Bundle LCHG Board Meeting in Public Session 7 January 2025

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

1 Introduction, Welcome and Chair's Opening Remarks
Group Chair

2 Public Questions

2.1 Ward Accreditation
Greetwell Ward - Bronze Accreditation
Harrowby Ward - Bronze Accreditation

3 Apologies for Absence
Group Chair

4 Declarations of Interest
Group Chair

5 Minutes of the meeting held on 5th November 2024
Group Chair
Item 5.1 Public Board Minutes November 2024

5.1 Matters arising from the previous meeting/action log
Chair
Item 5.2 Public Board Action log Nov 2024

6 Group Chief Executive Horizon Scan
Group Chief Executive
Item 6 Group CEO update public board January 2025 Final

6.1 CQC Unannounced Inspection - Pilgrim Hospital Boston
Group Chief Clinical Governance Officer
Item 6.1 Group Board (Public) - CQC Unannounced Inspection December 2024

6.2 Group Development Next Phase
Group Chief Executive
Item 6.2 Group Development Next Phase December 2024 v1
Item 6.2 Lincolnshire Group Overview Report for Group CEO Draft V8 December 2024

7 Patient/Staff Story

7.1 National Cardiac Audit Programmes National Heart Failure Audit 2023-24 Award
Group Chief Medical Officer
Item 7.1 Group Public Board Heart Failure v1.1 Roebuck

7.2 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 Upward Report November 2024
Item 8.1 Quality Committee Upward Report December 2024
Item 8.1 Appendix 1 - CNST Action update November 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 Committee
Chair, People Committee
Item 9.1 People Committee Upward Report November 2024 v1
Item 9.1 People Committee Upward Report Dec 2024

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

10.1 Assurance and Risk Report from the Finance Committee
Chair, Finance Committee
- Item 10.1 Finance Committee Upward Report November 2024
- Item 10.1 Finance Committee Upward Report December 2024

10.2 Revised Terms of Reference and Workplan for Finance Committee
Group Director of Corporate Affairs
- Item 10.2 Finance Committee ToR Front Sheet
- Item 10.2 Finance Committee Terms of Reference Dec 24
- Item 10.2 Finance Committee Work Plan v15.12

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

11.1 Assurance and Risk Report from the Integration Committee
Chair, Integration Committee
- Item 11.1 Integration Committee Upward Report December 2024
- Item 11.1 Appendix 2 IC Workshop Feedback report Dec 24

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
See Report at item 11.1

13 Integrated Performance Reports - ULTH/LCHS
Group Chief Integration Officer
To include an update on Operational performance over the seasonal period
- Item 13 Front Sheet Trust Board - IPR
- Item 13 IPR Trust Board December 2024
- Item 13.1 LCHS IPR Front Sheet
- Item 13.1 App 1 LCHS Integrated Performance Report - December- November 2024 Data - (1)

14 Risk and Assurance

14.1 Group Risk Management Report
Group, Chief Clinical Governance Officer
- item 14.1 LCHG Group Board Risk Report January 2025 v1
- Item 14.1 Appendix A LCHS Risk Report
- Item 14.1 Appendix B ULTH Risk Report Group Board January 2025

14.2 Board Assurance Framework
Group Director of Corporate Affairs
- Item 14.2 LCHG BAF 2024-25 Front Cover December 2024
- Item 14.2 LCHG BAF 2024-25 31.12.24

14.3 Board Committee Membership
Group Chair
- Item 14.3 Group Board Committee Membership

15 Any Other Notified Items of Urgent Business

16 The next meeting will be held on Tuesday 4th March 2025
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 Teaching Hospitals NHS Trust

Minutes of the Public Board in Common Board Meeting

Held on 5 November 2024

Via MS Teams Live Stream

Present

LCHS
Voting Members:
Mrs Elaine Baylis, Group Chair
Mr Jim Connolly, Non-Executive Director Miss Gail Shadlock, Non-Executive Director, LCHS
Mr Neil Herbert, Non-Executive Director
Mrs Rebecca Brown, Non-Executive Director
Ms Dani Cecchini, Non-Executive Director
Professor Karen Dunderdale, Group Chief Executive
Mr Daren Fradgley, Group Chief Integration Officer
Dr Colin Farquharson, Group Chief Medical Officer
Mrs Nerea Odongo, Group Chief Nurse
Ms Caroline Landon, Group Chief Operating Officer
Mr Paul Antunes Goncalves, Group Chief Finance Officer

LCHS
Non-Voting Members:
Miss Claire Low, Group Chief People Officer
Mr Ian Orrell, Non-Executive Director, LCHS
Miss Claire Low, Group Chief People Officer
Mrs Sarah Buik, Associate Non-Executive Director
Mrs Vicki Wells, Associate Non-Executive Director
Mr Mike Parkhill, Group Estates and Facilities Officer
Mrs Kathryn Helley, Group Chief Clinical Governance Officer

ULHT
Voting Members:
Mrs Elaine Baylis, Group Chair
Mrs Rebecca Brown, Non-Executive Director
Mr Jim Connolly, Non-Executive Director
Mr Neil Herbert, Non-Executive Director
Ms Dani Cecchini, Non-Executive Director
Professor Philip Baker, Non-executive Director ULTH
Professor Karen Dunderdale, Group Chief Executive
Mr Daren Fradgley, Group Chief Integration Officer
Mrs Nerea Odongo, Group Chief Nurse
Ms Caroline Landon, Group Chief Operating Officer

ULHT
Non-Voting Members:
Miss Claire Low, Group Chief People Officer
Mrs Sarah Buik, Associate Non-Executive Director
Mrs Vicki Wells, Associate Non-Executive Director
Mr Ian Orrell, Associate Non-Executive Director
Mr Mike Parkhill, Group Estates and Facilities Officer
Mrs Kathryn Helley, Group Chief Clinical Governance Officer

Mr Paul Antunes Goncalves, Group Chief Finance Officer
Dr Colin Farquharson, Group Chief Medical Officer

In attendance:
Mrs Jayne Warner, Group Director of Corporate Affairs
Mrs Karen Willey, Deputy Trust Board Secretary, ULTH
Mrs Rachel Lane, Corporate Administration Manager, LCHS (minutes)
Sister Bunmi Ogunyemi, Ward Manager, ULTH (item 2.1)
Jacob Axtell, Community Team Lead, LCHS (item 7)
Lynsey Russell-Daubney Specialist Physiotherapist, LCHS (item 7)

337/24	**Item 1 Introduction** The Chair welcomed Board members and members of the public, staff or interested parties who had joined the live stream.
338/24	The Chair took the opportunity to formally welcome the new Group Chief Finance Officer, Mr Paul Antunes Goncalves to the Board.
339/24	**Item 2 Public Questions** **Q1 Received from Vi King** Please can I ask if it is central booking that sends out the letters to patients regarding appointments. If so, please can I ask why people are getting letters after the appointment date or getting sent to hospitals that are a long distance from their home address. Is there not a way on the system that could identify if their appointment could be done at a hospital nearer to where they live.
340/24	The Chief Operating Officer responded that bookings were undertaken both by the central team and other teams across the organisation, however expressed a view that patients should not be receiving letters after their appointment date. The Chief Operating Officer had spoken to the administration manager to investigate the reasons for this happening.
341/24	The Chief Operating Officer also explained the patients could sometimes be offered appointments at Hospitals which were not necessarily close to their homes depending on the service they were waiting for as the organisation offered site

	specific services. It was recognised that the organisation did need to be more agile in respect of bookings and there was potential for appointments to take place closer to home. Work would be undertaken on a more standardised approach to bookings to provide a common service to all patients.
342/24	The Group Chair thanked the Chief Operating Officer for the response.
343/24	**Item 2.1 Ward Accreditation** The Group Chair was pleased to be able to commence the Board meeting with the celebration of achievement of the provision of high quality, safe care through the awarding of ward accreditation.
343/24	Sister Bunmi Ogunyemi from Ashby Ward was welcomed to the meeting to celebrate their achievements.
344/24	The Group Chief Nurse introduced the team who had successfully achieved the Bronze award as part of the quality accreditation programme. Board members were reminded of the core requirements the departments were required to achieve against a range of quality indicators, in addition to presenting a portfolio of evidence to the Quality Accreditation Panel.
345/24	Sister Ogunyemi informed those present that Ashby Ward was a neuro-rehabilitation Ward which treated patients with complex needs. Sister Ogunyemi took the opportunity to thank the organisation for introducing students on to the Ward who had been accepted within the team and had integrated well. The organisational Shared Decision-Making Council had also worked within the ward and had promoted good staff working. Sister Ogunyemi was pleased that the Ward was doing so well and was proud to be the Ward Sister as well as being proud of the achievements of the staff.
346/24	The Group Chair thanked Sister Ogunyemi for attending the meeting and asked that the thanks of the Board were extended to the ward staff. It was recognised that Ashby Ward had the challenges of a patient cohort that stayed for extended periods of time, and it was good to see that standards of care were being maintained whilst patients were being prepared to move forward.
347/24	The Group Chief Executive thanked Sister Ogunyemi for all the hard work the staff were undertaking on the ward, and looked forward to meeting the team when the formal presentation of an achievement certificate took place. The Group Chief Executive had been impressed with the way Sister Ogunyemi had presented the story adding that it was clear that Sister Ogunyemi was proud of the achievement of the team.
348/24	The Group Chair commented that it was good to hear a mention of the Shared Decision-Making Council and that this was being utilised and welcomed by staff in ensuring correct decisions were being made on behalf of patients.
349/24	The Group Chair explained that these awards were an important way of the Board gaining assurance on the safety and quality of care being provided for patients and

350/24	added that this was also an important way of being able to reflect upon and acknowledge the leadership within the organisation. The Group Chair endorsed comments received on behalf of the whole Board and added that the team should be proud of their achievements, and again thanked Sister Ogunyemi for attending the meeting.
351/24	**Item 3 Apologies for Absence** There were no apologies for absence.
352/24	**Item 4 Declarations of Interest** Ms Cecchini declared a recent appointment as a Trustee Director of the Carers First Charity.
353/24	**Item 5 Minutes of the meetings held on 3rd September 2024** The minutes of the meeting held on Tuesday 3rd September 2024 were approved as an accurate record.
354/24	**Item 5.1 Matters Arising from the previous meeting/log** There were no outstanding actions.
355/24	**Item 6 Chief Executive Horizon Scan** The Group Chief Executive presented the report to the Board, noting that significant operational pressures were being experienced entering the autumn and winter period, however services across the Group continued to cope with operational pressures and staff were ensuring that patients were receiving the best care that could be offered.
356/24	There had been a heavy focus on the 2024/25 system Operational Plan in recent weeks and work would continue with partners in respect of delivery. The Group Chief Executive outlined that there would be challenging times ahead during the remainder of the year and into early 2025/26.
357/24	The Lincolnshire system had undertaken the quarterly system review meeting with the NHS England regional team during October, which had been a very supportive meeting and positive feedback had been received on continued improvements in the County and across the Group.
358/24	The system received the Winter planning and H2 priorities letter in September which set out year two of the Urgent and Emergency Care recovery plan. This had been followed by the NHS IMPACT Clinical and Operational Excellence Programme, which set out a series of improvement guides and supporting infrastructure.

359/24	The previous week the Group received the annual winter visit from NHS England and Integrated Care Board (ICB) colleagues which had been positive with colleagues being impressed with the progress being made.
360/24	The Group Chief Executive informed those present that Professor Lord Darzi had now published his review into the state of NHS. The review set the tone for the development of the ten-year Health plan which would be overseen by the King's Fund former Director of Policy, Sally Warren. The publication was noted as hard hitting however a fair reflection of what was being seen. The Group Chief Executive had been pleased to see that the report also reflected the hard work of teams and colleagues across the NHS.
361/24	In respect of the Group, the Group Chief Executive advised that all Board Executive roles had been appointed to, following the final appointment of the Group Chief Finance Officer, who had joined the Group on a twelve month secondment from Nottingham University Hospital.
362/24	From a financial perspective, work was underway across the Group to review the year end forecast alongside potential mitigations for both this year and 2025/26.
363/24	United Lincolnshire Hospitals NHS Trust (ULHT) had now received final confirmation from the Department of Health & Social Care of the official recognition and Establishment Order change to reflect Teaching hospital status and from 16 September 2024 ULHT became United Lincolnshire Teaching Hospitals NHS Trust (ULTH).
364/24	The Group Chief Executive offered congratulations to the ULTH Armed Forces staff network for winning two awards at a recent event in the House of Lords for the work undertaken as part of the Step into Health programme, which reinforced the commitment to the Armed Forces community that the organisation was fully supportive in their journey towards a career in the NHS.
365/24	LCHS had also been recognised with a Defence Employer Recognition Scheme Gold Award in September. This recognised the support offered to Reservists, Service leavers, Cadet Force Adult Volunteers, veterans and the spouses and partners of serving personnel, and followed ULTH in gaining the same award the previous year.
366/24	The Group Chief Executive had attended a meeting with the Secretary of State for Health who had visited the Midlands region on 20th September 2024, where the priorities for the NHS had been set out.
367/24	October had seen Black History Month and the REACH and CODE staff networks had arranged an all-day event on "Reclaiming the Narrative" which had been well attended by excellent external speakers and colleagues from the global minority workforce across Lincolnshire and allies.
368/24	The Care Quality Commission (CQC) had also undertaken an unannounced visit to the Lincoln Accident and Emergency Department during October. No areas of concern had been raised and there had been a focus on areas of good practice.

369/24	The Group Chief Executive also took the opportunity to thank Sam Wilde, Director of Finance and Business Intelligence for his dedication and commitment to LCHS over the last six years and more recently across the Group as the Director of Finance and wished him well in his new role, which he would be taking up in the next week.
370/24	The Group Chair also took the opportunity to thank Mr Wilde for his contributions to LCHS, whom she had worked on the Board with for many years. Mr Wilde had been a great anchor for LCHS and as the Group had developed and joined the rest of the Board in thanking him and offering good wishes for the new role. The Board: • **Received the report and noted the significant assurance provided**
371/24	**Item 6.1 CQC Unannounced Assessment Letter** The Group Chief Clinical Governance Officer informed Board members that an unannounced Care Quality Commission (CQC) visit had taken place on 16th October 2024 to review Urgent and Emergency Care Services at Lincoln County Hospital. No immediate patient safety concerns were reported back to the Trust following the visit.
372/24	The Group Chief Clinical Governance Officer explained that some initial actions had been identified. Next steps were to conclude the assessment process and several focus groups and interviews would take place. A request for evidence had been received and was submitted on 31st October 2024. Following this, the Trust would receive a report outlining the findings of the assessment and any actions identified.
373/24	Mrs Brown commented that the Quality Committee had received an early draft of the letter and received assurances from the Executive team. The Committee had been pleased to see the openness and to hear that several actions had already been taken.
374/24	Mrs Brown asked how partners would be supported and encouraged to have a say if there were issues and how these were being raised internally to support partners.
375/24	The Group Chief Nurse responded that following the CQC letter, weekly relationship meetings with East Midlands Ambulance Service NHS Trust (EMAS) had been established to build closer working relationships so that concerns could be raised and addressed. In respect of the minimum care standards, ambulance and patient partners were being worked with on the comfort and care standard which was being introduced in collaboration with patients. The Board: • **Received the report**
376/24	**Item 6.2 Group Development – Next Phase** The Group Chief Executive presented the report to Board members explaining that following the appointment of the Group Executive Leadership Team and the appointment of Group Non-Executive Directors, there was now a requirement to review the programme of work supporting the next phase of the Group development.

377/24	The Group Chief Executive informed those present that ten workstreams had been established and were being owned by each Board Director and work was underway with a Governance expert who was offering support to each Senior Responsible Officer (SRO) to identify actions and milestones for the workstreams. The final plan would be shared with Board members once this had been fully populated and progress would be reported via the Chief Executive's Horizon Scan reports. Overtime, this could include benefits realisation on the move to a Group and specific aspects of the programme would be reviewed via the relevant Board Assurance Committee or Board Development Sessions.
378/24	The Group Chief Executive commented that the Board had recently agreed to move from five to three strategic aims for 2025/26 and strategic objectives were being developed. A Board workshop would also take place early in the new year to agree the risk appetite and any amendments to the Board Assurance Framework for 2025/26. The Group Chief Executive explained that there would be opportunities to involve Board members in the engagement and development of the Group and advised that briefings would be offered at each Public Board meeting for an understanding of the position of the refresh of the programme, timelines, governance and oversight arrangements.
379/24	Mr Herbert reflected that one of the biggest challenges would be in respect of culture and asked about joint working to ensure an overall consistent culture. The Group Chief Executive agreed that if the culture element was not right with the relevant organisational development support this would not work. It was explained that during September a "Better Together" event had been held bringing leaders together from across the Group, where the culture programme had been discussed. The Group Chief Executive commented that this had been a positive session and a workplan was in the process of being developed.
380/24	The Group Chief Clinical Governance Officer informed those present that work was also taking place between departments to bring pieces of work together and advised that it was important to recognise the good work that was being undertaken.
381/24	The Group Chief People Officer explained that work was taking place collectively through staff engagement to develop a set of joined up values where it would be important to capture cultural issues.
381/24	The Group Chair explained that the Board would be undertaking a Board Development Programme with NHS Providers and facilitated sessions would be held in the coming months where leadership styles and the requirements for a high performing Board would be discussed. The Board: • **Received the report**
382/24	**Item 7 Patient/Staff Story**

383/24	The Group Chief Nurse introduced the item and explained that the story was from the Discharge to Access team with the Community Team Leader and Specialist Physiotherapist welcomed to the meeting.
384/24	The Board were presented with a video sharing Diane's story, who had unfortunately been involved in a road traffic collision in January 2024, resulting in many broken bones, and had been transferred to Hull Royal Infirmary where she had various surgeries. Diane had spent two weeks at Hull prior to being transferred to Boston Hospital where she spent a further ten weeks. At this point Diane was non-weight bearing and was introduced to the Discharge to Assess team which provided rehabilitation support for patients leaving hospital to help them get back to a baseline level of function and to achieve their therapy goals.
385/24	Diane explained that the team never made her to feel that their visits were time limited and at times had also provided mental health support and well as physical support. The team members had listened and been a large part of the recovery process. Diane had been through a life changing process and to have people coming to her home to support her in a positive way had been important. Diane explained that without the support of the team, her husband would have had to stop working whilst she recovered, and she added that the support of the team had made a huge difference to her family.
386/24	The Group Chair thanked Diane adding that Diane's recovery had clearly been a long process that required a range of physical and mental health and wellbeing as part of the recovery programme and thanked the Community Team Leader and Specialist Physiotherapist for their support to Diane.
387/24	The Group Chief Integration Officer thanked the Community Team Leader and Specialist Physiotherapist for the work they were undertaking across the Discharge to Assess service and commented that this service would enable the Group to undertake the left shift care into the community. The Group Chief Integration Officer was proud that the service was able to be offered to Lincolnshire patients and looked forward to seeing how the service could grow and develop in the coming months.
388/24	Mrs Wells thanked colleagues for the story and commented on the statement regarding never feeling rushed and being cared for in a dignified way and thanked the team for that. Mrs Wells added that it was good to see there was an overall holistic approach to care for those patients who were being discharged home.
389/24	The Group Chief Executive also offered thanks for the story and noted time previously spent with the team, where it had been possible to observe a very different patient story. The breadth and depth that the service could offer was observed both through the story presented to the Board and the experience of the visit to the team.
390/24	The Specialist Physiotherapist took the opportunity to thank Diane for sharing her story and offered thanks to the Board for the feedback which helped to realise the impact the team had on patients. It was also recognised that one patient story could be completely different to another, and the service offered support to all patients in a very holistic way to help them achieve their recovery goals.

391/24	The Community Team Leader also took the opportunity to express pride in all members of the team who were passionate about supporting people in the community. The Group Chair responded that both the Community Team Leader and Specialist Physiotherapist were right to be proud of what was being achieved and the direction of travel for patients and noted that it had been a pleasure to hear the patient story. The Board: • **Received the Patient/Staff Story**
	Item 8 Strategic Aim 1 To Deliver high quality, safe and responsive patient services
392/24	**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 meeting held on 17th September 2024 and 22nd October 2024.
393/24	The Infection, Prevent and Control Board Assurance Framework had been received which contained several red rated areas relating to the community elements of the Group, however the Mr Connolly assured the Board these issues had now been resolved.
394/24	Funding for the Children in Care Service had been secured until March 2025 which would improve waiting times, an issue which had previously been referred to the Board. However the Board were made aware that as the service was only secured until March, fragility remained despite some small improvements being made. It remained to be seen if this could be sustainable and further updates would be provided.
395/24	There had been positive feedback for acute colleagues regarding work to implement the patient safety strategy from the Healthcare Safety Investigation Branch (HSIB).
396/24	Mr Connolly drew attention to several appendices within the iBabs Reading Room relating to maternity and informed those present that there had been continued improvements on the regional heatmap which was being sustained which would see the organisation maintaining a positive position. ULTH was now a recognised maternity unit in respect of an audit undertaken by the Twins Trust which demonstrated continuing improvement. There had been an increase in the number of safeguarding complex cases within the maternity service and work was ongoing to support the safeguarding midwives to understand capacity issues and what may be required moving forward.
397/24	In respect to the Clinical Negligence Scheme for Trusts (CNST) for the organisation, Mr Connolly drew attention to four non-compliance areas against the standards with a request to review evidence which could be found within appendix 9.1 in the Reading Room. Progress was noted in respect of neonatal staffing requirements in respect of standard four, with the appendix available in the Reading Room and progress was also being made on standard six, saving babies lives, where discussion

	with the ICB concluded that the standard was being met and again was available within the Reading Room. Standard ten relating to maternity neonatal safety incidents showed no new incidents maintaining the current cumulative position at three cases being investigated as per process.
398/24	Mr Connolly advised those present that discussion regarding pressure ulcers across the Group demonstrated that a significant amount of work had been completed since the original deep dive in June 2024 and a Group wide action plan had been developed and was being implemented, however there remained high risks within the community. A further update had been requested in six months to allow learning and work programmes to embed across the Group.
399/24	A focussed discussion had been held on the pharmacy service at ULTH which recognised significant work undertaken as a result of historic concerns and examples of excellent work and improvements made had been provided.
400/24	The Committee had also noted the positive position on overdue policies and an improvement trajectory had been requested via monthly reporting.
401/24	A six month review of the Quality Committee in Common had taken place in October, and work was underway to review recommendations and actions, some of which had been referenced within the Group development paper and would be reported to the Board in due course.
402/24	The Group Chair thanked Mr Connolly for the comprehensive report which provided good scope and scale of the work through the Committee and the six-month report had demonstrated effectiveness during a period of transition. The Group Chair would welcome sight of further detail as the recommendations were worked through.
403/24	Mrs Brown, as the Maternity and Neonatal Safety Champion, also informed the Board that a Maternity Insight Visit had recently been undertaken where good feedback had been received demonstrating a favourable position for the maternity teams. One area for improvement had been identified in respect of the Local Maternity and Neonatal System (LMNS) and work was underway with ICB colleagues on this. The Board: • **Received the assurance reports** • **Received CNST Standards 4, 6 and 10** • **Noted the escalation in respect of the Children in Care service**
404/24	**Item 8.2 NHSE Listening to Women and Families – APPG Birth Trauma Report** The Group Chief Nurse presented the APPG Birth Trauma Report noting that this contained several recommendations many of which were already included within the three-year Delivery Plan. The initial benchmarking demonstrated a positive position for ULTH. The only red action was the delayed support for the use of System Development Funding (SDF) to develop a perinatal pelvic health service across Lincolnshire as per the three-year Delivery Plan. Funding had now been approved and the process of implementing a service for the women of Lincolnshire had commenced.

405/24	Mrs Brown commented that the Maternity and Neonatal Voices Partnership had also worked hard to support and triangulate information to ensure the correct support was in place for when things went wrong and also undertook learning to ensure that families received the correct support. Mrs Brown also provided reassurance that at the Maternity and Neonatal Oversight Group (MNOG) all high risk cases were discussed where there was evidence of reflection and learning from cases. The Board: • **Received the report** • **Remitted this item to the Quality Committee to monitor progress for maternity and neonatal issues**
	Item 9 Strategic Aim 2 To enable our people to lead, work differently, be inclusive, motivated and proud to work within LCHG
406/24	**Item 9.1 Assurance and Risk Report People Committee** Professor Baker provided the assurances received by the People Committee, at the meetings held during September and October 2024, where the October meeting had been the first Group Committee meeting.
407/24	Professor Baked highlighted that at the September meeting a deep dive had been received into pharmacy and assurance ratings for objectives had been reviewed with a recommendation to move objective 2b from a green to amber rating. Professor Baker commented that it was important to remain vigilant and constantly seek assurance around the objectives and the change in rating related particularly to cultural issues and concerns relating to undergraduate education provision.
408/24	At the October meeting, the Workforce Group presented a joint dashboard mirroring metrics across both organisations which was broadly moving in the right direction and the positive position in respect of the nursing establishment was noted.
409/24	A safer staffing report had been received for nursing and Allied Health Professionals (AHPs), and the Committee were looking forward to receiving a similar report for medical staffing. The reduction in agency spend had been noted by the Committee which included the challenges on AHP staffing, exacerbated by recruitment for the Community Diagnostic Centres (CDCs).
410/24	The quarterly report from the Freedom to Speak up Guardian (FTSUG) had been received and the high workload of the Guardian was noted. It had been encouraging from a cultural perspective to hear that colleagues felt they were able to raise concerns.
411/24	A verbal report regarding the General Medical Council (GMC) Junior Doctors Survey had been received and the formal report would be received at the November Committee meeting.
412/24	The Committee had received an update on the funding of clinical academic posts and cultural concerns relating to senior medical staffing in respect of a reluctance to engage in undergraduate education, this had also been flagged as critical within the

	GMC report. Professor Baker expressed a view that there appeared to be a heavy reliance on junior staff and teaching fellows to provide education. It was understood that this was a difficult issue to resolve however it had been encouraging to hear that steps were being taken to address this in the form of the identification of teaching leads for each division, and encouragement for consultants to identify time within clinics for teaching. A deep dive had been requested into Service Increment for Teaching (SIFT) educational monies to ensure this was progressing as it should.
413/24	Professor Baker explained that an update on outstanding policies and procedures had been received, 31 of 46 People policies were currently out of date and colleagues would be working hard to resolve this position and updates would be provided at each Committee meeting moving forward.
414/24	The Group Chief People Officer explained that work was underway to recruit and attract individuals to medical vacancies and a focused recruitment plan was now in place. There had been some good success in recent months and the recruitment team would continue to provide dedicated focus on recruiting to critical medical roles which would shore up the availability to offer teaching to undergraduate staff.
415/24	The Group Chief Medical Officer offered that the membership for the Education Oversight Group was being reviewed to include post-graduate and medical education. A further area being reviewed was the Clinical Academic Oversight Group between the Group and the University of Lincoln where a key area for discussion would be the funding for clinical academic roles, however this group was still in its transition phase.
416/24	The Group Chair thanked Professor Baker for the report and colleagues for their comments.
417/24	From a policies and procedures perspective, the Group Chief People Officer offered that a decision had been made to harmonise policies across the Group with Staffside colleagues and the priority policies were being reviewed first.
418/24	The Group Chair commented that it was good to hear of the triangulation across Committees in respect of pharmacy services and commented that it would be helpful within both the reports and minutes going forward to be clear on the reasons for proposing changes to the Board Assurance Framework ratings to understand the rationale for this. The Board: • **Received the assurance reports and noted the escalations**
	Item 10 Strategic Aim 3 To ensure services are sustainable, supported by technology and delivered from an improved estate
419/24	**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 meeting held in October 2024.

420/24	In respect of the Electronic Patient Record (EPR) Miss Shadlock reported that confirmation of the funding had now been received with the approval of the Full Business Case, amounting to £2.5m capital and £263k revenue.
421/24	A review of District Nurse establishments had been received and several options had been presented in respect of the banding of District Nursing staff and qualifications linked to that. The Committee had been supportive however noted further work was required of delivering the plan and further assurance of funding and the impact on health outcomes for patients had been requested.
422/24	The month six financial position reported a £1m deficit year to date, £178k favourable to plan with Cost Improvement Programmes (CIP) reports as on track and capital performance remained strong. The cash position was improving, however remained below plan. Agency was also below plan.
423/24	The stability of the Finance team had been discussed by the Committee with assurance sought from the Group Chief Finance Officer that this was being resolved.
424/24	Miss Shadlock explained that the Integrated Performance report (IPR) had been discussed and there were two statistics not capable of achieving target and work continued in both areas to resolve the position.
425/24	The Q2 2024/25 Operational Plan had been received which demonstrated that two projects had moved from green to red ratings. One relating to the Archer Assessment Unit (AAU). The Committee heard that the first AAU project linked to the Frailty Service and the Grantham Hub and Ward. It was noted that LCHS had considered use of the AAU at Louth however work was paused when the beds were used to take patients from Skegness. Consideration was being given, within available resource, for the development of a frailty hub at Louth and at Skegness.
426/24	An Estates Report had been received which had led to several risks being identified with the Committee noting limited assurance leading to a red assurance rating. Miss Shadlock escalated to the Board the risks and potential solutions over the coming months, and noted confidence that the Group estates team had the knowledge and skills to undertake the tasks required and expected this would move forward positively.
427/24	The Group Chair thanked Miss Shadlock for the report and comments in relation to estates and facilities were noted. It was recognised that with personnel changes it was possible that a range of issues would be identified which needed to be addressed and the Group Chair acknowledged that the Committee had oversight of this, and members of the Board would start to work through this.
428/24	The Group Chair noted the escalation from the Committee relating to the AAU and looked forward to receiving an update on this. The Board: • **Received the assurance report**

429/24	**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 September 2024 and October 2024 meetings.
430/24	In relation to finances, Ms Cecchini informed the Board that as at month six there was a £18.1 deficit position, against a plan position of £10.6m which was a significant overspend position. Concern was noted that the plan had demonstrated delivery of a surplus position of £300k, which in month had delivered a £2.2m deficit. The position had been discussed in detail at the October Committee meeting around the risk moving forward and, despite strong delivery in respect of CIP, the Committee reminded itself of the earlier profiling undertaken, which had been to deliver increased target levels during the latter half of the year.
431/24	The CIP report had identified significant risks in some schemes, specifically in relation to the medical agency cost reduction scheme which had fallen significantly behind plan. There were also significant overspends relating to pay and a thorough review of the position was being undertaken by the Group Chief Finance Officer.
432/24	The £16m investment gap across the system was also noted with circa £5m - £6m currently being resolved.
433/24	Delivery was progressing well in respect of the capital programme with £28m of the circa £78m funding being spent thus far. Cost pressures had however been identified relating to the Pilgrim ED and Endoscopy capital projects and the team were reviewing both schemes to undertaken potential cost increases and mitigations.
434/24	In respect of estates there were improved levels of assurance from the team in respect of the gaps and issues following strong system reviews of Authorised Engineers reports. Patient-Led Assessments of the Care Environment (PLACE) reports for Louth had also been received and some issues had been identified relating to disability and dementia facilities and ways in which to support environmental improvements were being addressed.
435/24	There had been some improvement in water safety however concerns remained and the Authorised Engineers report on ventilation demonstrated some improvement. The Committee also received the Premises Assurance Model which demonstrated improvement on the previous year which now required Board approval.
436/24	The Patient Level Information and Costing System (PLICS) report had been received and showed signs of improvement and further progress was anticipated in terms of the productivity strategy for the organisation.
437/24	An update was also received from the Procurement team and the Committee heard of strong delivery of £4.5m CIP from the team relating to some procurement activities

	and strong support of training regarding understanding the impact of the new Procurement Act.
438/24	The Annual Planning timeline for 2025/26 had alerted the Committee to some short turnaround investment case timelines and discussions were taking place with the ICB regarding this.
439/24	A deep dive had been received into discharge for urgent and emergency care and the Committee noted the focus on sprint initiatives and intensive support from NHS England. The metrics reflected a challenging position; 73% delivery on A&E performance and the 12% - 18% 12 hour ambulance handovers. The position regarding 65 and 78 week waits remained challenging. Good progress was however being made in relation to cancer delivery against the faster diagnostic standards.
440/24	A report had been received from the Transformation Steering Group which had been positive, however there was concern relating to medical agency performance which was lacking progress.
441/24	The Committee also received a report on outstanding policies and Ms Cecchini offered the Audit Committee Chair some assurance that the Committee would now be overseeing the update to policies relating to the Committee.
442/24	Ms Cecchini also reported that the Committee had received a report on Emergency Preparedness and the Trust was compliant in respect of 58 of 62 standards and partially compliant with four.
443/24	The Group Chief Integration Officer commented that there needed to be a more focused position into productivity to see enablers in terms of cost improvement and to move patients on waiting lists quicker. It was recognised that there was capacity within most services however processes were preventing utilisation to the full extent. Linked to that was the Project Management Office (PMO) for improvement and there was intelligence that the team had good focus on this, however, were not achieving operational changes to see improvements in productivity. The Board: • **Received the assurance report** • **Noted the concerns as outlined in respect of the financial position** • **Received and approved the Premises Assurance Model for publication**
444/24	**Item 10.3 Draft Terms of Reference for Finance Committee** The Group Director of Corporate Affairs explained that work had commenced to develop the Terms of Reference for the Finance Committee, following the arrival of the new Group Chief Finance Officer. Once reviewed these would be shared with Non-Executive Directors along with a workplan for the Committee. It was anticipated that there would be a move to a Group Finance Committee a soon as possible. The Board: • **Noted the update**

445/24	**Item 10.4 NHSE Publication Principles for Providing Safe and Good Quality Care in Temporary Escalation Spaces (TES)** The Group Chief Operating Officer presented the report following receipt of a publication from NHS England in recognition of anticipated pressures for winter, ensuring there were escalation areas that were safe and considered patient experience. The report was taken as read.
446/24	Mrs Brown was pleased to see the level of detail within the report which was commendable and noted that the previous year's temporary escalation spaces had worked well. It was felt that having designated spaces identified would put the organisation into a much-improved position.
447/24	The Group Chief Operating Officer advised that updates on this would be provided to the Quality Committee and work would take place with the Group Chief Nurse in respect of operationalising this to maintain safe patient experience.
448/24	The Group Chief Clinical Governance Officer commented that the impact would be fed into the Quality Committee in terms of any identified risks or incidents. Detail would also be added regarding professional and minimal standards of care relating to hospital handover delays for patients.
449/24	The Group Chief Integration Officer expressed a view that the paper offered focus, grip and control on escalation statuses and what to do in the event of pressure. The next steps would be to explore whether all the components could be brought together into a full hospital protocol for best practice, linking with pressure scores and with actions that could be audited. **Action: Chief Integration Officer, 7th January 2025** The Board: • **Received the report**
450/24	**Item 10.5 NHS Letter Winter and H2 Priorities** The Group Chief Integration Officer presented the report which provided an overview of the position at month six from an operational annual plan perspective and the key actions being taking in H2 to bring the Group back on track against the 2024/25 Plan.
451/24	The Group Chief Integration Officer also offered that NHSE had stood up the winter operating functions from 1st November 2024. In preparation for this organisations had been asked to review general and acute core functions and escalation bed capacity plans, review and test full capacity plans, ensure the fundamental standards of care were always in place in all settings, ensure appropriate senior clinical decision makers were able to make decisions in live time to manage flow and ensure plans were in place to maximise patient flow throughout hospitals, seven days a week.
452/24	

453/24 454/24 455/24	The Group Chief Integration Officer reported the Winter Visit the previous week had been positive and issues raised were already being actioned such as urgent and emergency care performance and discharge with external partners. It had been encouraging to line up with external scrutiny and further detail would be provided to Committees on this in due course. The Group Chief Integration Officer informed those present that work had also recently been taking place with local authority colleagues to look at discharges and with EMAS supporting the handover of crews to provide a timely service for the population of Lincolnshire. The report also focussed on governance, which had been commended as one of the best structures seen within the Midlands report. Workforce challenges were also identified in terms of maintaining profiles within plan and further discussions would be taking place with system partners on this, with the focus now on temporary workforce spend. In terms of patient safety elements, there would need to be careful thought on where the winter investments were made. The Group Chief Integration Officer explained that through discussions with the ICB it had been agreed that should schemes make good headway, they may be funded recurrently moving forward. The Board: • **Received the 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
456/24 457/24 458/24 459/24	**Item 11.1 Draft Terms of Reference for Integration Committee** The draft Terms of Reference for the new Group Integration Committee and workplan were offered to the Board noting that approval would allow the establishment of the new Committee, to be Chaired by Mrs Brown with the Group Chief Integration Officer as the lead Executive. It was proposed to utilise the first meeting to standardise the agenda template and one of the first items within the governance workstream would be to undertake a read across and a gap analysis across Committees. This would assure the Board that all areas had been captured and there was no duplication across the Committees. It was recognised that the Terms of Reference may need to be resubmitted should further developments be required to confirm how the Committee worked in practice. The Group Chair commented that it was good to see the first draft of the workplan and expressed a view that the Terms of Reference captured the aims of the Committee well. The Group Chief Executive noted that the introduction of this Committee would help to move the Group forward and requested Board support of this. The Board:

	• **Approved the draft Terms of Reference and Workplan noting the requirement for review** • **Established the Integration Committee**
	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.
460/24	**Item 13 Integrated Performance Reports** The Integrated Performance Reports were taken as read with the Board noting that the reports had been received and reviewed in depth by the Committees. The Board: • **Received the Integrated Performance Reports noting the moderate assurance**
	Item 14 Risk and Assurance
461/24	**Item 14.1 Group Risk Management Report** The Group Chief Clinical Governance Officer presented the risk report to the Board noting that from 1st December 2024 the Board would begin to see some commonality in terms of discussions regarding risks as a Joint Risk Policy had been agreed.
462/24	The Group Chief Clinical Governance Officer explained that the risks were as presented within the summary paper, which had been discussed during Committee meetings throughout October 2024.
463/24	The Group Chair thanked the Group Chief Clinical Governance Officer for the report which demonstrated the various movement in risks. The Board: • **Accepted the risks as presented noting the significant assurance**
464/24	**Item 14.2 Board Assurance Framework** The Group Director of Corporate Affairs presented the report noting that the Board Assurance Framework (BAF) had been considered by all Committees including the Audit Committee to confirm this remained effective. There was one escalation to draw to the attention of the Board, relating to the review of objective 2b which had been recommended by the People and OD Committee to move from green to amber in respect of education and training.
465/24	The Group Chair commented that the Group BAF remained a work in progress as this was further developed. The Board:

	• **Received the report noting the moderate assurance**
466/24	**Item 14.3 Assurance and Risk Report from the Group Audit Committee** The Chair of the Audit Committee, Mr Herbert, provided the assurances received by the Committee at the first Group meeting held on 17th October 2024 with the report being taken as read.
467/24	Mr Herbert informed the Board that the Committee was advised that moving forward the External Audit teams had been aligned to the Group so that both organisations would be audited by the same team.
468/24	The Committee had considered the audit actions and recommendations which had been issued following the year end audit for 2023/24 and agreed that these would continue to be reviewed at future meetings to ensure actions were closed.
469/24	Th Committee noted in the post balance sheet events discussion that LCHS was still subject to action by HMRC. The case was on hold awaiting the outcome of another case. External Audit were briefed on the position.
470/24	The Committee received the Internal Audit Progress Report for both organisations noting that whilst no internal audit reports had been finalised one report had been finalised since the publication of the papers.
471/24	The position with audit recommendations and the audit plan were noted by the Committee which was satisfied that reasonable progress had been made against the plan. Internal Audit recommendations continued to be closely monitored.
472/24	The Committee noted the progress report for both organisations and the LCHS Annual Report. Fraud Awareness Month would take place in November and Group Communications had been planned in support of this campaign.
473/24	The Committee received the quarterly compliance report which was being developed to reflect compliance across both organisations
474/24	The Committee received the quarterly update on the policy position. It was noted that the position remained poor. The Committee noted the actions being taken by the Executive to address the areas of concern however asked for assurance on when traction would be seen in delivering improvement.
475/24	The Group Chair commented that this had proved a good opportunity for a reset between the Executives and Auditors and hoped to see the benefits of this in future reports. The Group Chair noted the policy position and acknowledged that all Committees would focus on this until the position had improved satisfactorily. The Board: • **Received the assurance report**
476/24	**Item 14.3.1 Amended Corporate Governance Manuals ULTH and LCHS**

	The Group Director of Corporate Affairs offered the amended Corporate Governance Manuals for both ULTH and LCHS to the Board and advised that these would be subject to a substantial redraft to reflect Group working arrangements for Board and Committees later in the year, once the Committee development work had been completed. However, in the interim the documents had been updated to reflect Board voting arrangements and updated job titles for Board members. The Board: • **Approved the interim updates to the Corporate Governance Manuals as recommended by the Audit Committee**
477/24	**Item 14.4 Nomination of Group Deputy Chair** The Chair presented a report which set out a proposal to appoint Mrs Rebecca Brown, Non-executive Director to the role of Group Deputy Chair and Senior Independent Director (SID), which was in line with the Standing Orders for both LCHS and ULTH. The Board: • **Supported the recommendation to appoint Mrs Rebecca Brown as Group Deputy Chair with immediate effect**
478/24	**Item 15 Any Other Notified Items of Urgent Business** No further items were discussed.
479/24	The next scheduled meeting will be held on Tuesday 7 January 2025 via MS Teams live stream.

Voting Members	**7 May 24**	**2 July 2024**	**3 Sept 2024**	**5 Nov 2024**								
Elaine Baylis	X	X	X	X								
Andrew Morgan	X											
Karen Dunderdale	X	X	A	X								
Ian Orrell	X	X	A									
Jim Connolly	X	X	X	X								
Gail Shadlock	X	X	X	X								
Chris Gibson	X	X										
Philip Baker	A	A	X	X								
Neil Herbert	X	X	X	X								
Rebecca Brown	X	X	X	X								
Dani Cecchini	X	X	X	X								
Julie Frake-Harris	X	A										
Colin Farquharson	A	X	A	X								

Sam Wilde	X	X	X									
Anne-Louise Schokker	X											
Daren Fradgley			X	X								
Nerea Odongo			X	X								
Caroline Landon			A	X								
Paul Antunes Goncalves				X								

PUBLIC BOARD IN COMMON ACTION LOG

Agenda item: 5.1

Trust Board date	Minute ref	Subject	Explanation	Assigned to	Action due at Board	Completed
5th November 2025	449/24	NHSE Publication Principles for Providing Safe and Good Quality Care in Temporary Escalation Spaces (TES)	Exploration of all components for TES to develop a full hospital protocol for best practice to take place, to include pressure scores and auditable actions.	Group Chief Integration Officer	7th Jan 2025	

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	*7th January 2025*
Item Number	*Item 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.*

System Overview

a) All parts of the Lincolnshire health and care system remain under significant operational pressure but good work continues in order to cope with the ongoing operational pressures. Extraordinary actions have been taken to manage the demands, reflecting the collective system response.

b) United Lincolnshire Teaching Hospitals NHS Trust (ULTH) declared a critical incident during the height of this pressure in December 2024 due to a loss of critical IT systems, telephone lines and the continued pressure on our emergency and urgent care pathways. Thanks to the commitment of our colleagues and partners, we were able to de-escalate from the critical incident within 24 hours.

c) Towards the end of December, we usually see the publication of the NHS annual planning guidance. The 2025-26 guidance is likely to be published in the new year.

d) The 10-year health plan is part of the government's mission to build a health service fit for the future, with the first step in the process being Lord Darzi's review. As part of the national conversation to develop the 10 year health plan, NHSE held the Midlands Leadership Engagement Workshop on 28th November 2024 to gain insights from regional and system leaders to contribute to the plan. Further engagement events are planned both locally and nationally during the early part of 2025 to include colleagues and members of the public.

e) A full board session took place on Wednesday 11 December, for the first time in a number of years. The Trust Boards of all Lincolnshire provider trusts and

Lincolnshire ICB met to continue to strengthen the partnership working and contribution to the improved healthcare of the patients and population of Lincolnshire.

Group Overview

a) At Month 8, ULTH's YTD financial position is a £24.9m deficit, £15.2m adverse to the planned £9.7m YTD deficit.

b) LCHS's YTD financial position is a £0.7 deficit, £0.2m favourable to the planned £0.9m deficit position.

c) The ULTH CIP YTD has delivered savings of £21.3m, which is £0.4 lower than planned savings of £21.7m. LCHS CIP YTD has delivered £4.4m, which is £0.5m ahead of plan.

d) LCHS opened the new Scotter Ward on 1st November 2024 following a £4.5m transformation. The ward will shortly be open to patients and will play a vital role in preventing patients from having to be admitted to acute hospitals by offering community hospital care and has been co-designed with staff and patients to meet their needs.

e) The first Group Staff Awards ceremony happened on Friday 15 November, celebrating hundreds of staff from across both organisations. The staff awards had a number of categories including recognising excellence in patient care, compassion and respect amongst other things.

f) On 29th November 2024 I attended the official opening of the Skegness Community Diagnostic Centre (CDC). Approximately £42million has been invested into CDCs in Lincolnshire, of which £15m has been invested into the Skegness CDC. This significant NHS investment enables the offer of a range of elective (planned) diagnostic services, away from the main hospital sites which provides easier and quicker access to tests, closer to patients' homes.

g) Having successfully being identified as a pilot site, in December 2024 ULTH launched Martha's rule, Call For Concern service, which offers patients, their families and carers 24 hour access to a rapid review if there are concerns about a person's deteriorating condition. This has been launched as part of the Secretary of State for Health and Social Care and NHS England commitment to implement Martha's rule in the NHS nationally and builds on the existing safeguards already in place in our hospitals to offer a clear and direct way to escalate concerns.

h) On 16th October 2024 the Care Quality Commission (CQC) undertook an unannounced visit to Lincoln County Hospital to view urgent and emergency care services. The CQC thanked Trust staff for the help and support offered

throughout the day and saw good safeguarding practice and ambulance staff working together to protect patients.

i) On 27th November the CQC again conducted an unannounced visit at Pilgrim hospital which focused on urgent and emergency care pathways, along with a review of medical and surgical wards. The CQC provided feedback to note the well managed flexing and boarding arrangements for patients and good sepsis management within the Emergency Department (ED). There were a number of areas for potential improvements for both visits, which the Trust are working to address, but no immediate patient safety concerns were reported back to the Trust from either visit.

j) On 28th November 2024 I attended the Step into Health recruitment event as part of the national NHS programme which is designed to introduce Armed Forces personnel to the diverse range of career opportunities available. The event aims to support service leavers, veterans, reservists and family members to transition their skills and experience they gained in the Armed Forces and gain insight from NHS staff.

k) Due to an increase in respiratory illnesses including Covid-19, influenza A and RSV we have re-introduced additional infection prevention measures in some high-risk areas. From Friday 13 December 2024, patients and visitors have been asked to wear hospital-provided Type II face masks in high-risk areas across the Group, including Emergency Departments, Urgent Treatment Centres (UTCs) admission wards and haematology/oncology wards to reduce the spread of respiratory illnesses and provide better protection to themselves and those around them. All visitors to sites across the Group are also asked to wear masks when visiting.

l) Lincoln Neonatal Team recently won the Active Workplace award at the Lincolnshire Sport and Physical Activity Awards 2024. The awards provide an opportunity to recognise and celebrate the outstanding achievements of those who inspire and enable the county to be active. The Neonatal team goes above and beyond in supporting families on the Neonatal Unit, and this award highlights the importance of keeping active to improve physical and mental wellbeing to their team, patients and families.

NHS
Lincolnshire Community and Hospitals NHS Group

CQC Unannounced Inspection
Pilgrim Hospital Boston

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Teaching Hospitals NHS Trust

Meeting	*Lincolnshire Community and Hospitals Group Board meeting*
Date of Meeting	*7th January 2025*
Item Number	*6.1*

CQC Unannounced Inspection
Pilgrim Hospital Boston

Accountable Director	*Kathryn Helley, Group Chief Clinical Governance Officer* *Nerea Ondongo, Group Chief Nurse*
Presented by	*Kathryn Helley, Group Chief Clinical Governance Officer*
Author(s)	*Jeremy Daws, Head of Compliance*
Recommendations/ Decision Required	*The Group Board is asked to:-* • *Note the content of the report and the actions taken to date.*

How the report supports the delivery of the priorities within the LCHG Board Assurance Framework	*X*
1a Deliver high quality care which is safe, responsive and able to meet the needs of the population	*X*
1b Improve patient experience	*X*
1c Improve clinical outcomes	*X*
1d Deliver clinically led integrated services	
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 (ULTH)	
3f Reducing unwarranted variation in planned service delivery and ensure we meet all constitutional standards (ULTH)	
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	

Executive Summary

Background:

- CQC conducted an unannounced inspection on the Lincoln County Hospital site on the 16 October which was focused on access, flow and discharge processes. This inspection was of the Urgent & Emergency Care (UEC) Core Service, with visits to the Discharge Lounge.

- On the 27 November, CQC again conducted an unannounced inspection this time at Pilgrim Hospital Boston. This visit focussed on UEC pathways of care and a review medical and surgical wards which included a review of cohorting spaces used as part of the Trust's 'Plus 1' policy for flexing ward capacity to mitigate patient safety risks in the Emergency Department.

CQC Feedback following the 27 November Inspection:

- CQC provided verbal feedback to the Trust on the afternoon of the 27 November before CQC departed from site. This has now been followed up with receipt of formal written feedback.

- Despite the inspection taking place during a period of extreme operational pressure, the inspection team noted a number of positives including:

    - Warm and welcoming reception by Trust staff to the CQC visiting teams;

    - Well managed flexing and boarding arrangements for patients to mitigate pinch points in ED that CQC felt were safe;

    - Six patients were interviewed by CQC, all six provided very positive experiences and described 'excellent staff';

    - Good and responsive care by the Pre-Hospital Practitioner (PHP) with several patients;

    - Good sepsis management within ED;

    - Positive staff feedback who provided overall positive views of working within ED;

    - Staff were positive about the frailty SDEC pathway.

- CQC have confirmed that during their on-site inspection, there were no patient safety concerns that required immediate enforcement action.

- The CQC feedback letter also contains a number of areas for potential improvement. In summary these are as follows:

    - The discharge lounge and frailty SDEC locations are being used to support medical overflow patients and not as intended. This could impact on patient

experience and affect flow through the hospital. Some of the reasons for delay relate to external factors, including transport;

- Some inconsistencies were identified in documents around advanced care planning in two out of five cases;

- IPC/cleanliness issues were observed in a toilet and shower area on one of the wards, but this was immediately cleaned (CQC noted that this was early morning of the visit, so was likely before ward housekeeping staff had commenced work for the day);

- Feedback regarding a risk arising from one ward location where two rooms were found to have piped air and oxygen outlets situated beside each other. There has been previous alerts around the risk of inadvertent misidentification of such outlets when in close proximity. The Trust will review this and confirm appropriateness in line with previously issued guidance;

- The mental health room within the Emergency Department was in constant use for general patients and was observed to contain ligature points in the room with limited visibility from the outside of the room for staff (**NB:** this is a majors cubicle, so when not in use for patients with mental health reasons, it serves as an additional majors space. Equipment in use for majors patients (that could provide ligature risks) are removed from the room when in use for mental health patients).

Next Steps:

- The Trust is in the process of reviewing these points to determine a plan of action in response, linking in, to avoid duplication of effort, with the ongoing UEC Refresh Improvement Programme of work.

- The Trust will respond to CQC by the end of December to summarise the plan of action. This will serve to provide CQC with assurance and support them in compiling their final inspection report which be produced and published in due course.

- At this time, the Trust are supporting CQC with post-inspection activities. This includes focus groups with staff in the ED.

- CQC have also now written to the Trust requesting specific evidence. The Trust will respond in full, in line with stated timescales.

Conclusion:

- The Group Board is asked to note the content of the report and the actions taken to date.

NHS
Lincolnshire Community and Hospitals NHS Group

Group Development
Next Phase

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Teaching Hospitals NHS Trust

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*7th January 2025*
Item Number	*Item 6.2*

Group Development – next phase

Accountable Director	*Karen Dunderdale, Group Chief Executive*
Presented by	*Karen Dunderdale, Group Chief Executive*
Author(s)	*Wendy Booth, Interim Governance Advisor*
Recommendations/ Decision Required	*The Group Board is asked to:-* • *approve the group development programme plan;* • *note the proposed arrangements for future reporting on progress against delivery of the agreed actions and milestones within the programme plan;* • *agree the need for any additional information, action of assurance at this stage.*

Executive Summary

1. Background & Introduction

1.1 Further to the briefing provided to the board in October 2024, work to finalise the group development programme plan and timeline is now complete and is attached.

1.2 The key enablers required to ensure successful delivery and embedding of the agreed actions and milestones have also now been included within the plan, with comms & engagement and HR & OD support being a requirement across a number of work streams. Additional capacity will be sourced as required.

1.3 As previously advised, progress against delivery of the agreed actions and milestones within the programme plan will be reported to the board through the Chief Executive's bi-monthly briefing. Reporting will, in the first instance, focus on delivery against agreed programme milestones, however, over time will include reporting on benefits realisation of the move to group.

1.4 Where required and / or directed by the boards, specific aspects of the programme may also be reviewed through the relevant board (assurance) committee(s) or discussed in more detail at board development sessions. The first such workshop is due to be held on Tuesday, 21 January 2025, when the board will consider and approve the group strategic objectives, risk appetite and BAF format for 2025 onwards.

2.0 Trust Board Action Required

2.1 The Trust Board is asked to:

- approve the group development programme plan;
- note the proposed arrangements for future reporting on progress against delivery of the agreed actions and milestones within the programme plan;
- agree the need for any additional information, action of assurance at this stage.

FURTHER DEVELOPMENT OF THE LINCOLNSHIRE COMMUNITY & HOSPITALS NHS GROUP: PROGRAMME & TIMELINE REFRESH – WORKING DOCUMENT

UPDATED DECEMBER 2024

Introduction & Proposed Key Actions

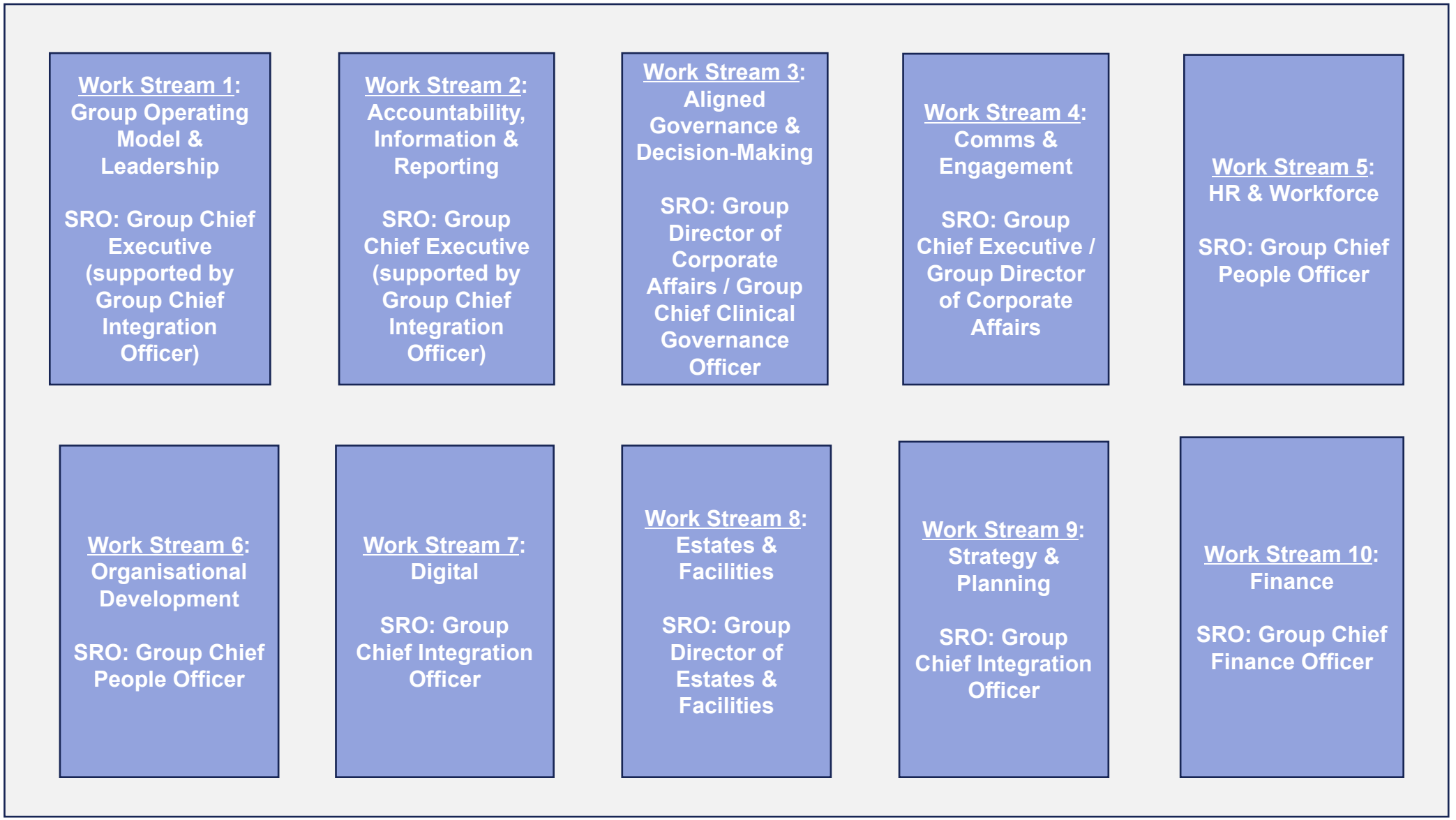
- Following the appointment of a Group Chief Executive and joint executive leadership team for the Lincolnshire Community & Hospitals NHS Group, it was agreed that there was a need to review the programme of work supporting the next phase of the group's development in order to ensure no loss of pace and progress. Key initial actions were agreed as follows:

1. **Refreshing the group development programme & timeline – with input from the group executive leadership team – to include a review of:**
    - work streams – *do the existing work streams remain appropriate and / or are other work streams required?;*
    - actions / milestones & enablers: *what are the actions / milestones & enablers within each work stream which are critical to the ongoing development of the group;*
    - work stream leads: *are any changes required to work stream leads in light of group executive leadership appointments?*
    - timescales: *(where indicated within existing work streams) are these sufficiently challenging but also realistic & achievable?*
2. **Refreshing the group development programme governance & oversight arrangements including reporting on progress to:**
    - Group Leadership Team (GLT)
    - Joint Trust Board
    - Wider organisation
    - Key external stakeholders (as required)

Current Position as at December 2024

- Following an initial discussion at the Executive Leadership Team (ELT) Time-Out held on Thursday, 12 September 2024, 10 work streams were identified as being critical to the next phase of the group's development. Details of the 10 proposed work streams and the Senior Responsible Officer (SRO) for each work stream, which are outlined on slide 4, were shared with the Joint Trust Board in November 2024
- The Interim Governance Advisor currently working with the two trusts was asked to support each SRO to identify and / or firm up the actions / milestones & enablers within each work stream which are critical to the next phase of the group's development and details are provided on slides 5 – 37
- An ELT discussion on timescales for the completion of the agreed actions and milestones was held on Thursday, 7 November 2024 and a further discussion to agree the updated programme & timescales, prior to sharing with the Joint Trust Board for approval in January 2025 was held on Thursday, 12 December 2024. [**Note:** In respect of the governance work stream (3), this also incorporates the comments and recommendations from the recent review undertaken by NHS Providers]
- Once fully populated and approved by the Joint Trust Board, it is proposed that progress against delivery of the agreed actions and milestones within the programme plan is reported to the Joint Trust Board through the Group Chief Executive's bi-monthly briefing
- Reporting will, in the first instance, focus on delivery against agreed programme milestones, but over time will include reporting on benefits realisation of the move to group
- Where required and / or directed by the Joint Trust Board, specific aspects of the programme may also be reviewed through the relevant board (assurance) committee(s) or discussed in more detail at board development sessions e.g. strategic aims and objectives and BAF development for the group

Group Development Programme: Work Streams



Work Stream 1: Group Operating Model & Leadership
SRO: Group Chief Executive (supported by Group Chief Integration Officer

Work Stream 1: Group Operating Model & Leadership: how the group operates & makes decisions

Key Tasks / Milestones	Timescales	Key Enablers	Inter-dependencies
Complete the group executive leadership recruitment processes including the development of an appropriate induction programme and agreement of the contractual arrangements for the new group executive roles	31 August 2024	HR & OD support Communications & engagement support Digital / BI support	Accountability, Information & Reporting (Work Stream 2) Aligned governance & decision-making (Work Stream 3) HR & Workforce (Work Stream 5) Organisational Development (Work Stream 6)
Once the executive leadership recruitment process is concluded, formalise the externally-set executive director statutory & regulatory accountability roles (to be reviewed alongside executive portfolios)	30 September 2024 **(complete)**		
Formally approve the overarching group model structure and associated implementation plan including the proposed re-design of the existing directorates to introduce a new Alliance Division as part of an enhanced collaborative operating model, enable each division / directorate to operate on a wider footprint and ensure that clinical leadership remains central to the group model as a key function of group leadership (example structure outlined on slide 8)	31 December 2024 **socialise & engage: model & implementation plan)** 4 March 2025 **(board approval)** 1 April 2025 **(implementation)**		
As part of the work to finalise the wider group and directorate structures, agree the division / balance of roles & responsibilities at group and trust level including alignment with Place (example outlined on slide 9), supported by the development of a clear Accountability & Performance Management Framework and aligned governance & decision-making processes and arrangements	As above		
Implement the new operating model and leadership structure, Accountability & Performance Management Framework and associated governance arrangements	1 April 2025 **(implementation)** 30 June 2025 **(embedded)**		
Align the group support services and associated policies, processes and arrangements	1 April 2025 **(implementation)** 30 June 2025 **(embedded)**		
Once all of the required changes to the trust's operating model including leadership and governance & decision-making arrangements have been made, communicate to staff across the group - to include the development of a simple visual representation of the trust's operating model	1 April 2025		

Outline Group Structure – draft

The Group HQ

Care Directorates

- Planned (LCHS)
- Unplanned (LCHS)
- Alliance Directorate (includes CPP & CSS) ***New***
- Family Health (ULTH)
- Surgery (ULTH)
- Medicine (ULTH)

Trusts

- Lincolnshire Community Health Services Trust
- United Lincolnshire Teaching Hospitals NHS Trust

Group Support Services

- Finance & Procurement
- Informatics
- Estates & Facilities
- People
- Clinical Governance
- Other Support Services

Roles & Responsibilities Across the Group

This slide outlines the **unique respective roles and contributions** of Group Leadership, the Directorates and Group Support Services to the delivery of our vision to be a high-performing group, renowned for excellence and innovations and providing safe and compassionate care to our patients and in support of delivery of the aims and objectives within our group strategy for 2024/25

Group Strategic Plan 2024/25 (our 'transition' year)

Patients | People | Services | Partners | Population Health

Action to evolve the group model in support of our group vision and strategy

Group Executive Leadership

Group Leadership provides the guiding mind for how the Group works in a collaborative and sustainable way. Group Directors have a greater focus on system working through the ICS, CPP & PCNs

Care Directorates

The directorates are responsible for operational delivery, including additional services devolved from GSS and Group Leadership. They will also have a greater focus on Place based working

Group Support Services

Group support services are a network that works in partnership with the directorates and other partners to provide best in class corporate services and to be able to offer these services more widely across Lincolnshire

Accountability & Performance Management Framework

All of the above will be supported by a clear Accountability & Performance Management Framework which outlines the accountabilities between different parts of the Group, reflecting the wider system context the Trustsoperate in

Division / balance of responsibilities across the group – example

Group Executive Leadership	**Group Development & Governance** • Setting organisational policy & standards • Group model integration, transformation and delivery of agreed objectives and benefits of the move to a group model • Post-integration harmonisation of policy and standards • Wider transformation • Professional leadership • Promotion of agreed values & behaviours • Governance & regulatory compliance	**Strategy & Partnerships** • Developing group and underpinning strategies • Regulator management • Clinical networks • ICS, CPP & PCN interface • External stakeholder / partner relations & engagement • Reputation management – trust and group level • Public & patient engagement	**Quality & Safety** • Driving the development and implementation of the agreed clinical strategy / plan and clinical pathways • Support to very challenged services • Quality & patient experience **People** • Setting the standards: culture, vision and values, E,D&I, education & training, staff well-being	**Operational Performance** • Complex performance challenges (which cannot be managed at trust level) • Complex cross-group change • Removing barriers in support of trust / directorate teams • Set financial plan
Directorates (supported by Group Executive Leadership & Group Support Services)	**Group Development & Governance** • Implementation of & adherence to organisational & regulatory governance requirements • Implementation of agreed Group / Trust strategies, policies & standards • Clinical engagement and collaboration between teams	**Place Interface / Leadership** • Oversight of Place interface **Local service and estate transformation** • Service transformation & delivery • Estates management & delivery • Digital	**Quality & Safety** • Trust level quality, safety & effectiveness • Implementation of agreed clinical strategy /plan and clinical pathways **People** • Implementing people strategy, staff management and well-being	**Operational Performance** • Trust level delivery of operational performance (e.g. NHS constitutional standards) • Trust level financial performance against plan

Work Stream 2: Accountability, Information & Reporting
SRO: Group Chief Executive (supported by Group Chief Integration Officer)

Work Stream 2: Accountability, Information & Reporting

Key Tasks / Milestones	Timescales	Key Enablers	Inter-dependencies
Design, approve and implement an Accountability & Performance Management Framework for the group which: • is aligned to the aims & objectives of the group and strategic partners; • is aligned to the relevant statutory and regulatory standards, requirements and contracts relevant to the trusts and wider group; • flows from ward / patient to board; • is aligned to and supports the board and board committee cycle; • is based on clear metrics with defined performance thresholds reported through a harmonised Integrated Performance Report (IPR) from a group, trust directorate & service perspective; • is balanced across strategy, quality & safety, performance: operational delivery, workforce, finance, governance & risk; • is underpinned by a harmonised accountability & performance review policy & process; • is action focussed in support of delivery and risk mitigation and which reflects best practice as set out in the latest NHSE guidance: 'The Insightful Provider Board'; [**Note:** There is a need to ensure relevant improvement programmes e.g. ULHT IIP is integral to and not separate from the above process including the alignment of trust / group KPIs]	31 January 2025 **(draft outline)** 28 February 2025 **(socialise)** 31 March 2025 **(approval)** 1 April 2025 **(implementation)** 30 June 2025 **(embedded)** [**Note:** Interim Position – Performance Review Meetings, which have been 'on hold', to be reinstated from January 2025]	Business Intelligence (BI) support	Operating Model & Leadership (Work Stream 1) Aligned Governance & Decision-Making (Work Stream 3) Digital (Work Stream 7)
Review the BI resource across the group to ensure this remains effective in support of the group Accountability & Performance Management Framework and the accurate, effective and timely reporting on performance and as part of the 'Vision for Information'	20 December 2024 **(Draft Vision)** 31 March 2025 **(Final Vision and Structure Proposal)**	Key development area: external expertise / support required	

Work Stream 3: Aligned Governance & Decision-Making

SROs: *Group Director of Corporate Affairs / Group Chief Clinical Governance Officer*

Key objectives for the development of aligned governance & decision-making

The development of the governance & decision-making arrangements for the group:

- must reflect and support the group operating model once agreed and be developed in conjunction with key staff in each trust;
- must ensure the retention of organisational sovereignty, accountability and identity;
- must ensure both trusts maintain and, where required, strengthen compliance with their respective statutory and regulatory duties and responsibilities and support the maintenance of the group and trusts as ‘well led’;
- should enhance the effectiveness of each organisation’s corporate governance arrangements and decision-making and deliver high quality assurance;
- should enable more timely, cohesive and equitable decision-making;
- should, where possible, allow streamlined and single reporting internally and externally on relevant issues;
- should provide ease of understanding for staff of governance & decision-making structures;
- should reduce duplication and bureaucracy including the number of meetings and time spent in meetings, ensuring effective and efficient use of group executive and other senior leadership time;
- should not preclude other organisations joining the group if appropriate at a later point

Work Stream 3: Aligned Governance & Decision-Making

Key Tasks / Milestones	Timescales	Key Enablers	Inter-dependencies
Board & Committee Governance			
Complete the transition from boards-in-common to a joint or group board (once all appointments have been made to group executive leadership roles and NHSE approval has been received for the appointment of joint or group and trust specific Non-Executive / Associate Non-Executive Directors (NEDs / ANEDs)	30 November 2024 **(complete – joint Trust Board in place)**	Interim external governance support & capacity in place Additional substantive capacity within the internal corporate governance team being considered as part of executive structure discussions	Operating Model & Leadership (Work Stream 1)
Complete the work to align the board business cycle (work plan)	31 December 2024 **(drafted)** 31 January 2024 **(approval)**		
Complete the work to transition the remaining board committees (Audit & Risk, People / Workforce, Finance & Performance) to work jointly including the development and approval by the trust board of harmonised terms of reference & work plans and the agreement of any changes to the naming convention for these committees. The development of harmonised terms of reference and work plans for all board committees to include a review of: • delegated authority and matters reserved to the Joint Trust Board; • membership (reflecting changes to group leadership structures); • reporting up from sub-groups (reflecting any changes to and / or alignment of those groups) • assurance ratings (ensuring these are aligned and consistent with those within the BAF) • the development of an 'assurance map' detailing the areas of oversight covered by each of the board committees; not least to avoid duplication and gaps	31 December 2024 **(harmonisation & approval of terms of reference & work plans & transition to new ways of working for all board committees)** 1 January – 31 March 2025 **(fully implemented & embedded)**		
Undertake a review of the operation and effectiveness of the Quality Committee nine months on and any required changes to the terms of reference, work plan & associated arrangements. Any learning to be used to inform the transition of the remaining committees to working jointly	31 October 2024 **(review complete)** 31 January 2025 **(board receipt of & implementation of recommendations)**		
Develop and seek approval from the trust board of terms of reference and a work plan for the proposed joint Integration Committee and agree the date for these meetings to commence and the required frequency	30 November 2024		
Develop a 'board & committee principles framework' to ensure there is collective understanding of joint working principles; that both trusts can continue to make decisions and operate in accordance with the statutory & regulatory requirements that apply to them; and there is continued robust corporate reporting	31 December 2024		
Develop (or make any required changes) to harmonised board & committee templates (report cover / front sheet, agenda, minutes, upward report & action log) and common report writing guidance in light of the move to group and working jointly. As part of the development or updating of the report writing guidance, consider the need for and introduce a programme of report writing training for key staff and develop an exemplar report front / cover sheet	31 January 2025 **(templates & guidance)** 31 March 2025 **(training)**		

Work Stream 3: Aligned Governance & Decision-Making (Cont'd)

Key Tasks / Milestones	Timescales	Key Enablers	Inter-dependencies
Non-Executive Director (NED) & Associate Non-Executive Director (ANED) Roles			
Complete the review of proposed NED / ANED roles for the group and secure the required internal and external approvals [**Note.** This is required to facilitate a formal move to a joint or group board and joint committees rather than 'in-common']	30 September 2024 **(complete: approvals received & arrangements effective from 1 October 2024)**	External: NHSE approval Internal: Remuneration Committee and board approval	Operating Model & Leadership (Work Stream 1)
Board Development			
Once the group executive leadership team is in post and informed by a board skills & knowledge assessment and aligned to the proposed group executive development programme, develop, agree & implement a Joint Board Development Programme. As an outline, a Board Development Programme may typically include: • board development days / time-outs ensuring dedicated time on key topics and priorities including group development and strategy; • information sharing / briefings (e.g. national policy, regulatory changes, learning and good practice from elsewhere); • board training / compliance requirements; • tailored sessions in response to identified development needs (including those identified from the skills & knowledge assessment or arising from the annual review of board effectiveness or any well led or governance review etc.)	From 1 October 2024 onwards **(underway)**	External support to the content and delivery of the board development programme sourced from NHS Providers External support to the content and delivery of the group executive development programme sourced from Aqua	Operating Model & Leadership (Work Stream 1) Organisational Development (Work Stream 6) Strategy and Planning (Work Stream 9)
Consider undertaking an annual board maturity assessment which in turn will contribute to any well led assessment and will inform the board development programme for the following year	31 March 2025		

Work Stream 3: Aligned Governance & Decision-Making (Cont'd)

	Timescales	Key Enablers	Inter-dependencies
Executive Governance			
Design, approve and implement the group executive governance & decision-making structure to include a review and alignment, as appropriate, of the sub-groups reporting up to the Executive Leadership Team (ELT) / Group Leadership Team (GLT). The design of the new structure to ensure: • there are effective & timely governance & decision-making arrangements in place that support operational delivery and meet the needs of the trusts and wider group; • there is appropriate alignment with the proposed Accountability Framework for the group; • the governance & decision-making arrangements in place support the trust and wider group to meet the relevant statutory and regulatory requirements; • there is consistency in how information and assurance is reported up to group executive and board & committee level; • there is a clear separation between management (escalation and decision-making) and assurance meetings; • the structure feeds and supports the new board and committee meeting cycle in a timely way; • there is scope for tailoring arrangements where necessary to specific trust-level risks and needs	31 January 2025 **(draft outline)** 28 February 2025 **(socialise)** 31 March 2025 **(approval)** 1 April 2025 **(implementation)** 30 June 2025 **(embedded)** [**NOTE:** Initial ELT discussion on meeting structures held on 7 November 2024. Further discussion held on 12 December 2025]	Interim external governance support & capacity in place	Operating Model & Leadership (Work Stream 1) Accountability, Information & Reporting (Work Stream 2)
As part of the above work, review the terms of reference for the ELT & GLT to ensure that roles & responsibilities are clear and that clinical leadership / input remains central to decision-making across the group	As above (**Terms of Reference drafted – to be finalised once management & meeting structures are agreed)**		

Work Stream 3: Aligned Governance & Decision-Making (Cont'd)

Key Tasks / Milestones	Timescales	Key Enablers	Inter-dependencies
Board Reporting Framework (BAF) & Risk Registers			
Phase 1: Complete the work to align the two trust BAFs including a review and alignment of 'assurance ratings' and ensure that each strategic risk is cross-referenced with related risks on the corporate risk registers. **[Note:** Whilst the aligned BAF will reflect risks to the delivery of the strategic objectives which have been agreed for the group and the controls, assurance, gaps and actions may be the same for each organisation, where there are risks which are specific to either ULHT or LCHS, the controls, assurances, gaps and actions to be explicitly referenced for each separate organisation]	31 October 2024 **(underway)**	Interim external governance support & capacity in place	Accountability, Information & Reporting (Work Stream 2)
Phase 2: Consider and agree the 'design' of the aligned BAF for 2025/26 onwards i.e. should the format of the aligned BAF look and feel different for the group? Agree the board committee oversight for each strategic aims & objective	21 January 2025 **(Trust Board workshop)**		
Agree the group risk appetite and ensure this is appropriately referenced within the BAF for each strategic objective	21 January 2025 **(Trust Board workshop)**		
Review and standardise the risk register and approach to risk management and risk reporting across the group including the management of Datix	31 December 2024 **(New joint Risk Policy launched 1 December 2024. Two separate risk registers remain in place)**		
Alignment of Group Meeting Cycle			
Once the work to design and align the board, committee, sub-group and other key trust meetings is complete, develop and update annually a single group meeting schedule (ensuring alignment with the Accountability & Performance Management Framework and performance review meetings)	**31 January 2025**	Interim external governance support & capacity in place	Accountability, Information & Reporting Work Stream 2)

Work Stream 3: Aligned Governance & Decision-Making (Cont'd)

Key Tasks / Milestones	Timescales	Key Enablers	Inter-dependencies
Document Control & Policy Approvals			
Agree and implement a harmonised and strengthened approach to document control and policy approvals for the group	31 March 2025	Interim external governance support & capacity in place	Operating Model & Leadership (Work Stream 1)
Review of Key Trust Documents & Governing Instruments			
Complete the review, alignment and approval of key documents & governing instruments to reflect the move to group and changes to the operating model to include but not limited to: • Standing Orders • Standing Financial Instructions • Scheme of Delegation & Powers Reserved for the Boards • Division of Responsibilities Schedule between the Group Chair and Chief Executive • Accountability Framework • Fit & Proper Persons Policy & associated processes Other trust documents to be aligned as part of work to implement the directorate structures and align the group support services and to socialise / launch the group brand	31 March 2025 [**Note:** Interim amendment to Standing Orders required to reflect the appointment of a Group Chief Executive and joint Leadership Team, changes to ELT and GLT decision-making and the proposed move to joint board and committees and any changes to voting rights]	Interim external governance support & capacity in place	Operating Model & Leadership (Work Stream 1) Accountability, Information & Reporting (Work Stream 2) Comms & Engagement (Work Stream 4) Finance (Work Stream 10)
Review and update relevant policies, documentation and templates to reflect the move to group and the group brand	31 March 2025		

Work Stream 3: Aligned Governance & Decision-Making (Cont'd)

Key Tasks / Milestones	Timescales	Key Enablers	Inter-dependencies
Group Working Agreements			
Review and update the Group Partnership Agreement to reflect the agreed changes to the operating model including the leadership and governance & decision-making arrangements, once finalised and agreed	31 March 2025	Interim external governance support & capacity in place	Operating Model & Leadership (Work Stream 1)
Review and update the Group Workforce Sharing Agreement to reflect the agreed arrangements for broader staff / staff groups from each trust, as required, to work across the group: such arrangements to maintain the existing employment relationship whilst avoiding the need for honorary contracts or secondment agreements	31 March 2025		
Review and update the Group Information & Data Sharing Agreement to reflect changes to the operation of the group and any changes to the requirements for sharing information & data	31 March 2025		

Work Stream 4: Communications & Engagement
SRO: Group Chief Executive / Group Director of Corporate Affairs

Work Stream 4: Communications & Engagement

Key Tasks / Milestones	Timescales	Key Enablers	Inter-dependencies
Group Strategy & Group Visual ID / Brand			
Develop and promote the group Communications & Engagement Strategy	31 March 2025	Additional communications & engagement expertise and capacity to be sourced as required	Aligned governance & decision-making (Work Stream 3)
Develop the group visual ID / brand ensuring adherence to the NHS Identity Guidelines specifically in respect of partnership branding	31 January 2025		
Develop guidelines and supporting suite of templates for the use of the group visual ID / brand (how and when it should be used including in respect of signage, document design, correspondence etc.)	31 January 2025		
Roll-out / socialise the group visual ID / brand & supporting guidelines	1 January 2024		
Internal & External Communication & Engagement Channels			
Merge the external facing social media platforms (e.g. Linked-In, Instagram, Facebook) currently in use within the two trusts to create combined group social media platforms. **NB.** X (formerly known as Twitter) to remain separate as not possible to merge	31 December 2024	Digital / IT support	Aligned governance & decision-making (Work Stream 3) HR & Workforce (Work Stream 5) Organisational Development (OD) (Work Stream 6)
Merge the staff closed Facebook Group	TBC		
Merge the internal communication & engagement channels (e.g. weekly e-newsletter, team brief / communications cascade) to include the use of the group visual ID / brand once agreed. **NB.** Group Chief Executive's weekly email already in use across the group	31 January 2025		
Develop and implement a communication & engagement toolkit aimed at ensuring wider awareness of service changes & developments across the group	31 March 2025		
Continue the ongoing comms on all aspects of group development and benefits realisation as changes occur including the development of FAQs for staff on changes to 'how things work across the group'. **NB.** Case studies and group wide log of engagement activities being maintained including learning from staff listening events	Ongoing		

Work Stream 4: Communications & Engagement cont'd

Key Tasks / Milestones	Timescales	Key Enablers	Inter-dependencies
Group Intranet & Internet			
Create and roll-out a group Intranet (including the migration of ULTH to nhs.net). **NB.** All staff across the group to have access to the group Intranet from 1 April 2024. Full migration to nhs.net to take up to a year	30 June 2025	Digital / IT support	Aligned governance & decision-making (Work Stream 3) Digital (Work Stream 7)
Create a single group three URL website which provides information at both a group and individual trust level and which meets accessibility legislation requirements	TBC	Funding required - Business Case being developed (costs to be confirmed)	
Communications & Engagement Team			
Continue to embed and develop the combined group Communications & Engagement Team building on the implementation of cross-group portfolios from September 2024	Ongoing	Additional communications & engagement expertise and capacity to be sourced as required	(Work Streams – All)
Continue to provide communications & engagement support, as required, to the group development programme work streams & SROs e.g. development of group strategy, aims & objectives, values and culture	Ongoing		
Continue to embed the merged media monitoring / horizon scanning and escalation process	Ongoing		

Work Stream 5: HR & Workforce
SRO: Group Chief People Officer

Work Stream 5: HR & Workforce

Key Tasks / Milestones	Timescales	Key Enablers	Inter-dependencies
For any consultation process moving staff into group roles from individual trusts, undertake an equality impact assessment in accordance with ACAS best practice	Ongoing	Staff Side Partnership support & input Some additional HR & OD capacity required – linked to executive structure discussions Communications & engagement support	Aligned Governance & Decision-Making (Work Stream 3) Organisational Development (Work Stream 6)
Develop a package of individual support for staff who will be affected by the change of the move to group	Ongoing **(full health & wellbeing offer in place including drop-in 'change workshops')**		
Harmonise contractual policies and processes across the group, working with union colleagues: six priority policies identified and agreed with union colleagues from both trusts in the first instance. Plan and timescale to be agreed for harmonising remaining policies and processes	31 March 2025		
Harmonise T&Cs – *linked to policy work*	As above		
Harmonise Reward & Recognition including the development of a group Reward & Recognition Policy	31 December 2024		
Move to a group induction: • Development of joint induction video • Harmonisation of face to face induction	 **In Place** 31 January 2025		
Ensure all training, progression, career development opportunities, apprenticeships and support are offered consistently across the group – *linked to policy work and supported by aligned of teams and portfolios*	31 January 2025 **(review of portfolios)**		
Ensure portability of staff for cross-site working	1 November 2024 **(interim solution)** 1 April 2025 **(long term solution)**		

Work Stream 6: Organisational Development (OD)
SRO: *Group Chief People Officer*

Work Stream 6: Organisational Development)OD)

Key Tasks / Milestones	Timescales	Key Enablers	Inter-dependencies
Continue to provide ongoing support to those staff most affected by the move to a group model	Ongoing **(Engagement 'Tube Map' and Change Workshops)**	Staff Side Partnership support & input Some additional HR & OD capacity required – linked to structure discussion	Operating Model & Leadership (Work Stream 1) Aligned Governance & Decision-Making (Work Stream 3) Communications & Engagement (Work Stream 4) HR & Workforce (Work Stream 5)
Develop proposals for a long term Organisational Development programme to support the transition to group and the new operating model with a focus on: • Directorate leadership development • Executive development • Board development	Ongoing **(Full Year Trust Board and Group Executive Leadership Team) Development Programmes in place)** 31 March 2026 **(Division / Directorate Leadership Programme (The 'Leeds Way') to be embedded**	External expertise sourced as required (e.g. NHS Providers, Acqua)	
Continue to align and develop the group culture including the agreement of one set of group values	31 January 2025 **(Outputs & Recommendations from 'Better Together' Programme & engagement sessions)** 31 March 2025 **(Approval)**	Communications & engagement support	
Continue to develop the staff health & well-being offer across the group including the introduction of menopause support	31 March 2025	Communications & engagement support	

Work Stream 7: Digital
SRO: Group Chief Integration Officer

Work Stream 7: Digital

Key Tasks / Milestones	Timescales	Key Enablers	Inter-dependencies
Develop a digital strategy, infrastructure & capabilities for the group with a focus on digital transformation and new ways of working to include the following specific actions / milestones:	31 March 2025	Comms & Engagement support	Accountability, Information & Reporting (Work Stream 2) Comms & Engagement (Work Stream 4)
• undertake an exercise to map the digital systems in place across the group & develop a plan for alignment of systems where feasible to do so e.g. ESR, Datix, Intranet, Document Management System etc.	31 January 2025 **(Map)** 31 March 2025 **(Plan)**		
• move to a single Microsoft 365 teams platform with the migration of ULTH to the national tenancy	31 March 2025 **(Migration case developed. Delivery Group in place)**		
• move to a single domain / directory login process	31 March 2025 **(Plan)** 31 October 2025 **(Full Implementation)**		
• move to standardised printing & print codes – significant piece of work – workarounds to be simplified in short term	31 March 2026 **(Full Implementation)**		

Work Stream 7: Digital cont'd

Key Tasks / Milestones	Timescales	Key Enablers	Inter-dependencies
• transition LCHS from the current AGEM IT support contract to the Group Digital support system	24 January 2025 **(Finalised Plan)** 1 October 2025 **(Full Service Migration – some things may take longer)**	Comms & engagement support	Accountability, Information & Reporting (Work Stream 2) Comms & Engagement (Work Stream 4)
• create a common identity for the Digital Team (linked to the group brand & associated actions)	31 March 2025		
• develop a 'Vision for Information' for the group including a review the Business Intelligence (BI) resource across the group to ensure this remains effective in support of the group Accountability Framework and the accurate, effective and timely reporting on performance	20 December 2024 **(Draft Vision)** 31 March 2025 **(Final Vision and Structure Proposal)**		
• move to aligned telecoms	31 March 2025 **(Single telephony team)** 30 May 2025 **(Secured single contract for Telephony Services)**		
• data hosting (underway)	31 March 2025 **(Server Migration Completion)**		

Work Stream 8: Estates & Facilities

SRO: Group Director of Estates & Facilities

Work Stream 8: Estates & Facilities

Key Tasks / Milestones	Timescales	Key Enablers	Inter-dependencies
Develop the Estates Strategy in support of delivery of the agreed group strategic aims & objectives, planned service developments & transformation projects and in support of reducing health inequalities:	31 March 2025 **(commencement of work to develop the strategy)** 30 September 2025 **(strategy approval)**	External expertise & capacity required for some elements of the plan Communications & engagement support Agreement of clinical strategy required to enable the Estates Strategy to be finalised	Strategy & Planning (Work Stream 9)
• consider & evaluate the different models for the provision of EFM services across the group to include the option of a wholly owned subsidiary model and present the findings and recommendations for approval to the Group Leadership Team and Trust Board	31 March 2025		
• undertake an estates rationalisation review with a focus on decompressing the acute site and agile working and present the findings and recommendations to the Group Leadership Team and Trust Board	30 June 2025		
• continue the programme of ward refurbishments, as funding is available	Ongoing		
• undertake a review of all leases and licences across the group	30 June 2025		
• produce a visual 'map' of all services and where they sit within the group and ensure this is aligned with each trust's CQC registration / Statement of Purpose'	31 December 2024		
• deliver the agreed EFM transformation projects and EFM improvement plans	31 March 2025		

Work Stream 8: Estates & Facilities (cont'd)

Key Tasks / Milestones	Timescales	Key Enablers	Inter-dependencies
Complete the restructure of the EFM senior management team and underpinning workforce plans and associated work plans to ensure the two trusts are able to meet and, where necessary, improve compliance with statutory requirements to include the bringing together of the emergency planning and health & safety teams	31 March 2025	HR & OD support	Aligned Governance & Decision-Making (Work Stream 3)
Continue to promote equality & inclusion and reduce workforce inequalities within EFM:	Ongoing	HR & OD support	Organisational Development (Work Stream 6)
• develop a single approach to the movement of EFM staff across the group	31 March 2025		
• commission a cultural review of estates services and continue to deliver the improvement actions identified in the facilities services cultural review	31 December 2025		
• align and improve the processes for staff development, on boarding etc. across EFM	31 December 2025		
Undertake a review of and strengthen the EFM governance structure and associated assurance processes across the group and ensure that the EFM governance structure is appropriately aligned to the wider group governance structures and decision-making arrangements:	30 September 2025	HR & OD support Joint Health & Safety Committee to be established	Aligned Governance & Decision-Making (Work Stream 3)
• align the process for the completion and submission of the annual Premises Assurance Model (PAM) assessment and for delivery of the agreed improvement actions	31 July 2025		
• undertake a review of Approved Persons (APs) for the relevant HTMs and as a key element of the EFM governance & assurance processes	30 September 2025		
• review, update and align the EFM policies and procedures across the group	31 December 2025		

Work Stream 9: Strategy & Planning
SRO: Group Chief Integration Officer

Work Stream 9: Strategy & Planning

Key Tasks / Milestones	Timescales	Key Enablers	Inter-dependencies
Harmonise the strategy & planning process across the two trusts including the development of a single strategy management policy and strategy group	31 December 2024	OD support and leading people through change workshops HR support for staff consultation if change of roles	Operating Model & Leadership (Work Stream 1) Accountability, Information & Reporting (Work Stream 2) Aligned Governance & Decision-Making (Work Stream 3) Finance (Work Stream 10)
Develop a combined strategy and set of strategic aims & objectives for the group: to include the development of an integrated delivery plan* setting out the programmes and projects to be delivered in Year 1 of the Strategy against the strategic aims, and the associated measures and outcomes [**Note:** The joint Trust Board has agreed to move from 5 to 3 strategic aims – board workshop planed for early 2025 to agree the underpinning strategic aims and linked to the review and alignment of the BAF and agreement of the 'risk appetite' for the group]	31 March 2025 21 January 2025 **(Trust Board workshop)**		
Harmonise the underpinning strategies e.g. clinical, quality, people, digital etc.	30 June 2025		
Develop a single operational & financial plan for the group including the responsibilities of divisions / directorates for the delivery of the strategic aims & objectives and priorities for the group (linked to the development of the Accountability & Performance Management Framework)	31 March 2025		
Develop transformation and improvement programmes to facilitate the delivery of the strategy	31 March 2025		
Develop a common Project Management Office (PMO) approach to enable accurate reporting aligned to the new governance arrangements across the group	31 March 2025		
Develop a Group Quality Improvement strategy and commence implementation of the Quality Management System (QMS)	31 March 2025		
Develop a proposal for primary, community and acute care collaboration (Alliance Model) and a spectrum of integration	31 March 2025		
Develop a Partnership Strategy for the group	31 March 2025		
Support development of the Group Sustainability & Green Plan - Phase 1	31 March 2025		
Develop a clinical services and practitioners strategy for the group	31 August 2025		
Build and shape a new group team with OD support to fully align with required functions			

Work Stream 10: Finance
SRO: Group Chief Finance Officer

Work Stream 10: Finance

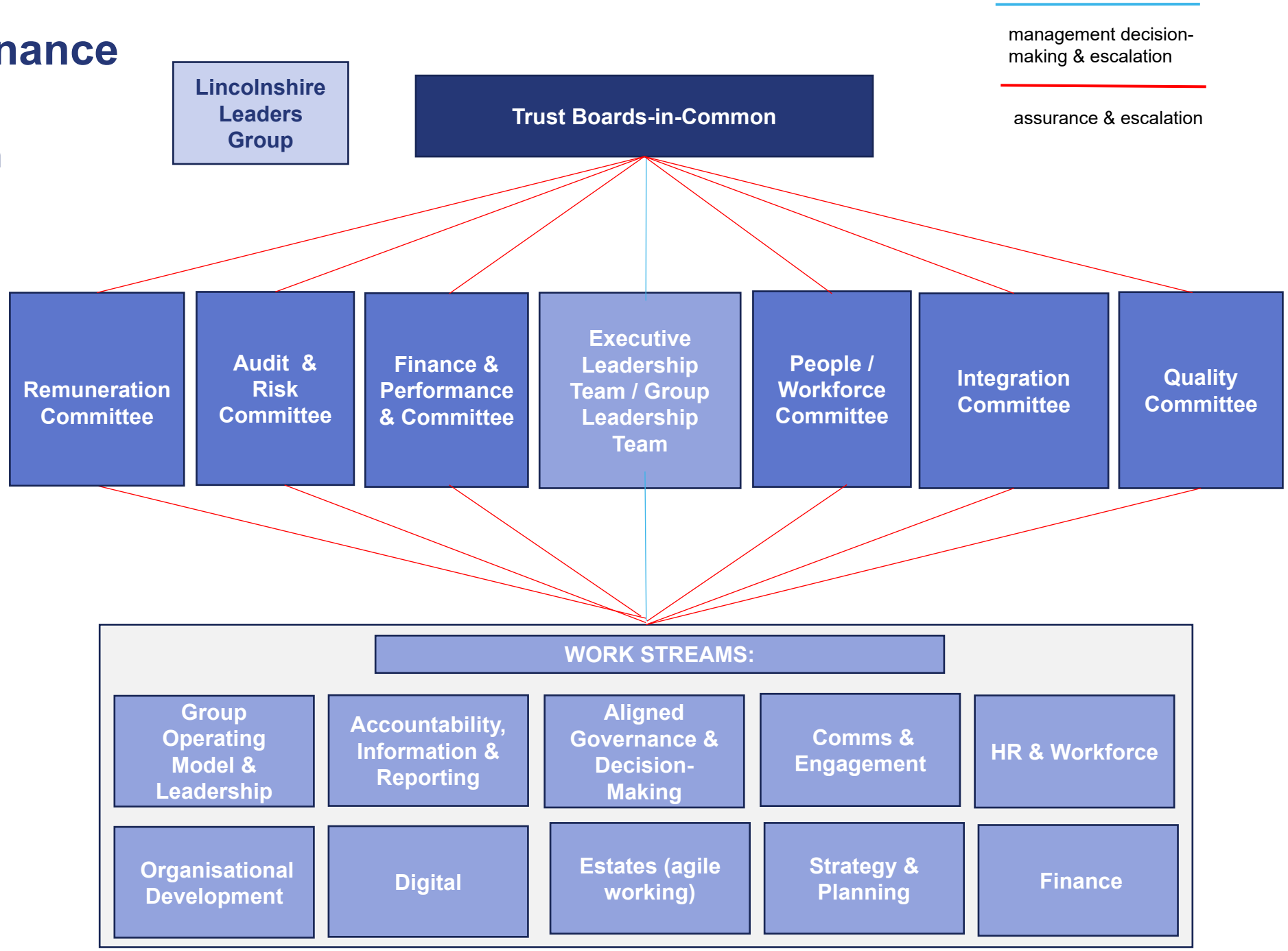
Key Tasks / Milestones	Timescales	Key Enablers	Inter-dependencies
Develop the Finance Strategy for the group in support of delivery of the agreed group strategic aims & objectives	30 June 2025	HR support Comms & engagement support	Aligned Governance & Decision-Making (Work Stream 3) Strategy & Planning (Work Stream 9)
Harmonise the financial planning & budget setting processes across the group	31 January 2025		
• produce and roll-out a revised budget holder manual	28 February 2025		
Develop a single operational & financial plan for the group including the responsibilities of divisions / directorates for the delivery of the strategic aims & objectives and priorities for the group (linked to the development of the Accountability Framework)	31 March 2025 (see also strategy slides)		
Align and strengthen financial reporting ensuring reporting from a group, individual trust and service level perspective and including the development of financial information dashboards reflecting user feedback	31 March 2025		
Harmonise the business case development, review and approval process ensuring a consistent approach and methodology	31 July 2025		
Apart of the development of the Accountability & Performance Management Framework for the group, align and strengthen the mechanisms for holding divisions / directorates to account for budgetary control, the delivery of financial plans and cost improvements	31 March 2025		
Complete the review, harmonisation and approval of key documents & governing instruments to reflect the move to group and changes to the operating model to include but not limited to: • Standing Financial Instructions • Scheme of Delegation & Powers Reserved for the Boards	31 March 2025		

Work Stream 10: Finance

Key Tasks / Milestones	Timescales	Key Enablers	Inter-dependencies
Harmonise the financial policies and processes across the group	December 2025	Governance support	Aligned Governance & Decision-Making (Work Stream 3) Strategy & Planning (Work Stream 9)
Align the Internal Audit arrangements	August 2025		
Review, harmonise and strengthen the financial training offer and culture	June 2025		

Programme Governance

- The programme will be overseen internally from a delivery and assurance perspective as shown opposite
- Reporting will, in the first instance, focus on delivery against agreed programme milestones but over time will include reporting on benefits realisation (of the move to a group model)
- External programme assurance will be undertaken by the Lincolnshire Leaders Group (LLG)



Lincolnshire Community and Hospitals NHS Group

Heart Failure: A Lincolnshire Success

‘improving quality enhances patient experience and reduces costs’

Professor Alun Roebuck FESC – Senior Consultant Nurse in Cardiology

What Is Heart Failure?

