Bundle LCHG Board Meeting in Public Session 3 September 2024

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

1 Introduction, Welcome and Chair's Opening Remarks
Chair

2 Public Questions
Chair

2.1 Ward Accreditation
AMSS - Bronze Accreditation
Hospice in the Hospital - Bronze Accreditation

3 Apologies for Absence
Chair

4 Declarations of Interest
Chair

5 Minutes of the meeting held on 2nd July 2024
Chair
Item 5 Public Board Minutes July 2024

5.1 Matters arising from the previous meeting/action log
Chair
Item 5.1 Public Action log July 2024

6 Group Chief Executive Horizon Scan
Group Chief Executive
Item 6 Group CEO update public board September 2024

7 Patient/Staff Story

7.1 BREAK

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

8.1 Assurance and Risk Report from the Quality Committee in Common
Chair, Quality Committee in Common
Item 8.1 Quality Committee in Common Upward Report July 2024
Item 8.1 Patient Experience Annual Report Front Sheet
Item 8.1 Patient Experience Annual Report 2023-2024 25.06.24
Item 8.1 Quality Committee in Common Upward Report August 2024
Item 8.1 Appendix 1.0 Maternity and Neonatal Assurance Report July 2024
Item 8.1 Appendix 4 - Birthrate Plus n Workforce Action Plan July 2024 v2
Item 8.1 Appendix 5 - Neonatal QIS improvement plan v2
Item 8.1 Appendix 9 - MNOG NED MayJune 24

8.2 ULHT and LCHS Safeguarding Annual Report
Group Chief Nurse
Item 8.2 Front Sheet LCHS Safeguarding Annual Report
Item 8.2 LCHS Annual Safeguarding Report 2023 - 2024 PEIG APPROVED 07.08.2024
Item 8.2 Front Sheet ULH Safeguarding Annual Report
Item 8.2 ULHT Annual Safeguarding Report 2023 - 2024 PEIG APPROVED 07.08.2024

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 - July 2024v1

Item 9.1 POD - Upward Report - August 2024v1 (2)
Item 9.1 WDES Annual Report Front Sheet
Item 9.1 WDES Annual Report 2023-24
Item 9.1 WDES_Action_Plan_2024_2027_vers_1_0
Item 9.1 WRES Annual Report Front Sheet
Item 9.1 WRES Annual Report 2023-24
Item 9.1 WRES_Action_Plan_2024_2027_vers_1_0

9.2 Sexual Safety Charter Update
Group Chief People Officer
Item 9.2 Board Report September 2024 NHS Sexual Safety Charter and Worker Protection Act 2024
Item 9.2 Appendix 1 LCHG Sexual Safety Charter Full P1 Condensed P2
Item 9.2 Appendix 2 Proposed Measures of Progress Sexual Safety for Discussion 060824

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
10.1 FPPIC Report to Public Board September 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 July 2024
Item 10.2 FPEC Upward Report August 2024

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 Reports - ULHT/LCHS
Chief Integration Officer/Director of Finance and Business Intelligence
Item 13 ULHT IPR Trust Board - Front page
Item 13 App 1 ULHT IPR Trust Board August 2024
Item 13 LCHS IPR Frontsheet August 2024 (002)
Item 13 - Appendix 1 LCHS Integrated Performance Report - August 2024 Data (1)

14 Risk and Assurance

14.1 Group Risk Management Report
Group Chief Clinical Governance Officer
Item 14.1 LCHG Board Strategic Risk Report Exec Summary September 2024
Item 14.1 Group Board ULHT Strategic Risk Report August 2024
Item 14.1 Group Board ULHT Appendix A- Risks rated 15-25 August 2024
Item 14.1 Group Board LCHS Strategic Risk Report August 2024
Item 14.1 LCHS Appendix A - Significant Risks 15-25 August 2024

14.2 Board Assurance Framework
Director of Corporate Affairs
Item 14.2 LCHG Draft BAF 2024-25 Front Cover September 2024
Item 14.2 LCHG BAF 2024-25 28.08.24

14.3 Assurance and Risk Report from the ULHT Audit Committee Meeting
Chair, ULHT Audit Committee
To include Local Counter Fraud Specialist Annual Report
Item 14.3 Audit Committee Upward Report September 24
ULHT LCFS Annual Report 2023-24 - FINAL (Trust Board)

15 Any Other Notified Items of Urgent Business

16 The next meeting will be held on Tuesday 5th November 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 2 July 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
Professor Karen Dunderdale, Group Chief Executive
Mr Sam Wilde, Director of Finance and Business Intelligence

LCHS
Non-Voting Members:
Mrs Rebecca Brown, Associate Non-Executive Director
Miss Claire Low, Group Chief People Officer
Mrs Kathryn Helley, Group Chief Clinical Governance Officer
Miss Claire Low, Group Chief People Officer

ULHT
Voting Members:
Mrs Elaine Baylis, Group Chair
Professor Karen Dunderdale, Group Chief Executive
Dr Colin Farquharson, Group Chief Medical Officer
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, Group Chief People Officer
Dr Sameedha Rich-Mahadkhar, Director of Improvement and Integration,
Mrs Sarah Buik, Associate Non-Executive Director
Mrs Vicki Wells, Associate Non-Executive Director
Mrs Kathryn Helley, Group Chief Clinical Governance Officer

In attendance:
Mrs Jayne Warner, Trust Secretary, ULHT
Ms Catherine Leggett, Deputy Director of Corporate Governance, LCHS
Mr Mike Parkhill, Director of Estates, ULHT
Mr David Picken, Deputy Director of Finance, ULHT
Mrs Rachel Lane, Trust Board Administration, LCHS (Minutes)

Apologies
Professor Philip Baker, Non-executive Director ULHT
Mrs Julie Frake-Harris, Chief Operating Officer LCHS/ULHT

Mrs Angie Davies, Director of Nursing ULHT
Mr Jonathan Young, Director of Finance, ULHT

126/24	**Item 1 Introduction** The Chair welcomed Board members and members of the public, staff or interested parties who had joined the live stream. The Chair formally welcomed Professor Dunderdale as the first Group Chief Executive, having commenced in post on 1 July 2024, following extensive recruitment processes. The Chair looked forward to seeing the impacts of the Group Chief Executive's leadership within the Board setting moving forward.
127/24	**Item 2 Public Questions** One question had been received from Vi King, however due to pre-election rules this would not be responded to within the meeting in the usual way. A response would be offered outside of the meeting.
128/24	**Item 3 Apologies for Absence** Apologies were received from Professor Philip Baker, Non-executive Director, UHLT, Mrs Julie Frake-Harris, Chief Operating Officer, LCHS/UHLT, Mrs Angie Davies, Director of Nursing, ULHT and Mr Jonathan Young, Director of Finance, ULHT.
129/24	**Item 4 Declarations of Interest** Mr Herbert declared a new interest; having joined the Board of M.I. Dickson Limited as a Non-executive Director. The Declarations of Interest Register would be updated accordingly. **Action: Trust Secretary, 2nd July 2024**
130/24	**Item 5 Minutes of the meetings held on 7 May 2024/action log** The minutes of the Board in Common meeting held on Tuesday 7th May 2024 were approved as an accurate record. There were no outstanding matters arising.
131/24	**Item 6 Chief Executive Horizon Scan** The Group Chief Executive presented the report to the Board expressing delight at having commenced in the role of Group Chief Executive. The latest round of Industrial Action had ended at 7am on 2 July and had been managed well across the Group.

132/24	The Group Chief Executive informed Board members that the 2024/25 System Operational Plan had now been submitted, following scrutiny of the outline plan by the National team on 25 May 2024 where this had been well received.
133/24	The Group Chief Executive drew attention to published national reports relating to the Infected Blood Inquiry and the All Parliamentary Committee on Birth Trauma, where recommendations were being reviewed and plans and mitigations were being put in place, in line with governance arrangements.
134/24	The Group Chief Executive took the opportunity to thank the former Chief Executive, Mr Morgan for the help and support received in achieving a smooth transition, prior to taking up the new role on 1 July 2024. Much of the last month had been spent recruiting to Group Executive Board roles and the process had almost concluded.
135/24	ULHT had been identified as a pilot site for Martha's Rule, and the Board would be kept informed of progress in the coming months.
136/24	The Group Chief Executive drew attention to areas of celebration across the Group during June, for national Volunteers week where over 270 volunteers had been recognised and had provided over 40,000 volunteering hours across the Group. ULHT had been shortlisted in the Patient Involvement in Safety category of the Health Service Journal (HSJ) Patient Safety Awards and LCHS had joined with Health Innovation East Midlands for a joint entry which had also been shortlisted, recognising the county's transforming wound care project in the Community Care Initiative of the Year category.
137/24	The Group Chief Executive had also spent some time celebrating National Estates and Facilities day in late June, recognising more than 1,100 estates and facilities colleagues who worked tirelessly to keep hospitals, community settings and GP surgeries running.
138/24	ULHT continued to await the outcome of its application for Teaching Hospitals status, and it was anticipated there may be an update on this post-election.
139/24	The Chair thanked the Group Chief Executive for the comprehensive report. The Board: • **Received the report and noted the significant assurance provided**
140/24	**Item 6.1 Infected Blood Inquiry** The Chief Medical Officer explained that the Government had recently published the final report pertaining to the Infected Blood Inquiry. As a consequence of this NHS England (NHSE) had written to Integrated Care Boards (ICBs) and Trusts to acknowledge the receipt of the letter. Further details relating to recommendations and actions would be known in due course.
141/24	The Chief Medical Officer provided assurance to the Board that the Group remained committed to the continued improvement, care and support of all patients utilising

	services and acknowledged that this would impact on those involved in historical events. The Board: • **Received the report**
	Item 8 Strategic Aim 1 To Deliver high quality, safe and responsive patient services
142/24	**Item 8.1 Assurance and Risk Report Quality Committee in Common** The Chair of the Quality Committee in Common, Mr Connolly, provided the assurances received by the Committee at the 21 May and 18 June 2024 meetings, noting that the inclusion of Patient Safety Partners at the June meeting had added different perspectives and expertise to the Committee which had been welcomed.
143/24	Assurance was provided that the Committee continued to develop well, and a six month review would be undertaken during October 2024 where it was hoped to understand further the work of the three sub-Committees and the future production of developing single reports as a Group.
144/24	Two further areas were highlighted by Mr Connolly; the Maternity and Neonatal Oversight Group had reported that the work was on track to deliver the ten safety actions for year six of the Clinical Negligence Scheme for Trusts (CNST) Maternity, which was an impressive step forward. There had also been a continued significant increase in respect of Saving Babies Lives with overall compliance reported at 90%, and an increase in assurance was being seen at each visit undertaken.
145/24	Pressure ulcers across LCHS had increased along with safeguarding referrals. A deep dive had been presented and assurance was provided that actions and issues identified as part of the deep dive were being addressed. A further review had been requested in three months to understand the impact along with any associated risks, including continence, across the system.
146/24	The Committee had received several annual reports, which would be considered by the Board in private session due to the pre-election period.
147/24	The Chair acknowledged that the Committee was progressing well and was pleased to hear that further review of pressure ulcers would be taking place. The maternity and neonatal elements presented were noted, which read positively recognising that further work would be required following the publication of the All Parliamentary Committee Birth Trauma report. It was good to see the achievements being made in maternity and neonatal services.
148/24	As Maternity and Neonatal Safety Champion, Mrs Brown added that excellent benchmarking was also being seen with a tool in place across the region which demonstrated that the organisation was in a good position and further details would be shared at a future meeting to provide additional assurance. Mrs Brown added that the Quality Committee in Common was going from strength to strength and thanked those who had worked behind the scenes to enable the Committee to achieve what it had by this point.

	The Board: • **Received the assurance report**
	Item 9 Strategic Aim 2 To enable our people to lead, work differently, be inclusive, motivated and proud to work within LCHG
149/24	**Item 9.1 Assurance and Risk Report People and Organisational Development Committee** Mrs Wells provided the assurances received by the People and Organisational Development Committee, at the meetings held on 14 May 2024 and 11 June 2024.
150/24	A report had been received from the Workforce Strategy and OD Group which included focussed work regarding the experiences of internationally recruited nurses, with positive detail presented in this area.
151/24	There had been continued focus on the improvement of statutory and mandatory training and good progress was being made.
152/24	The Safer Staffing report had provided significant assurance to the Committee where the positive nature of the report had been acknowledged and suggested further developments to include non-nursing staffing detail within future reports.
153/24	The Equality Diversity and Inclusion Annual Report had been received and positive developments continued to be seen. The Annual Report from the Guardian of Safe Working had also been received and consideration was given to issues for locally employed Doctors, where issues were being experienced in relation to educational opportunities. Progress was being made on this as well as clinical supervision aspects.
154/24	The Just Culture Steering Group report was received, and the Committee noted significant improvements which was positive. Good work was also being undertaken, following receipt of the National Staff Survey results with Mrs Wells outlining that staff workshops had taken place across the organisation and Divisions had been provided with detailed analysis of the results to develop local action plans. It was anticipated that there would be an improvement for future survey results.
155/24	A Research and Innovation update required further focus to expand on clinical trials and clinical work, and the Committee was seeking positive developments moving forward.
156/24	The first report had also been received from the Clinical Academic Oversight Group and the Committee had been pleased with progress made.
157/24	The Chair acknowledged the focus on internationally educated nurses and the pastoral care offered, and that the employment status of locally employed Doctors was being recognised. It was pleasing to hear that Divisions were taking action in respect of local accountability of the Staff Survey results which was important. The Chair added that Research and Innovation was gaining traction in the county, and it

	was hoped that the Group would be in a position to maximise opportunities that may be presented. The Board: • **Received the assurance reports**
	Item 10 Strategic Aim 3 To ensure services are sustainable, supported by technology and delivered from an improved estate
158/24	**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 24 May 2024 and 27 June 2024 meetings, noting that several new objectives had been rated red until quarter one data was received.
159/24	A leavers update had been presented, covering quarters three and four of 2023/24 where the turnover figure had been 12.03%, below the 15% threshold, with the TUPE transfer of staff having impacted upon the figures. There were also a high number of staff retiring with an overall return rate of 91%. A previous trend relating to a high number of leavers with less than 12 months service was also no longer being seen.
160/24	A report relating to the Equality, Diversity and Inclusion (EDI) improvement plan for high impact actions had been received and the Committee was reassured that the high impact actions were constantly being cross-referenced to ensure they were being met. A further update would be provided in six months. The EDI Annual Report had also been received and the Committee had noted the achievements from the previous year and the good work that had taken place. The Annual Report was recommended for approval by the Board.
161/24	A response rate of 32% for the quarterly Pulse survey had been achieved, and the Trust was maintaining previous scores, the engagement score remained 7/10 and given the current period of change the Committee was assured that this was positive.
162/24	The 2023/24 Caldicott Guardian Annual Report was received and recommended for approval by the Board.
163/24	The system report and recovery programme had retained an amber rating due to the early stages of the year and at that point contracts had not been signed with the ICB, this had now been rectified and an element of unidentified efficiency saving was improving, which was positive.
164/24	The final Financial Planning Submission had been made on 12 June 2024 with revised phasing of planned expenditure from an LCHS perspective, which was linked to the Cost Improvement Programme (CIP) and was phased beyond month two. An additional £700k capital expenditure had also been received from the fair share allocation from the system.
165/24	The Audit Committee had requested the Committee reviewed procurement waivers to provide additional governance with two waivers authorised during 2023/24 which

	were received. Neither had been retrospective and both had been considered appropriate in the circumstances.
166/24	A water safety report had been received and work had been undertaken across the Group through new ways of working and the Committee had felt more assured.
167/24	A business case for a potential Electronic Patient Record had been received and would be discussed by the Board in private session.
168/24	The proposed 2024/25 Board Assurance Framework had been received and it was noted that there were a several objectives yet to be rated.
169/24	The Chair thanked Miss Shadlock for the comprehensive report and asked how the leavers data was promoted and if there was anything that could be learnt from the wider system, which would be considered. The Board also noted the financial position. The Board: • **Received the assurance report**
170/24	**Item 10.2 Assurance and Risk Report from the Finance, Performance and Estates Committee** The Chair of the Finance, Performance and Estates Committee, Ms Cecchini, provided the assurances received by the Committee at the 23 May 2024 and 20 June 2024 meetings.
171/24	Ms Cecchini explained that a revised financial plan had been submitted on 12 June 2024 following further refinement in relation to the profile of spend and Cost Improvement Programme (CIP) delivery undertaken across the system. No changes had been made to the outturn planned. Months one and two delivery matched the final plan as agreed locally and nationally. Additional capital resource had also been made available through the fair share allocation of £7.6m for the Integrated Care System (ICS) of which the ULHT share had been £6.9m.
172/24	There continued to be a gap in identified CIP reflecting the additional element required for 5% total delivery. The Committee had further reflected on this position and noted that there were still investments where funding had not yet been agreed. Consideration would be given to affordability in respect of investments should funding not be forthcoming.
173/24	The Better Payment Practice Code (BPPC) demonstrated some improvement and 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.
174/24	A cash drawn down report had been received which had been regular practice pre-pandemic however had not been required since. Due to erosion of the position the Committee had been advised of an expectation to request cash in the second half of the financial year.

175/24	An estates report had been received where there had been assurance provided that there was no Reinforced Autoclaved Aerated Concrete (RAAC) on the Trust sites. The Committee also 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 regarding the use of non-clinical rooms as treatment rooms with clinical assessments being completed to support services to locate to appropriate environments.
176/24	In respect of Health and Safety the 2023/24 Annual Report had been received and remained under review, the main issues related to hoists and the required maintenance checks being undertaken. Issues had also been raised in respect of regular water flushing taking place.
177/24	A deep dive relating to Urgent and Emergency care was received and strong performance was noted which had resulted from the actions put in place to address previous performance. There had been co-creation of the improved pathway with oversight through the Urgent and Emergency Care Board.
178/24	Two programmes of work had been drawn to the Committee's attention, early supported discharge and flow and the unplanned care alliance. Those programmes of work had focussed on bed occupancy and reducing length of stay, ensuring the correct support at the front door to correctly signpost patients.
179/24	There had also been positive progress in several areas, including 4-hour waits and a reduction in ambulance handover waits.
180/24	Ms Cecchini advised of a small deterioration in the faster diagnosis standard relating to the 62 day target which was not currently being met, however a recovery plan was in place and remained on target.
181/24	The Anchor Plan and Green Plans were received, and the Committee were advised that the Group was in the process of appointing a sustainability lead. It was noted that work was also ongoing in relation to fragile services.
182/24	The Chair thanked Ms Cecchini for the comprehensive report which demonstrated the scope of the Committee.
183/24	The Chair understood a request received from Non-executive Directors to move to a Finance Committee in Common as soon as possible and this was on the workplan of the Governance leads and would be progressed once new Executive leads were in place. The 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
	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
	No items.
184/24	**Item 13 Integrated Performance Reports** The Director of Finance and Business Intelligence presented the LCHS Integrated Performance Report highlighting that Committees had received and reviewed the detail in depth. Three indicators demonstrated deterioration which included the vacancy rate, which was being impacted by the additional vacancy controls in place. There were however seven indictors showing improvement, which included sickness absence and agency expenditure.
185/24	The Director of Improvement and Integration presented the ULHT Integrated Performance Report noting the overall assurance level remained as moderate. Attention was drawn to one fall reported during May and 39 category two pressure ulcers during May where actions had been taken to improve performance. Medication errors was another key workstream moving forward to ensure improvement with operational performance also noted.
186/24	Mrs Brown commented on the increase in ambulance figures over the last month where conveyancing had increased and expressed a view that the Board should recognise the work through the urgent and emergency care pathway. Through the increase in the number of community beds available, the pathway was demonstrating improvement, and it was also noted that the Summary Hospital-level Mortality Indicator (SHMI) rate was demonstrating a good position for the Trust with good recognition of patient safety.
187/24	Dr Gibson asked if discussions were taking place with East Midlands Ambulance Service NSH Trust (EMAS) colleagues in relation to the increase in conveyance figures and commented on the positive decrease in the number of vacancies from 10% to 5% which was demonstrated a positive continuous trend.
188/24	The Director of Improvement and Integration responded that the unplanned care alliance was working well within the system and EMAS colleagues where there had been an increase in attendance, occupancy and acuity, which was also being seen across the region. The work of the Group was now paying dividends in respect of bed occupancy and patient flow with a key area of work being undertaken on system demand and capacity modelling with health and social care partners. Through this the EMAS data would be reviewed, and an update would be provided to the Board at an appropriate time.
189/24	The Chair commented that it was positive to hear of the work with system partners and that the Group was acting as one, demonstrating an impact on patient safety to manage demand. The Board:

	• **Received the Integrated Performance Reports noting the moderate assurance of the ULHT report**
	Item 14 Risk and Assurance
190/24	**Item 14.1 Group Risk Management Report** The Group Chief Clinical Governance Officer presented the monthly risk report to the Board noting that there had been several changes since the last update.
191/24	There had been changes from a Quality Committee in Common perspective in the reduction of two risks, one in relation to serious harm for patient falls which was testament to the team with the score reducing from 20 to 12 and the other related to echocardiograms which had reduced to a score of 16 from 20.
192/24	There had been no changes from a People and OD Committee perspective and for the Finance, People and Estates Committee one new risk had been added to the register relating to the Medical Air Plant at Grantham with a score of 20. This was being kept under review by the Estates team to mitigate any issues.
193/24	From a LCHS perspective three new risks had been added to the Risk Register relating to District Nurse care and pressure ulcers in the community; there had been a focused discussion relating to pressure ulcers at the Quality Committee in Common and correlation with the detail included on the Risk Register. There had also been three risks closed and some changes to scores.
194/24	From a Finance, Performance, People and Innovation Committee perspective, there had been several changes including the increase in risk score relating to financial plans and efficiency savings in recognition of the new financial year and plans were in the process of being developed.
195/24	Reflecting on fire risks over the last year, Dr Gibson commented that the ULHT had invested substantially in improving equipment and facilities and asked what more could be done to reduce the highly scored risks and whether further investment was required. The Director of Estates and Facilities responded that much of this related to an extensive capital programme of work, such as fire compartmentalisation, replacement fire alarms and replacement fire doors. It was noted that training had helped to reduce the risks to ensure buildings were safer, which would be continued throughout the year. The Board: • **Accepted the risks as presented noting the significant assurance**
196/24	**Item 14.2 Board Assurance Framework** The Director of Corporate Governance presented the report noting that this had been considered by all Committees during May and June 2024 and ratings were proposed as documented within the report. Some objectives had not yet been rated due to the new objectives and assurance being developed in line with Group Governance and the assurance processes being worked through.

197/24	One area to note related to the amount of work that had been undertaken in developing the Joint Group Board Assurance Framework and the Deputy Trust Secretary was thanked for this, and for pulling together detail across several areas which were still in development with planning teams. Digital support was also being reviewed to support the Board Assurance Framework, potentially via Datix.
197/24	The Chair commented that the document was developing well, adding that this required Executive support to populate the correct deliverables and information to ensure that the data was used meaningfully. The Board: • **Received the report noting the moderate assurance**
198/24	**Item 14.3 Assurance and Risk Report from the LCHS Audit Committee** The Chair of the LCHS Audit Committee, Mr Orrell, provided the assurances received by the Committee at the May and June 2024 meetings and the report was taken as read.
199/24	The draft Annual Accounts had been reviewed and subject to small finalisation issues, were recommended to the Board for approval. Alongside this, the Auditors reports and conclusions had also been offered to the Committee which had demonstrated a positive result.
200/24	From an Internal Audit perspective the Committee had received several reports and good progress towards the end of the year had been noted. The Head of Internal Audit opinion had offered reasonable levels of assurance, demonstrated a good position and reflected the work undertaken with external auditors.
201/24	The 2023/24 Clinical Audit Annual Report had been received along with the 2023/24 Freedom to Speak up Guardian Annual Report where clear channels for raising concerns remained effective.
202/24	Good progress had been made from a Counter Fraud perspective and the Counter Fraud Operational Plan for 2024/25 had been approved.
203/24	Progress was noted in relation to Procedural documents and more generally, assurance was received relating to effective processes within other Committees regarding risk management. The 2023/24 Claims Annual Report had also been received.
204/24	The 2023/24 Audit Committee Annual Report was also presented to the Board.
205/24	The Chair thanked Mr Orrell for the report noting the positive position with both internal and external auditors relating to the annual accounts and annual report, which demonstrated the efficiency and effectiveness of the Audit Committee. The Board: • **Received the assurance report and Audit Committee Annual Report**

206/24	**Item 14.4 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 June 2024 meeting where the final review of the Annual Accounts and Annual Report had taken place. It was noted that the Head of Internal Audit opinion for 2023/24 had provided reasonable assurance.
207/24	The Committee was pleased to note the continued improvement of the control environment and progress made in completing outstanding actions.
208/24	The external audit report raised no significant issues, however recognised the good work of the finance team and smooth year end process.
209/24	The Annual Accounts and Annual Report had been received and were recommended to the Board for approval.
210/24	The Chair thanked Mr Herbert for the report which reflected systems and process controls were in place and took the opportunity to thank Mr Herbert for his leadership of the Committee, supported by the Non-executive Directors and Executive colleagues. The Board: • **Received the assurance report**
211/24	**Item 15 Any Other Notified Items of Urgent Business** The Chair informed those present that this would be Dr Gibson's last Public Board meeting due to reaching the end of his term of office on the 31 July 2024. Dr Gibson had been a Non-executive Director for the last seven years which was testament to his personal resilience for working through many challenges.
212/24	The Chair thanked Dr Gibson for his contributions as a member of all the assurance Committees at ULHT throughout the years and for taking on the Chair role as and when called upon, demonstrating flexibility, knowledge and skill to work effectively.
213/24	The Chair also thanked Dr Gibson for his contributions in chairing the Charitable Funds Committee, where good step changes had been seen.
214/24	The Chair also offered personal thanks for the support provided by Dr Gibson through some challenging periods and for offering knowledge which could be relied upon.
215/24	On behalf of the Board, the Chair wished Dr Gibson all the best for the future. In response, Dr Gibson extended thanks for the kind words and comments received. Dr Gibson had felt privileged to work within the NHS and when commencing in post as a Non-executive Director, ULHT had been in multiple special measures. Tribute was paid to those who had seen progress made through the longest period of industrial action and a global pandemic and had shown curtesy and patient focus to ensure the organisation was now in a much-improved position. Dr Gibson wished fellow Board members well for the future.

216/24	No further items were discussed.
217/24	The next scheduled meeting will be held on Tuesday 3 September 2024 via MS Teams live stream.

Voting Members	**7 May 24**	**2 July 2024**										
Elaine Baylis	X	X										
Andrew Morgan	X											
Karen Dunderdale	X	X										
Ian Orrell	X	X										
Jim Connolly	X	X										
Gail Shadlock	X	X										
Chris Gibson	X	X										
Philip Baker	A	A										
Neil Herbert	X	X										
Rebecca Brown	X	X										
Dani Cecchini	X	X										
Julie Frake-Harris	X	A										
Colin Farquharson	A	X										
Sam Wilde	X	X										
Anne-Louise Schokker	X											
Jon Young	X	A										

PUBLIC BOARD IN COMMON ACTION LOG

Agenda item: 5.1

Trust Board date	Minute ref	Subject	Explanation	Assigned to	Action due at Board	Completed
2nd July 2024	129/24	Declarations of Interest	Register be updated to reflect additional Declaration of Interest for Mr Herbert, Non-executive Director	Trust Secretary	September 2024	Completed

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	*3 September 2024*
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) Since my last Board report we have had a new Government take office. The Government has made a number of announcements that were referenced in the King's speech. The new Secretary of State for Health, Wes Streeting, has set out his initial priorities for the NHS with regard to the prevention agenda including health inequalities; Out of Hospital care (community care, primary care and neighbourhood working) and the digital agenda. All of which is consistent with what we are doing and intending to do in Lincolnshire.

b) Mr Streeting has appointed Professor Lord Darzi to undertake a rapid review into the state of NHS. Professor Lord Darzi is a lifelong surgeon and innovator, independent peer and former health minister. The review will help the Government to develop a 10 year plan for health which will be overseen by the King's Fund former Director of Policy, Sally Warren.

c) All parts of the Lincolnshire health and care system remain busy, but good work continues in order to cope with the ongoing operational pressures. We planned ahead of the GP collective action following the outcome of the recent ballot and continue to monitor any impact with ICB colleagues on any of our services across the Group.

d) The BMA Junior Doctors Committee has recommended that its members vote to accept the most recent pay offer by the Government. The online referendum opened on 19 August and closes at 11.59pm on Sunday 15 September.

e) There is continued focus on the 2024/25 system operational plan and we continue to work with partners to deliver this.

f) The Lincolnshire system had its quarterly system review meeting with the NHS England regional team in July. This was a very supportive meeting, where we received positive feedback on our continued improvements.

g) The Department of Health and Social Care published the interim report of Dr Penny Dash's review into the operational effectiveness of the Care Quality Commission in July. The interim report, which will be followed by a final report this autumn, provides a summary of the emerging findings and outlines a series of recommendations.

h) We saw the first graduation of the Lincoln Medical School in July and this has received positive media attention locally, regionally and nationally.

i) The first Lincolnshire Health and Armed Forces Conference took place at RAF Cranwell in July and along with the Chair and other board members, we attended with others from health and care to further strengthen our relationship with veterans and serving Armed Forces colleagues.

Group Overview

a) Following the last public board meeting, I have continued to appoint to all of the Group board executive roles and would like to welcome Kathryn Helley as the Group Chief Clinical Governance Officer, Caroline Landon as the Group Chief Operating Officer, Mike Parkhill as the Group Chief Estates and Facilities Officer and Jayne Warner as the Group Director of Corporate Affairs, in addition to Claire Low as the Group Chief People Officer, Nerea Odongo as the Group Chief Nurse, Daren Fradgley as the Group Chief Integration Officer and Dr Colin Farquharson as the Group Chief Medical Officer.

b) At Month 4, ULHT's YTD position is a £15.1m deficit, £4.4m adverse to the planned £10.7m YTD deficit. At a headline level £4m is a justifiable adverse variance with the remaining £360k the impact of other pressures related to medical agency spend and the impact of the extra contractual rate.

c) The Trust released £300k of technical benefit to reduce the adverse variance to plan from £4.7m to £4.4m, this was to support the system position, ULHT therefore has a £600k underlying adverse pressure YTD that has materialised in Month 4.

d) LCHS's YTD position is a £902k deficit, £125k better than the planned £1.027m deficit position.

e) The ULHT CIP YTD has delivered savings of £8.5m, which is £2.2m higher than planned savings of £6.3m. The CIP delivery is offsetting cost pressures. LCHS

CIP YTD has delivered £1.399m, which is £30k worse than planned savings of £1.429m.

f) I attended build progress events at the Skegness CDC and Lincoln CDC in August. Which were celebrations of these exciting projects. The Lincoln CDC represents a total £23m investment in NHS services in Lincolnshire and, will offer a variety of diagnostic services including X-ray, MRI, CT and non-obstetric ultrasound, for convenient, timely care away from busy hospital sites. It will also have dedicated facilities to support the training of future radiographers, with ULHT becoming one of the first NHS Trusts in the country to link directly with a school of radiography at the University of Lincoln.

g) In addition, the Skegness CDC represents a £15m investment in NHS services in the town; a figure believed to be the largest single NHS investment in Skegness in many years. It will offer a variety of diagnostic services not previously available in the area, including CT, MRI, echocardiograms and dental X-ray. We are also developing plans to include a chemotherapy service to reduce travel for cancer patients.

h) Finally, I attended Grantham CDC with VIP colleagues to officially open the additional £5m investment into the CDC to create a modern and welcoming space for state-of-the-art MRI and CT scanners.

i) The ULHT part of the Group has been successfully identified as one of the pilot sites for Martha's Rule.

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

k) Finally, I would like to thank Jon Young for all his dedication and commitment to ULHT over the last 10 years as the Deputy Director of Finance and more recently the Director of Finance at ULHT and wish him well in his new role.

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	*3 September 2024*
Item Number	*8.1*

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

Accountable Director	*Nerea Odongo, Group Chief Nursing Officer*
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 the group had requested that further work be undertaken in respect on the incident category regarding appointment, admission, transfer, discharge and referrals due to an increase in reported incidents. An update would be offered to the group in August.

An increase in pharmacy incidents had also been noted and again the group would be undertaking further work to understand the position.

The Committee was **assured** in respect of duty of candour being completed for both LCHS and ULHT despite LCHS reporting red due to a data timing issue.

The Committee was pleased to note the sign-off of 4 Serious Incidents for LCHS by the Integrated Care Board and noted that pressure ulcers remained an area of concern.

An escalation in regard to the deteriorating patient was offered to the Committee for information at this time due to there being no lead at ULHT which had slowed progress across the group in this area of work.

Concern was noted in respect of the Medicines Quality Group report which had been received by the group with a **lack of assurance** due to this not indicating actions that would be taken to address the issues raised. The Committee noted that support had been offered to the group to support the production of the report.

The group continued to receive divisional reports which continued to demonstrate the grip and understanding held regarding patient safety issues.

High Profile Cases Report
The Committee received the joint report noting the position presented and **assurance** offered through the report.

Focussed Discussion – IPC Annual Reports
The Committee undertook a focused discussion relating to the Infection Prevention and Control Annual Reports, receiving the ULHT report (appended) with the LCHS report receive the previous month.

The Committee was **assured** in respect of the ULHT report presented and the verbal update offered for LCHS on the progress that had been made in the 23/24 year for both organisations.

Of specific note was the collaborative working across the Group that demonstrated the level of integrated work which had been achieved towards the end of the financial year.

The Committee noted that whilst there were areas for improvement for both organisations there were clear opportunities for learning which were being progressed.

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 in respect of the workshop session to help guide the approach to be taken across the Group.

The Committee noted the positive engagement with external stakeholders at the group including Health Watch with proposals offered to the group agreed by all.

Work was taking place to ensure that reporting offered assurance to the group from both organisations and to ensure that statutory reporting was undertaken appropriately.

The ULHT Patient Experience Annual Report (appended) provided **assurance** to the Committee and was recommended to the Board.

Focussed discussion – Children in Care (LCHS)
The Committee undertook a focused discussion on Children in Care noting that this had been an area of concern for some time with the Committee noting the difficulties in achieving the target of a 20-day turnaround.

Whilst work had been undertaken to improve efficiencies, any progress made had been the result of additional bank GP hours worked. The Committee noted that the service had been supported through the additional hours provided however recognised that the issue in service delivery was as a result of funding.

Data reported to the Committee demonstrated a high number of children who did not attend appointments however the Committee noted the benefit of having received data not previously available.

The Committee expressed support to the Deputy Divisional Lead for Children and Young People and the service, for delivery to the levels described and noted support for wider conversations to support this in progressing.

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 and reflecting on the number of national audits that had been considered by the group.

Ongoing improvements were noted in respect of Structured Judgment Reviews (SJRs) however it was recognised that these continued to be completed outside of appropriate timeframes. Action was being taken to address this.

The group had received an update in respect of research, with the Committee noting the formal reporting route of through the People and OD Committee and was pleased to note the ongoing areas of improvement across both organisations.

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 Group Board Assurance Framework (BAF) with **assurance** noting the ongoing work to ensure further population of the document.

During the meeting the Committee considered the RAG ratings of the objectives where assurance reports had been received with objective 1b rated as amber, from green and would be presented to the Board in September for ratification.

Risk Report
The Committee received the joint report with **assurance** noting updates that had been made to the risk register.

The Committee noted that the first draft of the joint risk policy was due to be circulated for comment with the intention of new processes being in place from October 2024.

Topical, Legal and Regulatory Update
The Committee received the report for information noting the content and receiving reassurance that the issue highlighted in relation to death certification reform was being addressed.

CQC Assurance Report
The Committee received the report with **assurance** noting the continued improvement of actions being embedded and closed. Work continued to develop the forward view report to offer to the Committee which would detail the work undertaken in relation to the new CQC framework and the self-assessment.

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 noted the increased length of stay in community beds however recognised that this position was due to patients being received sooner from the acute setting for reablement and rehabilitation.

Operational Plan Report (LCHS) and Integrated Improvement Plan: Patients Assurance Report (ULHT)
The Committee received the Integrated Improvement Plan with **moderate assurance** noting the month 2 position and reflecting that a number of items within the report had been considered through the group upward reports.

The Operational Plan Report was received with **assurance.**

Interim ToR and Work Programme
The Committee received the interim terms of reference and work programme accepting the updates made to reflect the 2024/25 LCHG Strategic Aims and Objectives and recognising that updates would be made as Executive appointments were made to the Group.

Issues where assurance remains outstanding for escalation to the Board

The Committee agreed to refer Children in Care to the Board which was deemed to be a fragile service.

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	X					
Chris Gibson Non-Executive Director	X	X	X	X	X	X	A					
Karen Dunderdale Executive Director of Nursing, ULHT/LCHS	X	X	D	D	X	X						
Nerea Odongo, Group Chief Nursing Officer												
Colin Farquharson, Group Chief Medical Officer	X	X	X	X	X	X	X					

Rebecca Brown, Non-Executive Director (Maternity Safety Champion), ULHT/LCHS	X	X	X	X	X	X	X					
Gail Shadlock, Non-Executive Director, LCHS	X	X	X	X	X	X	X					
Julie Frake-Harris, Chief Operating Officer, ULHT/LCHS	X	X	X	X	X	X	D					
Anne-Louise Schokker, Medical Director for Frailty, LCHS	X	X	A	X	A	X	X					

X in attendance
A apologies given
D deputy attended

Meeting	*Lincolnshire Community and Hospitals Group Board Meeting*
Date of Meeting	*3rd September 2024*
Item Number	*8.1*

2023/24 Patient Experience Annual Report

Accountable Director	*Nerea Odongo, Group Chief Nurse*
Presented by	*Nerea Odongo, Group Chief Nurse*
Author(s)	*Jennie Negus, Head of Patient Experience*
Report previously considered at	*Quality Committee in Common* *20th August 2024*

How the report supports the delivery of the priorities within the LCHG 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	
1d Deliver clinically led integrated services	
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	
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)	
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	
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	

Risk Assessment	*Risk No: 4629, 4980, 4981*
Financial Impact Assessment	*Not applicable*
Quality Impact Assessment	*Not applicable*
Equality Impact Assessment	*Not applicable*
Assurance Level Assessment	• *Significant*

Recommendations/ Decision Required	• *The Board are asked to approve the 2023/24 Patient Experience Annual Report*

Executive Summary

Despite considerable challenges through the last 12 months, this Patient Experience Annual Report demonstrates the continued work across the Trust to achieve the ambition of Outstanding Care, Personally Delivered. This report demonstrates how we draw out the intelligence of the feedback we receive from our patients and their families and use this in a meaningful way to make improvements. Equally our work engaging with patients through our patient panel and codesign work continues to be seen as an essential forum in involving, listening to and working with our patients.

Patient Experience Annual report 2023 – 2024

Prepared by: Jennie Negus. Head of Patient Experience

Endorsed by: Patient Experience & Involvement Group – *add date*

Quality Governance Committee – *add date*

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Executive Summary

The ambition of United Lincolnshire Hospitals NHS Trust, is to provide 'Outstanding Care, Personally Delivered'

All our efforts to do this put the interests of our patients first and foremost, and are underpinned by our values which were selected by our staff, patients and public:

- Patient-centred - Putting patients at the heart of our care.
- Compassion - Caring for patients and loved ones.
- Respect - Treating our patients and each other positively.
- Safety - Ensuring patients and staff are free from harm.
- Excellence - Supporting innovation, improvement and learning.

'Patient experience' is what the process of receiving care *feels* like for the patient, their family and carers. It is a key element of quality, alongside providing clinical excellence and safer care. A person's experience starts from their very first contact with the health and care system, right through to their last, which may be years after their first treatment, and can include end-of-life care.

The NHS has a long-standing commitment to offering high quality patient experience, as described in the NHS Patient Experience Framework which is currently under review. There are 5 pillars to the framework

1. Organisational Culture
2. Capacity and capability to effectively collect patient feedback
3. Analysis and triangulation
4. Using feedback to drive improvement and learning
5. Reporting & publication.

This Annual Report describes our performance and achievements over the last year and details our aspirations and ambitions for the coming year. I would like to thank our caring and compassionate staff and volunteers for their commitment and dedication in providing great care and treatment to our patients.

Professor Karen Dunderdale. Group Chief Executive.

Patient and carer experience plan 2022 – 2025.

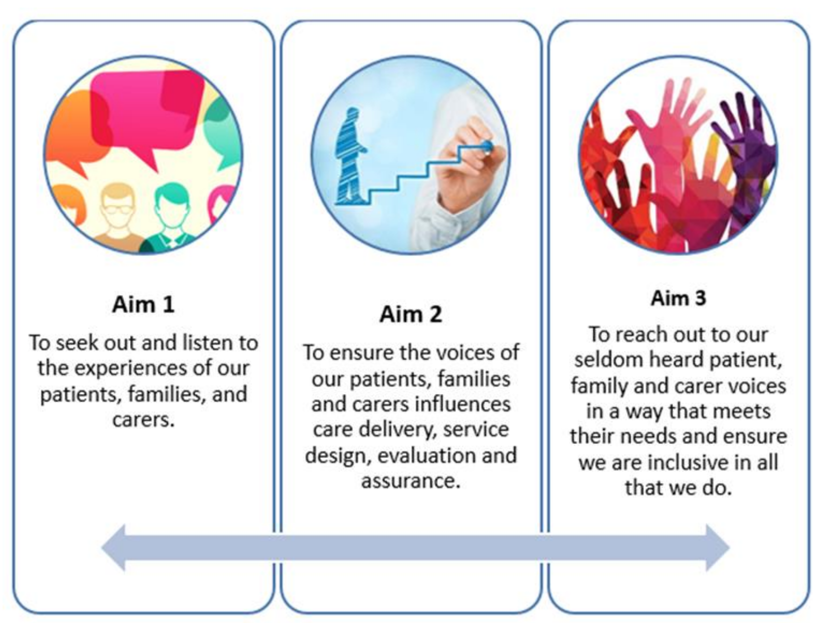
Our new Patient and Carer Experience Plan was approved and published in October 2022 and reflects the overarching Trust strategic objectives within the Integrated Improvement Plan and also the Nursing and Midwifery Framework.

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

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

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

And there are three core aims:



An associated workplan supports delivery of key priorities, progress reports have been prepared and provided quarterly to Patient Experience Group demonstrating good progress is being made. Whilst some achievements are detailed elsewhere in this report others include:

- Over 500 staff attended either standalone Patient Experience training sessions or invited the team to attend workshops and events.
- Patient Experience Data Insight Manager has worked with divisional data analysts to promote the SUPERB dashboard and make it the ‘go-to’ data source for patient experience intelligence.
- Patient Panel has continued to flourish and mature, and two new expert reference groups launched; one attached to the Improvement Academy and one to the Digital Transformation programme.
- Divisional Patient Experience Groups established to drive local improvement activity.
- Patient Story secured at Trust Induction and intranet based digital story library continues to grow with 27 stories now in place.
- Equality Delivery System (EDS) Domain 1 work undertaken across three clinical teams.

Patient Experience Group (PEG)

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

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

Board Assurance Framework (BAF)

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

Each month the BAF is reviewed in light of assurance received at Patient Experience Group. PEG contributes to the Board Assurance Framework specifically in relation to 'Objective 1b Improve Patient Experience' and the risk of failing to provide a caring, compassionate service to patients and their families.

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

Risks

There are currently four corporate patient experience risks on the risk register though at the time of this report risk 5345 is about to be closed.

Quarterly reports are provided to PEG and controls in place are closely monitored.

ID	Module	Name	Action required
5345	Risks	580 patient information leaflets across the Trusts within the patient information database which need to be reviewed and considered against changes in accessibility, branding, copywrite and evidence base. The risk is that information may be inaccurate, out of date or not accessible.	Review Risk
4981	Risks	Codesign shifts the traditional design process where a health care team is independently coming up with ideas for problems. Co-design involves the patients in the design process and works with them to understand their met and unmet needs. If we do not involve our patients and their carers from the outset with our service design and evaluation then we will not achieve our ambition of person centred care.	Review Risk
4980	Risks	Patient engagement can inform service design and evaluation as well as enhance its delivery and governance. It is the process of building the involvement of patients, families and carers, supporting their active involvement in order to enhance their care, care experience, safety, quality and patient-centredness. If we do not build the expectation to engage with our patients then we will not achieve patient centred care and if we do not reach out to 'hard to reach' groups our intelligence will fail to be diverse and inclusive.	Review Risk
4629	Risks	If we do not listen to the voices of our patients, carers and families through not seeking out, hearing and appreciating their experiences and then acting on them, we will fail in our ambition to deliver patient centred care.	Review Risk

Controls include:

Risk 4981 Codesign	Patient Panel & Expert reference groups Codesign workshops held specifically addressing improvements to outpatients' letters and appointments, visiting and care partners. o Patient Panel members invited to attend QI training to understand the principles and methodologies and enable greater involvement in improvement codesign.
Risk 4980 Engagement	IIP milestone reports. Patient Panel & Expert Reference Group evaluations. Upward reports to PEG. Patient Experience and Communication training offer under review to include virtual, face to face, self-study and bite size. Stakeholder feedback and engagement at Patient Experience Group Evaluations and outputs from implementation of 'What Matters to You' and 'You Care We Care to Call' initiatives
Risk 4629 Listening	Patient experience metrics and reporting (FFT, Care Opinion, PALS & Complaints, Healthwatch data, compliments all of which are triangulated through SUPERB); National survey reports (NIPS, UEC, Maternity, NCPES, CYP). PEG - rolling programme of divisional assurance reporting. Patient Stories at Trust Board. PLACE annual inspections and internal PLACE Lite visits. Ward and department assurance visits as part of Quality Accreditation programme. Policies: Care Partners, Visiting, Care of the Dying Patient, Patient Information, Complaints & PALs. Overarching thematic action plan developed drawing cross cutting themes from across all national surveys.

2023 – 2024 patient feedback; what our patients have told us (Data sources as stated; collated via SUPERB dashboard)

- 94,242 people shared feedback with us:
    - 75,367 people left a rating on Friends and Family test.
    - 765 stories were told on Care Opinion
    - 5,058 people raised a complaint or PALs concern
    - 13,052 compliments were received

S.U.P.E.R.B - Single Unified Patient Experience Reporting Board						
Friends and Family Test			Care Opinion	Counting Compliments	PALS Concerns & Complaints Issues	
Positive %	Negative %	Eligible Responses	Total count of our patients' stories published	Total count of all recorded compliments received	Complaints Issues	PALS Concerns
87%	7%	488915	765	13052	1036	4022
69574	5793					

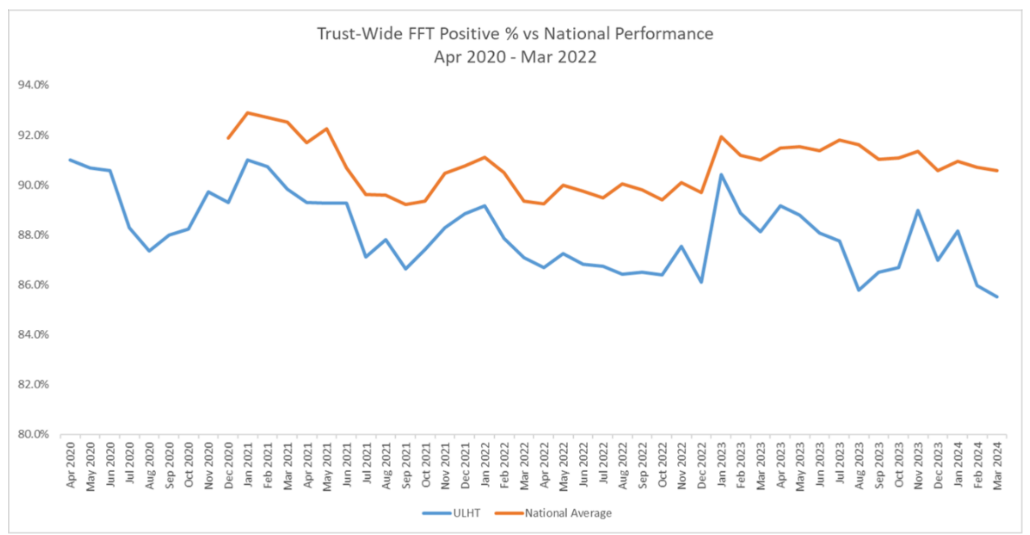
1. Friends & Family Test (FFT)

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

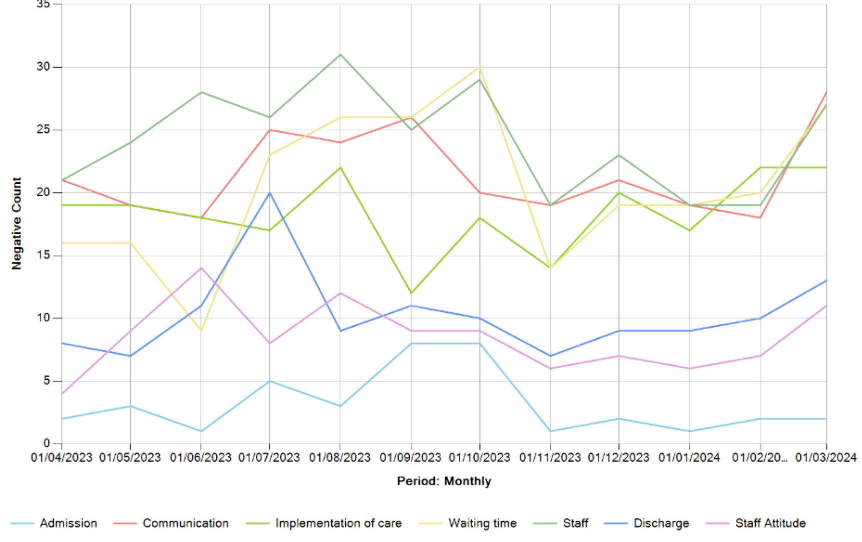
01.04.23 – 31.03.24

- 75,367 responses were received
- 69,574 were positive, equating to 87%
- 5,793 were negative, 7%.

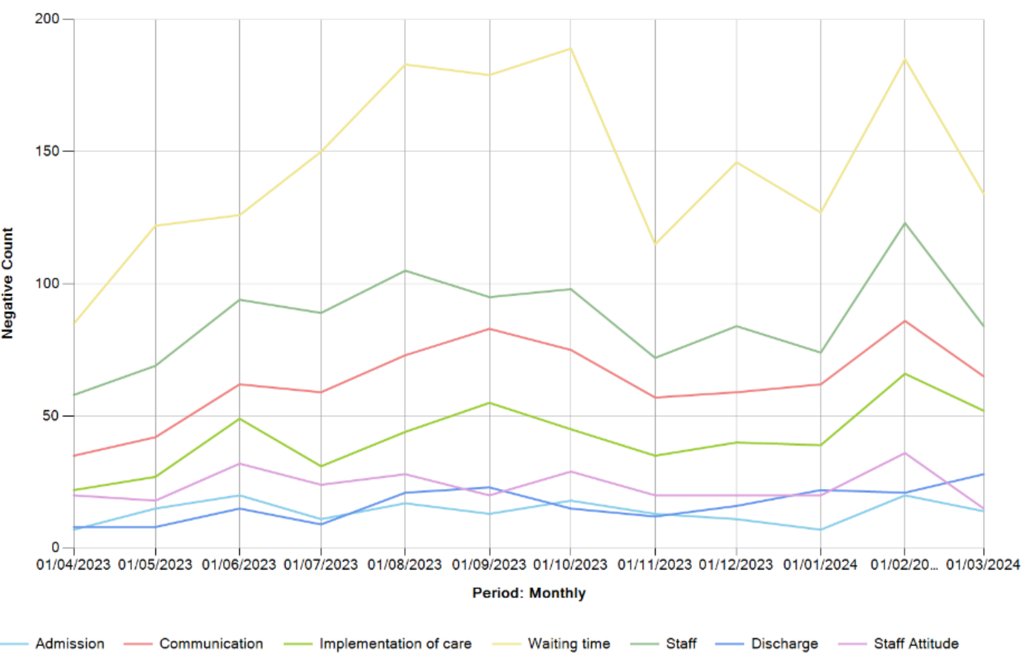
This is almost exactly the same percentage rating as 2022 – 2023 which was 87.4% and 7.1%.



National reporting was paused (due to Covid) until December 2022 though we still gathered data and reported on it internally. Once reporting resumed our performance historically stayed fairly consistent tracking below the National average. However, across the past 12 months is appears that there is more variance between our performance and the picture seen nationally. It is hoped that through improvement projects within our Patient & Carer Experience Plan alongside the benefits of group working across Lincolnshire Community Health Services that this gap will narrow. The prevalent themes for the inpatient stream in terms of negative scores are communication and admission (from the comments this refers to delays and cancellations) and staff attitude.

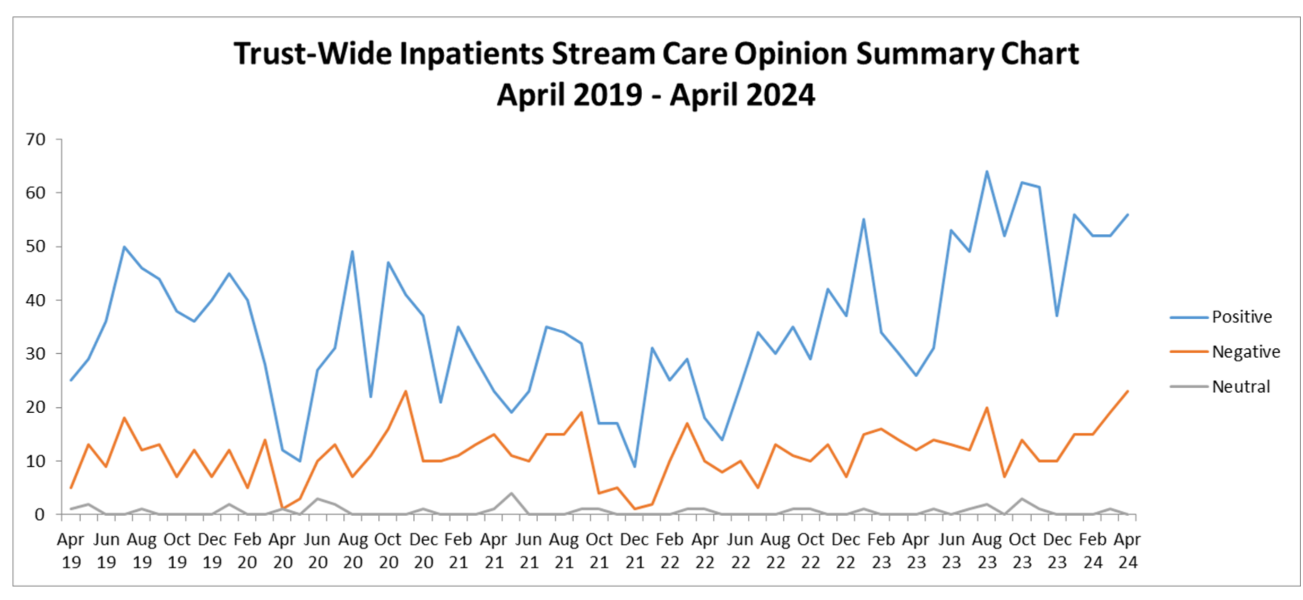


For the A&E stream waiting times is unsurprisingly at the top reflecting the pressures within our emergency departments.



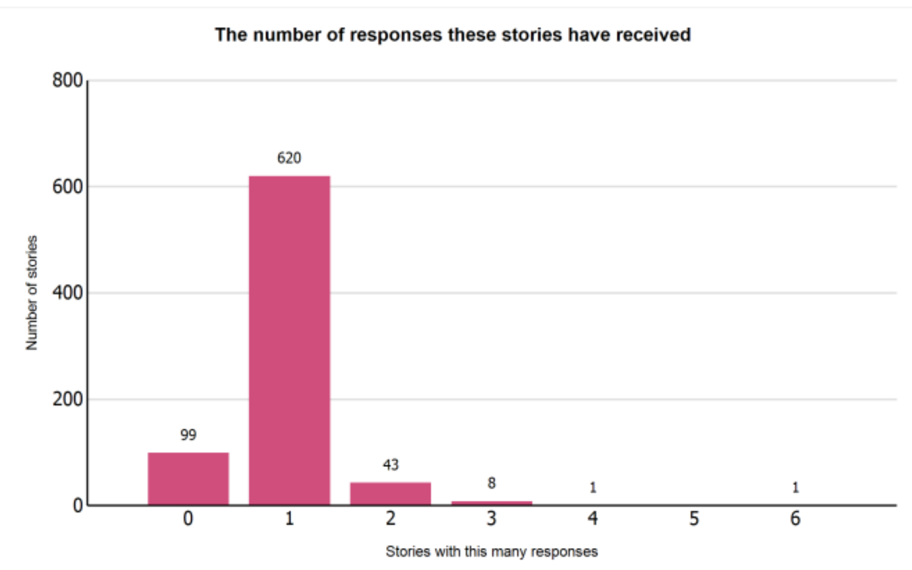
2. Care Opinion

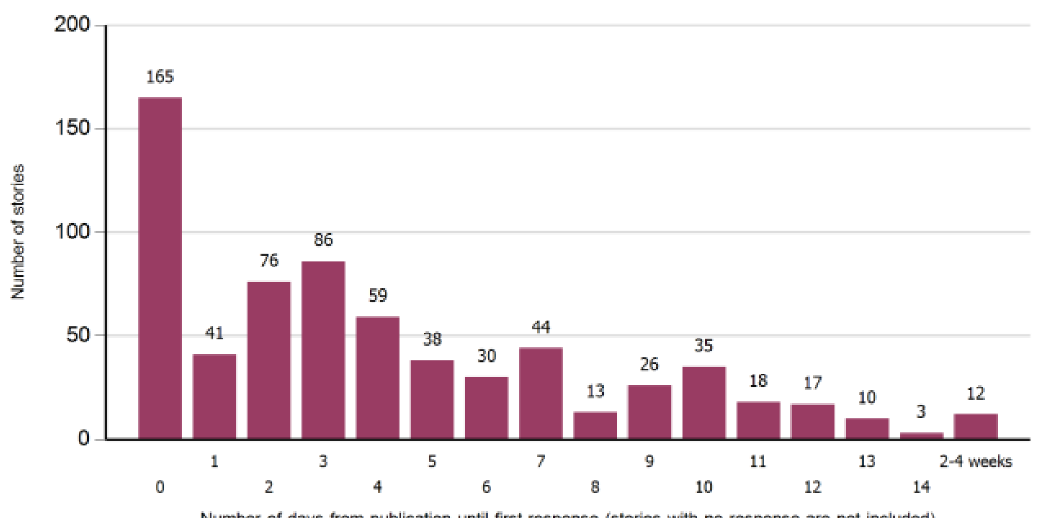
Care Opinion is a non-profit organisation that shares people's experiences of health and care services online and enables us to engage with the storyteller and respond to their experience. The platform provides analytics and reports that are hugely valued and considered as one of our most powerful data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



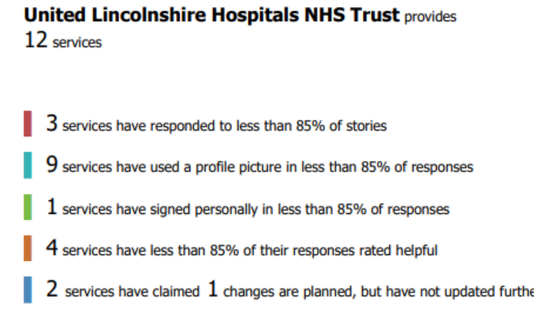
Throughout the past 12 months there's been an upward trend in the numbers of stories received, and specifically the Positive ones. As per previous years, a lot of Positive stories from the Gynae services and teams, but also an increasing number regarding Endoscopy. A&E seems to attract more a mix between Positive and Negative.

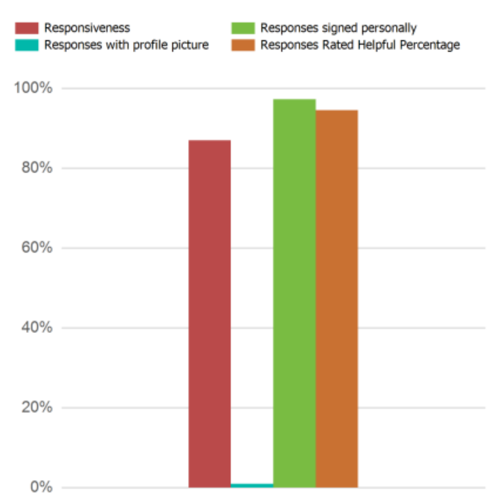
Responsiveness is really important; it shows patients we are listening.





The quality of responses is also a key factor; when patients receive a personalised response it shows an openness that is appreciated.

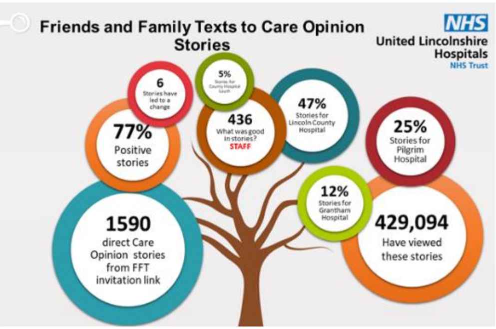




Sharon Kidd, Patient Experience Manager has contributed to Care Opinion through blogs during the year and presented at their annual conference:

[Creative use of the Invitation Links | Care Opinion](#)
[ULHT using Care Opinion webinar - follow up | Care Opinion](#)

Hello my name is Sharon, a Patient Experience Manager at United Lincolnshire Hospitals NHS Trust. We place great importance on capturing and sharing patient feedback, and we are continuously seeking ways to improve our services. That's why we have implemented Care Opinion across all our services, enabling us to gather feedback from patients who may not have had the opportunity to provide it before. Our journey with Care Opinion started way back in 2012 and so far we have received over 6,300 stories with 2.19 million people reading them and a response rate back to the storytellers at 80%.



Positive stories are great to read, and staff appreciate the feedback; we know it brings pride and motivation to their work. The following are examples:

I am truly grateful for all the hard work

1091944

Chris532 *the patient* 17/07/2023

59 views

The AMSS ward was amazing and a credit to the hospital. The staff there were, helpful reassuring and friendly. They really looked after me. The wards and toilets were meticulously clean and well looked after. I am truly grateful for all the hard work that every person took to look after me during my stay from the porters and admin staff to the nurses and doctors.

Would recommend? (Friends and family test): Extremely likely

Lisa Codd *Ward Manager* ULHT 31/07/2023

Dear Chris532

I really appreciate you taking the time to send such positive feedback.

Thank you.

Lisa

If ever angels exist in people then Mary is one!

1149023

Grajm43 *a service user* 19/12/2023

200 views

Due to a reason which was out of anyone's control, my scheduled operation did not take place and has been postponed to a later date.

I wanted to comment on the outstanding care, support and advice I received from both the anaesthetist and surgeon at Grantham hospital. Furthermore the second to none care from the nurse Mary who took the time out of her busy schedule to discuss my concerns with me and went above and beyond to reassure me. If ever angels exist in people then Mary is one!

Thank you.

Julie Record *Matron* United Lincolnshire Hospitals NHS Trust 19/12/2023

Dear Grajm43

Thank you so much for your lovely comments and I will ensure all the staff read this especially Mary

I am so pleased you had such a positive experience and I hope you are recovering well

I will share with the surgeons as well

Please take care

Kr

Julie

My tonsillectomy aftercare

1155862

EncryptedJay *the patient* 15/01/2024

56 views

After my surgery, general anaesthesia definitely made me feel groggy and tired. My discharge nurse, Jayan, was very helpful and extremely kind. We got to some conversation about our studies, previous or current. He showed me everything I needed to know clearly, and surely was the most-loved nurse on the Surgical admissions lounge.

Colette King *Sister, Surgical Admissions Lounge, LCH* ULHT 23/01/2024

Hi Encrypted Jay

Many thanks for taking the time to leave this positive feedback about the care you received following your tonsillectomy.

Jayan has been with us for a little over a year so to read your comments will be very encouraging for him. I will show him your feedback and also this recognises this is the care we aspire to for every patient that we see.

Kind Regards

Colette King

Sister - SAL

Lincoln County Hospital

Negative stories are harder to read but it is important that we show have listened and taken the patients feedback seriously; a personalised, compassionate, open and transparent response helps to do this.

Trying to get my shoulder fixed

1159558

Rockchic the patient 23/01/2024

59 views

The Dr and staff were very nice, concerned for me, trying to help me, thank you so much, but the system is failing me. I have a shoulder impingement trapping blood flow to my head when I use arm. Dr said we will get you in by end of 2023 for surgery to fix it. They didn't . I am still waiting. You'd have thought if something was trapping blood flow to your brain they would get you in quick. When I went back last week the dr said he couldn't understand why they haven't got me in yet. So it doesn't seem to be in his control who gets in and when.

When I ring the waiting list team they tell me the dr selects 6 people at a time to operate on and then does those, then after a few weeks selects another 6. I am 12th on waiting list. Still waiting. It is not good enough. My life is a misery of pain and being unable to use that arm without horrendous symptoms.

Sharon Kidd *Patient Experience Manager* United Lincolnshire Hospitals NHS Trust 24/01/2024

Dear Rockchic

Thank you for taking the time to share your story. Please accept our sincere apologies for what is clearly a very difficult and distressing time for you while awaiting for your surgery.

Clearly we are not able to resolve your appointment for an operation via Care Opinion and if you are able to take the time to send your details to our PALS department, they will be able to liaise with the orthopaedic team directly to sort out a confirmed date for your surgery to take place.

You can contact our PALS team via pals@ulh.nhs.uk or 01522 707071. If you could please quote CO1159558, the team will be able to read your story.

Regards

Sharon, Patient Experience Team

Rockchic

Thank you very much, I will ring them today and see if they can help. Much appreciated.

My stay in hospital

1117

Persephone027 the patient 21/09/2023

96 \

I was admitted to Lincoln hospital with vomiting for the last 24 hours and severe abdominal pain. I had my bloods taken and it showed an infection and bad dehydration. I was then told I would be admitted under the surgical team. I waited in A&E for 13 hours, sometimes sat on the floor while vomiting continuously.

I felt quite dismissed by some nurses on the surgical wards I was on; I complained of pain when they were giving me my IV antibiotics; it was making my arm really painful and I believed my cannula was no longer in my vein. The nurse told me that it was all psychological.

I was asking for meds to help with the sickness and asked if I could have them IV, but they said the doctor have prescribed it orally. I was throwing my tablet up and then couldn't have any more medication.

Some staff were amazing but some were awful, one nurse was really rude to me and when you feel ill and vulnerable it is more upsetting.

Rebecca Stanham *Lead Nurse General Surgery, Vascular, Head and Neck* United Lincolnshire Hospitals NHS Trust 21/09/2023

Dear Persephone027

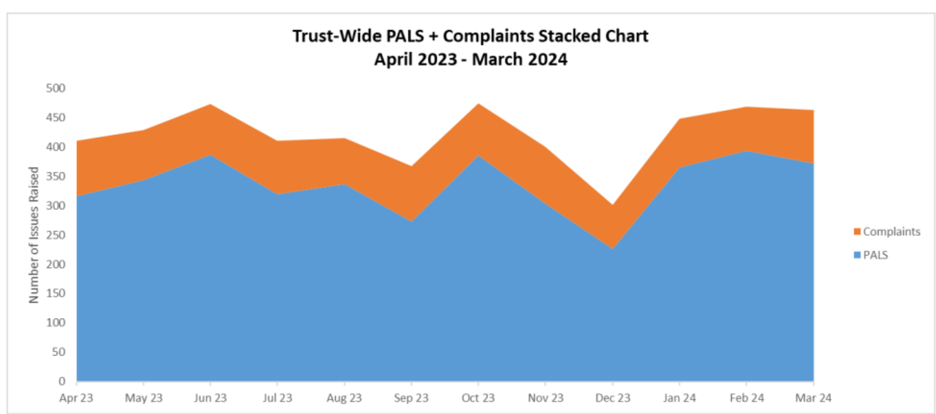
I am sorry to read about your experience and I would like to discuss your experience with you. Please can you email me on Rebecca.stanham@ulh.nhs.uk so we can arrange a telephone conversation or meeting.

Thanks

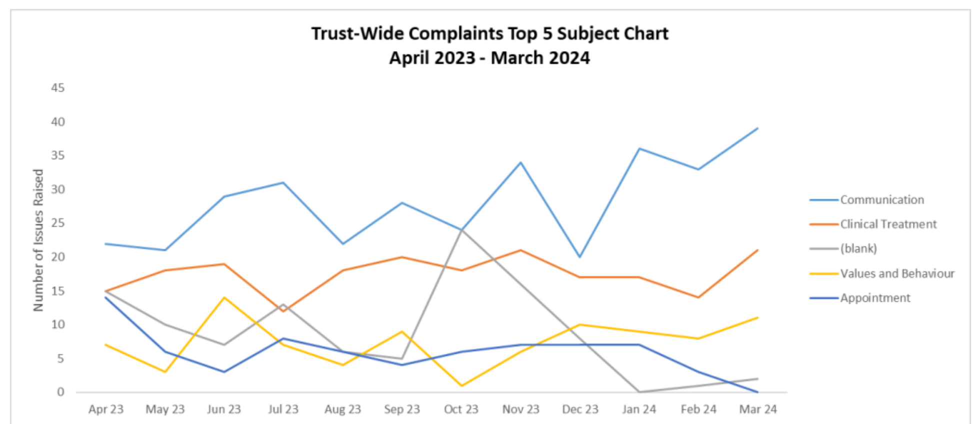
Rebecca

3. Complaints & PALS

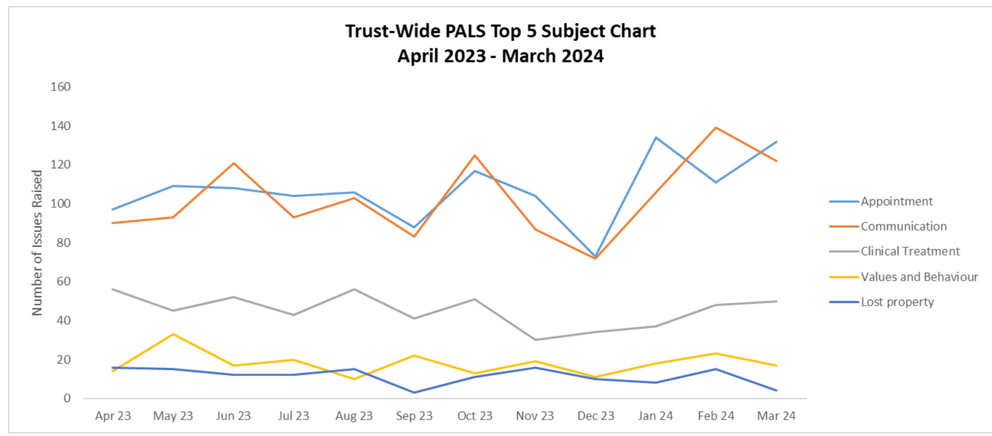
During 2023-2024 the Trust received 1044 Complaints and 4328 PALS enquiries,



The top two themes within complaints were communication and clinical treatment

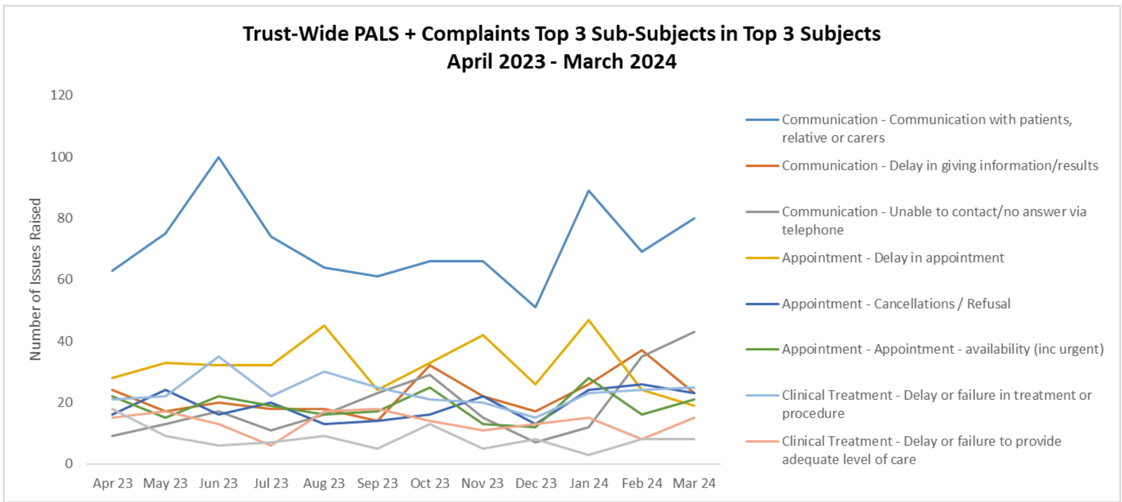


and within PALS were appointments and communication.



53% of Complaints received pertained to Communication (30% in total) and Clinical Treatment (20% in total). It is notable that 'Appointment' only features as the 5th

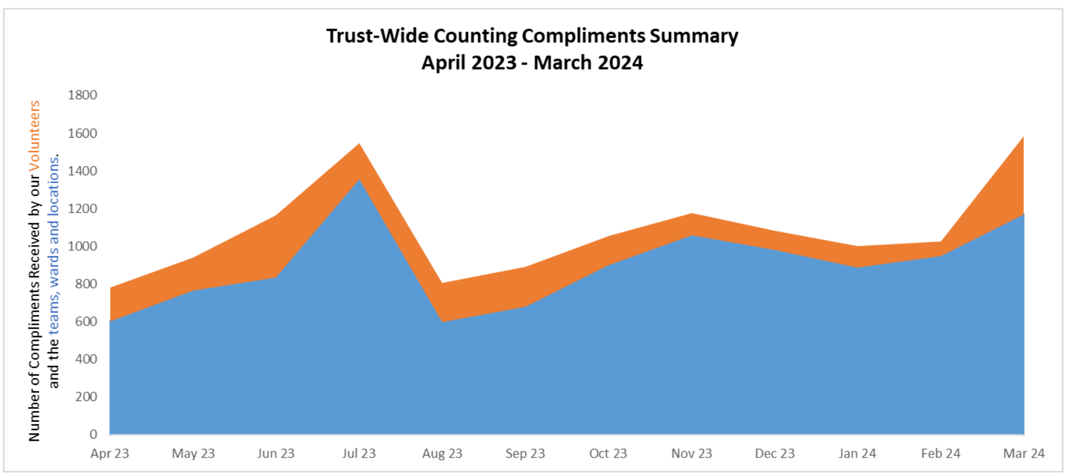
most prevalent high-level theme (7% of total), in stark contrast to the picture seen within PALS which is indicative of the PALS team resolving many of these concerns prior to them reaching the stage of a complaint?



We can see that there are peaks in December and January which can be associated with winter pressures, extremely busy hospitals coupled with industrial action before Christmas and in the first weeks of January 2024.

4. Compliments

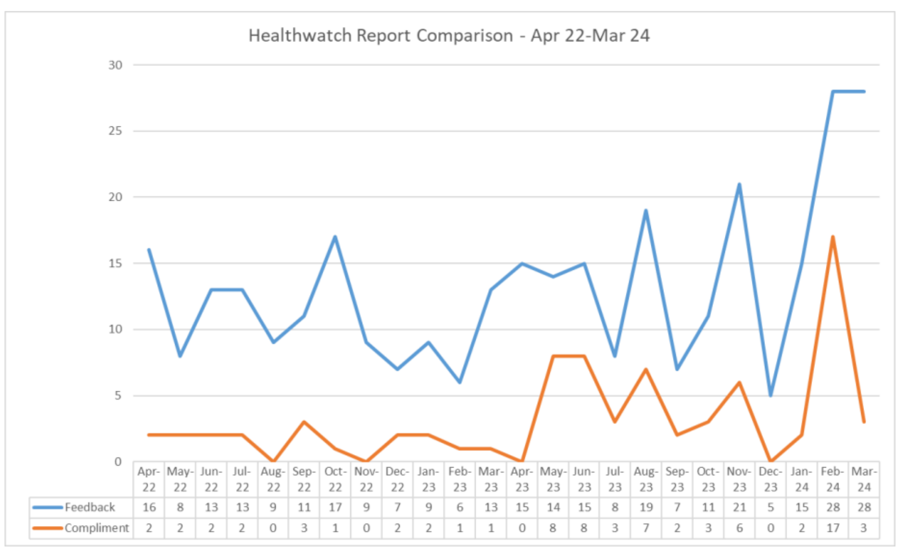
There has still not been a real recovery when it comes to the counting, collating and submitting of compliments data following on from the impacts of the pandemic. There is anecdotal evidence that the compliments are still being received, but that the issue lies instead in teams finding the capacity to record, collate and submit their compliments data.



When teams submit their compliments, they can include examples, some of which are shown below:

5. Healthwatch

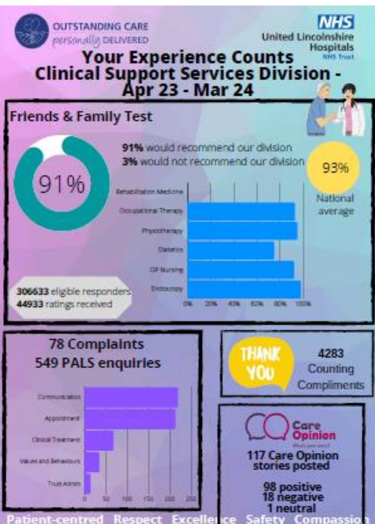
Each month our partners in Healthwatch report feedback they have received through their engagement activities. Our teams treat this feedback in the same way as any feedback received and provide a response to Healthwatch. The chart below shows that overall the numbers of reports received by Healthwatch has increased steadily during the year. Completed reports are shared at PEG.



	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Feedback	16	8	13	13	9	11	17	9	7	9	6	13	15	14	15	8	19	7	11	21	5	15	28	28
Compliment	2	2	2	2	0	3	1	0	2	2	1	1	0	8	8	3	7	2	3	6	0	2	17	3

6. Patient Experience Infographics

Each month the Patient Experience Team prepare a suite of infographics at Trust and divisonal level which are shared through PEG and to the divisions.



Data Insight Manager Award

Between May 2022 and December 2023, Martyn Staddon, Patient Experience Insight Manager undertook a Level 4 Data Analyst Apprenticeship course arranged through the ULHT Talent Academy and provided by Cambridge Spark. The course ran alongside his day to day duties and help to cement his knowledge in some areas and fill in some other gaps, whilst also bringing wider benefits to our team and to the Trust. These ranged from different approaches to undertaking Data Analysis overall, as well as specific tools, methods and concepts to explore and

make better use of with regards to making best use of our Patient Experience data to bring about improvements. One aspect that the course offered was access to a ‘Knowledge Base’, where course-specific and more general questions around Data Analysis could be asked and answered by representatives from Cambridge Spark themselves, or by other members of the course cohort. This tool allowed for easy sharing of concepts back and forth and collaboration with others to help everyone to succeed in their course goals.

In March 2024, Martyn attended an End of Course Celebration dinner, held at St. John’s College, Cambridge. At this event he not only received a certificate to commemorate his successful completion of the course, but additionally was awarded the ‘Knowledge Base Contributor of the Year 2024’ award. This was in recognition for his engagement with the Knowledge Base platform throughout his course, both in terms of asking his own questions and appreciating the efforts of others in resolving them and also in terms of them applying his own knowledge and views to help others resolve their queries. This award not only served to raise Martyn’s own profile, but additionally reflected well on our Patient Experience team and the Trust as a whole.

Congratulations Martyn!

Patient Stories

A patient story is a powerful tool that provides a glimpse into a patient's healthcare journey, in their own words. It is a conversation that captures the essence of their experience and helps us identify areas where we need to improve the quality of our services. These stories can be positive, negative, or a combination of both, and they help us capture evidence of the quality of services we provide. By sharing patient stories, we can learn from what was good and what needs improvement, and the clinical teams involved can take forward any necessary changes.

Unlike surveys, patient stories are collected face-to-face, providing an opportunity to ask for more information or clarity where needed. These stories capture the experiences from the patient's point of view, helping us put ourselves in their shoes and focus on what matters most to them. Collectively, patient stories help us build a picture of what it is truly like to be a patient or carer. The Patient Experience Team creates and films these stories, which can be told by the patient or a family member, or a member of staff on their behalf. These stories are also created to highlight improvement projects and where teams have developed new ideas for the benefit of our patients. Let us use these powerful stories as an inspiration to continuously improve and provide the best possible care for our patients and their families.

The dedicated digital patient story library on the intranet page continues to grow and act as a resource for staff to use stories within training sessions and divisional meetings.

A digital patient story always features as the first agenda item at the Trusts Board meetings. Divisional patient experience group meetings and many other forums always commence with a written or verbal patient story and Patient Experience assurance reports presented to the Patient Experience Group also contain a written patient story. Currently there are 30 stories published and stories this year include:

Neonatal Services
April 2023

https://youtu.be/NMXvmjFac-w

Lincolnshire Heart Centre – going the 'extra mile'
May 2023

https://youtu.be/qzDpKTe2ouI

Caitlin's Story - Welcoming Clara, an Autism Assistance Dog in MEAU
June 2023

https://youtu.be/NZBwaxOg8sw

Fran's experience in A & E - 36 hours and counting:
July 2023

https://youtu.be/RuISdsz3O7U

Discharge Lounge, Pilgrim - Our journey of improvement to ensure patient centred care at discharge
September 2023

Oonagh's Mum's story - From Pilgrim ED to the Butterfly Hospice
October 2023

https://youtu.be/Ysr5VpjfU9s

Stuart & Pip - Our stay on AMSS
November 2023

https://youtu.be/78gx26UQZPA

Pauline & Ernie's Story - Endoscopy
January 2024

https://youtu.be/veB06Hwaw3k

Young Carers
March 2024

https://youtu.be/0LEHw1LaNN8

National Survey Programme

The CQC is responsible for overseeing the national survey programme, which serves as a valuable tool in gauging public opinion on the NHS healthcare services. By soliciting feedback from individuals who have used these services, the programme provides valuable insights into the strengths and weaknesses of the NHS, allowing for more informed assessments of its performance. In addition to its role in assessing performance, the CQC also utilizes survey results in regulatory activities such as registration, ongoing compliance monitoring, and reviews. By leveraging these insights, the CQC is able to ensure that healthcare providers are meeting the highest standards of care and delivering quality services to patients. Overall, the national survey programme plays a critical role in supporting the mission

of the NHS, and the CQC's management of this programme is a testament to their commitment to excellence in healthcare.

Urgent and emergency care survey 2022 - Published: July 2023

This survey collected information on the experiences of people who received care from urgent and emergency care services. Nationally the CQC found that:

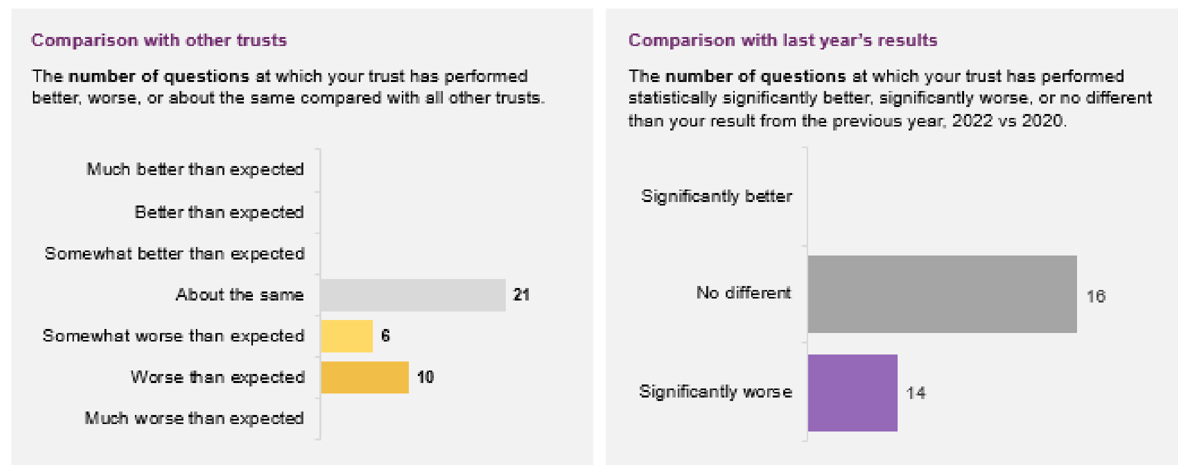
- People's experience of urgent and emergency care are worse than in previous years, particularly for Type 1 services
- Some aspects of care in Type 3 services remained positive, such as being listened to by health professionals
- Waiting times, staff availability, privacy and pain management have seen significant declines compared to previous years
- Information provided before leaving A&E or the urgent treatment centre remains an area for improvement

Where patient experience is best

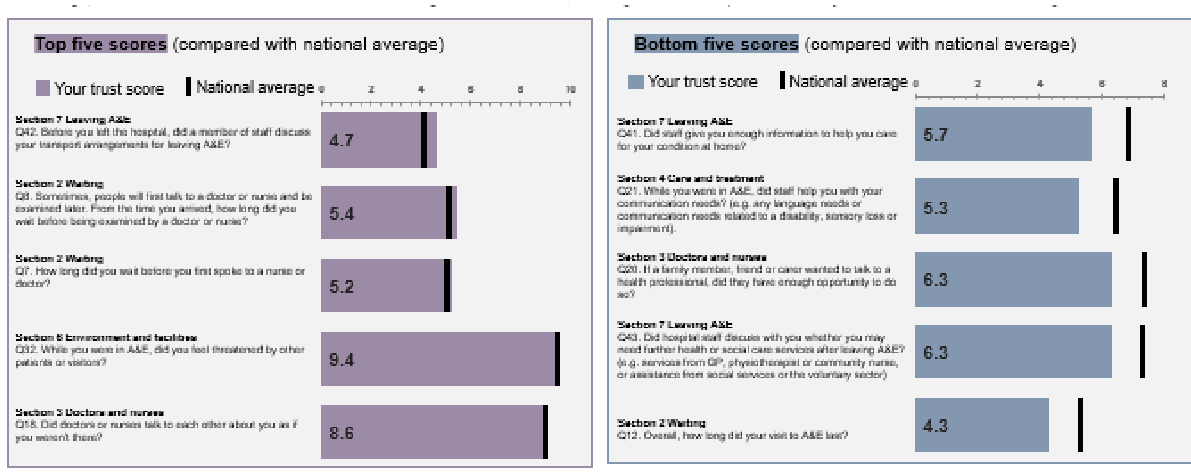
- Transport when leaving A&E: Staff discussing patients' transport arrangements before they leave A&E
- Waiting: Length of wait before patients are examined by a doctor or nurse
- Waiting: Length of waiting before patients first speak to a nurse or doctor
- Safety: Patient perception of feeling threatened by other patients or visitors
- Communication: Doctors or nurses talking to each other as if patients aren't there

Where patient experience could improve

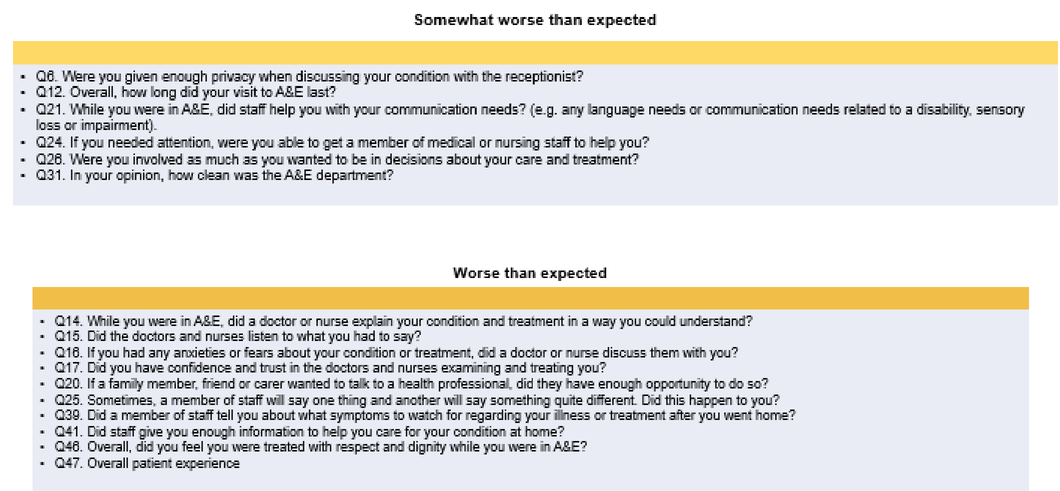
- Information: Staff giving patients enough information to help them care for their condition at home
- Communication needs: Staff helping patients with any communication needs they have
- Family involvement: Family members, friends or carers having enough opportunity to talk to health professionals
- Further care: Staff discussing with patients whether they need health or social care services after leaving A&E
- Length of visit: Length of patients' A&E visit



Best and worst performance relative to the national Trust average. These five questions are calculated by comparing our Trust results to the average Trust score across England.



There were no questions where on comparison to other Trusts where we performed much better, better, somewhat better. There were a number of questions however where we were ranked as somewhat worse or worse than others.



Somewhat worse than expected

- Q6. Were you given enough privacy when discussing your condition with the receptionist?
- Q12. Overall, how long did your visit to A&E last?
- Q21. While you were in A&E, did staff help you with your communication needs? (e.g. any language needs or communication needs related to a disability, sensory loss or impairment).
- Q24. If you needed attention, were you able to get a member of medical or nursing staff to help you?
- Q26. Were you involved as much as you wanted to be in decisions about your care and treatment?
- Q31. In your opinion, how clean was the A&E department?

Worse than expected

- Q14. While you were in A&E, did a doctor or nurse explain your condition and treatment in a way you could understand?
- Q15. Did the doctors and nurses listen to what you had to say?
- Q16. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?
- Q17. Did you have confidence and trust in the doctors and nurses examining and treating you?
- Q20. If a family member, friend or carer wanted to talk to a health professional, did they have enough opportunity to do so?
- Q25. Sometimes, a member of staff will say one thing and another will say something quite different. Did this happen to you?
- Q39. Did a member of staff tell you about what symptoms to watch for regarding your illness or treatment after you went home?
- Q41. Did staff give you enough information to help you care for your condition at home?
- Q46. Overall, did you feel you were treated with respect and dignity while you were in A&E?
- Q47. Overall patient experience

Adult inpatient survey 2022 - Published: September 2023

This survey looked at the experiences of people who stayed at least one night in hospital as an inpatient. Nationally the CQC found that:

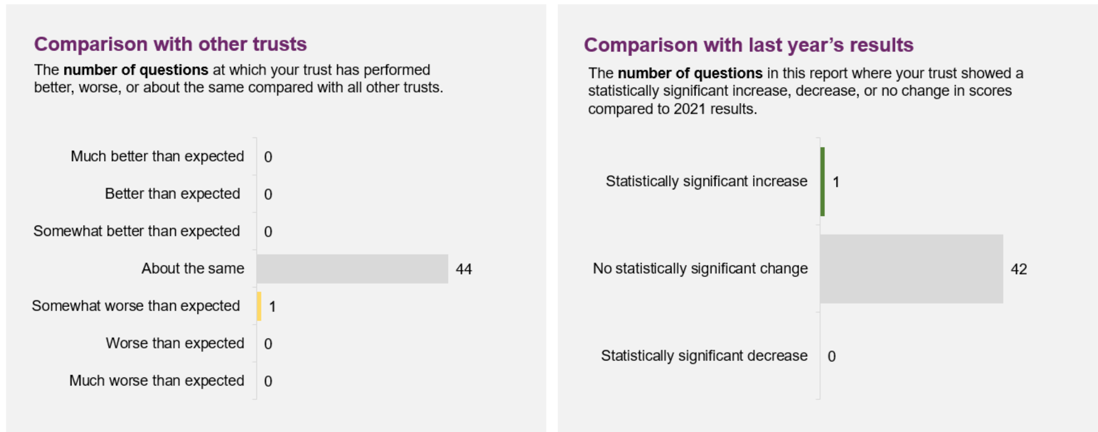
- The majority of patients felt they were treated with dignity and respect, and reported positive interactions with doctors and nurses
- Many patients felt their individual needs were met, which is generally consistent with last year although still lower than in 2020
- Waiting times and staffing levels have seen declines compared to previous years
- Four in 10 elective patients said their health deteriorated while waiting to be admitted to hospital, while a further half said their health remained the same

Where patient experience is best

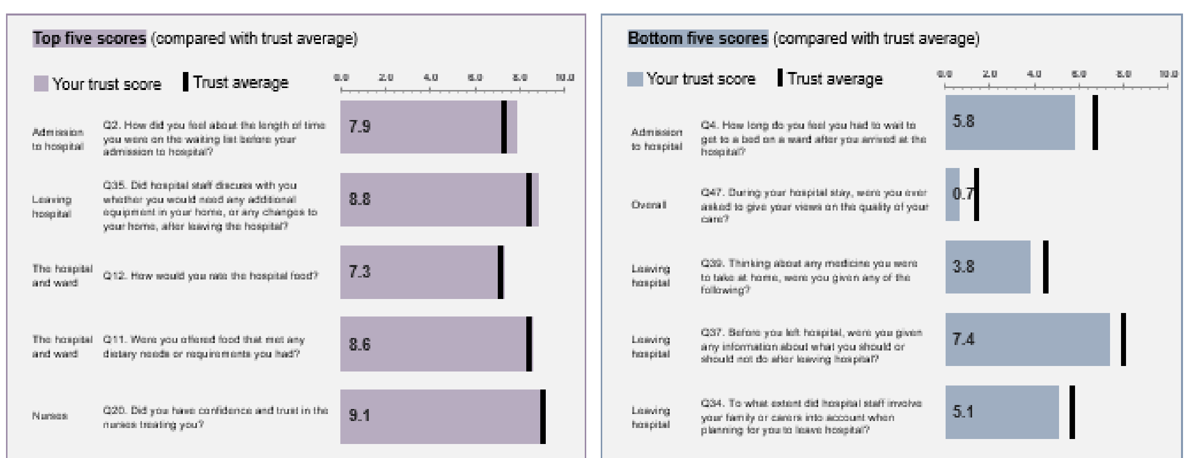
- Waiting to be admitted: patients feeling that they waited the right amount of time on the waiting list before being admitted to hospital
- Equipment and adaptations in the home: hospital staff discussing if any equipment or home adaptations were needed when leaving hospital
- Quality of food: patients describing the hospital food as good
  Dietary needs or requirements: patients being offered food that met any dietary needs or requirements they had
- Confidence and trust: patients having confidence and trust in the nurses treating them

Where patient experience could improve

- Waiting to get to a bed: patients feeling that they waited the right amount of time to get to a bed on a ward after they arrived at the hospital
- Feedback on care: patients being asked to give their views on the quality of their care
- Information about medicines to take at home: patients being given information about medicines they were to take at home
- Information on discharge: patients being given information about what they should or should not do after leaving hospital
- Home and family situation: staff considering the patients family situation and carers when planning for them to leave hospital, if needed



Best and worst performance relative to the trust average



Across all questions ULHT were ranked ‘about the same’ as other Trusts and did not have any questions that slipped into the worse categories.

Maternity survey 2023 - Published: February 2024

This survey looked at the experiences of women and other pregnant people who had a live birth in early 2023, including ethnic minorities in January and March. Nationally the CQC found that:

- All areas of antenatal care improved from 2022.
- Mental health support has shown improvement during antenatal and postnatal care.
- Availability of staff has worsened in during labour and birth, in hospital after birth and during postnatal care.
- Those who had poor continuity of care, report worse experiences during antenatal care, labour and birth and postnatal care.

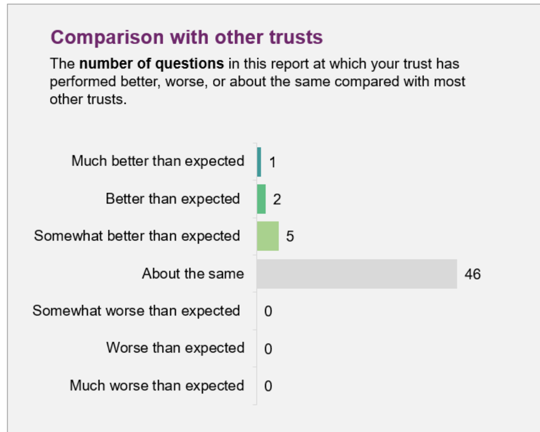
Summary findings for United Lincolnshire Hospitals NHS Trust

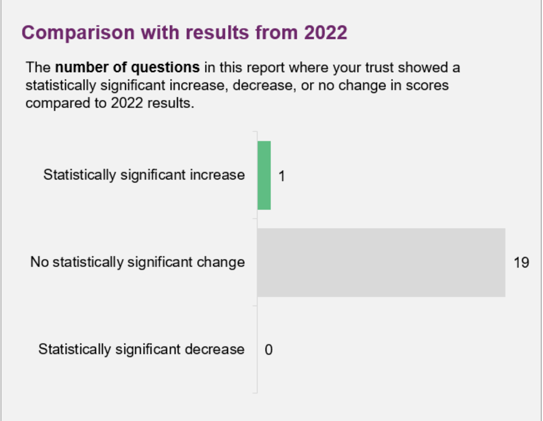
Where maternity service users' experience is best at the trust

- Midwives providing service users with relevant information, during their pregnancy, about feeding their baby.
- Midwives or the doctor appearing to be aware of service users' medical history during antenatal check-ups.
- Maternity service users feeling that if they raised a concern during labour and birth it was taken seriously.
- During antenatal check-ups, maternity service users being given enough information from either a midwife or doctor to help decide where to have their baby.
- Maternity service users having the opportunity to ask questions about their labour and the birth after the baby was born.

Where maternity service users' experience could improve at the trust

- Partners or someone else involved in the service user's care being able to stay with them as much as the service user wanted during their stay in the hospital.
- Maternity service users being given appropriate information and advice on the benefits associated with an induced labour, before being induced.
- Partners or someone else close to the service user were involved in their care as much as they wanted to be during labour and birth.
- Maternity service users being given appropriate information and advice on the risks associated with an induced labour, before being induced.
- Midwives or doctors appearing to be aware of the medical history of the service user during labour and birth.





Best and worst performance relative to the trust average

Comparison to other trusts

Somewhat worse than expected	Somewhat better than expected
• Your trust has not performed "somewhat worse than expected" for any questions.	• B7. During your antenatal check-ups, did your midwives or doctor appear to be aware of your medical history? • B16. Did you have confidence and trust in the staff caring for you during your antenatal care? • C13. If you raised a concern during labour and birth, did you feel that it was taken seriously? • C19. After your baby was born, did you have the opportunity to ask questions about your labour and the birth? • F1. Thinking about your postnatal care, were you involved in decisions about your care?

Better than expected	Much better than expected
• B15. During your pregnancy did midwives provide relevant information about feeding your baby? • C15. Thinking about your care during labour and birth, were you spoken to in a way you could understand?	• F11. Did a midwife or health visitor ask you about your mental health?

Overarching, thematic national survey action plan

The overarching national patient survey action plan has brought together actions required on questions where the Trust is poorly performing across more than one survey. The action plan brings together all of the patient surveys:

- National Inpatient Survey (NIPS)
- Maternity Survey
- National Cancer Patient Experience Survey (NCPES)
- Children & Young People (CYP)
- Urgent & Emergency Care (UEC)

The action plan whilst overseen and led by the Patient Experience Team is driven locally by the Divisions and is regularly updated at each of the newly established Divisional Patient Experience Groups. Its primary function is to consolidate the survey questions that the organization has identified into a single plan in order to eliminate the need for multiple individual action plans and duplicate actions. Additionally, it serves as an assurance mechanism for the Patient Experience Group, providing them with a structured approach to monitor and evaluate the organisation's progress in enhancing patient experience. This action plan reflects the organisation's commitment to continuously improve the quality of care and services provided to our patients.

Equality Delivery System (EDS) – Domain 1

The main purpose of the EDS is to help local NHS systems and organisations, in discussion with local partners and local populations, review and improve their performance for people with characteristics protected by the Equality Act 2010. It is a mandatory requirement for the Trust to complete EDS each year, under the NHS standard contract. Domain 1 focuses on engagement with patients and public and there are 4 outcomes to assess.

Domain	Outcome
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service
	1B: Individual patients (service users) health needs are met
	1C: When patients (service users) use the service, they are free from harm
	1D: Patients (service users) report positive experiences of the service

As a Trust, we needed to assess ourselves, consider the evidence and a score and against the guidance we scored ourselves an 8 = underdeveloped.

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	• National surveys: ○ National Inpatient Survey ○ Urgent & Emergency Care Survey ○ National Cancer Patient Experience Survey ○ Maternity Survey ○ Children & Young People's national survey. • National Survey Thematic Overarching Action Plan. • Patient Information Task & Finish Group action plan. • Patient Information Policy and library • Patient Panel and Expert Reference Groups agendas and minutes • Patient Experience Groups; corporate and divisional. • Patient Experience Annual Report • Patient and Carer Experience Plan • Interpreting & Translation Policy • Trust website & 'ReciteMe' • Trust social media. • SUPERB monthly reports • Patient Experience infographics	2	Patient Experience
		• Business Unit / divisional governance meetings • Patient stories / library. • Complaints and PALs • Mixed Sex Accommodation Policy and monthly validation reports. • Care Partners Policy and shared care agreement. • Visiting Policy & Charter • National Dementia Audit • NHSI-Learning Disability benchmarking submission • National Audit programme • Stroke PREMs audit 2022/23		
	1B: Individual patients (service users) health needs are met	• Cancer services holistic needs assessment • Cancer services support group • Cancer Patients Expert Reference Group. • Lincolnshire Cancer Board & Strategy. • Mental Health, neuro-disability and Dementia Steering Group agendas and minutes. • Safeguarding vulnerable adults and children statement of intent and associated policies. • United Against Discrimination group agendas and minutes. • EDI reports to Patient Experience Group. • Patient Nursing Assessment booklets	2	Patient Experience
		• Clinical Nurse Specialist meeting agendas and minutes. • Veteran Aware • Voluntary Services plan and Volunteer Policy		
	1C: When patients (service users) use the service, they are free from harm	• Complaints and PALs Policy • Patient safety policies e.g. medications, IPC, tissue viability, falls • Security Management Policy • Fire Safety Policy & procedures • Health and Safety Policy • Ward Accreditation, ward assurance and matrons audits. • 15 steps, PLACE, PLACE Lite audits • Cleaning audits • Missing Adults Patient Policy • Number of Incidents and Level of severity of Harm • Patient Moving and Handling Policy • Risk Management Policy • Risk Management Strategy • Safeguarding Policies • Patient Safety Partners • Mixed Sex Accommodation Policy • Adjustment to Professional Practice Group • Nursing, Midwifery & Allied Health Professional forum	2	Patient Experience and Patient Safety

We also identified three services to examine in more detail to assess and demonstrate achievement against or working towards these outcomes.

Three clinical areas undertook the assessment; each using a patient experience to illustrate achievement against the standards.

Hospice in Hospital, Grantham Hospital

Please explain how you engaged with your patients and services users, their carers and representatives? Was this different to previous engagement?	Patient referred to the Hospice in the Hospital at Grantham and District Hospital for End-of-Life Care and a place of safety. Referral made by the Community Hospice at Home team in Lincoln which is approximately 30 Miles from the Hospice in the Hospital base at Grantham. The referral was different from previous engagement as previously patients in the Lincoln area would be consider for the Hospice based in Lincoln to enable the patients to be nearer to their home address, relatives, and friends. The Hospice in the Hospital provides services for any patients with Palliative and End of Life Care needs across Lincolnshire, which is the UK's second largest County, the reason why this referral was different from previous engagement was the distance from the Patients normal residence. It is normal and usual to provide Palliative and End of Life Care to patients nearer to their hometown, as most patients want to be nearer to their loved ones and want to be in a familiar place to them. Due to no bed availability in Lincoln and the Safeguarding issues it was appropriate for the admission to come to the Hospice in the Hospital in Grantham for a place of safety and assessment of palliative and end of life symptoms.

Shuttleworth Ward, Lincoln County Hospital

Please explain how you engaged with your patients and services users, their carers and representatives?

Was this different to previous engagement?

In November 2023 the Trauma and Orthopaedics Division opened a Trauma assessment Unit (TAU) at Lincoln County Hospital located within Shuttleworth Ward (SW). The assessment unit cares for muscular skeletal (MSK) trauma orthopaedic adult patients who normally would be seen and treated within the Emergency Department (ED) or UTC.
A Standard Operating Procedure (SOP) has been developed and updated to outline the procedures to be followed for the daily operation of the unit.

It defines the roles and responsibilities of the staff to support the safe and effective admission, assessment and treatment or plan for MSK trauma adult patients at the Trust.

By adhering to this SOP, United Lincolnshire Hospital Trust will benefit from the following:

- The efficient and effective management of MSK trauma orthopaedic patients
- Reduced length of stay
- Timely admission
- Improved time to admission from decision to admit
- Early medical assessment by consultants
- Improve patient experience

The TAU will consist of 5 recliner chairs for patients to be seated in and 1 trolley for examination of patients. The TAU operates Mon-Fri 8-4 pm with an experienced Orthopaedic Registered Nurse based within the unit.

AMSS, Pilgrim Hospital, Boston

Please explain how you engaged with your patients and services users, their carers and representatives?

Was this different to previous engagement?

The Acute Medical Short Stay unit (AMSS) is located at Pilgrim Hospital in Boston. Patients are admitted primarily from the Emergency Department and length of stay is usually short whilst they undergo tests and consultations to determine the best pathway through care for them.

At ULHT much work has been done over the last 2 years to create a library of digital stories that can be used to share patients and staff experiences for learning, awareness and for improvements. This case study is one such story that was crafted by Pip who is Stuart's wife regarding his stay on AMSS and was shared at Trust Board in December 2023.

What is different in our storytelling is that we use the words and feelings and experiences of our patients and staff and not us as professionals telling the story from our perspective – the story belongs to the patients.

The story describes how Stuart went to the Emergency Department in August 2023 with pin and needles in his right arm and following an admission, he was diagnosed with high grade multi focal glioblastoma on 11th September 2023 that was inoperable.

The couple have been together for 17 years and have never had the time to get married. The staff on AMSS knew how important it was for them both, so they made this happen and pulled together with the help of the chaplaincy team they organised a legal emergency wedding in two days which was attend by their family and staff.

The story also shows what happens when a ward make a call to the chaplaincy teams and the steps required to allow for an emergency wedding in a hospital setting to be undertaken

Real-time surveying

Having recognised for a long time now that a lot of our feedback is only analysed and considered after a significant gap in time, the need for a more immediate feedback channel (for both positive and negative feedback) to be opened up was identified. As a result of these thoughts the need for Real-time Surveying of our patients was identified and a system developed to begin to collect data in this way. Built on a foundation of Microsoft Forms the process allows for feedback to be received both unprompted from our patients, but also in a more controlled manner through use of our Volunteers.

At the time of this report, we have performed a live test of the Real-time Surveying method (assisted by our Volunteers) to support the 'You Care – We Care to Call' project. Through this testing some initial teething problems were identified which have since been corrected and the system for gathering data is now considered to be quite robust. With the initial trial phase having been completed the planned next steps for a phased rollout have been established. At first the plan was to roll out in small steps across discrete areas, as we recruited more Volunteers to support the initial project 'test pilots', however circumstances and other priorities within the Trust have changed these.

Currently we have rolled out an Urgent & Emergency Care survey for the Emergency Departments and Urgent Treatment Centres across the Group – with this being promoted through posters with a QR code and a call for feedback. Additionally, we have (Volunteer support pending) worked alongside the Cancer Services specialty team to create a Cancer area specific survey which has now been fully approved and will be launched as soon as Volunteer support is identified. Following the uptake of these, the next steps are to introduce an Inpatient-specific survey, establish a system for rapid turnaround of basic snapshot data analysis around this and implement it and this continued roll out is a key priority for the coming year.

You Care, We Care to Call (YCWCC)

After a pilot project commenced the second half of 2022, the YCWCC project set out to ensure we keep relatives up to date with important information without the challenges of getting through to the right person on the ward. Ward staff have become increasingly busy, and with additional external pressures, phone calls were being missed or not answered, increasingly Pals and Complaints were received from families/those that care – 134 in March 2023. YCWCC turned this around through staff proactively calling relatives either as a full call or supporting the patient to pass on more complicated information. This not only aimed to reduce phone traffic but also, most importantly, communicate more effectively with families.

Wards have adopted varying approaches appreciating that ward timetables and structures are different; some for example discuss at board rounds, others at team

handovers and huddles. The project lead has worked with each ward to help them find their best solution. The principle is to first confirm who needs an update phone call, when and how frequently, what information needs to be shared and to establish the best person to make that call. The nursing staff invariably make the calls but depending on the information needing to be shared it could just as easily be a doctor or therapist. The team then document that the call has been made so that everyone is aware and up to date on information shared providing continuity for the next update. Where a patient chooses to update the family independently, that they have done so is confirmed and also recorded in their notes. These are auditable by the ward manager or Matron.

The Integrated Improvement Plan (IIP) progress target

The initiative was to roll out YCWCC to 38 wards across the trust and was identified as a project within the 2023-2024 IIP. With a starting point of 5 wards engaged during the project trial phase this called for 3 new wards each month. There were a number of status positions identified: joined, scheduled, discussing, revisiting, on hold and not needed, where there was clear evidence that systems in place were already working well with keeping relatives informed. The graphic shows a sample of the milestone plan to keep track on progress.

Trajectory	8	11	14	17	20	23	26	29	29	32	35	38
Reportable Total	5	9	11	14	22	25	29	32	32	37	37	45
Joined	5	4	2	3	2	2	4	3	0	3	0	4
Scheduled	4	0	1	0	4	0	0	0	1	1	0	0
Discussing	4	3	4	2	5	1	1	0	0	0	1	0
Revisiting	0	0	1	0	0	1	1	0	0	1	0	0
Not needed	0	0	0	0	6	1	0	0	0	2	0	4
On Hold	0	0	0	0	0	2	1	0	0	0	0	0
No Engagement Yet (Permanent Wards only)	36	31	26	22	9	5	4	3	3	0	1	1

			Milestone plan											
Ward Name	Site	Beds	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Hospice	Grantham													
Belton (Harrowby)	Grantham	22												
EAU	Grantham	28												
Surgical Unit	Grantham													
Ashby Ward	Lincoln	18												
Branston	Lincoln	14												
Burton	Lincoln	20												

The outcome targets were to roll out across the 38 wards and to achieve a 50% reduction in complaints relating to difficulty in getting through to the ward, the phone not being answered or a relative not being kept informed, which, had YCWCC been in place, that complaint could have been avoided – therefore an ‘avoidable complaint’

Type	Description	Data source	Data lead	Measure frequency	Baseline (Mar-23)	Target		Monthly performance											
								2023									2024		
								Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Progress	Number of wards adopting YCWCC	YCWCC project lead	Patient Experience Manager	Monthly	5	+ 3 per month 38 total	Target	8	11	14	17	20	23	26	29	29	32	35	38
							Actual	5	9	11	14	22	26	29	32	32	37	37	45
Outcome	Number of complaints & concerns relating to communication	PALs & complaints	Patient Experience Data Insight Manager	Monthly	various			23	19	31	35	21	23	29	23	13	33	41	30
Outcome	Avoidable* complaints	PALs & complaints	Patient Experience Data Insight Manager	Monthly	134 per year	0		3	6	13	8	2	1	5	3	1	4	5	2

Both targets were not only achieved but exceeded, with 45 wards on board by the end of March 2024 and a 61% reduction in avoidable complaints.

Ongoing monitoring will continue, reviewing communication complaints, identifying those that were avoidable and linking up with the ward and responsible matron.

The project has now been subsumed into the Communication Improvement Group and will, going forward, report on a quarterly basis through this group to PEG.

A number of incidental initiatives were also identified during the project and work continues to explore and embed these; these include:

- Introduction of call queuing on ward phones.
- Widening staff engagement to other professional groups, particularly engagement by all levels of the medical teams from consultant downwards.
- Supporting staff, particularly newly qualified and internationally educated staff to have confidence in making calls.
- A communications campaign encouraging families to identify a single contact to minimise the number of calls for each patient.
- Exploring the call traffic data to better understand demand and responsiveness.
- A separate project is in progress to improve significant issues with answering calls in OPD/secretaries.

- Piloting the use of hands-free headsets for the ward-clerks – 4 wards identified.

- A planned campaign to create a culture that values responsiveness to a ringing telephone. Considering something such as a 'no pass zone' responding to a ringing phone whether they are nurses, doctors, managers, chaplains or therapists. Answering a phone is a proxy for how much the relative thinks we care and we want to implement a culture where you don't walk by ringing phone no matter who you are. While a non-ward member is not going to be able to answer specific questions from the caller or give out specific information, they are perfectly capable of taking a message and finding the person who can or taking details for a call back.

The Wardrobe

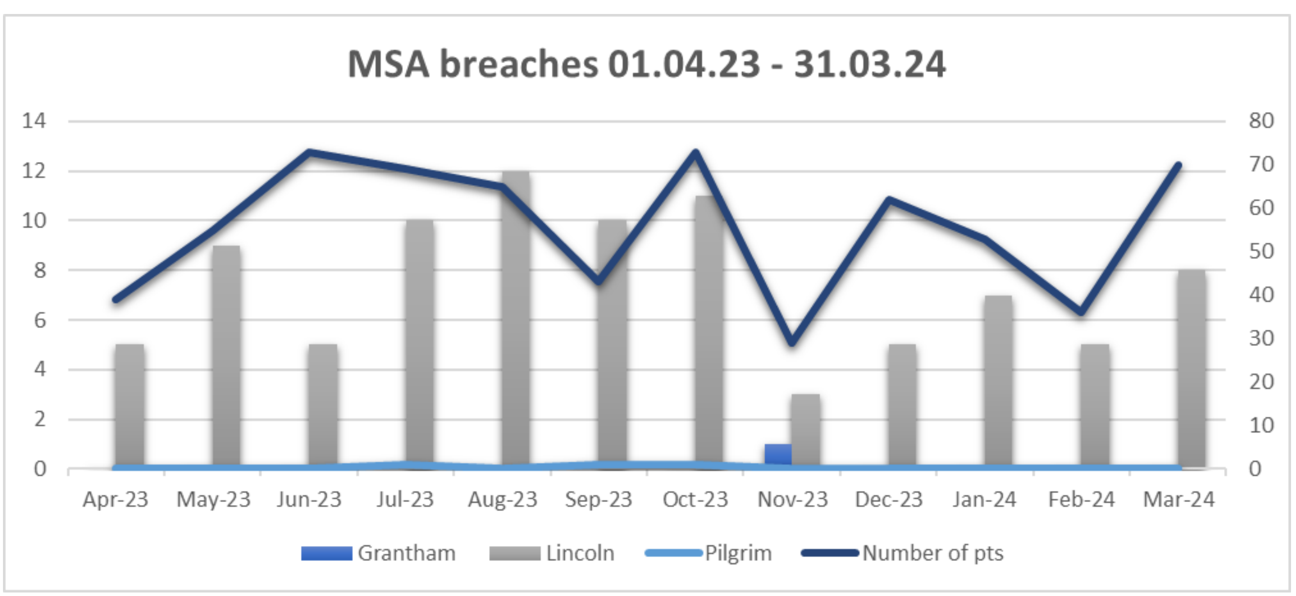
The team have been working to create a dedicated facility on each of the main hospital sites where donated adult clothing is stored. The aim is that this can be accessed by any staff member at any time to ensure a patient in need is able to have a change of clothes or be discharged home in appropriate clothing. Locations have been identified and set up with support from ULH Charity for shelving and boxes and stocked with clothes donated by staff.

The current work is around seeking public donations in a managed way. Dedicated wheelie bins are on order and a standard operating policy in place ready to take this forward. Day to day management will be provided by volunteers and targeted public campaigns supported by our communications team.

Mixed Sex Accommodation

In line with the Trust Eliminating Mixed Sex Accommodation Policy (C-P-25 June 2021) when a breach occurs a DATIX report is required and as part of the scrutiny a Mixed Sex Accommodation Investigation report completed to enable validation of the breach. Validation is undertaken by the Head of Patient Experience and considers the NHSI and NHSE Guidance Delivering Same Sex Accommodation 2019 definition in order to determine whether the breach was justified or unjustified in line with the guidance. If justified, it is reported internally as a breach of dignity and if unjustified is required to be reported via the NHS Strategic Data Collection Service (SDCS).

During 2023 – 2024 there were 94 episodes of mixed sex accommodation breaching across the 3 sites affecting a total of 667 patients. All of these were validated and authorised at Gold Command level as being justified and as such not required to be reported to the Strategic Data Collection Service (SDCS) at NHS Digital.



The majority of episodes occurred on surgical wards at Lincoln County Hospital and particularly on Greetwell Ward and Surgical Emergency Assessment Unit (SEAU) and the root causes being 55% due to no female beds and 32% no male beds. The remaining causes were due to lack of specialist beds. In the first 6 months of the year Hatton Ward were reporting breaches due to lack of Level 1 (L1) beds, this was reviewed and shown not necessary as having a L1 high dependency bay the guidance states a breach is only considered in these settings when an individual or

group of patients continue to be accommodated in the mixed environment when their clinical condition no longer requires this. To monitor this a local reporting system was developed and this is now included within monthly validation reports.

Patient Information

The Trust has a responsibility to provide patients with information that is based on evidence, which is essential for improving patient experience, supporting self-management and enabling shared decision making along with ensuring all information is up-to-date and reliable. It is imperative that the patient information we produce adheres to strict guidelines regarding accuracy, accessibility, and readability. We understand that updating our patient information when evidence or processes change is essential to ensuring the best possible outcomes for our patients. Moreover, we recognize the importance of making patient information available in alternative formats, such as other languages and accessible formats, whenever possible.

The comprehensive review of all of our patient information commenced in April 2023 with a refresh of policy and process, development of flowcharts and checklists and guidance and the establishment of a Patient Information Approval Group (PIAG) to oversee the process. PIAG has worked to systematically review every known patient information ‘product’. At the time of this report 546 have been through the process with the following outcomes:

- 424 - approved
- 51 – directed to other trusted sources of information
- 45 - not approved, or out of scope of PIAG
- 11 - no longer required
- 15 – on hold/pending further information from information authors

There are now 78 approved Trusted Sources. These are agencies and organisations who provide patient information and who PIAG have appraised against a checklist that includes:

- Can the information be easily located with a single link?
- Can the link be added to an internal repository?
- Is the information freely (no cost) downloadable / printable?
- Is the information available in an Easy Read format?
- Is the information available in other languages?
- Does it cover all of the information that is required?
- Is the information clearly dated and evidence of review?

On reviewing information PIAG consider whether there is an alternative provider and if so, will direct the ULHT author to consider this first.

Copywrite: Where authors have used clip art, pictures, photos or images from other sources such as publications or the internet they are required under copyright to provide proof that the images can be used. Resources such as clip art are not necessarily free to use. A field within the database has been created to document all image sources to be sure the Trust is compliant with copyright law.

Publishing: not all information is publicly available, some is only available internally as it needs to be given and explained to patients in person or has fields where individual details are completed by a clinician. All information is made available in the internal repository and staff can download and print as required. There are currently 237 information leaflets in the repository. The external website has information that can be accessed publicly and there are currently 175 information leaflets published.

Home > Patients and Visitors > Patient Information Library

Patient Information Library

All ULHT patient information leaflets curated on one page

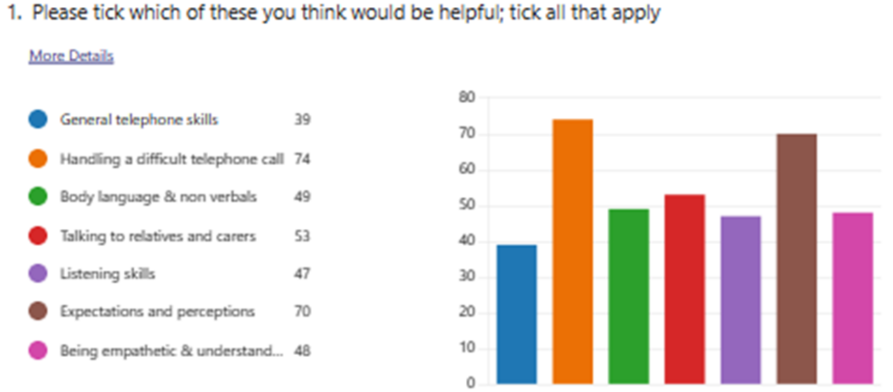
Communication Improvement Group

The Communication Improvement Group is a subgroup of the Patient Experience Group, it meets alternate months and has membership from across the divisions and services who are driving forward a dedicated action plan.

Completed actions this year include:

- Introducing a Patient Story now shown at Trust Induction; https://youtu.be/iBLQnThJ6w0

- Undertaking a staff survey to determine communication training needs; 89 staff responded.



There were 35 responses to '*Are there any other topics you think would be helpful*?' Having removed those that were conversational and kindly agreeing with what had already been asked, the remaining 29 have been grouped:

- Civility
- Difficult conversation, bad news & end of life care
- Written Skills
- Embracing diversity

This feedback has been valuable for the Patient Experience Team in reviewing the training offer and a new suite of communication training will be launched in the late summer of 2024.

Completed actions currently being worked to embed:

- Drive the communication elements within the National Survey Thematic Action Plan to demonstrate progress.
- You Care We Care to Call initiative embedded throughout the organisation.
- Develop and deliver continuing programme of Hearing it Your Way training.

In progress / on track:

- Introduce a Communication Always Event – we are refocusing this to align with a training programme within Cancer Services.
- Evaluate impact and outcomes of Dignity Pledges – we have seen improvements within our national
- That the 'What Matters to You' principles are adopted and embedded throughout the organisation.

Hearing it Your Way (HIYW)

Hearing it Your Way is a training programme based loosely upon An Objective Structured Clinical Examination (OSCE) format. OSCE is a common method of assessing clinical competence in medical education and uses role play scenarios and activities.

Different scenarios (or stations) are prepared, and staff attend each station as part of the session, role play the scenario and receive feedback.

HIYW is all about communication, and as communication by its very nature is interpersonal and individual an OSCE approach is perfect for training. Having initially been developed by the Trauma & Orthopaedics clinical business unit a proposal to roll out the training across the Trust was welcomed by senior leaders and a HIYW Faculty was launched in December 2023. Having a faculty means we can have a body of staff that we support and train on our training processes who can then support the delivery of training sessions. The faculty has created the training materials and developed resources and programmes and has scheduled the first sessions commencing in June 2024.

Emergency Departments; observations of care

It is sometimes easy to forget that although the tasks associated with treatment may be entirely impersonal, the care of the patient must always be completely personal. Sometimes we become so accustomed to seeing the same things happening around us, we fail to notice either the positive or the negative impact these things have on others. To walk in a patient’s shoes and to understand how day-to-day routines and behaviours may be detrimental to the patient’s well-being are key to delivering outstanding care – personally delivered.

By taking dedicated time out to stop, look and listen to what happens to a patient we can reflect on the care process, the environment and the many human interactions the patient has with staff during their time in hospital.

In October 2023 observations of care were undertaken by members of the Patient Experience Team across each of our three Emergency Departments. Using best practice from the Picker Institute, Kings Fund and NHS Institute a tool was developed and methodology principles and governance agreed which involved looking at both transactional issues (processes of care) and relational issues (human interactions between staff and patients).

The results of the audit were shared at Patient Experience Group and with the Urgent & Emergency Care teams and used to provide direction for change and improvements.

Lincoln County

Lincoln ED 10/10/2023 10am

- On arrival:

• Number of patients in dept.	87 (capacity 50)
• Number of crews waiting	5
• Longest wait in dept.	43hrs
• Number patients waiting beds	52

Evidence of good practice	Areas for improvement
Staff addressing long waits and engaging with patients. Some staff introducing themselves. Evidence of care of the vulnerable patients despite long waits over full department. Some good signage Some relevant posters e.g. carers, dignity pledges etc Area inside department clean and tidy Water available for all patients Vending machine available	New chairs have been ordered for seating area to increase capacity. Pagers have been ordered so that carers/relatives can sit elsewhere but be paged when needed so that seating area can be for patients. Discussions/training to be had around timely answering of telephones/YCWCTC roll out. More signage being explored for transparency of wait times. Signage on toilets to be reviewed. De-cluttering of posters around department and focussing on information needed for patients and relatives. Roll out of 'hello my name is' badges

Pilgrim, Boston

Pilgrim ED 11/10/2023

- On arrival:

• Number of patients in dept.	52 (capacity 20)
• Number of crews waiting	6
• Longest wait in dept.	33hrs
• Number patients waiting beds	23

Evidence of good practice	Areas for improvement
Kindness and compassion from staff Good interactions between staff Nurse in Charge appeared to know the patient's needs in her department overall even though it was over capacity Evidence of a transfer team to ease burden from department staff Good skill mix of staff on shift	Roll out of 'hello my name is' badges to help with staff identification Discussions around supporting Nutrition and hydration rounds for patients. Discussion of improving productivity of transfer staff to improve flow of patients out of department.

Grantham

Grantham ED 17/10/2023

- On arrival:

• Number of patients in dept.	36 (capacity 17)
• Number of crews waiting	0
• Longest wait in dept.	4 hrs 33mins
• Number patients waiting beds	1

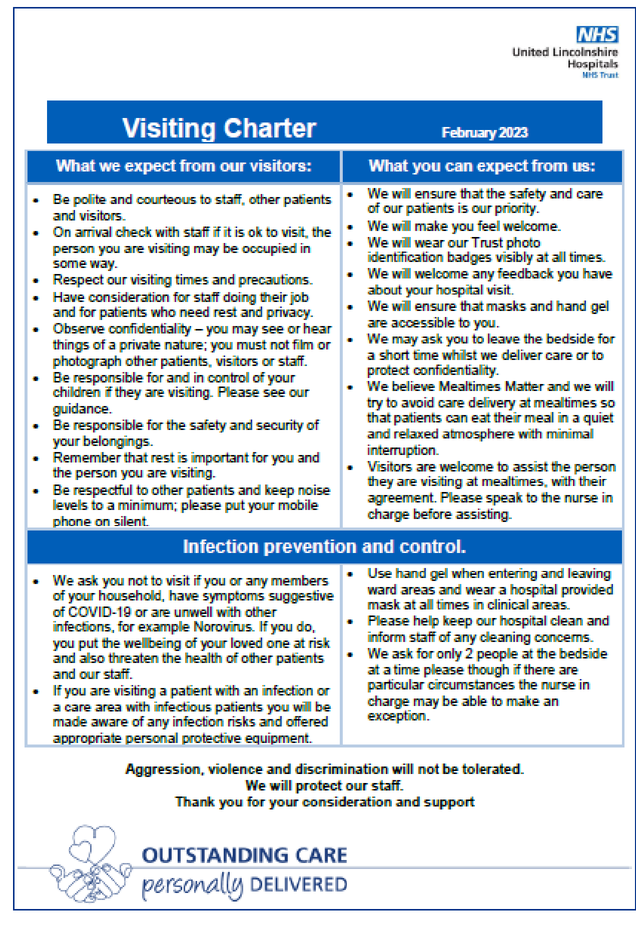
Evidence of good practice	Areas for improvement
Wait in department lowest of all three sites. Compassionate care shown by all staff. Very productive, competent students using initiative and demonstrating good levels of care. Evidence of nutrition and hydration rounds for patients and also compassionate care in resus Caring positive attitudes witnessed from admin staff. Nurse in charge was well versed in the needs of the patients in the department. No ambulances waiting Flow through department appeared good	Review of information in waiting areas and in cubicles for better patient information Roll out of 'hello my name is' badges Some work to be encouraged/initiated between consultants from Grantham to Lincoln regarding transfer acuity criteria to avoid confusion. Discussion around upskilling staff as to paediatric needs and staffing of paediatric area.

Visiting

Following enthusiastic codesign workshops to review visiting and supporting carers that were held in February and March of 2023 the new Visiting Policy was formally launched in May 2023. With effect from 2nd May, we introduced new standardised core visiting times for all areas of all our hospitals agreed and developed in partnership with staff and patients. The new policy importantly distinguished between visitors, who may be a friend or family member, and a Carer / Care Partner who we recognise as needing to be there more formally to support a patient.

Every area across all of our sites now welcome visitors every day between 2pm and 8pm, with exceptions in place for Carers / Care Partners, birth partners and in other exceptional circumstances. We acknowledged that visiting may need to be restricted or have additional precautions in place in some areas due to IPC or other issues, on an ad-hoc basis, though Carers / Care Partners would still be supported as we did throughout the pandemic.

This new blanket approach to visiting times significantly simplified the process for all colleagues, patients and their visitors, reduced confusion and concerns where times have varied and helped to reduce phone calls to our hospitals and individual wards. The new policy included a Visiting Charter that was codesigned with staff and patients outlining our expectations around visiting and in return what visitors can expect from us in terms of help and support. Importantly, the charter contains key information on infection prevention and control measures that remain in place for the safety of our staff, patients and the visitors themselves.



NHS
United Lincolnshire Hospitals
NHS Trust

Visiting Charter February 2023

What we expect from our visitors:	What you can expect from us:
• Be polite and courteous to staff, other patients and visitors. • On arrival check with staff if it is ok to visit, the person you are visiting may be occupied in some way. • Respect our visiting times and precautions. • Have consideration for staff doing their job and for patients who need rest and privacy. • Observe confidentiality – you may see or hear things of a private nature; you must not film or photograph other patients, visitors or staff. • Be responsible for and in control of your children if they are visiting. Please see our guidance. • Be responsible for the safety and security of your belongings. • Remember that rest is important for you and the person you are visiting. • Be respectful to other patients and keep noise levels to a minimum; please put your mobile phone on silent.	• We will ensure that the safety and care of our patients is our priority. • We will make you feel welcome. • We will wear our Trust photo identification badges visibly at all times. • We will welcome any feedback you have about your hospital visit. • We will ensure that masks and hand gel are accessible to you. • We may ask you to leave the bedside for a short time whilst we deliver care or to protect confidentiality. • We believe Mealtimes Matter and we will try to avoid care delivery at mealtimes so that patients can eat their meal in a quiet and relaxed atmosphere with minimal interruption. • Visitors are welcome to assist the person they are visiting at mealtimes, with their agreement. Please speak to the nurse in charge before assisting.
Infection prevention and control.	
• We ask you not to visit if you or any members of your household, have symptoms suggestive of COVID-19 or are unwell with other infections, for example Norovirus. If you do, you put the wellbeing of your loved one at risk and also threaten the health of other patients and our staff. • If you are visiting a patient with an infection or a care area with infectious patients you will be made aware of any infection risks and offered appropriate personal protective equipment.	• Use hand gel when entering and leaving ward areas and wear a hospital provided mask at all times in clinical areas. • Please help keep our hospital clean and inform staff of any cleaning concerns. • We ask for only 2 people at the bedside at a time please though if there are particular circumstances the nurse in charge may be able to make an exception.

