Bundle LCHG Board Meeting in Public Session 5 November 2024

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

1 Introduction, Welcome and Chair's Opening Remarks
Chair

2 Public Questions
Chair

2.1 Ward Accreditation
Bronze Accreditation - Ashby Ward

3 Apologies for Absence
Chair

4 Declarations of Interest
Chair

5 Minutes of the meeting held on 3rd September 2024
Chair

Item 5.1 Public Board Minutes September 2024

5.1 Matters arising from the previous meeting/action log
Chair

6 Group Chief Executive Horizon Scan
Group Chief Executive

Item 6 Group CEO update public board November 2024 final version

6.1 CQC Unannounced Assessment Letter
Group Chief Nurse

Item 6.1 Board Paper CQC Visit

6.2 Group Development - Next Phase
Group Chief Executive

Item 6.2 Group CEO - Group Development next phase- November 2024

7 Patient/Staff Story

7.1 BREAK

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

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

Item 8.1 Quality Committee in Common Upward Report September 2024

Item 8.1 Quality Committee in Common Upward Report October 2024

8.2 NHSE Listening to Women and Families - APPG Birth Trauma Report
Group Chief Nurse

Item 8.2 Birth Trauma Report

Item 8.2 Appendix 1 NHS England » Maternity and neonatal services – listening to women and families

Item 8.2 Appendix 2 Birth Trauma Inquiry Report for Publication_May13_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 POD - Upward Report - September 2024v1

Item 9.1 People Committee in Common Upward Report October 2024v1

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

10.1 Assurance and Risk Report from the Finance, Performance, People and Innovation Committee
Chair, Finance, Performance, People and Innovation Committee
Item 10.1 FPPIC Report to Public Board October 2024

10.2 Assurance and Risk Report from the Finance, Performance and Estates Committee
Chair, Finance, Performance and Estates Committee
Item 10.2 FPEC Upward Report September 2024v1
Item 10.2 FPEC Upward Report October 2024v1
Item 10.2 App1 FPEC PAM 23-24 ULTH

10.3 Draft Terms of Reference for Finance Committee
Group Director of Corporate Affairs
Verbal

10.4 NHSE Publication Principles for Providing Safe and Good Quality Care in Temporary Escalation Spaces (TES)
Group Chief Operating Officer
Item 10.4 Temporary Escalation Spaces
Item 10.4 Appendix One Plus One Placement Principles Standard Operating Procedure UHL Guideline
Item 10.4 Appendix Two FCP risk assessment proforma
Item 10.4 Appendix Three Plus One Risk Assessment Fire Safety
Item 10.4 Appendix Four Continuous Flow Policy inclusion Plus One Placement Standard Operational Procedure V 1.1

10.5 NHSE Letter Winter and H2 Priorities
Group Chief Integration Officer
Item 10.5 Cover Paper_Trust Board_5thNov
Item 10.5 ULHT17 - Appendix 1 - Lincs Winter Plan 24-25 Draft 25 10 24 RN 281024
Item 10.5 H2 priorties and winter_v5.1

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 Draft Terms of Reference for Integration Committee
Group Director of Corporate Affairs
Item 11.1 Integration Committee ToR Front Sheet
Item 11.1 Appendix 1 Integration Committees in Common Terms of Reference
Item 11.1 Appendix 2 Workplan

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

13 Integrated Performance Reports - ULTH/LCHS
Group Chief Integration Officer
Item 13 IPR Trust Board - Front page
Item 13 IPR Trust Board October 2024
Item 13 LCHS IPR Frontsheet October 2024
Item 13 IPR Trust Board October 2024

14 Risk and Assurance

14.1 Group Risk Management Report
Group Chief Clinical Governance Officer
Item 14.1 LCHG Board Strategic Risk Report Exec Summary November 2024
Item 14.1 Group Board ULTH Strategic Risk Report November 2024
Item 14.1 Appendix A- Group Board ULTH Risks 15-25 November 2024

Item 14.1 Group Board LCHS Strategic Risk Report November 2024
Item 14.1 Appendix LCHS Risks

14.2 Board Assurance Framework
Group Director of Corporate Affairs
Item 14.2 LCHG BAF 2024-25 Front Cover November 2024
Item 14 Appendix 1 Board Assurance Framework

14.3 Assurance and Risk Report from the Group Audit Committee
Chair, Group Audit Committee
Item 14.3 Audit Committee Upward Report - October 24

14.3.1 Approval of amended Corporate Governance Manual ULTH and LCHS
Group Director of Corporate Affairs
Item 14.3.1 Interim Updates to Corporate Governance Manuals for ULTH and LCHS
Item 14.3.1 Appendix Updated Corporate Governance Manual 11.10.24 ULTH
Item 14.3.1 Appendix Updated Corporate Governance Manual 11.10.24 LCHS.docx

14.4 Nomination of Group Deputy Chair
Group Chair
Item 14.4 Group Deputy Chair

15 Any Other Notified Items of Urgent Business

16 The next meeting will be held on Tuesday 7th January 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 Hospitals NHS Trust

Minutes of the Public Board in Common Board Meeting

Held on 3 September 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
Mr Sam Wilde, Director of Finance and Business Intelligence
Mr Daren Fradgley, Group Chief Integration Officer
Mrs Nerea Odongo, Group Chief Nurse

LCHS
Non-Voting Members:
Mrs Rebecca Brown, Associate Non-Executive
Miss Claire Low, Group Chief People Officer
Mrs Kathryn Helley, Group Chief Clinical Governance Officer
Mr Mike Parkhill, Group Chief Estates and Facilities Officer

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

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
Mrs Kathryn Helley, Group Chief Clinical Governance Officer
Mr Mike Parkhill, Group Chief Estates and Facilities Officer

In attendance:
Mrs Jayne Warner, Group Director of Corporate Affairs
Dr Anne-Louise Schokker, Medical Director for Frailty
Mrs Rachel Lane, Trust Board Administration, LCHS (Minutes)
Sister Lisa Roberts, AMSS ULHT (Item 2.1)
Sister Kerry Nuttall, AMSS ULHT (Item 2.1)
Sister Lisa Codd, Hospice in the Hospital ULHT (Item 2.1)
Katie Clements, Clinical Lead Childrens Respiratory Services, LCHS (Item 7)

Apologies

Professor Karen Dunderdale, Group Chief Executive
Dr Colin Farquharson, Group Chief Medical Officer
Ms Caroline Landon, Group Chief Operating Officer
Mr Ian Orrell, Non-Executive Director, LCHS

218/24	**Item 1 Introduction** The Chair welcomed Board members and members of the public, staff or interested parties who had joined the live stream.
219/24	The Chair took the opportunity to formally welcome new Group Executive Directors; Dr Colin Farquharson, Group Chief Medical Officer, Miss Claire Low, Group Chief People Officer, Mrs Nerea Odongo, Group Chief Nurse, Mr Daren Fradgley, Group Chief Integration Officer, Mrs Kathryn Helley, Group Chief Clinical Governance Officer, Mr Mike Parkhill, Group Chief Estates and Facilities Officer and Mrs Jayne Warner, Group Director of Corporate Affairs.
220/24	**Item 2 Public Questions** **Q1 received from Vi King** **Please can I ask why in urology that when patients are going for a yearly check-up and an ultrasound is required as informed via a letter from their previous appointment; why they are not booked before the patient's appointment with the Doctor. Patients are going for appointments with the Doctor who do not have anything to compare with from the previous year. This is a waste of time for the Dr and the patient.** **Patients are then having to go for their ultrasound then have to have another appointment with the Doctor. If the ultrasound had been done before it would have been better and more cost effective for everyone.**
221/24	The Group Chief Integration Officer thanked Vi for the question and explained that the team had confirmed there was a process in place for urology patients to ensure those requiring repeat diagnostics had them undertaken prior to their next review. This was to ensure the results were available at the time of the next Consultant appointment.
222/24	However it was acknowledged the process had not worked in this instance, and the team had therefore been asked to review the processes to ensure this was compliant. Should any issues be discovered they would be appropriately dealt with. The Group Chief Integration Officer advised that if there were specific concerns relating to individual patients, the organisation should be made aware to enable review on an individual basis.
223/24	

	The Chair thanked the Group Chief Integration Officer for the response and Vi for posing the question.
224/24	**Item 2.1 Ward Accreditation** The Chair was pleased to be able to commence the Board meeting with the celebration of achievement of the provision of high quality, safe care through the awarding of ward accreditation.
225/24	Sisters Lisa Codd and Kerry Nuttall, Acute Medicine Short Stay (AMSS) and Lisa Roberts, Hospice in the Hospital were welcomed to the meeting to celebrate their achievements.
226/24	The Group Chief Nurse introduced the two teams 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.
227/24	Colleagues described areas of improvement within their Ward and Departments.
228/24	Sister Codd described a process that had been put in place to prevent incidents of lost property; the team had recognised that there had been some issues with this and therefore had introduced a list for patients on admission to the Ward which had reduced the number of items being lost. A particular patient story was described where a patient had lost a very sentimental item, however the team had quickly discovered that this had not been brought to the Ward when the patient had been admitted and was discovered within the Emergency Department. The patient was subsequently reunited with this irreplaceable item and the patient's reaction to this had been priceless.
229/24	Sister Nuttall was extremely proud of the large team of staff within AMSS advising that they would continue to work hard to make further improvements to strive for excellence and the team had already commenced working towards achieving the silver accreditation.
230/24	Sister Roberts explained that the Hospice in the Hospital based at Grantham Hospital was celebrating its ten-year anniversary. An area of improvement made for patients had been for those at the end of life, to orientate them when they may have been sleeping for long hours and at unusual times. Dementia clocks had been added to all rooms within the department, which clearly showed the date and time in order that patients could easily recall when and where they were. Sister Roberts also described personalised care that the team provided to patients at the end of life, which included helping them to spend time with family and friends and to also to help the patient to feel more comfortable. Sister Roberts added that the Hospice in the Hospital team were relatively small, however was proud of what had been achieved and for all that they did to ensure patients were kept safe.
231/24	

   232/24 233/24 234/24	The Chair thanked the teams noting the passion and compassion for the work that they did and the focus on the patients had really shone through within the presentations. Mrs Wells commented on the addition of dementia clocks and suggested that a wider conversation took place to introduce them on all wards across the organisation. The 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 added that this was also an important way of being able to reflect upon and acknowledge the leadership within the organisation. The Chair endorsed comments received on behalf of the whole Board and added that the teams should be proud of their achievements, and thanked colleagues for attending the meeting.
235/24	**Item 3 Apologies for Absence** Apologies were received from Professor Karen Dunderdale, Group Chief Executive; Dr Colin Farquharson, Group Chief Medical Officer; Ms Caroline Landon, Group Chief Operating Officer and Mr Ian Orrell, Associate Non-executive Director, LCHS.
236/24	**Item 4 Declarations of Interest** There were no new Declarations of Interest.
237/24	**Item 5 Minutes of the meetings held on 2nd July 2024/action log** The minutes of the Board in Common meeting held on Tuesday 2nd July 2024 were approved as an accurate record. There were no open actions.
238/24 239/24 240/24	**Item 6 Chief Executive Horizon Scan** The Group Chief Integration Officer presented the report to the Board in the Group Chief Executive's absence, noting that work was underway in respect of alignment with the new Government and the early priorities set out by the Secretary of State for Health. This included the digital agenda which was being kept in mind as the next cycle of Strategy setting was undertaken. The Group Chief Integration Officer explained that the Group continued to work closely with primary care colleagues and the Primary Care Network (PCN) Alliance to ensure patients were kept safe during collective industrial action by GP colleagues. Planning for those instances was going well and for action taken so far there had been plans in place to manage safety and patient flow accordingly. In terms of the partnership agenda, the Group Chief Integration Officer drew attention to the first graduates from the Lincoln Medical School and the work being undertaken through the Health and Armed Forces Conference including internal Staff Network focus.

241/24	The new Executive Director appointments were referenced within the report and the Group Chief Integration Officer offered congratulations to all newly appointed members of the team.
242/24	Several visits to the new Community Diagnostic Centres (CDCs) had been undertaken in recent months and the Group Chief Integration Officer drew attention to the significant amount of investment in local communities, some within areas of highest deprivation which should not be underestimated. The Group Chief Integration Officer added that this also presented an opportunity for the Group to partner with primary care to deliver care more locally and to work on the diagnostic pathways.
243/24	On behalf of the Group Chief Executive, the Group Chief Integration Officer also took this opportunity to thank Mr Young, Director of Finance for all his hard work over the last ten years whilst he had been working with ULHT, as he would be leaving the organisation in mid-September. On behalf of all the Executive team, the Group Chief Integration Officer wished Mr Young best wishes for the future.
244/24	The Chair thanked the Group Chief Integration Officer for the comprehensive report. The Chair expressed a view that the Group were best placed to deliver on any forthcoming national developments in respect of out of hospital prevention and the digital agenda and added that the Group would continue to act in the best interests of the population of Lincolnshire, to deliver high quality safe healthcare across the County. The Board: • **Received the report and noted the significant assurance provided**
245/24	**Item 7 Patient/Staff Story** The Group Chief Nurse introduced this item and explained that this was a very moving patient story and took the opportunity to thank the team for their hard work and for providing care to this patient and his family and expressed a view that this story truly demonstrated the work of the Group.
246/24	The Board were presented with a video of Ethan (patient) and Celia's (mother) story where details of Ethan's chronic lung condition and other conditions were shared. Ethan had been provided with support from the rapid response respiratory physiotherapists since he had been a child. Celia outlined how Ethan's chest problems were managed to ensure that where possible, he could remain within his own home and she added that without the support of the team, Ethan would not have been able to remain at home and numerous hospitals admissions had been avoided. Celia added that the team had taught family members to manage Ethan's condition at pace, should this deteriorate, whilst not losing sight of Ethan's requirements. Celia expressed a view that the service provided life changing results whilst dealing with complex issues across the county to enable patients to remain within their home environment, for which she was grateful and without which family life would be much more challenging.
247/24	The Clinical Service Lead, Children outlined the specialist service provided to both children and adults with complex physical disabilities who also had additional

	respiratory problems. The service was physiotherapy led and had two aspects; preventative and alignment to the virtual ward, offering a seven-day service with 20 beds available during Autumn/Winter and 10 beds during the Summer months. The service was also now aligned to the virtual ward project, which relied on good multi-disciplinary working and good relationships with partners within the Group.
248/24	The Chair thanked the Clinical Service Lead for the inspirational and emotional story, and extended thanks to Ethan and his family for allowing their story to be shared so that the nature of the care provided could be understood by the Board and how the service had responded to Ethan's needs and had transformed his life.
249/24	The Group Chief Integration Officer thanked the Clinical Service Lead for presenting the story noting that there had been a description of some benefits that the Group needed to focus on more in the future, in particular the work of out of hospital services within the community. The Group Chief Integration Officer added that this was a good example of referral free care and delivering services close to home for patients to provide improved access where care was not congestive. The Group Chief Integration Officer thanked the team and expressed a view that there would be more that could be done for residents within the future Group Strategy.
250/24	The Chair agreed with the Chief Integration Officer's comments and added that careful thought would need to be undertaken in terms of the Group and recalled when the original business case for this service had been presented to the LCHS Trust Board. The Chair thanked the Clinical Service Lead for believing and delivering the vision for Ethan and other patients and members of the community and also thanked the Clinical Service Lead for being robust and tenacious in ensuring that this was the correct service to move forward with and for leading the team. The Board: • **Received the Patient/Staff Story**
	Item 8 Strategic Aim 1 To Deliver high quality, safe and responsive patient services
251/24	**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 23 July 2024 where there had been two items to bring to the Board's attention.
252/24	Mr Connolly informed those present that the ULHT Infection Prevention Control Annual Report for 2023/24 had been received and would be recommended to the Board for approval in due course. The Committee had noted the good collaborative work starting to develop across the Group in this area, recognising that there were still some areas of improvement; however shared learning was being progressed.
253/24	A focussed discussion had taken place at the July meeting in respect of the LCHS Children in Care service, which provided health assessments for children between 0-18 years entering the care system. Mr Connolly advised that this service had a history of challenge over the years and more recently achieved an improved position in terms of delivering against the 20-day target, however this had not been sustained

	and the Committee wished to escalate the Children in Care service to the Board as a fragile service. Mr Connolly explained that there were mitigations and development plans in place to stabilise the service, and further updates would be provided to the Board in due course.
254/24	Mr Connolly explained that a six-month review of the Quality Committee in Common would shortly be undertaken and requested Board members provided feedback on areas for improvement outside of the meeting. The Committee received and recommended to the Board the Patient Experience Annual Report 2023/24.
255/24	Mrs Brown provided the assurances received by the Committee from the August 2024 meeting held on the 20 August. The Interim Governance Advisor had been present at the meeting to evaluate and assist with moving the Committee forward from a governance perspective.
256/24	At the August meeting there had been continuing concern and limited assurance in respect of medicines management and a further deep dive had been requested by the Committee. Mrs Brown commented that actions were being taken, however sustained improvement was not being seen. A further deep dive in relation to the deteriorating patient area had also been requested where there had been several changes in leadership over recent months.
257/24	A positive presentation had been received from the Human Factors Faculty and this was an area the Committee would see more of in the future and was a growing area within ULHT with development taking place across the Group. The Board would also be undertaking some training to champion this area in the coming months.
258/24	The Maternity Regional Scorecard had been received and Mrs Brown was pleased to inform Board Members that there had been continued improvement in the position and the latest scorecard showed the organisation at the top of the league. Mrs Brown commented that the Executive Team, in particular the Group Chief Executive, who had supported the team to get to this position, should be proud of this achievement.
259/24	The Committee had requested an update around the Clinical Negligence Scheme for Trusts (CNST) position and Mrs Brown explained that it was important for the Board to be fully sighted on this and documents had been appended to the upward report. The Committee had received and approved the detailed update and plans for the required standards on behalf of the Board. Mrs Brown added that at this stage the Committee was confident that the service continued to meet most areas, there were some challenges however the team were working closely to ensure delivery and evidence was being captured which was being externally scrutinised, which was a forward-thinking way of managing evidence.
260/24	The Chair acknowledged the escalations to the Board in respect of Children in Care, which had been a fragile service for some time, and expressed a view that it was important for this group of children to be supported in the right way.
261/24	The Group Chief Nurse explained that discussions were taking place with ICB colleagues, and the business case was being reviewed. Full time paediatric medical

	cover had also been reviewed and the Executive Leadership Team (ELT) had agreed, in the short term, some additional monetary support to mitigate the position, which would allow cases to be reviewed and bring the service back in line with the 20-day target.
262/24	The Chair thanked the Group Chief Nurse for the reassurance and for progressing this issue.
263/24	The Chair was pleased to see that a deep dive relating to deteriorating patients was being undertaken as historically this area had required close review. The Chair expressed concern regarding the leadership issue and the Group Chief Clinical Governance Officer explained that there had been some leadership issues across the Group and as a result some of the workstreams had slowed, however the leads had been working closely on a potential way forward. A paper would be submitted to the next Patient Safety Group meeting to demonstrate progression and an update would be provided to the Board in due course. The Chair thanked the Group Chief Clinical Governance Officer for the reassurance.
264/24	Mrs Brown commented that the three areas of children in care, deteriorating patients and medicines management were complex areas and needed to demonstrate improvement over the last 12 months; whilst there had been some slight improvement this was not at the level the Group would want it to be at for patients. Mrs Brown was hopeful that the deep dive at the September meeting would show some additional improvement.
265/24	On behalf of the Board, the Chair asked the Quality Committee in Common to exercise scrutiny on these three areas and to undertake the required due diligence and looked forward to receiving a report which demonstrated improvements.
266/24	In respect of maternity and neonatal services, the Chair drew attention to the series of reports that had been shared with the Board and the CNST standards referenced within pages three and four of the upward report. It was evident that the Quality Committee had reviewed those documents in detail and that the relevant due diligence had been undertaken. The Chair also took the opportunity to thank the Director of Midwifery and team for the clarity of detail within the papers and the additional regional performance underlined throughout the scorecard, which demonstrated that good working was being undertaken across maternity and neonatal services.
267/24	The Chair acknowledged the Patient Experience Annual Report which set out positive engagement with patients and the step changes made throughout 2022/23. The Board: • **Received the assurance reports** • **Received the Maternity and Neonatal Oversight Group reports** • **Received the Patient Experience Annual Report 2023/24**
268/24	**Item 8.2 2023/24 ULHT and LCHS Safeguarding Annual Reports**

	The Group Chief Nurse presented the 2023/24 Safeguarding Annual Reports for both ULHT and LCHS, which demonstrated the good work across the Group, improving processes and working with system partners.
269/24	The reports highlighted the number of Section 42's and themes particularly in relation to pressure ulcers and discharge. The Group Chief Nurse provided assurance to the Board that work was being undertaken regarding themes and learning to improve care for patients.
270/24	The Chair commented that the reports provided a sense of the two organisations coming together and a positive focus and assurance. The Board: • **Received and approved the 2023/24 Safeguarding Annual Reports for LCHS and ULHT**
	Item 9 Strategic Aim 2 To enable our people to lead, work differently, be inclusive, motivated and proud to work within LCHG
271/24	**Item 9.1 Assurance and Risk Report People and Organisational Development Committee** Professor Baker provided the assurances received by the People and Organisational Development Committee, at the meetings held on 16 July 2024 and 13 August 2024.
272/24	Professor Baker acknowledged it had been encouraging to see some of the trajectories in relation to nursing vacancy rates, with ULHT having the lowest rates in the Country, which was a remarkable achievement. Good progress had also been made on DBS checks in conjunction with the Fuller report and the timescales set for compliance to ensure all staff received the appropriate checks. Professor Baker added that whilst it was unlikely that the timescales would be achieved the organisation was ahead of the revised trajectory.
273/24	The current vacancy control process was having an impact and there had been some concern that some of the fiscal savings may not be achieved along with the level of clinical input in relation to some decision making for authorising vacancies. This had been raised with Executives and the Group Chief People Officer confirmed that the Group Chief Nurse and Group Chief Operating Officer would be joining the vacancy control meetings moving forward to add an additional layer in terms of decision making.
274/24	Work had been undertaken to raise the profile of the Freedom to Speak up Guardian which had seen a positive impact; however this had created a significant workload for the Guardian and the Committee wished to draw this to the Board's attention.
275/24	A GMC Junior Doctor survey had been undertaken and the Committee wished to raise significant concerns in relation to the provision of education within the Trust to the Board. It was highlighted that there was a reliance of teaching fellows and locums to deliver education which raised challenges when individuals were unable to deliver the education.

276/24	Engagement challenges with consultant staff had also been highlighted and whilst it was recognised that some staff had been appointed to positions where there was no expectation of education responsibilities, as a medical practitioner there was a responsibility to teach trainees. Actions were being taken to address concerns around the provision of education within the Trust and a new sub-group was being formed to bring together those responsible for education across the Group, once a new People Committee in Common was formed.
277/24	The Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) Annual Reports for 2023/24 had been received by the Committee along with an action plan to address areas for improvement, moving from one to three year action plans. Whilst the Committee welcomed that, there was a request for increased development around the milestones within the action plans.
278/24	The Trust had also received a national award for pastoral care provision for international staff.
279/24	In relation to the Freedom to Speak up Guardian workload, the Group Chief People Officer explained that a meeting would be taking place to review the workload and an update would be provided at a future meeting once a plan was in place to move forward. It was noted that there were also potential opportunities to work across the Group.
280/24	The Chair acknowledged that it was good to see that individuals were raising concerns with the Guardian, however it was also important for people to be thoroughly supported and that the workload was managed accordingly.
281/24	The Chair expected a greater focus on education, specifically in respect of the Board Assurance Framework, which would support the work of the Committee in terms of scrutiny and that there would be additional opportunities once objective setting for 2025/26 commenced.
282/24	The Chair commented that the 2023/24 WRES and WDES Annual Reports and action plans were well written and unequivocal in terms of what work was required and acknowledged the signs of improvement in terms of service metrics where a significant step change was required for both disabled colleagues and those of ethnic backgrounds. The Board: • **Received the assurance reports** • **Approved the 2023/24 WRES and WDES Annual Reports and action plans**
283/24	**Item 9.2 Sexual Safety Charter Update** The Group Chief People Officer provided the Board with an update on the progress of the Group towards full compliance with the NHS Sexual Safety Charter, which also provided the framework for the Group to be ready for the forthcoming Worker Protection Act 2023, which would come into force on 26 October 2024.

284/24	An action plan had been developed for all sources of sexual misconduct and the Group had signed up to the Charter, committing to a zero tolerance policy in respect of this type of behaviour and to the ten principles outlined within the Charter. A further update would be provided to the Board once the Charter was live.
285/24	Miss Shadlock commented that the document was well set out however expressed a view that one challenging area would be where work moved into social life. The Chair agreed that this was a salient point, however the organisation should start with people within its employment at times when they were at work.
286/24	The Director of Finance and Business Intelligence asked if incidents would be reported via Datix. The Group Chief People Officer responded that in terms of reporting this would be part of the national Charter and any incidents would need to be formally reported, however agreed to meet with the Group Chief Clinical Governance Officer in relation to this in respect of reporting any cases that fall within the sexual charter characteristic or definition of. **Action: Group Chief People Officer/Group Chief Clinical Governance Officer, 5 November 2024** The Board: • **Noted the progress made thus far towards full compliance with the ten NHS Sexual Safety Charter requirements** • **Championed the remaining steps required to achieve 100% compliance with the NHS Sexual Safety Charter** • **Committed to Sexual Safety Charter for the Group**
	Item 10 Strategic Aim 3 To ensure services are sustainable, supported by technology and delivered from an improved estate
287/24	**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 meetings held on 26 July 2024 and 27 August 2024 meetings, noting that good progress had been made in relation to objectives 2a and 2b, particularly in relation to the development of a collaborative bank across the Group, where there had been a reduction in agency staffing use.
288/24	Good progress had also been made in relation to equality, diversity and inclusion and the 2023/24 WRES and WDES Annual Reports had been received and would be published by the required deadline. Key highlights from the reports included that individuals were becoming more open to disclosing disabilities and long term conditions. There had also been an increase in the number of Black and ethnic minority staff members and there were some clear actions ensuring people, including leaders, were aware of how to address bullying and harassment issues. There was also a plan in place to undertake a period of reverse mentoring across the Group, starting at Board level.
289/24	

	In respect of finances for months three and four, there was an improving position, and a revised system financial report and financial recovery plan had been received.
290/24	In terms of risk, number 455 which had been failing to achieve, had been decreased in July due to the signing of the ICB contract, however the same risk had increased again during August as a no faults letter had been received from the ICB in respect of the MSK contract.
291/24	The National Cost Collection submission had been made and overall activity had risen by 5%, whilst costs had risen at 4% demonstrating an overall increase in productivity.
292/24	Good progress was being made in respect of digital and Miss Shadlock confirmed that the Electronic Patient Record (EPR) Business Case had been approved for LCHS by NHS England and had been positively supported.
293/24	There were red rated areas of concern highlighted in respect of Estates, however the Board were advised that the Trust would be moving away from a Shared Service to a more joined up contract with ULHT shortly. The Committee had been reassured of a significant amount of work being undertaken led by the Group Estates and Facilities Officer and the team and a detailed update had been received relating to water safety. An Estates Strategy was also under development.
294/24	Miss Shadlock advised that a discussion had taken place regarding procedural documents and concern had been raised that the Fire Safety policy had been out of date since September 2023. Reassurance had been provided that significant work was being undertaken on fire safety and related operational issues and the policy was being updated.
295/24	The Chair thanked Miss Shadlock for the comprehensive report, and acknowledged the due diligence of the Committee in respect of the 2023/24 WRES and WDES Annual Reports.
296/24	The Chair remained apprehensive in respect of estates and facilities, specifically regarding water safety which had been an ongoing issue within LCHS in recent years. However it was acknowledged that the Group service would begin to understand the risks and actions that were required to mitigate areas of real concern moving forward. The Board: • **Received the assurance reports**
297/24	**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 25 July 2024 and 22 August 2024 meetings.
298/24	

	Ms Cecchini informed the Board of a deteriorating financial position and advised that August had closed with a £15.1m deficit, £4m adverse to plan. The Committee however had been reassured that some of this was due to items of inflationary pressure, not funded within the plan. Alongside this there had been good Cost Improvement Programme (CIP) delivery to date, which was ahead of plan. Ms Cecchini reminded Board members of the rephasing to deliver significant cost savings to move to a deficit position of £6.9m.
299/24	In respect of capital, good progress had been made and £13.5m had been spent year to date, however this was £3m short of the plan. The Better Payment Practice Code continued to achieve the 90% target.
300/24	A medical agency CIP deep dive had been received and the report would be made available for Board members to review. Whilst there were good processes in place, this was set up with significant risk and the initiative was responsible for a quarter of the total CIP target.
301/24	The Health and Safety Committee upward report had been received and it was reported that there had been some improvements however moving and handling remained a concern specifically in relation to hoists and this would be kept under review. A policy group had also been established to manage the health and safety policies to ensure these were appropriately updated and approved for sign off.
302/24	In terms of estates, a review of confined spaces was expected to be completed by the end of August and a report would be received shortly. The team had been working on the premises assurance model which had been submitted during August and there was no expectation that there would be any deterioration since the last submission.
303/24	A Patient-Led Assessment of the Care Environment (PLACE) light review had been undertaken where some issues had been identified with food, and the Estates team would be undertaking a review of catering arrangements.
304/24	Lincolnshire Fire and Rescue had recently visited some of the sites and found no significant issues.
305/24	Ventilation issues continued to be a concern across the estate; however assurances had been received that clinical risk oversight was taking place within the Infection Prevention and Control Committee. The Emergency Preparedness, Resilience and Response (EPRR) annual submission had also been made at the end of August 2024 and the Trust was expected to meet most of the core standards.
306/24	July had been challenging from an operational perspective due to industrial action and infection prevention and control issues and there had been concern raised relating to Urgent and Emergency Care (UEC) metrics and theatre capacity regarding the ability to deliver against some targets. There had also been concern at the time of the meeting regarding GP collective action which had been due to commence. Challenges had been seen during July and August with achieving 65 week waits, making it unlikely to deliver on the September target. A deep dive report on productive theatres had also identified further work required and a need for additional

	staff, however there was work to be done to understand if the current number of theatres were required as well as determining theatre capital requirements.
307/24	Ongoing discussions were taking place relating to the ULHT EPR and the profile of the funding. A full business case was expected to be received at the October meeting to progress the development of this.
308/24	A planning paper had been launched for the new financial year and beyond and had been positively received.
309/24	Mrs Brown asked about the resource investment the Board had previously committed to and asked if this was pertinent to the improvements in capital fund spending. The Director of Finance responded that this was due to the positive work the existing team had undertaken, however the investment in resource would take this to the next level.
310/24	The Chair acknowledged the current revenue position and identified risks and was pleased to hear that the Committee was undertaking a deep dive regarding medical agency spend and that the CIP position was exceeding the plan.
311/24	The Chair also acknowledged the improvement in Estates and Facilities reporting and the assurances from the Lincolnshire Fire and Rescue visit.
312/24	The Group Chief Integration Officer offered to the Board that work was being undertaken to develop a new Group Performance Report which would be developed and reported to the Committees in due course.
313/24	Miss Shadlock raised the issue of separate business cases being submitted by both LCHS and ULHT in respect of EPR, which there were valid reasons for, and suggested that there may be some oversight required of this moving forward. The Group Chief Integration Officer explained that in terms of EPR, one approach often did not work and in this case it was better to have two EPRs and a shared record that would sit over the top as the functionality of the two systems would be greatly different in terms of how they operated. The Board: • **Received the assurance reports**
	Item 11 Strategic Aim 4 – To collaborate with our primary care, ICS and external partners to implement new models of care, transform services and grown our culture of research and innovation
	No items.
	Item 12 Strategic Aim 5 – To embed a population health approach to improve physical and mental health outcomes, promote well-being and reduce health inequalities across an entire population
	No items.

314/24	**Item 13 Integrated Performance Reports** The Integrated Performance Reports were taken as read noting that they had been received and reviewed in depth by Committees.
315/24	Mrs Brown commented that it was pleasing to hear that a more streamlined report was being created in respect of measures both in and out of hospital. There had been some good improvements relating to ambulance delays and ambulance triage however it was acknowledged that the organisation was not seeing any traction on 12-hour trolley waits. Mrs Brown asked if there was work being undertaken across the pathway.
316/24	The Group Chief Integration Officer responded that this had been discussed within Committees and advised that a UEC sprint programme of work was being undertaken looking at decongesting A&E pathways, starting at the access portal; this included speciality referrals in reaching to A&E and looking at the downstream metrics. Discussions had also taken place regarding increased oversight of UEC and the planned care pathways including in and out of hospital care; all of which should see a move on 12-hour trolley waits, length of stay and over occupancy on sites.
317/24	The Director of Finance and Business Intelligence advised Board members that from an LCHS perspective there were now only two indicators not capable of achieving target, which was an improvement from four at the previous meeting. The Board: • **Received the Integrated Performance Reports noting the moderate assurance**
	Item 14 Risk and Assurance
318/24	**Item 14.1 Group Risk Management Report** The Group Chief Clinical Governance Officer presented the monthly risk report to the Board noting that there had been some changes since the previous update. ULHT now had nine very high quality and safety risks; there had been one reduction in risk score relating to the processing of echocardiograms and the test work teams had undertaken.
319/24	Three risks had increased to high; one new very high risk linked to the People and OD Committee in relation to the cancellation of elective lists as a result of a lack of theatre staff and the finance related risks remained static as previously reported.
320/24	In respect of LCHS one new risk had been added pertaining to Children in Care, one risk had reduced in score aligned to the Finance, Performance, People and Innovation Committee relating to the fire risk at Skegness Hospital.
321/24	In relation to the new risk regarding theatre staffing, Ms Cecchini commented that given the discussion at the Finance, Performance and Estates Committee it would be helpful for follow up conversations to take place to understand what exactly the Board would be required to do, or what action Executives were planning to take to mitigate

322/24	the risk. The Chair agreed that this was a good observation and asked the Group Chief People Officer to discuss with the Executives the triangulation of information into Committees and how that pulled through as a risk for the Board. The Group Chief Clinical Governance Officer advised those present that the team had been asked to consider this in terms of wider work around theatre productivity. The Chair thanked the Group Chief Clinical Governance Officer for the report noting the reassurance provided that the risk confirm and challenge meetings were producing some dynamic movement within the Risk Register. The Board: • **Accepted the risks as presented noting the significant assurance**
323/24	**Item 14.2 Board Assurance Framework** The Director of Corporate Affairs presented the report noting that the Board Assurance Framework remained work in progress in respect of populating the detail, and work was ongoing with the newly appointed Executives and their teams. This had been considered by all Committees during July and August 2024 and there had been no change to the ratings, which remained static during this period.
324/24	Professor Baker commented that it was pleasing to see the increased focus on education and noted the challenges in respect of research and innovation and the grip of this. It was anticipated that the new Committee would work in conjunction with the People and OD Committee on this area moving forward.
325/24	The Chair agreed that 2024/25 was a transitional year and the new Executive Directors would need time to review this, additionally the two organisations managed the Board Assurance Frameworks differently and standard procedures would need to be implemented moving forward.
326/24	New strategic objectives would be established from 1 April 2025 and Board Development time would be planned in the meantime to discuss priorities and how those would align to Committees and work programmes in order to execute strategies moving forward. The Chair added that during this time the Board Assurance Framework would continue to be used in the way that it was intended and was a good indication of progress being made. The Board: • **Received the report noting the moderate assurance**
327/24	**Item 14.3 Assurance and Risk Report from the ULHT Audit Committee** The Chair of the ULHT Audit Committee, Mr Herbert, provided the assurances received by the Committee at the meeting held on 8 August 2024 with the report being taken as read.
328/24	Mr Herbert explained that the Committee had received four new internal audit reports with 3 providing reasonable assurance and one providing limited assurance with the

329/24	Committee recognising the positive improvements being seen in the control environment. The local Counter Fraud Specialist Annual Report had also been received which had been appended to the report and was an excellent summary of the work undertaken during the year.
330/24	There had been a disappointing deterioration in overdue policies and guidelines and the previously agreed trajectory for improvement had been missed. The Committee agreed this should be escalated to the Board.
331/24	The Committee had also approved its own Annual Report for 2023/24.
332/24	The Chair thanked Mr Herbert for the report which demonstrated strong process and controls in place, with the exception of policies and guidelines. The Chair acknowledged the escalation from the Audit Committee and requested Executives discussed this matter further, requesting an update in due course.
333/24	The Group Director of Corporate Affairs explained that following the escalation from the Audit Committee, policy data had been shared with ELT and had been escalated through Performance Review Meetings (PRMs), with specific actions to address the failings noted on the trajectory. The Chair noted the escalation process in place and commented that the impact of this would need to be understood. The Board: • **Received the assurance report and the Local Counter Fraud Annual Report**
334/24	**Item 15 Any Other Notified Items of Urgent Business** The Chair informed those present that this would be Mr Young's last Public Board meeting, as he would be leaving the organisation on 20 September 2024. The Chair took the opportunity to thank Mr Young for his hard work over the last ten years.
335/24	The Chair commented that the organisation was in a much improved place, as a consequence of his personal input and leadership of the Finance team in becoming more modern and fit for purpose. The Chair added that Mr Young would leave a great legacy behind, and wished him well in his future endeavours. The Director of Finance thanked Board colleagues for their kind comments.
336/24	No further items were discussed.
	The next scheduled meeting will be held on Tuesday 5 November 2024 via MS Teams live stream.

Voting Members	**7 May 24**	**2 July 2024**	**3 Sept 2024**									
Elaine Baylis	X	X	X									

Andrew Morgan	X											
Karen Dunderdale	X	X	A									
Ian Orrell	X	X	A									
Jim Connolly	X	X	X									
Gail Shadlock	X	X	X									
Chris Gibson	X	X										
Philip Baker	A	A	X									
Neil Herbert	X	X	X									
Rebecca Brown	X	X	X									
Dani Cecchini	X	X	X									
Julie Frake-Harris	X	A										
Colin Farquharson	A	X	A									
Sam Wilde	X	X	X									
Anne-Louise Schokker	X											
Daren Fradgley			X									
Nerea Odongo			X									
Caroline Landon			A									

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	*5th November 2024*
Item Number	*6*

Group Chief Executive's Report

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

System Overview

a) All parts of the Lincolnshire health and care system remain under significant operational pressure as we enter the autumn/winter period, but good work continues in order to cope with the ongoing operational pressures. We planned ahead of the GP collective action following the outcome of the recent ballot and continue to monitor any impact with ICB colleagues on any of our services across the Group.

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

c) The Lincolnshire system had its quarterly system review meeting with the NHS England regional team in October. This was a very supportive meeting, where we received positive feedback on our continued improvements, alongside an acknowledgment of the challenges and risks that the system face.

d) The system received the Winter planning and H2 priorities letter in September which set out year 2 of the UEC recovery plan. This was followed by the NHS IMPACT Clinical and Operational Excellence Programme, which sets out a series of improvement guides and supporting infrastructure. The purpose of this work is to bring together and codify the best clinical and operational practice from across the country, to support further local improvement. Encouragingly our planning captures all the points in the Winter letter and we continue to work collaboratively to ensure we are in the best position over the coming 6 months.

e) Professor Lord Darzi published his review into the state of NHS. The review sets the tone for the development of the 10 year Health plan which will be overseen by the King's Fund former Director of Policy, Sally Warren.

Group Overview

a) Following the last public board meeting, I have now appointed to all the board executive roles with the final appointment of Paul Antunes Goncalves as the Chief Finance Officer, who joins us from Nottingham University Hospital on a 12 month secondment.

b) At Month 6, ULHT's YTD position is a £18.1m deficit, £7.6m adverse to the planned £10.6m YTD deficit.

c) LCHS's YTD position is a £1.0m deficit, £0.2k better than the planned £1.2m deficit position.

d) The ULHT CIP YTD has delivered savings of £15.9m, which is £2.2m higher than planned savings of £13.7m. The CIP delivery is offsetting cost pressures. LCHS CIP YTD has delivered £2.6m, which is in line with plan.

e) United Lincolnshire Hospitals Trust (ULHT) received final confirmation from the Department of Health & Social Care of the official recognition and Establishment Order change to reflect Teaching hospital status. From the 16 September ULHT became United Lincolnshire Teaching Hospitals NHS Trust (ULTH).

f) Congratulations to our ULTH Armed Forces staff network for winning two awards at a recent event in the House of Lords for the work they have undertaken as part of the Step into Health programme, which reinforces our commitment to our Armed Forces community that we are fully supportive in their journey towards a career in the NHS.

g) LCHS was recognised with a Defence Employer Recognition Scheme Gold Award in September. This recognises the support we offer to Reservists, Service leavers, Cadet Force Adult Volunteers, veterans and the spouses and partners of serving personnel, and follows ULTH in gaining the same award last year.

h) On the 20th September the Secretary of State for Health visited the Midlands region and met with Acute and community providers, ICB, mental health providers and local authority CEOs. I attended with Lincolnshire colleagues to listen to his priorities for the NHS.

i) October was Black History Month and our REACH & CODE staff networks arranged an all-day event on 'Reclaiming the Narrative'. This was attended by excellent external speakers, colleagues from the global minority workforce across Lincolnshire and allies.

j) Finally, I would like to thank Sam Wilde for all his dedication and commitment to LCHS over the last 6 years and more recently across the Group as the Director of Finance and wish him well in his new role.

CQC Unannounced Assessment of Urgent and Emergency Care

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

Meeting	*Trust Board*
Date of Meeting	*5 November 2024*
Item Number	

Unannounced Assessment of Urgent and Emergency Care

Accountable Director	*Nerea Odongo, Group Chief Nurse*
Presented by	*Nerea Odongo, Group Chief Nurse*
Author(s)	*Kathryn Helley, Group Chief Clinical Governance Officer*
Recommendations/ Decision Required	*The Board is asked to:-* *Note the content of the report.*

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	
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

On 16 October 2024 the Care Quality Commission (CQC) undertook an unannounced visit to Lincoln County Hospital to review Urgent and Emergency Care Services.

No immediate patient safety concerns were reported back to the Trust as a result of the visit.

The CQC thanked the Trust staff for all the help and support offered throughout the day. They saw examples of good safeguarding practice with emergency department staff and ambulance staff working well together to protect patients. They also observed good patient care throughout the different areas within the department and staff working hard whilst the department was at capacity.

Some initial actions were identified as follows:-

- ensure that the National Early Warning Score process is fully embedded
- improve access to trolleys in the emergency department to assist with patient flow
- review staffing within the CDU escalation area.

Next Steps

To conclude the assessment process a number of focus groups and interviews are to take place. A request for evidence has been received and is due to be submitted on 31 October 2024. Following this, the Trust will receive a report outlining the finding of the assessment and any actions identified.

Trust Board Action

The Trust Board is asked to note the content of the report.

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	*5th November 2024*
Item Number	*6.2*

Group Development – Next Phase

Accountable Director	*Professor Karen Dunderdale, Group CEO*
Presented by	*Professor Karen Dunderdale, Group CEO*
Author(s)	*Professor Karen Dunderdale, Group CEO* *Wendy Booth, Interim Governance Advisor*

Recommendations/ Decision Required	*The Board is asked to:-* • Note the work which is underway to refresh the group development programme plan including proposed work streams and key actions / milestones; • Agree the need for any further information, assurance or actions at this stage.

Executive Summary

Following the appointment of the Group Executive Leadership Team and the appointment of Group Non-Executive Directors there is now a need to review the programme of work supporting the next phase of the groups development.

The key initial actions are included within the report along with the workstreams that have been identified as being critical to the next stage of the groups development.

1. Background & Introduction

1.1 Having completed the process of appointing the Group Executive Leadership Team and following the NHSE approval for the appointment of four 'group' Non-Executive Directors (NEDs) as well as one trust specific NED within each trust, there is also now a need to review the programme of work supporting the next phase of the group's development. Key initial actions include:

- **Refreshing the group development programme & timeline to include a review of:**
  - work streams – *do the previously identified 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;*
  - timescales: *agreement of timescales which are sufficiently challenging but also realistic and achievable.*

- **Refreshing the group development programme governance & oversight arrangements including reporting on progress to:**
  - Group Leadership Team (GLT)
  - Trust Boards
  - wider organisation
  - key external stakeholders (as required)

2.0 Current Position

2.1 Following an initial discussion at the Executive Leadership Team Time-Out held on Thursday, 12 September 2024, the following work streams have been identified as being critical to the next stage of the group's development. A high level summary of proposed key actions within each work stream and the proposed Senior Responsible Officer (SRO) for each work stream is also detailed below:

- **Work stream 1: Group Operating Model & Leadership**
  (development of the group model structure and associated implementation plan including the proposed re-design of the operating functions to work on a wider footprint and ensuring that clinical leadership remains central to the group model)
  SRO: Group Chief Executive

- **Work stream 2: Accountability, Information & Reporting**
  (development of a Group Accountability Framework including an

aligned Integrated Performance Report (IPR) / Key Performance Indicators (KPIs) and an aligned performance review process)
SRO: Group Chief Executive (supported by the Group Chief Integration Officer)

- **Work stream 3: Aligned Governance & Decision-making** *(development of an aligned board reporting framework and the move from boards-in-common to a group or joint board, review of the combined quality committee**(*)**, transition of the remaining board committees to work jointly, development of harmonised board and committee templates and common reporting writing guidance and agreement of executive governance structures which are aligned to and support the agreed group and trust level operating model)*
  SRO: Group Director of Corporate Affairs / Group Chief Clinical Governance Officer

  (*It is worth noting that review of the Quality Committee is now complete. The review was undertaken by the external Interim Governance Advisor currently working with the two trusts and the report from that review concluded: *"In summary, the combining of the two trust Quality Committees appears to have worked well and there is a good level of participation, debate and challenge in the committee. The committee also appears to have oversight of the key quality & safety issues affecting the two trusts and wider group although the dilution of reporting into the committee from some of the previous sub-groups (e.g. Safeguarding & Vulnerabilities and Infection Control) is a potential risk. Inevitably, there is still work to do to further strengthen and embed the revised arrangements and recommendations have been made to support this work".* The outcome of the external review was considered by the Quality Committee at a workshop held on Friday 18 October 2024 and the outcome of that discussion and the response to the recommendations from the external review will be reported to the boards-in-common in due course. It is also worth noting that there is learning from the review of the Quality Committee which can be transferred to the other board committees as they transition to working jointly. The relevant recommendations have therefore been captured within Work stream 3: aligned governance & decision-making.)

- **Work stream 4: Comms & Engagement** *(socialising / launch of group brand and associated actions (e.g. review of signage, documentation, social media etc.)*
  SRO: Group Director of Corporate Affairs

- ***Work stream 5: HR & Workforce*** *(harmonisation of employment policies & processes, T&Cs, reward & recognition, induction etc., development of group values)*
  SRO: Group Chief People Officer

- **Work stream 6: Organisational Development** *(agreement of long term organisational development programme to support the transition*

to group and the new operating model including the provision of external expertise as required)
SRO: Group Chief People Officer

- **Work stream 7: Digital** *(alignment of digital infrastructure and capabilities including the development of the 'Vision for Information')*
  SRO: Group Chief Integration Officer

- **Work stream 8: Estates & Facilities** *(development of a group estates strategy (including the completion of an estate rationalisation review) and the strengthening of estates & facilities management governance structures)*
  SRO: Group Director of Estates & Facilities

- **Work stream 9: Strategy & Planning** *(development of the group strategy and strategic aims & objectives and development and alignment of the underpinning strategies e.g. clinical, quality, people etc.)*
  SRO: Group Chief Integration Officer

- **Work stream 10: Finance** *(development and agreement of a financial strategy and plan for the group, harmonisation of policies and processes, aligned approach to budgetary control etc.)*
  SRO: Group Chief Finance Officer

2.2 The Interim Governance Advisor has been 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 to populate the programme plan accordingly. This work is currently underway.

2.3 Once populated, the plan will be formally shared with the boards and once agreed, it is proposed that progress against delivery of the agreed actions and milestones within the programme plan is reported to the boards through the 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.

2.4 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. One such example: the boards have recently agreed to move from five to three strategic aims for the group for 2025 / 26 with a focus on: Patients, People & Population. The detailed strategic objectives under each aim are currently being worked up and a board development workshop is planned early in the New Year to agree them, alongside agreement of the group's 'risk appetite' and any required changes to the format of the Board Assurance Framework (BAF) for 2025 / 26.

3.0 Trust Board Action Required

3.1 The boards-in-common are asked to:

- note the work which is underway to refresh the group development programme plan including proposed work streams and key actions / milestones;

- agree the need for any further information, assurance or actions at this stage.

Professor Karen Dunderdale
Group Chief Executive
October 2024

Quality Committee in Common Upward Report

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

Meeting	*Lincolnshire Community and Hospitals Group Board Meeting*
Date of Meeting	*5 November 2024*
Item Number	*8.1*

Quality Committee in Common Upward Report of the meeting held on 17 September 2024

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

Purpose

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

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

Upward Report

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

Patient Safety Group (PSG) in Common Upward Report
The Committee received the report with **assurance** noting the review being undertaken in respect of the reduction in reported incidents for ULTH.

Duty of Candour was reported positively across the Group. Despite the LCHS figures appearing low it was known that this was due to timescales and data availability.

A new approach was being developed across the Group in respect of Central Alert System and Field Safety Notices so that this was joined up.

Triangulation of incident and complaints would also tale place and would enable consideration of the Patient Safety Incident Response Framework plan for the next financial year.

In respect of the deteriorating patient the Committee recognised the ongoing work with the division to seek improvements with the Committee noting that alignment of the responsibility for this was being considered. It was recognised that it would take some time for any implemented changes to demonstrate improvements.

The Committee was keen to understand if there was a patient safety impact being seen due to their being no deteriorating patient lead across the Group. Assurance was offered that incidents were reviewed on a daily basis and there was no evidence to suggest an impact.

The Committee was pleased to note the positive report received by the group form the Medicines Quality Group in respect of there having been a 25% increase in Controlled Drug audits.

The Committee received and noted the Infection Prevention and Control (IPC) Board Assurance Frameworks (BAF) for both LCHS and ULTH nothing that there were some red rated areas within the LCHS BAF however this was a timing issue in reporting to the region to identify the Director of IPC.

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

Children in Care Service Update Report – LCHS
The Committee received the report with **assurance** noting that funding had been secured until March 2025 for full paediatric services with interest from 2 Doctors to work part time within the service.

Work was being undertaken in order to algin current reporting systems to ensure appropriate visibility of data and administration support was noted as being in place in order to support performance reporting.

The Committee noted that escalations had been made to the System Quality Group as this was an ICB statutory responsibility however the Trust was progressing at risk as current funding only ran until March 2025.

A formal update would be received by the Committee in December in respect of the improvements in service provision.

Assurance in respect of Objective 1b – Improve patient experience

Patient Experience and Involvement Group in Common Upward Report
The Committee received the report with **assurance** noting the ongoing work to improve Friends and Family Test responses with continued themes from

feedback being received relating to communications. As a result, this was being considered for mandatory training for staff.

The Committee noted the escalation raised by the group in respect of Equality Diversity and Inclusion (EDI) which had recognised that whilst the was strong leadership in place for staff, this was not the case for patients. Therefore, the group was considering how the patient EDI agenda could be delivered. This could support triangulation of patient survey data for the Group to understand whose voice was being heard.
The group had considered a number of patient surveys including the cancer inpatient and CQC inpatient survey. The outcome of these had been positive and indicated improvement in terms of the position of ULTH.

Concern had been noted in respect of mixed sex accommodation due to a number of breaches being reported from the surgery division within ULTH and it was noted that this was due to the management of patients.

The Committee was pleased to note that the group had considered the staff survey results for the previous year for both organisations with the Committee specifically pleased to note the statistically significant improvement for ULTH.

Assurance in respect of Objective 1c – Improve clinical outcomes

Clinical Effectiveness Group in Common Upward Report
The Committee received the report with **assurance** noting the Epilepsy 12 audit which had been appended to the report where there was a risk of ULTH being an outlier. As a result, an action plan had been requested from the Family Health Division to address this.

The Committee considered the Sentinel Stroke National Audit Programme (SNNAP) data for which a recovery action plan was noted as being in place with some improvements being seen across the areas of audit. The Committee focused discussions on those patients remaining on the stroke unit longer than necessary and recognised the work being undertaken to review the service delivery. A referral was made to the Finance, Performance and Estates Committee, ULTH, in respect of the service review to seek assurance on the timeline for delivery of the revised service provision.

Lose notes had been highlighted by the group as an area of concern with the Committee noting the need for a referral to be made to the Finance, Performance and Estates Committee, ULTH due to the reporting route for this. Concern was raised that lose filing could have a quality impact on the patient journey if information was not available.

Focussed Discussion – National Audit Programme
The Committee undertook a focused discussion on the National Audit Programme noting the year-on-year increase in the number of audits to be undertaken.

The Committee noted the participation of ULTH in 58 audits over the year for which the Trust was 100% compliant.

The programme was LCHS was being reviewed as there were currently on 2 national audits being participated in and therefore there was a need to ensure all relevant audits were being addressed.

The Committee noted the clear process in place to undertake and manage audits with reports presented to specialty governance meetings. Clinical Audit Facilitators offered links to the division and assisted the Clinical Audit Leads with both national and local audit programmes.

Work was underway to ensure that those audits spanning multiple divisions were appropriately allocated and actions and outcomes were addressed accordingly. It was recognised that at times, where outlier status was indicated, this was due to data accuracy and upon resolving removed outlier status.

It was recognised that in order to support data accuracy there was a need to ensure that the audit clerks within the divisions were appropriately supported and that there was a network in place to ensure skills were maintained.

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

Not for discussion.

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

Not for discussion.

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

Not for discussion.

Assurance in respect of other areas

Group Board Assurance Framework 2024/25
The Committee received the draft Group Board Assurance Framework (BAF) with **assurance** noting updates continued to be sought on a monthly basis for consideration by the Committee.

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

Emergency Planning Quarterly Report: Quarter 1 2024 – LCHS
The Committee received the report with **assurance** noting the partial compliance that was reported and reflected that this position had been consistent for some time.

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

There had been a number of changes to high risks for LCHS with the Committee noting the difference in risk ratings across the 2 organisations. Work was also being undertaken to ensure that risks were appropriately reflected across the Group where necessary.

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

Group CQC Forward View
The Committee received the report with **assurance** noting that the report provided an update on the progress being made in respect of the new CQC Single Assessment Framework.

The Committee noted that the evidence collection would support discussions as to areas requiring support with a need to ensure the quality of the evidence and data being provided.

Quality Impact assessment Quarterly Assurance Report – LCHS and ULTH
The Committee received the reports with **assurance** for both ULTH and LCHS noting what had been received by the QIA panel for both organisations with work also progressing in respect of a joint policy process moving forward.

Committee Performance Dashboard - ULTH and LCHS
The Committee received the reports for ULTH and LCHS with **assurance** noting that the discussions held by the Committee through the reports reflected the performance position reflected.

The Committee noted concern in respect of the reporting of the Summary Hospital-Level Mortality Indicator (SHMI) through the SPC chart as this was not responsive to the moving target for which ULTH reported against. Work would be undertaken to determine the most appropriate reporting approach.

Integrated Improvement Plan - ULTH
The Committee received the Integrated Improvement Plan report for information noting the **moderate assurance** and recognised that the report triangulated with the wider discussions of the Committee.

Interim ToR and Work Programme
The Committee received the interim terms of reference and work programme for information.

Issues where assurance remains outstanding for escalation to the Board

No escalations required.

Items referred to other Committees for Assurance

The Committee referred to the ULTH Finance, Performance and Estates Committee the issues of lose notes and stroke services.

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			
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			
Rebecca Brown, Non-Executive Director (Maternity Safety Champion), ULHT/LCHS	X	X	X	X	X	X	X	X	X			
Gail Shadlock, Non-Executive Director, LCHS	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			
Caroline Landon, Group Chief Operating Officer								X	X			
Daren Fradgley, Group Chief Integration Officer								X	X			

X in attendance
A apologies given
D deputy attended

Quality Committee in Common Upward Report

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

Meeting	*Lincolnshire Community and Hospitals Group Board Meeting*
Date of Meeting	*5 November 2024*
Item Number	*8.1*

Quality Committee in Common Upward Report of the meeting held on 22 October 2024

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

Purpose

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

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

Upward Report

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

Patient Safety Group (PSG) in Common Upward Report
The Committee received the report with **assurance** noting the group had reviewed the data associated with the perceived reduction in incident reporting however, due to the charts not correlating further investigation would be undertaken.

There had been a positive position reported in respect of Field Safety Notices with an improvement since March 2024 of 86% in terms of closure of actions. This was as a result of dedicated focus being given to this work.

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 group had received an update in respect of Martha's rule with a number of reports shared with the Committee for oversight, specifically the Call 4 Concern documents. The Committee noted the implementation date of December and noted further national guidance was awaited in respect of reporting expectations.

The Committee noted the report received in respect of DKA which had been awaited for some time and demonstrated the significant work which had been undertaken offering **reassurance** to the group and Committee.

Detailed upward reports continued to be received by the group from the Divisions which demonstrated the level of grip and control in place.

The Committee noted the terms of reference for the Medical Devices Safety Group with a query regarding appropriate membership to ensure this was reflective across the Group, this would be reviewed and revised if necessary.

The Medicines Optimisation Strategy was received with the Committee noting the content and reflecting that this had been well written however noted the need to ensure that there was a clear direction of travel across the Group in respect of strategies and how and where these were approved and managed.

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

Maternity and Neonatal Oversight Group Upward Report
The Committee received the report with **assurance** noting the improved position of ULTH on the regional heat map having achieved a score of 18 in month. It was anticipated that this score would continue to reduce over time, further improving the position of the Trust.

The roll out of Badgernet was anticipated in April 2025 with the project team progressing the associated work to achieve this. The Committee noted that the Trust was compliant with Saving Babies Lives with preparation underway for the go live of physiology on 6 November 2024.

The Committee was pleased to note the upgrade of the service from 'participating' to a 'recognised' maternity unit in respect of the Twins Trust Audit. This was a positive development for the small team who managed the twin pregnancy pathway.

The Pelvic Health Project Lead Midwife had been appointed an would commence in post at the end of October supporting delivery of the service, incorporating education in relation to prevention.

The Committee received and noted a number of appended reports in relation to the neonatal workforce including the action plan to achieve the 75% trajectory of qualified in specialty staff.

A significant increase in safeguarding cases had been noted with 2 Safeguarding Midwives within the service however it was noted, due to the increase, that further work was required to support the team.

In respect of the Clinical Negligence Scheme for Trusts (CNST) the Committee noted the midpoint review, receiving and approving a series of associated documents which have been made available to the Board in the reading room of iBabs.

- CNST Standard 4: Short-term locum engagement: Note the exception report **See Appendix 9.1** and agree on decision to submit non-compliance with additional request for NHSR to review the evidence relating to this action with a potential to upgrade to complaint.

- CNST Standard 4: BAPM Nurse Standards: NNU is currently not staffed to BAPM requirements for the neonatal nursing workforce, however progress is being made to address the deficiencies. The Quality Committee and Trust Board should note the progress made in respect of the previous action plan. **See Appendix 1.5, 1.5.1, 1.5.2, 1.5.3, 1.5.4**

- CNST Standard 6: Trust Board should note the progress made towards Saving Babies Lives Care Bundle and the agreement for divergence to the guidance relating to obstetric leads. The ICB and the Business Unit has reviewed the position and feels that the standard has been met with the 0.1wte in addition to the Fetal Monitoring Lead Midwife. **See Appendix 1.1, 10, 10.1, 10.2, 10.3**

- CNST Standard 10: Upward reporting to Trust Board of **appendix 1.6**, and narrative that demonstrates that during this reporting period there have been no additional MNSI/EN cases. The accumulative numbers for the current CNST reporting period are currently 3 MNSI cases, 2 of which qualified for Early Notification. For all three cases, families received both verbal and written Duty of Candour and the relevant information about the role of EN and MNSI.

Focussed Discussion – Pressure Ulcers
The Committee undertook a focused discussion on pressure ulcers following the deep dive undertaken in June 2024 to understand the progress that had been made.

The Committee received the report and associated action plan noting 3 key themes of education standards for staff, identification through care pathways and processes for escalation and holistic care for LCHS.

LCHS had initiated an assurance programme for skin integrity in May 2024 which continued to meet on a weekly basis which maintained oversight of the position. Since the introduction of the assurance programmes there had been an increase in awareness amongst staff in respect of pressure damage with the assurance profile improving over time.

The Committee noted that pressure ulcers was held as a high risk on the LCHS risk register and at this time it was not felt appropriate to reduce this. There was a clear action plan in place with oversight assurance processes along with Group working to support improvement.

Consideration had also been given to Moisture Associated Skin Damage (MASD) and continence due to potential concern of a correlation. Whilst it was noted that, following a case note review, there was no direct correlation further work would be undertaken by the Skin Integrity Group to consider any learning and actions that could be identified.

The Committee noted the update provided by ULTH through the focussed discussion with significant improvements having been noted from the position 2 years prior.

Monthly Skin Integrity meetings were held in addition to a Skin Integrity Improvement Group being in place which offers support to specific areas if required.

Moisture was noted as one of the main issues for ULTH with a range of actions in place to ensure this was a priority for improvement. A moisture group had been established across the Group with the intention to standardise some of the variances being seen in care.

A project was also taking place to consider the impact of temperature on moisture damage as peaks had been noted in the summer and winter months. Data was being gathered to determine if there was a need for temperature-controlled environments to support the nursing teams.

The Committee was pleased to note the progress that was being made in respect of pressure ulcers and recognised the significant journey ahead for the teams to continue to realise improvements. The Committee requested a further update be provided in 6-months with the anticipation of seeing further improvements.

Focussed Discussion – Pharmacy/Medicines Management
The Committee undertook a focused discussion in respect of Pharmacy and Medicines Management following concerns that had been raised at previous meetings in respect of the service.

The Committee noted the work that had been undertaken in the service over the past 18 months including successful recruitment of over 50 staff. Whilst some attrition was noted there was a low vacancy rate of 1.6% against the funded establishment.

The service had undertaken a number of cultural surveys with the repeat survey undertaken in March 2024 showing significant progress however issues remained in respect of staff progression, weekend working, staff retention and ePMA.

To address ePMA issues the service had set up a focus group to involve the team and to ensure collaboration with others to ensure progress was made in respect of the project.

The Committee noted the impact on staff of weekend working with drop-in sessions being held to support staff. A case of need had been developed in order to support full working days at the weekend, including bank holidays.

To support staff the service had introduced regular newsletters which offered celebrations of the team and showcasing developments within the service along with wellbeing support for staff.

Medicines reconciliation remained static and whilst a bid had been made for recent winter monies it was noted that this had not been successful. Despite this the Committee noted that the service continued to pursue the national standards required.

Progress was noted in respect of the CQC actions as well as the implementation of the self-administration policy. Work was also taking place across the Group with the review of the medicines management policy and a new Aseptic unit, processes and staff were in place for ULTH.

The Committee was pleased to note the update that was provided including noting the areas of excellence that had been demonstrated, however reflected on the need for further support to be offered to the service for continued development which would be undertaken by the Group Chief Integration Officer.

Assurance in respect of Objective 1b – Improve patient experience

Patient Experience and Involvement Group in Common Upward Report
The Committee received the report with **assurance** noting that the data considered by the group was now joined up across the Group, allowing LCHS to access and triangulated data, mirroring the ULTH process.

It was noted that there would be continued development of the dashboard to ensure appropriate narrative supported the data presented as well as developing You Said, We Did, in order to determine required actions. Work was also taking place to improve the Friends and Family Test with the Committee noting the approval of the performance indicators.

Through the Patient Advice and Liaison Service the group continued to note the common theme of communication and waiting times with the Committee noting that there was a failure to communicate waiting times clearly to patients.

The group received updates from the divisions demonstrating where improvements were being made, including learning from patient stories.

Assurance in respect of Objective 1c – Improve clinical outcomes

Clinical Effectiveness Group in Common Upward Report
The Committee received the report with **assurance** noting the low Hospital Standardised Mortality Ratio (HSMR) along with a low crude death rate. The Summary Hospital Mortality Indicator (SHMI) was also reported as within the expected range and work continued in respect of the appropriate reporting for the indicator.

The Committee noted the reduction in the completion of Structured Judgement Reviews (SJRs) within timescale to 81%, below the set benchmark of 90%. It was noted that this was reported on a 12-month rolling reporting analysis.

The group received a detailed update from LCHS regarding the Integrated Urgent and Emergency Care position with significant improvements noted in overdue NICE guidance. The group would continue to monitor the position however reassurance had been received.

National Confidential Enquiry into Patient Outcome and Death (NCEPOD) audit data for ULTH continued to show outstanding actions which were over 12 months old. Whilst there had been an improvement in the position from 33 to 18 overdue the group had sought updates from the Divisions as to the actions being taken to address the overdue NCEPOD actions.

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

Not for discussion.

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

Not for discussion.

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

Not for discussion.

Assurance in respect of other areas

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

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

Risk Report
The Committee received the joint report with **assurance** noting the dynamic nature of the risk register and recognising the work taking place across the Group to align risk. It was noted that a joint policy had been developed with an anticipated implementation date of 1 December 2024 which would provide a consistent approach to risk across the Group.

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

Policies Overdue for Review
The Committee received the report with **assurance** noting the position presented in respect of overdue policies noting that this would continue to be reported on a monthly basis to ensure oversight and progress.

The Committee noted that there would be benefit in the inclusion of a trajectory to address the updates required.

Quarterly Group CQC Progress Update
The Committee received the report with **assurance** noting that there had been a number of changes to the position since the report had been produced.

It was noted that the changes to the assessment process had been placed on hold by the CQC however the Group would continue to monitor any outstanding actions whilst the new assessment framework was determined by the CQC.

Maternity Insights Visit – 24 September 2024 - ULTH
The Committee received the report with **assurance** and noted the feedback offered. It was recognised that any actions resulting from the visits would be collated and monitored through the clinical governance team however the formal report was still awaited.

CQC Feedback Letter – Assessment of UEC
The Committee received the letter noting the outcome and recognised that a formal report would follow. Where necessary and action plan would be developed for those areas identified as requiring improvement.

Committee Performance Dashboard - ULTH and LCHS

The Committee received the reports for ULTH and LCHS with **assurance** noting the transition work of the dashboard which had been discussed at the Quality Committee workshop.

The Committee noted the performance reported reflected the discussions held during the course of the meeting and reporting would in future be aligned to the patient journey.

Operational Plan Report - LCHS and Integrated Improvement Plan - ULTH
The Committee received the reports with **assurance** noting that work was taking place to move this to a Group approach which would provide greater oversight and triangulation of the position.

The Committee noted the new approach to divisional reporting with a new style report expected to be received from November to the Committee.

Interim ToR and Work Programme
The Committee received the interim terms of reference and work programme for information.

Any Other Business – Quality Committee Workshop
The Committee received a verbal update following the workshop which had been held on the 18 October, as the 6-month review of the Committee in Common.

The Committee noted that the workshop had considered the report of the external consultant which contained a number of recommendations. The report, along with the feedback from the reporting groups would be reported to the Committee formally in November, outlining the discussions and recommendations and would also be reported to the Board.

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		
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		
Rebecca Brown, Non-Executive Director (Maternity Safety Champion), ULHT/LCHS	X	X	X	X	X	X	X	X	X	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		
Caroline Landon, Group Chief Operating Officer								X	X	X		
Daren Fradgley, Group Chief Integration Officer								X	X	X		

X in attendance
A apologies given
D deputy attended

Meeting	*Lincolnshire Community and Hospitals Group Board Meeting*
Date of Meeting	*5th November 2024*
Item Number	*8.2*

NHSE Listening to Women and Families – APPG Birth Trauma Report

Accountable Director	*Nerea Odongo, Group Chief Nurse*
Presented by	*Nerea Odongo, Group Chief Nurse*
Author(s)	*Libby Grooby, Director of Midwifery*
Report previously considered at	*MNOG* *June 2024* *For information*

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	
1c Improve clinical outcomes	
1d Deliver clinically led integrated services	
2a Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	
2b To be the employer of choice	
3a Deliver financially sustainable healthcare, making the best use of resources	
3b Drive better decision and impactful action through insight	*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)	
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	*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	

Risk Assessment	*Insert risk register reference*
Financial Impact Assessment	*Insert detail*
Quality Impact Assessment	*Insert detail*
Equality Impact Assessment	*Insert detail*
Assurance Level Assessment	*Insert assurance level* • *Significant* • *Moderate* • *Limited* • *None*

Recommendations/ Decision Required	• *The Board are asked to note the content of the report*

Executive Summary

The All-Party Parliamentary Committee launched a report on their findings from the Birth Trauma Inquiry on the 13th of May entitled *"Listen to Mums: Ending the Postcode Lottery on Perinatal Care".* The background to the report includes the three major investigations into failures in maternity care and that almost half of maternity units in the UK are rated as "inadequate" or "needs improvement" by the CQC. The report asserts that in spite of the numerous policy documents that there is no single overarching strategy to improve maternity care.

The inquiry received 1300 submissions from people who had experienced traumatic births and a further 100 submissions from maternity professions. There were also seven evidence sessions which included both parents and experts. The inquiry has documented harrowing experiences of maternity care and the impact in both the short and long-term of birth trauma. Research evidence indicates about 4-5% of women develop post-traumatic stress disorder and around 1/3 describe their births as traumatic, the report considers the significant social and economic costs associated with these outcomes. The inquiry concluded that *"The picture to emerge was of a maternity system where poor care is all-too-frequently tolerated as normal, and women are treated as an inconvenience".*

The report has made a number of recommendations many of which are already included in the Three-Year Delivery Plan. The initial benchmarking demonstrates a positive position for ULHT. The only red action we had in ULHT was the delayed support for the use of SDF funding to develop a perinatal pelvic health service across Lincolnshire as per the Three-Year Delivery Plan. The funding has now been approved and we are in the process of implementing a service for the women of Lincolnshire.

The recommendation is 'Maternity units to implement NHS England's Perinatal Pelvic Health service specification, which includes providing information for women in antenatal period, such as the importance of pelvic floor exercises; increased education for health professionals including GPs; and early access to care for symptoms of incontinence. Women with perineal injuries to be seen by specialists in pelvic health clinics.

Date published: 17 May, 2024
Date last updated: 17 May, 2024

Maternity and neonatal services – listening to women and families

Publication (/publication)

Content

- Maternity and neonatal services - listening to women and families
- Annex 1: Integrated care board allocations for maternity and neonatal voice partnerships

Classification: Official
Publication reference: PRN01359

To:

- Integrated care boards (ICBs):
  - chief executives
  - chairs
  - chief nurses

    - medical directors
- Provider trust:
    - chief executives
    - chairs
    - chief nurses
    - medical directors

cc.

- Local maternity and neonatal system (LMNS) chairs/leads
- Neonatal operational delivery network (ODN) leads
- Regional:
    - directors
    - chief nurses
    - medical directors
    - chief midwives
    - lead obstetricians

Dear colleague,

Maternity and neonatal services – listening to women and families

The importance of listening to women, and taking appropriate action in response, has again been brought into sharp focus this week following publication of the report by the All-Party Parliamentary Group (APPG) on Birth Trauma (https://www.theo-clarke.org.uk/sites/www.theo-clarke.org.uk/files/2024-05/Birth%20Trauma%20Inquiry%20Report%20for%20Publication_May13_2024.pdf).

We are grateful to the APPG on Birth Trauma for giving a voice to mothers and families who have experienced birth trauma. There is no single solution to reducing risks before, during and after birth, and the needs of each mother, baby and family affected by a traumatic birth will be different, and local services have important roles to play in preventing traumatic births, and better supporting those who experience them. We urge all Boards, and those that work in maternity and neonatal services to read the report and how its themes and recommendations inform existing local plans to implement the three year delivery plan for maternity and neonatal services.

The Priorities and operational planning guidance 2024/25 (https://www.england.nhs.uk/publication/priorities-and-operational-planning-guidance-2024-25/) makes clear that the implementation of the Three year delivery plan for maternity and neonatal services (https://www.england.nhs.uk/publication/three-year-delivery-plan-for-maternity-and-neonatal-services/) continues to be a key priority for integrated care boards (ICBs), Trusts and primary care. The vast majority of women, babies and families receive safe care, and the plan commits the NHS to making maternity and neonatal care safer, more personalised, and more equitable, and prioritises listening to women and families to achieve this.

Trust boards and ICBs have a duty to ensure regular, robust oversight of maternity and neonatal services in line with the perinatal quality surveillance model (https://www.england.nhs.uk/publication/implementing-a-revised-perinatal-quality-surveillance-model/). In particular, if not already done so, boards must review the commissioning and implementation of existing commitments for which you have received funding for implementation in 23/24, and which will help address recommendations in the All-Party Parliamentary Group (APPG) on Birth Trauma report:

- perinatal pelvic health services, in line with the national service specification (https://www.england.nhs.uk/publication/service-specification-perinatal-pelvic-health-services/)
- maternal mental health services, in line with national guidance
- availability of bereavement services 7 days a week
- local maternity and neonatal system (LMNS) equity and equality action plans, working across organisational boundaries

Since 2020 there has been a contractual requirement to offer women a maternal postnatal consultation with a GP (https://www.england.nhs.uk/long-read/gp-six-to-eight-week-maternal-postnatal-consultation-what-good-looks-like-guidance/), and in December 2023 we issued 'what good looks like (https://www.england.nhs.uk/long-read/gp-six-to-eight-week-maternal-postnatal-consultation-what-good-looks-like-guidance/)' guidance in support of this. We therefore ask ICBs to review local delivery of this standard.

NHS England is providing an additional £3 million of funding for maternity and neonatal voice partnerships (MNVPs) in 2025/26 and 2026/27, with a part-year effect of £1.2 million in 2024/25. This funding is part of a £35 million package of additional investment in maternity and neonatal services over three years that was announced in the Spring budget. ICBs should already be providing appropriate levels of funding and resourcing to MNVPs, and therefore the additional funding recognises the central role MNVPs play in helping to improve care as outlined in Maternity and neonatal voices partnership guidance (https://www.england.nhs.uk/long-read/maternity-and-neonatal-voices-partnership-guidance/), and the need to strengthen the neonatal parental voice component. This letter confirms allocations for 2024/25 (Annex 1 (https://www.england.nhs.uk/long-read/maternity-and-neonatal-services-listening-to-women-and-families/#annex-1-integrated-care-board-allocations-for-maternity-and-neonatal-voice-partnerships)), which have been calculated on a per unit basis. The funding will be available for ICBs to draw down by June.

We look forward to continuing to work with you to improve maternity and neonatal care.

Yours sincerely,

Dame Ruth May, Chief Nursing Officer, NHS England.
Professor Sir Stephen Powis, National Medical Director, NHS England.
Dr Emily Lawson DBE, Chief Operating Officer, NHS England.

Annex 1: Integrated care board allocations for maternity and neonatal voice partnerships

Org code	Org name	No. of units	Allocation 2024/25
QOX	Bath and North East Somerset, Swindon and Wiltshire ICB	3	£23,077
QHG	Bedfordshire, Luton and Milton Keynes ICB	3	£23,077
QHL	Birmingham and Solihull ICB	3	£23,077
QUA	Black Country ICB	4	£30,769
QUY	Bristol, North Somerset and South Gloucestershire ICB	2	£15,385

Org code	Org name	No. of units	Allocation 2024/25
QU9	Buckinghamshire, Oxfordshire and Berkshire West ICB	3	£23,077
QUE	Cambridgeshire and Peterborough ICB	3	£23,077
QYG	Cheshire and Merseyside ICB	8	£61,538
QT6	Cornwall and The Isles Of Scilly ICB	1	£7,692
QWU	Coventry and Warwickshire ICB	3	£23,077
QJ2	Derby and Derbyshire ICB	3	£23,077

Org code	Org name	No. of units	Allocation 2024/25
QJK	Devon ICB	4	£30,769
QVV	Dorset ICB	2	£15,385
QNQ	Frimley Integrated Care ICB	2	£15,385
QR1	Gloucestershire ICB	1	£7,692
QOP	Greater Manchester Integrated Care ICB	8	£61,538
QRL	Hampshire and The Isle Of Wight ICB	5	£38,462
QGH	Herefordshire and Worcestershire ICB	2	£15,385

Org code	Org name	No. of units	Allocation 2024/25
QM7	Hertfordshire and West Essex ICB	3	£23,077
QOQ	Humber and North Yorkshire ICB	6	£46,154
QKS	Kent and Medway ICB	5	£38,462
QE1	Lancashire and South Cumbria ICB	5	£38,462
QK1	Leicester, Leicestershire and Rutland ICB	2	£15,385
QJM	Lincolnshire ICB	2	£15,385

Org code	Org name	No. of units	Allocation 2024/25
QH8	Mid and South Essex ICB	3	£23,077
QMM	Norfolk and Waveney ICB	3	£23,077
QMJ	North Central London ICB	5	£38,462
QHM	North East and North Cumbria ICB	10	£76,923
QMF	North East London ICB	5	£38,462
QRV	North West London ICB	6	£46,154
QPM	Northamptonshire ICB	2	£15,385

Org code	Org name	No. of units	Allocation 2024/25
QT1	Nottingham and Nottinghamshire ICB	3	£23,077
QOC	Shropshire, Telford and Wrekin ICB	1	£7,692
QSL	Somerset ICB	2	£15,385
QKK	South East London ICB	5	£38,462
QWE	South West London ICB	5	£38,462
QF7	South Yorkshire ICB	5	£38,462
QNC	Staffordshire and Stoke on Trent ICB	1	£7,692

Org code	Org name	No. of units	Allocation 2024/25
QJG	Suffolk and North East Essex ICB	3	£23,077
QXU	Surrey Heartlands ICB	3	£23,077
QNX	Sussex ICB	5	£38,462
QWO	West Yorkshire ICB	6	£46,154
Total		156	£1,200,000

Date published: 17 May, 2024
Date last updated: 17 May, 2024

▲Back to top

Listen to Mums:

Ending the Postcode Lottery on Perinatal Care

A report by The All-Party Parliamentary Group on Birth Trauma

Share this report using #BirthTraumaInquiry

About ... 3
FOREWORD ... 6
EXECUTIVE SUMMARY ... 8
Introduction ... 10
KEY THEMES ... 14
Chapter 1: Birth trauma: an overview ... 22
Chapter 2: What we can learn from other countries ... 30
Chapter 3: Birth injuries ... 35
Chapter 4: Birth trauma and mental health services ... 42
Chapter 5: The wider impact of birth trauma ... 48
Chapter 6: Partners' perspectives ... 53
Chapter 7: Marginalised groups ... 58
Vision: what does 'good' look like in maternity? ... 65
APPENDIX 1 ... 68
APPENDIX II ... 70
ENDNOTES ... 73

About

About the Birth Trauma Inquiry

On 9 January 2024, the All-Party Parliamentary Group (APPG) on Birth Trauma established the first national inquiry in the UK Parliament to investigate the reasons for birth trauma and to develop policy recommendations to reduce the rate of birth trauma. Seven oral evidence sessions took place on consecutive Mondays between 5 February and 18 March 2024 in the House of Commons.

The Inquiry was also informed by written submissions which were received following a public call-for-evidence.

About the Author

The report was written by Dr Kim Thomas, Secretariat of the APPG on Birth Trauma and CEO of the Birth Trauma Association. She has also published two books about birth trauma: "Birth Trauma: A Guide for You, Your Friends and Family to Coping with Post-Traumatic Stress Disorder Following Birth", and "Postnatal PTSD: a Guide for Health Professionals".

Acknowledgements

The APPG on Birth Trauma would like to thank the following individuals without whom this Inquiry would not be possible:

Birth Trauma Inquiry Special Advisory Group: Gill Castle, Rhiannon Evans, Chloe Oliver, Laura Seebohm, Kim Thomas and Nikki Wilson.

Submission Readers: Julia Andrew, Sarah Barnes, Debra Bick, Gill Castle, Sarah Embleton, Sophie Franks, Bob Freeman, Hannah Horne, Rachael McGrath, Heather Simmons, Louise Peacock, Jo Prance and Trudi Webber

Report production: Max Austin, Hannah Farrimond, James Fisk, Beth Holloway, Elliott Malik, Lily Leigh-Matthews and Avnish Popat

About the All-Party Parliamentary Group for Birth Trauma

Theo Clarke MP – Chair
Theo was elected as the MP for Stafford in 2019 and set up the APPG for Birth Trauma following the difficult birth of her daughter. She led the first debate on birth trauma in the House of Commons. The public response to her speech led her to launch this inquiry. Theo was previously a member of the Women and Equalities Select Committee in Parliament. She serves as one of the Prime Minister's Trade Envoys and as Parliamentary Private Secretary to the Department of Education. Theo chairs the sub-committee of the International Development Select Committee on the work of the Independent Commission for Aid Impact.

Rosie Duffield MP – co-Chair
Rosie was first elected as MP for Canterbury in 2017. She has served on the Environment, Food and Rural Affairs select committee since 2020 and was previously chair of the Women's Parliamentary Labour Party and a member of the Work and Pensions select committee. Rosie is a vocal advocate for women's rights, having spoken in the House of Commons about her own experience of domestic abuse, and representing her constituents affected by the deaths of mothers and babies at the East Kent University Hospitals NHS Trust.

Cherilyn Mackrory MP – Vice-Chair
Cherilyn has represented Truro & Falmouth since 2019. Before her election She was a Cornwall Councillor. Before moving to Cornwall, Cherilyn worked as an IT project manager.
Cherilyn is Co-Chair of the APPG on Baby Loss where she fights for better and safer maternity services and aims to develop policies that support families dealing with the grief and loss of a baby. She is Co-Chair of the Women's Health APPG**,** aiming to ensure women are listened to and make informed choices. She is married to Nick, and they have a young daughter.

Bell Ribieiro-Addy MP – Vice-Chair
Bell has represented her home constituency of Streatham in South London as a Labour MP since the 2019 General Election. Bell is a dedicated feminist, anti-racist and trade unionist, who has campaigned extensively on the issue of Black maternal health currently sits on the Women & Equalities Committee and Joint Human Rights Committees in Parliament. She also chairs the All Party-Parliamentary Groups for Black Maternal Health, Afrikan Reparations, and Endometriosis.

Mark Pawsey MP
Mark has represented Rugby since 2010. Before entering politics, Mark obtained a degree in Estate Management from the University of Reading, before moving into business and becoming a local Councillor.
Mark has been a member of Select Committees and acted as a Parliamentary Private Secretary to the Departments of Defence, BEIS, and Work and Pensions. He chairs the All-Party Groups for Packaging and Manufacturing. Mark is married to Tracy, and they live in the village of Grandborough, close to Rugby.

Darren Henry MP
Darren has represented Broxtowe since 2019. Before entering politics Darren spent 26 years in the Royal Air Force. Darren has been Trade Envoy to the Caribbean, as well as an Assistant Government Whip. He began campaigning to ensure that parents who lose their partner in childbirth have an automatic right to leave in 2022 following a surgery with a constituent who found himself unable to do so. Following his work, this Bill is now set to become law this year. Darren is a father to twins, who themselves had difficult births so is passionate in helping others through this report.

Helen Morgan MP
Helen has represented North Shropshire for over two years during which she has campaigned continuously for improved maternity services. Unfortunately, in Shropshire, preventing avoidable baby loss is an extremely poignant cause for many people so shortly after being elected, Helen became a Co-Chair of the APPG for Baby Loss. By holding debates and events, Helen has worked to be a voice for bereaved parents and urge the Government to act on staffing issues in UK maternity services.

Sally-Ann Hart MP
Sally-Ann has represented Hastings and Rye since 2019. Before entering Parliament, she went to university in London and qualified as a lawyer specialising in corporate finance law with a City of London law firm. After taking a career break to bring up her children, Sally-Ann later became a local Magistrate in Hastings and a District Councillor at Rother. Sally-Ann has a drive to support rough sleepers and the homeless, as well as vulnerable children, young adults and families.

FOREWORD

For any parent, having a child will be one of the most momentous and memorable occasions of their life. When something unexpected happens during a pregnancy or birth it can lead to lifelong physical and psychological consequences that often remain unknown and unspoken about.

This Birth Trauma Inquiry is, in its simplest form, an attempt to break this taboo and share the stories and experiences of mothers and fathers publicly and start a public discussion on the realities of giving birth and how we can practically improve maternity services.

Our key conclusion has been on the need to introduce a base standard in maternity services across the United Kingdom. **Currently there are several strategy documents relating to maternity but no single overarching document. We believe that maternity strategy should be brought into a single, living document, hosted on the UK government website and continuously brought up-to-date.**

To this end, the All-Party Parliamentary Group on Birth Trauma calls on the UK Government to publish a National Maternity Improvement Strategy, led by a new Maternity Commissioner who will report to the Prime Minister, which will outline ways to:

1. Recruit, train and retain more midwives, obstetricians and anaesthetists to ensure safe levels of staffing in maternity services and provide mandatory training on trauma-informed care.
2. Provide universal access to specialist maternal mental health services across the UK to end the postcode lottery.
3. Offer a separate 6-week check post-delivery with a GP for all mothers which includes separate questions for the mother's physical and mental health to the baby.
4. Roll out and implement, underpinned by sufficient training, the OASI (obstetric and anal sphincter injury) care bundle to all hospital trusts to reduce risk of injuries in childbirth.
5. Oversee the national rollout of standardised post birth services, such as Birth Reflections, to give all mothers a safe space to speak about their experiences in childbirth.
6. Ensure better education for women on birth choices. All NHS Trusts should offer antenatal classes. Risks should be discussed during both antenatal classes and at the 34-week antenatal check with a midwife to ensure informed consent.
7. Respect mothers' choices about giving birth and access to pain relief and keep mothers together with their baby as much as possible.

8. Provide support for fathers and ensure nominated birth partner is continuously informed and updated during labour and post-delivery.
9. Provide better continuity of care and digitise mother's health records to improve communication between primary and secondary health care pathways. This should include the integration of different IT systems to ensure notes are always shared.
10. Extend the time limit for medical negligence litigation relating to childbirth from three years to five years.
11. Commit to tackling inequalities in maternity care among ethnic minorities, particularly Black and Asian women. To address this NHS England should provide funding to each NHS Trust to maintain a pool of appropriately trained interpreters with expertise in maternity and to train NHS staff to work with interpreters.
12. NIHR to commission research on the economic impact of birth trauma and injuries, including factors such as women delaying returning to work.

Over the past three months, we have been privileged to hear from parents from across the United Kingdom. They have trusted us with some of their most personal reflections and thoughts, often relating to deeply troubling memories and experiences. This, the first Parliamentary Inquiry into Birth Trauma, is as much their report as it is ours.

Our special thanks also go to all those who have supported the Inquiry and most especially to Kim Thomas who has authored this report. The issues and stories contained in the following pages may be difficult to read but underline that this issue transcends party lines and it will be up to whoever forms successive Governments to listen and act.

Theo Clarke MP
Chair
APPG on Birth Trauma

Rosie Duffield MP
Co-Chair
APPG on Birth Trauma

EXECUTIVE SUMMARY

The inquiry received more than 1,300 submissions from people who had experienced traumatic birth, as well as nearly 100 submissions from maternity professionals. It also held seven evidence sessions, in which it heard testimony from both parents and experts, including maternity professionals and academics.

The stories told by parents were harrowing. They included accounts of stillbirth, premature birth, babies born with cerebral palsy caused by oxygen deprivation, and life-changing injuries to women as the result of severe tearing. In many of these cases, the trauma was caused by mistakes and failures made before and during labour. Frequently, these errors were covered up by hospitals who frustrated parents' efforts to find answers.

There were also many stories of care that lacked compassion, including women not being listened to when they felt something was wrong, being mocked or shouted at and being denied basic needs such as pain relief. Women frequently felt they were subjected to interventions they had not consented to, and many felt they had not been given enough information to make decisions during birth. The poor quality of postnatal care was an almost-universal theme. Women shared stories of being left in blood-stained sheets, or of ringing the bell for help but no one coming.

The inquiry also heard, both from the submissions and the evidence sessions, accounts of the short-term and long-term impact of birth trauma. This included difficulties in bonding with the baby, stress on the relationship with their partner and wider family and, often, an inability to return to work.

Some of the most devastating accounts came from women who had experienced birth injuries, causing a lifetime of pain and bowel incontinence. Many of these women said they could no longer work, and described their injuries as having destroyed their sense of self-worth. Other women wrote movingly of having to provide round-the-clock care for children left severely disabled as a result of birth injuries.

Women from marginalised groups, particularly those from minoritised ethnic groups, appeared to experience particularly poor care, with some reporting direct and indirect racism.

The inquiry also heard from partners who had been psychologically distressed after witnessing traumatic birth, but whose emotional needs were disregarded, both during the birth and postnatally.

Many women wrote of their difficulty in accessing maternal health services, either facing long waiting lists or being told they didn't meet the criteria for help. There were, however, some positive stories from women who had successfully accessed therapy and been helped to recover.

We also heard from maternity professionals who reported a maternity system in which overwork and understaffing was endemic. Some referred to a culture of bullying.

The picture to emerge was of a maternity system where poor care is all-too-frequently tolerated as normal, and women are treated as an inconvenience. We have made a set of recommendations that aim to address these problems and work towards a maternity system that is woman-centred and where poor care is the exception rather than the rule.

Introduction

Why an inquiry into birth trauma?

While many women in the UK have a positive experience of birth, resulting in a healthy baby, this is not always the case, and this inquiry has focused on the times when birth has been traumatic, leading to poor outcomes for the mother or baby. In the past 10 years, there have been three major investigations into failings in maternity care at specific NHS trusts: Morecambe Bay[1], Shrewsbury and Telford[2], and East Kent[3]. A fourth is underway at Nottingham University Hospitals. These reports all led to recommendations to improve maternity care, but a current programme of inspections by the Care Quality Commission (CQC) has resulted in nearly half of maternity units in England being rated as either "inadequate" or "requires improvement".[4] Current policy on improving maternity care is fragmented. Although there are several national policy documents that address the need to improve maternity care, the inquiry heard that there is no single overarching strategy document.

Donna Ockenden, who is chairing the inquiry into maternity care failings in Nottingham, told the inquiry: "Leaders across maternity services report continuous requests for information from multiple bodies responsible for 'oversight' of maternity care in the UK. Frequently the requests are duplicated or only very slightly different showing that there is ineffective coordination between these multiple bodies. This is not efficient and wastes time. The system of maternity service oversight must be streamlined & this made more effective."

Research evidence shows that 4-5% of women develop post-traumatic stress disorder (PTSD) every year after giving birth[5], amounting to approximately 30,000 women in the UK, while about a third of women experience birth as traumatic.[6]

It is clear that this could have significant social and economic consequences, including: the cost to the NHS of treating PTSD and birth injuries; the cost to the NHS of litigation; of the effect on women's relationship with their baby and partner; and the effect on women's ability to return to the workplace. Yet the data on the impact of birth trauma is sparse. We welcome the UK government's decision to include birth trauma in the Women's Health Strategy, an important step in recognising the importance of birth trauma and making it possible to take steps to address it.[7]

Inspired in part by a parliamentary inquiry into birth trauma in New South Wales, Australia, launched in 2023, the aim of this inquiry was to look at the reasons why women experience birth trauma, how the condition affects them, the wider social impact and the steps we can take to prevent birth trauma.

The inquiry was guided by a Special Advisory Group (SAG) consisting of representatives from five organisations that campaign on issues relating to maternity (the Birth Trauma Association, MASIC, Make Birth Better, the Maternal Mental Health Alliance and Mumsnet), as well as birth campaigner Gill Castle.

How we gathered and analysed evidence

Our inquiry invited written submissions both from parents about their experience of traumatic birth and from maternity professionals. The call for evidence was published on Theo Clarke MP's website and advertised widely through social media. Witnesses were asked to provide their evidence as free-text submissions, up to 1,500 words in length.

The window for submissions ran from 9 January to 20 February 2024. We received 1,311 personal submissions from parents, and 92 from professional bodies, charities, campaign organisations and individuals working in maternity, such as midwives and obstetricians.

The inquiry also carried out seven oral evidence sessions, each with a different theme, which ran on consecutive Mondays from 5 February to 18 March. The inquiry heard from many NHS professionals as well as parents.

Apart from the second session, which heard from international experts and was held online, all the sessions were held in parliament in front of members of the all-party parliamentary group (APPG) of MPs, and were open to the public. The parliamentary sessions consisted of two 45-minute panels, with one panel consisting of expert witnesses, and the other of parents with lived experience of birth trauma. The final question for each panel was about the policy steps they'd like to see the UK government take to improve maternity care in the area discussed in the session. Their answers helped us shape our final recommendations.

Finally, Chair Theo Clarke MP held a separate online meeting with parents affected by failings in care at Nottingham. A short report on this meeting is included in Chapter 1.

Both the professional and personal written submissions were read by a team of volunteers linked to the organisations represented on the SAG.

The team reading the submissions kept a record on a spreadsheet of each account, including quotes and key details of the birth (such as the year it took place, whether it was a caesarean section, whether the baby was induced, whether the woman experienced tearing and so on).

We also used an open-source statistical package using R software to help us identify some of the word clusters and hence, key themes, to be found in the submissions. For example, the words "pain", "agony" "screaming" and "paracetamol", "epidural" and "finally" were often clustered together, leading us to stories where women were offered paracetamol for serious pain. Similarly, "husband," "Covid", "hospital" and "home" often appeared together, pointing to stories where partners were sent home from hospital during the pandemic. The words "forceps," "bladder", "stitches," "incontinence" and "surgery" also appeared together, telling their own story.

The oral evidence sessions were all transcribed, and, along with the written submissions, informed the findings of this report.

The structure of this report

We begin with a section on the key themes to emerge from the written submissions from parents. The following seven chapters map on to the themes of the seven inquiry sessions:

1. Birth trauma: an overview
2. What we can learn from other countries
3. Birth injuries
4. Birth trauma and mental health services
5. The wider impact of birth trauma
6. Partners' perspectives
7. Marginalised groups

Each chapter draws on research evidence, as well as evidence from the personal written submissions, the professional written submissions and the oral evidence. We conclude the main body of the report with a Vision chapter, which describes what we think a good maternity care system would look like. Appendix 1 lists recommendations for improvement in maternity care. These were drawn up by SAG members and are largely based on the recommendations made by witnesses in the oral sessions in answer to the question about policy changes.

Note on quotations

Unless otherwise stated, the quotations in this report come from the written evidence, and, except for one standalone case study in Chapter 5, who gave permission to be named, they have been kept anonymous. Names are used for quotations from the oral evidence sessions.

Thanks

We are immensely grateful to everyone who wrote in, particularly those who shared personal stories, many of which shared intensely distressing experiences. Every single story was read, and, although we were unable to acknowledge each one individually, they all provided valuable insights that have gone to inform the findings in this report.

KEY THEMES

Although the majority of personal submissions related to medical emergencies, the emergency itself typically only formed part of the trauma. Many spoke of feeling fearful that they or their baby would die: the word "terrified" appears in 266 submissions. Words like "shame," "humiliation" and "embarrassment" also come up repeatedly, while the word "broken" appears in 328 submissions. The overwhelming narrative was one of distress at being neglected, ignored or belittled at a time when women were at their most vulnerable.

Below are some of the most common themes to emerge.

Failure to listen

A failure to listen to women when they said that something was wrong was a feature of many, if not most, of the written submissions. Often, they were told they were being over-anxious. One woman who was in extreme pain for the last few weeks of her pregnancy, had "anxious mother" recorded on her notes. In fact, she was bleeding internally as the result of spontaneous hemoperitoneum, a rare and often fatal complication of pregnancy whereby tissue had torn behind her uterus.

Another woman wrote of how she kept calling the hospital for a scan:

"My bump height had dropped 8 days before and my midwife had sent for a growth scan, but nobody contacted me to tell me the scan had been refused. I called up chasing it 44 times on one day, but was just told there was a note saying 'scan refused, bring induction forwards', which nobody did. My midwife kept reassuring me it was her head in my pelvis, so I didn't know whether to be worried or not so I pushed for the scan to see if there was something wrong."

Had she been given a scan, as recommended in National Institute for Health and Care Excellence (NICE) guidelines, it would have identified that her baby was experiencing growth restriction and appropriate action taken. Her baby died during labour.

This failure to listen continued postnatally. One woman who experienced "horrendous urinary and faecal incontinence" was told by a consultant that there was nothing physically wrong with her, and that the symptoms were a result of her poor mental health. Another described reporting her concerns about her baby:

"I was concerned that my baby was looking 'yellow' and asked the midwife. She told me I was being overly anxious and he was fine. She wrote in my notes that I was an overly anxious mother and my baby was NOT jaundiced. My husband intervened and a doctor confirmed my baby was jaundiced and he was treated. The next day the page written by the midwife had been torn out."

One woman described how her severe physical symptoms, including fatigue and tremors, were wrongly diagnosed as psychological in origin, leading her to receive eight sessions of electroconvulsive therapy. After several years, she was diagnosed as having a rare thyroid condition.

Lack of informed consent

The problems with consent start antenatally. Although the case of Montgomery v Lanarkshire[8] established that patients should be informed about risks, this is often not happening in practice.

Many women told us that they were not informed that they had raised risks of particular complications, such as tearing, which would have enabled them to make more appropriate decisions. One woman was told she had a bicornuate uterus, but was not told that this put her at risk of premature birth. She went into labour at 28 weeks, and her baby died shortly after birth. Another wrote:

"Nobody informed me of the tear or in fact any risks associated with episiotomies and forceps deliveries, and when it became clear to me, due to daily incontinence, that extended well beyond 6 weeks postpartum that I had suffered some major injuries, it took constant emails to the midwives and my GP before anyone would refer me to gynaecology where they eventually, after months and months on a waiting list, diagnosed the tear, multiple organ prolapse, cysts caused by infected stitches, and nerve damage."

During labour itself, numerous women told us that they had procedures such as vaginal examinations or cervical sweeps performed without consent. This caused a lot of understandable distress. One wrote:

"Whilst contracting and alone a doctor came to examine me. She did a vaginal examination and without consent broke the rest of my waters."

There was also a clear problem with consent when interventions such as forceps or caesarean sections were being carried out. Many women said that, at the point when they were required to

sign a consent form, they were in no position to give informed consent, either because of the urgency of the situation, or because they were too ill:

"Feeling slightly delirious and with tears streaming down my face I kept asking [my partner] where the doctor was. I became more hysterical by the minute and felt nauseous and disoriented from all the gas and air. Finally the doctor arrived to tell me that a theatre was being prepared and to talk me through the consent form. I had absolutely no interest in going through anything, and I could barely talk properly anyway. I took the gas and air attachment out of my mouth, nodded my consent then scribbled my signature on the form and stuck the mouthpiece straight back in again. I closed my swollen, tear-stained eyes and just wished for the whole experience to be over."

A number of women also reported having their request for caesarean section denied, either before labour or during labour. One wrote:

"I had stated I felt my little boy was stuck and that I was not going to be able to get him out myself. I was only getting pain on my right side which was so intense. I had to wait for what felt like forever for an epidural and begged them for a c-section as I just knew something wasn't right. She laughed at me and told me it doesn't work like that."

Poor communication

Many women described not being told what was happening during labour, with some only finding out that they had a particular condition when they read their medical notes or had a birth debrief months later.

In other cases, there were unfortunate communication mix-ups. Heather Simmons, giving oral evidence in session 5, told the inquiry that, after an intensely traumatic birth, in which her baby was taken to the neonatal intensive care unit (NICU) and she herself was barely able to walk, she was told by the midwife that her blood results showed she had been taking drink and drugs in her pregnancy. As a result, her daughter was given an HIV test, without Heather's consent. In fact, the midwife had been reading from someone else's notes.

One woman described in a written submission how her daughter was born poorly. Although she was well cared for, the neonatal team did not give clear information about her prognosis:

"They were saying her condition could cause anything from mild dyslexia to severe cerebral palsy, and in the same conversation they were talking about end-of-life care. How is a discussion about mild dyslexia compatible with deciding on end-of-life care?"

Her daughter was transferred to a specialist unit at a different hospital, where she received good care until she died when she was five days old. The first hospital, however, had informed the health visitor team of the birth, but not the circumstances, so the day before she died, the mother received a call: "Congratulations on your baby! When can I come and see you?"

At her daughter's inquest, the hospital repeatedly called their daughter by the wrong name.

Lack of pain relief

A high proportion of the submissions referred to a lack of pain relief, with women left to labour in agony. In many cases, women in acute pain were offered paracetamol. One woman who turned down paracetamol because she thought it was insufficient says the midwife responded by throwing the paracetamol in the sink:

"I was literally left lying on the ground in pain wanting to die as the pain was so intense and unbearable. Although I was not dilated enough to push, I was having intense contractions every 2 minutes and the pain was excruciating and exhausting. My partner kept asking for help but was dismissed."

During her 36-hour labour, she was also denied an epidural because her platelets were too low. She remembers being violently sick, and jolting from the pain of having her waters broken. She sustained a third-degree tear:

"Without an epidural the pain was intense, but the midwife nonetheless chastised me for flinching in pain when he had a go at stitching me up when in fact surgery was necessary."

Lack of kindness

The overwhelming majority of written submissions referred to a lack of kindness or compassion on the part of the health professionals looking after them:

"My husband was sent home. It was after visiting hours. I was moved to the ward. I could not stand or walk. I had a catheter. I was covered in blood and my own faeces but there was no one to help

me wash. A plastic sheet was put on the bed and I lay on it in my filth. Around midnight I was woken up by a woman (I don't know who she was? A nurse? A midwife?) who reprimanded me for not feeding my baby. He was asleep. I didn't know what to do and I couldn't pick him up. I tried to get out of the bed but when she saw I was covered in blood and shit and hooked up to a catheter, she told me to get back in and said she'd hand him to me. I didn't know how to breastfeed. She told me if I didn't get it, she would take my son and give him a bottle. I felt like I was failing at mothering and I'd only been a mother for a few hours."

This lack of kindness was apparent even in cases where the baby died. Giving oral evidence in session 4, Emily Barley told the inquiry that staff ignored red flags during her labour, including meconium-stained waters. After her baby was found to have died, Emily pleaded for a caesarean, but the consultant obstetrician refused, and then walked out, without explanation, followed by all the other midwives and obstetricians who had been in the room:

"I was around eight centimetres dilated. The baby was imminent. But I was left without care for over half an hour. Just my mum. I remember asking 'Where has everyone gone? Where are they?'"

A few written submissions mentioned how much women valued kindness from health professionals when it was displayed, with one writing: "The kindness of midwives/nurses where it exists stands out for its rarity – and there were, both times for me, some truly wonderful staff."

Breastfeeding problems

A large number of women referred to problems with breastfeeding as major contributory factors in their trauma. There were stories about being forced to attempt breastfeeding when it was impossible (for example because they had a severe postpartum haemorrhage), or being made to feel like a failure for not being able to breastfeed.

Frequently, women were pressured to breastfeed, but not given help to do so:

"As my baby lay crying, waiting for a feed that I had no idea how to give, covered in my own blood, without even a glass of water by the bed, I have never felt so alone. I had no idea how to breastfeed – ringing the bell brought no one during the night, and attempts to ask midwives during the day were brushed off."

"When the midwife returned I said I wanted to breastfeed my baby, she just lifted my top and flipped my breast up and said 'You've got no milk in there'. I was completely blindsided and humiliated, I couldn't process what was happening to me."

Postnatal care

Poor postnatal care was mentioned in nearly all the personal submissions. On the postnatal ward, women described being left alone, often unable to move after an emergency caesarean or difficult forceps birth, but with no one to help them go to the toilet or lift their baby. Many wrote of ringing the bell to call for help and having no one come:

"About 6 hours after [my son] was born, I experienced a heavy bleed. I could see my white hospital bedsheets going red and I thought I was haemorrhaging again. I pressed my bell, nobody came. I pressed it again harder and nobody came. Another mum opposite me saw the sheets going red and my distress and went to get somebody. In that moment, I believed I was dying and my baby was going to be there in the hospital alone, with his mother dying next to him and nobody there who loved him or even knew his name. I was terrified."

Several had stories of being left to lie in their own blood, urine or excrement, or even berated by midwives for having soiled themselves. One woman said that after an emergency caesarean she developed sepsis and was put on an antibiotic drip, restricting her mobility. Her husband was sent home. Her baby, having been taken away and given antibiotics for suspected meningitis, was brought back:

"I was not only expected to try and calm her but also change her as she had been sick and was soiled on arrival. Staff pushed her in to the end of the bed, told me to clean the baby up because she'd been sick and was soiled and walked off. I could hear the staff all outside the bay sat at the nurses' station laughing and planning on ordering a Chinese takeaway before they closed."

The poor care typically continued once women had gone home. In some cases, women reported having birth injuries that went undiagnosed. Mental health symptoms as the result of a traumatic birth were ignored or treated dismissively. The six-to-eight week GP check, if it happened at all, was often cursory, and frequently focused on the baby rather than on the physical or mental health of the mother.

Giving evidence to the enquiry, Professor Angie Doshani, a consultant gynaecologist and obstetrician, quoted an American obstetrician, Alison Stuebe on the lack of postnatal care: "The baby is the candy, the mum is the wrapper, and once the baby is out of the wrapper, we cast it aside." This felt particularly pertinent in the stories we read.

The impact of Covid

Surveys of women in England after they had given birth showed a sharp increase in the proportion experiencing postnatal post-traumatic stress (PTS) in 2020.[9] The most plausible explanation is that restrictions during pregnancy and birth (for example, partners not being allowed to attend throughout the labour or remain on the postnatal ward, and the absence of mental health support or networks postnatally) raised the likelihood of women becoming traumatised by birth.

We had numerous submissions from women who gave birth in 2020 and 2021. They typically spoke of feelings of isolation and fear when their partners were not allowed to be with them during the early stages of labour, or sent away after the birth. One woman experienced a postpartum haemorrhage on the postnatal ward after her husband had been sent home, and was given a manual clot removal. "It was the scariest and most painful experience of my life," she wrote. "My daughter lay nearby, but I couldn't reach her. I felt like a failure... My husband was contacted, and he came back, but I'd already experienced my trauma alone."

Another woman who gave birth during lockdown, found herself left alone after a traumatic birth:

"I cried. I cried and cried. I couldn't walk, I had no strength to hold my baby, I had no breast milk yet, I had no help, no aid, no support. This was the most vulnerable state I'd ever been in. The magic and joy of having your first child, experiencing the hardship yet pride of childbirth had been brutally removed."

The midwife told her to "stop being a baby" and that it was "time to grow up."

She added: "I felt bullied, humiliated and dirty. As I was wheeled away, covered in dried blood stains, oily hair, dirty skin, smelly sweaty clothes, pants still covered in my birth water. I felt disgusted and embarrassed."

For some, the pandemic reawakened memories of earlier trauma. A woman whose traumatic birth happened in 1990 has been left with long-term anxiety, flashbacks and intense needle phobia. She

wrote that the pandemic "was unbearable, it was like living in my own hellish mind. Who would have thought that the whole world would become reliant on the NHS, and a needle delivering a vaccine? The continuous news stories, images, publicity campaigns and conversations tormented me to the point of a breakdown. I had multiple triggers every single day. I had to have 6 months off work." She now despairs of ever overcoming her trauma:

"My life is like a never-ending horror show, with triggers every day. It is often unbearable. I took an overdose in December 2023 out of pure desperation, and I was disappointed that I survived it."

Complaints and medical negligence

Many written submissions described how the experience of birth trauma was made worse by a failure of hospitals to deal sensitively with complaints about poor care. A common theme was that complaints were often treated dismissively, with failings in care unacknowledged. Birth notes were often falsified or lost.

One woman gave birth to a stillborn baby. At 36 weeks she reported that her baby's movements had slowed, and she says she was told that this was "normal for this stage in pregnancy". Her notes incorrectly stated that she had said the baby's movements were normal. In labour, she was denied a caesarean section and administered a morphine injection that she did not consent to. Later she agreed to a post-mortem for her daughter "with the expectation and assurance that my placenta would also be analysed." The placenta, however, was "lost due to midwife admin errors resulting in no details as to why my daughter died."

Some women struggled to take legal action because, by the time they felt well enough to go to law, they had passed the three-year time limit. In other cases, hospitals challenged the woman's version of events. One husband wrote:

"The hospital basically discounted her account, and seemingly tried to find flaws, even saying that someone suffering with PTSD could not have mentally written the complaint. The eventual outcome was the hospital admitted failures and settled out of court, after stringing her along for over a year, I believe in the hope she would give up."

It is clear that the statutory duty of candour, introduced in the wake of the Francis report, is not being applied effectively. The government's decision, announced in December 2023, to review the statutory duty of candour may help to change this.

Chapter 1: Birth trauma: an overview

Drawing on research evidence, testimony from the first oral evidence session and written testimony from parents and maternity professionals, this chapter offers an overview of the causes and effects of birth trauma, and highlights the key themes to emerge from the inquiry. It also has a section looking specifically at stillbirth and neonatal death, because these were a feature of many of the personal submissions. It concludes with an account of concerns reported by parents affected by poor maternity care in Nottingham in a meeting with Theo Clarke MP. Later chapters will explore in more detail the wider consequences of birth trauma for the NHS and for the economy.

What is birth trauma?

Birth trauma can be defined as "a woman's experience of interactions and/or events directly related to childbirth that caused overwhelming distressing emotions and reactions, leading to short- and/or long-term negative impacts on a woman's health and well-being."[10] Some people also use the term to describe injuries the mother may have sustained during birth, such as third- or fourth-degree tears. Traumatic birth experiences are subjective – it is the woman's perceptions of threat that are most important. About 4-5% of women develop post-traumatic stress disorder (PTSD) every year after giving birth, equivalent to approximately 30,000 women in the UK.[11]

Women with postnatal PTSD are also at greater risk of developing depression.

Symptoms and diagnosis

Birth trauma presents on a scale. At the most severe end, women may meet the clinical diagnosis of PTSD, a severe and debilitating mental illness. Even those who would not meet the diagnostic criteria, however, can struggle intensely with their symptoms.

To be diagnosed with PTSD, someone has to have been exposed to actual or threatened death, serious injury or sexual violence. Women who develop postnatal PTSD have almost all had an experience of childbirth where they believed that they or their baby were going to die. There are four symptom categories: intrusions; avoidance; changes in cognition and mood; and arousal and reactivity (such as becoming hypervigilant). A diagnosis of PTSD requires someone to experience all four symptoms for at least one month.[12]

Intrusion symptoms typically encompass flashbacks and nightmares, while arousal symptoms take the form of a feeling of intense anxiety or being on high alert. Avoidance means that an individual avoids

any reminder of the trauma, such as television programmes about birth or appointments with health professionals. Characteristic changes in cognition are feelings of guilt or low mood.

Causes of birth trauma

Research has identified particular risk factors for developing PTSD. Women who have preterm births, stillbirths, or severe complications are more likely to develop PTSD (16%-19%).[13] Other risk factors include a negative subjective birth experience, an assisted vaginal birth (forceps or Ventouse) or caesarean, and psychological dissociation. Support during birth is a protective factor.[14]

Certain factors not related to the birth also increase the likelihood of a woman developing PTSD. These include depression in pregnancy, fear of childbirth, poor health or complications in pregnancy, previous trauma (such as sexual assault), or previous therapy for pregnancy or birth-related problems.[15] Survivors of sexual abuse, for example, are 12 times more likely to experience birth as a traumatic event.[16]

People are twice as likely to develop PTSD after a traumatic event caused by another person (such as rape) than after an impersonal trauma such as a natural disaster.[17] Research into postnatal PTSD suggests that for most women, it is not simply the birth complications, but the combination of complications with poor care from health professionals, that leads to psychological distress.[18]
This was supported by the first-hand personal accounts we received in written submissions, as well as the evidence we heard in the oral inquiry sessions from both experts and women.

Am analysis of the personal submissions highlighted some of the most common features of women's birth experiences:

- 694 gave birth by caesarean section (in almost all cases, this was an emergency rather than planned)
- 378 women gave birth by forceps
- 247 had a baby who spent time in intensive care or special care
- 106 experienced a third-degree tear
- 41 experienced a fourth-degree tear

In most cases, then, there was an objectively traumatic element – a baby who was born poorly, for example, an emergency resulting in caesarean or forceps, or a physical injury. On their own,

however, these don't necessarily mean that a woman will develop postnatal PTSD. In practice, the vast majority of evidence, both in the written submissions and in the oral testimony, spoke of poor and sometimes negligent care as major contributory factors to the trauma, as we already saw in the Key Themes section.

In session 1, Rachael McGrath gave oral evidence about her twin pregnancy, which ended with her being rushed to hospital with an abrupted placenta, and believing that she was bleeding to death. Her babies were born by caesarean section under general anaesthetic and then taken to special care. Rachael went into renal failure and on day five postpartum experienced a complete dehiscence (disintegration) of her C- section scar. "Nobody treated the fact that my insides were now on the outside," she said. "They stuck a sanitary towel over my abdomen and left me there for 10 days until eventually…I became gravely ill again."

