Bundle Trust Board Meeting in Public Session 6 September 2022

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

1 Introduction, Welcome and Chair's Opening Remarks
Chair

2 Public Questions
Chair

3 Apologies for Absence
Chair

4 Declarations of Interest
Chair

5.1 Minutes of the meeting held on 2 August 2022
Chair
Item 5.1 Public Board Minutes August 2022v1.docx

5.2 Matters arising from the previous meeting/action log
Chair
Item 5.2 Public Action log August 2022.docx

6 Chief Executive Horizon Scan
Chief Executive
Item 6 CEO Trust Board 07.09.22.docx

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

7.1 Ward Accreditation Presentation
Director of Nursing

7.2 BREAK

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

8.1 Assurance and Risk Report from the Quality Governance Committee
Item 8.1 QGC Upward report August 2022v1.doc
Item 8.1 Appx 1 QGC Upward Report - United Hosps Lincs 19072022 - FINAL.pdf

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

9.1 Assurance and Risk Report from the People and Organisational Development Committee - No meeting held

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

10.1 Assurance and Risk Report from the Finance, Performance and Estates Committee
Item 10.1 FPEC Upward Report August 2022.docx

10.2 Green Plan
Chief Operating Officer
Item 11.3 Green Plan FPEC Paper Aug 22 (002).docx
Item 11.3 ULHT Green Plan Final Draft v 2.1.docx

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

12 Integrated Performance Report
Item 12 IPR Trust Board - Front page.docx
Item 12 IPR Trust Board August 2022.docx

13 Risk and Assurance

13.1 Risk Management Report
Director of Nursing

Item 13.1 Strategic Risk Report - September 2022.docx

Item 13.1 Appendix A - Trust Board All active risks rated 15-25 (002).pdf

13.2 Board Assurance Framework

Trust Secretary

Item 13.2 BAF 2022-23 Front Cover September 2022.docx

Item 13.2 BAF 2022-2023 30.08.2022.xlsx

14 Any Other Notified Items of Urgent Business

15 The next meeting will be held on Tuesday 4 October 2022

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

Minutes of the Trust Board Meeting

Held on 2 August 2022

Via MS Teams Live Stream

Present

Voting Members:
Mrs Elaine Baylis, Chair
Mr Andrew Morgan, Chief Executive
Dr Karen Dunderdale, Director of Nursing/ Deputy Chief Executive
Ms Dani Cecchini, Non-Executive Director
Professor Philip Baker, Non-Executive Director
Dr Colin Farquharson, Medical Director
Dr Chris Gibson, Non-Executive Director

Non-Voting Members:
Dr Sameedha Rich-Mahadkar, Director of Improvement and Integration

In attendance:
Mrs Jayne Warner, Trust Secretary
Mrs Karen Willey, Deputy Trust Secretary (Minutes)
Ms Michelle Harris, Deputy Chief Operating Officer
Ms Anne Dobbs, Consultant Nurse Emergency Medicine – item 7
Ms Jennie Negus, Head of Patient Experience – item 7

Apologies
Mrs Sarah Dunnett, Non-Executive Director
Mr Paul Matthew, Director of Finance and Digital/ Director of People and OD
Mr Simon Evans, Chief Operating Officer
Dr Maria Prior, Healthwatch Representative
Ms Cathy Geddes, Improvement Director, NHSE/I

1287/22	**Item 1 Introduction** The Chair welcomed Board members and members of the public who had joined the live stream to the meeting. The Trust Board continue to hold meetings open to the public through the use of MS Teams Live however the format of future meetings was being considered following the lifting of national restrictions. The national operating status at NHS National level had also been downgraded however the Trust continued to be cautious in terms of

	access to sites in order to maintain the highest levels of infection, prevention and control. The Chair welcomed those members of the public who had joined the meeting virtually.
1288/22	The Chair moved to questions from members of the public. **Item 2 Public Questions** **Q1 from Chris Sharman** **Information given within the Monthly Board report continues to show communication as one of your users main causes of dissatisfaction and complaint.** **Whilst it is to be applauded that the Trust publishes numerous patient information leaflets on your website, it should also be recognised that the majority of these leaflets are both inaccessible to those patients needing to use screen reader technology and, more importantly, are out of date if the review dates shown on the leaflets are accurate.** **As a patient there is nothing more frustrating than taking the time to "self serve", only to find the information found is not up to date. This is especially relevant to leaflets which contain contact information. The leaflet at https://website.ulh.nhs.uk/documents/patient_information_leaflets/1122%20Urology%20Clinical%20Nurse%20Specialist%20Key%20Worker%20v5.pdf is just one of many examples.** **Can you please advise what action is being taken to ensure your leaflets are both meeting the accessibility standards and are also factually correct?"**
1289/22	The Director of Nursing responded: The Trust was currently undertaking work to review all patient information leaflets, to not only ensure that all content was up to date, but to also ensure this was accessible and available in multiple formats.
1290/22	We recognise that with many local service changes some content and service locations details had changed and it was recognised that this would require continual updates.
1291/22	This was significant piece of work that would take some time, but results would be much improved for patients. In a number of areas the Trust used nationally approved leaflets to complement those produced internally and recently the Trust had updated the policy for developing patient information so that all leaflets maintained a certain level and standard.
1292/22	

  1293/22 1294/22 1295/22	The Director of Nursing assured Mr Sharman that work was already underway and offered to ensure that Mr Sharman was personally updated on the progress if this was felt to be appropriate. By way of an example the Director of Nursing noted that, in July, some easy read documents had been developed by the Lead Nurse for Learning Disabilities, which complied with the national accessible standards. These documents were in the process of being made available through the Trust website and to all wards who had an up-to-date learning disabilities folder, including laminated copies of easy-to-read documents. The Director of Nursing noted that the information offered was done so to demonstrated that work had commenced in what was a huge area of need.
1296/22 1297/2 1298/22 1299/22	**Q2 from Vi King** **Please can I ask if the new Grantham theatres are on schedule for opening. If not what is the timeframe.** **Also, will they be 24 hours seven days a week.** The Deputy Chief Operating Officer responded: The Grantham theatres are behind schedule, and should have been commissioned on 29 July, due to a delay caused by a change to the heating installation design by the contractor. This change was rejected by the Trust with a return made to the original design work. Work will not be completed until 26 August meaning that the theatres will be commissioned and handed to the Trust on 30 September 2022. As the theatres will be for elective surgery there is no requirement for these to be open 24 hours seven days a week and furthermore this had not been considered by the Trust.
1300/22	**Q3 from Jody Clark** **Having received a message from a distraught mother on Sunday, who's 3 year old was having a seizure and has other health issues. After phoning 999, she was told no ambulances were available. Her neighbour took them to Grantham Hospital, who provided treatment before transferring her to Lincoln, via ambulance after a long wait, for a full check up and immediate tests (EEG & ECG) so transferred with a treatment plan. Although she got a bed, she was seen in 30 mins and discharged, with none of the tests given? This was at 10pm, with no way home. The mother had to wait for someone to drive from Grantham to collect them.** **My question is, what was the point in her being transferred with a treatment plan and that not being delivered at next Hospital? This is an ongoing issue for**

	Grantham patients, Grantham transfer with a plan and that doesn't happen when you get transferred to Lincoln? Can communication be improved so that Grantham patients get the care they need?
1301/22	The Deputy Chief Operating Officer responded: Contact had been made with the family with an assessment and review of the patients' journey through the events being undertaken.
1302/22	Treatment plans put in place when a patient attends Grantham and subsequently requires transfer will be followed unless there is a need for this to be altered once the patient had been seen be a specialist.
1303/22	The Trust had made contact with East Midlands Ambulance Service NHS Trust (EMAS) in order to understand the delays in ambulance transfer.
1304/22	Communications work was taking place with the emergency departments in regard to the translation of treatment plans however when a patient was moved to a specialist department there would always be a possibility that plans could be changed.
1305/22	**Item 3 Apologies for Absence** Apologies were received from the Director of Finance and Digital/Director of People and Organisational Development, Chief Operating Officer, Mrs Dunnett, Non-Executive Director and Dr Prior, Healthwatch representative.
1306/22	The Chair noted that the Deputy Director of Finance, Deputy Director of People and Organisational Development and Deputy Chief Operating Officer were in attendance in the absence of the Directors.
1037/22	The Chair welcomed the new Non-Executive Directors who had joined the Trust on 1 August 2022 noting that they would be formally at the Board meeting in September.
1308/22	**Item 4 Declarations of Interest** There were no new declarations of interest with the new Non-Executive Directors having made the relevant declaration which would be published on the Trust website.
1309/22	**Item 5.1 Minutes of the meeting held on 5 July 2022 for accuracy** The minutes of the meeting held on 5 July 2022 were agreed as a true and accurate record subject to the following amendment:
1310/22	1048/22 – To read – The Board noted that it had been possible to step the critical incident down within 24 hours
1311/22	**Item 5.2 Matters arising from the previous meeting/action log** 1914/21 – Action log – The Director of Nursing noted that there had been positive conversations with colleagues in the endoscopy units however more refinement of

	the work was required. As such the final outcome was not yet ready to present to the Board.
1312/22	It was anticipated that this would be presented to the Board in October.
1313/22	The action log would be updated accordingly to reflect this being received by the Board in October.
1314/22	**Item 6 Chief Executive Horizon Scan** The Chief Executive presented the report to the Board noting that system pressures remained and that this was no different across any other system. This was also being reported in national media and was not specific to Lincolnshire.
1315/22	The flow challenges being seen often manifested in ambulance waiting times, waits in Accident and Emergency but also, an indication of pressures in all systems, was the ability to discharges patients once acute hospital episodes had finished. Unless discharges took place it was not possible to admit new patients.
1316/22	These pressures remained and the system continued to work hard to tackle this however there had been additional issues such as the recent heatwave. Whilst this had only lasted for a relatively short time this had required significant planning, business continuity and ensuring the welfare of staff across the system as well as ensure that patients were as comfortable as possible.
1317/22	The Chief Executive noted that it was now the holiday season with Lincolnshire being a holiday destination which increased the pressure at a time when the NHS workforce also wanted to take holiday. This created a demand and supply challenge.
1318/22	The Board was assured that all parts of the system were working on the factors described noting that this was not just about the hospitals but the whole system.
1319/22	The Chief Executive noted that the NHS Pay Award had been announced with the Government accepting the pay review body recommendations from the various pay review boards.
1320/22	Trade unions were now discussing next steps and possible industrial action and if this was to take place the form that it would take. Talks were underway with local representatives and it was noted that should industrial action be taken then business continuity and contingency plans would need to be put in place.
1321/22	The Chief Executive advised the Board that NHS England had updated the Covid-19 autumn booster and flu vaccination programme with well-established system and processes in place across the county. These would now commence with the updated programmes.
1322/22	The memorandum of understanding between the Integrated Care Board (ICB) and NHS England was being worked through to identify what should be included and once signed processes would be put in place.

1323/22	A stock take was being undertaken around the Provider Collaborative to consider the issues with the report being available by the end of August for Charis and Chief Executives. This would ensure there was clarity on the role and purpose along with how the working arrangements applied in addition to values, behaviours and governance.
1324/22	There were three key parts, these being the Integrated Care Partnership (ICP), ICB and Provider Collaborative. All parts of this were new however the Provider Collaborative had been working for some time. Before this was launched further it was felt to be appropriate to conduct the stock take and ensure the direction of travel was comfortable for all involved. This would be a short, intensive piece of work which would be presented back to the Board.
1325/22	The Chief Executive offered the Trust updates noting the reported deficit at the end of month 3 which mainly related to Covid-19 costs but also the flow and discharge issues. The Trust continued to have more beds open than was ideal and many of these were being staffed with agency. Therefore, there were significant costs attached. Work was underway with system partners on this.
1326/22	It was noted that more work was required in respect of Cost Improvement Programmes (CIP) in order that the Trust could be as effective as possible to deliver the position. The Trust had, over recent years, built a much-improved reputation for delivery of financial plans and with the change from the financial regime during Covid-19 focus was required.
1327/22	The Board noted that the funding for the emergency department at Pilgrim had been announced by the Prime Minister in 2019 and was now finally a full business case that had been signed off. Ministerial approval had been given and was in time to ensure that the contracts could be sent out at the appropriate time. The total cost of the development was £43.4m with the Trust intending to move as swiftly as possible to mobilise the scheme.
1328/22	The Chief Executive noted that it had been a difficult process through the national mechanisms, and it was important that this was pushed on at pace.
1329/22	It was noted that the Nuclear Medicine consultation outcome would be received by the Board in September with the consultation having concluded at the end of June.
1330/22	The Chief Executive reflected that there had been a positive meeting with NHS England recently as part of the process of exiting special measures in March. The meeting had been positive about the progress and improvements that had been seen along with lessons learnt and ongoing support that would ensure a continued upward trajectory for the organisation.
1331/22	There had been a series of pre-procurement engagement activities with a number of potential suppliers for the Electronic Patient Record, who may be interested in bidding for work, having an opportunity to present to the organisation.
1332/22	The Chair noted the update offered and reflected that the Board recognised the pressure on the operational teams. Thanks were offered to staff for the extra

	ordinary efforts as the Trust continued to aspire to provide outstanding care personally delivered.
1333/22	It was important that the governance framework for the ICP was clear, and the Provider Collaborative stock take was welcomed. It would be useful for this to be received by the Board in order to agree the direction of travel.
1334/22	The difficult process regarding the Pilgrim emergency department and appreciation of the full Board was expressed to those involved in the process of the development of the business case for the resilience and attention to detail that had been given. This had been a great outcome for the Trust and the population of Lincolnshire.
1335/22	The Chair was delighted to congratulate the Chief Executive on achievement of 40 years in the NHS noting the 19 different jobs in 14 organisations across 8 parts of the country, of which 18 years had been in the role of Chief Executive.
1336/22	On behalf of the Board members the Chair thanked the Chief Executive for his unrelenting public service. The Trust Board: • **Received the report and significant assurance provided**
1337/22	**Item 7 Patient Story** The Director of Nursing welcomed Ann Dobbs, Consultant Nurse Emergency Medicine and Jennie Negus, Head of Patient Experience who offered richness around a particular story relating to the Same Day Emergency Care (SDEC) Service.
1338/22	The Trust Board, via the presentation, gained a full understanding of SDEC and the provision of care offered to patients noting the developments that had taken place within the service since 2019.
1339/22	The specific patient story offered to the Board detailed the experience of a patient who arrived at the service 6 minutes prior to its closure for the day. The patient offered positive feedback of the experience on Care Opinion and the Board noted that had the patient arrived sooner to the service it would have been likely that they could have been discharged the same day rather than requiring a short stay.
1340/22	The patient had been admitted for 48 hours due to having sepsis and requiring improvement before being sent home.
1341/22	The Trust Board noted the potential improvements that could be made to SDEC including a virtual ward that was due to open in the coming week, longer opening hours and development of different pathways.
1342/22	The Chair offered thanks for the presentation noting the positive feedback that had been received from both the patient and the wider patient cohort.

1343/22	Professor Baker asked, if resources were not limited, what proportion of emergency admissions could be taken through the SDEC pathways and not require admissions and also what proportion of patents being seen did not need to attend hospital.
1344/22	The Consultant Nurse Emergency Medicine advised that from January 2022 there had consistently been 30% of acute medical patients taken through SDEC and noted with similar demographics, that in Oxford 50% of patients were taken through this route.
1345/22	It was noted that there were some pathways not currently in place, such as respiratory, due to Covid-19 however it was anticipated that the service could reach 50% at Lincoln.
1346/22	The Consultant Nurse Emergency Medicine noted that this specific story focused on acute medical SDEC and that SDEC needed to be thought of as a concept and not a place. Consideration needed to be given to SDEC for all specialities.
1347/22	Around 50% of the patients seen were referred from GPs meaning that most patients are not attending accident and emergency first that should not be there. If patients were considered inappropriate, then this was discussed with the Lead for Primary Care to consider if the referral was appropriate and to consider if there were cohorts of patients that could be managed differently.
1348/22	The Medical Director noted that, when considered across specialities, the amount of patients suitable for SDEC ranged between 35-55% meaning there would be a benchmark figure of 40-50%, depending on the resource.
1349/22	As stated by the Consultant Nurse Emergency Medicine this needed to be a concept rather than a physical location and as such would mean clinicians could consider suitable patients. A number of patients were referred through primary care and were appropriate and again considering this as a concept would enable further support to patients.
1350/22	The Medical Director noted that this was an excellent piece of work and was proud of the service and the staff.
1351/22	Ms Cecchini asked if there was any benefit in this being a 24-hour service and also asked if service improvement was considered following patient feedback, such as that offered through the public question received by the Board.
1352/22	The Consultant Nurse Emergency Medicine noted that the service stopped taking patients at 6pm and closed at 8pm to allow patients to be treated and safely sent home however patients attending later in the day could, if required, come back the following day.
1353/22	Consideration was being given to opening until 10pm to support the busier time for the emergency department which was usually 6pm – 8pm. It was not felt that there would be benefit in running the service for 24-hours due to the reliance on diagnostic testing with a significant proportion of patients being referred by GPs. With GP practices closing at 6pm this had determined the current cut off time.

1354/22	Practice was considered, including patient experience with the service, at the point of establishment, having patient involvement and feedback sought. Since being with SDEC over the past 3 years the Consultant Nurse Emergency Medicine advised that only 1 complaint had been received. Clearly the service was working well however this needed to grow in order to support as many patients as possible.
1355/22	The Deputy Chief Operating Officer noted that national benchmarking had been undertaken at the time the service was established with some units trailing a 24/7 model. Based on the patient throughput and requirements it had been determined that this was not needed and as such the service was open at the optimum time to see patients and expedite a safe discharge home.
1356/22	The Director of Improvement and Integration noted the ability to rotate staff from the emergency department to SDEC and asked what the advantages of this were.
1357/22	The Consultant Nurse Emergency Medicine noted that rotating staff meant that the workforce were able to work across both SDEC and the emergency department with staff not being as burnt out, due to the challenging environment of the emergency department. There was more variety in the workload with greater learning for staff. This was also being taken onboard by the Doctors and it was hoped that this could be replicated across other sites.
1358/22	The Chief Executive asked if there was any support required from the Board to support further developments and improvements across SDEC.
1359/22	The Consultant Nurse Emergency Medicine noted that the Board had been extremely supportive of SDEC, particularly in the past year and noted that if required the Chief Operating Officer supported and addressed any blockages. The service was not seeing around 100 patients per week and saving 600 beds days, if all of those patients had been admitted.
1360/22	From a Lincoln perspective there was a requirement for additional space however this was being addressed and until this was available it would not be possible to write a business case to further support SDEC developments.
1361/22	The Head of Patient Experience noted that feedback from patients could not be underestimated noting that the patient panel had been involved in the development of this and there was also research being conducted in relation to SDEC.
1362/22	It was known that patients did not want to come into hospital and would like to receive treatment and go home and, if necessary, return the next day. There was a need to showcase that this had been coproduced with patients.
1363/22	The Director of Nursing offered congratulations to both the Consultant Nurse Emergency Medicine and Head of Patient Experience on the fantastic service that was adaptable and primarily led by non-medical professionals, Advanced Clinical Practitioners (ACPs) in particular.

1364/22	SDEC was clearly the way forward with patients being clear that this was also wanted by them. In terms of being adaptable the service had offered significant support to the emergency department at Lincoln when the fire had taken place.
1365/22	The Director of Nursing was proud of the Consultant Nurse Emergency Medicine, the team and the service delivered through SDEC and was keen to see how the virtual SDEC would develop noting that any support required would be offered.
1366/22	The Chair added thanks to the Consultant Nurse Emergency Medicine and Head of Patient Experience for the presentation offered. The Chair noted that the Consultant Nurse Emergency Medicine was an exemplar in the Trust of great leadership and noted the positive feedback the service was receiving. The Trust Board: • **Received the patient story**
	Item 8 Objective 1 To Deliver high quality, safe and responsive patient services, shaped by best practice and our communities
1367/22	**Item 8.1 Assurance and Risk Report Quality Governance Committee** The Chair of the Quality Governance Committee, Dr Gibson provided the assurances received by the Committee at the 19 July 2022 meeting, the day on which Lincolnshire set the temperature record.
1368/22	The meeting was not quorate due to members of the Committee dealing with issues arising as a result of the unprecedented heatwave although the whole agenda was considered.
1369/22	Dr Gibson noted that the Committee received the report from the Clinical Harm Oversight Group noting that there was great interest from the Committee, and public, due to potential harm due to delays. This continued to be scrutinised with Datix being used to record harms and the data being used to triangulate the position.
1370/22	The Committee had been pleased to receive the Ward Accreditation report noting the change in approach and the number of levels of achievement. There were a number of wards achieving standards for the diamond accreditation meaning that they would be able to apply for the bronze diamond award. The ability to apply for this, and a number of other levels, demonstrated wards achieving significant periods of no harm.
1371/22	Dr Gibson noted the positive performance against patient safety alerts however advised the Board of the revised process relating to Field Safety Notices due to the current backlog open within the Trust. A group had been established to review the backlog and process which would use risk stratification.
1372/22	The Committee welcome the Specialist Nurse for Safeguarding Children who offered the Safeguarding and Vulnerabilities Oversight Group upward report. The Committee noted that 100% of staff were now trained on child protection information sharing which had been an action required from a previous Care Quality Commission (CQC) inspection.

