8. National/Region directives	442 Recruitment 470 Staffing levels		Primary: 1 Integrated Care System (ICS) Strategy 2. Integrated Care Board 5-year joint forward plan 3. LCHS People Strategy 2023-28 4. Clinical Strategy 2023-28 5. People Strategy Group 6. LCHS Operational Plans 7. Divisional delivery plans 8. Action Plans (eg Workforce Race Equality Scheme/Workforce Disability Equality Scheme) 9. Equality Diversity and Inclusion Lead/ Freedom to speak up guardian (FTSUG) /Staff Networks/ Health and Wellbeing Lead and Champions 10. Mental Health First Aid Champions 11. Swartz Rounds 12. Staff Networks 13. Equality Delivery System (EDS) 3 Action Plan 14. International Recruitment (IR) Project Group 15. Costs of Living Working Group Secondary: 1. People Executive Group (PEG) 2. Finance, People, Performance and Investment Committee (FFPIC) 3. Lincolnshire People Board 4. Audit Committee 5. Equality, Diversity and Inclusion Group 6. Trust Well-Being Guardian 7. Lincolnshire People Plan 23/24 8. Trust Leadership Team (TLT) 9. Transformation Delivery Group (TDG) 10. Stakeholder Engagement and Involvement Group (SEIG) 11. Performance Management Reviews (PMRs) 12. Transformation Delivery Group (TDG) 13. Trust Leadership Team (TLT) 14. Quality and Risk Committee (Q&RC) 15. Lincolnshire People Hub 16. Lincolnshire Integrated Care Board 17. Lincolnshire Health and Care Collaborative Delivery Board 18. Strategic Delivery Plan (SDP) Programme Board Tertiary: 1. Audit 2. NHS National Staff Survey 3. Regional People Board 4. Equality Delivery System (EDS) 3 5. CQC 6. System Improvement Director 7. NHS People Plan 8. National/Regional Benchmarking	1. 10 Year NHSE Workforce Plan	1. 10 Year NHSE Workforce Plan	1. Delivery of the LCHS People Strategy 23/24 Action Plan 2. Standard People Metrics (Sickness/Turnover/MT /Vacancy/agency spend etc) better than LCHS targets and benchmarking 3. NHS National Staff Survey results above average in all People Promise areas 4. Delivery of the Lincs People Plan 23/24 and improved system people metrics (sickness, staff survey, turnover, agency spend etc) 5. Efficient use of Apprentice Levy funds 6. Improved NHS Freedom to Speak Up Guardian (FTSUG) Index score 7. National Quarterly Pulse Survey (Quarter 1, Quarter 2 and Quarter 4) above benchmarking 8. Improved Workforce Race Equality Scheme (WRES) and Workforce Disability Equality Scheme (WDES) Data 9. Corporate Benchmarking in the lowest quartile for People Functions 10. Delivery of the EDS3 Action Plan 23/24 11. Recruitment of 50 International Recruits (40 Nurse and 10 AHP)			People and Organisational Development Committee	G
			2. Workforce Planning	1. Work Planning Solution - Implement the KPMG strategic workforce planner											
			3. Inclusion	3.1. Representative Workforce Reduce total pay gaps - race, disability, gender 3.2. Inclusive Recruitment Processes											
			4. Pipeline	4.1. Group Bank 4.2. Apprenticeships 4.3. Wider Workforce											
			5. Flexibility	5.1. Enabling a flexibility by default approach											
			6. Retention	6.1. Support better retention											
			7. Civility and respect	7.1. Allyship 7.2. Reduce bullying and harassment											
			8. Health and Wellbeing	8.1. Research into staff self-care/role of leadership											
			9. Leadership and Talent	9.1. Inclusive Talent Development											
			10. Workforce Transformation	10.1. New ways of working 10.2. Develop New Roles and Skills											
2b	To be the employer of choice	Group Chief People Officer												People and Organisational Development Committee	G

Ref	Objective	Executive Lead	Linked programmes in Integrated Improvement Plan/Operational Plan	Linked projects in Integrated Improvement Plan/Operational Plan	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
SA3 To ensure services are sustainable, supported by technology and delivered from an improved estate															
			1. Develop foundational insight	1.1. Develop regular integrated portfolio analysis 1.2 Develop and embed a multi-level performance management framework and conditions for a performance and improvement culture	1.Mindset and behaviour of leaders 2.Lack of capacity 3.Lack of skills and capability 4.Leadership capacity and capability 5.A poor internal reputation 6.National guidance changes 7.System finance/data requests	528 Breakeven Duty - Cost Control 529 Efficiency Requirement 530 System Risk and Gain Share - Financial Risk 532 Non attainment of capital plan		Primary: 1. Integrated Care System (ICS) Strategy 2. Integrated Care Board 5-year joint forward plan 3. Finance and Business Intelligence (FBI) Strategy 2023-28 4. FBI Strategy update on current year plan 5. Finance reporting to Finance Performance, People and Innovation Committee (FPPIC) 6. Trust Leadership Team (TLT) reports 7. LCHS Operational Plan reports 8. Clinical Strategy 2023-28 9. Chief Clinical Digital Information Officer (CCDIO) 10. Lincolnshire Long Term Plan 11. Strategic Delivery Plan as part of the Recovery Support Programme 12. NHSE Planning Guidance Secondary: 1. LCHS Finance Performance, People and Investment Committee (FPPIC) 2. Quality and Risk Committee (Q&RC) 3. LCHS Trust Leadership Team (TLT) 4. Transformation Delivery Group (TDG) 5. Data Quality Group 6. Capital Investment Group 7. LCHS private board 8. Performance Management Reviews (PMR) 9. Lincolnshire Integrated Care Board 10. Lincolnshire Health and Care Collaborative Delivery Board 11. Strategic Delivery Plan (SDP) Programme Board 12. System Financial Assurance Group 13. System Financial Leaders Group (FLG) 14. System Digital, Data and Technology (DDAT) Tertiary: 1. Internal audit – Standard Financial Controls Annual Audit 2. External audit – Annual Independent Audit and Opinion on Financial Statements 3. Benchmarking data 4. National Oversight Framework rating 5. Clinical audit reports 6. National best practice data and reports 7. CQC rating 8. National Oversight Framework (NOF) rating quarterly letter	Skills and capability to use tools and frameworks	Programme of knowledge and skills development for FBI and stakeholder partners	1. Delivery of the financial plan measured through reporting and variances to planned performance 2. Deliver the required operating budget alongside leaders feeling engaged, informed and empowered to drive their service efficiency agenda 3. Delivery of the FBI Strategy plan 2023-24 4. National Oversight Framework (NOF) rating (annual and quarterly)				

Ref	Objective	Executive Lead	Linked programmes in Integrated Improvement Plan/Operational Plan	Linked projects in Integrated Improvement Plan/Operational Plan	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
3a	Deliver financially sustainable healthcare, making best use of resources	Group Chief Finance Officer	2. Produce a multi-year financial plan including the key service transformation priorities	2.1 Develop frameworks to identify, scope and prioritise tactical, operational and transformational efficiency opportunities	1.Mindset and behaviour of leaders 2.Lack of capacity 3.Lack of skills and capability 4.Leadership capacity and capability 5.A poor internal reputation 6.National guidance changes 7.System finance/data requests	528 Breakeven Duty - Cost Control 529 Efficiency Requirement 530 System Risk and Gain Share - Financial Risk 532 Non attainment of capital plan		Primary: 1. Integrated Care System (ICS) Strategy 2. Integrated Care Board 5-year joint forward plan 3. Finance and Business Intelligence (FBI) Strategy 2023-28 4. FBI Strategy update on current year plan 5. Finance reporting to Finance Performance, People and Innovation Committee (FPPIC) 6. Trust Leadership Team (TLT) reports 7. LCHS Operational Plan reports 8. Clinical Strategy 2023-28 9. Chief Clinical Digital Information Officer (CCDIO) 10. Lincolnshire Long Term Plan 11. Strategic Delivery Plan as part of the Recovery Support Programme 12. NHSE Planning Guidance Secondary: 1. LCHS Finance Performance, People and Investment Committee (FPPIC) 2. Quality and Risk Committee (Q&RC) 3. LCHS Trust Leadership Team (TLT) 4. Transformation Delivery Group (TDG) 5. Data Quality Group 6. Capital Investment Group 7. LCHS private board 8. Performance Management Reviews (PMR) 9. Lincolnshire Integrated Care Board 10. Lincolnshire Health and Care Collaborative Delivery Board 11. Strategic Delivery Plan (SDP) Programme Board 12. System Financial Assurance Group 13. System Financial Leaders Group (FLG) 14. System Digital, Data and Technology (DDAT) Tertiary: 1. Internal audit – Standard Financial Controls Annual Audit 2. External audit – Annual Independent Audit and Opinion on Financial Statements 3. Benchmarking data 4. National Oversight Framework rating 5. Clinical audit reports 6. National best practice data and reports 7. CQC rating 8. National Oversight Framework (NOF) rating quarterly letter	Skills and capability to use tools and frameworks	Programme of knowledge and skills development for FBI and stakeholder partners	1. Delivery of the financial plan measured through reporting and variances to planned performance 2. Deliver the required operating budget alongside leaders feeling engaged, informed and empowered to drive their service efficiency agenda 3. Delivery of the FBI Strategy plan 2023-24 4. National Oversight Framework (NOF) rating (annual and quarterly)			Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee	A
								Primary: 1. Integrated Care System (ICS) Strategy 2. Integrated Care Board 5-year joint forward plan 3. Finance and Business Intelligence (FBI) Strategy 2023-	Strategic business partnering approach well-established	Embedding FBI structure and new ways of working	1. Partner satisfaction ratings with FBI (internal) 2. Delivery of the Finance and Business Intelligence (FBI) Strategy plan 2023-24 3. National Oversight				

Ref	Objective	Executive Lead	Linked programmes in Integrated Improvement Plan/Operational Plan	Linked projects in Integrated Improvement Plan/Operational Plan	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
			3. Deliver a multi-year financial plan including the key service transformation priorities	3.1 Support to deliver the operational efficiency initiatives and the strategic transformation/new operating models	1. Mindset and behaviour of leaders 2. Lack of capacity 3. Lack of skills and capability 4. Leadership capacity and capability 5. A poor internal reputation	529 Efficiency requirement 530 System Risk and Gain Share - Financial Risk		28 4. FBI Strategy update on current year plan 5. Finance reporting to Finance Performance, People and Innovation Committee (FPPIC) 6. Trust Leadership Team (TLT) reports 7. LCHS Operational Plan reports 8. Clinical Strategy 2023-28 9. Chief Clinical Digital Information Officer (CCDIO) 10. Lincolnshire Long Term Plan 11. Strategic Delivery Plan as part of the Recovery Support Programme 12. NHSE Planning Guidance Secondary: 1. LCHS Finance Performance, People and Investment Committee (FPPIC) 2. Quality and Risk Committee (Q&RC) 3. LCHS Trust Leadership Team (TLT) 4. LCHS Strategy and Planning Group (SDP) 5. Transformation Delivery Group (TDG) 6. Performance Management Reviews (PMR) 7. Lincolnshire Integrated Care Board 8. Lincolnshire Health and Care Collaborative Delivery Board 9. Strategic Delivery Plan (SDP) Programme Board 10. System Financial Leaders Group (FLG) Tertiary: 1. Internal audit 2. External audit 3. Benchmarking data 4. Partnership satisfaction ratings 5. Clinical audit reports 6. National best practice data and reports 7. CQC rating 8. National Oversight Framework (NOF) rating quarterly letter			3. National Oversight Framework (NOF) rating (annual and quarterly)				
				1.1 Use integrated portfolio				Primary: 1. Integrated Care System (ICS) Strategy 2. Integrated Care Board 5-year joint forward plan 3. Finance and Business Intelligence (FBI) Strategy 2023-28 4. FBI Strategy update on current year plan 5. Finance reporting to Finance Performance, People and Innovation Committee (FPPIC) 6. Trust Leadership Team (TLT) reports 7. LCHS Operational Plan reports 8. Clinical Strategy 2023-28 9. Chief Clinical Digital Information Officer (CCDIO) 10. Lincolnshire Long Term Plan 11. Strategic Delivery Plan as part of the Recovery Support Programme 12. NHSE Planning Guidance Secondary: 1. LCHS Finance Performance,	Strategic business partnering approach well-established	Embedding FBI structure and new ways of working	1. Partner satisfaction ratings with FBI (internal) 2. Delivery of the Finance and Business Intelligence (FBI) Strategy plan 2023-24 3. National Oversight Framework (NOF) rating (annual and quarterly)				