Aggression, violence and discrimination will not be tolerated.
We will protect our staff.
Thank you for your consideration and support

OUTSTANDING CARE
personally DELIVERED

Caring for Carers

We have worked over the last 18 months with NHS England as one of 12 pilot sites for the development of a new national Care Partners Policy.

As a pilot site we commit to testing the principles and processes and develop local policies and systems and as a member of the advisory board feedback at national level.

Where are you with your care partner work ?

- Codesign groups held and agreed:
  - Definitions
  - Distinguishing between Care Partners & visitors
  - Agreeing that its all about the principles and that we see Carers & Care Partners as synonymous
- Outputs include:
  - New Visiting Policy & charter. Agreed visiting hours across all sites & services.
  - Existing Carers Policy reviewed & rewritten to become Care Partners Policy.
  - Carers Badges rebranded & relaunched
  - Resource boxes created for every ward
  - Carers Stories created & shared

What have been your lessons so far ?

- The importance & value of codesign in securing collaborative agreements.
- Initial focus had been on inpatient areas but quickly recognised need to consider particularly EDs and OPDs.
- How this work is inextricably linked with all that we do such as communication, information, accessibility, translations, health inequalities.
- That even if things have 'always been that way' & 'we simply can't change that…' (e.g. numerous visiting times) with the right narrative, stories and codesign you can make changes.

What/Who have been your enablers?

- Setting up a multi-agency steering group; having experts of experience.
- Telling stories – the most powerful tools.
- Senior leadership – pushing against an open door.
- Governance structure – reporting upwards & ability to escalate if needed.
- Rooting the work in patient experience – its why we are here after all.
- The fact that this is being led nationally – helping us to lead the way.
- Liking in with our #WMTY work.

What/Who have been contributed to the barriers ?

- Medical staff – paternalistic medical model….'doctor knows best'.
- Misplaced belief that not having care partners & visitors around makes the job easier……when in fact the opposite is true.
- Time – urban myth that as so stretched for time engaging with carers will add to this.
- Systems working hindered by different process and particularly IT.
- Fatigue….'another project'……

In November 2023 the NHSE leads visited ULHT to hold an appreciative enquiry workshop. This was well attended across all sites and all roles including executive colleagues. The workshop considered:

- What do you feel you need for a successful implementation?
- What enables a successful implementation?
- What does the introduction of care partner mean to you?
- Why is it important?

A graphic artist captured the discussion, and the outputs were shared at the national forum.

In January 2024 the Carers Hub was 'opened' on the 6th floor at Pilgrim Hospital funded by ULH Charity. This space has been designed in the spirit of the very successful Macmillan Cancer Information service hubs where people can pop in opportunistically or call or email for advice, support and information relating to their role as a carer.

Working in partnership with Carers First the plan is that this will be manned by volunteers under the supervision of one of the Patient Experience Managers and Voluntary Services. At the time of this report volunteers are being trained with a hope to being operational in July.

Patient Panel

Patient Panel continues to mature and develop and is seen across the Trust as a valuable and important forum. Meeting every monthly for 2 & ½ hours the discussions and topics have been hugely varied as the list below shows.

On average we have seen 19 panel members at each meeting which makes for vibrant discussion. In addition to the set meetings, we have also held standalone workshops / codesign sessions on car parking, clinical strategy and the Lincolnshire Community and Hospitals Group model. Five panel members attended Trust wide Clinical Strategy full day events in Woodhall Spa contributing to important discussions and decisions about the future direction and plans for the organisation.

A significant piece of work this past year has been in relation to outpatient letters and a series of 3 codesign workshops were held that reviewed our letter templates and redesigned 3 new templates: one for face-to-face appointments, one for video and the third for telephone appointments. These have then been used as the core templates for a Trustwide review for an Improvement Programme audit of letter templates held across all the outpatient folders reviewing over 883 documents containing thousands of lines of data holding information for patients to advise on their appointments. This has been a huge project that was kick started by patient panel escalating their concerns to senior leaders and is a great example of how our patient panel voice is heard and acted upon.

Mar-23	YCWCC
	Visiting Policy & Care Partners Policy
Apr-23	Patient Safety Partners
	Communication Improvement Plan
May-23	Face to face meeting
Jun-23	What Matters to Me
	Time Out Day Overview & TOR Review
	Quality Account
Jul-23	Smoking Shelters
	Paediatric Consultation
	Nutrition and Hydration
Aug-23	No meeting
Sep-23	Workforce/OD Plans
	Armed Forces Network Update
	Lincoln Endoscopy Update
Oct-23	All things/plans food & meals
	Partnership Project
	PREPARE
	Maternity Update
Nov-23	Signage Audit update
	Hybrid Mail
	Health Village
Jan-24	Complaints
	Improvement Academy
	Update Research Project
	Quality Account
Feb-24	Charity Strategy 2025
	Clinical Diagnostic Centre
	Musculoskeletal Physio
Mar-24	Endoscopy Update
	Lincoln Stroke Unit Expansion
	Group Model Patient Panel

Four panel members have also gone on to become Patient Safety Partners which has been great to see, and they have continued to come to panel and update members on their wider work demonstrating the importance of a patient voice within safety conversations.

Summary

We all recognise that patient experience is, and should be, central to all that we do. Despite considerable challenges through the last 12 months, this Patient Experience Annual Report demonstrates the continued work across the Trust to achieve the ambition of *Outstanding Care, Personally Delivered*. This report demonstrates how we draw out the intelligence of the feedback we receive from our patients and their families and use this in a meaningful way to make improvements. Equally our work engaging with patients through our patient panel and codesign work continues to be seen as an essential forum in involving, listening to and working with our patients.

The year ahead

At the time of this report, we are actively exploring and scoping how we work together in all things Patient Experience within our new group model of Lincolnshire Community and Hospitals Group. The year ahead will see joint working, triangulation of data and intelligence as well as individual organisational workplans – all of which will be focused on our commitment to ensuring patients are involved and partners in their care and treatment and that we have a shared vision and aim to continue our ambition for patient centred care.

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	*3 September 2024*
Item Number	*8.1*

Quality Committee in Common Upward Report of the meeting held on 20 August 2024

Accountable Director	*Nerea Odongo, Group Chief Nursing Officer*
Presented by	*Rebecca Brown, Quality Committee in Common Deputy 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 ULHT had declared 2 Never Events in the current financial year which were being investigated through the Patient Safety Incident Investigation process.

The Committee was pleased to noted that there were no remaining Serious Incidents open for LCHS with the ICB having signed these off and reporting moving in line with the Patient Safety Incident Response Framework (PSIRF).

Duty of candour remained positive for both LCHS and ULHT with the Committee noting the increase duty of candour reporting at LCHS due to the changes in reporting of pressure ulcer damage. This increase was in line with national reporting.

Deteriorating patient concerns and **limited assurance** continued to be noted by the Committee with a position statement due to be offered to the group in September. Whilst work was taking place in a number of areas there was currently no lead in place and therefore the escalation was offered to the Committee.

Work was taking place in respect of medicines management and bringing this together across the Group with the Committee noting that there were a number of areas for consideration in this. **Limited assurance** had been received through the ULHT report and support had been offered to improve this and ensure that assurance could be provided.

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.

Maternity and Neonatal Oversight Group Upward Report
The Committee received the upward report and suite of reports with **assurance** noting the progress being made against the maternity improvement plan.

Recent agreement was noted by the system in respect of funding for the perinatal pelvic health service with a number of applications received for the associated roles.

The Committee noted the position of the ULHT in respect of the regional oversight tool which supports ongoing monitoring of the position against national drivers. The Trust was performing well with the Committee asking for consideration to be given as to how this could be shared more widely in an appropriate manner.

Ongoing difficulties were noted in respect of the nursing workforce and the appointment of qualified specialty rotas to meet national standards however a trajectory was in place alongside an action plan to move this forward and achieve the 70% target. Whilst actions were progressed mitigations were in place.

In respect of the Clinical Negligence Scheme for Trusts (CNST) maternity, the Committee noted the following standards, receiving and approving a series of associated documents which are appended to the report:

- CNST Standard 4: BAPM Recommendations for Neonatal Workforce: NNU is staffed to BAPM requirements for the neonatal medical workforce.

- CNST Standard 4: BAPM Nurse Standards: NNU is currently not staffed to BAPM requirements for the neonatal nursing workforce, however progress is being made to address the deficiencies. The Committee and Trust Board should approve the action plan (**appendix 5**) and note the progress made in respect of the previous action plan, summarised as follows:

    - Network funded posts – the Clinical Governance post and the Practice Educator post are now fully recruited with start dates agreed;
    - Discussion to be arranged with Director of Nursing regarding plans for Nursery Nurse posts – potential plan to over-recruit Band 5 roles whilst decision is being made to help offset impact of vacancies that are being held whilst future state is agreed;
    - QIS training trajectory completed for Lincoln (Boston already achieve QIS standards) – trajectory being monitored via governance processes to enable early identification of any deviations

- CNST Standard 5: The Trust Board should note that the Trust is not compliant with a funded establishment based on BirthRate+ or equivalent calculations. Quality Committee and Trust Board need to review and agree the action plan (**appendix 4**), which includes timescale for achieving the appropriate uplift in funded establishment (trajectory: June 2025). The action plan includes details of mitigations in place to cover any shortfalls, which are summarised as follows:

    - The deficit is around triage in antenatal services, in line with BSOTS,
    - Some of the BSOTS standards have already been implemented,
    - Triage service is in place in assessment areas to ensure a safe service in the interim,
    - In addition, there is a robust Maternity Escalation Plan although escalation can impact on other services e.g. Continuity, which is captured.

- CNST Standard 6: Trust Board should note the progress made towards Saving Babies Lives Care Bundle, with continued improvement in compliance noted across all 6 elements.

- CNST Standard 9: Note that a non-executive director (NED) is appointed, attended MNOG and provided detailed updates on their role as a Board Level Safety champion (**appendix 9**) and is working alongside the current Board Safety Champions.

- CNST Standard 9: Evidence that MNOG, with upward reporting to Quality Committee and Trust Board have undertaken a review of maternity and

neonatal quality and safety data using a minimum data set. This is provided as evidence at **appendix 1**.

CNST Standard 10: Upward reporting to Trust Board of **appendix 1**, and narrative that demonstrates that during this reporting period there was 1 qualifying MNSI/EN incident. This has been reported to MNSI and NHS Resolution and the families concerned have received information on the role of MNSI and NHS Resolution's EN scheme as well as having duty of candour completed. This is evidenced in **appendix 1.**

Focussed Discussion – Update on Human Factors Faculty
The Committee undertook a focused discussion relating to Human Factors noting the progress that had been made across ULHT in respect of the programme of work and the staff trained through the faculty.

Whilst this was a ULHT programme of work the Committee noted the interest of LCHS staff to harness the opportunity to embed this into practice with requests being made to attend future courses.

The Committee noted with interest the links to fatigue and risk management strategies noting the intention to produce a briefing paper to consider the implementation of a Human Factors approach to this.

There was interest from Committee members for Human Factors to be explored by the Board with the intention to consider this for a future Board Development session.

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 that there was poor compliance in respect of training attendance for safeguarding training.

There had been an increase in complaints for both LCHS and ULHT with the LCHS complaints attributed to urgent treatment centre attendances and access to treatment and medicines. Actions were in place to address this.

Despite the increase in complaints there had been an increase in the number of complaints being responded to on time. Work was taking place with the team to further improve Group reporting.

The Committee considered the diversity of the patient panel and the need to review this to ensure the membership remained relevant and was broadened to different communities.

Focussed discussion – Safeguarding Annual Reports LCHS and ULHT
The Committee received the annual safeguarding reports for LCHS and ULHT with **assurance** and recommended these to the Board (appended).

The similarities of the service across both organisations was noted through the reports with a focus of work moving from safeguarding and harm for LCHS to safeguarding and vulnerabilities. This meant that further work was being undertaken by the team and enabling joint discussions across the Group.

An increase in section 42 investigations had been seen over the past year which were managed through process and relevant action plans were in place.

In respect of the UHLT report the Committee noted the increase in support for mental health and dementia patients in respect of vulnerabilities. It remained unclear if there would be a move to liberty protect safeguards, from deprivation of liberties, with further information awaited before changes may come in.

The Committee noted the Group work taking place across the services with the Deputy Director of Safeguarding leading both teams at ULHT and LCHS.

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 engagement of the group and the levels of assurance being provided through the reporting.

Whilst it was noted that ULHT was an outlier for a number of national audits however the position of these was understood and appropriate actions were being taken to address areas of concern. In some cases this related to historical data and the lag in reporting of the audit outcomes.

The Committee noted concern about the level of service being provided to stroke patients due to the deterioration in the national clinical audit however assurance was offered that there was no patient harm and a report would be offered to the Executive Leadership Team to work through the service requirements. It was noted that there was a need to change the service delivery to support early assisted discharge of patients.

Staffing of the children and young people's epilepsy service was also noted as being below recommended levels with the Committee requesting that the group consider the position and provide an update through the upward report.

Focussed Discussion – NICE Update
The Committee undertook a focused discussion on NICE and Technology Appraisals (TAs) noting that UHLT had achieved 100% compliance with TAs for the past 2-years.

ULHT was compliant with 95% (258) of NICE baseline assessments with 271 of these applicable to the Trust. Benchmarking with other Trusts had been considered however it was recognised that there was limited information in the public domain regarding this.

Review of the actions associated with NICE assessments was being completed to ensure that there were realistic timescales to complete relevant actions and, should it be required, derogations agreed.

Work had commenced in respect of the Group for NICE and TAs to standardise the approach across the Group with a willingness for this work to progress.

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 ongoing work to continue to populate the narrative within this.

During the meeting the Committee considered the RAG ratings of the objectives where assurance reports had been received and noted that there were no changes to these in month.

Risk Report
The Committee received the joint report with **assurance** noting the dynamic nature of the risk register with a reduction in one very high risk due to the realignment of the risk.

The Committee noted that the risks presented were reflective of the discussions held during the course of the meeting. The report was accepted.

Internal Audit – Assurance review of Pharmacy Procurement Processes (ULHT)
The Committee received the report noting that this offered **reasonable assurance** with relevant actions being taken.

Group CQC Forward View

The Committee received the report with **assurance** noting that the report provided focus to the proactive work being undertaken in respect of the new CQC Single Assessment Framework.

The Committee noted the development of the virtual libraries which would hold the available evidence and recognised the need to ensure the quality of the information being provided. As the quality was assured there could be a change in the self-assessment ratings presented.

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.

Operational Plan Report (LCHS) and Integrated Improvement Plan: Patients Assurance Report (ULHT)
The Committee received the Integrated Improvement Plan report for information noting the **moderate assurance** and recognised the need to further discussion through the September Committee. The Operational Plan Report was due to be received in October.

Interim ToR and Work Programme
The Committee received the interim terms of reference and work programme accepting the updates made to reflect the 2024/25 LCHG Strategic Aims and Objectives and the revised membership.

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

Maternity & Neonatal Safety Assurance Report

Libby Grooby, Director of Midwifery

July 2024

CQC rating: Good

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Item 1: Executive Summary

In line with the Trusts values, and as part of our commitment to these values, this report outlines progress on maternity and neonatal related activities against the maternity and neonatal transformation work, regulatory and professional requirements and national agendas.

This includes, but is not limited to:

- Ockenden actions
- Three year delivery plan
- Perinatal Quality Surveillance Model (PQSM)
- Saving Babies Lives Care Bundle V3 (SBLv3)
- CQC Single Assessment Framework
- Maternity and neonatal safety improvement plan (MatNeoSIP)
- Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive scheme (MIS) Year 6
- Maternity and neonatal dashboard
- Regional Maternity Heatmap

Progress is monitored through MNOG, which is chaired by the Director of Nursing. The Executive Director of Nursing Executive sponsor and trust Board Maternity safety Champion. The Non-Executive Director Board Maternity safety Champion also attends this meeting. MNOG in turn reports directly into Quality Governance Committee (QGC), which is a subcommittee of the Board. QGC has delegated responsibility for Maternity oversight. The MNOG upward report and documents added as appendices are then upwardly shared with Trust Board. This ensures Board oversight.

This report is provided, with any escalations clearly identified, for review and consideration, alongside accompanying presentation at the Maternity and Neonatal Oversight Group (MNOG). The Trust Board is asked to review and note the contents of this report and supporting documents provided via the IBABS system and continue to support the maternity and neonatal teams with identified challenges.

Item 2: Key highlights

2.1 Maternity and Neonatal Safety Improvement Plan (MatNeoSip)

As of July 2024

Section	Total Actions	**Red** Not yet completed / significantly behind agreed timescales or non-compliance expected	**Amber** In progress / on track / completion expected	**Green** Completed & ongoing and / or not yet fully embedded (awaiting evidence of embedding)	**Blue** Completed & embedded with evidence, to be signed off at MNSC prior to closure
Optimise Safety	**22** (+6)	0 (=)	17 (+6)	4 (-1)	1 (+1)
Optimise Experience	**6** (-2)	0 (-1)	6 (-1)	0 (=)	0 (=)
Improve Leadership	**0** (=)	0 (=)	0 (=)	0 (=)	0 (=)
Choice & Personalised Care	**5** (-1)	1 (=)	3 (-1)	1 (=)	0 (=)
Provide Assurance	**3** (=)	0 (=)	3 (=)	0 (=)	0 (=)
CNST	**11** (-42)	3 (+1)	6 (+5)	2 (-48)	0 (=)
SBL	**11** (-2)	0 (=)	6 (-1)	5 (-3)	0 (=)
3YDP – ULHT	**46** (+46)	0 (=)	19 (+19)	25 (+25)	2 (+2)
3YDP – ICB	**29** (+29)	1 (+1)	8 (+8)	20 (+20)	0 (=)
TOTAL	**133** (-34)	**5** (+1)	**74** (+43)	**57** (-7)	**3** (+3)
Archived Actions	**291** (+64)	Completed, embedded and signed off by MNSC for closure			

	Action No	Action Milestone	Responsible Lead	Due Date	Comments
1	CPC19	All trusts must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of birth. They should have been trained in dealing with bereavement and in the purpose and procedures of post-mortem examinations.	Bereavement Lead Midwife (RB) Obstetric Leads	30/09/2024	Bereavement Midwife collates compliance. Have requested for the module to be added to ESR, work in progress since October 2023, ELOD now prioritising workload. RB exploring if this can be added to the risk register to aid prioritisation of adding the modules to ESR. Remains on Obstetric and Mortuary Governance agendas. Compliance as of 13/06:

		Compulsory ELFH bereavement communication and PM consent package to be completed 3yrly by all Obstetric and Neonatal Registrars & Consultants.			Post-mortem consent training compliance; LCH Consultants = 10/11 (91%); LCH Reg = 3/15 (20%); PHB Consultants = 7/9 (78%); PHB Reg = 8/12 (67%). Bereavement training compliance; LCH Consultants = 10/11 (91%); LCH Reg = 4/15 (27%); PHB Consultants = 5/9 (56%); PHB Reg = 9/12 (75%). Obstetric Leads contacted to update on their support to improve compliance.
2	CNST04 .6	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing staffing? And is this formally recorded in Trust Board minutes?	Lead Neonatal Nurse (CF) Neonatal Matron (RW)	March 2025	QIS remains a concern and we will unlikely be able to submit compliance for this action. To achieve compliance with this action in MIS Y5, a mitigation plan was submitted. In view of this action remaining a concern in MIS Y6, this action will remain on the MatSIP for continue oversight, and will be monitored within the CNST MIS Y6 Audit Tool. 12/06/2024 Position presented at MNOG/LMNS 03/06 & 10/06 as per CNST Year 6. Situation replicated nationally. NNU peer review due 24th June.
3	CNST.Y 6.08.02	Can you demonstrate the following attendance at the end of the 12 month period 1 December 2023 to 30th November 2024 (concerning groups in bold): Maternity emergencies and multi-professional training 90% of obstetric consultants 90% of all other obstetric doctors including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows foundation year doctors and GP trainees contributing to the obstetric rota 90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives 90% of maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum). **A) 90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors** **B) 90% of all other obstetric anaesthetic doctors (including anaesthetists in training, SAS and LED doctors) who contribute to the obstetric anaesthetic on-call rota in any capacity. This updated requirement is supported by the RCoA and OAA.** **C) 70% of non-obstetric anaesthetic doctors (including anaesthetists in training, SAS and LED doctors) who contribute to the obstetric anaesthetic on-call rota in any capacity. This updated requirement is supported by the RCoA and OAA.**	Clinical Education Team	30/11/2024	03/06/2024 May compliance: >90%. On track for first 4 groups. Compliance: **A)** May: LCH 87.5%, PHB 76.92% Trust-wide 82.75% (reduction in compliance) **B)** April: LCH – 75% (2 Staff currently out of date. 1 staff needs rebooking, 1 booked for 24th May 2024) PHB – 71.43% (2 Staff currently out of date. 1 rebooked for 11th July 2024 and 1 rebooked for 8th August 2024) Trust – 73.33% (Need 3 more staff to be at 90%, X3 staff already booked so will be at 90% by 8th August) **C)** May: Trust-wide: 12.5% (April 0%) Plan at present is to hold an anaesthetic PROMPT half day for OC cons to attend. We will have 4 dates over Sept & Oct, 1 per site per month and content will include scenarios from PROMPT package. Education team to facilitate. This will be MDT teaching as the education team will be there as midwives.

4	CNST.Y6.08.04	Can you demonstrate the following attendance at the end of the 12 month period 1 December 2023 to 30th November 2024: Neonatal basic life support 90% of neonatal Consultants or Paediatric consultants covering neonatal units 90% of neonatal junior doctors (who attend any births) 90% of neonatal nurses (Band 5 and above who attend any births) 90% of maternity support workers, health care assistants and nursery nurses *dependant on their roles within the service - for local policy to determine. 90% of advanced Neonatal Nurse Practitioner (ANNP) Is a formal plan in place demonstrating how you will ensure a minimum of 90% of neonatal and paediatric medical staff who attend neonatal resuscitations have a valid resuscitation council NLS certification by year 7 of MIS and ongoing. 90% of midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives)	Clinical Education Team	30/11/2024	21/05/2024: Trust: 89.8% (-1) LCH 87% (21 out of date, all rebooked). PHB 92%, Bank 95% May >90% NNU action turned red due to no confirmation of neonatal medical compliance and lack of monitoring between MIS periods. WF to contact Piper Coghill to share position and concern.
5	3YDP.ICB.01	Commission and implement perinatal pelvic health services by the end of March 2024, in line with national service specifications, to identify, prevent, and treat common pelvic floor problems in pregnant women and new mothers.	ICB	March 2024	PPHS for LMNS covers ULHT service users only, those using NLAG and NWAFT will access service. Business Case presented at Investment Panel 15/3/24; did not meet the thresholds' for assessment, or priority for ICS. This is now a risk to compliance, propose to include on ULHT and LMNS Risk Register.

2.2 CNST MIS Year 6: 10 Steps to Safety

Safety Action	Total requirements	Red	Amber	Green	Blue	Anticipated compliance	Comments
1 PMRT	6	0	0	6	0	On track to achieve	Evidence filed to date- on track
2 MSDS	2	0	2	0	0	Close monitoring required	On track- no concerns (Closely monitored weekly by digital team)
3 TC	3	0	1	2	0	On track to achieve	Evidence filed to date. QI project registered with QI team and initial audits underway. Updated at MNOG and QSM.
4 Clinical workforce	16	0	15	1	0	Close monitoring required	Obstetric workforce: Audits underway until end of August. 1 x action returned to red awaiting confirmation of short-term locum compliance. Anaesthetic workforce: Rotas filed and under review

							Neonatal workforce: Awaiting Peer Review paper. QIS mitigations in place including reporting as per MIS Year6
5 Midwifery workforce	6	0	0	6	0	On track to achieve	On track-no concerns
6 SBLv3.1	6	0	3	3	0	On track to achieve	On track-no concerns
7 MNVP	6	0	5	1	0	On track to achieve	1 x red turned to amber as evidence now received in part (awaiting JD from ZL and BC. For clarification on budget document.
8 Training	18	3	7	8	0	At risk of non-compliance	PROMPT: below 90% (anaesthetists and support workers) however all but 1 are booked onto PROMPT training in July and August. July's compliance anticipated to be over 90%. NLS: RW to submit NNU training date by COP 08/07/2024
9 Floor to Board	8	0	8	0	0	On track to achieve	PQSM document under review- plan to update following confirmation of safety champions. LMNS review returned.
10 MNSI	8	0	8	0	0	On track to achieve	On track- no concerns
Total	**79**	**3**	**49**	**27**	**0**		

No concerns to escalate at present. Actions will remain amber/green until formal sign off prior to submission.

2.3 Saving Babies Lives Care Bundle (v3)

% of interventions fully implemented (LMNS) validation	**Assessment one**	**Assessment two**	**Assessment three**	**Assessment four**	**Comments/actions**
Review quarter	Q2 July-Sept 2023	Q3 Oct-Dec 2023	Q4 Jan-Mar 2024	Q1 Apr-Jun 2024	
Assurance review date	02/10/2023	29/12/2023	18/03/2024		
Element 1	50%	70%	90%		Gap in training compliance for VBA – now on PROMT so will be mandatory from April.
Element 2	90%	90%	95%		Digital BP equipment for community due for delivery
Element 3	100%	100%	100%		
Element 4	20%	100%	100%		

Element 5	74%	74%	81%		Fetal fibronectin cases unavailable, issues with evidence collection (Medway)
Element 6	33%	83%	100%		
TOTAL	69%	81%	90%		Touch Point 4 for final submission is due on 24.7.24. For update of position at September meeting

2.4 Three Year Delivery Plan

Theme	Position	Comments/actions
Listening to women and families with compassion	6 outstanding actions added to the MatSIP and monitored through MNSC	Infant feeding On ULHT risk register from BFI point of view Neonatal infant feeding lead added to LMNS risk register Pelvic health To be added to ULHT risk register and LMNS risk register although funding has now been agreed.
Supporting our workforce	10 outstanding actions added to the MatSIP	
Developing and sustaining a culture of safety	11 outstanding actions added to the MatSIP	
Meeting and improving standards and structures	9 outstanding actions added to the MatSIP	

2.5 Perinatal Quality Surveillance Model

Data measure	Location of information
Findings of review of all perinatal deaths using the real time data monitoring tool	• Maternity dashboard • Learning lessons
Findings of review of all cases eligible for MNSI	• Learning lessons • Maternity dashboard

Number of incidents graded as moderate or above and what action is being taken	
Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	• Maternity dashboard • Training compliance
Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover vs actual prospectively	• Maternity dashboard
Service User Voice feedback	• Listening to our families
Staff feedback from frontline champions and walk-abouts	• Listening to our staff
MNSI/NHSR/CQC or other organisations with a concern or request for action made directly with the Trust	• Learning lessons • Maternity dashboard
Coroner Reg 28 made directly to the Trust	• Learning lessons • Maternity dashboard
Progress in achievement of CNST 10	• Key highlights • CNST update report

2.6 Ockenden actions

Ockenden actions are now monitored through the MatNeoSip with a bi-monthly focus at MNSC, although the focus for improvements is now the 3 yr delivery plan.

	Number of individual actions	Number of actions completed	Percentage completed
Ockenden 1 Report	115	112	97%
Ockenden 2 Report	78	34	44%

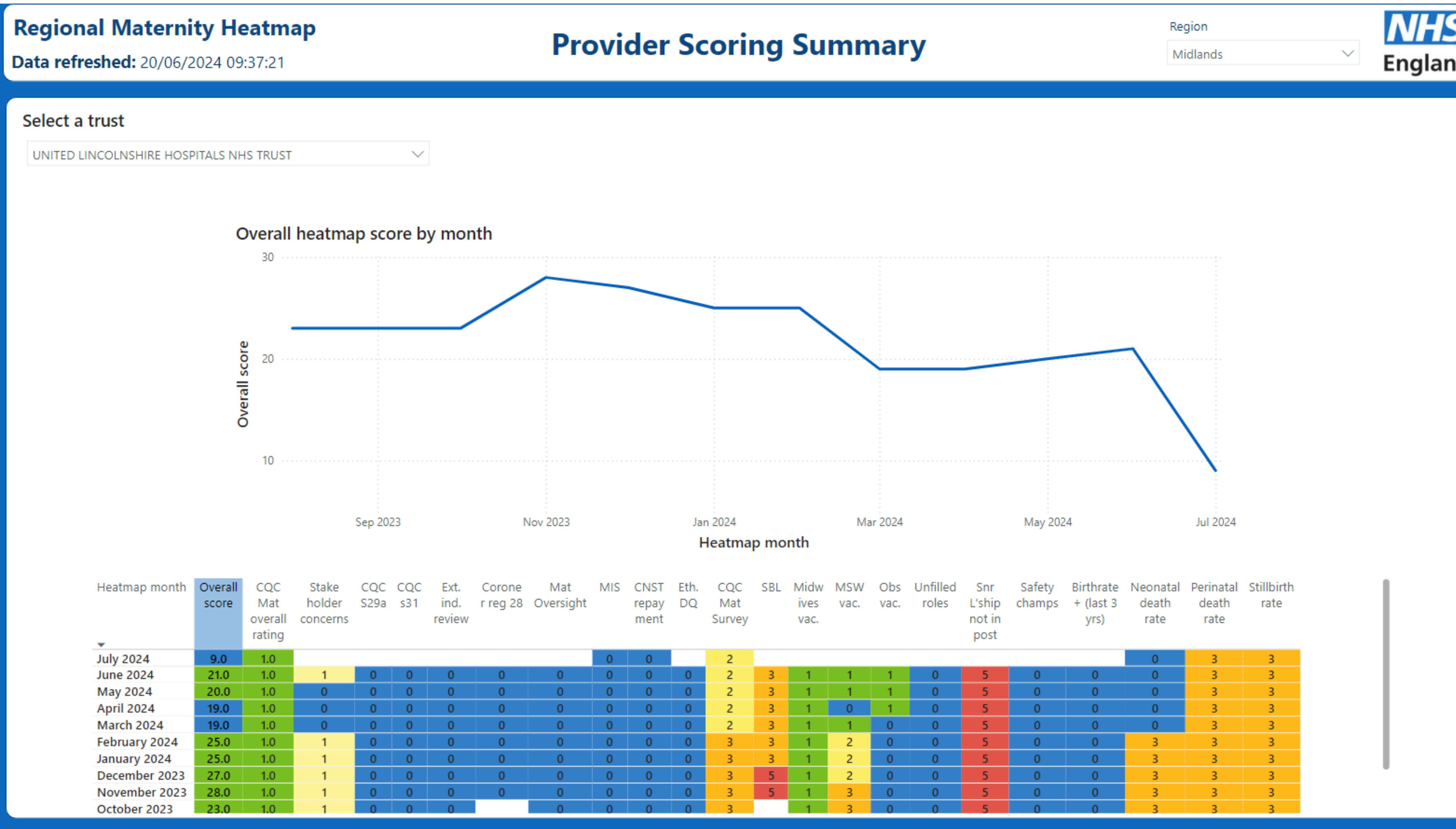
2.8 Maternity and Neonatal Dashboards

The full maternity dashboard can be reviewed in appendix one and is available via this link Maternity Dashboards (sharepoint.com).

Dashboard item	SPC trigger	Current position	Comments/actions being taken
Maternity Dashboard			
PPH		Currently at 13.39% against a target of 8.6%	PPH figures correlate with IOL and LSCS rates. Quarterly report to understand if any themes/trends Action plan produced including: • implementation of carbetocin • renewed PPH risk assessment • new and improved pph proforma for use in emergencies • implementation of ROTEM for rapid coagulation assessment (this is going to clinical cabinet again on Thursday before CRIG)
SATOD		9.65% against a target of 6%	This is an improving picture and has reduced from 13.11%.
MNSI	2	2 ongoing investigations	Plan to change the dashboard to show MNSI reported in month not ongoing

Neonatal Dashboard		
Lincoln County Hospital		
% NNU Term Admissions (Live Term births) - Target <5%	6.3%	Term admissions increased in June 2024. Under review
Hypothermia -	2 cases for both May and June for NNU and one case for both May and June for TC	Training for midwives due to vomiting and becoming cold
Neonatal Death	1	Placental abruption
BLS (Target >95%)	79%	Sessions in place for staff to attend
% staff with in-date NLS (Target 100%)	98%	One member of staff to undertake a resit
Pilgrim Hospital Boston		
Hypothermia	3 cases in May for NNU, 2 cases in June for NNU and 1 for TC	Notes currently being reviewed. To give update next month. Staff reminded to Datix hypothermias.
Ex-utero transfer (<32weeks)	1	1 x 28/40 delivered and transferred to Hull. Unable to transfer out inutero.
Mandatory training compliance	Core – NNU 97% / TC 91% Core Plus – NNU 91% / TC 90%	Decreased due to modules being added. Staff reminded to complete. To be monitored by ward manager on a monthly basis
% staff with in-date NLS (Target 100%)	90%	Two members of staff expired NLS certificate. To be booked asap

2.9 Regional Maternity Heatmap



Heatmap month	Overall score	CQC Mat overall rating	Stake holder concerns	CQC S29a	CQC s31	Ext. ind. review	Corone r reg 28	Mat Oversight	MIS	CNST repay ment	Eth. DQ	CQC Mat Survey	SBL	Midw ives vac.	MSW vac.	Obs vac.	Unfilled roles	Snr L'ship not in post	Safety champs	Birthrate + (last 3 yrs)	Neonatal death rate	Perinatal death rate	Stillbirth rate
July 2024	9.0	1.0							0	0		2									0	3	3
June 2024	21.0	1.0	1	0	0	0	0	0	0	0	0	2	3	1	1	1	0	5	0	0	0	3	3
May 2024	20.0	1.0	0	0	0	0	0	0	0	0	0	2	3	1	1	1	0	5	0	0	0	3	3
April 2024	19.0	1.0	0	0	0	0	0	0	0	0	0	2	3	1	0	1	0	5	0	0	0	3	3
March 2024	19.0	1.0	0	0	0	0	0	0	0	0	0	2	3	1	1	0	0	5	0	0	0	3	3
February 2024	25.0	1.0	1	0	0	0	0	0	0	0	0	3	3	1	2	0	0	5	0	0	3	3	3
January 2024	25.0	1.0	1	0	0	0	0	0	0	0	0	3	3	1	2	0	0	5	0	0	3	3	3
December 2023	27.0	1.0	1	0	0	0	0	0	0	0	0	3	5	1	2	0	0	5	0	0	3	3	3
November 2023	28.0	1.0	1	0	0	0	0	0	0	0	0	3	5	1	3	0	0	5	0	0	3	3	3
October 2023	23.0	1.0	1	0	0	0		0	0	0	0	3		1	3	0	0	5	0	0	3	3	3

Item 3:

In month developments and updates

3.1Maternity updates

- **PMRT - SOP for parents taking babies home –** The SOP has been drafted. The Specialist Bereavement Midwife is currently working with the trust contracted funeral director to arrange transportation from home back to the hospital. The SOP will be completed once the details are finalised.
- **Contraception Proposal –** No resolution as yet regarding the implementation of long term contraception prior to discharge from the maternity unit for vulnerable women and teenage mothers. Ongoing meetings/conversations between Rebecca Ross, Nicola Plaskitt (Equity and Prevention Lead Lincolnshire Maternity and Neonatal Programme), Sam Crow (Senior Public Health Officer, LCC) and Heidi Shooter from LISH. Nicola and Sam will submit a paper to the relevant individuals responsible for commissioning the service, further updates will be shared.
- **Clinical Audit Award Winner** – Miss Sucheta Jindal (Consultant Obstetrician), Dr Batra, Dr Win, Dr Agboola, Dr Subbiah, Dr Alex-Okoro and midwives Sarah Dudley and Amanda Poole received an award for their project on Gestational Diabetes Mellitus (GDM) Audit Diagnosis Management & Outcomes 2024 (re-audit closing the loop)
- **Labour Ward Coordinator Education and Development Framework** – Following on from ULHT coordinators being involved with the development of the framework we have put ourselves forward to be an early implementer. The Readiness and Workforce Assessment has been completed and submitted. The group will be updated as work progresses.
- **Twins Trust re-audit** is due 19th and 26th July. Results will be shared through MNOG.
- **Midwifery Standards Benchmarking Exercise** – We have received the latest standards of proficiency for midwives. Included was a mapping tool to benchmark our organisation against the standards. This work is currently being undertaken and will be brought back to MNOG once completed.
- **NEWTT2 Implementation Poster –** *See Appendix 1.1* – Poster developed to support implementation of NEWTT2 and demonstrate improvements. Significant reduction in admissions for short term monitoring across the trust. This has directly impacted avoidable admission rates within our ATAIN review.

3.2 Neonatal updates

- **Workforce: Medical/Nursing**
  - Continue to experience difficulties with QIS ratios meeting national standards, currently 53% LCH and 68% PHB. Clear trajectory of training in place with an aim of 61% by November 24, and 72% November 25. This does not take into account dilution of QIS levels with new starters and experienced staff leaving the service over the next 6-12 months. An updated trajectory to be submitted in August 24. Mitigations in place utilising clinical educators and specialist nurses when required. No safety incidents reported in relation to staffing on either site. Staffing meetings take place across CYP to ensure safety on both sites.
  - Trainee ANNP post appointed to – commencing Sept 24.
  - Risk and Governance Lead – Currently out to advert as a development opportunity seconded post. Closing date 14.7.24.
  - Medical staffing: fully recruited.
  - Substantive Neonatal Matron post successfully appointed to.
  - Ward Manager post, LCH to be advertised within the next 2 weeks
- **Complaints/PALS:**
  - One complaint received through PALS in June 24. This was in relation to a perception of missed opportunities following NIPE checks. Outcome following thorough review – Follow up should have been planned and identified on Badger discharge letter. Further training in NIPE and recognition of dysmorphic features to be undertaken.
  - Matron and MNVP Chair have been working on the Neonatal feedback through the Better Births website. Whilst up and running on the website low amounts of feedback received via this route and therefore paper copies continue to be used whilst resident. Further promotion to obtain feedback currently in place.
- **NNAP** - Q1 report attached – *See Appendix 1.2*
- **Action plan to improve our data?**
  - Antenatal steroids, Antenatal Magnesium Sulphate, deferred cord clamping, temperature on admission – PeriPrem Optimum preterm care bundle introduced which covers the NNAP measures and is a joint collaboration with Obstetrics and Neonatal teams. This includes training and awareness of aspects with a prompt booklet to complete for every preterm delivery. Subsequent auditing the Optimum preterm care bundle and its effectiveness.

- Nurse Staffing – we have recently recruited more staff nurses and trainee nursing associates to enable us to reach full workload capacity. Junior staff are put through their QIS training to enable them to care for our Intensive and High dependency babies when they have completed a comprehensive induction package.
- BPD – Less Invasive Surfactant Administration (LISA) technique introduced which allows some of our babies to be given surfactant, which helps their lungs mature, without the need for mechanical ventilation. Subsequent auditing of the LISA technique.
- Early breastmilk feeding and breastmilk feeding at discharge – Improved awareness and promotion of the importance of breastmilk to preterm babies as part of the Baby Friendly Initiative (BFI). Unit participation in the BFI and working towards higher level.
- A project to implement the use of Donor Breast Milk is currently in progress. A timescale for the completion of this to be agreed.
- Mother and Baby Demographics – Working with staff to ensure all demographics completed. Staff champions in place to promote this piece of work.
- Introduction of iPads for FaceTime on ward rounds for parents unable to attend at ward round times. Improved awareness of need to document initial parent consultation and ensure within first 24hrs of life. It is worth noting that all parents have an initial update however sometimes this is by an ANNP/ Junior Doctor and therefore is not valid for NNAP standard.
- ROP – missed babies invited back for screening at earliest suitable time and these screens have now been completed. Staff informed to use Badger lists to gain ROP window dates to ensure screening is completed within correct time frame.
- 2 year follow-up – Boston have introduced more clinics to combat this and teaching/education will be given to medical team at both sites to ensure data is entered and these follow-ups are recorded on BadgerNet.

* **BFI -** Training packages, guidelines and audits currently being completed to submit stage 1. Upon completion a gap analysis will be carried out prior to submitting stage 2. Awaiting dates of the 5-day train the trainer course. Marie Jarrett/Early years secured funding for 4 members of ULHT staff who attended beginning of July and second part in 2 weeks.
* **BFI Lead -** Briefing paper written and approved by SRO within ICB. Awaiting update.
* **ATAIN -** Continuing to experience high levels of term admissions. Weekly reviews taking place and reports generated. Low avoidable rates, however looking to reduce separation using initiatives identified below. ATAIN reviews now taking place on a weekly basis.

  Action plan in progress with midwifery team – SMART actions to be implemented and monitored. Refurbishment plans detail treatment room for procedures and in addition midwives completing competencies for administering antibiotics.

- **Cardmedic -** Pilot scheme being implemented within the Network, ULHT to be a part of this scheme to ensure an equitable service across the Network for families moving between Units. Cara Hobby to update when date agreed to roll out. Champions identified within the Trust and will work with the Network leads to implement on both sites.
- **Peer Review -** We welcomed 14 visitors from the Neonatal Operational Delivery Network, LMNS and other peers to the Trust on 1.7.24. The visit toured both Neonatal Units and culminated in a review meeting and feedback in the afternoon, with Family Health Senior Team present. The team provided the following high level feedback in response to the visit:
  - The team felt very welcome and where well Looked after, which they expressed thanks for.
  - Clear evidence of a cohesive team that works well together as a neonatal service, that works well with maternity services and externally with the LMNS
  - They loved the shipmates and little siblings club at Lincoln and are enthusiastic for the service to expand this
  - They loved the QI project around the name bands for mum and baby in cases where separation is unavoidable and the story that supported this proactive innovation (this would be excellent Patient Experience CQC evidence!)
  - Medical workforce improved again since last visit in 2022
  - Weekly meeting with Nottingham is good
  - Excellent feedback from parents which they viewed as the most important acid test of a quality service.
  - Things to work on – which will likely form the ask of the action plan:
  - QIS ratios: Look again at trajectories, especially allowing for natural loss rate and what else can be done to get to 70% target **NB**: this is a CNST requirement and Board will need to be able to evidence line of sight on QIS compliance rates and accompanying action plan. This is planned via MNOG with upward report to Quality Committee and then Board)
  - Split out Transitional care staff from data: they felt the current reporting is over inflating compliance with requirement and if split out would demonstrate some gaps that need further work
  - Nursing Associates included in registered staff: The team where concerned by this approach and suggested this needs to be looked at again. They are aware that this would also have a negative impact on the current QIS levels of compliance also.
  - Pharmacy and AHP gaps: The team felt these gaps in service are significant and whilst progress with AHPs has been made, there are still significant gaps in terms of what is required. They will further support with this and ICB work. Pharmacy was focussed on in detail here and recognised significant gap in dedicated establishment.
  - FAB worker: The team were concerned about continued funding for that post
  - Communication: They noted a slight disconnect between management team and clinical teams around communications. The example cited was some lack of clarity around who the maternity and neonatal safety champions are.

In summary: the team felt the service had come on massively. Well done to all!

- **Update on Clinical Audit Report Overdue actions** – *See Appendix 1.3*

Item 4: Maternity dashboard

4.1 Activity indicators

Activity Indicators ULHT																					
Metric	Threshold			Data Source/ Standard	Link to Tab	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Average Percentage	SPC Special Cause identified	Comments
	R	A	G																		
Total Number of bookings				Careflow Maternity (CM)	Bookings	480	437	431										1348			
Women booked by 9+6 weeks	<67.50%		>67.50%	CM/HES Data 2021	BookedBy9+6	71.25%	72.31%	70.07%											71.21%		
Women booked onto Continuity Pathway				CM/ULHT default plan	BookedToCoCo	23.96%	25.63%	24.59%											24.73%		
BMI >25 at Booking				CM/PHE 2018	BMIBooking	55.00%	55.61%	59.63%											56.75%		
BMI >35 at Booking				CM/PHE 2018		11.88%	13.27%	15.31%											13.49%		
BMI >40 at Booking				CM/PHE 2018		3.13%	5.95%	6.26%											5.11%		
Total number of Births				CM	BirthNumbers	368	385	379										1132			
Total Number of Live Births				CM		366	382	379										1127			
Unassisted Vaginal Birth Rate				CM/HES Data 2020	NVB	49.73%	48.05%	51.98%											49.92%		
Home Birth Rate	<2.40%		≥2.40%	CM/ONS 2020	HomeBirth	2.99%	2.60%	0.79%											2.13%		
Forceps and Ventouse				CM/HES Data 2020	Forcep&Ventouse	8.97%	7.79%	8.71%											8.49%		
Total Caesarean Section Rate				CM	Caesarean	40.76%	43.38%	37.73%											40.62%		
Emergency Caesarean Section				CM		23.91%	27.79%	24.80%											25.50%		
Elective Caesarean Section				CM		16.85%	15.58%	12.93%											15.12%		
Women booked on Continuity Pathway received care in labour/birth by continuity Team				CM/NHSIE	ContinuityCare	28.13%	30.91%	23.66%											20.67%		
Induction of Labour Rate	>40%		≤40%	CM/HES Data 2021	IoL	36.07%	37.43%	37.00%											36.83%		
Smoking at Booking				CM/MSDS 2021	SmokingBooking	11.46%	12.13%	11.83%											11.81%		
Smoking at the time of Delivery	>6%		<6%	CM/NHSE 2023	SmokingDelivery	8.74%	9.16%	9.65%											9.19%		

4.2 Maternal morbidity indicators

Maternal Morbidity Indicators ULHT																					
Metric	Threshold			Data Source/ Standard		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Average Percentage	SPC Special Cause identified	Comments
	R	A	G																		
PPH ≥1.0 litre	>8.60%		<8.60%	CM/Obs CYMRU	PPH>1l	13.39%	12.04%	9.38%											11.60%		
PPH ≥1.0 litre SVB	>4.90%		<4.90%	CM/Obs CYMRU	PPH>1lSVB	4.73%	8.77%	5.24%											6.25%		
PPH ≥1.0 litre Instrumental	>18.40%		<18.40%	CM/Obs CYMRU	PPH>1lInstrumental	24.24%	10.00%	15.15%											16.46%		
PPH ≥ 1.0litre EL/LCS	>8.50%		<8.50%	CM/Obs CYMRU	PPH>1lEL/LSCS	12.90%	13.33%	10.20%											12.15%		
PPH ≥ 1.0litre EM/LSCS	>19.80%		<19.80%	CM/Obs CYMRU	PPH>1lEM/LSCS	28.41%	18.69%	15.96%											21.02%		
PPH ≥1.5 litre	>3.30%		<3.30%	CM/Obs CYMRU	PPH>1500	4.10%	3.66%	2.95%											3.57%		
PPH ≥2.0 litre	>1.30%		<1.30%	CM/Obs CYMRU	PPH>2l	1.09%	0.79%	1.07%											0.98%		
3rd and 4th degree Tear	>3%		≤3%	CM/OASI post-bundle stats	3rd4thDegTears	3.24%	2.33%	3.04%											2.87%		From Apr 24 only includes vaginal & instrumental births
Admission to ITU	≥1		0	Inpatient Matron	ITU	0	1	0										1			
No of PN Readmissions up to 42 days of birth	>3.30%		<3.30%	Self serve/ NMPA 2022	PNReadmissions	3.83%	5.24%	4.02%											4.36%		

4.3 Neonatal mortality and morbidity indicators

Neonatal Mortality & Morbidity Indicators ULHT																					
Metric	Threshold			Data Source/ Standard		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Average Percentage	SPC Special Cause identified	Comments
	R	A	G																		
Unexpected Term admissions to the NICU (based on Term births)	>6%		<6%	CM/ATAIN National target	UnexpectedNICU	4.96%	6.67%														Reports 1 month behind
No. of babies transferred for therapeutic cooling	≥1		0	NNU	Cooling	0	0	0										0			
Pre-Term Birth 22+0-36+6 wks	≥10%		<10%	CM/SBL	PreTerm	6.25%	6.49%	7.12%											6.62%		
No. of Antenatal stillbirths	≥1			CM	AntenatalSB	2	1	0										3			
No. of Intrapartum stillbirths	≥1			CM	IntrapartumSB	0	0	0										0			
Rolling stillbirth rate (12 months)	>3.8 per 1000		≤3.8 per 1000	CM/ONS 2020	RollingSB	2.94	2.93	2.69													
No. of NND (from 22+0 weeks)	≥1			CM and NNU	NoNND	0	0	1										1			
Rolling NND rate from 22+0 weeks (12 months)	>2.2 per 1000		≤2.2 per 1000	CM and NNU/ONS 2020	RollingNND	1.58	1.58	1.57													
AN Steroids Eligible / Full course Administered	<55%		>55%	NNU	ANSteroids	28.57%	33.33%	42.86%											34.92%		
AN Magnesium Sulphate Eligible / Administered	<90%		>90%	NNU	ANMagSulph	#N/A	50.00%	0.00%													
SGA detection rate	< 41.2%		>41.7%	ANC/SBL Perintatal Institute	SGA	60.42%	50.00%	59.32%											56.58%		

4.4 Workforce indicators, including training compliance

Workforce Indicators ULHT																					
Metric	Threshold			Data Source/ Standard		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Average Percentage	SPC Special Cause identified	Comments
	R	A	G																		
Midwife to Birth Ratio (funded)	01:27		01:26			01:26	01:26	01:26													
Midwife to Birth Ratio (Actual)	01:27		01:26			01:25	01:26	01:26													
1-1 in labour	<100%		>100%	CM/CNST	1-1Labour	100.00%	99.42%	100.00%											99.81%		
Sickness Rate	>4.3%		<4.3%	Workforce Intelligence	Sickness	4.02%	4.46%	4.90%											4.46%		
Co-ordinator Supernumerary	<100%		>100%	Inpatient Matron/CNST	Co-ordinator	99.00%	99.30%	97.40%											98.57%		
Prompt Training Compliance	<90%		≥90%	CE team/ CNST	PROMPT	94.77%	91.12%	89.52%											91.80%		
Mandatory Training Compliance	<90%		≥90%	CE team/ CNST	MMTD	94.87%	95.93%	91.88%											94.23%		

		Trained	Possible	%
PROMPT	Lincoln MW	154	164	93.90
	Lincoln Drs	30	33	90.91
	Lincoln Anaes	15	16	93.75
	Lincoln HCSW/MSW	45	46	97.83
	LCH Prompt	244	259	**94.21**
	Bank Only MW (Trustwide)	20	21	**95.24**
	On Call Anaes (Trustwide)	4	18	**22.22**
	Pilgrim MW	97	107	90.65
	Pilgrim Drs	29	31	93.55
	Pilgrim Anaes	9	13	69.23
	Pilgrim HCSW/MSW	24	28	85.71
	PHB Prompt	159	179	**88.83**
	Trust Compliance Prompt	427	477	**89.52**
NLS (Midwives)	Lincoln	152	164	93.00
	Pilgrim	96	107	89.72
	Trust compliance NLS (Midwives)	248	271	**91.51**
Fetal Surveillance and Human Factor	Lincoln MW	160	164	97.56
	Lincoln Drs	27	27	100.00
	LCH FS & HF	187	191	**97.91**
	Pilgrim MW	103	107	96.26
	Pilgrim Drs	22	23	95.65
	PHB FS & HF	125	130	**96.15**
	Trust Compliance FS & HF	312	321	**97.20**

4.5 Postnatal indicators

Postnatal Indicators ULHT																					
Metric	Threshold			Data Source/ Standard		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Average Percentage	SPC Special Cause identified	Comments
	R	A	G																		
Skin to Skin Contact at Birth	<80%		≥80%	CM/BFI 2024	SkinToSkin	77.87%	71.99%	79.42%											76.43%		
Breastmilk at first feed	<72.9%		≥72.9%	CM/HES 2021	FirstFeed	67.23%	65.60%	65.03%											65.95%		

4.6 Risk management indicators

Risk Management Indicators ULHT																					
Metric	Threshold			Data Source/ Standard		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Average Percentage	SPC Special Cause identified	Comments
	R	A	G																		
No. of unit closures	≥1		0	Inpatient Matron		1	1	2										4			
No. of PSII's	≥1		0	Risk		0	0	2										2			
No of AAR's	≥1		0	Risk		0	0	1										1			
No. of Never Events	≥1		0	Inpatient Matron		0	0	0										0			
No of MNSI (from Nov 23)	≥1		0	Risk		4	3	2										9			
PMRT commenced within CNST timeframe	<95%		≥95%	Bereavement Midwife		100.00%	100.00%	100.00%											100.00%		
PMRT completed within CNST timeframe	<50%		≥50%	Bereavement Midwife		100.00%	100.00%	100.00%											100.00%		
No of current coroners cases / inquests pending				Legal		0/1	0	0										0			
No of coroners Regulation 28 (prevention of future death reports) made direct to the trust)				Legal		0	0	0										0			
No of Formal Complaints				Complaints		3	2	2										7			

Item 5: Neonatal dashboard

United Lincolnshire Hospitals NHS
NHS Trust

Neonatal Quality and Safety Dashboard - 2024/2025

Lincoln County Hospital

	Performance Measure	Source	2021/22 Monthly Avg	2022/2023 Monthy Avg	2023/2024 Monthy Avg	YTD/ Average	Apr 2024	May 2024	June 2024	July 2024	Aug 2024	Sept 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Total	
Neonatal Unit	Live Births	Maternity	234.3	233.2	227.5	235.7	232	236	239										707	
	No of all NNU Admissions (including re-admissions, transfers in, etc)	Badger	30.9	29.8	28.3	24.3	21	28	24										73	
	No of First Episode Admissions	Badger	24.9	23.8	22.6	21.0	19	22	22										63	
	% of First Episode Admissions against Live Births		10.6%	10.1%	9.9%	8.9%	8.2%	9.3%	9.2%										N/A	
	No of Admissions to TC	Badger	18.3	19.0	13.4	16.3	18	11	20										49	
	All Ex-utero transfers	Badger	5.8	5.3	4.4	2.3	1	3	3										7	
	Ex-utero transfers <27 weeks	Badger	0.1	0.3	0.6	0.0	0	0	0										0	
	In-utero transfers	Maternity	0.9	0.8	1.1	1.3	1	1	2										4	
	In-utero transfers <27 weeks	Maternity	0.5	0.5	0.5	0.7	0	0	2										2	
	NNU Term Admissions	Badger	14.2	13.8	13.0	13.7	11	15	15										41	
	Term Live Births	Maternity	215	216	209	222.0	215	224	227										666	
	% NNU Term Admissions (Live Term births) - Target <5%		6.5%	6.4%	6.2%	6.0%	5.1%	6.7%	6.3%										N/A	
	Avoidable Term Admissions - total				0.8	1	1	1	Under review										2	
	Avoidable Term Admissions - %				7.9%	7.8%	9.0%	6.6%	Under review										0	

United Lincolnshire Hospitals NHS
NHS Trust

Neonatal Quality and Safety Dashboard - 2024/2025

Lincoln County Hospital

	Performance Measure		Source	2021/22 Monthly Avg	2022/2023 Monthy Avg	2023/2024 Monthy Avg	YTD/ Average	Apr 2024	May 2024	June 2024	July 2024	Aug 2024	Sept 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Total	
Neonatal Unit - continued	Cot Occupancy - %	NNU	Badger	69%	71%	67%	57%	48.4%	64.1%	58.4%										N/A	
		TC	Badger	45%	43%	37%	38%	47.5%	24.6%	41.7%										N/A	
		Total (NNU & TC)		61%	63%	56%	50%	48.1%	50.4%	52.6%										N/A	
	Hypothermia on Admission - Ep.1 (<36.5◦c)	NNU	Badger	2.3	1.2	2.5	2	1	2	2										5	
		TC		1.3	1.9	0.7	1	1	1	1										3	
	(% of first episode admissions)	NNU %		0.1	4.6	10.1	7.7%	5.2%	9.0%	9.0%										N/A	
		TC %		0.1	9.6	4.7	6.5%	5.6%	9.0%	5.0%										N/A	
	Transferred for Therapeutic Cooling		Badger	0	0	0.5	0.0	0	0	0										0	
	HIE (all grades)		Badger	0.5	0.3	0.4	0.0	0	0	0										0	
	Neonatal Deaths (following admission to NNU)		Badger	0.1	0.0	0.0	0.3	0	0	1										1	
	Neonatal Deaths (delivery room)				0.1	0.4	0.3	0	1	0										1	
	Unit Closures (any)		Ward Manager	0.0	0.0	0.1	0.0	0	0	0										0	
	No. of Exceptions		Ward Manager	1.8	1.1	1.3	0.3	1	0	0										1	
	Medication Errors (no/low harm)⊡						1.3	1	2	1										4	
	Medication Errors (moderate and above)					0.0	0.0	0	0	0										0	
	Patient Safety Learning Event (previously SI)		Qual. & Eff. Support Manager	0.1	0.0	0.1	0.0	0	0	0										0	

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Staffing	Appraisals - % (Target 100%)	Registered and unregistered	Ward Manager	86%	89%	76%	0.9	93.0%	100%	90%										N/A	
		ANNPs	Matron	71%	79%	62%	81.67%	78.0%	78.0%	89.0%										N/A	
	Sickness - % (Target - Trust avg <4%)	Registered and unregistered	ESR	6.8%	6.8%	5.2%	0.1	6.1%	8.3%	6.1%										N/A	
		ANNPs	ESR	4.9%	9.7%	3.1%	0.1	7.6%	5.9%	1.8%										N/A	
	Mandatory training % (Core Learning) (Target >95%)	Registered and unregistered	ESR	90%	95%	93%	94.2%	93.0%	94.2%	95.4%										N/A	
		ANNPs	ESR	90%	94%	96%	0.9	94.0%	95.0%	95.0%										N/A	
	Mandatory training % (Core Learning Plus) (Target >95%)	Registered and unregistered	ESR	86%	90%	89%	0.9	93.0%	94.2%	95.4%										N/A	
		ANNPs	ESR	86%	87%	93%	0.9	90.0%	92.0%	92.0%										N/A	
	BLS (Target >95%)		ESR	77%	82%	76%	0.7	56.0%	71.0%	79%										N/A	
	QIS - % WTE (Target >70%)		Ward Manager	64%	64%	46%	0.5	49.0%	53.0%	53.8%										N/A	
	No. of QIS in training - WTE		Ward Manager	2.3	1.6	3%	0.0	2.2%	2.6%	2%										N/A	
	% staff with in-date NLS (Target 100%)		Ward Manager	90%	100%	99%	1.0	98.2%	98%	98%										N/A	

Neonatal Quality and Safety Dashboard - 2024/2025

Pilgrim Hospital, Boston

	Performance Measure	Source	2021/22 Monthly Avg	2022/2023 Monthly Avg	2023/2024 Monthly Avg	YTD/ Average	Apr 2024	May 2024	June 2024	July 2024	Aug 2024	Sept 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Total	
Neonatal Unit	Live Births	Maternity	149.8	142.5	137.4	140.7	134	148	140										422	
	No of all NNU Admissions (including re-admissions, transfers in, etc)	Badger	18.2	17.1	19.4	16.0	10	18	20										48	
	No of First Episode Admissions	Badger	15.9	15.1	15.9	13.3	10	13	17										40	
	% of First Episode Admissions against Live Births	Maternity	10.6%	10.6%	11.6%	9.5%	7.5%	8.8%	12.1%										N/A	
	No of Admissions to TC	Badger	6.7	7.1	6.9	9.3	12	8	8										28	
	All Ex-utero transfers	Badger	1.9	2.1	2.7	1.3	0	2	2										4	
	Ex-utero transfers (<32 weeks)	Badger	0.8	0.6	0.8	1.0	0	2	1										3	
	All in-utero transfers	Maternity	0.7	0.8	1.0	1.3	1	2	1										4	
	In-utero transfers (<32 weeks)	Maternity	0.4	0.8	0.7	1.0	1	1	1										3	
	NNU Term Admissions	Badger	9.4	8.7	10.3	7.3	6	9	7										22	
	Term Live Births	Maternity	139	132	128	130	128	136	125										389	
	% NNU Term Admissions (Live Term births) Target <5%	Maternity	6.7%	6.6%	8.1%	5.4%	4.7%	6.6%	5.0%										N/A	
	Avoidable Term Admissions - total	Matron			1.7	1	0	2	Under review											
	Avoidable Term Admissions - %	Matron			14.7%	11%	0.0%	22.2%	Under review											

Neonatal Quality and Safety Dashboard - 2024/2025

Pilgrim Hospital, Boston

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Neonatal Unit - continued	Cot Occupancy - %	NNU	Badger	42%	38%	43%	47%	45.0%	48.0%	47.1%										N/A	
		TC	Badger	51%	55%	52%	55%	54.2%	43.5%	68.3%										N/A	
		Total (NNU & TC)		45%	43%	46%	50%	48.1%	46.5%	54.2%											
	Hypothermia on Admission - Ep.1 (<36.5◦c) (% of first episode admissions)	NNU	Badger	2.5	1.5	1.7	2.3	2	3	2										7	
		TC		0.4	0.2	0.6	0.3	0	0	1										1	
		NNU %		0.2	10.8	9.0%	18%	20.0%	23.0%	11.7%										N/A	
		TC %		0.1	3.3	5.8%	4%	0.0%	0.0%	12.5%										N/A	
	Transferred for Therapeutic Cooling		Badger	0.1	0.1	0.0	0	0	0	0										0	
	HIE (all grades)		Badger	0.2	0.1	0.0	0	0	0	0										0	
	Neonatal Deaths (following admission to NNU)		Badger	0	0	0.0	0	0	0	0										0	
	Neonatal Deaths (delivery room)				0	0.1	0	0	0	0										0	
	Unit Closures (any)		Ward Manager	0	0	0	0	0	0	0										0	
	No. of Exceptions		Ward Manager	1.8	1.2	1.3	2	0	4	2										6	
	Medication Errors (no/low harm)						1	0	1	2										3	
	Medication Errors (moderate and above)						0	0	0	0										0	
	Patient Safety Learning Event (previously SI)		Qual. & Eff. Support Manager	0	0	0	0	0	0	0										0	

Neonatal Quality and Safety Dashboard - 2024/2025

Pilgrim Hospital, Boston

	Performance Measure		Source	2021/22 Monthly Avg	2022/2023 Monthly Avg	2023/2024 Monthy Avg	YTD/ Average	Apr 2024	May 2024	June 2024	July 2024	Aug 2024	Sept 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Total	
Staffing	Appraisals - % (Target 100%)	NNU	Ward Manager	83%	73%	92%	89%	96.0%	85.0%	86%										N/A	
		Outreach	Lead Nurse			83%	100%	100%	100%	100%											
	Sickness - % (Target - Trust avg <4%)	NNU	Ward Manager	6.3%	10.5%	6.6%	12%	12.5%	12.1%	9.9%										N/A	
		Outreach	Lead Nurse			8.5%	1%	0%	0%	3.2%											
	Mandatory training % (Core Learning) (Target >95%)	NNU	Ward Manager	98%	98%	98%	97%	96.5%	97.0%	97.0%										N/A	
		Outreach	Lead Nurse			94%	96%	98.0%	100%	91.0%											
	Mandatory training % (Core Learning Plus) (Target >95%)	NNU	Ward Manager	96%	96%	95%	93%	94.0%	94.0%	91.0%										N/A	
		Outreach	Lead Nurse			93%	91%	90.0%	93.0%	90.0%											
	BLS (Target >95%)	NNU	Ward Manager	96%	93%	95%	92%	86.0%	95.0%	95%										N/A	
		Outreach	Lead Nurse			84%	100%	100%	100%	100%											
	QIS - % WTE (Target >70%)		Ward Manager	70%	74%	69%	65%	64.0%	64.0%	68.0%										N/A	
	No. of QIS in training - WTE		Ward Manager	1.5	1.1	0.8	0.5	0.8	0.8	0										N/A	
	% staff with in-date NLS (Target 100%)	NNU	Ward Manager	98%	99%	97%	90%	90.0%	90.0%	90.0%										N/A	

Item 6: Learning lessons

6.1 Incidents overview

Incidents *As of 9th July 2024*	**Obstetrics and community midwifery**	**Neonates**	**Actions being taken**
Patient safety incidents reported May-June '24 by severity	No Harm: 180 Low Harm: 55 Moderate Harm: 1 Fatal: 0	No Harm: 17 Low Harm: 1 Moderate Harm: 0 Fatal: 0	
Open incidents on Datix	Open: 213 Overdue: 128	Open: 16 Overdue: 5	Datix's monitored by the risk team to try and improve the compliance with timeframes.
Open MNSI	3		
PSII	3 (All MNSI investigations)	0	All PSII are MNSI cases, therefore external investigations
AAR	1	0	AAR report written, a/w trust sign off
Outstanding Duty of Candour	0	0	
PMRT (Jan-March 2024)	Stillbirths: 2 Late fetal losses: 1 Neonatal deaths: 2 ULHT reviews: 5 External reviews: 0		For individual actions from published reports, please see quarterly report.
Overdue actions	17 overdue for Obstetrics		Re-viewed weekly at the action review meeting with divisional and corporate governance teams.
Accumulative Patient Event Numbers 8th Dec '23 – 30th Nov '24 (CNST year 6)			
MNSI - 2	Qualifies for Early Notification - 1	DOC verbal and written (including EN and MNSI information) – 2	

6.2 Learning lessons update

Appendix 1.3

6.3 Detail of incidents graded moderate or above

MNSI number	Qualify for EN? If Yes, include reference	Have the family received notification of role of MNSI/EN?	Compliant with Duty of candour?	Details/update
MI - 036719	Yes	Notification of both	Yes, written and verbal	Report published, 3 safety recommendations: 1) The trust to ensure there is a robust system that supports IOL to be booked for the gestation that has been agreed and staff are supported to use this. 2) The Trust to ensure that Mothers are provided with information and discussion about the risks, benefits and options once a pregnancy reaches 41+0 weeks to support their involvement in the decision for and the timing of IOL. 3) The Trust to update the intrapartum fetal monitoring guideline and cardiotocograph (CTG) assessment tool in line with national guidance, to support robust interpretation of fetal heart rate tracings.
MI - 037281	No	MNSI (don't qualify for EN)	Yes, written and verbal	AAR held 25/5/24. TOR received from MNSI and currently staff interviews being undertaken.
MI - 037631	Yes	Notification of both	Yes, written and verbal	Referred on the 8/7/24. Timeline circulated and AAR to be arranged

Datix number and detail	Obstetric/ Neonatal	Grading (Moderate or above, cases considered at PSRP, AARs, PSII)	Learning/action taken/update
13024 – Maternal and fetal hyponatraemia, baby transferred to level 3 care due to having seizures. Had ECMO at Leicester and treated for sepsis. Returned to Lincoln to complete course of IVAB's and then discharged home	Obstetrics	Low Harm: Initially discussed with MNSI but didn't meet the criteria as baby wasn't actively cooled.	Thematic review to be done and findings presented at PSRP meeting.

		Discussed at PSRP meeting and thematic review to take place of all hyponatraemia cases as highlighted as a theme.	
314 – MNSI case for closure at trust level: MCDA pregnancy, TTTS and had ablation at 17 weeks, twin 1 demise post ablation. Cardiac Arrest at home, intubated at home and brought to A&E. Confirmation of demise of 2nd twin by USS. Transferred to ICU, on CTPA large PE. Twins delivery with PPH in ICU, patient treatment withdrawn in consultation with the family. Patient died in ICU.	Obstetrics	Fatal: MNSI report published and no safety recommendations. Action plan developed for divisional learning.	Taken to Patient Safety Executive Oversight meeting, HSIB report and action plan presented and closed by the trust. ***CASE CLOSED***
15815 – 32 weeks inpatient for PSROM, reported blood stained liquor, cat 2 EM LSCS, baby born pale and resuscitation required. Transferred to NNU, but treatment withdrawn and NND at 1 hour and 32 mins old.	Obstetrics	Low Harm: Taken to PSRP meeting, to follow the PMRT process	PMRT meeting planned for 22/7/24

6.4 Key themes & trends

Theme/trend	Additional actions being taken
Noted increase in reactions to Monofer	Reviewing Datix and claims Benchmarking Ferrinjet and Monofer Patient information leaflet on staining and fish boning
Hyponatraemia and vomiting in labour and late pregnancy	Highlighted with several cases of hyponatraemia over the past year. There is very poor compliance with fluid balance completion in labour and postnatally. Safety team to carry out a QSI project to improve compliance.
IOL issues highlighted in the last MNSI report published	IOL pathway being reviewed and QSI project being carried out by the Patient Safety Team which will incorporate the MNSI recommendations.

Item 7: Listening to our families

7.1 Feedback

Feedback type	Obstetrics and community midwifery	Neonates	Comments/actions
Open complaints	1	1	
Overdue complaints	0	0	
Open PALS contact	0	0	7 logged in June
Overdue PALS contact	0	0	
Compliments (SUPERB)	12	15	
Social media	May-June- 99		
Maternity and Neonatal Voices Partnership – ***see Appendix 1.4 & 1.5***	• MNVP meetings continue. • Feedback reviewed to identify themes. • Notice boards in maternity reviewed and updated with MNVP input.		
Family and Friends Test	• For 2023/24, the Trust average was 87% against a national average of 93%. Maternity achieved 98% (includes Neonates) • For May 2024, the Trust average was 89% against a national average of 93%. Maternity achieved 100% (includes Neonates)		
Family Health Patient Experience Meeting escalation	• Good work going on within all areas. • The name 'Maternity' can be distressing for those women coming in for miscarriage/termination. Shows gender inequality – Discussion regarding renaming the tower at Pilgrim and the refurbishment works when complete at Lincoln – call it another name?		

7.2 Key themes & trends

Theme	Additional actions being taken
Lack of help/support with feeding	Conversations with LMNS around additional feeding support/peer supporter
Values and behaviours – new theme	Deep dive undertaken -spike in Nov 23 – Feb 24. Spread across all areas. Monitor through Patient Experience

Item 8: Listening to our staff

8.1 Annual survey

Source	Statement	2018	2020	2021	2022	2023
NHS Staff survey	Proportion of midwives responding with 'agree or strongly agree' on whether they would recommend their trust as a place to work or receive treatment	34.6% 42.3%	59.8% 61.7%	55.1% 54.2%	57.7% 61%	57.52% 57.52%
GMC National Training Survey	Proportion of speciality trainees in Obstetrics and Gynaecology responding with 'excellent or good' on how would they rate the quality of clinical supervision out of hours	87.5% (2019)	No data	78.79%	86.88%	88.89%

Green=increase, Amber=decrease

8.2 SCORE survey

On going work to set up listening events with the staff that were trained during the perinatal culture and leadership programme.

Discussion to set up staff experience group to mirror the Patient experience Group

8.3 Feedback

Feedback type/source	Number/detail	Comments/actions
Greatix	May-June: 35	
Staff surveys		SCORE as above
Freedom to Speak Up		No escalations
NED		See separate report

Appendix

1.1 – NEWTT2 Implementation Poster
1.2 – NNAP Report Jan-March 2024 v1
1.3 – QG4 July 2024 Neonatal Trustwide Audit Lead Report
1.4 – MNVP Feedback May 2024 Update
1.5 – MNVP Feedback June 2024 Update

Family Health Division
Maternity Services
Birth Rate Plus / Workforce Action Plan

Governance Meeting responsible for oversight: Family Health Cabinet Meeting

Responsible Leads: Libby Grooby, DoM. Emma Upjohn, HoM

Key: BLUE=COMPLETE, GREEN=ON TRACK, AMBER=COMMENCED NOT REACHING TIMESCALE, RED=NOT STARTED/ TIMESCALE PASSED

Background

Current BR+ report (received April 24) highlighted a deficit of 12.10WTE midwives across the service. The report included the recommendation of the provision of a 24hr triage service and the deficit in midwives appears to be from the funding of this service. This service is not currently in place on either site.

CNST Yr 6 - In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls.

ULHT are funded to 2021 BR+ and received the new report in 2024. The action plan below demonstrates the plan to achieve the uplift recommended.

No.	Objective	Action	Lead	Timescale	Progress	Evidence	RAG
1.	Review triage and antenatal assessment services across ULHT in line with BSOTS	Appoint band 7 to lead on Triage and AAC	Matron	August 24	Band 7 appointed and due to commence in post August	Band 7 in post	
		Review service in line with BSOTS standards	Band 7 triage	December 24	Awaiting Band 7 start		
		Recommendations/ report around provision of service to be written	Band 7 triage	December 24	Awaiting Band 7 start		
		Report to be presented to MNOG/ LMNS to gain approval	Band 7 triage	January 25	Awaiting Band 7 start		
		Business case process to be followed to gain agreement to proceed	Band 7 triage/ Matron	February 25			

V1
Libby Grooby
Date: 11.7.2024

No.	Objective	Action	Lead	Timescale	Progress	Evidence	RAG
		Start recruitment process once agreed	Band 7 triage/ Matron	June 25	Aim to have new starters in post end June 25		
2.	Maintain safe staffing in the period before uplift agreed and staff recruited	Daily staffing huddle to review staffing across all sites and areas. Twice weekly forward staffing review to ensure all services appropriately covered. Robust escalation policy in place Monitoring of incident reporting related to staffing	Matrons	Continue until uplift agreed	All actions in place and ongoing	Daily huddle reports Escalation policy Incident reports	

Family Health Division

Neonatal Qualified in Speciality (QIS) Improvement Plan

Governance Meeting responsible for oversight: Family Health Cabinet Meeting

Responsible Leads: Cathy Franklin, Rachel Wright

Key: BLUE=COMPLETE, GREEN=ON TRACK, AMBER=COMMENCED NOT REACHING TIMESCALE, RED=NOT STARTED/ TIMESCALE PASSED

No.	Objective	Action	Lead	Timescale	Progress	Evidence	RAG
1.	To ensure ULHT Neonatal establishment meets BAPM Standards nursing ratios: 1:4 Special care 1:2 High dependency 1:1 Intensive Care	1. To monitor acuity and dependency daily 2. To utilise RAG scoring system and escalation process as per policy and guidelines 3. Monitor and action as per peer review recommendations 4. Meeting with Finance monthly to	Matron	ongoing	**26/07/2024** Opel status completed daily and capacity discussed through network capacity and Trust safer staffing meetings Vacancies for B6 out to advert Governance Lead interviews Monday 29th July 2024 B5 vacancies to be advertised through Trac	Badger staffing Network Opel and safety huddles. FH staffing Report to be added when received.	

No.	Objective	Action	Lead	Timescale	Progress	Evidence	RAG
	Source of Recommendation: Neonatal Toolkit (DoH 2009)	monitor vacancy – pipeline for recruitment 5. Input staffing data into Badger and review compliance quarterly through network governance 6. complete workforce tool on a quarterly basis 7. Complete training needs analysis for identification of funding 8. Staff to undertake QIS training through various providers 9. Complete training trajectory 10. Utilise specialist nurses and Ward			Nursery Nurse workforce to be discussed w/c 29/07/24 and actioned through workforce planning Ward Manager monitoring staffing levels on a daily basis	Budget and Governance ELOD TNA Copy of ULHT Lincoln workforce tool Q4 20: Copy of ULHT Pilgrim workforce tool Q4 20: Copy of new QIS trajectory LCH 2024.x	

No.	Objective	Action	Lead	Timescale	Progress	Evidence	RAG
		Manager during periods of high acuity 11. Datix and monitor themes in relation to staffing concerns 12. Ensure lack of QIS is identified on risk register				Risk register/ Governance	
2.	A minimum of 70% of the registered nursing and midwifery workforce establishment hold an accredited post registration qualification in specialised neonatal care (QIS)	Develop trajectory plan Source multiple providers To gain divisional approval and funding Monitor monthly via Neonatal Dashboard	PDN/Education team	March 2025	**26/07/24** Trajectory completed RNs accessing QIS training from Nottingham, Nottingham Trent and De Montfort – Funding received through LBR QIS metric included in Neonatal monthly dashboard Staff access the network foundation course	LCH June 24 Neonatal Dashboard.p PHB June 24 Neonatal Dashboard.p	

No.	Objective	Action	Lead	Timescale	Progress	Evidence	RAG
	Source of Recommendation: Neonatal Toolkit (DoH 2009)				Revamp of eligibility of staff to undertake QIS currently underway		
3.	To implement an education strategy across ULHT Neonatal Services to meet the BAPM and national standards *Source of Recommendation: Neonatal Toolkit (DoH 2009)* *Peer Review 2018 and 2019*	1 – To complete an education strategy 2 – To complete annual training needs analysis through appraisal process 3 – To complete and update education plan monthly, through governance process 4 – QIS trajectory 5 – Monthly in-house multi-disciplinary development days facilitated through the Education Team	Matron/ Ward Managers/ PDN/ Clinical Educators	Dec 2020 Reviewed July 2024	Monthly education plan updated/escalated through speciality governance. TNA in progress QIS trajectories completed. Monthly in house development days commenced. SIM programme in place across both sites	Education Plan Version 2 August 20	

No.	Objective	Action	Lead	Timescale	Progress	Evidence	RAG
		6 – Monthly multi-professional SIM training 7 – To utilise opportunities available through ULHT Talent Academy, through staff appraisals 8 – To implement competency document for succession planning and development.			Matron commencing Senior Leadership Masters course through University of Lincoln- January 20th 2020 – Funded through ULHT Talent Academy To utilise RCN competency documents Working collaboratively with maternity education team to access multi professional training		

V2
Cathy Franklin
Rachel Wright
Date: 25/07/24

NED Maternity & Neonatal Safety Champion's Report: May – June 2024

Executive summary:
The role of the Maternity & Neonatal Champions is to provide proactive Board level leadership to ensure that: • High quality clinical care • Maternity & neonatal service & facilities • Workforce numbers • Learning & training systems (includes ensuring authentic engagement with service users and ensuring the service acts upon their feedback) • Effective team working are all in place. This Maternity & Neonatal Safety NED Champion's report aims to report and provide assurance in support of the above areas. Where required, the report will include risks and concerns requiring escalation as well as good practice, improvement, and innovation.
Activities undertaken:
Since the last report, the MNSC NED attended the following meetings: 7th May – Public Group Board 7th May – Private Group Board 7th May – NED Briefing 8th May - 1:1 with Group Chair 14th May – Maternity Safety Champion Virtual Clinic 21st May – Board Development Session 21st May – Group Quality Committee 21st May 1:1 Director of Governance 23rd May – Lincolnshire MNVP Meeting 28th May – 1:1 Director of Midwifery 3rd June – Maternity Neonatal Oversight Group Meeting 4th June – Internal Senior Stakeholder Panel Group Chief Nurse 10th June – Lincolnshire LMNS Board Meeting 11th June – Maternity Safety Champion Virtual Clinic 13th June – Pre meet with Regional Maternity Team 14th June – Audit Committee 18th June – Group Quality Committee 24th June – Armed Forces Symposium Since the last report the MNSC NED spent time involved in planning the following items: • Next sessions for the Regional Maternity Safety Champions • Promoting an improvement program for Nettleham via the preceptees meeting.

Learning Lessons:	Service User Voice Feedback:	Staff Experience & Feedback:
• Building on continuity of care teams, targeting towards areas greatest need – 4 teams now in place including Skegness • Consolidated improvement plan and ensuring evidence objectively reviewed prior to sign off. • Completing CNST evidence and sign off by the MNOG,LMNS and Trust Board. • Newsletter improving communication. • Detailed deep dives continue to take place and lessons learnt and improvements are acted on timely • Incident Review Meetings are in place and are proactive to identify lessons learnt	• Sensitivity when safeguarding referral is required including documentation and communication with families • Environmental issues at both maternity sites. • Good CQC Survey, which will be used to review current provision and actions, added to the Improvement Plan. • MNVP feedback from varies sites and events. All very positive. Key areas of additional support required is feeding. • Individual mum's story on transfer from Peterborough. Excellent feedback for the Spalding Team.	• Continued concerns about the Medway IT system the need to keep staff informed of progress • Strong Visibility of Senior leadership team • Positive recruitment but recognition that training is putting pressure on staff (staff not complaining as pleased to have new colleagues) • Environmental issues that require progressing as a priority, Pilgrim site – Theatre provision, sanitation pipe leaks and smell – currently being addressed. • FTSU concerns raised and triangulated with NED visits feedback. • Excellent Team ethos • Pride of staff • Not taking breaks and late finishing causing fatigue in staff • Increase clinical risk of mums putting pressure on all staff • Concerns raised of the professional clashing of Midwives and Medical teams • Increased language and cultural barriers • Medical support not used

Good practice, improvements & innovation to share:
• Excellent results within Maternity Regional League Table • Dedication and delivery of the Military Voices and Military Maternity Coordinator • Candour of staff • Correlation with HOM on staff issues and concerns • Strengthening research within the department • Relationship with University • Completion of Birth Rate Plus Staffing bench marking tool – full review of unplanned pathway expected prior to requesting staffing uplift.

- MNVP feedback Newsletter is excellent and shared widely to ensure feedback used to improve services.
- Excellent user feedback for Neonatal services
- Short Listed for two regional awards
- Excellent recruitment to senior roles
- Extended Practise (wound Care)

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

Ongoing

- Funding of the Pelvic Health Service particular focus on birth trauma
- Cultural Sessions require further work due to miscommunication
- Status and timing of capital plans at Lincoln site, Status, timing, and disruption of capital works at Pilgrim site
- Implementation of new maternity IT system – System purchased and implementation plan in place.
- Relationship and workload issues between Labour Ward and Nettleham.
- Medical Cover over night and limited cover on antenatal ward

Activities planned:

- Improve utilisation of the Virtual Clinics
- Attending Teddy Bear Armed Forces Picnic
- Chair Regional Meeting
- Revisit Skegness Maternity Team

Outstanding from last report

- Compile a video for social media to share the role of the Maternity and Neonatal Safety Champion role and to publicise the virtual drop in clinics

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

Report to the Lincolnshire Community and Hospitals Group Board Meeting

Date of meeting	3rd September 2024	Agenda item	8.2
Title	2023/24 Safeguarding Annual Report		
Report of	Nerea Odongo, Group Chief Nurse	Prepared by	Nerea Odongo, Group Chief Nurse
Previously considered by / Date	Quality Committee in Common 20th August 2024	Approved?	Yes
Summary	The Quality Committee in Common reviewed the 2023/24 Safeguarding Annual Report at the meeting held on 20th August 2024, the Board are recommended to approve the Annual Report for publication.		

1. To deliver high quality, safe and responsive patient services	**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	
	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	*Not applicable*					
Legal/ Regulation	*Not applicable*					

Recommendations/ Actions Required

The Board are recommended to approve the 2023/24 Safeguarding Annual Report

Appendices

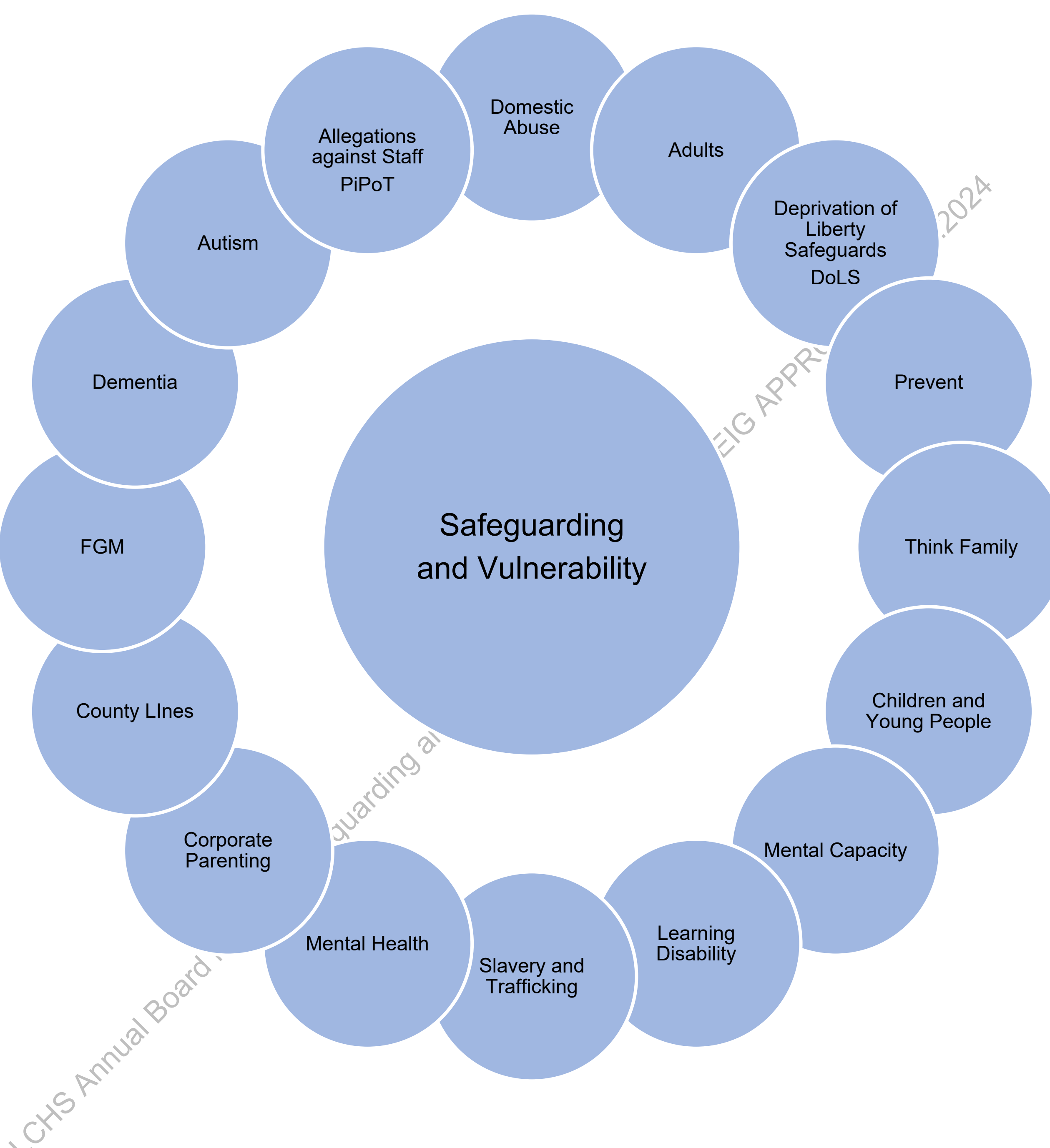
Appendix 1 – 2023/24 Annual Report

Glossary

Not applicable

Lincolnshire Community Health Services NHS Trust

Safeguarding and Vulnerability Annual Report 2023 - 2024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Domestic Abuse
Adults
Deprivation of Liberty Safeguards DoLS
Prevent
Think Family
Children and Young People
Mental Capacity
Learning Disability
Slavery and Trafficking
Mental Health
Corporate Parenting
County LInes
FGM
Dementia
Autism
Allegations against Staff PiPoT

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Foreword

As the Executive Lead for Safeguarding within Lincolnshire Community Health Services NHS Trust (LCHS), I am pleased to introduce the first combined Safeguarding and Vulnerabilities Annual Report for 2023/24. Over the past year, the Trust continued to deliver quality and compassionate care and treatment across the communities in which we provide inpatient, community and emergency services.

As the Lincolnshire Community Health Services NHS Trust and United Lincolnshire Hospitals NHS Trust move towards a Group model, one of the first teams to develop a closer working relationship was the safeguarding and vulnerabilities team under the oversight of the Director of Safeguarding.

This has provided an opportunity of reflection, to review the safeguarding work undertaken across both Trusts and whilst the past year has continued to be challenging as the NHS continues to experience significant operational pressures, there is a lot to celebrate and be proud of with the safeguarding work undertaken across the two organisations, and by the achievements and progress of the Lincolnshire Safeguarding Partnerships working together. LCHS have continued in their commitment to ensure that we help all residents of Lincolnshire live lives free from abuse and neglect.

Safeguarding can be complex and emotive work, and to safeguard effectively requires all agencies to work together in a collaborative and supportive way to develop seamless and effective safeguarding plans. We would like to thank our safeguarding partners across Lincolnshire for working with us to safeguard the population of Lincolnshire.

This report provides assurance to the Trust Board and our regulators, our patients and their families, and our partner agencies that everyone working at LCHS see safeguarding as part of their core business, and that we recognise that safeguarding children, young people, and adults is a shared responsibility, with the need for effective joint working between partner agencies and professionals, so that vulnerable groups in society are protected from harm. We all have a role to play in ensuring our patients and their families receive outstanding care.

The Trust Board of Directors are committed to ensuring all patients accessing our services are protected from harm and abuse ensuring that safeguarding remains a priority within the organisation. The Trust **has a commitment to Safeguarding which are reflected within the following Safeguarding Declaration LCHS Safeguarding Declaration**

The Trust has specialist Safeguarding staff who lead on and embed the practice of protecting adults and children from abuse, neglect, modern slavery, domestic abuse, and radicalisation. The LCHS team continue in their transition to take on the wider

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remit additional specialist areas of Learning Disability/Autism (Neurodiversity), Dementia and Mental Health.

Over the last 12 months there have been improvements in care pathways from community to Hospital and back home for some of our most complex patients. The team works tirelessly to ensure that our frontline staff have the required skills and knowledge to protect people, uphold their human rights and assess capacity.

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

Professor Karen Dunderdale

Group Deputy CEO/Chief Nurse / Executive Lead for Safeguarding (LCHS & ULHT)

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Statement from Lincolnshire Safeguarding Adults Board (LSAB)

LCHS has been instrumental in progressing the strategic priorities of the Lincolnshire Safeguarding Adults Board. Evidence that supports this statement is detailed below.

LCHS are leading on behalf of the board the implementation of the recommendations of the recent "Anthony" Safeguarding Adult Review. This was a challenging case and LCHS are considering how best as a partnership we may address the complex issue of discharge planning from hospital settings and how individuals may best be supported in the community.

LCHS are always consistent attendees at our board meetings and subgroups, contributing significantly to many aspects of the work that the board undertakes. I regularly attend from an independent perspective the Safeguarding and Vulnerabilities group. This allows me to hear first-hand how health practitioners are safeguarding individuals both in hospital settings and the community, where the use of patient stories helps to identify good practice and learning so the agencies can improve the care they provide.

Richard Proctor

Lincolnshire Safeguarding Adults Board - Independent Chair.

Statement from Lincolnshire Safeguarding Childrens Partnership (LSCP)

Over the last year Safeguarding children has been the subject of a national reform programme and Lincolnshire has been selected to be one of four wave one pathfinders. During this period, the staff from LCHS have been engaged in this work and worked hard in partnership to design a new model for the County. The overarching system level reform incorporates leadership, culture, and information sharing.

Whilst historically Lincolnshire has developed a strong multi agency approach to protecting children we are always seeking new methodology to strengthen our offer to children and families and your staff have reacted positively to this important programme. During the last year, the staff from the trust have contributed to the development of the partnership and I am grateful for their commitment and professionalism in this important and sensitive arena.

'Partnership is not a posture but a process, a continuous process that grows stronger each year as we devote ourselves to common tasks.'

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John F Kennedy.

The recent coming together of your Trusts can only strengthen our relationships and arrangements providing a more consistent approach to policies and training and an increased sharing of best practice across the organisation.

I would like to take this opportunity to thank your staff for their continued dedication to safeguarding and look forward to working with them to implement the new arrangements later this year.

Remember

'Coming together is a beginning, staying together is progress and working together is success.'

Henry Ford.

Chris Cooke

Lincolnshire Safeguarding Childrens Partnership - Independent Chair.

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1.0 Purpose of Report

The purpose of the report is to provide the Board with an annual update of the work undertaken in 2023 - 2024 with regards to safeguarding children and adults, Prevent, Mental Capacity and Deprivation of Liberty Safeguards (DoLS), Learning Disability /Autism (Neurodiversity), Dementia and Mental Health and the proposed areas of development for 2024 - 2025.

2.0 Legislative Background

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

Domain 1 Preventing people from dying prematurely.

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

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

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

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

In terms of safeguarding the key domains are:

Domain 4 Ensuring people have a positive experience of care,

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

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

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

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

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2.1 Safeguarding Children

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

In 2024 the face of safeguarding children is very different to that of the late 1990s and an emphasis on early help rather than punitive action is what currently drives the system and as such the number of children on plans continues to vary.

Whilst systems change, at a national level we continue to see tragic cases involving child abuse such as Arthur Labinjo-Hughes aged 6 (Solihull) and Star Hobson aged 1 (Keighley) and more locally Darren Boulton aged 9 (Louth) who all died at the hands of the very people who were expected to protect them.

Safeguarding and promoting the welfare of children is defined in Working Together to Safeguard Children (2018 *– updated 2023*) as

- Providing help and support to meet the needs of children as soon as problems emerge.
- Protecting children from maltreatment, whether that is within or outside the home, including online.
- Preventing impairment of children's mental and physical health or development.
- Ensuring that children grow up in circumstances consistent with the provision of safe and effective care.
- Promoting the upbringing of children with their birth parents, or otherwise their family network through a kinship care arrangement, whenever possible and where this is in the best interests of the children.
- Taking action to enable all children to have the best outcomes in line with the outcomes set out in the Children's Social Care National Framework.

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

This is a standard requirement within all LCHS contracts of employment.

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

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- Senior management commitment to the importance of safeguarding and promoting children's welfare.
- A clear statement of the agency's responsibilities towards children for all staff.
- A clear line of accountability within the organisations for safeguarding and promoting the welfare of children and Adults.
- Service developments that take account of the need to safeguard and promote welfare and is informed, where appropriate, by the views of children and families.
- Staff training on safeguarding and promoting the welfare of children for all staff working with or in contact with children and families.
- Safe recruitment procedures in place.
- Effective inter-agency working to safeguard and promote the welfare of children.
- Effective information sharing.
- CQC Fundamental Standards 2022 which have a safeguarding thread running through all.

An audit of Section 11 duties is undertaken by the Local Safeguarding Children Partnership (LSCP) and any subsequent action plans will be monitored in line with the current governance arrangements.

The most recent section 11 submission took place in March 2024 and the trust reports ***full compliance following peer review. The final grading will be available in September 2023 once the peer reviews have been formally approved by the LSCP.***

2.2 Safeguarding Adults

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

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

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

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

The Act recognises the need to focus on openness and transparency, in the drive to improve the quality of care individuals receive. This segues neatly with our own health service requirement for "Candour" as set down in the LCHS Open and Honest Care Policy (P-CIG-16) and in line with the statutory Duty of Candour as defined in Regulation 20 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

2.3 Implications for Safeguarding Adults at Risk

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

Safeguarding Principles

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

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2.3 PREVENT

2.3.1 What is PREVENT?

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

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

Prevent	Pursue	Protect	Prepare
Safeguard people from becoming terrorists or supporting terrorism	Stop terrorist attacks happening in the UK and overseas	Stregthen our protection against a terrorist attack in the UK or overseas	Mitigate the impact of a terrorist incidents if it occurs
Primary outcome			
Reduce intent	Reduce capability	Reduce vulnerability	Reduce impact
Address strategic factors Extremism Conflict and instability Developments in technology			
Overall effect			
Reduce risk			

The Health Service is a key partner in PREVENT and encompasses all parts of the NHS, charitable organisations and private sector bodies which deliver health services to NHS patients and forms part of the Safeguarding accountability and assurance framework (NHS England 2022)

PREVENT has 3 national objectives:

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

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

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

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

PREVENT training is undertaken in line with the Prevent Training and Competencies Framework - Department of Health and Social Care (2022)

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2.3.2 Why Health care staff?

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

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

3.0 Designated and Named Professionals for the Trust and its Commissioners.

3.1 Children

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

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

All NHS Trusts must identify a named doctor, a named nurse, and a named midwife (where maternity services are provided) for safeguarding with the focus of the named professional being on safeguarding children within their own organisation. Both a Named Nurse and Named Doctor are in post within the Trust.

3.2 Adults

Following the publication of Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework (July 2022) there is an expectation that Designated (ICB) and Named professional (LCHS) for safeguarding adults are in place.

Within LCHS (from June 2023) the ULHT Director of Safeguarding acts as the Trust Safeguarding lead with strategic responsibility for both children and adults and the Trust have a Named Nurse responsible for Safeguarding Adults and Mental Capacity supported by a team of specialist nurses.

4.0 The Safeguarding and Vulnerabilities Teams

The Safeguarding Team has been in place for several years and historically was responsible for Child Protection (LCHS), Adult Protection (LCHS) and the PREVENT agenda (LCHS). During 2023 to 2024 the teams remit expanded and now takes a stronger lead on Mental Capacity /DoLS and is steadily increasing its remit for Mental Health, Learning Disability, Autism and Dementia.

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

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5.0 Safeguarding Governance Arrangements

The responsibility for safeguarding rests with the Chief Executive Officer, supported by the Executive Director with Board responsibility (Prof Karen Dunderdale).

During 2023 and 2024 LCHS moved from a safeguarding strategy group to a Safegaurding, and Vulnerabilities Oversight Group (SVOG) model chaired by the ULHT Director of Safeguarding. This group reports to the Quality and Risk Committee. A new LCHS Operational group responsible to SVOG was formed which is chaired by the Named Nurse for Safeguarding - (figure 1)

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Figure 1

Safeguarding Governance (LCHS)
Accountability and Oversight 2023 -2024

During 2024 to 2025 both LCHS and ULHT SVOG will join to form one strategic group and the ULHT Mental Health, Neurodiversity and Dementia Group will be expanded to cover both ULHT and LCHS

LCHS Annual Boar

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

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

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

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

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

6.1 LSCP Key areas of action

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

LSCP business plan 2022 - 2025

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6.2 LSAB Key areas of action

- Prevention and Early Intervention.
- Making Safeguarding Personal (MSP).
- Learning and shaping future practice.
- Safeguarding Effectiveness.

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

Lincolnshire Safeguarding Adult Board Strategy 2022 - 2025

7.0 Child Safeguarding Practice Reviews (Previously Serious Case Reviews - SCR) / Safeguarding Adults Review (SAR) / Domestic Abuse Related Death Reviews (DARDR)

7.1 Children

Child Safeguarding Reviews have been in place for many years and nationally about 400 take place every year. A review is always carried out by the Safeguarding Partnership when a child dies and abuse or neglect is known, or suspected, to be a factor in the death. Working Together (2018) guidance also states that LSCP should consider holding a review *where a child has sustained a life-threatening injury through abuse or neglect, serious sexual assault, or through serious and permanent impairment of health or development through abuse or neglect.* The purpose of a review is to establish what lessons can be learnt about the way professionals and organisations worked together, how they will be acted upon and what is expected to change to improve inter-agency working and improve safeguarding practice to children. Reviews are exercises in learning and improving policy and practice and outcomes for children and young people and are not inquiries into how a child died or who was culpable; this is the business of Coroner's and the Criminal Court.

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

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learnt, the LSCP then ratifies the conclusions and recommendations for actioning the lessons.

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

LCHS are currently involved in one new Child Safeguarding Practice Review (CSPR) which was commissioned in February 2024, there are currently no actions identified.

7.2 Adults

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

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

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

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

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

During 2023 – 2024 LCHS was not involved in any reviews however did complete an outstanding action for 2022-2023.

7.3 Domestic Abuse Related Death Reviews (DARDR)

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

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

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

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When DARDRs started in Lincolnshire, there were 12 notifications during the period of 2012-2017 however since 2018 the number of notifications has doubled leading to 30 cases that have met the criteria for a domestic homicide review in Lincolnshire between 2012 and 2023.

During 2023-24 LCHS has been involved in nine newly commissioned Domestic Homicide Reviews (DARDRs) for Lincolnshire.

In total, LCHS is currently involved in thirteen DARDRs; three of which were identified in 2021, and two that were ongoing prior to 2021.

During 2023-2024, LCHS submitted information to support 1 Lincolnshire DARDR decision-making panel at which it was determined that the criteria for undertaking a DARDR had not been met. The trust also completed a data trawl for one out of area DARDR decision-making panel, however no information was held by LCHS so there was no further involvement in the Review.

Actions for LCHS in relation to one of the previously commissioned DARDRs is ongoing, and the newly commissioned reviews have not yet generated actions for individual agencies.

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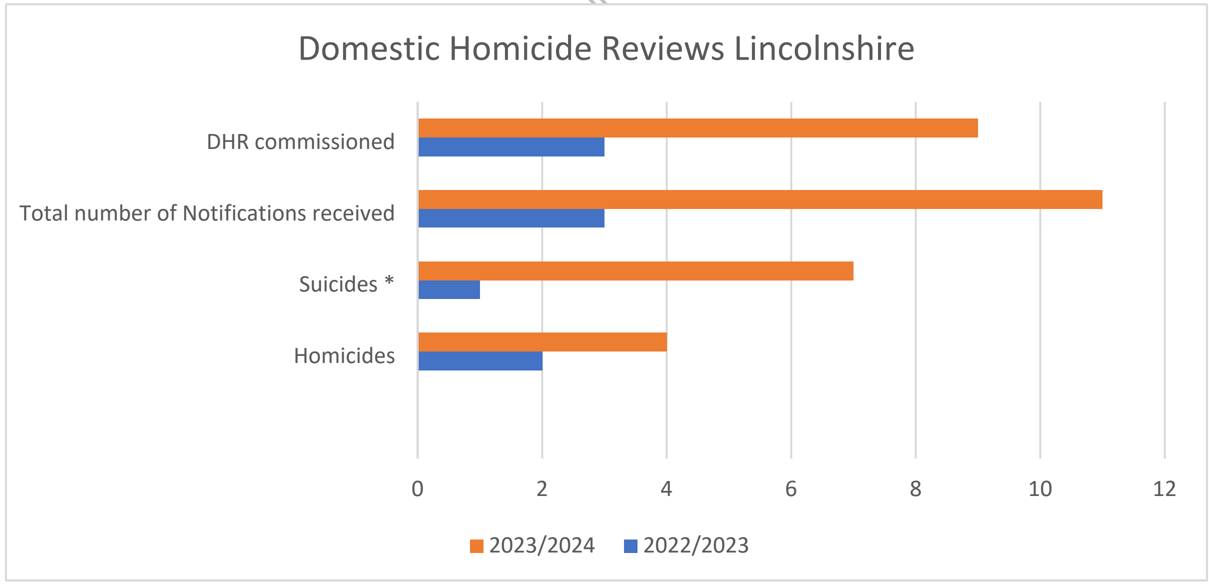
Figure 2: Number of cases referred for discussion to DARDR panel.



*** Since 2022 DARDR criteria have changed to include all deaths by suicide where there has been a known history of domestic violence within the current/past relationship.**

8.0 Child Protection Cases

Lincolnshire holds child protection conferences on each working day and therefore the numbers for children who currently have a child protection plan vary daily Monday to Friday and can be influenced by families moving in and out of the local authority. Overall, the numbers of children on plans (figure 4) have slowly risen over the last 5 years whereas the mean for England has demonstrated a downward trend.

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

During this period there has continued to be a high number of unborn babies who have become subject to child protection / court proceedings and as such a significant impact on the midwifery workload however has not directly impacted on LCHS generic services however does impact on the Children Looked after service.

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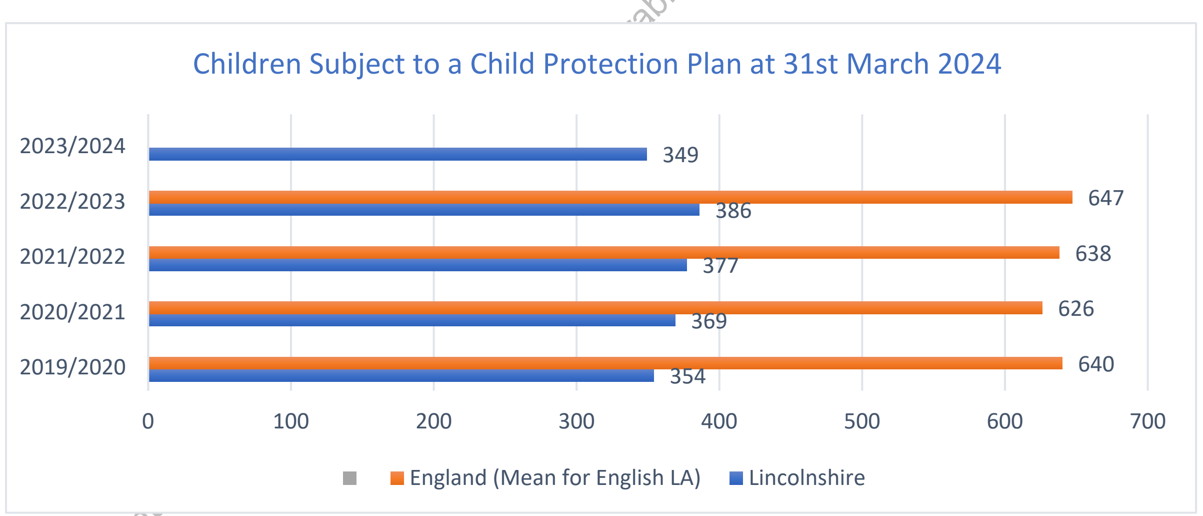
Figure 3: Number of children having a child protection plan within the Local Authority area who may be receiving services from LCHS (April 2019– March 2024) ***(England Mean 23/24 not available at time of report)***



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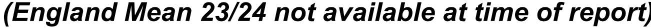
8.1 Child in Need

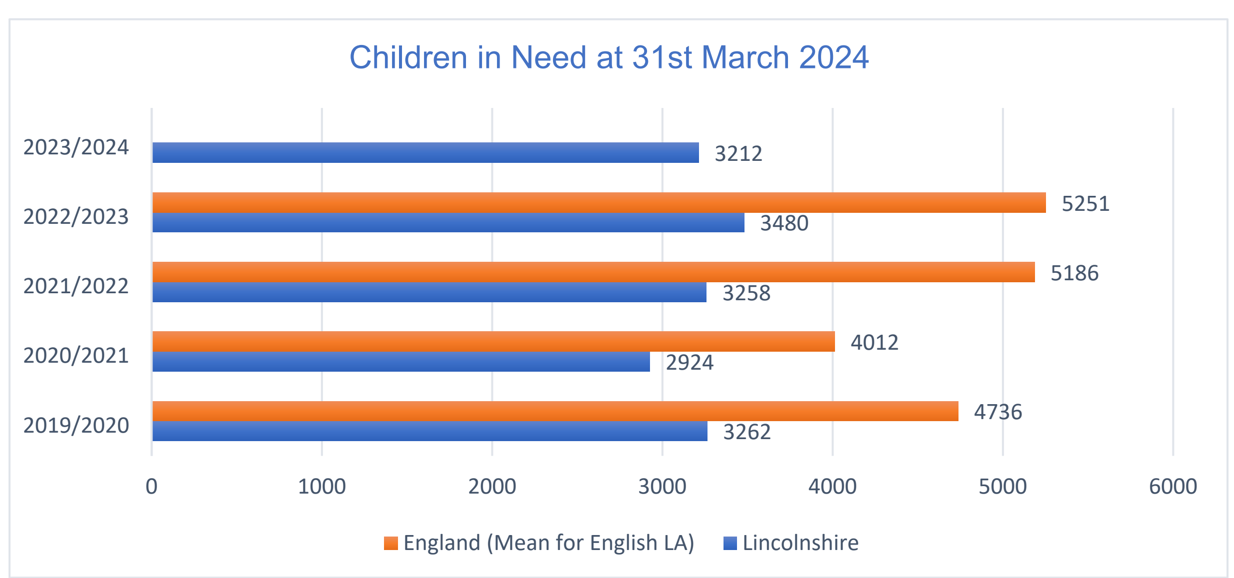
Some children will not meet the criteria for a child protection plan but still require a service which can be met at a lower level 'children in need' of support. The data in figure 5 demonstrates the number of children in need across Lincolnshire with a decrease in numbers over the last 12 months remains below the England mean.

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

Figure 4: Number of children classed as a Child in Need within the Local Authority area who may be receiving services from LCHS (April 2019 – March 2024)



(England Mean 23/24 not available at time of report)



8.2 Children in Care

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

Many of these children will access the services within LCHS by way of UTC or our Children, Young People and Specialist Services. Research demonstrates that children in care will continue to have a high levels of Adverse Childhood Experiences (ACES) which impact on lifelong health and opportunities and therefore continue to access services long into their adult life.

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

The Trust have worked closely with our multi-agency/multi-professional partners to ensure that these children received the best possible care.

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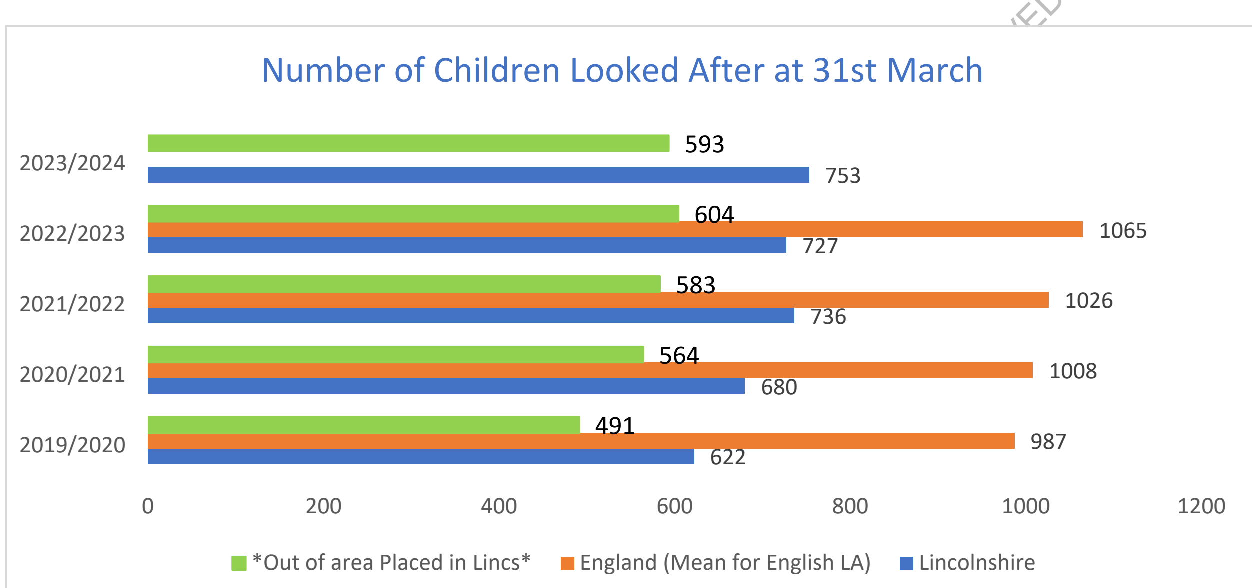
Over the last 5 years the number of children in the care of Lincolnshire Local Authority has risen in line with the England mean, although there was a slight dip during 2022 - 2023. This steady increase is also noted in the number of children placed into Lincolnshire by other Local Authorities.

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

Figure 5: Number of children classed as a Child in Care within the Local Authority Area who may be receiving services from LCHS (April 2019 – March 2024)

(England Mean 23/24 not available at time of report)



*** Out of area placements are reliant on external Local authorities notifying Lincolnshire of the placement and therefore this is likely to be an under reporting and the actual figure being higher***

8.3 LCHS Children Looked After Team.

Within LCHS some of these children will access services such as UTC and LiSH however LCHS is also directly commissioned to provide the Children in Care Service.

The service employs registered nurses, General Practitioners, and administrators to support children and young people living in Lincolnshire who are in the care of the Local Authority or placed into Lincolnshire by external authorities. The service is primarily responsible for carrying out Initial and Review Health Assessments (IHA and RHA) for these children in care. During 2023 the service was also supported by a consultant community paediatrician within ULHT to add additional capacity to the service and facilitate a greater number of IHAs delivered within the 20-working day timescale.

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At the end of March 2024 there were 753 children in the care of Lincolnshire County Council, an increase of 4% from the previous year and 21% over the last 5 years - this is considerably higher than the national average increase of 8% over the last 5 years. The introduction of the National Transfer Scheme in November 2021 triggered a significant rise in Unaccompanied Asylum-Seeking Children receiving support from the service. The number of children and young people placed into Lincolnshire by external authorities also continues to rise significantly putting additional pressure on the team (21% increase over the last 5 years).

The number of Independent Registered Residential Children's Homes in the county has risen in recent years. The majority of the young people living in these homes are placed by external authorities and many are victims of Child Exploitation. This brings specific health needs therefore each home has been allocated a link nurse from the team. The first we know about a new home is sometimes when we receive a notification that a young person has moved there.

To maintain effective services, Lincolnshire local authority opened a new residential home in September 2023, and another is due to open in early 2024.

Data collection - Currently the data entry, admin pathways and patient record for the service makes retrieving and collating information about the service and the outcomes for the Children and Young People difficult. The service has information held in more than one place, creating time consuming admin pathways.

In January, the team began a transition to their own SystmOne unit bringing all the data and recording into one place. Work is ongoing with performance and digital health to create the SystmOne templates/questionnaires it needs to ensure that information is fully reportable. Unfortunately, this work has taken longer than originally envisaged due to the volume of data collection required and therefore it is unlikely that data will be available until the summer of 2024.

As part of future proofing the service to ensure that it can deliver timely and effective care to our children and young people, LCHS are currently in discussions with the ICB to consider a new funding model and structure of the team moving forward.

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9.0 Adult at risk

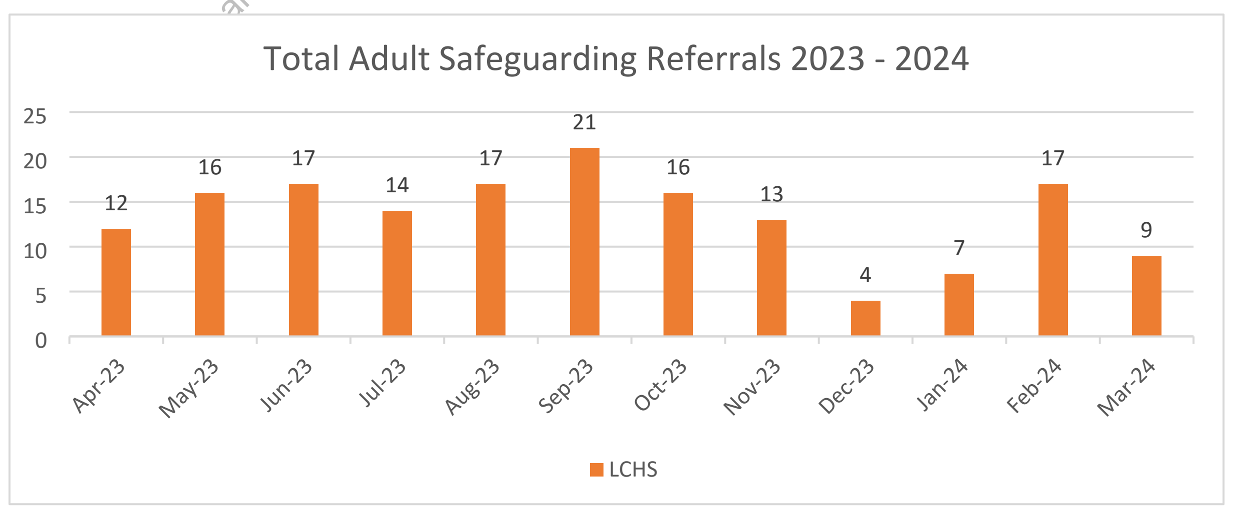
Adult Safeguarding is extremely complex and impacts on much of the day to day work of the Trust i.e., Complaints/PALS, Serious incidents/PSIRF, pressure ulcers, patient safety and HR. Safeguarding is about more than simply keeping someone safe, it is about respecting and protecting an individual's needs,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

There is increased emphasis on 'making safeguarding personal' and involvement of the patient in their safeguarding decisions. Audits from the LSAB and internally continue to suggest that this is an area which requires further improvement so remains a priority for 2024 - 2025.

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

The number of referrals raised during 2023 - 2024 by LCHS was 163 (26% increase) indicating that the trust is actively identifying issues of concern. Work continues to ensure that all referrals are appropriate and include the patients views wherever possible.

Figure 6: Number of safeguarding adult referrals made by LCHS to the Local Authority (April 2023 – March 2024) including divisional breakdown.



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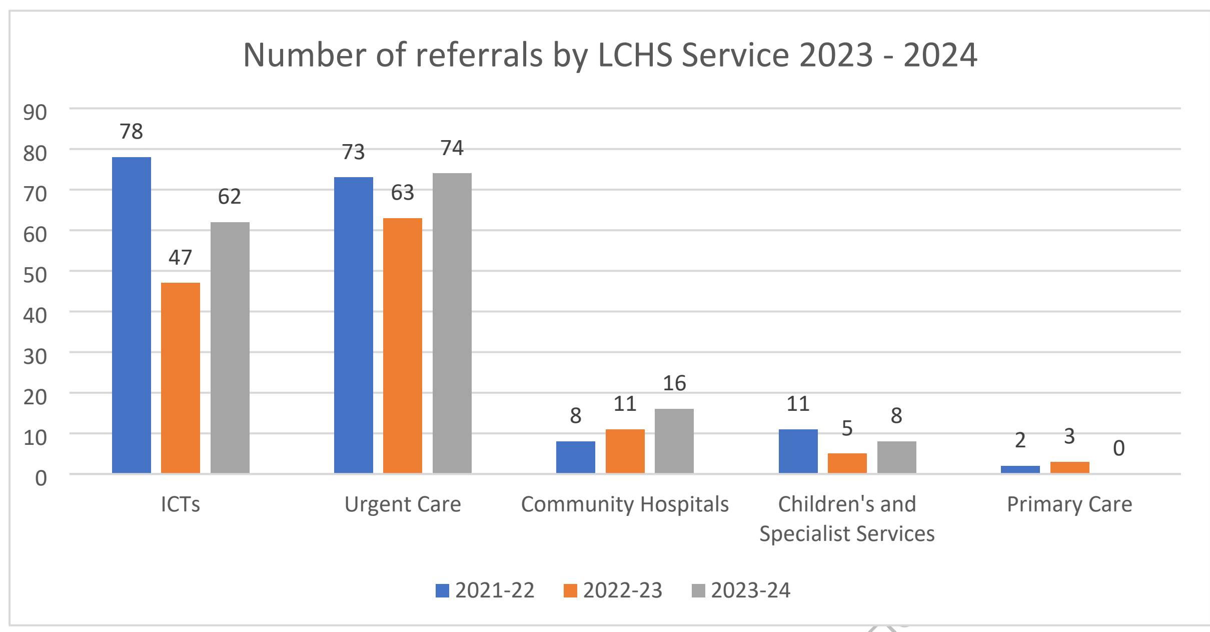
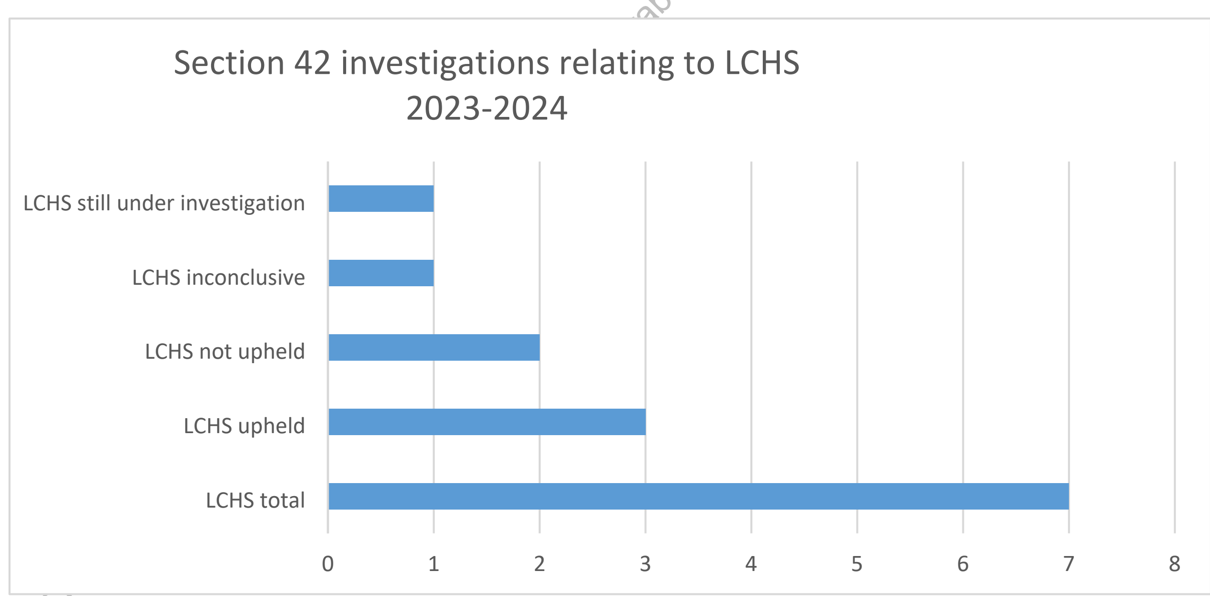


9.1 Safeguarding referrals made against the Trust.

The number of safeguarding allegations raised against the trust continues to vary however over the last 12-month period was 7 for LCHS.



LCHS: Trends from these investigations highlight issues as follows.

- Lack of holistic assessment and understanding of the impact of underlying conditions on tissue viability.
- Lack of pressure ulcer risk assessment and preventative measures.
- Lack of care planning that reflects the needs /changes in condition of the patient.

- Allocation of visits to staff who do not have the knowledge and skills to perform the visit.
- Failure to recognise deterioration in wound and underlying condition.
- Failure to perform sepsis screening when signs of infection present.

A number of lessons learnt, and actions have been put into place to minimise future risks. The Named professional meets with the CQC and separately with the ICB and LA to ensure that there is an open and honest dialect maintained and works on the premise of 'no surprises.

Quality assurance

All referrals are quality assured. Moving forward as the group develops these processes will be standardised across the teams.

All safeguarding incidents reported on datix are reviewed by the Safeguarding Team, this provides an immediate quality assurance process, and ensures that all actions have been completed, and that records & documentation are appropriately completed. The safeguarding team provide 'in hours' follow up to incidents that occur out of hours, including liaison with health professionals and confirming actions with Social Care and the Police.

The graph below shows that there has been an increase in the number of incidents reported on datix. Reporting culture remains positive, and during the most challenging times operationally, reporting culture was not affected.

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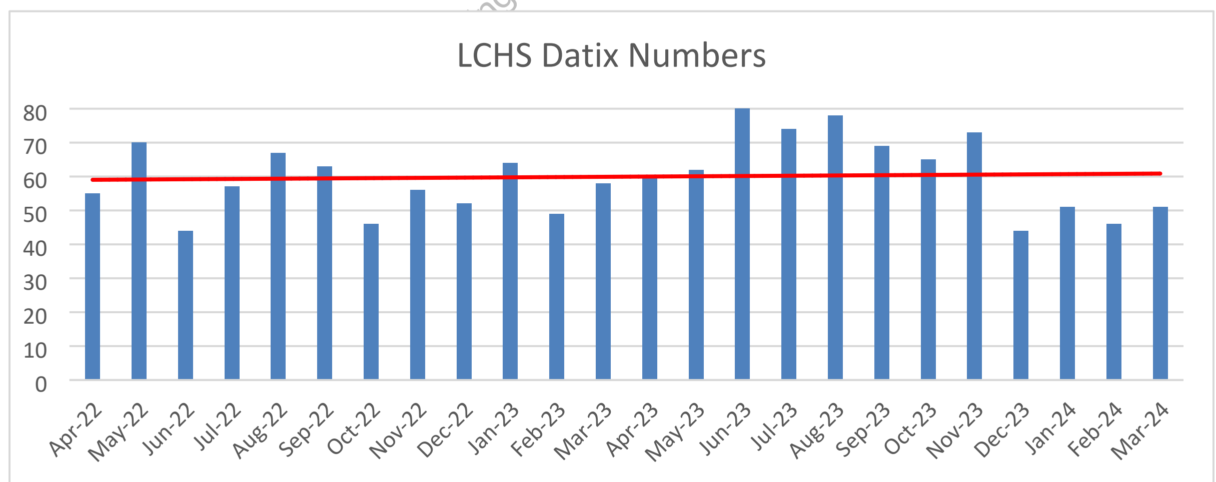

10.0 Legal statements / Court process

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

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

Other teams adversely affected by this increase are the Children, Young People and Specialist Services UTC Departments across site with pressures being placed on frontline clinicians to provide reports and statements in greater detail and in a much shorter timescale.

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

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

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

LCHS have not identified any cases requiring CoP however have worked with ULHT to assist in transition of some of the more complex mental capacity cases from the hospital to the community.

During 2023 to 2024 ULHT commissioned a series of Court craft and legal updates for staff which currently continue to March 2025 and cover court skills suitable for children and family / Coroners' Courts as well as updates around the Mental Capacity Act and relevant changes in case law. These events where opened to LCHS staff in 2023 and will continue to be provided across the Group going forward.

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11.0 Safeguarding Clinical Supervision

11.1 Children

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

Safeguarding supervision is mandated to specific staff groups at either 3 monthly or 6 monthly periods and is managed *in LCHS by way of the Supervision App.*

As of 31st March 2024, compliance rates are as follows.

Overall compliance 30.98%.

Compliance within LCHS is delivered by the safeguarding team but staff self-report via the safeguarding app. Currently work is ongoing to simplify the app as data collected by the safeguarding team would suggest that compliance is much higher. Until this work is completed safeguarding Supervision will remain on the risk register.

Compliance figures for Safeguarding supervision are notoriously difficult to maintain due to 3 - 6-month time scales and regularly changing staff groups particularly amongst medical staff. In order to proactively manage this challenge, the safeguarding team use the above figures in conjunction with the Safeguarding training compliance figures to identify high-risk areas of concern and target specific staff groups.

Compliance is monitored by the teams with bi-monthly reports provided to Safeguarding Operational Group / Divisional Leads for escalation and via SVOG.

11.2 Adults

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

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12.0 Training and learning

Safeguarding training has always been a high priority within the Trust and is implicit within the National contract and Safeguarding legislation. A new joint training plan was introduced for safeguarding children and safeguarding adults in 2023 as the first stage of bringing both Trusts closer together and ensuring compliance with statutory guidance. As part of this process all training courses were reviewed and updated as necessary with the vision that moving forward staff from either Trust could attend any course and still gain compliance.

As a move away from pandemic working, the training has moved away from e-learning to delivering more face-to-face courses. This has improved interaction in training sessions and allows for detailed scenario discussions. From March 2024 most e-learning safeguarding courses have been switched off.

Training levels with the Trust on the 31st of March 2024 were as follows.

KPI Description ***(A measurable value that demonstrates the success of your change, to include trajectory to achieve target)***	**Measures** ***(How will this be Measured)***	**Target** ***(Desired level of performance)***	**LCHS** ***END March 2024 figures*** ***Trend compared with March 2023***
To reach 90% for Safeguarding children level 1	Monthly training report (MTR)	90%	97.22% →
To reach 90% for Safeguarding children level 2	MTR	90%	90.88% ↓
To reach 90% for Safeguarding children level 3	MTR	90%	83.61% ↓
To reach 90% for Safeguarding children level 4	MTR	90%	100% →
To reach 90% for Safeguarding adults level 1	MTR	90%	97.22% →
To reach 90% for Safeguarding adults level 2	MTR	90%	91.63% ↓
To reach 90% for Safeguarding adults level 3	MTR	90%	91.15% →
To reach 90 % for MCA / DOLS	MTR	90%	Not delivered ** to commence April 2024
To reach 90% for PREVENT basic level	Quarterly training report	NHSE/I target 85%.	97.48% ↑

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To reach 90% for PREVENT Higher level	Quarterly training report	NHSE/I target 85%	91.63% ↓
To reach 90% for Mental Health	MTR	90%	Not delivered - to commence during 24 - 25
To reach 90% for Dementia	MTR	90%	Not delivered to commence during 24 - 25
Oliver McGowan Specific Tier 1 e-learning (part 1) *	MTR	90%	83%
Oliver McGowan Specific Tier 2 e-learning (part 1) *	MTR	90%	76%

*** LCHS Commenced 1st March 2023 - Only training delivered is Oliver McGowan part 1 as part 2 is not yet available**

**** Mental Capacity/DoLS training was introduced in LCHS on 1st April 2024**

Olive McGowan e-learning training is being rolled out across the trust however for full compliance staff members must attend a second module which is a face-to-face course.

The uptake is reliant on the availability of the face-to-face course and at present these are very limited nationally as the course must be delivered by experts with lived experience.

The trust is working with the Lincolnshire system partners to commission these modules however whilst tier one modules are slowing becoming more available it is likely to be 12 to 18 months before the tier two module is available and only then in limited numbers.

13.0 Female Genital Mutilation (FGM)

Whilst the issue of FGM affects women / girls across all operational services the main clinic services able to identify the mutilation are midwifery and Gynaecology teams within the hospital and LiSH services within LCHS. In line with national guidance the trust has in place an FGM policy.

From 1st April 2015, and in line with National Guidance, Hospital Trusts and General Practitioners began to routinely submit FGM data. This data is submitted monthly to NHS Digital.