1373/22	The Infection Prevention and Control (IPC) upward report identified that there had been a number of Covid-19 outbreaks as new variants continued to affect the population however there had been a recent downward trend in staff and patient outbreaks.
1374/22	Dr Gibson was pleased to advise the Board that written confirmation had been received from the NHS England Regional IPC team of the green rating achieved by the Trust within inpatient and non-inpatient areas. This was a significant achievement by the Trust IPC team.
1375/22	It was noted that the Committee had not received the Medicines Management Group report which was a key issue for the Committee. The Committee looked forward to receiving this at the August meeting and would also welcome receipt of the Medicines Management Annual Report.
1376/22	Dr Gibson noted the report received from the Maternity and Neonatal Oversight Group for which 3 appendices were offered to the Board. The report noting the application to exit from the Maternity Safety Support programme was positive for the Trust as this meant the achievement of progress however this would see the removal of central support. The progress to achieve this should be recognised by the Board.
1377/22	The written report on the Ockenden Insight Visit was also appended following the reive of the immediate and essential actions from the first report. The review made some very positive remarks, particularly about the staff in maternity services.
1378/22	The Avoiding Term Admissions into Neonatal units (ATAIN) report, which was appended, supported the Clinical Negligence Scheme for Trusts (CNST) with a number of amber and red actions. The Committee was assured that these ratings were applied as the group wished to be sure that actions to achieve performance were thoroughly embedded. It was expected that future reports would contain green ratings.
1379/22	Dr Gibson advised that the Committee had received the National Inpatient Survey for Cancer noting that due to Covid-19 only 55 Trusts, across the country, had taken part. This meant that benchmarking data was not available however there appeared to be improvements for the Trust although there were a number of actions required.
1380/22	The Committee noted the establishment of the Cancer Patient Expert Group which would be key for consultation and improvements going forward.
1381/22	The Committee received annual reports for complaints, mandated organ donation, National Confidential Enquiry into Patient Outcome and Death (NCEPOD) and clinical audit. These all provided a level of assurance on quality issues within the Trust.
1382/22	The Director of Nursing noted the 3 maternity papers presented with the report noting that the Trust had received the application to exit the Maternity Safety Support Programme. This was due to be submitted to the national team with the Board asked to note the application, following which the regional midwife would be advised of this.

1383/22	The Director of Nursing noted the excellent feedback from the Ockenden insight visit, which had been mentioned in the Chief Executive Officers briefing in July. This demonstrated, through visits and observations, the highly credible outstanding leadership of the inspirational Head of Midwifery, Libby Grooby along with the passionate staff who were skilled, cohesive and enthusiastic as a team.
1384/22	As with any visit to the Trust there were areas of consideration which had been received grateful and would be considered as part of the overall improvement plan for maternity services.
1385/22	Finally, the ATAIN quarterly report had been made available for the Board with the Director of Nursing noting that this would support CNST and the requirement from the final Ockenden report.
1386/22	The Director of Nursing highlighted, as mentioned by Dr Gibson, the fantastic news that the regional IPC team had recognised the improvements made over the past 2 years, and in the backdrop of a pandemic. The annual report was received by the Board in July and the letter received was further evidence of the improvements reported. The letter would be offered to the Committee in August and to the Board the following month.
1387/22	The Chief Executive also noted the significant outcome and highlighted the Ockenden insight visit which detailed the outstanding Senior Leadership Team within maternity services including the excellent Executive and Non-Executive Director visibility and inspirational Head of Midwifery. The enthusiasm of the team was also commented on and clearly applied to many people.
1388/22	The Chief Executive also praised the Director of Nursing for the work undertaken and Mrs Dunnett as the Non-Executive Director Maternity Safety Champion for the huge impact that had been made.
1389/22	Professor Baker, noting his background as an obstetrician, reiterated the congratulations offered to maternity services and the staff delivering care on a daily basis.
1390/22	Ms Cecchini noted within the report the withdrawal of support from Lincolnshire Partnership Foundation NHS Trust (LPFT) in respect of restraint and asked if this was an agreed position.
1391/22	Ms Cecchini also noted the update in respect of complaint and triangulating this to the delays in responding to Freedom of Information (FOI) requests and Subject Access Requests (SARs) asked if there was more that was required to deliver this.
1392/22	The Director of Nursing noted that, working in conjunction with LPFT, there had been an agreement on how the Trust would be supported in respect of restraint and the safety of patients. This was particularly about the training of staff however where there were complex individuals requiring complex support this would be sought from LPFT. The Trust was acting accordingly and would seek expert support when needed.

1393/22	In relation to FOIs and SARs and the standard associated with responses, it was recognised that there was more to be done to achieve this. The Director of Finance and Digital was the lead of Information Governance, supported by the Trust Secretary's office and linked with the team who lead on complaints and this was often where the output of failure to achieve those standards was seen.
1394/22	Additional resource was being considered and conversations were being held through the Executive Team in order to determine the level of oversight required. The issue was recognised with a plan in place to address this.
1395/22	Dr Gibson noted that this also related to the timeliness of responding but also to a number of issues of convers about overall communications, specifically the timeliness in responding to complaints. This had been recognised by the complaints team who, through planning for the next year, had identified this as a key objective.
1396/22	The Chair noted the fantastic work that had been achieved in maternity and IPC and offered personal congratulations to all those involved.
1397/22	The Chair sought the support of the Board for the application from the Maternity Safety Support Programme and noted the ATAIN paper and the onward input to this.
1398/22	As a Board the efforts made in maternity services were recognised and congratulations offered to all involved in relation to the excellent feedback following the insight visit. The Trust Board: • **Received the assurance report** • **Noted and supported the application to exit the Maternity Safety Support Programme**
	Item 9 Objective 2 To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT
1399/22	**Item 9.1 Assurance and Risk Report People and Organisational Development Committee** The Chair of the People and Organisational Development Committee, Professor Baker provided the assurances received by the Committee at the 12 July 2022 meeting.
1400/22	Professor Baker noted that the report was lengthier than usual due to the full agenda of the Committee as a result of there being no meeting held in June.
1401/22	The Committee had considered issues around Disclosure and Barring Service (DBS) with progress noted toward compliance with the Savile report. The Committee was keen to see continued progress.
1402/22	Professor Baker noted that the issue of appraisals had been considered noting that the existing software provider had been decommissioned as this was not achieving

	the desired impact. It was important that staff appraisals took place to a greater extent but also that these were effective.
1403/22	The Committee had been provided with a plan and interim solution towards achieving a situation where every member of staff within the Trust had an effective appraisal process.
1404/22	The Safer Staffing report was received for both June and July with the Committee interested to note that across the 2 reports there had been an increase in staff fill rates and this was associated to a reduction in incidents. Consideration was being given to reviewing trends in fill rates to see if it was possible to demonstrate similar effects.
1405/22	Professor Baker noted that the Committee had received the Culture and Leadership Group upward report noting the work of the Committee to instil a process of having a series of sub-groups in place. It was noted that this group continued to develop in order to effectively deliver plans which would impact on the Trust.
1406/22	The Committee received the annual report from the Guardian of Safe Working with some concerns flagged to the Committee around Junior Doctor issues impacting on clinical care. This had been referred to the Quality Governance Committee to consider if this issue was impacting on quality and safety for patients.
1407/22	Time was spent talking to the Guardian about rotas and rota coordination with the Committee noting the instigation of a central staffing function within Human Resources which would address many of the concerns.
1408/22	The Committee received a very positive report from the Freedom to Speak Up Guardian which had demonstrated a marked increase in activity thanks to the work of the Guardian and others. It was noted that, in comparison to other Trusts, the Trust had very few issues raised anonymously which demonstrated confidence in people being able to speak up and have issues addressed.
1409/22	Professor Baker noted that the Equality, Diversity and Inclusion Group continued to develop, and the Committee had looked critically at the membership of the group to ensure there was appropriate representation to be effective.
1410/22	An encouraging update had been received from the University Teaching Hospitals Group in relation to the medical school and education and the way in which the Trust and University of Lincoln were working together.
1411/22	Less assurance had been received from the Research and Innovation Governance Group with work required with the group to address some concerns, mainly around the level of activity. It was noted that following activity which had been Covid-19 related there have been a fall in research activity which could impact on the desire to attain University or Teaching Hospital status.
1412/22	The Committee reviewed the performance dashboard offering month on month performance against key metrics and noted those metrics are not yet showing improvement that the many actions the Trust was taking would yield.

1413/22	Professor Baker noted that the Committee was not in a position to be able to revise the assurance ratings within the Board Assurance Framework however remained confident that this would be possible by the end of the year.
1414/22	The Chair noted the report and structure and rigour that was being applied to the reporting arrangements into the Committee. It was positive to hear that the groups were starting to have work programmes and clear expectations from the Committee in order to offer assurance to the Board.
1415/22	Caution was noted in terms of the current position and the red rating presented within the Board Assurance Framework however it was the job of the Committee to report accurately to the Board. Reporting from the Committee felt more substantial that had been received previously by the Board.
1416/22	Dr Gibson supported the comments made regarding the research position noting that only 13% of cancer inpatients were asked if they wanted to take part in trials. It was known that participation improved outcomes.
1417/22	The Director of Improvement and Integration supported the observation of research and innovation and the teaching hospital. Work was underway with research and innovation team to align ambitions and to recognise that the culture and leadership aspect of developing research would take time. A clear roadmap was required on what was required and it was hoped that a more detailed update could be provided to the next Committee meeting regarding the plans for development.
1418/22	The Chair noted that it was be helpful for this to be received for assurance to the be offered to the Board. It was also pleasing to note the referral to the Quality Governance Committee to ensure concerns raised were being considered by the right Committee. The Trust Board: • **Received the assurance report**
	Item 10 Objective 3 To ensure that service are sustainable, supported by technology and delivered from an improved estate
1419/22	**Item 10.1 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 21 July 2022 meeting.
1420/22	Ms Cecchini noted that the Committee had been unable to complete the agenda due to the volume of papers and noted that there had been a number of significant items including the digital and procurement strategies.
1421/22	There had been significant discussion with regard to the financial position which was reported to the Board through the report.

1422/22	Ms Cecchini noted the estates update for which the Committee had noted some unprecedented numbers of significant incidents that the estates team had dealt with during the hot weather. The Committee had joined others in commending both the estates teams and organisation in dealing with the situation.
1423/22	The Board was advised that NHS England had also commended the organisation for the planning and preparation undertaken ahead of the unprecedented heat noting that the Trust was better prepared than others.
1424/22	The Committee had noted the activity being undertaken with regard to the redefinition of confined spaces and the Health and Safety Executive notice. Once activity had been undertaken the Trust would request an audit be undertaken by the British Safety Council to support closure of the notice.
1425/22	Fire safety issues continued to be worked through following the fire at Lincoln and issues of storage in corridors. The Committee would continue to oversee the work being undertaken and noted that overall, there continued to be limited assurance received by the Committee in respect of estates.
1426/22	Significant assurance had been received through the Emergency Planning Group upward report around the Trust's ability to respond to emergency plans with some activity around training and evidence collection required to support this.
1427/22	Ms Cecchini noted that the Committee continued to receive significant assurance regarding low surface temperature works noting that the Trust was now commencing work on accommodation not owned by the Trust to ensure this was safe for patients.
1428/22	The Board noted the financial position and the significant deficit of £5.2m at the end of quarter 1 however received good descriptions as to the position presented which had been described in the Chief Executives update.
1429/22	On the basis of the discussions by the Committee the Board Assurance Framework rating for objective 3b had been moved to red.
1430/22	Ms Cecchini noted that the Committee had received the Cost Improvement Programme (CIP) report noting there was circa £29m of CIP required with £17m worth of schemes with a forecast saving of £13m in year. This was behind plan was contributing to the adverse financial position.
1431/22	The Committee also noted that the capital allocation had reduced from £41m to £38.4m however noted that this was an agreed system position.
1432/22	The Committee received the Information Governance Group upward report noting the continued poor performance relating to freedom of information and subject access requests which would be considered in detail at a future meeting.
1433/22	The continued levels of demand were having an adverse impact of operational performance with some concern noted around the ability to make progress on 104 week waits. It was noted that both the fire and heatwave had impacted negatively on

	diagnostic services. Performance in respect of cancer and the 62-day backlog had progressed however remained challenging.
1434/22	The Committee noted that the improvement seen in breast services continued to be sustained.
1435/22	The Committee received the upward report of the second meeting of the Improvement Steering Group noting that progress could be seen in the conversations being held. Difficulties were noted with operational challenges and pressures and the ability for staff to engage in discussions.
1436/22	Ms Cecchini noted that there were some deferred items that would be discussed at the August meeting.
1437/22	The Director of Improvement and Integration noted that the Trust had adopted a 3 tier approach to CIP and this had been worked through with the divisions. A first cut of opportunities had been identified and a sub-group created for finance, people and activity to identify further opportunities.
1438/22	It was noted that whilst the Improvement Steering Group had been established this was not yet mature however this was being built on to provide grip and control to deliver CIP.
1439/22	The Chair sought an update on the operational position from the Deputy Chief Operating Officer in order to better understand the current situation.
1440/22	The Deputy Chief Operating Officer noted that during the course of July the Trust had been impacted by a further wave of Covid-19 with numbers similar to waves 1 and 2. The Trust was starting to see an increase in attendances at Urgent and Emergency Care (UEC) meaning that the departments were becoming crowded.
1441/22	Patients attending were now having longer stays within the Trust which was, by definition, creating exit blocks as it was not possible to safely move patients. Patients were also attending with underlying medical conditions and work was underway with system partners on pathways 1-3.
1442/22	This activity was vital to ensure traction on the exit block to ensure there were benefits at the front door. Benefits were also being seen through Same Day Emergency Care (SDEC) which needed to progress so that patients were seen in the right place at the right time.
1443/22	The Deputy Chief Operating Officer noted that there was an immense amount of work continuing to take place however the benefit was not yet being seen. There was confidence that this would deliver.
1444/22	The Chair noted that progress with the plans needed to continue in order to have the intended impact.
1445/22	The Chair also noted the capacity of the Committee suggesting a discussion be held outside of the meeting, given the scale of what the Trust was trying to achieve.

	There was a need to ensure there was sufficient time spent on those matters requiring discussion to ensure this could move forward. The Trust Board: • **Received the assurance report**
	Item 11 Objective 4 To implement integrated models of care with our partners to improve Lincolnshire's health and wellbeing
1446/22	No items
1447/22	**Item 12 Integrated Performance Report** The Board received the Integrated Performance Report with the Chair inviting Executive Directors to bring to the attention of the Board any items that had not been addressed through the upward reports of the Committees.
1448/22	The Medical Director noted that there was a typographical error within the cancer section of the report noting that the 104 plus day waiters should be reported as 123 patients which was a reduction on the previous month.
1449/22	The Director of Nursing advised the Board of the position of Duty of Candour noted that there had been a number of discussions held by the Board and that when the CQC had previously visited the Trust was struggling with performance of written duty of candour.
1450/22	The Board noted that there continued to be an exponential improvement in written Duty of Candour with a detailed report due to be presented to the Quality Governance Committee in August. This would show an improvement in both written and verbal Duty of Candour.
1451/22	The Chair noted the report and reflected that as the Trust moved in to the winter period then some focused work on the position of the Trust should be undertaken. A view on when this would be conducted would be taken from the Executive Directors. The Trust Board: • **Received the report noting the limited assurance**
	Item 13 Risk and Assurance
1452/22	**Item 13.1 Risk Management Report** The Director of Nursing presented the monthly report to the Board noting that there continued to be 9 very high quality and safety risks which predominantly related to delays in planned care, non-admitted patients, cancer pathways and ambulance handovers.
1453/22	As reported to the Board in July there had been delays in the echocardiogram service and in addition learning lessons from patient safety incidents, potential serious harm from falls, medication issues and paper documentation.

1454/22	There were 8 quality and safety risks rates as high and remained the same as the previous month with no changes noted in the themes. All risks had been reviewed by the Quality Governance Committee.
1455/22	The Director of Nursing noted the 3 very high workforce risks associated with recruitment and retention of doctors and nurses and low morale which may impact on quality and safety. These risks had been reviewed through the People and Organisational Development Committee.
1456/22	The Board noted the 2 very high risks relating to Finance, Performance and Estates in relation to the cost reliance on temporary staffing and the potential for a fire safety incident. There were also 3 high risks, all had been received by the Finance, Performance and Estates Committee.
1457/22	The Director of Nursing noted that there were clear mitigations in place for each risk and noted the continued risk register confirm and challenge meetings that took place along with the Medical Director. Work took place with both the divisions and corporate areas to review all associated risks.
1458/22	The appendix offered to the report detailed all risks.
1459/22	The Director of Improvement and Integrations noted that an IIP session had taken place for each of the divisional teams over the previous week and whilst this had been to primarily describe actions for improvement plans this triangulated with the presented risks. The work had been helpful to triangulate organisational risks and to work with the divisions to support the mitigation of these.
1460/22	The Chair was pleased to note the triangulation and the more active engagement of the divisions.
1461/22	The report continued to develop and clearly presented the risks offering significant assurance with processes set out.
1462/22	The Chair asked the Board members to consider and confirm that the risks presented were those being faced by the organisations and that all members of the Board were satisfied all mitigations relevant were appropriate. The Trust Board: • **Accepted the top risks within the risk register** • **Received the report and noted the significant assurance**
1463/22	**Item 13.2 Board Assurance Framework** The Trust Secretary presented the report to the Board noting that this had been considered by all Board Committees during July 2022.
1464/22	As highlighted by the Chair of the Finance, Performance and Estates Committee a full review of objective 3b had resulted in presenting to the Board, for approval, the move of the objective from amber to red.

1465/22	The Committee intended to conduct a deep dive of objectives 3d, 3e and 3f at a future meeting with the objectives having been slightly adjusted.
1466/22	The Trust Secretary noted that the cover sheet in relation to objective 4c had not been correctly reported and would be amended to reflect the content of the report.
1467/22	The Board noted the current position against the achievement of the strategic objectives. The Trust Board: • **Received the report noting the moderate assurance**
1468/22	**Item 13.3 Audit Committee Upward Report** Dr Gibson offered the report to the Trust Board in the absence of the Chair of the Audit Committee from the meeting held on 11 July 2022.
1469/22	The Committee reviewed the external audit programme which had concluded and reflected on the planning for the next year.
1470/22	Progress had commenced on the Internal Audit Plan for the year and it was noted that there would be key performance indicators to monitor delivery and quality of the Internal Audit plan.
1471/22	Dr Gibson noted that a key area of concentration would be the follow up of audit recommendations noting that there were currently 36 live actions of which 20 were overdue. Whilst this was an improved position from the last quarter the Audit Committee and all other Committees would continue to monitor the implementation of recommendations.
1472/22	The Committee received the Counter Fraud programme report noting that some areas of the Counter Fraud Standard Return were rated as red and amber however an overall green rating had been submitted on 1 June 2022.
1473/22	Dr Gibson noted the receipt of the regular compliance report which offered oversight of regulatory notices.
1474/2	The Trust had made the annual Data Security and Protection Toolkit submission with a rating of approaching the standards. All standards had been met with the exception of Information Governance core training for which actions to recover were in place.
1475/22	The Committee approved the Standards of Business Conduct and Declarations of Interest Policy.
1476/22	Dr Gibson noted that the Committee had received the risk register noting the rigour being brought to risk management and advised the Board that risk management would be subject to an internal audit as part of the 2022/23 plan.

1477/22	An update was received in regard to the large-scale project relating to policies which had offered limited assurance. The Committee noted the resource in place and the continued scrutiny of the Executive Leadership Team.
1478/22	The Committee confirmed the assurance rating for objective 2a Well Led Services which remained amber.
1479/22	The Chair was pleased to note that actions from internal audits would be monitored and executed accordingly and also welcomed the internal audit of risk management following the work that had been undertaken within the Trust. This would offer external validation on the progress made. The Trust Board: • **Received the report noting the moderate assurance**
1480/22	**Item 14 Any Other Notified Items of Urgent Business** There were no items of other business.
1481/22	The next scheduled meeting will be held on Tuesday 6 September 2022, arrangements to be confirmed taking account of national guidance.