Ref	Objective	Executive Lead	Linked programmes in Integrated Improvement Plan/Operational Plan	Linked projects in Integrated Improvement Plan/Operational Plan	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
3b	Drive better decisions and impactful action through insight		1. Drive change, insight and direction	1.1 Use integrated portfolio analysis to inform strategic and tactical decision making and prioritise opportunities 1.2 Drive change, insight and direction through a business partnering approach and culture 1.3 Use performance management framework to identify key areas to maximise performance, and swiftly address areas of underperformance to ensure tangible better outcomes for patients	1. Mindset and behaviour of leaders 2. Lack of capacity 3. Lack of skills and capability 4. Leadership capacity and capability 5. A poor internal reputation	529 Efficiency requirement 530 System Risk and Gain Share - Financial Risk		People and Investment Committee (FPPIC) 2. Quality and Risk Committee (Q&RC) 3. LCHS Trust Leadership Team (TLT) 4. LCHS Strategy and Planning Group (SDP) 5. Transformation Delivery Group (TDG) 6. Performance Management Reviews (PMR) 7. Lincolnshire Integrated Care Board 8. Lincolnshire Health and Care Collaborative Delivery Board 9. Strategic Delivery Plan (SDP) Programme Board 10. System Financial Leaders Group (FLG) 11. System Digital and Data Team (DDAT) Tertiary: 1. Internal audit 2. External audit 3. Benchmarking data 4. Partnership satisfaction ratings 5. Clinical audit reports 6. National best practice data and reports 7. CQC rating 8. National Oversight Framework (NOF) rating quarterly letter					Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee	G
3c	A modern, clean and fit for purpose environment across the Group	Group Chief Operating Officer	1. Safe and Sustainable Foundations (Estates and Transformation)	1.1. Driving the efficiency of our estate 1.2. Transparency in our Estates Utilisation	1. Lack of resources 2. Lack of skills and capability 3. Leadership capacity 4. External partnerships and ways of working 5. Patients and public behaviours 6. Mindset of leaders 7. Staff health and wellbeing 8. Patient and public engagement	389 NHSPS Water Supply 405 NHSPS Maintenance of LCHS estate 390 JCH Theatre Ventilation 406 NHSPS property ventilation 391 JCH Water Purity 393 Skegness Hospital Water Purity 649 Fire Core Risk 491 Estates Compliance in UTCs 684 JCH Scotter Ward		Primary: 1. Estates and Transformation Strategy 2. Clinical Strategy 3. Lincolnshire Long Term Plan 4. LCHS Operational Plan 5. Integrated Care System (ICS) Strategy 6. Integrated Care Board 5-year joint forward plan 7. Strategic Delivery Plan as part of the Recovery Support Programme 8. LCHS Green Plan 9. NHS Lincolnshire Green Plan Secondary: 1. Health and Safety Committee 2. Finance, Performance, People and Investment Committee (FPPIC) 3. Audit Committee 4. Lincolnshire Strategic Infrastructure and Investment Group 5. Transformation Delivery Group (TDG) 6. Group Leadership Team (GLT) 7. Performance Management Reviews (PMRs) 8. Quality and Risk Committee (Q&RC) 9. Capital Investment Group 10. Lincolnshire System Operational Estates Group 11. Lincolnshire Greener NHS Group Tertiary: 1. Estates Returns Information Collection (ERIC) Return 2. Patient-Led Assessments of Care Environment (PLACE) Report 5. Internal Audit 6. Health and Safety Executive Standards 7. CQC rating 8. Benchmarking data 9. Healthcare Information and Management Systems Society Assessment (HIMSS)	1. Fully developed Estates dashboard 2. Fully developed 3rd party compliance dashboard	1. Programme of work around information into the dashboard and further training for staff 2. Programme of work to share compliance data across organisations into a dashboard 3. Demobilisation of the Estates Shared Services into ULHT Estates.	1. Delivery of the Estates and Transformation Strategy 23/24 Action Plan 2. Delivery of the LCHS Green Plan action plan 23/24 3. Increased compliance and safety 4. Delivery of LCHS Capital Plan 23/24 5. Greater utilisation of Estate	1. Robust signed off Service Level Agreements (SLAs) for the Estates Shared Service	1. Demobilisation of Estates Shared Services plan.	Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee	R

Ref	Objective	Executive Lead	Linked programmes in Integrated Improvement Plan/Operational Plan	Linked projects in Integrated Improvement Plan/Operational Plan	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
3d	Reduce waits for patients who require urgent care and diagnostics to constitutional standards	Group Chief Operating Officer												Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee	A
3g	Reducing unwarranted variation in community service delivery and ensure we meet all constitutional standards	Group Chief Operating Officer												Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee	R
SA4 To collaborate with our primary care, ICS and external partners to implement new models of care, transform services and grow our culture of research and innovation															
4a	Establish collaborative models of care with all our partners including Primary Care network Alliance (PCNA), GPs, health and social care and voluntary sector	Group Chief Integration Officer	1. Community Primary Partnerships	1.1 Neighbourhood Working 1.2 Tobacco Dependence Team move 1.3 First Costal Development										Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee (To move to: Transformation and Integration Committee)	R
			2. Support and provider leadership to the ICS operating framework and governance	2.1 Paly an active role in the governance structures of the ICS	1.Mindset and behaviour of leaders 2.Lack of capacity 3.Lack of skills and capability 4.Leadership capacity and capability 5.Commissioning practices 6.A poor external reputation"	444, 481, 504, 526, 530 - TO BE CHECKED AGAINST DATIX		1. Integrated Care System (ICS) Strategy 2. Integrated Care Board 5-year joint forward plan 3. Lincolnshire Long Term Plan 4. LCHS IIP 5. Clinical Strategy 2023-28 6. NHS England Planning Guidance 7.Performance Management Reviews (PMR) 8.Lincolnshire Leaders Board 9.Better Lives Lincolnshire Leadership Team 10.System joint committees 11.System Financial Leaders Group (FLG) 12.Quarterly System Review Meeting (QSRM) 13.National Oversight Framework (NOF) rating (annual and quarterly 14.Internal audit 15.External audit	No up to date survey of partner views	CIO once in post to take a view on whether (and when) to conduct a survey of partner views.	1.Delivery of the FBI Strategy plan 2024-25 2.National Oversight Framework (NOF) rating (currrently out to consultation) 3.LCHS representation on system boards, committees and groups 4.Compliance with system mechanisms e.g. Risk/Gain Share 5.LCHS delivery of its elements of system projects	Partner satisfaction ratings	CIO once in post to take a view on whether (and when) to conduct a survey of partner views.		
			3. Play an active role in collaborations that make a difference	3.1 Play and active role as a key partner in the Lincolnshire Health and Care Collaborative 3.2 Work in partnership to identify and deliver initiatives that can only succeed in collaboration	1.Mindset and behaviour of leaders 2.Lack of capacity 3.Lack of skills and capability 4.Leadership capacity and capability 5.Commissioning practices 6.A poor external reputation"	444, 481, 504, 526, 530 - TO BE CHECKED AGAINST DATIX		1. Integrated Care System (ICS) Strategy 2. Integrated Care Board 5-year joint forward plan 3. Lincolnshire Long Term Plan 4. LCHS IIP 5. Clinical Strategy 2023-28 6. NHS England Planning Guidance 7.Performance Management Reviews (PMR) 8.Lincolnshire Leaders Board 9.Better Lives Lincolnshire Leadership Team 10.System joint committees 11.System Financial Leaders Group (FLG) 12.Quarterly System Review Meeting (QSRM) 13.National Oversight Framework (NOF) rating (annual and quarterly 14.Internal audit 15.External audit	No up to date survey of partner views	CIO once in post to take a view on whether (and when) to conduct a survey of partner views.	1.Delivery of the FBI Strategy plan 2024-25 2.National Oversight Framework (NOF) rating (currrently out to consultation) 3.LCHS representation on system boards, committees and groups 4.Compliance with system mechanisms e.g. Risk/Gain Share 5.LCHS delivery of its elements of system projects	Partner satisfaction ratings	CIO once in post to take a view on whether (and when) to conduct a survey of partner views.		
4b	Successful delivery of the Acute Services Review	Group Chief Integration Officer												Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee (To move to: Transformation and Integration Committee)	A

Ref	Objective	Executive Lead	Linked programmes in Integrated Improvement Plan/Operational Plan	Linked projects in Integrated Improvement Plan/Operational Plan	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
4c	Grow our research and innovation through education, learning and training	Group Chief Integration Officer												People and Organisational Development Committee (To move to: Transformation and Integration Committee)	
4d	Enhanced data and digital capability	Group Chief Integration Officer	1. Care Closer to Home (Digital)	1.1. Technology Enabled Transformation	1. Lack of resources 2. Lack of skills and capability 3. Leadership capacity 4. External partnerships and ways of working 5. Patients and public behaviours 6. Mindset of leaders 7. Staff health and wellbeing 8. Patient and public engagement	430 Cyber Security		Primary: 1. Digital Health Strategy Secondary: 1. Digital Strategy Group (DSG) 2. Digital Executive Group (DEG) 3. Finance, Performance, People and Investment Committee (FPPIC) 4. System Digital, Data and Technology Board (DDaT) 5. Transformation Delivery Group (TDG) 6. Group Leadership Team (GLT) 7. Performance Management Reviews (PMRs) 8. Capital Investment Group Tertiary: 1. Annual Network and Security Penetration Test (DSPT) 2. Data Security and Protection Toolkit 3. Internal Audit 4. Benchmarking data 5. Healthcare Information and Management Systems Society Assessment (HIMSS)	1. Patient Digital Literacy maturity Information 2. Workforce Digital Literacy maturity Information	1. Creation of a patient co-design group 2. Trust wide Digital skills training needs analysis 3. Programme of work around information into the dashboard and further training for staff	1. Delivery of the Digital Health Strategy 23/24 Action Plan 2. Improved use of digital technologies 3. Delivery of LCHS Capital Plan 23/24 4. Greater uptake of digital services from the public 5. Digital Maturity Assesment			Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee (To move to: Transformation and Integration Committee)	G
			2. Safe and Sustainable Foundations (Digital)	2.1. Safe Practice 2.2. Technology Optimisation					1. Fully developed cyber security dashboard	1. Programme of work to share compliance data across organisations into a dashboard					
			1. Change Ready Workforce (Digital)	1.1. Digital Ready Workforce 1.2. Digital Leadership					1. Patient Digital Literacy maturity Information 2. Workforce Digital Literacy maturity Information	1. Creation of a patient co-design group 2. Trust wide Digital skills training needs analysis					