Rachael described being treated as "a birthing vessel" and "a slab of meat." She added: "It was so impersonal…I would have somebody holding a blood pressure cuff taking my blood pressure and on their phone giggling and texting with the other hand. I was in for such a long time and some of the staff would come and get in my room and talk about other patients unkindly and talk about other staff members unkindly."

Many of the personal submissions talked about feeling unprepared for childbirth, with many women unaware of the possible adverse outcomes, such as third- or fourth-degree tearing. Dr Ranee Thakar, president of the Royal College of Obstetricians and Gynaecologists, told session 1 of the inquiry that women commonly asked her why they hadn't been told that perineal tearing was a possibility: "We often don't talk to them because we think that women will be frightened and they will want to have a caesarean section if we tell them about birth trauma, but research that we have done has actually shown us that women want to know, they want to know the details and they will be the people who will make the decisions."

How birth trauma and PTSD affect women

At a time when a woman is already dealing with the difficulties and stress of looking after a newborn, PTSD is debilitating. Women may avoid mother-and-baby groups because they fear being triggered and experiencing flashbacks. They may be so fearful of the baby coming to harm that they refuse to leave the house or let anyone else hold the baby. Rachael told the inquiry how postnatal PTSD made her terrified her babies were going to die: "If I don't check that the babies are still breathing, they will stop. If I go and get a shower, the babies will be dead by the time I get out. If I go downstairs the

dog is downstairs, the dog is dirty, the babies will catch a bug." Her marriage nearly broke up, and because she couldn't go back to work, for a while faced financial ruin. Eleven years on, she still experiences the mental and physical health consequences of what happened to her.

While the majority of the submissions we received described births that happened in the past 5-10 years, a minority of submissions came from women still affected by a traumatic birth that happened decades ago. These were profoundly moving. Women in their 60s and 70s wrote about how the memory of the birth was still vivid, and how the experience of writing it down had affected them emotionally. Some of these stories were heartbreaking accounts of baby loss, often compounded by a lack of care and compassion. One woman who gave birth in 1973, for example, wasn't allowed to see her stillborn baby, or told whether it was a boy or a girl. In other cases, it was the trauma of the birth itself that continued to affect them.

There were other women who had given birth in the past 10-25 years who were deeply affected, physically and psychologically, by their traumatic birth. In many cases, they continued to suffer depression or PTSD. Often their marriages had broken up, or they had chosen to have no more children, supporting the findings of a joint survey carried out by the APPG on birth trauma and Mumsnet in 2023. This survey, which received 1,042 responses, found that more than half of the mothers who replied said they were less likely to have more children because of their experience.[19]

Some women had had to give up work. Many spoke of having their self-confidence, and their sense of worth, destroyed. Others wrote of living with constant physical pain or incontinence as a result of damage sustained during the birth. One woman provided a list of injuries she had sustained as a result of birth, and which continued to affect her many years afterwards. These included a broken hip, broken pelvis, multiple internal injuries and infections, a twisted bowel, damage to the base of her spine and damage to her glutes. She can no longer carry out simple tasks such as standing to wash dishes.

Kate Lough, a pelvic health specialist physiotherapist, told the inquiry that she sees women in their 60s and 70s who have developed prolapse many years after their birth, but are able to vividly describe the events of their birth decades earlier: "They can still tell you exactly what went on, how they felt, the language that was used."

Some women described how the memory of the birth continued to affect them. One wrote:

“I’ve tried, but at times I’m transported back to that darkened room where I’m held down as someone cuts me open without my consent and then belittles me for daring to show that I was in excruciating pain. Fifteen, nearly sixteen years down the line, and that feeling of being dehumanised is still as fresh in my mind as the day it happened. Mothers are frequently described as heroes, but how much of our heroics are only necessary because our pain is dismissed?”

Stillbirth and neonatal death

Some of the most concerning stories in written submissions came in those (a sizeable minority) that recounted stories of babies who were stillborn or died shortly after birth. These stories were almost all characterised by two things: mistakes made during labour and a lack of compassion towards the mother. One wrote:

“The scenes in theatre can only be described as chaotic and these along with subsequent events have left me traumatised and suffering with PTSD. During the operation I could hear phrases such as ‘where the bloody hell is the consultant’, as well as other panicked comments.”

There were several stories from women who experienced signs of labour in the second trimester but were told that they were mistaken. One woman carrying twins, who went into premature labour at 19 weeks, was initially disbelieved. After she lost the first baby, she wrote:

“I was told by one of the consultants to stop my crying, calm down and try to save the other baby. His words were: ‘This baby was dead a long time anyway so you should stop stressing over it and let’s try to save the other one.’”

The other baby also died, however, and 17 years later she is still “traumatised by this whole experience that has left me suicidal. I am unable to move on with a normal life, while still struggling with my mental health…I don’t know if I will ever be myself again. Animals are treated better than the way we were treated in hospital.”

In another case a woman who had a high-risk pregnancy started having period-type pains at 23 weeks. Initially the hospital told her they were “growing pains” and gave her paracetamol. A few days later, a midwife told her the pains were caused by thrush. Shortly afterwards, it became clear that she was in labour. She gave birth to a little boy who died 11 days later.

Other women mentioned being put on a ward with other women who were labouring. One woman, who gave birth three years ago, was advised to terminate her pregnancy because her baby had an

abnormality that meant she would likely die before birth. She describes having an injection to stop the baby's heart and then being admitted to the labour ward for an induction:

"I was ultimately there for 11 days trying to deliver my dead baby, listening to other women's labouring noises and baby's cries. They had a 'bereavement suite' which we were able to move into partway through but it was still on labour ward."

In some cases, the neglect continued after the birth. One woman, who gave birth to a stillborn baby at 23 weeks in 2023, described being told by her GP that she wasn't entitled to a six-week check because she didn't have a living baby.

Almost all the women who had lost a baby, whether recently or decades ago, said that it had permanently affected them psychologically, with many reporting feeling suicidal.

What does good care look like?

It is clear that some problems in maternity arise from under-staffing, resulting in overworked staff experiencing burnout. As Gill Walton, president of the Royal College of Midwives, told session 1 of the inquiry, having a "fully-staffed and highly-trained workforce that have time to work with women antenatally to provide the right care during labour and birth" is a prerequisite to preventing birth trauma.

Donna Ockenden, chair of the Independent Review of Maternity Services at Nottingham, told session 4 of the inquiry that there was a particular problem with retention, which was not easily solved by recruiting junior midwives: "If we are losing midwives with 20, 30, 35 years' experience, if they are leaving the NHS in their fifties, early sixties because they can't cope with the physicality of the role, and if they are then being replaced by a more junior workforce who are not being supported in those early days of their career…two going out doesn't equal two coming in."

Without addressing the issue of retention and recruitment, improving care will be challenging. Some women who wrote to the inquiry were able to provide examples of good care, however, despite the birth itself being traumatic. One contrasted the care she received at her local hospital with the care she later received at a tertiary care hospital. Initially, she was told by a consultant that one of her twin babies would likely die, thereby causing the death of the other. He recommended "selective feticide". She decided to keep the babies, and from that point had shared care between her local hospital and the tertiary hospital 160 miles away.

The care at her local hospital was poor (for example, she was kept waiting up to 12 hours for regular blood tests), but her babies were delivered "safely and calmly" at the tertiary hospital, at 27 weeks, 5 days of pregnancy. While the birth was traumatic, there was "a strong sense of solace and comfort that here…they clearly had done this many times before and they knew what to do. I felt as a patient, actively heard and firmly and safely 'caught.' The delivering consultant proudly telling me hours before the birth, 'This is the safest place in the world for your girls to be born today.' And I believed and trusted her. I remember her."

This sense of being heard, and being cared for, seems to be the key to good care, and the element that is missing from so many of the other stories we received. Having a premature baby is a traumatic and anxious experience, and she describes her twins' 150 days in NICU as "filled with major surgeries, ventilation and many blood transfusions." Two years on, she reflects that she is "one of the lucky ones", because her babies came home, but her maternity journey was a bumpy one, and she has not found an NHS service to provide her with the emotional support she needs. She adds: "We have to provide safety netting universally throughout the whole passage."

Nottingham families

After the formal inquiry sessions were over, Theo Clarke MP met with seven families affected by failings in maternity care at Nottingham University Hospitals Trust. Currently nearly 1,900 cases are being investigated by Donna Ockenden as part of her review into maternity services at the trust.

All the families shared stories in which medical neglect led to the deaths or injuries to their babies, or in one case, injury to the mother. The neglect was compounded by a cover-up on the part of the trust, who failed to acknowledge mistakes, falsified notes and lied to families about what had happened.

The stories were uniformly horrifying. Jack and Sarah Hawkins spoke of how Sarah had experienced contractions for six days but was refused admission to the maternity unit. Their baby Harriet was stillborn, because of staff's failure to perform basic checks. The hospital then falsely told the parents that Harriet had died from an infection. Because Harriet was stillborn, there was no inquest. "The reason she was a stillbirth was because I had such negligent care that she couldn't take a breath," Sarah said.

In another case, Natalie Needham's son Kouper died of respiratory problems one day after being born. Natalie told the meeting that a midwife had wrongly stated on Kouper's discharge papers that

she'd seen him have a four ounce bottle and that she was "happy and content that he was established feeding." Natalie and her husband were initially arrested on suspicion of murder, and not told for six months that they were in the clear. She was also mistakenly sent pictures of Kouper's postmortem in the post.

During an emergency caesarean, Felicity Benyon had her healthy bladder removed, and was wrongly told that the placenta percreta had enveloped the bladder, and that she would have lost it anyway. It was a urologist who blew the whistle and told her that the mistake had been covered up.

Sarah Sissons's son Ryan suffered brain damage at birth. Again, the hospital tried to avoid taking responsibility for his injuries, and at one point Sarah was accused of having Munchausen's by Proxy – in other words, of inventing his injuries.

Kimberley Errington's son Teddy died after the hospital failed to carry out monitoring for post-natal hypoglycaemia. Carly Wesson and Carl Evlington had a test that indicated their baby had a condition that meant she wouldn't survive much beyond birth and were advised to terminate the pregnancy. After they made a complaint about aspects of their treatment, the hospital carried out a further investigation and told them that tests showed there had been nothing wrong with their daughter. No one has been held accountable for the errors.

Sarah Andrews's daughter Wynter died after numerous mistakes were made during labour, including a failure to monitor the baby's heart rate.

The parents felt it was important that hospitals should be subject to greater accountability than they are at present. Jack Hawkins said: "Not a single person has been held to account in any way whatsoever by the regulatory bodies…All of these are manslaughter, failure of duty of care, failure of duty of candour. "

Chapter 2: What we can learn from other countries

Introduction

In session 2 of the inquiry, we heard evidence on birth trauma from experts based in Australia, Switzerland and the Netherlands.

Access to, and provision of, maternity care varies widely across the globe. Women in low and middle-income countries (LMICs) generally have poorer access to maternity care and higher levels of socio-economic disadvantage, leading to worse maternal and infant outcomes.[20] Information gathered during the UK-led INTERSECT study (www.intersectstudy.org), which publishes its first results later this year, is expected to highlight vast differences in access and type of maternity care across countries.

Most research on traumatic births and postnatal post-traumatic stress disorder (PTSD) has been conducted in high-income countries, such as the UK, Australia, USA and some European countries. Research on postnatal PTSD in LMICs is sparse but largely suggests a higher rate than that in developed countries (29% in Iran, for example[21]), though a study from Sri Lanka reported a rate of 3.6%.[22]

In Europe, collaborative work has resulted in a set of recommendations for reducing traumatic birth, including respecting women's rights before, during, and after childbirth; preventing maltreatment and obstetric violence; and integrating principles of trauma-informed care across maternity settings.[23]

Initial work on prevention by Professor Antje Horsch at the University of Lausanne found that, by engaging women who'd experienced a potentially traumatic birth in a visuo-spatial game, Tetris, it was possible to interrupt the laying down of traumatic memories and stop the development of PTSD.[24] This proof-of-principle study is now being followed by a double randomised controlled trial with 100 women, in which women are asked to come back to the hospital where they had a traumatic birth, having avoided it for up to several years afterwards. "If they play Tetris for 20 minutes as part of a procedure that we carry out with them, we are actually able to reduce the already established post-traumatic stress and symptoms," Professor Horsch told the inquiry in the oral evidence session.

Support for women with birth trauma is limited, however. A 2021 mapping exercise of 18 European countries, which looked at policies on prevention and support for traumatic birth, found that only

one, the Netherlands, had a national policy relating to screening, treatment and prevention of a traumatic birth. The exercise "highlighted a lack of national policy guidance on the prevention, care, and treatment of a traumatic birth experience."[25] In a small number of countries, the gap is filled by charities, notably the UK's Birth Trauma Association, founded in 2004, the Australasian Birth Trauma Association (ABTA) and New Zealand's Birth Trauma Aotearoa.

Australia

Australia's Birth Experience Study (BESt), a national survey of more than 8,500 women who had given birth in the previous five years, found that 11% responded "yes" or "maybe" to a question asking whether they had experienced obstetric violence, which refers to abusive behaviour or forced intervention on the part of a maternity professional. Many of these reported feeling violated, dehumanised or powerless.[26] Complaints from dozens of women about traumatic births experienced as a result of poor care at Wagga Wagga Base Hospital led to a decision by the New South Wales parliament to hold an inquiry into birth trauma. The inquiry, whose results have not yet been published, received more than 4,000 submissions and heard oral testimony from many deeply traumatised women.[27]

ABTA's submission to the New South Wales inquiry, based partly on its own survey of women with birth injuries, included stories in which physical injuries combined with poor care to cause psychological trauma. Women in severe pain as a result of injuries found it difficult to access medical treatment, with one saying: "I also presented to an emergency department on multiple occasions in extreme pain, being barely able to walk. The medical staff laughed at my extreme reaction of pain to a physical examination and dismissed me as a stupid woman who should see her GP."[28]

Amy Dawes, CEO of ABTA, told the UK inquiry that the Australian maternity care and training system are largely modelled on the UK and therefore have similar outcomes. One of the themes to come out of the New South Wales inquiry was a lack of informed consent. Ms Dawes said that women were not informed antenatally about the risks of instrumental birth. This includes obstetric tearing and ani levator avulsion, when the ani levator muscle separates from the pubic bone, creating a risk of urinary and bowel incontinence and pelvic organ prolapse. She said it was impossible to "provide informed consent if the first time you're hearing about an induction is in that moment, and you're not being given the facts and the risks and the potential outcomes of a cascade of intervention."

Ms Dawes said that birth injuries could have a major impact on women's ability to lead a normal life. They may be unable to engage in physical activity, for example, return to work, or enjoy a sexual relationship. Often women's self-esteem suffers, and women with these injuries have higher rates of suicidal ideation, Ms Dawes added. She highlighted her concerns about the normal birth policy, "which is really adopting that one size fits all approach to birth and not looking at individualized care and bringing it down to an individual's unique set of wants and needs."

ABTA, Ms Dawes told the inquiry, recommended a model of care "where we have midwives and doctors and pelvic health, physios and mental health clinicians working collaboratively to provide information that's relevant to their expertise so that women can be empowered with information and make the choices that best suit their individual wants and needs."

Emma Hurst, an MP in the New South Wales Parliament, who chairs the Australian inquiry into birth trauma, said that she had also heard stories from sexual assault survivors who had been given physical examinations during birth without consent being sought, retraumatising them: "It's made them feel as though they were sexually assaulted again, so we need to make sure that trauma-informed care goes across the entire healthcare system."

Some women who had experienced stillbirth gave accounts of being left in a birthing suite where they could hear other mothers giving birth. Others reported being denied pain relief, or of being subjected to inappropriate comments, such as being mocked for not knowing how to breastfeed their babies. Many said that they felt they were not listened to.

Like the UK, Australia has a high proportion of women giving birth whose first language isn't English, with 30-40% of birthing women having immigrated from another country. Ms Hurst said that while there were interpreters available, they weren't always expert in health care: "This adds more stress on the marginalised women that are entering hospitals to give birth as well."

Dr Hazel Keedle, senior lecturer and director of academic programmes for midwifery at the School of Nursing and Midwifery, Western Sydney University, added that the BESt study had found that First Nations communities had a birth trauma rate of 37%, higher than non-Indigenous women, whose rate was about 28%.[29] Among Indigenous groups, one in six said they had experienced obstetric violence, compared to one in 10 of non-indigenous women.

Dr Keedle said she would like to see the implementation of a continuity of care model, in which a woman is supported during birth by a midwife who knows her personal history and what her expectations are for the birth. Women would also be better able to provide informed consent, because they would have had conversations with their midwife during pregnancy.

Europe

Across Europe, there is variation in the incidence of birth injury, particularly obstetric anal sphincter injury (OASI), also known as a third- or fourth-degree tear. The association between OASI and postnatal PTSD is well-established,[30] so efforts to reduce OASI rates could also reduce the incidence of PTSD.

OASI is much more common with forceps births and, to a lesser extent, Ventouse (also known as vacuum) births. In England, approximately 7.5% of all births are by forceps, while 5.1% are by Ventouse.[31] Forceps can result in damage to a woman's pelvic floor, anus and perineum leading to urinary and bowel incontinence and pelvic organ prolapse, in which the uterus, for example, bulges out of the vagina.[32] In some cases, the prolapse occurs many years after the birth.[33]

In certain European countries, such as Sweden and Austria[34], the incidence of forceps use is much lower, and some countries have abandoned its use altogether.[35] These countries use Ventouse as the main instrument of delivery, leading to much lower rates of OASI. One plausible explanation for the differential use of forceps is that in the UK, the failure rate with Ventouse is high – about 25%, compared to a 2% failure rate for forceps.[36] If a Ventouse delivery fails, then the obstetrician is likely to move either to forceps or to a more risky emergency caesarean section (compared to one planned or performed earlier in labour). For this reason, anecdotally, many obstetricians prefer to avoid Ventouse in favour of forceps.

In contrast, the Netherlands has a 3% failure rate for Ventouse.[37] If we could identify why some countries have a lower failure rate for Ventouse, that could help improve Ventouse success rates in the UK, and reduce the use of forceps, thus lowering the number of women experiencing birth injuries and developing PTSD or birth trauma. Jan Willem de Leeuw, a Dutch obstetrician, told our inquiry that in the Netherlands, only 7% of births used instruments, and in the vast majority of cases, this was Ventouse rather than forceps. At the same time, caesarean rates are much lower than the UK – about 18% to the UK's 28%. Leeuw attributed the difference in rates of forceps use between the Netherlands and the UK to "tradition", adding: "I had discussions with colleagues from the UK

who denied my thesis that it is possible to perform modern obstetrics almost entirely without the use of forceps."

One woman's written submission to this inquiry contrasted her experience of giving birth in the UK with that of giving birth in Switzerland. After her baby was born she developed a prolapse, but the physiotherapist she sought help from did nothing other than to perform a "very rough" internal examination, announce she was "fine" and advise her to do some Kegel exercises. She noted that she had not been informed of the possibility of prolapse antenatally. In Switzerland, however, she was given help from a psychiatrist to help her process her first birth and a consultation with an anaesthetist to discuss pain relief options. In the waiting rooms there were leaflets about common postnatal difficulties such as prolapse, and after birth women are offered sessions to rehabilitate their pelvic floor. The new Perinatal Pelvic Health Initiative (PPH) is now making this available in England.

Chapter 3: Birth injuries

This chapter addresses the topic of perineal tearing, drawn on personal testimony from women in written submissions, and oral testimony from both experts and women with lived experience given in session 3. It goes on to look at work in Norway that shows how we could reduce the rates of birth injury.

During vaginal birth, many women experience perineal tearing. In most cases, these tears are minor and heal quickly. Some women, however, experience third- or fourth-degree tears, also known as obstetric anal sphincter injuries (OASI). These can cause lasting problems, including urinary and bowel incontinence, chronic pain and pelvic organ prolapse, when an organ such as the uterus or bladder descends into the vagina. Professor Mike Keighley, a colorectal surgeon, told the inquiry that he and his colleagues saw a high referral rate in women aged 50-60, "in whom incontinence or prolapse had either emerged for the first time or has become worse, all due to an injury during childbirth that becomes unmanageable in later life."

Financial cost of OASI to the NHS

There has been little research on the financial cost to the NHS of anal sphincter injuries sustained during childbirth, though it can be partly measured through litigation costs. NHS figures show:

- The highest rate of litigation in clinical practice is for childbirth injuries.
- The value of maternity claims doubled between 2016/17 and 2022/23.[38] In 2022/2023 the total cost of maternity payouts was £1.1bn.[39]

The value of the average damages awarded for these claims has increased significantly. In 2006/2007 the average maternal injury claim was worth approximately £82,011 and in 2022/2023 it averages at £301,492.

Other costs to the NHS (GP appointments, repeated surgeries, physiotherapy and counselling) have not been measured – though Professor Keighley told the inquiry that he estimated the cost to the NHS of one woman's repeated procedures over 20 years to be approximately £80k. His "guesstimate" of the overall cost to society was £100-400m a year.

Incidence of OASI

There is a shortage of good quality data about OASI incidence, but the most recent available figures suggest that 3.1% of all vaginal births result in OASI – roughly 14,000 a year in the UK.[40] This is likely to be an underestimate, however, because so many tears are missed, with one study estimating the incidence as about 10% of all women who give birth vaginally.[41] This is important, because if an OASI is diagnosed and repaired shortly after birth, it is possible for women to make a full recovery. In the past 12 years, Professor Keighley told the inquiry, he had seen more than 200 women with third- or fourth-degree tears, and in 60% of cases, the tear had been missed when the baby was born.

Risk factors for OASI

The two biggest risk factors for OASI are first vaginal birth and instrumental (assisted) birth. Amongst first-time mothers giving birth instrumentally, 7.5% experience a severe tear, compared with 1.6% of those who have a spontaneous, non-instrumental vaginal birth, and have given birth before.[42] The risk of OASI is nearly six times higher with forceps, and three times higher with Ventouse, than with spontaneous vaginal delivery.[43]

Canadian research found that more than a quarter of successful forceps births involved maternal trauma. In nearly nine out of 10 of those cases, the injury was an OASI, but other injuries included cervical tears, vaginal lacerations and damage to the urethra or bladder.[44] Forceps birth is also associated with a greater risk of pelvic organ prolapse.[45]

As we saw in Chapter 2, one likely reason for the UK's high incidence of OASI is the preference amongst obstetricians for forceps: 7.5% of all births in England are by forceps, compared with 0.5% in Sweden and Austria.[46,47]

Currently a collaborative group led by the two main obstetric societies and including representatives of the royal colleges, is producing a consensus statement on assisted vaginal birth, which aims to ensure the safety of mother and baby. The statement may help obstetricians to make decisions about when forceps or Ventouse may be more appropriate.

While first-time vaginal birth and forceps use are the two principal risk factors for OASI, others include[48]:

- Prolonged second stage of labour
- Persistent occipito-posterior position (baby is "back-to-back")
- Baby's birthweight is greater than 4kg
- Older maternal age
- South Asian ethnicity
- Baby is born quickly (precipitate labour)
- Shoulder dystocia (the baby's shoulder gets stuck behind the pubic bone)
- Short maternal stature

OASI risks and informed consent

There are good arguments for making women aware of their individual risk profile during pregnancy, taking into account factors such as age and ethnicity. One study has found, for example, that Asian women have an OASI risk nine times higher than that for Caucasian women.[49]

The 2015 Supreme Court Montgomery ruling states that clinicians should disclose risks of childbirth with patients.[50] Yet many women told us that their care providers did not discuss the risks of OASI with them before giving birth. Geeta Nayar, a South Asian woman who gave oral evidence to the inquiry, said that she had not been informed antenatally of her higher risk.

We saw many other examples where informed consent was not sought. In a written submission, one woman described telling a community midwife that, as a sexual assault survivor, her biggest fear was a forceps birth, and that in the case of an emergency, she would prefer a caesarean. The midwife told her a caesarean would be dangerous, without further explanation. In the event, she experienced a frightening forceps birth that led to a complex third-degree tear and two organ prolapses leaving her in constant pain. She feels that if she had been informed of the comparative risks, she would have requested caesarean. She describes feeling "broken" and "permanently damaged," adding: "I used to think I was a resilient and strong woman. Birth showed me I am not."

Diagnosing and treating OASI

If OASI is diagnosed shortly after birth, and treated appropriately through a repair of the tear followed by a course of physiotherapy with a specialist, then women can make a full recovery. We received dozens of submissions, however, from women who wrote of their distress at their tear either going undiagnosed or being misdiagnosed (for example, as a second-degree tear), leading to

significant long-term problems. They then found it difficult to access support, as Sarah Embleton told session 3 of the inquiry:

"GPs are the gatekeepers to any referrals. So, first of all you have got to have a GP that understands there is something wrong and acknowledges it and understands it and can send you somewhere else. Then there is: where do you go? Do you go to the gynaecologist? Do you go to a colorectal surgeon? Do you go to physio? You know you probably need a multidisciplinary team, but I couldn't get referred. I couldn't get anyone to understand there was something wrong with me."

One woman described in a written submission how her fourth-degree tear was misdiagnosed by a midwife as a second-degree tear and repaired accordingly. Her later bowel incontinence was then wrongly diagnosed as irritable bowel syndrome, while a consultant at the hospital where she gave birth told her simply that her symptoms were the result of being "psychologically traumatised". Over the course of 21 years she had 18 surgical procedures, the last being a colostomy in 2019.

In a number of cases, health professionals seemed ill-equipped to give even basic guidance about managing a tear. One was given a booklet that said she should not wash her wounds, until a gynaecologist told her otherwise. She wrote:

"For three months, with urinary and faecal incontinence as well as post-partum bleeding, I hadn't been washing properly. Sometimes I think I can still smell myself, on days where my mental health is really low."

This theme was echoed in many of the submissions. Twenty-two women experienced rectovaginal fistula (a hole between the rectum and vagina), yet some reported being disbelieved by health professionals. One wrote:

"In the months that followed I suspected I wasn't healing well. I had many trips back and forth to the GP practice and to the local hospital, nobody seemed to appreciate my concern that stool was leaking from my vagina. My GP questioned the direction I was wiping, which felt really condescending. I was told by one gynaecologist that what I was describing was 'extremely rare and normally only seen in third world countries.' I felt dismissed and unheard again."

Much of the problem stems from a lack of understanding on the part of many health professionals, including midwives and GPs, of the causes and impact of OASI – a midwife who assisted at a birth is unlikely to see a woman again and therefore may not be aware of the long-term impact. Midwife Posy Bidwell told the inquiry that midwives currently receive little undergraduate training in pelvic

health anatomy and the impact of tearing on a woman's pelvic health. She recommended that there should be an annual "mandatory perineal health update day for every midwife on the shop floor."

The planned introduction of pelvic health clinics, as part of NHS England's new perinatal pelvic health initiative (PPHI), which offer a one-stop shop for women with problems such as incontinence and prolapse, aim to address the difficulty women have in accessing expert help. There is also a case, argued Professor Pauline Slade, for linking the pelvic health clinics with maternal mental health services so that women can receive integrated care.

Impact of OASI

In both the written submissions and oral evidence, women spoke movingly about the lasting impact of OASI on their lives. This included:

- Ongoing physical pain
- Bladder and bowel incontinence
- Sexual dysfunction and difficulties in their relationship with their partner
- Effect on body image
- Difficulties in bonding and developing a relationship with their child
- An inability to return to work, because of incontinence and the need for multiple surgeries over the course of many years
- Financial problems, resulting from the inability to work and the cost of treating the injury
- Psychological distress, including depression and suicidal feelings, as well as a loss of confidence
- An inability to carry out normal everyday activities such as going shopping, taking exercise or socialising with friends

In written evidence, one specialist pelvic health physiotherapist described the emotional impact of OASI as "isolation, loneliness, shame, disgust, depression and anxiety." This was confirmed by women who highlighted the profound psychological impact OASI had on their self-confidence. Geeta, a high-flying lawyer at the time her daughter was born, described how, as a result of her birth injury, she "went from being a resilient, independent young woman to needing significant help, not able to leave the house, enduring multiple repair procedures."

A number of women found that an OASI affected their ability to work. Jenny Tighe told session 3 of the inquiry: "I was having daily episodes of bladder incontinence, bowel incontinence. My job initially was quite supportive, but I got demoted and that just destroyed my self- esteem and confidence, so in the end I just resigned and then I didn't work properly for several years."

Many women described in written evidence how her fourth-degree tear affected their ability to lead a normal life. The following experience described in a written submission is typical:

“I still had accidents. I had to take spare clothes with me at all times. I had to strip off in disabled toilets with my children watching as I cleaned the faeces off me. I was scared to be intimate with my husband, as the risk of soiling myself was so high. I would never have another child. I was ‘tutted’ at for using the disabled toilets by strangers and acquaintances. I eventually had to leave a job that I loved. I was teaching children with complex needs, but I couldn’t control my bowels during a lesson and would have to take the children back to their classes so I could get changed. I could only wear black jeans, otherwise the staff would know I had soiled myself again.

"The pain was chronic and still is after 10 years. Being in constant pain and soiling myself had a huge effect on my mental health. I was diagnosed with severe depression and anxiety, was given more medication. I didn’t want to leave the house. I didn’t want to socialise, I was constantly thinking about where the closest toilets are and I still am. My pain was stopping me being able to do basic functions in the house, like cooking for the family, walking the dogs or sorting out the laundry. The pressure on my husband and our relationship took its toll and there were times we were close to divorce.

“I had to reduce my hours at work and we decided that we would make adaptations to the house so I could have more independence. We had to re-mortgage our house to do so. Financially we were close to bankruptcy, so I applied for PIP. I had to go to tribunal, where the doctor on the panel said to me ‘why don’t I just a stick an anal plug in and get on with my day,’ one of the many comments from healthcare professionals that don’t understand the complexities of a birth injury. In 2023 alone, I have had three gynaecologist appointments, two pessary fittings for my prolapse, three pelvic floor physio sessions, two colorectal appointments and surgery planned again for a few months’ time.”

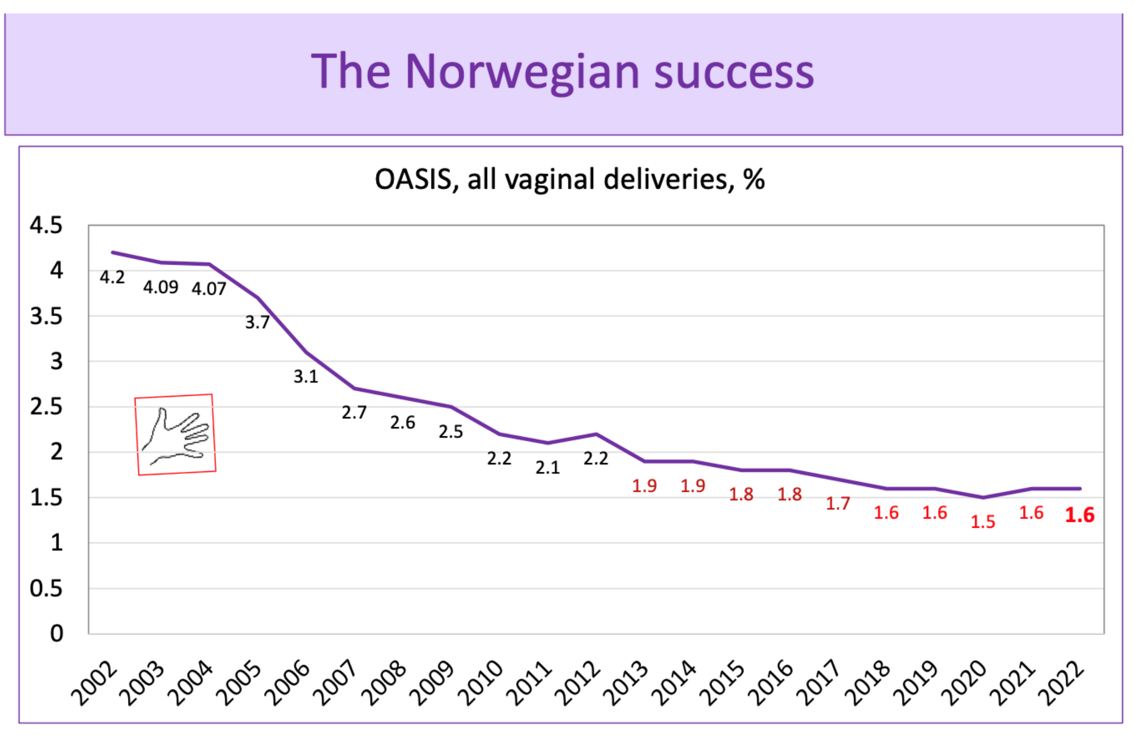
Addressing OASI

OASI can best be tackled through prevention, as well as better diagnosis and treatment. One method is to adopt a risk assessment tool such as UR-CHOICE, which can calculate a woman’s risk of developing symptoms in the long-term after pelvic floor injury and enable women to make decisions based on that information.[51] Risk calculators are routinely used to assess risk in other areas of health care, such as prostate and breast cancer and heart disease.

Several Scandinavian studies have shown it is possible to cut OASI rates by manually supporting the perineum during the pushing stage. In Norway, this change in practice has cut rates of OASI by 50%.[52] In the UK, an OASI care bundle developed jointly by RCOG and RCM incorporates:

- Antenatal education that informs women about OASI and how to reduce the risk of it occurring
- Manual perineal protection during birth
- Episiotomy when indicated
- A rectal examination after birth, provided the woman consents

It has been piloted in 16 maternity units, which saw OASI rates fall in over 50,000 women by 20%.[53] In Norway, the two pilot hospitals showed a rapid reduction of 50%. When rolled out more widely, however, the reduction was more gradual, and it took a number of years before a national reduction of 50% was achieved (see graph). In total, however, the policy has led to approximately 16,000 women avoiding OASI between 2005 and 2022.



Despite the successful pilot, the OASI care bundle has not been implemented in all maternity units, partly because it has not been recommended by the National Institute of Health and Care Excellence (NICE).

Chapter 4: Birth trauma and mental health services

Introduction

This chapter looks at the mental health support available for parents with birth trauma. It includes evidence from experts and people with lived experience of birth trauma from session 4 of the oral evidence session, as well as testimony provided in written evidence from women and mental health organisations.

After birth, about one in 10 women develop postnatal depression, while one in 25 develop post-traumatic stress disorder (PTSD).[54] A larger number develop symptoms of psychological distress such as intense anxiety as the result of traumatic birth. While not meeting the full criteria for a PTSD diagnosis, these women may still be in need of mental health support.

Postnatal PTSD is more common in women who have had previous trauma or pre-existing health challenges.[55] About half of women who develop postnatal PTSD also develop postnatal depression.[56] About one or two in 1,000 women develop postpartum psychosis, the most severe form of postnatal mental illness. It is characterised by symptoms such as mania, delusions and low mood, and is considered a psychiatric emergency.[57]

Mental health problems after birth can be debilitating and need to be taken seriously. Suicide is the leading cause of maternal death six weeks to a year after birth.[58] Left untreated, PTSD symptoms can continue to affect women for many years: the inquiry heard from women in their 60s, 70s and even 80s, who still felt traumatised by their experience of giving birth decades earlier. One mother wrote in to describe, tragically, how her daughter had taken her own life, having been profoundly affected by a traumatic twin birth nine years previously. Many others wrote that they had attempted suicide or were plagued by suicidal feelings.

Postnatal PTSD and other symptoms of trauma can, in the majority of cases, be treated effectively by two therapies, both recommended by NICE: trauma-focused cognitive behavioural therapy (CBT) and eye movement desensitisation and reprocessing (EMDR). In people with PTSD, the experience of the trauma feels ever-present: they continually relive the traumatic event. Both trauma-focused CBT and EMDR are intensive therapies that involve going over and over the trauma until it is stored in long-term memory, the same as any other memory. Typically, these therapies require eight to 12 sessions with a specially-trained therapist. Other treatments are available, but lack the strong evidence base of trauma-focused CBT and EMDR.

Peer support has also been shown to be effective in helping people experiencing trauma symptoms after a traumatic birth.[59]

Mental health services in the UK: current provision

Specialist perinatal mental health community services support women and their families experiencing the most severe mental health problems, during pregnancy and for the first year after birth.

Money for these services is now administered at the local level, as part of the general allocation to integrated care systems, but 73% of teams in England reported a shortfall in funding for 2022/23.[60] Workforce-related issues were the most frequently cited reason for underspending against budgets.

Between 2019 and 2024, NHS England set up regional Maternal Mental Health Services (MMHS) that provide treatment for serious mental health problems arising as a result of a woman's maternity experience, including stillbirth, postnatal PTSD, tokophobia (fear of childbirth), neonatal death, pregnancy termination and loss of custody. These offer support up to two years after birth. Susan Ayers, professor of maternal and child health at City University, London, told session 1 of the inquiry that in providing these services, England was "ahead of the rest of the world".

The services face challenges, however. There is significant variation in size and therefore the support they are able to provide.[61] Some have not secured ongoing funding. An NHS workforce census in 2023 concluded that the rapid set-up and expansion of these services mean there are workforce challenges that are likely to remain for some time.[62] Similarly, a report by the Maternal Mental Health Alliance in May 2023 found that many women still face long waiting lists for therapy, through a combination of high demand and under-staffing.[63]

A joint submission to the inquiry from Oxford Specialist Perinatal Mental Health Services (OSPMH) and Oxfordshire Maternal Mental Health Service (MMHS) spoke of a lack of funding to recruit permanent staff, resulting in staff burnout. Women were having to wait six months for a psychologist appointment, and nine months for a debrief. The submission also reported challenges in integrating with maternity wards that do not see mental health as a primary concern.

Another challenge mentioned in submissions from MMHS organisations was of communication being fragmented across services, because of the use of different electronic record systems. A submission from the Perinatal Parent Infant Mental Health Service) and TULIP/Maternal Mental Health Service in North East Foundation Trust mentioned problems caused by the 28-day window midwives have for

making a referral, which meant that some women were being referred too soon after birth, when often their symptoms resolve on their own without the need for specialist input.

Women who want to access a mental health service can ask for a referral from their community midwife, health visitor or GP. In practice, while new guidelines[64] state that GPs should ask women about birth trauma at the six-to-eight week postnatal check, some women report that GPs ask little, if anything, about mental health.[65]

Other specialist services

In England, women experiencing mental health problems postnatally can also self-refer to NHS Talking Therapies (formerly IAPT). The therapies offered vary locally and not all have specialists in perinatal mental health. Waiting lists are often long. There are also specialist perinatal mental health midwives and consultants who work within maternity teams or the local perinatal mental health team to make sure that there are clear integrated pathways of care for women with perinatal mental illness.

Many maternity units run birth debriefing services, which offer women the opportunity to review their maternity notes with a clinician (usually a midwife) to better understand their birth experience. Research shows a wide variation in how the services are run, however, and there is currently no published standard for how a debriefing service should be carried out.[66] One specialist debriefing midwife said in written evidence that women were often referred inappropriately to the debriefing service when they should have been referred to the complaints service, with the debriefing experience then leaving them frustrated and angry.

A number of voluntary organisations also offer peer support services, including SANDS, the Birth Trauma Association and MASIC. In their written submissions, some women reported being supported by these charities when they could not access help elsewhere.

Devolved nations

Scotland, Wales and Northern Ireland all offer community-based perinatal mental health services. There are examples of good practice, such as Scotland's introduction of a participation officer role, working with health boards and the Scottish government to gather feedback from women and family members to improve the service. Nonetheless, provision is patchy in each of the devolved nations, and all face workforce challenges.[67]

Accessing mental health services: barriers to care

The inquiry heard evidence that mental health provision is very much a postcode lottery.

We received many submissions from women who had been unsuccessful in accessing appropriate mental health help. Reasons included a failure on the part of GPs or other health professionals to recognise PTSD symptoms, long waiting lists, or a refusal by services to accept women because they were not ill enough or, in some cases, too ill, or because they were past the cut-off point of one year after birth. One woman whose baby was stillborn wrote that in the area in which she lives, there was no specialist maternity loss and trauma service:

"The final kick in the teeth after she died and I was feeling intensely suicidal was that the perinatal mental health team wouldn't take me on because I had no living baby."

Dr Rebecca Moore, a consultant perinatal psychiatrist, told the inquiry of her concern that some services were "tailored to diagnoses, so to fit this service you have to have PTSD, whereas in reality you can have seven of the 11 symptoms of PTSD and be significantly affected and traumatised day-to-day, and that might persist for years and flare up in the next pregnancy."

In oral evidence, Natalie Tasker told the inquiry that when she described her obsessive anxiety about the baby to her GP, the GP responded with: "I just don't...sorry, what's the actual issue here, because you've had this beautiful baby. Are you depressed? Are you upset? I don't really get what you're saying is wrong." Even though Natalie's husband explained that she wasn't depressed, but was experiencing intrusive thoughts, the GP wrote a prescription for anti-depressants.

Emily Barley, whose daughter was stillborn after failings of care during labour, was told by the perinatal mental health team that they were unable to help her. However, her GP was able to refer her to the local mental health trust's specialist suicide prevention team. She had her first session within two days of referral, and in all had nine weeks of treatment. Giving oral evidence, Emily said: "They did save my life. They were amazing." The service was a pilot project, however, available in only a few areas of the country.

One written submission describes a woman's difficulty accessing support after a traumatic birth, which had left her psychologically distraught:

"I was crying uncontrollably daily; suffering flashbacks multiple times a day; nightmares; screaming in my sleep; unable to leave my son and hypervigilance; lost contact with friends; no socialisation with

other parents; unable to go to or past the hospital; panic attacks when seeing ambulances; unable to travel down certain roads".

When she eventually decided to seek professional help, she was given a diagnosis of severe complex PTSD with severe anxiety and moderate depression, but because her son was more than 12 months old, she was not eligible to be fast-tracked. After spending time on a waiting list, she was assigned a trainee counsellor, and, later, a trauma-focused CBT counsellor who had no experience of birth, which meant she had to explain to him some of the practical elements of childbirth. This was so distressing that her trauma scores increased. She decided to seek EMDR, which involved being discharged, completing a second self-referral and starting the whole assessment process from the beginning: "By the time I received EMDR it was approximately 18 months after my first self-referral. I had no support at all whilst on the waiting lists. At no point did I receive therapy from any one with experience of birth trauma."

Other women told us they had no option but to turn to private therapy. Neera Ridler-Mayor, who experienced nightmares and intense anxiety after she lost seven litres of blood in a postpartum haemorrhage, told session 4 of the inquiry that she had spent over £6,000 for more than 50 hours of mental health support after she was unable to access NHS therapy.

Barriers to access for marginalised groups

Giving oral evidence, Honey Attridge said that she had been frightened that if she admitted to mental illness, her baby would be taken away from her. Since becoming a peer support worker for an NHS perinatal mental health team, she had found that many other women have a similar fear. These fears may be particularly prevalent among ethnic minority women, younger women and women from disadvantaged communities, who are (often with reason) distrustful of people in positions of authority. Some women may feel that seeking specialist help is a sign they have failed as a mother. Dr Moore told the inquiry that peer support could play an important part in bridging the gap for women who felt reluctant to access professional help.

Dr Moore also noted that, among the women who have died by suicide, very many are young women with multiple disadvantages, who have been let down by fragmented services: "Often when you look at the women that have died, they have been involved with numerous services, none of whom have been communicating with each other and they have often had lots of different support, but nobody has really looked at it as a whole. Then when you see the story afterwards, you see that everybody held a vital piece of information but no one shared it together."

Good practice

We saw examples of good practice in some of the written submissions. Several women said they received excellent support from their perinatal mental health team and were helped to recover by referral to appropriate therapy. One woman said that the care she received from the perinatal mental health team had been "second to none" and that "I truly believed they saved my life."

For women who have had a traumatic birth, a subsequent pregnancy can be a very fearful time, and it is important that they are supported through the pregnancy and birth. One woman described in a written submission how she had developed PTSD after experiencing poor care during a long, painful labour, followed by a retained placenta and postpartum haemorrhage. In her second pregnancy, however, she was well looked after:

"As a result of my prior experiences, I was placed under the case of the perinatal health team during my pregnancy, and I was allowed to carefully plan my delivery and chat through my concerns in advance with a specialist midwife and anaesthetist. The team looking after me during and before my son's birth spoke to me with kindness and compassion, always explaining their actions and seeking consent. I can say that my son's birth was the happiest day of my life."

Chapter 5: The wider impact of birth trauma

This chapter looks at the impact of birth trauma, not just on the individual who experiences it but on those around them. It includes evidence heard in session 5 from experts and people with lived experience of birth trauma, as well as testimony provided in written evidence from women and health professionals.

Birth trauma can have a profound psychological impact, with flashbacks, nightmares and feelings of intense anxiety. This means that birth trauma can affect every aspect of a woman's life, including her bond with her baby, her relationship with her partner, her older children and her friends and family. It can also affect her ability to work. All of this ripples out into wider society, with the cost felt in NHS treatment, family breakup and the removal of women from the workplace.

Relationship with the baby

Research suggests that birth trauma makes it harder for some women to bond with their babies, while others become excessively protective, sometimes to the extent of refusing to leave the house with their baby.[68,69] Traumatic birth is also associated with low birth weight and lower rates of breastfeeding,[70] and there are suggestions that postnatal PTSD "may be associated with an increased number of problems in mother-infant attachment and child behaviour."[71]

The inquiry received submissions from a number of women who found their relationship with their child had suffered as a result of traumatic birth, though some also wrote that it had improved with time. Feelings of guilt are common. One woman wrote: "I struggled with sleep deprivation and I started to become really tearful and have negative thoughts about putting my baby up for adoption as I felt that I couldn't do it. I couldn't be a mum."

Four years on, she has "the most special bond" with her child, but is still "haunted" by the birth trauma, which included losing four litres of blood: "I continue to struggle with anxiety and depression and feel that I will never be the person I was prior to this experience. I am now trying to navigate life as a mum with a mental illness and I am at last hoping to start some trauma-based therapy in the near future."

Physical injuries can also affect the mother-child bond. A survey of 325 women by the charity MASIC, which supports women with third- and fourth-degree tears, found that 85% believed their injury had affected their relationship with their child, with 14% saying the damage to the relationship was irrevocable.[72] In a written submission, one woman said that her third-degree tear had affected

her ability to mother effectively: "I am now just over a year postpartum and still unable to actively play with my children. I can't lift or chase my eldest child, the tear has completely limited the mother I want to be for my children."

Relationship with partner and family

A mother's relationship with her partner may be affected in several ways after a traumatic birth.[73] Some report that, because their partner did not advocate for them effectively during birth, they no longer trust them.[74] Others find that their partner discourages them from talking about the birth, telling them to "move on" or "focus on the baby", making the woman feel isolated. Postnatal PTSD can make people feel irritable or lead to outbursts of anger, further damaging the relationship. Many women avoid sexual intimacy, in some cases because a birth injury has made it too painful, or because sex triggers flashbacks to the birth, or because they fear becoming pregnant again.[75] One woman wrote: "Even though I'm on birth control I am so scared it won't work and I will end up pregnant I won't go anywhere near my husband which is starting to put a strain on our marriage."

A number of women said in written submissions that their birth experience affected relationships with friends and wider family as well as with their partner. This was particularly the case for those whose babies were born with brain injuries caused by being deprived of oxygen at birth (see box-out).

In cases where a child has a severe disability, siblings live with the knowledge that when their parents die, they may be expected to take over the care of the child, Suzanne White, head of clinical negligence for law firm Leigh Day, told the inquiry: "That's a huge responsibility that they live with all their life."

Economic cost

There is currently no research on the economic cost of birth trauma. Professor Susan Ayers of City University, London has suggested that NHS Resolution data on litigation claims could be used as a proxy measure, and that there is a lack of current funding to analyse the data.

A government cost-benefit analysis of the women's health hubs notes that the average cost of a maternity claim is about £293,000, and that if the harm leads to brain injury at birth the average cost of a claim is about £9.4 million. This economic impact applies only to cases where there has been a physical injury leading to litigation, however. We know that the majority of women psychologically affected by traumatic birth will not make a negligence claim.[76]

It is clear, however, from the numerous submissions we received from women either unable to go back to work, or delaying going back to work, as a result of PTSD triggers, that there must be a wider economic cost.

In other cases, women felt that financially they had no choice but to return, even if they were too ill to do so. Heather Simmons, giving oral evidence to session 5 of the inquiry, described how her traumatic birth had led to her child having a hypoxic brain injury. Before the birth she'd worked in a hospital as an ophthalmic technician. She described how her "place of safety," where she'd always felt comfortable, became her "place of trauma". When her daughter was six months old, Heather was in the middle of a "full breakdown," but returned to work for financial reasons. It was, she said, a "horrific" experience: "I had panic. I couldn't concentrate. I couldn't bear to be away from her."

Heather left the NHS and took a private job working nights so she could be with her daughter during the day. Ultimately, however, the culture of workplace bullying was too traumatising and she left, later becoming a full-time carer for her husband when he fell ill.

Women with birth injuries may also find their physical ill-health prevents them from returning to the workplace, with one survey finding that one in five women with birth injuries said it had affected their ability to work.[77] Even those who do go back to work say that their trauma has had an impact on their working life. The woman with a third-degree tear, quoted earlier, wrote in her submission that she "spent thousands of pounds on private appointments, gynaecology, and pelvic floor physiotherapy".

Ms White noted that, even if a woman returns to work after a birth injury, the effect of the injury can re-emerge at menopause. One professionally successful client was "likely to be incontinent after menopause because the perineum deteriorates at that stage, and that is something that she is dreading throughout her whole life."

Case Study: Helen

Helen's son Julian was born with a hypoxic brain injury as a result of proven medical negligence during his birth, which the hospital tried to cover up. (Helen won substantial damages against the hospital to pay for the care of her child.)

Her son's injury has affected every aspect of Helen's life.

"My marriage broke down as he [her husband] could not handle a disabled child. He more or less had a breakdown and ran away to start a new life," she says. He has not seen his child for nine years.

Her own life has been turned upside down: "I am now a single mother, doing this alone. Julian will always be dependent on me. I had my elder children young and always thought that I would be able to live life when they were older, but now I have Julian as a forever dependant."

Her other children have been affected too: "They are all fantastic with their little brother but ongoing sleep and behavioural issues have caused disruption with exams and schooling through lack of sleep for instance."

Helen still suffers mental and physical pain, and has never been able to heal. Having to explain what happened to her over and over again during a six-year litigation was particularly mentally draining. She adds: "My life will never be as it should be. I never returned to work, I live a very secluded life, as friends and family shun you when you have a disabled child that they might not understand or are scared of."

Maternity staff

Evidence suggests that midwives in particular experience high levels of stress and burnout, with data showing that they have the highest rate of absences for mental health reasons of any group in the NHS.[78] One large-scale survey of midwives found significant levels of emotional distress, with two-thirds saying they had considered leaving the profession.[79]

Several studies have looked at the incidence of PTSD in maternity professionals. A review of research that looked at studies of midwives, nurses and obstetricians found that the proportion of participants meeting the diagnostic criteria for PTSD ranged from 3.1%-46%.[80] Authors of a scoping review of research found that "witnessing abusive care was associated with more severe post-traumatic stress than other types of trauma events" and concluded that "adverse events during childbirth have a serious impact on care providers."[81] An Australian study found that staff of black or minority ethnicity were at increased risk.[82]

Amongst the submissions we received from midwives, common themes included under-staffing, a poor physical environment and a harmful working culture. Some found it difficult to see how women were treated in the system: one midwife wrote that she and her colleagues "are witness daily to the devastating impact of poor staffing, poor provision of resources, poor care and poor communication, which result in people lacking confidence in the service and the standard of care they will receive."

Another former midwife described how she'd left the NHS in 2022 after 15 years as a result of "accumulated vicarious trauma and moral injury". She described working in a particularly hierarchical maternity unit where one consultant obstetrician behaved aggressively towards staff and treated the women in his care inappropriately. In one instance, during repair of a second-degree perineal tear, the woman "was leaping up the bed and groaning in agony due to his stitching. I asked him to stop and provide more pain relief; he shouted at me in front of the woman and told me that 'women do not have nerves in their vagina'." She also described an extraordinary incident when the same doctor "dragged another outspoken midwife by her hair along an antenatal clinic corridor."

In her final NHS shift, she described caring for a mother whose baby was stillborn before being called to an emergency forceps birth in which "the woman was screaming with fear and panic in her eyes, the obstetrician was useless in her communication and didn't gain consent for the episiotomy or the forceps." The result was "another unnecessarily traumatised mother and father starting parenthood."

Chapter 6: Partners' perspectives

This chapter looks at the impact of traumatic birth on partners, using evidence from written submissions and oral testimony to session 6 of the inquiry.

Partners can be affected in two main ways by a traumatic birth:

- They may develop psychological symptoms of trauma, as a result of experiencing the terror of believing that they are going to lose both mother and baby. A review of research has found that 1.2% of fathers develop PTSD after witnessing their partner give birth – approximately 7,000 people every year in the UK.[83] It is likely that many more develop some trauma symptoms.
- They may be required to support – practically, emotionally and financially – a woman who is experiencing the physical and psychological consequences of traumatic birth.

Yet there is very little help available for partners. After birth, the focus is on the mother, and her partner will not normally be asked by health professionals whether he (or she) is coping psychologically. Many partners feel that, because they did not go through the traumatic birth themselves, they are not entitled to ask for help. They may also feel that they have a responsibility to be strong and hold the family together.

The impact of traumatic birth on partners

The small amount of research on the impact of witnessing traumatic birth on partners has identified recurring themes, such as feelings of helplessness as the trauma unfolds, a fear that the mother or baby are going to die, a sense of abandonment if the mother and baby are taken to a different room and a lack of communication from staff.[84]

Dr Andrew Mayers, an academic psychologist at Bournemouth University, told the inquiry that his research had found that "fathers who are in that birthing room when it all starts going so dramatically wrong feel utterly helpless." He added: "They are witnessing potentially the loss of their partner, wife and/or baby and yet what we were finding consistently was that they were not being informed." Conversely, his study found, when health professionals communicated effectively, this acted as a protective factor against the father developing postnatal mental health problems.[85]

Dr Mayers's findings were echoed in the submissions the inquiry received from fathers. One man wrote that his wife experienced an obstetric emergency that resulted in the death of their baby daughter. Describing the "chaos" in the operating theatre, he wrote:

"As a father I was sat at the head end of the table with my partner and had no explanation as to what was happening or going on. When my partner started feeling sick and shaking I was literally presented with an anaesthetist sat to my left on her mobile phone and handed a sick bowl and told she will be all right in a minute…Prior to that any other requests for information were ignored, all I knew was that alarms were going off and people were running into theatre. No support was offered to myself or my partner. This experience has left me with regular flashbacks, mental health issues and a diagnosis of PTSD."

Scott Mair, whose son was taken to intensive care after the birth, had to visit him alone while his wife lay ill in bed. That was traumatic enough, he told session 6 of the inquiry, adding: "My biggest trauma came from the fact that I was then told to go upstairs and break that news to my wife that our baby might not make it. There is no support, there was nobody to come with you to have that conversation."

One man told us in a written submission that after he had witnessed his wife receiving abusive treatment during birth, he found himself reliving the birth in the form of flashbacks and nightmares. He added:

"I developed avoidance behaviours in the form of avoiding any conversation about birth or hospitals, avoiding friends, family and isolating myself from the outside world. During conversations I would completely tune myself out to the point I could not hear or take in what was being said. Having another baby felt like an impossibility."

He also experienced "heightened feelings of a sense of threat in the form of over sensitivity to sounds, feeling jumpy, extremely irritable, worried about losing my wife or daughter."

In some cases, both partners are affected. Mark Williams and his wife both developed mental health problems after her traumatic birth experience 20 years ago in which he feared that she and their baby would die. The effect has been long-lasting: Mark told the inquiry that even recently he had woken up in "in sweats, thinking my wife and baby died."

The impact of traumatic birth on the couple relationship and family life

We saw in Chapter 5 the impact a traumatic birth could have on the partner relationship, often creating tension and anxiety, with women sometimes blaming their partner for not advocating effectively for them during labour. [86]

Physical injuries such as OASI can, as we have seen, have a devastating impact. One man said that his wife's birth injury, sustained before they met, had affected every aspect of their lives: "where we can

go, our careers, the additional financial outgoings associated with treatments, our sex life, not being able to have further children, our health and wellbeing." Before each of his wife's surgeries, he had had to prepare himself for the possibility that she might die on the operating table, adding: "I'm just grateful that she has shown the resilience and courage to keep going."

There may often be a financial impact. Paternity leave is only two weeks, but if a mother is too ill to look after herself and the baby, the partner may have to take unpaid leave to take care of her or sometimes drop out of employment altogether. Lucy Allen-Goss, whose partner was unwell after a traumatic birth, told the inquiry she was unable to return to her academic post, leaving a year-long gap on her CV that she couldn't easily explain – which led, ultimately, to a change of career.

Same-sex partners

There is a dearth of research on the impact of traumatic birth on same-sex partners. Laura-Rose Thorogood of LGBT+ Mummies told the inquiry that there was an assumption in the NHS that same-sex partners were less important, even though in some case, the partner may be genetically related to the child through egg donation. There was, similarly, a lack of awareness amongst health professionals that some same-sex couples will have a history of trauma in overcoming barriers to conception, such as repeated attempts at IVF.

Lucy told the inquiry of witnessing her female partner have a traumatic emergency c-section, after which both mother and baby developed sepsis: "One of the things that went wrong was that people didn't know who I was. So I kept getting shut out of the room she was in and they tended to think I was another nurse or another midwife."

This happened both during the birth and postnatally. While she was in the postnatal ward with her partner Emma, staff assumed that she was a health professional taking care of her: "My partner was catheterised, she was bleeding very heavily, she was very high on morphine, she didn't know where she was. And she was being expected to change and also to tube feed this very fragile newborn we'd got, and a lot of the time I couldn't get to her. We realised quite a bit later that we nearly killed our daughter because they had expected both of us to tube feed this baby without actually having told us how to do it."

When they returned home, Lucy found that the midwives and health visitor who attended Emma seemed to resent her presence: "I remember at one point the health visitor saying, 'You know you can tell her to go away' to my partner about me, and my partner said, 'I don't want her to go away.'"

Laura-Rose and her wife have both given birth twice, and their experiences echoed Lucy's, with the non-birthing mother being asked to leave the room and make tea while the health professional was talking to the birthing mother.

Mental health support for partners

The lack of support for partners continues postnatally. Scott shared with the inquiry his experience of leaving his sick wife and baby in the hospital: "The worst thing is after all of that you get in the car and you go home. Nobody helps with that transition out to the car park, nobody sits you down and says 'Is everything okay? That was rough'. You don't get any sort of debrief."

Currently, neither mothers nor fathers are screened postnatally for PTSD, though the means to do so is available – researchers at City, University of London have devised separate scales to measure postnatal PTSD in mothers and partners.[87] Whereas mothers are routinely screened for postnatal depression, and have opportunities to mention mental health difficulties to health professionals, fathers and non-birthing mothers are not offered mental health screening after the birth. The NICE guideline on antenatal and postnatal mental health does not mention fathers at all.[88]

The only time partners have the opportunity to share their mental health difficulties with a health professional is if they choose to accompany the mother to a birth debrief. Otherwise, a father who wants mental health support must actively seek it. In England, this will typically be by self-referring to the local NHS Talking Therapies service. In the other UK countries, it will entail asking for a GP referral. Kieran Anders, operations manager for Dad Matters, told the inquiry that, while new mothers with psychosis are treated as a blue-light emergency with direct treatment, a father with psychosis may have a three month wait for treatment, even though the risk to the child is the same.

Research suggests that fathers would welcome the opportunity to share their experience of the birth. In one study, fathers expressed the view that healthcare professionals were unconcerned about fathers' mental health, and that support is only offered once "you try to harm yourself or you have a breakdown."[89] Fathers, another study found, "specifically wanted healthcare professionals to sign-post them to someone they can talk to for emotional support, and to be taught coping strategies which would help them to support both their partner and baby."[90]

Since 2018, NHS England has been gradually expanding its perinatal mental health services to include partners, so that if a woman has a perinatal mental health problem, her partner is also offered a mental health check and signposted to professional support if necessary. The limitation of this, as Dr Mayers pointed out, is that it does not identify those fathers who have developed mental health problems, but whose partners are not in contact with perinatal mental health services.

There is a postcode lottery to the support available. Dr Mayers noted that, when he helped develop local mental health services for fathers, in Hampshire and Dorset these were provided through the local mental health trust, but in London, they were provided through the charity Mind.

There are areas of good practice, however. Leeds Perinatal Mental Health Service, for example, has set up a Partners Peer Support Service to support new fathers. These include face-to-face sessions, dads and kids pram walks, baby sensory sessions and Zoom games nights to help new fathers gain confidence as parents and talk about their mental health.[91] In Greater Manchester, the NHS funds Dad Matters as part of their peer support offer alongside Home Start and other charities. Dad Matters takes referrals from professionals who see fathers, and offers attachment and bonding support, as well as signposting fathers to Talking Therapies if necessary.

Financial and economic costs

A 2014 report calculated that perinatal health problems in women cost the country £8.1bn a year, and that an investment of £280m annually could offset much of that cost.[92] Similar figures are not available for partners, but Dr Mayers told the inquiry that he believed that investment in caring for partners, coupled with extended paternity leave and greater support in the workplace, could reduce the likelihood of PTSD and subsequent problems for the child.

Chapter 7: Marginalised groups

This chapter looks at the experience of birth trauma on marginalised groups, using evidence drawn from written submissions and oral evidence given by experts and parents in oral sessions, particularly session 7, of the inquiry.

There are approximately 700,000 births a year in the UK.[93] Regular reports from the MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) programme, however, show that maternal outcomes vary widely according to demographic factors such as age, ethnicity and deprivation. These outcomes include maternal deaths during pregnancy, childbirth and the postnatal period, as well as stillbirths and neonatal deaths.

Evidence suggests that marginalised groups also have a poorer experience of maternity care. As well as ethnicity, deprivation and age, other factors that may affect an individual experience of maternity care can include neurodiversity, sexuality and gender identity. Some factors may, of course, interact.

Maternal outcomes

The most significant variations in maternal outcomes relate to ethnicity and deprivation.

In 2021, 28% of babies in England were born to mothers of non-white ethnic minority origin.[94] MBRRACE's most recent report, which analysed data from 2020-22, showed that Black women were almost four times as likely as white women to die during pregnancy, childbirth or the postnatal period, while Asian women were twice as likely to die as white women. Similarly, the maternal mortality rate for women living in the most deprived areas of the UK was more than twice as high as that of women living in the least deprived areas. [95]

Ethnic disparities can also be seen in stillbirth rates, which are significantly higher for babies of Black ethnicity (7.52 per 1,000 total births) and babies of Asian ethnicity (5.15 per 1,000 total births) than for babies of white ethnicity (3.30 per 1,000 total births). Again, there are striking disparities relating to socioeconomic status, with rates of 2.37 stillbirths per 1,000 total births in the least deprived quintile compared with 4.69 in the most deprived quintile.[96]

Although Black and Asian mothers are more likely to live in deprived areas, and are therefore particularly affected by the socioeconomic disparity, MBRRACE found that stillbirth rates for babies of Black and Asian ethnicity are higher than for babies of white ethnicity in all five socioeconomic categories.

Black women are also one-and-a-half times more likely to develop pre-eclampsia than white women, and six times more likely to develop pre-eclampsia superimposed on chronic hypertension.[97]

Gypsy, Roma and Traveller women are not included in the MBRRACE statistics, but a review of research suggests they have worse maternal outcomes than other groups.[98]

Certain other marginalised groups experience strikingly poor outcomes. Women in prison are five times more likely to have a stillbirth,[99] while young women who have been through the care system are far more likely to die by suicide in the perinatal period.[100] Women aged 19 and under are more likely to have premature babies and extremely low birthweight babies than women aged 20-35.[101]

Disparities in experience of maternity care

The reasons for the disparities in maternal outcomes are not clear – apart from suicide, the causes of maternal deaths are not broken down by ethnicity or socioeconomic status. Research provides some clues, however. Studies show that risk factors vary between ethnic groups. For example, Black women are more likely to have a history of cardiovascular disease than white women,[102] while South Asian women have higher rates of gestational diabetes than white women,[103] and six-to-nine times the risk of anal sphincter injury.[104] Yet, as Professor Angie Doshani, a consultant obstetrician gynaecologist, told the inquiry, women are not routinely informed antenatally of their greater risk.

Similarly, Black and South Asian women are at greater risk of Vitamin D deficiency, which leads to a greater risk of diabetes, miscarriage, pre-term birth, high blood pressure and pre-eclampsia. This could be addressed by a simple campaign to take Vitamin D in pregnancy, Carol King-Stephens, the equality, diversity and inclusion lead midwife at Walsall Healthcare NHS Trust, told the inquiry.

A 2022 report by campaign group Five X More, based on a survey of 1,320 Black or mixed heritage women, found three areas where maternal health care fell short: attitudes, knowledge and assumptions. These included, for example, using racially discriminatory language, poor awareness of Black women's physiology (one woman was told that "black people are more stretchy") and an assumption that Black women were being over-dramatic. Some reported that health professionals did not understand how particular conditions such as jaundice might appear differently on black skin.[105]

One South Asian woman, Neera Ridler-Mayor, told session 4 of the inquiry that the reason her major obstetric haemorrhage was initially missed was because of her skin colour: “A Caucasian lady who has a postpartum haemorrhage would go pale. I don’t go pale. I will go grey and ashy.” It was Neera’s mother who spotted that her skin colour had changed, but her medical notes had been amended to state, incorrectly, that the midwife had noticed she had a haemorrhage because she had gone pale.

A survey on the experiences of Muslim women in maternity found many reported being patronised and having decisions made without their consent.[106] Describing a focus group of Somali women, some of whom had previously given birth in European countries, the report says that in the UK maternity system they were “subjected to racist attitudes” whereas in countries such as Norway and the Netherlands they were treated “with more kindness, consideration and compassion.”

Mothers from ethnic minority backgrounds may be more likely to suffer from mental health problems, with one study finding that Indian and Pakistani women were at greatest risk.[107]. A study of Black Caribbean women found, however, that their interactions with professionals in the perinatal period were “protocol driven and formulaic, affording little scope to discuss psychological distress, identify morbidity, or deliver interventions that might restore or maintain maternal mental health.”[108]

Language is also an important factor in the experiences of minority ethnic women in maternity care. In 2022, 30.3% of all live births in England and Wales were to women born outside the UK, the majority of whom were non-EU nationals. The most common country of birth for non-UK mothers was India, followed by Pakistan, Romania and Poland respectively.[109]

Many of those women will not have English as a first language, meaning that interpreters are essential. Yet an investigation by the BBC found that a lack of interpreters in the NHS is leading to adverse outcomes in maternity. Interpreting issues, it found, “were a contributing factor in at least 80 babies dying or suffering serious brain injuries in England between 2018 and 2022.” Some staff are using online translation tools to deliver serious news to non-English speaking patients.[110]

Giving oral evidence to the inquiry, Professor Doshani said that for some women, the use of interpreters from their own community could be problematic because of the lack of confidentiality. She also noted that some women from ethnic minority communities can’t read, even in their mother tongue. The app she has developed, JanamApp, includes animated videos to reach those women. Speaking to service users, she also found that if they didn’t understand a question they were asked

by a health professional, they would often say "yes", creating the impression that they were giving consent when they weren't.

Ms King-Stephens told the inquiry that many women from marginalised groups simply cannot afford to travel to the hospital or their GP practice, and therefore miss important antenatal appointments. In Walsall, the council and the local bus company have now provided free day savers so mothers can attend the appointments. Sometimes the NHS is not mindful of cultural practices, she added – offering appointments to Muslim women on a Friday, for example, when they might be at mosque. Similarly, Clotilde Abe, co-founder of Five X More, giving evidence in session 1, suggested that it was possible to reach some minority women through offering sessions after church services.

A number of submissions, including some from professionals, mentioned more explicit racism, with one Asian woman, for example, saying that she was treated with greater respect when her white husband was present. Another, who was very seriously ill after a complicated birth (and suffered permanent injuries) wrote of the on-call consultant:

"She came the next morning and spent the whole time talking to my sister (who is also brown skinned) who was sat on the chair next to me. She said I looked much better and didn't even realise that wasn't me."

In a written submission, Dr Aditi Sharma, who conducted research with South Asian women on birth trauma, said that many feel coerced and dehumanised in childbirth, with one saying that two white women giving birth at the same time "had a lot more support and staff were being very responsive to them." Similarly, some organisations representing Black mothers said that many were treated automatically as being of higher risk than white women, and therefore put on a more medicalised pathway.

There were examples too of medical professionals making inappropriate comments. One woman wrote: "I tore, and as I was being stitched up, the doctor said, 'I'll stitch you up so you'll never do this again.'" I thought the doctor told me this because I was young and my baby was of mixed heritage. I thought I probably deserved it."

Other marginalised groups

We have less information about the outcomes and experiences of women from other marginalised groups, such as lesbian women or women with neurodivergent conditions, though a large-scale Californian study found that same-sex couples had significantly higher risk of adverse outcomes such as postpartum haemorrhage.[111]

There is some research evidence that marginalised groups may experience poorer maternity care, supported by testimony heard by the inquiry. Same-sex couples, for example, can face prejudice from health professionals, including the assumption that a birthing mother must be heterosexual. They therefore find themselves having to "come out" repeatedly to health professionals throughout the pregnancy, birth and postnatal period.[112] One qualitative Swedish study found that LBTQ parents experienced "disrespectful treatment from healthcare professionals that violated their bodily integrity."[113]

Laura-Rose Thorogood, a woman in a same-sex relationship, told session 6 of the inquiry that when she introduced her wife to the consultant, the consultant's attitude "just switched", and from that point on the care was "unprofessional". This included "shouting at the midwife in front of a whole room of us because she couldn't work out where baby was facing, to giving me an internal and crudely yanking a massive clot out of me, without an apology or explanation." When the baby was born by forceps, the doctor "pulled the baby out and she was 'flung' on top of my lower stomach and landed like a sack of potatoes. My wife gagged, because as she did, blood flew up everywhere and went all up me and over my face."

Qualitative research on how autistic women experience pregnancy has found they have more physical difficulties, such as nausea and pain, during pregnancy than non-autistic participants. Maternity professionals did not have a good understanding of autism and the women did not always feel comfortable telling professionals about their autism diagnosis. They also needed professionals to communicate with them clearly and to make changes during appointments such as dimming lights to reduce sensory overload.[114] Because autistic women may appear calm even when in severe distress, caregivers do not always trust women's reports of being in pain.[115] As one woman quoted in a submission from the National Autistic Society said: "It can be difficult when people expect you to be performing your pain in a way they recognise at a time when you have nothing spare to spend on doing the right facial expressions!"

Some submissions from young mothers suggested that they were treated less sympathetically because of their age. Jayde Edwards, who became pregnant when she was 15, told session 7 of the inquiry that the first question her GP asked her was whether she had considered having an abortion: "When I said to her, 'No I'm keeping the baby', she made a referral to social services and didn't tell me why…if she had explained, 'Maybe you need a bit more support,' I would've said I have family around, I was attending a church at the time and I have a really strong support network."

Jayde drew the inquiry's attention to the fact that many people may be marginalised in more than one way, and that certain types of marginalisation go together: young mothers, for example, are 22% more likely to be living in poverty by the age of 30[116], while those who have been through the care system are three times more likely to become mothers by the age of 18.[117]

Exceptionally vulnerable women

There are some women who are so vulnerable their voices are rarely heard: women in prison, for example, refugees, women who have been through the care system, or women whose babies are taken into care. One woman described in her submission feeling that she was "tortured" by midwives withholding essential care from her while she was in labour, which she believes is because she had been a heroin addict, though clean by the time of giving birth. She was given opiates for pain relief, and the fact that her urine test then showed traces of opiate was used against her in court when a decision was made to take her baby away from her. She wrote of the aftermath of her traumatic birth: "I have urine infections constantly and need to always be near a toilet as I have to urinate frequently, but the mental scars are far worse. I was treated like an animal, a second-class citizen that didn't deserve to be treated with any form of care."

Naomi Delap, a director of the charity Birth Companions, which supports marginalised women in childbirth, told the inquiry that many women have overlapping vulnerabilities: they may be victims of domestic abuse, of child sexual abuse, of trafficking; these women are likely to be single mothers, and they may be in prison, or have had a baby taken into care. Birth Companions is able to advocate for these women, who often may not feel listened to, or and who often feel pressured into particular choices during labour. Women who have had previous trauma, she pointed out, are three times as likely to develop postnatal PTSD as other women. Survivors of sexual abuse, for example, may find vaginal examinations – a common way of establishing progress during labour – intensely traumatic. "If maternity staff are aware of this aspect of woman's history this is something that can be planned for," she said.

Improving care

The evidence presented to the inquiry demonstrated the variety of ways in which it is possible to feel marginalised during labour and childbirth. Every individual who gives birth has their own unique history and needs. It might be that their ethnicity puts them at greater risk of tearing, or that their trauma history makes them terrified of internal examinations, or that their autism makes them particularly sensitive to sensory input. As Jacob Stokoe, a trans man giving oral evidence in session 7, said: "It's about seeing the person in front of you and responding to them as they need."

Ms Delap emphasised the importance of continuity of care – which, she pointed out, "doesn't necessarily reside in continuity of carer." Instead, it could be that "everybody has an understanding of trauma, that everybody is compassionate and kind, that there is continuity of information-sharing so that people don't have to keep on reiterating their trauma, telling their stories over and over again to different people." It should, she added, "also include individualised approach, individualised care plans, meaningful consent."

If we are to offer good quality maternity care to everyone, then this focus on individuality, on care and on consent is essential.

Vision: what does ‘good’ look like in maternity?

Our inquiry has uncovered a pattern of poor maternity care across the country, resulting in many women being deeply traumatised. In many cases, the effects extend beyond the individual woman to her partner, her children, wider family and friends. Many women spoke of being unable to return to work and of having to spend years undergoing NHS treatment for both psychological and physical injuries. In some cases, the impact of traumatic birth was still felt decades later.

We believe that it doesn’t have to be like that. Sometimes unavoidable emergencies happen during birth, and sometimes, unfortunately, mothers or babies are harmed. It is not always possible to prevent stillbirth, for example, and sometimes a woman will experience a severe obstetric tear as the baby is born.

But it is possible both to reduce the incidence of harm and to make sure that women and their partners are better supported when harm occurs.

The common theme running through the personal submissions was of women not being listened to when they thought that something was wrong, or when they asked for help. Red flags that indicated a difficulty in pregnancy or labour were often ignored. Women told us that they felt belittled or dismissed when they raised concerns. After birth, women wrote of being unable to access basic help on the postnatal ward, even if they were too ill or weak to lift their baby. Partners, too, wrote of being ignored by staff and left unaware of what was happening. Attempts by parents to gain answers after a difficult birth in which mistakes were made often result in efforts to cover up or minimise the harm caused.

We suggest that a good maternity service would include the following elements:

Antenatal education

All pregnant women should have the opportunity to access good quality antenatal education that explains, clearly and straightforwardly, what giving birth involves, what the risks are and the kinds of choices they might have to make during labour so that they can think them through beforehand. Women should also have access to a risk calculator that helps them understand their own individual risk profile and to make choices about their birth accordingly.

Listening to women

Too many of the stories we heard involved women not being listened to. If a woman is concerned about bleeding in pregnancy, or reduced fetal movements, or that her bump has stopped growing, for example, then these concerns should be taken seriously and investigated. If she asks for pain relief, then she should be offered it. There should not be a default assumption that women are being over-anxious or over-dramatic when they express concerns.

Sharing good practice and using evidence-based care

Women should be able to feel reassured that the care they receive is based on agreed standards and guidelines. Where a maternity unit has been successful in, for example, reducing stillbirth rates, staff in other maternity units should have the opportunity to learn from that. Training in known problem areas (for example, correctly reading a CTG trace) should be given regularly, so that staff skills are up-to-date.

Consent

Except in an emergency, no procedure should be carried out on a woman without her consent.

Safe working environment for staff

All maternity units should be fully staffed. Staff should not be subjected to bullying from other staff members. It should be taken as a given that obstetricians and midwives work as a team, with the same goals in mind. Instances of bullying or bad behaviour should be dealt with robustly.

Postnatal care

All women should receive good quality postnatal care. This means that, on the postnatal ward, they are given appropriate help to go to the toilet, if necessary, or to pick up their baby. Women who want to breastfeed should receive help from staff trained in breastfeeding support. No woman should be made to feel inadequate or a failure for not being able to breastfeed. Staff should be trained to identify signs of illness postpartum, such as sepsis or haemorrhage.

Transparency and accountability

If mistakes happen during a woman's care, then hospitals must be open and honest with her about the mistake, in line with the duty of candour requirement. Mistakes should be treated as an opportunity to learn and improve future practice.

Partners

If a woman chooses to have her partner with her during birth, then a staff member should be assigned to keep the partner informed about what is happening if a problem arises.

Racism

No woman or staff member should be subjected to racist attitudes or assumptions. Women whose first language is not English should be offered a good-quality interpreting service. Cultural differences should be understood and respected.

Trauma-informed care

Women who disclose that they have had a previous traumatic experience (including traumatic birth) should be offered trauma-informed care, including the opportunity to receive mental health support from a professional and the opportunity to discuss potential triggers, and how they can be avoided, with the obstetric team.

Mental health support

Women and partners should be offered routine screening to see if they display trauma symptoms after birth, and offered appropriate mental health help if necessary.

Conclusion

Some of the findings in this inquiry – in particular the scale of birth trauma and the devastating impact it has on women and their families – will be new to a lot of people. Yet there is much still to be explored, and we hope this inquiry will begin a national conversation on birth trauma. Despite being a relatively common experience, the very first time birth trauma was discussed in parliament was in October 2023. Now that the taboo has been broken, we hope there will be many more such debates and that birth trauma will be taken seriously. We call on the prime minister and the UK government to implement our recommendations in full.

APPENDIX I

Birth Trauma Inquiry Witnesses

Evidence session 1: 5th February 2024

Ranee Thakar, President, Royal College of Obstetricians and Gynaecologists

Gill Walton, Chief Executive, Royal College of Midwives

Professor Susan Ayers, Professor of Maternal and Child Health, City University London

Maureen Treadwell, Co-founder, Birth Trauma Association

Rachael McGrath, Chair, Birth Trauma Association

Clotilde Abe, Co-Founder, Five X More

Evidence session 2: 12th February 2024

Emma Hurst MLC, Member of the Legislative Council of New South Wales

Dr Hazel Keedle, Researcher, BESt Study and New South Wales Birth Trauma Inquiry

Amy Dawes, CEO Australasian Birth Trauma Association

Professor Antje Horsch, University of Lausanne

Jan Willem De Leeuw, Consultant Obstetrician and Gynaecologist

Evidence session 3: 19th February 2024

Dr Nitish Raut, Gynaecologist, Stoke-on-Trent Hospital

Dr Posy Bidwell, Chair of the MASIC Foundation, Deputy Head of Midwifery, South Warwickshire Foundation Trust

Professor Michael Keighley, Founder, MASIC Foundation

Geeta Nayar, mother with lived experience

Jenny Tighe, mother with lived experience

Sarah Embleton, mother with lived experience

Evidence session 4: 26th February 2024

Dr (h.c.) Donna Ockenden, Chair, Independent Review into Maternity Services

Dr Rebecca Moore, Perinatal Psychiatrist

Honey Attridge, Peer Supporter for the CNWL Maternity Trauma and Loss Care Service

Neera Ridler-Mayor, mother with lived experience

Emily Barley, mother with lived experience

Natalie Tasker, mother with lived experience

Evidence session 5: 4th March 2024

Professor Pauline Slade, Professor in Clinical Psychology, University of Liverpool

Kate Lough, Chair, Pelvic Obstetric and Gynaecological Physiotherapy Group (POGP)

Suzanne White, Head of Medical Negligence, Leigh Day

Professor Robert Freeman, Consultant Gynaecologist, University of Plymouth

Heather Simmons, mother with lived experience

Neya Joshi, mother with lived experience

Evidence session 6: 11th March 2024

Dr Andrew Mayers, Psychologist, University of Bournemouth

Mark Williams, Founder, Fathers Reaching Out

Kieran Anders, Operations Manager, Dad Matters

Scott Mair, Director, Fatherhood Solutions

Lucy Allen-Goss, Academic and Writer

Laura-Rose Thorogood, Founder, LGBT+ Mummies

Evidence session 7: 18th March 2024

Professor Angie Doshani, Consultant Obstetrician and Gynaecologist

Illyin Morrison, Midwife and Birth Trauma Specialist

Carol King-Stephens, Midwife and Lead on Inequality for the West Midlands

Jayde Edwards, Project Manager at Mental Health Foundation for Young Mums Connect

Naomi Delap, Director, Birth Companions

Jacob Stokoe, Founder, Transparent Change

APPENDIX II

Summary of Recommendations

Chapter One:

1. Recruit, train and retain more midwives, obstetricians and anaesthetists to ensure safe levels of staffing in maternity services and provide mandatory training on trauma-informed care.
2. Make sure all NHS trusts offer antenatal classes to inform parents of what to expect from birth and to outline their options.
3. Make an awareness of the causes and impact of birth trauma a mandatory part of both midwifery and obstetrics training.

Chapter Two:

1. Make training in trauma-informed care a mandatory part of midwifery and obstetric education.
2. At the 34-week appointment, discuss with women their options during birth, including the risk factors relating to instrumental and caesarean birth.
3. Offer regular CPD training to maternity professionals on communicating risk.

Chapter Three:

1. Roll out and implement, underpinned by sufficient training, the OASI (obstetric and anal sphincter injury) care bundle to all hospital trusts to reduce risk of injuries in childbirth.
2. Introduce mandatory data gathering, so we know exactly how many women experience OASI.
3. Maternity units to adopt the recommendations of the consensus statement on instrumental birth, to be published this year.
4. Government to provide funding to validate the UR-CHOICE pelvic floor risk disorders calculator so it can be used in clinical practice.
5. Maternity units to implement NHS England's Perinatal Pelvic Health service specification, which includes providing information for women in antenatal period, such as the importance of pelvic floor exercises; increased education for health professionals including GPs; and early access to care for symptoms of incontinence. Women with perineal injuries to be seen by specialists in pelvic health clinics.[118]

Chapter Four:

1. Provide universal access to specialist maternal mental health services across the UK to end the postcode lottery.
2. Make a more focused effort to train and recruit perinatal mental health staff.
3. Introduce specialist training in birth trauma for CBT and EMDR therapists.
4. Introduce national oversight of maternal mental health services, with resources developed nationally instead of each service having to create their own.
5. NHS to commission research on birth debriefs, with the aim of creating a standard, evidence-based model that works and can be applied throughout the country.
6. NHS to commission an academic researcher to develop two standard screening questions about birth trauma that can be asked by the GP at the six-to-eight week postnatal check.

Chapter Five:

1. Government to commission research on the economic impact of birth trauma, including factors such as women delaying returning to work, the break-up of relationships and the costs of raising a disabled child.
2. Government to commission research on the costs to the NHS and social care of birth trauma, including the long-term cost of repairing birth injuries, providing mental health support and providing care for disabled children.
3. NHS to offer better support for maternity professionals, including opportunities to debrief and receive counselling after witnessing trauma.
4. Government to introduce more robust procedures for investigating bullying behaviour in NHS maternity care.

Chapter Six:

1. Offer mental health screening to partners after birth. This could be in the form of one or two questions from a health professional.
2. NHS England to develop guidance for keeping partners informed about an obstetric emergency (for example, assigning a health professional to update the partner on what is happening during and after the emergency).
3. Government and employers to consider offering extended parental leave in cases where a father or non-birthing mother has to support a new mother who is physically or mentally unwell.

Chapter Seven:

1. Commit to tackling inequalities in maternity care among ethnic minorities, particularly Black and Asian women. To address this NHS England should provide funding to each NHS Trust to maintain a pool of appropriately trained interpreters with expertise in maternity and to train NHS staff to work with interpreters.
2. Launch a national NHS-wide campaign to publicise the importance for Black and Asian women of taking Vitamin D during pregnancy.
3. Introduce specialist midwives for young parents who understand the intersection with other vulnerabilities, such as deprivation or care experience.
4. Provide training for maternity staff in trauma-informed care.

ENDNOTES

[1] Kirkup B (2015). *The report of the Morecambe Bay investigation*. London: The Stationery Office https://assets.publishing.service.gov.uk/media/5a7f3d7240f0b62305b85efb/47487_MBI_Accessible_v0.1.pdf

[2] Independent Maternity Review. (2022). *Ockenden report – Final: Findings, conclusions, and essential actions from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust* (HC 1219). Crown.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1064302/Final-Ockenden-Report-web-accessible.pdf

[3] Kirkup, B (2022) Reading the Signals: maternity and neonatal services in East Kent – report of the independent investigation
https://assets.publishing.service.gov.uk/media/634fb083e90e0731a5423408/reading-the-signals-maternity-and-neonatal-services-in-east-kent_the-report-of-the-independent-investigation_print-ready.pdf

[4] CQC (2023) The state of health care and adult social care in England 2022/23.
https://www.cqc.org.uk/publications/major-report/state-care/2022-2023

[5] Yildiz P, Ayers S and Phillips L (2017) The prevalence of posttraumatic stress disorder in pregnancy and after birth: A systematic review and meta-analysis. *Journal of Affective Disorders 15,* 208, 634–645. doi: 10.1016/j.jad.2016.10.009

[6] Soet, J, Brack, G, Dilorio, C (2003) Prevalence and Predictors of Women's Experience of Psychological Trauma During Childbirth. *Birth 30*, 1, 36-46. doi: 10.1046/j.1523-536x.2003.00215.x

[7] DHSC (2024) Health Secretary announces new women's health priorities for 2024
https://www.gov.uk/government/news/health-secretary-announces-new-womens-health-priorities-for-2024

[8] Montgomery v Lanarkshire Health Board (2015) SC 11 [2015] 1 AC 1430

[9] Harrison, S et al (2024) The impact of the Covid-19 pandemic on postnatal anxiety and posttraumatic stress: Analysis of two population-based national maternity surveys in England**.** Journal of Affective Disorders 356, 122-136**.** doi: 10.1016/j.jad.2024.04.003

[10] Leinweber J et al (2022) Developing a woman-centered, inclusive definition of traumatic childbirth experiences: a discussion paper. *Birth* 49:687–96. doi: 10.1111/birt.12634

[11] Yildiz P, Ayers S and Phillips L (2017) The prevalence of posttraumatic stress disorder in pregnancy and after birth: A systematic review and meta-analysis. *Journal of Affective Disorders 15,* 208, 634–645. doi: 10.1016/j.jad.2016.10.009

[12] Horsch A et al (2024) Childbirth-related posttraumatic stress disorder: Definition, risk factors, pathophysiology, diagnosis, prevention, and treatment. *AJOG* doi.org/10.1016/j.ajog.2023.09.089

[13] Yildiz P, Ayers S and Phillips L (2017) The prevalence of posttraumatic stress disorder in pregnancy and after birth: A systematic review and meta-analysis. *Journal of Affective Disorders 15,* 208, 634–645. doi: 10.1016/j.jad.2016.10.009

[14] Ayers S et al (2016) The aetiology of post-traumatic stress following childbirth: a meta-analysis and theoretical framework. *Psychological Medicine*, 46(6), 1121-34. doi: 10.1017/S0033291715002706

[15] ibid.

[16] Soet, J, Brack, G, Dilorio, C (2003) Prevalence and Predictors of Women's Experience of Psychological Trauma During Childbirth. *Birth 30*, 1, 36-46. doi: 10.1046/j.1523-536x.2003.00215.xs

[17] Bryant, R (2019) Post-traumatic stress disorder: a state-of-the-art review of evidence and challenges. *World Psychiatry* 18, 3, 259-269. doi: 10.1002/wps.20656

[18] Hollander, M et al (2017) 'Preventing traumatic childbirth experiences: 2192 women's perceptions and views' *Archives of women's mental health*, *20*, 4, 515–523. doi.org/10.1007/s00737-017-0729-6

[19] APPG on Birth Trauma/Mumsnet (2023) Results of the birth trauma survey. https://www.theo-clarke.org.uk/sites/www.theo-clarke.org.uk/files/2023-09/Birth%20trauma%20survey%20results__%20%281%29.pdf

[20] World Health Organisation (2019) Trends in Maternal Mortality: 2000 to 2017. https://www.who.int/publications/i/item/9789241516488

[21] Abdollahpour, S, Khadivzadeh, T (2022) Prevalence of Traumatic Childbirth and Post-traumatic Stress After Delivery in Iran: A Systematic Review and Meta-Analysis *Journal of Obstetrics, Gynecology and Cancer Research*, 4(3), pp. 86-92. doi: 10.30699/jogcr.4.3.86

[22] Gankanda WI et al (2021) Prevalence and associated factors of post-traumatic stress disorder (PTSD) among a cohort of Srilankan post-partum mothers: a cross-sectional study. *BMC Pregnancy Childbirth*. Sep 17;21(1):626. doi: 10.1186/s12884-021-04058-z.

[23] Ayers S et al (2023) Traumatic birth and childbirth-related post-traumatic stress disorder: International expert consensus recommendations for practice, policy, and research. *Women Birth*. Dec 8:S1871-5192(23)00309-8. doi: 10.1016/j.wombi.2023.11.006.

[24] Horsch A et al (2017) Reducing intrusive traumatic memories after emergency caesarean section: A proof-of-principle randomized controlled study. *Behav Res Ther*. Jul;94:36-47. doi: 10.1016/j.brat.2017.03.018

[25] Thomson, G., Diop, M.Q., Stuijfzand, S. *et al* (2021) Policy, service, and training provision for women following a traumatic birth: an international knowledge mapping exercise. *BMC Health Serv Res* 21, 1206 (2021). doi.org/10.1186/s12913-021-07238-x

[26] Keedle, H et al (2022) Dehumanized, Violated, and Powerless: An Australian Survey of Women's Experiences of Obstetric Violence in the Past 5 Years. Violence Against Women, 0(0). doi.org/10.1177/10778012221140138

[27] See eg SBS News (2023) 'Naomi's birthing experience left her profoundly traumatised. Here's what it led to' 9 September https://www.sbs.com.au/news/article/naomis-birthing-experience-left-her-profoundly-traumatised-heres-what-its-led-to/77y2g3n0c

[28] ABTA (2023) NSW Parliamentary Inquiry into Birth Trauma Submission. https://www.parliament.nsw.gov.au/lcdocs/submissions/80748/0254%20The%20Australasian%20Birth%20Trauma%20Association.pdf

[29] Western Sydney University (2023) Submission to the NSW Inquiry into Birth Trauma https://www.parliament.nsw.gov.au/lcdocs/submissions/80699/0232%20Western%20Sydney%20University.pdf

[30] Hernández-Martínez A et al (2020) Perinatal factors related to post-traumatic stress disorder symptoms 1-5 years following birth. *Women Birth*. Mar;33(2):e129-e135. doi: 10.1016/j.wombi.2019.03.008. Epub 2019 Apr 4.

[31] Statista Distribution of the method of childbirth delivery in National Health Service (NHS) hospitals in England in 2020/21. https://www.statista.com/statistics/407706/method-of-delivery-in-england/

[32] Friedman T, Eslick GD, Dietz HP (2019) Delivery mode and the risk of levator muscle avulsion: a meta-analysis. *Int Urogynecol J*. 2019;30:901-907. doi: 10.1007/s00192-018-3827-8

[33] Volloyhaug I et al (2015) Forceps delivery is associated with increased risk of pelvic organ prolapse and muscle trauma: a cross-sectional study 16-24 years after first delivery. *Ultrasound Obstet Gynecol* 46(4): 487-495. doi: 10.1002/uog.14891

[34] Gyhagen, M et al (2021) Temporal trends in obstetric anal sphincter injury from the first vaginal delivery in Austria, Canada, Norway, and Sweden. *AOGS* 11: 100: 1969-19762021. doi: 10.1111/aogs.14244

https://obgyn.onlinelibrary.wiley.com/doi/10.1111/aogs.14244?af=R

[35] Seijmonsbergen-Schermers AE et al (2020) Variations in use of childbirth interventions in 13 high-income countries: a multinational cross-sectional study. *PLoS Med* 2020;17:e1003103. doi: 10.1371/journal.pmed.1003103

[36] Murphy DJ et al, on behalf of the Royal College of Obstetricians Gynaecologists (2020) Assisted Vaginal Birth. *BJOG* ;127:e70–e112. doi: 10.1111/1471-0528.16092

[37] Perined (Dutch National Obstetric Perinatal Database)

[38] NHS Resolution (2017) Annual report and accounts. https://resolution.nhs.uk/wp-content/uploads/2017/07/NHS-Resolution_2016_17-Annual-report-and-accounts.pdf

[39] NHS Resolution (2023) Annual report and accounts https://resolution.nhs.uk/wp-content/uploads/2023/07/NHS-Resolution-Annual-report-and-accounts-2022_23-3.pdf

[40] NMPA Project Team (2022) National Maternity and Perinatal Audit. Clinical Report 2022 Based on births in NHS maternity services in England and Wales between 1 April 2018 and 31 March 2019. Royal College of Obstetrics and Gynaecologists.

[41] MASIC (2021) Anal incontinence following obstetric anal sphincter injuries at birth. https://masic.org.uk/wp-content/uploads/2021/05/Anal-Incontinence-after-OASI-Study.pdf

[42] NHS England and NHS Improvement (2020) Better Births Four Years On: a Review of Progress. https://www.england.nhs.uk/wp-content/uploads/2020/03/better-births-four-years-on-progress-report.pdf

[43] Tung C et al (2015) Incidence and Risk Factors of Obstetric Anal Sphincter Injuries after Various Modes of Vaginal Deliveries in Chinese Women. *Chinese Medical Journal (Engl)* 2015; 128, 18, 2420–5. doi: 10.4103/0366-6999.164874

[44] Giulia M Muraca et al (2022) Maternal and neonatal trauma following operative vaginal delivery. *CMAJ* Jan; 194 (1) E1-E12. doi: 10.1503/cmaj.210841

[45] Volloyhaug I et al. Forceps delivery is associated with increased risk of pelvic organ prolapse and muscle trauma: a cross-sectional study 16-24 years after first delivery. *Ultrasound Obstet Gynecol.* 2015; 46(4): 487-495. doi: 10.1503/cmaj.210841

[46] Statista Distribution of the method of childbirth delivery in National Health Service (NHS) hospitals in England in 2020/21. https://www.statista.com/statistics/407706/method-of-delivery-in-england/

[47] Gyhagen, M et al (2021) Temporal trends in obstetric anal sphincter injury from the first vaginal delivery in Austria, Canada, Norway, and Sweden. *AOGS*; 11: 100: 1969-19762021. doi: 10.1111/aogs.14244

[48] ibid.

[49] Baruch, Y et al (2023) High Incidence of Obstetric Anal Sphincter Injuries among Immigrant Women of Asian Ethnicity. *Journal of Clinical Medicine*. 12(3):1044. doi:10.3390/jcm12031044

[50] Montgomery v Lanarkshire Health Board (2015) SC 11 [2015] 1 AC 1430.

[51] Bugge C et al (2022) Should pregnant women know their individual risk of future pelvic floor dysfunction? A qualitative study. *BMC Pregnancy Childbirth*. Feb 28;22(1):161. doi: 10.1186/s12884-022-04490-9

[52] Laine K et al (2012) Incidence of obstetric anal sphincter injuries after training to protect the perineum: cohort study. *BMJ Open* 2**:**e001649. doi: 10.1136/bmjopen-2012-001649

[53] Jurczuk, M et al (2021) The OASI care bundle quality improvement project: lessons learned and future direction. *Int Urogynecol J* 32, 1989–1995 https://doi.org/10.1007/s00192-021-04786-y

[54] Heyne CS et al (2022) Prevalence and risk factors of birth-related posttraumatic stress among parents: A comparative systematic review and meta-analysis. *Clin Psychol Rev*. Jun;94:102157. doi:10.1016/j.cpr.2022.102157.

[55] Cohen, M et al (2004) Post-traumatic stress disorder after pregnancy, labor and delivery. *Journal of Women's Health 13* 315–324. doi: 10.1089/154099904323016473

[56] Parfitt, Y and Ayers,S (2009) The effect of post-natal symptoms of post-traumatic stress and depression on the couple's relationship and parent-baby bond. *Journal of Reproductive and Infant Psychology 27*, 2, 127–142. doi: 10.1080/02646830802350831

[57] Raza SK, Raza S. Postpartum Psychosis. [Updated 2023 Jun 26]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2024 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK544304/

[58] Knight, M et al (2023) Saving Lives, Improving Mothers' Care 2019-21. NPEU. https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2023/MBRRACE-UK_Maternal_Compiled_Report_2023.pdf

[59] McLeish, J, Redshaw, M (2017) Mothers' accounts of the impact on emotional wellbeing of organised peer support in pregnancy and early parenthood: a qualitative study. *BMC Pregnancy Childbirth 17*, 28. doi: 10.1186/s12884-017-1220-0

[60] Maternal Mental Health Alliance (2023) Specialist perinatal mental health care in the UK 2023. https://maternalmentalhealthalliance.org/media/filer_public/9a/51/9a513115-1d26-408a-9c85-f3442cc3cb2b/mmha-specialist-perinatal-mental-health-services-uk-maps-2023.pdf

[61] National Institute for Health and Care Research (2022) The Effectiveness and Implementation of Maternal Mental Health Services. https://arc-swp.nihr.ac.uk/wp/wp-content/uploads/2023/05/ESMII-report-august-2022_final-1.pdf

[62] The National Specialist Perinatal Mental Health Workforce Report: England workforce census 2022/23. An NHS Benchmarking Network project commissioned by NHS England Workforce, Training and Education Director. September 2023.

[63] Maternal Mental Health Alliance (2023) Specialist perinatal mental health care in the UK 2023. https://maternalmentalhealthalliance.org/media/filer_public/9a/51/9a513115-1d26-408a-9c85-f3442cc3cb2b/mmha-specialist-perinatal-mental-health-services-uk-maps-2023.pdf

[64] NHS England (2023) GP six to eight week maternal postnatal consultation – what good looks like guidance https://www.england.nhs.uk/long-read/gp-six-to-eight-week-maternal-postnatal-consultation-what-good-looks-like-guidance/#perinatal-mental-health

[65] Wilkinson, E (2023) Mothers 'failed' over six-week postnatal checks, claims patient group. *Nursing in Practice* 27 March. https://www.nursinginpractice.com/latest-news/mothers-failed-over-six-week-postnatal-checks-claims-patient-group/

[66] Thomson, G and Garrett, C (2019) Afterbirth support provision for women following a traumatic/distressing birth: Survey of NHS hospital trusts in England. *Midwifery*, 71, 63-70. doi: 10.1016/j.midw.2019.01.004

[67] Maternal Mental Health Alliance UK (2023) Specialist Perinatal Mental Health Care in the UK 2023. https://maternalmentalhealthalliance.org/media/filer_public/9a/51/9a513115-1d26-408a-9c85-f3442cc3cb2b/mmha-specialist-perinatal-mental-health-services-uk-maps-2023.pdf

[68] Taghizadeh Z, Irajpour A, Arbabi M (2013) Mothers' response to psychological birth trauma: a qualitative study. *Iran Red Crescent Med J*. Oct;15(10):e10572. doi: 10.5812/ircmj.10572. Epub 2 Oct 5.

[69] Nicholls, K & Ayers, S (2007). Childbirth-related post-traumatic stress disorder in couples: A qualitative study. *British journal of health psychology*, *12*(4), 491–509. doi: 10.1348/135910706X120627

[70] Cook N, Ayers S, Horsch A (2018) Maternal posttraumatic stress disorder during the perinatal period and child outcomes: A systematic review. *J Affect Disord*. Jan 1;225:18-31. doi: 10.1016/j.jad.2017.07.045. Epub 2017 Jul 27..

[71] Van Sieleghem S et al (2022) Childbirth related PTSD and its association with infant outcome: A systematic review. Early Hum Dev. 2022 Nov;174:105667. doi: 10.1016/j.earlhumdev.2022.105667. Epub Sep 16.

[72] Bick, D et al (2022) The impact of severe perineal trauma on a woman's relationship with her child: a hidden consequence. *Midwifery* 108. https://masic.org.uk/wp-content/uploads/2022/06/Bick-Hall-Keighley-Commentary-Midwifery-2022-1.pdf

[73] Delicate A et al (2018) The impact of traumatic childbirth on a couple's relationship: a systematic review and meta-synthesis. *Journal of Reproductive and Infant Psychology*, 36(1), 102-115. doi: 10.1080/02646838.2017.1397270

[74] Ayers, S et al (2006) The effects of childbirth-related post-traumatic stress disorder on women and their relationships: a qualitative study. *Psychology, Health & Medicine 11*, 4, 389-398. doi: 10.1080/13548500600708409

[75] Skinner, E (2019) *The link between somatic and psychological sequelae of traumatic vaginal birth*. PhD thesis. University of Sydney.

[76] DHSC (2023) Women's health hubs: cost benefit analysis. https://www.gov.uk/government/publications/womens-health-hubs-information-and-guidance/womens-health-hubs-cost-benefit-analysis

[77] Dawes, A et al (2022) Birth Injuries: the hidden epidemic. https://masic.org.uk/wp-content/uploads/2022/08/FinalBirthinjuriesreportJune2022.pdf

[78] Garratt, K (2023) Research briefing: The NHS Workforce in England. House of Commons library

[79] Hunter, B (2019) Work, Health and Emotional Lives of Midwives in the United Kingdom: The UK WHELM study. https://www.rcm.org.uk/media/2924/work-health-and-emotional-lives-of-midwives-in-the-united-kingdom-the-uk-whelm-study.pdf

[80] Uddin N, Ayers S, Khine R, Webb R (2022) The perceived impact of birth trauma witnessed by maternity health professionals: A systematic review. *Midwifery*. Nov;114:103460. doi: 10.1016/j.midw.2022.103460. Epub 2022 Aug 13.

[81] Nieuwenhuijze M, et al (2024) The impact of severe perinatal events on maternity care providers: a scoping review. *BMC Health Serv Res*. Feb 7;24(1):171. doi: 10.1186/s12913-024-10595-y

[82] Slade, P et al (2020) Work-related post-traumatic stress symptoms in obstetricians and gynaecologists: findings from INDIGO, a mixed-methods study with a cross-sectional survey and in-depth interviews. *BJOG: An International Journal of Obstetrics and Gynaecology 127*, 5, 600–800. doi: 10.1111/1471-0528.16076

[83] Heyne CS et al (2022) Prevalence and risk factors of birth-related posttraumatic stress among parents: A comparative systematic review and meta-analysis. *Clin Psychol Rev*. Jun;94:102157. doi: 10.1016/j.cpr.2022.102157. Epub 2022 Apr 21.
[84] Etheridge, J and Slade, P (2017) 'Nothing's actually happened to me.': the experiences of fathers who found childbirth traumatic.' *BMC Pregnancy And Childbirth 17*, 80. doi: 10.1186/s12884-017-1259-y

[85] Daniels, E et al (2020) Be quiet and man up: a qualitative questionnaire study into fathers who witnessed their Partner's birth trauma. *BMC Pregnancy Childbirth 20:* 236. doi: 10.1186/s12884-020-02902-2

[86] Ayers, S et al (2006) The effects of childbirth-related post-traumatic stress disorder on women and their relationships: a qualitative study. *Psychology, Health & Medicine 11*, 4, 389-398. doi: 10.1080/13548500600708409

[87] Webb, R et al (2021) Development and Validation of a Measure of Birth-Related PTSD for Fathers and Birth Partners: The City Birth Trauma Scale (Partner Version). doi: 10.3389/fpsyg.2021.596779

[88] NICE (2020) Antenatal and postnatal mental health: clinical management and service guidance. https://www.nice.org.uk/guidance/cg192

[89] Hambidge, S et al (2021) "What kind of man gets depressed after having a baby?" Fathers' experiences of mental health during the perinatal period. *BMC Pregnancy Childbirth* **21**, 463 https://doi.org/10.1186/s12884-021-03947-7

[90] Mayers, A et al (2020) Supporting women who develop poor postnatal mental health: what support do fathers receive to support their partner and their own mental health? *BMC Pregnancy Childbirth* **20**, 359 https://doi.org/10.1186/s12884-020-03043-2

[91] Berrisford, G and Dunkley-Bent, J (2023) Perinatal mental health services – supporting pregnant women and new mothers https://www.england.nhs.uk/blog/perinatal-mental-health-services-supporting-pregnant-women-and-new-mothers

[92] Bauer, A et al (2014) The costs of perinatal mental health problems. https://www.lse.ac.uk/cpec/assets/documents/CPEC-Perinatal-Economics-2022.pdf

[93] Statista (2023) Births in the United Kingdom (UK) - Statistics & Facts. https://www.statista.com/topics/5204/births-in-the-uk/#topicOverview

[94] Raleigh, V (2023) The health of people from ethnic minority groups in England. https://www.kingsfund.org.uk/insight-and-analysis/long-reads/health-people-ethnic-minority-groups-england

[95] MBRRACE-UK (2023) Maternal mortality 2019-2021 https://www.npeu.ox.ac.uk/mbrrace-uk/data-brief/maternal-mortality-2019-2021

[96] MBRRACE (2023b) UK perinatal deaths for births from 1 January 2021 to 31 December 2021 https://timms.le.ac.uk/mbrrace-uk-perinatal-mortality/surveillance/

[97] Thomas, T (2024) Black women in England suffer more serious birth complications, analysis finds. The Guardian, 8 April. https://www.theguardian.com/society/2024/apr/08/black-women-in-england-suffer-more-serious-birth-complications-analysis-finds

[98] Ekezie, W et al (2024) Perinatal health outcomes of women from Gypsy, Roma and Traveller communities: A systematic review, *Midwifery*, vol 129, February. doi: 10.1016/j.midw.2023.103910

[99] Murray, N and Summers, H (2021), Jailed women in UK five times more likely to suffer stillbirths, data shows. *The Observer*, 5 December. https://www.theguardian.com/society/2021/dec/05/jailed-women-in-uk-five-times-more-likely-to-suffer-stillbirths-data-shows

[100] MBRRACE-UK (2022) Saving Lives, Improving Mothers' Care https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2022/MBRRACE-UK_Maternal_CORE_Report_2022_v10.pdf

[101] Marvin-Dowle K et al (2018) Impact of adolescent age on maternal and neonatal outcomes in the Born in Bradford cohort

BMJ Open 2018;**8:**e016258. doi: 10.1136/bmjopen-2017-016258

[102] Gad MM, et al (2021). Disparities in Cardiovascular Disease Outcomes Among Pregnant and Post-Partum Women. *J Am Heart Assoc*. Jan 5;10(1):e017832. doi: 10.1161/JAHA.120.017832.

[103] Lamri A et al (2022) The genetic risk of gestational diabetes in South Asian women. *Elife*. Nov 22;11:e81498. doi: 10.7554/eLife.81498.

[104] Davies-Tuck, M et al (2015) Maternal Asian ethnicity and the risk of anal sphincter injury. *Acta Obstetricia et Gynecologica Scandinavica 94*, 3, 308-315. doi: **10.1111/aogs.12557**

[105] Awe, T and Abe, C (2022) The Black Maternity Experiences Survey https://fivexmore.org/blackmereport

[106] Gohir, S (2022) Invisible: Maternity experiences of Muslim women from racialised minority communities https://www.mwnuk.co.uk//go_files/resources/maternity_report_120722.pdf

[107] Moore, L et al (2019) Migration, ethnicity and mental health: evidence from mothers participating in the Millennium Cohort Study. *Public Health 171*, 66-75. doi: 10.1016/j.puhe.2019.03.022

[108] Edge D (2011) 'It's leaflet, leaflet, leaflet then, "see you later"': black Caribbean women's perceptions of perinatal mental health care. *Br J Gen Pract*. Apr;61(585):256-62. doi: 10.3399/bjgp11X567063.

[109] ONS (2023) Births by parents' country of birth, England and Wales: 2022

https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/bulletins/parentscountryofbirthenglandandwales/2022

[110] BBC (2023) NHS interpreting service problems contributed to patient deaths, 21 November. https://www.bbc.co.uk/news/uk-england-bristol-66605536

[111] Leonard SA et al (2022) Sexual and/or gender minority disparities in obstetrical and birth outcomes. *Am J Obstet Gynecol* 226:846.e1-14. doi: 10.1016/j.ajog.2022.02.041

[112] Hammond, C (2014) Exploring same sex couples' experiences of maternity care, *British Journal of Midwifery* 22;7. doi: 10.12968/bjom.2014.22.7.495

[113] Klittmark, S et al (2023) When complications arise during birth: LBTQ people's experiences of care, *Midwifery*, Vol 121,103649. doi:d10.1016/j.midw.2023.103649.

[114] Hampton S et al (2023). A qualitative exploration of autistic mothers' experiences I: Pregnancy experiences. *Autism*. Jul;27(5):1271-1282. doi: 10.1177/13623613221132435.

[115] Lewis, L F et al (2021) Exploring the Birth Stories of Women on the Autism Spectrum. *JOGNN*, 50, 679–690; 2021. doi: 10.1016/j.jogn.2021.08.099

[116] Maternal Mental Health Alliance (2023) The maternal mental health experiences of young mums. https://maternalmentalhealthalliance.org/about-maternal-mental-health/inequalities/young-mums/

[117] Haydon, D (2003) Teenage pregnancy and looked after children/care leavers; Resource for teenage pregnancy coordinators. London: Barnardo's. https://deenahaydon.com/wp-content/uploads/2021/03/Teenage-pregnancy-and-looked-after-children-a-resource-for-teenage-pregnancy-coordinators-2003.pdf

[118] NHS England (2023) Service specification: Perinatal Pelvic Health Services. https://www.england.nhs.uk/wp-content/uploads/2023/10/PRN00147-Service-specification-perinatal-pelvic-health-services.pdf

Report to:	Lincolnshire Community and Hospitals Trust Board Meeting
Title of report:	People and OD Committee Assurance Report to Board
Date of meeting:	10 September 2024
Chairperson:	Professor Phil Baker, Chair
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the People and OD Assurance Committee. The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board. This assurance committee meets monthly and takes scheduled reports according to an established work programme. The Committee worked to the 2024/25 objectives. The Committee meeting was shortened to reflect the reduced attendance as a result of annual leave, receiving a number of papers for information enabling focused discussions on relevant areas.
Assurances received by the Committee	**Assurance is respect of SO 2a** **Issue: Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise** **Workforce Strategy and Organisational Development Group (WSODG) Upward Report and Committee Performance Dashboard** The Committee received the report noting that the meeting was quorate with the group continuing to focus on job plans and sharing of best practice to ensure ongoing monitoring of the position. An increase in the vacancy position was noted however there was good assurance in respect of workforce plans with the increase resulting from the availability and timing of data in ESR. Appraisal compliance continued to be reviewed by the group and it was noted that, whilst appraisals were being undertaken, they were not being captured in the system. A clear action had been cascaded through the divisions to ensure capture in the system to identify compliance. Concern was noted in respect of the increase in sickness levels however this was due to sickness episodes not being correctly closed when staff returned to work. Job planning was noted as an area of concern by the Committee with recognition of the extension of the deadline for the completion of these. It was however noted that, despite the extension, challenge continued to the completion of these with formal escalations being made through the divisional Performance Review Meetings.

	The Committee requested that the group consider more widely the wellbeing agenda across the Trust and for there to be regular review of this to identify further opportunities and risks. **Reward and Recognition Harmonisation Update** The Committee received the report noting that 12 of the 18 employee benefits were now aligned across the Group with work required to align the DBS approach across both ULHT and LCHS. The Committee noted that the Reward and Recognition Policy was due to go live in December and would be progressed as a Group policy with formal agreement required from LCHS Staff Side. **NHS and System People Plan Update** The Committee received the update noting that focus continued in respect of supporting the system financial recovery plan in respect of the Cost Improvement Programme (CIP) gap. External funding was now not available for the People Hub and the Committee noted the full review of the ICB operating model which would incorporate the People Hub. **Vacancy Control – verbal** The Committee received a verbal update in respect of vacancy controls noting that the panel would be extended to include clinical and medical representation to offer further check and challenge to the process. The Committee noted that quarterly reviews were undertaken of all decisions made and the impact of those from both a financial and patient perspective. **Safer Staffing** The Committee received the report and was pleased to note that there had been 0% agency off-framework usage in month along with a significant reduction of agency use to 1.3%. Despite these improvements there has been an increase in bank and overtime use and therefore focus would be given to the triangulation of this against recruitment. Increases were noted in respect of the AHP workforce as a result of recruitment to the Community Diagnostic Centres (CDCs) posts which should in turn see a reduction in the current agency use. Concern was noted in respect of red flags associated to patient falls and pressure ulcers however assurance was provided that this was not related to staffing but due to patient type and acuity.