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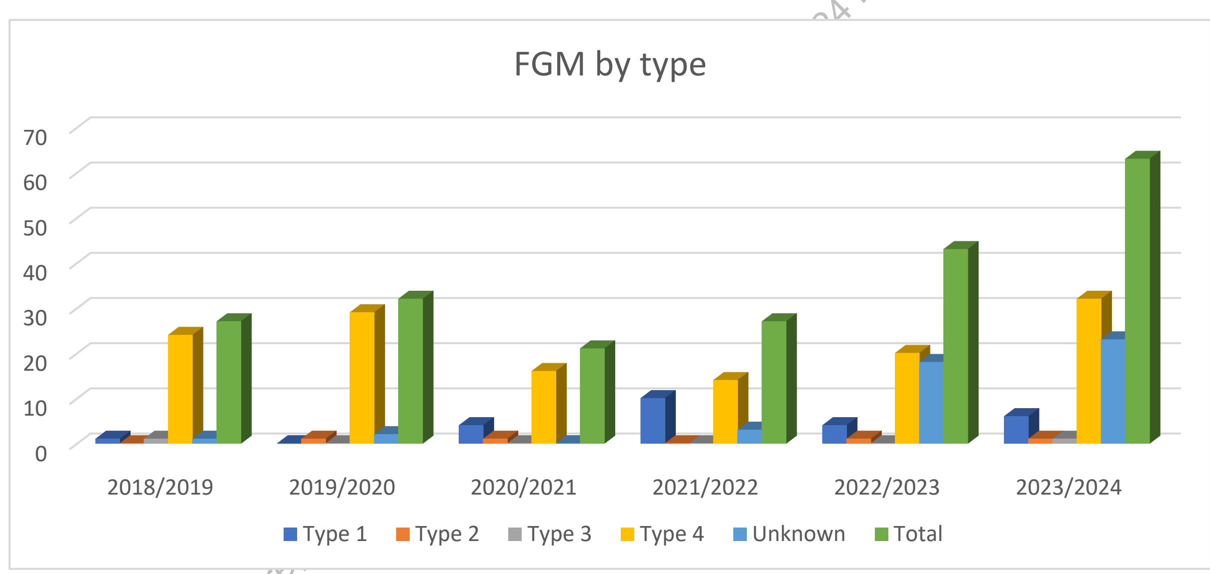
Nationally since April 2015, 35,415 individual women and girls had an attendance where FGM was identified.

Between April 2023 and March 2024, 63 cases of FGM were reported within the NHS in Lincolnshire, an increase of 47% over the last 12 months, 135% over the last 5 years): of which 32 were Type 4 (piercings); 6 were Type 1, 1 was type 2, 1 was type 3 and 23 were of an unknown type. All cases reported were reported by adults and those reporting Type 1 had undergone the FGM as children in their countries of origin.

As a Community Trust LCHS is not required to submit data as part of the national data set as Primary care data is submitted as part of the GP requirement.

LCHS is required however to refer any FGM cases as part of the mandatory reporting requirements

Figure 7: FGM specific data by WHO type classification.



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

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

The trust is represented at the twice-weekly MARAC meetings by the Safeguarding Specialist Nurses and at the Domestic Abuse Operational and Strategic Boards by the Named Nurses for Safeguarding and the Director for Safeguarding, respectively.

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14.1 Key Facts

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

Figure 8: shows a higher percentage of adults experienced domestic abuse by a partner or ex-partner (4.4%) than by a family member (1.8%) in the last year. Of those who experienced partner abuse, 88% experienced non-physical abuse, 9% experienced sexual assault and 16.1% experienced stalking.

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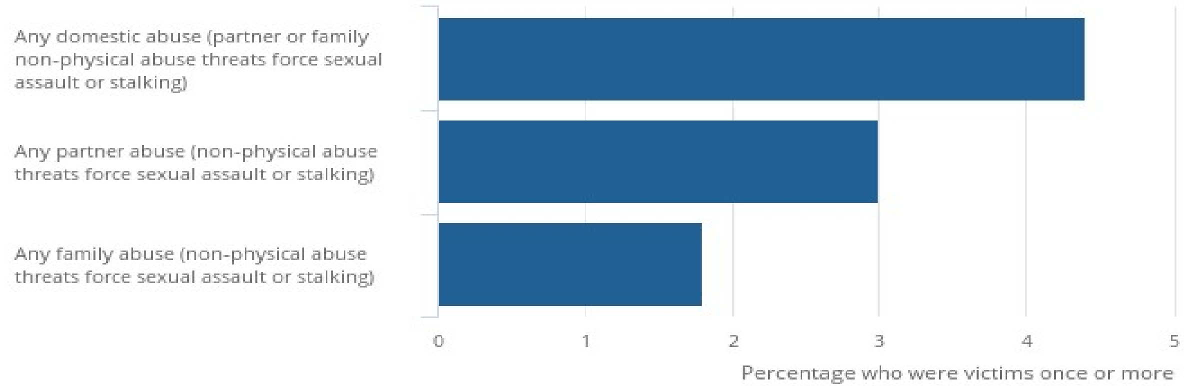

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One in 25 people experience domestic abuse in the year ending March 2023

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

Domestic abuse remains an under reported issue. CSEW national figures suggest that only 31% of partner abuse victims told someone in an official position about their abuse (i.e., police, health professionals, or local council department). 18.9% of victims told the police, 18% told a health professional and 5% told a local council department. The majority of partner abuse victims instead told somebody they knew personally about their abuse. 1 in 4 partner abuse victims told nobody at all about their abuse (27%), a

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

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

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

14.2 Domestic abuse in Lincolnshire

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

Figure 9: Domestic Abuse Cases

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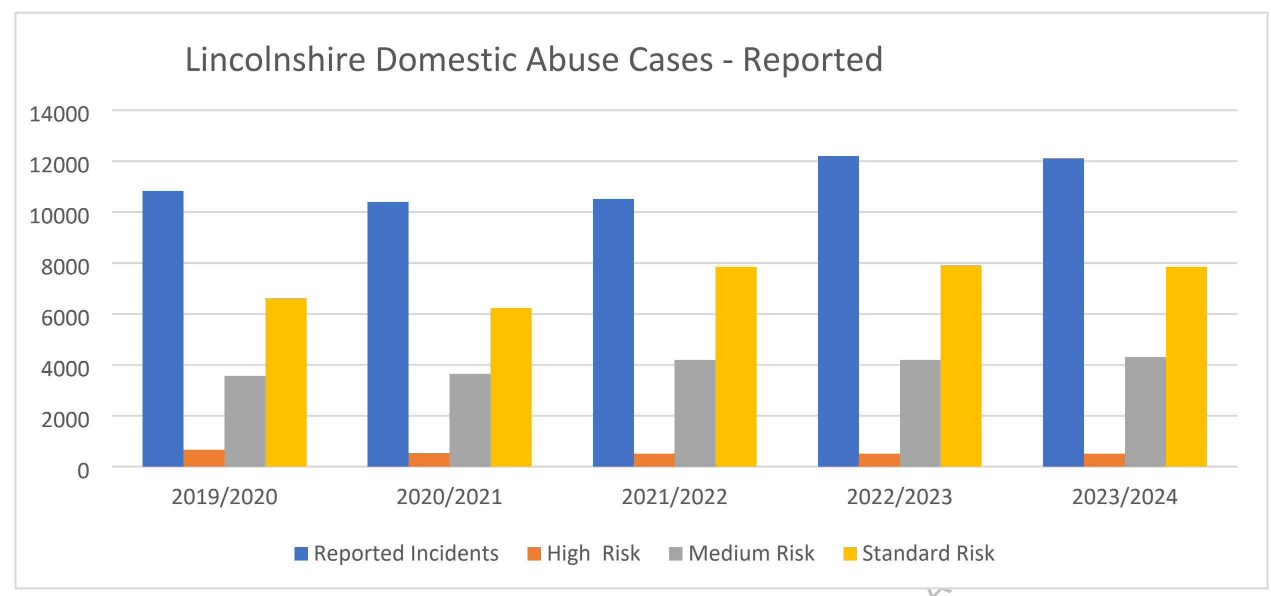

14.3 Domestic abuse and children

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

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

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

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

14.4 MARAC cases

There were 1201 victims who were at high risk of serious harm or death referred into the Multi Agency Risk Assessment Conference (MARAC) by partner agencies in 2023-2024. On average 300 referrals are made to MARAC every quarter (last 5 years ending March 2024).

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Figure 10: MARAC Cases

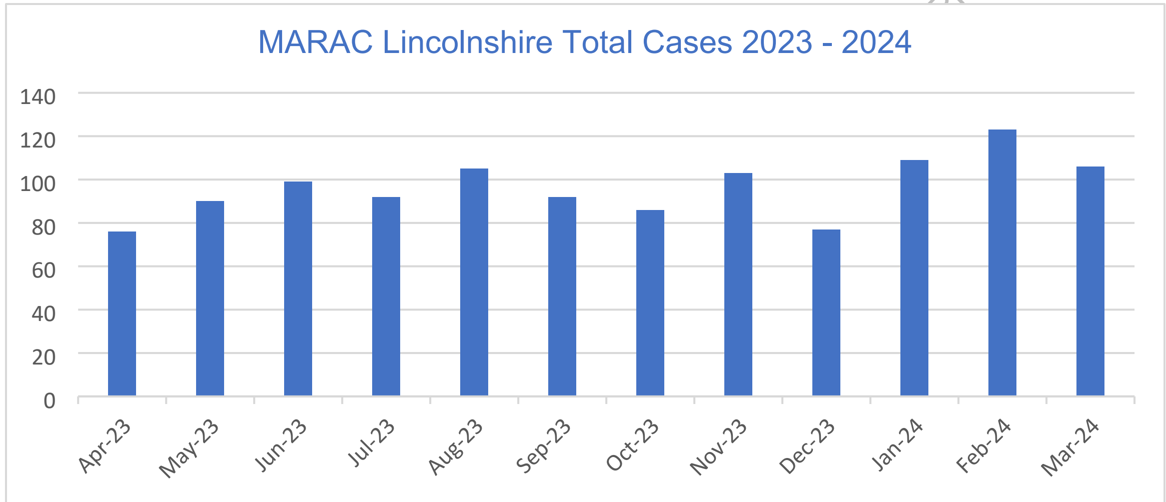
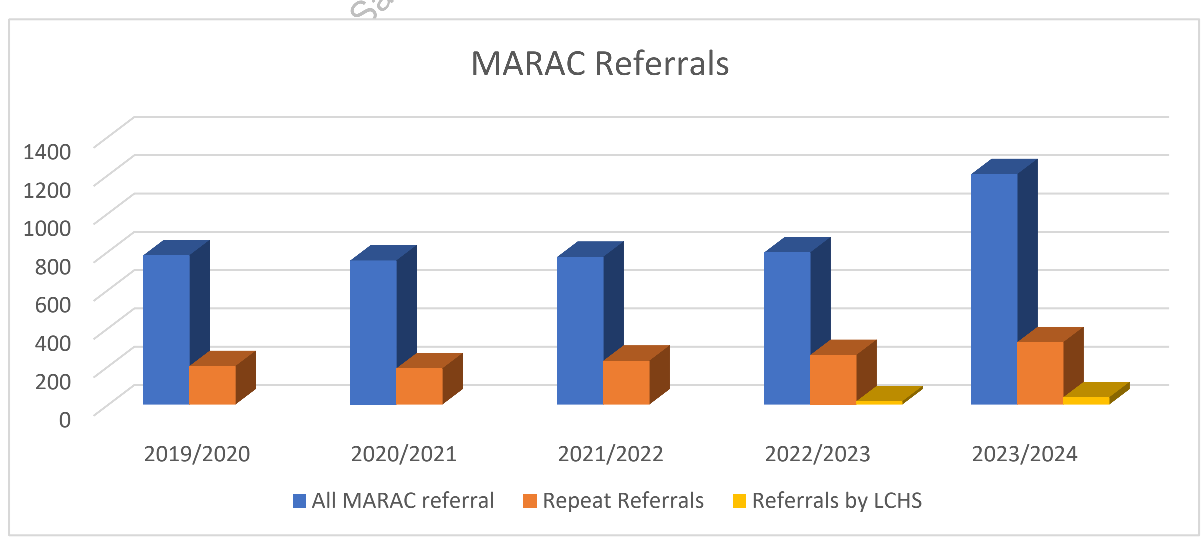
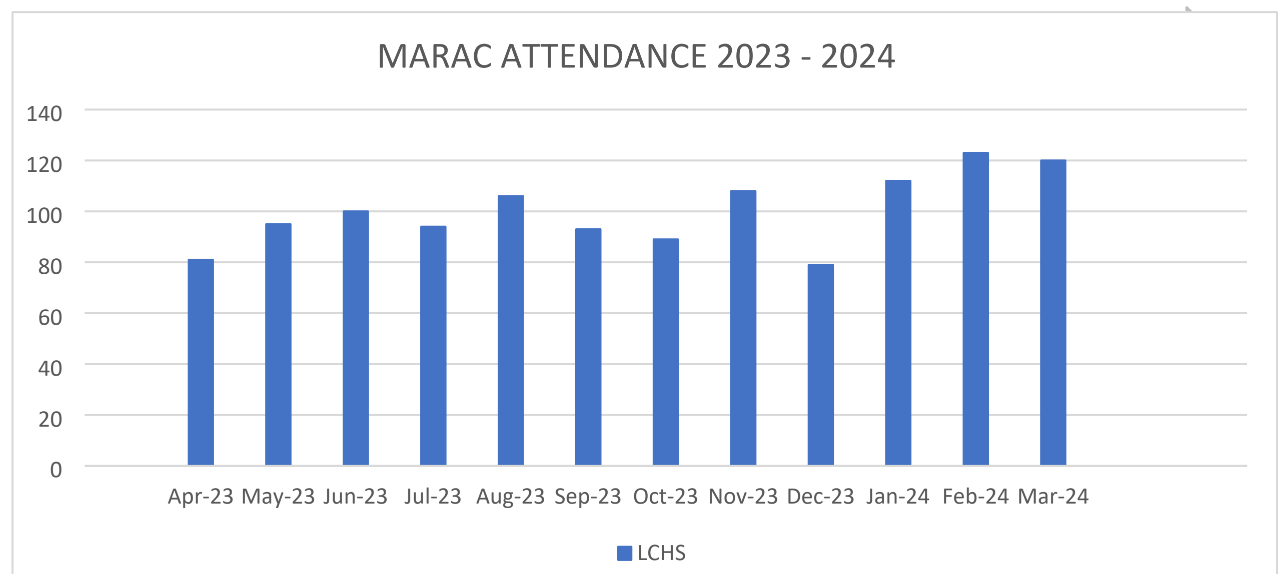


Figure 11: MARAC Referrals – all risk levels



MARAC conferences are held weekly in Lincolnshire on both a Wednesday and Thursday and during the last 12 months both teams have continued to attend all MARAC meetings. More recently legislation has changed to include additional meetings to be held under Domestic Violence Disclosure Scheme.

Figure 12: MARAC cases attended by LCHS Safeguarding Professionals



14.5 Domestic Abuse support

On the 1st of April 2023, the previous domestic abuse support service (EDAN Lincs) ended and a new support service (Lincolnshire Domestic Abuse Specialist Service – LDASS) was launched.

Across Lincolnshire a Total of 1985 adult referrals were received into LDASS between the 1st of April 2023 and 31st of March 2024 for adult victims of domestic abuse to specialist outreach support services in Lincolnshire – this is a decrease from the previous year due to the introduction of the Victim Lincs Referral Pathway resulting in a significant drop in referrals received into LDASS Lincs from the police. Victim Lincs allows for direct referrals from professionals and self-referrals into LDASS.

A total of 10,146 enquiries were received into the service from members of the public for advice regarding domestic abuse, an increase of 31% on the previous 12 months.

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15.0 PREVENT Lincolnshire Profile

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

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

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

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

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

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

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

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

LCHS are represented at the Prevent Steering group by the Named Professional for Safeguarding and MCA (ULHT) who is also the point of contact for the Regional Prevent Coordinators. It is also the responsibility of the PREVENT lead to ensure that the Trust is compliant with our reporting requirements including submission of the data required by NHS England (NHSE) to capture Prevent activities undertaken by the Trust on a quarterly basis.

LCHS have not made any Prevent referrals however have provided research on several cases over the last 12 months in compliance with our PREVENT duty.

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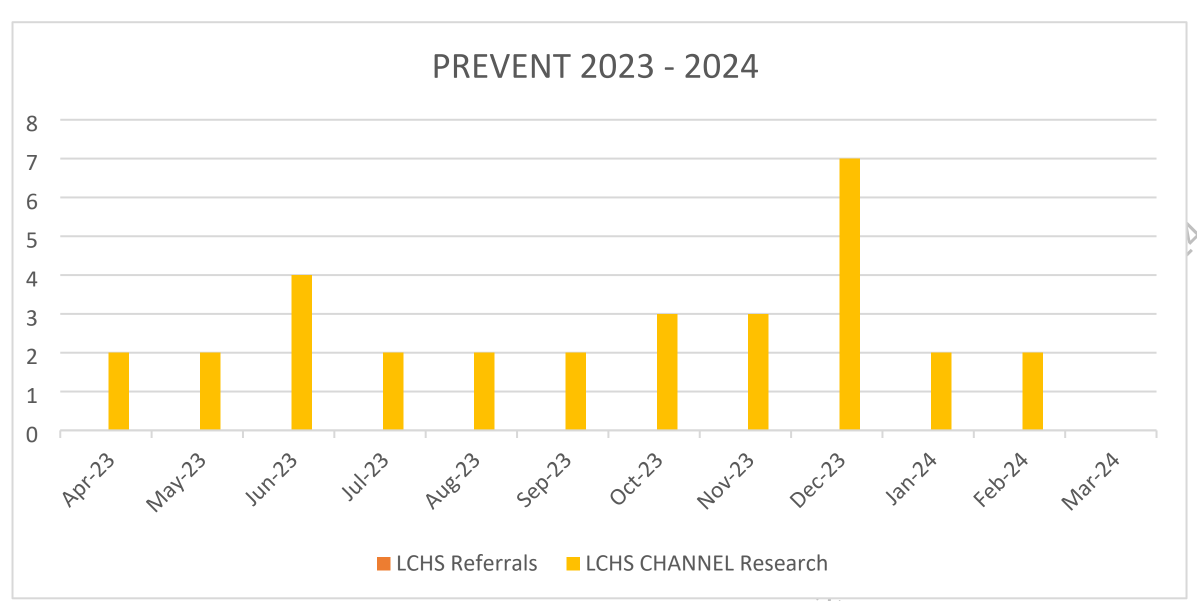
Figure 13: Number of PREVENT data analysis cases undertaken by LCHS as part of Channel Process (April 2023 – March 2024)



16.0 Multi-Agency Public Protection Panel (MAPPA)

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

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

There are 4 categories of MAPPA-eligible offender:

Category 1 registered sexual offenders.

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

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

Category 4 terrorism convicted and terrorism risk individuals.

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

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Figure 14: Lincolnshire Area MAPPA Eligible offenders on 31st March 2024 (2024 figures are not yet available) *Comparative figures 31st March 2022*

Category 1: Registered Sex offender	886	(0)	➡
Category 2: Violent offenders	146	(0)	➡
Category 3: Other dangerous offenders	4	(0)	➡
Total:	1036	(0)	➡

17.0 Persons in Positions of Trust (PiPoT)

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

In line with the Children Act 1989 / 2004 and the Care Act 2014 the LSCP / LSAB have a PiPoT protocol which the Trust is signed up to. This Protocol must be followed in all cases where information (whether current or historical) is identified in connection with:

- The PiPoTs own work.
- The PiPoTs life outside work which may raise concerns re contact with adults with care and support needs (for example where a son is accused of abusing his older mother and he also works as a domiciliary care worker with adults with care and support needs. Or where a woman is convicted of grievous bodily harm and works in a residential home for people with learning disabilities).
- The PiPoT is admitted with drug and/or alcohol use that compromises their ability to undertake their job with children or adults.
- The PiPoTs admission causes concern for wider safety of vulnerable children and adults.

As part of this protocol the Named Nurse for Safeguarding Adults (LCHS) has been identified as PiPoT lead and supports managers and HR with cases where concerns are raised. The role supports with sharing of information and risk management processes. HR relations have been strengthened with an increase in the safeguarding support offered by the teams, strengthening compliance with legislation and improving Trust assurance processes.

The PiPoT lead has positive working relationship and undertakes significant collaborative working with the Police enabling timely communication and appropriate information exchange.

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During the past 12 months support and advice has been offered in 13 possible PiPoT/Staff safeguarding issues. Of the cases identified several have resulted in a disciplinary sanction and referral to external agencies for support.

18.0 Mental Capacity Act and Deprivation of Liberty Safeguards - DoLS

18.1 Background

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

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

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

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

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18.2 Mental Capacity Act

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

The Mental Capacity Act provides:

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

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

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

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

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

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

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

Other provisions of the Act include:

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

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18.3 Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards came into effect in 2009 and are part of a legal framework set out in the Mental Capacity Act. They set out the principles that should guide such decisions, including the need to act in the person's best interests and to achieve the desired outcome in ways that put the least restriction on the person's rights and freedom of action, and empowering people to make their own decisions wherever possible. The reason the Safeguards were introduced was to address the problem that arises if a person does not have the mental capacity to make an informed decision about care or treatment.

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

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

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

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

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

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

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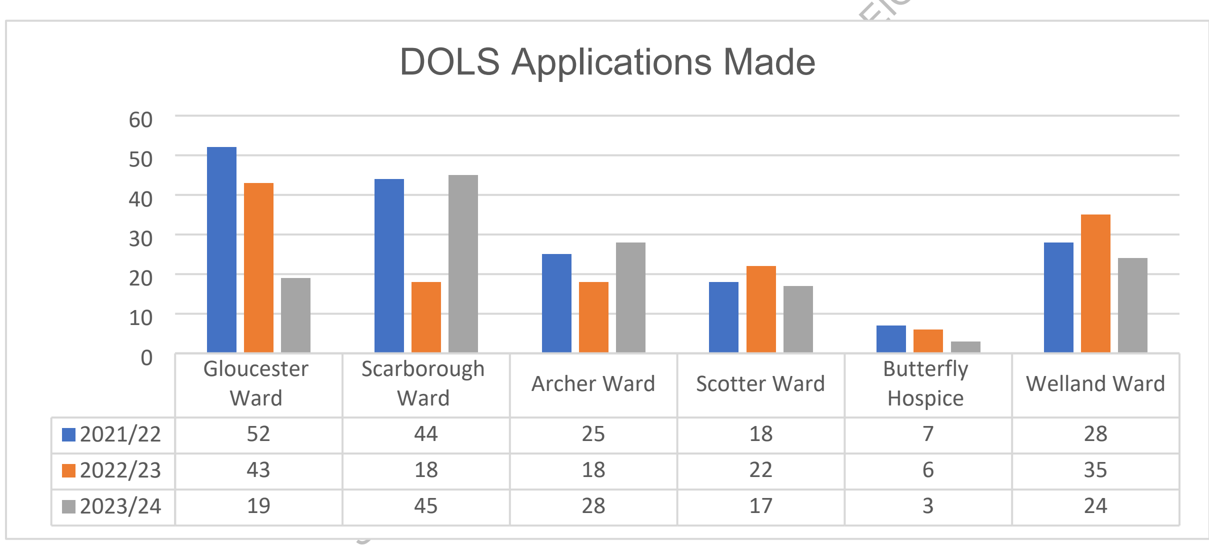
The Safeguarding Team keeps a live log of the DOLS within inpatient settings and liaises weekly with the local authority mental capacity team weekly to ensure that all DOLS are appropriately assessed and authorised. All DOLS applications are reviewed by the Safeguarding Team to check that any restrictions are proportionate to the risk, and least restrictive option available. The Safeguarding Team support with best interest meetings where decisions related to discharge residence are being made. Audit has taken place 6 monthly to ensure that DoLS are in place for all those who require one.

During this review period LCHS submitted 136 applications for Deprivation of Liberty Safeguards.

Figure 15: The number of LCHS DoLS referral made between April 2023 and March 2024 including a break down for community ward activity.



	Gloucester Ward	Scarborough Ward	Archer Ward	Scotter Ward	Butterfly Hospice	Welland Ward
2021/22	52	44	25	18	7	28
2022/23	43	18	18	22	6	35
2023/24	19	45	28	17	3	24

Audits undertaken within the clinical areas demonstrated an ongoing lack of on understanding of the mental capacity act and poor completion of some DoLS documentation. As a result of this the safeguarding team members now spend significantly more time in these areas to support and audit the MCA/ DoLS process and from 1st of April 2024 MCA training became mandatory for all clinical staff within LCHS.

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19.0 Dementia

19.1 What we know about dementia?

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

19.2 The impact of dementia

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

Figure 16: Projected costs of dementia for older people (£million), 2019-2040

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

19.3 Dementia in Lincolnshire

There are an estimated 12,458 people aged 65 and over living with dementia in Lincolnshire – equivalent to 6.8% of the over-65 population and 1.6% of the whole population. This is predicted to increase to 16,558 by 2030 and 17,949 by 2035 (44.1%), which is higher than the expected national increase of 40.3%. This will equate to 7.86% of the over-65 population or 2.3% of the whole population.

The number of people aged 65 or over in Lincolnshire is projected to increase by 60,000 (33.5%) between 2019 and 2035, with the highest proportion of people in this age group who are living with dementia estimated to be in Lincoln, Boston, North Kesteven and South Holland. South Kesteven is expected to see the greatest increase in people with dementia (66.75%), given a predicted shift towards a higher proportion of older people.

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

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

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

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

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

Of the 4436 people with a learning disability below the age of 65, (0.8%) 35 have a diagnosis of dementia and of the 408 people 65+ with a Learning Disability 43 have been identified as having dementia (10.5%).

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

A number of behavioural and disease factors are known to increase the likelihood of developing dementia and many of these are more prevalent in Lincolnshire than at

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both regional and national levels, including physical inactivity, being overweight or obese, hypertension, stroke, diabetes, CHD, and depression. These factors are not evenly spread across Lincolnshire, which creates inequalities in those populations experiencing deprivation.

19.4 Progress 2023 - 2024

The Safeguarding and Vulnerability team within LCHS assist in promoting dementia understanding across staff groups and will introduce the new dementia training across the Trust in the coming year.

Relationships continue to be developed with LPFT, ULHT and the wider ICB for collaborative working using skills, experience and services which will support our patients and their families and embed the Dementia Strategy for Lincolnshire.

LCHS is currently working with our partners on the refresh of the 'All About Me' document, to give staff a snapshot of what the patient needs to have a positive experience whilst in our care. It allows staff to understand the person's background; their likes and dislikes and any triggers of distress, to support reminiscence conversations, make reasonable adjustments to their community and hospital care and transition, reduce the distress and anxiety of being in an unfamiliar environment.

A new Dementia eLearning package is written and ready to launch during 2024, and embeds information across all staff groups to ensure staff have at least an awareness of dementia and how they can support that person, or their family, from answering the phone, meeting someone in a corridor, through to how we can meet their needs on our wards and clinical areas as well as being able to support through the discharge process to ensure our patients, and their carers have support.

20.0 Learning Disability and Autism

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

This may mean they can have difficulty with:

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

A visit to clinical environment can be difficult for anybody, but it is particularly challenging for people who have a learning disability or Autism. Reasonable

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adjustments to the health care of people are not only a statutory duty under the Equality Act 2010 but are also beneficial for all involved.

20.1 Learning Disability and Autism in Lincolnshire

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

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

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

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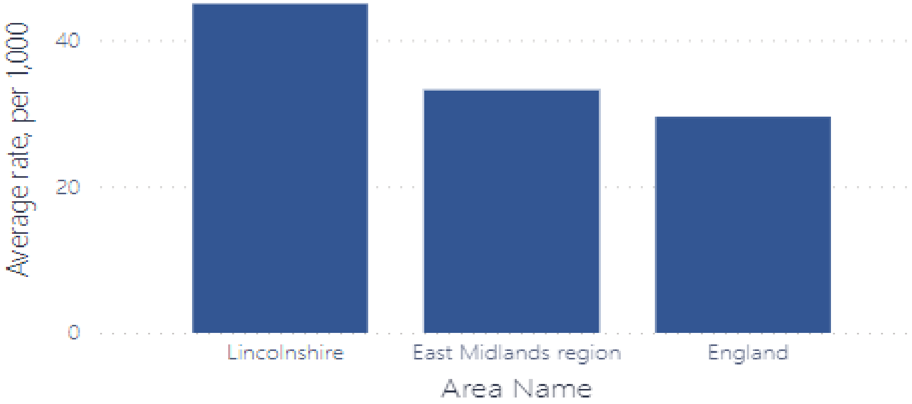
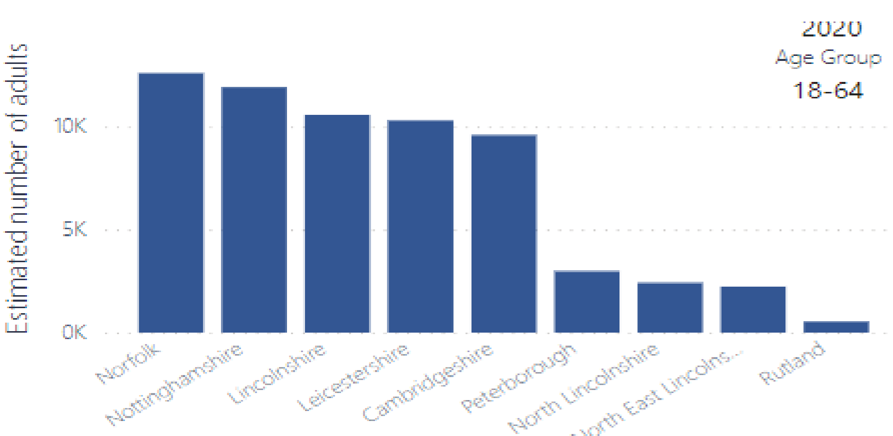
Figure 17: Children with Moderate Learning Difficulties Known to Schools 2020



Lincolnshire Health Intelligence Hub 2022

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



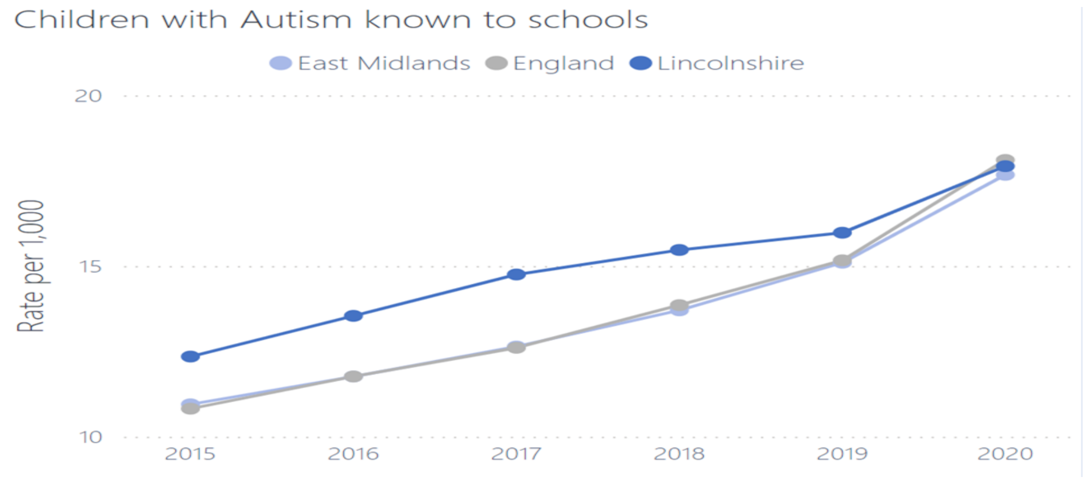
Lincolnshire Health Intelligence Hub 2022

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

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

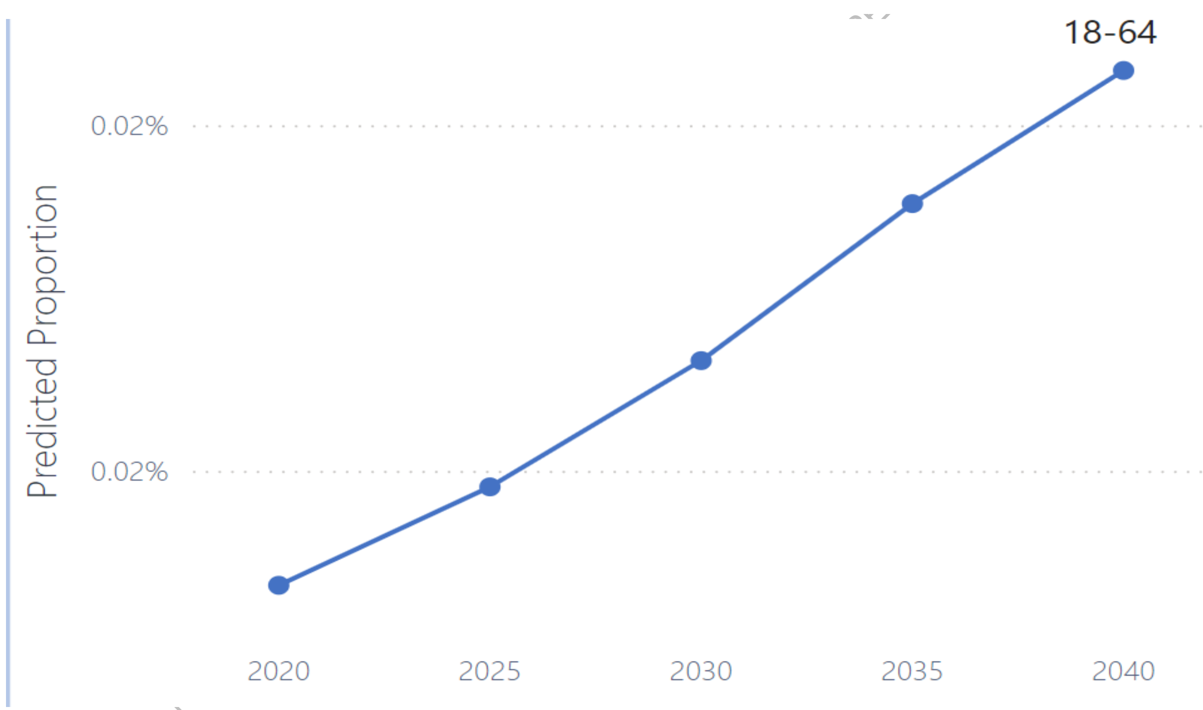
Nationally autism is underdiagnosed amongst certain groups such as older people, those who identify as females and individuals from Black, Asian and minority ethnic groups. This is due to the assessment tools used in autism diagnosis and limited awareness of the ways in which autism can present in different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

Figure 19: Children with Autism Known to Schools 2020



Lincolnshire Health Intelligence Hub 2022

Figure 20: People aged 18-64 predicted to have autistic disorders by 2040.



Lincolnshire Health Intelligence Hub 2022

20.2 Learning Disability and Autism

In 2023 LCHS embedded Learning disability and Autism within the safeguarding portfolio and governance framework and as a result the remit of the safegaurding team was expanded and will continue to develop over the coming years.

During 2023 – 2024 the team have worked more closing with our system colleagues to enable improvements in practice for our client groups who need investigations and admission to hospital.

In July 2022, the newly legislated 'Oliver McGowan' Training** was announced as a minimum benchmark for NHS Trusts and was launched across the Trust in 2023. Over the last 12 months we have worked together as a system to develop a local process based on the high standards and minimising impact of this training across Lincolnshire. This work is still ongoing and is likely to take a further 2 – 3 years for it to be fully embedded.

Easy read information is being developed in partnership with ULHT and will shortly be available on both external and intranet pages for anyone to access. There are plans to add to this and increase the resources available in easy read although this is just the start of the meeting our Accessible information standard requirement.

Whilst the focus of the work has been within the hospital setting, over the next 12 months this work, and learning will be cascaded through LCHS.

Since the development of the joint working between LCHS and ULHT Safeguarding teams there have been several patients who have benefitted from a more joined up approach in transition from community to hospital and includes a system wide approach for developing and embedding the Autism Pathway with specific work undertaken by LCHS regarding the autism diagnostic observation schedule, improved links with SEND and development of educational health plans.

Within LCHS a specific Downs Syndrome group now runs within Child Therapy, a group co-produced with families and the Downs syndrome association. In addition to this a pilot of an advice telephone line has been launched with a focus on fine motor and lower-level sensory problems associated specifically with learning disability and autism clients.

Over the last 12 months the staff within the school aged immunisation service have all been training in Makaton to further support our children and young people with learning disabilities and autism.

The LCHS Macmillan team have been successful in securing funding and implementation of No Barriers Here© - Advance Care Planning which aims to improve advanced care planning (ACP) conversations and address inequalities in palliative care.

Initially targeted at LD patients, the idea is to implement ACP in an arts and crafts-based approach to those patients who struggle verbally or don't feel listened to by healthcare professionals, aim to reduce hospital admissions longer term and encourage more ACP in those group of patients who struggle to access palliative care due to inequity (as per NHS ambitions for palliative and end of life care).

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20.3 Future plans for 2024 – 2025

LeDeR / SJR / patient safety and mortality – Review and audit the feedback from LeDeR and the actions from governance group to look at LCHS role in improving the outcomes of people with Learning Disabilities. Feedback will be added to the bimonthly MHNDD Steering group Learning Disability report which both Trusts and all divisions are represented. Individual feedback also given directly to clinical areas to ensure direct learning for each area is shared across teams.

Increase the number of flags and alerts for people with Autism and Learning disabilities in line with the NHS reasonable adjustment requirements to ensure more meaningful information is shared.

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

Explore the possibility of developing a specific Learning disability / autism role within LCHS ensuring clients in community have an equitable service.

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21.0 Safeguarding Risks

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

Figure 21: Summary of current risks and risks scoring for 2023 – 2024.

LCHS 453	Staff are not able to effectively support patients who lack mental capacity/ have cognitive impairments and exhibit challenging behaviours. which places themselves and others at risk of harm/injury.	HIGH (9)
LCHS 659	The trust is not able to clearly identify staff who are non-compliant with safeguarding supervision and make comparison to safeguarding training and competencies	HIGH (9)
LCHS 670	If there is inconsistent compliance with Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) requirements it could have a severe adverse impact on the mental health and wellbeing of the patient and may increase the likelihood of subsequent legal proceedings against the Trust.	HIGH (12)

During 2023 – 2024 the safeguarding teams have been actively involved with working to reduce and manage these risks which are monitored by the Safeguarding and Vulnerabilities Oversight Group.

22.0 A review of 2023 – 2024

The last 12 months have been a challenge for everyone across the United Kingdom in a way that no one could have envisaged. Across the safeguarding system the new ways of working that were developed during the pandemic have been modified to improve efficiency and effectiveness ensuring we continue to help support our most vulnerable in society as well as provide a wider level of support to all staff within the trust and the external safeguarding teams.

The normal pattern of safeguarding across Lincolnshire has changed because of the pandemic and some of the impacts have still being felt within the safeguarding arena.

During 2023 to 2024 safeguarding activity remains high particularly in relation to patients admitted due to eating disorders/disordered eating and Mental Health related issues as well as cases being more complex in nature.

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

Since June 2023 the LCHS safeguarding team and ULHT team have had the same manager which has brought improved communication between the two trusts and a more seamless approach for some of our most vulnerable.

- Face to face supervision as expanded, with additional sessions available via Teams to facilitate attendance across both trusts and work is ongoing to improve levels of attendance.
- Safeguarding and vulnerabilities pathways and processes to support staff in managing safeguarding related concerns have been reviewed and some shared working between the two teams has already begun and will be expended further in the coming year.
- A shared Safeguarding training plan was launched across the two trusts ensuring that there is a commonality within staff groups and that any training sessions delivered will be available to all staff no matter which trust they work for, or which trust is delivering the course. This will increase a joint understanding across teams, allow for a more flexible delivery and thereby facilitate increased attendance, understanding and knowledge of local processes.

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- Maintained and increased our presence in external / partnership processes such as the LSCP / LSAB / strategy meetings / MARAC etc.
- A new governance approach was embedded within LCHS to replicate that of ULHT ensuring that both trusts had a fit for purpose Safeguarding governance process across all divisions ensuring that safeguarding remained at the forefront of operation business.
- Continued to develop policies and improvements, undertook audits to maintain safety and identify risks.
- Continue to develop and expand safeguarding roles within the team to ensure that the trust can deliver a safeguarding and vulnerability service (child protection / adult protection / MCA / PREVENT/learning disability / autism and mental health)
- Continue to support staff members who are required to produce statements for, or attend as a witness in, Family or Criminal Court.
- Further developed and training in relation to Learning disability and Autism by launching the first phase of Oliver McGowan training across the Trust ensuring a system wide approach to the challenges that the delivery brings.
- Safeguarding team actively involved in the review of complaints and Serious Incidents with a safeguarding or MCA aspect.
- Continue to undertake ward spot checks /audits in relation to MCA/ DoLS
- Strengthen the Safeguarding Champions' Network across the trust.
- Continued to support with HR processes in relation to staff members for whom Safeguarding concerns have been raised (LADO/PiPoT)
- Supported the Children's Services Front Door Strategy Discussions process.

23.0 Safeguarding Developments and ongoing work for 2024-2025

- Maintain momentum to achieve 90% across safeguarding training areas.
- Finalise and embed pathways for clients with learning disability / autism ensuring smooth transition from primary / community care to secondary care.
- Continue the transition towards fully embedded the newly legislated Oliver McGowan training (3-year plan)
- Launch and continue to embed the training of MCA/DOLS within the trust ensuring that there is a better understanding of best interest planning, and that staff can more readily identify patients who require extra care and have clear plans to follow in line with legislative requirements.
- Audit adult concerns submissions within the trust to ensure compliance with 'Making Safeguarding Personal.'

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- Identify the training cohort, launch, and embed the new De-Escalation, Management, and Intervention (DMI) training across LCHS, skilling up staff, ensuring a shared vision of support for our patients.
- Continue to review and roll out MHA procedures.
- Review the ligature risk assessment process and rollout the ligature cutter (QUAD) pack across clinical areas alongside new ligature training.
- Rollout Mental health training.
- Rollout Dementia training.
- Develop a system of flags and alerts across the trust for people with Autism and Learning disabilities making use of the national 'reasonable adjustment' flags as appropriate.
- Explore the viability of employment of Learning Disability and Autism Support Practitioners across the Group.
- Explore the viability to facilitate the employment of an expert by experience role within the Trust.
- Continue to improve the service delivery of health assessments for our Children Looked After by way of developing a business case for additional funding and growth within the team.

24.0 Conclusion

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

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

The last 12 months have demonstrated the value that the two trusts working together can add in relation to joint understanding of service provision, shared insight, and improved communication, all of which improve the safeguarding of our most vulnerable patients.

As the new group develops there will be further advantages and benefits gained from economy of scale with less repetition and duplication ensuring that the teams can continue to effectively support patients, staff, and the organisations. The forthcoming year promises to be full of further developments and challenges for both the teams and the Group.

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25.0 Recommendations

It is recommended that the Trust Board

i) Receive the safeguarding report.

ii) Approve the plans for 2024 - 2025.

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Appendix 1: Safeguarding Team – Structure March 2024

Safeguarding and Vulnerabilities Team

March 2024

Portfolio:

Safeguarding Children

Safeguarding Adults

Mental Capacity and DOLS

Learning Disability / Autism

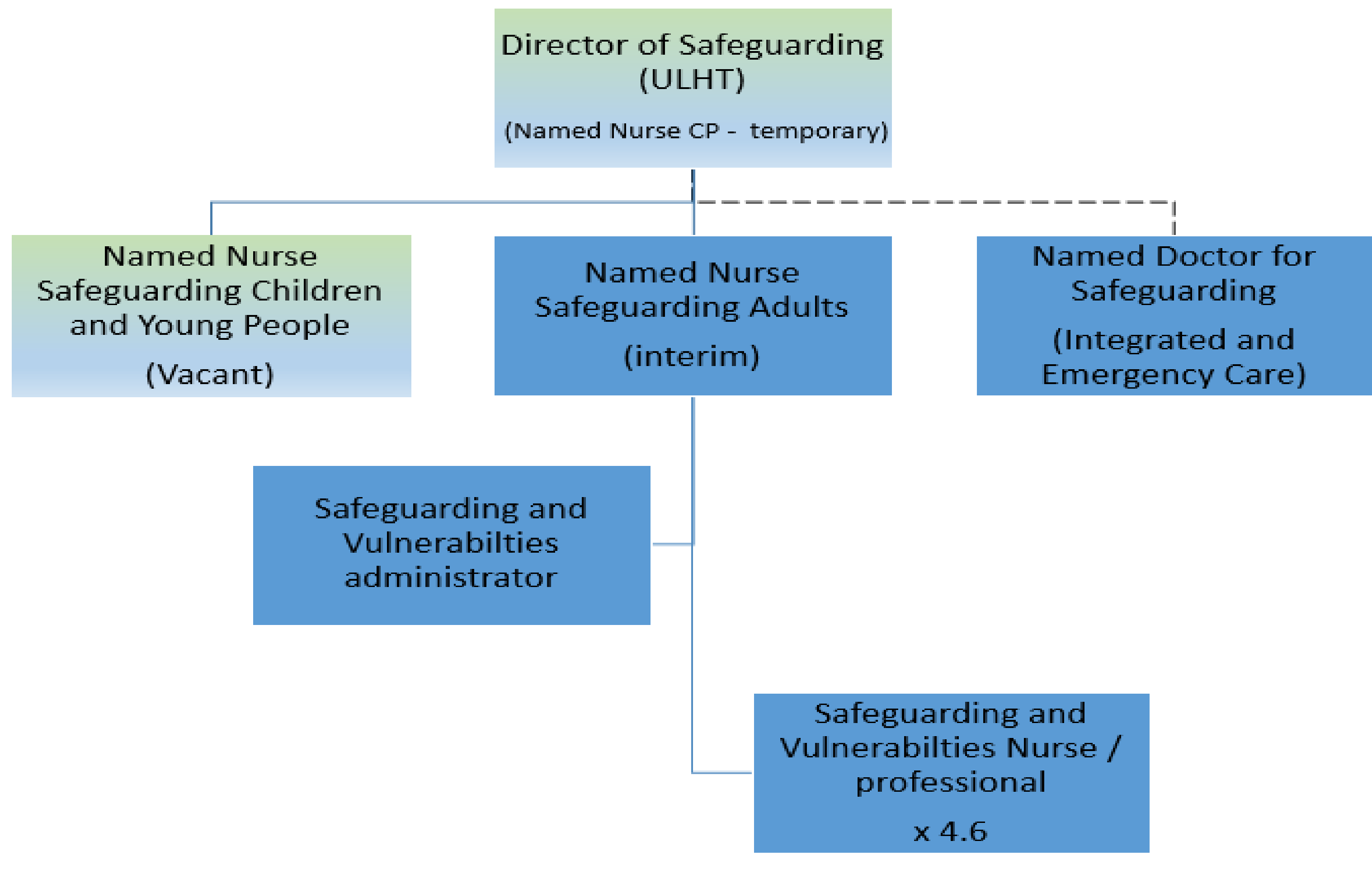
Dementia

Mental Health

PREVENT

Domestic Abuse

LCHS



Meeting	*Lincolnshire Community and Hospitals Group Board Meeting*
Date of Meeting	*3rd September 2024*
Item Number	*8.2*

2023/24 Safeguarding Annual Report

Accountable Director	*Nerea Odongo, Group Chief Nurse*
Presented by	*Nerea Odongo, Group Chief Nurse*
Author(s)	*Nerea Odongo, Group Chief Nurse*
Report previously considered at	*Quality Committee in Common* *20th August 2024*

How the report supports the delivery of the priorities within the LCHG 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	
1d Deliver clinically led integrated services	
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	
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)	
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	
5a Develop a Population Health Management (PHM) and Health Inequalities (HI) approach for our Core20PLUS5 with our ICS	

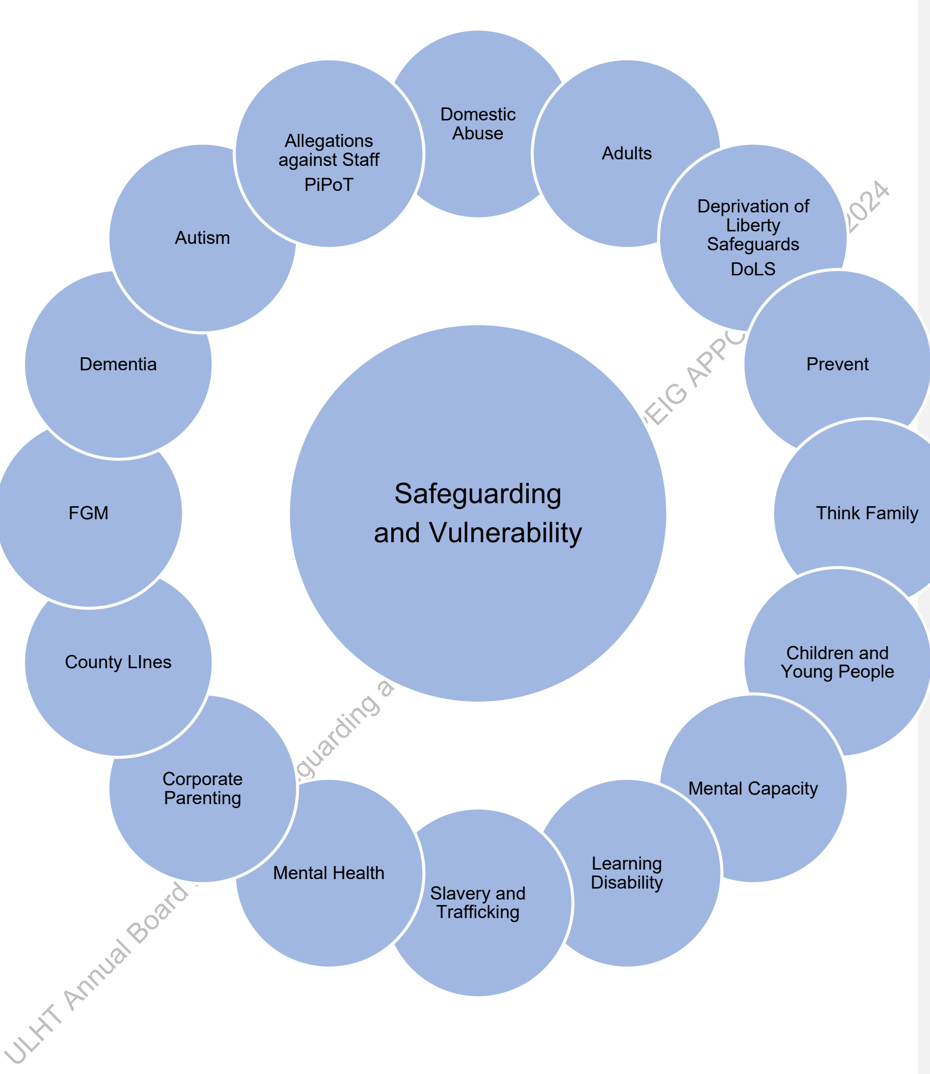
5b Co-create a personalised care approach to integrate services for our population that are accessible and responsive	
5c Tackle system priorities and service transformation in partnership with our population and communities	
5d Transform key clinical pathways across the group resulting in improved clinical outcomes	

Risk Assessment	*Not applicable*
Financial Impact Assessment	*Not applicable*
Quality Impact Assessment	*Not applicable*
Equality Impact Assessment	*Not applicable*
Assurance Level Assessment	• *Moderate*

Recommendations/ Decision Required	• *The Board are recommended to approve the 2023/24 Safeguarding Annual Report*

United Lincolnshire Hospitals NHS Trust

Safeguarding and Vulnerability Annual Report 2023 - 2024



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Foreword

As the Executive Lead for Safeguarding within United Lincolnshire Hospitals NHS Trust (ULHT), I am pleased to introduce the Safeguarding and Vulnerabilities Annual Report for 2023/24. Over the past year, the Trust continued to deliver quality and compassionate care and treatment across the communities in which we provide inpatient, community, and emergency services.

As the United Lincolnshire Hospitals NHS Trust and the Lincolnshire Community Health Services NHS Trust move towards a Group model, one of the first teams to develop a closer working relationship was the Safeguarding and Vulnerabilities Team under the oversight of the Director of Safeguarding.

This has provided an opportunity of reflection, to review the safeguarding work undertaken across both Trusts and whilst the past year has continued to be challenging as the NHS continues to experience significant operational pressures, there is a lot to celebrate and be proud of with the safeguarding work undertaken across the two organisations, and by the achievements and progress of the Lincolnshire Safeguarding Partnerships working together. ULHT have continued in their commitment to ensure that we help all residents of Lincolnshire live lives free from abuse and neglect.

Safeguarding can be complex and emotive work, and to safeguard effectively requires all agencies to work together in a collaborative and supportive way to develop seamless and effective safeguarding plans. We would like to thank our safeguarding partners across Lincolnshire for working with us to safeguard the population of Lincolnshire.

This report provides assurance to the Trust Board and our regulators, our patients and their families, and our partner agencies that everyone working at ULHT see safeguarding as part of their core business, and that we recognise that safeguarding children, young people, and adults is a shared responsibility, with the need for effective joint working between partner agencies and professionals, so that vulnerable groups in society are protected from harm. We all have a role to play in ensuring our patients and their families receive outstanding care.

The Trust Board of Directors are committed to ensuring all patients accessing our services are protected from harm and abuse ensuring that safeguarding remains a priority within the organisation. The Trust **has a commitment to Safeguarding which is reflected within the following Safeguarding Declaration ULHT Safeguarding Declaration.**

The Trust has specialist safeguarding staff who lead on and embed the practice of protecting adults and children from abuse, neglect, modern slavery, domestic abuse,

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and radicalisation. The ULHT team continue to embed the additional specialist areas of Learning Disability/Autism (Neurodiversity), Dementia and Mental Health.

Over the last 12 months there have been improvements in care pathways from community to Hospital and back home for some of our most complex patients. The team works tirelessly to ensure that our frontline staff have the required skills and knowledge to protect people, uphold their human rights and assess capacity.

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

Professor Karen Dunderdale

Group Deputy CEO/Chief Nurse / Executive Lead for Safeguarding (ULHT & LCHS)

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Statement from Lincolnshire Safeguarding Adults Board (LSAB)

ULHT has been instrumental in progressing the strategic priorities of the Lincolnshire Safeguarding Adults Board. Evidence that supports this statement is detailed below.

ULHT are leading the board's development of guidance in relation to "executive function" and the challenges it may present for practitioners when assessing mental capacity. They are also leading a review with partners of the board's "Self-Neglect" protocol.

ULHT are always consistent attendees at our board meetings and subgroups, contributing significantly to many aspects of the work that the board undertakes. I regularly attend from an independent perspective the Safeguarding and Vulnerabilities group. This allows me to hear first-hand how health practitioners are safeguarding individuals both in hospital settings and the community, where the use of patient stories helps to identify good practice and learning so the agencies can improve the care they provide.

Richard Proctor

Lincolnshire Safeguarding Adults Board - Independent Chair.

Statement from Lincolnshire Safeguarding Childrens Partnership (LSCP)

Over the last year Safeguarding children has been the subject of a national reform programme and Lincolnshire has been selected to be one of four wave one pathfinders. During this period, the staff from ULHT have been engaged in this work and worked hard in partnership to design a new model for the County. The overarching system level reform incorporates leadership, culture, and information sharing.

Whilst historically Lincolnshire has developed a strong multi agency approach to protecting children we are always seeking new methodology to strengthen our offer to children and families and your staff have reacted positively to this important programme. During the last year, the staff from the trust have contributed to the development of the partnership and I am grateful for their commitment and professionalism in this important and sensitive arena.

'Partnership is not a posture but a process, a continuous process that grows stronger each year as we devote ourselves to common tasks.'

John F Kennedy.

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The recent coming together of your Trusts can only strengthen our relationships and arrangements providing a more consistent approach to policies and training and an increased sharing of best practice across the organisation.

I would like to take this opportunity to thank your staff for their continued dedication to safeguarding and look forward to working with them to implement the new arrangements later this year.

Remember

'Coming together is a beginning, staying together is progress and working together is success.'

Henry Ford.

Chris Cooke

Lincolnshire Safeguarding Childrens Partnership - Independent Chair.

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1.0 Purpose of Report

The purpose of the report is to provide the Board with an annual update of the work undertaken in 2023 - 2024 with regards to safeguarding children and adults, Prevent, Mental Capacity and Deprivation of Liberty Safeguards (DoLS), Learning Disability /Autism (Neurodiversity), Dementia and Mental Health and the proposed areas of development for 2024 - 2025.

2.0 Legislative Background

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

Domain 1 Preventing people from dying prematurely.

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

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

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

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

In terms of safeguarding the key domains are:

Domain 4 Ensuring people have a positive experience of care,

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

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

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

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

2.1 Safeguarding Children

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

In 2024 the face of safeguarding children is very different to that of the late 1990s and an emphasis on early help rather than punitive action is what currently drives the system and as such the number of children on plans continues to vary.

Whilst systems change, at a national level we continue to see tragic cases involving child abuse such as Arthur Labinjo-Hughes aged 6 (Solihull) and Star Hobson aged 1 (Keighley) and more locally Darren Boulton aged 9 (Louth) who all died at the hands of the very people who were expected to protect them.

Safeguarding and promoting the welfare of children is defined in Working Together to Safeguard Children (2018 *– updated 2023*) as

- Providing help and support to meet the needs of children as soon as problems emerge.
- Protecting children from maltreatment, whether that is within or outside the home, including online.
- Preventing impairment of children's mental and physical health or development.
- Ensuring that children grow up in circumstances consistent with the provision of safe and effective care.
- Promoting the upbringing of children with their birth parents, or otherwise their family network through a kinship care arrangement, whenever possible and where this is in the best interests of the children.
- Taking action to enable all children to have the best outcomes in line with the outcomes set out in the Children's Social Care National Framework.

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

This is a standard requirement within all ULHT contracts of employment.

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

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- Senior management commitment to the importance of safeguarding and promoting children's welfare.
- A clear statement of the agency's responsibilities towards children for all staff.
- A clear line of accountability within the organisations for safeguarding and promoting the welfare of children and Adults.
- Service developments that take account of the need to safeguard and promote welfare and is informed, where appropriate, by the views of children and families.
- Staff training on safeguarding and promoting the welfare of children for all staff working with or in contact with children and families.
- Safe recruitment procedures in place.
- Effective inter-agency working to safeguard and promote the welfare of children.
- Effective information sharing.
- CQC Fundamental Standards 2022 which have a safeguarding thread running through all.

An audit of Section 11 duties is undertaken by the Local Safeguarding Children Partnership (LSCP) and any subsequent action plans will be monitored in line with the current governance arrangements.

The most recent section 11 submission took place in March 2024 and the trust report ***full compliance following peer review. The final grading will be available in September 2023 once the peer reviews have been formally approved by the LSCP.***

2.2 Safeguarding Adults

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

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

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

UHDB Annual Board report_Safeguarding and Vulnerability 2023 - 2024 REIG APPROVED 07.08.2024

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

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

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

2.2.1 Implications for Safeguarding Adults at Risk

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

Safeguarding Principles

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

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2.3 PREVENT

2.3.1 What is PREVENT?

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

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

Prevent	Pursue	Protect	Prepare
Safeguard people from becoming terrorists or supporting terrorism	Stop terrorist attacks happening in the UK and overseas	Stregthen our protection against a terrorist attack in the UK or overseas	Mitigate the impact of a terrorist incidents if it occurs
Primary outcome			
Reduce intent	Reduce capability	Reduce vulnerability	Reduce impact

Address strategic factors
Extremism
Conflict and instability
Developments in technology

Overall effect
Reduce risk

The Health Service is a key partner in PREVENT and encompasses all parts of the NHS, charitable organisations and private sector bodies which deliver health services to NHS patients and forms part of the Safeguarding accountability and assurance framework (NHS England 2022)

PREVENT has three national objectives:

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

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

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

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

PREVENT training is undertaken in line with the Prevent Training and Competencies Framework - Department of Health and Social Care (2022)

2.3.2 Why Health care staff?

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

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

3.0 Designated and Named Professionals for the Trust and its Commissioners.

3.1 Children

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

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

All NHS Trusts must identify a named doctor, a named nurse, and a named midwife (where maternity services are provided) for safeguarding with the focus of the named professional being on safeguarding children within their own organisation. These

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professionals are in post within ULHT and include a lead anaesthetist for safeguarding children as recommended by the Royal College of Anaesthetists (2012).

3.2 Adults

Following the publication of Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework (July 2022) there is an expectation that Designated (ICB) and Named professionals (ULHT) for safeguarding adults are in place.

Within ULHT the Director for Safeguarding holds the strategic lead for both children and adults and the Trust has a Named Professional responsible for Safeguarding Adults and Mental Capacity Act supported by specialist nurses with responsibility for Safeguarding Adults, Learning Disability/Autism (Neurodiversity), Dementia and Mental Health

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4.0 The Safeguarding and Vulnerabilities Teams

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

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

5.0 Safeguarding Governance Arrangements

The responsibility for safeguarding rests with the Chief Executive Officer, supported by the Executive Director with Board responsibility (Prof Karen Dunderdale).

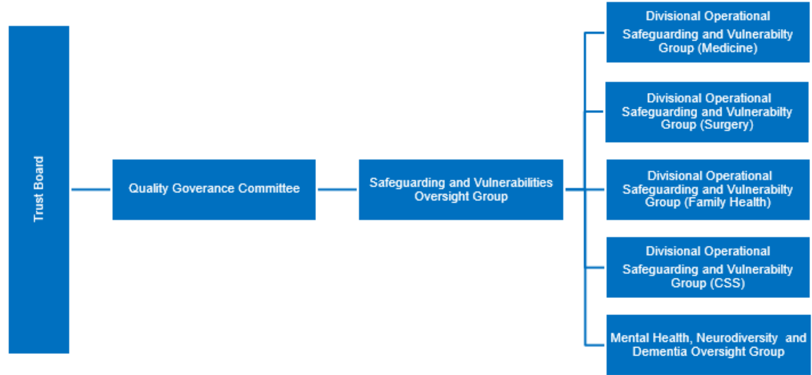
ULHT has in place the following safeguarding specific groups:

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

Mental Health, Neurodiversity and Dementia Group (MHNDD) which reports to the Safeguarding and Vulnerabilities Oversight Group (figure 1). The group is active in the

management of the current action plans / issues within the specialist area. The Named Professional for Safeguarding Adults chairs the group.

Figure 1



During 2024 to 2025 the SVOG within ULHT and LCHS will join to form one strategic group and the Mental Health, Neurodiversity and Dementia Group will be expanded to cover both ULHT and LCHS

ULHT Annual Board report - Safeguarding -

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

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

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

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

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

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6.1 LSCP Key areas of action

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

LSCP business plan 2022 - 2025

6.2 LSAB Key areas of action

- Prevention and Early Intervention.
- Making Safeguarding Personal (MSP).
- Learning and shaping future practice.
- Safeguarding Effectiveness.

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

Lincolnshire Safeguarding Adult Board Strategy 2022 - 2025

7.0 Child Safeguarding Practice Reviews (Previously Serious Case Reviews - SCR) / Safeguarding Adults Review (SAR) / Domestic Abuse Related Death Reviews (DARDR)

7.1 Children

Child Safeguarding Reviews have been in place for many years and nationally about 400 take place every year. A review is always carried out by the Safeguarding Partnership when a child dies and abuse or neglect is known, or suspected, to be a factor in the death. Working Together (2018) guidance also states that LSCP should consider holding a review *where a child has sustained a life-threatening injury through abuse or neglect, serious sexual assault, or through serious and permanent impairment of health or development through abuse or neglect.* The purpose of a review is to establish what lessons can be learnt about the way professionals and organisations worked together, how they will be acted upon and what is expected to change to improve inter-agency working and improve safeguarding practice to children. Reviews are exercises in learning and improving policy and practice and outcomes for children and young people and are not inquiries into how a child died or who was culpable; this is the business of Coroner's and the Criminal Court.

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

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learnt, the LSCP then ratifies the conclusions and recommendations for actioning the lessons.

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

ULHT are currently involved in one new Child Safeguarding Practice Review (CSPR) which was commissioned in February 2024, there are currently no actions identified.

7.2 Adults

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

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

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

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

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

During 2023 – 2024, ULHT was not involved with any reviews however did complete an outstanding action for 2022-2023.

7.3 Domestic Abuse Related Death Reviews (DARDR)

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

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

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

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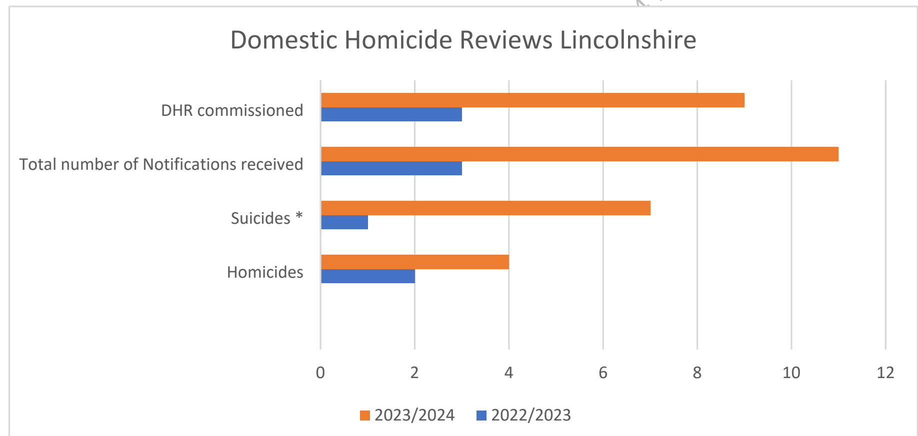
When DARDRs started in Lincolnshire, there were twelve notifications during the period of 2012-2017 however since 2018 the number of notifications has doubled leading to 30 cases that have met the criteria for a domestic homicide review in Lincolnshire between 2012 and 2023.

ULHT is currently involved in 18 Lincolnshire DARDRs and 2 out of County DARDRs, involving submission of a chronology and report on former patients who were resident in Sunderland and Rutland at the time of their death. Some of the Lincolnshire DARDRs are complete however are still awaiting final sign off by the Home Office.

There are currently no outstanding actions for ULHT, and the newly commissioned reviews have not yet generated actions for individual agencies.

Figure 2: Number of cases referred for discussion to DARDR panel.



*** Since 2022 DARDR criteria have changed to include all deaths by suicide where there has been a known history of domestic violence within the current/past relationship.**

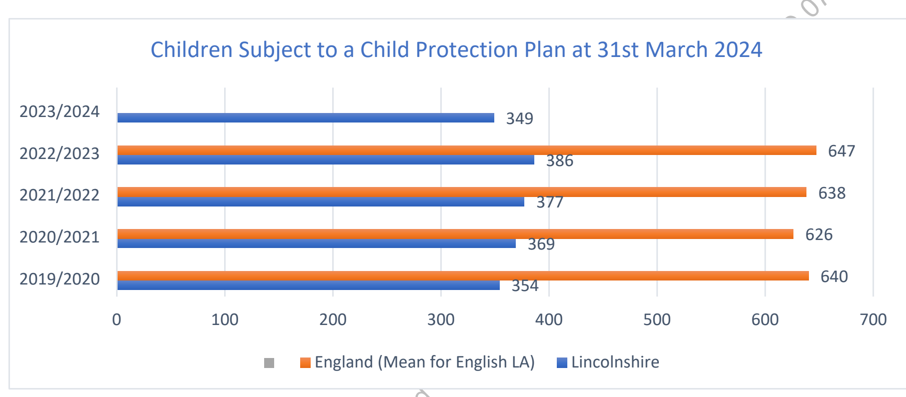
8.0 Child Protection Cases

Lincolnshire holds child protection conferences on each working day and therefore the numbers for children who currently have a child protection plan vary daily Monday to Friday and can be influenced by families moving in and out of the local authority. Overall, the numbers of children on plans (figure 4) have slowly risen over the last 5 years whereas the mean for England has demonstrated a downward trend.

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

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

Figure 3: Number of children having a child protection plan within the Local Authority area who may be receiving services from ULHT (April 2019– March 2024) ***(England Mean 23/24 not available at time of report)***



8.1 Child in Need

Some children will not meet the criteria for a child protection plan but still require a service which can be met at a lower level 'children in need' of support. The data in figure 5 demonstrates the number of children in need across Lincolnshire with a decrease in numbers over the last 12 months remains below the England mean.

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

Figure 4: Number of children classed as a Child in Need within the Local Authority area who may be receiving services from ULHT (April 2019 – March 2024)

(England Mean 23/24 not available at time of report)

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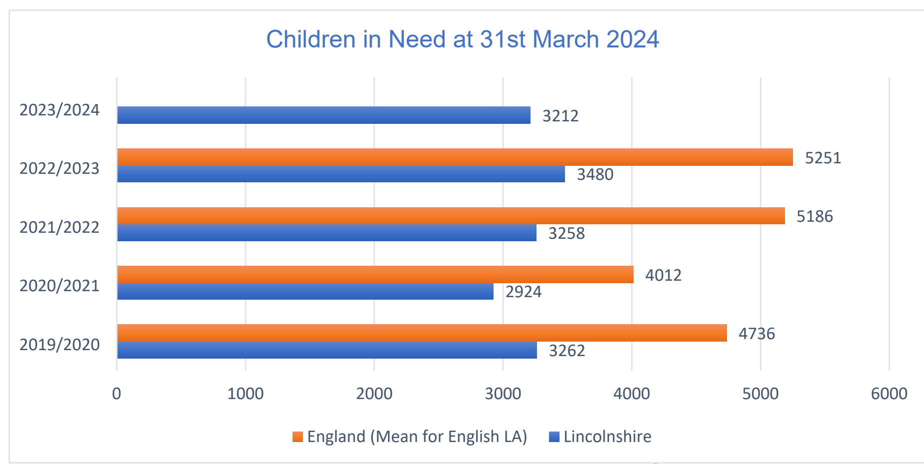

8.2 Children in Care

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

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

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

During 2023 to 2024 the Trust as provided specific care to several children who have been placed by other Local Authorities and who potentially posed a risk to themselves and others within the paediatric setting. The Trust have worked closely with our multi-agency/multi-professional partners to ensure that these children received the best possible care.

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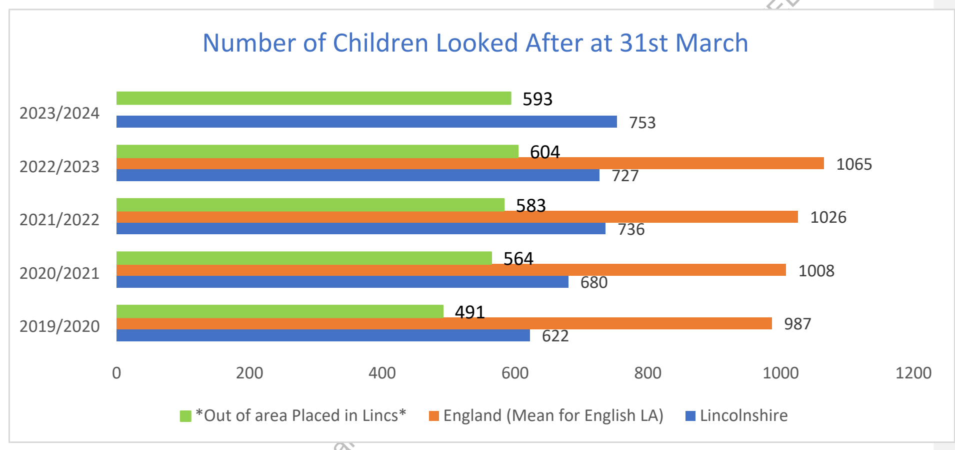
Over the last 5 years the number of children in the care of Lincolnshire Local Authority has risen in line with the England mean, although there was a slight dip during 2022 - 2023. This steady increase is also noted in the number of children placed into Lincolnshire by other Local Authorities.

Children within the trust are identified within Care flow, SystmOne and via the Lincolnshire Care Portal.

Figure 5: Number of children classed as a Child in Care within the Local Authority Area who may be receiving services from ULHT (April 2019 – March 2024)

(England Mean 23/24 not available at time of report)



*** Out of area placements are reliant on external Local authorities notifying Lincolnshire of the placement and therefore this is likely to be an under reporting and the actual figure being higher***

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9.0 Adult at risk

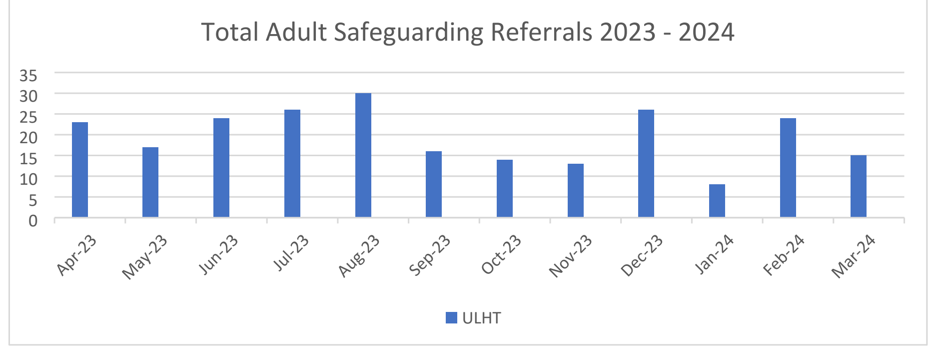
Adult Safeguarding is extremely complex and impacts on much of the day to day work of the Trust i.e., Complaints/PALS, Serious incidents/PSIRF, pressure ulcers, patient safety and HR. Safeguarding is about more than simply keeping someone safe, it is about respecting and protecting an individual's needs,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

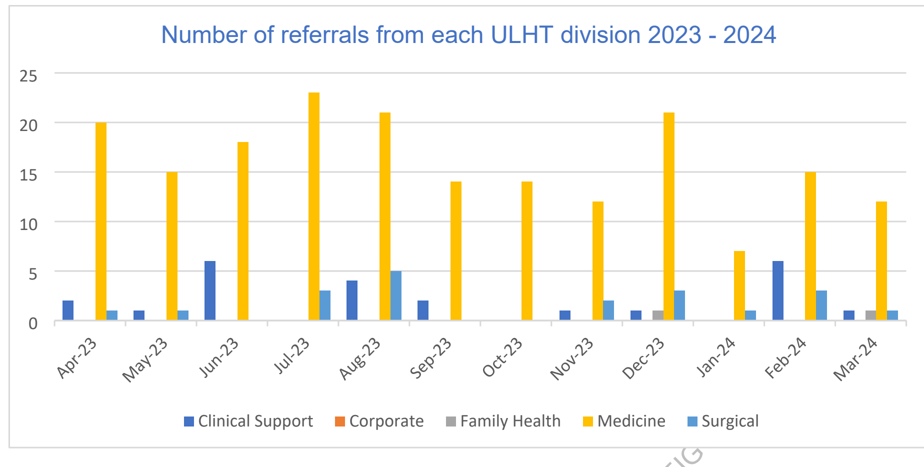
There is increased emphasis on 'making safeguarding personal' and involvement of the patient in their safeguarding decisions. Audits from the LSAB and internally continue to suggest that this is an area which requires further improvement so remains a priority for 2024 - 2025.

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

The number of referrals raised during 2023 - 2024 by ULHT was 238 (29% increase) indicating that the trust is actively identifying issues of concern. Work continues to ensure that all referrals are appropriate and include the patients views wherever possible.

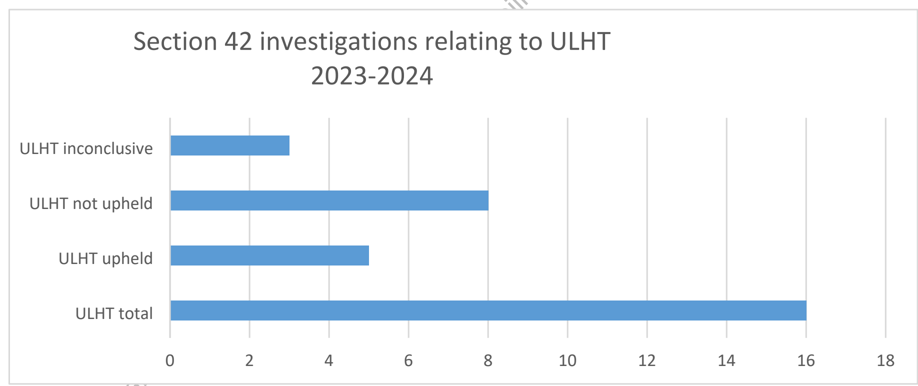
Figure 6: Number of safeguarding adult referrals made by ULHT to the Local Authority (April 2023 – March 2024) including divisional breakdown.





9.3 Safeguarding referrals made against ULHT.

The number of safeguarding allegations raised against the trust continues to vary however over the last 12-month period was 16 for ULHT.



ULHT - Trends from these investigations highlight issues as follows.

- Lack of coordinated discharge.
- Failure to supply discharge medication.
- Lack of pressure ulcer risk assessment and preventative measures.
- Lack of use of MCA and Best interest processes.
- Poor communication / record keeping.

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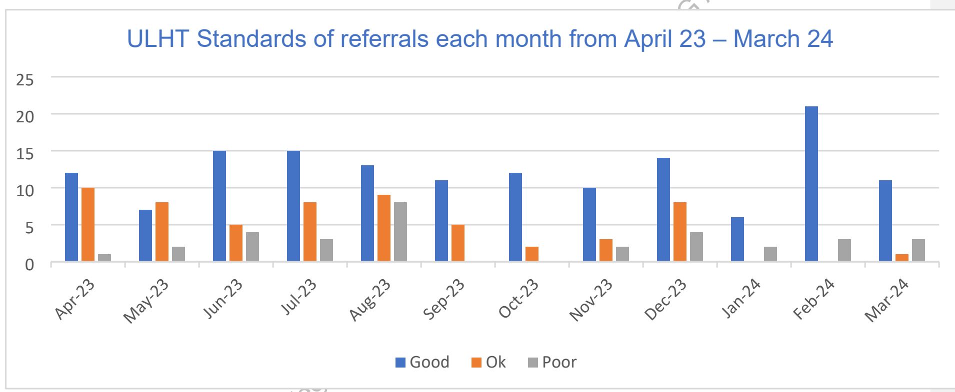
A number of lessons learnt, and actions have been put into place to minimise future risks. The Named professionals meet with the CQC and separately with the ICB and LA to ensure that there is an open and honest dialect maintained and works on the premise of no surprises.

Quality assurance

All referrals are quality assured. Moving forward as the group develops in 2024 – 2025 these processes will be standardised across the teams.

ULHT is reliant on paper records hence the audit of referrals is undertaken in a less timely fashion however follow up contact with the referrer is made when appropriate.



10.0 Legal statements / Court process

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

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

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

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

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

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

ULHT have taken one case to the CoP in the past year and have sought legal advice on several.

During 2023 to 2024 the ULHT commissioned a series of Court craft and legal updates for staff which currently continue to March 2025 and cover court skills suitable for children and family / Coroners' Courts as well as updates around the Mental Capacity Act and relevant changes in case law. These events where opened to LCHS staff in 2023 and are being provide across the Group going forward.

11.0 Safeguarding Clinical Supervision

11.1 Children

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

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

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As of 31st March 2024, compliance rates are as follows.

ULHT

3 Monthly - 80%

6 Monthly – 53 %

Compliance figures for Safeguarding supervision are notoriously difficult to maintain due to 3 - 6-month time scales and regularly changing staff groups particularly amongst medical staff. In order to proactively manage this challenge, the safeguarding team use the above figures in conjunction with the Safeguarding training compliance figures to identify high-risk areas of concern and target specific staff groups.

Compliance is monitored by the teams with bi-monthly reports provided to Safeguarding Operational Groups / Divisional Leads for escalation and via SVOG.

11.2 Adults

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

12.0 Training and learning

Safeguarding training has always been a high priority within the Trust and is implicit within the National contract and Safeguarding legislation. A new joint training plan was introduced for safeguarding children and safeguarding adults in 2023 as the first stage of bringing both Trusts closer together and ensuring compliance with statutory guidance. As part of this process all training courses were reviewed and updated as necessary with the vision that moving forward staff from either Trust could attend any course and still gain compliance.

As a move away from pandemic working, the training has moved away from e-learning to delivering more face-to-face courses. This has improved interaction in training sessions and allows for detailed scenario discussions. From March 2024 most e-learning safeguarding courses have been switched off.

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Training levels with the Trust on the 31st of March 2024 were as follows.

KPI Description *(A measurable value that demonstrates the success of your change, to include trajectory to achieve target)*	**Measures** *(How will this be Measured)*	**Target** *(Desired level of performance)*	**ULHT** *END March 2024 figures* *Trend compared with March 2023*
To reach 90% for Safeguarding children level 1	Monthly training report (MTR)	90%	95.72% ↑
To reach 90% for Safeguarding children level 2	MTR	90%	86.86% ↑
To reach 90% for Safeguarding children level 3	MTR	90%	87.98% ↑
To reach 90% for Safeguarding children level 4	MTR	90%	100% →
To reach 90% for Safeguarding adults level 1	MTR	90%	95.24% ↑
To reach 90% for Safeguarding adults level 2	MTR	90%	85.55% ↑
To reach 90% for Safeguarding adults level 3	MTR	90%	80.29% ↓
To reach 90 % for MCA / DOLS	MTR	90%	84.62% ↑
To reach 90% for PREVENT basic level	Quarterly training report	NHSE/I target 85%. ULH target 90%	95.74%% ↑
To reach 90% for PREVENT Higher level	Quarterly training report	NHSE/I target 85%. ULH target 90%	87.98% ↑
To reach 90% for Mental Health	MTR	90%	96.27% ↑
To reach 90% for Dementia	MTR	90%	96.41% ↑
To reach 90% for Learning Disability / Autism Tier 1	MTR	90%	95.94% ↑
To reach 90% for Learning Disability / Autism Tier 2	MTR	90%	93.58% ↑
Oliver McGowan Specific Tier 1 e-learning *	MTR	90%	15.13%
Oliver McGowan Specific Tier 2 e-learning *	MTR	90%	19.33%

*** (ULHT- Commenced 1st March 2023 – gradual merge with standard Tier 1/ Tier 2 by March 2026)**

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Oliver McGowan e-learning training is being rolled out across the trust however for full compliance staff members must attend a second module which is a face-to-face course.

The uptake is reliant on the availability of the face-to-face course and at present these are very limited nationally as the course must be delivered by experts with lived experience.

The Trust is working with the Lincolnshire system partners to commission these modules however whilst tier one modules are slowing becoming more available it is likely to be 12 to 18 months before the tier two module is available and only then in limited numbers.

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13.0 Safeguarding issues within Pregnant Women

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

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

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

During 2023 – 2024, 443 Social Care referrals were made by ULHT Maternity Services due to safeguarding concerns **(an increase of 88 on the previous year)**

278 unborn babies within the safeguarding database had an allocated Social Worker **(a decrease of 2 on the previous year)** , 171 were made subject to Child in Need plans **(a decrease of 7 on the previous year)**, 22 subject to Child Protection plans **(a decrease of 3 on the previous year)** and the remaining 85 unborn babies were managed with the legal arena under pre-proceedings due to the severity of the safeguarding concerns with **(an increase of 8 from the previous year)**

Thirty-four babies being removed on discharge from their mother's care **(an increase of 3 on the previous year)**

Five babies were discharged into Mother and Baby placements **(an increase of 3 on the previous year)**

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

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

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

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

The implementation of providing memory boxes to parents and their babies who are being separated on discharge from hospital due to proceedings, is underway. This will hopefully provide some comfort to the families devastated by separation and will allow them to capture the special time they spend with their babies prior to discharge from the maternity unit.

The Named Midwife for Safeguarding receives all Police incidents regarding pregnant women, 375 notifications were received in 2023/24 **(an increase on 4 on the previous year)** the majority being domestic abuse incidents with 57 pregnant women being heard at MARAC in that period due to concerns of high-risk domestic abuse.

The notifications ensure that any outstanding actions are completed, ongoing monitoring of safeguarding concerns takes place and any required referrals to partner agencies are made.

The Safeguarding Midwives provide regular Safeguarding supervision to all Midwives and join the Neonatal Unit's safety huddle and the maternity Unit operational weekly meeting to offer safeguarding support and advice on babies and their families within the Trust.

During the last 12 months there has been a noticeable increase in the complexities of safeguarding cases identified within maternity services and it has therefore been

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imperative that all staff work together to ensure the safest outcomes for the families whom we care for.

Figure 7: Safeguarding Specific Maternity data.

14.0 Female Genital Mutilation (FGM)

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

From 1st April 2015, and in line with National Guidance, ULHT began to routinely submit FGM data. This data is submitted monthly to the Trust's Information Support team for onward submission to NHS Digital. Nationally since April 2015, 35,415 individual women and girls had an attendance where FGM was identified.

Between April 2023 and March 2024, ULHT reported 63 cases of FGM (an increase of 47% over the last 12 months, 135% over the last 5 years): of which 32 were Type 4 (piercings); 6 were Type 1, 1 was type 2, 1 was type 3 and 23 were of an unknown type. All cases reported were reported by adults and those reporting Type 1 had undergone the FGM as children in their countries of origin.

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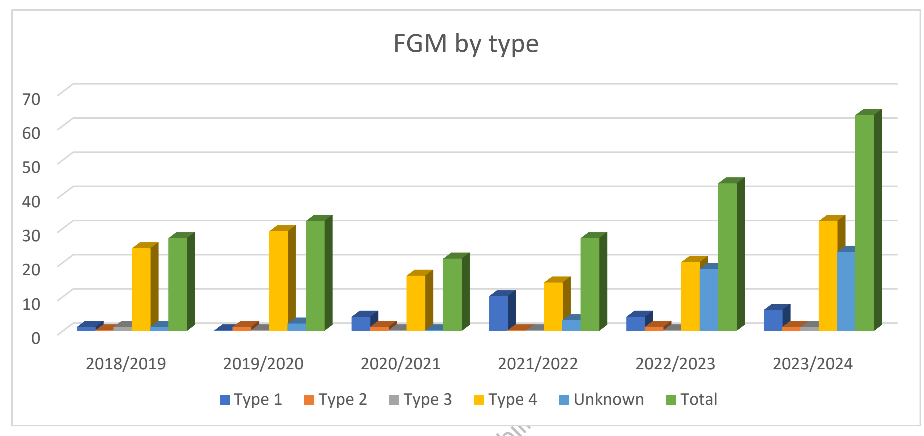
For those Type 1 cases, appropriate safeguards were initiated in respect of the unborn: with the Trust also complying with the appropriate NHSE alerting protocols.

Figure 8: FGM specific data by WHO type classification.



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

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

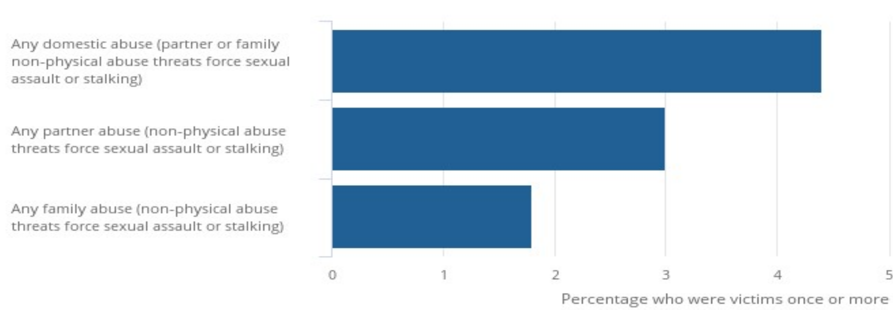
The Trust is represented at the twice-weekly MARAC meetings by the Safeguarding Specialist Nurses and at the Domestic Abuse Operational and Strategic Boards by the Named Nurses for Safeguarding and the Director for Safeguarding, respectively.

15.1 Key Facts

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

Figure 9: shows a higher percentage of adults experienced domestic abuse by a partner or ex-partner (4.4%) than by a family member (1.8%) in the last year. Of those

who experienced partner abuse, 88% experienced non-physical abuse, 9% experienced sexual assault and 16.1% experienced stalking.



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One in 25 people experience domestic abuse in the year ending March 2023

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

Domestic abuse remains an under reported issue. CSEW national figures suggest that only 31% of partner abuse victims told someone in an official position about their abuse (i.e., police, health professionals, or local council department). 18.9% of victims told the police, 18% told a health professional and 5% told a local council department. The majority of partner abuse victims instead told somebody they knew personally about their abuse. 1 in 4 partner abuse victims told nobody at all about their abuse (27%), a much more concerning statistic amongst males where 1 in 2 (49%) told nobody about suffering abuse at the hands of their partner. (Source: Office of National Statistics)

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

- On average a woman will experience **35 assaults** before going to the police
- **2 - 3 women a week** are killed by their current or former partner
- **1 in 7 males** will experience domestic violence and abuse.
- Domestic violence often starts or intensifies during and after pregnancy.

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- 3.7 million women in England and Wales have been sexually assaulted at some point since the age of sixteen.
- Around 2,000 women are raped each week. 34% of all rapes recorded are committed against children under 16 years of age.
- Estimated 66,000 women in England and Wales have undergone Female Genital Mutilation and over 24,000 girls are estimated to be at risk.
- One in four lesbian, gay, bisexual, and transgender people have experienced domestic violence and abuse in their relationship.
- Disabled women are twice as likely to experience domestic violence and abuse than non-disabled women and over a longer period of time, suffering more severe injuries because of the violence.
- Domestic violence and abuse in teen relationships is increasingly recognised as a significant issue. Research now suggests that women between the ages of 16 and 25 are at highest risk.

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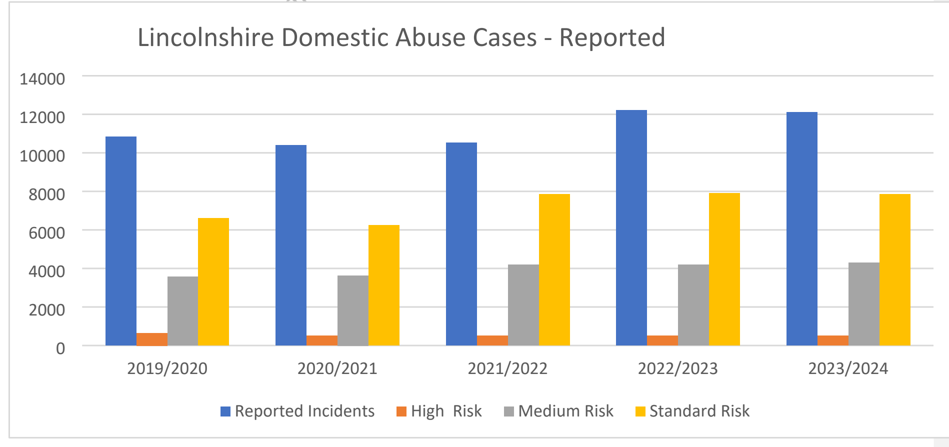
15.2 Domestic abuse in Lincolnshire

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

Figure 10: Domestic Abuse Cases



15.3 Domestic abuse and children

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

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

The high rate at which children are present during partner abuse incidents has a number of consequences. At a basic level it places additional responsibility on those agencies encountering domestic abuse to ensure that appropriate checks, risk assessments and safeguarding referrals are being made for child witnesses as well as adult victims of domestic abuse. Domestic abuse is the single most prevalent assessment factor identified in children's social care assessments. It is more prevalent than the presence of factors such as mental health, alcohol misuse, drug misuse, disability and illness, emotional abuse, physical abuse, or sexual abuse. In Lincolnshire during 2018-19, 55.1% of assessments identified domestic abuse as an issue. This is higher than the national average of 50.6%, and places Lincolnshire 42nd among the 151 local authorities in England that supplied information. (Source: Department for Education) Domestic abuse has also specifically been identified as a factor in 54% of all serious case reviews, which investigate child deaths relating to maltreatment, abuse, and neglect. *(S Framp, Community Safety Analyst, Lincolnshire County Council, May 2021).*

15.4 MARAC cases

There were 1201 victims who were at high risk of serious harm or death referred into the Multi Agency Risk Assessment Conference (MARAC) by partner agencies in 2023-2024. On average 300 referrals are made to MARAC every quarter (last 5 years ending March 2024).

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Figure 11: MARAC Cases

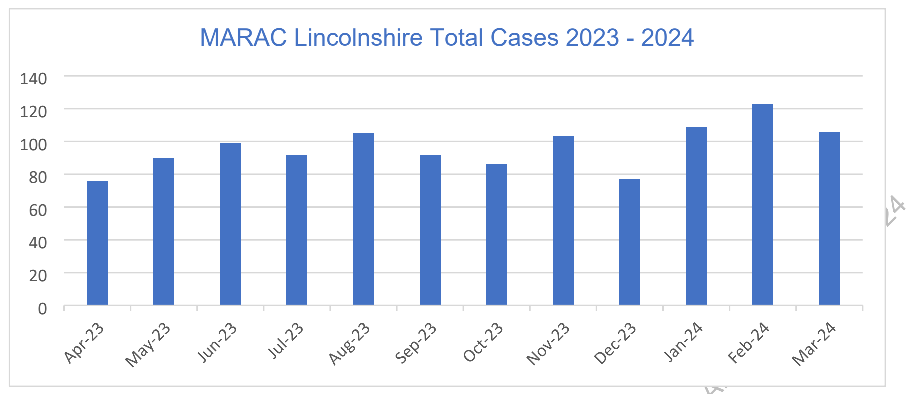
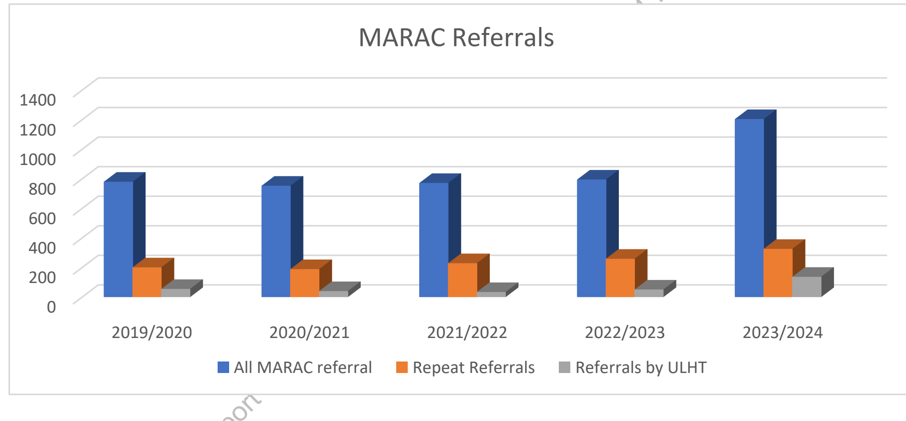


Figure 12: MARAC Referrals – all risk levels

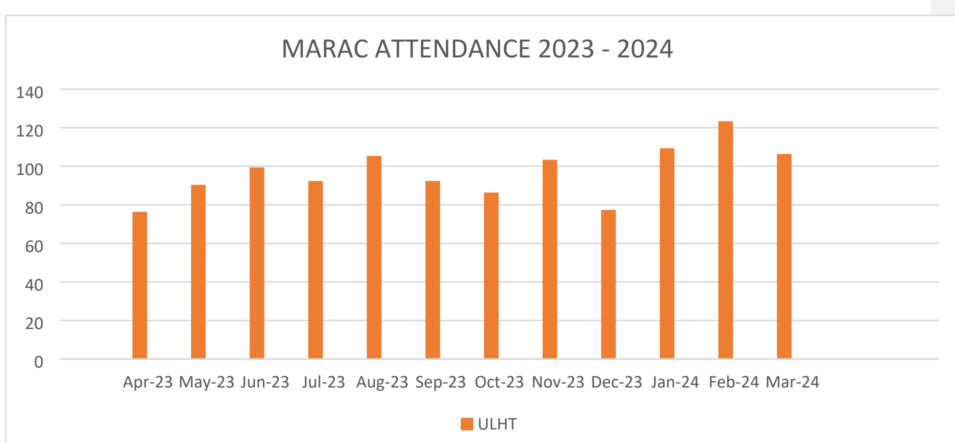


MARAC conferences are held weekly in Lincolnshire on both a Wednesday and Thursday and during the last 12 months both teams have continued to attend all MARAC meetings. More recently legislation has changed to include additional meetings to be held under Domestic Violence Disclosure Scheme.

During 2023 – 2024 as part of a recommissioning process within Lincolnshire of the DV service, the two independent Domestic violence advocates based within the hospital were removed placing additional pressure on the ULHT team.

Additional funding was found within the ULHT budget during 23-24 and a ULHT employed DV advocate will start in post in July 2024

Figure 13: MARAC cases attended by ULHT Safeguarding Professionals



15.5 Domestic Abuse support

On the 1st of April 2023, the previous domestic abuse support service (EDAN Lincs) ended and a new support service (Lincolnshire Domestic Abuse Specialist Service – LDASS) was launched. The 2 Independent Domestic Violence Advocates (IDVA) employed by EDAN Lincs based within the Safeguarding and Vulnerabilities team who provided 1:1 work with victims and support staff to manage disclosures of Domestic Abuse were removed and this added additional workload to the team. Additional funding has now been identified within ULHT to employ our own advocate commencing July 2024.

Across Lincolnshire a Total of 1985 adult referrals were received into LDASS between the 1st of April 2023 and 31st of March 2024 for adult victims of domestic abuse to specialist outreach support services in Lincolnshire – this is a decrease from the previous year due to the introduction of the Victim Lincs Referral Pathway resulting in a significant drop in referrals received into LDASS Lincs from the police. Victim Lincs allows for direct referrals from professionals and self-referrals into LDASS.

A total of 10,146 enquiries were received into the service from members of the public for advice regarding domestic abuse, an increase of 31% on the previous 12 months.

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16.0 PREVENT Lincolnshire Profile

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

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

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

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

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

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

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

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

ULHT are represented at the Prevent Steering group by the Named Professional for Safeguarding and MCA (ULHT) who is also the point of contact for the Regional Prevent Coordinators. It is also the responsibility of the PREVENT lead to ensure that the Trust is compliant with our reporting requirements including submission of the data required by NHS England (NHSE) to capture Prevent activities undertaken by the Trust on a quarterly basis.

ULHT has not made any Prevent referrals during the year however have provided research on several cases over the last 12 months in compliance with our PREVENT duty.

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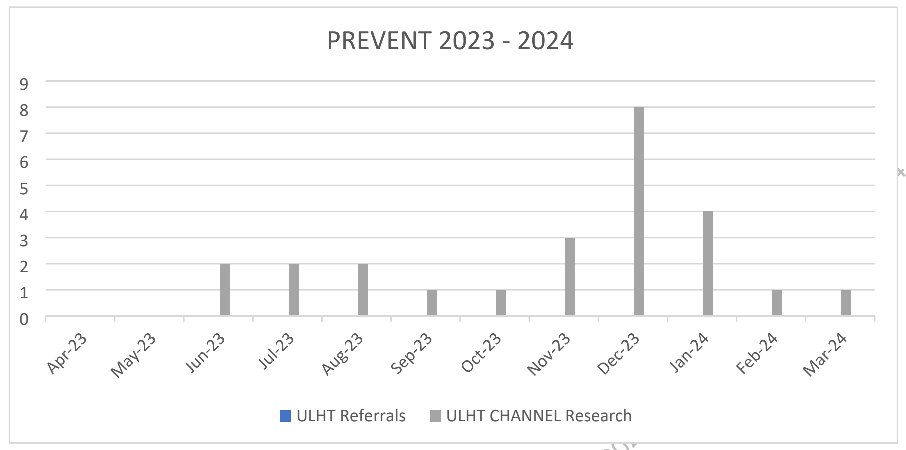
Figure 14: Number of PREVENT data analysis cases undertaken by ULHT as part of Channel Process (April 2023 – March 2024)



17.0 Multi-Agency Public Protection Panel (MAPPA)

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

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

There are four categories of MAPPA-eligible offender:

Category one registered sexual offenders.

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

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

Category four terrorism convicted and terrorism risk individuals.

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

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Figure 15: Lincolnshire Area MAPPA Eligible offenders on 31st March 2024 (2024 figures are not yet available) *Comparative figures 31st March 2022*

Category 1: Registered Sex offender	886	(0)	➡
Category 2: Violent offenders	146	(0)	➡
Category 3: Other dangerous offenders	4	(0)	➡
Total:	1036	(0)	➡

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18.0 Persons in Positions of Trust (PiPoT)

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

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

- The PiPoTs own work.
- The PiPoTs life outside work which may raise concerns re contact with adults with care and support needs (for example where a son is accused of abusing his older mother and he also works as a domiciliary care worker with adults with care and support needs. Or where a woman is convicted of grievous bodily harm and works in a residential home for people with learning disabilities).
- The PiPoT is admitted with drug and/or alcohol use that compromises their ability to undertake their job with children or adults.
- The PiPoTs admission causes concern for wider safety of vulnerable children and adults.

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

The PiPoT leads have positive working relationship and undertake significant collaborative working with the Police enabling timely communication and appropriate information exchange.

During the past 12 months support and advice has been offered in eighty-two possible PiPoT/Staff safeguarding issues. Of the cases identified several have resulted in a disciplinary sanction, some short of dismissal, a small number of dismissal and referral to external agencies for support.

19.0 Mental Capacity Act and Deprivation of Liberty Safeguards - DoLS

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19.1 Background

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

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

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

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

19.2 Mental Capacity Act

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

The Mental Capacity Act provides:

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

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

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

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

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

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

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

Other provisions of the Act include:

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

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19.3 Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards came into effect in 2009 and are part of a legal framework set out in the Mental Capacity Act. They set out the principles that should guide such decisions, including the need to act in the person's best interests and to achieve the desired outcome in ways that put the least restriction on the person's rights and freedom of action, and empowering people to make their own decisions wherever possible. The reason the Safeguards were introduced was to address the problem that arises if a person does not have the mental capacity to make an informed decision about care or treatment.

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

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

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

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

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

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

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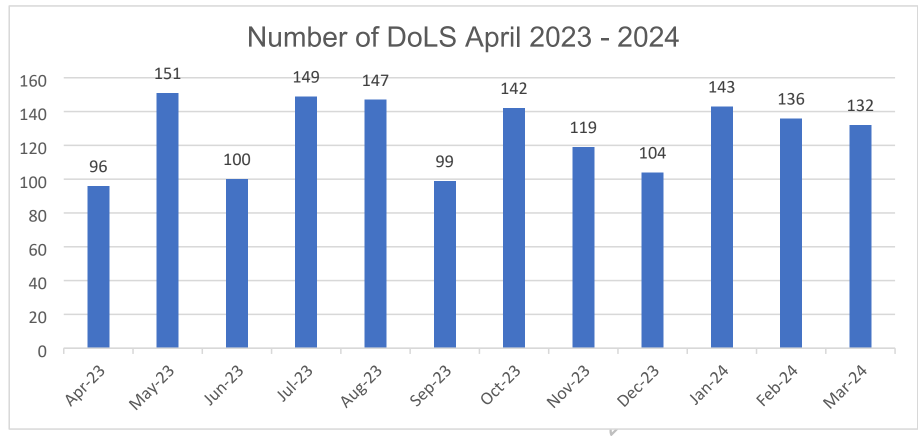
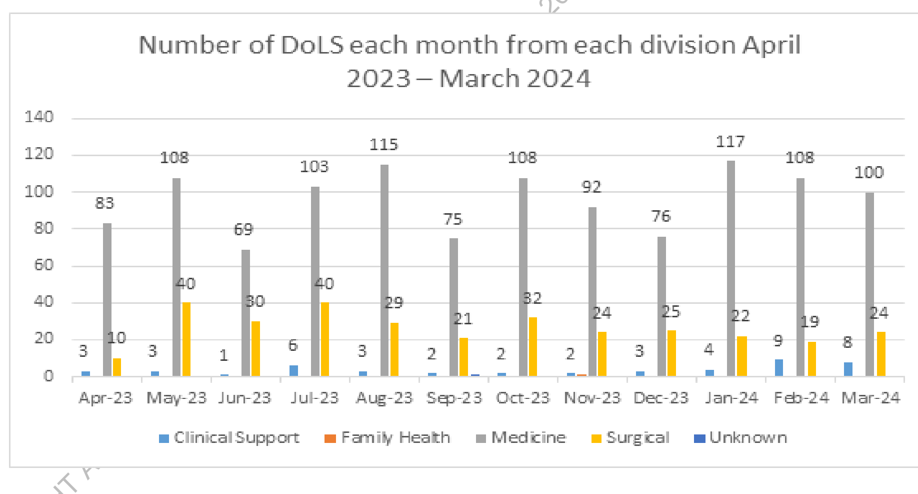
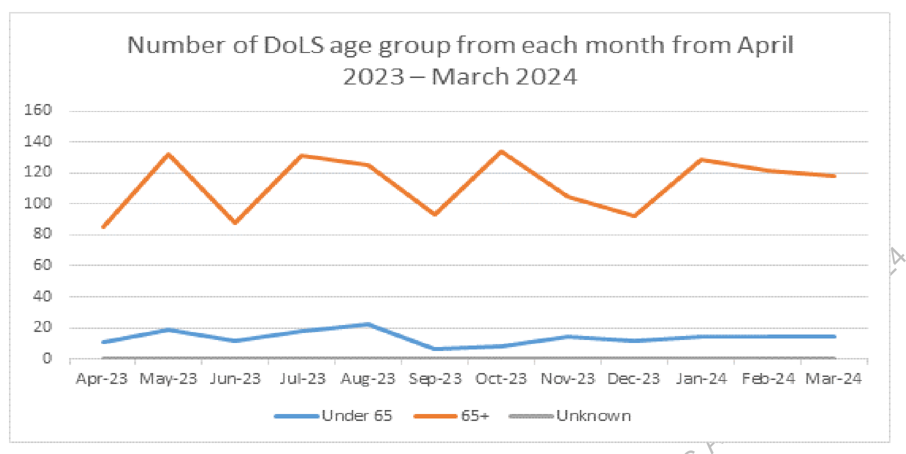
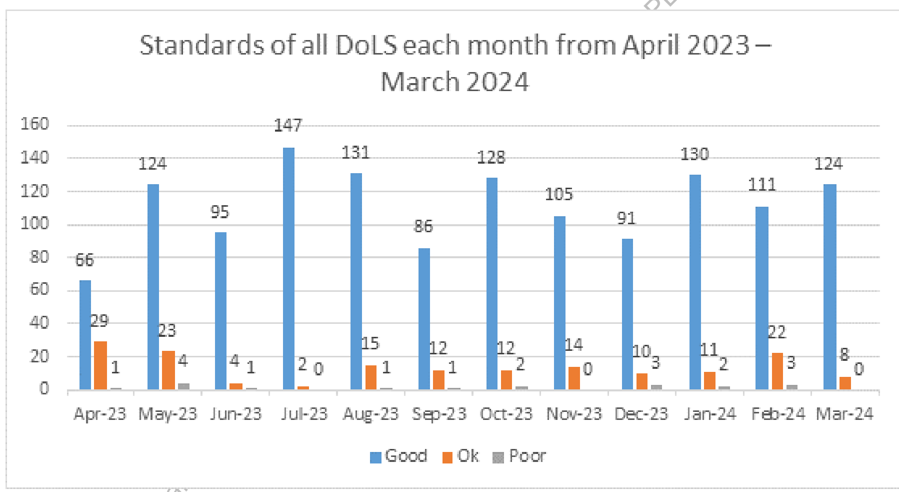
Figure 16: The number of DoLS referral made between April 2023 and March 2024 including a break down for divisional activity, quality of completion and age.



Over the last 4 years there has been a steady increase in DoLS applications.







ULHT Annual Boa

20.0 Dementia

20.1 What we know about dementia?

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

20.2 The impact of dementia

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

Figure 17: Projected costs of dementia for older people (£million), 2019-2040

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

20.3 Dementia in Lincolnshire

There are an estimated 12,458 people aged sixty-five and over living with dementia in Lincolnshire – equivalent to 6.8% of the over-65 population and 1.6% of the whole population. This is predicted to increase to 16,558 by 2030 and 17,949 by 2035 (44.1%), which is higher than the expected national increase of 40.3%. This will equate to 7.86% of the over-sixty-five population or 2.3% of the whole population.

The number of people aged sixty-five or over in Lincolnshire is projected to increase by 60,000 (33.5%) between 2019 and 2035, with the highest proportion of people in this age group who are living with dementia estimated to be in Lincoln, Boston, North Kesteven and South Holland. South Kesteven is expected to see the greatest increase in people with dementia (66.75%), given a predicted shift towards a higher proportion of older people.

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

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

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

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

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

Of the 4436 people with a learning disability below the age of 65, (0.8%) 35 have a diagnosis of dementia and of the 408 people 65+ with a Learning Disability 43 have been identified as having dementia (10.5%).

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

A number of behavioural and disease factors are known to increase the likelihood of developing dementia and many of these are more prevalent in Lincolnshire than at

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both regional and national levels, including physical inactivity, being overweight or obese, hypertension, stroke, diabetes, CHD, and depression. These factors are not evenly spread across Lincolnshire, which creates inequalities in those populations experiencing deprivation.

20.4 Progress 2023 - 2024

In 2021 ULHT embedded dementia within the safeguarding portfolio and governance framework and as a result appointed a Safeguarding Adults/Dementia Specialist Nurse within the team. There are numerous projects ongoing to improve and develop the services for our patients who have dementia or are likely to have an undiagnosed dementia and to support those who have a delirium whilst in our hospitals. As part of the ongoing work there has been a notable increase in the need to support dementia patients with MCA – particularly in the outpatients setting as well as patients who come into the Trust for whom there are safeguarding concerns raised.

Relationships continue to be developed with LPFT, LCHS and the wider ICB for collaborative working using skills, experience and services which will support our patients and their families and embed the Dementia Strategy for Lincolnshire.

Work includes supporting all staff to refer patients who we are concerned may have an underlying dementia directly through to the memory clinics, rather than requesting GP referral via EDD. We also refer patients with a dementia, and/or their carers to the Dementia Support Services who can help from the point of diagnosis through to end of life. Contact has also been developed with third sector services to engage and support in clearer ways. We have excellent communication with Carers First and the iForget service though AgeUK to ensure the carers of our patients are also supported and advised as required. We are also linked into the Regional Care Providers meeting to discuss and build bridges with care providers where many of patients are transferred from.

Carers are a huge asset to our patients who have dementia, and it is an important part of care that we work with them as care partners, ensuring they are supported. During 2023 – 2024 the Trust launched the Carers Hub at Pilgrim Hospital, a space staffed by volunteers who can offer signposting and advice to the carers as well as a space for them to have a drink and someone to talk to if things are difficult whilst in hospital. Work has also been undertaken to ensure our young carers and informal carers are included too.

The care partner's policy has also been relaunched and promoted heavily for our dementia patients.

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Dementia Support Practitioners are in post at both Boston and Lincoln. They work with patients and their families early into the hospital admission to develop a one-page care plan, based around the 'All About Me' document, to give staff a snapshot of what the patient needs to have a positive experience whilst in ULHT. It allows staff to understand the person's background; their likes and dislikes and any triggers of distress, to support reminiscence conversations, make reasonable adjustments to their hospital admission, reduce the distress and anxiety of being in an unfamiliar environment.

With support and guidance from the Patient Experience team the new 'All About Me' document has been developed and is currently out for consultation with both professionals and users. It is important to note that this document is for all people in Lincolnshire who have or may develop communication difficulties – not just those living with dementia. Once ready for relaunch it is expected that all organisations will embed this as part of the normal care pathway and the document used in a wider way.

Each ward area has a Dementia Distraction Box which are filled with various activities to distract, stimulate, and comfort our patients. We have fiddle mitts, kindly donated by various knitting groups, games such as dominoes, snap, cards. Larger building blocks and musical instruments as well as colouring packs and puzzles. We often find patients with Dementia are concerned that they cannot afford to pay for their stay or for their meals etc. available in the boxes are small purses and coins to alleviate some of these worries. Our dementia support practitioners also have access to other tools to support patients as required.

The distraction boxes are constantly reviewed and will shortly include the introduction of sensory bags within A and E and UTC departments which is a nationally used tool predominately for patients with Learning Disabilities.

Face to face training on the HCSW induction programme took place bi-monthly to develop their understanding of dementia and delirium and how we should be supporting our patients with Dementia. Looking at skills and trying to give staff the understanding of how these patients will feel in a strange, busy environment with different people coming and going as well as losing the routine that they all thrive on. Dementia was removed from the new care camp set up; however, it has been realised that there is a need for the information, so work is planned with the clinical educator's team to develop this programme.

A new Dementia eLearning package is written and ready to launch, and embeds information across all staff groups to ensure staff have at least an awareness of dementia and how they can support that person, or their family, from answering the phone, meeting someone in a corridor, through to how we can meet their needs on

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our wards and clinical areas as well as being able to support through the discharge process to ensure our patients, and their carers have support.

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

Nutrition and hydration have been a focus across the Trust, and we have been keen to have a focus on our patients with dementia having enough support. Having researched and piloted a national scheme called #butfirstadrink, which follows the #mynameis… initiative that every time we go to a patient, regardless of reason or discipline we offer the patient a drink – even just a sip is an improvement and has been found to improve care overall. The second phase of the roll out is underway currently and so far good feedback with the plan of roll out across the Trust.

21.0 Learning Disability and Autism

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

This may mean they can have difficulty with:

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

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

21.1 Learning Disability and Autism in Lincolnshire

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

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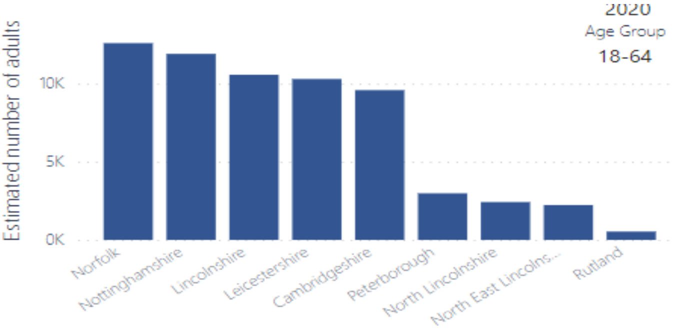
Learning disabilities are often confounded with multiple physical and mental health conditions and so there is an increased risk of developing chronic conditions from genetic and lifestyle factors. Evidence suggests rates of numerous major diseases (heart failure, epilepsy, severe mental illness, diabetes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

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

Figure 18: Children with Moderate Learning Difficulties Known to Schools 2020

Lincolnshire Health Intelligence Hub 2022

Figure 19: People aged 18-64 predicted to have a learning disability



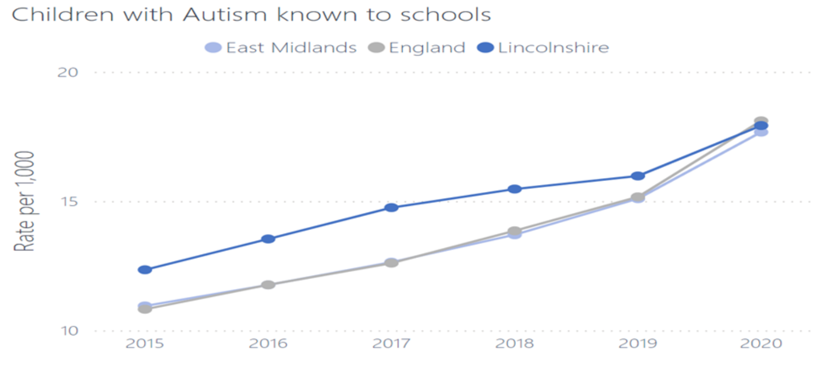
Lincolnshire Health Intelligence Hub 2022

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

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

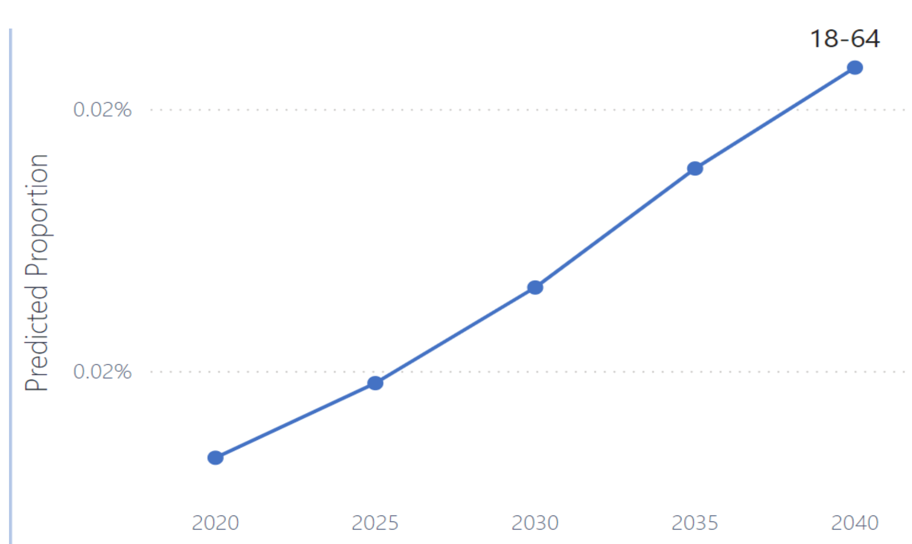
Nationally autism is underdiagnosed amongst certain groups such as older people, those who identify as females and individuals from Black, Asian and minority ethnic groups. This is due to the assessment tools used in autism diagnosis and limited awareness of the ways in which autism can present in different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

Figure 20: Children with Autism Known to Schools 2020



Lincolnshire Health Intelligence Hub 2022

Figure 21: People aged 18-64 predicted to have autistic disorders by 2040.



Lincolnshire Health Intelligence Hub 2022

21.2 Learning Disability and Autism

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

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

In July 2022, the newly legislated 'Oliver McGowan' Training** was announced as a minimum benchmark for NHS Trusts and was launched across the Trust. Over the last 12 months we have worked together as a system to develop a local process based on the high standards and minimising impact of this training across Lincolnshire. This work is still ongoing and is likely to take a further 2 – 3 years for it to be fully embedded.

ULHT Annual Board report: Safeguarding and Vulnera

**** Oliver McGowan Training was added to the ULHT Trust Risk Register (236 – moderate) in April 2023 due to the significant impact that delivering the training will have on the Trust – work is ongoing at a national and system level to try to mitigate the risk and develop a workable solution**

Since starting in post, the Specialist Learning Disability Nurse has provided additional advice, guidance, and support to patients with a learning disability, their carers/ parents, staff within the hospital as well as working collaboratively with health and social care partner agencies to ensure sure a multiagency response to those more complex patients.

The post holder continues to directly support patients, give advice, and make recommendations to health and social care colleagues for a number of patients each month. This has directly improved patient care and experience and supported ward and clinical areas with understand the needs of people with Learning disabilities, educating staff and role modelling interacting with patient with alternative communication needs.

The post holder has also supported a small number of children with additional needs (Autism and or learning disability) elective admission via Childrens wards or transition 16/17-year-olds attending through the adult elective pathway.

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

Multi-agency and multi-disciplinary partnership working has been an essential part of the role, establishing strong partnerships with LPFT Learning disability teams especially the Acute Learning Disability Nurses (ALN) and LCC Learning Disability Social care. The Trust are now involved in a number of proactive physical health meetings across the Lincolnshire services to ensure ULHT are included in plans for people with learning disabilities. This includes attending regular meetings with LPFT LD CAMHS regarding the elective admission for children and Healthy Lives working Group which is chaired and facilitated by people with learning disabilities.

Currently the team are continuing to revise the Learning Disability Care Bundle which every patient with a learning disability should have completed on admission to a ward. This will be aligned with the Dementia bundle and in the future the mental health bundle to ensure constantly for staff. The bundle encourages staff to have open and transparent communications with patient and or parent and carer, to identify and plan how they can meet the needs of people with learning disabilities, including reasonable adjustments when in an acute setting. This includes the use of the carers agreement to look at carers role in hospital to prevent any miss communication in the future.

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Bespoke Learning Disability and Autism awareness training continues to be delivered across wards and departments as learning is identified though Patient Safety and LeDeR feedback and delivering training within the clinical educator's forums across sites along with bespoke clinical skills session's divisions / ward areas are providing. This bespoke training enhances the knowledge already gained though the Oliver McGowan training as this focuses on resources and support available within ULHT, where to access it, the learning disability bundle and how to use it, along with practical advice related to the acute hospital. Thus, enhancing staff confidence and knowledge of how to care and support someone with a learning disability and or Autism.

Easy read information is now on the external and intranet ULHT pages for anyone to access. There are plans to add to this, to increase the resources available in easy read and this is just the start of the process to meet our Accessible information standard requirement. Plans are in the very early stages of looking at easy read appointment letters for the Trust as part of the "Give it A go" campaign the Improvement Team ran this year. During 2024 – 2025

With support from Experts by Experience the team have spent time producing a suite of videos which demonstrate hospital experience from a client perspective which will become available during the summer of 2024.

An example of the filming is attached in the following link.

https://youtu.be/W19l8wmVmxM

Whilst the focus of the work has been within the hospital setting, over the next 12 months this work, and learning will be cascaded through LCHS.

Since the development of the joint working between ULHT and LCHS Safeguarding teams there have been several patients who have benefitted from a more joined up approach in transition from community to hospital and includes a system wide approach for developing and embedding the Autism Pathway with specific work undertaken by LCHS regarding the autism diagnostic observation schedule, improved links with SEND and development of educational health plans.

21.3 Future plans for 2024 – 2025

The 'All About Me' Hospital passport is now over 10 years old and is undergoing a refresh. It has been revised and second draft is currently out for consultation. This has been a joint piece of work lead by the Dementia safeguarding nurse and Learning disability safeguarding nurse with the expertise of Patient Experience Manager for the technical side of the document. The document has been reviewed and feedback gathered from staff within all health and social care systems within Lincolnshire, along

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with private sector and voluntary sector to ensure everyone has had an opportunity to commitment. Feedback has also been sort from Peer Support Workers and Experts by Experience in LPFT services. The new document will be for all ages and patients with mental health, dementia, physical health conditions and those with Learnings disabilities and or autism. Potentially the list of patients that could benefit from this passport is endless.

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

Transition - young people of 16 and 17 years old with additional needs, learning disabilities and or Autism who are listed for elective admission is also becoming a challenge. Focus on this within the surgical pathway will be added as an area to resolve.

LeDeR / SJR / patient safety and mortality – Review and audit the feedback from LeDeR and the actions from governance group to look at ULHT role in improving the outcomes of people with Learning Disabilities. Feedback will be added to the bimonthly MHNDD Steering group Learning Disability report which all divisions are represented. Individual feedback also given directly to clinical areas, department leads / ward sisters to ensure direct learning for each area is shared across teams.

Increase the number of flags and alerts across the trust for people with Autism and Learning disabilities in line with the NHS reasonable adjustment requirements to ensure more meaningful information is shared.

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

Expand the role into LCHS ensuring clients in community have an equitable service.

Sensory bags and Emergency Department / UTC focused work. Currently producing guidance on the role out of piloting sensory bags for UTC at Grantham and A&E at Pilgrim and Lincoln. These sensory bags have been kindly funded by ULHT Charitable Funds after extensive research and seeking views of people with Learning disability and or autism. It is hoped they will provide a welcome support, distraction and sensory reducing effect for people who are waiting in these busy areas. From a sensory point

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of view these are over stimulating with loud sounds, different smells, and bright lights. These bags can be taken home with them or used on the ward if admitted. It is hoped after feedback from the pilot that they will prove beneficial, and a business case can be made to order further sensory bags which can be provided for all our UTC departments.

Further work within ULHT Emergency departments is the development of a stamp to be used on the A&E documents which highlights need for a referral to ALN service, so the patient and staff get support from ALN service in a timely manner. Its widely acknowledged through local and national LeDeR feedback if a patient has the support of a Learning Disability nurse they have a better hospital experience and outcome.

A resource folder for UTC/A&E is being developed with the support of staff to provide information and resources aimed at improving knowledge of staff. This will be developed with the support of experts by experience.

Set up honorary contracts for LPFT ALN nurses with ULHT to support them to access ULHT systems and process thus enhancing their role and the support they can offer without barriers of system access.

Plans are in place to support LPFT to move forward with a business case for developing and expanding the ALN service. This service is currently for 18 years plus with a diagnoses Learning Disability which runs Monday to Friday 9.00hrs to 17.00hrs. There are currently two whole time ALN nurses and one part time Practitioner for the three main hospital sites. The long-term aim would be for an all-age service, 7 days a week thus proving an equitable service for children and adults and over the whole week.

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22.0 Safeguarding Risks

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

Figure 22: Summary of current risks and risks scoring for 2023 – 2024.

ULHT 359	If the Trust cares for patients with significant learning disabilities and complex needs in a manner that is not appropriate to their needs (e.g., because there is no pathway to achieve a General Anaesthetic for procedures such as blood tests/ MRI, etc.) it could lead to sub-optimal care and delays in diagnosis or treatment with an increased likelihood of serious harm or a poor clinical outcome.	LOW (6)
ULHT 211	If a patient becomes agitated and in response the Trust applies sedation, restraint, chemical restraint, or rapid tranquilisation inappropriately it could result in serious harm to the patient; other patients; or members of staff and could lead to subsequent legal or regulatory action	MODERATE (9)
ULHT 236	The Trust will be unable to comply with the legal requirement to deliver the Oliver McGowan training across the full staff cohort which came into effect July 2022	MODERATE (9)

During 2023 – 2024 the safeguarding team have been actively involved with working to reduce and manage these risks which are monitored by the Safeguarding and Vulnerabilities Oversight Group.

23.0 A review of 2023 – 2024

The last 12 months have been a challenge for everyone across the United Kingdom in a way that no one could have envisaged. Across the safeguarding system the new ways of working that were developed during the pandemic have been modified to improve efficiency and effectiveness ensuring we continue to help support our most vulnerable in society as well as provide a wider level of support to all staff within the two Trusts and the external safeguarding teams.

The normal pattern of safeguarding across Lincolnshire has changed because of the pandemic and some of the impacts have still being felt within the safeguarding arena.

During 2023 to 2024 safeguarding activity remains high particularly in relation to patients admitted due to eating disorders/disordered eating and Mental Health related issues as well as cases being more complex in nature.

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

Since June 2023 both ULHT and LCHS safeguarding teams have had the same manager which has brought improved communication between the two Trusts and a more seamless approach for some of our most vulnerable.

- Face to face supervision as expanded, with additional sessions available via Teams to facilitate attendance across the trust and work is ongoing to improve levels of attendance.
- Safeguarding and vulnerabilities pathways and processes to support staff in managing safeguarding related concerns have been reviewed and some shared working between the two teams has already begun and will be expended further in the coming year.
- The Safeguarding Hub on the ULHT Intranet site has been revised to improve accessibility for Practitioners requiring support and/or safeguarding-related resources.
- A shared Safeguarding training plan was launched across the two Trusts ensuring that there is a commonality within staff groups and that any training sessions delivered will be available to all staff no matter which trust they work for, or which trust is delivering the course. This will increase a joint understanding across teams, allow for a more flexible delivery and thereby facilitate increased attendance, understanding and knowledge of local processes.
- Maintained and increased our presence in external / partnership processes such as the LSCP / LSAB / strategy meetings / MARAC etc.
- Continued to develop policies and improvements, undertook audits to maintain safety and identify risks.
- Continue to develop and expand safeguarding roles within the team to ensure that the trust can deliver a safeguarding and vulnerability service (child protection / adult protection / MCA / PREVENT/learning disability / autism and mental health)
- Provided continued support with chairing complex MDT meetings and best interest meetings.
- Continue to support staff members who are required to produce statements for, or attend as a witness in, Family or Criminal Court.
- Facilitated the delivery of quarterly court craft skills training events and bi-annual Legal updates for staff who are required to attend court delivered by the trust solicitors.

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- Further developed training in relation to Learning disability and Autism by combining the first phase of Oliver McGowan training across the Trust ensuring a system wide approach to the challenges that the delivery brings.
- Safeguarding team actively involved in the review of complaints and Serious Incidents with a safeguarding or MCA aspect.
- Continue to undertake ward spot checks /audits in relation to MCA/ DoLS
- Review the ligature risk assessment process and rollout the ligature cutter (QUAD) pack across clinical areas within ULHT alongside refreshed ligature training.
- Strengthen the Safeguarding Champions' Network across the trust.
- Continued to support with HR processes in relation to staff members for whom Safeguarding concerns have been raised (LADO/PiPoT)
- The new De-Escalation, Management, and Intervention (DMI) training across the trust was launched in July 2023 and continues to roll out across the identified staff groups.
- Fully embed RITA (Reminiscence Interactive Therapy Activities) within the clinical areas.

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

- Development of accessible information about how to access our hospitals, including videos co-produced by our patients with lived experience of people.
- Launched CP-IS phase 2 within Community Paediatrics
- Developed a business case for a post of Safeguarding Domestic Abuse Advocate for ULHT who will come into post in July 2024
- Facilitated discussions between the ICB, Family Health and Children's Social care to progress the creation of a Business Case to support the implementation of a new model for the provision of CP Medicals
- Supported the Children's Services Front Door Strategy Discussions process.

24.0 Safeguarding Developments and ongoing work for 2024-2025

- Maintain momentum to achieve 90% across safeguarding training areas.
- Finalise and embed pathways for clients with learning disability / autism across ULHT trust services ensuring smooth transition from primary and community care.
- Continue the transition towards fully embedded the newly legislated Oliver McGowan training (3-year plan)
- Launch the trust wide ULHT dementia pathway.

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- Continue to embed the training of MCA/DOLS within ULHT ensuring that there is a better understanding of best interest planning, and that staff can more readily identify patients who require extra care and have clear plans to follow in line with legislative requirements.
- Audit adult concerns submissions within the trust to ensure compliance with 'Making Safeguarding Personal.'
- Continue to review and roll out MHA procedures.
- Review and embed the new Learning Disability bundle and shared care agreements within ULHT.
- Develop a system of flags and alerts across the trust for people with Autism and Learning disabilities making use of the national 'reasonable adjustment' flags as appropriate.
- Continue to embed the surgical assessment process for patients with a learning disability who requiring a GA (ULHT)
- Explore the viability of employment of Learning Disability and Autism Support Practitioners across ULHT and LCHS.
- Explore the viability to facilitate the employment of an expert by experience role within the Trust.
- Develop in partnership with Family Health a new model of service delivery for Child Protection Medicals.
- Introduction of dedicated SG CYP Supervision sessions for Managers and Matrons to be rolled-out from July 2024,
- Development of the DA Advocate role, with the aim of providing additional support and training to staff members, thereby improving the quality of risk assessments and referrals undertaken.
- Continued work with ED teams to ensure the potential risks to young people (16-17 years) are recognised and managed in accordance with processes.