Ref	Objective	Executive Lead	Linked programmes in Integrated Improvement Plan/Operational Plan	Linked projects in Integrated Improvement Plan/Operational Plan	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
SA5 To embed a population health approach to improve physical and mental health outcomes, promote well-being, and reduce health inequalities across an entire population															
5a	Develop a Population Health Management (PHM) and Health Inequalities (HI) approach for our Core20PLUS5 with our ICS	Group Chief Nurse/Group Chief Medical Officer	1. Develop foundational insight	1.1 Develop the Population Health Management (PHM) and Health Inequalities (HI) approach	1.Mindset and behaviour of leaders 2.Lack of capacity 3.Lack of skills and capability 4.Leadership capacity and capability 5.A poor internal reputation 6.National guidance changes 7.System finance/data requests			Primary: 1. Integrated Care System (ICS) Strategy 2. Integrated Care Board 5-year joint forward plan 3. Finance and Business Intelligence (FBI) Strategy 2023-28 4. FBI Strategy update on current year plan 5. Trust Leadership Team (TLT) reports 6. LCHS Operational Plan reports 7. Clinical Strategy 2023-28 8. Chief Clinical Digital Information Officer (CCDIO) 9. Lincolnshire Long Term Plan 10. Strategic Delivery Plan as part of the Recovery Support Programme 11. NHSE Planning Guidance Secondary: 1. LCHS Finance Performance, People and Investment Committee (FPPIC) 2. Quality and Risk Committee (Q&RC) 3. LCHS Trust Leadership Team (TLT) 4. Transformation Delivery Group (TDG) 5. Data Quality Group 6. Performance Management Reviews (PMR) 7. Lincolnshire Integrated Care Board 8. Lincolnshire Health and Care Collaborative Delivery Board 9. System Digital, Data and Technology (DDAT) Tertiary: 1. Benchmarking data 2. Clinical audit reports 3. National best practice data and reports 4. CQC rating	Skills and capability to use tools and frameworks	Programme of knowledge and skills development for FBI and stakeholder partners				Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee (To move to: Transformation and Integration Committee)	R
5b	Co-create a personalised care approach to integrate services for our population that are accessible and responsive	Group Chief Nurse/Group Chief Medical Officer												Quality Committee	
5c	Tackle system priorities and service transformation in partnership with our population and communities	Group Chief Integration Officer												Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee (To move to: Transformation and Integration Committee)	R

Ref	Objective	Executive Lead	Linked programmes in Integrated Improvement Plan/Operational Plan	Linked projects in Integrated Improvement Plan/Operational Plan	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
			1.1. Care Closer to Home (Estates and Transformation)	1.1. Supporting Models of Care 1.2. Driving Integrated Working	1. Lack of resources 2. Lack of skills and capability 3. Leadership capacity 4. External partnerships and ways of working 5. Patients and public behaviours 6. Mindset of leaders 7. Staff health and wellbeing 8. Patient and public engagement	430 Cyber Security 454 NHSPS Water Supply 460 Cost of estate 461 NHSPS Maintenance of LCHS estate 483 JCH Theatre Ventilation 473 NHSPS property ventilation 551 JCH Water Purity 552 Skegness Hospital Water Purity 553 Migration from network drives to SharePoint		Primary: 1. Digital Health Strategy 2. Estates and Transformation Strategy 3. Clinical Strategy 4. Lincolnshire Long Term Plan 5. LCHS Operational Plan 6. Integrated Care System (ICS) Strategy 7. Integrated Care Board 5-year joint forward plan 8. Strategic Delivery Plan as part of the Recovery Support Programme 9. LCHS Green Plan 10. NHS Lincolnshire Green Plan Secondary: 1. Digital Strategy Group (DSG) 2. Estates Delivery Group 3. Digital Executive Group (DEG) 4. Health and Safety Committee 5. Finance, Performance, People and Investment Committee 6. Audit Committee (FPPIC) 7. Estates Shared Service Programme Group (ESSPG) 8. System Digital, Data and Technology Board (DDaT) 9. Lincolnshire Strategic Infrastructure and Investment Group 10. Transformation Delivery Group (TDG) 11. Trust Leadership Team (TLT) 12. Performance Management Reviews (PMRs) 13. Quality and Risk Committee (Q&RC) 14. Capital Investment Group 15. Lincolnshire System Operational Estates Group 16. Lincolnshire Greener NHS Group Tertiary: 1. Estates Returns Information Collection (ERIC) Return 2. Patient-Led Assessments of Care Environment (PLACE) Report 3. Annual Network and Security Penetration Test (DSPT) 4. Data Security and Protection Toolkit 5. Internal Audit 6. Health and Safety Executive Standards 7. CQC rating 8. Benchmarking data 9. Healthcare Information and Management Systems Society Assessment (HIMSS)	1. Patient Digital Literacy Information 2. Workforce Digital Literacy Information 3. Fully developed Estates dashboard	1. Creation of a patient co-design group 2. Trust wide Digital skills training needs analysis 3. Programme of work around information into the dashboard and further training for staff	1. Digital Health Strategy 23/24 Action Plan 2. Estates and Transformation Strategy 23/24 Action Plan 3. Delivery of the LCHS Green Plan action plan 23/24 4. Improved use of digital technologies 5. Improved Cyber security reporting and oversight 6. Increased compliance and safety 7. Robust signed off Service Level Agreements (SLAs) for the Estates Shared Service 8. Delivery of LCHS Capital Plan 23/24 9. Greater uptake of digital services from the public				
			2. Transforming Nursing in the Community	2.1. Reviewing existing and ensuring the right longer term Skin Integrity (incl. Lymphoedema) services for Lincolnshire 2.2. Reviewing the Community Nursing offer- what does "good Community Nursing look like" (the catalogue) Specialist Service criteria, including but not limited to: - Proactive care provisions - Catheters - IV Therapy, INR - Skin Integrity, Lymphoedema - Community Nursing Safer Staffing 2.3 Voice Before You Visit Service Evaluation											

Ref	Objective	Executive Lead	Linked programmes in Integrated Improvement Plan/Operational Plan	Linked projects in Integrated Improvement Plan/Operational Plan	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
5d	Transform key clinical pathways across the group resulting in improved clinical outcomes	Group Chief Integration Officer/Group Chief Medical Director	3. Transforming Community Hospitals	3.1. Rebranding / Standardisation of Community Hospital offer - Discharge hub - Proactive care provisions - Correct bed distribution										Quality Committee	
			4. Children's Services Transformation	4.1. Childrens hub in Lincolnshire 4.2. Children's services reviews - ALL LCHS Children's services 4.2.1. Children In Care 4.3. Children's services reviews - ALL LCHS Children's services 4.3.1. Childrens Therapy - SALT										
			5. Development of Community Neurology Services	5.1. One community Neuro team with the scope of maximising the capability of existing Community Neuro Nursing and Therapy Services - currently at ULHT and LCHS - Community Outreach and Parkinson's										
			6. Transforming Operations Centre	6.1. Transformation of One Front Door including Ops Centre, CAS, Home Visiting and UCR including triage and dispatch										
			7. IUEC Pathways	7.1. Initial unplanned pathways, response project 7.2. UTC Review - outcomes and recommendations 7.3. Virtual Wards										

Ref	Objective	Executive Lead	Linked programmes in Integrated Improvement Plan/Operational Plan	Linked projects in Integrated Improvement Plan/Operational Plan	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
			8. Seasonal Planning Reviews - Winter Schemes	8..1. Seasonal Planning Reviews - Development											
			9. Agile Workstream	9.1. Continence Re-model of service 9.2. TB & SAIS 9.3. LISH / NLISH 9.4. NLISH											

Lincolnshire Community and Hospitals Group
Board Assurance Framework (BAF) 2024/25

Strategic Aims	Board Committee
Patients - To deliver high, quality, safe and responsive patient services	Quality Committee
People - To enable our people to lead, work differently, be inclusive, motivated and proud to work within LCHG	People and Organisational Development Committee
Services - To ensure services are sustainable, supported by technology and delivered from an improved estate	Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee
Partners - To collaborate with our primary care, ICS and external partners to implement new models of care, transform services and grow our culture of research and innovation	Transformation and Integration Committee
Population Health - To embed a population health approach to improve physical and mental health outcomes, promote well-being, and reduce health inequalities across an entire population	Quality Committee / Transformation and Integration Committee

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

Objective alignment
Lincolnshire Community Health Services NHS Trust objectives
United Lincolnshire Hospitals NHS Trust objective

Ref	Objective	Executive Lead	Linked programmes in Integrated Improvement Plan/Operational Plan	Linked projects in Integrated Improvement Plan/Operational Plan	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
SA1 To deliver high, quality, safe and responsive patient services															
1a	Deliver high quality care which is safe, responsive and able to meet the needs of the population	Group Chief Nurse/Group Chief Medical Officer						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. MQG will retain oversight of the relevant IIP programme of work through divisional upward reports Electronic prescribing has been rolled out to areas where this was planned, although some challenges are being identified post-rollout	Gaps identified within-internal audits undertaken by Grant Thornton Lack of adherence to Medicines management policy and procedures (i.e. Controlled Drugs processes as evidenced by regular audit work programmes) Lack of 7 day clinical pharmacy service and specific specialty specfic gaps in service (i.e. Emergency Departments, Childrens and young persons, as identified by Neonatal ODN Network visit in June 2024) Some medicines management policies are overdue / past their review dates Medicines reconcilliation compliance is poor and has remained an outlier during 2023/2024	Replacement of manual prescribing processes with an electronic prescribing system; improvements to medication storage facilities; strengthening of Pharmacy involvement in discharge processes. Divisional Upward Report template to be developed to ensure divisional assurances are provided against actions/improvement work linked to Grant Thornton and CQC now that Medicines Management Action Task and Finish Group has closed	Upward Report from the Medicines Quality Group to PSG Routine analysis and reporting of medication incidents and outcomes from medicines audits in to Medicines Quality Group Omitted doses audit Controlled Drugs Audit Prescribing Quality reports Robust Divisional reporting and attendance into MQG monthly Internal Audit report Upward reporting from other groups	Lack of upward reporting from the Medical Gases, Sedation Group Pharmacy audits only occurring in areas they are providing a clinical service to. Some gaps in other groups not reporting to MQG / or concerns in respect of effectiveness (i.e. Drugs and Therapeutics Group, Patient Group Directive (PGD))	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 Committee	G
								Appropriate policies and procedures in place to recognise and treat the deteriorating patient, reported to deteriorating patient group and upwardly to PSG and QGC. Deteriorating Patient Group set up as a sub group of the Patient Safety Group to identify actions taken to improve; has its own sub-groups covering AKI; sepsis (Ensuring early detection and treatment of deteriorating patients) (PSG)	Work required to develop the maturity of the group. New Chair identified and full review of membership and remit required. Maturity of some of the sub-groups of DPG not yet realised. This will be considered as part of the review of DPG.	Observation policy ready to go to next NMAAF Fluid management policy approved by DPG/PSG and awaiting approval at NMAAF Deteriorating Patient Group set up as a sub group of the Patient Safety Group to identify actions taken to improve; has its own sub-groups covering AKI; sepsis; CCOT	Audit of response to triage, NEWS, MEWS and PEWS Sepsis Six compliance data Audit of compliance for all cardiac arrests Upward reports into DPG from all areas Number of incidents occurring regarding lack of recognition of the deteriorating patient Robust upward reports received monthly into PSG	Fluid Management group has not been meeting and therefore concerns through PSG have been raised.	The chair of DPG is undertaking a relaunch of the Fluid Management group with revised attendance and reporting into DPG - currently reviewing TOR to encompass LCHS to align functions to the Group model.		
								Robust process in place to monitor delivery against the CQC Must Do and Should Do actions and regulatory notices (Delivering on all CQC Must Do actions and regulatory notices). Includes regular meetings with divisions, CQC action plan which goes to relevant committees, TLT, etc. Regular executive challenge meetings on delivery. Escalation routes into PRM and TLT. (CG)	No gaps identified.	Not applicable.	Monthly reporting to sub-committees with the relevant extract of the action plan. CYC and TLT receive monthly reports. QGC receive quarterly update on the entire plan. Quarterly updates Trust Board. Feedback to CQC on achievements at monthly engagement meeting. CQC assurance data.	CQC assurance data not yet complete. CQC assurance data not yet shared with committees. Output from PRM is not clear. Escalations not always acted upon promptly.	Use of exec led meeting to pick up escalations which may not occur via other routes. Additional resource identified for compliance team to support with sourcing levels of assurance.		