	Pharmacy Update The Committee welcomed the Divisional Managing Director to the Committee receiving an update against the CQC Actions and current position of the service. It was recognised that staffing continued to be an area of concern however the service was now delivering a 7-day dispensary service, through the utilisation of bank and additional hours. There had been positive recruitment to the service and despite these not all being pharmacists there had been some success in recruiting trainee pharmacists. The Committee recognised that the challenges being experienced by the Trust were not isolated to Lincolnshire with others areas experiencing the same pressures. The Committee requested that a further update be provided in 6-months' time and that this extended to include the position in respect of morale and feedback from leavers to gain a wider understanding.
	Assurance in respect of SO 2b **Issue: To be the employer of choice** **Guardian of Safe Working Quarterly Report** The Committee welcomed the Guardian of Safe Working to the meeting noting that concern had been raised in respect of tenancy costs for Junior Doctors utilising housing on Trust sites. The Committee noted that this was being addressed through the Executive Leadership Team. Provision of educational supervisors was also raised as an area of concern with the Committee noting that discussions were now ongoing between the Guardian and Deputy Medical Director to progress the position.
	Assurance in respect of SO 4c **Issue: Grow our research and innovation through education, learning and training** **University Teaching Hospital and Research and Innovation Report** The Committee received the report noting that recruitment numbers to trials were not at the levels hoped however was reassured of the pipeline in the current year which should see an increase in recruitment. The Committee was pleased to note the increase in Principal Investigators coming forward and the upcoming opportunities for research in family health which would support recruitment figures. Concern continued to be noted in respect of the lack of data reported in respect of non-medical and non-clinical research and innovation activities

	with reassurance received that work continued to develop this for inclusion in future dashboards.
	Assurance in respect of other areas: **Integrated Improvement Plan** The Committee received the report for information noting the position presented. **CQC Forward View** The Committee received the report noting the ongoing work in respect of the self-assessment to identify the current position, measures and focus for improvement. **Fuller Report** The Committee received the report noting there had been some capacity issues in respect of administration in order to record competencies within ESR with a need to define resource within the relevant teams to support this. Progress had been made in respect of DBS checks however there remained a small number of outstanding checks with work being undertaken with the Estates team to attempt to resolve the position. Escalations would be undertaken if required. **Band 2 and 3 Position** The Committee received a verbal update noting that work was ongoing to review the position of bands 2 and 3 recognising that this would be taken through appropriate governance and approvals.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	None
Committee Review of corporate risk register	The Committee received the risk register noting the current risks presented with changes to the very high and high rated risks from the previous report.
Matters identified which Committee recommend are escalated to SRR/BAF	The Committee considered the BAF ratings and determined that objective 2b would be rated amber, from green, due to a lack of robust assurance.
Committee position on assurance of strategic risk areas that align to committee	The Committee considered the reports which it had received which provided assurances against the strategic risks to strategic objectives.

Areas identified to visit in ward walk rounds	No areas identified

Attendance Summary for rolling 12 month period

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

X in attendance
A apologies given
D deputy attended

People Committee in Common Upward Report

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Hospitals NHS Trust

Meeting	*Lincolnshire Community and Hospitals Group Board Meeting*
Date of Meeting	*5 November 2024*
Item Number	*9.1*

People Committee in Common Upward Report of the meeting held on 15 October 2024

Accountable Director	*Claire Low, Group Chief People Officer*
Presented by	*Professor Philip Baker, Non-Executive Director (ULTH)*
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 in Common*

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 this had been the first meeting held in common and the dashboard had been developed to mirror both organisations.

A Group dashboard was also presented with the Committee noting the continuation to identify opportunities for best practice when developing further.

The Committee noted an increase in sickness levels for LCHS which were being monitored with targeted areas being addressed in order to bring levels back in line with trajectory.

LCHS Medical and dental vacancies were noted as appearing to be a high percentage however reassurance was provided that this equated to a small number of whole-time equivalents and therefore was not currently a cause for concern.

The Committee was pleased to note the very positive position for nursing establishment, which was due to the intake of newly qualified nurses and reflected the joint working between nursing and recruitment.

Safer Staffing Nursing and AHP
The Committee received the joint report with **assurance** noting that the report had been further developed to include the wider staff groups. Despite this remaining under development the Committee was pleased to note the £6m year to date saving achieved in respect of the nurse agency workforce.

The midwifery staffing position was noted with a number of new starters due to commence in post in November which would reduce the current 10 whole-time equivalent vacancy to 0.

The Committee noted the ULTH AHP dashboard recognising the challenges with the associated data however this would increase overtime. It was noted that there was a high number of vacancies and a high turnover rate, however there was an impact on this due to the recruitment associated with the Community Diagnostic Centres (CDCs).

Due to positive recruitment in the LCHS AHP workforce it was noted that the associated patient backlog had been addressed, reducing from 58 week waits to 2 weeks.

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, with a focus noted on job planning.

Sexual Safety Charter
The Committee received the update in respect of the Sexual Safety Charter with **assurance** which demonstrated the Group's commitment to the charter with the Group signing up to all 10 charter compliance factors.

The Committee noted the progress made against the charter requirements and offered continued support and approval to the next steps in order to achieve 100% compliance.

The Committee noted that the Group Chief Executive was the Sexual Safety Charter responsible officer for the Group with the work led by the People Directorate and work being aligned to ensure both organisations were in the same position.

Nurse Revalidation – LCHS
The Committee received the report with **assurance** noting that there would be further context added to future reports to detail appropriate NMC reporting.

The Committee noted that 32% of the LCHS nursing workforce had revalidated over the past year with only 2 extensions required, for which staff had successfully revalidated.

Community Nursing Establishment – LCHS
The Committee received the report with **assurance** noting the completion of the review had identified themes related to skills mix and the benefit of the District Nurse Specialist Practitioner Qualification.

The recognition of the qualification would mean that those holding this would be a Band 7 District Nurse with changes being seen to the establishment as a result.

The changes being proposed, including the consideration of apprenticeship training plans, would support a skills escalator approach to recruitment.

The Committee recognised the financial implications of the changes to the establishment noting that this would also be considered by the Finance, Performance and Innovation Committee for LCHS however recognised the positive cultural impact this would have.

National Quarterly Pulse Survey – LCHS
The Committee received the report with **assurance** noting that the frequency of the survey was undertaken in line with best practice.

The utilisation of the quarterly survey enabled Trusts to undertake more relevant surveys due to the adaptability of local questions with LCHS having an above average response rate to the survey.

The Committee noted the reporting to the divisions in respect of the results with oversight of the themes from the surveys being considered through the reporting groups of the Committee. This would include the development of action plans where necessary.

Medical Engagement Development Plan – ULTH
The Committee received the report with **assurance** noting that the report offered the themes being seen across the medical workforce with a need to better understand interprofessional standards and cross specialty working.

The intention was to continue to utilise and strengthen already established meetings to support engagement with the medical workforce and to ensure appropriate representation was in place.

The Committee was pleased to note the amount of progress described through the delivery of the paper however reflected that this was not evident within the report which was offering reassurance on the progress.

The Committee requested that an updated paper be offered to the Committee in November so that assurance could be taken in respect of the significant progress that had been described during the meeting.

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

Staff Benefits – LCHS
The Committee received the report with **assurance** noting the work being undertaken in order to develop the Reward and Recognition Policy across the Group which would support the harmonisation of benefits to staff.

The policy was expected to go live in December which would ensure ongoing support to staff.

Freedom to Speak Up Quarterly Report – ULTH
The Committee received the report with **assurance** noting the continuation of the small number of anonymous staff speaking up which was a positive position.

The Committee noted the increase in the number of Freedom to Speak Up Champions supporting the organisation and noted that high level feedback was being offered through professional network meetings, where this was appropriate to be offered.

GMC Junior Doctor Survey Action Plan - ULTH
The Committee received a verbal update noting that whilst a detailed action plan had been developed this had not been received. The report would be considered by the Committee at the November meeting.

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 content and the changes to reporting moving forward as the Committees in Common developed across the Group.

Concern was noted in respect of the funding of clinical academic posts however, the challenges in identifying such monies were recognised; it was noted that there may be an opportunity to consider funding across the health and care system in future.

Medical Education Update - ULTH
The Committee received the report, noting ongoing concerns regarding teaching not being led by consultants as would be expected; this raised cultural concerns.

The Committee noted the developments within the Medical Directorate to identify teaching leads within services, noting that there was a need for a sustainable, divisional led approach to teaching. Work was taking place to ensure time was allocated within job plans with clear roles and responsibilities outlined for those with teaching roles.

An ongoing deep dive was being undertaken in respect of funding to identify where this was being held and managed in order to offer **assurance** to the Committee that funding was being spent in the correct areas.

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 draft Group Board Assurance Framework (BAF) with **assurance** noting the ongoing work to continue to populate the narrative within this.

During the meeting the Committee considered the RAG ratings of the objectives where assurance reports had been received.

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

Reporting Group update and ToR
The Committee received the report noting the work which had been undertaken to develop the reporting groups to the Committee across the Group.

The Committee noted the benefit of having the groups in place to provide assurance to the Committee however noted that the Education Oversight Group had not yet met which would be pivotal to the assurances required for objective 2b.

The terms of reference for the reporting groups were approved by the Committee with a view for the groups to progress. A review of the reporting groups and the Committee would be scheduled for 6-months' time to ensure these were functioning effectively.

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

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 noting the position presented and the ongoing work to review and update policies across the Group. The Committee noted that all LCHS policy and guideline documents were in date with ULTH having 31 overdue policies of a total of 46 for the People Directorate. 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.

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.

CQC Report
The Committee received the report with **assurance** noting this for information.

Issues where assurance remains outstanding for escalation to the Board

- Cultural issues relating to the provision of undergraduate education
- Outstanding policies

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		
Gail Shadlock, Non-Executive Director, LCHS										X		
Claire Low, Group Chief People Officer										X		
Colin Farquharson Group Chief Medical Officer										D		
Nerea Odongo, Group Chief Nurse										X		

X in attendance
A apologies given
D deputy attended

Report to the Lincolnshire Community and Hospitals Group Board

Date of meeting	5th November 2024	Agenda item	10.1
Title	Report on the Finance, Performance, People and Innovation Committee meetings held on 25th October 2024.		
Report of	Gail Shadlock, Non-Executive Director and Chair of FPPIC	Prepared by	Jayne Warner, Group Director of Corporate Affairs
Previously considered by / Date	None	Approved?	None
Summary	The FPPIC Committee met on 25th October 2024. **Green:** Effective controls are definitely in place and the committee is satisfied that appropriate assurances are available **Amber:** Effective controls are thought to be in place but assurances are uncertain and/or possibly insufficient **Red:** Effective controls may not be in place and/or appropriate assurances are not available		

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

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

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

Recommendations/ Actions Required

Board is asked to:
- **NOTE** the report.

Appendices

None

Glossary

A&E – Accident and Emergency
BPPC – Better Payment Practice Code
CIP – Cost Improvement Programme

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

Report on the FPPIC meetings held on 25th October 2024

1. Purpose

To make the Board aware of key issues from the Finance, Performance, People and Innovation Committee (FPPIC) meetings held on 25th October 2024.

2. Key Issues

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

GREEN ASSURANCE

Strategic Aim 3. To ensure services are sustainable, supported by technology and delivered from an improved estate:
Strategic Objective 3a. Deliver financially sustainable healthcare, making the best use of resources
Strategic Objective 3b. Drive better decisions and impactful action through insight

Strategic Aim 4. To collaborate with our primary care, ICS and external partners to implement new models of care, transform services and grow our culture of research and innovation:
Strategic Objective 4a. Establish collaborative models of care with all our partners including Primary Care Network Alliance (PCNA), GPs, health and social care and voluntary sector
Strategic Objective 4d. Enhanced data and digital capability

Strategic Aim 5. To improve physical and mental health outcomes, promote well-being, and reduce health inequalities across an entire population:
Strategic Objective 5a. Develop a Population Health Management (PHM) and Health Inequalities (HI) approach for our Core20Plus5 with our ICS

AMBER ASSURANCE

Strategic Aim 3. To ensure services are sustainable, supported by technology and delivered from an improved estate:
Strategic Objective 3d. Reduce waits for patients who require urgent and emergency care and diagnostics and ensure we meet all constitutional standards

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

RED ASSURANCE

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

Strategic Aim 5. To improve physical and mental health outcomes, promote well-being, and reduce health inequalities across an entire population:
Strategic Objective 5c. Tackle system priorities and service transformation in partnership with our population and communities

Electronic Patient Record Business Case
The committee received an update on the business case for the LCHS EPR (electronic patient record). Confirmation of funding for LCHS EPR had now received with the approval of the Full Business Case (FBC). This amounted to £2.5m capital and £263k revenue.

The Committee sought confirmation from the Executive that the required legal review had been instructed.

The EPR would be a continuation and strengthening of what was already in place. Work continued on how the systems could align and integrate across the two organisations going forward. No one supplier can provide this functionality at present.

District Nursing Establishment Review Update

The Committee received a report which updated on the District Nursing Establishment Review. The report also presented options for change in respect of banding for roles. The Committee were supportive but recognised that there was more work to be done in terms of the delivery plan for the proposals made. The Committee sought further assurance on how the plans would be delivered in terms of funding and the impact on health outcomes for patients.

The Committee noted that the report had previously been considered by the Executive Leadership Team who had also queried how the plans could be achieved financially. The Committee were advised that the service were working hard to address the overspend in overtime and bank and were confident that this could be achieved.

The update would be taken away and considered further by the Executive Team.

Single Point of Access for Community Services

An update was provided to Committee giving assurance that the single point of access was going live in November 2024. This would provide a single point of access across all community services.

Monthly Finance Reports
The committee reviewed the month 6 finance reports at its meetings noting the financial position of a £1m year to date financial deficit which was £178k favourable to plan.

It was noted that the Trust CIP (Cost Improvement Programme) delivery remained on plan noting that the CIP was backloaded to year end. The plan was underpinned with fully identified schemes. None of the schemes were RAG rated as RED for month 6.

Capital performance remained strong, and the Committee were advised that a request for the capital-related risk score to be reduced would be made to the Risk Confirm and Challenge

Group.

The cash position improved but remains below planned levels.   Agency expenditure levels remain below plan.

The Committee noted that concerns had been raised previously about the stability of staffing in the finance team and sought assurances that this was being resolved.

The Committee agreed that the assurance rating in respect of Objective 3a should remain as Green.

Integrated Performance Report
The committee reviewed the Integrated Performance Reports covering September 2024 performance.

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

(i) Home Visiting Compliance
(ii) Ethnicity recording in A&E data sets

The committee received an update that changes were being made to shift times to improve compliance. A new system for recording ethnicity will be in place from November which should support driving up performance.

It was noted that there had been some evidence of deterioration in four other metrics and evidence of improvement in five others.

Performance Management Review (PMR) Report
The committee reviewed the reports from the August PMR meetings.

PMR reporting format was being brought together across the Group for consistency. No specific issues were alerted to the Committee.

Procurement Waivers
There had been no waivers in the period.

Non Acute Productivity Measure Update
Positive improvement could be seen in productivity during 23/24 when compared to previous year but remains below pre pandemic levels.

Operational Plan Progress Report

The Committee were advised that overall there had been a decline in progress against the plan since the previous quarter. Quarter 1 performance had been very strong but seen some fall back in Quarter 2. Two projects had slipped from Green to Red. The first was delivering a population health needs-based service that maximises the potential of our estate from Archer Assessment Unit (AAU). The second was transparency in our estates utilisation.

The Committee heard that the first AAU project linked to the Frailty Service and the Grantham Hub and Ward. It was noted that the Trust then looked at the use of the AAU at Louth but work was paused when these beds were used to take patients from Skegness. Consideration is being given, within available resource, the development of a frailty hub at Louth and at Skegness. Both plans are on hold due to operational pressures within the teams and the impact of GP collective action where a withdrawal of some services is being seen. Existing staff are moving to support some of these treatment areas as we are seeing increased footfall in some areas as a result of this. . The Committee heard that the Trust continue to monitor this with the ICB. This has impacted on the intended development of the AAU.

Health and Safety and Estates Update

The Committee were advised fresh oversight was being given on these areas as part of the group working. Solutions were not being offered at this stage but these would be delivered over the next 6 months with action plans for areas of concern.

The Committee were advised that lease data was being gathered but that some gaps in this data and the information held had already been identified. The Trust were currently in the process of confirming whether legal advisors had retained copies of relevant documents but the Committee were advised that there was a risk that some information would not be able to be obtained.

Once the position was confirmed it was anticipated that there would be a proposal for better utilisation.

The Committee were advised that water risk assessments were currently being done across the estate.

Space utilisation audits had also commenced. Every site was showing people in unsuitable spaces and people needing further space. Details would be brought to the Committee once this work was completed.

The Committee were advised that a full and more detailed report in respect of Health and Safety would be brought back to a future meeting.

The Committee noted that on the basis of the overview presented in the reporting it was clear that the assurance being provided was limited assurance and that the area should be rated as RED.

The Committee agreed that an escalation of these issues was needed to Board and that this was a real step back from what had previously been presented to the Committee. The Committee noted the significant risk and the work that was being completed at pace to deliver a clear presentation of the position to the Committee and Board.

Premises Assurance Model (PAM)

The PAM provides self-assessment using a national reporting tool. The Committee were advised that there was no documented evidence available to support the previous returns. This was being pursued.

The Committee were advised that the self-assessment reflected a comparison to previous returns which showed a significant backward step against the previous submission.

The submission covered
- Hard FM (Facilities Management) Safety
- Soft FM safety
- Patient Experience
- Efficiency
- Effectiveness
- Governance

The Committee agreed that this issue also needed to be presented to Board.

Authorising Engineer Report on Fire

The Committee were advised that the Chief Estates and Facilities Officer was now the executive with defined responsibility for fire.

The Committee noted the recommendations and actions from the report in respect of the effectiveness of fire safety and management from the independent Authorised Engineer. The report provided no assurance with a lack of escalating of issues in respect of fire.

The Committee were advised that work was underway to bring together a Health and Safety Committee for the Group which would support the governance arrangements around Fire. Having the appropriate safety groups including fire group under this would support Committee and Board by providing the assurances needed.

The Committee also reflected that there may be a need for retraining to be completed in some areas.

The Committee would seek support from Board in monitoring the position going forward and a prompt response to the actions.

Finance Executive Group Report
The report was noted.

Risk Assurance Report
The committee reviewed the Risk Assurance Report at each meeting noting proposed new risks, closures and changes in risk scores. The Committee asked for the risk relating to fire to be further considered through the Risk Confirm and Challenge Group based on the discussion at the meeting.

Board Assurance Framework

At its October meeting the committee reviewed its elements of the BAF 2024/25, noting this continued to evolve. Assurance ratings were agreed for the strategic objectives for which FPPIC has oversight responsibility as set out above.

Procedural Documents Renewal Calendar

The committee reviewed the Procedural Documents Renewal Calendar report at its May meeting and noted that the Fire Safety Policy was now under review as part of the Fire Improvement Action Plan with an expected completion date of end of November 2024.

FPPIC Reporting Cycle

The committee reviewed its reporting cycle at each meeting.

Meeting Review

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

Control Issues Framework

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

The following items were approved:

- Minutes of the meeting held on 23rd August 2024

Issues referred to or from Audit Committee

None. However, the Committee did review the outstanding audit recommendations at the request of the Audit Committee. Noting that issues were still being experienced in aligning the position in the report from the audit portal and the Trust view of position.

Items referred to or from Quality Committee

None

Items referred to or from Trust Board

The Committee escalated specifically to Trust Board the risks associated with Health and Safety, Fire Safety and the Premises Assurance Model and the limited assurance for these areas.

The Committee also wished to escalate the impact of the delay in implementation of plans for the AAU and Frailty Service. This had been operationally impacted by the need to move operational staff to support some of the treatment areas which were seeing increases in footfall resulting from patient transfer produced from the GP actions.

3. Conclusion/Recommendations

Board is asked to:

- **NOTE** the report.

Report to:	Lincolnshire Community and Hospitals Group Board Meeting
Title of report:	Finance, Performance and Estates Committee Assurance Report to Board
Date of meeting:	19 September 2024
Chairperson:	Dani Cecchini, Chair
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received, and key decisions made by the Finance, Performance and Estates Committee (FPEC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme. The Committee worked to the 2024/25 objectives.
Assurances received by the Committee	**Assurance** in respect of SO 3a Deliver financially sustainable healthcare, making best use of resources **Finance Report inc Efficiency, Contracts, Capital, CRIG upward report** The Committee received the finance report with limited assurance noting the month 5 deficit position o £15.9m which was £5.1m adverse to plan with further challenges expected as the year progresses. It was noted that the £16m planning shortfall, agreed as part of the overall Integrated Care System (ICS) plan had been reduced by £6m, transacted through contract variation into the Trust position. The resolution of a further £10m remains outstanding of which £4m has been identified. The Committee noted the £48m Cost Improvement Programme (CIP) which includes £4m stretch target and the full year impact of the previous year's plans. At month 5 £12.2m was delivered against a target of £9.8m. Schemes to reduce use of medical bank and agency were highlighted as a risk, with a c£6m unmitigated shortfall forecast. Productivity was recognised as an area requiring more focus and improvement in order to support the financial and operational position of the Trust with oversight now in place from NHS England. The Committee received and noted the contract report, particularly in terms of the transfer of AQP activity from the ICB. Concern was raised in terms of the impact on both the financial position and operational performance. Discussions are currently underway to clarify the position. Moderated assurance was received in respect of the overall position.

	The Committee received the capital report with moderate assurance and noted the full year capital plan of £78.1m, inclusive of IFRS 16 lease allocations. Positive activity continued to track an upward trajectory month on month in respect of the capital spend with £20.4m spent year to date. Whilst this was £3.3m behind plan this was due to timing and was not a cause for concern. The development of the Electronic Patient Record FBC continued to progress with recent meetings taking place with the NHS England Regional Finance Capital Lead. Discussions centred on funding available and profile of spend which was different to values believed to have been previously agreed. Some re-assurance had been received in respect of the capital funds with other opportunities being explored in respect of required revenue funding. The Patient Level Information Costing System (PLICS) report was received with moderate assurance, and which continues to indicate areas for potential productivity gains and cost savings. This will become increasingly important as the Trust develops its productivity improvement plans and strategies. **Procurement Update** The Committee received the report with significant assurance noting the ongoing training taking place within the team and the achievements of the team in passing various procurement exams. The Committee was pleased to note the achievement of £4.5m CIP delivery in the financial year with the team aiming to delivery over £5m of savings in total. The Inventory Management System was being implemented although the Committee noted that there had been some delay in this due to the time taken to recruit to the project manager role. The Committee received a detailed update in respect of the Procurement Act which was expected to go live at the end of February 2025. There had been training undertaken by the team to prepare for this due to the introduction of a number of legal requirements, including the need to publish an 18-month procurement pipeline and the ceasing of the use of waivers. The challenges to publish the pipeline were noted by the Committee however it was recognised where capital spend spanned multiple years this would be possible. The Committee noted the forward view of contracts as reported noting these would come forward to the Committee and Board at the appropriate time. **Strategic Projects – Pilgrim ED Update**

	The Committee received the report noting that progress was being made however recognised that a number of risks remained in respect of the substation and high voltage ring which were being managed.
	Assurance in respect of SO 3b Drive better decisions and impactful action through insight **No reports due**
	Assurance in respect of SO 3c A modern, clean and fit for purpose environment across the Group **Estates Report** The Committee received the upward report from the estates and facilities team, noting the overall improvement in assurance being offered whilst continuing to recognise areas for ongoing improvement and focus including ventilation, fire and water. Cleanliness Audits following NSoHC guidance identified average star ratings of 4 and 5 across all risk categories. Within that position MEAU returned a rating of 3 or below as did three admin areas at Pilgrim Hospital. A recent recruitment event at Lincoln would look to address the current staffing vacancies contributing to this position. The Patient-Led Assessments of the Care Environment (PLACE) had been undertaken at Louth Hospital with issues identified regarding disability and dementia facilities. A case had been put forward to the Charitable Funds Committee to support the purchase of dementia clocks. Water safety improvements had been seen in the low use flushing over the past quarter and whilst some concern remained it was noted that this was being overseen and managed through the Infection Prevention and Control Group. The Committee was pleased to note the continued Authorised Engineer reports which were being received with notable improvements in ventilation. Progress was noted in respect of the Carbon Energy Fund and the project to move to net zero for the Trust. Cases had been developed and would now be taken through the appropriate governance process.
	Assurance in respect of SO 3d Reduce waits for patients who require urgent care and diagnostics to constitutional standards **As reported at SO 3f**
	Assurance in respect of SO 3e Reducing unwarranted variation in cancer service delivery and ensure we meet all constitutional standards **As reported at SO 3f**

	Assurance in respect of SO 3f Reducing unwarranted variation in planned service delivery and ensure we meet all constitutional standards **Operational Performance against National Standards** The Committee received the report for information as senior members of the operational team were unable to attend the Committee meeting this month. **Improvement Programme Deep Dive – Outpatients** The Committee received the report noting that wider engagement was required in order to realise sustained improvements for outpatients with discussions due to take place with the Group Chief Operating Officer regarding the approach to be taken. Focus was now being provided through the Deputy Chief Operating Officer taking on the Senior Responsible Officer (SRO) role with a focus on 3 workstreams including slot utilisation, clinical templates and nurse led clinics. Specialty reviews were also being completed and it was noted that there was a need to embed improvements whilst also understanding the totality of the outpatient delivery model for which a 5-year plan was being developed.
	Assurance in respect of SO 4a Establish collaborative models of care with our partners including Primary Care Network Alliance (PCNA) **No reports due**
	Assurance in respect of SO 4b Successful delivery of the Acute Services Review **No reports due**
	Assurance in respect of SO 4d Enhanced data and digital capability **Information Governance Group Upward Report** The Committee received the report noting the update provided and noted concern regarding Data Security Protection Toolkit achievement and Subject Access Request Compliance. The Committee would ensure more detailed discussions were held at the November Committee.
	Assurance in respect of SO 5a Develop a Population Health Management (PHM) and Health Inequalities (HI) approach for our Core20PLUS5 with our ICS **No reports due**

	Assurance in respect of SO 5c Tackle system priorities and service transformation in partnership with our population and communities **No reports due**
	Assurance in respect of other areas: **Topical, Legal and Regulatory Update** The Committee received the report noting the update provided recognising that at this time there were no items raised within the report which required consideration as an agenda item. **Integrated Improvement Plan (IIP)** The Committee received the report noting this offered moderate assurance at month 5. Progress was being seen against 67 of the patient metrics giving moderate assurance, people also remained moderate with services reported as limited due to overall performance. The Committee noted that assurance in respect of population health remained moderate and noted the ongoing work in respect of partners and the development of the health inequalities dashboard. **Improvement Steering Group (ISG) Upward Report** The Committee received the report with moderate assurance noting the positive CIP position at the end of month 5 however there would be an increase in delivery targets from month 6 onwards which would require an increased level of savings to be achieved. The Medical Workforce schemes continued to be a key area of focus with the programme currently behind target. Work was being undertaken to ensure the programme would have the expected impact. The Committee was assured in respect of the processes in place to support the programmes of work and noted that should revision of targets to be met or areas to be considered required refocus this would require a Board discussion. **Committee Performance Dashboard** The Committee received the report noting the 4-hour target which was set at 78%, for which the Trust had achieved performance of 73.67%. It was recognised that there had been 17.68% of patients exceeding 12-hour waits in the emergency departments and ambulance conveyances had averaged 32 minutes.

	In terms of long waits the Committee was pleased to note zero 104-week waits and only 3 patients waiting over 78-weeks, 2 due to patient choice and 1 due to validation. The Committee note that the errors in previous DM01 reporting had been resolved and recognised the pressured areas in diagnostics as MRI and audiology. Faster Diagnosis Standards (FDS) for cancer had achieved 76.2% against a target of 75%, with deterioration seen in 62-calssic standards at 64% in July. **Scorecard of system plan commitments** The Committee received the scorecard noting that a monthly report would be produced which would reflect all elements of the dashboard and provide triangulation and a system perspective. Further work would be undertaken to determine how a single scorecard could be developed in order to avoid duplication.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	None
Committee Review of corporate risk register	The Committee received the risk register noting the risk as presented.
Matters identified which Committee recommend are escalated to SRR/BAF	No items identified
Committee position on assurance of strategic risk areas that align to committee	The Committee considered the reports which it had received which provided assurances against the strategic risks to strategic objectives.
Areas identified to visit in dept walk rounds	None

Attendance Summary for rolling 12-month period

Voting Members	O	N	D	J	F	M	A	M	J	J	A	S
Dani Cecchini, Non-Exec Director	X	X	X	X	X	X	X	X	X	X	X	X
Director of Finance	X	X	X	X	X	X	X	X	X	X	X	X
Chief Operating Officer	X	X	X	X	X	X	X	X	X	D		
Group Chief Operating Officer											X	A
Group Chief Integration Officer											X	D
Group Chief Estates and Facilities Officer											X	X
Director of Improvement & Integration	X	X	X	X	X	X	X	D	X	X		
Sarah Buik, Associate Non-Executive Director	X	X	X	X	X	X	X	X	X	X	X	X

X in attendance
A apologies given
D deputy attended

Report to:	Lincolnshire Community and Hospitals Group Board Meeting
Title of report:	Finance, Performance and Estates Committee Assurance Report to Board
Date of meeting:	24 October 2024
Chairperson:	Dani Cecchini, Chair
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received, and key decisions made by the Finance, Performance and Estates Committee (FPEC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme. The Committee worked to the 2024/25 objectives.
Assurances received by the Committee	**Assurance** in respect of SO 3a Deliver financially sustainable healthcare, making best use of resources **Finance Report inc Efficiency, Contracts, Capital, CRIG upward report, National Cost Collection** The Committee received the report noting month 6 year to date delivery of £18.1m deficit compared to a plan of £10.6m deficit. The in-month plan for month 6 was for a surplus of £0.3m compared to actual in month result of £2.2m deficit. Work was now taking place in respect of the forecast for the remainder of the year. The Trust received £0.7m of funding to support the industrial action from earlier in the year against total costs of £1.2m which had been expected in the previous month's figures. Significant risks to delivery were highlighted requiring further work to ensure appropriate mitigations were in place. Further work would be required in respect of income and activity reporting to ensure better transparency and understanding of delivery. The Committee noted the planning £16m risk which had been agreed with the ICB but not funded of which £5m had been resolved with a further £11m to be identified. The Committee noted that the Trust had delivered £15.9m of Cost Improvement Programme (CIP) savings against a £13.7m target. A forecast gap of £6.9m was noted with work taking place to mitigate the position and ensure recurrency of the programme. The cash position was reported as £7m, a positive variance to the planned £6.4m, this was an area of concern however with a request made to the national team for a £14m cash draw down to support the position. The Board has previously approved this request.

	Positive performance was noted against the Better Payment Practice Code (BPPC) for September at 96% / 93% by value/volume with a number of invoices to be cleared which would impact on the position. Capital had been delivered above the monthly target for September with a £28m spend year to date. 37% of the annual programme had been committed in the first half of the year with the spend run rate increasing in line with plan over the second half of the year. Pay expenditure has significantly exceeded budget with key elements of this being the year-to-date variance on the increase in expenditure on medical bank and agency, the investment to support delivery of CIP schemes, incremental drift in addition to the agreed but unfunded elements of the planning investments. Work was taking place in respect of the medical workforce to address the premium pay for both usage and rate reductions, this would continue to be pursued over the remainder of the year. Initial work on the forecast outturn position has identified some significant challenges with work progressing to stress test the unmitigated FOT, including reviews of the ERF position, understanding the drivers of the pay position, service improvement schemes, grip and control and any other non-recurrent opportunities. The Committee received and noted the Capital, Revenue and Investment Group Upward report. **Strategic Projects – Pilgrim ED Update** The Committee received the report noting the ongoing discussions regarding compensation events due to the delays resulting from electrical supply issues. **Strategic Projects – Endoscopy Project Update** The Committee received the report noting the progress being made in respect of the project and noted concern in respect of costs as these were not yet secured.
	Assurance in respect of SO 3b Drive better decisions and impactful action through insight **No reports due**
	Assurance in respect of SO 3c A modern, clean and fit for purpose environment across the Group **Premises Assurance Model** The Committee received the report with significant assurance noting the progress demonstrated through the assessment process for 23/24 compared to the prior year's findings.

	Action plans would be developed for all areas with the report appended for Board oversight and onward approval to NHS England. **Emergency Planning Group Upward Report** The Committee received the report which was taken as read and noted the improvement in business continuity plans which were now being maintained by the directorates and business units.
	Assurance in respect of SO 3d Reduce waits for patients who require urgent care and diagnostics to constitutional standards **As reported at SO 3f**
	Assurance in respect of SO 3e Reducing unwarranted variation in cancer service delivery and ensure we meet all constitutional standards **As reported at SO 3f**
	Assurance in respect of SO 3f Reducing unwarranted variation in planned service delivery and ensure we meet all constitutional standards **Operational Performance against National Standards** The Committee received the report noting that this reflected the discussions held through the Committee Performance Dashboard item. **Improvement Programme Deep Dive – Discharge and Urgent and Emergency Care** The Committee received the report noting that there was focus on the sprint discharge work. Three areas of focus were noted including seeing discharge as part of the whole patient journey rather than an objective to achieve, recognising patients admitted to an acute bed would likely flow to a community bed in future months and improvement of processes for smoother discharge. The sprint work being undertaken would continue through the winter and would be refined as progress was made with a recognition that there was an imbalance in the number of non-complex and complex discharges that needed to be resolved. An intensive support team would also be introduced to support the activity being undertaken with a focus on interprofessional standards for pathway zero.
	Assurance in respect of SO 4a Establish collaborative models of care with our partners including Primary Care Network Alliance (PCNA) **No reports due**

	Assurance in respect of SO 4b Successful delivery of the Acute Services Review **Grantham ASR Implementation Update** The Committee received the report which was taken as read noting that previous commitments had been made however it had not been possible to incorporate plans into the current financial year. Plans would be reviewed and revised and offered back to the Committee at the appropriate time.
	Assurance in respect of SO 4d Enhanced data and digital capability **Digital Hospital Group Upward Report and EPR Upward Report** The Committee received the upward reports noting the progress both in respect of the Electronic Patient Record (EPR) and Electronic Document Management System (EDMS). Further work was being undertaken on the revenue position in respect of the EDMS business case which would be presented back to the Committee in November with cross benefits from the EPR being considered to support the EDMS programme of work.
	Assurance in respect of SO 5a Develop a Population Health Management (PHM) and Health Inequalities (HI) approach for our Core20PLUS5 with our ICS **No reports due**
	Assurance in respect of SO 5c Tackle system priorities and service transformation in partnership with our population and communities **No reports due**
	Assurance in respect of other areas: **Annual Planning Update** The Committee received the report noting that the focus on the annual plan was population health and whilst this was noted as the right strategic direction there was recognition by the Committee that achievement of this would take some time. The Committee noted the ask of the ICB for investment cases to be submitted by the end of October however this would not be achievable given there was a need for the first draft of the plan to be in place to support identification of investment requirements. A planning timetable was included in the report together with a clear governance structure support review, oversight and approval. Productivity was noted as a core element of the plan with more detailed conversations required with the divisions to ensure a clear

	understanding of the requirements. Triangulation between capacity, workforce and finance would also be required. **Integrated Improvement Plan (IIP) and Improvement Steering Group (ISG) Upward Report** The Committee received the reports with an alignment of executive owners being undertaken against improvement programmes of work to gain further traction. There were some areas of significant risks in respect of CIP delivery, one being the medical agency spend with focus being given to the programme of work. It was noted that the ambition of £9.2m would not be achieved however it was anticipated that circa £7m could be delivered, however reforecasting would take place to confirm the position. Theatre productivity was also noted by the Committee as an area requiring focus with a recognition of the ongoing work to support capability and productivity. Whilst staffing challenges were recognised this was not the main driver of the position. **Committee Performance Dashboard** The Committee received the report noting the timeline for the redesign of this to follow the patient pathways with similar discussions held with the Quality Committee with the intention of being able to identify performance issues across a pathway. Work had commenced on the availability of live performance data which would be expanded in the coming months, particularly from those areas undergoing sprint activity. The Committee noted that ambulance handover times were exceeding the 30-minute target by 4minutes 15 seconds with work taking place at the front door and with EMAS to improve the position. 12-hour patient waits had increased, and it was recognised that this was due to the discharge position not enabling admissions to take place in a timely manner. Work was due to commence with ECIST on board rounds and professional standards to improve the position. Bed occupancy was high, and it was noted that the 92% target was not realistic give the current demand. Performance for 28-day cancer had been delivered since May 2024 and continued to increase with 2-week wait patients subsumed within this metric. The 62-day backlog had reduced in month however an increase was starting to be seen due to the impact of the challenges being faced in the cancer centre with interim support being sought.

	The Committee noted that there were 3 patients in September waiting over 78-wekks, 2 due to clinical reasons and 1 due to patient choice. The 65- week also continued to be challenging and whilst 392 was delivered the Trust continued to work on the route to zero by the end of December 2024. Improvements were noted in DM01 with further improvements expected as the Community Diagnostic Centres commenced activity. The Committee noted the productivity piece noting that focus was required in respect of the waiting list as well as appropriate grip and control on the booking system to ensure bookings were well managed. **Policy Position Update** The Committee received the report with assurance noting the position presented and the ongoing work to review and update policies. The Committee noted the benefit in the lead directors being identified within the report and the consideration of trajectories. **Internal Audit Recommendations** The Committee received the outstanding audit recommendations noting the requirement for the actions to be reviewed to ensure these were accurate and to enable closure. **CQC Update** The Committee received the report for information noting the position presented.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	None
Committee Review of corporate risk register	The Committee received the risk register noting the risk as presented.
Matters identified which Committee recommend are escalated to SRR/BAF	No items identified
Committee position on assurance of strategic risk areas that align to committee	The Committee considered the reports which it had received which provided assurances against the strategic risks to strategic objectives.
Areas identified to visit in dept walk rounds	None

Attendance Summary for rolling 12-month period

Voting Members	N	D	J	F	M	A	M	J	J	A	S	O
Dani Cecchini, Non-Exec Director	X	X	X	X	X	X	X	X	X	X	X	X
Group Chief Finance Officer												X
Director of Finance	X	X	X	X	X	X	X	X	X	X	X	X
Chief Operating Officer	X	X	X	X	X	X	X	X	D			
Group Chief Operating Officer										X	A	X
Group Chief Integration Officer										X	D	X
Group Chief Estates and Facilities Officer										X	X	X
Director of Improvement & Integration	X	X	X	X	X	X	D	X	X			
Sarah Buik, Associate Non-Executive Director	X	X	X	X	X	X	X	X	X	X	X	X

X in attendance
A apologies given
D deputy attended

Meeting	*LCHG Board*
Date of Meeting	*5 November 2024*
Item Number	*Item 10.2*

2023-24 NHS Premises Assurance Model (PAM) return to NHSE/I

Accountable Director	*Mike Parkhill, Group Chief Estates and Facilities Officer*
Presented by	*Mike Parkhill, Group Chief Estates and Facilities Officer*
Author(s)	*Angela Dawson - Estates & facilities Compliance Manager* *Chris Davies – Deputy Director of Estates & Facilities*
Report previously considered at	*EFM Divisional SMT* *Finance, Performance and Estates Committee – 24 October 2024*

How the report supports the delivery of the priorities within the LCHG Board Assurance Framework	
1a Deliver high quality care which is safe, responsive and able to meet the needs of the population	
1b Improve patient experience	*X*
1c Improve clinical outcomes	
1d Deliver clinically led integrated services	
2a Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	*X*
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	
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	

Risk Assessment	*Full E&F Risk Register*
Financial Impact Assessment	*N/A*
Quality Impact Assessment	*N/A*
Equality Impact Assessment	*N/A*
Assurance Level Assessment	*Insert assurance level* • *Significant*

Recommendations/ Decision Required	• *Note the internal NHS PAM self-assessment outcomes for information and assurance* • *Approve the submission of the 2023-2024 PAM assessment to NHSE/I*

Executive Summary

Executive Summary

The Trust estate and its related services are integral to the delivery of high-quality clinical care. Therefore, it is essential that the Trust provide a safe, high quality, efficient and effective estate.

The NHS Premises Assurance Model (PAM) is a national Estates and Facilities benchmarking tool designed to be used by NHS organisations for Board reporting, and externally to provide assurance to Regulators and Commissioners.

NHSE/I PAM require the assessment to be formally approved by the Trust Board or a suitable subcommittee with delegated powers (FPEC), prior to submission online.

NHS England and NHS Improvement (NHSE /I) developed NHS PAM reporting template. It is used to collect a snapshot of Estates and Facilities performance to ensure services are "fit for purpose based on national best practice and the current regulatory requirements". A Series of Self-Assessment Questions (SAQ's) require response to produce a summary report that to demonstrate that robust systems are in place to assure that Trust premises and associated services are safe or identify actions to address.

Additional SAQ's areas have been added for the 2023/24 these are , SH21 Ligature Reducing Harm by practice, FM Maturity 002, all additional tabs have been completed as part of the assessment.

The attached report (Appendix 1) provides a high-level summary overview of the NHS PAM process undertaken for 2023/24 and details the results of the self-assessment exercise.

Following submission of the PAM assessment, action plans need to be developed by Estates and Facilities to address areas identified as inadequate or requiring improvement.

The ratings of the PAM assessment for -2022 -23 have been included in the report as a comparator to the ratings for 2023-24.

Introduction

The Trust's estate and its related services are integral to the delivery of high-quality clinical care. Therefore, it is essential that the Trust provide a safe, high quality, efficient and effective estate. Completion of NHS PAM was made mandatory for all NHS Trusts from April 2020.

The objectives of NHS PAM is to support the NHS constitution pledge to:
"Provide services from a clean and safe environment that is fit for purpose based on national best practice" and the current regulatory requirements to ensure that "service users are protected against risks associated with unsafe and unsuitable premises".

NHS PAM is a self-assessment management tool, designed to provide a nationally consistent approach to evaluate NHS premises performance against a set of common indicators. NHS PAM has six domains:

- Safety (Hard),
- Safety (Soft),
- Patient Experience,
- Efficiency,
- Effectiveness,
- Governance.

Each domain has a set of Self-Assessment Questions (SAQs), with a sub set of questions known as prompt questions covering specific areas e.g. fire safety, car parking and cleanliness. The response to the prompt questions are scored/rated with due regard to the evidence gathered in relation to the following requirements:

- **Relevant guidance and legislation**: Policies, procedures, working practises etc. should comply with any relevant guidance and legislation,
- **Evidence should demonstrate**: The approach (policies, procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.

This provides a structured framework to facilitate evidence based self-assessment and measure compliance with each of the requirements.

Assessment Methodology

For each SAQ, information and evidence was collected which would be used to determine the rating based on qualification criteria issued by NHSE. The assessor(s), then rated accordingly.

The assessments for each SAQ have been reviewed on a monthly basis by domain leads and Subject matter experts through dedicated review meetings, progress being feedback through monthly updates to E&F SMT and via the upward report to FPEC.

All documentation to support the rating has been stored in an evidence folder on the Estates and Facilities M Drive, in the event NHSE look for clarification of rating.

Summary of 23-24

For the Domains below key points to note are:

- **Safety (Hard)** – a number of evidence-based improvements were achieved, in this domain, training, costed action plans and more robust action plans.
- **Safety (Soft)** – improvements identified, further improvements will be achieved with the ongoing catering waste and portering reviews.
- **Patient Experience** – ratings remain as good.
- **Efficiency** – improvements made, further improvements in progress.
- **Effectiveness** – Travel and Transport plan included on this year's assessment -.
- **Governance** – internal governance and escalation processes were improving based on the 22/23 assessment with regular reporting through relevant boards.

- **Helipad** – Some slippage on the compliance scoring due a further understanding of the CAP 1264 regulations with the ongoing Helipad review.

Appendix one provides a detailed comparison between financial years 2022/23 & 2023/24.

4. Next steps

The EFM Division will use the PAM submission as a baseline throughout the year and working groups have been set up to review 24/25 submission and create action plans. Progress will be monitored via Divisional SMT and via the upward report to FPEC.

5. Conclusion

The NHS PAM assessment process for 23/24 demonstrates good progress within Estates and Facilities when compared to 22/23 final ratings.

A mitigation / action plan for all categories rated as Inadequate or requiring Moderate improvement will be developed by November 2024 and updated on a Quarterly basis.

6. Recommendations

FPEC are requested to:

1) Receive the report and approve for official submission.
2) Note the internal NHS PAM self-assessment outcomes for information and assurance,
3) Receive quarterly updates of progress against the mitigation/action plans via the routine EFM FPEC report.

APPENDIX A

	Hard FM - Safety	Soft FM - Safety	Patient Experience	Efficiency	Effectiveness	Governance
5. Inadequate	22	6	1	2	3	3
4. Requires moderate improvement	18	5	0	6	9	9
3. Requires minimal improvement	102	25	0	1	4	4
2. Good	154	43	20	15	9	9
1. Outstanding	0	0	0	0	0	0

	Hard FM - Safety	Soft FM - Safety	Patient Experience	Efficiency	Effectiveness	Governance	Helipad
5. Inadequate	0	0	0	0	0	0	1
4. Requires moderate improvement	9	3	0	3	2	0	8
3. Requires minimal improvement	44	28	0	4	13	4	0
2. Good	104	62	22	19	9	21	0
1. Outstanding	0	0	0	0	0	0	0

Principles for providing safe and good quality care in temporary escalation spaces

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

Meeting	*Lincolnshire Community and Hospitals Group Board Meeting*
Date of Meeting	*5th November 2024*
Item Number	*10.4*

Principles for providing safe and good quality care in temporary escalation spaces

Accountable Director	*Caroline Landon, Group Chief Operating Officer*
Presented by	*Caroline Landon, Group Chief Operating Officer*
Author(s)	*Caroline Landon, Group Chief Operating Officer* *Katy Mooney, Medicines Divisional Nurse*
Recommendations/ Decision Required	*The Board is asked to note the principles*

How the report supports the delivery of the priorities within the LCHG Board Assurance Framework	
1a Deliver high quality care which is safe, responsive and able to meet the needs of the population	*X*
1b Improve patient experience	*X*
1c Improve clinical outcomes	
1d Deliver clinically led integrated services	
2a Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	
2b To be the employer of choice	
3a Deliver financially sustainable healthcare, making the best use of resources	
3b Drive better decision and impactful action through insight	
3c A modern, clean and fit for purpose environment across the Group	
3d Reduce waits for patients who require urgent and emergency care and diagnostics and ensure we meet all constitutional standards	
3e Reducing unwarranted variation in cancer service delivery and ensure we meet all constitutional standards (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

Our aim is always to deliver high standards of care for patients in the right place and at the right time.

Taking into consideration that NHS England believes the delivery of care in temporary escalation spaces (TES) in departments experiencing patient crowding (including beds and chairs) is not acceptable and should not be considered as standard, the current healthcare landscape at ULTH means that the Trust are using temporary escalation spaces for increased periods of time and not just in time of extremis.

The management of the Rapid Placement of Adult Patients across ULTH is a process of shared risk across the organisation when the Emergency Department(s) and Medical Emergency Assessment Unit-Lincoln (MEAU), Surgical Emergency Assessment Unit-Lincoln (SEAU) and/or Integrated Assessment Unit Boston (IAC) has more patients than it can safely care for and to prevent holding patients on ambulances which has a direct impact in delays to responding to emergencies in the community. Allocating one additional patient to suitable wards on a risk assessment basis, shares this risk across the Trust and reduces risk within the ED and the community. There is a Standard Operating Procedure (SOP) **(Appendix 4)** in place to support safe, decision making when Rapid Plus One is instigated. It is recognised the decision making will be based on a specific risk assessment for each patient that is to be placed, in the context of the risk on the accepting ward. The SOP outlines the principles to be considered. The key principle is that the decision to place any patient will be based upon risks to patient safety and will seek to balance the risk to patients across ULTH and the community. Assessments of risk for potential harm and safety for staff and patients that are being considered for care in Temporary Escalation spaces are assessed by criteria as part of the Plus One Principles **(Appendix 1).** Patients are only be moved under the Plus One placement of patient SOP if they meet criteria for transfer from ED /Assessment Units and the receiving ward can accommodate the care needs of the individual patient.

The aims of the Rapid Plus One (where patients are sent from an admitting area to a receiving base ward prior to the bed being available on the receiving ward) are to stop the need for patients to be held on ambulances due to high occupancy within the ED, reduce congestion in ED & facilitate specialty patients moving at the earliest opportunity to the right ward.

The SOP guides and supports all staff involved in the implementation of Rapid Plus One principles to ensuring equitable access to appropriate beds for all patients admitted to ULTH and that our patients are treated with respect, dignity and in accordance with ULHT values. A risk assessed approach ensures the risk of patients being exposed to Hospital Acquired Infections is minimised. A full Infection Prevention assessment is made for any areas affected by outbreak or high prevalence of infection and the option to Plus one is suspended until resolved to minimise risk.

Safe staffing levels are assessed 3 times per day by the Operational Matron and Safer Staffing Lead and included within the Workforce Safeguard Report as an itemised

assessment to ‘plus one’. For each area an assessment is made to determine whether it is safe for the area to take an additional patient as per Plus One placement. This assessment is supported with Decision Support Criteria to aid the decision making and risk assessment process. The assessment is completed as part of the Safer Staffing Operational process so with all safety measures have been considered. This is a dynamic risk assessment that can be completed at any opportunity that wards report that they feel the risk to take a plus one patient is too great. The decision to NOT temporarily escalate in an area is made on the assessment of safety by the divisional senior nursing leadership team and the risk confirmed with Divisional Nurse/Deputy and/or the Deputy Chief Operating Officer or on call manager. Areas of concern are escalated to the Group Chief Nurse, Group Chief Medical Officer, Group Chief Operating Officer or nominated deputy. Overall, the balance of risk relating to staffing and staff wellbeing is considered in the context of unseen risk within our communities.

All temporary escalation areas are a designated space within each ward that has a full supported risk assessment **(Appendix 2)** and fire risk assessment **(Appendix 3)** completed.

Patient and colleague experience impact is reviewed through reported incidence by the Divisions and Patients Experience teams by monitoring the number of reported Datix incidents in relation to temporary escalation placement and patients experience indicators and complaints are monitored.

PLUS ONE Principles

Plus One Placement of Patients Process activated only when:

- OPEL Level 4 **And/Or**
- Unable to handover patients on ambulances or due to no capacity across ED (Majors and Resus) or no capacity for inbound ambulances

- Bed Management Team Manager utilise daily discharge list to identify patients to be transferred to the Discharge Lounge. Identify potential discharges and prepare areas to except Plus One patients from 08:00hrs

- We would transfer from ED to Assessment areas 24/7 as required
- We will Plus One from the Assessment Units to base wards 08:00hrs- 22:00hrs
- All areas will accept a maximum of +1 patient as per risk assessment

The following groups of patients are excluded from patient placement:

- Clinically unstable with an unmanaged NEWS >4
- Patients requiring Humidified, High Flow Oxygen or NIV
- Patients requiring Level 1/high dependency care
- Patients requiring Cardiac Monitoring
- Patients with severe cognitive impairment i.e. restless / agitated, delirium, requiring enhanced monitoring
- Patients with complex learning disabilities
- Patients whose death is imminent (within 12hrs)
- Patients being discharged from a side room (IPC reasons)
- Patients where dignity cannot be maintained within the Plus one space
- Patients who require isolation because they are at risk of transmitting or acquiring an infection.
- Patients identified as requiring enhanced falls prevention measures

In the event at 22:00hrs there is an additional patient on the Ward after Plus One has occurred and the scheduled discharge is no longer happening. The Ward based team must contact the Clinical site manager/Bed Manager for the most appropriate patient on the Ward to be allocated an alternative bed space within the organisation, unless the plus one space the patients is residing in has been risk assessed as being suitable for the patient to remain overnight.

THE PATIENT WILL NOT BE RETURNED TO THE ASSESSMENT UNITS

Appendix 2: Risk Assessment Proforma *(Reviewed September 2014)*

Plus One Statement	**Plus One patient MUST be placed into a bed space with a fit and well discharge/potential discharge patient placed in the boarding space identified.**
Activity (or area) being assessed	To assess the risks for boarding patient in treatment room and relatives room
People/Service affected by the risk *Tick all that apply*	Patient x☐ Trust Staff ☐x Visitor/Relative ☐x Contractors x ☐ Agency/locum ☐x Other *(e.g. service)* specify…………………………
Site	Lincoln
Division/Specialty	Surgical Division
Location	Hatton Ward
Name of assessor	
Date of assessment	04/03/2019
What is the hazard? **Something that has the potential to cause injury, illness, harm, loss or damage**	During boarding, there is going to be disturbance for patients, staff and visitors. Patient would be boarded in corridor by nurses' station with no access to call bell, emergency bell, or oxygen. This will also reduce access to ward corridor which is the main fire escape as well as reducing accessibility in clinical emergency situations. Impact on ability to maintain patient confidentiality as the nurses' station has the main ward telephones so there is potential for the boarding patient to overhear confidential information.

Say how the hazard could cause harm Give a very brief description of the risk scenario or event.	• If patient becomes unwell the patient is not in a bed space so any initial lifesaving treatment would be administered in the corridor and then the patient would require rapid transfer to a bed space resulting in another patient being boarded in the corridor • If any patients require resuscitation in the ward boarding a patient in the corridor will potentially hinder the access to the resus trolley • In the event of fire boarding a patient at the nurses' station will potentially reduce access to the main evacuation route from the ward, it could also impact in the event of the neighbouring ward needing to evacuate into the ward. • Extra patient boarding will impact safe staffing levels

Existing control measures used
 	
What is already in place to reduce the consequence or likelihood of harm occurring?
	• Not currently an area used routinely to board patients due to the unsuitability of the environment and the risks of harm detailed above
	• When used in times of extreme pressure the following measures are taken:
	  ○ Ensure that the patient is boarding for the shortest time
	  ○ Provide additional support to expedite any discharge to release bedspace
	  ○ Ensure ward is appropriately staffed and if required reallocation of nursing resource
	  ○ Ensure all members of ward team are aware of boarding patient
	  ○ Complete Intentional Rounding for boarding patient

Risk Rating (*Rate from 1 to 5 for likelihood and severity using the risk matrix)* Note if risk score is 12+ risk must be escalated to Division, and recorded on risk register.	**Likelihood:**	3	**Risk Score 15**	High
	Severity:	5		

Proposed actions What action can be taken to reduce the likelihood and/or the severity of the risk? Who is responsible for implementing the action plan? What is the timescale for implementation?	• **Due to lack of a suitable space and the risks associated the proposed action is for this ward not to be used for boarding – this would need to be an action agreed at a senior level**			
Risk Rating after proposed action Re-assess the likelihood and severity to show how the proposed action will be effective in reducing the risk.	**Likelihood:**	1	**Risk Score 5**	low
	Severity:	5		
Date action started	04/03/19			
Date action completed				

Linked Strategic Objective	**What is the risk?** *What could happen and what would be the likely consequence to the objective if it did?*	Risk type	Executive / Divisional lead	Risk lead	Division	CBU / Directorate	Specialty / Department	**Controls in place** *What national and ULHT policies and governance arrangements are in place to mitigate the risk?*	**How is the risk measured?** *What data can be used and what do those data currently show?*	Likelihood (current)	Severity (currently)	Risk rating (current)	**Risk reduction plan** *What is the current plan of action to reduce the risk? (detailed action plans do not need to be added here, they can be attached to Datix)*	Expected completion date	Risk level (acceptable)	Date risk was assessed	Risk assessed by
3b. Efficient use of our resources	**Background** Proposed boarding (plus one) process for all in-patient areas to mitigate risk in ED departments. **Risks - summary** During boarding, there is going to be disturbance for patients, staff and visitors. Patients would be boarded either in corridor by nurses' station or in non-bedspace areas with no access to call bell, emergency bell, or oxygen and suction. This will also reduce access to clinical rooms in clinical emergency situations as well as potential reduced access to fire exits. In areas where patients would be boarded in corridors there could be delays in non-mobile patients receiving personal care as staff would be required to move patient to an occupied bedspace, moving the current patient to the boarding area. This would have an impact on patient dignity and care delivery. **Clinical risk to patient dignity and care delivery** Impact on ability to maintain patient confidentiality as the nurses' station has the main ward telephones so there is potential for the boarding patient to overhear confidential information. **Emergency resusitation** If patient becomes unwell the patient is not in a bed space so any initial lifesaving treatment would be administered in the corridor and then the patient would require rapid transfer to a bed space resulting in another patient being boarded in the corridor If any patients require resuscitation in the ward boarding a patient in the corridor will potentially hinder the access to the resus trolley. **Evirnomental life safety risks from fire** In the event of fire a patient being boarding will potentially reduce/hinder access to evacuation routes from the ward. additionally , it could also impact in the event of the neighbouring ward needing to evacuate into the ward. **Risks to staffing levels and assoicated impact.** Extra patient boarding will impact safe staffing levels. This process will also have a negative impact on patient experience and staff experience impacting recruitment, retention, attendance and staff survey results	Service disruption					Trust-wide	SAFER Model FCP protocol Safer Staffing process Rapid flow policy Clinical governance Matron quality assurance Ward Lead Spot Checks Safety Huddle processes Harm Free Care agenda 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 & related procedures / protocols / records - Fire & Security Team / Fire Safety Advisors - Staff training and awareness ULH governance: - Fire Safety Group / Fire Engineering Group, accountable to Trust Board through Finance, Performance & Estates Committee (FPEC) - Health & Safety Committee & site-based H&S committees - Fire drills and evacuation training for staff. - Local weekly fire safety checks undertaken with reporting for FEG and FSG.	Safety and Quality metrics Incident reporting Patient Experience - Compliance audits against fire safety standards - Fire risk Asssessment reviews	Reasonably likely	Noticeable	6	Integrated Discharge Hub - reducing numbers of medically optimised pathway 1,2 and 3 patients Ward/department engagement with Web V use to ensure effective communication to reduce delays SAFER principles embedded in wards/departments Productive Ward roll-out to all clinical areas Effective communication to all wards/departments regarding rationale for Plus One Process Ensure all areas have Plus One space on Web V board 'Script' for staff communicating process to patients regarding Plus One process Patient guide to their hospital stay to be scoped to include all pertinent information relating to in-patient stay and discharge Safer Staffing Process Planned review with local fire officer and health and safety team audits conducted by fire safety team Mechanism for patients to alert staff in the event that there is no call bell access (e.g. bell) Review of location of resus trolley to improve access in event of patient boarding				
3b. Efficient use of our resources	**Health & Safety related risks** Increased anxiety to staff and patients due to nature of environment/ high levels of activity taking place. Increased potential for trips and falls within the evironment.	Physical or psychological harm					Trust-wide		Safety and Quality metrics Incident reporting Patient Experience - Compliance audits against fire safety standards - Fire risk Asssessment reviews	Reasonably likely	Noticeable	6	Boarding SOP (with staff allocation)				
3b. Efficient use of our resources	**Health & Safety related risks** Risk of patient falls due to inability to safely monitor patients and associated risks due to constraints of the evironment and equipment restricitng movement to affect emergency protocols for patient handling	Physical or psychological harm					Trust-wide	Ensure process to risk assess equipment requirements during shift however limited facilities available if multiple patients waiting therefore boarding will mitigate risk Safer staffing process	Safety and Quality metrics Incident reporting Patient Experience - Compliance audits against fire safety standards - Fire risk Asssessment reviews	Reasonably likely	Noticeable	6	Ward level risk assessment staffing (risk assessment) Matron/ on-call manager/site team oversight				
3b. Efficient use of our resources	**Health & Safety related risks** Unable to access in emergency situation, equipment not available in emergency situation and the staff to carry out procedures	Physical or psychological harm					Trust-wide	Ensure process to risk assess equipment requirements during shift however limited facilities available if multiple patients waiting therefore boarding will mitigate risk Safer staffing process	Safety and Quality metrics Incident reporting Patient Experience - Compliance audits against fire safety standards - Fire risk Asssessment reviews	Reasonably likely	Noticeable	6	Ward level risk assessment staffing (risk assessment) Matron/ on-call manager/site team oversight				
3b. Efficient use of our resources	**Health & Safety related risks** Enhanced surveillance by regulators due to continued failure to meet constitutional targets Contractual sanctions by commissioners due to continued failure to meet constitutional targets Risk of adverse media attention from high patient dissatisfaction	Regulatory compliance					Trust-wide	Briefings/communication with CCG Emergency planning	Safety and Quality metrics Incident reporting Patient Experience - Compliance audits against fire safety standards - Fire risk Asssessment reviews	Reasonably likely	Noticeable	6	Briefings/communication with CCG Emergency planning Boarding should improve internal patient flow and make achievement of constitutional targets more likely				
	Infection Prevention and Conntrol related risks - increased cases of HCAI due to inadequate bed spacing in the contect of ageing environmental infrastructure e.g. ventilation. Increased scrutiny from external agencies, e.g. NHSE due to non-compliance with bed spacing	Patient safety					Trust wide	Surveillance of HCAI to detect an increase in cases of infection. Robust audit of standards processes. Good Divisional IPC knowledge and engagement with IPC Group assurance and monitoring	Surveillance and audit of HCAI and IPC standards	Reasonably likely			Ensure additional patient bed is occupied in line with IPC risk reduction and this is communicated sand implemented with monitoring processes to achieve compliance				

Procedure for Rapid Flow-Plus 1 Placement

Standard Operating Procedure

Version:	1.0
New or Replacement:	New
Policy number:	NA
Document author(s):	Katy Mooney, Divisional Nurse - Medicine
Contributor(s):	
Consultation:	
Executive Sponsor:	Michelle Harris
Title of person responsible for review of document (e.g. Deputy Chief Nurse or Trust Lead)	Chief Operating Officer
Key Words:	Emergency Department, Ambulance Handover, Plus 1, Plus 2, Risk Assessment
Approved by:	TLT
Date approved:	27th October 2023
Review date:	27th October 2024

SOP is:	**Trust-wide**

Version History Log

Version	Date Implemented	Details of Key Changes
1.0	28th October 2023	

Contents

Section	Title	Page
1.	Introduction	2
2.	Scope	3
3.	Plus One Placement Triggers	3
4.	Roles	4
5.	The Process of Plus One	5
6.	Ongoing Management of Plus One Patients	8
7.	The Process of Plus Two	9
8.	Capacity Meeting	9
9.	Safer Staffing	9
10.	Education & Training	10
11.	Monitoring Compliance	10
Appendix 1	Plus One Placement Principles V1	12
Appendix 2	Plus One/Two areas plan	13

1. Introduction

1.1 This document sets out the United Lincolnshire Hospitals NHS Trust (ULHT) Standard Operating Procedure (SOP) for the Management of the Rapid Placement of Adult Patients across ULHT. The SOP describes the process of sharing risk across the organisation when the Emergency Department(s) (ED) and Medical Emergency Assessment Unit-Lincoln (MEAU), Surgical Emergency Assessment Unit-Lincoln (SEAU) and/or Integrated Assessment Unit Boston (IAC) has more patients than it can safely care for and to prevent holding patients on ambulances which has a direct impact in delays to responding to emergencies in the Community. Allocating one additional patient to suitable Wards on a risk assessment basis, shares this risk across the Trust and reduces risk within the ED and the Community.

1.2 The placement of patients occurs when specialty patients are transferred from the admitting areas (Emergency Department (ED) and Assessment Units) to specialty Base Wards, into a bed space of a patient identified as being discharged that day from the specialty Ward/or a designated area of the Ward. These patients will be transferred against the base wards known discharge profile.

1.3 The principle will be in the first phase of patient flow; patients will be transferred from ED into the Assessment Units (maximum x1 patient per assessment areas (medical/surgical). In the second phase of flow, the patient(s) will be transferred from the Assessment Unit(s) to specialty base wards, in relation to normal discharge profile, to facilitate patient safety and at a rate of 1 patient per hour.

1.4 Patients nominated for placement should not be placed to another specialty base ward e.g.

Medicine to Surgery or Surgery to Medicine. Patients will be transferred to the correct receiving Ward when they are ready to proceed from the ED

1.5 The purpose of this SOP is to support safe, decision making when Rapid Plus One is instigated. It is recognised the decision making will be based on a specific risk assessment for each patient that is to be placed, in the context of the risk on the accepting ward. This SOP will outline the principles to be considered. The key principle is that the decision to place any patient will be based upon risks to patient safety and will seek to balance the risk to patients across ULHT and the community.

1.6 The aims of the Rapid Plus One (where patients are sent from an admitting area to a receiving base ward prior to the bed being available on the receiving ward) are to:

a) Stop the need for patients to be held on ambulances due to high occupancy within the ED
b) Reduce congestion in ED
c) To facilitate specialty patients moving at the earliest opportunity to the right ward
d) To promote each ward discharging patients before 12:00hrs and maximize utilisation of the Discharge Lounge
e) To improve flow and operational performance into admitting areas

1.7 This SOP will guide and support all staff involved in the implementation of Rapid Plus One principles to ensure:

a) Equitable access to appropriate beds for all patients admitted to ULHT
b) Patients are treated with respect, dignity and in accordance with ULHT values
c) Accommodation of patients in single sex areas with the exception of Level 1 facilities & the Intensive Care Unit (ICU).
d) The risk of patients being exposed to Hospital Acquired Infections is minimised
e) The inability to affectively risk assess patients in ambulances and/or the Community
f) Patients waiting extended lengths of time in ED

1.8 The Rapid Plus One principle is defined as being, the transfer of a patient from an admitting area to a receiving Ward prior to the bed being available on the receiving ward.

2. Scope

2.1 This SOP applies to patients admitted through ED and the Admission Units and will be the responsibility of the Clinical Site Managers (CSM) and Bed Management Team, ED Coordinators, Lead Nurse, Matron and Ward Managers to implement.

2.2 This SOP relates specifically to the Placement of Adult patients admitted to adult beds within ULHT.

3. Rapid Plus One Placement Triggers

3.1 The ULHT Capacity Meeting considers activation of the Rapid Plus One SOP process when one or more of the following criteria have been met:

a) OPEL Level 4 and/or

b) Unable to handover patients on ambulances or due to no capacity within ED or no capacity for inbound ambulances and/or
c) No Capacity in Resus with no out flow and/or
d) Majors full with priority patients in the Chairs For Treatment Area waiting to access majors cubicles

4. Roles

4.1 Chief Operating Officer, Director of Nursing and Medical Director are the Executive Leads for this SOP:

a) All beds within the Trust remain under the executive responsibility and management of the Chief Operating Officer.
b) The day-to-day operational responsibility for Capacity and Flow through ULHT is managed by the Site Operational Team who have overall responsibility for decisions made to place patients during normal operating hours during the week, in line with Capacity Meetings and Plus One placement triggers
c) Out of Hours responsibility (evenings, weekends and Bank Holidays) is via Strategic Command), Tactical Command and the Site Operational Team as appropriate
d) Have responsibility for safe operationalisation of this policy, monitoring safety, patient, and staff experience incidents

4.3 Operational Lead Nurse Divisional Nurse/Divisional Managing Director/Divisional Clinical Director/General Manager/Deputy Divisional Nurse/Lead Nurse:

a) Have a responsibility to ensure that Plus One is carried out in line with this SOP and in line with Operational Pressures Escalation Levels (OPEL)
b) Ensure that processes are in place to monitor each patient, the length of time patients are waiting for an available bed and document any concerns via the Datix reporting system
c) Ensure that processes are in place to provide Live WebV update availability and accurately reflect patient pathway and predicted date for discharge (PDD).
d) Ensure that all patients on ward wards have received a consultant led review in order to maximise discharges

4.4 ULHT Clinical Site Manager:

a) Support and facilitate divisional plans to enable the emergency and elective flow of patients throughout the Trust
b) The ULHT Capacity Meetings held x 3 daily should determine the ability to provide sufficient admitting capacity and influence the decision making around Plus One placement.

4.5 Consultants:

a) Responsible in conjunction with the multidisciplinary team for identification of patient's suitable for a morning discharge at 'Daily Board'/'Ward Rounds' and at 'Afternoon Huddles'. Documentation to be completed on both WebV and in the patients' medical notes
b) Patients who are placed will become the responsibility of the named Ward Consultant

4.6 Matrons

a) Provide clinical advice, and where necessary, practical support with the implementation of the Plus One SOP with particular reference to ensuring patients are identified and those identified meet the criteria

b) The Matrons are responsible for undertaking a professional nursing assessment in the Base Wards to understand the relative risk in the clinical areas at the time

c) The Matrons have the responsibility to ensure that effective board rounds take place daily led by Matron/Ward Lead & WebV/Patients notes reflect accurate patient pathway, plan and PDD

4.7 Ward Sisters / Charge Nurses / Nurse in Charge

a) The Nurse in Charge (NIC) of ED with the support of the Flow Co-ordinator is responsible for maintaining ED flow by ensuring the timely and appropriate transfer of patients to Assessment Units and other direct admission wards (Cardiology/Stroke/Orthopaedics/ENT/Frailty)
b) The NIC of Assessment Units are responsible for maintaining flow collaborating to ensure 1 patient is transferred to Wards every hour between 08:00hrs and 20:00hrs. They will ensure that by 20:00hrs every night there are empty beds.
c) Appropriate and prompt escalation to Divisional CBU teams for all delays to patient pathway
d) Ensure early utilisation and maximise the utilisation of Discharge Lounge

The NIC of each inpatient Ward is responsible for ensuring that all:

a) Patients receive a Consultant / senior medical review on a daily basis (with escalation if this does not occur)
b) Pathway Zero patients have been discharged from the Ward before midday.
c) Identifying the most suitable patients to transfer to the identified Plus One space
d) They must ensure that the bed state accurately reflects expected discharges / transfers and work with the Matron to identify appropriate patient transfers
e) Provide support at Ward level for the implementation of the Rapid Plus One SOP; with particular reference to ensuring that patients identified meet the criteria
f) Ensure WebV remains a live reflection of the patient pathway/journey

g) Ensure discharge information is provided to the Bed Management Team in line with OPEL levels

h) Communicating with the patients' family / carers regarding placement of patients

i) Complete a Datix for patients any patient that have been moved into a Plus

One area that does not meet the inclusion criteria

4.8 Bed Management Teams:

a) Day to day responsibility in hours for the placement of elective and emergency admissions
b) Maintains patient in flow and out flow of admission units and escalates capacity problems to the Clinical Site manager.
c) Communicates timely and accurate bed states, capacity issues and delay actions if any to the Clinical Site Manager

d) Monitor and record patient movement and ensure early utilisation and maximise the utilisation of Discharge Lounge

4.9 Infection Prevention Team

a) Provide Infection Prevention (IP) advice to Ward based nursing and medical staff, Operational & Bed Management Teams, with specific reference to identification of patients to be placed

5. The Process of Rapid Plus One

5.1 If there is a need for the placement of Plus One patients between 08:00hrs – 22:00hrs, this should be done in line with plans identified by Clinical site Management Team and enacted by the Bed Management Team at a specific threshold (section 3). This will take place at the 08:30hrs, 12:30hrs and 17:00hrs ULHT Capacity Meetings and the decision to enact discussed and agreed with the Chief Operating Officer / nominated Deputy.

a) WebV must be regularly updated and always show current ward position so that the bed state across the Trust can be accurately known. This will enable timely decision making and reduce the number of phone calls to confirm the bed state

b) Early discharge (home or Discharge Lounge) before midday. The Discharge Lounge should be used for all patients waiting for discharge medication (TTO) or transport, in order to facilitate discharge before midday. Discharge Lounge should be used routinely for all discharges from elective and non-elective bed bases.

c) Direct admission and Admission Unit patients will transfer from the Emergency Department 24hrs a day 7 days a week

d) Placement of patients occurs in line with individual ward discharge profiles between 08:00hrs and 22:00hrs across all three sites (appendix 1). This can be at the rate of 1 patient per hour

e) In phase one of placement of patients the incoming patient from the ED must be admitted to a bed space whilst the exiting patient is placed in the dedicated area

f) In phase two of placement of patients the incoming patient from the Admission Unit will either be admitted to the bed space on the Ward or into the dedicated area. This will depend on the clinical needs of the patients involved in the transfer and will require the professional judgement of the nurse receiving the patient transfer

g) Bed Management Teams will liaise with Admission Unit Nurses in Charge to identify suitable patients to transfer to the relevant Wards. This will be dependent on the gender of the incoming patient admissions and Wards normal discharge profile

h) Prior to Plus One taking place on inpatient Wards, the patient must be accepted by the respective medical / surgical team as per current process.

i) **Transferring Ward:** The registered nurses currently looking after the patient must provide the receiving Ward with a verbal handover. Web V must be updated detailing all clinical data relating to the patient's admission and care of the patient. They should also inform the patient's family / carers of the transfer.

Receiving Ward: The receiving Ward Lead/ coordinator takes overall responsibility for the ward placement and on-going care and management of the patient who has

been placed onto their ward. The patient placed will become the clinical responsibility of the named Consultant for the ward area. If the ward is unable to identify a bed for the plus one patient, then this will require escalation to the Matron & Clinical Site Manager

a) All Medical and Nursing documents, medication and property, should transfer with the patient to the placement Ward
b) Specific risk issues **must be** communicated verbally to the receiving Ward, staff on duty will need to re assess the patient when they arrive on the Ward
c) The Patient and family / carers need to be advised of the early transfer to another Ward
d) Bed Management Team will communicate regularly with the Clinical site manager to ensure that Plus One patient placement information is up to date
e) Patients will continue to have timely, on-going treatment or continued discharge planning whilst Rapid Flow is occurring on inpatient Wards
f) Plus One placement will not take place after the hours of 22:00hrs on base wards. In the event at 22:00hrs there is an additional patient on the ward after Plus One has occurred and the scheduled discharge is no longer happening, the Ward based team must contact the site team to advise them and to ascertain if a more appropriate patient should be allocated and an alternative bed space found within the organisation. Some plus one areas within ULHT have been identified as suitable to have a plus one patient remaining within the allocated space overnight. However, there needs to be a plan implemented for the movement of the patient the following day thus not to prevent further flow. **The patient should not be returned to the Assessment Units or ED.**
g) The Divisional Nurse/Lead Nurse will approve the cessation of Plus One placement in Ward areas

5.2 Adult Patients suitable for placement

a) Patients nominated for placement must have seen a Consultant already during that admission to ensure medical clerking and a treatment plan /medications have been confirmed
b) Patients nominated for placement will have been identified at the morning Board / Ward round/Afternoon Huddle by the Consultant or Registrar in conjunction with the Ward Lead / Ward coordinator the previous day
c) Patients must have a clear medical management plan and Predicted Date of Discharge that can be followed on the inpatient Ward
d) Patients should only be moved under the Plus One placement of patient SOP if they meet criteria for transfer from ED /Assessment Units Floor and the receiving Ward can accommodate the care needs of the individual patient. This will differ depending on the specialism of the Plus One patient placed and the area being placed too (equipment needs etc.)

The following groups of patients are excluded from patient placement:

1. Clinically unstable with an unmanaged Early Warning Score (NEWS >4)
2. Patients requiring Humidified, High Flow Oxygen or NIV
3. Patients requiring High Dependency level care
4. Patients requiring cardiac monitoring

5. Patients with severe cognitive impairment i.e. restless / agitated, delirium, requiring 1:1 care
6. Patients with complex learning disabilities
7. Patients whose death is imminent (within12hrs)
8. Patients being discharged from a side room (occupying a side room due to isolation)
9. Patients whose dignity is unable to be maintained within the allocated plus one space (this will be assessed by the ward team
10. Patients who require isolation because they are at risk of transmitting or acquiring an infection.
11. Patients identified as requiring enhanced falls prevention measures
12. Any concerns in relation to placement of patients, at any time should be escalated to the Matron/Lead Nurse in hours and Clinical Site manager OOH

6. On-going Management of Plus One patients

6.1 The receiving Ward takes overall responsibility for the Plus One patient placement and on-going care and management of the patient who has been placed onto their Ward

6.2 The patient placed will become the clinical responsibility of the named Consultant for the Ward area

6.3 The Plus One patient should be placed into an identified bed space with the query / confirmed discharge or another appropriate patient placed into the dedicated plus one space

6.4 The Ward Lead/Ward co-ordinator needs to ensure that the placed patient has appropriate treatment, observations and medication regimes prescribed including TTOs and a designated Registered Nurse accountable for their care

6.5 In the event at 22:00hrs there is an additional patient on the Ward after Plus One has occurred and the scheduled discharge is no longer happening. The Ward based team must contact the Clinical site manager/Bed Manager for the most appropriate patient on the Ward to be allocated an alternative bed space within the organisation, unless the plus one space the patients is residing in has been risk assessed as being suitable for the patient to remain overnight.

7. The Process of Plus TWO

7.1 If there is a need for the placement of Plus Two patients between 08:00hrs – 22:00hrs, this should be done in line with plans identified by Clinical site Management Team and enacted by the Bed Management Team at a specific threshold (section 3). This will take place at the 08:30hrs, 12:30hrs and 17:00hrs ULHT Capacity Meetings and the decision to enact discussed and agreed with the Chief Operating Officer / nominated Deputy.

Plus TWO can **only** be enacted when:

1. ALL Plus One areas has a patient boarded
2. All available escalation has been utilised

3. Staffing is re-reviewed and risk assessed as safe to take a further additional patient.

a) WebV must be regularly updated and always show current ward position so that the bed state across the Trust can be accurately known. This will enable timely decision making and reduce the number of phone calls to confirm the bed state
b) Early discharge (home or Discharge Lounge) before midday. The Discharge Lounge should be used for all patients waiting for discharge medication (TTO) or transport, in order to facilitate discharge before midday. Discharge Lounge should be used routinely for all discharges from elective and non-elective bed bases.
c) Direct admission and Admission Unit patients will transfer from the Emergency Department 24hrs a day 7 days a week
d) Placement of patients occurs in line with individual ward discharge profiles between 08:00hrs and 22:00hrs across all three sites (appendix 1). This can be at the rate of 1 patient per hour
e) In phase two of placement of patients the incoming patient from the ED must be admitted to a bed space whilst the exiting patient is placed in the dedicated area
f) In phase two of placement of patients the incoming patient from the Admission Unit will either be admitted to the bed space on the Ward or into the dedicated area. This will depend on the clinical needs of the patients involved in the transfer and will require the professional judgement of the nurse receiving the patient transfer
g) Bed Management Teams will liaise with Admission Unit Nurses in Charge to identify suitable patients to transfer to the relevant Wards. This will be dependent on the gender of the incoming patient admissions and Wards normal discharge profile
h) Prior to Plus Two taking place on inpatient Wards, the patient must be accepted by the respective medical / surgical team as per current process.

8. ULHT Capacity Meeting

8.1 Identification and need for patients to be placed is to be determined at the Trust Capacity Meetings. These meetings are held at specific points in the day, but times can be adjusted according to the organisational response levels required
8.2 These meetings will focus on the provision and availability of daily admitting capacity for Emergency and Elective activity
8.3 Numbers of patients placed will be reviewed during these meetings
8.4 Escalate any delays in Plus One patient placement to the respective Division
8.5 In the event at 22:00hrs there is an additional patient on the Ward after Plus One has occurred and the scheduled discharge is no longer happening. The Ward based team must contact the Clinical site manager/Bed Manager for the most appropriate patient on the Ward to be allocated an alternative bed space within the organisation, unless the plus one space the patients is residing in has been risk assessed as being suitable for the patient to remain overnight.

9. Safer Staffing

9.1 Included within the Workforce Safeguard Report is an itemised assessment to ‘plus one’. For each area an assessment needs to be made to determine whether it is safe for the area to take an additional patient as per Plus One placement.

9.2 This assessment will be supported with Decision Support Criteria to aid the decision making & risk assessment process.

9.3 The assessment will be completed as part of the Safer Staffing Operational process so with all safety measures have been considered.

9.4 This is a dynamic risk assessment that can be completed at any opportunity that wards report that they feel the risk to take a plus one patient is too great.

9.5 The decision to NOT support Plus One/Plus Two in an area is made on the assessment of safety by the divisional senior nursing leadership team and the risk confirmed with Divisional Nurse/Deputy and/or the Deputy Chief Operating Officer or on call manager. Areas of concern should be escalated to the Director of Nursing, Medical Director, Chief Operating Officer or nominated deputy. Overall, the balance of risk relating to staffing must be considered in the context of unseen risk within our communities.

10. Education and Training

10.1 Training should be given to the necessary individuals responsible for bed management within the Operational Team and Ward staff operationalising the placement of patients' process.

11. Monitoring Compliance

What will be measured to monitor compliance	How will compliance be monitored	Monitoring lead	Frequency	Reporting arrangements

a) Number of Times Plus One placement of patients SOP enacted b) No. of Datix incidents received in relation to Plus One placement c) Patient Experience indicators / Complaints	Recording sheets / Web V reports Datix incidents Complaints	Operational Command Lead/Operational Lead	Quarterly	Quality and Safety Groups
d) Patient impact: 1) Timely administration of treatment 2) Delays in the completion of assessments due to additional patients on Wards 3) Reduced visibility of patients due to increased RN / HCA ratio 4) Delays in meeting patients personal hygiene requirements due to increased RN / HCA ratio 5) Altered patient experience due to being allocated a non-clinical bed space	Datix incidents Complaints	Operational Command Lead/Operational Lead	Quarterly	Quality and Safety Groups
e) Colleague experience	Datix incidents	Operational Command Lead/Operational Lead	Quarterly	CMG Quality and Safety Groups

Appendix 1 Plus One Placement Principles

PLUS ONE Principles

Plus One Placement of Patients Process activated only when:

- OPEL Level 4 **And/Or**
- Unable to handover patients on ambulances or due to no capacity across ED (Majors and Resus) or no capacity for inbound ambulances

- Bed Management Team Manager utilise daily discharge list to identify patients to be transferred to the Discharge Lounge. Identify potential discharges and prepare areas to except Plus One patients from 08:00hrs

In the event at 22:00hrs there is an additional patient on the Ward after Plus One has occurred and the scheduled discharge is no longer happening. The Ward based team must contact the Clinical site manager/Bed Manager for the most appropriate patient on the Ward to be allocated an alternative bed space within the organisation, unless the plus one space the patients is residing in has been risk assessed as being suitable for the patient to remain overnight.

THE PATIENT WILL NOT BE RETURNED TO THE ASSESSMENT UNITS

The following groups of patients are excluded from patient placement:

- Clinically unstable with an unmanaged NEWS >4
- Patients requiring Humidified, High Flow Oxygen or NIV
- Patients requiring Level 1/high dependency care
- Patients requiring Cardiac Monitoring
- Patients with severe cognitive impairment i.e. restless / agitated, delirium, requiring enhanced monitoring
- Patients with complex learning disabilities
- Patients whose death is imminent (within 12hrs)
- Patients being discharged from a side room (IPC reasons)
- Patients where dignity cannot be maintained within the Plus one space
- Patients who require isolation because they are at risk of transmitting or acquiring an infection.
- Patients identified as requiring enhanced falls prevention measures

- We would transfer from ED to Assessment areas 24/7 as required
- We will Plus One from the Assessment Units to base wards 08:00hrs- 22:00hrs
- All areas will accept a maximum of +1 patient as per risk assessment

Appendix 2

Areas that can Plus One/Two

WARD	SITE	PLUS 1	PLUS 2
STROKE UNIT	LCH	BED	
BURTON WARD	LCH	BED	BED
NAVENBY WARD	LCH	CHAIR	
JOHNSON WARD	LCH	BED	
CSSU	LCH	BED	
WITHAM/RSU	LCH	BED	CHAIR
FAU/LANCASTER WARD	LCH	BED OR CHAIR	CHAIR
SCAMPTON WARD	LCH	BED OR CHAIR	
DIXON WARD	LCH	BED	
MEAU	LCH	Used as Rapid Handover	Used as Rapid Handover
NEUSTADT-WELTON WARD	LCH	Used as Rapid Handover	Used as Rapid Handover
CATH LAB	LCH		
CARLTON COLEBY	LCH		
CLAYTON WARD	LCH		
GREETWELL	LCH	BED	CHAIR-OVERNIGHT
HATTON	LCH	BED	BED
SEAU	LCH	TROLLEY	BED
SHUTTLEWORTH	LCH	BED	BED
DIGBY	LCH	CHAIR	
SAL	LCH		
WADDINGTON	LCH	TROLLEY	
ASHBY	LCH		
WARD 1	PHB	BED	
7B	PHB	BED	BED
8A	PHB	BED	TROLLEY/CHAIR
8B	PHB	BED	
ACU	PHB	CHAIR	
6A	PHB		
6B	PHB	BED OR CHAIR	CHAIR
IAC	PHB		
AMSS	PHB	Used as Rapid Handover	Used as Rapid Handover
5A	PHB	BED	BED
5B	PHB	BED	BED
7A	PHB	BED	BED
9A	PHB	BED	BED
BOSTONIAN	PHB	CHAIR	
HARROWBY	GDH	BED	
EAU	GDH		
GSU	GDH		

H2 / Winter Priorities

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Hospitals NHS Trust

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*5th November 2024*
Item Number	*10.5*

Productivity Briefing

Accountable Director	*Daren Fradgley, Group Chief Integration Officer*
Presented by	*Daren Fradgley – Chief Integration Officer* *Caroline Landon – Chief Operating Officer*
Author(s)	*Dave Plumb – Deputy Director Strategy & Partnership* *David Picken / Paula Sargeant – Finance* *Georgina Grace / Kerry Swift – Workforce* *Shaun Caig / Anthony Burgess / Howard Justice – Activity* *Helen Shelton – Patient Safety* *Henry Wilkinson / Maria Kordowicz – Strategy & Planning*

Recommendations/ Decision Required

This paper provides a briefing on H2 / Winter Priorities.

It provides an overview of where we are at month 6 from an operational annual plan perspective, and the key actions we are taking in H2 to bring us back on track against our 2024/25 plan.

NHSE stand-up the Winter operating functions from 1st November 2024. In preparation for this, Trusts were asked to:

- *Review general and acute core and escalation bed capacity plans.*
- *Review and test full capacity plans.*
- *Ensure the fundamental standards of care are in place in all settings at all times.*
- *Ensure appropriate senior clinical decision-makers are able to make decisions in live time to manage flow.*
- *Ensure plans are in place to maximise patient flow throughout the hospital, 7 days per week*

Each winter, the health service faces significant challenges due to increased pressures across all parts of the system. Effective and comprehensive planning is essential to maintain resilience and ensure continuity of care during these demanding times. 24/25 Winter plan is attached in appendix 1.

Lincolnshire Integrated Care System

Winter Preparedness

2024-2025

DRAFT

Executive Summary

The Lincolnshire Integrated Care System (ICS) Winter Plan for 2024/25 has been developed collaboratively and influenced by national winter guidance issued by NHS England as well as applying learning from previous winters within our local system, regionally and nationally.

During the summer of 2024, the Lincolnshire system experienced sustained levels of demand following the winter period and did not experience the usual small dip in activity. We must ensure that our services can respond to the expected increases in demand over winter and that resilience can only be achieved through continued partnership working across the health and care system. As partners of the Lincolnshire ICS, we are committed to working together to manage these challenges and ensure that our population can access safe services and have good outcomes with a positive experience.

The purpose of this Winter Plan is to highlight the local assumptions for winter and set out our planned response to manage the urgent care and patient flow pressures that the system will inevitably experience. The plan is designed to supplement the ongoing improvements and developments in urgent care in line with the National Urgent and Emergency Care Recovery Plan and is inclusive of those requiring both physical and mental health care. During August 2024 NHS England Midlands Regional team shared a set of Key Lines of Enquiry (KLOEs) to support development of local winter plans.

This year we have again focussed on the avoidance of patient harm by adopting an approach that focuses on clinical risk, the main areas of risk in the Urgent and Emergency Care pathway are as follows:

- **Patients could wait for an urgent or emergency response in community settings**
- **Patients could experience long waits in Emergency Departments**
- **Patients could wait on ambulances prior to entering Emergency Departments**
- **Patients may experience waits for discharge home or into community settings**
- **Impact of GP collective action on Urgent and Emergency Care pathways and patient experience**
- **Some service fragility along the East Coast and Boston specifically for Childrens and Young Peoples and some Mental Health services**
- **Confusion amongst the public regarding the most effective access to health and care services**

DRAFT

Contents

1. Introduction
2. Context
3. Preparation for Winter 2024/25
    3.1 Capacity and Demand Reviews
    3.2 Trends, Forecasts and Impact of Infectious Disease
4. Winter Response
    4.1 Primary and Community Care
    4.2 Hospital Care & Discharge
    4.3 Mental Health
    4.4 Children & Young People
    4.5 Specific Support for Care Homes
5. System Working and Escalation
    5.1 System Co-ordination Centre
    5.2 Escalation and Assurance
6. Workforce
7. Quality and Risk Management
    7.1 Risk Management
8. Communication
9. Conclusion & Evaluation

1. Introduction

Integrated care is about ensuring that people get the help and support they need, joined up across local councils, the NHS, and other local partners. It removes traditional and historical divisions between hospitals and family doctors, between physical and mental health, and between NHS and council services. In the past, these divisions have meant that too many people experienced disjointed care and over the years we have recognised the importance of all local health and care providers and commissioners working together to provide the best services we can.

This document outlines the Lincolnshire collective response to urgent and emergency care during anticipated peak times of demand, during winter, to ensure patients get the safest, most effective, and efficient services responding to their need. This winter we recognise the importance of managing patients wherever appropriate and safe to do so including within their own homes or usual place of residence, providing health and care in an integrated way and relying less on acute inpatient services. This plan sets out how we will ensure services provided by each of the partners that make up our system will be resilient through this winter. We have arrangements across all Lincolnshire ICS partners to manage patient flow between our services. Working together, we use the Operational Pressures Escalation Level (OPEL) system which identifies the actions we all need to take when we are under increased pressure.

We learned much from the pandemic and from our response during that time and importantly it demonstrated that, on a day-to-day basis, all our partner organisations in Lincolnshire are stronger and better when we work more closely together. We have a shared commitment and determination to ensure people are cared for in the right place at the right time, so that they can achieve the best health outcomes.

During 2024 we have continued to deliver our system Urgent and Emergency Care strategy and our overall vision for Urgent and Emergency care in Lincolnshire is:

"System Partners in Health and Care from across Lincolnshire have together committed to support people who present to our services in an emergency or with urgent needs to access safe, seamless, compassionate and timely care in the right place from the right team."

DRAFT

The recent review by Lord Darzi highlighted nationally several key themes for the 10-year health plan which align to our vision, including:

- Engagement of staff and empowerment of patients
- Shift care closer to home
- Simplify care delivery
- Increase use of technology

In addition, we continue to ensure that our clinical ambitions detailed below are at the forefront of all Urgent and Emergency Care service delivery and any improvement work undertaken.

- ✓ **Our team members have optimal time and resources to provide great care, in line with agreed professional standards.**
- ✓ **Our patients and team members are treated with respect, kindness, and compassion.**
- ✓ **Our teams work collaboratively across the whole system, to join up care in a way which matters to our patients and those who matter to them.**
- ✓ **All patients are cared for in an appropriate and safe environment, minimizing the risk of hospital acquired infection and harm.**
- ✓ **Patient records are shared across clinical teams to enhance patient safety and reduce the need to share the same information multiple times.**
- ✓ **Where possible care is delivered 'closer to home,' if patients need a stay in hospital, they are admitted quickly to the right bed to meet their clinical needs and when they are ready, they are discharged home without delay.**
- ✓ **Our culture is one of learning and continuous quality improvement.**

As a system we will work together to drive delivery of the plans set out in this document, managing risk and daily patient flow between all our partners through our System Co-ordination Centre who, along with our Winter Director, will ensure a continuous focus on this plan so we deliver the safest, most appropriate care we can, for the population of Lincolnshire, over the winter months.

2. Context

The purpose of this winter plan is to demonstrate the Lincolnshire system approach to operational management of winter, detailing the specific pressures anticipated for our system and how we intend to mitigate them to ensure we deliver our vision for Urgent and Emergency Care across the county.

Urgent and Emergency Care continues to be under significant pressure both locally and nationally and we have faced our busiest summer for many years with increasing numbers of people attending our Emergency Departments and Urgent Treatment Centres as well as high levels of wider system demand within primary, community and mental health care. Despite the growing demand for urgent care services, we have made some notable improvements for our population with a marked improvement in overall category 2 ambulance response times and a reduction in handover delays from our ambulance service (East Midlands Ambulance Service) to our acute provider (United Lincolnshire Hospital Trust). However, there is still much more to do, alongside delivering our commitments in relation to cancer care, elective (those needing operations) and outpatient care, maternity and children's and young people's care, as well as mental health care and support for those with, learning disabilities and autism.

Planning assumptions for the upcoming winter have been informed by data and insights from the UK Health Security Agency (UKHSA). Infectious diseases such as Influenza, Covid-19, and Norovirus typically place increased strain on health and care services during the winter months. While the expected profiles of these common infectious diseases for winter 2024/25 are not yet fully understood, early planning assumptions are based on a cyclical pattern, with a likely early impact like that of the previous winter. To manage the associated risks, the Lincolnshire system has implemented the following measures:

- ✓ **Arrangement with our community provider to prescribe influenza prophylaxis to those meeting the clinical requirements.**
- ✓ **Covid 19 Medicines Delivery Unit (CMDU) moving to 7-day service for winter.**
- ✓ **Care Home Infection Prevention and Control (IPC) support including local outbreak management support, with dedicated Senior Health Protection Nurse for each setting.**
- ✓ **Integrated Health Protection approach across the system and Infection Prevention and Control collaborative in place.**
- ✓ **Integrated Care Board (ICB) engagement in all outbreak meetings across the system.**

As we navigate the post-pandemic landscape, our focus remains on protecting those in society who are at a higher risk of severe Covid 19 infection and other infectious diseases. To achieve this, we continue to implement planned and targeted vaccination programmes across the county. Ensuring

DRAFT

a sustainable Covid 19 vaccination programme is a crucial aspect of health protection, and we are committed to making vaccination services accessible to all eligible groups. The Lincolnshire Covid 19 vaccination programme has been highly successful, achieving excellent uptake amongst our population, and we take pride in continuing to be one of the best performing systems both regionally and nationally.

Our vaccination strategy includes:

- ✓ **Care home residents and staff to be prioritised early in the programme and Covid 19 vaccination to begin by 3rd October 24.**
- ✓ **Covid 19, and influenza vaccination delivery through a combination of Primary Care Networks and their GP Practices and Community Pharmacies providing local access to vaccinations.**
- ✓ **Respiratory Syncytial Virus (RSV) programme commenced 1st September 24 for those aged 75 – 79 years old delivered by GP Practices.**
- ✓ **Assurance that we have a skilled and competent workforce to deliver the programmes safely.**
- ✓ **Delivery of a co-ordinated vaccination programme that incorporates co-delivery of other vaccinations when possible and incorporates appropriate health advice/screening where appropriate.**
- ✓ **Provision of dedicated clinics for at-risk children and our school based programme for all eligible Primary and Secondary school children in Lincolnshire.**
- ✓ **A robust staff vaccination plan, delivered at various locations across the county which champions peer to peer vaccinations.**
- ✓ **A dedicated Immunisation programme team will monitor performance and ensure all eligible cohorts have access to a vaccination, this includes coordination of a roving vaccination model to deliver to housebound patients, care homes and other settings.**

Uptake targets for Covid 19 vaccination are 76% of all eligible cohorts and we expect to achieve or exceed this based upon previous performance. The influenza vaccination programme starts in October for adults aged over 65 and those identified as at risk and in September for our eligible school age children. All 82 General Practices across Lincolnshire will be offering influenza vaccine with most offering them alongside Covid 19 vaccines.

3. Preparation for Winter 2024/25

Building on our learning from last winter, and the work undertaken throughout the year including our Urgent and Emergency Care Strategy and the Urgent and Emergency Care prioritisation work completed by all system partners, the following preparatory work and actions has been undertaken:

- **May:** Finalisation of 24/25 operational plan assumptions around capacity and demand plans including winter period.
- **May:** Review of winter learning at Urgent and Emergency Care System Leadership Group and Service Delivery and Performance Committee
- **July:** System clinical and quality meeting facilitated by the ICB Medical Director in response to the 'Maintaining focus and oversight on quality of care and experience in pressurised services' letter from NHS England.
- **August:** System Winter Workshop to review the anticipated requirements of the NHS England winter letter 24/25, respond to winter Key Lines of Enquiry (KLOEs) for the NHS England Midlands Region and determine and agree priority areas of focus for the Lincolnshire winter plan.
- **August:** Formal response to the regional winter KLOEs with high levels of assurance.
- **September:** System attendance at the NHS England Midlands regional winter event with early indications of national expectations.
- **October:** Local confirm and challenge of the system winter plan and finalisation of any winter initiatives.

In July 2023, NHS England wrote to all Integrated Care Systems setting out the national approach to deliver operational resilience across the NHS this winter, building on the Urgent and Emergency Care Service (UEC) Recovery Plan published in January 2023, which was followed up in May 2024 with a year 2 plan to build on learning from year 1.

In September 2024, NHS England published the winter and H2 priorities letter which set out expectations of the NHS to support people to stay well and to maintain patient safety and experience, https://www.england.nhs.uk/long-read/delivering-operational-resilience-across-the-nhs-this-winter/. The letter provides focus in relation to performance metrics and this plan has been developed to support our key performance targets including our category 2 ambulance response times, ambulance handover delays and the time people wait in our Emergency Departments.

In addition, the letter specifically requests that we review progress against the 10 High Impact Interventions for Urgent and Emergency Care which were originally detailed as part of the Urgent and Emergency Care Recovery Plan. A self-assessment against the national framework has been completed and provides strong assurance against 9 of the interventions with them all either increasing their maturity score, compared to the assessment completed last year, or remaining the same with ongoing improvement where the score was already high. The exception to this is the provision of Acute Respiratory Infection (ARI) hubs which were in place as a pilot last winter. A review and evaluation of that pilot has been undertaken and a new model for winter 2024/25 is in development.

3.1 Capacity and Demand Reviews

Capacity and Demand assumptions for Winter 204/25 were originally submitted as part of our operational plan for 24/25 earlier in the year, however, we continuously revisit and challenge our original modelling assumptions both using the current activity and performance data, and when new interventions are mobilised tor changes and improvements made to ensure that they are rebased using shared learning. Working across system partners we will undertake dynamic reviews of demand and capacity modelling to understand and manage winter pressures effectively, minimise excessive delays in the Emergency Departments including waits for admission and ambulance handover delays.

Throughout the winter period we will continue to refine and redefine modelling work considering:

- **Further Urgent and Emergency Care programme and winter initiatives as they come online together with assessing our assumptions for level of impact.**
- **The impact GP Collective Action.**
- **The position against recovery plans for Elective and Cancer activity and performance.**
- **The emerging assumptions and projections around infectious diseases such as Influenza, Covid 19 and RSV.**
- **Met Office forecasting for excessive cold weather periods, as a predictor of increased respiratory conditions and falls.**

The capacity and demand modelling continues to suggest three key areas of focus for our system during winter which are critical in ensuring our urgent care system can manage the anticipated pressures:

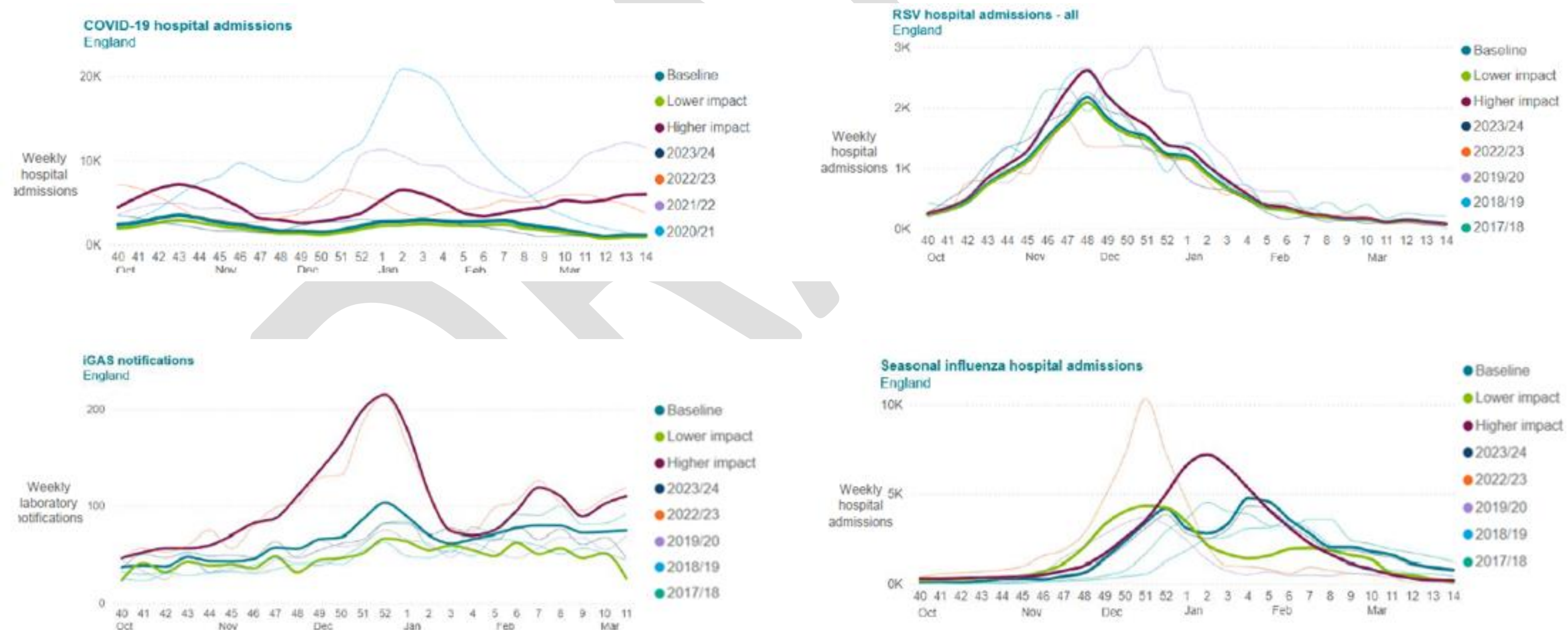
- **Attendance Avoidance**
- **Admission Avoidance**
- **Reduced Lenth of Stay**

DRAFT

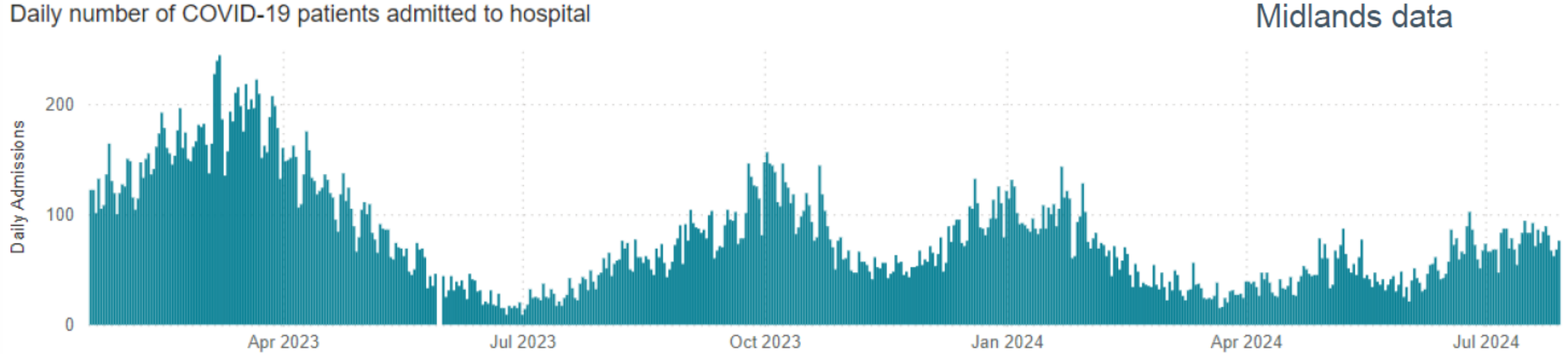
3.2 Trends, Forecasts and Impact of Infectious Disease

Predicting trends and peaks in demand during the winter period is crucial for mitigating risks and managing system pressures. However, it remains challenging to accurately forecast what the winter 2024/25 period may look like in terms of Covid 19, Respiratory Syncytial Virus (RSV), Invasive Group A Streptococcal (iGAS) disease and Influenza. Despite this uncertainty, the transmission levels of viral respiratory pathogens in late summer were as expected, suggesting that we are likely to see similar levels this winter as in recent years.

This suggests that we are likely to see highest rates of Influenza, Covid 19 and RSV during late December and early January. This period coincides with Christmas, New Year, and the re-opening of schools, which aligns with hospitalisation and disease notification trends from previous years, as illustrated in the charts below. Last winter, RSV followed the expected 6-week epidemic pattern, peaking in November and December, with the highest admission rates in the 0–4-year age group. Nationally, influenza activity in 23/24 was lower but observed over a longer period, resulting in fewer hospitalisations compared to previous influenza seasons.



Covid 19 admissions to hospital across the Midlands during 2023/24 followed a cyclical pattern which is likely to continue throughout winter 2024/25.



Norovirus has been higher across the East Midlands and England during the summer months, which is seasonally atypical, however at this time there is nothing to suggest that the typical winter presentation will not occur.

Measles cases are now declining after a significant outbreak across England in early October 2023, primarily centred in Birmingham. To date, Lincolnshire has reported minimal cases. Our focus remains on our preventative work which includes robust infection, prevention, and control measures, as long with as targeted vaccination campaigns, to prevent and contain any potential outbreaks within the county.

Pertussis (whooping cough) cases have remained stable over the summer period but may increase in the autumn. These outbreaks are believed to be linked to reduced exposure during the Covid 19 pandemic. Effective vaccination campaigns, particularly targeting pregnant women, are crucial in preventing and controlling potential cases.

All respiratory syndromic data will be analysed weekly to ascertain significant changes in prevalence and incidence, as well as short-term trajectory. These data will be shared across the system fortnightly, or on a needs basis based on likely impact, to ensure the system is informed on potential future demand caused by communicable diseases.

System wide plans are in place to mitigate risks associated with both respiratory and other communicable diseases which may pose a threat this winter. This includes plans for respiratory viruses (covid, flu, RSV, pertussis, and others), Mpox, measles, and other vaccine preventable diseases. All plans include proactive and reactive elements, ensure that the system is doing all they can to increase vaccination uptake, cascade key messages of how to keep yourself well, whilst also planning for significant outbreak response.

4. Winter Response

Over the last two years NHS systems have received financial investment for service improvement and additional monies to provide short term winter services. This year, money was received as part of our overall financial allocation at the beginning of the financial year to aid planning and to allow systems to continue to fund those initiatives implemented over the last two winters in a sustainable way.

Within Lincolnshire we have used our allocation to fund:

- ✓ **Community services to support attendance and admission avoidance and to help patients be cared for in their own homes or usual place of residence.**
- ✓ **Children and young people (CYP) services, both within community settings and within our Emergency Departments.**
- ✓ **Capacity within our Urgent Treatment Centres, Emergency Departments and Same Day Emergency Care (SDEC) units.**
- ✓ **Jointly commissioned with Lincolnshire County Council, Active Recover Beds with Primary Care and Adult Care support.**
- ✓ **Capacity for those patients being discharged from hospital that require rehabilitation services (Pathway One).**
- ✓ **Extra acute and community bed capacity to be used during times of surge.**
- ✓ **Capacity to support discharge processes across acute and community settings.**
- ✓ **Extra transport capacity to support hospital discharge.**
- ✓ **Additional therapy support to patients in community hospitals to increase flow**
- ✓ **Additional support for patients, their relatives and carers who have been discharged from our Emergency Departments not requiring admission to hospital.**
- ✓ **Enhanced pharmacy support for those with complex illness following discharge from hospital.**
- ✓ **Development of cardiology and respiratory Hot Clinics to reduce unnecessary admission to hospital.**
- ✓ **Increased Mental Health support for those living in Boston and the east coast localities.**

4.1 Primary and Community Care

Whilst the impact of GP Collective Action remains an unquantifiable risk the impact on Urgent and Emergency Care pathways could be significant, to support mitigation the Integrated Care Board has introduced a system framework for monitoring, identification of early impact and to ensure a coordinated response to any escalations.

There is an ongoing review of Primary Care Network (PCN) plans to make sure that these are being optimised ahead of winter. The work on self-referral pathways is also continuing to promote and increase utilisation. Supporting use of online consultation tools will enable access and reduce system demand.

The ongoing expansion of community capacity and increase in utilisation of community services is key in delivering our ambition to reduce reliance on acute services. We know that increasing numbers of patients are accessing our Urgent Treatment Centres and demand across community services is growing. Wherever possible we continue to work with wider system colleagues to ensure that wherever appropriate and safe to do so we are accessing alternatives to attendance and admission, supporting people in their own home or within community settings through:

- ✓ **Consistent risk stratification of patients to proactively identity and support those that are vulnerable and frequent users of our services by Care Co-ordinators within Primary Care Networks and neighbourhood teams.**
- ✓ **Maximise utilisation of our 2-hour Urgent Community Response (UCR) service and other community-based admission avoidance pathways.**
- ✓ **Maximise utilisation and capacity of Virtual Wards across Lincolnshire.**
- ✓ **Single Point of Access (SPoA) for Health Care Professionals (HCPs) to help navigate admission avoidance pathways including ambulance crews calling for community support before conveying to an Emergency Department.**
- ✓ **Integration of the Lincolnshire Clinical Assessment Service, the East Midlands Ambulance Service (EMAS) Emergency Operations Centre and the LIVES falls service to support timely and appropriate responses to people in the community.**

DRAFT

We have heard clearly from our clinicians that attendance and admission avoidance pathways need to be simplified and the introduction of the Lincolnshire Single Point of Access (SPoA) will further support simplification of access with professionals across the system not needing to know which service they need. The SPoA was established during winter 23/24 and has continued to develop and is now available 24/7 and fully integrated into our system. A full operational and clinical review of our Virtual Wards is currently underway to ensure that we can maximise this capacity, fully, over winter, and we recognise the opportunity to increase the step-up utilisation to enable patients to be supported at home without the need for a hospital attendance.

Frailty care and support continues to be a focus for Lincolnshire and this year we have developed a delivery model to implement the Lincolnshire Older Peoples Strategy which focuses on 5 connected pillars, Proactive Care, Primary Care' Single Point of Access, Integrated Services, and an Integrated Workforce.

To date we have progressed the following which will help support our older adult population:

- ✓ **Communications plan which will launch in October to support older people to age well including directing people to existing services, campaign leaflets, films, pop up events, and published service details.**
- ✓ **14 pro-active care interventions to support older people living with frailty with harder to reach populations prioritised.**
- ✓ **Frailty specific acute same day emergency care.**
- ✓ **Centralised point of access, via our Single Point of Access for Health Care Professionals for all frailty needs.**
- ✓ **Training for our workforce on undertaking comprehensive geriatric assessments (CGAs) to commence in October.**

4.2 Hospital Care and Discharge

Planning for effective hospital care and discharge must start at the point of arrival at one of our hospitals. Whilst we have made some significant improvements to ambulance handover delays, we are committed to ongoing improvements, so our patients receive safe and effective care in a timely way and delays are reduced to minimum. Over the winter period ambulance crews will have continued direct access to a range of alternative settings where clinically safe to avoid an Emergency Department.

Where patients are admitted to inpatient areas for care we will ensure that they are discharged in a timely way with the correct level of support and with full assessments taking place outside of the hospital setting. The ethos of Discharge to Assess (D2A) is well embedded within the system which means we should have capacity and skill available to make patient assessments in their own home rather than in a hospital setting, and to wherever possible and safe to do so, support patients in their own home rather than in a bedded service.

Ahead of winter, system partners have implemented new processes to improve community bed outcomes, and support efficiency and flow. This includes clinician to clinician referrals pulling the most appropriate patients for therapy beds and supporting maximising Discharge to Assess capacity, flexible support for social care led Active Recovery Beds and piloting an Assertive In Reach service as well as Therapy at the Front Door to maximise Discharge to Assess discharges from our Emergency Departments rather than following an inpatient stay.