25.0 Conclusion

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

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

The last 12 months have demonstrated the value that the ULHT and LCHS safeguarding teams working together can add in relation to joint understanding of

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service provision, shared insight, and improved communication, all of which improve the safeguarding of our most vulnerable patients.

As the new group develops there will be further advantages and benefits gained from economy of scale with less repetition and duplication ensuring that the teams can continue to effectively support patients, staff, and the organisations. The forthcoming year promises to be full of further developments and challenges for both the teams and the Group.

26.0 Recommendations

It is recommended that the Trust Board

i) Receive the safeguarding report.

ii) Approve the plans for 2024 - 2025.

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Appendix 1: Safeguarding Team – Structure March 2024

Safeguarding and Vulnerabilities Team

March 2024

Portfolio:

Safeguarding Children

Safeguarding Adults

Mental Capacity and DOLS

Learning Disability / Autism

Dementia

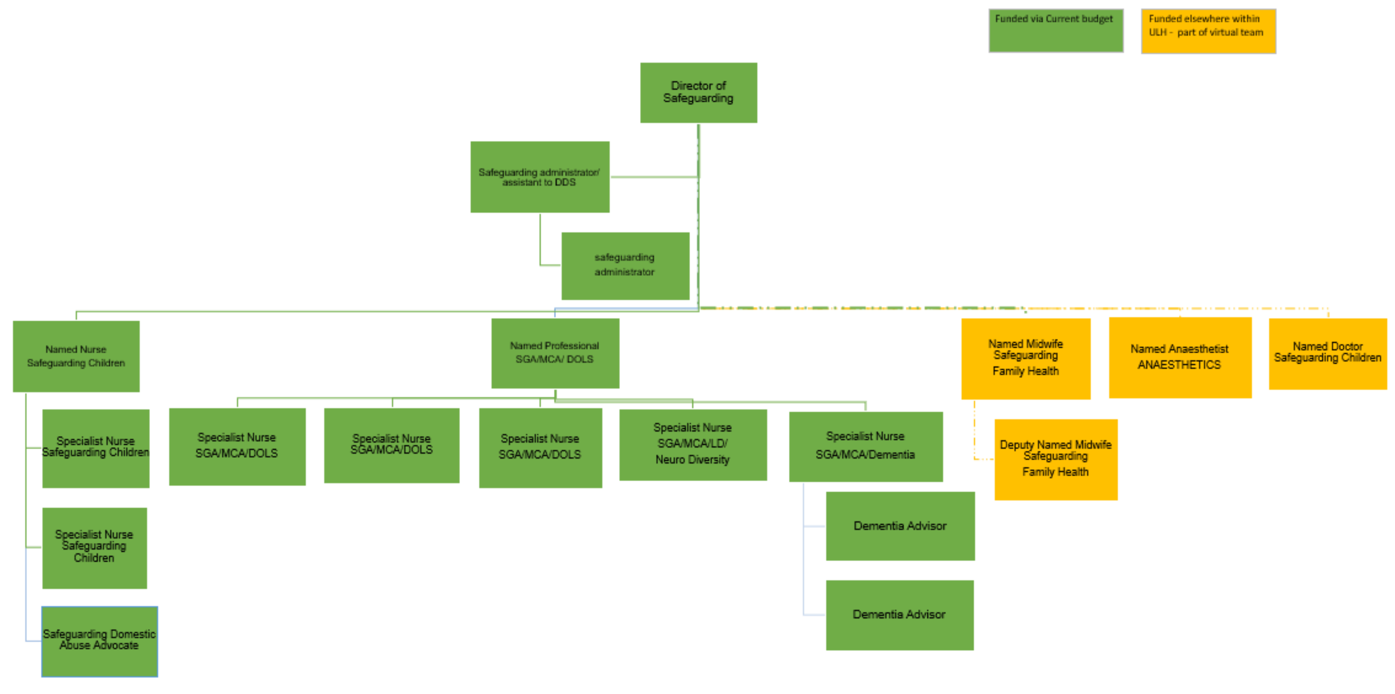
Mental Health

PREVENT

Domestic Abuse

ULHT

Safeguarding and Vulnerabilites Team - ULHT structure March 2024



Report to:	Lincolnshire Community and Hospitals Group Board Meeting
Title of report:	People and OD Committee Assurance Report to Board
Date of meeting:	16 July 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 ongoing improvement in engagement at the meeting and the presentation related to the medical workforce programme of work. It was recognised that the achievement of CIP was reported with a positive variance of £168k however the programme would due to deliver large savings in the later stages of the year, Planning had commenced on the winter vaccination campaign with flu vaccines to be available from the 3 October. The Committee noted that there had not yet been confirmation of Covid-19 vaccinations. Progress was being made in respect of statutory and mandatory training however there would remain a focus on medical compliance. Positive updates were noted in respect of the Nursing Transformation Group and the positive in respect of recruitment, agency spend and safer staffing. Absence management continued to be monitored by the group with a revised target of 5.5% with an anticipation of further improvement follow the completion of the Occupational Health review. **Committee Performance Dashboard** The Committee received the dashboard noting the performance presented and reflected on the position of registered nurses at the Trust, noting that the Trust was the best in the country in respect of vacancy rates. These continued to be below target.

	Disclosure and Barring Service (DBS) checks remained ahead of trajectory with a number of checks completed through recruitment processes or no longer being required due to leavers. **Impact of Vacancy Controls** The Committee received a verbal update noting that further work was required to ascertain associated costs being saves through the process with the Committee noting the complexity of those vacancies being held in budget which were not required to be taken through process. **Staff incentive update** The Committee received a verbal update noting that this would be aligned to the new appraisal cycle commencing on 1 April 2025. A formal paper being offered to the Committee in September providing an options appraisal. **Safer Staffing** The Committee received the report with significant assurance noting the intention for the paper to be developed further to include other areas of the workforce. The intention was for this to be replicated across the medical workforce and would be offered to the Committee as a regular report.
	Assurance in respect of SO 2b **Issue: To be the employer of choice** **Freedom to Speak up Quarterly Report** The Committee received the report noting that numbers remained high for staff speaking up; and considered the workload implications for the Freedom to Speak Up guardian. Work was underway to work through the recent listening events in the Emergency Departments and was being aligned with the wellbeing team and People Promise Manager. The Committee sought to understand if there was a trend in data and higher reporting periods and noted that the Freedom to Speak Up Guardian saw an increase in cases following promotion. The Committee was pleased to note that the core plus training for speak up was now live and staff would be required to complete this. This would ensure a wider understanding of speaking up across the organisation. **GMC Junior Doctor Survey Update** The Committee received the update and sought a further update on the reimbursement of monies for education to medical students to ensure this was being distributed appropriately. It was noted that a task and finish

	group had been established to understand the financial flows, quality of education and assurance being offered to the Committee. Significant concern was noted in respect of the provision of education within the Trust. There was a reliance on teaching fellows and locums to deliver this with some engagement challenges with consultant staff. These gaps in provision were recognised and actions to address them were planned. The committee will monitor this issue carefully. **NHS EDI Improvement Plan – High impact actions** The Committee received the report receiving assurance on the 6 high impact actions with the NHS EDI Improvement Plan which were being addressed across the Group. **WRES and WDES Annual Reports (appended)** The Committee received the annual reports noting that there had been movement across a number of indicators; further actions were being taken to address areas requiring improvement. The Committee noted the national award that had been won by the Trust in respect of pastoral care which reflected the integration for international staff within the organisation. **Culture and Leadership Group Upward Report** The Committee received the report noting that a synthesis event for the discovery phase had taken place to discuss the findings and determine the next steps to the design phase. The Committee was pleased to note that efforts were being made, through this work, to ensure that any current work was not duplicated through the programme. **Just Culture Steering Group Upward Report** The Committee received the report noting that the Group Chief Executive had attended as a member of the group and assurance continued to be received on the project plans and programmes of work. Development of the disciplinary policy had been completed and was progressing through Staffside, HR and the patient safety team.
	Assurance in respect of SO 4c **Issue: Grow our research and innovation through education, learning and training** **University Teaching Hospital and Research and Innovation Report** The Committee received the first combined report and noted the requirement to broaden the research aspect of the report to include other research activities, aligned to all professions of the Trust.

	The Committee noted the need for further clarity to be provided across the Trust, in respect of time allocated for clinicians to undertake research activity across the Trust. There was a need for a consistent and robust process to be put in place.
	Assurance in respect of other areas: **Topical, Legal and Regulatory Update** The Committee received the report for information noting the content. **Integrated Improvement Plan** The Committee received the report for information noting the position presented. **CQC Action Plan** The Committee received the report noting that 76% of actions had been completed with mapping work having been completed against the new CQC single assessment framework. Work would continue to ensure all remaining actions were closed. **Fuller Recommendations** The Committee received a verbal update noting that that the target completion date of July was unlikely to be achieved however actions were in place to progress DBS checks.
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	A	S	O	N	D	J	F	M	A	M	J	J
Philip Baker (Chair)	X	X	X	No meeting	X	X	X	A	X	X	X	X	X
Karen Dunderdale	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	X		X	D	X	D	D	D	X	X	D
Chris Gibson	A	X	A		X	X	X	X	A	X	X	A	A
Vicki Wells	X	X	A		X	X	X	A	X	X	X	X	X
Nerea Odongo													X

X in attendance
A apologies given
D deputy attended

Report to:	Trust Board
Title of report:	People and OD Committee Assurance Report to Board
Date of meeting:	13 August 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. The Committee meeting was shortened to reflect the reduced attendance as a result of annual leave, receiving a number of papers for information enabling focused discussions on relevant areas.
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 and Committee Performance Dashboard** The Committee received the report and was pleased to note that the meeting had been quorate with positive conversations regarding the medical workforce programme. The Committee noted that, whilst there were no escalations from the performance dashboard, vacancy rates had increased as expected in line with the workforce plan. Disclosure and Barring Service (DBS) checks continued ahead of trajectory with focus being given to those areas of high priority. Progress was also being seen in sickness absence and it was noted that statutory and mandatory training remained a key focus of the group. **Safer Staffing** The Committee received the report which offered significant assurance with a reduction being seen in the nurse agency workforce. A decrease in falls and medication incidents was also noted, attributed to the vacancy position and focus was being afforded to reducing overtime spend, alongside bank spend.

	Impact of vacancy controls update The Committee received the report noting that, since the introduction of controls there had been 804 requests, of which 578 had been reviewed with a number having proceeded to advert. Concerns were raised around the clinical input to the decision-making process, particularly if a need to deliver the targeted savings further impacted on the thresholds for deciding whether vacancies were filled. The process would be discussed by the Executive Leadership Team as it was recognised that there were improvements which could be made to support the process and realisation of financial savings. The Committee would receive a further update on the impacts in the coming months.
	Assurance in respect of SO 2b **Issue: To be the employer of choice** **WRES and WDES Action Plans (Appended)** The Committee received the WRES and WDES action plans, having received the annual reports at the July Committee. The change in format was noted moving from a 1-year plan to a 3-year plan resulting in longer term actions. The Committee noted that there could be further development of the relevant milestones within the action plans to ensure these were deliverable to the timescales identified. **Culture and Leadership Group Upward Report** The Committee received the report for information noting the position presented. **EDI Group Upward Report** The Committee received the report for information noting the position presented.
	Assurance in respect of SO 4c **Issue: Grow our research and innovation through education, learning and training** **University Teaching Hospital and Research and Innovation Report** The Committee received the report for information noting the position presented. **Lincolnshire Health and Care, Colleges and Universities Join Work Update** The Committee received the final partnership agreement endorsing this to be received by the Board. It was recognised that future developments to this may be required.

	Assurance in respect of other areas: **Integrated Improvement Plan** The Committee received the report for information noting the position presented.
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	**A**	**S**	**O**	**N**	**D**	**J**	**F**	**M**	**A**	**M**	**J**	**J**	**A**
Philip Baker (Chair)	X	X	No meeting	X	X	X	A	X	X	X	X	X	X
Karen Dunderdale	D	A		D	D	A	D	D	D	D	A		
Claire Low	X	X		X	X	X	X	X	X	X	X	X	D
Colin Farquharson	D	X		X	D	X	D	D	D	X	X	D	D
Chris Gibson	X	A		X	X	X	X	A	X	X	A	A	
Vicki Wells	X	A		X	X	X	A	X	X	X	X	X	X
Nerea Odongo												X	X

X in attendance
A apologies given
D deputy attended

Meeting	*Lincolnshire Community and Hospitals Group Board Meeting*
Date of Meeting	*3rd September 2024*
Item Number	*9.1*

Workforce Disability Equality Standard (WDES) Annual Report, 2023-2024

Accountable Director	*Claire Low, Chief People Officer*
Presented by	*Claire Low, Chief People Officer*
Author(s)	*Claire Low, Chief People Officer*
Report previously considered at	*People and Organisational Development Committee* *13th August 2024*

How the report supports the delivery of the priorities within the LCHG 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	
1d Deliver clinically led integrated services	
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	
3b Drive better decision and impactful action through insight	
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	
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)	
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	

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	

Risk Assessment	*This report demonstrates the Trust's compliance with contractual duties and thereby evidences the mitigation and removal of associated risk.*
Financial Impact Assessment	*No financial impact*
Quality Impact Assessment	*N/A*
Equality Impact Assessment	*This report demonstrates and evidences how the Trust is meeting its statutory and contractual duties in relation to the Equality Act 2010, the Public Sector Equality Duty 2011 and the NHS Standard Contract.*
Assurance Level Assessment	• *Moderate*

Recommendations/ Decision Required	• *The 2023/24 WDES Annual Report is recommended to the Board for approval*

Executive Summary
Publication of the WDES Report and Action Plan on the Trust website is a requirement of the national contractual duty. Due to the detailed action plans not being compliant with internet accessibility tools, once the action plan is agreed in principle, a high-level overview of the action plan will be placed in the public domain.

Workforce Disability Equality Standard (WDES) Report 2023-2024

Report author: Tim Couchman, Head of Equality, Diversity and Inclusion
June 2024

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Introduction:

“The Workforce Disability Equality Standard (WDES) is a set of ten specific measures (metrics) which enables NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff. NHS organisations use the metrics data to develop and publish an action plan, building on high impact actions shared in the first ever EDI improvement plan. Year on year comparison enables NHS organisations to demonstrate progress against the indicators of disability equality to create the cultures of belonging and trust that will improve retention, recruit from the widest possible talent pool and provide sustainable careers.

Making a difference for disabled staff

The WDES is important, because research shows that a motivated, included and valued workforce helps to deliver high quality patient care, increased patient satisfaction and improved patient safety.

The WDES puts data into the hands of people in NHS organisations who best understand the experiences of their disabled staff and how to make positive change. A more inclusive environment for disabled people working and seeking employment in the NHS is better for our people, for teams and for patients.” NHS England WDES website.

Launched in January 2019, the WDES is mandated in the NHS Standard Contract for all NHS Trusts and Foundation Trusts from April 2019. The WDES is based on the principles of the Workforce Race Equality Standard (WRES) and the NHS in England has committed to both equality standards in the NHS Long Term Plan and the NHS People Plan. Like the WRES, the WDES draws on workforce data, NHS Staff Survey data and leadership data. Further information about the WDES can be located on the NHS England WDES website: NHS England » Workforce Disability Equality Standard

Methodology:

The data for the WDES report was collated and prepared in the first quarter of 2024-2025. The workforce data has been verified by the Equality, Diversity and Inclusion (EDI) team. The NHS Staff Survey data is taken straight from the national staff survey database. The verified workforce data has been

submitted to the NHS England Mandated Standards Team utilising the national data reporting platform ahead of the reporting deadline of the 31 May 2024.

Over the summer 2024, the data is being shared with the Trust's MAPLE (Mental and Physical Lived Experience) staff network for consideration and active engagement in relation to the actions for improvement required. The resulting action plan will be produced in partnership with our staff networks and published by 30 September 2024, as required by NHS England.

This current report provides an overview of the data by metric and compares the data to the previous years' reports, as appropriate. Further, since the inception of the WDES in 2019, the Trust has been tracking the trends over time for each of the WDES metrics. For the first time in this report, the data trends are reviewed and analysed. Infographics relating to the data trends for each of the metrics are provided in Appendix 1.

WDES Metric 1:

WDES Metric 1 reviews the workforce and compares the data relating to disabled staff and non-disabled staff. The indicator further disaggregates the data and compares clinical staff, non-clinical staff and medical staff.

In general terms the percentage of disabled staff employed by the Trust has increased in 2023-2024 to a total of 5.0%. This is a continued slight increase up from 4.22% in the 2022-2023 data.

The data confirms we have more staff with a disability / long-term condition working in non-clinical roles. The data informs us that staff in medical and clinical roles are more likely not to share their disability status with the Trust on the ESR system. Further, for clinical and non-clinical staff our data informs us that we employ fewer staff who have declared a disability / long-term condition in more senior positions. However, this needs to be understood in the context that for both clinical and non-clinical staff in these senior positions we have the higher non-disclosure rates for disability status on ESR.

In reviewing and analysing the trend data for Metric 1 since the start of the WDES reporting a small but steady increase on self-declaration rates is noted from 2.9% in 2019 to 5.0% in the current reporting cycle. These increases in

colleagues feeling comfortable and confident to share their disability with the Trust on ESR are encouraging. The increases also bear witness to the excellent work of the MAPLE network in raising awareness of disability and long-term conditions in the workplace.

Actions to address the issue of more staff feeling confident and comfortable to share their disability status on ESR need to be reviewed and implemented, as the percentage of staff reporting they have disability on the anonymous NHS Staff Survey in 2023 is significantly higher at 25.75%.

WDES Metric 2:

WDES Metric 2 reviews Trust recruitment data and compares the data relating to disabled staff and non-disabled staff. This indicator compares specifically the data and the relative likelihood of staff being appointed from shortlisting across all posts.

The Trust data for this metric for 2023-2024 confirmed that to a likelihood of 1.33 non-disabled staff are more likely to be appointed from shortlisting across all posts. In practical terms this is best understood that non-disabled people are approximately a third more likely to be appointed from shortlisting. This is a deterioration when compared with the 2022-2023 data return of 1.16 and indeed, in the reporting years 2021 to 2022 the Trust had achieved relative parity for disabled staff / staff with a long-term condition and non-disabled staff.

In reviewing and analysing the data for Metric 2 since the start of WDES reporting since 2019, it is disappointing to note that in the current reporting cycle the Trust has in effect returned to almost the same relative likelihood as in 2019. Following improvement in years prior to 2022-2023 this deterioration needs to be reviewed and robust actions put in place as a matter of urgency.

WDES Metric 3:

WDES Metric 3 reviews the Trust’s Human Resources data and compares the data relating to disabled and non-disabled staff. This indicator specifically reviews the relative likelihood of staff entering the formal capability procedure, as measured by entry into the formal capability process. As the figures for this

metric are numerically very small, the data is calculated using a rolling average from the last two years of data.

The Trust data for this indicator for 2023-2024 confirmed that the likelihood is 0. The reason for this zero return, is that in the rolling average of the last two years of data, there were no formal capability cases registered on the Human Resources system where a staff member had a disability or a long term condition. This is an improvement on the previous data return from 2022-2023 where to a likelihood of 2.85 disabled staff were more likely to enter the formal capability process. However, it is noted for the current reporting cycle although there were no staff with a disability / long-term condition recorded in the formal capability data, there was a number of staff recorded where the disability status was unknown. Although these numbers for disability status unknown are removed from the data calculation by the national algorithm, when linked to Metric 1, this highlights the importance of improving staff confidence in self-reporting their disability / long-term condition status.

In reviewing and analysing the data trend for this metric since the inception of the WDES, whilst the data trend evidences improvements in recent years, it also highlights significant fluctuations in the data. This is in part due to the statistically very small numbers in relation to formal capability cases, hence the use of two-year rolling average data, but also highlights challenges in relation to local data quality and the impact of the Trust not knowing a staff member's disability status when analysing data for this metric.

It is important that Metric 1 and Metric 3 are considered together when developing action plans for improvement.

WDES Metric 4:

WDES Metric 4a(i):

WDES Metric 4a(i) is taken from the NHS Staff Survey and compares the data relating to disabled staff / staff with a long-term condition and non-disabled staff. This indicator compares specifically the data and percentages of staff reporting they have experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months.

The percentages of disabled and non-disabled staff reporting they have experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months has reduced slightly for both groups. For disabled / long-term condition staff this has reduced from 32.02% in 2022 to 29.40% in 2023. For non-disabled staff the figure has reduced from 24.11% in 2022 to 22.74% in 2023. Whilst this continued reduction is welcome and our data is now below the national average for comparable Trusts, we still have more work to do and to further embed the United Against all Forms of Discrimination campaign.

In reviewing and analysing the data trend for this metric since the inception of the WDES in 2019, it is encouraging to note that since the 2021 report our staff are informing us through the NHS staff survey that there is a steady improvement in their experience.

WDES Metric 4a(ii):

WDES Metric 4a(ii) is taken from the NHS Staff Survey and compares the data relating to disabled / long term condition and non-disabled staff. This indicator compares specifically the data and percentages of staff reporting they have experienced harassment, bullying or abuse from managers in the last 12 months.

The percentages of disabled and non-disabled staff reporting they have experienced harassment, bullying or abuse from managers in the last 12 months has reduced slightly for both groups. For disabled staff / staff with a long-term condition this has reduced from 18.93% in 2022 to 17.66% in 2023. For non-disabled staff the figure has reduced from 11.69% in 2022 to 11.35% in 2023. Whilst this continued reduction is welcome, our data is above the national average for comparable Trusts. Further the disparity between the experience of disabled and non-disabled staff is of concern. The Trust still has more work to do and to further embed the United Against all Forms of Discrimination campaign.

In reviewing and analysing the data trend for this metric since the inception of the WDES in 2019, it is encouraging to note that since the 2021 report our staff are informing us through the NHS staff survey that there is a steady improvement in their experience. However, as noted above the disparity of >6% between the reported experience of disabled staff / staff with a long-term

condition when compared to non-disabled staff remains a concern and an area of improvement focus.

WDES Metric 4a(iii):

WDES Metric 4a(iii) is taken from the NHS Staff Survey and compares the data relating to disabled staff / staff with a long-term condition and non-disabled staff. This indicator compares specifically the data and percentages of staff reporting they have experienced harassment, bullying or abuse from other colleagues in the last 12 months.

The percentages of disabled and non-disabled staff reporting they have experienced harassment, bullying or abuse from other colleagues in the last 12 months has reduced slightly for both groups. For disabled staff / staff with a long-term condition this has reduced from 28.78% in 2022 to 27.36% in 2023. For non-disabled staff the figure has reduced from 20.07% in 2022 to 19.91% in 2023. Whilst this continued reduction is welcome, our data is above the national average for comparable Trusts. Further the disparity between the experience of disabled and non-disabled staff is of concern. The Trust still has more work to do and to further embed the United Against all Forms of Discrimination campaign.

In reviewing and analysing the data trend for this metric since the inception of the WDES in 2019, it is encouraging to note that since the 2022 report our staff are informing us through the NHS staff survey that there is a steady improvement in their experience. However, as noted above the disparity of >7% between the reported experience of disabled staff / staff with a long-term condition when compared to non-disabled staff remains a concern and an area of improvement focus.

WDES Metric 4b:

WDES Metric 4b is taken from the NHS Staff Survey and compares the data relating to disabled staff / staff with a long-term condition and non-disabled staff. This indicator compares specifically the data and percentages of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.

The percentage of disabled / staff with a long-term condition saying that the last time they experienced harassment, bullying or abuse at work, they or a

colleague reported it has decreased from 50.44% in 2022 to 49.89% in 2023. Whereas the percentage of non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it has increased from 42.02% in 2022 to 45.96% in 2023. Whilst the improvement in reporting for non-disabled staff is welcome, the reduction in reporting for disabled staff / staff with a long-term condition needs further investigation. Moreover, our data is below the national average for comparable Trusts. Further, the disparity between the experience of disabled and non-disabled staff is of concern. The Trust still has more work to do and to further embed the United Against all Forms of Discrimination campaign.

In reviewing and analysing the data trend for this metric since the inception of the WDES in 2019, it is encouraging to note an overall trend of improvement, the year-by-year data is somewhat random with no steady or consistent improvement trend evident. However, with fewer than 50% of all staff or a colleague reporting when harassment, bullying or abuse at work is experienced, there remains significant scope for improvement in this area.

WDES Metric 5:

WDES Metric 5 reviews Trust NHS Staff Survey data and compares the data relating to disabled staff / staff with a long-term condition and non-disabled staff. This indicator compares specifically the percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion.

The percentages of disabled and non-disabled staff reporting they believe that the organisation provides equal opportunities for career progression or promotion has increased slightly for both groups. For disabled staff / staff with a long-term condition staff this has increased from 48.43% in 2022 to 50.65% in 2023. For non-disabled staff the figure has increased from 57.04% in 2022 to 57.16% in 2023. Whilst this continued increase is welcome, our data remains below the national average for comparable Trusts. Further the disparity between the experience of disabled and non-disabled staff is of concern. The Trust will review and revise WDES action plans, in partnership with the MAPLE network, to develop a longer-term approach to improvement.

In reviewing and analysing the data for this metric, it is important to note that when the NHS introduced the NHS People Promise, the algorithm for calculating this question in the NHS Staff Survey was changed. It is for this reason that we are only able to compare data for the last three years. Although it is encouraging to note the improvement in all staff reporting through the NHS Staff Survey in relation to this metric, the >6% disparity between the reported experience between disabled staff / staff with a long-term condition and non-disabled staff is noted and further work to improve this is required.

WDES Metric 6:

WDES Metric 6 reviews Trust NHS Staff Survey data and compares the data relating to disabled / staff with a long-term condition and non-disabled staff. This indicator compares specifically the percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

The percentages of disabled and non-disabled staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties has decreased slightly for both groups. For disabled staff / staff with a long-term condition this has decreased from 30.42% in 2022 to 29.29% in 2023. For non-disabled staff the figure has decreased from 22.22% in 2022 to 22.16% in 2023. Whilst this continued decrease is welcome, our data remains above the national average for comparable Trusts. Further the disparity between the experience of disabled and non-disabled staff is of concern. The Trust will review and revise WDES action plans, in partnership with the MAPLE network, to develop a longer-term approach to improvement.

In reviewing and analysing the data trend for this metric since the inception of the WDES in 2019, it is encouraging to note a general steady improvement in the scores for all staff. There is one notable deterioration in the data for all staff and this was in 2021 and this was at the height of the pandemic. However, at this time the disparity between disabled staff / staff with a long-term condition is also at its greatest at 11%. This would seem to indicate that at times of increased challenge and vulnerability, or disabled staff / staff with a long-term condition are likely to experience or feel increased pressure.

Thankfully since that time our staff reported experience has continued to improve, however a >7% disparity between the experience of disabled staff / staff with a long-term condition and non-disabled staff remains. This needs to be further explored and understood and improvement actions identified and implemented.

WDES Metric 7:

WDES Metric 7 reviews Trust NHS Staff Survey data and compares the data relating to disabled staff / staff with a long-term condition and non-disabled staff. This indicator compares specifically the percentage of staff satisfied with the extent to which their organisation values their work.

The percentages of disabled and non-disabled staff who are satisfied with the extent to which their organisation values their work has increased for both groups. For disabled staff / staff with a long-term condition staff this has increased from 31.93% in 2022 to 33.43% in 2023. For non-disabled staff the figure has increased from 39.80% in 2022 to 45.18% in 2023. Whilst this continued increase is welcome, our data remains slightly below the national average for comparable Trusts. Further the disparity between the experience of disabled and non-disabled staff is of concern. The Trust will review and revise WDES action plans, in partnership with the MAPLE network, to develop a longer-term approach to improvement.

In reviewing and analysing the data for this metric since the inception of the WDES in 2019, it is encouraging to note a general improvement for all staff over time. The data for all staff did deteriorate between 2020 and 2022 and this is likely to be related to the experience of the pandemic. Although it is encouraging that the data for all staff is steadily improving, the disparity of >11% in reported experience between disabled staff / staff with a long-term condition and non-disabled staff is an area of concern. This needs to be reviewed in partnership with the MAPLE network and improvement plans identified and put in place.

WDES Metric 8:

WDES Metric 8 reviews Trust NHS Staff Survey data and reviews the data relating to disabled / staff with a long-term condition in relation to reasonable

adjustments being made. This indicator reviews the percentage of staff with a long-term health condition or illness saying their employer has made reasonable adjustments to enable them to carry out their work. Please note, as reasonable adjustments are a legal requirement embedded within the Equality Act 2010 for people with a disability, this is not a metric where data with non-disabled staff is compared.

The percentage of staff with a long-term health condition or illness saying their employer has made reasonable adjustments to enable them to carry out their work has decreased slightly in the current reporting cycle. In 2022 the figure was 71.52% and this decreased in 2023 to 70.59%. This figure is just under 3% lower than the national average for comparable Trusts. The Trust will review and revise WDES action plans, in partnership with the MAPLE network, and the publication of the new Reasonable Adjustments Policy and associated guidance is an important action for delivery in 2024-2025.

In reviewing and analysing the data for this metric since the inception of the WDES in 2019, it is encouraging to note a general improvement. However, there is currently no consistency or steadiness in improvement and the new Reasonable Adjustment Policy can only serve to support managers in relation to making reasonable adjustments and improving the experience of our staff for whom reasonable adjustments are essential for them remaining happy and healthy in work.

WDES Metric 9:

WDES Metric 9a:

WRES Metric 9a is taken from the NHS Staff Survey and is the staff engagement score for disabled / staff with long-term condition compared to non-disabled staff and the overall engagement score for the organisation.

The engagement score for disabled staff / staff with a long-term condition decreased slightly from 6.16 in 2022 to 6.05 in 2023. For non-disabled staff the engagement score increased slightly from 6.53 in 2022 to 6.63 in 2023. Overall, the engagement score for the organisation increased slightly from 6.44 in 2022 to 6.48 in 2023. The scores for disabled staff / staff with a long-term condition and non-disabled staff remain below the national averages for

comparable Trusts. Continued engagement with and through the MAPLE network is central to the wider WDES work in the organisation in 2024-2025.

In reviewing and analysing the trend data for this metric since the inception of the WDES in 2019, whilst there is an improvement over time for non-disabled staff, there is a slight deterioration over time for disabled staff / staff with a long-term condition. Through further engagement with the MAPLE network this needs to be explored and understood, so that further improvement plans can be put in place.

WDES Metric 9b:

WDES Metric 9b is a free text question asking: Have you taken action to facilitate the voices of disabled staff to be heard in your Trust? The Trust can evidence through the great work of the MAPLE network, that we routinely take action to facilitate the voices of our disabled and staff with long-term conditions in a structured manner.

WDES Metric 10:

WDES Metric 10 reviews the organisation's leadership in relation to the establishment of the Trust Board.

In the 2022-2023 WDES data return all members of the Trust Board identified as not being disabled / having a long-term condition or disability status was unknown. In the 2023-2024 WRES data return of the 15 Trust Board members 2 identified as having a disability / long-term condition, 5 identified as not having a disability / long-term condition and for 8 their disability status is unknown.

In reviewing and analysing the data trends for this metric since the inception of the WDES in 2019, it is encouraging that in the current reporting cycle, for the first time we have two voting Trust Board members who have chosen to declare their disability / long-term condition status. However, we still have a number of voting members who have not yet declared their disability status on ESR.

Conclusion:

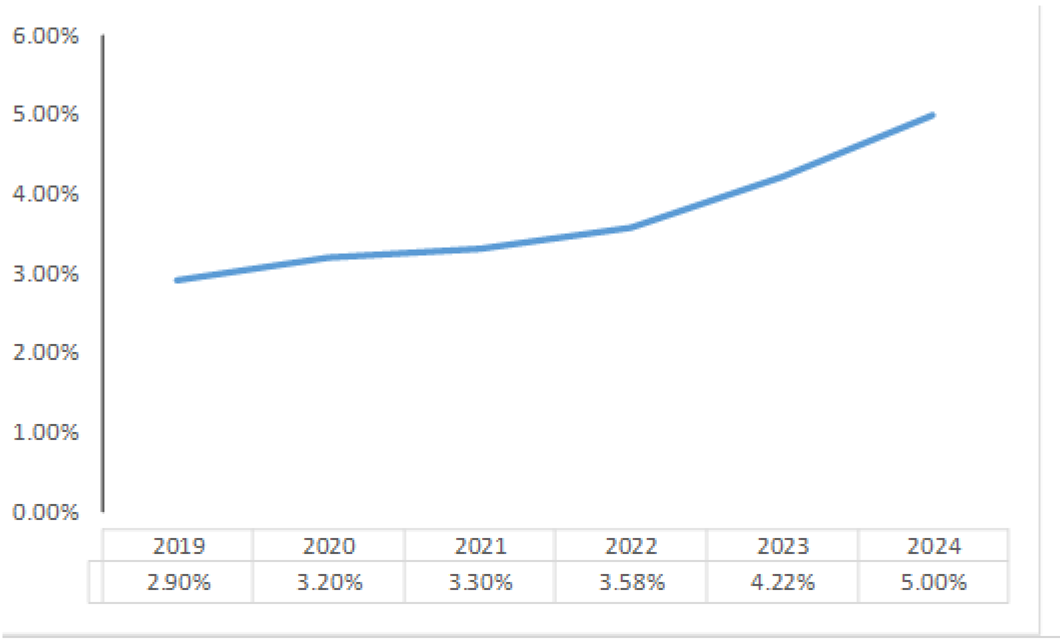
In this report, for the first time, we have included a data trend analysis of the WDES from 2019 through to the current reporting cycle. Whilst for most of the WDES metrics there is, over time, an encouraging improvement, this is not true for all metrics and indeed, there remains room for continued improvement across all metrics, as we continue to strive for equity in experience for all our staff. Of particular concern across a number of the metrics is the disparity in experience between disabled staff / staff with long-term conditions and non-disabled staff.

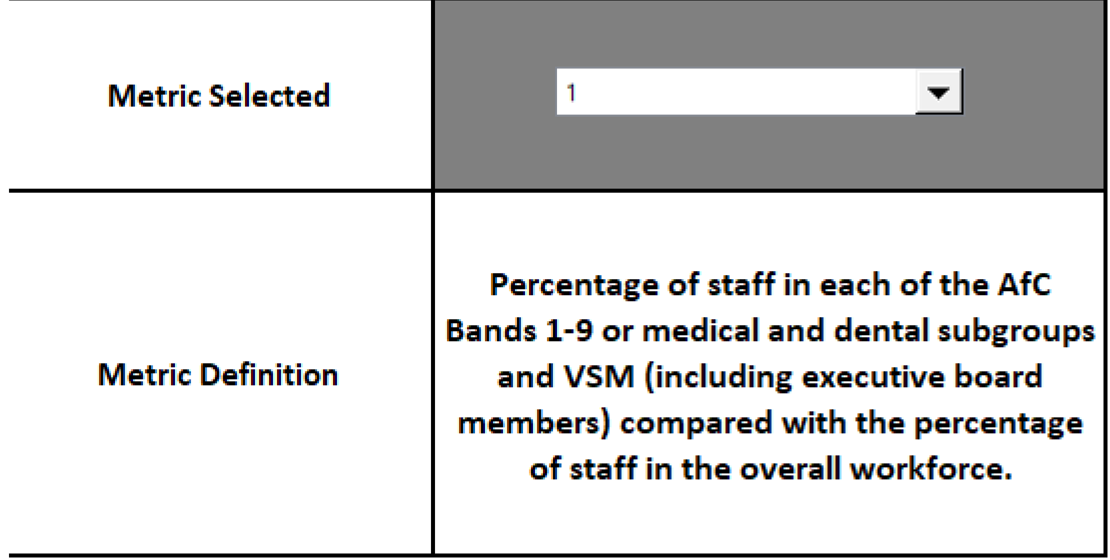
Over the summer of 2024 engagement with our MAPLE network and other key stakeholders will take place as we agree and craft our actions for improvement. It is proposed, that in line with national best practice, we move from an annual action plan to a more agile three-year plan, which can then be updated when required to reflect latest data driven intelligence. Further for the first time, we will be recommending actions for improvement across the Lincolnshire Community and Hospitals NHS Group.

Once completed, the WDES action plans will be shared with the People and Organisational Development Committee and the Trust Board for approval, before publishing on the Trust's website by 30 September 2024, as required by NHS England.

Appendix 1

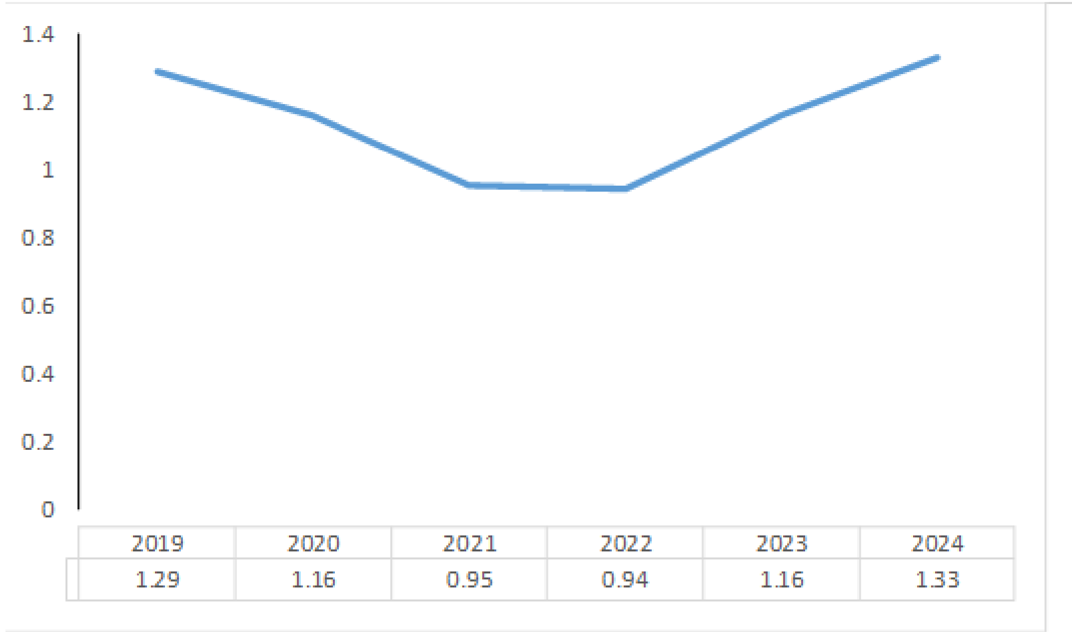
Metric 1:

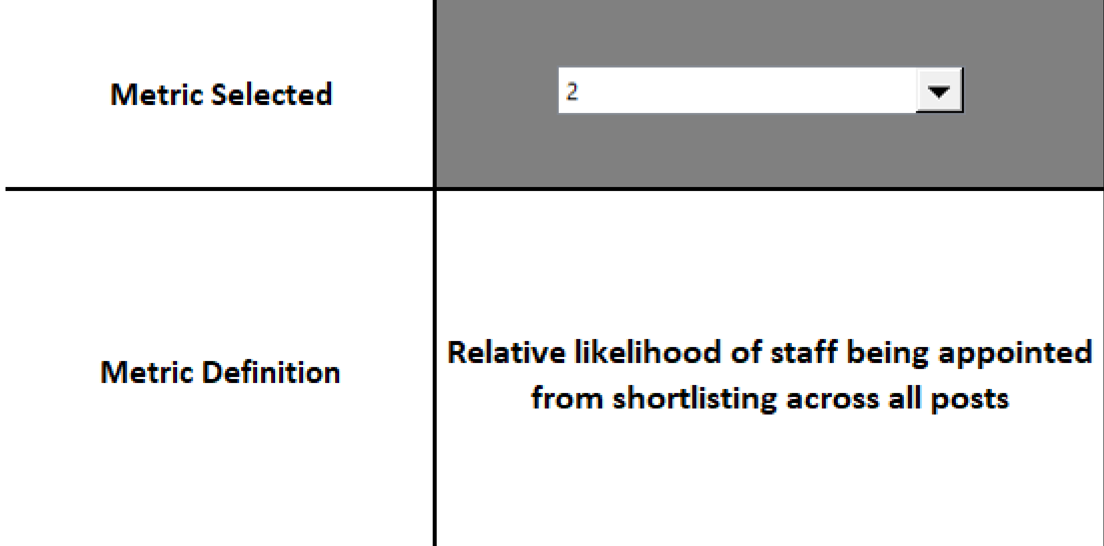




Metric Selected	1
Metric Definition	**Percentage of staff in each of the AfC Bands 1-9 or medical and dental subgroups and VSM (including executive board members) compared with the percentage of staff in the overall workforce.**

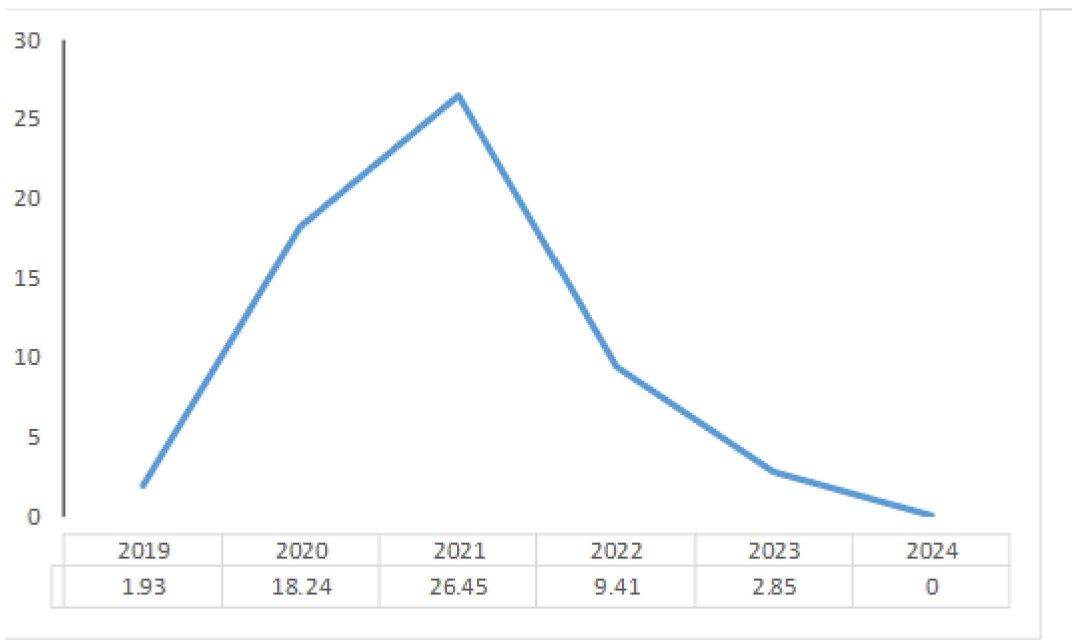
Metric 2:

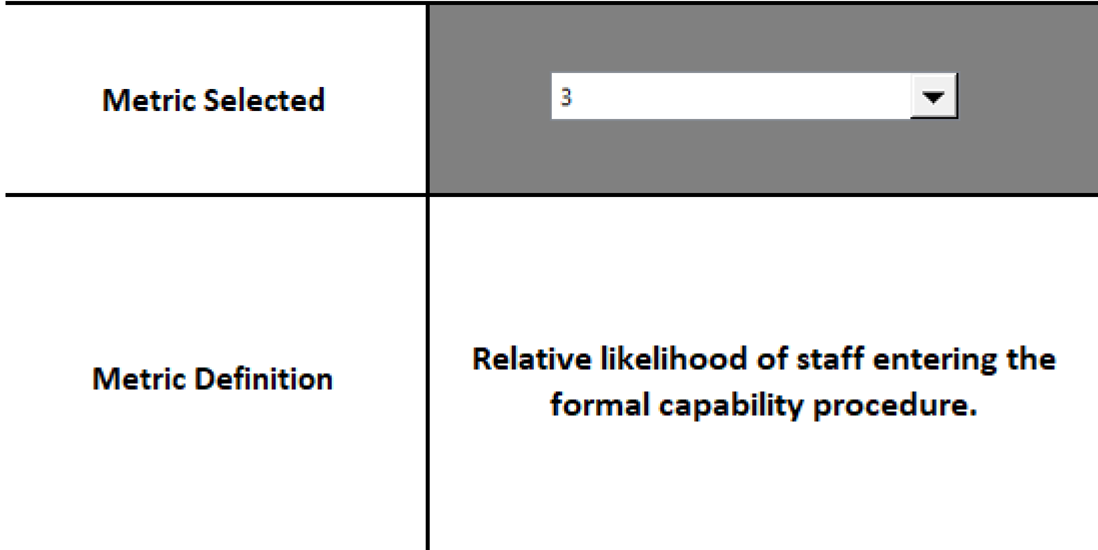




Metric Selected	2
Metric Definition	**Relative likelihood of staff being appointed from shortlisting across all posts**

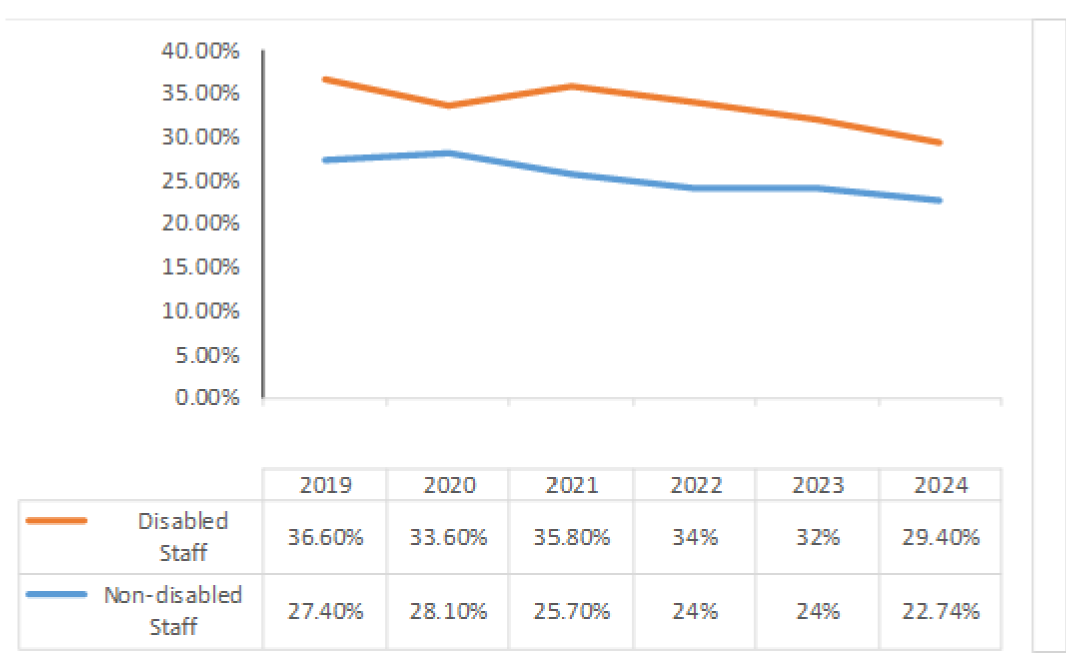
Metric 3:





Metric Selected	3
Metric Definition	**Relative likelihood of staff entering the formal capability procedure.**

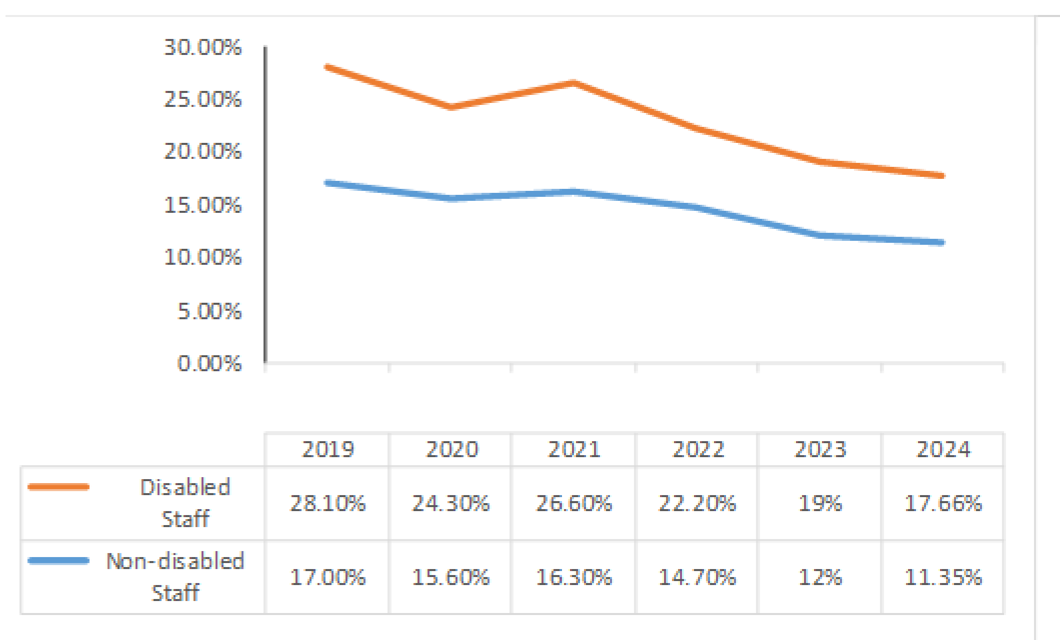
Metric 4a (i):



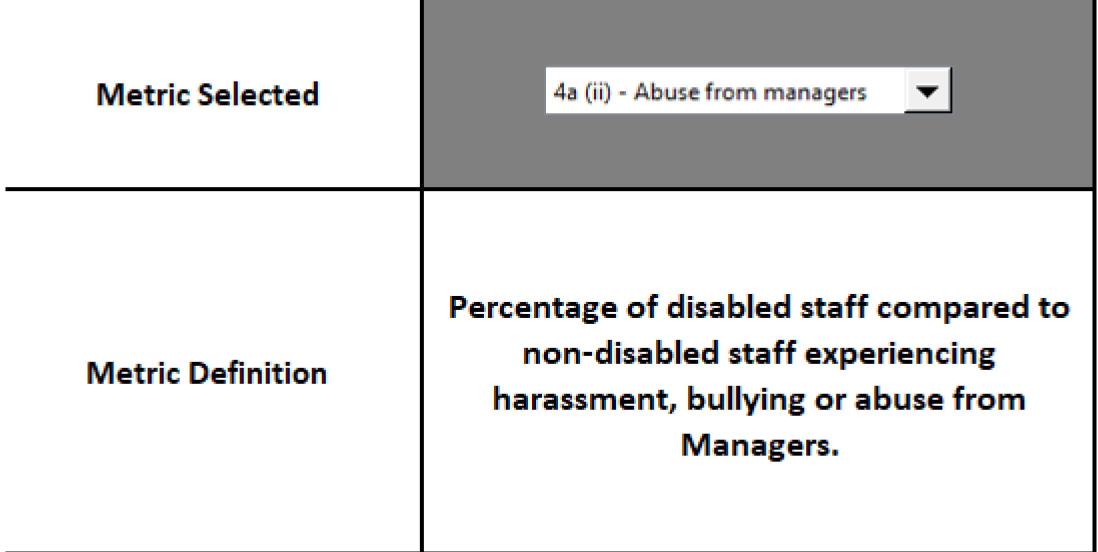
	2019	2020	2021	2022	2023	2024
Disabled Staff	36.60%	33.60%	35.80%	34%	32%	29.40%
Non-disabled Staff	27.40%	28.10%	25.70%	24%	24%	22.74%

Metric Selected	4a (i) - Abuse from patients and s
Metric Definition	**Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Patients/service users, their relatives or other members of the public**

Metric 4a (ii):

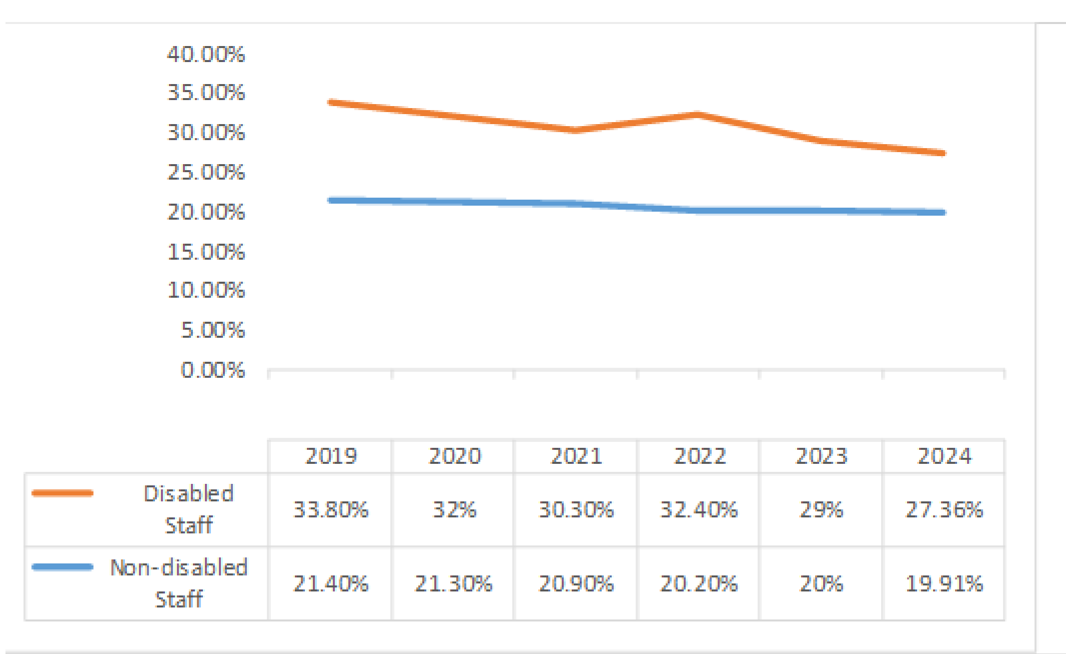


	2019	2020	2021	2022	2023	2024
Disabled Staff	28.10%	24.30%	26.60%	22.20%	19%	17.66%
Non-disabled Staff	17.00%	15.60%	16.30%	14.70%	12%	11.35%



Metric Selected	4a (ii) - Abuse from managers
Metric Definition	**Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Managers.**

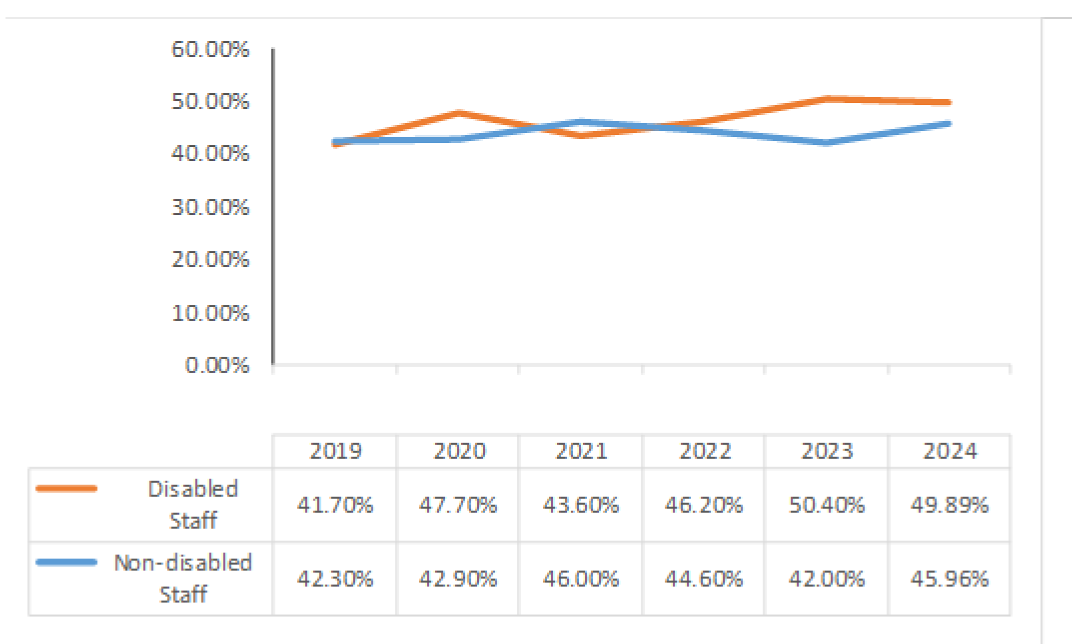
Metric 4a (iii):



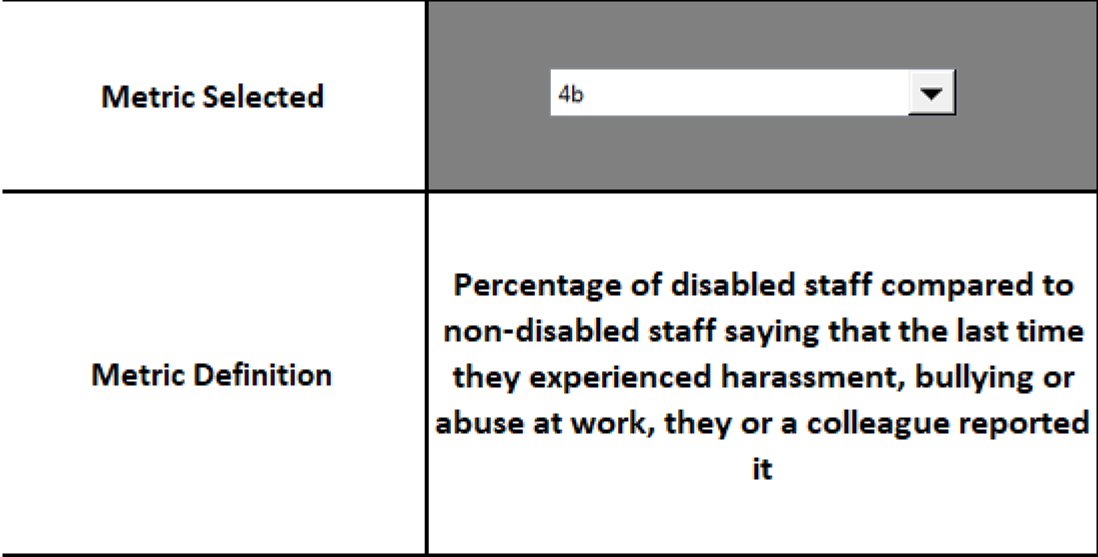
	2019	2020	2021	2022	2023	2024
Disabled Staff	33.80%	32%	30.30%	32.40%	29%	27.36%
Non-disabled Staff	21.40%	21.30%	20.90%	20.20%	20%	19.91%

Metric Selected	4a (iii) - Abuse from other colleag
Metric Definition	**Percentage of disabled staff compared to non-disabled other staff experiencing harassment, bullying or abuse from other Staff**

Metric 4b:

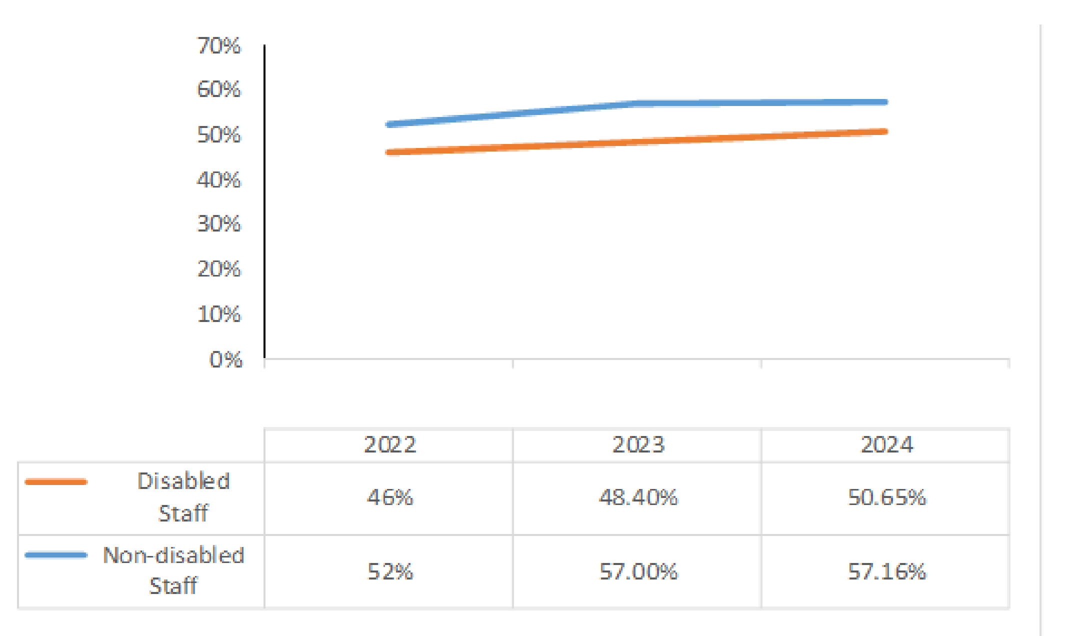


	2019	2020	2021	2022	2023	2024
Disabled Staff	41.70%	47.70%	43.60%	46.20%	50.40%	49.89%
Non-disabled Staff	42.30%	42.90%	46.00%	44.60%	42.00%	45.96%

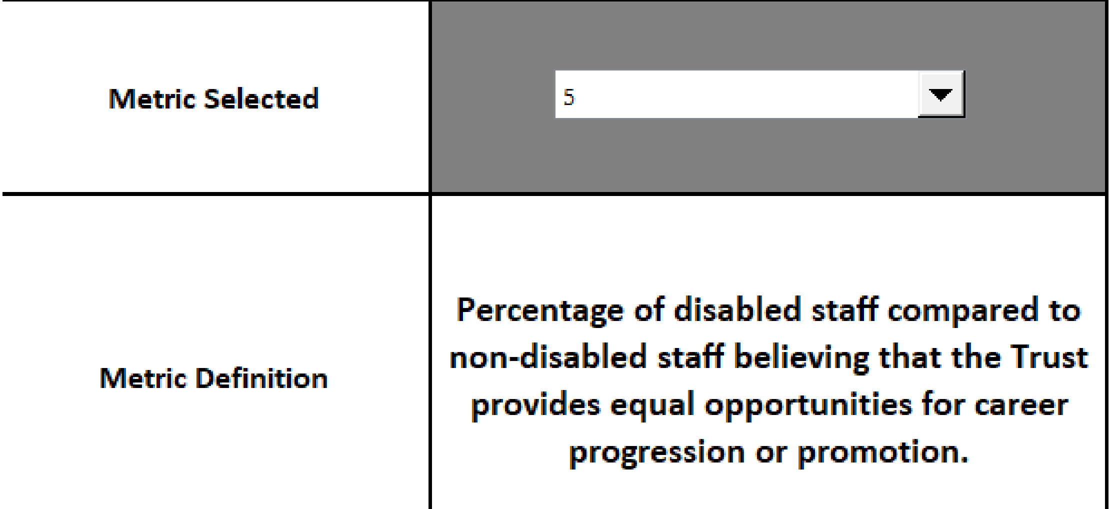


Metric Selected	4b
Metric Definition	**Percentage of disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it**

Metric 5:

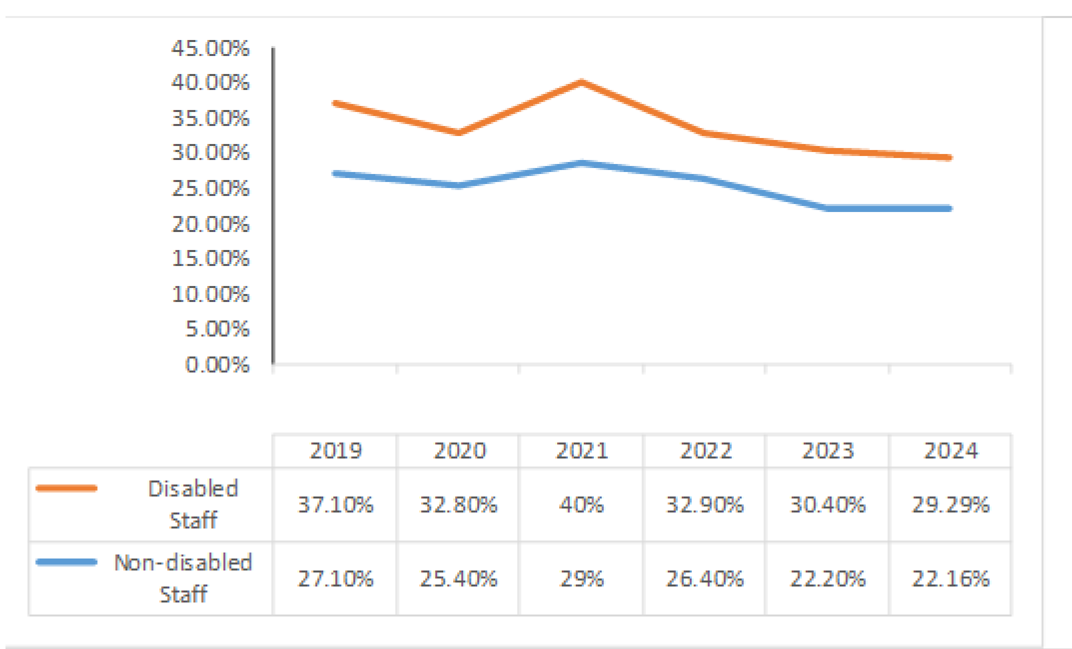


	2022	2023	2024
Disabled Staff	46%	48.40%	50.65%
Non-disabled Staff	52%	57.00%	57.16%

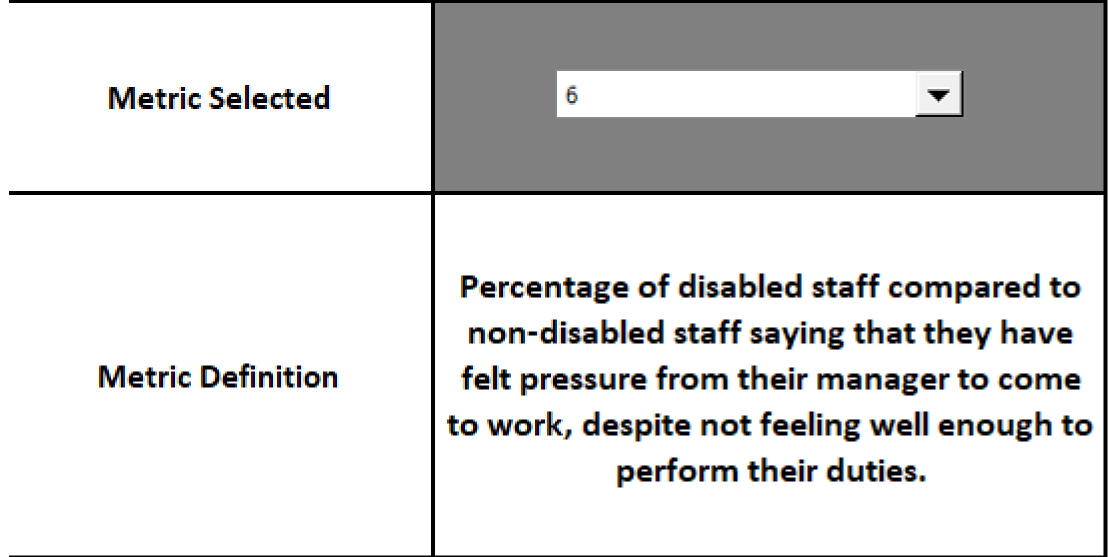


Metric Selected	5
Metric Definition	**Percentage of disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.**

Metric 6:

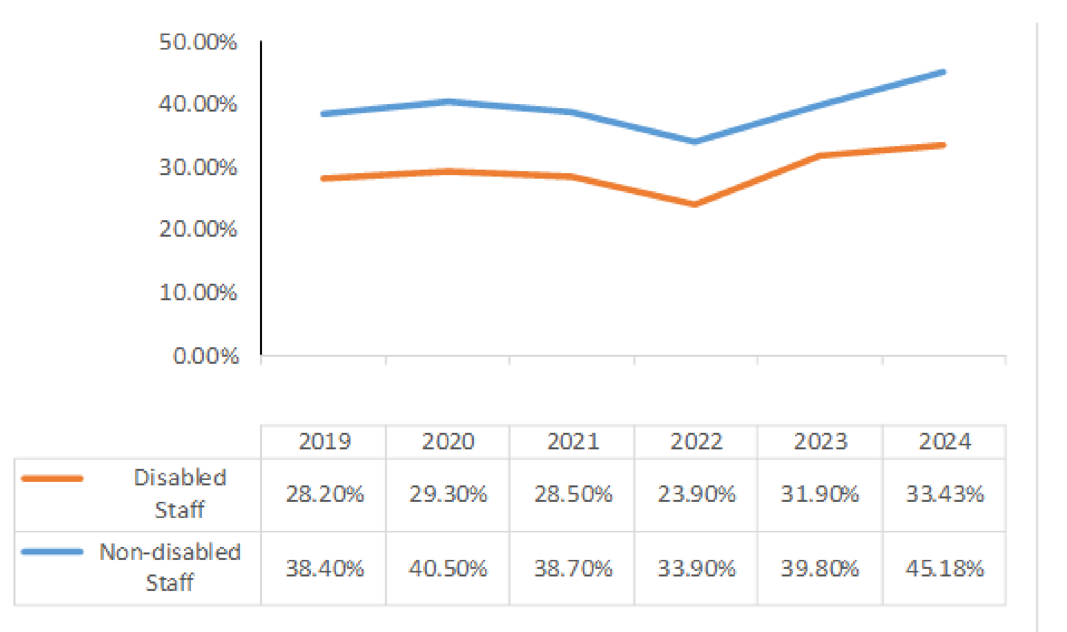


	2019	2020	2021	2022	2023	2024
Disabled Staff	37.10%	32.80%	40%	32.90%	30.40%	29.29%
Non-disabled Staff	27.10%	25.40%	29%	26.40%	22.20%	22.16%

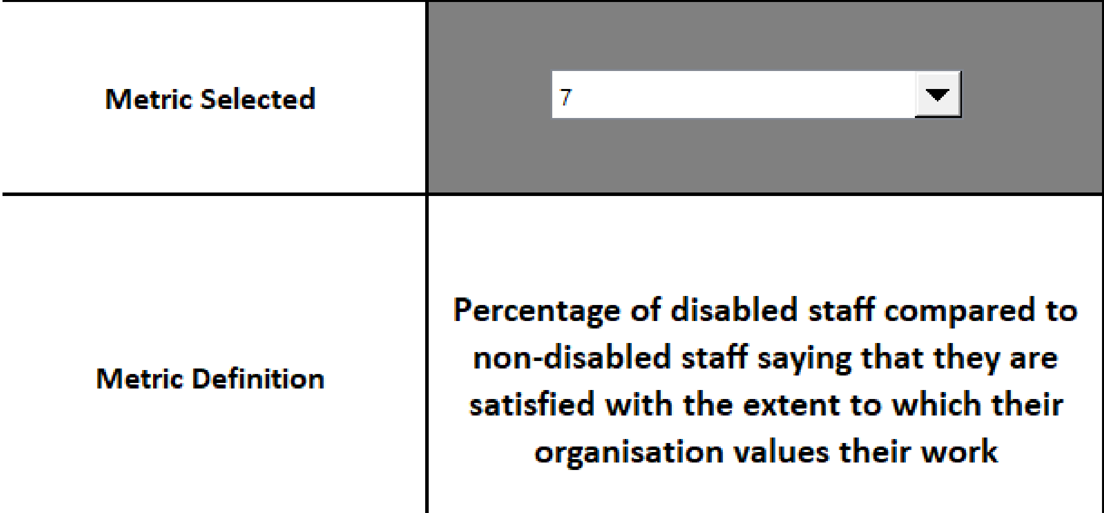


Metric Selected	6
Metric Definition	**Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.**

Metric 7:

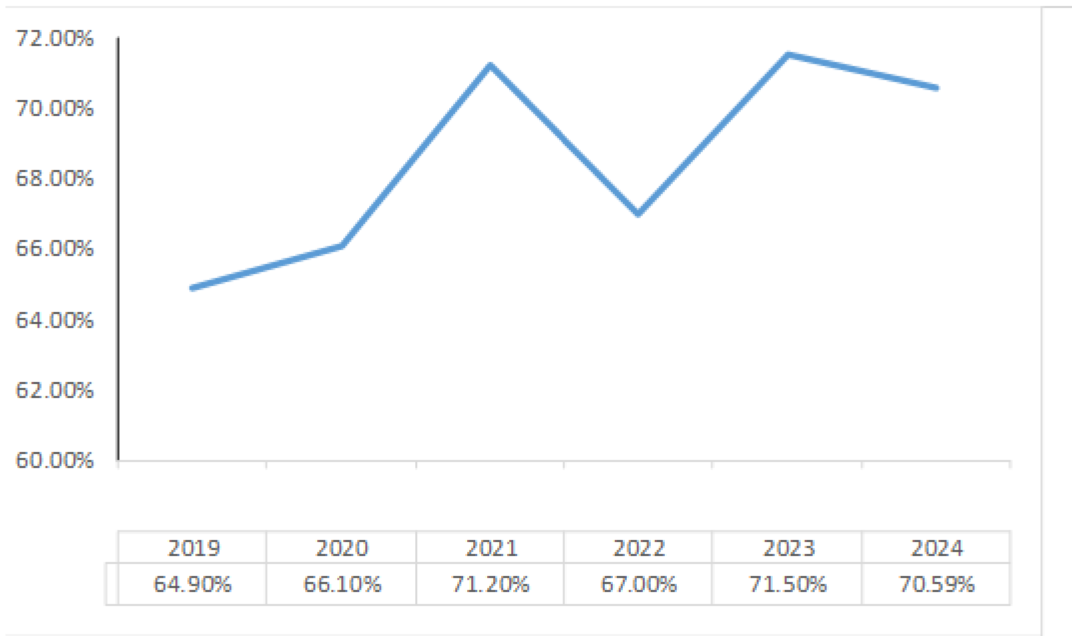


	2019	2020	2021	2022	2023	2024
Disabled Staff	28.20%	29.30%	28.50%	23.90%	31.90%	33.43%
Non-disabled Staff	38.40%	40.50%	38.70%	33.90%	39.80%	45.18%

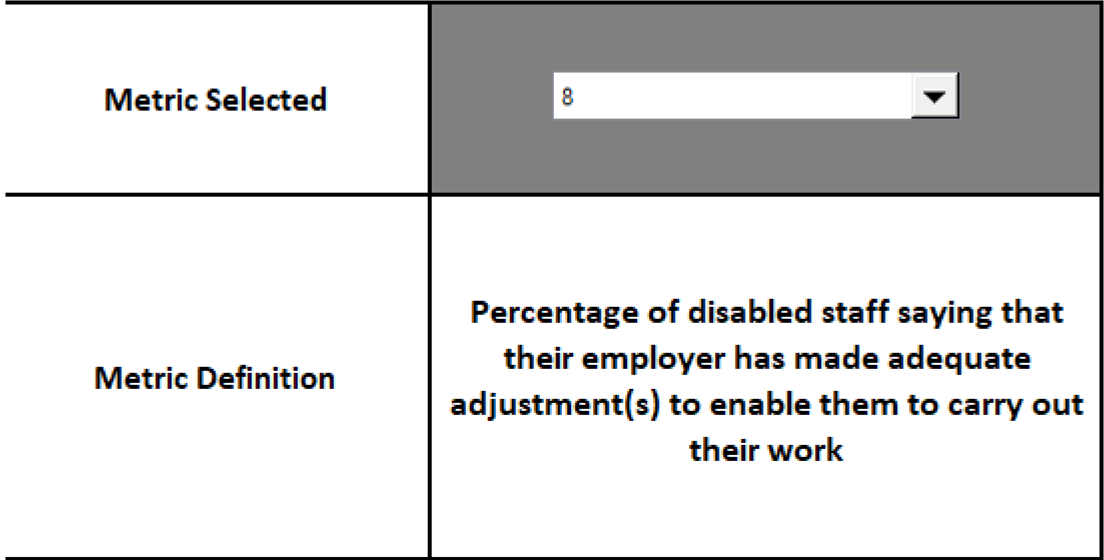


Metric Selected	7
Metric Definition	**Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work**

Metric 8:

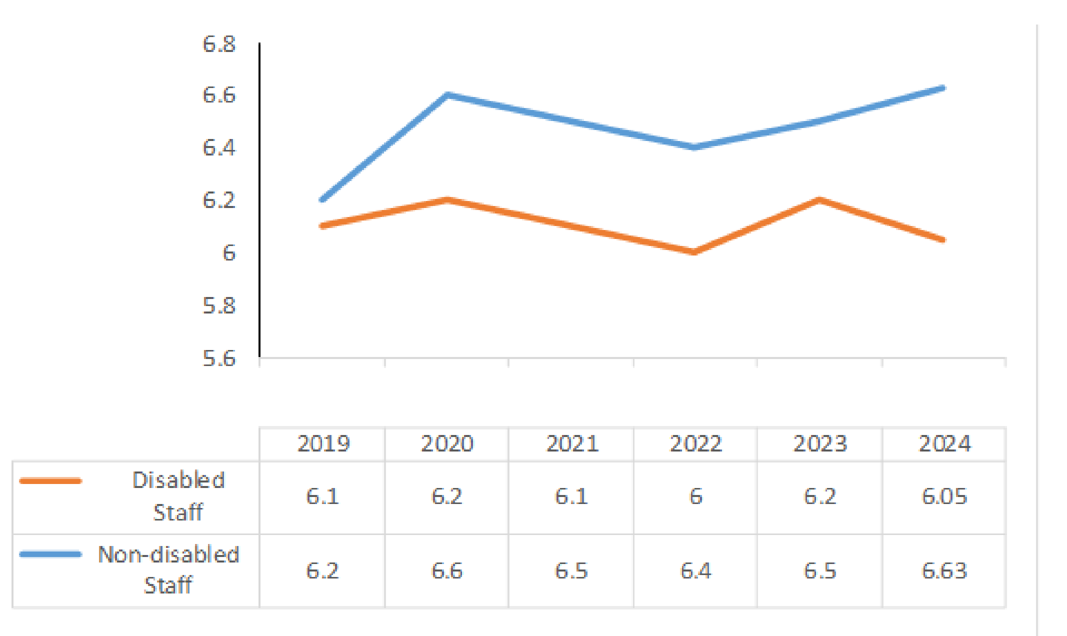


2019	2020	2021	2022	2023	2024
64.90%	66.10%	71.20%	67.00%	71.50%	70.59%

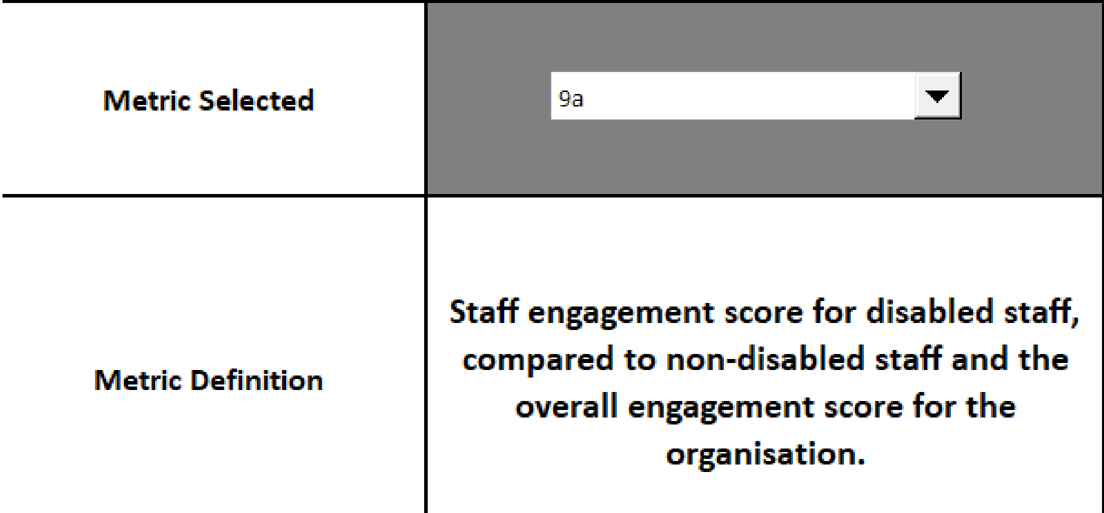


Metric Selected	8
Metric Definition	**Percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work**

Metric 9a:



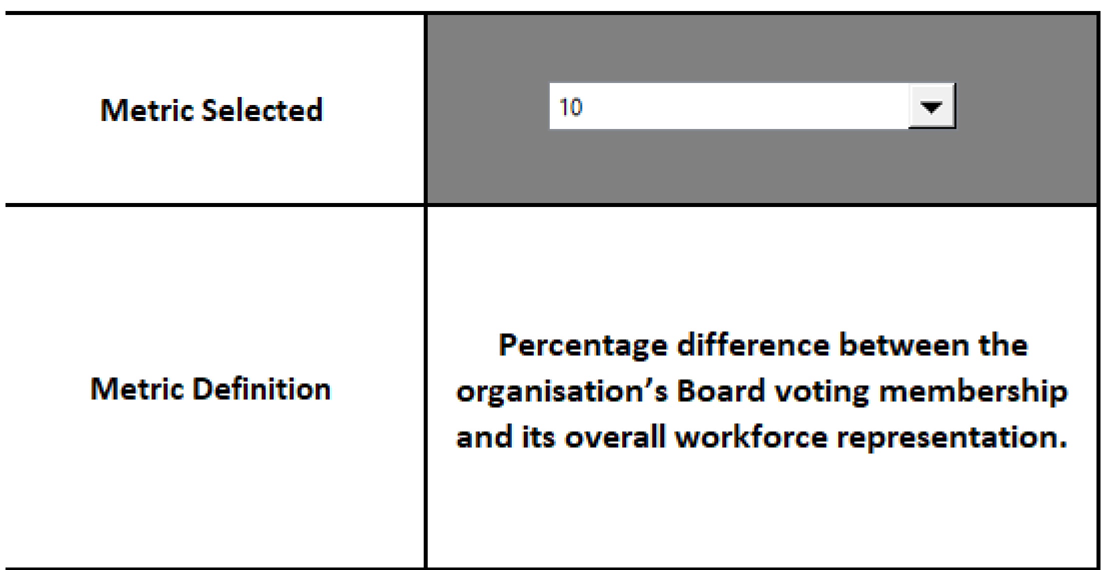
	2019	2020	2021	2022	2023	2024
Disabled Staff	6.1	6.2	6.1	6	6.2	6.05
Non-disabled Staff	6.2	6.6	6.5	6.4	6.5	6.63



Metric Selected	9a
Metric Definition	**Staff engagement score for disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.**

Metric 10:

2019	2020	2021	2022	2023	2024
No representation	No representation	No representation	No representation	No representation	2 Board members identified as having a disability / LTC



Metric Selected	10
Metric Definition	**Percentage difference between the organisation's Board voting membership and its overall workforce representation.**

WDES Action Plan 2024 - 2027

Metrics	Task	Actions	Responsible Officer/s	Milestones						Outcome / evidence
				Q1	Q2	Q3	Q4	2025/26	2026/27	
Metric 1: Percentage of staff in each of the AfC Bands 1-9 or medical and dental subgroups and VSM (including executive board members) compared with the percentage of staff in the overall workforce.	Establish Reciprocal Mentoring Programme with new Group Trust Board and Group Staff Networks. High Impact Action 1	Align the Lincolnshire Reciprocal Mentoring model to LCHG	Tim Couchman / Rachel Higgins			★				
		Recruit first cohort of Reciprocal Mentors	Tim Couchman / Rachel Higgins			★				
		Deliver first cohort of Reciprocal Mentoring at LCHG	Tim Couchman / Rachel Higgins				★			
		Evaluate first cohort of Reciprocal Mentoring at LCHG	Tim Couchman / Rachel Higgins					★		Evidence: Reciprocal Mentoring programme evaluation.
		Deliver second cohort of Reciprocal Mentoring	Tim Couchman / Rachel Higgins					★		
		Reciprocal Mentoring Programme as Business as Usual at LCHG	Tim Couchman / Rachel Higgins						★	
	Establish meaningful career conversations with disabled and neurodiverse colleagues and staff with long-term conditions in Agenda for Change roles, recognising where they have substantial previous experience, to ensure targeted career support. High Impact Action 2	Engage with Organisational Development and MAPLE network to establish mechanisms required to progress this action.	EDI Team With support from the OD & MAPLE network				★			Evidence: Improvement in National Staff Survey scores for question relating to equal opportunities for career progression or promotion (cf. Indicator 7)
		Effective engagement mechanisms established and Business and Usual	EDI Team With support from the OD & MAPLE network						★	
	Increase disability / long-term condition self-disclosure rates on ESR for staff with a condition. High Impact Actions 4 & 6	Engage with OD Team and MAPLE network to agree a plan to encourage staff to update their equality data on ESR, with particular focus on engagement with medical colleagues where self-disclosure rates are low.	EDI Team With support from the OD & MAPLE network			★				
		Enact plan to encourage staff to update their ESR equality data.	EDI Team					★		Outcome measure: Increase in disability self-

			With support from the OD, MAPLE network and Communications Team							disclosure status on ESR measured in annual WDES data (31.03.2024 = 5%) and closing of the disparity between ESR and NHS Staff Survey.
	Establish and enact a talent management plan for Trust Board and Senior Leadership Teams, which includes improvements in the diversity of these teams. High Impact Actions 1 & 2	Engage with the new LCHG Trust Board and Senior Leadership Teams to establish mechanisms required to progress this action.	EDI Team With support from the Trust Board and Senior Leadership Teams							Evidence: demonstrable improvement in race and disability representation in senior leadership roles (Band 8 and above), as measured in Indicator 1.
		Effective mechanisms established and Business and Usual	EDI Team With support from the Trust Board and Senior Leadership Teams							
	Implement a plan to widen recruitment opportunities within local communities, aligned to the NHS Long Term Workforce Plan and Lincolnshire Integrated Care Board (ICB), to	Engage with the Lincs ICB partners to establish mechanisms required to progress this action. (Link to Disability Confident actions)	Recruitment Team and Lincs ICB partners							Evidence tbc

	include those with disabilities, including pathways into employment for those with Physical Disabilities, Learning Disabilities or Difficulties, Autism, ADHD, Dyslexia, Dyscalculia, Sensory Processing Disorder and other neuro-diversities. High Impact Action 2	Effective mechanisms established and Business and Usual	Recruitment Team and Lincs ICB partners						★	
Metric 2: Relative likelihood of staff being appointed from shortlisting across all posts.	Implement the Lincs ICB Inclusive Recruitment Toolkit. High Impact Action 2	Develop a plan to implement the ICB Inclusive Recruitment Toolkit across the LCHG	EDI Team			★				
		Effective implementation enacted and Business and Usual	EDI Team						★	Evidence: demonstrable improvement in Indicator 2 data.
	The Trust will undertake a deep and broad Inclusive Recruitment review, including feedback from staff networks. High Impact Action 2	Develop a plan to review recruitment processes and data from an inclusion perspective. (use of the CQ-Leading Inclusively model and cross reference to "No More Tick Boxes" guidance. The aim is to ensure that the process and training is even more inclusive from end-to-end, at all touchpoints & stages, from the perspective of candidates as well as recruiting managers and the recruitment team.)	EDI and Recruitment Teams			★				

		Undertake a review of the recruitment processes and data from an inclusion perspective.	EDI and Recruitment Teams							
		Engagement with Staff Networks to inform recommendations to improve inclusive recruitment.	EDI Team and Staff Networks							Evidence tbc
		New inclusive recruitment strategies / approach enacted	EDI and Recruitment Teams							Outcome: Improved data for this indicator.
	Achieve Disability Confident Leader status. High Impact Action 2	Utilising the national Disability Confident Leader framework, develop a plan with the MAPLE network to work towards Leader status	EDI Team and MAPLE Network							
		Commence delivery of the Disability Confident Leader plan	EDI Team and MAPLE network							
		Achieve Disability Confident Leader status	EDI Team and MAPLE network							It is recognised that achievement of Disability Confident Leader status is a 3-year commitment
Metric 3: Relative likelihood of staff entering the formal capability procedure, as measured by entry into formal investigation.	Implement the new Just Culture at the Trust. High Impact Action 6	Just Culture implemented in the Trust.	Director of People & OD							Just Culture (sharepoint.com)
		Just Culture implementation reviewed and analysed	Just Culture Programme Manager							
		Just Culture impact on formal capability processes / cases reviewed and analysed.	Just Culture Programme Manager and Senior HR Manager							
		Just Culture embedded as BAU	Director of People & OD							Outcomes: Through the Just Culture approach numbers of formal capability cases reduced and measured through the annual WDES data return.

										Reduction in Employment Tribunals citing disability discrimination.
	Deliver Leading Inclusively with Cultural Intelligence (CQ) Programme to LCHG leaders. High Impact Action 6	CQ established as effective leadership programme in the Trust	Head of EDI	★						By March 2024 >450 leaders completed the CQ programme.
		Established a recurrent budget for delivery of CQ programme to set cohorts of leaders on an annual basis	EDI Team				★			
		CQ recorded via ESR and part of the established leadership offer at LCHG .	EDI and OD Teams							
Metric 4a: (i) Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months. (ii) Percentage of staff experiencing bullying, harassment or abuse from managers in the last 12 months. (iii) Percentage of staff experiencing bullying, harassment or abuse from other colleagues in the last 12 months.	Relaunch and expand the implementation of United against all forms of Discrimination programme. High Impact Action 6	Relaunch the poster campaign with new QR code reporting system, including anonymous option.	EDI Team			★				
		Evaluate the use and feedback from the QR code reporting system and consider whether sufficient usage to enable anonymised upward reporting.	EDI Team, Staff Network Council &Freedom To Speak Up Service					★		Outcome measures: improved NHS Staff Survey data.
	Deliver a workshop for "calling out and calling in". Topics to include: racism, LGBTQ+ hate, misogyny, ageism High Impact Action 6	Co-design a "Calling out and Calling in" workshop and run pilot.	EDI, OD Teams and Staff Networks			★				
		Evaluate "Calling out and Calling in" workshop and scope next steps.	EDI, OD Teams and Staff Networks				★			Evidence: Evaluation data
	Implement the award winning Lincs ICB Allyship toolkit High Impact Action 6	Develop a plan to implement the ICB Allyship Toolkit across the LCHG	EDI Team				★			
		Effective implementation enacted and Business and Usual	EDI Team					★		

	Complete the NHS Culture & Leadership Programme (CLP) with emphasis on respect and civility. High Impact Action 6	CLP Discovery Phase end stage report to People & OD Committee and Trust Board, to include recommendations for the Design Phase	CLP Programme Manager		★					
		Complete CLP Design Phase	CLP Programme Manager and OD Team			★				
		Implement and complete CLP Delivery Phase	CLP Programme Manager and OD Team					★		
		Evaluate CLP and report to LCHG Board	CLP Programme Manager and OD Team					★		
Metric 4b: Percentage of disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.	Relaunch and expand the implementation of United against all forms of Discrimination programme. High Impact Action 6	See actions in metric 4a above								Evidence for both 4a & 4b – demonstrable improvement in Staff Survey data.
Metric 5: Percentage believing that the Trust provides equal opportunities for career progression or promotion.	To better understand the data for this indicator which informs that staff with a disability / long-term condition report a lower belief that the Trust provides equal opportunities for career progression or promotion. High Impact Actions 2	Commence engagement with the MAPLE network members to better understand their experience.	EDI Team and MAPLE Network			★				
		Work with the MAPLE Network to develop a plan of actions to improve the experience of colleagues with a disability / long-term condition.	EDI Team and MAPLE Network				★			
		Deliver and evaluate plan.	EDI Team and MAPLE Network					★		Evidence: Reduction of disability disparity in senior positions (Band 8 and above, as measured in indicator 1)

	Reciprocal Mentoring programme & Career Conversations – as per Metric 1.									
	Inclusive recruitment review – as per Metric 2.									
Metric 6: Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	Write and implement a Reasonable Adjustments Policy to support managers and staff with a disability / long-term condition to remain and stay healthy in work, but also to understand the importance of disability leave when a person is unwell.	Draft the Reasonable Adjustments Policy.	MAPLE network							
		Present draft Reasonable Adjustments Policy to JNF and Policy Approval Group for sign-off.	MAPLE network							
		Publish and launch new Reasonable Adjustment Policy.	MAPLE network, EDI & Comms Team							Evidence: policy published for use
	Link to United Against all Forms of Discrimination work – Metric 4a									
Metric 7: Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.	Reciprocal Mentoring programme & Career Conversations – as per Metric 1.									
	Inclusive recruitment review – as per Metric 2.									

Metric 8: Percentage of disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work	Implement Reasonable Adjustments Policy – as per Metric 6									
Metric 9a: The staff engagement score for disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.	To ensure that all disabled staff are well-supported in the Trust, with positive experience in all divisions – including those with less visible disabilities, mental health conditions and wellbeing (including men – with the establishment of a men's network) and those who are neurodiverse.									
Metric 9b: Have you taken action to facilitate the voices of disabled staff to be heard in your Trust?	Free text, not data driven, response in the WDES. The Trust can demonstrate significant facilitation of the voices of disabled staff, primarily through the active MAPLE Network.	Continue to empower and develop the MAPLE network through the opportunities of the LCHG model.	EDI Team and MAPLE network.							

Metric 10: Percentage difference between the organisation's Board voting membership and its overall workforce representation.	Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable. High Impact Action 1	To be progressed at LCHG Board level, once the full Board is established	EDI Leads and Trust Board							Evidence: Improvement in NSS Staff Survey data for this metric.

<u>Key:</u>

Green – action on target
Amber – action in development
Red – action behind target

- Action delivered / delivery expected

Meeting	*Lincolnshire Community and Hospitals Group Board Meeting*
Date of Meeting	*3rd September 2024*
Item Number	*9.1*

Workforce Race Equality Standard (WRES) Annual Report, 2023-2024

Accountable Director	*Claire Low, Chief People Officer*
Presented by	*Claire Low, Chief People Officer*
Author(s)	*Claire Low, Chief People Officer*
Report previously considered at	*People and Organisational Development Committee* *13th August 2024*

How the report supports the delivery of the priorities within the LCHG 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	
1d Deliver clinically led integrated services	
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	
3b Drive better decision and impactful action through insight	
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	
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)	
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	

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	

Risk Assessment	*This report demonstrates the Trust's compliance with contractual duties and thereby evidences the mitigation and removal of associated risk.*
Financial Impact Assessment	*No financial impact*
Quality Impact Assessment	*N/A*
Equality Impact Assessment	*This report demonstrates and evidences how the Trust is meeting its statutory and contractual duties in relation to the Equality Act 2010, the Public Sector Equality Duty 2011 and the NHS Standard Contract.*
Assurance Level Assessment	• *Moderate*

Recommendations/ Decision Required	• *The 2023/24 WRES Annual Report is recommended to the Board for approval*

Executive Summary
Publication of the WRES Report and Action Plan on the Trust website is a requirement of the national contractual duty. Due to the detailed action plans not being compliant with internet accessibility tools, once the action plan is agreed in principle, a high-level overview of the action plan will be placed in the public domain.

Workforce Race Equality Standard (WRES) Report 2023-2024

Author: Tim Couchman, Head of Equality, Diversity and Inclusion

June 2024

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Introduction:

"Implementing the Workforce Race Equality Standard (WRES) is a requirement for NHS commissioners and NHS healthcare providers including independent organisations, through the NHS standard contract.

The NHS Equality and Diversity Council announced on 31 July 2014 that it had agreed action to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

This is important because studies shows that a motivated, included and valued workforce helps deliver high quality patient care, increased patient satisfaction and better patient safety.

In April 2015, after engaging and consulting with key stakeholders including other NHS organisations across England, the WRES was mandated through the NHS standard contract, starting in 2015/16." NHS England WRES website.

The WRES is the first NHS England equality standard and was followed in 2019 by the WDES. Both NHS England equality standards draw on workforce data, NHS Staff Survey data and leadership data. Further information about the WRES can be located on the NHS England WRES website: NHS England » NHS Workforce Race Equality Standard

NHS England commenced work and trialling of the Medical WRES and WRES for Bank staff in 2023-2024. In May 2024 the NHS England Mandated Standards Team informed NHS Trust's that no reporting for either the Medical WRES or WRES for Bank staff would be required in the current reporting cycle for 2023-2024 data.

Methodology:

The data for the WRES report was collated and prepared in the first quarter of 2024-2025. The workforce data has been verified by the Equality, Diversity and Inclusion (EDI) team. The verified workforce data has been submitted to the NHS England Mandated Standards Team utilising the national data reporting platform ahead of the reporting deadline of the 31 May 2024.

The NHS Staff Survey data is taken straight from the national staff survey database. NHS Staff Survey data is in the public domain and can be accessed on the NHS Staff Survey website: Local results for every organisation | NHS Staff Survey (nhsstaffsurveys.com).

Over the summer 2024, the data is being shared with the Trust's REACH (Race, Ethnicity and Cultural Heritage) staff network, the Equality, Diversity and Inclusion Group and other professional leads for consideration and active engagement in relation to the actions for improvement required. The resulting action plan will be produced in partnership with our staff networks and published by 30 September 2024, as required by NHS England. For the first time the Lincolnshire Community and Hospitals NHS Group EDI Teams will be working on joint action plans across the group model.

This current report provides an overview of the data by metric and compares the data to the previous years' reports, as appropriate. Unfortunately, the Trust failed to submit the first WRES data report appropriately in 2015 and was recorded as non-reporter, as the data quality was poor and incorrect and the person who compiled the data had left the Trust. However, since 2016 the Trust has completed and submitted the WRES data appropriately.

Since starting the WRES in 2016, the Trust has been tracking the trends over time for each of the WRES metrics. For the first time in this report, the data trends are reviewed and analysed. Infographics relating to the data trends for each of the metrics are provided in Appendix 1.

WRES Indicator 1:

WRES Indicator 1 reviews the workforce and compares the data relating to white staff and black, Asian and minority ethnic staff. The indicator further disaggregates the data and compares clinical staff, non-clinical staff and medical staff. The full and detailed data report for this indicator is available upon appropriate formal request.

In general terms the percentage of black, Asian and minority ethnic staff employed by the Trust has increased in 2023-2024 to a total of 24.6%. This is an increase of 4% compared to the 2022-2023 data. This also continues the

trend of an increasing black, Asian and Minority ethnic workforce in the Trust in recent years.

The data continues to confirm that the majority of our black, Asian and minority ethnic colleagues work in clinical and medical roles. In clinical roles the biggest challenge the Trust needs to address is in relation to the high number of black, Asian and minority ethnic staff in Agenda for Change pay band 5 and the disproportionately lower numbers in higher pay bandings. There exist similar challenges the Trust needs to address in relation to the medical workforce. Actions to address these issues need to be reviewed and implemented.

In reviewing and analysing the higher-level trend data for this indicator from 2016 to the current reporting cycle, the most noteworthy point is the steady increase in the percentage of the black, Asian and minority ethnic staff in the workforce. In 2016 black, Asian and minority ethnic staff comprised a total of 10.9% or the workforce, over the years this has increased to a total of 24.6% in the current reporting cycle. Please refer to the infographic in appendix 1 for this WRES indicator.

The Trust, like most NHS organisations, has for many decades proudly developed and grown a diverse workforce across all protected characteristic groups. In relation to race this has predominantly, but not exclusively, been in the clinical workforce and in recent years there has been a particular focus on growing the internationally educated nursing workforce. The focus in developing and growing the internationally educated nursing workforce can be seen by the steeper increase in staff from 2021 onwards. In reviewing and developing appropriate actions the Trust will be mindful of some of the disparities identified above and seek to redress the imbalances identified in our more detailed data.

WRES Indicator 2:

WRES Indicator 2 reviews Trust recruitment data and compares the data relating to white staff and black, Asian and minority ethnic staff. This indicator compares specifically the data and the relative likelihood of staff being appointed from shortlisting across all posts.

The Trust data for this indicator for 2023-2024 confirmed that to a likelihood of 1.64 white staff are more likely to be appointed from shortlisting across all posts. This is a slight deterioration of 0.04 when compared with the 2022-2023 data. Further, following improvement in years prior to 2022-2023 this deterioration needs to be reviewed and robust actions put in place as a matter of urgency.

In reviewing and analysing the higher-level trend data for this indicator from 2016 to the current reporting cycle, it is noted that although the data in the first few years of the WRES continued to deteriorate, from 2019 to 2021 the Trust saw an improvement in the data and indeed, in one year, 2021, black, Asian and minority ethnic people were slightly more likely than white people to be appointed from shortlisting. Sadly thereafter the data started to deteriorate and the Trust now has data almost matching the worst data return recorded in 2018. Please refer to the infographic in appendix 1 for this WRES indicator.

The Trust must urgently review the detailed action plans from last year to overhaul the recruitment processes and align to the NHS EDI Improvement Plan, High Impact Action to overhaul recruitment processes. Revised and new actions, revised and developed in partnership with the REACH network, must be implemented as a matter of urgency.

WRES Indicator 3:

WRES Indicator 3 reviews the Trust Human Resources data and compares the data relating to white staff and black, Asian and minority ethnic staff. This indicator specifically reviews the relative likelihood of staff entering the formal disciplinary procedure, as measured by entry into the formal investigation process.

The Trust data for this indicator for 2023-2024 confirmed that the likelihood is 1.0. This means there is parity in the numbers of white and black, Asian and Minority Ethnic staff entering the formal disciplinary procedure. In 2022-2023 the likelihood was 0.82, which meant that white staff were more likely to enter the formal disciplinary procedure. With the embedding of Just Culture in the organisation it is envisaged that the new Just Culture approach will have a direct impact on the numbers of formal disciplinary cases in the Trust.

In reviewing and analysing the higher-level trend data for this indicator from 2016 to the current reporting cycle, the most noteworthy point is the steady decline in the relative likelihood of the black, Asian and minority ethnic staff entering the formal disciplinary process. Although there were increases in 2020 and 2021, thereafter the continue decrease toward parity continued. It is imperative that the Trust continues to implement improvements in this area and particularly in relation to the Just Culture approach. Please refer to the infographic in appendix 1 for this WRES indicator.

WRES Indicator 4:

WRES Indicator 4 reviews Trust training data and compares the data relating to white staff and black, Asian and minority ethnic staff. This indicator compares specifically the data and the relative likelihood of staff accessing non-mandatory training and continued professional development (CPD).

The Trust data for this indicator for 2023-2024 confirmed to a likelihood of 0.74 black, Asian and minority ethnic staff are more likely to access non-mandatory training and CPD. This means that white staff are less likely to access non-mandatory training and CPD and the Trust needs to focus ensuring parity, which would be a relative likelihood score of 1.0. One of the challenges, however, in relation to this indicator and linked to indicator 1, is why this increase in black, Asian and minority ethnic accessing non-mandatory training and CPD, is currently not translating to an increase of these staff in more senior positions. Trust actions are being reviewed and implemented to address this matter.

In reviewing and analysing the higher-level trend data for this indicator from 2016 to the current reporting cycle, the most noteworthy point is the steady journey to parity in the relative likelihood of the black, Asian and minority ethnic staff accessing non-mandatory training and CPD, and then how since 2022 the likelihood of black, Asian and minority ethnic staff accessing non-mandatory training and CPD has increased significantly. In one sense, when one compares this to the increase in internationally educated staff, particularly nurses, since 2022 (see indicator 1 above), the resulting increase in uptake in non-mandatory training and CPD is understandable. The Trust needs to now

explore the disproportionate underrepresentation of black, Asian and minority ethnic staff, particularly in higher Agenda for Change pay bandings and develop actions, in partnership with the REACH network, to redress these imbalances. Please refer to appendix 1 below for the data trend infographic related to this indicator.

WRES Indicator 5:

WRES Indicator 5 is taken from the NHS Staff Survey 2023 and compares the data relating to white staff and black, Asian and minority ethnic staff. This indicator compares specifically the data and percentages of staff reporting they have experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months.

The percentages of white and black, Asian and minority ethnic staff reporting they have experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months has reduced slightly for both groups. For white staff this has reduced from 25.64% in 2022 to 24.25% in 2023. For black, Asian and minority ethic staff the figure has reduced from 27.42% in 2022 to 25.23% in 2023. Whilst this continued reduction is welcome and our data is now below the national average for comparable Trusts, we still have more work to do and to further embed the United Against all Forms of Discrimination campaign.

In reviewing and analysing the data trends for this indicator from 2016 to the current reporting cycle, it is noted that the first figure in 2016 for black, Asian and minority ethnic staff is quite an outlier when compared with the rest of the data. This is probably due to the fact that 2016 was the last year in which the Trust only invited a 20% sample of the workforce to complete the NHS Staff Survey. From 2017 onwards the entire workforce was invited to undertake the NHS Staff Survey. This in turn is likely to explain the increases noted for all staff, before the start of a gradual reduction in all staff reporting harassment, bullying or abuse from patients, relative of the public in the last 12 months. It is noted that in 2023 there was a slight spike in the numbers of black, Asian and minority ethnic staff reporting this, but thankfully in the current reporting cycle this has reduced. However, with some 25% of all staff reporting harassment, bullying or abuse from patients, relatives or the public in the 12 months, the

work of the United Against All Forms of Discrimination campaign must continue. Please refer to appendix 1 for the data trend infographic related to this indicator.

WRES Indicator 6:

WRES Indicator 6 is taken from the NHS Staff Survey 2023 and compares the data relating to white staff and black, Asian and minority ethnic staff. This indicator compares specifically the data and percentages of staff reporting they have experienced harassment, bullying or abuse from staff in the last 12 months.

The percentages of white and black, Asian and minority ethnic staff reporting they have experienced harassment, bullying or abuse from staff in the last 12 months has increased slightly for white staff, but reduced by 5% for black, Asian and minority ethnic staff. For white staff this has increased from 26.85% in 2022 to 26.88% in 2023. For black, Asian and minority ethic staff the figure has reduced from 31.76% in 2022 to 26.74% in 2023. Whilst we particularly welcome the 5% reduction for black, Asian and minority ethnic staff, and our data still remains above the national average for comparable Trusts. We still have more work to do and to further embed the United Against all Forms of Discrimination campaign.

In reviewing and analysing the data trends for this indicator from 2016 to the current reporting cycle, as noted above in indicator 5, the first data return for black, Asian and minority ethnic staff in 2016 is likely to be linked with the smaller sample of 20% of the workforce being invited to undertake the NHS Staff Survey in that year. With the full workforce being invited to take the survey from 2017 onwards the data quality improves. Similar to indicator 5, after an initial increase in the numbers of all staff reporting harassment, bullying and abuse from staff in the last 12 months, from 2019/2020 a general decrease commences. However, it remains of significant concern that >25% of all staff continue to report harassment, bullying or abuse from staff members. This emphasizes the importance of the United Against All Forms of Discrimination campaign, alongside divisions and directorates understanding hotspots in their areas and developing and implementing actions to address

inappropriate harassment, bullying or abuse amongst colleagues. Please refer to the infographic relating to this indicator in appendix 1.

WRES Indicator 7:

WRES Indicator 7 is taken from the NHS Staff Survey 2023 and compares the data relating to white staff and black, Asian and minority ethnic staff. This indicator compares specifically the data and percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.

Please note that with the implementation of the NHS People Promise from 2022 the algorithm associated with the original NHS Staff Survey question changed. It is for this reason that the data trend can only cover the years 2022-2024.

The percentage of black, Asian and minority ethnic staff reporting they believe the organisation provides equal opportunities for career progression or promotion has increased by 4% from 47.42% in 2022 to 51.62% in 2023. However, for white staff the percentage has decreased slightly from 56.51% in 2022 to 56.40% in 2023. The percentage score for black, Asian and minority ethnic staff is above the national average, whereas the score for white staff is below the national average for comparable Trusts.

In reviewing and analysing the data trends for this indicator from 2022-2024 it is encouraging to see a steady improvement in staff reporting for this indicator. However, it is noted that an approximate disparity of 5% exists between the experience of black, Asian and minority ethnic staff and white staff. The Trust action plan is being reviewed and further actions, agreed with our networks, will be implemented. Please refer to the data trend infographic for this indicator in appendix 1.

WRES Indicator 8:

WRES Indicator 8 is taken from the NHS Staff Survey 2023 and compares the data relating to white staff and black, Asian and minority ethnic staff. This

indicator compares specifically the data and percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in the last 12 months.

The percentage of black, Asian and minority ethnic staff reporting they have experienced discrimination at work from a manager / team leader or other colleague in the last 12 months has decreased from 18.64% in 2022 to 17.21% in 2023. However, for white staff the percentage has increased from 7.37% in 2022 to 8.34% in 2023. Both scores are above the national averages for comparable Trusts. We still have more work to do and to further embed the United Against all Forms of Discrimination campaign.

In reviewing and analysing the data trends for this indicator from 2016 to the current reporting cycle, it noteworthy that after relatively low percentage scores in 2016, the data for both black, Asian and minority ethnic staff and white staff deteriorated. This might in part be due to the Trust moving from a 20% sample NHS Staff Survey to a full staff survey from 2017, but also that the WRES started to focus peoples' minds on discrimination. Whilst in the current reporting cycle it is encouraging that black, Asian and minority ethnic staff are reporting a reduction in discrimination, there has been an increase reported by white staff. However, one of the primary areas of concern since the inception of the WRES is significant disparity in experience (currently at around 9% in 2024). This needs to be addressed in the review and updating of the WRES action plans in collaboration with the REACH network. Please refer to the appendix 1 for the infographic associated with this indicator.

WRES Indicator 9:

WRES Indicator 9 reviews the organisation's leadership in relation to the establishment of the Trust Board.

In the 2022-2023 WRES data return all members of the Trust Board identified as white or their ethnicity was unknown. In the 2023-2024 WRES data return of the 15 Trust Board members 10 identified as white, 1 as black, Asian or minority ethnic heritage and 4 were ethnicity unknown. Compared to the overall workforce data (WRES Indicator 1) there is an underrepresentation of black, Asian and minority ethnic leaders at Trust Board level.

Please refer to the infographic in appendix 1 for the data trends for this indicator from 2016 – 2024.

Conclusion:

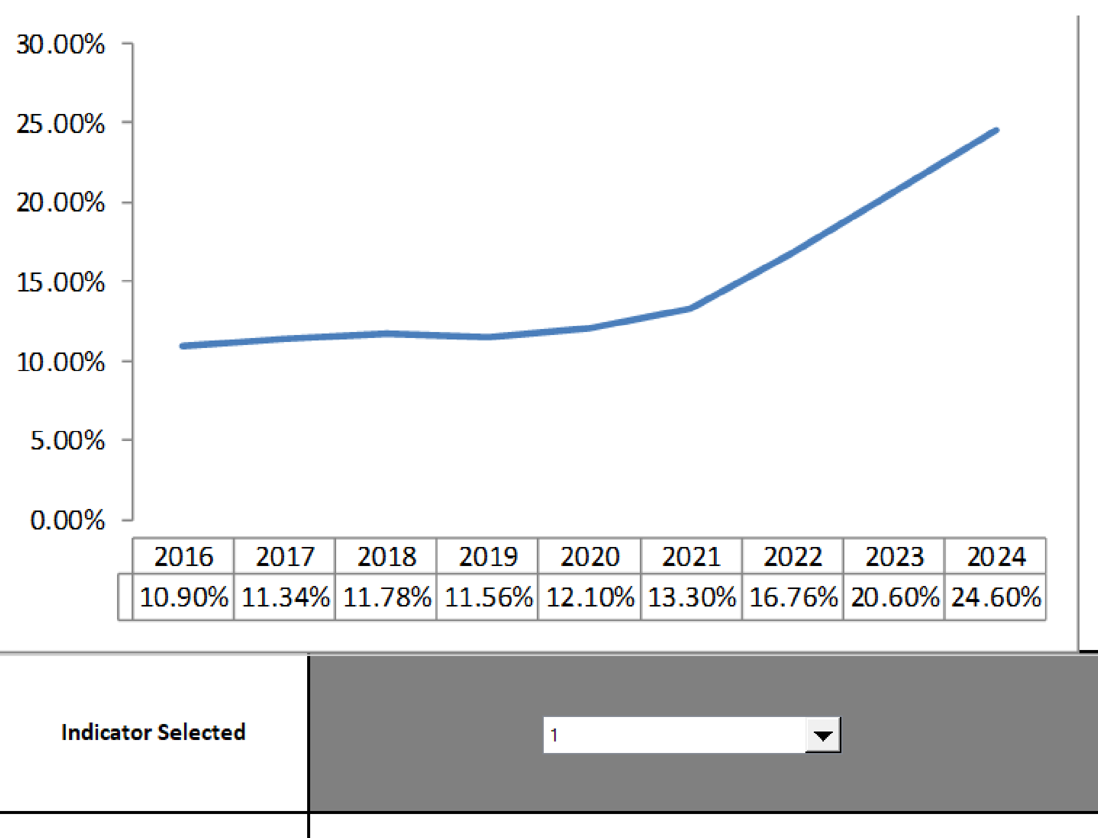
In this report, for the first time, we have included a data trend analysis of the WRES from 2016 through to the current reporting cycle. Whilst for most of the WRES indicators there is, over time, an encouraging improvement, this is not true for all indicators and indeed, there remains room for continued improvement across all indicators, as we continue to strive for equity in experience for all our staff.

Over the summer of 2024 engagement with our REACH network and other key stakeholders will take place as we agree and craft our actions for improvement. It is proposed, that in line with national best practice, we move from an annual action plan to a more agile three-year plan, which can then be updated when required to reflect latest data driven intelligence. Further for the first time, we will be recommending actions for improvement across the Lincolnshire Community and Hospitals NHS Group.

Once completed, the WRES action plans will be shared with the People and Organisational Development Committee and the Trust Board for approval, before publishing on the Trust's website by 30 September 2024, as required by NHS England.