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								Maximise safety of patients in our care, through learning from incidents, reducing incidents causing harm and reviewing external reports and assessments of our services (PSG)							
								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.		
1b	Improve patient experience	Group Chief Nurse						Patient and Carer Experience (PACE) plan 2022 - 2025 The PACE Delivery Plan is actioned and embedded over the life of the delivery plan. (PEG)	There are no identified control gaps.	Not applicable	Patient Experience & Carer Plan progress report to Patient Experience Group as per schedule. Ongoing assurances provided to PEG re: actions.	There are no assurance gaps identified.	Not applicable	Quality Committee	G
								Enhance patient experience by learning from patient feedback and demonstrating our values and behaviours in the delivery of care with a specific focus on discharge of patients. (PEG)	National surveys evidence overall poor experiences in relation to discharge with a number of questions being benchmarked as worse than others Trusts.	Amalgamated survey action plan in development to identify Trust wide improvement focus. Rolling out of #WMTY initiative to ensure patients are involved in decisions and discussions about their discharge plans. Patient Experience Team working with Discharge Lounge staff facilitating understanding of discharge experience and improvements. Discharge work programme being implemented as part of the UEC improvement work.	Discharge experience reports to PEG quarterly.	Work required with the lead nurse for discharge to ensure experience data is collected, analysed and acted upon.	Support to be provided to the lead nurse for discharge.		
1c	Improve clinical outcomes	Group Chief Nurse/Group Chief Medical Officer						Maternity & Neonatal Oversight Group (MNOG) in place to have oversight of the quality of maternity & neonatal services and to provide assurance that these services are safe and in line with the National Safety Ambition / Transformation programme. Thematic review of SIs and complaints undertaken - recommendations being progressed as part of the Maternity & Neonatal Improvement Plan. External independent input in to SI process. MNOG will retain oversight of the implementation of the relevant IIP programme of work. (MNOG)	Issues with the environment. Ongoing difficulties with the Maternity Medway system which has the potential to impact on compliance with the CNST Year 4 Safety Actions.	Improvements to the environment to be completed as part of planned ward refurbishment. Team to continue to liaise with E&F to resolve and immediate issues as they arise ensuring escalation where delays are encountered. Issues with the Medway system being progressed at local and system level.	Monthly Maternity & Neonatal Assurance Report. Maternity & Neonatal Improvement Plan. Executive & NED Safety Champions in place and work closely with local Safety Champions. NHSE/I appointed MIA in place and supporting the Trust - monthly reports of progress to MNOG. Validation of the implementation & embedding of the Ockenden IEAs has been provided by the regional maternity team. There is a process in place for ongoing testing through supported site visits. Training compliance data.	None Identified	Not applicable.	Quality Committee	G

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								Ensure we provide clinically safe services, through an increased number of Diamond Award Accredited Wards / Departments (PEG)	there are no identified Control gaps	Not applicable	monthly Quality metrics dashboard meeting with all clinical areas. Diamond award applications received and supported by corporate nursing team. Diamond Award Panel chaired by DoN/DepDoN. Award presented by Trust Chair. Metric included with the IIP, and measured Quarterly.	None Identified	Not applicable		
1d	Deliver clinically led integrated services	Group Chief Nurse/Group Chief Medical Officer												Quality Committee	
SA2 To enable our people to lead, work differently, be inclusive, motivated and proud to work within LCHG															
								Workforce planning and workforce plans Recruitment to agreed roles - plan for every post, for Agenda for Change, Medical and Dental Workforce Associate Director of Transformation and Workforce planning in post who is leading workforce planning in conjunction with HRBP's, finance and improvement team. This is established and regular reviews are now in place. Reported through to the Operational Workforce and Strategy Group and then included within the highlight report for People & OD Committee highlight report to Board	None identified	None identified	Workforce plans submitted for 2023/24 Operational Planning. Recruitment plans are in place. Divisional Recruitment Pipeline Reports are refreshed regularly for each division working with each of the SHRBP's and are reporting through to FPAM in terms of pipeline linked to reducing agency spend.	None identified	None Identified	
								Focus on retention of staff - creating positive working environment and integration of People Promise 'themes' System retention role established and in place for 2023/24. People Promise Y1 work complete with funding for Y2 agreed. Education and Learning Team in place and actively working to improve compliance with Statutory and Mandatory Training. Organisational Development Team in place and actively working to improve completion rates for Appraisals.	System People Promise Manager has been recruited for Yr2. Consideration to the concept of group appraisals and appraisal lite to form part of the review of people policies and procedures.	Workforce Strategy and OD Group to discuss group appraisal and appraisal lite - On Going.	Workforce, Strategy and OD Group upward report to PODC including scorecard analytics i.e. appraisal, statutory and mandatory training.	Appraisal compliance levels have improved and continue to be on target for full year effect. Mandatory Training compliance have improved and continue to be on target for full year effect.	To be monitored through the Workforce Operational Group and FPAM meetings and will feature in the highlight report to PODC. Phased targeted approach in 23/24 KPI's as featured in the Integrated Improvement Plan.	
								Reducing sickness absence - Absence Management System	Manager call back compliance and return to work interview	Compliance with use of AMS being addressed through People Management Essential Training and AMS training from HRBPs Early Occupational Health led interventions are being explored for top two reasons for sickness absence	Sickness/absence data Deep dive by Workforce Strategy and OD Group into absence data Internal Audit Report Actions	Various reports through Heads of HR to Divisions. Output from WSOD Group deep dive into absence data.	Work continues with the completion of the audit actions and work/training with the departmental managers and HR. To be monitored through the Workforce Operational Group and FPAM meetings and will feature in the highlight report to PODC. Phased targeted approach in 23/24 KPI's as featured in the Integrated Improvement Plan. A deep dive is being undertaken of the full utilisation of the AMS management system as early indications show improvement is needed.	

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2a	Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	Group Chief People Officer						Ensuring access to the personal and professional development that enables people to deliver outstanding care and ensures ULHT becomes known as a learning organisation Establish ULHT Education and Learning service Promote benefits and opportunities of Apprenticeships	None identified		WSODG, FPAM and PODC data Workforce, Strategy and OD Group upward report to PODC including scorecard analytics i.e. appraisal, statutory and mandatory training	Appraisal compliance levels have improved and continue to be on target for full year effect. Mandatory Training compliance have improved and continue to be on target for full year effect.	To be monitored through the Workforce Operational Group and FPAM meetings and will feature in the highlight report to PODC. Phased targeted approach in 23/24 KPI's as featured in the Integrated Improvement Plan.	People and Organisational Development Committee	G
								Improve the consistency and quality of leadership through:- Reset leadership development offer and support (Leadership SkillsLab and PME) •Improved mandatory training compliance •Improved appraisals rates using the WorkPal system •Developing clear communication mechanisms within teams and departments. Leading together Programme for multi disciplinary senior leaders across the Organisation.	New Training and Development department in place with full recruitment programme now complete	Dedicated capacity and project leadership identified for Culture and Leadership Programme.	WSODG, FPAM and PODC data Culture and Leadership Task Force Reports to PODC	None identified			
								Proactively support staff to remain well and at work, however should the need arise, supporting them through illness and their return to work Staff Vaccination Programme Health and wellbeing Programme for staff.	Improvement in sickness rate in 23/34 full year affect of 4.5% required. Continue to fill vacancies within the HR department to support Divisions with sickness management.	Continue to fill vacancies within the HR department to support Divisions with sickness management. Now at a fully recruited position within HR.	Health and wellbeing Manager and Health and Wellbeing Group/Wellbeing Champions Upward reporting to WSODG from H&WB Group Board level HWB Guardian change enacted Vaccination Programme updates through WSOD Group	None identified			
								Vacancy levels below 4% across all staff groups Aligned to the plan for every post, recruitment plans for each division and aligned to the workforce submission plan for 23/24.	None identified		Key Performance indicators have been identified as part of the IIP and will be monitored through the scorecard at Workforce Operational and Strategy Group. Pastoral care award received for recruitment and on-boarding of international nurses	None identified			
								Reduce our staff turnover rate to 6% across all staff groups	6% turnover rate yet to be embedded as BAU in all staff groups	Aligned to the continued work under the People Promise Manager role and plans for 23/24 to continue to improve work life balance, flexible working requests, flexible retirement/retire and return options. People Promise Mgr funding identified for Yr2	Key Performance indicators have been identified as part of the IIP and will be monitored through the scorecard at Workforce Operational and Strategy Group. Pastoral care award received for recruitment and on-boarding of international nurses	None identified			