- Heart Failure is an increasingly common syndrome that accounts for approximately 4% of NHS Budget
- **Prevalence is set to double over the next decade**
  - National median LOS 9-days
  - Average total cost per admission £13,000
- Symptoms include: shortness of breath, inability to breath, reduced physical capabilities, inability to lie flat and to sleep properly. Fluid overload (swelling/ oedema) of the legs and in some cases abdomen and chest
- The syndrome may also impact on emotional and mental health
- Causes financial hardship, reduced quality of life and significantly impacts on care giver burden
- Symptoms often compared to terminal cancer
- Strong link to social deprivation (Heat Maps suggested up to x20-year difference in survival between post codes within Lincolnshire)

Can Heart Failure Be Treated?

- A 70-year old person with severe LVSD (EF<40%) and NYHA Class III symptoms (breathlessness with minimal activity) with severe LVSD who is not treated has up to an 80% mortality at x1-year
- With correct treatment the same person has up to an 80% survival at x10-years (more likely to die of frailty)
  - Drug treatment is with the 'Pillars of Heart Failure' - Beta Blockers/ MRA/ ACE/ SGLT2 *remember the 'pillars' for later…*
  - Device treatment with a Cardiac Resynchronisation Pacemaker (CRT) may help selected patients have better physical functioning and remain at home
  - Self-actualisation and cardiac rehabilitation play an important role

The Vision

- An advisory group consisting of patients, care givers, commissioners, primary care clinicians, ICB Clinical Leads, the LCHS HF Team and the Acute Cardiology Team was convened
- Alun Roebuck seconded to LCHS x1 day per week (Group working)
  - Clinically led
  - Supported via ‘Care Closer to Home Board’
  - NICOR (National Cardiac Audit Programme) findings:
  - You live longer with a better quality of life if you are under the care of a cardiologist
  - Survival and morbidity is further improved if you are under the care of a specialist team
- Investment plan written
- Service redesigned around the patient
  - Key ‘patient’ stipulation was 7/7 – if you rang 111 on a Saturday…you got admitted

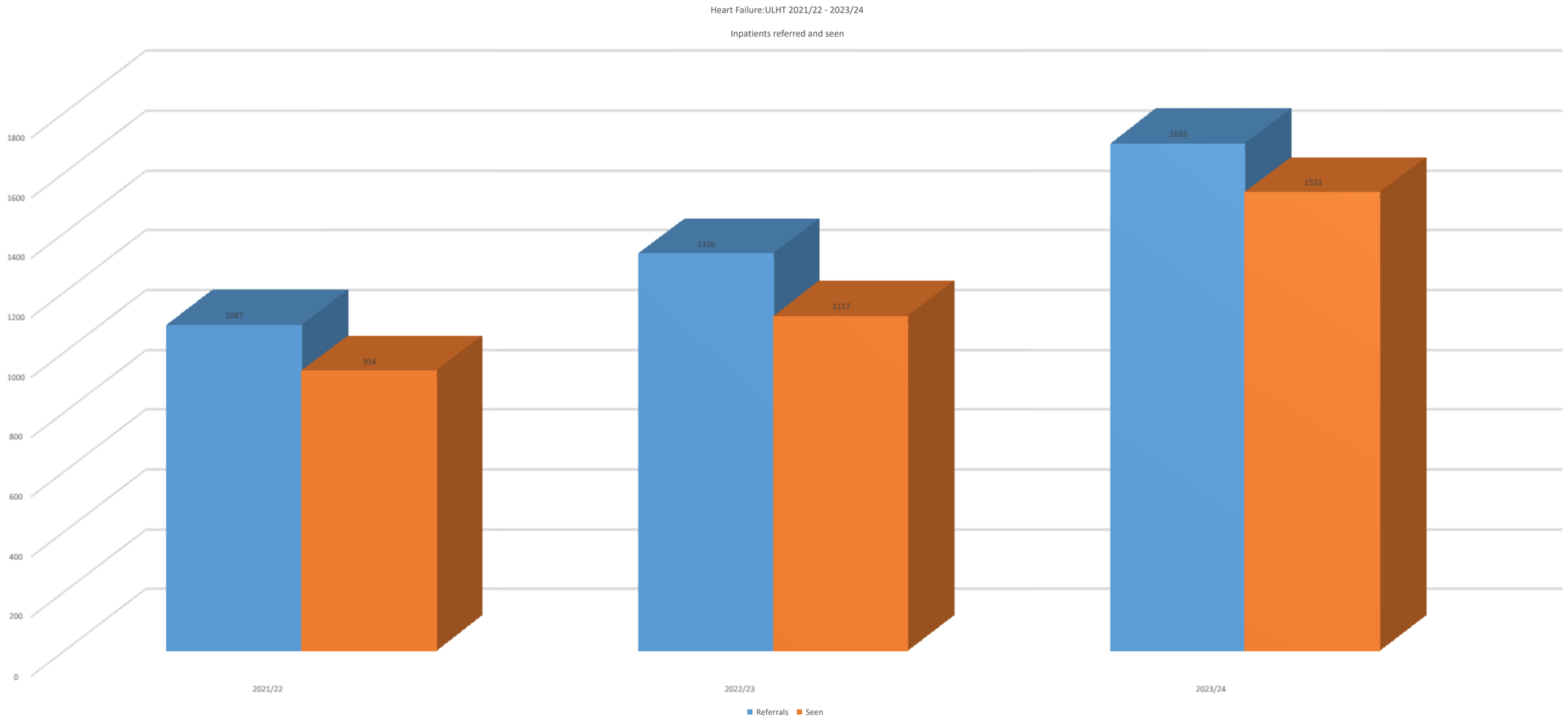
Interventions

- x7 day a week community and acute service
- x7 day a week 30-bed Heart Failure Virtual Ward (one of the first in England)
- Advanced Clinical Practitioners (ACPs) recruited and trained
- Daily (7/7) ACP-led Virtual Ward
- Heart Failure Beds introduced on CSSU with direct entry from community team (avoiding long ED waits and earlier appropriate treatment initiation)
- EMAS and LIVES pathways introduced
- x2 per week cardiologist-led Multi-Disciplinary Meetings (MDT) introduced
- In hospital specialty team review 7/7 (target <24-hours after admission)
- Consultants 'job planned' to support heart failure
- Consultant Nurse Heart Failure
- REACH Cardiac Rehabilitation introduced
- IV Drop in Clinics in SDEC (GDH/ PHB/LCH)
- BNP (a blood test for heart failure) rolled out
- Rapid Access Heart Failure Clinics (GDH/ PHB/LCH)
- Psychological Support/ advice (LPFT) via MDT
- Complex Device (CRT) service expanded
  - Second implanter recruited
  - Impedance Pre-Alert introduced
- PCN Virtual MDTs (pharmacist-led)/ practice registries searched
- STRONG (rapid initiation and up-titration of medications/ *up to a 34% reduction in MACE*)
- HF Audit Support
- Genetic screening expanded *(ICC Clinic planned)*
- Cloud based remote ECHO pilot
  - AI LV Assessment
- Domiciliary IV Furosemide (diuretic) pilot

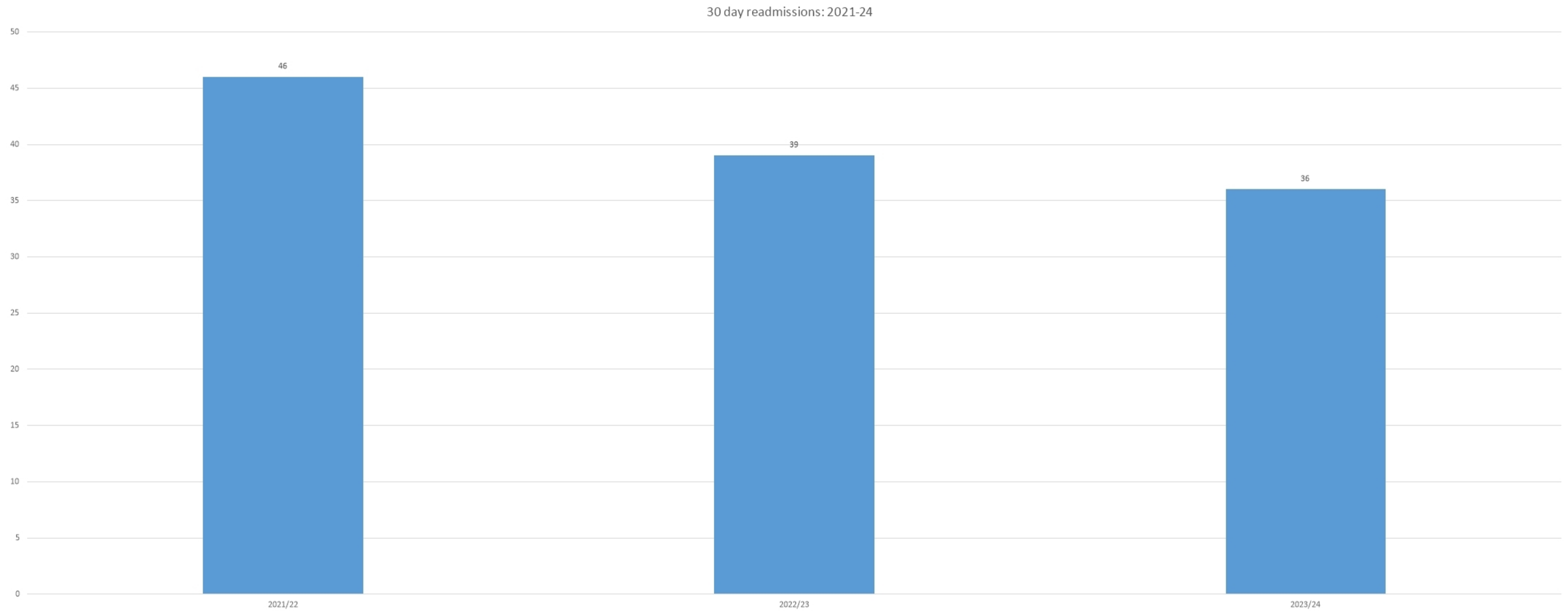
The Patients Voice (anonymised 2022)

"I was amazed I could speak to a specialist on a Saturday morning when I felt unwell"

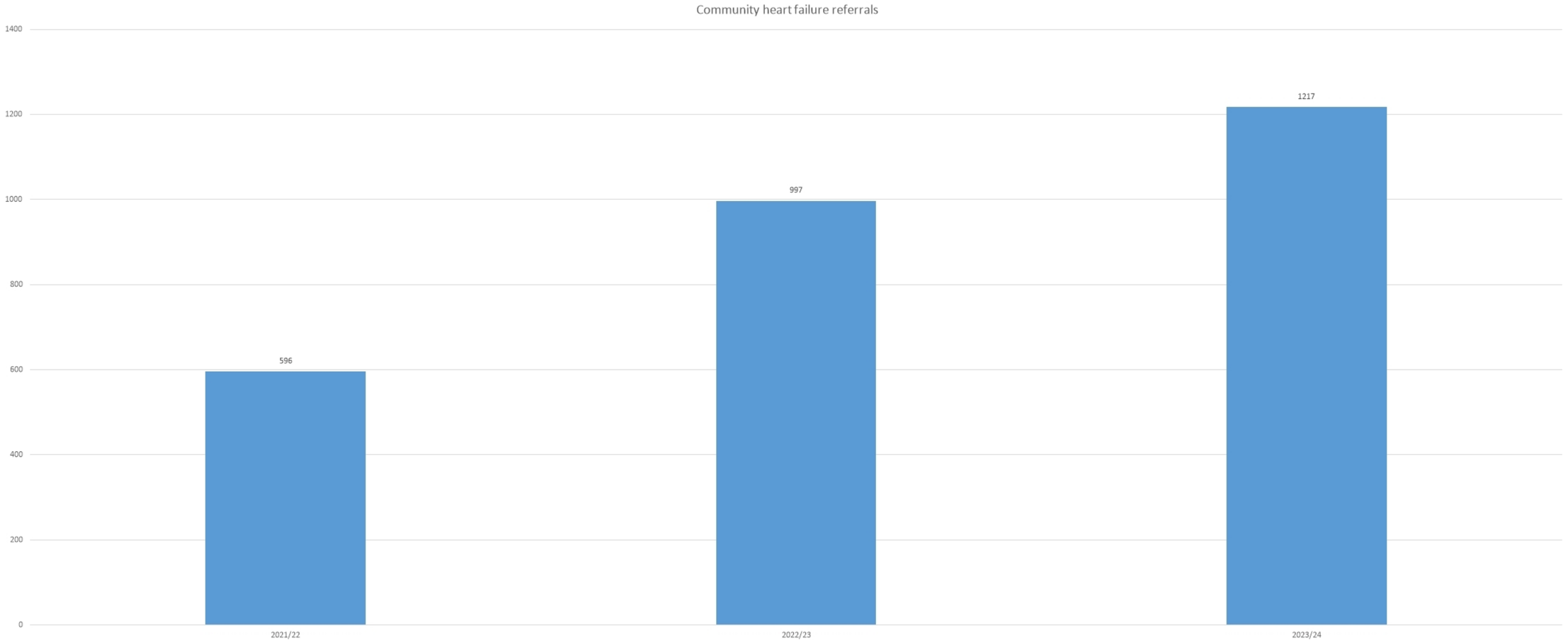
Number of IP Referrals: ULHT2021-2024



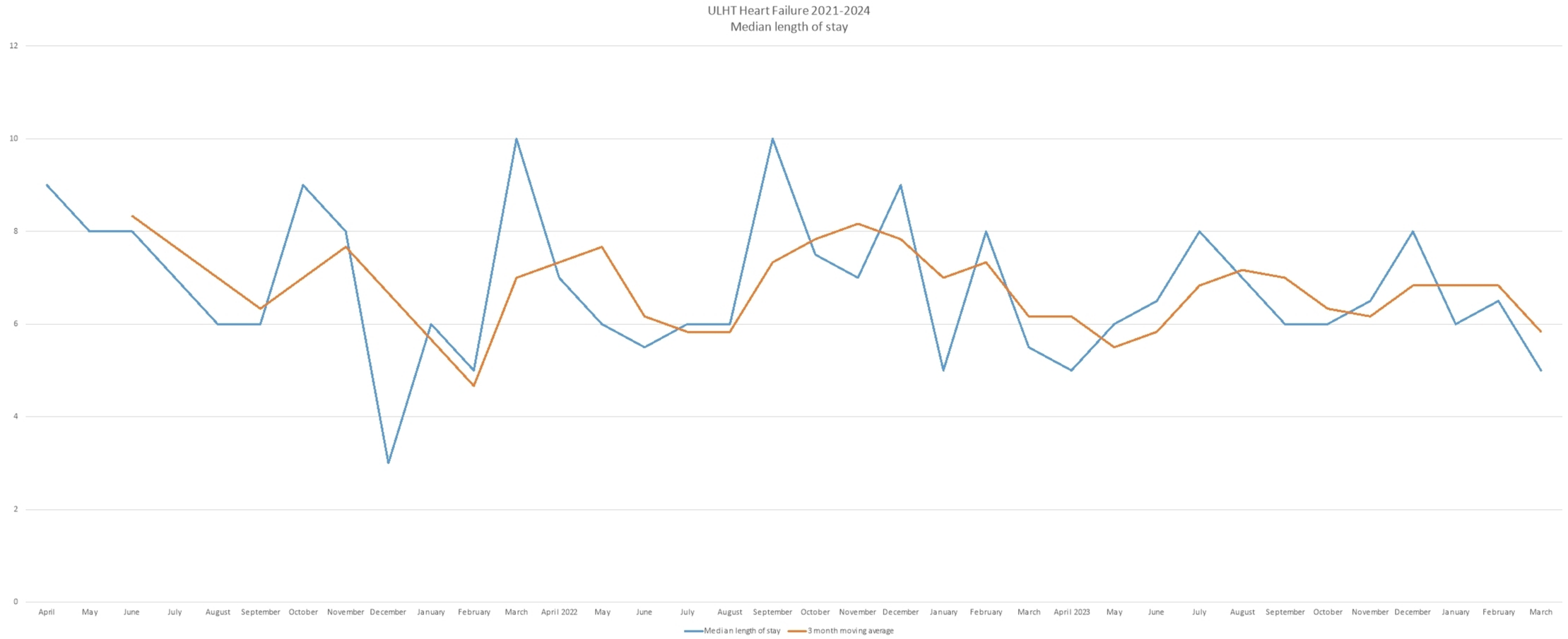
x30-Day Readmissions



Number of Community Heart Failure Referrals



Median Length of Stay



Have We Made a Difference?
Yes We Have

- 13% reduction in admissions (allowing for population growth)
- Over 1,000 bed days released per annum
- Care Closer to Home
  - High patient satisfaction (PROM/ PREM)
- £1,000,000 annual cost reduction
- Reduction of 1-1.5 bed days: *note: in-patient case mix more complicated as many patients being treated at home*
- x1000 under active intervention by the LCHS Community HF Team i.e. 'Care Closer to Home *(in this case at home)'*

NCAP
NATIONAL CARDIAC AUDIT PROGRAMME

NICOR

National Heart Failure Audit (NHFA)

2024 Summary Report

(2022/23 data)

BRITISH SOCIETY FOR HEART FAILURE

Heart failure - Report at a glance

2022/23 data unless otherwise stated.

There is a threefold difference in prescribing rates for all three outcome-improving drugs across Integrated Care Boards, Health Boards and Cardiac Networks

The maps show the prescribing rates for all three standard disease-modifying drugs across:

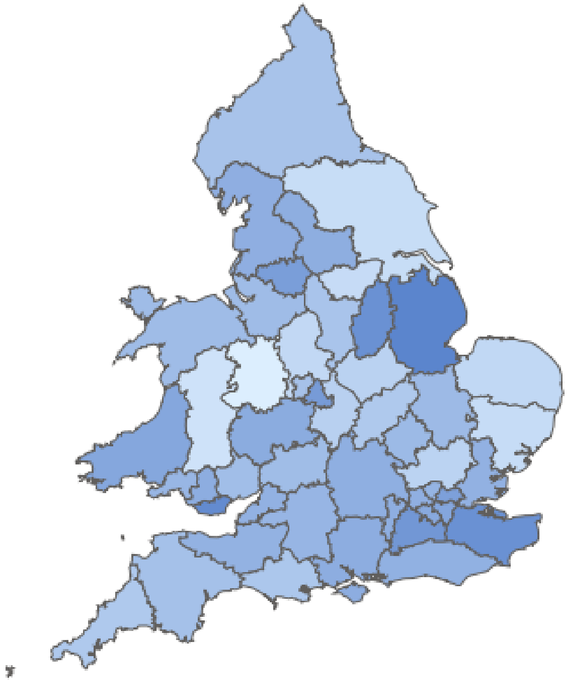
- the 42 Integrated Care Boards (ICBs) in England
- the seven University Health Boards (HBs) in Wales (commissioning organisations)
- the 16 Cardiac Networks (operational delivery networks)

Variation is seen in the prescription of all three standard outcome-improving drugs (ACEi/ARB/ARNI + BB + MRA) in patients with HFrEF. The darker the area the higher the prescribing levels.

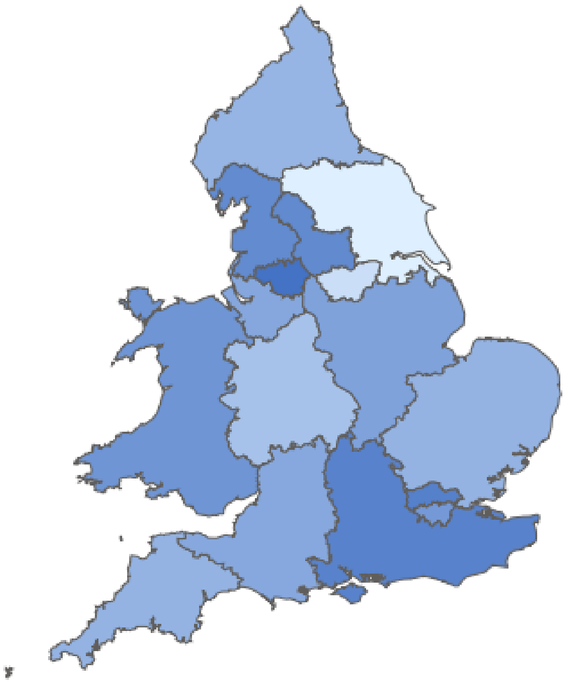
For ICBs and HBs, the lowest rate was 29% in Shropshire, Telford and Wrekin and the highest was 89% in Lincolnshire.

For the CNs, the lowest rate was 35% in Humber and North Yorkshire and the highest was 74% in Greater Manchester.

ACEI/ARB/ARNI + BB + MRA prescribing rates at discharge based on patient home location by ICB/HB (2022/23)



ACEI/ARB/ARNI + BB + MRA prescribing rates at discharge based on hospital location by Cardiac Network (2022/23)



Note: the ‘pillars’ of heart failure discussed earlier

List of drug names

NICOR

→ Contents page

Our Success Has Been Shared With

- The National Heart Tsar (Dr Simon Rae)
- NHSE National Workforce Team
- The European Society of Cardiology
- British Association of Cardiovascular Care (BANCC)
- British Association of Cardiovascular Prevention and Rehabilitation
- British Cardiovascular Society
- Shorted listed for x2 national awards
  - Price of Wales Award for Service Integration
  - Nursing Times ‘Team of the Year Award’
- The National Getting It Right First Time (GIRFT) Team
  - We have supported several other Trusts with their service improvements

Thank You For Listening

(where next?)

alun.roebuck@ulh.nhs.uk

NHS
Lincolnshire Community and Hospitals NHS Group

Quality Committee Upward Report

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Teaching Hospitals NHS Trust

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*7 January 2025*
Item Number	*8.1*

Quality Committee Upward Report of the meeting held on 19 November 2024

Accountable Director	*Nerea Odongo, Group Chief Nursing Officer*
Presented by	*Jim Connolly, Quality Committee Chair*
Author(s)	*Karen Willey, Deputy Trust Secretary, ULTH*
Recommendations/ Decision Required	*The Board is asked to:-* • *Note the discussions and assurance received by the Quality Committee*

Purpose

This report summarises the assurances received, and key decisions made by the Quality Committee. 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 Teaching Hospitals NHS Trust (ULTH). The Committee worked to the 2024/25 objectives for the Lincolnshire Community and Hospitals NHS Group (LCHG) and was attended by both ULTH 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

The Committee received the following reports under objective 1a **with assurance** noting there were **no escalations** from the Committee to the Board:

- Patient Safety Group Upward Report
- High Profile Cases Report
- NHS Publication Principles for Providing Safe and Good Quality Care in Temporary Escalation Spaces (TES) and Ambulance to Hospital Professional Standards of Care - Focused Discussion

The Committee was pleased to note the feedback from the Healthcare Safety Investigation Board (HSIB) in respect of the ULTH being the leading organisation in

the country in respect of the work undertaken to implement the requirements of the Patient Safety Strategy.

The Committee noted the implementation date of December in respect of Call 4 Concern and noted further national guidance was awaited in respect of reporting expectations.

C-difficile rates were noted as having increased nationally however the Committee was pleased to note that ULTH remained within trajectory with 54 cases recorded year to date against a trajectory of 95.

The Committee held a focused discussion in respect of the NHSE Publication Principles for Providing Safe and Good Quality Care in Temporary Escalation Spaces (TES) and Ambulance to Hospital Professional Standards of Care. The initiatives implemented to improve ambulance offloading and ED efficiency were noted including the provision of additional care for those patients who could not be offloaded in a timely manner.

Temporary escalation spaces were noted as having been introduced to alleviate ED pressures with spaces continually reviewed to ensure they were appropriate and safe with the removal of spaces deemed unsuitable as a result of continual review.

Assurance in respect of Objective 1b – Improve patient experience

The Committee received the following reports under objective 1b **with assurance** noting there were **no escalations** from the Committee to the Board:

- Patient Experience and Involvement Group Upward Report
- Safeguarding and Vulnerabilities Oversight Group Upward Report including Children in Care Update

The Committee noted that data in respect of patient experience was now joined up across the Group, allowing LCHS to access and triangulate data, mirroring the ULTH process. The dashboard would continue to be developed to ensure narrative supported the data presented.

Common theme of communication was noted in respect of complaints and concerns being raised with action to review the communication training portfolio and associated uptake.

The Committee noted the ongoing concerns regarding training attendance in respect of safeguarding with a number of cancellations associated with DMI training.

Slow progress was noted in respect of children in care and whilst a paediatric doctor appointment had been made the start date had been delayed due to process. It was recognised that this risk was held on the risk register and escalation had been made through the System Quality Meeting.

Assurance in respect of Objective 1c – Improve clinical outcomes

The Committee received the following reports under objective 1c **with assurance** noting there were **no escalations** from the Committee to the Board:

- Clinical Effectiveness Group (CEG) Upward Report

The Committee noted the low Hospital Standardised Mortality Ratio (HSMR) along with a low crude death rate and the Summary Hospital Mortality Indicator (SHMI) was also reported as within the expected range. Work continued in respect of the appropriate reporting for the indicator.

Assurance in respect of other areas

The Committee received the following reports **with assurance** in respect of other areas:

- Group Board Assurance Framework 2024/25
- Outcome of the Six-month review of the Quality Committee
- CQC Unannounced Assessment update
- Human Tissue Authority Visit
- Policy Position Update
- ULTH, NHSE and ICB Infection Prevention and Control Visit – 26 September 2024
- Topical, Legal and Regulatory Update
- Committee Performance Dashboard – ULTH/LCHS
- Operational Plan Report – LCHS (due January 2025) and Integrated Improvement Plan - ULTH
- Quality Impact Assessment Assurance Report – LCHS and ULTH
- Terms of Reference and Work Programme

The Committee received the report in respect of the outcome of the six-month review of the Committee noting the significant progress that had been made to development the Quality Committee. The key findings from the review and recommendations were noted with the Committee recognising the change to reporting of the Safeguarding and Vulnerabilities Oversight Group directly to the Committee.

A further review would be conducted after 1-year of the Committee being held to allow time for the reporting groups to strengthen both reporting and assurance processes.

A verbal update on the recent CQC unannounced assessment at ULTH noting that further evidence had been submitted by the Trust and staff forums had been undertaken. The formal report was awaited.

The Committee received a verbal update on the recent visit from the Human Tissue Authority (HTA) with very positive feedback offered to ULTH with only a small number of areas for improvement identified. The formal report was awaited.

The Committee received the Infection Prevention and Control (IPC) NHS England letter following the unannounced visit on the 26 September noting that ULTH remains in enhanced IPC monitoring. Actions remained in place to address shortfalls.

During the meeting the Committee considered 2024/25 draft Group Board Assurance Framework (BAF) RAG ratings of the objectives where assurance reports had been received and noted that there were no changes to these in month.

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	X	A	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						
Colin Farquharson Medical Director, ULHT	X	X	X	X	X	X	X	X	X	X	D	
Rebecca Brown, Non-Executive Director (Maternity Safety Champion), ULHT/LCHS	X	X	X	X	X	X	X	X	X	X	A	
Gail Shadlock, Non-Executive Director, LCHS	X	X	X	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, LCHS	X	X	A	X	A	X	X					
Nerea Odongo, Group Chief Nurse							X	X	X	D	X	
Caroline Landon, Group Chief Operating Officer								X	X	X	X	
Daren Fradgley, Group Chief Integration Officer								X	X	X	D	

X in attendance
A apologies given
D deputy attended

NHS
Lincolnshire Community and Hospitals NHS Group

Quality Committee Upward Report

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Teaching Hospitals NHS Trust

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*7 January 2025*
Item Number	*8.1*

Quality Committee Upward Report of the meeting held on 17 December 2024

Accountable Director	*Nerea Odongo, Group Chief Nursing Officer*
Presented by	*Jim Connolly, Quality Committee Chair*
Author(s)	*Karen Willey, Deputy Trust Secretary, ULTH*
Recommendations/ Decision Required	*The Board is asked to:-* • *Note the discussions and assurance received by the Quality Committee*

Purpose

This report summarises the assurances received, and key decisions made by the Quality Committee. 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 Teaching Hospitals NHS Trust (ULTH). The Committee worked to the 2024/25 objectives for the Lincolnshire Community and Hospitals NHS Group (LCHG) and was attended by both ULTH 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

The Committee received the following reports under objective 1a **with assurance** noting there were **no escalations** from the Committee to the Board:

- Patient Safety Group (PSG) Upward Report – to include gap analysis from Patient Safety Rights Charter
- High Profile Cases Report
- Maternity and Neonatal Oversight Group Upward Report
- LCHG DHU Contract Changes
- AHP Staffing Gaps and Quality Impact – Focussed discussion

The Committee noted the Infection Prevention and Control (IPC) trajectories remained positive, as reported through the PSG upward report, however ongoing

risks were noted in respect of water safety which was being managed through the IPC Group and Estates and Facilities.

The Committee received the Maternity and Neonatal Oversight Group Upward Report and associated appendices required in respect of the Clinical Negligence Scheme for Trusts (CNST) Maternity. The full update is attached for the Board at appendix 1 with the appendices available to all Board members within the iBabs reading room.

Changes in respect of the DHU contract were noted with the Committee discussing the number of incidents which has been managed by the Group, relating to 111 and the current provider. Clear actions and mitigations are in place with the Committee requesting that the ICB works with the Group to evaluate potential harm related to the example cases provided.

The focused discussion on AHP staff gaps and quality impact was received with assurance with long waits recognised in some therapy services within the community. The Committee noted that this was captured on the risk register and a number of discussions had previously been held.

The Quality Committee noted that the recruitment, retention and talent management of AHPs would be for the consideration of the People Committee with the Quality Committee continuing to monitor and quality associated risks.

Assurance in respect of Objective 1b – Improve patient experience

The Committee received the following reports under objective 1a **with assurance** noting there were **no escalations** from the Committee to the Board:

- Patient Experience and Involvement Group Upward Report
- Children in Care Update
- Update on Children's Cardiology

The Committee received the children in care update noting disappointment in performance with challenges remaining. Whilst it was positive to note the recruitment of a whole-time equivalent doctor it was recognised that the post holder would not commence until January 2025.

A verbal update was received in respect of children's cardiology with clear actions in progress however a detailed report was requested to be presented to the meeting in January to ensure this provided assurance.

Assurance in respect of Objective 1c – Improve clinical outcomes

The Committee received the following reports under objective 1a **with assurance** noting there were **no escalations** from the Committee to the Board:

- Clinical Effectiveness Group – Chairs Report

The Committee noted the recent Human Tissue Authority visit which had taken place and noted that the formal report was awaited and would be presented back to a future meeting. An action plan would also be presented to the Committee.

Due to the ongoing actions associated with HR and estates from the HTA visit and Fuller reports updates would be formally offered to the People and Finance Committees for oversight.

Assurance in respect of other areas

The Committee received the following reports **with assurance** in respect of other areas:

- Group Board Assurance Framework 2024/25
- Risk Report
- Policy Position Update
- CQC Unannounced Assessment – Pilgrim Hospital Boston
- Committee Performance Dashboard
- Integrated Improvement Plan – for information
- Terms of Reference and Work Programme

Disappointment was noted in respect of the progress related to policy documents, whilst this had not deteriorated there had been no positive progress with the Committee continuing to maintain oversight on a monthly basis.

The Committee noted the update in respect of the CQC Unannounced Assessment to Pilgrim Hospital to review flow and discharge pathways. Positive feedback was offered in respect of staff attitude and boarding processes with assurance offered to the CQC on risk processes. The formal report was awaited.

During the meeting the Committee considered 2024/25 draft Group Board Assurance Framework (BAF) RAG ratings of the objectives where assurance reports had been received and noted that there were no changes to these in month.

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	X	A	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						
Colin Farquharson Medical Director, ULHT	X	X	X	X	X	X	X	X	X	X	D	A
Rebecca Brown, Non-Executive Director (Maternity Safety Champion), ULHT/LCHS	X	X	X	X	X	X	X	X	X	X	A	X
Gail Shadlock, Non-Executive Director, LCHS	X	X	X	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, LCHS	X	X	A	X	A	X	X					
Nerea Odongo, Group Chief Nurse							X	X	X	D	X	X
Caroline Landon, Group Chief Operating Officer								X	X	X	X	A
Daren Fradgley, Group Chief Integration Officer								X	X	X	D	A

X in attendance
A apologies given
D deputy attended

Appendix 1 – Maternity and Neonatal Oversight Group Upward Report CNST requirements

The Quality Committee:

- Noted the upward report
- CQC Benchmarking Report – Organisational support will be needed as to how women are included in the conversations around incidents they are involved in.
- Bereavement facilities and the need for Charitable Committee to act quickly.
- Note the ongoing discussions around the Perinatal Dashboard and how it can be used to support MNOG.

Recognising the CNST guidance for Trust Board reporting/evidence, the group request that Quality Committee formally approve and upwardly report and request specific reference in the Trust Board minutes of the following updates. **See Appendix 1**:

- CNST Standard 1- PMRT: Trust Board should note receipt of the quarterly PMRT report **See Appendix 13 & 13.1** including details of the deaths reviewed from 8 December 2023, any themes identified and the consequent action plans.

- CNST Standard 4- Clinical workforce: **See Appendix 1**
  Long-term locums: Trust Board should note compliance with implementation of the RCOG guidance on engagement of long-term locums.
  Consultant attendance: Trust Board should note compliance with the RCOG workforce document 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology.'
  Short-term locums: Trust Board should note that NHS Resolutions have advised a submission of non-compliance with an accompanying evidence review
- *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 Quality Committee and Trust Board should note the progress made in respect of the previous action plan **See Appendix 9 & 9.1**

- CNST Standard 5- Midwifery workforce: Trust Board should formally record in Trust Board Minutes receipt of the bi-annual midwifery staffing report and progress with the agreed action plan for achieving the appropriate uplift in funded establishment **See Appendix 11**

- CNST Standard 6- Saving Babies Lives: Trust Board should note the progress made towards Saving Babies Lives Care Bundle **See Appendix 1.0**

- CNST Standard 9- Floor to board: For the Boards assurance and for formal recording in Trust Board minutes, during the reporting period for MIS Year 6 the Board Safety Champions have met with the perinatal leadership team/perinatal quad leadership team, in line with the CNST recommendations of bi-monthly through the Maternity and Neonatal Oversight Group meeting.

- CNST Standard 9- Floor to board: The Board are asked to formally record in Trust Board minutes the progress with the maternity and neonatal culture improvement plan including the introduction of the Staff Experience Group, and that progress will be monitored through MNOG. **See Appendix 1**

- CNST Standard 10- MNSI/EN: Trust Board should note sight of maternity clinical governance records of qualifying MNSI/EN incidents and numbers reported to MNSI and NHS Resolution including evidence that families have received information on the role of MNSI/EN. In addition, please note compliance with statutory duty of candour for the above cases. **See Appendix 10**

Clinical Negligence Scheme for Trusts
Maternity Incentive Scheme Year 6
November 2024

Safety Action	Anticipated compliance	Comments
1 PMRT	On track to achieve	Standard 1.3: 1 x missed deadline- however compliance remains 95% Last date in reporting period 30th November- anticipating full compliance with all standards in action 100% for Q2, 1 x missed start of review in Q3- will be reflected in q3 report. Compliance remains on track within CNST standards.
2 MSDS	Achieved	Action now complete- evidence filed
3 TC	On track to achieve	On track-no concerns **QI project:** To reduce the number of babies that are separated from their mothers simply for cannulation and administration of IV antibiotics, a registered QI project is underway to train midwives to become second-checkers for IV antibiotics. Outstanding actions for this project include staff training, educational workbook and formal launch which is anticipated in February 2025. Progress on this project will be reported through the ATAIN quarterly report which remains a standing agenda item on the MNOG Work Programme.
4 Clinical workforce	Awaiting decision on submission	All audits now complete On-going discussion re short-term locum **Agenda item 7.8:** **Long-term locums:** following a 6 month audit- the Trust employed five long-term locums. All long term locums were engaged as per RCOG guidance with evidence of completed checklists available for review. Findings of the audit have been shared at Obstetrics and Gynaecology Governance and an updated version of the checklist circulated to consultants responsible for recruiting and on-boarding long-term locums. **Compensatory rest:** Although not reportable in MIS Year 6, progress has been made on the action plan to address the shortfall in compliance relating to implementation of RCOG guidance on compensatory rest with recruitment of additional consultants on each site. Action plan available for review. **Consultant attendance:** Following a 6 month audit- the Trust are over 90% compliant with consultant attendance for clinical situations listed in the RCOG workforce document. The audit is due to be presented at the audit meeting to share learning to further improve compliance. Individual learning has already occurred.
5 Midwifery workforce	On track to achieve	On track-no concerns
6 SBLv3.1	On track to achieve	On track- no concerns **Signed-declaration:** MIS year 6 requires that 'trusts should be able to provide a signed declaration from the Executive Medical Director declaring that Saving Babies' Lives Care Bundle, Version 3 will be in place as agreed with the ICB.' NHSR have confirmed that there is no template for the signed-declaration and Trusts can decide on how assurance is presented.

		Therefore, use of the implementation tool evidencing progress and regular meetings with the ICB and subsequent Assurance included in the bi-monthly assurance report and upward reporting to QGC since the release of SBLv3.
7 MNVP	On track to achieve	On track- no concerns Progress on co-produced action plan shared with safety champions
8 Training	At risk of non-compliance	We are really pleased to share that we have achieved over 90% compliance for all staff groups in the following training requirements (EFM, PROMPT and NLS). Owing to reporting deadlines, the training stats within this report do not reflect the final compliance as the reporting period ends on the 30th November, however there is no concern that compliance will change before then.
9 Floor to Board	On track to achieve	On track- no concerns The NHS England Perinatal Culture and Leadership Programme (PCLP) aims to improve the quality of care by enabling leaders to drive change with a better understanding of the relationship between leadership, safety improvement and safety culture. To date we have worked through the first two phases which included dedicated time for the Quad to work and learn together and the SCORE survey. Regular updates in relation to the SCORE survey have been provided bi-monthly through the MNOG assurance report 'listening to our staff' section. We are excited to present the third phase of the PCLP which we have named the staff experience group. The aim is to create and craft the conditions for a positive culture of safety and continuous improvement, enabling a more psychologically safe, collaborative, and supportive workplace. This will be done through selection of themes from the SCORE survey that are not already being addressed eg environment, IT systems. The staff experience group will be a platform for the staff voice, increase self-reported feeling of being respected and valued, offer signposting for further support, springboard for quality improvements and create conditions for teams to thrive This will be done through staff forums with monitoring through the staff experience action plan with upward reporting to QGC and Trust Board where required. Next steps include: agreement of initial themes, create initial action plan, co-produce terms of reference with staff and agree launch date. We are working with the Freedom to Speak up Guardian and hope that this proves may be useful to other divisions in the future.
10 MNSI	On track to achieve	On track- no concerns During the reporting period (8th December 2023- 30th November 2024) the accumulative patient event numbers are as follows: There have now been 6 cases eligible for MNSI referral and 4 of those required Early notification. Only 5 are included within this report as the 6th occurred 11th November and will be included in January's report. 100% of the eligible cases had duty of candour completed both verbally and in writing and in each case the families received the relevant information about MNSI/ EN. Any eligible MNSI and EN cases that occur within the rest of the MIS reporting period (up to 30th November 2024) will be included in the next assurance and learning lessons report and upwardly reported to QGC.

People Committee Upward Report

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Hospitals NHS Trust

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*7 January 2025*
Item Number	*9.1*

People Committee Upward Report of the meeting held on 12 November 2024

Accountable Director	*Claire Low, Group Chief People Officer*
Presented by	*Professor Philip Baker, People Committee Chair*
Author(s)	*Karen Willey, Deputy Trust Secretary, ULTH*
Recommendations/ Decision Required	*The Board is asked to:-* • *Note the discussions and assurance received by the People Committee*

Purpose

This report summarises the assurances received, and key decisions made by the People 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 Teaching NHS Trust (ULTH). The Committee worked to the 2024/25 objectives for the Lincolnshire Community and Hospitals NHS Group (LCHG) and was attended by both ULTH and LCHS colleagues.

Upward Report

Assurance in respect of Objective 2a – Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise

LCHG Workforce Strategy Group Upward Report and Committee Performance Dashboard – LCHS and ULTH

The Committee received the reports with **assurance** noting that the first Group meeting had been held with good representation from both LCHS and ULTH with the report reflecting the significant agenda discussed.

The Committee noted the scorecard and the performance reported through these noting the ongoing development of a proposed Group dashboard to ensure this presented a clear view of performance across the Group.

International recruitment was considered with reassurance offered that there would be a reduction in international recruitment work to ensure the future provision of vacancies for university graduates.

The Committee noted the intention to implement best practice across the Group with differences in performance data noted. Confirmation was offered that sickness would be a key priority in quarter 3 of the year with a new sickness absence policy being aligned across the Group.

Safer Staffing Nursing and AHP
The Committee received the report with **assurance** noting that community nursing had seen a 10% increase in deferred visits and an increase in activity within Urgent Treatment Centres impacting on nursing spend.

The Committee was pleased to note the achievement for LCHS Allied Health Professionals (AHPs) being the first in the country to have training for Advanced Occupational Therapy and Physiotherapy Practitioners. This would support the teaching status in Lincolnshire.

An increase in agency use was noted due to the Community Diagnostic Centres (CDCs); recruitment activity was taking place to address this.

Safer Staffing Medical
The Committee received the report with **assurance** noting the continued development of the report and the improving position of a 8.1% turnover rate against a target of 12%.

High bank and agency spend continued to be reported with the Committee noting that this was preferable than utilising the Extra Contractual Rates (ECR) at a higher cost. Active negotiations had commenced in respect of ECRs with the British Medical Association (BMA).

The Committee requested that the paper continue to develop, ensuring this provide a Group position rather than the ULTH focus.

Group Harmonisation Report – for information
The Committee received the report with **assurance** and recognised the developments taking place across the Group.

Vacancy Control Update – ULTH
The Committee received a verbal update on the vacancy control position noting that this had not delivered the anticipated cost savings. As a result, further discussions were being held by the Executive Leadership Team.

Estates and Facilities Update paper – Staff survey, vacancies and absence – ULTH
The Committee received the report with **assurance,** noting that vacancies remained outside of target and agency use was in a positive position at 1%. There had also been a notable reduction during September in respect of bank usage with ongoing work to identify sickness trends within the workforce group.

The Committee noted the action plan in place to support further improvement within the directorate and requested that this be updated to ensure actions were SMART, with a request for a further update to be provided in March 2025 to monitor ongoing improvements.

Medical Engagement Development Plan – ULTH
The Committee received the report with **limited assurance** noting the draft plan which had been presented. It was recognised that there were difficulties in respect of engagement, however support was in place for managers to increase engagement.

Despite the challenges the Committee noted that progress was being made. Further consideration would also be given to ensure consistency across the Group, recognising there was a difference in the medical workforce across the two organisations.

Assurance in respect of Objective 2b – To be the employer of choice

Guardian of Safe Working Quarterly Report – ULTH
The Committee received the report with **assurance** noting the significant work that had been undertake regarding Locally Employed Doctors and the allocation of Clinical Supervisors to provide additional support. The Committee was pleased to note the positive response to this development.

GMC Junior Doctor Survey Action Plan – ULTH
The Committee received the report with **assurance.** The Committee noted that this currently offered a level of moderate assurance, however, given the challenges being faced, the Committee noted that limited assurance was more reflective of the current position.

The Committee noted the actions presented and recognised the work being undertaken to ensure training provision, culture change, patient safety concerns and infrastructure issues were addressed.

SIFT monies were noted as an issue in respect of the awareness and allocation, however, it was noted that, despite money being available, some roles were challenging to backfill. The Committee noted that there could be benefit from the consideration of the non-medical workforce assisting with appropriate teaching to improve the position.

Assurance in respect of Objective 4c – Grow our research and innovation through education, learning and training

Research, Development and Innovation and University Teaching Hospital Update – ULTH
The Committee received the report with **assurance** noting the work to develop a dashboard, included within the report to demonstrate further project updates. The Committee requested that this be expanded to include non-patient recruitment to clinical trials. Discussions were also being held with the library team to achieve a collaborative approach and provide support to new researchers and investigators.

The Committee noted the future work to be undertaken to develop the Research and Innovation Culture within the Trust and to identify operational delivery plans to support this.

Assurance in respect of other areas

Interim ToR and Work Programme
The Committee received the interim terms of reference and work programme for the Committee noting these reflected the 2024/25 LCHG Strategic Aims and Objectives.

Group Board Assurance Framework 2024/25
The Committee received the 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.

Following consideration of the ratings the Committee confirmed that there were no changes to the objective ratings in month.

Integrated Improvement Plan – for information – ULTH
The Committee received the report with **assurance** for information noting the 3% increase of compliance in project improvement compared to the previous month.

Risk Report
The Committee received the joint report with **assurance** noting the dynamic nature of the risk register with 5 very high risks noted.

The Committee noted the movement of risks over the month and noted there were no escalations to consider.

Policy Position Update
The Committee received the report with **assurance** noting the position presented and the ongoing work to review and update policies across the Group.

It was noted that 18 policies for ULTH were overdue however a number of these were being reviewed with a view to develop these as Group policies. The target completion date for the majority of overdue documents was quarter 4 of the 24/25 year.

Internal Audit Recommendations
The Committee received the report, noting the outstanding actions with a scheduled review due to take place within the People Directorate to update or close open actions.

Band 2 and Band 3 Verbal Update
The Committee received the verbal update with **assurance** noting the completion of the work within ULTH to move staff from Band 2 to Band 3 in line with national process.

The Committee noted the support in place for staff with a number of staff choosing to opt-out of the process. It was recognised that the final position, including the financial analysis, would be presented to the Committee in January.

Work had commenced with LCHS staff side to commence engagement sessions and support the process.

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
Phil Baker, Non-Executive Director, ULTH (Chair)										X	X	
Gail Shadlock, Non-Executive Director, LCHS										X	A	
Claire Low, Group Chief People Officer										X	D	
Colin Farquharson Group Chief Medical Officer										D	X	
Nerea Odongo, Group Chief Nurse										X	X	

X in attendance
A apologies given
D deputy attended

People Committee Upward Report

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Hospitals NHS Trust

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*7th January 2025*
Item Number	*9.1*

People Committee Upward Report of the meeting held on 20 December 2024

Accountable Director	*Claire Low, Group Chief People Officer*
Presented by	*Professor Philip Baker, Non-Executive Director (ULTH)*
Author(s)	*Jayne Warner, Group Director of Corporate Affairs*
Recommendations/ Decision Required	*The Board is asked to:-* • *Note the discussions and assurance received by the People Committee*

Purpose

This report summarises the assurances received, and key decisions made by the People Committee. 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 Teaching Hospitals NHS Trust (ULTH). The Committee worked to the 2024/25 objectives for the Lincolnshire Community and Hospitals NHS Group (LCHG) and was attended by both ULTH and LCHS colleagues.

Upward Report

Assurance in respect of Objective 2a – Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise

LCHG Workforce Strategy Group Upward Report and Committee Performance Dashboard – LCHS and ULTH

The Committee received the reports and the dashboard which had been developed to mirror both organisations.

The Committee recognised that this was the most mature reporting group in terms of assurance.

The Medical workforce CIP programme was reported as above target at end of Oct. The Medical Director commented that the CIP may increase as part of realignment if this happens there is a likelihood that the revised stretch target will not be met (not through deterioration of the actions but through the stretch of the target).

The Committee noted the additional governance being put in place in respect of bank and agency usage.

The Committee noted that sickness rates had seen a spike in LCHS not seen at ULTH. This would be an area of focus for the workforce strategy group going forward.

Committee members were able to confirm that assurances in relation to AHP's and the gaps and actions triangulates with what was seen at the Quality Committee.

The Committee noted that appraisal completion looked as if it was levelling off. The Committee were advised that this is probably linked to winter and this has created an issue with winter pressures. The Committee sought assurance going forward on the quality of the appraisals being completed.

The Committee asked for assurance that the Group was not facing a developing risk in respect of HCSW. The Committee received assurance that good progress had been made with the rebanding. Adverts were out and this should support vacancies. Strong pipeline. It was anticipated that the posts would be more attractive with change of banding.

The Committee recognised that there were some early indicators being seen in relation to culture across the Group and asked for assurance on how these were being responded to.

The Committee were advised that the OD programme on preparing for change and supporting the journey of Group had now been launched. The Committee would be able to consider the results from the national survey feeding in as well as the local wellbeing survey. A deep dive was planned in early spring.

Safer Staffing Nursing and AHP
The Committee received the joint report with **assurance**

The Group continue to manage bank and agency usage. Proactively working to attract talent across the patch.

The Committee noted that the Group were still seeing red flags from pressure ulcers in community nursing.

The Group Chief Nurse advised that the Group had introduced Safe Care in our community hospitals. This would allow the Group to do one picture staffing review at end of year across whole Group.

The Committee were advised that ULTH had seen a decrease in nursing posts and occupational therapy posts.

Community were still seeing a risk in speech and language therapies. High vacancies and this was a 'hard to recruit to' area.

The Committee were advised that AHPs had been attending student events in Universities to support recruitment.

Midwifery remained in a good position with recruitment and vacancy gaps closing.

Overall the Committee were advise that the report showed limited assurance for LCHS –linked to risks still carrying in community nursing – Pressure ulcers and speech and language therapies

Safe staffing for ULTH was reported - with good assurance.

Safer Staffing Medical

The Committee received a verbal update in respect of the development of the reporting which offered **reassurance** to the Committee on the actions being taken.

The report to the Committee focussed on some key issues – vacancy and sickness rates and agency and bank spend and training

The Committee were advised that this area was driven largely by the ULTH part of the Group. Community was being considered but numbers driven by acute staffing.

The Committee were advised that going forward the report would also include information on ACPs.

Medical vacancy rate was just above 5%, a reduction of 2% since the last reports. Actively recruiting into vacancies. Medical posts were largely exempt from the vacancy controls in place.

The Committee noted that the extra contractual rate was higher than that paid to bank and agency so are currently spending more on bank and agency as that is the cheaper option. Moving forward, a credible offer would be made on extra contractual payments using benchmarking from comparable trusts.

Statutory appraisals part of professional registration – Just over 95% for med appraisals and 100% for dental.

NHS and System People Plan Update

The Committee noted that the new Director of Workforce starts in January so Chief People Officer will step away from Interim role in the system. Work collaboratively moving forward.

It was noted that the running costs of the people hub have been significantly streamlined and reduced.

Really great work had been moved forward on medical refugee work.

Assurance in respect of Objective 2b – to be the employer of choice

Culture and Leadership Group Upward Report

The Committee noted that this was the first meeting for this group for both organisations. The Group would bring together discussion and learning around case work and detailed discussions around policies. Bringing together would support the key changes that needed to be taken forward.

The Committee asked for assurance that there would be KPIs developed for the Group. This had formed part of the initial discussions and the group were working these through. It was agreed that these needed to be prioritised.

The terms of reference and the membership of the Group would be agreed with the Committee.

EDI Group Upward Report

The Committee noted that whilst the requirement remained for each organisation to report their statutory position separately the focus and the actions would now come together across the group.

Good progress had been made in bringing together the staff networks. Learning was being gathered from the experiences in both organisations. The joint work had allowed initiatives to be launched in ULTH that LCHS already had in place.

Education and Oversight Group

The Education and Oversight Group had held initial discussions about joint terms of reference. The focus was on making sure the offer is comparable across the Group going forward

Medical Education Update

The Committee noted that there were still challenges to release colleagues to do dedicated education activity.

The Committee asked for assurance of a detailed plan to be scrutinised by sub committee about the medical School challenges. It was recognised that work had been completed on the money flow but also need to be looking at quality of the training provided as well.

The Committee were assured that the organisation had scored very highly on student feedback despite the challenges.

Employee Exclusions

The Committee noted 6 ongoing exclusions in ULTH – police investigation has led to delays in the HR process.
There were 2 ongoing exclusions in LCHS.

The Committee asked for assurance to be presented in future reporting where staff have conditions and restrictions on their practice.

Assurance in respect of other areas

Group Board Assurance Framework 2024/25

The Committee received the draft Group Board Assurance Framework (BAF) 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.

The Groups reporting into the committee had not reached the level of maturity to enable the Committee to move objective 2b back to Green from Amber. Aiming for early 2025 to move this.

Following consideration of the ratings the Committee confirmed that there were no changes to the objective ratings in month.

Integrated Improvement Plan
The Committee received the report with **assurance** noting the content as reported.

Slightly behind in relation to vacancy rate. This was set before vacancy controls were put in place and therefore will have been impacted by this.

Risk Report
The Committee received the joint report with **assurance** noting the dynamic nature of the risk register.

The Committee expressed a view that they did not believe the report contained enough information. Did not feel it was reflective of the actions being taken operationally. The Committee were not assured that the register was up to date enough.

The Committee also considered that there were greater risks relating to our people and culture which needed to be reflected.

Policy Position Update
The Committee received the report noting the position presented and the ongoing work to review and update policies across the Group. Updates would be offered to the Committee on a monthly basis via the dashboard.

The complexity of working in partnership with union bodies was noted due to these being different across the organisations however a policy group had been established with appropriate representation.

The risk was recognised by the Committee of pushing out review dates, but recognised that some were more risky than others. Prioritisation work had been completed of some of the policies based on the risks.

Internal Audit Recommendations
The Committee received the report noting the outstanding actions with actions in place to review and ensure updates are offered to close the actions.

Issues where assurance remains outstanding for escalation to the Board

- Risk register entries being updated and feeling truly reflective of some of the people challenges being felt through the move to Group

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
Phil Baker, Non-Executive Director, ULTH (Chair)										X	X	X
Gail Shadlock, Non-Executive Director, LCHS										X	A	X
Claire Low, Group Chief People Officer										X	D	X
Colin Farquharson Group Chief Medical Officer										D	X	X
Nerea Odongo, Group Chief Nurse										X	X	X

X in attendance
A apologies given
D deputy attended

NHS
Lincolnshire Community and Hospitals NHS Group

Finance Committee Upward Report

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Teaching Hospitals NHS Trust

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*7th January 2025*
Item Number	*10.1*

Finance Committee Upward Report of the meeting held on 21 November 2024

Accountable Director	*Paul Antunes-Goncalves, Group Chief Finance Officer*
Presented by	*Dani Cecchini, Finance Committee Chair*
Author(s)	*Karen Willey, Deputy Trust Secretary, ULTH*
Recommendations/ Decision Required	*The Board is asked to:-* • *Note the discussions and assurance received by the Finance Committee*

Purpose

This report summarises the assurances received, and key decisions made by the Finance Committee. 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 Teaching Hospitals NHS Trust (ULTH). The Committee worked to the 2024/25 objectives for the Lincolnshire Community and Hospitals NHS Group (LCHG) and was attended by both ULTH and LCHS colleagues.

This particular meeting was time limited due to the scheduled committee development session which followed.

Upward Report

Assurance in respect of Objective 3a Deliver financially sustainable healthcare, making best use of resources

Finance Report including Capital and Efficiency – LCHS and ULTH
The Committee received the reports for LCHS and ULTH with **amber assurance** for LCHS and **limited assurance for ULTH.**

The LCHS position was reported at a £1m deficit, £100k ahead of plan and a surplus delivered in month 7.Expectations were for the Cost Improvement

Programme (CIP) to increase for the remainder of the year to mitigate the deficit and achieve the planned break-even position.

The Committee noted that there had been no capital spend for LCHS in month 7 with planned spend in months 7-9 bringing capital spend to circa £5.4m.

The Committee noted the month 7 position for ULTH which was reported as a £4.5m deficit which was £4.8m adverse to plan as a result of a further deterioration to the run rate position. The key drivers associated with this were the non-pay position, challenges in the system planning assumption and the significant workforce cost pressures including medical bank and investment supporting CIP delivery.. Pressures had also been experienced in respect of pay across, pharmacy and nursing.

Challenge was noted in respect of CIP with a number of technical adjustments having been undertaken to support the position. It was noted that there would be a review of CIP reporting to ensure this offered consistency.

A significant change was noted in respect of non-pay, associated with the reclassification of pay costs which had been incorrectly charged. It was also noted that there was a need to ensure timely reporting of activity to ensure accuracy of reporting as the current lag in reporting was impacting on the reported position.

The increase in capital funding and programmes of work was also noted as impacting on the financial position due to the required increase in resources to support delivery, which included staffing.

Concern was noted in respect of the payroll growth as a result of schemes signed off with income not following with the Committee noting the need for there to be reviews of business cases that has resulted in growth to ensure delivery followed. There was confidence noted in the vacancy control position.

The Committee noted the outturn bridge position which highlighted the planned deficit of £6.9m with a system breakeven position planned. Work continued to review the position to ensure delivery of a realistic position across the system.

Assurance in respect of Objectives 3d, 3e and 3f Reduce waits for patients who require urgent care and diagnostics to constitutional standards

Operation Performance against National Standards – Combined Report – ULTH

The Committee received the report with **limited assurance.** Whilst the operation performance report was considered, there was no Performance report received.

Pressures were noted in respect of 65-week waits however improvements were being seen through September and into October with 151 waits forecast for November, and a trajectory to 0 being forecast by the end of December.

Whilst improvements had been noted in respect of Urgent and Emergency Care (UEC) with a number of months of sustained improvement in the 4-hour standards it was noted that there had been a decline during October. This was due to the increase in attendances, ambulance conveyances as well as acuity.

The Committee noted the significant reduction in patients waiting over a year in respect of referral to treatment (RTT) standards as a result of insourcing activity and also noted the improvements being seen in diagnostics. There did however remain concern regarding ultrasound and urology due to pressures being experienced.

Cancer performance was reported as below national standards however there continued to be consecutive increases in performance standards and longest waits having significantly decreased. Improvements made by ULTH had been recognised by the region.

Assurance in Respect of Objective 3g Reducing unwarranted variation in community service delivery and ensure we meet all constitutional standards – LCHS

Performance Report – LCHS
The Committee received the report which was taken as read and noted that detailed discussions would take place when there was appropriate representation at the meeting.

It was noted however that work was taking place to develop performance reporting across the Group.

Assurance in respect of other areas

Group Board Assurance Framework 2024/25
The Committee received the draft Group Board Assurance Framework (BAF) noting the updates provided.

During the meeting the Committee considered the RAG ratings of the objectives where assurance reports had been received and noted that objective 3a would be rated red, from amber, due to the current financial position and the work being undertaken to meet the 24/25 plan.

Risk Report
The Committee received the report noting the need for a review of the risks to be undertaken to ensure these were reflective of the current position.

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
Dani Cecchini Non-Executive Director (Chair)											X	
Sarah Buik, Associate Non-Executive Director											X	
Ian Orrell, Associate Non-Executive Director											X	
Paul Antunes-Goncalves, Group Chief Finance Officer											X	
Caroline Landon, Chief Operating Officer, ULHT/LCHS											D	
Daren Fradgley, Group Chief Integration Officer											D	
Mike Parkhill, Group Chief Estates and Facilities Officer											X	

X in attendance
A apologies given
D deputy attended

NHS
Lincolnshire Community and Hospitals NHS Group

Finance Committee Upward Report

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Teaching Hospitals NHS Trust

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*7th January 2025*
Item Number	*10.1*

Finance Committee Upward Report of the meeting held on 19 December 2024

Accountable Director	*Paul Antunes-Goncalves, Group Chief Finance Officer*
Presented by	*Dani Cecchini, Finance Committee Chair*
Author(s)	*Karen Willey, Deputy Trust Secretary, ULTH*
Recommendations/ Decision Required	*The Board is asked to:-* • *Note the discussions and assurance received by the Finance Committee*

Purpose

This report summarises the assurances received, and key decisions made by the Finance Committee. 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 Teaching Hospitals NHS Trust (ULTH). The Committee worked to the 2024/25 objectives for the Lincolnshire Community and Hospitals NHS Group (LCHG) and was attended by both ULTH and LCHS colleagues.

Upward Report

Assurance in respect of Objective 3a Deliver financially sustainable healthcare, making best use of resources

Finance Report to include CIP and Capital
The Committee received the report noting the development of the report to include an additional slide to summarise the Group position.

Continued pressures on the financial position of ULTH and the system were noted however the Committee noted the progress being made in respect of the cash position, with £6.9m cash secured from the national team. The risk pool issue had also been resolved after a number of months with £4.1m being received into the ULTH position.

The Executive Team had met with all Divisions across the Group in respect of efficiency programmes to undertake a bottom-up review of the position and to support the identification of further recovery actions. The Divisions were asked to come back with further plans by the end of December and monthly meetings would be arranged to hold the Divisions to account. This process would be also be reflected across corporate areas.

The Committee noted the capital position and the increase in funding to £83.9m which reduced the level of overcommitment during the current year. Further discussions were also taking place in respect of additional capital funding which could be drawn down.

Communication from the regulator was noted in respect of the deteriorating run rate with a recent meeting held with system colleagues to emphasise the need to find a route to breakeven. Support continued to be in place for the Trust and system to succeed with a need to work through the position against the mitigations and to confirm what further actions had been identified by the Divisions.

The Committee noted the significant workforce growth in the 24/25 year which had stepped down in months 7 and 8 due to bank and agency controls.

Overall, the Committee noted the current financial position of ULTH at a £20.9m deficit year to date, being £15.2m adverse variance. The cash position resolution was noted.

The Committed noted the performance of LCHS which was performing in line with plan with a shift to manage costs to support activity with all actions in place being so across the Group for a consistent approach.

The Committee confirmed the RED rating in relation to this objective within the Board Assurance Framework

Assurance in respect of Objectives 3c A modern, clean and fit for purpose environment across the Group

Estates and Facilities Report – LCHG

The Committee received the reports noting that this provided an update across the Group however recognised the intention to develop to a single report.

It was recognised that there were currently some gaps in data being available from an LCHS perspective due to current resource however this was being addressed through teams working across the Group.

Concerns was noted in respect of reporting from NHS Property Services however this was being addressed through representatives being invited to participate in relevant meetings so that there was a wider awareness of the position.

Space utilisation was also noted as an area of concern for LCHS with work required to ensure appropriate utilisation of space across the LCHS estate to enable this to be used more widely.

The Committee noted the position presented for ULTH and recognised the previous request for Authorised Engineer actions plans with some remaining outstanding. An update on the position of these was requested in future reports.

Assurance in respect of Objectives 3d, 3e and 3f Reduce waits for patients who require urgent care, cancer and diagnostics to constitutional standards

Operational Performance Report and Committee Performance Dashboard – LCHS/ULTH

The Committee received the reports noting the development of the approach to performance reporting across the Group.

The Committee noted the current performance of the 4-hour target noting that this had been reported at 72.87% for November with a target of 78% by year end as the national trajectory.

There was an aspiration for achievement however it was recognised that there had been a significant increase in ambulance conveyances compared to the previous year, impacting on the ability to deliver.

Improvements were seen in 12-hour trolley waits however these was not being consistently maintained and it was noted that in part this was due to data capturing which was being resolved.

52-week and 65-week waits continued to be worked through with an anticipation of 107 65-week waits being reported to NHS England at the end of December.

Consistent delivery was noted in respect of 28-days however 62-days was not delivering to trajectory with a need to revisit the trajectory for diagnostics.

Significant improvements were noted in DM01 with further improvements expected in cancer therapy screening due to staff being in place.

For those areas not performing as expected the Committee noted the **reassurance** offered through the delivery of the paper however noted that this did not provide assurance at this time.

The Committee requested consideration of a forward trajectory to the SPC charts to demonstrate the ambition of achievement against the trends being reported.

Work continued on the performance reports which would offer a triangulated position with the Committee pleased to note the development of the live dashboards.

The Committee noted the challenges across the system in terms of flow and the need to ensure that discharge was effective due to current delays in patients being discharged in a timely manner.

Productivity Plans
The Committee received the report noting that the report presented the local position against national benchmarks which indicated the size of the opportunity.

The Committee noted the intention to further develop a productivity strategy needing to build on the current model within the ability to make change whilst remaining focused on delivery.

In the 25/26 year the focus would be on outpatients, theatres and the medical workforce with a need for focus to also be given to Urgent and Emergency Care and discharge.

The Improvement Team would become task focused with the presented model allowing this change in focus. The improvement plans across the Group would also be redesigned into a single Productivity and Development Programme with productivity being one aspect which development would consider the left shift into the Community.

Assurance in Respect of Objective 3g Reducing unwarranted variation in community service delivery and ensure we meet all constitutional standards – LCHS

Operational Performance Report and Committee Performance Dashboard – LCHS/ULTH
As reported above.

Assurance in respect of other areas

Group Board Assurance Framework 2024/25
The Committee received the draft Group Board Assurance Framework (BAF) noting the updates provided.

During the meeting the Committee considered the RAG ratings of the objectives where assurance reports had been received and noted that objective 3g would be rated amber, from red, due to the current position of delivery.

Annual Planning Update
The Committee received the report noting that a Planning Steering Group has been established to ensure a triangulated approach to planning.

It was noted that planning was currently taking place in line with best practice which national planning guidance was awaited, this was anticipated to be available to Trusts in January 2025.

It was recognised that the financial exit rate of the 24/25 year would impact on the entry rate in to 25/26 and therefore influence planning. Uncertainty around the position of the Elective Recovery Fund in to the 25/26 year was noted with clarification awaited on the release of the planning guidance.

In order to support the Group in developing the annual plans the Divisions had been requested to undertake risk-based assessments on required funding with further work required to bring these to a feasible position.

There was a need to increase productivity and development and ensure a focus on bottom line improvements and the community first approach to left shift services.

Risk Report
The Committee received the report noting that the finance risks had been reviewed by the Group Chief Finance Officer which had confirmed these remained accurate.

Policy Position Update
The Committee received the report noting the position presented and the movement within the figures which reflected the appropriate alignment of policy documents to Executive Directors.

Emergency Department Activity Recording
The Committee received the report noting the historical Urgent Treatment Centre (UTC) coding of type 3 performance and the advice of the national and regional teams to combine collocated UTCs in to type 1 activity to bring this in line with national reporting.

The Committee supported the change to reporting noting this was based on national and regional guidance.

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
Dani Cecchini Non-Executive Director (Chair)											X	X
Sarah Buik, Associate Non-Executive Director											X	X
Ian Orrell, Associate Non-Executive Director											X	X
Paul Antunes-Goncalves, Group Chief Finance Officer											X	X
Caroline Landon, Chief Operating Officer, ULHT/LCHS											D	X
Daren Fradgley, Group Chief Integration Officer											D	X
Mike Parkhill, Group Chief Estates and Facilities Officer											X	X

X in attendance
A apologies given
D deputy attended

NHS
Lincolnshire Community and Hospitals NHS Group

Finance Committee
Draft Terms of Reference and Workplan

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Teaching Hospitals NHS Trust

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*7th January 2025*
Item Number	*10.2*

Finance Committee Draft Terms of Reference and Workplan

Accountable Director	*Paul Antunes Goncalves, Group Chief Finance Officer*
Presented by	*Jayne Warner, Group Director of Corporate Affairs*
Author(s)	*Jayne Warner, Group Director of Corporate Affairs*
Recommendations/ Decision Required	*The Board is asked to:-* • *Note the draft Finance Committee Terms of Reference and Workplan*

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	
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	*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 (ULTH)	
3f Reducing unwarranted variation in planned service delivery and ensure we meet all constitutional standards (ULTH)	
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	
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	

Finance Committee
Terms of Reference

1. Authority

The Finance Committee is established as a joint committee by the Trust Boards of both Lincolnshire Community Health Services NHS Trust (LCHS) and United Lincolnshire Teaching Hospitals NHS Trust (ULTH) and in line with the Group Partnership Working Agreement and the powers set out in the trusts' Standing Orders and Standing Financial Instructions.

The Finance Committee holds only those powers as delegated in these Terms of Reference as determined by the Trust Boards.

The Finance Committee is authorised by the Trust Boards to investigate or to have investigated and / or to seek further action or assurance in relation to any activity within its Terms of Reference. This includes referral of matters for consideration to another board committee or other relevant group.

The Standing Orders and Standing Financial Instructions of the Trust Boards and the Group Partnership Working Agreement, as far as they are applicable, shall apply to the committee and any of its established groups, either jointly or individually.

2. Purpose of the Committee

The Finance Committee exists to scrutinise the robustness of and provide assurance to the Trust Boards of LCHS and ULTH that there is an effective system of governance and internal control across the across the areas of finance, operational performance, estates and information governance / data security compliance within the two trusts and wider group to deliver the agreed strategic objectives and provide high quality care.

The relevant Strategic Aims & Objectives aligned to the Finance Committee for 2024/25 are:

Strategic Aim 3: Services

To ensure services are sustainable, supported by technology and delivered from an improved estate

Strategic Objectives:

- 3a: Deliver financially sustainable healthcare making best use of resources
- 3b: Drive better decisions 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 ensure we meet all constitutional standards

  ULTH
- 3e: Reducing unwarranted variation in cancer service delivery and ensure we meet all constitutional standards
- 3f: Reducing unwarranted variation in planned service delivery and ensure we meet all constitutional standards

  LCHS
- 3g: Reducing unwarranted variation in community service delivery and ensure we meet all constitutional standards

The committee will work with the other board committees to ensure that full oversight of the areas of responsibility are covered.

3. Membership

The members of the committee are:

- Joint Non-Executive Director **(Chair)**
- Two Joint Associate Non-Executive Directors
- Group Chief Finance Officer
- Group Chief Operating Officer/Group Chief Integration Officer
- Group Chief Estates & Facilities Officer

The following roles will be routine attendees at the committee:

- Group Director of Corporate Affairs / Trust Secretary & / or deputy
- Deputy Director of Finance

4. Attendance and Quorum

The committee will be quorate when four of the membership are present. This must include two Non-Executive / Associate Non-Executive Directors and one Executive Director.

Where members are unable to attend, they should ensure that a deputy is in attendance who is able to participate on their behalf. A deputy in attendance for a committee member will contribute to the quoracy but does not negate the need for the attendance of the Non-Executive Directors and Executive Directors referred to above.

Members should attend at least 80% of meetings each financial year but should aim to attend all.

The Group Chair and Group Chief Executive will be given a standing invitation to the meetings.

Other attendees may be invited to attend the meetings as appropriate / the agenda dictates.

Observers will be permitted as agreed by the Chair.

5. Frequency

The committee will meet monthly.

6. Specific Duties

The Finance Committee will:

- Agree a set of Key Performance Indicators to be presented in the committee Performance Dashboard monthly
- Approve the business planning timetable
- Seek assurance that the trusts and wider group have in place robust and effective operational and financial planning arrangements and delivery plans
- Review, challenge and monitor in-year financial and operational performance
- Consider the control and mitigation of finance, operational performance and estates related risks and provide assurance to the Trust Boards that such risks are being effectively controlled and managed
- Provide oversight of and receive assurance on delivery of agreed Cost Improvement Plans and associated efficiency and productivity programmes
- Provide oversight of and receive assurance on procurement processes and performance
- Review delivery of the relevant aspects of the estates strategy, priorities and compliance including health & safety requirements and compliance with the Premises Assurance Model (PAM)
- Provide oversight of and receive assurance in respect of compliance with the Data Security Protection Toolkit
- Provide assurance to the Trust Boards that all legal and regulatory requirements relating to finance, operational, estates performance and data security are met, including directives, regulations, national standards (including constitutional standards), policies, reports, reviews and best practice
- Review and provide assurance to the Trust Boards on those strategic objectives within the Board Assurance Framework, identified as the responsibility of the committee, seeking further assurance and actions where necessary. This may include the commissioning of 'deep dives' to identify the necessary improvements and actions.

7. Administrative support

The committee will be supported administratively by the corporate administrative team.

The committee will operate using a work plan to inform its core agenda. Topical / emerging issues will be added to the agenda as required. The agenda will be agreed with the Chair and the Group Chief Financial Officer prior to the meeting.

Agendas and supporting papers will be circulated no later than 5 working days in advance of meetings. Any items to be placed on the agenda are to be submitted no later than 8 working days in advance of the meeting. Items which miss the deadline for inclusion on the agenda may be added with permission from the Chair.

Minutes will be taken at all meetings, presented according to the corporate style, circulated to members within 7 working days along with the action log and ratified by agreement of members at the following meeting.

8. Accountability and Reporting Arrangements

The Chair of the committee shall report to the Trust Boards after each meeting and provide an upward report on assurances received, escalating any concerns where necessary.

The committee will advise the Audit Committees of the adequacy of assurances available and contribute to the Annual Governance Statements.

The committee will refer any necessary issues outside its Terms of Reference, as appropriate, to the relevant board committee or other relevant group.

9. Monitoring effectiveness and Compliance with Terms of Reference

The committee will complete an annual review of its effectiveness and provide an annual report to the Trust Boards on its work in discharging its responsibilities, delivering its objectives and complying with its terms of reference, specifically commenting on relevant aspects of the Board Assurance Framework and relevant regulatory frameworks.

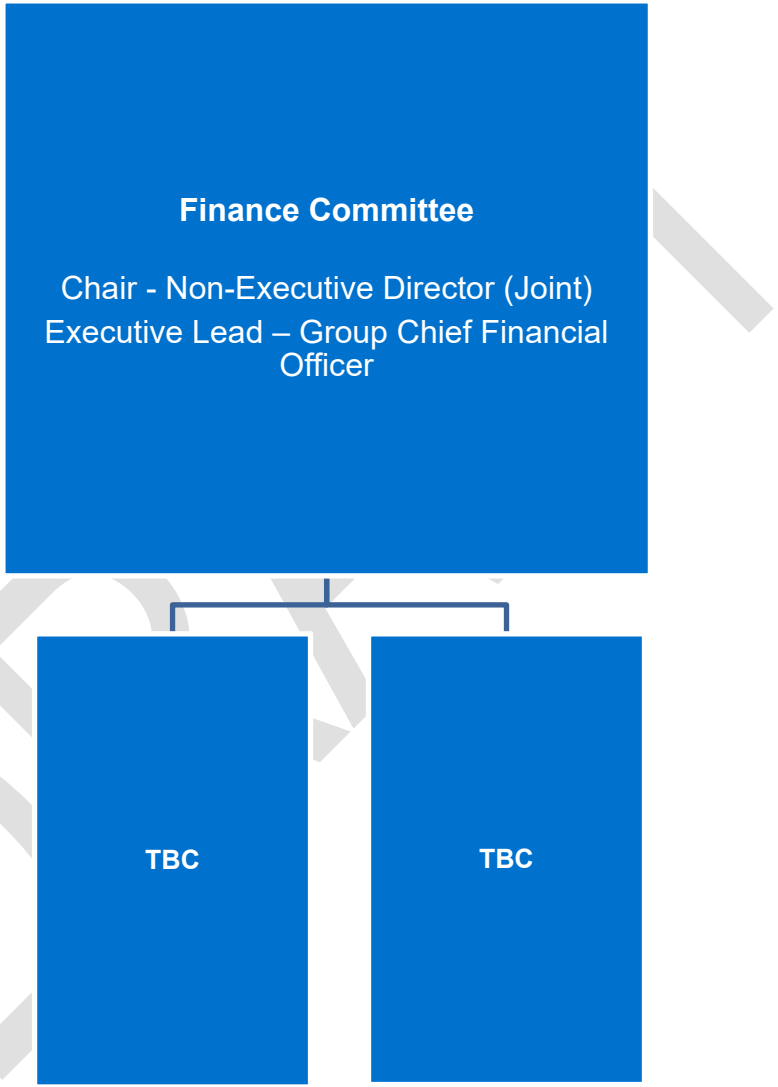
10. Review of Terms of Reference

The Terms of Reference for the committee will be reviewed annually by the committee and submitted to the Trust Boards for approval and, together with the work plan, will be reviewed at each meeting of the committee to ensure they remain fit for purpose.

The committee will on an annual basis review and approve the terms of reference and work programmes of all of its reporting groups.