Voting Members	**3 Aug 2021**	**7 Sept 2021**	**5 Oct 2021**	**2 Nov 2021**	**7 Dec 2021**	**1 Feb 2022**	**1 Mar 2022**	**5 Apr 2022**	**3 May 2022**	**7 June 2022**	**5 July 2022**	**2 Aug 2022**
Elaine Baylis	X	X	X	X	X	X	X	X	X	X	X	X
Chris Gibson	X	X	A	X	A	X	X	A	X	X	X	X
Geoff Hayward												
Neill Hepburn												
Sarah Dunnett	X	X	X	X	X	X	X	A	X	A	X	A
Elizabeth Libiszewski	X	X	X	X	X							
Paul Matthew	X	X	X	X	X	X	A	X	X	X	X	A
Andrew Morgan	X	X	X	X	X	X	X	X	X	A	A	X
Mark Brassington	X											
Simon Evans		X	X	X	X	X	X	X	X	X	X	A
Karen Dunderdale	X	X	X	X	X	X	X	X	X	X	X	X
David Woodward	A	X	X	X	X							
Philip Baker	X	X	X	X	X	X	X	X	X	X	X	X
Colin Farquharson	X	X	X	X	X	X	X	X	X	X	X	X
Gail Shadlock						X	X	X	X	X	X	
Dani Cecchini						X	X	X	X	X	X	X

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 5.2

Trust Board date	Minute ref	Subject	Explanation	Assigned to	Action due at Board	Completed
7 December 2021	1914/21	Action Log	Establishment reviews for endoscopy and ED would be received once considered at Committee in Jan/Feb 2022 Endoscopy review to be received in July	Director of Nursing	~~01/03/2022~~ ~~05/07/2022~~ ~~02/08/2022~~ 04/10/200	Deferred to October
5 July 2022	1265/22	Integrated Performance Report	Board to review performance report through IPR ahead of the winter pressures, with focus to be afforded to the scorecard performance and position of a range of metrics.	Trust Secretary	06/09/2022	

Meeting	*Public Trust Board*
Date of Meeting	*6 September 2022*
Item Number	*Item number 6*
Chief Executive's Report	
Accountable Director	*Andrew Morgan, Chief Executive*
Presented by	*Andrew Morgan, Chief Executive*
Author(s)	*Andrew Morgan, Chief Executive*
Report previously considered at	*N/A*

How the report supports the delivery of the priorities within the Board Assurance Framework	
1a Deliver harm free care	
1b Improve patient experience	
1c Improve clinical outcomes	
2a A modern and progressive workforce	
2b Making ULHT the best place to work	
2c Well Led Services	*X*
3a A modern, clean and fit for purpose environment	
3b Efficient use of resources	
3c Enhanced data and digital capability	
4a Establish new evidence based models of care	
4b Advancing professional practice with partners	
4c To become 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	• *Significant*

Recommendations/ Decision Required	• *To note*

Executive Summary

System Overview

a) All parts of the system continue to be under significant pressure, as is the case across the country. In recognition of this, NHSE has issued national guidance relating to increasing capacity and operational resilience in urgent and emergency care ahead of winter. This sets out the core objectives and key actions for operational resilience. These are - preparing for variants of COVID-19 and respiratory challenges; increasing capacity outside acute trusts; increasing resilience in NHS 111 and 999 services; targeting category 2 response times and ambulance handover delays; reducing overcrowding in A&E departments and targeting the longest waits in ED; reducing hospital occupancy; ensuring timely discharge; providing better support for people at home. Six key metrics have been identified. These are - 111 call abandonment rate; mean 999 call answering times; category 2 ambulance response times; average hours lost to ambulance handover delays per day; adult general and acute Type 1 bed occupancy; percentage of beds occupied by patients who no longer meet the criteria to reside. A new Board Assurance Framework has been developed to help local systems, through the ICB, to ensure there is effective oversight on local performance. The local system in Lincolnshire is working through this new guidance and the plans that need to be in place over winter.
b) The e-financials system across provider Trusts in the county has been unavailable since 3rd August following a service outage at 'Advanced' the organisation who provide the service. This outage is a national issue that has affected a range of services provided to the NHS by Advanced. Whilst this outage is being addressed, business continuity plans have been enacted to minimise disruption to supplies and ensure payments to suppliers can continue. An update on the current position will be provided at the Board meeting.
c) The stocktake into Lincolnshire Health and Care Collaborative (LHCC), the provider collaborative in the county, has now reported. The draft report is now being discussed by both the Lincolnshire NHS Leaders' Group (LLG) and LHCC. The draft stocktake report contains recommendations for both LLG and LHCC.
d) The implications of the current cost of living pressures are being worked through in terms of their impact on organisations, patients and staff. This covers issues such as energy costs and food costs for Trusts, travel costs for both patients and staff and the implications for the wider physical and mental health of the population.
e) As part of the NHS Oversight Framework for 2022/23, ICBs must lead the oversight of NHS Providers in their system. This should be done in collaboration with the local Regional Office of NHSE. This will involve a joint approach to segmenting NHS providers as part of the Oversight Framework. The ICB has been asked to confirm any proposed changes to the current segmentation by 8th September 2022. There are 4 segments with 1 being the highest and 4 the lowest. At present LCHS and LPFT are in segment 1 and ULHT are in segment 3, having moved from segment 4 upon exiting special measures in March 2022.

Trust Overview

a) At Month 4, the Trust reported a year to date deficit of c£6.33m against a year to date plan of break-even. After removing gains from disposals of £115k, this equates to a deficit of c£6.5m in relation to the system financial plan. CIP delivery and agency cost reduction are two areas of focus for bringing spend back on track.
b) Further consideration is needed relating to the outcome of the public consultation on the future of Nuclear Medicine Services in the Trust. It was originally hoped that the

outcome of consultation would come to the September Board in public. This is no longer feasible. It is hoped that the outcome can come in October.

c) Further national guidance has been received relating to patient and staff COVID testing in periods of low COVID prevalence. This guidance is being reviewed to see what changes need to be made to the Trust's processes and procedures. It is also appropriate for a further review to take place into visiting arrangements in the Trust and public access to the Trust's restaurants.

d) A review is also going to take place into the working from home arrangements in the Trust. This will also incorporate the approach to 'hot desking' bearing in mind the limited space in the Trust.

Main Body
which should not exceed 5 sides of A4
(Section Headings)

Purpose

Key messages

Conclusion/Recommendations

Report to:	Trust Board
Title of report:	Quality Governance Committee Assurance Report to Board
Date of meeting:	23 August 2022
Chairperson:	Chris Gibson, Non-Executive Director
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the Quality Governance Committee (QGC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme. The Committee worked to the 2022/23 objectives.
	Assurance in respect of SO 1a Issue: Deliver high quality care which is safe, responsive and able to meet the needs of the population **Mortality Report** The Committee received the Mortality Report and noted the improvement in HSMR data with good benchmarking against peer group hospitals. The Committee noted some challenging pathways however was advised of the improvement in performance for SHMI. **Duty of Candour Update** The Committee was pleased to note that for the first month the Trust had achieved 100% in both written and verbal duty of candour. This demonstrated the impact of the actions put in place at the end of the last year with the divisions. These actions were now embedding with continued training and support in place through the central team. The Committee noted the moderate assurance being offered noting that if the high level of compliance continued in the coming months monitoring could revert through the performance report. **Serious Incident Summary Report** The Committee received the report noting the position presented including the continued reduction in the number of open actions. **High Profile Cases** The Committee received the report noting the content.

	Infection Prevention and Control (IPC) Group Upward Report The Committee received the upward report noting that there had been no new MRSA cases however there had been some Trust acquired Clostridium-Difficile cases. The Trust continued to manage Covid-19 in line with updated policies and procedures. The CPE outbreak that had been previously advised to the Committee was being managed with work being undertaken through estates and facilities to replace wash hand basins. The Committee was please to receive the letter (appended) from the NHS England Regional IPC team which confirmed the green rating awarded to the Trust following the regional visit. Significant progress had been made in order to achieve this position which had been done against the backdrop of the pandemic. **Medicines Quality Group Upward Report** The Committee noted, through the upward report, a reduction in the number of incidents causing harm to patients over the 3 month reporting period however this decrease had not been seen in relation to DKA. The Committee noted that there was a separate workstream underway to consider diabetes. The Committee noted the impact that workforce issues were having on medicines reconciliation and this would continue to be monitored through the group and upwardly reported to the Committee. The Committee requested that the medicines management annual report be received directly once complete. **Medicines Management Task and Finish Group Upward Report** The Committee noted the work plan with 11 separate projects identified which had project leads assigned. The Committee noted the phased approach being taken on the projects due to interdependencies however concern was noted due to the proposed timescales to address the outstanding actions from previous CQC and Internal Audit reports. **Patient Safety Group Upward Report** The Committee received the upward report noting that behaviour continued as an incident category. This had been reviewed by the group and further review of incident categories would be undertaken. The Committee was pleased to note that there had been successful appointment of 3 new Volunteer Patient Safety Advisors who would be able to support patient safety related meetings across the Trust.

	Children and Young People Oversight Group Upward Report The Committee received the upward report from the group for both the June and August meetings noting that the group considered the assurance process on actions outstanding from previous CQC inspections. The Committee noted that progress was being made in respect of the actions and specifically with the emergency department and the children and young people provision. The Committee discussed the interim children and young people model currently in place at Pilgrim hospital noting that work was underway to evaluate the model.
	Assurance in respect of SO 1b Issue: Improve Patient Experience **Patient Experience Group Upward Report** The Committee received the report specifically noting that attitude continued to be identified as a negative theme. Work would be undertaken with organisational development colleagues to ensure that there was an awareness by staff of the impact that attitude had on patient experience with data due to be shared. A refresh of staff values and behaviours was being undertaken. The Committee noted the concern about the difficulties in identifying specific space for bereaved relatives the hospital sites recognising that work was underway to address this with specific areas being identified where building developments were taking place. Work continued to improve the Trust telephone systems in order to improve experience of those trying to contact the Trust. **National Survey - Inpatient** The Committee received the report noting the results of the survey being advised of the task and finish group that had been established to consider all results of national surveys. The Trust would be taking a joined up approach to develop a single action plan for all survey outcomes that had been divided into 10 domains. Where possible actions would be included within current actions being undertaken by the Trust. **Complaints Report** The Committee received the quarter 1 report noting the continued support to the divisions in order to ensure that complaints were closed in a timely manner. The Committee noted the reduction in the backlog and the recruitment underway for a Clinical Complaints role within the team to further support

	the work with the divisions. The Committee was pleased to note the inclusion of health inequality data relating to ethnicity and age within the report. This would support the Trust to ensure that there was effective engagement across of patient groups.
	Assurance in respect of SO 1c Issue: Improve Clinical Outcomes **NICE Report** The Committee was pleased to note 99% compliance with Technology Assessments noting that the 2 outstanding were due to be closed in the coming month. Whist risk stratification was not yet complete for NICE Guidance this would enable prioritisation once in place. This would ensure that the potential for harm, whilst guideline revisions took place, was reduced. **CQUIN Report** The Committee received the report and noted that the Trust would be reporting CQUINs for 2022/23, agreement of these had been delayed due to a request to NHS England, by the system, to be exempt from CQUINS for the year which had been declined. Reporting would be received from quarter 2 and a CQUIN delivery group established with the relevant teams, supported by informatics, to ensure delivery. **Clinical Audit Report** The Committee noted the increased grip and control being demonstrated through the report in respect of clinical audit noting the recent Internal Audit which had offered significant assurance. The Committee suggested that staff should be encouraged to disseminate the outcome of the audits and to consider presenting these to regional meetings or submitting papers to support the enhancement of research. It was hoped that learning events would start to take place with the divisions to share good practice through clinical audit , complaints and serious incidents in order to change practice. **Clinical Effectiveness Group Upward Report** The Committee received the upward report noting the continued clinical engagement at the meetings and the improve discussion taking place as a result. Divisional reports demonstrated a good understanding of divisional issues and actions in place to mitigate against these. The group escalated to the Committee the issue of data opt out noting

	that the Trust required a policy to be in place. This would be discussed at the meeting in September.
	Assurance in respect of other areas: **Integrated Improvement Plan** The Committee received the report noting the limited assurance that had been provided in particular the need to understand the key areas that would improve clinical effectiveness. Further work was required to fully populate the metrics in order to ensure that deliverability of schemes could be demonstrated and to demonstrate evidence based practice. **Internal Audit Recommendations** The Committee received the internal audit recommendations for information noting that there had been a reduction in the number of overdue recommendations. Work would take place in order to ensure that all recommendations were appropriately updated. **Savile Action Plan** The Committee received the updated action plan noting that this offered moderate assurance on the progress of the actions identified. It was noted that progress was being made with the action plan however concern was noted in respect of actions relating to Human Resources and the impact on quality within the organisation. The Committee would refer its concerns to the People and Organisational Development Committee in order to receive assurance on the progress being made. The Committee would continue to receive the action plan until all actions were complete and embedded. **CQC Action Plan** The Committee received the report noting that there had been little movement from the previous month due to staffing levels at this time of year. The Committee was advised of the confirm and challenge meetings that would take place in September regarding the position of the actions and to confirm progress of these and to identify, if required support to the divisions. **Committee Performance Dashboard** The Committee received the performance dashboard noting the content and reflecting that the reports received by the Committee had enable discussions in relation to the reported performance.

	The Committee considered those metrics that were not yet populated and recognised that whilst SPC charts were used there may be additional benefit in trends being reported.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	The Committee wished to refer concerns regarding progress on the Human Resources element of the Savile action plan to the People and OD Committee to seek wider assurance on the progress of the actions identified The Committee wished to refer to the People and OD Committee the issue of patient experience training being mandatory training and the identification of the relevant training for staff groups to ensure this was accurately identified.
Committee Review of corporate risk register	The Committee noted the risk register noting those risks contained within the register.
Matters identified which Committee recommend are escalated to SRR/BAF	None
Committee position on assurance of strategic risk areas that align to committee	The Committee considered the reports which it had received which provided assurances against the strategic risks to strategic objectives.
Areas identified to visit in dept walk rounds	None

Attendance Summary for rolling 12-month period

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

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

Karen Dunderdale
United Lincolnshire Hospitals NHS Trust,
Trust HQ,
Lincoln County Hospital,
Main Entrance,
Greetwell Road,
Lincoln
LN2 5QY

NHS England- Midlands
Regional Chief Nurse
Cardinal Square – 4th Floor
10 Nottingham Road
Derby
DE1 3QT

19 July 2022

Dear Karen,

United Lincolnshire Hospitals RAG Rating Follow Up

Thank you for your patience in respect of my response over the Trusts current RAG rating against the NHSE IPC matrix.

As we discussed during our call, when we arranged the visit to site in April 2022, we agreed this with your team on the basis that this was a peer review visit to support with the actions that were identified following the previous visit in February 2022, where the Trust were rated AMBER. From our perspective we believed that we had conveyed that this was for assurance but was not intended to trigger a review of the RAG rating, this was to support and ensure that improvements were on track ahead of the full review in September. I understood from our conversation that you however believed that this was a full review based on the wording in the letter and that the RAG rating was going to be reassessed.

Following our discussion we have reviewed the information that we have available to us and we have agreed that the Trust will be moved to a GREEN rating until the re-alignment onto the new matrix following the full review that is scheduled in September 2022.

Yours sincerely,

Kirsty Morgan
Assistant Director of IPC

Report to:	Trust Board
Title of report:	Finance, Performance and Estates Committee Assurance Report to Board
Date of meeting:	25 August 2022
Chairperson:	Dani Cecchini, Non-Executive Director
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received, and key decisions made by the Finance, Performance and Estates Committee (FPEC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme. The Committee worked to the 2022/23 objectives.
Assurances received by the Committee	**Assurance** in respect of SO 3a A modern, clean and fit for purpose environment **Estates Report** The Committee noted the continued limited assurance being offered however reflected the progress being made on issues reported. The Committee was pleased to note the positive feedback from NHS England in respect of the Trust's ability to plan exceptionally well for the heatwave which had resulted in the Trust addressing a number of issues which had presented for some time. Progress was noted with policies across Health and Safety along with the positive relationship in place with the British Safety Council who had written a letter of commendation to the Trust in respect of the work done with them during Covid-19. The Committee explored PLACE assessments and when these would be fully reintroduced from PLACE Lite. It was noted that work was underway and there had been some progress made. The Committee requested that an update be provided at a future meeting on the position of the Estates Strategy. **Premises Assurance Model Report** The Committee received the report and recognised that the Trust had an independent assessor reviewing the scoring. A Premises Assurance Model Group would be established to managed the workload and ensure that progress and improvement was made with the Committee suggesting that the red actions be prioritised.

	The Committee noted that once the independent review had been completed this would be due for submission and would support the consideration of movement within the BAF of the current assurance rating. The Committee noted the moderate assurance offered at this time. **Health and Safety Committee Upward Report** The Committee noted that the report had been received as part of the Estates Report and was advised that standalone reports would be offered in future to the Committee. **ULHT Green Plan** The Committee received significant assurance with regard to the Green Plan which detailed the green opportunities for the Trust, which were increasing. The Committee noted that the plan was ambitious but that this covered a significant period of time until 2040. In order to gain a greater understanding of the plan the Committee requested site of those areas and actions relevant to the 2022/23 year. This would allow confirmation of alignment to the Estates Strategy. **Low Surface Temperature Report** The Committee received the report noting that significant assurance was offered with remedial work having been completed at Louth County Hospital. Works had been completed with an underspend achieved. Work continued with regard to third party premises utilised by the Trust.
	Assurance in respect of SO 3b Efficient Use of Resources **Finance Report inc Efficiency, Capital, Contract and CRIG Upward Report** The Committee received the report noting that limited assurance was being offered. There was an increasing focus on agency spend which was being driven by the number of beds open within the hospitals. The impact of cost was both in terms of volume and price with a focus from NHS England. The Committee recognised the current position with the cost improvement programme noting the intent of a renewed approach to delivery. Whilst slippage was noted on the capital programmes this was not a cause for concern. The Committee took the CRIG upward report as read and noted within contracting the risk and gain share element which remained under discussion. The Committee noted the continued breakeven forecast for the year but recognised the increasing challenges on delivery.

	National Cost Collection Submission 2021/22 The Committee received the submission noting the moderate assurance and intention to improve use of the available data within the Trust to support greater financial understanding.
	Assurance in respect of SO 3c Enhanced data and digital capability **Data Security Protection Toolkit submission and 2022/23 action plan** The Committee noted the submission that had been made at the end of June noting that the Trust had achieved 'approaching standards'. Work continued to achieve 95% compliance with Information Governance Training and an action plan was in place to address this. Once achieved this would be submitted and the Trust would achieve full compliance. Updates on the 22/23 submission would be offered to the Committee on a quarterly basis once released in August 2022. **Digital Hospital Group Upward Report** The Committee received the report noting the discussion held regarding the confirmation from NHS England that there is no longer any further funding available to implement the Maternity EPR outline business case and that would now need to be considered as part of the wider Trust electronic patient record business case .
	Assurance in respect of SO 3d Improving Cancer Services Performance **Operational Performance against National Standards** The Committee received the combined report noting that deterioration was seen in all areas of performance and the limited assurance offered. Urgent Care continued to present a number of challenges that required a system response in order to improve. Winter planning had also commenced with an initial plan submitted earlier than previous years. The plan had been submitted at a system level and the Committee was reassured that this was in line with the Trust improvement plan. The Committee continued to note concern relating to pathway 1 patients and available capacity within the community however was advised that this capacity should start to be seen in September. Planned care continued to be challenged due to the relationship between the availability of beds and issues with dealing with the backlog of patients which presented challenges. Outpatients was also a concern where there were challenges in restoring capacity to pre-Covid-19 levels. There was a need to increase over and above this in order to recover the delays as a result of Covid-19.

	Some improvement which had previously been made in cancer services had since been lost with specific issues noted in colorectal pathways. This was due to the availability of experienced staff and whilst recruitment had been successful there was a period of time before staff were able to function at the required capacity. Mutual aid was continuously being sought in order to support and make improvements in the pathway. A deep dive would be undertaken in respect of the colorectal improvement plan which would be presented to the Committee in September.
	Assurance in respect of SO 3e Reduce waits for patients who require planned care and diagnostics to constitutional standards **As reported at SO 3d**
	Assurance in respect of SO 3f Urgent Care **As reported at SO 3d**
	Assurance in respect of SO 4a Establish new evidence based models of care **Objective 4a Update** The Committee received the report noting that the update offered and noted the planned Board Development Session that would offer further insight into the current activity for evidence based models of care.
	Assurance in respect of other areas: **Committee Performance Dashboard** The Committee noted the limited assurance offered and noted that continued deterioration was being seen in many metrics, of particular note urgent care and ambulance handovers. The Committee was concerned that there continued to remain a number of items for which there was not yet clarity, these would be addressed by the Executive team. **Audit Recommendations** The Committee received the report noting the outstanding internal audit recommendations and recognising that current work and a re-audit would likely address the outstanding recommendations. **CQC Action Plan** The Committee considered the CQC Action plan noting the moderate assurance and areas highlighted specifically in relation to estates which would be followed up by the Director of Estates and Facilities to support progress.

	Due to the operational focus of actions and quality impact the Committee requested a review of the actions assigned to ensure these were correctly aligned. **Integrated Improvement Plan** The Committee received the report noting the month 4 position as reported and intended to undertake a focused review at the September meeting. **Improvement Steering Group Upward Report** The Committee received the report noting the ongoing actions in place including the CIP workshop that would be held to drive forward improve and achieve greater traction.
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. The Committee agreed that Objectives 3d, 3e and 3f should be rated red, amber and red respectively.
Areas identified to visit in dept walk rounds	None

Attendance Summary for rolling 12-month period

Voting Members	S	O	N	D	J	F	M	A	M	J	J	A
David Woodward, Non-Exec Director	X	X	X	X								
Dani Cecchini, Non-Exec Director					X	X	X	X	X	X	X	X
Chris Gibson, Non-Exec Director	A	X	X	X	X	X						
Gail Shadlock, Non-Exec Director						X	A	X	A	A	X	
Director of Finance & Digital	X	X	X	X	X	X	X	X	X	X	X	X
Chief Operating Officer	X	X	X	X	X	X	D	X	D	X	X	X
Director of Improvement & Integration					X	X	X	X	X	D	X	D
Sarah Buik, Associate Non-Executive Director												X

X in attendance

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

Meeting	*Trust Board*
Date of Meeting	*25 August 2022*
Item Number	*Item 11.3*
Green Plan	
Accountable Director	*Simon Evans, Chief Operating Officer*
Presented by	*Simon Evans, Chief Operating Officer*
Author(s)	*Claire Hall, Associate Director, Strategic Business Planning*
Report previously considered at	*Trust Board – April 2022* *FPEC – August 2022*

How the report supports the delivery of the priorities within the Board Assurance Framework	
1a Deliver harm free care	*X*
1b Improve patient experience	*X*
1c Improve clinical outcomes	*X*
2a A modern and progressive workforce	*X*
2b Making ULHT the best place to work	*X*
2c Well Led Services	*X*
3a A modern, clean and fit for purpose environment	*X*
3b Efficient use of resources	*X*
3c Enhanced data and digital capability	*X*
4a Establish new evidence based models of care	*X*
4b Advancing professional practice with partners	*X*
4c To become a university hospitals teaching trust	

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

Recommendations/ Decision Required	• *To approve The Trust's Green Plan*

Executive Summary

The NHS aims to provide health and high quality care for all, now and for future generations. This requires a resilient NHS, currently responding to the health emergency that COVID-19 brings, protecting patients, our staff and the public. The NHS also needs to respond to the health emergency that climate change brings, which will need to be embedded into everything we do now and in the future

NHS England's ambition is to be Carbon Net Zero by 2040, achieved by controlling direct emissions (e.g. fossil fuel use, anaesthetics, fleet vehicles) and Net Carbon Zero Plus by 2045 by reducing the emissions we can influence (e.g. food catering, travel, ICT)

In order to achieve this goal, each Trust has a duty to support NHS England to tackle the health impacts of the Climate emergency. Lincolnshire being a coastal county and subject to risk of flooding and the wider health implications, the Trust, as the largest employer in the county, needs to be leading the way in implementing measures to reduce our Carbon Footprint.