In addition, we will also:

- ✓ **Reduce the number of patients experiencing long waits in our Emergency Departments by ensuring our senior clinical decision makers are available at our front doors and undertake rapid improvement cycles (sprints).**
- ✓ **Maximise utilisation and impact of our Clinical Navigators employed by East Midlands Ambulance Service (EMAS) to ensure people arriving on ambulances are directed to the most appropriate place within the hospital.**
- ✓ **Ensure dedicated space within our Emergency Departments is available so that in times of escalation people can still access hospital care and not be waiting on ambulances unnecessarily.**
- ✓ **Minimise delays for people being discharged from hospital across all pathways supported by our Transfer of Care Hubs and our non-emergency transport service which will respond to the growing requirements for additional support that patients need upon discharge from hospital.**

DRAFT

4.3 Mental Health

The implementation of the Mental Health Urgent Assessment Centre in Lincolnshire continues to be a great success and ensures that those patients with a mental health need only, do not need to attend our hospital Emergency Departments and instead they can attend a more appropriate environment which provides a better patient experience and improved outcomes. The service now delivers an all-age model of care, further supporting our Emergency Departments and Urgent Treatment Centres with Children and Young People presenting with a mental health need this winter.

Patients in Lincolnshire will continue to be supported by robust crisis and home treatment teams and the integration of those services with NHS 111 option 2 Mental Health service was introduced in the early summer. This provides 24/7 Mental Health advice and increases capacity for our crisis teams who were managing these calls previously. Crisis house capacity and 'Crisis Café' provision is in place across the county.

Two crisis response vehicles are in operation across our county to respond to those with urgent mental health needs alongside a trained nurse who is based within the Police Control Room to support any calls and required response to 999.

We also invest in our Voluntary, Community and Social Enterprise (VCSE) partners over the winter period by creating warm spaces within our wellbeing hubs, allowing our community connectors to establish targeted additional capacity in the form of initiatives to support people over the winter period, alongside additional capacity in some of our wider mental health and wellbeing VCSE projects which provide activities tackling suicide prevention, social isolation, befriending or other wellbeing support.

Key activities to increase resilience of the winter period include:

- ✓ **Employing dedicated staff to run the Crisis Vehicle Response (CVR) and Police Control Room (PCR) functions.**
- ✓ **Expanding alternatives to specialist crisis services, including the expansion of crisis cafes across the county.**
- ✓ **Expansion of Voluntary, Community and Social Enterprise support to create warm spaces within our wellbeing hubs.**
- ✓ **Online resource to help people to navigate support and training - www.haylincolnshire.co.uk**
- ✓ **Integrate Mental Health Support with NHS111 and supplement the local mental health helpline.**
- ✓ **Mental Health Urgent and Emergency Care champions to raise awareness, provide visibility and interface with system partners.**
- ✓ **Reducing the number of patients experiencing long waits in our Emergency Departments by ensuring our senior clinical staff are available to support decisions.**

DRAFT

4.4 Children and Young People

Children and Young People with physical and mental health needs are a priority cohort for the Lincolnshire system this winter. We have continued with last year's investment in both paediatric support in our Emergency Departments and we continue with our recruitment plans to increase our Child and Adolescent Mental Health service capacity in the Boston and east coast localities.

We have recently secured a pilot for Family Support Workers at Lincoln County Hospital funded by Barnardo's, these Family Support Works will support those who have attended with low level illness at either our Emergency Department of Urgent Treatment Centre, as well as supporting Children and Young People who attend with asthma by organising access a post exacerbation review and annual review at their GP practice.

4.5 Care Homes

Keeping people well at home is a key strategic component of the Lincolnshire 'Home First' strategy and that includes people where a care home setting is their own home and usual place of residence. When those living in care homes become ill, staff have swift access to health care support. In Lincolnshire the Clinical Assessment Service (CAS) has a dedicated service (CAS for care homes) available for care home staff where senior clinical advice can be accessed swiftly. We have also invested in CAS this year with increased capacity and skill set that will further support care home staff and wider system professionals to support people without the need for inpatient care wherever appropriate and safe to do so. Digital telehealth has also been available across Lincolnshire for several years but during this winter period we will ensure that this strategy is maximised.

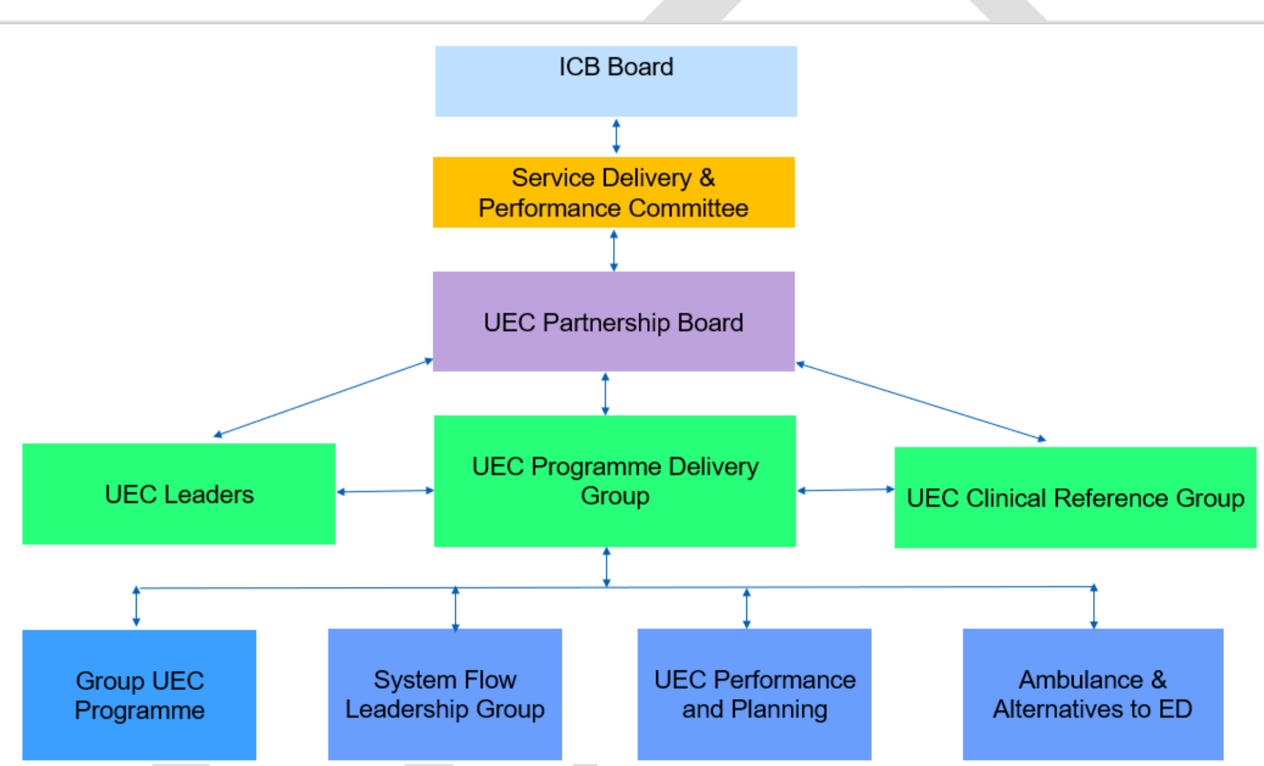
Each care home has an identified 'wrap around' PCN led Enhanced Health in Care Homes Team which undertakes weekly meetings with the care home and Multi-Disciplinary Team (MDT) discussion to proactively manage any identified patients who may have health concerns. Each care home is aligned to a Primary Care Network and with a named clinical lead. This is in addition to a named Nurse through the Local Authority Health Protection Team. Leading into the winter period all care homes will receive regular updates with detailed information on how to manage seasonal illnesses which will include guidance related to testing for COVID-19 and other Acute Respiratory Infections and pathways for escalation to the Local Authority and other Health partners. Seasonal webinars are being offered to all Adult Social Care settings in addition to the core education offer providers receive through the IPC Link Champion Programme and there will continue to be access to advice and guidance through the Local Authority Health Protection Duty Desk during the week and UKHSA East Midlands Team Out of Hours.

Falls in care homes remains a priority and this year 80 care homes have received raiser lifting equipment from the Integrated Care Board to assist with Falls response. An overarching policy has been agreed to assist with staff training, which is almost complete and will complement our bespoke commissioned falls service across our county.

DRAFT

5. System Working and Escalation

The Integrated Care System Urgent and Emergency Care Partnership Board (UECPB) has strategic responsibility for overseeing the development and mobilisation of robust winter capacity and resilience plans for Lincolnshire. The Performance and Planning Group has operational responsibility to monitor performance over winter and plan, accordingly, escalating as required. Our governance arrangements are detailed fully below:



Whilst the Urgent and Emergency Care Partnership Board meets monthly, the Urgent and Emergency Care Leaders Group and the Urgent and Emergency Care Clinical Reference Group meet weekly over the winter period, providing strategic and clinical leadership and guidance whilst maintaining oversight of system pressures and risk.

5.1 System Co-ordination Centre

System Co-ordination Centres (SCC) were introduced across England in 2022 to ensure the safest highest quality of care possible for the entire population across every area by balancing the clinical risk within and across all acute, community, mental health, primary care, and social care services.

The Lincolnshire SCC ensures that there is robust oversight of all system pressures and is operational 8am – 8pm, 7 days per week, reporting to the ICB Deputy Director for System Delivery with escalation to the Director for System Delivery and Senior Responsible Officer for Urgent and Emergency Care. After 8pm a full operational handover to ICB Strategic and Tactical On Call Commanders ensures full visibility of pressures and risk going into the overnight period. On-call commanders in the ICB attend provider escalation calls throughout the overnight period as required for support in addition to usual escalation processes and are also able to rapidly convene system calls as required.

The Lincolnshire SCC lead on monitoring demand, capacity and pressure within the system as follows:

- ✓ **Daily system calls 0930 and 1300hrs, these facilitate early warnings of current and potential issues that are logged, and actions raised for that day.**
- ✓ **Level of escalation for each provider discussed on system calls, including reasons for level and how we can work as a system to de-escalate where necessary.**
- ✓ **Extra system calls added if continued high demand.**
- ✓ **Attendance at Regional Reporting and Escalation Call each day.**
- ✓ **Continued monitoring of demand using a range of digital options and dashboards including but not limited to SHREWD Resilience dashboard and East Midlands Ambulance Service arrivals screen to pre-empt any delays.**

DRAFT

In addition to the operational management of the system the SCC also have dedicated staff to help rapidly diagnose issues, complete lessons learnt through rapid cycles of improvement, this is a fundamental element of the SCC as we strive to improve our performance across the county and ensure our patients receive timely access to Urgent and Emergency Care.

The SCC continually monitors systems pressures through reviewing data and daily calls with system partners to review new and emerging risks. It has clinical leadership and Standard Operating Procedures to ensure consistent escalation into the ICB nursing and quality leads. In periods of escalation nursing and quality leads join system calls to provide clinical input and oversight. Over the winter period the SCC will continue to facilitate collaboration between system partners to enact resource sharing and resource flexing to increase flow out of acute settings.

5.2 Escalation and Assurance

The use of the NHS Operational Pressure Escalation Levels (OPEL) Framework and associated Action Cards are fundamental to the delivery of assurance and governance for our system. Managed by our System Coordination Centre through daily calls which provide a focal point of operational escalations and support and by working collaboratively with our system partners to resolve daily issues and challenges. Our SCC and partners utilise the framework to ensure the correct level of response and urgency which is vital to ensuring a consistent system response which can be benchmarked with other systems.

Executive level leadership for winter is in place with weekly oversight by our system Urgent and Emergency Care Leaders Group which is chaired by the ICB Winter Director for Lincolnshire. Our Chief Executive Officers, along with our Chief Operating Officers and ICB Winter Director meet twice weekly to consider Urgent and Emergency Care issues and oversee delivery and response as well as monthly updates by the Winter Director to the Service Delivery and Performance Committee during the winter season for oversight and assurance from our Non-Executive Directors.

DRAFT

6. Workforce

When we consider workforce we do this through two lenses, firstly how our workforce feel, particularly when under pressure and making sure they have the right support to remain well and in work and secondly how we will move our workforce around where needed if critical services are understaffed. Keeping our staff well this winter is part of supporting residents and patients across the system. All organisations are putting a strong emphasis on the importance of having wellbeing conversations with team members to support their physical and mental health and signposting them to our services across the system where necessary. We are providing the following support to our people:

- ✓ **Ensuring that managers are having the right conversations with their teams and signposting appropriately.**
- ✓ **Influenza and Covid 19 vaccinations will be made available to all eligible staff.**
- ✓ **Continuing to operate a hybrid way of working which includes, for those that can, a mixture of working from home and office based.**
- ✓ **Our system Wellbeing Hubs, provided by our Mental Health Trust have a range of support from financial wellbeing to mental health support and ideas for physical activity.**
- ✓ **Each organisation has an Employee Assistance offer which staff can access as well as Occupational Health services.**
- ✓ **We have a number of cultural ambassadors, Mental Health First Aiders and Mentors across the system who are all offering their support for one-to-one conversations where needed.**

We have a Memorandum of Understanding in place across the Lincolnshire health and care system which allows the sharing of workforce across individual organisations. This was used successfully during the Covid 19 pandemic and would be utilised again to mitigate against any potential escalation in demand or shortage of workforce.

DRAFT

7. Quality and Risk Management

People in our care as well as their families and carers deserve to be treated with kindness, dignity and respect and receive safe standards of care. There is a shared responsibility across all our services to ensure quality (patient safety, experience, and outcomes) and we are working with partners to:

- ✓ **Provide alternatives to Emergency Department attendance and admission, especially for those frail older people who are better served with a community response in their usual place of residence.**
- ✓ **Maximising in hospital flow with timely discharge regardless of the pathway a patient is leaving hospital or a community bedded facility on.**
- ✓ **Ensuring that all care settings have the basic standards of care in place based on CQC fundamental standards. This includes a project called 'Care and Comfort' which is improving the overall quality and safety of patient care and experience within our Emergency Departments and Urgent Treatment Centres.**
- ✓ **Working to ensure safe timely discharge out of Emergency Departments and out of hospital.**
- ✓ **Reviewing services and providing feedback to ensure quality is maintained.**

7.1 Risk Management

The system Urgent and Emergency Care programme maintains a risk register which is routinely reviewed as part of programme delivery but also in the context of winter, the Winter Director will have ownership of any risks in relation to this plan, overseen by the Urgent and Emergency Care Leaders Group.

DRAFT

As identified, there are several unknown variables now that are likely to be influential on the success of our winter plan and the ability of the system to deliver safe and effective care during the winter period. These include:

- Measuring the impact of rapid improvement initiatives across the system and whether they deliver the assumed improvement.
- The potential unquantified impact of GP Collective Action
- The position against Elective and Cancer Recovery plans.
- The emerging assumptions and projections around infectious diseases such as Influenza, Covid 19, RSV and potential impact of national threats such as Mpox.
- Met Office forecasting for excessive weather including:
  - The potential for flooding in Lincolnshire as a result of heavy rainfall
  - Cold weather periods and the impact of national changes to the eligibility for Cold Weather Payments, as a predictor of increased respiratory conditions.

As a result, the overarching risk remains:

'As a result of demand exceeding capacity and despite investment and service developments detailed within this plan, we may still be unable to mitigate against all risks, previously outlined, to ensure our patients receive safe, timely and accessible care'.

DRAFT

8. Communication

The Urgent and Emergency Care Winter Communications Plan for 2024/25 aims to co-ordinate the joined-up communications work already happening across Lincolnshire into a single point of reference for stakeholders. This iteration of the plan includes specific actions around the winter period and has been developed as a whole Lincolnshire NHS communications system, with all partners signed up to supporting and delivering the activities within it. Communication resources will originate both from system partners and the national team who produce dedicated winter campaigns and resources. The objectives of this plan are to:

- ✓ **Raise awareness of the wide range of services that are available across Lincolnshire.**
- ✓ **Prioritise the 'talk before you walk' message about seeking the right service for your care needs.**
- ✓ **Ensure that those who should be attending our facilities do so and are not dissuaded by messaging.**
- ✓ **Normalise the discharge conversation when in a hospital setting.**
- ✓ **Use staff communications to promote the patient safety message for improving Urgent and Emergency Care performance**
- ✓ **Put in place a trusted series of comms actions when the system is in an escalated position**
- ✓ **Using social marketing techniques to deliver a targeted behavioural change approach which will supplement our standard communications support**

Our communications delivery will adhere to the following principles:

- Speak as one local Lincolnshire voice.
- Seek to influence behaviour through behavioural change/social marketing techniques.
- Prioritise signposting to appropriate services.
- Ensure that staff well-being messaging is a key part of our communication.
- Ensure that mental health is a key part of our messaging.

Draft

This winter, we have segmented our approach into five key areas:

1. Talk before you Walk

Use of national '111 First' messaging and localised campaigns (including the use of local case studies) encouraging patients to seek the right service for their care need. This will include:

- Localised talk before you walk campaign using a series of local patient case studies to encourage people to think about their choices and behaviours in making a decision about how to access care
- Promoting use of the WaitLess App
- Educating the population to think pharmacy first
- Promoting the use of NHS 111/ NHS 111 online
- Promoting the mental health element of NHS 111, alongside other local emotional support helplines and walk in at mental health urgent assessment centre
- Working with primary care to highlight the most appropriate place/s to signpost patients to

2. Core communications approach

Including delivery of our Warning and Informing Emergency Preparedness Resilience and Response (EPRR) responsibilities and promotion of vaccination programmes, prevention, and self-care campaigns.

This will include use of national resources around the below, as well as internal and external communications, as required, around specifics Lincolnshire projects:

- Discharge communications - utilising Where Best Next and resources
- Admissions avoidance messaging
- Promotion of the vaccinations programme for both Covid19 and Influenza
- Promotion of the importance of looking after our own mental wellbeing
- Ordering medications early for Christmas and New Year Bank Holidays

DRAFT

3. Escalation management approach

Our reactive and escalation communications approach will be taken in line with system escalation levels, as described below:

<table>
<tr><th colspan="2">Operational Pressures Escalation Levels</th></tr>
<tr><td>OPEL 1 & 2</td><td>Messaging posted on social media in line with usual organisation and system social media plans. Plans to incorporate seasonal messaging, including:
• Promotion of the range of services that are available
• Promotion of Hay Lincolnshire and Night Light cafes
• Promotion of WaitLess
• Promotion of self-care
• Promotion of NHS 111 online and NHS 111
• Promotion of mental health helplines and urgent assessment centre
• Promoting pharmacies and what they can offer</td></tr>
<tr><td>OPEL 3</td><td>Messaging posted on social media as above, plus a slight reduction in organisational focused message, and increased posts on:
• Accessing services locally
• Discharge messaging – internally and externally
Where there is an identifiable specific cause of increased pressure, which public messaging can influence, unique social media content will be developed and shared.</td></tr>
<tr><td>OPEL 4</td><td>Messaging posted on social media as above and paid for targeted social media activity to be stepped up where there is prolonged pressures or industrial action and would be requested by Strategic Command meetings. Where there is a clear group/location needed to be targeted, communications colleagues to step this up sooner at their discretion.

System to stand down non-urgent messaging on social media and unite behind key messaging agreed with tactical/ops leads. This will incorporate any key asks of the public. Wider distribution through ICS partner channels e.g. local authority, fire, police, VCSE to be encouraged.

Social media response to be developed in line with the agreed key messages, may include a short clip from a designated spokesperson, image/text, infographic, stories – this will depend on time pressures and professional advice given by communications team.

Work with local media to push messaging.

Next Door to be used as an additional channel to reach specific neighbourhoods. We will offer proactive/reactive media interviews from representatives.</td></tr>
</table>

DRAFT

4. Data-driven behavioural change campaign

Using data and insight to develop a social marketing behavioural change campaign, focussed on those demographics and conditions which we know are driving significant attendances to our Urgent and Emergency Care services. We will extend the work we undertook in 23/24 on this element of our communications, incorporating the learnings from our campaign reporting process, updated data, intelligence gathered through an extensive public engagement exercise on Urgent and Emergency Care as well as our recent strategy engagement and insights database. We will continue to liaise with our involvement, informatics and public health colleagues in the development of this. This year we will again focus on the ages 0-4 as the highest attending group, but also include messages targeting 75-79 year olds, as this group is also known to be high attenders.

We will use creative and graphic elements developed as part of the 23/24 winter campaign to retain familiarity and recall but building upon these to incorporate updated intelligence and data for this winter, we will ensure we use the right messaging in the right style, via the right platforms and media to optimise our impact.

5. Staff communication

Internal communications will be incredibly important to us this year. We know that, together, our staff make up a significant proportion of the Lincolnshire population. They have a direct ability to impact performance, and of course they are also significant influencers across their peers, family and friends.

This year we will focus on two new aspects to our staff communications. These will complement the existing approach of informing and educating our staff regarding the winter schemes, performance and rationale for the winter plan.

The first is a greater focus on patient safety. We know this is a national emphasis this year, and it has always been at the forefront of our work in Lincolnshire. The difference this year will be the prominence of this messaging element alongside our performance information.

The second is the treatment of messaging to our staff. This year we will incorporate more 'story-telling' and emotive angles to our messages to staff. This again will work alongside our informative, succinct and action focused messages, but by introducing more emotive approaches which highlight the importance and impact of every single person's actions, and elevating the feel of personal responsibility and impact, we intend to test the response of our colleagues, adapting as we progress through the winter campaign.

DRAFT

9. Conclusion & Evaluation

Our winter plan will be monitored via our governance routes and operationally, daily, through the System Co-ordination Centre activities and specifically via:

- ✓ **System oversight through the Urgent and Emergency Care Partnership Board and associated sub governance groups**
- ✓ **Weekly live oversight of the winter period via the Urgent and Emergency Care Leaders Group, chaired by our Winter Director, with escalation where required.**
- ✓ **Ongoing monitoring of Demand and Capacity to understand performance and delivery over the winter period and the impact of existing, planned and any further initiatives and change.**
- ✓ **Performance and Planning Group review of performance and activity including impact of interventions monthly.**
- ✓ **Urgent and Emergency Care Partnership Board review of the Urgent and Emergency Care performance dashboard monthly.**

This winter plan sets out the starting point for the management of winter 2024/25 in Lincolnshire across the health and care system. We acknowledge that our assumptions around demand and the impact of the planned initiatives and interventions may not be completely accurate at this point, but we will ensure ongoing dynamic review of demand, capacity, and impact of interventions.

We will utilise all available resource to ensure that we are delivering safe and accessible services to our patients and that we improve their experience and outcomes. The Urgent and Emergency Care programme governance will ensure that there is robust oversight of the delivery of this plan, with both strategic and clinical leadership and guidance. We will review the plan early next year to ensure we can identify the learning and impact in preparation for winter 25/26 and to secure ongoing service development and improvement for our population.

DRAFT

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Hospitals NHS Trust

Group Winter Plan and H2 priorities

1 Nov 2024- v5.1

Executive Summary (1 of 2)

This paper provides an overview of where we are at month 6 from an operational annual plan perspective and the key actions we are taking in H2 to bring us back on track against our 2024/25 plan.

NHSE will stand-up the Winter operating function from 1st November 2024. In preparation for this, Trusts were asked to:

- Review general and acute core and escalation bed capacity plans.
- Review and test full capacity plans.
- Ensure the fundamental standards of care are in place in all settings at all times.
- Ensure appropriate senior clinical decision-makers are able to make decisions in live time to manage flow.
- Ensure plans are in place to maximise patient flow throughout the hospital, 7 days per week

Each winter, the health service faces significant challenges due to increased pressures across all parts of the system. Effective and comprehensive planning is essential to maintain resilience and ensure continuity of care during these demanding times. 24/25 Winter plan is attached in appendix 1.

Activity

- In line with system ambition in 24/25 ULHT submitted a plan to deliver 113% (monetary value) of 2019/2020 activity. At the end of month 6, we are £113k ahead of plan (CIP) slides 5-7)

- ULHT activity target was to achieve 130% exit against 19/20 for elective recovery by the end of the year (for all divisions except surgery which was 115%) and 25% reduction for follow ups without a procedure.

- We are behind plan and under significant pressure to improve, we are focusing on key specialties to drive activity forward through. The system and ULHT have built the delivery of the ERF target into their financial plans. Any deviation from the planned activity targets will directly impact the financial position of the system and ULHT. This delivery and expectation of additional ERF income forms part of the CIP programme in both the system and ULHT. Based on current activity performance the step up to the targets in H2 will present a significant challenge for the divisions. LCHS is on plan to delivery its CIP.

- Productivity is intrinsically linked to activity and a key priority across multiple improvement programmes (outpatients, productive theatres and medical workforce), operational leadership and financial recovery.

- To support the triangulation of productivity within ULTH improvement programmes we are establishing a Productivity Steering & Oversight Group to support and escalate points or actions from Productive Theatres Oversight Group, Outpatient Recovery & Improvement Group, Workforce Steering Group and Temporary Staffing Solutions Group. This grow will evolve naturally to include operational, financial and corporate productivity items.

Executive Summary (2 of 2)

Workforce

- ULTH is outside of plan for substantive, bank and agency staff, with an overall total workforce of -168.55 WTE against plan (taking into account substantive, bank and agency).
- LCHS is within plan for substantive, bank and agency staff, with an overall total workforce of 34.58 WTE against plan. (slides 13-14)

Finance

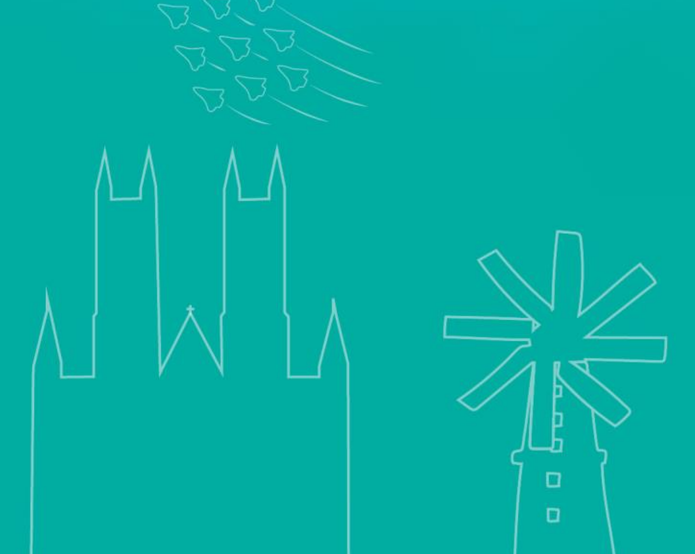
- The Group's financial plan for 2024/25 is a deficit of £6.9m. At the end of month 6, the Group is reporting a deficit of £19.1m or £7.4m adverse to plan. (slides 12.-13)
- The Group's CIP plan for 2024/25 is deliver savings of £47.1m (or £51.1m including stretch). At the end of month 6, the Group is reporting savings delivery of £18.5m or £2.2m favourable to plan.
- The Group's capital plan for 2024/25 is a capital programme of £83.5m. At the end of month 6, the Group is reporting capital spend of £29.9m or £0.9m adverse to plan.
- Demand and capacity aspects covered via winter plan

Maintaining patient safety and experience

- We continue to make progress against the patient safety requirements as set out in the operational planning guidance with a focus on quality and safety based on approach set out in the Shared Commitment to Quality, Patient Safety Strategy and applying Patient Safety Incident Response Framework (PSIRF) (slides 14 / 15).
- **Long patient delays and patient safety issues** - Monthly incident reports are produced across LCHG that are presented at the monthly Patient safety group and upwardly reported into the Quality Committee in Common. The incident report for ULTH includes all incidents that may have occurred as part of a clinical delay, for example a 12 hour ED wait and if harm has been caused these incidents are reviewed via our PSIRF processes. The committee are also sighted on regular performance reports as per business as usual.
- **Fundamental standards of care -** Fundamental standards of care are in place across the Group, for assurance the Matron's and Ward/Department leads undertake weekly and monthly audits alongside the annual ward/department review visits as part of the Quality Accreditation Programme.

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Hospitals NHS Trust

Activity



2024/25 ULTH Activity Submission

The Trust is planning to deliver 113% of 2019/20 activity (financial value)

Electives	19/20^	23/24*	Total 24/25	24/25 H1 Actuals	24/25 H1 Plan
Total number of specific acute day case spells	44,299	62,993	65,783	33,508	31,587
Total number of specific acute elective spells	7,029	7,061	8,521	3,990	4,091

Outpatients	19/20^	23/24*	Total 24/25	24/25 H1 Actuals	24/25 H1 Plan
Total outpatient attendances (all TFC; consultant and non consultant led)	615,899	668,867	673,988	358,201	340,058
Consultant-led first outpatient attendances (Spec acute)	168,368	168,156	190,206	88,432	89,813
Consultant-led follow-up outpatient attendances (Spec acute)	277,190	268,953	290,717	144,857	152,619
Outpatient procedures - ERF scope	119,973	125,570	141,082	69,117	72,788
Outpatient first attendances without a procedure - ERF scope	191,041	193,737	201,639	101,796	95,124
Outpatient follow up attendances without procedure - ERF scope	293,102	315,638	286,841	169,390	155,202

A&E	Mar-24	Performance By March 25	Sep-24
Type 1 A&E Performance	35.20%	50.70%	39.32%
Type 3 A&E Performance	91.70%	91.60%	92.47%
All Type A&E Performance	72.50%	78.00%	74.35%

Cancer	Feb-24	Performance By March 25	Sep-24
62 Day Standard	53.90%	70.30%	
28 Day Waits	74.60%	77.00%	

RTT	Feb-24	Trajectory	Sep-24
52 Week Waits	2,768	0 by March 2025	2949
65 Week Waits	399	0 by May 2024	388

^ 19/20 based on ERF applicable specialties / baseline - Therefore not all specialties included

* Based on 23/24 M12 SLAM actuals, HRGs & 0 Price tarrif not taken into account within OP Proc split

All periods - Daycase figures include Bowel Screening

All Periods - Based on activity submitted to SUS therefore Therapies and Diagnostic Imaging not included

- Daycases, OP 1sts and OP Fups (non-procedure) are behind plan (day cases and OP 1sts too little, OP FUps too much)
- Elective activity just ahead of plan
- All suffered a little from industrial action and August reduction in activity levels
- Concern at all PODs as activity increases in H2 from H1, especially with winter pressures
- Further work around re-introducing further faster approach, looking at weekly increments of activity from previous week with drive through Divisions (notwithstanding other operational pressures such as ED and 65 weeks)
- ED behind trajectory for performance, sprint actions taking place over previous few weeks to address 4 hour performance, total waits in department under 12 hours and ambulance handovers
- RTT - didn't clear 65 weeks by September 2024 deadline, revised trajectory expected clearance by December 2024, albeit ENT and Gastroenterology remain areas of concern

Next Steps: Activity Plan 24/25 and 25/26

- We have commenced planning for next year as part of our continuous planning process.

- In lieu of any national guidance, the initial plan for 2025/26 was set to match the total overall activity plan for the full 24/25 financial year. Whilst this matches the overall planned activity levels for 24/25, it does not take into account the phasing of 2024/25 planned activity which is expected to increase as we move through the year.

- Based on current activity levels we need to have focussed approach to drive delivery in order to achieve the overall planned activity target set for 24/25 (based on SLAM actuals and only ERF Pods & Specs).

- The below table shows the variation in performance across the divisions for H1 of 24/25. The percentages indicate the extent to which the activity target is met. The full year targets set for 24/25 were based the divisional plans which in some cases were uplifted based higher historical activity levels. A phasing profile was applied to the 24/25 plan to achieve an exit of 130% of 19/20 in M12 (115% exit for Surgery). Based on current activity levels only CSS look likely to achieve the M12 in month target. The table below shows whilst the trust has hit the 24/25 plan for H1, it is unlikely to hit either the H2 or full year targets due to the phasing of the plan. The ranges shown within the H2 and overall columns take into account that historically more activity is undertaken within the second half of the financial year.

	H1 Actuals	Likely Performance Against 24/25 Planned Activity	
Division	**H1 (M1-6)**	**H2 (M7-12)**	**Overall Full Yr**
Surgery	No (92.1%)	No (83.3%-87.5%)	No (87.5% - 89.7%)
Medicine	Yes (111.7%)	Maybe (97.5%-102.4%)	Yes (104.1%-106.7%)
Family Health	No (90.2%)	No (82.6%-86.7%)	No (86.2%-88.4%)
CSS	Yes (120.4%)	Yes (117.7%-123.6%)	Yes (119%-122%)
Trust	**Yes (100.3%)**	**No (90.7%-95.3%)**	**No (95.3%-97.6%)**

- Based on the activity targets set this translated into an overall financial of 113% average delivery on ERF for the year. The system and ULHT have built the delivery of this financial target into their financial plans. Any deviation from the planned activity targets will directly impact the financial position of the system and ULHT. This delivery and expectation of additional ERF income forms part of the CIP programme in both the system and ULHT.

- Based on current activity performance the step up to the targets in H2 will present a significant challenge for the divisions.

25/26 Planning

- The first cut activity for 25/26 is inclusive of any productivity improvements the divisional teams indicated they could achieve. This includes any reductions in DNA rates and improvements in both outpatient slot and theatre utilisation.

- Collation of divisional cut 1 returns show that the overall trust position for the first cut of 25/26 is above both current activity levels (forecast outturn) and the overall position last year (23/24 Actuals). This is the case for both Inpatient and outpatient pods.

- For inpatient pods, the overall 1st cut is broadly in line with the initial ask (combining DC & EL spells). While OP 1sts are above the initial ask, OP FUPs with a procedure are under target by a greater variance. Overall the 1st cut of activity is slightly under the initial ask for the ERF pods & specialties.

2024/25 LCHS Activity Submission (source: 24/25 Planning Submission)

Virtual ward capacity

				Jan-24	Plan Basis	Apr 2024-Mar 2025 Average	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Virtual ward capacity	E.T.5	Numerator	The number of patients on the virtual ward	130	Plan	145	138	138	138	138	138	138	138	155	155	155	155	155
					Actual	97	88	100	100	102	95	96						
	E.T.5	Denominator	The number of patients that the virtual ward is able to simultaneously manage	169	Plan	172	172	172	172	172	172	172	172	172	172	172	172	172
					Actual	145	138	132	133	142	142	182						
	E.T.5	Percentage	Virtual ward occupancy	76.92	Plan	84.35	80.23	80.23	80.23	80.23	80.23	80.23	80.23	90.12	90.12	90.12	90.12	90.12
					Actual	66.86	63.77	75.76	75.19	71.83	66.9	52.75						

Staffing capacity on the Wards makes for lower numbers to be able to be handled - for example, Frailty is 40 but cannot safely handle more than 20 patients. Sometimes seasonal changes can cause lower referrals into services also. We are currently working on 172 beds but the funding will not cover this.

Community beds occupancy - Community Hospitals + Transitional Care

				Plan Basis	Apr 2024-Mar 2025 Average	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Community beds occupancy	E.T.6	Numerator	Community beds occupied	Plan	184	187	183	184	172	175	176	177	189	189	189	192	189
				Actual	140	143	140	138	140	139	138						
	E.T.6	Denominator	Community beds available	Plan	200	210	200	200	195	195	195	195	203	203	203	203	203
				Actual	155	157	153	154	155	157	156						
	E.T.6	Percentage	%	Plan	91.56	89.05	91.5	92	88.21	89.74	90.26	90.77	93.1	93.1	93.1	94.58	93.1
				Actual	89.94	90.89	91.64	89.87	90.22	88.57	88.48						

Bed occupancy fell slightly short of target but if admissions accepted but not arrived until the day after this figure would be above 90%. Were transport to be booked more proactively more admissions would arrive the same calendar day that they were accepted. Whilst Community Hospitals do 'pull' patients from the Acute the most effective services to fill occupancy are the referring services, the Acute hospitals

Community services waiting list

				Sep-23	Plan Basis	Apr 2024-Mar 2025 Average	Quarter 1 2024/25	Quarter 2 2024/25	Quarter 3 2024/25	Quarter 4 2024/25
Community services waiting list	E.T.2	Count	Community services waiting list	2375	Plan	5694	5694	5694	5694	5694
					Actual	5358.5	5626	5091		
	E.T.2a	Count	Number of CYP (0-17 years) on community waiting lists per system	1501	Plan	2384	2384	2384	2384	2384
					Actual	718	720	716		
	E.T.2b	Count	Number of Adults (18+ years) on community waiting lists per system	874	Plan	3310	3310	3310	3310	3310
					Actual	4640.5	4906	4375		

Our NHSE submission also now goes through a sign off process that involves the deputy divisional leads so they have sight on the figures every month. At the beginning of the financial year, we had 2327 breached waits, at the end of Q1 we had 1029 and now we have 943. Our longest waiter has dropped from 68 weeks in April to 58 weeks. The average wait has dropped from 7 weeks to 5 weeks

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Hospitals NHS Trust

Workforce

2024/25 ULTH Workforce Submission (as at M06)

Total of Establishment, Substantive Staff in Post & Total Workforce (inc. Bank and Agency)	Baseline				
	Outturn	Estb'mnt	Plan M06	Actual M06	Variance Plan v Actual M06
	Mar-24	Mar-24	Sep-24	Sep-24	Sep-24
Total Establishment (Funded)	9,134.36	9,134.36	9,218.76	9,617.74	-398.98
Total Workforce (Actual)	9,492.99	9,134.36	9,454.11	9,622.66	-168.55
Substantive staff	8,522.10	9,134.36	8,765.15	8,858.90	-93.75
Bank staff	743.15	0.00	493.22	608.68	-115.46
Agency staff	227.74	0.00	195.74	155.08	40.66

Substantive 'Actual' Staff in Post (by Staff Group)	Baseline				
	Outturn	Estb'mnt	Plan M06	Actual M06	Variance Plan v Actual M06
Substantive:	Mar-24	Mar-24	Sep-24	Sep-24	Sep-24
Registered Nursing, Midwifery and Health visiting staff	2,464.83	2,482.06	2,541.10	2,639.88	-98.78
Registered/Qualified Scientific, Therapeutic and Technical Staff	813.21	980.60	812.95	862.51	-49.56
Support to Clinical staff	2,081.33	2,218.78	2,092.43	2,079.67	12.76
NHS Infrastructure Support	2,094.37	2,311.37	2,228.32	2,146.12	82.20
Medical & Dental	1,068.36	1,141.55	1,090.35	1,130.73	-40.38

- ULTH is outside of plan for substantive, bank and agency staff, with an overall total workforce of -168.55 WTE against plan (taking into account substantive, bank and agency).
- There has been a reduction in agency use of c.40.66 FTE across the Trust which is a positive position.
- Bank use has not reduced at the level originally outlined in the workforce plan (as at the June 2024 submission).
- It should be noted that the 'Total Establishment (Funded)' shows a plan which is and estimated profile in equal twelfths for indicative purposes.
- Across the Staff Groups, there has been increases in the majority of clinical Staff Groups with:
  a) 98.78 FTE more Nursing/Midwifery against plan
  b) 49.56 FTE more Registered/Qualified STT against plan
  c) 40.38 FTE more Medical & Dental staff against plan which is largely due to an increased number of Junior Drs within August 2024.
- It should be noted that the variance to plan within ULTH is as a result of delays to confirmed investment approvals within the System, and the plan not included all at the point of submission. This is being monitored locally alongside Finance and the System.

2024/25 LCHS Workforce Submission (as at M06)

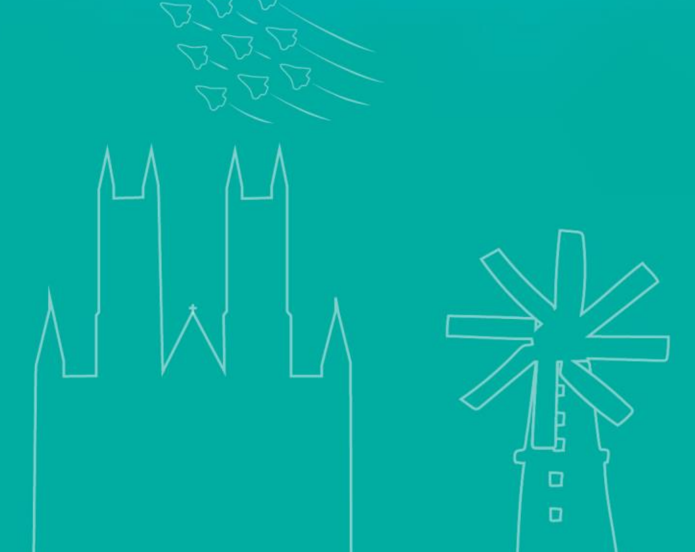
Total of Establishment, Substantive Staff in Post & Total Workforce (inc. Bank and Agency)	Baseline				
	Outturn	Estb'mnt	Plan M06	Actual M06	Variance Plan v Actual M06
	Mar-24	Mar-24	Sep-24	Sep-24	Sep-24
Total Establishment (Funded)* (does not include bank & agency)	2,156.93	2,156.93	2,103.37	2,103.37	0.00
Total Workforce (Actual)	2,127.43	2,156.93	2,113.20	2,078.62	34.58
Substantive staff	2,011.40	2,156.93	2,030.46	2,009.97	20.49
Bank staff	86.95	0.00	63.42	57.92	5.50
Agency staff	29.08	0.00	19.32	10.68	8.64

Substantive 'Actual' Staff in Post (by Staff Group)	Baseline				
	Outturn	Estb'mnt	Plan M06	Actual M06	Variance Plan v Actual M06
Substantive:	Mar-24	Mar-24	Sep-24	Sep-24	Sep-24
Registered Nursing, Midwifery and Health visiting staff	711.60	810.09	752.10	753.10	-1.00
Registered/Qualified Scientific, Therapeutic and Technical Staff	310.00	329.45	319.11	311.49	7.62
Support to Clinical staff	578.90	515.82	541.50	540.25	1.25
NHS Infrastructure Support	389.60	470.57	395.00	383.72	11.28
Medical & Dental	21.30	31.00	22.75	21.27	1.48

- LCHS is within plan for substantive, bank and agency staff, with an overall total workforce of 34.58 WTE against plan.
- There has been a reduction in support to clinical staff and increase in nursing and midwifery due to a number of IEN's successfully achieving their OCSEs, resulting in changes to the staff group. This was built into the plan.
- There has been a slight reduction in NHS Infrastructure support where a number of fixed term posts have ended and corporate staff have left the Trust and not been replaced as we transition into the group model.
- The vacancy control process is impacting on timescales for recruitment into a number of roles, which has contributed to being below planned numbers.

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Hospitals NHS Trust

Finance



Financial Plan 2024-25 : Key Metrics

Key Metric:	LCHS	ULTH	Group Total	Month 6 position
Income & Expenditure Plan 2024-25	£0.0m Breakeven	£6.88m Deficit	£6.88m Deficit	£7.4m YTD adverse to plan
CIP Target (5%)	£7.0m	£40.1m	£47.1m	£2.2m YTD favourable to plan
CIP Plans Identified £	£3.0m	£34.2m	£37.2m	
CIP Plans Identified %	43%	85%	79%	
Unmitigated Risk (2024-25 Excess inflation)	£7.0m	£6.4m	£13.4m	
Capital Plan	£3.9m	£86.7m	£90.6m	£0.9m YTD adverse to plan
Capital Committed Range	£3.9m	£77.1m - £80.7m	N/A	
Capital to be Prioritised Range	£0.0m	£9.6m - £6.0m	N/A	

- The Group YTD financial position is **£7.4m adverse to plan** (driven by ULTH's position):
  - **£4m system planning pressure**; £16m planning gap at start of the year of which circa £5m has been addressed, leaving a residual pressure of £11m (£4m YTD).
  - **£0.8m pay pressure linked to UEC nursing review** that was anticipated to be funded from the system risk pool (held by the ICB); the £4.1m risk pool is made up of contributions from ULTH (£3.0m), LCHS (£0.5m) and LPFT (£0.6m); the UEC investment is incurring in the run-rate, and funding needs to be resolved.
  - **£0.8m pay pressure linked to investment in cancer services;** this investment is not built into the financial plan.
  - **£0.5m shortfall in Industrial Action Funding**; national funding for Industrial Action is below actual costs resulting in a non-recurrent pressure.
  - **£2.6m of other pay pressures**; majority (£2m) of the pressure is within Medical Workforce.
- Mitigating actions (following a review of the baseline forecast to ensure appropriateness):
  - **Resolve residual system planning gap of £11m** to improve both the year-to-date & year-end positions (as well as cash).
  - **Resolve the release of funding from the risk pool re UEC nursing review** to improve both the year-to-date position year-end positions (as well as cash).
  - **Develop appropriate proposals to access the remaining risk pool balance** to support the Trust in key areas of overspend.
  - **Deep dive into current CIP schemes** to maximise benefits in 24/25.
  - **Assessment of ERF potential** in year to go, maximising income available.
  - **Overview of grip and control** across the Group.
  - **Detailed pay review focusing on productivity**.
  - **Assessment of potential non recurrent actions** to support in year performance.

Financial Planning: Summary

- The trust previously submitted a Mid Term Financial plan covering 23-24 to 25-26 with a £18m deficit assumed for 24-25.
- From the **2023-24 deficit of £20.8m**, an assessment was made of our underlying position, incorporating cost pressures arising in 2023-24, which results in an underlying exit position of £35.0m (UDL). The ICB have agreed to fund excess inflation for 23-24, which reduces the underlying position to **£29.8m Deficit**.
- Following the receipt of the national finance & contracting guidance, the technical planning assumptions differ from those assumptions made in the MTFP. These technical adjustments have been applied to the UDL and consideration has been given to planned pressures which will have an impact on 2024-25.
- Before CIP targets are applied, this results in a £46.89m planned deficit. After a target of **£40.1m CIP** is applied **(5%)**, this results in a **Final 2024-25 Plan of £6.88m deficit**.
- The plan is aligned and triangulated with the workforce plan, specifically relating to any additional investments.
- The plan excludes any investments which have not been approved through the Lincolnshire Investment Panel. This process is ongoing, and resolution is expected by the end of May 24. This does present a risk in the system and to the trusts financial plan.
- The CIP plan includes a 50/50 gain share approach with the ICB to the net benefit planned for the delivery of the **113% ERF** activity modelling for 2024-25. Marginal costs to deliver the elective activity plan have been included and agreed with the ICB.
- No growth funding has been assumed for the Non-Elective services in 2024-25. This will be monitored in year and raised via the contract route with the ICB if significant growth is seen. This is consistent with the approach across the Midlands.
- Matched income & cost has been included for the two nationally funded investments (in line with the expected revenue allocations) for CDC's & EPR.
- The trust has contributed to a 0.5% Risk Pool in line with the Lincolnshire Financial Framework. This risk pool has been held at the ICB & ringfenced in the system plan. This funding will be allocated on a criteria basis in year.

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Hospitals NHS Trust

Patient Safety Elements of Planning Guidance

2024/25 Priorities and Operational Planning Guidance

	24/25 Planning Guidance Requirement	Group Position at month 6
1	Focus on quality and safety based on approach set out in A Shared Commitment to Quality.	Review to be undertaken to assess the current position across the group. System work required and conversations have begun regarding this.
2	Focus on quality and safety based on approach set out in the NHS Patient Safety Strategy.	LCHG gap analysis presented at a Board briefing session in June 2024 and a further updated taken to the Quality Committee in Common in October 2024. This demonstrated that the Group are mostly delivering against target with further work being overseen by the Patient Safety Group.
3	Applying the Patient Safety Incident Response Framework (PSIRF) in the development and maintenance of patient safety incident response policies and plans.	Complete – both LCHS and ULHT have implemented PSIRF. A Joint Group Policy has been approved. There are individual plans for 2024/5 with a view to having a joint plan for 2025/6.
4	Complete NHS IMPACT self-assessment and use this to crease a shared, measurable plan for embedding quality improvement.	ULHT self- assessment undertaken during 2023/24. A strategy linked to the NHS Impact Assessment is currently being developed. Work underway to determine LCHS position.
5	Robust governance and reporting frameworks in place. The Insightful Board guidance to be published shortly.	Review when guidance published.
6	Embed a robust quality and equality impact assessment (QEIA) process.	The QIA panel is now convened across the Group with work underway on a Group Impact Assessment Policy and alignments with both QIA/EHIIA into a single oversight process with Group Chief sign off.
7	Improve engagement of patients and families in response to incidents.	ULTH have appointed a 0.6wte FLO who commenced in post in September 2024. This appointment will strengthen the patient / family engagement as part of the PSIRF process. This role is currently under review to establish the needs within LCHS and this will be progressed through the Clinical Governance Directorate in due course.
8	Use the new Learn from Patient Safety Events (LFPSE) to support learning.	Both LCHS and ULHT have implemented LFPSE. Further work needed to ensure that it is used to full potential. To date, no national reports published by LFPSE.
9	Support the uptake of training under the new Patient Safety Syllabus.	Level 1 and Level 2 training is now mandatory across LCHG. Level 1 and 2 training is live on ESR at LCHS and compliance is being monitored. Level 1 training is live on ESR at ULTH however awaiting level 2 training to be uploaded onto the system.
10	Ensure the patient insight is embedded by appointing at least 2 PSPs to safety-related governance committees.	There are now 6 PSP's working across LCHG. Two PSP's have now progressed to level 4 and attend the Quality Committee in Common on a monthly basis.

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Hospitals NHS Trust

Winter Bids

LCHS Winter Plans

Context

The Winter plan sets out the activity LCHS is taking to ensure there is alignment between Winter and Operational Plans and is also aligned to the Urgent and Emergency Care Recovery Plan and Identified High Impact Interventions. LCHS is in the second year of the NHS England published Urgent and Emergency Care Recovery Plan underpinned by an extensive programme of work to deliver improvements across urgent and emergency care ahead of winter. The 24/25 Winter Plan, along with the NHS's primary care and elective recovery plans, and the broader strategic and operational plans and priorities for the NHS, provides a firm basis for preparing for the 2024/25 Winter period.

Despite recent improvements and ongoing transformation work, the UEC pathway remains fragile. While systems and providers are undertaking significant programmes of work to recover and improve services, there is a collective responsibility to ensure that the NHS in England has plans in place to remain as resilient as possible and respond to operational pressures this winter.

To address the NHSE Winter Operating Function, LCHS are undertaking the following:
The three key system priorities are community pathways, ambulance conveyance and accelerated discharge. All actions directly or indirectly also support the system 4-hour performance of urgent care pathways/EMAS Category 2 response mean time and 12 hour waits in Emergency Departments. LCHS services will support these system priorities through the following activities:

- Single point of access and call before convey.
- Community response and in-reach teams to ensure timely discharge of patients from the acute trust.
- Maximising admission avoidance activity through Community Therapy, Community Nursing, the Clinical Assessment Service (CAS) and Urgent Care Home Visiting including Urgent Community Response team.
- Proactively managing the anticipated rise in demand at the Urgent Treatment Centres.
- Providing operational leadership to manage local capacity and escalations relating to patient flow across the system.
- Dynamic management response to any potential demand exceeding capacity within Community Hospitals.

Health Inequalities

The ICB Health Inequalities and Prevention Team are gathering proposals for investment, assessing these proposals, and recommending to system leadership which investment proposals will be most effective in increasing prevention and reducing inequalities. A number of proposals were submitted from the Group and 2 were selected to progress to the next stage in the process which requires completion of a business case and FSIP proforma to be submitted by the Health Inequalities team as part of the 25/26 planning process.

The two proposals are as follows:

- Reduction of Outpatient Did Not Attend (DNA) due to health Inequalities – following a successful pilot in ENT, funding would allow ULHT Outpatients to continue this work across all specialties with a high DNA rate by employing a team to telephone patients, targeting those most likely to DNA their Outpatient appointment inequalities across Lincolnshire, confirm and rebook where appropriate, and utilise vacant slots. The ICB team have suggested our bid is increased to a funding envelope of £150k in year 1 and the business case is currently being written.

- Pop-up one stop health and social care bus stops - bringing care closer to home and promoting better health and prevention in a 'one stop shop, brought to you' – the ICB have asked the LCHS Integrated Community Partnerships Team to work with two teams in the ICB to combine this proposal with ones related to weight management and childhood vaccinations within a total funding envelope of £500k in year 1. Teams are working on this currently.

Divisions who submitted other proposals have been advised to consider these against the investment criteria and if appropriate, submit these via the 25/26 planning process.

LCHS Winter Bids

LCHS has submitted the following winter funding initiatives:

- Introduction of 7-day therapy in community hospitals. During Winter 23/4 this reduced average length of stay to below the annual average and smoothed out discharges by reducing the traditional Friday surge. This will be of increased importance for Winter 24/25 where Community Hospital Occupancy rates are higher, fluctuating around the 95% mark, and there has been an increase in patients with specialist therapy needs. Estimated cost of £328k.

- Two-day post-discharge pharmacy support. Reduces readmission, improves recording of medications stopped and changed. Targeted at patients discharged on high-risk medicines, 4 or more medicines, aged 65 or higher, suffering from conditions requiring time-criticaledicines, or have had a hospital admission in the last 6 months. Estimated cost of £82k.

- Establishment of 11 WTE staff (8 x B4 practitioners, 3 x B6 therapists) to increase Pathway 1 capacity. This will build resilience, increase capacity for care visits and reduce length of stay by increasing capacity for additional care plan reviews.

- Assisted Discharge Offer 24/7. Either targeted discharge support for ward areas or direct deployment of staff to ED, both supporting patients post-discharge for up to 72 hours. Estimated cost of £64k.

- Increase community flow manager to 7-day cover. This will support an increase in flow at weekends to reduce length of stay and support weekend discharges. This was proven to work in Winter 23/24. Estimated cost of £83k.

- On-site Community Support Officer for Lancaster Ward. Provides additional health and social care input to support patients who are medically fit for discharge, but are unable to take their next transfer to a place to continue their care plan. Estimated cost of £600k to £1.1m depending on the chosen delivery option.

ULHT Winter Bids

ULHT has submitted the following winter funding initiatives:

- Respiratory and Cardiology Hot Clinics bid submitted to the ICB (to stay under £500k)

- Medicine division opening 7A at Pilgrim. Funds ringfenced for this for 5 months (ward didn't close until May this year so we've only got funding for 4 months now). Result is additional 16 beds, and operate as a Frailty Assessment Unit.

- Funding from ICB to staff the clinical transfer team to reduce waits in ED.

- Funding to support the H&N weekend working initiative, to support with patient flow.

Attached winter plan in Appendix 1

Integration Committee Terms of Reference

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

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*5th November 2024*
Item Number	*11.1*

Integration Committee Terms of Reference

Accountable Director	*Daren Fradgley, Group Chief Integration 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:-* • *Approve the draft Integration 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	*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

Integration Committee
Terms of Reference

1. Authority

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

The Integration 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.

DRAFT

2. Purpose of the Committee

The Integration Committee exists to scrutinise the robustness of and provide assurance to the Trust Boards on delivery of the group's transformation & integration agenda, aims and objectives – both internally within ULTH & 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 too Mental Health, Primary Care, Third and Voluntary Sector organisations.

The Integration Committee with 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 & facilities.

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

Strategic Aim 1: Patients

Strategic Objectives:

- 1d: Deliver clinically led integrated services

Strategic Aim 3: Services

Strategic Objectives:

- 3c: A modern, clean and fit for purpose environment across the Group

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

Strategic Objectives:

- 4a: Establish collaborative models of care with our partners including Primary Care Network Alliance (PCNA)
- 4b: Successful delivery of the Acute Services Review
- 4d: Enhanced data & digital capabilities

Strategic Aim 5: Population

To embed a population health approach to improve physical and mental health outcomes, promote well-being, and reduce health inequalities across an entire population

Strategic Objectives

5a: Develop a Population Health Management and Health Inequalities 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

The Integration Committee will 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

DRAFT

- Regeneration plans with partners
- Anchor institution

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)**
- Non-Executive Director (LCHS)
- Joint Associate Non-Executive Directors
- Group Chief Integration Officer / Deputy Group Chief Executive **(group executive lead for the committee)**
- Group Chief Operating Officer
- Group Chief Finance Officer
- Group Chief Medical Officer OR Group Chief Nurse
- Group Director of Estates & Facilities

The following roles will be routine attendees at the Committee:

- Group Director of Corporate Affairs / Trust Secretary & / or deputy
- PCNA Representative

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 two group Executive Directors (or their formally appointed deputies).

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.

DRAFT

5. Frequency

The Committee will meet monthly.

6. Specific Duties

The Integration Committee will:

- Agree a set of Key Performance Indicators to be presented in the committee Performance Dashboard monthly with exception reporting as the norm.
- Through the receipt of upward reports from relevant reporting groups, have oversight and scrutiny of the functions for which they have delegated responsibility from the Integration Committee.
- Consider progress with and risks to delivery of the group's integration agenda & objectives and provide assurance to the Trust Boards that such risks are being effectively controlled and managed and / or escalate such risks to ensure timely and appropriate mitigating actions are put in place. Where appropriate, the committee may seek to request deep dives are undertaken to identify the required improvement and actions.
- Receive assurance that all appropriate actions are being taken to ensure full participation in population partnership initiatives and programmes of change and, in turn provide assurance to the Trust Boards on the robustness of delivery plans. This will include the receipt of plans for the continued development of Community Primary Partnership(s) over time supporting both Place and group strategies and seeking assurance on the robustness of plans to increase the range and scope of the Community primary partnership(s), anchor partners work and the group's role within them.
- Seek assurance on the adequacy of plans to realise the group's ambition of addressing the wider determinants of health and health inequalities.
- Seek assurance for the operational performance and delivery of Out of Hospital Services delivering on Integrated Care..
- Ensure that proposed changes to services are being made on the basis of strong clinical evidence and best practice.
- Seek assurance in respect of delivery of the group's digital agenda and objectives including development of the 'Vision for Information'.
- Review and seek assurance on delivery of the estates strategy, priorities and compliance with relevant statutory requirements.
- Ensure that key enablers to the delivery of the integration agenda are properly considered as part of the agreement of the group integration plan and programmes of work and that these plans and programmes of work are appropriately aligned to the longer term strategy, vision and values for the group.
- 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

DRAFT

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 committee Chair and the Group Chief Integration 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 5 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

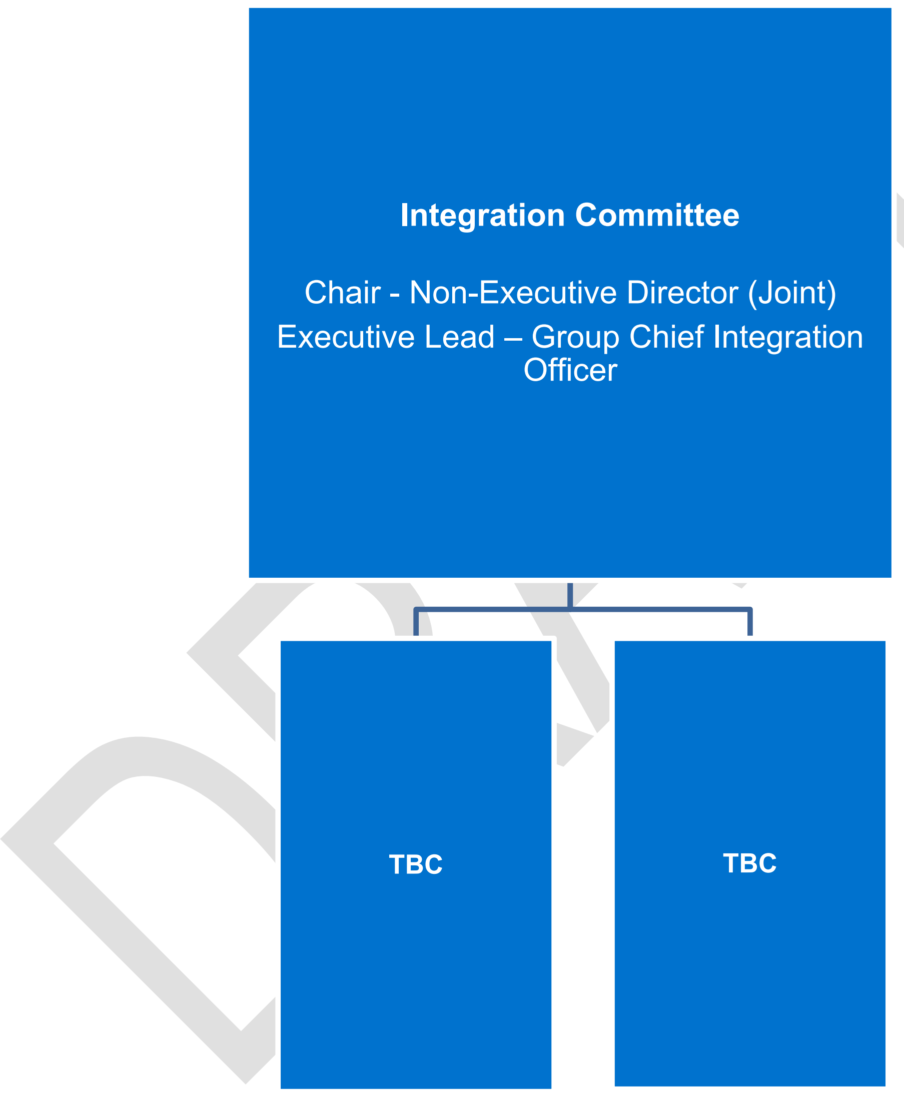
The Terms of Reference for the committee will be reviewed annually by the committee and submitted to the Trust Boards for approval and, together with the work plan, will be reviewed at each meeting of the committee to ensure they remain fit for purpose.

DRAFT

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

DRAFT V1

Lincolnshire Community & Hospitals NHS Group:
United Lincolnshire Teaching Hospitals NHS Trust (ULTH)
Lincolnshire Community Health Services NHS Trust (LCHS)

Integration 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		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		Monthly	X	X	X	X	X	X	X	X	X	X	X	X	Noting
Integration Committee Performance / KPI Dashboard		Written	Group Executive Lead(s)		Monthly	X	X	X	X	X	X	X	X	X	X	X	X	Discussion
Topical, Legal & Regulatory Update		Verbal / Written, as required	Group Director of Corporate Affairs		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	As required	**To be added to the agenda as required**												Discussion
Matters to be referred to other Board Committees		Written		Committee Chair	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		Monthly	X	X	X	X	X	X	X	X	X	X	X	X	Discussion & Assurance
Risk Register Report		Written	Group Executive Lead(s)		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		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)		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 1: Patients - To deliver high quality, safe and responsive patient services																		
Objective 1d: Deliver clinically led integrated services																		
Strategic Aim 3: Services - To ensure services are sustainable, supported by technology and delivered from an improved estate																		
Objective 3c: A modern, clean and fit for purpose environment across the group																		
Estates & Facilities Update including Key Risks		Written	Group Director of Estates & Facilities		Monthly	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	Assurance
PLACE																		
Premises Assurance Model (PAM) Annual Self Assessment		Written	Group Director of Estates & Facilities		Annually				**X**									Assurance
Estates Strategy		Written	Group Director of Estates & Facilities		TBC												**X**	Review & Endorse for Trust Board
Sustainability & Green Strategic Plan		Written																
Strategic Aim 4: Partners																		
Objective 4a: Establish collaborative models of care with our partners including Primary Care Network Alliance (PCNA)																		
Specialty Reviews Update																		
EMAP Leadership & Delivery Programme																		
System Anchor Plan																		
Partnership Plan - Commerical Opportunities																		
Future Models of Care with Primary Care Dental																		
Objective 4b: Successful delivery of the Acute Services Review																		
Stroke Implementation																		
Grantham ASR Implementation																		
Objective 4d: Enhanced data & digital capabilities																		

Digital Plan Delivery Update		Written	Group Chief Integration		Bi-monthly	X		X		X		X		X		X		Assurance
Data Security Protection Toolkit		Written	Group Director of Corporate Affairs		Annually						X							Approval
Digital Strategy		Written	Group Chief Integration Officer		TBC													Review & Endorse for Trust Board Approval
Strategic Aim 5: Population - To embed a population health approach to improve physical and mental health outcomes, promote well-being, and reduced health inequalities across an entire population																		
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 integrated services for our population that are accessible and responsive																		
Objective 5c: Tackle system priorities and service transformation in partnership with our population and communities																		
Widening Participation e.g. third sector organisations																		
Objective 5d: Transform key clinical pathways across the group resulting in improved clinical outcomes																		
Upward Reports from Sub-Groups, as appropriate																		
TBC																		Assurance
Notes																		
*In some instances reporting and assurance to the Integration Committee will happen via the oversight / reporting sub-group upward reports. Where appropriate, reports submitted directly to the Integration Committee will however have been considered and be supported by the upward report from the relevant oversight sub-group; specifically key highlights and any required escalations. This will help to avoid duplication of discussions and actions. Where relevant, the upward reports from reporting sub-groups will be aligned on the agenda to the relevant strategic objectives for which the committee has the oversight role. This will support both the flow of the meeting and the process of triangulation and assurance **This work plan reflects the core business of the Integration Committee. Topical / emerging issues will be added to the committees' agenda as required.																		

Meeting	*Lincolnshire Community and Hospitals Group Board Meeting*
Date of Meeting	*5th November 2024*
Item Number	*13*

Integrated Performance Report for September 2024

Accountable Director	*Daren Fradgley, Group Chief Integration Officer*
Presented by	*Daren Fradgley, Group Chief Integration Officer*
Author(s)	*Sharon Parker, Performance Manager*
Report previously considered at	*N/A*

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

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

Recommendations/ Decision Required	*• The Board is asked to note the current performance* *• The Board is asked to approve action to be taken where performance is below the expected target* *Key to note:* *Quality* *• Medication incidents reported as causing harm increased this month to 13.5% against a trajectory of 10.7%.* *• Duty of Candour Verbal compliance for August increase to 95%, written compliance increased to 95%.* *Performance* *• The year end target for 4 hour performance was established at 78%, with September set at 76%. The full UEC combined Type 1, Type 3 (both co-located and separate sites) achieved 74.53% in September.* *• For September 19.86% of patients exceeded 12 hour wait in department in ED.* *• Average response time for Cat2 ambulance conveyances in September was approximately 34.15 minutes against a 30 minute target.* *• Long Waiters - at the end of September, the Trust reported 0 patients waiting longer than 104 weeks; 3 patients waiting over 78 weeks and 560 patients waiting over 65 weeks* *• Performance for DM01 in September showed another improvement to 75.65%. MRI saw a significant improvement in performance with the most pressured diagnostics now being Dexa, NOUS and Audiology.* *• 28-day Faster Diagnosis Standard (FDS) showed a slight deterioration in August at 76.2% which was above the 75% target.* *• 62-day classic treatment performance for August was 61%, a slight deterioration from the July position of 64%, but this is still significantly lower than the national KPI of 85%.* *• 104+ day waiters increased to 81 at the end of September compared to 43 at the end of August, the highest risk specialities are colorectal, head & Neck and prostate.*

Finance

- *The Trust's YTD position is a £18.1m deficit, which is £7.6m adverse to the planned £10.6m YTD deficit.*

- *CIP savings of £15.9m have been delivered YTD, which £2.2m favourable to planned savings of £13.7m.*

- *Capital delivery of £28.0m is £2.3m lower than plan of £30.3m.*

Workforce

- *Mandatory training for September is 93.81% against plan of 90%*

- *September sickness rate at 5.28% against Q2 target of 5.47%*

- *Staff AfC appraisals at 80.42% for September against Q2 target 81.18%*

- *Staff turnover at 10.22% for September against target of 11.48%*

- *Vacancies at 7.89% for September against Q2 target of 7.71%*

Executive Summary

Quality

Falls

There have been 4 falls 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. Continued focus on patient education, ensuring patients are aware of their risk of a fall in hospital due to their current health challenges and the change in environment.

Pressure Ulcers

There have been 32 category 2 and 3 category 3 pressure ulcers in September. 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.

VTE Compliance

Compliance has increased to 95.94% for the month of September. This is reflective of the work being undertaken around improvement with data collection processes with a plan to transition using the ePMA system as the main source for VTE data compliance.

Medications

Medication incidents reported as causing harm increased this month to 13.5% against a trajectory of 10.7%. The majority of incidents are at the point of prescribing and administration of medication and the main error is omitting medicines. Improving medication incidents from omitted medicines is a work stream as part of the new Patient Safety Incident Response Framework (PSIRF) and has been presented at the Executive Oversight panel in August with plans in place to commence actions across the Trust.

Patient safety Alerts

There were no alerts due in September. 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 105.97 for September but remains within expected limits. Any diagnosis group alerting is subject to a case note review. HSMR is at 93.35.

eDD Compliance

eDD Performance continues to be below the 95% target, currently at 91.6%. A meeting is being coordinated to discuss eDD.

Sepsis compliance – based on August data

The **screening compliance for inpatient child** increased to 90% (target 90%). 18 children out of 20 that had PEWS of 5 or above were screened for sepsis within 60 minutes. Harm reviews found that all patients with delayed or omitted screens had either a non-bacterial cause for raised PEWS or an illness that was treated with oral antibiotics.

IVAB ED Children – The administration of IVAB for children in ED decreased to 69% (target 90%). 9 children out of 13 were treated with IV antibiotics within the 60 minute timeframe. Harm reviews were completed for both of the patients with delayed treatment and no harm was found.

IVAB Inpatient Children – The administration of IVAB for inpatient children increased to 80%. There was 1 patient out of 5 this month that had delayed administration of antibiotics. Harm reviews completed and no harm found.

Duty of Candour (DoC) – August Data

DoC compliance in August for verbal and written was at 95%. This has subsequently increased to 100%.

Complaints investigated and responded to within agreed timescales

Compliance has decreased slightly this month to 83%. The Team is working closely with the Divisions to maintain compliance. Meetings are being offered in the first instance to try and resolve complaints at an earlier stage.

Operational Performance

This report pertains to the performance during September 2024. As of the 30th September, the Trust had documented 52 PCR confirmed positive COVID-19 inpatients. It is noteworthy that the peak for inpatients during the month of September was 10 patients; this number subsequently decreased in alignment with local and regional trends, as well as the emergence of new variants. Throughout September, a total of 827 flu tests were administered, yielding 3 positive results, denoting a 0.36% positivity rate. Similarly, 2 out of 259 patients tested for RSV returned positive results, indicating a 0.77% positivity rate. Presently, there are no active Flu/RSV patients at our sites.

Tracking against ERF is not currently available. At the end of M6, percentages against plan for key PODS are: Day case 107%, Electives 98%, Outpatient Firsts (Total) 104%, Outpatient Follow ups 93%

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

A & E and Ambulance Performance

The annual 4-hour performance target has been established at 78%, with monthly progress monitoring. In September 2024, the trust achieved a performance of 74.53%, representing a deviation of 1.47% from the target of 76.00% but a consistent monthly improvement seen since July 2024. The SPC chart in the report displays both the 23/24 and 24/25 targets, encompassing Type 1 and Type 3 activities. Notably, there was a significant improvement in performance for Type 1 at Lincoln/Pilgrim ED, increasing from 34.57% to 39.32% since August (4.75% increase).

In September 2024, there was an increase of 1.43% in the number of average daily attendances within the UEC (Urgent and Emergency Care) pathway. Responding to the persistent pressure observed within the UEC pathways, the Emergency Department prioritized minimizing the overall time spent in the department. Unfortunately, 19.86% of the patients exceeded the 12-hour benchmark, however a 2.18% decrease compared to August 24 , this is still a 1.42% improvement to Q1.

In September, the average Category 2 mean response time was approximately 34.15 minutes, which was an increase of 2 minutes compared to August 2024 against the 30 minute target. The overall Category 2 mean response time includes conveyances where the patient did not attend ULHT but their postcode was within our catchment area. The SPC chart below shows the number of occasions where handover of patients took longer than 59 minutes. However the chart is unable to demonstrate the volume or presentations within the same window or patient acuity at arrival. With an average of >17% patients scoring greater than 5 on NEWS at first observations recorded on WEBV.

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. Aug performance saw a slight reduction in performance to 67.09% which was due a high Trauma demand throughout the summer, but performance in September bounced back to 85.96%

Length of Stay
In September, the Non-Elective Length of Stay showed an improvement of 0.08 days compared to August 2024, with the current performance level at 4.71 days, exceeding the maximum threshold by 0.21 days. The average bed occupancy rate, in relation to "Core G&A," was 95.04%. To ensure safe and efficient operational flow within acute sites, an average of 56 escalation beds/boarding spaces were allocated, resulting in an occupancy versus escalation ratio of 89.84%, 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 would result in 98.20%, and core plus escalation at 92.31%.

In September 2024, System Partners encountered 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.

The identification of timely support for facilitating discharge from the acute care setting for pathways 1 to 3 still poses challenges for System Partners. Moreover, the Trust reinitiated the SAFER practitioner’s assistance with education/compliance in the recording and monitoring of the percentage of discharges within 24 hours of the predicted date of discharge (PDD). Notably, September exhibited an immediate improved performance of 41.30% compared to August 36.71%.

Referral to Treatment
August performance showed a slight deterioration, reporting a performance of 51.64% compared to 52.64% in July. The Trust continues to report patients waiting over 104, 78, 65 & 52 weeks. At the end of September, the Trust reported zero patients waiting longer than 104 weeks. The trust exited September with 3 patients waiting more than 78 weeks, and whilst this wasn’t zero, 2 were down to patient choice and the other 1 was a clinically complex case requiring specialist theatre kit that is currently unavailable.. The national ambition of clearing patients waiting over 65-weeks by the end of March has now moved to September. September Outturn was 392 which led to significant pressure from the regional and national teams.

The trust was an early adopter of the Further Faster programme which is a national initiative to reduce patients waiting over 52 weeks. In August the Trust reported 3,280 patients waiting over 52 weeks. Whilst we have been performing strongly against this metric, recent months have remained static.

Waiting Lists

Nationally, we are seeing increased focus on total waiting list size. Whilst the trust has made huge improvements in reducing long waiting patients, total waiting list size has remained relatively static at 72-75k since November 2022. Due to the continued focus, reduction in total waiting list size started to be evident in October 2023 with a further reduction each month. The total waiting list in August sat at 71,995 which was slightly higher than the 71,778 seen in July. The trust has committed to a timeline that will see all services return to directly bookable Outpatients slots over the next 6 months. This will give greater visibility over our waiting times to GPs and improve patient choice.

As of 29th September 2024, ASI sat at 1067. 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 September showed another improvement, increasing from 72.91% in August to 75.65%. MRI saw a significant improvement in performance with the most pressured diagnostics now being Dexa, NOUS and Audiology.

Cancelled Ops

After improving in August, September outturn for cancelled operations on the day significantly deteriorated to 3.86%. Lack of time and lack of theatre staff were again the main reasons for cancellations.

Included in the 3.86% of on the day cancellations, 46 patients were not treated within the 28-day standard. Despite more patients being cancelled on the day, more were rebooked within the 28 day standard. 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 August sat at 76.2%, whilst this was a slight deterioration on July, this is still above the 75% target.

62-day classic treatment performance for August was 61%, a slight deterioration from the July position of 64%

104+ day waiters increased to 81 at the end of September compared to 43 at the end of August. 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. August performance was 92.9% compared to 90.2% in July.

Workforce

Mandatory Training – Our September 2024 Core Learning Rate is 93.81% against a Target of 90.00%. This is a slight decrease when compared to last month. 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) through enhanced reporting provided Divisionally by the Education & Learning Team within our People & OD Directorate. The provisions of 'pop-up' core learning sessions for departments and individual users requiring additional input continue. The Mandatory Training Action Plan has been approved, the review of all core topics has been completed and changes made to the core and core+ offer as required. There continues to be a drive for all staff groups to improve their Core Training compliance through Finance, People and Activity meetings, with areas needing specific focus being highlighted by the People & OD Directorate to ensure that we are able to maintain an above target position within 2024/25.

Sickness Absence – Our September 2024 Sickness Rate is 5.28% against a Q2 Target of 5.47%. Sickness absence rates have remained stable over across 2023/24, and continues in this way so far within 2024/25. We are continuing to work towards further reducing our vacancy level and as such, we are hopeful this continued improvement will impact positively on our colleague's health and wellbeing throughout 2024/25.

Compliance for RTW and call backs remain low, this is having a knock on effect on the length of sickness episodes. Stress and Anxiety remains the top reason for the largest number of absence days, with Gastrointestinal Problems being the largest reason for the number of sickness episodes seen across the Trust.

There is a continued focus on supporting managers and leaders in absence processes and supporting our people to attend the work environment will be delivered through the mandated 'People Management Essentials' training. There continues to be discussions about sickness absence as part of the Workforce & Organisational Development Group, and a recognition that levels are being maintained and are not worsening. Occupational Health are supporting the Trust with initial actions when a report of certain absences are flagged on the Absence Management System. This is to ensure that early support and intervention, if required, is in place to support the staff member.

In addition, focussed work is being undertaken with Divisions where sickness absence trends have been identified so as to further our journey towards a “supporting attendance” approach as opposed to managing absence. Staff continue to be signposted to our health and wellbeing services. Divisional Heads of HR continue to work with Divisions to understand sickness absence trends and this is reported and discussed with the monthly Finance, People and Activity meetings required.

Staff Appraisals – Our September 2024 appraisal rate is measured against a Q2 Target of 81.18%, and in month we have achieved a Trustwide position of 81.75%. This is a slight decrease when compared to the previous month, but remains in an overall improved position.

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

To support continued improvement, we continue to recommend 90 minute appraisals for each colleague to ensure that staff have had an appraisal. Work continues to educate leaders on the process required to update ESR, including the use of ‘how to’ guides/sessions and utilising reporting to identify areas of low completion. Additionally, raising through FPAM discussions provides a further opportunity for Divisional Teams to seek support from People & OD if required, as well as raise any challenges they are facing with being able to focus attention on appraisals. 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 September 2024 Turnover Rate is 10.22% against a Q2 Target of 11.48% and shows a continued stable position with a consistent improvement seen since November 2023. Our 2024/25 target is to achieve 9.00% or less by 31st March 2025, which we are on trajectory to meet /exceed.

Operational pressures, staffing and culture challenges are continued challenges, although despite this we are in line with our Turnover trajectories for the year-to-date

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

Vacancies – Our September 2024 Vacancy Rate is 7.89% against a 2024/25 Q2 Target of 7.71%. This position is within target tolerance and in line with the 2024/25 trajectory. Despite the increase seen in July 2024, this has now stabilised continues to demonstrate the strong reduction seen over the last 12 months Our levels of recruitment continue to be successful, and there has been a consistent improvement in the number of substantive staff we are recruiting over the last 12 months.

We were successful with a further expressions of interest for additional NHSE funding in 2024/25 for International Recruits within our Allied Health Professional staff group who are supporting the roll out of our Community Diagnostic Centres across Lincolnshire, and pro-active recruitment to these roles continues. We have continued to see further reductions in Nursing & Midwifery vacancies, and there is a strong focus currently on pro-actively supporting a reduction in vacancies within the Medical & Dental staff group, working closely with the Medical Workforce Programme.

AHP recruitment remains a challenge locally and nationally, and will continue to be a focus area in 2024/25 as we further develop the Community Diagnostic Services within Lincolnshire and embrace the continued success of international staff .There is already significant work being undertaken within the Trust via the Talent Academy to support developing the Pharmacy workforce, with support using data insights into vacancies and turnover as required. We expect the previously seen success within this staff group to continue but will monitor this against our plan.

For AHP recruitment we have a dedicated Resourcing Advisor to support this recruitment with a Talent Acquisition approach, we are also looking at using one of our higher performing agencies to support this recruitment. AHP & Pharmacy recruitment remains under significant focus but we believe we are making strong progress in both areas. We continue to work closely with NHSE to successfully recruit international staff specifically for Community Diagnostic Centres.

Finance

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

Post completion of the month 2 position, the Trust submitted a revised financial plan with a revised phasing; the revised plan brought the YTD plan in line with actual spend. The month 6 financial position is reported against the revised plan phasing.

The Trust's YTD position is a £18.1m deficit, which is £7.6m adverse to the planned £10.6m YTD deficit.

CIP savings of £15.9m have been delivered YTD, which £2.2m favourable to planned savings of £13.7m.

Capital funding levels for 2024/25 have been agreed with NHSE and system partners; the Trust delivered capital expenditure of £28.0m YTD, which is £2.3m lower than planned capital expenditure of £30.3m.

The cash balance is £7.0m (plan £6.4m); this is a decrease of £43.9m against the March year-end cash balance of £50.9m. Cash balances have decreased in September by 11.7m. It is anticipated that a series of PDC revenue drawdowns (cash) will be required during Q3 to enable the Trust to continue paying suppliers in line with the BPPC target. A business case has been prepared and submitted to NHSE in support of this and seeks drawdown of £14m (Nov: £10m, Dec: £4m). This business case was agreed by September Trust Board.

Daren Fradgley
Group Chief Integration Officer
October 2024

Key to Variation and Assurance Icons and SPC Dots

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

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

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

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

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

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

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

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

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

Performance Overview - Quality

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Jul-24	Aug-24	Sep-24	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Clostridioides difficile position	Safe	Patients	Director of Nursing	9	8	12	5	48	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	0.01	0.01		
	E. coli bacteraemia cases counts and 12-month rolling rates, by reporting acute trust and month using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.02	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	0.08	0.23	0.12	0.14	P	
	Pressure Ulcers category 3	Safe	Patients	Director of Nursing	4.3	10	3	3	26	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%	95.27%	94.85%	96.94%	95.48%	?	H
	Never Events	Safe	Patients	Director of Nursing	0	2	0	0	2	P	
	Reported medication incidents per 1000 occupied bed days	Safe	Patients	Medical Director	4.30	5.05	4.77	4.33	4.79	P	

Performance Overview - Quality

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Jul-24	Aug-24	Sep-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%	9.50%	8.50%	13.50%	11.93%	?	
	Patient Safety Alerts responded to by agreed deadline	Safe	Patients	Medical Director	100.00%	None due	0.00%	None due	44.43%	F	
	Hospital Standardised Mortality Ratio - HSMR (basket of 56 diagnosis groups) (rolling year data 3 month time lag)	Effective	Patients	Medical Director	100	95.75	94.17	93.35	94.42	P	
	Summary Hospital Mortality Indicator (SHMI) (rolling year data 6 month time lag)	Effective	Patients	Medical Director	100	105.02	105.73	105.97	104.77	F	H
	The Trust participates in all relevant National clinical audits	Effective	Patients	Medical Director	100.00%	100.00%	100.00%	100.00%	100.00%	P	H
	eDD issued within 24 hours	Effective	Patients	Medical Director	95.00%	91.50%	87.60%	91.60%	90.85%	F	
	Sepsis screening (bundle) compliance for inpatients (adult)	Safe	Patients	Director of Nursing	90.00%	92.33%	95.60%	Data Not Available	92.19%	P	
	Sepsis screening (bundle) compliance for inpatients (child)	Safe	Patients	Director of Nursing	90.00%	66.00%	90.00%	Data Not Available	79.58%	F	
	IVAB within 1 hour for sepsis for inpatients (adult)	Safe	Patients	Director of Nursing	90.00%	97.87%	96.00%	Data Not Available	96.37%	P	H
	IVAB within 1 hour for sepsis for inpatients (child)	Safe	Patients	Director of Nursing	90.00%	60.00%	80.00%	Data Not Available	78.22%	F	
	Sepsis screening (bundle) compliance in A&E (adult)	Safe	Patients	Director of Nursing	90.00%	91.63%	93.86%	Data Not Available	91.90%	P	

Performance Overview - Quality

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Jul-24	Aug-24	Sep-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%	95.00%	91.50%	Data Not Available	92.67%	P	
	IVAB within 1 hour for sepsis in A&E (adult)	Safe	Patients	Director of Nursing	90.00%	95.73%	94.30%	Data Not Available	94.61%	P	
	IVAB within 1 hour for sepsis in A&E (child)	Safe	Patients	Director of Nursing	90.00%	87.50%	69.00%	Data Not Available	78.48%	F	
	Rate of stillbirth per 1000 births	Safe	Patients	Director of Nursing	3.80	2.70	2.25	1.81	2.55	P	L
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%	85.00%	95.00%	Data Not Available	93.20%	F	
	Duty of Candour compliance - Written	Responsive	Patients	Medical Director	100.00%	85.00%	95.00%	Data Not Available	90.40%	F	

21/10/2024 13:41

Performance Overview - Quality

Venous Thromboembolism (VTE) Risk Assessment

Sep-24
96.94%
Variance Type
Special cause variation - improvement (Indicator where high is good)
Target
95.00%
Achievement
Variation indicates inconsistently passing and falling short of the target
Executive Lead
Medical Director

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

What the chart tells us:
In September, VTE risk assessment compliance rate reached 96.94%, surpassing the national benchmark. This achievement highlights our commitment to ensuring patient safety and aligning with national standards. However, maintaining consistent compliance remains a challenge.

Issues:
Although our compliance rate is creditable, it has shown fluctuations over time, indicating a need for more reliable and consistent data collection process. One significant issue impacting our compliance consistency is the current data collection method. At present, we pull data from Careflow, which has shown some discrepancies, leading to occasional variations in our reported compliance rates. These inconsistencies in data accuracy pose potential risks to our overall VTE risk assessment efforts, making difficult to sustain a consistently high compliance rate.

Actions:
To address the issues, we are actively working towards improving our data collection process. Our primary action is transitioning to using the ePMA system as the main source for VTE compliance data source. ePMA provides a more reliable data source, which will enable us to have real time insight into our compliance performance. This transition will allow us to not only enhance data accuracy, but also monitor trends more closely and identify areas for further improvement.

Mitigations:
By implementing ePMA as the primary data source we expect to achieve and sustain a compliance rate of 95% or higher. This approach will mitigate the risk of inconsistent compliance by establishing a dependable data collection method. Additionally, ongoing support will be provided to staff to ensure they are competent in utilising ePMA for completing VTE risk assessment. With these measures in place we anticipate more consistent compliance rates, improved alignment with national standards and the ability to address potential non- compliance issues proactively.

Performance Overview - Quality

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

30%
25%
20%
15%
10%
5%
0%

Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23 Jan-24 Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24

Data Mean Target Control Limits

Sep-24
13.50%
Variance Type
Common cause variation
Target
10.70%
Achievement
Variation indicates inconsistently passing and 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 September the number of medication incidents reported was 148. This equates to 4.43 incidents per 1000 bed days. The number of incidents causing some level of harm (low /moderate /severe / death) is 13.5% 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

Patient Safety Alerts responded to by agreed deadline

100%
80%
60%
40%
20%
0%
Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23 Jan-24 Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24
Data Mean Target Control Limits

Sep-24
None Due
Variance Type
Common cause variation
Target
100.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Medical Director

Background:
Patient safety alerts responded to by agreed deadline.

What the chart tells us:
There were no Alerts due in September, although deviances in compliance continue to be seen.

Issues:
The Trust was previously not demonstrating compliance with the target set for Patient Safety Alerts. The performance was below the lower control limit, with non-compliance in December 2023, March and June 2024. There had been an improvement with 100% compliance in May.

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

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

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

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

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

Y-axis values: 98, 100, 102, 104, 106

X-axis months: Jul-23, Aug-23, Sep-23, Oct-23, Nov-23, Dec-23, Jan-24, Feb-24, Mar-24, Apr-24, May-24, Jun-24, Jul-24, Aug-24, Sep-24

Legend: Data, Mean, Target, Control Limits

Sep-24
105.97
Variance Type
Special cause variation - cause for concern (Indicator where high is a concern)
Target
To remain in 'as expected' range
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Medical Director

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

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

Issues:
The data includes deaths within 30 days. 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.

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

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 93.35

Performance Overview - Quality

eDD issued within 24 hours

Sep-24
91.60%
Variance Type
Common cause variation
Target
95.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Medical Director

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

What the chart tells us:
eDD Performance continues to be below the 95% target, currently at 91.60%.

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

No Narrative owner

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

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

Performance Overview - Quality

Sepsis screening (bundle) compliance for inpatients (child)

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

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

What the chart tells us:
The data for Sepsis screening this month for Paediatric inpatients is 90%. This is equal to the 90% standard. 18 children out of 20 that had PEWS of 5 or above were screened for sepsis within 60 minutes.

Issues:
This month two patients were not screened for sepsis within the hour. The reasons given for these omissions were due to either patient workload /acuity or that they were waiting for Drs to see the patients. Both of these delays were on the Pilgrim site.

Actions:
There is ongoing work within the Family health team to not only increase compliance but to try and maintain these results. Monthly meeting are held between the team and Resus Practitioner. Plans are put in place or updated from this meeting.

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

Performance Overview - Quality

IVAB within 1 hour for sepsis for inpatients (child)

Aug-24
80.00%
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 or administration of IV antibiotics this month with one hour in inpatient areas was 80.0%. This is below the 90% required standard. 1 child out of 5 received their antibiotics outside of the one-hour timeframe.

Issues:
There was one patients this month that had delayed administration of antibiotics. The child had been admitted for bilateral arm fractures but then became unwell and developed a temperature. Due to the bilateral arm casts the child had limited places in order to site a cannula. Emla cream was used to numb the area prior to insertion which takes 45 minutes to one hour to work and this led to the delay.

Actions:
There is an ongoing action plan on both paediatric sites this month to improve and maintain compliance. Although all 3 sites have improved this month one area is still struggling so extra work is being put in place there. Regular meetings with Ward sister and Educator in this area alongside monthly meetings with the family health team.

Mitigations:
Harm review completed and no harm found in this patient.

Performance Overview - Quality

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

Aug-24
69.00%
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 in A&E (child).

What the chart tells us:
The compliance for Sepsis treatment within 60 minutes in A and E was 69%. 9 children out of 13 were treated with IV antibiotics within the 60 minute timeframe. This is well below the 90% required standard but an improvement on previous month.

Issues:
There were four children this month within the ED departments with delayed Sepsis treatment. There were two children on the Pilgrim site with delayed treatment, these were both surgical patients and the delay was from waiting for surgical teams to see patients and make a decision about treatment. One child had Lincoln was very difficult to cannulate, he was given IM antibiotics at 128 minutes. The second child was prescribed IV antibiotics at 19:50 but they weren't given until 21:15, there is no documented reason for this delay.

Actions:
Fortnightly Sepsis training is ongoing within the departments by Sepsis Practitioner. Lead Consultant has also done some training for medical staff. Staff engagement this month to training has been positive for training held within there department but there is a lack of engagement from ED staff to attend the Monthly Sepsis focus group meeting. This has been escalated.

Mitigations:
Harm reviews were completed for all of the patients with delayed treatment and no harm was found.

Performance Overview - Quality

Duty of Candour compliance - Verbal

Aug-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 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:
95% compliance achieved this month.

Issues:
Improvement had been noted due to the new processes that have been put in place within the incident and clinical teams, and the bespoke tools that have been developed on the DatixIQ system, including the support now being provided by the incident team with written Duty of Candour.

We are hoping that this improvement will continue, however it should be noted that the incident team has a vacancy within the officer cohort which may impact our ability to maintain this in the short term.

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

Weekly tracking in progress by the incident team.

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

Performance Overview - Quality

Duty of Candour compliance - Written

100%
80%
60%
40%
20%
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Data
Mean
Target
Control Limits

Aug-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:
95% compliance achieved this month.

Issues:
Improvement had been noted due to the new processes that have been put in place within the incident and clinical teams, and the bespoke tools that have been developed on the DatixIQ system, including the support now being provided by the incident team with written Duty of Candour.

We are hoping that this improvement will continue, however it should be noted that the incident team has a vacancy within the officer cohort which may impact our ability to maintain this in the short term.

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

Weekly tracking in progress by the incident team.

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

Performance Overview - Operational Performance

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Jul-24	Aug-24	Sep-24	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Patient Experience	% Triage Data Not Recorded	Effective	Patients	Chief Operating Officer	0.00%	0.29%	0.18%	0.27%	0.25%	0.00%	F	L
Improve Clinical Outcomes	4hrs or less in A&E Dept	Responsive	Services	Chief Operating Officer	76.00%	72.12%	73.67%	74.53%	73.14%	75.09%	F	H
Improve Clinical Outcomes	12+ Trolley waits	Responsive	Services	Chief Operating Officer	0	993	732	950	5,530	0	F	
Improve Clinical Outcomes	%Triage Achieved under 15 mins	Responsive	Services	Chief Operating Officer	88.50%	81.50%	84.92%	82.46%	81.95%	88.50%	F	H
Improve Clinical Outcomes	52 Week Waiters	Responsive	Services	Chief Operating Officer	2,027	3,182	3,280		15,931	10,135	F	L
Improve Clinical Outcomes	65 Week Waiters	Responsive	Services	Chief Operating Officer	0	493	560		2,193	0	F	L
Improve Clinical Outcomes	18 week incompletes	Responsive	Services	Chief Operating Officer	84.10%	52.64%	51.64%		51.79%	84.10%	F	
Improve Clinical Outcomes	Waiting List Size	Responsive	Services	Chief Operating Officer	58,965	71,778	71,955		N/A	N/A	F	H
Improve Clinical Outcomes	28 days faster diagnosis	Responsive	Services	Chief Operating Officer	75.00%	78.90%	76.20%		77.62%	75.00%	P	H
Improve Clinical Outcomes	62 day classic	Responsive	Services	Chief Operating Officer	85.39%	64.00%	61.00%		60.26%	85.39%	F	
Improve Clinical Outcomes	2 week wait suspect	Responsive	Services	Chief Operating Officer	93.00%	74.20%	76.00%		75.12%	93.00%	F	

21/10/2024 13:41

Performance Overview - Operational Performance

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Jul-24	Aug-24	Sep-24	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Clinical Outcomes	2 week wait breast symptomatic	Responsive	Services	Chief Operating Officer	93.00%	87.80%	58.60%		61.82%	93.00%	F	
	31 day first treatment	Responsive	Services	Chief Operating Officer	96.00%	91.40%	93.10%		89.96%	96.00%	F	
	31 day subsequent drug treatments	Responsive	Services	Chief Operating Officer	98.00%	87.50%	94.70%		89.30%	98.00%	F	
	31 day subsequent surgery treatments	Responsive	Services	Chief Operating Officer	94.00%	92.90%	76.90%		73.88%	94.00%	F	
	31 day subsequent radiotherapy treatments	Responsive	Services	Chief Operating Officer	94.00%	89.30%	95.00%		86.98%	94.00%	F	
	62 day screening	Responsive	Services	Chief Operating Officer	90.00%	89.50%	69.60%		71.84%	90.00%	F	
	62 day consultant upgrade	Responsive	Services	Chief Operating Officer	85.00%	65.20%	65.30%		70.04%	85.00%	F	
	Diagnostics achieved	Responsive	Services	Chief Operating Officer	99.00%	67.19%	72.91%	75.65%	72.74%	99.00%	F	
	Cancelled Operations on the day (non clinical)	Responsive	Services	Chief Operating Officer	0.80%	2.71%	1.91%	3.86%	2.26%	0.80%	F	H
	Not treated within 28 days. (Breach)	Responsive	Services	Chief Operating Officer	0	41	47	46	213	0	F	H
	#NOF 48 hrs	Responsive	Services	Chief Operating Officer	90.00%	78.69%	67.09%	85.96%	73.56%	90.00%	F	

Performance Overview - Operational Performance

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Jul-24	Aug-24	Sep-24	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Clinical Outcomes	#NOF 36 hrs	Responsive	Services	Chief Operating Officer	TBC	44.26%	37.97%	43.86%	43.25%			
	EMAS Conveyances to ULHT	Responsive	Services	Chief Operating Officer	4,657	4,774	4,639	4,541	4,696	4,657	?	H
	EMAS Conveyances Delayed >59 mins	Responsive	Services	Chief Operating Officer	0	418	255	404	349	0	F	L
	104+ Day Waiters	Responsive	Services	Chief Operating Officer	10	51	43	81	329	60	F	H
	Average LoS - Elective (not including Daycase)	Effective	Services	Chief Operating Officer	2.80	2.63	2.49	3.07	2.71	2.80	P	
	Average LoS - Non Elective	Effective	Services	Chief Operating Officer	4.50	4.83	4.79	4.71	4.78	4.50	F	
	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	32,149	32,863	32,927	31,753	4,524	F	H
	% discharged within 24hrs of PDD	Effective	Services	Chief Operating Officer	45.00%	39.34%	37.15%	41.30%	38.84%	45.00%	F	

Performance Overview - Operational Performance

% Triage Data Not Recorded

Chart series: Data, Mean, Target, Control Limits. Y-axis: 0.00%, 0.20%, 0.40%, 0.60%, 0.80%. X-axis: Jul-23, Aug-23, Sep-23, Oct-23, Nov-23, Dec-23, Jan-24, Feb-24, Mar-24, Apr-24, May-24, Jun-24, Jul-24, Aug-24, Sep-24.

Sep-24
0.27%
Variance Type
Special cause variation - improvement (Indicator where low is good)
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:
September 24 reported a non-validated position of 0.27% of data not recorded versus the target of 0%. 56% 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 32 minutes.

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

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

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

Performance Overview - Operational Performance

%Triage Achieved under 15 mins

Sep-24
82.46%
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:
September outturn was 82.46% compared 84.92% in August (validated). This is a 6.04% negative variance to the target of 88.50%
September's performance is a 13.01% 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.

Performance Overview - Operational Performance

4hrs or less in A&E Dept

Sep-24
74.53%
Variance Type
Special cause variation - improvement (Indicator where high is good)
Trajectory
76.00%
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.
However, continuing the improved monthly performance trend.
Achieving 74.53% compared to Sept 2023 of 67.61%
What the chart doesn't tell us is also the increased acuity of presentations to the department.

Issues:
In September 2024, Type 1 (ED) witnessed an average daily patient volume of 327, reflecting an increase from the 313 patients attended to in August 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 CDIFF and CPE contacts impacted the availability of resources for movement and cleaning, thereby affecting timely movements.

Type 3 (All locations) observed a static average of 600 daily patients, representing a similar position in both August and September 2024.

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 ULHT 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

Month	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24

Legend: Data, Mean, Target, Control Limits

Sep-24
950
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:
September experienced 950 breaches, an increase from 732 in August, marking a deterioration of 29.78% (218 more patients). The 950 breaches accounted for 70.04% of all type 1 attendances. Additionally, the chart did not capture the adhoc internal decisions made to prioritise total time in the Emergency Department, aimed at minimizing exposure risk and mortality rate.

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

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

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

Performance Overview - Operational Performance

EMAS Conveyances to ULHT

Sep-24
4,541
Variance Type
Special cause variation - cause for concern (Indicator where high is a concern)
Target
4,657
Achievement
Variation indicates inconsistently passing and falling short of the target
Executive Lead
Chief Operating Officer

Background:
EMAS Conveyances to ULHT.

What the chart tells us:
In September 2024, the overall number of patients transported to ULHT increased by 5% compared to the same period in 2023, which means there were at least 200 more conveyances seen.

What the chart doesn't show is that 42% of the daily emergency department attendances were from EMAS transports, and 51.45% of these patients were admitted to an inpatient bed.

Issues:
The timing of patient arrivals results in a higher influx during late afternoon and evening hours, which corresponds with an increase in walk-in visits. Despite ongoing efforts, the utilisation of alternative pathways to divert patients from being admitted to the Trust remains incomplete, although progress is evident. The pressure experienced by neighbouring Trusts has led to an escalated demand for assistance, most of which has been turned down.

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

Mitigations:

21/10/2024 13:41

Performance Overview - Operational Performance

EMAS Conveyances Delayed >59 mins

Sep-24
404
Variance Type
Special cause variation - improvement (Indicator where low is good)
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 September, there was a decline in ambulance handover performance. There were 404 arrivals recorded over a 59-minute period, compared to 255 in August, which constitutes 8.90% of all arrivals. (17.05% of patients arriving in September 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.
EMAS Clinical Navigator trial imminent to test whether a dedicated senior ambulance member would be able to direct the flow of patients more successfully in conjunction with the operations centre on each site.

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

Performance Overview - Operational Performance

Average LoS - Non Elective

Sep-24
4.71
Variance Type
Common cause variation
Target
4.50
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
September outturn of 4.71 is an improvement of 0.08 days and a 0.21-day negative variance against the agreed target.
What the chart doesn't tell us is the change by pathway:
Pathway 0 (0.1) less days
Pathway 1 (1.2) less days
Pathway 2 (1.2) less days
Pathway 3 (2.5) less days

Issues:
In September, there was an increase in the number of super-stranded patients, with the daily average rising from 108 to 115. Similarly, the number of stranded patients (14 days) decreased in performance from 190 daily to 196. 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

Aug-24
3,280
Variance Type
Special cause variation - improvement (Indicator where low is good)
Trajectory
2,027
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
The Trust reported 3,280 incomplete 52-week breaches for August 2024, an increase of 98 from July's 3,182.

Issues:
As shown above, 52 week waiters are negatively performing against trajectory, with a slight increase 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 40.52% of patients in this wait band. An increase of 1.32% from last month.

Actions:
The Integrated Elective Care Co-Ordination Programme continues to be used for admitted patients, providing an increased efficiency of the 642 process.
ENT continue to have additional weekend clinics throughout September. Additional insourcing commenced on 30th August for weekend Audiology clinics. Additional insourcing is due to commence in September for Maxillo-Facial clinics.

Mitigations:
Due to an overall improved position, ULHT are no longer in the national tiering system for elective recovery.
ULHT 52 week position in current data (W/E 25th August '24) ranks 5th for this metric within the Midlands region (11 Providers).

Performance Overview - Operational Performance

65 Week Waiters

Aug-24
560
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 560 incomplete 65-week breaches for August 2024, an increase of 67 from July's 493.

Issues:
ULHT's 104 week wait position was zero for August.

As shown above, 65 week waiters are starting to slowly increase.

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

Mitigations:
ORIG supports delivery of Outpatient improvements for the non-admitted pathways. To ensure Outpatient capacity is fully utilised and efficiency schemes are implemented and well used.
Current data (W/E 25th August'24) ranks ULHT 5th for 65w cohort metrics within the Midlands region (11 Providers).

Performance Overview - Operational Performance

18 week incompletes

Aug-24
51.64%
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. August 2024 saw RTT performance of 51.64% against an 84.1% target, which is 1% down from July.

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 – 6,545 (increased by 121)
Gastroenterology – 2,903 (increased by 35)
Ophthalmology – 2,658 (increased by 57)
Gynaecology – 2,535 (increased by 57)
Urology – 1,984 (increased by 19)

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

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

Performance Overview - Operational Performance

Waiting List Size

Aug-24
71,955
Variance Type
Special cause variation - cause for concern (Indicator where high is a concern)
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 July, with August showing an increase of 177 to 71,955.
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 – 10,319
Ophthalmology – 6,258
Gynaecology – 5,434
Gastroenterology – 5,427
Trauma & Orthopaedics 4,957

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 commence December 2024, the remainder in the next financial year.

Mitigations:
The number of patients waiting over 78 weeks has remained the same as July. Current data (W/E 25th August '24) ranks ULHT 5th 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

Data, Mean, Target, Control Limits — Jul-23 to Sep-24 (y-axis 60%–100%)

Sep-24
75.65%
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 Sep 2024 75.65 against the 99.00% target amended target 85% by May 2024.

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

Actions:
Additional MRI CDC capacity from end of December 23 Skegness and LCH, 2nd inhouse scanner should be operational by September 2024, Skegness CDC mobile scanner funding and additional 5 days a Month from March 2024. Radiology are working to their recovery plans that were discussed at the planned care and cancer board.

Mitigations:
Patients are being seen in clinical priority.

Performance Overview - Operational Performance

Cancelled Operations on the day (non clinical)

Chart axis: 0%, 1%, 2%, 3%, 4%; months Jul-23, Aug-23, Sep-23, Oct-23, Nov-23, Dec-23, Jan-24, Feb-24, Mar-24, Apr-24, May-24, Jun-24, Jul-24, Aug-24, Sep-24

Legend: Data, Mean, Target, Control Limits

Sep-24
3.86%
Variance Type
Special cause variation - cause for concern (Indicator where high is a concern)
Target
0.80%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
There has been a significant increase in the number of non-clinical cancellations in September to 3.86% compared to 1.91% in August.

Issues:
No Theatre Staff 28
Lack of time 20
Patient DNA'd 8
No Surgeon 6
No Equipment 6
Patient Accepted Then Cancelled 6

Actions:
Theatre staffing highlighted in 642 Pre-meets.
Reduce Late Starts- Business Units to ensure clinicians are arriving on time and reviewing lists in advance, this will reduce cancellations due to lack of time.
Equipment issues are highlighted to Steris.

Mitigations:
Ongoing staff sickness remains an issue particularly at Boston.
A power cut in September resulted in cancellations on the day due to lack of time as theatres had to pause activity until Estates gave the all-clear to restart. This was due to an issue with the National Grid and outside the control of the Organisation (we have had further power cuts in October).

Performance Overview - Operational Performance

Not treated within 28 days. (Breach)

Chart axis: 0, 20, 40, 60; months Jul-23 to Sep-24. Legend: Data, Mean, Target, Control Limits

Sep-24
46
Variance Type
Special cause variation - cause for concern (Indicator where high is a concern)
Target
0
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
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 decreased in September to 46 compared to 47 in August.

Issues:
-Patient choice remains a significant factor.
-Surgeons have also been on leave, making it more difficult than normal to co-ordinate lists.
-Waiting List team are also short staff at the moment due to Maternity Leave, AL and vacancies.

Actions:
Divisional Triumvirate are reviewing role of Waiting List and their current staffing arrangements with support from a new Project Manager.

Patients cancelled previously, are now placed first on the list where possible to avoid a second cancellation in the event of a list over-run.

Mitigations:
Patient choice, surgeon annual leave and Waiting List staffing remain the key mitigations.

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

#NOF 48 hrs

Legend: Data, Mean, Target, Control Limits

Y-axis: 40%, 60%, 80%, 100%

X-axis: Jul-23, Aug-23, Sep-23, Oct-23, Nov-23, Dec-23, Jan-24, Feb-24, Mar-24, Apr-24, May-24, Jun-24, Jul-24, Aug-24, Sep-24

Sep-24
85.96%
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 September 2024 is 85.96%.

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.

Performance Overview - Operational Performance

Partial Booking Waiting List

Sep-24
32,927
Variance Type
Special cause variation - cause for concern (Indicator where high is a concern)
Target
4,524
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
Currently at 32,927 against a target of 4,524. During Covid the number of patients overdue significantly increased and since then the trend has seen a steady increase of patients overdue their follow up appointment. The exception was Aug 23 – Nov 23 which saw a slight reduction each month.

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

Actions:
Regular Outpatient Waiting Lists (OWL) meeting with 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 cohort.

Performance Overview - Operational Performance

% discharged within 24hrs of PDD

Sep-24
41.30%
Variance Type
Common cause variation
Target
45.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
% discharged within 24 hrs of PDD.

What the chart tells us:
The current performance metrics have displayed a significant improvement since the implementation of the SAFER practitioner to monitor Webv Compliance resulting in an outcome of 41.30% from Augusts out turn of 37.15%.

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:
The delivery team has committed to providing support to the wards commencing in December, resulting in improved performance. Ongoing weekly monitoring is being conducted, and any identified areas of concern are being brought to the attention of ward sisters and matrons to ensure performance enhancement. In July, a new project 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

62 day classic

90%
80%
70%
60%
50%
40%
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Data
Mean
Target
Control Limits

Aug-24
61.00%
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 61.0% 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. Deep Dives are being undertaken by each CBU to understand how diagnostic turnaround times for positive cancers can be improved as this will be key to achieving the NHSE target of 70% by March '24.

Mitigations:
A process is now in place to ensure the Pre-Diagnosis CNS is made aware of patients who are likely to be non-compliant or in need of support at the time of receipt of referral to allow for early intervention and a more efficient journey on the cancer pathway.

Please also see Mitigations on accompanying pages.

Performance Overview - Operational Performance

2 week wait suspect

Aug-24
76.00%
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 76% 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 61.46% of the Trust's 14-day breaches, this is expected to improve for August performance.

Actions:
The Radiology Recruitment Strategy and intensive support meetings are in place to address the fragile Breast Service One-Stop appointment alignment issues. Respiratory Consultant capacity is ongoing as well as the BC for an increase in consultant workforce to 10-15 consultants. 2 x Lung Cancer CNS posts (funding until March 25) for risk stratification to reduce unnecessary CT scans demand on consultant triage are now established. The Lung Rapid Access pathway will now include CT referrals to accurately reflect performance and has recently been implemented. We 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.

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

100%
80%
60%
40%
20%
0%

Jun-23 Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23 Jan-24 Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24

Data — Mean — Target — Control Limits

Aug-24
58.60%
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 58.6% 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.

31 day first treatment

Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24

Chart y-axis: 82% – 100%. Legend: Data, Mean, Target, Control Limits

Aug-24
93.10%
Variance Type
Common cause variation
Target
96.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 93.1% 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

Aug-24
94.70%
Variance Type
Common cause variation
Target
98.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 94.7% 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:

21/10/2024 13:41

Performance Overview - Operational Performance

31 day subsequent surgery treatments

Chart: y-axis 40%–100%; x-axis Jun-23, Jul-23, Aug-23, Sep-23, Oct-23, Nov-23, Dec-23, Jan-24, Feb-24, Mar-24, Apr-24, May-24, Jun-24, Jul-24, Aug-24. Legend: Data, Mean, Target, Control Limits.

Aug-24
76.90%
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 76.9% against a 98% target.

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

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

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

Performance Overview - Operational Performance

31 day subsequent radiotherapy treatments

Aug-24
95.00%
Variance Type
Common cause variation
Target
94.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 95% 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

Chart data (axis labels): 100%, 80%, 60%, 40%, 20%; Jun-23, Jul-23, Aug-23, Sep-23, Oct-23, Nov-23, Dec-23, Jan-24, Feb-24, Mar-24, Apr-24, May-24, Jun-24, Jul-24, Aug-24

Legend: Data, Mean, Target, Control Limits

Aug-24
69.60%
Variance Type
Common cause variation
Target
90.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 69.6% 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

Aug-24
65.30%
Variance Type
Common cause variation
Target
85.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 65.3% against an 85% target.

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

Please also see Issues on accompanying pages.

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

Please also see Actions on accompanying pages.

Mitigations:
Please also see Mitigations on accompanying pages.

Performance Overview - Operational Performance

104+ Day Waiters

Sep-24
81
Variance Type
Special cause variation - cause for concern (Indicator where high is a concern)
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 9th October the 104 Day backlog is at 81 patients.
There are 3 main tumour sites of concern:-

Head and Neck 27
Colorectal 16
Urology 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 13.5% of these patients require support from the Pre-Diagnosis CNS as they have mental or social care needs that have the potential to significantly impact on the length of their pathway.

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

Mitigations:

Performance Overview - Workforce

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Jul-24	Aug-24	Sep-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%	93.71%	93.99%	93.81%	93.72%	90.00%	P	H
	Number of Vacancies	Well-Led	People	Director of HR & OD	7.71%	8.51%	8.51%	7.89%	7.02%	8.51%	F	
	Sickness Absence	Well-Led	People	Director of HR & OD	5.47%	5.42%	5.36%	5.28%	5.37%	5.49%	P	L
	Staff Turnover	Well-Led	People	Director of HR & OD	11.48%	10.00%	10.15%	10.22%	10.12%	12.10%	P	L
	Staff Appraisals	Well-Led	People	Director of HR & OD	81.18%	77.58%	80.20%	80.42%	77.66%	78.98%	F	H

OUTSTANDING CARE personally DELIVERED

Performance Overview - Workforce

Number of Vacancies

10%
8%
6%
4%
2%

Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23 Jan-24 Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24

Data | Mean | Trajectory | Control Limits

Sep-24
7.89%
Variance Type
Common cause variation
Trajectory
7.71%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of HR & OD

Background:
September 2024 reported Vacancy Rate is 7.89% against a Q2 target of 7.71%.

What the chart tells us:
That we are not within the Q2 target for September 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

Staff Appraisals

95%
90%
85%
80%
75%
70%

Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23 Jan-24 Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24

Data — Mean — Trajectory — Control Limits

Sep-24
80.42%
Variance Type
Special cause variation - improvement (Indicator where high is good)
Trajectory
81.18%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of HR & OD

Background:
Completion is currently 80.42% for AfC staff, 93.30% for Medical & Dental and 81.75% for Trustwide.

What the chart tells us:
We are meeting the quarterly target for AfC appraisal in month and have seen further improvement compared to previous month.

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

Actions:
- 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.