Approved:
Approved by:
Next Review Date:

Committee reporting group structure:



DRAFT V1

Lincolnshire Community & Hospitals NHS Group:
Finance & Performance Committee Work Plan 2024 / 25

						Quarter 1			Quarter 2			Quarter 3			Quarter 4			
Agenda Item	**Oversight Group***	**Method of Reporting**	**Executive / Non-Executive Lead**	**Report Lead**	**Frequency**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Action**
Business Items (all committees)**																		
Minutes of the Previous Meetings		Written	Committee Chair	Deputy Trust Secretary	Monthly	X	X	X	X	X	X	X	X	X	X	X	X	Approval
Matters Arising & Action Log (management & monitoring of committee actions)		Written	Committee Chair	Deputy Trust Secretary	Monthly	X	X	X	X	X	X	X	X	X	X	X	X	Noting
Topical, Legal & Regulatory Update		Verbal / Written, as required	Group Director of Corporate Affairs	Deputy Trust Secretary	Quarterly			X			X			X			X	Discussion & Assurance
Review of Committee Effectiveness - Self Assessment		Written	Committee Chair	Group Director of Corporate Affairs	Annually										X			Discussion
Annual Report - Review of Committee Effectiveness		Written	Committee Chair	Group Director of Corporate Affairs	Annually											X (Draft)	X (Final)	Discussion & Assurance
Review of Committee Terms of Reference & Work Plans		Written	Committee Chair	Group Director of Corporate Affairs	Annually	X (Final)							X (Initial Draft November 2024 - New Committee)				X (Annual Review)	Approval
Review of Reporting Group Terms of Reference & Work Plans		Written	Committee Chair	Group Director of Corporate Affairs	Annually	X (Final)											X (Annual Review)	Approval
Matters Referred (all committees)**																		
Matters referred by the Trust Boards or other Board Committees		Written	Committee Chair	Group Director of Corporate Affairs	As required	**To be added to the agenda as required**												Discussion
Matters to be referred to other Board Committees		Written	Committee Chair	Group Director of Corporate Affairs	As required	**To be added to the agenda / agreed at the relevant meeting as required (and recorded in the minutes & action log)**												Discussion
Risk and Assurance (all committees)**																		
Board Assurance Framework		Written	Group Director of Corporate Affairs	Deputy Trust Secretary	Monthly	X	X	X	X	X	X	X	X	X	X	X	X	Discussion & Assurance
Risk Register Report		Written	Group Executive Lead(s)	Group Chief Clinical Governance Officer	Quarterly		X (Q4)			X (Q1)			X (Q2)			X (Q3)		Discussion & Assurance
Review of relevant internal & external audit reports & recommendations (as required)		Written	Group Director of Corporate Affairs	Deputy Trust Secretary	As required	**To be added to the agenda as required**												Discussion
Review of relevant external reports, recommendations & assurances including CQC, as appropriate		Written	Group Executive Lead(s)	Group Director of Corporate Affairs / Group Chief Clinical Governance Officer	As required	**To be added to the agenda as required**												Discussion & Assurance
CQC Action Plan		Written	Group Executive Lead(s)	Head of Compliance	As required	X	X	X	X	X	X	X	X	X	X	X	X	Discussion & Assurance
Committee Specific Business Items**																		
Strategic Aim 3: Services - To ensure services are sustainable, supported by technology and delivered from an improved estate																		
Objective 3a: Deliver financially sustainable healthcare making best use of resources																		
Financial Strategy		Written	Group Chief Finance Officer	TBC	Three Yearly													Review & Endorse for Trust Board Approval
Procurement Strategy		Written	Group Chief Finance Officer	TBC	Three Yearly													Review & Endorse for Trust Board Approval
Business Planning Timetable		Written	Group Chief Finance Officer	TBC	Annually													Approve
Annual Plan (Operational & Financial) including Cost Improvement Programme (CIP)		Written	Group Chief Finance Officer / Group Chief Operating Officer	TBC	Annually													Review & Endorse for Trust Board Approval
Winter Plan		Written	Group Chief Operating Officer	TBC	Annually													Review & Endorse for Trust Board Approval
Finance Report		Written	Group Chief Finance Officer	TBC	Monthly	X	X	X	X	X	X	X	X	X	X	X	X	Discussion & Assurance
CIP Report		Written	Group Chief Finance Officer	TBC	Monthly	X	X	X	X	X	X	X	X	X	X	X	X	Discussion & Assurance
Productivity Plans		Written	Group Chief Finance Officer / Group Chief Operating Officer	TBC	TBC	X			X			X			X			Discussion & Assurance
Capital Report		Written	Group Chief Finance Officer	TBC	Monthly	X	X	X	X	X	X	X	X	X	X	X	X	Discussion & Assurance
Costing & Benchmarking Report		Written	Group Chief Finance Officer	TBC	TBC				X (Annual submission)		X (Q1)			X (Q2)			X (Q3)	Discussion & Assurance
Procurement Report		Written	Group Chief Finance Officer	TBC	Quarterly			X			X			x			X	Discussion & Assurance
Contract Awards / Approvals		Written	Group Chief Finance Officer	TBC	As required	**To be added to the agenda as required**												Approval
Deep Dives & Improvement Plans		Written	Group Chief Finance Officer	TBC	As required	**To be added to the agenda as required**												Assurance
Objective 3c: A modern, clean and fit for purpose environment across the group																		
Estates & Facilities Update		Written	Group Chief Estates & Facilities Officer	TBC	Monthly	X	X	X	X	X	X	X	X	X	X	X	X	Assurance
PLACE		Written	Group Chief Estates & Facilities Officer	TBC	TBC													
Premises Assurance Model (PAM) Annual Self Assessment		Written	Group Chief Estates & Facilities Officer	TBC	Annually				X									Assurance
Emergency Planning Standards		Written	Group Chief Estates & Facilities Officer	TBC	TBC													Assurance
Objective 3d: Reduce waits for patients who require urgent and emergency care and ensure we meet all constitutional standards																		
Finance & Performance Committee Performance / KPI Dashboard / Scorecard		Written	Group Executive Lead(s)	TBC	Monthly	X	X	X	X	X	X	X	X	X	X	X	X	Discussion & Assurance
Deep Dives & Improvement Plans		Written	Group Executive Lead(s)	TBC	As required	**To be added to the agenda as required**												Discussion & Assurance
ULHT:																		
Finance & Performance Committee Performance / KPI Dashboard / Scorecard		Written	Group Executive Lead(s)	TBC	Monthly	X	X	X	X	X	X	X	X	X	X	X	X	Discussion & Assurance
Deep Dives & Improvement Plans		Written	Group Executive Lead(s)	TBC	As required	**To be added to the agenda as required**												Discussion & Assurance
LCHS:																		
Finance & Performance Committee Performance / KPI Dashboard / Scorecard		Written	Group Executive Lead(s)	TBC	Monthly	X	X	X	X	X	X	X	X	X	X	X	X	Discussion & Assurance
Deep Dives & Improvement Plans		Written	Group Executive Lead(s)	TBC	As required	**To be added to the agenda as required**												Discussion & Assurance
Strategic Aim 4: 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																		
Objective 4d: Enhanced data & digital capabilities																		
Data Security Protection Toolkit - Annual Submission & Quarterly Updates		Written	Group Director of Corporate Affairs	Head of Information Governance	Annually (Declaration) Quarterly (Updates)						X							Approval (Annual Declaration) / Assurance (Quarterly Updates)
TBC																		Assurance
Notes																		
*In some instances reporting and assurance to the Finance & Performance Committee will happen via the oversight / reporting sub-group upward reports. Where appropriate, reports submitted directly to the Finance & Performance																		

NHS
Lincolnshire Community and Hospitals NHS Group

Integration Committee Upward Report

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Teaching Hospitals NHS Trust

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*7th January 2025*
Item Number	*11.1*

Integration Committee Upward Report of the meeting held on 18 December 2024

Accountable Director	*Daren Fradgley, Group Chief Integration Officer/Deputy CEO*
Presented by	*Rebecca Brown, Integration Committee Chair*
Author(s)	*Karen Willey, Deputy Trust Secretary, ULTH*
Recommendations/ Decision Required	*The Board is asked to:-* • *Note the discussions and assurances received by the Integration Committee*

Purpose

This report summarises the assurances received, and key decisions made by the Integration Committee. 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

The Committee received the following reports noting there were **no escalations** from the Committee to the Board:

- **Final Sub-Group Map and Terms of Reference for Sub-Groups**
  The Committee received the report with **assurance** noting the commencement of the process to identify the reporting groups to the Committee and received the suite of terms of reference for those groups that would be reporting to the Committee.

  The Committee noted the objectives which would be considered by each group and therefore where assurance should be received as well as recognising that further work was required in order to ensure that the meetings took place across the Group whilst ensuring appropriate ownership.

Further development of the Out of Hospital Group was required prior to the terms of reference being drafted and offered to the Committee however it was recognised that these would be developed in line with the development of the alliance plan.

- **Update on Out of Hospital Model and Update on Community Provider Partnerships (CPPs)**

  The Committee received the report in respect of the Out of Hospital Model with **assurance** and the verbal update relating to the CPPs noting this offered **reassurance.**

  The Committee was pleased to note the developments that were taking place and the pace and engagement which was being achieved in respect of the alliance model. It was recognised that alongside the alliance development, discussions were taking place in respect of CPPs and how plans could be aligned.

  As part of the developments and the pace it was recognised that the governance needed to be included in the development and therefore evidence from the workshops already undertaken was being collated.

  The Committee recognised the enthusiasm around the developments in respect of both the alliance model and CPPs and noted the need to ensure that this was driven from self-care in the community to support patients and the overall population health.

  There was a recognition of the need to ensure engagement with wider partners was undertaken appropriately to ensure there was clarity on the direction of travel and where responsibilities sat. Updates would be received by the Committee on a monthly basis.

- **Digital Hospital Group Upward Report**

  The Committee received the upward report with **assurance** noting the updates provided in respect of the development of the Electronic Patient Record (EPR) which was continuing through the final approval stages. There had been significant input from ULTH in order to respond to the questions raised through the proves.

  Currently the approval date remained however modelling was taking place to understand the impact should this not be achieved by March 2025. The Committee was pleased to note that the framework being utilised had now been extended to the end of December 2025, removing the risk that had been present of this ending in March 2025.

  It was noted that work was taking place across the Group in respect of digital competency and the digital portfolio to ensure learning across the Group as well as the utilisation of resources.

The Committee noted that the Electronic Document Management System (EDMS) continued to be developed with the financial position being considered in respect of both revenue and capital costs to ensure this was affordable.

The tenant move for ULTH was recognised as a significant project which was being undertaken by the Trust faster than any other Trust had done before. A pilot had commenced with 100 digital staff and had identified the level of support that would be required for staff moving forward to complete the move.

- **Workshop Feedback (appended)**
  The Committee received the report following the initial workshop help in November and noted the output from this and the continuing development of the reporting groups and work programme of the Committee. The Committee was pleased with the level of engagement, drive and motivation which was apparent through the workshop.

- **Board Assurance Framework**
  The Committee received the Board Assurance Framework noting that, due to the construct of the agenda for the first meeting, it was not possible to consider assurance ratings however it was recognised that the work programme of the Committee was being developed to support assurance being provided against the relevant Committee objectives.

- **Risk Report**
  The Committee noted the work taking place to align the relevant risks to the Committee noting that a formal report would be received to the January meeting.

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
Rebecca Brown, Non-Executive Director (Chair)											X	
Gail Shadlock, Non-Executive Director, LCHS											X	
Sarah Buik, Associate Non-Executive Director											X	
Daren Fradgley, Group Chief Integration Officer											X	
Mike Parkhill, Group Chief Estates and Facilities Officer											X	
Caroline Landon, Group Chief Operating Officer											A	
Claire Low, Group Chief People Officer											A	
Paul Antunes-Goncalves, Group Chief Finance Officer											A	
Colin Farquharson, Group Chief Medical Officer											A	
Nerea Odongo, Group Chief Nurse											A	
Kathryn Helley, Group Chief Clinical Governance Officer											A	

X in attendance
A apologies given
D deputy attended

NHS
Lincolnshire Community and Hospitals NHS Group

Integration Committee Workshop Feedback

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Teaching Hospitals NHS Trust

Meeting	*Integration Committee*
Date of Meeting	*18 December 2024*
Item Number	*9*

Integration Committee Workshop Feedback

Accountable Director	*Daren Fradgley, Group Chief Integration Officer/Deputy CEO*
Presented by	*Karen Willey, Deputy Trust Secretary, ULTH*
Author(s)	*Karen Willey, Deputy Trust Secretary, ULTH*
Recommendations/ Decision Required	*The Committee is asked to:- note the discussion which took place at the workshop of the Integration Committee*

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	
1c Improve clinical outcomes	
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	
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	*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 (ULTH)	
3f Reducing unwarranted variation in planned service delivery and ensure we meet all constitutional standards (ULTH)	
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	*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*

Executive Summary

Background

On 4 September 2023, the Boards of United Lincolnshire Teaching Hospitals NHS Trust (ULTH) and Lincolnshire Community Health Services NHS Trust (LCHS) met to discuss the proposal to begin to work together in group model arrangements.

In order to support the group model arrangements, the Committees of the Boards are required to work as joint Committees with the recognition of the need for the establishment of a fourth Committee, this being the Integration Committee.

On the 28 November 2024 a workshop was held with the members of the Integration Committee to hold discussions on the purpose of the Committee and the direction of travel.

Arrangements for the Joint Integration Committee
It was recognised that the Integration Committee exists to scrutinise the robustness of and provide assurance to the Trust Boards on delivery of the group's transformation and integration agenda, aims and objectives – both internally within ULTH and LCHS and through the ongoing development of relationships with external partners including Community Primary Partnerships – for the benefit of our population.

The Integration Committee will oversee the development of the Out of Hospital Model and the direct delivery work with other system partners not limited to Mental Health, Primary Care, Third and Voluntary Sector organisations.

The Integration Committee will be the lead committee for oversight of the group's digital delivery and transformation agenda including the development for the "Vision for Information" and for oversight of estates and facilities.

The Committee will be responsible for the following strategic objectives:

- Objective 1d – Deliver clinically led integrated services
- Objective 3c – A modern, clean and fit for purpose environment across the Group
- Objective 4a – Establish collaborative models of care with our partners including Primary Care Network Alliance (PCNA)
- Objective 4b – Successful delivery of the Acute Services Review
- Objective 4d – Enhanced data and digital capabilities
- Objective 5a – Develop a Population Health Management and Health Inequalities approach for our Core20PLUS5 with our ICS
- Objective 5b – Co-create a personalised care approach to integrate services for our population that are accessible
- Objective 5c – Tackle system priorities and service transformation in partnership with our population and communities
- Objective 5d – Transform key clinical pathways across the group resulting in improved clinical outcome

The Committee will also have oversight of and seek assurance in relation to the following areas:

- Socioeconomic development
- Sustainability and the Green Strategic Plan
- Widening participation e.g. third sector organisations
- Regeneration plans with partners
- Anchor institution

The draft Terms of Reference and Work Plan were presented with the recognition of further developments being required to ensure the identification of reports to be presented to the Committee to provide assurance in respect of the relevant objectives.

A key consideration of the workshop was regarding the alignment of regulatory, compliance and safety issues which would be monitored through the Finance Committee with the Committee noting those areas considered in and out of scope of the Committee, as demonstrated below:

Digital

Integration Committee will oversee	Out of Scope
• The Digital Strategy • Digital risks • The Digital Programme (examples including the EPR programme, M365 tenant move, AGEM service transition into the group, etc.) • Digital Innovation	• Digital Clinical Safety • Prioritisation of the Digital Service's activities / agenda (recognising that there isn't the capacity to do everything that is required) • The Digital Capital Programme • Approval of Digital related business / clinical business cases • Route Cause Analysis (RCAs) of Digital issues / outages • Digital regulator adherence

Productivity and Transformation (*new)

Integration Committee will oversee	Out of Scope
• The Transformation and Clinical Strategy development and delivery • Development of productivity group and delivery • Quality Improvement Strategy and delivery	• Cost Improvement Programme (CIP) • Annual Planning • Investment Prioritisation linked to Annual Planning • Activity delivery

Estates Strategy

Integration Committee will oversee	Out of Scope
• Development and delivery of the estates strategy • Space utilisation • Sustainability, green plan agenda	• Compliance • Health and safety • Operational performance

Arrangements for Integration Committee Reporting Groups
Through the workshop the reporting groups for the Committee were considered with a commitment to present draft Terms of Reference for the reporting groups to the Committee. These have been offered at the December meeting for the following groups:

- Transformation Delivery Group
- Planning Steering Group
- Improvement Steering Group

- Digital Delivery Group
- Space Management Group

It is recognised that these remain in development with a need to develop the work programmes for the proposed groups, and to continue to consider developments to the Terms of

Next steps
The Committee is asked to identify any further actions required at this time and to note that reviews of the Committee will be built into the work plan.

The review of the Committee will be undertaken after six months to determine any learning that had been identified and to identify any actions required to further strengthen the Committee.

NHS
Lincolnshire Community and Hospitals NHS Group

Integrated Performance Report (ULTH)

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Teaching Hospitals NHS Trust

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*7th January 2025*
Item Number	*13*

Integrated Performance Report for November 2024 (ULTH)

Accountable Director	*Daren Fradgley, Group Chief Integration Officer*
Presented by	*Daren Fradgley, Group Chief Integration Officer*
Author(s)	*Sharon Parker, Performance Manager*

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

- *Medication incidents reported as causing harm remained static this month at 17.6% against a trajectory of 10.7%.*
- *Duty of Candour Verbal compliance for October improved to 100%, written compliance improved to 95%.*

Performance

- *The year end target for 4 hour performance was established at 78%, with November set at 76.70%. The full UEC combined Type 1, Type 3 (both co-located and separate sites) achieved 72.87% in November.*
- *17.81% of patients (T1 only) exceeded 12 hour wait in department in ED.*
- *Average response time for Cat2 ambulance conveyances in November was approximately 45.46 minutes and increase of 1 minute compared to October, against a 30 minute target.*
- *Long Waiters - at the end of November, the Trust reported 0 patients waiting longer than 104 weeks; 2 patients waiting over 78 weeks and 134 patients waiting over 65 weeks, which was better than forecast and still on track to hit zero for the end of December.*

- *Performance for DM01 in November showed a slight deterioration to 73.91%. MRI performance remained strong with the most pressured diagnostics now being Dexa, NOUS and Audiology.*

- *28-day Faster Diagnosis Standard (FDS) showed a slight improvement in October at 79.5% which was above the 75% target.*

- *62-day classic treatment performance for October was 62.3%, an improvement from the September position of 60.5%, but this is still significantly lower than the national KPI of 85%.*

- *104+ day waiters increased to 72 as of 11th December compared to 69 as of 14th November, the highest risk specialities are Colorectal, Head & Neck and Urology..*

Finance (is now reported for the Group)

- *The Group has planned a deficit for 2024/25 of £6.9m inclusive of a £47.1m cost improvement programme.*

- *The Group has delivered CIP savings of £25.8m, which is £0.1m favourable to planned CIP savings of £25.7m.*

- *The Group has a £89.3m capital programme and the Group has YTD delivered capital expenditure of £46.9m, which is £2.8m higher than planned capital expenditure of £44.1m.*

Workforce

- *Mandatory training for November is 93.55% against plan of 90%*

- *November sickness rate at 5.23% against Q3 target of 5.54%*

- *Staff AfC appraisals at 79.76% for November against Q3 target 85.58%*

- *Staff turnover at 9.65% for November against target of 10.24%*

- *Vacancies at 7.09% for November against Q3 target of 6.11%*

The Board is asked to approve action to be taken where performance is below the expected target.

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	X
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	X
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	X
3e Reducing unwarranted variation in cancer service delivery and ensure we meet all constitutional standards (ULTH)	X
3f Reducing unwarranted variation in planned service delivery and ensure we meet all constitutional standards (ULTH)	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	
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	

Executive Summary

Quality

Falls

There has been 1 fall resulting in moderate harm which is a decrease from the previous month. All incidents are under validation to ensure the correct level of review is undertaken. Bay nursing relaunched in November 2024. Communications have been distributed and additional support available to teams regarding understanding and embedding bay watch processes to maximise effective use of staffing resources and enhance visibility.

Pressure Ulcers

There have been 38 category 2 pressure ulcers in November, an increase of 10 from the previous month. 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.

Medications

Medication incidents reported as causing harm remained static this month at 17.6% 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) with action planning underway following the completion of the review.

Patient safety Alerts

There was 1 Safety Alert with a deadline for completion in November which went overdue as not all actions were completed. Monthly Safety Alerts exception report is now discussed at Patient Safety Group. 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.

SHMI

The Trust SHMI has increased slightly to 106.09 for November but remains within expected limits. Any diagnosis group alerting is subject to a case note review. HSMR is at 95.75.

eDD Compliance

eDD Performance continues to be below the 95% target, currently at 90.4%. A meeting is being coordinated to discuss eDD.

Sepsis compliance – based on October data

The **screening compliance for inpatient child** increased to 82.3% (target 90%). 28 children out of 34 that had PEWS of 5 or above were screened for sepsis within 60 minutes. No Harm was found in the harm reviews completed as the children had a viral illness or non-infective cause for illness / raised PEWS.

IVAB ED Children – The administration of IVAB for children in ED increased to 66.6% (target 90%). 12 children out of 18 were treated with IV antibiotics within the 60 minute timeframe. Harm reviews were completed for all children with delayed treatment and no harm was found.

IVAB Inpatient Children – The administration of IVAB for inpatients increased to 100%.

Duty of Candour (DoC) – October Data

DoC compliance in October for verbal was 100% and for written was 95%. Dedicated members of the Incident Team have been aligned to Divisions with an aim to improve compliance.

Operational Performance

This report addresses the performance metrics observed during November 2024.

The month of November recorded a notable increase in attendances across the Urgent and Emergency Care (UEC) pathways, with an 8% rise compared to previous months. Furthermore, the acuity of patients showed an upward trend, as evidenced by 10% of patients scoring above 5 on the National Early Warning Score (NEWS) at their initial assessments.

Specifically, the paediatrics department experienced a marked seasonal effect, reflecting a 9.07% increase in attendances relative to November 2023.Seasonal infections continue to exert an impact on our services. By the conclusion of November, the Trust had recorded 29 PCR confirmed inpatients with positive COVID-19 tests. Throughout the month, a total of 1,728 flu tests were conducted, representing an increase of 50% compared to November 2022. This yielded 38 positive results, resulting in a positivity rate of 2%. In contrast, among the 614 patients tested for respiratory syncytial virus (RSV), 128 were found to be positive, indicating a positivity rate of 21%. Furthermore, November experienced a 63% increase in the number of RSV tests administered in comparison to the previous year.

A & E and Ambulance Performance

The annual performance target for the 4-hour wait time has been established at 78%, with monthly progress assessments conducted. In November 2024, the trust recorded a performance rate of 72.87%, signifying a 3% improvement compared to November 2023. While there has been consistent monthly advancement since July 2024, it is important to note that both October and November have exhibited a decline in performance.

The (SPC) chart included in the report delineates the performance targets for the 2023/24 and 2024/25 fiscal years, focusing on Type 1 and Type 3 activities. It is noteworthy that there was a significant enhancement in Type 1 performance, with Lincoln Emergency Department increasing from 39.77% to 44.47%, reflecting an improvement of 4.70%. Conversely, the Pilgrim Emergency Department maintained a relatively stable performance, decreasing from 37.21% to 37.18%. In summary, Type 1 performance achieved an overall increase of 2.80%, culminating in an outturn of 41.50%.

In November 2024, there was a further increase of 8% in the number of average daily attendances within the UEC (Urgent and Emergency Care). Responding to the persistent pressure observed within the UEC pathways, the Emergency Department prioritized minimizing the overall time spent in the department. Unfortunately, 17.81% of the patients exceeded the 12-hour benchmark (T1 Only) however this is a 3.61% decrease compared to October 24.

In November, the average Category 2 mean response time was approximately 45.46 minutes, which was an increase of 1 minute compared to October 2024 against the 30 minute target. The overall Category 2 mean response time includes conveyances where the patient did not attend ULTH 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. However the chart is unable to demonstrate the volume or presentations within the same window or patient acuity at arrival. With an average of >15% patients scoring greater than 5 on NEWS at first observations recorded on WEBV. 18.01% of Paediatrics arriving via EMAS were scoring 5 or greater, Adults were 14.76%.

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. November saw a significant drop in performance down to 40.45% which was driven by increased and sustained UEC pressures and demand

Length of Stay
In November, the Non-Elective Length of Stay showed a sharp improvement of 0.34 days compared to October 2024, with the current performance level at 4.39 days, exceeding the maximum threshold by 0.11 days. ULTH hasn't seen a performance of this rate in the past rolling 12 months. The average bed occupancy rate, in relation to "Core G&A," was 95.70%. To ensure safe and efficient operational flow within acute sites, an average of 48 escalation beds/boarding spaces were allocated, resulting in an occupancy versus escalation ratio of 91.32%, meeting the new national standard of less than 92%. Notably, approximately 44 beds were designated for elective flow at Grantham. If the metrics exclude this site, the core will result in 98.38%, and core plus escalation at 93.60%.

In September 2024, System Partners embarked on the "Discharge Sprint" and the "System Sprint" to tackle challenges in providing timely assistance for facilitating discharges from the acute care setting for Pathways 0,1,2 and 3 continuing throughout November, with a monthly programme of MADE running through the remainder of 2024 and into 2025.

The identification of timely support to facilitate discharges from the acute care setting for pathways 1 to 3 continues to pose significant challenges for System Partners. Furthermore, the Trust has reinstated the involvement of SAFER practitioners to enhance education and compliance in the recording and monitoring of the percentage of discharges occurring within 24 hours of the predicted discharge date (PDD). In November, the performance achievement was 38.71%, reflecting a decline from the target of 45% and a decrease in comparison to the results obtained in September.

Referral to Treatment
September performance improved, reporting a performance of 52.23% compared to 50.8% in September. The Trust continues to report patients waiting over 104, 78, 65 & 52 weeks. At the end of November, the Trust reported zero patients waiting longer than 104 weeks. The trust exited November with 2 patients waiting more than 78 weeks, and whilst this wasn't zero, this was down to patients requesting to

delay their treatment. The trust exited November with 134 patients waiting over 65 weeks which was better than forecast and still on track to hit zero for the end of December.

The trust was an early adopter of the Further Faster programme which is a national initiative to reduce patients waiting over 52 weeks. In October the Trust reported 2.181 patients waiting over 52 weeks which was a significant reduction from the 2,949 reported in September.

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 October rose slightly to 71,839.

As of 2nd December 2024, ASI sat at 1053. Whilst this is higher than the agreed trajectory of 550, the number fluctuates week on week and is a significant improvement overall. Additional resource has been directed to resolving missing outcomes which is having a positive effect on the bookings team being able to move the ASIs to open referrals.

DM01

The report for DM01 in November showed a slight deterioration, decreasing from 74.93% in October to 73.91%. MRI performance remained strong with the most pressured diagnostics now being Dexa, NOUS and Audiology.

Cancelled Ops

November outturn for cancelled operations on the day improved from 1.6% in October to 1.14%. Lack of time and lack of theatre staff were again the main reasons for cancellations.

Included in the 1.14% of on the day cancellations, 21 patients were not treated within the 28-day standard which is another improvement. This 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) for October sat at 79.5%, which is another month on month improvement and is still above the 75% target.

62-day classic treatment performance for October was 62.30%, and an improvement from August.

104+ day waiters increased slightly to 72 at the end of November compared to 69 at the end of October. The highest risk specialities are colorectal, head & Neck and prostate. The divisions are working hard to resolve but are facing challenges from a high number of complex and disengaged patients.

We are starting to see a greater focus regionally on 31 day performance. After 5 months of consecutive improvement, November performance saw a slight deterioration to 93%.

Workforce

Mandatory Training – Our November 2024 Core Learning Rate is 93.55% against a Target of 90.00%. This is a slight decrease when compared to last month, although we are exceeding our overall target. Compliance will continue to be monitored in line with our 2024/25 target to ensure that we remain in line with our overall trajectory.

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)

Sickness Absence – Our November 2024 Sickness Rate is 5.23% against a Quarter 3 Target of 5.54%. This is within trajectory and has met the end of year target.

Sickness absence rates have remained stable 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. The trajectory outlines a potential for increased sickness absence during Quarter 3 winter months, however we remain in an exceeding target position.

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 'People Management Essentials' training.

Staff Appraisals – Our November 2024 appraisal rate is measured against a Quarter 3 Target of 85.58%, and in month we have achieved a Trustwide position of 81.15%. This is a slight increase when compared to the previous month, but remains just outside of target. It is the Agenda for Change appraisals which require the focus in order to ensure that the Quarter 3 target is able to be achieved.

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. Our Education, Learning & OD Team are developing an approach which will support specific teams where compliance rates are less than 50% in the same way we did with Core Learning. It is expected that this will see further improvements.

Staff Turnover – Our November 2024 Turnover Rate is 9.65% against a Quarter 3 Target of 10.24%. This is within trajectory and 0.65% from meeting the end of year target.

Operational pressures, staffing and culture are continued challenges, although despite this we are in line with our trajectory and year-end target. With the introduction of the Equality, Diversity & Inclusion Group, Culture & Leadership Group, Education Oversight Group, and the refresh of the Workforce Strategy Group across Lincolnshire Community Hospitals Group (LCHG) there are additional platforms where retention of staff can be considered through various workforce lenses.

We continue to work closely with Divisional colleagues and support reduction in vacancies to reduce the impact of staffing and associated operational pressures.

Vacancies – Our November 2024 Vacancy Rate is 6.23% against a Quarter 3 Target of 6.11%. This is within trajectory tolerance levels for Quarter 3 and 1.73% from meeting the end of year target of 4.50% by 31 March 2025. We have seen a further reduction in vacancy rates across Medical & Dental, Allied Health Professionals and Nursing & Midwifery remains in a stable improved position.

Our recruitment levels have continued to be consistent during 2024/25. There continues to be a strong focus on reducing the number of vacancies within Medical & Dental and Allied Health Professionals in direct response to local and national programmes of work.

As we have introduced a local process of vacancy deferment, we will monitor any potential impact of this on the Trust vacancy position, and if required escalate accordingly in line with Trust governance and assurance processes.

Finance

The Group has planned a deficit for 2024/25 of £6.9m inclusive of a £47.1m cost improvement programme.

Revenue position - The Group's YTD position is a £25.6m deficit, which is £15.0m adverse to the planned £10.6m YTD deficit. The Group are working with system partners on mitigation actions to improve the financial position.

Capital position - The Group has a £89.3m capital programme and the Group has YTD delivered capital expenditure of £46.9m, which is £2.8m higher than planned capital expenditure of £44.1m.

CIP position - The Group has delivered CIP savings of £25.8m, which is £0.1m favourable to planned CIP savings of £25.7m.

Cash position - The Group's cash balance is £27.0m, which is £12.0m lower than the planned cash balance of £39.0m.

	Group performance			LCHS performance			ULTH performance		
Month 8 Position	Year To Date			Year To Date			Year To Date		
	Plan £m	Actual £m	Var. £m	Plan £m	Actual £m	Var. £m	Plan £m	Actual £m	Var. £m
Surplus / (Deficit)	(10.6)	(25.6)	(15.0)	(0.9)	(0.7)	0.2	(9.7)	(24.9)	(15.2)
Capital Spend	44.1	46.9	2.8	0.4	4.2	(3.8)	43.7	42.6	1.0
CIP Delivery	25.7	25.8	0.1	4.0	4.5	0.5	21.7	21.3	(0.4)
Agency Spend	(14.2)	(17.8)	(3.6)	(1.8)	(1.3)	0.5	(12.4)	(16.5)	(4.1)
Cash Balance	39.0	27.0	(12.0)	30.0	21.6	(8.4)	9.0	5.4	(3.6)

Daren Fradgley
Group Chief Integration Officer
December 2024

Key to Variation and Assurance Icons and SPC Dots

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

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

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

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

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

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

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

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

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

OUTSTANDING CARE personally DELIVERED

Performance Overview - Quality

NHS United Lincolnshire Teaching Hospitals NHS Trust

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Sep-24	Oct-24	Nov-24	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Clostridioides difficile position	Safe	Patients	Director of Nursing	9	5	6	11	65	P	
	MRSA bacteraemia	Safe	Patients	Director of Nursing	0	0	0	0	1	P	
	MSSA bacteraemia cases counts and 12-month rolling rates of hospital-onset, by reporting acute trust and month using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.01	0.01	0.03	0.01		H
	E. coli bacteraemia cases counts and 12-month rolling rates, by reporting acute trust and month using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.04	0.05	0.04	0.04		
	Catheter Associated Urinary Tract Infection	Safe	Patients	Director of Nursing	1	Data Not Available	Data Not Available	Data Not Available			
	Falls per 1000 bed days resulting in moderate, severe harm & death	Safe	Patients	Director of Nursing	0.19	0.12	0.22	0.08	0.14	P	
	Pressure Ulcers category 3	Safe	Patients	Director of Nursing	4.3	3	4	1	31	P	
	Pressure Ulcers category 4	Safe	Patients	Director of Nursing	1.3	0	0	0	3	P	
	Venous Thromboembolism (VTE) Risk Assessment	Safe	Patients	Medical Director	95.00%	96.94%	96.73%	96.61%	95.78%	P	H
	Never Events	Safe	Patients	Director of Nursing	0	0	0	0	2	P	
	Reported medication incidents per 1000 occupied bed days	Safe	Patients	Medical Director	4.30	4.33	4.98	3.81	4.69	P	

OUTSTANDING CARE personally DELIVERED

Performance Overview - Quality

NHS United Lincolnshire Teaching Hospitals NHS Trust

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Sep-24	Oct-24	Nov-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%	13.50%	17.60%	17.60%	13.35%	F	
	Patient Safety Alerts responded to by agreed deadline	Safe	Patients	Medical Director	100.00%	None due	100.00%	0.00%	46.66%	F	
	Hospital Standardised Mortality Ratio - HSMR (basket of 56 diagnosis groups) (rolling year data 3 month time lag)	Effective	Patients	Medical Director	100	96.35	98.57	95.75	N/A		
	Summary Hospital Mortality Indicator (SHMI) (rolling year data 5 month time lag)	Effective	Patients	Medical Director	100	105.97	105.99	106.09	N/A		
	The Trust participates in all relevant National clinical audits	Effective	Patients	Medical Director	100.00%	100.00%	100.00%	100.00%	100.00%	P	H
	eDD issued within 24 hours	Effective	Patients	Medical Director	95.00%	91.60%	92.00%	90.40%	90.94%	F	
	Sepsis screening (bundle) compliance for inpatients (adult)	Safe	Patients	Director of Nursing	90.00%	91.38%	92.80%	Data Not Available	92.16%	P	
	Sepsis screening (bundle) compliance for inpatients (child)	Safe	Patients	Director of Nursing	90.00%	75.70%	82.30%	Data Not Available	79.41%	F	
	IVAB within 1 hour for sepsis for inpatients (adult)	Safe	Patients	Director of Nursing	90.00%	96.00%	98.12%	Data Not Available	96.57%	P	H
	IVAB within 1 hour for sepsis for inpatients (child)	Safe	Patients	Director of Nursing	90.00%	60.00%	100.00%	Data Not Available	78.73%	F	
	Sepsis screening (bundle) compliance in A&E (adult)	Safe	Patients	Director of Nursing	90.00%	92.00%	93.62%	Data Not Available	92.16%	P	

OUTSTANDING CARE personally DELIVERED

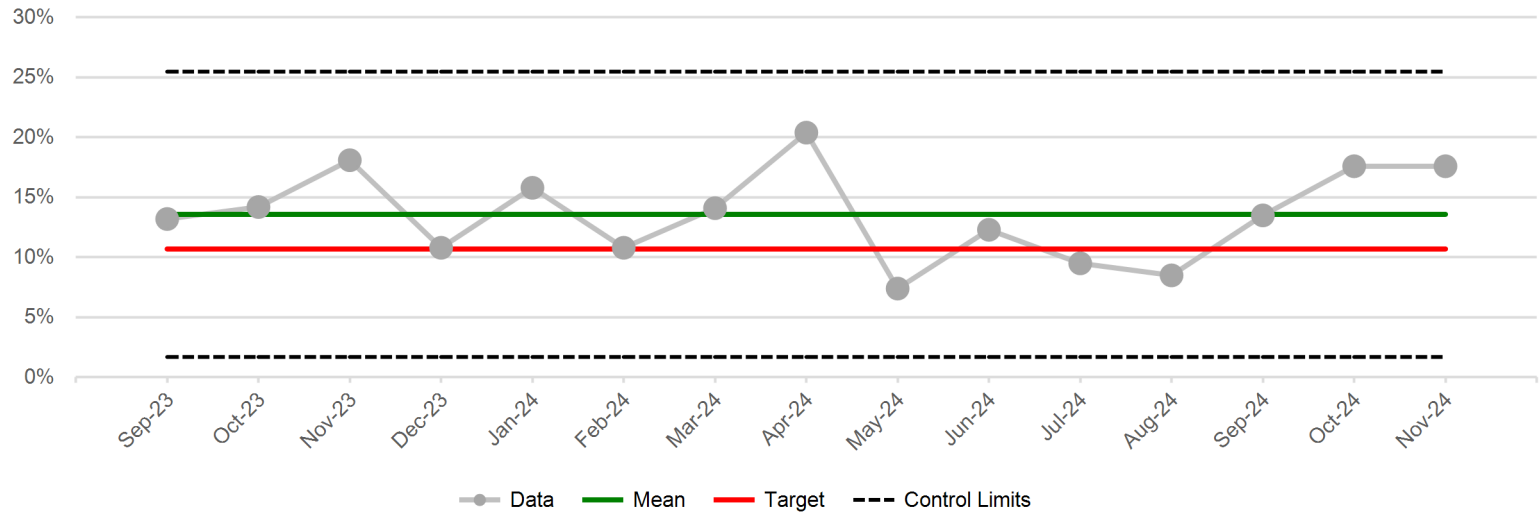
Performance Overview - Quality

NHS United Lincolnshire Teaching Hospitals NHS Trust

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Sep-24	Oct-24	Nov-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%	93.50%	95.10%	Data Not Available	93.14%	P	
	IVAB within 1 hour for sepsis in A&E (adult)	Safe	Patients	Director of Nursing	90.00%	95.73%	96.22%	Data Not Available	95.00%	P	
	IVAB within 1 hour for sepsis in A&E (child)	Safe	Patients	Director of Nursing	90.00%	53.80%	66.60%	Data Not Available	73.26%	F	
	Rate of stillbirth per 1000 births	Safe	Patients	Director of Nursing	3.80	1.81	2.91	2.93	2.65	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%	82.00%	100.00%	Data Not Available	92.57%	F	
	Duty of Candour compliance - Written	Responsive	Patients	Medical Director	100.00%	77.00%	95.00%	Data Not Available	89.14%	F	

Performance Overview - Quality

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



Nov-24
17.60%
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).

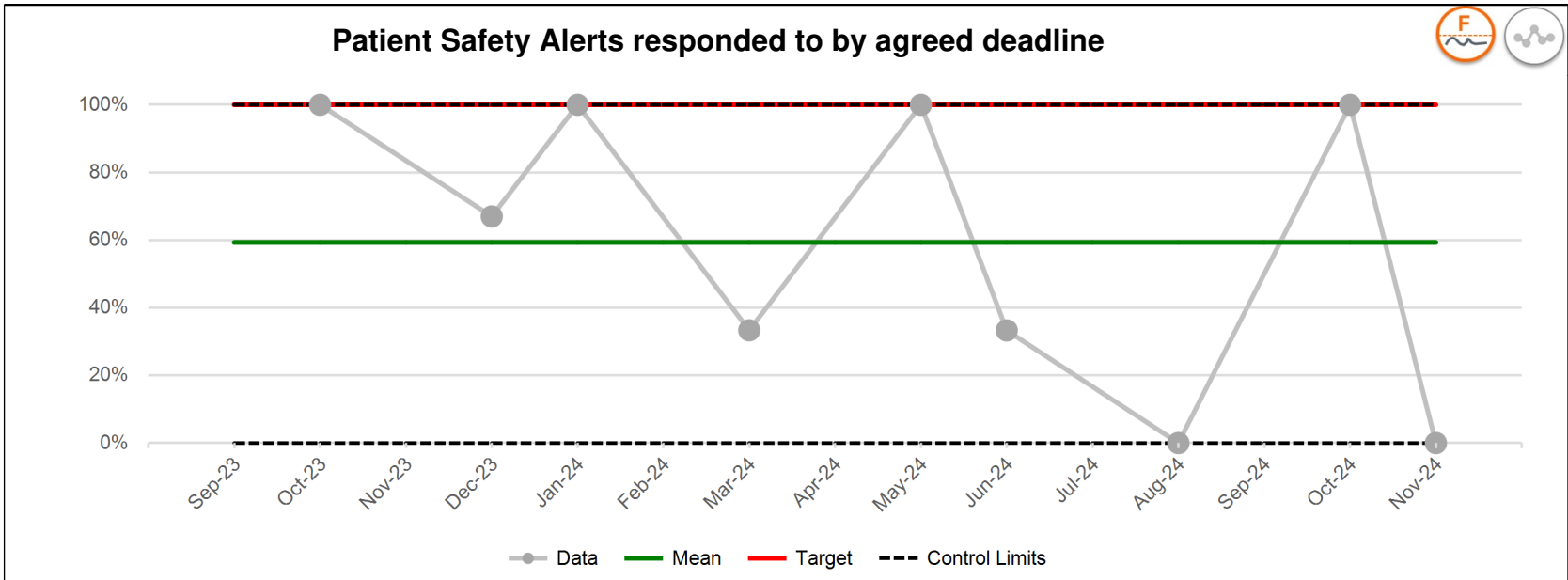
What the chart tells us:
In the month of November the number of medication incidents reported was 131. This equates to 3.81 incidents per 1000 bed days. The number of incidents causing some level of harm (low /moderate /severe / death) is 17.6% which is above the national average of 11%.

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

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

Mitigations:

Performance Overview - Quality



Nov-24
0.00%
Variance Type
Common cause variation
Target
100.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Medical Director

Background:
Patient safety alerts responded to by agreed deadline.

What the chart tells us:
There was 1 Safety Alert with a deadline for completion in November which was overdue the action completed deadline. Deviances continue to be seen in compliance.

Issues:
The Trust was previously not demonstrating compliance with the target set for Patient Safety Alerts. The performance continues to fluctuate.

Actions:
Monthly Safety Alerts exception report is now discussed at Patient Safety Group, and a full review Quarterly report submitted.

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 – outstanding actions monitored and escalation when appropriate. Meetings held with appropriate Leads when new Alerts received to ensure actions are assigned to relevant Trust leads and are completed within deadlines.

Mitigations:
Compliance is discussed monthly at Patient Safety Group, and a monthly escalation report highlights Alerts with upcoming deadlines for Leads to action and outstanding actions for overdue Alerts.

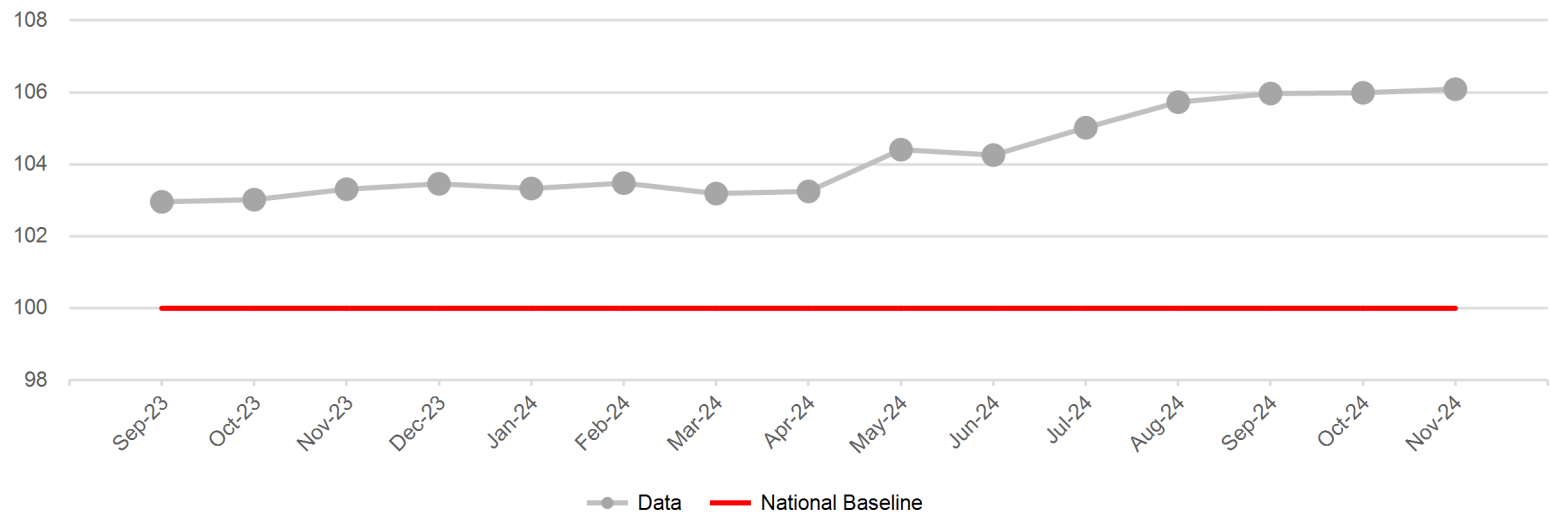
A CAS/FSN Alerts Oversight Group convenes monthly to discuss issues which may arise and prevent the Trust meeting the deadlines and to put plans in place to mitigate.

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

Performance Overview - Quality

United Lincolnshire Teaching Hospitals NHS Trust

Summary Hospital Mortality Indicator (SHMI) (rolling year data 5 month time lag)



Nov-24
106.09
Variance Type
Target
To remain in 'as expected' range
Achievement
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. Legislation came into effect from 9 September 2024 for all deaths in Lincolnshire to be reviewed by an ME.

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.

Mortality reviews are discussed at either Speciality Governance or M&Ms to aid learning.

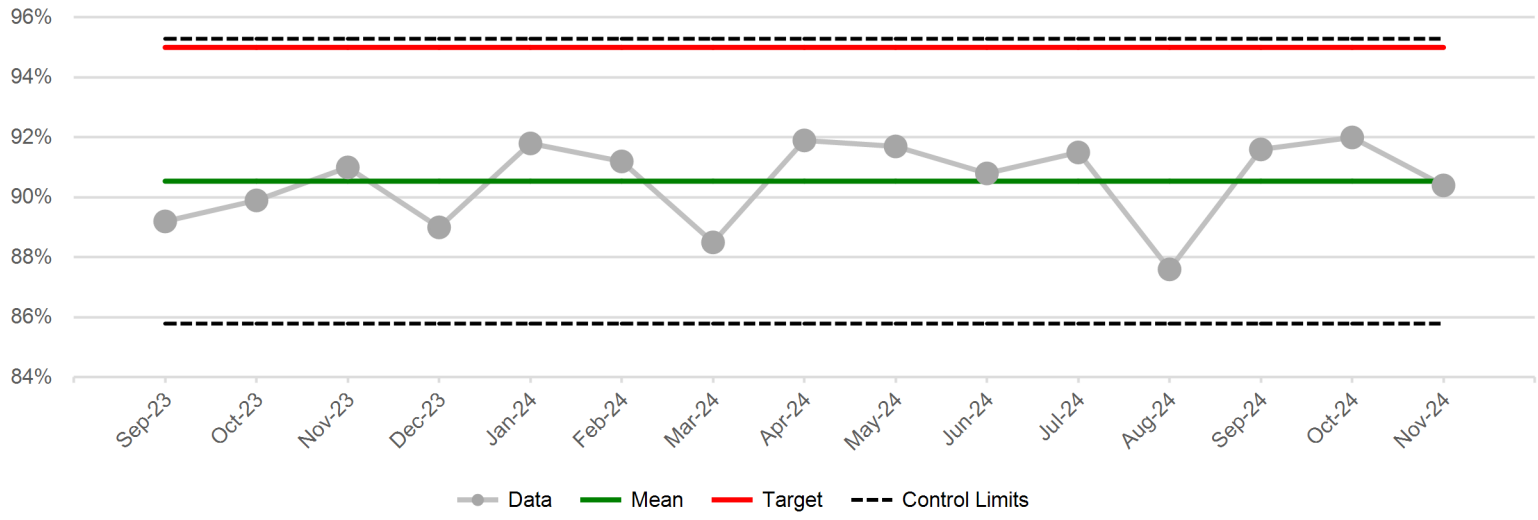
Mitigations:
The MEs have commenced reviewing all deaths in the community which will enable oversight of deaths in 30 days post discharge of which learning can be identified.

HSMR is 95.75

Performance Overview - Quality

United Lincolnshire Teaching Hospitals NHS Trust

eDD issued within 24 hours



Nov-24
90.40%
Variance Type
Common cause variation
Target
95.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Medical Director

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

What the chart tells us:
eDD Performance continues to be below the 95% target, currently at 90.40%.

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

No Narrative owner

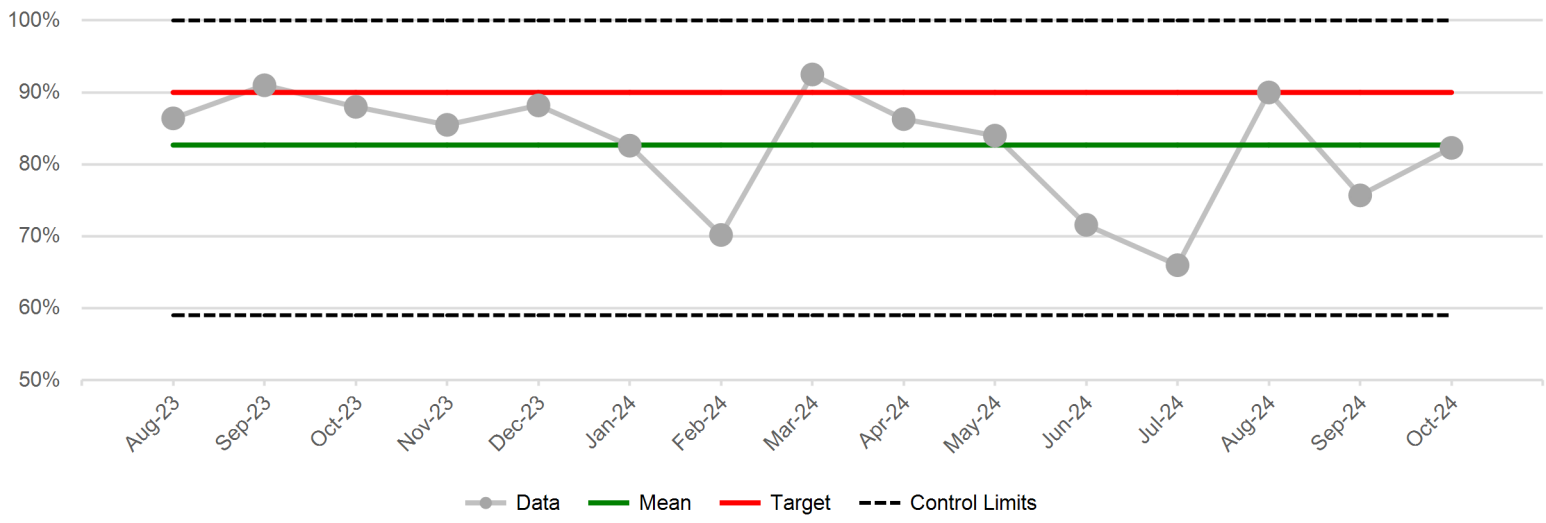
Actions:
A dashboard is in place to highlight compliance at both ward and consultant level with each Division now reviewing this metric.

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

Performance Overview - Quality

United Lincolnshire Teaching Hospitals NHS Trust

Sepsis screening (bundle) compliance for inpatients (child)



Oct-24
82.30%
Variance Type
Common cause variation
Target
90.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of Nursing

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

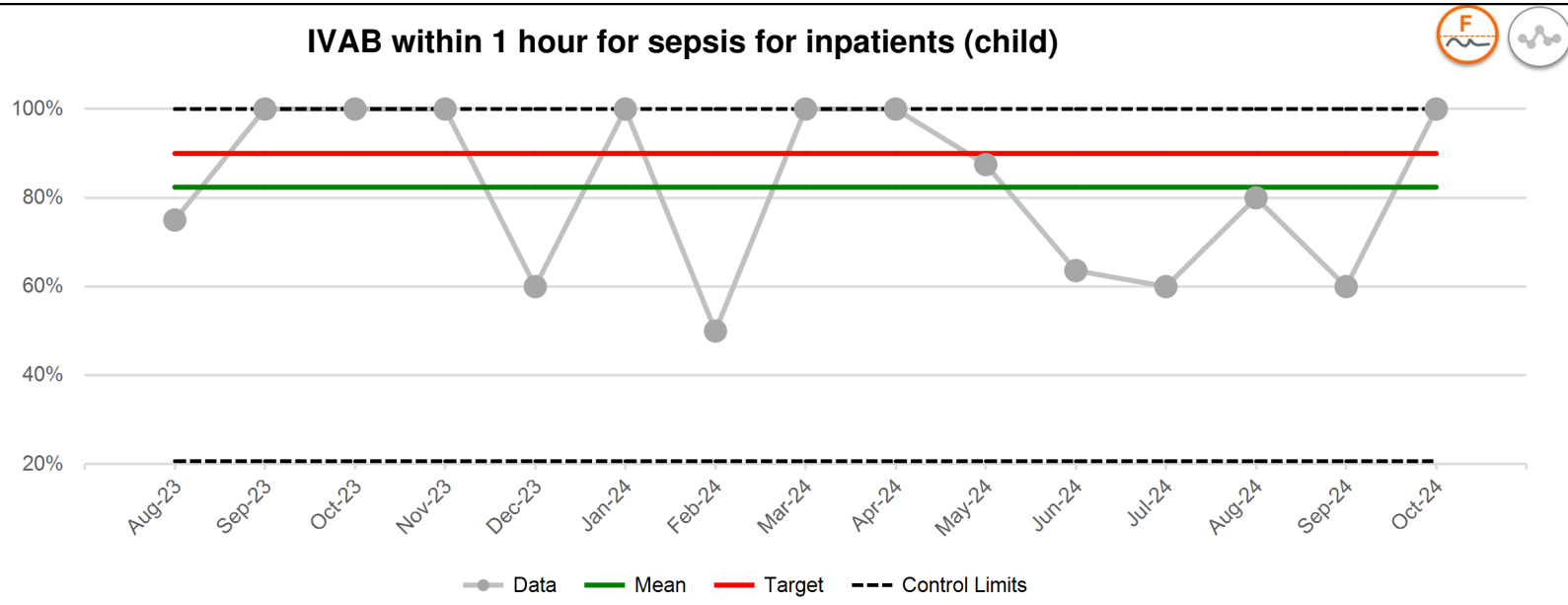
What the chart tells us:
The Sepsis screening compliance this month was 82.3%, which is below the 90% target. 28 of 34 patients were screened within the 60-minute timeframe.

Issues:
There were 6 patients this month with delayed sepsis screening. The data is raw data taken from WEBV before notes have been reviewed. All six patients had a PEWS of 5 but had had no screen completed on WEBV.

Actions:
Ward Managers / clinical Educators are reviewing patient notes to see how long patients were waiting for a medical review..
Ward Managers will discuss with staff involved about the importance of completing screen as well as 5 being the trigger PEWS.
Simulation training involves Sepsis for all staff.

Mitigations:
No Harm found in harm reviews done. Patients found to have viral illness or non-infective cause for illness / raised score.

Performance Overview - Quality



Oct-24
100.00%
Variance Type
Common cause variation
Target
90.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of Nursing

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

What the chart tells us:
The compliance for Sepsis treatment this month is 100% which is excellent and above the 90% target.
6 out of 6 patients were treated with IV antibiotics within the 1 hour timeframe.

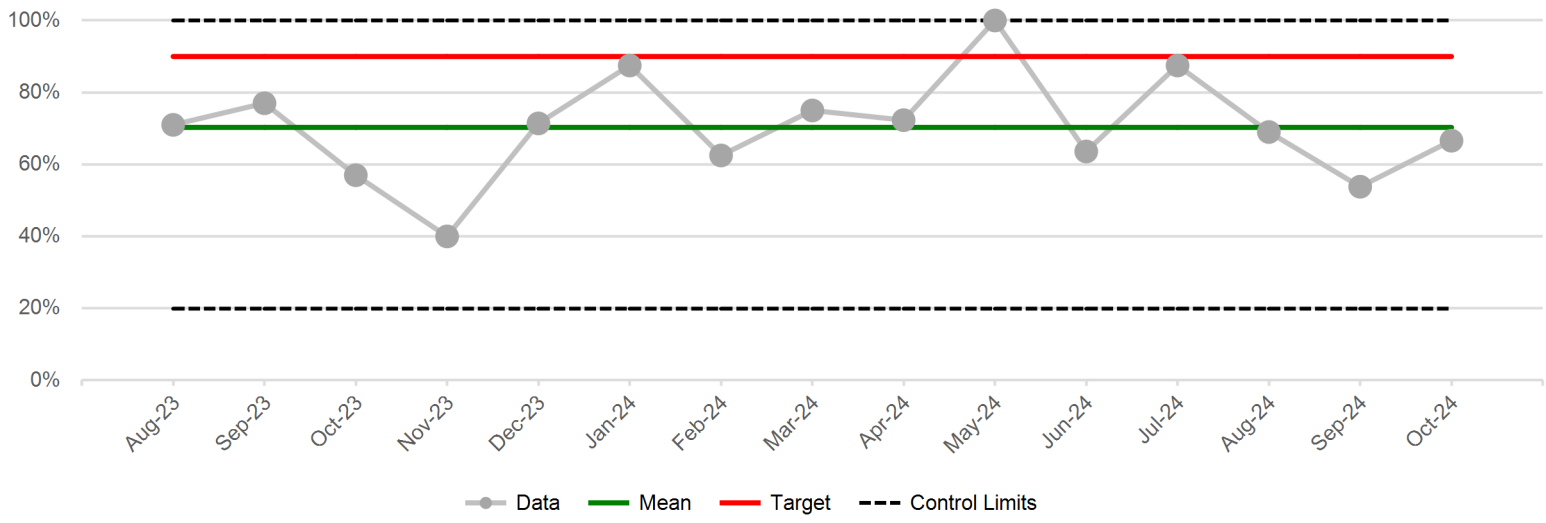
Issues:
There were no patients this month in inpatient areas with delayed Sepsis treatment.

Actions:
Treatment compliance this month is excellent at 100%. All previous plans continue in order to try to maintain good compliance for the longer term.

Mitigations:
There were no harm reviews to complete for inpatient treatment this month.

Performance Overview - Quality

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



Oct-24
66.60%
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 administration of IVAB within one hour was 66.6%, which is well below the 90% standard. 12 out of 18 patients received their antibiotics within a timely manner.

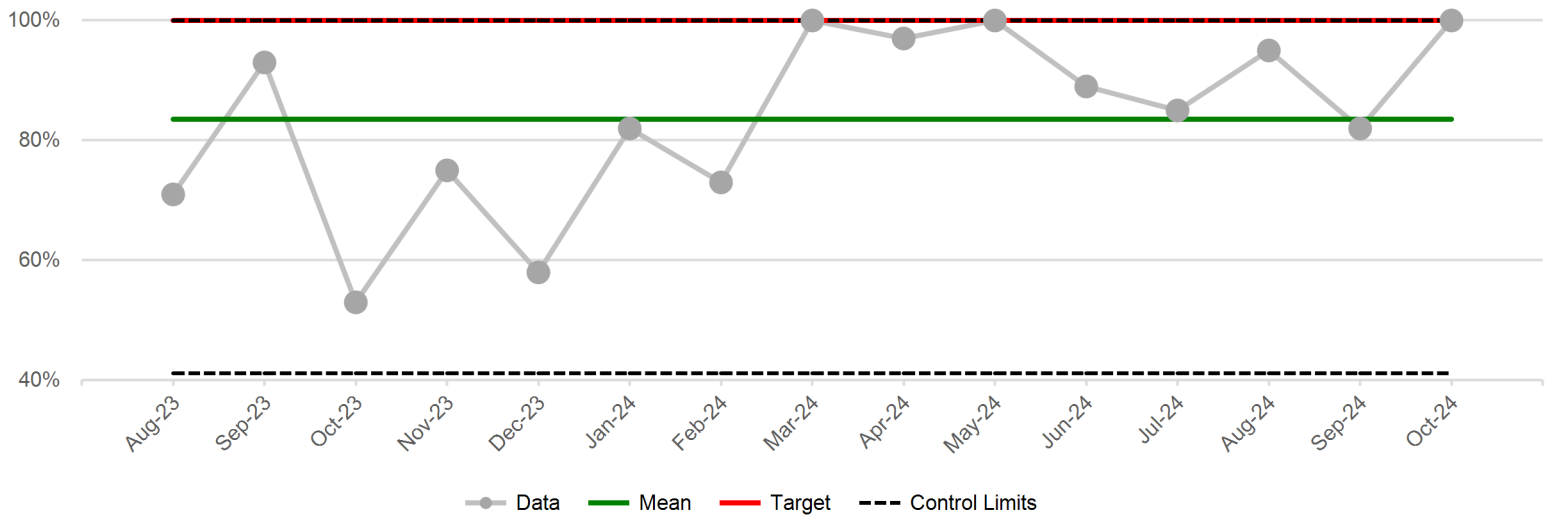
Issues:
There were 6 patients this month with delayed Sepsis treatment. All six delays were on one site.
Themes for delays were found to be:
-Waiting for Paediatric / specialist teams before making clinical decision.
-Long delays between prescribing and administration
-Difficulty obtaining IV access
There is one parent complaint as they questioned sepsis numerous times before treatment given.

Actions:
Themes escalated to ED manager, Sepsis link nurses and Consultant. One member of medical team was identified as waiting for other teams on a number of occasions; Consultant will speak with this staff member. Paediatric teams are planning some joint training with ED team.
Staff are reviewing notes.

Mitigations:
Harm reviews completed for all patients with delayed treatment – No harm found. Some training needs identified.

Performance Overview - Quality

Duty of Candour compliance - Verbal



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

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

What the chart tells us:
Compliance has improved this month.

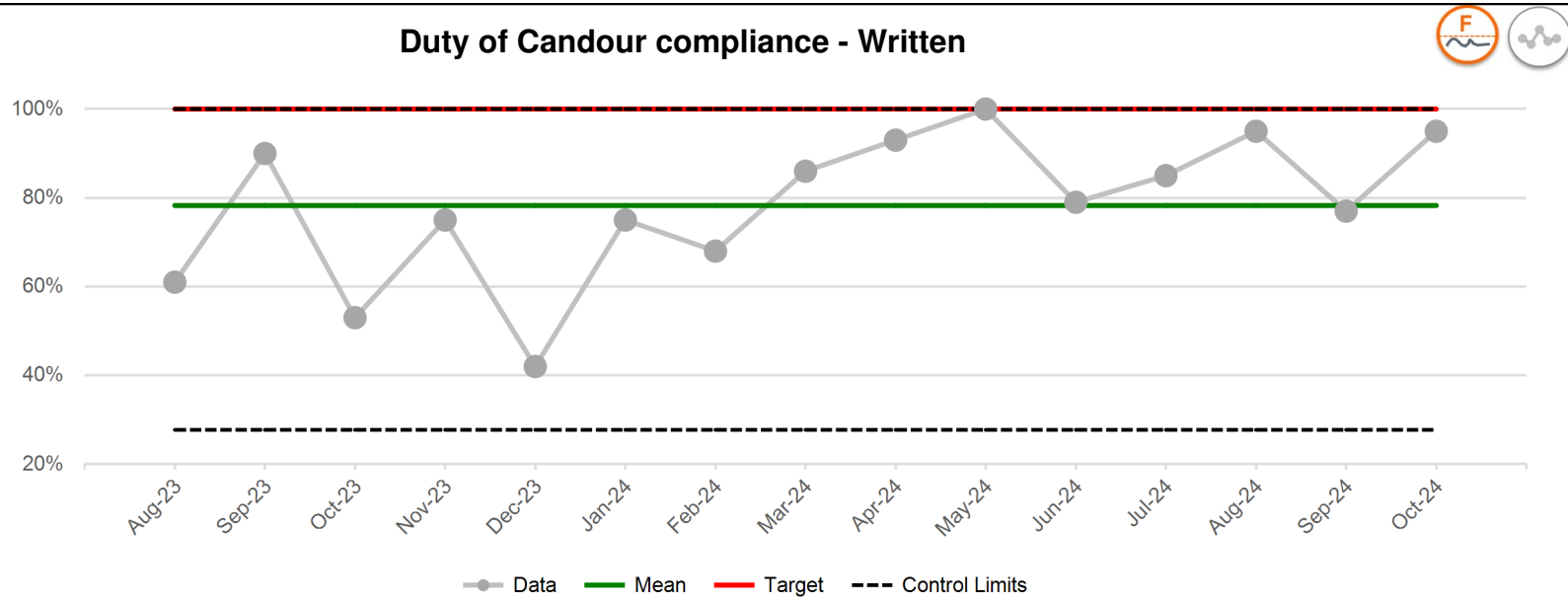
Issues:
From March 2024, a new parameter in DatixIQ has been used to monitor Duty of Candour compliance to ensure accuracy of data. This enables the incident team to ensure the grading of harm is accurate to enable the Duty of Candour regulation to be triggered.

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



Oct-24
95.00%
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 improved 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.

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Teaching Hospitals NHS Trust

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Sep-24	Oct-24	Nov-24	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Patient Experience	% Triage Data Not Recorded	Effective	Patients	Chief Operating Officer	0.00%	0.27%	0.40%	0.30%	0.27%	0.00%	F	
Improve Clinical Outcomes	4hrs or less in A&E Dept	Responsive	Services	Chief Operating Officer	76.70%	74.53%	73.04%	72.87%	73.09%	75.44%	F	H
	12+ Trolley waits	Responsive	Services	Chief Operating Officer	0	950	1,171	874	7,575	0	F	
	%Triage Achieved under 15 mins	Responsive	Services	Chief Operating Officer	88.50%	82.46%	77.42%	76.22%	80.67%	88.50%	F	H
	52 Week Waiters	Responsive	Services	Chief Operating Officer	2,027	2,949	2,181		21,061	14,189	F	L
	65 Week Waiters	Responsive	Services	Chief Operating Officer	0	388	201		2,782	0	F	L
	18 week incompletes	Responsive	Services	Chief Operating Officer	84.10%	50.80%	52.23%		51.71%	84.10%	F	
	Waiting List Size	Responsive	Services	Chief Operating Officer	58,965	71,784	71,839		N/A	N/A	F	L
	28 days faster diagnosis	Responsive	Services	Chief Operating Officer	75.00%	78.20%	79.50%		77.97%	75.00%	P	
	62 day classic	Responsive	Services	Chief Operating Officer	85.39%	60.50%	62.30%		60.59%	85.39%	F	
	2 week wait suspect	Responsive	Services	Chief Operating Officer	93.00%	73.90%	72.90%		74.63%	93.00%	F	

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Teaching Hospitals NHS Trust

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Sep-24	Oct-24	Nov-24	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Clinical Outcomes	2 week wait breast symptomatic	Responsive	Services	Chief Operating Officer	93.00%	68.70%	76.70%		64.93%	93.00%	F	
	31 day first treatment	Responsive	Services	Chief Operating Officer	96.00%	95.30%	93.00%		91.16%	96.00%	F	
	31 day subsequent drug treatments	Responsive	Services	Chief Operating Officer	98.00%	89.20%	92.80%		89.79%	98.00%	F	
	31 day subsequent surgery treatments	Responsive	Services	Chief Operating Officer	94.00%	88.90%	85.20%		77.64%	94.00%	F	
	31 day subsequent radiotherapy treatments	Responsive	Services	Chief Operating Officer	94.00%	88.70%	94.60%		88.31%	94.00%	F	
	62 day screening	Responsive	Services	Chief Operating Officer	90.00%	58.60%	58.80%		68.09%	90.00%	F	
	62 day consultant upgrade	Responsive	Services	Chief Operating Officer	85.00%	69.90%	73.00%		70.44%	85.00%	F	
	Diagnostics achieved	Responsive	Services	Chief Operating Officer	99.00%	75.65%	74.93%	73.91%	73.16%	99.00%	F	
	Cancelled Operations on the day (non clinical)	Responsive	Services	Chief Operating Officer	0.80%	1.86%	1.58%	1.14%	1.78%	0.80%	F	
	Not treated within 28 days. (Breach)	Responsive	Services	Chief Operating Officer	0	38	33	21	259	0	F	
	#NOF 48 hrs	Responsive	Services	Chief Operating Officer	90.00%	85.96%	67.02%	40.45%	68.60%	90.00%	F	

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Teaching Hospitals NHS Trust

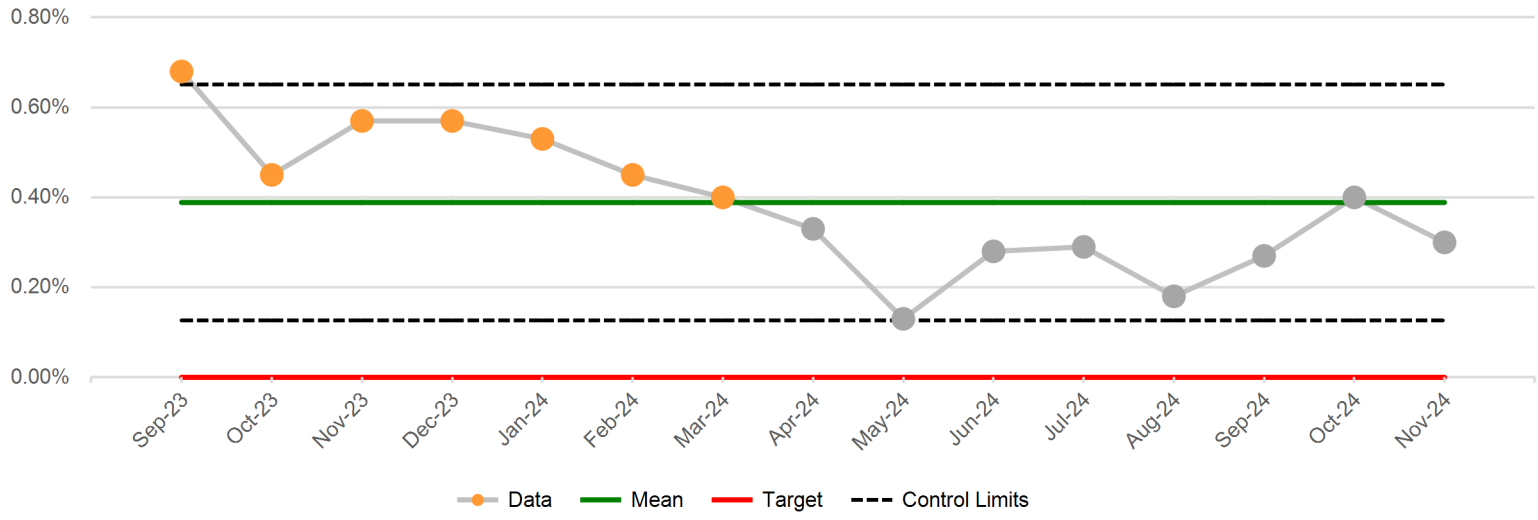
5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Sep-24	Oct-24	Nov-24	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Clinical Outcomes	#NOF 36 hrs	Responsive	Services	Chief Operating Officer	TBC	43.86%	43.62%	25.84%	41.12%			L
	EMAS Conveyances to ULHT	Responsive	Services	Chief Operating Officer	4,657	4,541	4,602	4,645	4,678	4,657	P	
	EMAS Conveyances Delayed >59 mins	Responsive	Services	Chief Operating Officer	0	404	717	670	435	0	F	
	104+ Day Waiters	Responsive	Services	Chief Operating Officer	10	81	69	72	470	80	F	
	Average LoS - Elective (not including Daycase)	Effective	Services	Chief Operating Officer	2.80	3.07	2.77	2.28	2.66	2.80	P	
	Average LoS - Non Elective	Effective	Services	Chief Operating Officer	4.50	4.71	4.73	4.39	4.72	4.50	F	L
	Delayed Transfers of Care	Effective	Services	Chief Operating Officer	3.50%	Submission suspended	Submission suspended	Submission suspended				
	Partial Booking Waiting List	Effective	Services	Chief Operating Officer	4,524	32,927	32,823	33,164	32,063	4,524	F	H
	% discharged within 24hrs of PDD	Effective	Services	Chief Operating Officer	45.00%	41.30%	40.20%	38.71%	38.99%	45.00%	F	

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Teaching Hospitals NHS Trust

% Triage Data Not Recorded



Nov-24
0.30%
Variance Type
Common cause variation
Target
0.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
Percentage of triage data not recorded.

What the chart tells us:
November reported a non-validated position of 0.30% of data not recorded versus the target of 0%. To note, 76% 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 117 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.

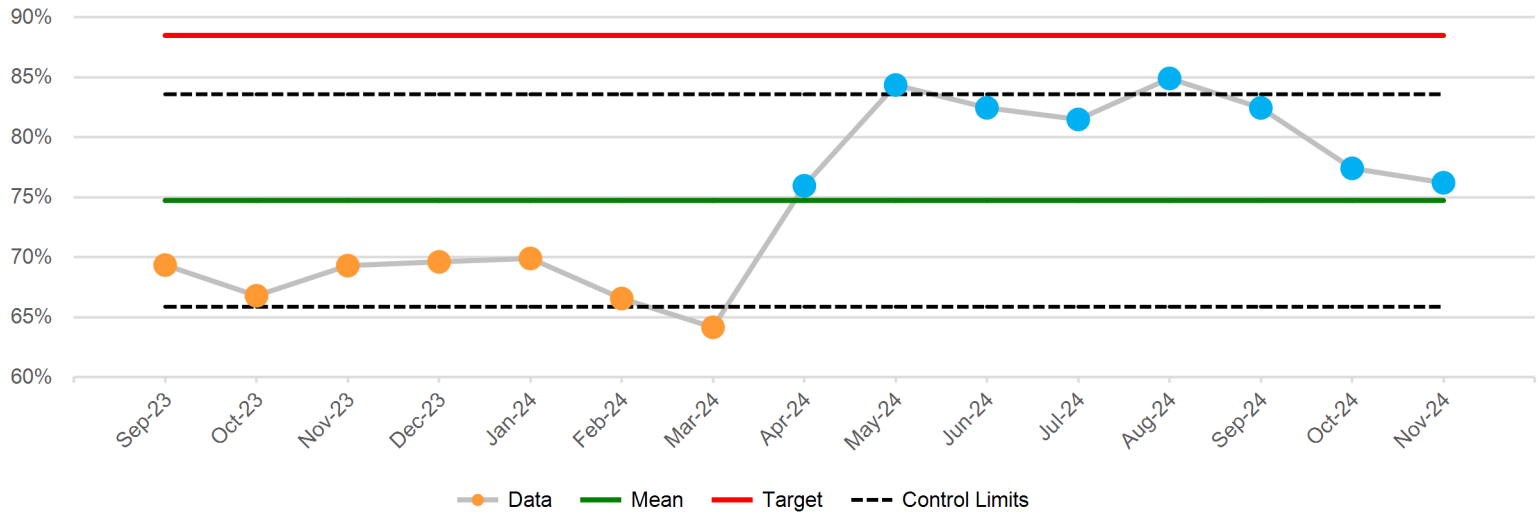
Mitigations:
- Earlier identification of recording delays via 3 x daily Capacity and performance meetings and confirmation via bespoke UEC daily updates.
- Increased nursing workforce following a targeted recruitment campaign has been successful and supernumerary period, has, in the main come to an end.
- 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).

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Teaching Hospitals NHS Trust

%Triage Achieved under 15 mins



Nov-24
76.22%
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:
November outturn was 76.22% compared 77.42% in October (validated). This is a 12.28% negative variance to the target of 88.50%
November's performance is a 6.91% 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:
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
UEC Sprint commenced also in August 2024.

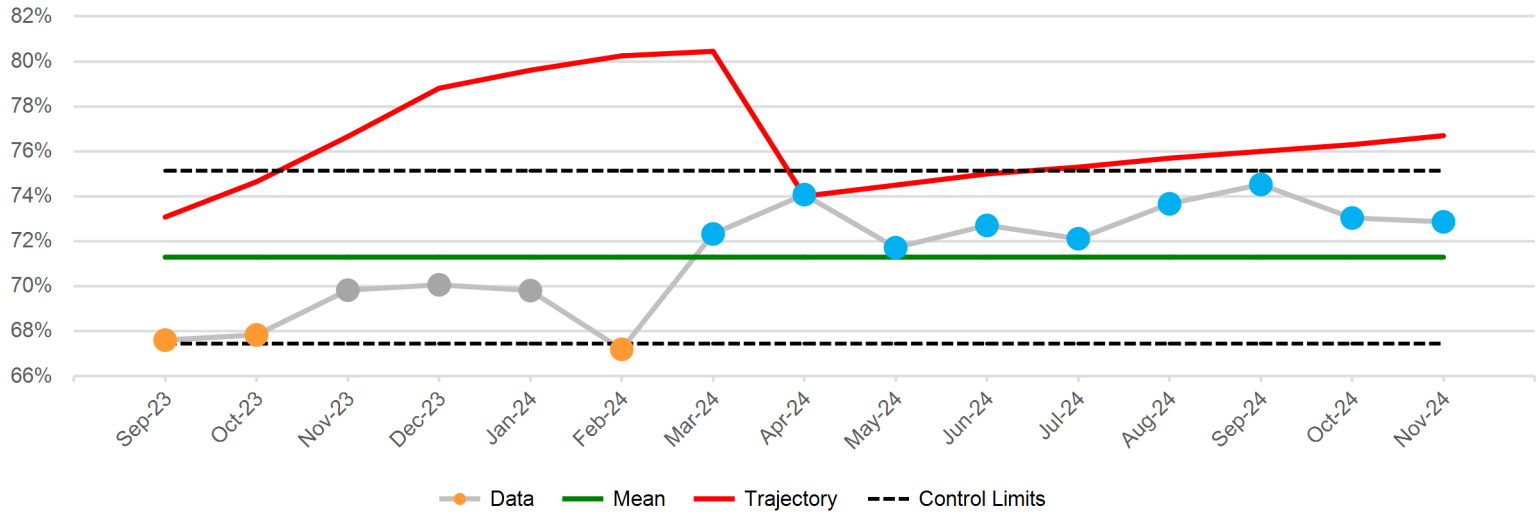
Mitigations:
The Senior Nurse Leads maintain oversight and support in periods of either high attendance demand or when the second triage stream is compromised due to duality of role issues.
The confirmation of 2 triage streams is ascertained at the 4 x daily Capacity meetings.
Early escalation and rectification 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.

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Teaching Hospitals NHS Trust

4hrs or less in A&E Dept



Nov-24
72.87%
Variance Type
Special cause variation - improvement (Indicator where high is good)
Trajectory
76.70%
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 72.87% compared to October's performance of 73.04%
What the chart doesn't tell us is also the increased volume and acuity of presentations to the department.

Issues:
In November 2024, Type 1 (ED) witnessed an average daily patient volume of 361, reflecting an increase from the 334 patients attended to in October 2024. ED encountered a deficiency in discharges from the wards, with an average of 30 fewer patient discharges per day than necessary to meet the demand. This led to extended wait times for inpatient beds during the night. Additionally, delayed identification of patients eligible for prolonged stays in the ED was noted, with over 60% of patients being identified only after 4 pm daily. Furthermore, the closure of beds on the wards due to COVID19, Influenza and RSV impacted the availability of resources for movement and cleaning, thereby affecting timely movements.

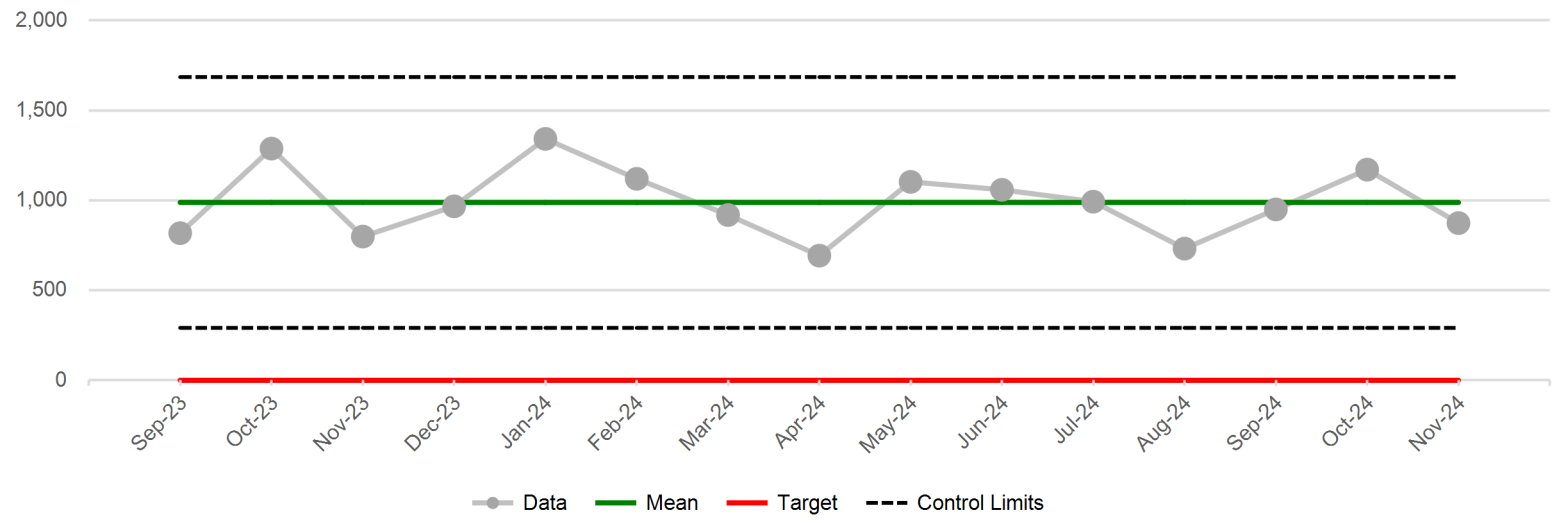
Type 3 (All locations) observed a static average of 609 daily patients, representing a similar position in the preceding 3 months.

Actions:
Project 76 & UEC Sprint 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 ULTH and LCHS.
A new Group UEC & 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.

Performance Overview - Operational Performance

12+ Trolley waits



Nov-24
874
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:
November experienced 874 breaches, a decrease from 1171 in October, marking an improvement of 25.36% (297 less patients). The 874 breaches accounted for 8.07% of all type 1 attendances.

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.

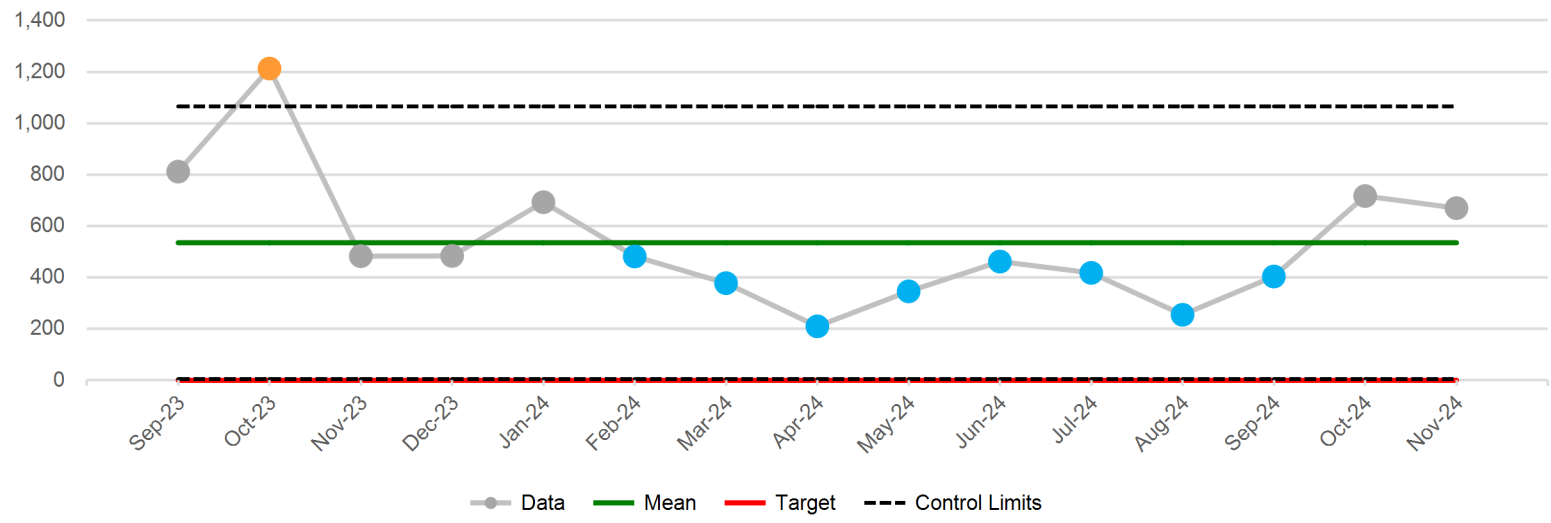
Additionally, the chart did not capture the adhoc internal decisions made to prioritise total time in the Emergency Department, aimed at minimising exposure risk and mortality rate.

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 Delayed >59 mins



Nov-24
670
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 November, there was an improvement in ambulance handover performance. There were 670 arrivals recorded over a 59-minute period, compared to Octobers 717 total. The total of >59min breaches constitutes 14.42% of all arrivals seen in November. (15% of patients arriving in November were already scoring >5 on NEWS score at presentation from EMAS).

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

Actions:
All ambulances approaching 30 minutes without a plan to off load are escalated to the Clinical Site Manager in hours and SOC out of hours
Daily communication with EMAS crews to sign post to alternative pathways and reduce conveyances to the acute setting.
Active monitoring of the EMAS inbound screen to ensure the departments are ready to respond.
Rapid handover protocol, designated escalation areas have been identified/confirmed to assist in reducing delays in handover.
Plus 1/2 Process active to alleviate pressure/capacity in ED.