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								Reset ULH Culture and Leadership through delivery and implementation of Culture and Leadership Programme and Restorative and Just Culture Programme. Cultural deep dives, specific / ad hoc pieces of OD work with individual areas, as identified that requires support / help and associated action plans agreed and owned by Clinical/Management teams. Working in conjunction with HRBP's and OD Business Partners for a joined up approach to tackle culture challenges. The OD, Education and Development Directorate was restructured as part of the redesign piece of work within People & OD Directorate and investment made to increase the workforce.	Culture shift takes time to be embedded however improvements continue to be recognised in engagement scores in the National Staff Survey results. Very strong performing staff networks now in place and being recognised nationally for awards. Investment in wellbeing manager leading the wellbeing work across the Trust under Occupational Health offering direct support for staff who may require it in addition to the Employee Assistance Programme available. Increase in the number of staff reaching out to FTSU guardian is a positive reflection of the effectiveness of the FTSU processes.	Leading Together Forum - regular bi-monthly leadership event Delivery Plan and actions to be confirmed further to results of Leadership Survey LTF Forward Plan Leadership SkillsLAB - essentials in management and leadership for existing managers. Comprehensive follow up and prioritisation of NSS results - key areas of concern identified for action 7 point action plan presented and agreed to ELT/TLT in August to offer a plan in terms of 23/24 National Staff Survey plans and individual priorities being taken forward in preparation for the next NSS. Restorative Just and Learning Culture project team has been formed with a full project plan and roll out being undertaken.	Culture and Leadership Group and System People Board Culture and Leadership Programme Group upward report NSS results (Feb 2023/Feb 2024) Themes from cultural deep dives presented to PODC. Patient complaints and compliments data. staff complaints data. FTSU data. External stakeholders feedback. Just and Learning Steering group offer a highlight report to PODC. Culture and Leadership Group offer a highlight report to PODC. Staff Networks and their effectiveness is measured through the EDI action plan.				
								Support Divisions to achieve 95% of our people having completed all relevant statutory and mandatory training by March 2024 Trust aligned to National Core Skills Training Framework Mandatory Training Governance Group in place. Manager reports re: training compliance MTTG used as Gateway to core learning Mapping of core training on more individual basis.	Dedicated Education Department now in place as part of the restructure. Aligned to the People Promise continued work for 23/24. Updates to ESR system to allow better monitoring and reporting. Consideration of appraisal lite and group appraisal now embedded. Further work required aligned to the Quarterly Pulse survey and promotion of this. 95% compliance yet to be embedded as BAU.	HRBP support in each Division and Directorate supporting the promotion of mandatory training and appraisals, using reported data to show progress. New Appraisal paperwork embedded. Recommendations captured through the National Staff Survey.	Workforce Operational Group training report Upward reporting to People and OD Committee CQC Monthly reporting Individual core training matrix on ESR	Appraisal compliance levels not yet at expected level but is improving Mandatory Training compliance not yet at agreed level but continues to improve Limited uptake of quarterly staff survey	To be monitored through the Workforce Operational Group and FPAM meetings and will feature in the highlight report to PODC. Phased targeted approach in 23/24 KPI's as featured in the Integrated Improvement Plan has been implemented Additional monthly assurance offered to CQC through governance team regular meetings.		
								Support our Divisions to provide all staff with an appraisal and clear objectives	None identified	None identified	Workforce Operational Group reports Upward reporting to People and OD Committee CQC Monthly reporting	None identified	None identified		
								55% of our staff recommending ULHT as a place to work.	NSS results show a requirement to improve this recommendation	Annual NSS. Pulse surveys staff feedback through FaceBook, exit interviews, Attractive recruitment campaigns and packages; Retention strategy being developed. Attrition rates monitored	Workforce Operational Group reports Upward reporting to People and OD Committee CQC Monthly reporting National Awards e.g. Pastoral Care Award received for IEN recruitment.	None identified	None identified		
								53% of our staff recommending ULHT as a place to receive care	NSS results show a requirement to improve this recommendation	Further work required aligned to the Quarterly Pulse survey and promotion of this. Annual NSS. Patient feedback. National recognition for improvements in service delivery and care Eg. Maternity Service Improvements.	Workforce Operational Group Reports Upward reporting to People and OD Committee CQC Monthly reporting Recognition certificate and letter received for the 2022 National Staff Survey Patient Experience Group Staff satisfaction reports	None identified	None identified		

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2b	To be the employer of choice	Group Chief People Officer						Embed continuous improvement methodology across the Trust	Embedding and sustaining cultural improvement change when the ability of the ULHT teams to engage is limited or constrained when we are operationally challenged. Ability to demonstrate quick impact on the cultural change due to various interventions will be limited (as these are multi year/multi factorial projects).	Improvement Academy now report all training & associated activity to embed continuous improvement through Improvement Steering Group for oversight and escalations. Working with each improvement programme and Divisions to develop identify and align improvement plans.	Internal training reports produced by Improvement academy. Improvement programmes identifying personalised training needs for ULHT staff. Divisions training plan (aligned to the IIP) presented at FPAM.	Information is reported to ISG - Low uptake of our various training offers despite general and targeted comms through various platforms. Services are struggling to release staff for QI training due to pressures. Plan for a QI relaunch in the new financial year. Use of virtual training option via MS Teams.	Weekly meetings with Improvement Academy to increase offer with more agile training methods to meet the needs of the varied staff. Developing communications & engagement strategy for on-going awareness of Improvement Academy to enable improvement culture change (not just limited to sending email updates but being creative and being on site on wards to talk about quality improvement)	People and Organisational Development Committee	G
								Compliance with National agency utilisation target of 3.7% agency and locum workforce	None identified		FRP and ISG	None identified			
								Lincs Belonging Strategy EDI Delivery Plan 2022-25	None identified		Council of Staff Networks Internal Audit - Equality, Diversity and Inclusion NHS NSS EDI/EDS objectives	None identified			
SA3 To ensure services are sustainable, supported by technology and delivered from an improved estate															
3a	Deliver financially sustainable healthcare, making best use of resources	Group Chief Finance Officer						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	Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee	A
								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.		
3b	Drive better decisions and impactful action through insight							Provide our people with real-time data to support high quality care delivery to all clinical staff						Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee	
								Continual improvement towards meeting PLACE assessment outcomes	PLACE assessments have been suspended and delayed for a period during COVID	Use of PLACE Light assessments and other intelligence reports.	PLACE Light Assessments PLACE Full assessments starting in September 22	PLACE/Light do not provide as deep an assurance review as PLACE with limited input.	Combination of PLACE Light and other intelligence (IPC Group/Compliance Reports and Capital Delivery Group) will help triangulate areas of concern and response. With PLACE Full assessments starting in September gaps will be closed further.		
								Review and improve the quality and value for money of Facility services including catering and housekeeping	Value for Money schemes have been delayed during COVID	Improvement teams have started in 2022/23 working through value for money and financial efficiency schemes included development of Housekeeping, Security and Portering Business Cases for future models	MiC4C cleaning inspections Staff and user surveys 6 Facet Surveys	6 Facet Survey are not recent and require updating.	Cleanliness is reported through IPC Group to QGC. Water Safety and Fire Safety Groups will report through to relevant sub-committees and provide a more comprehensive view offering assurance were it is possible and describing improvement where it is not with Annual Reporting providing assurance and gap analysis on all AE domains.		

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3c	A modern, clean and fit for purpose environment across the Group	Group Chief Operating Officer						Develop business cases to demonstrate capital requirement in line with Estates Strategy	Business Cases require level of capital development that cannot be rectified in any single year.	Estates Strategy sets out a framework of responding to issues and management of risk. Capital Delivery Group has oversight of the delivery of key capital schemes. External Specialist Advisor working jointly NHSE & ULHT providing external guidance and validation. Use of the premises assurance model PAM will help identify gaps and subsequent actions or schemes of improvements.	Capital Delivery Group Highlight Reports Compliance report to Finance, Performance and Estates Committee Updates on progress above linked to the estates strategy. PAM Quarterly internal review and annual submission.	Funding gap when considering the full £100m+ backlog in first year. Future years will at most tackle £20m of backlog in any given year 6 Facet Surveys used to quantify and identify schemes are out of date and need reviewing.	Estates improvement and Estates Group review compliance and key statutory areas. Progress against Estates Strategy/Delivery Plan and IIP via sub groups upward reports. Delivery of 2022/23 Capital Programme will continue to ensure progress against remaining backlog of critical infrastructure. Capital Delivery Group will monitor the delivery of key capital programmes and ensure robust programme governance. Structure review including upward reports are being reviewed by specialist advisor with recommendations of reporting lines.	Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee	A
								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.		
3d	Reduce waits for patients who require urgent care and diagnostics to constitutional standards	Group Chief Operating Officer						3x daily internal capacity meetings to improve discharge and flow and trouble shoot operational issues at the front door Project 76 meetings with Group/ICB stakeholders in place with weekly deep dives into divisional actions plans across both organisations and weekly project review with system partners Group Discharge Board in place (from 10/04/2024) Daily ICB UEC call to escalate issues across the system and provide support to unblock pressure areas Group UEC Board established reflecting 5 Pillars of Improvement System Urgent Care Partnership Board.	Internal professional standards not embedded Medical and Nursing WFP not reflective of 24/7 UEC service requirements Lack of understanding at ward level re SAFER leading to poor implementation Assessment areas not substantively funded Capacity Team unable to provide adequate cover 24/7 due to WFP	5 Pillars / Workstreams reflecting key cross system programs of work. Progress of the above measured through the Group UEC Board Monitoring of performance at Tiering Meetings with NHSE, although these have now been stepped back to fortnightly as UEC has moved from Tier 2 to Tier 3 External reviews including GRFT have identified gaps in services which have been included in actions plans within the relevant specialties/divisions	Improvement against 3 key metrics as agreed with NHSE and monitored via Tier 2 meetings : % of patients in Emergency Department >12 hrs (Total Time) 4 hour Type 1 performance Cat 2 Mean EMAS performance Updates full suite of metrics to ELT, TLT and Board. Updates provided to Group UEC Board and UEC System Partnership Board	Pathway 0 patients discharge is being effectively planned from the point of admission All PW1-3 capacity is used on a daily basis Escalation policy is not fit for purpose and not used to define triggers and actions form divisions and support services. Process and deployment of Full Capacity Protocol not clear and not used effectively as not aligned to Escalation Policy. Specialist teams are attending ED within 30 mins of request in line with IP standards	Weekly Group UEC Board from January 2024 through which x 5 pillars of cross LCHS/ULHT work are monitored Daily 76% EAS meetings taking place to monitor in-day delivery against the standard EAS discussed at every capacity meeting Daily Breach understanding is circulated along with performance MTD, previous day and in-day progress Revised capacity meetings implemented from Sept 2023 and led by COO Office x 4 days a week and Divisions 1 day a week. Full capacity protocol including +1 and +2 on wards has been updated and implemented from September 2023.	Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee	
								Maximisation of capacity and efficiencies to reduce waiting times in ED Support discharge processes, ensuring services are provided within timeframes which are safe and responsive, enabling a reduction in length of stay/bed occupancy and increased flow			Trajectories for all specialties in place, weekly position statements offered to ELT and TLT New board has a suite of metrics to measure improvements and focus divisional leadership teams on discharge target actions to ensure patients are bale to return to their usual place of residence or most fitting place of care sooner		Further rollout of SAFER will be supported by 4 B6 nurses to support discharge and flow out of wards and improve "pull" from ED. New Group Discharge Board set up to pull together workstreams that focus on discharge and flow, including SAFER principles, criteria led discharge and divisional flow targets		
								Development of plans for seven day working, across all of our services			Requires scoping and costing for all support and direct care services				