In order to set out the Trust's own ambitions to become Carbon Neutral by 2040, The Trust needs to produce a plan that sets out its intentions and the actions to be undertaken to reduce its impact on the environment. Demonstrate improvements to the healthcare provided to our patients and visitors and to share our vision with our staff.

The Green Plan is a living document and sets out the starting point - where The Trust is now, where it intends to be and how objectives will be achieved.

The Green Plan requires support from the Trust Board to endorse our commitment to reducing our Carbon Footprint and to meet the requirements of NHS England to become Carbon Net Zero by 2040/45

NHS
United Lincolnshire Hospitals
NHS Trust

Green Plan 2022 - 2025

Contents

Contents 2
Foreword 3
Highlights 4
Introduction 5
Organisational Vision 8
Drivers for Change 10
The UN Sustainable Development Goals 13
Linking the Green Plan to NHS Net Zero 14
The Current Position 17
Emissions Reduction Trajectory 19
Areas of Focus Contents 20
Workforce and System Leadership 21
Workforce 24
Sustainable Models of Care 27
Digital Transformation 30
Travel and Transport 34
Estates and Facilities 41
Capital Projects 47
Water Efficiencies 50
Waste and Recycling 53
Biodiversity and Greenspace 57
Medicines – Volatile Anaesthetic Gases and Inhalers 59
Supply chain and procurement 64
Food and Nutrition 72
Adaptation 76
Conclusion 79

Foreword

One of the most significant longer-term challenges that the NHS faces is the climate emergency and consequent correlation to a health emergency, with poor environmental health contributing to major diseases, including cardiac problems, asthma and cancer.

In Lincolnshire we are not immune from the health harms and impacts of climate change. As a coastal county some areas of Lincolnshire are at serious threat of flooding from future rising sea levels as a result of climate change, and our service users and staff, face potential risks.

As the largest employer in the County, United Lincolnshire Hospitals NHS Trust (ULHT) recognises its responsibility to reduce our impact on the environment and, by implementing and delivering our Green Plan, will work to protect and improve the health of our communities, patients, staff, residents and public.

The ULHT Green plan will showcase what we have already undertaken to improve our environmental impact, what more we can do and how our contributions will support the NHS to deliver a 'Net Zero' National Health Service by 2040. We are working together with Lincolnshire Partnership NHS Foundation Trust, Lincolnshire Community Health Service NHS Trust and our County and District Council partners to promote the opportunities that a Greener NHS can have on health inequalities and improving social value.

Our Trust believes that the responsibility lies with all of us to make a difference, large or small, and that we need to embrace and invest in changes that have a positive impact on our future sustainable lives. The actions, initiatives and projects we action will reflect increased awareness, knowledge of, and understanding of our objectives and responsibilities, sharing our impact in reducing carbon emissions produced by the Trusts activity.

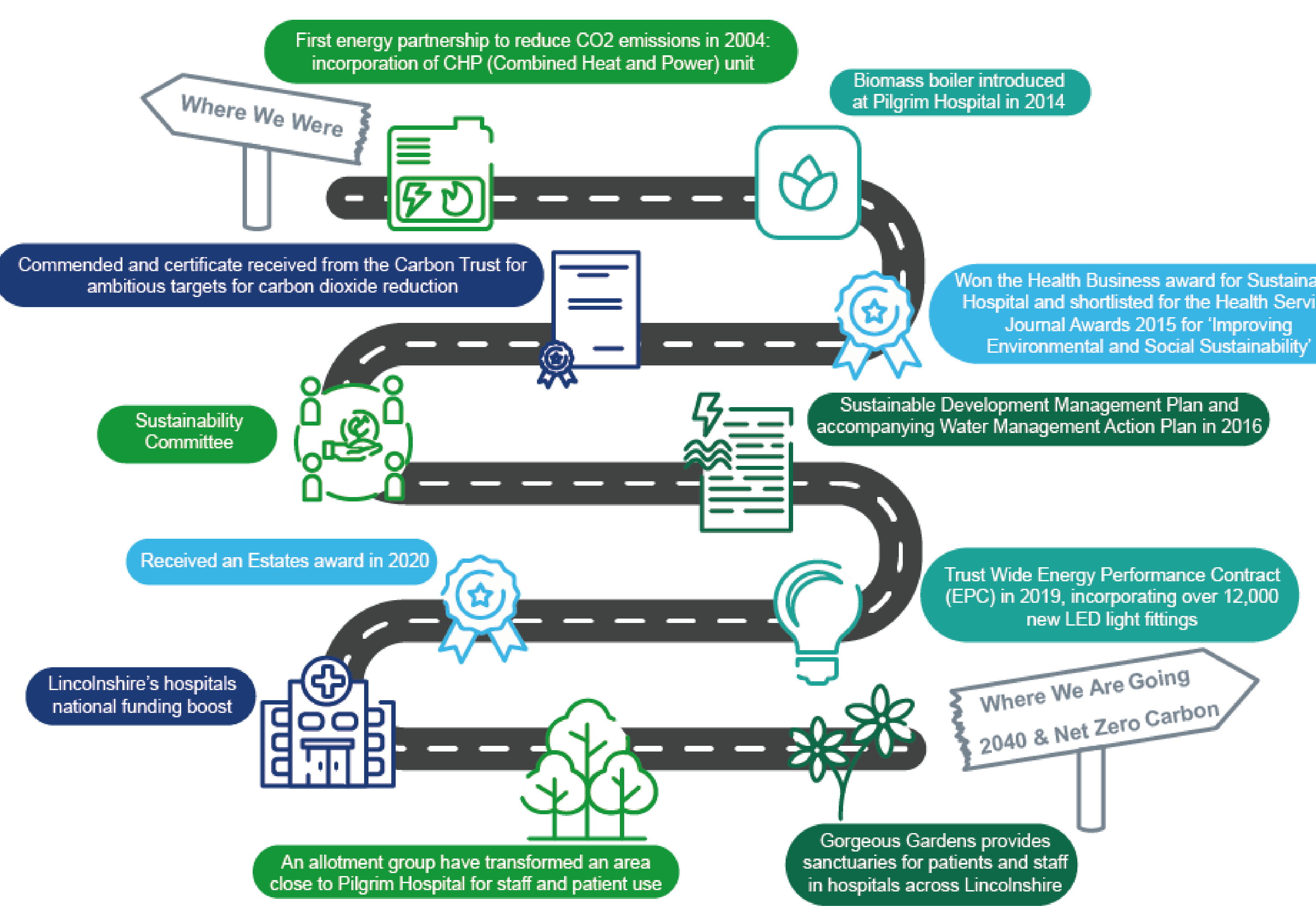
Undoubtedly, we will face challenges – Lincolnshire is the second largest county in the country, and the rurality and transport infrastructure pose their own problems - but we will endeavour to look at every aspect of our business and the services we provide, taking a holistic approach to reducing every aspect of our environmental footprint, whilst working hard towards providing sustainable high-quality services for the present and future generations.

Simon Evans

Chief Operating Officer

Highlights

The Trust has undertaken a number of sustainability initiatives. These include a Health Business Award for a Sustainable Hospital and an Estates Innovation Award following a LED lighting replacement scheme, in addition to a commendation from the Carbon Trust. The Trust strives to continue to lead the way in sustainable healthcare provision, as evidenced in this Green Plan



Introduction

"While the NHS is already a world leader in sustainability, as the biggest employer in this country and comprising nearly a tenth of the UK economy, we're both part of the problem and part of the solution.

That's why we are mobilising our 1.3 million staff to take action for a greener NHS, and it's why we have worked with the world's leading experts to help set a practical, evidence-based and ambitious route map and date for the NHS to reach net zero."
Sir Simon Stevens, former NHS Chief Executive

United Lincolnshire Hospitals NHS Trust (ULHT) is proud to share the Trust's Green Plan, which seeks to embed sustainability and low carbon practice in the way vital healthcare services are offered and help the NHS to become the first health service in the world with net zero greenhouse gas (GHG) emissions.

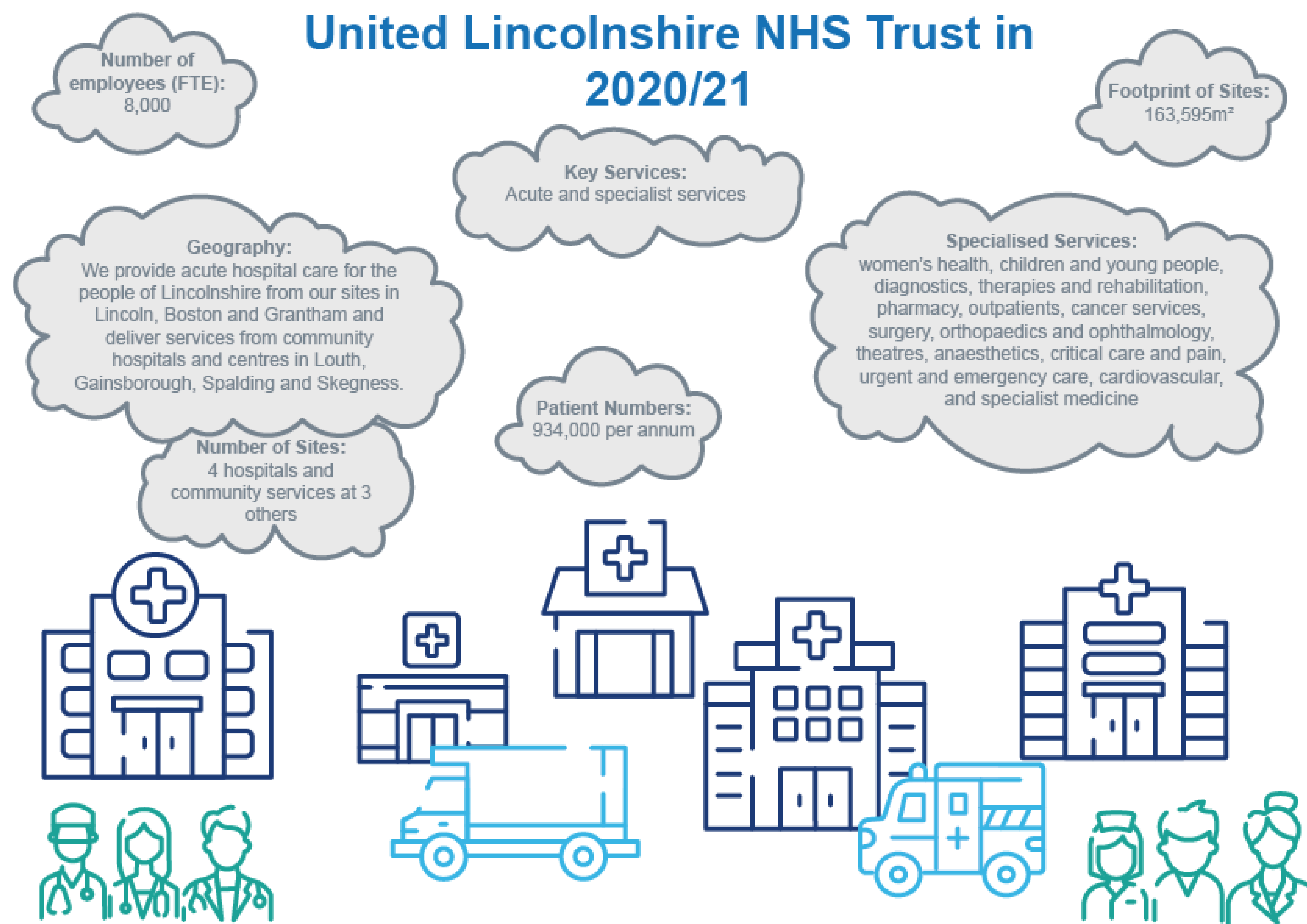
The climate crisis is also a health crisis. Rising temperatures and extreme weather will disrupt care and impact the health of patients and the public, especially the most vulnerable in society.

People with mental health issues may experience a higher degree of 'climate anxiety', and there may be co-morbidities associated with the physical impacts of climate change and a deterioration in mental health.

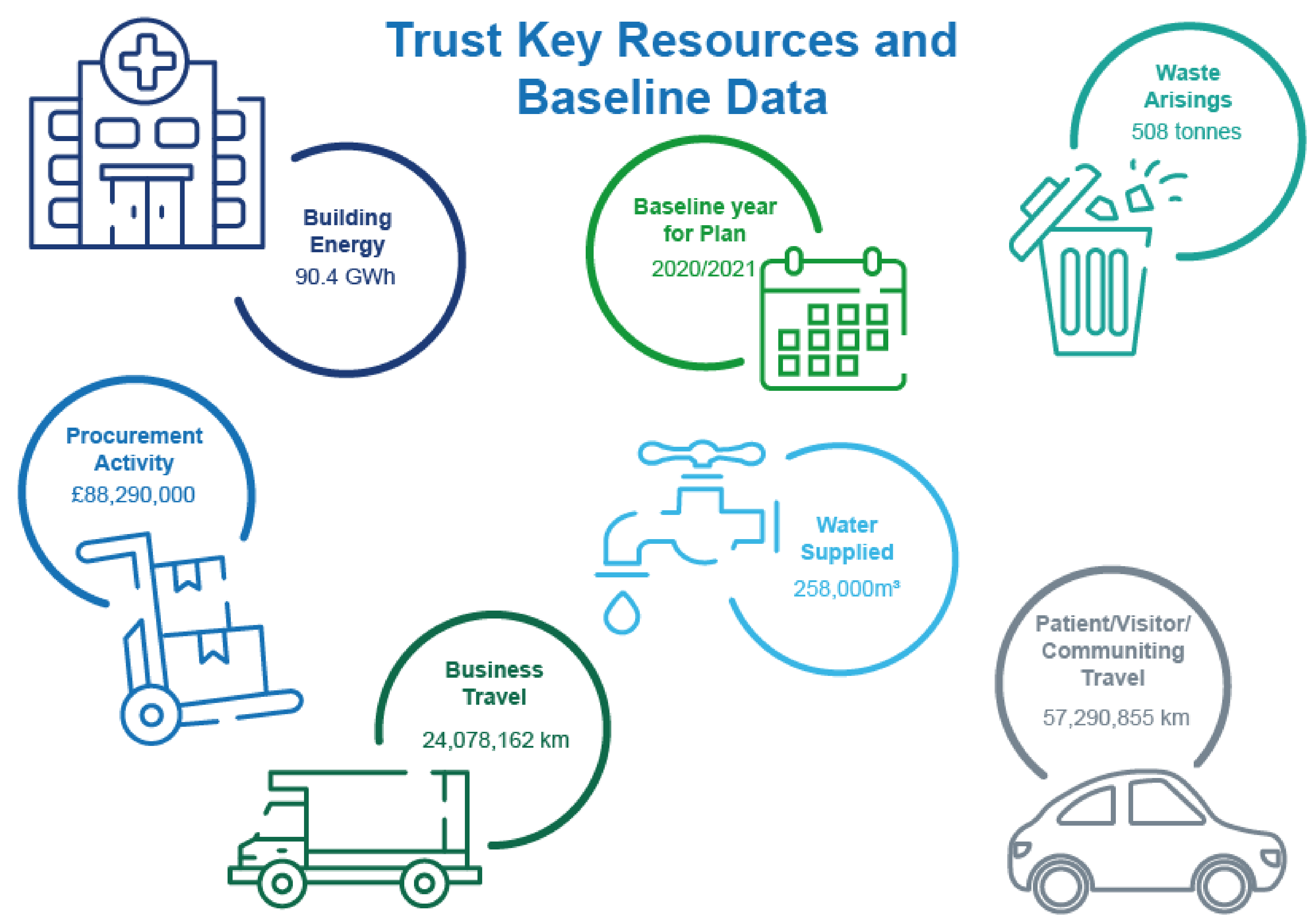
ULHT has a central role to play in reducing health inequalities and helping the NHS to reach net zero.

This Green Plan serves as the central document for ULHT's sustainability agenda and provides the rationale for sustainability at the Trust. Through this Green Plan, ULHT will work with staff, patients and partners to take powerful sustainable development and climate action as part of the Trust's commitment to offer the highest quality care to the Lincolnshire community.

The Trust will establish a Sustainability Committee that will meet regularly and project manage the delivery of Green Plan activities by multiple teams. The Green Plan will be incorporated as a part of the Sustainability Committee agenda, reviewed annually, and updated where necessary to ensure continual improvement.


United Lincolnshire NHS Trust in 2020/21
Number of employees (FTE): 8,000
Footprint of Sites: 163,595m²
Key Services: Acute and specialist services
Geography: We provide acute hospital care for the people of Lincolnshire from our sites in Lincoln, Boston and Grantham and deliver services from community hospitals and centres in Louth, Gainsborough, Spalding and Skegness.
Specialised Services: women's health, children and young people, diagnostics, therapies and rehabilitation, pharmacy, outpatients, cancer services, surgery, orthopaedics and ophthalmology, theatres, anaesthetics, critical care and pain, urgent and emergency care, cardiovascular, and specialist medicine
Patient Numbers: 934,000 per annum
Number of Sites: 4 hospitals and community services at 3 others

Trust Key Resources and Baseline Data



Organisational Vision

These core values are embedded within the Trust's 2021/22 Strategic Objectives and are integral to the Green Plan to achieve sustainable, person-centred care in a safe and quality-focused way.

The Green Plan adds further environmental and social dimensions to the delivery of care, especially in terms of the widely accepted climate and ecological crisis.

Green Plan Vision

Net Zero: resource consumption and Greenhouse Gas (GHG) emission reductions that align with NHS net zero targets and mitigate against climate change.

Climate Resilience: adaptation strategies that strengthen the Trust's ability to maintain quality care and provide a basis for us to become a climate change resilient organisation.

Social Value: actions that influence the collective social wellbeing of patients, staff and surrounding community.

The Green Plan has nine Areas of Focus that appraise the Trust's status and set actions to be achieved within the next three years:

1. Workforce and Systems Leadership
2. Sustainable Models of Care
3. Digital Transformation
4. Travel and Transport
5. Estates and Facilities
6. Medicines
7. Supply Chain and Procurement
8. Food and Nutrition
9. Adaptation

Staff member. Source: ULHT Library

Drivers for Change

ULHT is committed to deliver the NHS Long Term Plan, Standard Contract, and the recommendations in the Priorities and Operational Planning Guidance and 'Delivering a Net Zero NHS' report, all of which have informed the Green Plan and shape the Trust's Vision.

The Trust will work through this plan to fulfil sustainable development requirements from the NHS (as shown in Figure 2) and other relevant legislation (as listed on the next page in Figure 3) that are aligned with the relevant United Nations (UN) Sustainable Development Goals (SDGs). This includes obligations to minimise adverse impacts on the environment and secure wider social, economic and environmental benefits for communities.

The Trust also commits to review and participate in regional partnerships and strategies related to sustainable development wherever appropriate.

Grantham and District Hospital sign. Source: ULHT Library

Priority	Link to our Green Plan
NHS Long Term Plan (LTP)	2.18 Take action on healthy NHS premises. 2.21 Reduce air pollution from all sources. 2.24 Take a systematic approach to reduce health inequalities. 2.3 Improve preventative care. 2.37 Commission, partner with and champion local charities, social enterprises and community interest companies. 4.38 Make the NHS a consistently great place to work – promoting flexibility, wellbeing and career development. 4.42 Place respect, equality and diversity at the heart of workforce plans. 16 Play a wider role in influencing the shape of local communities. 17 Lead by example in sustainable development and in reducing use of natural resources and the carbon footprint of health and social care 18 Create social value in local communities as an anchor institution.
NHS Standard Contract 21/22 SC18	18.1 Take all reasonable steps to minimise adverse impact on the environment. 18.2 Maintain and deliver a Green Plan, approved by the Governing Body, in accordance with Green Plan Guidance.
Planning Guidance 21/22 PG	C1 Where outpatient attendances are clinically necessary, at least 25% should be delivered remotely by telephone or video consultation
Estates 'Net Zero' Carbon Delivery Plan NZCDP	1. Making every kWh count: Investing in no-regrets energy saving measures 2. Preparing buildings for electricity-led heating: Upgrading building fabric 3. Switching to non-fossil fuel heating: Investing in innovative new energy sources 4. Increasing on-site renewables: Investing in on-site generation
Greener NHS / Net Zero Plan	Net zero by 2040 for the NHS Carbon Footprint, with 80% reduction by 2028 to 2032. Net zero by 2045 for the NHS Carbon Footprint 'Plus', with an ambition for an 80% reduction by 2036 to 2039.