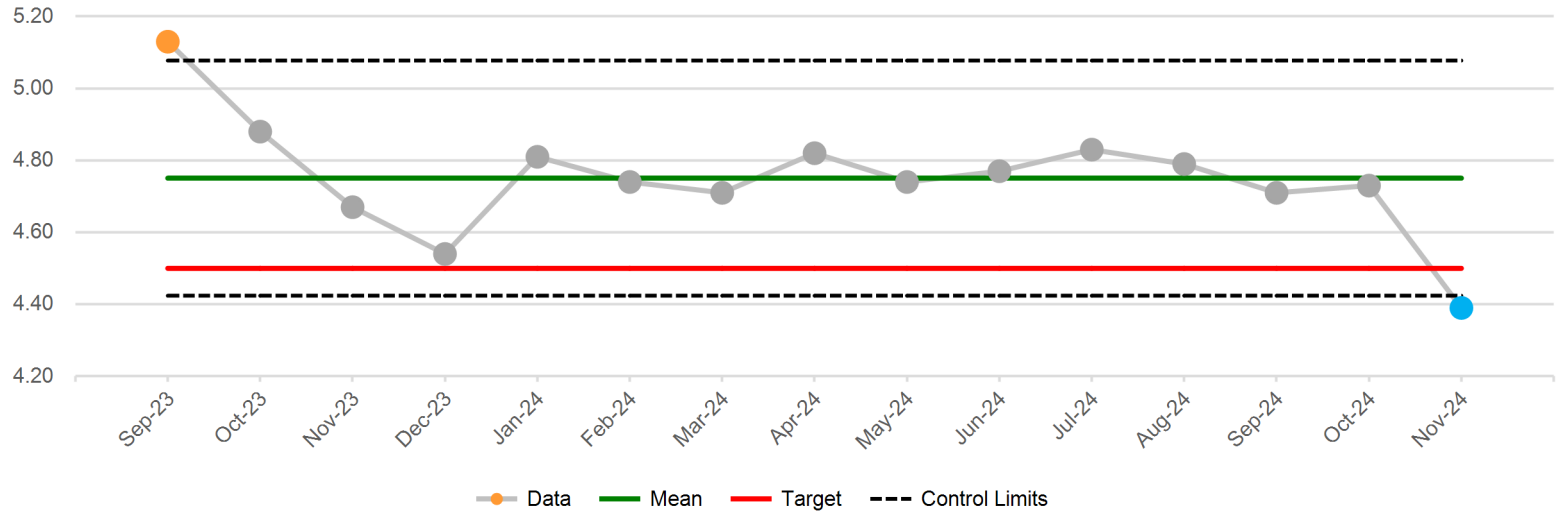
Mitigations:
Early intelligence of increasing EMAS demand has allowed for planning and preparedness to receive and escalate.
Contact points throughout the day and night with the Clinical Site Manager and Tactical Lead (in and out of hours) to appreciate EMAS on scene (active calls) and calls waiting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

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Teaching Hospitals NHS Trust

Average LoS - Non Elective



Nov-24
4.39
Variance Type
Special cause variation - improvement (Indicator where low is good)
Target
4.50
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
November outturn of 4.39 is a sharp improvement of 0.34 days and a 0.11-day negative variance against the agreed target.
What the chart doesn't tell us is the change by pathway:
Pathway 0 (0.3) less days
Pathway 1 (1.1) less days
Pathway 2 (0.3) more days
Pathway 3 (1.6) more days

Issues:
In November, there was a decrease in performance in the number of super-stranded patients, with the daily average increasing to 120 from 115. However, the number of stranded patients (14 days) increased in performance from 205 daily to 197. Weekend discharges consistently remained lower than weekdays, with a 47% reduction and an average of 65 less patients discharged. This reduction in weekend discharges presents a challenge in meeting the capacity and demand for emergency admissions.

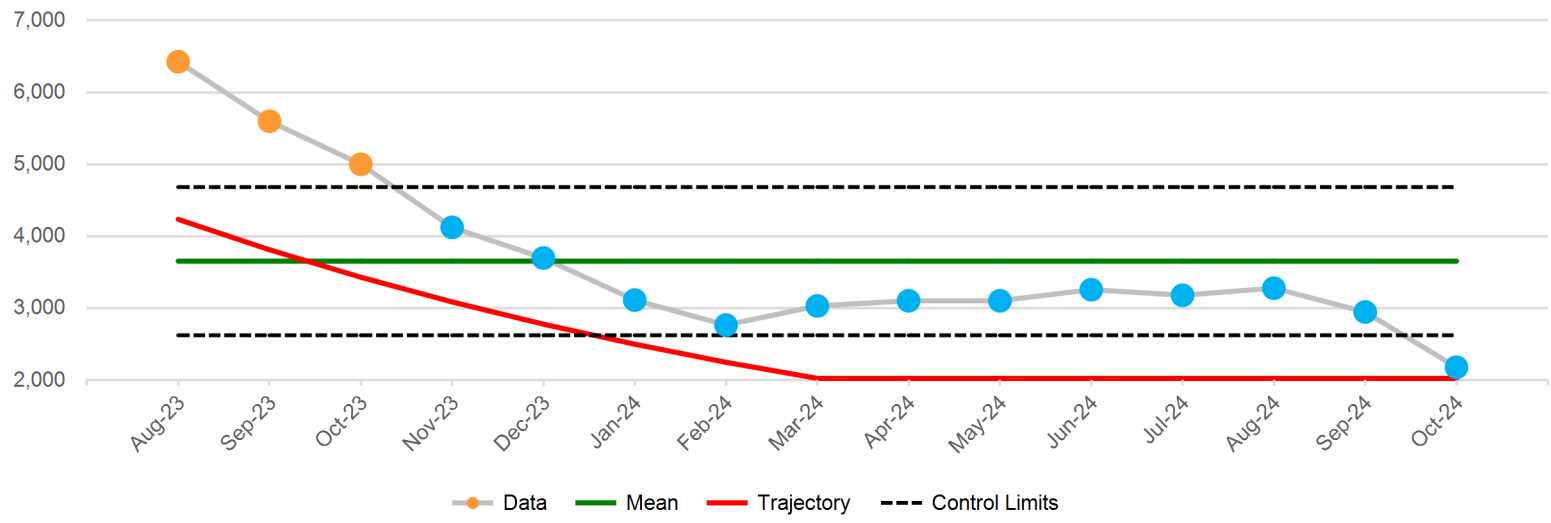
The Transfer of Care Hub continue to gain traction on moving discharges forward at an improved pace. Higher acuity of patients requiring a longer period of recovery.

Actions:
- Ensure that patient discharge is efficiently managed on a daily basis.
- Discuss the progress of medically optimised patients with system partners twice daily, 7 days a week to ensure timely planning and zero tolerance for delays exceeding 24 hours.
- Make full use of all community and transitional care beds when it's not possible to secure onward care promptly.
- Conduct a thorough review of all pathways, ensuring that patients who do not meet the residency criteria are identified.
- Hold monthly face-to-face events called MADE on each site, focusing particularly on reviewing all pathways and paying close attention to patients with a length of stay exceeding 7 days.

Mitigations:
Divisional Leads are providing support for addressing delays in patient discharges. Efforts to streamline corporate and divisional meetings are underway to prioritise the increase of daily discharges
An automated daily site update notification is now distributed at 6 AM to notify Key Leaders of the Emergency Department (ED) status, patient flow, and the operational pressures escalation level (OPEL) by site.
Transitioning to a 5-day workweek over a 7-day period is in progress.
A revised recurring schedule for Managing Ambulatory and Discharge Events (MADE) has been approved, with an agreed frequency of every 8 weeks.

Performance Overview - Operational Performance

52 Week Waiters



Oct-24
2,181
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 2,181 incomplete 52-week breaches for October 2024, a decrease of 768 from September's 2,949.

Issues:
As shown above, 52 week waiters are negatively performing against trajectory, albeit with a decrease in numbers from last month. Both admitted and non-admitted patients sit within this wait band, however, the most significant pressure is in the non-admitted pathways. ENT continues to be the specialty under greatest pressure, which together with audiology, accounts for 39.52% of patients in this wait band. An increase of 0.76% from last month.

Actions:
Insourcing for both ENT & Audiology continue throughout December (with the option to extend with external providers). A super clinic was held the first weekend of November which saw 240 patients. Additional Audiology clinics continue at weekends at both Lincoln & Pilgrim. Max Fax is now back on track with only 19 patients in the December 65 week cohort and 25 in January therefore insourcing is due to stop on the 14th December. The additional clinics continue to reduce both total waiting list size and long waiters.

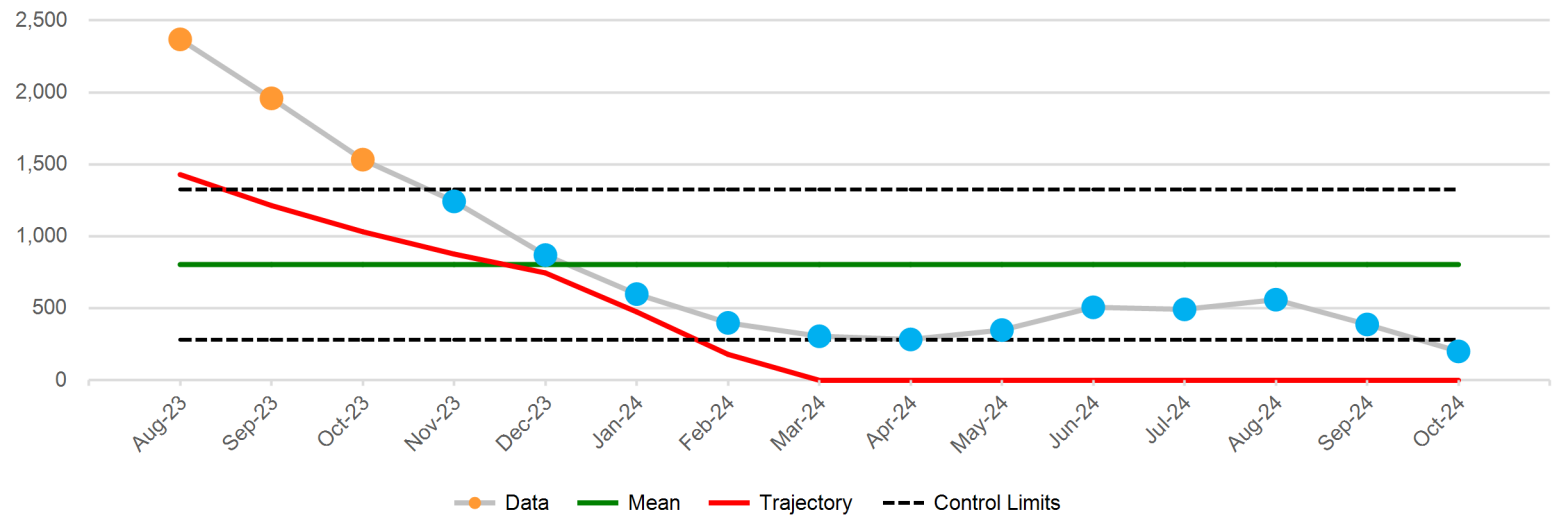
Mitigations:
ULTH 52 week position in current data (W/E 24th November '24) ranks 3rd for this metric within the Midlands region (11 Providers).

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Teaching Hospitals NHS Trust

65 Week Waiters



Oct-24
201
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 201 incomplete 65-week breaches for October 2024, a decrease of 187 from September's 388.

Issues:
ULHT's 104 week wait position was zero for October.
As shown above, 65 week waiters have decreased again this month.

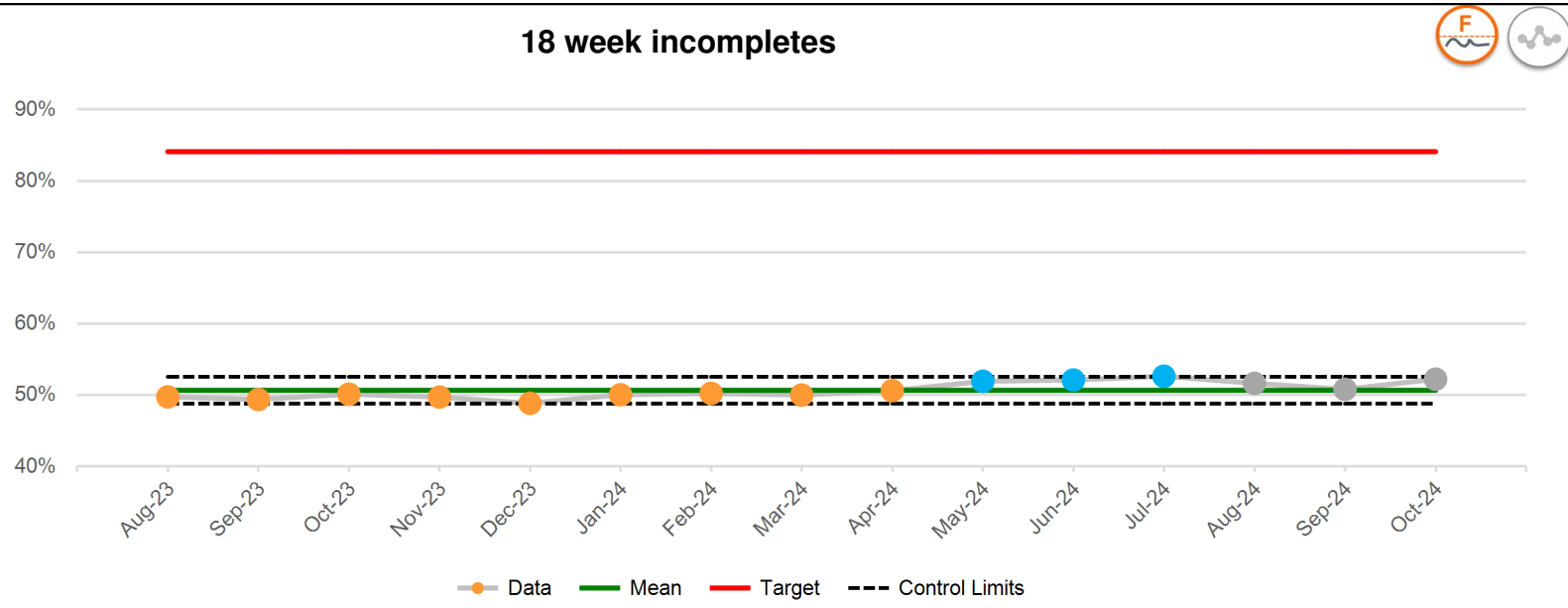
Actions:
Incomplete patient pathways are discussed with individual specialities weekly, through PTL meetings.
This meeting is currently focusing on patients in the 65w cohort for the current month. Due to the high volume of patients, this is being held twice a week.

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

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Teaching Hospitals NHS Trust



Oct-24
52.23%
Variance Type
Common cause variation
Target
84.10%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
There is significant backlog of patients on incomplete pathways. October 2024 saw RTT performance of 52.23% against an 84.1% target, which is 1.43% up from September.

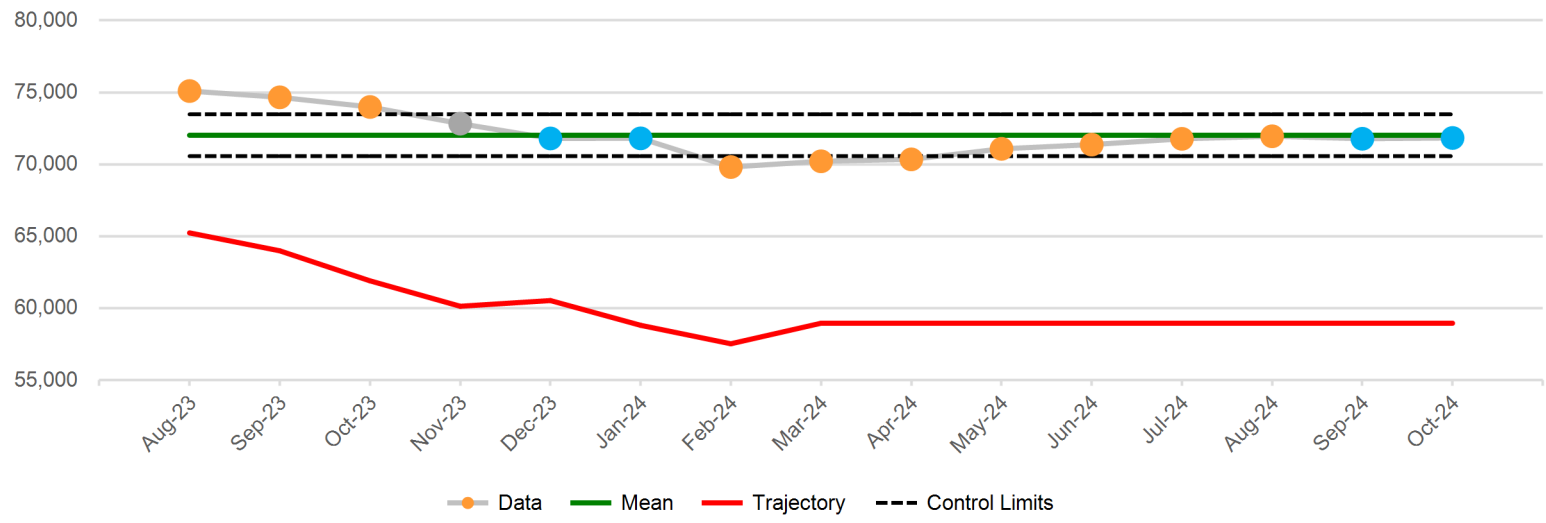
Issues:
Performance is currently below trajectory and standard. The five specialties with the highest number of 18 week breaches at the end of the month were:
ENT - 6,487 (increased by 60)
Gastroenterology – 2,942 (decreased by 30)
Ophthalmology – 2,757 (decreased by 1)
Gynaecology – 2,587 (decreased by 40)
Dermatology – 1,959 (decreased by 77).

Actions:
Priority remains focussed on clinically urgent and Cancer patients. National focus is on patients that are waiting 65 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 >65 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. Current data (W/E 24th November '24) ranks ULTH 10th for RTT performance metrics within the Midlands region (11 Providers).

Performance Overview - Operational Performance

Waiting List Size



Oct-24
71,839
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 September, with October showing an increase of 55 to 71,839.
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 – 10,138
Gastroenterology – 5,944
Ophthalmology – 5,943
Gynaecology – 5,488
Trauma & Orthopaedics 5,308

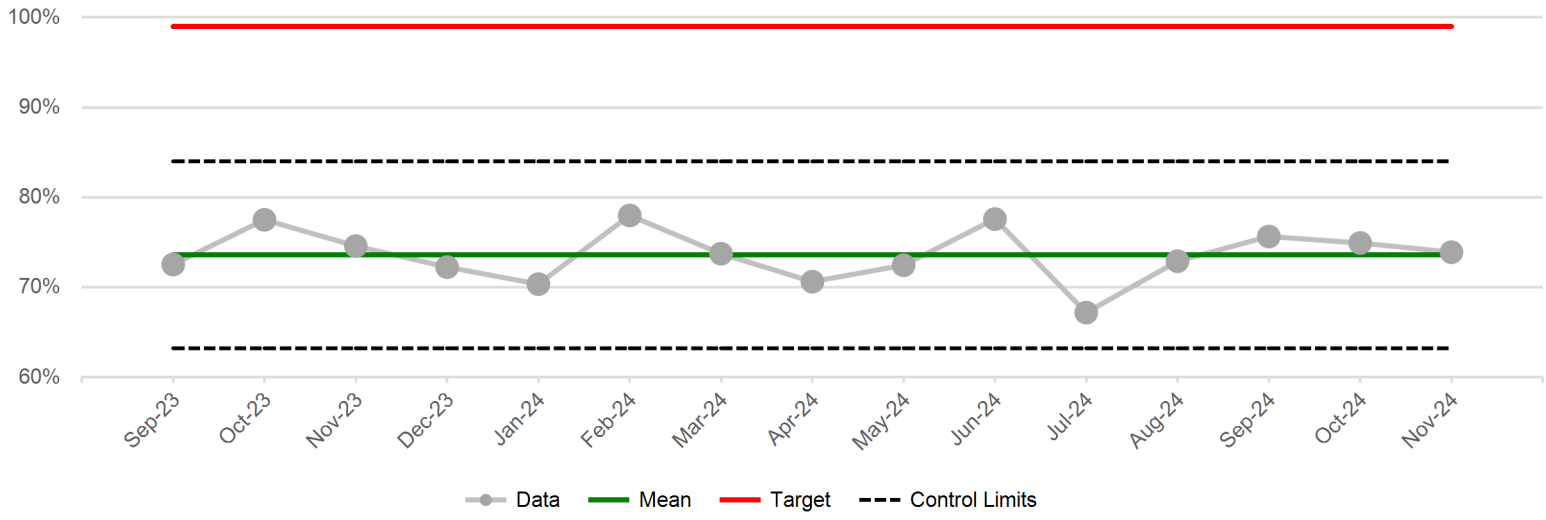
Actions:
Improvement programmes as described above for RTT performance. The EACH is also supporting by contacting ENT, Dermatology, Gastroenterology, and Maxillo-Facial patients to determine if a first appointment is still required. An internal review of ENT pathways is being undertaken to standardise in line with GIRFT recommendations. Approval has been agreed to invest in a substantive internal validation team. Half to be recruited this financial year with the remainder in the next financial year. Recruitment is underway for an initial 6 posts.

Mitigations:
The number of patients waiting over 78 weeks has decreased by two since last month. Current data (W/E 24th November '24) ranks ULTH 3rd for this metric within the Midlands region (11 Providers)

Appropriate admitted and non-admitted patients continue to be transferred out to ISP's or insourced, with an established process for this in place for several specialties.

Performance Overview - Operational Performance

Diagnostics achieved



Nov-24
73.91%
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 for November 2024 was 73.91 against the 99.00% target.

Issues:
The majority of diagnostic breaches sit in ultrasound, Audiology and Dexa . A full recovery trajectory has been submitted and is being monitored closely.

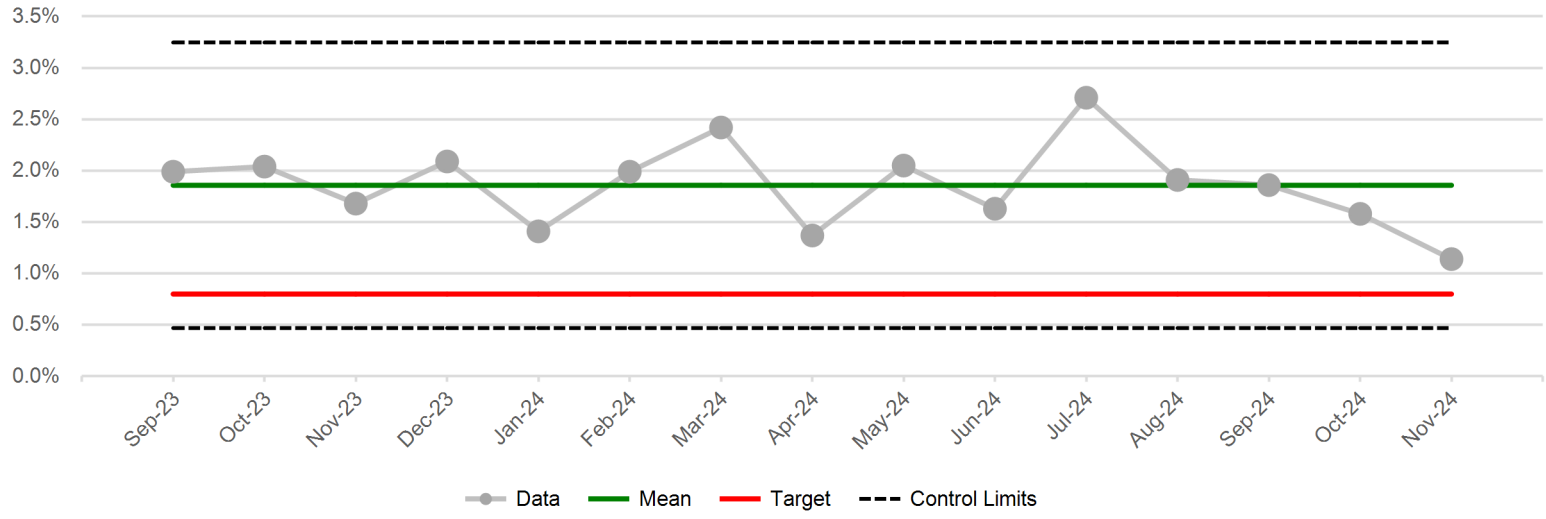
Actions:
Ultrasound has a large vacancy factor and is scanning in clinical urgency order.
Dexa has experienced significant sickness and vacancies. In the process of reprofiling staffing and training there should be an increase in performance in January return.
The increase in the long waiters is stopping any audiology recovery.

Mitigations:
Patients are being seen in clinical priority.

Performance Overview - Operational Performance

United Lincolnshire Teaching Hospitals NHS Trust

Cancelled Operations on the day (non clinical)



Nov-24
1.14%
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 decrease in the number of non-clinical cancellations in November to 1.14% compared to 2.43% in October although we remain over the 0.80% target.

Issues:
Top 3 issues were:
Lack of time
Admission cancelled on behalf of patient;
No theatre staff;

Some quick wins identified were where patients had changes made to their TCI prior to the date but were not captured correctly and are therefore not true cancellations on the day.

Actions:
Increased work around reducing our late starts and improved communication with business units around actions and outcomes needed.

Task & Finish Group is now underway with work ongoing within teams to address theatre utilisation with a focus on COTD and late starts.

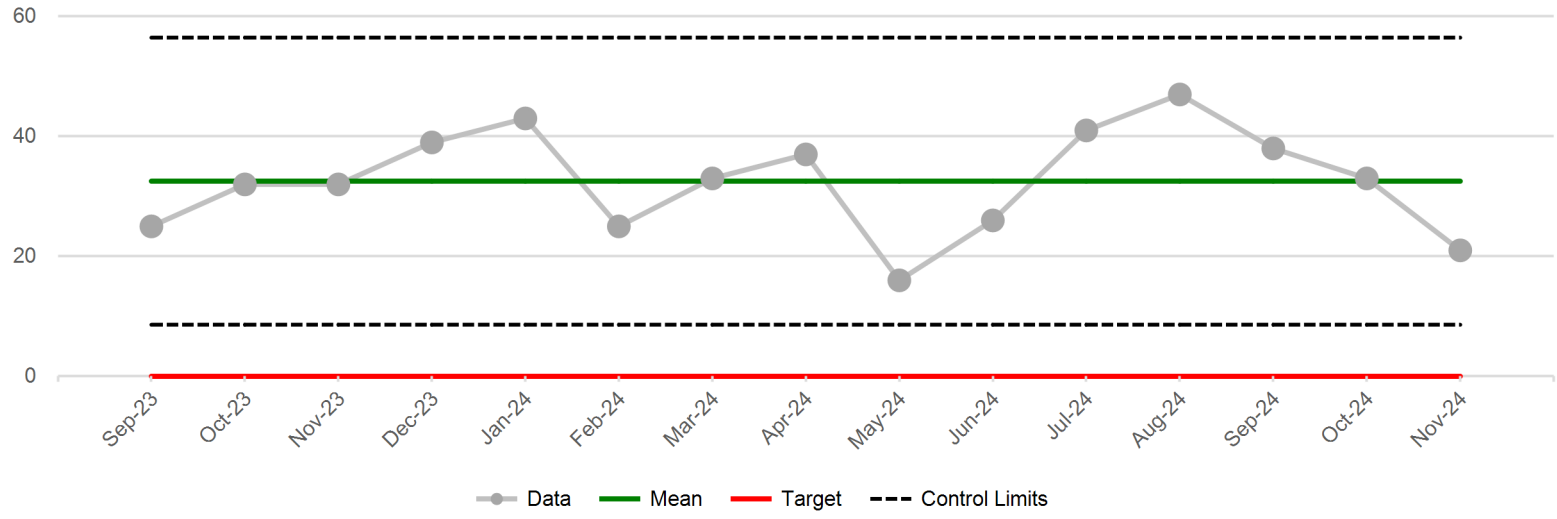
Business Units will be involved and will be held accountable for issues within their control.

Mitigations:
There has been further reduction in the amount of COTD due to staffing because of to improvements in our forward view.

Sickness on the day remains a factor and where staff must move sites, theatres or when lists have to be merged, the subsequent delays can lead to COTD for lack of time.

Performance Overview - Operational Performance

Not treated within 28 days. (Breach)



Nov-24
21
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 further decreased in November to 21 compared to 33 in October.

Issues:
The impact of the 65-week work has meant that available slots are reduced as these patients are taking priority.
Waiting List staffing remains an issue and, whilst recruitment is taking place, there will be an impact due to notice periods/training.
Our trauma backlog has had an impact on elective lists at Boston and Lincoln and has made rebooking patients more difficult.

Actions:
A Task & Finish Group around Waiting Lists has commenced and is looking at current waiting list processes and staffing. This will include the 642 process which we are reviewing.

At Theatre 642 Pre-Meets, patients cancelled previously are placed first on the list where possible to avoid a second cancellation in the event of a list over-run.

Mitigations:
Overtime has been authorised to the waiting list team to help reduce the impact of their staffing gaps.

Improvements in 642 and the CBU pre meets should further improve ability to redate our patients.

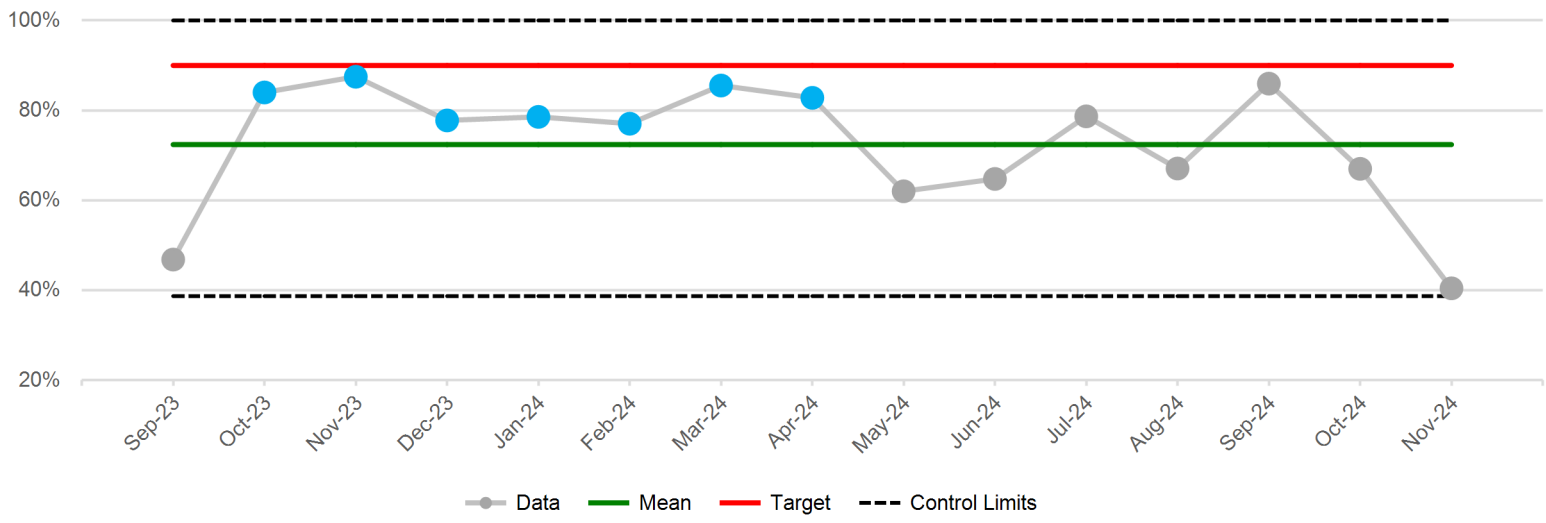
The implementation of average timings for surgical procedures started on 2nd December and should start to highlight additional capacity on lists.

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Teaching Hospitals NHS Trust

#NOF 48 hrs



Nov-24
40.45%
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 November was 40.45%.

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
- Awaiting specialist surgeon
- Delays for MRI and CT scan prior to surgery
- Breaches caused by lack of KIT for the planned procedure.

Actions:
- 'Golden patient' initiative to be fully implemented.
- Additional Trauma lists to be planned on both sites
- 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 to avoid 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.
- Trauma coordinators to identify suitable patients that could be operated on at Grantham and Louth.

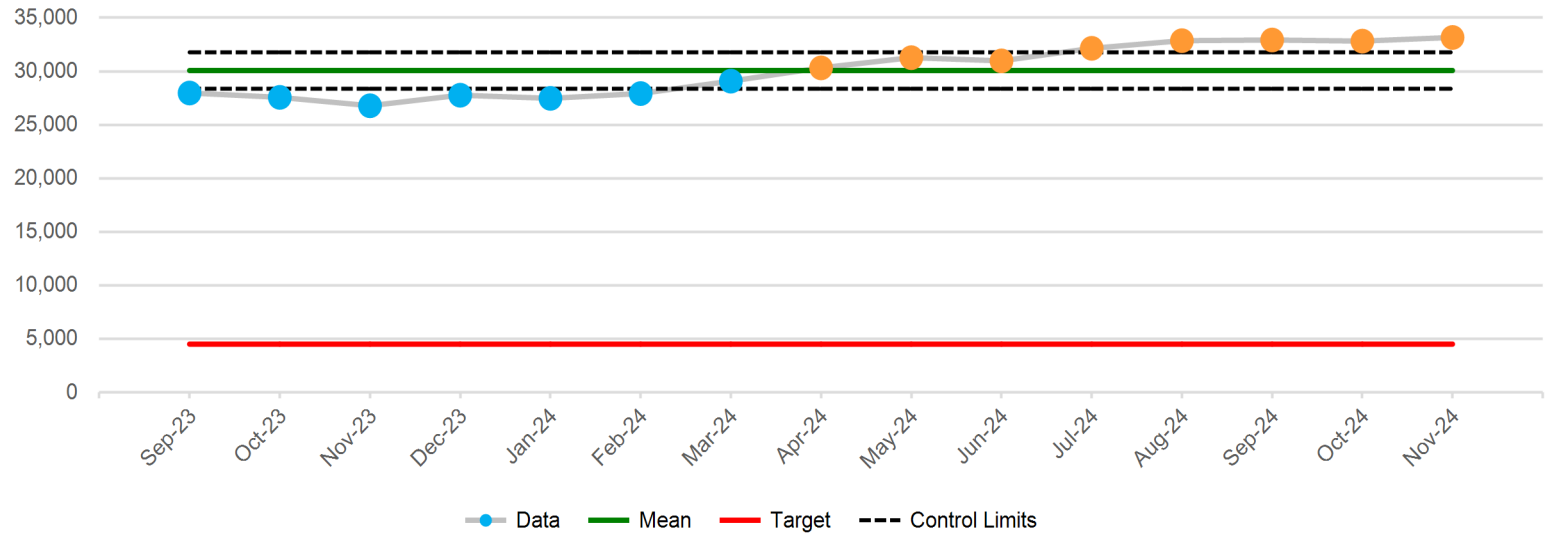
Mitigations:
- Ensure trauma lists are fully optimised.
- Reduce 'on the day' change in order of the trauma list where clinically appropriate.
- Daily Trauma huddles via MS teams with the trauma coordinators and the CBU to discuss extra theatre capacity on all sites.
- CBU to review elective cases for clinical priority.

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Teaching Hospitals NHS Trust

Partial Booking Waiting List



Nov-24
33,164
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.

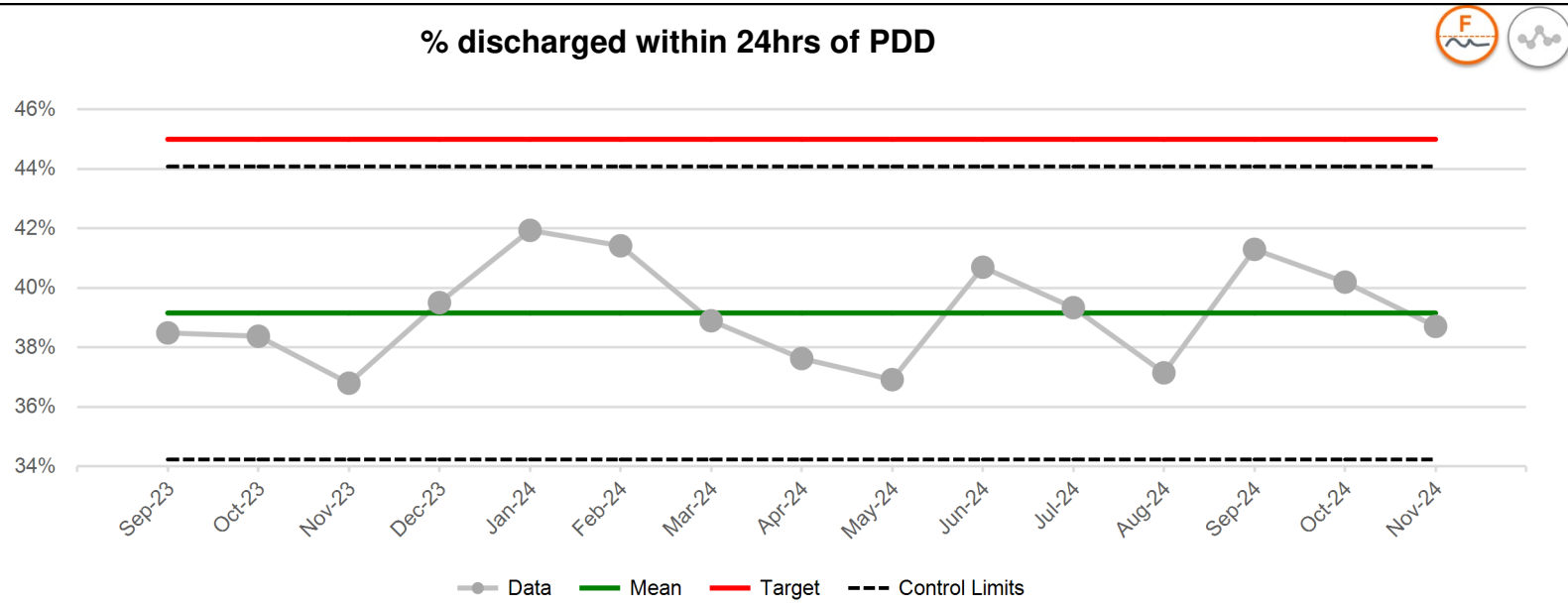
What the chart tells us:
Currently at 33,164 against a target of 4,524. During Covid the number of patients overdue significantly increased and the trend has seen a steady increase since, the exception being Aug 23 – Nov 23. More recently Oct 24 saw a slight decrease on previous months, however this increased again in Nov.

Issues:
The organisation has several competing priorities. The current focus is on the long waiting patients (> 65 weeks), potential cancer patients and additional outpatient 'hot clinics' to alleviate winter pressures on UEC. 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 speciality CBU's to improve focus, and discussions continue regarding reduction of non-tariff f/ups. PIFU uptake continues to be an area of focus for specialties. The 642 process is 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 clinic utilisation and maximise capacity.

Mitigations:
Booking team priorities are to support rebooking due to short notice patient cancellations and hospital cancellations, the Personalised Outpatient Plan and the booking of the 65-week and urgent suspected cancer patient cohort.

Performance Overview - Operational Performance



Nov-24
38.71%
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 decrease of Novembers outturn at 38.71% compared to Septembers improvement at 41.30% achievement

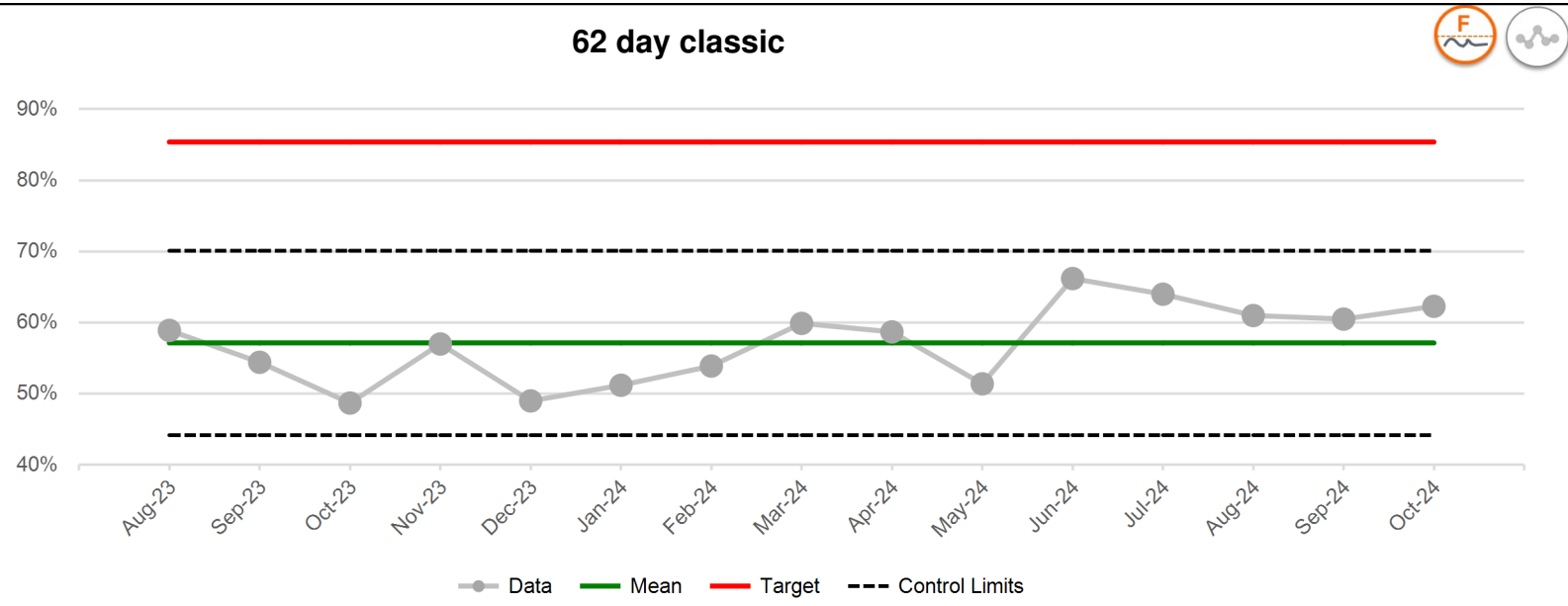
Issues:
The delivery team previously provided support to the wards to enhance WebV compliance. However, after the team ceased their support and transitioned the responsibility to Business As Usual (BAU), there was a noticeable decline in performance. Currently, SAFER practitioners are conducting WebV compliance training. Nevertheless, there is an ongoing discussion within the Clinical Business Unit (CBU) regarding the Standard Operating Procedure (SOP) for making alterations during an inpatient spell or retaining the preliminary Patient Discharge Document (PDD) set upon admission.

Actions:
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 was 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

United Lincolnshire Teaching Hospitals NHS Trust



Oct-24
62.30%
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 62.30% 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.
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.

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:

Deep Dives are being undertaken by each CBU to understand how diagnostic turnaround times for positive cancers can be improved as this will be key to achieving the NHSE target of 70% by March '24.

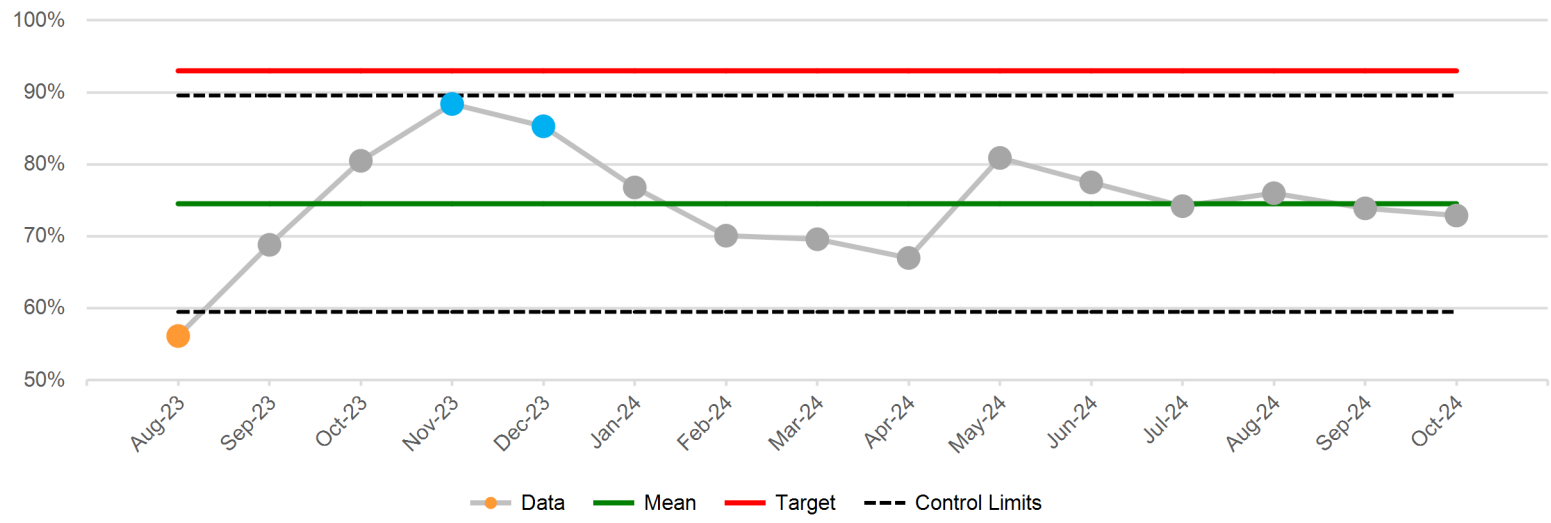
Please also see Actions on accompanying pages.

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Teaching Hospitals NHS Trust

2 week wait suspect



Oct-24
72.90%
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 72.90% 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, however there has been a significant improvement for breaches occurring within that specific tumour site in since July. Additionally, Skin tumour site accounted for 79.6% of the Trust's 14-day breaches in October.

Actions:

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

Actions:
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 have seen the impact of this in improved FDS performance since May. UGI Triage CNS has started in post and further job planning underway. Gastro admin team are now cross referencing USC referrals while the CBU work towards sustainable solutions to managing the start of the UGI USC referrals.
Processes – SOPs relating to DNAs & multiple cancellations are currently being taken through CBU Governance processes for approval.
Please also see Actions on accompanying pages.

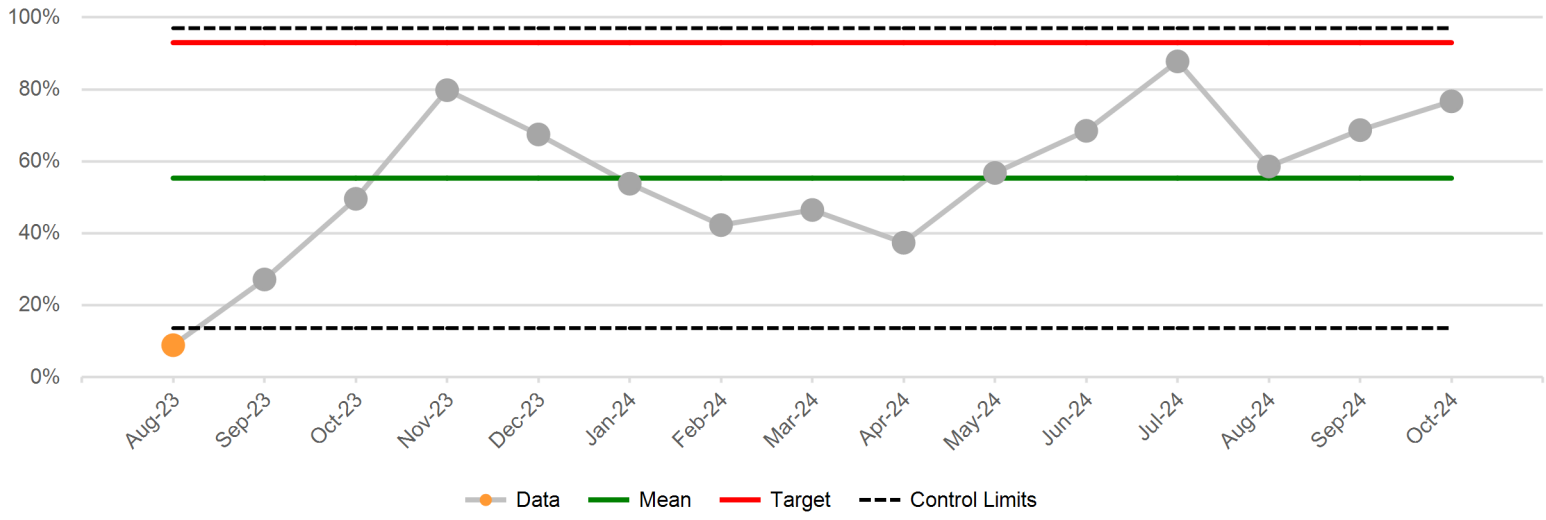
Mitigations:
Haematology is in fragile services due to vacancy/capacity. Issues with inappropriate referrals and GP engagement continue to be escalated and supported by the ICB and Cancer Navigators will be able to streamline this process. Delays in the booking and utilisation of appointment slots which 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.

Performance Overview - Operational Performance

2 week wait breast symptomatic



Oct-24
76.70%
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 76.70% 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.

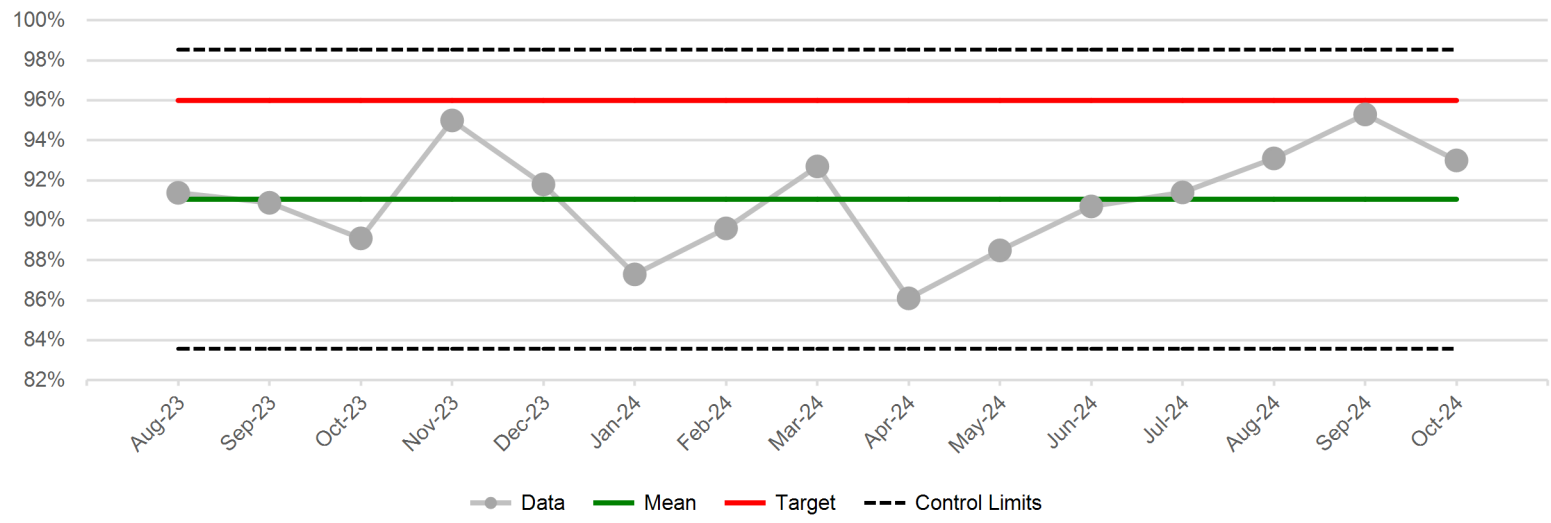
Mitigations:
A mastalgia pathway is now up and running with primary care and system partners which has the potential to reduce inbound referrals by circa 15-20%. Further and more regular comms to improve utilization of this pathway within Primary Care are being supported by the ICB.

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Teaching Hospitals NHS Trust

31 day first treatment



Oct-24
93.00%
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 93.00% against a 96% target.

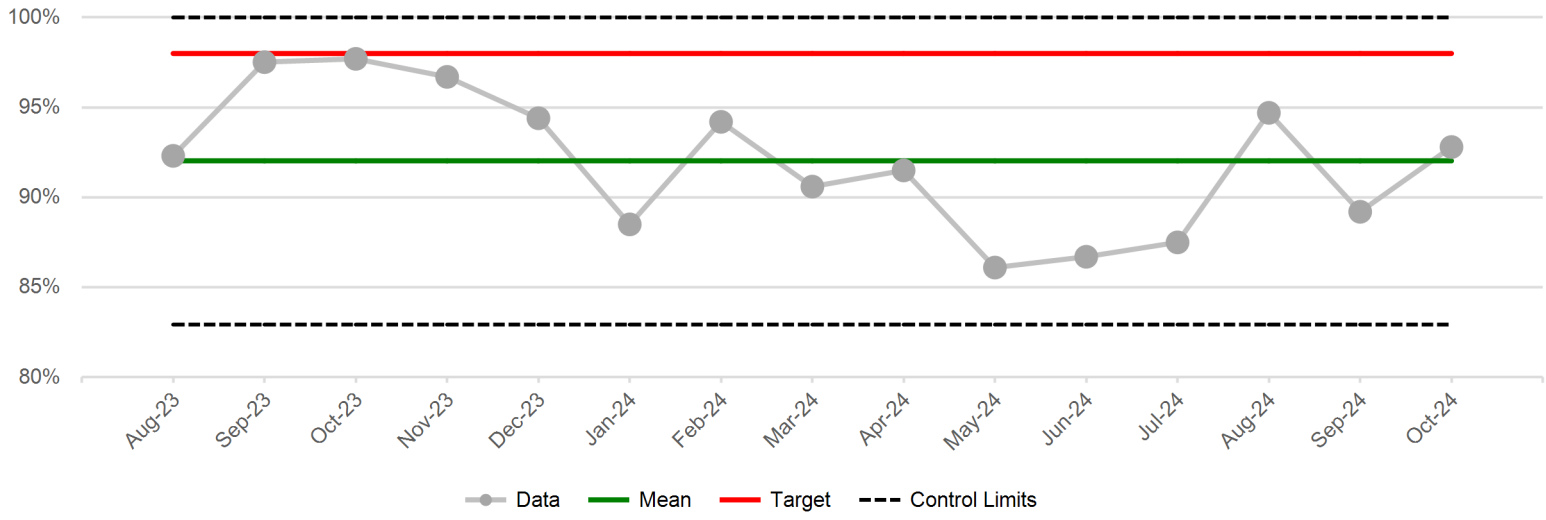
Issues:
The failure of the 31 Day standards was primarily attributed to limited theatre capacity and limited AA and pre-op capacity impacts the ability to be able to populate lists at short notice.
In Oncology, recent Linac breakdowns and pharmacy staffing shortages have resulted in delayed treatment 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



Oct-24
92.80%
Variance Type
Common cause variation
Target
98.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 92.80% 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.

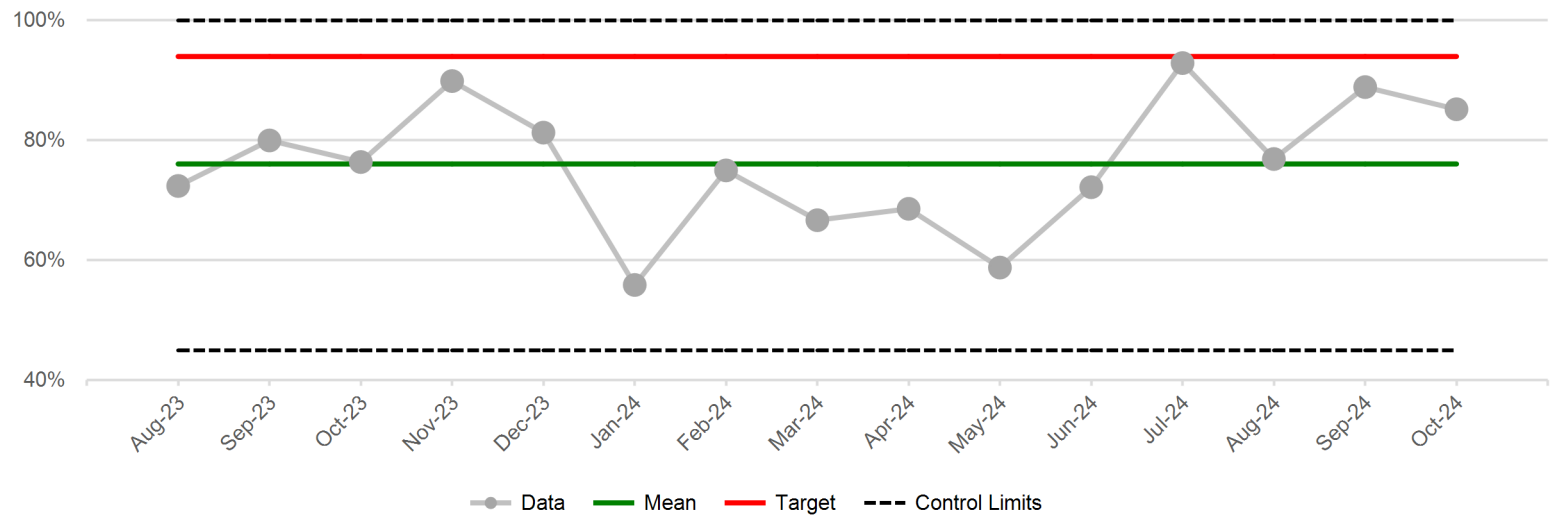
Mitigations:

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Teaching Hospitals NHS Trust

31 day subsequent surgery treatments



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

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

What the chart tells us:
We are currently at 85.20% 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.

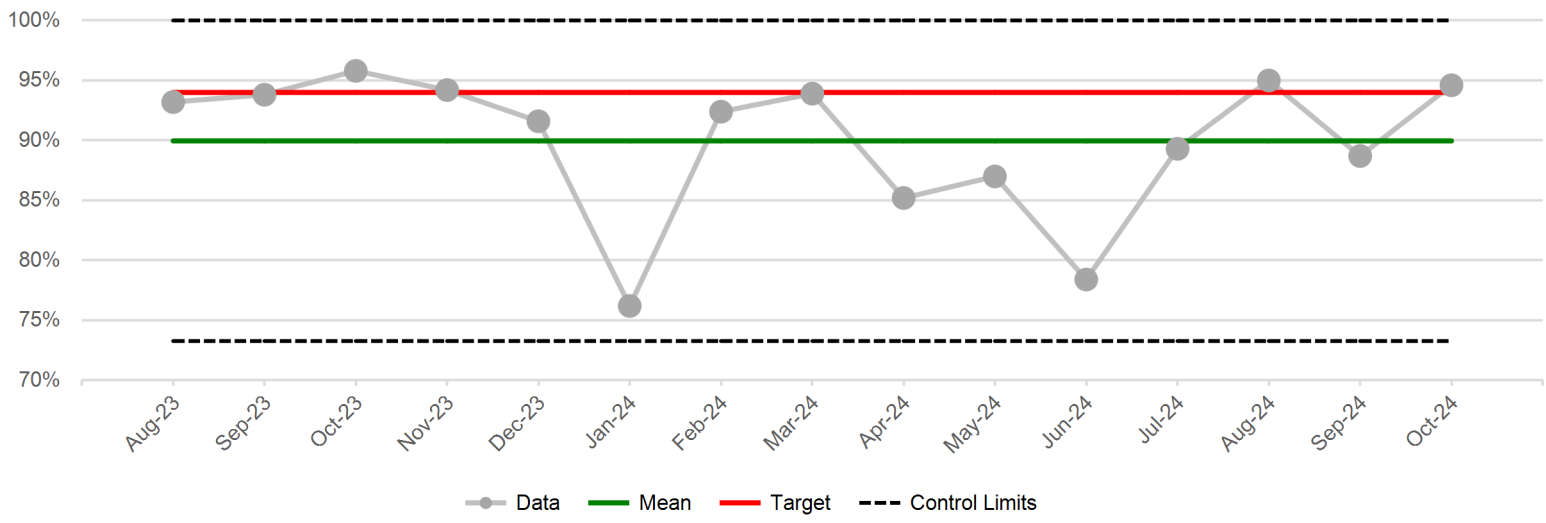
Mitigations:
In Dermatology, a Minor Op Clinic process review, alongside SpDr training, is underway to increase capacity. A training plan for Skin Surgery nurses to support with head and neck lesions is being developed.
In Head and Neck, an ENT consultant has recently commenced in post and further recruitment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

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Teaching Hospitals NHS Trust

31 day subsequent radiotherapy treatments



Oct-24
94.60%
Variance Type
Common cause variation
Target
94.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 94.60% against a 94% target.
.

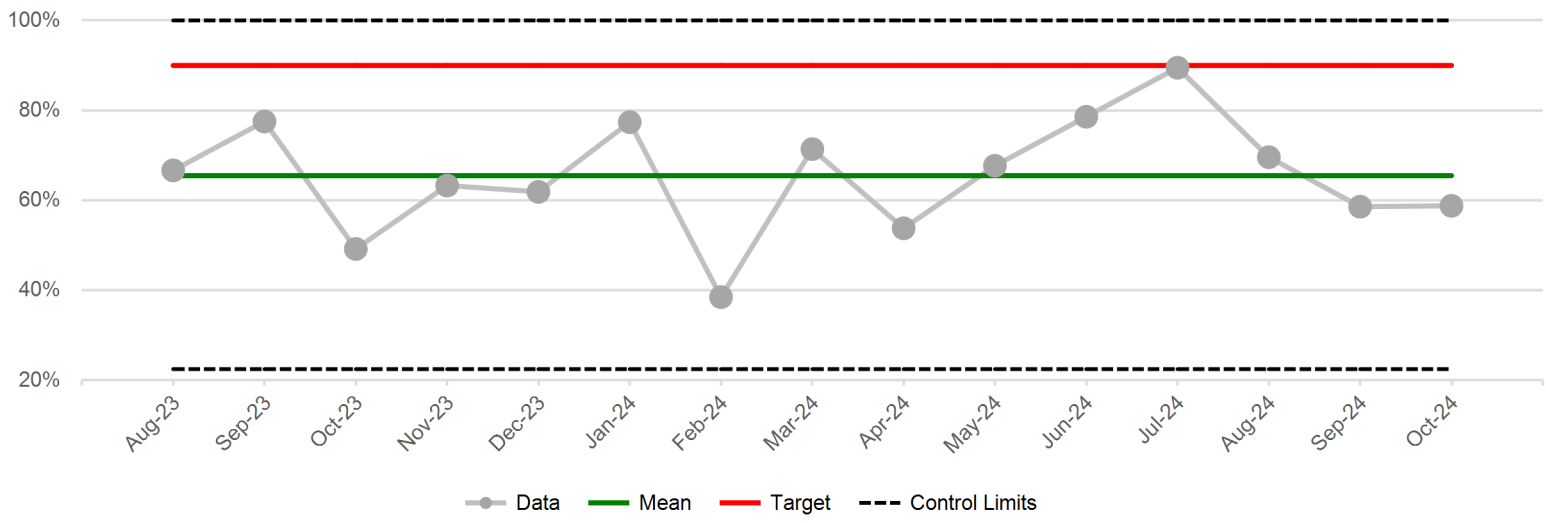
Issues:
Radiotherapy – Recent Linac breakdowns have resulted in delayed treatment start dates.

Actions:
Oncology Fragile Service - A piece of work on right-sizing the Oncology service workforce is ongoing and recruitment is underway.
A deep dive is being undertaken to ensure shared access to information to ensure breach reasons are recorded accurately.

Mitigations:

Performance Overview - Operational Performance

62 day screening



Oct-24
58.80%
Variance Type
Common cause variation
Target
90.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 58.80% against a 90% target.

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

Please also see Issues on accompanying pages.

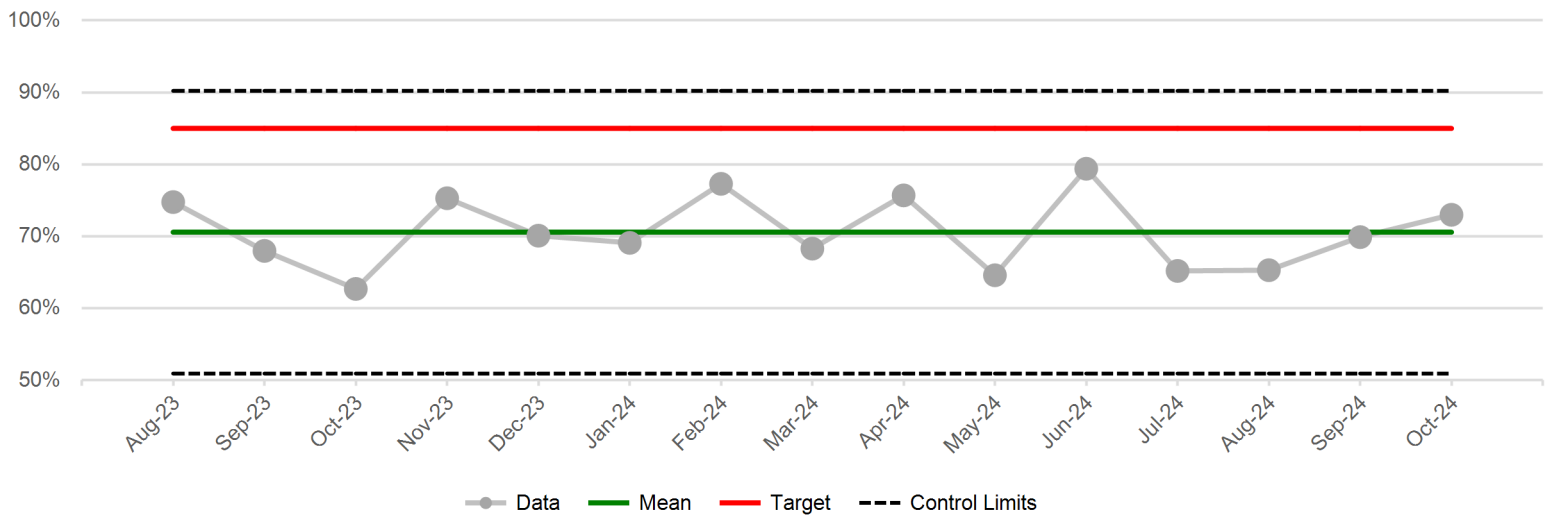
Actions:
Oncology Fragile Service – A piece of work on right-sizing the Oncology service workforce is ongoing and posts are out to advert.
Robotic Lists are progressing well, though proving difficult to populate at short notice if there are cancellations due to the lack of trained staff within theatres, 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



Oct-24
73.00%
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 73.00% 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.

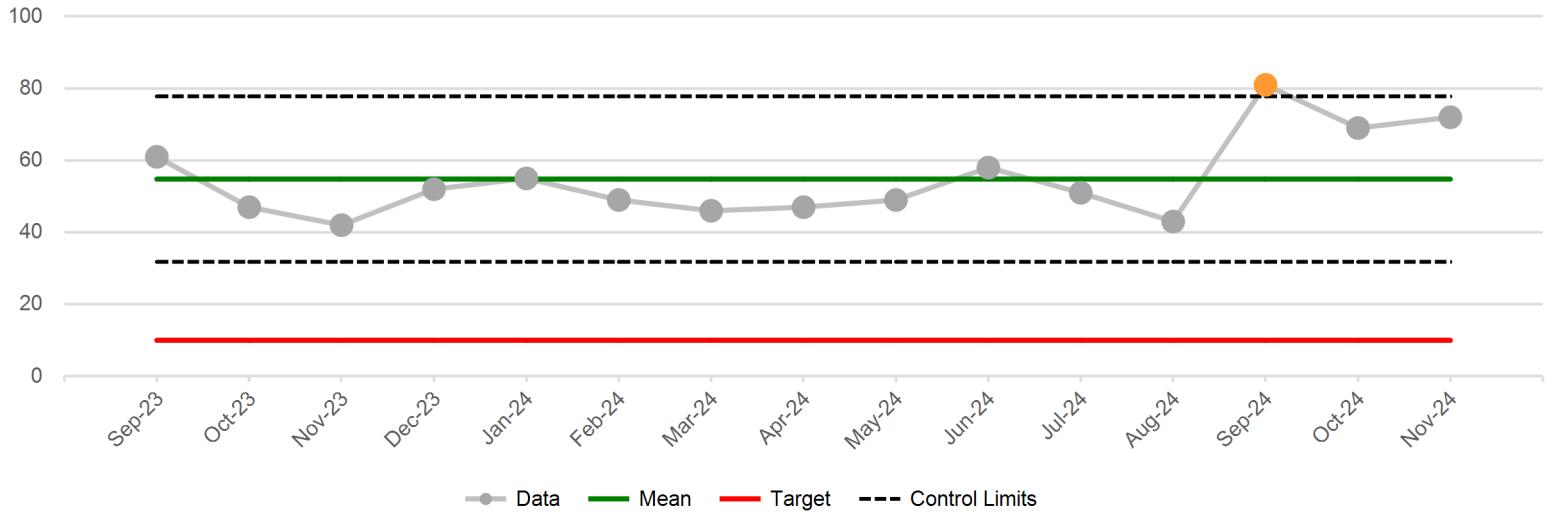
Mitigations:
Please also see Mitigations on accompanying pages.

Performance Overview - Operational Performance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Teaching Hospitals NHS Trust

104+ Day Waiters



Nov-24
72
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 11th December the 104 Day backlog is at 72 patients.
There are 3 main tumour sites of concern:-

Colorectal 20
Urology 13
Head and Neck 12

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 26.4% 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.

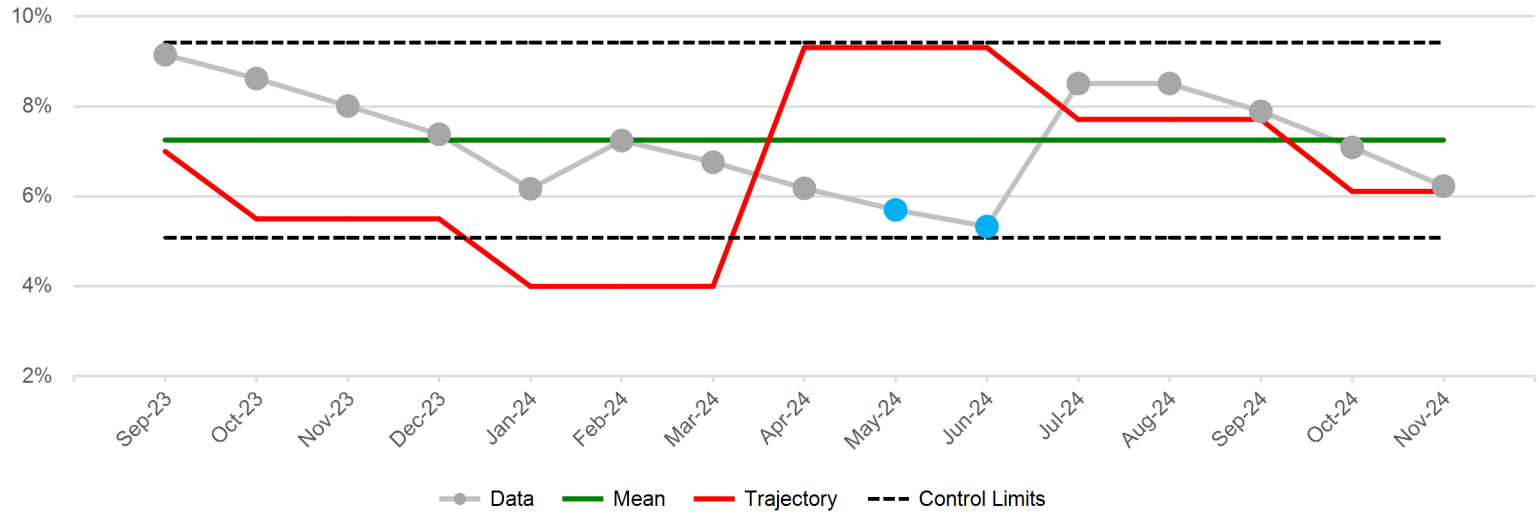
Performance Overview - Workforce

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Sep-24	Oct-24	Nov-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%	93.81%	93.75%	93.55%	93.70%	90.00%	P	
	Number of Vacancies	Well-Led	People	Director of HR & OD	6.11%	7.89%	7.09%	6.23%	6.93%	7.91%	F	
	Sickness Absence	Well-Led	People	Director of HR & OD	5.54%	5.28%	5.23%	5.23%	5.34%	5.50%	P	L
	Staff Turnover	Well-Led	People	Director of HR & OD	10.24%	10.22%	10.04%	9.65%	10.05%	11.64%	P	L
	Staff Appraisals	Well-Led	People	Director of HR & OD	85.58%	80.42%	80.04%	79.76%	78.22%	80.63%	F	H

Performance Overview - Workforce

United Lincolnshire Teaching Hospitals NHS Trust

Number of Vacancies



Nov-24
6.23%
Variance Type
Common cause variation
Trajectory
6.11%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of HR & OD

Background:
November 2024 reported Vacancy Rate is 6.23% against a Q3 target of 6.11%.

What the chart tells us:
That we are not within the Q3 target for November 2024 as slightly above target, 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.

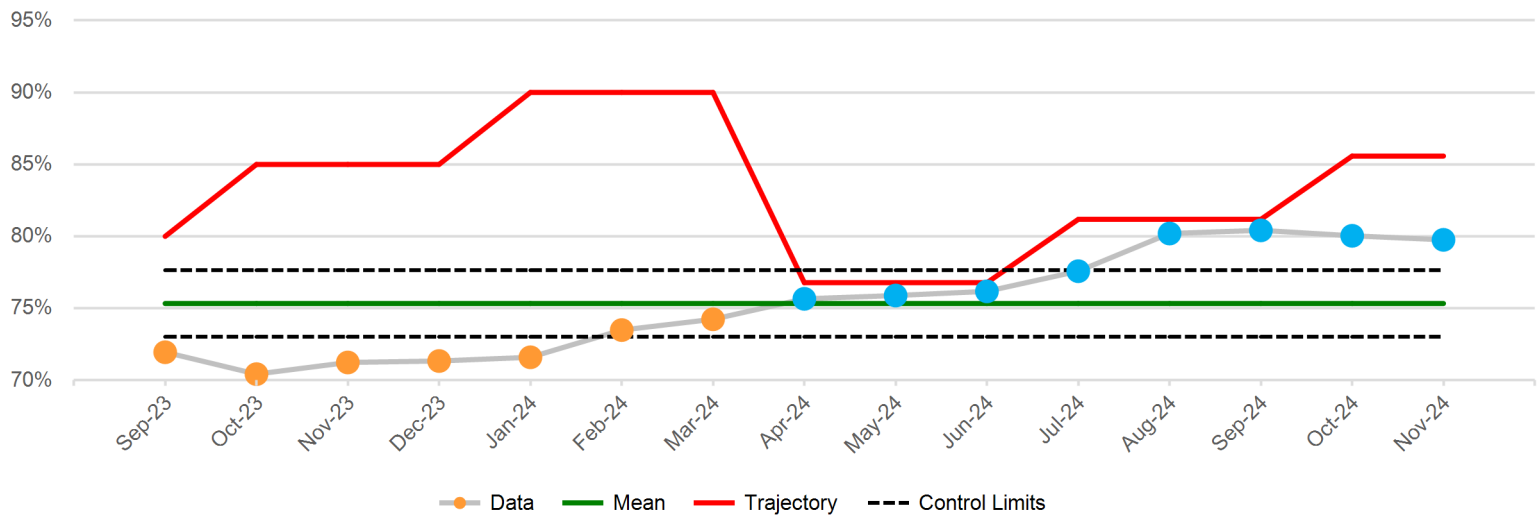
• Our Recruitment Team have supported closing the gap between the Establishment and the number of Staff In Post.

OUTSTANDING CARE personally DELIVERED

Performance Overview - Workforce

NHS United Lincolnshire Teaching Hospitals NHS Trust

Staff Appraisals



Nov-24
79.76%
Variance Type
Special cause variation - improvement (Indicator where high is good)
Trajectory
85.58%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of HR & OD

Background:
Completion is currently 79.76% for Agenda for Change staff which is outside of the Q3 target of 85.58%

What the chart tells us:
We are not meeting the quarterly target for AfC appraisal in 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:
- Launched 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.

NHS
Lincolnshire Community and Hospitals NHS Group

Integrated Performance Report, LCHS

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Teaching Hospitals NHS Trust

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*7th January 2025*
Item Number	*13.1*

Integrated Performance Report, LCHS (November 2024 performance)

Accountable Director	*Daren Fradgley, Group Chief Integration Officer*
Presented by	*Daren Fradgley, Group Chief Integration Officer*
Author(s)	*Amanda Heyes, Business Support Technician, LCHS*
Recommendations/ Decision Required	*The Board is asked to:-* • *Note the performance position*

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	*X*
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	*X*
3b Drive better decision and impactful action through insight	*X*
3c A modern, clean and fit for purpose environment across the Group	
3d Reduce waits for patients who require urgent and emergency care and diagnostics and ensure we meet all constitutional standards	
3e Reducing unwarranted variation in cancer service delivery and ensure we meet all constitutional standards (ULTH)	
3f Reducing unwarranted variation in planned service delivery and ensure we meet all constitutional standards (ULTH)	
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	
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	*X*
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	

Executive Summary

Performance up until the end of November is set out in the report. The Quality Committee and Finance, Performance, People, and Innovation Committee reviewed November performance in their December 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	2	9	
	Inconsistently Capable	3	11	3
	Not Capable	2	1	
	No Target	2	16	2

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

1. Home Visiting

The staff consultation over shift times is currently under way.

2. Ethnicity recording in A&E data sets.

Use of the new Data Quality system “RINSE” is expected to drive up performance to the 95% target between November 2024 and March 2025.

3. Patient Incidents per 1,000 wte

At the request of the Quality Committee the measurement has been changed (with effect from May 2024) to exclude patient incidents which have been reported but don’t relate to LCHS. This is enabling more meaningful comparison with national benchmarks. We have also changed the interpretation of the SPC chart so that a lower patient incident rate is regarded as an improvement.

Control limits will be reset in due course once we have sufficient data points using the new measurement basis.

5 indicators are showing special cause deterioration currently:

1. Out of Hours and CAS Cases Closed

OOH & CAS Cases Closed shows special cause concern since April 2024 following the 111 contract changes.

2. Community Pressure Ulcer – Rate per 1000 contacts (c2,c3 & c4)

3. Ops Centre Calls: Answered in Timescale; and
4. Ops Centre Calls: Abandoned

September continued to be a challenge for the Ops Centre. Training has commenced with the new staff that joined mid-month, however demand exceeded capacity on some days which made performance unrecoverable and resulted in longer wait times. Additional recruitment continues to fill the remaining vacancies.

5. Community Hospital Discharge Summaries

Following the implementation of live data dashboards further improvement on this metric is expected.

9 indicators are currently showing special cause improvement, which is a strong indication of our continuous improvement culture:

1. Patient Incidents per 1000 WTE;
2. Ethnicity in A&E Data Sets
3. GU Patients seen within 2 working days;
4. Staff Turnover;
5. Friends & Family Test;
6. UTC 15 Minute Assessments; and
7. Vacancy Rate.
8. Total Falls
9. Home Visiting Activity

Lincolnshire Community Health Services NHS Trust

INTEGRATED PERFORMANCE REPORT

November 2024 Performance Data

CONTENTS

SPC Scorecard

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

Executive Summary

Safe

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

✓ MRSA compliance achieving target.

X Patient Incidents Community Rate per 1000 WTE increased from234.53 in October to 261.02 in November and is above the benchmark of 201.27

✓ Total LCHS Patient Medication Incidents has decreased this month from 48 in October to 31 in November

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

Caring

X FFT scores not achieving 95% target.

✓ Complaints have decreased from previous month.

✓ Compliments increased from previous month.

Responsive

X Discharge Summaries – Community Hospitals, not achieving target.

✓ Discharge Summaries – Urgent Treatment Centres achieving target.

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

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

X 15-minute Ambulance Handover is 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.

Effective

✓ Environmental Cleanliness achieving target.

✓ Bed Occupancy rate achieving 93% while the target is at 85%

✓ Average Length of Stay is on target for November.

X Community Hospitals Pressure Ulcers rate per 1000 OBDs – reporting higher benchmark.

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

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

Well-Led

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

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

✓ Staff Turnover is within the 15% target.

✓ Year to date agency expenditure is within plan.

✓ Month 8 Trust's YTD deficit is a £240k favourable variance to plan.

✓ Overall efficiency (CIP) slightly ahead of plan.

✓ Cash balances are £23M, behind the 25.5M original plan.

X Better Payment Practice Code (by volume) is not achieving the 95% target

X Capital expenditure is ahead of plan.

✓ Vacancy rate within the 8% target.

✓ Training Compliance is achieving the 90% target.

X Total Sickness Absence is not achieving the 5% target.

X Long-Term Sickness Absence is not 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.

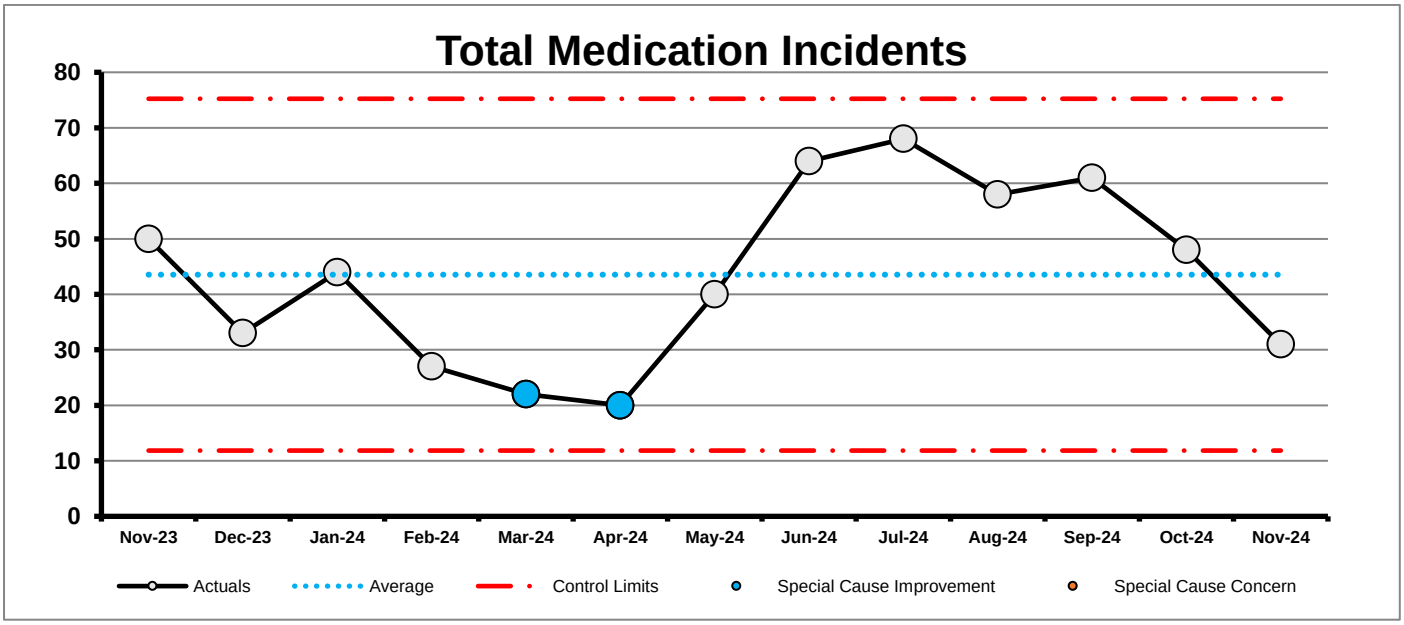
A medicine-related incident can pose a threat to the patient as well as the organisation. The member of staff who made the error can also be affected. Broadly speaking, medicine-related incidents encompass prescribing, preparation, dispensing, administration, and monitoring.

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

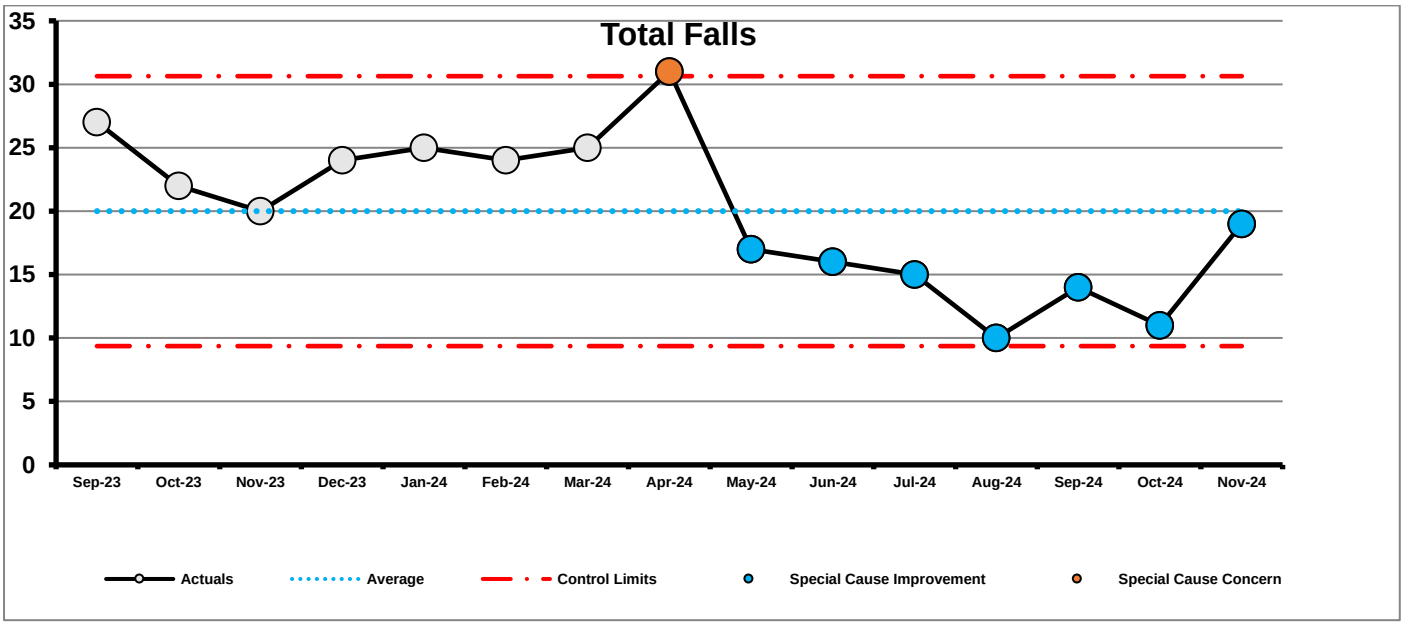
The Trust's total medication incidents have not varied significantly in the period.