Financial Position 2024/25

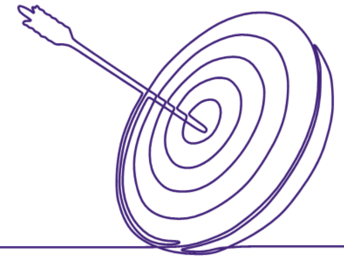
Finance Report M06

5 Year Priority – Efficient Use of Resources

NHS
United Lincolnshire Hospitals
NHS Trust

Financial Position 2024/25

M06 Headlines - ULHT



Adjusted financial performance	Current Month			Year to Date		
	Plan £000's	Actual £000's	Variance £000's	Plan £000's	Actual £000's	Variance £000's
Operating Income from patient care activities	64,299	63,390	(909)	377,932	379,114	1,182
Other operating Income	3,825	4,132	307	21,747	23,144	1,397
Employee Expenses	(43,607)	(45,744)	(2,137)	(266,631)	(278,679)	(12,048)
Operating expenses excl employee expenses	(23,477)	(23,377)	100	(139,839)	(138,630)	1,209
Operating Surplus/(Deficit)	**1,040**	**(1,599)**	**(2,639)**	**(6,791)**	**(15,051)**	**(8,260)**
Net finance costs	(893)	(719)	174	(4,836)	(4,208)	628
Other gains/(losses) including disposal of assets	0	0	0	12	20	8
Surplus / (Deficit) for the period	**147**	**(2,318)**	**(2,465)**	**(11,615)**	**(19,239)**	**(7,624)**
Remove capital donations/grants/peppercorn lease I&E impact	45	14	(31)	348	408	60
Remove PFI revenue costs on an IFRS 16 basis	117	116	(1)	704	704	0
Adjusted financial performance surplus/(deficit)	309	(2,188)	(2,497)	(10,563)	(18,127)	(7,564)

Revenue position

- The Trust's 2024/25 financial plan is a deficit of £6.9m; the Trust's planned deficit is part of a break-even plan submitted by the Lincolnshire ICS.
- The accompanying table shows that:

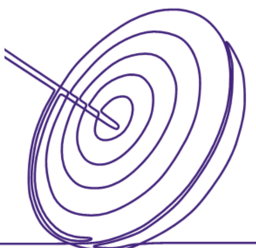
❑ The Trust delivered an in-month deficit of £2.2m or £(2.5)m adverse to a planned surplus of £0.3m.

❑ The Trust delivered a YTD deficit of £18.1m or £7.6m adverse to a planned deficit of £10.6m.

- The drivers of the movement from plan include £4.6m of justifiable adverse variances to plan and £3.0m net of other cost pressures.
- A request for funding of the nurse establishment review (£1.7m FYE at substantive cost) to come from the system risk pool was considered by the system in September, but a decision was deferred to allow due consideration to be given to this risk in the context of other system risks.
- The in-month deficit of £2.2m is £1.3m higher than the deficit of £0.9m reported in August. However, the August position included income accruals re prior periods of £1.2m in relation to Industrial Action and £0.7m re contract variations in relation to the £16m investment gap. Without the prior period income, the reported actual in-month deficit in August would have been £2.8m.
- Given the Trust has only received Industrial Action funding of £0.7m in September, not £1.2m as accrued in August, the in-month position in September could therefore have been expected to be a deficit of £3.3m, such that the reported £2.2m deficit is an improvement of £1.1m, which is due primarily due to a fall in pay expenditure.
- ERF performance remains weak despite the adverse revenue position.

Financial Position 2024/25

Key areas of focus – CIP, cash, BPPC & Capital



CIP position

- The Trust's CIP plan for 2024/25 is to deliver savings of £40.1m; the Trust YTD has delivered savings of £15.9m, or £2.2m higher than planned savings of £13.7m. The early delivery of CIP is temporarily offsetting cost pressures in the YTD revenue position.

Cash

- The September 2024 cash balance is £7.0m (plan: £6.4m); this is a decrease of £43.9m against the March year-end cash balance of £50.9m.
- Cash balances have decreased in September by £11.7m. It is anticipated that a series of PDC revenue drawdowns (cash) will be required during Q3 to enable the Trust to continue paying suppliers in line with the BPPC target. A business case has been prepared and submitted to NHSE in support of this and seeks drawdown of £14m (Nov: £10m, Dec: £4m) . This was agreed by September Trust Board.

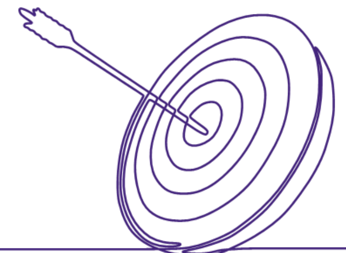
BPPC

- The BPPC performance for September was 96% / 93% by value / volume of invoices paid (appendix 5d). Year to date performance is at 94% / 94%; this compares to the full year performance in 2023/24 of 88% / 83%.
- At the end of September there were circa 800 unpaid invoices (£2.5m) over term August 700 / £2.1m). These will impact future BPPC performance levels as they are paid.
- Following receipt of a letter from Julian Kelly re-iterating the 95% target and directing the Trust to improve performance from April 23, a multi-faceted improvement plan was implemented. This led to an improvement in 2023/24 which has continued into the first half of 2024/25. A significant element of this is due to process improvements and additional resourcing within pharmacy.

Capital position

- The Trust's 2024/25 capital plan amounts to c£75.7m; the Trust delivered YTD capital expenditure of £28.0m, or £2.3m lower than planned capital expenditure of £30.3m.

Finance Dashboard



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

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

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

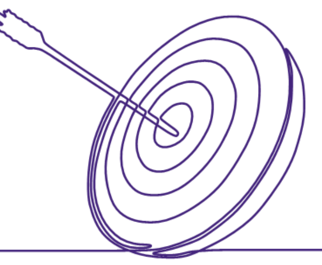
The finance assessment seeks to answer the question: ***How effectively is the trust managing its financial resources to deliver high quality, sustainable services for patients?*** It does this at a high level using the 5 key indicators and each of which is rated 1 to 4 [which represent Outstanding,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

Finance and use of resources rating	Full Year ending:						Actual	Forecast
	Mar-19	Mar-20	Mar-21	Mar-22	Mar-23	Mar-24	Sep-24	Mar-25
Capital service cover metric	(10.40)	(1.73)	0.06	3.60	1.48	1.19	(0.10)	2.71
Capital service cover rating	4	4	4	1	3	4	4	1
Liquidity metric	(98.73)	(128.28)	3.71	2.50	(10.91)	(19.40)	(29.53)	(18.37)
Liquidity rating	4	4	1	1	3	4	4	4
I&E margin metric	(19.71%)	(7.62%)	0.38%	0.29%	(1.80%)	(2.63%)	(4.68%)	(0.86%)
I&E margin rating	4	4	2	2	4	4	4	3
Agency metric	77.00%	110.00%	113.00%	120.00%	~~0.00%~~	~~0.00%~~	~~0.00%~~	~~0.00%~~
Agency rating	4	4	4	4	~~1~~	~~1~~	~~1~~	~~1~~
I&E margin: distance from financial plan - metric	(2.80%)	0.70%	n/a	0.01%	(1.80%)	0.23%	(1.99%)	(0.86%)
I&E margin: distance from financial plan - rating	4	1	n/a	1	3	1	3	2

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

Financial Position 2024/25

Key areas of focus - Income



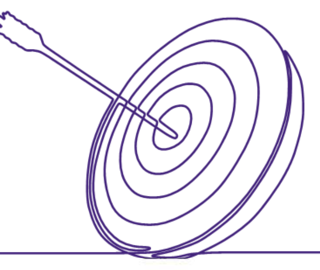
	Current Month			Year to Date		
	Plan £000's	Actual £000's	Variance £000's	Plan £000's	Actual £000's	Variance £000's
NHSE & ICB TOTAL	63,862	63,195	(667)	375,846	377,614	1,768
Non-NHS: private patients	17	8	(9)	95	79	(16)
Non-NHS: overseas patients (non-reciprocal, chargeable to patient)	45	19	(26)	327	320	(7)
Injury cost recovery scheme	90	115	25	516	560	44
Other patient care activties Income	285	53	(232)	1,148	541	(607)
Sub-Total - Operating income from patient care activties	**64,299**	**63,390**	**(909)**	**377,932**	**379,114**	**1,182**
Education and training	2,329	2,352	23	12,491	12,863	372
Income in respect of employee benefits accounted on a gross basis	498	434	(64)	2,661	2,660	(1)
Non-patient care services	391	469	78	2,459	2,501	42
Catering	251	248	(3)	1,498	1,482	(16)
Research and development	103	153	50	660	827	167
Rental revenue from operating leases	102	109	7	629	670	41
Car parking income	86	91	5	543	577	34
Other operating income	65	276	211	806	1,564	758
Sub-total - Other operating income	**3,825**	**4,132**	**307**	**21,747**	**23,144**	**1,397**
Total - Income	**68,124**	**67,522**	**(602)**	**399,679**	**402,258**	**2,579**

- **Operating Income from Patient Care Activities**
  Patient Care Activities income is £1.2m YTD favourable to plan; this includes over performance on pass through, £0.1m over performance in relation to ERF gain share (CIP) & recognition of £(1.2)m of risk that the YTD under spend on national EPR funding will be withdrawn. ERF Performance remains weak and that is a risk to the position in H2 should that continue; work to understand this by specialty is being undertaken.

- **Other Operating Income**
  Other Operating income is £1.4m YTD favourable to plan; this most notably includes £0.4m on education & training, £0.2m re R&D and £0.4m in relation to income generation.

Financial Position 2024/25

Key areas of focus - Pay

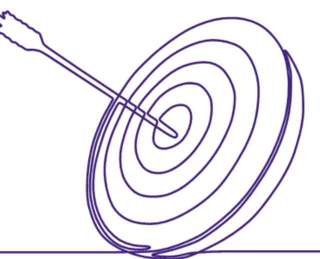


	Current Month			Year to Date		
	Plan £000's	Actual £000's	Variance £000's	Plan £000's	Actual £000's	Variance £000's
Substantive staff including on-costs	(36,684)	(38,928)	(2,244)	(221,305)	(229,354)	(8,049)
Agency / contract	(1,107)	(2,106)	(999)	(10,789)	(13,937)	(3,148)
Bank staff including on-costs	[illegible]	(4,332)	1,137	(32,385)	(33,161)	(776)
Other	(347)	(378)	(31)	(2,152)	(2,227)	(75)
Total employee expenses	(43,607)	(45,744)	(2,137)	(266,631)	(278,679)	(12,048)

- The pay position is £12.0m YTD adverse to plan.
- Pay expenditure of £45.7m in August is £2.1m adverse to plan but £1.0m lower than pay expenditure of £46.7m in August.
- The £1.0m reduction in overall pay expenditure in September reflects in part the fact that August included £0.5m of SAS doctors pay arrears and £0.2m of Bank Holiday enhancements, and the fact that September includes the release of £0.3m more technical pay savings (in Bank) than released in August.
- However, while the position also includes a reduction of £0.7m in medical & dental bank expenditure in the clinical divisions, this has not flowed to the bottom line pay position because agency pay expenditure has increased by £0.2m compared to August and the rest of the favourable movement in bank pay expenditure has been consumed by an increase in substantive staffing expenditure.
- It is noted that overall agency pay expenditure in H1 of 2024/25 has fallen by £3.2m in comparison to the same period in 2023/24. However, overall agency expenditure in 2023/24 was relatively flat in H2, and it has only been in August in September that it has fallen from below that previous expenditure trend; medical & dental agency expenditure account for 84% of total agency pay expenditure in September.

Financial Position 2024/25

Key areas of focus – Non-Pay



	Current Month			Year to Date		
	Plan £000's	Actual £000's	Variance £000's	Plan £000's	Actual £000's	Variance £000's
Other operating expenses	(20,777)	(21,150)	(373)	(124,693)	(125,285)	(592)
Depreciation & amortisation	(2,700)	(2,227)	473	(15,146)	(13,345)	1,801
Total operating expenses excl Exployee Expenses	**(23,477)**	**(23,377)**	**100**	**(139,839)**	**(138,630)**	**1,209**

- The non-pay position is £1.2m YTD favourable to plan driven by lower than planned expenditure on capital charges.
- Non-pay expenditure of £23.4m in September is £0.1m favourable to plan but £0.6m higher than expenditure of £22.7m in August. The £0.6m increase in non-pay expenditure notably includes a £0.8m increase in passthrough drugs and a £0.4m reduction in spend on clinical supplies and services.

❖ **Depreciation & amortisation - £1.8m favourable to plan**

❖ **Excess inflation – £(1.9)m adverse to plan**

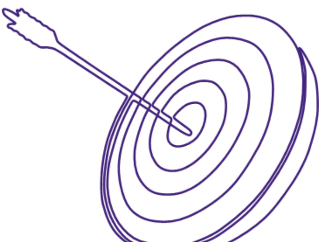
While the 2024/25 financial plan includes non-pay inflation as per national planning guidance, the actual level of inflation suffered was expected to be higher than planned; our estimate of excess non-pay inflation suffered YTD of £0.9m is still subject to validation and the true figure may be higher as we receive actual invoices.

❖ **CIP – £2.1m favourable to plan**

The Trust has planned to deliver £15.2m of non-pay CIP savings in 2024/25; the plan expected £3.9m to be delivered YTD and £5.9m or £2.0m more than planned has been delivered; £1.9m of the favourable movement relates to early delivery of technical pay savings release.

❖ **Other – £(0.8)m adverse to plan** [inclusive of higher than planned expenditure on pass through].

Balance Sheet



	31-Mar-24	30-Sep-24			31-Mar-25	
		Plan	Actual	Variance	Plan	Forecast
	£000	£000	£000	£000	£000	£000
Intangible assets	10,924	8,670	8,742	(72)	6,071	6,093
Property, plant and equipment	333,031	351,752	351,325	427	384,843	380,254
Right of use assets	13,956	12,831	12,777	54	13,741	13,603
Receivables	2,022	2,038	2,072	(34)	2,038	2,038
Total non-current assets	**359,933**	**375,291**	**374,916**	**375**	**406,693**	**401,988**
Inventories	6,581	6,910	6,543	367	6,910	6,500
Receivables	19,781	31,562	25,408	6,154	31,562	24,551
Cash and cash equivalents	50,858	6,442	6,982	(540)	25,308	25,308
Total current assets	**77,220**	**44,914**	**38,933**	**5,981**	**63,780**	**56,359**
Trade and other payables	(95,425)	(65,450)	(78,697)	13,247	(75,518)	(78,823)
Borrowings	(3,167)	(3,167)	(3,175)	8	(3,167)	(3,167)
Provisions	(12,154)	(4,234)	(7,874)	3,640	(2,734)	(1,320)
Other liabilities	(1,195)	(6,734)	(7,821)	1,087	(6,734)	(6,734)
Total current liabilities	**(111,941)**	**(79,585)**	**(97,567)**	**17,982**	**(88,153)**	**(90,044)**
Total assets less current liabilities	**325,212**	**340,620**	**316,282**	**24,338**	**382,320**	**368,303**
Borrowings	(13,557)	(12,100)	(12,134)	34	(12,619)	(12,619)
Provisions	(5,271)	(5,409)	(5,428)	19	(5,583)	(5,271)
Other liabilities	(10,566)	(10,314)	(10,314)	-	(10,063)	(10,063)
Total non-current liabilities	**(29,394)**	**(27,823)**	**(27,876)**	**53**	**(28,265)**	**(27,953)**
Total assets employed	**295,818**	**312,797**	**288,406**	**24,391**	**354,055**	**340,350**
Financed by						
Public dividend capital	756,760	785,299	768,585	16,714	823,858	810,263
Revaluation reserve	48,454	47,853	47,850	3	47,249	47,246
Other reserves	190	190	190	-	190	190
Income and expenditure reserve	(509,586)	(520,545)	(528,219)	7,674	(517,242)	(517,349)
Total taxpayers' equity	**295,818**	**312,797**	**288,406**	**24,391**	**354,055**	**340,350**

Note 1: The plan presented reflects the June resubmission of the 2024/25 financial plan

Note 2: As at 30 September the balance sheet is broadly in line with plan. Notable exceptions being:
- Receivables / Payables, with movements combining to mean that revenue cash support has not yet been required.
- PDC Dividend linking to the above where revenue PDC draws have not yet been required.

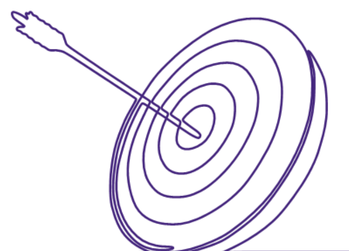
Note 3: The 2024/25 capital programme is the largest undertaken by the Trust at £78.2m. Depreciation is similarly significantly increased on recent years. The net impact is that Property, Plant, Equipment & Intangibles are expected to increase by £42m in year.

Note 4: Receivables is predominantly a mix of invoiced debt £3.5m, accrued income £8.7m, VAT £1.1m and prepayments £12.8m, offset in part by bad debt provisions of £1.4m.

Note 5: The overall level of Trade and other payables has reduced to £78.7m including capital creditors of £14.8m.

Note 6: The level of provisions have reduced in month by £0.6m and are expected to reduce further through 2024/25 as the remaining 'Flowers,' and Litigation issues are reviewed and resolved.

Cashflow reconciliation – April 2024– March 2025



	31-Mar-24	30-Sep-24			31-Mar-25	
		Plan	Actual	Variance	Plan	Forecast
	£000	£000	£000	£000	£000	£000
Operating surplus / (deficit)	(20,954)	(6,791)	(15,049)	8,258	1,021	57
Depreciation and amortisation	25,768	15,146	13,345	1,801	36,123	36,123
Impairments and reversals	6,580	-	-	-	-	-
Income recognised in respect of capital donations	(114)	-	(78)	78	(50)	(78)
Amortisation of PFI deferred credit	(503)	(252)	(252)	-	(503)	(503)
(Increase) / decrease in receivables and other assets	33,556	(11,797)	(5,664)	(6,133)	(11,797)	(4,828)
(Increase) / decrease in inventories	(448)	(329)	38	(367)	(329)	81
Increase/(decrease) in trade and other payables	358	(13,510)	(4,481)	(9,029)	(10,543)	(6,305)
Increase/(decrease) in other liabilities	(65)	5,539	6,626	(1,087)	5,539	5,539
Increase / (decrease) in provisions	(5,390)	(7,834)	(4,175)	(3,659)	(9,160)	(10,886)
Net cash flows from / (used in) operating activities	**38,784**	**(19,828)**	**(9,690)**	**(10,138)**	**10,301**	**19,200**
Interest received	2,551	790	1,113	(323)	1,206	1,648
Purchase of intangible assets	(7,132)	-	-	-	-	(50)
Purchase of property, plant and equipment	(44,652)	(47,070)	(40,602)	(6,468)	(90,032)	(86,369)
equipment	59	17	26	(9)	17	77
Net cash flows from / (used in) investing activities	**(49,227)**	**(46,263)**	**(39,463)**	**(6,800)**	**(88,809)**	**(84,694)**
Public dividend capital received	32,718	28,539	11,824	16,715	67,098	53,502
Other loans repaid	(805)	(403)	(403)	-	(805)	(805)
Capital element of finance lease rental payments	(2,393)	(1,212)	(891)	(321)	(2,475)	(2,475)
Interest paid	(9)	-	(3)	3	-	(3)
Interest element of finance lease	(142)	(105)	(105)	-	(252)	(252)
PDC dividend (paid)/refunded	(9,328)	(5,143)	(5,140)	(3)	(10,603)	(10,016)
Cash flows from (used in) other financing activities	(9)	(1)	(5)	4	(5)	(7)
Net cash flows from / (used in) financing activities	**20,032**	**21,675**	**5,277**	**16,398**	**52,958**	**39,944**
Increase / (decrease) in cash and cash equivalents	**9,589**	**(44,416)**	**(43,876)**	**(540)**	**(25,550)**	**(25,550)**
Cash and cash equivalents at 1 April - b'f	**41,269**	**50,858**	**50,858**	**(0)**	**50,858**	**50,858**
Cash and cash equivalents at period end	**50,858**	**6,442**	**6,982**	**(540)**	**25,308**	**25,308**

Note 1: Cash held at 30 September was £7.0m against a plan of £6.4m. This represents a decrease of £43.9m against the March year-end cash balance of £50.9m and a decrease from August of £11.7m.

Note 2: The September cash reduction is in line with the updated receipts and payments forecast.

Note 3: The capital programme for 2024/25 is funded through a mix of internally generated resource £33.5m and external PDC £44.5m. This is being drawn down in line with capital spend – YTD £11.8m.

Note 4 External support will be required in Q3. A business case has been submitted to NHSE to access cash support of £14m (Nov: £10m, Dec £4m) this required to fund the cash impact of:

- The planned deficit of £6.9m plus any excess beyond plan.
- Release / utilisation of provisions associated with litigation and contractual obligations – circa £8m.
- Reduction in capital creditors

Note 5: During October / November the 2024/25 pay award and arrears will be processed. The Trust will be funded for the cash impact of this with funding from LICB and NHSE.

Report to the Lincolnshire Community and Hospitals Group Board Meeting

Date of meeting	5th November 2024	Agenda item	13.
Title	LCHS Integrated Performance Report (September 2024 performance)		
Report of	Daren Fradgley, Group Chief Integration Officer	Prepared by	Annan Galloway, Business Support Technician
Previously considered by / Date	September 2024 performance considered by October FPPIC and QC meetings	Approved?	N/A
Summary	Performance up until the end of September is set out in the report. The Quality Committee and Finance, Performance, People, and Innovation Committee reviewed September performance in their October 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	3	3	
	Inconsistently Capable	3	13	3
	Not Capable	1	2	
	No Target	1	19	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. Subject to the outcome of the consultation, changes to shift times are due for implementation in November 2024.

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. CAS Activity CAS activity has shown special cause concern since April 2024 following the 111 contract changes. 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. **8 indicators are currently showing special cause improvement, which is a strong indication of our continuous improvement culture:** 1. Patient Incidents per 1000 WTE; 2. Sickness Absence; 3. GU Patients seen within 2 working days; 4. Staff Turnover; 5. Friends & Family Test; 6. UTC Discharge Summaries; 7. UTC 15 Minute Assessments; and 8. Vacancy Rate.

1. To deliver high quality, safe and responsive patient services	**1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population**	**X**
	1b. Improve patient experience	**X**
	1c. Improve clinical outcomes	**X**
	1d. Deliver clinically led integrated services	
2. To enable our people to lead, work differently, be inclusive, motivated and proud	**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**

to work within LCHG		
3. To ensure services are sustainable, supported by technology and delivered from an improved estate	3a. Deliver financially sustainable healthcare, making the best use of resources	X
	3b. Drive better decision and impactful action through insight	X
	3c. A modern, clean and fit for purpose environment across the Group	
	3d. Reduce waits for patients who require urgent and emergency care and diagnostics and ensure we meet all constitutional standards	
	3e Reducing unwarranted variation in cancer service delivery and ensure we meet all constitutional standards (ULHT)	
	3f Reducing unwarranted variation in planned service delivery and ensure we meet all constitutional standards (ULHT)	
	3g Reducing unwarranted variation in community service delivery and ensure we meet all constitutional standards (LCHS)	X
4. To collaborate with our primary care, ICS and external partners to implement new models of care, transform services and grow our culture of research and innovation	4a Establish collaborative models of care with all our partners including Primary Care Network Alliance (PCNA), GPs, health and social care and voluntary sector	
	4b Successful delivery of the Acute Services Review	
	4c Grow our research and innovation through education, learning and training	
	4d Enhanced data and digital capability	X
5. To embed a population health approach to improve physical and mental health outcomes, promote well-being, and reduce health inequalities across an	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	

entire population					
Impact of proposal/ report	N/A Assurance Report				
CQC	**Safe**	**Caring**	**Effective**	**Responsive**	**Well-Led**
Links to risks	Relates to all Strategic Aims and therefore all risk				
Legal/ Regulation	NHS Single Oversight Framework				

Recommendations/ Actions Required

Board is asked to **NOTE** the performance position

Appendices

Appendix 1 – LCHS Integrated Performance Report on September 2024 Data

Glossary

BPPC – Better Payment Practice Code
CAS – Clinical Assessment Service
CiC – Children in Care
CIP – Cost Improvement Plan
CHPPD – Care Hours Per Patient Day
FFT – Friends and Family Test
FPPIC – Finance, Performance, People & Innovation Committee
FTE – Full-Time Equivalent
IHA – Initial Health Assessment
IPR – Integrated Performance Report
KPI – Key Performance Indicator
LAC – Looked-After Children
LoS – Length of Stay
MIU – Minor Injury Unit
MRSA - Methicillin-Resistant Staphylococcus Aureus
NHSPS – NHS Property Services
OOH – Out of Hours
PMR – Performance Management Review
PU – Pressure Ulcer
Q&RC – Quality & Risk Committee
SI – Serious Incident
SPC - Statistical Process Control
STI – Sexually Transmitted Infection
UTC – Urgent Treatment Centre
WTE – Whole Time Equivalent
YTD – Year-To-Date

Executive Summary

Quality

Falls

There have been 4 falls 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. Continued focus on patient education, ensuring patients are aware of their risk of a fall in hospital due to their current health challenges and the change in environment.

Pressure Ulcers

There have been 32 category 2 and 3 category 3 pressure ulcers in September. 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.

VTE Compliance

Compliance has increased to 95.94% for the month of September. This is reflective of the work being undertaken around improvement with data collection processes with a plan to transition using the ePMA system as the main source for VTE data compliance.

Medications

Medication incidents reported as causing harm increased this month to 13.5% against a trajectory of 10.7%. The majority of incidents are at the point of prescribing and administration of medication and the main error is omitting medicines. Improving medication incidents from omitted medicines is a work stream as part of the new Patient Safety Incident Response Framework (PSIRF) and has been presented at the Executive Oversight panel in August with plans in place to commence actions across the Trust.

Patient safety Alerts

There were no alerts due in September. 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 105.97 for September but remains within expected limits. Any diagnosis group alerting is subject to a case note review. HSMR is at 93.35.

eDD Compliance

eDD Performance continues to be below the 95% target, currently at 91.6%. A meeting is being coordinated to discuss eDD.

Sepsis compliance – based on August data

The **screening compliance for inpatient child** increased to 90% (target 90%). 18 children out of 20 that had PEWS of 5 or above were screened for sepsis within 60 minutes. Harm reviews found that all patients with delayed or omitted screens had either a non-bacterial cause for raised PEWS or an illness that was treated with oral antibiotics.

IVAB ED Children – The administration of IVAB for children in ED decreased to 69% (target 90%). 9 children out of 13 were treated with IV antibiotics within the 60 minute timeframe. Harm reviews were completed for both of the patients with delayed treatment and no harm was found.

IVAB Inpatient Children – The administration of IVAB for inpatient children increased to 80%. There was 1 patient out of 5 this month that had delayed administration of antibiotics. Harm reviews completed and no harm found.

Duty of Candour (DoC) – August Data

DoC compliance in August for verbal and written was at 95%. This has subsequently increased to 100%.

Complaints investigated and responded to within agreed timescales

Compliance has decreased slightly this month to 83%. The Team is working closely with the Divisions to maintain compliance. Meetings are being offered in the first instance to try and resolve complaints at an earlier stage.

Operational Performance

This report pertains to the performance during September 2024. As of the 30th September, the Trust had documented 52 PCR confirmed positive COVID-19 inpatients. It is noteworthy that the peak for inpatients during the month of September was 10 patients; this number subsequently decreased in alignment with local and regional trends, as well as the emergence of new variants. Throughout September, a total of 827 flu tests were administered, yielding 3 positive results, denoting a 0.36% positivity rate. Similarly, 2 out of 259 patients tested for RSV returned positive results, indicating a 0.77% positivity rate. Presently, there are no active Flu/RSV patients at our sites.

Tracking against ERF is not currently available. At the end of M6, percentages against plan for key PODS are: Day case 107%, Electives 98%, Outpatient Firsts (Total) 104%, Outpatient Follow ups 93%

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

A & E and Ambulance Performance

The annual 4-hour performance target has been established at 78%, with monthly progress monitoring. In September 2024, the trust achieved a performance of 74.53%, representing a deviation of 1.47% from the target of 76.00% but a consistent monthly improvement seen since July 2024. The SPC chart in the report displays both the 23/24 and 24/25 targets, encompassing Type 1 and Type 3 activities. Notably, there was a significant improvement in performance for Type 1 at Lincoln/Pilgrim ED, increasing from 34.57% to 39.32% since August (4.75% increase).

In September 2024, there was an increase of 1.43% in the number of average daily attendances within the UEC (Urgent and Emergency Care) pathway. Responding to the persistent pressure observed within the UEC pathways, the Emergency Department prioritized minimizing the overall time spent in the department. Unfortunately, 19.86% of the patients exceeded the 12-hour benchmark, however a 2.18% decrease compared to August 24 , this is still a 1.42% improvement to Q1.

In September, the average Category 2 mean response time was approximately 34.15 minutes, which was an increase of 2 minutes compared to August 2024 against the 30 minute target. The overall Category 2 mean response time includes conveyances where the patient did not attend ULHT but their postcode was within our catchment area. The SPC chart below shows the number of occasions where handover of patients took longer than 59 minutes. However the chart is unable to demonstrate the volume or presentations within the same window or patient acuity at arrival. With an average of >17% patients scoring greater than 5 on NEWS at first observations recorded on WEBV.

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. Aug performance saw a slight reduction in performance to 67.09% which was due a high Trauma demand throughout the summer, but performance in September bounced back to 85.96%

Length of Stay
In September, the Non-Elective Length of Stay showed an improvement of 0.08 days compared to August 2024, with the current performance level at 4.71 days, exceeding the maximum threshold by 0.21 days. The average bed occupancy rate, in relation to "Core G&A," was 95.04%. To ensure safe and efficient operational flow within acute sites, an average of 56 escalation beds/boarding spaces were allocated, resulting in an occupancy versus escalation ratio of 89.84%, 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 would result in 98.20%, and core plus escalation at 92.31%.

In September 2024, System Partners encountered 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.

The identification of timely support for facilitating discharge from the acute care setting for pathways 1 to 3 still poses challenges for System Partners. Moreover, the Trust reinitiated the SAFER practitioner’s assistance with education/compliance in the recording and monitoring of the percentage of discharges within 24 hours of the predicted date of discharge (PDD). Notably, September exhibited an immediate improved performance of 41.30% compared to August 36.71%.

Referral to Treatment
August performance showed a slight deterioration, reporting a performance of 51.64% compared to 52.64% in July. The Trust continues to report patients waiting over 104, 78, 65 & 52 weeks. At the end of September, the Trust reported zero patients waiting longer than 104 weeks. The trust exited September with 3 patients waiting more than 78 weeks, and whilst this wasn’t zero, 2 were down to patient choice and the other 1 was a clinically complex case requiring specialist theatre kit that is currently unavailable.. The national ambition of clearing patients waiting over 65-weeks by the end of March has now moved to September. September Outturn was 392 which led to significant pressure from the regional and national teams.

The trust was an early adopter of the Further Faster programme which is a national initiative to reduce patients waiting over 52 weeks. In August the Trust reported 3,280 patients waiting over 52 weeks. Whilst we have been performing strongly against this metric, recent months have remained static.

Waiting Lists

Nationally, we are seeing increased focus on total waiting list size. Whilst the trust has made huge improvements in reducing long waiting patients, total waiting list size has remained relatively static at 72-75k since November 2022. Due to the continued focus, reduction in total waiting list size started to be evident in October 2023 with a further reduction each month. The total waiting list in August sat at 71,995 which was slightly higher than the 71,778 seen in July. The trust has committed to a timeline that will see all services return to directly bookable Outpatients slots over the next 6 months. This will give greater visibility over our waiting times to GPs and improve patient choice.

As of 29th September 2024, ASI sat at 1067. 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 September showed another improvement, increasing from 72.91% in August to 75.65%. MRI saw a significant improvement in performance with the most pressured diagnostics now being Dexa, NOUS and Audiology.

Cancelled Ops

After improving in August, September outturn for cancelled operations on the day significantly deteriorated to 3.86%. Lack of time and lack of theatre staff were again the main reasons for cancellations.

Included in the 3.86% of on the day cancellations, 46 patients were not treated within the 28-day standard. Despite more patients being cancelled on the day, more were rebooked within the 28 day standard. 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 August sat at 76.2%, whilst this was a slight deterioration on July, this is still above the 75% target.

62-day classic treatment performance for August was 61%, a slight deterioration from the July position of 64%

104+ day waiters increased to 81 at the end of September compared to 43 at the end of August. 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. August performance was 92.9% compared to 90.2% in July.

Workforce

Mandatory Training – Our September 2024 Core Learning Rate is 93.81% against a Target of 90.00%. This is a slight decrease when compared to last month. 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) through enhanced reporting provided Divisionally by the Education & Learning Team within our People & OD Directorate. The provisions of 'pop-up' core learning sessions for departments and individual users requiring additional input continue. The Mandatory Training Action Plan has been approved, the review of all core topics has been completed and changes made to the core and core+ offer as required. There continues to be a drive for all staff groups to improve their Core Training compliance through Finance, People and Activity meetings, with areas needing specific focus being highlighted by the People & OD Directorate to ensure that we are able to maintain an above target position within 2024/25.

Sickness Absence – Our September 2024 Sickness Rate is 5.28% against a Q2 Target of 5.47%. Sickness absence rates have remained stable over across 2023/24, and continues in this way so far within 2024/25. We are continuing to work towards further reducing our vacancy level and as such, we are hopeful this continued improvement will impact positively on our colleague's health and wellbeing throughout 2024/25.

Compliance for RTW and call backs remain low, this is having a knock on effect on the length of sickness episodes. Stress and Anxiety remains the top reason for the largest number of absence days, with Gastrointestinal Problems being the largest reason for the number of sickness episodes seen across the Trust.

There is a continued focus on supporting managers and leaders in absence processes and supporting our people to attend the work environment will be delivered through the mandated 'People Management Essentials' training. There continues to be discussions about sickness absence as part of the Workforce & Organisational Development Group, and a recognition that levels are being maintained and are not worsening. Occupational Health are supporting the Trust with initial actions when a report of certain absences are flagged on the Absence Management System. This is to ensure that early support and intervention, if required, is in place to support the staff member.

In addition, focussed work is being undertaken with Divisions where sickness absence trends have been identified so as to further our journey towards a "supporting attendance" approach as opposed to managing absence. Staff continue to be signposted to our health and wellbeing services. Divisional Heads of HR continue to work with Divisions to understand sickness absence trends and this is reported and discussed with the monthly Finance, People and Activity meetings required.

Staff Appraisals – Our September 2024 appraisal rate is measured against a Q2 Target of 81.18%, and in month we have achieved a Trustwide position of 81.75%. This is a slight decrease when compared to the previous month, but remains in an overall improved position.

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

To support continued improvement, we continue to recommend 90 minute appraisals for each colleague to ensure that staff have had an appraisal. Work continues to educate leaders on the process required to update ESR, including the use of 'how to' guides/sessions and utilising reporting to identify areas of low completion. Additionally, raising through FPAM discussions provides a further opportunity for Divisional Teams to seek support from People & OD if required, as well as raise any challenges they are facing with being able to focus attention on appraisals. 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 September 2024 Turnover Rate is 10.22% against a Q2 Target of 11.48% and shows a continued stable position with a consistent improvement seen since November 2023. Our 2024/25 target is to achieve 9.00% or less by 31st March 2025, which we are on trajectory to meet /exceed.

Operational pressures, staffing and culture challenges are continued challenges, although despite this we are in line with our Turnover trajectories for the year-to-date

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

Vacancies – Our September 2024 Vacancy Rate is 7.89% against a 2024/25 Q2 Target of 7.71%. This position is within target tolerance and in line with the 2024/25 trajectory. Despite the increase seen in July 2024, this has now stabilised continues to demonstrate the strong reduction seen over the last 12 months Our levels of recruitment continue to be successful, and there has been a consistent improvement in the number of substantive staff we are recruiting over the last 12 months.

We were successful with a further expressions of interest for additional NHSE funding in 2024/25 for International Recruits within our Allied Health Professional staff group who are supporting the roll out of our Community Diagnostic Centres across Lincolnshire, and pro-active recruitment to these roles continues. We have continued to see further reductions in Nursing & Midwifery vacancies, and there is a strong focus currently on pro-actively supporting a reduction in vacancies within the Medical & Dental staff group, working closely with the Medical Workforce Programme.

AHP recruitment remains a challenge locally and nationally, and will continue to be a focus area in 2024/25 as we further develop the Community Diagnostic Services within Lincolnshire and embrace the continued success of international staff .There is already significant work being undertaken within the Trust via the Talent Academy to support developing the Pharmacy workforce, with support using data insights into vacancies and turnover as required. We expect the previously seen success within this staff group to continue but will monitor this against our plan.

For AHP recruitment we have a dedicated Resourcing Advisor to support this recruitment with a Talent Acquisition approach, we are also looking at using one of our higher performing agencies to support this recruitment. AHP & Pharmacy recruitment remains under significant focus but we believe we are making strong progress in both areas. We continue to work closely with NHSE to successfully recruit international staff specifically for Community Diagnostic Centres.

Finance

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

Post completion of the month 2 position, the Trust submitted a revised financial plan with a revised phasing; the revised plan brought the YTD plan in line with actual spend. The month 6 financial position is reported against the revised plan phasing.

The Trust's YTD position is a £18.1m deficit, which is £7.6m adverse to the planned £10.6m YTD deficit.

CIP savings of £15.9m have been delivered YTD, which £2.2m favourable to planned savings of £13.7m.

Capital funding levels for 2024/25 have been agreed with NHSE and system partners; the Trust delivered capital expenditure of £28.0m YTD, which is £2.3m lower than planned capital expenditure of £30.3m.

The cash balance is £7.0m (plan £6.4m); this is a decrease of £43.9m against the March year-end cash balance of £50.9m. Cash balances have decreased in September by 11.7m. It is anticipated that a series of PDC revenue drawdowns (cash) will be required during Q3 to enable the Trust to continue paying suppliers in line with the BPPC target. A business case has been prepared and submitted to NHSE in support of this and seeks drawdown of £14m (Nov: £10m, Dec: £4m). This business case was agreed by September Trust Board.

Daren Fradgley
Group Chief Integration Officer
October 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.

Performance Overview - Quality

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Jul-24	Aug-24	Sep-24	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Clostridioides difficile position	Safe	Patients	Director of Nursing	9	8	12	5	48	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	0.01	0.01		
	E. coli bacteraemia cases counts and 12-month rolling rates, by reporting acute trust and month using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.02	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	0.08	0.23	0.12	0.14	P	
	Pressure Ulcers category 3	Safe	Patients	Director of Nursing	4.3	10	3	3	26	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%	95.27%	94.85%	96.94%	95.48%	?	H
	Never Events	Safe	Patients	Director of Nursing	0	2	0	0	2	P	
	Reported medication incidents per 1000 occupied bed days	Safe	Patients	Medical Director	4.30	5.05	4.77	4.33	4.79	P	

Performance Overview - Quality

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Jul-24	Aug-24	Sep-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%	9.50%	8.50%	13.50%	11.93%	?	
	Patient Safety Alerts responded to by agreed deadline	Safe	Patients	Medical Director	100.00%	None due	0.00%	None due	44.43%	F	
	Hospital Standardised Mortality Ratio - HSMR (basket of 56 diagnosis groups) (rolling year data 3 month time lag)	Effective	Patients	Medical Director	100	95.75	94.17	93.35	94.42	P	
	Summary Hospital Mortality Indicator (SHMI) (rolling year data 6 month time lag)	Effective	Patients	Medical Director	100	105.02	105.73	105.97	104.77	F	H
	The Trust participates in all relevant National clinical audits	Effective	Patients	Medical Director	100.00%	100.00%	100.00%	100.00%	100.00%	P	H
	eDD issued within 24 hours	Effective	Patients	Medical Director	95.00%	91.50%	87.60%	91.60%	90.85%	F	
	Sepsis screening (bundle) compliance for inpatients (adult)	Safe	Patients	Director of Nursing	90.00%	92.33%	95.60%	Data Not Available	92.19%	P	
	Sepsis screening (bundle) compliance for inpatients (child)	Safe	Patients	Director of Nursing	90.00%	66.00%	90.00%	Data Not Available	79.58%	F	
	IVAB within 1 hour for sepsis for inpatients (adult)	Safe	Patients	Director of Nursing	90.00%	97.87%	96.00%	Data Not Available	96.37%	P	H
	IVAB within 1 hour for sepsis for inpatients (child)	Safe	Patients	Director of Nursing	90.00%	60.00%	80.00%	Data Not Available	78.22%	F	
	Sepsis screening (bundle) compliance in A&E (adult)	Safe	Patients	Director of Nursing	90.00%	91.63%	93.86%	Data Not Available	91.90%	P	

Performance Overview - Quality

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Jul-24	Aug-24	Sep-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%	95.00%	91.50%	Data Not Available	92.67%	P	
	IVAB within 1 hour for sepsis in A&E (adult)	Safe	Patients	Director of Nursing	90.00%	95.73%	94.30%	Data Not Available	94.61%	P	
	IVAB within 1 hour for sepsis in A&E (child)	Safe	Patients	Director of Nursing	90.00%	87.50%	69.00%	Data Not Available	78.48%	F	
	Rate of stillbirth per 1000 births	Safe	Patients	Director of Nursing	3.80	2.70	2.25	1.81	2.55	P	L
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%	85.00%	95.00%	Data Not Available	93.20%	F	
	Duty of Candour compliance - Written	Responsive	Patients	Medical Director	100.00%	85.00%	95.00%	Data Not Available	90.40%	F	

Performance Overview - Quality

Venous Thromboembolism (VTE) Risk Assessment

97%
96%
95%
94%
93%
92%
Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23 Jan-24 Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24
Data Mean Target Control Limits

Sep-24
96.94%
Variance Type
Special cause variation - improvement (Indicator where high is good)
Target
95.00%
Achievement
Variation indicates inconsistently passing and falling short of the target
Executive Lead
Medical Director

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

What the chart tells us:
In September, VTE risk assessment compliance rate reached 96.94%, surpassing the national benchmark. This achievement highlights our commitment to ensuring patient safety and aligning with national standards. However, maintaining consistent compliance remains a challenge.

Issues:
Although our compliance rate is creditable, it has shown fluctuations over time, indicating a need for more reliable and consistent data collection process. One significant issue impacting our compliance consistency is the current data collection method. At present, we pull data from Careflow, which has shown some discrepancies, leading to occasional variations in our reported compliance rates. These inconsistencies in data accuracy pose potential risks to our overall VTE risk assessment efforts, making difficult to sustain a consistently high compliance rate.

Actions:
To address the issues, we are actively working towards improving our data collection process. Our primary action is transitioning to using the ePMA system as the main source for VTE compliance data source. ePMA provides a more reliable data source, which will enable us to have real time insight into our compliance performance. This transition will allow us to not only enhance data accuracy, but also monitor trends more closely and identify areas for further improvement.

Mitigations:
By implementing ePMA as the primary data source we expect to achieve and sustain a compliance rate of 95% or higher. This approach will mitigate the risk of inconsistent compliance by establishing a dependable data collection method. Additionally, ongoing support will be provided to staff to ensure they are competent in utilising ePMA for completing VTE risk assessment. With these measures in place we anticipate more consistent compliance rates, improved alignment with national standards and the ability to address potential non- compliance issues proactively.

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

30%
25%
20%
15%
10%
5%
0%

Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23 Jan-24 Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24

Data Mean Target Control Limits

Sep-24
13.50%
Variance Type
Common cause variation
Target
10.70%
Achievement
Variation indicates inconsistently passing and 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 September the number of medication incidents reported was 148. This equates to 4.43 incidents per 1000 bed days. The number of incidents causing some level of harm (low /moderate /severe / death) is 13.5% 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

Patient Safety Alerts responded to by agreed deadline

Sep-24
None Due
Variance Type
Common cause variation
Target
100.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Medical Director

Background:
Patient safety alerts responded to by agreed deadline.

What the chart tells us:
There were no Alerts due in September, although deviances in compliance continue to be seen.

Issues:
The Trust was previously not demonstrating compliance with the target set for Patient Safety Alerts. The performance was below the lower control limit, with non-compliance in December 2023, March and June 2024. There had been an improvement with 100% compliance in May.

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

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

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

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

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

106
104
102
100
98
Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23 Jan-24 Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24
Data Mean Target Control Limits

Sep-24
105.97
Variance Type
Special cause variation - cause for concern (Indicator where high is a concern)
Target
To remain in 'as expected' range
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Medical Director

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

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

Issues:
The data includes deaths within 30 days. 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.

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

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 93.35

Performance Overview - Quality

eDD issued within 24 hours

Chart axis: 84%, 86%, 88%, 90%, 92%, 94%, 96%; months Jul-23 to Sep-24. Legend: Data, Mean, Target, Control Limits.

Sep-24
91.60%
Variance Type
Common cause variation
Target
95.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Medical Director

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

What the chart tells us:
eDD Performance continues to be below the 95% target, currently at 91.60%.

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

No Narrative owner

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

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

Performance Overview - Quality

Sepsis screening (bundle) compliance for inpatients (child)

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

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

What the chart tells us:
The data for Sepsis screening this month for Paediatric inpatients is 90%. This is equal to the 90% standard. 18 children out of 20 that had PEWS of 5 or above were screened for sepsis within 60 minutes.

Issues:
This month two patients were not screened for sepsis within the hour. The reasons given for these omissions were due to either patient workload /acuity or that they were waiting for Drs to see the patients. Both of these delays were on the Pilgrim site.

Actions:
There is ongoing work within the Family health team to not only increase compliance but to try and maintain these results. Monthly meeting are held between the team and Resus Practitioner. Plans are put in place or updated from this meeting.

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

Performance Overview - Quality

IVAB within 1 hour for sepsis for inpatients (child)

Aug-24
80.00%
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 or administration of IV antibiotics this month with one hour in inpatient areas was 80.0%. This is below the 90% required standard. 1 child out of 5 received their antibiotics outside of the one-hour timeframe.

Issues:
There was one patients this month that had delayed administration of antibiotics. The child had been admitted for bilateral arm fractures but then became unwell and developed a temperature. Due to the bilateral arm casts the child had limited places in order to site a cannula. Emla cream was used to numb the area prior to insertion which takes 45 minutes to one hour to work and this led to the delay.

Actions:
There is an ongoing action plan on both paediatric sites this month to improve and maintain compliance. Although all 3 sites have improved this month one area is still struggling so extra work is being put in place there. Regular meetings with Ward sister and Educator in this area alongside monthly meetings with the family health team.

Mitigations:
Harm review completed and no harm found in this patient.

Performance Overview - Quality

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

Legend: Data, Mean, Target, Control Limits

Months: Jun-23, Jul-23, Aug-23, Sep-23, Oct-23, Nov-23, Dec-23, Jan-24, Feb-24, Mar-24, Apr-24, May-24, Jun-24, Jul-24, Aug-24

Axis: 0%, 20%, 40%, 60%, 80%, 100%

Aug-24
69.00%
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 in A&E (child).

What the chart tells us:
The compliance for Sepsis treatment within 60 minutes in A and E was 69%. 9 children out of 13 were treated with IV antibiotics within the 60 minute timeframe. This is well below the 90% required standard but an improvement on previous month.

Issues:
There were four children this month within the ED departments with delayed Sepsis treatment. There were two children on the Pilgrim site with delayed treatment, these were both surgical patients and the delay was from waiting for surgical teams to see patients and make a decision about treatment. One child had Lincoln was very difficult to cannulate, he was given IM antibiotics at 128 minutes. The second child was prescribed IV antibiotics at 19:50 but they weren't given until 21:15, there is no documented reason for this delay.

Actions:
Fortnightly Sepsis training is ongoing within the departments by Sepsis Practitioner. Lead Consultant has also done some training for medical staff. Staff engagement this month to training has been positive for training held within there department but there is a lack of engagement from ED staff to attend the Monthly Sepsis focus group meeting. This has been escalated.

Mitigations:
Harm reviews were completed for all of the patients with delayed treatment and no harm was found.

Performance Overview - Quality

Duty of Candour compliance - Verbal

Aug-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 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:
95% compliance achieved this month.

Issues:
Improvement had been noted due to the new processes that have been put in place within the incident and clinical teams, and the bespoke tools that have been developed on the DatixIQ system, including the support now being provided by the incident team with written Duty of Candour.

We are hoping that this improvement will continue, however it should be noted that the incident team has a vacancy within the officer cohort which may impact our ability to maintain this in the short term.

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

Weekly tracking in progress by the incident team.

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

Performance Overview - Quality

Duty of Candour compliance - Written

Aug-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:
95% compliance achieved this month.

Issues:
Improvement had been noted due to the new processes that have been put in place within the incident and clinical teams, and the bespoke tools that have been developed on the DatixIQ system, including the support now being provided by the incident team with written Duty of Candour.

We are hoping that this improvement will continue, however it should be noted that the incident team has a vacancy within the officer cohort which may impact our ability to maintain this in the short term.

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

Weekly tracking in progress by the incident team.

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

Performance Overview - Operational Performance

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Jul-24	Aug-24	Sep-24	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Patient Experience	% Triage Data Not Recorded	Effective	Patients	Chief Operating Officer	0.00%	0.29%	0.18%	0.27%	0.25%	0.00%	F	L
Improve Clinical Outcomes	4hrs or less in A&E Dept	Responsive	Services	Chief Operating Officer	76.00%	72.12%	73.67%	74.53%	73.14%	75.09%	F	H
	12+ Trolley waits	Responsive	Services	Chief Operating Officer	0	993	732	950	5,530	0	F	
	%Triage Achieved under 15 mins	Responsive	Services	Chief Operating Officer	88.50%	81.50%	84.92%	82.46%	81.95%	88.50%	F	H
	52 Week Waiters	Responsive	Services	Chief Operating Officer	2,027	3,182	3,280		15,931	10,135	F	L
	65 Week Waiters	Responsive	Services	Chief Operating Officer	0	493	560		2,193	0	F	L
	18 week incompletes	Responsive	Services	Chief Operating Officer	84.10%	52.64%	51.64%		51.79%	84.10%	F	
	Waiting List Size	Responsive	Services	Chief Operating Officer	58,965	71,778	71,955		N/A	N/A	F	H
	28 days faster diagnosis	Responsive	Services	Chief Operating Officer	75.00%	78.90%	76.20%		77.62%	75.00%	P	H
	62 day classic	Responsive	Services	Chief Operating Officer	85.39%	64.00%	61.00%		60.26%	85.39%	F	
	2 week wait suspect	Responsive	Services	Chief Operating Officer	93.00%	74.20%	76.00%		75.12%	93.00%	F	

Performance Overview - Operational Performance

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Jul-24	Aug-24	Sep-24	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Clinical Outcomes	2 week wait breast symptomatic	Responsive	Services	Chief Operating Officer	93.00%	87.80%	58.60%		61.82%	93.00%	F	
	31 day first treatment	Responsive	Services	Chief Operating Officer	96.00%	91.40%	93.10%		89.96%	96.00%	F	
	31 day subsequent drug treatments	Responsive	Services	Chief Operating Officer	98.00%	87.50%	94.70%		89.30%	98.00%	F	
	31 day subsequent surgery treatments	Responsive	Services	Chief Operating Officer	94.00%	92.90%	76.90%		73.88%	94.00%	F	
	31 day subsequent radiotherapy treatments	Responsive	Services	Chief Operating Officer	94.00%	89.30%	95.00%		86.98%	94.00%	F	
	62 day screening	Responsive	Services	Chief Operating Officer	90.00%	89.50%	69.60%		71.84%	90.00%	F	
	62 day consultant upgrade	Responsive	Services	Chief Operating Officer	85.00%	65.20%	65.30%		70.04%	85.00%	F	
	Diagnostics achieved	Responsive	Services	Chief Operating Officer	99.00%	67.19%	72.91%	75.65%	72.74%	99.00%	F	
	Cancelled Operations on the day (non clinical)	Responsive	Services	Chief Operating Officer	0.80%	2.71%	1.91%	3.86%	2.26%	0.80%	F	H
	Not treated within 28 days. (Breach)	Responsive	Services	Chief Operating Officer	0	41	47	46	213	0	F	H
	#NOF 48 hrs	Responsive	Services	Chief Operating Officer	90.00%	78.69%	67.09%	85.96%	73.56%	90.00%	F	

Performance Overview - Operational Performance

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Jul-24	Aug-24	Sep-24	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Clinical Outcomes	#NOF 36 hrs	Responsive	Services	Chief Operating Officer	TBC	44.26%	37.97%	43.86%	43.25%			
	EMAS Conveyances to ULHT	Responsive	Services	Chief Operating Officer	4,657	4,774	4,639	4,541	4,696	4,657	?	H
	EMAS Conveyances Delayed >59 mins	Responsive	Services	Chief Operating Officer	0	418	255	404	349	0	F	L
	104+ Day Waiters	Responsive	Services	Chief Operating Officer	10	51	43	81	329	60	F	H
	Average LoS - Elective (not including Daycase)	Effective	Services	Chief Operating Officer	2.80	2.63	2.49	3.07	2.71	2.80	P	
	Average LoS - Non Elective	Effective	Services	Chief Operating Officer	4.50	4.83	4.79	4.71	4.78	4.50	F	
	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	32,149	32,863	32,927	31,753	4,524	F	H
	% discharged within 24hrs of PDD	Effective	Services	Chief Operating Officer	45.00%	39.34%	37.15%	41.30%	38.84%	45.00%	F	

Performance Overview - Operational Performance

% Triage Data Not Recorded

Sep-24
0.27%
Variance Type
Special cause variation - improvement (Indicator where low is good)
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:
September 24 reported a non-validated position of 0.27% of data not recorded versus the target of 0%. 56% 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 32 minutes.

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

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

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

Performance Overview - Operational Performance

%Triage Achieved under 15 mins

Sep-24
82.46%
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:
September outturn was 82.46% compared 84.92% in August (validated). This is a 6.04% negative variance to the target of 88.50%
September's performance is a 13.01% 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.

Performance Overview - Operational Performance

4hrs or less in A&E Dept

Sep-24
74.53%
Variance Type
Special cause variation - improvement (Indicator where high is good)
Trajectory
76.00%
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.
However, continuing the improved monthly performance trend.
Achieving 74.53% compared to Sept 2023 of 67.61%
What the chart doesn't tell us is also the increased acuity of presentations to the department.

Issues:
In September 2024, Type 1 (ED) witnessed an average daily patient volume of 327, reflecting an increase from the 313 patients attended to in August 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 CDIFF and CPE contacts impacted the availability of resources for movement and cleaning, thereby affecting timely movements.

Type 3 (All locations) observed a static average of 600 daily patients, representing a similar position in both August and September 2024.

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 ULHT 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

Month	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24

Legend: Data, Mean, Target, Control Limits (y-axis: 0, 500, 1,000, 1,500, 2,000)

Sep-24
950
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:
September experienced 950 breaches, an increase from 732 in August, marking a deterioration of 29.78% (218 more patients). The 950 breaches accounted for 70.04% of all type 1 attendances. Additionally, the chart did not capture the adhoc internal decisions made to prioritise total time in the Emergency Department, aimed at minimizing exposure risk and mortality rate.

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

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

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

Performance Overview - Operational Performance

EMAS Conveyances to ULHT

Sep-24
4,541
Variance Type
Special cause variation - cause for concern (Indicator where high is a concern)
Target
4,657
Achievement
Variation indicates inconsistently passing and falling short of the target
Executive Lead
Chief Operating Officer

Background:
EMAS Conveyances to ULHT.

What the chart tells us:
In September 2024, the overall number of patients transported to ULHT increased by 5% compared to the same period in 2023, which means there were at least 200 more conveyances seen.

What the chart doesn't show is that 42% of the daily emergency department attendances were from EMAS transports, and 51.45% of these patients were admitted to an inpatient bed.

Issues:
The timing of patient arrivals results in a higher influx during late afternoon and evening hours, which corresponds with an increase in walk-in visits. Despite ongoing efforts, the utilisation of alternative pathways to divert patients from being admitted to the Trust remains incomplete, although progress is evident. The pressure experienced by neighbouring Trusts has led to an escalated demand for assistance, most of which has been turned down.

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

Mitigations:

21/10/2024 13:41

EMAS Conveyances Delayed >59 mins

Sep-24
404
Variance Type
Special cause variation - improvement (Indicator where low is good)
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 September, there was a decline in ambulance handover performance. There were 404 arrivals recorded over a 59-minute period, compared to 255 in August, which constitutes 8.90% of all arrivals. (17.05% of patients arriving in September 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.
EMAS Clinical Navigator trial imminent to test whether a dedicated senior ambulance member would be able to direct the flow of patients more successfully in conjunction with the operations centre on each site.

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

Performance Overview - Operational Performance

Average LoS - Non Elective

Sep-24
4.71
Variance Type
Common cause variation
Target
4.50
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
September outturn of 4.71 is an improvement of 0.08 days and a 0.21-day negative variance against the agreed target.
What the chart doesn't tell us is the change by pathway:
Pathway 0 (0.1) less days
Pathway 1 (1.2) less days
Pathway 2 (1.2) less days
Pathway 3 (2.5) less days

Issues:
In September, there was an increase in the number of super-stranded patients, with the daily average rising from 108 to 115. Similarly, the number of stranded patients (14 days) decreased in performance from 190 daily to 196. 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

Aug-24
3,280
Variance Type
Special cause variation - improvement (Indicator where low is good)
Trajectory
2,027
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
The Trust reported 3,280 incomplete 52-week breaches for August 2024, an increase of 98 from July's 3,182.

Issues:
As shown above, 52 week waiters are negatively performing against trajectory, with a slight increase 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 40.52% of patients in this wait band. An increase of 1.32% from last month.

Actions:
The Integrated Elective Care Co-Ordination Programme continues to be used for admitted patients, providing an increased efficiency of the 642 process.
ENT continue to have additional weekend clinics throughout September. Additional insourcing commenced on 30th August for weekend Audiology clinics. Additional insourcing is due to commence in September for Maxillo-Facial clinics.

Mitigations:
Due to an overall improved position, ULHT are no longer in the national tiering system for elective recovery.
ULHT 52 week position in current data (W/E 25th August '24) ranks 5th for this metric within the Midlands region (11 Providers).

Performance Overview - Operational Performance

65 Week Waiters

Aug-24
560
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 560 incomplete 65-week breaches for August 2024, an increase of 67 from July's 493.

Issues:
ULHT's 104 week wait position was zero for August.

As shown above, 65 week waiters are starting to slowly increase.

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

Mitigations:
ORIG supports delivery of Outpatient improvements for the non-admitted pathways. To ensure Outpatient capacity is fully utilised and efficiency schemes are implemented and well used.
Current data (W/E 25th August'24) ranks ULHT 5th for 65w cohort metrics within the Midlands region (11 Providers).

18 week incompletes

90%
80%
70%
60%
50%
40%

Jun-23 Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23 Jan-24 Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24

Data — Mean — Target — Control Limits

Aug-24
51.64%
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. August 2024 saw RTT performance of 51.64% against an 84.1% target, which is 1% down from July.

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 – 6,545 (increased by 121)
Gastroenterology – 2,903 (increased by 35)
Ophthalmology – 2,658 (increased by 57)
Gynaecology – 2,535 (increased by 57)
Urology – 1,984 (increased by 19)

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

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

Performance Overview - Operational Performance

Waiting List Size

80,000
75,000
70,000
65,000
60,000
55,000

Jun-23 Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23 Jan-24 Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24

Data — Mean — Trajectory — Control Limits

Aug-24
71,955
Variance Type
Special cause variation - cause for concern (Indicator where high is a concern)
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 July, with August showing an increase of 177 to 71,955.
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 – 10,319
Ophthalmology – 6,258
Gynaecology – 5,434
Gastroenterology – 5,427
Trauma & Orthopaedics 4,957

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 commence December 2024, the remainder in the next financial year.

Mitigations:
The number of patients waiting over 78 weeks has remained the same as July. Current data (W/E 25th August '24) ranks ULHT 5th 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

Sep-24
75.65%
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 Sep 2024 75.65 against the 99.00% target amended target 85% by May 2024.

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

Actions:
Additional MRI CDC capacity from end of December 23 Skegness and LCH, 2nd inhouse scanner should be operational by September 2024, Skegness CDC mobile scanner funding and additional 5 days a Month from March 2024. Radiology are working to their recovery plans that were discussed at the planned care and cancer board.

Mitigations:
Patients are being seen in clinical priority.

21/10/2024 13:41

Performance Overview - Operational Performance

Cancelled Operations on the day (non clinical)

Sep-24
3.86%
Variance Type
Special cause variation - cause for concern (Indicator where high is a concern)
Target
0.80%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
There has been a significant increase in the number of non-clinical cancellations in September to 3.86% compared to 1.91% in August.

Issues:
No Theatre Staff 28
Lack of time 20
Patient DNA'd 8
No Surgeon 6
No Equipment 6
Patient Accepted Then Cancelled 6

Actions:
Theatre staffing highlighted in 642 Pre-meets.
Reduce Late Starts- Business Units to ensure clinicians are arriving on time and reviewing lists in advance, this will reduce cancellations due to lack of time.
Equipment issues are highlighted to Steris.

Mitigations:
Ongoing staff sickness remains an issue particularly at Boston.
A power cut in September resulted in cancellations on the day due to lack of time as theatres had to pause activity until Estates gave the all-clear to restart. This was due to an issue with the National Grid and outside the control of the Organisation (we have had further power cuts in October).

Performance Overview - Operational Performance

Not treated within 28 days. (Breach)

Sep-24
46
Variance Type
Special cause variation - cause for concern (Indicator where high is a concern)
Target
0
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
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 decreased in September to 46 compared to 47 in August.

Issues:
-Patient choice remains a significant factor.
-Surgeons have also been on leave, making it more difficult than normal to co-ordinate lists.
-Waiting List team are also short staff at the moment due to Maternity Leave, AL and vacancies.

Actions:
Divisional Triumvirate are reviewing role of Waiting List and their current staffing arrangements with support from a new Project Manager.

Patients cancelled previously, are now placed first on the list where possible to avoid a second cancellation in the event of a list over-run.

Mitigations:
Patient choice, surgeon annual leave and Waiting List staffing remain the key mitigations.

Performance Overview - Operational Performance

#NOF 48 hrs

Sep-24
85.96%
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 September 2024 is 85.96%.

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.

Performance Overview - Operational Performance

Partial Booking Waiting List

Sep-24
32,927
Variance Type
Special cause variation - cause for concern (Indicator where high is a concern)
Target
4,524
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
Currently at 32,927 against a target of 4,524. During Covid the number of patients overdue significantly increased and since then the trend has seen a steady increase of patients overdue their follow up appointment. The exception was Aug 23 – Nov 23 which saw a slight reduction each month.

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

Actions:
Regular Outpatient Waiting Lists (OWL) meeting with 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 cohort.

Performance Overview - Operational Performance

% discharged within 24hrs of PDD

Month	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24

Legend: Data, Mean, Target, Control Limits

Sep-24
41.30%
Variance Type
Common cause variation
Target
45.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
% discharged within 24 hrs of PDD.

What the chart tells us:
The current performance metrics have displayed a significant improvement since the implementation of the SAFER practitioner to monitor Webv Compliance resulting in an outcome of 41.30% from Augusts out turn of 37.15%.

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:
The delivery team has committed to providing support to the wards commencing in December, resulting in improved performance. Ongoing weekly monitoring is being conducted, and any identified areas of concern are being brought to the attention of ward sisters and matrons to ensure performance enhancement. In July, a new project 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

62 day classic

Aug-24
61.00%
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 61.0% 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. Deep Dives are being undertaken by each CBU to understand how diagnostic turnaround times for positive cancers can be improved as this will be key to achieving the NHSE target of 70% by March '24.

Mitigations:
A process is now in place to ensure the Pre-Diagnosis CNS is made aware of patients who are likely to be non-compliant or in need of support at the time of receipt of referral to allow for early intervention and a more efficient journey on the cancer pathway.

Please also see Mitigations on accompanying pages.

Performance Overview - Operational Performance

2 week wait suspect

Aug-24
76.00%
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 76% 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 61.46% of the Trust's 14-day breaches, this is expected to improve for August performance.

Actions:
The Radiology Recruitment Strategy and intensive support meetings are in place to address the fragile Breast Service One-Stop appointment alignment issues. Respiratory Consultant capacity is ongoing as well as the BC for an increase in consultant workforce to 10-15 consultants. 2 x Lung Cancer CNS posts (funding until March 25) for risk stratification to reduce unnecessary CT scans demand on consultant triage are now established. The Lung Rapid Access pathway will now include CT referrals to accurately reflect performance and has recently been implemented. We 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.

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

Aug-24
58.60%
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 58.6% against a 93% target.

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

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

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

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

Performance Overview - Operational Performance

31 day first treatment

Chart: Jun-23 to Aug-24; Data, Mean, Target, Control Limits (y-axis 82%–100%).

Aug-24
93.10%
Variance Type
Common cause variation
Target
96.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 93.1% 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

100%
95%
90%
85%
80%

Jun-23 Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23 Jan-24 Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24

Data Mean Target Control Limits

Aug-24
94.70%
Variance Type
Common cause variation
Target
98.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 94.7% 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:

Performance Overview - Operational Performance

31 day subsequent surgery treatments

Aug-24
76.90%
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 76.9% against a 98% target.

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

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

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

Performance Overview - Operational Performance

31 day subsequent radiotherapy treatments

Aug-24
95.00%
Variance Type
Common cause variation
Target
94.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 95% 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

Chart: Data, Mean, Target, Control Limits — Jun-23 to Aug-24 (y-axis 20% to 100%)

Aug-24
69.60%
Variance Type
Common cause variation
Target
90.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 69.6% 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.

62 day consultant upgrade

Aug-24
65.30%
Variance Type
Common cause variation
Target
85.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 65.3% against an 85% target.

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

Please also see Issues on accompanying pages.

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

Please also see Actions on accompanying pages.

Mitigations:
Please also see Mitigations on accompanying pages.

Performance Overview - Operational Performance

104+ Day Waiters

Month	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24

Legend: Data, Mean, Target, Control Limits

Sep-24
81
Variance Type
Special cause variation - cause for concern (Indicator where high is a concern)
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 9th October the 104 Day backlog is at 81 patients.
There are 3 main tumour sites of concern:-

Head and Neck 27
Colorectal 16
Urology 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 13.5% of these patients require support from the Pre-Diagnosis CNS as they have mental or social care needs that have the potential to significantly impact on the length of their pathway.

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

Mitigations:

Performance Overview - Workforce

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Jul-24	Aug-24	Sep-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%	93.71%	93.99%	93.81%	93.72%	90.00%	P	H
	Number of Vacancies	Well-Led	People	Director of HR & OD	7.71%	8.51%	8.51%	7.89%	7.02%	8.51%	F	
	Sickness Absence	Well-Led	People	Director of HR & OD	5.47%	5.42%	5.36%	5.28%	5.37%	5.49%	P	L
	Staff Turnover	Well-Led	People	Director of HR & OD	11.48%	10.00%	10.15%	10.22%	10.12%	12.10%	P	L
	Staff Appraisals	Well-Led	People	Director of HR & OD	81.18%	77.58%	80.20%	80.42%	77.66%	78.98%	F	H

OUTSTANDING CARE personally DELIVERED

Performance Overview - Workforce

Number of Vacancies

Sep-24
7.89%
Variance Type
Common cause variation
Trajectory
7.71%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of HR & OD

Background:
September 2024 reported Vacancy Rate is 7.89% against a Q2 target of 7.71%.

What the chart tells us:
That we are not within the Q2 target for September 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

Staff Appraisals

Sep-24
80.42%
Variance Type
Special cause variation - improvement (Indicator where high is good)
Trajectory
81.18%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of HR & OD

Background:
Completion is currently 80.42% for AfC staff, 93.30% for Medical & Dental and 81.75% for Trustwide.

What the chart tells us:
We are meeting the quarterly target for AfC appraisal in month and have seen further improvement compared to previous month.

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

Actions:
- 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.

Financial Position 2024/25

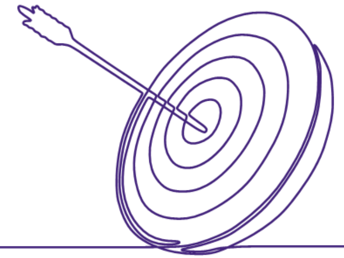
Finance Report M06

5 Year Priority – Efficient Use of Resources

NHS
United Lincolnshire Hospitals
NHS Trust

Financial Position 2024/25

M06 Headlines - ULHT



Adjusted financial performance	Current Month Plan £000's	Current Month Actual £000's	Current Month Variance £000's	Year to Date Plan £000's	Year to Date Actual £000's	Year to Date Variance £000's
Operating Income from patient care activities	64,299	63,390	(909)	377,932	379,114	1,182
Other operating Income	3,825	4,132	307	21,747	23,144	1,397
Employee Expenses	(43,607)	(45,744)	(2,137)	(266,631)	(278,679)	(12,048)
Operating expenses excl employee expenses	(23,477)	(23,377)	100	(139,839)	(138,630)	1,209
Operating Surplus/(Deficit)	**1,040**	**(1,599)**	**(2,639)**	**(6,791)**	**(15,051)**	**(8,260)**
Net finance costs	(893)	(719)	174	(4,836)	(4,208)	628
Other gains/(losses) including disposal of assets	0	0	0	12	20	8
Surplus / (Deficit) for the period	**147**	**(2,318)**	**(2,465)**	**(11,615)**	**(19,239)**	**(7,624)**
Remove capital donations/grants/peppercorn lease I&E impact	45	14	(31)	348	408	60
Remove PFI revenue costs on an IFRS 16 basis	117	116	(1)	704	704	0
Adjusted financial performance surplus/(deficit)	309	(2,188)	(2,497)	(10,563)	(18,127)	(7,564)

Revenue position

- The Trust's 2024/25 financial plan is a deficit of £6.9m; the Trust's planned deficit is part of a break-even plan submitted by the Lincolnshire ICS.
- The accompanying table shows that:

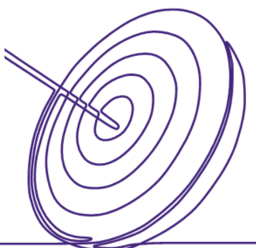
❑ The Trust delivered an in-month deficit of £2.2m or £(2.5)m adverse to a planned surplus of £0.3m.

❑ The Trust delivered a YTD deficit of £18.1m or £7.6m adverse to a planned deficit of £10.6m.

- The drivers of the movement from plan include £4.6m of justifiable adverse variances to plan and £3.0m net of other cost pressures.
- A request for funding of the nurse establishment review (£1.7m FYE at substantive cost) to come from the system risk pool was considered by the system in September, but a decision was deferred to allow due consideration to be given to this risk in the context of other system risks.
- The in-month deficit of £2.2m is £1.3m higher than the deficit of £0.9m reported in August. However, the August position included income accruals re prior periods of £1.2m in relation to Industrial Action and £0.7m re contract variations in relation to the £16m investment gap. Without the prior period income, the reported actual in-month deficit in August would have been £2.8m.
- Given the Trust has only received Industrial Action funding of £0.7m in September, not £1.2m as accrued in August, the in-month position in September could therefore have been expected to be a deficit of £3.3m, such that the reported £2.2m deficit is an improvement of £1.1m, which is due primarily due to a fall in pay expenditure.
- ERF performance remains weak despite the adverse revenue position.

Financial Position 2024/25

Key areas of focus – CIP, cash, BPPC & Capital



CIP position

- The Trust's CIP plan for 2024/25 is to deliver savings of £40.1m; the Trust YTD has delivered savings of £15.9m, or £2.2m higher than planned savings of £13.7m. The early delivery of CIP is temporarily offsetting cost pressures in the YTD revenue position.

Cash

- The September 2024 cash balance is £7.0m (plan: £6.4m); this is a decrease of £43.9m against the March year-end cash balance of £50.9m.
- Cash balances have decreased in September by £11.7m. It is anticipated that a series of PDC revenue drawdowns (cash) will be required during Q3 to enable the Trust to continue paying suppliers in line with the BPPC target. A business case has been prepared and submitted to NHSE in support of this and seeks drawdown of £14m (Nov: £10m, Dec: £4m) . This was agreed by September Trust Board.

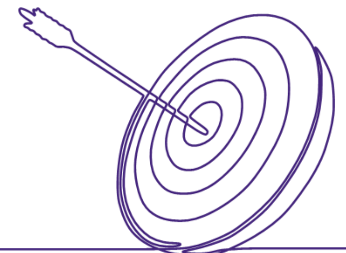
BPPC

- The BPPC performance for September was 96% / 93% by value / volume of invoices paid (appendix 5d). Year to date performance is at 94% / 94%; this compares to the full year performance in 2023/24 of 88% / 83%.
- At the end of September there were circa 800 unpaid invoices (£2.5m) over term August 700 / £2.1m). These will impact future BPPC performance levels as they are paid.
- Following receipt of a letter from Julian Kelly re-iterating the 95% target and directing the Trust to improve performance from April 23, a multi-faceted improvement plan was implemented. This led to an improvement in 2023/24 which has continued into the first half of 2024/25. A significant element of this is due to process improvements and additional resourcing within pharmacy.

Capital position

- The Trust's 2024/25 capital plan amounts to c£75.7m; the Trust delivered YTD capital expenditure of £28.0m, or £2.3m lower than planned capital expenditure of £30.3m.

Finance Dashboard



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

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

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

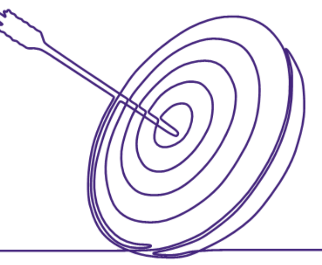
The finance assessment seeks to answer the question: ***How effectively is the trust managing its financial resources to deliver high quality, sustainable services for patients?*** It does this at a high level using the 5 key indicators and each of which is rated 1 to 4 [which represent Outstanding,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

Finance and use of resources rating	Full Year ending:						Actual	Forecast
	Mar-19	Mar-20	Mar-21	Mar-22	Mar-23	Mar-24	Sep-24	Mar-25
Capital service cover metric	(10.40)	(1.73)	0.06	3.60	1.48	1.19	(0.10)	2.71
Capital service cover rating	4	4	4	1	3	4	4	1
Liquidity metric	(98.73)	(128.28)	3.71	2.50	(10.91)	(19.40)	(29.53)	(18.37)
Liquidity rating	4	4	1	1	3	4	4	4
I&E margin metric	(19.71%)	(7.62%)	0.38%	0.29%	(1.80%)	(2.63%)	(4.68%)	(0.86%)
I&E margin rating	4	4	2	2	4	4	4	3
Agency metric	77.00%	110.00%	113.00%	120.00%	~~0.00%~~	~~0.00%~~	~~0.00%~~	~~0.00%~~
Agency rating	4	4	4	4	~~1~~	~~1~~	~~1~~	~~1~~
I&E margin: distance from financial plan - metric	(2.80%)	0.70%	n/a	0.01%	(1.80%)	0.23%	(1.99%)	(0.86%)
I&E margin: distance from financial plan - rating	4	1	n/a	1	3	1	3	2

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

Financial Position 2024/25

Key areas of focus - Income



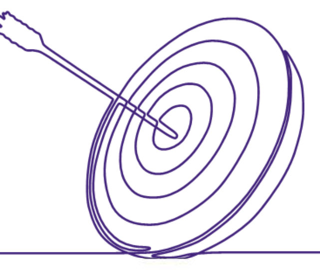
	Current Month			Year to Date		
	Plan £000's	Actual £000's	Variance £000's	Plan £000's	Actual £000's	Variance £000's
NHSE & ICB TOTAL	63,862	63,195	(667)	375,846	377,614	1,768
Non-NHS: private patients	17	8	(9)	95	79	(16)
Non-NHS: overseas patients (non-reciprocal, chargeable to patient)	45	19	(26)	327	320	(7)
Injury cost recovery scheme	90	115	25	516	560	44
Other patient care activties Income	285	53	(232)	1,148	541	(607)
Sub-Total - Operating income from patient care activties	**64,299**	**63,390**	**(909)**	**377,932**	**379,114**	**1,182**
Education and training	2,329	2,352	23	12,491	12,863	372
Income in respect of employee benefits accounted on a gross basis	498	434	(64)	2,661	2,660	(1)
Non-patient care services	391	469	78	2,459	2,501	42
Catering	251	248	(3)	1,498	1,482	(16)
Research and development	103	153	50	660	827	167
Rental revenue from operating leases	102	109	7	629	670	41
Car parking income	86	91	5	543	577	34
Other operating income	65	276	211	806	1,564	758
Sub-total - Other operating income	**3,825**	**4,132**	**307**	**21,747**	**23,144**	**1,397**
Total - Income	**68,124**	**67,522**	**(602)**	**399,679**	**402,258**	**2,579**

- **Operating Income from Patient Care Activities**
  Patient Care Activities income is £1.2m YTD favourable to plan; this includes over performance on pass through, £0.1m over performance in relation to ERF gain share (CIP) & recognition of £(1.2)m of risk that the YTD under spend on national EPR funding will be withdrawn. ERF Performance remains weak and that is a risk to the position in H2 should that continue; work to understand this by specialty is being undertaken.

- **Other Operating Income**
  Other Operating income is £1.4m YTD favourable to plan; this most notably includes £0.4m on education & training, £0.2m re R&D and £0.4m in relation to income generation.

Financial Position 2024/25

Key areas of focus - Pay

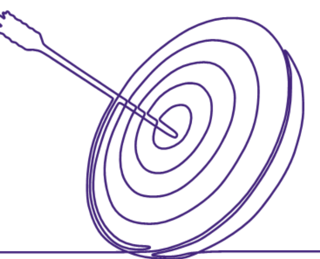


	Current Month			Year to Date		
	Plan £000's	Actual £000's	Variance £000's	Plan £000's	Actual £000's	Variance £000's
Substantive staff including on-costs	(36,684)	(38,928)	(2,244)	(221,305)	(229,354)	(8,049)
Agency / contract	(1,107)	(2,106)	(999)	(10,789)	(13,937)	(3,148)
Bank staff including on-costs	[illegible]	(4,332)	1,137	(32,385)	(33,161)	(776)
Other	(347)	(378)	(31)	(2,152)	(2,227)	(75)
Total employee expenses	(43,607)	(45,744)	(2,137)	(266,631)	(278,679)	(12,048)

- The pay position is £12.0m YTD adverse to plan.
- Pay expenditure of £45.7m in August is £2.1m adverse to plan but £1.0m lower than pay expenditure of £46.7m in August.
- The £1.0m reduction in overall pay expenditure in September reflects in part the fact that August included £0.5m of SAS doctors pay arrears and £0.2m of Bank Holiday enhancements, and the fact that September includes the release of £0.3m more technical pay savings (in Bank) than released in August.
- However, while the position also includes a reduction of £0.7m in medical & dental bank expenditure in the clinical divisions, this has not flowed to the bottom line pay position because agency pay expenditure has increased by £0.2m compared to August and the rest of the favourable movement in bank pay expenditure has been consumed by an increase in substantive staffing expenditure.
- It is noted that overall agency pay expenditure in H1 of 2024/25 has fallen by £3.2m in comparison to the same period in 2023/24. However, overall agency expenditure in 2023/24 was relatively flat in H2, and it has only been in August in September that it has fallen from below that previous expenditure trend; medical & dental agency expenditure account for 84% of total agency pay expenditure in September.

Financial Position 2024/25

Key areas of focus – Non-Pay



	Current Month			Year to Date		
	Plan £000's	Actual £000's	Variance £000's	Plan £000's	Actual £000's	Variance £000's
Other operating expenses	(20,777)	(21,150)	(373)	(124,693)	(125,285)	(592)
Depreciation & amortisation	(2,700)	(2,227)	473	(15,146)	(13,345)	1,801
Total operating expenses excl Exployee Expenses	**(23,477)**	**(23,377)**	**100**	**(139,839)**	**(138,630)**	**1,209**

- The non-pay position is £1.2m YTD favourable to plan driven by lower than planned expenditure on capital charges.
- Non-pay expenditure of £23.4m in September is £0.1m favourable to plan but £0.6m higher than expenditure of £22.7m in August. The £0.6m increase in non-pay expenditure notably includes a £0.8m increase in passthrough drugs and a £0.4m reduction in spend on clinical supplies and services.

❖ **Depreciation & amortisation - £1.8m favourable to plan**

❖ **Excess inflation – £(1.9)m adverse to plan**

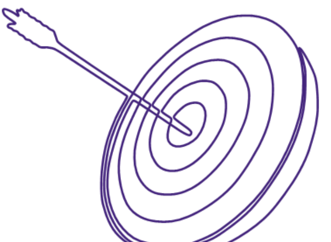
While the 2024/25 financial plan includes non-pay inflation as per national planning guidance, the actual level of inflation suffered was expected to be higher than planned; our estimate of excess non-pay inflation suffered YTD of £0.9m is still subject to validation and the true figure may be higher as we receive actual invoices.

❖ **CIP – £2.1m favourable to plan**

The Trust has planned to deliver £15.2m of non-pay CIP savings in 2024/25; the plan expected £3.9m to be delivered YTD and £5.9m or £2.0m more than planned has been delivered; £1.9m of the favourable movement relates to early delivery of technical pay savings release.

❖ **Other – £(0.8)m adverse to plan** [inclusive of higher than planned expenditure on pass through].

Balance Sheet



	31-Mar-24	30-Sep-24			31-Mar-25	
		Plan	Actual	Variance	Plan	Forecast
	£000	£000	£000	£000	£000	£000
Intangible assets	10,924	8,670	8,742	(72)	6,071	6,093
Property, plant and equipment	333,031	351,752	351,325	427	384,843	380,254
Right of use assets	13,956	12,831	12,777	54	13,741	13,603
Receivables	2,022	2,038	2,072	(34)	2,038	2,038
Total non-current assets	**359,933**	**375,291**	**374,916**	**375**	**406,693**	**401,988**
Inventories	6,581	6,910	6,543	367	6,910	6,500
Receivables	19,781	31,562	25,408	6,154	31,562	24,551
Cash and cash equivalents	50,858	6,442	6,982	(540)	25,308	25,308
Total current assets	**77,220**	**44,914**	**38,933**	**5,981**	**63,780**	**56,359**
Trade and other payables	(95,425)	(65,450)	(78,697)	13,247	(75,518)	(78,823)
Borrowings	(3,167)	(3,167)	(3,175)	8	(3,167)	(3,167)
Provisions	(12,154)	(4,234)	(7,874)	3,640	(2,734)	(1,320)
Other liabilities	(1,195)	(6,734)	(7,821)	1,087	(6,734)	(6,734)
Total current liabilities	**(111,941)**	**(79,585)**	**(97,567)**	**17,982**	**(88,153)**	**(90,044)**
Total assets less current liabilities	**325,212**	**340,620**	**316,282**	**24,338**	**382,320**	**368,303**
Borrowings	(13,557)	(12,100)	(12,134)	34	(12,619)	(12,619)
Provisions	(5,271)	(5,409)	(5,428)	19	(5,583)	(5,271)
Other liabilities	(10,566)	(10,314)	(10,314)	-	(10,063)	(10,063)
Total non-current liabilities	**(29,394)**	**(27,823)**	**(27,876)**	**53**	**(28,265)**	**(27,953)**
Total assets employed	**295,818**	**312,797**	**288,406**	**24,391**	**354,055**	**340,350**
Financed by						
Public dividend capital	756,760	785,299	768,585	16,714	823,858	810,263
Revaluation reserve	48,454	47,853	47,850	3	47,249	47,246
Other reserves	190	190	190	-	190	190
Income and expenditure reserve	(509,586)	(520,545)	(528,219)	7,674	(517,242)	(517,349)
Total taxpayers' equity	**295,818**	**312,797**	**288,406**	**24,391**	**354,055**	**340,350**

Note 1: The plan presented reflects the June resubmission of the 2024/25 financial plan

Note 2: As at 30 September the balance sheet is broadly in line with plan. Notable exceptions being:
- Receivables / Payables, with movements combining to mean that revenue cash support has not yet been required.
- PDC Dividend linking to the above where revenue PDC draws have not yet been required.

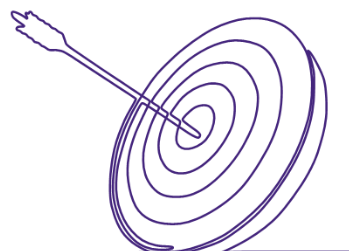
Note 3: The 2024/25 capital programme is the largest undertaken by the Trust at £78.2m. Depreciation is similarly significantly increased on recent years. The net impact is that Property, Plant, Equipment & Intangibles are expected to increase by £42m in year.

Note 4: Receivables is predominantly a mix of invoiced debt £3.5m, accrued income £8.7m, VAT £1.1m and prepayments £12.8m, offset in part by bad debt provisions of £1.4m.

Note 5: The overall level of Trade and other payables has reduced to £78.7m including capital creditors of £14.8m.

Note 6: The level of provisions have reduced in month by £0.6m and are expected to reduce further through 2024/25 as the remaining 'Flowers,' and Litigation issues are reviewed and resolved.

Cashflow reconciliation – April 2024– March 2025



	31-Mar-24	30-Sep-24			31-Mar-25	
		Plan	Actual	Variance	Plan	Forecast
	£000	£000	£000	£000	£000	£000
Operating surplus / (deficit)	(20,954)	(6,791)	(15,049)	8,258	1,021	57
Depreciation and amortisation	25,768	15,146	13,345	1,801	36,123	36,123
Impairments and reversals	6,580	-	-	-	-	-
Income recognised in respect of capital donations	(114)	-	(78)	78	(50)	(78)
Amortisation of PFI deferred credit	(503)	(252)	(252)	-	(503)	(503)
(Increase) / decrease in receivables and other assets	33,556	(11,797)	(5,664)	(6,133)	(11,797)	(4,828)
(Increase) / decrease in inventories	(448)	(329)	38	(367)	(329)	81
Increase/(decrease) in trade and other payables	358	(13,510)	(4,481)	(9,029)	(10,543)	(6,305)
Increase/(decrease) in other liabilities	(65)	5,539	6,626	(1,087)	5,539	5,539
Increase / (decrease) in provisions	(5,390)	(7,834)	(4,175)	(3,659)	(9,160)	(10,886)
Net cash flows from / (used in) operating activities	**38,784**	**(19,828)**	**(9,690)**	**(10,138)**	**10,301**	**19,200**
Interest received	2,551	790	1,113	(323)	1,206	1,648
Purchase of intangible assets	(7,132)	-	-	-	-	(50)
Purchase of property, plant and equipment	(44,652)	(47,070)	(40,602)	(6,468)	(90,032)	(86,369)
equipment	59	17	26	(9)	17	77
Net cash flows from / (used in) investing activities	**(49,227)**	**(46,263)**	**(39,463)**	**(6,800)**	**(88,809)**	**(84,694)**
Public dividend capital received	32,718	28,539	11,824	16,715	67,098	53,502
Other loans repaid	(805)	(403)	(403)	-	(805)	(805)
Capital element of finance lease rental payments	(2,393)	(1,212)	(891)	(321)	(2,475)	(2,475)
Interest paid	(9)	-	(3)	3	-	(3)
Interest element of finance lease	(142)	(105)	(105)	-	(252)	(252)
PDC dividend (paid)/refunded	(9,328)	(5,143)	(5,140)	(3)	(10,603)	(10,016)
Cash flows from (used in) other financing activities	(9)	(1)	(5)	4	(5)	(7)
Net cash flows from / (used in) financing activities	**20,032**	**21,675**	**5,277**	**16,398**	**52,958**	**39,944**
Increase / (decrease) in cash and cash equivalents	**9,589**	**(44,416)**	**(43,876)**	**(540)**	**(25,550)**	**(25,550)**
Cash and cash equivalents at 1 April - b'f	**41,269**	**50,858**	**50,858**	**(0)**	**50,858**	**50,858**
Cash and cash equivalents at period end	**50,858**	**6,442**	**6,982**	**(540)**	**25,308**	**25,308**

Note 1: Cash held at 30 September was £7.0m against a plan of £6.4m. This represents a decrease of £43.9m against the March year-end cash balance of £50.9m and a decrease from August of £11.7m.

Note 2: The September cash reduction is in line with the updated receipts and payments forecast.

Note 3: The capital programme for 2024/25 is funded through a mix of internally generated resource £33.5m and external PDC £44.5m. This is being drawn down in line with capital spend – YTD £11.8m.

Note 4 External support will be required in Q3. A business case has been submitted to NHSE to access cash support of £14m (Nov: £10m, Dec £4m) this required to fund the cash impact of:

- The planned deficit of £6.9m plus any excess beyond plan.
- Release / utilisation of provisions associated with litigation and contractual obligations – circa £8m.
- Reduction in capital creditors

Note 5: During October / November the 2024/25 pay award and arrears will be processed. The Trust will be funded for the cash impact of this with funding from LICB and NHSE.

Risk Reporting to the Group Board

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Hospitals NHS Trust

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*5 November 2024*
Item Number	*14.1*

Executive Summary LCHS / ULHT Strategic Risk Reports

Accountable Director	*Kathryn Helley, Group Chief Clinical Governance Officer*
Presented by	*Kathryn Helley, Group Chief Clinical Governance Officer*
Author(s)	*Helen Shelton, Deputy Director of Clinical Governance*
Recommendations/	*The Group Board is invited to review the content of the report, no further escalations at this time.*

Joint Executive Summary

It is evident that currently both organisations have their own Risk Strategy or Policy, and both have subtle differences in the approach to risk management, risk support, risk appetite and risk scoring compounded by two sets of strategic objectives.

The Risk management policies across the Group have been reviewed and revised into a single policy document with the draft version shared as part of a Group Board development session in September 2024. A revised risk appetite statement, linked to the updated LCHG strategic objectives, will be added to the Policy and published once it has been developed and agreed by the Group Board for this financial year 2024/2025. Roll out plans are now being devised with a proposed launch date of the Group policy on the 1 December across LCHG. Of note, up until that time both organisations will continue to work to their individual policies. The Group Board will be provided with a joint executive summary until full alignment with reporting has been achieved.

ULHT

As of October 2024, there were 578 risks recorded on the Trust risk register and aligned to the sub committees of the Group Board; this is a decrease 2 risks from the previous report in September 2024.

There were 9 quality and safety risks rated Very High (20-25) reported to the Quality Committee in Common in September, which remains stable but with risk movement from the previous month's reporting period:

- Patient flow through Emergency Departments
- Recovery of planned care cancer pathways
- Reliance on paper medical records
- Reliance on manual prescribing processes;
- Delivery of paediatric epilepsy pathways-community

- Quality and safety risk from inability to deliver epilepsy pathways within Acute Paediatrics that meet National standards
- Medicines reconciliation compliance
- Removal of lift in H Block PHB affecting service delivery to patient records
- Risk of Gastro service not being viable due to current fragility of Consultant workforce - **Risk presented at September RRC&C meeting and validated for increase of score from 12 Moderate Risk to 20 Very High.**

Following presentation at the Risk Confirm and Challenge Meeting during this period, the following risks aligned with QC have been updated:

- Risk 4740 - Demand for Haematology outpatient appointments was closed in August and combined with existing risk 4996 which is aligned with PODC.

There are 5 People and Organisational Development risks rated Very High (20-25) which were reported to the People & Organisational Development Committee this month, remaining stable from the previous reporting period:

- Staffing levels requiring an increase in Pharmacy to be able to provide a seven-day service.
- Pharmacy workload demands
- Service configuration (Haematology)
- Consultant workforce capacity (Haematology)
- Cancellation of elective lists due to lack of theatre staff

There are 7 Very high risks (20-25) reported to the Finance, Performance and Estates Committee this month, an increase of 1 from the previous reporting period:

- Potential for a major fire;
- Compliance with fire safety standards, assessed by Lincolnshire Fire and Rescue Service;
- Exceeding the agency cap due to the cost of reliance upon temporary clinical staff
- Reliance on agency / locum medical staff in Urgent & Emergency Care
- SAR's Compliance and access to Health records in accordance with statuary requirements.
- Grantham Medical Air Plant Fault/Failure
- Failure to meet 24/25 CIP - **Risk presented at August Risk Confirm and Challenge, validated for increase in score to 20 Very high.**

Details of all current High and Very high risks are provided in ULHT **Appendix A**.

LCHS

As of the October 2024, there were 111 risks recorded on the Trust risk register aligned to the sub-committees of the Group Board, this is an increase of 10 risks from the previous report in September 2024.

There were 7 quality and safety risks rated Significantly High (15 - 25) reported to the Joint Quality Committee. This is a reduction of 2 from the previous reporting period.
These 7 risks relate to:

- 495 – Treatment Room Capacity
- 403 - Children Young People Therapy treatment delays

- 672 - Timely Unplanned Palliative Response 24/7
- 695 - Lack of District Nurse Specialist Practice qualified staff in community nursing affecting the quality of care
- 714 - Delivery of pressure ulcer care in the community
- 715 - Community nursing lacks capacity and skill set to meet community demand
- 681 - Children in Care - unable to meet Initial Health Assessment and Review Health Assessment timescales

The following risks have been **updated** since the last report:

- 409 - Lymphoedema service capacity – following review and scrutiny at Risk Register Confirm and Challenge (RRC&C) on 24th September the score was revised and **decreased** to **12 High risk** (previously 16)
- 395 – TB Demand and Capacity – Following review and scrutiny by RRC&C on 28th August 2024 the score was revised and **decreased** to **12 High risk** (previous 16).

There were 5 risks rated significantly High (15 – 25) reported to the Finance, Performance, People and Innovation Committee. This is a reduction of 3 from the previous reporting period. These 5 relate to:

- 444 – Failure to deliver the financial plan (cost) - Score reviewed at RRC&C 28 August and **increase** to score to **16** (previously 15).
- 390 – John Coupland Hospital Theatres Ventilation
- 391 – John Coupland Hospital Water Safety
- 393 – Skegness Hospital Water Safety
- 649 – Fire Safety Core Risk

The following risk has been **updated** since the July report:

- 442 – Efficiency Requirement 24/25 – Score reviewed at RRC&C 28 August 2024 and **decreased** to **12 High risk** (previously 20).
- 455 – Failure to deliver financial plan 24/25 (Income) – Score reviewed at RRC&C 28 August 2024 and **decreased** to **12 High risk** (previously 20).
- 418 – Medical Gases Compliance. Score reviewed at the RRC&C 28 August 2024 and **closed**. The risk will be **replaced with a new risk 746 scoring 12**.

There are 0 People and Organisational Development risks rated Significant (15-25) for this reporting period.

Details of all current Significant risks are provided in LCHS **Appendix A**.

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*5 November 2024*
Item Number	*14.1*

Strategic Risk Report

Accountable Director	*Kathryn Helley, Group Chief Clinical Governance Officer*
Presented by	*Kathryn Helley, Group Chief Clinical Governance Officer*
Author(s)	*Sarah Davy, Risk & Datix Manager* *Rachael Turner, Risk & Datix Facilitator*
Report previously considered at	*Lead assurance committees for each strategic objective*

How the report supports the delivery of the priorities within the LCHG Board Assurance Framework	
1a Deliver high quality care which is sae, responsive and able to meet the needs of the population	*X*
1b Improve patient experience	*X*
1c Improve clinical outcomes	*X*
1d Deliver clinically led integrated services	*X*
2a Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	*X*
2b To be the employer of choice	*X*
3a Deliver financially sustainable healthcare, making the best use of resources	*X*
3b Drive better decision and impactful action through insight	*X*
3c A modern, clean and fit for purpose environment across the Group	*X*
3d Reduce waits for patients who require urgent and emergency care and diagnostics and ensure we meet all constitutional standards	*X*
3e Reducing unwarranted variation in cancer service delivery and ensure we meet all constitutional standards (ULHT)	*X*
3f Reducing unwarranted variation in planned service delivery and ensure we meet all constitutional standards (ULHT)	*X*
3g Reducing unwarranted variation in community service delivery and ensure we meet all constitutional standards (LCHS)	*X*
4a Establish collaborative models of care with all our partners including Primary Care Network Alliance (PCNA), GPs, health and social care and voluntary sector	*X*
4b Successful delivery of the Acute Services Review	*X*
4c Grow our research and innovation through education, learning and training 4d Enhanced data and digital capability	*X*

5a Develop a Population Health Management (PHM) and Health Inequalities (HI) approach for our Core20PLUS5 with our ICS	*X*
5b Co-create a personalised care approach to integrate services for our population that are accessible and responsive	*X*
5c Tackle system priorities and service transformation in partnership with our population and communities	*X*
5d Transform key clinical pathways across the group resulting in improved clinical outcomes	*X*

Risk Assessment	*Multiple – Please see report*
Financial Impact Assessment	*None*
Quality Impact Assessment	*None*
Equality Impact Assessment	*None*
Assurance Level Assessment	*Significant*

Recommendations/ Decision Required	• *The Group Board are invited to review the content of the report, no further escalations at this time.*

Executive Summary

This Strategic Risk Report focuses on the highest priority risks to the Trust's strategic objectives (those with a current rating of High or Very High risk, 15-25); only risks that have been validated by the Risk Register Confirm & Challenge Group and reported to the appropriate lead committee are included in this report.

This report contains data that covers August and September 2024.

There were 9 quality and safety risks rated Very High (20-25) reported to the Quality Committee in Common in September, which remains stable but with risk movement from the previous month's reporting period:

- Patient flow through Emergency Departments
- Recovery of planned care cancer pathways
- Reliance on paper medical records
- Reliance on manual prescribing processes;
- Delivery of paediatric epilepsy pathways-community
- Quality and safety risk from inability to deliver epilepsy pathways within Acute Paediatrics that meet National standards
- Medicines reconciliation compliance
- Removal of lift in H Block PHB affecting service delivery to patient records
- Risk of Gastro service not being viable due to current fragility of Consultant workforce - **Risk presented at September RRC&C meeting and validated for increase of score from 12 Moderate Risk to 20 Very High.**

Following presentation at the Risk Confirm and Challenge Meeting during this period, the following risks aligned with QC have been updated:

- Risk 4740 - Demand for Haematology outpatient appointments was closed in August and combined with existing risk 4996 which is aligned with PODC.

There are 5 People and Organisational Development risks rated Very High (20-25) which were reported to the People & Organisational Development Committee this month, remaining stable from the previous reporting period:

- Staffing levels requiring an increase in Pharmacy to be able to provide a seven-day service.
- Pharmacy workload demands
- Service configuration (Haematology)
- Consultant workforce capacity (Haematology)
- Cancellation of elective lists due to lack of theatre staff

There are 7 Very high risks (20-25) reported to the Finance, Performance and Estates Committee this month, an increase of 1 from the previous reporting period:

- Potential for a major fire;
- Compliance with fire safety standards, assessed by Lincolnshire Fire and Rescue Service;
- Exceeding the agency cap due to the cost of reliance upon temporary clinical staff
- Reliance on agency / locum medical staff in Urgent & Emergency Care
- SAR's Compliance and access to Health records in accordance with statuary requirements.
- Grantham Medical Air Plant Fault/Failure
- Failure to meet 24/25 CIP - **Risk presented at August Risk Confirm and Challenge, validated for increase in score to 20 Very high.**

Purpose

The purpose of this report is to enable the Group Board to review the management of significant risks to strategic objectives and consider the overall extent of risk exposure within the Trust at this time.

1. Introduction

1.1 The Trust's risk registers are recorded on the DatixIQ Risk Management System. This report is focussed on significant risks to each objective, those with a current rating of Very High risk (a score of 20-25).

1.2 Full details of all active Very High and High risks (those with a current risk score of 15-25) are included in **Appendix A**, and a summary of Very High risks is provided in Section 2 below. Moderate and Low risks (those with a score of 12 and below) are managed at divisional level.

1.3 The Risk Register Confirm and Challenge Group continues to meet on a monthly basis, reviewing all High and Very high risks as well as receiving presentations from clinical and corporate business areas on a rotational basis to enable constructive feedback to be provided.

2. Trust Risk Profile

2.1 There are 578 active and approved risks reported to lead committees this month, a decrease of 2 risks since the last report.

2.2 There are 21 risks with a current rating of Very High risk (20-25) and 54 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)
51 (+2) (9%)	**139 (+9)** (24%)	**313 (-14)** (54%)	**54 (-)** (9%)	**21 (+1)** (4%)

Strategic Objective Updates

A full review has been undertaken of the Lincolnshire Community and Hospitals Group Board Assurance Framework (BAF) 2024/25. Following this review the Strategic Objectives on the Trust's Risk Register have been aligned appropriately.

The updated Strategic Objectives aligned with the Quality Committee in Common are:

- 1a - Deliver high quality care which is safe, responsive and able to meet the needs of the population
- 1b - Improve patient experience
- 1c - Improve clinical outcomes
- 1d - Deliver clinically led integrated services
- 5b - Co-create a personalised care approach to integrate services for our population that are accessible and responsive
- 5d - Transform key clinical pathways across the group resulting in improved clinical outcomes

The updated Strategic Objectives aligned with PODC are:

- 2a - Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise
- 2b -To be the employer of choice
- 4c - Grow our research and innovation through education, learning and training

Work is still ongoing to align PODC risks to the correct objective, therefore for the purpose of this report the Strategic Objectives aligned with PODC remain the same as previously.

The updated Strategic Objectives aligned with FPEC are:

- 3a Deliver financially sustainable healthcare, making the best use of resources
- 3b Drive better decision and impactful action through insight
- 3c A modern, clean and fit for purpose environment across the Group
- 3d Reduce waits for patients who require urgent and emergency care and diagnostics and ensure we meet all constitutional standards
- 3e Reducing unwarranted variation in cancer service delivery and ensure we meet all constitutional standards (ULHT)

- 3f Reducing unwarranted variation in planned service delivery and ensure we meet all constitutional standards (ULHT)
- 4a Establish collaborative models of care with all our partners including Primary Care Network Alliance (PCNA), GPs, health and social care and voluntary sector
- 4b Successful delivery of the Acute Services Review
- 4d Enhanced data and digital capability
- 5a Develop a Population Health Management (PHM) and Health Inequalities (HI) approach for our Core20PLUS5 with our ICS

Strategic objective 1a: Deliver high quality care which is safe, responsive and able to meet the needs of the population

2.3 There are 7 Very High risks, remaining stable and 17 High risks, an increase of 4 recorded in relation to this objective. A summary of the Very High risks is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
5143	The demolition of H Block will remove facilities and amenities that the health records teams utilise. The impact of removing the lift will restrict the movement of patient notes and potentially the number of patients being seen in outpatients. The health records team will need to move notes in the dumbwaiters which is previously resulted in injury and legal action. With using the dumbwaiters, this will impact information governance and security of notes due to the storage and location. Staff morale will be impacted due to extra manual handling and loss of amenities required to support with mitigating this risk. This risk also has an impact on staff workload due to extra time the tasks will now take, this will also have a knock on effect to other services such as porters, secretaries. With no lift to support the department if any large items fail i.e printer or racking, replacement items will be unable to be delivered.	Very high risk (25)	To reduce the impact the team will use dumb waiters, one of which is in another area with limited access. Change of processes to mitigate risk and transfer notes over a longer period. Walk around with senior individuals and project team to look at different ways of working and potential solutions. Risks to be highlighted in QIA. Risk to be presented at PRM. Health and Safety guidance to be delivered to Team. Further discussions to be had regarding whether all clinicians requiring paper based notes in clinic.	17/10/2024

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
5016	If there is not sufficient flow through the Trusts Emergency Departments, due to demand outstripping capacity and insufficient availability of beds in the hospitals leading to overcrowding. This may result in increased likelihood of long waits in the departments for patients, and an increase in the potential for patient harm, delays in care, poor patient and staff experience and impact on the reputation of the Trust .	Very high risk (25)	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.	02/10/2024
4879	If there are significant delays within the planned care cancer pathway then patients may experience extended waits for diagnosis and surgery, resulting in failure to meet national standards and potentially reducing the likelihood of a positive clinical outcome for many patients	Very high risk (20)	Planned care recovery plan (cancer) Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions.	04/10/2024
5101	Quality and safety risk from inability to deliver Community epilepsy pathways that meet National standards due to resourcing and capacity factors.	Very high risk (20)	1. Business case is being produced to enable establishment of fully funded epilepsy service 2. Agreement for spending has been obtained, moving forward. 3. Epilepsy workshop with ICB	14/10/2024

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4947	There is an issue in which the Trust is failing to meet NICE medicines reconciliation targets on a consistent basis and not being able to review discharges. This is caused by lack of pharmacy resource. Resulting in potential for patient harm due to incorrect or delayed medication, financial implications due to increased length of stay or unnecessary supply and risk of continuation of errors onto the discharge letter and further more into the community.	Very high risk (20)	There are many options but we are utilising these; - We have prioritised pharmacist and technician cover to acute admission areas as patient turnover is highest on these areas and gives us the best opportunity to conduct a medicines reconciliation under 24 hours - We prioritise patients which have stayed in the longest and have critical medication where known. Prioritisation of the highest risk patients decreases the risk of harm - No ward visits are divided as much as possible. To significantly reduce this risk requires additional ward based pharmacy staff cover across 7 days.	17/10/2024
5100	Quality and safety risk from inability to deliver epilepsy pathways within Acute Paediatrics that meet National standards due to resourcing and capacity factors.	Very high risk (20)	1. Multi-professional working group tasked with delivering improvements that will support achievement of audit compliance.	14/10/2024

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
5450	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 areas. 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.	Very high risk (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.	07/10/2024

Updates since the last report

Following the August and September RRC&C meetings the following changes were agreed and validated:

- Risk 4740 - **Demand for Haematology outpatient appointments** was closed and combined with existing risk 4996 which is aligned with PODC.
- Risk 5450 - **Risk of Gastro service not being viable due to current fragility of Consultant workforce**. This risk was presented in September and validated for an increase in score from 3x4:12 Moderate Risk to 5x4:20 Very High Risk.

Strategic objective 1b: Improve patient experience

2.4 There are no Very High risks, remaining stable and 4 High risks, an increase of 1 since the last reporting period.

Updates since the last report:

- Risk 5494 - **Lack of adequate provision for appropriate Obstetric care of bereaved families** - new risk presented in September and validated for score of 4x4:16 High Risk.

Strategic objective 1c: Improve clinical outcomes

2.5 There are 2 Very High risks, remaining stable and 6 High risks, both remaining stable in relation to this objective. A summary of the Very High risks is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
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.	26/09/2024- **N.B This risk is currently under review and updates will be provided in the next reporting period**.
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

Strategic objective 2a. A modern and progressive workforce

2.6 There are 4 Very High risks, remaining stable, and 13 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
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.	30/09/2024
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	18/10/2024
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	18/10/2024
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.	21/10/2024

Updates since the last report

Following the August and September RRC&C meetings the following changes were agreed and validated:

- Risk 5439 - **Weekend workload (dispensing and checking of medication) exceeds staffing capacity on all sites** - presented in August and validated 5x3:15 High Risk.
- Risk 5249 - **Staff Retention**, this risk was presented in September and validated for a reduction in score from 4x4:16 to 3x4:12 Moderate Risk.
- Risk 5173- **Executive Director Vacancy Risk**, this risk was presented in September and validated for a reduction in score from a 4x4:16 High Risk to 3x2:6 Low Risk

Strategic objective 2b. Making ULHT the best place to work

2.7 There is 1 Very High risk, remaining stable and 2 High risks, a reduction 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
4948	Workload demands within Pharmacy persistently exceed current staffing capacity which leads to work related stress resulting in serious and potentially long-term effects on staff health and wellbeing. Adding to this with additional workload demands with insufficient staffing, or required level of experience and skill, the risk is patients will not be reviewed by a pharmacist leading to poorer clinical outcomes, reduced flow on acute wards, delayed discharges and increased risk of omitted medicines. For staff the risk is long term absence. This may result in the failure to meet the national and local targets for KPIs	Very high risk (20)	Review current provision and identify gaps in service to inform business cases for change to support 7 day working (working with Surgery and Medicine Divisions as appropriate). Skill mix requires review due to complexity of patients. Pragmatic management of workload & provision of management support. Ongoing exploration of recruitment options.	30/09/2024

Updates since the last report

Following the August and September RRC&C meetings the following changes were agreed and validated:

- Risk 4992 - **WRES (Workforce Race Equality Standard) compliance**. This risk was presented in September and validated for a reduction in score from 4x4:16 High Risk to 3x4:12 Moderate Risk.
- Risk 4993 - **WDES (Workforce Disability Equality Standard) compliance**. This risk was presented in September and validated for a reduction in score from 4x4:16 High Risk to 3x4:12 Moderate Risk.

Strategic objective 3a: Deliver financially sustainable healthcare, making the best use of resources

2.8 There are 3 approved Very High risks (20-25) an increase in 1 since the last report, and 1 High risks (15-16) a decrease of 2, recorded in relation to this objective. A summary of the Very High risks is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
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	28/10/2024
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	23/10/2024

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
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. **Increase in risk score validated at the RRC&C meeting August 2024.**	23/10/2024

Updates since the last report

Following the August and September RRC&C meetings the following changes were agreed and validated:

- Risk 5215 - **SUS/SLAM reconciliation and recording issues relating to API contract and a System incentive / penalty**. This risk was presented in August and validated for a reduction in score from 4x4:16 High Risk to 3x4:12 Moderate Risk.
- Risk 4665 - **Delivery of CIP plan**. This risk was presented and validated in August was an increase in score from 4x4:16 High Risk to 5x4:20 Very High Risk.

Strategic objective 3b: Drive better decision and impactful action through insight

2.9 There are no Very High risks (20-25) and no High risks (15-16) recorded in relation to this objective.

Strategic objective 3c: A modern, clean and fit for purpose environment across the Group

2.10 There are 3 approved Very High risks (20-25) and 7 High risks (15-16) recorded in relation to this objective. A summary of the Very High risks is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4648	If a fire occurs on one of the Trust's hospital sites and is not contained (due to issues with fire / smoke detection / alarm systems; compartmentation / containment) it may develop into a major fire resulting in multiple casualties and extensive property damage with subsequent long term consequences for the continuity of services.	Very high risk (20)	- Capital investment programme for Fire Safety being implemented on the basis of risk - costed budget plan for FEG submission Sept 2022. - Trust-wide replacement programme for fire detectors. - Fire Doors, Fire/Smoke Dampers and Fire Compartment Barriers above ceilings in Pilgrim, Lincoln and Grantham require improvements to ensure compliant fire protection. - Fire safety protocols development and publication. - Fire drills and evacuation training for staff. - Fire Risk assessments being undertaken on basis of inherent risk priority; areas of increased residual risk to be added to the risk register for specific action required - Local weekly fire safety checks undertaken with reporting for FEG and FSG. Areas not providing assurance receive Fire safety snapshot audit. - Staff training including bespoke training for higher risk areas - Planned preventative maintenance programme by Estates	28/10/2024

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4647	If Lincolnshire Fire & Rescue Service (LFRS) carries out an inspection and finds the Trust to be systemically non-compliant with fire safety regulations and standards it could result in regulatory action and sanctions, with the potential for financial penalties and disruption to services if sites are required to close.	Very high risk (20)	- Statutory Fire Safety Improvement Programme based upon risk - Policy and protocols framework and improvement plan reported into weekly Estates teams meeting - Progress reviewed by FEG and FSG monthly, to mitigate against the risk of sanctions - LFR involvement and oversight through the FSG - Regular updates with LFR provided indicating challenges during winter pressure and Covid - Fire safety audits being conducted by Fire Safety team - Fire wardens in place to monitor local arrangements with Fire Safety - Weekly Fire Safety Checks being undertaken - Improve PPM reporting for FEG and FSG By Estates Teams - Fire safety team weekly Risk assessment confirm and challenge reviews by Fire safety team - All areas of Trust allocated RAG rating for fire using occupancy profile, escape provision, height above ground and sleeping risk - Higher rated residual risks from risk assessments being incorporated into risk register	28/10/2024

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
5415	Grantham Site Medical Air Plant failure/limited functionality. The current medical air plant has 2 associated compressors of which are of an age where failure is likley, the units are MIM manufacturer who no longer are trading. one compressor has failed and the site is operating on one compressor only supported by an emergency manifold cylinder. The compressors are beyond life and obsolete, at this time there are no abilities to repair the failed unit and replacement is required. at present if the only remaining unit fails, the site will be operating on a cylinder manifold designed only for emergency use with limited time capacity. This failure will impact on all surgical services	Very high risk (20)	Short term solution is to provide a hire set medical gas compressor system in replacement of the existing unit, this is at a substantial cost and not a long term effective strategy. Long term plan is for a medical gas compressor plant replacement.	28/10/2024

Strategic objective 3d: Reduce waits for patients who require urgent and emergency care and diagnostics and ensure we meet all constitutional standards

2.11 There are no Very High risks (20-25) and no High risks (15-16) recorded in relation to this objective.

Strategic objective 3e: Reducing unwarranted variation in cancer service delivery and ensure we meet all constitutional standards (ULHT)

2.12 There are no Very High risks (20-25) and no High risks (15-16) recorded in relation to this objective.

Strategic objective 3f: Reducing unwarranted variation in planned service delivery and ensure we meet all constitutional standards (ULHT)

2.13 There are no Very High risks (20-25) and no High risks (15-16) recorded in relation to this objective.

Strategic objective 4a: Establish collaborative models of care with all our partners Including Primary Care Network Alliance (PCNA), GPs, health and social care and voluntary sector

2.14 There are no Very High risks (20-25) and no High risks (15-16) recorded in relation to this objective.

Strategic objective 4b: Successful delivery of the Acute Services Review

2.15 There are no Very High risks (20-25) and no High risks (15-16) recorded in relation to this objective

Strategic objective 4d: Enhanced data and digital capability

2.16 There is 1 approved Very High risk (20-25) and 3 High risks (15-16) recorded in relation to this objective. A summary of the Very High risk is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4657	If the Trust does not comply with Subject Access Requests (SARs) and Access to Health Records provisions in accordance with statutory requirements specified legislation, then it could lead to complaints to the Trust and Information Commissioner's Office (ICO). This could result in regulatory action and possibly financial penalties. Inconsistent levels of expertise outside of the IG team regarding SAR requirements.	Very high risk (20)	Current active communications with ICO- regulator. Changes to processes are being constantly discussed and implemented. Resource needs being discussed and temporarily increased to support. Monitored through the IGG in DP KPI report. Head of IG leading on work to review and improve. Working in a more digital way where feasible. Workforce change is required which will be a much longer process.	22/10/2024

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
	Lack of technical tools to carry out a search of emails / systems to identify personal information held. Potential financial implications."		Early identifications of chasers and urgent requests to reduce the likelihood of complaints.	