Figure 1 NHS Environmental Drivers

Legislative Drivers	UK Guidance
Civil Contingencies Act 2004	National Policy and Planning Framework 2012
Climate Change Act 2008 (as amended)	Department of Environment, Food and Rural Affairs (DEFRA) The Economics of Climate Resilience 2013
Public Services (Social Values) Act 2012	Department for Environment, Food and Rural Affairs (DEFRA) Government Buying Standards for Sustainable Procurement 2016
Mandatory; those mandated within the NHS	The Stern Review 2006; the Economics of Climate Change
Standard Form Contract requirements	Health Protection Agency (HPA) Health Effects of Climate Change 2012
HM Treasury's Sustainability Reporting Framework	The National Adaptation Programme 2013; Making the country resilient to the changing climate
Public Health Outcomes Framework	Department of Environment, Food and Rural Affairs (DEFRA) 25 Year Plan
International	**Health Specific Requirements**
Intergovernmental Panel on Climate Change (IPCC) AR5 2013	Delivering a Net Zero National Health Service 2020 and Greener NHS guidance
UN Sustainable Development Goals (SDGs) 2016	Five Year Forward View 2014
World Health Organisation (WHO) toward environmentally sustainable health systems 2016	Sustainable Development Strategy for the Health and Social Care System 2014-2020
World Health Organisation (WHO) Health 2020	Adaptation Report for the Healthcare System 2015
The Global Climate and Health Alliance. Mitigation and Co-benefits of Climate Change	The Carter Review 2016
	National Institute for Clinical Excellence (NICE) Physical Activity; walking and cycling 2012
	Health Technical Memoranda (HTM) and Health Building Notes (HBN)
	Sustainable Transformation Partnerships (STP) Plans

Figure 2 Legislative Drivers with UK Guidance

The UN Sustainable Development Goals

The Trust is working meaningfully towards the United Nations (UN) Sustainable Development Goals (SDGs) through the Green Plan, which have been aligned to relevant SDG targets.

The SDGs underpin a global action framework to 2030, adopted by every UN member country to address the biggest challenges facing humanity.

Each goal has targets and indicators to help nations and organisations prioritise and manage responses to key social, economic and environmental issues.

"The NHS belongs to all of us" *

The NHS and its people contribute to multiple SDGs through the delivery of its core functions, for example, target 3.8, to achieve universal health coverage.

Established on 5th July 1948, the UK's National Health Service is the world's first modern fully universal healthcare system, free at the point of use, and celebrating its 75th year in 2023.

* Constitution of NHS England

ULHT will work to ensure:

- Meaningful alignment to SDG targets within each Green Plan area of focus
- The establishment of effective partnerships for the goals within our region and beyond
- Awareness of and links to the SDG's global context, wherever appropriate

Linking the Green Plan to NHS Net Zero

Contributing to around 4% of the country's carbon emissions, and over 7% of the economy, the NHS has an essential role to play in meeting the net zero targets set under the Climate Change Act.

Two clear and feasible net zero targets for NHS England are outlined in the 'Delivering a 'Net Zero' National Health Service' report (aka NHS Net Zero Report):

- **The NHS Carbon Footprint** for the emissions under direct control, net zero by **2040**
- **The NHS Carbon Footprint 'Plus'** for the emissions under influence, net zero by **2045.**

All NHS trusts are to align their Green Plans with NHS England's net zero ambitions. Those emissions have been calculated from all the sources listed in the NHS Net Zero Report should be reduced by approximately 4% year-on-year (akin to Science Based Targets) until each of the relevant target dates.

Greenhouse Gas Emissions

Greenhouse gas emissions are conventionally classified into one of three 'scopes', dependent on what the emission source is and the level of control an organisation has over the emission source. They are reported in 'tonnes of carbon dioxide equivalent' (t CO2e).

The emission sources and their 'scopes' are shown in the infographic (Figure 4).

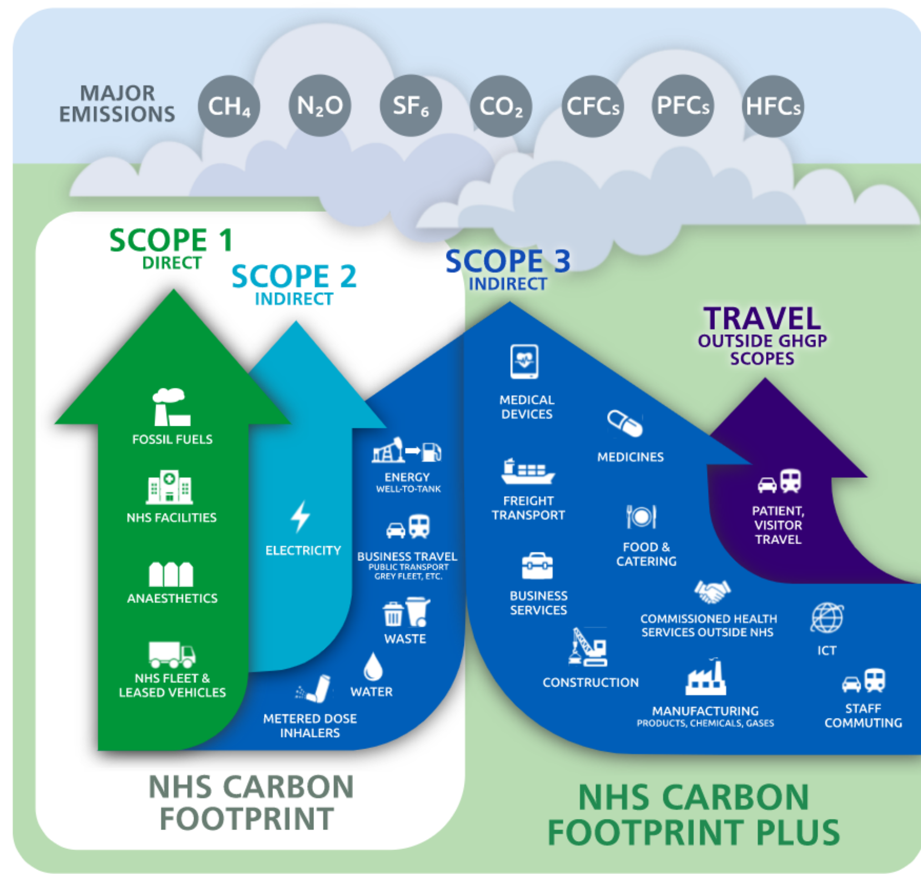


Figure 3 Greenhouse gas emission sources, and their 'scopes'

Data and methodology

The result of a GHG emission calculation varies in accuracy depending on the data set provided. The more accurate the data supplied, the more accurate the result, which will subsequently

allow for better targeting of areas where improvements can be made.

ULHT's GHG emissions footprint has been calculated according to the GHG Protocol for Corporate Reporting and aligned with ISO 14064:1.

The Trust's carbon footprint has been calculated from 2018/19 to 2020/21 in terms of building energy and delivery of care, travel, and the supply chain, as per the categorisations in the NHS Net Zero report. Data for 2021/22 was projected based on these calculations.

The Trust has used the following primary data:

- resource consumption (electricity, gas, water) data from utility bills
- waste arisings from data sets from waste contractors
- fleet vehicle fuel use from fuel reports/receipts
- business miles travelled (by car) from the expenses system
- published procurement spend

Data was unavailable for business travel (rail and air) and for inhaler and volatile anaesthetics, in large part due to pressure from the COVID-19 pandemic. The carbon footprint will record these emissions in the future.

The Trust has used the NHS Health Outcomes of Travel Tool (HOTT) to estimate emissions from staff commuting, patient and visitor travel and published procurement expenditure to derive spend-based emission values for categories within our supply chain.

The Trust is using 2020/21 as the baseline year to set targets against as calculations were made before the 2021/22 financial year was complete.

Clinical ward doctors. Source: ULHT Library

ULHT's Net Zero Ambitions

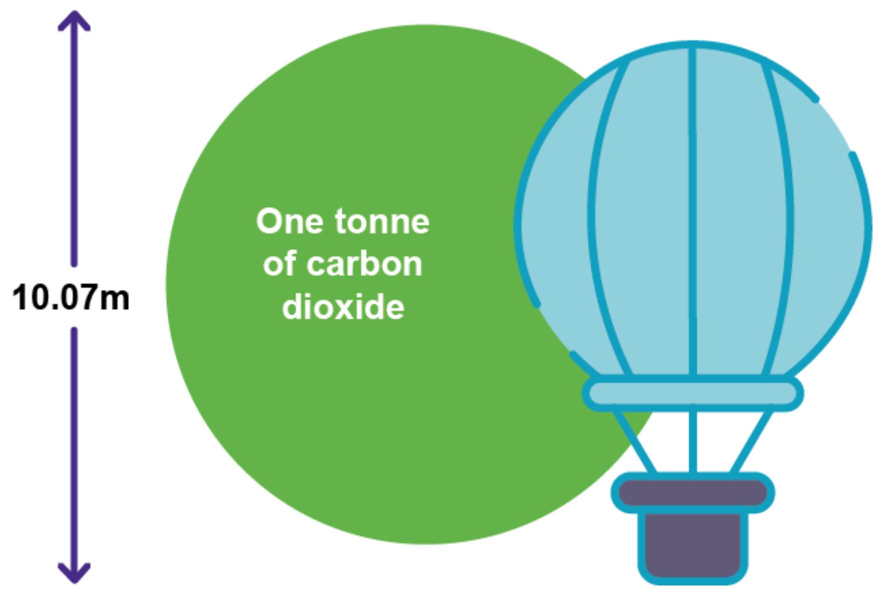
ULHT fully commits to reducing greenhouse gas emissions to Net Zero to prevent the worst impacts of climate change and meet NHS Net Zero commitments. This plan outlines high-level emissions reductions and enabling actions for each area of focus. This means ULHT needs to act now to reduce emissions from a variety of direct and indirect sources; from the estate to the delivery of care and beyond, each year from now until Net Zero is achieved.

The Trust is using this Green Plan to improve Net Zero-related data collation, carbon footprint and reporting capacity over time.

This Includes:

- Determining weaknesses in our current reporting processes and taking remedial action to ensure robust data is collected
- Developing processes to measure/record emissions we have not previously tracked, such as emissions related to volatile anaesthetics and our supply chain
- Identifying reduction actions for categories we cannot yet easily measure

An emissions-reduction trajectory for each emission source has been given in each Area of Focus (if applicable) for the next three years until 31st March 2025. To achieve these emission reductions, a series of actions in each Area of Focus has been listed. There will be residual emissions at both the 2040 and 2045 target dates, and these will need to be 'offset' or sequestered (which is not in the scope of this Plan).



What does 1 tonne of carbon dioxide look like?

One tCO2e can be visualised as a volume of gas the size of a hot air balloon – a sphere about 10 metres in diameter.

The average 3-bedroom semi-detached home in North West England emits around 1 tCO2e per year from electricity consumption and almost 2 tCO2e from the use of natural gas for heating and cooking.

The Current Position

The Carbon Footprint in 2020/21 was 99,523 tCO2e

To meet the NHS Net Zero commitments, around 3,119 tCO2e needs to be avoided from all sources each year until 2040/45.

Akin to the NHS Net Zero report, most of the emissions (81%) came from sources not under the Trust's direct control: 69% from the supply chain, a further 9% from patient and visitor travel, and 3% from commissioned health services.

The remaining 19% arose from sources that can be controlled or strongly influenced: 18% of the emissions came from the operation of buildings and 1% from transport associated with the delivery of care (including staff commuting).

See Figure 5 for the split of each emission category, as per the NHS Net Zero report categorisation. Data shown relate to emissions in tCO2e and their relative proportion of the footprint.

Key:

Delivery of Care:

Personal Travel:

Supply Chain:

Commissioned Services

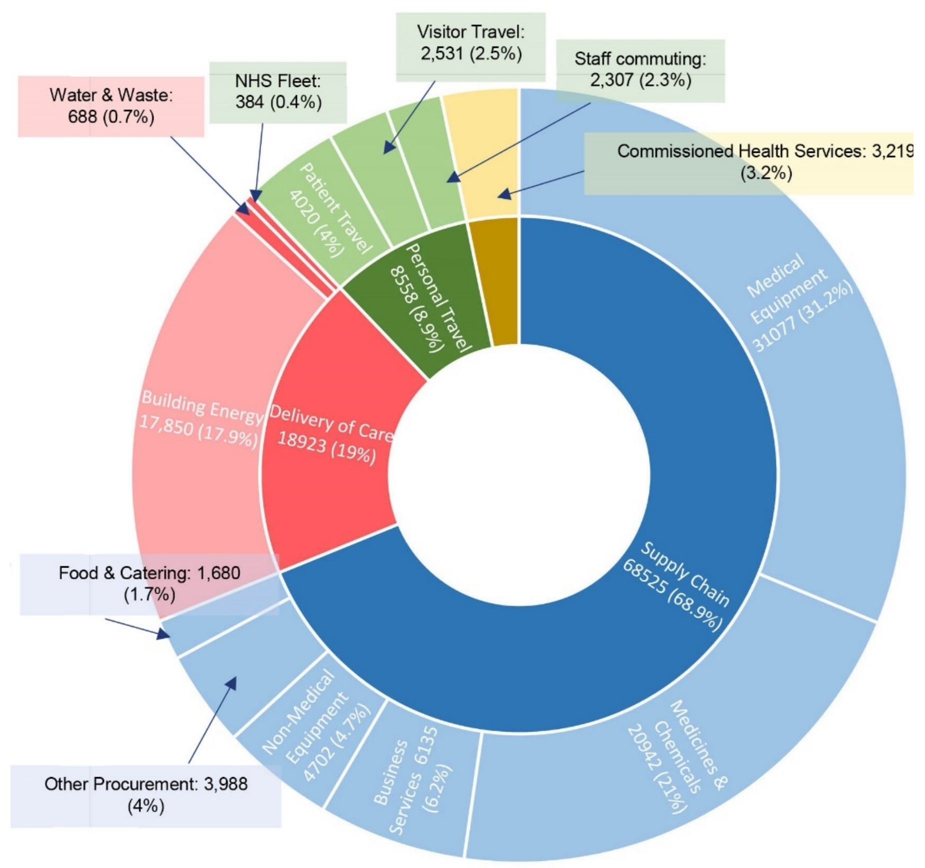
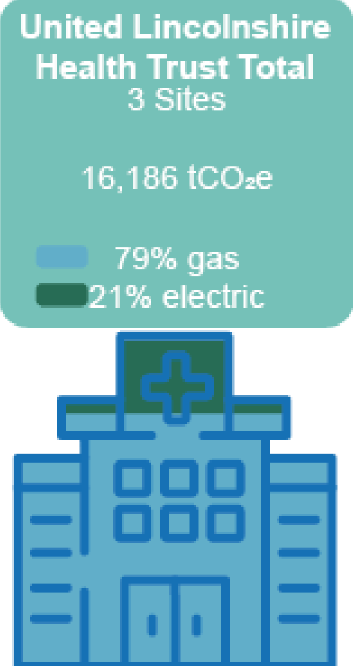


Figure 4 ULHT total carbon footprint breakdown in 2019/20

Emissions from the built environment are shown in Figure 6, and a more detailed breakdown of emission sources for the financial years 2018/19 to 2020/21 to illustrate trends over this period, as shown in Figure 7.

Figure 5 Emissions from the built environment in 2020/21



Emissions Reduction Trajectory

Emission sources have been grouped together and yearly emission reduction targets have been calculated until 2024/25 (Figure 7).

Emissions rose in 2020/21 compared to 2019/20. This is due to the response to the COVID-19 pandemic, entailing a higher procurement spend and additional waste arisings.

Total emissions need to be reduced by 12,476 tCO_2e from the 2020/21 baseline by 2024/25 (taking into consideration the recent procurement of renewable electricity). This roughly equates to **3,119 tCO_2e** per annum.

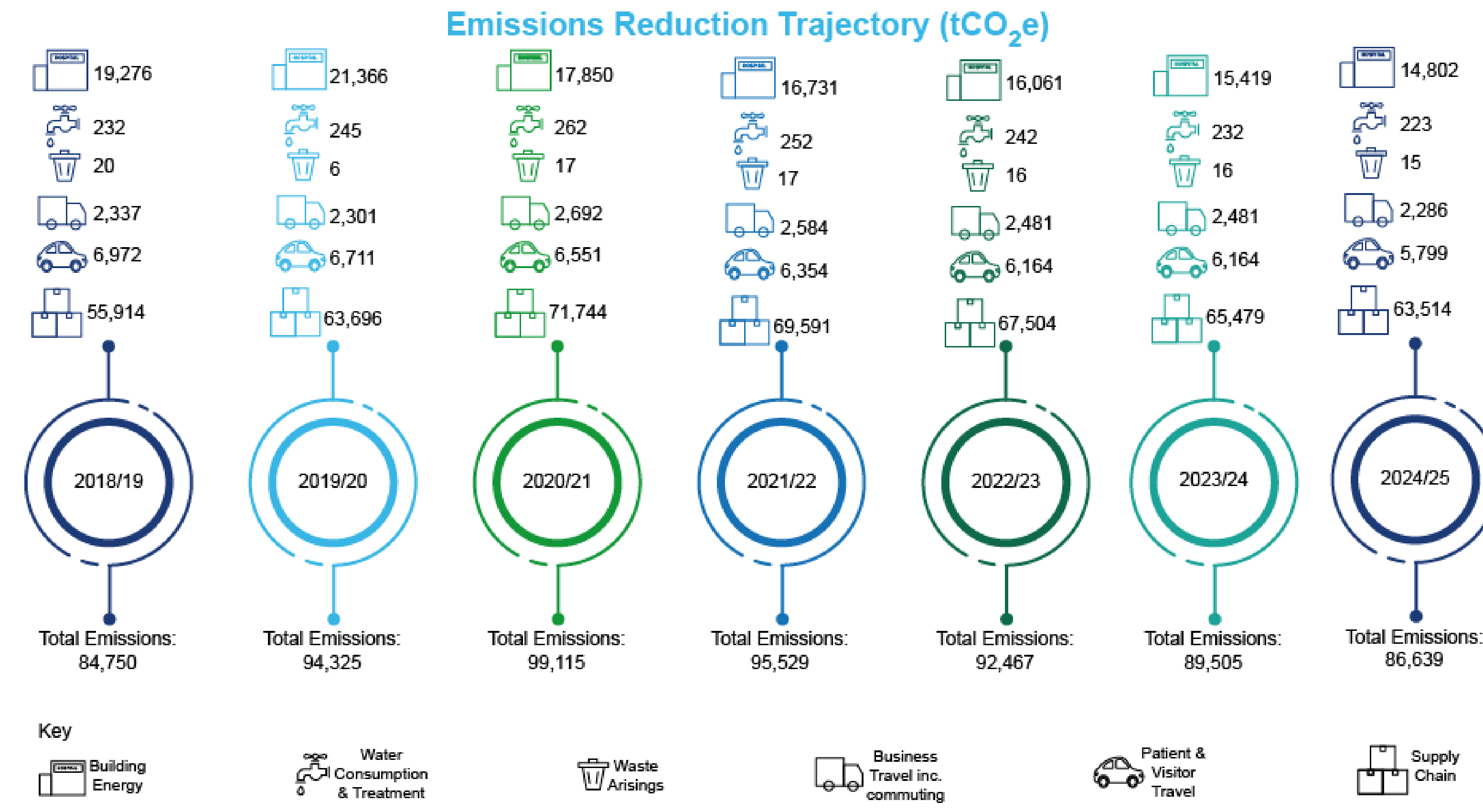


Figure 6 ULHT's Estimated GHG Reduction Target for three years by activity to meet 'Delivering a Net Zero NHS'

Areas of Focus Contents

The following 'Areas of Focus' give an overview of the Trust's current performance/status, each including an Action Plan.

The Action Plans state individual actions to achieve the Trust's Green Plan goals over the next three years. Individual actions are to be monitored and evaluated routinely, and progress status changed accordingly.

Indicative costs and emission reductions are given for each action. These are very high-level assumptions. A key is given below.

Key:

Indicative Cost to achieve:

£ No or low cost

£ Moderately expensive

£ Significantly expensive

Indicative Emissions reduction:

Low or incremental reduction

Moderate reduction

Significant reduction

Not applicable

Workforce and System Leadership

The Trust will build the Green Plan into its strategic planning and governance, including clinical and operational policies and procedures to ensure sustainable development is a part of the Trust's daily work and how success is measured.

The Trust's board-level Net Zero lead will oversee the resourcing and delivery of this Green Plan. Action plans identified by this Green Plan will be reviewed in discussion with Finance and Capital Planning teams to identify suitable budgets. The Trust will seek to identify internal and third-party funding to support the roll-out of Green Plan actions.

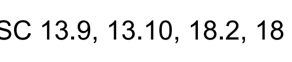
This Green Plan is approved by the Trust Board and will be reviewed (and revised if necessary). These reviews and progress against the actions in the Green Plan will be submitted to the Coordinating Commissioner.