Total Trust Falls

Background

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

Current Performance



Narrative

The data above shows a shift of improvement towards lower falls – unfortunately this has been a month with more falls. That said, see below because of the very high bed occupancy falls per 1000 bed days has not risen as dramatically. There have been a number of Patient Safety awards handed out as falls on the wards has sustained at lower levels. This has been achieved with improved measures around enhanced care 'Baywatch'. Further improvements are expected as new templates enhance personalised care and therapy begins to work 7 days.

SPC

SPC shows that the Trust's total falls have not varied significantly in the period. Showing special cause improvement and sitting slightly below the average.

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.

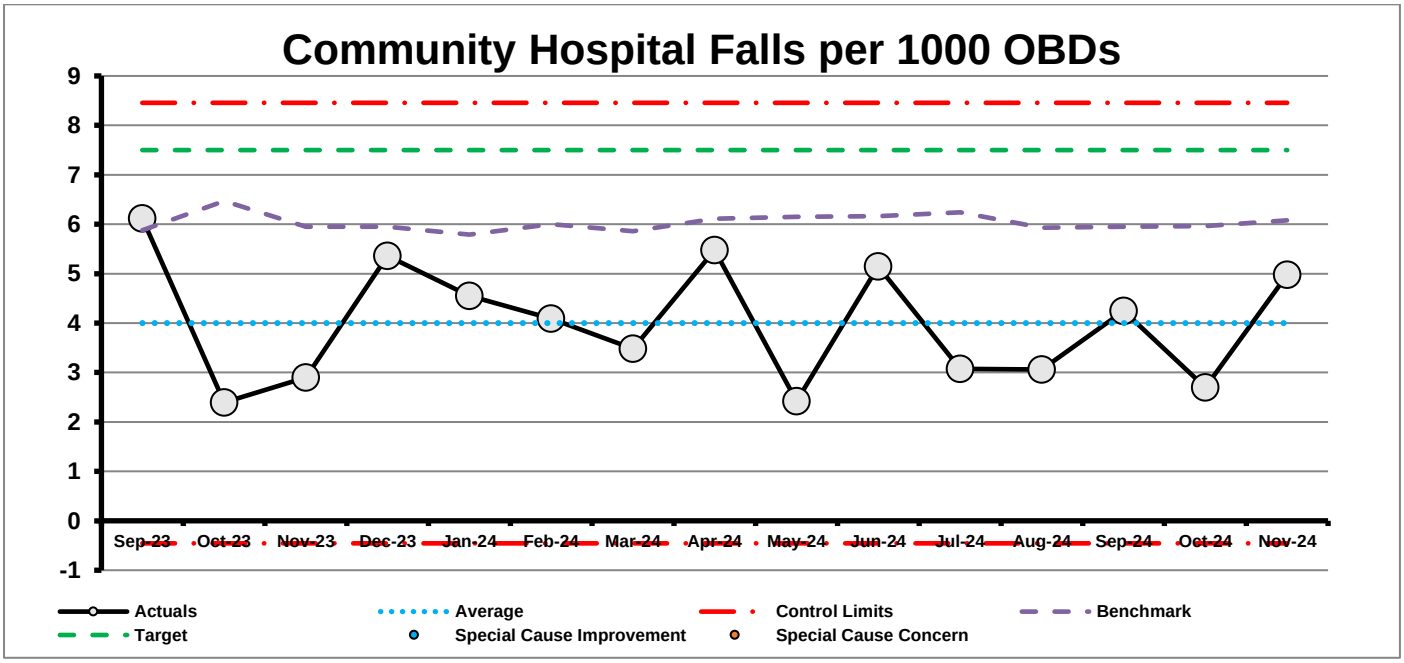
Falls are categorised and captured as the following: -

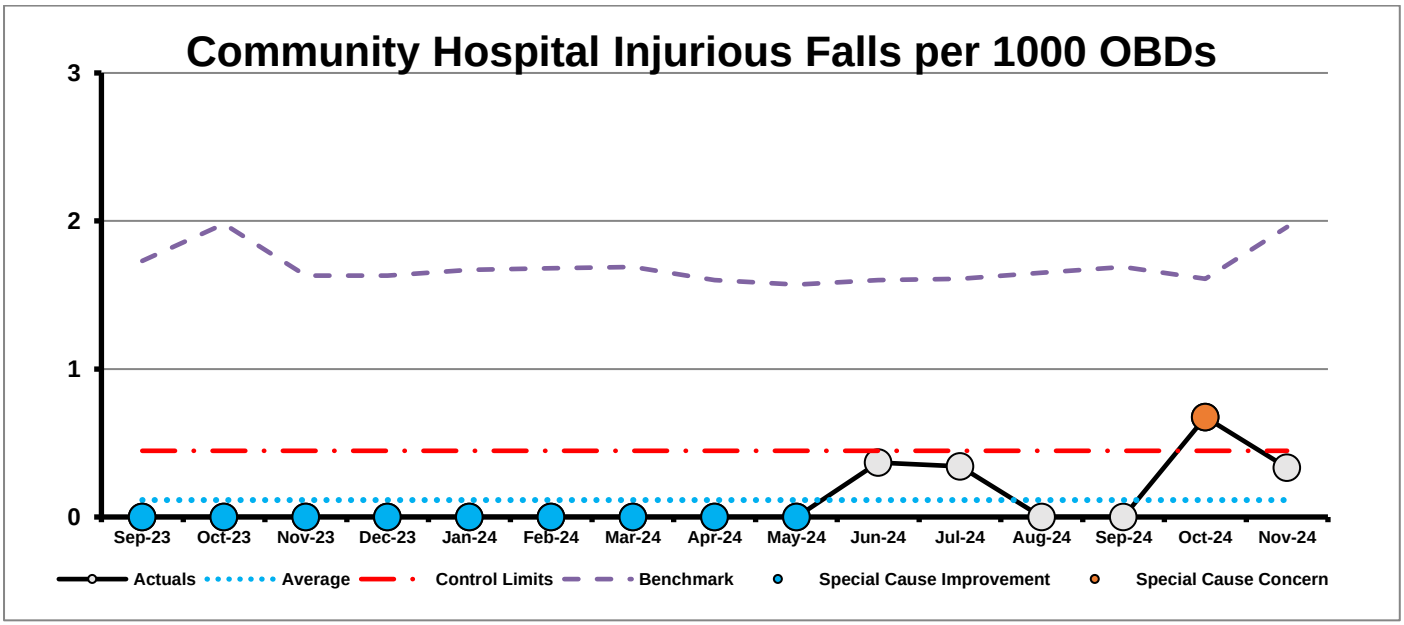
- Fall from a height / bed / chair (these falls tend to result in the highest level of injury of harm
- Slip / trip / fall on level ground.
- Supported lower to ground/ bed / chair / other (many of these are during direct patient care or therapeutic interventions)

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 (September) for all Community Hospital falls is 6.08. The latest monthly benchmark of injurious falls is 1.96.

Current Performance





Narrative

In spite of the low number of overall falls there was unfortunately a fall with harm on Butterfly for the month in question.

SPC

Community Hospital Falls per 1000 OBDs

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

Community Hospital Injurious Falls per 1000 OBDs

SPC for Community Hospital Injurious falls per 1000 OBDs shows special cause no variation for November 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)”.

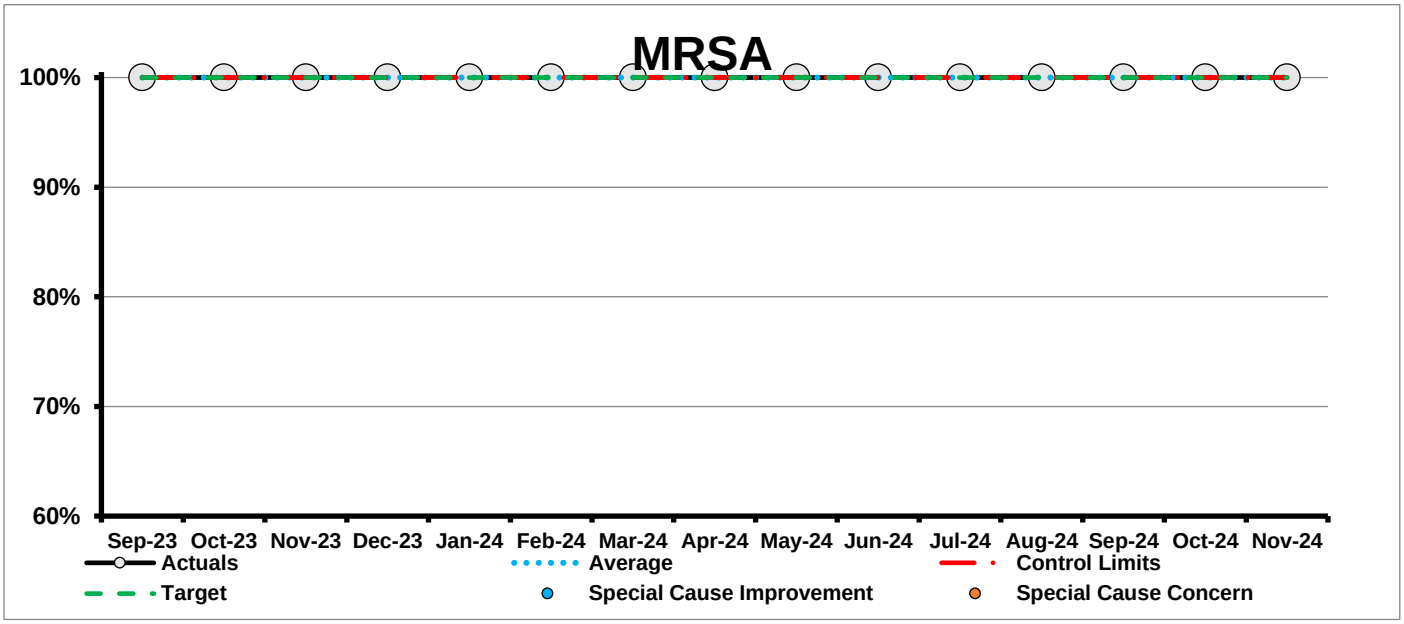
The guidance advocates that those patients previously identified as MRSA positive, and those patients admitted to high-risk units are screened.

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 146 patients admitted across all sites, 14 patients were eligible for MRSA screening, of which all 14 were screened.

SPC

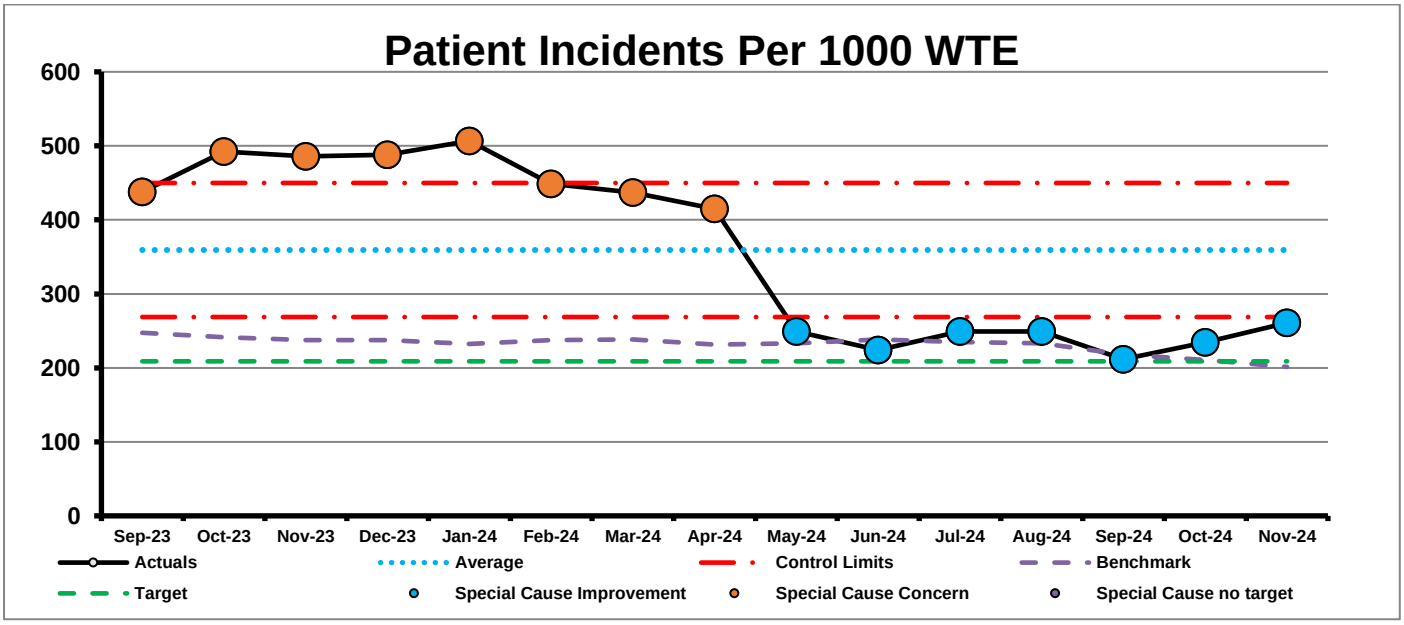
MRSA screening compliance has not varied over the period.

Patient Incidents

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

Benchmarking / target
LCHS has been consistently a high reported of incidents using the Datix system.
The latest available 6 monthly average numbers of incidents per 1,000 WTE staff in the Community Trust Benchmarking group was 218.01.

Current Performance



Narrative

- The graph shows LCHS patient safety incidents per 1000 WTE from 1 July 2023 to 30 November 2024. The sharp decrease is because as of May'24, only patient safety incidents related to LCHS are being reported on the divisional dashboards and therefore the benchmarking chart that is being submitted into Quality Committee was re-aligned. The benchmarking data is always available on the 10th of each month, and it will therefore be added to the graph retrospectively every month.
- At the time of reporting:
  - CYPSS & IUEC are meeting trajectory around overdue Datix. The remaining divisions are taking actions to realign to trajectory by weekly quality review meetings with leadership oversight.
  - Duty of a candour continues to be tracked weekly. There continues to be improvement in the timeliness of Duty of Candour compliance.
  - There are zero Never Event investigations ongoing, nor have any been declared.

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 Incident SPC has shown special cause improvement since May 2024.

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.

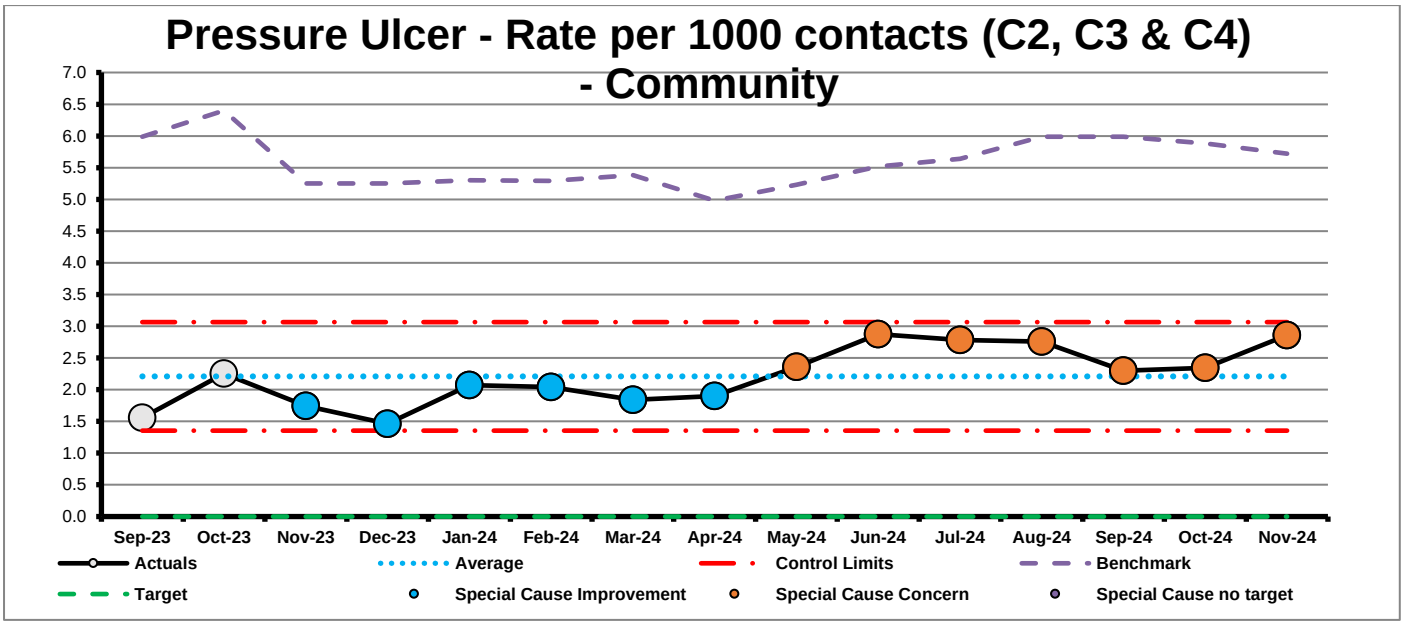
Reduction in patient harm related to pressure damage is the highest priority objective for the Lincolnshire Safeguarding Adults Board.

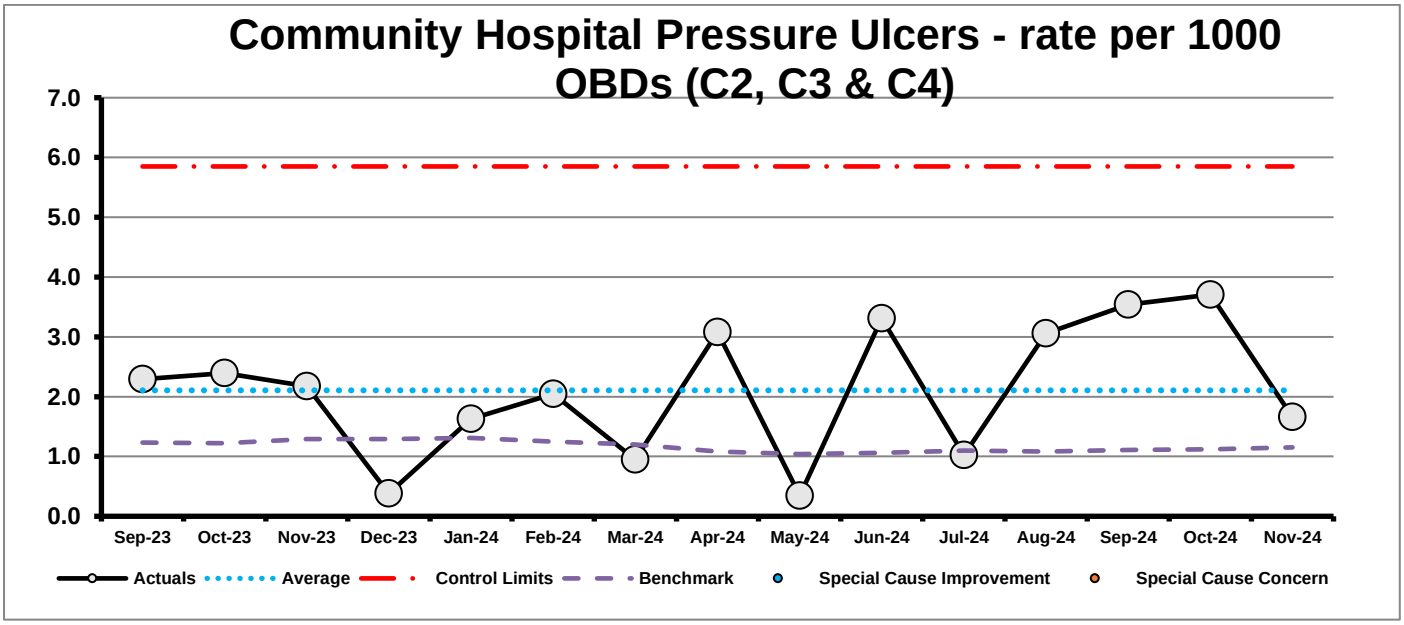
The Lincolnshire System Quality Group have agreed their first quality priority to be pressure damage – eradication of harm, standardising and improving care.

Benchmark
Benchmarking will continue to be calculated in community teams by 1,000 patient contacts – currently the national mean benchmark is 5.72.

Community Hospital benchmarking is calculated by 1000 Occupied Bed Days (OBDs) – currently the national benchmarking rate is 1.15.

Current Performance





Narrative for Community:

Ongoing work on PU across all Community Nursing Teams. Weekly PU audit continues to show improvements in PU care and prevention.

Narrative for Community Hospitals:

Training on the new mattresses is ongoing. With the changes to the recording there is likely be show a sustained increase as reporting will be higher. There are a number of other improvement projects in place including safety huddles and increasing clinical supervision around pressure ulcers.

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 has not varied significantly since August 2024.

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

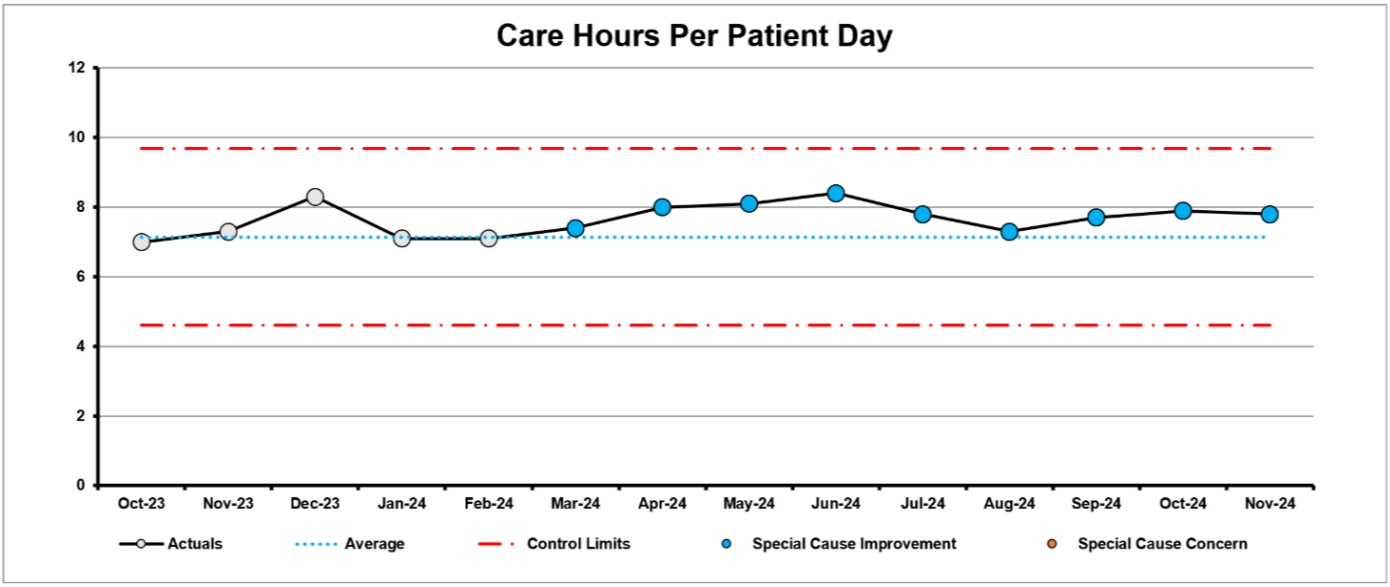
Care Hours Per Patient Day (CHPPD)

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 Teams.

Actions

A full complement of registered nurse staffing is seen within wards with resolving reductions in RN cover in Skegness as part of the international recruitment programme. Louth hospital has increased its bed base to pre COVID levels and is now meeting its contractual obligations.

HCSW vacancy remains in some areas with recruitment to entry posts continuing to be challenging. There is noticeable offset in hours allocated to registrant posts in areas with lower HCSW levels backfilled by international nursing recruits who are waiting to transition from ward areas into permanent role in other community teams and HCSW recruitment is ongoing.

SPC

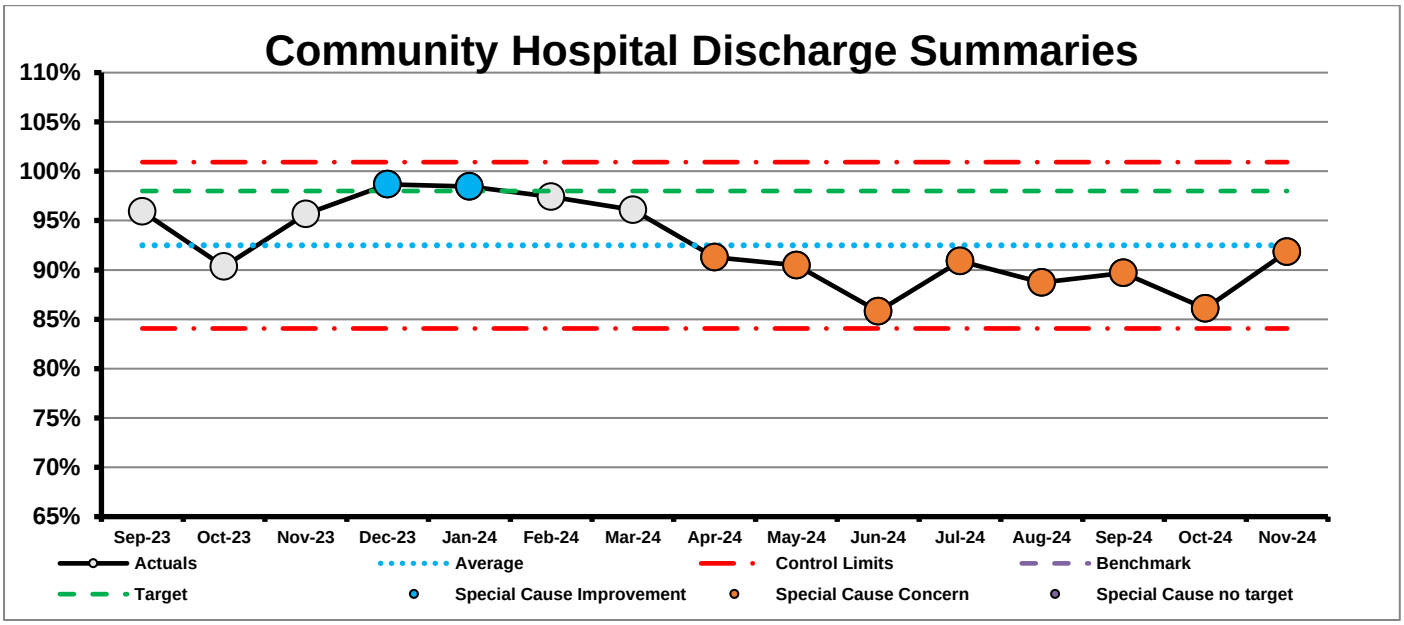
Care hours per patient day shows no significant variation over the period.

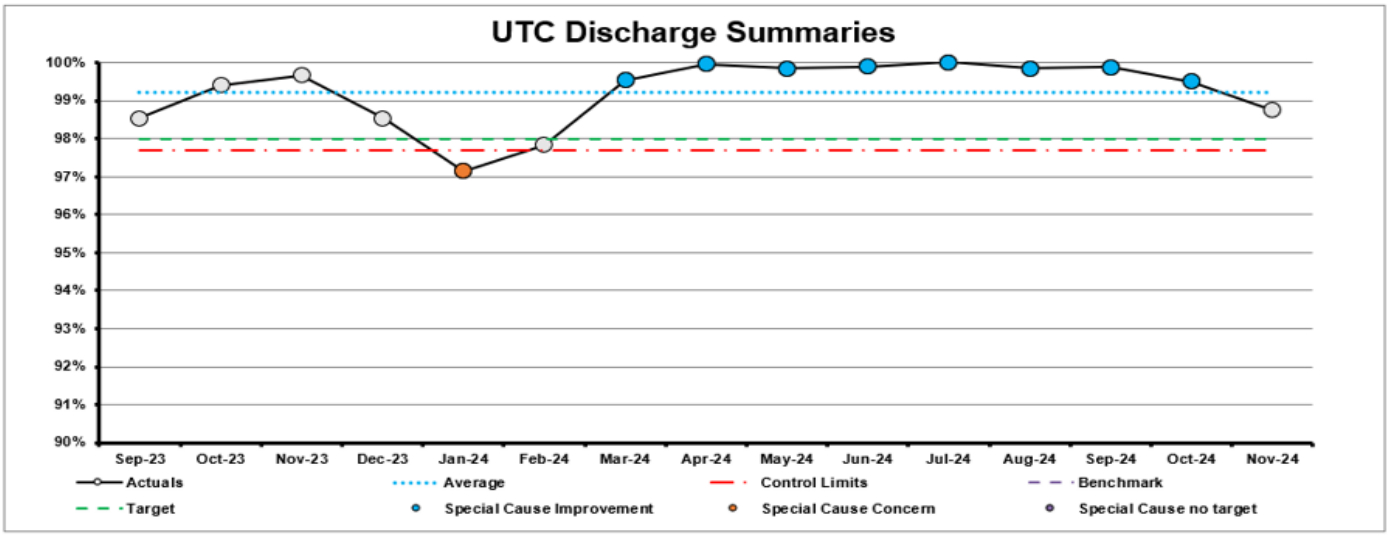
Discharge Summaries

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

The senior nurses in Community Hospitals are responsible for accepting admissions and for discharge planning. The sending of a discharge summary is part of the latter. The way we accepted admissions changed in Feb 24 which put more pressure on the job role and a symptom of this was this parameter dropping, as outlined in the chart. We have now changed the process for accepting admissions again to

make it more streamlined and it is hoped therefore this parameter will pick back up. It is too early to tell but November showed an early improvement.

Actions

Service is exploring potential for discharge team.

Urgent Treatment Centres

Discharge letters sent via System 1 remain above national standard, ensuring that patients are safe upon discharge from the Urgent Treatment Centres

SPC

Discharge Summaries - Community Hospitals
Community Hospital Discharge Summaries has shown special cause concern since April 2024.

Discharge Summaries – Urgent Treatment Centres

UTC Discharge Summaries has not shown any significant variation in the period .

Overdue & Reported Datix

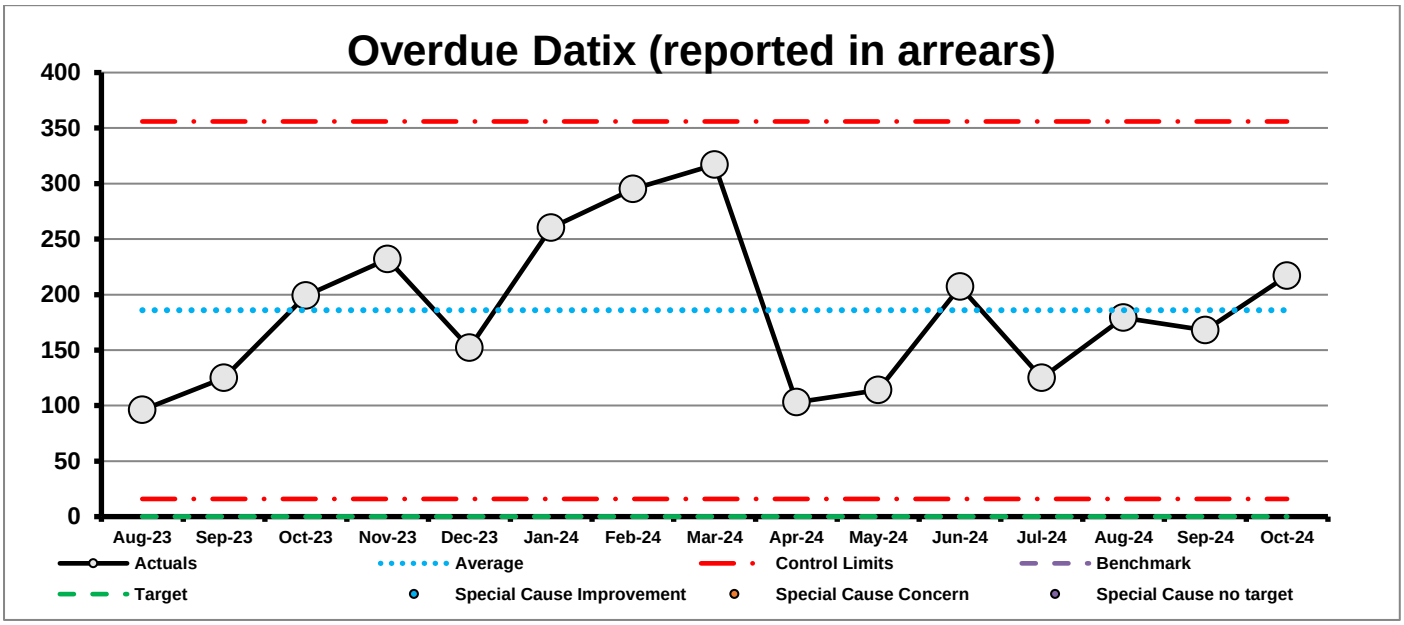
Background
When a Datix is raised to alert or escalate an incident (IR1 form) – it is imperative that the details are reviewed and considered in terms of any immediate actions that have or should be taken particularly regarding patient and staff safety.

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

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

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

Current Performance



Narrative

The 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.

CYPSS & IUEC divisions are taking actions to realign to trajectory by weekly quality review meetings with leadership oversight.

Within Community nursing there are a number of ‘overdue Datix’ that are pending approval (‘being approved’) because they are awaiting steering group (PU’s) and thematic review (medicines) validation. These numbers are consistent each month however relate to different events awaiting the monthly review which happens after PSG in the reporting cycle. These events are reviewed at steering group and then closed.
Within Community Hospitals overdue Datix marked as ‘awaiting final approval’ have been fully investigated by the clinical team and are awaiting final sign off by Clinical Service Lead. Community Hospitals and services have agreed on a timeline of 2-3 months to close the oldest outstanding Datix reports within the division.

SPC
Overdue Datix levels have not varied over the period.

Children in Care (reported one month in arrears)

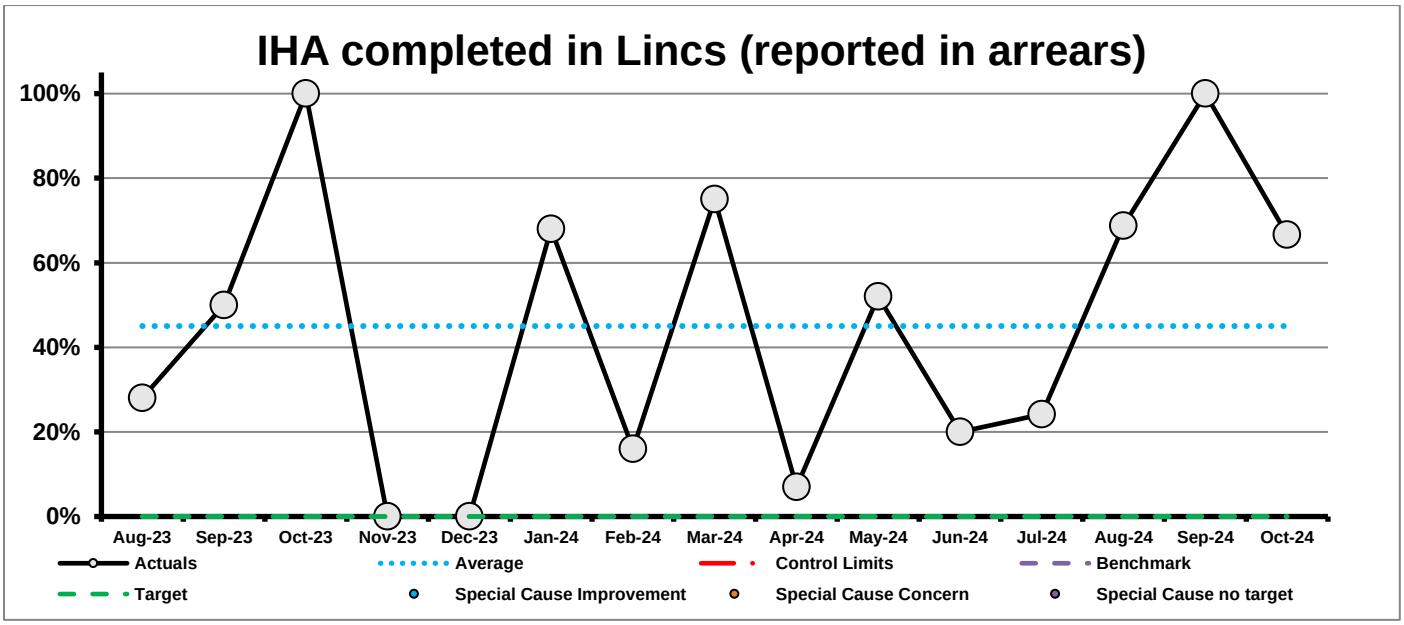
Background

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

Benchmarking / Target

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

Current Performance



Narrative

We have now been able to reinstate the 17:00 – 17:00 reporting group on SystmOne which includes the Children in Care unit, meaning we have a direct feed for the data in the daily strategic reporting extract.

The Children in Care service remains under significant pressure to deliver the IHA appointments within 20 working days of the looked after date.

In October 18 children entered care in Lincolnshire, 12 of which received an initial health assessment within 20 working days of them becoming looked after.

SPC

The SPC for IHA Performance is above average in October.

Environmental Cleanliness

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

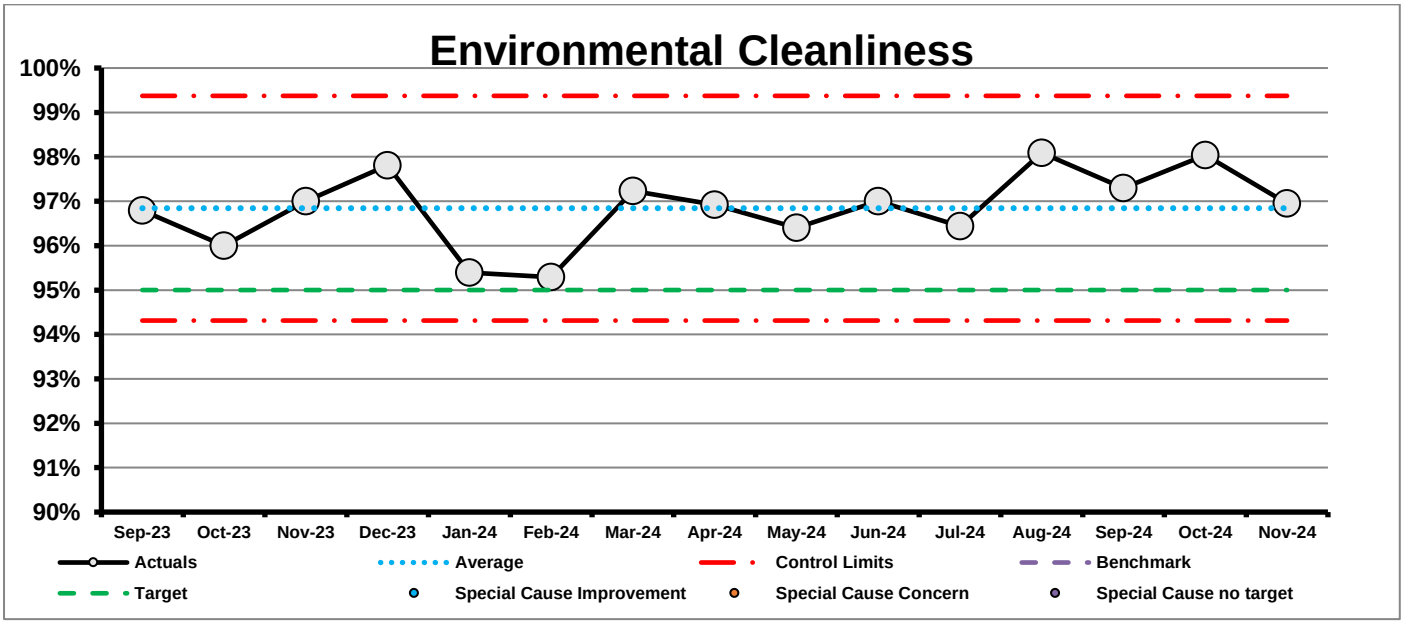
The requirements of the new National Standards of Healthcare Cleanliness that were published at the end of April 2021 have been rolled out across all LCHS community premises by OCS as well as being adopted by NHSPS and the in-house teams at the hospital sites.

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 96.95% compliance of cleanliness audits and has achieved the 95% target every month. Visible improvements in the cleaning standards across all the community premises are being sustained. During the quarter, all sites achieved scores that would rate them as either 4 or 5 stars, in accordance with the new Healthcare cleaning standards.

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

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

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

Community Hospital Bed Occupancy

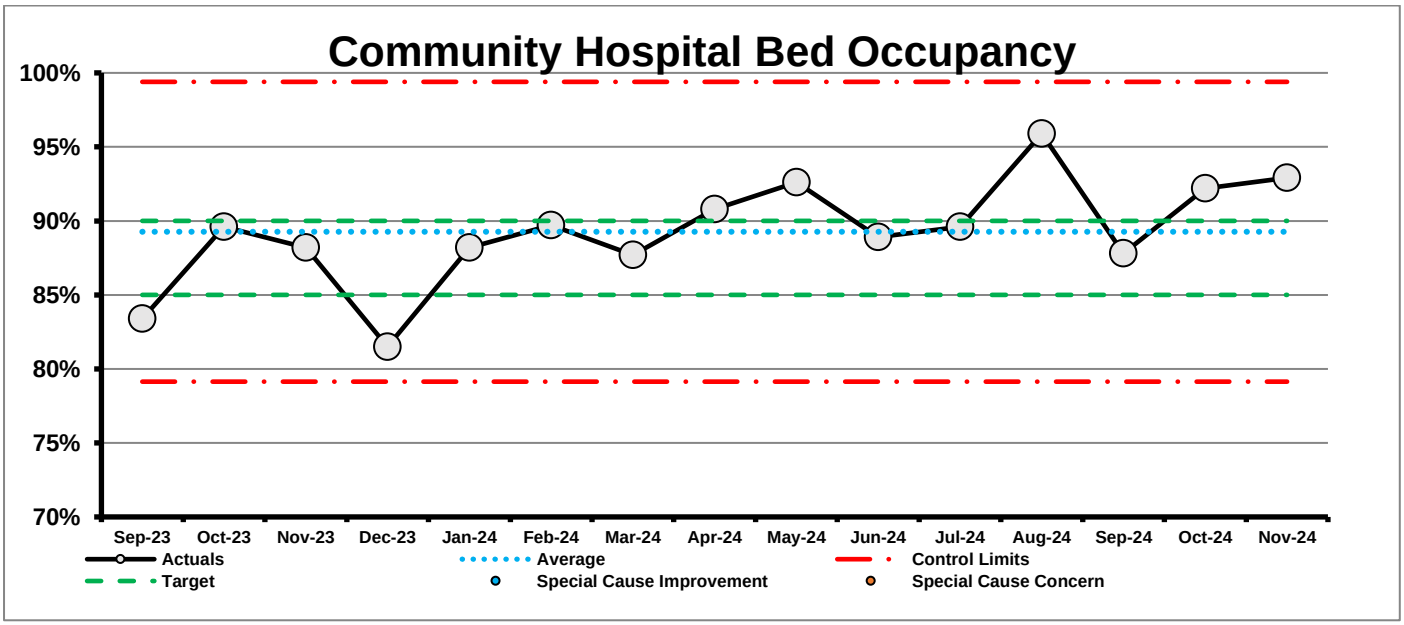
Background

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

Benchmark/Target

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

Current Performance



Narrative

High bed occupancy shows sustained activity above target.

Actions

Deputy Divisional Lead exploring whether there is capacity elsewhere in the Patient Flow workforce. It should be noted the staff model for Community Hospitals was originally set at a lower target bed occupancy than we are now frequently displaying.

SPC

Community Hospital bed occupancy performance has not varied significantly over the period and continues to be above the target.

Average Length of Stay

Background

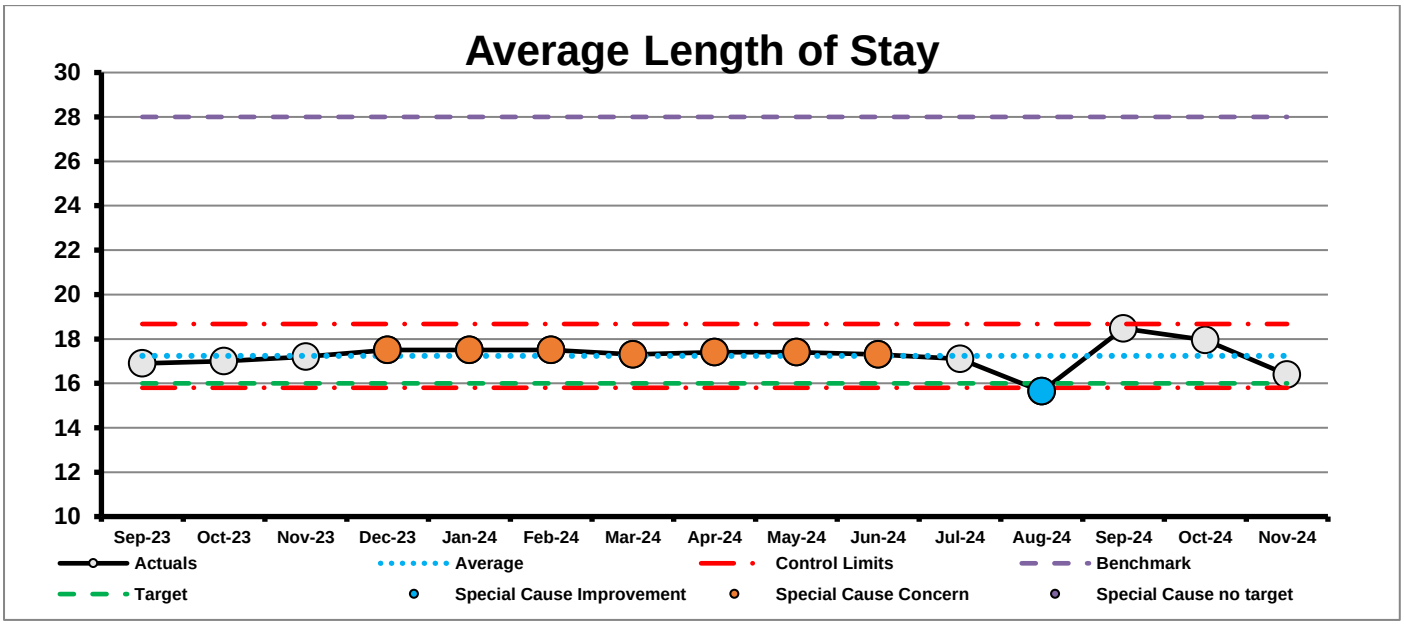
This measure is defined as the difference in days between the date the patient was discharged from the hospital, and the date they were admitted. The average time in hospital in days for all the patients who underwent a procedure in an NHS trust is then calculated (NHS Digital, 2018).

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

There is clear evidence 7 day therapy would improve patient safety and length of stay. The reason for the recent increase is due to a number of patients with very complex needs who are experiencing long lengths of stay. Funding for 7-day therapy has been achieved for the winter period and recruitment is underway.

Actions

Recruitment in progress.

SPC

Average length of stay has not varied significantly in the period, sitting slightly above the lower control limit.

Friends and Family Test

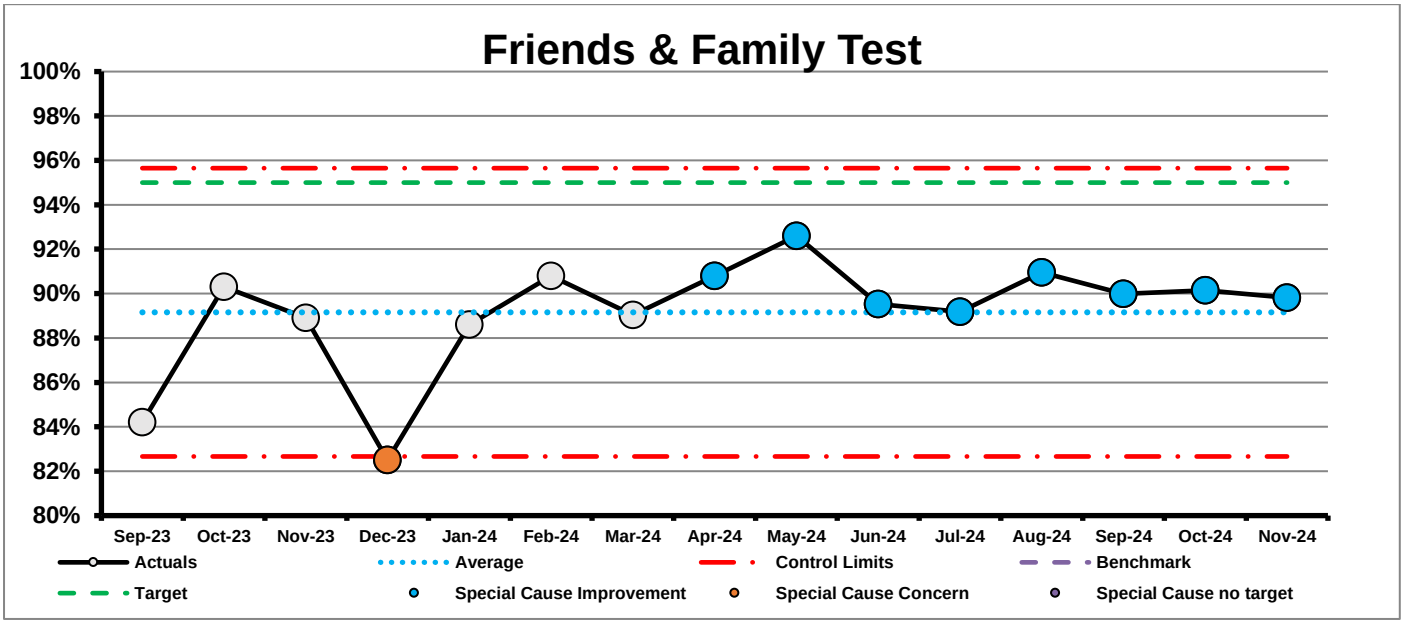
Background

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 November (89.92%) shows an decrease on last month's performance activity (90.15%).

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.

Compliments

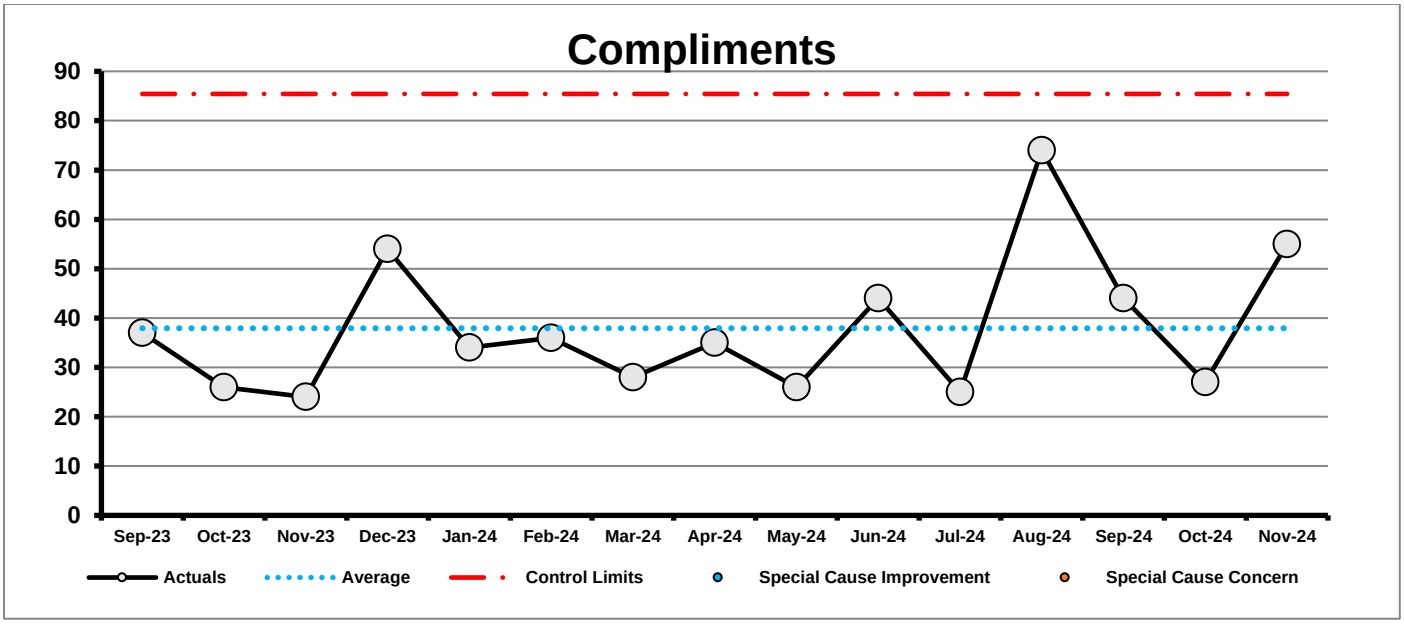
Background

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

There seems to be a slight increase in November with 55 recorded. These are mainly Community Hospitals (18) Childrens and Specialist Services (17), Collaborative Community Care (7) and Urgent Care (10) . The pals and complaints team also received 3 this month.

SPC

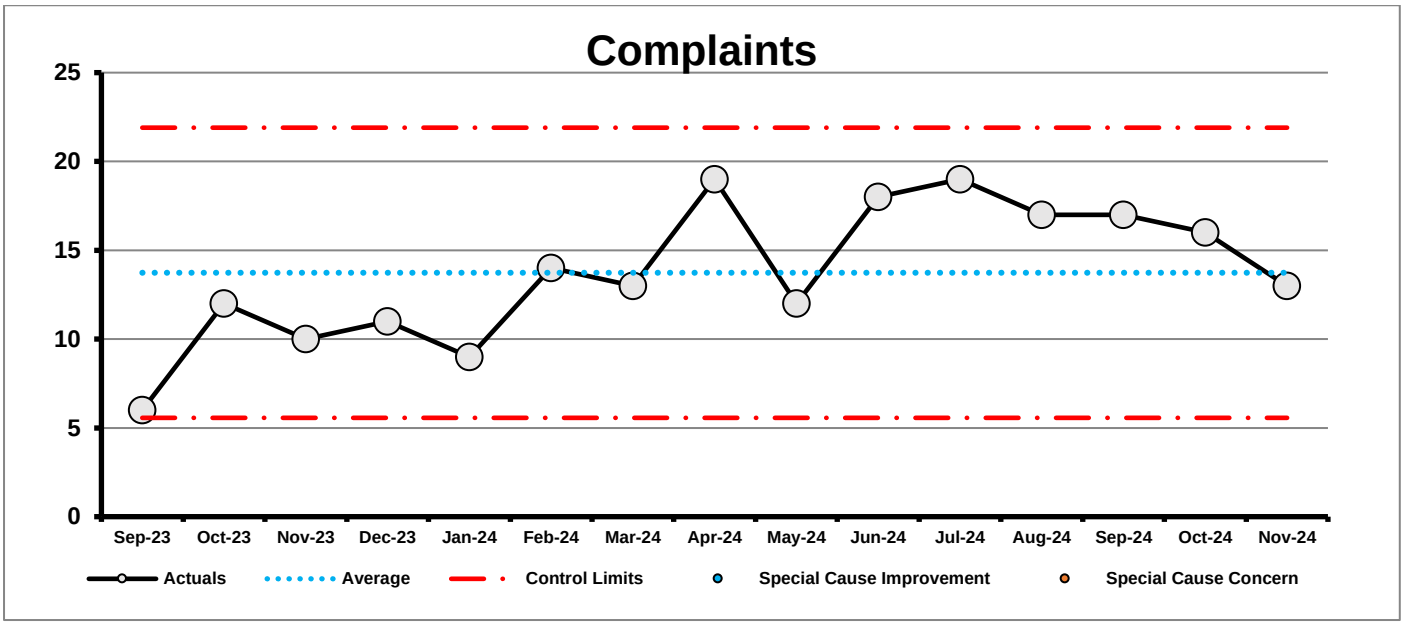
Compliments have not varied significantly over the period.

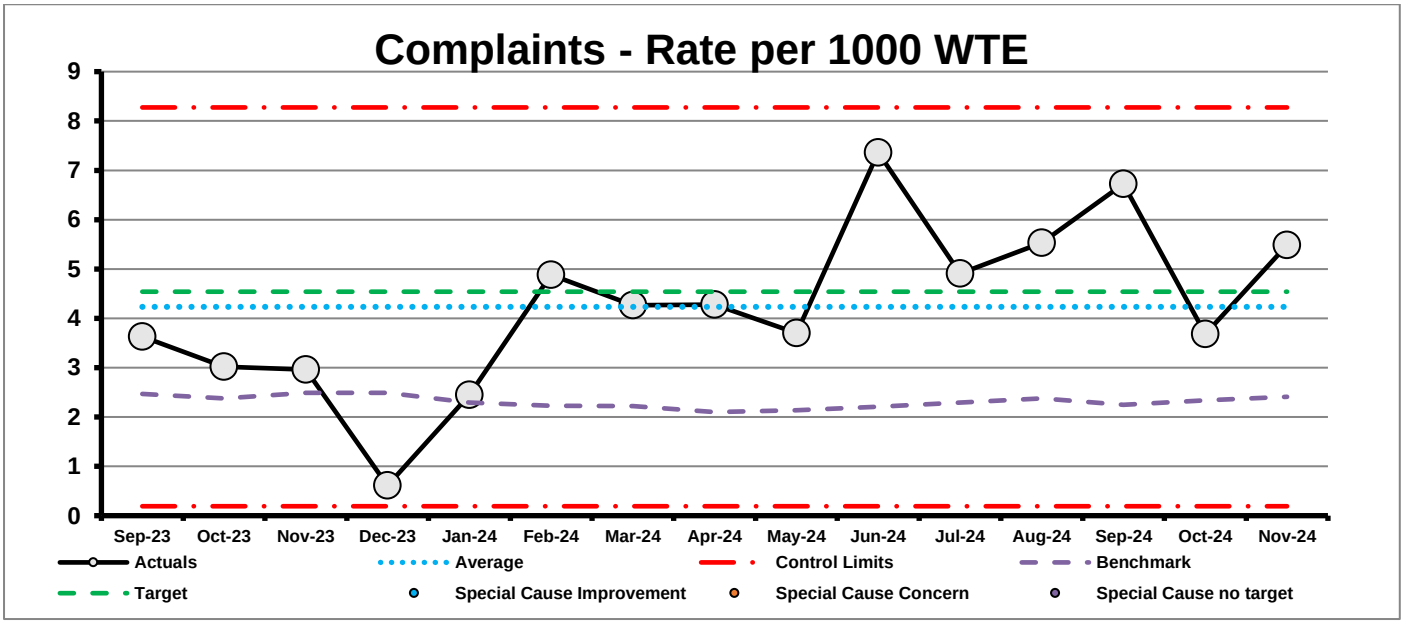
Complaints

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, we have implemented a complaint handler for each complaint who will work more closely 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 and align the complaints process with colleagues at ULHT. Discussions are being held with the divisions to gain feedback before implementing a new process.

Actions

The complaints team are continuing to improve the complaints process. There will be more changes to the current process over the next few months and talks have started with some of the divisions regarding the planned new process.

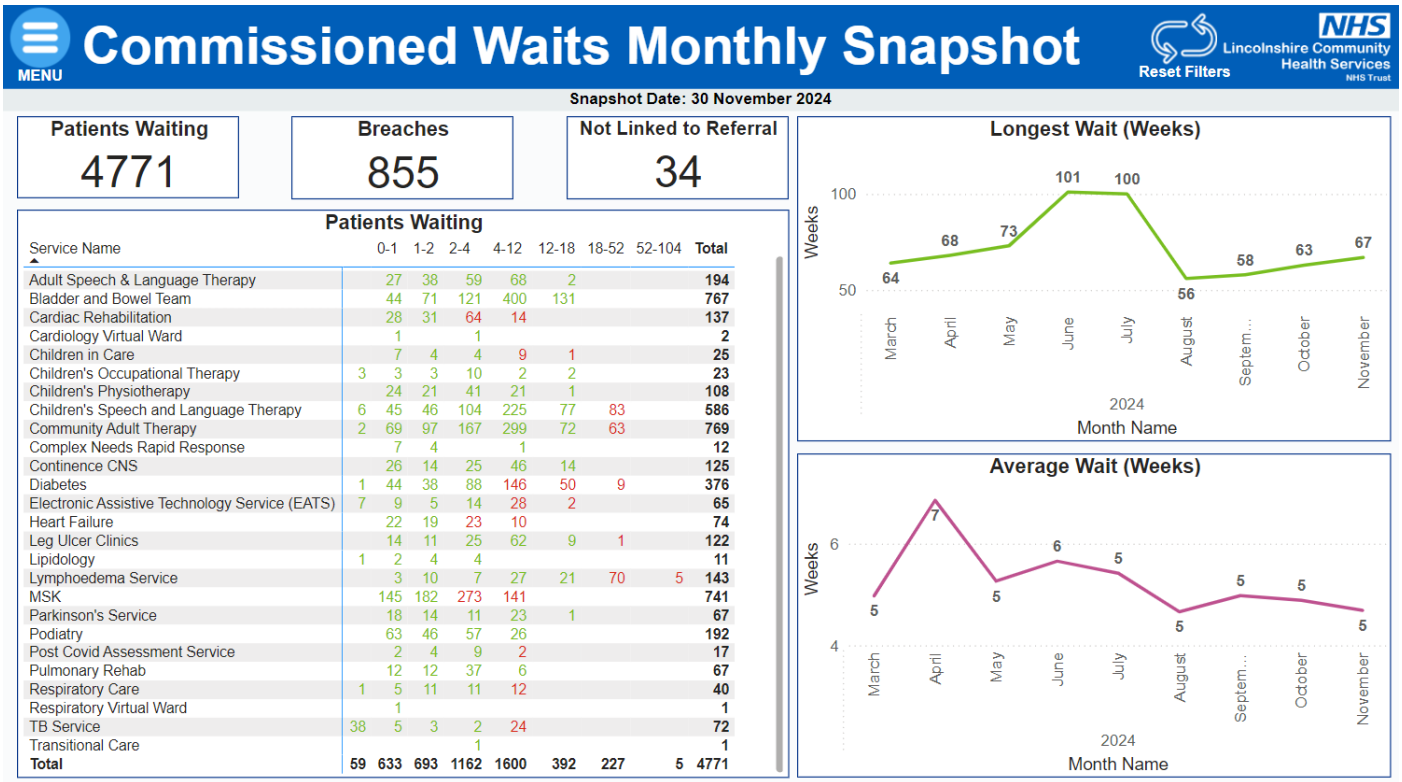
SPC

SPC for complaints has not varied significantly over the period for complaints, and also for complaints rate per 1000 WTE since January 2024.

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
Adult Speech & Language Therapy		27	38	59	68	2		194
Bladder and Bowel Team		44	71	121	400	131		767
Cardiac Rehabilitation		28	31	64	14			137
Cardiology Virtual Ward		1		1				2
Children in Care		7	4	4	9	1		25
Children's Occupational Therapy	3	3	3	10	2	2		23
Children's Physiotherapy		24	21	41	21	1		108
Children's Speech and Language Therapy	6	45	46	104	225	77	83	586
Community Adult Therapy	2	69	97	167	299	72	63	769
Complex Needs Rapid Response		7	4		1			12
Continence CNS		26	14	25	46	14		125
Diabetes	1	44	38	88	146	50	9	376
Electronic Assistive Technology Service (EATS)	7	9	5	14	28	2		65
Heart Failure		22	19	23	10			74
Leg Ulcer Clinics		14	11	25	62	9	1	122
Lipidology	1	2	4	4				11
Lymphoedema Service		3	10	7	27	21	70	5 143
MSK		145	182	273	141			741
Parkinson's Service		18	14	11	23	1		67
Podiatry		63	46	57	26			192
Post Covid Assessment Service		2	4	9	2			17
Pulmonary Rehab		12	12	37	6			67
Respiratory Care	1	5	11	11	12			40
Respiratory Virtual Ward		1						1
TB Service	38	5	3	2	24			72
Transitional Care				1				1
Total	**59**	**633**	**693**	**1162**	**1600**	**392**	**227**	**5 4771**

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 have now implemented this process, recording referral to initial contact.

Lymphoedema has seen an increase in urgent referrals which has meant that those referred and triaged as routine must unfortunately wait longer. Safe waiting advice and safety netting is in place. A review of referral criteria and collaborative work with Essity for additional clinics had a positive impact on waiting lists and as they rise again the service is seeking to repeat this Essity support next year. The service has submitted a Case of Need and a Business Case to expand capacity.

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

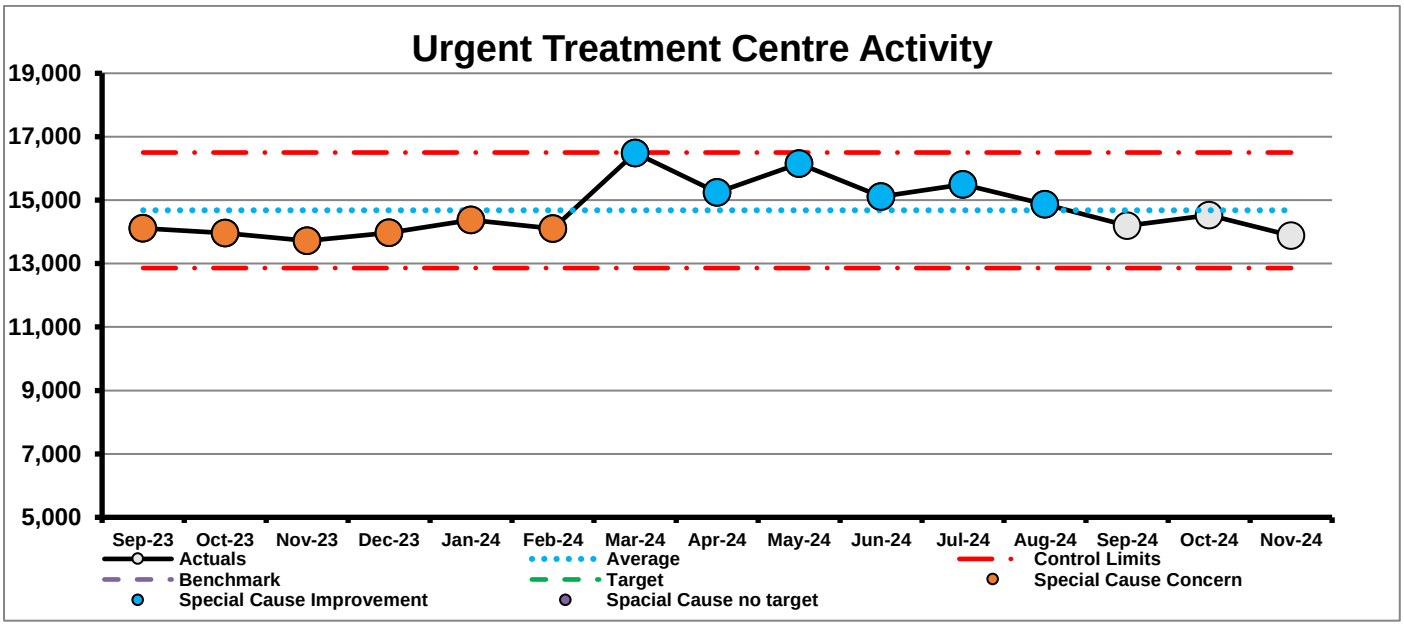
Child Therapy	18 Weeks
Children in Care	20 Working Days
CNS Continence	18 Weeks
Diabetes	4 Weeks
Electronic Assistive Technology Service	6 Weeks
Heart Failure	2 Weeks
Musculoskeletal Physiotherapy	15 Working Days
Parkinson’s	18 Weeks
Podiatry	18 Weeks
Post Covid	6 Weeks
Pulmonary Rehab	10 Weeks
Complex 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 November 2024 decreased moderately from last month but remains within expected activity ranges. This was similar to the same period last year. We are continuing to monitor when the peak in footfall arrives at UTC's and monitoring whether GP collective action is having impacts on the UTC footfall.

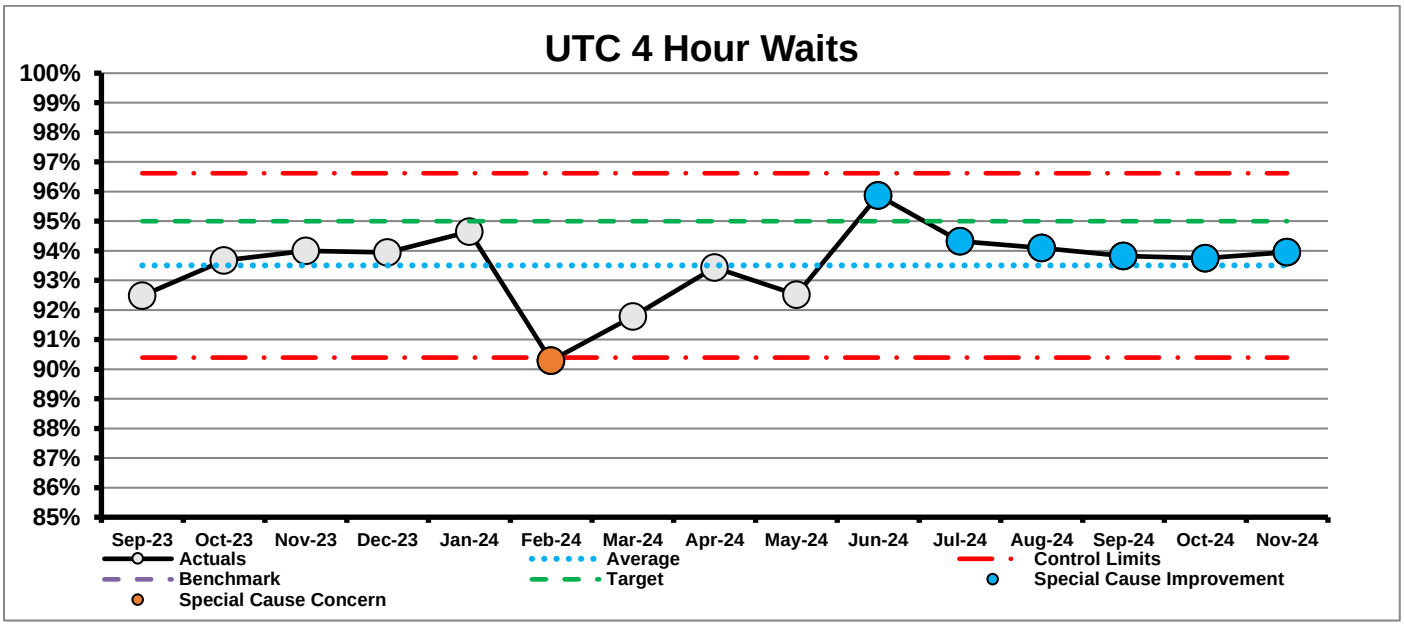
SPC

UTC activity has not varied significantly since August 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

November 2024 shows a slight increase in performance with 4-hour waits 93.95% compared to October 2024 at 93.75%. The performance sits just under our target of 95%. 15-minute assessment remains consistent at 96%

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. The issue around speciality waits, orthopaedic, bloods and x-rays have been escalated back into the group as more data has been readily available. Work continues to resolve these issues.

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, 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.

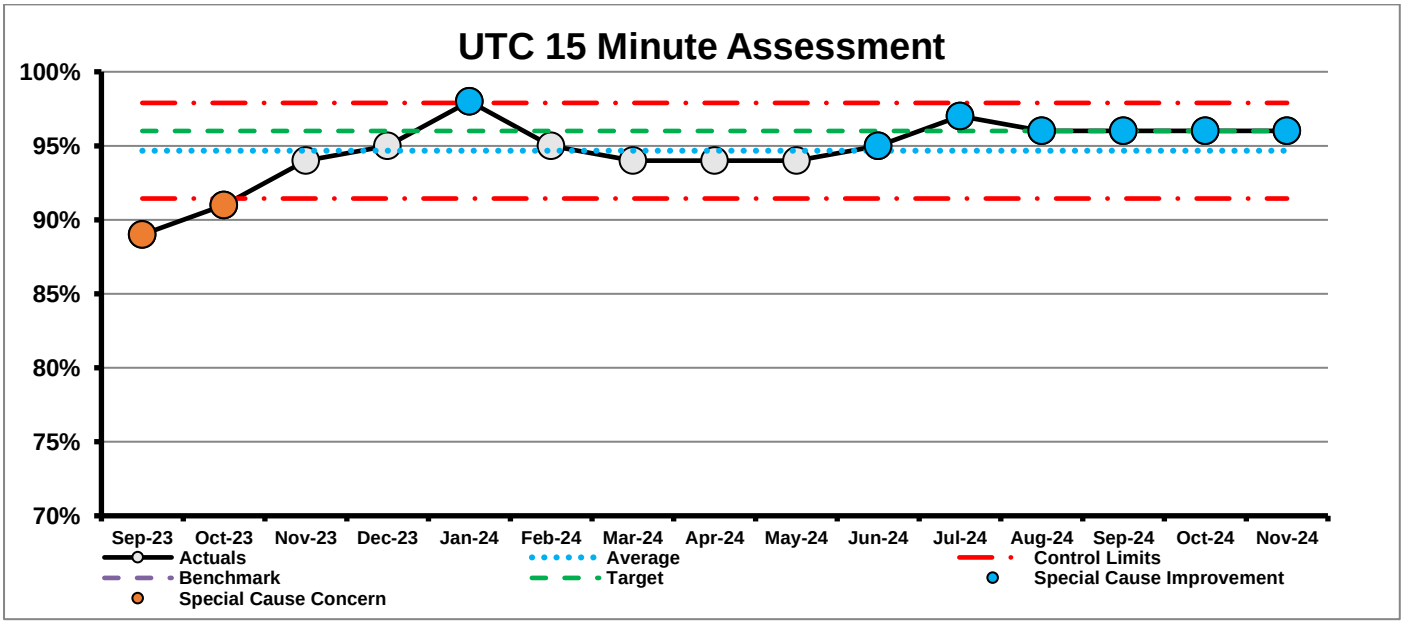
SPC

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. 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 4 months.

This month 96% of UTC patients were triaged within 15 minutes against a target of 95%.

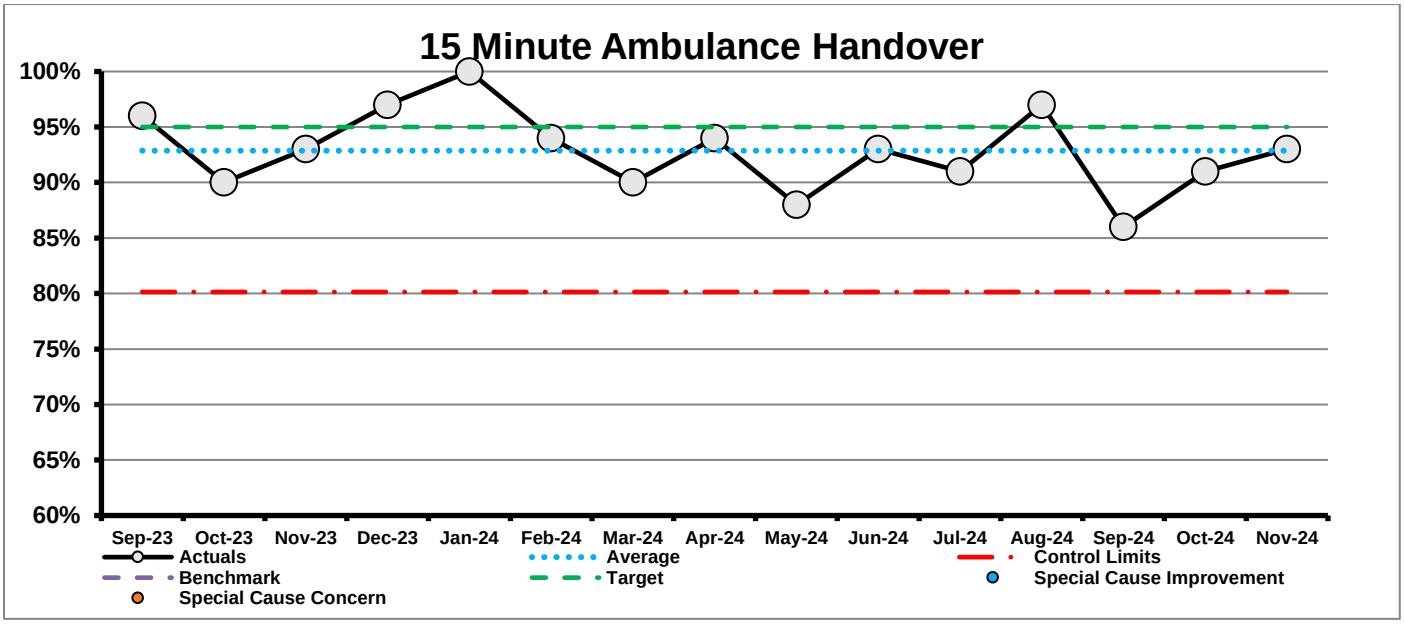
SPC

UTC 15-minute assessment shows special cause improvement since June 2024.

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 continued to increase from 86% to 93% over the period of September to November. We continue to work closely and meet regularly with EMAS partners to enhance admission avoidance pathways.

SPC

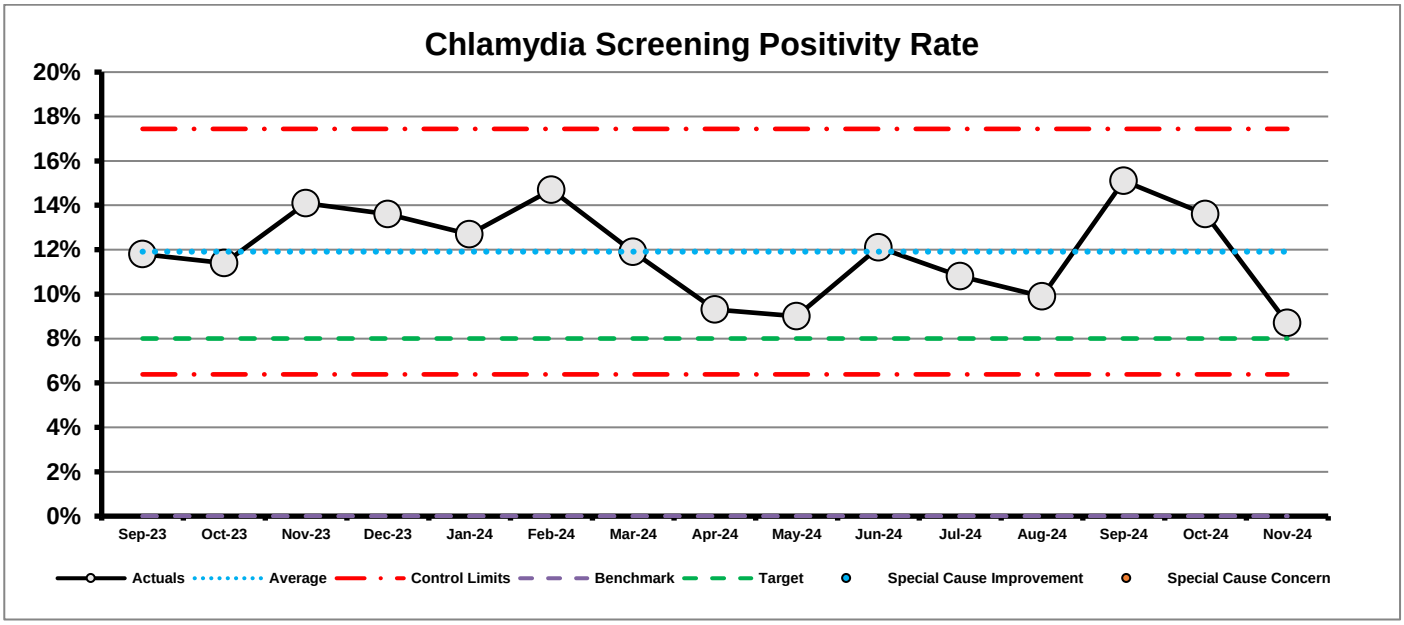
15-minute Ambulance Handover performance has not varied significantly over the period.

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.

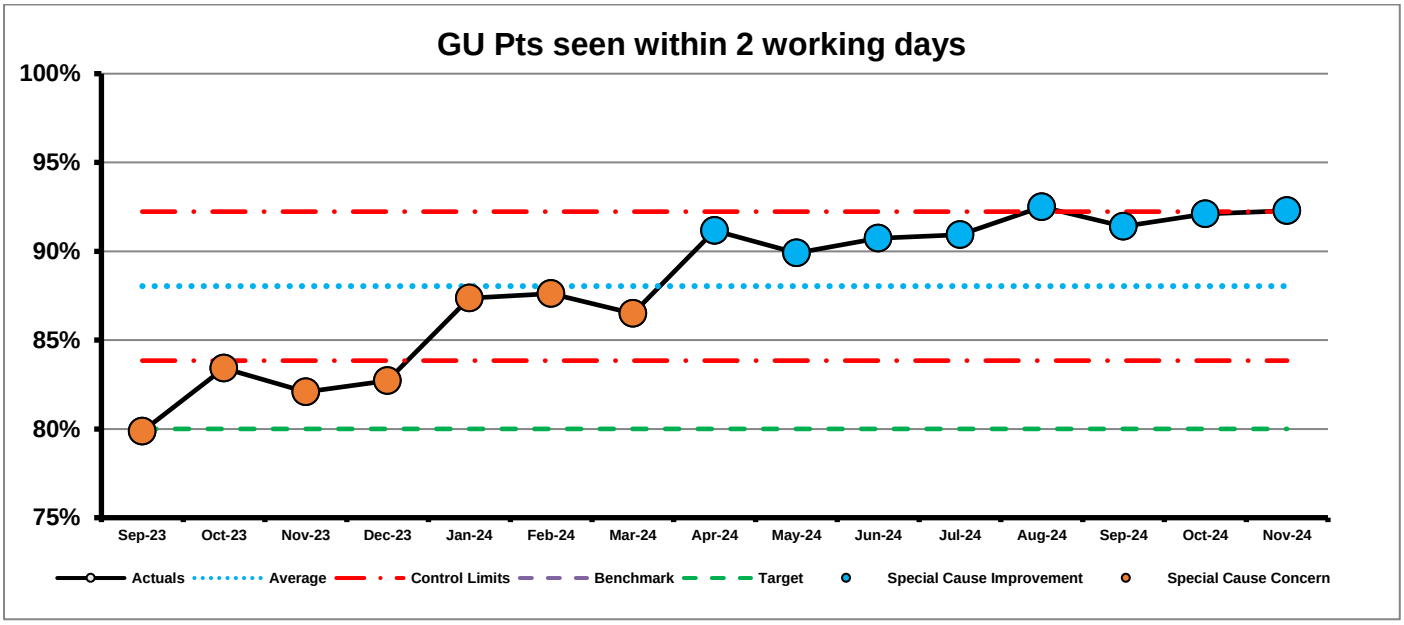
Actions

To continue developing and raising awareness of the service within the younger population.

SPC

Chlamydia screening positivity rates are consistently 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 April 2024. This measure is consistently capable of achieving the 80% target.

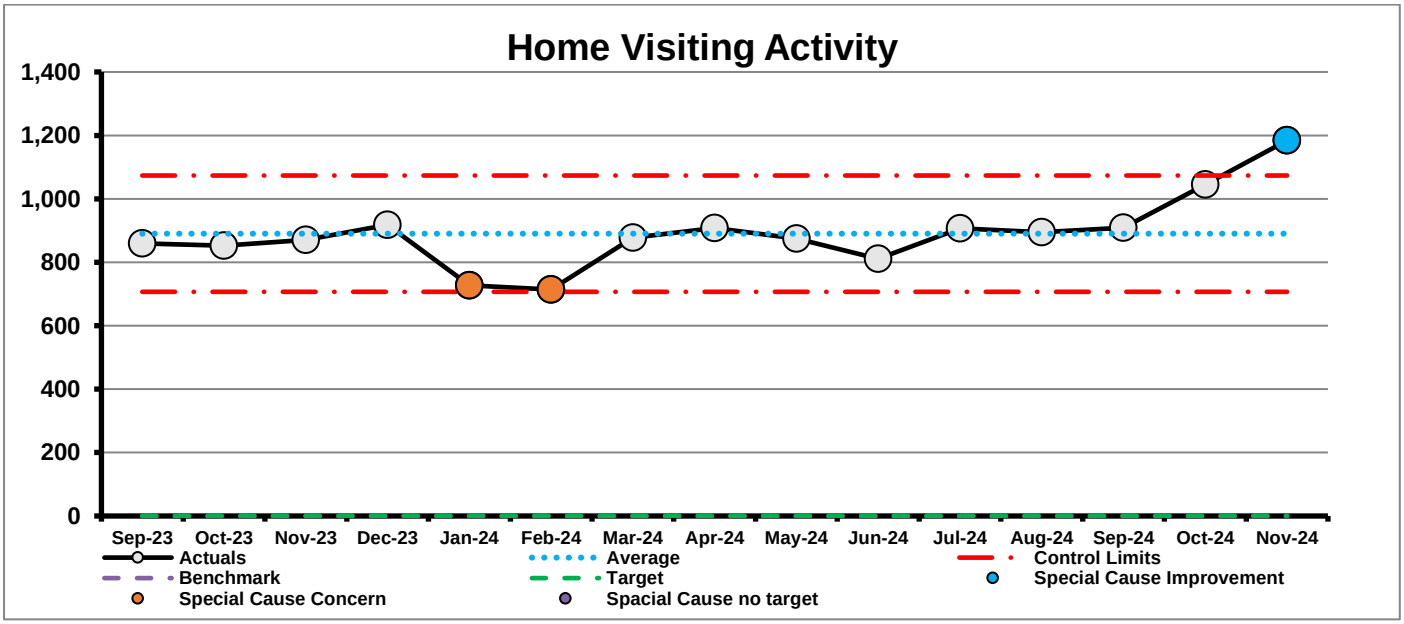
Home Visiting Report

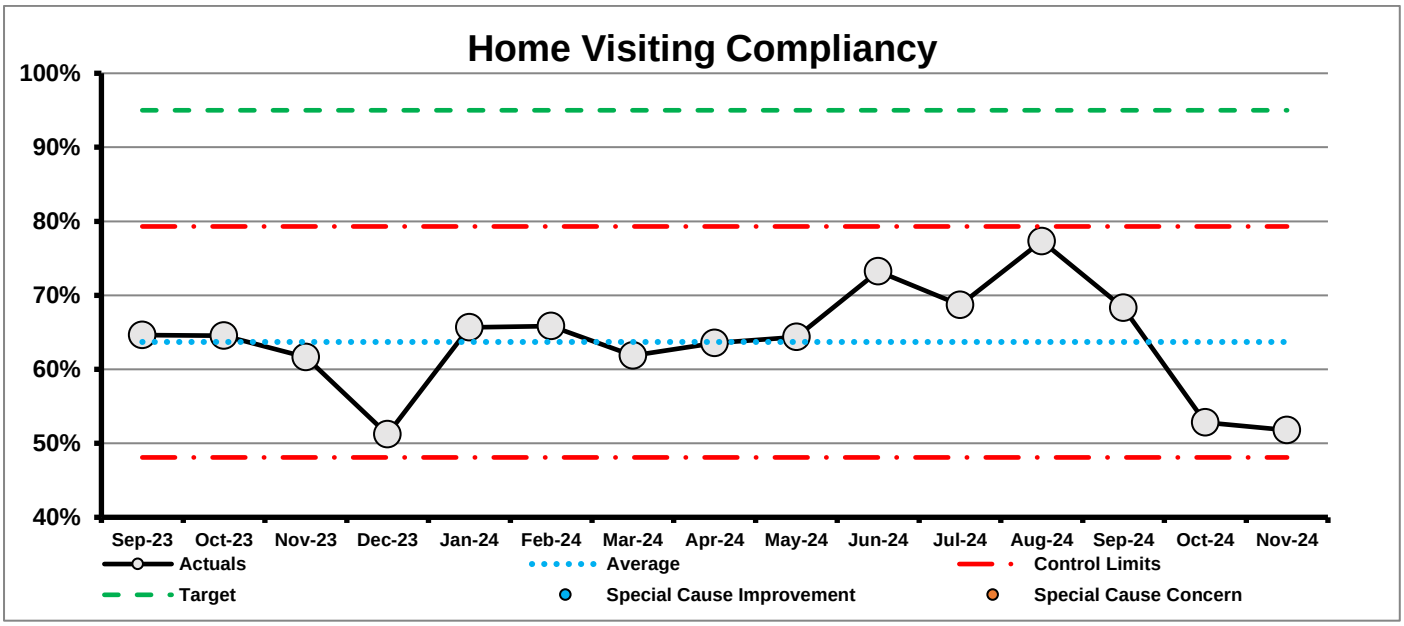
Background

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

November has again seen a significant increase in demand. The three main trends for this activity continue to be 1) The start of the new unplanned catheter pathway across IUEC and community nursing (commenced on the 30th of September) (309 referrals), 2) An increase in unplanned palliative referrals (331 referrals) and 3) An increase in care home referrals (also demonstrated via the CAS data) (254 referrals).