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3e	Reducing unwarranted variation in cancer service delivery and ensure we meet all constitutional standards	Group Chief Operating Officer					Cancer Standards 62 day, 14 day and 28 Day FDS	Daily reporting of all three metrics (62 day backlog, FDS and 62 day performance) Twice weekly Intensive Support meetings to review all 3 metrics and position of patients on the cancer PTL Fortnightly cancer recovery meeting System Cancer Improvement Board Weekly ICB/Group oversight through Planned Care and Cancer catch up	Capacity v demand across all tumour site pathways not completed Insufficient oversight of system partners contribution (e.g. primary care testing and workups)	Cancer Leadership Group Deep Dive Workshops (e.g. Colorectal) Intensive Support Meetings (Trust and ICS)	Cancer board assurance and performance reports Routine Performance and pathway data provided by Sommerset system Cancer Intensive Support Meetings Cancer Intensive Support Meetings Monthly Trust Board reporting for planned care and cancer	Process information below the cancer stages are not always captured Some digital systems are not linked and not all wait information is recorded e.g. MIME system	Trajectories in place agreed with all tumour sites, to achieve a reduction in number patients >62 days, achievement FDS 75% March and reduction in patients >104 days. At the end of March >62 days was 217 (aligned with trajectory), >104 was 63 patients of which 51 were tertiary patients, FDS at 74.44% (75%)	Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee	
								Achievement of FDS, 104 and 62 week performance trajectory	Capacity to deliver Faster Diagnosis (FDs) for all services		Weekly system elective and cancer recovery meetings 3x weekly cancer meetings for all T Sites led by Deputy COO, Urgent Care and Cancer and ICB Cancer lead		Due to sustained improvement, NHSE de-escalated cancer from Tiering in December 2023.		
								Maximisation of capacity and efficiencies to reduce waiting times and support discharge processes, ensuring services are provided within timeframes which are safe and responsive, enabling a reduction in length of stay/bed occupancy			Trajectories for all specialties in place, weekly position statements offered to ELT and TLT RAPs at Tumour Site level available from March through which performance will be monitored		Focused piece of work in place to review Navigator role in terms of WF capacity and capability has been undertaken with a training program in place and supported PTLs as a result. Additional support from external ICB funded cancer specialist to further refine the PTL process and provide on the job coaching and training of the cancer team. Breast are developing a		
3f	Reducing unwarranted variation in planned service delivery and ensure we meet all constitutional standards	Group Chief Operating Officer		Outpatient Recovery and Improvement Group (ORIG) Productive Theatres Group (PTOG) Medical Workforce Programme	Hybrid Mail	4877 - Planned Care Admitted 4878 - Planned Care Non-Admitted	Referral to Treatment (18week wait) Standards Diagnostic 6week (DM01)	Internal assurance process through ISG and corporate into ELT, GLT and FPEC Planned Care & Diagnostic Board	Inconsistent approach to validation Clinic slot utilisation driven by DNAs and last minute cancellations Theatre utilisation, including; 1. Preop 2. Estate utilidation 3. Late starts/early finishes 4. Daycase rates 5. On the day cancellations Gaps in Job planned and delivered activity for Admitted & Non-Admitted Workforce gaps, particulary in theatres	Improvement programmes driving workstreams to address control meassures. These include; 1. Outpatient letter project to reduce variation of clinic template letters, ensuring patients receive timely and accurate information 2. Hybrid mail project to digitilise and streamline Outpatient correspondence 3. Use of PIFU to reduce unnecessary follow up 4. Preop focused workstream to increase access to preop and build a prospective service 5. GIRFT workstreams focused on compliance with BADS identified daycase procedures and unexpected conversion to Inpatients 6. 6-4-2 Processes in Outpatients and THeatres to ensure clinics/lists fully utilised 7. Look Back Wednesday to address unexpected changes to theatre lists impacting utilisation 8. Ongoing work to match jobplans with clinic session	Performance Data Planned Care Improvement and Performance Reporting Integrated Improvement Plan Highlight and Status Reports GIRFT Reports and Model Hospital Regional Performance Packs	Escalations & issues through ISG when required Limited Diagnostic reporting/assurance	Reporting through Improvement Steering Group & FPEC Diagnostic reoprting tools and process currently being developed	Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee	
								HVLC/GIRFT Programme - Theatre productivity and efficiency	Ability of the ULHT teams to engage in the programme Emergency pressures resulting in elective cancellations Culture mindset change takes time.	Full robust Theatre programme with focus on KPIs now meeting weekly to oversee and drive changes	Theatre dashboard has been created and reviewed by operational teams for booking & scheduling - aim for 90% 6-4-2/scheduling now in place and now has a Senior Leader attendance rota. Weekly Capacity meetings held to ensure theatre utilisation	Increased in NEL demand may impact staffing levels, elective bed capacity, and therefore could impact on elective activity. KPIs potentially impacted: OTD cancellations and actual utilisation against planned levels	Reporting through Improvement Steering Group/FPEC/HVLC		

Ref	Objective	Executive Lead	Linked programmes in Integrated Improvement Plan/Operational Plan	Linked projects in Integrated Improvement Plan/Operational Plan	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
								Maximisation of capacity and efficiencies to reduce and eliminate 78 week, 65 week waits across all specialties and moves to ambition of reducing 52 week to 700 by end of Q4 2023/2024			Trajectories for all specialties in place, weekly position statements offered to ELT and TLT Weekly planned care update meeting				
SA4 To collaborate with our primary care, ICS and external partners to implement new models of care, transform services and grow our culture of research and innovation															
4a	Establish collaborative models of care with all our partners including Primary Care network Alliance (PCNA), GPs, health and social care and voluntary sector	Group Chief Integration Officer						Lead the Lincolnshire ICS and Provider Collaborative as an Anchor Institution and play an increasing leadership role within the East Midlands Acute Services Collaborative	Governance arrangements for Provider Collaborative, Integrated Care Board still in development Clarity on accountability of partners in integration/risk and gain Lincolnshire ICS anchor organisation plan not yet in place Wider regional governance to provide East Midlands oversight of population need and outcomes not yet finalised (via East Midlands Acute Provider Collaborative (EMAP)) ULHT have not embedded a culture of contributing towards population health across the whole organisation and a further understanding of health inequalities and mitigating actions.	Map key stakeholders and priorities for a partnership strategy focussing on addressing health inequalities and prevention Board and senior leadership team sessions on understanding the new ICS landscape and ULHT role within this Lincolnshire System Anchor Workshops underway to align areas of focus and develop system Anchor Plan - looking to agree priorities and exploring opportunities associated with Greater Lincolnshire devolution EMAP Governance structure now agreed, EMAP Managing Director in post and will be hosted by ULHT. ULHT engagement in 3 EMAP work programmes. EMAP MOU pending Board approval. Scope what a good effective partnership look like. Stakeholder mapping & engagement plan. Develop appropriate comms for the Lincolnshire ICS and our provider collaborative Agreements to support the development of the Provider Collaborative have been designed and shared. The Provider Collaborative is undertaking a stock take of services.	ULHT Green Plan Risk and Gain share (provider collaborative) Early Warning Discharge Indicators/development a common set of agreed metrics for flow and discharge across the system ICB delegation agreement ULHT Partnership Strategy EMAP governance structures/MOU	Green Pan under-delivery A better understanding of effective partnerships and what good looks like Clarity around role/accountability of partners within the Provider Collaborative Clarity around system improvement plan and provider collaborative plan and what outcomes each seeks to achieve Shared understanding and implications of the early warning discharge indicators, risk and gain share agreement within ULHT	Green Plan assurance - governance and PMO plan Part of the refreshed IIP Reporting processes Regular updates to ELT/TLT/TB on Provider Collaborative, Health Inequalities, EMAP and our ICS Evidence and intelligence gathered from Service Reviews, Business Planning, Population Health and all other aspects of work will be pulled into this strategy to support the wider considerations of partnership working and future opportunities (commercial and non-commercial) The process of building the Trust Clinical Strategy has commenced taking information from Specialty Reviews to inform accordingly, and building on outputs from the Business Planning process.	Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee (To move to: Transformation and Integration Committee)	
								A Joint Forward Plan by June 2023 and continued utilisation of Joint Strategic Needs Assessment (JSNA), population health data from Optum and the health and wellbeing strategy, to influence our collective approach	JFP completed February 2024 and shared with Board	JFP triangulation with IIP Year 5	JFP completed and considered in Chief Executives Group and formally to the Board	JFP triangulation with IIP not yet completed or signed off - gaps to be identified	Year 5 IIP will include JFP triangulation for Boards prior to sign to off, April 2024		
								Joint working with system partners, maximising care homes, virtual wards and admission avoidance schemes, such as the frailty programme	Investment Business Cases not yet in place (SDEC frailty assessment, ED Paed Hub, Community Child Nurse, Rapid Assessment and Triage (RAT), Hospital at Night, SAFER)	Business Cases being presented to CRIG in July	Business Cases Shared Performance Dashboard - frequent attenders	Business Cases in development Dashboard in development	Business Cases being presented to CRIG in July Joint work with Optum to create dashboard		
								Play an increasing leadership role within the East Midlands Acute Provider Collaborative to develop key partnerships	EMAP work programmes establishing - outcomes/deliverables not yet agreed	Programme Boards in place with monthly meetings underway Highlight reports being overseen by monthly EMAP executive meetings EMAP updates to ELT/TLT	EMAP executive meeting minutes	EMAP programme highlight reports - still in development	Verbal updates at EMAP exec meetings and ULHT representation at EMAP programme groups		

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4b	Successful delivery of the Acute Services Review	Group Chief Integration Officer						Develop a ULHT clinical service strategy with focus on fragile services in order to provide sustainable and safe services for the future Identify the key services to focus on for Clinical Service Review (taking into account CIP, benchmarking, GIRFT and other core data)	Divisional IIPs need to be completed to ensure links into fragile services/clinical service strategy Identify resources to implement ASR outcomes	First and second cohort of specialty reviews underway and on track Programme management support being identified via Provider Collaborative to help deliver ASR phase 1 Individual work streams to be established Clinical Strategy engagement period has successfully concluded - 1st draft document has been socialised for feedback from key stakeholders. Delay in launch due to resource availability - Strategy planned to be presented to Board in July 2024 for approval.	Health inequalities and core25 PLUS indicators Early Warning Discharge Indicators Rigorous engagement, both for feedback from the ASR review and further implementation	Evidence available but working on a process to bring together the information for services to aid the identification of the Top 5 areas for focus in 2022/23.	Part of the refreshed IIP Reporting processes Publish ULHT clinical service strategy July/August 2024 Working with Divisions to identify ASR implementation requirements with draft outline plans in place for Orthopaedics and Stroke. Stroke Capital/Estates Group meetings now diarised and being led by the Business Case Team. Orthopaedics ASR taken to HOSC in Dec 2022 and confirmed as complete through ULT upward reporting. Stroke ASR are working on a 'Perfect Week' to further progress and have commenced relevant staff consultation processes required - pressures remain in length of stay and outliers but capital build planning is progressing. GDH ASR: UTC is mobilised and open with integrated community model being completed early 2024.	Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee (To move to: Transformation and Integration Committee)	
								Shared understanding and implications of the UHA guidance and identify relationship management of key stakeholders nationally (DH, UHA) Agree contract with UOL, R&I team to Increase the number of Clinical Academic posts	Funding for Clinical Academic posts and split with UOL to be agreed	Monthly meetings with ULHT and Uni of Lincoln to discuss funding position and agree MOU. Clinical Academic Oversight Group to oversee recruitment of clinical academic model, recruitment and delivery. *Group meetings being support discussion on performance and any adjustments to job plans* Meetings with ULHT and UOL finance/contracting teams to finalise financial model and MOU based on principles of the Selby report produced early 2024.	Contract agreed with UOL for Clinical academic posts. UoL and ULHT have draft contracts and offer letters ready for use. Increase in numbers of Clinical Academic posts - agreed to prioritise on clinical specialities where there are workforce gaps/high agency spend to mitigate ULHT cost pressure RD&I Strategy and implementation plan agreed by Trust Board Upward reporting and	Unknown financial commitment for the Trust in relation to the clinical academic roles until the financial model is completed and recruitment commences.	Monthly meetings with ULHT and Uni of Lincoln Financial best case, most likely and worst case models reviewed by ELT and shared with Board in March 2024 to agree risk appetite Exploring all opportunities across ULHT and UoL to mitigate the financial risk through addtional income geenration, wider socio-economic impact		
								The training and support environment for students and clinical academics will be in place. ULHT Library and training facilities improvements are now complete.	Lack of a model for research training and support for new clinical academics as they start to be employed No current agreement between ULHT/UoL in relation to clinical academic accommodation and resources model	Clinical Academic Model financial model and contract will include facilities and resource provision. Exploratory work underway to understand package of support e.g. via clinical rails unit, UoL	Clinical academic financial model once complete GMC training survey Stock check against checklist Internal Audit - Education Funding	Clinical Academic financial model not yet agreed	A new R&I group has been set up being led by Director of R&I/Deputy Medical Director, this will provide more oversight and rigor in developing an R&I agenda with representation from key stakeholders and clear milestones for delivery		