3. Conclusions & recommendations

- There are 9 quality and safety risks rated Very High (20-25) reported to the Quality Committee this reporting period:

  - Patient flow through Emergency Departments
  - Recovery of planned care cancer pathways
  - Reliance on paper medical records
  - Reliance on manual prescribing processes;
  - Delivery of paediatric epilepsy pathways-community
  - Quality and safety risk from inability to deliver epilepsy pathways within Acute Paediatrics that meet National standards
  - Medicines reconciliation compliance
  - Removal of lift in H Block PHB affecting service delivery to patient records
  - Risk of Gastro service not being viable due to current fragility of Consultant workforce

- There are 5 People and Organisational Development risks rated Very High (20-25) reported to the People & Organisational Development Committee this reporting period:

  - Staffing levels requiring an increase in Pharmacy to be able to provide a seven-day service.
  - Pharmacy workload demands
  - Service configuration (Haematology)
  - Consultant workforce capacity (Haematology)
  - Cancellation of elective lists due to lack of theatre staff

- There are 7 Very High risks (20-25) reported to the Finance, Performance and Estates Committee this reporting period:

  - Potential for a major fire;
  - Compliance with fire safety standards, assessed by Lincolnshire Fire and Rescue Service;
  - Exceeding the agency cap due to the cost of reliance upon temporary clinical staff
  - Reliance on agency / locum medical staff in Urgent & Emergency Care
  - SAR's Compliance and access to Health records in accordance with statuary requirements.
  - Grantham Medical Air Plant Fault/Failure
  - Failure to meet 24/25 CIP

3.3 The Group Board is invited to review the content of the report, no further escalations at this time.

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
2a. A modern and progressive workforce	4844	38	Service disruption	Lynch, Diane	Costello, Mr Colin	Workforce Strategy Group	Medicines Quality Group	19/01/2022	20	Risk assessments	Clinical Support Services	Pharmacy CBU	Pharmacy		The ability to provide a seven day a week pharmacy service requires a level of staffing above the current levels. Benchmarking has taken place against peer Trusts for staffing levels. Until this is funded the seven day a week service is unobtainable and this puts patients at risk.	Service planning & annual budget setting processes: Pharmacy / CSS Division	Staffing levels / budget benchmarked against other similar trusts. Reported medication incidents occurring out of hours.	30/09/2024	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.	[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. [09/02/2023 10:43:37 Paul White] Status changed to awaiting approval pending review by division and validation by Risk Register Confirm & Challenge Group. [22/12/2022 14:55:29 Rose Roberts] Confirmed with Paul White that the risk level can be raised here and confirm and challenge will invite the risk lead to discuss it.	4	29/10/2021	28/04/2023	30/10/2024
2a. A modern and progressive workforce	5447	691	Service disruption	Capon, Mrs Catherine	Rojas, Mrs Wendy	Patient Safety Group	Workforce Strategy Group	05/06/2024	16		Surgery	Theatres, Anaesthesia and Critical Care CBU	Theatres		Nurse staffing in theatres does not support current activity. There is a risk of elective lists being cancelled due to lack of theatre staff. Business case has been written to source funding. Currently in a difficult position. The off framework is going to stop soon with an impact that will possibly cancel lists. Lengthy discussions have been had to support Theatres. Break Glass agency workers are starting to be put in place but we are still very short. ODP has been approved but no back fill.	AFPP guidelines for staffing in perioperative setting Daily review of staffing/lists Daily prioritisation of patients Use of agency staff	Incident reporting Review of staffing/cancellations	21/10/2024	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.	[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		21/11/2024
4d. Enhanced data and digital capability	4657	7	Reputation	Matthew, Mr Paul	Hobday, Fiona	Information Governance Group	Digital Hospital Group	10/01/2022	12	Risk assessments	Corporate	Trust Headquarters	Corporate Secretary		If the Trust does not comply with Subject Access Requests (SARs) and Access to Health Records provisions in accordance with statutory requirements specified legislation, then it could lead to complaints to the Trust and Information Commissioner's Office (ICO). This could result in regulatory action and possibly financial penalties. Inconsistent levels of expertise outside IG team regarding SAR requirements. Lack of technical tools to carry out a search of emails / systems to identify personal information held. Implementation of digital systems which don't include a disclosure process. Potential financial implications.	ULHT policy in place. Monitoring through IGG and at exec level. Temporary additional resource has been put in place to oversee. Proposal made to ELT and IGG regarding process which has removed reliance on clinical staff to review all cases. Increased training provided to team.	Monthly reporting completed. Compliance rate is monitored by the Supervisor and reports taken to IGG in our KPI report. Volume of ICO complaints and Trust complaints received.	22/10/2024	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.	[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. *Have seen an increase in complex cases and Maternity related in last couple of months.	6	29/12/2023	31/12/2024	22/11/2024

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
2a. A modern and progressive workforce	4996	39	Physical or psychological harm	Lynch, Diane	Chester-Buckley, Sarah	Patient Safety Group	Outpatient Improvement Group	22/08/2022	16		Clinical Support Services	Cancer Services CBU	Haematology (Cancer Services)	Trust-wide	As a result of lack of investment for Haematology workforce historically there is insufficient workforce and to meet increasing demand of the service (and we have recruited posts at risk above budget) which would lead to additional stress and burn out causing the remaining staff to leave and the service to collapse which would also lead to significant patient harm. Patients would need to be referred to other neighbouring Trusts which in turn would cause other Trusts to collapse. Particular areas of concern are Clinical Governance Lead and Head of Service for Haematology.	Completed a fragile services paper CG lead duties shared between consultants but no one wishes to take on role. Introduction of nurse-led clinics to manage demand. Fixed term Locum Consultants / High cost agency above budget to support service. Ad-hoc additional clinics outside of consultant job plan	New referrals and PBWL show ongoing capacity issues. RTT and cancer performance below target. Increased PA's for substantive consultants. Outcome from Staff Survey results Financial constraints of group Monitoring of outpatient appointments Datix incidents / Clinical Harm reviews / Complaints / PALS	18/10/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	*Workforce review - Now Completed July 2023 *Refresher of Fragile Services Paper - NB there is a National shortage of Haematology consultants - Now completed September 2023 *Recruitment of further substantive consultants - December 2024 *Additional unfunded ST3+ for Haematologist starts in August 2022 - Now completed*	[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 this is still a very fragile service. Once new staff are in post and embedded, the score will be reviewed. [23/04/2024 13:06:20 Gemma Staples] Risk reviewed and still awaiting outcome of ICB investment panel	8	30/09/2023	01/04/2025	18/11/2024
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	4879	28	Physical or psychological harm	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	04/10/2024	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	[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 benefits realisation can provide a funding stream to enable some / all of the case to be supported to fit with the recently modified system business case process. [23/04/2024 13:03:48 Gemma Staples] Risk reviewed and still awaiting outcome of ICB investment panel [25/03/2024 10:05:36 Gemma Staples] Haematology rightsizing SJBC presented at ICB investment panel on 15th March, still awaiting outcome. [26/02/2024 16:48:25 Gemma] Risk reviewed and ongoing	8	31/03/2023	31/03/2023	04/11/2024
3a. Deliver financially sustainable healthcare, making best use of resources	4665	14	Finances	Young, Jonathan	Sargeant, Paula	Financial Turnaround Group		11/01/2022	20	Risk assessments	Corporate	Finance and Digital	Finance	Trust-wide	The Trust has a £40.1m Financial improvement target for 24/25. If the Trust fails to deliver the CIP Plan, this will have a significant adverse impact on the ability of the Trust and the Lincolnshire ICS to deliver its breakeven financial plan for the year. This represents a 5% target which is greater than any financial improvement the trust has delivered in previous years. In addition to this target, invest to save investments required to deliver the savings plan will need to be funded via more CIP identification/ delivery. Failure to deliver the CIP plan will have an adverse impact on the trusts ability to decrease its underlying deficit and build towards a sustainable pipeline of cost improvement for the future.	National policy: - NHS annual budget setting and monitoring processes ULHT policy: - Detailed Financial plan inclusive of the establishments and embedding of the 3 T's; Transactional, Targeted and Transformational. - Alignment of the Trust financial improvement opportunities with system partners to develop an integrated financial recovery plan aligned to CIP. - Development of Divisional Schemes assured through FPAMS (Transactional) - Establishment of future looking programme to develop schemes for a sustainable cost improvement programme for the future. (Transformational) - Establishment of a suite of cross cutting schemes aligned to the Trust Improvement Strategy. (Targeted) - Divisional CIP targets allocated as part of the budget setting process. ULHT governance: - Detailed CIP reporting via the CIP tracker supported by QIA process at Improvement Steering Group (ISG) - Programme Management Office (PMO) monitors full programme & dedicated Head of Financial Improvement. - Introduction of the Trust wide Improvement Steering Group to monitor, challenge and hold accountable for the Targeted and Transformational Schemes. - FPAMs to monitor, challenge and hold accountable for the Transactional Schemes	The Trust is monitored externally against the Trust CIP target through the monthly finance return to NHSE/I. For 2024/25 the Trust continues to be monitored twice a month on the FRP by the ICB and system Improvement Director. To exit NOF3, into NOF2, the system must deliver against the FRP plan for 2 consecutive quarters and ULHT is held to account to deliver their element of this £40.1m FYE. The Trust monitors internally against its CIP targets inclusive of specific Divisional and targeted scheme targets through the Improvement Steering group and Finance, Performance and Activity meetings. (FPAM's). Scrutiny & oversight will be	23/10/2024	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.	[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. [22/07/2024 11:35:26 Rachael Turner] £40.1m programme – fully identified with opportunities, delivery assurance of detailed plans & KPI's is ongoing A stretch target of a further £4m has been set and opportunities being explored. Launch of Planning / continuous planning has taken place which will include CIP	4	31/03/2023	31/03/2024	23/11/2024

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5100	487	Physical or psychological harm	Rivett, Kate	Herath, Dr Durga	Patient Safety Group	Clinical Effectiveness Group	14/03/2023	20		Family Health	Children and Young Persons CBU	Paediatric Medicine	Trust-wide	Quality and safety risk from inability to deliver epilepsy pathways within Acute Paediatrics that meet National standards due to resourcing and capacity factors.	1. Single Consultant Paediatrician (DH) is currently managing all children with Epilepsy alongside a single specialist epilepsy nurse; 2. Wider consultant body supporting the care of children who are prescribed 2 antiepileptics in the absence of a consultant paediatrician with expertise in epilepsy; 3.Single Consultant Paediatrician is developing individualized care plans for each patient to optimise management of condition; 4. Liaison with ICB and regional network to support development and improvement of local services	1. Audit of compliance with NICE guideline NG217 - Epilepsies in Children, Young People and Adults and NICE quality standard QS27 - Epilepsy in Children and Young People;	14/10/2024	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.	[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 ongoing acute concerns, the risk will remain open but scoring may be reduced. [14/02/2024 14:54:26 Nicola Cornish] No change. Business case meeting this week to progress so that bid can be submitted to ICB for funds. [10/01/2024 14:26:18 Nicola Cornish] No change. Need to complete	8	14/03/2024		14/11/2024
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5101	487	Physical or psychological harm	Rivett, Kate	Herath, Dr Durga	Patient Safety Group	Clinical Effectiveness Group	14/03/2023	20		Family Health	Children and Young Persons CBU	Children's Community Services	Trust-wide	Quality and safety risk from inability to deliver epilepsy pathways within Community Paediatrics that meet National standards due to resourcing and capacity factors.	1. Single Consultant Paediatrician (DH) is currently managing all children with Epilepsy alongside a single specialist epilepsy nurse; 2. Wider consultant body supporting the care of children who are prescribed 2 antiepileptics in the absence of a consultant paediatrician with expertise in epilepsy; 3.Single Consultant Paediatrician is developing individualized care plans for each patient to optimise management of condition; 4. Liaison with ICB and regional network to support development and improvement of local services	1. Audit of compliance with NICE guideline NG217 - Epilepsies in Children, Young People and Adults and NICE quality standard QS27 - Epilepsy in Children and Young People;	14/10/2024	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	[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 vulnerable patients. [21/11/2023 14:24:17 Kate Rivett] 21/11/23 - KR 1. Significant levels of risk remains as there are only x2 specialist nurses and x1 consultant to manage a cohort of in excess of 900 patients, some of whom have	8	14/03/2024	16/02/2024	14/11/2024
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5016	22	Physical or psychological harm	Hamer, Fiona	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.	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	02/10/2024	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.	[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. [24/04/2024 13:30:50 Nicola Cornish] Discussed at RRC&C meeting on 24/04/24 - have been improvements but not in a position to reduce the scoring yet. Need to review controls and actions to reflect the work that has been done and is still ongoing. [15/04/2024 10:59:26 Rachael Turner] Flow is improving slightly. SAFER has been implemented. Risk currently remains with same scoring. [05/03/2024 09:09:07 Rachael Turner] Risk reviewed, no change. [07/02/2024 09:17:37 Rachael Turner] Risk reviewed, no change. [09/01/2024 15:07:09 Rachael Turner] Risk reviewed. We have introduced cohorting to offload ambulances. We are holding medical colleagues accountable for discharges. But overcrowding still stands. Risk score to remain. [13/12/2023 16:47:38 Rachael Turner] No significant update to this risk, flow expected to ramin challenging across winter. Re: implementation of SAFER	10	02/09/2023	31/03/2024	02/11/2024

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
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)	23/10/2024	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	[23/10/2024 10:29:40 Nicola Cornish] In 2024/25, the Trust's financial plan requires the Trust to make a similar level of reduction to agency expenditure as made in 2023/24, as it requires a reduction to agency expenditure of £17.5m in 2024/25 compared to the reduction of £18.4m made in 2023/24. In 2024/25, the focus of the programme is to reduce agency expenditure in relation to medical and dental (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 £13.9m is £3.2m lower than spend of £17.1m in the same period of 2023/24 but is £3.1m higher than planned agency expenditure of £10.8m. This adverse movement to plan YTD is driven by M&D agency expenditure being £3.6m 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	8	31/03/2023	31/03/2024	23/11/2024
3c. A modern, clean and fit for purpose environment across the Group	4647	1	Reputation	Landon, Caroline	Davey, Keiron	Fire Safety Group	Fire Safety Group	14/12/2021	20	External Inspections	Corporate	Estates and Facilities	Fire and Security	Trust-wide	If Lincolnshire Fire & Rescue Service (LFRS) carries out an inspection and finds the Trust to be systemically non-compliant with fire safety regulations and standards it could result in regulatory action and sanctions, with the potential for financial penalties and disruption to services if sites are required to close.	National policy: - Regulatory Reform (Fire Safety) Order 2005 - NHS Fire safety Health Technical Memoranda (HTM 05-01 / 05-02 / 05-03) ULH policy: - Fire Policy (approved April 2019, due for review April 2022) & related procedures / protocols / records - Fire & Security Team / Fire Safety Advisors ULH governance: - Fire Safety Group / Fire Engineering Group, accountable to Trust Board through Finance, Performance & Estates Committee (FPEC) - Health & Safety Committee & site-based H&S committees	- Compliance audits against fire safety standards - Progress with fire safety improvement plans - PPM compliance assurance (current lack of required detail for internal and regulator assurance)	28/10/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	- Statutory Fire Safety Improvement Programme based upon risk - Policy and protocols framework and improvement plan reported into weekly Estates teams meeting - Progress reviewed by FEG and FSG monthly, to mitigate against the risk of sanctions - LFR involvement and oversight through the FSG - Regular updates with LFR provided indicating challenges during winter pressure and Covid - Fire safety audits being conducted by Fire Safety team - Fire wardens in place to monitor local arrangements with Fire Safety - Weekly Fire Safety Checks being undertaken - Improve PPM reporting for FEG and FSG By Estates Teams - Fire safety team weekly Risk assessment confirm and challenge reviews by Fire safety team - All areas of Trust allocated RAG rating for fire using using occupancy profile, escape provision, height above ground and sleeping risk - Higher rated residual risks from risk assessments being incorporated into risk	[28/10/2024 11:11:09 Rachael Turner] Following several inspections by Lincolnshire fire and rescue and the receiving of broadly compliant letters the risk is reduced from 5 to 3 with a likely outcome whilst Fire Door maintenance and compartmentation works continue. This risk will be presented at the November RRC&C meeting for reduction in score. [17/09/2024 09:08:49 Rachael Turner] Recently had Lincolnshire Fire & Rescue audit at Louth, Spalding, Pilgrim and Grantham. Awaiting confirmation letter of outcome of visit. No adverse comments received from Lincolnshire Fire and Rescue. Once confirmation received a review will be made to reduce risk score. [14/08/2024 16:19:02 Rachael Turner] several fire safety audits continue to be conducted by Lincolnshire Fire and Rescue (Grantham, Skegness, Spalding. tulip suites (Boston) with no actions received as a result of these audits. [16/07/2024 09:18:20 Rachael Turner] Work continues on statutory fire risk assessments reviews, capital project works in regard to compartmentation and fire doors remedials. [13/06/2024 14:18:00 Rachael Turner] Risks are presented to FEG for confirm, challenge and review. following the meeting the risks are escalated to FSG and presented to trust health and Safety committee. [13/06/2024 13:57:11 Rachael Turner] No change risk score remains. [10/05/2024 14:39:55 Rachael Turner] No change mapping exercise continues on fire doors and work to commence shortly on Damper mapping. survey of new fire doors undertaken at Pilgrim and Lincoln [11/04/2024 12:29:32 Rachael Turner] No change to Risk score as work continues with remedial action on compartmentation. 39 new doors on order and 2 year fire door remedial risk based programme prepared. additional joiners roles advertised. Compartmentation works ongoing based upon risk, new fire alarm and remedials works tender specification complete for marketplace April/May 2024. fire warden number continue to rise across divisions	4	30/06/2022	31/03/2024	28/11/2024
3c. A modern, clean and fit for purpose environment across the Group	5415	626	Service disruption	Parkhill, Michael	Whitehead, Mr Stuart	Medical Gasses Working Group		10/04/2024	12		Corporate	Estates and Facilities	Estates	Grantham & District Hospital	Grantham Site Medical Air Plant failure/limited functionality. The current medical air plant has 2 associated compressors of which are of an age where failure is likley, the units are MIM manufacturer who no longer are trading. one compressor has failed and the site is operating on one compressor only supported by an emergency manifold cylinder. The compressors are beyond life and obsolete, at this time there are no abilities to repair the failed unit and replacement is required. at present if the only remaining unit fails, the site will be operating on a cylinder manifold designed only for emergency use with limited time capacity. This failure will impact on all surgical services	one compressor still functioning with increased service support and back up emergency manifold, along with back flow feed kits available, but this is not sufficient to reduce risk enough.	inspection and service monitoring	28/10/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	short term solution is to provide a hire set medical gas compressor system in replacement of the existing unit, this is at a substantial cost and not a long term effective strategy. long term plan is for a medical gas compressor plant replacement.	[28/10/2024 11:17:10 Rachael Turner] Risk reviewed, no current change from last update. Risk score remains. [17/09/2024 09:20:35 Rachael Turner] Currently waiting for timescales, the scheme is going ahead. Work remains ongoing. Temporary airplant have been put in Pilgrim to help mitigate this risk. [20/08/2024 16:18:09 Rachael Turner] Contract Award Report has been signed off which will allow for the works to go ahead. Timescales to be provided. [18/07/2024 13:59:58 Rachael Turner] Replacement of the plant is on the capital plan for 2024/25 timescale is yet to be confirmed but will definitely be completed this financial year. [14/06/2024 11:14:16 Rachael Turner] Risk reviewed, no change at present. Risk score remains the same. [16/05/2024 18:06:34 Rachael Turner] Replacement costs received and capital scheme in process of being developed for replacement following 1 compressor failure. Plant needs to be added to capital list for 2024/25. [24/04/2024 12:54:04 Nicola Cornish] Discussed at RRC&C meeting on 24/04/24. Need to add potential timescales for replacement of plant. Agreed for this to be added to register with a score of 20.	4	31/03/2025		28/11/2024

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
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.	17/10/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Installation of a lift – Chris Rose – November 2024 (E&F)	[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. Dumb waiter will be completed in July. On completion of the dumb waiter we will need to re-assess with the view the risk is reduced. [03/06/2024 11:03:37 Gemma Staples] We have a new date of September of the lift being installed and the dumb waiter being upgraded. We have lost further staff due to the environment.	1	01/05/2023		25/10/2024
1c. Improve clinical outcomes	4828	31	Physical or psychological harm	Farquharson, Colin	Costello, Mr Colin	Medicines Quality Group	Digital Hospital Group, Patient Safety Group	17/01/2022	20	Risk assessments	Clinical Support Services	Pharmacy CBU	Pharmacy	Trust-wide	The trust currently uses a manual prescribing process across all sites, which is inefficient and restricts the timely availability of patient information when required by Pharmacists. Where information about patient medication is not accurate, up to date and available when required by Pharmacists then it could lead to delays or errors in prescribing and administration, resulting in a widespread impact on quality of care, potentially reducing the likelihood of a positive clinical outcome and/or causing serious patient harm	National policy: - NICE Guideline NG5: Medicines optimisation, etc. ULHT policy: - Policy for Medicines Management: Sections 1-8 (various approval / review dates) ULHT governance: - Trust Board assurance via Quality Governance Committee (QGC) / Medicines Quality Group (MQG)	Medication incident analysis Audit / review of medicines management processes	26/09/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Risk currently under review for possible closure following the roll out across the Trust. However work underway to review the risk in Maternity and Outpatients as manual prescribing remains in place – plan to take through to Septembers RRC&C meeting	[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. [13/02/2024 13:04:52 the reporter] EPMA is now rolled out across all adult inpatient areas. The risk will now be monitored and review how effective the EPMA system is. [17/01/2024 12:08:04 Gemma] EPMA is currently being rolled out. The will be in all adult inpatient areas by 22nd January. [21/12/2023 13:28:32 Divisional Dashboards] Lisa-Marie Moore: epma roll out currently in final stages for inpatients with only pilgrim surgical areas left and due to be rolled out from 15th January (delayed roll out due to Drs strikes)	4	31/12/2023	01/04/2024	25/10/2024
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	4947	27	Physical or psychological harm	Sakthivel, Mr Kulandaivel	Saddick, Ahtisham	Medicines Quality Group	Clinical Effectiveness Group	17/06/2022	20	Policy/Protocol Issues	Clinical Support Services	Pharmacy CBU			There is an issue in which the Trust is failing to meet NICE medicines reconciliation targets on a consistent basis and not being able to review discharges. This is caused by lack of pharmacy resource. Resulting in potential for patient harm due to incorrect or delayed medication, financial implications due to increased length of stay or unnecessary supply and risk of continuation of errors onto the discharge letter and further more into the community.	NICE guidance NG5 states that in an acute setting, that we should accurately list all of the patient's medicines (including prescribed, over-the-counter and complementary medicines) and carry out medicines reconciliation within 24 hours or sooner if clinically necessary, when the person moves from one care setting to another – for example, if they are admitted to hospital.	We conduct monthly medicines reconciliation audits, which consistently have shown us failing to meet NICE targets and we are operating significantly below the national average. This audit is presented at the MQG.	17/10/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	There are many options but we are utilising these; - We have prioritised pharmacist and technician cover to acute admission areas as patient turnover is highest on these areas and gives us to best opportunity to conduct a medicines reconciliation under 24 hours - We prioritise patients which have stayed in the longest and have critical medication where known. Prioritisation of the highest risk patients decreases the risk of harm - No ward visits are divided as much as possible. A partial mitigation for medication error reduction is incorporation of discharge functionality within EMIS (the link and seamless transition of medication from inpatient to discharge). This will reduce prescription errors into the discharge medication. Discharge functionality is not available currently within EMIS. To significantly reduce this risk requires additional ward based pharmacy staff cover across 7 days.	[17/10/2024 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 such as DMS to be implemented, without the former it is not possible to implement DMS [26/09/2023 14:06:35 Rachel Thackray] To meet with Medical Director to discuss lack of progress [07/09/2023 14:03:55 Lisa Hansford] 07.09.23 no changes to current situation	8	30/06/2023	31/12/2024	15/11/2024

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
2b. Making ULHT the best place to work	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	30/09/2024	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	[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 [06/04/2023 12:52:25 Paul White] Discussed at Risk Register Confirm & Challenge 29 March, risk agreed with feedback provided for consideration.	8	30/06/2023	30/10/2023	30/10/2024
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)	28/10/2024	Quite likely (4) 71-90% chance	Extreme (5)	Very high risk (20-25)	20	- Capital investment programme for Fire Safety being implemented on the basis of risk - costed budget plan for FEG submission Sept 2022. - Trust-wide replacement programme for fire detectors. - Fire Doors, Fire/Smoke Dampers and Fire Compartment Barriers above ceilings in Pilgrim, Lincoln and Grantham require improvements to ensure compliant fire protection. - Fire safety protocols development and publication. - Fire drills and evacuation training for staff. - Fire Risk assessments being undertaken on basis of inherent risk priority; areas of increased residual risk to be added to the risk register for specific action required - Local weekly fire safety checks undertaken with reporting for FEG and FSG. Areas not providing assurance receive Fire safety snapshot audit. - Staff training including bespoke training for higher risk areas - Planned preventative maintenance programme by Estates	[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. [16/07/2024 09:19:46 Rachael Turner] Risk is reviewed within the FEG and escalation into FSG for trust HS committee. [13/06/2024 14:18:49 Rachael Turner] Fire door assurance review being conducted by Fire safety team. compartmentation ventilation damper mapping exercise being undertaken by fire safety and CAFM team [13/06/2024 13:56:21 Rachael Turner] No change, risk score remains. [10/05/2024 14:42:03 Rachael Turner] No change in score as work continues on fire doors, compartmentation and damper mapping. new door surveyed at Pilgrim and Lincoln. [11/04/2024 12:32:39 Rachael Turner] No change to Risk score as work continues with remedial action on compartmentation. 39 new doors on order and 2 year fire door remedial risk based programme prepared. additional joiners roles advertised. Compartmentation works ongoing based upon risk, new fire alarm and remedials works tender specification complete for marketplace April/May 2024. fire warden number continue to rise across divisions, Fire drills continue across trust areas.	10	31/03/2022	31/03/2025	28/11/2024
3a. Deliver financially sustainable healthcare, making best use of resources	5020	6	Finances	Hamer, Fiona	Lentz, Blanche	Workforce Strategy Group	WORK	02/09/2022	20		Medicine	Urgent and Emergency Care CBU			If there is a continued reliance on bank and agency staff for medical workforce in Urgent & Emergency Care there is a risk that there is not sufficient fill rate for medical rotas both ward / department fill and on call shifts which will impact on patient safety and have a negative impact on the CBU budget	Robust medical plan for every post meetings Close working with temporary medical staffing team Daily management of any gaps to support minimum staffing levels Fundamental overview of tier 1 and tier 2 docs in medicine and ED based on RCP safer staffing levels. Introduction of BMA rate cards This will reduce once output on medical workforce plan is in place, not due to come online in this review period.	Plan for every post meetings Budget reports	28/10/2024	Quite likely (4) 71-90% chance	Extreme (5)	Very high risk (20-25)	20	Robust recruitment plan International recruitment Medical Workforce Management Project	[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. [05/03/2024 09:10:47 Rachael Turner] Risk reviewed, no change. [07/02/2024 09:16:42 Rachael Turner] Risk reviewed, no change. [09/01/2024 15:13:18 Rachael Turner] Consultation ongoing with completion due end of Feb/March. Risk currently remains the same. [13/12/2023 16:48:28 Rachael Turner] Improvement seen against Acute and GIM	10	02/09/2023		28/11/2024

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
1c. Improve clinical outcomes	4731	33	Physical or psychological harm	Landon, Caroline	Carter, Mr Damian	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	5450	659	Physical or psychological harm	Thomson, Cheryl	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 gastronenterology 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.	Workforce gaps Capacity of the service Cover of rota's (inpatient ward cover and on-call bleed cover)	07/10/2024	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.	[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 RRC&C meeting in September.	8	05/06/2025		07/11/2024
2a. A modern and progressive workforce	4997	41	Service disruption	Lynch, Diane	Chester-Buckley, Sarah	Workforce Strategy Group	Patient Safety Group	22/08/2022	16		Clinical Support Services	Cancer Services CBU	Haematology (Cancer Services)		As a result of current Consultant staffing and on-call arrangements there is a single consultant covering both sites during weekend so cover limited if critically unwell patients on both sites which could lead to potential patient harm, delays in care/discharge.	Middle Grade cover in Oncology & Haematology over and above budget therefore using high cost agency. VC ward rounds are taking place if face to face ward rounds are not possible.	Datix incidents Complaints and PALS Outcome from Staff Survey results Financial constraints of group	18/10/2024	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	*Workforce review - Now Completed July 2023 *Refresher of Fragile Services Paper - NB there is a National shortage of Haematology consultants - Now completed September 2023 *Recruitment of further substantive consultants - December 2024 *Additional unfunded ST3+ for Haematologist starts in August 2022 - Now completed*	[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 investment panel. Further update to be provided at a later date. [02/11/2023 15:21:13 Vicky Dunmore] Rightsizing haem Business Case to go to CRIG Nov 2023 [14/09/2023 15:02:19 Rose Roberts] Rightsizing Haem paper to be presented at	8	01/04/2023	01/04/2023	18/11/2024

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
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	02/12/2024
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
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	19/08/2024	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	[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. Email sent to Rachel Turner to ask that this be discussed in January 2024 RRC&C [02/10/2023 10:19:22 Rachael Turner] Risk discussed at RRC&C meeting agreed to be reduced to 4x3: 12 Moderate risk. [15/09/2023 09:07:47 Rachael Turner] Risk to be presented at RRC&C to upgrade	4	30/12/2024		19/11/2024

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
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	30/09/2024	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.	[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. [26/09/2023 15:02:00 Charles Smith] As of 11/09/23: •There are a total of 125 cardiac MRI studies awaiting reporting •The oldest scan on the reporting list is from 24 July 2023 (seven weeks) •There are 13 scans from July, 68 scans from August and 44 scans from September waiting to be reported	3	01/07/2024		30/12/2024
1c. Improve clinical outcomes	4928	89	Service disruption	Ratcliff, Carl	Marsh, David	Patient Safety Group		28/04/2022	16	Professional Guidance	Medicine	Cardiovascular CBU	Cardiology		Increase in risk of delays to patient care/harm as a result of increasing backlog of planned care activity across Cardiology arising from Covid19 constraints / service restrictions/ site escalation pressures.	additional clinics/lists (cost pressure) additional staffing where feasible to increase capacity (cost pressure)	weekly monitoring of RTT and PBWL	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	5095	59	Physical or psychological harm	Capon, Mrs Catherine	Chamberlain, Liz (Elizabeth)	Patient Safety Group		24/02/2023	16		Surgery	Surgery CBU	Vascular Surgery	Pilgrim Hospital, Boston	Due to increased demand for PICC services there is a risk that within the current establishment there is a significant delay to patients. This can delay treatment, hinder flow and cause poorer outcomes for patients. 8 years ago, venous access within the Trust was classed as central lines (internal jugular insertion) and cannulas. Peripheral central catheters (PICC) were undertaken occasionally for oncology patients and portacaths and Hickman lines were done in theatre, as they still are. The vascular ACPs started to learn how to insert picc PICC lines starting from one morning clinic on a Tuesday (supported by the Consultants). The needs for PICC increased and we went to two full day clinics in a week. They were only inserting in pilgrim at that time. It was then determined that Total Parental Nutrition (TPN) needed to be given centrally and not peripherally, and the work load increased two fold. A business case was successful for a 1.0 WTE band 6 venous access nurse to take on the clinics as the work load for the ACPs was also increasing. The Royal College of Radiologists state that a PICC line should be inserted with 72 hours. However, due to the varied nature of why a line is required particulary for urgent cases this has been deemed locally as 24 hours.	At present there is one 1.0 WTE VAN (band 6) and two 22.5 hours HCSW (band 2) covering: - Lincoln clinics (in patient only) Monday (up to and including 6 patients) and a Wednesday out/in patients - Pilgrim clinics Tuesday and Thursday, both in and outpatients - All clinics have slots for up to 6 patients, however, many late referrals are received and the clinic can increase to anything up to 12 patients. This means that the VAN goes home late most nights that incurs overtime payment. This additional activity is driven through urgent care pathways and is reliant upon a stretched team to meet this demand. As services enter a a post COVID climate there has been a recognised increase in complexity of presentations due to non-presentation at an earlier point. Case of Need has been written with final finance input outstanding to then go to CRIG ACPs are trained in this procedure but should not be relied upon as takes away from other core duties and is not a sustainable. Interventional Radiology is picking up some activity although this exposes patients to radiation and is not a sustainable option. This also require anaesthetics and theatre resources.	Volume of requests against number of staff and time taken to acquire IR1 submissions - started to see an increase in incidents being reported.	27/06/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Business case established with final finance input outstanding to then go to CRIG 6 month secondment for a PICC nurse has been advertised and will require training Give consideration to training of a wider network of clinicians associated with their individual service needs	[27/06/2024 10:31:25 Nicola Cornish] Business case needs to be put in to the new template and then seals of approval sought. [31/05/2024 12:07:02 Nicola Cornish] Business case needs to be reviewed before presentation to CRIG. Looking at funding sources across other divisions as it is a Trust wide service. 6 month secondment has been extended to end of March 2025. [28/05/2024 14:48:51 Nicola Cornish] No further update [23/10/2023 11:25:05 Nicola Cornish] Extended secondment until end of March 2024, approval and QIA for business case are ongoing [03/05/2023 10:26:45 Rachael Turner] Following further quantitative data provided this risk has now been validated as an active risk for the trust register. [26/04/2023 11:26:50 Rachael Turner] Risk needs to return to RRC&C once we have the quantitative data confirmed. Needs to look at where this risk sits as possibly more appropriate with CSS. This will be re-presented in the May RRC&C meeting. [25/04/2023 10:06:15 Chris Sewell] Due to unforeseen circumstances and long term absence the service has had to rely on the ACP and Interventional Radiology options as outlined in the risk controls. It is anticipated that they will return at the beginning of May. This has led to an increase in IR1s.	1	01/06/2023		27/09/2024

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	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
2b. Making ULHT the best place to work	5251	53	Reputation	Low, Claire	MacDonald, Damian			06/09/2023	16		Corporate	People and Organisational Development	Organisation Development	Trust-wide	If the Trust doesn't have an effective approach to employee appraisals then it could have a negative impact on morale and lead to poor performance, inappropriate behaviours, reduced productivity, non-compliance with policy, increased turnover.	1. Dedicated page for Staff Appraisals on the Intranet with a wealth of easily accessible information that sets out the process, principles, benefits, fact-sheets 2. Leading an Effective Appraisal 2-hour virtual workshop available to all managers to support them in developing their skills and confidence to undertake staff appraisals 3. Creation of an Appraisal and Career Discussion form that is simple but allows for discussion on performance, professional relationships, career and development goals, and wellbeing. It also allows for performance and development objectives to be set, an overall assessment of performance to be made and a check on completion of mandatory training to be undertaken. There are also forms to support managers to undertake regular 1:1 'check-ins' and to undertake mid-year reviews 4. Trust governance: Board assurance through People and OD Committee 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.	04/10/2024	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"	[04/10/2024 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 organisational to individual level ('golden thread') • Scope out the potential for utilising ESR for eAppraisal or whether an alternative solution would need to be found – review what system colleagues are doing and whether the Trust could use or learn from their solutions Ongoing service pressures and staffing challenges in the Trust continue to impact appraisal completion rates but month on month there is a slight improvement	8	31/03/2025	31/03/2025	04/01/2025

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
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.	05/08/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Daily & Weekly IPC checks, Staff well being checks, frequent monitoring of safety issues. Escalation to H&S Team via audit process. Monthly updates to MICAD system, Escalation via IPC FLO audit process.	[05/08/2024 11:06:56 Gemma Staples] Still awaiting on Estates to block off the corridors. We are working with Estates & Strategies to to look at service provision across therapies and rehab medicine to look at provision on and off site. There have been requests to Estates that have been declined due to cost and this is knock on effect on staffing. [07/05/2024 11:15:24 Gemma Staples] OT have moved into Physio now and Rehab Medicine are moving into the better part of the dept on 9/05/2024. The riskiest corridor will then be secured and locked and the other corridor will be storage only and limited access. Staff are reporting an impact on wellbeing capacity to do their job. There is ongoing lack of office space to be able to do none clinical work effectively and lack of space to accommodate lunch breaks. There is a clear drive for us to consider off site premises with the support of the Estates team. [05/02/2024 11:05:23 Gemma] Rehabilitation Medicine will move across into the OT area as an interim measure while further suitable accommodation is sourced. [01/02/2024 13:40:16 Gemma] We will be moving to the physio therapy department as an interim measure until new premises sought within the hospital. Moving to physio hopefully before the end of the financial year. [27/09/2023 12:05:47 Rachael Turner] Risk discussed at RRC&C Meeting for an increase in score to a High Risk score of 16. There could be regulatory impact if this was not looked at and also issues reputationally. [08/09/2023 14:08:38 Maddy Ward] Likelihood of risk has been updated to quite likely in review meeting making it a high risk. Glass is falling from window frames more frequently due to rotten window frames and we have had water/rain coming into electrics. This is included in the estates escalation report. [23/06/2023 14:00:51 Rose Roberts] Flooring has been approved and has been accepted by estates. Not got a date yet. Windows etc have been escalated.	4	31/03/2022	31/03/2023	05/11/2024
3c. A modern, clean and fit for purpose environment across the Group	5104	8	Regulatory compliance	Dunning, Mr Paul	Rinaldi, Dr Ciro	Mortality and Learning Strategy (MoraLS) Group	Estates Infrastructure and Environment Group	16/03/2023	10		Clinical Support Services	Path Links (Pathology)	Mortuary (Pathology)	Trust-wide	As a result of the HTA's concerns relating to the fabric and capacity of the Trusts mortuary service and the delay in timescales by which the Trust is able to refurbish these following the HTA inspection in May 2022. There is a risk that The HTA as the regulator could impose conditions on our licence to store the body of a deceased person within the Trusts mortuary facilities.	-HTA oversight group has been established-meeting to manage the action plan. -Papers have been to CRIG for initial funding to establish planning and building work. This has been approved. -Draft business case has been developed and approved. -Initial concerns have been addressed from Lincoln site. -The Trust currently has two Titan units (temporary additional mortuary capacity) which provides additional capacity in the event of winter pressure peaks in demand and also in the event of equipment failure, 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	22/08/2024	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 adddress 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. 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 CCTV repositioning has not been included Additional levels of swipe access not included as part of the refurb	[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 timescales may slip back due to delays in appointing a contractor. Further update to be provided when more information known. [05/07/2023 11:06:25 Rachael Turner] Risk discussed in June RRC&C meeting, agreed to reduce risk score from 20 to a 16 High Risk	20	31/03/2024	31/03/2024	22/11/2024
2a. A modern and progressive workforce	5469	697	Service disruption	Rinaldi, Dr Ciro	Chablani, Manish			21/06/2024	16		Corporate	Medical Director's Office	Medical Education	Trust-wide	As a result of Pharmacy struggling to budget and recruit into the role whilst there are budgetary provisions on the medical education side there is a risk that without adequate educators we would fail to deliver the curriculum across the entire clinical years for years 3,4 & 5 which would lead failure of our contractual requirements and this would bring into question our newly gained status as a teaching hospital.	We are currently liasing with the Pharmacy department around the appointment of a part time prescribing skills lead. This would be a 50/50 appointment shared with the pharmacy team	Meeting reviews.	31/07/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Increase the workforce, investment into staff and education	[31/07/2024 13:24:09 Rachael Turner] Risk presented at RRC&C meeting 31/07/2024. Risk validated as a High risk score 4x4:16 High risk.	8	21/06/2025		31/10/2024
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		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	21/12/2024

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	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
2b. Making ULHT the best place to work	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.	04/10/2024	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.	[04/10/2024 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 likelihood of this risk from low to extremely likely and this continues. Plans have been tried and tested and all mitigations are in place. Oversight and governance through the Operational/Tactical/Silver Cell, Medical Workforce Cell	4	31/03/2025	31/03/2023	04/01/2025
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	25/09/2024	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.	[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		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
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.	25/09/2024	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.	[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		25/12/2024
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	4935	58	Service disruption	Farquharson, Colin	Sewell, Chris	Patient Safety Group	Workforce Strategy Group	26/05/2022	16	Workforce Metrics	Surgery	Theatres, Anaesthesia and Critical Care CBU	Critical Care		Insufficient medical staffing in Intensive Care Units at Lincoln and Boston. Uncovered shifts may result in Unit being decompressed. Medical staff asked to work extra hours compromising workforce directive. Unsafe cover in Unit when doctors are called to attend patients in A&E. Could result in harm to both patients and staff (in terms of wellbeing/morale).	Locums to recruit. Recruitment adverts out. Staff are being paid in TOIL in order to mitigate the financial risk to staff. Rotas are set and monitored -a Consultant formulates the rota and identifies gaps which cannot be covered in advance. Agency requests. Escalation to Divisional Triumvirate when gaps cannot be filled. Escalations are made to the medical director re payment agreements in accordance with NHSE/I policy. Business Continuity Plans are in place for both sites.	Rotas (gaps). Agency spend - financial risk. Number of Datix incidents recorded.	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

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	(Historical Deleted User)	Fulloway, Mr Ian	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.	03/09/2024	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.	[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		03/12/2024
2a. A modern and progressive workforce	4741	42	Service disruption	Lynch, Diane	Chester-Buckley, Sarah	Workforce Strategy Group		13/01/2022	20	Risk assessments	Clinical Support Services	Cancer Services CBU	Oncology	Trust-wide	As a result of lack of investment for Oncology workforce historically there is insufficient workforce to meet demand of the service (and we have recruited posts at risk above budget) which would lead to additional stress and burn out causing the remaining staff to leave. We are heavily reliant on high cost agency covering vacant posts due to the national shortage of Oncologists. If the service was to stop for specific tumour sites this would lead to significant patient harm whereby patients would have to travel following referral to neighbouring Trusts for radiotherapy and chemotherapy treatment, which in turn would put further pressure on other Trusts who could potentially collapse. Oncology is considered to be a fragile service due to consultant oncologist gaps. Demand vastly exceeds the capacity, requiring an increase in establishment. 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	5423	635	Physical or psychological harm	Landon, Caroline	Chamberlain, Leanne	Patient Safety Group		26/04/2024	9		Surgery	Urology, Trauma and Orthopaedics, and Ophthalmology CBU	Ophthalmology		There is a risk of patients suffering sight loss due to waiting times for time sensitive injections and for emails to be processed. This is a result of a combination of injection room availability which is already on the risk register, and staff availability due to new starter within the nurse injector team, sickness within the nurse injector team, and lack of ophthalmology trained outpatient nurses to allow additional clinics.	Absence being managed as per policy and phased return plan worked out for return, new starter is injecting independently and so will start to help with backlog, outpatients have just recruited X4 RNs which will all be trained in ophthalmology once started in post which will support additional activity. bi-weekly meetings gone into diary to keep grip and control of position.	Incdent reporting	04/09/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Estates works on injection room to be completed to allow the room to be brought back in to use.	[04/09/2024 16:20:47 Nicola Cornish] Discussed at Ophthalmology Governance meeting on 4th September. Expect to have the Lincoln injection room back in use on 16th September. Possible similar issues at Louth that may need to be reflected in this risk. Did not agree reduction in score - whilst the backlog has reduced significantly, patients are still waiting longer than they should which still presents a risk of sight loss. [28/08/2024 13:33:38 Nicola Cornish] Risk discussed at Risk Register Confirm & Challenge meeting on 28th August. Panel felt that a reduction in score should be considered due to the significant progress made with reducing waiting list. It was also felt that the risk description should be revised to reflect that the issue is now primarily around the lack of appropriate estate rather than staffing concerns. NC to work with LC to action this and present changes for approval at next meeting. [27/08/2024 15:07:35 Nicola Cornish] The time sensitive injection backlog has reduced to 11 currently but there is no assurance that this will not increase again quickly whilst the injection room remains unavailable. There is a plan for remedial estates works to take place this week, and the room will then require a deep clean and IPC sign off. It is anticipated that the room will be in use again by end of September. [26/06/2024 15:16:52 Rachael Turner] Risk presented at June RRC&C meeting to propose increase in score. Risk severity increased due permanent site loss. The frequency of incidents are increasing. Risk validated at 4x4:16 High Risk. [20/05/2024 15:16:40 Nicola Cornish] Propose to increase risk score to High due to 2 patient harm incident - 1 severe and 1 moderate - relating to delay in injection appointment delay. No assurance that there will not be more cases. Current position: We currently have a backlog of 724 overdue injection appointments, but 998 in total waiting to be booked. This is coming down and was over 1500.	3	31/12/2024		04/12/2024

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	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
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5142	65	Physical or psychological harm	Ratcliff, Carl	Lentz, Blanche	Patient Safety Group		12/04/2023	20		Medicine	Urgent and Emergency Care CBU	Accident and Emergency	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
2b. Making ULHT the best place to work	5422	684	Service disruption	Costello, Mr Colin	Martinez, Francisca	Patient Safety 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	Near misses/incidents Staff health and wellbeing Staff concerns Delays on chemotherapy appointments Chemotherapy waste	28/08/2024	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	[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		28/11/2024

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
2a. A modern and progressive workforce	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	4646	66	Physical or psychological harm	Dunderdale, Karen	Gibbins, Donna	Patient Safety Group	Clinical Effectiveness Group	14/12/2021	20	Policy/Protocol Issues, Risk assessments	Medicine	Specialty Medicine CBU	Respiratory Medicine	Trust-wide	If the Trust is not consistently compliant with with NICE Guidelines and BTS / GIRFT standards to support the recognition of type 2 respiratory failure then there may be delays to the provision of treatment using Non-Invasive Ventilation (NIV), resulting in serious and potentially life-threatening patient harm.	National policy: - NICE Guideline NG115 - COPD in Over-16s: diagnosis and management - NICE Quality Standard QS10 - COPD in Adults - British Thoracic Society (BTS) / Get It Right First Time (GIRFT) standards for NIV ULHT policy: - Guidelines and Care Pathway for commencing Non-invasive Ventilation (NIV) in the non-ITU setting - NIV-trained clinical staff - Dedicated NIV beds (Respiratory wards) ULHT governance: - Medicine Division clinical governance arrangements / Specialty Medicine CBU / Respiratory Medicine - Trust Board assurance through Quality Governance Committee (QGC) / lead Patient Safety Group (PSG) / NIV Group and Integrated Improvement Plan (IIP) / Improving Respiratory Services Programme	- Frequency and severity of patient safety incidents involving delayed NIV - recent history of rare but serious harm incidents - Total elapsed time from Type 2 Respiratory Failure (T2RF) suspicion to commencement of NIV <120mins - not being met at LCH or PHB as of Dec 21 - Start time for NIV <60mins from Arterial Blood Gas (ABG) - not being met at LCH or PHB as of Dec 21 - NIV progress for all patients to be reviewed (once NIV commenced) < 4hours - not being met at LCH as of Dec 21 update: There is a NIV audit captured monthly which determines both trust wide compliance and site specific- this is shared through PRM and available for cabinet and CBU governance meetings	31/07/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Delivery of the NIV Pathway project as part of the Improving Respiratory Service Programme within the Integrated Improvement Plan (IIP): 1. Understand the Trust-wide demand and capacity for Acute and Non Acute NIV. 2. Provision of ring-fenced beds for NIV. 3. Develop Trust-wide Model and Pathway for Acute and Non Acute NIV To meet BTS/GIRFT Standards. 4. Provision of NIV service (ED) which meets the BTS Quality Standards. 5. To have a trained workforce with the skills required to meet the needs of the patients and BTS standards. 6. Governance Process for NIV Demonstrating a Safe Service where Lessons are Learnt.	[31/07/2024 13:04:42 Rachael Turner] Risk discussed as part of the Deep Dive at RRC&C meeting 31/07/24. We are currently not in a position to reduce currently. We continue to have NIV Dashboard and targets where we have an annual review. We are currently not delivering to the standard. The education in recognising type 2 respiratory is still an issue, it is not consistent due to changes in workforce and operational pressures. Meeting booked with ED on 14th August and we continue to review the SOP. Incidents are also increasing around NIV. Risk score to remain. [18/07/2024 11:48:19 Donna Gibbins] Risk remains at 16, lack of equitable services at PHB against BTS at pilgrim. Additionally, the monthly NIV dashboard continues to report themes and concerns in relation to education in ED. Concerns relating to NIV being started in ED which is currently outside of policy. A review of the NIV policy which is due in August 24 is underway, involving ED colleagues. Incidents in relation to NIV being commenced in ED which has been incorrectly set up and SJR's with concerns in relation to ringfenced provision. Mitigations of daily ringfenced capacity continues and is a sustained improved position against the standard. [26/04/2024 14:32:58 Rachael Turner] Risk currently remains at 16 due to lack of equitable service to comply against BTS at Pilgrim. The Monthly NIV audit has demonstrated that there are educational shortfalls with ED and delays in type 2 respiratory failure and escalation. An initial meeting has taken place with respiratory and ED to discuss and review the NIV in a non-ITU setting Sop due in august 24 to consider any contributory factors for commencing NIV in ED. The availability of the ringfenced remains an improved position against the standard. [23/01/2024 14:57:00 Rachael Turner] Meeting is planned in March to discuss NIV and ED, previous meeting were stepped down due to industrial action. We continue to see Datix incidents relating to NIV in ED. Meeting needs to take place before any change can be made. Support is needed for phase 2 of respiratory	4	30/09/2022	31/12/2024	31/10/2024
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		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

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
2a. A modern and progressive workforce	4862	44	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)	12/09/2024	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.	[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 looking at developing ACP roles and Nodule Nurse post. [01/12/2022 11:15:13 Carl Ratcliff] plan for 3 consultants now being on boarded	4	30/12/2022	03/06/2024	12/12/2024
2a. A modern and progressive workforce	5467	695	Service disruption	Babu, Suresh	Chablani, Manish	Undergraduate Governance Committee		21/06/2024	16		Corporate	Medical Director's Office	Medical Education	Lincoln County Hospital	As a result of the respiratory teaching at Lincoln currently being delivered by a locum consultant (via bank), who has previously indicated they wish to retire and as there are no consultant job planned or capacity. This could result in the Trust failing our contractual requirements which would bring into question our newly gained status as a teaching hospital.	No controls in place at the moment. This risk has been escalated up to the head of Respiratory by Dr Babu DME as per Dr Chablani's request.	Workforce	31/07/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Increase the workforce, include undergraduate teaching as a part of the job plan of a few consultants to share the workload and provide resiliance. Investment into staff and education	[31/07/2024 13:21:11 Rachael Turner] Risk presented at RRC&C meeting 31/07/2024. Risk validated as a High risk score 4x4:16 High risk.	8	21/06/2025		31/10/2024
2a. A modern and progressive workforce	5466	698	Service disruption	Babu, Suresh	Chablani, Manish	Undergraduate Governance Committee		21/06/2024	16		Corporate	Medical Director's Office	Medical Education	Trust-wide	As a result of the current Paediatrics teaching fellow leaving in September at the end of this academic year, there is a need for a departmental plan to ensure training is in place for a new teaching fellow ready for the students starting in March 2025. Without this the Trust would be unable to deliver the required teaching in Paediatrics. This could lead to the Trust failing on our contractual requirements and this would bring into question our newly gained status as a teaching hospital.	No controls in place at the moment. This risk has been flagged up to the head of Paediatric service by the modules leads, Dr Broodbank and Dr Herath.	Workforce	31/07/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Increase the workforce, include undergraduate teaching as a part of the job plan of a few consultants to share the workload and provide resiliance. Investment into staff and education	[31/07/2024 13:25:41 Rachael Turner] Risk presented at RRC&C meeting 31/07/2024. Risk validated as a High risk score 4x4:16 High risk.	8	21/06/2025		31/10/2024
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5491	701	Physical or psychological harm	Parkhill, Michael	Davies, Chris	Estates Investment and Environment Group	Clinical Effectiveness Group, Infection Prevention and Control Group	18/07/2024	16		Corporate	Estates and Facilities	Estates	Trust-wide	As a result of wards and departments not following the Change of Use Policy this has resulted in rooms being used for clinical treatments in which ventilation requirements are inadequate. This could lead to patients harm and patients contracting Hospital acquired infections.	Change of Use Policy Space Management Policy-this was approved by H&S Committee IPC Action Plan to review all current areas that are being used inappropriately.	IPC Action Plan. Datix incidents raised.	31/07/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	IPC Action Plan has been developed and carried out identifying all areas where treatment rooms are being used with inadequate ventilation. Estates Actions: •Estates to progress a ventilation compliance review upon Trust approved Capital Funding. •If mechanical ventilation is present – discuss / request Estates feasibility to increase air changes for treatment rooms found to have less than 10 air changes. •Estates to progress environmental infrastructure remedial work upon Trust approved funding. Clinical Division Actions •Where treatments rooms are not up to standard, the relevant Clinicians to be informed by the Divisions so that they can perform their own assessment of risk / responsibility. IPC will support risk assessments. •Red rated treatment rooms to be a priority for relocation to a safer environment. The IPC action plan where areas identified	[31/07/2024 13:53:50 Rachael Turner] Risk presented at RRC&C meeting 31/07/2024. Risk validated at 4x4:16 High Risk. [22/07/2024 15:33:13 Rachael Turner] Treatment room action plan updated version uploaded with feedback from CSS.	8	18/07/2025		31/10/2024

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
2a. A modern and progressive workforce	5468	696	Service disruption	Babu, Suresh	Chablani, Manish	Undergraduate Governance Committee		21/06/2024	16		Corporate	Medical Director's Office	Medical Education	Trust-wide	As a result of failing to provide the curriculum requirements for clinic based specialties across the board but especially Dermatology, ENT Ophthalmology and Rheumatology. This has resulted in clinics being overbooked and the patient numbers not being reduced to allow for teaching the medical students. Which could lead to failing on our contractual requirements and this would bring into question our newly gained status as a teaching hospital.	None at the moment. Dr Chablani has written to the Clinical Leads asking them to support with reduced patient numbers in teaching clinics and for the clinical and attachment leads to work closely together to ensure a balance between service provision and teaching but is yet to get reassurance or a formal response.	Work around appropriate remuneration with Business Units and recognising the need to release clinicians to deliver teaching. Reduce patients in clinics - balancing waiting lists alongside teaching opportunities	31/07/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Increase the workforce, investment into staff and education	[31/07/2024 13:22:46 Rachael Turner] Risk presented at RRC&C meeting 31/07/2024. Risk validated as a High risk score 4x4:16 High risk.	8	21/06/2025		31/10/2024
1c. Improve clinical outcomes	4778	94	Physical or psychological harm	Mooney, Mrs Katy	Marsh, David	Patient Safety Group		16/01/2022	15	Risk assessments	Medicine	Cardiovascular CBU	Stroke		Risk of failure to meet best practice standards for stroke patients due to lack of timely access to community rehabilitation services. Length of stay for patients is set at 10 working days. Currently all processes for moving patients on from stroke unit for rehab is going over which is having an effect on patients rehab causing potential patient harm, service delays and burn out for staff. This is having an effect of staff morale and performance where they feel they are not delivering the service that they would like to.	LCHS provides Lincolnshire Community Stroke Services with a broadened access criteria post 100 day challenge. This is offering some increased access to stroke rehab in the community. One year seconded band 6 OT is currently covering Lincoln Stroke Unit 2 days. Her remit is to identify and facilitate timely discharge from acute to community. This service has KPI's to measure this. -Teams Groups with LCH to facilitate handover. -Joint email to narrow where referrals are directed and sent. -Reviewing prioritise lists everyday to decide appropriate pathways for patients. This is carried out every morning at 08:30. -Joint assessment with OT and PT to increase effectiveness and reduce time to decide which pathway is best for the patient. -Pathways currently in place are HomeFirst, ABI referral pathway --Working with CHC to create meeting of discussion for patients to trust each other within our assessments.	SNNAP data scores . Service provision not in top quartile	02/09/2024	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	[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 implantation work. Risk review on 28.04.2022 Stroke pathway in place. Limited community capacity. ASR review outcome	6	31/03/2025	28/02/2023	02/12/2024
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.	17/09/2024	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.	[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		17/12/2024
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5227	439	Regulatory compliance	Lynch, Diane	Hughes, Robert	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, likely to be no longer needed when refurbishment work completed at the end of April 2024. Access is via a locked gated yard.	The frequency and extended use of the temporary body store at Lincoln has increased the risk.	02/08/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Actions being taken: Assess security vulnerability (on the back of recent incident at NLAG/DPoW) with NLAG/ULHT/Police review of security: Date: End of July 2024 (Meeting held during July to understand findings and discuss next steps. Actions in response need to be understood)	[02/08/2024 12:17:24 Gemma Staples] All 3 sites main mortuaries have intruder alarm that is connected to the Switchboard. The Titan temporary body store also now has an intruder alarm. Significant progress has been made. We are now awaiting clarity on the timescales for removing the Titan Unit at Lincoln (when refurb completed) and the outcome of the police led review [24/04/2024 13:12:25 Nicola Cornish] Discussed at RRC&C on 24/04/24. Likelihood has increased due to longer use of the temporary units but the severity has also increased due to the current acute focus on mortuary security following well publicised local and national incidents. Agreed to increase in score to 16 (4x4). [03/04/2024 16:03:33 Jeremy Daws] As a result of the refurbishment programme of work taking longer than first planned (Paper to ELT submitted) and the demolition of B Store to enable refurbishment work at Lincoln, the use of the Temporary Body Store at Lincoln has increased and will be in use for much longer than first planned (?End of September 2024). There has been a security near miss incident at Boston which was reported to the HTA. There has been a well publicised security incident at Grimsby which has increased the focus on security. The Fuller inquiry has also focussed on security. Given this context, it has been proposed to increase the risk to a 4 x 4 (16) risk. It is requested for this to be approved at next Risk Register confirm and challenge meeting. [27/02/2024 16:17:34 Gemma] The risk has been reviewed at the HTA	6	02/08/2024		01/11/2024

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 (current)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
2a. A modern and progressive workforce	5427	699	Service disruption	Babu, Suresh	Chablani, Manish	Undergraduate Governance Committee		30/04/2024	16		Corporate	Medical Director's Office	Medical Education		Student report discrepancy in teaching between Lincoln and Boston site especially in HCOL and stroke where there is only one educator. To mitigate this , we plan to employ Teaching Fellows so they can offer similar amount of teaching on both sides.	We have appointed Teaching Fellow in Stroke and shortly will do so in HCOL.	Workforce	31/07/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Increase the workforce, investment into staff and education	[31/07/2024 13:26:57 Rachael Turner] Risk presented at RRC&C meeting 31/07/2024. Risk validated as a High risk score 4x4:16 High risk. [10/06/2024 15:43:27 Gemma Staples] Request for the handler to be amended from Catherine Wormington to Dr Maish Chablani. [29/05/2024 13:48:30 Gemma Staples] No attendance to present so deferred to June RRC&C meeting	4	30/04/2025	30/04/2025	31/10/2024
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	28/08/2024	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	[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. [26/03/2024 15:47:41 Gemma Staples] Risk discussed at RRC&C today and agreed that further work be undertaken and then the risk brought back for discussion at the April meeting to be approved and agree the risk rating.	6	13/03/2025		28/11/2024
3c. A modern, clean and fit for purpose environment across the Group	4858	12	Service disruption	Parkhill, Michael	Whitehead, Mr Stuart	Water Safety Group	Emergency Planning Group, Estates Infrastructure and Environment Group	10/02/2022	25	Risk assessments	Corporate	Estates and Facilities	Estates	Trust-wide	If there is a critical failure of the water supply to one of the Trust's hospital sites then it could lead to unplanned closure of all or part of the hospital, resulting in significant disruption to multiple services affecting a large number of patients, visitors and staff	Estates Infrastructure and Environment Committee (EIEC). Estates risk governance & compliance monitoring process. Emergency Planning Group / Major Incident Plan and departmental business continuity plans.	Surveys of water supply infrastructure - Pilgrim Hospital is served by only one incoming water main. This is in very poor condition and has burst on several occasions causing loss of supply to the site.	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 $243m^3$/243,000L, This is potable quality water & will supply the hospital for approx. 20 hours. [21/10/2022 09:06:00 Walter Thompson] Scheme for replacement of critical water tanks - Pilgrim HB- is being developed for the capital plan 22/23 Scheme of work and design currently being produced.	5	30/10/2020	31/03/2023	17/12/2024
2a. A modern and progressive workforce	5381	560	Service disruption	Landon, Caroline	Markall, Amanda			09/02/2024	15		Corporate	Operations	Operations		Discharge Lounge (DL) has insufficient substantive workforce to meet current service demands. Significant RN and HCSW WTE shortfall. No B7 manager in place. B6 jnr sister post is unfunded secondment. No ward clerk. Insufficient housekeeping hours. This means that DL cannot staff each shift witihin budget and relys on temporary workforce and inpatient ward support. RNs and HCSWs act as ward clerk and Housekeeper. The risks are:- service is not well led on every shift contributing to delays, failed discharges, reduced patient capacity and turnover, reduced patient flow impacting on front door, omissions in care, omissions in documentation, errors, patient safety incidents, poor staff wellbeing, Poor patient notes and careflow management, poor patient experience. Improvement to practice very challenged to implement due to temporary staffing. Unable to function within current budget. Reputational damage. Inability to meet CQC requirement from 2021 audit.	Each shift has substantive, bank or ward swap nurse in charge. Staffing issues on the day managed by ops matron. Shifts go to bank and then to agency. Dynamic risk assessment; capping capacity or refusing complex patients. Strategic on call sign off required to close discharge lounge due to staffing. Orientation of temporary staff; Induction materials. limited support and advice from operations centre. RNs and HCSWs complete meal and refreshment service. RNs and HCSWs complete cleaning required outside of 2hrs allocated Housekeeper time. RNs and HCSWs complete ward clerk duties.	Healthroster, Workforce safeguard spreadsheet, 8a lead audit, flo audit, datix, PALS feedback and complaints, e-mail feedback, monthly budget, CQC assurance summary, DL patient flow dashboard, daily delays escalation, complaints, PALS feedback, TSSG, Confirm and challenge process. Sickness rates.	25/06/2024	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	1)Recruiting RNs against potential agency savings as part of TSSG. 2)Case of need in progress to fund appropriate establishment to meet demand.	[25/06/2024 17:05:43 Rachael Turner] Risk reviewed, no change, risk score remains. [28/02/2024 11:51:43 Rachael Turner] Risk presented at RRC&C meeting 28/02/2024. Risk validated at 5x3: 15 High Risk.	4	09/02/2025		25/09/2024

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
1b. Improve patient experience	4701	85	Reputation	Grooby, Mrs Libby	Upjohn, Emma	Estates Investment and Environment Group	Patient Experience Group	13/01/2022	15	Risk assessments	Family Health	Women's Health and Breast CBU	Obstetrics	Trust-wide	If the quality and condition of the hospital environment and facilities used within Maternity services are poor then it may have a negative impact on patient experience and staff morale resulting in loss of confidence in the Trust and damage to reputation; there is also an increased infection risk	- Trust procedures for capital investment and Estates project management - Corporate oversight through Estates Investment & Environment Group / Finance, Performance & Estates Committee (FPEC)	Patient & staff feedback on the environment in Maternity services. Audits of infection prevention & control compliance. Reported health & safety and IPC incidents.	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
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	28/08/2024	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Continue to monitor and assess medication shortages and alternatives – Andrew Baines - Ongoing	[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- no further updates	6	01/12/2021	31/05/2023	28/11/2024
2a. A modern and progressive workforce	4762	47	Service disruption	Capon, Mrs Catherine	Rojas, Mrs Wendy	Workforce Strategy Group	Nursing, Midwifery and AHP Forum, WORK	14/01/2022	15	Risk assessments	Surgery	Theatres, Anaesthesia and Critical Care CBU	Critical Care	Lincoln County Hospital	Issues with maintaining nurse staffing levels/skill to establishment in ICU at Lincoln.	Nursing workforce planning arrangements. Nurse recruitment / retention processes. Clinical Governance arrangements in Critical Care / Surgery Division.	Staffing vacancy rate within ICU nursing	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
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.	04/09/2024	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	[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		04/12/2024
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	Ratcliff, Carl	East, Mr Sean	Patient Safety Group		09/05/2023	15		Clinical Support Services	Therapies and Rehabilitation CBU		Lincoln County Hospital	Approx 15-20 Stroke outliers at any time on the LCH site. Therefore not on the stroke unit and not receiving specialist stroke therapy at the frequency and duration required by SSNAP. Outlier patients are not cohorted on site and can be on any ward therefore Stroke staff cannot go and review and advise. Stroke patient on other non stroke ward will not be assessed as a priority as they are not medically optimised and ready for discharge. Current staffing levels are for the 28 bedded Stroke unit only. If a stroke patient is seen o a non stroke ward this is to the detriment of another patient on that ward. Increased staff stress. General wards do not have the treatment facilities that Stroke patients need.	Stroke Therapy Team review all outliers at the cost of not seeing the Stroke ward patients as much. Stroke team will advise general ward based therapy team. Minimal basic Stroke assessment and treatment skills for general ward therapy staff. Proposal to implement Trusted Assessor Stroke Assessment.	Datixes M&H injury to staff and patient	05/08/2024	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Moving of Stroke specialist therapy staff from PHB to LCH Robust stroke training plan for general ward staff Attendance at Stroke Board to influence change and need for cohorting of outliers Review of Stroke staffing in line with latest staffing levels needed 16/10/23 funding transferred to LCH budget to help support staffing and recruitment has started	[05/08/2024 11:15:56 Gemma Staples] We are currently involved in a review of Estates. Meeting to take regarding plans. Trying to get a Consultant / AHP job description matched to try and support the staffing issues on the Stroke Unit. We have a joint band 6 OT post with LCHS focussing on flow and discharge. Ongoing work with LCHS to enhance the pathway in order to meet standards required. Ongoing discussions with finance & ICB around additional staffing. [07/05/2024 11:25:01 Gemma Staples] Increased staffing - additional full time band 6 Physio and a rotational band 6. x 2 Band 6 OT's increase. Extra x1 band 4. Currently collecting data on Stroke and Neurological outliers to consider an outlier team. [05/02/2024 11:11:38 Gemma] Risk reviewed and is still ongoing [16/10/2023 11:12:34 Sean East] 16/10/23 funding transferred to LCH budget to help support staffing and recruitment has started [08/09/2023 14:20:40 Maddy Ward] Consultation in progress currently with the intention to move some money across to Lincoln. This links in with joint working with LCHS. [23/06/2023 14:13:54 Rose Roberts] No change, went to C&C recently and level agreed. [07/06/2023 12:45:33 Rachael Turner] Risk discussed at RRC&C meeting 07/06/2023. Hyper acute patients outlied to LCH site.Specialist staff not currently available to support these patients. Patients are at risk due not being put into priorities causing delays.This causes a risk of patient harm due not progressing or adding to disability due to not being seen in appropriate pathway. This is also impacting is discharging delays to patients. More work is also required with the community. Score agreed at 15	8	13/05/2024		05/11/2024

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
2a. A modern and progressive workforce	4905	48	Physical or psychological harm	Cooper, Mrs Anita	Taylor, Ruth	Workforce Strategy Group		22/04/2022	12	Workforce Metrics, Risk assessments, Aggregation of Incident/Claims & Complaints/PALS	Clinical Support Services	Therapies and Rehabilitation CBU		Trust-wide	As a result of having insufficient staffing, or required level of experience and skill, the risk is patients will not receive assessment and rehabilitation leading to poor clinical outcome. Reduced flow on Ashby and the acute wards, delayed discharges, delayed referral to response times. Increase in avoidable harm i.e. deconditioning. Patient reviews delayed. Lack of specialist service area resource impacting on long term social value outcomes. Lack of consistency of provision across Lincolnshire footprint. Existing staff stretched to cover additional beds. Increased stress and sick leave on substantive staff.	Recruitment and retention strategies being work through. Therapies and rehab right sizing and service review. Improved joint working with LCHS and system colleagues. Clear therapies and rehab strategy to include CIPP and CON. Working with finance on establishment and nominal role review. Plan in place for sustainable medical workforce rehab medicine. Development team established for therapies. Neuro psych posts recruited too, therapies at front door service substantive funding in place.	Patient complaints. Monitoring of flow at front and back door. Site escalation. Vacancy rate monitoring. Roster fill rates. Waiting list numbers of frequency of follow ups. Staff absence. Staff survey and feedback.	08/08/2024	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	[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, then we can start measuring whether we are falling below safe staffing levels, we	9	30/09/2023	18/12/2023	08/11/2024
1b. Improve patient experience	4724	86	Physical or psychological harm	Lynch, Diane	Taylor, Ruth	Workforce Strategy Group	Patient Experience Group	13/01/2022	20	Risk assessments	Clinical Support Services	Therapies and Rehabilitation CBU		Lincoln County Hospital	If Therapies and Rehabilitation service provision is not sufficient to deliver 7 day service provision, it leaves services without cover at a weekend or with inadequate cover during the week, leading to delayed patient flow; delayed discharge; extended length of stay; impacting on patient experience with potential for serious harm. This includes the neuropsychology cover on Ashby, SLT cover for inpatients, and therapy cover on ITU.	ULH policy: - Service planning & budget setting processes - Business case decision making processes ULH governance: - Capital & Revenue Investment Group (CRIG) management of business case process - CSS Division, CBU / speciality governance arrangements	Level of cover at weekends. Length of stay, patient flow, delayed discharges. Level of funding - Some 7 day funding, but limited to orthopaedics at LCH, minimal service. Inadequate for level of service demand.	05/08/2024	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Review current provision and identify gaps in service to inform business cases for change (working with Surgery and Medicine Divisions as appropriate). Skill mix requires review due to complexity of patients. Prioritisation tool helps to identify patients with greatest acuity or importance which will directly impact patient flow and current bed situation.	[05/08/2024 11:07:48 Gemma Staples] Risk reviewed and remains the same. [07/05/2024 11:16:36 Gemma Staples] Risk reviewed and remains the same. Increased extra ward cover at Lincoln. [05/02/2024 11:06:18 Gemma] Risk reviewed and ongoing. [06/12/2023 13:09:39 Gemma] Conversations are currently happening in regards to appropriate staffing levels for ICU for Therapy Services. Further update to follow [25/10/2023 15:07:18 Rachael Turner] Business case being undertaken by CSS, needs to go through approval process. [08/09/2023 14:14:43 Maddy Ward] Reviewed at quarterly risk register review meeting. Risk is ongoing at present. [23/06/2023 14:07:53 Rose Roberts] Recruited into the Neuro psychology post. Increase risk in consultant cover - sickness and resignation. potential to have to stop admissions. [10/03/2023 13:43:06 Rose Roberts] Awaiting nhse results. Neuro psychology bid waiting to go to CRIG [13/01/2023 12:51:48 Lesley Bradley] 13/1/23 NHSE reviewed Ashby ward this month-await recommendations for staffing levels [15/12/2022 09:53:21 Alex Measures] No update [30/11/2022 10:04:52 Rose Roberts] Neuropsychology bid is still awaiting CRIG approval as CRIG has been stood down. Business cases completed for all areas. 130622 Neuropsychology bid is going to CRIG this mth. All others to be confirmed. Work in progress.	4	05/01/2024	31/03/2023	05/11/2024
3c. A modern, clean and fit for purpose environment across the Group	5383	615	Regulatory compliance	Cooper, Mrs Anita	Rigby, Lauren	Estates Investment and Environment Group	Estates Strategy Group, Health and Safety Group	13/02/2024	15		Clinical Support Services	Cancer Services CBU	Haematology (Cancer Services)	Pilgrim Hospital, Boston	As a result of the treatment room not being compliant with HBN 00-03 procedures are being performed in an area that is not compliant, Adhoc and urgent bone marrow biopsies and intrathecal chemotherapy will still be performed in this room which would lead to an infection risk to patients.	Room is being decluttered Estates have reviewed, still awaiting if they can increase the air exchanges and how much this would cost. Larger organisation piece of work being undertaken Regular bone marrow biopsy clinics have been moved to outpatient department Venesections have been confirmed by the lead Estates Nurse can continue Risk assessment and precautions have been circulated to staff to adhere to for adhoc and urgent bone marrow biopsies and intrathecal chemo.	Datix incidents Complaints / PALS Assessment against regulations	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

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Source of Risk	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
2a. A modern and progressive workforce	5474	700	Service disruption	Babu, Suresh	Wormington, Catherine	Undergraduate Governance Committee		01/07/2024	15		Corporate	Medical Director's Office	Medical Education	Trust-wide	As a result of undergraduate administration Teams at both Pilgrim and Lincoln currently being understaffed this could lead to the medical students not receiving the support required. Which would result in not having adequate staffing to organise the placement schedules and support the medical students to fulfil the Trust's contractual obligations with the medical school Including the B4 Undergraduate Co-ordinators, there would usually be four full time members of the undergraduate administration team on the Pilgrim hospital Boston site, and three full time and two part time members of the team on the Lincoln County Hospital site. The undergraduate administration team at PHB is currently short staffed owing to planned sickness absence and an unexpected resignation. It is likely two further members of the team may need to take compassionate and planned sick leave over the course of the coming weeks. The planned sick leave for one of the PHB administrators and could be for a period of up to 3 months. It is unknown how long the B4 Co-ordinator at LCH may need to take off for compassionate bereavement leave. This will leave the administration team on both hospital sites extremely short staffed but in particular the Pilgrim Hospital Boston site with just one member of the administration team being onsite to support approximately 80 medical students. Currently the team on the LCH site are supporting with administrative tasks which can be carried out remotely, although they also have one new full time member of the team who is not as experienced and able to cover additional modules. It is important that there is a presence on the PHB site to support the medical students and ensure teaching rooms are set up for teaching sessions. The other full time member of staff at PHB has two weeks of annual leave booked at the end of August. This also coincides with the undergraduate manager's leave and one week of the B4 Co-ordinators annual leave.	An advertisement is currently out to replace the B3 administrator at PHB. Two B5 Operational Assistant Manager's have been appointed and this is currently going through the HR Recruitment process. The appointees are the current B4 co-ordinators. One co-odinator is currently on planned sick leave with the other likley to need to take some compassionate bereavement leave. The backfill for the co-ordinator positions is being reviewed and a JD has been prepared and is awaiting review by the Assistant Director of Medical Education. The possibility of bank administration support has been looked into as well as colleagues awaiting redeployment.	Vacancy numbers Sickness episodes Student feedback School of Medicine Feedback CBU Feedback/Complaints	31/07/2024	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Bank admin support Redeployment opportunities Explore use of agency	[31/07/2024 13:28:59 Rachael Turner] Risk presented at RRC&C meeting 31/07/2024. Risk validated as a High risk score 5x3:15 High risk.	6	01/07/2025		31/10/2024
2a. A modern and progressive workforce	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	28/08/2024	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	[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		28/11/2024

Report to the Lincolnshire Community and Hospitals Group Board

<table>
<tr><td>Date of meeting</td><td>5th November 2024</td><td>Agenda item</td><td colspan="2">14.1</td></tr>
<tr><td>Title</td><td colspan="4">Strategic Risk Report</td></tr>
<tr><td>Report of</td><td>Kathryn Helley, Group Chief Clinical Governance Officer</td><td>Prepared by</td><td colspan="2">Lorna Adlington, Head of Patient Safety and Quality Governance</td></tr>
<tr><td>Previously considered by / Date</td><td>Sub-Committees of the Trust Board – October 2024</td><td>Approved?</td><td colspan="2">Yes</td></tr>
<tr><td>Summary</td><td colspan="4">This report was written based on data up to and including 7th October 2024 and provides a Trust overview of strategic risks.

This Strategic Risk Report focuses on the highest priority risks to the Trust's strategic objectives (those with a current rating of Significant Risk, 15-25).</td></tr>
<tr><td rowspan="4">1. To deliver high quality, safe and responsive patient services</td><td colspan="3">1a. Deliver high quality care, which is safe, responsive and able to meet the needs of the population</td><td>√</td></tr>
<tr><td colspan="3">1b. Improve patient experience</td><td>√</td></tr>
<tr><td colspan="3">1c. Improve clinical outcomes</td><td>√</td></tr>
<tr><td colspan="3">1d. Deliver clinically led integrated services</td><td>√</td></tr>
<tr><td rowspan="2">2. To enable our people to lead, work differently, be inclusive, motivated and proud to work within LCHG</td><td colspan="3">2a. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise</td><td>√</td></tr>
<tr><td colspan="3">2b. To be the employer of choice</td><td>√</td></tr>
<tr><td rowspan="7">3. To ensure services are sustainable, supported by technology and delivered from an improved estate</td><td colspan="3">3a. Deliver financially sustainable healthcare, making the best use of resources</td><td>√</td></tr>
<tr><td colspan="3">3b. Drive better decision and impactful action through insight</td><td>√</td></tr>
<tr><td colspan="3">3c. A modern, clean and fit for purpose environment across the Group</td><td>√</td></tr>
<tr><td colspan="3">3d. Reduce waits for patients who require urgent and emergency care and diagnostics and ensure we meet all constitutional standards</td><td>√</td></tr>
<tr><td colspan="3">3e Reducing unwarranted variation in cancer service delivery and ensure we meet all constitutional standards (ULHT)</td><td></td></tr>
<tr><td colspan="3">3f Reducing unwarranted variation in planned service delivery and ensure we meet all constitutional standards (ULHT)</td><td></td></tr>
<tr><td colspan="3">3g Reducing unwarranted variation in community service delivery and ensure we meet all constitutional standards (LCHS)</td><td>√</td></tr>
</table>

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

Impact of proposal/ report	*Please outline the potential impact/ expected outcome* (Quality/ Equality, Diversity/ Equality Delivery System 3/ Health Inequalities/ Financial/ People)				
CQC	**Safe** √	**Caring** √	**Effective** √	**Responsive** √	**Well-Led** √
Links to risks	Noted within the report				
Legal/ Regulation	CQC regulations, NHSI, Standing Orders, Health and Social Care Act.				

Recommendations/ Actions Required

Group Board is invited to review the content of the report, no further escalations at this time

Appendices

Appendix A - Strategic Risks (15 – 25) – 7th October 2024

Glossary

NHS – National Health Service
LCHS – Lincolnshire Community Hospitals
LCHG – Lincolnshire Community and Hospitals NHS Group
TLT – Trust Leadership Team
BAF – Board Assurance Framework
RRCC – Risk Register Confirm and Challenge

Group Board – Strategic Risk report

1. Executive Summary

The purpose of this report is to enable the Group Board to review the management of significantly high risks to strategic objectives and consider the overall extent of risk exposure within the Trust, (those with a current rating of significant risk, 15-25). Of note detailed progress updates against each risk within this report can be found in Appendix A.

As of the 7th October 2024, there were 111 risks recorded on the Trust risk register aligned to the sub-committees of the Group Board. This is an increase of 10 from the previous reporting period.

There were 7 quality and safety risks rated Significantly High (15 - 25) reported to the Joint Quality Committee. This is a reduction of 2 from the previous reporting period.
These 7 risks relate to:

- 495 – Treatment Room Capacity
- 403 - Children Young People Therapy treatment delays
- 672 - Timely Unplanned Palliative Response 24/7
- 695 - Lack of District Nurse Specialist Practice qualified staff in community nursing affecting the quality of care
- 714 - Delivery of pressure ulcer care in the community
- 715 - Community nursing lacks capacity and skill set to meet community demand
- 681 - Children in Care - unable to meet Initial Health Assessment and Review Health Assessment timescales

The following risks have been **updated** since the last report:

- 409 - Lymphoedema service capacity – following review and scrutiny at Risk Register Confirm and Challenge (RRC&C) on 24th September the score was revised and **decreased** to **12 High risk** (previously 16)
- 395 – TB Demand and Capacity – Following review and scrutiny by RRC&C on 28th August 2024 the score was revised and **decreased** to **12 High risk** (previous 16).

There were 5 risks rated significantly High (15 – 25) reported to the Finance, Performance, People and Innovation Committee. This is a reduction of 3 from the previous reporting period. These 5 relate to:

- 444 – Failure to deliver the financial plan (cost) - Score reviewed at RRC&C 28 August and **increase** to score to **16** (previously 15).
- 390 – John Coupland Hospital Theatres Ventilation
- 391 – John Coupland Hospital Water Safety
- 393 – Skegness Hospital Water Safety
- 649 – Fire Safety Core Risk

The following risk has been **updated** since the July report:

- 442 – Efficiency Requirement 24/25 – Score reviewed at RRC&C 28 August 2024 and **decreased** to **12 High risk** (previously 20).

- 455 – Failure to deliver financial plan 24/25 (Income) – Score reviewed at RRC&C 28 August 2024 and **decreased** to **12 High risk** (previously 20).
- 418 – Medical Gases Compliance. Score reviewed at the RRC&C 28 August 2024 and **closed**. The risk will be **replaced with a new risk 746 scoring 12**.

There are 0 People and Organisational Development risks rated Significant (15-25) for this reporting period.

From April 2024, a joint monthly Risk Register Confirm & Challenge meeting is in place across the Group which supports alignment of risk management processes.

2. Purpose

The process to manage risks continues to be applied according to the organisation's Risk Management Strategy and Process. Risks are raised according to the strategy and are managed through risk leads across directorates. The Trust currently holds three risk registers:

- Corporate Risk Register notes all strategic risks with an overall rating of 12 or above;
- Operational Risk Register reflects all trust risks with an overall score of 4 to 11;
- Local risk register is held for all risks with an overall score or 1-3.

All risks are owned by Executive Directors, accountable for mitigating actions and progression against these. Risk Leads oversee all risks raised and review these monthly, as a minimum, and are presented to assurance groups for discussion and agreement prior to committee reporting.

3. Overview of LCHS Risks

a. Open risks:

There are currently 111 open risks on the Trust risk registers an increase of 10 since the last reporting period. Current ratings are noted below:

Risk Register Type / Score	1	3	4	5	6	8	9	10	12	15	16	20	Grand Total
Corporate Risk Register (12-25)									25	4	7	1	37
Local Risk Register (1-3)	1	3											4
Operational Risk Register (4-11)			7	2	17	16	17	11					70
Grand Total	1	3	7	2	17	16	17	11	25	4	7	1	111

b. Heat map/ dispersion of risk across the risk assessment matrix

Heat map/ spread of risks across the risk matrix	Consequence					
	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic	Total

Likelihood							
	1 Rare: This will probably never happen	1	0	0	2	1	4
	2 Unlikely: Do not expect it to happen again but it is possible	0	4	10	10	7	31
	3 Possible: May recur occasionally	3	7	17	10	4	41
	4 Likely: Will probably recur, but is not a persistent issue	1	6	15	7	0	29
	5 Almost Certain: Will undoubtedly recur, possibly frequently	1	4	0	1	0	6
	Total	6	21	42	30	12	111

A summary of the significantly high risks and any movement are outlined below aligned to the strategic objectives:

Strategic objective1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population.

There were 7 significantly high risks recorded in relation to this objective. A summary is provided below:

ID	Title	Risk Score	Division	Updates by reviewers	Date of review
495	Treatment room clinic capacity	20	Collaborative Community Care – Community Hospitals	LCHS now provides a treatment room service for the K2 PCN due to them serving notice as part of GP collective action. The risk has been reviewed but score remains the same. It is expected that more areas will require support with Treatment Rooms. Clinic Space remains an issue in Skegness, Boston, Mablethorpe. Demand on the service is high and there are not enough appointments to meet demand. The service continues to work above the agreed specification delivering support to patients across the system. The capacity of the clinics continues to impact on wider services such as IUEC.	September 2024
681	Children in Care - unable to meet IHA and RHA timescales	16	Children's, Young People and Specialist Services	Paper presented to ELT (27.08.2024) agreement given for overspend to be increased. Discussion with ULHT family health to procure a senior paediatrician at the earliest opportunity. 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. Demand	September 2024

				has outstretched capacity increasing the risk to an already group of vulnerable children.	
403	Children Young People Therapy treatment delays (SLT)	16	Children's, Young People and Specialist Services	A joint ICB / LCC / LCHS paper for consideration of Public Health funding grant for early intervention and targeted offer has been shared with the CYP board, and it was well received. An outcome and decision is pending. **Risk reviewed and discussed at September RRCC. No changes to the score.**	September 2024
695	Collaborative Community Care	16	Lack of District Nurse Specialist Practice qualified (DNSPQ) staff in community nursing affecting quality of care	Recommendations discussed with ELT and supported by board to increase workforce capacity. Further information on how this can be financed is to be agreed. Six new DNSPQ students started in September. 6 practice teachers are now on the course.	September 2024
714	Collaborative Community Care	16	Patients are not always receiving the correct level of care for pressure ulcers within community nursing settings	Improvements noted in data collected from weekly audits. Noted increase in completion of Purpose T, Observations, and using the safeguarding checklist. A reduction in Cat 4 PU's. Score to remain the same currently. There is an increase in patients with Category 3 PUs due to national changes around classification of 'unstagable'. Service action plan to improve pressure ulcer care implemented and an educational training plan has been initiated for all community clinicians. Weekly meetings continue to monitor progress of improvement plans.	September 2024
715	Collaborative Community Care	16	The community nursing service is unable to meet the demand of patients within Lincolnshire	Recommendations discussed with ELT and supported by board to increase workforce capacity. Further information on how this can be financed is to be agreed. Six new DNSPQ students started in September. 6 practice teachers are now on the course. Twice daily matron led safety huddles take place. Senior leaders have been allocated to risk areas for oversight. Support from UCR and CYPSS services is in place to support unplanned demand.	September 2024

672	Timely Unplanned Palliative Response 24/7	16	Childrens and Specialist Services /joint risk across divisions	Discussed at Palliative Oversight Group 02/09/24. Progress made with Specialist Response Model, which is on track for completion in December 2024. To be reviewed with the intention to propose a decrease in score at the next meeting.	September 2024

Strategic objective 3. To ensure services are sustainable, supported by technology and delivered from an improved estate

There were 5 significantly high risks (15 – 20) recorded in relation to this objective. A summary is provided below:

ID	Title	Risk Score	Division	Updates by reviewers	Date of review
444	Failure to deliver financial plan 24/25 - Cost	16	Finance	Score reviewed at Risk Register Confirm and Challenge meeting 28/08/24. A review of scoring and impact led to an agreed change of score from L3 x C5 = 15 to **final score L4 x C4 = 16.**	October 2024
390	John Coupland Hospital Theatres ventilation	15	Corporate	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.	September 2024
391	John Coupland Hospital Water Safety	15	Corporate	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 will be updated.	September 2024
393	Skegness Hospital Water Safety	15	Corporate	SG 27 pipework has been replaced. Chemical disinfection run and resampling has taken place. Awaiting results. Twice daily flushing continues with filters replaced every 30 days.	September 2024
649	Fire Safety Core Risk	15	Corporate	Fire updates presented at H&S committee. Work continues in line with action. No Change to score currently.	September 2024

4. Conclusions and Recommendations

There were 7 quality and safety risks rated Significantly High (15 - 25) reported to the Joint Quality Committee. This is a reduction of 2 from the previous reporting period – both risks decreased in score. These 7 risks relate to:

- 495 – Treatment Room Capacity
- 403 - Children Young People Therapy treatment delays
- 672 - Timely Unplanned Palliative Response 24/7
- 695 - Lack of District Nurse Specialist Practice qualified staff in community nursing affecting the quality of care
- 714 - Delivery of pressure ulcer care in the community
- 715 - Community nursing lacks capacity and skill set to meet community demand
- 681 - Children in Care - unable to meet Initial Health Assessment and Review Health Assessment timescales

There were 5 risks rated significantly High (15 – 20) reported to the Finance, Performance, People and Innovation Committee. This is a reduction of 3 from the previous reporting period. These 5 relate to:

- 444 – Failure to deliver the financial plan (cost)
- 390 – John Coupland Hospital Theatres Ventilation
- 391 – John Coupland Hospital Water Safety
- 393 – Skegness Hospital Water Safety
- 649 – Fire Safety Core Risk

Group Board is invited to review the content of the report, no further escalations at this time.

Trust Board Significant High Risks - October 2024

ID	Division	Title	There is a risk that:	Caused by:	Resulting in	Rating (initial)	Controls in place	Likelihood (current)	Consequence (current)	Rating (current)	Updates by reviewers	Risk level (current)	Rating (Target)	Movement of risk
495	Collaborative Community Care	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	12	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	5 Almost Certain: Will undoubtedly recur, possibly frequently	4 Major	20	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 currently in progress to discuss with ICB in March. Changes have been made to the tariff with a 20% uplift for QTR 3/4 23/24 however the review should highlihght our options going forward.	Extreme	2	No change
681	Children, Young People, and Specialist Services	Children in Care - unable to meet IHA and RHA timescales	There is a risk that there is insufficient capacity within the children in care service to meet the current demand for Initial Health Assessments (IHAs) and Review Health Assessments (RHAs). Initial Health Assessment is required within 20 days of a child coming into care. Review Health Assessments are required annually for children over 5 years of age, and twice yearly for children under the age of 5 years.	At the end of 2023 there were 728 children in the care of Lincolnshire County Council, this number continues to increase year on year (increased by 7% from the previous year alone and 18% over the last 5 years). The introduction of the National Transfer Scheme in November 2021 has also triggered a significant rise in Unaccompanied Asylum-Seeking Children receiving support from the service. The number of children and young people placed into Lincolnshire by external authorities also continues to rise significantly putting additional pressure on the team (22% increase over the last 5 years). The current budget for the Children in Care Service has not been reviewed for several years and is no longer sufficient to meet this increasing demand.	This means there is a significant increase in the number of children in care in Lincolnshire resulting in an increased demand for IHA and RHAs. These assessments are statutory and the service will be unable to meet the timescales these should be completed within. This will impact on the health needs of children in care living in Lincolnshire and delay access to care they may require. The reputation of the service will also be affected if they are unable to meet these statutory assessment timescales. Service user and carer feedback will also be impacted as children have to wait longer than expected for these assessments.	20	The number of children under the care of Lincolnshire County Council continues to grow year on year increasing the demand for IHA and RHA assessments. The service has only been able to offer the amount of IHA appointments needed to meet this demand at significant cost pressure to LCHS. LCHS are unable to continue to cover this additional financial support needed from 01.04.24. An options appraisal has been completed to identify the increase in funding to meet the increased demand for IHA and RHAs, this is attached to the record.	4 Likely: Will probably recur, but is not a persistent issue	4 Major	16	20/09/2024 Discussed at CYPSS Quality SMT 19/09/24: update from Director of Safeguarding CF was acknowledged. 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. 25/07/2024 Discussed at CYPSS Quality Scrutiny Group 25/07/24: The service is still supporting IHA/RHA appointments outside their funding at cost pressure to themselves (approx £67,000), but what they need is £300,000 agreed budget to be able to meet the demand and to deliver the service appropriately. Caveat re: DNA / Was not brought: the slots cannot be filled at short notice. The division agreed that the score remains unchanged at a L4 x C3 = 12. For further discussion at RRCC, as query raised regarding the score needing to be higher. 20/07/2024 Discussed at CYPSS Quality SMT 18/07/24: the case for change has been completed and sent to ELT. A business case is to be deleveoped to add funding. No change to score. 03/07/2024 Discussed at CYPSS Quality SMT 20/06/24: a paper was written for proposed changes, and it is hoped that it would be added for discussion at ELT. No change to score. 16/05/2024 Discussed at Quality Meeting 16.5.24 No change to risk 17/04/2024 Updated with DL, DDL, CSL & CTL 15/04/24: The risk's score remains unchanged. There is limited capacity with regards to the number of IHA appointment slots. Due to a reduction in the CiC nurse hours, this has started to impact further on the RHA timescale. The current budget has not been reviewed yet and is no longer sufficient to meet the IHA & RHA demands. An Options Appraisal was completed to identify the increase in funding needed to meet this demand; the paper is under review within LCHS. 24/03/2024 Discussed at divisional QSG 14/03/24: the service continue to mitigate this risk at their own cost. Score remains the same.	Extreme	3	No change
403	Children, Young People, and Specialist Services	Children SLT Therapy treatment delays	Children / young people will wait much longer than usual for the treatment option of block of therapy intervention following assessment (6-8 months as opposed to 2-4 months pre-Covid).	During the pandemic, the Children's SLT service were initially unable to carry out therapy blocks except via Q Health, which lead to a backlog due to virtual appointments not being appropriate for all	Patient impact: treatment delays, impact on patients' mental health & social inclusion. Organisation impact: reputational (increase in complaints / concerns)	9	1. Advice and activities are given the patient's family and/or educational setting, ensuring they are safe to wait. 2. An appropriate skill mix is used, for example assessments are carried out by SLT and most therapy blocks completed by SLTAs. 3. Mix of face to face and virtual sessions "	4 Likely: Will probably recur, but is not a persistent issue	4 Major	16	20/09/2024 Discussed at CYPSS Quality SMT 19/09/24: the score remains the same. For further discussion at RRCC when CYPSS is scheduled for their risk deep dive. 19/08/2024 agreed for resubmission to RRCC meeting for consideration of increase of 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 • Jul'24 vacancies at 4.3 WTE • Workload remains unachievable to meet demand even with full staffing • Budget not available (currently met at cost pressure for LCHS) • 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. • Disproportionate impact of service challenges on males (gender), children in their early years (age), children with learning disabilities (disability), and those living in deprivation compared to peers, leading to the risk of their health inequalities increasing 19/08/2024 Discussed at CYPSS Quality SMT 15/08/24: Service review paper is going through, new vacancies, evidence of harm is being considered for inclusion on a population scale level in a draft ICB paper. Propose to increase the score being discussed separately DDL/DL/CSL/QPIL. 07/08/2024 Discussed at RRCC 31/07/2024: the Group considered the increase of Likelihood to 5, which would have made the score a 20. However, it was agreed that the score should remain L4 X C4 = 16. 20/07/2024 Discussed at CYPSS Quality SMT 18/07/24: A band 6 staff member has submitted their resignation today. A paper for consideration of Public Health funding grant for early intervention and targeted offer is due today. A joint ICB / LCC / LCHS paper was also submitted to the CYP board, and it was well received. However, no decision was made as of yet regarding which model to go for. No change in score. 03/07/2024 Discussed at CYPSS Quality SMT 20/06/24: additional deterioration due to recent B5 staff member's resignation. Locum support is being considered. The staff morale is very low. This risk will not improve until the review of the paper addressing the service model completes. Propose to increase score to L5 x C4 = 20. 16/05/2024 Issue continues. Waits increasing due to vacancies and demand. Impacting on staff morale. HWB support provided by CSL. Paper expected at CYP Board July to review the model 14/04/2024 Discussed at divisional QSG 11/04/24: All vacancies are out to advert, with waiting times expected to be impacted over the next few weeks, as AP, B5, and 2 x B6 have left or are in the process of leaving the service. Anticipated deterioration due to further staff resignations, but score remains the same this month. 24/03/2024 Discussed at divisional QSG 14/03/24: the trajectory has been downwards for waiting times, but this has been slowing down and might change direction, as additional sickness within the team. No change to score	Extreme	4	No change
672	Integrated Urgent & Emergency Care	Community Palliative Care Provision	LCHS are not consistently providing proactive, co-ordinated support, and timely urgent responses to palliative / EOL patients.	Continued increased demand during a 24 hours time period. Overlap of multiple triage points. Lack of clear service criteria and pathways. Lack of standardisation of appropriate training.	Longer waits for symptom control/management. Poor experience patients / relatives. Negative impact on staff wellbeing. Increased complaints. Reputational risk. Mis-aligned stakeholder engagement.	20	BCP actions for comfort calls when delays take place. Unplanned pathway work (in development). Macmillan investigating different ways of working in terms of proactive management (in progress). Funding sourced to support additional recruitment into Home Visiting.	4 Likely: Will probably recur, but is not a persistent issue	4 Major	16	04/09/2024 Discussed at Palliative Oversight Group 02/09/24: A meeting to discuss progress for actions 921 and 922 (Elecronic CD1 Forms and Centralising OOH Prescribing in IUEC) will take place WC 09/09/24. Potential change of score expected on completion of the meeting. Progress made with action 855 (Specialist Response Model), which is on track for completion in Dec'24. 06/08/2024 Discussed at Palliative Oversight Group 06/08/24: no recent evidence to support the need to amend the score. No change expected until completion of actions that are due in Sep'24. 25/07/2024 Community Nursing QSG Update: Workshop attended by Siobhan Kidd and Zoe Wills looking at full palliative pathway. Current unplanned pillar work on SOS visits is ongoing. 09/07/2024 Risk content and actions fully updated at PEOL Risk summmit 09/07/24. 03/07/2024 Discussed at CYPSS Quality SMT 20/06/24: discussion to be had with the other divisions at Operational Delivery Group in terms of where this risk sits. 03/07/2024 Discussed at CCC Community Nursing Divisional Quality Scrutiny Group 25/06/24: acknowledged the impact on teams, especially at the start and at the end of the shifts. Staff often work overtime to pick up stat doses that come in, but with insulin runs and less staff on late shifts, it's become challenging to pick up any SOS visits. There are several workstreams looking into palliative care, and community nursing leaders are involved in some work at present. 18/06/2024 Discussed at IUEC Divisional Quality Scrutiny Group pre-meet on 11/06/2024: 5 Home visiting staff are finishing their supernumerary period & improvement is expected once they are fully in post. Additional home visiting base will go live in Sleaford once the car is delivered. Breached response times for urgent palliative patients remain high. Score remains the same. 16/05/2024 Discussed at CYP SS Quality meeting 16.5.24 Patients are still waiting outside wait times. In particular between 4 - 8pm due to inability ofand capacity of community nursing and home visiting. Advice and specialist guidance is provided by Macmillan via PSPA 15/04/2024 Discussed at divisional QSG 09/04/24: CSEG did not agree decrease of risk, so score remains 16. To involve palliative care strategic work in further conversations. Refreshing all data for HV paper to TLT should provide additional information. Score remains the same. 14/04/2024 Discussed at CYPSS divisional QSG 11/04/24: acknowledged that CSEG did not agree decrease of score to 12. Incidents are still being submitted for delays to providing palliative care. Score remains the same.	Extreme	4	No change
714	Collaborative Community Care	Delivery of pressure ulcer care in the community	Patients are not always receiving the correct level of care for pressure ulcers within community nursing settings	Variability in the delivery of care for pressure ulcers across community Lack of consistent senior clinical case review Variable clinical skill set of team members in delivering pressure ulcer care	Deterioration in pressure ulcers Increasing referrals for S42 safeguarding responses Poor patient and family/carer experience ICB/CQC oversight of pressure ulcer care	16	Daily BeSafe reviews of patient care Service action plan to improve pressure ulcer care implemented ICB oversight Educational training plan for all community clinicians initiated Assurance programme commenced Monthly thematic review of pressure ulcers highlighting themes and risks in care	4 Likely: Will probably recur, but is not a persistent issue	4 Major	16	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. 30/05/2024 New risk agreed at Risk Register Confirm & Challenge Group 29/05/2024	Extreme	8	No change

695	Collaborative Community Care	Lack of District Nurse Specialist Practice qualified staff in community nursing affecting the quality of care	Community nursing teams fail to provide high quality care due to reduced levels of District Nurse Qualified staff within the team structure	Lack of value placed upon the importance of the DNSPQ qualification within community nursing teams Failure to reimburse staff undertaking the role relevant to their responsibilities and thereby retaining them Failure to train sufficient number of DNSPQ qualified staff Lack of standard use of the Enhanced Practitioner role in community nursing teams and defined role Lack of qualified DN	Insufficient levels of qualified DNSPQ support for junior members of teams Lack of oversight for complex case management. Identified theme in case of patient harm Reduced safe management of caseload sizes in community nursing teams Lack of professional support and guidance for team development	16	BSAFE initiated for daily oversight of safe care BSAFE audits by CSL level staff Reallocation of qualified DNSPQ staff to teams with low levels to aid safety Identification of new assessors for DNSPQ trainees Allocation of trainers to training places for increased trajectory of DNSPQ training Recovery trajectory and commitment to model of care for excellence to be submitted to ELT as part of a wider strategy for service	4 Likely: Will probably recur, but is not a persistent issue	4 Major	16	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	Extreme	4	No change
715	Collaborative Community Care	There is a risk that the Community nursing lacks capacity and skill set to meet community demand	The community nursing service is unable to meet the demand of patients within Lincolnshire	Increased demand for service of 8% Care unit allocation above the maximum of 15 care units daily Case load levels above 150 max levels Reduced numbers of DNSPQ qualified staff	Variance in care delivery Ineffective case load management Poor patient experience Reduced complex caseload efficiency Task based service provision with a lack of holistic care planning	16	Daily BSafe - escalation/oversight review Twice daily matron led safety huddles Re allocation of senior resource to at risk areas Operational oversight of risk daily Service evaluation of DNSPQ role Support from UCR and CYPSS services to aid meeting unplanned demand when required	4 Likely: Will probably recur, but is not a persistent issue	4 Major	16	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	Extreme	6	No change
444	Corporate	Failure to deliver financial plan 24/25 - Cost	The Trust fails to deliver breakeven duty aspect of its financial plan by failing to contain costs within planned levels	Service pressures, continued pressure in the system and level of demand being experienced, and/or failure to manage performance effectively or unforeseen events; Inflationary 'cost of living pressures	Reputational damage including reduction in the SOF rating and/or lack of financial sustainability going forward, and a failure to meet statutory financial duties.	15	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.	4 Likely: Will probably recur, but is not a persistent issue	4 Major	16	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 Risk decrease from 12 in December 2023 to 6. Risk updated on 29/04/2024 with Mike Pockett.'' At the start of the year there is a lot of people involved in bringing a quality efficiency program to be delivered. There were risks that didn't happen and as the year has gone on a lot of changes have happened because of financial benefits so the risk reduced. 9 months worth of efficiency financial measure allowed a more informed view of were the organisation is going for the next few months. 27/04/2024 Retrospective decrease of score noted following FPPIC report 26/04/24. Narrative to follow on 29/04/24.	Extreme	6	No change
390	Corporate	John Coupland Hospital Theatres ventilation	Patient safety/ infection control / loss of service and disrupted service to patients	Theatre one - The plant in JCH theatre 1 is running inconsistently resulting in temperatures being close to or over the limit of 22c and humidity at times being close to or breaching the limit of 60.	Creating a patient safety risk if not effectively monitored, theatre lists have had to be cancelled for patient safety at short notice, a risk to service delivery and LCHS reputation.	10	1. PPMs and recording undertaken by NHSPS. 2. Yearly survey reports on high risk equipment (theatres) undertaken by NHSPS. 3. Monitoring of compliance undertaken by Estates Shared Service. 4. Compliance information reported into LCHS Safety and Compliance Group (SACG) monthly and Health and Safety Committee Quarterly. 5. Weekly maintenance checks are being undertaken by NHSPS.	3 Possible: May recur occasionally	5 Catastrophic	15	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 review by our Hard FM Specialist and Ventilation AE. Once their feedback and direction are received the design will be finalised.	Extreme	2	No change
391	Corporate	John Coupland Hospital Water Safety	Water supply to patients, staff and visitors has been contaminated;	The regulatory routine maintenance of the landlord (NHSPS) being ineffective;	Risk of harm from Legionella and other waterborne pathogens	20	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	3 Possible: May recur occasionally	5 Catastrophic	15	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.	Extreme	10	No change
393	Corporate	Skegness Hospital Water Safety	Water supply to patients, staff and visitors has been contaminated;	The regulatory routine maintenance of the landlord (NHSPS) being ineffective	Risk of harm from Legionella and other waterborne pathogens	20	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	3 Possible: May recur occasionally	5 Catastrophic	15	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 chemical disinfection was carried out in the UTC on the 15th March. A thermal disinfection has been carried out in the rest of the hospital on the 23rd March. Resampling is taking place W/C 25th March. Filters on positive outlets replaced every month and documented.	Extreme	10	No change
649	Corporate	Fire Safety Core Risk	There is a risk of harm to building occupants (including patients)caused by fire. There is a risk that the Trust cannot demonstrate statutory compliance in accordance with the Regulatory Reform (Fire Safety) Order 2005 (RRO).	Inadequate fire protection systems, maintenance, training and procedures	Loss of facilities, services and injuries to patients and staff.	15	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.	3 Possible: May recur occasionally	5 Catastrophic	15	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] ULHT are supporting LCHS with all elements of fire safety. Also a recruitment process has taken place to increase the capacity in the ULHT team.	Extreme	5	No change

Board Assurance Framework 2024/24

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

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*5 November 2024*
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 AMBER rating of objective 2b – To be the employer of choice*

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 September and October, including the Audit Committee in Common held on 17 October.

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 September People and OD Committee, ULTH, are proposing that objective 2b – To be the employer of choice be rated as amber from green.

This position was confirmed through the People Committee in Common at the October meeting for both ULTH and LCHS.