Since the introduction of the unplanned catheter pathway, there have been regular meetings with internal stakeholders to review progress and ensure patient safety whilst improving patient outcomes. The peaks in

demand have not followed previous demand mapping and this has led to some backlogging of work which has been difficult for teams to recover and subsequently led to a poorer responsiveness.

Recovery Actions:

1) Unplanned catheter pathway referral process amended as of 20 November 2024 to move some demand back into community nursing (as appropriate) if patient is likely to breach. Further amendment planned to identify specific community nursing teams with sufficient capacity to take back the unplanned work in their areas.
2) Pilot of a clinical coordinator role to manage the Home Visiting stack daily and monitor patient safety and responsiveness throughout the day is working well and will continue throughout winter. This went live on 19 November 2024 and this person is providing a daily sit rep and escalation of any concerns.
3) Ongoing discussions between Home Visiting, Community Nursing and pSPA to ensure appropriate pathways are being followed for all unplanned palliative needs.
4) Deep dive breach analysis in progress of all November's breaches and early information shows that a significant proportion of these were not true breaches (due to recording issues) and will be revalidated. The responsiveness rate for November will then be re-run and should show an improvement.
5) Unplanned Care Risk Summit held on 10 December 2024 with representation from all relevant operational teams alongside corporate partners from quality, HR and finance. Multiple improvement actions identified (many linked to planned care) which will be taken forward as part of the Unplanned Care Project Group).

SPC

Home Visiting activity has increased significantly over the period and exceeds control limits.

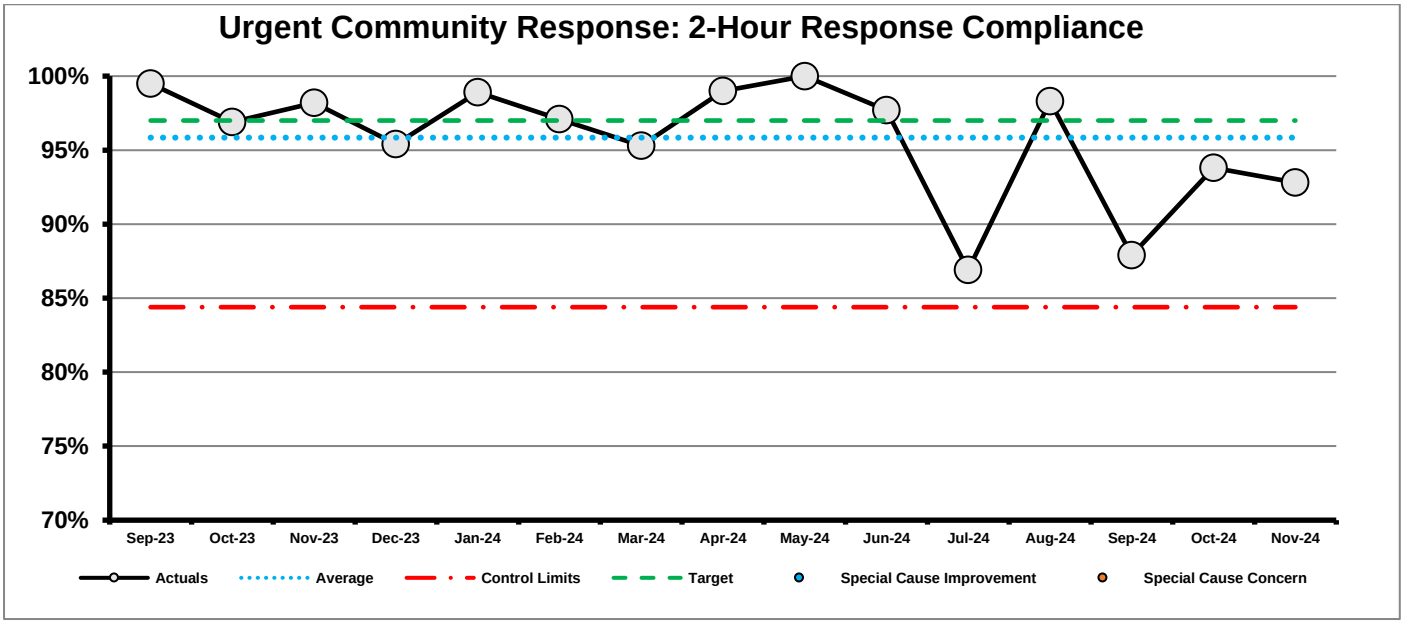
Urgent Community Response

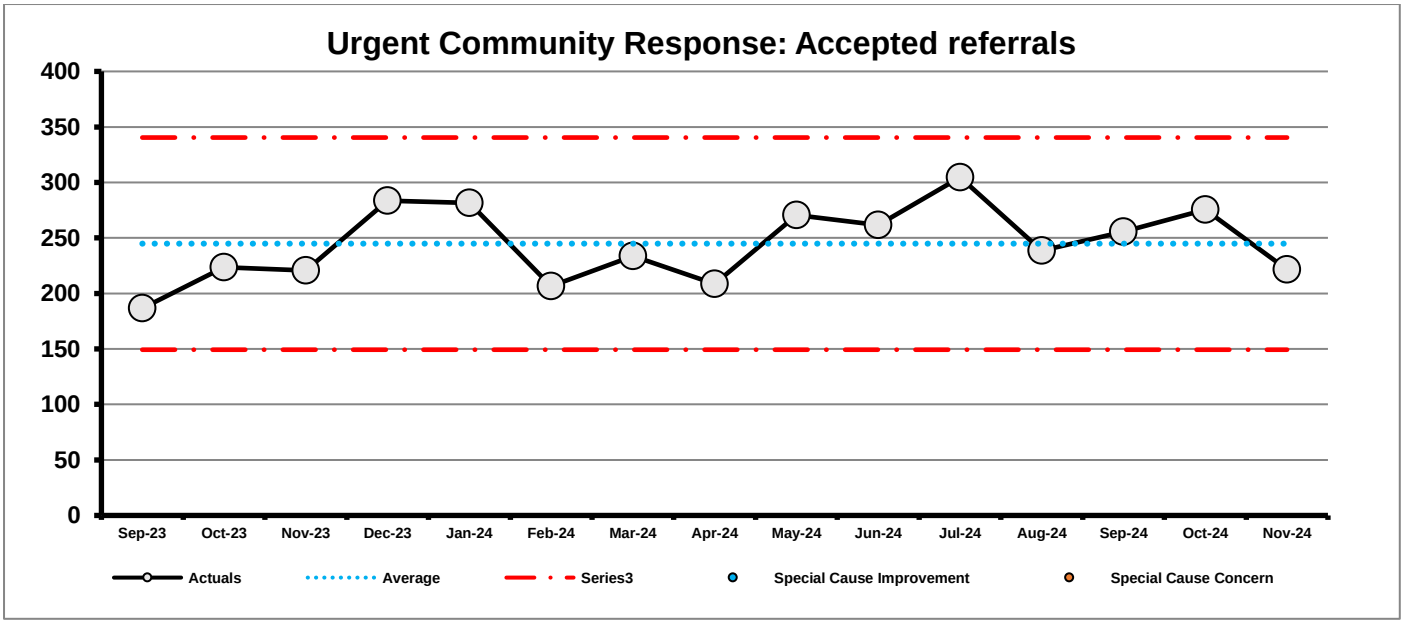
Background

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

There has been a slight increase in referrals however it remains on average for UCR. The 2-hour compliancy is comparative to the number of referrals. This is expected to improve in the new year with recent vacancy recruitment (service currently has 7 vacancies including 2.73 ACPs). The service continues

to showcase the service capabilities at countywide events and will work alongside CAS, Home Visiting and EMAS to identify cases appropriate for a UCR response.

SPC

The 2-hour response rate has not varied significantly over the period. This measure is inconsistently capable of achieving the 97% target and is expected to miss the target more often than not.

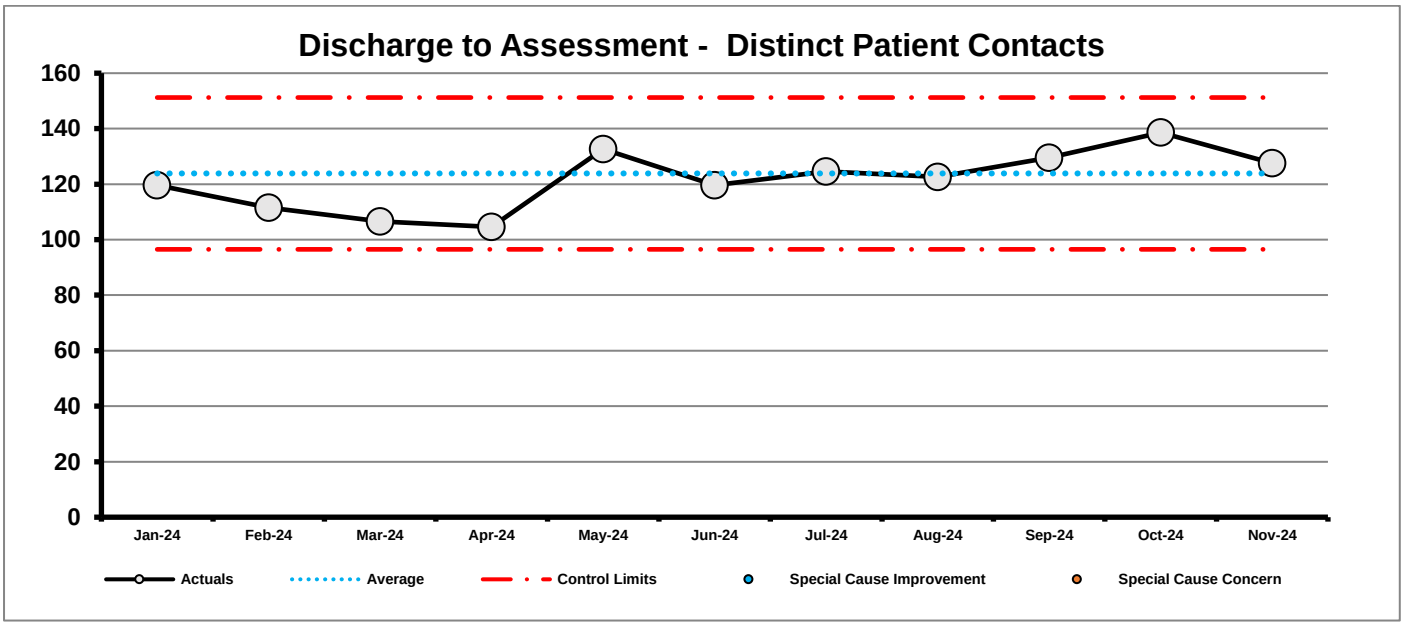
The number of accepted referrals for Urgent Community Response has not varied significantly over the period.

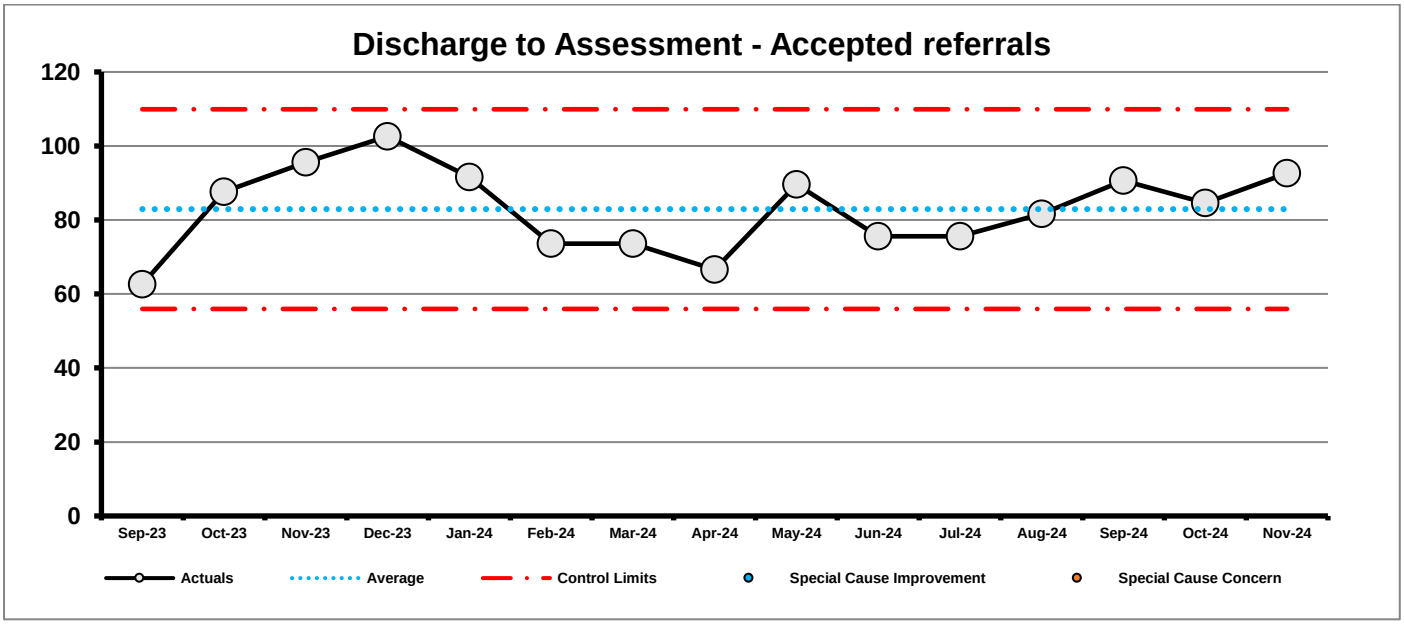
Discharge To Assessment

Background

The Discharge to Assessment programme has been introduced to expedite patients to leave acute care and return to their own home for reablement.

The service works closely with Adult Social Care and supports patients with a wide range of needs.





Narrative

The number of referrals accepted into the Pathway 1 D2A service has risen, compared with October. Number of accepted referrals remains above the annual average.

Continued work with the ULTH Front Door Therapy Service and LCC HBRS service has supported this work, in addition to trialling new ways of working between the D2A and LCHS community hospital teams.

Actions

Further collaboration with the HBRS reablement service; agreed to re-commence weekly meetings to discuss hybrid packages of support. Through these meetings the teams can share feedback and updates but also discuss and agree alterations to the hybrid offer to best suit service user requirements.
Work between D2A and ULTH Front Door Therapy (FDT) continues, with SystmOne access granted to the FDT team. Once e-learning training is completed, agreed for practical support from the D2A team for the use of SystmOne and to build in a pathway to support both timely discharges and service user experience.

3 x Band 4 Assistant Practitioner and 3 x Band 5 Therapist posts offered, following successful recruitment in November; 11 shortlisted for B6 AHP vacancies.
D2A sits within the winter initiatives and there has been an ask to increase the capacity of the service by another 50 visits per day. For this demand, the service has identified the need for an additional 8 x Band 4 Assistant Practitioners and 3 x Band 6 therapists which are all out to recruitment as detailed above.

SPC

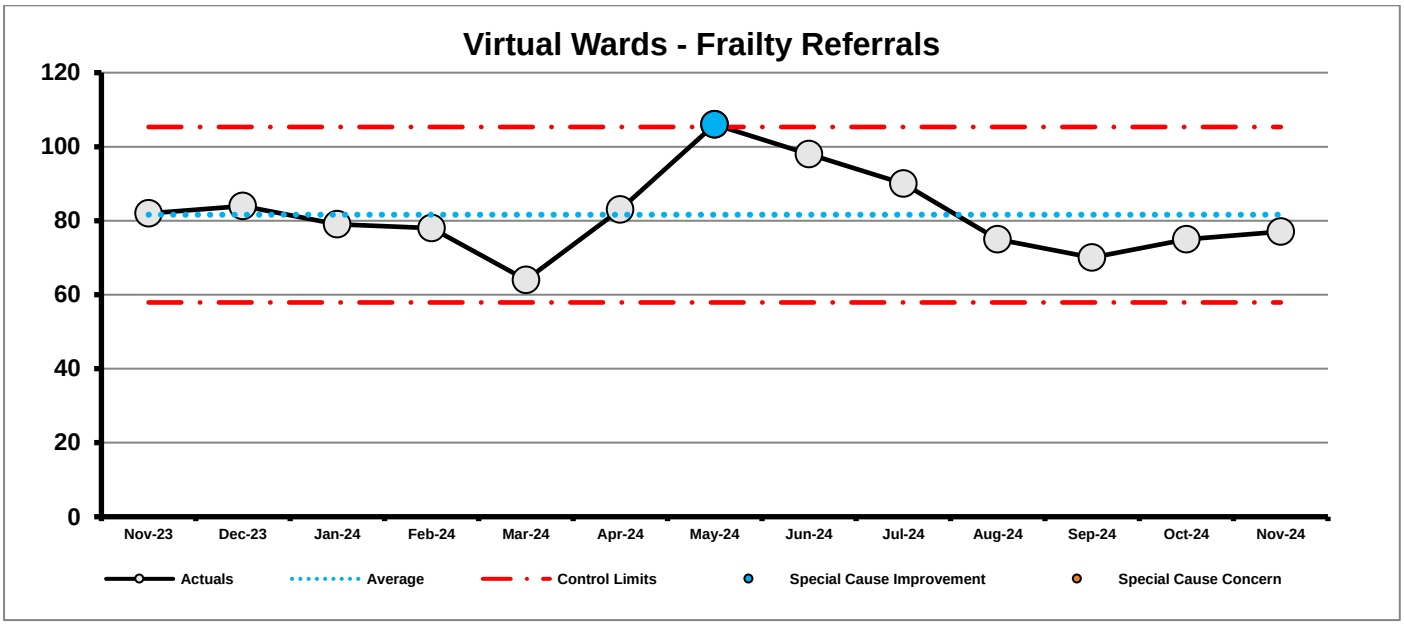
The number of distinct patient contacts has not varied significantly over the period and remains above average.

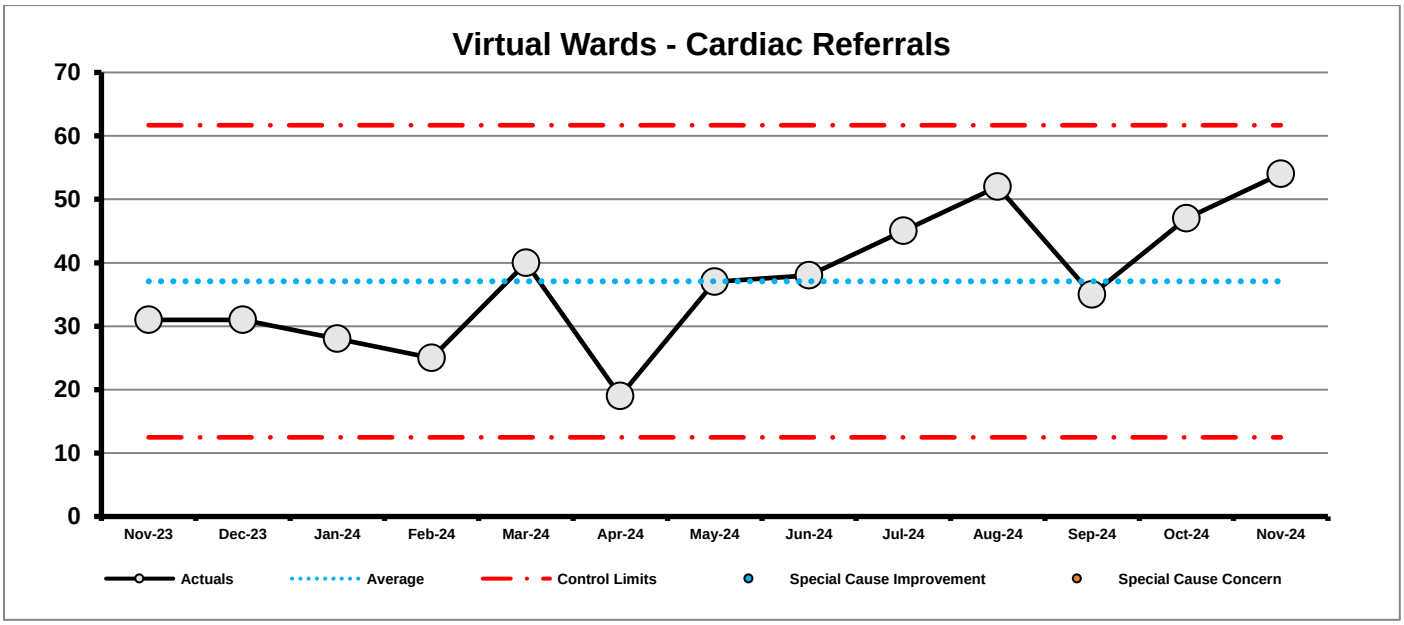
The number of D2A accepted referrals has not varied significantly and also remains above average.

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.

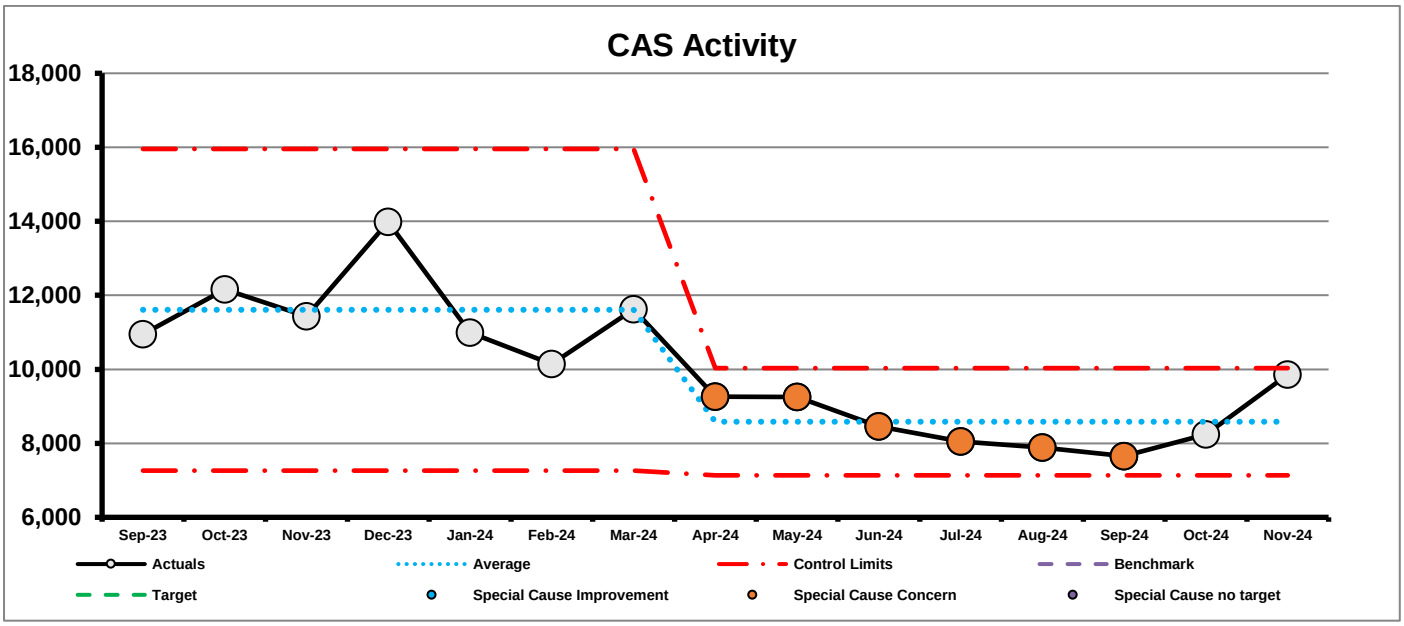
SPC

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

Following the 111 contract changes in April (which equated to a loss of approximately 100 calls per day into CAS), activity has consistently fallen within the service up until October where we saw a small increase followed by another more significant increase in November (although this remains just under 2000 less calls than November 2023).

There has been significant work within CAS to ensure we are using the established resource and increasing utilisation. This has included various projects.

- Ongoing pilot of CAS physically basing themselves within EMAS Eoc which to date has avoided the dispatch of 117 ambulances. The ICB have requested that we increase input to 7 days a week over winter due to the success of the project so far.
- CAS for Care Homes successful relaunch (impact of which can be seen in increased referral numbers throughout October and November)
- Healthcare SPA went live 14.10.24.
- Same Day Access Pilot went live 18.11.24.

There are ongoing discussions with the ICB regarding the return of interim dispositions and ED validations from DHU to CAS following significant concerns about DHU's performance and patient safety/experience with the new pathway. This may mean pausing some of the ongoing pilots discussed above but this is yet to be confirmed.

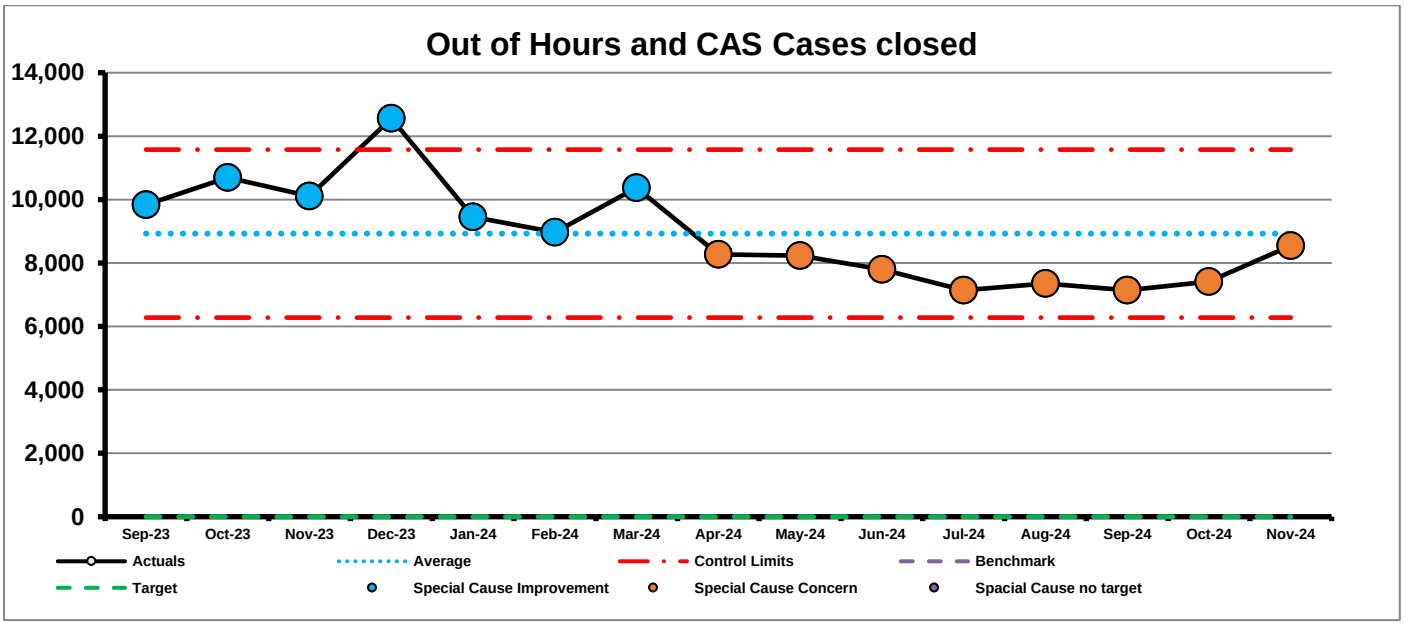
SPC

CAS activity has shown special cause concern since June, this, however, seems to have recovered to average (post contract change).

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 not pulling correctly from Systm1 into PowerBI and the FBI continue to investigate this. November saw a significant increase in cases closed which is in direct correlation with the higher activity seen within CAS.

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.

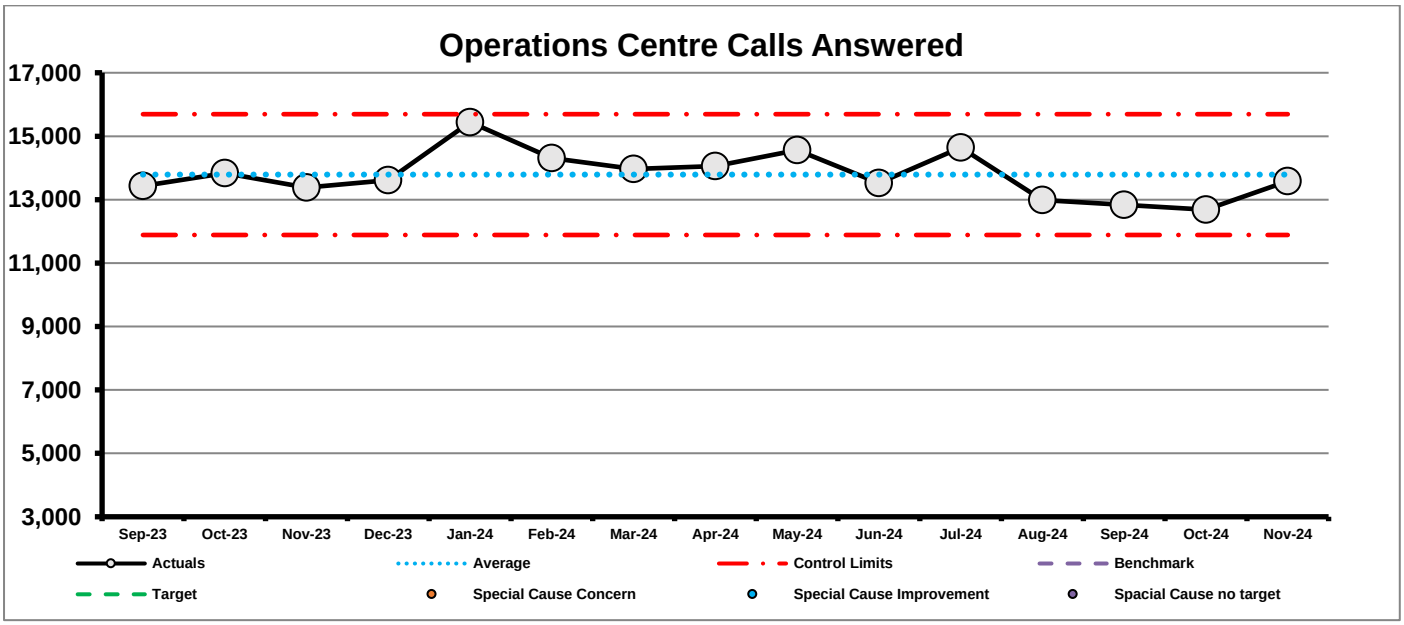
SPC

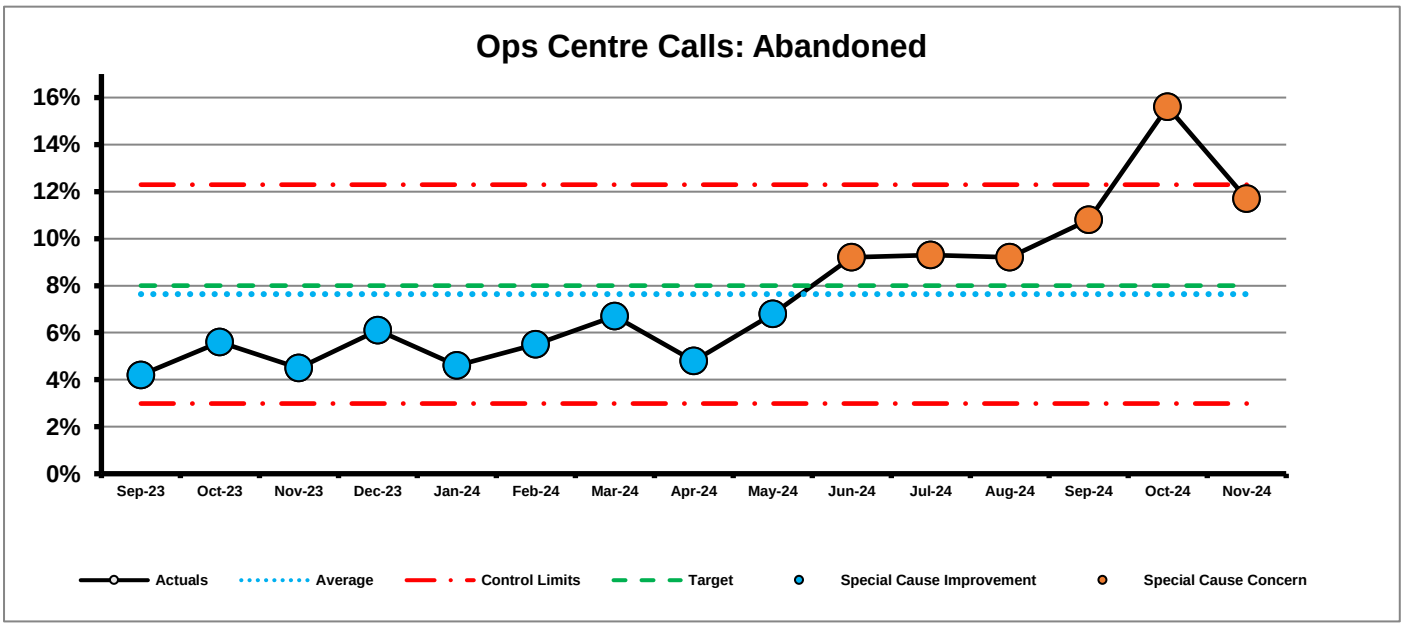
OOH & CAS Cases Closed shows special cause concern since April 2024 following the 111 contract changes.

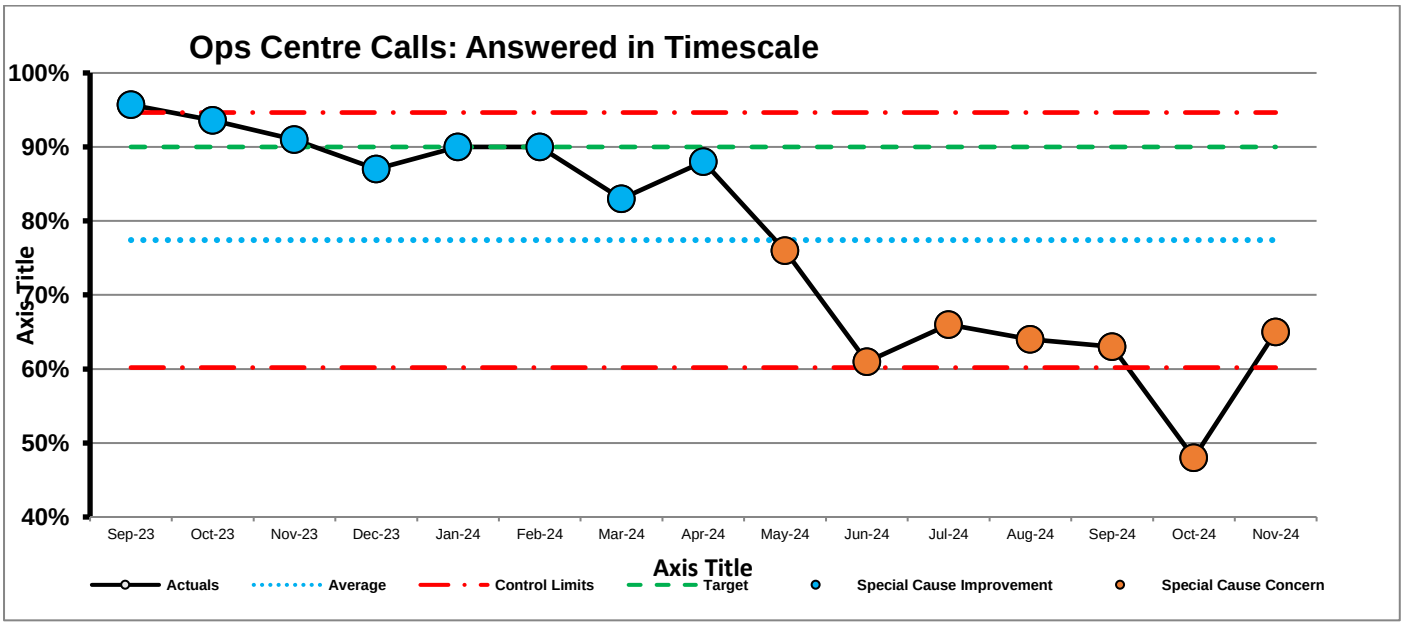
Operation Centre Calls Metrics

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

Volumes into Operations achieved close to 17,000 calls, 13,500 were answered.

We have several new starters who are being shadowed and developed, we should bear the fruit of this in February 2025 when they are up to speed with what is required, we have had some acute short-term sickness coupled with a couple of long-term sickness cases.

Abandoned calls reduced this month, answered calls remained on par with last month.

Almost all KPI's reduced closer to target but still above where we need to be at the moment, but as mentioned, new starters and absence due to sickness have all been a factor in the results this month.

SPC

The number of calls answered within the Ops Centre has not varied significantly since December 2023.

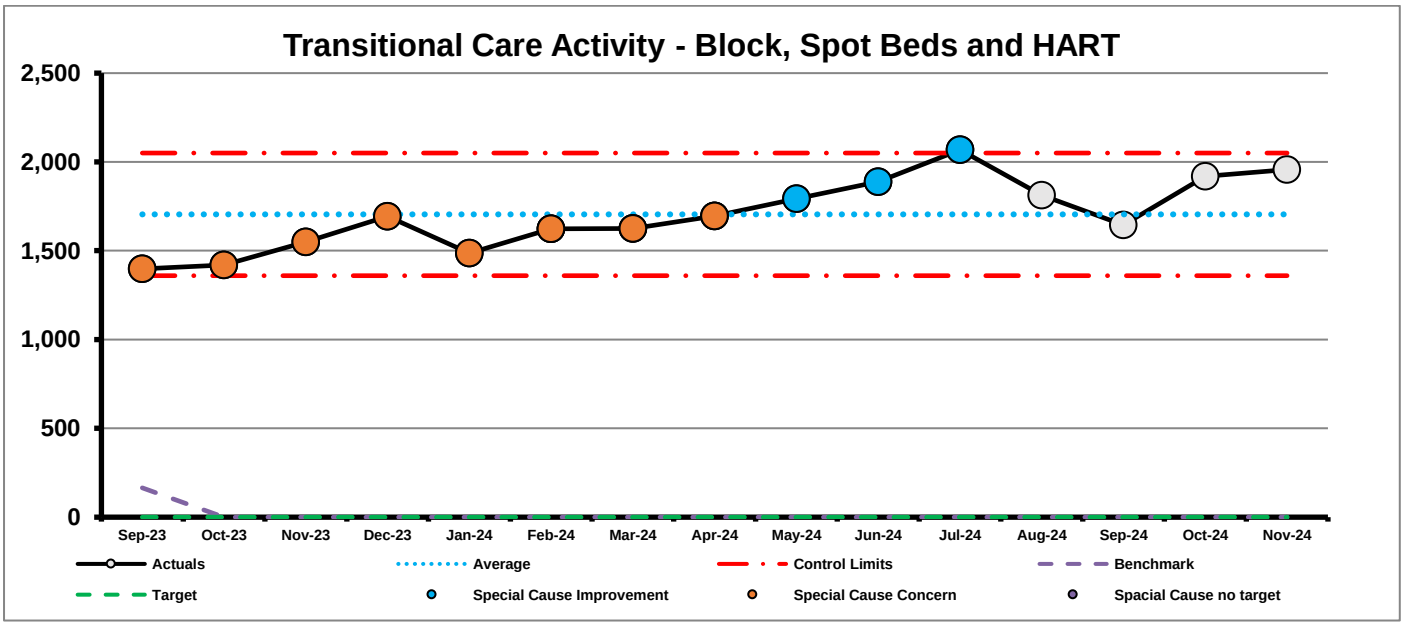
Ops Centre Calls Abandoned shows special cause concern since June 2024. It is inconsistently capable of achieving the 8% target but achieves target more often than not.

Ops Centre Calls Answered within Timescale has shown special cause concern since June 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 resources has again risen in November, reflecting continued work to support system partners with flow.

Use of block purchase bed stock remains high, due to continued work between community hospitals and system partners to enable timely flow; it is now BAU for the service to support the step-down of patients from the community hospitals, so promoting timely flow from the acute (as bed capacity is maximized).

Actions

Our Commissioned service HART's productivity is being regularly scrutinised as it remains below the contracted levels within both the core contract and the additional winter funding. Ongoing discussions are being held as to the future of these contracts which are due to end 31st March 2025. There has been a request from the system to increase spot purchase beds from our current maximum of 12 to 20 over the winter period. This has been costed along with the additional AHP workforce which would be required and submitted to the ICB for consideration.

SPC

Transitional care activity has not varied significantly since May 2024

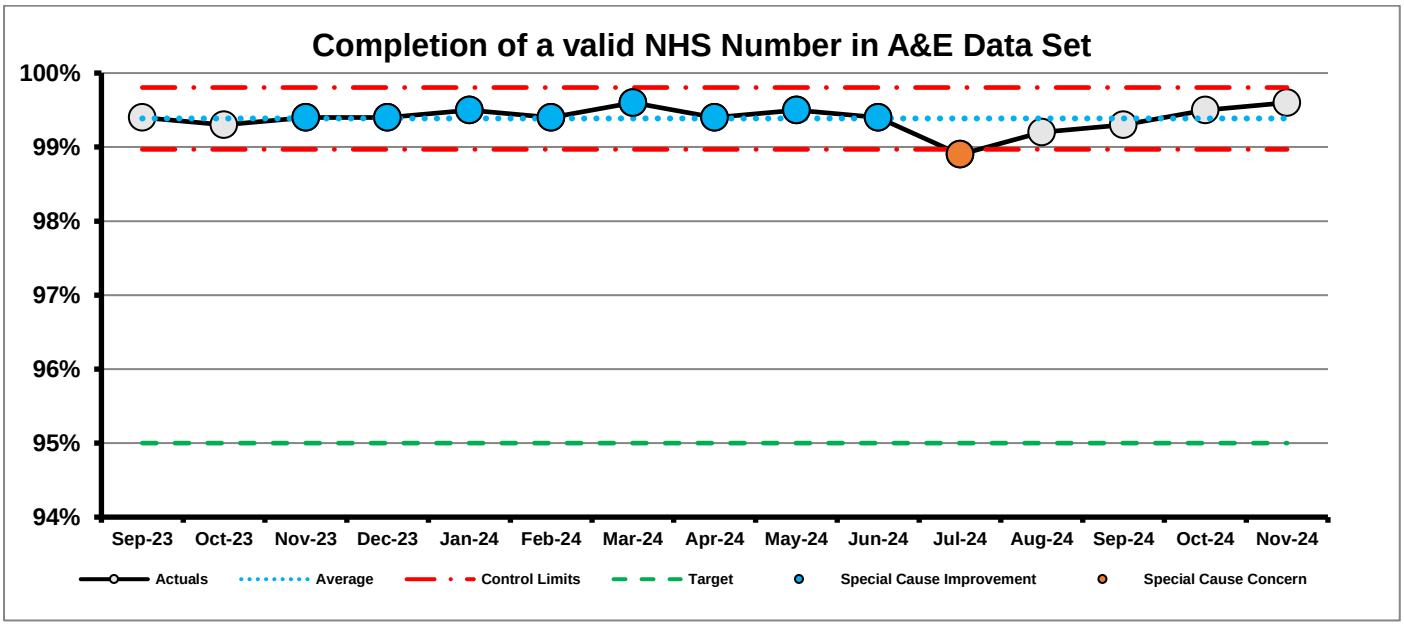
Completion of a Valid NHS Number in A&E Data Set

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

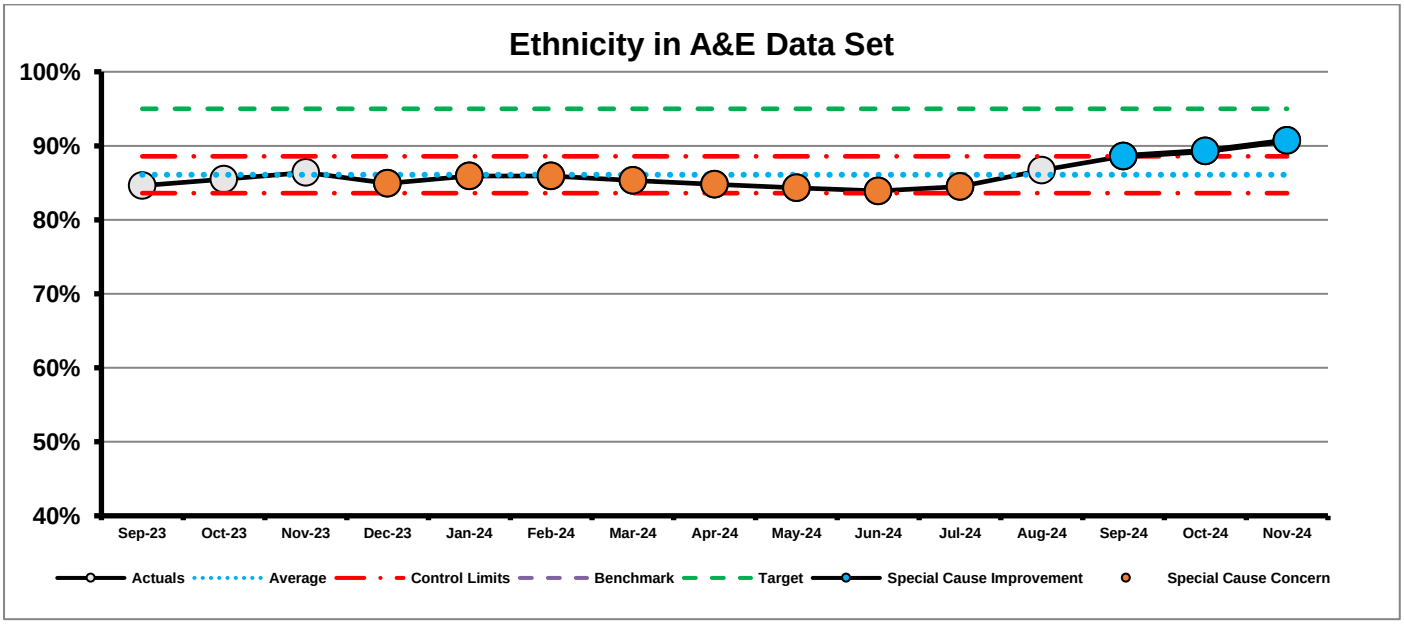
Completion of a valid NHS number for A&E datasets has not varied significantly since June 2024 and is consistently capable of achieving the 95% target.

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

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 87% is through a process developed to download an extra patient dataset from Systm1 which reports on Ethnicity for all patients. Following this validation process, 87% 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.

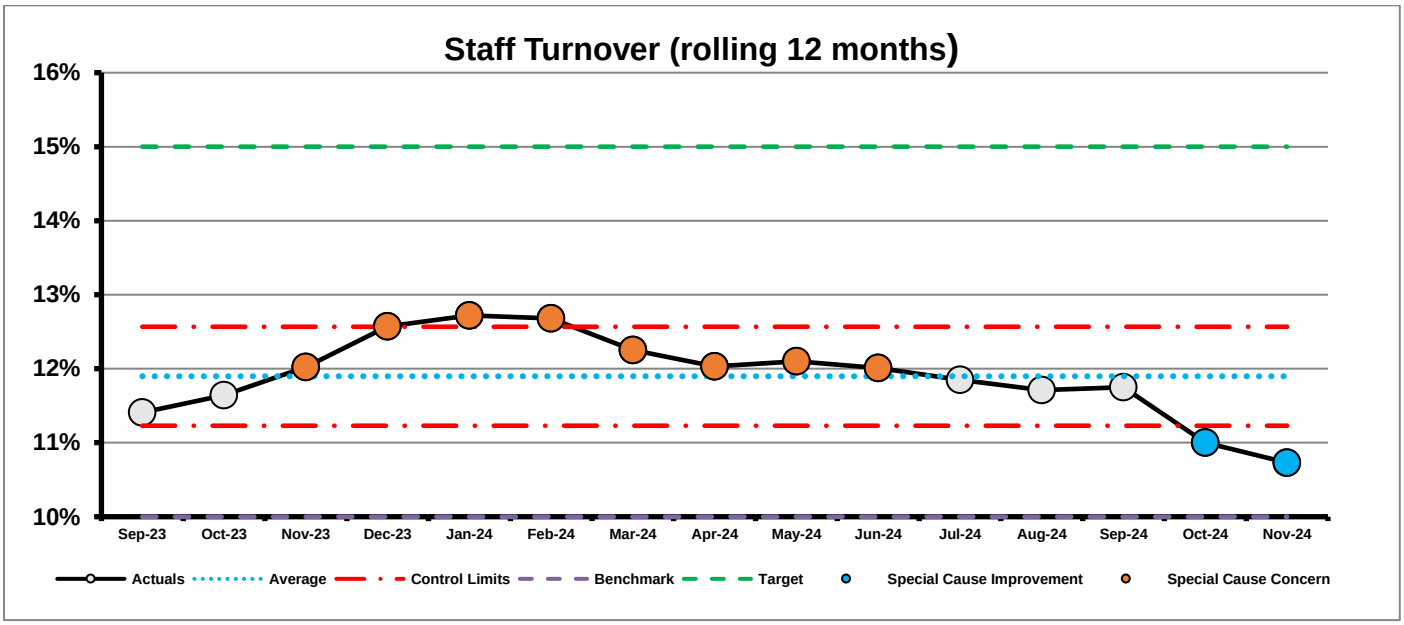
SPC

Ethnicity in A&E dataset has not varied significantly since August 2024. This metric is not capable of achieving the 95% target without further redesign. Use of the new Data Quality system "RINSE" is expected to drive up performance to the 95% target between November 2024 and March 2025.

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 10.73% for the period. The “target” level of 15% represents a ceiling to stay within. A healthy level of staff turnover is positive for refreshing the workforce and securing new or additional talent into the organisation, however rising turnover would be indicative of potential staff dissatisfaction and impacts on service delivery.

Actions

Staff turnover is managed by leaders at local levels with supportive frameworks to enable staff to maintain health and wellbeing, freedom to speak up and engage with changes to their service delivery.

SPC

Staff turnover has shown special cause improvement since September 2024 and is consistently capable of achieving the 15% target.

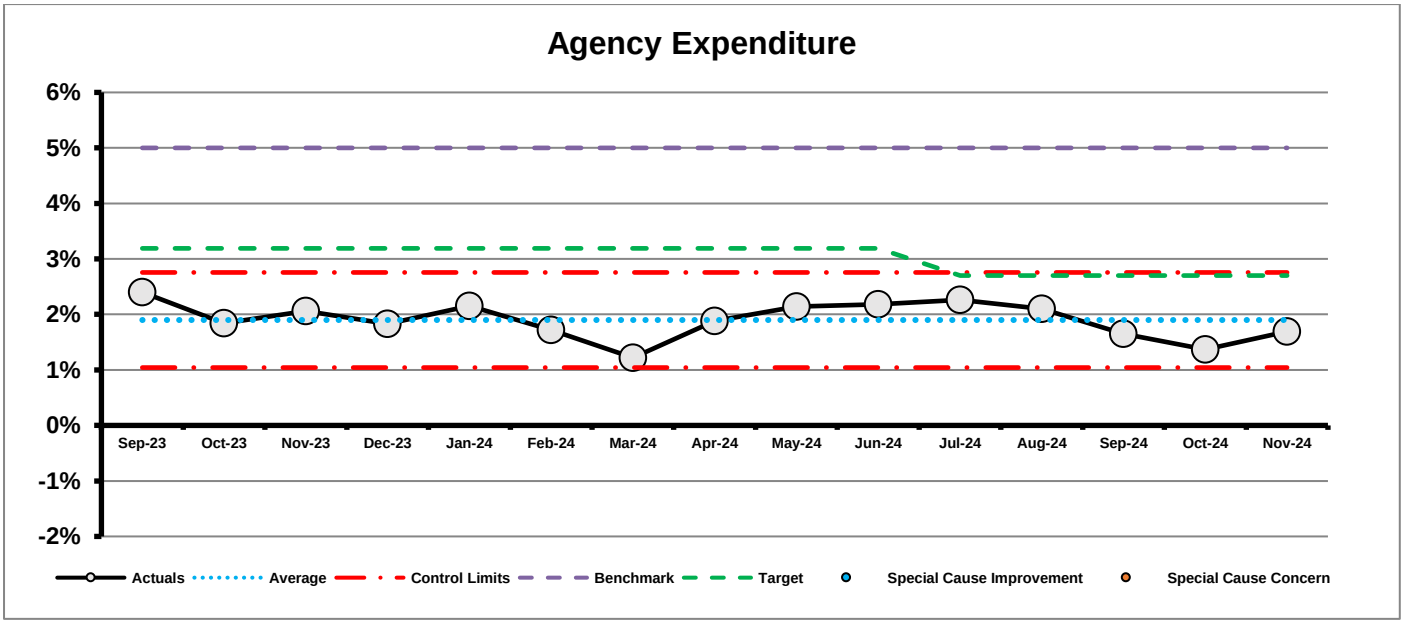
Financial Performance Summary

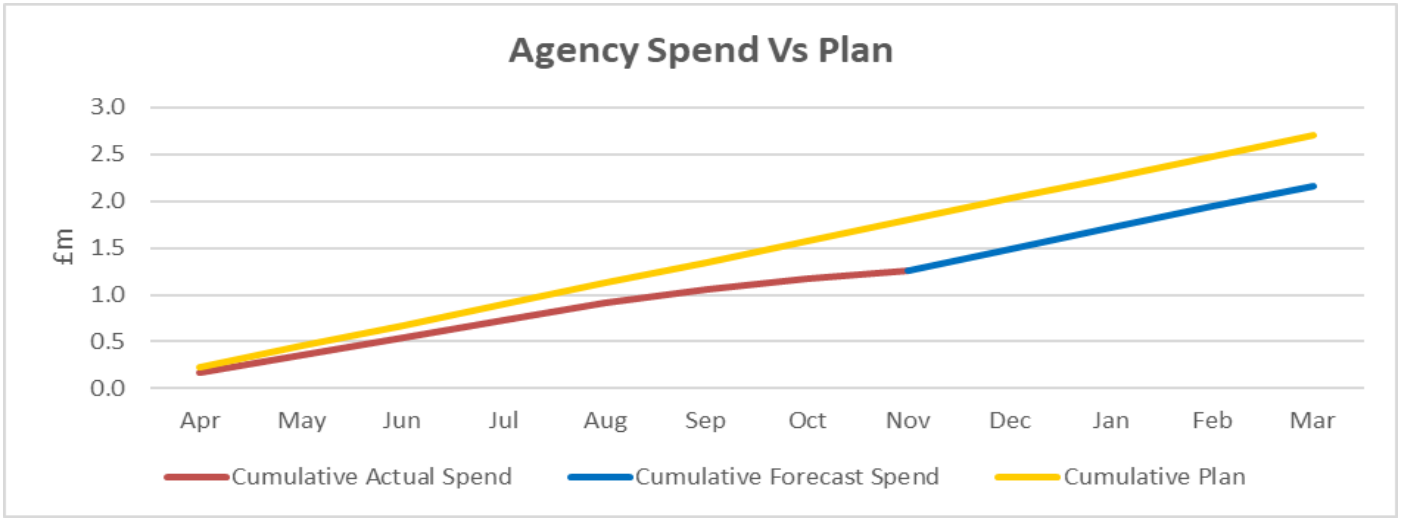
Financial Summary Table (Month 8)	
Description	**Narrative**
Position in November	£134k surplus
Position YTD	£240k surplus
Position FOT	Breakeven
CIP in November	£1.181k against plan of £680k
CIP YTD	£4.477m against plan of £3.960m
CIP FOT	£7.317m against plan of £7m
Agency in November	£89k against plan of £225k
Agency YTD	£1.26m against plan of £1.81m
Agency FOT	£2.3m against plan of £2.7m
Capital in November	£2.44m against plan of £0
Capital YTD	£4.23m against plan of £417k
Capital FOT	£6.346 against plan of £5.386m
Cash	£22m against forecast 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

- M8 agency spend was £89k compared to £225k plan, continuing to trend below the System agency ceiling
- YTD agency spend (at M8) is £1.26m which is £625k lower than plan, noting that this excludes the benefit of £143k accrual release (M3) and £169k accrual release (M8) relating to prior year invoicing to show a true comparison. This is in line with expected CIP savings for agency.
- In respect of the split of Agency spend:
    - Collaborative Community Care - £653kk (68%)
    - UEC Collaborative - £298k (31%)
    - Agency Nursing represented 53% of Agency costs YTD

SPC

Agency expenditure has not varied significantly since June 2024. It is inconsistently capable of achieving the 2.7% target but expected to achieve target more often than not.

Efficiencies Plan (CIP)

Background

This information represents year-to-date delivery against the planned Cost Improvement Plan (CIP).

	Aspyre	Plan Month 8 £000	Actual Month 8 £000	Variance Month 7 £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	£111	£2	£867	£951	£85	£1,300	£1,385	£85	R
LCHS income to cover initiatives without System support		£97	£97	£0	£773	£773	£0	£1,159	£1,159	£0	NR
Procurement		£43	£54	£11	£117	£142	£26	£300	£308	£8	R
Non-Pay Savings		£6	£6	£0	£53	£192	£139	£140	£279	£139	R/NR
Estates Savings		£23	£20	-£3	£60	£47	-£13	£150	£117	-£33	R/NR
Delay to POCT Project		£25	£0	-£25	£25	£125	£100	£125	£125	£0	NR
Continence products		£8	£8	£0	£39	£14	-£25	£70	£62	-£8	R
Service Redesign		£110	£135	£25	£641	£602	-£39	£1,177	£1,177	£0	R
Agency Reduction	✓	£120	£136	£16	£598	£539	-£59	£1,100	£1,044	-£56	R
Use of ULHT GP cover overnight		£11	£12	£1	£45	£93	£49	£127	£139	£12	R
POCT and FBI posts removed		£10	£10	£0	£50	£50	£0	£107	£107	£0	R
Vacancy Savings (additional 1%)		£110	£48	-£62	£551	£353	-£198	£992	£753	-£239	NR
Bank and Overtime Reduction		£9	£9	£0	£47	£60	£13	£105	£126	£21	NR
Unidentified Gap		£0	£0	£0	£96	£0	-£96	£178	£0	-£178	R/NR
Technical CIP		£0	£537	£537	£0	£537	£537	£0	£537	£537	NR
2024-25 CIP Programme		**£680**	**£1,181**	**£501**	**£3,960**	**£4,477**	**£517**	**£7,030**	**£7,317**	**£287**	

Recurrent		£416	£471	£55	£2,384	£2,413	£29	£4,256	£4,287	£31
Non-Recurrent		£264	£710	£446	£1,576	£2,064	£487	£2,774	£3,030	£256
		£680	**£1,181**	**£501**	**£3,960**	**£4,477**	**£517**	**£7,030**	**£7,317**	**£287**

Narrative

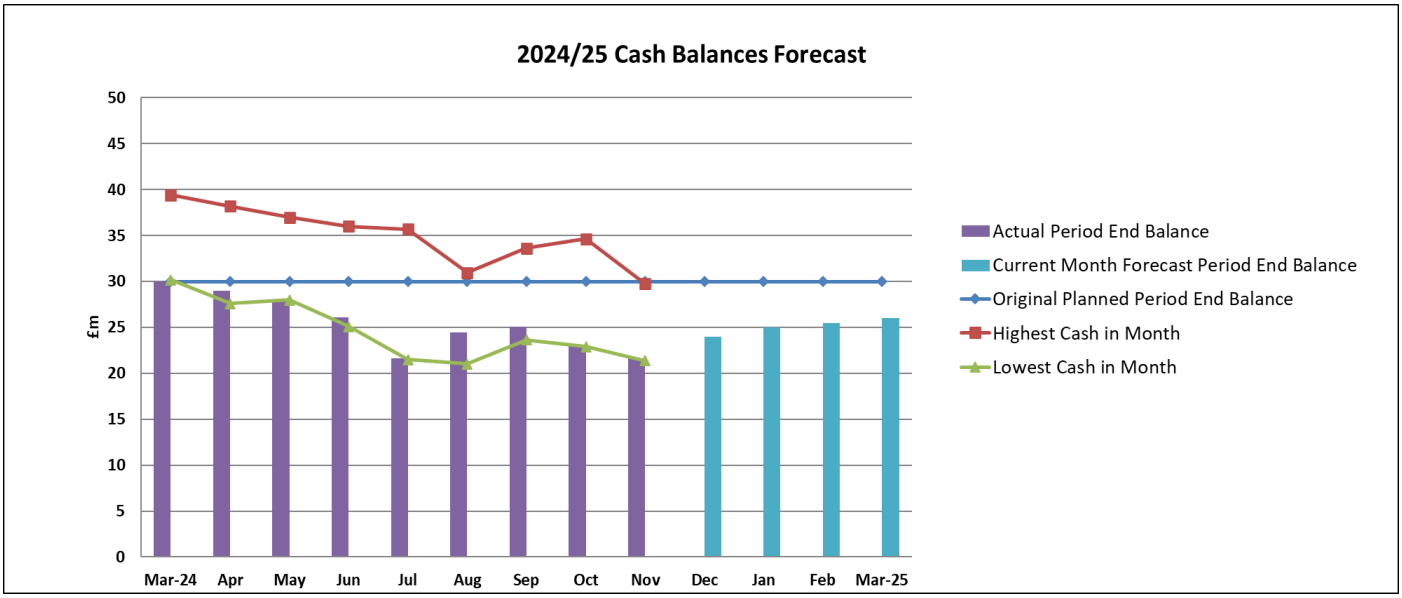
- M8 delivery £501k ahead of plan, due to technical CIP release in month.
- Technical CIP release and forecast, gives £287k surplus forecast for full year.
- Majority of CIP now devolved to budget holders.
- Fortnightly governance reviews now established with Estates and Procurement.
- Ongoing monitoring on status of delivery as H2 CIP increases significantly working with leads.

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:



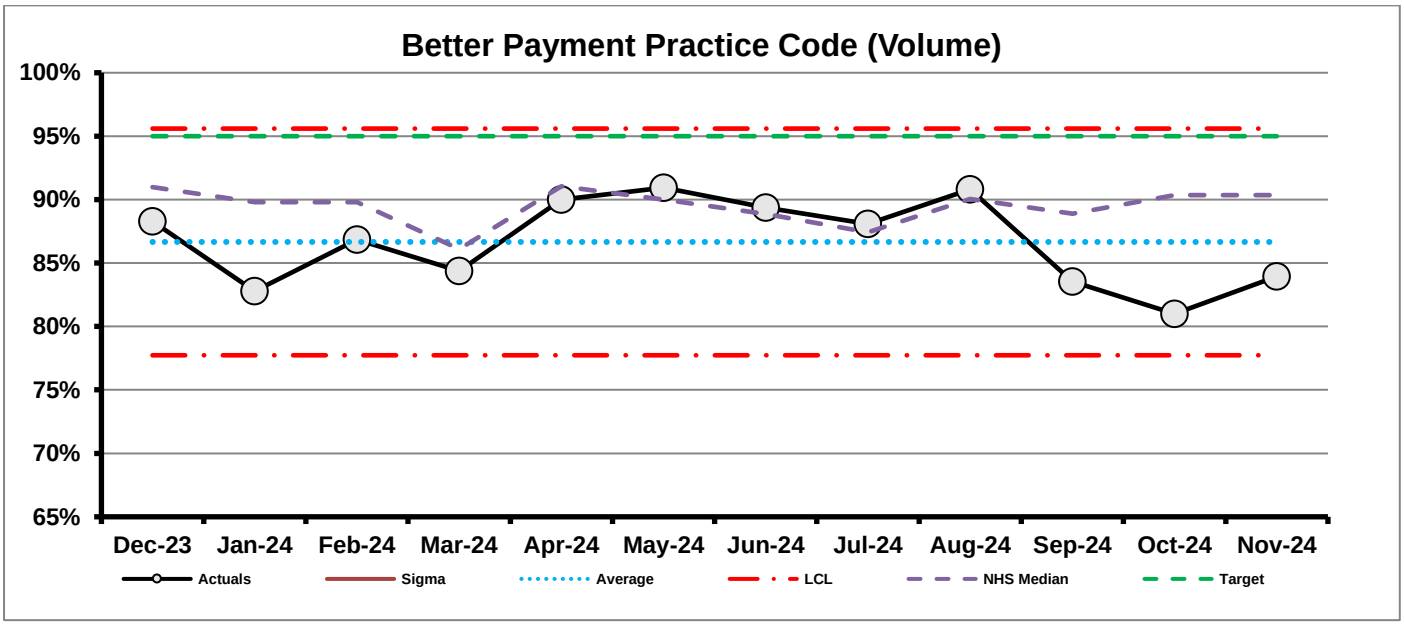
Narrative

- The LCHS cash balance for M8 was £22m, £8m below original planned balance, this is lower than forecast due to the payment of pay award and Band 8a+ increment in M7 and M8, with the ICB income coming in M9 for this. YTD cash impact of approx. £2.3m.
- 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 position expected to partially recover over the year, not to original planned levels due to the impact of PY invoices.

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 number of invoices for November at 84%, up 3% versus prior month and below the target of 95% (noting that BPPC by value of invoices is close to target at 92%).
- The NHSE Median has not yet been released, so estimated at the same as prior month at 90%. There has been an improvement in month, and there remains a focus within the Finance team on improving the turnaround.
- Finance are reviewing ASD access, and training members of staff to pick up the monitoring of BPPC, so that there is a renewed focus on achieving 95% working closely with ULTH accounts payable team to understand areas of concern and agreed actions to address.

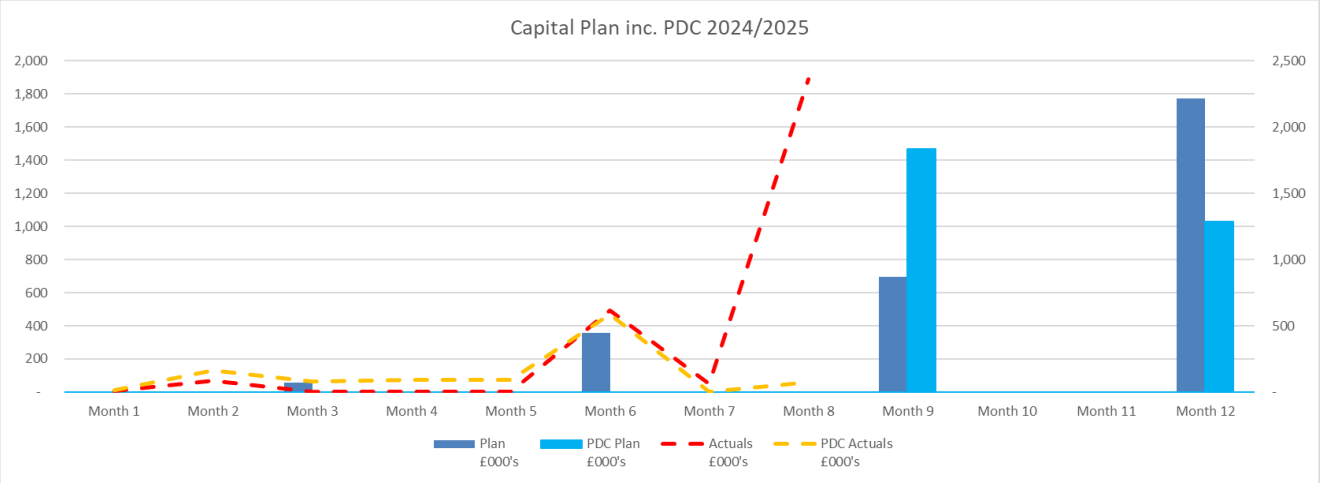
SPC

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.



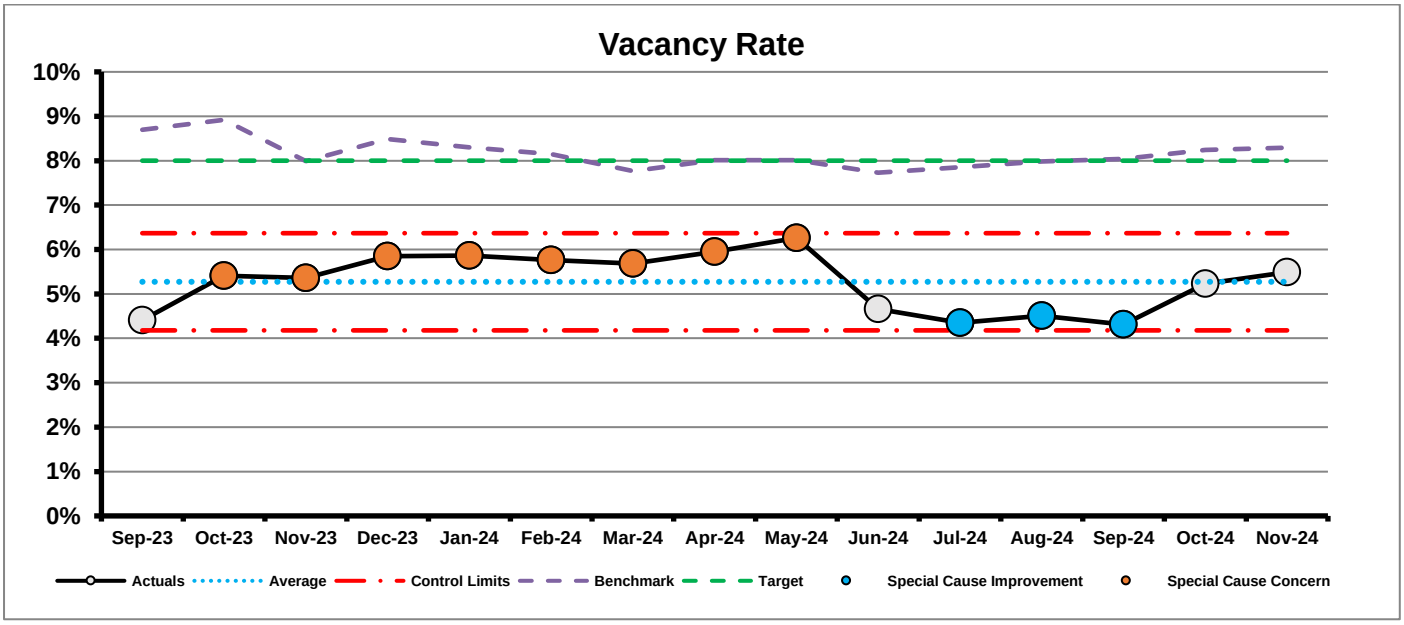
Narrative

- The LCHS capital plan for the financial year totals c£5.386m, £2.086m of capital allocation, £2.5m of PDC and £800k of IFRS16 funding.
- Year-to-date capital spend up to M8 equated to £4.23m. 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.
- There is a YTD overspend, and expected overspend full year (£960k), this relates to increases in leases captured in M8.
- The year to date spend has been incurred in the following areas (bracketed numbers are full year plan)
    - Information Management & Technology - £86k (£650k)
    - Estates investment schemes - £20k (£816k)
    - Clinical Equipment schemes - £306k (£620k)
    - IFRS16 - £2.7m (£800k)
    - PDC – £1.09m (£2.5m)

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.

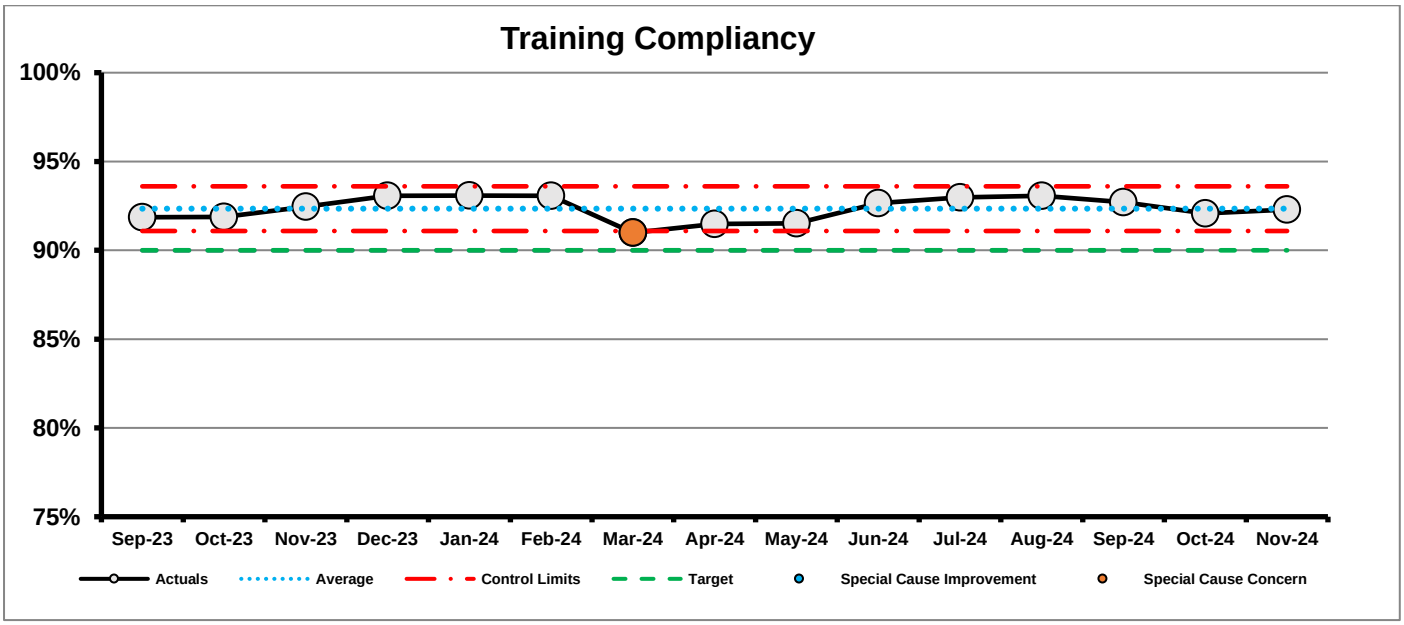
SPC

The vacancy rate has not varied significantly in the period 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 30 November 2024:

The overall mandatory training compliance rate which includes all core and role specific modules has increased slightly to 92.30% 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 slightly to 95.74% 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 support those returning to work from long term absence to update.

Most divisions/directorates have overall compliance remaining above the national/local target of 90% except for IUEC who remain just under and Operational Leadership who have fallen below the 90% target.

Children's, Young People's, and Specialist Services	94.05%	↑
Collaborative Community Care	91.94%	↑
Corporate Services	95.76%	↑
Integrated Urgent and Emergency Care	88.47%	↑
Operational Business Services	96.54%	↓
Operational Leadership	84.04%	↑
System	94.58%	↑

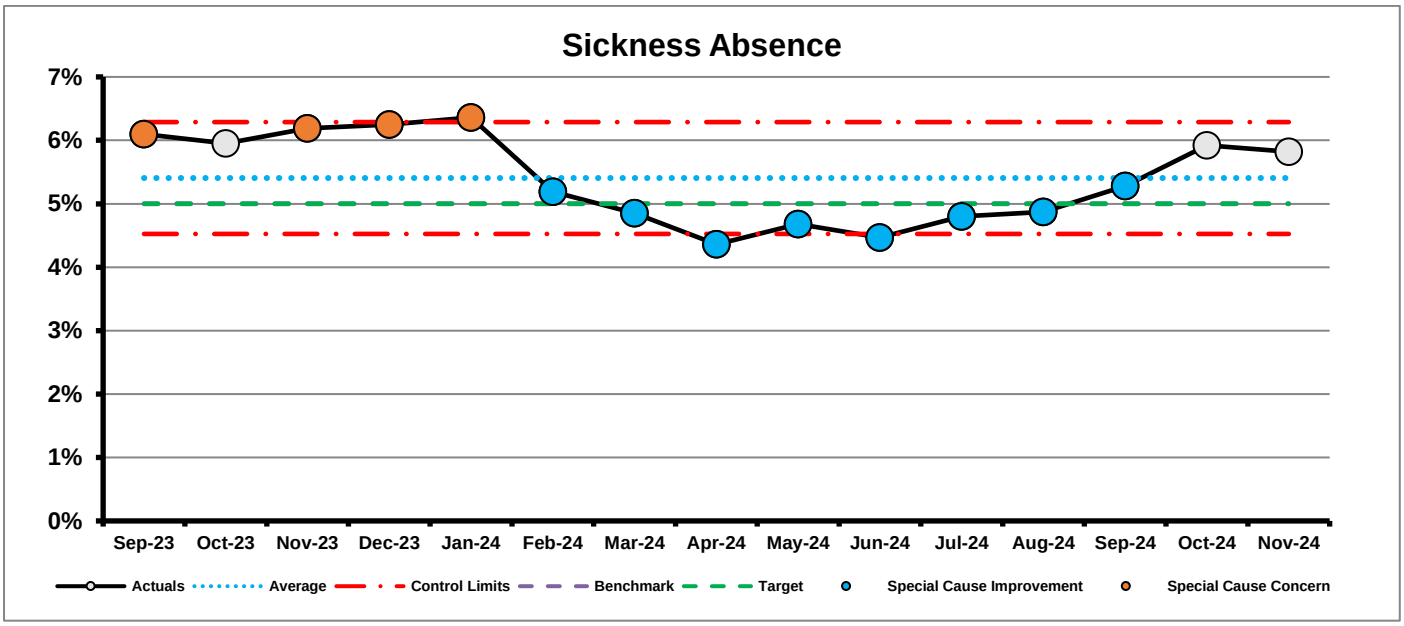
SPC

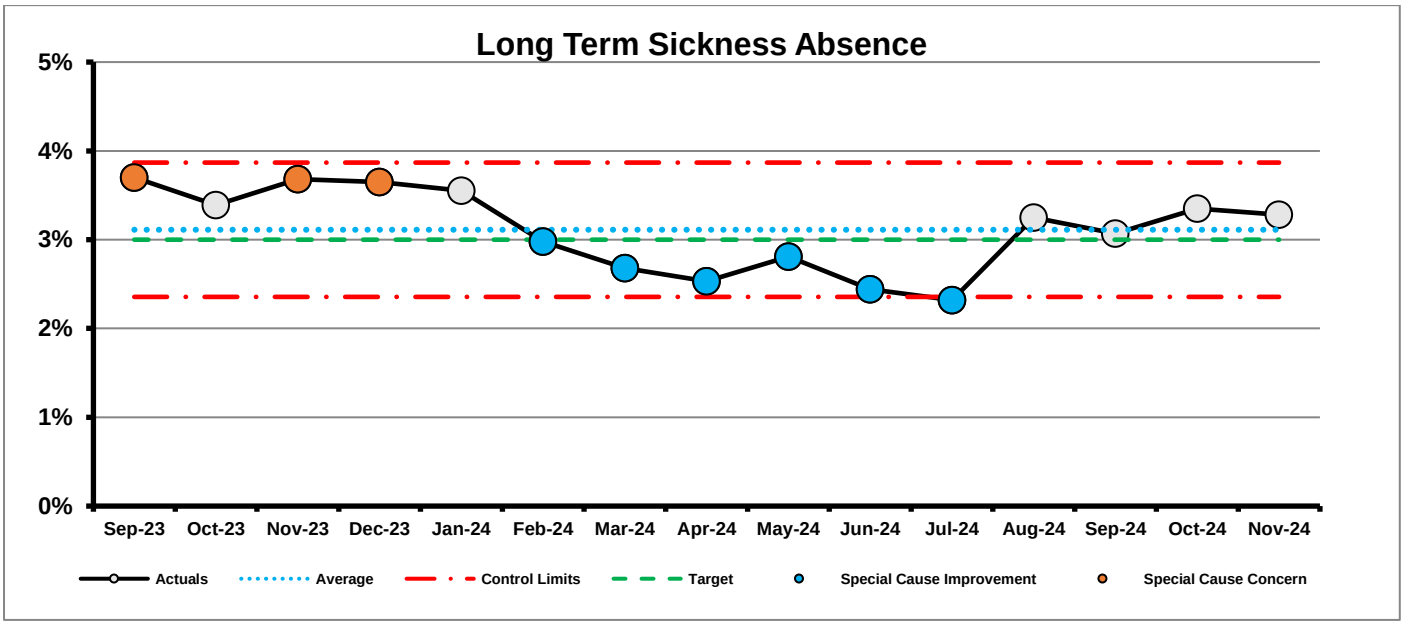
Mandatory Training compliance has not varied significantly since March 2024. The measure is consistently capable of achieving the 90% target.

Sickness Absence

Background

The Trust target for total sickness absence is 5%.





Narrative

The overall sickness levels in November have marginally decreased to 5.82%, compared with 5.92% in October. This still remains above the agreed target of 5%.

For overall sickness absence, there are three areas which are above target as of November: Integrated Urgent and Emergency Care (9.61%), Operational Business Services (7.15%) and Collaborative Community Care (6.11%).

The top three reasons accounting for overall sickness absence in November are anxiety, stress and depression, gastrointestinal problems and cold/cough/flu, which is consistent with previous months – although in a different order.

Long Term

The long-term sickness level in November has seen a slight decrease to 3.28% from 3.35% in October, although this remains above the agreed target of 3%.

In relation to long term absence, there are three areas above target: Integrated Urgent and Emergency Care (5.83%), Operational Business Services (4.12%) and Collaborative Community Care (3.19%).

The top three reasons for long term sickness absence for November were: anxiety, stress and depression, injury/fracture and gastrointestinal problems.

Short Term

The short-term sickness level in November has also marginally decreased to 2.54% from 2.56% in October and remains above the 2% target.

In respect of short-term sickness, there are four areas who remain above target: Integrated Urgent and Emergency Care (3.78%), Operational Business Services (3.03%), Collaborative Community Care (2.92%) and Children's Young People and Specialist Services (2.10%).

The top three reasons for short term sickness absence in November remain the same as the previous month and were: cold/cough/flu, anxiety, stress and depression and gastrointestinal problems.

Actions

- The Workforce Strategy Group is focussing 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 a number of bespoke attendance management workshops have been held with leaders. 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 has not varied significantly in the period and is inconsistently capable of achieving the 5% target. The target is expected to be missed more often than achieved.

Long-Term Sickness Absence has not varied significantly since July 2024 and is inconsistently capable of achieving the 3% target. The target is expected to be missed more often than achieved.

Workforce Dashboard

November 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	549.45	507.01	42.44	7.72%	8.32%	0.62%	4.70%	2.10%	2.60%	94.05%	95.64%	92.83%
Collaborative Community Care	759.11	769.87	-10.76	-1.42%	9.91%	0.31%	6.11%	2.92%	3.19%	91.94%	87.81%	84.16%
Corporate Services	224.33	214.39	9.94	4.43%	20.79%	1.77%	1.52%	0.36%	1.17%	95.76%	97.99%	91.30%
Integrated Urgent & Emergency Care	435.17	356.56	78.61	18.07%	5.90%	0.56%	9.61%	3.78%	5.83%	88.47%	97.04%	94.83%
Operational Business Services	111.44	107.12	4.32	3.88%	13.19%	0.63%	7.15%	3.03%	4.12%	96.54%	96.30%	
Operations	14.90	12.88	2.02	13.56%	35.71%					84.04%	100.00%	77.78%
System	19.00	29.57	-10.57	-55.65%	38.55%		0.68%	0.68%		94.58%	84.00%	93.75%
Total	**2,113.40**	**1,997.40**	**116.00**	**5.49%**	**10.73%**	**0.60%**	**5.82%**	**2.54%**	**3.28%**	**92.30%**	**93.09%**	**89.10%**

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	224.33	214.39	9.94	4.43%	20.79%	1.77%	1.52%	0.36%	1.17%	95.76%	97.99%	91.30%
Chief Exec	20.95	11.45	9.50	45.33%	38.42%	17.46%	8.63%	0.54%	8.09%	96.25%	100.00%	
Finance & Business Intelligence	54.40	49.53	4.87	8.95%	28.45%		0.31%	0.31%		97.17%	100.00%	
Medical Directorate	21.25	26.64	-5.39	-25.36%	13.81%		2.38%	0.50%	1.88%	91.17%	95.65%	80.00%
People & Innovation	84.77	90.53	-5.76	-6.80%	14.80%	1.99%	0.42%	0.42%		95.85%	97.70%	100.00%
Quality	42.96	36.23	6.73	15.67%	24.84%		2.93%	0.09%	2.84%	97.56%	97.14%	100.00%
Total	**224.33**	**214.39**	**9.94**	**4.43%**	**20.79%**	**1.77%**	**1.52%**	**0.36%**	**1.17%**	**95.76%**	**97.99%**	**91.30%**

NHS
Lincolnshire Community and Hospitals NHS Group

Group Board Risk Report

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Teaching Hospitals NHS Trust

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*7th January 2025*
Item Number	*14.1*

Risk Report

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* *Lorna Adlington, Head of Patient safety and Quality Governance, LCHS* *Sarah Davy, Risk and Datix Manager, ULTH* *Rachael Turner, Risk & Datix Facilitator*
Recommendations/ Decision Required	*The Group Board are invited to review the content of the report, no further escalations at this time.*

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	*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 (ULTH)	*X*
3f Reducing unwarranted variation in planned service delivery and ensure we meet all constitutional standards (ULTH)	*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	*X*
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*

Executive Summary

From the 1st December 2024, the Group Risk Policy was launched which sees full alignment across both organisations of the risk profiles against each of the strategic objectives. The following report includes information pertaining to risks scoring 15 – 25 which are in relation to the highest risks across the Group.