Appendix 1:

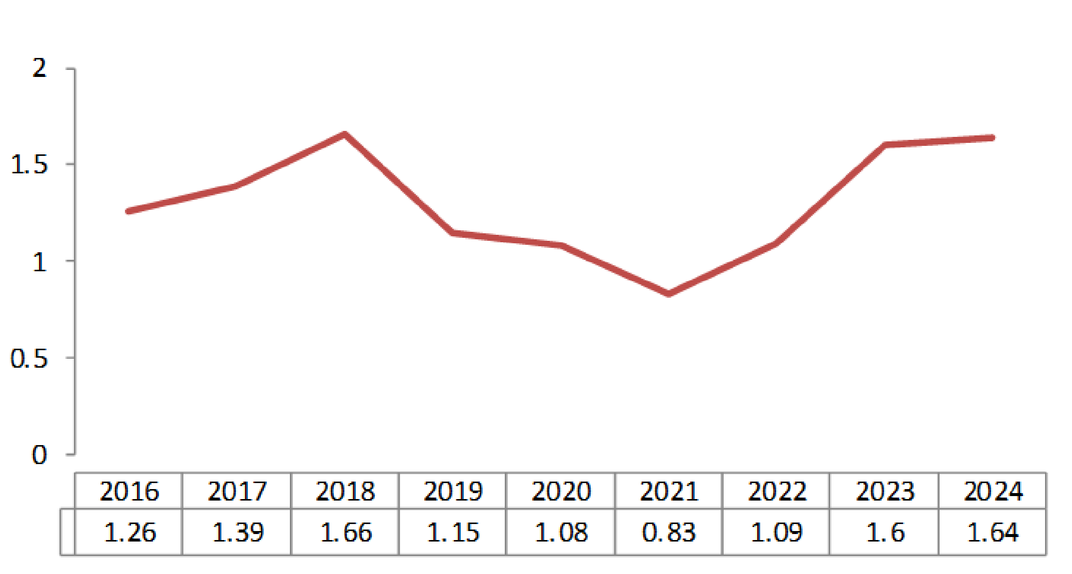
WRES Indicator 1:



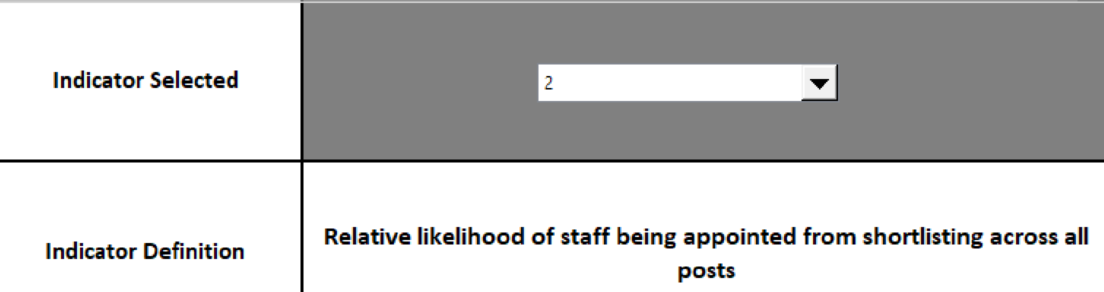
2016	2017	2018	2019	2020	2021	2022	2023	2024
10.90%	11.34%	11.78%	11.56%	12.10%	13.30%	16.76%	20.60%	24.60%

Indicator Definition	**Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce.**

WRES Indicator 2:

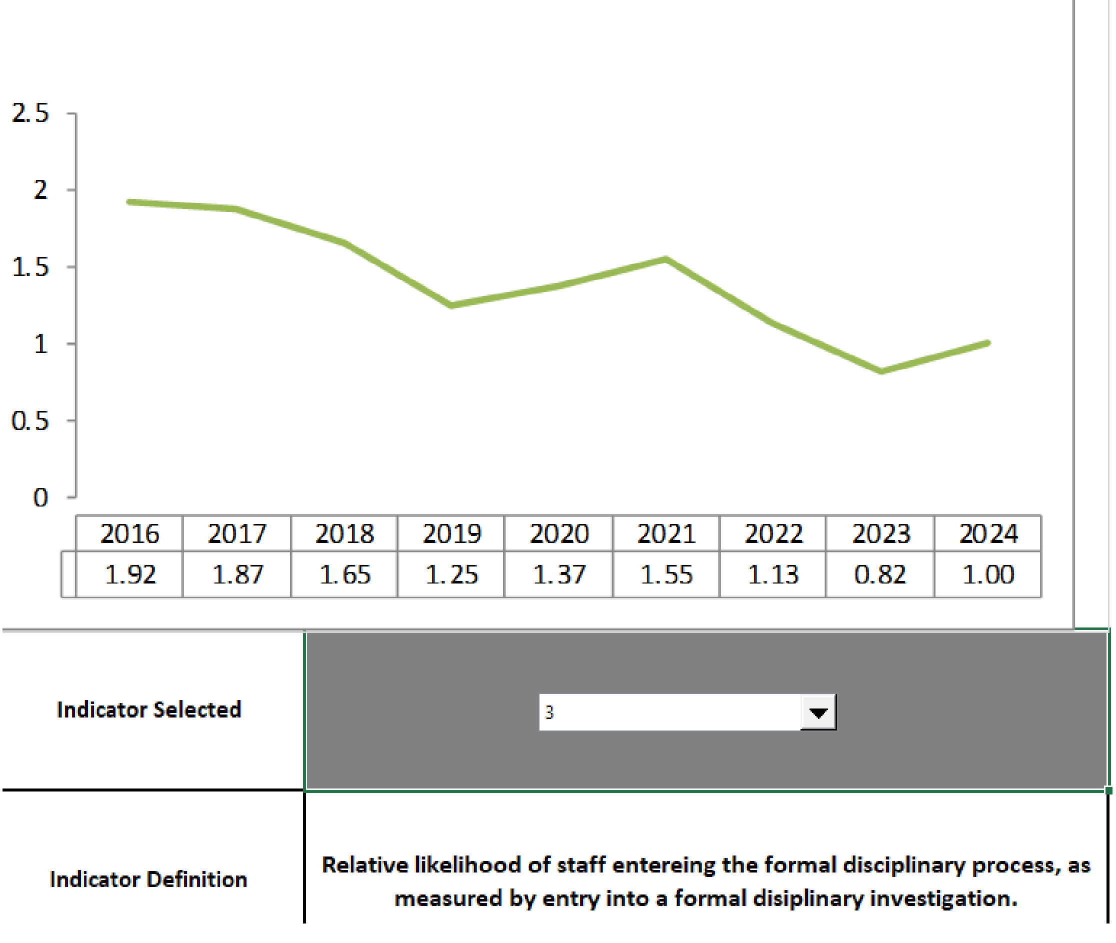


2016	2017	2018	2019	2020	2021	2022	2023	2024
1.26	1.39	1.66	1.15	1.08	0.83	1.09	1.6	1.64

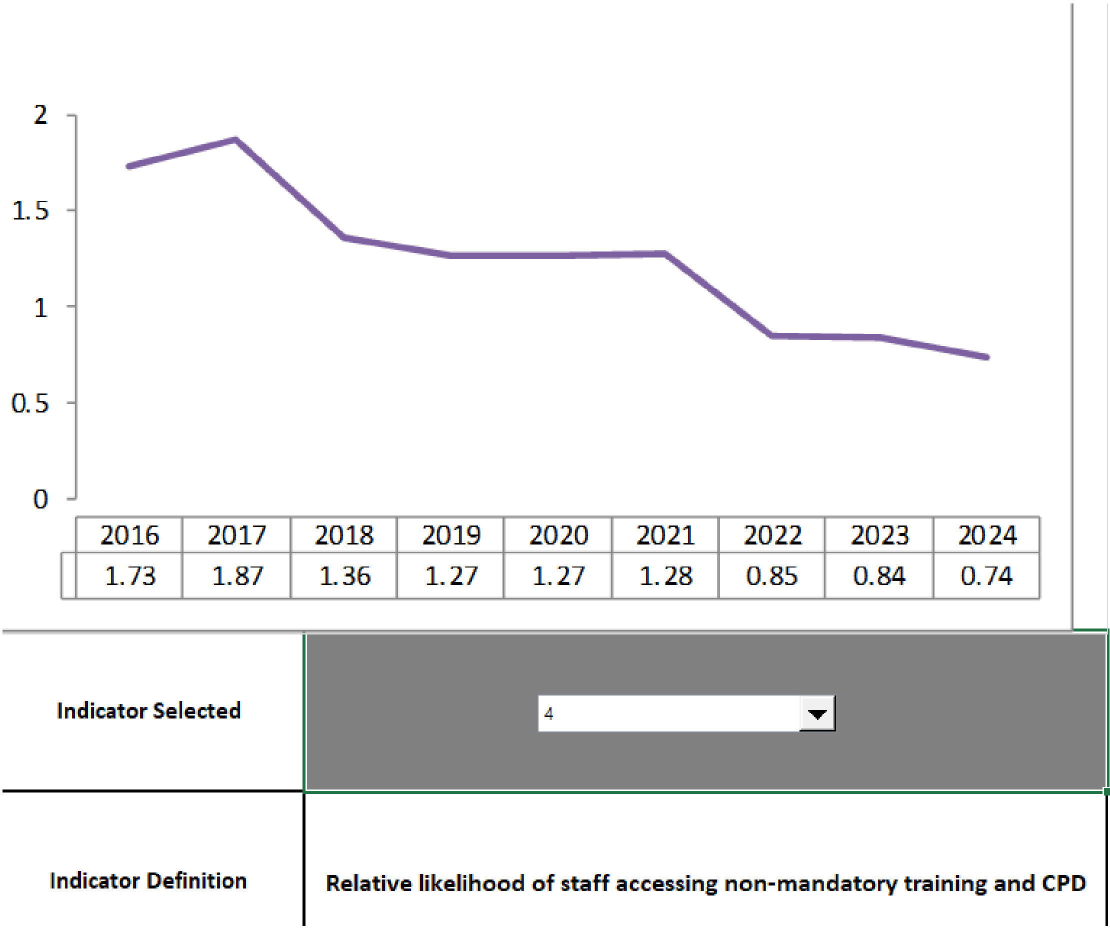


Indicator Selected	2
Indicator Definition	**Relative likelihood of staff being appointed from shortlisting across all posts**

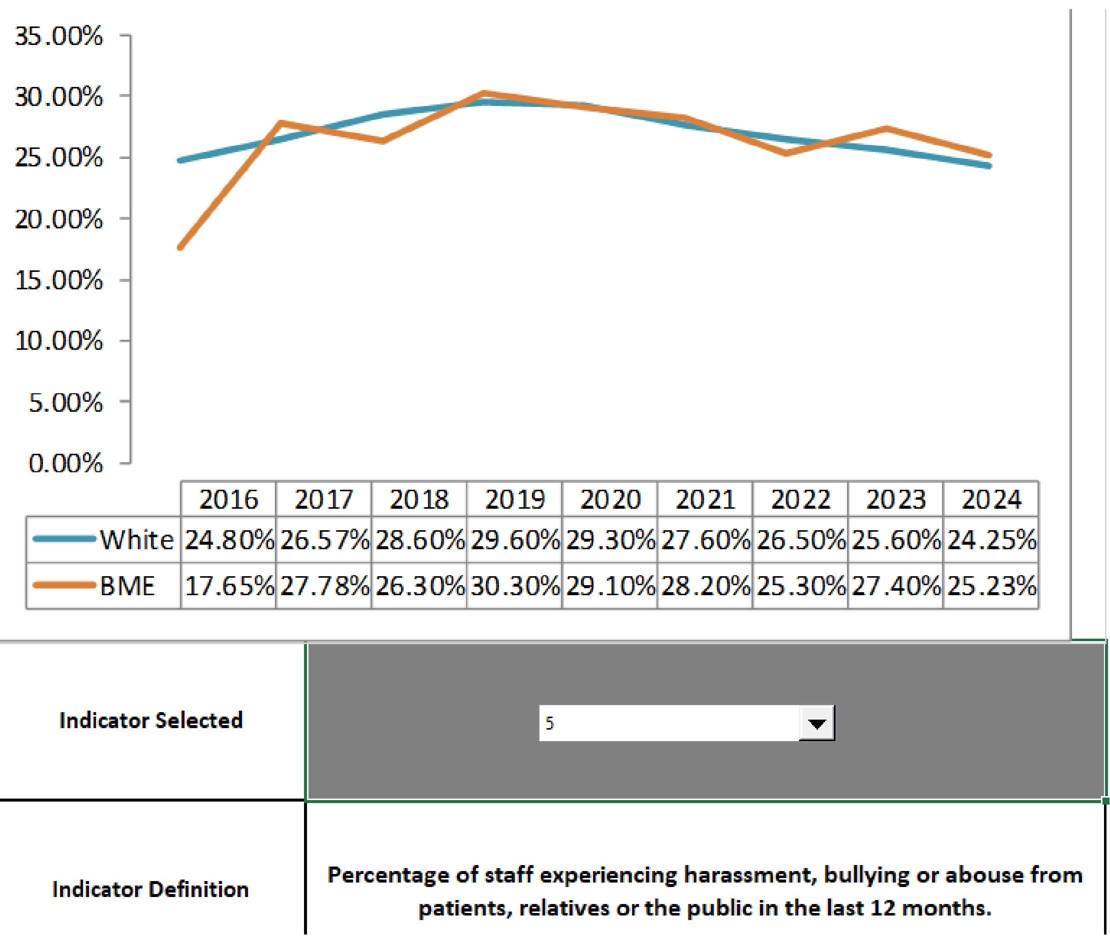
WRES Indicator 3:



WRES Indicator 4:



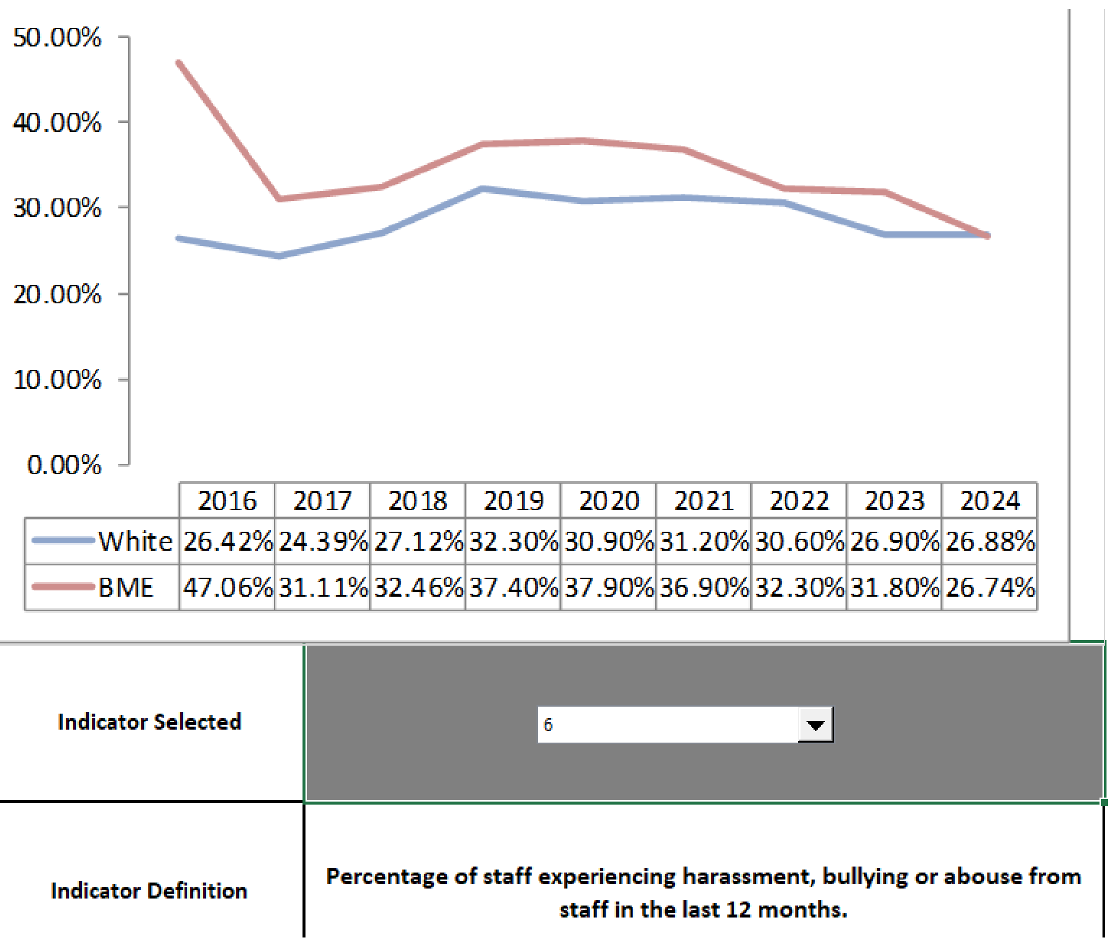
WRES Indicator 5:



	2016	2017	2018	2019	2020	2021	2022	2023	2024
White	24.80%	26.57%	28.60%	29.60%	29.30%	27.60%	26.50%	25.60%	24.25%
BME	17.65%	27.78%	26.30%	30.30%	29.10%	28.20%	25.30%	27.40%	25.23%

Indicator Selected	5
Indicator Definition	**Percentage of staff experiencing harassment, bullying or abouse from patients, relatives or the public in the last 12 months.**

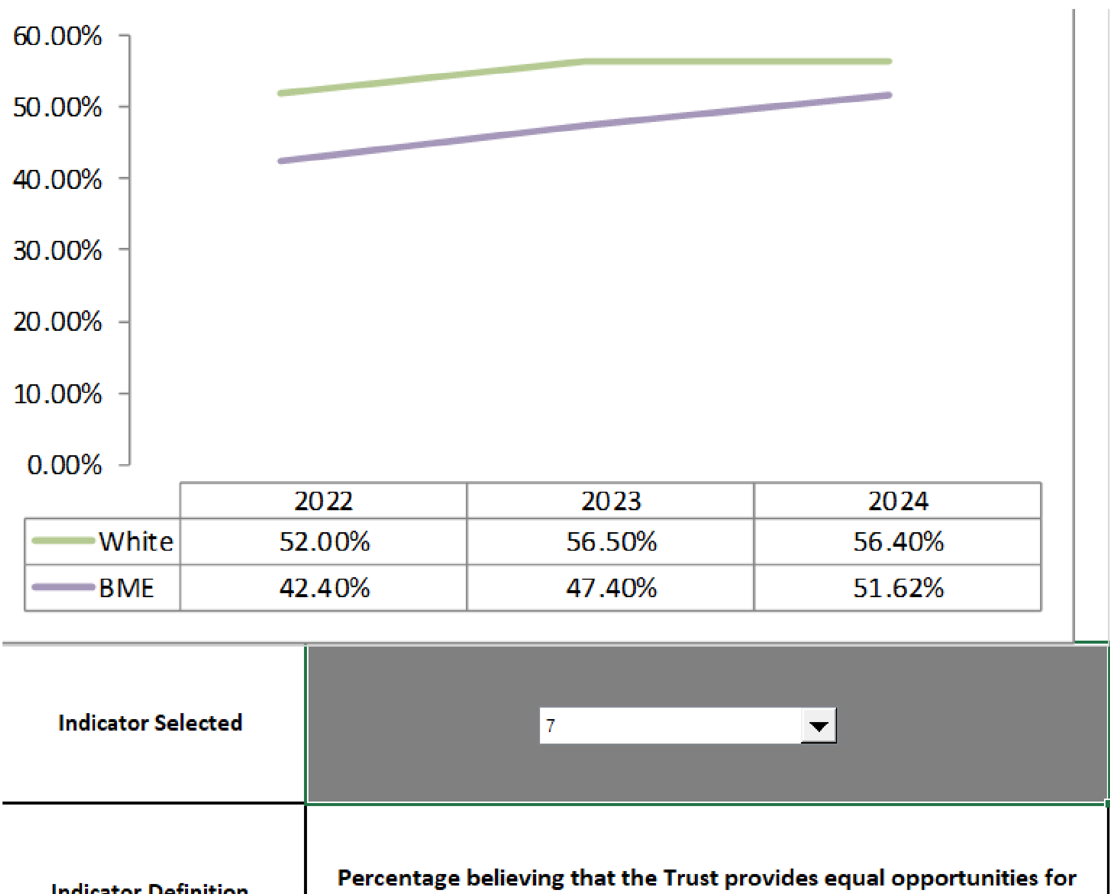
WRES Indicator 6:



	2016	2017	2018	2019	2020	2021	2022	2023	2024
White	26.42%	24.39%	27.12%	32.30%	30.90%	31.20%	30.60%	26.90%	26.88%
BME	47.06%	31.11%	32.46%	37.40%	37.90%	36.90%	32.30%	31.80%	26.74%

Indicator Selected	6
Indicator Definition	**Percentage of staff experiencing harassment, bullying or abouse from staff in the last 12 months.**

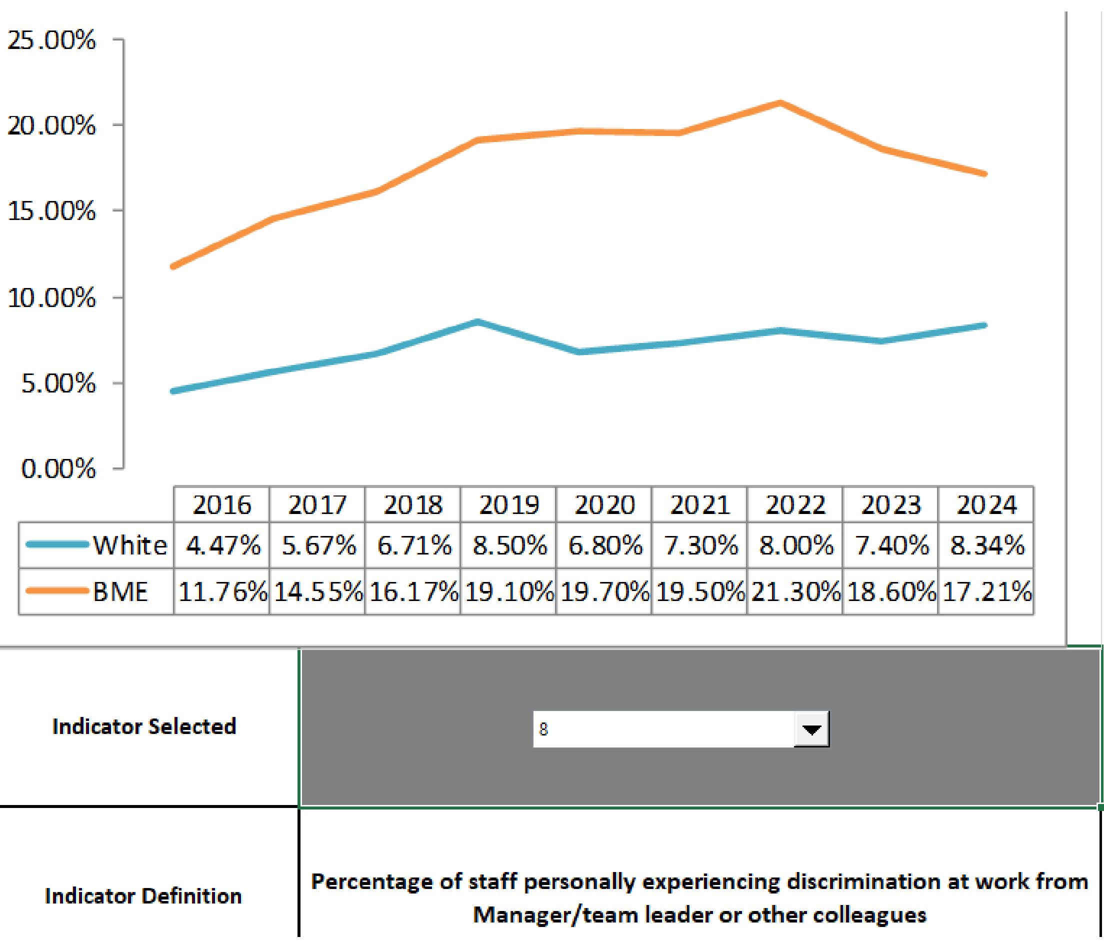
WRES Indicator 7:



	2022	2023	2024
White	52.00%	56.50%	56.40%
BME	42.40%	47.40%	51.62%

Indicator Selected	7
Indicator Definition	**Percentage believing that the Trust provides equal opportunities for career progression or promotion**

WRES Indicator 8:

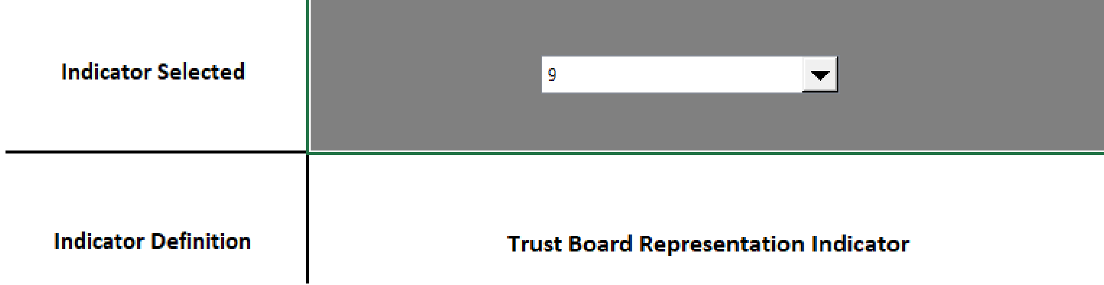


	2016	2017	2018	2019	2020	2021	2022	2023	2024
White	4.47%	5.67%	6.71%	8.50%	6.80%	7.30%	8.00%	7.40%	8.34%
BME	11.76%	14.55%	16.17%	19.10%	19.70%	19.50%	21.30%	18.60%	17.21%

Indicator Selected	8
Indicator Definition	**Percentage of staff personally experiencing discrimination at work from Manager/team leader or other colleagues**

WRES Indicator 9:

2016	2017	2018	2019	2020	2021	2022	2023	2024
All Board members identify as white	All Board members identify as white	One Board member identified as BME	All Board members identify as white	All Board members identify as white	All Board members identify as white	All Board members identify as white	All Board members identify as white	One Board member identified as BME



Indicator Selected	9
Indicator Definition	Trust Board Representation Indicator

WRES Action Plan 2024 - 2027

Indicator	Task	Actions	Responsible Officer/s		Milestones					Outcome / evidence
				Q1	Q2	Q3	Q4	2025/26	2026/27	
Indicator 1: Percentage of staff in each of the AfC Bands 1-9 or medical and dental subgroups and VSM (including executive board members) compared with the percentage of staff in the overall workforce.	Establish Reciprocal Mentoring Programme with new Group Trust Board and Group Staff Networks. High Impact Action 1	Align the Lincolnshire Reciprocal Mentoring model to LCHG	Tim Couchman / Rachel Higgins			★				
		Recruit first cohort of Reciprocal Mentors	Tim Couchman / Rachel Higgins			★				
		Deliver first cohort of Reciprocal Mentoring at LCHG	Tim Couchman / Rachel Higgins				★			
		Evaluate first cohort of Reciprocal Mentoring at LCHG	Tim Couchman / Rachel Higgins					★		Evidence: Reciprocal Mentoring programme evaluation.
		Deliver second cohort of Reciprocal Mentoring	Tim Couchman / Rachel Higgins					★		
		Reciprocal Mentoring Programme as Business as Usual at LCHG	Tim Couchman / Rachel Higgins						★	
	Establish meaningful early career conversations with internationally-educated colleagues in Agenda for Change Clinical roles, recognising where they have substantial previous experience, to ensure targeted career support. High Impact Actions 2 & 5	Engage with Organisational Development and International Onboarding Team to establish mechanisms required to progress this action.	EDI Team With support from the OD & International Onboarding Teams				★			Evidence: Improvement in National Staff Survey scores for question relating to equal opportunities for career progression or promotion (cf. Indicator 7)
		Effective engagement mechanisms established and Business and Usual	EDI Team With support from the OD & International Onboarding Teams						★	
	To incorporate good practice examples from Northants “Levelling-Up” programme for Internationally Educated	Engage with Organisational Development and International Onboarding Team to establish mechanisms required to progress this action.	EDI Team With support from the OD & International					★		

	Nurses, and the Great Western Hospitals "Stay & Thrive" initiative and other emerging best practice initiatives. High Impact Actions 2 & 5		Onboarding Teams							Evidence: tbc
		Effective practice mechanisms established and Business and Usual	EDI Team With support from the OD & International Onboarding Teams							
	Establish and enact a talent management plan for Trust Board and Senior Leadership Teams, which includes improvements in the diversity of these teams. High Impact Actions 1 & 2	Engage with the new LCHG Trust Board and Senior Leadership Teams to establish mechanisms required to progress this action.	EDI Team With support from the Trust Board and Senior Leadership Teams							Evidence: demonstrable improvement in race and disability representation in senior leadership roles (Band 8 and above), as measured in Indicator 1
		Effective mechanisms established and Business and Usual	EDI Team With support from the Trust Board and Senior Leadership Teams							Evidence: closure of gaps in WRES indicators 1 and 9
	Implement a plan to widen recruitment opportunities within local communities, aligned to the NHS Long Term Workforce Plan and Lincolnshire Integrated Care Board (ICB)	Engage with the Lincs ICB partners to establish mechanisms required to progress this action.	Recruitment Team and Lincs ICB partners							Evidence tbc

	High Impact Action 2	Effective mechanisms established and Business and Usual	Recruitment Team and Lincs ICB partners							
Indicator 2: Relative likelihood of staff being appointed from shortlisting across all posts.	Implement the Lincs ICB Inclusive Recruitment Toolkit. High Impact Action 2	Develop a plan to implement the ICB Inclusive Recruitment Toolkit across the LCHG	EDI Team							
		Effective implementation enacted and Business and Usual	EDI Team							Evidence: demonstrable improvement in Indicator 2 data
	The Trust will undertake a deep and broad Inclusive Recruitment review, including feedback from staff networks. High Impact Action 2	Develop a plan to review recruitment processes and data from an inclusion perspective. (use of the CQ-Leading Inclusively model and “No More Tick Boxes” guidance. NHSE Recruitment Research Doc (cf 2023 action plan) The aim is to ensure that the process and training is even more inclusive from end-to-end, at all touchpoints & stages, from the perspective of candidates as well as recruiting managers and the recruitment team.)	EDI and Recruitment Teams							
		Undertake a review of the recruitment processes and data from an inclusion perspective.	EDI and Recruitment Teams							

		Engagement with Staff Networks to inform recommendations to improve inclusive recruitment.	EDI Team and Staff Networks					★		Evidence tbc
		New inclusive recruitment strategies / approach enacted	EDI and Recruitment Teams						★	Outcome: Improved data for this indicator
Indicator 3: Relative likelihood of staff entering the formal disciplinary procedure, as measured by entry into formal investigation.	Implement the new Just Culture at the Trust. High Impact Action 6	Just Culture implemented in the Trust.	Director of People & OD	★						[Just Culture (sharepoint.com)]
		Just Culture implementation reviewed and analysed	Just Culture Programme Manager				★			
		Just Culture impact on formal disciplinary cases reviewed and analysed.	Just Culture Programme Manager and Senior HR Manager				★			
		Just Culture embedded as BAU	Director of People & OD					★		Outcomes: Through the Just Culture approach numbers of formal disciplinary cases reduced and measured through the annual WRES data return. Reduction over time in Employment Tribunals citing race discrimination.
	Deliver Leading Inclusively with Cultural Intelligence (CQ) Programme to LCHG leaders. High Impact Action 6	CQ established as effective inclusion leadership programme in the Trust	Head of EDI	★						Evidence: March 2024 >450 leaders completed the CQ programme.
		Established a recurrent budget for delivery of CQ programme to set cohorts of leaders on an annual basis	EDI Team				★			
		CQ recorded via ESR and part of the established leadership offer at LCHG	EDI and OD Teams							
Indicator 4: Relative likelihood of accessing non-mandatory training & CPD	To better understand the data for this indicator which informs that staff	Review and analyse data regarding non-mandatory training / CPD, by role and declared racial heritage.	EDI and OD Teams			★				

	from black, Asian and minority ethnic heritages are accessing non-mandatory training and CPD to greater levels than white heritage staff and the disparity with Indicator 1 that black, Asian and minority ethnic staff are more represented in junior A4C and medical grades. High Impact Actions 2 & 5	Engage with staff through the REACH staff network to analyse data and develop strategies to address issues identified.	EDI Team / REACH network							
		Embed new strategies to enable career development for staff.	EDI Team and OD Team							Evidence: Reduction of race disparity in senior positions (Band 8 and above, as measured in indicator 1)
Indicator 5: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	Relaunch and expand the implementation of United against all forms of Discrimination programme. Trust to become and anti-racist organisation. High Impact Action 6	Relaunch the poster campaign with new QR code reporting system, including anonymous option.	EDI Team							
		Evaluate the use and feedback from the QR code reporting system and consider whether sufficient usage to enable anonymised upward reporting.	EDI Team and Staff Network Council							Outcome measures: improved NHS Staff Survey data.
	Deliver a workshop for "calling out and calling in". Topics to include: racism, LGBTQ+ hate, misogyny, ageism High Impact Action 6	Co-design a "Calling out and Calling in" workshop and run pilot.	EDI, OD Teams and Staff Networks							
		Evaluate "Calling out and Calling in" workshop and scope next steps.	EDI, OD Teams and Staff Networks							Evidence: tbc
	Design a programme of training / support for those who are receiving and line-managing international recruits into their teams. High Impact Actions 5 & 6	Design and pilot a training / support programme	EDI & OD Teams and Onboarding Team							
		Evaluate pilot programme and scope for future delivery.	EDI & OD Teams and Onboarding Team							Evidence: Improvement in NSS Staff Survey data for this indicator

Indicator 6: Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	Relaunch and expand the implementation of United against all forms of Discrimination programme. High Impact Action 6	Relaunch the poster campaign with new QR code reporting system, including anonymous option.	EDI Team			★				
		Evaluate the use and feedback from the QR code reporting system and consider whether sufficient usage to enable anonymised upward reporting.	EDI Team and Staff Network Council					★		Evidence: Improvement in NSS Staff Survey data for this indicator
	Implement the award winning Lincs ICB Allyship toolkit	Develop a plan to implement the ICB Allyship Toolkit across the LCHG	EDI Team				★			
		Effective implementation enacted and Business and Usual	EDI Team					★		
	Complete the NHS Culture & Leadership Programme (CLP) with emphasis on respect and civility. High Impact Action 6	CLP Discovery Phase end stage report to People & OD Committee and Trust Board, to include recommendations for the Design Phase	CLP Programme Manager		★					
		Complete CLP Design Phase	CLP Programme Manager and OD Team			★				
		Implement and complete CLP Delivery Phase	CLP Programme Manager and OD Team					★		
		Evaluate CLP and report to LCHG Board	CLP Programme Manager and OD Team					★		
Indicator 7: Percentage believing that trust provides equal opportunities for career progression or promotion.	Reciprocal Mentoring programme & Career Conversations – as per Indicator 1.									
	Inclusive recruitment review – as per Indicator 2.									

	Access to non-mandatory training and CPD – as per Indicator 4.									Evidence: Improvement in NSS Staff Survey data for this indicator.
Indicator 8: Percentage of staff who personally experienced discrimination at work from a manager, team leader or other colleagues.	Please see Actions for indicators 5 and 6 above.									
										Evidence: Improvement in NSS Staff Survey data for this indicator
Indicator 9: Percentage difference between the organisation's Board voting membership and its overall workforce BME representation.	Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable. High Impact Action 1	To be progressed at LCHG Board level, once the full Board is established	EDI Leads and Trust Board							Evidence: Improvement in NSS Staff Survey data for this indicator

Key:

Green – action on target
Amber – action in development
Red – action behind target

- Action delivered / delivery expected

Meeting	*Lincolnshire Community and Hospitals Group Board Meeting*
Date of Meeting	*3rd September 2024*
Item Number	*9.2*

Update re: NHS Sexual Safety Charter and Preparation for the Worker Protection Act (employer's preventative duty re: sexual harassment)

Accountable Director	*Claire Low, Group Chief People Officer Executive Sponsor: Professor Karen Dunderdale, Group Chief Executive Officer*
Presented by	*Claire Low, Group Chief People Officer*
Author(s)	*Alison Marriott, Senior Programme Manager People & OD*
Report previously considered at	*This report reflects the status of the Group's compliance with the NHS Sexual Safety Charter, as agreed at the latest Sexual Safety Working Group held on 6th August 2024.*

How the report supports the delivery of the priorities within the Board Assurance Framework	
1a Deliver high quality care which is safe, responsive and able to meet the needs of the population	
1b Improve patient experience	
1c Improve clinical outcomes	
2a A modern and progressive workforce	*X*
2b Making ULHT the best place to work	*X*
2c Well Led Services	*X*
3a A modern, clean and fit for purpose environment	*X*
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	
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	*Positive impact for all protected characteristics*
Assurance Level Assessment	*Moderate*

Recommendations/ Decision Required	• *To note the progress made so far towards full compliance with the ten NHS Sexual Safety Charter requirements.* • *To champion the remaining steps required to evidence 100% compliance with the NHS Sexual Safety Charter (and hence robust readiness for the Worker Protection Act 2023)* • *To personally as an individual Board Member, and collectively as a whole Board, commit to the Group's Sexual Safety Charter, attached at Appendix 1.*

Executive Summary

The purpose of this paper is:

1) To update the Board on the Group's progress towards full compliance with the NHS Sexual Safety Charter. The NHS Sexual Safety Charter also provides the framework for the Group to be ready for the forthcoming Worker Protection Act 2023, which comes into force on 26th October 2024.
2) To seek personal, individual commitment from all Board Members (whether Executive or Non-Executive) as well as collective Board commitment to the Group's Sexual Safety Charter. This has been co-produced by the Sexual Safety Working Group across LCHG and is now attached to this paper at Appendix 1.

Background Summary

This update was requested by the Group Chair, Elaine Baylis QPM.

The key provisions of the Worker Protection Act 2023, which is an amendment to the Equality Act 2010, are that:

- Employees are better-protected from sexual harassment by prioritising prevention.
- Employers in the UK will have a legal duty to work preventatively, from 26th October 2024, and not just retrospectively – to address sexual harassment in the workplace.
- Employers "*must take reasonable steps to prevent sexual harassment of employees in the course of their employment*."
- This will extend to when employees are working outside of their office (for example, in the community or at work events held at external venues) and when they are attending social events that are considered an extension of work (for example, team celebration events outside of work and the Group Staff Awards)
- Employers who fail to prevent sexual harassment towards an employee, can also face financial repercussions. If a claim of sexual harassment is upheld at Employment Tribunal, an employee may be awarded up to 25% compensation uplift from the employer.

The Key Principles of the NHS Sexual Safety Charter - which responds to the findings of sexual harassment in the NHS and also assists NHS organisations to comply with the Worker Protection Act 2023 - are that:

- Those who work, train and learn within the healthcare system have the right to be safe and feel supported at work.
- Organisations across the healthcare system need to work together and individually to tackle unwanted, inappropriate and/or harmful sexual behaviour in the workplace.
- We all have a responsibility to ourselves and our colleagues and must act if we witness these behaviours.

As signatories to this charter already, since November 2023, we have committed to a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours towards our workforce. We have committed to the following 10 principles and actions contained in the NHS Sexual Safety Charter to achieve this. A summary of progress towards full compliance is contained in the body of this report.

An LCHG Sexual Safety Working Group has been in place during 2024, and members of the Sexual Safety Working Group include: Staffside chairs and representatives; Freedom to Speak Up Guardians; Staff Network Leads representing all Staff Networks; HR colleagues; Health & Wellbeing colleagues; Safeguarding colleagues; EDI colleagues; Postgraduate Medical Education colleagues and Communications colleagues. The Executive Sponsor is Professor Karen Dunderdale.

With the kind input of the working group, a central message has been co-produced. The aim is to engage with the widest possible audience, in the form of an LCHG Sexual Safety Charter. This can be found at Appendix 1. There are two pages – the first is the full charter, and the second is a simplified version of the first page, for widest accessibility. There are existing policies and procedures in place behind the engaging Charter, and the Charter does not replace these or conflict with them, but does compliment them and more fully fulfils the aims of the NHS Sexual Safety Charter and the Worker Protection Act 2023 by clearly setting out in a simple way what protection can be expected and the standards of behaviour required.

The data across the Group shows that whilst the reported prevalence of sexual misconduct towards staff is below the NHS national average (using the 2023 National Staff Survey data as the benchmark), it is more prevalent from patients/relatives/public towards staff, than between staff. The work undertaken by the LCHG Sexual Safety Working Group reflects this need to address all sources of potential sexual harassment, including patient-to-staff harassment, as well as that between colleagues.

Also, it is essential to note that whilst percentage-wise, colleague-to-colleague incidents are below the national NHS average, this still represents a significant number of colleagues and incidents where sexual safety has been compromised, because together we are a large workforce. Therefore it is important that the work of the Group has taken into account both patients and colleagues, and this also aligns with the provisions in the Worker Protection Act 2023 that are expected of us as employers, from 26th October 2024.

Key messages

As signatories to the NHS Sexual Safety charter already, we have committed to a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours towards our workforce. We have committed to the following 10 principles and actions contained in the NHS Sexual Safety Charter to achieve this. A progress update is imbedded below for each Principle:

Principle & RAG status	**NHS Sexual Safety Charter Commitment**	**Progress/Action to date**
1	We will actively work to eradicate sexual harassment and abuse in the workplace.	Working Group meeting monthly, Executive Sponsor in place. Action Plan agreed and in place, evidencing progress.
2	We will promote a culture that fosters openness and transparency, and does not tolerate unwanted, harmful and/or inappropriate sexual behaviours.	Baseline data established from multiple sources across LCHG: National Staff Survey; Datix; FTSUG and Staffside; HR/ER data. Next step: agree regular reporting arrangements including how progress will be measured (please see point 10 for further detail) All-staff facing Charter co-produced and signed-off by working group. Attached to this paper as Appendix 1. ELT and Board commitment to this is sought, including personal commitment - in line with Nolan Principles of public life. Charter is designed to be patient and public-facing, as well as for colleagues. Designed to be displayed in simple format (i.e. the second page of the Charter) in public areas. This is in line with the United against Discrimination project. There is already an SOP (flowcharts) in place, since July 2023, to manage incidents of discrimination and abuse from patients/the public towards staff. A stakeholder map and communications plan is under

		development by the Communications sub-group of the Sexual Safety Working Group - ready to launch the LCHG Sexual Safety Charter before 26th October across the Group. NHSE resources have been developed for us all to use. LCHG has been a key stakeholder in developing these with the national Domestic & Sexual Violence team and we have shared our existing resources for responding to discrimination and abuse towards staff. The LCHG Sexual Safety Working Group has agreed to deploy the NHSE managers' toolkit, the eLearning which will be available in ESR free of charge, and the national resources for Sexual Safety Advocates. These are expected to be published imminently by NHS England. Trusts are eagerly anticipating these. LCHG will create intranet pages to host these for our staff and they will also need to be shared with contractors and partners working with us. Currently they would need to be hosted separately for LCHS and ULHT in the absence of a shared intranet, however the content would be the same.
3	We will take an intersectional approach to the sexual safety of our workforce, recognising certain groups will experience sexual harassment and abuse at a disproportionate rate.	The LCHG Sexual Safety Working Group includes staff network leads from across the Group model, who attend when they are able to and receive updates by email and invitations to feedback on documents and plans. This is additional to their substantive roles. Further data analysis will highlight those experiencing sexual harassment & abuse at a disproportionate rate, starting with NSS results for Questions 17a and b. Information about the

		Sexual Safety Charter will be disseminated via the staff networks as part of the Communications plan, to ensure wide awareness and encourage confidence to speak-up. Once the Charter is in place and embedded, lived experience stories will also be sensitively sought via staff networks, recognising that this may not always be possible due to the traumatic nature of sexual assault. Alternatively, examples are available as part of the Communications Plan through the "Surviving in Scrubs" website.
4	We will provide appropriate support for those in our workforce who experience unwanted, inappropriate and/or harmful sexual behaviours.	Support is kindly available and identified through existing teams such as Safeguarding, Occupational Health and signposting to specialist services such as LDASS and the Sexual Assault Referral Centre (SARC) and the Police. The Trust also employs an IDVA (Independent Domestic Violence Advisor) who provides services to our patients. Recognising the potential for additional demand and delays in accessing specialist support, the Working Group has recently agreed, with the support of the Executive Sponsor, to explore setting-up a Lincolnshire system-wide partnership of Independent Sexual Violence Advisor (ISVA) roles x2. These ISVA's would specifically support all health and social care workers in Lincolnshire and would be able to advise on sexual safety matters both inside and outside of work.
5	We will clearly communicate standards of behaviour. This includes expected action for those who witness inappropriate, unwanted and/or harmful sexual behaviour.	Please also see Principle 2. In addition: We are imbedding the Sexual Safety Charter into Induction at both Trusts, as well as regular internal communications.

		We are imbedding it into the People Management Essentials Training via the Just Culture training being developed for the new Just Culture-related policies and procedures (disciplinary, grievance, dignity at work etc.) which are now being develop as a Group. We are planning specific workshops for those who may need to be more involved in handling reports of sexual misconduct. To include HR colleagues, Freedom to Speak Up Champions, and those who volunteer from existing groups such as Wellbeing Responders and Mental Health First Aiders to be Sexual Safety Advocates. We are reaching out to system partners such as Rape Crisis and the SARC, to seek their expertise in providing these workshops. Also as part of the wider health and care economy, we will be understanding how LCHG could support these partners in return.
6	We will ensure appropriate, specific, and clear policies are in place. They will include appropriate and timely action against alleged perpetrators.	Dignity at Work (ULHT) Policy and Civility & Respect Charter (LCHS) are already in place, with specific reference to sexual misconduct, and where there is a case to answer, disciplinary hearings are held. Already there is sufficient content regarding sexual safety to enable robust action to be taken. A strong link to the Just Culture Programme is in place, under same Programme Manager. Disciplinary, Dignity at Work and Grievance policies are under review as part of the Just Culture programme. This will ensure that Sexual Safety is imbedded into these.

		Quarterly reporting will provide further evidence for this commitment. NHSE are due to publish a template Sexual Safety policy imminently, which will not be mandatory for Trusts, but it will be taken into full consideration as part of the Just Culture review of policies. HR Policy Manager is aware and involved.
7	We will ensure appropriate, specific, and clear training is in place.	Please see Principles 2 and 5 which provide these details.
8	We will ensure appropriate reporting mechanisms are in place for those experiencing these behaviours.	Review of reporting mechanisms already in place via HR/FTSUG/Staffside has taken place, and training and resources identified to support them. Reporting mechanisms are included on the LCHG Sexual Safety Charter for all to see, along with a QR code for those who wish to use it.
9	We will take all reports seriously and appropriate and timely action will be taken in all cases.	Reporting processes are in place The metrics proposed under the Just Culture programme will monitor for timely action in case management for matters involving colleagues. Further metrics are proposed in Principle 10 below.
10	We will capture and share data on prevalence and staff experience transparently.	Proposal is with working group for consideration, and anticipated sign-off at September working group (proposal attached as appendix 2)

These commitments will apply to everyone in Lincolnshire Community and Hospitals NHS Group.

Next Steps and Further Considerations

Where any of the above is not currently in place, the Group is committed to work towards ensuring it is in place by **11th October 2024** (ready for the Worker Protection Act 2023, taking force 26th October 2024)**.** This is dependent on the NHSE resources being published before 11th October 2024. It is also expected that the further work to explore the provision of ISVA support for the health and social care workforce in Lincolnshire will take longer, as this is an enhanced level of support.

There will be a further checkpoint at **11th February 2025** (Sexual Safety Awareness Week) where any new developments will be shared and further awareness-raising will take place.

Doctors in Training are covered by all of the above work. However, further provisions for Doctors in Training have been noted at the August Sexual Safety Working Group, and by HR and Postgraduate Medical Education colleagues, as circulated by the Regional Postgraduate Dean – East Midlands. These are contained in the document “Response to a Disclosure of Sexual Misconduct” circulated to Directors of Medical Education on 16th July 2024, along with an indication that Deanery workshops will be available to Supervisors this Autumn, regarding disclosures of sexual misconduct.

Conclusion/Recommendations

It is recommended that the Board:

- Notes the progress made so far towards full compliance with the ten NHS Sexual Safety Charter requirements.
- Champions the remaining steps required to evidence 100% compliance with the NHS Sexual Safety Charter (and hence robust readiness for the Worker Protection Act 2023)
- Personally as an individual Board Member, and collectively as a whole Board, commits to the Group’s Sexual Safety Charter, attached at Appendix 1.

Lincolnshire Community and Hospitals NHS Group

SEXUAL SAFETY CHARTER

This charter applies to all employees, workers, volunteers, apprentices, trainees, students, patients, visitors and relatives, contractors and anyone else engaging with Lincolnshire Community and Hospitals NHS Group (ULHT and LCHS).

This charter addresses the issue of unwanted, inappropriate and/or harmful sexual behaviours.

The commitments to protect and the responsibilities in this Charter apply to everyone, without exception.

You have the right to feel safe from sexual harm

You should never feel uncomfortable, frightened or intimidated in a sexual way by e.g. colleagues or patients, or anyone else you come into contact with during your work. It is essential that we are united against all forms of sexual harm, making sure that it does not negatively impact on each other.

We all commit to everyone behaving in a way that makes the environment safe, from a sexual safety point of view

To keep everyone safe everyone must commit to these sexual safety standards:

- I understand that sexual activity with another person must always be through mutual consent, never through coercion, abuse of power or as a punishment
- I will not try to talk another person into engaging in sexual activity or harass another person sexually
- I commit to being conscious of how my behaviour makes others feel, to listening when someone tells me it is making them uncomfortable and to changing my behaviour. If I need help to do this, I will ask for it.
- I will speak up on behalf of others if I see or hear about someone else being put at risk of harm, being hurt, harassed or assaulted, whether physical or verbal.

And this means that ULHT and LCHS commit to holding those who do not do this to account - with the principles of Just Culture in mind.

The Group (LCHG) commits to providing simple and effective ways of speaking up about sexual harassment and abuse that will be accessible to all

We will always take your concerns seriously, treating you with kindness and understanding. We know how difficult it may be for you to speak up. We will listen to you and hear you. We will work with you and put you in contact with relevant support services. We will take appropriate action when you do speak up, to hold those responsible to account.

If you are worried about your safety, or that of another person, please speak to a manager, a HR colleague, a Freedom to Speak Up Champion or the Freedom to Speak Up Guardian in confidence, your Staff-side representative or our Safeguarding team. Contact details are on the intranet, or ask a trusted colleague for help if you are unsure.

If you use Datix, you can report it in there too

What is Sexual Abuse?

Sexual abuse: Includes rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, indecent exposure and misusing power to commit sexual assault or sexual acts to which the adult has not consented, or was pressured into consenting.

What is Sexual Harassment?

Sexual harassment: Is unwanted behaviour of a sexual nature, which can be a one-off incident or an ongoing pattern of behaviour. Examples include flirting, gesturing or making sexual remarks about someone's body, clothing or appearance, asking questions about someone's sex life, telling sexually offensive jokes, making sexual comments or jokes about someone's sexual orientation or gender reassignment, displaying or sharing pornographic or sexual images, or other sexual content, touching someone against their will, sexual assault or rape.

What if it is just "banter"?

What some people might consider as joking, 'banter' or part of their workplace or professional group's culture is still sexual harassment if:

- the behaviour is of a sexual nature
- it's unwanted
- it violates someone's dignity or creates an intimidating, hostile, degrading, humiliating or offensive environment for them

Sexual harassment is usually directed at an individual, but it's not always the case. Sometimes there can be a culture of sexual harassment in a workplace that's not specifically aimed at one person – such as sharing sexual images.

This is why it is important to be aware of how your own behaviour makes others feel, to listen when someone tells you it is making them uncomfortable, and to change your behaviour.

Who does this charter apply to and protect?

It applies to everyone - of all ages, women, men and non-binary people, whether disabled/living with a long-term condition or not, all sexual orientations (all LGBTQ+ people), all religions or beliefs (including none), all races, ethnicities and cultural heritages, all gender identities – including transgender people and cisgender people. It applies on the grounds of pregnancy and maternity too, and to any marital or civil partnership status. It applies to all pay bands and roles in LCHG.

SEXUAL SAFETY CHARTER

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We all commit to everyone behaving in a way that makes the environment safe, from a sexual safety point of view

We commit to providing simple and effective ways of speaking up about sexual harassment and abuse that will be accessible to all

If you are worried about your safety, or that of another person, scan the QR code to find the most appropriate route to report it.

If you use Datix, you can report it in there too

QR code to go here

What we have committed to do (NHS Sexual Safety Charter requirement)	How we propose to do it
We will capture and share data on prevalence and staff experience transparently.	Phase 1: By 1st October 2024 • Baseline data from NSS Q17a) and b) in place for LCHS and ULHT. Anonymised – number of cases in total at each Trust. • Datix – baseline data in place • ER/HR cases – baseline data in place. Where available, FTSUG and Staffside case numbers too. • Report quarterly to PODC, with quarterly Comms to everyone in LCHG. • Comparison of the sources – is prevalence higher in NSS than actually reported to the Trust for action to be taken? Phase 2: By 31st March 2025 • Further data analysis by occupational group and other factors (protected characteristics)

	can be undertaken, with suitable measures in place to ensure that no individual is identifiable. Anonymised learning shared with everyone in LCHG. • Consider & agree further options for tracking progress, such as: - Staff turnover by gender/gender identity - NDA's by gender/gender identity - Potential Pulse question "Do staff believe if they report sexual harassment or abuse to the Trust, it will be resolved"

DRAFT

Report to the Lincolnshire Community and Hospitals Group Board Meeting

Date of meeting	3rd September 2024	Agenda item	10.1
Title	Assurance and Risk Report from the Finance, Performance, People, and Innovation Committee meetings held on 26th July 2024 and 23rd August 2024.		
Report of	Gail Shadlock, Non-Executive Director, and Chair of FPPIC	Prepared by	Claire Low, Chief People Officer Caroline Landon, Chief Operating Officer Darren Fradgley, Chief Integration Officer Mike Parkhill – Chief Estates & Facilities Officer Nerea Odongo, Chief Nursing Officer Colin Farquharson, Chief Medical Officer Sam Wilde, Director of Finance and Business Intelligence
Previously considered by / Date	None	Approved?	None
Summary	The FPPIC Committee met on 26th July 2024 and 23rd August 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	**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**

proud to work within LCHG		
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.

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 26th July 2024 and 23rd August 2024.

1. Purpose

To make the Board aware of key issues from the Finance, Performance, People and Innovation Committee (FPPIC) meetings held on 26th July 2024 and 23rd August 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 3a. Deliver financially sustainable healthcare, making the best use of resources
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 4a. Establish collaborative models of care with all our partners including Primary Care Network Alliance (PCNA), GPs, health and social care and voluntary sector
Strategic Objective 4d. Enhanced data and digital capability

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)

AMBER ASSURANCE

Strategic Aim 3. To ensure services are sustainable, supported by technology and delivered from an improved estate:
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 5. To improve physical and mental health outcomes, promote well-being, and reduce health inequalities across an entire population:
Strategic Objective 5c. Tackle system priorities and service transformation in partnership with our population and communities (New objective not yet rated)

People Strategy Q1 Strategy Update
The committee reviewed the People Strategy Q1 update at its July meeting and agreed the proposed green ratings for the People programmes of work supporting strategic objectives 2a and 2b. It was noted that all areas were rated green with good progress in particular relating to the development of a collaborative bank across LCHS and ULHT and increases in flexible working.

EDI Progress Report
EDS - The committee received the quarterly EDI progress report. It was noted that NHS England has now declared EDS as 'business as usual' and that two out of three divisions have completed their EDS self-assessments for domain 1, with common themes being a lack of EDI patient data collection and engagement with patients for that service. Domains 2 and 3 going forward have been linked into the national EDI improvement plan, including the 6 high impact actions.

WRES/WDES -The 2024 annual reports for WRES and WDES are completed and going through the assurance processes. They will be published on the public facing website before the deadline of the 31st of October.

Staff Networks – The EDI lead attended the ULHT Council of Staff Networks. The Group CEO suggested a face-to-face session with both ULHT and LCHS chair/vice chair for all staff networks in October.

Workforce Disability Equality Standard Annual Report (WDES)
The committee reviewed the WDES annual report and action plan and approved this for onward reporting at Board, prior to publication on the public website. Key areas of progress/highlights and actions were:
Progress:

- Increasing the number of staff disclosing disability or long-term conditions (LTC) on ESR to 9.8% (from 9.6% in 2023). Highest in community Trusts around the country.
- % of disabled staff compared to non-disabled staff experiencing harassment, bullying, or abuse from patients, has positively decreased by 0.9% - now at 26.7% from 27.6%.
- % of staff experiencing bullying, harassment, or abuse from line managers in the last 12 months has positively decreased by 3.9% to 11.9% from 15.8%.
- % of staff who believe the Trust provides equal opportunities for career progression or promotion has positively increased by 1.4% from 62.7% in 2023, compared to 2022 at 61.3%.

Key actions:

- Raise staff and line managers' awareness about the Health Passport.
- Continue embedding cultural intelligence programme across senior leadership.
- Start to collect the disability pay gap data to develop next year's Pay Gap Report.
- Enhancing knowledge about reporting bullying and harassment and other supporting procedures for staff.

Workforce Race Equality Standard Annual Report (WRES)

The committee reviewed the WRES annual report and action plan and approved this for onward reporting at Board, prior to publication on the public website. Key areas of progress/highlights and actions were:

Progress:

- There has been a positive increase of 1.9% of BME staff, from 5.4% (127) to 7.3% (173).
- The percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months is 19.7% which is a positive decrease of 4.9% of BME staff, from 24.6% to 19.7%.
- A positive decrease of relative likelihood of BME entering formal disciplinary compared to white staff from 2.36 to 0.6.

Actions:

- Continue embedding cultural intelligence programme across senior leadership.
- Develop and analyse the Race Pay GAP Report.
- Enhancing knowledge about reporting bullying and harassment and other supporting procedures for staff.
- Inclusive staff management, improve diversity across senior leaders by raising awareness on updating equality and diversity data on ESR.
- Planning of advanced Reverse Mentoring Programme across the group starting with the new Group Trust Board

Exclusions Quarterly Thematic Review

The committee received the quarterly Exclusions review paper and noted there were no new exclusions this quarter. The previous 2 exclusions were both still ongoing and linked to external investigations (police and CQC) which were impacting on timescales. It was also noted that appropriate wellbeing and other support was in place for the individuals.

Monthly Finance Reports

The committee reviewed the months 3 and 4 finance reports at its meetings noting an improving financial position. The committee also reviewed the Lincolnshire ICS System Financial reports, the Lincolnshire Financial Recovery Programme Finance reports and the Lincolnshire System Workforce reports. At the July meeting the committee approved reductions in scores for risk 455 - failure to achieve planned levels of income (following signature of the main ICB contract) and risk 442 – failure to deliver the efficiency requirement (recognising substantial progress in addressing the unidentified CIP gap). At the August meeting the committee approved increases in scores for risk 455 - failure to achieve planned levels of income (following a no-fault notice letter being received in respect of the Any Qualified Provider MSK contract) and risk 462 – failure to deliver the cash management aspect of the plan (recognising the continued worsening of the cash position). The committee agreed to maintain the recommended amber rating for strategic objective 3a 'Deliver financially sustainable healthcare, making best use of resources' until we have fully identified

the entirety of the CIP requirement.

Integrated Performance Report
The committee reviewed the Integrated Performance Reports covering June and July 2024 performance.

Only 1 indicator was not statistically capable of achieving performance targets without redesign at the end of July 2024:
(i) Home Visiting Compliance

5 metrics were showing signals of special cause deterioration at the end of July with some factors impacting on multiple metrics:
(i) CAS activity.
(ii) OOH and CAS cases closed.
(iii) Ops Centre Calls Answered in Timescale.
(iv) Ops Centre Calls Abandoned; and
(v) Urgent Community Response – 2 Hour Compliance

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

Commissioned Waits Update Review
The committee received the commissioned waits paper providing assurance on the level of oversight and visibility for waiting times as of the end of Q1 across community services. The committee noted good progress in the data quality, oversight and management of all waiting lists supported by the introduction of the dashboard on Power BI and reviews within the PMR.

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

Finance and Business Intelligence Q1 Strategy Update
The committee reviewed the FBI Strategy Q1 update at its July meeting and agreed the proposed green ratings for the FBI programmes and projects supporting strategic objectives 3a, 3b, 4a and 5a. It was noted that the project to develop regular integrated portfolio analysis was on hold pending a decision on the future of the Strategy & Planning Group in light of the new LCHG Group arrangements.

Operational Plan Progress Report
The committee reviewed the Q1 Operational Plan Progress Report at its July meeting noting the strong overall performance, addition of 3 new projects in June and detailed information on exceptions.

Finance Executive Group Report
At its July meeting the committee received and reviewed a report from the FEG meeting held on 20th June 2024 noting 3 areas were rated as green and 3 as amber. The approved minutes of the FEG meeting held on 4th April 2024 were also received.

Procurement Waivers
There were no waivers to review at the July meeting. 3 waivers were reviewed at the August meeting. All were considered appropriate. The committee noted positively that the Director

of Finance and Business Intelligence had indicated he would not authorise any future waiver requests for 2 of the 3.

National Cost Collection 23-24 post submission report

The committee reviewed a report confirming the Trust has submitted its 2023/24 National Cost Collection report on time and in-full. Cost coverage was slightly higher than in the previous year at 83.8%. On a non-weighted basis overall activity rose by 5% whilst cost growth was contained at 4%, suggesting an improvement in overall productivity. National results will be published in due course and show how we fare in comparison to other NHS providers.

Strategic Partnerships Development

The committee reviewed a Strategic Partnership Development Update at its July meeting noting the proposed green ratings for the 2 programmes of work under strategic objective 4a and actions planned for the next period.

Digital and Estates Q1 Strategy Update

The committee received the quarter 1 update on progress implementing the Innovation strategies, proposing, and agreeing green ratings for the strategic objectives 4d and 5d. It was proposed and agreed that strategic objective 3c (A modern, clean, and fit for purpose environment across the Group) would be rated as red due to the ongoing work around the estates transition from LPFT shared service to a ULHT hosted group model service.

Data Security and Protection Toolkit – Statement of Compliance

The committee received the Data Security and Protection Toolkit Statement of Compliance. The toolkit has been submitted for LCHS in July 2024 with a status of 'Standards Met' meaning the Trust is fully compliant.

Water Safety Update

63 Monks Road – 24.08.24 - 2x Positive results from post flush samples which indicate legionella species (300cfu/l and 50 cfu/l) with an action to continue flushing, clean the outlet and retest. Core underlying issue being underutilisation of the property. Issues with the hot water supply would also factor into water quality issues.

Ravendale – 08.08.24 - 2x positives for Pseudomonas, pre & post flush within visitor WC. Quotation received from Aqua Protec for remedial work. Upon review on site, the specified works are to be amended to remove stored hot water capacity, remove strainers and replace/disinfect supply pipework. A Point of Use filter is installed and being maintained together with regular flushing to support localised management until remedial works actioned.

TMV Servicing – 27.08.24 - Is progressing according to schedule. Riverside has been the only site recording 4x non-conformances and requiring remedial action. Awaiting quotation for approval.

LCHS Commercial Leased Sites – 27.08.24 - Lease SLA's have been recently reviewed and it is now clear where water management responsibilities lay. Where commercial managing agents have been absent from their responsibilities, ULHT will ensure communal maintenance is undertaken under the lease terms & conditions.

NHSPS Sites – 27.08.24 - ULHT currently has limited access to water hygiene monitoring data from NHSPS. Until recent weeks, information has been reported through the LCHS/LPFT Water Safety Group. ULHT is still awaiting latest data. Access to data expected to be in place week commencing 2nd September.

Water Hygiene Risk Assessments – ULHT is yet to receive copies of all LCHS, property specific WHRA. We wish to determine remedial actions have been completed according to the risk rating. This is to be included within the ULHT/LCHS risk register until we are satisfied.

LCHS Transition – 23.08.24 – ULHT has received access to the Aqua Protec data for the commercially leased and freehold sites. Further analysis and review from the Estates Team is required to rationalise sampling and monitoring frequencies and volumes.

Health and Safety Updates

The committee received the report which provided updated information on the management of health & safety within LCHS. Key elements / areas set out in the report have been implemented and will be reviewed and monitored against the outcomes assigned within the Action Plan. The Group Model guiding principles to establish common standards and protocols across trusts to ensure consistency and quality of care remains an active goal for the ULHT Health & Safety Management Team. The team continue their journey with LCHS and expressed thanks for their positive and proactive engagement.

Risk Assurance Report

The committee reviewed the risk assurance report noting all significantly high risks across the trust. Oversight is given to new risks, increases and decreases in risk score. All significantly high risks are scrutinised at the group risk register confirm and challenge meeting.

Board Assurance Framework

At its August meeting the Committee reviewed the Strategic Objectives within the Board Assurance Framework which related to the Committee Terms of Reference. Consideration was given to the assurances which had been received during the meeting. Proposed assurance ratings were agreed for the strategic objectives for recommendation to the Group Board.

Procedural Documents Renewal Calendar

The Committee reviewed the Procedural Documents Renewal Calendar report and noted that there were three policies which were overdue for review. Concern was expressed that the Fire Safety Policy was considerably overdue. The Committee were advised that significant work was required to bring the policy up to date and that the work 'on the ground' was being prioritised as part of the wider work programme in Estates and Facilities. The policy would be updated in due course.

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.

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

The following items were approved:
- Minutes of the meetings held on 27th June 2024 and 26th July 2024.
- Workforce Disability Equality Standard Annual Report 2023/24; and
- Workforce Race Equality Standard Annual Report 2023/24.

Issues referred to or from Audit Committee
None

Items referred to or from Quality Committee
None

Items referred to or from Trust Board
The committee wanted to highlight to Board the improvement in overall productivity suggested in the 2023/24 National Cost Collection submission. The committee will look at this in more detail when the national results are published.

3. Conclusion/Recommendations
Board is asked to:
- **NOTE** the report.

Report to:	Lincolnshire Community and Hospitals Group Board Meeting
Title of report:	Finance, Performance and Estates Committee Assurance Report to Board
Date of meeting:	25 July 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 and Capital** The Committee received the suite of finance reports noting the year to date position of £11.7m deficit which is £1.8m adverse to plan of £9.8m deficit. This is driven by industrial action and system level risks across a number of identified schemes. The cash position was reported at £10.9m, which is higher than plan and the Better Payment Practice Code continued to report good performance at circa 90% and 92% ytd. The Trust was ahead of plan by £500k against the Cost Improvement Programme (CIP), having delivered £4.4m savings year to date. The Committee noted the net risk to the financial position at £6.4m, associated with inflationary pressures which was not included in plan, following NHS England guidance. Mitigations were in place to address the gap in the position with the ICS continuing to commit to resolve the overall system gap of £17m. A resource allocation of £82.7m in year for capital was noted with spend of £8.1m achieved in month 3 which is £2m adverse to plan. It was noted that there had been some variance due to timing issues with CDC and Pilgrim ED works however these were not a concern to delivery and were being managed. It was recognised that this had been the largest capital spend ever in Q1 for the Trust. Despite this there remained a significant amount of capital spend for the remainder of the year.

	Discussions took place around the Electronic Patient Record and the funding for this with the outline business case having been signed off and a need for the full business case to be developed and signed off through national process. This would be the largest enabling project the Trust had ever undertaken. **Medical Agency Deep Dive – Extra Contractual Rates** The Committee received the deep dive noting the realignment of improvement team resource to ensure sufficient support was in place for this programme of work. It was expected that, should the proposed spend caps within the divisions be achieved, the full saving of £9.2m, could be delivered. The Committee noted that the work would be progressive, commencing with internal extra-contractual rates in order to set a baseline position. A phased approach would then be taken starting with Trust employed doctors and working through to agency staff. The Committee recognised the need for job plans to be completed alongside this work with focused activity taking place. **Strategic Projects – Pilgrim ED Update** The Committee received the report noting the progress to date however recognised the ongoing risk surrounding high and low voltage delays. Some mitigations had been achieved in respect of delayed damage claims. **Strategic Projects – CDC Programme Update** The Committee received the report and was pleased to note the successful programme of work to date both from a works and financial perspective. Positive feedback had been received from NHS England about the projects with the Trust now being recognised as an example of best in class overall.
	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 Report** The Committee received the report noting the confirmation that there had no Reinforced Autoclaved Aerated Concrete (RAAC) found across the Trust, following a formal survey.

	Progress on the submission of the Premises Assurance Model (PAM) was noted with a deadline submission of September, with a level of confidence that areas previous rated good remaining as such. An internal review of confined spaces was due to conclude at the end of August and once completed the Health and Safety Executive would be invited back to the Trust to review the previous enforcement actions with a view to formally closing this. Concern was noted through the PLACE Lite report in respect of food service for both quality and service however it was noted that a Project Manager had been working on the review of catering services. A trend was noted in respect of critical chiller failures which had impacted MRI capacity with the team working through a strategy and critical list which may require some capital spend to resolve issues. The Committee was pleased to note that, following a number of visits from Lincolnshire Fire and Rescue, that there had been no significant issues reported to the Trust. Critical and theatre ventilation and the utilisation of clinic space continued to be a concern with oversight by the infection prevention and control group.
	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 the challenging month of June due to both industrial action and significant infection prevention and control issues, leading to a reduction in capacity across the Group, as well as a significant increase in demand. The Committee noted the risk surrounding theatre capacity which impacted on the organisations ability to service long waits, cancer and other emergencies. The Committee also noted the potential impact of the GP collective action which was due to take place in the near future. This was expected to impact across all urgent and emergency pathways, as well as elective pathways and cancer. Challenges were noted in respect of the achievement of 65-week waits with the position re-forecasted for September delivery.
	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) **Specialty Reviews** The committee received the report and noted the intention of the team to tailor support to specialties, which would provide a bespoke approach to each review.
	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 **Digital Hospital Group Upward Report** The Committee received the report noting that there were no escalations to the Committee. It was noted that there were some funding considerations in respect of the Electronic Patient Record however this was noted as a timing issue. The Committee noted that a longer session would be required to consider the full business case once developed.
	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: **Board Assurance Framework (BAF) 24/25** The Committee received the report noting the updates which had been provided however recognised the need for further updates to be offered, with particular focus on how the Trust would be prevented from meeting the objectives. **Integrated Improvement Plan (IIP) and Improvement Steering Group (ISG) Upward Report** The Committee received the report noting that overall assurance of the IIP remained moderate.

	Through the ISG report the Committee noted positive progress in respect of the CIP position however noted that further work was required in order to offer greater assurance on the programmes of work. **Committee Performance Dashboard** The Committee received the report noting the performance reported which triangulated with the operational performance updates provided. Improvements were noted against DM01 which was reported at 77.59% against a target of 72.46% and strong improvement for May as noted in respect of the 28-day Faster Diagnosis Standard. **Planning Paper** The Committee received the report noting that the planning had been launched for the following year, earlier than previous years, with winter planning having commenced. There had been good attendance at the launch event with this work progressing across the Group and further work required in respect of the quality and patient safety elements being triangulated with this. **CQC Action Plan** The Committee received the report noting the continuation of the improvement in actions being embedded noting that the proactive work continued in respect of the CQC Single Assessment Framework which would be presented to the Committee in August. A close down report would be presented to the Committee in October.
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	A	S	O	N	D	J	F	M	A	M	J	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	D	X	X	X	X	X	X	X	X	X	X	D
Director of Improvement & Integration	X	X	X	X	X	X	X	X	X	D	X	X
Sarah Buik, Associate Non-Executive Director	X	X	X	X	X	X	X	X	X	X	X	X

X in attendance
A apologies given
D deputy attended

Report to:	Lincolnshire Community and Hospitals Group Board Meeting
Title of report:	Finance, Performance and Estates Committee Assurance Report to Board
Date of meeting:	22 August 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, CRIG upward report and Cash Draw Down** The Committee received the report noting the capital risks associated with EPR funding however this had a 10-year capital plan with a level of pre-commitment which was being managed. Moderate assurance was offered in respect of contracting with the Committee noting that whilst contracts had been signed there may be some change to the AQP contract. The Committee noted Cost Improvement Programme (CIP) delivery of £8.5m year to date, a positive variance of £2.2m against target. This was underpinned by nurse agency reduction and the elective recovery fund. Upward reports were received from the Capital, Revenue and Investment Group with the Committee pleased to receive the reports detailing the cases put forward, a number of which would be received by the Charitable Funds Committee. The Committee received the cash paper noting the request for delegated authority for a cash draw down in Q3 to support the position in the second half of the year. Better Payment Practice Code remained strong in month at 96% / 92% by value/volume. **Strategic Projects – Pilgrim ED Update** The Committee received the report noting the position reported and that there were no escalations to be made to the Committee.

	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 Capital Investment Prioritisation** The Committee received the report for information noting the position presented. **Health and Safety Committee Upward Report** The Committee received the report noting that discussions had commenced in respect of the meeting being held across the Group with an anticipation that this would take place in the next quarter. Progress was noted in respect of manual handling and the checking of hoisting equipment however further progress was required. Overall compliance with ventilation was noted with work being undertaken on treatment rooms and issues with non – clinical rooms being utilised in this manner. The Committee noted that some actions remained in respect of fire, particularly fire doors and compartmentation however progress could be demonstrated. A number of policies had been approved by the committee bringing these in date. The Committee received the Health and Safety Annual Report noting some amendments would be required prior to this being presented to the Board. The Health and Safety draft strategy was also received, and comments offered by the Committee. Work would continue to further develop this. **Emergency Planning Group Upward Report** The Committee received the report and was pleased to note the progress made in respect of the Business Continuity Plans for testing and improvements. Concern was noted in respect of lockdown however reassurance was offered of the level of lockdown which could be achieved and a review of the requirements would be undertaken. The Committee noted the EPRR submission which was due at the end of August with an expectation of meeting the majority of core standards. The Committee reflected the need for cyber risk preparedness to be considered through this.

	Assurance in respect of SO 3d Reduce waits for patients who require urgent care and diagnostics to constitutional standards **As reported at SO 3f**
	Assurance in respect of SO 3e Reducing unwarranted variation in cancer service delivery and ensure we meet all constitutional standards **As reported at SO 3f**
	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** The Committee received the report noting the position presented and reflected on the need for improved reporting in respect of length of stay. The emergency access standard was noted as requiring improvement with type 3 activity masking the challenging type 1 activity. 12-hour waits remained an area of concern however these were reducing. The Committee noted the work which had commenced in the emergency departments with a sprint programme of work in place to make improvements. There was a need for improvement to be made in Same Day Emergency Care performance in order to improve the position at the front door. Concern was noted in respect of 65-week waits however it was noted that this could be reflective of the national position with a need to benchmark against peers to confirm this. Equipment issues were impacting on diagnostics however recovery was on track with the services working to maximise use of the Community Diagnostic Centres. **Improvement Programme Deep Dive – Productive Theatres** The Committee received the report noting that the report demonstrated the structured governance and plans in place however concern was noted in respect of the vacancy position that was reported. The Committee noted however that this reflected the position should delivery of the services continue as described however with the delivery of the improvement programme the establishment would alter. Consideration was given to the wider operating model by the Committee who noted that the utilisation of space and services across the Trust could change the activity through theatres in the acute setting.

	Assurance in respect of SO 4a Establish collaborative models of care with our partners including Primary Care Network Alliance (PCNA) **East Midlands Acute Provider Network Q1 Update** The Committee received the report for information.
	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 **Digital Hospital Group Upward Report and EPR Update** The Committee received the reports noting that there were no escalations to the Committee and reflected on the need to ensure appropriate clinical engagement to successfully deliver the EPR. The Committee was aware of the need to progress the full business case and to ensure funding flows took place at the appropriate time.
	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 (IIP) and Improvement Steering Group (ISG) Upward Report** The Committee received the reports noting that there had been some decline in performance of some of the programmes of work reported. **Committee Performance Dashboard** The Committee received the report with moderate assurance noting that there was a need to consider this rating alongside the Operational Performance Report due to the need for consistency in the data presented. Improvement was being seen in respect of 28-day Faster Diagnosis Standard, against national trajectory and 62-day waits were also showing improvement. **Internal Audit Reports**

	The Committee received the Project Management, Data Quality and Patient Flow internal audit reports noting the assurance levels provided and recognising that actions would be addressed to respond to findings. **CQC Forward View** The Committee agreed to defer the item due to the meeting being reduced in time.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	None
Committee Review of corporate risk register	The Committee 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	S	O	N	D	J	F	M	A	M	J	J	A
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	X	X	X	X	X	X	X	X	D	
Group Chief Operating Officer												X
Group Chief Integration Officer												X
Group Chief Estates and Facilities Officer												X
Director of Improvement & Integration	X	X	X	X	X	X	X	X	D	X	X	
Sarah Buik, Associate Non-Executive Director	X	X	X	X	X	X	X	X	X	X	X	X

X in attendance
A apologies given
D deputy attended

Meeting	*Lincolnshire Community and Hospitals Group Board Meeting*
Date of Meeting	*3rd September 2024*
Item Number	*13*

Integrated Performance Report for July 2024

Accountable Director	*Daren Fradgley, Group Chief Integration Officer*
Presented by	*Daren Fradgley, Group Chief Integration Officer*
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:* *Quality* *The Trust SHMI has decreased slightly to 105.02 for July but remains within expected limits.* *Medication incidents reported as causing harm decreased this month to 9.5% against a trajectory of 10.7%.* *Duty of Cancdour Verbal compliance for June decreased to 89%, written conpliance also decreased to 79%.* *Performance* *The year end target for 4 hour performance was established at 78%, with July set at 75.30%. The full UEC combined Type 1, Type 3 (both co-located and separate sites) achieved 72.12% in July.* *21.05% of patients exceeded 12 hour wait in department in ED.* *Average response time for Cat2 ambulance conveyances in July was approximately 35 minutes against a 30 minute target.* *Long Waiters - at the end of July, the Trust reported 0 patients waiting longer than 104 weeks; 2 patients waiting over 78 weeks and 524 patients waiting over 65 weeks* *The report for DM01 in June showed improvement to 77.59% compared to May's 72.46%. Echo has long been the pressured area, sustained improvement is bringing performance back in line. Recent declines in MRI and Ultrasound have been observed due to capacity and availability issues* *28-day Faster Diagnosis Standard (FDS) showed a strong improvement in June at 81.5% which was above the 75% target for the first time.* *62-day classic treatment performance for June was 66.2%, and an improvement from the May position of 51.4%, but this is still significantly lower than the national KPI of 85%.*

- *104+ day waiters decreased to 51 at the end of July compared to 58 at the end of June, with the highest risk speciality still being Colorectal.*

Finance

- *The Trust's YTD position is a £15.1m deficit, which is £4.4m adverse to the planned £10.7m YTD deficit.*
- *CIP savings of £8.5m have been delivered YTD, which £2.2m favourable to planned savings of £6.3m.*
- *Capital delivery of £13.5m is £3.0m lower than plan of £16.5m.*

Workforce

- *Mandatory training for July is 93.71% against plan of 90%*
- *July sickness rate at 5.42% against Q2 target of 5.47%*
- *Staff AfC appraisals at 77.58% for July against Q2 target 81.18%*
- *Staff turnover at 10.00% for July against target of 11.48%*
- *Vacancies at 8.51% against Q2 target of 7.71%*

Executive Summary

Quality

Falls

There have been 2 falls resulting in moderate harm and 1 fall resulting in severe harm during the month of July. Overall the Trust saw a decrease for inpatient falls for the month. All incidents are under validation to ensure the correct level of review is undertaken. Focus on Fundamentals will include continence care in preventing falls during August. The first Group Falls day is planned for September and will include activities related to incident themes and support wider shared learning. Falls documentation has been reviewed in collaboration with clinical staff and has been adjusted to make it easier to read and complete in a timely way.

Pressure Ulcers

There have been 37 category 2 and 10 category 3 pressure ulcers in July. All Category 3 and 4 incidents will be reviewed at the weekly Patient Safety Response meeting to determine if they require an After-Action Review (AAR). Tissue Viability and Quality Matron Team are undertaking a detailed review of these incidents to identify any additional learning. August educational bulletin will promote the implementation of preventative equipment to offload vulnerable areas.

Medications

Medication incidents reported as causing harm decreased this month to 9.5% 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) and will be presented at the Executive Oversight panel in August.

Patient safety Alerts

There were no alerts due to be responded in July. 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. Meetings held with appropriate Leads when new Alerts received to ensure actions are assigned to relevant Trust leads.

SHMI

The Trust SHMI has decreased slightly to 105.02 for July but remains within expected limits. Any diagnosis group alerting is subject to a case note review.

eDD Compliance

eDD Performance continues to be below the 95% target, currently at 91.5%. The Improvement Team are in the process of allocating resources to improve compliance with sending eDD within 24 hours of a patients discharge

Sepsis compliance – based on June data

The **screening compliance for inpatient child** decreased to 71.6% (target 90%). 38 children out of 53 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.

IVAB ED Children – The administration of IVAB for children in ED decreased to 63.6% (target 90%). 7 children out of 11 were treated with IV antibiotics within the 60 minutes. There were 4 children this month within ED with delayed Sepsis treatment, although they were in the ED department, 3 of the delays were due to delays by Paediatric teams.

IVAB Inpatient Children – The administration of IVAB for inpatient children decreased to 63.6%. 7/11 children received their antibiotics within one hour. Harm reviews completed and no harm found in 3 patients, low harm identified for patient that continued to have seizures. IR1 completed for this patient.

Duty of Candour (DoC) – June Data

DoC compliance decreased in June with verbal compliance at 89% and written compliance at 79%. Weekly tracking in progress by the incident team.

Operational Performance

This report pertains to the performance of July 2024. As of August 7th, the Trust has reported 7 PCR confirmed positive COVID-19 inpatients. It is noteworthy that the peak for the month of July was 10 patients, and this figure has subsequently decreased in accordance with the local and regional trends as well as the emergence of new variants. During July, a total of 974 flu tests were conducted, yielding 1 positive, signifying a 0.10% positivity rate. Similarly, 1 out of 305 patients tested for RSV returned positive results, indicating a 0.33% positivity rate. It is worth noting that there are presently no active Flu/RSV patients at our sites. ULHT experienced 12 confirmed CDIFF cases of which 7 were on the Boston site, significantly influencing capacity and flow throughout the site.

Tracking against ERF is not currently available. At the end of M4, percentages against plan for key PODS are: Day case 108%, Electives 101%, Outpatient Firsts (Total) 108%, Outpatient Follow ups with procedures 94%

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

The year-end 4-hour performance target has been established at 78%, with a monthly trajectory to monitor progress. In July 2024 the trust achieved 72.12% against a trajectory of 75.30%, a negative variance of 3.18%. The SPC chart in the report shows both the 23/24 and 24/25 targets, encompassing Type 1 and Type 3 activities. Performance for Type 1 at Lincoln/Pilgrim ED declined from 32.19% to 31.25%, Grantham UTC Type 3 improved from 84.29% to 87.30%, contributing to the overall 4 hour target.

In July 2024 there was an increase of 1.92% number of attendances (565 patients) across the UEC pathway with higher acuity patients remaining with us for longer. In response to this pressure, the Emergency Department focus was on total time spent in department, unfortunately 21.05% of the patients exceeded the 12-hour benchmark, however a 0.87% decrease compared to June 24.

In July, the average Category 2 mean response time was approximately 35 minutes, which was a decrease of 4 minutes compared to June 2024 against the 30 minute target. The overall Category 2 mean response time includes conveyances where the patient did not attend ULHT but their postcode was within our catchment area. The SPC chart below shows the number of occasions where handover of patients took longer than 59 minutes. It's also worth noting that some of these vehicles may have been for the same patient.

Fractured Neck of Femur 48hr Pathway (#NOF)

After a significant improvement in October 23 #NOFs going to theatre within 48 hours has continued to perform well, with a slight dip in June performance. However, July outturn saw a significant improvement at 78.69%.

Length of Stay

In the month of July, the Non-Elective Length of Stay exhibited a 0.06-day decrease in performance as compared to June 2024. The existing performance level stood at 4.83 days, surpassing the maximum threshold by 0.33 days. When evaluated against the "Core G&A," the average bed occupancy was determined to be 96.81%. In order to maintain safe and efficient operational flow within the acute sites, an average of 60 escalation beds/boarding spaces were allocated. The ratio of occupancy versus escalation yielded a secure percentage of 91.16%, aligning with the new national standard of less than 92%. It is worth noting that approximately 44 beds are allocated elective flow at Grantham. If this site was not included in the metrics then core would resulted as 99.43% and core plus escalation at 93.09%

In July 2024, System Partners encountered challenges in providing timely assistance for facilitating discharges from the acute care setting for Pathways 1 to 3. It is noteworthy that Pathway 2 demonstrated the most significant improvement, manifesting a marked reduction in length of stay in July 2024 by 5.6 days.

The identification of timely support for facilitating discharge from the acute care setting for pathways 1 to 3 posed challenges for System Partners. Moreover, the Trust has initiated the recording and monitoring of the percentage of discharges within 24 hours of the predicted date of discharge (PDD). Notably, July exhibited a performance of 39.23%, which was a deterioration to the 40.07% observed in June.

Referral to Treatment

June performance continued to show improvement, reporting a performance of 52.11%. The Trust continues to report patients waiting over 104, 78, 65 & 52 weeks. At the end of July, the Trust reported zero patients waiting longer than 104 weeks. The trust exited July with 2 patients waiting more than 78 weeks, and whilst this wasn't zero, both were down to patient choice. The national ambition of clearing patients waiting over 65-weeks by the end of March has now moved to September. July Outturn was 524 which was slightly better than trajectory again. A revised forecast has been set of 450 for August. Achieving zero at the end of September is starting to look unlikely, so mitigation plans and financial implications are being worked through.

The trust was an early adopter of the Further Faster programme which is a national initiative to reduce patients waiting over 52 weeks. In June the Trust reported 3,259 patients waiting over 52 weeks. Whilst we have been performing strongly against this metric, recent months have remained static.

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 June sat at 71,375 which was slightly higher than seen in April. 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 5th August 2024, ASI sat at 638. Whilst this is lower 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 June showed another month on month improvement, increasing from 72.46% in May to 77.59%. 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

July outturn for cancelled operations on the day deteriorated from 1.63% in June to 2.71%. Recent deterioration has largely been driven by cancellations due to a lack of theatre staff, this month saw a significant increase in cancellations due to lack of theatre staff. This is a continuing theme and the surgical division have identified an under establishment of 60 wte.

Included in the 2.71% of on the day cancellations, 41 patients were not treated within the 28-day standard. This is a significant increase and continues to be driven by the pressure to date long waiters and Cancer patients.

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 strong improvement in June at 81.5% which was above the 75% target for the first time.

62-day classic treatment performance for June was 66.2%, and an improvement from the May position of 51.4%, but this is still significantly lower than the national KPI of 85%.

104+ day waiters decreased to 51 at the end of July compared to 58 at the end of June, with the highest risk speciality still being Colorectal.

Workforce

Mandatory Training – Our July 2024 Core Learning Rate is 93.71% against a Target of 90.00%. This is an increase when compared to last month. Compliance will continue to be monitored during Q2 to ensure that we remain in line with our overall trajectory for 2024/25.

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 have been 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.

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 July 2024 Sickness Rate is 5.42% against a Q2 Target of 5.47%. Sickness absence rates have remained stable across 2023/24, and continues in this way so far within 2024/25. 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.

Our 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.

There is a continued focus on supporting managers and leaders in absence processes and supporting our people to attend the work environment will be delivered through the mandated 'Basics Brilliantly' workshops which is an action we are taking forward following the staff survey results. There continue to be discussions as part of the Workforce & Organisational Development Group about sickness

absence, and a recognition that levels are being maintained and are not worsening. 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 July 2024 Appraisal Rate is measured against a Q2 Target of 81.18%, and in month we have achieved a Trustwide position of 79.31%. Our Medical & Dental appraisal compliance rates are 94.07% for July 2024, and Agenda for Change (AfC) is 77.58% which is an improved position when compared to June 2024.

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 that there is further focus required for 2024/25 in improving compliance if we are to ensure that there is a Trustwide focus on our ambition to 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.

Staff Turnover – Our July 2024 Turnover Rate is 10.00% against a Q1 Target of 11.48% and shows a stable position when compared to June 2024 with a consistent improvement seen since November 2023. Our 2024/25 target is to achieve 9.00% or less by 31st March 2025, which we are on trajectory to meet /exceed.

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.

There is a 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 has already commenced within the Trust for our 2025/26 workforce plan, with close working with our Talent Academy and Education, Learning & Organisational Development teams being a priority. We are working towards a more robust process via ESR to capture leavers' data and understand trends.

There continues to be 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 July 2024 Vacancy Rate is 8.51% against a 2024/25 Q2 Target of 7.71%. The increase in vacancy rate is due to the budgets being finalised and translating into reporting. Despite this month seeing an increase, we have still seen a reduction in our Vacancy Rate when compared to the same time last year (July 2023) when our vacancy rate was 9.78%.

Our levels of recruitment continue to be successful, and there has been a consistent improvement in the number of substantive staff we are recruiting over the last 12 months.

We have been successful with a further expressions of interest for additional NHSE funding in 2024/25 for International Recruits within our Allied Health Professional staff group who are supporting the roll out of our Community Diagnostic Centres across Lincolnshire.

However, AHP recruitment remains a challenge locally and nationally, and will continue to be a focus area in 2024/25 as we further develop the Community Diagnostic Services within Lincolnshire and embrace the continued success of international staff .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. AHP & Pharmacy recruitment remains under significant focus but we believe we are making strong progress in both areas.

Finance

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

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. The month 4 financial position is reported against the revised plan phasing.

The Trust's YTD position is a £15.1m deficit, which is £4.4m adverse to the planned £10.7m YTD deficit.

CIP savings of £8.5m have been delivered YTD, which £2.2m favourable to planned savings of £6.3m.

Capital funding levels for 2024/25 have been agreed with NHSE and system partners; the Trust delivered capital expenditure of £13.5m YTD, which is £3.0m lower than planned capital expenditure of £16.5m.

The cash balance is £31.3m (plan £11.9m); this is a decrease of £19.6m against the March year-end cash balance of £50.9m. This increase in cash balances of £13m in July is likely to be temporary.
Whilst LICB have provided short term cash support in Q2, it is anticipated that a Drawdown of revenue PDC (cash) will be required during Q3.

Daren Fradgley
Group Chief Integration Officer
August 2024

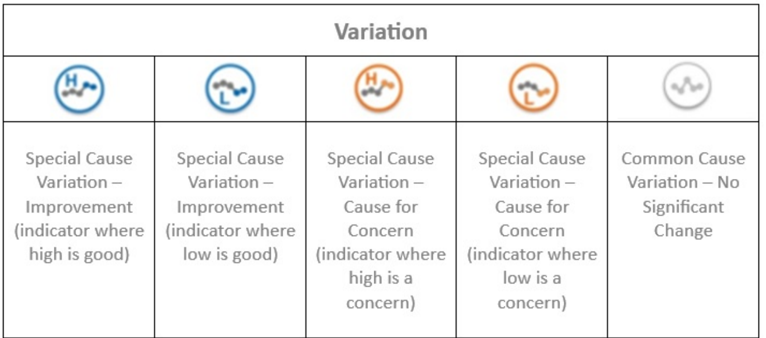
Key to Variation and Assurance Icons and SPC Dots

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		
H	L	H	L		P	F	?
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.

Performance Overview - Quality

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	May-24	Jun-24	Jul-24	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Clostridioides difficile position	Safe	Patients	Director of Nursing	9	8	9	8	31	P	
	MRSA bacteraemia	Safe	Patients	Director of Nursing	0	1	0	0	1	P	
	MSSA bacteraemia cases counts and 12-month rolling rates of hospital-onset, by reporting acute trust and month using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.01	0.02	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	0.04	0.05	0.02	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	0.17	0.14	0.08	0.12	P	
	Pressure Ulcers category 3	Safe	Patients	Director of Nursing	4.3	3	3	10	20	P	H
	Pressure Ulcers category 4	Safe	Patients	Director of Nursing	1.3	1	2	0	3	P	
	Venous Thromboembolism (VTE) Risk Assessment	Safe	Patients	Medical Director	95.00%	95.01%	94.88%	95.27%	95.27%	?	
	Never Events	Safe	Patients	Director of Nursing	0	0	0	2	2	P	H
	Reported medication incidents per 1000 occupied bed days	Safe	Patients	Medical Director	4.30	5.64	5.13	5.05	4.92	P	

Performance Overview - Quality

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	May-24	Jun-24	Jul-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%	7.40%	12.30%	9.50%	12.40%	F	
	Patient Safety Alerts responded to by agreed deadline	Safe	Patients	Medical Director	100.00%	100.00%	33.30%	None due	66.65%	F	
	Hospital Standardised Mortality Ratio - HSMR (basket of 56 diagnosis groups) (rolling year data 3 month time lag)	Effective	Patients	Medical Director	100	Not available	Not available	95.75	95.75	P	
	Summary Hospital Mortality Indicator (SHMI) (rolling year data 6 month time lag)	Effective	Patients	Medical Director	100	104.41	104.26	105.02	104.24	F	H
	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%	91.70%	90.80%	91.50%	91.48%	F	
	Sepsis screening (bundle) compliance for inpatients (adult)	Safe	Patients	Director of Nursing	90.00%	91.00%	90.00%	Data Not Available	91.00%	P	
	Sepsis screening (bundle) compliance for inpatients (child)	Safe	Patients	Director of Nursing	90.00%	84.00%	71.60%	Data Not Available	80.63%	F	
	IVAB within 1 hour for sepsis for inpatients (adult)	Safe	Patients	Director of Nursing	90.00%	96.00%	96.00%	Data Not Available	96.00%	P	
	IVAB within 1 hour for sepsis for inpatients (child)	Safe	Patients	Director of Nursing	90.00%	87.50%	63.60%	Data Not Available	83.70%	?	
	Sepsis screening (bundle) compliance in A&E (adult)	Safe	Patients	Director of Nursing	90.00%	91.00%	91.00%	Data Not Available	91.33%	P	

Performance Overview - Quality

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	May-24	Jun-24	Jul-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%	92.80%	93.40%	Data Not Available	92.29%	P	
	IVAB within 1 hour for sepsis in A&E (adult)	Safe	Patients	Director of Nursing	90.00%	95.00%	94.00%	Data Not Available	94.33%	P	
	IVAB within 1 hour for sepsis in A&E (child)	Safe	Patients	Director of Nursing	90.00%	100.00%	63.60%	Data Not Available	78.63%	F	
	Rate of stillbirth per 1000 births	Safe	Patients	Director of Nursing	3.80	2.93	2.69	2.70	2.82	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%	89.00%	Data Not Available	95.33%	F	
	Duty of Candour compliance - Written	Responsive	Patients	Medical Director	100.00%	100.00%	79.00%	Data Not Available	90.67%	F	

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Performance Overview - Quality

Pressure Ulcers category 3

Jul-24
10
Variance Type
Special cause variation - cause for concern (Indicator where high is a concern)
Target
4.3
Achievement
Variation indicates consistently passing the target
Executive Lead
Director of Nursing

Background:
Category 3
Pressure Ulcers

What the chart tells us:
The Trust recorded 10 Category 3 incidents against a target of 4.3 per month.

Issues:
The number of Category 3 incidents in July have increased by 7 from last month. None of these incidents were device related.
8 out of the 10 Category 3 incidents reported this month would previously be classified as Unstageable pressure ulcers.

Themes identified as areas of focus for improvement are:
• A number were an evolvement from Deep Tissue Injury
• Ensure effective offloading equipment is implemented in a timely way when there are limitations with repositioning.
Following National changes in pressure ulcer categorisation in April 2024, all ulcers previously categorised as Unstageable will now be classified as a minimum of Category 3 ulcers, and therefore an increase in Category 3 incidents is expected.

Actions:
All Category 3 incidents will be reviewed at the weekly Pressure Ulcer Support and Supervision Panel meeting
Tissue Viability and Quality Matron Team undertaking a detailed review of these incidents to identify any additional learning
August educational bulletin will promote the implementation of preventative equipment to offload vulnerable areas.

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

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Performance Overview - Quality

Venous Thromboembolism (VTE) Risk Assessment

Jul-24
95.27%
Variance Type
Common cause variation
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 is improving, and has reached target this month.

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.

Mitigations:

Performance Overview - Quality

Never Events

Jul-24
2
Variance Type
Special cause variation - cause for concern (Indicator where high is a concern)
Target
0
Achievement
Variation indicates consistently passing the target
Executive Lead
Director of Nursing

Background:	Issues:	Actions:	Mitigations:
SI's that have been defined by the NHS as wholly preventable where nationally available systemic barriers have been locally implemented. **What the chart tells us:** During the month there were 2 Never Events declared within the Surgery division.	There had been no Never Events declared in 2024/25 prior to this month.	No actions remain open relating to Never Events.	The Incident team continue to monitor open actions in liaison with the action owners and divisions.

Performance Overview - Quality

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

Jul-24
9.50%
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 July the number of medication incidents reported was 179. This equates to 5.05 incidents per 1000 bed days. The number of incidents causing some level of harm (low /moderate /severe / death) is 9.5% 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

Jul-24
None Due
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:
No Alerts were due to be responded to in July 2024, but previous deviances were seen in December 2023, March and June 2024.

Issues:
The Trust was previously not demonstrating compliance with the target set for Patient Safety Alerts. The performance was below the lower control limit, with non-compliance in December 2023, March and June 2024. There had been an improvement 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 is monitored on dashboards by Risk & Datix Team and Leads with overall responsibility for the alerts and escalated where appropriate.

CAS/FSN Alerts Oversight Group meetings held monthly.

Meetings held with appropriate Leads when new Alerts received to ensure actions are assigned to relevant Trust leads.

Mitigations:
Compliance is discussed monthly at Patient Safety Group, and a monthly escalation report highlights Alerts with upcoming deadlines for Leads to action.

A CAS/FSN Alerts Oversight Group has been implemented which convenes monthly 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.

OUTSTANDING CARE personally DELIVERED

Performance Overview - Quality

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

Jul-24
105.02
Variance Type
Special cause variation - cause for concern (Indicator where high is a concern)
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 and the data is being reviewed to understand the impact of these changes.

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.

The Performance and Governance teams are working collaboratively to review the target for SHMI and incorporate this into the SPC charts and reporting. This will ensure that the predicted SHMI based on patients comorbidities, which is modified and then provided at a National level on a monthly basis, is reflected as the considered target to achieve in our reporting going forward. We expect this to be in place within the next 2 months.

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

Month	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24

Legend: Data, Mean, Target, Control Limits

Jul-24
91.50%
Variance Type
Common cause variation
Target
95.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Medical Director

Background:	Issues:	Actions:	Mitigations:
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 91.50%.	Ownership of completion of the EDD remains an issue, including the timely completion. No Narrative owner	A dashboard is in place to highlight compliance at both ward and consultant level with each Division now reviewing this metric.	eDD should be considered by Divisions to include in PRM discussions.

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Performance Overview - Quality

Sepsis screening (bundle) compliance for inpatients (child)

Jun-24
71.60%
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 71.6%. This is below the 90% standard. 38 children out of 53 that had PEWS of 5 or above were screened for sepsis within 60 minutes.

Issues:
This month fifteen 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. The majority of these were for a score of 5. From discussions with medical staff they appear to not be aware when time zero starts.

Actions:
Emergency meeting held with family health team and there will be monthly meetings going forward. Data will be discussed at CYP Governance and Oversight meetings. Sepsis practitioner attending medical handovers to discuss. Training arranged with new cohort Drs. All Paediatric simulations have a Sepsis Focus. Figures will also be shared with all ward staff.

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 for inpatients (child)

Jun-24
63.60%
Variance Type
Common cause variation
Target
90.00%
Achievement
Variation indicates inconsistently passing and falling short of the target
Executive Lead
Director of Nursing

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

What the chart tells us:
The compliance or administration of IV antibiotics this month with one hour in inpatient areas was 63.6%. This is below the 90% required standard. 7 patients out of 11 received their antibiotics within one hour.

Issues:
There were four patients this month that had delayed administration of antibiotics. Themes for delays were initial diagnosis of virus and then deteriorated so treatment started or waiting for tests to be done One child was delayed by 2 days with increasing seizures, Drs have documented no signs of infection however patient already on oral antibiotics for UTI, had a positive urine and raised inflammatory markers.

Actions:
There has been Sepsis simulation training on both sites this month for both Medical and Nursing staff which will continue.As above intensive plan has been put into place to support and train staff. All Paediatric management team aware of audit results and will share with all staff

Mitigations:
Harm reviews completed and no harm found in 3 patients, low harm identified for patient that continued to have seizures. IR1 completed for this patient.

Performance Overview - Quality

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

Jun-24
63.60%
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 63.6%. 7 children out of 11 were treated with IV antibiotics within the 60 minute timeframe. This is well below the 90% required standard.

Issues:
There were four children this month within the ED departments with delayed Sepsis treatment. Although they were in the ED department 3 of the delays were due to delays by Paediatric teams and not ED staff. One child had seizure and was treated when he had a second seizure not first. Paediatric Drs requested that 2 patients were moved to the ward before they cannulated and started treatment. The fourth child was delayed as Paediatric Consultant wanted to do a lumbar puncture before treating despite being challenged by ED staff.

Actions:
Weekly Sepsis training is ongoing within the departments 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. The delays due to the Paediatric teams has been discussed at CYP governance and with medical staff.

Mitigations:
Harm reviews were completed for all four of the patients with delayed treatment and no harm was found. IR1 completed for child that waited for tests prior to treatment.

Performance Overview - Quality

Duty of Candour compliance - Verbal

Month	Data
Apr-23	
May-23	
Jun-23	
Jul-23	
Aug-23	
Sep-23	
Oct-23	
Nov-23	
Dec-23	
Jan-24	
Feb-24	
Mar-24	
Apr-24	
May-24	
Jun-24	

Chart axis: 100%, 80%, 60%, 40%. Legend: Data, Mean, Target, Control Limits

Jun-24
89.00%
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 declined this month.

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

Jun-24
79.00%
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 declined this month.

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 - Operational Performance

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	May-24	Jun-24	Jul-24	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Patient Experience	% Triage Data Not Recorded	Effective	Patients	Chief Operating Officer	0.00%	0.13%	0.28%	0.29%	0.26%	0.00%	F	
Improve Clinical Outcomes	4hrs or less in A&E Dept	Responsive	Services	Chief Operating Officer	75.30%	71.72%	72.71%	72.12%	72.74%	74.70%	F	
Improve Clinical Outcomes	12+ Trolley waits	Responsive	Services	Chief Operating Officer	0	1,103	1,059	993	3,848	0	F	
Improve Clinical Outcomes	%Triage Achieved under 15 mins	Responsive	Services	Chief Operating Officer	88.50%	84.37%	82.47%	81.50%	81.08%	88.50%	F	H
Improve Clinical Outcomes	52 Week Waiters	Responsive	Services	Chief Operating Officer	2,027	3,105	3,259		9,469	8,108	F	L
Improve Clinical Outcomes	65 Week Waiters	Responsive	Services	Chief Operating Officer	0	349	507		1,140	0	F	L
Improve Clinical Outcomes	18 week incompletes	Responsive	Services	Chief Operating Officer	84.10%	51.93%	52.11%		51.55%	84.10%	F	H
Improve Clinical Outcomes	Waiting List Size	Responsive	Services	Chief Operating Officer	58,965	71,082	71,375		N/A	N/A	F	L
Improve Clinical Outcomes	28 days faster diagnosis	Responsive	Services	Chief Operating Officer	75.00%	78.40%	81.50%		77.67%	75.00%	F	H
Improve Clinical Outcomes	62 day classic	Responsive	Services	Chief Operating Officer	85.39%	51.40%	66.20%		58.77%	85.39%	F	
Improve Clinical Outcomes	2 week wait suspect	Responsive	Services	Chief Operating Officer	93.00%	80.90%	77.50%		75.13%	93.00%	F	

Performance Overview - Operational Performance

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	May-24	Jun-24	Jul-24	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Clinical Outcomes	2 week wait breast symptomatic	Responsive	Services	Chief Operating Officer	93.00%	56.80%	68.50%		54.23%	93.00%	F	
	31 day first treatment	Responsive	Services	Chief Operating Officer	96.00%	88.50%	90.70%		88.43%	96.00%	F	
	31 day subsequent drug treatments	Responsive	Services	Chief Operating Officer	98.00%	86.10%	86.70%		88.10%	98.00%	F	L
	31 day subsequent surgery treatments	Responsive	Services	Chief Operating Officer	94.00%	58.80%	72.20%		66.53%	94.00%	F	
	31 day subsequent radiotherapy treatments	Responsive	Services	Chief Operating Officer	94.00%	87.00%	78.40%		83.53%	94.00%	F	
	62 day screening	Responsive	Services	Chief Operating Officer	90.00%	67.70%	78.60%		66.70%	90.00%	F	
	62 day consultant upgrade	Responsive	Services	Chief Operating Officer	85.00%	64.60%	79.40%		73.23%	85.00%	F	
	Diagnostics achieved	Responsive	Services	Chief Operating Officer	99.00%	72.46%	77.59%		73.56%	99.00%	F	
	Cancelled Operations on the day (non clinical)	Responsive	Services	Chief Operating Officer	0.80%	2.05%	1.63%	2.71%	1.94%	0.80%	F	
	Not treated within 28 days. (Breach)	Responsive	Services	Chief Operating Officer	0	16	26	41	120	0	F	
	#NOF 48 hrs	Responsive	Services	Chief Operating Officer	90.00%	62.03%	64.77%	78.69%	72.08%	90.00%	F	

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Performance Overview - Operational Performance

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	May-24	Jun-24	Jul-24	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Clinical Outcomes	#NOF 36 hrs	Responsive	Services	Chief Operating Officer	TBC	39.24%	36.36%	44.26%	44.42%			
	EMAS Conveyances to ULHT	Responsive	Services	Chief Operating Officer	4,657	4,924	4,667	4,774	4,748	4,657	F	
	EMAS Conveyances Delayed >59 mins	Responsive	Services	Chief Operating Officer	0	346	462	418	359	0	F	
	104+ Day Waiters	Responsive	Services	Chief Operating Officer	10	49	58	51	205	40	F	
	Average LoS - Elective (not including Daycase)	Effective	Services	Chief Operating Officer	2.80	3.22	2.35	2.63	2.67	2.80	P	
	Average LoS - Non Elective	Effective	Services	Chief Operating Officer	4.50	4.74	4.77	4.83	4.79	4.50	F	
	Delayed Transfers of Care	Effective	Services	Chief Operating Officer	3.50%	Submission suspended	Submission suspended	Submission suspended		3.50%		
	Partial Booking Waiting List	Effective	Services	Chief Operating Officer	4,524	31,278	30,977	32,149	31,182	4,524	F	H
	% discharged within 24hrs of PDD	Effective	Services	Chief Operating Officer	45.00%	36.92%	40.70%	39.23%	38.62%	45.00%	F	

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Performance Overview - Operational Performance

% Triage Data Not Recorded

Jul-24
0.29%
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:
July 24 reported a non-validated position of 0.29% of data not recorded versus the target of 0%. 80% of those without a triage recorded "did not wait" to be seen or diverted to UTC. Of those who did not wait to be seen they waited an average of 41 minutes

Issues:
- Identification of patients who left or refused treatment prior to triage, as well as patients who were transferred to another site for specialised 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

Jul-24
81.50%
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:
July outturn was 81.50% compared 82.47% in June (validated). This is a 7% negative variance to the target of 88.50% July's performance is a 9.17% improvement compared to 2023 of the same month.

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

Actions:
Most actions are repetitive but remain relevant.
Increased access to MTS2 training.
Increased registrant workforce to support 2 triage streams to be in place via Emergency Department recruitment campaign.
To move to a workforce model with Triage dedicated registrants and remove the dual role component.
The metric forms part of the Emergency Department safety indicators and is monitored/scrutinised at 4 x daily Capacity and Performance Meetings
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 4 x daily Capacity meetings.
Early escalation and rectification are also managed through the Emergency Department Teams Chat and Staffing Cell.
A twice daily staffing meeting 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

Chart axis: 64% to 82%; months May-23 to Jul-24. Legend: Data, Mean, Trajectory, Control Limits

Jul-24
72.12%
Variance Type
Common cause variation
Trajectory
75.30%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
The 24/25 target has been set at 78% with a rolling trajectory by month to achieve by year end.

What the chart tells us:
The 4-hour transit performance for Type 1/3 combined has not been met.
Achieving 72.12% a negative variance of 3.18%. Julys out turn is a 0.59% decline to June's performance. What the chart doesn't tell us is the increased acuity of presentations to the department.

Issues:
Type 1 (ED) saw an average of 323 patients daily, which was a decrease from the 329 patients seen in June 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 recognised 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 infections of COVID19 and CPE contacts, leading to an impact on timely movements.

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

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.

12+ Trolley waits

Jul-24
993
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:
July experienced 993 breaches, a decrease from 1059 in June, marking an improvement of 6.23% (66 less patients). The 993 breaches accounted for 9.80% of all type 1 attendances.
Additionally, the chart did not capture the adhoc internal decisions made to prioritise total time in the Emergency Department, aimed at minimising exposure risk and 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

Jul-24
4,774
Variance Type
Common cause variation
Target
4,657
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
EMAS Conveyances to ULHT

What the chart tells us:
In July 2024, the overall conveyance to ULHT exhibited a 8% surge in activity compared to the corresponding period in 2023. This equates to a minimum of 15 additional daily conveyances. Pilgrim site saw the highest increase with 249 additional conveyances compared to July 2023. (14.04%)

Issues:
The timing of patient arrivals results in a higher influx during late afternoon and evening hours, which corresponds with an increase in walk-in visits. Despite ongoing efforts, the utilisation of alternative pathways to divert patients from being admitted to the Trust remains incomplete, although progress is evident. The pressure experienced by neighbouring Trusts has led to an escalated demand for assistance, most of which has been turned down.

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:

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Performance Overview - Operational Performance

EMAS Conveyances Delayed >59 mins

Jul-24
418
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:
In July, there was a notable improvement in ambulance handover, with 418 arrivals recorded over a 59-minute period compared to June 462, constituting 8.76% of all arrivals. Julys figure represents a 9.52% decrease compared to June 24.

Issues:
It is important to note that the accompanying chart does not capture the heightened acuity of cases and extended group presentation times, which have led to challenges in promptly offloading patients into the department.
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 - Non Elective

Jul-24
4.83
Variance Type
Common cause variation
Target
4.50
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
July outturn of 4.83 is a decline of 0.06 days and a 0.33-day negative variance against the agreed target.
What the chart doesn't tell us is the change by pathway:
Pathway 0 (0.5) more days
Pathway 1 (1.1) less days
Pathway 2 (5.6) less days
Pathway 3 (0.1) less days

Issues:
The number of super-stranded patients has exhibited an increase in July from a daily average of 124 to 130. Similarly stranded (14days) has also increased from 208 to 214 daily.

Weekend Discharges remain consistently lower than weekdays,(49% reduction/ average 64 patients) which are required to meet Emergency Admission Capacity and Demand.
The Transfer of Care Hub continue to gain 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 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

Legend: Data, Mean, Trajectory, Control Limits

Y-axis: 2,000 – 8,000; X-axis: Apr-23 to Jun-24

Jun-24
3,259
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 3,259 incomplete 52-week breaches for June 2024, an increase of 154 from May's 3,105.

Issues:
As shown above, 52 week waiters are negatively performing against trajectory, increasing compared to last month's.
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 having 29.11% of patients in this wait band.

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 continuing for ENT patients.

Mitigations:
Due to an overall improved position, ULHT are no longer in the national tiering system for elective recovery.

Performance Overview - Operational Performance

65 Week Waiters

Jun-24
507
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 507 incomplete 65-week breaches for June 2024, an increase of 158 from May's 349.

Issues:
ULHT's 104 week wait position was zero for June. As shown above, 65 week waiters are starting to slowly increase.

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.

Performance Overview - Operational Performance

18 week incompletes

Jun-24
52.11%
Variance Type
Special cause variation - improvement (Indicator where high is good)
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. June 2024 saw RTT performance of 52.11% against an 84.1% target, which is 0.18% up from May.

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 – 6,535 (decreased by 134)
Gastroenterology – 2,936 (increased by 20)
Gynaecology – 2,552 (decreased by 84)
Ophthalmology – 2,533 (increased by 32)
Urology – 2,128 (increased by 22).

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

Jun-24
71,375
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 May, with June showing an increase of 293 to 71,375.
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 – 10,592
Ophthalmology – 6,625
Gastroenterology – 5,267
Gynaecology – 5,222
Dermatology – 4,429

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. An internal review of ENT pathways is being undertaken to standardise in line with GIRFT recommendations. Approval has been given to invest in 6wte substantive posts for a Trust internal validation team, commencing December 2024.

Mitigations:
The number of patients waiting over 78 weeks has shown a decrease of one from May.
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

Chart: Diagnostics achieved, Apr-23 to Jun-24. Legend: Data, Mean, Target, Control Limits. Y axis: 60% to 100%.

Jun-24
77.59%
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 June 2024 77.59% against the 99.00% target, amended target 85% by June 2024.

Issues:
- A decrease in month in performance
- 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.
- Ultrasound demand has risen by 20,000 FYE since the introduction of webV, contributing to delays. The last month's data was incorrect and under-reported the breaches.
- Power and equipment failures caused 4 weeks disruption in MRI and 5 days of CT causing the increase in breaches.

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 Additional staffing has been trained and DM)1 breaches have halved since May 2024, trajectory is on track .

Mitigations:
- Additional MRI CDC capacity from end of December 23 Skegness and LCH, 2nd inhouse scanner should be operational by September 2024, Skegness CDC mobile scanner funding and additional 5 days a Month from March 2024.

Performance Overview - Operational Performance

Cancelled Operations on the day (non clinical)

Month	Data
May-23	
Jun-23	
Jul-23	
Aug-23	
Sep-23	
Oct-23	
Nov-23	
Dec-23	
Jan-24	
Feb-24	
Mar-24	
Apr-24	
May-24	
Jun-24	
Jul-24	

Legend: Data, Mean, Target, Control Limits

Jul-24
2.71%
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 significant increase in the number of non-clinical cancellations in July to 2.71% compared to June's figure of 1.63% This remains significantly above the agreed target of 0.8%.

Issues:
-No Theatre Staff 42
-Lack of time 26
-No Surgeon 15
-No Equipment 12
-Theatre Closed 6
-Admission Moved Back 5
-More Urgent Case 5

Actions:
Look Back Meeting started Wednesday 12.6.24. Current focus is on GDH. Need to reinvigorate CBU engagement.
New Divisional Escalation Chat to aid prompt escalation and authorisation of cancellations. New Project Manager working with TACC DGM from 19.8.24 with a focus on Late Starts –to reduce cancellations due to Lack of Time.
Theatre Staffing Business Case.

Mitigations:
-Sickness was the underlying reason for the largest number of non-clinical cancellations.
There are no underlying themes to the staff sickness and it is being managed as per policy.
Very limited agency shift pick-up in July.

Performance Overview - Operational Performance

Not treated within 28 days. (Breach)

Jul-24
41
Variance Type
Common cause variation
Target
0
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
Breaches have increased in July to 41 compared to 26 in June.

Issues:
Staffing in the Waiting List Teams is a factor. However, this month patient choice has had a significant impact with patient's being offered dates that they cannot accept due to holidays or other plans.
Theatre Staffing resulting in list cancellations has led to patients being cancelled multiple times.

Actions:
Plans are in place to support cross-speciality cover for the Waiting List teams. There is a new Project Manager working with TACC and the Surgical Division. Waiting List and Theatres will form their portfolio.
Where possible, patients who have been cancelled previously, are now placed first on the list unless other patients take clinical priority.

Mitigations:
Sickness and staff shortages in the Waiting List Team remain a factor, but should improve now that recruitment has taken place.
Surgeons on annual leave and Theatre Staff sickness have reduced the number of lists available.
Patient choice is a significant factor over the summer period.

Performance Overview - Operational Performance

#NOF 48 hrs

Jul-24
78.69%
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 July was 78.69%.

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.
- 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
- Theatre capacity

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.
- Trauma coordinator team to ensure that femur fractures are listed on the trauma list before breaches.
- Daily Trauma huddles via MS teams with the trauma coordinators and the CBU to discuss extra theatre capacity on all sites
- Theatre-man to be accessed daily by the trauma coordinators to see what capacity is available.

Mitigations:
- Ensure trauma lists are fully optimised.
- Reduce 'on the day' change in order of the trauma list where clinically appropriate.
- Daily Trauma huddles via MS teams with the trauma coordinators and the CBU to discuss extra theatre capacity on all sites.
- CBU to review elective cases for clinical priority.

Actions continued:
- Trauma coordinators to identify suitable patients that could be operated on at Grantham and Louth.

Performance Overview - Operational Performance

Partial Booking Waiting List

Jul-24
32,149
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 32,149 against a target of 4,524. During Covid the number of patients overdue significantly increased and since then the trend has seen a steady increase of patients overdue their follow up appointment. The exception was Aug 23 – Nov 23 which saw a slight reduction each month.

Issues:
The organisation has several competing priorities. The current focus is on the long waiting patients (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 to improve attendance and focus. Discussions continue with CBU's regarding reducing F/ups by 25%. PIFU continues to be an area of focus for specialties. The 642 process currently being rolled out to improve capacity and vacant slots. Clinic Scheduler x 2 in post and digital room booking system in procurement to improve utilisation and maximise capacity.

Mitigations:
Booking team priorities are to support rebooking cancelled patients due to industrial action, the Personalised Outpatient Plan and the booking of the 65 week cohort.

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Performance Overview - Operational Performance

% discharged within 24hrs of PDD

Jul-24
39.23%
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 decline 39.23% in July from 40.70% in June.

Issues:
Previous guidance related to PDD has caused confusion upon wards re- amending timeframes. Some areas keep patients dates static of a PDD set at admission whereas others alter depending on patients clinical progress.
A PDSA has commenced with the Discharge Team/ SAFER practitioners in July to target specific areas and roll out new guidance and target trajectory.

Actions:
The delivery team has committed to providing support to the wards commencing in December, resulting in improved performance. Ongoing weekly monitoring is being conducted, and any identified areas of concern are being brought to the attention of ward sisters and matrons to ensure performance enhancement. In July, a new project will be launched in collaboration with the SAFER practitioners to address daily issues pertaining to wards with incomplete fields or patients who are due for discharge and those exceeding their target date.

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

Jun-24
81.50%
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 81.50% 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 Breast PAN Trust MDT's will be implemented from 12th August.
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 continues to be developed.
OP hysteroscopy and truclear capacity – additional scopes and job planning to introduce and maintain capacity is now in place. The first Urology Stakeholder session has taken place, a second is provisionally booked for September 2024.
UGI and HPB MDT streamlining conversations continue within the division, UGI MDT lead EOI has been sent to the clinical team.

Performance Overview - Operational Performance

62 day classic

Jun-24
66.20%
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 66.20% 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 and posts are out to advert.
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 starting from July.

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.

Actions continued:
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.

Performance Overview - Operational Performance

2 week wait suspect

Jun-24
77.50%
Variance Type
Common cause variation
Target
93.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 77.50% 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 15% of the Trust's breaches occurring within that specific tumour site. Additionally, Skin tumour site accounted for 72% of the Trust's 14-day breaches, this is expected to improve for June performance.

Actions continued

Processes – SOPs relating to DNAs & multiple cancellations are currently being taken through CBU Governance processes for approval.

Please also see Actions on accompanying pages.

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.
UGI Triage CNS has been recruited to and due to start September 2024 ICB EACH are continuing to support with 2ww referrals to reduce delays from receipt of referral to STT booking.

Mitigations:
Haematology is in fragile services due to vacancy/capacity. Issues with inappropriate referrals and GP engagement continue to be escalated and supported by the ICB and Cancer Navigators will be able to streamline this process. 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.

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Performance Overview - Operational Performance

2 week wait breast symptomatic

Chart legend: Data, Mean, Target, Control Limits

Y axis: 0%, 20%, 40%, 60%, 80%, 100%

X axis: Apr-23, May-23, Jun-23, Jul-23, Aug-23, Sep-23, Oct-23, Nov-23, Dec-23, Jan-24, Feb-24, Mar-24, Apr-24, May-24, Jun-24

Jun-24
68.50%
Variance Type
Common cause variation
Target
93.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 68.50% against a 93% target.

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

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

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

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

Performance Overview - Operational Performance

31 day first treatment

Chart: 31 day first treatment, Apr-23 to Jun-24 (y-axis 80%–100%). Legend: Data, Mean, Target, Control Limits.

Jun-24
90.70%
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 90.70% 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

31 day subsequent drug treatments

Jun-24
86.70%
Variance Type
Special cause variation - cause for concern (Indicator where low is a concern)
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 86.70% 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 ensure shared access to information to ensure breach reasons are recorded accurately.

Mitigations:

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Performance Overview - Operational Performance

31 day subsequent surgery treatments

Jun-24
72.20%
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 surgery.

What the chart tells us:
We are currently at 72.20% 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

Jun-24
78.40%
Variance Type
Common cause variation
Target
94.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 78.40% 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:

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Performance Overview - Operational Performance

62 day screening

Jun-24
78.60%
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 78.60% 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 is ongoing and posts are out to advert.
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 starting from July.

Please also see Actions on accompanying pages.

Mitigations:
Please also see Mitigations on accompanying pages.

Performance Overview - Operational Performance

62 day consultant upgrade

Jun-24
79.40%
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 79.40% against an 85% target.

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

Actions:
Oncology Fragile Service – A piece of work on right-sizing the Oncology service workforce is ongoing and posts are out to advert.
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 starting from July.

Please also see Actions on accompanying pages.

Mitigations:
Please also see Mitigations on accompanying pages.

Performance Overview - Operational Performance

104+ Day Waiters

Jul-24
51
Variance Type
Common cause variation
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 7th August the 104 Day backlog is at 51 patients.
There is one main tumour site of concern:-

Colorectal 13
Head and Neck 13

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 25.4% of these patients require support from the Pre-Diagnosis CNS as they have mental or social care needs that have the potential to significantly impact on the length of their pathway.

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

Please also see Actions on accompanying pages.

Mitigations:
Please also see Mitigations on accompanying pages.

Performance Overview - Workforce

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	May-24	Jun-24	Jul-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%	93.67%	93.42%	93.71%	93.63%	90.00%	P	H
	Number of Vacancies	Well-Led	People	Director of HR & OD	7.71%	5.70%	5.33%	8.51%	6.43%	8.91%	?	
	Sickness Absence	Well-Led	People	Director of HR & OD	5.47%	5.39%	5.41%	5.42%	5.40%	5.50%	P	L
	Staff Turnover	Well-Led	People	Director of HR & OD	11.48%	10.09%	9.98%	10.00%	10.09%	12.41%	P	L
	Staff Appraisals	Well-Led	People	Director of HR & OD	81.18%	75.89%	76.18%	77.58%	76.33%	77.88%	F	H

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OUTSTANDING CARE personally DELIVERED

Performance Overview - Workforce

Number of Vacancies

Jul-24
8.51%
Variance Type
Common cause variation
Trajectory
7.71%
Achievement
Variation indicates inconsistently passing and falling short of the target
Executive Lead
Director of HR & OD

Background:
July 2024 reported Vacancy Rate is 8.51% against a Q2 target of 7.71.

What the chart tells us:
That we are not within the Q2 target for July 2024, although we are within our control limits.

Issues:
• The increase in vacancy rate is due to the budgets being finalised and translating into reporting.

• AHP recruitment remains an area of focus 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.

• We have been successful with a further expressions of interest for additional NHSE funding in 2024/25 for International Recruits within our AHP staff who are supporting the roll out of our Community Diagnostic Centres across Lincolnshire.

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

OUTSTANDING CARE personally DELIVERED

Performance Overview - Workforce

Staff Appraisals

Jul-24
77.58%
Variance Type
Special cause variation - improvement (Indicator where high is good)
Trajectory
81.18%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of HR & OD

Background:
Completion is currently 77.58% for AfC staff, 94.07% for Medical & Dental and 79.31% for 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.
- Contacting staff and team managers who are <50.00% for compliance.

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

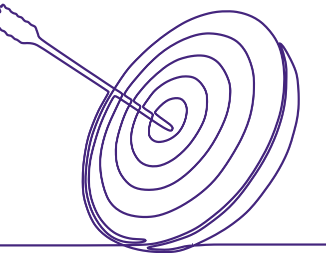
Financial Position 2024/25

Finance Report M04

5 Year Priority – Efficient Use of Resources

Financial Position 2024/25

M04 Headlines - ULHT



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	63,701	63,052	(649)	250,477	250,695	218
Other operating Income	3,567	3,711	144	14,598	14,996	398
Employee Expenses	(43,542)	(46,737)	(3,195)	(180,564)	(186,196)	(5,632)
Operating expenses excl employee expenses	(23,921)	(22,932)	989	(92,896)	(92,523)	373
Operating Surplus/(Deficit)	**(195)**	**(2,906)**	**(2,711)**	**(8,385)**	**(13,028)**	**(4,643)**
Net finance costs	(866)	(716)	150	(3,068)	(2,849)	219
Other gains/(losses) including disposal of assets	0	5	5	12	20	8
Surplus / (Deficit) for the period	**(1,061)**	**(3,617)**	**(2,556)**	**(11,441)**	**(15,857)**	**(4,416)**
Remove capital donations/grants/peppercorn lease I&E impact	45	81	36	258	315	57
Remove PFI revenue costs on an IFRS 16 basis	118	117	(1)	470	469	(1)
Adjusted financial performance surplus/(deficit)	(898)	(3,419)	(2,521)	(10,713)	(15,073)	(4,360)

2024/25 Plan

- The Trust's 2024/25 financial plan is a deficit of £6.9m; the Trust's planned deficit is part of a break-even plan submitted by the Lincolnshire ICS.
- Post completion of the month 2 financial position, the Trust was required to submit a revised financial plan.
- While the Trust's planned level of deficit did not change, the submission included a revised phasing which brought the YTD plan at month 2 in line with actual spend and phased the £3.1m adverse variance reported at month 2 over future months.
- The month 4 financial position is reported against the revised plan phasing.

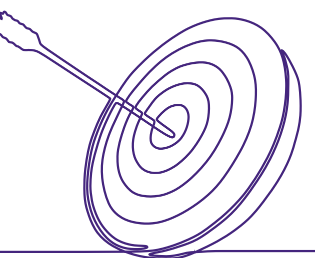
Revenue position - The above table shows that the Trust's YTD position is a £15.1m deficit i.e., £4.4m adverse to the planned £10.7m YTD deficit. The drivers of the movement from plan are analysed in the following slide; this shows that £(0.5)m relates to the additional costs of Industrial Action in June and July, £(0.6)m relates to the recognition of the risk that the YTD under spend on national EPR funding will be withdrawn, £(1.5)m relates to risks maturing which were outside of the plan, & the balance of the movement to plan can be attributed to investments with no funding yet agreed.

CIP position - The Trust's CIP plan for 2024/25 is to deliver savings of £40.1m; the Trust YTD has delivered savings of £8.5m, or £2.2m higher than planned savings of £6.3m.

- **Capital position** - The Trust's capital plan for 2024/25 is c£80m; the Trust YTD delivered capital expenditure of £13.5m, or £3.0m lower than planned capital expenditure of £16.5m.

Financial Position 2024/25

Key areas of focus - Income



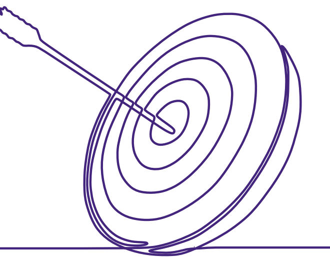
	Year to Date		
	Plan £000's	Actual £000's	Variance £000's
NHSE & ICB Total	249,268	249,798	530
Non-NHS: private patients	62	60	(2)
Non-NHS: overseas patients (non-reciprocal, chargeable to patient)	236	184	(52)
Injury cost recovery scheme	335	346	11
Other Patient Care Activities Income	576	307	(269)
Sub-total - Operating income from patient care activities	**250,477**	**250,695**	**218**
Education & Training	8,133	8,377	244
Non-patient care services	1,677	1,641	(36)
Income in respect of employee benefits accounted on a gross basis	1,866	1,529	(337)
Car parking income	371	395	24
Catering income	996	985	(11)
Research and development	454	543	89
Rental revenue from operating leases	425	454	29
Other Income	676	1,072	396
Sub-total - Other Operating Income	**14,598**	**14,996**	**398**
Total - Income	265,075	265,691	616

- **Operating Income from Patient Care Activities**
  The YTD Patient Care Activities income position is £0.2m favourable to plan; this includes over £0.7m over performance in relation to ERF gain share (CIP) and recognition of £(0.6)m of risk that the YTD under spend on national EPR funding will be withdrawn. Discussions about funding for other investments are ongoing [including several investments for which the Trust already has costs in the run-rate].

- **Other Operating Income**
  The YTD Other Operating income position is £0.4m favourable to plan; while there is some minor variation to plan across several categories, this includes amendments to coding of income.

Financial Position 2024/25

Key areas of focus - Pay



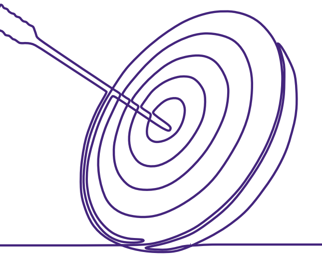
	Current Month			Year to Date		
	Plan £000's	Actual £000's	Variance £000's	Plan £000's	Actual £000's	Variance £000's
Substantive staff including on-costs	(35,253)	(38,135)	(2,882)	(148,325)	(151,565)	(3,240)
Bank staff including on-costs	(5,191)	(5,567)	(376)	(22,124)	(23,224)	(1,100)
Agency / contract	(2,056)	(2,623)	(567)	(8,658)	(9,910)	(1,252)
Other	(353)	(381)	(28)	(1,457)	(1,497)	(40)
Total - Employee Expenses	(42,853)	(46,706)	(3,853)	(180,564)	(186,196)	(5,632)

- While several contract variations have been signed since M3, reducing the gap reported at M3 in relation to pay, the YTD pay position is £5.6m adverse to plan.
- The adverse movement includes £(0.1)m re prior year consultant pay arrears paid in July to correct an underpayment because of a national issue with ESR not recognising incremental dates, £(0.3)m re the additional pay cost of Industrial Action in June and July, £0.5m re incremental drift (which the system decided to keep outside of the plan), and several investments agreed by the system but where funding has yet to be identified.

- **Total Pay** - Expenditure of £46.7m in July is £0.1m higher than expenditure of £46.6m in June.
- 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.
- **Substantive Pay** – Substantive pay spend of £38.1m in July is £0.3m higher than spend of £37.8m in June reflecting the fact that contracted numbers continue to grow without an equivalent offset in Bank & Agency expenditure.
- **Agency Pay** – Agency pay spend of £2.4m in July is unchanged compared to spend of £2.4m in June.
- **Bank Pay** – Bank pay spend of £5.9m in July is £0.3m lower than spend of £6.1m in June; this decrease reflects a reduced impact in relation to industrial action.

Financial Position 2024/25

Key areas of focus – Non-Pay



	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	(2,710)	(2,228)	482	(9,738)	(8,893)	845
Other operating expenses	(21,211)	(20,705)	506	(83,158)	(83,630)	(472)
Total - Operating expenses excl employee expenses	(23,921)	(22,932)	989	(92,896)	(92,523)	373

- Several contract variations have been signed since M3, reducing the gap reported at M3 in relation to non-pay, such that the YTD non-pay position is £0.4m favourable to plan.
- The YTD non-pay position includes excess inflation as well as early delivery of CIP, and some investments which have been agreed by the system but where funding has yet to be identified.

- Total Non-Pay - Spend of £22.9m in July is £1.0m favourable to plan & £0.4m lower than spend of £23.3m in June.
- The YTD non-pay position includes:

❖ **Depreciation & Amortisation - £0.8m favourable to plan.**
Any under spend YTD should not be expected to continue.

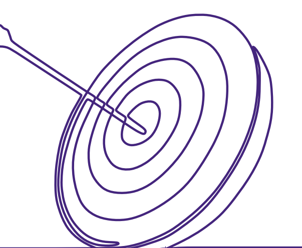
❖ **Excess inflation – £(0.9)m adverse to plan**
While the 2024/25 financial plan includes non-pay inflation as per national planning guidance, the actual level of inflation suffered was expected to be higher than planned; our estimate of excess non-pay inflation suffered YTD of £0.9m is still subject to validation and the true figure may be higher as we receive actual invoices.

❖ **CIP – £1.6m favourable to plan**
The Trust has planned to deliver £15.2m of Non-Pay CIP savings in 2024/25 of which £1.8m was planned YTD and £2.4m was delivered; the planned level of CIP savings delivery increases significantly going forward as therefore does the financial impact of under delivery.

❖ **Other – £(1.2)m adverse to plan**
This includes the impact of unfunded investment and increased activity.

Financial Position 2024/25

Key areas of focus – Cash & BPPC



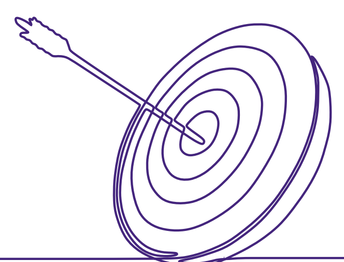
Cash

- The July 2024 cash balance is £31.3m (plan: £11.9m); this is a decrease of £19.6m against the March year-end cash balance of £50.9m.
- Cash balances have increased in July by £13m. This due to a variety of factors including cash support from LICB, drawdown of PDC associated with the capital programme and reduced volume / value of payments being processed in July.
- Whilst LICB have provided short term cash support in Q2, it is anticipated that a Drawdown of revenue PDC (cash) will be required during Q3 to enable the Trust to continue paying suppliers in line with the BPPC target.

BPPC

- The BPPC performance for July was 96% / 92% 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 July there were circa 1,000 unpaid invoices (£2.1m) over term (June 800 / £2.2m). 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. Appendix 5f provides further analysis.

Finance Dashboard



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

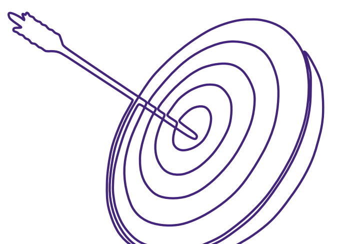
Metric	Rating Boundary			
	1	2	3	4
Capital servicing capacity	2.5	1.75	1.25	<1.25
Liquidity ratio (days)	0	-7	-14	<-14
I&E Margin	1%	0%	-1%	<=-1
I&E margin distance from plan	0%	-1%	-2%	<=-2%
Agency	0%	25%	50%	>=50%

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	Jul-24	Mar-25
Capital service cover metric	(10.40)	(1.73)	0.06	3.60	1.48	1.19	(0.74)	2.68
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)	(24.16)	(18.33)
Liquidity rating	4	4	1	1	3	4	4	4
I&E margin metric	(19.71%)	(7.62%)	0.38%	0.29%	(1.80%)	(2.63%)	(5.85%)	(0.86%)
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%	(1.76%)	(0.86%)
I&E margin: distance from financial plan - rating	4	1	n/a	1	3	1	3	2

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

Balance Sheet



	31-Mar-24	31-Jul-24			31-Mar-25	
		Plan	Actual	Variance	Plan	Forecast
	£000	£000	£000	£000	£000	£000
Intangible assets	10,924	9,437	9,486	(49)	6,071	6,093
Property, plant and equipment	333,031	342,084	339,846	2,238	384,843	384,933
Right of use assets	13,956	13,238	13,234	4	13,741	13,603
Receivables	2,022	2,038	2,045	(7)	2,038	2,038
Total non-current assets	**359,933**	**366,797**	**364,611**	**2,186**	**406,693**	**406,667**
Inventories	6,581	6,910	6,681	229	6,910	6,500
Receivables	19,781	31,562	24,955	6,607	31,562	29,640
Cash and cash equivalents	50,858	11,853	31,306	(19,453)	25,308	32,219
Total current assets	**77,220**	**50,325**	**62,942**	**(12,617)**	**63,780**	**68,359**
Trade and other payables	(95,425)	(68,492)	(83,995)	15,503	(75,518)	(89,948)
Borrowings	(3,167)	(3,167)	(3,175)	8	(3,167)	(3,167)
Provisions	(12,154)	(11,271)	(8,730)	(2,541)	(2,734)	(2,196)
Other liabilities	(1,195)	(10,334)	(13,785)	3,451	(6,734)	(6,734)
Total current liabilities	**(111,941)**	**(93,264)**	**(109,685)**	**16,421**	**(88,153)**	**(102,045)**
Total assets less current liabilities	**325,212**	**323,858**	**317,868**	**5,990**	**382,320**	**372,981**
Borrowings	(13,557)	(12,502)	(12,537)	35	(12,619)	(12,619)
Provisions	(5,271)	(5,409)	(5,428)	19	(5,583)	(5,270)
Other liabilities	(10,566)	(10,398)	(10,398)	-	(10,063)	(10,063)
Total non-current liabilities	**(29,394)**	**(28,309)**	**(28,363)**	**54**	**(28,265)**	**(27,952)**
Total assets employed	**295,818**	**295,549**	**289,505**	**6,044**	**354,055**	**345,029**
Financed by						
Public dividend capital	756,760	767,905	766,303	1,602	823,858	814,970
Revaluation reserve	48,454	48,054	48,051	3	47,249	47,246
Other reserves	190	190	190	-	190	190
Income and expenditure reserve	(509,586)	(520,600)	(525,040)	4,440	(517,242)	(517,377)
Total taxpayers' equity	**295,818**	**295,549**	**289,504**	**6,045**	**354,055**	**345,029**

Note 1: The plan presented reflects the June resubmission of the 2024/25 financial plan

Note 2: As at 31 July the balance sheet is broadly in line with plan. The only notable exceptions being:
- Cash which is higher than planned, offset in the main by payables. The July increase in payables being down to the final July payment run being 'early' in the month.

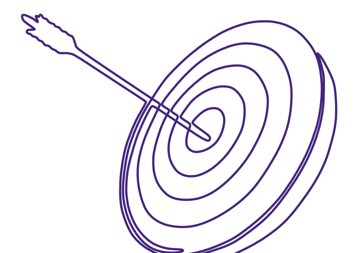
Note 3: The 2024/25 capital programme is the largest undertaken by the Trust at £82.8m. Depreciation is similarly significantly increased on recent years. The net impact is that Property, Plant, Equipment & Intangibles are expected to increase by £47m in year.

Note 4: Receivables is predominantly a mix of invoiced debt £4.0m, accrued income £6.9m, VAT £1.5m and prepayments £13.1m, offset in part by bad debt provisions of £1.3m.
See Appendix 5a-b

Note 5: The overall level of Trade and other payables has reduced to £84.0m including capital creditors of £12.5m. BPPC and aged creditor performance is reported at Appendix 5c-f.

Note 6: The level of provisions have reduced in month with payment of Bank Annual Leave arrears and release of specific litigation provisions. Provisions are anticipated to reduce further through 2024/25 as the remaining 'Flowers,' and Litigation issues are reviewed and resolved.

Cashflow reconciliation – April 2024– March 2025



	31-Mar-24	31-Jul-24			31-Mar-25	
		Plan	Actual	Variance	Plan	Forecast
	£000	£000	£000	£000	£000	£000
Operating surplus / (deficit)	(20,954)	(8,385)	(13,028)	4,643	1,021	661
Depreciation and amortisation	25,768	9,738	8,892	846	36,123	36,123
Impairments and reversals	6,580	-	-	-	-	-
Income recognised in respect of capital donations	(114)	-	(8)	8	(50)	(50)
Amortisation of PFI deferred credit	(503)	(168)	(168)	-	(503)	(503)
(Increase) / decrease in receivables and other assets	33,556	(11,797)	(5,205)	(6,592)	(11,797)	(9,917)
(Increase) / decrease in inventories	(448)	(329)	(100)	(229)	(329)	81
Increase/(decrease) in trade and other payables	358	(12,502)	(337)	(12,165)	(10,543)	(3,653)
Increase/(decrease) in other liabilities	(65)	9,139	12,590	(3,451)	5,539	5,539
Increase / (decrease) in provisions	(5,390)	(797)	(3,319)	2,522	(9,160)	(10,011)
Net cash flows from / (used in) operating activities	**38,784**	**(15,101)**	**(683)**	**(14,418)**	**10,301**	**18,270**
Interest received	2,551	703	810	(107)	1,206	1,248
Purchase of intangible assets	(7,132)	-	-	-	-	(50)
Purchase of property, plant and equipment	(44,652)	(34,485)	(28,282)	(6,203)	(90,032)	(82,603)
equipment	59	17	26	(9)	17	77
Net cash flows from / (used in) investing activities	**(49,227)**	**(33,765)**	**(27,446)**	**(6,319)**	**(88,809)**	**(81,328)**
Public dividend capital received	32,718	11,145	9,542	1,603	67,098	58,209
Other loans repaid	(805)	(403)	(403)	-	(805)	(805)
Capital element of finance lease rental payments	(2,393)	(810)	(488)	(322)	(2,475)	(2,475)
Interest element of finance lease	(142)	(71)	(71)	-	(252)	(252)
PDC dividend (paid)/refunded	(9,328)	-	-	-	(10,603)	(10,251)
Cash flows from (used in) other financing activities	(9)	-	(3)	3	(5)	(7)
Net cash flows from / (used in) financing activities	**20,032**	**9,861**	**8,577**	**1,284**	**52,958**	**44,419**
Increase / (decrease) in cash and cash equivalents	**9,589**	**(39,005)**	**(19,552)**	**(19,453)**	**(25,550)**	**(18,639)**
Cash and cash equivalents at 1 April - b'f	**41,269**	**50,858**	**50,858**	**(0)**	**50,858**	**50,858**
Cash and cash equivalents at period end	**50,858**	**11,853**	**31,306**	**(19,453)**	**25,308**	**32,219**

Note 1: Cash held at 31 July was £31.3m against a plan of £11.9m. This represents a decrease of £19.6m against the March year-end cash balance of £50.9m and an increase from June of £20.4m.

Note 2: The July cash increase is principally due to:
- Timing, with one fewer payment run in month - £22m in payments being made against a monthly average of £28m over the first 4 months.
- Short term cash support provided by LICB of £5.8m, shown as deferred income (other liabilities within the balance sheet).
- Drawdown of £9.5m PDC in relation to the capital programme.

Note 3: The capital programme for 2024/25 is funded through a mix of internally generated resource £33.5m and external PDC £49.2m. This will be drawn down in line with capital spend.

Note 4 The Trust received short term cash support from LICB in July. External support will be required in Q3 as the temporary support 'unwinds'. Support is required to fund the cash impact of:
- The planned deficit of £6.9m plus any excess beyond plan.
- Release / utilisation of provisions associated with litigation and contractual obligations – circa £8m.
- Reduction in capital creditors

Note 5: Appendix 8 maps movements in cash, borrowings and net current assets from March 2022.

Report to the Lincolnshire Community and Hospitals Group Board Meeting

Date of meeting	3rd September 2024	Agenda item	13
Title	LCHS Integrated Performance Report (May 2024 performance)		
Report of	Sam Wilde, Director of Finance and Business Intelligence	Prepared by	James Hickson, Business Support Technician
Previously considered by / Date	Quality Committee 20th August 2024 FPPIC 23rd August 2024	Approved?	N/A

Summary

Performance up until the end of July is set out in the report. The Quality Committee and Finance, Performance, People, and Innovation Committee reviewed July performance in their August 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	
	Inconsistently Capable	4	12	4
	Not Capable		1	1
	No Target	2	16	3

Great care, close to home

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

(i) Average Length of Stay
This process operates between control limits of 16.5 days and 17.7 days, slightly above the 16-day target. There is clear evidence that having either discharge coordinators (or a discharge team across Community Hospitals) and/or 7-day therapy would both reduce length of stay.

(ii) Home Visiting Compliancy
The service continues to develop in a way that is supportive of the patient need; with the staff consultation over shift times currently under way and a plan to implement the unplanned catheter care workstream on 2nd September.

8 indicators are showing special cause deterioration currently:

(i) CAS Activity
CAS activity has dropped significantly since April due to the changes in the DHU 111 contract (with DHU now completing ED validations and interim dispositions). There has been a loss of approximately 100 calls per day. Other options have been implemented to increase referrals into the service. A paper was presented at TLT on 27th June on the wider impact of the new contract on both the system and around patient experience and outcomes. Datix are also being monitored closely to monitor patient safety as a result of the change. These datix have increased in volume and are being reported back to the ICB. A risk around UTCs across the county having seen an increase in referrals in line with this call volume is emerging 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.

(ii) Out of Hours and CAS Cases Closed
Ongoing discussions ae being held to explore the value of this metric continuing to be included within IPR reporting. Volumes have reduced following the closure of the Grantham OOH service as part of the ASR review. Changes to the DHU 111 contract from April 2024 have also resulted in reduced call volume to CAS and a decrease in booked appointments.

(iii) Urgent Community Response: 2 Hour Response Compliance
July is the service's first full month of utilising the new clinical triage tool and staff have provided feedback that it has made completing the triage lengthier. The service has also been impacted by acute and long-term sickness. Record numbers of referrals to the service were seen in July with over 300 in total and 23 on one day on 12th July.

(iv) Ops Centre Calls: Answered in Timescale; and
(v) Ops Centre Calls: Abandoned
July saw record volumes of contacts into the Ops Centre, with 16,338 calls and 7,200 emails. The Ops Centre continues to experience sustained staffing shortfalls, with vacancies, long term and acute sickness within the Service Advisor resource pool as well as being down two Band 6 Team Managers. Low staff morale and sustained demand continue to impact on our ability to cover shortfalls through bank and overtime. The team successfully recruited to three of the Service Advisor vacancies that were approved, and they start early September.

(vi) Average length of stay
Average length of stay has been above the 17.1 day average but still within the 17.7 upper control limit for the past 9-months. Options to improve length of stay further include the introduction of discharge coordinators/discharge team and/or a move to 7-day therapy provision.

<table>
<tr><td rowspan="1"></td><td colspan="2">

(vii) Community Hospital Injurious Falls per 1000 OBDs
The injurious fall rate per 1,000 Occupied Bed Days is generally 0 but has exceeded the upper control limit in each of the last two months. Performance does remain significantly better than the national benchmark. The rate of overall falls (injurious and non-injurious) in community hospitals is not showing significant variation at present and remains below both target and national benchmark. Following consideration of a patient fall at Butterfly Hospice a multi-disciplinary review will be undertaken to ascertain the learning and improvement opportunities across multiple stakeholders.