Ref	Objective	Executive Lead	Linked programmes in Integrated Improvement Plan/Operational Plan	Linked projects in Integrated Improvement Plan/Operational Plan	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
4c	Grow our research and innovation through education, learning and training	Group Chief Integration Officer						Develop a joint research strategy with the UoL by September 2023, which identified shared research focus areas which is needed to meet UHA requirements	A joint MOU is in place at a Lincolnshire System level as agreed in April 2022, and the Steering Group and ELT has agreed that this should be used as the overarching MOU A draft ULHT/UOL MOU has been prepared but this has not been signed off as ideally it will need be combined with the final clinical academic model into a shared contract. Draft priorities based on initial dialogue with vice dean of the medical school has been created, further work to develop UOL strategy is being undertaken.	Working closely with the University of Lincoln, monthly meetings. Through these meetings have completed first draft of the Joint Strategy. There is an existing ULHT R&I Strategy in place and a new version will be developed for 24/25 as the current one is it its final year. The Lincolnshire ICS have commenced work on a system wide R&I strategy - UHLT Director of R&I is engaged with this process. As ULHT are not currently in a position to apply for UHA status due to the lack of clinical academics employed, the shared Strategy is not required currently. However it will need to be in place ahead of a UHA application.	RD&I Strategy and implementation plan agreed by Trust Board	Clinical Academic Model is required to support shared Strategy development UoL have refreshed their Research Strategy and as at end Oct 2022 ULHT are awaiting a copy of this to then align to joint strategy between the two organisations.	Monthly meetings with ULHT and Uni of Lincoln and through ULHT Steering Group Shared Strategy is a requirement for UHA application and not Teaching Hospital Status	People and Organisational Development Committee (To move to: Transformation and Integration Committee)	R
								Develop a strong professional relationship with the University of Lincoln and the Medical School and jointly create a strategy with a focus on developing rural healthcare, medical/nursing/AHPs/Clinical Scientists/R&I staff education and other healthcare roles	Evidence bound by UHA requirements Clear plan/strategy on development of medical/nursing/SHPs/Clinical scientists/R&I staff education roles	A new R&I group has been set up, being led by Director of R&I/Deputy Medical Director. We continue active stakeholder management with Medical Director of ICS and UOL VC.	ULHT healthcare roles plan Increased recruitment/academic posts (across ICS)	The change to the UHA Guidance (20xClinical Academics) is a challenge. Received further feedback from UHA and need to have at least 20 clinical academics remain unchanged.	Working closely with University of Lincoln to develop plans for recruitment of Clinical Academic posts with a view to maximising existing research relationships where possible. Two potential candidates have been identified for the Clinical Academic recruitment.		
								Successfully recruit 6 Clinical Academics within the first year of agreement of the UoL/ULHT model	Agreed clinical academic financial model	A financial model for the appointment of clinical academics is in development that describes a timeline to achieve the required 6% of medical workforce for UHA status	Working group Meetings, ULHT/UOL Exec meetings and R&I meetings	The financial model is not yet agreed which is delaying appointment of clinical academic roles Identified early adopter Clinical Academic roles once model agreed	Ongoing meetings between ULHT and UoL, commissioned working group developing final proposal which will be used to inform the financial model and MOU. Update to Trust Board shared in March 2024 to agree risk appetite and next steps.		
4d	Enhanced data and digital capability	Group Chief Integration Officer						Development and approval of Electronic Patient Record OBC	Regional and National approval of OBC Affordability of OBC	Digital Services Steering Group Digital Hospital Group e-HR Programme Steering Group Capital, Revenue and Investment Group Engagement with regional colleagues	Delivery of OBC Agreement of funding	Regional feedback on OBC	OBC approved by Frontline Digitalisation ePR Investment Board (EPRIB) on 19th July 2023. OBC approved by JIC on 28th July 2023. OBC approved by Cabinet Office Commercial Spend Controls Process on 3rd Oct 2023. ITT published 6th October 2023 with bid submission deadline on 29th November 2023 but only three bid submissions received with non of them being fully compliant. After listening to the market and involving all parties (including legal), changes have been made to the ITT, including provide increased flexibility in the approach to T&Cs and updating the wording of one of the Mandatory Compliance Questions. ITT republished 29th February 2024 with bid submission	Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee (To move to: Transformation and Integration Committee)	
								Upgrade of our technological infrastructure to support technology advancements	Insufficient cap/rev to replace aging technology Insufficient capacity to deliver purchased equipment	Technical Design Authority Digital Hospital Group Information Governance Group (for cyber / info security)	Digital Maturity Assessment		Looking to procure a Technical / Implementation Partner to provide capacity as and when required Enabling infrastructure funded via FD (EPR) rollout going to plan.		

Ref	Objective	Executive Lead	Linked programmes in Integrated Improvement Plan/Operational Plan	Linked projects in Integrated Improvement Plan/Operational Plan	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
								Enhance our organisational digital capability and skills through training	Insufficient capacity to create and deliver training materials	Digital Hospital Group			Looking to procure a Technical / Implementation Partner to provide capacity as and when required This is now well underway with 2 comms centres purchased in 23/24 and will be commissioned in 24/25, wireless network being upgraded		
SA5 To embed a population health approach to improve physical and mental health outcomes, promote well-being, and reduce health inequalities across an entire population															
5a	Develop a Population Health Management (PHM) and Health Inequalities (HI) approach for our Core20PLUS5 with our ICS	Group Chief Nurse/Group Chief Medical Officer						Gain a greater understanding of the Lincolnshire population and support a reduction in health inequalities	Core20PLUS dashboard not yet developed	Development of Core20PLUS dashboard by June 2023	Core20PLUS dashboard	Core20PLUS dashboard not yet developed	Dashboard due to be in place by June 2024	Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee (To move to: Transformation and Integration Committee)	
5b	Co-create a personalised care approach to integrate services for our population that are accessible and responsive	Group Chief Nurse/Group Chief Medical Officer												Quality Committee	
5c	Tackle system priorities and service transformation in partnership with our population and communities	Group Chief Integration Officer						Build a Partnership strategy to support improvements in safe and sustainable care, and harness benefits for the population of Lincolnshire	Partnership Strategy not yet in place	Associate Director of Partnerships started in post May 2023 and has started to draft Partnership Plan. Board development session 5th December 2023 and intention to have signed off by July 2024 Partnership work is already underway across the organisation and is not being delayed by the lack of formal strategy e.g opportunities emerging for the speciality review programme	Signed off Partnership Strategy	Strategy not yet completed or signed off	Work is underway to develop the strategy, which needs to align with the new IIP and ULHT clinical services strategy.	Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee (To move to: Transformation and Integration Committee)	
5d	Transform key clinical pathways across the group resulting in improved clinical outcomes	Group Chief Integration Officer/Group Chief Medical Director												Quality Committee	

Lincolnshire Community Health Services NHS Trust

Report to the Lincolnshire Community and Hospitals Group Board

Date of meeting	2nd July 2024	Agenda item	14.3
Title	Report on the Audit Committee meetings held on 3rd May 2024 and 17th June 2024		
Report of	Ian Orrell, Non-Executive Director and Chair of Audit Committee	Prepared by	Sam Wilde, Director of Finance and Business Intelligence
Previously considered by / Date	None	Approved?	N/A
Summary	The Audit Committee met on 3rd May 2024 and 17th June 2024. This paper provides a summary of the key issues for the Board to be aware from the meetings. These include: - External Audit; - Internal Audit; - Clinical Audit - Report from Board Committees; - Review of Board Committee Self Assessments; - Freedom to Speak Up Guardian Update Report; - Risk Report; - Counter Fraud Update; - Review of Shared Services 3rd Party Assurance; - Annual Report of the Audit Committee; - Review of Waivers, Hospitality, Gifts and Sponsorship; - Procedural Document Status Report; - Review of Claims (including Losses and Special Payments); - Annual Report for Deceased Patients with No Next of Kin; - Group Model Update; - Review of Reporting Cycle;		

1. To deliver high quality, safe and responsive patient services	**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**
	1d. Deliver clinically led integrated services	**X**
2. To enable our people to lead, work differently, be inclusive, motivated and proud to work within LCHG	**2a. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise**	**X**
	2b. To be the employer of choice	**X**

3. To ensure services are sustainable, supported by technology and delivered from an improved estate	**3a. Deliver financially sustainable healthcare, making the best use of resources**	**X**
	3b. Drive better decision and impactful action through insight	**X**
	3c. A modern, clean and fit for purpose environment across the Group	**X**
	3d. Reduce waits for patients who require urgent and emergency care and diagnostics and ensure we meet all constitutional standards	**X**
	3e Reducing unwarranted variation in cancer service delivery and ensure we meet all constitutional standards (ULHT)	**X**
	3f Reducing unwarranted variation in planned service delivery and ensure we meet all constitutional standards (ULHT)	**X**
	3g Reducing unwarranted variation in community service delivery and ensure we meet all constitutional standards (LCHS)	**X**
4. To collaborate with our primary care, ICS and external partners to implement new models of care, transform services and grow our culture of research and innovation	**4a Establish collaborative models of care with all our partners including Primary Care Network Alliance (PCNA), GPs, health and social care and voluntary sector**	**X**
	4b Successful delivery of the Acute Services Review	**X**
	4c Grow our research and innovation through education, learning and training	**X**
	4d Enhanced data and digital capability	**X**
5. To embed a population health approach to improve physical and mental health outcomes, promote well-being, and reduce health inequalities across an entire population	**5a Develop a Population Health Management (PHM) and Health Inequalities (HI) approach for our Core20PLUS5 with our ICS**	**X**
	5b Co-create a personalised care approach to integrate services for our population that are accessible and responsive	**X**
	5c Tackle system priorities and service transformation in partnership with our population and communities	**X**
	5d Transform key clinical pathways across the group resulting in improved clinical outcomes	**X**
Impact of proposal/ report	*Not Applicable*	
CQC	**Safe** | **Caring** | **Effective** | **Responsive** | **Well-Led**	
Links to risks	*Links to overall risk management process and therefore all risks.*	
Legal/ Regulation	*HFMA Audit Committee Handbook.*	

Recommendations/ Actions Required

Board is asked to:

- **NOTE** the report; and

- **RECEIVE** the Audit Committee annual report (Appendix 1).