As of 10 December 2024, there are 713 (ULTH 594 and LCHS 119) risks recorded on the Group risk registers.

LCHS

The are 2 Very High risks (20 - 25) reported to the Quality Committee, this remains static from the previous reporting period. These relate to:

- 403 - Children SLT Therapy Treatment Delays – **Risk presented at November RRC&C meeting and validated for increase in score to 5 x 4 = 20 (Very High)** previously 4 x 4 = 16.
- 395 - TB Demand and Capacity

The following risks have been updated since the last report:

- 495 – Treatment Room Capacity – **Risk presented at November RRC&C meeting and validated for decrease in score to 4 x 4 = 16 (High Risk)** (previously 5 x 4 =20).

There are no Very High risks (20-25) reported to the Finance, People and Integration Committees this month.

ULTH

The are 9 Very High risks (20-25) reported to the Quality Committee this month, remaining stable from last month's reporting period, these relate to:

- 5016 - Patient flow through Emergency Departments
- 4879 - Recovery of planned care cancer pathways
- 4731 - Reliance on paper medical records
- 4828 - Reliance on manual prescribing processes
- 5101 - Delivery of paediatric epilepsy pathways-community
- 5100 - Quality and safety risk from inability to deliver epilepsy pathways within Acute Paediatrics that meet National standards
- 4947 – NICE Medicines reconciliation compliance
- 5143 - Removal of lift in H Block PHB affecting service delivery to patient records
- 5450 - Risk of Gastro service not being viable due to current fragility of consultant workforce

There are 5 Very High risks (20-25) reported to the People Committee this month, remaining stable from the previous reporting period:

- 4844 - Staffing levels requiring an increase in Pharmacy to be able to provide a seven-day service.
- 4948 - Pharmacy workload demands

- 4997 - Service configuration (Haematology)
- 4996 - Consultant workforce capacity (Haematology)
- 5447 - Cancellation of elective lists due to lack of theatre staff

There are 7 Very High risks (20-25) reported to the Finance Committee this month, remaining stable from the last reporting period, these relate to:

- 4648 - Potential for a major fire
- 4647 - Compliance with fire safety standards, assessed by Lincolnshire Fire and Rescue Service
- 4664 - Exceeding the agency cap due to the cost of reliance upon temporary clinical staff
- 5020 - Reliance on agency / locum medical staff in Urgent & Emergency Care
- 4657 - SARs Compliance and access to Health records in accordance with statuary requirements
- 4665 - Failure to meet 24/25 CIP
- 5277 - Risk of additional financial pressures from possible application of national profiles to existing Job Descriptions. **Risk presented at November RRC&C meeting and validated for an increase in score from 3x4:12 Moderate Risk to 5x4:20 (Very High Risk).**

The following risk was presented at Risk Confirm and Challenge in November and validated to be closed:

- 5415-Grantham Medical Air Plant-all work on Grantham Medical Air Plant has now been completed.

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 Group at this time.

1. Introduction

1.1 The Group's risk registers are recorded on Datix. 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 (LCHS) and Appendix B (ULTH)**, 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. Group Risk Profile

2.1 There are 713 (ULTH 594 and LCHS 119) active and approved risks reported to lead committees in December.

2.2 LCHS

There are 2 risks with a current rating of Very High risk (20-25) and 13 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)
4 (3%)	**29** (24%)	**71** (60%)	**13** (11%)	**2** (2%)

2.3 ULTH

There are 21 risks with a current rating of Very High risk (20-25) and 61 rated High risk (15-16) reported to lead committees this month. **Table 1** below shows the number of active risks by current risk rating and proportion of the overall Trust risk profile:

Very low (1-3)	**Low** (4-6)	**Moderate** (8-12)	**High** (15-16)	**Very high** (20-25)
53 (+2) (9%)	**141 (+2)** (24%)	**318 (+5)** (54%)	**61 (+7)** (10%)	**21 (-)** (3%)

Strategic objective 1a: Deliver high quality care which is safe, responsive and able to meet the needs of the population

2.4 **LCHS**

There are 2 Very High risks, remaining stable from the previous reporting period and 5 High risks recorded in relation to this objective. A summary of the Very High risks is provided below:

Risk ID	Title	Risk score	Division	Progress Update	Date of latest review
403	Children SLT Therapy Treatment Delays	20	Children, Young People, and Specialist Services	Reviewed at Risk Register Confirm and Challenge in November. Referrals are 188% higher in 2023/24 than in 2019 Waiting times are breaching the 18 week wait requirement with follow up and therapy waits over a year. There is a decrease of staff morale & staff retention – from fully staffed at the end of 2023 to 4.3 WTE vacancies, staff citing service challenges as reason for exit. Service working in OPEL 4 since Sep'23 and activating BCP, with no plans to reinstate lower level referrals	29/11/2024
395	TB demand and capacity	20	Community Partnerships	Demand is exceeding capacity within the TB service in particular managing the LTBI referrals which have increased significantly. People with LTBI are not being case managed in line with NICE guidance, this includes HSCW working within the system who are known to have latent TB and may become ill or pose a risk to patients, other staff and the wider public.	13/11/2024

Updates since the last report

Following the previous report the following changes were agreed and validated at the Risk Register Confirm or Challenge meetings:

Risk ID	Title	Change in score	Reason for change
495	Treatment room clinics do not have capacity to meet demand	**Decreased to 4 x 4 = 16** (previously 5 x 4 = 20)	There is a plan in place for stabilising Treatment Rooms and staffing across the county. This plan is already demonstrating an early impact.
403	Children SLT Therapy Treatment Delays	**increased to 5 x 4 = 20** previously 4 x 4 = 16	Referrals 188% higher in 2023/24 than in 2019 with an average of 354 referrals / month 12/23-04/24.
719	DHU contract changes resulting in external validation of Lincolnshire Patients	**Increased to 3 x 5 = 15** (previously 3 x 3 = 9).	Triangulation of patient safety incident data highlighted an increased likelihood of a significant patient safety incident occurring.

2.5 **ULTH**

There are 7 Very High risks, remaining stable and 19 High risks recorded in relation to this objective. A summary of the Very High risks is provided below:

ID	Title	Risk level (current)	Division	Progress update	Date of latest risk review
5101	Delivery of paediatric epilepsy pathways-community	Very high risk (20-25)	Family Health	Outlier notice received; action plan developed for delivering improvements - seeking approval from ICB for funding for a Band 6 epilepsy specialist nurse post. Business case completed and service has been added to the investment tracker for 2025/26.	09/12/2024
4947	NICE medicines reconciliation targets	Very high risk (20-25)	Clinical Support Services	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). RCEM/ED pharmacy case developed and submitted for winter pressures funding – unsuccessful. Case to be resubmitted for next financial year 2025/26.	16/12/2024
5016	Patient Flow Through Emergency Departments	Very high risk (20-25)	Medicine	There is a new COO lead project in place around patient flow this looks not only at ED but also Ops for Wards and Discharge planning. Ongoing work in place for long lengths in stay. Agreed at RRC&C joint risk between UEC and Ops. From Emergency Care perspective - UEC refresh project being undertaken. Performance is currently between 70-76%.	03/12/2024
5100	Quality and safety risk from inability to deliver epilepsy pathways within Acute Paediatrics that meet National standards	Very high risk (20-25)	Family Health	Outlier notice received; action plan developed for delivering improvements - seeking approval from ICB for funding for a Band 6 epilepsy specialist nurse post. Business case completed and service has been added to the investment tracker for 2025/26.	09/12/2024
4879	Recovery of planned care cancer pathways	Very high risk (20-25)	Clinical Support Services	Following ELT meeting case of need to be written for presentation at CRIG and ICB investment panel to include Oncology and Haematology workforce. The DOF requested this case to be managed via the 25/26 planning cycle. DL and Cancer leadership team presented impact assessment to ELT 27/08/2024. More work for the division to do to secure substantive funding for 25/26. Approval given to retain 20 posts across Haem/Onc that have been recruited 'at risk' and above establishment with prior approval in 2023 from CEO and COO.	11/12/2024
5143	Removal of lift in H Block PHB affecting service delivery to patient records	Very high risk (20-25)	Clinical Support Services	Dumb waiter upgrade completed and working with some minor changes in process needed to maximise use. Schedule of works received showing completion by 31 March 2025, initial work started, staff have been relocated to accommodate works.	20/12/2024
5450	Risk of Gastro service not being viable due to current fragility of Consultant workforce	Very high risk (20-25)	Medicine	Gastroenterology : Service Sustainability Impact Assessment document which demonstrates the current position of this risk has been added as evidence of Very High Risk Score in supporting documents. Due to fragile service with 17 whole time equivalent workforce (15 on which are in post), however 5 of these have retired and returned on outpatient only. Service sustainability paper drafted for ELT. Awaiting formal outcome, further deterioration has led to further options appraisal going forward. Large workforce CoN supported at initial 2025/26 investment priorities process. Guidelines on Management of Upper Gastro-Intestinal Bleeding currently under review.	10/12/2024

Strategic objective 1b: Improve patient experience

2.6 **LCHS**
There are no Very High risks and no High risks recorded in relation to this objective.

2.7 **ULTH**
There are no Very High risks, remaining stable and 4 High risks, remaining stable since the last reporting period.

Strategic objective 1c: Improve clinical outcomes

2.8 **LCHS**
There are no Very High risks and no High risks recorded in relation to this objective.

2.9 **ULTH**
There are 2 Very High risks, remaining stable and 5 High risks, a reduction of 1, 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	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	Very high risk (20)	Risk currently under review for possible closure following the roll out across the Trust. However work underway to review the risk in Maternity, Paediatrics, Intensive Care and Outpatients as manual prescribing remains in place.	24/12/2024
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.	28/10/2024

Updates since the last report:

- Risk 5423 – Ophthalmology injection appointment availability - closed risk confirmed in November RRC&C all mitigating actions complete.

Strategic objective 1d: Deliver clinically led integrated services

2.10 **LCHS**
There are no Very High risks and no High risks recorded in relation to this objective.

2.11 **ULTH**
There are no Very High risks and no High risks recorded in relation to this objective.

Strategic objective 2a. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise

2.12 **LCHS**
There are no Very High risks and no High risks recorded in relation to this objective.

2.13 **ULTH**

There are 5 Very High risks, an increase of 1, and 16 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
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.	20/12/2024
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 - completed * Refresher of Fragile Services Paper - NB there is a National shortage of Haematology consultants - completed * Recruitment of further substantive consultants – December 2024 * Additional unfunded ST3+ for Haematology starts in August 2022 - completed	19/12/2024
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 - Completed *Refresher of Fragile Services Paper - NB there is a National shortage of Haematology consultants - completed *Recruitment of further substantive consultants - December 2024 *Additional unfunded ST3+ for Haematologist starts in August 2022 - completed	19/12/2024
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.	28/11/2024
4948	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	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. Wellbeing team supporting staff - regular visits organised	30/12/2024

Strategic objective 2b. To be the employer of choice

2.14 **LCHS**

There are no Very High risks and no High risks recorded in relation to this objective.

2.15 **ULTH**

There are no Very High risks and no High risks recorded in relation to this objective.

Strategic objective 3a: Deliver financially sustainable healthcare, making the best use of resources

2.16 **LCHS**

There is no Very High risk and 3 High risks recorded in relation to this objective.

2.17 **ULTH**

There are 4 Very High risks (20-25), an increase of 1, and 1 High risk (15-16), remaining stable, recorded in relation to this objective. A summary of the Very High risks is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
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	03/12/2024
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	19/12/2024

4665	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.	Very high risk (20)	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.	20/12/2024
5277	Risk of additional financial pressure to the Trust from the possible application of national profiles to existing job descriptions for a number of Band 2 and Band 3 roles and the potential wider impact of any decision.	Very high risk (20)	Following proposals being reviewed and challenged, discussions will take place with HR regarding the change process and following this the true cost impact will be calculated. Confirmed high level costing if backdated to August 2021 is £692,517, a significant reduction to the previous anticipated £3.2m financial impact. Possible application and impact of the national profiles for Band 2 and Band 3 roles are currently being consulted through staff side.	19/12/2024

Updates since the last report

Following the last report the following changes were agreed and validated:

- Risk 5277 – **Risk of additional financial pressures from possible application of national profiles to existing Job Descriptions**. This risk was presented in November and validated for increase in score from 3x4:12 Moderate Risk to 5x4:20 Very High Risk. This is due to the movement of all band 2's to band 3 apart from staff members who may rejected it. This has now been recalculated to include all approximately 1,000 people.

Strategic objective 3b: Drive better decision and impactful action through insight

2.18 **LCHS**

There are no Very High risks and no High risks recorded in relation to this objective.

2.19 **ULTH**

There are no Very High risks and no High risks recorded in relation to this objective.

Strategic objective 3c: A modern, clean and fit for purpose environment across the Group

2.20 **LCHS**

There are no Very High risks and 4 High risks recorded in relation to this objective.

2.21 **ULTH**

There are 2 approved Very High risks (20-25), a reduction of 1, and 8 High risks (15-16), 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
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)	- 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	05/12/2024
4647	If Lincolnshire Fire & Rescue Service (LFRS) carries out an inspection and finds the Trust to be systemically non-compliant with fire safety regulations and standards it could result in regulatory action and sanctions, with the potential for financial penalties and disruption to services if sites are required to close.	Very high risk (20)	- Statutory Fire Safety Improvement Programme based upon risk - Policy and protocols framework and improvement plan reported into weekly Estates teams meeting - Progress reviewed by FEG and FSG monthly, to mitigate against the risk of sanctions - LFR involvement and oversight through the FSG - Regular updates with LFR provided indicating challenges during winter pressure and Covid - Fire safety audits being conducted by Fire Safety team - Fire wardens in place to monitor local arrangements with Fire Safety - Weekly Fire Safety Checks being undertaken - Improve PPM reporting for FEG and FSG By Estates Teams - Fire safety team weekly Risk assessment confirm and challenge reviews by Fire safety team - All areas of Trust allocated RAG rating for fire using using occupancy profile, escape provision, height above ground and sleeping risk - Higher rated residual risks from risk assessments being incorporated into risk register	05/12/2024

Updates since the last report

Following the last report the following changes were agreed and validated:

- Risk 5189 **- Med Air Plant LCH (Medical Gas) –** this risk was presented in November and closed as all work has been completed.
- Risk 5272 - **Lincoln cardiac catheter lab is not connected to the emergency power supply at Lincoln County Hospital -** This risk was presented in November and validated for increase in score from 3x4:12 Moderate Risk to 4x4:16 High Risk.

Strategic objective 3d: Reduce waits for patients who require urgent and emergency care and diagnostics and ensure we meet all constitutional standards

2.22 **LCHS**
There are no Very High risks and no High risks recorded in relation to this objective.

2.23 **ULTH**
There are no Very High risks and no High risks recorded in relation to this objective.

Strategic objective 3e: Reducing unwarranted variation in cancer service delivery and ensure we meet all constitutional standards (ULTH)

2.24 There are no Very High risks and no High risks recorded in relation to this objective.

Strategic objective 3f - Reducing unwarranted variation in planned service delivery and ensure we meet all constitutional standards (ULTH)

2.25 There are no Very High risks and no High risks recorded in relation to this objective.

Strategic objective 3g – Reducing unwarranted variation in community service delivery and ensure we meet all constitutional standards (LCHS)

2.26 There are no Very High risks and no High risks 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

2.27 **LCHS**
There are no Very High risks and no High risks recorded in relation to this objective.

2.28 **ULTH**
There are no Very High risks and no High risks recorded in relation to this objective.

Strategic objective 4b: Successful delivery of the Acute Services Review

2.29 **LCHS**
There are no Very High risks and no High risks recorded in relation to this objective.

2.30 **ULTH**

There are no Very High risks and no High risks recorded in relation to this objective.

Strategic objective 4c. Grow our research and innovation through education, learning and training

2.31 **LCHS**

There are no Very High risks and no High risks recorded in relation to this objective.

2.32 **ULTH**

There are no Very High risks and no High risks recorded in relation to this objective.

Strategic objective 4d: Enhanced data and digital capability

2.33 **LCHS**

There are no Very High risks and no High risks recorded in relation to this objective.

2.34 **ULTH**

There is 1 approved Very High risk (20-25), remaining stable, and 5 High risks (15-16), an increase of 2, 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. Lack of technical tools to carry out a search of emails / systems to identify personal information held. Potential financial implications."	Very high risk (20)	Current active communications with ICO-regulator. Changes to processes are being constantly discussed and implemented. Resource needs being discussed and temporarily increased to support. Monitored through the IGG in DP KPI report. Head of IG leading on work to review and improve. Working in a more digital way where feasible. Workforce change is required which will be a much longer process. Early identifications of chasers and urgent requests to reduce the likelihood of complaints.	18/11/2024

Updates since the last report

Following the last report the following changes were agreed and validated:

- Risk 5519 - Risk of the unsafe deployment of Health IT Systems at ULHT - **this new risk was presented in October and validated score of 4x4:16 High Risk**

Strategic objective 5a - Develop a Population Health Management (PHM) and Health Inequalities (HI) approach for our Core20PLUS5 with our ICS

2.35 **LCHS**

There are no Very High risks and no High risks recorded in relation to this objective.

2.36 **ULTH**

There are no Very High risks and no High risks recorded in relation to this objective.

Strategic objective 5b: Co-create a personalised care approach to integrate services for our population that are accessible and responsive

2.37 **LCHG**

There are no Very High risks and no High risks recorded in relation to this objective.

Strategic objective 5c: Tackle system priorities and service transformation in partnership with our population and communities.

2.38 **LCHG**

There are no Very High risks and no High risks recorded in relation to this objective.

Strategic objective 5d: Transform key clinical pathways across the group resulting in improved clinical outcomes.

2.39 **LCHG**

There are no Very High risks and no High risks recorded in relation to this objective.

3.0 Conclusions

3.1 As of 10 December 2024, there are 713 (ULTH 594 and LCHS 119) risks recorded on the Group risk registers.

3.2 **LCHS**

The are 2 Very High risks (20 - 25) reported to the Quality Committee this reporting period:

403 - Children SLT Therapy Treatment
395 - TB Demand and Capacity

There are no Very High risks (20-25) reported to the Finance, People and Integration Committees this reporting period.

3.3 **ULTH**

There are 9 Very High risks (20-25) reported to the Quality Committee this reporting period:

- 5016 - Patient flow through Emergency Departments
- 4879 - Recovery of planned care cancer pathways
- 4731 - Reliance on paper medical records
- 4828 - Reliance on manual prescribing processes
- 5101 - Delivery of paediatric epilepsy pathways-community

- 5100 - Quality and safety risk from inability to deliver epilepsy pathways within Acute Paediatrics that meet National standards
- 4947 – NICE Medicines reconciliation compliance
- 5143 - Removal of lift in H Block PHB affecting service delivery to patient records
- 5450 - Risk of Gastro service not being viable due to current fragility of consultant workforce

There are 5 Very High risks (20-25) reported to the People Committee this reporting period:

4844 - Staffing levels requiring an increase in Pharmacy to be able to provide a seven-day service.
4948 - Pharmacy workload demands
4997 - Service configuration (Haematology)
4996 - Consultant workforce capacity (Haematology)
5447 - Cancellation of elective lists due to lack of theatre staff

There are 7 Very High risks (20-25) reported to the Finance Committee this reporting period:

- 4648 - Potential for a major fire
- 4647 - Compliance with fire safety standards, assessed by Lincolnshire Fire and Rescue Service
- 4664 - Exceeding the agency cap due to the cost of reliance upon temporary clinical staff
- 5020 - Reliance on agency / locum medical staff in Urgent & Emergency Care
- 4657 - SARs Compliance and access to Health records in accordance with statuary requirements
- 4665 - Failure to meet 24/25 CIP
- 5277 - Risk of additional financial pressures from possible application of national profiles to existing JDs

3.4 The Group Board is invited to review the content of the report, no further escalations at this time.

APPENDIX A - LCHS Very High and High Risks - December 2024

ID	Group Risk Type	Risk Lead	Opened	Division	Service	Title	There is a risk that:	Caused by:	Resulting in	Controls in place	Date of last review	Likelihood (current)	Consequence (current)	Risk level (current)	Rating (current)	Updates by reviewers	Risk level (Target)	Next review date
403	Physical or Psychological Harm	Griffiths, Claire	13/09/2022	Children, Young People, and Specialist Services	Children's Therapy	Children SLT Therapy Treatment Delays	Children & young people will not receive the speech and language support they require to meet their social, emotional, educational, and health needs in a timeframe appropriate for their development.	Demand has increased nationally & regionally for SLT support overwhelming commissioned capacity. Referrals 188% higher in 2023/24 than in 2019.	Untreated speech, language, and communication needs (SLCN), which leads to: Children 6-11 times more likely to be behind educationally & more likely to be excluded from schools; 60-70% of young offenders reported to have poor language skills; 81% children with emotional behaviours problems have SLCN; SLCN children are twice as likely to be unemployed as an adult due to poor cognitive & social outcomes increasing lifelong health inequalities. Reputational damage from increased complaints & appeals to MPs & press	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. Increased the referral acceptance criteria: focused on highly complex patients only	27/11/2024	Extremely likely (5) >90% chance	Severe (4)	Very High Risk (20-25)	20	29/11/2024 Discussed at RRCC 27/11/24: agreed to increase the score from L4 x C4 = 16 score to L5 x C4 = 20. 14/11/2024 Discussed with DDL KJK 14/11/24: Propose to increase the score from L4 x C4 = 16 score to L5 x C4 = 20, based on the below narrative: • Referrals 188% higher in 2023/24 than in 2019 (average 354 / month 12/23-04/24) • Waiting times breaching the 18 week wait requirement – follow up and therapy waits over a year. • Decrease of staff morale & staff retention – from fully staffed at the end of 2023 to 4.3 WTE vacancies, staff citing service challenges as reason • Service working in OPEL 4 since Sep'23 and activating BCP, with no plans to reinstate lower level referrals • Oct'23 50+% lower-level needs CYP on the caseload not eligible for a service under the OPEL 4 threshold • Increase in concerns and complaints (from 2.1 monthly to 11.5 monthly, increase of 360% post OPEL 4 implementation) • 67% surveyed stakeholders feeling that the decision to cease early intervention services will impact them negatively • Vacancies at 4.3 WTE • Workload remains unachievable to meet demand even with full staffing • Evidence is clear that untreated speech, language, and communication needs (SLCN) result in a high risk of social, emotional, behavioural and cognitive problems in adulthood with 60%-70% of young offenders reported to have poor language skills	Low Risk (4-6)	16/12/2024
395	Physical or Psychological Harm	Humphreys, Julie	09/07/2020	Community Partnerships	Tuberculosis Adult Services	TB Demand and Capacity	Demand is exceeding capacity within the TB service in particular managing the LTBI referrals which have increased significantly. People with LTBI are not being case managed in line with NICE guidance, this includes HSCW working within the system who are known to have latent TB and may become ill or pose a risk to patients, other staff and the wider public.	Current commissioned staffing model doesn't match the increased activity. Additional staff currently recruited at cost pressure. HSCW employees with known latent TB are not being treated or managed in accordance with NICE. Some LTBI have inadvertently started taking prescribed medication without being case managed. Administrative support has been reduced = 1 WTE at Band 2managed	Rise of active TB, MDRTB, hospital admissions, deaths, risk to public health. Impact to patients' mental, social, economic & physical health. Impact on staff wellbeing, retention of specialist TB nurses. No capacity to respond to TB outbreaks - most recent and ongoing in Boston leading to operating an unplanned 7 day service. Staff unable to timely review/update service SOPs / NICE compliance. LTBI employees not being managed. Potential Regulatory enforcement action. Increased waits	1. Placed on fragile services register. 2. Paper to SLT / ELT for approval to request further investment from ICB. 3. Review of case management and option to move to nurse-led model with enhanced technology. 4. Running service at cost pressure and through loan of TB nurse from another division has led to ability to case managed active TB cases, community LTBI cases (excludes employees with LTBI) 5. Video Supported Treatment was introduced that provides case managers assurance that doses were not missed in the absence of support, but this still lacks the prompt and support elements. 6. Prioritisation of TB and MDR TB management. System LTBI employees not beginning treatment as no capacity to case manage. 7. Additional CTL post agreed for CDRT (VRRT funded)	13/11/2024	Extremely likely (5) >90% chance	Severe (4)	Very High Risk (20-25)	20	02/12/2024 Discussed at CDRT Quality Scrutiny Group 13/11/24: No change to score. 11/10/2024 Operations Delivery Group (ODG) reviewed the risk and requested a higher risk rating, placement on the system risk register and agreed this is a system risk relating the employees working in LCHS / system who have LTBI and are untreated. There are now 117 employees (data to Sept 24) who have been referred with LTBI (57 to LCHS and Apr - Sept 60 further referred to OH from DoH). In addition the TB service with their existing case load (active TB and community LTBI) are still delivering under cost pressure with no progress on additional investment to date. The service has also been requested to deliver neonatal BCG vaccinations as the current contracted service needs to focus on other priorities. This amounts to 30-50 babies to vaccinate per month. With no additional investment / decision on delivery model this is undoubtedly recurring with major consequences to public/ patient health. 13/09/2024 Discussed at CDRT QSG meeting 11/09/24: paper has been submitted to ELT regarding options for staffing model and costs associated with each model, this is to ensure ELT consider the preferred model and agree to the submission to ICB for additional funding. TB service are working through updating their SOPs. The additional staff for the service is being provided under cost pressures for LCHS. The risk around latent TB remains. No change to score. 30/08/2024 Confirm and Challenge Meeting attended by Assoc. Director CP- accepted reduction in risk to risk score 12 20/08/2024 Risk reviewed at CDRT Ops meeting 14/08/24: 1 x	Very Low Risk (1-3)	11/12/2024

681	Regulatory Compliance	Griffiths, Claire	05/02/2024	Children, Young People, and Specialist Services	Children in Care	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.	21/11/2024	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16	23/11/2024 Discussed at CYPSS Quality SMT 21/11/24: reduced concerns this month because there have been fewer referrals combined with increased availability from the doctors; however this is normal activity fluctuation consistent with last year's around the same time. Temporary doctor starting in Jan'25. No change to score. 17/10/2024 Discussed at CYPSS Quality SMT 17/10/24: no change to score. 20/09/2024 Discussed at CYPSS Quality SMT 19/09/24: update from Director of Safeguarding CF was acknolwedged. No change to score. 28/08/2024 Paper presented to ELT (27.08.2024) agreement given for overspend to be increased as per Option 2 - If the service were to recruit a substantive Specialist Paediatric Doctor from September 2024, the projected overspend for 2024/25 would be: £90,020. Five months bank paediatrician (£26,320) and seven months Specialist Doctor (£63,700). Service will now open discussion with ULHT family health to procure a senior paediatrician at the earliest opportunity 19/08/2024 Discussed at CYPSS Quality SMT 15/08/24: Overspend to be officially agreed; paper to be submitted to ELT with regards to overspend (interim while waiting for the business case to be worked through). No change to score. 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. 5/07/2024 Discussed at CYPSS Quality Scrutiny Group 25/07/24: The service is still supporting IHA/RHA appointments outside	Very Low Risk (1-3)	01/03/2025
714	Physical or Psychological Harm	Brunton, Michael	16/05/2024	Collaborative Community Care	Community Nursing	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	05/11/2024	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16	05/11/2024 - Keeping current score, we are seeing improvements but this is not consistent across all of the county. Data evidencing this is being shown in QA audit processes. 08/10/2024 - Made improvements using data collected from weekly audits, increase in Purpose T, Obs, and using the safe guarding checklist. Need to look at patients with convenience issues. Seen a reduction in Cat 4 PU's. Further suspected S42. Score to remain the same currently. We have moved the Consequence score in the target risk matrix table as this will always stay the same and likelihood will move after mitigations. 10/09/2024 Increase in Cat 2's in the month. Cat 3's have now gone up due to unstagables are now included in Cat 3. No reduction in score at this time. 23/08/2024 Whilst there are some improvements can be seen in assurance standards there is insufficient progress against the action plan for this risk to be confident that a reduction in score is currently warranted 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	Moderate Risk (8-12)	01/03/2025
695	Service Disruption	Brunton, Michael	12/03/2024	Collaborative Community Care	Community Nursing	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	05/11/2024	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16	05/11/2024 - Increasing DNSPQ mentors and 6 people currently going through this process. 08/10/2024 - Update in 715 as these are linked. 10/09/2024 Still awaiting ELT conversation on proposed changes to CN structure. 23/08/2024 No change in the level of score currently. ELT conversation on business case for community nursing to be had 25/07/2024 Paper finalised which has been writen by Angie Davies and Michael Brunton. This has been shared with new Director of Nursing and Exec. Possibility of going to ELT either Aug/Sept 2024. This paper is proposing the need to increase DN speciality to band 7 and aligned with QNI caseload recommendation. 30/05/2024 New risk agreed at Risk Register Confirm & Challenge Group 29/05/2024	Low Risk (4-6)	01/03/2025

715	Physical or Psychological Harm	Brunton, Michael	16/05/2024	Collaborative Community Care	Community Nursing	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	05/11/2024	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16	05/11/2024 - No change currently 08/10/2024 - paper has gone to ELT and has been backed by the board, awaiting information on if/how this can be financed to increase capacity and value DNSPQ workforce. 6 now DNSPQ students started in September. 6 practice teachers are now on the course. 10/09/2024 No change 23/08/2024 No change in score as capacity continues to not meet demand for service 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. 30/05/2024 New risk agreed at Risk Register Confirm & Challenge Group 29/05/2024	Low Risk (4-6)	01/03/2025
495	Physical or Psychological Harm	Parkin, Hayley	25/07/2023	Collaborative Community Care	Leg Ulcer Service	Treatment room clinics do not have capacity to meet demand	The Treatment Room clinics are working off contracted specification High service demand beyond contracted obligation Patient safety risk as patients with complex wound management needs are being seen in clinics staffed and set up for minor wounds The clinics are underfunded (-250K initial investment needed)	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. Proposed GP IA likely to exacerbate this problem	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 and community nursing covering gaps in demand No budget to expand the service to meet need Cost pressure to LCHS	Initial service review carried out and shared with the ICB to highlight the gap in service and patient risk No guidance from the ICB around future service specifications See attached risk assessment. 28/02/24: Full in-depth service review carried out in relation to demand, capacity and cost of the service Meetings with ICB to discuss IA impact	05/11/2024	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16	05/11/2024 - Plan in place for stabilising Treatment Rooms and staffing across the county. This has reduced likelihood to 4. 08/10/2024 - No change in score, LCHS has now started to provide TR for K2 PCN due to them serving notice as part of GP collective action. 10/09/2024 Score to stay the same, this is due to the GP Collective Action and the risk of more areas needing support with Treatment Rooms. Clinic Space an issue in Skegness, Boston, Mablethorpe. Type of things being seen in clinics is not what we are comissioned for. Work on going with ICB on being funded appropriately. K2 have serviced notice and currently working up costs for this. Skegness/Mablethorpe are full this week and are having to extend clinics as still 20 patients needing support. 27/08/2024 Initial review identified a potential reduction of service risk score to 16. However IA impact has increased risk back to previous threshold 25/07/2024 Paper being finalised to provide options to ICB for the ability to deliver the service sustainably going forward. Hayley Parkin will present this to trust board in Aug/September 2024. 24/06/2024 No identified change in score. Awaiting ELT conversation 18/04/2024 The risk to the service remains unchanged demand on the service is high and there are not enough appointments at times to meet demand. Deep dive sent to ICB and situation escalated in LCHS. 07/02/2024 No change to risk. Deep dive service review	Very Low Risk (1-3)	01/03/2025
444	Finances	Finance and Business Intelligence	30/06/2022	Corporate	Finance	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.	25/11/2024	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16	and control implementation by association as part of LCHG group financial recovery plan. 17/10/2024 Maintain current score. Delivery of plan contingent on delivering 25% reduction in run rate spend on overtime, required to mitigate cost pressures associated with apprentices and international nurses 04/09/2024 Score reviewed at Risk Register Confirm and Challenge meeting 28/08/24 and agreed to increase likelihood to 4 and decrease consequence to the same, overall increase from L3 x C5 = 15 to final score L4 x C4 = 16. 23/07/2024 Monthly update. No change 20/05/2024 Decisions regarding cost pressures need to be made by ELT. [14/05/2024 15:33:43 Peter Chiutsi] 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. 13/02/2024 Commentary to be added following FPPIC approval on 19/02/24 24/11/2023 - no change to score following monthly review.	Low Risk (4-6)	01/03/2025
754	Physical or Psychological Harm	Director of Nursing	09/10/2024	Corporate	Nursing	Moving and Handling	Clinical staff are inadequately trained in moving and handling	Poor compliance with expected standards. Training content currently being re evaluated. As a consequence there has been a pause in delivery. Cohort of staff requiring training being reviewed	Risk of injury to staff and patients. Potential for claims and complaints. There will be a disruption to the planned training schedule (impact presently being evaluated)	Mutual support request to ULHT. Internal sources of alternate training support being identified. Reviewing training schedule and package. Action plan in place to increase attendance when training is reinstated. Engagement with operational colleagues to confirm appropriate staff requiring training.	05/11/2024	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16	05/11/2024 Discussed at Risk Register Confirm and Challenge 30/10/24: agreed as new risk scoring L4 x C4 = 16.	Very Low Risk (1-3)	01/03/2025

651	Finances	Medical Director	09/10/2024	MedicalDirectorate	Medicines Management	Contracted Pharmacy Service - Co-op	Despite Co-op winning the tender for the contracted pharmacy service for LCHS from April 2023 (medicines supply and clinical pharmacy service), the contract is still unsigned 6 months later.	Co-op have not signed the new contract & have requested to re-negotiate the spec & KPIs, despite bidding for and winning against these versions. Management costs have significantly increased.	LCHS not receiving a comprehensive pharmacy service in line with the new spec/CV. KPIs/audits for the clinical pharmacy service have not been agreed thus reporting/assurance is limited. Cost pressure.	Co-op continue to provide the pharmacy service against the previous spec, KPIs. Controls include: - Quarterly CD checks via Co-op - Monthly Chart Checker audits via Co-op - Safe and Secure Handling of Medicines/CD audits continue to be led by LCHS MMT on a quarterly basis - All medicines related incidents reviewed by Divisional Senior Pharmacy Technicians and by LCHS pharmacist Mitigating actions: - LCHS have chased and now (from October 2023) have in place monthly operational meetings with Co-op pharmacist lead (Claire Rogers) to discuss any issues of concern e.g., relating to patient safety - Snapshot audit completed (October 2023) in relation to discharge delays associated with	15/11/2024	Extremely likely (5) >90% chance	Moderate (3)	High Risk (15-16)	15	15/11/2024 Discussed at risk summit with DDMD SB and QPIL AM 15/11/24: As part of planning for 2025/26, a case of need has been presented at CRIG and ELT in relation to taking the clinical pharmacy services in house. No change to score. 05/11/2024 Discussed at Risk Register Confirm and Challenge 30/10/24: agreed to increase the score from L4 x C3=12 to L5 x C3 = 15. 18/10/2024 Discussed at risk summit with DDMD SB and QPIL AM 18/10/24: priority of need not agreed by Finance in relation to funding (JT 03/10/24). 10/10/2024 Discussed at risk summit with Deputy Director of Medical Directorate SB: Risk to patient safety and quality of service (as evidenced by staff survey and recent evaluation of service) was discussed at Community SLT 19/09/2024, along with a proof of concept paper for a community hospital pharmacist - not approved due to funding. DDMD SB to discuss further with finance. This issue has been escalated to the Quality Committee through the upwards Patient Safety Group report in Aug'24. Propose to increase the score from L4 x C3=12 to L5 x C3 = 15 - for approval at RRCC Oct'24. 20/09/2024 Risk to patient safety and quality of service (as evidenced by staff survey and recent evaluation of service) was discussed at Community SLT 19/09/2024, along with a proof of concept paper for a community hospital pharmacist - not approved due to funding. DDMD SB to discuss further with finance. This issue has been escalated to the Quality Committee through the upwards Patient Safety Group report in Aug'24	Very Low Risk (1-3)	01/03/2025
649	Regulatory Compliance	Chief Operating Officer	12/09/2023	Corporate	Estates	Fire Safety Core Risk	There is a risk of harm to building occupants (including patients)caused by fire. There is a risk that the Trust cannot demonstrate statutory compliance in accordance with the Regulatory Reform (Fire Safety) Order 2005 (RRO).	Inadequate fire protection systems, maintenance, training and procedures	Loss of facilities, services and injuries to patients and staff.	1. LCHS Fire Safety Operational Meeting 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.	11/10/2024	Reasonably likely (3) 31-70% chance	Extreme (5)	High Risk (15-16)	15	11/10/2024 After a conversation with Mike Parkhill this risk has been moved to Alan Smith with Mike having overall responsibility for the risk. 10/09/2024 Fire updates are being presented at H&S committee and the action plan is still being worked through. No Change to score currently. 16/08/2024 The Group fire team continue to work against the FRA action plan and the risk score will be reviewed once this is complete. No change to score currently. 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 15:47:05 Dan Dring] ULHT are supporting LCHS with all elements of fire safety. Also a recruitment process has taken place to increase the capacity in the ULHT team. The LCHS Fire AE is just about to be undertaken	Low Risk (4-6)	15/11/2024
390	Physical or Psychological Harm	Chief Operating Officer	01/08/2020	Corporate	Estates	John Coupland Hospital Theatres ventilation	Patient safety/ infection control / loss of service and disrupted service to patients	Theatre one - The plant in JCH theatre 1 is running inconsistently resulting in temperatures being close to or over the limit of 22c and humidity at times being close to or breaching the limit of 60.	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.	11/10/2024	Reasonably likely (3) 31-70% chance	Extreme (5)	High Risk (15-16)	15	11/10/2024 After a conversation with Mike Parkhill this risk has been moved to Alan Smith with Mike having overall responsibility for the risk. 12/09/2024 Local meetings have taken place with the project team and the work is still planned for start in the middle of October. No change to risk score and continues to be monitored. 16/08/2024] Project has now began to replace the air handling units. This is being planned for the middle of October. The risk can be reviewed completely when the work has been completed. Risk will continue to be monitored in the interim. 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	Very Low Risk (1-3)	15/11/2024

391	Physical or Psychological Harm	Chief Operating Officer	01/12/2022	Corporate	Estates	John Coupland Hospital Water Safety	Water supply to patients, staff and visitors has been contaminated;	The regulatory routine maintenance of the landlord (NHSPS) being ineffective;	Risk of harm from Legionella and other waterborne pathogens	1. Joint Water Safety Group 2. NHSPS planned maintenance regime 3. Infection Control Group. 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	11/10/2024	Reasonably likely (3) 31-70% chance	Extreme (5)	High Risk (15-16)	15	11/10/2024 After a conversation with Mike Parkhill this risk has been moved to Alan Smith with Mike having overall responsibility for the risk. 16/08/2024 NHSPS Update: Scotter ward decant is planned for September. Once the ward is empty the suspect pipework will be isolated and removed. This will eradicate the issue and the risk can be reviewed. 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	Moderate Risk (8-12)	15/11/2024
393	Physical or Psychological Harm	Chief Operating Officer	01/12/2022	Corporate	Estates	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. Infection Control Group 2. NHSPS planned maintenance regime 3. Appointed Authorising Engineer (AE) for water 4. NHSPS is undertaking flushing of outlets. 5. Water sampling - with all results being sent to the Trust AE and Estates Shared Services 6. Estates shared service and AE follow up actions required on high count outlets. 7. Any positive counts have a filter fitted immediately	11/10/2024	Reasonably likely (3) 31-70% chance	Extreme (5)	High Risk (15-16)	15	11/10/2024 After a conversation with Mike Parkhill this risk has been moved to Alan Smith with Mike having overall responsibility for the risk. 16/08/2024 Awaiting results from NHSPS. No change to score and risk continues to be monitored. 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	Moderate Risk (8-12)	15/11/2024
719	Physical or Psychological Harm	Mckee, Nat	10/06/2024	Integrated Urgent & Emergency Care	Clinical Assessment Service (CAS)	DHU contract changes resulting in external validation of Lincolnshire Patients	patient and staff experience will be poorer and system impact will be significant due to clinical validation being completed by DHU. This may damage the organisation and may delay patient care.	Regional agreement with no input from Lincs ICB. New contract for clinical validations of all interim dispositions and ED validation to DHU from CAS. Loss of approx 100 CAS calls per day	potential for reduction in funding, booked appointments, signposting to UTCs, reduced referrals to HV,pt sent to UTC with min triage,additional conveyance to ED. Pt experience, staff morale	Support and regular updates to staff, close monitoring of staffing levels, data monitoring, monitoring of datix	27/11/2024	Reasonably likely (3) 31-70% chance	Extreme (5)	High Risk (15-16)	15	29/11/2024 Discussed at RRCC 27/11/24 and agreed to increase the score from L3 x C3 = 9 to L3 x C5 = 15, based on new available evidence from incidents that the consequence score should be higher as detailed in narrative from 22/11/24. 22/11/2024 Risk updated by DL NMcK and DDL LA following request at RRCC to review the risk's consequence score; agreed consequence should be changed from 3 to 5. This is based on the high risk patients being inappropriately booked into the UTCs: •Complex pregnant patient with palpitations & dizziness post fall down the stairs •Patient with history of collapse who then collapsed in the UTC •Patient with severe chest pain who then had episode of asystole in the department •5/52 old baby with hx of sepsis •42wk old child with head injury post submersion in water For review at the Risk Register Confirm and Challenge meeting Nov'24. 18/10/2024 Discussed at IUEC Quality Scrutiny Group pre-meet 08/10/24: incidents have remained consistent and regularly reported, no change to score. 18/09/2024 Discussed at IUEC QSG pre-meet 10/09/24: No significant incidents in regards to poor clinical validation, still waiting data from DHU. ICB are triangulating LCHS/ULHT/EMAS data. No change to score. [17/08/2024 20:16:27 Ana Morgan] Discussed at IUEC divisional QSG pre-meet 13/08/24: Consequence estimated incorrectly	Very Low Risk (1-3)	01/03/2025

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. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	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, resulting in patient cancellations and delays. 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	28/11/2024	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 with staffing workshop planned for September. Project group commenced at Lincoln to introduce activity manager to try to support planning and management of deficits.	[28/11/2024 10:06:10 Nicola Cornish] Task and finish group now established to look at theatre workforce. [21/10/2024 13:06:13 Nicola Cornish] Business Case is ongoing and risk of cancellation remains very high. Long line agency was agreed but with limited fill. Sourced International nurses and CV's received - awaiting completion of interviews. [11/09/2024 14:23:33 Nicola Cornish] Risk reviewed, no change. [29/08/2024 08:44:21 Nicola Cornish] Off framework has stopped. Limited availability of agency staff but now agreed that we can source long line agency bookings. Theatre staffing workshop in September to support business case. Project group commenced at Lincoln to introduce activity manager to try to support planning and management of deficits. [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		28/12/2024
4d. Enhanced data and digital capability	4557	7	Reputation	Matthew, Mr Paul	Hobday, Fiona	Information Governance Group	Digital Hospital Group	10/01/2022	12	Risk assessments	Corporate	Trust Headquarters	Corporate Secretary	Trust-wide	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 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. 18/11/24- Procured new solution to better manage requests.	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.	18/11/2024	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.	[18/11/2024 14:41:01 Fiona Hobday] x2 new staff joining team in November. Pilot of new system carried out successfully. Full roll out scheduled for Dec 1st. [22/10/2024 09:27:29 Fiona Hobday] Issues with system to extract data for staff SARs- leading to delays. x2 staff resigned in service (1 remaining staff member)- x2 appointed to Disclosure Team following recruitment- expect to start in Nov. [10/09/2024 09:01:56 Fiona Hobday] Update from Sept IGG- plan and trajectory for improvement to be developed for closer monitoring at IGG. Discussion as to what has led to recent compliance drop- staffing matters to be managed. [02/09/2024 12:00:37 Fiona Hobday] New system has been built in UAT and signed off. Live system is ready and initial training scheduled Sept 24. Soft go live currently planned for Oct and full go live in Nov. Capacity issues remain- working through process to seek approval to recruit. [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.	6	29/12/2023	30/04/2025	20/12/2024
2a. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	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)		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.	CG lead duties shared between consultants but no one wishes to take on role (Clinical Governance Lead to commence post in April 2025) 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 Workforce review completed Refresher of Fragile Services Paper completed (NB there is a National shortage of Haematology consultants) Additional unfunded ST3+ for Haematologist started in August 2022	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	19/12/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Recruitment of further substantive consultants - Sarah Chester-Buckley April 2025 Cancer Services paper written awaiting CRIG invitation - Sarah Chester-Buckley - February 2025	[19/12/2024 11:38:08 Gemma Staples] Cancer Services paper written awaiting CRIG invitation [18/11/2024 12:37:44 Gemma Staples] Business case submitted and proceeding to next stage of the process within the Trust. [18/10/2024 10:36:47 Gemma Staples] CoN written to be submitted on 31st October 2024 to ensure this is included in the planning round 2025/26. [20/09/2024 10:49:48 Gemma Staples] Attended ELT, asked to produce new Business Case for Cancer Services to be presented at CRIG asap to ensure the staffing requirement is put into planning for 2025/2026. [28/08/2024 14:45:28 Rachael Turner] Risk presented at RRC&C meeting 28/08/2024. Risk validated. [22/08/2024 08:39:24 Gemma Staples] Risk remains the same as previous update as awaiting ELT on the 28th August 2024. [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	8	30/09/2023 01/04/2025		20/01/2025

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
3a. 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	19/11/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	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.	[19/11/2024 09:11:00 Rachael Turner] Risk of Delivery remains high with a direct impact on the financial position of the trust. Mitigating actions required at pace to improve delivery. List of potential mitigations compiled and senior finance team meeting with relevant Execs in W/C 18/11/24 to establish impact expected for 2024/25 and appetite for options proposed. To include a deep dive into areas of CIP not delivering for this financial year. [23/10/2024 11:04:51 Nicola Cornish] Improvement Steering Group met on the 10th to review actions to move each scheme from RED to Amber and Amber to Green. Actions are in the process of being costed to revise the initial finance forecast with a Programme led forecast. Actions stepped up on the Medical Workforce Programme which currently remains RED on the financial RAG rating due to time taken to embed controls across the organisation. [20/09/2024 09:23:11 Rachael Turner] Risk remains high risk with a forecast of £35.2m presented to ELT and FPEC on the 19th Sept 24 against the £40.1m CIP target for the year. This will have a direct impact on the ability of the organisation and system being able to meet its financial plan for this financial year. Main area of shortfall is Medical agency & bank reduction programme focussed on reducing the current high cost of medical staff. Of the stretch target set to cover CIP investments, £2m has been identified, with further opportunities presented to ELT & FPEC to agree next steps. [28/08/2024 12:45:00 Rachael Turner] Risk presented at RRC&C as part of the Deep Dive. Due to this risk linking with our reliance of agency and regulatory compliance this risk will be increased to 5x4:20 Very High Risk. [20/08/2024 21:31:09 Rachael Turner] Risk reviewed. The proposal is to increase the risk from a rating of 16 (High) to 20 (Very High Risk), this is due to current performance and forecast at month 4. This risk will be presented by Jon Young at the RRC&C meeting in August.	4	31/03/2023	31/03/2024	19/12/2024
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5101	487	Physical or psychological harm	Rivett, Kate	Herath, Dr Durga	Patient Safety Group		14/03/2023	20			Family Health	Children and Young Persons CBU	Children's Community Services	Trust-wide	Quality and safety risk from inability to deliver epilepsy pathways within Community Paediatrics that meet National standards due to resourcing and capacity factors.	1. Single Consultant Paediatrician (DH) is currently managing all children with Epilepsy alongside a single specialist epilepsy nurse; 2. Wider consultant body supporting the care of children who are prescribed 2 antiepileptics in the absence of a consultant paediatrician with expertise in epilepsy; 3.Single Consultant Paediatrician is developing individualized care plans for each patient to optimise management of condition; 4. Liaison with ICB and regional network to support development and improvement of local services	1. Audit of compliance with NICE guideline NG217 - Epilepsies in Children, Young People and Adults and NICE quality standard QS27 - Epilepsy in Children and Young People;	09/12/2024	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. Appointing 2 x epilepsy nurses. 4. Epilepsy workshop with ICB	[09/12/2024 13:21:53 Nicola Cornish] Business case has been submitted to PMO office, awaiting date for presentation to CRIG. [11/11/2024 15:06:06 Nicola Cornish] Business case has been completed, and the service has been added to the investment tracker for 2025/26. [14/10/2024 14:01:56 Nicola Cornish] Draft business case completed and submitted to Finance. Liaising with ICB regarding funding priorities for 2025/26. [09/09/2024 14:48:10 Nicola Cornish] No further progress. Received an outlier notice, action plan developed for delivering improvements - seeking approval from ICB for funding for a Band 6 epilepsy specialist nurse post as part of this. [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	8	14/03/2024	16/02/2024	09/01/2025
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)	19/12/2024	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	[19/12/2024 11:17:47 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. In 2024/25, the focus of the programme is to reduce agency expenditure in relation to medical and dental (M&D) staffing, whereas in 2023/24 the focus was upon reducing agency expenditure in relation to registered nursing and midwifery. The 2024/25 financial plan includes a total agency plan of £14.9m and the expenditure profile in the 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 £2.3m in the third financial quarter of the year. • To £1.8m in the final quarter of the year. Agency expenditure YTD of £16.5m is £4.1m higher than planned agency expenditure of £12.4m driven by M&D agency expenditure being higher than planned. The adverse agency pay position is part of a larger adverse movement to plan in the overall pay position, which in turn is a major driver of the adverse movement to plan in the overall financial position. The agency pay position will therefore be of considerable concern to both our ICS and our regulator, and both will expect/require the Trust to take actions at the scale required to address the adverse impact of the pay position on the overall financial position.	8	31/03/2023	31/03/2024	18/01/2025

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, Paediatrics, Outpatients and ICU using manual prescribing processes which are inefficient and restrict the timely availability of patient information when required by Pharmacists this 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. EPMA rolled out across the Trust - Outpatients, ICU, Paediatrics and Maternity were removed from scope. • Outpatients module installed as part of ePMA, due to the COVID19 delays, reconfiguration of services and complexities with the nature of outpatient prescribing, it was agreed by the ePMA Steering group to defer this to either EPR or a later optimisation piece of work. • Maternity was removed from scope at their request due to them pursuing a new digital solution of their own that would have its own prescribing feature. • The ePMA software is not suitable for ICU for very complex infusions, there was a different project - metavision which is an ICU specific ePMA, this was stopped due to safety concerns.	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	25/11/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Maternity : Pursuing new digital system which would have own prescribing feature - Badgernet? - Lorraine Brooks - May 2025 ICU : Suitable software for very complex infusions being sought - Lead? - May 2025 Outpatients : Outpatients module installed as part of EPMA, due to COVID delays, reconfiguration of services and complexities with nature of outpatient prescribing agreed by EPMA Steering Group to defer to either the EPR or later optimisation piece of work - Lead to be confirmed once in post - May 2025	[25/11/2024 10:46:08 Sarah Davy] Outpatients - Product Manager JD is undergoing review for banding and will be appointed once completed. Funds for post have been agreed. [25/11/2024 10:41:10 Sarah Davy] Kate Rivett confirmed that there are mitigations in place where they would accept the minimal risk to Paediatrics. No plans to employ full time Paediatrician for EPMA [29/10/2024 10:20:16 Lisa Hansford] Risk to be agreed at MOpS on 12th November, then will need presenting at confirm and challenge in December. [26/09/2024 12:15:50 Gemma Staples] As EPMA is now rolled out, risk to be presented at October RRC&C to seek approval of closure. The areas that are still manually prescribing are to add individual risks for their divisions if required. [09/09/2024 12:40:05 Gemma Staples] Risk to go to RRC&C to agree closure of this risk. A new risk has been created for manually prescribing in Outpatient and Maternity (Risk ID 5509) and this will also be taken to RRC&C for approval. [29/08/2024 07:51:18 Lisa Hansford] No further update [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.	4	31/12/2023	30/06/2025	23/12/2024
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		Trust-wide	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.	16/12/2024	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.	[16/12/2024 10:27:27 Lisa Hansford] No further update [12/11/2024 14:24:12 Lisa Hansford] RCEM/ED pharmacy case developed and submitted for winter pressures funding- this was unsuccessful. The case will be resubmitted for the next financial year (25/26) [17/10/2024 09:41:28 Lisa Hansford] no further update [19/09/2024 12:57:45 Lisa Hansford] no further update, risk remains the same [20/08/2024 09:27:39 Lisa Hansford] no further update [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	8	30/05/2023	30/04/2025	16/01/2025
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	Trust-wide	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. The development of a CDU in October 2024 will enable some flow from the emergency department to home for patients requiring treatment to discharge. This will be monitored through UEC improvement work to ensure area is fit for purpose. If CDU is utilised to enable ambulances to offload before 2 hours this will effect the flow through CDU.	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	03/12/2024	Quite likely (4) 71-90% chance	Extreme (5)	Very high risk (20-25)	20	Ongoing work in place for long lengths of stay. There is a discharge work progress team in place. 78% performance project currently in place which is supported by the improvement team. 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.	[03/12/2024 13:47:06 Rachael Turner] Following discussion at the Risk Confirm and Challenge meeting it has been agreed that this risk sits as a joint risk between Urgent and Emergency Care and Ops. From an Emergency Care perspective there is a UEC refresh project taking place, this involves a whole refresh of UEC. Performance is currently between 70-76%. An update from an Ops perspective to be provided. [13/11/2024 11:21:35 Rachael Turner] UEC improvement plan and discharge improvement plan are currently in process to reduce admissions where viable i.e. signpost to SDEC, Hot Clinics, ETC. The Discharge element is focussing on reduction in length of stay and implementing criteria led discharge to facilitate reduction in length of stay. Both projects should support improvement in flow and to attain 78% performance. Risk score currently remains. [11/11/2024 14:59:29 Rachael Turner] Risk reviewed, no further update. [02/10/2024 12:03:02 Rachael Turner] There is a new COO lead project in place around patient flow this looks not only at ED but also Ops for Wards and Discharge planning. Risk remains at the same level. [03/09/2024 15:04:06 Rachael Turner] Risk reviewed, remains in same position. Mitigation is in place to manage but needs to remain at current risk level. [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.	10	02/09/2023	31/03/2024	03/01/2025

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. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	4948	50	Physical or psychological harm	Cooper, Mrs Anita	Walker, Helen	Workforce Strategy Group	Health and Safety Group, Medicines Quality Group, Patient Safety Group	17/06/2022	20	Workforce Metrics	Clinical Support Services	Pharmacy CBU			Workload demands within Pharmacy persistently exceed current staffing capacity which leads to 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	29/11/2024	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	[29/11/2024 10:18:44 Lisa Hansford] No further update [29/10/2024 10:21:55 Lisa Hansford] Full business case in development. [30/09/2024 13:45:19 Gemma Staples] Risk reviewed and remains the same [05/09/2024 14:06:45 Lisa Hansford] no further update [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	8	30/06/2023	30/10/2023	30/12/2024
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5100	28	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;	09/12/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	1. Multi-professional working group tasked with delivering improvements that will support achievement of audit compliance.	[09/12/2024 13:20:30 Nicola Cornish] Business case has been submitted to PMO office, awaiting date for presentation to CRIG. [11/11/2024 15:04:28 Nicola Cornish] Business case has been completed, and the service has been added to the investment tracker for 2025/26. [14/10/2024 13:59:49 Nicola Cornish] Draft businness case completed and submitted to Finance. Liaising with ICB regarding funding priorities for 2025/26. [09/09/2024 14:47:00 Nicola Cornish] No further progress. Received an outlier notice, action plan developed for delivering improvements - seeking approval from ICB for funding for a Band 6 epilepsy specialist nurse post as part of this. [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	8	14/03/2024		09/01/2025
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	4879	28	Physical or psychological harm	Carter, Mr Damian	Lynch, Diane	Patient Safety Group		28/03/2022	20	Risk assessments	Clinical Support Services	Cancer Services CBU	Oncology	Trust-wide	As a result of National long waits post COVID there may be significant delays within the cancer pathway and as a consequence patients may experience extended waits for diagnosis and surgery which would lead to a failure in meeting 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 Intensive support meetings in association with the ICB - 2/52 Cancer Delivery and recovery - 2/52 Cancer Board - Monthly	Cancer patients awaiting surgery - all within 31 days New standards: 28 days for first diagnosis; 62 day max wait Diagnostic standard less than 6 weeks	11/12/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Recovery trajectory of 62+ waits to 0 – Damian Carter – March 2025 Through the intensive support process, specialties to identify and assess any areas of specific risk not addressed through the recovery trajectory, putting in place necessary mitigating actions – Damian Carter – March 2025	[11/12/2024 11:47:31 Gemma Staples] The Cancer right-sizing Business Case for Haematology and Oncology was prioritised by CSS Division and submitted in line with the Trust's programme for 25/26, aligned to the health System process. Next step for review via this process is 19 December 2024. It was also presented to Cancer Board on 29 November 2024 as part of the governance process. [11/11/2024 13:18:53 Gemma Staples] Risk reviewed and remains the same. No further update. [04/10/2024 14:49:53 Gemma Staples] Following ELT meeting case of need to be written for presentation at CRIG and ICB investment panel to include Oncology and Haematology workforce. The DOF requested this case to be managed via the 25/26 planning cycle. [16/09/2024 12:38:28 Gemma Staples] DL and Cancer leadership team presented impact assessment to ELT 27/08/2024. More work for the division to do to secure substantive funding for 25/26. Approval given to retain 20 posts across Haem/Onc that have been recruited 'at risk' and above establishment with prior approval in 2023 from CEO and COO. [22/08/2024 15:09:20 Gemma Staples] Impact assessment / QIA for potential removal of 16 wte posts approved 'at risk' by Execs in 2023 deferred date for ELT to 27/08/2024. Being presented by Dl and the Cancer leadership team. [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	8	31/03/2023	31/03/2023	10/01/2025

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
3a. 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	03/12/2024	Quite likely (4) 71-90% chance	Extreme (5)	Very high risk (20-25)	20	Robust recruitment plan International recruitment Medical Workforce Management Project	[03/12/2024 16:57:16 Rachael Turner] No changes with scoring, rota finalised and working with Tier 2 team to potentially implement annualised rota in April 25. [13/11/2024 11:36:06 Rachael Turner] Options appraisal for the Tier 2 rota sent to Quadumvirate for approval planned to implement rota 1st April 2025 subject to approval. [28/10/2024 11:02:45 Rachael Turner] This remains very high as we are still in process of recruiting and finalising the tier 2 rota to ensure the correct provision. Hoping to have a resolution and start date by end of November. Recruitment continues for consultant posts. [03/09/2024 15:05:32 Rachael Turner] We are recruiting but are not yet in post. Extra shifts are being put out to bank. Still in same position currently, will review next month for possible reduction. [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.	10	02/09/2023		03/01/2025
1c. Improve clinical outcomes	4731	33	Physical or psychological harm	Landon, Caroline	Landon, Caroline	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.	28/10/2024	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.	[28/10/2024 11:14:13 Rachael Turner] Risk reviewed, no change to current scoring. [12/09/2024 20:14:05 Rachael Turner] Risk reviewed, remains unchanged, no change to risk score. [20/08/2024 16:20:51 Rachael Turner] Risk reviewed, risk score remains accurate until EDMS is in place. [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.	4	30/06/2018	31/03/2025	28/11/2024
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	As a result of the demolition of H Block it removed facilities and amenities that the Health Record Teams (also Porters & Secretaries) utilised. The risk is that staff are now having to use dumbwaiters to transport notes between the main library and outpatient clinics with additional manual handling requirements, the impact on the staff has meant an increase in staff injuries, an increase in staff turnover with multiple vacancies and low staff morale. The impact on staff has meant to change to processes, an increase in workload and a more physically demanding role. Additional concerns are that the notes are being delayed to clinic which could cause the potential for appointments to be cancelled and also there is an IG issue with notes being transported in dumbwaiters that open in patient areas. 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 in the coding dumbwaiter and with the upgrade to the dumbwaiter in Health record the limit has been increased to 4 boxes. Process in place to ensure notes are either with a member of staff or in lockable storage areas. Quality Impact Assessment completed Risk presented every month to PRM with an update Health and Safety guidance delivered to Team on regular basis	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.	25/11/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Installation of a lift – Chris Rose – November 2024 (E&F)	[25/11/2024 14:47:23 Gemma Staples] Schedule of works received showing completion by 31st March 2024; initial work has started and staff have been moved around to accommodate works; working with estates to limit disruption whilst works take place. [30/10/2024 16:08:46 Gemma Staples] Dumb waiter upgrade completed and working with some minor changes in process needed to maximise use. Awaiting schedule of works for main lift from estates, however it is indicated further delays in implementation, due date now March 2025. [17/10/2024 12:00:04 Laura Kearney] Estimation for lift installation has been extended to March 2025. [25/09/2024 10:19:53 Gemma Staples] Upgrade of dumbwaiter completed awaiting impact of this before mitigation is taken into account and risk to be reviewed. Meeting to review progress and timelines for lift installation arranged for end of September 2024. [02/09/2024 09:46:56 Gemma Staples] Working together with estates team. The dumb waiter is currently being upgraded and causing the team additional issues but we were aware of the issues and agreed that these will be mitigated as far as they can be whilst the works are progressing on the dumb waiter. Currently still working to the end of November as the date for the installation of the bigger person lift. [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.	1	01/05/2023		25/12/2024

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
3a. Deliver financially sustainable healthcare, making best use of resources	5277	469	Finances	Young, Jonathan	Treasure, Vanessa			09/10/2023	12		Corporate	Finance and Digital	Finance	Trust-wide	Risk of additional financial pressure to the Trust from the possible application of national profiles to existing job descriptions for a number of Band 2 and Band 3 roles and the potential wider impact of any decision.	Initial high level financial risk modelling undertaken by finance. Proformas completed by divisional lead/lead nurse, supported by DHoHR and DHoF to capturing: • how many posts required at each level across each teams • how many current employees currently match the Band 2 profile and Band 3 profiles. Deputy Director of Nursing and Assistant Director of Nursing to review/challenge and agree proposals.	Potential worst case scenario of £3.2m has been calculated. Feedback has been given regarding the need to ensure other band 2 & 3 roles are considered and the possible impact of decisions for those already in a number of band 3 roles."	19/12/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Following proposals being reviewed and challenged, discussions will take place with HR regarding the change process and following this the true cost impact will be calculated. Confirmed high level costing if backdated to August 2021 is £692,517, a significant reduction to the previous anticipated £3.2m financial impact. Possible application and impact of the national profiles for Band 2 and Band 3 roles are currently being consulted through staff side.	[19/12/2024 11:20:07 Rachael Turner] The risk is we have upgraded all band 2's who wanted to move to a band 3 in November and will be actioning back pay as per Hr and union agreement in January. [27/11/2024 13:43:00 Rachael Turner] Risk presented at Risk Confirm and Challenge, risk validated for increase in score 5x4:20 [18/11/2024 14:40:08 Rachael Turner] Payment for those moving to a Band 3 will start in November, so all band 2's wishing to take up the role of the band 3 will be paid a band 3 in November, backdated pay has still not yet been finalised. [13/11/2024 11:57:12 Rachael Turner] Risk to be presented at RRC&C in November for increase in score. [23/10/2024 11:01:47 Nicola Cornish] The Band 2 to 3 has moved significantly, ELT / Board agreed to move ALL band 2's to band 3 with the exception of staff members whom may rejected it. This has now been recalculated to include all approximately 1,000 people: 1 Financial impact recurrently is Part year 2024/25 £1,127,500 and Full year 2025/26 ongoing of £2,706,000. 2 Back pay not yet agreed but costed at £3,559,803. Therefore, I think this risk needs to move to, highly likely as the comms have gone out about it and severity high. [19/07/2024 10:27:38 Rachael Turner] Risk reviewed, risk reduction plan for 24/25 updated, risk score reduced to 2x4:8. [18/04/2024 17:07:23 Rachael Turner] Possible application and impact of the application of national profiles for Band 2 and Band 3 roles are currently being	4	09/10/2025		20/01/2025
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5450	659	Physical or psychological harm	Mooney, Mrs Katy	Highfield, Kimmi			05/06/2024	12		Medicine	Specialty Medicine CBU	Gastroenterology	Trust-wide	The capacity of the Gastroenterology Consultant workforce is reducing due to individuals wishing to take resign, retire or partially retire and return with reduce job planned activity. This is impacting the inpatient and outpatient activities of the service. However, as the drive to resign/retire/reduce job planned activity focuses on removal of all inpatient and on-call activity as a 'must' the primary impact is being felt in these area's. If the Consultant Medical workforce for Gastroenterology depletes further and/or does not recruit to vacancies within the workforce, the service will not be able to maintain a two site Gastroenterology inpatient cover, outpatient/ cancer performance and Upper GI Bleed On Call service.	-Recruitment - full time Gastroenterology gaps are out with Agency and on TRAC for NHS Locums. The Business Unit manage the gaps proactively and will put out a variation of gaps (for example, ward cover only) to seek cover for the gaps in the service. -When on-call bleed rota not covered at one site calls are diverted to the other, however this mitigation provides a lower level of service. -Management of UGI Guidelines policy. -Guidelines on Management of Upper Gastro-Intestinal Bleeding (UGIB)	Workforce gaps Capacity of the service Cover of rota's (inpatient ward cover and on-call bleed cover)	10/12/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Explore recruiting to Hepatology specialist posts with ERCP and EUS included. -Robust recruitment plan to cover establishment gaps, including non substantive workforce. -Single site on-call cover in place-currently covering both sites to mitigate for gaps. -Development of clinical service strategy for Gastroenterology by end of 2024/25 financial year. -Paper to go to executive detailing short fall and asking for support with further mitigation by close of play September 2024.	[10/12/2024 14:52:10 Rachael Turner] Risk reviewed, one more consultant has started at Pilgrim with another possible for late 2025. Workforce business case has been submitted. Risk score remains and unchanged. [22/11/2024 10:23:18 Rachael Turner] Guidelines on Management of Upper Gastro-Intestinal Bleeding (UGIB) is currently under review. Controls for this risk have been updated. [18/11/2024 07:58:41 Charles Smith] Risk ongoing - Service sustainability paper drafted for ELT in October 2024. Awaiting formal outcome, further deterioration has led to further options appraisal going forward. This has been signed off by Medicine CD and to be shares with exec. Large workforce CoN supported at initial 2025/26 investment priorities process. SBJC being drafted for 22/11 deadline. [07/10/2024 13:08:56 Rachael Turner] Gastroenterology : Service Sustainability Impact Assessment document which demonstrates the current position of this risk has been added as evidence of Very High Risk Score in supporting documents. Risk currently remains at same level. [25/09/2024 13:05:15 Rachael Turner] Risk presented at RRC&C meeting 25/09/2024. Risk validated as a 5x4:20 Very High Risk. [04/09/2024 12:22:35 Rachael Turner] Risk reviewed. Due to fragile service with 17 whole time equivalent workforce (15 on which are in post), however 5 of these have retired and returned on outpatient only. This leads to increasing pressure of specific parts of the service, most notably the inpatient service. This leads pressure to on-call rota bleed rota. Gastro also has a significant challenge to long waiters and in unlikely to meet the regional ask to clear the 65 week cohort by close of play September 2024. The service has also experienced gaps due to consultant sickness since August 2024. Risk score requested to be increased to 5x3:15. This will be presented at the	8	05/06/2025		10/01/2025
2a. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	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. Workforce review completed Refresher of Fragile Services Paper completed (NB there is a National shortage of Haematology consultants) Additional unfunded ST3+ for Haematologist started in August 2022	Datix incidents Complaints and PALS Outcome from Staff Survey results Financial constraints of group	19/12/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Cancer Services paper written awaiting CRIG invitation - Sarah Chester-Buckley - February 2025 Recruitment of further substantive consultants - Sarah Chester-Buckley - April 2025	[19/12/2024 11:34:12 Gemma Staples] Cancer Services paper written, awaiting CRIG invitation [18/11/2024 12:37:17 Gemma Staples] Business case submitted and proceeding to next stage of the process within the Trust. [18/10/2024 10:35:59 Gemma Staples] CoN written to be submitted on 31st October 2024 to ensure this is included in the planning round 2025/26. [20/09/2024 10:49:24 Gemma Staples] Attended ELT, asked to produce new Business Case for Cancer Services to be presented at CRIG asap to ensure the staffing requirement is put into planning for 2025/2026. [22/08/2024 08:38:53 Gemma Staples] Risk remains the same as previous update as awaiting ELT on the 28th August 2024. [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	8	01/04/2023	01/04/2023	20/01/2025

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. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	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.	29/11/2024	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 is due to be submitted to CSS CBU to resolve the issue of current workload on Saturday and Sunday mornings, however this will not address the risk associated with being unable to provide clinical services to the wards which will require a separate business case. Work continues to help recruit too hard to fill posts, pipeline talent attraction and Recruitment and Retention premia principles being explored for the hard to recruit to posts.	[29/11/2024 10:17:21 Lisa Hansford] No further update [29/10/2024 10:16:49 Lisa Hansford] Weekend supply business case going to CRIG November. Case of need for ED pharmacy cover also going to November CRIG. Full business case still in development. [30/09/2024 13:37:45 Gemma Staples] Risk reviewed and remains the same. [05/09/2024 14:05:09 Lisa Hansford] No further update [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.	4	29/10/2021	28/04/2023	30/12/2024
1b. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5200	283	Physical or psychological harm	Rivett, Kate	Coghill, Piper	Children & Young Persons Oversight Group	Children & Young Persons Oversight Group	30/06/2023	8		Family Health	Children and Young Persons CBU	Paediatric Cardiology		As a result of a backlog Paediatric Cardiology clinic appointments patients are at risk of undiagnosed cardiac conditions, lack of follow up within appropriate timeframes and subsequent delay in treatment, which could lead to life limiting outcomes or death. RTT Target is 18 weeks, best practice is to be seen within 6-8 weeks to ensure the risk of life limiting conditions and death is significantly reduced and treatment can be undertaken when necessary by appropriate clinician.	-Manage clinics follow up and new patients based on demand with flexibility to swap between either based on waiting times and outcomes -Additional clinics at Boston and Lincoln -Escalated to ELT regarding waiting list -Cardiology meetings monthly with Leicester -Cancellation list in place to ensure clinic is filled and prioritise patients who are overdue and chasing an appointment	-Number of patients awaiting an appointment -Audits -Staff feedback -Next of kin feedback -Incidents -Complaints/PALS	27/11/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	-Continuing to support Paediatric Consultant undertaking PEC training to gain Cardiology experience -Ongoing discussions with ELT regarding plan to address clinic backlogs -Review undertaken by East Midlands Congenital Heart Services; awaiting outcome -Source space to facilitate ECHO clinics -Recruited additional Paediatrician at PHB, support being given to upskill to deliver Cardiology clinics	[27/11/2024 13:51:27 Nicola Cornish] Discussed at Risk Register Confirm & Challenge meeting on 27th November. Region-wide issue which executive team are fully sighted on. Approved increase in score to 4x4=16. [07/11/2024 09:51:37 Rachael Turner] Updated risk description due to external review by East Mids Congenital Heart Services - awaiting outcome of report. Risk score increased due to number of patients waiting appointments-risk to be presented at Risk Confirm and Challenge in November for increase in score [07/11/2024 09:33:20 Sarah Davy] Review undertaken by East Midlands Congenital Heart Services; awaiting outcome to review actions and risk score [07/11/2024 09:19:57 Sarah Davy] (current 60 ww for new appointments - 216 new referrals waiting; 1116 follow ups - 307 which are overdue). [09/09/2024 15:49:14 Nicola Cornish] No change, awaiting review feedback and also job planning. Need to look at other options for delivering clinics to make them more efficient eg overbooking, ad hoc extra clinics when funding available etc. [10/06/2024 15:28:01 Nicola Cornish] Need to review what the current backlog is. An independent external review of cardiology service was done last week, awaiting feedback. Recruitment ongoing for locum consultant post at Boston who will completed spin training in cardiology. Intention is to put additional clinics on to reduce backlog. ULHT also feed in to regional dashboard held by EMCHN as this is a regional issue. [09/04/2024 11:07:37 Nicola Cornish] A proposal is being developed to engage a short term locum cardiology consultant to help clear the backlog of patient review. A virtual case review is also being done for all patients on the waiting list to identify and remove any patients that no longer need to be seen. [10/01/2024 14:24:44 Nicola Cornish] For discussion at governance with view to downgrading [11/09/2023 15:58:53 Jasmine Kent] further risk assessment required regarding	8	30/06/2024	30/06/2025	27/02/2025
4c. Grow our research and innovation through education, learning and training	5160	56	Reputation	Dunderdale, Karen	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	19/09/2024	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	[19/09/2024 17:16:16 Rachael Turner] United Lincolnshire Hospitals NHS Trust has been awarded teaching hospital status as of September 2024. The Trust has started the roll out of adopting our new name of United Lincolnshire Teaching Hospitals NHS Trust (ULTH). [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		19/12/2024

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	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	Trust-wide	As a result of the Trust not being consistently compliant with NICE Quality Standards for PEOL and commissioning guidance for specialist palliative care (SPC) due to staffing resource there is a risk of lack of identification of palliative need, delays to assessment, patients not achieving preferred place of care/death across the Trust resulting in serious physical and psychological patient and family harm, with a poor patient experience of care and service. This could lead to Regulatory action.	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 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 Senior leadership for direct support to PEOL at ULHT by addition of deputy lead nurse for PEOL Workforce plan to identify gaps in alignment with national policy and guidance completed	Frequency of referrals outside SPC referral criteria Frequency of referrals that require more information for triage Datix incident / HPF's Complaints/concerns Frequency of patients died/discharged before seen Frequency of patients dying outside Preferred place of death Frequency of first assessment (over 24hrs) from service KPI's. SPC workforce review including staffing deficits and skills gap analysis Daily OPEL level Frequency of support needed by teams from SPC	27/11/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Business Case to be developed - Sarah Chester-Buckley Ongoing training for PEOL champions. Event planned - Jill Edwards - March 2025 Development of SPC SOP & business continuity plan - Jill Edwards - March 2025	[27/11/2024 16:55:04 Gemma Staples] business case in final draft and going through process for submission to CRIG. CSS looking at funding additional consultant (10 PA's). Long term CNS absence has increased delays and need for additional clinical support for Deputy Lead Nurse to cover. [19/08/2024 11:08:04 Gemma Staples] Business case continues to be developed. Developing standard for what current team can provide with available resources based on commissioning guidance and deficit to support prioritisation. Previous challenges continue and increased due to further staffing deficit. Risk managed with deputy lead nurse cover but this can only be sustained for a short period of time. Remains high risk. [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.	4	30/12/2024		27/02/2025
2a. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	4862	44	Service disruption	Mooney, Mrs Katy	Smith, Charles	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)	10/12/2024	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.	[10/12/2024 14:48:18 Rachael Turner] Business case has now been completed and submitted for investment for 25/26. No current change at this time. [12/09/2024 14:12:18 Rachael Turner] Workforce review is underway, however this is still fragile, likely to be a business case for workforce consultants in near future due to THLC (Targeted Lung Health Check). [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	4	30/12/2022	03/06/2024	10/03/2025
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5142	65	Physical or psychological harm	Thomson, Cheryl	Lentz, Blanche	Patient Safety Group		12/04/2023	20		Medicine	Urgent and Emergency Care CBU	Accident and Emergency	Trust-wide	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.	02/10/2024	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.	[03/10/2024 09:15:45 Rachael Turner] Risk reviewed, no change. [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	9	31/08/2023	01/11/2023	02/01/2025

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	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	12/12/2024	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.	[12/12/2024 14:49:24 Rachael Turner] As of Monday 9th December: •There are 266 CMR scans awaiting reporting • The oldest scan awaiting reporting is from 30.09.24 (70 days) With regard to current reporting 'performance', the number of reports per operator over the last week was: • Houghton 26 • Andrews 5 • Disbrow-Carpenter 2 (supervised reports) • Kylintireas 0 [30/09/2024 11:07:44 Rachael Turner] Current backlog has increased to 194 which were waiting to be reported. The oldest scan is from the 8th August. Business case is still going ahead. Currently waiting to see if we need to go through CRIG process. [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.	3	01/07/2024		12/03/2025
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	30/09/2024	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.	[30/09/2024 11:11:54 Rachael Turner] Delays occur due to waiting for diagnostic tests for ECG monitors to come through. Currently 17 waiting for 52 weeks and above. This continues to be monitored. [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	8	15/01/2025 01/03/2024		30/12/2024
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	02/09/2024	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.	[02/09/2024 11:20:05 Rachael Turner] Follow ups are improving for TIA and stroke. Patients are being reviewed virtually and from Friday we are including validation on Partial Booking Waiting List. 659 patients currently waiting this is split between stroke and TIA. [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	4	31/03/2022 29/12/2023		10/12/2024

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	5520	753	Physical or psychological harm	Landon, Caroline	Hunter, Sarah			11/10/2024	16		Medicine	Cardiovascular CBU	Stroke	Trust-wide	As a result of ULHT not having a Thrombectomy centre, we have to transport patients to Nottingham. There is a risk of transfer delays for patients with acute neurological presentation suspected to be a stroke having access to a designated thrombectomy centre for consideration of mechanical Thrombectomy. This could lead to more brain cell death, increase risk to life and ultimately poor functional outcomes/severe disability. On occasions delays have been so long the offer of intervention has been withdrawn.	Attempts to streamline pathway to hold crew bring patient to Lincoln for further transfer to Nottingham however not often successful due to pathway delays. [current acute pathway QI project] Escalating to operation centre as soon as Ambulance requested for transfer if original crew already stood down/handed over. Explored option of increasing category allocated to Stroke transfers [Currently CAT2] so far despite regional engagement Ambulance service unable to re-categorise.	Regional meetings - Integrated Stroke Delivery Network M&M meetings [local & regional] Datix incidents reported.	27/11/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Action 1. Continue to work to streamline pathway to avoid transfer delays. Consultant Stroke Practitioner & Stroke ACP lead responsible for streamlined internal pathway – current QI project till December [Code thrombolysis/Stroke] Action 2. Develop internal processes to escalate transfer delays more quickly. Stroke CBU/Acute team to liaise with Operations department for clear escalation process. Action 3. Ongoing communications/meetings with Ambulance service. Consultant stroke Practitioner liaising with ISDN & Ambulance service [Claire] ongoing Action 4. Look to the future to develop local thrombectomy centre to ensure fair access to emergency stroke treatments for the people of Lincolnshire, reducing long-term disability, dependence of health & social services, overall reducing the socio-economic burden of stroke. – Executive responsibility for service allocation?	[27/11/2024 13:02:18 Rachael Turner] Risk presented at Risk Register Confirm and Challenge 27/11/24. Risk validated 4x4:16 High Risk. [11/10/2024 12:34:10 Rachael Turner] Risk to be presented for validation at November Risk Register Confirm and Challenge meeting.	8	11/10/2025		27/02/2025
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	19/09/2024	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.	[19/09/2024 16:37:07 Rachael Turner] Work is continuing to commission the two new locations at Lincoln and also to locate a suitable location for a new development at Pilgrim. Work is also planned next year to develop new second rooms at Louth and Grantham as well as refresh the current spaces. Work is also ongoing to provide connectivity resilience from the new facilities on the Lincoln Site to provide connectivity from both rooms to the site edge distribution cabinets and also look at the power supplies in these cabinets. [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.	4	31/03/2023	31/03/2023	19/12/2024
4d. Enhanced data and digital capability	5245	19	Service disruption	Young, Jonathan	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.	19/09/2024	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.	[19/09/2024 16:39:50 Rachael Turner] This risk is linked to risk 575. In that we have commissioned the Rubrik product that manages our backup processes and also keeps an immutable copy in the cloud which allows restoration to anywhere. This system is being refined with Operations to prioritise systems into P1, P2,etc for DR instances and provide a plan for recovery if a complete or partial lose of infrastructure is felt. [14/08/2024 21:12:12 Rachael Turner] Work has been ongoing for a while to purchase and install a new backup and recovery tool. This is now in place and has been commissioned, it provides both on site and cloud capability and also immutable capability. This provides for a much more hardened and capable solution if ever required in anger. We are also able to preform full recovery testing. Work now continues with the Operations team to identify critical systems first to apply the solution to. [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		19/12/2024

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. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	4439	49	Service disruption	Low, Claire	Gates, Karen	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	1).Workforce plans & rota management procedures. 2).Temporary staffing arrangements. 3).Business Continuity Policy with associated procedures & guidelines. 4).Local service-specific business continuity plans & recovery procedures. 5).Executive oversight (Chief Operating Officer) through Emergency Planning Group.	1.Frequency of industrial action events. 2.Publicised staff polls / surveys by professional bodies on possible industrial action. 3. When there is industrial action we can monitor percentage rate of strike which will allow us to identify whether there is an increase.	04/12/2024	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.	[04/12/2024 11:28:29 Rachael Turner] This risk will be reviewed at the beginning of Jan, looking at the likelihood score and consider a presenting at Jan Risk Confirm and Challenge for a reduction in score, providing there has been no further notifications. [04/10/2024 11:52:48 Rachael Turner] As of Sept 24 the BMA Junior Doctors Committee accepted the Governments pay offer, this is expected to reduce the impact of strike action for this staff group. However, there remains a risk that other staff groups may take industrial action for this reason the risk remains at present. Risk score to remain at current level and will be regularly monitored. [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	4	31/03/2025	31/03/2023	08/01/2025
2a. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	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 5. A current development of the appraisal cycle is underway as a result of best practice learning from LCHS.	1. Compliance rates reported at Divisional and Trust level in a variety of forums monthly. 2. Turnover rates.	04/12/2024	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"	[04/12/2024 11:25:17 Rachael Turner] As of Quarter 3 there is an appraisal rate target of 85.58% and as a collective our Trust is 81.15% as of month 7 which is outside of target but within tolerance levels. Its agenda for change staff where improvements need to be made. We have continued focus through FPAM meetings and offers of support through People Directorate with a focus on targeted areas with the least compliance rates. This risk will be reviewed at the beginning of Jan to see if the risk is ready for a reduction in score. [04/10/2024 12:03:17 Rachael Turner] 1. Appraisal rate has improved within 24/25 we have seen a seven and half percent Trust wide improvement since March 24 and as of Quarter 2 of 24/25 are exceeding our trajectory. 2. Further improvement is required within the Agenda For Change staff groups, this is monitored through FPAM. Recommendation is to monitor risk score when we get to the end of Quarter three. If we continue to meet trajectory we will consider a reduction in risk score. [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	8	31/03/2025	31/03/2025	08/01/2025
3c. A modern, clean and fit for purpose environment across the Group	4725	466	Physical or psychological harm	Taylor, Ruth	Taylor, Ruth	Estates Investment and Environment Group	Health and Safety Group	13/01/2022	20	Risk assessments	Clinical Support Services	Therapies and Rehabilitation CBU	Rehabilitation	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.	04/11/2024	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.	[04/11/2024 11:02:36 Gemma Staples] We are currently looking at alternatives to the current establishment - we are being included in looking at the provision of outpatient off site. We are also looking at Therapy only options. [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	4	31/03/2022	31/03/2023	04/02/2025