Nurses. Source: ULHT Library

Sustainability Committee

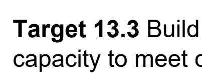
The committee will manage and drive sustainable development within the Trust. The Trust plans to identify a number of Sustainability Champions, who will be environmentally conscious volunteers.

LTP 2.24, 17



SC 13.9, 13.10, 18.2, 18

NZ 4.2.3



Target 13.2 Integrate climate change measures into policy and planning

Target 13.3 Build knowledge and capacity to meet climate change

No	ULHT Green Plan Actions	Trust Area	Target Year	Pro-gress	Indicative Cost to Achieve	Indicative Emissions Reduction	Responsible lead/dept	NHS Req.
01	Review and approve the plan at the Board level, monitoring delivery at Board meetings and relevant committees.	Governance & policy	On-going		£		Trust Board	SC 18.2
02	Nominate and empower a Climate Change Adaptation Lead and keep the Co-ordinating Commissioner informed at all times of the persons holding these positions.	Governance & policy	22/23		£		Trust Board	LTP 2.24,17 SC 18.2.2
03	Identify budgets for the delivery of each 'area of focus' and the Green Plan as a whole.	Governance & policy	22/23		£		Trust Board	LTP 2.24,17
04	Streamline data collection processes and produce a comprehensive monthly data report with relevant Green Plan metrics	Governance & policy	22/23		£		Estates and Facilities	NZ 3.1.1, 3.1.2
05	Produce an annual granular carbon account in line with HM Treasury's 'Public sector annual reports: sustainability reporting guidance', with the intention of widening its scope and data quality, when possible, along with an annual review of the progress against the Green Plan actions / emission reduction targets	Core responsibilities	22/23		£		Estates and Facilities	SC 18.3
06	Ensure staff are resourced to undertake Green Plan duties and nominate a lead person or department for each Green Plan area of focus to develop and coordinate action through the existing Sustainability Steering Group.	Governance & policy	23/24		£		Trust Board	LTP 2.24,17
07	Ensure the Green Plan delivery is reflected in the corporate risk register.	Governance & policy	23/24		£		Trust Board	LTP 2.24,17
08	Review procurement plan at board level to achieve a net zero supply chain. Fulfil the Trust's role as an anchor institution to achieve social value and wider benefits for communities, particularly for the Trust's care groups.	Procurement & Supply Chain	23/24		£		Trust Board	LTP 2.24,17

09	**Identify and action ways to engage patients and community in Green Plan delivery, including links between health inequality and climate action.**	**Working with patients, staff & communities**	**23/24**		£		**HR**	**LTP 2.24,17**
10	Identify internal and third-party funding to enable key Green Plan actions.	Governance & policy	On-going		£		Estates and Facilities	LTP 2.24,17
11	Work in partnership with neighbouring NHS trusts and public authorities to enhance the delivery of the Green Plan and share best practice	Governance & policy	On-going		£		Trust Board	LTP 2.24,17
12	Ensure quarterly Greener NHS Data Collection uploads are made	Core responsibilities	On-going		£		Estates and Facilities	NZ 3.1.1, 3.1.2

Figure 7 Green Plan actions for system leadership

Workforce

All colleagues are needed for the Trust's Green Plan to be successful.

The NHS is the biggest employer in Europe and the world's largest employer of highly skilled professionals and the NHS Long Term Plan aims to ensure it is a rewarding and supportive place to work.

A 2018 national survey of NHS staff showed that 98% of those surveyed thought it was important that the health and care system works in a way that supports the environment, and ULHT will enable colleagues to lead the way to achieve a greener NHS.

However, the Trust's Green Plan needs to be embedded within its culture, with the recognition that people are at the core of the NHS. The Trust will empower staff to deliver this Green Plan at all levels of the organisation. To do this, the team will further utilise the Greener NHS "One Year On" Communications Toolkit, currently used for general messaging and press releases.

Energy saving and sustainability are to be promoted at future inductions, with mandatory training and team meetings being considered. There is also a plan for the Directorate of People and Organisation Development to produce a Sustainability Strategy.

Maternity ward staff. Source: ULHT Library

LTP 4.1, 4.3, 4.39, 4.42, 4.43, 4.7

SC 13.1 through 13.10

Target 8.5 Full employment and decent work with equal pay

Target 13.3 Build knowledge and capacity to meet climate change

Target 16.B Promote and enforce non-discriminatory laws and

No	ULHT Green Plan Actions	Trust Area	Target Year	Pro-gress	Indicative Cost to Achieve	Indicative Emissions Reduction	Responsible lead/dept	NHS Req.
01	Establish a Sustainability Group and incorporate the Green Plan into its agenda.	Governance & policy	22/23		£		Estates and Facilities	**LTP** 4.1, 4.3, 4.39, 4.42 **SC** 13.1 to 13.10
02	Building on current practice, review policies and processes against NHS aims for ensuring rewarding, flexible and supportive work, positive action on promoting equalities, including through the Workforce Race Equality Standard and new Workforce Disability Equality Standard, and regular reporting against the NHS Model Employer Strategy.	Governance & policy	On-going		£		People & OD	**LTP** 4.1, 4.3, 4.39, 4.42 **SC** 13.1 to 13.10
03	Incorporate the Green Plan into the Essential Mandatory Training and Induction policies.	Governance & policy	22/23		£		Education Services	**NZ** 4.2.1
04	Create Green Plan intranet pages for staff access and external webpages for other stakeholders; upload Green Plan content and progress updates accordingly.	Governance & policy	22/23		£		Sustainability Lead	**NZ** 4.2.1

05	Use the Green NHS 'ONE YEAR ON' Communications Toolkit and/or the 'Healthier Planet, Healthier People' Toolkit to create and share communications about the Green Plan.	Working with patients, staff & communities	22/23		£		Communications & Engagement	**NZ** 4.2.1
06	Encourage staff to actively participate in the Greener NHS community and other forums such as the Greener AHP Hub, Centre for Sustainable Healthcare and related workspaces on the Future NHS platform.	Working with patients, staff & communities	22/23		£		Communications & Engagement	**NZ** 4.2.1
07	Consult, explore and action how clinical and non-clinical staff can best participate in the Green Plan delivery process, ensuring this is incorporated into work plans, work-time allocations, performance reviews, and collaborating with other trusts where appropriate.	Governance & policy	22/23		£		Sustainability Lead	**NZ**4.2, 4.2.1, 4.2.2, 4.3.3
08	Provide additional training related to this Green Plan to build capability in all staff, including on the link between climate change and health and practical actions that staff can take to help achieve net zero.	Core responsibilities	23/24		£		Training and Development	**NZ** 4.2.1
09	Work with suppliers to ensure that onsite workers are subject to the Real Living Wage, fair working practices and protections against discrimination.	Procurement & People & OD	23/24		£	✕	Procurement & People & OD	**LTP** 4.1, 4.3, 4.39, 4.42

Figure 8 Green Plan actions for workforce

Indicative cost:

£ No or low cost

£ Moderately expensive

£ Significantly expensive

Indicative emissions reduction:

Low or incremental reduction

Moderate reduction

Significant reduction

Not applicable

Sustainable Models of Care

The NHS Long Term Plan updates the NHS service model, with a focus on preventative care in communities and tackling health inequalities, now and in the future. This has been linked to emissions reductions and greener activities.

ULHT delivers acute and specialist clinical services to Lincolnshire and neighbouring counties. Services are provided from three acute hospitals in Lincolnshire, including community services, population-screening services, and a comprehensive range of planned and unscheduled secondary care services.

The National Patient Safety Improvement Programmes and the Investment Impact Fund indicators (IIF) provide underpinning principles for sustainable models of care, such as preventative care interventions and reducing health inequalities. Staff training and empowerment, as detailed in the previous sections, are critical to enhancing sustainable models of care.

The Trust provides excellent preventative care. Adhering to the Getting it Right First Time programme (GiRFT) helps to avoid additional hospital bed days and patient and visitor travel to clinics, and their associated environmental impacts. Strong interagency partnership working enhances GiRFT, providing a better care package. A GiRFT report quarterly is produced quarterly and the Trust is in the process of strengthening the reporting process.

The Trust will commit to link greenhouse gas reductions with the delivery of the Long Term Plan sustainable care model.

Nurse with patient. Source: ULH Library

No	ULHT Green Plan Actions	Trust Area	Target Year	Pro-gress	Indicative Cost to Achieve	Indicative Emissions Reduction	Responsible lead/dept	NHS Req.
01	Build on current efforts Getting it Right First Time (GiRFT), National Safety Improvement Programme to reduce health inequalities and improve early intervention, linking this work to potential emissions reductions.	Governance & policy	On-going		£		Trust Board and relevant clinical leads	LTP 2.26 SC13.9.118.4.2.1 NZ 4.1.3
02	Use the Embedding Public Health into Clinical Services Programme's toolkit and Sustainability in Quality Improvement (SusQI) Framework to ensure the best possible health outcomes with minimum financial and environmental costs, while adding positive social value at every opportunity.	Governance & policy	On-going		£		Trust Board and relevant clinical leads	LTP 2.26 SC13.9.118.4.2.1 NZ 4.1.3
03	Continue to collaborate with other trusts and public authorities on the population's health.	Governance & policy	On-going		£		Trust Board	LTP 1.53 SC 18.6 NZ 4.1.3
04	Appoint a Health Inequalities Lead to coordinate delivery of an updated Health Inequalities Action Plan.	Core Responsibilities	22/23		£		Trust Board	LTP 2.26 SC 13.9.2, 13.10 NZ 4.1.3
05	Follow Greener NHS guidance or support the development of GHG emissions reduction metrics linked with sustainable care actions, including establishing links between better health outcomes and reduction in emissions from avoided care and travel.	Core responsibilities	23/24		£		Estates and Facilities	SC 18.4.2.1 NZ 4.1.1, 4.1.2
06	Work to engage suppliers related to sustainable care in relevant emissions reduction and health equalities activities.	Procurement	23/24		£		Procurement & service providers	**NZ** 4.1.3

07	Explore new ways of delivering care at or closer to home, meaning fewer patient journeys to hospitals.	Working with patients, staff & communities	On-going		£		Clinical divisions	**NZ** 4.1.1

Figure 9 Green Plan actions for Sustainable care models

Indicative cost:

£ No or low cost

£ Significantly expensive

£ Moderately expensive

Indicative emissions reduction:

Low or incremental reduction

Significant reduction

Moderate reduction

Not applicable

Digital Transformation

The NHS Long Term Plan commits all NHS bodies to focus on digital transformation by establishing a 'digital front door', enabling digital first care. The NHS App is one example of this, providing patients with a simple and secure way to access NHS services on their smartphone.

The NHS Planning Guidance requires that at least 25% of all clinically necessary outpatient appointments should be delivered remotely by telephone or video consultation. Streamlining and digitising administrative functions also reduces paper waste and expedites processes.

ULHT strives to use digital care as a tool to promote inclusion and increase access to quality care across Lincolnshire and is committed to ensuring that digital services are tailored to meet the needs of the different specific care groups. The Government's Greening ICT and Digital Services Strategy 2020-2025 is also taken into consideration when looking at the improvement of the Trust's digital care services. A new Digital Strategy is being produced in collaboration with wider health bodies across Lincolnshire.

The 'What Good Looks Like' framework', designed to guide Trusts towards the successful integration of digital care systems, neatly summarises the Trust's position:

'The pandemic enabled us to achieve a level of digital transformation that might have otherwise taken several years. As we move into the recovery period, it is critical that we build on the progress we've made and ensure that all health and care providers have a strong foundation in digital practice'.

Staff using computer. Source: ULHT Library

Digital Services

The Trust's digital services complement and link to "in-person services". Since the beginning of the pandemic, the number of face-to-face, telephone and video consultations has increased significantly. Approximately 40% of outpatient appointments were delivered remotely in 2020/21. This included 6,429 video consultations and 240,145 telephone consultations in 2020/21. However, there will always be a need for face-to-face appointments and consultations for some patient groups.

The COVID-19 pandemic has led to a blended working approach, especially for office-based staff – for example, a mixture of in office and home-based working. Many staff now work in an agile way, and the Trust is exploring how to embed this as a new sustainable way of working. A number of 'hot desk' facilities have been provided to support this alongside Microsoft Teams and other collaborative tools that are provided for online meetings and such.

Improvements to ULHT's clinical pathways are ongoing to further maximise the opportunities for remote digital care.

The Trust predominantly uses paper patient records, but these have many drawbacks, particularly when attempting to work in an agile way. The planned introduction of Electronic Patient Record (EPR) over the next few years will significantly improve this. In addition, patient correspondence (including appointment and reminder letters) is increasingly being automatically produced and sent by the Trust's Healthcare Communications solution. Furthermore, there is a Community Care Portal that links the Trust's patient information systems with those of the Trust's Lincolnshire provider partners (including Lincolnshire County Council) to ensure a rich set of information is available to those who are authorised and require it for direct patient care.

Nurse using prescribing hub. Source: ULHT Library

No	ULHT Green Plan Actions	Trust Area	Target Year	Pro-gress	Indicative Cost to Achieve	Indicative Emissions Reduction	Responsible lead/dept.	NHS Req.
01	Build on current practice and current online patient guidance, participate in delivery of the Long-Term Plan commitments for digital first primary care and an NHS digital front door, linking this to potential emissions reductions.	Governance & policy	On-going		£		ICT	**LTP** 1.43, 1.44, 5 **NZ** 4.1.4
02	Follow NHS guidance on information collection, including any subsequent process for GHG emissions reduction metrics linked with digital-first care actions, such as the Centre for Sustainable Healthcare CSH's Carbon Calculator for Avoided Patient Travel	Governance & policy	On-going		£		Sustainability manager & Infrastructure services.	**SC** 28
03	Offer more digital and remote appointments: set targets against the baseline recorded in 2020/21.	Working with patients, staff & communities	22/23		£		Care Groups	**PG** C1
04	Use the What Good Looks Like Framework, the Greening Government: ICT and Digital Services Strategy 2020-25 and The Technology Code of Practice as guides to ensure the Trust has robust ICT systems in place to deliver on digital transformation.	Procurement & ICT	23/24		£		ICT	**NZ** 4.1.4
05	Build on current practice of engaging staff and care groups in digital care channels, meaning fewer patient journeys.	Working with patients, staff & communities	On-going		£		ICT	**NZ** 4.1.4 **PG** C1
06	Transfer paper-based systems such as prescribing, bed state, observations, ward state, referrals, and expense claims forms to a digital alternative.	Working with patients, staff & communities	23/24		£		ICT	**LTP** 1.43, 1.44, 5
07	Planned migration of data systems to cloud-based systems. Adoption of staff and patient portals. Continued cyclical replacement programme of IT hardware, including the provision of smart phones to all front-line staff.	Working with patients, staff & communities	23/24		£		ICT& Business & Value	**LTP** 1.43, 1.44, 5

Figure 10 Green Plan actions for digital transformation

Indicative cost:

£ No or low cost

£ Moderately expensive

£ Significantly expensive

Indicative emissions reduction:

Low or incremental reduction

Moderate reduction

Significant reduction

Not applicable

Travel and Transport

The Trust is committed to developing a Green Travel Plan, outlining the aims and objectives related to reducing congestion, single occupancy travel, and CO2 emissions. It will explore how to promote active travel to staff and visitors. In addition, the Trust will produce site-specific plans to focus on the individual challenges of each hospital.

ULHT Fleet Vehicles

The Trust operates a fleet of 71 vehicles that are a mix of pool cars for business use and delivery of patient care in the community, and commercial vehicles that are used for non-patient transport services for the wider health community in Lincolnshire, digital services, diagnostic screening and estates maintenance.

Emissions associated with the Trust's business travel could not be determined due to the unavailability of business expense data. This will be amended in future carbon footprint reporting.

However, using the NHS' Health Outcomes Travel Tool (HOTT), most transport-related emissions (5,616 tCO2e) can be linked to staff commuting and patient/visitor travel.

In 2020/21, these vehicles travelled just over 714,000 km, emitting 384 tCO2e.

The new NHS Non-Emergency Patient Transport Services (NEPTS) target is to have:

- From 2023, **50%** of all fleet vehicles to be of the latest emissions standards, Ultra-low Emission Vehicles (ULEVs, such as plug-in electric hybrid), or Zero Emission Vehicles (ZEVs, such as electric cars)
- From 2025, **75%** of all fleet vehicles to be of the latest emissions standards, ULEVs or ZEVs
- From 2030, **100%** of all fleet vehicles to be ULEVs or ZEVs, including a minimum of 20% ZEVs

At present, ULEV and ZEV large vans are limited, though more will be coming onto the market.

ULEV and ZEV small vans and cars are becoming commonplace, with many options available.

ULHT needs to undertake a fleet review to see how the vans and large vans are being used, and whether suitable ULEVs and ZEVs are available. Additionally, the Trust must review the choice of company cars on offer and change the specifications to reflect the targets within the NEPTS.

If the Trust changed all of the fleet vehicles to ZEVs, based on 2020/21 data and using 100% renewable electricity, there would be a likely 89% drop in emissions (emissions associated with electric vehicles are due to transmission and distribution losses in the national grid). This would result in total emissions dropping to around 12 tCO2e per year, with the added benefit of no tail pipe emissions.

Aside from the electrification of transport, the Trust needs to reduce emissions from the fleet by 58 tCO2e by 2024/25, equating to just over 15 tCO2e per year.

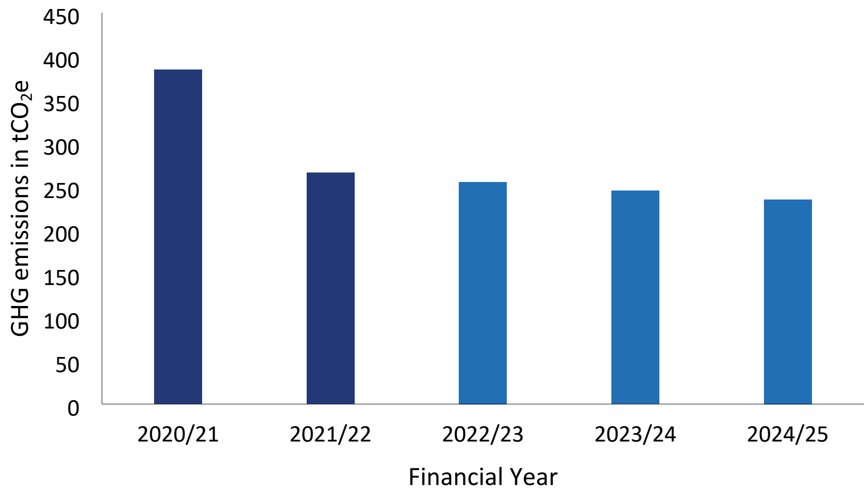


Figure 11 Emissions from fleet vehicles and emissions reduction trajectory to 2024/25

Other Lease Vehicles

Staff have the option to lease personal vehicles through the NHS Fleet Solutions Salary Sacrifice Scheme.

Emissions from these vehicles (used for staff personal use) are outside of the scope of this report (although they do impact on emissions arising from commuting somewhat). However, as a Trust, the availability of vehicles on offer can be limited based on their engine size and emissions. Furthermore, the Trust can incentivise staff to choose Ultra Low Emission Vehicles (plugin hybrid cars) or Zero Emission Vehicles (electric cars).

Porters van. Source: ULHT Library

Grey Fleet

The Trust has a 'grey fleet', which refers to employees' own vehicles and/or hire cars used for business purposes. As a Trust that provides care in the community, emissions associated with the grey fleet are sizeable.

ULHT reimburses staff and bank staff for the fuel used in line with their duties through an expenses system. However, the grey fleet emissions could not be determined due to the unavailability of expenses data. This will be amended in future carbon footprint reporting.

It is worth noting that in 2020/21, with the changed working styles affected by the pandemic, grey fleet mileage and therefore greenhouse gas emissions are projected to have fallen. This reinforces that there are opportunities regarding these changes in working practice that should be reviewed.

As the electrification of transport continues, the emissions will reduce accordingly. This also brings forth the issue of providing additional electric vehicle charge points in the future.

Electric Vehicle Charging Infrastructure

An EV charging point project is being undertaken with a potential of fifteen charging points across the Trust being installed for staff and visitor use.

Parking sign. Source: ULHT Library

Commuting, Visitor/Patient Travel

The Trust is developing an in-house car share scheme that seeks to discourage single occupancy travel. The subsidised bus fare salary sacrifice scheme offers reduced costs for bus travel in zoned areas and this will be available at Lincoln County Hospital soon.

The Trust operates a salary sacrifice cycle to work scheme and provides covered cycle storage at all three sites for staff, in addition to visitor cycle storage at Pilgrim and Lincoln County Hospitals. Lockers are available for walkers and cyclists and there are on-site shower facilities. There is a hire-bike station with e-bikes at Lincoln County Hospital for staff and visitor use that link to other docking stations in the city. Staff have benefitted from free cycle maintenance sessions and free adult cycle training is available.

Increasing the number of cycle parking spaces, improving shower/changing facilities, and offering other incentives for active travel will be explored.

Public transport provision to or near the sites remains a vital service to the Trust's communities and helps to reduce health inequalities. The Boston site is well connected and includes InterConnect routes to Lincoln and Skegness, in addition to local services. There is also a railway station that is a 30 minute walk from Pilgrim Hospital. Lincoln County Hospital is situated close to Lincoln Central bus station, which is served by an extensive number of routes. In addition, the railway station is a 25 minute walk away. Lincoln is also served by a park and ride facility, and the possibility of the service being redirected to cover the hospital site is being explored.