Lincolnshire Community and Hospitals Group
Board Assurance Framework (BAF) 2024/25

Strategic Aims	Board Committee
Patients - To deliver high, quality, safe and responsive patient services	Quality Committee
People - To enable our people to lead, work differently, be inclusive, motivated and proud to work within LCHG	People and Organisational Development Committee
Services - To ensure services are sustainable, supported by technology and delivered from an improved estate	Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee
Partners - To collaborate with our primary care, ICS and external partners to implement new models of care, transform services and grow our culture of research and innovation	Transformation and Integration Committee
Population Health - To embed a population health approach to improve physical and mental health outcomes, promote well-being, and reduce health inequalities across an entire population	Quality Committee / Transformation and Integration Committee

Assurance Rating Key:	
Red	Effective controls may not be in place and/or appropriate assurances are not available to the Board
Amber	Effective controls are thought to be in place but assurances are uncertain and/or possibly insufficient
Green	Effective controls are definitely in place and Board are satisfied that appropriate assurances are available

Objective alignment
Lincolnshire Community Health Services NHS Trust objectives
United Lincolnshire Hospitals NHS Trust objective

Ref	Objective	Executive Lead	Linked programmes in Integrated Improvement Plan/Operational Plan	Linked projects in Integrated Improvement Plan/Operational Plan	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating											
SA1 To deliver high, quality, safe and responsive patient services																										
1a	Deliver high quality care which is safe, responsive and able to meet the needs of the population	Group Chief Nurse/Group Chief Medical Officer	1. Improve medical devices and use of in practice	1.1. Develop in house maintenance programme 1.2. Review contracts for medical supplies and medical device management 1.3. Support implementation of Point of Care (POC) testing at Urgent Treatment Centres 1.4. Modernising and innovating use of technology to improve quality of patient care 1.5. Virtual Ward Programme Support	1. Lack of resources 2. Lack of skills and capability 3. Leadership capacity 4. External partnerships and ways of working 5. Patients and public behaviours 6. Mindset of leaders 7. National releases on best practice	467 Medicines management practice 472 NHS Property Services provision of medical gases within LCHS sites. 511 Medical Devices Asset Register 519 Medicines - prescribing 524 Staff Training 536 Medicines Administration Error 554 Lincolnshire-wide Medicines Management Input 556 Medicines Management: Trust-Wide 510 LCHS Patient Waiting Lists Data								Quality Committee			G	G	G	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				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 chalenge process.	Continued Observation of Section 42 incidents across community services. Intial reduction in number of Safeguarding referrals relating to pressure ulcers being monitored													
			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										
					1. Lack of System Engagement and Comms Team/ recruitment			Primary: 1. Clinical Strategy 2023-28 and linked reporting of delivery 2. Integrated Care System (ICS) Strategy 3. Integrated Care Board 5-year joint forward plan 4. Trust Leadership Team (TLT) reports 5. LCHS Operational Plan reports 6. Lincolnshire Long Term Plan 7. Quality Team/ Patient Experience and Involvement leads 8. Complaints, Patient Advice and Liaison (PALS, and Claims Team 9. System Communications and Engagement Team 10. Volunteering Services Team 11. Triumvirate weekly complaints, incidents and claims reviews 12. Divisional monthly operational plan reporting 13. Quality Assurance Groups	1. System Engagement Team not currently in place and timeline not confirmed. 2. Data - not connected Datix/ Business Intelligence/ System 1	1. System CEOs meeting to progress decisions. 2. FBI developed rollout plan for datix being pulled into the data warehouse. 3. FBI developed rollout plan for Systemone data linkage to datix incidents/ complaints/ claims.	1.1 Recruitment and delivery of System Statutory Engagement Team resource and plan 2.1 LCHS involvement plan, feedback, improvement and delivery of plan (including national patient surveys) 3.1 LCHS experience plan, feedback, improvement and delivery of plan 3.2 Improved service design, access and experience			Quality Committee

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	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		Secondary: 1. Stakeholder Engagement and Involvement Group (SEIG) 2. Clinical Safety and Effectiveness Group (CSEG) 3. Strategy and Planning Group (SPG) 4. Quality and Risk Committee (QRC) 5. Audit Committee 6. Trust Leadership Team (TLT) 7. Performance Management Reviews (PMRs) Tertiary: 1. Care Quality Commission Engagement and Assessment 2. Healthwatch monthly reports 3. Patient-Led Assessments of Care Environment (PLACE) Report 4. NHS Resolution reporting 5. Audit - internal/ external 6. Patient and Public feedback/ surveys/ NHS Choices 7. Volunteering placement evaluations/ take up of opportunities 8. Complaints and Claims benchmarking data 9. Friends and Family Test data									G	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 overight. Monthly oversight commenced in community nursing	Monthy 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 imporvement 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					
			2. In collaboration develop a quality dashboard and infrastructure to provide best evidence to demonstrate quality of care	2.1. Develop an overarching infrastructure to ensure quality improvement and performance can be continually monitored, evidenced and understood from ward to Board ensuring that evidence can easily be collated for CQC assessments																						
			3. Improve People Involvement	3.1. Develop a programme of assurance with effectiveness of clinical procedural documents																						
1d	Deliver clinically led integrated services	Group Chief Nurse/Group Chief Medical Officer	1. Review and transformation of Intermediate Pathways of Care Review	1.1. Working with system partners to review priority pathways for looked after children in Lincolnshire 1.2. Links to system Intermediate Care Review. This is currently paused so will be picked up again once this has been reinstated. 1.3. Maximising the use, occupancy and pathways in to our Community Hospitals and Transitional Care Beds- review of the Integrated Discharge Hub										Quality Committee												
			2. Frailty Pathways	2.1. Community Hospitals being recognised as Frailty specialists within our Lincolnshire system 2.2. Adult Community Therapy Frailty Rebranding 2.3. Delivering a population health needs based service that maximises the potential of our estate from Archer Assessment Unit																						

			3. Childrens Services Transformation	3.1. Child to adult transition of services - Business Cases and Case for Change being prepared nationally - where do these children go - for example Asthma - there is no adult service for this																						
			4. Palliative Pathways	4.1. Review the palliative pathways across LCHS to meet the needs of all palliative patients and their families.																						
SA2 To enable our people to lead, work differently, be inclusive, motivated and proud to work within LCHG																										
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 Learning & Development Leads Group (LDLG) 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 leaderhsip 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 eaulity, diversity and inclusion with key stakeholders across the Group. This will report into People Committee on a bi-monthly basis.	Finance, Performance, People and Innovation Committee			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				Finance, Performance, People and Innovation Committee			G	G	G	G	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		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, Performance and Estates Committee / Finance, Performance, People and Innovation Committee			A	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, Performance and Estates Committee / Finance, Performance, People and Innovation Committee			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 assuarnce relating to statutory compliance of the estate. No Authorising Engineer audits being undertaken. LPFT Shared Service Provdier little assuarnce 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 effectivley manage the estate and maximise potential going forward.	Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee			R	R	R	R	R					
3d	Reduce waits for patients who require urgent care and diagnostics to constitutional standards	Group Chief Operating Officer												Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee			A	A	A	A	A					
3g	Reducing unwarranted variation in community service delivery and ensure we meet all constitutional standards	Group Chief Operating Officer											New Group objective. Assurance and governance reporting against this TBC.		Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee			R	R	R	R	R					

SA4 To collaborate with our primary care, ICS and external partners to implement new models of care, transform services and grow our culture of research and innovation																										
4a	Establish collaborative models of care with all our partners including Primary Care network Alliance (PCNA), GPs, health and social care and voluntary sector	Group Chief Integration Officer	1. Community Primary Partnerships	1.1 Neighbourhood Working 1.2 Tobacco Dependence Team move 1.3 First Costal Development								New Group objective. Assurance and governance reporting against this TBC.		Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee (To move to: Transformation and Integration Committee)			R	G	G	G	G					
			2. Support and provider leadership to the ICS operating framework and governance	2.1 Paly an active role in the governance structures of the ICS	1.Mindset and behaviour of leaders 2.Lack of capacity 3.Lack of skills and capability 4.Leadership capacity and capability 5.Commissioning practices 6.A poor external reputation"	444, 481, 504, 526, 530 - TO BE CHECKED AGAINST DATIX		1. Integrated Care System (ICS) Strategy 2. Integrated Care Board 5-year joint forward plan 3. Lincolnshire Long Term Plan 4. LCHS IIP 5. Clinical Strategy 2023-28 6. NHS England Planning Guidance 7.Performance Management Reviews (PMR) 8.Lincolnshire Leaders Board 9.Better Lives Lincolnshire Leadership Team 10.System joint committees 11.System Financial Leaders Group (FLG) 12.Quarterly System Review Meeting (QSRM) 13.National Oversight Framework (NOF) rating (annual and quarterly 14.Internal audit 15.External audit	No up to date survey of partner views	CIO once in post to take a view on whether (and when) to conduct a survey of partner views.	1.Delivery of the FBI Strategy plan 2024-25 2.National Oversight Framework (NOF) rating (currently out to consultation) 3.LCHS representation on system boards, committees and groups 4.Compliance with system mechanisms e.g. Risk/Gain Share 5.LCHS delivery of its elements of system projects	Partner satisfaction ratings New Group objective. Assurance and governance reporting against this TBC.	CIO once in post to take a view on whether (and when) to conduct a survey of partner views.													
			3. Play an active role in collaborations that make a difference	3.1 Play and active role as a key partner in the Lincolnshire Health and Care Collaborative 3.2 Work in partnership to identify and deliver initiatives that can only succeed in collaboration	1.Mindset and behaviour of leaders 2.Lack of capacity 3.Lack of skills and capability 4.Leadership capacity and capability 5.Commissioning practices 6.A poor external reputation"	444, 481, 504, 526, 530 - TO BE CHECKED AGAINST DATIX		1. Integrated Care System (ICS) Strategy 2. Integrated Care Board 5-year joint forward plan 3. Lincolnshire Long Term Plan 4. LCHS IIP 5. Clinical Strategy 2023-28 6. NHS England Planning Guidance 7.Performance Management Reviews (PMR) 8.Lincolnshire Leaders Board 9.Better Lives Lincolnshire Leadership Team 10.System joint committees 11.System Financial Leaders Group (FLG) 12.Quarterly System Review Meeting (QSRM) 13.National Oversight Framework (NOF) rating (annual and quarterly 14.Internal audit 15.External audit	No up to date survey of partner views	CIO once in post to take a view on whether (and when) to conduct a survey of partner views.	1.Delivery of the FBI Strategy plan 2024-25 2.National Oversight Framework (NOF) rating (currently out to consultation) 3.LCHS representation on system boards, committees and groups 4.Compliance with system mechanisms e.g. Risk/Gain Share 5.LCHS delivery of its elements of system projects	Partner satisfaction ratings New Group objective. Assurance and governance reporting against this TBC.	CIO once in post to take a view on whether (and when) to conduct a survey of partner views.													
4b	Successful delivery of the Acute Services Review	Group Chief Integration Officer												Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee (To move to: Transformation and Integration Committee)			A	A	A	A	A					
4c	Grow our research and innovation through education, learning and training	Group Chief Integration Officer												People and Organisational Development Committee / Quality Committee (To move to: Transformation and Integration Committee)												
			1. Care Closer to Home (Digital)	1.1. Technology Enabled Transformation				Primary: 1. Digital Health Strategy Secondary: 1. Digital Strategy Group (DSG) 2. Digital Executive Group (DEG) 3. Finance, Performance, People and Investment Committee (FPPIC)	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																

4d	Enhanced data and digital capability	Group Chief Integration Officer	2. Safe and Sustainable Foundations (Digital)	2.1. Safe Practice 2.2. Technology Optimisation	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		4. System Digital, Data and Technology Board (DDaT) 5. Transformation Delivery Group (TDG) 6. Trust Leadership Team (TLT) 7. Performance Management Reviews (PMRs) 8. Capital Investment Group Tertiary: 1. Annual Network and Security Penetration Test (DSPT) 2. Data Security and Protection Toolkit 3. Internal Audit 4. Benchmarking data 5. Healthcare Information and Management Systems Society Assessment (HIMSS)	1. Fully developed 3rd party compliance dashboard	1. Programme of work to share compliance data across organisations into a dashboard	1. Delivery of the Digital Health Strategy 23/24 Action Plan 2. Improved use of digital technologies 3. Delivery of LCHS Capital Plan 23/24 4. Greater uptake of digital services from the public			Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee (To move to: Transformation and Integration Committee)			G	G	G	G	G					
			1. Change Ready Workforce (Digital)	1.1. Digital Ready Workforce 1.2. Digital Leadership					1. Patient Digital Literacy Information 2. Workforce Digital Literacy Information	1. Creation of a patient co-design group 2. Trust wide Digital skills training needs analysis																
SA5 To embed a population health approach to improve physical and mental health outcomes, promote well-being, and reduce health inequalities across an entire population																										
5a	Develop a Population Health Management (PHM) and Health Inequalities (HI) approach for our Core20PLUS5 with our ICS	Group Chief Nurse/Group Chief Medical Officer	1. Develop foundational insight	1.1 Develop the Population Health Management (PHM) and Health Inequalities (HI) approach	1.Mindset and behaviour of leaders 2.Lack of capacity 3.Lack of skills and capability 4.Leadership capacity and capability 5.A poor internal reputation 6.National guidance changes 7.System finance/data requests			Primary: 1. Integrated Care System (ICS) Strategy 2. Integrated Care Board 5-year joint forward plan 3. Finance and Business Intelligence (FBI) Strategy 2023-28 4. FBI Strategy update on current year plan 5. Trust Leadership Team (TLT) reports 6. LCHS Operational Plan reports 7. Clinical Strategy 2023-28 8. Chief Clinical Digital Information Officer (CCDIO) 9. Lincolnshire Long Term Plan 10. Strategic Delivery Plan as part of the Recovery Support Programme 11. NHSE Planning Guidance Secondary: 1. LCHS Finance Performance, People and Investment Committee (FPPIC) 2. Quality and Risk Committee (Q&RC) 3. LCHS Trust Leadership Team (TLT) 4. Transformation Delivery Group (TDG) 5. Data Quality Group 6. Performance Management Reviews (PMR) 7. Lincolnshire Integrated Care Board 8. Lincolnshire Health and Care Collaborative Delivery Board 9. System Digital, Data and Technology (DDAT) Tertiary: 1. Benchmarking data 2. Clinical audit reports 3. National best practice data and reports 4. CQC rating	Skills and capability to use tools and frameworks	Programme of knowledge and skills development for FBI and stakeholder partners		New Group objective. Assurance and governance reporting against this TBC.		Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee (To move to: Transformation and Integration Committee)			R	G	G	G	G					
5b	Co-create a personalised care approach to integrate services for our population that are accessible and responsive	Group Chief Nurse/Group Chief Medical Officer												Quality Committee												
5c	Tackle system priorities and service transformation in partnership with our population and communities	Group Chief Integration Officer										New Group objective. Assurance and governance reporting against this TBC.		Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee (To move to: Transformation and Integration Committee)			R	R	R	R	R					

			1.1. Care Closer to Home (Estates and Transformation)	1.1. Supporting Models of Care 1.2. Driving Integrated Working	1. Lack of resources 2. Lack of skills and capability 3. Leadership capacity 4. External partnerships and ways of working 5. Patients and public behaviours 6. Mindset of leaders 7. Staff health and wellbeing 8. Patient and public engagement	430 Cyber Security 454 NHSPS Water Supply 460 Cost of estate 461 NHSPS Maintenance of LCHS estate 483 JCH Theatre Ventilation 473 NHSPS property ventilation 551 JCH Water Purity 552 Skegness Hospital Water Purity 553 Migration from network drives to SharePoint		Primary: 1. Digital Health Strategy 2. Estates and Transformation Strategy 3. Clinical Strategy 4. Lincolnshire Long Term Plan 5. LCHS Operational Plan 6. Integrated Care System (ICS) Strategy 7. Integrated Care Board 5-year joint forward plan 8. Strategic Delivery Plan as part of the Recovery Support Programme 9. LCHS Green Plan 10. NHS Lincolnshire Green Plan Secondary: 1. Digital Strategy Group (DSG) 2. Estates Delivery Group 3. Digital Executive Group (DEG) 4. Health and Safety Committee 5. Finance, Performance, People and Investment Committee 6. Audit Committee (FPPIC) 7. Estates Shared Service Programme Group (ESSPG) 8. System Digital, Data and Technology Board (DDaT) 9. Lincolnshire Strategic Infrastructure and Investment Group 10. Transformation Delivery Group (TDG) 11. Trust Leadership Team (TLT) 12. Performance Management Reviews (PMRs) 13. Quality and Risk Committee (Q&RC) 14. Capital Investment Group 15. Lincolnshire System Operational Estates Group 16. Lincolnshire Greener NHS Group Tertiary: 1. Estates Returns Information Collection (ERIC) Return 2. Patient-Led Assessments of Care Environment (PLACE) Report 3. Annual Network and Security Penetration Test (DSPT) 4. Data Security and Protection Toolkit 5. Internal Audit 6. Health and Safety Executive Standards 7. CQC rating 8. Benchmarking data 9. Healthcare Information and Management Systems Society Assessment (HIMSS)	1. Patient Digital Literacy Information 2. Workforce Digital Literacy Information 3. Fully developed Estates dashboard	1. Creation of a patient co-design group 2. Trust wide Digital skills training needs analysis 3. Programme of work around information into the dashboard and further training for staff	1. Digital Health Strategy 23/24 Action Plan 2. Estates and Transformation Strategy 23/24 Action Plan 3. Delivery of the LCHS Green Plan action plan 23/24 4. Improved use of digital technologies 5. Improved Cyber security reporting and oversight 6. Increased compliance and safety 7. Robust signed off Service Level Agreements (SLAs) for the Estates Shared Service 8. Delivery of LCHS Capital Plan 23/24 9. Greater uptake of digital services from the public															
			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																						

5d	Transform key clinical pathways across the group resulting in improved clinical outcomes	Group Chief Integration Officer/Group Chief Medical Director	3. Transforming Community Hospitals	3.1. Rebranding / Standardisation of Community Hospital offer - Discharge hub - Proactive care provisions - Correct bed distribution										Quality Committee
			4. Children's Services Transformation	4.1. Childrens hub in Lincolnshire 4.2. Children's services reviews - ALL LCHS Children's services 4.2.1. Children In Care 4.3. Children's services reviews - ALL LCHS Children's services 4.3.1. Childrens Therapy - SALT										
			5. Development of Community Neurology Services	5.1. One community Neuro team with the scope of maximising the capability of existing Community Neuro Nursing and Therapy Services - currently at ULHT and LCHS - Community Outreach and Parkinson's										
			6. Transforming Operations Centre	6.1. Transformation of One Front Door including Ops Centre, CAS, Home Visiting and UCR including triage and dispatch										
			7. IUEC Pathways	7.1. Initial unplanned pathways, response project 7.2. UTC Review - outcomes and recommendations 7.3. Virtual Wards										

			8. Seasonal Planning Reviews - Winter Schemes	8..1. Seasonal Planning Reviews - Development										
			9. Agile Workstream	9.1. Continence Re-model of service 9.2. TB & SAIS 9.3. LISH / NLISH 9.4. NLISH										

Lincolnshire Community and Hospitals Group
Board Assurance Framework (BAF) 2024/25

Strategic Aims	Board Committee
Patients - To deliver high, quality, safe and responsive patient services	Quality Committee
People - To enable our people to lead, work differently, be inclusive, motivated and proud to work within LCHG	People and Organisational Development Committee
Services - To ensure services are sustainable, supported by technology and delivered from an improved estate	Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee
Partners - To collaborate with our primary care, ICS and external partners to implement new models of care, transform services and grow our culture of research and innovation	Transformation and Integration Committee
Population Health - To embed a population health approach to improve physical and mental health outcomes, promote well-being, and reduce health inequalities across an entire population	Quality Committee / Transformation and Integration Committee

Assurance Rating Key:	
Red	Effective controls may not be in place and/or appropriate assurances are not available to the Board
Amber	Effective controls are thought to be in place but assurances are uncertain and/or possibly insufficient
Green	Effective controls are definitely in place and Board are satisfied that appropriate assurances are available

Objective alignment
Lincolnshire Community Health Services NHS Trust objectives
United Lincolnshire Hospitals NHS Trust objective

Ref	Objective	Executive Lead	Linked programmes in Integrated Improvement Plan/Operational Plan	Linked projects in Integrated Improvement Plan/Operational Plan	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
SA1 To deliver high, quality, safe and responsive patient services															
								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)	Deteriorating Patient Lead role vacant across the Group impacting on function of the DPG 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	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 Surgicla Division at ULHT presenting brifeing paper at PSG for onward plans to lead DPG due to be received September		

Implementation and overishgt of natoinal patient safery strategy (cultre and systems) Human Factors Faculty	Development of Safety Culture review process inconjunction with People and OD	Working group establihsed 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 trianuglating acorss multiple key stakeholders to conisder 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	Working group due to meet in October Funding secured for further cohort for TTT in Jan 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 Stregnthed oversight of desiganted Execuitve and Patient Safety Specialist on recveing CAS alerts and final sign off (PSG)	CAS and FSN Group policy	Development of CAS and FSN Group Policy commenced, expected completion October 2024	Quarterly report to PSG with escalation to QC as necessary and montlhy excpetion 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.	
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

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	5143 5016 4879 5101 4740 4947 5100		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.				G	G	G
								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 in place reviews all Category 3 and 4 incidents.	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	Observed a reduced number of Safeguarding referrals relating to pressure ulcers being completed	Weekly pressure ulcer support panel with Quality and Safeguarding team representation reviews all required pressure ulcers against the Safeguarding adults protocol:pressure ulcers and raising a safeguarding concern guidance.													
								Patient and Carer Experience (PACE) plan 2022 - 2025 The PACE Delivery Plan is actioned and embedded over the life of the delivery plan. (PEG)	There are no identified control gaps.	Not applicable	Patient Experience & Carer Plan progress report to Patient Experience Group as per schedule. Ongoing assurances provided to PEG re: actions.	There are no assurance gaps identified.	Not applicable													
1b	Improve patient experience	Group Chief Nurse						Enhance patient experience by learning from patient feedback and demonstrating our values and behaviours in the delivery of care with a specific focus on discharge of patients. (PEG)	National surveys evidence overall poor experiences in relation to discharge with a number of questions being benchmarked as worse than others Trusts.	Amalgamated survey action plan in development to identify Trust wide improvement focus. Rolling out of #WMTY initiative to ensure patients are involved in decisions and discussions about their discharge plans. Patient Experience Team working with Discharge Lounge staff facilitating understanding of discharge experience and improvements. Discharge work programme being implemented as part of the UEC improvement work.	Discharge experience reports to PEG quarterly.	Work required with the lead nurse for discharge to ensure experience data is collected, analysed and acted upon.	Support to be provided to the lead nurse for discharge.	Quality Committee			G	A	A							

1c	Improve clinical outcomes	Group Chief Nurse/Group Chief Medical Officer				4824 4731		Maternity & Neonatal Oversight Group (MNOG) in place to have oversight of the quality of maternity & neonatal services and to provide assurance that these services are safe and in line with the National Safety Ambition / Transformation programme. Thematic review of SIs and complaints undertaken - recommendations being progressed as part of the Maternity & Neonatal Improvement Plan. External independent input in to SI process. MNOG will retain oversight of the implementation of the relevant IIP programme of work. (MNOG)	Issues with the environment. Ongoing difficulties with the Maternity Medway system which has the potential to impact on compliance with the CNST Year 4 Safety Actions.	Improvements to the environment to be completed as part of planned ward refurbishment. Team to continue to liaise with E&F to resolve and immediate issues as they arise ensuring escalation where delays are encountered. Issues with the Medway system being progressed at local and system level.	Monthly Maternity & Neonatal Assurance Report. Maternity & Neonatal Improvement Plan. Executive & NED Safety Champions in place and work closely with local Safety Champions. NHSE/I appointed MIA in place and supporting the Trust - monthly reports of progress to MNOG. Validation of the implementation & embedding of the Ockenden IEAs has been provided by the regional maternity team. There is a process in place for ongoing testing through supported site visits. Training compliance data.	None Identified	Not applicable.	Quality Committee			G	G	G							
								Ensure we provide clinically safe services, through an increased number of Diamond Award Accredited Wards / Departments (PEG)	there are no identified Control gaps	Not applicable	monthly Quality metrics dashboard meeting with all clinical areas. Diamond award applications received and supported by corporate nursing team. Diamond Award Panel chaired by DoN/DepDoN. Award presented by Trust Chair. Metric included with the IIP, and measured Quarterly.	None Identified	Not applicable													
1d	Deliver clinically led integrated services	Group Chief Nurse/Group Chief Medical Officer												Quality Committee												
SA2 To enable our people to lead, work differently, be inclusive, motivated and proud to work within LCHG																										
			Medical Workforce Programme (Medical Staffing Project)	Medical Workforce Programme - Medical Staffing Project with focus on: a) Plan for Every Post b) NHSE Workforce Productivity Tool c) Reporting				Workforce planning and workforce plans. Recruitment to agreed roles - plan for every post, for Agenda for Change, Medical and Dental Workforce People Planning & Transformation Team are in post, with Senior Lead (Director of People & OD) overseeing functions. Strong working relationships to utilise Divisional Heads of HR, Finance and Improvement Team to monitor compliance against KPIs set out within the IIP. This is established and regular reviews are now in place. Reported through to the Workforce Strategy & OD 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. Compehensive review of prject plan has been undertaken to ensure the Plan for Every Post' progress is fully reflective and able to	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 Staffin Project within the Medical workforce Programme. Reported at Medical Workforce Steering Group and ISG on a monthly basis. It is ecpected that thjis will be a key enabler to suporting the Trust in rducing temporary staffing spend within this staff group.													

											provide upward level of assurance on deliverables weithin 2024/25.															
								Focus on retention of staff - creating positive working environment and integration of People Promise 'themes' System retention role established and in place for 2023/24. People Promise Y1 work complete with funding for Y2 agreed. Education and Learning Team in place and actively working to improve compliance with Statutory and Mandatory Training. Organisational Development Team in place and actively working to improve completion rates for Appraisals.	System People Promise Manager has been recruited for Yr2. Consideration to the concept of group appraisals and appraisal lite to form part of the review of people policies and procedures.	Turnover (retention):Turnover has continued to improve over the last 12 months and is on track to deliver against the 2024/25 KPI set out within the IIP. To further support this, work has begun to understand how we develop exit data to gather insights for 'reasons for leaving' and support our staff to remain working Statutory & Mandatory Training: Reported into Workforce Strategy & OD Group (monthly) and within Divisional FPAM (monthly) with areas<50% compliance highlighted. Support offered to Divisional Teams by Head of HR and 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.	Workforce, Strategy and OD 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 Operational Group and FPAM meetings and will feature in the highlight report to PODC. Phased targeted approach in 2024/25 KPIs as featured in the Integrated Improvement Plan. As of Quarter 3 within 2024/25 there will be a new: 1) LCHG Learning & Development Leads Group (LDLG) 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 leaderhsip with key stakeholders across the Group. This will report into People Committee on a monthly basis.													

		Appraisals: Workforce Strategy and OD Group to discuss group appraisal and appraisal lite Ongoing discussions are in place with agenda items on Workforce and OD Strategy Group as required.			
Reducing sickness absence - Absence Management System	Manager call back compliance and return to work interview	Compliance with use of AMS being addressed through People Management Essential Training and AMS training from HRBPs Early Occupational Health led interventions are being explored for top two reasons for sickness absence. Absence reported at Divisional FPAMs with areas of concern highlighted (eg: CBU and Staff Group information) to support targeted action if required.	Sickness/absence data with detailed report available for Head of HR use to support targeted actions with Divisions. Deep dive by Workforce Strategy and OD Group into absence data Internal Audit Report Actions Report via FPAM (monthly), Workforce & OD Group (monthly) and into PODC via Scorecard.	Various reports through Heads of HR to Divisions. Output from WSOD Group deep dive into absence data.	Work continues with the completion of the audit actions and work/training with the departmental managers and HR. To be monitored through the Workforce Operational Group and FPAM meetings and will feature in the highlight report to PODC. Phased targeted approach in 24/25 KPI's as featured in the Integrated Improvement Plan. A deep dive is being undertaken of the full utilisation of the AMS management system as early indications show improvement is needed aligned to Health and Wellbeing initiatives.
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 & OD Group Finance, People & Activity Meeting and People Committee data Workforce, Strategy and OD 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 Operational Group and FPAM meetings and will feature in the highlight report to PODC. Phased targeted approach in 24/25 KPI's as featured in the Integrated Improvement Plan. As of Quarter 3 within 2024/25 there will be a new LCHG Learning & Development Leads Group (LDLG) 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.	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 & OD 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 leaderhsip with key stakeholders across the Group. This will report into People Committee on a monthly basis.
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 WSOD Group Compliance rates continue to be monitored via the People Committee Scorecard for the below: 1) Rolling 12mths Sickness Absence rate	None Identified	None Identified

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		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	People and Organisational Development Committee				G	G	G	G	G
								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 & OD 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 Wokring 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.	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 leaderhsip 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 Operational Group and FPAM meetings and will feature in the highlight report to PODC. Phased targeted approach in 24/25 KPI's as featured in the Integrated Improvement Plan has been implemented Additional monthly assurance offered to CQC through governance team regular meetings. As of Quarter 3 within 2024/25 there will be a new LCHG Learning & Development Leads Group (LDLG) 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 Learning & Development Leads Group (LDLG) 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 Learning & Development Leads Group (LDLG) 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 Learning & Development Leads Group (LDLG) 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 & OD Group. On a monthly basis. As of Quarter 3 within 2024/25 there will be a new: 1) LCHG Learning & Development Leads Group (LDLG) 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 leaderhsip 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 eaulity, diversity and inclusion with key stakeholders across the Group. This will report into People Committee on a bi-monthly basis.	People and Organisational Development Committee			G	G	G	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	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	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	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.	2.4 Development of a 5 year capital programme cross referenced to risk register.		national limits are lower than the level that would be investable based on 'local' available resources.	Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee			A	A	A	A	A					
					Cash - Deficits in the last 3 years have depleted cash reserves. Factoring in the 2024/25 deficit plan with additional delivery risks alongside a large capital programme means that the availability of cash to meet Pay and Non pay obligations is at substantially increased risk unless carefully managed.			3.1 Cashflow Monthly Projection to 30 June 2025 3.2 Daily cashflow projected 3 months ahead 3.3 Monthly reporting to FPEC 3.4 Access to cash support via NHSE subject to formal Board approval and application process 3.5 Facility to move cash around Lincolnshire System utilising NHSE cash support process	3.1, 3.2 & 3.3 Cash forecasting dependent upon accurate capital, CIP and I&E projections and certainty of delivery. 3.4 Cash support above the level of the I&E deficit is subject to more rigorous challenge through the business case process. May not be approved. 3.5 Transfer of cash between Lincolnshire bodies requires formal agreement by both parties. 3.5 Process to enable cash transfer between NHS bodies requires the repayment of PDC by the donor and issuing of PDC to the recipient (ULHT). LCHS has very limited PDC that can be repaid which in turn restricts the ability to transfer cash within LCHG.	3.1, 3.2 & 3.3 Capital, CIP & I&E risks are separately identified with mitigations. 3.5 System discussions to facilitate moving of cash.	3.1 - 3.5 Cash and working capital reporting to FPEC	3.1 - 3.5 Underlying Capital, I&E projections / timelines are best assessments at a point in time.	3.1 - 3.5 Ongoing review													
					CIP - Not delivering the identified required £40.1m of CIP schemes			4.1 Delivery of CIP Schemes 4.2 Medical Recruitment improvement 4.3 Medical job planning 4.4 Agency price reduction 4.5 Workforce alignment 4.6 Service Reviews process and transformational programmes of work 4.7 Budget compliance	4.1 & 4.6 Maximisation of resources to deliver CIP 4.2 Reliance on temporary staff to maintain services, at premium cost 4.3 Management within staff departments and groups to funded levels. 4.4 Maximisation of below cap framework rates 4.5 Rapid ability to on-board temporary staff to substantive contracts 4.7 Manage divisions to contain costs within budgetary envelope.	4.4 Embedding of centralised agency & bank team. 4.1 , 4.2 , 4.3 & 4.4 Workforce Groups / Delivery programmes to provide grip 4.1 & 4.6 Improvement Steering Group to provide oversight across the group 4.5 Overseas & local recruitment support fragile services and substantive staff aligned to fragile areas 4.1 & 4.7Continuous Non-Clinical Agency sign off process & Vacancy control process	4.1 - 4.6 Delivery of the planned agency reduction target, supported by substantive recruitment to vacancies 4.7 Budget compliance reported to FPAM's	4.3 Granular detailed plan for every post plans 4.2 & 4.7 Rota and job plan sign off in a timely manner	4.1 -4.5 The Trust monitors internally against its financial plan inclusive of specific targets for agency and bank spend by staff group 4.1 & 4.6 The Trust CIP workstreams are reported to the Improvement Steering Group 4.1 & 4.7 The Divisional cut of the workstreams are reported to the relevant FPAM 4.7 The staff areas of key focus - Medical and Nursing are reported through their Workforce Groups 4.1 Fortnightly FRP Board assurance with Lincolnshire ICB														
3b	Drive better decisions and impactful action through insight							Provide our people with real-time data to support high quality care delivery to all clinical staff						Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee													
								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 Operating 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, Performance and Estates Committee / Finance, Performance, People and Innovation Committee			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 (Authurised 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 2024/24 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 Abestoc 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 mamaged by Fire Safety group which monitors progress against fire safety actions preveoulsy held under prohibition notices Health and Safety Committee upward report British Safety Council	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 accuratley reflects the quality and risks being carried by the current estate.	Monhtly 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 refresshed	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										

Ref	Objective	Lead						Controls	Gaps in controls	Sources of assurance	Positive assurance	Gaps in assurance	Actions	Committee	Rating
								Refurbishment of 8 theatres, across our sites	Funding stream			Thetare 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 align 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, Performance and Estates Committee / Finance, Performance, People and Innovation Committee	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 standards	Group Chief Operating Officer					Cancer Standards 62 day, 14 day and 28 Day FDS	Daily reporting of all three metrics (62 day backlog, FDS and 62 day performance) Twice weekly Intensive Support meetings to review all 3 metrics and position of patients on the cancer PTL Fortnightly cancer recovery meeting System Cancer Improvement Board Weekly ICB/Group oversight through Planned Care and Cancer catch up	Capacity v demand across all tumour site pathways not completed Insufficient oversight of system partners contribution (e.g. primary care testing and workups)	Cancer Leadership Group Deep Dive Workshops (e.g. Colorectal) Intensive Support Meetings (Trust and ICS)	Cancer board assurance and performance reports Routine Performance and pathway data provided by Sommerset system Cancer Intensive Support Meetings Cancer Intensive Support Meetings Monthly Trust Board reporting for planned care and cancer	Process information below the cancer stages are not always captured Some digital systems are not linked and not all wait information is recorded e.g. MIME system	Trajectories in place agreed with all tumour sites, to achieve a reduction in number patients >62 days, achievement FDS 75% March and reduction in patients >104 days.	Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee	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.		

								Maximisation of capacity and efficiencies to reduce waiting times and support discharge processes, ensuring services are provided within timeframes which are safe and responsive, enabling a reduction in length of stay/bed occupancy			Trajectories for all specialties in place, weekly position statements offered to ELT and TLT RAPs at Tumour Site level available from March through which performance will be monitored		Focused piece of work in place to review Navigator role in terms of WF capacity and capability has been undertaken with a training program in place and supported PTLs as a result. Additional support from external ICB funded cancer specialist to further refine the PTL process and provide on the job coaching and training of the cancer team. Breast are developing a													
3f	Reducing unwarranted variation in planned service delivery and ensure we meet all constitutional standards	Group Chief Operating Officer		Outpatient Recovery and Improvement Group (ORIG) Productive Theatres Group (PTOG) Medical Workforce Programme	Hybrid Mail		Referral to Treatment (18week wait) Standards Diagnostic 6week (DM01)	Internal assurance process through ISG and corporate into ELT, GLT and FPEC Planned Care & Diagnostic Board	Inconsistent approach to validation Clinic slot utilisation driven by DNAs and last minute cancellations Theatre utilisation, including; 1. Preop 2. Estate utilisation 3. Late starts/early finishes 4. Daycase rates 5. On the day cancellations Gaps in Job planned and delivered activity for Admitted & Non-Admitted Workforce gaps, particularly in theatres	Improvement programmes driving workstreams to address control measures. These include; 1. Outpatient letter project to reduce variation of clinic template letters, ensuring patients receive timely and accurate information 2. Hybrid mail project to digitalise and streamline Outpatient correspondence 3. Use of PIFU to reduce unnecessary follow up 4. Preop focused workstream to increase access to preop and build a prospective service 5. GIRFT workstreams focused on compliance with BADS identified daycase procedures and unexpected conversion to Inpatients 6. 6-4-2 Processes in Outpatients and Theatres to ensure clinics/lists fully utilised 7. Look Back Wednesday to address unexpected changes to theatre lists impacting utilisation 8. Ongoing work to match job plans with clinic session	Performance Data Planned Care Improvement and Performance Reporting Integrated Improvement Plan Highlight and Status Reports GIRFT Reports and Model Hospital Regional Performance Packs	Escalations & issues through ISG when required Limited Diagnostic reporting/assurance	Reporting through Improvement Steering Group & FPEC Diagnostic reporting tools and process currently being developed	Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee							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.	Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee (To move to: Transformation and Integration Committee)
								A Joint Forward Plan by June 2023 and continued utilisation of Joint Strategic Needs Assessment (JSNA), population health data from Optum and the health and wellbeing strategy, to influence our collective approach	JFP completed February 2024 and shared with Board	JFP triangulation with IIP Year 5	JFP completed and considered in Chief Executives Group and formally to the Board	JFP triangulation with IIP not yet completed or signed off - gaps to be identified	Year 5 IIP will include JFP triangulation for Boards prior to sign to off, April 2024	
								Joint working with system partners, maximising care homes, virtual wards and admission avoidance schemes, such as the frailty programme	Investment Business Cases not yet in place (SDEC frailty assessment, ED Paed Hub, Community Child Nurse, Rapid Assessment and Triage (RAT), Hospital at Night, SAFER)	Business Cases being presented to CRIG in July	Business Cases Shared Performance Dashboard - frequent attenders	Business Cases in development Dashboard in development	Business Cases being presented to CRIG in July Joint work with Optum to create dashboard	
								Play an increasing leadership role within the East Midlands Acute Provider Collaborative to develop key partnerships	EMAP work programmes establishing - outcomes/deliverables not yet agreed	Programme Boards in place with monthly meetings underway Highlight reports being overseen by monthly EMAP executive meetings EMAP updates to ELT/TLT	EMAP executive meeting minutes EMAP Quarterly reports	Impact of EMAP programmes	Verbal updates at EMAP exec meetings and ULHT representation at EMAP programme groups, quarterly EMAP updates via IIP	
								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.	Finance, Performance and Estates Committee

4b	Successful delivery of the Acute Services Review	Group Chief Integration Officer								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.	/ Finance, Performance, People and Innovation Committee (To move to: Transformation and Integration Committee)							
4c	Grow our research and innovation through education, learning and training	Group Chief Integration Officer						Shared understanding and implications of the UHA guidance and identify relationship management of key stakeholders nationally (DH, UHA) Agree contract with UOL, R&I team to Increase the number of Clinical Academic posts	Funding for Clinical Academic posts and split with UOL to be agreed	Monthly meetings with ULHT and Uni of Lincoln to discuss funding position and agree MOU. Clinical Academic Oversight Group to oversee recruitment of clinical academic model, recruitment and delivery. Group meetings being held to support discussion on performance and any adjustments to job plans Meetings with ULHT and UOL finance/contracting teams to finalise financial model and MOU based on principles of the Selby report produced early 2024.	Contract agreed with UOL for Clinical academic posts. UoL and ULHT have draft contracts and offer letters ready for use. Increase in numbers of Clinical Academic posts - agreed to prioritise on clinical specialities where there are workforce gaps/high agency spend to mitigate ULHT cost pressure RD&I Strategy and implementation plan agreed by Trust Board Upward reporting and approval sought	Unknown financial commitment for the Trust in relation to the clinical academic roles until the financial model is completed and recruitment commences.	Monthly meetings with ULHT and Uni of Lincoln Financial best case, most likely and worst case models reviewed by ELT and shared with Board in March 2024 to agree risk appetite Exploring all opportunities across ULHT and UoL to mitigate the financial risk through additional income generation, wider socio-economic impact	People and Organisational Development Committee (To move to: Transformation and Integration Committee)			R	R	R	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, Performance and Estates Committee / Finance, Performance, People and Innovation Committee (To move to: Transformation and Integration Committee)
								Upgrade of our technological infrastructure to support technology advancements	Insufficient cap/rev to replace aging technology Insufficient capacity to deliver purchased equipment	Technical Design Authority Digital Hospital Group Information Governance Group (for cyber / info security)	Digital Maturity Assessment		Looking to procure a Technical / Implementation Partner to provide capacity as and when required Enabling infrastructure funded via FD (EPR) rollout going to plan.	
								Enhance our organisational digital capability and skills through training	Insufficient capacity to create and deliver training materials	Digital Hospital Group			Looking to procure a Technical / Implementation Partner to provide capacity as and when required This is now well underway with 2 comms centres purchased in 23/24 and will be commissioned in 24/25, wireless network being upgraded	
SA5 To embed a population health approach to improve physical and mental health outcomes, promote well-being, and reduce health inequalities across an entire population														
5a	Develop a Population Health Management (PHM) and Health Inequalities (HI) approach for our Core20PLUS5 with our ICS	Group Chief Nurse/Group Chief Medical Officer						Gain a greater understanding of the Lincolnshire population and support a reduction in health inequalities	Core20PLUS dashboard not yet developed	Development of Core20PLUS dashboard by June 2023	Core20PLUS dashboard	Core20PLUS dashboard not yet developed	Dashboard due to be in place by June 2024	Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee (To move to: Transformation and Integration Committee)
5b	Co-create a personalised care approach to integrate services for our population that are accessible and responsive	Group Chief Nurse/Group Chief Medical Officer												Quality Committee

5c	Tackle system priorities and service transformation in partnership with our population and communities	Group Chief Integration Officer						Build a Partnership strategy to support improvements in safe and sustainable care, and harness benefits for the population of Lincolnshire	Partnership Strategy not yet in place	Associate Director of Partnerships started in post May 2023 and has started to draft Partnership Plan. Board development session 5th December 2023 and intention to have signed off by July 2024 Partnership work is already underway across the organisation and is not being delayed by the lack of formal strategy e.g opportunities emerging for the speciality review programme	Signed off Partnership Strategy	Strategy not yet completed or signed off	Work is underway to develop the strategy, which needs to align with the new IIP and ULHT clinical services strategy.	Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee (To move to: Transformation and Integration Committee)												
5d	Transform key clinical pathways across the group resulting in improved clinical outcomes	Group Chief Integration Officer/Group Chief Medical Director												Quality Committee												

Audit Committee in Common Upward Report

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

Meeting	*Lincolnshire Community and Hospitals Group Board Meeting*
Date of Meeting	*5 November 2024*
Item Number	

Audit Committee in Common Upward Report of the meeting held on 17th October 2024

Accountable Director	*Neil Herbert, Audit Committee Chair*
Presented by	*Neil Herbert, Audit Committee Chair*
Author(s)	*Jayne Warner, Director of Corporate Affairs*
Recommendations/ Decision Required	*The Board is asked to:-* • *Note the upward report*

This report summarises the assurances received, and key decisions made by the Audit 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 quarterly and takes scheduled reports 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).

External Audit
The Committee noted that there was no formal update from External Audit in to this meeting. The Committee were 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.

The Committee considered the audit actions and recommendations which had been issued following the year end audit for 2023/24 and agreed that they would continue to review these at future meetings to ensure actions were closed.

It was noted that the outstanding formal approval relating to exit packages was still awaited. The Committee noted that Remuneration Committee members had been briefed on these areas previously.

It was 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.

Internal Audit

The Committee received the Internal Audit Progress Report for both organisations noting that whilst no internal audit reports had been finalised one report had gone final since the publication of the papers. It was noted that a number of reviews were underway and at varying stages of completion. The Committee recognised the need to maintain the traction which had been achieved with the audit plan in the previous year and to ensure that finalised reports were being issued at the earliest opportunity.

It was agreed that a reset of expectations both with the Internal Audit providers and with the Executive Leadership would be helpful. Ensuring that focus was maintained on responding in a timely manner to progressing the audit plans. System led contract meetings continued where all audit plans were regularly considered. The Committee noted that both Trusts would be overseen by a new Head of Internal Audit.

The position with audit recommendations and the audit plan were noted. The Committee were satisfied that reasonable progress had been made against plan. Internal Audit recommendations continued to be closely monitored.

Local Counter Fraud Specialist Progress Reports and LCHS Annual Report

The Committee noted the progress report both organisations and the LCHS Annual Report. The Committee noted that it was Fraud Awareness Month in November and were advised that Group Communications had been planned in support of this campaign.

Going forward consideration would be given to the role of Counter Fraud Champion in both Trusts to understand whether this would be best served by one Champion going forward.

Compliance Report

The Committee received the quarterly compliance report which was being developed to reflect compliance across both organisations.

It was noted that the levels of waivers had stabilised after an increase had been seen at the last meeting.

Improvements had also been seen in the levels of stock being lost to write off.

Assurance Committee Chairs triangulated the following issues into the Committee. The Finance Committee for ULTH noted that the Trust were not meeting the financial plan or CIP programme. A system meeting to conduct a deep dive into medical bank and agency was planned. The People Committee alerted to the fact that establishment reviews were underway in both organisations. The Quality Committee had undertaken a deep dive into medicines management issues as there was concern that this was an area where improvements had not been seen. The

Development of the Integration Committee was underway and the first meeting would be held in November.

Policies Update
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 but asked for assurance on when traction would be seen in delivering improvement. It was noted that compliance was now being monitored through all Committees not just Audit Committee.

The Committee requested consideration of risk rating of policies and guidelines recognising that corporate teams could not risk rate in terms of clinical policies and this would need buy in from the authors.

Interim Update to Standing Orders and Standing Financial Instructions

An interim update to Standing Orders and SFIs for both organisations was approved to recommend for final sign off by Board. A full review was programmed for later in the year once Group governance arrangements were embedded.

Board Assurance Framework and Risk Register

The Committee reviewed the BAF and Risk Register confirming that each remain fit for purpose.

Interim Updates to Corporate Governance Manuals for ULTH and LCHS

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

Meeting	*Lincolnshire Community and Hospitals Group Board Meeting*
Date of Meeting	*5th November 2024*
Item Number	*14.3.1*

Interim Updates to Corporate Governance Manuals

Accountable Director	*Jayne Warner, Group Director of Corporate Affairs*
Presented by	*Jayne Warner, Group Director of Corporate Affairs*
Author(s)	*Jayne Warner, Group Director of Corporate Afairs*
Recommendations/ Decision Required	• *The Group Board is asked to:-* *Approve the interim updates to the Corporate Governance Manuals as recommended by the Audit Committee at their meeting in October*

Purpose

The Corporate Governance Manual for both ULTH and LCHS will be subject to a substantial redraft to reflect the Group working arrangements for Board and Committees later in the year once the Committee development work is complete, however, as an interim the documents have been updated to reflect the Board voting arrangements and updated job titles for Board members.

These amendments were considered by the Audit Committees of both organisations in October and are recommended for approval.

CORPORATE GOVERNANCE MANUAL

Document Information

Trust Policy Number : ULH-CORPORATE-SO01

Version : ~~July 2021~~October 2024

Status : For approval by Board

Issued by : ~~Trust Secretary~~Director of Corporate AffairsDirector of Corporate Affairs

Issued date :
Approved by :
Date of approval :
Date of review : October 2024

Change Control

Previous Versions :

Changes: Additions :~~Reflection of updated corporate governance /Committee structure and revised Trust Operating Model~~Updates made to reflect new Executive Director job titles and voting rights

Modifications :

Deletions :

Date of Issue :

Review Date :
Referenced Documents :

Relevant Legislation NHS Corporate Governance Framework / NHS Manual for Accounts

Relevant Standards :

FOREWORD

The Standing Orders, Scheme of Delegation and Standing Financial Instructions provide a comprehensive regulatory and business framework for the Trust.

All directors, and all members of staff, should be aware of the existence of these documents and be familiar with all relevant provisions. These rules fulfill the dual role of protecting the Trust's interests and protecting staff from any possible accusation that they have acted less than properly.

Failure to comply with any part of standing orders is a disciplinary matter, which could result in dismissal. Non-compliance may also constitute a criminal offence of fraud in which case the matter will be reported to the Trust's local counter fraud specialist in accordance with the Counter Fraud Bribery and Corruption Policy. Where evidence of fraud, corruption or bribery offences is identified, this may also result in referral for prosecution which could lead to the imposition of criminal sanctions.

STANDING ORDERS

1. INTRODUCTION

1.1 Statutory Framework

The United Lincolnshire Hospitals NHS Trust (the Trust) is a statutory body which came into existence on 20th April 2000 under The United Lincolnshire Hospitals NHS Trust (Establishment) Order 2000 No 410, (the Establishment Order) and The United Lincolnshire Hospitals NHS Trust (Establishment) Amendment Order 2001 No 154. and The United Lincolnshire Hospitals NHS Trust (Establishment) Amendment Order 2024 No 951

The principal places of business of the Trust are Lincoln County Hospital, Lincoln; Pilgrim Hospital, Boston; Grantham and District Hospital, Grantham and Louth Hospital, Louth.

NHS Trusts are governed by Acts of Parliament, mainly the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 2012 and the Health and Care Act 2022 and the functions of the Trust are conferred by this legislation.

As a statutory body, the Trust has specified powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable as well as to the Secretary of State for Health.

The Trust has a duty to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions (SFIs) as an integral part of Standing Orders setting out the responsibilities of individuals. The Board must also comply with the standard for members of NHS Board and CCG Governing Bodies in England 2012.

The Trust will also be bound by such other statutes and legal provisions which govern the conduct of its affairs.

1.2 NHS Framework

In addition to the statutory requirements the Secretary of State through the Department of Health and Social Care, ~~NHS Improvement~~NHS England ~~and~~ NHS England, issues further directions and guidance. These are normally issued under cover of a circular or letter.

The NHS Code of Conduct & Accountability requires that, among other things, Boards draw up a schedule of decisions reserved to the Board, and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior officers (a scheme of delegation). The code also requires the establishment of audit and remuneration committees with formally agreed terms of reference. The NHS Code of Conduct & Accountability makes various requirements concerning possible conflicts of interest of Board Directors.

The Freedom of Information Act sets out the requirements for public access to information about the Trust's business.

1.3 Delegation of Powers

The Trust has powers to delegate and make arrangements for delegation. The Standing Orders set out the detail of these arrangements. Under the Standing Order relating to the Arrangements for the Exercise of Functions the Trust is given powers to "make arrangements for the exercise, on behalf of the Trust of any of their functions by a committee, sub-committee or joint committee appointed by virtue of Standing Order 4 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit or as the Secretary of State may direct". Delegated Powers are covered in the Scheme of Delegation and Reservation and have effect as if incorporated into the Standing Orders and Standing Financial Instructions.

1.4 NHS Board Governance

NHS Trust Boards must put in place and maintain good corporate governance arrangements, integrated across the organisation and all aspects of governance. This will encompass corporate, financial, clinical, information and research governance. Integrated governance will better enable the Board to take a holistic view of the organisation and its capacity to meet its legal and statutory requirements and clinical, quality and financial objectives.

2. THE TRUST BOARD

2.1 Corporate role of the Board

All business shall be conducted in the name of the Trust.

All funds received in trust shall be held in the name of the Trust as corporate trustee.

The powers of the Trust established under statute shall be exercised by the Board meeting in public session except as otherwise provided for in Standing Order No.3.

The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the 'Schedule of Matters Reserved to the Board' and shall have effect as if incorporated into the Standing Orders. Those powers which it has delegated to officers and other bodies are contained in the Scheme of Delegation.

2.2 Composition of the Membership of the Trust Board

In accordance with the Membership and Procedure Regulations the composition of the Board shall be:

The Chair of the Trust (Appointed by ~~NHS Improvement~~NHS England);

Up to 7 non- executive directors (appointed by ~~NHS Improvement~~NHS England);

5 executive directors including:

- the Chief Executive;
- the ~~Director of Finance~~Chief Officer~~ and Digital;~~Chief Finance Officer
- the ~~Director of Nursing~~Chief Nursing Officer
- the ~~Medical Director~~Chief Medical Officer
- The ~~Director of Improvement and Integration~~Chief Integration Officer/ Deputy Chief Executive

~~The Trust currently operates with 5 Non-Executive Directors not the maximum of 7 allowed by the statutory instrument.~~

The following officers will attend the Board meetings in a non-voting capacity unless the Board resolves that they should not attend

- Chief People Officer
- Chief Operating Officer
- Chief Clinical Governance Officer
- Chief Estates and Facilities Officer
- Director of Corporate Affairs

2.3 Appointment of Chair and Directors of the Trust

The Chair and Directors of the Trust - are appointed by ~~NHSI~~NHSE on behalf of the Secretary of State. The appointment and tenure of office of the Chair and Directors are set out in the Membership and Procedure Regulations.

2.5 Terms of Office of the Chair and Directors

The regulations setting out the period of tenure of office of the Chair and directors and for the termination or suspension of office of the Chair and directors are contained in regulation 7 and regulations 8 and 9 of the Membership and Procedure Regulations, respectively.

2.6 Appointment and Powers of Vice-Chair

Subject to Standing Order below, the Chair and directors of the Trust may appoint one of their numbers, who is not also an executive director, to be Vice-Chair, for such period, not exceeding the remainder of their term as a member of the Trust, as they may specify on appointing them.

Any director so appointed may at any time resign from the office of Vice-Chair by giving notice in writing to the Chair. The Chair and directors may thereupon appoint another director as Vice-Chairman in accordance with the provisions of Standing Orders

Where the Chair of the Trust has died or has ceased to hold office, or where they have been unable to perform their duties as Chair owing to illness or any other cause, the Vice-Chair shall act as Chair until a new Chair is appointed or the existing Chair resumes their duties, as the case may be; and references to the Chair in these Standing Orders shall, so long as there is no Chair able to perform those duties, be taken to include references to the Vice-Chair.

2.7 Joint Directors

Where more than one person is appointed jointly to a post mentioned in regulation 2 of the Membership and Procedure Regulations those persons shall count for the purpose of Standing Order 2.1 as one person.

2.8 Role of Directors

The Board will function as a corporate decision-making body, executive and Non-executive directors will be full and equal directors. Their role as directors of the Board of Directors will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

(1) Executive Directors

Executive Directors shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Delegation.

(2) Chief Executive

The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. He is the **Accountable Officer** for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the Accountable Officer Memorandum for Trust Chief Executives and other such requirements as determined by ~~NHS Improvement~~NHS England.

(3) ~~Director of Finance~~Chief Finance Officer

The ~~Director of Finance~~Chief Finance Officer shall be responsible for the provision of financial advice to the Trust and to its directors and for the supervision of financial control and accounting systems. They shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

(4) Non-Executive Directors

The Non-Executive Directors shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as directors of or when chairing a committee of the Trust which has delegated powers.

(5) **Chair**

The Chair shall be responsible for the operation of the Board and chair all Board meetings when present. The Chair must comply with the terms of appointment and with these Standing Orders.

The Chair shall liaise with ~~NHS Improvement~~NHS England over the appointment of Non-Executive Directors and once appointed shall take responsibility either directly or indirectly for their induction, their portfolios of interests and assignments, and their performance.

The Chairman shall work closely with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

2.9 Lead Roles for Board Directors

The Chair will ensure that the designation of lead roles or appointments of Board Directors as required by the Department of Health and Social Care or as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirement (e.g. appointing a Lead Board Director with responsibilities for Infection Control or Safeguarding etc.).

3. MEETINGS OF THE TRUST BOARD

3.1 Admission of public and the press

The public and representatives of the press may attend all meetings of the Trust, but shall be required to withdraw upon the Trust Board resolving as follows:

A body may by resolution, exclude the public from a meeting (whether during the whole or part of the proceedings') wherever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings; and where such a resolution is passed, this Act shall not require the meeting to be open to the public during proceedings to which the resolution applied. (Public Bodies (Admission to meetings) Act 1960.

The Chair shall give such directions as they thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Trust Board resolving as follows:

That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Trust Board to complete its business without the presence of the public'. Section 1(8) Public Bodies (Admissions to Meetings) Act I960

Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the Trust or Committee thereof. Such permission shall be granted only upon resolution of the Trust.

3.2 Calling meetings

Ordinary meetings of the Board shall be held at regular intervals at such times and places as the Board may determine.

The Chair of the Trust may call a meeting of the Board at any time.

One third or more directors of the Board may request a meeting in writing. If the Chair refuses, or fails, to call a meeting within seven days of a request being presented, the directors signing the request may forthwith call a meeting.

3.3 Notice of Meetings and the Business to be transacted

Before each meeting of the Board a notice specifying the business proposed to be transacted shall be delivered to every director, so as to be available to them at least three clear days before the meeting. The notice shall be signed by the Chair or by an officer authorised by the Chair to sign on their behalf.

Want of service of such a notice on any director shall not affect the validity of a meeting.

In the case of a meeting called by directors in default of the Chair calling the meeting, the notice shall be signed by those directors.

No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under Standing Order 3.6.

Before each meeting of the Board a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's principal offices at least three clear days before the meeting, (required by the Public Bodies (Admission to Meetings) Act 1960 Section 1 (4) (a)).

3.4 Chair of meeting

At any meeting of the Trust Board the Chair, if present, shall preside. If the Chair is absent from the meeting, the Vice-Chair (if the Board has appointed one), if present, shall preside.

If the Chair and Vice-Chair are absent, such director (who is not also an Executive Director of the Trust) as the directors present shall choose shall preside.

3.5 Chair's ruling

The decision of the Chair of the meeting on questions of order, relevancy and regularity and their interpretation of the Standing Orders and Standing Financial Instructions, at the meeting, shall be final.

3.6 Quorum

No business shall be transacted at a meeting unless at least one-third of the whole number of the Chair and directors (including at least one director who is also an executive director of the and one non- executive director) is present.

An Officer in attendance for an Executive Director but without written acting up status may not count towards the quorum.

If the Chairman or director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see SO

No.7) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3.7 Voting

Every question at a meeting shall be determined by a majority of the votes of directors present and voting on the question. In the case of an equal vote, the person presiding (i.e.: the Chair of the meeting) shall have a second, and casting vote.

All questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chair directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.

If at least one third of the directors present so request, the voting on any question may be recorded so as to show how each director present voted or did not vote (except when conducted by paper ballot).

If a director so requests, their vote shall be recorded by name.

In no circumstances may an absent director vote by proxy. Absence is defined as being absent at the time of the vote.

An Officer who has been formally appointed to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy shall be entitled to exercise the voting rights of the Executive Director.

An Officer attending the Trust Board meeting to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An Officer's status when attending a meeting shall be recorded in the minutes.

3.8 Minutes

The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they shall be signed by the person presiding at it.

No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendments to the minutes shall be agreed and recorded at the next meeting.

3.9 Record of Attendance

The names of the Chair and Directors present at the meeting shall be recorded in the minutes.

3.10 Annual Public Meeting

The trust will publicise and hold an annual public meeting on or before 30th September in every year in accordance with the NHS Trusts (Public meeting) Regulations 1991 (SI 1991) 482.

3.11 Variation and amendment of Standing Orders

These Standing Orders shall not be varied except in the following circumstances:

- that two thirds of the Board directors are present at the meeting where the variation or amendment is being discussed, and that at least half of the Trust's Non-Executive directors vote in favour of the amendment;
- providing that any variation or amendment does not contravene a statutory provision or direction made by the Secretary of State.

3.12 Suspension of Standing Orders

Except where this would contravene any statutory provision or any direction made by the Secretary of State or the rules relating to the Quorum any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the whole number of the directors of the Board are present (including at least one executive director of the Trust and one non-executive director) and that at least two-thirds of those directors present signify their agreement to such suspension. The reason for the suspension shall be recorded in the Trust Board's minutes.

(ii) A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chairman and directors of the Trust.

(iii) No formal business may be transacted while Standing Orders are suspended.

(iv) Every decision to suspend standing orders shall be reported to the Audit Committee.

4. ARRANGEMENTS FOR THE EXERCISE OF TRUST FUNCTIONS BY DELEGATION

4.1 Delegation of Functions to Committees, Officers or other bodies

Subject to regulation 17 and 18 of the Membership and Procedure Regulations, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions by a committee, or sub-committee appointed by virtue of Standing Order 4, or by an officer of the Trust, or by another body as defined in Standing Order 5 below, in each case subject to such restrictions and conditions as the Trust thinks fit.

Regulation allows for the functions of NHS trusts to be carried out jointly with any other NHS body or other NHS trust, or any other third party.

4.2 Emergency Powers

The powers which the Board has reserved to itself within these Standing Orders may in emergency or for an urgent decision be exercised by the Chief Executive and the Chairman after having consulted at least two non-executive directors. The exercise of such powers by the Chief Executive and Chairman shall be reported to the next formal meeting of the Trust Board in public session for formal ratification.

4.3 Unavailability of Chair/ Vice Chair

In addition to the statutory power of the vice chair, if the chair is unavailable for whatever reason to transact the business of the Trust expressly or impliedly delegated to the chair, then, if so requested by the Chief Executive, the vice chair shall be empowered to act in the chair’s place and to exercise all the powers and duties of the chair until the chair is again available.

If the vice chair is unavailable for whatever reason to transact the business of the Trust expressly or impliedly delegated to the vice chair, then if so requested by the chief executive in relation to any particular matter, any non-executive director shall be empowered to act in the vice chairs place and exercise all the powers and duties of the vice chair in relation to that matter.

4.4 Delegation to Committees

The Board shall agree from time to time to the delegation of executive powers to be exercised by other committees, or sub-committees, or joint-committees, which it has formally constituted in accordance with directions issued by the Secretary of State. The constitution and terms of reference of these committees, or sub-committees, or joint committees, and their specific executive powers shall be approved by the Board. The powers of such committees shall be limited to those set out in their terms of reference.

4.5 Delegation to Officers

Those functions of the Trust which have not been retained as reserved by the Board or delegated to a committee or sub-committee or joint-committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions he will perform personally and shall nominate officers to undertake the remaining functions for which he will still retain accountability to the Trust.

The Chief Executive shall prepare a Scheme of Delegation identifying his proposals which shall be considered and approved by the Board.

Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the ~~Director of Finance~~Chief Finance Officer to provide information and advise the Board in accordance with statutory or Department of Health and Social Care requirements. Outside these statutory requirements the roles of the ~~Director of Finance~~Chief Finance Officer shall be accountable to the Chief Executive for operational matters.

The arrangements made by the Board as set out in the "Schedule of Matters Reserved to the Board" and "Scheme of Delegation" of powers shall have effect as if incorporated in these Standing Orders.

4.6 Non-compliance with Standing Orders and Standing Financial Instructions

If for any reason these Standing Orders are not complied with, full details of the non-compliance and justification for non-compliance and the circumstances shall be reported to the next formal meeting of the Board for action or ratification. All directors of the Trust Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive and Chair as soon as possible.

5. TRUST COMMITTEES

5.1 Appointment of Committees

Subject to such directions as may be given by the Secretary of State for Health, the Trust Board may appoint committees of the Trust.

The Trust shall determine the membership and terms of reference of committees and shall receive and consider reports from such committees.

5.2 Applicability of Standing Orders and Standing Financial Instructions to Committees

The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall as appropriate apply to meetings and any committees established by the Trust. In which case the term "Chair" is to be read as a reference to the Chair of other committee as the context permits, and the term "member" is to be read as a reference to a member of other committee also as the context permits.

(There is no requirement to hold meetings of committees established by the Trust in public.)

5.3 Terms of Reference

Each such committee shall have such terms of reference and powers and be subject to such conditions as the Board shall decide and shall be in accordance with any legislation and regulation or direction issued by the Secretary of State. Such terms of reference shall have effect as if incorporated into the Standing Orders.

5.4 Delegation of powers by Committees to Sub-Committees

Where committees are authorised to establish groups they may not delegate executive powers to the group unless expressly authorised by the Trust Board.

5.5 Approval of Appointments to Committees

The Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines, and regulations permit, that persons, who are neither directors nor officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board as defined by the Secretary of State. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

5.6 Appointments for Statutory functions

Where the Board is required to appoint persons to a committee and/or to undertake statutory functions as required by the Secretary of State, and where such appointments are to operate independently of the Board such appointment shall be made in accordance with the regulations and directions made by the Secretary of State.

5.7 Committees established by the Trust Board

The committees established by the Board are as follows:

- Remuneration Committee
- Audit and Risk Committee
- Quality ~~Governance~~ Committee
- Finance, Performance and Estates Committee
- People ~~and Organisational Development~~ Committee

6. RELATIONSHIP WITH OTHER TRUST POLICY STATEMENTS/PROCEDURES, REGULATIONS AND THE STANDING FINANCIAL INSTRUCTIONS

6.1 Policy statements: general principles

The Trust Board will from time to time agree and approve policy statements/ procedures which will apply to all or specific groups of staff employed by the Trust. The decisions to approve such policies and procedures will be recorded in an appropriate Trust Board minute and will be deemed where appropriate to be an integral part of the Trust's Standing Orders and Standing Financial Instructions.

6.2 Specific Policy statements

Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following Policy statements:

- the Standards of Business Conduct and Declarations of Interest Policy for United Lincolnshire Hospitals NHS Trust staff;
- the staff Disciplinary and Appeals Procedures adopted by the Trust
- The Counter Fraud, Bribery and Corruption Policy

6.3 Standing Financial Instructions

Standing Financial Instructions adopted by the Trust Board in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders.

6.4 Specific guidance

Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with guidance and requirements issued by or on behalf of the Secretary of State for Health.

7. DUTIES AND OBLIGATIONS OF BOARD DIRECTORS AND UNDER THESE STANDING ORDERS

7.1 Declaration of Interests

All Board members and staff of the Trust are required to comply with the Standards of Business Conduct and Declarations of Interest Policy. If Board directors have any doubt about the relevance of an interest they should discuss it with the chair or the ~~Trust Secretary~~Director of Corporate Affairs.

7.2 Recording of Interests in Trust Board minutes

At the time Board directors' interests are declared, or updated, they should be recorded in the Trust Board minutes.

7.3 Publication of declared interests in Annual Report

Board directors' declarations of interests will be published in the Trust's annual report.

7.4 Conflicts of interest which arise during the course of a meeting

At the start of every Board meeting there will be an agenda item which invites Directors to declare whether they have any interests which might be relevant to any items of business on the agenda. Directors should declare all such interests whether or not they have already declared them for the register. If a conflict of interest is established, the Board director concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

7.5 Register of Interests

The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Board members.

The Register will be available to the public and the Chief Executive will take reasonable steps to bring the existence of the Register to the attention of local residents and to publicise arrangements for viewing it.

7.6 Exclusion of Chairman and Directors in proceedings of the Board

Subject to the following provisions of this Standing Order, if the Chair or a director of the Trust Board has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust Board at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

The Secretary of State may, subject to such conditions as he/she may think fit to impose, remove any disability imposed by this Standing Order in any case in which it appears to him/her in the interests of the National Health Service that the disability should be removed.

The Trust Board may exclude the Chair or a director of the Board from a meeting of the Board while any contract, proposed contract or other matter in which he/she has a pecuniary interest, direct or indirect, is under consideration.

Any remuneration, compensation or allowance payable to the Chair or a Director by virtue of Schedule 5 of the National Health Service Act 1977 (pay and allowances) shall not be treated as a pecuniary interest for the purpose of this Standing Order.

This Standing Order applies to a committee as it applies to the Trust and applies to a member of any such committee (whether or not he/she is also a member of the Trust) as it applies to a director of the Trust.

7.7 Canvassing of and Recommendations by Directors in Relation to Appointments

Canvassing of directors of the Trust or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

Directors of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

7.8 Relatives of Directors or Officers

Candidates for any staff appointment under the Trust shall, when making an application, disclose in writing to the Trust whether they are related to any director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal.

The Chairman and every director and officer of the Trust shall disclose to the Trust Board any relationship between himself and a candidate of whose candidature that director or officer is aware. It shall be the duty of the Chief Executive to report to the Trust Board any such disclosure made.

On appointment, directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Trust whether they are related to any other director or holder of any office under the Trust.

8. CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

8.1 Custody of Seal

The common seal of the Trust shall be kept by the Chief Executive or a nominated Officer by him/her in a secure place.

8.2 Sealing of Documents

Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of by the Chief Executive, and Chairman or named deputy, and shall be attested by them.

8.3 Register of Sealing

The Chief Executive shall keep a register in which he/she, or another manager of the Authority authorised by him/her, shall enter a record of the sealing of every document. The register shall be reported to the Audit Committee.

8.4 Use of Seal – General guide

The Seal shall be affixed in the following general circumstances;

- All contracts for the purchase/lease of land and/or building
- All contracts for capital works exceeding £250,000

This list is not exhaustive and further advice regarding the affixation of the Seal should be gained from the ~~Trust Secretary~~Director of Corporate Affairs or ~~Director of Finance~~Chief Finance Officer.

8.5 Signature of documents

Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any Executive Director.

In land transactions, the signing of certain supporting documents will be delegated to Managers and set out clearly in the Scheme of Delegation but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

In the case of contracts for goods, works and services relating to non-pay expenditure officers should refer to Standing Financial Instructions.

9 SCHEME OF RESERVATION AND DELEGATION OF POWERS

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
SO 2.9 (1)	THE BOARD	**General Enabling Provision** The Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers. General Matters Reserved 1. to ensure effective financial stewardship through value for money, financial control and financial planning and strategy; 2. to ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation; 3. to appoint, appraise and remunerate senior executives and hold them to account; 4. to ratify the strategic direction of the organisation within the overall policies and priorities of the Government and the NHS, define its annual and longer term objectives and agree plans to achieve them; 5. to oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary; 6. to ensure effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs.
SO 2.9 (1)	THE BOARD	***Regulations and Control*** 1. Approve Standing Orders (SOs), a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business. 2. Suspend Standing Orders. 3. Vary or amend the Standing Orders. 4. Ratify any urgent decisions taken by the Chairman and Chief Executive in public session in accordance with SO 5.2 5. Approve a scheme of delegation of powers from the Board to committees.

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
		6. Require and receive the declaration of Board directors' interests that may conflict with those of the Trust and determining the extent to which that director may remain involved with the matter under consideration. 7. Require and receive the declaration of officers' interests that may conflict with those of the Trust. 8. Approve arrangements for dealing with complaints. 9. Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto. 10. Receive reports from committees including those that the Trust is required by the Secretary of State or other regulation to establish and to take appropriate action on. 11. Confirm the recommendations of the Trust's committees where the committees do not have executive powers. 12. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust. 13. Establish terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board. 14. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailee for patients' property. 15. Authorise use of the seal. 16. Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive's attention in accordance with SO 5.6. 17. Discipline directors of the Board or employees who are in breach of statutory requirements or SOs.
SO 2.9 (1)	THE BOARD	**Appointments/ Dismissal** 1. Appoint the Vice Chairman of the Board. 2. Appoint and dismiss committees (and individual directors) that are directly accountable to the Board. 3. Appoint, appraise, discipline and dismiss Executive Directors (subject to SO 2.2). 4. Confirm appointment of members of any committee of the Trust as representatives on outside bodies. 5. Appoint, appraise, discipline and dismiss the Secretary to the Board. 6. Approve proposals of the Remuneration Committee regarding appropriate remuneration and terms of service for the Chief Executive and other Directors.
SO 2.9 (1)	THE BOARD	***Strategy, Plans and Budgets*** 1. Define the strategic aims and objectives of the Trust.

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
		2. Approve proposals for ensuring quality and clinical governance in services provided by the Trust, having regard to any guidance issued by the Secretary of State. 3. Approve the Trust's policies and procedures for the management of risk. 4. Approve Outline and Final Business Cases for Capital Investment in excess of £1,000,000 5. Approve budgets. 6. Approve annually the Trust's proposed organisational development proposals. 7. Ratify proposals for acquisition, disposal or change of use of land and/or buildings. 8. Approve PFI proposals. 9. Approve the opening of bank accounts. 10. Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £1,000,000 over a 3 year period or the period of the contract if longer. 11. Approve individual compensation payments. 12. Approve proposals for action on litigation against or on behalf of the Trust. 13. Review use of NHS Resolution risk pooling schemes (LPST/CNST/RPST).
SO 2.9 (1)	THE BOARD	**Policy Determination** ***1.*** Approve management policies including personnel policies incorporating the arrangements for the appointment, removal and remuneration of staff.
SO 2.9 (1)	THE BOARD	**Audit** 1 Approve the appointment (and where necessary dismissal) of External Auditors on the advice of the Audit Panel. 2. Receive the annual management letter from the external auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit Committee. 3. Receive an annual report from the Internal Auditor and agree action on recommendations where appropriate of the Audit Committee.
SO 2.9 (1)	THE BOARD	**Annual Reports and Accounts** 1. Receipt and approval of the Trust's Annual Report and Annual Accounts. 2. Receipt and approval of the Annual Report and Accounts for funds held on trust.

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
SO 2.9 (1)	THE BOARD	**Monitoring** 1. Receive of such reports as the Board sees fit from committees in respect of their exercise of powers delegated. 2. Continuous appraisal of the affairs of the Trust by means of the provision to the Board as the Board may require from directors, committees, and officers of the Trust as set out in management policy statements. 3. All monitoring returns required by the Department of Health and the Charity Commission shall be reported, at least in summary, to the Board. 4. Receive reports from ~~Director of Finance~~Chief Finance Officer ~~& Digital~~ on financial performance against budget and annual plan. 5. Receive reports from ~~Director of Finance~~Chief Finance Officer ~~& Digital~~ on actual and forecast income from contracts.

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
SFI 11.1.1 and SO 4.8	AUDIT COMMITTEE	The Committee will: 1. Advise the Board on internal and external audit services; 2. The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives; 3. Monitor compliance with Standing Orders and Standing Financial Instructions; 4. Review schedules of losses and compensations and making recommendations to the Board. 5. Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and ~~Director of Finance~~Chief Finance Officer (for losses and special payments) previously approved by the Board. 6. Review the annual financial statements prior to submission to the Board. 7. Other duties as set out within the Audit Committee Handbook and its Terms of Reference.
SFI 20.1.1 and SO 4.8	REMUNERATION AND TERMS OF SERVICE COMMITTEE	The Committee will: 1. Decide on the appropriate remuneration and terms of service for the Chief Executive, other Executive Directors and other senior employees to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff. Aspects to include: • Salary (including any performance-related elements/bonuses); • Provisions for other benefits, including pensions and cars; • Arrangements for termination of employment and other contractual terms; advise on and oversee appropriate contractual arrangements for such staff; 2. Proper calculation and scrutiny of any termination payments taking account of such national guidance as is appropriate. The Committee shall report in writing to the Board the basis for its recommendations.
SO 4.8	QUALITY ~~GOVERNANCE~~ COMMITTEE	The Core duties of the Committee are as follows:

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		• Agree a set of Key Performance Indicators to be presented in the Committee Performance Dashboard monthly • Consider the control and mitigation of quality related risks and provide assurance to the Board that such risks are being effectively controlled and managed. Whilst the committee's remit covers all of the Trust's services, the committee has a specific oversight role in relation to the quality & safety of the Trust's maternity services (reference: Ockendon) • Provide assurance to the Board that all legal and regulatory requirements relating to quality are met, including directives, regulations, national standards, policies, reports, reviews and best practice • Review and provide assurance on those strategic objectives within the Board Assurance Framework, identified as the responsibility of the committee seeking where necessary further action as outlined below: **Deliver Harm Free Care:** • Developing a safety culture • Improving the safety of medicines management • Ensuring early detection and treatment of deteriorating patients • Ensuring safe surgical procedures • Ensuring a robust safeguarding framework is in place to protect vulnerable patients and staff • Maintaining HSMR and improving SHMI • Delivering on all CQC Must Do actions and regulatory notices • Ensure continued delivery of the hygiene code **Improve patient experience:** • Greater involvement in the co-design of services working closely with Healthwatch and patient groups • Greater involvement in decisions about care • Deliver year three objectives of our Inclusion Strategy • Redesign our communication and engagement approaches to broaden and maximise involvement with patients and carers **Improve clinical outcomes:**

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		• Ensuring our respiratory patients receive timely care from appropriately trained staff in the correct location • Ensuring recommendations from Get it Right First Time (GIRFT) reviews are implemented • Ensuring compliance with local and national clinical audit reports • Reviewing of pharmacy model and service
SO 4.8	FINANCE, PERFORMANCE AND ESTATES COMMITTEE	The Core duties of the Committee are as follows: • Agree a set of Key Performance Indicators to be presented in the Committee Performance Dashboard monthly • Consider the control and mitigation of finance, operational performance, estates and digital services related risks and provide assurance to the Board that such risks are being effectively controlled and managed • Provide assurance to the Board that all legal and regulatory requirements relating to finance, operational performance, estates and digital services are met, including directives, regulations, national standards, policies, reports, reviews and best practice • Review and provide assurance through the Integrated Improvement Plan and Performance Review Meeting reporting, on those strategic objectives within the Board Assurance Framework, identified as the responsibility of the committee seeking where necessary further action as outlined below: **A modern, clean and fit for purpose environment:** • Developing a business case to demonstrate capital requirement • Delivering environmental improvements in line with Estates Strategy • Continual improvement towards meeting PLACE assessment outcomes

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		• Reviewing and improving the quality and value for money of facilities services including catering and housekeeping • Continued progress on improving infrastructure to meet statutory Health and Safety compliance **Efficient use of resources:** • Delivering cost improvement programme • Delivering financial plan • Utilising Model Hospital, Service Line Reporting and Patient Level Costing data to drive focussed improvements • Implementing the CQC use of resources report recommendations **Enhanced data and digital capability:** • Improving utilisation of the Care Portal with increased availability of information • Commencing implementation of the electronic health record • Implement a single new business intelligence platform that supports decision making and drives improvement • Implementing robotic process automation • Improving end user utilisation of electronic systems • Completing roll-out of data quality kite mark

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		Establish new, evidence-based models of care: • Supporting the implementation of new models of care across a range of specialties • Supporting creation of integrated care system • Support the consultation for Acute Service Review (ASR) • Improvement programmes for cancer, outpatients, theatres and urgent care • Development and implementation of new pathways for paediatric services • Urology transformation change programme • Pre-Operative assessment Modernisation
SO 4.8	PEOPLE AND ~~ORGANISATIONAL DEVELOPMENT~~ COMMITTEE	The Core duties of the Committee are as follows: • Agree a set of Key Performance Indicators to be presented in the Committee Performance Dashboard monthly • Consider the control and mitigation of workforce related risks and provide assurance to the Board that such risks are being effectively controlled and managed • Provide assurance to the Board that all legal and regulatory requirements relating to the workforce are met, including directives, regulations, national standards, policies, reports, reviews and best practice • Review and provide assurance through the Integrated Improvement Plan and Performance Review Meeting reporting, on those strategic objectives within the Board Assurance Framework, identified as the responsibility of the committee seeking where necessary further action as outlined below:

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		A modern and progressive workforce: • Embedding robust workforce planning and development of new roles • Delivery of annual appraisals and mandatory training • Talent Management - Creating a framework for people to achieve their full potential • Ensuring access to the personal and professional development that enables people to deliver outstanding care and ensures ULHT becomes known as a learning organisation **Making ULHT the best place to work** • Address the concerns around equity of treatment and opportunity within ULHT, so that the Trust is seen to be an inclusive and fair organisation • Improving the consistency and quality of leadership and line management across ULHT • Resetting the ULHT Culture and Leadership Programme – Trust Values and Staff Charter • Reviewing the way in which we communicate with staff and involve them in shaping our plans • Agreeing and promoting the core offer of ULHT, so our staff feel valued, supported and cared for • Focus on junior doctor experience key roles: Freedom to Speak Up, Guardian of Safe Working and Wellbeing Guardian • Embed a programme focused on staff wellbeing • Develop staff networks • Implementing Schwartz Rounds

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		To Become a University Teaching Hospital • Developing a business case to support the case for change • Increasing the number of Clinical Academic posts • Improve the training environment for students • Develop a portfolio of evidence to apply for membership to the University Hospitals Association • Developing a memorandum of understanding with the University of Lincoln
SO 4.8	CHARITABLE FUNDS COMMITTEE	The Committee will: • administer those charitable funds received by the Trust in accordance with any statutory or other legal requirements or best practice required by the Charities Commission. • advise the board in relation to the discharge of the Trust's duties with respect to the above.

REF	DELEGATED TO	DUTIES DELEGATED
7	CHIEF EXECUTIVE (CE)	Accountable through NHS Accounting Officer to Parliament for stewardship of Trust resources
9	CHIEF EXECUTIVE AND ~~DIRECTOR OF FINANCE~~CHIEF	Ensure the accounts of the Trust are prepared under principles and in a format directed by the SofS. Accounts must disclose a true and fair view of the Trust's income and expenditure and its state of affairs. Sign the accounts on behalf of the Board.

REF	DELEGATED TO	DUTIES DELEGATED
	FINANCE OFFICER & DIGITAL	
10	CHIEF EXECUTIVE	Sign a statement in the accounts outlining responsibilities as the Accountable Officer. Sign a statement in the accounts outlining responsibilities in respect of Internal Control.
12 & 13	CHIEF EXECUTIVE	Ensure effective management systems that safeguard public funds and assist the Trust Chair to implement requirements of corporate governance including ensuring managers: • have a clear view of their objectives and the means to assess achievements in relation to those objectives • be assigned well defined responsibilities for making best use of resources • have the information, training and access to the expert advice they need to exercise their responsibilities effectively."
12	CHAIR	Implement requirements of corporate governance.
13	CHIEF EXECUTIVE	Achieve value for money from the resources available to the Trust and avoid waste and extravagance in the organisation's activities. Follow through the implementation of any recommendations affecting good practice as set out on reports from such bodies as the National Audit Office (NAO).
15	DIRECTOR OF FINANCECHIEF FINANCE OFFICER & DIGITAL	Operational responsibility for effective and sound financial management and information.
15	CHIEF EXECUTIVE	Primary duty to see that Director of FinanceChief Finance Officer & Digital discharges this function.
16	CHIEF EXECUTIVE	Ensuring that expenditure by the Trust complies with Parliamentary requirements.
18	CHIEF EXECUTIVE AND DIRECTOR OF FINANCECHIEF	Chief Executive, supported by Director of FinanceChief Finance Officer & Digital, to ensure appropriate advice is given to the Board on all matters of probity, regularity, prudent and economical administration, efficiency and effectiveness.

REF	DELEGATED TO	DUTIES DELEGATED
	Finance Officer ~~& Digital~~	
19	Chief Executive	If CE considers the Board or Chair is doing something that might infringe probity or regularity, he should set this out in writing to the Chair and the Board. If the matter is unresolved, he/she should ask the Audit Committee to inquire and if necessary NHS England/Improvement and the Department of Health.
20	Chief Executive	If the Board is contemplating a course of action that raises an issue not of formal propriety or regularity but affects the CE's responsibility for value for money, the CE should draw the relevant factors to the attention of the Board. If the outcome is that you are overruled it is normally sufficient to ensure that your advice and the overruling of it are clearly apparent from the papers. Exceptionally, the CE should inform NHS England/Improvement and the DH. In such cases, and in those described in paragraph 24, the CE should as a member of the Board vote against the course of action rather than merely abstain from voting.
1.3.1.7	Board	Approve procedure for declaration of hospitality and sponsorship.
1.3.1.8	Board	Ensure proper and widely publicised procedures for voicing complaints, concerns about misadministration, breaches of Code of Conduct, and other ethical concerns.
1.31.9 & 1.3.2.2	All Board members	Subscribe to the NHS Code of Conduct & Accountability.
1.3.2.4	Board	Board directors share corporate responsibility for all decisions of the Board.
1.3.2.4	Chair and non Executive Directors	Chair and non-executive directors are responsible for monitoring the executive management of the organisation and are responsible to the SofS for the discharge of those responsibilities.
1.3.2.4	Board	The Board has six key functions for which it is held accountable by the Department of Health on behalf of the Secretary of State: 1. to ensure effective financial stewardship through value for money, financial control and financial planning and strategy; 2. to ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation;

		3. to appoint, appraise and remunerate senior executives; 4. to ratify the strategic direction of the organisation within the overall policies and priorities of the Government and the NHS, define its annual and longer term objectives and agree plans to achieve them; 5. to oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary; 6. to ensure effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs.
1.3.24	BOARD	It is the Board's duty to: 1. act within statutory financial and other constraints; 2. be clear what decisions and information are appropriate to the Board and draw up Standing Orders, a schedule of decisions reserved to the Board and Standing Financial Instructions to reflect these, 3. ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives for the main programmes of action and for performance against programmes to be monitored and senior executives held to account; 4. establish performance and quality measures that maintain the effective use of resources and provide value for money; 5. specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Board can fully undertake its responsibilities; 6. establish Audit and Remuneration Committees on the basis of formally agreed terms of reference that set out the membership of the committee, the limit to their powers, and the arrangements for reporting back to the main Board.
1.3.2.5	CHAIR	1. provide leadership to the Board; 2. enable all Board members to make a full contribution to the Board's affairs and ensure that the Board acts as a team; 3. ensure that key and appropriate issues are discussed by the Board in a timely manner, 4. ensure the Board has adequate support and is provided efficiently with all the necessary data on which to base informed decisions; 5. lead Non-Executive Board members through a formally-appointed Remuneration Committee of the main Board on the appointment, appraisal and remuneration of the Chief Executive and (with the latter) other Executive Board members; 6. appoint Non-Executive Board members to an Audit Committee and other Committees of the main Board; 7. advise the Secretary of State on the performance of Non-Executive Board members.

1.3.2.5	CHIEF EXECUTIVE	The Chief Executive is accountable to the Chairman and Non-Executive members of the Board for ensuring that its decisions are implemented, that the organisation works effectively, in accordance with Government policy and public service values and for the maintenance of proper financial stewardship. The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the Board. The other duties of the Chief Executive as Accountable Officer are laid out in the Accountable Officer Memorandum.
1.3.2.6	NON-EXECUTIVE DIRECTORS	Non-Executive Directors are appointed by the Trust Development Authority to bring independent judgement to bear on issues of strategy, performance, key appointments and accountability through the Department of Health to Ministers and to the local community.
1.3.2.8	CHAIR AND DIRECTORS	Completion of their entry on the Trust's Register of Interest and prompt declaration of conflict of interest which may arise during the course of their duties for the Trust.
1.3.2.9	BOARD	NHS Boards must comply with legislation and guidance issued by the Department of Health on behalf of the Secretary of State, respect agreements entered into by themselves or in on their behalf and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money.

SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
1.1	CHAIR	Final authority in interpretation of Standing Orders (SOs).
2.4	BOARD	Appointment of Vice Chairman
3.1	CHAIR	Call meetings.
3.9	CHAIR	Chair all Board meetings and associated responsibilities.
3.10	CHAIR	Give final ruling in questions of order, relevancy and regularity of meetings.
3.12	CHAIR	Having a second or casting vote
3.13	BOARD	Suspension of Standing Orders
3.13	AUDIT COMMITTEE	Audit Committee to be notified of every decision to suspend Standing Orders (power to suspend Standing Orders is reserved to the Board)
3.14	BOARD	Variation or amendment of Standing Orders.
4.1	BOARD	Formal delegation of powers to committees, sub-committees or joint committees and approval of their constitution and terms of reference.
5.2	CHAIR & CHIEF EXECUTIVE	The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chair and Chief Executive after having consulted at least two Non-Executive members.
5.4	CHIEF EXECUTIVE	The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals that shall be considered and approved by the Board, subject to any amendment agreed during the discussion.
5.6	ALL	Disclosure of non-compliance with Standing Orders to the Chief Executive as soon as possible.
7.1	THE BOARD	Declare relevant and material interests.
7.2	CHIEF EXECUTIVE	Maintain Register(s) of Interests.
7.4	ALL STAFF	Comply with the Department of Health's "Standards of Business Conduct for NHS Staff" and Trust policy.

SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
7.4	ALL	Disclose relationship between self and candidate for staff appointment. (CE to report the disclosure to the Board.)
8.1/8.3	CHIEF EXECUTIVE	Keep seal in safe place and maintain a register of sealing.
8.4	CHIEF EXECUTIVE/ EXECUTIVE DIRECTOR	Approve and sign all documents which will be necessary in legal proceedings.

* Nominated officers and the areas for which they are responsible should be incorporated into the Trust's Scheme of Delegation document.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
10.1.3	~~Director of Finance~~Chief Finance Officer ~~& Digital~~	Approval of all financial procedures.
10.1.4	~~Director of Finance~~Chief Finance Officer ~~& Digital~~	Advice on interpretation or application of SFIs.
10.1.6	All members of the Board and employees	Have a duty to disclose any non-compliance with these Standing Financial Instructions to the ~~Director of Finance~~Chief Finance Officer ~~& Digital~~ as soon as possible.
10.2.4	Chief Executive	Responsible as the Accountable Officer to ensure financial targets and obligations are met and have overall responsibility for the System of Internal Control.
10.2.4	Chief Executive & ~~Director of Finance~~Chief Finance Officer ~~& Digital~~	Accountable for financial control but will, as far as possible, delegate their detailed responsibilities.
10.2.5	Chief Executive	To ensure all Board members, officers and employees, present and future, are notified of and understand Standing Financial Instructions.
10.2.6	~~Director of Finance~~Chief Finance Officer ~~& Digital~~	Responsible for: a) Implementing the Trust's financial policies and coordinating corrective action; b) Maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared and documented; c) Ensuring that sufficient records are maintained to explain Trust's transactions and financial position; d) Providing financial advice to members of Board and staff; e) Maintaining such accounts, certificates etc as are required for the Trust to carry out its statutory duties.
10.2.7	All members of the Board and employees	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Financial Instructions and financial procedures.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
10.2.8	Chief Executive	Ensure that any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income are made aware of these instructions and their requirement to comply.
11.1.1	Audit Committee	Provide independent and objective view on internal control and probity.
11.1.2	Chair	Raise the matter at the Board meeting where Audit Committee considers there is evidence of ultra vires transactions or improper acts.
11.1.3 & 11.2.1	~~Director of Finance~~Chief Finance Officer ~~& Digital~~	Ensure an adequate internal audit service, for which he/she is accountable, is provided (and involve the Audit Committee in the selection process when/if an internal audit service provider is changed.)
11.2.1	~~Director of Finance~~Chief Finance Officer ~~& Digital~~	Decide at what stage to involve police in cases of misappropriation and other irregularities not involving fraud or corruption.
11.3	Head of Internal Audit	Review, appraise and report in accordance with NHS Internal Audit Manual and best practice.
11.4	Audit Committee	Ensure cost-effective External Audit.
11.5	~~Director of Finance~~Chief Finance Officer ~~& Digital~~	Monitor and ensure compliance with SofS Directions on fraud and corruption including the appointment of the Local Counter Fraud Specialist.
11.6	~~Director of~~Chief Estates & Facilities Officer	Monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management including appointment of the Local Security Management Specialist.
13.1.1	Chief Executive	Compile and submit to the Board an Annual Plan which takes into account financial targets and forecast limits of available resources. The Annual Plan will contain: • a statement of the significant assumptions on which the plan is based; • details of major changes in workload, delivery of services or resources required to achieve the plan.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
13.1.2 & 13.1.3	~~Director of Finance~~Chief Finance Officer ~~& Digital~~	Submit budgets to the Board for approval. Monitor performance against budget; submit to the Board financial estimates and forecasts.
13.1.6	~~Director of Finance~~Chief Finance Officer ~~& Digital~~	Ensure adequate training is delivered on an ongoing basis to budget holders.
13.3.1	Chief Executive	Delegate budget to budget holders.
13.3.2	Chief Executive & Budget Holders	Must not exceed the budgetary total or virement limits set by the Board.
13.4.1	~~Director of Finance~~Chief Finance Officer~~& Digital~~	Devise and maintain systems of budgetary control.
13.4.2	Budget Holders	Ensure that a) no overspend or reduction of income that cannot be met from virement is incurred without prior consent of Board; b) approved budget is not used for any other than specified purpose subject to rules of virement; c) no permanent employees are appointed without the approval of the CE other than those provided for within available resources and manpower establishment.
13.4.3	Budget Holders	Identify and implement cost improvements and income generation activities in line with the Annual plan
13.6.1	Chief Executive/ ~~Director of Finance~~Chief Finance Officer ~~& Digital~~	Submit monitoring returns
14.1	~~Director of Finance~~Chief Finance Officer ~~& Digital~~	Preparation of annual accounts and reports.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
15.1	~~Director of Finance~~Chief Finance Officer ~~& Digital~~	Managing banking arrangements, including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories. (Board approves arrangements.)
16.	~~Director of Finance~~Chief Finance Officer ~~& Digital~~	Income systems, including system design, prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems for employees whose duties include collecting or holding cash.
16.2.3	All employees	Duty to inform ~~Director of Finance~~Chief Finance Officer ~~& Digital~~ of money due from transactions which they initiate/deal with.
17.	Chief Executive	Tendering and contract procedure.
17.5.3	Chief Executive	Waive formal tendering procedures.
17.5.3	Chief Executive	Report waivers of tendering procedures to the Board.
17.5.5	~~Director of Finance~~Chief Finance Officer ~~& Digital~~	Where a supplier is chosen that is not on the approved list the reason shall be recorded in writing to the CE.
17.6.2	Chief Executive	Responsible for the receipt, endorsement and safe custody of tenders.
17.6.3	Chief Executive	Shall maintain a register to show each set of competitive tender invitations dispatched.
17.6.4	Chief Executive and ~~Director of Finance~~Chief Finance Officer ~~& Digital~~	Assess for value for money and fair price in circumstances where one bid is received against a tender.
17.6.6	Chief Executive	Consideration and authorisation, as appropriate, of a tender which commits expenditure in excess of that which has been allocated by the Trust.
17.6.8	~~Director of Estates And Facilities~~Chief Estates and Facilities Officer	Will appoint a manager to maintain a list of approved firms.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
17.6.9	CHIEF EXECUTIVE	Shall ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.
17.7.2	CHIEF EXECUTIVE	Responsibility to ensure they, or their nominated deputy, award tenders in accordance with Trust procedures.
17.10	CHIEF EXECUTIVE	The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.
17.10	Board	Approval of all PFI proposals
17.11	CHIEF EXECUTIVE	Nomination of an officer to oversee and manage each contract on behalf of the Trust.
17.12	CHIEF EXECUTIVE	Nomination of officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.
17.15	CHIEF EXECUTIVE	Ensure that best value for money can be demonstrated for all services provided on an in-house basis.
17.15.5	CHIEF EXECUTIVE	The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.
18.1.1	CHIEF EXECUTIVE	Ensure that the Trust enters into suitable contracts with service commissioners for the provision of NHS services
18.3	CHIEF EXECUTIVE	Ensure that regular reports are provided to the Board detailing actual and forecast income from contracts
20.1.1	BOARD	Establish a Remuneration & Terms of Service Committee
20.1.2	REMUNERATION COMMITTEE	Advise the Board on and make recommendations on the remuneration and terms of service of the CE, other officer members and senior employees to ensure they are fairly rewarded having proper regard to the Trust's circumstances and any national agreements; Monitor and evaluate the performance of individual senior employees; Advise on and oversee appropriate contractual arrangements for such staff, including proper calculation and scrutiny of termination payments.
20.1.3	REMUNERATION COMMITTEE	Report in writing to the Board its advice and its bases about remuneration and terms of service of directors and senior employees.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
20.1.4	BOARD	Approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees and officers not covered by the Remuneration Committee.
20.2.2	CHIEF EXECUTIVE	Approval of variation to funded establishment of any department.
20.3	CHIEF EXECUTIVE	Staff, including agency staff, appointments and re-grading.
20.10.1 and 20.10.2	~~DIRECTOR OF FINANCE~~CHIEF FINANCE OFFICER ~~& DIGITAL~~	Payroll: a) specifying timetables for submission of properly authorised time records and other notifications; b) final determination of pay and allowances; c) making payments on agreed dates; d) agreeing method of payment; e) issuing instructions (as listed in SFI 10.4.2).
20.10.3	NOMINATED MANAGERS*	Submit time records in line with timetable. Complete time records and other notifications in required form. Submitting termination forms in prescribed form and on time.
20.10.5	~~DIRECTOR OF FINANCE~~CHIEF FINANCE OFFICER ~~& DIGITAL~~	Ensure that the chosen method for payroll processing is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.
20.5	NOMINATED MANAGER*	Ensure that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and deal with variations to, or termination of, contracts of employment.
21.1	CHIEF EXECUTIVE	Determine, and set out, level of delegation of non-pay expenditure to budget managers, including a list of managers authorised to place requisitions, the maximum level of each requisition and the system for authorisation above that level.
21.1.3	CHIEF EXECUTIVE	Set out procedures on the seeking of professional advice regarding the supply of goods and services.
21.2.1	REQUISITIONER*	In choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply shall be sought.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
21.2.2	~~Director of Finance~~Chief Finance Officer ~~& Digital~~	Shall be responsible for the prompt payment of accounts and claims.
21.2.3	~~Director of Finance~~Chief Finance Officer ~~& Digital~~	a) Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed; b) Prepare procedural instructions [where not already provided in the Scheme of Delegation or procedure notes for budget holders] on the obtaining of goods, works and services incorporating the thresholds; c) Be responsible for the prompt payment of all properly authorised accounts and claims; d) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable; e) A timetable and system for submission of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment; f) Instructions to employees regarding the handling and payment of accounts within the Finance Department; g) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received
21.2.4	Appropriate Executive Director	Make a written case to the ~~Director of Finance~~Chief Finance Officer ~~& Digital~~ to support the need for a prepayment.
21.2.4	~~Director of Finance~~Chief Finance Officer ~~& Digital~~	Approve proposed prepayment arrangements.
21.2.4	Budget Holder	Ensure that all items due under a prepayment contract are received (and immediately inform ~~Director of Finance~~Chief Finance Officer ~~& Digital~~ if problems are encountered).
21.2.5	Chief Executive	Authorise who may use and be issued with official orders.
21.2.6	Managers and Officers	Ensure that they comply fully with the guidance and limits specified by the ~~Director of Finance~~Chief Finance Officer.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
21.2.7	Chief Executive Director of FinanceChief Finance Officer & Digital	Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Director.
22.1.1	Director of FinanceChief Finance Officer & Digital	The Director of FinanceChief Finance Officer & Digital will advise the Board on the Trust's ability to pay dividend on PBC and report, periodically, concerning the PDC debt and all loans and overdrafts.
22.1.2	Board	Approve a list of employees authorised to make short term borrowings on behalf of the Trust. (This must include the CE and Director of FinanceChief Finance Officer.)
22.1.3	Director of FinanceChief Finance Officer & Digital	Prepare detailed procedural instructions concerning applications for loans and overdrafts.
22.1.4	Chief Executive or Director of FinanceChief Finance Officer & Digital	Be on an authorising panel comprising one other member for short term borrowing approval.
22.2.2	Director of FinanceChief Finance Officer & Digital	Will advise the Board on investments and report, periodically, on performance of same.
22.2.3	Director of FinanceChief Finance Officer & Digital	Prepare detailed procedural instructions on the operation of investments held.
23	Director of FinanceChief Finance Officer & Digital	Ensure that Board members are aware of the Financial Framework and ensure compliance
24.1.1 & 2	Chief Executive	Capital investment programme: a) ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on plans

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		b) responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost; c) ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences; d) ensure that a business case is produced for each proposal.
24.1.2	~~Director of Finance~~Chief Finance Officer ~~& Digital~~	Certify professionally the costs and revenue consequences detailed in the business case for capital investment.
24.1.3	Chief Executive	Issue procedures for management of contracts involving stage payments.
24.1.4	~~Director of Finance~~Chief Finance Officer ~~& Digital~~	Assess the requirement for the operation of the construction industry taxation deduction scheme.
24.1.5	~~Director of Finance~~Chief Finance Officer ~~& Digital~~	Issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure.
24.1.6	Chief Executive	Issue manager responsible for any capital scheme with authority to commit expenditure, authority to proceed to tender and approval to accept a successful tender. Issue a scheme of delegation for capital investment management.
24.1.7	~~Director of Finance~~Chief Finance Officer ~~& Digital~~	Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes.
24.2.1	~~Director of Finance~~Chief Finance Officer~~& Digital~~	Demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.
24.2.1	BOARD	Proposal to use PFI must be specifically agreed by the Board.
24.3.1	Chief Executive	Maintenance of asset registers (on advice from ~~Director of Finance~~Chief Finance Officer ~~& Digital~~).

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
24.3.5	~~Director of Finance~~Chief Finance Officer ~~& Digital~~	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
24.3.8	~~Director of Finance~~Chief Finance Officer ~~& Digital~~	Calculate and pay capital charges in accordance with Department of Health requirements.
24.4.1	Chief Executive	Overall responsibility for fixed assets.
24.4.2	~~Director of Finance~~Chief Finance Officer ~~& Digital~~	Approval of fixed asset control procedures.
24.4.4	Board Members and All senior staff	Responsibility for security of Trust assets including notifying discrepancies to ~~Director of Finance~~Chief Finance Officer ~~& Digital~~, and reporting losses in accordance with Trust procedure.
25.2	Chief Executive	Delegate overall responsibility for control of stores (subject to ~~Director of Finance~~Chief Finance Officer ~~& Digital~~ responsibility for systems of control). Further delegation for day-to-day responsibility subject to such delegation being recorded. (Good practice to append to the scheme of delegation document.)
25.2	~~Director of Finance~~Chief Finance Officer ~~& Digital~~	Responsible for systems of control over stores and receipt of goods.
25.2	Chief Pharmacist	Responsible for controls of pharmaceutical stocks
25.2	~~Director of Estates and Facilities~~Chief Estates and Facilities Officer	Responsible for control of stocks of fuel oil and coal.
25.2	Nominated Officers*	Security arrangements and custody of keys
25.2	~~Director of Finance~~Chief Finance Officer ~~& Digital~~	Set out procedures and systems to regulate the stores.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
25.2	~~Director of Finance~~Chief Finance Officer ~~& Digital~~	Agree stocktaking arrangements.
25.2	~~Director of Finance~~Chief Finance Officer ~~& Digital~~	Approve alternative arrangements where a complete system of stores control is not justified.
25.2	~~Director of Finance~~Chief Finance Officer ~~& Digital~~	Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items.
25.2	Nominated officers*	Operate system for slow moving and obsolete stock, and report to ~~Director of Finance~~Chief Finance Officer ~~& Digital~~ evidence of significant overstocking.
25.3.1	Chief Executive	Identify persons authorised to requisition and accept goods from NHS Supplies stores.
26.1.1	~~Director of Finance~~Chief Finance Officer ~~& Digital~~	Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers.
26.2.1	~~Director of Finance~~Chief Finance Officer ~~& Digital~~	Prepare procedures for recording and accounting for losses, special payments and informing police in cases of suspected arson or theft.
26.2.2	All Staff	Discovery or suspicion of loss of any kind must be reported immediately to either head of department or nominated officer. The head of department / nominated officer should then inform the CE and ~~Director of Finance~~Chief Finance Officer ~~& Digital~~.
26.2.2	~~Director of Finance~~Chief Finance Officer ~~& Digital~~	Where a criminal offence is suspected, ~~Director of Finance~~Chief Finance Officer ~~& Digital~~ must inform the police if theft or arson is involved. In cases of fraud and corruption ~~Director of Finance~~Chief Finance Officer ~~& Digital~~ must inform the relevant LCFS and Regional Team in line with SoS directions.
26.2.2	~~Director of Finance~~Chief Finance Officer ~~& Digital~~	Notify and External Audit of all prima facie or actual acts of fraud.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
26.2.3	~~Director of Finance~~Chief Finance Officer ~~& Digital~~	Notify Board and External Auditor of losses caused theft, arson, neglect of duty or gross carelessness (unless trivial).
26.2.4	Audit Committee	Approve write off of losses (within limits delegated by DH).
26.2.6	~~Director of Finance~~Chief Finance Officer ~~& Digital~~	Consider whether any insurance claim can be made.
26.2.7	~~Director of Finance~~Chief Finance Officer ~~& Digital~~	Maintain losses and special payments register.
27.1	~~Director of Finance~~Chief Finance Officer ~~& Digital~~	Responsible for accuracy and security of computerised financial data.
27.1	~~Director of Finance~~Chief Finance Officer ~~& Digital~~	Be satisfied that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation assurances of adequacy must be obtained from them prior to implementation.
27.1.3	~~Trust Secretary~~Director of Corporate Affairs	Shall publish and maintain a Freedom of Information Publication Scheme.
27.2.1	Relevant Officers	Send proposals for general computer systems to ~~Director of Finance~~Chief Finance Officer ~~& Digital~~
27.3	~~Director of Finance~~Chief Finance Officer ~~& Digital~~	Ensure that contracts with other bodies for the provision of computer services for financial applications clearly define responsibility of all parties for security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage, and allow for audit review. Seek adequate assurances from the provider that appropriate controls are in operation.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
27.4	~~DIRECTOR OF FINANCE~~CHIEF FINANCE OFFICER ~~& DIGITAL~~	Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery plans are in place.
27.5	~~DIRECTOR OF FINANCE~~CHIEF FINANCE OFFICER ~~& DIGITAL~~	Where computer systems have an impact on corporate financial systems satisfy himself that: a) systems acquisition, development and maintenance are in line with corporate policies; b) data assembled for processing by financial systems is adequate, accurate, complete and timely, and that a management rail exists; c) ~~Director of Finance~~Chief Finance Officer ~~& Digital~~ and staff have access to such data; Such computer audit reviews are being carried out as are considered necessary.
28.2	CHIEF EXECUTIVE	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.
28.3	~~DIRECTOR OF FINANCE~~CHIEF FINANCE OFFICER ~~& DIGITAL~~	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of.
28.6	DEPARTMENTAL MANAGERS	Inform staff of their responsibilities and duties for the administration of the property of patients.
29.1	~~DIRECTOR OF FINANCE~~CHIEF FINANCE OFFICER ~~& DIGITAL~~	Shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately.
30	~~DIRECTOR OF FINANCE~~CHIEF FINANCE OFFICER ~~& DIGITAL~~	Ensure all staff are made aware of the Trust policy on the acceptance of gifts and other benefits in kind by staff
32	CHIEF EXECUTIVE	Retention of document procedures in accordance with HSC 1999/053.
33.1	CHIEF EXECUTIVE	Risk management programme.
33.1	BOARD & ALL COMMITTEES	Approve and monitor risk management programme.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
33.2	Board	Decide whether the Trust will use the risk pooling schemes administered by the NHS Resolution or self-insure for some or all of the risks (where discretion is allowed). Decisions to self-insure should be reviewed annually.
33.4	~~Director of Finance~~Chief Finance Officer ~~& Digital~~	Where the Board decides to use the risk pooling schemes administered by the NHS Resolution the ~~Director of Finance~~Chief Finance Officer ~~& Digital~~ shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The ~~Director of Finance~~Chief Finance Officer ~~& Digital~~ shall ensure that documented procedures cover these arrangements. Where the Board decides not to use the risk pooling schemes administered by the NHS Resolution for any one or other of the risks covered by the schemes, the ~~Director of Finance~~Chief Finance Officer ~~& Digital~~ shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The ~~Director of Finance~~Chief Finance Officer ~~& Digital~~ will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed.
33.4	~~Director of Finance~~Chief Finance Officer ~~& Digital~~	Ensure documented procedures cover management of claims and payments below the deductible.

* Nominated officers and the areas for which they are responsible should be incorporated into the Trust's Scheme of Delegation document.

STANDING FINANCIAL INSTRUCTIONS

10. INTRODUCTION

10.1 General

10.1.1 The Trust shall agree Standing Financial Instructions for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. They shall have effect as if incorporated in the Standing Orders (SOs).

10.1.2 These Standing Financial Instructions (SFIs) are issued in accordance with the Financial Directions issued by the Secretary of State for Health under the provisions of Section 99 (3), 97 (A) (4) and (7) and 97 (AA) of the National Health Service Act 1977 for the regulation of the conduct of the Trust in relation to all financial matters. The Code of Accountability requires that the Trust shall give, and may vary or revoke Standing Financial Instructions for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. These Standing Financial Instructions (SFIs) are issued in accordance with the Code.

These Standing Financial Instructions shall have effect as if incorporated in the Standing Orders (SOs)

All directors and all members of staff should be aware of the existence of these documents and be familiar with all relevant provisions. These rules fulfil the dual role of protecting the Trust's interests and protecting the staff from any possible accusation that they have acted improperly.

10.1.3 These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations including Trading Units. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the ~~Director of Finance~~Chief Finance Officer.

10.1.4 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the ~~Director of Finance~~Chief Finance Officer must be sought before acting. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the Trust's Standing Orders.

10.1.5 The failure to comply with Standing Financial Instructions and Standing Orders can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.

10.1.6 Overriding Standing Financial Instructions – If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the ~~Director of Finance~~Chief Finance Officer as soon as possible.

10.2 Responsibilities and delegation

10.2.1 The Trust Board

The Board exercises financial supervision and control by:

(a) formulating the financial strategy and agreeing the long term financial model;

(b) requiring the submission and approval of budgets within approved allocations/overall income;

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);

(d) defining specific responsibilities placed on members of the Board and employees as indicated in the Scheme of Delegation document.

10.2.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out within the Scheme of Delegation. All other powers have been delegated to such other committees as the Trust has established.

10.2.3 The Chief Executive and ~~Director of Finance~~Chief Finance Officer

The Chief Executive and ~~Director of Finance~~Chief Finance Officer will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

Within the Standing Financial Instructions, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accountable Officer, to the Secretary of State, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chairman and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

10.2.4 It is a duty of the Chief Executive to ensure that Members of the Board and, employees and all new appointees are notified of, and put in a position to understand their responsibilities within these Instructions.

10.2.5 The ~~Director of Finance~~Chief Finance Officer

The ~~Director of Finance~~Chief Finance Officer is responsible for:

(a) ensuring that the Standing Financial Instructions are maintained and regularly reviewed.

(b) implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;

(c) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(d) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

Without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the ~~Director of Finance~~Chief Finance Officer include:

(e) the provision of financial advice to other members of the Board and employees;

(f) the design, implementation and supervision of systems of internal financial control;

(g) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

10.2.6 **Board Members and All Employees**

All members of the Board and employees, severally and collectively, are responsible for:

(a) the security of the property of the Trust;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources;

(d) conforming to the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

10.2.7 **Contractors and their employees**

Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

10.2.8 For any and all members of the Board and any employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and employees discharge their duties must be to the satisfaction of the ~~Director of Finance~~Chief Finance Officer.

11. AUDIT

11.1 Audit Committee

11.1.1 In accordance with Standing Orders, the Board shall formally establish an Audit Committee, with clearly defined terms of reference (based on those contained in the latest NHS Audit Committee Handbook), which will provide an independent and objective view of internal control by:

(a) overseeing Internal and External Audit services;

(b) reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments;

(c) review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives;

(d) monitoring compliance with Standing Orders and Standing Financial Instructions;

(e) reviewing schedules of losses and compensations and making recommendations to the Board;

(f) Reviewing the arrangements in place to support the Board Assurance Framework process prepared on behalf of the Board and advising the Board accordingly.

11.1.2 Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chairman of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally the ~~Director of Finance~~Chief Finance Officer may be instructed to refer the matter to the Department of Health and Social Care. Matters pertaining to fraud, bribery and/or corruption must be reported to the Local Counter Fraud Specialist (LCFS) for investigation in accordance with the Trust's Local Counter Fraud, Bribery and Corruption Policy and Response Plan.

11.1.3 The Minutes of Audit Committee meetings shall be formally recorded and an upward report submitted to the Board.

11.2 ~~Director of Finance~~Chief Finance Officer

11.2.1 It is the responsibility of the ~~Director of Finance~~Chief Finance Officer to ensure an adequate Internal Audit service is provided. The Audit Committee shall be advised of the selection process and appointment when / if an Internal Audit service provider is changed.

11.2.2 The ~~Director of Finance~~Chief Finance Officer is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;

(b) ensuring that the Internal Audit is adequate and meets the NHS mandatory audit standards;

(c) deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;

(d) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee [and the Board]. The report must cover:

(i) a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the Department of Health and Social Care including for example compliance with control criteria and standards;
(ii) major internal financial control weaknesses discovered;
(iii) progress on the implementation of internal audit recommendations;
(iv) progress against plan over the previous year;
(v) strategic audit plan covering the coming three years;
(vi) a detailed plan for the coming year.

11.2.2 The ~~Director of Finance~~Chief Finance Officer or designated auditors and LCFS are entitled (without necessarily giving prior notice) to require and receive:

(a) access to all records, documents and correspondence and data relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises or members of the Board or employee of the Trust;

(c) the production of any cash, stores or other property of the Trust under a member of the Board and an employee's control; and

(d) explanations concerning any matter under investigation.

11.2.3 The Trust's Chief Executive and ~~Director of Finance~~Chief Finance Officer are responsible for ensuring that access rights are given to NHS Counter Fraud Authority (NHSCFA) where necessary for the prevention, detection and investigation of cases of fraud, bribery and corruption, in accordance with NHSCFA Provider Standards.

11.3 Role of Internal Audit

11.3.1 Internal Audit will review, appraise and report upon:

(a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

(b) the adequacy and application of financial and other related management controls;

(c) the suitability of financial and other related management data;

(d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) fraud and other offences;
(ii) waste, extravagance, inefficient administration;
(iii) poor value for money or other causes.

(e) Internal Audit shall also independently verify the Assurance Statements in accordance with guidance from the Department of Health and Social Care.

11.3.2 Whenever any matter arises which involves, or is thought to involve, fraud, bribery or corruption, the matter must be reported to the LCFS, in accordance with the Trust's Local Counter Fraud, Bribery and Corruption Policy and Response Plan. All other irregularities, or suspected irregularities, concerning cash, stores, or other property of the Trust, or the exercise of any function of a pecuniary nature, must be notified to the ~~Director of Finance~~Chief Finance Officer immediately.

11.3.3 The Chief Internal Auditor will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chairman and Chief Executive of the Trust.

11.3.4 The Chief Internal Auditor shall be accountable to the ~~Director of Finance~~Chief Finance Officer. The reporting system for internal audit shall be agreed between the ~~Director of Finance~~Chief Finance Officer, the Audit Committee and the Chief Internal Auditor. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Standards. The reporting system shall be reviewed at least every three years.

11.3.5 Internal Audit terms of reference shall have effect as if incorporated within these Standing Financial Instructions. The terms of reference cover the scope of internal audit work, authority and independence, management responsibilities, co-ordination of assurance work, reporting and key outputs and the operational responsibilities.

11.4 External Audit

11.4.1 The External Auditor is appointed and paid for by the Trust. The Audit Committee must ensure a cost-efficient service. If there are any problems relating to the service provided by the External Auditor, then this should be raised with the External Auditor.

11.5 Fraud Bribery and Corruption

11.5.1 In line with their responsibilities, the Chief Executive and ~~Director of Finance~~Chief Finance Officer shall monitor and ensure compliance with the NHS Standard contract

Service Condition 24 to put in place and maintain appropriate anti-fraud, bribery and corruption arrangements, having regard to the NHS Counter Fraud Authority standards.

11.5.2 The ~~Director of Finance~~Chief Finance Officer is the executive board member responsible for countering fraud, bribery and corruption in the Trust.

11.5.3 The Trust shall nominate a professionally accredited Local Counter Fraud Specialist ("LCFS"), to conduct the full range of anti-fraud, bribery and corruption work on behalf of the Trust as specified in the NHS Counter Fraud Authority (NHSCFA) Counter Fraud Standards.

11.5.4 The LCFS shall report to the ~~Director of Finance~~Chief Finance Officer and shall work with staff in the NHS Counter Fraud Authority (NHSCFA) in accordance with the NHS Counter Fraud Authority Counter Fraud Standards, the NHS Counter Fraud manual and the NHSCFA's Investigation Case File Toolkit.

11.5.6 If it is considered that evidence of offences exists and that a prosecution is desirable, the LCFS will consult with the ~~Director of Finance~~Chief Finance Officer to obtain the necessary authority and agree the appropriate route for pursuing any action e.g. referral to the police or NHSCFA.

11.5.7 The LCFS will at least annually provide a written report to the Audit Committee on anti-fraud, bribery and corruption work within the Trust.

11.5.8 The LCFS will ensure that measures to mitigate identified risks are included in an organisational work plan which ensures that an appropriate level of resource is available to the level of any risks identified. Work will be monitored by the ~~Director of Finance~~Chief Finance Officer and outcomes fed back to the Audit Committee.

11.5.9 The Trust shall have a whistle-blowing mechanism to report any suspected or actual fraud, bribery or corruption concerns and internally publicise this, together with the NHSCFA's national fraud and corruption reporting line and online referral form.

11.5.10 The Trust will report annually on how it has met the standards set by the NHS Counter Fraud Authority in relation to anti-fraud, bribery and corruption work and the ~~Director of Finance~~Chief Finance Officer shall sign-off the annual self-review and authorise its submission to the NHS Counter Fraud Authority.
The ~~Director of Finance~~Chief Finance Officer shall sign-off qualitative assessments (in years when this assessment is required) and submit it to the relevant authority.

11.6 Security Management

11.6.1 In line with their responsibilities, the Trust Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management.

11.6.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS security management.

11.6.3 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the ~~Director of Estates and Facilities~~Chief Estates and Facilities Officer and the appointed Local Security Management Specialist (LSMS).

12. RESOURCE LIMIT CONTROL

Not applicable to NHS Trusts.

13. BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

13.1 Preparation and Approval of Plans and Budgets

13.1.1 The Chief Executive will prepare annually, a statement of strategic direction for approval by the Board of Directors.

13.1.2 The Chief Executive will submit to the Board of Directors an annual business plan (the "Annual Plan") which takes into account financial targets and forecast limits of available resources. The annual plan will contain:

(a) a statement of the significant assumptions on which the plan is based;

(b) details of major changes in workload, delivery of services or resources required to achieve the plan.

In preparing the Annual Plan the Trust should ensure:

(a) financial performance measures have been defined and will be monitored;

(b) reasonable targets have been identified for these measures;

(c) a robust system is in place for managing performance against the targets;

(d) reporting lines are in place to ensure overall performance is managed;

(e) arrangements are in place to manage/respond to adverse performance.

13.1.3 Prior to the start of the financial year the ~~Director of Finance~~Chief Finance Officer will, on behalf of the Chief Executive, prepare and submit a financial plan and associated income & expenditure budget to the Board for approval. The plan will contain:

(a) a statement of any significant assumptions on which the plan is based and an assessment as to whether they are realistic;

(b) details of major changes in workload, delivery of services or resources required to achieve the plan.

The budget will:

(a) be in accordance with the aims and objectives set out in the Annual Plan and long term financial model;

(b) accord with activity and manpower plans;

(c) be produced following discussion with appropriate budget holders;

(d) be prepared within the limits of available income;

(e) identify potential risks.

13.1.4 The ~~Director of Finance~~Chief Finance Officer shall monitor financial performance against budget and Annual Plan, periodically review them, and report regularly to the Board.

13.1.5 All budget holders must provide information as required by the ~~Director of Finance~~Chief Finance Officer to enable budgets to be compiled and financial performance against budgets to be monitored.

13.1.6 All budget holders will sign up to their allocated budgets at the commencement of each financial year.

13.1.7 The ~~Director of Finance~~Chief Finance Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage budgets successfully.