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	5104	8	Regulatory compliance	Farquharson, Colin	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 undertook an unannounced inspection during October/November 2024. This visit centred on the Lincoln site which was mid-refurbishment. No significant concerns were identified from HTA inspectors. -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, although the Boston refurbishment has enabled the Titan unit at Boston to be no longer needed. -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	25/11/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Risk reduction plan to assure HTA during March 2023 that risk was controlled as a result of above mitigations in place to address their immediate 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. HTA unannounced on site inspection during October and November did not identify any significant concerns. Escalation of concerns to designated individual with respect to the Lincoln refurbishment process and security disparities in terms of alarm, CCTV and swipe card controls. Improvements made with alarm now fitted to Titan unit. CCTV repositioning has not been included in refurbishment plans Additional levels of swipe access not included as part of the refurbishment plans Refurbishment completion at Lincoln will result in this risk reducing in terms of likelihood	[25/11/2024 16:16:31 Gemma Staples] HTA undertook an unannounced inspection during October/November 2024. This visit centred on the Lincoln site which was mid-refurbishment. No significant concerns were identified from HTA inspectors. [22/08/2024 08:04:09 Gemma Staples] The HTA have recently confirmed to all Trusts about the greater powers of enforcement now granted which includes the ability to visit and inspect Trust's mortuary facilities unannounced. Plans are in place to review evidence required to ensure this would be available in such a situation and that this is of good quality. [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	20	31/03/2024	01/01/2025	25/02/2025
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5533	754	Physical or psychological harm	Mooney, Mrs Katy	Hunter, Sarah			07/11/2024	16		Medicine	Cardiovascular CBU	Stroke	Trust-wide	As a result of being unable to provide specialist assessment and investigation to people whom have had a suspected TIA within 24 hours [in line with guidelines] this may result in subsequent stroke due to a delay in intervention/treatment. Stroke may cause lifelong disability or death.	Reviewing patients as soon as we can in clinic and arranging investigations to coincide with clinic appointment [limited to imaging slots allocated per day] We convey ambulance referrals to have patients reviewed in ED by ACP team, if adequate space was provided for rapid TIA review there could be hospital avoidance [better patient experience/reduce cost and better patient flow]	Audit delays from referral to physical review in TIA clinic – Stroke Co-ordinator/service manager Recent data provided by Vascular team reports delays to carotid Doppler scans being performed, creating less benefit from surgical intervention which may result in no intervention being completed Datix review of hospital admissions with stroke symptoms post TIA clinic referral and not yet seen	27/11/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Allocate appropriate facilities for rapid TIA clinic – recommend similar set up to NOTTINGHAM or alternative – SOP attached. Area to assess patients perform clinic plus access to imaging [carotid dopplers & Head imaging in a timely manner- SDEC approach] Responsible divisional/service managers	[27/11/2024 13:11:28 Rachael Turner] Risk presented at Risk Confirm and Challenge 27/11/2024. Risk validated as 4x4:16. Risk controls and reduction plan to be strengthened with current position.	8	07/11/2025		27/02/2025
2a. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	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.	18/12/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Increase the workforce, investment into staff and education	[18/12/2024 11:06:27 Rachael Turner] Risk presented at Risk Register Confirm & Challenge 18/12/2024 this will be reduced following recruitment has taken place. Risk score to remain until established post. [26/11/2024 14:59:10 Rachael Turner] We have nearly come to an agreement with LCHS regarding a shared appointment. This is a now a low risk and may not require to be on the register. This risk will be presented at Risk Register Confirm and Challenge in December for a reduction in score. [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		18/03/2025

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. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	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. Oncology Consultants do not have capacity to review patients as required for their treatment which has a knock on effect on Pharmacy services. 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. The workload is also unmanageable for current staffing levels of Middle grade/ACP workforce therefore adding to the fragility of the Oncology Service. Currently unfunded for LCH OAU. SPA time not able to be adequately given	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 Support offered through on-call consultant, this is not adequate due to their workload.	Monitoring tumour site performance data Datix incidents Complaints and PALS Outcome from Staff Survey results Financial constraints of group	18/10/2024	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)	[18/10/2024 10:37:20 Gemma Staples] CoN written to be submitted on 31st October 2024 to ensure this is included in the planning round 2025/26. [23/09/2024 09:58:14 Gemma Staples] Following the CSS Confirm & Challenge meeting it was agreed to combine this risk with 5180. [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	4	31/03/2023	31/03/2023	17/01/2025
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5488	738	Physical or psychological harm	Rivett, Kate	Flatman, Deborah	Children & Young Persons Oversight Group		12/07/2024	16	Risk assessments	Family Health	Children and Young Persons CBU	Children's Community Services	Community	Patient safety risk from inadequate staffing Levels resulting in lack of capacity to safely manage the Children's Community Nursing Caseload. Potential for unrecognised deterioration due to lack of timely visits, increased hospital admissions due to inability to manage effectively in the community, plus increased length of stay due to inability to facilitate timely discharge into community. There is also a risk to staff health and wellbeing as a result of unmanageable workload.	Weekly Senior children's community nurse safety huddles to monitor staffing levels. Weekly CYP Senior Team huddle for escalation of situation Clinical governance reporting. Merged Boston CCN Patient caseload into Lincoln & Grantham CCN teams creating a North and South team due to lack of Boston Team Leader oversight & unsafe staffing > 75% CCN deficit. Approx 50 patients transferred to Grantham & 32 transferred to Lincoln. only 0.8wte Boston CCN available to Grantham. No Boston CCNs available to support Lincoln. Merger was to ensure Caseload oversight & review of Boston BCYP patients.	commenced submission of IR1s	30/10/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	CCNs from all x3 Teams regularly cross-cover and provide support to managing the county-wide caseload. There is UEC funding within the CCN budgets to recruit more CCNs	[30/10/2024 14:50:31 Nicola Cornish] Discussed at Risk Register Confirm & Challenge meeting on 30th October 2024. The updated risk description was approved with a score of 16. [28/08/2024 14:35:58 Nicola Cornish] Risk discussed at Risk Register Confirm & Challenge meeting on 28th August. Not approved - need to update the risk description to include more detail about the impact on patients to justify high risk score. NC to work with KR to update. [16/07/2024 13:57:49 Nicola Cornish] New risk discussed with Kate Rivett. Agreed that proposed scoring of 16 is appropriate and Kate will present this to Risk Register Confirm & Challenge meeting for approval.	6	31/01/2025		30/01/2025
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5306	713	Physical or psychological harm	Cooper, Mrs Anita	Rambani, Reena	Patient Safety Group		28/08/2024	20	Risk assessments	Clinical Support Services	Path Links (Pathology)	Microbiology (Pathology)		As a result of the inadequate resource of Microbiologists provided via the service contracted from NLAG, there is inadequate specialist input to ULH for complex cases or reviews on the correct use of high risk treatments used. This would lead to patient care being unsafe and can result in harm including death. It would also lead to extended hospital stays, readmissions, poor bed flow affecting access to Acute NHS care, increased morbidity and increases risk of antimicrobial resistance as a Public Health threat which harms our patients further. There are severe restrictions to prescribers accessing Microbiologist Specialist advice as it is now limited to Consultant level only that can access. This is resulting in patients being managed without the specialist required input, including for complex cases. Due to lack of Microbiologist capacity there is no pro-active input either in the form of Microbiologists undertaking regular ward rounds in high risk areas, no offer of call-backs, no Microbiologists delivering educational sessions, poor input in revising antimicrobial guidelines and no Microbiologist action on trends in a timely manner.	Currently being directed through Consultant Antimicrobial Pharmacist within own working hours and remit. Being flagged at various forums. Regular communication and reminders about availability of Antimicrobial team and guidelines and any resources available	Through antimicrobial consumption and surveillance Audit results Specialist time input from Antimicrobial Team Survey Pending Infection prevention & control surveillance and audits	18/10/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Trust to consider Antimicrobial Nurses - initiative put forward by ASSG and supported by MQG - as a matter of urgency Trust to review Microbiologist contracting - as a matter of urgency ASSG formally writing to clinical Directors (including ICB Medical Director) with this concern Antimicrobial Guidelines being revised to make them specific to ULHT rather than shared with NLAG as they are now.	[18/10/2024 13:44:29 Reena Rambani] The restriction to calls from "Consultants and GPs only" were lifted end of August when a new locum Consultant Microbiology, Dr Rashmi Dube joined the team as NHS locum for 6 months.The three substantive Consultant Microbiology posts have been advertised and closing date is 31st October.Also another new locum Consultant Microbiology, Dr Milind Khare, has joined the department this week. Having said that, the risk due to staff shortage continues in Microbiology department due to planned leave of multiple colleagues for the next few weeks [28/08/2024 14:11:06 Nicola Cornish] Risk discussed at Risk Register Confirm & Challenge meeting on 28th August. Risk description updated to reflect that Microbiology is a service contracted from NLAG. Agreed score of 16 (Severity 4, Likelihood 4). [15/07/2024 12:45:42 Gemma Staples] Risk reviewed and details amended. Risk 5305 is a Reputational risk scoring a 12 and this risk is regarding the Patient safety risk. Risk to be presented by Bal at RRC&C in August 2024 for approval. [13/06/2024 14:21:57 Gemma Staples] Risk reviewed and assigned to Pathology - Bal to present at the next RRC&C meeting.	4	30/11/2025	01/06/2025	17/01/2025
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.	10/10/2024	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.	[10/10/2024 10:10:14 Lisa Hansford] No further update [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.	4	30/09/2022	31/03/2023	10/01/2025

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	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.	11/09/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Recruit to vacant posts.	[11/09/2024 14:27:43 Nicola Cornish] Risk reviewed, no change. [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		11/12/2024
1b. Improve patient experience	5495	725	Physical or psychological harm	Grooby, Mrs Libby	Bond, Rachel	Maternity & Neonatal Oversight Group	Estates Infrastructure and Environment Group, Patient Experience Group	07/08/2024	16		Family Health	Women's Health and Breast CBU	Obstetrics	Lincoln County Hospital	Lack of adequate provision for appropriate clinical care of bereaved families within Obstetrics at Lincoln County Hospital. There is a risk of psychological harm due to hearing labouring women and crying babies, and having to share facilities with mothers and their new-borns.	Have allocated a room on labour ward to care for the women, which is not within the centre of the labour ward and has its own en-suite facilities. Women not to be moved to Nettleham ward at any point during their admission.	Incident reports PMRT reviews Patient complaints	09/12/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Specific bereavement facilities to be included as part of proposed redevelopment of labour ward - unknown timeframe.	[09/12/2024 14:36:27 Nicola Cornish] There are plans to move forward with changing one of the labour ward rooms into a designated area for bereaved families. Talks currently underway with specialist bereavement Midwife, inpatient Matron and HOM of how to move forward with this plan. [25/09/2024 13:22:59 Nicola Cornish] Discussed at RR Confirm & Challenge meeting on 25th September 2024. Panel queried scoring of 16 - Gemma Rayner explained that this issue is a common finding in every PRMT review at Lincoln whereas it is not found at Boston. Significant patient complaints regarding psychological harm - one patient described it as torture. Scoring of 16 approved. [07/08/2024 10:27:39 Nicola Cornish] Plan to enhance facilities in a designated room on labour ward to improve patient experience with current confinements.	4	07/08/2025		09/03/2025
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5515	737	Service disruption	Grooby, Mrs Libby	Sant, Manjusha	Maternity & Neonatal Oversight Group		25/09/2024	16		Family Health	Women's Health and Breast CBU	Obstetrics		Due to increasing demand for Elective Caesarean Section (El LSCS) exceeding the capacity of the current dedicated El LSCS lists, the maternity service is having to perform El LSCS outside of the planned pathways using both the emergency medical and theatre teams. As a result, there is a risk of severe harm or death to mother and baby should a second emergency arise whilst the second emergency team is performing an elective procedure. Currently there are dedicated El LSCS list on a Tuesday and Thursday morning at the Lincoln site and all day Wednesdays. On average Lincoln performs 2-3 El LSCS every day Monday - Friday. At Boston there are 4 on a Wednesday and 2 on a Friday.	Elective section activity is managed on a daily basis and cancellations made where required. Additional emergency team called in when required.	Any delayed, cancelled LSCS or when the 2nd theatre is opened are reported on Datix	30/10/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Exploring with theatres the ability to provide further El LSCS lists across both sites.	[30/10/2024 14:44:18 Nicola Cornish] Discussed at Risk Register Confirm & Challenge meeting on 30th October 2024. Panel approved the score but requested mitigations described are reflected in the Datix record. ULHT is not an outlier in terms of our EICS rate. [25/09/2024 13:24:51 Nicola Cornish] New risk agreed by Libby Grooby. To be added to agenda for October RRC&C meeting for approval.	2	30/09/2025		30/01/2025

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	4843	57	Physical or psychological harm	Landon, Caroline	Landon, Caroline	Patient Safety Group	Medicines Quality Group	19/01/2022	20	Risk assessments	Corporate	Operations	Operations		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	[02/09/2024 17:26:56 Gemma Staples] Risk agreed to sit under COO - now amended [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	4	01/10/2021	31/07/2023	09/10/2024
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.	09/12/2024	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.	[09/12/2024 10:11:00 Nicola Cornish] Risk reviewed by Emma Upjohn - no further progress, still awaiting trust board decision regarding refurbishment plans for the whole maternity unit at Pilgrim. [25/09/2024 13:09:11 Nicola Cornish] Discussed at RR Confirm & Challenge meeting on 25th September. Acknowledged the mitigations in place and requested that data on incident numbers/harm occurring is included in progress updates. [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		09/03/2025
3c. A modern, clean and fit for purpose environment across the Group	5272	455	Physical or psychological harm	Mooney, Mrs Katy	Miller, Mrs Sally	Estates Investment and Environment Group		06/10/2023	12		Medicine	Cardiovascular CBU	Cardiology	Lincoln County Hospital	Lincoln cardiac catheter lab is not connected to the emergency power supply at Lincoln County Hospital. There is currently emergency power to safely abort procedures, however without being connected to an uninterrupted power supply we could potentially be unable to offer a PPCI service (primary percutaneous cardiac intervention). There is a risk if any patient undergoing a procedure at a time of a power cut that loss of power could result in serious harm or death or possible implications around infection.	Temporary electrical fix via Estates-UPS-however there have been mechanical failures which has required Estates to manually to change it over. Estates had a third party assess the UPS switch-this needs to be re-wired but are currently awaiting a date for this to be carried out. Both of the Cath Labs will need re-wiring. Estates have stated they cannot provide power in the event of national grid power outage. Business Continuity Plan Cath Lab-short term power cut would look at utilising Thrombolysis. Prolonged power outage we would need to request mutual aid from those that offer PPI in neighbouring organisations.	Monthly audit internally (Cath Lab) Incidents of power outage raised on Datix.	02/12/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Job has been raised with Estates-this may be tied in with Lab replacement. Request to Estates to provide sufficient power to Cath Lab during a power outage has been made. Estates are currently working on solutions for this.	[02/12/2024 09:10:52 Rachael Turner] Both labs were tested this morning (29th November) simulating a power cut. Lab 2 worked as planned. During the simulated power cut screening was provided by the 3 phase UPS. When power was restored by estates lab2 reverted back to normal operation. In Lab1 the simulation was repeated. Cath lab 1 did not perform as expected. During the simulated power cut the machine did not switch over to the UPS as expected. The power supply was struck in what Siemens call emergency by-pass. This is the same situation that happened during the last proper power cut where the pacemaker case had to be stopped mid case. There is an automatic switch in the circuit that is supposed to detect a loss in power and then switch over to 3 phase UPS. It is our understanding is that it is this automatic switch that has caused the failure. We are currently waiting on estates to give a time when the work can be carried out. [27/11/2024 13:36:30 Rachael Turner] Risk presented at Risk Confirm and Challenge, risk validated for increase in score 4x4:16 High Risk. [13/11/2024 10:56:53 Rachael Turner] Incidents raised relating to this are: 23069 & 23237 [13/11/2024 10:26:28 Rachael Turner] Risk reviewed. Controls and risk reduction plan updated. There was recently an incident where a patient was on the table where a national grid power cut occurred. Although there was no harm caused to the patient there is an increased risk of infection due to the patient having to be re-opened to continue with the procedure. With these incidents increasing there is a increased risk of severe harm or death to patients. With previous mitigation	1	31/12/2023		02/03/2025

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
1c. Improve clinical outcomes	5154	88	Regulatory compliance	Simpson, Mr Andrew	Hansford, Lisa			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	10/10/2024	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.	[10/10/2024 10:14:02 Lisa Hansford] Awaiting packages to be uploaded to ESR [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	31/03/2025		10/01/2025
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.	22/10/2024	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.	[22/10/2024 09:20:44 Fiona Hobday] Still awaiting answer from Digital re money for resource. Move to national tenant has began- no SME to support. Project to procure scanning provider has started- no SME to support. EMDS project reaching contract award- no SME for any implementation. [10/09/2024 09:06:00 Fiona Hobday] Sept IGG- as part of risk review HofIG raised urgency for Trust to resolve RM SME resource due to key strategic projects. HofIG is currently supporting as much as possible- but is not current in field. Outstanding action for Digital to confirm funding in various project pots to inform discussion as to resource and where roles may sit. Final decision made re move to national 365 tenant adds to urgency to resolve this role. [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.	4	28/06/2024	31/03/2025	21/01/2025
3c. A modern, clean and fit for purpose environment across the Group	5136	10	Physical or psychological harm	Parkhill, Michael	Davies, Chris	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.	17/09/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	The issues identified with exposure levels are not unique to ULHT, as with most NHS Trusts investment is required to upgrade Ventilation to comply with HTM 03-01. NHSEI issued guidance on the 2nd March 2023 for NHS Trusts to follow. Noting where ventilation is insufficient, human factors are critical in reducing staff exposure, such as: 1. Providing clear instructions to patients on correct use of equipment being used, including exhaling into the rebreather mask or out through the mouthpiece 2. Staff positioning relative to exhaust N2O and the direction of ventilation flow 3. Turning gas and air off when not in use 4. Unplugging regulators from outlets when not in use 5. Monitoring the condition of equipment for leakages. These factors can't directly be influenced by Estates and require the support and influence of Clinical Leads and Occupational Health. ULHT Health and Safety Team have recently implemented software to assist with COSHH assessments and training. The Team provide support with the Health Safety Environmental and Welfare Operational Audit programme. Occupational Health have been directly	[17/09/2024 08:44:20 Rachael Turner] We continue to monitor Datix in regards with Occupational ill health. Zero Datix have been received around Nitrous Oxide [17/09/2024 08:43:11 Rachael Turner] The ventilation systems are still not functioning as expected, work with a consultant is currently in place and exploring alternative ventilation options. [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	10	28/03/2024		17/12/2024

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
1b. Improve patient experience	5234	510	Service disruption	Lynch, Diane	Biddulph, Victoria	Estates Investment and Environment Group		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.	29/11/2024	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.	[29/11/2024 14:16:09 Gemma Staples] Meeting was held on the 27/11/2024 with Family Health and the risks were discussed and Simon Hallion escalated to estates stating the urgency to get this resolved. Handler amended to Victoria Biddulph. [03/09/2024 12:06:05 Gemma Staples] This has been escalated to Estates asking for an update and a quote. Email sent on the 7 of august. [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		28/02/2025
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 The e-Outcomes Out-Patient clinic system has had an additional field added to record these required appointments which will be greater than 6 weeks.	Monitoring Ophthalmology PBWL Clinical harm reviews / reported incidents due to appointment delays	07/10/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Need to ensure future sustainability once recovered.	[08/10/2024 12:59:55 Nicola Cornish] 07/10/2024 - Leanne Chamberlain no changes [04/09/2024 16:16:00 Nicola Cornish] Discussed at Ophthalmology Governance meeting on 4th September. Agreed that scoring should increase to Very High. Recruitment to vacant posts within the establishment is ongoing and working with the ICB to review how stable glaucoma patients can be managed in the community to free up clinic capacity to review patients with higher clinical urgency. Explore options for holding extra clinics at the weekend if clinicians are willing to participate. Also need to review how existing clinics are utilised to enable trainees to see patients where appropriate. Review other strategies within each sub-specialty eg medical retina could switch to longer acting injections such as Eylea HD that require less frequent review, although this needs agreement with Pharmacy as it is not a pre-filled injection. [28/08/2024 13:38:12 Nicola Cornish] NC to work with LC to action this and present any changes to next meeting for approval. [28/08/2024 13:37:28 Nicola Cornish] Risk discussed at Risk Register Confirm & Challenge meeting on 28th August. Panel felt that scoring should be reconsidered as the likelihood appears to have increased due to the increase in patients on the PBWL. The mitigations in place also need to be described in more detail and risk reduction plan to include discussion with LCHS about what support they could provide. [27/08/2024 15:14:20 Nicola Cornish] There are currently 5000 patients on PBWL, which is a significant increase from 4000 patients when the risk was first raised, despite the mitigations in place. All patients on the PBWL are being reassessed and prioritised so they are seen in order of clinical need rather than date order. Further vacancies have cancelled out the additional capacity that had previously been created by engagement of a locum doctor to focus exclusively on the PBWL. Recruitment requires the job description to be agreed by Royal College of	4	31/07/2021	30/06/2022	07/01/2025
2a. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	5422	684	Service disruption	Costello, Mr Colin	Martinez, Francisca	Patient Safety Group	Medicines Quality Group	28/08/2024	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 Cancer Services CBU has discussed the timely prescribing of chemotherapy with their Oncology and Haematology consultants. All consultants aim to prescribe 48 hours ahead of dosing with chemo.	Near misses/incidents Staff health and wellbeing Staff concerns Delays on chemotherapy appointments Chemotherapy waste	29/11/2024	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 - completed	[18/12/2024 16:46:51 Gemma Staples] Risk is being monitored to see if Consultants are prescribing with the 48 hours notice and escalate if not. [18/12/2024 15:43:01 Gemma Staples] Cancer Services CBU has discussed the timely prescribing of chemotherapy with their Oncology and Haematology consultants. All consultants aim to prescribe 48 hours ahead of dosing with chemo. [29/11/2024 10:13:46 Lisa Hansford] No further update [28/08/2024 14:25:03 Nicola Cornish] Risk discussed at Risk Register Confirm & Challenge meeting on 28th August. Revised risk description relating to service description was approved. [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		28/02/2025

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. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	5093	40	Service disruption	Costello, Mr Colin	Baines, Andrew	Medicines Quality Group	Workforce Strategy Group	16/02/2023	20		Clinical Support Services	Pharmacy CBU	Pharmacy	Trust-wide	As a result of a long term sickness absence within the invoicing team and a capability issue within the purchasing team (therefore both teams are a staff member reduced) there is a risk that any further absence due to sickness or leave will mean the remaining staff member doesn't have the capacity to do the work of all 3 sites which would impact staff wellbeing and also impact drug ordering and invoice payment and there is a Trust target to pay invoices within 30 days with any further absence, we would not be able to meet this.	Band 7 covering the Band 3 gap when needed We have two members of staff who are trained and substantive part time staff but also able to provide bank support (though their availability to work is not guaranteed)	Staff Survey Staff Feedback Staff sickness Finance performance on invoice payment Workload	04/10/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	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 - Andrew Baines - July 2025	[04/10/2024 10:24:54 Gemma Staples] Recruitment recently completed for 0.8 WTE band 3 purchase clerk and 0.2 WTE band 3 purchase clerk maternity leave cover; 1.0 WTE band 3 purchase clerk currently on redeployment pathway following capability pathway – no longer working in the purchasing office. This means currently we have 2 purchasers actively working in the role Monday-Friday and so risk currently elevated if either of them is on leave or off sick. Recruitment to the third post will commence following outcome of redeployment. Band 7 senior procurement technician can backfill gaps in the short term. 0.64 WTE part time band 2 invoice clerk is on a long term sickness absence. This means we currently have 2 0.6 WTE part time invoice clerks actively working in the role and so risk currently elevated if either of them is on leave or off sick. Finance KPIs continue to be met at this time – continuing to monitor. [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.	4	16/02/2024	16/02/2024	03/01/2025
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	Emergency Planning Group, Health and 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.	05/12/2024	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	[05/12/2024 10:30:15 Nicola Cornish] Discussed at speciality governance meeting on 5th December. Still waiting for business case to be considered at CRIG. [29/10/2024 14:25:18 Nicola Cornish] The business case is still waiting approval. The secondment has been extended for a further 6 months. [29/10/2024 08:53:09 Nicola Cornish] Risk reviewed, no change. [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		05/03/2025
3c. A modern, clean and fit for purpose environment across the Group	4648	2	Physical or psychological harm	Landon, Caroline	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)	18/12/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	- 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	[18/12/2024 11:16:34 Rachael Turner] Risk presented at Risk Confirm and Challenge 18/12/2024, risk validated for reduction in score of 4x4:16 High Risk. [05/12/2024 12:49:00 Rachael Turner] Risk mitigation currently in place includes fire door mapping work is now complete. 22 new fire doors are currently being installed across the Trust. An additional 21 have been ordered and a further 74 doors are being sent out for costings with the intention to be installed within this financial year. We have a fire safety trainer to competently inspect all fire doors. An additional 6 estate joiners have also been allocated a course for fire door inspection. Capital works for compartmentation remedials and replacement across all three sites continues to make good progress with work being targeted on the basis of risk. Fire Warden numbers across the Trust continue to rise. Due to these mitigations risk proposed for a reduction in score to 4x4:16. [07/11/2024 12:44:43 Rachael Turner] Risk discussed at Fire Safety Group due to current mitigation in place request for risk to reduced to 4x4:16 High Risk. This risk will be presented at RRC&C meeting in December to validate reduction in score. [28/10/2024 11:25:19 Rachael Turner] Risk reviewed, no current change from previous update. Risk score remains. [17/09/2024 08:59:59 Rachael Turner] Work continues with capital based upon risk. Fire door mapping work is completed. Discussions are in place around maintenance on fire doors. [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.	10	31/03/2022	31/03/2025	18/03/2025

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	4646	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	27/11/2024	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.	[27/11/2024 12:16:28 Rachael Turner] NIV provision being reviewed with the implementation of a study day for staff in ED at band 6 and 7, this will be followed by a competence pack whereby staff will be required to set up 5 NIV and be signed off by staff on respiratory. The NIV in a non itu setting SOP is being reviewed to consider options for commencement of NIV in ED. There continues to be significant issues with failure to recognise type 2 respiratory failure in ED and refer patients. Education continues as part of the study day and relationship with ED. A daily communications in place with escalations whereby the ringfenced bed is not available for immediate action which is successful to ensure the pathway is not compromised. [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	4	30/09/2022	31/12/2024	27/02/2025
1c. Improve clinical outcomes	4866	87	Service disruption	Costello, Mr Colin	Saddick, Ahtisham	Workforce Strategy Group	Medicines Quality Group	01/03/2022	15	Risk assessments	Clinical Support Services	Pharmacy CBU	Pharmacy	Trust-wide	Recruitment of ULHT pharmacy technicians to ward-based clinical pharmacy roles affects the balance of the pharmacy workforce and impacts on the core pharmacy service provided	Pharmacy should be fully involved in the development and implementation of these roles. The Chief Pharmacist is accountable for the professional management of these roles, however there is not a clear understanding of the supervision and development framework for the new roles.	Monitoring of Pharmacy Technician performance	10/10/2024	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.	[10/10/2024 10:09:29 Lisa Hansford] No further update [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	10/01/2025
2a. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	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	18/12/2024	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	[18/12/2024 11:28:22 Rachael Turner] Risk presented to Risk Register Confirm and Challenge 18/12/2024. Until post filled this risk will remain at current level. [26/11/2024 15:03:32 Rachael Turner] Another locum consultant has been appointed to this position for the next year. This is now a low risk. This risk will be presented at December Risk Confirm and Challenge to validate reduction in score. [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		18/03/2025
2a. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	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	26/11/2024	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	[26/11/2024 15:06:27 Rachael Turner] Interviews are taking place in the next couple of weeks. This is still a risk until an appointment is made. [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		26/02/2025

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	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.	19/11/2024	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. The IPC action plan where areas identified	[19/11/2024 12:16:52 Rachael Turner] Risk action plan remains ongoing. Estates and capital are working towards replacement. A meeting is booked on the 9th December to discuss capital funding. A new ventilation safety group has been put together, chaired by head of estates. Audits and actions are being produced to find solutions for all ventilation issues. Validation reports are available for all critical plants. [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		19/02/2025
2a. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	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	26/11/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Increase the workforce, investment into staff and education	[26/11/2024 15:08:57 Rachael Turner] A meeting with Dermatology has taken place and this is no longer a risk in Dermatology. Further meetings are planned over the next few weeks with ENT and Ophthalmology [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		26/02/2025
1c. Improve clinical outcomes	4778	94	Physical or psychological harm	Mooney, Mrs Katy	Marsh, David	Patient Safety Group	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	03/12/2024	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	[03/12/2024 10:49:59 Rachael Turner] Nothing has changed other than working on contributing to uplift staffing linked to the Navenby stroke expansion, as part of a business case. [02/09/2024 11:21:16 Rachael Turner] Risk remains ongoing. No current change to risk score. [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	6	31/03/2025	28/02/2023	03/03/2025
3a. Deliver financially sustainable healthcare, making best use of resources	5389	559	Finances	Landon, Caroline	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.	19/12/2024	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.	[19/12/2024 13:05:31 Rachael Turner] There is currently no source of funding so Business Case cannot be heard. Finances are being looked currently looking at the overspend. Money is still left in staffing budget but this due to current staff not being yet at the top of their band. [17/09/2024 10:24:21 Rachael Turner] Risk remains with no change at present. [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		19/03/2025

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
4d. Enhanced data and digital capability	5519	739	Physical or psychological harm	Humber, Michael	Evans, Thomas	Digital Hospital Group	Clinical Effectiveness Group	02/08/2023	12		Corporate	Finance and Digital	Digital Services (ICT)	Trust-wide	As a result of the lack of an established Digital Clinical Risk Management system (Health IT system), processes and resource resulting in non-compliance with the Digital Clinical Safety Standards DCB0129 and DCB0160 (the Standards mandated by NHSE to ensure the safe manufacture, development, deployment, and use of Health IT Systems) this could lead to patient safety incidents involving digital systems, resulting in or contributing to patient harm or death. An informal 'best endeavours' approach has previously been taken and digital clinical systems have been deployed that have not fully met the Standards. The Standards also mandate an approach to Clinical Risk Management which continues for the entire lifecycle of the Health IT system, not just prior to initial deployment. Under the standards, the CRMS must have proactive and reactive elements to effectively manage post deployment patient safety concerns / incidents and this element has also previously not existed within at the Trust in any formal way with a lack of formal governance and assurance for clinical safety.	•Previously no defined lead for digital clinical safety established in the Trust. The CNIO has voluntarily taken the lead on Digital Clinical Safety (Trained CSO) within their substantive role, although clinical safety responsibility not outlined in job description / role and responsibilities. However, no resource for non-project/non funded DCSO work = risk •Digital Clinical Safety Officer (DCSO) post recruited into May 2024, as part of EPR programme (not revenue funded = risk). 1 further DCSO post has been included in the resource model for EPR implementation (>2025 funding) however, given the large volume of current in-flight Health IT System projects and legacy systems outside of EPR, this is not an adequate resource. •Digital Clinical Safety Policy now in the organisation (approved at DHG and Corp Gov – awaiting publication on the intranet) •Draft Clinical Risk Management System developed by new DCSO and awaiting Clinical Governance review before formal approval at DHG •Further development of required structures and governance standards to meet/comply with National standards and strengthen our position underway. •Digital Clinical Safety processes / awareness will require significant 'socialisation' to ensure they are effectively embedded. This will include clinical safety training for clinical / digital / operational colleagues as appropriate to their role.	•Number of digital systems without full compliance with the Standards i.e Clinical Risk Management File, Clinical Risk Management Plan, Clinical Safety Case Report, Hazard Logs etc. •Lack of digital clinical safety resource and no policy or standard within the Trust prior to recently created and published policy. •Known new and upcoming digital projects are tracked, and activities aligned to new policy and the National standards. •Previous deployments will require review and a post deployment safety assessment and remain subject to further clinical safety activities under the National standards and guidance	30/10/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Action 1. Develop and strengthen Digital Clinical Safety Function - will require funding for permanent staff including administrative resource to administer / manage the CRMS. Action 2. Continue to work towards meeting the National standards, all new projects will have the Digital Clinical Safety Standards applied. Action 3. Further development of the new CRMS, embedding of associated processes and improved digital clinical safety literacy among digital, clinical, and operational teams. Action 4. Review of previous projects and live systems, deployed under previous arrangements to ensure a clinical safety review is applied under the new standards. Action 5. Ensure effective application of Digital Clinical Risk Management activities through regular audits	[30/10/2024 13:44:35 Rachael Turner] Risk presented at RRC&C meeting 30/10/2024. Risk validated at 4x4:16 High Risk score.	12	08/10/2025		30/01/2025
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	Estates Investment and Environment Group	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, following completion of refurbishment at Boston. Access is via a locked gated yard.	The frequency and extended use of the temporary body store at Lincoln has increased the risk.	25/11/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Significant progress has been made in reducing identified security gaps, but risk remains. Assess security vulnerability (on the back of recent incident at NLAG/DPoW) with NLAG/ULHT/Police review of security (Meeting held during July to understand findings and discuss next steps. Actions in response need to be agreed, to be tabled at HTA Governance meeting)	[25/11/2024 16:11:34 Gemma Staples] Boston Temporary Body store is not currently in use, following completion of refurbishment at Boston. Access is via a locked gated yard. Meeting held in July with NLAG/ULHT/Police review of security to understand findings and discuss next steps. Actions in response have been discussed at the HTA Governance Meeting and the recommendations made in the report have been ratified by the group. The HTA DI will progress this with facilities and security teams. [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.	6	02/08/2024	01/01/2025	25/02/2025
2a. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	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	26/11/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Increase the workforce, investment into staff and education	[26/11/2024 15:13:38 Rachael Turner] There are barriers within the Business Unit in terms of the JD/funding for the Specialty Teaching Fellow, which is delaying the appointment to this post. This should be a joint risk which sits with the Business Unit as we are unable to move forwards with this from an undergraduate perspective. [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	26/02/2025

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	5403	712	Regulatory compliance	Cooper, Mrs Anita	Cragg, James	Estates Investment and Environment Group		28/08/2024	15		Clinical Support Services	Path Links (Pathology)	Microbiology (Pathology)	Pilgrim Hospital, Boston	As a result of the breakdown of the Microbiology Class A Waste Autoclave (since 11 December 2023) the Trust does not meet HSE Regulatory Compliance (this stipulates that Category A and B wastes are inactivated on-site before final disposal because they may contain high concentrations of biological agents and pose an increased risk of exposure) which could lead to financial penalties to the Trust. As a result, the current failure has led to business continuity plan enactment which necessitates diversion of this work to Scunthorpe which causes a direct impact on patient care. This is affecting ULHT / NLAG and 81 ICB Surgeries and patient flow as patients are waiting longer for a diagnosis which could have a negative impact on their outcome In addition; without the ability to inactivate Category B waste onsite via the autoclave at Boston, waste is going out in a higher category stream at increased cost to the Trust. We are sending approximately 250 lower respiratory samples (sputum, bronchial lavage and pleural fluid) to Scunthorpe each week. Half of these samples will be subject to a 24 hour delay in the reporting of culture findings. Due the additional pressure on the Scunthorpe laboratory, they have needed to redistribute work to ourselves to compensate. This comprises of approximately 250 bacteriology swab samples (throat swabs, ear swabs, eye swabs and wound swabs) sent to Boston each week. These samples are also subject to a 24 hour delay in the reporting of culture findings. So, in summary, we can state that approximately 125 lower respiratory samples and 250 bacteriology swabs per week are subjected to delayed reporting by 24 hours. This has a considerable clinical impact as there is a delay to clinicians receiving reports that may (a) instigate a course of antibiotic treatment, (b) modify a course of antibiotic treatment, (c) allow for the cessation of a course of antibiotic treatment. This is likely to increase length of stay, contribute to poorer outcomes for patients in general and increase infection prevention issues (as there will be delayed diagnoses of such things as multiply resistant bacterial infections and pulmonary tuberculosis).	Ceased processing of respiratory samples as the Trust have no method of making waste from these tests safe prior to disposal. Business Continuity Plan diversion of this work to Scunthorpe Using Taxis but this is incurring a cost to ULHT Staff working additional hours at Scunthorpe Two units were moved to Boston from Lincoln as part of the transfer of microbiology service in 2009, one of the units failed and has been out of use for 10+ years. The second unit has been supported by E&F onsite at Boston with LTE servicing and repairing when required.	Audit KPI's Datix Incidents Complaints / PALS	29/11/2024	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Specification to be completed and sent to E&F – James Cragg/Michael Jewsbury to submit by 30/07/2024 BCP to be reviewed – James Cragg/Michael Jewsbury reviewed 30/07/2024 LEBBS – Lincolnshire Charity Bikes to be contacted regarding Monday to Friday support - James Cragg - Pending response 02/08/24-06/08/24 Apply for derogation once specification / plan is in place – James Cragg and Michael Jewsbury - 16/08/2024 Purchase and installation of new Autoclave Unit - Chris Davies - 30/01/2025	[29/11/2024 16:15:24 Gemma Staples] Derogation application pending ULHT security team site plan and risk assessment for work around. ULHT team confirmed purchase and installation of a replacement today after E&F approval, spec confirmed pending . [28/08/2024 14:13:41 Rachael Turner] Risk presented at RRC&C meeting 28/08/2024. Risk validated at a 5x3: 15 High Risk. [19/08/2024 10:12:54 Gemma Staples] Update from James Cragg: Working through Derogation application, met with ULHT team actions below: Meeting Andy Miles/Keiron Davey/Joseph Pearson apologies. Action Email ULHT DGSA for consulation/report, Updated H&S Risk assessment for waste derogation, Porters training, Pathology staff training, Keiron advised Threat risk assessment - Gareth Holder - storage of waste below removal. Site visits organised for W/C 19/08/2024, two suppliers attending. [06/08/2024 12:02:09 Gemma Staples] Update: Discussions taken place with E&F to look at alternative options. Quoted £50k for 3 years for a van to go to Scunthorpe and back. LEBS - Lincolnshire Charity Bikes Lead contacted and is going to respond with what actions they can support with our request for additional support Monday - Friday. Antenatal department is potentially looking at a case in ULHT Charitable funds as although LEBS is a charity there are costs associated with this so some funds from NLAG & ULH Charitable funds may be a way to do this. [29/05/2024 13:47:47 Gemma Staples] No attendance to present so deferred to June RRC&C meeting [02/05/2024 10:41:24 Gemma Staples] Additional information has been added to the risk detail and this will go to May RRC&C meeting for approval.	6	13/03/2025		28/02/2025
4d. Enhanced data and digital capability	5161	62	Physical or psychological harm	Rivett, Kate	Flatman, Deborah	Medical Records Group		23/04/2023	20		Family Health	Children and Young Persons CBU	Children's Community Services	Community	Quality and safety risk from non-integrated paper records.	Community matron, Team Leaders and service leads aware of the risks. Risk escalated to senior management team Meeting held with Digital Transformation Leads	To complete IR1 reports	15/10/2024	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	1) CCNS to have access to SystemOne	[15/10/2024 13:38:13 Nicola Cornish] Implementation of SystmOne is still anticipated in November 2024. [16/07/2024 15:32:52 Nicola Cornish] Work ongoing to implement System One, go live date now planned for Autumn. [16/04/2024 14:07:55 Nicola Cornish] The move to System One is anticipated to take place in June this year, work commenced to facilitate this. [31/01/2024 12:12:29 Rachael Turner] Risk discussed as a part of Deep Dive at RRC&C meeting 31/01/2024. Risk reviewed, funding has been secured. Absence on Datix reported. Risk score updated: 4x2: 8 Moderate risk. [17/01/2024 12:56:17 Nicola Cornish] No progress with SystmOne, This has been escalated to Director of Safeguarding and COO to expedite. Initial timescale given of 6 months is not acceptable, need to progress quicker. [21/11/2023 13:35:58 Kate Rivett] 21/11/23 - KR 1. Reviewed at monthly Risk Register Review meeting; 2. Meeting held between representatives from ULHT, LCHS (local hosts for SystmOne) and ICB; 3. LCHS unable to commit to supporting team with SystmOne access at the moment due to capacity constraints. ULHT would also need to provide funding to enable delivery of SystmOne to the organisation; 4. Meeting to be scheduled between TV (Lincs ICB) and SH (Divisional MD) to discuss possible options. [17/10/2023 14:25:52 Nicola Cornish] Met with Digital transformation team, 3 options considered but SystemOne is the only viable option and some colleagues are already using this system. [18/07/2023 13:25:46 Jasmine Kent] As we move to increase CCN team and deliver an on call service, the absence of an integrated electronic record system is going to post a larger risk, staff will be asked to provide opinion on children they	6	30/04/2024		15/01/2025
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.	17/09/2024	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.	[17/09/2024 08:35:28 Rachael Turner] We are still trying to identifying appropriate funding for this survey but are still awaiting feedback. Risk score remains the same. [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 243m³/243,000L, This is potable quality water & will supply the hospital for approx. 20 hours. [21/10/2022 09:06:00 Walter Thompson] Scheme for replacement of critical water tanks - Pilgrim HB- is being developed for the capital plan 22/23 Scheme of work and design currently being produced.	5	30/10/2020	31/03/2023	17/12/2024

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. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	5381	560	Service disruption	Landon, Caroline	Hodgkins, Mr James			09/02/2024	15	Risk assessments	Corporate	Operations	Operations		Discharge Lounge (DL) has insufficient substantive workforce to meet current service demands. Significant RN and HCSW WTE shortfall. No B7 manager in place. B6 jnr sister post is unfunded secondment. No ward clerk. Insufficient housekeeping hours. This means that DL cannot staff each shift witihin budget and relys on temporary workforce and inpatient ward support. RNs and HCSWs act as ward clerk and Housekeeper. The risks are:- service is not well led on every shift contributing to delays, failed discharges, reduced patient capacity and turnover, reduced patient flow impacting on front door, omissions in care, omissions in documentation, errors, patient safety incidents, poor staff wellbeing, Poor patient notes and careflow management, poor patient experience. Improvement to practice very challenged to implement due to temporary staffing. Unable to function within current budget. Reputational damage. Inability to meet CQC requirement from 2021 audit.	Each shift has substantive, bank or ward swap nurse in charge. Staffing issues on the day managed by ops matron. Shifts go to bank and then to agency. Dynamic risk assessment; capping capacity or refusing complex patients. Strategic on call sign off required to close discharge lounge due to staffing. Orientation of temporary staff; Induction materials. Iimited 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
1c. Improve clinical outcomes	4840	329	Physical or psychological harm	Costello, Mr Colin	Baines, Andrew	Medicines Quality Group		19/01/2022	15	Risk assessments	Clinical Support Services	Pharmacy CBU	Pharmacy	Trust-wide	As a result of National shortages of medications there is a risk that there will be a potential impact on patient treatment unless we can source suitable alternatives which may include unlicensed imports (this is licensed in the country of origin but not UK licensed). The shortages can impact multiple wards / divisions. Use of unlicensed products is associated with an increased administrative burden for Pharmacy and Clinicians. There is a risk within unlicensed products where not labelled in English so Pharmacy manage an over labelling process.	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) - Purchasing for Safety - Unlicensed Medicines Policy Medicines Shortage Notification (MSN) tracker completed regularly assessing each medication - (This goes to the MQG and is attached to the risk)	Monitoring medication stock levels / reported shortages Shortage tracker	29/11/2024	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Continue to monitor and assess medication shortages and alternatives – Andrew Baines - Ongoing	[29/11/2024 10:11:09 Lisa Hansford] No further update [28/08/2024 13:58:20 Rachael Turner] Risk presented at RRC&C meeting August 2024. There are no concerns of the quality and safety of the drugs. Due to the complexity of this risk it has been requested to develop an Overarching Medication risk for the Trust and then Pharmacy to provide individual risk assessments for each drug. Governance to support. Following this we can agree the risk score. Risk to remain open at current score until this risk is developed. [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-	6	01/12/2021	31/05/2023	28/02/2025
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.	24/10/2024	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.	[24/10/2024 15:12:06 Nicola Cornish] Risk reviewed, no change. [25/09/2024 13:13:56 Nicola Cornish] Discussed at RR Confirm & Challenge meeting on 25th September 2024. Risk severity was scored as 5 when initially added but ward has since relocated and some issues addressed so consideration to be given to reducing this to 4. Bring back to next meeting for approval. [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.	6	31/03/2025	31/03/2025	24/01/2025

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. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	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.	04/11/2024	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 - Ruth Taylor Lead to all above with completion dates as March 2025	[04/11/2024 11:14:51 Gemma Staples] Risk reviewed and remains the same [20/08/2024 09:21:14 Gemma Staples] Risk reviewed and will be reviewing progress monthly as is part of our workstream plan. [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,	9	30/09/2023	18/12/2023	04/02/2025
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5196	309	Regulatory compliance	Costello, Mr Colin	Hansford, Lisa	Medicines Quality Group		20/06/2023	15		Clinical Support Services	Pharmacy CBU	Pharmacy		As a result of regular audits not being completed, the standards for medicines storage are likely to fall below the required standards. Medicines storage and temperature monitoring was raised by CQC during the last inspection, as 'must do' actions. Some of these audits have legal implications such as the controlled drugs audits and safe and secure medicines storage. As we have had the same 'must do' action since 2018 with no improvement, there is possibility without full assurance they could impose improvement notices. Due to a shortage in staffing, Pharmacy department are unable to complete the annual medicines management and temperature monitoring audits for all clinical areas that store medication. The organisation is required to be compliant with both the RPS Guidance for the safe and secure handling of medicines and the Health Building Note (HBN 14-02).	The matrons and quality matrons complete ward assurance audits that include some medicines management questions.	Review of incomplete audits, highlights that there are ongoing issues with timely completion of medicines management audits due to the lack available staff to complete these. Datix incidents reported indicate ongoing issues with medicines management.	06/12/2024	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Business Case to be completed to improve Pharmacy staffing - Ahtisham Saddick - September 2025	[06/12/2024 17:41:52 Lisa Hansford] No further update [04/09/2024 14:09:01 Gemma Staples] Lisa Hansford reviewed the risk and updated details and felt the risk should stay as a 5x3. [21/08/2024 16:34:29 Gemma Staples] A request for a decrease to go to September RRC&C meeting from a 5x3 to a 4x2 [10/07/2024 11:21:47 Lisa Hansford] no further update [04/04/2024 09:05:12 Lisa Hansford] No further update, still not in a position to be able to complete the safe and secure medicines storage audits due to staffing. [29/12/2023 12:55:51 Lisa Hansford] No further update [26/09/2023 14:53:17 Rachel Thackray] No further update [07/09/2023 14:10:05 Lisa Hansford] 7.9.23 no further update	4	20/06/2024		06/03/2025
2a. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	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	11/09/2024	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Review of current recruitment strategy. Advertisement for vacant posts.	[11/09/2024 14:26:31 Nicola Cornish] Risk reviewed, no change. [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,	6	30/06/2021	30/09/2022	11/12/2024

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	4830	11	Service disruption	Cooper, Mrs Anita	Myers, Joseph	Estates Investment and Environment Group	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	10/10/2024	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	[10/10/2024 09:55:21 Lisa Hansford] further leak 07.10.24 – we have had to switch off lighting to an area of pharmacy. Thankfully leak started whilst we were on site otherwise could have destroyed lots of stock, including some on shortage list (KCl) – minimal loss due to quick response: [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	10/01/2025
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5169	60	Physical or psychological harm	Mooney, Mrs Katy	Hunter, Sarah	Patient Safety Group		09/05/2023	15	Risk assessments	Clinical Support Services	Therapies and Rehabilitation CBU		Lincoln County Hospital	Approx 15-20 Stroke outliers at any time on the LCH site. Therefore not on the stroke unit and not receiving specialist stroke therapy at the frequency and duration required by SSNAP. Outlier patients are not cohorted on site and can be on any ward therefore Stroke staff cannot go and review and advise. Stroke patient on other non stroke ward will not be assessed as a priority as they are not medically optimised and ready for discharge. Current staffing levels are for the 28 bedded Stroke unit only. If a stroke patient is seen o a non stroke ward this is to the detriment of another patient on that ward. Increased staff 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	04/11/2024	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	[04/11/2024 13:21:24 Gemma Staples] We have been working with finance to look at the uplift of staffing against the current staffing guidelines as part of a wider business case linked to the Stroke Estates. [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.	8	13/05/2024		04/02/2025
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.	04/11/2024	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.	[04/11/2024 11:04:16 Gemma Staples] We have been working with finance to look at the uplift of staffing against the current staffing guidelines as part of a wider business case linked to the Stroke Estates. [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	04/02/2025

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	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	08/10/2024	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Estates job logged to see if can increase air exchange to 10 - Stuart Whitehead - December 2024 Wider organisational piece of work - Karen Bailey - December 2024	[08/10/2024 10:11:18 Gemma Staples] Venesections can remain, we have moved BM biopsies out, urgent is undertaken with risk assessment, still awaiting works to make the room right. [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	08/01/2025
2a. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	5439	714	Service disruption	Costello, Mr Colin	Saddick, Ahtisham	Workforce Strategy Group		14/05/2024	20		Clinical Support Services	Pharmacy CBU	Pharmacy	Trust-wide	As a result of weekend workload (dispensing and checking of medication) exceeds staffing capacity on all sites, which leads to colleagues staying late and workplace stress. This results in serious and long-term effects on staff health and wellbeing. The Working Time Regulations (1998) state that breaks are mandatory but under current working structures, the weekend team are staying late to complete the workload. Therefore the Trusts is failing to comply with the legal requirements of rest periods as the weekend team feel undertaking breaks will compound on late finishes. A key improvement theme from the pharmacy staff survey identifies service resilience and quality- It is felt that weekend understaffing and negativity is leading to stress, burnout, dissatisfaction and low morale. There is the possibility that goodwill of staff will cease therefore the weekend dispensary team will finish on time and not stay late. The consequence is the workload will become unsafe for one on-call pharmacist. Without adequate staffing, the wellbeing of the pharmacy team would be compromised, as they will continue to work extended hours without breaks. This situation poses a high risk in terms of patient safety as errors occur due to fatigue. Additionally, regulatory compliance issues with the Care Quality Commission (CQC) would arise, further jeopardising the quality-of-service delivery.	Staff working voluntary overtime to complete workload Case of need and Business case developed and approved at CSS Business meeting	Late finishes (data from healthroaster and time sheets) Items dispensed on a weekend - workload Near misses/error recording systems Staff surveys discussing welling Staff concerns regarding lack of breaks / late finishes Staff sickness	29/11/2024	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Case of need and Business Case to seek approval from CRIG - Ahtisham Saddick - November 2024 A proposal is being developed which will review workforce allocation and suggest a new way of working on the weekends. This will discuss an increase in staffing resource and will form the basis of the CoN/BC – Ahtisham Saddick – End of July 2025	[29/11/2024 10:09:34 Lisa Hansford] Case of need and Business Case to seek approval from CRIG - Ahtisham Saddick - November 2024 A proposal is being developed which will review workforce allocation and suggest a new way of working on the weekends. This will discuss an increase in staffing resource and will form the basis of the CoN/BC – [28/08/2024 14:20:51 Nicola Cornish] Risk discussed at Risk Register Confirm & Challenge meeting on 28th August. Likelihood score of 5 agreed because it is happening every weekend but severity approved at 3. Case of need timescale needs to be amended as this is already written. [29/07/2024 12:13:26 Gemma Staples] The pharmacy service currently operates as a half a day service on the weekend, this is not a service which has been separately funded. Five-day cover was expanded with existing staffing resource to include an additional two half days for Lincoln and Pilgrim sites and one additional half a day for Grantham; this has created further clinical cover gaps during the working week. [29/05/2024 12:44:11 Nicola Cornish] Discussed at RRC&C meeting on 29/05/24 - not approved, need to articulate the mitigations and risk reduction plans more fully, also need to review scoring to consider the level of harm to staff and how often it is happening at this level. Look at whether there is any incident data to demonstrate patient harm that would support a Very High score.	3	14/05/2025	31/07/2025	28/02/2025

NHS
Lincolnshire Community and Hospitals NHS Group

Board Assurance Framework 2024/25

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Teaching Hospitals NHS Trust

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*7 January 2025*
Item Number	*14.2*

Lincolnshire Community and Hospitals Group Board Assurance Framework 2024/25

Accountable Director	*Professor Karen Dunderdale, Group Chief Executive*
Presented by	*Jayne Warner, Group Director of Corporate Affairs*
Author(s)	*Karen Willey, Deputy Trust Secretary, ULTH*
Recommendations/ Decision Required	*The Board is asked to:-* • *Consider the Board Assurance Framework for 2024-25* • *Confirm the proposed RED rating of objective 3a – Deliver financially sustainable healthcare, making the best use of resources (ULTH)* *Confirm the proposed AMBER rating of objective 3g – Reducing unwarranted variation in community service delivery and ensure we meet all constitutional standards (LCHS)*

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	*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 (ULTH)	*X*
3f Reducing unwarranted variation in planned service delivery and ensure we meet all constitutional standards (ULTH)	*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	X
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

Executive Summary

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 November and December with the exception of the Audit Committee.

Monthly review and update of the BAF is being undertaken routinely which will enable the Committees to consider the content and assurance ratings with bi-monthly reporting to the Board. Reporting to the Audit Committee in Common will continue on a quarterly basis.

Following review through the Committees, the November Finance Committee proposed that objective 3a – Deliver financially sustainable healthcare, making the best use of resources be rated as red from amber. The December Finance Committee proposed that objective 3g – Reducing unwarranted variation in community service delivery and ensure we meet all constitutional standards (LCHS)be rated amber from red.

The Board is asked to confirm the ratings.

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 Committee
Services - To ensure services are sustainable, supported by technology and delivered from an improved estate	Finance Committee / Integration 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	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	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 Teaching 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				Skin Integrity Group (SIG) established as a sub group of the Patient Safety Group to provide oversight, monitoring and accountability of the ongoing improvement work around prevention of pressure ulcers and the wider skin integrity programme of work. Skin Integrity management policies, procedures and pathways in place.	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 and 4 incidents is expected and has been observed.	Weekly Pressure Ulcer Assurance meetings with the community nursing teams with safeguarding support. Thematic review of all Category 3 and 4 incidents completed monthly and presented into QSG and SIG.	Skin Integrity care is reviewed in the weekly ward/service leader's assurance and monthly Matrons audits for CoHo and CoNu. The monthly Quality Metrics review meeting monitors ward and services performance relating to skin integrity. 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. Skin Integrity incidents are analysed to identify themes and trends which are reported through SIG and improvement actions identified. Overarching action plan for incidents, themes and improvement actions is in place and monitored through Skin Integrity Group	Work progressing on live data stream identifying all current pressure ulcer in the community. Requirement to triangulate oversight for complex wound with increase specialist support and confirm and challenge process.	Continued Observation of Section 42 incidents across community services. Initial reduction in number of Safeguarding referrals relating to pressure ulcers being monitored	Quality Committee	G G G G 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	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	395 495 681 403 714 695 715									
			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																						
								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. Funding identified for new B7 Patient Experience Manager for LCHS. This is the sole establishment and Patient Experience now a Group managed model. 8. Complaints, Patient Advice and Liaison (PALS), and Claims Team. Data now included within SUPERB dashboard. 9. System Communications and Engagement Team 10. Volunteering Services Team. Voluntary Services now a Group managed model.	1. System Engagement Team not currently in place and timeline not confirmed. 2. Data - not connected Datix/ Business Intelligence/ System 1 Head of Patient Experience & Patient Experience Data Insight Manager need LCHS systems access. Group approach to Patient Panel explored & agreed separate ULHT & LCHS Patient Panels that come together 1/4rly. Draft ToR and plan prepared with aim to commence recruitment in Jan 25 and launch April 25.	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. PEIG Task & Finish Group established to lead Group modelling, planning and working.	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 3.3 LCHG plan in development that will include ULHT priorities, LCHS priorities and collaborative priorities. Self assessment completed by PEIG Task & Finish Group. Timetable is for this to be approved at Feb 24 PEIG and QGC for		New template for divisional assurance reports developed and scheduled reports received at PEIG. SUPERB now includes LCHS data, monthly reports and infographics received at PEIG and circulated. To identify service level champions / leads to work in partnership with Patient Experience Team.	Quality Committee												

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		a Group managed model. 11. Triumvirate weekly complaints, incidents and claims reviews 12. Divisional monthly operational plan reporting. Divisions have now commenced Patient Experience Group meetings. 13. Quality Assurance Groups Secondary: 1. LCHG Patient Experience & Involvement Group (PEIG) 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 Aiming to promote Care Opinion as a source. Data now included within SUPERB dashboard 7. Volunteering placement evaluations/ take up of opportunities 8. Complaints and Claims benchmarking data 9. Friends and Family Test data. New tender exercise across LCHS, ULTH, LPFT commenced. Current contract extended by 6 months			PERG and QSC for launch April 25.						G	A	A	A	A	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				Weekly assurance within Community hospitals with monthly overnight. Monthly oversight commenced in community nursing	Monthly senior review in CoHo with developing weekly review in CoNu. Defined therapy assurance and assurance for specialist services.	Quality team support and leadership in building programme	Monthly assurance meetings overseeing divisional performance and quality improvement plans	Increased senior assurance in Coho and other services where model not yet built	Bi monthly quality assurance oversight aiding continued development of the model and harm free care certification building accreditation process	Quality Committee			G	G	G	G	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																				
			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																				

1d	Deliver clinically led integrated services	Group Chief Nurse/Group Chief Medical Officer	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										Integration Committee																
			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																														
2a	Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	Group Chief People Officer	1. 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 (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	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	Sub-Group meetings within the People Directorate are not yet in place	As of Quarter 3 within 2024/25 there will be a new: 1) LCHG Education Oversight Group (EOG) commence which will oversee key aspects of education and learning with key stakeholders across the Group. This will report into People Committee on a monthly basis. 2) LCHG Culture & Leadership Group (CLG) commence which will oversee key aspects of culture and leadership with key stakeholders across the Group. This will report into People Committee on a monthly basis. 3) LCHG Equality, Diversity & Inclusion Group (EDIG) commence which will oversee key aspects of equality, diversity and inclusion with key stakeholders across the Group. This will report into People Committee on a bi-monthly basis.	People Committee			G	G	G	G	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																										
			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 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	1. 10 Year NHSE Workforce Plan	1. 10 Year NHSE Workforce Plan				People Committee			G	G	G	G	A	A	A			
SA3 To ensure services are sustainable, supported by technology and delivered from an improved estate																									

			1. Develop foundational insight	1.1. Develop regular integrated portfolio analysis 1.2 Develop and embed a multi-level performance management framework and conditions for a performance and improvement culture	1.Mindset and behaviour of leaders 2.Lack of capacity 3.Lack of skills and capability 4.Leadership capacity and capability 5.A poor internal reputation 6.National guidance changes 7.System finance/data requests	528 Breakeven Duty - Cost Control 529 Efficiency Requirement 530 System Risk and Gain Share - Financial Risk 532 Non attainment of capital plan		Primary: 1. Integrated Care System (ICS) Strategy 2. Integrated Care Board 5-year joint forward plan 3. Finance and Business Intelligence (FBI) Strategy 2023-28 4. FBI Strategy update on current year plan 5. Finance reporting to Finance Performance, People and Innovation Committee (FPPIC) 6. Trust Leadership Team (TLT) reports 7. LCHS Operational Plan reports 8. Clinical Strategy 2023-28 9. Chief Clinical Digital Information Officer (CCDIO) 10. Lincolnshire Long Term Plan 11. Strategic Delivery Plan as part of the Recovery Support Programme 12. NHSE Planning Guidance Secondary: 1. LCHS Finance Performance, People and Investment Committee (FPPIC) 2. Quality and Risk Committee (Q&RC) 3. LCHS Trust Leadership Team (TLT) 4. Transformation Delivery Group (TDG) 5. Data Quality Group 6. Capital Investment Group 7. LCHS private board 8. Performance Management Reviews (PMR) 9. Lincolnshire Integrated Care Board 10. Lincolnshire Health and Care Collaborative Delivery Board 11. Strategic Delivery Plan (SDP) Programme Board 12. System Financial Assurance Group 13. System Financial Leaders Group (FLG) 14. System Digital, Data and Technology (DDAT) Tertiary: 1. Internal audit – Standard Financial Controls Annual Audit 2. External audit – Annual Independent Audit and Opinion on Financial Statements 3. Benchmarking data 4. National Oversight Framework rating 5. Clinical audit reports 6. National best practice data and reports 7. CQC rating 8. National Oversight Framework (NOF) rating quarterly letter	Skills and capability to use tools and frameworks	Programme of knowledge and skills development for FBI and stakeholder partners	1. Delivery of the financial plan measured through reporting and variances to planned performance 2. Deliver the required operating budget alongside leaders feeling engaged, informed and empowered to drive their service efficiency agenda 3. Delivery of the FBI Strategy plan 2023-24 4. National Oversight Framework (NOF) rating (annual and quarterly)																	
								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,	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)																	

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		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						Finance Committee			A	G	G	G	G	G	G										
			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		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. LCHS Strategy and Planning	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)																

								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																										
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		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. 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	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)			Finance Committee			G	G	G	G	G	G	G			

3c	A modern, clean and fit for purpose environment across the Group	Group Chief Estates and Facilities 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	Lack of assurance relating to statutory compliance of the estate. No Authorising Engineer audits being undertaken. LPFT Shared Service Provider little assurance reporting.	LCHS Estates now being managed by ULHT Estates & Facilities Services following termination of shared service agreement. Group Chief Estates & Facilities Officer. ULHT Safety Groups being reviewed to include LCHS Estate. Performance meetings being held with NHSPS. Group Estates & Facilities structure being developed to provide capacity to effectively manage the estate and maximise potential going forward. Further Authorising Engineers audit on fire safety being undertaken in November 2024 to ascertain what level of improvement has been made since the last audit and actions taken by ULTH Fire safety Team. Safety Groups being established across the Group expected to commence January 2025 which have oversight of all risks, e.g. fire safety, electrical safety, water safety, medical gas management etc. Premises Assurance Model completed and tabled at FPPIC which shows significant areas in improvement required - action plans being developed.	Finance Committee / Integration Committee			R	R	R	R	R	R	R			
3d	Reduce waits for patients who require urgent care and diagnostics to constitutional standards	Group Chief Operating Officer												Finance Committee			A	A	A	A	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 Committee			R	R	R	R	R	R	A			
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																										
			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.														

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	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.	Integration Committee			R	G	G	G	G	G	G			
			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													Integration Committee			A	A	A	A	A	A	A			
4c	Grow our research and innovation through education, learning and training	Group Chief Integration Officer													People 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. 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 Committee / Integration Committee			G	G	G	G	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	engagement			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	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. Assurance and governance reporting against this TBC.		Integration Committee			R	G	G	G	G	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												Integration 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.		Integration Committee			R	R	R	R	R	R	R			

5d	Transform key clinical pathways across the group resulting in improved clinical outcomes	Group Chief Integration Officer/Group Chief Medical Director	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			Integration Committee												
			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																					

			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 Teaching 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															
								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)	DPG has not met for a number of months. Sub-groups of DPG also no assurance if meeting. No upward reports received through PSG for a number of months. 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 Work taking place across the Group to support Deteriorating Patient agenda. Development of DPG across Group Chair now appointed as the Deputy Medical Director. First meeting undertaken in November to review terms of reference / workplan and subgroups.	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. Reporting not being received by PSG from DPG due to vacancy	Support across Group with regards resus training and Surgical Division at ULHT presenting briefing paper at PSG for onward plans to lead DPG due to be received September - DPG to be relaunched with new interim chair (Associate Medical Director)- first meeting planned for 28th November 2024		

Implementation and oversight of national patient safety strategy (culture and systems) Human Factors Faculty	Development of Safety Culture review process in conjunction with People and OD	Working group established to review and propose framework to be utilised	Patient Safety Board Development session held - June 2024 6 monthly gap analysis against National Patient Safety Strategy reporting in to PSG and upwardly to Quality Committee Safety Culture review process From Q2 Group Patient Safety report triangulating across multiple key stakeholders to consider patient safety culture and future plans of work, to report to PSG and QC quarterly	Working group outputs not yet available due to group in infancy	Initial meeting held in October, verbal updated expected at November PSG. Clarification on project lead required. Commenced recruitment process for TTT for Human Factors cohort for Jan/Feb 2025.
Appropriate policies in place to ensure CAS alerts and Field Safety Notices are implemented as appropriate. One central monitoring process now in place. Monthly Group Oversight Meeting for CAS and FSN alerts Strengthen oversight of designated Executive and Patient Safety Specialist on recovering CAS alerts and final sign off (PSG)	CAS and FSN Group policy	Development of CAS and FSN Group Policy commenced, expected completion December 2024	Quarterly report to PSG with escalation to QC as necessary and monthly exception report to PSG. Compliance included in the integrated governance report for Divisions.	None identified	None identified
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.

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			Failure to provide safe care Failure to provide timely care Failure to use medical devices and equipment safely Failure to use medicines safely Failure to manage blood and blood products safely Failure to manage radiation safely Failure to deliver planned improvements to quality and safety of care Failure to respond to patient safety alerts appropriately	5101 4947 5016 5100 4879 5143 5450 5002 5142 5267 4779 5488 5306 4868 4935 5515 4843 5423 4746 5095 4646 5491 5227 5403 5196 5169		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.	Quality Committee			G	G	G	G	G	G	G			
									Clinical Effectiveness Group in place as a sub group of QC 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													
								Skin Integrity Group (SIG) established as a sub group of the Patient Safety Group to provide oversight, monitoring and accountability of the ongoing improvement work around prevention of pressure ulcers and the wider skin integrity programme of work. Skin Integrity management policies, procedures and pathways in place.	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 and 4 incidents is expected and has been observed.	Weekly Pressure Ulcer Support and Supervision panel with Quality, Tissue Viability and Safeguarding team representation reviews all Category 3 and 4 pressure ulcers against the safeguarding adults protocol for all pressure ulcers and raising a safeguarding concern guidance.	Skin Integrity care is reviewed in the weekly ward/dept. leader's assurance and monthly Matrons audits. The monthly Quality Metrics review meeting monitors ward and departments' performance relating to skin integrity. 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. Skin Integrity incidents are analysed to identify themes and trends which are reported through SIG and improvement actions identified. Overarching action plan for incidents, themes and improvement actions is in place and monitored through Skin Integrity Group	No gaps identified.	Not applicable.													

1b	Improve patient experience	Group Chief Nurse				5495 5234 4701 4724		Patient and Carer Experience (PACE) plan 2022 - 2025 The PACE Delivery Plan is actioned and embedded over the life of the delivery plan. (PEIG)	PACE plan due for review in 2025. Patient Experience Team capacity to support both ULHT & LCHS imperatives.	LCHG plan in development that will include ULHT priorities, LCHS priorities and collaborative priorities. Self assessment completed by PEIG Task & Finish Group. Timetable is for this to be approved at Feb 24 PEIG and QGC for launch April 25. Funding identified for LCHS Patient Experience Manager - aiming for recruitment in January 2025	Patient Experience & Carer Plan progress report to Patient Experience & Involvement Group (PEIG) as per schedule. PEIG Task & Finish Group upward reports provided to PEIG re: progress and actions.	There are no assurance gaps identified.	Not applicable	Quality Committee			G	A	A	A	A	A	A			
								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. (PEIG)	National surveys evidence overall poor experiences in relation to discharge and UEC with a number of questions being benchmarked as worse than others Trusts. Patient Experience Team working with divisions to support improvements including a deep dive triangulation across data sources and real time surveying.	Amalgamated national survey action plan in place to identify Trust wide improvement focus; the current plan is cumbersome for divisional engagement so will be managed by Patient Experience Team and collective focus across all divisions to be linked to targets within each benchmarked quartile: 'upper' - cleanliness and food, 'about the same' - individual needs met and information, 'bottom' - moving wards at night and sleep. Rolling out of new suite of communication and patient experience training including Hearing it Your Way and at induction. Patient Experience Team working with Discharge and UEC teams staff facilitating real time surveying to enable improvements and developments	New template for divisional assurance reports developed and scheduled reports received at PEIG. SUPERB now includes LCHS data, monthly reports and infographics received at PEIG and circulated.	Engagement capacity within discharge and UEC teams to lead patient experience improvement initiatives and developments.	To identify service level champions / leads to work in partnership with Patient Experience Team.												
1c	Improve clinical outcomes	Group Chief Nurse/Group Chief Medical Officer				4828 4731 4928 5154 4866 4778 4840		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	G	G	G	G			
								Ensure we provide clinically safe services, through an increased number of Diamond Award Accredited Wards / Departments (PEIG)	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												Integration 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 Workforce 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. Comprehensive review of project plan has been undertaken to ensure the Plan for Every Post' progress is fully reflective and able to provide upward level of assurance on deliverables within 2024/25.	Currently Medical & Dental vacancies are not managed by Position Number	Continued progress with refreshed approach to 'Plan for Every Post' being developed as part of the Medical Staffing Project within the Medical workforce Programme. Reported at Medical Workforce Steering Group and ISG on a monthly basis. It is expected that this will be a key enabler to supporting the Trust in reducing temporary staffing spend within this staff group. Divisional roll out of the refreshed Plan for Every Post process has commenced, with the largest Divisions being the priority.		
								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. Maintain a link between the Education, Learning & OD Team and their work that supports the approach to Just Culture & Leadership through the Culture & Leadership Group (CLG). Maintain a 'golden	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 LCHG Workforce Strategy Group (monthly) and within Divisional FPAM (monthly) with areas<50% compliance highlighted. Support offered to Divisional Teams by Head of HR and Education, Learning & OD (ELOD) Team to improve in these areas to ensure that staff are compliant with mandatory training, and where issues identified are supported as required. All staff are now being	Workforce Strategy Group upward report to PODC including scorecard analytics i.e. appraisal, statutory and mandatory training.	Mandatory Training compliance has 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 Strategy 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. As of Quarter 3 within 2024/25 there will be a new: 1) LCHG Education Oversight Group commenced which will oversee key aspects of education and learning with key stakeholders across the Group. This will report into People Committee on a monthly basis. 2) LCHG Culture & Leadership Group (CLG) commenced which will oversee key aspects of culture and leadership with key stakeholders across the Group. This will report into People Committee on a monthly basis.		

								(CLG). Maintain a 'golden thread' of Civility& Respect, Compassionate Leadership and Just Culture throughout all interactions and developments.		required. All staff are now being contacted with regards to their compliance rates where thy are <90% and not just those who are <50% compliance so as to ensure we can sustain our improved position. Appraisals: Workforce Strategy Group to discuss group appraisal and appraisal lite Ongoing discussions are in place with agenda items on Workforce Strategy Group as required. Focus on those areas where there are <50% compliance to encourage improved compliance rates, ensuring that where support to record is required this is offered.																
								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 Workforce Strategy 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 Strategy 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.														
								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	Workforce Strategy Group Finance, People & Activity Meeting and People Committee data Workforce Strategy Group upward report to People Committee 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 Strategy 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. As of Quarter 3 within 2024/25 there will be a new LCHG Education Oversight Group (EOG) commence which will oversee key aspects of education and learning with key stakeholders across the Group. This will report into People Committee on a monthly basis.														
								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. Maintain a link between the Education, Learning & OD Team and their work that supports the approach to Just Culture & Leadership through the Culture & Leadership Group (CLG). Maintain a 'golden thread' of Civility& Respect, Compassionate Leadership and	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.	Workforce Strategy Group Finance, People & Activity Meeting and People Committee data Culture and Leadership Task Force Reports to PODC	Sub-Group meetings within the People Directorate are not yet in place	As of Quarter 3 within 2024/25 there will be a new LCHG Culture & Leadership Group (CLG) commence which will oversee key aspects of culture and leadership with key stakeholders across the Group. This will report into People Committee on a monthly basis.														

									Compassionate Leadership and Just Culture throughout all interactions and developments.																			
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		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% sickness absence target 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 Workforce Strategy Group Compliance rates continue to be monitored via the People Committee Scorecard for the below: 1) Rolling 12mths Sickness Absence rate 2) Return to Work compliance 3) Flu vaccination rate 4) Occupational Health referral data	None Identified	None Identified	People Committee			G	G	G	G	G	G	G							
								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 Compliance rates	None Identified	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 Strategy Group Pastoral care award received for recruitment and on-boarding of international nurses Compliance rates continue to be monitored via the People Committee Scorecard for the below: 1) Turnover rate 2) Flexible Working agreement rates	None Identified	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. Maintain a 'golden thread' of Civility& Respect, Compassionate Leadership and Just Culture throughout all interactions and developments.	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.	Sub-Group meetings within the People Directorate are not yet in place	As of Quarter 3 within 2024/25 there will be a new LCHG Culture & Leadership Group (CLG) commence which will oversee key aspects of culture and leadership with key stakeholders across the Group. This will report into People Committee on a monthly basis.
								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	Sub-Group meetings within the People Directorate are not yet in place	To be monitored through the Workforce Strategy 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. As of Quarter 3 within 2024/25 there will be a new LCHG Education Oversight Group (EOG) commence which will oversee key aspects of education and learning with key stakeholders across the Group. This will report into People Committee on a monthly basis.
								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	Sub-Group meetings within the People Directorate are not yet in place	As of Quarter 3 within 2024/25 there will be a new LCHG Education Oversight Group (EOG) commence which will oversee key aspects of education and learning with key stakeholders across the Group. This will report into People Committee on a monthly basis.
								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.	Sub-Group meetings within the People Directorate are not yet in place	As of Quarter 3 within 2024/25 there will be a new LCHG Education Oversight Group (EOG) commence which will oversee key aspects of education and learning with key stakeholders across the Group. This will report into People Committee on a monthly basis.

								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	Sub-Group meetings within the People Directorate are not yet in place	As of Quarter 3 within 2024/25 there will be a new LCHG Education Oversight Group (EOG) commence which will oversee key aspects of education and learning with key stakeholders across the Group. This will report into People Committee on a monthly basis.													
			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. Sub-Group meetings within the People Directorate are not yet in place	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 Group. On a monthly basis. As of Quarter 3 within 2024/25 there will be a new: 1) LCHG Education Oversight Group (EOG) commence which will oversee key aspects of education and learning with key stakeholders across the Group. This will report into People Committee on a monthly basis. 2) LCHG Culture & Leadership Group (CLG) commence which will oversee key aspects of culture and leadership with key stakeholders across the Group. This will report into People Committee 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. Sub-Group meetings within the People Directorate are not yet in place	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) As of Quarter 3 within 2024/25 there will be a new LCHG Equality, Diversity & Inclusion Group (EDIG) commence which will oversee key aspects of equality, diversity and inclusion with key stakeholders across the Group. This will report into People Committee on a bi-monthly basis.	People Committee			G	G	G	A	A	A	A			
			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													
					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.		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	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.	2.3 & 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.	2.5 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													

3a	Deliver financially sustainable healthcare, making best use of resources	Group Chief Finance Officer				5020 4664	CQC Well Led CQC Use of Resources	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.		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.	CRIG, GLT and FPEC. 2.4 Development of a 5 year capital programme cross referenced to risk register.		calculations. As it stands, the national limits are lower than the level that would be investable based on 'local' available resources.	Finance Committee			A	A	A	A	A	R	R			
					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 Committee												
								Continual improvement towards meeting PLACE assessment outcomes	None	N/A	PLACE Light Assessments PLACE Full assessments completed annually PLACE Steering Group monitors action plans following audits															

3c	A modern, clean and fit for purpose environment across the Group	Group Chief Estates and Facilities Officer			Longer term impact on supplier services (including raw materials) who are supporting the improvement, development, and maintenance of our environments. Availability of funding to support the necessary improvement of environments (capital and revenue)	4648 4647 5415	CQC Safe	Review and improve the quality and value for money of Facility services including catering and housekeeping	Review of catering services currently being undertaken		MiC4C cleaning inspections Staff and user surveys Catering project plan Cleanliness is reported through IPC Group to QGC. Water Safety and Fire Safety Fire Safety, confined spaces, working at heights, electrical safety, security management, lift safety and medical gases report to the Health & safety Committee via an upwards report.			Finance Committee / Integration Committee			A	A	A	A	A	A	A				
								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. Up to date 6 facet survey completed in 2024, high & significant being identified to place on the risk register.	Funding gap when considering the full £100m+ backlog in first year. Future years will at most tackle £20m of backlog in any given year	Statutory compliance and actions from AE (Authorised Engineers) reports monitored through safety groups which report into the Health & Safety Committee. Progress against Estates Strategy/Delivery Plan and IIP via sub groups upward reports. Delivery of 2024/25 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. Combination of PLACE Light and other intelligence (IPC Group/Compliance Reports and Capital Delivery Group) will help triangulate areas of concern and response.													
								Continued progress on improving infrastructure to meet statutory Health and Safety compliance		Water/Fire safety meetings are in place and review of controls are part of external validation from authorised engineers. Health and Safety Committee new terms of reference approved and now chaired by Group Chief Estates and Facilities officer. Upward reporting to Finance, Performance and Estates Committee Medical gas, ventilation, Water safety group, electrical safety group, confined spaces group, Lift Safety group and Asbestos Working Group have all been established and include the relevant authorising engineers in attendance. These groups monitor and manage risks and report upwards any exceptions or points of escalation.	Reports from authorised engineers Response times to urgent estates requests Estates led condition inspections of the environment Response times for reactive estates repair requests Action tracker managed by Fire Safety group which monitors progress against fire safety actions previously held under prohibition notices Health and Safety Committee upward report British Safety Council External Review 2023 -	Improvement needed in closing AE audit actions. Review of infrastructure risks currently being undertaken which will result in additional risks being placed on the Trust Risk Register which accurately reflects the quality and risks being carried by the current estate.	Monthly meeting held by Head of Compliance. Upwards reports to include more detail relating to progress being made to close AE audit actions.													
								Estates Strategy currently being refreshed	Funding gaps between overall plan of replacement vs available funding. Availability of Suppliers and Changes in market forces. Availability of raw materials and specialist components to replace/repair etc.	Business Case Development and preparation pre-empting available capital to maximise available. Use of procurement framework and liaison with NHSE to coordinate bids and larger schemes	Estates Group Upward Report												
								Refurbishment of 8 theatres, across our sites	Funding stream			Theatre strategy Group												
								Support capacity maximisation ensuring modernisation and utilisation of space, including that leased off the main acute sites			Revised Space Management Policy developed.	Revised Space Management Policy needs embedding.												

								Reduce our net carbon footprint		Trust Green Plan. CEF business case to bring investment in energy related improvements at Pilgrim																	
								Develop Health Master Plans to better algin wards																			
3d	Reduce waits for patients who require urgent care and diagnostics to constitutional standards	Group Chief Operating Officer						3x daily internal capacity meetings to improve discharge and flow and trouble shoot operational issues at the front door Project 76 meetings with Group/ICB stakeholders in place with weekly deep dives into divisional actions plans across both organisations and weekly project review with system partners Group Discharge Board in place (from 10/04/2024) Daily ICB UEC call to escalate issues across the system and provide support to unblock pressure areas Group UEC Board established reflecting 5 Pillars of Improvement System Urgent Care Partnership Board.	Internal professional standards not embedded Medical and Nursing WFP not reflective of 24/7 UEC service requirements Lack of understanding at ward level re SAFER leading to poor implementation Assessment areas not substantively funded Capacity Team unable to provide adequate cover 24/7 due to WFP	5 Pillars / Workstreams reflecting key cross system programs of work. Progress of the above measured through the Group UEC Board Monitoring of performance at Tiering Meetings with NHSE, although these have now been stepped back to fortnightly as UEC has moved from Tier 2 to Tier 3 External reviews including GRFT have identified gaps in services which have been included in actions plans within the relevant specialties/divisions	Improvement against 3 key metrics as agreed with NHSE and monitored via Tier 2 meetings : % of patients in Emergency Department >12 hrs (Total Time) 4 hour Type 1 performance Cat 2 Mean EMAS performance Updates full suite of metrics to ELT, TLT and Board. Updates provided to Group UEC Board and UEC System Partnership Board	Pathway 0 patients discharge is being effectively planned from the point of admission All PW1-3 capacity is used on a daily basis Escalation policy is not fit for purpose and not used to define triggers and actions form divisions and support services. Process and deployment of Full Capacity Protocol not clear and not used effectively as not aligned to Escalation Policy. Specialist teams are attending ED within 30 mins of request in line with IP standards	Weekly Group UEC Board from January 2024 through which x 5 pillars of cross LCHS/ULHT work are monitored Daily 76% EAS meetings taking place to monitor in-day delivery against the standard EAS discussed at every capacity meeting Daily Breach understanding is circulated along with performance MTD, previous day and in-day progress Revised capacity meetings implemented from Sept 2023 and led by COO Office x 4 days a week and Divisions 1 day a week. Full capacity protocol including +1 and +2 on wards has been updated and implemented from September 2023.	Finance Committee							A	A	A			
								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	Group Chief Operating Officer					Cancer Standards 62 day, 14 day and 28 Day	Daily reporting of all three metrics (62 day backlog, FDS and 62 day performance) Weekly Intensive Support meetings to review all 3 metrics and position of patients on the cancer PTL Monthly 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. Tool developed to identify optimum ptl sizes for FDS/62 days for each tumour site. This allows us to identify key pressure areas and focus support	Finance Committee							A	A	A			
								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.													

	meet all constitutional standards						and 28 Day FDS	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 provide a backdrop for continuous achievement of all 3 cancer targets. Number of capacity increasing BCs have been agreed by CRIG and others dependent upon slippage. Each tumour site has worked through mitigations and impact.													
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. Day case 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 day case 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 & FC Diagnostic reporting tools and process currently being developed	Finance Committee						A	A	A			
								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

4a	Establish collaborative models of care with all our partners including Primary Care network Alliance (PCNA), GPs, health and social care and voluntary sector	Group Chief Integration Officer						Lead the Lincolnshire ICS and Provider Collaborative as an Anchor Institution and play an increasing leadership role within the East Midlands Acute Services Collaborative	Governance arrangements for Provider Collaborative, Integrated Care Board still in development Clarity on accountability of partners in integration/risk and gain Lincolnshire ICS anchor organisation plan not yet in place Wider regional governance to provide East Midlands oversight of population need and outcomes not yet finalised (via East Midlands Acute Provider Collaborative (EMAP)) ULHT have not embedded a culture of contributing towards population health across the whole organisation and a further understanding of health inequalities and mitigating actions.	Map key stakeholders and priorities for a partnership strategy focussing on addressing health inequalities and prevention Board and senior leadership team sessions on understanding the new ICS landscape and ULHT role within this Lincolnshire System Anchor Workshops underway to align areas of focus and develop system Anchor Plan - looking to agree priorities and exploring opportunities associated with Greater Lincolnshire devolution EMAP Governance structure now agreed, EMAP Managing Director in post and will be hosted by ULHT. ULHT engagement in 3 EMAP work programmes. EMAP MOU pending Board approval. Scope what a good effective partnership look like. Stakeholder mapping & engagement plan. Develop appropriate comms for the Lincolnshire ICS and our provider collaborative Agreements to support the development of the Provider Collaborative have been designed and shared. The Provider Collaborative is undertaking a stock take of services.	ULHT Green Plan Risk and Gain share (provider collaborative) Early Warning Discharge Indicators/development a common set of agreed metrics for flow and discharge across the system ICB delegation agreement ULHT Partnership Strategy EMAP governance structures/MOU	Green Pan under-delivery A better understanding of effective partnerships and what good looks like Clarity around role/accountability of partners within the Provider Collaborative Clarity around system improvement plan and provider collaborative plan and what outcomes each seeks to achieve Shared understanding and implications of the early warning discharge indicators, risk and gain share agreement within ULHT	Green Plan assurance - governance and PMO plan Part of the refreshed IIP Reporting processes Regular updates to ELT/TLT/TB on Provider Collaborative, Health Inequalities, EMAP and our ICS Evidence and intelligence gathered from Service Reviews, Business Planning, Population Health and all other aspects of work will be pulled into this strategy to support the wider considerations of partnership working and future opportunities (commercial and non-commercial) The process of building the Trust Clinical Strategy has commenced taking information from Specialty Reviews to inform accordingly, and building on outputs from the Business Planning process.	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													
								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	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													

4b	Successful delivery of the Acute Services Review	Group Chief Integration Officer								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.			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.	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 Committee (To move to: Integration Committee)			R	R	R	R	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.	
4d	Enhanced data and digital capability	Group Chief Integration Officer				4657		Development and approval of Electronic Patient Record OBC	Regional and National approval of OBC Affordability of OBC	Digital Services Steering Group Digital Hospital Group e-HR Programme Steering Group Capital, Revenue and Investment Group Engagement with regional colleagues	Delivery of OBC Agreement of funding	Regional feedback on OBC	OBC approved by Frontline Digitalisation ePR Investment Board (EPRIB) on 19th July 2023. OBC approved by JIC on 28th July 2023. OBC approved by Cabinet Office Commercial Spend Controls Process on 3rd Oct 2023. ITT published 6th October 2023 with bid submission deadline on 29th November 2023 but only three bid submissions received with non of them being fully compliant. After listening to the market and involving all parties (including legal), changes have been made to the ITT, including provide increased flexibility in the approach to T&Cs and updating the wording of one of the Mandatory Compliance Questions. ITT republished 29th February 2024 with bid submission	Finance Committee / 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	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												Integration 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.	Integration Committee												
5d	Transform key clinical pathways across the group resulting in improved clinical outcomes	Group Chief Integration Officer/Group Chief Medical Director												Integration Committee												

NHS
Lincolnshire Community and Hospitals NHS Group

Group Board Committee Membership

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Teaching Hospitals NHS Trust

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*7th January 2025*
Item Number	*14.3*

Group Board Committee Membership

Accountable Director	*Elaine Baylis, Group Chair*
Presented by	*Elaine Baylis, Group Chair*
Author(s)	*Jayne Warner, Group Director of Corporate Affairs*
Recommendations/ Decision Required	*The Board is asked to:-* *Note the Board Committee membership following the Group Executive and Non Executive Appointments*

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	*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 (ULTH)	*X*
3f Reducing unwarranted variation in planned service delivery and ensure we meet all constitutional standards (ULTH)	*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	*X*
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*

Executive Summary

Committee	Remuneration Committee	Audit Committee	Charitable Funds Committee (ULTH)	Charitable Funds Committee (LCHS)
Non-Executive Directors	Elaine Baylis (Chair) Rebecca Brown Jim Connolly Phil Baker Neil Herbert Dani Cecchini Gail Shadlock	Neil Herbert (Chair) Jim Connolly Rebecca Brown Dani Cecchini Phil Baker Ian Orrell	Dani Cecchini (Chair) Sarah Buik	Gail Shadlock (Chair) Ian Orrell
Executive Directors	Group Chief Executive Group Chief People Officer Group Director of Corporate Affairs	Group Chief Finance Officer Group Chief Clinical Governance Officer Group Director of Corporate Affairs	Group Chief Finance Officer Group Chief Nurse Group Director of Corporate Affairs	Group Chief Finance Officer Group Director of Corporate Affairs

Committee	Quality Committee	People Committee	Finance Committee	Integration Committee
Non-Executive Directors	Jim Connolly (Chair) Rebecca Brown Vicki Wells	Phil Baker (Chair) Gail Shadlock (Deputy Chair) Vicki Wells	Dani Cecchini (Chair) Sarah Buik Ian Orrell	Rebecca Brown (Chair) Gail Shadlock Sarah Buik
Executive Directors	Group Chief Nurse Group Chief Medical Officer Group Chief Operating Officer/Group Chief Integration Officer Group Chief Clinical Governance Officer	Group Chief People Officer Group Chief Nurse Group Chief Medical Officer	Group Chief Finance Officer Group Chief Estates Officer Group Chief Operating Officer/Group Chief Integration Officer	Group Chief Integration Officer/ Group Chief Operating Officer Group Chief Medical Officer/ Group Chief Nurse Group Chief Estates and Facilities Officer Group Chief Clinical Governance Officer