The previous travel survey was undertaken in 2019 but was not formally recorded. In lieu of travel plan survey data, which will be collected annually going forward, the NHS HOTT Tool has been used to estimate the emissions associated with staff commuting and patient and visitor travel. The HOTT Tool uses national and regional datasets to generate figures for transport mode, distances, and emissions from a 2018 baseline and projections into the near future (shown in Figure 13).

However, these figures are indicative and need to be bolstered and verified by local travel plan survey data. Hence, the impacts of COVID-19, with less need for commuting, do not fully feature in the results for 2020/21 and the projected 2021/22 data (the sequentially lower emissions are attributed to improvements in vehicle efficiencies and electrification of transport).

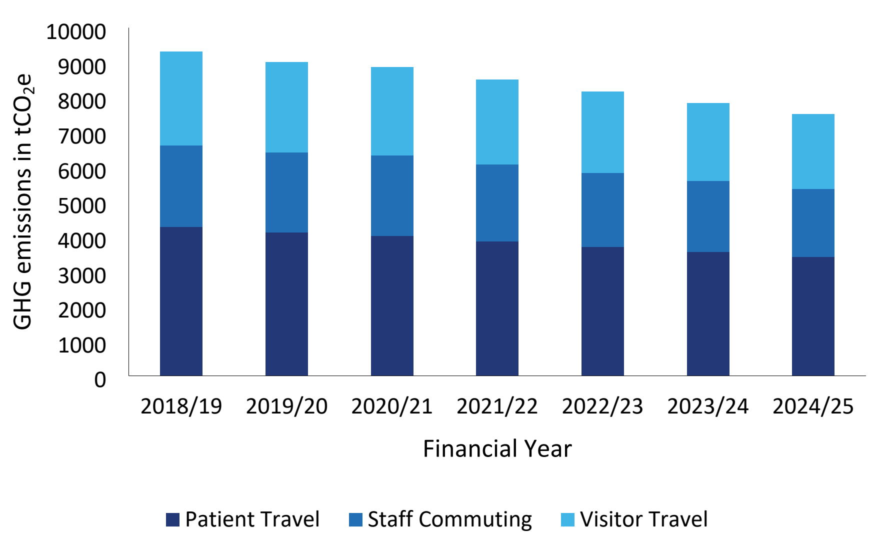


Figure 12 Stacked bar chart to show total emissions from patient, visitor and staff travel and emissions reduction trajectory to 2024/25

Air Quality

Air quality, climate change and health outcomes are highly interconnected, and the NHS Net Zero plan calculates that reaching UK ambitions on emissions reductions in line with Paris Agreement targets could save 38,000 lives with improved air quality.

According to the World Health Organisation (WHO), poor air quality leads to over 7 million deaths globally and that 9 out of 10 people worldwide breathe polluted air

Travel is a key contributor to air pollution, and with as many as 1 in 20 road journeys in the UK attributable to the NHS, the Trust's activity has enormous potential impact on local communities' air quality. Additionally, the gas-fired boilers that the Trust uses contribute to air pollution, and the decarbonisation of heating will address these pollutants in the future.

The Trust is committed to tackling this issue through investment and engagement with staff, patients and partner local authorities. The Trust will give special consideration to the air quality surrounding the estate and opportunities to improve its impacts on care groups.

Bike Lock up. Source: ULHT Library

No	ULHT Green Plan Actions	Trust Area	Target Year	Pro-gress	Indicative Cost to Achieve	Indicative Emissions Reduction	Responsible lead/dept.	NHS Req.
01	Embed an updated sustainable travel plan, with new modal shift targets to be supported by an active travel expenses policy and a facilities review.	Governance & policy	23/24		£		Estates and Facilities	**LTP** 2.21, 3.82, 17 **SC** 18.4.1.3 **NZ** 3.2, 3.2.2
02	Conduct annual Travel Plan surveys to quantify staff commuting and visitor travel and verify HOTT Tool outputs.	Working with patients, staff & communities	Annual, ongoing		£		Estates and Facilities	**NZ** 3.2, 3.2.2
03	Review existing staff lease scheme and incorporate additional incentives for the uptake of ULEV and ZEVs.	Governance & policy	23/24		£		Finance	**NZ** 3.2, 3.2.2
04	Undertake a Green Fleet review of the fleet vehicles to ascertain usage and distance travelled, with a view to integrating ULEVs and ZEVs	Governance & policy	23/24		£		Finance	**NZ** 3.2, 3.2.2
05	Ensure that any new vehicle purchased or leased are ultra-low emission (ULEV) or zero emission (ZEV) from 2023, in line with the latest NHS non-emergency transport guidance.	Core Responsibilities	23/24		£		Estates and Facilities	**SC**.18.4.1.1, 18.4.1.4 **NZ** 3.2.1
06	Enhance the staff mileage reimbursement system to collate vehicle type/engine size and fuel type data to allow more accurate emissions foot printing, monitoring and reduction targets.	Governance & policy	23/24		£		Finance	**NZ** 3.2, 3.2.2
07	Enhance the business travel expense system to capture the to- and from- destinations for rail, air, bus and taxi journeys and collate data from expenses.	Governance & policy	23/24		£		Finance	**NZ** 3.2, 3.2.2
08	Improve stores provision and work with suppliers to consolidate goods orders through better planning wherever possible, reducing transport emissions.	Procurement	23/24		£		Procurement	**NZ** 3.2, 3.2.2

09	Work with staff currently home-working under pandemic conditions to explore voluntary blended working.	Working with patients, staff & communities	23/24		£		People and OD	**NZ** 3.2, 3.2.2

Figure 13 Green plan actions for Travel, Logistics and Air Quality

Indicative cost:

£ No or low cost

£ Significantly expensive

£ Moderately expensive

Indicative emissions reduction:

Low or incremental reduction

Significant reduction

Moderate reduction

Not applicable

Estates and Facilities

As an NHS Trust, the carbon footprint of the built environment is significant. Overall, the health and care system in England is responsible for an estimated 4-5% of the country's carbon emissions.

As the Trust provides critical services 24 hours a day, energy and resource consumptions are substantial. Therefore, there is a need to optimise energy use in buildings and move away from using fossil fuels to meet NHS Net Zero goals.

The Trust's utilised estate includes facilities housed in other organisation's buildings. This presents challenges to retrofitting resource efficiency measures and heating improvements in isolation. ULHT will work with other organisations and the aims of their Green Plans to improve efficiencies at these sites.

ULHT will be following the four-step approach within the NHS' 'Estates 'Net Zero' Carbon Delivery Plan' to address the estate:

1. Making every kWh count: Investing in no-regrets energy saving measures
2. Preparing buildings for electricity-led heating: Upgrading building fabric
3. Switching to non-fossil fuel heating: Investing in innovative new energy sources
4. Increasing on-site renewables: Investing in on-site generation

Estates & Facilities: Energy

- 17,850 tCO_2e emitted from buildings across the estate in 2020/21.
- The Trust has procured 100% renewable electricity since April 2021.
- ULHT needs to reduce energy consumption by over 2,771,437 kWh per year to achieve the emissions reduction target of 14,802 tCO_2e in 2024/25.

Energy and Emissions

The Trust has 3 hospital sites for which the energy supply contracts are procured. Buildings under the Trust's ownership will be revised for energy efficiency improvements.

Figure 15 shows the total emissions liberated from electricity and gas use from 2018/19 to 2020/21. ULHT needs to reduce emissions by 3,048 tCO2e by 2024/25 from the 2020/21 baseline (this includes the reduction in emissions from procuring renewable electricity).

As an example, Pilgrim Hospital energy consumption is significant at 2,093 tCO2e in 2020/21.

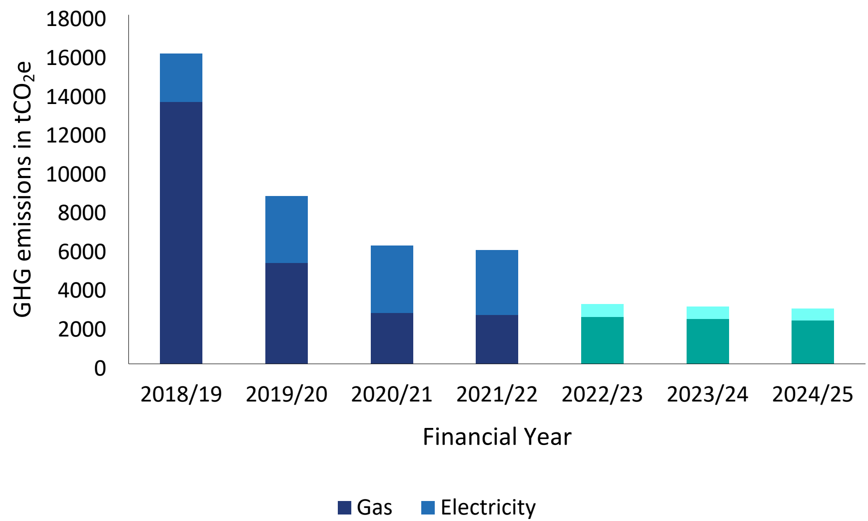


Figure 14 Emissions from the built environment

From April 2022, the Trust will be procuring 100% renewable electricity, resulting in an 80% reduction in emissions arising from procured electricity. The emission reductions from this are illustrated in Figure 16.

Despite the negated emissions from renewable electricity procurement, there is still a need to reduce electricity and gas consumption at all of the sites, at a rate of 2,771,437 kWh per year!

Since 2020, the Trust has delivered energy efficiency upgrades to the Estate, including the installation of 12,000 LED light fittings as part of a Trust-wide Energy Performance Contract (EPC).

The Trust sets out to achieve comfortable room / space temperatures for its service users, employees, and visitors.

Predominantly, target space temperatures range between 18-28°C as set out for general areas in HTM03-01, Part A. Comfort heating and cooling is delivered using various techniques, utilising underfloor heating, radiant ceiling panels, traditional thermostatic controlled radiators, air handing systems, fan coil units, Variable Refrigerant Flow (VRF) systems and split air conditioning systems.

Primary heating systems used within the Trust vary across all sites, but at Lincoln County Hospital and Pilgrim Hospital there has been a renewal of the Combined Heat and Power, (CHP) equipment. The Trust is now exploring ways to replace end of life boilers with new sustainable technology at Grantham Hospital as part of the major building management system (BMS) upgrade.

The Trust has installed and operates a biomass boiler at Pilgrim Hospital, which is fuelled by virgin and recyclable woodchip.

Detailed building energy surveys will be needed to provide robust energy efficiency recommendations at each of the Trust's sites, building upon the works already completed.

The decarbonisation of the Trust's heating systems will become increasingly important to reach net zero emissions. A biomass boiler installed at Pilgrim Hospital, continues to be considered a leading example seven years after its installation. However, transitioning remaining oil and gas-fired boilers to electrical alternatives remains a significant challenge.

This transition will inevitably result in much higher electricity consumption, and of particular concern is the viability of increasing the electrical site capacity (load in kilovolt-amps) from the electricity grid.

Extensive on-site renewable energy systems, such as solar photovoltaics and integrated large battery storage technologies, will help mitigate this, and provide additional resilience to power outages, with the potential to negate using the back-up diesel generators.

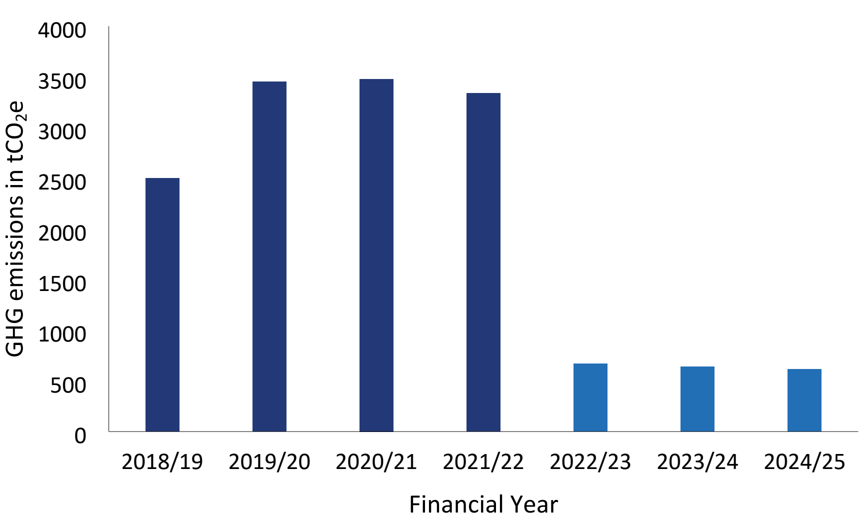


Figure 15 Emissions from electricity consumption and emission reduction trajectory to 2024/25 (note the difference following the expected procurement of 100% renewable electricity in April 2022)

No	ULHT Green Plan Actions	Trust Area	Target Year	Pro-gress	Indicative Cost to Achieve	Indicative Emissions Reduction	Responsible lead/dept.	NHS Req.
01	Enhance Planned Preventative Maintenance (PPMs) of all facilities and assets to be proactively energy--focused and to identify opportunities to upgrade equipment/plant.	Core responsibilities	22/23		£		Estates and Facilities	**LTP** 17 **SC** 18.4.2.1 **NZ** 3.1.1, 3.1.2
02	The Trust will procure 100% renewable electricity with Renewable Energy Guarantees of Origin (REGO) certificates backed by Npower.	Procurement	22/23		£		Estates and Facilities	**SC** 18.5
03	Access the NHS Energy Efficiency Fund (NEEF) to upgrade all lighting to LED alternatives.	Core responsibilities	22/23		£		Estates and Facilities	**LTP** 17 **SC** 18.4.2.1 **NZ** 3.1.1, 3.1.2
04	Follow Estates 'Net Zero' Carbon Delivery Plan guidance on efficiency and decarbonisation protocols for the built environment.	Core responsibilities	22/23 & on-going		£		Estates and Facilities	**NZCDP** **NZ** 3.1.1, 3.1.2

05	Install solar photovoltaic cells and collate a monthly generation report	Governance & policy	22/23		£		Estates and Facilities	**NZCDP** **NZ** 3.1.1, 3.1.2
06	Optimise energy use by embedding networked Automatic Meter Readers (AMRs) across the Estate with appropriate controls to reduce energy consumption, and report sub-metered data monthly	Core responsibilities	23/24		£		Procurement	**LTP** 17 **SC** 18.4.2.1 **NZ** 3.1.1, 3.1.2
07	Conduct detailed building energy surveys to identify further energy/thermal efficiency opportunities, including the installation of heat recovery systems on Air Handling Units (AHUs)	Core responsibilities	23/24		£		Estates and Facilities	**LTP** 17 **SC** 18.4.2.1 **NZ** 3.1.1, 3.1.2
08	Develop a Decarbonisation of Heat Plan that focuses on the phase out of existing gas-fired boilers and replacement with low-carbon alternatives, where feasible.	Governance & policy	On-going		£		Estates and Facilities	**LTP** 17 **SC** 18.4.2.1 **NZ** 3.1.1, 3.1.2

LTP 17

SC 18.4.1.2, 18.5

NZ 3.1.1, 3.1.2

Target 7.2 Increase global percentage of renewable energy

Target 7.3 Double the improvement in energy efficiency

Target 13.2 Integrate climate change measures into policy and planning

Target 13.3 Build knowledge and capacity to meet climate change

No	ULHT Green Plan Actions	Trust Area	Target Year	Pro-gress	Indicative Cost to Achieve	Indicative Emissions Reduction	Responsible lead/dept.	NHS Req.
09	Explore the possibility of creating District Heat Networks with neighbouring partners.	Working with patients, staff & communities	On-going		£		Estates and Facilities	**LTP** 17 **SC** 18.4.2.1 **NZ** 3.1.1, 3.1.2
10	Conduct a comprehensive review of the chiller and HVAC systems.	Core responsibilities	22/23		£		Estates and Facilities	**NZ** 3.1.1
11	Look to procure 'green gas' through the Green Gas Certification Scheme as and when existing energy contracts are due for renewal.	Procurement	23/24		£		Procurement	**SC** 18.5
12	Incorporate energy conservation into staff training and education programmes and deliver behaviour-based energy saving campaigns.	Working with patients, staff & communities	23/24		£		Training and Development	**NZ** 3.1.1
13	Develop communication materials for the patients that highlight energy efficiency projects, and discuss plans	Working with patients,	23/24		£		Estates and Facilities &	**NZ** 3.1.1

	with the local community, including exploring potential community energy projects.	staff & communities					People and OD	
14	Explore how the Trust can implement an ISO 50001 Energy Management System.	Governance & policy	24/25		£		Estates and Facilities	**NZ** 3.1.1
15	De-steam Lincoln County and Pilgrim Hospitals.	Core responsibilities	23/24		£		Estates and Facilities	**NZ** 3.1.1

Figure 16 Green plan action table for Energy and Emissions from the built environment

Indicative cost:

£ No or low cost

£ Significantly expensive

£ Moderately expensive

Indicative emissions reduction:

Low or incremental reduction

Significant reduction

Moderate reduction

Not applicable

Capital Projects

The Built Environment of the NHS influences both the quality of care and environmental impact.

The Trust’s design and construction of buildings will play a key role in the collective ability to achieve net zero carbon emissions.

Buildings have significant environmental impacts in terms of emissions resulting from the use of gas, electricity and water. Improving the energy efficiency of a building is pivotal to reducing these impacts. However, there are embodied carbon emissions within materials, such as cements, steel and glass which are used in the construction of buildings. These indirect ‘Scope 3’ emissions are generally much greater than emissions caused by the operation of a building.

Cement and concrete production on its own accounts for a huge 8% of all global greenhouse gas emissions from all sources, according to the Dutch Environmental Assessment Agency.

Estates & Facilities: Capital Projects

- Building energy efficiency standards should be considered for new builds and refurbishments. For example, BREEAM ‘Excellent’ rating, the Zero Carbon Hospital Standard, and implementation of on-site renewables.
- Construction supplier alignment to net zero commitments, such as on-site contractor measures on waste reduction and low emission construction plans.
- Low carbon substitutions and product innovation, such as lower embodied carbon construction materials.

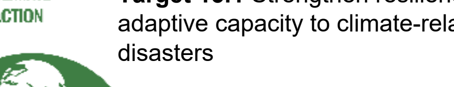
LTP 16

SC 18.4.2.1, 18.4.2.3

NZ 3.1.1, 3.3.1

Target 8.5 Full employment and decent work with equal pay

Target 9.4 Upgrade all industries and infrastructures for sustainability



Target 13.1 Strengthen resilience and adaptive capacity to climate-related disasters

Target 13.2 Integrate climate change measures into policy and planning

No	ULHT Green Plan Actions	Trust Area	Target Year	Pro-gress	Indicative Cost to Achieve	Indicative Emissions Reduction	Responsible lead/dept.	NHS Req.
01	Implement the upcoming Net Zero Hospital Building Standard in any new builds and BREEAM 'Excellent' for any major refurbishments.	Governance & policy	On-going		£		Estates and Facilities	**LTP** 16 **SC** 18.4.2.1 **NZ** 3.1.1
02	Explore options to achieve emissions reductions in smaller works and projects across the estate.	Core Responsibilities	22/23		£		Estates and Facilities	**NZ** 3.1.1
03	Encourage and measure local subcontractor and supply chain spend as part of the anchor institution approach.	Procurement	22/23		£		Procurement	**NZ** 3.3.1
04	Ensure capital development accounts for risks identified in climate adaptation plans and addresses these in design/delivery.	Core responsibilities	23/24		£		Estates and Facilities	**SC** 18.4.2.3
05	Work with the Procurement team to enable specification of low and zero carbon materials and designs, as well as achieving waste reduction and other opportunities through contractor engagement.	Procurement	23/24		£		Procurement	**NZ** 3.3.1
06	Continue to ensure that the design process is informed by staff, patients and community views for capital projects.	Working with patients, staff & communities	23/24		£		Estates and Facilities, Procurement & HR	**LTP** 16 **SC** 18.4.2.1 **NZ** 3.1.1

Figure 17 Green plan action table for Capital Projects

Indicative cost:

- £ No or low cost
- £ Significantly expensive
- £ Moderately expensive

Indicative emissions reduction:

- Low or incremental reduction
- Significant reduction
- Moderate reduction
- Not applicable

Water Efficiencies

In 2020/21, the Trust used 258,002m3 of water, which cost a total of £614,867.

There are emission impacts associated with the supply of fresh water and treatment of wastewater, equating to 262 tCO_2e in 2020/21 (see Figure 19).

Although the emissions are low compared to those produced by energy use, being water efficient is important to prevent and alleviate water stress.

As a water efficiency and leak preventative measure, the Trust will look to collate the data from the Automatic Meter Readers water network. This will help us pinpoint areas of high water usage, understand how and where water is being used, locate leaks and take remedial action.

Details of ongoing water efficiency measures the Trust is taking can be found in the Water Management Action Plan.

Water conservation and sustainable drainage shall also be explored. Rainwater harvesters collect rainwater for non-potable purposes, such as for flushing toilets. They will help reduce water stress and potentially alleviate flooding by attenuating surface water run-off in storm events.