Appendices

1 - Audit Committee Annual Report – 2023/24

Glossary

BAF – Board Assurance Framework
BPPC – Better Payment Practice Code
FPPIC – Finance, Performance, People & Innovation Committee
FTSUG – Freedom To Speak up Guardian
HFMA – Healthcare Financial Management Association
HoIA – Head of Internal Audit Opinion
HMRC – His Majesty's Revenue & Customs
LCHG – Lincolnshire Community & Hospitals NHS Group
NHSE – National Health Service England
PGMOL – Professional Game Match Officials Limited
TIAA – The Internal Audit Agency

Report on the Audit Committee meetings held on 3rd May 2024 and 17th June 2024

1. **Purpose**
   To make the Board aware of key issues from the Audit Committee meeting held on 3rd May 2024 and 17th June 2024.

2. **Key messages**
   Key issues for the Board to be aware of are as follows:

   a. **External Audit**
   The committee received and considered a progress report from Mazars at the May meeting. At the June meeting the committee reviewed the draft annual accounts and draft annual report and (subject to a small number of finalisations) agreed to recommend these to the Board for approval. The committee also received and reviewed Forvis Mazars Audit Completion Report and draft Annual Auditors Report. The committee reviewed the proposed letter of representations and recommended the accountable officer sign the letter on the relevant date.

   b. **Internal Audit**
   At its May meeting:
   - The committee received a 2023/24 Summary Internal Controls Audit report from TIAA at its May meeting noting the Emergency Preparedness and Business Continuity Planning review report had been issued with a reasonable assurance rating.
   - The committee approved the Indicative Audit Strategy 2024-27 and Annual Audit Plan 2024-25.

   At its June meeting the committee received:
   - TIAA's 2023/24 Internal Audit Annual Report which has an overall Head of Internal Audit Opinion of Reasonable Assurance.
   - Final 2023/24 internal audit reviews for the reviews of Core Financial Systems (Reasonable Assurance), BAF and Risk Management (Reasonable Assurance) and Data Security Protection Toolkit (Substantial Assurance). The committee asked that a revised version of the BAF and Risk Management report be prepared that correctly reflected management comments.

   c. **Clinical Audit**
   At its June meeting the committee received and reviewed the Clinical Audit Report for 2023/24.

   d. **Report from Board Committees**
   At each meeting the committee considered the reports of the meetings of FPPIC, and Group Quality Committee that had been provided to Board since it last met. No issues had been referred to Audit Committee from other committees. The committee were assured that that the other committees were following due processes and reviewing the Board Assurance Framework (BAF) and risks.

   e. **Review of Board Committee Self-Assessments;**
   At its June meeting the committee reviewed the annual self-assessments carried out

by FPPIC and Quality Committee. It was noted that those committees had used a different assessment tool from the checklist from the HFMA Audit Committee Handbook checklist used in previous years (and used by the Audit Committee for its own 2023/24 self-assessment).

f. Freedom to Speak Up Guardian Update Report
The Freedom to Speak Up Guardian presented her annual report for 2023/24 to the June meeting of the committee. The committee were content that this channel for raising concerns continued to operate effectively.

g. Risk Report
The committee reviewed risk reports at both meetings and was assured that the processes to manage risk continues to be applied in accordance with the Trust's Risk Management Strategy and Process.

h. Counter Fraud Update
At its May meeting the committee reviewed a comprehensive Counter Fraud progress update, noting green assessments were expected in all elements of the counter fraud standards return. The committee approved the counter fraud operational plan for 2024/25.

i. Review of Shared Services 3rd Party Assurance
At its June meeting the committee reviewed assurance on the shared financial services and payroll services provided by 3rd parties contained within the internal audit review of core financial systems.

j. Annual Report of the Audit Committee
At the May meeting the committee considered a proposed annual report (Appendix 1) on its operation and agreed to recommend this to Board.

k. Review of Waivers, Hospitality, Gifts and Sponsorship
At its May meeting the committee reviewed the 2023/24 quarter 4 report which included 3 waivers and 0 declarations of gifts and hospitality. The committee asked that going forward individual waivers be reviewed by the relevant committee (FPPIC or Quality Committee) in addition to the quarterly reporting into Audit Committee. This would align the approach across the Lincolnshire Community and Hospitals NHS Group.

l. Procedural Document Status Report
The committee reviewed the procedural document status report at its May meeting and progress made for the number of documents beyond their review date.

m. Review of Claims (including Losses and Special Payments)
The committee received and approved the quarter 4 review of claims (including losses and special payments) at its May meeting and the 2023/24 Annual Claims Report at its June meeting, recommending the annual report to Board for approval.

n. Annual Report for Deceased Patients with No Next of Kin
At its June meeting the committee received and approved the Annual Report for Deceased Patients with No Next of Kin, noting there had been no such patient deaths

in 2023/24 and a previous case relating to the death of a patient in care in 2020/21 had now been resolved and closed.

o. **Group Model Update**
The committee received verbal updates on latest developments with the Lincolnshire Community and Hospitals NHS Group at each meeting.

p. **Review of Reporting Cycle**
The committee reviewed its 2024/25 reporting cycle at each meeting.

3. **Recommendations/ Actions**
Board is asked to:
- **NOTE** the report;
- **APPROVE** the 2023/24 Annual Claims Report**;** and
- **RECEIVE** the Audit Committee Annual Report (Appendix 1).

2023-24 Annual Report of the Audit Committee

1. Membership

The committee is required to have members, drawn from the independent Non-Executive Directors, not including the Trust Board Chair. At least one member must have significant recent and relevant financial experience. One member must act as chair.
Membership of the committee during 2022/23 has been as follows:

Name	Period	Chair	Recent and Relevant Financial Experience
Ian Orrell	All year	Yes	Yes
Gail Shadlock	All year	No	No
Rebecca Brown (Associate NED)	From 07.02.24	No	No

2. Quorum and Membership Officer Attendance

The quorum is at least 2 non-executive directors and one executive director. Members should attend at least 80% of meetings but should aim to attend all.

All meetings have been quorate and all members have fulfilled the attendance requirement.

Name/ Position	17/05/23	21/06/23	04/10/23	06/12/23	07/02/24	Attendance %
Ian Orrell	√	√	√	√	√	100
Gail Shadlock	√	√	√	√	√	100
Sam Wilde, Director of Finance and Business Intelligence (in attendance, required for quoracy)	√	√	√	√	√	100
Rebecca Brown (Associate NED)					X	0
Quorate?	Yes	Yes	Yes	Yes	Yes	

3. Other Officer Attendance

The terms of reference also require regular attendance from a number of other officers. Attendance of those officers was as shown:

Other Officers in attendance					
Officer	17/05/23	21/06/23	04/10/23	06/12/23	07/02/24
Deputy Director of Finance, Performance & Information	x	x	√	x	x
Deputy Director of Corporate Governance	√	√	√	√	√
Director of Audit (Internal Audit)	√	√	√	√	√
Midlands Lead for NHS Audit (External Audit)	√	√	√	√	√
Local Counter Fraud Specialist.	x	√	√	√	√

Committee members have previously considered whether they believe a second Finance representative should be in regular attendance in addition to the Director of Finance and Business Intelligence, and concluded that one Finance representative only is required.

The Accountable Officer should attend when the committee considers the Annual Report and Accounts and Draft Annual Governance statement. Maz Fosh attended the June 2023 meeting at which the annual accounts were reviewed and approved.

Other executive directors/managers have been invited to attend when the committee has been discussing areas of risk that are their responsibility. For example Freedom to Speak Up Guardian joined the December 2023 meeting to present the Freedom to Speak up Guardian Assurance report to the Committee.

4. Schedule of Meetings

The committee met 5 times during 2023/24 in line with the suggested benchmark. No additional meetings of the committee were requested by the Trust Board, Accountable Officer, external auditors or internal auditors.

The committee meet privately with the auditors at the start of every meeting.

5. Duties and Responsibilities

Integrated Governance, Risk Management and Internal Control

The committee has reviewed the maintenance of an effective system of integrated governance, risk management and internal control in support of the achievement of objectives. In particular the committee has

- Reviewed the Board Assurance Framework at each meeting
- Reviewed the Claims Management Policy, Management of Arrangements where the Deceased Has No Relatives or N|ext of Kin Policy, Protocol and Procedure for Accessing External Legal Advice, Petty Cash procedure and Losses, Compensation Policy and Countering Fraud, Bribery and Corruption Policy.
- Considered a cyber security assurance throughout the year.

During the year Audit Committee has reviewed the reports to Board from the Quality Committee (previously Quality and and Risk Committee) and Finance, Performance, People and Innovation Committee.

Internal Audit
The committee has reviewed the internal audit plan for 2023-24, considered the findings of internal audits reviews and management responses to them and carried out an annual review of internal auditor effectiveness.

External Audit
The committee has considered the proposed external audit strategy including nature, scope, evaluation of risks and assessment of the organisation. The committee has reviewed reports on auditor independence. The committee reviewed the external audit report and has carried out an annual review of external auditor effectiveness.

Other Assurance
The committee has reviewed other sources of assurance including the clinical audit plan and the work of the other committees. The committee approved a plan for improving Better Payment Practice Code (BPPC) compliance ahead of submission to NHS England and received assurance reports from FPPIC who oversaw implementation of that plan.

Counter Fraud
The committee has reviewed the annual counter fraud plan, its implementation and the outputs of its work, noting national updates throughout the year, attendances and queries being raised at staff induction sessions and of suspicions of fraud and bribery being reviewed and investigated though quarterly reporting into the Committee. The committee carried out an annual review of counter fraud effectiveness.

Financial Reporting
The committee has monitored the integrity of the annual accounts and considered will consider reviews of financial systems by both internal and external auditors. The committee considered proposed accounting estimates and judgements for 2023/34 in respect of the dispute with HMRC.

Whistleblowing
The committee has considered the adequacy and security of arrangements to raise concerns in confidence including both the Freedom to Speak Up (FTSU) Guardian and Counter Fraud whistleblowing channels. Reports from both Counter Fraud and the FTSU Guardian have been received on a regular basis.

Arbitration
It has not been necessary during the year for the committee to arbitrate in any disputes between officers of the organisation and auditors.

6. Reporting
The Chair of the committee has provided a written report to the Trust Board following each of its meetings. Approved minutes of committee meetings have also been made available to the Board.

7. Administrative Support
Full administrative support fulfilling all requirements has been provided to the committee by the Corporate Administration Team.

8. Access
Both internal and external auditors have had a right of direct access to the committee chair.

9. Review
The committee's terms of reference were reviewed in December 2023 and approved by the Trust Board in January 2024, as noted in appendix 1.

Approved May 2024

United Lincolnshire Hospitals NHS Trust

Meeting	*Lincolnshire Community and Hospitals Group Board meeting*
Date of Meeting	*2 July 2024*
Item Number	*14.4*

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 Internal Audit Annual Report including the Head of Internal Audit Opinion for 2023/24. 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 Reasonable Assurance.

External Audit

The Committee received the External Audit Completion Report. The Committee were advised by the External Auditor that there had been no significant issues or deficiencies in internal control identified and that the Trust had been given an unqualified Internal Audit Opinion.

The Committee were advised that the audit had produced two none significant deficiencies in internal control which related to backing documentation for patient care income and delays linked to the oversight of the annual report. The Trust had responded to the recommendations.

The External Audit provider commended the team for the way they had responded to the process.

The Committee received the Audit Completion Report.

Annual Accounts and Annual Report 2023/24

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.