(viii) Total Medication Incidents
There is an emerging theme around administration of time critical medication. To mitigate this, the in-house medicines management pharmacy team supported the community hospitals and the contracted pharmacy service provider to develop and implement processes to ensure that time critical medications are administered within a defined time frame. Work has commenced to strengthen the guidance within the medicines policy and introducing fit for purpose audits within community hospitals that will track practice. Clinical staff have been encouraged to complete a datix whenever time critical medications are administered outside the defined time frame. This has led to a significant increase in the number of incidents reported in June & July when compared to previous months.

7 indicators are currently showing special cause improvement, which is a strong indication of our continuous improvement culture:

(i) GU Patients seen within 2 working days;
(ii) Sickness Absence;
(iii) Agency Expenditure;
(iv) Long Term Sickness;
(v) Friends & Family Test;
(vi) UTC 15 Minute Assessment; and
(vii) Transitional Care Activity</td></tr>
<tr><td rowspan="4">**1. To deliver high quality, safe and responsive patient services**</td><td>**1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population**</td><td>X</td></tr>
<tr><td>**1b. Improve patient experience**</td><td>X</td></tr>
<tr><td>**1c. Improve clinical outcomes**</td><td>X</td></tr>
<tr><td>**1d. Deliver clinically led integrated services**</td><td></td></tr>
<tr><td rowspan="2">**2. To enable our people to lead, work differently, be inclusive, motivated and proud to work within LCHG**</td><td>**2a. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise**</td><td></td></tr>
<tr><td>**2b. To be the employer of choice**</td><td></td></tr>
<tr><td rowspan="4">**3. To ensure services are sustainable, supported by technology and delivered from an improved estate**</td><td>**3a. Deliver financially sustainable healthcare, making the best use of resources**</td><td>X</td></tr>
<tr><td>**3b. Drive better decision and impactful action through insight**</td><td>X</td></tr>
<tr><td>**3c. A modern, clean and fit for purpose environment across the Group**</td><td>X</td></tr>
<tr><td>**3d. Reduce waits for patients who require urgent and emergency care and diagnostics and ensure we meet all constitutional standards**</td><td>X</td></tr>
</table>

	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	N/A Assurance Report				
CQC	**Safe**	**Caring**	**Effective**	**Responsive**	**Well-Led**
Links to risks	N/A				
Legal/ Regulation	*N/A*				

Recommendations/ Actions Required

Board is asked to note the content of the report

Appendices

Appendix 1 – LCHS Integrated Performance Report on July 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
OBD – Occupied Bed Day
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

INTEGRATED PERFORMANCE REPORT

July 2024 Performance Data

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SPC SCORECARD

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

Executive Summary

Safe

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

✓ Community Hospital Falls per 1000 OBD is within target.

✓ MRSA compliance achieving target.

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

Caring

X FFT scores not achieving 95% target.

X Complaints rate per 1000 WTE is above target.

Responsive

X Performance against the UTC 4-hour wait target is not achieving 95%.

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 Urgent Community Response is not achieving the 97% target for 2-hour response compliance.

X Ops Centre Calls Answered in Timescale is not achieving 90% target.

X Ops Centre Calls Abandoned is not achieving 8% target.

X Discharge Summaries – Community Hospitals, not achieving target.

✓ Discharge Summaries – Urgent Treatment Centres achieving target.

Effective

✓ 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 within target range at 89.59%.

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

Well-Led

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

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

✓Staff Turnover is within the 15% target.

✓ Year to date agency expenditure is within plan.

✓ Month 4 Trust's YTD deficit is a £125k favourable variance to plan.

X Overall efficiency (CIP) slightly behind plan.

X Cash balances are £21.5M, which is worse than plan. We expect to recover to target over the next 3-months with a £3.8m catch-up receipt expected in August.

X Better Payment Practice Code (by volume) is not achieving the 95% target (although we are achieving target when measured by value).

✓ Capital expenditure is ahead of plan.

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

✓ Training Compliance is achieving the 90% target.

✓ Total Sickness Absence is achieving the 5% target.

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

Medicine-related Incidents

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

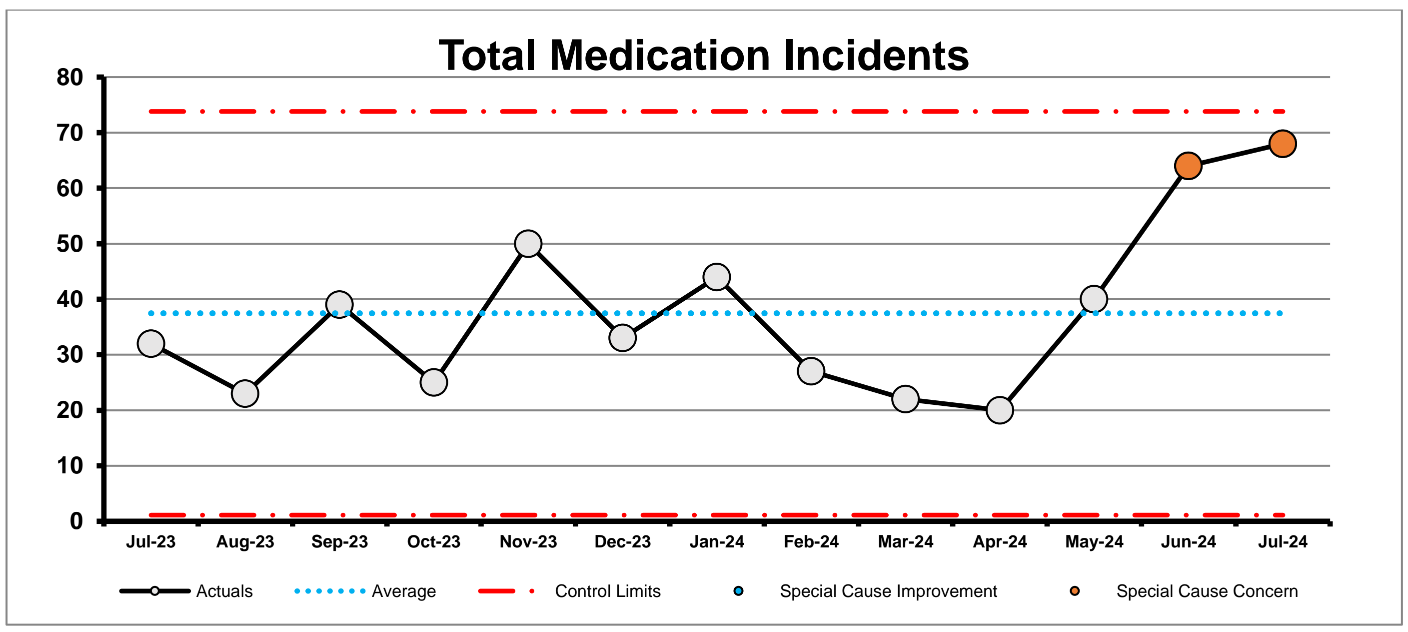
A medicine-related incident can pose a threat to the patient as well as the organisation. The member of staff who made the error can also be affected. Broadly speaking, medicine-related incidents encompass prescribing, preparation, dispensing, administration, and monitoring.

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

Benchmark / target

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

Current Performance



Narrative

In LCHS, Co-operative pharmacy is the contracted pharmacy service provider to our community hospitals. There is an emerging theme around administration of time critical medication. To mitigate this, the in-house medicines management pharmacy team supported the community hospitals and the contracted pharmacy service provider to develop and implement processes to ensure that time critical medications are administered within a defined time frame. Work has commenced to strengthen the guidance within the medicines policy and introducing fit for purpose audits within community hospitals that will track practice. Clinical staff have been encouraged to complete a datix whenever time critical medications are administered outside the defined time frame. This has led to a significant increase in the number of incidents reported in June & July when compared to previous months. Administration of time Critical medicine incidents will continue to be tracked to ensure that improvement is embedded & sustained. Examples of time critical medicines include antiparkinsons, psychotropics, blood thinners such as warfarin and antiepileptics.

The inhouse pharmacy team has worked closely with the effective practice facilitator to ensure that time critical medicines are covered in the medicines management training.

LCHS have employed an Associate Chief Pharmacist who is also the trusts medicines safety officer. Part of this role entails improving the reporting and learning from medication incidents. He has been attending various steering groups reiterating and reinforcing the importance of encouraging staff to report medicines related incidents. He also supports teams with action plans ensuring that learning is cascaded and used to improve practice.

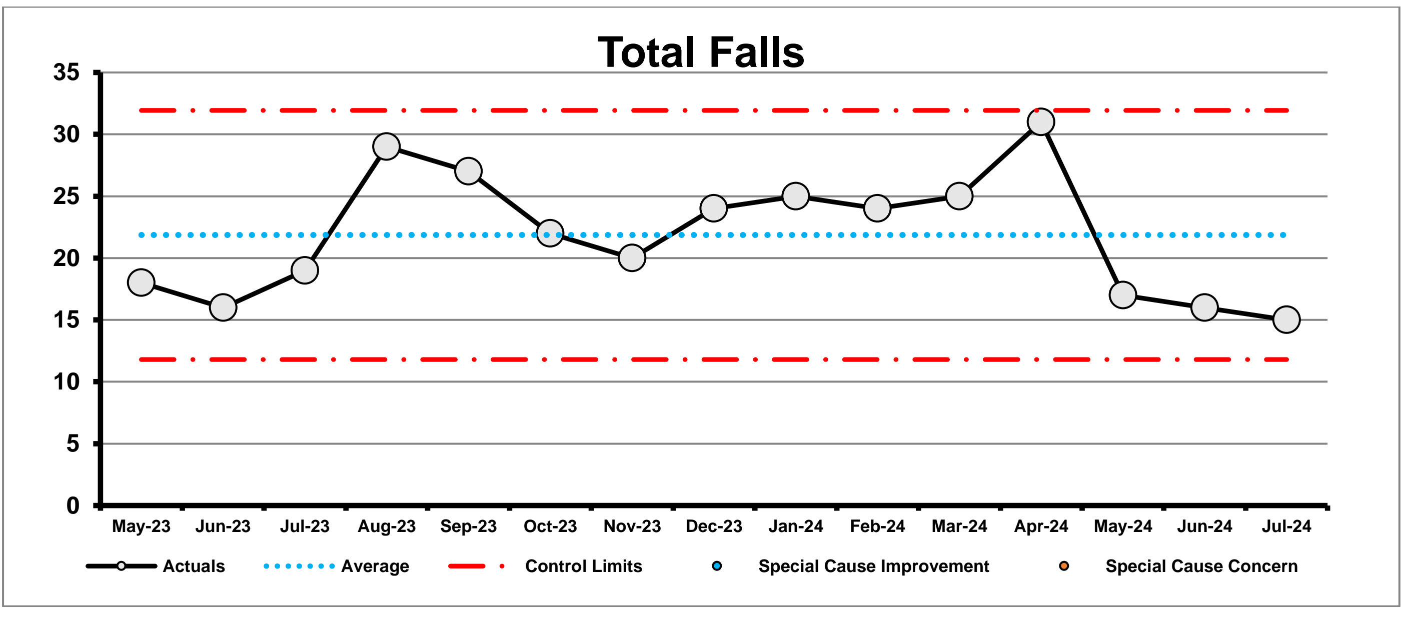
SPC

SPC shows that the Trust's total medication incidents have shown special cause concern since June 2024.

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

Monthly variation is expected as the patient presentation varies monthly. Improvement work for personalised care is ongoing.

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.

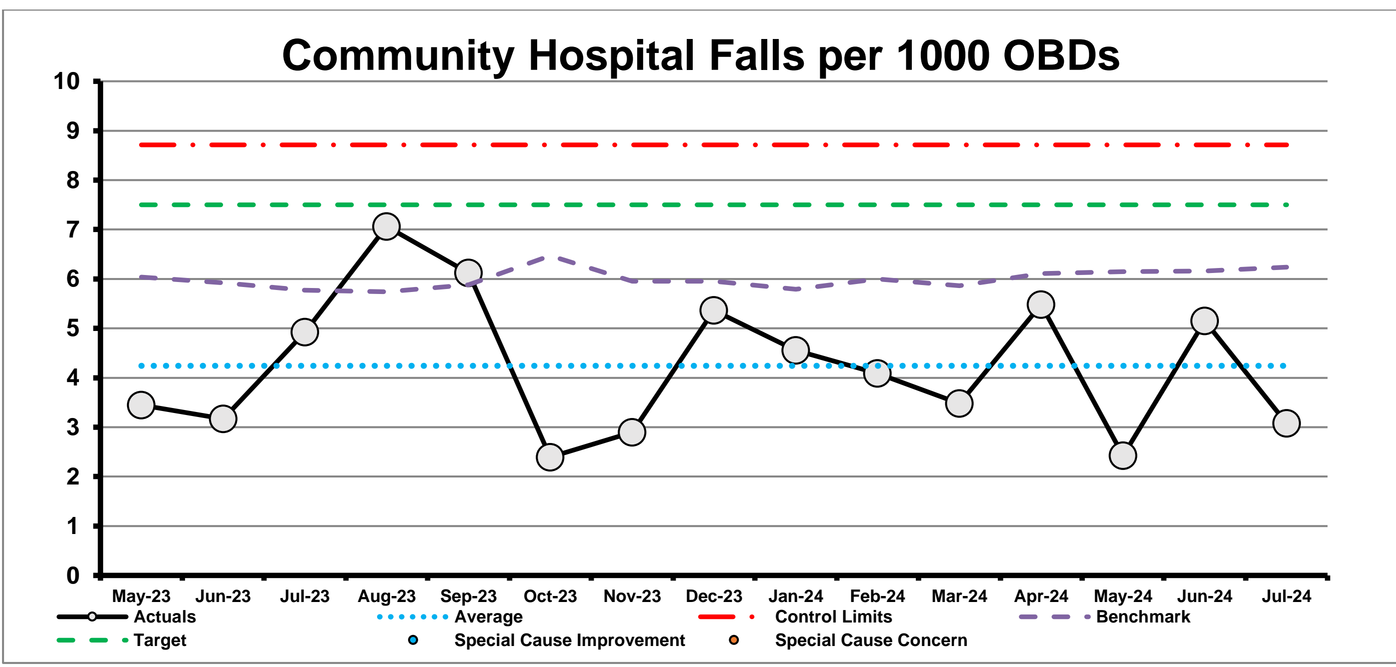
Falls are categorised and captured as the following: -

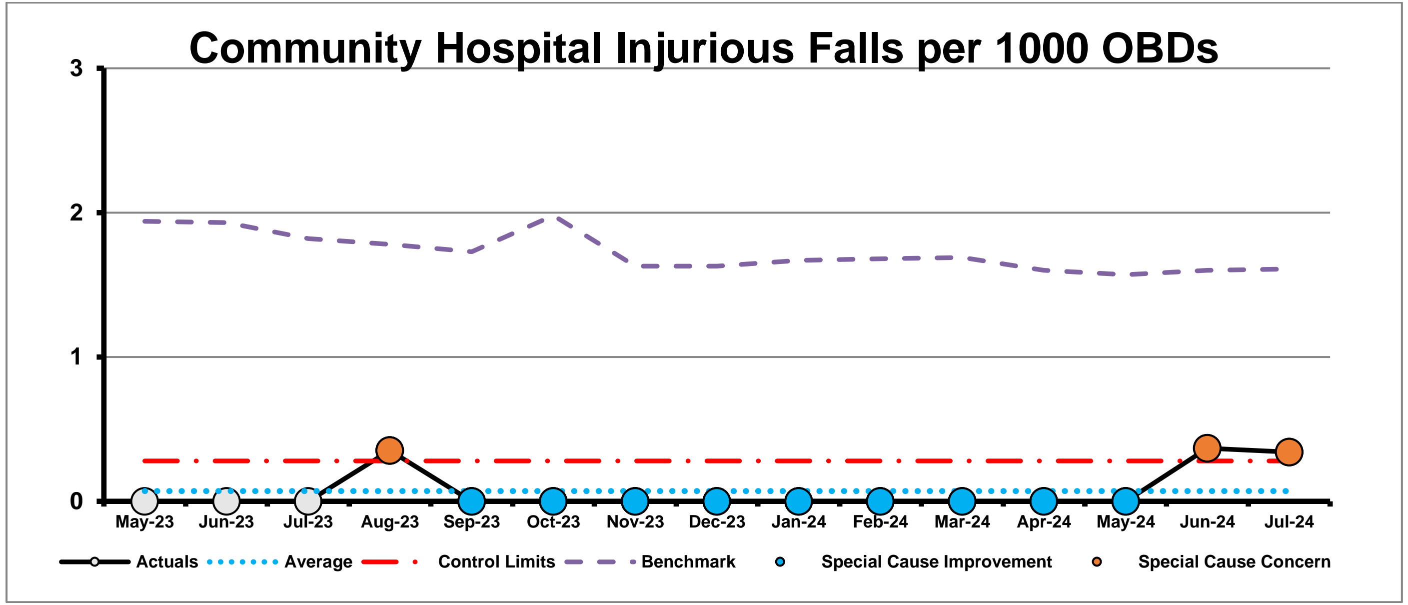
- Fall from a height / bed / chair (these falls tend to result in the highest level of injury of harm
- Slip / trip / fall on level ground.
- Supported lower to ground/ bed / chair / other (many of these are during direct patient care or therapeutic interventions)

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 (June) for all Community Hospital falls is 6.24 The latest monthly benchmark of injurious falls is 1.61.

Current Performance





Narrative

All patient falls are reviewed with the intention to identify areas for learning and improvement. Areas for improvement and review will be discussed by the 'group' falls group for shared learning and improvement actions.
Action: Following consideration of a patient fall at Butterfly Hospice a multi-disciplinary review will be undertaken to ascertain the learning and improvement opportunities across multiple stakeholders.

SPC

Community Hospital Falls per 1000 OBDs
Community falls per 1000 OBDs have not varied significantly over the period.
Rate of Falls per 1000 OBD is inconsistently capable, but the target is achieved more often than not.

Community Hospital Injurious Falls per 1000 OBDs
Community Hospital Injurious falls per 1000 OBDs has shown special cause concern since June 2024.

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)".

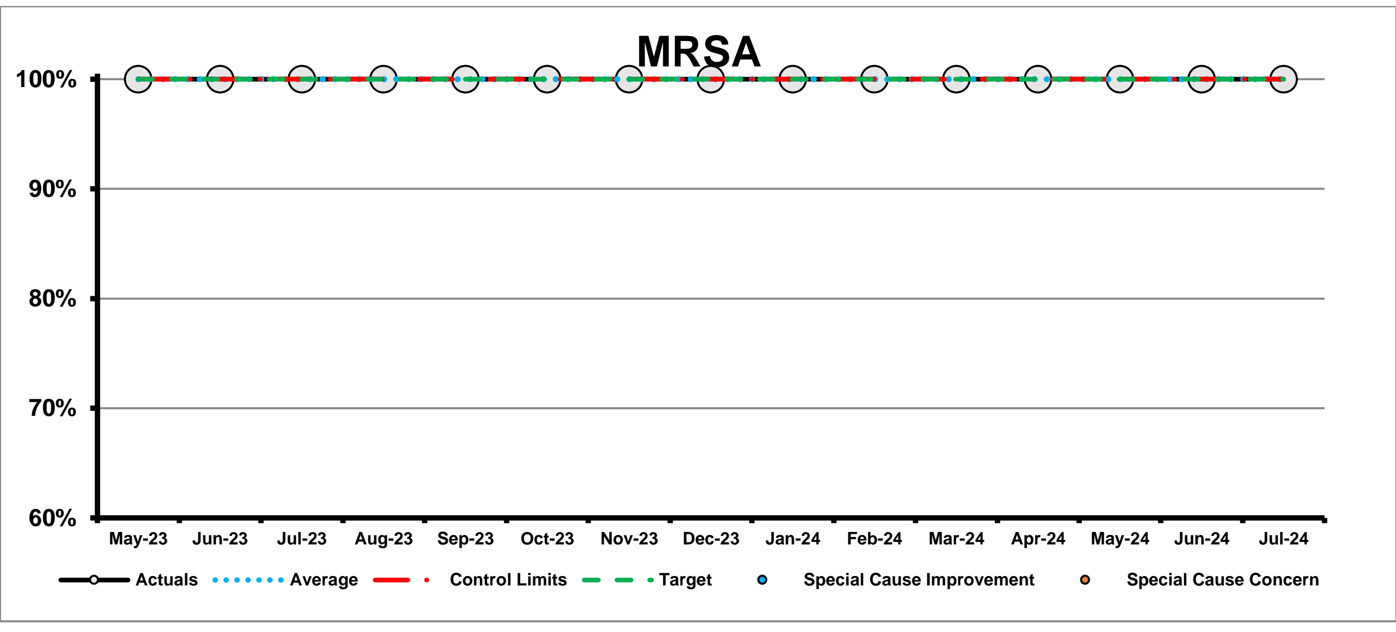
The guidance advocates that those patients previously identified as MRSA positive, and those patients admitted to high-risk units are screened.

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 162 patients admitted across all sites, 7 patients were eligible for MRSA screening, of which all 7 were screened.

SPC

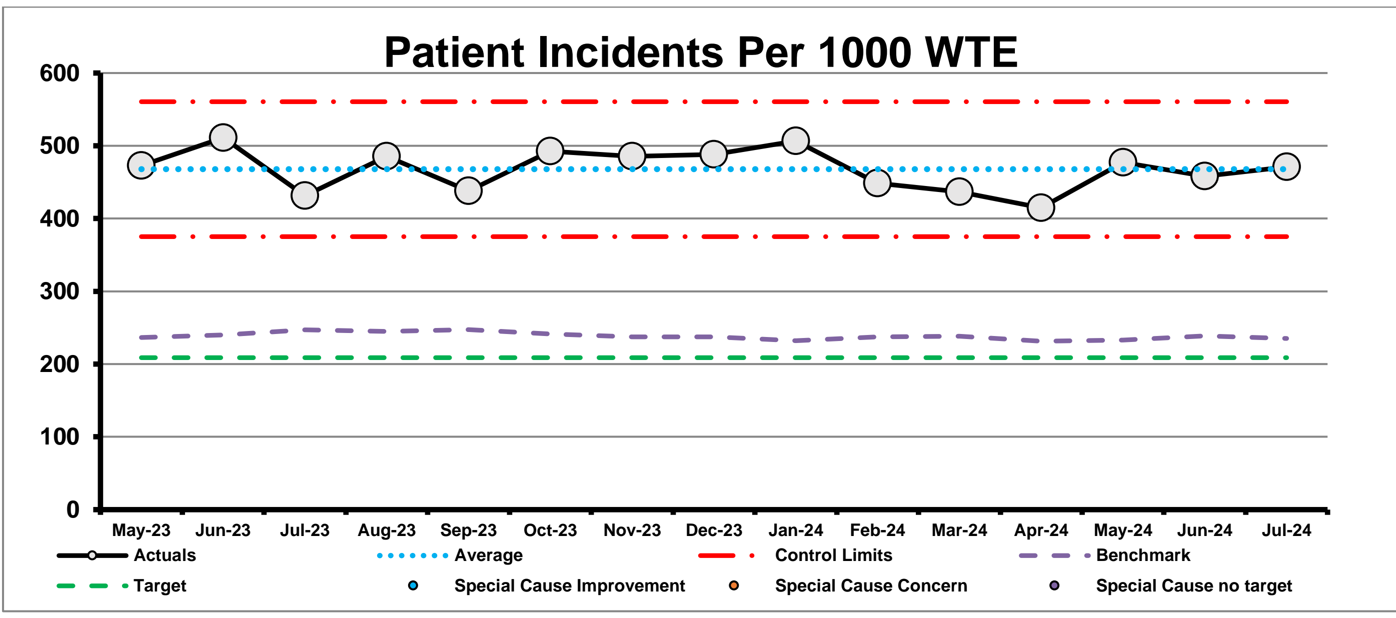
MRSA screening compliance has not varied significantly over the period and is consistently capable of meeting the 100% target.

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 235.04.

Current Performance



Narrative

LCHS remains a consistently high reporter of incidents. Data reported represents all reported incidents and not just those patient safety related. With effect from June patient safety event reporting upward through patient safety group focuses on those events which have an impact on patient safety. From September Quality Committee three months reporting will be available to give a clear review of patient safety events against benchmark. This will demonstrate reporting more in line with benchmarking.

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.

Upgrade and redevelopment of the Datix system to Datix IQ is currently being explored to bring LCHS in line with ULHT partners.

SPC

Patient Incidents per 1000 WTE shows no significant variation over the period and is consistently capable of achieving target.

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.

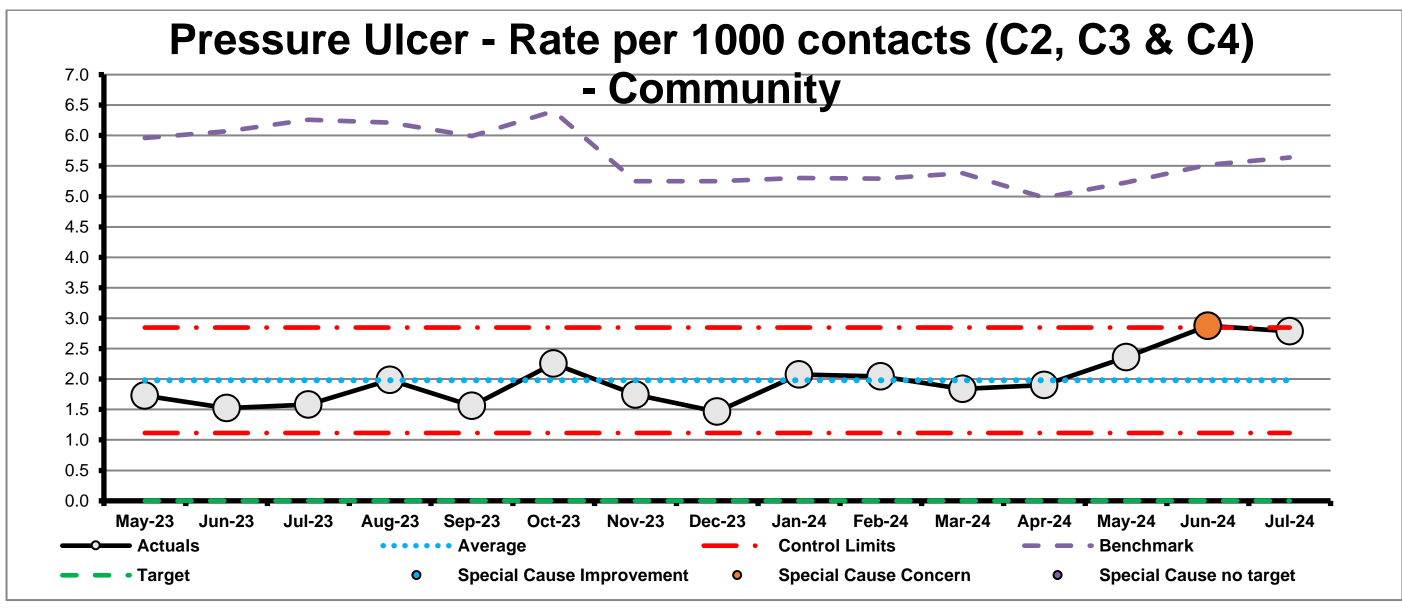
Reduction in patient harm related to pressure damage is the highest priority objective for the Lincolnshire Safeguarding Adults Board.

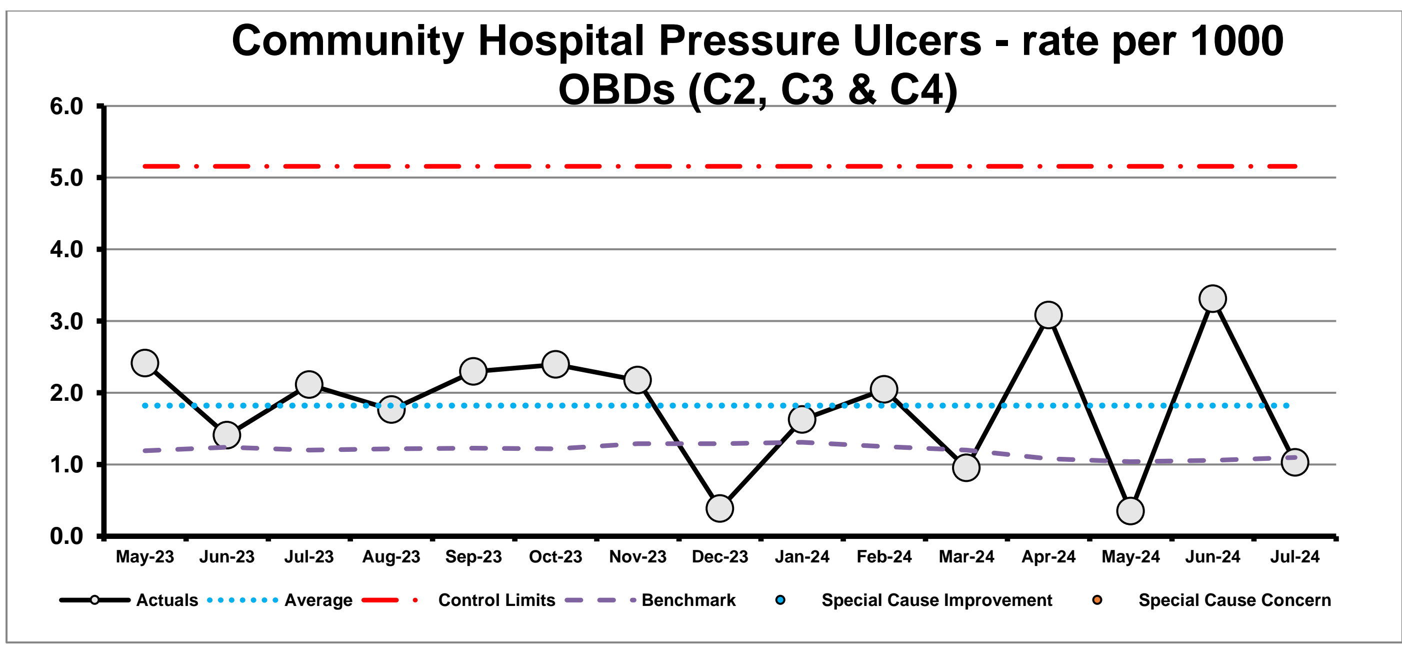
The Lincolnshire System Quality Group have agreed their first quality priority to be pressure damage – eradication of harm, standardising and improving care.

Benchmark
Benchmarking will continue to be calculated in community teams by 1,000 patient contacts – currently the national mean benchmark is 5.64.

Community Hospital benchmarking is calculated by 1000 Occupied Bed Days (OBDs) – currently the national benchmarking rate is 1.10.

Current Performance





Narrative for Community:
59 x (C3&4) and 142 x (C2) pressure ulcers were recorded within the Community for this month the month of July. There is a revised focus on skin integrity reporting through patient safety group. A trust wide pressure ulcer improvement plan has been developed and will be monitored monthly for progress.

Narrative for Community Hospitals:
All actions are detailed and tracked monthly through the skin integrity group and patient safety group as part of the pressure ulcer improvement plan. There were no noticeable changes in July.

Actions

A working group is reviewing new mattresses at Butterfly.

SPC

Pressure Ulcers - rate per 1000 contacts (C2, C3 & C4) – Community
Pressure Ulcer rate/1000 contacts shows hasn't varied significantly since June 2024.

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

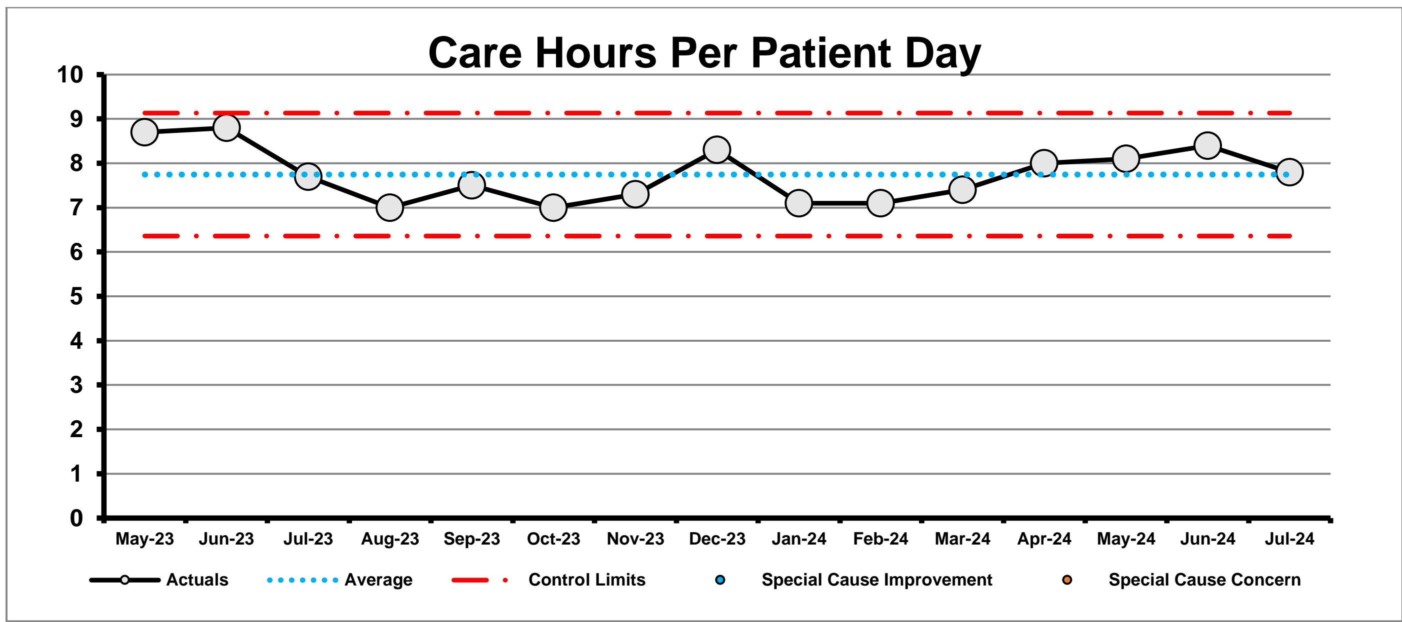
Care Hours Per Patient Day (CHPPD)

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. Planned recruitment for these areas using IEN staff has occurred with staff now being onboarded. This will resolve current vacancy factor and allow for Louth hospital to increase its bed base to pre COVID levels.

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

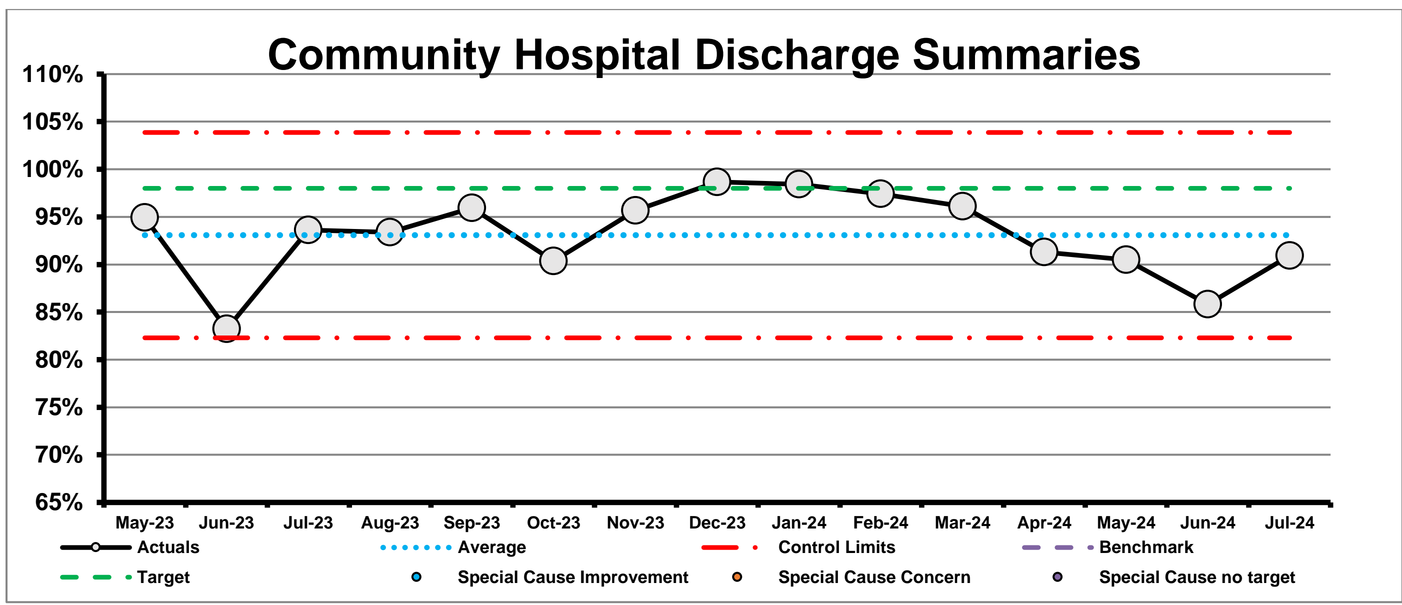
Care hours per patient day shows no significant variation over the period.

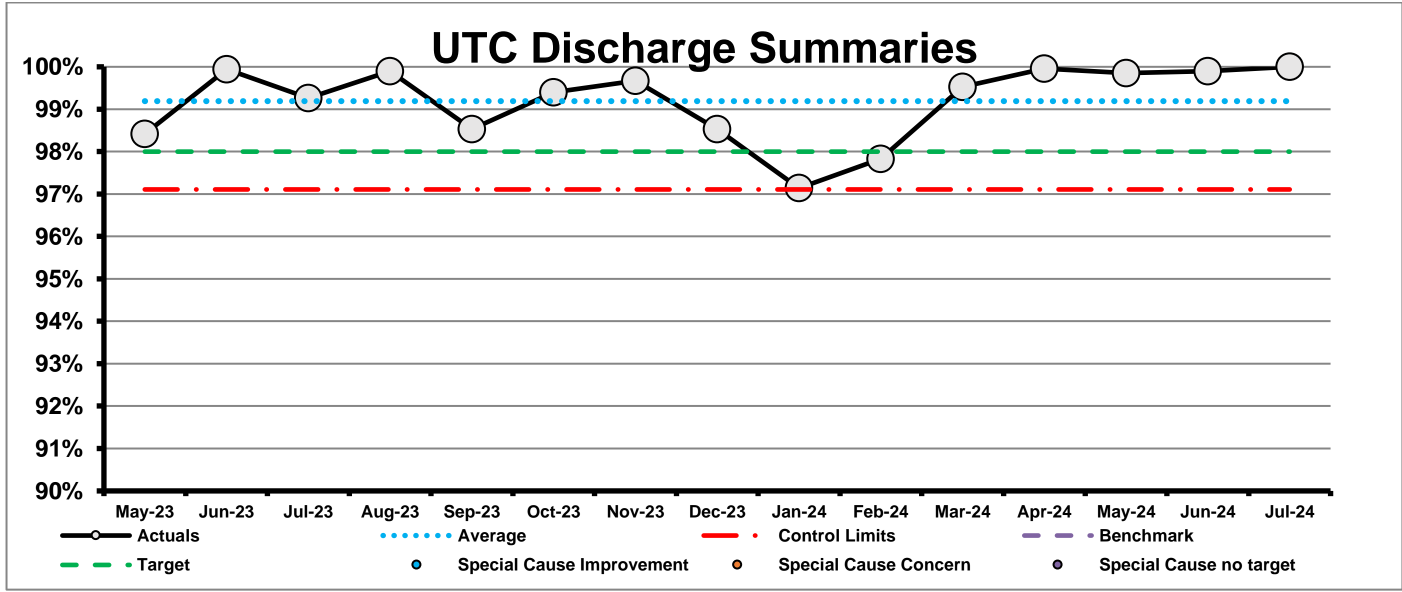
Discharge Summaries

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

Although not meeting trajectory this is an improving picture. Due of change to patient flow (inbound) there has been pressure on the staffing group for discharge letters (outbound) which we are adjusting to.

Actions

Service is exploring potential for discharge team.

Urgent Treatment Centres

The UTC's continue to ensure patients remain safe by ensuring the patients GP are aware when they have visited a Urgent Treatment Centre by achieving 100%

SPC

Discharge Summaries - Community Hospitals
SPC Community Hospital Discharge Summaries shows no significant variation over the period. This metric is inconsistently capable of achieving the 98% target, the target is missed more often than not.

Discharge Summaries – Urgent Treatment Centres
UTC Discharge Summaries shows no significant variation over the period. This metric is inconsistently capable of achieving the 98% target, the target is achieved more often than not.

Overdue & Reported Datix

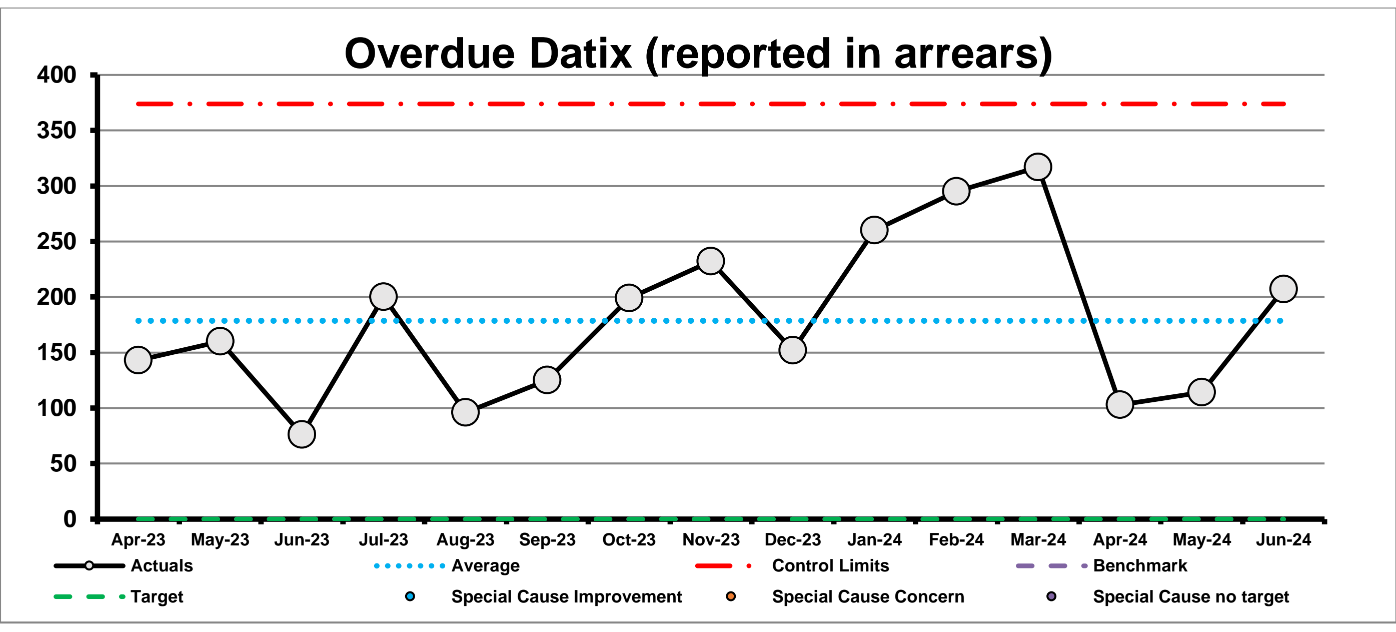
Background
When a Datix is raised to alert or escalate an incident (IR1 form) – it is imperative that the details are reviewed and considered in terms of any immediate actions that have or should be taken particularly regarding patient and staff safety.

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

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

Datix are reported as at the end of the preceding month (i.e., below is the position for 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.

The timescale covering the period between an incident being reported to it being reviewed and finally approved is one calendar month. An incident is marked overdue if it has not been finally approved within 31 days of the incident being reported.

Historically a target of 10% of all reported incidents has been used as the tolerance threshold. This target was agreed under the Serious incident framework. With implementation of PSIRF the opportunity is being taken to review this trajectory and targets with the utilisation of index cases for themed events.

At the time of reporting CYPSS are the only division meeting trajectory around overdue Datix. This is a snapshot in time and is a changing picture. All Divisions are taking actions to realign to trajectory by weekly quality review meetings with leadership oversight. Month on month breakdown is cited in divisional dashboards outlined within the report and is scrutinised at monthly quality scrutiny group meetings.

SPC
Overdue Datix has not varied significantly in the period.

Children in Care (reported one month in arrears)

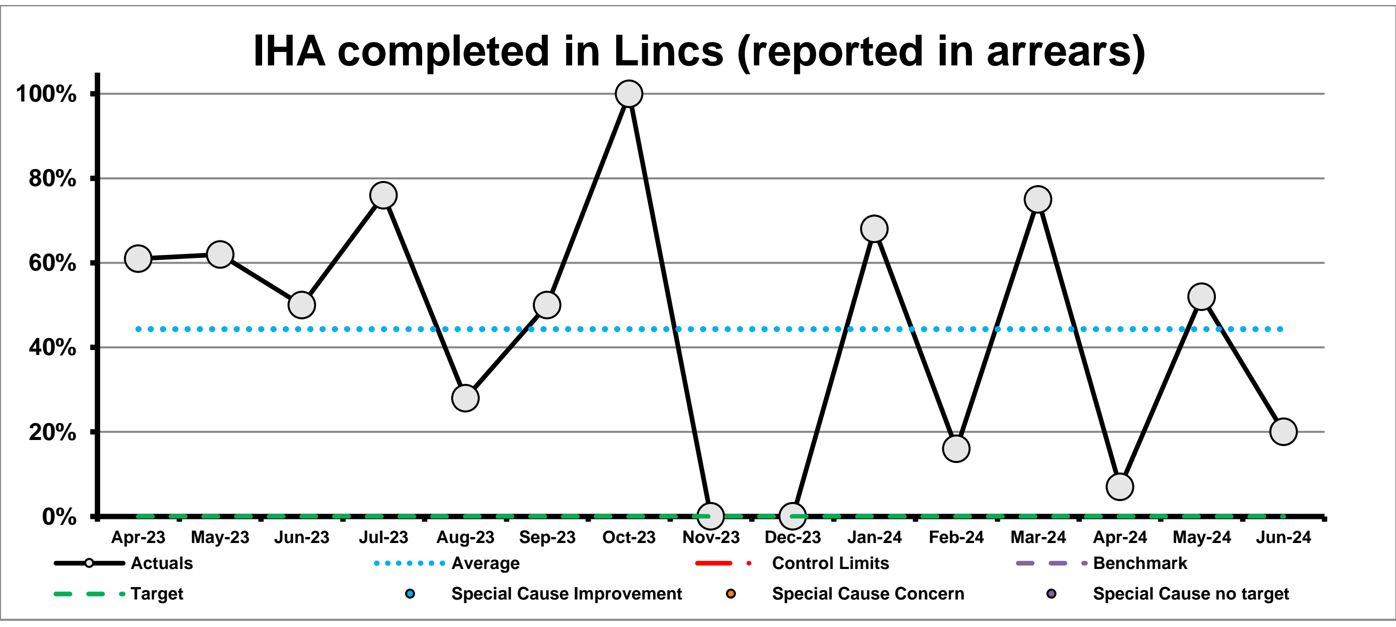
Background

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

We now have a temporary solution to gather the necessary Children in Care data required for reporting. However, we are still in the process of requesting that TPP reinstates the unit in the midnight-to-midnight reporting group as a temporary solution until the infrastructure development for the 17:00 – 17:00 extract can take place.
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.

The CIC service remains under significant pressure to deliver the IHA appointments within 20 working days of the looked after date. Those not meeting the 20-working day deadline are categorised as:

- 7 late due to lack of appointment availability.
- 8 late due to incorrect paperwork from placing authority.

We have one bank Consultant undertaking IHA appointments with the CIC team who has had a considerable amount of time off therefore this created a backlog of IHA appointments. The Bank consultant on a full working month will undertake ¾ of all IHAs requested. Therefore when they are on leave there is no back up capacity to support completion of IHAs within the required timescale.

SPC

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.

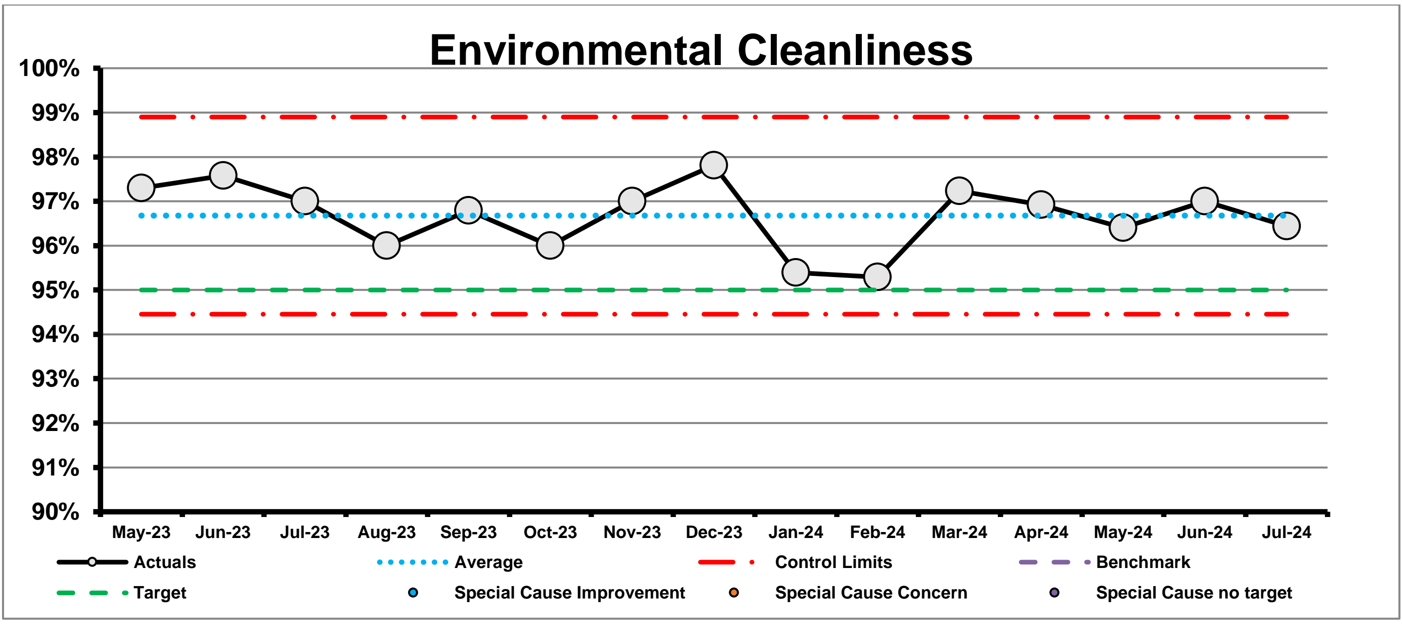
The requirements of the new National Standards of Healthcare Cleanliness that were published at the end of April 2021 have been rolled out across all LCHS community premises by OCS as well as being adopted by NHSPS and the in-house teams at the hospital sites.

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 96.44% 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
Cleanliness audits performance has not varied over the period. This measure is inconsistently capable of achieving the 95% target but achieves target more often than not.

Community Hospital Bed Occupancy

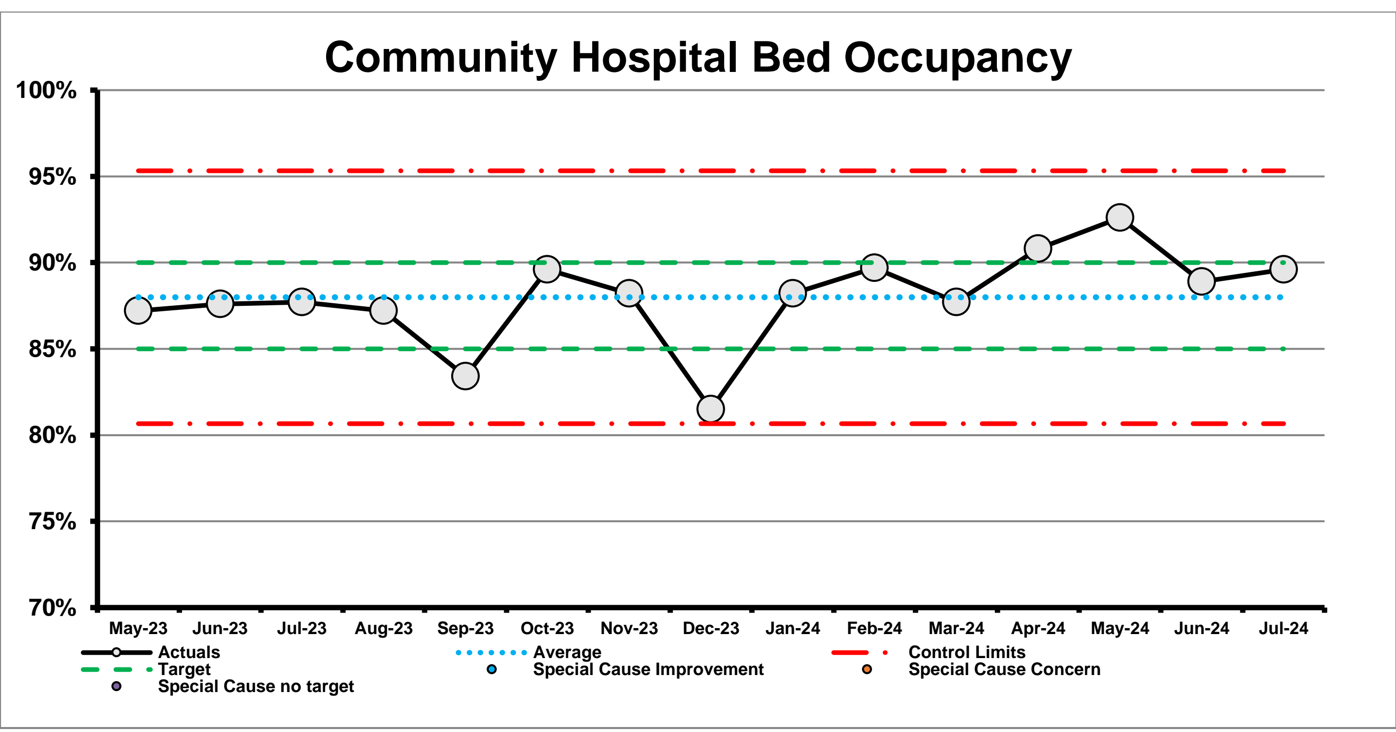
Background

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

The target range for bed occupancy in this non-winter period is 85%-90%.

Current Performance



Narrative

High bed occupancy is continuing to be maintained due to the change to direct referrals from Acute. However, this pathway has shifted demand to Community Hospital senior clinical staff.
Action: Deputy Divisional Lead exploring whether there is capacity elsewhere in the Patient Flow workforce.

SPC

Community Hospital bed occupancy performance has not varied significantly over the period. This measure is inconsistently capable of performing within the target range.

Average Length of Stay

Background

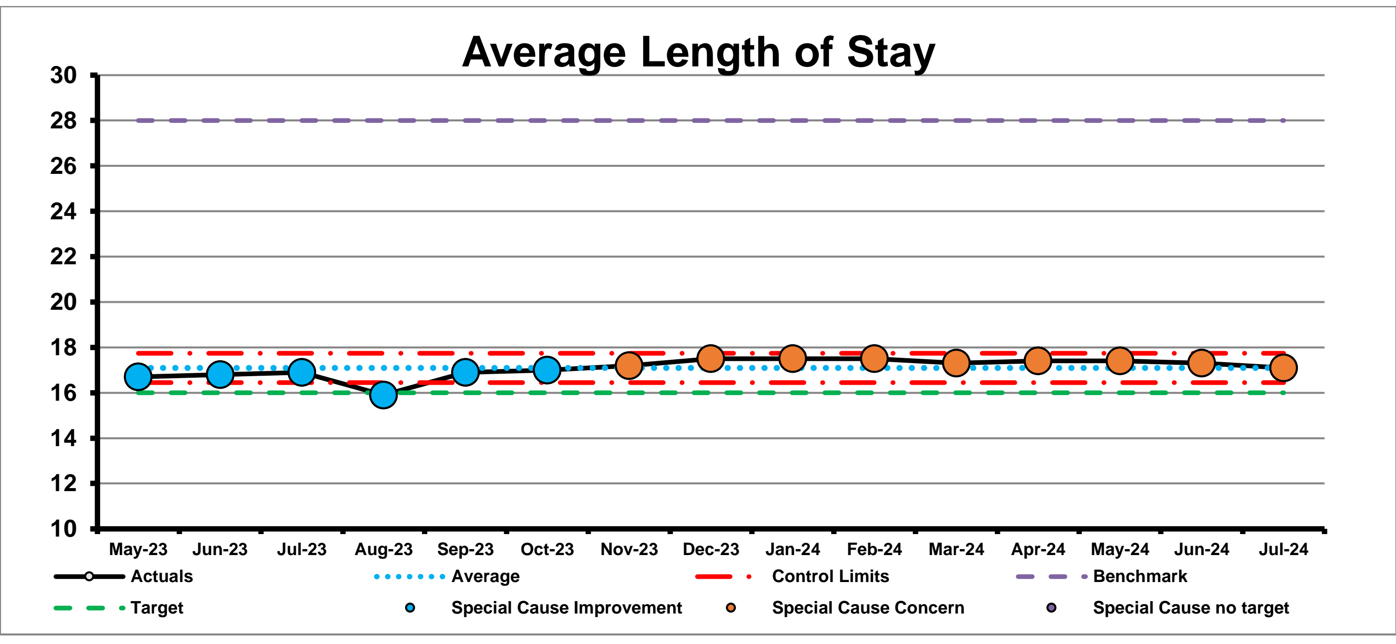
This measure is defined as the difference in days between the date the patient was discharged from the hospital, and the date they were admitted. The average time in hospital in days for all the patients who underwent a procedure in an NHS trust is then calculated (NHS Digital, 2018).

Benchmark/ Target

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

Target length of stay is 16 days.

Current Performance



Narrative

Not notable change in month. There is clear evidence that having discharge coordinators or a discharge team across Community Hospitals would reduce length of stay. There is clear evidence 7-day therapy would improve patient safety and length of stay.

Actions

Deputy Divisional Lead exploring with stakeholders whether the introduction of this team and 7 day therapy could be funded. Service lead for therapy is introducing a new protocol to Community Therapy at the weekends where they will provide some support to Community Hospital patients.

SPC

Average length of stay shows special cause concern since October 2023. Average length of stay is not capable of achieving the local target of 16 days without redesign.

Friends and Family Test

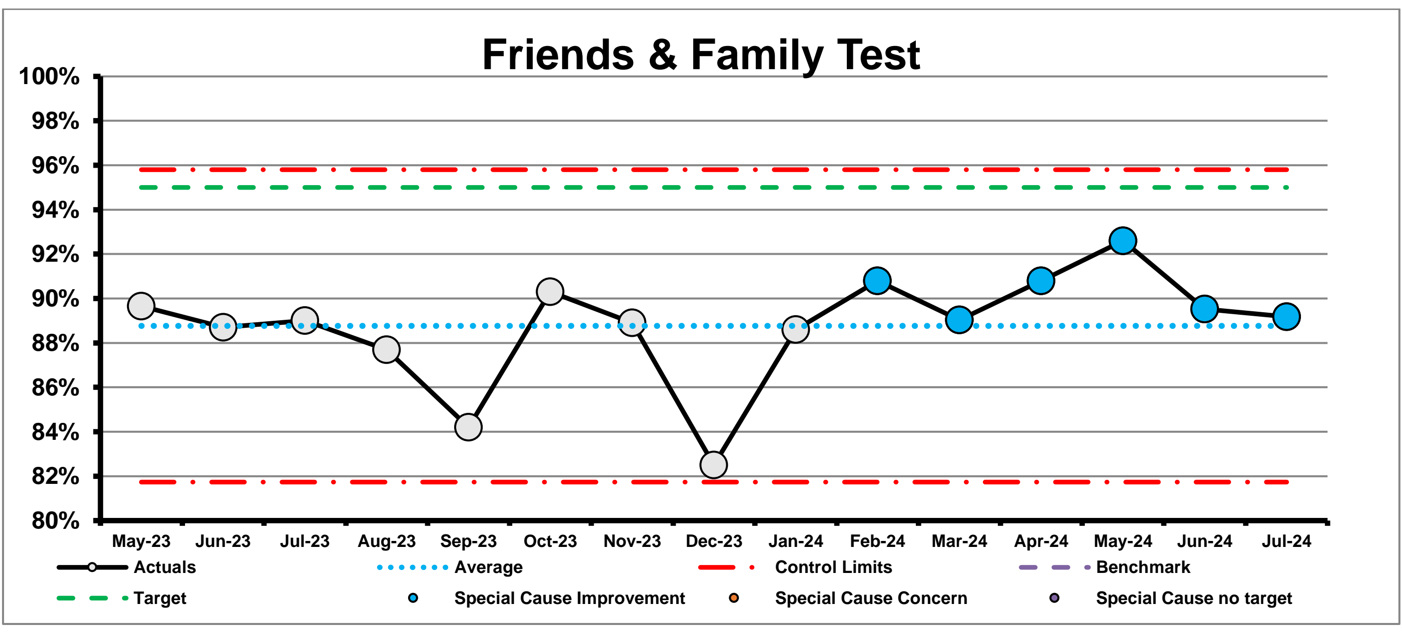
Background

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 June (89.18%) shows a decrease on last month's performance activity (89.53%).

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 shown special cause improvement since February 2024. This measure is inconsistently capable of achieving the 95% target with the target being missed more often than not.

Compliments

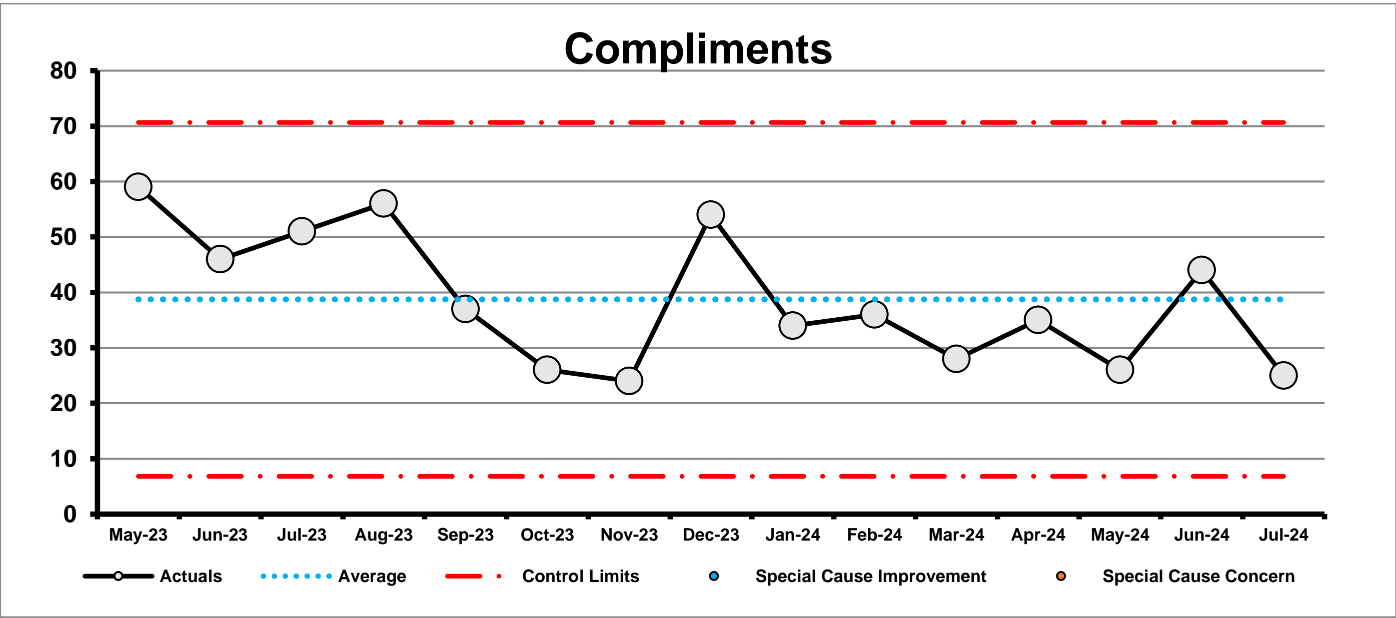
Background

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.
July shows a slight decrease from the previous month.

SPC

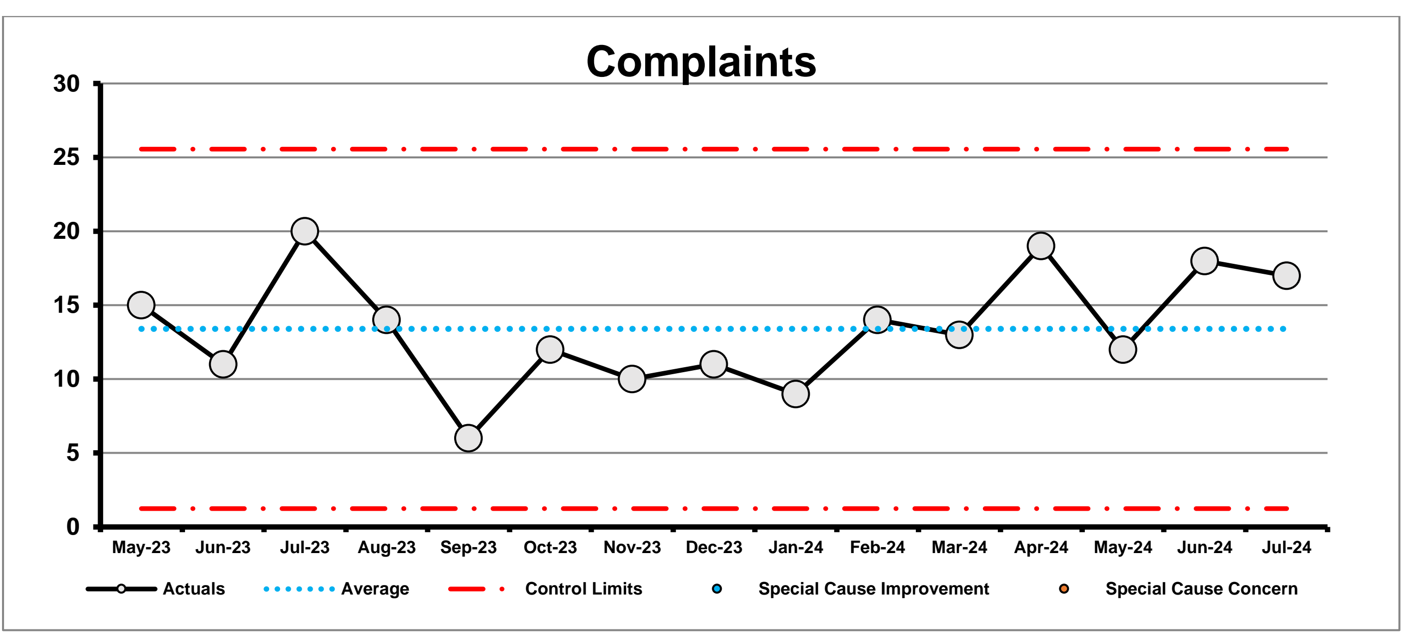
Compliments have not varied significantly over the period.

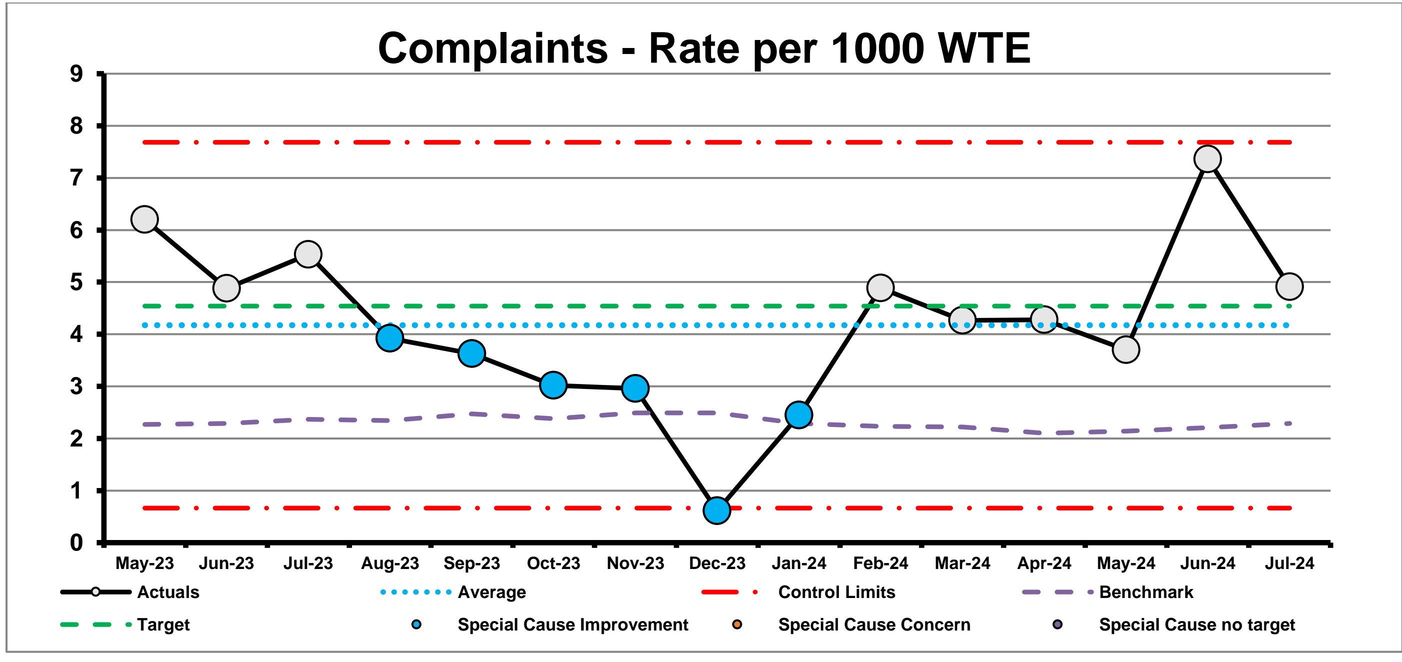
Complaints

Benchmark / Target

LCHS is benchmarked by the number of complaints reported per 1,000 WTE budgeted staff.

Current Performance





Narrative

As a Trust we are keen to resolve any complaints or issues concerning contact that patients or family members have with our services.

We are currently working with divisions to streamline the complaints process, initially writing more response letters with the investigator of the complaint. Significant work will take place over the coming months to improve the flow of the complaint process across the Trust.

Actions

The complaints team are continuing to work with divisions on producing some meaningful actions from upheld and part upheld complaints to enable the Trust to learn from these complaints and improve patient experience.

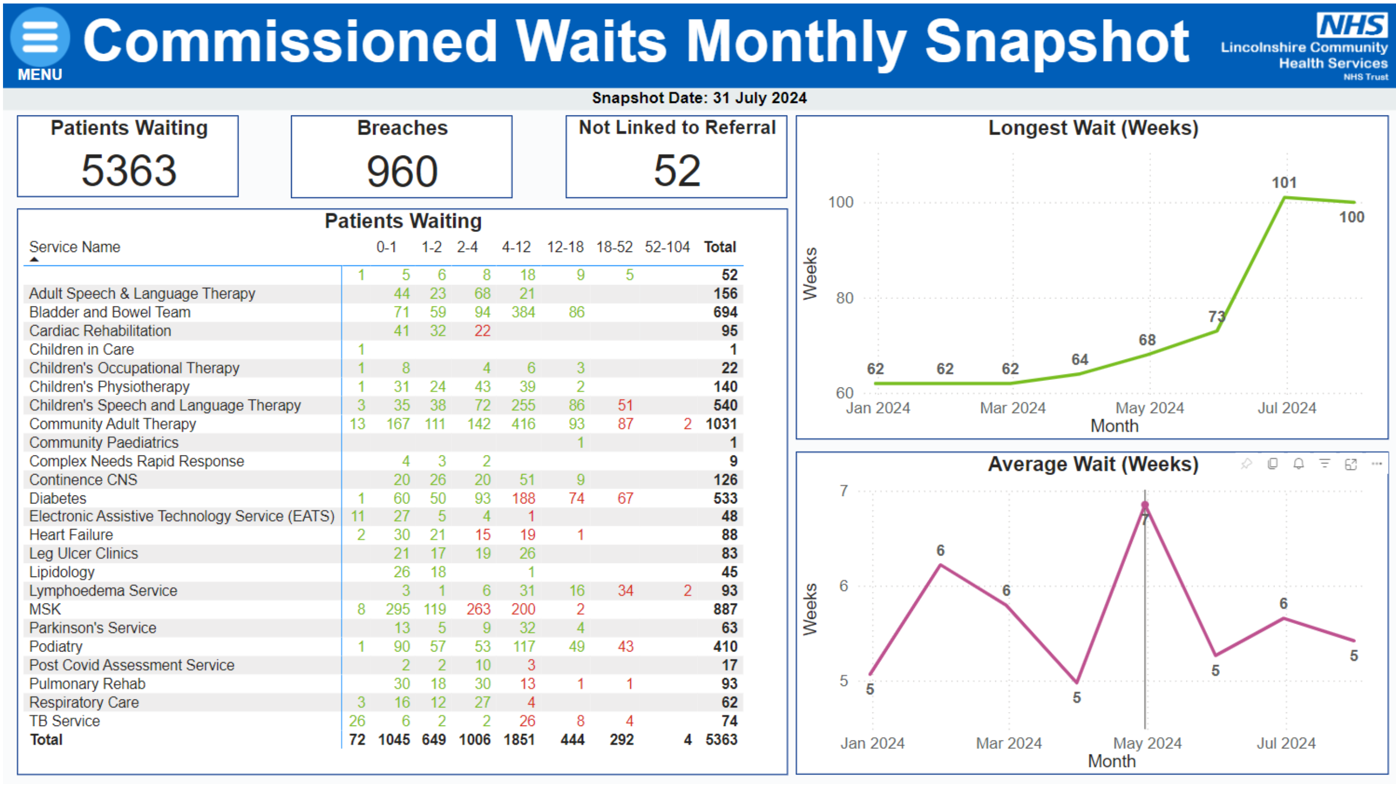
SPC

Complaints number have not varied significantly over the period.
The complaints rate per 1000 WTE has not varied significantly since January 2024. This measure is inconsistently capable of achieving its target but is expected to achieve target more often than not.

LCHS Commissioned Waits

Background

LCHS Commissioned waits are the agreed target waits set out by each service level agreement and therefore not all services will be aligned to an 18 week wait target.



Patients Waiting

Service Name		0-1	1-2	2-4	4-12	12-18	18-52	52-104	Total
	1	5	6	8	18	9	5		52
Adult Speech & Language Therapy		44	23	68	21				156
Bladder and Bowel Team		71	59	94	384	86			694
Cardiac Rehabilitation		41	32	22					95
Children in Care	1								1
Children's Occupational Therapy	1	8		4	6	3			22
Children's Physiotherapy	1	31	24	43	39	2			140
Children's Speech and Language Therapy	3	35	38	72	255	86	51		540
Community Adult Therapy	13	167	111	142	416	93	87	2	1031
Community Paediatrics						1			1
Complex Needs Rapid Response		4	3	2					9
Continence CNS		20	26	20	51	9			126
Diabetes	1	60	50	93	188	74	67		533
Electronic Assistive Technology Service (EATS)	11	27	5	4	1				48
Heart Failure	2	30	21	15	19	1			88
Leg Ulcer Clinics		21	17	19	26				83
Lipidology		26	18		1				45
Lymphoedema Service		3	1	6	31	16	34	2	93
MSK	8	295	119	263	200	2			887
Parkinson's Service		13	5	9	32	4			63
Podiatry	1	90	57	53	117	49	43		410
Post Covid Assessment Service		2	2	10	3				17
Pulmonary Rehab		30	18	30	13	1	1		93
Respiratory Care	3	16	12	27	4				62
TB Service	26	6	2	2	26	8	4		74
Total	**72**	**1045**	**649**	**1006**	**1851**	**444**	**292**	**4**	**5363**

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 June 2024 have now implemented this process, recording referral to initial contact.

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

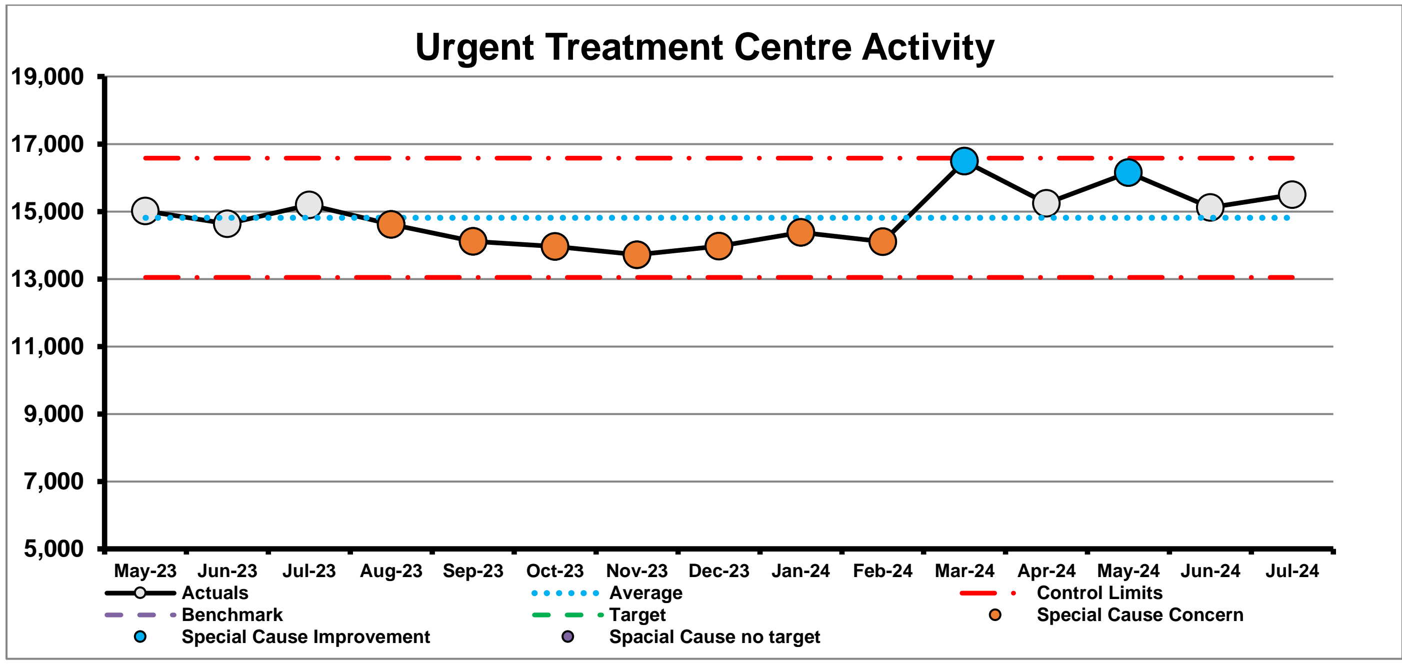
Diabetes	4 Weeks
Electronic Assistive Technology Service	6 Weeks
Heart Failure	2 Weeks
Musculoskeletal Physiotherapy	15 Working Days
Parkinson's	18 Weeks
Podiatry	18 Weeks
Post Covid	6 Weeks
Pulmonary Rehab	10 Weeks
Complex Needs Rapid Response	18 Weeks
Respiratory (CCM, Oxygen, Physiotherapy)	4 Weeks
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 July 2024 increased moderately from last month to within more expected activity ranges. Although footfall has not varied significantly over the past few months there has been a sustained increase compared to the same period last year

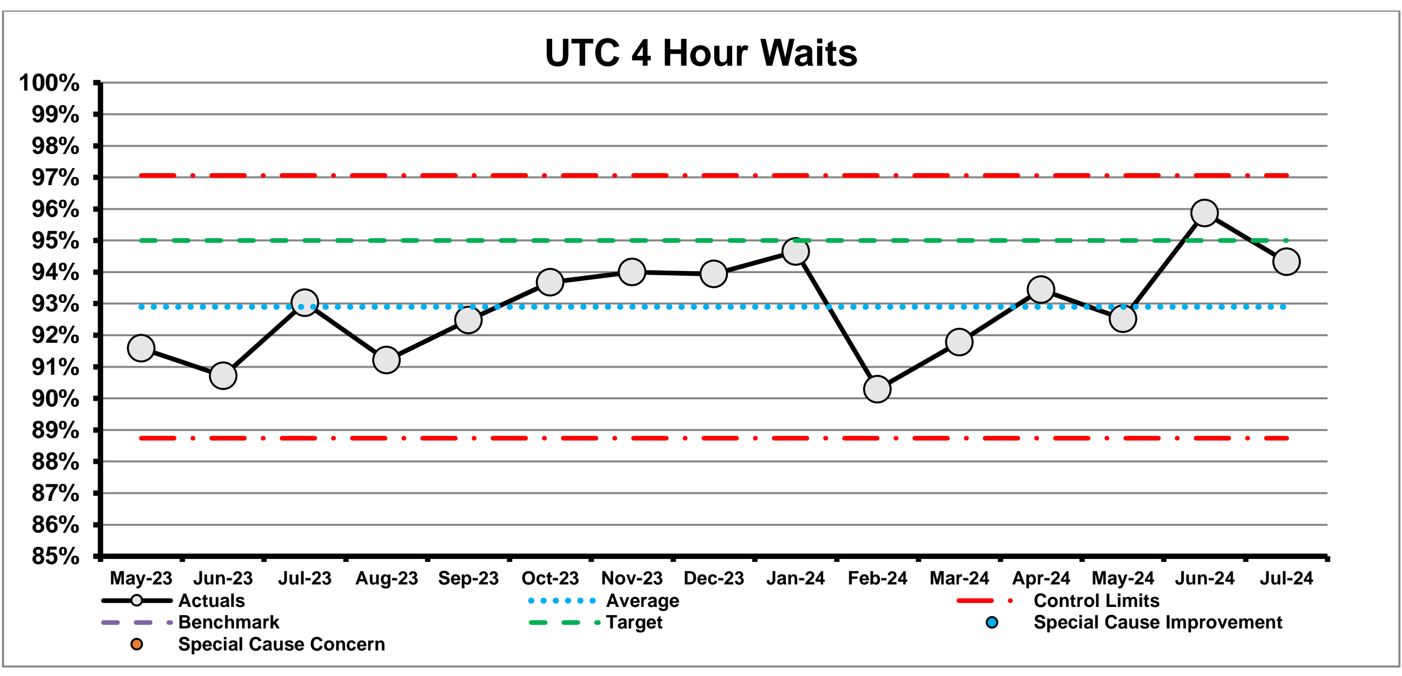
SPC

UTC activity has not varied significantly over since May 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

July 2024 shows a slight drop in performance with 4-hour waits compared to June 2023 and decreased from 95.87% to 94.32%. Some of this may be due to a moderate increase in attendances from last month, however the performance sits just under our target of 95%.

It is the time to departure at our co-located sites, in particular Lincoln UTC and Boston UTC, that has the most significant impact 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 reducing our 4-hour waiting times, and if activity returns back down to target levels, we anticipate that this improvement will become more consistent and sustained.

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.

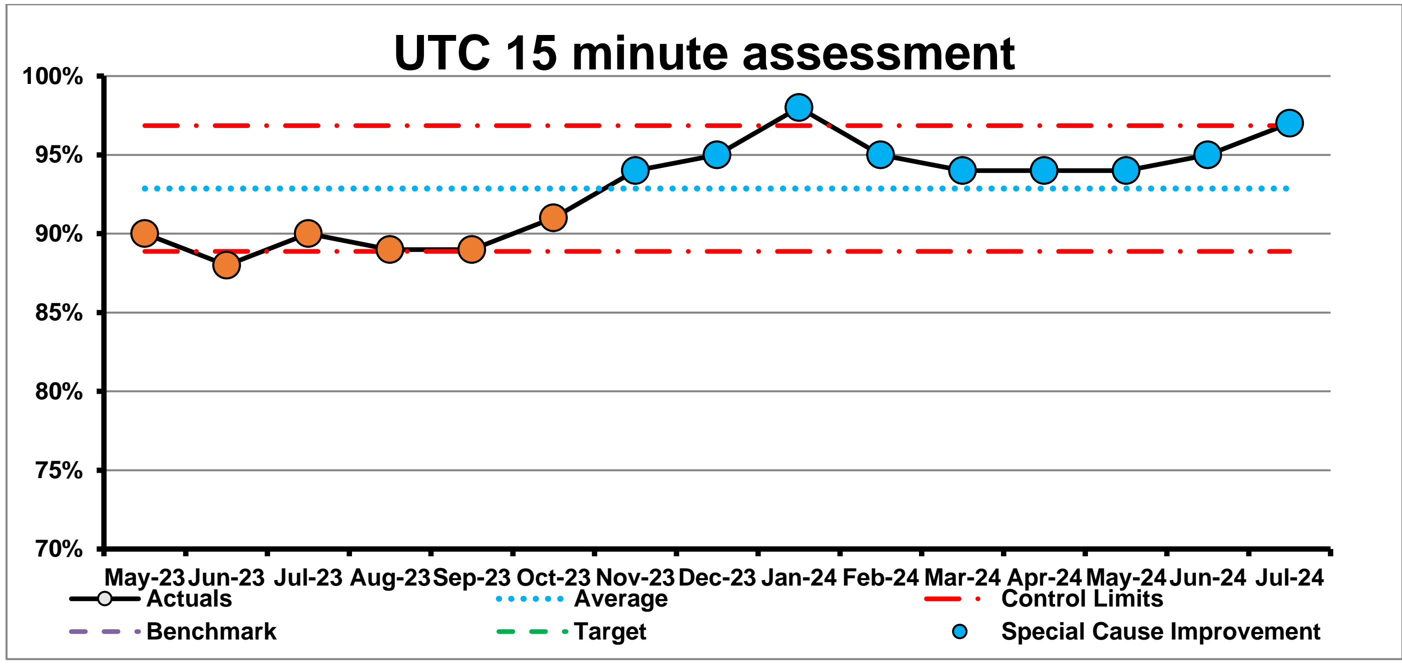
SPC

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 sitting at 94%-95% for the past 3 months in a row and has now risen to 97% for the month of July.

Continued focus on improving 15-minute compliance has had a significant positive impact at Gainsborough UTC. Gainsborough's' performance has risen from 88% to 95% for the month of July. The Gainsborough team are committed to ensuring that this improved performance is sustained. All UTC's performed at 95% or above for the month of July.

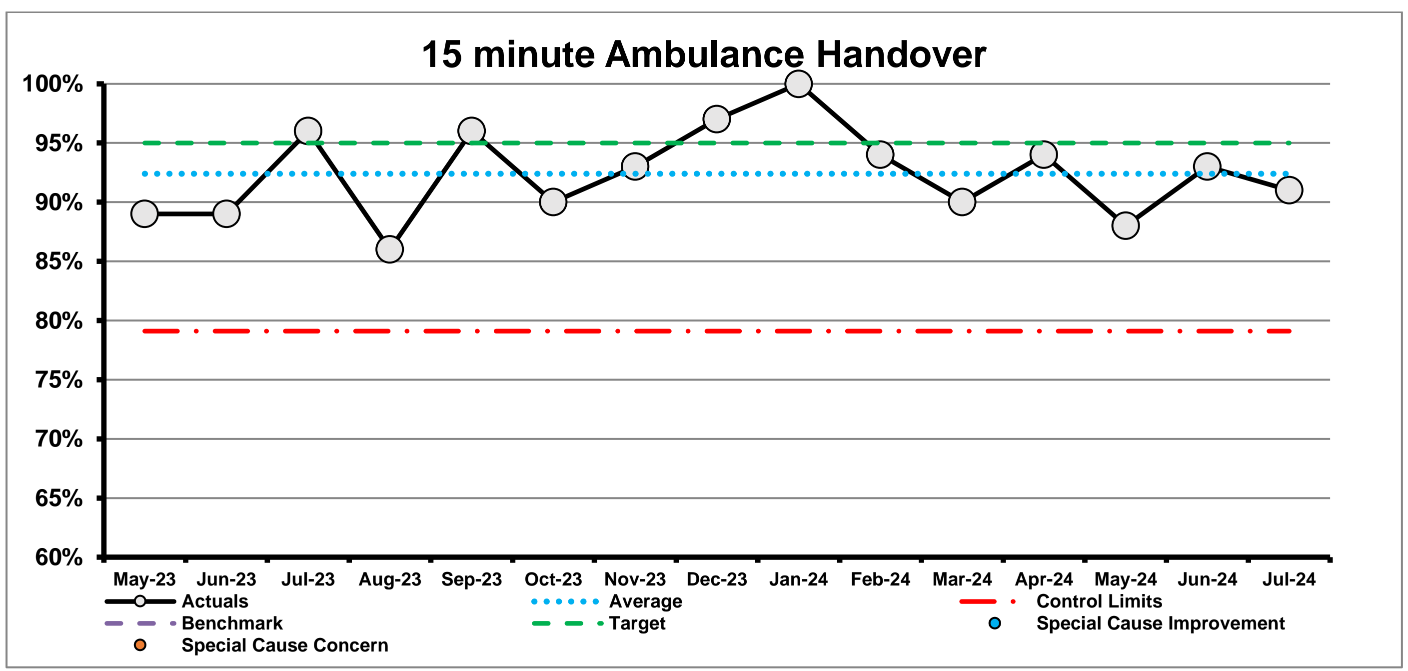
SPC

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 of 1% in performance from last month. We continue to work closely and meet regularly with EMAS partners to enhance admission avoidance pathways.

SPC

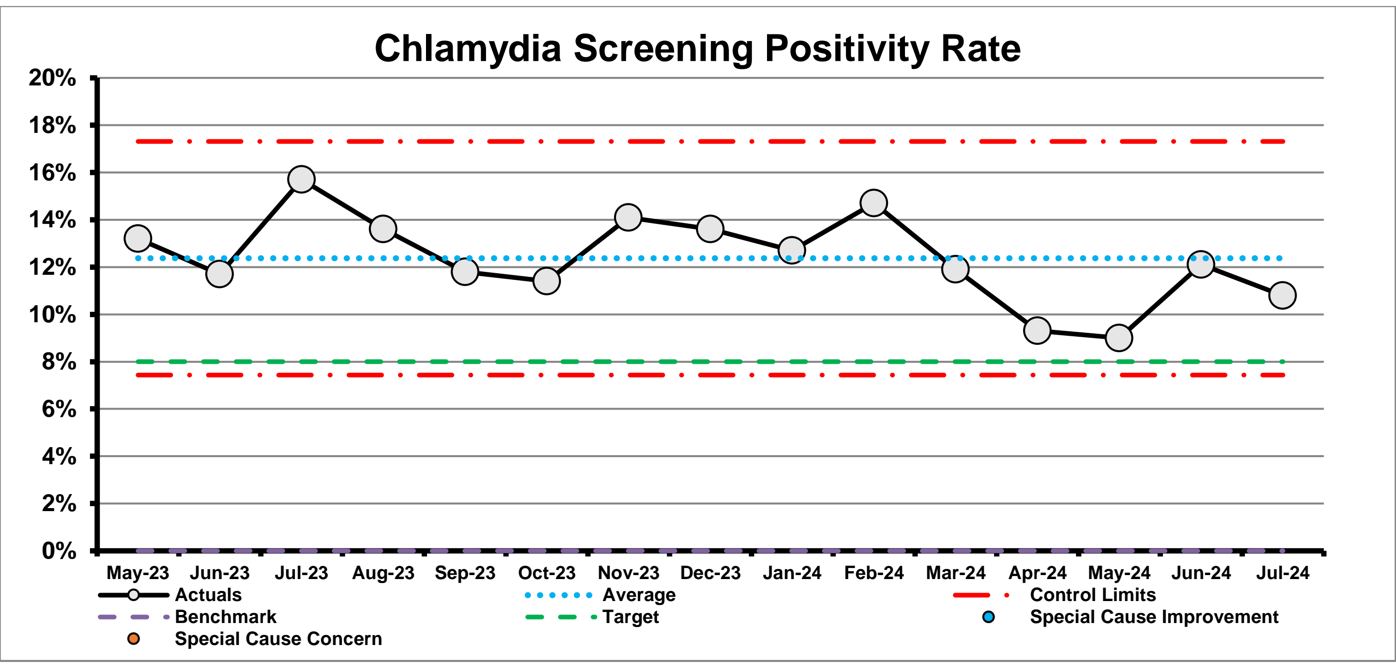
15-minute Ambulance Handover performance has not varied significantly over the period.

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

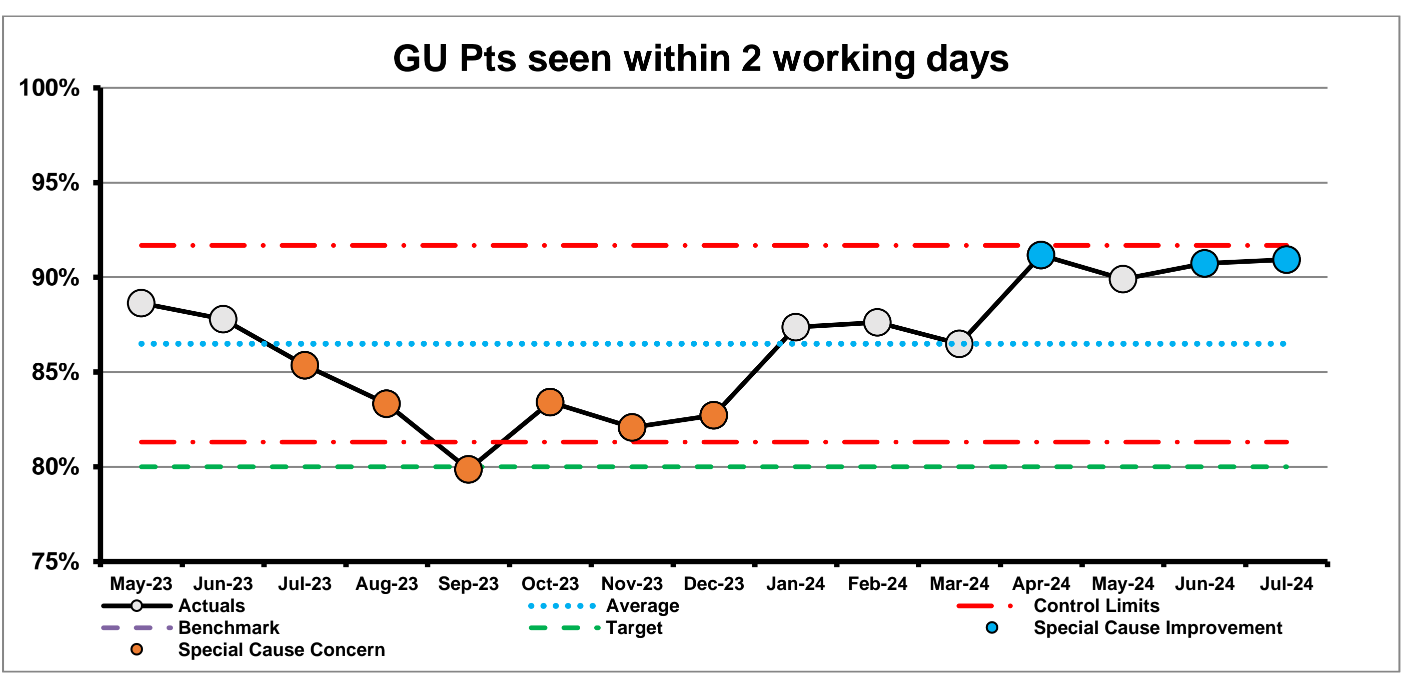
To continue developing and raising awareness of the service within the younger population.

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 shows special cause improvement since June 2024. This measure is consistently capable of achieving the 80% target.

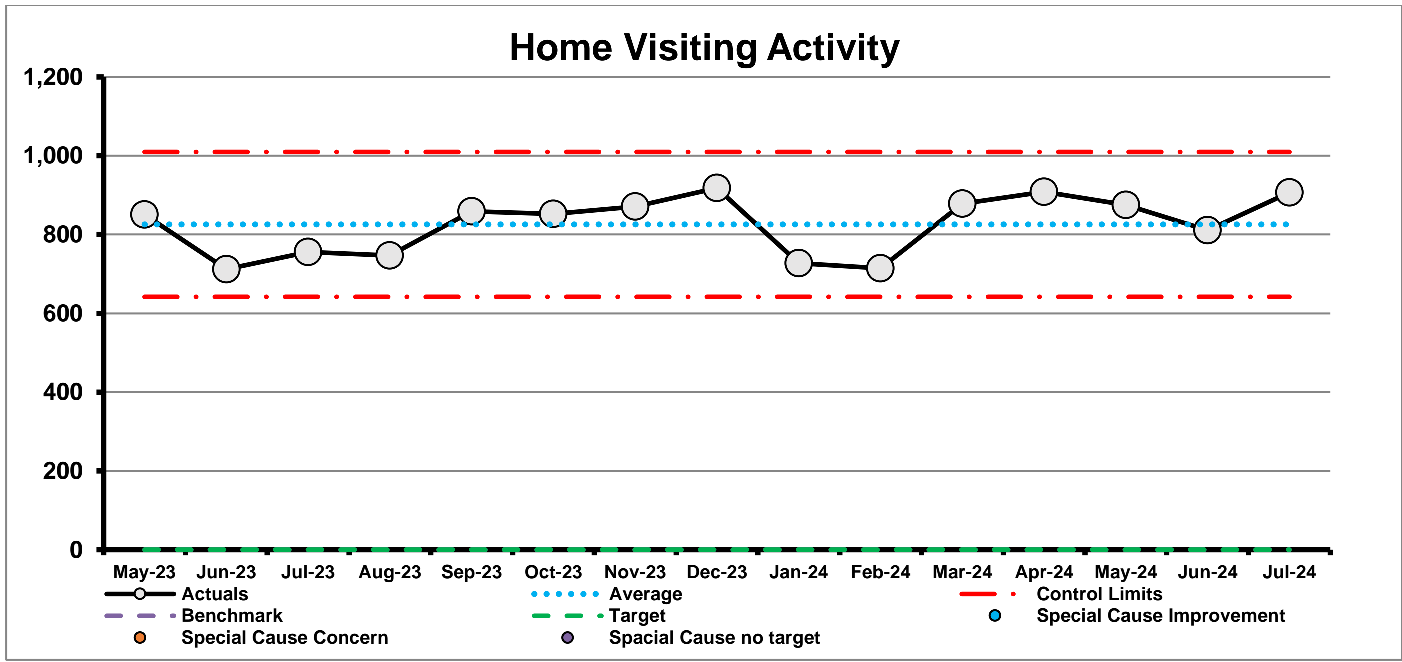
Home Visiting Report

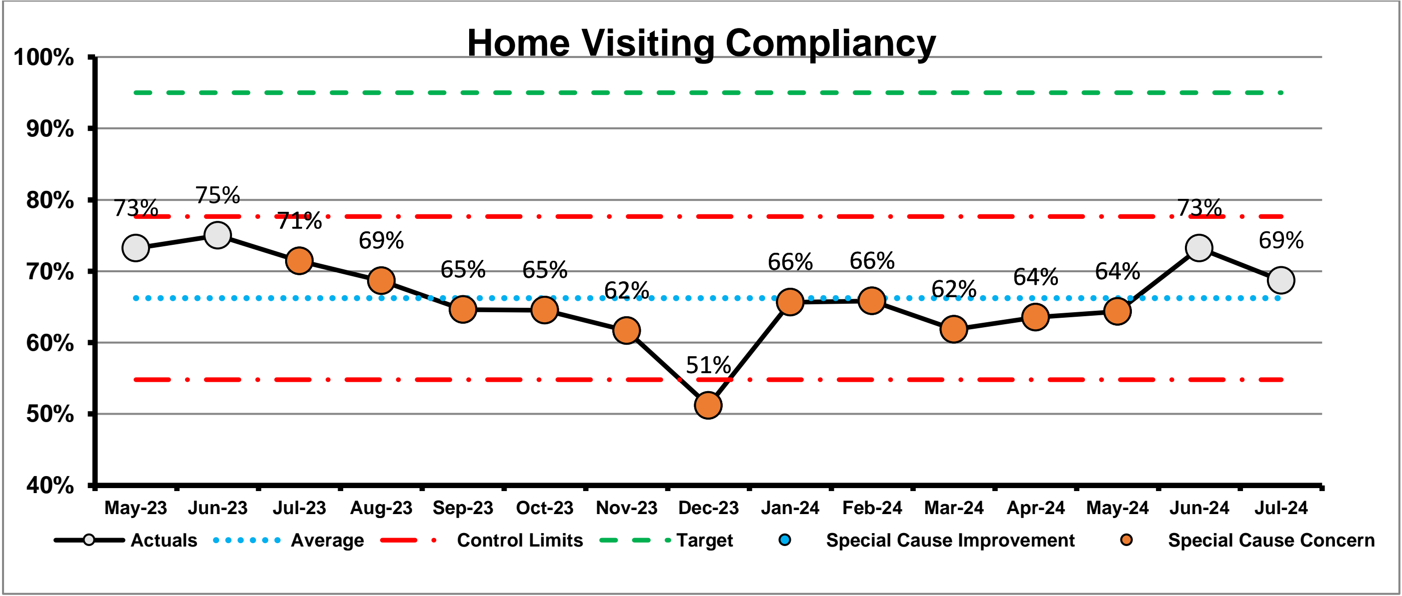
Background

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

Unfortunately, there has been a 4% decrease in the compliancy compared with the previous reporting month. However, it should be noted that there has been a spike in activity with the service seeing 907 cases (highest since December 24). When compared to similar reporting months where activity has been at this level the compliancy has been lower. The service continues to develop in a way that is supportive of the patient need; with the staff consultation over shift times currently under way and a plan to implement the unplanned catheter care workstream on the 2nd of September.

SPC

Home Visiting activity has not varied significantly over the period.

Home Visiting compliance has not varied significantly since May 2024 and is not capable of achieving the 95% target without redesign.

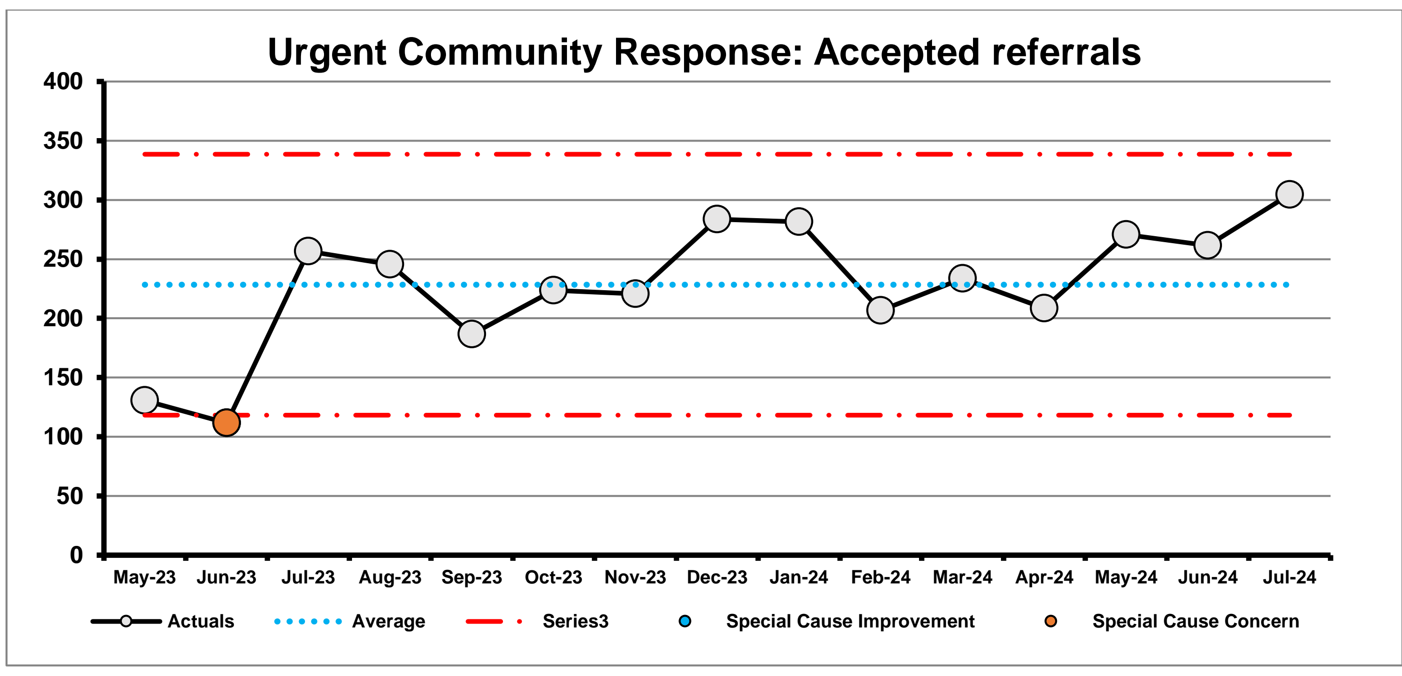
Urgent Community Response

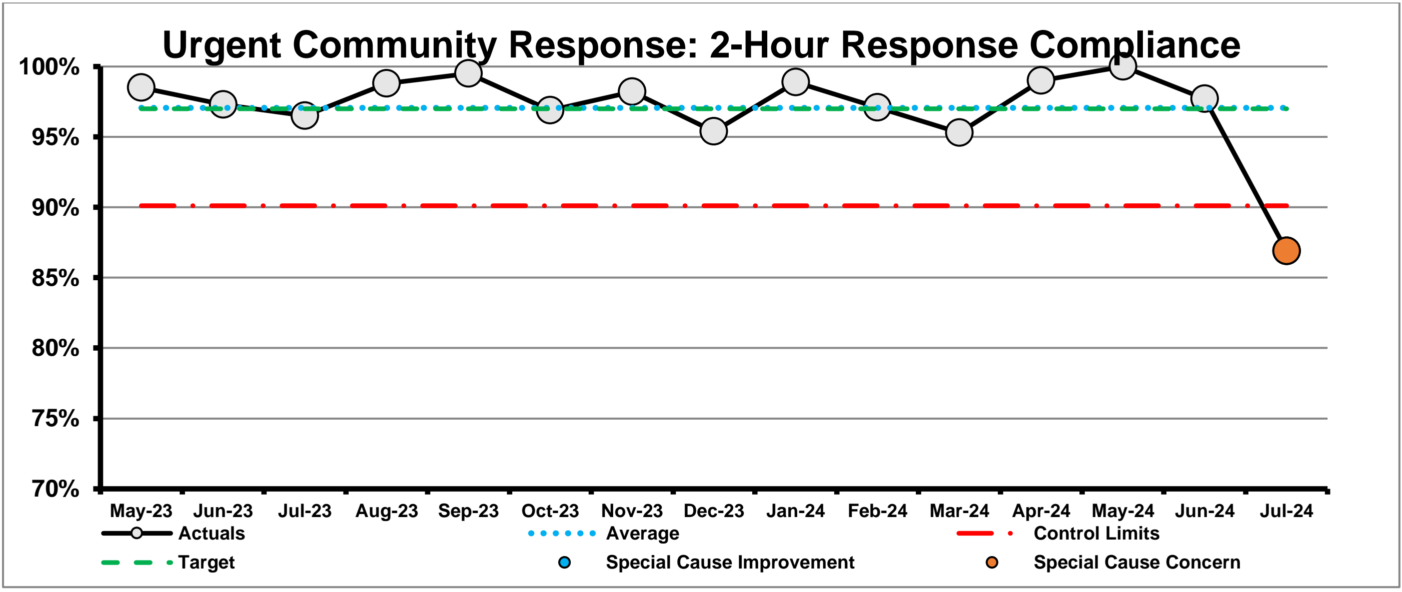
Background

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 continue a positive trajectory for referrals. The highest reason for referral is 'reduced function' and the level of need patients require has increased in complexity. The compliance has dipped significantly but it does need to be raised that on the 12th of July the service received 23 referrals and the 27th of July we received 18 referrals. This is the highest number of referrals the service has received at any one time. It should be noted that July is the service's first full month of utilising the new clinical triage tool and staff have

provided feedback that it has made completing the triage lengthier. The service has also been impacted by acute and long-term sickness.

SPC

The number of accepted referrals for Urgent Community Response has not varied significantly since June 2023.

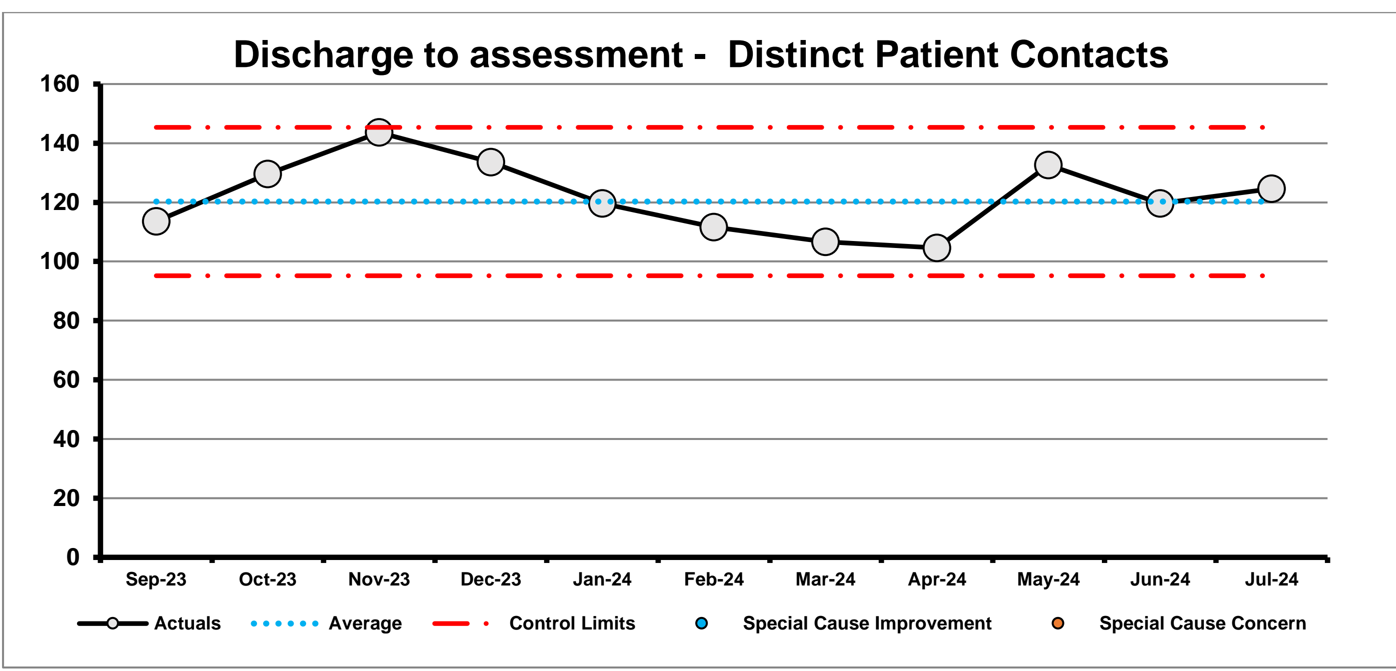
2-hour response compliance shows special cause concern in July 2024. The 2-hour response rate is inconsistently capable of achieving the 97% target but is expected to achieve the target more often than not.

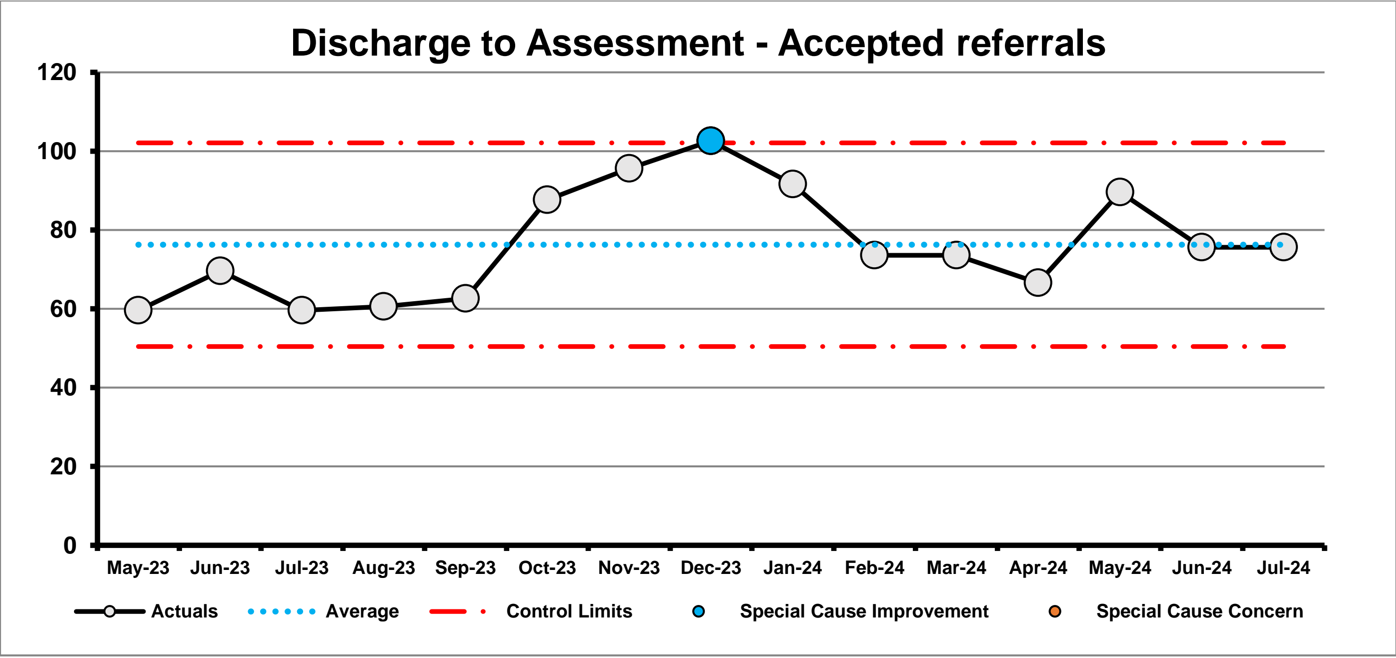
Discharge To Assessment

Background

The Discharge to Assessment programme has been introduced to expedite patients to leave acute care and return to their own home for reablement.

The service works closely with Adult Social Care and supports patients with a wide range of needs.





Narrative

The number of referrals accepted into the Pathway 1 D2A service remained consistent with figures shown in June, remaining higher than the expected caseload of 70.

Actions

Work alongside the transfer of care (TOC) hubs is ongoing – the aim of this is to proactively identify an increased number of patients who would benefit from D2A step-down from the acute hospital sites, where traditionally they may have been considered for step-down into a community bed. Discussions with our LCC partners are also ongoing, with the aim of increasing the number of hybrid packages of support D2A and the LCC Home-Based Reablement Service (HBRS) can offer collaboratively.

In addition to this, collaborative discussion with the Urgent Community Response (UCR) leadership continues, with the aim of reviewing ways in which D2A and UCR can work together to safely support patients to remain at home (and therefore not inappropriately attend ED or require a community hospital bed).

Significant steps have been taken to recruit to therapy posts which have sat vacant for some time – x2 B5 (rotational), x2 B6 and x1 B7 therapists have since joined the service. In addition to this, x2 B6 nurse posts and x4 B4 posts are also in various stages of recruitment. The expectation will be that this will have a direct impact on the number and complexity of patients that the D2A service can support in the longer term.

SPC

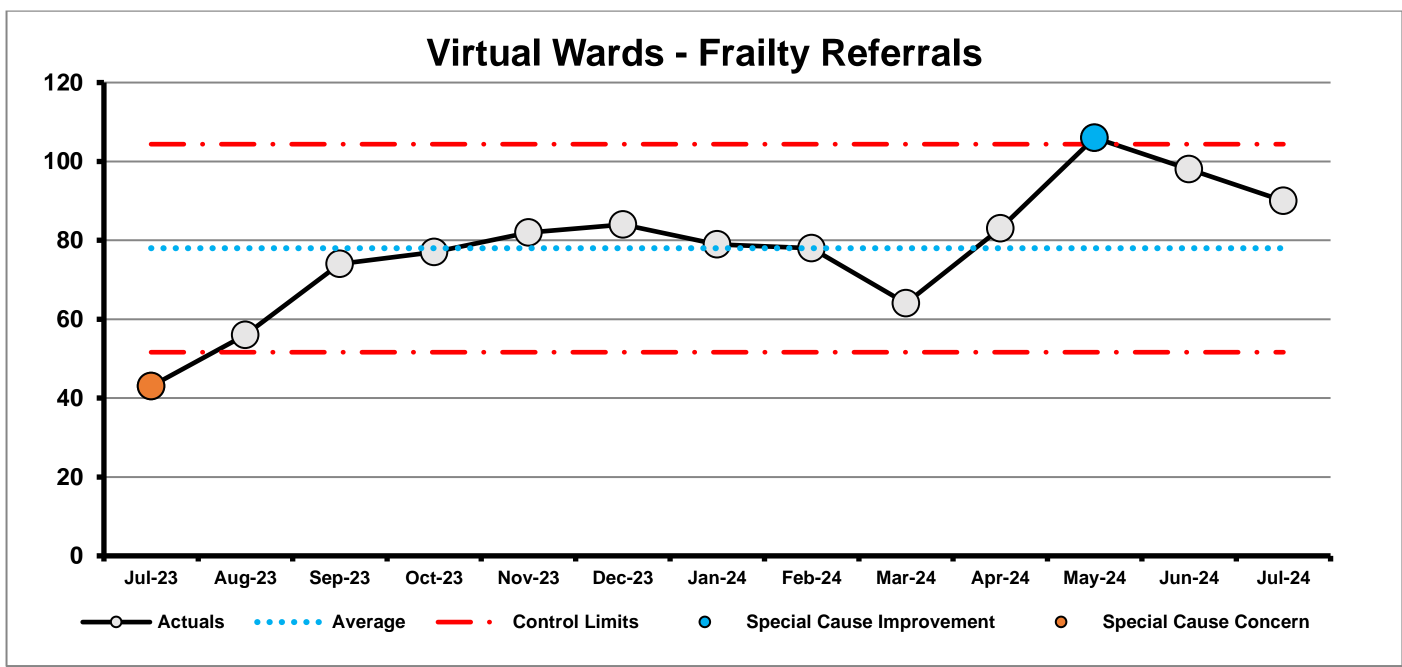
The number of distinct patient contacts has not varied significantly over the period.

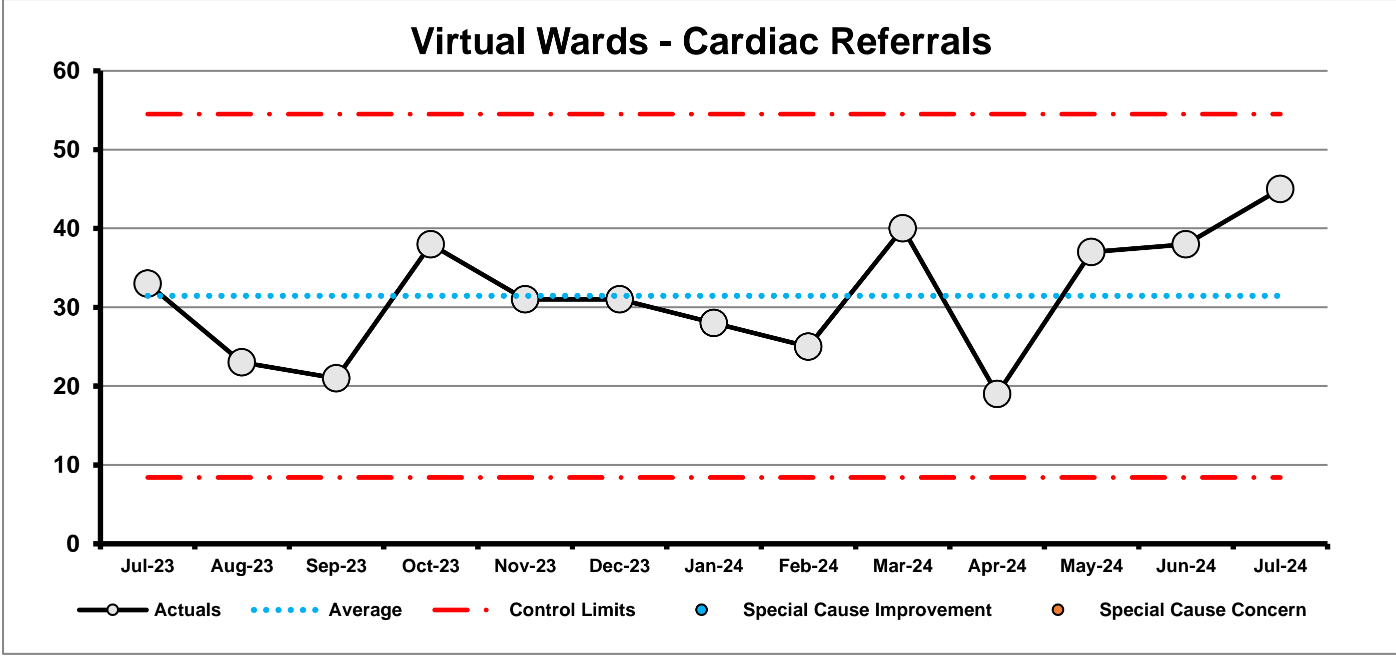
The number of D2A accepted referrals has not varied significantly since December 2023.

Virtual Wards

Background

The Trust's current virtual ward offering includes frailty, cardiology and respiratory. The service closely collaborates with ULHT, and patients are cared for in the community, with guidance from ULHT consultants.





Narrative

Reporting continues to encompass frailty, respiratory and cardiology virtual wards. OPAT & SDEC data is being progressed with ULHT. FBI are supporting the virtual ward team, cross referencing the different reporting that currently takes place (e.g., NHSE, SHREWD and internal reports) to make sure that the data is consistent and that all virtual wards are included in all our reporting.

SPC

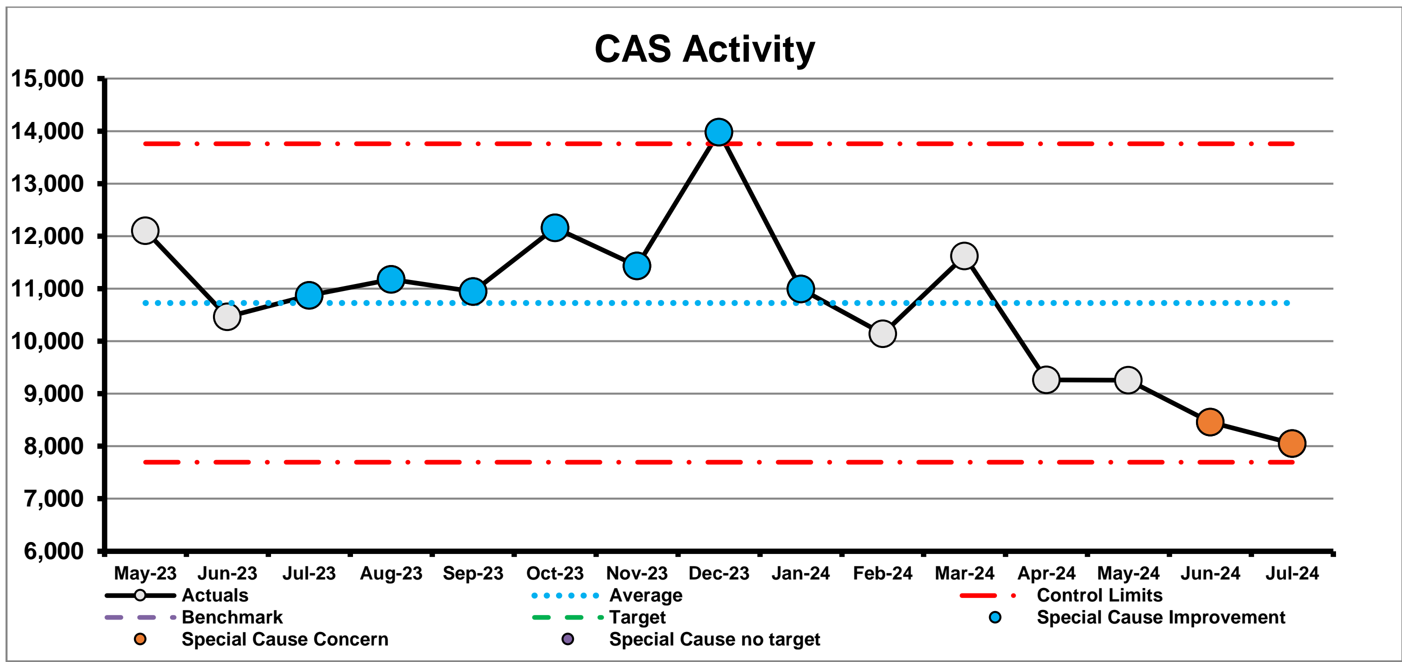
The number of referrals to the frailty virtual ward has not varied significantly since May 2024.

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 dipped significantly due to the 111 contract changes and equated to a loss of approximately 100 calls per day. This trend has continued, and activity is being closely monitored. Other options have been implemented to increase referrals into the service. A paper was presented at TLT on 27th June on the wider impact of the new contract on both the system and around patient experience and outcomes. Datix are also being monitored closely to monitor patient safety as a result of the change. These datix have increased in volume and are being reported back to the ICB.

Although there appears to be a further drop in cases for July, it needs to be noted that June had 5 whole weekends. Saturdays and Sundays tend to have at least double the volume of calls so this could account for the drop. Additionally, there has been an issue in the way that extracts have been pulled to get these figures. This has now been identified and the figures may change in the coming days.

Action

Meeting put in place for urgent review of data and to ensure this is correct. 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 avoidable conveyances). A risk around UTCs across the county having seen an increase in referrals in line with this call volume is emerging 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

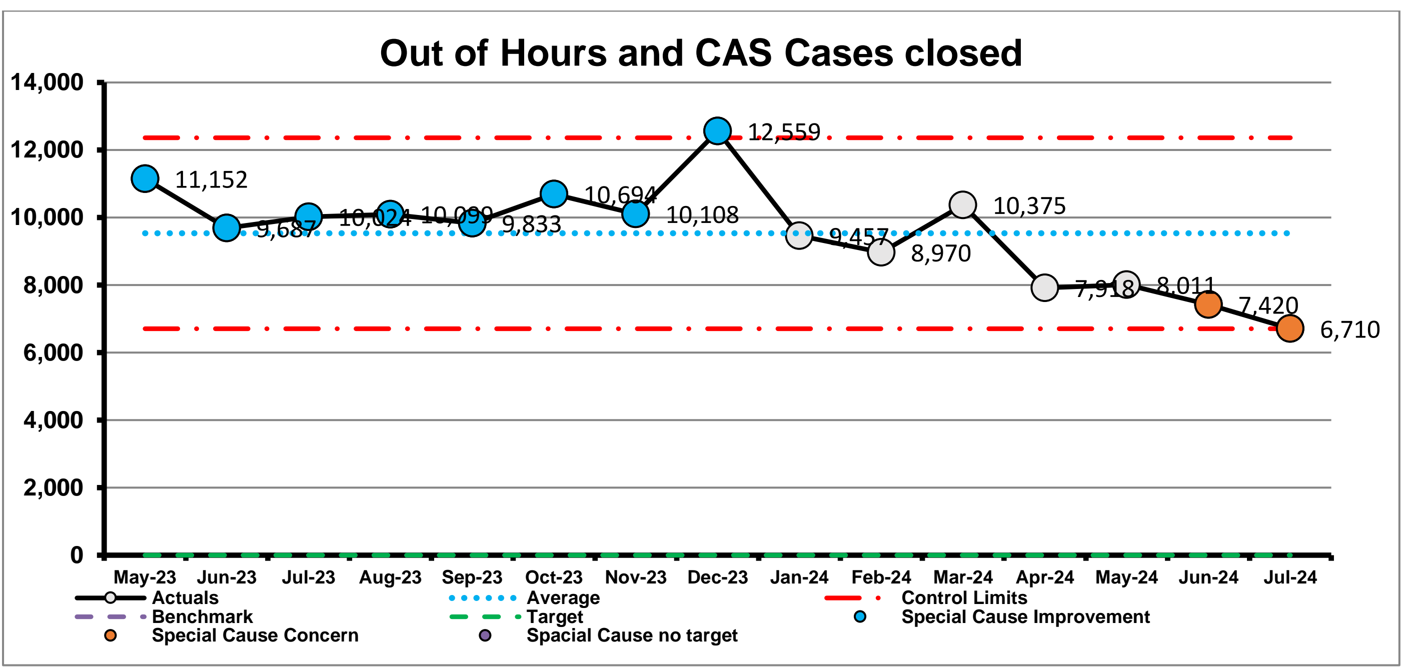
SPC

CAS activity has shown special cause concern since June 2024.

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 due to the change in the DHU contract and the reduction in call volume to CAS and therefore a decrease in booked appointments. Some concern around data for CAS/OOH which is being looked into.