13.2 Budgetary Delegation

13.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities.

This will be achieved through the approval by the Chief Executive of the Executive Devolution Policy setting out Delegation of authority and decision-making power to Corporate Directorates and Divisions, This policy will provide for differential levels of delegated authority dependent upon the Performance of the Directorate or Division.

13.2.2 Subject to any specific provisions arising from a particular set of circumstances, Budgets shall be delegated as far as possible to the lowest level consistent with effective operational management.

13.2.3 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

13.2.4 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

13.2.5 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the ~~Director of Finance~~Chief Finance Officer.

13.2.6 All Business Cases will be approved in accordance with the authority set out in Investment Appraisal Framework and Scheme of Reservation and Delegation of Powers to the Board.

13.3 Budgetary Control and Reporting

13.3.1 The ~~Director of Finance~~Chief Finance Officer will devise and maintain systems of budgetary control. All managers whom the Trust may empower to engage staff or

otherwise incur expenditure, collect or generate income, shall comply with the requirements of those systems.
The ~~Director of Finance~~Chief Finance Officer shall also be responsible for providing budgetary information and advice to enable the Chief Executive and other operational managers to carry out their budgetary responsibilities and issue to all relevant staff, rules and procedures governing the operation of Budgets.

13.3.2 The ~~Director of Finance~~Chief Finance Officer is responsible for presenting financial reports to the Board giving details of underlying performance, financial efficiency, liquidity and achievement of plan, as well as details of the overall financial risk ratings score.

(a) Monthly financial reports in a form approved by the Board will contain as a minimum:

(i) income and expenditure to date showing trends and forecast year-end position;
(ii) progress against the efficiency / savings programme
(iii) summary cash flow and balance sheet including a forecast year-end position;
(iv) details of new cash borrowings in month and cumulative debt levels
(v) movements in working capital;
(vi) External Financial Limit (EFL) target and performance against Capital Resource Limit (CRL)
(vii) capital project spend and projected outturn against plan;
(viii) explanations of any material variances from plan;
(ix) details of any corrective action where necessary and the Chief Executive's and/or ~~Director of Finance~~Chief Finance Officer' view of whether such actions are sufficient to correct the situation;
(x) monitoring of management action to correct variances;
(xi) Performance against risk assurance metrics

13.3.3 The ~~Director of Finance~~Chief Finance Officer is responsible for the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

13.3.4 Each Budget Holder is responsible for ensuring that:

(a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of a member of the Executive Team;

(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;

(c) no permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and manpower establishment as approved by the Board.

(d) No temporary employees are appointed which would lead to an overspend on the delegated budget without approval of the Chief Executive.

(e) The systems of budgetary control established by the ~~Director of Finance~~Chief Finance Officer are complied with fully.

(f) cost improvements, productivity, efficiency and income generation initiatives are identified and implemented in accordance with the requirements of the Annual Plan

13.3.5 The Chief Executive may delegate the responsibility for identifying and implementing cost improvements and income generation initiatives to Divisions and Directorates in accordance with the requirements of the Annual Plan and its delivery.

13.3.6 The ~~Director of Finance~~Chief Finance Officer shall devise and maintain adequate systems to ensure that the Trust can identify, implement and monitor opportunities for schemes to be included within cost improvement and income generating programmes.

13.4 Capital Expenditure

13.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. All capital procurement shall be carried out in accordance with the Tendering and Contract Procedures. (The particular applications relating to capital are contained in SFI 24).

13.5 Monitoring Returns

13.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation in line with the agreed timescales.

13.6 Value for Money

13.6.1 The Chief Executive in conjunction with the ~~Director of Finance~~Chief Finance Officer shall be responsible for the efficient and effective use of the total financial resources available to the Trust and ensure that good value for money is achieved.

14. ANNUAL ACCOUNTS AND REPORTS

14.1 The ~~Director of Finance~~Chief Finance Officer, on behalf of the Trust, will:

(a) prepare financial returns in accordance with the accounting policies and guidance given by the Department of Health and Social Care and the Treasury, the Trust's accounting policies, and International Financial Reporting Standards;

(b) prepare and submit annual financial returns and accounts to the Department of Health and Social Care in accordance with the national timetable and published requirements;

14.2 The Trust's annual accounts must be audited by the Trust's external auditor as appointed by the Audit Panel and thereafter adopted by the Trust Board.

14.3 The Trust will publish an annual report, in accordance with the national timetable. The document will comply with the relevant Department of Health and Social Care guidance including that contained in the Department of Health Group Accounting Manual.

14.4 The Audited Annual Report and Accounts must be presented to a public meeting and made available to the public.

15. BANK ACCOUNTS

15.1 General

15.1.1 The ~~Director of Finance~~Chief Finance Officer is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/ directions and best practice advice issued by the Department of Health and Social Care and

Treasury. In line with 'Cash Management in the NHS' Trusts should minimise the use of commercial bank accounts and consider using Government Banking Service (GBS) accounts for all banking services.

The Board of Directors shall approve the banking, working capital and investment arrangements including a review of the Trust's Treasury Management Policy on an annual basis.

15.2 Bank Accounts

15.2.1 The ~~Director of Finance~~Chief Finance Officer is responsible for:

(a) the operation Government Banking Service (GBS) and other bank accounts held by the Trust, Working Capital Facilities and the appropriate investment of the Trust's cash.

(b) establishing separate bank accounts for the Trust's non-exchequer funds;

(c) ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made;

(d) reporting to the Board all instances where bank accounts may become or have become overdrawn (together with remedial action taken);

(e) ensuring the Board of Directors is notified of changes to the Trust's borrowing facilities; and

(f) monitoring compliance with Department of Health and Social Care or any other relevant guidance on the level of cleared funds.

15.3 Banking Procedures

15.3.1 The ~~Director of Finance~~Chief Finance Officer will prepare detailed instructions on the operation of all Trust bank accounts, investments and borrowings which must include:

(a) the conditions under which each bank and GBS account is to be operated, including the limit to be applied to any overdraft

(b) a panel of officers with delegated authority to sign cheques or authorise payments drawn on the Trust's accounts and the number of signatories required on each authority to pay.

(c) those authorised to invest monies; and

(d) any records which must be maintained in respect of the above.

15.3.2 The ~~Director of Finance~~Chief Finance Officer must advise the Trust's bankers in writing of the conditions under which each account will be operated.

15.3.3 All funds shall be held in accounts in the name of the Trust. No members of staff other than those designated by the Chief Executive and the ~~Director of Finance~~Chief Finance Officer shall open any bank or building society account in the name of the Trust. Any employee aware of the existence of such an account shall report the matter to the ~~Director of Finance~~Chief Finance Officer.

15.3.4 Where an agreement is entered into with any other body for payment to be made on behalf of the Trust from bank accounts maintained in the name of the Trust or other body, or by Electronic Funds Transfer (BACS), the ~~Director of Finance~~Chief Finance Officer shall ensure that satisfactory security regulations of the Trust/other body

relating to bank accounts exist and are observed. This will be specified in an agreement with the appropriate body.

15.4 Investments

15.4.1 The ~~Director of Finance~~Chief Finance Officer is responsible for arrangements for the investment of surplus cash with the National Loans fund ensuring:

(a) a competitive rate of return within a minimal risk profile;
(b) the availability of cash to meet operational requirements;

15.4.2 The ~~Director of Finance~~Chief Finance Officer is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

15.4.3 The ~~Director of Finance~~Chief Finance Officer will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

15.5 Tendering and Review

15.5.1 The ~~Director of Finance~~Chief Finance Officer will review any commercial banking arrangements of the Trust at five yearly intervals to ensure they reflect best practice and represent best value for money.

15.5.2 Competitive tenders shall be sought and the results reported to the Board. This review is not necessary for the operation of Government Banking Services accounts required by the Department of Health and Social Care.

16. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

16.1 Income Systems

16.1.1 The ~~Director of Finance~~Chief Finance Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

16.1.2 The ~~Director of Finance~~Chief Finance Officer is also responsible for the prompt banking of all monies received.

16.1.3

16.1.4 The Trust may carry on activities for the purpose of making additional income available in and/or to better carry out the Trust's principal purpose subject to any restrictions contained in the Regulatory Framework.

16.1.5 Disposal of materials and items surplus to requirements shall be dealt with in accordance with relevant financial procedure notes – see overlap with SFI 26.1.

16.2 Fees and Charges

16.2.1 The Trust shall follow the Department of Health and Social Care's advice in setting prices for NHS service agreements. The charges will be in line with National Tariff or locally agreed where tariff is not applicable.

16.2.2 The ~~Director of Finance~~Chief Finance Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by

the Department of Health and Social Care or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

Where sponsorship income is considered the guidance in the Trust's 'Standards of Business Conduct and Declarations of Interest Policy shall be followed.

16.2.3 All employees must inform the ~~Director of Finance~~Chief Finance Officer promptly of money due from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings, overseas patients and other transactions.

16.2.4 In relation to Income Generation Schemes, the ~~Director of Finance~~Chief Finance Officer shall ensure that all costs and revenues attributed to each scheme can be identified.

16.3 Debt Recovery

16.3.1 The ~~Director of Finance~~Chief Finance Officer is responsible for the appropriate recovery action on all outstanding debts including detailed procedures for the issuing of credit notes and write-off of debts after all reasonable steps have been taken to secure payment.

16.3.2 Income not received should be dealt with in accordance with losses procedures and reported to the Audit Committee.

16.3.3 The ~~Director of Finance~~Chief Finance Officer is responsible for ensuring that systems are in place to prevent salary and other overpayments. Where overpayments occur, recovery should be initiated as per the Trust's debt recover procedure.

16.4 Security of Cash, Cheques and other Negotiable Instruments

16.4.1 The ~~Director of Finance~~Chief Finance Officer is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

(b) ordering and securely controlling any such stationery;

(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

16.4.2 Official money shall not under any circumstances be used for the encashment of private cheques or for the granting of personal loans of any kind.

16.4.3 All cheques, postal orders, cash receipts shall be banked intact to the credit of the Trust's Main Account or, if appropriate, the Trust's Charitable fund bank account. Disbursements shall not be made from cash received, except under arrangements approved by the ~~Director of Finance~~Chief Finance Officer.

16.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

16.4.5 All unused cheques and other orders shall be subject to the same security precautions as are applied to cash.

16.4.6 Any loss or shortfall of cash, cheques or other negotiable instruments, however occasioned shall be reported immediately to the ~~Director of Finance~~Chief Finance Officer and dealt with in accordance with the agreed procedure for reporting losses.

17. PROCUREMENT AND CONTRACTING PROCEDURE

17.1 Duty to comply with Standing Orders and Standing Financial Instructions

The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Orders and Standing Financial Instructions (except where Standing Order No. 3.12 Suspension of Standing Orders is applied).

17.2 UK Regulations Governing Public Procurement

The Public Contracts Regulations including the current financial thresholds prescribe procedures for advertising and awarding all forms of contracts shall have effect as if incorporated in these SFIs.

17.3 Policy and Procedure

The ~~Director of Finance~~Chief Finance Officer is responsible for ensuring policies and procedures are in place for the control of all procurement activity carried out within the Trust.

17.4 Competitive Tendering

Competitive Tendering is the process by which price and/or quality is evaluated on a competitive basis between Tenderers in the market to determine the award of a contract.

17.4.1 General Applicability

(i) Procurement is categorized into 4 ranges of expenditure, explained below. Unless specifically exempted below the Board shall ensure that competitive offers are invited for:

- the supply of goods, materials and manufactured articles;
- for the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the Department of Health and Social Care);
- for the design, construction and maintenance of building and engineering works, including construction and maintenance of grounds and gardens;
- disposals.

(ii) Through the Trust's Finance System purchase orders are automatically generated for catalogue items where pricing has been competitively contracted or benchmarked against approved suppliers to ensure best value.

(iii) For all goods and services Trust Standing Orders and UK legislation dictates the different purchasing thresholds and the process route of purchasing.

(iv) For spend below £10,000 (excluding VAT) no formal procurement exercise is required, but value for money must still be demonstrated.

(v) For goods and services ~~non NHS Supply Chain~~ spend between £10,000-£25,000 (excluding VAT) or between £10,000- £100,000 for services described in schedule 3 of PCR 2015 or for Capital Works spend between £10,000-£500,000. Procurement should be undertaken through one of the routes outlined below:

a. Proportionate Procurement, for example, a best value Request for Quote process comparing price and quality,
b. Further competition or direct award under a compliant framework agreement ~~– if there is a competitive market and /or the potential for future growth in spend.~~
c. Three quotes – for a one-off purchase but in a competitive market a price only quote process can be undertaken
d. Less than three quotes – where a competitive market is not established, or demand in the market limits procurement options, one to three quotes will be accepted on the basis there is evidence of attempts to seek quotes and this is documented on a procurement record.
e. Direct award – where only one provider can deliver the requirement, or for a unique requirement (value for money must still be demonstrated). A short Contract Award Report is required to demonstrate justifiable direct award.
f. Contract variation under an existing contract – providing the contract variation is no more than 10% of the original contract value or for technical or economic reasons, the variation is no more than 50% of the original contract value. Contract variations higher than these thresholds will require a new procurement process.

See SFI 17.9 for further details.

(vi) For spend above £25,000 (excluding VAT) but below the current tender thresholds within PCR2015, or £100,000 for services described in Schedule 3 of PCR 2015, or £500,000 for works as described in PCR2015

Procurement must be engaged to undertake one of the following processes

a. Proportionate Procurement Exercise in the open market – where a price and quality evaluation is required, then a proportionate tendering approach to test the market should be undertaken by the Procurement Team.
b. Mini-competition through a compliant framework agreement.
c. Direct award under a compliant framework agreement
d. Contract variation under an existing contract – providing the contract variation is no more than 10% of the original contract value or for technical or economic reasons, the variation is no more than 50% of the original contract value. Contract variations higher than these thresholds are not permitted and will require a new procurement. Contract variations which result in a total value contract above procurement thresholds are not permitted, and will require a compliant procurement under the Public Contract Regulations 2015
e. In exceptional circumstances, a single tender waiver may be required

(vii) For spend above the current UK tender threshold limit, Procurement must be engaged to undertake one of the following

a. Procurement Process in line with procedures detailed within the Public Contracts Regulations 2015 i.e. competitive Tender
b. Further competition / direct award under a compliant framework agreement.
c. Contract variation under an existing contract – providing the contract variation is no more than 10% of the original contract value or for technical or economic reasons, the variation is no more than 50% of the original contract value. Contract variations higher than these thresholds are not permitted and will require a new procurement. Contract variations which

result in a total value contract above procurement thresholds are not permitted, and will require a compliant procurement under PCR2015

d. In exceptional circumstances, a compliant direct award under the rules determined in Regulation 32 of PCR2015

For works contracts subject to a VFM assessment the Trust shall procure all building and estates capital schemes with an estimated value over £500,000 using the NHS Procure 22 Framework, or alternative public sector works Framework Agreement, unless there are valid and significant reasons for not doing so, as approved by the ~~Director of Finance~~Chief Finance Officer. The Trust will follow Department of Health and Social Care and Treasury guidelines for the procurement of all estates capital schemes. Procurement contracts and frameworks used to commission contractors shall be appropriate to the type and nature of capital scheme being procured and will be required to demonstrate value for money.

An appropriate record should be kept in the contract file where it has not been possible to invite a building or estates tender above UK Procurement limits through a framework.

(viii) All procurements must be undertaken in accordance with Procurement Standard Operating Procedures.

17.4.2 **Healthcare Services**

Where the Trust elects to invite tenders for the supply of healthcare services these Standing Orders and Standing Financial Instructions shall apply as far as they are applicable to the procurement and contracting procedure and need to be read in conjunction with SFI 17.11 and SFI No. 18.

Where procurement of healthcare services on the open market is undertaken, these will be in line with the Light Touch Regime for common procurement vocabulary codes described within Schedule 3 of the Public Contracts Regulations 2015.

Where the procurement of a sub-contractor for CCG commissioned service is required, the NHS England Standard Contract: Sub-contracts should be utilised in all cases.

17.4.3 **Exceptions and instances where formal tendering need not be applied**

Formal tendering procedures (i.e. local or UK) **<u>need not be applied</u>**:

(a) where the estimated expenditure or income does not, or is not reasonably expected to, exceed **£25,000**;

(b) where the supply is proposed under special arrangements negotiated by the Department of Health and Social Care in which event the said special arrangements must be complied with;

(c) regarding disposals as set out in SFI No. 26;

(d) where works or services connected to proposed works are to be commissioned from an approved Procure 22 Principal Supply Chain Partner (PSCP), as appointed formally to the Department of Health and Social Care framework agreement or its successor schemes; or

(e) where the supply is proposed under any external compliant contract / framework agreement to which the Trust has access. In such circumstances value for money and compliance to the agreement should be demonstrated.

17.4.4 Formal procurement procedures (i.e. local or above threshold tender / quotes or direct award) **may be waived** in the following circumstances:

(a) in very exceptional circumstances where formal procurement procedures would not be practicable and the circumstances are detailed in an appropriate Trust record.

(b) where the timescale genuinely precludes competitive procurement but failure to plan the work properly would not be regarded as a justification for a single tender;

(c) where specialist expertise is required and is available from only one source;

(d) when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

(e) there is a clear benefit to be gained from maintaining continuity with an earlier project or compatibility with existing equipment / service. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive procurement;

(f) for building and engineering construction works and maintenance where there is either a direct legal enforcement of safety the consequence of which would result in the closure of the Trusts services and/or prosecution of the Trust and it's officials or a specified National or Local Health economy imperative where failure to deliver could place patients safety at risk.

The waiving of procurement procedures should not be used to avoid competition or for administrative convenience or to award further work to a supplier originally appointed through a competitive procedure unless specifically covered within the original procurement notice or contract.

Where it is decided that competitive procurement is not applicable and should be waived, the fact of the waiver and the reasons should be documented reviewed by procurement, authorised by the ~~Director of Finance~~Chief Finance Officer and / or Chief Executive and recorded in an appropriate Trust record and reported to the Audit Committee at each meeting.

17.4.5 **Fair and Adequate Competition**

Other than where the exceptions set out in SFI Nos. 17.1 and 17.4.1 and 17.4.3 apply, the Trust shall ensure that requests for procurement are sent to no less than three firms/individuals to provide fair and adequate competition as appropriate, and in no case less than two firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required. The deadline for returns must be considered reasonable.

.

17.5 Tendering Procedure for Goods, Materials, Services and Disposals including non NHS provided health care.

17.5.1 **Invitation to tender**

(i) All invitations to tender shall be issued via the appropriate e procurement/sourcing portal in use within the Trust.

(ii) All invitations to tender shall state that no tender will be accepted unless it has been submitted via the appropriate e procurement/sourcing portal adhering to all the required terms of the invitation to tender but specifically the requested time and date of return.

(iii) Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Terms and Conditions of Contract as are applicable. Any contract that is projected not to be under such terms must be referred to the Deputy Director of Procurement prior to any contractual agreement.

(iv) Every tender for building or engineering works not procured under the procure 22 framework with an approved Principal Supply Chain Partner (except for maintenance work, when Estmancode guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract) Standard forms of contract or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with Department of Health guidance and, in minor respects, to cover special features of individual projects.

17.5.2 **Receipt and safe custody of tenders**

The Chief Executive or his/her nominated representative will be responsible for the electronic receipt, and safe custody of tenders received within the e-procurement system until the time appointed time for the electronic seal to be opened.

17.5.3 **Opening tenders and Register of tenders**

(i) As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, the electronic vault will be opened by the procurement project lead

(ii) Every tender received shall be marked with the date of opening automatically by the e-procurement software and will maintain a full auditable record of the opening process.

(iii) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, shall be addressed in accordance with PCR 2015 Regulation 56(4)

(iv) Appropriately detailed electronic notes shall be kept in the contract file to detail any matters such as action taken in respect of late tenders, non-compliant bids or any other matters relevant to tender receipt and opening.

17.5.4 **Admissibility**

(i) Tenders submitted but not received until after the due time and date (at which point the electronic vault is locked), may be considered only if confirmation of submission is received from the e-sourcing portal. The Chief Executive or

his/her nominated officer will decide whether there are exceptional circumstances e.g. System failure on the part of the Portal having been uploaded in good time but delayed through no fault of the tenderer.

(ii) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Chief Executive or his nominated officer or if the process of evaluation and adjudication has not started.

(iii) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Chief Executive or his nominated officer.

(iv) Where only one tender is sought and / or received, it must be demonstrated that the price to be paid is fair and reasonable and will ensure value for money for the Trust. This will be recorded in the appropriate documentation namely the contract award report.

17.5.5 **Acceptance of formal tenders (See overlap with SFI No. 17.6)**

(i) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of his tender before the award of a contract will not disqualify the tender. All such questions must be raised and responded to via the e procurement system to maintain audit trails and transparency.

(i) Evaluation criteria will be based on either:

- the lowest price; or
- the most economically advantageous cost over the whole life of the Contract based on a combined evaluation of price and quality

It is accepted that the lowest price does not always represent the best value for money. Other factors affecting the success of a project may include (without limitation):

(a) Qualitative elements of the bidders proposal;

(b) understanding of client’s needs;

(c) feasibility and credibility of proposed approach;

(d) ability to complete the project on time.

Where other factors are taken into account in selecting a tenderer, these must be documented in the contract award report, and the reason(s) for not accepting the lowest priced tender clearly stated.

Criteria taken into account in selecting a successful tenderer must be clearly recorded and documented in the invitation to tender/quote.

(iii) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these instructions except with the authorisation of the Chief Executive or nominated officer

(iv) The use of these procedures must demonstrate that the award of the contract was:

(a) not in excess of the going market rate / price current at the time the contract was awarded; or

(b) that best value for money was achieved.

(v) All tenders should, subject to compliance with the provisions of the Freedom of Information Act 2000 as amended, be treated as confidential and should be retained for:

(a) 6 years after contract completion - successful tenders
(b) 6 years after contract start - unsuccessful tenders.

(vi) All tenders should be assessed for embedded derivatives and embedded leases utilising a standard checklist. Any proposed tender award which indicates the existence of either should be notified to the Assistant ~~Director of Finance~~Chief Finance Officer – Financial Services, prior to award.

17.6 Authorisation of Procurement Awards (Internal Trust Process)

Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation for the awarding of a contract (internal Trust process) must be authorised by the following staff to the value of the contract as follows:

	Threshold Value (total requirement)	Operational Purchasing Manager	Head of Category Procurement Governance Manager	Deputy Director of Procurement	~~Director of Finance~~Chief Finance Officer	Chief Executive	Trust Board
Aggregated Total Contract Value	< £10,000	✔					
	< £25,000	✔	✔				
	< £100,000		✔	✔			
	< £250,000		✔	✔	✔		
	< £250,000 - £1m		✔	✔	✔	✔	
	£1m+		✔	✔	✔	✔	✔

For all contract awards requiring Trust Board approval, these must be submitted to FPEC for assurance.

These levels of authorisation may be varied or changed only with the express agreement of the Trust Board.

Formal authorisation to initiate any procurement process must be put in writing in the form of a Procurement Sponsorship Form for all procurement processes where the award value is expected to exceed £25,000..

17.7 Signing of Commercial Procurement Contracts (External Document)

17.7.1 The signing of the commercial procurement contracts must only be undertaken by the following Trust Staff and within the identified value limits

< £50,000 – Deputy Director of Procurement
£50,000 – £250,000 ~~Director of Finance~~Chief Finance Officer
>£250,000 – ~~Director of Finance~~Chief Finance Officer and Chief Executive

17.8 Private Finance and leasing for capital procurement (see overlap with SFI No. 24)

17.8.1 When the Board proposes, or is required, to use finance provided by the private sector (PFI) the following should apply:

(a) The ~~Director of Finance~~Chief Finance Officer shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

(b) Where the sum exceeds delegated limits, a business case must be referred to the appropriate department or agency for approval or treated as per current guidelines.

(c) The proposal must be specifically agreed by the Board of the Trust.

(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

17.8.2 Where it is proposed that leasing be considered in preference to capital procurement then the following should apply:

(a) The selection of a contract / finance company shall be on the basis of a competitive process;

(b) All proposals to enter into a leasing agreement shall be referred to the ~~Director of Finance~~Chief Finance Officer before acceptance of any offer;

(c) The ~~Director of Finance~~Chief Finance Officer shall ensure that the proposal demonstrates best value for money; and

(d) The proposal shall be agreed in writing by the ~~Director of Finance~~Chief Finance Officer prior to acceptance of any offer to the lease.

In the case of property leases the relevant NHS guidance shall be followed and procurement rules do not apply.

17.9 Compliance requirements for all contracts

The Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a) The Trust's Standing Orders and Standing Financial Instructions;

(b) UK Procurement Regulations and other statutory provisions;

(c) any relevant directions issued by Treasury, the Department of Health or other Statutory Body.

(d) such of the NHS Standard Contract Conditions as are applicable.

(e) contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance.

(f) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis of the Procurement.

(g)

17.10 Personnel and Agency or Temporary Staff Contracts (see overlap with SFI Nos. 20.6, 20.9, 21.2.3)

The Chief Executive shall nominate officers with delegated authority to design and operate a process for engaging with and enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

17.11 Healthcare Services Agreements (see overlap with SFI No. 18)

Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with the National Health Service Act 2006 as amended and administered by the Trust. Service agreements are not contracts in law and therefore not enforceable by the courts. However, a contract with a Foundation Trust, being a PBC, is a legal document and is enforceable in law.

The Chief Executive shall nominate officers to commission service agreements with providers of healthcare in line with a commissioning plan approved by the Board.

Where Health Services require an external contractor or non-NHS provider, SFI 17.4.2 must be considered.

17.12 Disposals (See overlap with SFI No 26)

Competitive Procurement procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his/her nominated officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;

(c) items to be disposed of with an estimated sale value of less than £5,000, this figure to be reviewed on a periodic basis;

(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

(e) land or buildings concerning which DH guidance has been issued but subject to compliance with such guidance.

17.13 In-house Services

17.13.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also

determine from time to time that in-house services should be market tested by competitive procurement.

17.13.2 In all cases where the Board determines that in-house services should be subject to competitive procurement the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or nominated officer/s and specialist/s.

(b) In-house bid group, comprising a nominee of the Chief Executive and technical support.

(c) Evaluation team, comprising normally a specialist officer, a Procurement Officer and ~~Director of Finance~~Chief Finance Officer or nominated representative. For services having a likely annual expenditure exceeding £ 1,000,000, a non-officer member should be a member of the evaluation team.

17.13.3 All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house bid group may participate in the evaluation.

17.13.4 The evaluation team shall make recommendations to the Board.

17.13.5 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

17.14 Applicability of SFIs to Procurement using funds held in trust (see overlap with SFI No. 29)

These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased by the United Lincolnshire Hospitals Trust Charity.

17.15 Cancellation of Contracts

17.15.1 Except where specific provision is made in model forms of contracts or standard schedules of conditions approved for use within the NHS, there shall be inserted in every written contract a clause empowering the Trust to cancel the contract and to recover from the contractor the amount of any loss resulting from such cancellation, if:

(a) the contractor shall have offered, or given or agreed to give, any person any gift or consideration of any kind as an inducement or reward for doing or forbearing to do or for having done or forborne to do any action in relation to the obtaining or execution of the contract or any other contract with the Trust;

(b) for showing or forbearing to show favour or disfavour to any person in relation to the contracts or any other contract with the Trust, or if the like acts shall have been done by any person employed by him or acting on his behalf (whether with or without the knowledge of the contractor);

(c) in relation to any contract with the Trust the contractor or any person employed by him or acting on his behalf shall have committed any offence under the extant Bribery Act and other appropriate legislation.

17.16 Determination of Contracts for Failure to Deliver Goods or Material

There shall be inserted in every written contract for the supply of goods or materials a clause to secure that, should the contractor fail to deliver the goods or materials or any portion thereof within the time or times specified in the contract, the Trust may without prejudice determine the contract either wholly or to the extent of such default and purchase other goods, or material of similar description to make good:

(a) such default, or
(b) in the event of the contract being wholly determined the goods or materials remaining to be delivered.

Further the amount by which the cost of purchasing other goods or materials exceeds the amount which would have been payable to the contractor in respect of the goods or materials shall be recoverable from the contractor.

18. AGREEMENTS FOR PROVISION OF HEALTHCARE SERVICES (see overlap with SFI No. 17.11)

18.1 The Chief Executive, as the Accountable Officer of the Trust, supported by the ~~Director of Finance~~Chief Finance Officer and Deputy Chief Executive, is responsible for negotiating contracts with commissioners for the provision of services to patients in accordance with national guidance and the Annual Plan.

18.2 All agreements should aim to implement the agreed priorities contained within the NHS Operating Framework and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- the standards of service quality expected;
- the provision of reliable information on cost and volume of services;
- existing agreements, to ensure where appropriate they build on existing partnership arrangements;
- the mandated performance indicators;
- existing Joint Investment Plans;
- the need to ensure agreements are based on integrated care pathways; and any model contracts issued by the Department of Health and Social Care.

In carrying out these functions, the Chief Executive should take account the advice of the ~~Director of Finance~~Chief Finance Officer regarding:

- the National Tariff Payment System and associated guidance (e.g. national activity recording and coding requirements, the National Grouper etc.) and the costing and pricing of services;
- payment terms and conditions;
- amendments to agreements and other NHS patient services arrangements.

All agreements should be underpinned by the NHS standard contract clauses.

18.3 Involving partners and jointly managing risk

The risks involved in joint working will be assessed and articulated within a legally binding contract. Such a contract will be informed by the view of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the ~~Director of Finance~~Chief Finance Officer to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The agreement will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

18.4 Sub-contracting Provision of Services to Non-NHS Providers

Where the Trust makes arrangements for the provision of services by non-NHS providers, it is the ~~Director of Finance~~Chief Finance Officer, who is responsible for ensuring that the agreements put in place have due regard to the quality and the cost-effectiveness of the services provided. Before making any agreement with non-NHS providers, the Trust should explore fully the scope to make maximum cost-effective use of NHS facilities and ensure all sub-contracting is in accordance with the NHS Standard Contract. This is to ensure that the quality and performance measures reflect the Trust contract with their main commissioners.

18.5 The ~~Director of Finance~~Chief Finance Officer, on behalf of the Chief Executive, shall be responsible for drawing up and agreeing to the financial details and terms and conditions contained in the legally binding contract entered into by the Trust.

18.6 Agreements should be so devised as to minimise risk whilst maximising the Trust's opportunity to generate income. Agreement prices shall comply with the latest costing guidelines.

18.7 The ~~Director of Finance~~Chief Finance Officer shall be responsible for establishing arrangements for the identifying, gaining approval for and invoicing of other NHS patient services referrals.

18.8 Reports to Board on contracts

The ~~Director of Finance~~Chief Finance Officer will ensure that regular reports are provided to the Board detailing actual and forecast income from the contracts. Contract performance will be reported separately by the Deputy Chief Executive.

19. COMMISSIONING

Not applicable

20. HUMAN RESOURCES AND PAY

20.1 Remuneration and Terms of Service (see overlap with SO No. 5.7)

20.1.1 In accordance with Standing Orders the Board shall establish a Remuneration and Terms of Service Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

20.1.2 The Committee will:

(a) advise the Board about appropriate remuneration and terms of service for the Chief Executive, other officer members employed by the Trust and other senior employees including:

(i) all aspects of salary (including any performance-related elements/bonuses);

(ii) provisions for other benefits, including pensions and cars;

(iii) arrangements for termination of employment and other contractual terms;

(b) make such recommendations to the Board on the remuneration and terms of service of officer members of the Board (and other senior employees) to ensure they are fairly rewarded for their individual contribution to the Trust - having

proper regard to the Trust’s circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate;

(c) monitor and evaluate the performance of individual officer members (and other senior employees);

(d) receive assurance from appropriately qualified officers of the trust in regard to appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate;

(e) advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments exceeding £50,000 taking account of such national guidance as is appropriate.

- For any payment less than £50,000 the Executive Team has authority to consider and approve.
- For any termination payment over £150,000 the payment must gain Board approval.

(f) Special severance payments (those outside normal statutory or contractual requirements) cannot be made without Treasury and Board approval

20.1.3 The Committee shall report in writing to the Board the basis for its recommendations. The Board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of officer members. Minutes of the Board's meetings should record such decisions.

20.1.4 The Board will consider and need to approve proposals presented by the Chief Executive for the setting of remuneration and conditions of service for those employees and officers not covered by the Committee.

20.1.5 The Trust will pay allowances to the Chairman and non-officer members of the Board in accordance with instructions issued by the Secretary of State for Health.

20.2 Funded Establishment

20.2.1 The Executive Devolution Policy provides for a degree of earned autonomy to be reflected in the delegation of powers to Directorates and Divisions in varying Establishment. Unless otherwise devolved, the following apply:

- The workforce plans incorporated within the annual budget will form the funded establishment.
- All new posts must be approved through the business planning process.
- The funded establishment of any department may not be varied in any way which causes expenditure to exceed the authorised annual budget without the prior written approval of the ~~Director of Finance~~Chief Finance Officer or nominated deputy.

20.2.2 The authority to fill a funded post on the establishment with permanent or fixed term staff sits with the budget holder except when the Trust is operating under special measures when this authority may be rescinded.

20.2.5 The authority each budget manager is attributed in relation to all pay and non-pay decisions is set out within the Executive Devolution Policy (See SFI No. 13.3.1 and 21.2)

20.3 Staff Appointments

20.3.1 No officer or Member of the Trust Board or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration unless:

(a) authorised to do so by the Chief Executive;

(b) within the limit of their approved budget and funded establishment or as set out within the Executive Devolution Policy.

20.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc., for employees.

20.3.3 Any monies due to employees as a result of all employments with the Trust howsoever arising shall be paid through the Trust payroll.

20.4 Variation to existing job plans

20.4.1 Only the Clinical Director or Business Manager of the relevant Clinical Business Unit can authorise variations to existing job plans within the agreed budget.

20.5 Authorisation of overtime and additional sessions

20.5.1 The budget holder is responsible for authorising overtime and additional sessions.

20.5.2 Overtime and additional sessions must be authorised prior to being worked. In exceptional circumstances where documentation or electronic systems are not authorised prior to the work being undertaken, these must be completed as soon as possible.

20.6 Authority to engage bank and agency staff, Self-employed or Third Party Workers

20.6.1 Within delegated budget:

(a) The budget holder holds the responsibility to authorise the booking of bank and agency staff or self-employed or Third Party Workers

Outside of delegated budget:

(b) The booking of bank and agency personnel or self-employed or Third Party Workers outside of budget must be agreed in advance with the appropriate Executive Director in consultation with the ~~Director of Finance~~Chief Finance Officer.

20.6.2 All bookings of bank or agency staff must be made through the agreed process, variations to this can only be made with the express authority of the ~~Director of Finance~~Chief Finance Officer.

20.7 Leave Policy

20.7.1 The Director of Human Resources is responsible for agreement and publication of Leave Policy, to cover Annual, Maternity, Paternity and other Special Leave categories.

20.7.2 The Director of Human Resources is responsible for agreement and implementation of a Policy to support Career Breaks.

20.8 Redundancy

20.8.1 All staff redundancies must be authorised by the ~~Director of Finance~~Chief Finance Officer.

20.9 Engagement of Workers off Payroll – (see overlap with SFI No 21.2.3)

20.9.1 The ~~Director of Finance~~Chief Finance Officer shall issue detailed guidance setting out responsibilities and required actions for managers engaging workers ‘off-payroll’.

20.9.2 Only in exceptional cases should a worker be engaged and not paid through the Trust payroll.

20.9.3 Prior to engagement, the tax status of the ‘worker’ must be determined. To facilitate this, the engaging manager must complete an online IR35 assessment which prior to engagement must be reviewed and agreed by a nominated officer within the Finance Directorate.

20.9.4

20.9.5 Appropriate arrangements shall be in place to ensure that income tax deductions and national insurance contributions for both the Trust and worker are properly made and paid to HM Revenue & Customs in line with current legal and regulatory requirements.

20.9.6 ~~NHSI~~NHSE payment Caps may not be exceeded without the express agreement of the appropriate Executive Director;

20.10 Processing Payroll

20.10.1 The ~~Director of Finance~~Chief Finance Officer is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;

(b) the final determination of pay and allowances;

(c) making payment on agreed dates;

(d) agreeing method of payment.

20.10.2 The ~~Director of Finance~~Chief Finance Officer will issue instructions regarding:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the Data Protection Act;

(g) procedures for payment by cheque, bank direct credit (including BACS), or cash to employees and officers;

(h) procedures for the recall of bank direct credits (including BACS) and stopping of cheques;

(i) Pay advances and their recovery;

(j) maintenance of regular and independent reconciliation of pay control accounts;

(k) separation of duties of preparing records;

(l) a system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

20.10.3 The Budget Holder has delegated responsibility for:

(a) submitting time records, and other notifications in accordance with agreed timetables;

(b) submitting appointment forms and change forms in the prescribed form, immediately upon knowing the effective date of an employee's appointment or change in circumstances;

(c) completing time records and other notifications in accordance with the ~~Director of Finance~~Chief Finance Officer' instructions and in the form prescribed by the ~~Director of Finance~~Chief Finance Officer;

(d) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfill obligations in circumstances that suggest they have left without notice, the ~~Director of Finance~~Chief Finance Officer must be informed immediately.

20.10.4 Individual employees are responsible for:

(a) Keeping accurate time records

(b) Submitting time records and claims for reimbursement of overtime, enhancements and extra duties to line management for authorisation each month or where required more frequently in accordance with published timetables

(c) Submitting claims for reimbursement of travel and other expenses within 3 months of being incurred. Claims outside this period must be authorised by the ~~Director of Finance~~Chief Finance Officer or nominated Deputy.

(d) Checking their pay each month and immediately notifying Payroll of any identified error for correction in the following pay period.

20.10.5 Regardless of the arrangements for providing the payroll service, the ~~Director of Finance~~Chief Finance Officer shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

20.10.6 All timesheet, pay records and other pay notifications shall be certified and submitted in accordance with the instructions of the ~~Director of Finance~~Chief Finance Officer. A

list of designated authorising Officers shall be maintained, detailing the limits of authorisation and shall contain specimen signatures.

20.10.7 The ~~Director of Finance~~Chief Finance Officer shall determine the dates on which the payment of salaries, wages, expenses, allowances, termination or compensation payments, and any other form of remuneration are to be made, having regard to the general rule that it is undesirable to make payments in advance, except in special circumstances.

20.10.8 The ~~Director of Finance~~Chief Finance Officer will publish a salary overpayments and advances policy detailing the Trust approach to and process for recovery of overpayments and circumstances under which an advance of salary may be made.

20.11 Contracts of Employment

20.11.1 It is the responsibility of the Director of Human Resources for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation;

(b) dealing with variations to, or termination of, contracts of employment in accordance with the requirements of Standing Orders and Standing Financial Instructions

21. NON-PAY EXPENDITURE

21.1 Delegation of Authority

21.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the ~~Director of Finance~~Chief Finance Officer will determine the level of delegation to budget managers.

21.1.2 The ~~Director of Finance~~Chief Finance Officer will set out:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services;

(c) the maximum level of each requisition and the system for authorisation above that level.

The list of managers and limits of financial authority will be set out within the Trust authorisation matrix hierarchy. This defines the actions individuals have delegated authority to carry out on behalf of the Trust. The authority will be restricted in most cases to a limited range of budget areas for which the manager is responsible. The matrix incorporates delegated authority in relation to Human Resources (e.g. recruitment), Procurement / Invoice authorisation, Admin rights, budget amendments and Charitable Fund requests.

21.1.3 No contract in respect of the supply of revenue or capital goods and/or services may be authorised other than by approved budget managers in conjunction with advice from Procurement or Estates services or exceptionally by the Chief Executive. The approved manager shall not authorise a contract in respect of a budget for which they are not accountable.

21.1.4 The ~~Director of Finance~~Chief Finance Officer shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

21.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services (see overlap with SFI No. 17)

21.2.1 **Requisitioning**

The requisitioner in specifying the item to be supplied (or the service to be performed) shall always engage with Procurement Services to obtain the best value for money for the Trust.

21.2.2 It should be the duty of the Associate Director of Procurement to exercise general supervision over all purchases, except for drugs and pharmaceutical supplies. After making reasonable efforts to resolve conflicts, and having due regard to materiality, he shall inform the ~~Director of Finance~~Chief Finance Officer of any requisition which appears to be in conflict with the Trust's Standing Orders and Standing Financial Instructions. In the case of drugs and pharmaceutical supplies this duty falls to the Chief Pharmacist.

21.2.3 Where services are required from an individual, consideration should be given to the nature of the role to be undertaken to ensure that the contract will be a contract FOR services (non-pay) and not a contract OF service (pay). It is the responsibility of the Budget Manager to ensure that when making an appointment or agreement for services that the individual is paid appropriately in accordance with the relevant tax regime. This also applies where services are offered by ex-employees or individuals supplying through their own personal service companies: it is the nature of the role which determines the appropriate pay or non-pay arrangement and advice of the Procurement team should be sought where necessary.
The relevant Finance Manager must be consulted when engaging with a PSC for the provision of personal services to ensure IR35 tax legislation is consistently applied. (see overlap with SFI 20.9)

21.2.4 **System of Payment and Payment Verification**

The ~~Director of Finance~~Chief Finance Officer shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

21.2.5 The ~~Director of Finance~~Chief Finance Officer will:

(a) advise the Board regarding the setting of thresholds for each route to procurement ; and, once approved, the thresholds should be incorporated in Standing Orders and Standing Financial Instructions and regularly reviewed;

(b) prepare procedural instructions and guidance for governing the procurement of non-pay goods and services within agreed authorisation limits.

(c) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) A list of Trust employees (including specimens of their signatures where appropriate) authorised to certify invoices.

(ii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;

- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;

- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;

- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;

- the account is arithmetically correct;

- the account is in order for payment.

(iii) A timetable and system for submission to the ~~Director of Finance~~Chief Finance Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(d) be responsible for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions are set out in SFI No. 21.2.6 below.

21.2.6 **Prepayments**

Prepayments are only permitted where exceptional circumstances apply. The ~~Director of Finance~~Chief Finance Officer will provide a list of suppliers or services where payment in advance is permitted. Any situations not covered will require explicit authorisation from the ~~Director of Finance~~Chief Finance Officer. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages.

(b) The appropriate budget holder must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

(c) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

21.2.7 **Official orders**

All goods, services or works will unless otherwise exempted be ordered on an official order and contractors shall be notified that they should not accept orders unless in an official form. The only exceptions to raising an official order shall be for:

(a) cases of emergency or urgent necessity where a confirmation order number should be used.;

(b) those specific approved goods and services for which a non-stock requisition is not required (as advised by the Head of Procurement on the 'Official exemption list).

(c) those purchases made with a procurement card or by petty cash in accordance with the relevant approved procedure.

Official Orders must:

(a) be uniquely numbered;
(b) be in a form approved by the ~~Director of Finance~~Chief Finance Officer;
(c) state the Trust's terms and conditions of trade;
(d) only be issued to, and used by, those duly authorised by the Chief Executive.
(e) Confirmation order numbers shall be issued only by an Officer designated by the Chief Executive and used only in cases of emergency or urgent necessity. These shall be confirmed by an official order issued as soon as possible and ideally the next working day. The order should be clearly marked "Confirmation Order".

Orders / requisitions shall only be raised (or electronically processed) by Officers so authorised by the Chief Executive.
Lists of authorised Officers shall be maintained detailing the limits of authorisation within the Trust authorisation matrix (SFI 21.1.2).

21.2.8 **Purchasing Cards**

(a) All purchase cards are issued subject to the appropriate budget holder completing a business case of need, and authorisation by the Associate Director of Procurement.
(b) The card must be utilised according to the procedures documented in the Purchase Card Manual.
(c) Purchase card transactions and relevant backing information will be subject to audit by finance to ensure it is appropriately completed and stored.
(d) Illicit use of the purchase card for inappropriate or personal spend will result in disciplinary action and referral to the local counter fraud specialist where applicable.

21.2.9 **Duties of Managers and Officers**

Managers and officers must ensure that they comply fully with the guidance and limits specified by the ~~Director of Finance~~Chief Finance Officer and that:

(a) all contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the ~~Director of Finance~~Chief Finance Officer in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement;

(c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health and Social Care;

(d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(ii) conventional hospitality, such as lunches in the course of working visits;

(This provision needs to be read in conjunction with the Trust's "Standards of Business Conduct and Declarations of Interest Policy");

(e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the ~~Director of Finance~~Chief Finance Officer on behalf of the Chief Executive;

(f) all goods, services, or works (unless specifically exempted by the ~~Director of Finance~~Chief Finance Officer – SFI 21.2.7) are ordered on an official order;

(g) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(h) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase (indemnity forms should be completed for all trial/loan and free issue equipment); All trials or loans must be authorised in advance through the relevant governance structure.

(i) changes to the list of employees and officers authorised to commit resources and certify invoices are notified to the ~~Director of Finance~~Chief Finance Officer;

(j) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the ~~Director of Finance~~Chief Finance Officer;

(k) petty cash records are maintained in a form as determined by the ~~Director of Finance~~Chief Finance Officer.

21.2.10 No Officer shall place a requisition, purchase from petty cash, by procurement card or require an official order to be raised with an individual to whom they are related or with any person or organisation with whom they hold a financial interest or from whom they are likely to receive any payment, gift or other consideration, without first making a disclosure. of the circumstances in writing to the Chief Executive and receiving his written authority to proceed. A copy of an authority so given must be lodged with the ~~Director of Finance~~Chief Finance Officer.
Related Party disclosure should be made in accordance with the Trust Standards of Business Conduct and Declarations of Interest policy.

21.2.11 The Chief Executive and ~~Director of Finance~~Chief Finance Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within the high level principles described within Health Building Note 00-08. The evaluation of the efficiency and effectiveness of these contracts shall be the responsibility of the ~~Director of Estates and Facilities~~Chief Estates and Facilities Officer.

22. EXTERNAL BORROWING

22.1.1 The ~~Director of Finance~~Chief Finance Officer will advise the Board concerning the Trust's ability to pay dividend on, and repay Public Dividend Capital and any proposed new borrowing, within the limits set by the Department of Health and Social Care. The ~~Director of Finance~~Chief Finance Officer is also responsible for reporting periodically to the Board concerning the PDC debt and all loans and overdrafts.

22.1.2 The ~~Director of Finance~~Chief Finance Officer shall be responsible for ensuring that the best value is obtained in securing loan finance and other sources of external

funding and shall prepare detailed procedural instructions concerning applications for loans and overdrafts and on the form or records to be maintained.

22.1.3

22.1.4 Borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position, represent good value for money, and comply with the latest guidance from the Department of Health and Social Care.

22.1.5 Any short-term borrowing must be with the authority of two members of an authorised panel, one of which must be the Chief Executive or the ~~Director of Finance~~Chief Finance Officer. The Board must be made aware of all short term borrowings at the next Board meeting.

22.1.6 All long term borrowings must be agreed by the Trust Board. Loan documentation must be authorised by the Chief Executive and ~~Director of Finance~~Chief Finance Officer.

22.1.7 All long term borrowing must be consistent with the plans outlined in the current financial plan as reported to the Department of Health and Social Care and be approved by the Trust Board.

22.1.8 The ~~Director of Finance~~Chief Finance Officer is responsible for ensuring that an adequate system of monitoring financial performance is in place to enable the Trust to fulfill the requirement to maintain adequate cash balances. The Board of Directors will receive details of the Trust's performance from the ~~Director of Finance~~Chief Finance Officer.

23. FINANCIAL FRAMEWORK

23.1.1 The ~~Director of Finance~~Chief Finance Officer should ensure that members of the Board are aware of the NHS Financial Regime. The ~~Director of Finance~~Chief Finance Officer should also ensure that the direction and guidance issued as part of the NHS Financial Regime is followed by the Trust.

24. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

24.1 Capital Investment

24.1.1 The Chief Executive:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to budget;

(c) shall ensure that the capital investment is not undertaken without confirmation of Commissioner support (where appropriate) and the availability of resources to finance all revenue consequences, including VAT and capital charges.

24.1.2 For every capital expenditure proposal the Chief Executive shall ensure:

(a) that a business case (in line with current Department of Health and Social Care guidance and the Trusts Investment Appraisal Framework is produced setting out:

(i) an option appraisal of potential financial and non-financial benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

(ii) the involvement of appropriate Trust personnel and external agencies;

(iii) appropriate project management and control arrangements;

(b) that the ~~Director of Finance~~Chief Finance Officer has certified professionally to the costs and revenue consequences detailed in the business case and involved appropriate Trust personnel and external agencies in the process.

(c) that advice is taken and acted upon to minimise the VAT and other taxes payable;

24.1.3 For capital schemes where the contracts stipulate stage payments, the ~~Director of Finance~~Chief Finance Officer will issue procedures for their management.

24.1.4 The ~~Director of Finance~~Chief Finance Officer shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with HM Revenue and Customs guidance.

24.1.5 The ~~Director of Finance~~Chief Finance Officer shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure. This as a minimum shall include reporting to the Board on:

(a) an individual scheme / project

(b) the source and level of funding, and

(c) the expenditure incurred against the annual plan profile

24.1.6 The approval of a capital programme shall not constitute approval for the initiation of expenditure on any individual scheme, because it is also necessary to undertake the mandatory procurement processes of the Trust.

The Chief Executive shall issue to the manager responsible for any scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender (see overlap with SFI No. 17.6);

(c) approval to accept a successful tender (see overlap with SFI No. 17.6).

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with current Department of Health and Social Care guidance and the Trust's Standing Orders.

24.1.7 The ~~Director of Finance~~Chief Finance Officer shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

24.1.8 The ~~Director of Finance~~Chief Finance Officer shall issue procedures for the use of capital receipts from the sale of assets and will ensure that the Trust's financial plans incorporate any expected capital receipts.

24.1.9 The Board of Directors will approve details of the Capital Expenditure Programme as part of the Annual Plan.

24.1.10 The Board of Directors will approve the acquisition / disposal of land and property.

24.1.11

24.1.11 The classification and recording of capital expenditure should be in accordance with the requirements laid down in the Department of Health Group Accounting Manual.

24.2 Private Finance and leases (see overlap with SFI No. 17.8)

24.2.1 The Trust should consider market-testing against Private Finance Initiative Funding (PFI) and / or leasing agreements when considering a large capital procurement.

24.3 Asset Registers

24.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the ~~Director of Finance~~Chief Finance Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted on a rolling basis every two years.

24.3.2 Each Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be sufficient to meet requirements set out within International Financial Reporting Standards and other requirements as stipulated in the Department of Health Group Accounting Manual.

24.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

(b) stores, requisitions and salary records for own materials and labour including appropriate overheads;

(c) lease agreements in respect of assets held under a finance lease and capitalised.

24.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

24.3.5 The ~~Director of Finance~~Chief Finance Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

24.3.6 The value of each asset shall be depreciated using methods and rates as specified in the Trust's accounting policies and indexed / revalued annually as appropriate.

24.3.7 The ~~Director of Finance~~Chief Finance Officer shall calculate and make dividend payments in accordance with instructions issued by the Department of Health.

24.4 Security of Assets

24.4.1 The overall control of non-current assets is the responsibility of the Chief Executive.

24.4.2 Asset control procedures (including fixed assets, cash, cheques, negotiable instruments, and donated assets) must be approved by the ~~Director of Finance~~Chief Finance Officer. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset;

(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

24.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the ~~Director of Finance~~Chief Finance Officer who may also undertake such other independent checks as considered necessary.

24.4.4 Whilst each employee and officer has a responsibility for the security of property of the Trust; it is the responsibility of Board members and senior employees in all disciplines to apply such appropriate routine security checks and practices in relation to Trust and NHS property as may reasonable or as otherwise specified by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

24.4.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses – see SFI 26.2.

24.4.6 Where practical, assets should be marked as Trust property.

24.4.7 Employees unless specifically authorised by the Chief Executive shall not use Trust assets for personal use.

24.4.8 The up-to-date maintenance and annual checking of asset records shall be the responsibility of designated departmental managers or Budget Holders for all items for which the initial purchase or replacement is within their delegated responsibilities.

24.4.9 Registers shall be maintained to record all controlled items issued to individuals, and where practicable, receipts shall be obtained.

24.4.10 Records shall also be maintained and receipts obtained for:

- equipment on loan to patients; and
- all contents of furnished lettings.

25. STORES AND RECEIPT OF GOODS

25.1 General position

25.1.1 Stocks are those goods normally utilised in day-to-day activity but which, at any point in time, have not yet been consumed (excluding capital assets). They are usually held in controlled stores and within departments.

Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum level commensurate with delivery and cost effective purchasing;

(b) subjected to annual stock take;

(c) valued at the lower of cost and net realisable value except where otherwise determined by the Trust's accounting policies.

25.2 Control of Stores, Stocktaking, condemnations and disposal

25.2.1

Subject to the requirements of the ~~Director of Finance~~Chief Finance Officer for the systems in use, overall responsibility for the control of stores shall be delegated to an Officer by the Chief Executive. The day-to-day responsibility may be delegated by him to departmental employees and stores managers/keepers The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel to a designated estates manager.

25.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as Trust property.

25.2.3 The ~~Director of Finance~~Chief Finance Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.
All stock records shall be in such form, and shall comply with such systems of control, as the ~~Director of Finance~~Chief Finance Officer shall approve.

25.2.4 Stocktaking arrangements shall be agreed with the ~~Director of Finance~~Chief Finance Officer and there shall be a physical check covering all items in store at least once a year. The physical check shall involve at least one Officer other than the storekeeper and his staff. The stocktaking records shall be numerically controlled and signed by the Officers undertaking the check. Any surplus or deficiencies revealed on stocktaking shall be reported to the ~~Director of Finance~~Chief Finance Officer immediately.

25.2.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the ~~Director of Finance~~Chief Finance Officer.

25.2.6 The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the ~~Director of Finance~~Chief Finance Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the ~~Director of Finance~~Chief Finance Officer any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI No 26 Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

25.3 Goods supplied by NHS Supply Chain

25.3.1 For goods supplied via NHS Supply Chain central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note and report

discrepancies to avoid overpayment where such discrepancies cannot be resolved via the Procurement Team.

26. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

26.1 Disposals and Condemnations

26.1.1 **Procedures**

The ~~Director of Finance~~Chief Finance Officer must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

26.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will determine the estimated market value of the item, taking account of professional advice where appropriate. Advice should be sought from the Deputy Director of Procurement as to the most appropriate disposal process (for example: auctions < £5,000 market value or quotation / tender > £5,000).
(see overlap with SFI 17.14)

26.2 Losses and Special Payments

26.2.1 **Procedures**

The ~~Director of Finance~~Chief Finance Officer must prepare procedural instructions on the recording, approval of and accounting for losses, and special payments.

26.2.2 Any officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the ~~Director of Finance~~Chief Finance Officer or confidentially inform an officer charged with responsibility for responding to concerns involving loss or potential fraud. This officer will then appropriately inform the ~~Director of Finance~~Chief Finance Officer.
The loss must be recorded by the Officer on Datix (risk management system) and a Datix reference number obtained.

26.2.3 Where a criminal offence is suspected, the ~~Director of Finance~~Chief Finance Officer must have in place provision to immediately inform the police.
In cases of theft or arson the ~~Director of Finance~~Chief Finance Officer must immediately inform the police.
In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the ~~Director of Finance~~Chief Finance Officer must inform the Local Counter Fraud Specialist (LCFS).

26.2.4 The ~~Director of Finance~~Chief Finance Officer must ensure arrangements are in place to notify the Audit committee of all suspected frauds.

26.2.5 For losses apparently caused by theft, fraud, arson, neglect of duty or gross carelessness, except if trivial and where fraud is not suspected, the ~~Director of Finance~~Chief Finance Officer must ensure the following are notified:-

(a) the Board of Directors; and
(b) the External Auditor

26.2.6 The Audit Committee shall approve the writing-off of losses and special payments

26.2.7 For any loss, the ~~Director of Finance~~Chief Finance Officer should consider whether any insurance claim can be made.

26.2.8 The ~~Director of Finance~~Chief Finance Officer shall maintain a Losses and Special Payments Register in which write-off action is recorded.

26.2.9 No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health and Social Care.

26.2.10 All losses and special payments must be reported to the Audit Committee on a quarterly basis.

26.2.11 The ~~Director of Finance~~Chief Finance Officer shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations. This should include:

(a) when a bankruptcy, liquidation or receivership is discovered, all payments should be ceased pending confirmation of the bankruptcy, etc. As a matter of urgency, a statement must be prepared listing the amounts due to and from the Trust.

(b) ensuring that any payments due by the Trust are made to the correct person.

(c) ensuring that any claim by the Trust is properly lodged with the correct party and without delay.

27. INFORMATION TECHNOLOGY

27.1 Responsibilities and duties of the ~~Director of Finance~~Chief Finance Officer

27.1.1 The ~~Director of Finance~~Chief Finance Officer, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which the Director is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 2018 and any subsequent legislation;

(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director may consider necessary are being carried out.

27.1.2 The ~~Director of Finance~~Chief Finance Officer shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

27.1.3 The ~~Director of Finance~~Chief Finance Officer shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our Trust that we make publicly available.

27.2 Contracts for Computer Services with other health bodies or outside agencies

The ~~Director of Finance~~Chief Finance Officer shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

Where another health organisation or any other agency provides a computer service for financial applications, the ~~Director of Finance~~Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.

27.3 Risk Assessment

The Deputy Chief Executive shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans and vulnerability to cyber-security attack.

27.4 Requirements for Computer Systems which have an impact on corporate financial systems

Where computer systems have an impact on corporate financial systems the Deputy Chief Executive shall need to be satisfied that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as the Integrated Digital Care Strategy;

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) ~~Director of Finance~~Chief Finance Officer staff have access to such data;

(d) such computer audit reviews as are considered necessary are being carried out.

27.5 Acquisition and Disposal of Computer Systems

The ~~Director of Finance~~Chief Finance Officer will devise procedures which ensure that orders for the acquisition of computer hardware, software and services (other than consumables) are placed in accordance with the Integrated Digital Care strategy.

27.6 The ~~Director of Finance~~Chief Finance Officer will ensure that separate control procedures are put in place for computer systems. This procedure will include:

- the acquisition and disposal of IT, systems and equipment;
- the decommissioning of systems containing confidential data; and in accordance with any guidance issued by the Information Commissioner and the Department of Health and Social Care.

28. PATIENTS' PROPERTY

28.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of terminal or deceased patients in hospital.

28.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets;

- hospital admission documentation and property records;
- the advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

28.3 The ~~Director of Finance~~Chief Finance Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients.

28.4 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates (Small Payments) Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

28.5 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

28.6 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

29. FUNDS HELD ON TRUST

29.1 Corporate Trustee

(1) Standing Order No. 2 outlines the Trust’s responsibilities as corporate trustee for the management of funds it holds on trust, along with SFI 4.8.3 that defines the need for compliance with Charities Commission latest guidance and best practice.

(2) The discharge of the Trust’s corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

The ~~Director of Finance~~Chief Finance Officer shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

29.2 Accountability to Charity Commission and Secretary of State for Health and Social Care

(1) The trustee responsibilities must be discharged separately and full recognition given to the Trust’s dual accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for health and Social Care for all Exchequer funds.

(2) The Schedule of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Trust Board members and Trust officers must take account of that guidance before taking action.

29.3 Applicability of Standing Financial Instructions to funds held on Trust

(1) In so far as applicable these Standing Financial Instructions will apply to the management of funds held on trust. (See overlap with SFI No 17.16).

(2) The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

30. ACCEPTANCE OF GIFTS BY STAFF AND LINK TO STANDARDS OF BUSINESS CONDUCT (see overlap with SO No. 6 and SFI No. 21.2.6 (d))

The ~~Director of Finance~~Chief Finance Officer shall ensure that all staff are made aware of the Trust Standards of Business Conduct and Declarations of Interest policy. This policy deemed to be an integral part of these Standing Orders and Standing Financial Instructions (see overlap with SO No. 6).

31. PAYMENTS TO INDEPENDENT CONTRACTORS

Not applicable to NHS Trusts

32. RETENTION OF RECORDS

32.1 All NHS records are public records under the terms of the Public Records Act 1958 Section 3 (1) – (2). The Chief Executive and senior managers of the Trust are personally accountable for records management within the organisation.

32.2 The Trust will follow the latest guidance Records Management Code of Practice for Health and Social Care 2016") issued by NHS Digital. The Records Management Code sets out the minimum length of time for the retention of particular.

32.3 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with the Trust policy.
Records held in archives shall be capable of retrieval by authorised persons.

32.4 Records held in accordance with latest guidance shall only be destroyed at the express instigation of the Chief Executive. Detail shall be maintained of records so destroyed.
Day to day responsibility for decisions to destroy records following achievement of the retention date, and maintenance of the destruction register, is the responsibility of the Records Manager taking into account the provisions of the Records Management Code. The Records Manager is accountable to the SIRO and Chief Executive for decisions taken.

33. RISK MANAGEMENT AND INSURANCE

33.1 Programme of Risk Management

The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current Department of Health and Social Care assurance framework requirements, which must be approved and monitored by the Board.
A Board Assurance Framework shall be in place to enable the monitoring of risk.

The programme of risk management shall include:

a) a process for identifying and quantifying risks and potential liabilities;

b) engendering among all levels of staff a positive attitude towards the control of risk;

c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

d) contingency plans to offset the impact of adverse events;

e) audit arrangements including; Internal Audit, clinical audit, health and safety review;

f) decision on and a clear indication of which risks shall be insured through arrangements with either the Risk Pooling Schemes administered by NHS Resolution or commercial insurance. ;

g) arrangements to review the Risk Management programme.

h) appropriate levels of external accreditation.

These matters shall be defined in more detail in the Risk Management Strategy or Policy. The existence, integration and evaluation of the above elements will support statements and conclusions within the Annual Governance Statement (AGS).

33.2 Insurance: Risk Pooling Schemes administered by NHS Resolution

The Board shall decide if the Trust will insure through the risk pooling schemes administered by NHS Resolution or self-insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

33.3 Insurance arrangements with commercial insurers

33.3.1 The Trust may not enter into insurance arrangements with commercial insurers except:

(1) for the purpose of **insuring motor vehicles** owned by the Trust including insuring third party liability arising from their use;

(2) where the Trust is involved with a consortium in a **Private Finance Initiative contract** and the other consortium members require that commercial insurance arrangements are entered into; and

(3) where **income generation activities** take place, income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from NHS Resolution. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements the ~~Director of Finance~~Chief Finance Officer should consult NHS Resolution.

(4) for the purposes of insuring Directors and Officers against any liability arising in their appointment,

(5) where, in the opinion of the Board of Directors, the level of cover afforded through the NHS Resolution Scheme in the event of significant or total loss of a facility

would be insufficient to enable the re-provision of a safe and appropriate level of care to service users.

33.4 Arrangements to be followed by the Board in agreeing Insurance cover

(1) Where the Board decides to use the risk pooling schemes administered by NHS Resolution the ~~Director of Finance~~Chief Finance Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The ~~Director of Finance~~Chief Finance Officer shall ensure that documented procedures cover these arrangements.

(2) Where the Board decides not to use the risk pooling schemes administered by NHS Resolution for one or other of the risks covered by the schemes, the ~~Director of Finance~~Chief Finance Officer shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The ~~Director of Finance~~Chief Finance Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

(3) All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'excess'). The ~~Director of Finance~~Chief Finance Officer should ensure documented procedures also cover the management of claims and payments below 'excess' levels.

Governance Manual
1.Standing Orders

Reference No:	P_CoG_23
Version:	4.1
Ratified by:	Lincolnshire Community Health Services NHS Trust Board
Date ratified:	9 January 2024
Name of originator/author:	~~Deputy Director of Corporate Governance~~Director of Corporate Affairs
Name of responsible committee/individual:	Audit Committee
Date Approved by committee/individual:	15 February 2023
Date issued:	March 2023
Review date:	July 2024
Target audience:	All staff
Distributed via:	Website

~~Chair: Malcolm Burch~~
~~Group Chief Executive: Andrew Morgan~~

Standing Orders
Version Control Sheet

Version	Section/ Para/ Appendix	Version/ Description of Amendments	Date	Author/ Amended by
1	New Policy	Based on archived P_oG_02	9 October 2018	Interim trust board business manager/ director finance and business intelligence
2	All	Complete review	November 2020	~~Deputy Director of Corporate Governance~~Director of Corporate Affairs
3	All	Review	November 2021	~~Deputy Director of Corporate Governance~~Director of Corporate Affairs
3.1	Minor sections	Minor amends further to legislation change	May 2022	~~Deputy Director of Corporate Governance~~Director of Corporate Affairs
4	Annual review	Full review	January 2023	~~Deputy Director of Corporate Governance~~Director of Corporate Affairs
4.1		This document has been checked by the policy owner who has confirmed that it is fit for use and that it will be fully reviewed and updated as appropriate before the end of the extension period granted by LCHS Trust Board on 11/01/2024	January 2024	Corporate Governance Team
4.2		Interim update to reflect revised voting arrangements and director job titles	October 2024	Director of Corporate Affairs

Copyright © 2024 Lincolnshire Community Health Services NHS Trust, All Rights Reserved. Not to be reproduced in whole or in part without the permission of the copyright owner.

Contents

SO1 Purpose 5
1.1 Statutory Framework 5
1.2 NHS Framework 6
1.3 Delegation of Powers 6
1.4 System Governance 6
SO2 Definitions 7
SO3 The Trust Board: Composition of Membership, Tenure and Role of Members 9
3.1 Composition of the Membership of the Trust Board 9
3.2 Appointment of Chair and Members of the Trust 10
3.3 Terms of Office of the Chair and Members 10
3.4 Appointment and Powers of Deputy -Chair 10
3.5 Joint Members 11
3.6 Role of Members 11
3.7 Corporate Role of the Board 12
3.8 Schedule of Matters Reserved to the Trust Board and Scheme of Delegation 13
3.9 Lead Roles for Board Members 13
SO4 Meetings of the Trust 13
4.1 Calling meetings 13
4.2 Notice of Meetings and the Business to be Transacted 13
4.3 Agenda and Supporting Papers 14
4.4 Petitions 14
4.5 Notices of Motion 14
4.6 Emergency Motions 14
4.7 Amendments to Motions 15
4.8 Withdrawing a Motion 15
4.9 Chair of Meeting 15
4.10 Chair's Ruling 15
4.11 Quorum 16
4.12 Voting 16
4.13 Suspension of Standing Orders 17
4.14 Variation and Amendment of Standing Orders 17
4.15 Record of Attendance 17
4.16 Minutes 17
4.17 Admission of Public and the Press 18
4.18 Observers at Trust Meetings 18
SO5 Appointment of Committees and Sub-Committees 18
5.1 Appointment of Committees 18
5.2 Joint Committees 18
5.3 Appointment of Sub-committees 19
5.4 Applicability of Standing Orders and Standing Financial Instructions to Committees 19
5.5 Terms of Reference 19
5.6 Delegation of Powers by Committees to Sub-Committees 19

5.7 Approval of Appointments to Committees 20
5.8 Appointments for Statutory functions..20
5.9 Committees to be Established by the Trust Board 20
SO6. Arrangements for the Exercise of Trust Functions by Delegation.................22
6.1 Delegation of Functions to Committees, Employees or Other Bodies..........23
6.2 Delegation to Committees 23
6.3 Delegation to Employees...23
6.4 Schedule of Matters Reserved to the Board and Scheme of Delegation of Powers 24
6.5 Duty to Report Non-Compliance with Standing Orders and Standing Financial Instructions 24
SO7 Overlap with other Trust Policy Statements/ Procedures, Regulations and the Standing Financial Instructions..24
7.1 Policy Statements: General Principles 24
7.2 Specific Policy Statements 25
7.3 Standing Financial Instructions...25
7.4 Specific Guidance..25
SO8. Duties and Obligations of Board Members/Directors and Senior Managers under these Standing Orders...25
8.1 Declaration of Interests...26
8.2 Register of Interests 28
8.3 Exclusion of Chair and Members in Proceedings on Account of Pecuniary Interest 28
Under regulation 11(2) of the Membership and Procedure Regulations, there is a power for NHS England to issue waivers if it appears to NHS England in the interests of the health service that the disability in regulation 11 (which prevents a Chair or a Member from taking part in the consideration or discussion of, or voting on any question with respect to, a matter in which he has a pecuniary interest) is removed. 29
8.4 Standards of Business Conduct 30
SO9 Custody of Seal, Sealing of Documents and Signature of Documents 31
9.1 Custody of Seal 31
9.2 Sealing of Documents 31
9.3 Register of Sealing 31
9.4 Signature of Documents 31

STANDING ORDERS

SO1 Purpose

These Standing Orders form a central part of Lincolnshire Community Health Services NHS Trust's (the Trust) Governance Manual. Together with the Standing Financial Instructions and the Schedule of Matters Reserved for the Board and Scheme of Delegation, they fulfil the dual role of protecting the Trust's interests and protecting Employees and Officers of the Trust from possible accusation that they have acted less than properly (provided that individuals have followed the correct procedures outlined in the relevant document).

All Executive and Non-Executive Members of the Board and all other Employees should be aware of the existence of these documents and be familiar with their detailed provisions.

1.1 Statutory Framework

The Lincolnshire Community Health Services NHS Trust (the Trust) is a statutory body which came into existence on 1 April 2011 under The Lincolnshire Community Health Services NHS Trust (Establishment) Order 2011, (Establishment Order).

(1) The principal place of business of the Trust is Beech House, Witham Park, Waterside South, Lincoln, LN5 7JH.

(2) NHS Trusts are governed by Acts of Parliament, mainly by the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012 and Health and Care Act 2022) and regulations made under that legislation (the Legislation).

(3) The functions of the Trust are conferred by the Legislation.

(4) As a statutory body, the Trust has specified powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable as well as to the Secretary of State for Health and Social Care.

(5) The National Health Service Trusts (Membership and Procedure) Regulations 1990 require the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions (SFIs) as an integral part of Standing Orders (SOs) setting out the responsibilities of individuals.

(6) The Trust will also be bound by such other statutes and legal provisions which govern the conduct of its affairs.

1.2 NHS Framework

The Secretary of State for Health and Social Care may issue further directions and guidance. The Trust may be issued directions or receive guidance from NHS England in the carrying out of its functions and governance.

1.3 Delegation of Powers

SO5 summarises the Trust's powers under to make arrangements for the exercise, on behalf of the Trust, of any of their functions by a committee or subcommittee appointed by virtue of SO5 or by an Employee of the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit or as the Secretary of State for Health and Social Care may direct.

The Schedule of Matters Reserved to the Board & Scheme of Delegation and the Standing Financial Instructions have effect as if incorporated into these Standing Orders.

Employees only have the authority to exercise powers specifically delegated to them, as summarised in Scheme of Delegation or as detailed in accordance with SO6.3. Wherever the title Chief Executive, Chief Financial Officer, or other Employee position is used in these Standing Orders, it will be deemed to include such other Employees as have been duly authorised to deputise, in accordance with the principles of SO6.

1.4 System Governance

The Trust has a pivotal role in the Lincolnshire system and shared accountability for health outcomes and financial balance and to drive transformation in the system. Recent legislation confirmed the statutory position of Integrated Care Systems and provided a firmer underpinning for Provider Collaboratives. Guidance has been issued outlining requirements for:

- joint decision-making at system level, including local authorities and other stakeholders, through around integrated commissioning arrangements for health and social care.
- provider collaboration to deliver services to populations at ICS level e.g. community, ambulance, Mental Health and acute through horizontal integration or through vertical integration at 'place' level.

There are many different duties the Trust must consider when exercising its statutory functions, including, amongst others, a new duty referred to as the 'Triple Aim' (the 'duty to have regard to wider effect of decisions' as set out in the Legislation). This requires the Trust when exercising our functions to consider:

- the health and wellbeing of the people of England (including inequalities in that health and wellbeing)

- the quality of services provided or arranged by both them and other relevant bodies (including inequalities in benefits from those services)
- the sustainable and efficient use of resources by both them and other relevant bodies

SO2 Definitions

Save as otherwise permitted by law, at any meeting the Chair's interpretation of these Standing Orders (on which the Chief Executive or ~~Deputy Director of Corporate Governance~~Director of Corporate Affairs may advise) shall be final.

Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in this document, the Standing Financial Instructions and Schedule of Matters Reserved to the Board and Scheme of Delegation, shall have the same meaning as set out in the Legislation and the following defined terms shall have the specific meanings given to them below:

"Accountable Officer" means the NHS Employee responsible and accountable for funds entrusted to the Trust. The employee shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

"Board or Trust Board" means the Chair, Executive Directors and Non-Executive Directors of the Trust collectively as a body.

"Budget" means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

"Budget holder" means the director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation.

"Chair of the Board (or Trust)" is the person appointed by NHS England to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chair of the Trust" shall be deemed to include the Vice-Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable.

"Chief Executive" means the chief officer of the Trust.

"Quality ~~and Risk~~ Committee" means a committee whose functions are concerned with the arrangements for the purpose of monitoring and improving the quality of healthcare for which the Lincolnshire Community Health Services NHS Trust has responsibility.

"Finance, Performance, ~~People~~ and Innovation Committee" means a committee whose functions are concerned with the arrangements for the

purpose of reviewing, monitoring and challenging the financial, people and operational performance and investments for which Lincolnshire Community Health Services NHS Trust has responsibility.

"Commissioning" means the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources.

"Committee" means a committee or sub-committee created and appointed by the Trust.

"Committee members" means persons formally appointed by the Board to sit on or to chair specific committees.

"Contracting and procuring" means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

"~~Deputy Director of Corporate Governance~~Director of Corporate Affairs" means a person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chair in addition to monitoring the Trust's compliance with the law, Standing Orders, the Department of Health and Social Care, Care Quality Commission and NHS ~~Improvement~~ England guidance.

"~~Director of Finance & Business Intelligence~~Chief Finance Officer" means the ~~Director of Finance and Business Intelligence~~Chief Finance Officer of the Trust.

"Employee" means employee of the Trust or any other person holding a paid appointment or office with the Trust.

"Executive Director" means a Member of the Trust who is either an employee of the Trust or is to be treated as an employee by virtue of regulation 5 of the Membership and Procedure Regulations

"**Financial Directions"** set out Revenue resource limits, Capital resource limits and certain expenditure controls which NHS bodies in England must adhere to.

"Funds held on trust" shall mean those funds which the Trust holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under paragraph 14(2)(c) of Schedule 4 to the 2006 Act. Such funds may or may not be charitable.

"**Joint Committee**" refers to the new provision of 65Z6 in the Health and Care Act 2022 which notes that where a function is exercisable jointly a 'relevant body' may establish a joint committee with another relevant

body, a local authority or a combined authority to
(a)arrange for the function to be exercised by a joint committee of theirs;
(b)arrange for one or more of the bodies, or a joint committee of the bodies, to establish and maintain a pooled fund.

"Member" means Executive Director or Non-Executive Director of the Board as the context permits. Member in relation to the Board does not include its Chair.

"Membership and Procedure Regulations" means the National Health Service Trusts (Membership and Procedure) Regulations (SI 1990/2024) as amended from time to time.

"Motion" means a formal proposition to be discussed and, if required, voted on during the course of a meeting of the Board.

"Nominated employee" means an employee charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

"Non-Executive Director" means a member of the Trust who is not an employee of the Trust and is not to be treated as an employee by virtue of regulation 5 of the Membership and Procedure Regulations.

"**Schedule of Matters Reserved to the Board and Scheme of Delegation"** document setting out the reservation of powers to the Trust & delegation of powers.

"SFIs" means Standing Financial Instructions.

"SOs" means Standing Orders.

"Trust" means the Lincolnshire Community Health Services NHS Trust.

"Vice-Chair" means the Non-Executive Director appointed by the Board to take on the Chair's duties if the Chair is absent for any reason.

"2006 Act" means The National Health Service Act 2006 (as amended).

SO3 The Trust Board: Composition of Membership, Tenure and Role of Members

3.1 Composition of the Membership of the Trust Board

In accordance with the Membership and Procedure Regulations and the Trust's Establishment Order the composition of the Board shall be:

(1) The Chair of the Trust (appointed by NHS England);

(2) 5 Non-Executive Directors (appointed by NHS England);

(3) 5 Executive Directors with full voting rights including:

- the Chief Executive;
- the ~~Director of Finance & Business Intelligence~~Chief Finance Officer;
- the ~~Director of Nursing, Quality & AHPs~~Chief Nursing Officer
- the ~~Director of People and Innovation~~Chief Integration Officer
- the Chief Medical Officer ~~Director~~

~~(4) Chief Operating Officer is an Executive Officer of the Trust and will be in attendance in a non-voting capacity unless the board resolves that they do not attend.~~

The following officers will attend the Board meetings in a non-voting capacity unless the Board resolves that they should not attend

- Chief People Officer
- Chief Operating Officer
- Chief Clinical Governance Officer
- Chief Estates and Facilities Officer
- Director of Corporate Affairs

3.2 Appointment of Chair and Members of the Trust

(1) Appointment of the Chair and Members of the Trust - Paragraph 3 of Schedule 4 to the 2006 Act provides that the Chair is appointed by the NHS England. The appointment and tenure of office of the Chair and Members are set out in the Membership and Procedure Regulations.

3.3 Terms of Office of the Chair and Members

Regulation 7 of the Membership and Procedure Regulations sets out the period of tenure of office of the Chair and members and Regulations 8 and 9 of the Membership and Procedure Regulations set out provisions regarding the termination or suspension of office of the Chair and members.

3.4 Appointment and Powers of Deputy -Chair

Subject to Standing Order 3.4 (2) below, the Chair and members of the Trust may appoint one of their numbers, who is not also an Executive Director, to be Deputy-Chair, for such period, not exceeding the remainder of his term as a member of the Trust, as they may specify on appointing him.

Any member so appointed may at any time resign from the office of Deputy-Chair by giving notice in writing to the Chair. The Chair and members may

thereupon appoint another member as Deputy-Chair in accordance with the provisions of Standing Order 2.4 (1).

Where the Chair of the Trust has died or has ceased to hold office, or where they have been unable to perform their duties as Chair owing to illness or any other cause, the Deputy-Chair shall act as Chair until a new Chair is appointed or the existing Chair resumes their duties, as the case may be; and references to the Chair in these Standing Orders shall, so long as there is no Chair able to perform those duties, be taken to include references to the Deputy-Chair.

3.5 Joint Members

Where more than one person is appointed jointly to a post mentioned in regulation 6 of the Membership and Procedure Regulations those persons shall count for the purpose of Standing Order 3.1 as one person.

Where the office of a Member of the Board is shared jointly by more than one person:

(a) either or both of those persons may attend or take part in meetings of the Board.

(b) if both are present at a meeting, they should cast one vote if they agree;

(c) in the case of disagreements, no vote should be cast;

(d) the presence of either or both of those persons should count as the presence of one person for the purposes of Standing Order 3.11 Quorum.

3.6 Role of Members

The Board will function as a corporate decision-making body, Executive Directors and Non-Executive Directors will be full and equal members. Their role as members of the Board of Directors will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

(1) Executive Members

The five voting Executive Members shall exercise their authority within the terms of these Standing Orders, the Standing Financial Instructions and the Schedule of Matters Reserved to the Board and the Scheme of Delegation.

(2) Chief Executive

The Chief Executive shall be responsible for the overall performance of the

executive functions of the Trust. The Chief Executive is the Accountable Officer for the Trust and shall be responsible for ensuring the discharge of obligations under the Standing Financial Instructions and in line with the requirements of the Accountable Officer Memorandum for Trust Chief Executives and the Department of Health and Social Care Group Accounting Manual.

(3) ~~Director of Finance & Business Intelligence~~Chief Finance Officer

The ~~Director of Finance & Business Intelligence~~Chief Finance Officer shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. He shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Standing Financial Instructions.

(4) Non-Executive Members

Non-Executive Members will not usually be granted individual executive powers on behalf of the Trust. They may, however, exercise collective authority when acting as members of or when chairing a committee of the Trust which has delegated powers.

(5) Chair

The Chair shall be responsible for the operation of the Board and chair all Board meetings when present. The Chair has certain delegated executive powers. The Chair must comply with the terms of appointment and with these Standing Orders.

The Chair shall liaise with NHS England over the appointment of Non-Executive Directors and once appointed shall take responsibility either directly or indirectly for their induction, their portfolios of interests and assignments, and their performance.

The Chair shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

3.7 Corporate Role of the Board

All business shall be conducted in the name of the Trust.

All funds received in trust shall be held in the name of the Trust as corporate trustee.

The powers of the Trust established under statute shall be exercised by the Board meeting in public session except as otherwise provided for in SO4.

The Board shall define and regularly review the functions it exercises on behalf of NHS England.

3.8 Schedule of Matters Reserved to the Trust Board and Scheme of Delegation

The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the "Schedule of Matters Reserved to the Board and shall have effect as if incorporated into the Standing Orders. Those powers which it has delegated to employees and other bodies are contained in the Scheme of Delegation.

3.9 Lead Roles for Board Members

The Chair will ensure that the designation of Lead roles or appointments of Board members as required by NHS England or as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirement.

SO4 Meetings of the Trust

4.1 Calling meetings

Ordinary meetings of the Board shall be held at regular intervals at such times and places, or by electronic means, as the Board may determine.

The Chair of the Trust may call a meeting of the Board at any time.

One third or more members of the Board may requisition a meeting in writing. If the Chair refuses, or fails, to call a meeting within seven days of a requisition being presented, the members signing the requisition may forthwith call a meeting at such time and place, or by electronic means, as they determine.

4.2 Notice of Meetings and the Business to be Transacted

Before each meeting of the Board a written notice specifying the business proposed, to be transacted, and any supporting papers, shall be provided electronically to every Member, so as to be available to members at least three clear days before the meeting. The notice shall be approved by the Chair or by an Employee authorised by the Chair.. Want of service of such a notice on any member shall not affect the validity of a meeting.

In the case of a meeting called by Members in default of the Chair calling the meeting, the notice shall be approved by those members.

No business shall be transacted at the meeting other than that specified on the agenda or emergency Motions allowed under SO4.6.

Members of the Board may propose agenda items through the Chair and Chief Executive at least 10 clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 10 days before a meeting may be included on the agenda at the discretion of the Chair.

Before each meeting of the Board a public notice of the time and place of the meeting and the public part of the agenda, shall be displayed on the Trust's website and a media release will be sent to all local media outlets at least three clear days before the meeting, (required by the Public Bodies (Admission to Meetings) Act 1960 Section 1 (4) (a)).

4.3 Agenda and Supporting Papers

Trust Board papers must be written in the required Trust Board format and be submitted to the Chief Executive's Office at least 7 clear days before the date of the Trust Board meeting to facilitate timely distribution of the papers.

The agenda should be sent to members at least 7 days before the meeting and supporting papers, whenever possible, shall accompany the agenda, being dispatched no later than 3 clear days before the meeting, save in emergency.

4.4 Petitions

Where a petition has been received by the Trust the Chair may, in his/her absolute discretion, include the petition as an item for the agenda of the next meeting.

4.5 Notices of Motion

Any motion **included on the agenda shall be** considered by the Board.

4.6 Emergency Motions

Subject to the agreement of the Chair, a Member of the Board may give written notice of an emergency Motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order and approved for inclusion by

the Chair, it shall be declared to the Trust Board at the commencement of the meeting as an additional item included in the agenda. The Chair's decision on whether to include the item at that meeting shall be final.

4.7 Amendments to Motions

When a motion is under discussion or immediately prior to discussion, it is open to any Board Member to move:

- An amendment to the Motion.
- The adjournment of the discussion or the meeting.
- That the meeting proceeds to the next business.
- The appointment of an ad hoc committee to deal with a specific item of business.
- That the Motion be now put; or
- A motion under Section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960 resolving to exclude the public (including the press).

No amendment to any Motion will be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the Motion.

4.8 Withdrawing a Motion

A motion may be withdrawn by the proposer with the agreement of the Chair.

4.9 Chair of Meeting

At any meeting of the Trust Board the Chair, if present, shall preside. If the Chair is absent from the meeting, the Deputy-Chair (if the Board has appointed one), if present, shall preside.

If the Chair and Deputy-Chair are absent, such member (who is not also an Executive Director of the Trust) as the Members present shall choose shall preside.

4.10 Chair's Ruling

The decision of the Chair of the meeting on questions of order, relevancy and regularity (including procedure on handling Motions) and their interpretation of the Standing Orders and Standing Financial Instructions, at the meeting, shall be final.

4.11 Quorum

No business shall be transacted at a meeting unless at least one-third of the whole number of the Chair and other voting Members of the Board (including at least two Members who are Executive Directors of the Trust and two Members who are Non-Executive Directors) are present.

An Employee in attendance for an Executive Director may not count towards the quorum.

If the Chair or Member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see SO 7) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

4.12 Voting

The Board will use its best endeavours to decide all questions by consensus. Where that cannot be achieved, and a vote is necessary, such questions shall be decided by a majority of the votes of the Chair and the Board Members present.

Save as provided in SO 4.13 - Suspension of Standing Orders and SO 4.14 - Variation and Amendment of Standing Orders, every question put to a vote at a meeting shall be determined by a majority of the votes of the voting members present and voting on the question. In the case of an equal vote, the person presiding, ie: the Chair of the meeting shall have a second, and casting vote.

At the discretion of the Chair all questions put to the vote shall be determined by oral expression or by a show of hands unless the Chair directs otherwise.

If a Member so requests, their vote shall be recorded by name. The Chair may direct that all votes and abstentions are recorded by name.

In no circumstances may an absent Member vote by proxy. Absence is defined as being absent at the time of the vote.

.

An Employee attending the Trust Board meeting to represent an Executive Director during a period of incapacity or temporary absence may not exercise the voting rights of the Executive Director. An Employee's status when attending a meeting shall be recorded in the minutes.

Joint member voting protocol is set out in SO3.5.

4.13 Suspension of Standing Orders

Except where this would contravene any statutory provision or any direction made by NHS England or the rules relating to the Quorum (SO 4.11), any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the whole number of the members of the Board are present (including at least one member who is an Executive Director of the Trust and one member who is not) and that at least two-thirds of those members present signify their agreement to such suspension. The reason for the suspension shall be recorded in the Trust Board's minutes.

A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chair and members of the Trust.

No formal business may be transacted while Standing Orders are suspended.

The Audit Committee shall review every decision to suspend Standing Orders.

4.14 Variation and Amendment of Standing Orders

These Standing Orders may be varied with the approval of the Board.

4.15 Record of Attendance

The names of the Chair and Directors/members present at the meeting shall be recorded.

4.16 Minutes

The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they shall be tabled by the Chair/ delegated person presiding at it

No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. A record will be made to note Board Members approval of the minutes of the prior meeting and clarifications or additional discussions, as directed by the Chair.

Where providing a record of a public meeting the minutes shall be made available to the public (required by Code of Practice on Openness in NHS)

4.17 Admission of Public and the Press

The LCHS Board will operate in an open and transparent fashion, except where confidentiality necessitates discussions being held in private. Accordingly, the Board meets in both public and private session.

The Board is covered by the Public Bodies (Admission to Meetings) Act 1960 (as amended). The Chair of the Board will give such directions as s/he thinks fit in regard to the arrangements for meetings, including accommodation of the public and representatives of the press, so as to ensure that the Board's business may be conducted without interruption and disruption and the confidential nature of any business can be respected when required.

Members of the public, or representatives of the press, should not make their own recording of proceedings other than in writing or make any oral report of the proceedings as they take place, without the prior agreement of the Board.

Members of the public and press are not admitted to meetings of the Board's Committees, except by specific invitation.

4.18 Observers at Trust Meetings

The Trust Board will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Trust Board's meetings and may change, alter or vary these terms and conditions as it deems fit.

SO5 Appointment of Committees and Sub-Committees

5.1 Appointment of Committees

The Trust Board may appoint committees of the Trust.

The Trust Board shall determine the membership and terms of reference of committees and sub-committees and shall if it requires to, receive, and consider reports of such committees.

5.2 Joint Committees

The Trust may arrange for any functions exercisable by it to be exercised by or jointly with a "relevant body", a local authority or a combined authority (as defined in the Legislation).

A "relevant body" means—

(a) NHS England,
(b) an integrated care board,
(c) an NHS trust established under section 25,
(d) an NHS foundation trust, or
(e) such other body as may be prescribed by law.

Arrangements under this provision may be made on such terms as may be agreed between the parties. Where a function is exercisable jointly this may be by a committee of the parties including Members or Employees of the Trust, or wholly or partly of persons who are not members or employees of the Trust.

5.3 Appointment of Sub-committees

Any committee appointed under these Standing Orders may appoint sub--committees consisting wholly or partly of members of the committees (whether they include directors of the Trust) or wholly of persons who are not members of the committee (whether or not they include Members of the Trust).

5.4 Applicability of Standing Orders and Standing Financial Instructions to Committees

The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall as appropriately apply to meetings and any committees established by the Trust. In which case the term “Chair” is to be read as a reference to the Chair of other committee as the context permits, and the term “member” is to be read as a reference to a member of other committee also as the context permits. (There is no requirement to hold meetings of committees established by the Trust in public.)

5.5 Terms of Reference

Each such committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with any legislation and regulation or direction issued by the Secretary of State. Such terms of reference shall have effect as if incorporated into the Standing Orders.

5.6 Delegation of Powers by Committees to Sub-Committees

Where committees are authorised to establish sub-committees, they may not delegate executive powers to the sub-committee unless expressly authorised by the Trust Board.

5.7 Approval of Appointments to Committees

The Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines, and regulations permit, that persons, who are neither members nor employees, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board as defined by NHS England. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

5.8 Appointments for Statutory functions

Where the Board is required to appoint persons to a committee and/or to undertake statutory functions as required by NHS England, and where such appointments are to operate independently of the Board such appointment shall be made in accordance with the regulations and directions made by NHS England.

5.9 Committees to be Established by the Trust Board

The committees, sub-committees, and joint committees established by the Board are:

(1) **Audit Committee**

In line with the requirements of the NHS Audit Committee Handbook, NHS Codes of Conduct and Accountability, the Higgs report, an Audit Committee will be established and consist of a minimum of three non-executive directors, one of which must have significant, recent and relevant financial experience.

Its role is to provide the Trust Board with an independent and objective review on its financial systems, information used by the Trust and compliance with laws, guidance, and regulations governing the NHS including assurance framework systems and performance and risk management systems. By independently reviewing internal control the Committee provides assurance to the Chief Executive Officer, as Accountable Officer, about the fulfillment of duties under the terms of the National Health Service Act 2006

The Terms of Reference will be approved by the Trust Board and reviewed on an annual basis.

Specified members of the Committee will act as an Auditor Panel to advise on the appointment of external auditors as detailed in Schedule 4 of the Local Audit and Accountability Act 2014. Authority to carry out this duty is delegated to Audit Committee by Trust Board.

(2) **Remuneration and Terms of Service Committee**

A Board Remuneration and Terms of Service Standing Committee has been established to oversee, review, and advise the Board about appropriate terms of service and remuneration for the Chief Executive and the other Executive Directors, including:

(I) all aspects of salary (including any performance-related elements /bonuses).

(ii) provisions for other benefits, including pensions and cars.

(iii) arrangements for termination of employment and other contractual terms.

In addition, the Committee will also review redundancy payments for all Trust Employees.

Membership of the Remuneration and Terms of Service Committee comprises of the Trust Chair and the Non-Executive Directors.

(3) **Trust and Charitable Funds Committee**

In line with its role as a corporate trustee for any funds held in trust, either as charitable or non-charitable funds, the Trust Board will establish a Trust and Charitable Funds Committee to administer those funds in accordance with any statutory or other legal requirements or best practice required by the Charities Commission.

The provisions of this Standing Order must be read in conjunction with SO3.7 and SFI 18.

(4) **Quality ~~and Risk~~ Committee**

The Quality ~~and Risk~~ Committee role within the Trust includes the review, consideration, investigation, monitoring and approval, as appropriate, of the following:

- monitor, review, and report on the quality of services provided by the Trust.
- including review of corporate governance, compliance and regulation, clinical risk management and internal control systems to ensure that the Trust's services deliver safe, high quality, patient-centered care.
- performance against internal and external quality improvement targets; and progress in implementing action plans to address shortcomings in the quality of services, should they be identified.

Membership will comprise of two Non-Executive Directors (one of whom will act as Chair) and two Executive Members. The Terms of Reference will be

approved by the Trust Board and reviewed on an annual basis. The Committee receives reports from other groups within the governance structure and reports directly to the Trust Board on a bi-monthly basis.

(5) **Finance, Performance, People, and Innovation Committee**

The Finance, Performance, People, and Innovation Committee role within the Trust includes the review, consideration, investigation, monitoring and approval, as appropriate, of the following:

- Financial policy, management, and reporting.
- Performance management and reporting
- Innovation and investment policy, management, and reporting.
- Operational Plan
- Digital Strategy
- Finance and Business Intelligence strategy
- Estates strategy
- People Strategy
- Information Governance
- Health and Safety
- Equality, Diversity, and Inclusion
- Health Inequalities
- Population Health Management

Membership of the Committee comprises two Non-Executive Directors (one of whom will act as Chair) and two Executive Directors, including the ~~Director of Finance & Business Intelligence~~Chief Finance Officer. The Committee receives reports from the People Executive Group, the Health and Safety Committee, the Data Privacy and Digital Innovation Group and reports directly to the Trust Board on a bi-monthly basis.

(6) **Auditor Panel**

An Auditor Panel has been established to advise on the appointment of external auditors as detailed under Schedule 4 of the Local Audit and Accountability Act 2014 (see SO5).

(7) **Other Committees**

The Board may also establish such other committees as required to discharge the Trust's responsibilities.

SO6. Arrangements for the Exercise of Trust Functions by Delegation

6.1 Delegation of Functions to Committees, Employees or Other Bodies

Subject to such directions as may be given by NHS England, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions by a committee, sub-committee appointed by virtue of Standing Order 4, or by an employee of the Trust in each case subject to such restrictions and conditions as the Trust thinks fit.

Paragraph 18 of Schedule 4 of the 2006 Act allows the functions of the Trust to be carried out jointly with any one or more of the following: NHS trusts, Special Health Authorities, or any other body or individual, on such terms as the Trust considers appropriate.

(1) **Emergency Powers and Urgent Decisions**

The powers which the Board has reserved to itself within these Standing Orders (see SO 3.9) may in emergency or for an urgent decision be exercised by the Chief Executive and the Chair after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and Chair shall be reported to the next formal meeting of the Trust Board in public session for formal ratification.

The powers to commit resources proportionate to an incident response, which are reserved to the Board within these Standing Orders may, for a major incident or emergency that requires the immediate commitment of resources be exercised by the Strategic Commander on-call. The exercise of such powers by the Strategic Commander on-call shall be notified to the next meeting of the Trust Leadership Team and shall be reported to the next meeting of the Trust Board for formal ratification.

6.2 Delegation to Committees

The Board shall agree from time to time to the delegation of executive powers to be exercised by other committees, or sub-committees which it has formally constituted in accordance with the Membership and Procedure Regulations. The constitution and terms of reference of these committees, or sub-committees and their specific executive powers shall be approved by the Board.

6.3 Delegation to Employees

Those functions of the Trust which have not been retained as reserved by the Board or delegated to other committees or sub-committees shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions will be performed personally and shall nominate Employees to undertake the remaining functions for which the Chief Executive

will still retain accountability to the Trust.

The Chief Executive shall prepare a Scheme of Delegation identifying proposals which shall be considered and approved by the Board. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board.

Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the ~~Director of Finance and Business Intelligence~~Chief Finance Officer to provide information and advise the Board in accordance with statutory or NHS England requirements. Outside these statutory requirements the role of the ~~Director of Finance and Business Intelligence~~Chief Finance Officer shall be accountable to the Chief Executive for operational matters.

6.4 Schedule of Matters Reserved to the Board and Scheme of Delegation of Powers

The arrangements made by the Board as set out in the "Schedule of Matters Reserved to the Board” and “Scheme of Delegation” of powers shall have effect as if incorporated in these Standing Orders.

6.5 Duty to Report Non-Compliance with Standing Orders and Standing Financial Instructions

If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification. All members of the Trust Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

SO7 Overlap with other Trust Policy Statements/ Procedures, Regulations and the Standing Financial Instructions

7.1 Policy Statements: General Principles

The Trust Board will from time to time agree and approve Policy statements/ procedures which will apply to all, or specific groups of staff employed by Lincolnshire Community Health Services NHS Trust. The decisions to approve such policies and procedures will be recorded in an appropriate Trust Board minutes and will be deemed where appropriate to be an integral part of the Trust's Standing Orders and Standing Financial Instructions.

7.2 Specific Policy Statements

Notwithstanding the application of SO 7.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following Policy statements:

- the Standards of Business Conduct and Conflicts of Interest Policy for Lincolnshire Community Health Services NHS Trust staff.
- the staff Disciplinary and Appeals Procedures adopted by the Trust.

both of which shall have effect as if incorporated in these Standing Orders.

7.3 Standing Financial Instructions

Standing Financial Instructions adopted by the Trust Board in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders.

7.4 Specific Guidance

Notwithstanding the application of SO 7.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with all relevant legislation and guidance including, amongst others:

- Caldicott Guardian Manual 2010.
- Human Rights Act 1998.
- Freedom of Information Act 2000.
- Bribery Act 2010.
- The Public Contracts Regulations 2015.
- The Code of Conduct for NHS Managers 2002.
- The NHS Codes of Conduct and Accountability 2004.
- Commercial Sponsorship - Ethical Standards for the NHS 2000
- Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England. (2013)
- Standards of Business Conduct Policy (2017)
- Third party assurance from legal professionals

Where such legislation or guidance is updated or revised, the version in force at the relevant date must be considered.

SO8. Duties and Obligations of Board Members/Directors and Senior Managers under these Standing Orders

8.1 Declaration of Interests

Each Member has a duty to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or may conflict), or may be perceived to conflict, with the interests of the Trust. Members have a duty not to accept a benefit from a third party by reason of being a director or acting (or not acting) in that capacity.

(1) **Requirements for Declaring Interests and Applicability to Board Members**

Trust Board Members must declare interests which are relevant and material to the NHS Board of which they are a member. All existing Board members should declare such interests. Any Board members appointed subsequently should do so on appointment.

Board members are required to declare the nature and extent of any direct or indirect interests in any proposed contracts, transactions, or arrangements to the Trust Board prior to them being entered into. Such declarations should be made in writing (or were made orally at a meeting, confirmed in writing) and sent to the ~~Deputy Director of Corporate Governance~~Director of Corporate Affairs for consideration by the Trust Board. Should a declaration prove to be, or become, inaccurate or incomplete a further declaration should be made.

Responsibility to declare an interest is solely that of the director concerned and shall be declared within 14 days of appointment or, if arising later as soon as the director becomes aware of the interest.

(2) Interests which are Relevant and Material

(i) Interests which should be regarded as "relevant and material" are:

a) Directorships, including Non-Executive Directorships held in companies likely to be engaged in the business of the Trust, private companies, or PLCs (except for those of dormant companies).

b) Ownership or part-ownership of companies likely to be engaged in the business of the Trust, private companies, businesses, or consultancies likely or possibly seeking to do business with the Trust or NHS.

c) Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the Trust or NHS.

d) A position of authority in a company likely to be engaged in the business of the Trust, charity, or voluntary organisation in the field of health and social care.

e) Any connection with a voluntary or other organisation contracting for NHS services.

f) Research funding/grants that may be received by an individual or their department.

g) Interests in pooled funds that are under separate management.

h) Interests designated as such by any guidance issued by NHS England.

(ii) Any member of the Trust Board who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in SO 8.3 below and elsewhere) has any pecuniary interest, direct or indirect, the Board member shall declare his/her interest by giving notice in writing of such fact to the Trust as soon as practicable.

(3) **Advice on Interests**

If Board members have any doubt about the relevance of an interest, this should be discussed with the Chair of the Trust or with the ~~Deputy Director of Corporate Governance~~Director of Corporate Affairs.

International Accounting Standard No 24 (issued by the International Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered, together with spouses, partners, and other family members.

(4) **Recording of Interests in Trust Board Minutes**

At the time Board members' interests are declared, they should be recorded in the Trust Board minutes and the register of Member’s interests updated.

Any changes in interests should be declared at the next Trust Board meeting following the change occurring and recorded in the minutes of that meeting.

(5) **Publication of Declared Interests in Annual Report**

Board members' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

(6) **Conflicts of Interest which arise during a Meeting**

During a Trust Board meeting, if a conflict of interest is established, the

Board member concerned should withdraw from the meeting and play no part in the relevant discussion or decision. (See overlap with SO8.3)

8.2 Register of Interests

The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Board and Committee members. The Register will include details of all directorships and other relevant and material interests (as defined in SO 8.1) which have been declared by Members.

The Register and Member details will be reviewed at each public meeting of the Board and updated according to changes noted.

The Register will be available to the public and the Chief Executive will take reasonable steps to bring the existence of the Register to the attention of local residents and to publicise arrangements for viewing it.

8.3 Exclusion of Chair and Members in Proceedings on Account of Pecuniary Interest

(1) Definition of Terms used in Interpreting 'Pecuniary' Interest

For the sake of clarity, the following definition of terms is to be used in interpreting this Standing Order:

(i) "spouse" shall include any person who lives with another person in the same household (and any pecuniary interest of one spouse shall, if known to the other spouse, be deemed to be an interest of that other spouse).

(ii) "contract" shall include any proposed contract or other course of dealing.

(iii) "Pecuniary interest"

Subject to the exceptions set out in this Standing Order, a person shall be treated as having an indirect pecuniary interest in a contract if:-

a) he/she, or a nominee of his/her, is a member of a company or other body (not being a public body), with which the contract is made, or to be made or which has a direct pecuniary interest in the same, or
b) he/she is a partner, associate, or employee of any person with whom the contract is made or to be made or who has a direct pecuniary interest in the same.

iv) Exception to Pecuniary interests

A person shall not be regarded as having a pecuniary interest in any contract if: -

a) neither he/she or any person connected with him/her has any beneficial interest in the securities of a company of which he/she or such person appears as a member, or
b) any interest that he/she or any person connected with him/her may have in the contract is so remote or insignificant that it cannot reasonably be regarded as likely to influence him/her in relation to considering or voting on that contract, or
c) those securities of any company in which he/she (or any person connected with him/her) has a beneficial interest do not exceed £5,000 in nominal value or one per cent of the total issued share capital of the company or of the relevant class of such capital, whichever is the less.

Provided, however, that where paragraph (c) above applies the person shall nevertheless be obliged to disclose/declare their interest in accordance with SO8.1(2) (ii).

(2) Exclusion in Proceedings of the Trust Board

Subject to the following provisions of this Standing Order, if the Chair or a member of the Trust Board has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust Board at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

The Trust Board may exclude the Chair or a member of the Board from a meeting of the Board while any contract, proposed contract or other matter in which he/she has a pecuniary interest is under consideration.

Any remuneration, compensation or allowance payable to the Chair or a Member by virtue of paragraph 11 of Schedule 4 to the 2006 Act (pay and allowances) shall not be treated as a pecuniary interest for the purpose of this Standing Order.

This Standing Order applies to a committee or sub-committee as it applies to the Trust and applies to a member of any such committee or sub-committee (whether or not he/she is also a member of the Trust) as it applies to a member of the Trust.

(3) Waiver of Standing Orders made by NHS England

Under regulation 11(2) of the Membership and Procedure Regulations, there is a power for NHS England to issue waivers if it appears to NHS England in

the interests of the health service that the disability in regulation 11 (which prevents a Chair or a Member from taking part in the consideration or discussion of, or voting on any question with respect to, a matter in which he has a pecuniary interest) is removed.

8.4 Standards of Business Conduct

(1) Trust Policy and National Guidance

All Trust staff and members of must comply with the Trust's Standards of Business Conduct and Conflicts of Interest Policy and the national guidance contained in HSG(93)5 on "Standards of Business Conduct for NHS staff" (see SO 7.2).

(2) Interest of Employees in Contracts

Any employee or employee of the Trust who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in SO 8.3) has any pecuniary interest, direct or indirect, the employee shall declare their interest by giving notice in writing of such fact to the Chief Executive or ~~Deputy Director of Corporate Governance~~Director of Corporate Affairs as soon as practicable.

An employee should also declare to the Chief Executive any other employment or business or other relationship of his/her, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

The Trust will require interests, employment or relationships so declared to be entered in a register of interests of staff.

(3) Canvassing of and Recommendations by Members in Relation to Appointments

Canvassing of members of the Trust or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

Members of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a member from giving written testimonial of a candidate's ability, experience, or character for submission to the Trust.

(4) Relatives of Members or Employees

Candidates for any staff appointment under the Trust shall, when making an application, must disclose in writing to the Trust whether they are related to

any member or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

The Chair , Members and employees of the Trust shall disclose to the Trust Board any relationship between themselves and a candidate of whose candidature that member or employee is aware. It shall be the duty of the Chief Executive to report to the Trust Board any such disclosure made.

On appointment, Members (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Trust whether they are related to any other Member or holder of any office under the Trust.

SO9 Custody of Seal, Sealing of Documents and Signature of Documents

9.1 Custody of Seal

The common seal of the Trust shall be kept by the Chief Executive, the ~~Deputy Director of Corporate Governance~~Director of Corporate Affairs, or a nominated Manager by him/her in a secure place.

9.2 Sealing of Documents

Where it is necessary that a document shall be sealed, the seal shall be affixed and then authenticated by the Chair, or of some other person authorised (whether generally or specifically) by the Trust for that purpose, and of one other Director.

9.3 Register of Sealing

The Chief Executive shall keep a register in which he/she, or another manager of the Authority authorised by him/her, shall enter a record of the sealing of every document.

9.4 Signature of Documents

Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any Executive Director.

In land transactions, the signing of certain supporting documents will be delegated to Managers and set out clearly in the Scheme of Delegation but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

In the case of contracts for goods, works and services relating to non-pay expenditure, officers should refer to Standing Financial Instructions.

Appendix 1 Equality and Health Inequality Impact Assessment Tool

This tool has been developed by the Equality, Diversity and Inclusion Leads for use in the NHS Provider organisations in Lincolnshire. The tool is designed to ensure due regard is demonstrated to the Equality Act 2010, the Public Sector Equality Duty and potential health inequalities are also identified and addressed (as outlined in the Health and Social Care Act). Please complete all sections below. Instructions are in ***italics***. Email for all correspondence: email to lhnt.edifirst@nhs.net

A. Service or Workforce Activity Details	
1. Description of activity	*Governance Manual: Standing Orders annual review of document.*
2. Type of change	~~Full~~ INterimreview to the *Standing Orders*
3. Form completed by	*~~Catherine Leggett~~Jayne Warner*, *~~Deputy Director of Corporate Governance~~Director of Corporate Affairs*
4. Date decision discussed & agreed	*~~15.02.23~~11.10.2024*
5. Who is this likely to affect?	Service users x Staff x Wider Community x If you have ticked one or more of the above, please detail in section B1, in what manner you believe they will be affected.
B. Equality Impact Assessment	
Complete the following to show equality impact assessment considerations of the decision making to ensure equity of access and to eliminate harm or discrimination for any of the protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation. Further, please consider other population groups which are at risk of health inequality and can include, but not be limited to, people who are; living in poverty / deprivation, geographically isolated (e.g. rural), carers, armed forces, migrants, homeless, asylum seekers/refugees, surviving abuse, in stigmatised occupations (e.g. sex workers), use substances etc. Please ensure you consider the connections (intersectionality) between the protected characteristics and population groups at risk of health inequality (e.g. it is recognised that older men from a BAME background, with one or more comorbidities and living in deprivation are more at risk of a poorer outcome if they contract CV-19).	
1. How does this activity / decision impact on protected or vulnerable groups? (e. g. their ability to access services / employment and understand any changes?)	The Governance Manual sets out the manner in which the Trust will conduct its business in accordance with legislation, the establishment of the Trust and regulations as set out in each document. The governance manual is unlikely to impact negatively on protected or vulnerable groups but rather support and ensure accessibility of Trust activities.

Please ensure you capture expected positive and negative impacts.	
2. What data has been/ do you need to consider as part of this assessment? What is this showing/ telling you?	*e.g. Patient data / workforce data / population data / JSNA data etc, broken down by protected characteristics and groups at risk of health inequality.* The number of members of the public accessing public board sessions has been considered~~ and further engagement with members of the public has been undertaken throughout 2022-23 to review and shape accessibility of public sessions~~. Public sessions have remained online following the pandemic in response of views provided to the Trust.
C. Risks and Mitigations	
1. What actions can be taken to reduce / mitigate any negative impacts? (If none, please state.)	None – the governance manual is required by law for the Trust to set out publicly how it will conduct its business.
2. What data / information do you have to monitor the impact of the decision?	Members of the public are being and will continue to be engaged in how public board sessions are conducted.
D. Decision/Accountable Persons	
1. Endorsement to proceed?	Yes
2. Any further actions required?	*No*
3. Name & job title accountable decision makers	~~Sam Wilde~~Paul Antunes Gonclaves, ~~Director of Finance and Business Intelligence~~Chief Finance Officer ~~Catherine Leggett~~Jayne Warner, ~~Deputy Director of Corporate Governance~~Director of Corporate Affairs
4. Date of decision	~~14.03.23~~11.10.24
5. Date for review	*~~November 2023.~~October 2025*

Purpose of the Equality and Health Inequality Assessment tool

- The NHS in Lincolnshire has a legal duties under the Equality Act 2010, Public Sector Equality Duty 2011 and the Health and Social Care Act 2012 to demonstrate due regard in all decision making, for example, when making changes to services or workforce practices, to ensure access to services and workforce opportunities are equitable and to avoid harm and eliminate discrimination for each of the protected characteristics and other groups at risk of inequality.
- Within the guidance toolkit there are also some examples of decisions this tool has been used on in other organisations and the impacts they have identified.

Checklist

- Is the purpose of the policy change/decision clearly set out? Yes
- Have those affected by the policy/decision been involved? Yes
- Have potential positive and negative impacts been identified? Yes
- Are there plans to alleviate any negative impact? No
- Are there plans to monitor the actual impact of the proposal? Yes

Appointment of Group Deputy Chair

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

Meeting	*Lincolnshire Community and Hospitals Group Board Meeting*
Date of Meeting	*5th November 2024*
Item Number	*14.4*

Appointment of Group Deputy Chair

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:-* *Support the recommendation of the Group Chair to appoint Rebecca Brown as Group Deputy Chair with immediate effect*

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

In line with the powers laid out in the Standing Orders for LCHS

3.4 Appointment and Powers of Deputy -Chair
Subject to Standing Order 3.4 (2) below, the Chair and members of the Trust may appoint one of their numbers, who is not also an Executive Director, to be Deputy-Chair, for such period, not exceeding the remainder of his term as a member of the Trust, as they may specify on appointing him.
Any member so appointed may at any time resign from the office of Deputy-Chair by giving notice in writing to the Chair. The Chair and members may thereupon appoint another member as Deputy-Chair in accordance with the provisions of Standing Order 2.4 (1).
Where the Chair of the Trust has died or has ceased to hold office, or where they have been unable to perform their duties as Chair owing to illness or any other cause, the Deputy-Chair shall act as Chair until a new Chair is appointed or the existing Chair resumes their duties, as the case may be; and references to the Chair in these Standing Orders shall, so long as there is no Chair able to perform those duties, be taken to include references to the Deputy-Chair.

And those for ULTH

2.6 Appointment and Powers of Vice-Chair Corporate Governance Manual V5.2 (P–78) *Subject to Standing Order below, the Chair and directors of the Trust may appoint one of their numbers, who is not also an executive director, to be Vice-Chair, for such period, not exceeding the remainder of their term as a member of the Trust, as they may specify on appointing them.*
Any director so appointed may at any time resign from the office of Vice-Chair by giving notice in writing to the Chair. The Chair and directors may thereupon appoint another director as ViceChairman in accordance with the provisions of Standing Orders

Where the Chair of the Trust has died or has ceased to hold office, or where they have been unable to perform their duties as Chair owing to illness or any other cause, the Vice-Chair shall act as Chair until a new Chair is appointed or the existing Chair resumes their duties, as the case may be; and references to the Chair in these Standing Orders shall, so long as there is no Chair able to perform those duties, be taken to include references to the Vice-Chair.

The Group Chair wishes to propose the appointment of Rebecca Brown Non Executive Director to the role of Group Deputy Chair and Senior Independent Director (SID).

Remuneration for the role of Deputy Chair for the Group has been agreed by NHSE and the Group Remuneration Committees as £10,000 per annum in addition to the group non executive remuneration.

The Board are asked to support the recommendation of the Group Chair to appoint Rebecca Brown as Group Deputy Chair with immediate effect.