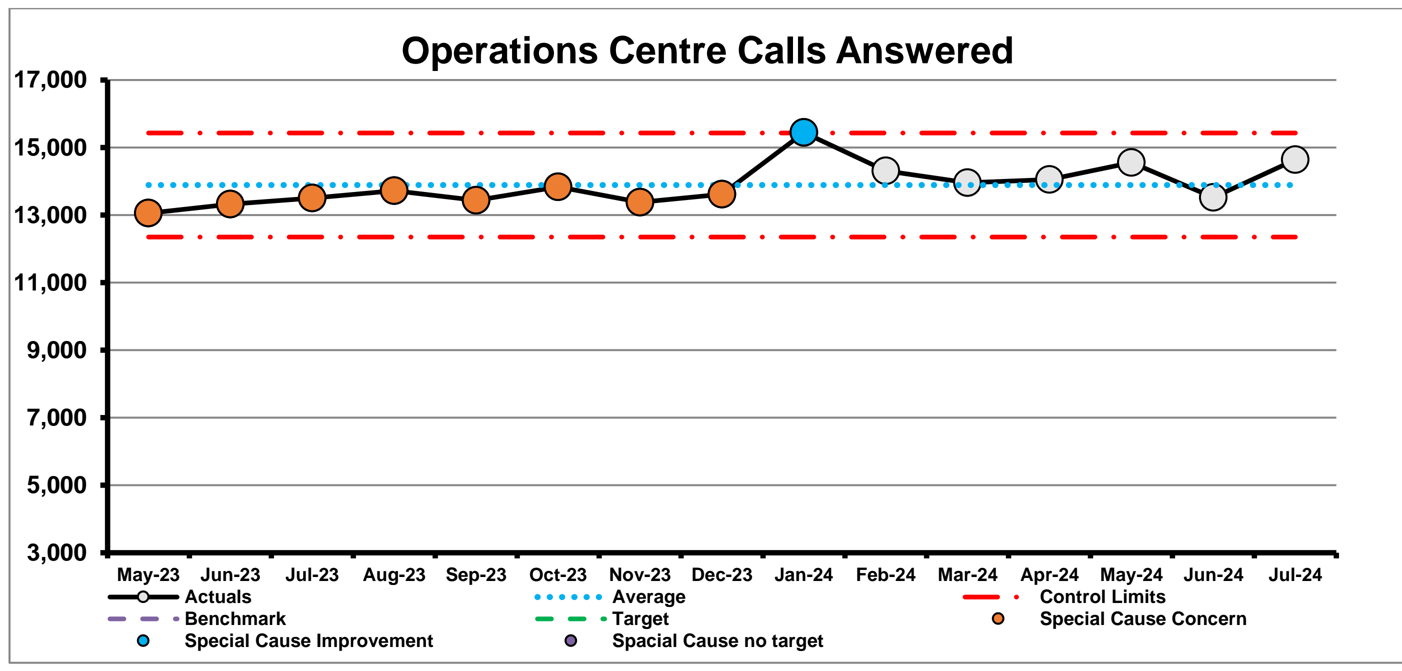
Action
Urgent meeting put in place to look at data and ensure this is being recorded accurately in Power BI. Ongoing discussions were being held as to the value of this data being included within FFPIC reporting due to Grantham OOH no longer being included.

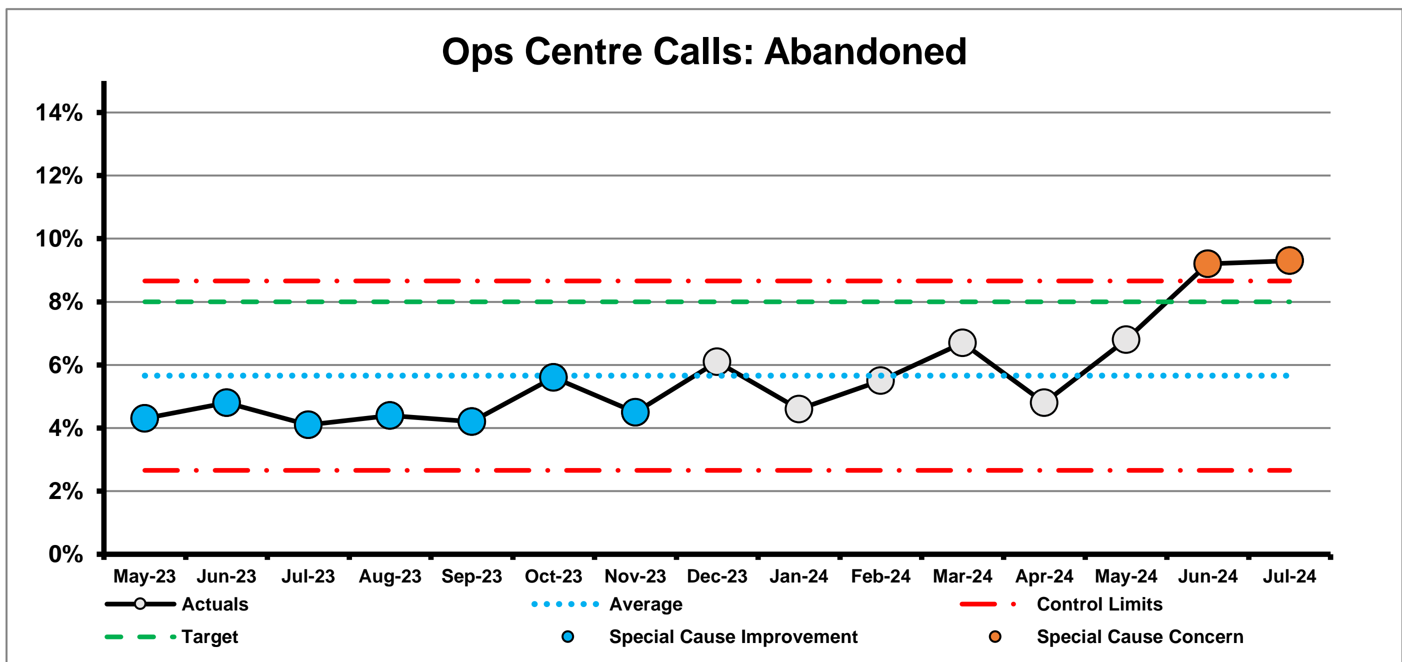
SPC
OOH & CAS Cases Closed shows special cause concern since June 2024.

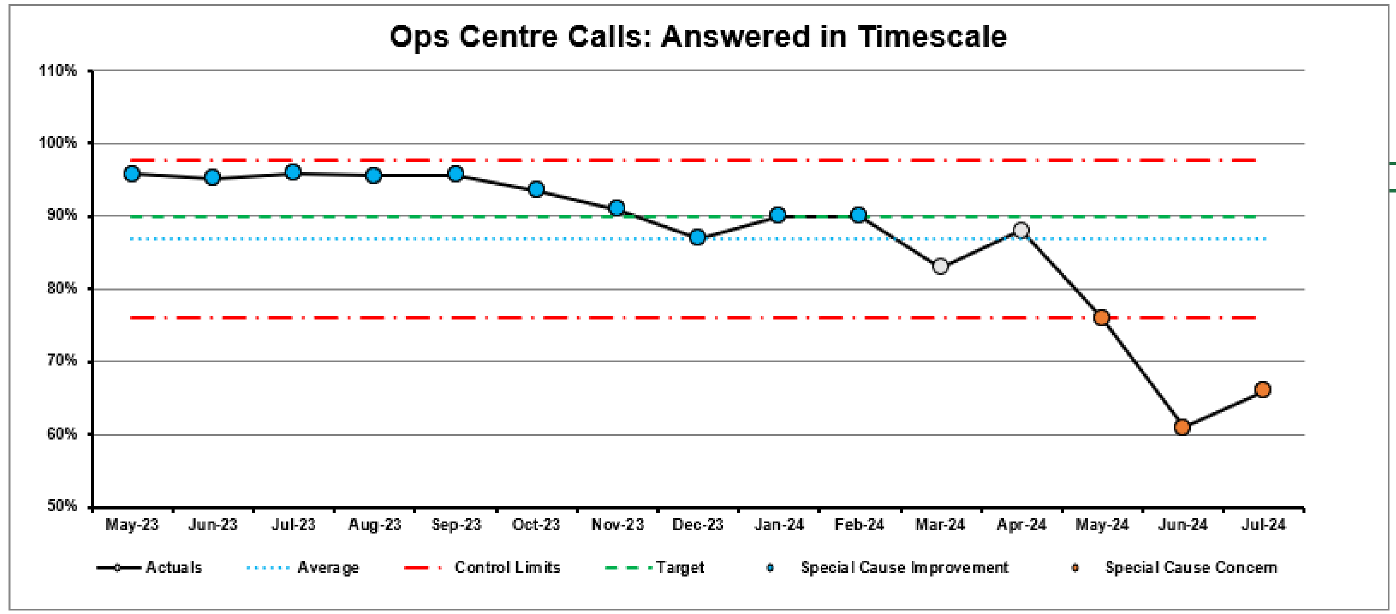
Operation Centre Calls Metrics

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

July saw record volumes of contacts into the Ops Centre, with 16,338 calls offered and 7,200 emails. The Ops Centre continues to experience sustained staffing shortfalls, with vacancies, long term and acute sickness within the Service Advisor resource pool as well as being down two Band 6 Team Managers. Low staff morale and sustained demand continue to impact on our ability to cover shortfalls through bank and overtime. The team successfully recruited to three of the Service Advisor vacancies that were approved, and they start early September.

SPC

The number of calls answered within the Ops Centre has not varied significantly since January 2024.

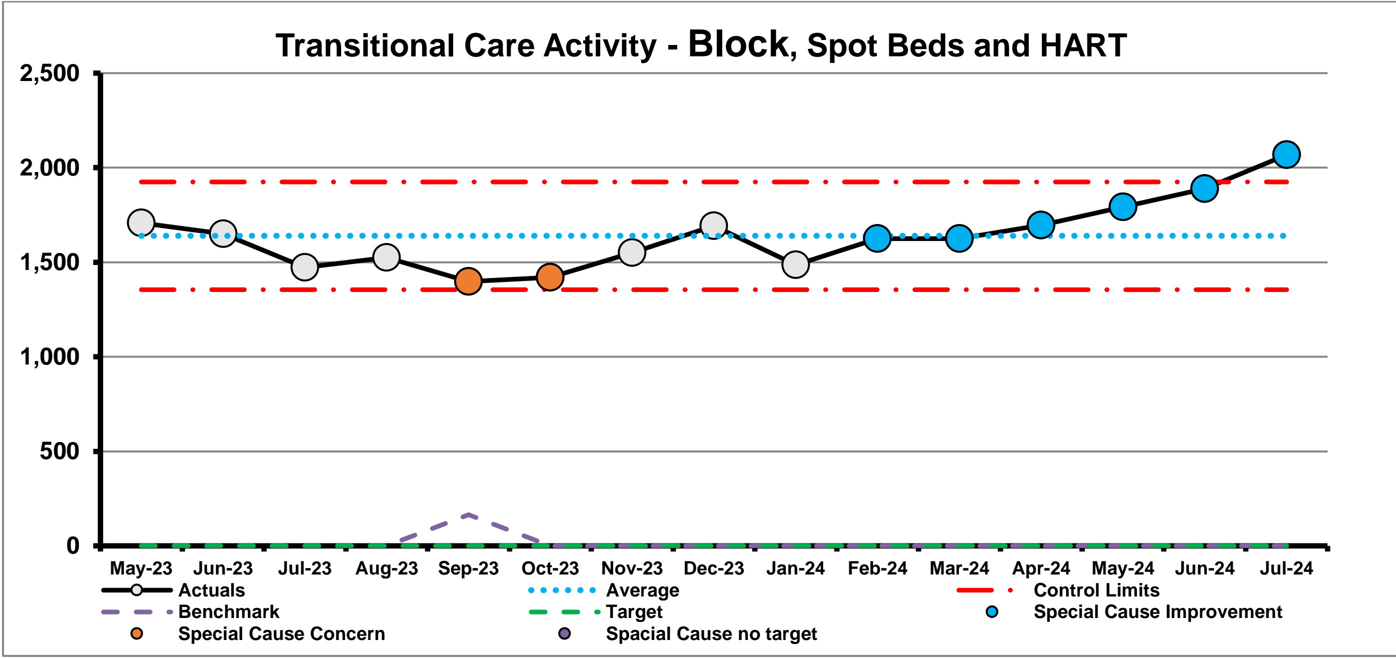
Ops Centre Calls Abandoned shows special cause concern since June 2024. It is inconsistently capable of achieving the 8% target but achieves target more often than not.

Ops Centre Calls Answered within Timescale has shown special cause concern since May 2024. It is inconsistently capable of achieving target and is expected to miss 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 continued to rise during July, demonstrating the highest utilisation when compared with data spanning the last year. The service has supported a significant amount of step-downs from community hospital beds in an attempt to alleviate system pressures and free up beds for the acute; this was, in part, a response to industrial action at the beginning of the month.

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 shows special cause improvement since February 2024.

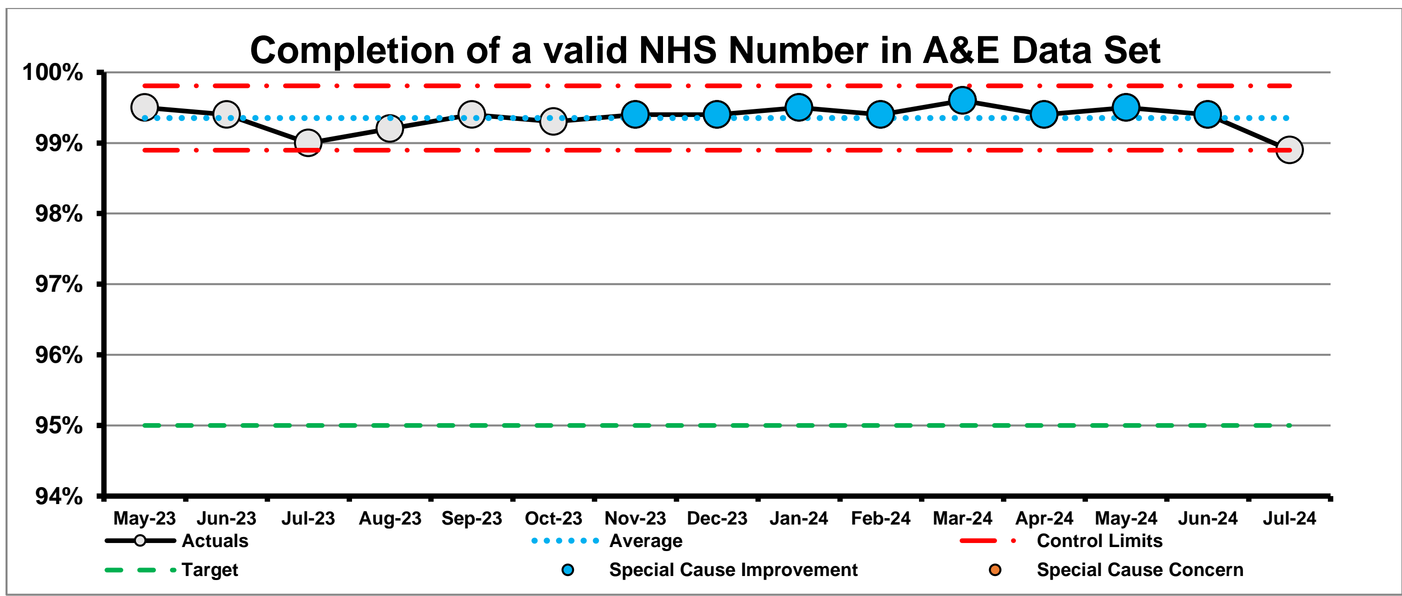
Completion of a Valid NHS Number in A&E Data Set

Background

The Data Quality Dashboards are a national resource to support the improvement and completeness of data flows by reporting on the validity of key data items in Secondary Uses Service (SUS) in accordance with published data standards. The information is provided by The Health and Social Care Information Centre and the areas applicable to LCHS are:

- Accident and emergency

The dashboards are reviewed against the national attainment and any data items that fall below the national attainment rate are highlighted for consideration and action planning.



Narrative

The latest available data demonstrates the completion of a valid NHS number for A&E Data Sets. The Trust maintains a high level of compliance – above 98% since April 2021. This is higher than the national average. Remarkably, July's figure would normally show concern, but this must be seen in context against the outstanding figures across the rest of the year.

Actions

The completions of NHS numbers within the A&E datasets continue to be raised with services, to ensure issues around data quality are addressed. The data system used is linked to the NHS Spine. Patients with no NHS number are not registered with a GP.

SPC

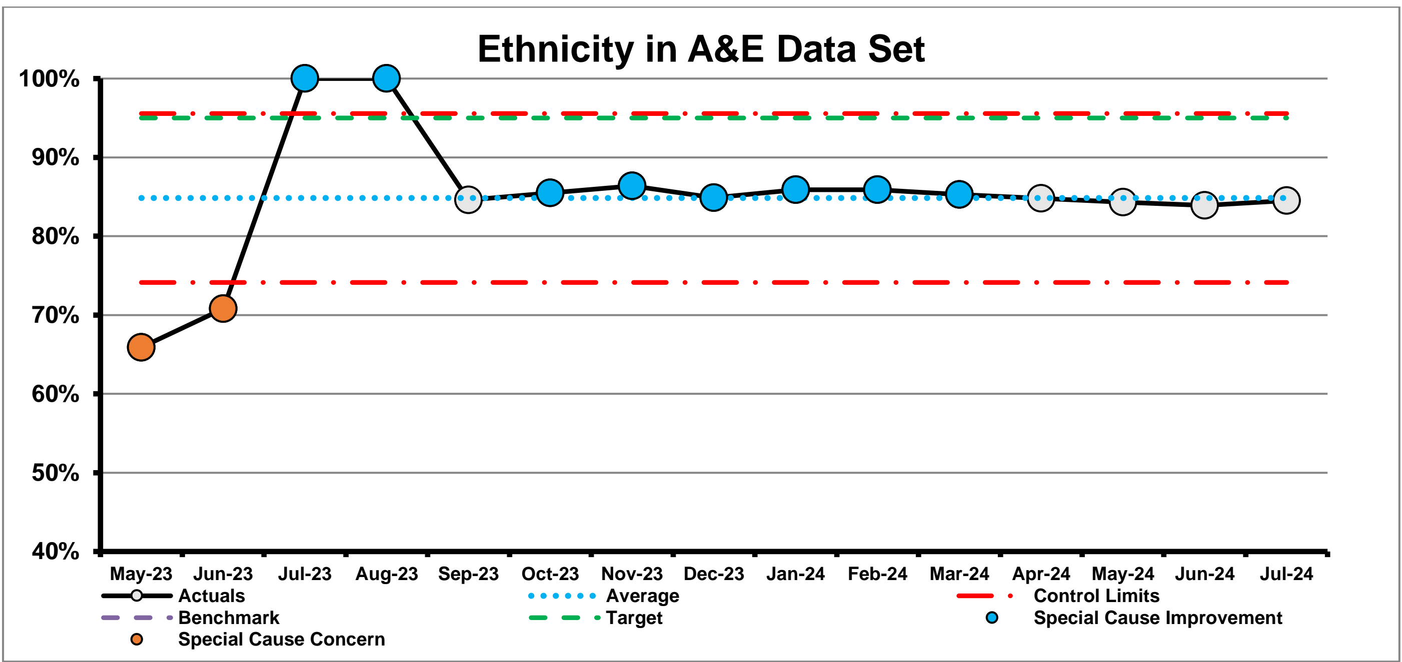
Completion of a valid NHS number for A&E datasets has not varied significantly since June 2024 and is consistently capable of achieving the 95% target.

Completion of Ethnicity in A&E data set

Background

The Data Quality Dashboards are a national resource to support the improvement and completeness of data flows by reporting on the validity of key data items in Secondary Uses Service (SUS) in accordance with published data standards. The information is provided by The Health and Social Care Information Centre and the areas applicable to LCHS are:

- Accident and emergency



Narrative

Ethnicity in A&E data shows significant improvement since June 2023. As reported previously changes to this process were being made to stop using local codes for ethnicity not stated and remove old codes.

Issues have been identified where SystmOne doesn't export patient's ethnicity if the data is not something added by the user onto the system. This has caused problems with us being unable to pull our ethnicity activity from within the extract. The months during July and august where we reported 100%, were due to a miscommunication between ourselves and NHS England during the validation period, where we were advised to reset blank ethnic codes. Since discovering these inaccuracies, we have resubmitted our activity and it is now reflected on a new download from SUS.

The increase from 67% to 85% is through a process developed to download an extra patient dataset from Systm1 which reports on Ethnicity for all patients. Following this validation process, 85% is a more reflective position on actual completion. Further work is still required with our UTC colleagues to continue to work towards improving the collating of our ethnicity data at the point of source.

We have initiated a new Data Quality system "RINSE" introduced to support managers to monitor and manage who hasn't completed ethnicity population. The FBI team continue to with digital health to ensure that any SOPs or training emphasis' the importance of completing the data.

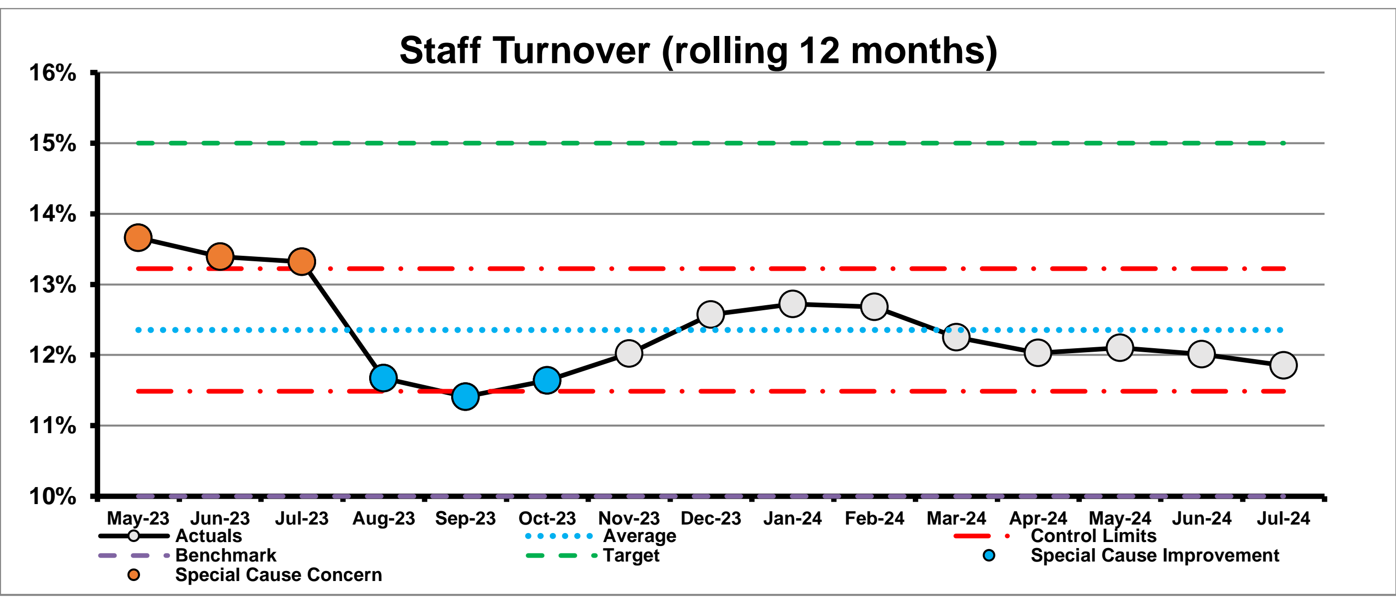
SPC

Ethnicity in A&E dataset has not varied significantly since March 2024. This metric is inconsistently capable of achieving the 95% target but expected to miss the target more often than not.

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 11.85% 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 and is consistently capable of achieving the 15% target.

Financial Performance Summary

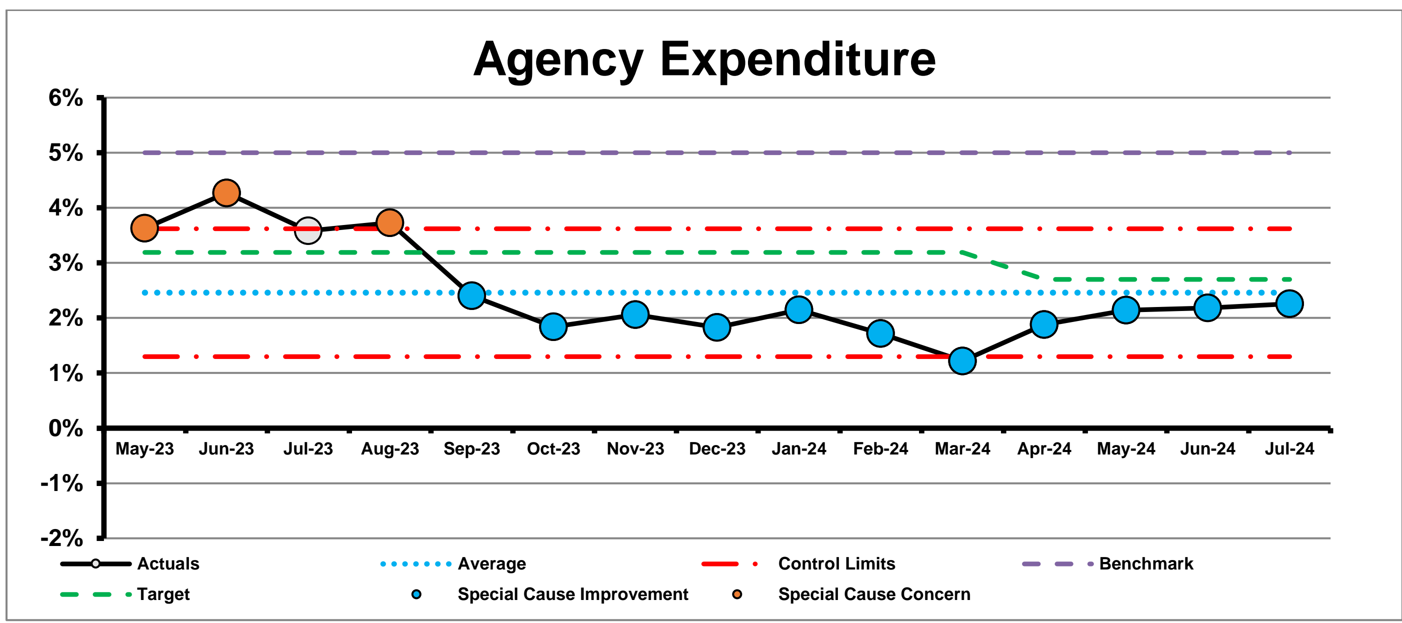
Financial Summary Table (Month 4)

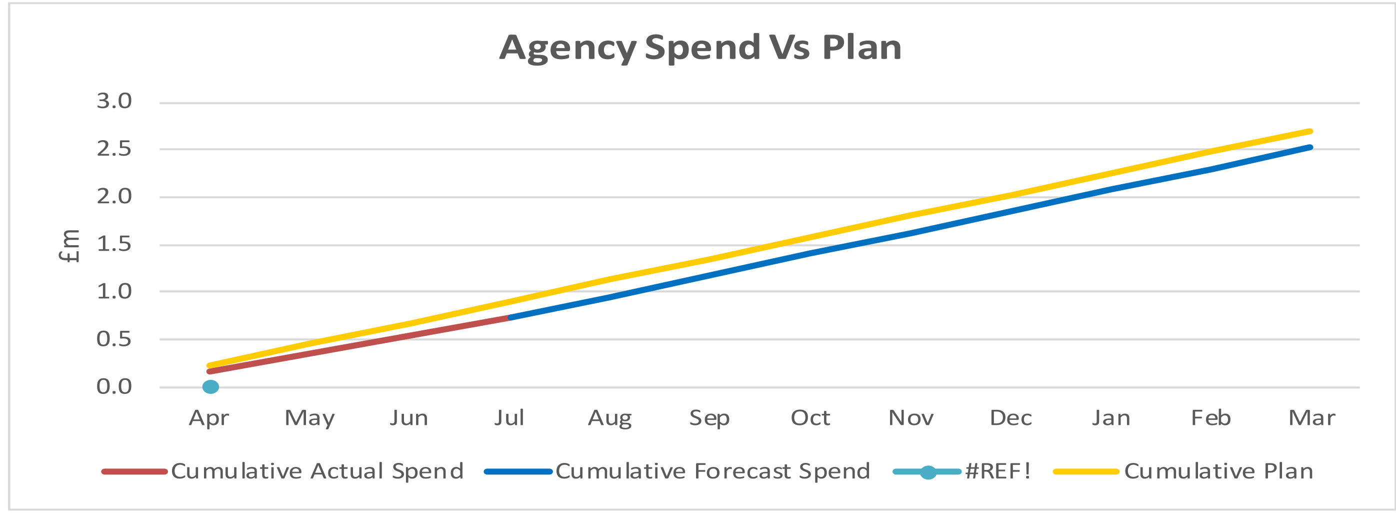
Description	Narrative
Position in July	£39k surplus against a plan of £86k deficit
Position YTD	£902k deficit against a plan of £1.027m deficit
CIP in July	£556k against plan of £586k
CIP YTD	£1.399m against plan of £1.429m
CIP FOT	£7m against plan of £7m
Agency in July	£192k against plan of £225k
Agency YTD	£589k against plan of £900k
Agency FOT	£2.6m against plan of £2.7m
Capital in July	£93k against plan of £0k
Capital YTD	£440k against plan of £31k
Capital FOT	£2m against plan of £2m
Cash	£22m against plan of £30m

Agency Expenditure

Background

For both 2023/24 and 2024/25 there is an agency ceiling at Lincolnshire System level rather than organisational level. The Trust planned for a 3.19% agency level in 2023/24 and is planning for a 2.70% agency in level in 2024/25 as its contribution to achieving the system agency ceiling.





Narrative

- M4 agency spend was £192k compared to £225k plan, continuing to trend below plan
- YTD agency spend (at M4) is £589k which is £311k lower than plan, noting that the favourable variance includes £143k accrual release (M3) relating to prior year invoicing.
- In respect of the split of Agency spend:
  - Collaborative Community Care - £392k (67%)
  - Uec Collaborative - £195k (33%)
  - Nursing represents 61% of Agency costs in M4 (57% YTD)

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).

	Plan Month 4 £000	Actual Month 4 £000	Variance Month 4 £000	Plan YTD £000	Actual YTD £000	Variance YTD £000	Annual Plan £000	Forecast £000	Variance £000	Overall Delivery of Savings RAG
Interest - GBS Bank Account	£108	£129	£21	£433	£506	£73	£1,300	£1,373	-£73	NR
LCHS income to cover initiatives without System support	£97	£97	£0	£386	£386	£0	£1,159	£1,159	£0	NR
Procurement	£10	£28	£18	£10	£28	£18	£300	£300	£0	R
Agency Reduction	£50	£40	-£10	£183	£173	-£10	£1,100	£1,100	£0	R
Non-Pay Savings	£31	£31	£0	£31	£50	£19	£140	£159	-£19	R/NR
Use of ULHT GP cover overnight	£6	£46	£40	£6	£46	£40	£127	£127	£0	R
Estates Savings	£0	£0	£0	£0	£0	£0	£150	£150	£0	R/NR
Delay to POCT Project	£0	£42	£42	£0	£42	£42	£125	£125	£0	NR
Continence products	£8	£3	-£5	£8	£3	-£5	£70	£70	£0	R
Posts to be removed	£10	£10	£0	£10	£10	£0	£107	£107	£0	R
Vacancy Savings (additional 1%)	£110	£30	-£80	£110	£30	-£80	£992	£928	£64	NR
Bank and Overtime Reduction	£9	£0	-£9	£9	£24	£15	£105	£129	-£24	NR
Service Redesign	£147	£100	-£46	£147	£100	-£46	£1,177	£1,177	£0	R
Unidentified Gap	£0	£0	£0	£96	£0	-£96	£178	£126	£52	R/NR
2024-25 CIP Programme	£586	£556	-£30	£1,429	£1,399	-£30	£7,030	£7,030	£0	

Narrative

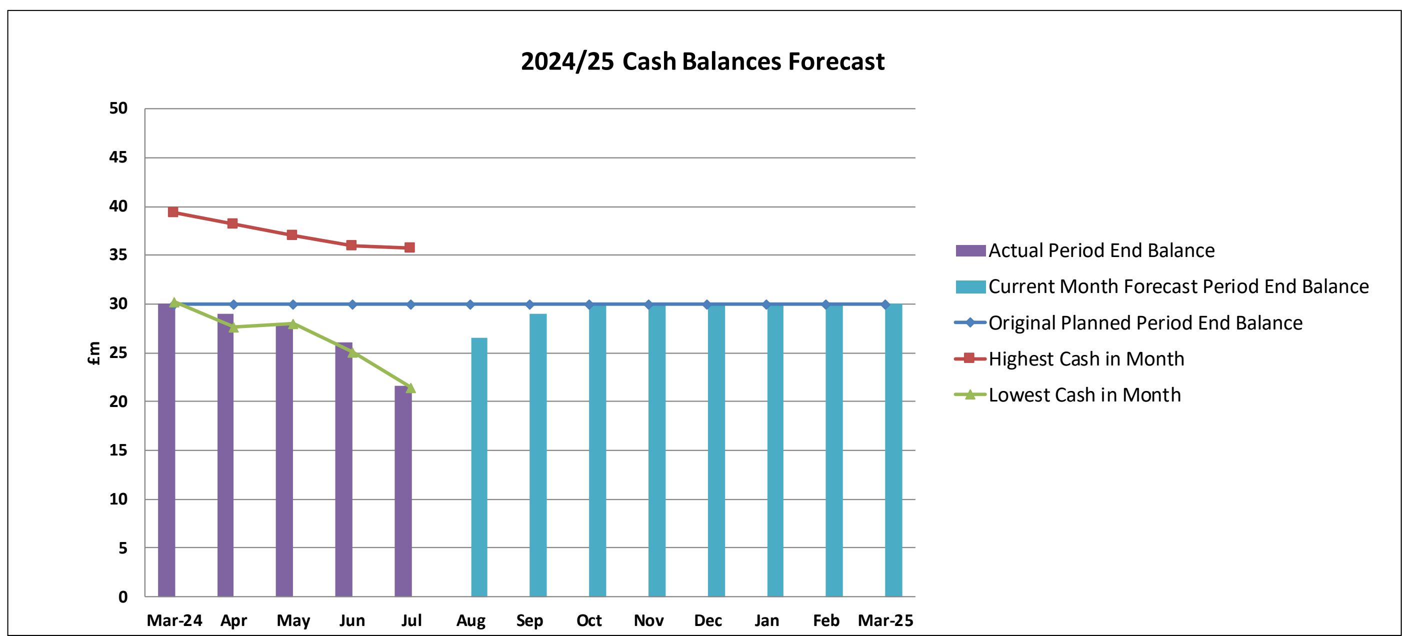
- M4 delivery £30k behind plan due to timing differences (CIP target for M4 was a 108% increase on M3)
- £1.1m unidentified gap as at M3 now reduced to just £126k in M4 with work underway to move remaining CIP held centrally out to the divisional budget holders
- Programmes split out to provide greater level of detail/clarity
- Monthly governance reviews now scheduled with Estates and Procurement
- Agency CIP savings split c35% WTE/65% rate – equating to a 15 Agency WTE reduction by M12

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 2024/25 are as below:



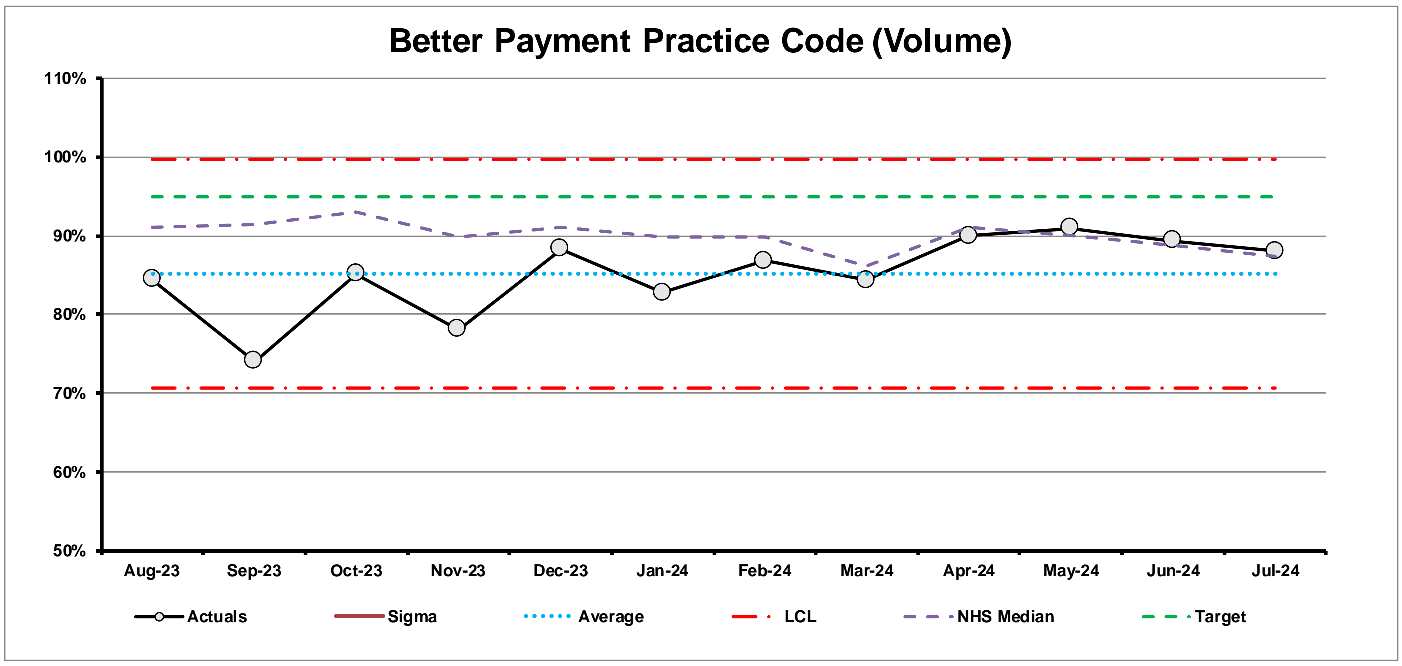
Narrative

- The LCHS cash balance for M4 was £21.5m, £8.5m below target
- £3.8m associated with the uplifted FY25 contract due from ICB will be paid in August payment run
- c£1m prior year estates invoices relating to revaluation of Johnson site in Spalding paid in M4
- Phasing of I&E plan, with a deficit of £0.9m YTD, also contributing to deterioration in cash position
- Cash out in M4 higher than prior months due to quarterly billing cycle of some suppliers
- Cash position is expected to recover back to target over the next three months

Better Payment Practice Code

Background

This metric represents the performance of our invoices paid within the agreed terms. The target Better Payment Practice Code (BPPC) is 95%.



Narrative

- BPPC by **volume** of invoices for July of 88%, down 1% versus prior month and below the target of 95% (noting that BPPC by ***value*** of invoices is ahead of target at 98% in July)
- LCHS continues to perform above the NHS Community Sector Median and has shown significant improvement over last 12 months. However, renewed focus required to ensure continued improvement up to 95% target this financial year.

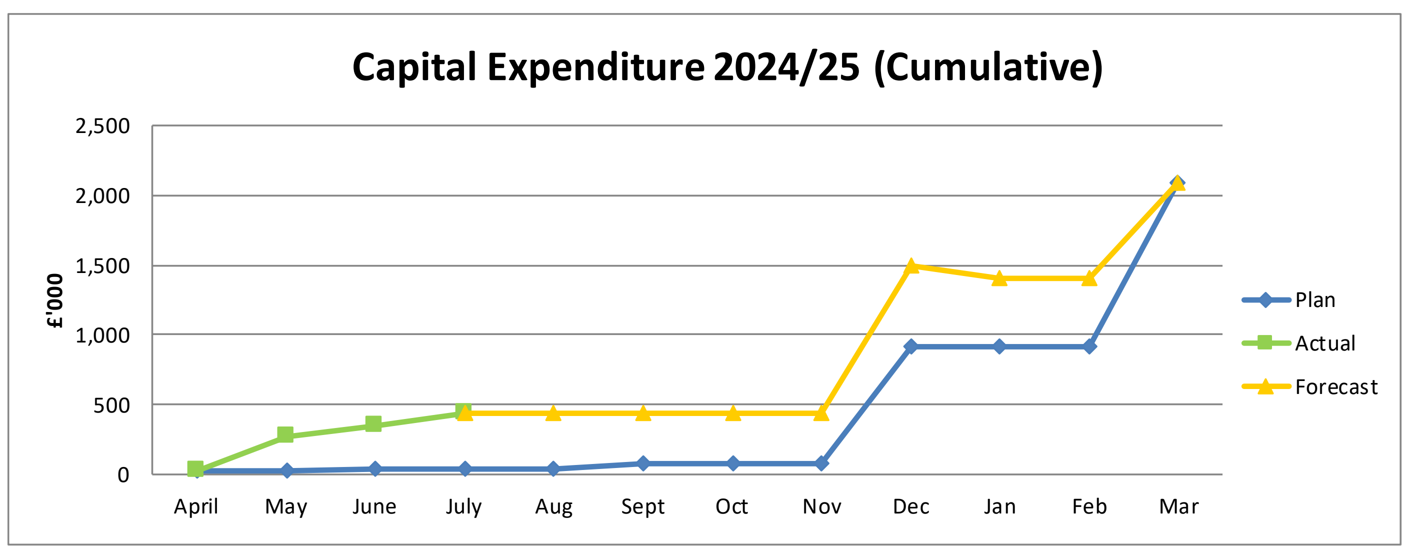
SPC

Monthly Better Payment Practice Performance by volume has not varied significantly over the period. This metric is inconsistently capable of achieving the 95% target and is expected to miss the target more often than not.

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 £2m for 2024/25.



Narrative

- The LCHS capital plan for the financial year totals c£2.086m

- Year-to-date capital spend up to M4 equated to £440k. The Plan assumed that capital spend would be incurred in M9 £1.0m) and M12 (£1.1m) with spend phased towards the end of the year to allow plans to be fully developed. The YTD overspend is a positive given historical levels of underspend in this area.

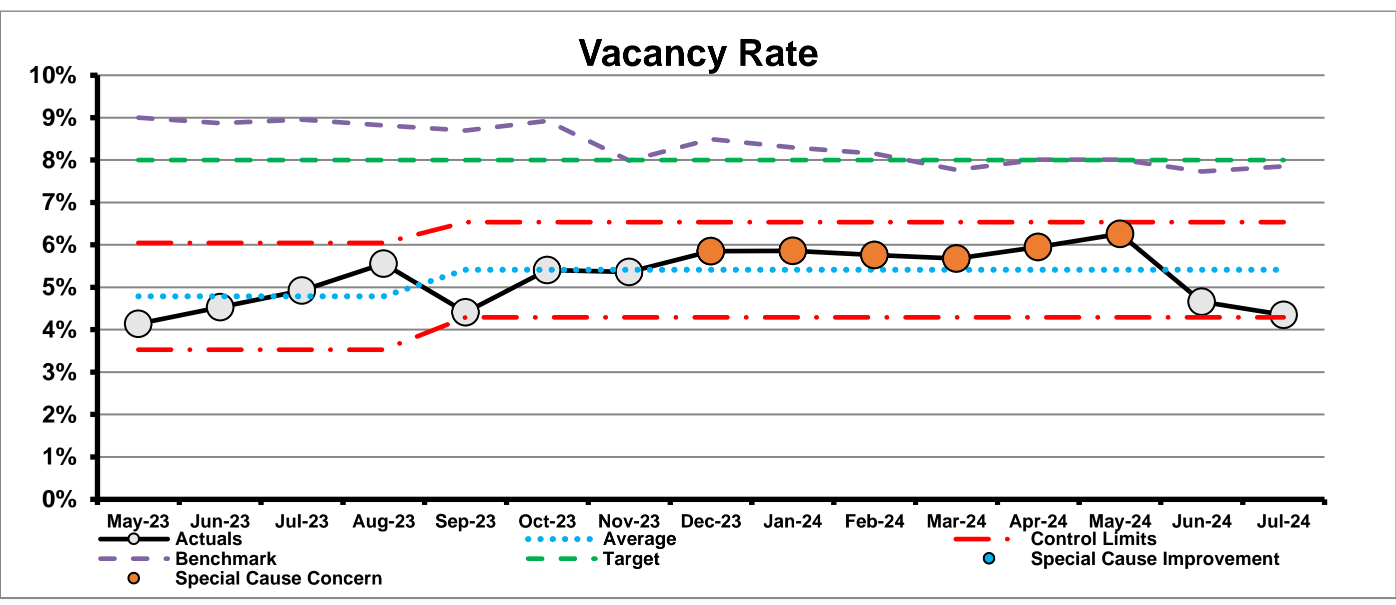
- The year to date spend has been incurred in the following areas (bracketed numbers are full year plan)

    - Information Management & Technology - £342k (£1,260k)
    - Estates investment schemes - £11k (£580k)
    - Clinical Equipment schemes - £87k (£246k)

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.

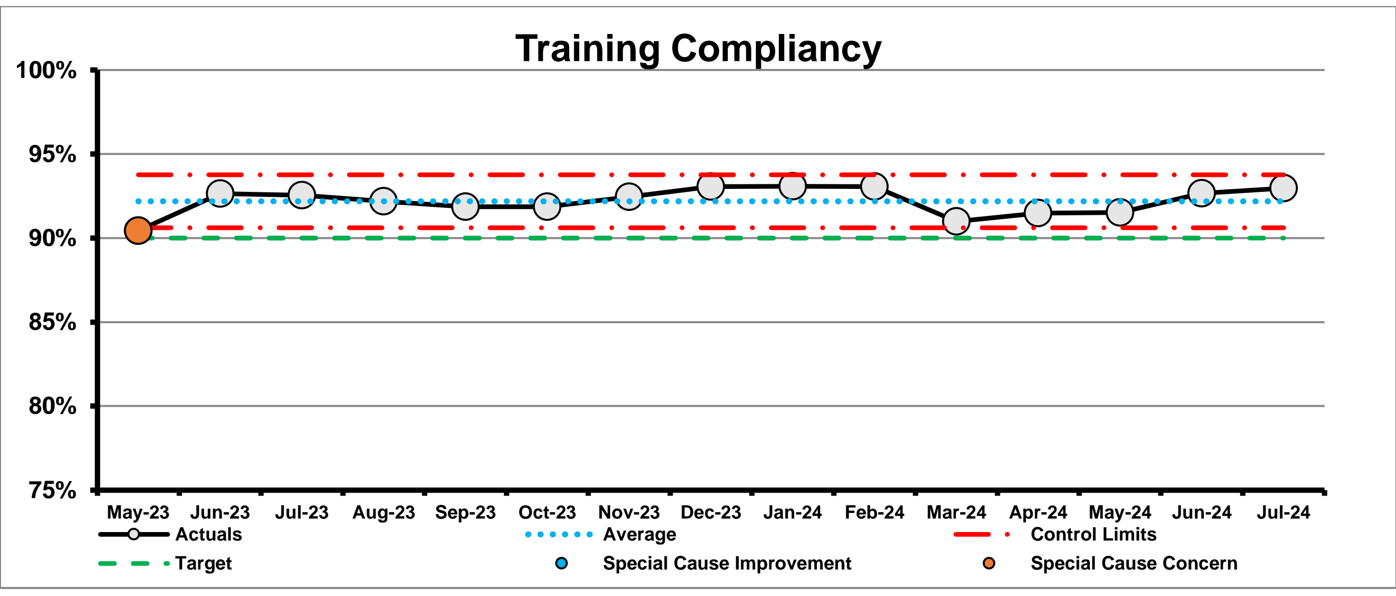
SPC

The vacancy rate has not varied significantly since May 2024 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 31.07.2024:

The overall mandatory training compliance rate which includes all core **and** role specific modules has increased to 92.97% which exceeds the local and national target of 90%.

Core mandatory training compliance (requirements for all staff): Overall compliance for the core mandatory modules has increased to 94.82% which exceeds the national/local target of 90%

The eLearning module remains live on ESR for staff to access at a time of their choice and will also support those returning to work from long term absence to update.

All divisions/directorates have overall compliance remaining above the national/local target of 90%.

Children's, Young People's, and Specialist Services	95.77%
Collaborative Community Care	94.19%
Corporate Services	96.06%
Integrated Urgent and Emergency Care	93.87%
Operational Business Services	96.09%
Operational Leadership	93.97%
System	92.75%

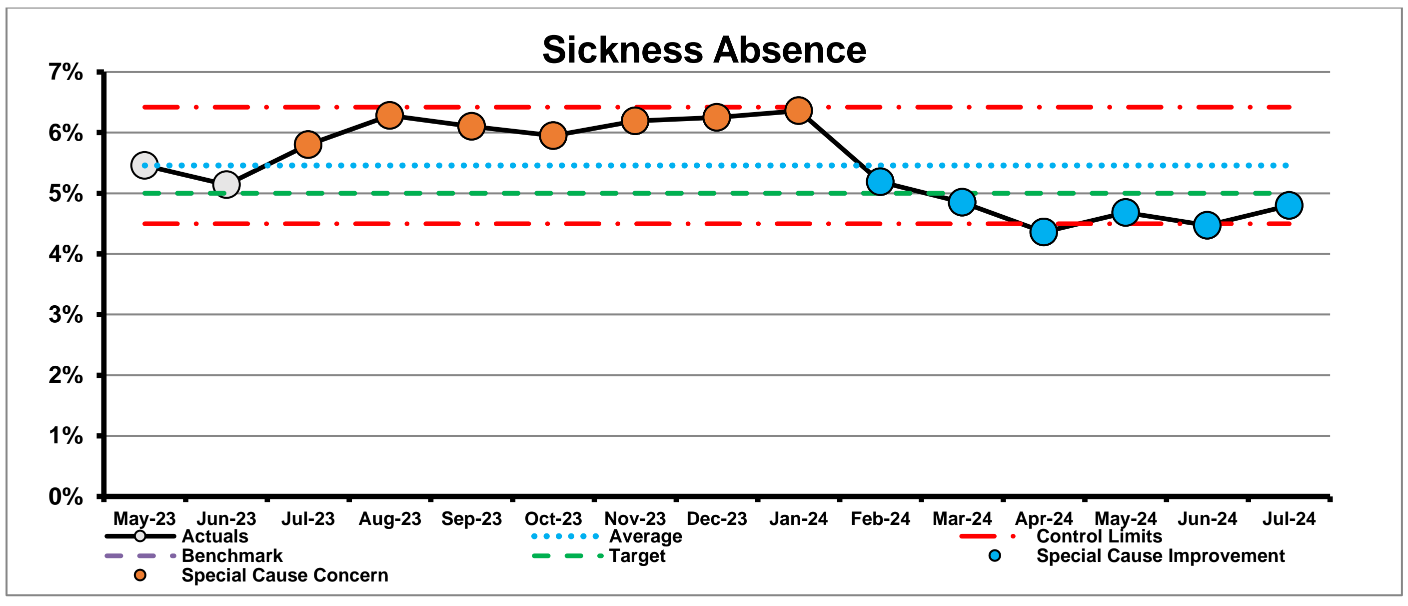
SPC

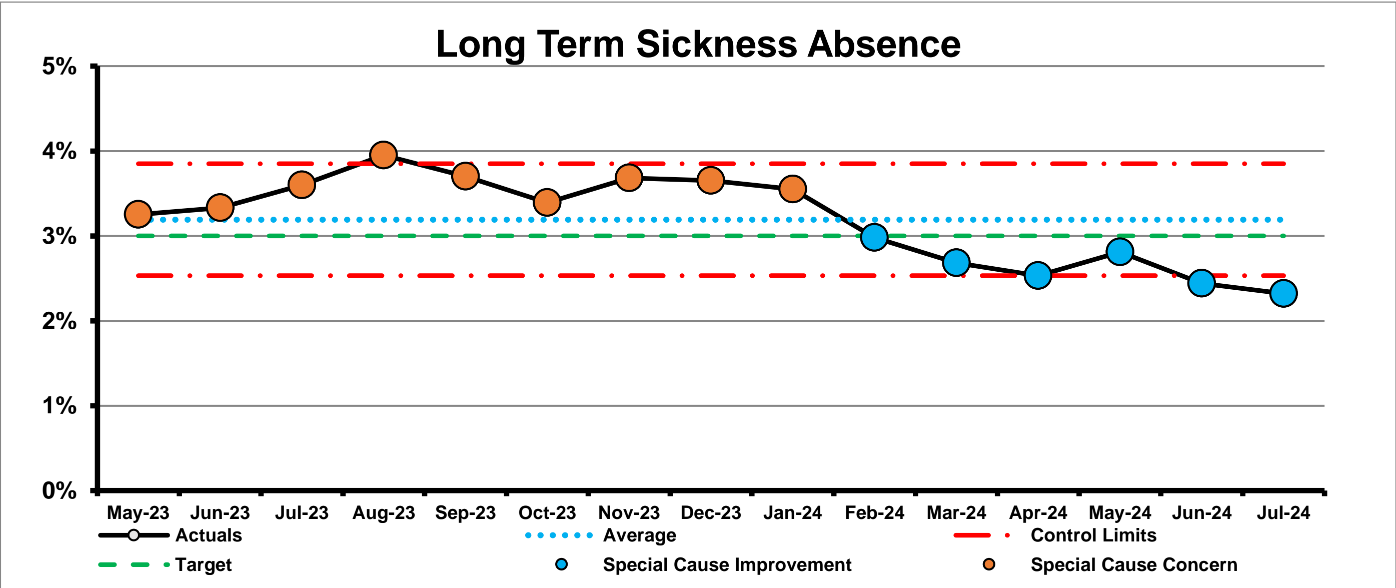
Mandatory Training compliance has not varied significantly since May 2023. The measure is consistently capable of achieving the 90% target.

Sickness Absence

Background

The Trust target for total sickness absence is 5%.





Narrative

The overall sickness level in July has increased slightly at 4.8% from 4.47% in June. This remains below the agreed target of 5%.

For overall sickness absence, there are four areas above target as of July: Operations (8.98%), Children's, Young People and Specialist Services (5.78%), Integrated Urgent and Emergency Care (5.36%) and Operational Business Services (5.22%).

The top three reasons accounting for overall sickness absence in July are: anxiety, stress and depression, gastrointestinal problems and genitourinary and gynaecological disorders.

Long Term

The long-term sickness level in July has remained below the agreed target of 3% at 2.32%.

In relation to long term absence, there are three areas above target: Operations (4.68%), System (3.32%) and Children's, Young People and Specialist Services (3.19%).

The top three reasons for long term sickness absence for July were: anxiety, stress and depression, genitourinary and gynaecological disorders and other musculoskeletal problems.

Short Term

The short-term sickness level in July has increased slightly to 2.48% (2.04% in June) and is now above the 2% target.

In respect of short-term sickness, there are five areas that are above target: Operations (4.29%), Integrated Urgent and Emergency Care (3.15%), Children's, Young People and Specialist Services (2.59%), Operational Business Services (2.48%) and Collaborative Community Care (2.34%).

The top three reasons for short term sickness absence in July remain the same as in the previous three months 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 February 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 shown special cause improvement since February 2024 and is inconsistently capable of achieving the 3% target. The target is expected to be missed more often than achieved.

Workforce Dashboard

July 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	524.68	491.68	33.00	6.29%	9.48%	0.17%	5.78%	2.59%	3.19%	94.64%	95.12%	96.27%
Collaborative Community Care	744.92	749.78	-4.86	-0.65%	11.35%	0.19%	4.19%	2.34%	1.85%	92.32%	86.60%	84.85%
Corporate Services	226.93	219.13	7.80	3.44%	20.42%	1.83%	3.06%	1.60%	1.46%	95.80%	91.04%	92.86%
Integrated Urgent & Emergency Care	421.92	363.81	58.11	13.77%	4.93%	0.55%	5.36%	3.15%	2.21%	90.16%	96.61%	94.49%
Operational Business Services	105.27	100.79	4.48	4.26%	22.75%	0.99%	5.22%	2.48%	2.74%	96.90%	93.64%	
Operations	40.90	34.39	6.51	15.93%	18.03%		8.98%	4.29%	4.68%	92.85%	82.05%	88.89%
System	19.00	33.37	-14.37	-75.65%	37.75%	5.99%	4.08%	0.76%	3.32%	92.88%	62.07%	92.86%
Total	**2,083.62**	**1,992.95**	**90.67**	**4.35%**	**11.85%**	**0.56%**	**4.80%**	**2.48%**	**2.32%**	**92.97%**	**90.98%**	**90.40%**

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	226.93	219.13	7.80	3.44%	20.42%	1.83%	3.06%	1.60%	1.46%	95.80%	91.04%	92.86%
Chief Exec	21.35	14.51	6.84	32.05%	30.33%		0.22%	0.22%		96.21%	86.67%	
Finance & Business Intelligence	56.00	50.53	5.47	9.76%	19.58%	1.98%	3.06%	1.88%	1.18%	97.24%	93.75%	
Medical Directorate	22.25	24.96	-2.71	-12.18%	42.31%		2.99%	2.99%		94.14%	91.67%	88.24%
People & Innovation	86.77	93.73	-6.96	-8.03%	13.23%	2.13%	2.62%	0.92%	1.70%	94.38%	96.63%	100.00%
Quality	40.56	35.40	5.16	12.72%	21.19%	2.82%	5.48%	2.60%	2.88%	98.44%	75.00%	95.83%
Total	**226.93**	**219.13**	**7.80**	**3.44%**	**20.42%**	**1.83%**	**3.06%**	**1.60%**	**1.46%**	**95.80%**	**91.04%**	**92.86%**

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	*3 September 2024*
Item Number	*14.1*

Executive Summary LCHS / ULHT Strategic Risk Reports

Accountable Director	*Kathryn Helley, Group Chief Clinical Governance Officer*
Presented by	*Kathryn Helley, Group Chief Clinical Governance Officer*
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 with an updated Group Risk Policy planned for completion by the end of August 2024. The Group Board will be provided with a joint executive summary until full alignment with reporting has been achieved.

ULHT

As of August 2024, there were 580 risks recorded on the Trust risk register and aligned to the sub committees of the Group Board; this is an increase of 15 risks from the previous report in July 2024.

There are 9 Quality and Safety risks rated Very high (20-25), reported to the Quality Committee in Common, 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 Very High and High risks aligned with Quality Committee have been updated:

- **Processing of echocardiograms**-Risk presented in July, reduction in score validated at Moderate (12) Current position: 93% of patients are being seen within 6 weeks. Agreed reduction in scoring to 12 (3x4).
- **Overdue patients on Ophthalmology PBWL**. Risk validated at July RRC&C for increase in score to 4x4:16.
- **Risk of clinical treatments being carried out in rooms that do that have appropriate ventilation levels.** New risk validated at July RRC&C 4x4:16.
- **Risk of failure to meet best practice standards for stroke patients due to lack of access to community rehabilitation service.** Risk validated at July RRC&C for increase in score to 4x4:16.
- **Frequency and duration of medication shortages.** Risk validated at July RRC&C for increase in score to 5x3:15.
- **Pharmacy capacity risk – Chemotherapy**- New Risk validated at July RRC&C 4x4: 16

There are 5 People and Organisational Development risks rated Very High (20-25) which were reported to the People & Organisational Development Committee, an increase of 1 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)
- **Cancellation of elective lists due to lack of theatre staff** - New risk validated at RRC&C meeting in June 2024 (20).

There are 6 Very high risks (20-25) reported to the Finance, Performance and Estates Committee, remaining stable 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.

Details of all current High and Very high risks are provided in ULHT **Appendix A**.

<u>LCHS</u>

As of the 31 July 2024, there were 101 risks recorded on the Trust risk register aligned to the sub-committees of the Group Board, this is an increase of 8 risks from the previous report in July 2024.

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 1 risk has increased in score and 1 risk decreased in score:

- 495 – Treatment Room Capacity
- 403 – Children Young People Therapy treatment delays
- 409 – Lymphoedema service capacity
- 395 – TB Demand and Capacity
- 672 – Timely Unplanned Palliative Response 24/7
- 695 – Lack of District Nurse Specialist Practice qualified staff in community nursing affecting the quality of care
- 714 – Delivery of pressure ulcer care in the community
- 715 – Community nursing lacks capacity and skill set to meet community demand
- 681 - **Children in Care** - unable to meet Initial Health Assessment and Review Health Assessment timescales – Risk validated at the RRC&C on 31st July 2024 score increased to 16 (previously 12) **.**

The following risks have been updated:

- 652 – **Interruption to Enhanced Practitioners and FVW business as usual activity** - Following review and scrutiny by RRCC on 31st July 2024 the score was revised and decreased to 10 (previous 16)

There were 8 Finance, Performance, People & Innovation risks rated Significant High (15 – 25) a reduction of 1 from the last reporting period:

- 442 – Efficiency Requirement 2024 / 2025
- 455 – Failure to deliver the financial plan – Income
- 444 – Failure to deliver the financial plan – Cost
- 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

The following risks have been updated:

- 665 – **Skegness Hospital Fire Safety Risk** - all roof void work has been completed and reviewed by Lincolnshire Fire and Rescue. Following review and scrutiny by FPPIC in July and RRCC on 31st July 2024 the score was revised and decreased to 10 (previous 15).

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**.

Meeting	*Lincolnshire Community and Hospitals Group Board Meeting*
Date of Meeting	*3 September 2024*
Item Number	*14.1*

ULHT Strategic Risk Report

Accountable Director	*Kathryn Helley, Group Chief Clinical Governance Officer*
Presented by	*Kathryn Helley, Group Chief Clinical Governance Officer*
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 August 2024.

There were 9 quality and safety risks rated Very High (20-25) reported to the Quality Committee in Common in August, which remains stable from the previous month's 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

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

- Processing of echocardiograms-Risk presented in July, reduction in score validated at Moderate (12) from High (16)

There are 5 People and Organisational Development risks rated Very High (20-25) which were reported to the People & Organisational Development Committee in August, an increase of 1 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)
- Cancellation of elective lists due to lack of theatre staff-**New risk validated at RRC&C meeting in June 2024 (20)**

There are 6 Very high risks (20-25) reported to the Finance, Performance and Estates Committee in August, remaining stable from the previous reporting period:

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

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.

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 overseen 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 580 active and approved risks reported to lead committees for the month of August, an increase of 15 risks since the last report.

2.2 There are 20 risks with a current rating of Very High risk (20-25) and 54 rated High risk (15-16) reported to lead committees. **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)
49 (+2) (8%)	**130 (+1)** (22%)	**327 (+2)** (57%)	**54 (+9)** (8%)	**20 (+1)** (3%)

Strategic Objective Updates

A full review has been undertaken of the Lincolnshire Community and Hospitals Group Board Assurance Framework (BAF) 2024/25. Following this review the Strategic Objectives on the Trust's Risk Register have been aligned appropriately.

The updated Strategic Objectives aligned with JQC are:
- 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
- 5b - Co-create a personalised care approach to integrate services for our population that are accessible and responsive
- 5d - Transform key clinical pathways across the group resulting in improved clinical outcomes

The updated Strategic Objectives aligned with PODC are:
- 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
- 4c - Grow our research and innovation through education, learning and training

Work is still ongoing to align PODC risks to the correct objective, therefore for the purpose of this report the Strategic Objectives aligned with PODC remain the same as previously.

The updated Strategic Objectives aligned with FPEC are:
- 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)

- 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
- 4d Enhanced data and digital capability
- 5a Develop a Population Health Management (PHM) and Health Inequalities (HI) approach for our Core20PLUS5 with our ICS

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, remaining stable and 13 High risks, an increase of 1 recorded in relation to this objective. A summary of the Very High risks is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
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 being 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.	01/08/2024

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
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.	09/08/2024
4879	If there are significant delays within the planned care cancer pathway then patients may experience extended waits for diagnosis and surgery, resulting in failure to meet national standards and potentially reducing the likelihood of a positive clinical outcome for many patients	Very high risk (20)	- Planned care recovery plan (cancer) - Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions.	22/08/2024
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	12/08/2024
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. If we are not able to meet the demands of the service, this potentially could cause severe harm to the patients.	Very high risk (20)	Workforce review completed. Right sizing work force paper being written. 2 x agency consultants out to support service	22/08/2024

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 furthermore 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.	20/08/2024
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.	12/08/2024

Updates since the last report

Following the June and July RRC&C meetings the following changes were agreed and validated:

- **Processing of echocardiograms**-Risk presented in July, reduction in score validated at Moderate (12) Current position: 93% of patients are being seen within 6 weeks. Agreed reduction in scoring to 12 (3x4).
- **Overdue patients on Ophthalmology PBWL**. Risk validated at July RRC&C for increase in score to 4x4:16.
- **Risk of clinical treatments being carried out in rooms that do that have appropriate ventilation levels.** New risk validated at July RRC&C 4x4:16.

Strategic objective 1b: Improve patient experience

2.4 There are no Very High risks remaining stable, and 3 High risks, an increase of 1 since the last reporting period.

Strategic objective 1c: Improve clinical outcomes

2.5 There are 2 Very High risks, remaining stable and 6 High risks, an increase of 3 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.	29/07/2024
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.	20/08/2024

Updates since the last report

Following the June and July RRC&C meetings the following changes were agreed and validated:

- **Risk of failure to meet best practice standards for stroke patients due to lack of access to community rehabilitation service.** Risk validated at July RRC&C for increase in score to 4x4:16.
- **Frequency and duration of medication shortages.** Risk validated at July RRC&C for increase in score to 5x3:15.
- **Pharmacy capacity risk – Chemotherapy**- New Risk validated at July RRC&C 4x4: 16

Strategic objective 2a. A modern and progressive workforce

2.6 There are 4 Very High risks, an increase of 1, and 14 High risks, an increase of 6, 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.	09/08/2024
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	24/07/2024
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	24/07/2024
5447	Nurse staffing in theatres does not support current activity. There is a risk of elective lists being cancelled due to lack of theatre staff. Business case has been written to source funding. Currently in a difficult position. The off framework is going to stop soon with an impact that will possibly cancel lists. Lengthy discussions have been had to support Theatres. Break Glass agency workers are starting to be put in place but we are still very short. ODP has been approved but no back fill.	Very high risk (20)	Establishment review Business case for funding in process to apply for funding. **New Risk validated at the June RRC&C meeting**	30/07/2024

Updates since the last report

Following the June and July RRC&C meetings the following changes were agreed and validated:

- **Cancellation of elective lists due to lack of theatre staff** (20) Following review this risk was realigned to this objective.
- **Failure to meet contractual requirements in Pharmacy teaching** (16)- New risk validated at July RRC&C meeting 4x4:16
- **Risk of failing to provide the curriculum requirements for clinic-based specialties** (16))- New risk validated at July RRC&C meeting 4x4:16
- **Respiratory Teaching Gaps at Lincoln County Hospital.** (16)- New risk validated at July RRC&C meeting 4x4:16
- **Risk of being unable to deliver required teaching in paediatrics if teaching fellow is not recruited for the March 2025 intake.** (16)- New risk validated at July RRC&C meeting 4x4:16
- **Student training discrepancy between Lincoln & Boston** (16)- New risk validated at July RRC&C meeting 4x4:16
- **Undergraduate administration Teams understaffed leading to medical students not receiving support required.** (15))- New risk validated at July RRC&C meeting 5x3:15.

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 risk 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.	09/08/2024

Strategic objective 3a: Deliver financially sustainable healthcare, making the best use of resources

2.8 There are 2 approved Very High risks (20-25), and 3 High risks (15-16) 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
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	09/08/2024

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4664	The Trust is overly reliant upon a large number of temporary agency and locum staff to maintain the safety and continuity of clinical services.	Very high risk (20)	Financial Recovery Plan schemes: - recruitment improvement; - medical job planning; - agency cost reduction; - workforce alignment	19/08/2024

Strategic objective 3b: Drive better decision and impactful action through insight

2.9 There are zero approved Very High risks (20-25) and zero High risks (15-16) recorded in relation to this objective.

Strategic objective 3c-A modern, clean and fit for purpose environment across the Group

2.10 There are 3 approved Very High risks (20-25) and 7 High risks (15-16) 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)	- 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	14/08/2024

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 - 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 occupancy profile, escape provision, height above ground and sleeping risk - Higher rated residual risks from risk assessments being incorporated into risk register	13/08/2024

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
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)	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.	20/08/2024

Strategic objective 3d - Reduce waits for patients who require urgent and emergency care and diagnostics and ensure we meet all constitutional standards

2.11 There are no approved Very High risks (20-25) and no High risks (15-16) recorded in relation to this objective.

Strategic objective 3e - Reducing unwarranted variation in cancer service delivery and ensure we meet all constitutional standards (ULHT)

2.12 There are no approved Very High risks (20-25) and no High risks (15-16) recorded in relation to this objective.

Strategic objective 3f - Reducing unwarranted variation in planned service delivery and ensure we meet all constitutional standards (ULHT)

2.13 There are no approved Very High risks (20-25) and no High risks (15-16) recorded in relation to this objective.

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

2.14 There are no approved Very High risks (20-25) and no High risks (15-16) recorded in relation to this objective

Strategic objective 4b - Successful delivery of the Acute Services Review

2.15 There are no approved Very High risks (20-25) and no High risks (15-16) recorded in relation to this objective

Strategic objective 4d Enhanced data and digital capability

2.16 There is 1 approved Very High risk (20-25) and 3 High risks (15-16) recorded in relation to this objective. A summary of the Very High risk is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4657	If the Trust does not comply with Subject Access Requests (SARs) and Access to Health Records provisions in accordance with statutory requirements specified legislation, then it could lead to complaints to the Trust and Information Commissioner's Office (ICO). This could result in regulatory action and possibly financial penalties. Inconsistent levels of expertise outside of the IG team regarding SAR requirements.	Very high risk (20)	"Current active communications with ICO- regulator. Changes to processes are being constantly discussed and implemented. Resource needs being discussed and temporarily increased to support. Monitored through the IGG in DP KPI report. Head of IG leading on work to review and improve. Working in a more digital way where feasible. Workforce change is required which will be a much longer process.	23/07/2024

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
	Lack of technical tools to carry out a search of emails / systems to identify personal information held. Potential financial implications."		Early identifications of chasers and urgent requests to reduce the likelihood of complaints."	

Updates since the last report:

Following presentation at the Risk Confirm and Challenge Meeting in July, the following risk was validated for a reduction in score:

- Malicious Cyber Traffic Hidden within Encrypted Data Streams- reduced from to 4x4 16 to 3x4:12 Moderate Risk.

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 5 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)
  - Cancellation of elective lists due to lack of theatre staff

- 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.	09/08/2024	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.	[09/08/2024 16:24:38 Lisa Hansford] risk remains the same [10/07/2024 11:08:48 Lisa Hansford] risk remains the same [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	4	29/10/2021	28/04/2023	09/09/2024
2a. A modern and progressive workforce	5447	691	Service disruption	Capon, Mrs Catherine	Rojas, Mrs Wendy	Patient Safety Group	Workforce Strategy Group	05/06/2024	16		Surgery	Theatres, Anaesthesia and Critical Care CBU	Theatres		Nurse staffing in theatres does not support current activity. There is a risk of elective lists being cancelled due to lack of theatre staff. Business case has been written to source funding. Currently in a difficult position. The off framework is going to stop soon with an impact that will possibly cancel lists. Lengthy discussions have been had to support Theatres. Break Glass agency workers are starting to be put in place but we are still very short. ODP has been approved but no back fill.	AFPP guidelines for staffing in perioperative setting Daily review of staffing/lists Daily prioritisation of patients Use of agency staff	Incident reporting Review of staffing/cancellations	30/07/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Establishment review Business case for funding in process to apply for funding.	[30/07/2024 08:56:34 Nicola Cornish] Case of need has been completed and is awaiting a date to be presented to CRIG. [26/06/2024 14:08:26 Rachael Turner] Risk presented at RRC&C meeting 26/06/24. Business case has been written to source funding. Currently in a difficult position. The off framework is going to stop soon with an impact that will possibly cancel lists. Lengthy discussions have been had to support Theatres. Break Glass agency workers are starting to be put in place but we are still very short. ODP has been approved but no back fill. Risk requires updates to reflect current position. Risk validated at 5x4:20 Very High Risk. [05/06/2024 09:53:31 Nicola Cornish] New high risk, to be presented at June RRC&C meeting for approval.	8	30/06/2025		30/08/2024
4d. 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.	23/07/2024	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.	[01/08/2024 15:33:56 Fiona Hobday] *Still awaiting outcome from ICO *New system being built- plan to test over Aug/ Sept. *Current capacity issues in service due to exit/ long term sickness of staff- recruitment to be looked at. [23/07/2024 14:48:19 Rachael Turner] Risk reviewed by Leanne World. No change from previous position. Risk score remains. [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	6	29/12/2023	31/10/2024	27/08/2024

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
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	4996	39	Physical or psychological harm	Lynch, Diane	Chester-Buckley, Sarah	Patient Safety Group	Outpatient Improvement Group	22/08/2022	16		Clinical Support Services	Cancer Services CBU	Haematology (Cancer Services)	Trust-wide	As a result of lack of investment for Haematology workforce historically there is insufficient workforce and to meet increasing demand of the service (and we have recruited posts at risk above budget) which would lead to additional stress and burn out causing the remaining staff to leave and the service to collapse which would also lead to significant patient harm. Patients would need to be referred to other neighbouring Trusts which in turn would cause other Trusts to collapse. Particular areas of concern are Clinical Governance Lead and Head of Service for Haematology.	Completed a fragile services paper CG lead duties shared between consultants but no one wishes to take on role. Introduction of nurse-led clinics to manage demand. Fixed term Locum Consultants / High cost agency above budget to support service. Ad-hoc additional clinics outside of consultant job plan	New referrals and PBWL show ongoing capacity issues. RTT and cancer performance below target. Increased PA's for substantive consultants. Outcome from Staff Survey results Financial constraints of group Monitoring of outpatient appointments Datix incidents / Clinical Harm reviews / Complaints / PALS	24/07/2024	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 - Decemember 2024) Additional unfunded ST3+ for Haematology starts in August 2022 - Now completed (Sarah Chester-Buckley - July 2023)	[05/08/2024 09:33:36 Gemma Staples] Following the deep dive in April, it was asked that risk 4996 & 4740 be reviewed to see if if these are one risk under different facets or if it is two distinct risks with similar mitigations. SCB - both risks have been reviewed and merged into one risk. 4996 will be the active risk and 4740 will be the closed risk. Both risks will be taken to August RRC&C meeting for agreement. [24/07/2024 11:46:17 Gemma Staples] Paper to be presented in August to ELT regarding staffing levels to seek approval to go over budget for patient safety. [28/06/2024 14:35:02 Gemma Staples] Risk reviewed. Haematology rightsizing paper will not be considered for funding until 2025/2026. Risk remains the same. [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	8	30/09/2023	01/04/2025	23/08/2024
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	4879	28	Physical or psychological harm	Landon, Caroline	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	24/07/2024	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	[24/07/2024 08:15:32 Gemma Staples] 23/07/2024 Funding is not available in 24/25. DL to take impact assessment/QIA to ELT 31 July 2024. [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.	8	31/03/2023	31/03/2023	23/08/2024
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	Clinical Effectiveness Group	14/03/2023	20		Family Health	Children and Young Persons CBU	Children's Community Services	Trust-wide	Quality and safety risk from inability to deliver epilepsy pathways within Community Paediatrics that meet National standards due to resourcing and capacity factors.	1. Single Consultant Paediatrician (DH) is currently managing all children with Epilepsy alongside a single specialist epilepsy nurse; 2. Wider consultant body supporting the care of children who are prescribed 2 antiepileptics in the absence of a consultant paediatrician with expertise in epilepsy; 3.Single Consultant Paediatrician is developing individualized care plans for each patient to optimise management of condition; 4. Liaison with ICB and regional network to support development and improvement of local services	1. Audit of compliance with NICE guideline NG217 - Epilepsies in Children, Young People and Adults and NICE quality standard QS27 - Epilepsy in Children and Young People;	12/08/2024	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	[13/08/2024 11:52:26 Nicola Cornish] Risk reviewed, no change. Regular meetings with ICB continue and commencing conversations with NUH about delivery of tertiary element. [16/07/2024 14:49:26 Nicola Cornish] No change to risk; Business case currently being developed to support increase in team size; Regular meetings in place with ICB to support improvements to epilepsy service; Service benchmarking against Epilepsy Deliverables to help better understand gaps. [18/06/2024 13:27:13 Nicola Cornish] Business case development is progressing. [21/05/2024 13:14:53 Nicola Cornish] Risk reviewed, no further progress. [16/04/2024 13:56:12 Nicola Cornish] Risk reviewed, no change [20/02/2024 13:08:27 Nicola Cornish] No change. Business case meeting is being held to progress so that bid can be submitted to ICB for funds. [17/01/2024 13:02:57 Nicola Cornish] No improvement, business case being written on new template. [21/12/2023 11:19:49 Nicola Cornish] Consultant caseload review commenced in order to apply RAG rating system to each case to enable identification of those most at risk. Reviewed 100 patients so far, 2 additional review dates to be scheduled. Nursing criteria to be changed shortly to focus on top tier most vulnerable patients. [21/11/2023 14:24:17 Kate Rivett] 21/11/23 - KR 1. Significant levels of risk remains as there are only x2 specialist nurses and x1 consultant to manage a cohort of in excess of 900 patients, some of whom have very complex epilepsy in addition to other vulnerability factors; 2. Business case being worked up in conjunction with ICB to seek additional funding to enable expansion of the team. [25/10/2023 11:47:32 Rachael Turner] Risk discussed at RRC&C meeting 25/10/2023, risk to remain at Very High risk.	8	14/03/2024	16/02/2024	12/09/2024

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	5016	22	Physical or psychological harm	Hamer, Fiona	Lentz, Blanche	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	09/08/2024	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	[09/08/2024 14:34:14 Rachael Turner] Risk reviewed. Meeting booked with new interim COO to look at support within Ops. Risk score remains. [02/07/2024 16:03:34 Rachael Turner] Safer Programme in place and SOP is being delivered for Operational meetings in the aim to process discharges and improve flow. Ongoing Care and Comfort project in place to mitigate both harm and risks. [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	10	02/09/2023	31/03/2024	09/09/2024
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	4740	37	Physical or psychological harm	Lynch, Diane	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	As a result of lack of investments historically within Haematology to meet the increasing demands of the service (increasing number of patients with patients with cancer, increasing number of treatments and requirements for review and follow up, increase in acuity), this also covers lifelong Haematological conditions which are none cancerous. Should staff leave due to burnout fix term posts or lack of funding, the service would collapse which would also lead to significant patient harm. Patients would need to be referred to other neighbouring Trusts which in turn would cause other Trusts to collapse.	Introduction of nurse-led clinics to manage demand. Fixed term Locum Consultants / High cost agency above budget to support service. Ad-hoc additional clinics outside of consultant job plan	Monitoring of outpatient appointments Datix incidents / Clinical Harm reviews Complaints and PALS Outcome from Staff Survey results Financial constraints of group	24/07/2024	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 - October 2024) * Additional unfunded ST3+ for Haematology starts in August 2022 - Now completed (Sarah Chester-Buckley - July 2023)	[05/08/2024 09:20:43 Gemma Staples] Following the deep dive in April, it was asked that risk 4996 & 4740 be reviewed to see if if these are one risk under different facets or if it is two distinct risks with similar mitigations. SCB - both risks have been reviewed and merged into one risk. 4996 will be the active risk and 4740 will be the closed risk. Both risks will be taken to August RRC&C meeting for agreement. [24/07/2024 11:52:53 Gemma Staples] Paper to be presented in August to ELT regarding staffing levels to seek approval to go over budget for patient safety. [28/06/2024 14:35:33 Gemma Staples] Risk reviewed. Haematology rightsizing paper will not be considered for funding until 2025/2026. Risk remains the same. [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	3	01/04/2023	01/04/2023	23/08/2024
3a. Deliver financially sustainable healthcare, making best use of 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 is overly reliant upon a large number of temporary agency and locum staff to maintain the safety and continuity of clinical services.	ULHT policy: - Financial plan set out the Trust limits in respect of temporary staffing spend - Financial plan for agency expenditure is based upon developed savings plans in relation to agency staffing; acknowledges the progress made in 2023/24 in relation to real reductions in actual agency expenditure - Monthly financial management & FRP monitoring arrangements are in place to identify variation; agency expenditure reduction is a major part of the FRP and as such is heavily monitored. - 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)	19/07/2024	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	[19/07/2024 09:39:22 Rachael Turner] In 2024/25, the Trust's financial plan requires the Trust to make a similar level of reduction to agency expenditure as made in 2023/24, as it requires a reduction to agency expenditure of £17.5m in 2024/25 compared to the reduction of £18.4m made in 2023/24. In 2024/25, the focus of the programme is to reduce agency expenditure in relation to medical and dental staffing, whereas in 2023/24 the focus was upon reducing agency expenditure in relation to registered nursing and midwifery. The 2024/25 financial plan requires agency expenditure to reduce: •From £7.3m in the first financial quarter of the year. •To £3.5m in the second financial quarter of the year. •To £2.4m in the third financial quarter of the year. •To £1.9m in the final quarter of the year. Agency expenditure YTD of £7.5m is £1.6m lower than spend of £9.1m in the same period of 2023/24 but is £0.2m YTD higher than planned agency expenditure of £7.3m. Risk description and controls updated to reflect current risk position. Proposed for risk score to be reduced to 4x4:16 This risk will be presented at Risk Confirm and Challenge in August for reduction in score. [13/06/2024 13:54:04 Rachael Turner] In 2023/24, agency pay expenditure of	8	31/03/2023	31/03/2024	19/08/2024

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
3c. A modern, clean and fit for purpose environment across the Group	4647	1	Reputation	Frake-Harris, Julie	Davey, Keiron	Fire Safety Group	Fire Safety Group	14/12/2021	20	External Inspections	Corporate	Estates and Facilities	Fire and Security	Trust-wide	If Lincolnshire Fire & Rescue Service (LFRS) carries out an inspection and finds the Trust to be systemically non-compliant with fire safety regulations and standards it could result in regulatory action and sanctions, with the potential for financial penalties and disruption to services if sites are required to close.	National policy: - Regulatory Reform (Fire Safety) Order 2005 - NHS Fire safety Health Technical Memoranda (HTM 05-01 / 05-02 / 05-03) ULH policy: - Fire Policy (approved April 2019, due for review April 2022) & related procedures / protocols / records - Fire & Security Team / Fire Safety Advisors ULH governance: - Fire Safety Group / Fire Engineering Group, accountable to Trust Board through Finance, Performance & Estates Committee (FPEC) - Health & Safety Committee & site-based H&S committees	- Compliance audits against fire safety standards - Progress with fire safety improvement plans - PPM compliance assurance (current lack of required detail for internal and regulator assurance)	10/07/2024	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	[16/07/2024 09:18:20 Rachael Turner] Work continues on statutory fire risk assessments reviews, capital project works in regard to compartmentation and fire doors remedials. [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	4	30/06/2022	31/03/2024	10/08/2024
3c. A modern, clean and fit for purpose environment across the Group	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	18/07/2024	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.	[18/07/2024 13:59:58 Rachael Turner] Replacement of the plant is on the capital plan for 2024/25 timescale is yet to be confirmed but will definitely be completed this financial year. [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		18/08/2024
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.	01/08/2024	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.	[01/08/2024 09:33:21 Gemma Staples] Lift on track for completion in November 2024 Dumb waiter upgrade not completed in July due to mix up on which dumb waiter was to be upgraded, issues resolved with estates and contractor. Re-booked in for completion end Aug / beginning Sept. [27/06/2024 12:56:15 Rachael Turner] Lift completion will be November. Dumb waiter will be completed in July. On completion of the dumb waiter we will need to re-assess with the view the risk is reduced. [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	1	01/05/2023		30/08/2024

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
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	As a result of Maternity & Outpatients currently using manual prescribing processes which is inefficient and restricts the timely availability of patient information when required by Pharmacists which would then 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 for Maternity / Outpatients	29/07/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Possible scope of EPR - Colin Costello - end of July 2026	[29/07/2024 11:58:02 Gemma Staples] AS to confirm if Maternity / Outpatients are in scope for EPR tender process. [10/07/2024 15:22:31 Gemma Staples] 03/07/2024 – Lisa Hansford has asked Ahtisham to review this risk to decide if to close this risk and create a new risk for outpatients / maternity as they are still manually prescribing – awaiting update [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	4	31/12/2023	01/04/2024	29/08/2024
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	4947	27	Physical or psychological harm	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.	17/07/2024	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. A partial mitigation for medication error reduction is incorporation of discharge functionality within EMIS (the link and seamless transition of medication from inpatient to discharge). This will reduce prescription errors into the discharge medication. Discharge functionality is not available currently within EMIS. To significantly reduce this risk requires additional ward based pharmacy staff cover across 7 days.	[17/07/2024 09:50:43 Lisa Hansford] risk reduction plan updated as follows: A partial mitigation for medication error reduction is incorporation of discharge functionality within EMIS (the link and seamless transition of medication from inpatient to discharge). This will reduce prescription errors into the discharge medication. Discharge functionality is not available currently within EMIS. [10/07/2024 11:05:06 Lisa Hansford] Risk reviewed and remains the same [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	8	30/06/2023	31/12/2024	19/08/2024
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	09/08/2024	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	[09/08/2024 16:25:26 Lisa Hansford] risk remains the same [10/07/2024 11:02:53 Lisa Hansford] Risk reviewed and remains the same [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.	8	30/06/2023	02/10/2023	09/09/2024

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3c. A modern, clean and fit for purpose environment across the Group	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. Low level of attendance/completion of fire safety training also contributes to this risk as there there may be significant non-adherence to fire safety policy and procedures which could lead to potential of a major fire.	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)	13/08/2024	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	[13/08/2024 18:09:19 Rachael Turner] Risk updated to incorporate low level of attendance/completion of fire safety training as this will contribute to a risk of major fire- risk 4674: Low levels of attendance/completion of fire safety training to be closed as all details are now contained within this risk. [13/08/2024 17:54:00 Rachael Turner] Work on Fire door mapping has concluded for all sites. capital compartmentation works continues across all 3 sites on a risk basis. [16/07/2024 09:19:46 Rachael Turner] Risk is reviewed within the FEG and escalation into FSG for trust HS committee. [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	10	31/03/2022	31/03/2025	13/09/2024
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5100	487	Physical or psychological harm	Rivett, Kate	Herath, Dr Durga	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;	12/08/2024	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.	[12/08/2024 14:25:12 Nicola Cornish] Risk reviewed, no change. Regular meetings with ICB continue and commencing conversations with NUH about delivery of tertiary element. [08/07/2024 12:48:00 Kate Rivett] 08/07/2024 - KR 1. Risk reviewed at Risk Register Review meeting; 2. No change to risk; 3. Business case currently being developed to support increase in team size; 4. Regular meetings in place with ICB to support improvements to epilepsy service; 5. Service benchmarking against Epilepsy Deliverables to help better understand gaps. [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	8	14/03/2024		12/09/2024
3a. Deliver financially sustainable healthcare, making best use of resources	5020	6	Finances	Hamer, Fiona	Lentz, Blanche	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	09/08/2024	Quite likely (4) 71-90% chance	Extreme (5)	Very high risk (20-25)	20	Robust recruitment plan International recruitment Medical Workforce Management Project	[09/08/2024 14:35:27 Rachael Turner] Risk remains, working towards reduction. No change to risk score. [02/07/2024 16:11:12 Rachael Turner] The recruitment is going well from tier 2 and consultant perspective but it is the tier two costing that remains an issue. This is discussed regularly at TSSG & Divisional Financial Efficiency Group. [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	10	02/09/2023		09/09/2024

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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.	16/07/2024	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.	[16/07/2024 12:40:46 Rachael Turner] Risk reviewed, no further updates. Risk score to remain. [26/06/2024 09:09:01 Rachael Turner] Until EDMS in in place and ePR alongside it this remains a risk as there is a potential for information not all in one place. An example of this is that we no longer file blood results in the notes but refer to WebV. Therefore it is not always feasible to add to the paper notes and a reliance on the clinician to check all digital solutions. [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	4	30/06/2018	31/03/2025	16/08/2024
2a. A modern and progressive workforce	4997	41	Service disruption	Lynch, Diane	Chester-Buckley, Sarah	Workforce Strategy Group	Patient Safety Group	22/08/2022	16		Clinical Support Services	Cancer Services CBU	Haematology (Cancer Services)		As a result of current Consultant staffing and on-call arrangements there is a single consultant covering both sites during weekend so cover limited if critically unwell patients on both sites which could lead to potential patient harm, delays in care/discharge.	Middle Grade cover in Oncology & Haematology over and above budget therefore using high cost agency. VC ward rounds are taking place if face to face ward rounds are not possible.	Datix incidents Complaints and PALS Outcome from Staff Survey results Financial constraints of group	24/07/2024	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 - December 2024) * Additional unfunded ST3+ for Haematology starts in August 2022 - Now completed (Sarah Chester-Buckley - July 2023)	[24/07/2024 11:45:27 Gemma Staples] Paper to be presented in August to ELT regarding staffing levels to seek approval to go over budget for patient safety. [28/06/2024 14:34:29 Gemma Staples] Risk reviewed. Haematology rightsizing paper will not be considered for funding until 2025/2026. Risk remains the same. [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.	8	01/04/2023	01/04/2023	23/08/2024
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	4779	61	Physical or psychological harm	Landon, Caroline	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	21/06/2024	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.	[21/06/2024 13:48:45 Rachael Turner] This remains the same. This has reduced but still a concern. Trying to mitigate through virtual clinics but lack of consultants in post makes this a challenge. [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	4	31/03/2022	29/12/2023	21/09/2024

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4c. Grow our research and innovation through education, learning and training	5160	56	Reputation	Morgan, Mr Andrew	Rich-Mahadkar, Sameedha			21/04/2023	16		Corporate				If we don't deliver against our ambition of becoming a University Hospital Trust, this could negatively impact our organisational reputation.	Following UHA guidance New Clinical Academic Oversight Group established to oversee development and agreement of MOU and recruitment 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	26/06/2024	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	[26/06/2024 09:13:16 Rachael Turner] Risk reviewed-new control now in place to mitigate this risk-New Clinical Academic Oversight Group established to oversee development and agreement of MOU and recruitment. Risk score to remain. [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		26/09/2024
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5002	535	Service disruption	Farquharson, Colin	Edwards, Mrs Jill	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	[17/07/2024 09:38:11 Gemma Staples] This risk is linked to 5475 (the regulatory risk). [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	4	30/12/2024		25/07/2024
2a. A modern and progressive workforce	4741	42	Service disruption	Lynch, Diane	Chester-Buckley, Sarah	Workforce Strategy Group		13/01/2022	20	Risk assessments	Clinical Support Services	Cancer Services CBU	Oncology	Trust-wide	As a result of lack of investment for Oncology workforce historically there is insufficient workforce to meet demand of the service (and we have recruited posts at risk above budget) which would lead to additional stress and burn out causing the remaining staff to leave. We are heavily reliant on high cost agency covering vacant posts due to the national shortage of Oncologists. If the service was to stop for specific tumour sites this would lead to significant patient harm whereby patients would have to travel following referral to neighbouring Trusts for radiotherapy and chemotherapy treatment, which in turn would put further pressure on other Trusts who could potentially collapse. 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, breast, Urology, Including testicular, upper GI (RT only). Due to only consultant covering Sarcoma retiring we will no longer have consultant cover for sarcoma from July 23. Particular areas of concern are Chemotherapy Lead and Clinical Lead for Oncology.	Medical staff recruitment processes Agency / locum arrangements Extra clinics offered Unable to cover sarcoma due to no capacity/specialisation so this is now picked up by NUH Job plans continuing to be reviewed Recruited at risk over and above budget to support service	Monitoring tumour site performance data Datix incidents Complaints and PALS Outcome from Staff Survey results Financial constraints of group	24/07/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Need to undertake a fragile service review (Sarah Chester-Buckley - December 2024)	[24/07/2024 11:38:27 Gemma Staples] Clinical Lead appointed due to start August 2024. SACT Lead appointed to, HR checks in progress, therefore no start date as yet. [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	4	31/03/2023	31/03/2023	24/10/2024

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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	21/06/2024	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.	[21/06/2024 13:51:51 Rachael Turner] We had reduced this, however we now have another backlog. A plan is in place but the reports must be done by a Cardiologist trained in Cardiac MRI. Lack of resource as a business unit, currently looking at working up a business case but this is in the very early stages. [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	21/09/2024
1c. Improve clinical outcomes	4928	89	Service disruption	Ratcliff, Carl	Marsh, David	Patient Safety Group		28/04/2022	16	Professional Guidance	Medicine	Cardiovascular CBU	Cardiology		Increase in risk of delays to patient care/harm as a result of increasing backlog of planned care activity across Cardiology arising from Covid19 constraints / service restrictions/ site escalation pressures.	additional clinics/lists (cost pressure) additional staffing where feasible to increase capacity (cost pressure)	weekly monitoring of RTT and PBWL	21/06/2024	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.	[21/06/2024 13:54:54 Rachael Turner] We have reduced the backlog. The Cardiology waiting list is in a much better position and we are monitoring ourselves against P Codes. We are utilising our capacity as best as we can by booking 6 weeks ahead. RTT continues to improve but routine patients are being appointed at 14 weeks. We have in excess of over 3000 follow ups. [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	8	15/01/2025	01/03/2024	21/09/2024
3a. Deliver financially sustainable healthcare, making best use of resources	4665	14	Finances	Young, Jonathan	Sargeant, Paula	Financial Turnaround Group		11/01/2022	20	Risk assessments	Corporate	Finance and Digital	Finance	Trust-wide	The Trust has a £40.1m Financial improvement target for 24/25. If the Trust fails to deliver the CIP Plan, this will have a significant adverse impact on the ability of the Trust and the Lincolnshire ICS to deliver its breakeven financial plan for the year. This represents a 5% target which is greater than any financial improvement the trust has delivered in previous years. In addition to this target, invest to save investments required to deliver the savings plan will need to be funded via more CIP identification/ delivery. Failure to deliver the CIP plan will have an adverse impact on the trusts ability to decrease its underlying deficit and build towards a sustainable pipeline of cost improvement for the future.	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 recovery plan aligned to CIP. - Development of Divisional Schemes assured through FPAMS (Transactional) - Establishment of future looking programme to develop schemes for a sustainable cost improvement programme for the future. (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. ULHT governance: - Detailed CIP reporting via the CIP tracker supported by QIA process at Improvement Steering Group (ISG) - Programme Management Office (PMO) monitors full programme & dedicated Head of Financial Improvement. - Introduction of the Trust wide Improvement Steering Group to monitor, challenge and hold accountable for the Targeted and Transformational Schemes. - 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. For 2024/25 the Trust continues to be monitored twice a month on the FRP by the ICB and system Improvement Director. To exit NOF3, into NOF2, the system must deliver against the FRP plan for 2 consecutive quarters and ULHT is held to account to deliver their element of this £40.1m FYE. The Trust monitors internally against its CIP targets inclusive of specific Divisional and targeted scheme targets through the Improvement Steering group and Finance, Performance and Activity meetings. (FPAM's). Scrutiny & oversight will be	22/07/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	- Training & Support offered to all Divisions and stakeholders through CIP planning workshops. - Increased CIP governance & monitoring arrangements introduced. - Alignment with the Trust Strategy and System objectives - CIP is embedded as part of the Trust Improvement Strategy not seen as a separate annual work stream. - Development of future programme of cost improvement. - Continual exploration of new opportunities.	[22/07/2024 11:35:26 Rachael Turner] £40.1m programme – fully identified with opportunities, delivery assurance of detailed plans & KPI's is ongoing A stretch target of a further £4m has been set and opportunities being explored. Launch of Planning / continuous planning has taken place which will include CIP workshops for divisions. [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	4	31/03/2023	31/03/2024	22/10/2024

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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.	27/06/2024	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	[27/06/2024 10:31:25 Nicola Cornish] Business case needs to be put in to the new template and then seals of approval sought. [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		27/09/2024
4d. 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	18/06/2024	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.	[19/06/2024 14:27:38 Rachael Turner] The Lincoln two new rooms have been delivered and have been handed over. Work is now continuing to connect the rooms into the existing building infrastructure and also start to migrate out of the old spaces. This will be an ongoing process for Q2 - Q4 of this year. [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.	4	31/03/2023	31/03/2023	18/09/2024
4d. 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	53	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	09/07/2024	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"	[09/07/2024 11:21:35 Rachael Turner] Risk reviewed. Approval from ELT to move to an annual appraisal cycle from 01/04/25, this will support an increase in compliance. Program of work commenced to move from current system to annual system from 1 April. [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	8	06/09/2024		09/10/2024

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3c. A modern, clean and fit for purpose environment across the Group	4725	466	Physical or psychological harm	Cooper, Mrs Anita	Froggatt, Hayley	Estates Investment and Environment Group	Health and Safety Group	13/01/2022	20	Risk assessments	Clinical Support Services	Therapies and Rehabilitation CBU		Lincoln County Hospital	If essential repairs and maintenance requirements at Lincoln County Hospital Occupational Therapy Department are not addressed then it may lead to accidents and injury resulting in potentially serious harm to staff, patients and visitors. There is a security risk to the building.	Legislation: - Health & Safety at Work Act 1974 -Management of Health & Safety at Work Regulations 1992 associated guidance. ULH policy: - Health & Safety Policy & related guidance - Health & safety training (Induction, Core Learning, Core Plus Learning and CPD) - Estates Planned Preventative Maintenance (PPM) / testing - Occupational Health services ULH governance: - Health & Safety Committee / site-based H&S Forums; accountable to Trust Board through Finance, Performance & Estates Committee (FPEC)	IPC flo scores, monitoring of incidents, staff satisfaction concerns, complaints / PALS Tracking of Estates work requests - The Department has a significant amount of outstanding jobs including, leaking windows, leaking roof tiles, carpeted areas, unsanitary toilet/shower & changing facilities, repeatedly broken toilets. Inability to monitor temperatures due to inappropriate fitting of radiator covers, swelling and uneven floor services following leaks.	05/08/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Daily & Weekly IPC checks, Staff well being checks, frequent monitoring of safety issues. Escalation to H&S Team via audit process. Monthly updates to MICAD system, Escalation via IPC FLO audit process.	[05/08/2024 11:06:56 Gemma Staples] Still awaiting on Estates to block off the corridors. We are working with Estates & Strategies to to look at service provision across therapies and rehab medicine to look at provision on and off site. There have been requests to Estates that have been declined due to cost and this is knock on effect on staffing. [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.	4	31/03/2022	31/03/2023	05/11/2024
2a. A modern and progressive workforce	5173	43	Service disruption	Morgan, Mr Andrew	Warner, Jayne	Trust Leadership Team		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
3c. A modern, clean and fit for purpose environment across the Group	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. Escalation of concerns to designated individual - Lincoln refurb CCTV repositioning has not been included Additional levels of swipe access not included as part of the refurb	[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
2a. A modern and progressive workforce	5469	697	Service disruption	Rinaldi, Dr Ciro	Chablani, Manish			21/06/2024	16		Corporate	Medical Director's Office	Medical Education	Trust-wide	As a result of Pharmacy struggling to budget and recruit into the role whilst there are budgetary provisions on the medical education side there is a risk that without adequate educators we would fail to deliver the curriculum across the entire clinical years for years 3,4 & 5 which would lead failure of our contractual requirements and this would bring into question our newly gained status as a teaching hospital.	We are currently liasing with the Pharmacy department around the appointment of a part time prescribing skills lead. This would be a 50/50 appointment shared with the pharmacy team	Meeting reviews.	31/07/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Increase the workforce, investment into staff and education	[31/07/2024 13:24:09 Rachael Turner] Risk presented at RRC&C meeting 31/07/2024. Risk validated as a High risk score 4x4:16 High risk.	8	21/06/2025		31/10/2024

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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.	10/07/2024	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.	[10/07/2024 11:13:39 Lisa Hansford] no further update [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.	4	30/09/2022	31/03/2023	10/10/2024
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.	09/07/2024	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.	[09/07/2024 11:14:55 Rachael Turner] Risk reviewed, there has been no current change. Risk score remains at 16. Recent Junior Doctor and Consult strike recently went according to plan with appropriate support in place. [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).	4		31/03/2023	09/10/2024
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	4843	57	Physical or psychological harm	Rinaldi, Dr Ciro	Chester-Buckley, Sarah	Patient Safety Group	Medicines Quality Group	19/01/2022	20	Risk assessments	Clinical Support Services	Cancer Services CBU	Haematology (Cancer Services)		As a result of a lack of Immunologist within the Trust, Screening, management and review mechanisms of patients requiring or in receipt of Intravenous Immunoglobulin (IVIg) is inadequate. The Clinicians prescribing Immunoglobulin are not able to receive advice from an Immunologist and as a result patients could receive incorrect treatment. Patients are receiving Immunoglobulin for longer than they should be.	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) Antimicrobial and High Cost Drugs Management Pharmacist undertaking administrative functions to ensure all referrals are screened and are done so in a timely manner.	Reported incidents involving use of Intravenous Immunoglobulin (IVIg)	09/07/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Employ an immunologist or have a local agreement with another Trust to have immunologist support - Colin Farquharson - End of December 2024 Shared Care arrangements and prescribing accountabilities to be reviewed - Colin Farquharson - End of December 2024	[24/07/2024 11:19:33 Gemma Staples] Sarah Chester-Buckley has spoken with Consultant Haematologist Charlotte Kallmeyer regarding this risk. Haematologists are able to prescribe Immunoglobulins without the input of a Immunologist. Previously the Trust employed an Immunologist for a small number of PAs, this is not required for the Haematology service as patients can be discussed with colleagues at Hull / Nottingham. [22/07/2024 12:54:39 the reporter] 22/07/2024 - Risk reviewed ad reworded with Fran. To discuss risk with Sarah Chester-Buckley. [09/07/2024 09:17:09 Gemma Staples] Incident reviewed and requires review on the incident. Gemma to meet with Fran to update the risk. [26/06/2024 09:36:19 Gemma Staples] Colin suggested this should still sit under CCS still under Haematology instead of Pharmacy as they are more likely to be administering the care. Now amended [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	4	01/10/2021	31/07/2023	09/10/2024

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3c. A modern, clean and fit for purpose environment across the Group	5334	533	Physical or psychological harm	Grooby, Mrs Libby	Carr, Katy	Patient Safety Group		26/01/2024	15		Family Health	Women's Health and Breast CBU	Obstetrics	Pilgrim Hospital, Boston	There is no second theatre within the confines of the labour ward within which to undertake any theatre based procedures when Theatre 8 is already in use. In time critical scenarios the increased time taken to transfer to Theatre 1 on ground floor and commence surgical management may impact on the health and/or wellbeing outcomes for mother and/or baby. There is a patient experience risk due to a lack of privacy and dignity for women when transferring to ground floor theatres through public corridors. There is also a potential for an increase in Caesarean Section rate as clinicians attempt to avoid late labour transfers.	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.	09/07/2024	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.	[09/07/2024 16:09:21 Nicola Cornish] This is ongoing, it is being be picked up as part of overall refurb at Pilgrim. [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		09/10/2024
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	10/07/2024	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.	[10/07/2024 11:11:57 Lisa Hansford] no further update [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		10/10/2024

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4d. Enhanced data and digital capability	4658	17	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.	27/06/2024	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.	[27/06/2024 17:20:09 Fiona Hobday] *Need to resolve SME for RM is increasing and potential impact of not having one in post, e.g. EDMS procurement, 365 move. *No update from Digital re funding available from various projects. *Head of IG raised with new CRG Chair re issue of no clinical records SME. [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	4	28/06/2024	30/09/2024	27/09/2024
3c. A modern, clean and fit for purpose environment across the Group	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.	25/06/2024	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.	[25/06/2024 09:13:33 Rachael Turner] Discussion to be had with Health and Safety Team for update and to share this risk. Chris Davies will discuss this next week. [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	10	28/03/2024		25/09/2024
1b. Improve patient experience	5234	510	Service disruption	(Historical Deleted User)	Fulloway, Mr Ian			25/08/2023	15		Clinical Support Services	Diagnostics CBU	Neurophysiology		No clinic space at Pilgrim Hospital resulting in only ad-hoc provision of outpatient nerve conduction testing at the hospital. Previous clinical space was taken from the service due to ED/UTC projects with temporary agreement for clinic room (agreed in 2020) ending in October 2022 with PHB physiologist retirement. No EEG or EMG service provided at PHB currently. No Inpatient provision for testing at PHB. Inpatients requiring tests have to be transferred by hospital transport to Lincoln County for testing. Current risk is not being able to restart the service. At the moment, this is an unequitable health offering.	Adhoc bookings of space available within Outpatients at PHB. Booked where and when possible.Recruitment of new overseas Physiologist has been undertaken and completed. The staff member is fully trained and ready to start clinics in PHB when appropriate, permanent space is provided. Space must meet IPC requirements.	Waiting times, travel times, Patient Feedback, IP LOS impacted by the service being unavailable on site.	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

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1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5423	635	Physical or psychological harm	Landon, Caroline	Chamberlain, Leanne	Patient Safety Group		26/04/2024	9		Surgery	Urology, Trauma and Orthopaedics, and Ophthalmology CBU	Ophthalmology		Currently have 2000 time sensitive injection patients waiting, and 400 emails waiting to be processed which is now posing a clinical risk to our patients site. This risk is down to a combination of injection room availability which is already on the risk register, and staff availability due to new starter within the nurse injector team, sickness within the nurse injector team, and lack of ophthalmology trained outpatient nurses to allow additional clinics.	Absence being managed as per policy and phased return plan worked out for return, new starter is injecting independently and so will start to help with backlog, outpatients have just recruited X4 RNs which will all be trained in ophthalmology once started in post which will support additional activity. bi-weekly meetings gone into diary to keep grip and control of position.	Incdent reporting	26/06/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	TBC	[26/06/2024 15:16:52 Rachael Turner] Risk presented at June RRC&C meeting to propose increase in score. Risk severity increased due permanent site loss. The frequency of incidents are increasing. Risk validated at 4x4:16 High Risk. [20/05/2024 15:16:40 Nicola Cornish] Propose to increase risk score to High due to 2 patient harm incident - 1 severe and 1 moderate - relating to delay in injection appointment delay. No assurance that there will not be more cases. Current position: We currently have a backlog of 724 overdue injection appointments, but 998 in total waiting to be booked. This is coming down and was over 1500. This is a result of a combination of factors, the injection room has been decommissioned due to lack of air flow, and some estates issues and this has been the case for quite a while, this has been further impacted on the LCH site by 1 injector vacancy and the other 2 injectors having prolonged periods of absence. There was also an issue around outpatients admin staff incorrectly adding these patient's to our PBWL instead of out coming them for our AMD team to ensure we meet the time critical nature of the appointments requested by the consultant. There are actions the CBU have put into place to support reducing the backlog of these injection appointments, we have recruited 1 nurse injector who is now fully trained and injecting independently, the other 2 have now returned from their absences and are completing injections. We are working with other surgical areas to use this rooms and move activity around to accommodate our injection appointments, as well as utilising available space at GDH, CHL, Spalding and PHB. In addition to work ongoing with IPC to get our room reinstated, the agreement is now for a risk assessment to be completed and estates work completed, but the air flow can remain unchanged under new guidance.	3		31/12/2024	20/08/2024
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	4746	121	Physical or psychological harm	Lacey, Mark	Knapp, Chris	Patient Safety Group	Clinical Effectiveness Group, Outpatient Improvement Group	14/01/2022	20	Risk assessments	Surgery	Urology, Trauma and Orthopaedics, and Ophthalmology CBU	Ophthalmology		Overdue patients on the Trust-wide Ophthalmology Partial Booking Waiting List who wait for longer than the expected wait time specified by clinician. This may result in deterioration of eye condition.	Ophthalmology / Surgery Division clinical governance arrangements Outpatient / PBWL management processes	Monitoring Ophthalmology PBWL Clinical harm reviews / reported incidents due to appointment delays	26/06/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	The e-Outcomes Out-Patient clinic system needs an additional field facility to record these required appointments which will be greater than 6 weeks. Need to ensure future sustainability once recovered.	[26/06/2024 15:07:30 Rachael Turner] Risk presented at June RRC&C meeting. Risk validated for increase in score 4x4:16 High risk. [20/05/2024 15:13:43 Nicola Cornish] Propose to increase risk scoring due to 2 Severe harm incidents reported in last 3 months, resulting in patients losing sight. No assurance that there won't be additional patients suffering harm as a result of the length of the PBWL wait times. Currently at approximately 4610 patients, and showing an increasing trend. Recruited an additional clinician whose sole responsibility is to review PBWL and prioritising urgent patients. [25/04/2024 12:58:54 Nicola Cornish] Risk reviewed, no further update. [14/03/2024 10:34:51 Nicola Cornish] We recently reviewed our PBWL to remove duplicate referrals & those patients already seen. In the longer term stable glaucoma patients & routine post-operative will be followed up by community Optometrists once funding is agreed by the trust. There are currently no plans for sub-specialities to opt out of the PBWL so this needs to be removed from the risk reduction plan. [16/01/2024 11:24:14 Nicola Cornish] Around 3592 patients on PBWL, which is an increase. Recovery actions in place - fully utilise all clinics to reduce PBWL and open referrals backlog, increase waiting list size. Main challenge is vacancies within clinical and booking teams - interviews for diagnostic bookers scheduled, also interviewing for secretaries today. [19/10/2023 11:56:15 Nicola Cornish] No further update [06/09/2023 16:22:00 Caroline Donaldson] Risk review - no change in status of the risk. Score also remains the same. [07/06/2023 11:37:31 Rachael Turner] Risk discussed at RRC&C as part of the deep dive. There have been no patients found to have resulted in harm whilst in waiting list. Score to remain at a 12.	4		31/07/2021	30/06/2022	20/08/2024
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5142	65	Physical or psychological harm	Ratcliff, Carl	Lentz, Blanche	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.	02/07/2024	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.	[02/07/2024 16:05:28 Rachael Turner] Tier 2 programme still ongoing, in the phase of implementation. Workshops in place to work with tier two cohort to proceed to job planning. Timeline to be completed by Q4. [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.	9		31/08/2023	01/11/2023	02/10/2024

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1c. Improve clinical outcomes	5422	684	Service disruption	Costello, Mr Colin	Martinez, Francisca	Patient Safety Group		26/04/2024	16		Clinical Support Services	Pharmacy CBU	Pharmacy		As a result of Chemotherapy prescriptions not being prescribed in a timely manner this impacts on staff health and wellbeing due to additional stress to staff. There have been a significant number of near miss incidents. This causes an ineffective service leading to a reduction of capacity to make chemotherapy and significant time is wasted by pharmacy staff ensuring correct processes have been followed. Products have to be wasted regularly and remade, causing a loss to the Trust of approximately £100k per month.	Pharmacy staff working increased hours to complete late chemotherapy orders. Chemotherapy Prescribing Policy	Near misses/incidents Staff health and wellbeing Staff concerns Delays on chemotherapy appointments Chemotherapy waste	22/07/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Agreement to be sought and implemented by CSS, cancer and pharmacy - Sarah Chester Buckley - End of December 2024	[01/08/2024 08:53:01 Gemma Staples] Risk updated by Fran and will be taken to RRC&C in August. [10/07/2024 09:05:11 Gemma Staples] Risk discussed at RRC&C (26/06/2024) and it was agreed to accept the risk as active but more work needed to be done on it and to look at whether it was a patient safety risk rather than service disruption. Once updated this is to be taken back to RRC&C.	4	09/04/2025		22/10/2024
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		Following authorisation to recruit an additional band 2 invoice clerk and band 3 purchase clerk, baseline pharmacy procurement staffing establishment is now at a level where the basic purchasing and invoicing functions could be routinely being delivered, though vacancy and an imminent maternity leave absence within the purchase clerks means this remains a risk, with current 0.6WTE gap covered by bank staff, and an imminent 0.4WTE maternity gap. Until these posts are filled and staff trained, the service is not able to withstand more than one prolonged absence due to leave, sickness or resignation. 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 harm or death, with a growing reliance on the transfer of stock between hospital sites or trusts, or the use of unlicensed imported stock (see risk 4840). 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. We are reliant on bank staff and existing staff working additional hours to fill gaps. On any days where we have fewer than two trained purchase clerks on duty there is an increased risk to 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 and chase orders which are not being received.	The team comprises four part time procurement clerks (with one 0.6WTE post currently vacant) and three part time invoice clerks working from a centralised office in Lincoln but responsible for trustwide ordering and invoicing, one driver (post currently vacant) and 5 storekeepers who work across the sites, and is led by a full time pharmacist and technician. From a procurement perspective the baseline staff level on a day would be 3 purchasing clerks (once vacancy filled and training complete); this will sustain one member of staff being absent for any reason. Should there be absences affecting two staff working on the same day this would leave only 1 purchasing clerk 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	26/06/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Further work required to recruit to the current vacancy and also the upcoming maternity leave; until this is complete, gap analysis highlights the main areas of ongoing concern are the management of shortages and to-follows. We have two members of staff who are trained and able to provide bank support (though their availability to work is not guaranteed) and also have trained some staff within the Lincoln pharmacy dispensary team to cover the purchasing role (though their availability is dependent on dispensary staffing and workload). The bank procurement support posts are being paid from vacancy money elsewhere in the department and so cannot be considered a robust long-term fix for the procurement gaps. A further case of need will be prepared to identify workforce requirements to better support the day to day management of the team and also shortages and stock management across the Trust.	[26/06/2024 10:59:16 Gemma Staples] Risk reviewed Description / Controls & Risk reduction plan have been reworded as agreed at the recent Pharmacy Summit follow up meeting. [19/06/2024 14:35:10 Gemma Staples] CSS have funded the additional vacancies and we have partially recruited into the positions but we have still got 3 days where we have a gap so still need to do more recruitment. We also have maternity leave imminently which will impact staff. Time will be required for new starters to provide adequate training. [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	4	16/02/2024	16/02/2024	26/09/2024
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	31/07/2024	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.	[31/07/2024 13:04:42 Rachael Turner] Risk discussed as part of the Deep Dive at RRC&C meeting 31/07/24. We are currently not in a position to reduce currently. We continue to have NIV Dashboard and targets where we have an annual review. We are currently not delivering to the standard. The education in recognising type 2 respiratory is still an issue, it is not consistent due to changes in workforce and operational pressures. Meeting booked with ED on 14th August and we continue to review the SOP. Incidents are also increasing around NIV. Risk score to remain. [18/07/2024 11:48:19 Donna Gibbins] Risk remains at 16, lack of equitable services at PHB against BTS at pilgrim. Additionally, the monthly NIV dashboard continues to report themes and concerns in relation to education in ED. Concerns relating to NIV being started in ED which is currently outside of policy. A review of the NIV policy which is due in August 24 is underway, involving ED colleagues. Incidents in relation to NIV being commenced in ED which has been incorrectly set up and SJR's with concerns in relation to ringfenced provision. Mitigations of daily ringfenced capacity continues and is a sustained improved position against the standard. [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	4	30/09/2022	31/12/2022	31/10/2024
1c. Improve clinical outcomes	4866	87	Service disruption	Costello, Mr Colin	Saddick, Ahtisham		Medicines Quality Group	01/03/2022	15	Risk assessments	Clinical Support Services	Pharmacy CBU	Pharmacy		Recruitment of ULHT pharmacy technicians to ward-based clinical pharmacy roles affects the balance of the pharmacy workforce and impacts on the core pharmacy service provided	Pharmacy should be fully involved in the development and implementation of these roles. The Chief Pharmacist is accountable for the professional management of these roles, however there is not a clear understanding of the supervision and development framework for the new roles.	Monitoring of Pharmacy Technician performance	10/07/2024	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.	[10/07/2024 11:22:38 Lisa Hansford] no further update [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	10/10/2024

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
2a. A modern and progressive workforce	4862	44		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 CBU continue to proactively manage workforce. Rotas are stable but continue to be challenged with gaps.	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)	31/07/2024	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.	[31/07/2024 13:09:17 Rachael Turner] Risk presented as part of the Deep Dive at RRC&C meeting 31/07/2024. Service remains fragile. Risk to remain at current score of 16. [30/07/2024 13:09:24 Charles Smith] Respiratory Medicine workforce review underway. Cons and ACP.10 Cons now, 7 NHSLocum/Ag. Continue to manage pro-actively but service remains fragile. [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:	4	30/12/2022	03/06/2024	31/10/2024
2a. A modern and progressive workforce	5467	695	Service disruption	Babu, Suresh	Chablani, Manish	Undergraduate Governance Committee		21/06/2024	16		Corporate	Medical Director's Office	Medical Education	Lincoln County Hospital	As a result of the respiratory teaching at Lincoln currently being delivered by a locum consultant (via bank), who has previously indicated they wish to retire and as there are no consultant job planned or capacity. This could result in the Trust failing our contractual requirements which would bring into question our newly gained status as a teaching hospital.	No controls in place at the moment. This risk has been escalated up to the head of Respiratory by Dr Babu DME as per Dr Chablani's request.	Workforce	31/07/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Increase the workforce, include undergraduate teaching as a part of the job plan of a few consultants to share the workload and provide resiliance. Investment into staff and education	[31/07/2024 13:21:11 Rachael Turner] Risk presented at RRC&C meeting 31/07/2024. Risk validated as a High risk score 4x4:16 High risk.	8	21/06/2025		31/10/2024
2a. A modern and progressive workforce	5466	698	Service disruption	Babu, Suresh	Chablani, Manish	Undergraduate Governance Committee		21/06/2024	16		Corporate	Medical Director's Office	Medical Education	Trust-wide	As a result of the current Paediatrics teaching fellow leaving in September at the end of this academic year, there is a need for a departmental plan to ensure training is in place for a new teaching fellow ready for the students starting in March 2025. Without this the Trust would be unable to deliver the required teaching in Paediatrics. This could lead to the Trust failing on our contractual requirements and this would bring into question our newly gained status as a teaching hospital.	No controls in place at the moment. This risk has been flagged up to the head of Paediatric service by the modules leads, Dr Broodbank and Dr Herath.	Workforce	31/07/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Increase the workforce, include undergraduate teaching as a part of the job plan of a few consultants to share the workload and provide resiliance. Investment into staff and education	[31/07/2024 13:25:41 Rachael Turner] Risk presented at RRC&C meeting 31/07/2024. Risk validated as a High risk score 4x4:16 High risk.	8	21/06/2025		31/10/2024
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5491	701	Physical or psychological harm	Parkhill, Michael	Davies, Chris	Estates Investment and Environment Group	Clinical Effectiveness Group, Infection Prevention and Control Group	18/07/2024	16		Corporate	Estates and Facilities	Estates	Trust-wide	As a result of wards and departments not following the Change of Use Policy this has resulted in rooms being used for clinical treatments in which ventilation requirements are inadequate. This could lead to patients harm and patients contracting Hospital acquired infections.	Change of Use Policy Space Management Policy-this was approved by H&S Committee IPC Action Plan to review all current areas that are being used inappropriately.	IPC Action Plan. Datix incidents raised.	31/07/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	IPC Action Plan has been developed and carried out identifying all areas where treatment rooms are being used with inadequate ventilation. Estates Actions: •Estates to progress a ventilation compliance review upon Trust approved Capital Funding. •If mechanical ventilation is present – discuss / request Estates feasibility to increase air changes for treatment rooms found to have less than 10 air changes. •Estates to progress environmental infrastructure remedial work upon Trust approved funding. Clinical Division Actions •Where treatments rooms are not up to standard, the relevant Clinicians to be informed by the Divisions so that they can perform their own assessment of risk / responsibility. IPC will support risk assessments. •Red rated treatment rooms to be a priority for relocation to a safer environment.	[31/07/2024 13:53:50 Rachael Turner] Risk presented at RRC&C meeting 31/07/2024. Risk validated at 4x4:16 High Risk. [22/07/2024 15:33:13 Rachael Turner] Treatment room action plan updated version uploaded with feedback from CSS.	8	18/07/2025		31/10/2024

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2a. A modern and progressive workforce	5468	696	Service disruption	Babu, Suresh	Chablani, Manish	Undergraduate Governance Committee		21/06/2024	16		Corporate	Medical Director's Office	Medical Education	Trust-wide	As a result of failing to provide the curriculum requirements for clinic based specialties across the board but especially Dermatology, ENT Ophthalmology and Rheumatology. This has resulted in clinics being overbooked and the patient numbers not being reduced to allow for teaching the medical students. Which could lead to failing on our contractual requirements and this would bring into question our newly gained status as a teaching hospital.	None at the moment. Dr Chablani has written to the Clinical Leads asking them to support with reduced patient numbers in teaching clinics and for the clinical and attachment leads to work closely together to ensure a balance between service provision and teaching but is yet to get reassurance or a formal response.	Work around appropriate remuneration with Business Units and recognising the need to release clinicians to deliver teaching. Reduce patients in clinics - balancing waiting lists alongside teaching opportunities	31/07/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Increase the workforce, investment into staff and education	[31/07/2024 13:22:46 Rachael Turner] Risk presented at RRC&C meeting 31/07/2024. Risk validated as a High risk score 4x4:16 High risk.	8	21/06/2025		31/10/2024
1c. Improve clinical outcomes	4778	94	Physical or psychological harm	Mooney, Mrs Katy	Marsh, David	Patient Safety Group		16/01/2022	15	Risk assessments	Medicine	Cardiovascular CBU	Stroke		Risk of failure to meet best practice standards for stroke patients due to lack of timely access to community rehabilitation services. Length of stay for patients is set at 10 working days. Currently all processes for moving patients on from stroke unit for rehab is going over which is having an effect on patients rehab causing potential patient harm, service delays and burn out for staff. This is having an effect of staff morale and performance where they feel they are not delivering the service that they would like to.	LCHS provides Lincolnshire Community Stroke Services with a broadened access criteria post 100 day challenge. This is offering some increased access to stroke rehab in the community. One year seconded band 6 OT is currently covering Lincoln Stroke Unit 2 days. Her remit is to identify and facilitate timely discharge from acute to community. This service has KPI's to measure this. -Teams Groups with LCH to facilitate handover. -Joint email to narrow where referrals are directed and sent. -Reviewing prioritise lists everyday to decide appropriate pathways for patients. This is carried out every morning at 08:30. -Joint assessment with OT and PT to increase effectiveness and reduce time to decide which pathway is best for the patient. -Pathways currently in place are HomeFirst, ABI referral pathway --Working with CHC to create meeting of discussion for patients to trust each other within our assessments.	SNNAP data scores . Service provision not in top quartile	26/06/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Stroke pathway development project on place. Close partnership working within community to expedite discharges into the community	[26/06/2024 15:03:44 Rachael Turner] Risk presented at June RRC&C meeting. Risk validated at 4X4: 16 High Risk score. [10/05/2024 14:02:56 Rachael Turner] Risk reviewed. Update to risk description and controls to reflect current status of the service. Risk score reviewed with a potential increase of score to 15. This will be sent to both CSS and Medicine Governance to be agreed before being presented at Risk Confirm and Challenge for validation of score change. [15/04/2024 14:28:03 Rachael Turner] We are currently communication with LCH for beds for community, however there is a funding gap, this is being costed and looking at next steps. There is also work going on in the background for referrals to community hospitals and what they will accept. [25/01/2024 10:51:13 Rachael Turner] Work remains ongoing-working with community for rehab. Risk remains. Stroke Implementation Group currently in place for improvements. [30/10/2023 15:39:47 Rachael Turner] Stroke monthly board has been established, looking at all areas in patient pathway. This will be looked at as a part of this board. [25/07/2023 09:38:47 Bev Vertigan] No further development with ASR. Working group meets monthly to review areas of SNAP. [14/03/2023 10:12:54 Charles Smith] Continuation - Update the same as previous, dependant on Stroke ASR work. [22/11/2022 15:31:56 Milena Casswell] 22/11/22 Update – Continue to work with community to ensure timely discharge, perfect week planned as part of ASR implantation work. Risk review on 28.04.2022 Stroke pathway in place. Limited community capacity. ASR review outcome expected May 22. Capacity remains a risk.	6	31/03/2022	28/02/2023	26/09/2024
3a. Deliver financially sustainable healthcare, making best use of resources	5389	559	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
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 Swipecard access but locked with key 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. Alarm system: All 3 sites main mortuaries have intruder alarm that is connected to the Switchboard. The Titan temporary body store also now has an intruder alarm. 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.	02/08/2024	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: End of July 2024 (Meeting held during July to understand findings and discuss next steps. Actions in response need to be understood)	[02/08/2024 12:17:24 Gemma Staples] All 3 sites main mortuaries have intruder alarm that is connected to the Switchboard. The Titan temporary body store also now has an intruder alarm. Significant progress has been made. We are now awaiting clarity on the timescales for removing the Titan Unit at Lincoln (when refurb completed) and the outcome of the police led review [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	6	02/08/2024		01/11/2024

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2a. A modern and progressive workforce	5249	46	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)	09/07/2024	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	[09/07/2024 11:25:58 Rachael Turner] A program of work around retention lead by the PPM has commenced and this will actively address this risk. Further details will be provided. [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		09/10/2024
2a. A modern and progressive workforce	5427	699	Service disruption	Babu, Suresh	Chablani, Manish	Undergraduate Governance Committee		30/04/2024	16		Corporate	Medical Director's Office	Medical Education		Student report discrepancy in teaching between Lincoln and Boston site especially in HCOL and stroke where there is only one educator. To mitigate this , we plan to employ Teaching Fellows so they can offer similar amount of teaching on both sides.	We have appointed Teaching Fellow in Stroke and shortly will do so in HCOL.	Workforce	31/07/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Increase the workforce, investment into staff and education	[31/07/2024 13:26:57 Rachael Turner] Risk presented at RRC&C meeting 31/07/2024. Risk validated as a High risk score 4x4:16 High risk. [10/06/2024 15:43:27 Gemma Staples] Request for the handler to be amended from Catherine Wormington to Dr Maish Chablani. [29/05/2024 13:48:30 Gemma Staples] No attendance to present so deferred to June RRC&C meeting	4	30/04/2025	30/04/2025	31/10/2024
3a. Deliver financially sustainable healthcare, making best use of resources	5215	13	Finances	Young, Jonathan	Chilengwe, Leah			14/07/2023	16		Corporate	Finance and Digital	Finance	Trust-wide	The national contract continues to include an API variable element for providers (similar to the ERF for Commissioners). In 2023/24 the Trust negotiated to have a block with Lincolnshire ICB to mitigate the majority of this risk. The Trust plan for 2024/25 is to get to 130% of 1920 exit run rate for all Divisions except Surgery (115% of 1920 exit run rate) leading to an overall position of 113% ERF achievement to support the System position. Current delivery plans do not achieve the Trust Plan. If the Trust falls below the national ERF target (not yet released for providers) the System will lose funding. The national Commissioner targets have been released (Lincolnshire has a target of 103% of 1920) but provider targets have not yet been released."	Delivery plans and productivity opportunities are being reviewed by the Improvement Team. If the plan is not achieived it would, under the national contract terms, be a financial risk to the Trust. The Trust is assessing whether to try to negotiate a local variation to the contract e.g. moving to a block. Local monitoring of ERF has been set up which matches the national ERF monitoring but is also available by specialty, this is shared with Trust managerial teams regularly. "	Monitoring of the variable adjustment and ERF and lost income	19/07/2024	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."	[19/07/2024 09:48:46 Rachael Turner] Currently the national detailed ERF release is yet to be published however an estimate file has been created in month 3 and is currently being validated. As soon as the national update is released wider speciality detail will be included. Risk description, controls and measurements updated to reflect current position. Proposed that risk score reduced to 3x3:9 Moderate Risk. This risk will be presented at the Risk Confirm and Challenge meeting in August for reduction in score. [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	9	31/03/2024		19/10/2024

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2b. Making ULHT the best place to work	4993	54	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	09/07/2024	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	[09/07/2024 11:27:12 Rachael Turner] Risk reviewed - WDES 2024 has been completed, action planning has commenced and will go to Board in August 2024. [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.	4	31/03/2023	31/03/2023	09/10/2024
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	09/07/2024	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)	[09/07/2024 11:27:50 Rachael Turner] Risk reviewed - WRES 2024 has been completed, action planning has commenced and will go to Board in August 2024. [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	4	31/03/2023	31/03/2023	09/10/2024
3c. A modern, clean and fit for purpose environment across the Group	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.	25/06/2024	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.	[25/06/2024 09:06:05 Rachael Turner] Survey work is ongoing, update to be provided by Paul. [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 $243m^3$/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	26/09/2024

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2a. A modern and progressive workforce	5381	560	Service disruption	Frake-Harris, Julie	Markall, Amanda			09/02/2024	15		Corporate	Operations	Operations		Discharge Lounge (DL) has insufficient substantive workforce to meet current service demands. Significant RN and HCSW WTE shortfall. No B7 manager in place. B6 jnr sister post is unfunded secondment. No ward clerk. Insufficient housekeeping hours. This means that DL cannot staff each shift 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.	25/06/2024	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.	[25/06/2024 17:05:43 Rachael Turner] Risk reviewed, no change, risk score remains. [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		25/09/2024
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.	09/07/2024	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.	[09/07/2024 16:06:45 Nicola Cornish] This is ongoing, business cases have been developed for both sites and it is anticipated that work will commence on the Lincoln site before the end of this year. [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	09/10/2024
1c. Improve clinical outcomes	4840	329	Physical or psychological harm	Cooper, Mrs Anita	Baines, Andrew	Medicines Quality Group		19/01/2022	15	Risk assessments	Clinical Support Services	Pharmacy CBU	Pharmacy		Risks to patient care due to frequency and duration of medication shortages and having to use high risk alternatives	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)	Monitoring medication stock levels / reported shortages.	26/06/2024	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Shortages of contract lines are reported centrally; shortages of non-contract lines rely on identification by Trust pharmacy staff. Where shortages are identified, aim to put in place an appropriate management plan, after liaison with relevant members of pharmacy staff or specialist clinicians. May mean increasing reliance on unlicensed import products. Management of shortages often involves procurement of more expensive alternatives. Identification of shortages is often at the point at which stocks are depleted – a more robust system would be desirable whereby we anticipate shortages Risk assessments when alternatives are high risk and ensure robust safety processes are developed where necessary	[09/08/2024 12:32:47 Gemma Staples] Following discussion at PSG it was asked that Pharmacy review the scoring due to the risk of serious harm to patients due to some of the drug shortages. Risk reviewed and request made for this to be increased to a 5x4(20). Increase in scoring to be presented at August RRC&C meeting for agreement. [26/06/2024 15:32:16 Rachael Turner] Risk presented at June RRC&C meeting. Risk score validated for an increase in score 5x3: 15. [19/06/2024 14:22:14 Gemma Staples] Request for risk to be increased to 5 likelihood and 4 Severity. Trended upwards in number of shortages since 2020. We are averaging 13 per month currently we are on 74 for 2024. We got to 118 total in 2023. The complexity and potential risk associated with MSNs appears to be increasing, with a growing requirement to scope the use of unlicensed imported medication – this is a more complex process in terms of risk assessment, engagement with clinicians, order receipt and stock management as such lines need to be held in quarantine to undergo a formal sign off by a member of pharmacy before being able to be put into use. [04/04/2024 09:07:26 Lisa Hansford] No further update [29/12/2023 14:09:12 Lisa Hansford] No further update [26/09/2023 14:31:35 Rachel Thackray] Supply outside of pharmacy control, mitigation in place. Improved internal risk assessment process for new drugs. [27/06/2023 09:42:07 Alex Measures] Discussed in risk register review meeting- no further updates [01/06/2023 14:51:14 Lisa-Marie Moore] Risk ongoing no further updates [29/03/2023 11:37:32 Maddy Ward] Further update from Andrew Baines regarding medication shortages, here is the full history: 2020 = 65 MSNs (medicine shortage notifications); 14 SDAs (supply disruption alerts); 1 VSN vaccine shortage notification (TOTAL = 80) 2021 = 86 MSNs, 16 SDAs, 2 VSNs (TOTAL = 104)	6	01/12/2021	31/05/2023	26/09/2024

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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
3c. A modern, clean and fit for purpose environment across the Group	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	10/07/2024	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	[10/07/2024 11:31:17 Lisa Hansford] no further update [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 asceptic 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	10/10/2024
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	05/08/2024	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Moving of Stroke specialist therapy staff from PHB to LCH Robust stroke training plan for general ward staff Attendance at Stroke Board to influence change and need for cohorting of outliers Review of Stroke staffing in line with latest staffing levels needed 16/10/23 funding transferred to LCH budget to help support staffing and recruitment has started	[05/08/2024 11:15:56 Gemma Staples] We are currently involved in a review of Estates. Meeting to take regarding plans. Trying to get a Consultant / AHP job description matched to try and support the staffing issues on the Stroke Unit. We have a joint band 6 OT post with LCHS focussing on flow and discharge. Ongoing work with LCHS to enhance the pathway in order to meet standards required. Ongoing discussions with finance & ICB around additional staffing. [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		05/11/2024

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
2a. A modern and progressive workforce	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	As a result of having 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. Patient reviews delayed. Lack of specialist service area resource impacting on long term social value outcomes. Lack of consistency of provision across Lincolnshire footprint. Existing staff stretched to cover additional beds. Increased stress and sick leave on substantive staff.	Recruitment and retention strategies being work through. Therapies and rehab right sizing and service review. Improved joint working with LCHS and system colleagues. Clear therapies and rehab strategy to include CIPP and CON. Working with finance on establishment and nominal role review. Plan in place for sustainable medical workforce rehab medicine. Development team established for therapies. Neuro psych posts recruited too, therapies at front door service substantive funding in place.	Patient complaints. Monitoring of flow at front and back door. Site escalation. Vacancy rate monitoring. Roster fill rates. Waiting list numbers of frequency of follow ups. Staff absence. Staff survey and feedback.	07/05/2024	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Good use of relocation and workforce development resources. Actively managing and reviewing the waiting lists to include RAG rating, use of TC/VC, PIFU and discharge . Case of need strategy in place linked to wider system work. Development team in place. Competency frameworks and preceptorship processes being developed. Joint working with LCHS including new joint system posts. Clear strategy in place to include capacity and demand management, workforce management and development.	[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
1b. Improve patient experience	4724	86	Physical or psychological harm	Lynch, Diane	Taylor, Ruth	Workforce Strategy Group	Patient Experience Group	13/01/2022	20	Risk assessments	Clinical Support Services	Therapies and Rehabilitation CBU		Lincoln County Hospital	If Therapies and Rehabilitation service provision is not sufficient to deliver 7 day service provision, it leaves services without cover at a weekend or with inadequate cover during the week, leading to delayed patient flow; delayed discharge; extended length of stay; impacting on patient experience with potential for serious harm. This includes the neuropsychology cover on Ashby, SLT cover for inpatients, and therapy cover on ITU.	ULH policy: - Service planning & budget setting processes - Business case decision making processes ULH governance: - Capital & Revenue Investment Group (CRIG) management of business case process - CSS Division, CBU / speciality governance arrangements	Level of cover at weekends. Length of stay, patient flow, delayed discharges. Level of funding - Some 7 day funding, but limited to orthopaedics at LCH, minimal service. Inadequate for level of service demand.	05/08/2024	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Review current provision and identify gaps in service to inform business cases for change (working with Surgery and Medicine Divisions as appropriate). Skill mix requires review due to complexity of patients. Prioritisation tool helps to identify patients with greatest acuity or importance which will directly impact patient flow and current bed situation.	[05/08/2024 11:07:48 Gemma Staples] Risk reviewed and remains the same. [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	05/11/2024
3c. A modern, clean and fit for purpose environment across the Group	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	As a result of the treatment room not being compliant with HBN 00-03 procedures are being performed in an area that is not compliant, Adhoc and urgent bone marrow biopsies and intrathecal chemotherapy will still be performed in this room which would lead to an infection risk to patients.	Room is being decluttered Estates have reviewed, still awaiting if they can increase the air exchanges and how much this would cost. Larger organisation piece of work being undertaken Regular bone marrow biopsy clinics have been moved to outpatient department Venesections have been confirmed by the lead Estates Nurse can continue Risk assessment and precautions have been circulated to staff to adhere to for adhoc and urgent bone marrow biopsies and intrathecal chemo.	Datix incidents Complaints / PALS Assessment against regulations	26/07/2024	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Estates job logged to see if can increase air exchange to 10 - Lauren Rigby - December 2024 Wider organisational piece of work - Karen Bailey - December 2024	[26/07/2024 10:59:13 Gemma Staples] Estates have been out to look at the room and we are awaiting a quote to see if they can undertake the 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	25/10/2024

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
2a. A modern and progressive workforce	5474	700	Service disruption	Babu, Suresh	Wormington, Catherine	Undergraduate Governance Committee		01/07/2024	15		Corporate	Medical Director's Office	Medical Education	Trust-wide	As a result of undergraduate administration Teams at both Pilgrim and Lincoln currently being understaffed this could lead to the medical students not receiving the support required. Which would result in not having adequate staffing to organise the placement schedules and support the medical students to fulfil the Trust's contractual obligations with the medical school Including the B4 Undergraduate Co-ordinators, there would usually be four full time members of the undergraduate administration team on the Pilgrim hospital Boston site, and three full time and two part time members of the team on the Lincoln County Hospital site. The undergraduate administration team at PHB is currently short staffed owing to planned sickness absence and an unexpected resignation. It is likely two further members of the team may need to take compassionate and planned sick leave over the course of the coming weeks. The planned sick leave for one of the PHB administrators and could be for a period of up to 3 months. It is unknown how long the B4 Co-ordinator at LCH may need to take off for compassionate bereavement leave. This will leave the administration team on both hospital sites extremely short staffed but in particular the Pilgrim Hospital Boston site with just one member of the administration team being onsite to support approximately 80 medical students. Currently the team on the LCH site are supporting with administrative tasks which can be carried out remotely, although they also have one new full time member of the team who is not as experienced and able to cover additional modules. It is important that there is a presence on the PHB site to support the medical students and ensure teaching rooms are set up for teaching sessions. The other full time member of staff at PHB has two weeks of annual leave booked at the end of August. This also coincides with the undergraduate manager's leave and one week of the B4 Co-ordinators annual leave.	An advertisement is currently out to replace the B3 administrator at PHB. Two B5 Operational Assistant Manager's have been appointed and this is currently going through the HR Recruitment process. The appointees are the current B4 co-ordinators. One co-odinator is currently on planned sick leave with the other likley to need to take some compassionate bereavement leave. The backfill for the co-ordinator positions is being reviewed and a JD has been prepared and is awaiting review by the Assistant Director of Medical Education. The possibility of bank administration support has been looked into as well as colleagues awaiting redeployment.	Vacancy numbers Sickness episodes Student feedback School of Medicine Feedback CBU Feedback/Complaints	31/07/2024	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Bank admin support Redeployment opportunities Explore use of agency	[31/07/2024 13:28:59 Rachael Turner] Risk presented at RRC&C meeting 31/07/2024. Risk validated as a High risk score 5x3:15 High risk.	6		01/07/2025	31/10/2024

Report to the Lincolnshire Community and Hospitals Group Board Meeting

Date of meeting	3rd September 2024	Agenda item	14.1
Title	Strategic Risk Report		
Report of	Kathryn Helley, Group Chief Clinical Governance Officer	Prepared by	Lorna Adlington, Head of Patient Safety and Quality Governance
Previously considered by / Date	Sub-Committees of the Trust Board – August 2024	Approved?	Yes
Summary	This report was written based on data up to and including 31st July 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)	√

<table>
<tr><td rowspan="4">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</td><td colspan="5">4a Establish collaborative models of care with all our partners including Primary Care Network Alliance (PCNA), GPs, health and social care and voluntary sector</td><td>√</td></tr>
<tr><td colspan="5">4b Successful delivery of the Acute Services Review</td><td>√</td></tr>
<tr><td colspan="5">4c Grow our research and innovation through education, learning and training</td><td>√</td></tr>
<tr><td colspan="5">4d Enhanced data and digital capability</td><td>√</td></tr>
<tr><td rowspan="4">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</td><td colspan="5">5a Develop a Population Health Management (PHM) and Health Inequalities (HI) approach for our Core20PLUS5 with our ICS</td><td>√</td></tr>
<tr><td colspan="5">5b Co-create a personalised care approach to integrate services for our population that are accessible and responsive</td><td>√</td></tr>
<tr><td colspan="5">5c Tackle system priorities and service transformation in partnership with our population and communities</td><td>√</td></tr>
<tr><td colspan="5">5d Transform key clinical pathways across the group resulting in improved clinical outcomes</td><td>√</td></tr>
<tr><td>Impact of proposal/ report</td><td colspan="6">Please outline the potential impact/ expected outcome (Quality/ Equality, Diversity/ Equality Delivery System 3/ Health Inequalities/ Financial/ People)</td></tr>
<tr><td>CQC</td><td>Safe √</td><td>Caring √</td><td>Effective √</td><td>Responsive √</td><td colspan="2">Well-Led √</td></tr>
<tr><td>Links to risks</td><td colspan="6">Noted within the report</td></tr>
<tr><td>Legal/ Regulation</td><td colspan="6">CQC regulations, NHSI, Standing Orders, Health and Social Care Act.</td></tr>
<tr><td colspan="7">Recommendations/ Actions Required</td></tr>
<tr><td colspan="7">Group Board is invited to review the content of the report, no further escalations at this time</td></tr>
<tr><td colspan="7">Appendices</td></tr>
<tr><td colspan="7">Appendix A - Strategic Risks (15 – 20) – 31st July 2024</td></tr>
<tr><td colspan="7">Glossary</td></tr>
<tr><td colspan="7">NHS – National Health Service
LCHS – Lincolnshire Community Hospitals
LCHG – Lincolnshire Community and Hospitals NHS Group
TLT – Trust Leadership Team
BAF – Board Assurance Framework
RRCC – Risk Register Confirm and Challenge</td></tr>
</table>

Group Board – Strategic Risk report

1. Executive Summary

The purpose of this report is to enable the Group Board to review the management of significantly high risks to strategic objectives and consider the overall extent of risk exposure within the Trust, (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 July 2024, there were 101 risks recorded on the Trust risk register aligned to the sub-committees of the Group Board. This is an increase of 8 from the previous reporting period.

There were 9 quality and safety risks rated Significantly High (15 - 20) reported to the Joint Quality Committee. This remains static from the previous reporting period – 1 risk has increased in score and 1 risk decreased in score. 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
- 672 - Timely Unplanned Palliative Response 24/7
- 695 - Lack of District Nurse Specialist Practice qualified staff in community nursing affecting the quality of care
- 714 - Delivery of pressure ulcer care in the community
- 715 - Community nursing lacks capacity and skill set to meet community demand
- 681 - Children in Care - unable to meet Initial Health Assessment and Review Health Assessment timescales - **reviewed by Risk Register Confirm and Challenge on 31st July 2024. There has been a significant increase in activity over the last year.** An options appraisal has been shared with the ICB**. Score increased to 16** (previously 12)

The following risks have been updated since the last report:

- 652 - Interruption to Enhanced Practitioners and FVW business as usual activity – **Following review and scrutiny by RRCC on 31st July 2024 the score was revised and decreased to 10** (previous 16)

There were 8 risks rated significantly High (15 – 20) reported to the Finance, Performance, People and Innovation Committee. This is a reduction of 1 from the previous reporting period. These 8 relate to:

- 442 – Efficiency Requirement 2024 / 2025
- 455 – Failure to deliver the financial plan - Income
- 444 – Failure to deliver the financial plan – cost
- 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

The following risk has been updated since the July report:

- 655 – Skegness Hospital Fire Safety Risk – all roof void work has been completed and reviewed by Lincolnshire Fire and Rescue. **Following review and scrutiny by FPPIC in July and RRCC on 31st July 2024 the score was revised and decreased to 10 (previous 15).**

There are 0 People and Organisational Development risks rated Significant (15-20) for this reporting period.

From April 2024, a joint monthly Risk Register Confirm & Challenge meeting is now in place across the Group which has supports alignment of 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 101 open risks on the Trust risk registers an increase of 8 since the last reporting period. Current ratings are noted below:

Risk Register	Overall current score												Grand Total
	2	3	4	5	6	8	9	10	12	15	16	20	
Corporate Risk Register (12-25)									14	5	9	3	31
Operational Risk Register (4-11)	1	4											5
Local Risk Register (0-3)			7	1	17	15	16	9					65
Grand Total	1	4	7	1	17	15	16	9	14	5	9	3	101

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	0	1	1	1	3
	2 Unlikely: Do not expect it to happen again but it is possible	1	5	11	7	6	30
	3 Possible: May recur occasionally	3	6	16	4	5	34
	4 Likely: Will probably recur, but is not a persistent issue	1	8	10	9	1	29
	5 Almost Certain: Will undoubtedly recur, possibly frequently	0	3	0	2	0	5
	Total	5	22	38	23	13	101

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	An options appraisal is being presented by divisional lead to Trust board in August / September 2024. The risk to the service remains unchanged. The demand on the service is high and there are not enough appointments to meet demand. The service continues to work above the agreed specification delivering support to patients across the system. 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.	July 2024
681	Children in Care - unable to meet IHA and RHA timescales	16	Children's, Young People and Specialist Services	The number of children under the care of Lincolnshire County Council continues to grow year on year increasing demand for IHA and RHA assessments. Demand has outstretched capacity increasing the risk to an already group of vulnerable children.	July 2024

				An options appraisal has been completed to identify the increase in funding to meet the increased demand for IHA and RHAs. **Risk reviewed by RRCC 31st July 2024 and score increased to 16 (4 x 4).**	
395	TB Demand and Capacity	16	Children's, Young People and Specialist Services	Recruitment complete for 1 x B6 and 2 x B3, of whom the B6 and one of the B3 are in post and currently training. CTL on phased return to work. Service moving to Community Partnerships as of Aug'24 and will benefit from additional resources. Discussions taking place to review whether funding for the 3 posts can be made permanent. **Risk reviewed by RRCC on 31st July 2024 and score decreased from L5 x C4 = 20 to L4 x C4 = 16.**	July 2024
403	Children Young People Therapy treatment delays (SLT)	16	Children's, Young People and Specialist Services	There have been 2 further resignations. A joint ICB / LCC / LCHS paper for consideration of Public Health funding grant for early intervention and targeted offer has been shared with the CYP board, and it was well received. An outcome and decision is pending. **Risk reviewed at RRCC on 31st July. No change in score at this time.**	July 2024
409	Lymphoedema service capacity	16	Children's, Young People and Specialist Services	There are regular meetings with ICB regarding service delivery and funding. Triage pathways have been amended ensuring only appropriate referrals are currently on the caseload. Ongoing recruitment continues. Work is ongoing with the ICB in regards to supporting Primary Care with the application of the Chronic Oedema pathways.	July 2024
695	Collaborative Community Care	16	Lack of District Nurse Specialist Practice qualified (DNSPQ) staff in community nursing affecting the quality of care	Paper shared with the Group Chief Nurse and executive team proposing an increase of the DN speciality to band 7 and aligned with QNI caseload recommendation. For review by GLT Aug/Sept 2024. There are currently insufficient levels of qualified Specialist practice qualified district nurses to support staff within community nursing teams which impacts on oversight for complex case management, contributes to	July 2024

				lack of professional support and guidance for team development and links directly to the safe management of caseloads.	
714	Collaborative Community Care	16	Patients 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 settings. Service action plan to improve pressure ulcer care implemented and an educational training plan has been initiated for all community clinicians. Weekly meetings are taking place to monitor progress of improvement plans.	July 2024
715	Collaborative Community Care	16	The community nursing service is unable to meet the demand of patients within Lincolnshire	A paper for service development shared with Group Chief Nurse. This will be shared with GLT August / September 2024. The establishment gap has been modelled on QNI 80/20 ratio. 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.	July 2024
672	Timely Unplanned Palliative Response 24/7	16	Childrens and Specialist Services /joint risk across divisions	Discussed at Palliative Oversight Group 06/08/24. No new evidence to support an amendment of score. No change expected until completion of actions that are due in Sep'24. This risk sits across all divisions and a number of workstreams and further consideration is required. Patients are still waiting outside target wait times; particularly between 4 - 8pm due to capacity of community nursing and home visiting. Advice and specialist guidance is provided by Macmillan Specialist teams.	July 2024

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	Further £2m of CIP identified leaving £1m gap remaining, plan in progress to meet this gap. **Proposal to decrease the score from L5 x C4 = 20 to L3 x C5 = 15.** Agreed by FPPIC in July. To be presented at the **August RRCC meeting for oversight.**	July 2024
455	Failure to deliver financial plan 24/25 - Income	20	Finance	Main contract with ICB now signed. **Proposal to decrease the score reduced from L4 x C5 = 20 to L2 x C5 = 10.** Agreed by FPPIC in July. To be presented at the **August RRCC meeting for oversight.**	July 2024
418	Medical Gases Compliance	16	Medical	**Discussed at Risk C&C meeting on the 31 July 2024.** Agreed to discuss risks and risk score with ULHT Estates leadership team to align approach/actions. Further discussion at MSOG 01/08/2024.	July 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.	July 2024
390	John Coupland Hospital Theatres ventilation	15	Corporate	NHSPS Update: the AHUs have been awarded to the contractor and the Finance decision support docs have been signed. Contract due to be signed. Initial project meeting in July to start the work at JCH	July 2024
391	John Coupland Hospital Water Safety	15	Corporate	NHSPS Update: positive counts low in the palliative suite in Scotter Ward. Recently thermally disinfected and awaiting the re sampling results. LCHS seeking additional support from the group water safety team.	July 2024
393	Skegness Hospital Water Safety	15	Corporate	NHSPS Update: SG 27 pipework has been replaced. Chemical disinfection run and resampling has taken place. Awaiting results. Twice daily flushing continues with filters replaced every 30 days.	July 2024
649	Fire Safety Core Risk	15	Corporate	LCHS Fire Safety meeting took place in June to support the wider dissemination of information. The plan to review all fire risk assessments was also shared.	July 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, supporting with risk assessments, training, and support.	

4. Conclusions and Recommendations

There were 9 quality and safety risks rated Significantly High (15 - 20) reported to the Joint Quality Committee. This remains static from the previous 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
- 672 - Timely Unplanned Palliative Response 24/7
- 695 - Lack of District Nurse Specialist Practice qualified staff in community nursing affecting the quality of care
- 714 - Delivery of pressure ulcer care in the community
- 715 - Community nursing lacks capacity and skill set to meet community demand
- 681 - Children in Care - unable to meet Initial Health Assessment and Review Health Assessment timescales**. Reviewed by Risk Register Confirm and Challenge Group on 31st July 2024. There has been a significant increase in activity over the last year**. An options appraisal has been shared with the ICB. Score **increased to 16** (previously 12)

There were 8 risks rated significantly High (15 – 20) reported to the Finance, Performance, People and Innovation Committee. This is a reduction of 1 from the previous reporting period. These 8 relate to:

- 442 – Efficiency Requirement 2024 / 2025
- 455 – Failure to deliver the financial plan - Income
- 444 – Failure to deliver the financial plan – cost
- 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.

APPENDIX ONE- SIGNIFICANT RISK LISTING REPORT 31st July 2024

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	July 2024 - Paper to provide options to ICB for the ability to deliver the service sustainably going forward. Divisional Lead to present this to trust board in Aug/September 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	July 2024 - LCHG have agreed to adopt a common approach to improvement programmes in 24/25. Revised position shared with FPPIC in July 2024. **Proposed reduction in score to 15 (L3 x C5) to be presented to August RRCC meeting**. 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	Main ICB contract now signed. Proposed risk score revision discussed at FPPIC in July 2024**. Proposed reduction in score to 10 (L2 x C3) to be presented to August RRCC 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	July 2024 - Two further resignations. A joint ICB / LCC / LCHS paper for consideration of Public Health funding grant for early intervention and targeted offer has been shared with the CYP board, and it was well received. An outcome and decision is pending. **Risk reviewed at RRCC on 31st July. No change in score at this time.** 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.	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	5/07/2024 Ongoing meetings with ICB regarding funding. The triage pathway into the service has change ensuring only appropriate referrals are currently on the caseload. [24/06/2024 Service continues to recruit to agreed new posts. 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.	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	July 2024 - Recruitment complete for 1 x B6 and 2 x B3, of whom the B6 and one of the B3 are in post and currently training. CTL on phased return to work. Service moving to Community Partnerships as of Aug'24 and will benefit from additional resources. Discussions taking place to review if the funding for the 3 posts can be made permanent. **Proposed to decrease the score from L5 x C4 = 20 to L4 x C4 = 16.** **Reviewed by RRCC on 31st July 2024 – this panel supported the decrease in score.** 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.	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	06/08/2024 Discussed at Palliative Oversight Group 06/08/24: no recent evidence to support the need to amend the score. No change expected until completion of actions that are due in Sep'24. 25/07/2024 Community Nursing QSG Update: Workshop looking at full palliative pathway. Current unplanned pillar work on SOS visits is ongoing. Risk content and actions fully updated at PEOL Risk summmit 09/07/24. 03/07/2024 Discussed at CCC Community Nursing Divisional Quality Scrutiny Group 25/06/24: acknowledged the impact on teams, especially at the start and at the end of the shifts. Staff often work overtime to pick up stat doses that come in, but with insulin runs and less staff on late shifts, it's become challenging to pick up any SOS visits. There are several workstreams looking into palliative care, and community nursing leaders are involved in some work at present. 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	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	25/07/2024 Paper finalised proposing the need to increase DN speciality to band 7 and aligned with QNI caseload recommendation.. This has been shared with new Director of Nursing and Exec. Possibility of going to ELT either Aug/Sept 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	25/07/2024 This has 2 workstreams ongoing. 1 for immediate actions in relation to current increase in S42's in specific teams. 2 is for overall improvement to PU care across all teams. Current weekly meetings being held and auditing of teams has started. A3 thinking has been completed with some areas which has supported development of quality improvement plans. This has been roll out now to all ICT Teams. Workshops mapping out pathways has been completed and themes that will improve care have been identified. These have been through the A3 thinking process and action plans for improvements are being created. 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	25/07/2024 Paper evidencing need for increase in registered staff in Community Nursing has been finalised and share with new Director of Nursing and other Excs. This paper should go to ELT in Aug/Sept 2024. The establishment gap has been modelled on QNI 80/20 ratio.	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.	1. Authorising engineer appointed and 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	02/08/2024 **Discussed at Risk C&C meeting on the 31 July 2024**. Agreed to discuss risks and risk score with ULHT Estates leadership team to align approach/actions. Also, discussed at MSOG 01/08/2024. 12/07/2024 Feedback from Shared services (LPFT) 23/05/2024 (MS): 'The Medical Gas AE As for Lincolnshire Community Healthcare Services NHS Trust (LCHS) had not issued any annual reports, having been advised that no LCHS sites have piped medical gas installations. Apparently, it was agreed with my predecessors to only provide AE Services for the medical gases on an as required basis, examples being advice and guidance via emails, and phone calls when needed, mainly regarding portable cylinders. If AE services where required to attend site, meetings, produce reports then he would quote a cost for these services. Following discussion with him about undertaking audits of the medical gas systems in the three community hospitals owned and operated by NHS Property Services, the cost was advised to be c.£3000 to attend all sites, inspect, and provide a written report'. MP (ULHT Estates) contacted to request Group advice on next steps, also escalated to Group COO. Awaiting response - e-mailed again on the 12/07/2024. Next Group Risk C&C on the 31/07/2024. [03/07/2024 Increase in score was deferred from May and June 2024 Group Risk Register Confirm & Challenge group. To arrange representation for July RRCC so the score increase proposal can be discussed / agreed. [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 10:47:08 Sangeeta Bassi] 19/04/2024: Lack of AE input into new	Extreme
681	Children's and Specialist Services	Children in Care - unable to meet IHA and RHA timescales	There is a risk that there is insufficient capacity within the children in care service to meet the current demand for Initial Health Assessments (IHAs) and Review Health Assessments (RHAs). Initial Health Assessment is required within 20 days of a child coming into care. Review Health Assessments are required annually for children over 5 years of age, and twice yearly for children under the age of 5 years.	At the end of 2023 there were 728 children in the care of Lincolnshire County Council, this number continues to increase year on year (increased by 7% from the previous year alone and 18% over the last 5 years). The introduction of the National Transfer Scheme in November 2021 has also triggered a significant rise in Unaccompanied Asylum-Seeking Children receiving support from the service. The number of children and young people placed into Lincolnshire by external authorities also continues to rise significantly putting additional pressure on the team (22% increase over the last 5 years). The current budget for the Children in Care Service has not been reviewed for several years and is no longer sufficient to meet this increasing demand.	This means there is a significant increase in the number of children in care in Lincolnshire resulting in an increased demand for IHA and RHAs. These assessments are statutory and the service will be unable to meet the timescales these should be completed within. This will impact on the health needs of children in care living in Lincolnshire and delay access to care they may require. The reputation of the service will also be affected if they are unable to meet these statutory assessment timescales. Service user and carer feedback will also be impacted as children have to wait longer than expected for these assessments.	The number of children under the care of Lincolnshire County Council continues to grow year on year increasing the demand for IHA and RHA assessments. The service has only been able to offer the amount of IHA appointments needed to meet this demand at significant cost pressure to LCHS. LCHS are unable to continue to cover this additional financial support needed from 01.04.24. An options appraisal has been completed to identify the increase in funding to meet the increased demand for IHA and RHAs, this is attached to the record.	4 Likely: Will probably recur, but is not a persistent issue	4 Major	16	07/08/2024 **Discussed at RRCC 31/07/24: content reviewed following feedback from Quality Committee Jul'24. Score agreed as L4 x C4 = 16.** 25/07/2024 Discussed at CYPSS Quality Scrutiny Group 25/07/24: The service is still supporting IHA/RHA appointments outside their funding at cost pressure to themselves (approx £67,000), but what they need is £300,000 agreed budget to be able to meet the demand and to deliver the service appropriately. Caveat re: DNA / Was not brought: the slots cannot be filled at short notice. The division agreed that the score remains unchanged at a L4 x C3 = 12. For further discussion at RRCC, as query raised regarding the score needing to be higher. 20/07/2024 Discussed at CYPSS Quality SMT 18/07/24: the case for change has been completed and sent to ELT. A business case is to be deleveoped to add funding. No change to score. 03/07/2024 Discussed at CYPSS Quality SMT 20/06/24: a paper was written for proposed changes, and it is hoped that it would be added for discussion at ELT. No change to score. 16/05/2024 Discussed at Quality Meeting 16.5.24 No change to risk 17/04/2024 Updated with DL, DDL, CSL & CTL 15/04/24: The risk's score remains unchanged. There is limited capacity with regards to the number of IHA appointment slots. Due to a reduction in the CiC nurse hours, this has started to impact further on the RHA timescale. The current budget has not been reviewed yet and is no longer sufficient to meet the IHA & RHA demands. An Options Appraisal was completed to identify the increase in funding needed to meet this demand; the paper is under review within LCHS.	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	23/07/2024 Monthly update. No change 10/05/2024 Decisions regarding cost pressures need to be made by ELT. Risk decrease from 12 in December 2023 to 6. Risk updated on 29/04/2024 with Mike Pockett.'' At the start of the year there is a lot of people involved in bringing a quality efficiency program to be delivered. There were risks that didn't happen and as the year has gone on a lot of changes have happened because of financial benefits so the risk reduced. 9 months worth of efficiency financial measure allowed a more informed view of were the organisation is going for the next few months.27/04/2024 Retrospective decrease of score noted following FPPIC report 26/04/24. Narrative to follow on 29/04/24.	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 Committee Quarterly. 5. Weekly maintenance checks are being undertaken by NHSPS.	3 Possible: May recur occasionally	5 Catastrophic	15	09/07/2024 Project kick off meeting is set for July to start the work at JCH. No change to risk score currently. 06/06/2024 NHSPS Update: the AHUs have been awarded to the contractor and the Finance decision support docs have been signed. Contract due to be signed and then lead time for the clinics to know when to mobilise once a pre start meeting has occurred. 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 review by our Hard FM Specialist and Ventilation AE. Once their feedback and direction are received the design will be finalised.	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	06/06/2024 NHSPS Update: positive counts low in the palliative suite in Scotter Ward. Recently thermally disinfected and awaiting the re sampling results. LCHS Update: seeking additional support from the group water safety team. 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.	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	22/07/2024 NHSPS Update: SG 27 pipework has been replaced. Chemical disinfection run and resampling has taken place. Awaiting results. Still twice daily flushing is taking place with filters replaced every 30 days. 06/06/2024 NHSPS Update: Room SG 26/27 (open space)continues to return high counts even after thermal disinfections. Adjoining room clear. Decision taken to replace pipework due to possible biofilm build up. This work has started. Will arrange resampling after works. Filter fitted and flushed twice daily. UTC Small counts still present. Plans to move part of the boiler room closer to UTC to increase return flow and water temps. Planned for July. Filters fitted and flushed daily. 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.	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	09/07/2024 Risk continues to be monitored. No change to score. 05/06/2024 LCHS Fire Safety meeting took place in June to support the wider dissemination of information. The plan to review all fire risk assessments was also shared. No change to score. 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.	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	07/08/2024 Decrease of score from 15 to 10 agreed at RRCC 31/07/24 25/06/2024 Due to the work undertaken by NHSPS and post the visit by Lincolnshire Fire & Rescue the score has been decreased. This has been signed off by the Director of Estates and Facilities. The risk will continue to be reviewed until the compartmentation work has been completed and the risk is at the target score. 05/06/2024 Lincolnshire Fire and Rescue attended the site on the 5th June. The feedback was good around the LCHS staff's ability to react in the case of an emergency and their knowledge on what would be required. NHSPS are updating their local risk assessments and once these have been shared our risk assessments will also be updated to reflect the work that has been undertaken. 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 work in the roof voids all risk assessments will be reviewed as well as the risk score. [14/03/2024 12:45:24 Dan Dring] 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.	Extreme

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	*3 September 2024*
Item Number	*14.2*

Lincolnshire Community and Hospitals Group Draft Board Assurance Framework 2024/25

Accountable Director	*Professor Karen Dunderdale, Group Chief Executive*
Presented by	*Jayne Warner, Director of Corporate Affairs*
Author(s)	*Karen Willey, Deputy Trust Secretary*
Recommendations/ Decision Required	*The Board is asked to:- Consider the 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 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).

All Committees have received the BAF during the months of July and August with the exception of the LCHS Audit Committee.

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.

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 G 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 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	A	A							
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	G	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																						
			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.																						
SA2 To enable our people to lead, work differently, be inclusive, motivated and proud to work within LCHG																										
			1. Workforce Planning	1. Work Planning Solution - Implement the KPMG strategic workforce planner	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. NHSE EDI Improvement Plan/6 High Impact Actions 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 2024/25 8. Executive Leadership Team 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	1. 10 Year NHSE Workforce Plan	1. 10 Year NHSE Workforce Plan	1. Delivery of the LCHS People Strategy 2024/25 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 NHSE EDI Improvement Action Plan	None Identified		Finance, Performance, People and Innovation Committee			G	G	G							
			2. Inclusion	2.1 Reduce total pay gaps - race, disability, gender 2.2 Inclusive Recruitment Processes																						
			3. Pipeline	3.1 Group Bank 3.2 Apprenticeships 3.3 Wider Workforce																						
			4. Flexibility	4.1. Enabling a flexibility by default approach																						

			5. Retention	5.1 Support better retention				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. NHSE EDI Improvement Plan/6 High Impact Actions 5. CQC 6. System Improvement Director 7. NHS People Plan 8. National/Regional Benchmarking																		
			6. Civility and respect	6.1 Allyship 6.2 Reduce bullying and harassment																						
			7. Health and Wellbeing	7.1 Research into staff self-care/role of leadership																						
			8. Leadership and Talent	8.1 Leadership Development 8.2 Inclusive Talent Development																						
			9. Workforce Transformation	9.1 New ways of working 9.2 Develop New Roles and Skills																						
2b	To be the employer of choice	Group Chief People Officer	1-9 highlighted above in 2a	1-9 highlighted above in 2a	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. NHSE EDI Improvement Plan/6 High Impact Actions Secondary: 1. People Executive Group (PEG) 2. Finance, People, Performance and Investment Committee (FPPIC) 3. Lincolnshire People Board 4. Audit Committee 5. Equality, Diversity and Inclusion Group 6. Trust Well-Being Guardian 7. Lincolnshire People Plan 24/25 8. Executive Leadership Team (ELT) 9. Stakeholder Engagement and Involvement Group (SEIG) 10. Performance Management Reviews (PMRs) 11. Transformation Delivery Group (TDG) 12. Trust Leadership Team (TLT) 13. Quality and Risk	1. 10 Year NHSE Workforce Plan	1. 10 Year NHSE Workforce Plan		None Identifed		Finance, Performance, People and Innovation Committee			G	G	G							

								Committee (Q&RC) 14. Lincolnshire People Hub 15. Lincolnshire Integrated Care Board 16. Lincolnshire Health and Care Collaborative Delivery Board 17. Strategic Delivery Plan (SDP) Programme Board Tertiary: 1. Audit 2. NHS National Staff Survey 3. Regional People Board 4. NHSE EDI Improvement Plan/6 HIAs 5. CQC 6. System Improvement Director 7. NHS People Plan 8. National/Regional Benchmarking						
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	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)			

								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																			
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	G	G							
								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. 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)															

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		1. LCHS Finance Performance, People and Investment Committee (FPPIC) 2. Quality and Risk Committee (Q&RC) 3. LCHS Trust Leadership Team (TLT) 4. LCHS Strategy and Planning Group (SDP) 5. Transformation Delivery Group (TDG) 6. Performance Management Reviews (PMR) 7. Lincolnshire Integrated Care Board 8. Lincolnshire Health and Care Collaborative Delivery Board 9. Strategic Delivery Plan (SDP) Programme Board 10. System Financial Leaders Group (FLG) 11. System Digital and Data Team (DDAT) 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	G	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	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		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: 2. Estates Delivery Group 4. Health and Safety Committee 5. Finance, Performance, People and Investment Committee (FPPIC) 6. Audit Committee 7. Estates Shared Service Programme Group (ESSPG) 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 5. Internal Audit 6. Health and Safety Executive Standards 7. CQC rating 8. Benchmarking data 9. Healthcare Information and Management Systems Society Assessment (HIMSS)	1. Fully developed Estates dashboard 2. Fully developed 3rd party compliance dashboard	1. Programme of work around information into the dashboard and further training for staff 2. Programme of work to share compliance data across organisations into a dashboard	1. Delivery of the 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. Robust signed off Service Level Agreements (SLAs) for the Estates Shared Service 5. Delivery of LCHS Capital Plan 23/24 6. Greater utilisation of Estate			Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee			R	R	R							

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	A	A
3g	Reducing unwarranted variation in community service delivery and ensure we meet all constitutional standards	Group Chief Operating Officer										New Group objective. Assurance and governance reporting against this TBC.		Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee			R	R	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								New Group objective. Assurance and governance reporting against this TBC.		Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee (To move to: Transformation and Integration Committee)			R	G	G
			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 (currently 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 New Group objective. Assurance and governance reporting against this TBC.	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 (currently 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 New Group objective. Assurance and governance reporting against this TBC.	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	A	A

4c	Grow our research and innovation through education, learning and training	Group Chief Integration Officer												People and Organisational Development Committee / Quality 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 553 Migration from network drives to SharePoint		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. Trust Leadership Team (TLT) 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 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. 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			Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee (To move to: Transformation and Integration Committee)			G	G	G
			2. Safe and Sustainable Foundations (Digital)	2.1. Safe Practice 2.2. Technology Optimisation					1. Fully developed 3rd party compliance 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 Information 2. Workforce Digital Literacy Information	1. Creation of a patient co-design group 2. Trust wide Digital skills training needs analysis									
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		New Group objective. As		Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee (To move to: Transformation and Integration Committee)			R	G	G

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										New Group objective. Assurance and governance reporting against this TBC.		Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee (To move to: Transformation and Integration Committee)			R	R	R							
			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															

5d	Transform key clinical pathways across the group resulting in improved clinical outcomes	Group Chief Integration Officer/Group Chief Medical Director	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										Quality Committee
			3. Transforming Community Hospitals	3.1. Rebranding / Standardisation of Community Hospital offer - Discharge hub - Proactive care provisions - Correct bed distribution										
			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																						
			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															
	Deliver high quality care which is safe, responsive and able to meet the needs of the population							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 specific 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 reconciliation 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		
								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.		

1a	Group Chief Nurse/Group Chief Medical Officer	5143 5016 4879 5101 4740 4947 5100	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.	Quality Committee	G	G	G
			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 onward reporting to QGC. (CEG)	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 with a request to focus on specific areas each quarter to see improvements GIRFT team in place to support divisions and ensure that appropriate activity takes place.	Upward reports to CEG and onward reporting to QC KPIs in the integrated governance report Process in place for feedback to divisions Reporting through IIP to QC	Reporting has begun to focus on outcomes but this is not yet well embedded.	Request from CEG for future reports to show improved outcomes as a result of GIRFT activity.				
			Clinical Effectiveness Group in place as a sub group of QGC and meets monthly CEG works to an annual work programme and standard agenda to ensure that all business is covered appropriately. Upward reports are received from reporting groups inc: Human Tissue Authority Group Transfusion Committee Organ Donation Group Adjustment to policy and procedures Group Mortality Groups VTE Group Radiation Protection Committee NATSSIP/LOCSIP Group Research Groups Role of CEG is to Improve clinical effectiveness through increased compliance with national and local standards. Quality of reporting into CEG has improved and is increasingly robust. (CEG)	Acknowledged that there is good engagement from nursing and AHPs, however work continues to encourage engagement from medics. Leads of the reporting groups attend CEG on a quarterly basis to present upward report	Invites to speakers to come direct from Mr Simpson as Chair of the Group in future. Mr Simpson to continue as Chair of the Group whilst appointment of Deputy Medical Director concluded and will commence in role of CEG chair Increasing engagement with leads of reporting groups	Effective upward reporting to QGC from reporting groups. Regular reports received from Divisions providing assurance that they understand their position with respect to clinical effectiveness	No gaps identified.	Not applicable.				
			Clinical Audit Group in place and meets monthly (CAG) with monthly upward reports to CEG Refocus of CAG to focus on the learning from audit. (CEG)	There are outstanding actions from local audits ULHT and LCHS Groups being considered as a single meeting to strengthen learning and assurance	ToR currently being reviewed as new Chair in place for CAG	Upward report to CEG confirming status of clinical and associated actions and shared learning	No gaps identified.	Not applicable.				

National and Local Audit programme in place and agreed which is signed off by QC. Improved reporting to CEG regarding outcomes from clinical audit. Reports and process in place for any areas where the Trust is identified as an outlier. (CEG)	None identified.	Not applicable	All National Audits presented to CEG with associated action plan Internal Audits undertake review of Clinical Audit Programme on a scheduled basis	None identified	Not applicable
Process for monitoring the implementation of NICE guidance and national publications in place and upwardly reported through QC (CEG)	There are sometimes delays in the completion of the gap analysis for the Clinical Guidelines.	Process in place for escalation if required within the Clinical Divisions.	Reports on compliance with NICE / TAs demonstrating improved compliance.	None identified	Not applicable
Process in place for taking part in the Patient Related Outcome Measures (PROMs) project. (CEG)	None identified.	Not applicable	Quarterly reports to CEG and upwardly reported to QGC Outcome measures report published annually and shared with CEG		
Specialised services quality dashboards (SSQD) Process in place for identifying outliers through Model Hospital. Clinical leads for outlying areas present updates to CEG quarterly. (CEG)	No gaps identified.	Not applicable.	Quarterly reports to CEG and upwardly reported to QGC. Action plans developed for all required areas.	No gaps identified.	Not applicable.
Process in place for monitoring of and implementation of NCEPOD requirements. (CEG)	None identified.	Not applicable	Quarterly reports to CEG on progress.	Some outstanding baseline assessments. Some overdue actions identified.	Work taking place with divisional leads to address.
Monthly MorALS meeting chaired by the Deputy Medical Director and attended by a representative of the Triumvirate for each division. Monthly reporting to CEG (CEG)	Timeliness of completion of SJRs	Process being developed for M&M meetings.	Dr Foster alerts HSMR and SHMI data Medical Examiner screening compliance and feedback Compliance with SJR completion reported through PRMs Divisional updates art MORaLs by the Triumvirates	None Identified	Not applicable
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

1b	Improve patient experience	Group Chief Nurse						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.	Quality Committee			G	A	A							

1c	Improve clinical outcomes	Group Chief Nurse/Group Chief Medical Officer				4824 4731		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	G	G							
								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														
			Medical Workforce Programme (Medical Staffing Project)	Medical Workforce Programme - Medical Staffing Project with focus on: a) Plan for Every Post b) NHSE Workforce Productivity Tool c) Reporting				Workforce planning and workforce plans. Recruitment to agreed roles - plan for every post, for Agenda for Change, Medical and Dental Workforce People Planning & Transformation Team are in post, with Senior Lead (Director of People & OD) overseeing functions. Strong working relationships to utilise Divisional Heads of HR, Finance and Improvement Team to monitor compliance against KPIs set out within the IIP. 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 2024/25 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. Medical Workforce Programme reports into ISG on a monthly basis following monthly Steering Group chaired by SRO.	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.	Turnover (retention):Turnover has continued to improve over the last 12 months and is on track to deliver against the 2024/25 KPI set out within the IIP. To further support this, work has begun to understand how we develop exit data to gather insights for 'reasons for leaving' and support our staff to remain working Statutory & Mandatory Training: Reported into Workforce Strategy & OD Group (monthly) and within Divisional FPAM (monthly) with areas<50% compliance highlighted. Support offered to Divisional Teams by Head of HR and ELOD Team to improve in these areas to ensure that staff are compliant with mandatory training, and where issues identified are supported as required. Appraisals: Workforce Strategy and OD Group to discuss group appraisal and appraisal lite Ongoing discussions are in place with agenda items on Workforce and OD Strategy Group as required.	Workforce, Strategy and OD Group upward report to PODC including scorecard analytics i.e. appraisal, statutory and mandatory training.	Mandatory Training compliance have improved and continue to be on target for full year effect. Appraisal compliance levels 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 2024/25 KPIs 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. Absence reported at Divisional FPAMs with areas of concern highlighted (eg: CBU and Staff Group information) to support targeted action if required.	Sickness/absence data with detailed report available for Head of HR use to support targeted actions with Divisions. Deep dive by Workforce Strategy and OD Group into absence data Internal Audit Report Actions Report via FPAM (monthly), Workforce & OD Group (monthly) and into PODC via Scorecard.	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 24/25 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 aligned to Health and Wellbeing initiatives.	

2a	Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	Group Chief People Officer				4844 4996 4997 5447		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	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	Mandatory Training compliance have improved and continue to be on target for full year effect. Appraisal compliance levels 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 24/25 KPI's as featured in the Integrated Improvement Plan.	People and Organisational Development Committee			G	G	G
								Improve the consistency and quality of leadership through:- a) Reset leadership development offer and support (Leadership SkillsLab and PME) b) Improved mandatory training compliance c) Improved appraisals rates using the WorkPal system d) Developing clear communication mechanisms within teams and departments. Better Together Programme for multi disciplinary senior leaders across the Organisation is in place across LCHG.	Education, Learning & OD Team in place with ELOD certified experts with a mission to "engage and develop our people, champion differences and nurturing relationships to embrace a culture of civility and respect. Becoming the employer of choice"	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.	2024/25 5.5% 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. Standardised absence reporting via FPAM, with Divisional HR Teams also having access to Division/CBU/Specialty level specific data to support the active management and monitoring of absence with Divisional colleagues. Staff are signposted to Health & Wellbeing services as a matter of routine through regular communications and in response to specific incidents/needs across the Trust (eg: Employee Assistance Programme).	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 4.5% across the Trust by 31st March 2025. Aligned to the plan for every post, recruitment plans for each division and aligned to the workforce submission plan for 24/25.	Changes in budgeted establishment as a result of approved (System and Interval) investments which increase establishment, thus widening the vacancy gap.	Regular monitoring of monthly reports and tracking of changes with clear rationale.	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 9.00% across the Trust by 31st March 2025	9.00% 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 24/25 to continue to improve work life balance, flexible working requests, flexible retirement/retire and return options. People Promise Mgr funding identified for Yr2. To be embedded as business as usual at the end of Year Two funding for the Group.	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							

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 by ELT and shared with Group Leadership Team. Restorative Just and Learning Culture project team has been formed with a full roll out now 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 and maintain 90.00% of our people having completed all relevant statutory and mandatory training by 31st March 2025. 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 24/25. 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. 90.00% 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 24/25 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 by 90.00% of our staff having an 'in-date' appraisal within 2024/25.	90.00% 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 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

			Education, Training & Development	Aligns to Integrated Improvement Plan at Trust Level and Divisional Level where there are in year plans within the People Objective with regards to developing staff and teams.	Capacity to release staff due to operational pressures to attend relevant training and development sessions.			Embedding continuous learning and personal development culture across the Trust	Dedicated Talent Academy Team who support wider access to apprenticeship programmes which support the ongoing development of current staff, and the attraction of new staff to the Trust. Education, Learning & Organisational Development Team who support the Trust to meet the regulatory areas of compliance, such as Mandatory Training, and also support ongoing learning which is bespoke to the needs of the Trust. For Medical Workforce, Clinicians are able to access the training provided by the Talent Academy. There is a gap in how this is reviewed and monitored within the Chief Medical Officer portfolio. This is an area of focus for 2024/25 to ensure that there is a robust mechanism for oversight and assurance.	Reported via People & OD Committee for regulatory needs/compliance. Updates provided within FPAM at Divisional Level with regards to attendance and engagement with: 1) People Management Essentials Training, 2) Just Culture Briefings and 3) 50% or less compliance for Mandatory Training Close working between Education, Learning & OD Team with regards to the co-ordination of the METIP and TNA so that this is aligned to the wider needs of Workforce Planning.	People & OD Committee Workforce Strategy & OD Group Nursing & AHP Transformation Group	None Identified, although regularly reviewed to consider platforms which are best placed to provide further insights and levels of assurance for Education, Training & Development.	Working closely with key roles and groups to better understand the needs of the organisation and staff. Collaborative working by ensuring that key functions are included as part of ad hoc or standing agendas for the regular review and discussion about kept areas within education, training and development. For example: Education is now a key area of focus with a regular slot on the Workforce, Strategy & OD Group. On a monthly basis.						
2b	To be the employer of choice	Group Chief People Officer				4948		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	G	G
			Medical Workforce Programme (Medical Staffing Project)					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																			
					ERF - Failure to deliver the ERF target of 113% of 19/20 planned activity will result in a potential clawback of an element of the ERF allocation made to Lincolnshire and non delivery against the ERF gain share CIP scheme for ULHT.			1.1 ERF clawback - Collective ownership across the Lincolnshire ICS of the planned care pathways leading to improved activity delivery. 1.2 Trust focus to deliver 113% of activity	1.1 Maximisation of the Trust Resources - Theatre and Outpatient productivity. 1.2 Ability to recruit and retain staff to deliver the capacity. 1.2 Production of an activity delivery plan.	1.1 Improved counting and coding, focus in this area including data capture and missing outcome reductions. 1.1 Shared risk and gain share agreements for the Lincolnshire ICS. 1.2 Divisional ownership and reporting 1.2 Reporting by POD and Specialty against the delivery plan	1.1 & 1.2 Delivery of the 113% target - phased trajectory.	1.1 & 1.2 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 113% ERF activity target.	1.1 The Lincolnshire ICS is monitored externally against the system activity target through the monthly activity returns 1.2 The Trust is monitored externally against the Trust activity target through the monthly activity returns 1.2 The Trust monitors internally against its activity targets inclusive of specific Divisional and Specialty plans and targets						

3a	Deliver financially sustainable healthcare, making best use of resources	Group Chief Finance Officer			Capital - Capital investment levels are significant and require delivery in 'live' environments. Robust planning is required to ensure that delivery of the agreed schemes takes place within the financial year to avoid any under-investment in our services.	5020 4664	CQC Well Led CQC Use of Resources	2.1 Three key capital groups; MDCG, DHG and Estates, are in existence to understand the issues and provide mitigations, alongside escalation where required. Escalation should be via Capital Delivery Group (CDG) and CRIG which links in the risk impacts of the requirement. Upward reporting from CDG/CRIG to GLT, FPEC and Trust Board is in place. 2.2 From a clinical divisional perspective, investment priorities continue to be identified and these are being reviewed and prioritised based on risk. 2.3 Lincolnshire does have an agreed Capital SOP that will be utilised if/where required in terms of risk management across all provider organisations. 2.4 ULHT has a rolling 5 year capital programme analysis that details the level of investment required across the organisation with financial estimates included. Financial assessments include; Medical Device equipment replacement cost, 6-Facet Survey within Estates and CIR calculations. 2.5 Business cases are produced for future investment that include capital requirements.	2.1 & 2.2 Difficult to compare Estate, Digital and Medical Equipment risks when allocating capital resources. 2.1 & 2.2 & 2.5 Robust timeframes for operational delivery of schemes required. Financial consequences (Capital & Revenue) if operational delivery is outside of agreed plans. 2.5 Capacity to produce business cases to access external funds. 2.1 - 2.5 Impact of IFRS16 (Right of Use Assets) agreements. 2.1 & 2.5 Contractor 'contracts' and transfer of risk away from ULHT.	2.1 & 2.2 & 2.3 & 2.5 Open and transparent discussion around proposed scheme deliverability to manage risks identified with Estates, Digital and Medical Devices. Presentations to FPEC and Trust Board to engage senior leaders in the proposed capital programme together with the risks that remain. Further discussion with Lincolnshire partners to ensure all opportunities are understood and awareness of shared risks. 2.5 Robust business case process with all key stakeholders involved in the support and approval of cases. Business Case (Green book & Local requirements) training roll out across the Trust and partners. 2.1 & 2.2 & 2.4 & 2.5 Risk rating pre & post investment required in all investment requests. 2.1 & 2.5 Key stakeholders involved in agreement of leases (IFRS16) aware that Finance need to be involved in all discussions to assess the implications of agreements proposed.	2.3 & 2.4 & 2.5 Capital Programme approval process ahead of the financial year - FPEC / Trust Board development session / Trust Board. 2.1 Capital Delivery Group (CDG) fortnightly monitoring of scheme delivery. Upwardly reported on a monthly basis to FPEC and Trust Board. 2.5 CRIG approval process for business cases. Upward reporting into GLT for final agreement. 2.5 Benefits realisation group review and upward reporting into CRIG, GLT and FPEC. 2.4 Development of a 5 year capital programme cross referenced to risk register.	2.5 Benefits identified in business cases not being fully delivered. Need to ensure greater accountability of delivery and learning lessons if ambitions were not achieved. 2.1 Control process for timeline changes for scheme delivery needs to be implemented.	2.4 Multi-year capital requirements prioritised to assess 'need' versus 'affordability'. Mitigations discussed and agreed at the key capital groups and escalation where required. Capital programme to be 'managed' within Lincolnshire therefore ability to 'pause' schemes if impact of 'new' scheme is greater is possible. 2.4 6-Facet survey completed and details being assessed to feed into a revised and more robustly prioritised multi-year capital planning requirement. 2.3 & 2.4 & 2.5 Discussions continue with NHSE regarding the level of capital limits (CDEL) applied to Lincolnshire and the need for this to be reviewed and increased as part of national calculations. As it stands, the national limits are lower than the level that would be investable based on 'local' available resources.	Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee			A	A	A
					Cash - Deficits in the last 3 years have depleted cash reserves. Factoring in the 2024/25 deficit plan with additional delivery risks alongside a large capital programme means that the availability of cash to meet Pay and Non pay obligations is at substantially increased risk unless carefully managed.			3.1 Cashflow Monthly Projection to 30 June 2025 3.2 Daily cashflow projected 3 months ahead 3.3 Monthly reporting to FPEC 3.4 Access to cash support via NHSE subject to formal Board approval and application process 3.5 Facility to move cash around Lincolnshire System utilising NHSE cash support process	3.1, 3.2 & 3.3 Cash forecasting dependent upon accurate capital, CIP and I&E projections and certainty of delivery. 3.4 Cash support above the level of the I&E deficit is subject to more rigorous challenge through the business case process. May not be approved. 3.5 Transfer of cash between Lincolnshire bodies requires formal agreement by both parties. 3.5 Process to enable cash transfer between NHS bodies requires the repayment of PDC by the donor and issuing of PDC to the recipient (ULHT). LCHS has very limited PDC that can be repaid which in turn restricts the ability to transfer cash within LCHG.	3.1, 3.2 & 3.3 Capital, CIP & I&E risks are separately identified with mitigations. 3.5 System discussions to facilitate moving of cash.	3.1 - 3.5 Cash and working capital reporting to FPEC	3.1 - 3.5 Underlying Capital, I&E projections / timelines are best assessments at a point in time.	3.1 - 3.5 Ongoing review						
					CIP - Not delivering the identified required £40.1m of CIP schemes			4.1 Delivery of CIP Schemes 4.2 Medical Recruitment improvement 4.3 Medical job planning 4.4 Agency price reduction 4.5 Workforce alignment 4.6 Service Reviews process and transformational programmes of work 4.7 Budget compliance	4.1 & 4.6 Maximisation of resources to deliver CIP 4.2 Reliance on temporary staff to maintain services, at premium cost 4.3 Management within staff departments and groups to funded levels. 4.4 Maximisation of below cap framework rates 4.5 Rapid ability to on-board temporary staff to substantive contracts 4.7 Manage divisions to contain costs within budgetary envelope.	4.4 Embedding of centralised agency & bank team. 4.1 , 4.2 , 4.3 & 4.4 Workforce Groups / Delivery programmes to provide grip 4.1 & 4.6 Improvement Steering Group to provide oversight across the group 4.5 Overseas & local recruitment support fragile services and substantive staff aligned to fragile areas 4.1 & 4.7Continuous Non-Clinical Agency sign off process & Vacancy control process	4.1 - 4.6 Delivery of the planned agency reduction target, supported by substantive recruitment to vacancies 4.7 Budget compliance reported to FPAM's	4.3 Granular detailed plan for every post plans 4.2 & 4.7 Rota and job plan sign off in a timely manner	4.1 -4.5 The Trust monitors internally against its financial plan inclusive of specific targets for agency and bank spend by staff group 4.1 & 4.6 The Trust CIP workstreams are reported to the Improvement Steering Group 4.1 & 4.7 The Divisional cut of the workstreams are reported to the relevant FPAM 4.7 The staff areas of key focus - Medical and Nursing are reported through their Workforce Groups 4.1 Fortnightly FRP Board assurance with Lincolnshire ICB						

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												
3c	A modern, clean and fit for purpose environment across the Group	Group Chief Operating Officer				4648 4647 5415		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.	Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee			A	A	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.													
								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.													
								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.													
								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)	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	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	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.	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													

3d	Reduce waits for patients who require urgent care and diagnostics to constitutional standards	Group Chief Operating Officer						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.		GIRFT have identified gaps in services which have been included in actions plans within the relevant specialties/divisions	performance Updates full suite of metrics to ELT, TLT and Board. Updates provided to Group UEC Board and UEC System Partnership Board	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	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			
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.	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 sustainability plan to be taken through CRIG in Q4 that will	

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		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 utilisation 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, particularly in theatres	Improvement programmes driving workstreams to address control measures. 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 digitalise 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 job plans 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 reporting 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	
								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														
								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	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	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	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	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	

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							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.	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 Partnership Strategy EMAP governance structures/MOU	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	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 Quarterly reports	Impact of EMAP programmes	Verbal updates at EMAP exec meetings and ULHT representation at EMAP programme groups, quarterly EMAP updates via IIP	
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)

4c	Grow our research and innovation through education, learning and training	Group Chief Integration Officer						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 held to 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 additional income generation, wider socio-economic impact	People and Organisational Development Committee (To move to: Transformation and Integration Committee)			R	R	R
								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						
								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						
								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.						
								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						

4d	Enhanced data and digital capability	Group Chief Integration Officer				4657							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	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.													
								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												

Meeting	*Lincolnshire Community and Hospitals Group Board meeting*
Date of Meeting	*3 September 2024*
Item Number	*14.3*

Audit Committee Upward Report

Accountable Director	*Neil Herbert, Audit Committee Chair*
Presented by	*Neil Herbert, Audit Committee Chair*
Author(s)	*Jayne Warner, Director of Corporate Affairs*
Report previously considered at	*N/A*

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

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

Recommendations/ Decision Required	• *Ask the Board to note the upward report*

Executive Summary

The Audit Committee met via MS Teams on the 8th August 2024. The Committee considered the following items:

Group Update
The Committee noted the progress with Group Executive Appointments. The process for Group Chief Finance Officer would run during August. A proposal for jointly appointed Non Executive posts had been presented to NHSE for approval.

The Quality Committee continued to run "in Common" across the two organisations and the workshop to move to a people committee for both organisations was diaried for August 2024. This would be followed by a workshop for the joined up Finance and Performance Committee.

Consideration was now being given to whether the Audit Committee could operate jointly for the two organisations moving forward but that would only be a consideration once all joint board appointments had been made.

External Audit
The Committee noted that the Annual audit had completed successfully and there was no external audit update to the Committee for its August meeting.

Internal Audit

The Committee received the Internal Audit Progress Report noting that four internal audit reports had been finalised and published since the previous meeting of the Committee. The reports relating to Pharmacy, Data Quality -KPI and Patient Flow had all received Reasonable Assurance. The Project Management and Post Benefit Realisation had received a Limited Assurance. Internal Audit confirmed that whilst they had been advised that a number of new systems and processes had been put in place, these were not embedded enough to allow for audit testing to be completed. Therefore it was recognised that the control environment was likely to have improved from the position reported.

The Committee reviewed the Internal Audit Plan and questioned when the last review had taken place relating to Health and Safety. It was confirmed that there had not been a recent internal audit. The Chair of the Finance, Performance and Estates Committee confirmed that the Trust had received a report from the British Safety Council. It was agreed this would be presented to Committee to determine if the assurance was such that an internal audit review was also warranted.

The position with audit recommendations and the audit plan were noted. The Committee were satisfied that reasonable progress had been made against plan. Internal Audit recommendations continued to be closely monitored.

Local Counter Fraud Specialist Progress Report and Annual Report

The Committee noted the progress report for quarter one. The NHS Counter Fraud Functional Return had been approved and submitted. The Counter Fraud Functional

Standard had been rated as Green for the Trust. The Committee noted two new Fraud Risks.

The Committee received the LCFS annual report which reflected the positive work seen during 2023/24. The Committee agreed to share this report with the Trust Board for information.

Compliance Report
The Committee received the quarterly compliance report. It was noted that the Board had taken part in the NHS England approved Cyber Training. Following on from this a board briefing would be provided to offer assurances against the Board questions raised by the session.
An increased volume and value of waivers was noted. It was confirmed that this reported to an error in the cut off for reporting in the previous report which should resolve in the next quarter.

Policies Update
The Committee received the quarterly update on the policy position. It was noted that there had been a deterioration in the position in respect of overdue policies and that some of the agreed improvement trajectories for the Divisions had now been missed. Recovery actions were presented and the Committee agreed that this should feature as an escalation to Board. Performance reports on policies would be shared in the divisional performance meetings with Executives and the overall position continued to be routinely reported to the Executive Leadership meeting.

Audit Committee Annual Report

The Committee report was considered and agreed along with objectives for 2024/25. This would be appended to the upward report presented to the Board.

Board Assurance Framework and Risk Register

The Committee reviewed the BAF and Risk Register confirming that each remain fit for purpose.

LOCAL COUNTER FRAUD SPECIALIST ANNUAL REPORT 2023/24

August 2024
Audit Committee
Peter Riches, Local Counter Fraud Specialist

Counter Fraud Plus is a collaborative fraud and compliance service for Northern Lincolnshire and Goole NHS Foundation Trust, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust, United Lincolnshire Hospitals NHS Trust, Lincolnshire Partnership NHS Foundation Trust, Lincolnshire Community Health Services NHS Trust, and Hull University Teaching Hospitals NHS Trust.

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1. EXECUTIVE SUMMARY

This report is a consolidated summary of all previous reports provided by the Local Counter Fraud Specialist (LCFS) to the Audit Committee from 1 April 2023 to 31 March 2024.

CFP is the operating name of the collaborative counter fraud and compliance service for United Lincolnshire Hospitals NHS Trust (ULHT), Northern Lincolnshire and Goole NHS Foundation Trust (NLaG), Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH), Lincolnshire Partnership NHS Foundation Trust (LPFT), Lincolnshire Community Health Services NHS Trust (LCHS) and Hull University Teaching Hospitals NHS Trust (HUTH). CFP provides a dedicated and resilient counter fraud service, meaning that ULHT enjoys a full time LCFS to deliver all aspects of counter fraud activity. The original collaborative arrangement commenced on 1 July 2013 and is hosted by NLaG, with LCHS and LPFT both joining on 1 September 2020. In April 2023, the CFP collaborative was expanded further to include Hull University Teaching Hospitals NHS Trust (HUTH).

During the reporting period the Trust continued to strategically support the counter fraud work performed by the LCFS. The Directors of Finance and the LCFS worked together on all aspects of counter fraud activity, which is turn was supported through direct oversight by the Audit Committee.

The 2023/24 counter fraud operational plan was underpinned by the local fraud risk assessment and was agreed by the DoF on 28 March 2023 and ratified by the Audit Committee on 19 April 2023. Monitoring of counter fraud activity has been undertaken during formal meetings with the DoF and the Chair of the Audit Committee. Detailed quarterly reports have also been provided along with verbal updates to the Audit Committee.

During 2023/24 the Trust has been adhering to the NHS Counter Fraud Functional Standard set by the NHS Counter Fraud Authority (NHSCFA) which is aligned to the Government Counter Fraud Functional Standard. The standard came into effect on 1 April 2021 and has twelve distinct areas of which all NHS organisations must comply (each being mapped to the former areas of strategic governance, inform and involve, prevent and deter and hold to account).

The Trust has continued to support the LCFS in developing an anti-fraud culture amongst staff, which is seen as a key component in preventing, deterring, and detecting fraud. All activities required by the NHSCFA have been undertaken and the details included in regular reports to the Audit Committee. Referrals received by the Trust's LCFS have been appropriately recorded on the NHSCFA's case management system, CLUE, as required by the NHS Counter Fraud Functional Standard. The Trust has recorded the following key facts during 2023/24:

- 23 fraud referrals received and progressed by the LCFS, an increase of five from 2022/23.
- 28 referrals closed on CLUE.
- 20 investigations remaining open at the year end.
- Fraud losses identified - £28,528.60.
- Fraud losses recovered - £1,332.47.
- Fraud losses prevented - £16,748.41.
- Three disciplinary sanctions administered to employees for fraud against the Trust.
- Five Local Proactive Exercises (LPEs) commenced in the reporting year.
- Six Fraud Prevention Notices (FPNs) actioned.
- Five Intelligence Bulletins (IBURNS) actioned.
- The CFFSR risk rating in respect of Fraud Risks (Component 3), previously rated as amber, now green; all NHS requirements now rated as green.
- Submission of Green rated Counter Fraud Functional Standard Return.

Overall, 2023/24 has been another productive year for the LCFS in all areas of counter fraud activity at the Trust.

This annual report is presented to the Audit Committee for information and will be utilised to

support any submission to the NHSCFA as evidence of activities carried out as part of their Quality Assessment process.

2. INTRODUCTION

2.1 The NHS Counter Fraud Authority (NHSCFA) and the NHSCFA Strategy.

Whilst the majority of people who work in and use the NHS are honest, a minority will seek to defraud it of its valuable resources. In 1998, the Government recognised the issue of fraud in the NHS and set up the NHS Counter Fraud Service (CFS). Over the succeeding years various transformations and name changes have occurred and on 1 November 2017 the organisation at that time was replaced by an independent Special Health Authority known as the NHS Counter Fraud Authority (NHSCFA). The NHSCFA is tasked to lead the fight against fraud, bribery, and corruption in the NHS.

On 8 June 2023 the NHSCFA issued its business plan for 2023/24. The plan outlined the NHSCFA's key commitments for 2023/24 using the four pillars outlined within their strategy – ***Understand***, ***Prevent***, ***Respond*** and ***Assure*** (detailed below) and has an overarching theme of working together to understand, find and prevent fraud, bribery, and corruption in the NHS.

The NHSCFA's vision is to lead and proactively support the NHS to understand, fight and respond to fraud and have identified four strategic pillars to this end:

1. To **understand** how fraud, bribery and corruption affects the NHS.
2. To ensure the NHS is equipped to take proactive action to **prevent** future losses from occurring.
3. To ensure the NHS is equipped to **respond** to fraud.
4. To **assure** key partners, stakeholders and the public that the overall response to fraud across the NHS is robust.

Figure 1.

The NHSCFA Strategy for 2023 to 2026 released in June 2023, highlighted how the NHSCFA continue to operate in line with the five internationally recognised principles of fraud and corruption work (see Figure 1). The Trust's Countering Fraud, Bribery and Corruption Policy and Response Plan is aligned and includes reference to this strategy.

The NHSCFA estimate that fraud costs the NHS £1.264 billion each year, which has a detrimental impact on NHS services by taking away vital funds from patient care.

Fraud continues to be a growing problem and is thought to account for approximately 40% of all crime within the UK. As a result, the NHS faces a wide range of fraud risks. The NHSCFA aims to use intelligence to build a better picture of those risks, and encourage fraud reporting, which plays a vital role in improving and understanding of fraud across the NHS. They have indicated the need to develop creative, innovative, and proportionate solutions to identified risks, and will continue to investigate organised and/or complex fraud.

The NHSCFA conducts an annual strategic intelligence assessment to estimate fraud losses, identify possible threats, vulnerabilities, and facilitators, and evaluate the risk of fraud to the NHS. The 2023 Strategic Threat Assessment highlights that in 2023 there has been a growth in the estimated financial vulnerability within the NHS to £1.264 billion, up £66 million from 2022.

In summary, the NHSCFA's task is to lead the fight against NHS fraud, working closely with Local Counter Fraud Specialists, Directors of Finance, Audit Committee Chairs and Counter Fraud Champions across the NHS as this is vital to the success of their strategy, and ultimately

to protecting NHS resources intended for patient care. The ULHT LCFS and the wider CFP team supports the Trust fully in achieving compliance with the NHS Counter Fraud Functional Standard and will continue to provide the full range of anti-fraud activities throughout 2024/25.

2.2 Counter Fraud Functional Standard Return.

To achieve the aims in 2.1 above, all NHS provider Trusts are required to comply with Service Condition 24 of the NHS Standard Contract. As part of the oversight arrangements, each Trust must assure its commissioners that it is compliant with the NHS Counter Fraud Functional Standard. Details of this Functional Standard appear below, however the four key principles (strategic governance, inform and involve, prevent and deter, and hold to account) remain and this report is structured around these principles.

The NHS Counter Fraud Functional Standard consists of twelve requirements with which all NHS bodies should be compliant:

1. Accountable Individual.
2. Counter Fraud, Bribery and Corruption Strategy.
3. Fraud, Bribery and Corruption Risk Assessment.
4. Policy and Response Plan.
5. Annual Action Plan.
6. Outcome-Based Metrics.
7. Reporting Routes for Staff, Contractors, and Members of the Public.
8. Report Identified Loss.
9. Access to Trained Investigators.
10. Undertake Detection Activity.
11. Access to and Completion of Training.
12. Policies and Registers for Gifts and Hospitality and COI.

All NHS bodies will once again perform the annual self-review exercise using the NHS Counter Fraud Functional Standard by completing the corresponding Counter Fraud Functional Standard Return (CFFSR). The CFFSR is required to be completed by the LCFS and agreed and signed off by the DoF and the Chair of the Audit Committee before submission to the NHSCFA as part of their national Quality Assessment programme. The 2023/24 CFFSR submission was completed, signed off and duly submitted to the NHSCFA on 15 May 2024, ahead of the 31 May 2024 deadline.

Peter Riches

2.3 LCFS Provision and the CFP Team.

Pete Riches is the Trust's nominated LCFS at ULHT and has led on counter fraud work since July 2013. Pete came to the NHS at that time with a long record of benefit fraud investigations and internal audit roles within local government. He also successfully completed a BSc. in Counter Fraud and Criminal Justice Studies through the University of Portsmouth. He is based on site at Lincoln County Hospital which ensures that he can conduct counter fraud work efficiently, effectively and promptly and thus provides visibility and easy access for all staff in relation to counter fraud activities.

Each organisation within the collaborative arrangement has their own nominated LCFS. The CFP team is fully contracted under a Service Level Agreement (SLA) whereby the Trust enjoys an effective and resilient counter fraud service, with flexibility to buy in extra resources should circumstances require. There is no additional burden of cost to ULHT for investigations (e.g., for support from other CFP team LCFS's for Interviews under Caution).

Sally Stevenson

The CFP team is headed by Sally Stevenson, Assistant Director of Finance – Compliance and Counter Fraud (and a Graduate Counter Fraud Specialist) for Northern Lincolnshire and Goole NHS Foundation Trust (NLaG). Sally became an accredited LCFS in 2000 and investigated many cases during her LCFS career, securing a range of sanctions. In June 2013 she graduated

with First Class Honours from Portsmouth University after successfully completing a BSc. in Counter Fraud and Criminal Justice Studies. Sally is responsible for the management of the CFP team and performs a supervisory role in the submission of prosecution files to the CPS, etc.

Taelor Straw

The ULHT LCFS is supported by their CFP colleagues, Taelor Straw (nee Martin), (LPFT and LCHS), Nicki Foley (NLaG and HUTH) and Mark Bishop (DBTH).

Taelor Straw, who is an Accredited NHS Local Counter Fraud Specialist, has continued to lead counter fraud work for both LPFT and LCHS throughout 2023/24. Taelor has over five years' experience as an LCFS after graduating from Nottingham Trent University with a first-class honours' degree in Criminology. This year, Taelor also secured a Distinction in her MSc Economic Crime degree, obtained from the University of Portsmouth. Taelor is also the nominated Support LCFS for ULHT.

Nicki Foley is the nominated LCFS for the NHS Humber Health Partnership, a Group model comprising of both NLaG and HUTH, and has been in post since June 2011. In her thirteen years as an LCFS, Nicki has experienced a wide range of LCFS work, particularly in the investigation sphere including working alongside both the NHSCFA National Investigation Service (NIS) and the Police on a former NLaG investigation involving agency timesheet/invoice fraud which saw seven defendants convicted of fraud, of which three received immediate custodial sentences. Nicki has been successful in securing a range of criminal, disciplinary and professional sanctions.

Nicki Foley

Mark Bishop

Mark Bishop is the nominated LCFS for DBTH and has been a LCFS in the NHS since 2004. He has an outstanding record for his counter fraud work and brings with him a wealth of law enforcement experience. Prior to becoming an LCFS, Mark spent 23 years in the Royal Military Police and for the latter 16 years of that career he served in the Special Investigation Branch investigating serious criminal offences.

Jacky Gibbons is the CFP team's Support Officer, joining in 2014, providing support to any member of the CFP team when necessary. Jacky's background is as a Payments' Manager at NLaG, and her knowledge of payments systems proves valuable in supporting the rest of the team, particularly with bank mandate compliance checks.

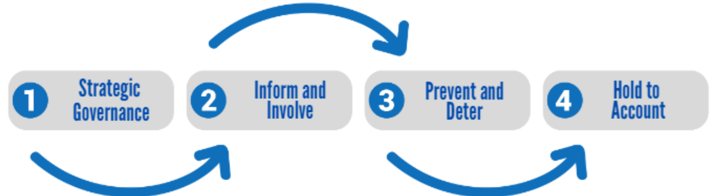
Jacky Gibbons

The team continue to support each other daily, despite often being in different locations, by seeking each other's advice and sharing good practice and intelligence as necessary. In addition, the team provides cross cover absence arrangements and assist each other with Interviews Under Caution (IUC's), etc. Formal team meetings have been held in person on a monthly basis throughout the financial year, with ad-hoc meetings convened as necessary in between scheduled meetings, which provides a platform for intelligence and best practices to be shared.

3. BACKGROUND INFORMATION

The NHSCFA and LCFS staff are responsible for tackling all types of fraud and corruption in the NHS and protecting resources so that they can be used to provide the best possible patient care.

All counter fraud work undertaken by the LCFS for 2023/24 followed the requirements of the NHS Counter Fraud Functional Standard and complied with guidance contained in the NHS Counter Fraud Manual. The LCFS has the responsibility to support the Trust, through the DoF, in carrying out the functions required by the NHSCFA. The Trust has tailored counter fraud work across the four key areas set out in the relevant standards:



All work carried out in these four areas is described in detail in Sections 5 to 8 of this report. The 'Hold to Account' element specifically details the work conducted by the LCFS in the investigation of allegations of fraud and, where necessary, require the LCFS to pursue criminal, civil, and disciplinary sanctions against anyone who commits fraud against the NHS. This area of work requires the LCFS to operate in accordance with current legislation, including but not exclusively limited to:

- The Police and Criminal Evidence Act 1984 (PACE)
- The Criminal Procedures and Investigations Act 1996 (CPIA)
- The Data Protection Act 2018 (DPA)
- The Regulation of Investigatory Powers Act 2000 (RIPA)
- The Investigatory Powers Act 2016
- The Fraud Act 2006 (FA)
- The Bribery Act 2010 (BA)
- The Human Rights Act 1998 (HRA)
- The Police, Crime, Sentencing and Courts Act 2022 (PCSC)

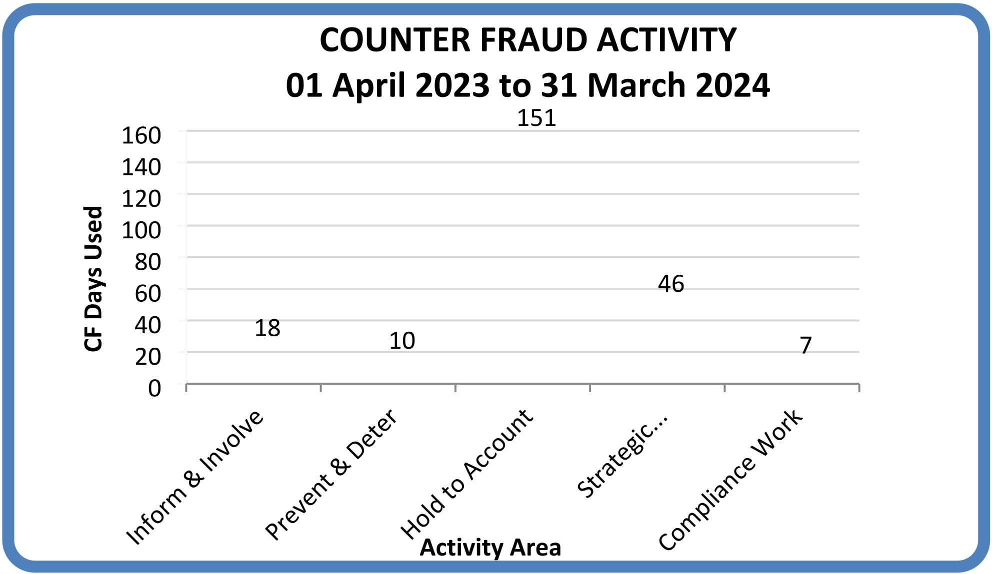
4. DELIVERY OF THE OPERATIONAL FRAUD PLAN 2023/24

On behalf of the Trust, the LCFS and DoF are required to prepare a Counter Fraud Operational Plan (CFOP) identifying specific objectives and methods of achievement that accords with the NHS Counter Fraud Functional Standard. The plan is a key document used within the NHSCFA Quality Assurance (QA) process designed to assess the organisations counter fraud arrangements. The 2023/24 CFOP was agreed by the DoF on 28 March 2023 and ratified by the Audit Committee on 19 April 2023.

One of the key elements of the QA process is ensuring NHS bodies allocate sufficient resources to counter fraud work based on risk analysis. The Trust's current counter fraud arrangements, as part of the collaborative agreement, led to the appointment of one full-time LCFS nominated for the Trust. This removed the need to identify the number of days allocated to counter fraud work (including associated daily charge rate) meaning the LCFS is not limited in the extent of work, particularly investigation work, which can be performed and essentially ring fenced a dedicated counter fraud provision with the resilience of CFP support. This model of service was verbally commended by a NHSCFA Quality Inspector as part of its quality inspection of counter fraud work at the Trust in 2015.

Although there is no time constraint on the counter fraud provision, key areas are monitored and recorded to provide the Audit Committee with an overview of where activity has taken place, and for 2023/24 activity by the LCFS is represented in the following graph, which considers the time spent by the CFP team Support Officer performing compliance checks at the Trust, particularly in relation to mandate fraud checks. It also includes the assistance of other CFP team LCFSs for investigation work, including the Trust's Support LCFS. The graph

does not include any support given by the CFP Team Manager in any area of counter fraud work.



It can be seen that due to the high number of fraud referrals and number of ongoing investigations as outlined in section 8, 'Hold to 'Account' accounted for the highest level of activity by the LCFS.

5. STRATEGIC GOVERNANCE

Any activity detailed in this section contributes to Components 1A, 1B, 2, 3 and 9 (and referenced in Components 5 and 7) of the NHS Counter Fraud Functional Standard.

5.1 Director of Finance (DoF) - Liaison.

Component 1A of the NHS Counter Fraud Functional Standard requires a member of the executive board to be accountable for the provision of strategic management of all counter fraud, bribery, and corruption work within the organisation. As such, the Trust's Director of Finance (DoF) is the executive lead for all counter fraud activity.

The LCFS provides regular updates to the DoF on all matters concerning fraud, bribery and corruption, including the status of investigations. An agenda was compiled for each meeting during the year and actions were documented and completed in a timely manner. Closure reports or summaries were submitted to the DoF at the conclusion of LCFS work on each referral, providing assurance that the actions of the LCFS were overviewed at an Executive level and that each referral was scrutinised to ensure that all appropriate sanctions were considered, that any control weaknesses were addressed, lessons were learnt and NHS money recovered, where appropriate.

5.2 Meetings with the Chair of the Audit Committee.

As good working practice and in support of an executive led overview of counter fraud activity, formal meetings have taken place between the LCFS and the Chair of the Audit Committee during 2023/24, prior to each Audit Committee meeting. These meetings are required to occur at least annually, as part of the Counter Fraud Operational Plan. The Chair of the Audit Committee and the LCFS have unrestricted lines of communication between each other as necessary.

5.3 Counter Fraud Liaison Protocols.

The LCFS continues to maintain formal liaison protocols with a number of key individuals / teams to ensure effective communication and working arrangements between the LCFS and the individual/team concerned, namely:

- Human Resources.

- Freedom to Speak Up Guardian.
- Communications' Team.
- Counter Fraud Champion.
- Payroll Team.
- Internal Audit.
- Local Security Management Specialist.

These protocols are kept under review to ensure they remain fit for purpose.

5.4 Liaison with the Counter Fraud Champion.

Component 1B of the NHS Counter Fraud Functional Standard stipulates that all NHS health bodies must nominate a Counter Fraud Champion (CFC). The Trust's CFC is the Trust Secretary, Jayne Warner. The CFC has routinely supported the counter fraud agenda at ULHT, which this year included the facilitation of a fraud awareness presentation by the LCFS to the Trust Board. Staff awareness of the CFC role is to be assessed by way of the 2024/25 Staff Fraud Awareness Survey.

5.5 Internal Audit Liaison.

The Trust enlisted a new Internal Audit team (TIAA) in April 2023. As outlined in 5.3, the LCFS issued an Internal Audit / LCFS Liaison protocol which supports the continued communication between the LCFS and the Trust's Internal Auditors, and was signed by Phillip Lazenby, Director of Audit at TIAA. The LCFS meets with Philip Lazenby, and / or Audit Manager, Amanda Blakey, on an at least a quarterly basis. The LCHS/LPFT LCFS, Taelor Straw, also attends these meetings to ensure there is a joined-up approach to counter fraud across the Lincolnshire patch. These meetings allow for potential areas of joint working to be identified and for intelligence building and sharing of information as appropriate.

5.6 External Audit Liaison.

The LCFS continued to liaise with the Trust's External Auditors where appropriate and provided responses to their requests for information, when necessary, as part of their year-end audit work on the Trusts financial statements.

5.7 Cyber Liaison.

The LCFS has an unrestricted line of communication with Paul Ryan, the Trust's Digital Security and Compliance Manager, and liaised with him throughout the year, on an as needed basis, to discuss matters of cybercrime and fraud.

5.8 Counter Fraud Operational Plan (CFOP).

Component 5 of the NHS Counter Fraud Functional Standard requires the Trust to have a Counter Fraud Operational Plan (CFOP) detailing the counter fraud activities that are to be conducted within the Trust over the course of the year. The LCFS devised a CFOP for 2023/24 which was agreed by the DoF on 28 March 2023 and ratified by the Audit Committee on 19 April 2023. This is a flexible document, meaning it can be altered throughout the year as necessary to include activities in response to emerging fraud risks.

5.9 NHSCFA – Counter Fraud Functional Standard Return (CFFSR).

The NHSCFA assesses every NHS body on its counter fraud provision which is carried out as part of the Quality Assessment (QA) process. Counter fraud activity conducted during 2023/24 was assessed against the NHS Counter Fraud Functional Standards by way of the Counter Fraud Functional Standard Return (CFFSR).

The assessment was completed by the LCFS, peer reviewed within the CFP team and then reviewed and approved by the DoF and the Chair of the Audit Committee prior to submission by the required deadline of 31 May 2024 (although this was extended by two weeks due to some national technical issues which caused problems for some LCFSs). The return was duly submitted on 15 May 2024 and the Trust assessed itself as having an overall rating of 'Green'. The RAG rating against each individual requirement was assessed as follows:

COMPONENT	1A	1B	2	3	4	5	6	7	8	9	10	11	12
RAG RATING	G	G	G	G	G	G	G	G	G	G	G	G	G

All CFFSR submissions are subject to ratification by the NHSCFA, and any Trust can be subjected to a further assessment if deemed necessary. For a summary of the Trust's compliance against the functional standard, and a formal declaration provided by the DoF, see **Appendix 1**.

As part of the 'NHS Counter Fraud Requirements' within the QA process required by NHSCFA, a summary of key data is attached at **Appendix 2.**

5.10 Fraud Risk Assessment.

Component 3 of the NHS Counter Fraud Functional Standard requires the Trust to carry out comprehensive local Fraud Risk Assessments (FRA) to identify fraud, bribery, and corruption risks. This assessment must be undertaken in line with the Government Counter Fraud Profession's (GCFP) methodology and risks must be recorded and managed in line with the Trust's Risk Management Policy. To date, the Trust has recognised and assessed 29 individual fraud risks and the number of risks at each risk level was determined as follows:

- **Very High (20-25) 0**
- **High (15-16) 0**
- **Moderate (8-12) 4**
- **Low (4-6) 5**
- **Very Low (1-3) 20**

Total 29

All risks were reviewed by the nominated risk owners during 2023/24. Fraud risks will continue to be reviewed and updated as necessary in conjunction with risk owners during 2024/25.

5.11 The Fraud Hub.

In 2023/24, the NHSCFA set up the new 'Fraud Hub' as the primary focal point for all health bodies to work in partnership with them to tackle fraud in the NHS. It functions as the main point of contact between the NHSCFA and the counter fraud community across the NHS. There are four key workstreams within the Fraud Hub:

- Stakeholder Relationship Management and Performance Improvement.
- Hub Enforcement Support.
- Hub Fraud Prevention Support.
- Clue Case Management.

Teams within the Fraud Hub work together to deliver on a range of collective objectives, whilst maintaining their expertise in their own specialised areas. This includes working in partnership with all units within the NHSCFA, as well as in close partnership with individual stakeholders and stakeholder groups. Throughout 2023/24, the LCFS frequently liaised with various streams of the Fraud Hub for support in the delivery of counter fraud activities at ULHT.

5.12 NHSCFA Extranet (NGAGE).

The NHSCFA Extranet site, known as NGAGE, acts as a central hub of information regarding NHS fraud for members of the NHS counter fraud community. It is accessible to the LCFS, DoF, Audit Committee Chair and CFC and provides news articles, links to useful resources and access to other NHSCFA webpages. The LCFS accesses NGAGE on a regular basis to ensure that all updates are noted and where necessary, any actions outlined on the site are implemented on a timely basis.

5.13 Public Sector Fraud Authority.

In 2022/23, the Government developed the Public Sector Fraud Authority (PSFA), a core function of the government aiming to modernise the public sector counter fraud response, build expert led services to fight fraud, develop capabilities to find, prevent and respond to fraud, and define good practices in the counter fraud arena. During 2023/24, the PSFA continued to share counter fraud guidance, much of which is applicable to the NHS. The LCFS is made aware of PSFA published documents via the NHSCFA NGAGE platform and, where appropriate, shares this guidance with appropriate staff / departments within the Trust.

5.14 Counter Fraud Managers' Group.

The CFP team manager attends meetings of the Counter Fraud Managers' Group (CFMG), a useful national networking forum of counter fraud managers employed by NHS organisations (not private firms). The meetings are also attended, at the invitation of the group, by representatives from the NHSCFA to discuss national issues, etc. The group is a useful forum for sharing of comparative information in respect of LCFS work being undertaken, problems encountered, etc. Feedback was provided by the CFP team manager to the CFP team following each CFMG meeting throughout 2023/24.

5.15 Continuing Professional Development (CPD).

Component 9 of the NHS Counter Fraud Functional Standard requires all NHS bodies to have an accredited Local Counter Fraud Specialist. In order to maintain professional competencies and to further expand their knowledge, the LCFS continued with professional development throughout the year with attendance at a number of fraud-related events including two Yorkshire and Humber Fraud Forum Masterclasses, of which the LCFS is a member. The LCFS also continued to attend the NHSCFA's webinars, which are designed to demonstrate their commitment to facilitate better engagement with the NHS Counter Fraud community. During 2023/24, the LCFS attended the following webinars:

- Mandate Fraud.
- Working elsewhere Fraud Prevention Notice forum.
- RSM Webinar - Failure to prevent fraud – what to consider.
- External Reporting Workshop.
- Yorkshire and Humber Fraud Forum (YHFF) Masterclasses:
  - The importance of good culture in your approach to fraud risk management.
  - R v Stephen Day: How Teamwork Brought a Dishonest Accountant to Justice.
- NHS Confederation - Counter fraud and security workshop.
- Fiscal Technologies – Managing the Risk of Fraud.

5.16 NHSCFA External Reports.

In January 2024, the NHSCFA released their external reporting platform. The reporting suite contains a range of bespoke reports concerning proactive and reactive activity, which alongside the ability to provide peer comparison and a national picture, is intended to inform, support and drive counter fraud activity. The reports are produced in Microsoft PowerBI and

hosted on Microsoft Sway. The weblink is accessible by the Trust's DoF, Audit Committee Chair, and Counter Fraud Champion should they wish to explore the data contained within these reports.

5.17 Counter Fraud Operational Plan – 2024/25.

Looking forward, the Counter Fraud Operational Fraud Plan for 2023/24 was agreed between the DoF and LCFS on 25 March 2024 and submitted to the April 2024 Audit Committee. This plan came into effect on 1 April 2024 and progress against this plan will form the basis of all planned formal meetings with the DoF and future progress reports to the Audit Committee.

6. INFORM AND INVOLVE

Any activity detailed in this section contributes to Components 4, 11 and 12 of the NHS Counter Fraud Functional Standard.

6.1 Counter Fraud, Bribery and Corruption Policy and Response Plan.

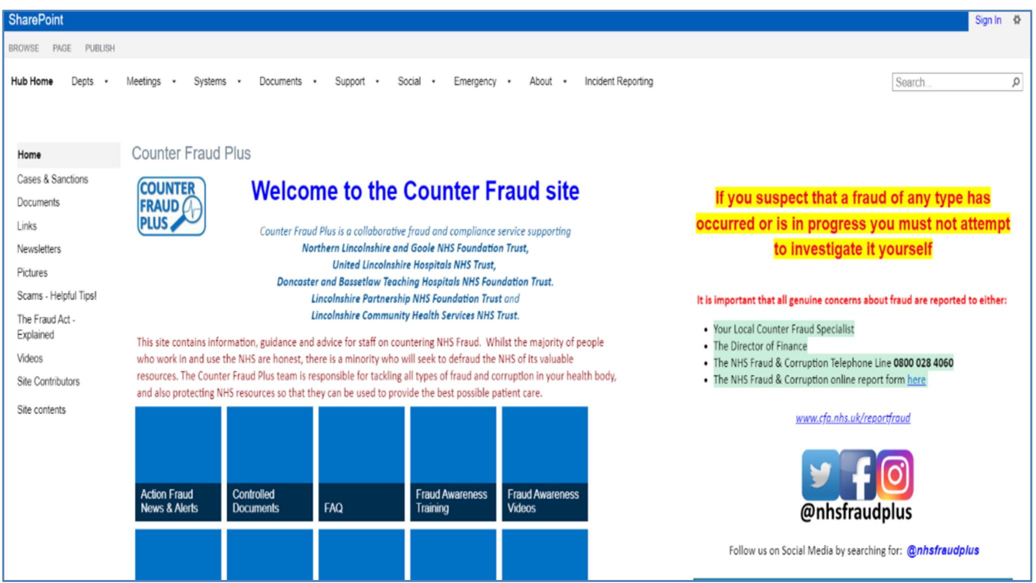
The LCFS conducted a review of the Trust's Counter Fraud, Bribery and Corruption Policy and Response Plan in July 2023, ensuring that the policy is up to date and fit for purpose. The LCFS continues to raise awareness of the policy via regular staff communications and induction training, and it is available to all staff via the Trust SharePoint.

6.2 Communications' Team Liaison.

The LCFS maintains a LCFS / Communications' Team liaison protocol document which is signed by the Trust's Associate Director of Communications and Engagement, Anna Richards. The document enables effective liaison between the two parties and outlines the responsibilities each have in relation to fraud, bribery, and corruption. The LCFS remains in contact with the Communications' Team and enlists their valuable support in promoting awareness of fraud, bribery, and corruption throughout the organisation as necessary. The Communications' Team assisted the LCFS on various occasions throughout the year.

6.3 Intranet Presence.

The LCFS maintains a presence on the Trust's intranet site. The Trust's counter fraud intranet pages are reviewed regularly by the LCFS to ensure that they remain up to date and fit for purpose. The CFP team also maintains its own informative intranet site. This provides staff with topical fraud related information and the local contact details for counter fraud specialists working across the collaborative. The site is hosted by NLaG and can be visited by any NHS computer here.



6.4 Fraud Awareness Month (FAM) and International Fraud Awareness Week (IFAW).

Once again, the CFP team in conjunction with all our collaborative Trust's designated November as Fraud Awareness Month (FAM), which coincided with International Fraud Awareness Week (IFAW). The Trust is a registered supporter of IFAW along with other global and UK public sector bodies. FAM and IFAW are dedicated periods of the year where fraud awareness activity is increased through all available communications methods. Activities conducted throughout the Trust during FAM 2023 included visits by the LCFS to Grantham and District Hospital to carry out visits to wards, offices, and departments, where information along with free pens and other promotional material was handed out. There was also detailed material released on a weekly basis by the Communications' team in the Weekly RoundUp, including articles on:

- What is NHS fraud?
- The many types of NHS fraud.
- What is the most common fraud committed by NHS staff?
- The ingredients for fraud.
- What do I do if I suspect NHS fraud?
- The activities and outcomes of the Counter Fraud Plus' team.

Significant promotion of the event and specific fraud related advice was also issued throughout the month by the CFP team across our social media platforms. The LCFS also utilised the 'ULHT Together' Facebook group to post several articles to promote awareness of NHS fraud.

6.5 'Fraud Through the Looking Glass' Newsletter.

The CFP team newsletter continued to be produced and distributed to staff during 2023/24 and is intended to be an informative and interesting read for staff covering current fraud related topics, with dedicated sections on successful NHS prosecutions and scams. It is also intended to serve as a vehicle for deterring staff from committing NHS fraud by the publicising of successful sanctions, both at a local and national level. Staff can subscribe to the newsletter, ensuring that it is received directly into their NHS email inbox as soon as it is published. In 2023/24 four editions of the newsletter were issued (May 2023, August 2023, November 2023, and February 2024). All editions of the newsletter are published on the Trust's intranet site and on ULHT's Staff Facebook page.

6.6 Social Media.

The CFP team operates dedicated X, Facebook and Instagram accounts and uses them as another medium to regularly promote counter fraud news, advice, and guidance, primarily to those staff within the collaborative CFP Trusts who choose to follow the counter fraud team. In addition to Trust staff, there are a number of external followers to the CFP Twitter account, notably law enforcement fraud and cybercrime units that help ensure the NHS anti-fraud

message is reaching a wider audience. The CFP X account currently has 874 followers. Throughout 2023/24, analytical data was captured from both X and Facebook and statistics relating to X and Facebook activity can be found within the Outcome Based Metrics at **Appendix 3** of this report.

6.7 Fraud Awareness E-Learning.

Fraud awareness training remains a core training requirement in the Trust and all new starters are required to undertake fraud awareness via an eLearning route. All staff have to refresh their fraud awareness training every three years. The following table shows the percentage of staff who, over time, completed counter fraud awareness training, either via eLearning or through a LCFS presentation (up to March 2024). Each quarterly report to the Audit Committee includes an update in respect of the Trust's compliance level for fraud awareness training, and as the table below shows, this has continued to remain a very high level across the Trust.

	LCH	PHB	GDH	Trust Total
May 2015	31.0%	27.0%	33.0%	**30.0%**
March 2016	80.0%	77.0%	84.0%	**79.0%**
March 2017	94.0%	93.0%	97.0%	**94.0%**
March 2018	96.6%	96.6%	97.8%	**96.8%**
March 2019	93.1%	93.9%	94.9%	**93.6%**
March 2020	94.2%	94.5%	96.4%	**94.6%**
March 2021	92.6%	93.3%	95.5%	**93.2%**
March 2022	92.3%	92.6%	93.2%	**92.5%**
March 2023	92.7%	93.4%	96.2%	**94.2%**
March 2024*	96.4%	96.2%	97.0%	**96.5%**

* As from November 2023, the Trust's compliance figures exclude staff on long term sickness absence (+ 28 days) and new employees (< three months).

6.8 Fraud Awareness Presentations / Workshops.

The LCFS promoted awareness of fraud, bribery, and corruption by conducting fraud awareness sessions, typically involving a short presentation or talk followed by a question-and-answer session. The LCFS also conducted fraud risk workshops within the Trust, which were interactive sessions used to explore fraud risks within the respective areas. During 2023/24 the LCFS delivered fraud awareness sessions / fraud risk workshops to the following teams:

- 1 August 2023, Trust Board Development Session to Non-Executive Directors of the Trust, plus one interim Executive Director.
- 12 September 2023, with the assistance of the Trust's Support LCFS, presented a fraud awareness workshop to 26 members of the Trust's POD / HR teams. Attendees participated in breakout rooms, where specific fraud risks were shared. Positive feedback was received following the session
- 3 January 2024, the LCFS undertook a general fraud awareness session with the Trust's Payroll team, which is part of a shared service provided by LPFT.
- The LCFS, alongside the Trust's Support LCFS, delivered an awareness workshop to 90+ employees within the Finance team, over two sessions in January and February 2024. The workshops included a series of breakout sessions whereby finance staff were asked to discuss, and feedback, on a number of fraud risks that may impact upon the Trust. Once again, positive feedback was received from those who attended.

6.9 Human Resources Liaison.

To ensure that for all allegations received within the Trust, appropriate sanctions were considered and achieved where possible, regular meetings took place between the LCFS and representatives from the Human Resources Directorate. This arrangement is invaluable and helps to maintain a strong working relationship between the LCFS and the HR staff, ensuring that where a potential fraud has been highlighted, close and supportive interaction and lawful information sharing between the LCFS and HR takes place, and that criminal and disciplinary investigations are carried out effectively and in accordance with relevant legal frameworks.

6.10 External Body Liaison.

The LCFS continues to maintain strong links with external investigative agencies and other stakeholders. Where applicable, all contacts follow relevant legislative protocols and appropriate guidance issued by the NHSCFA. Agencies communicated with during 2023/24 were as follows:

- NHS Counter Fraud Authority (NHSCFA).
- Internal Audit (TIAA).
- External Audit (Mazars).
- Nursing and Midwifery Council (NMC) regarding Fitness to Practice referrals.
- General Medical Council (GMC) concerning ongoing investigations.
- Lincolnshire Police.
- Humberside Police.
- Private Employers / companies.
- Other LCFS's from other NHS Trusts.

7. PREVENT AND DETER

Any activity detailed in this section contributes to Component 10 of the NHS Counter Fraud Functional Standard.

7.1 NHSCFA Intelligence Bulletins.

The LCFS received five intelligence bulletins (IBURNS) from the NHSCFA in 2023/24 in relation to mandate fraud, recruitment fraud and individuals who may pose a fraud risk to the NHS. All were circulated to appropriate staff and actioned accordingly.

7.2 NHSCFA Fraud Prevention Notices.

The NHSCFA continues to issue Fraud Prevention Notices (FPNs) as new information is made available to them. The purpose of these FPNs is to capture and analyse system weakness referrals and to create fraud prevention solutions and provide guidance to reduce system weakness vulnerabilities. All FPNs are actioned upon receipt and outline details are reported to the Audit Committee in routine progress reports from the LCFS.

During the reporting period, six FPNs were received and actioned, ensuring the Trust addressed potential system weaknesses.

7.3 Intelligence Reports.

In addition to the formal IBURNs that require specific action, the LCFS also receives Intelligence Reports (IRs) directly from the NHSCFA. In general, these documents are much more sensitive than IBURNs and ordinarily contain strictly controlled information for further development by the LCFS and they often include broad unsubstantiated pieces of information that cannot be disclosed elsewhere. If, on review of an IR, there are grounds to commence an investigation, then all further activity is recorded on the NHSCFA case management system.

During the reporting period, the LCFS received thirteen such IRs which either resulted in checks undertaken with no further action, appropriately sharing the information within the Trust or the wider NHS for consideration / action, or the commencement of a formal criminal investigation.

7.4 Bank Mandate Fraud.

The threat of this type of fraud has continued to remain real and significant, no longer just within the public sector but also across private companies. A robust local procedure is in place and is reviewed by the Trust's Purchase to Payments' Manager following receipt and sharing of intelligence by the NHSCFA and CFP team. All new intelligence regarding bank mandate fraud attempts is directed to key staff within the Payments' Team to ensure that a heightened awareness is maintained, and this continued to be the case during the reporting year.

The CFP team's Counter Fraud Support Officer (CFSO) performed sample compliance checks on the Trust's adherence to the procedure during 2023/24 and no issues of non-compliance were identified. Continued compliance with the procedure should provide the Trust with maximum prevention from this type of fraud and forms part of the compliance checks within the counter fraud collaborative.

7.5 Cabinet Office National Fraud Initiative.

The National Fraud Initiative (NFI) is an exercise, conducted by the Cabinet Office every two years. It matches electronic data within and between public and private sector bodies to prevent and detect fraud. The participating bodies include police authorities, local probation boards, fire and rescue authorities as well as local councils, a number of private sector bodies, and the NHS. The Trust participates in the NFI exercise and throughout 2023/24, the LCFS and Trust finance officers actioned the data matches for the 2023 exercise, ensuring they reached a satisfactory outcome.

831 matches were received in total, made up of **315 Payroll matches** (including Payroll to Procurement matches) and **516 Creditors matches**. The Accounts' Payable team reviewed all 516 Creditor matches and two invoices were identified as duplicate, which resulted in the Trust **recovering £1,094.40 from the supplier** via credit notes. At the end of March 2024, three payroll matches remained open, two of which related to ongoing LCFS investigations and a further match for which the LCFS anticipates a response in due course.

7.6 Local Proactive Exercises (LPEs).

The NHS Counter Fraud Functional Standard requires all Local Proactive Exercises (LPEs) to be solely risk based and recorded on the NHSCFA's case management system, CLUE. The system requires the appropriate risk rational to be recorded alongside the LPE and requires the LCFS to upload LPE outcome reports.

During 2023/24, four LPE's were conducted within the Trust in areas of heightened risk, covering mandate fraud, dual employment, impersonation of a medical professional and pre-employment checks.

7.7 NHSCFA Learning Reports.

During 2023/24, the NHSCFA began publishing Learning Reports to the NHS Counter Fraud community. The reports outline details of real cases for LCFS's to learn from and reduce fraud in the future where possible. One Learning Report was published by the NHSCFA in 2023/24 and focussed on 'Operation Bukowski' – a case study relating to offences of theft, fraud, and bribery within an NHS organisation. The report posed a number of questions for organisations to consider within their procurement processes and these were answered by the Trust's Procurement team, and details presented to the Audit Committee in January 2024.

7.8 NHSCFA – Quarterly Threat Assessments.

The NHSCFA continued to issue quarterly threat assessments throughout 2023/24 to highlight areas of fraud concerns. These threat assessments included information on the following themes:

- NHS Staff Fraud.
- Patient Exemption Fraud.
- Procurement and Commissioning.
- Fraudulent Access.
- Data Manipulation.
- Mandate Fraud.
- Pharmaceutical Contractor Fraud.

The LCFS continues to review the information provided within these reports for impact on the Trust, and actions are taken as appropriate. The specifics of each theme cannot be shared directly with the Audit Committee, due to the sensitivity of the information included.

7.9 Miscellaneous Prevention Activity.

The LCFS continued receiving intelligence from other counter fraud stakeholders nationally and locally within the CFP collaborative. Where appropriate this was shared with the Trust and assurance sought. During 2023/24 the LCFS received intelligence in the following areas which was shared with the Trust as appropriate:

- Bank mandate warnings.
- National concern re: International English Language Testing System (IELTS) Certificates.
- Community pharmacy scam.
- Bogus telephone calls.
- Cybersecurity incidents.
- Compromised supplier.
- Bed-hoppers.
- Online platform domain blocked.
- Mandate fraud – seasonal reminder.
- Targeting international colleagues for their Biometric Residence Permit and bank account details (non-NHS fraud).

8. HOLD TO ACCOUNT

Any activity detailed in this section contributes to Components 6 and 8 (and referenced in Component 9) of the NHS Counter Fraud Functional Standard.

8.1 System Weakness Reports (SWRs).

The NHSCFA case management system, CLUE, allows for the recording of system weakness reports (SWRs) that are required as part of Component 8 of the NHS Counter Fraud Functional Standard. System weakness reports can fall into several categories including lack of fraud awareness, lack of segregation of duties, poor record keeping, and poor form design, etc. There were two SWRs reported by the LCFS during 2023/24 which were identified during ongoing investigations.

SWR Reference	Subject of SWR	Status	Outcome
SWR/23/00064	RTW documentation can be completed by managers in the absence of the employee.	Closed	Having liaised with both the Acting DoF and the People Systems' Manager, Trust managers were advised to manually send the completed RTW document to their employee. Trust user guides and HR / POD training sessions will be updated accordingly.
SWR/23/00065	Discrepancies identified in sickness absence data recorded (in the Absence Management	Closed	An exercise was undertaken by HR to retrospectively review and correct previous non-aligned absence periods. Assurance provided to the LCFS by the Trust's *People*

	System, ESR, Health Roster) and the RTW documentation.		*Systems' Manager* that daily reports are produced to ensure that all three Trust systems have employee absence data which aligns.

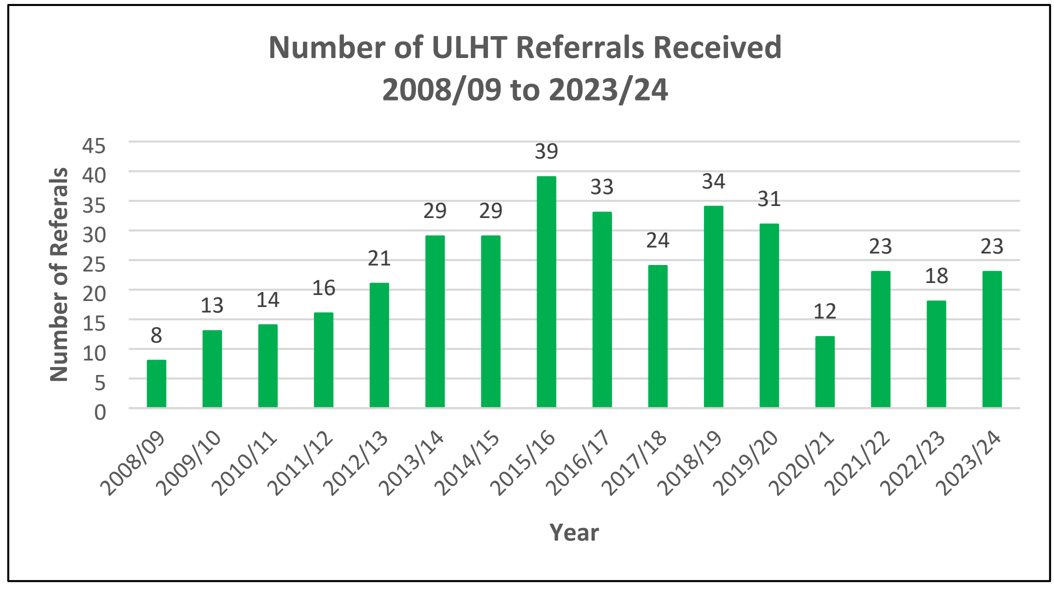
8.2 Miscellaneous Advice.

During the year, the LCFS was contacted on 28 occasions by a range of staff in the organisation, including management, regarding potential fraud concerns. The LCFS provided appropriate guidance and advice, to enable their concerns to be progressed in an appropriate and proportionate manner. It should be noted that these contacts were in addition to referrals uploaded to CLUE. This underpins the effectiveness of having a dedicated LCFS, embedded within the organisation, as a single point of focus for staff to discuss concerns of potential fraud.

8.3 Investigation Referrals.

Fraud referrals are received from many sources and are appropriately progressed by the LCFS through the gathering of evidence to ascertain whether a case to answer exists. The LCFS provided details of all fraud referrals received in routine progress reports to the Audit Committee, supported by verbal updates by the LCFS when required. Information included in this annual report is therefore in summary form only. Where evidence does not support a criminal case, it is referred to HR and / or a professional body where appropriate, for consideration of other disciplinary action. Where sanctions are imposed then the outcome is recorded on the on the case management system.

During the reporting period, 1 April 2023 to 31 March 2024, the LCFS dealt with 23 referrals of fraud, an increase of five on the previous year. The number of fraud referrals received since 2008/9 is shown in the graph below to provide a year-on-year comparison.



Of the 23 new referrals received during 2023/24, nineteen related to current or former employees, three related to unknown subjects and one to a patient. All new referrals are notified to the DoF upon receipt and to the Audit Committee via the quarterly progress reports. The status of each referral is updated on each progress report until the matter is concluded.

8.4 Closure of Cases / Information Reports.

It should be noted that information submitted on the Trust's Counter Fraud Functional Standard Return (CFFSR) does not always correlate with the information provided in this section of the Annual Report. To clarify:

- Information related to financial losses identified, monies recovered, and fraud prevented are only included on the CFFSR for cases which were closed during 2023/24 rather than when the money was recovered; non-fraud recovery information is not included on the CFFSR.
- Criminal or disciplinary sanctions are included on the CFFSR for cases which had sanctions applied during 2023/24, rather than when the Case was closed.

Within the four progress reports submitted to the Audit Committee during 2023/24, 28 referrals were reported to the Audit Committee as being closed on the national case management system.

8.5 Responsible Officer's Advisory Group (ROAG).

The LCFS has an effective working relationship with the new Chair of the ROAG, who is the Trust's new Deputy Medical Director for Professional Standards. The LCFS maintains contact with ROAG, through both the Chair and HR. Ongoing investigations are discussed where it is necessary and appropriate to do so.

8.6 Sanctions – Evaluation of Criminal, Disciplinary and Professional.

During 2023/24, the LCFS worked in line with the NHS Counter Fraud Functional Standard. Component 6 of the Standard states that the Trust should identify and report on annual outcome-based metrics with objectives to evidence improvement in performance. Metrics should include criminal and disciplinary sanctions.

The Trust's commitment to ensuring that appropriate sanctions are applied when necessary is contained with the Countering Fraud, Bribery and Corruption Policy and Response Plan and sanctions are pursued if an employee is suspected of being involved in a potential fraud. Applying a consistent and thorough approach for all referrals received will ensure that effective investigations are undertaken, where appropriate, including the gathering and assessment of all relevant material which may indicate fraud, bribery, corruption, misconduct and/or unfitness to practise. Each referral received by the LCFS is considered on its own merit for the full range of sanctions at the earliest opportunity. The LCFS maintains a HR / LCFS Liaison Protocol document which outlines how the two parties can work together to achieve parallel sanctions (i.e., criminal and disciplinary).

Criminal investigations are conducted separately to other investigations and the two processes have different purposes, rules of evidence, standards of proof and outcomes. The LCFS's close working relationship with the Trust's HR Department and the Trust's Deputy Medical Director for Professional Standards, ensures that where appropriate, disciplinary sanctions are considered and progressed where necessary. Such actions are duly reported to the Trust's Audit Committee within the LCFS progress reports for oversight and scrutiny.

The LCFS also discusses possible Professional Body referrals with the DoF, HR, ROAG and the Deputy Director of Nursing, where appropriate, with a view to ensuring that such sanctions are also considered and actioned by the Trust where appropriate. In conjunction with the DoF and, only, if necessary, the LCFS can refer individuals to external bodies if the situation supports this action, but ordinarily the Trust should make referrals in line with its own policies.

All instances of potential fraud are discussed with the DoF at regular intervals and upon conclusion and are only closed on CLUE once the DoF is satisfied that all sanctions have been considered and pursued where necessary. For each referral raised on NHSCFA's case management system, the LCFS provides the DoF with a summary of outcome via an email or report, for approval, which details the allegation and the outcome of Trust investigations. Each summary details whether any sanction was administered, either formal or informal and also reports on whether the subject was referred to a Professional Body and the outcome. To that end, the DoF has to be satisfied with the outcome of all referrals and that all sanctions have been considered and pursued where necessary.

In summary, the Trust regularly and robustly evaluates its sanctions arrangements through the mechanisms described above.

8.7 Sanctions Administered 2023/24 – Criminal, Disciplinary and Professional.

Although there were no criminal sanctions applied during 2023/24, as a result of close working between the LCFS, the following disciplinary sanction was achieved during the financial year:

- **Advisory letter issued** for an employee working elsewhere whilst on sickness absence from the Trust.

Following investigations undertaken by the LCFS / Trust, and subsequent referrals to a professional body, the following sanctions were applied:

- **Erasure** of a specialty doctor from the GMC register.
- **Warning Letter** issued to a Staff Nurse by the NMC for working elsewhere whilst on sickness absence from the Trust.

The LCFS had several ongoing investigations at the end of the financial year for which both criminal prosecution and / or disciplinary action is either being progressed or expected to be considered.

8.8 Sanctions – Evaluation of Trust's Financial Recovery.

Component 8 of the NHS Counter Fraud Functional Standard states that the Trust should record all financial recoveries on the approved case management system. Component 1B of the standard also states that the Trust should identify and report on annual outcome-based metrics including the value of fraud recoveries.

The Trust's commitment to the recovery of such monies is contained within the Counter Fraud, Bribery and Corruption Policy and Response Plan. In all potential fraud cases, consideration is given by the LCFS to the recovery of monies defrauded from the organisation or paid in error.

All instances of potential fraud are discussed with the DoF at regular intervals and upon conclusion are only closed on CLUE once the DoF is satisfied that all financial recoveries have been considered and pursued where necessary. Additionally, all matters are duly reported to the Trust's Audit Committee within the LCFS progress reports routinely submitted to each meeting throughout the year, for oversight and scrutiny.

The LCFS continued to work alongside Finance staff during the year to ensure that an effective process is in place to recover any such monies. Should recovery not be required or not possible to implement, the LCFS discusses these at the time. The LCFS also provides an appropriate explanation on the closure report or summary email. Only when the closure report or summary email have been approved by the DoF, is the referral closed on FIRST / CLUE.

In summary, the Trust regularly and robustly evaluates its financial recovery arrangements through the mechanisms described above.

8.9 Sanctions – Successful Financial Recoveries 2023/24.

During 2023/24, as a result of LCFS investigations, the Trust achieved the following recoveries:

- **£1,332.47** resulting from an employee who worked elsewhere whilst on sickness absence from the Trust [INV/22/00076].

The recovered money was returned to the Trust for their intended purpose of providing valuable patient care. There were several other ongoing local cases on 31 March 2024 which also have the potential to make financial recoveries and the LCFS, in conjunction with the DoF, will always seek to recover funds when appropriate to do so.

It is worth amplifying that whilst the sums referred to for 2023/24 are inconsequential in comparison to the Trust's financial stature, there is always a substantial and immeasurable deterrent effect achieved as a result of making any recovery from those committing fraud or attempting to divert monies away from their intended purpose. Consideration must also be given to the immeasurable financial effect achieved as a result of deterring people from

committing fraud against the Trust through the various fraud awareness measures deployed at the Trust since July 2013, including the presence of the LCFS.

As reported in section 7.5 of this report, **£1,094.40** was also recovered from suppliers as a result of the NFI exercise.

8.10 Fraudulent Activity - Payments Prevented.

Two referrals received during 2023/24 related to unsuccessful attempts to fraudulently obtain monies from the Trust by a mandate fraud attempt and a telephone scam.

In total, **£16,748.41** of fraudulent payments were prevented.

8.11 Outcome-Based Metrics.

In order to comply with Component 6 of the NHS Counter Fraud Functional Standard, the LCFS also reports on outcome-based metrics on an ongoing and frequent basis. These metrics must include all reported incidents of fraud, bribery and corruption, the value of identified fraud losses, the value of fraud recoveries, the value of fraud prevented, and both criminal and disciplinary sanctions.

The LCFS, alongside the CFP team, devised a list of outcome-based metrics upon which each of the collaborative Trust's will be measured, therefore allowing for benchmarking where appropriate. Originally, these metrics were presented in a way to accord with the four strategic areas of Strategic Governance, Inform and Involve, Prevent and Deter, and Hold to Account. However, evaluation of these metrics by the CFP team highlighted that this format did not showcase all of the good work being done by the LCFS. As such, the outcome-based metrics were developed to provide a comprehensive overview of all counter fraud activity. The outcome-based metrics for 2023/24 can be found at **Appendix 3** of this report.

8.12 Referral Types.

In addition to other ongoing referrals, the types of fraud allegations received and progressed by the Trust's LCFS during 2023/24 included:

- Payroll frauds - various MOs
- Email interception.
- False ULHT job applications forms – various MOs.
- Patient ID fraud.

9. FURTHER INFORMATION – REPORTING LINES

The Chief Executive is ultimately liable to be called to account for non-compliance with the NHS Standards for Providers (Fraud, Bribery and Corruption). However, the Director of Finance is the Executive Director with responsibility for overseeing and providing strategic management and support for all anti-fraud, bribery and corruption work within the Trust.

In addition to the foregoing, and to fulfil the requirements of the Functional Standard, the LCFS maintains close liaison with the Chair of the Audit Committee and the Counter Fraud Champion, who both strongly and positively supports counter fraud, bribery and corruption work within the Trust.

Contact details for key personalities are as follows:

Chief Executive	**Karen Dunderdale** United Lincolnshire Hospitals NHS Trust Lincoln County Hospital Greetwell Road Lincoln LN2 5QY ✉ karen.dunderdale@ulh.nhs.uk
Director of Finance (Acting)	**Jon Young**

	(Address as above) Tel: 01522 308751 Mobile: 07583 111142 ✉ Jonathan.young@ulh.nhs.uk
Chair of Audit Committee	**Neil Herbert** (Address as above) ✉ neil.herbert@ulh.nhs.uk
Local Counter Fraud Specialist	**Peter Riches** (Address as above) Mobile: 07890 253234 ✉ peter.riches@ulh.nhs.uk
Counter Fraud Champion	**Jayne Warner** (Address as above) Tel: 01522 573988 ✉ jayne.warner@ulh.nhs.uk
Freedom to Speak Up Guardian	**Deborah Elliot** (Address as above) Mobile: 07471 110490 ✉ Deborah.Elliott@ULH.nhs.uk

10. ACKNOWLEDGEMENT

This report summarises the wealth and breadth of counter fraud activity undertaken during 2023/24. The LCFS would like to acknowledge the support and assistance afforded by all those within ULHT in achieving the outcomes outlined in this report.

Pete Riches - Local Counter Fraud Specialist

Appendix 1 - Summary of the ratings for the 2023/24 CFFSR Submission.

Area of Activity	Red/Amber/Green (RAG)
Component 1A – Accountable Individual	Green
Component 1B – Accountable Individual	Green
Component 2 – Counter Fraud, Bribery and Corruption Strategy	Green
Component 3 – Fraud, Bribery and Corruption Risk Assessment	Green
Component 4 – Policy and Response Plan	Green
Component 5 – Annual Action Plan	Green
Component 6 – Outcome-based Metrics	Green
Component 7 – Reporting Routes for Staff, Contractors and Members of the Public	Green
Component 8 – Report Identified Loss	Green
Component 9 – Access to trained Investigators	Green
Component 10 – Undertake Detection Activity	Green
Component 11 – Access to and Completion of Training	Green
Component 12 – Policies and Registers for Gifts, and Hospitality and Conflicts of Interest	Green
Overall Rating indicated by the CFFSR automatic assessment	**Green**

The information in the above table reflects the results of the Functional Standard assessment conducted by the Trust for work conducted during 2023/24.

I declare that the counter fraud, bribery and corruption work carried out during 2023/24 has been self-reviewed against the NHS Counter Fraud Functional Standard, and that the above rating has been achieved.

Organisation	United Lincolnshire Hospitals NHS Trust
Director of Finance	Jonathan Young
Signature	*Signature removed for public meeting.*
Date	31.07.2024

Appendix 2 - Summary of the key data required for compliance with NHS Counter Fraud Requirements as reported on the Trust's 2023/24 CFFSR [1].

Counter Fraud Activity

AREA OF ACTIVITY	DAYS USED
Proactive Work	81
Reactive Work	151
Total Days Used	232

Nominations Overview

Role	Name of Nominated Person	Date of Change
Accountable Board Member	Jonathan Young	October 2023
Audit Committee Chair	Neil Herbert	September 2022
Counter Fraud Champion	Jayne Warner	March 2021
Lead LCFS	Peter Riches	July 2013
Supporting LCFS	Sally Stevenson	July 2013
Supporting LCFS	Nicki Foley	July 2013
Supporting LCFS	Mark Bishop	July 2013
Supporting LCFS	Taelor Straw	January 2021

FIRST Case Information Overview

FIRST INFORMATION	NUMBER
Cases carried over from previous years	6
Cases opened during the period	0
Cases closed during period	3
Cases ongoing	3

CLUE Investigation Information Overview

CLUE INFORMATION	NUMBER
Investigations carried forward from 2022/23	19
Investigations Opened during 2023/24	23
Investigations Closed during 2023/24	25
Investigations Ongoing as at 31/03/2024	17

[1] Figures recorded here relate to activity achieved within the period of 2023/24, as per the requirements of the CFFSR and the NHSCFA Quality Assessment process. Therefore, sanctions achieved outside of the requirements are not included and the figures may not match Trust's metrics data (Appendix 3, above).

Sanctions and Redress Overview

SANCTION IMPOSED	NUMBER
Disciplinary	3
Civil	0
Criminal	0
Fraud Identified	£28,528.60
Fraud Recovered	£1,332.47
Fraud Prevented	£16,748.41

Fraud Risk Assessments Overview

FRAUD RISK ASSESSMENTS	NUMBER
Number of FRAs reviewed in line with the organisations risk management policy	29
Number of new FRAs recorded in line with the organisations risk management policy	0

Local Proactive Exercises Overview

LOCAL PROACTIVE EXERCISES	NUMBER
Number of LPEs conducted during the year	4
Number of LPEs recorded on the NHSCFA Case management system as per Component 8	4
Number of LPEs concluded during the year	3

System Weakness Reports Overview

SYSTEM WEAKNESS REPORTS	NUMBER
Number of SWRs identified during the year	2
Number of SWRs concluded during the year on the NHS CFA Case management system as per Component 8	2
Number of new processes adapted or introduced as a result of SWRs	0

Appendix 3 - ULHT Outcome Based Dashboard 2023/24

#	METRIC	ACTIVITY / OUTCOME	2023/24 Q1	2023/24 Q2	2023/24 Q3	2023/24 Q4	2023/24 TOTAL
	STRATEGIC GOVERNANCE						
1.1	Gov013 Overall Compliance - RAG rated	OUTCOME	GREEN	N/A	N/A	N/A	GREEN
1.2	No. of new Fraud Risks identified	OUTCOME	0	0	0	0	**0**
1.3	No. of Fraud Risks Reducing in risk score	OUTCOME	0	0	0	0	**0**
1.4	No. of Fraud Risks Increasing in risk score	OUTCOME	0	0	0	0	**0**
1.5	Analysis of LCFS Days - Inform and Involve	ACTIVITY	1.66	8.29	3.77	4.67	**18.39**
1.6	Analysis of LCFS Days - Prevent and Deter	ACTIVITY	2.02	2.16	2.99	2.99	**10.16**
1.7	Analysis of LCFS Days - Hold to Account	ACTIVITY	31.93	44.17	35.62	39.50	**151.22**
1.8	Analysis of LCFS Days - Strategic Governance	ACTIVITY	18.43	11.37	7.95	8.22	**45.97**
1.9	Analysis of LCFS Days - Compliance	ACTIVITY	1.63	1.30	2.04	1.60	**6.57**
1.10	Analysis of LCFS Days - Total	ACTIVITY	55.67	67.29	52.37	57.00	**232.33**
#	**METRIC**	**ACTIVITY / OUTCOME**	**2023/24 Q1**	**2023/24 Q2**	**2023/24 Q3**	**2023/24 Q4**	**2023/24 TOTAL**
	INFORM AND INVOLVE						
2.1	No. of awareness/training sessions delivered	ACTIVITY	0	2	0	3	**5**
2.2	Mandatory eLearning requirement	ACTIVITY	Yes	Yes	Yes	Yes	**Yes**
2.3	LCH eLearning compliance rates (%) at ¼ End	OUTCOME	94.36%	95.02%	96.73%	96.37%	**96.37%**
2.4	PHB eLearning compliance rates (%) at ¼ End	OUTCOME	94.93%	95.43%	97.79%	96.73%	**96.73%**
2.5	GDH eLearning compliance rates (%) at ¼ End	OUTCOME	96.84%	97.41%	97.07%	96.45%	**96.45%**
2.6	Trust eLearning compliance rates (%) at ¼ End	OUTCOME	94.79%	95.39%	97.10%	96.49%	**96.49%**
2.7	No. of changes to awareness presentations as a result of audience feedback	OUTCOME	0	0	0	1	**1**
2.8	Twitter Activity - No. of Twitter posts	ACTIVITY	22	20	72	19	**133**
2.9	Twitter Activity - No. of Followers at ¼ End	OUTCOME	852	853	866	873	**873**
2.10	Twitter Activity - Tweet Impressions	OUTCOME	2,864	2,773	4,777	1,510	**11,924**
2.11	No. of Comms awareness items issued	ACTIVITY	2	2	13	2	**19**
2.12	No. of Comms items launching fraud awareness survey	ACTIVITY	N/A	N/A	N/A	N/A	**N/A**
2.13	No. of Respondents to fraud awareness survey	OUTCOME	N/A	N/A	N/A	N/A	**N/A**
2.14	Survey - % Response rate	OUTCOME	N/A	N/A	N/A	N/A	**N/A**
2.15	Survey results - % Trust takes allegations seriously	OUTCOME	N/A	N/A	N/A	N/A	**N/A**
2.16	Survey results - % would report fraud	OUTCOME	N/A	N/A	N/A	N/A	**N/A**
2.17	Survey results - % aware of Fraud, Bribery and Corruption Policy	OUTCOME	N/A	N/A	N/A	N/A	**N/A**
2.18	Survey results - % aware of Standards of Business Conduct Policy	OUTCOME	N/A	N/A	N/A	N/A	**N/A**
2.19	Survey results - % aware of existence of Counter Fraud Champion - new*	OUTCOME	N/A	N/A	N/A	N/A	**N/A**
2.20	No. of Counter Fraud Champion engagements with LCFS	ACTIVITY	1	2	0	2	**5**
2.21	No. of Counter Fraud Champion engagements with wider Trust	ACTIVITY	0	0	0	0	**0**
2.22	No. of Posts on CFP Facebook Page	ACTIVITY	13	15	57	15	**100**
2.23	Number of followers on CFP Facebook page at Quarter End	OUTCOME	63	69	74	82	**82**
2.24	Number of profile visits on CFP Facebook page	OUTCOME	56	156	190	53	**455**
2.25	Page reach for CFP Facebook page	OUTCOME	7,031	7,953	16,097	3,633	**34,714**

#	METRIC	ACTIVITY / OUTCOME	2023/24 Q1	2023/24 Q2	2023/24 Q3	2023/24 Q4	2023/24 TOTAL
	PREVENT AND DETER						
3.1	No. of FPN's received and issued by LCFS	ACTIVITY	0	3	2	1	**6**
3.2	No. of changes to systems / processes as a direct result of an FPN	OUTCOME	0	0	2	0	**2**
3.3	No. of LPE's commenced	ACTIVITY	1	2	1	0	**4**
3.4	No. of CF recommendations made	ACTIVITY	2	0	0	0	**2**
3.5	No. of CF recommendations accepted	OUTCOME	0	0	0	0	**0**
3.6	No. of Trust policies reviewed by LCFS	ACTIVITY	0	2	0	0	**2**
3.7	No. of recommended changes to Trust policies	ACTIVITY	0	3	0	0	**3**
3.8	No. of recommended changes accepted	OUTCOME	0	2	0	0	**2**
3.9	No. of system weaknesses reported on CLUE	ACTIVITY	2	0	0	0	**2**
3.10	No. of Intelligence Bulletins (IBURNS) Received and Actioned	ACTIVITY	2	1	0	1	**5**
3.11	Intelligence reports submitted to the NHSCFA	ACTIVITY	0	0	1	1	**2**
3.12	No. of Intelligence Reports Received from NHSCFA and Actioned	ACTIVITY	2	3	7	2	**14**
3.13	No. of LCFS Alerts / Warnings issued	ACTIVITY	5	5	9	15	**34**
#	**METRIC**	**ACTIVITY / OUTCOME**	**2023/24 Q1**	**2023/24 Q2**	**2023/24 Q3**	**2023/24 Q4**	**2023/24 TOTAL**
	HOLD TO ACCOUNT						
4.1	No. of Referrals Received	OUTCOME	4	4	10	5	**23**
4.2	No. of Anonymous Referrals included above	OUTCOME	1	0	6	3	**10**
4.3	No. of Referrals closed on FIRST / CLUE	ACTIVITY	1	5	19	3	**28**
4.4	No. of Disciplinary Sanctions Applied	OUTCOME	1	0	0	0	**1**
4.5	No. of Resignations associated with Investigation	OUTCOME	0	0	0	0	**0**
4.6	No. of Criminal Sanctions Secured	OUTCOME	0	0	0	0	**0**
4.7	No. of Professional Body Sanctions Applied	OUTCOME	0	1	1	0	**2**
4.8	Value of Financial Recoveries (Fraud & Non-Fraud)	OUTCOME	£0.00	£0.00	£3,203.34	£1,332.47	**£4,535.81**
4.9	Number of Financial Recoveries (Fraud & Non-Fraud)	OUTCOME	0	0	1	1	**2**
4.10	Value of Prevented Financial Losses	OUTCOME	£123.33	£0.00	£16,625.08	£0.00	**£16,748.41**
4.11	Number of Prevented Financial Losses	OUTCOME	1	1	1	0	**3**
4.12	Advice / Referrals Not Progressed	OUTCOME	2	10	7	9	**28**
4.13	Cases formally referred by the LCFS / Trust to a Professional Body	OUTCOME	0	1	0	0	**1**
#	**METRIC**	**ACTIVITY / OUTCOME**	**2023/24 Q1**	**2023/24 Q2**	**2023/24 Q3**	**2023/24 Q4**	**2023/24 TOTAL**
	NATIONAL FRAUD INITIATIVE (NFI)						
5.1	No. of Creditor Payments matches received (c/f from 2022/23)	ACTIVITY	516	0	0	0	**516**
5.2	No. of Creditor Payments matches checked	ACTIVITY	503	13	0	0	**516**
5.3	No. of Creditor Payment financial recoveries	OUTCOME	0	2	0	0	**2**
5.4	Value of Creditor Payment financial recoveries	OUTCOME	£0.00	£1094.90	£0.00	£0.00	**£1,094.90**
5.5	No. of Payroll matches received (inc. Procurement to Payroll) (c/f from 2022/23)	ACTIVITY	315	0	0	315	**315**
5.6	No. of Payroll matches checked	ACTIVITY	229	23	13	47	**312**
5.7	No. of Payroll matches financial recoveries	OUTCOME	0	0	0	0	**0**
5.8	Value of Payroll matches financial recoveries	OUTCOME	£0.00	£0.00	£0.00	£0.00	**£0.00**