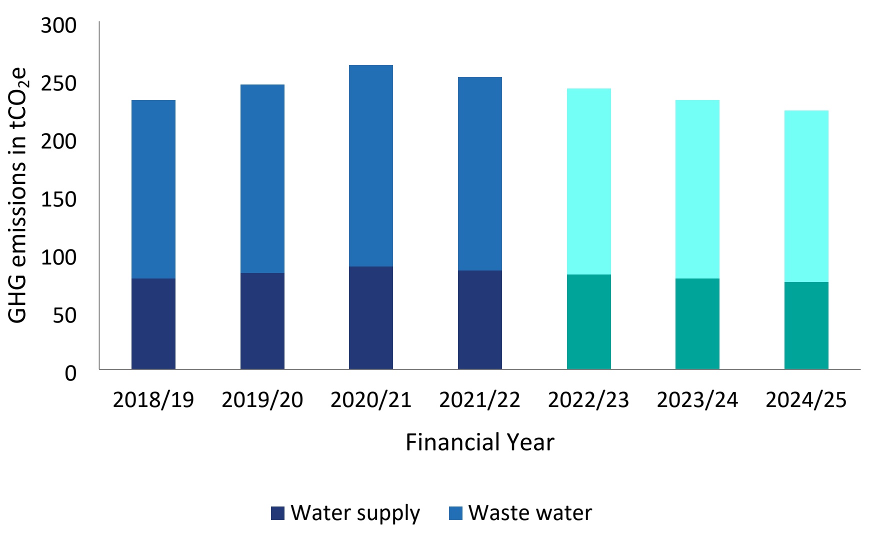


Figure 18 Stacked bar chart to show total water emissions from supply and wastewater treatment, and emissions reduction trajectory to 2024/25

Estates & Facilities: Water

- The Trust used 258,002 m3 of water in 2020/21 – enough water to fill 28 Olympic-size swimming pools
- 262 tCO_2e was attributed to the supply of water and wastewater treatment
- The Trust needs to reduce water consumption by 38,829 m3 by 2024/25
- Water efficiency and sustainable drainage will become ever more important in the future

No	ULHT Green Plan Actions	Trust Area	Target Year	Pro-gress	Indicative Cost to Achieve	Indicative Emissions Reduction	Responsible lead/dept.	NHS Req.
01	Explore and implement water efficiency targets on areas of the highest impact in the estate and delivery of care.	Governance & policy	22/23		£		Estates and Facilities	**LTP** 17 **SC** 18.4.3.1 **NZ** 3.1
02	Develop new water intensity metrics and incorporate these into greenhouse gas emissions reporting.	Governance & policy	22/23		£		Estates and Facilities	**NZ** 3.1
03	Collate water Automatic Meter Reader to determine water use patterns and aid leak detection, and report monthly	Core Responsibilities	23/24		£		Estates and Facilities	**NZ** 3.1
04	Utilise the most water efficient technologies, such as low flow taps throughout the estate, when replacing equipment and developing new sites	Core responsibilities	23/24		£		Estates and Facilities	**NZ** 3.1
05	Explore where rainwater harvesting and grey water systems can be installed and utilised.	Procurement	23/24		£		Estates and Facilities	**NZ** 3.1
06	Look to consolidate the suppliers across the estate to choose one or two that can provide the service, price, and efficiency the Trust expects.	Procurement	On-going		£		Estates and Facilities	**LTP** 17
07	Work with staff and patients by communicating the importance of water efficiency.	Working with patients, staff & communities	On-going		£		Estates and Facilities and Communications	**NZ** 3.1

08	Incorporate water efficiency measures within climate change adaptation work with the local community.	Working with patients, staff & communities	23/24		£	✕	Estates and Facilities	**NZ** 3.1

Figure 19 Green plan action table for Water

Indicative cost:

- £ No or low cost
- £ Significantly expensive
- £ Moderately expensive

Indicative emissions reduction:

- Low or incremental reduction
- Significant reduction
- Moderate reduction
- Not applicable

Waste and Recycling

The Trust collects five main waste types: general, clinical/offensive, confidential paper, dry mixed recycling and electrical and electronic equipment (WEEE) waste. There are collections for other waste streams, such as metal, fluorescent lamps and waste cooking oil, though amounts collected are not reported.

Figure 21 shows emissions emanating from the waste streams and Figure 22 the total waste arisings (all recorded waste streams).

The increase in waste arisings between 2019/20 and 2020/21 can be partly explained by the increased use of disposable items during the COVID-19 outbreak (with an uplift in waste being incinerated as Refuse Derived Fuel (RDF)). However, the Trust has received more robust data from waste contractors, which may also explain the increase in total waste arisings.

There are a limited number of dry mixed recycling bins, with the majority of non-clinical and non-hazardous waste being disposed of in the general waste bins in the buildings operated and managed by the Trust. This general waste is not further segregated at the waste handling centre and is ultimately sent to landfill.

Some of the clinical waste is incinerated (sharps), whilst other types are ultra-high temperature processed (alternative treatment) before being further recycled. Offensive waste is combined with clinical waste. The Trust provides training to clinical staff promoting increased use of tiger stripe clinical waste disposal bags where appropriate to ensure clinical waste is segregated correctly. This is included at induction and in mandatory training.

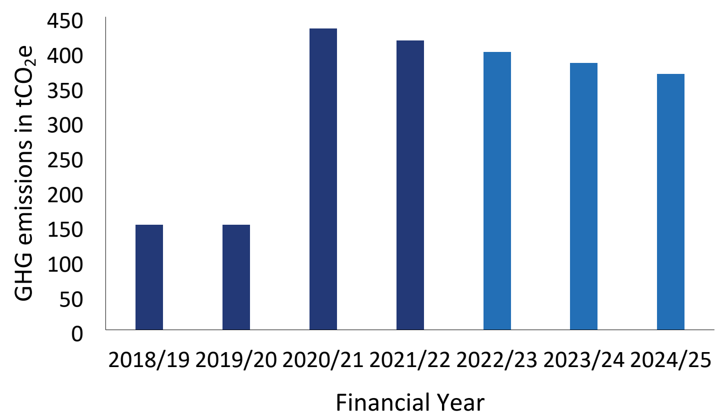


Figure 20 Emissions associated with waste streams and emission reduction trajectory to 2024/25

- 1,125 tonnes of waste were produced, emitting 433 tCO2e in 2020/21
- 488 tonnes were sent to landfill in 2020/21, emitting 408 tCO2e (84% of all emissions from waste)
- General Waste is sorted for recyclable materials at some sites, but most goes to landfill
- Food waste bins and collections will ensure food does not decompose in landfill sites, and instead is used for energy and compost generation

Food waste (kitchen waste such as vegetable peelings) is disposed of in onsite macerators located at each unit.

The Trust is aware of the amount of waste destined for landfill and need to segregate waste to improve recycling rates. This issue can be dealt with in two ways: installing recycling bins with clear signage for what can be recycled will improve recycling rates and help reduce waste processing costs; and changing the terms of the waste contract to ensure that general waste is sorted at the waste handling centre, with recyclable materials being segregated and non-recyclable waste incinerated (as Refuse Derived Fuel (RDF)) instead of going to landfill.

The COVID-19 pandemic has led to an increase in the usage of single-use plastic items; a necessary response to managing the crisis. This led to an increase of waste incineration of over 70% in 2020/21 compared to the previous year.

The Trust is mindful of the environmental impacts of single-use items throughout their lifecycle, from the crude oil used in their manufacture to the difficulty in recycling them at end-of-use.

Innovations are coming on to the market for reusable Personal Protection Equipment (PPE), such as face masks and aprons, that meet the various clinical safety standards. These alternatives should be explored to help reduce waste arisings.

The waste hierarchy of Reduce, Reuse, Recycle, Recovery (energy from waste) before disposal (landfill) must be embedded to ensure that waste duties of care and circular economic principles are being maintained. Recycling rates need to be improved. Shoring up the waste handling processes will ultimately reduce greenhouse gas emissions from waste treatment, other negative environmental impacts and landfill disposal costs.

Promotion of recycling throughout the Trust has been implemented through segregation training. Training is provided to all staff to ensure maximum recycling across the Trust and conduct audits. The Trust has also removed the excess general waste bins and improved the provision of recycling facilities in public and office areas and is working with suppliers to reduce packaging.

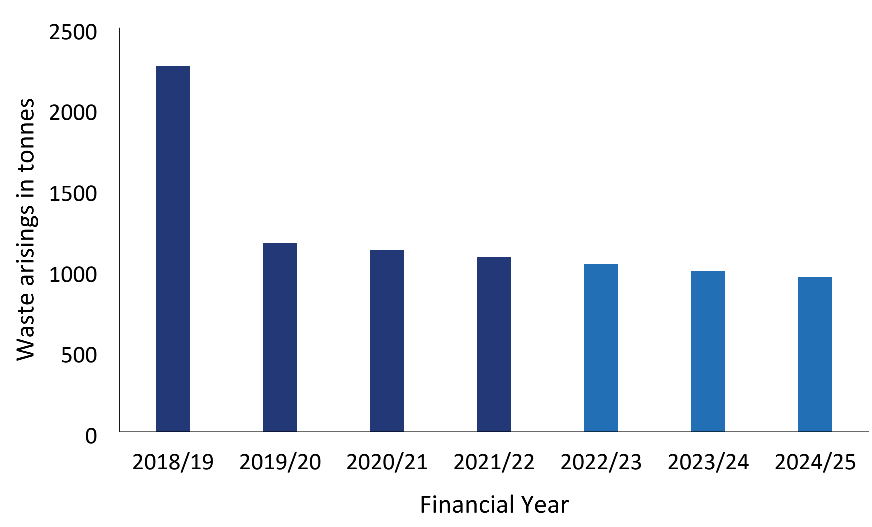


Figure 21 Total waste arisings in tonnes, and weight reduction trajectory to 2024/25

No.	ULHT Green Plan Actions	Trust Area	Target year	Pro-gress	Indicative Cost to Achieve	Indicative Emissions Reduction	Responsible Lead/Dept.	NHS Req.
01	Collate all waste stream data from all sites (including sites where the Trust is not responsible for waste collection) and produce monthly reports.	Core Responsibilities	22/23		£		Estates and Facilities	**NZ** 3.1
02	Ensure that single-use items in catering adhere to current legislation and elect to use sustainable alternatives as listed by NHS Supply Chain,	Core Responsibilities	22/23		£		Estates and Facilities	**LTP** 17 **SC** 18.4.3.1 **NZ** 3.1
03	Install Dry Mixed Recycling (DMR) bins across all sites and start DMR collections,	Core Responsibilities	23/24		£		Estates and Facilities	**LTP** 17 **SC** 18.4.3.1 **NZ** 3.1
04	Install food waste bins across all remaining sites and start food waste collections.	Core Responsibilities	23/24		£		Estates and Facilities & Catering	**NZ** 3.1
06	Work with staff and patients by communicating the importance of waste segregation.	Procurement	On-going		£		Estates and Facilities & HR	**NZ** 3.1
07	Explore whether reusable alternatives to single-use PPE items (aprons, wipes, face masks) are clinically appropriate.	Core Responsibilities	23/24		£		Clinical Teams & Procurement	**NZ** 3.1
08	Explore how the Trust can implement an ISO-14001 Environmental Management System.	Governance & policy	23/24		£		Estates and Facilities & HR	**LTP** 17 **SC** 18.4.3.1 **NZ** 3.1

Figure 22 Green plan action table for Waste

Indicative cost:

Indicative emissions reduction:

£ No or low cost

£ Moderately expensive

£ Significantly expensive

Low or incremental reduction

Moderate reduction

Significant reduction

Not applicable

Biodiversity and Greenspace

"Access to greenspaces have positive mental and physical health impacts, and these beneficial effects are greatest for those from socioeconomically disadvantaged groups. However, these groups also have the least access to greenspaces." – **Delivering a Net Zero NHS**

The Trust wants to protect biodiversity within the estate and region and reduce any negative impact on biodiversity, both locally and globally.

Greenspace and nature are important for the health and wellbeing of patients and colleagues alike. At a global scale, greenspace affects the planet's ability to absorb carbon dioxide.

The Trust will promote access to greenspace, considering areas of operations where this may be lacking.

The Trust will also consider opportunities and risks for biodiversity in its sites, for example priority woodland areas in the region.

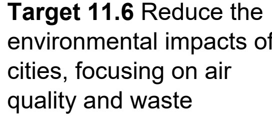
As part of the Project Dynamo initiative, there is a Gorgeous Gardens element that has tidied thirty four garden spaces across the three sites. The next phase is to begin renovations in a further eight gardens, to make them more inviting. At each of the three sites, there will be a dedicated patient and staff area.

Trees and lawn outside Pilgrim Hospital. Source: ULHT Library

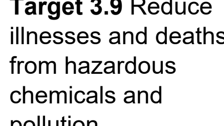
LTP 17

SC 18.4.3, 18.4.3.1 to 18.4.3

NZ 3.1.1, 3.3.2



Target 11.6 Reduce the environmental impacts of cities, focusing on air quality and waste



Target 3.9 Reduce illnesses and deaths from hazardous chemicals and pollution

Target 13.2 Integrate climate change measures into policy and planning

No	ULHT Green Plan Actions	Trust Area	Target Year	Pro-gress	Indicative Cost to Achieve	Indicative Emissions Reduction	Responsible lead/dept.	NHS Req.
01	Review policies and practices around green space and biodiversity, to ensure that the Trust's impact on these is reduced. Identify opportunities to provide safe and easy access to green space, where appropriate.	Governance & policy	23/24		£		Estates and Facilities	**LTP** 17 **SC** 18.1 **NZ** 3.5
02	Engage with regional partners to ensure that adequate green space and identified native species are considered and supported in planning and operations of the estate wherever possible. This includes supporting bees and other pollinators.	Core responsibilities	23/24		£		Estates and Facilities	**SC** 18.1 **NZ** 2.2, 3.5
03	Work to better understand biodiversity and habitat risks and opportunities in procurement. Where possible, apply evidenced standards or engage with suppliers to address issues, such as food production and provenance of meat, avoiding Palm Oil or limiting to RSCO-certified Palm Oil in food and cleaning products.	Procurement	23/24		£		Procurement	**SC** 18.1
04	Continue to engage the staff, patients, and communities in green space initiatives.	Working with patients, staff & communities	On-going		£		Clinical leads & HR	**NZ** 2.2, 3.5

Figure 23 Green plan action table for Greenspaces

Indicative cost:

- £ No or low cost
- £ Significantly expensive
- £ Moderately expensive

Indicative emissions reduction:

- Low or incremental reduction
- Significant reduction
- Moderate reduction
- Not applicable

Medicines – Volatile Anaesthetic Gases and Inhalers

In addition to carbon dioxide emissions, the NHS clinical activity and prescriptions, such as using inhalers, nitrous oxide and volatile inhaled anaesthetics like desflurane, contribute to a considerable proportion of the NHS' GHG footprint.

The Long Term Plan commits the NHS to reduce GHG emissions from anaesthetic gases by 40% (which on its own could represent 2% of the overall NHS England carbon footprint reduction target which the NHS must meet under Climate Change Act commitments) and significantly reduce GHG emissions by switching to lower global warming potential (GWP) inhalers.

Nitrous oxide

Compact nitrous oxide cylinders attached directly to the back of anaesthetic machines are now used.

There are innovations in capturing and catabolising exhaled nitrous oxide, including 'cracking' devices. Such devices are being trialled by other NHS Trusts, and if rolled out, will dramatically reduce the amount leaking into the atmosphere.

Furthermore, nitrous oxide use is steadily falling in surgery, as more efficacious anaesthetic and analgesic agents are superseding its use. However, Equanox™ still plays an important role in maternity.

Methoxyflurane (Penthrox™) pen-inhalers can be used to treat moderate to severe pain associated with trauma in the Accident and Emergency department. Methoxyflurane can be self-administered under medical supervision, in a similar fashion to nitrous oxide. It has a lower global warming potential (GWP) than nitrous oxide and switching to methoxyflurane would lessen emissions at point-of-use.

However, this comes at a cost, as methoxyflurane is delivered in non-reusable 3ml inhaler pens, creating additional non-recyclable waste.

Staff member in Pharmacy. Source: ULHT Library

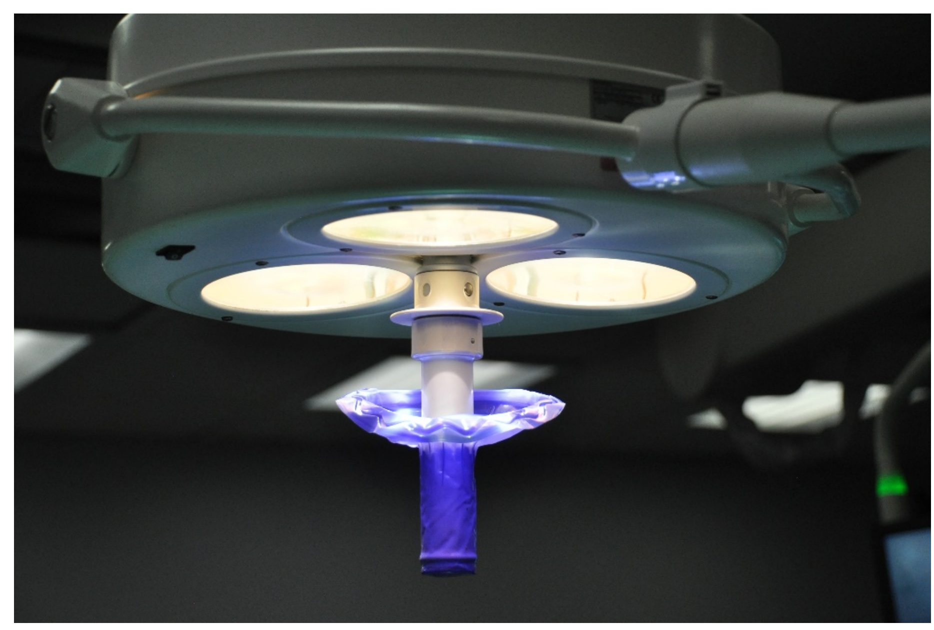
Desflurane

Desflurane is a fluorinated volatile anaesthetic. Like many fluorinated compounds (such as refrigerants and propellants), it has a very high GWP. Desflurane has a GWP rating of 2,540, which means it is 2,540 more potent as a greenhouse gas than carbon dioxide.

Other volatile anaesthetics, such as sevoflurane and isoflurane have far lower GWP ratings, 130 and 510 respectively. Shifting away from desflurane to these alternatives will significantly reduce emissions. However, both sevo- and isoflurane use will have an impact on the atmosphere.

The NHS Standard Contract and engagement efforts with clinicians have targeted a reduction of desflurane as a percentage of all volatile gas use by volume, from 20% in 2020/21 to 10% in 2021/22 across all NHS providers.

Emissions associated with the Trust's desflurane usage could not be determined due to the unavailability of data. This will be amended in future carbon footprint reporting. There are overarching goals across the NHS to deliver reductions in desflurane usage.



Surgery. Source: ULHT Library

Inhalers

Both Dry-powder (DPI) and Metered Dose Inhalers (MDI) are prescribed. Metered dose inhalers use fluorinated gases as the propellant: in 2020/21, 71% of the inhalers prescribed were MDI's. However, emissions data for inhalers could not be determined due to the unavailability of data. This will be amended in future carbon footprint reporting.

The NHS Standard Contract stipulates that 30% of all inhalers prescribed across NHS England should be DPIs, potentially saving 374 ktCO2e per year, according to the NHS Net Zero report. The Trust has almost reached this goal, as 29% of prescribed inhalers are DPIs, and endeavours to increase this percentage going forward.

New Impact and Investment Fund (IIF) indicators which have been released provide an additional steer on prescribing lower-carbon inhalers.

Dry-powder inhalers are an appropriate choice for many patients and contain as little as 4% of the GHGs emissions per dose compared with MDIs. Fluorinated gases in MDIs mean that each 10ml to 19ml inhaler cannister has the equivalent emissions of 30 to 80kg of carbon dioxide!

At the end of use, inhalers still contain as much as 20% of high-GWP propellant. Greener disposal of these items, where residual fluorinated gases are captured and destroyed, is therefore another key priority. Lastly, overuse of inhalers leads to 250,000 tonnes of equivalent carbon emissions (250 ktCO2e) annually across the UK, according to a new study.

ULHT will work across the Trust to address disposal and overuse, and work with clinical staff and patients through the NICE Patient decision aid to help increase the uptake of low-carbon inhalers wherever clinically appropriate.

Pharmacy Nurse. Source: ULHT Library

No	ELTH Green Plan Actions	Trust Area	Target Year	Pro-gress	Indicative Cost to Achieve	Indicative Emissions Reduction	Responsible lead/dept.	NHS Req.
01	Collate inhaler prescribing data and report quarterly.	Working with patients, staff & communities	22/23		£	✖	Clinical Pharmacy Team	**LTP** 17
02	Collate volatile anaesthetic gas use data and report quarterly.	Working with patients, staff & communities	22/23		£	✖	Clinical Pharmacy Team	**LTP** 17
03	Collate methoxyflurane (Penthrox™) use data and report monthly	Working with patients, staff & communities	22/23		£	✖	Clinical Pharmacy Team	**LTP** 17
04	Work with clinicians and the Clinical Pharmacy Team to enable uptake of alternative inhalers where appropriate.	Governance & policy	22/23		£		Clinical Pharmacy Team	**SC** 18.6 **NZ** 3.4.1
05	Explore the procurement and use of nitrous oxide 'cracking' devices.	Procurement; Working with patients, staff & communities	23/24		£		Procurement	**LTP** 17 **SC** 18.4.2.2 **NZ** 3.4.1

06	Switch to methoxyflurane (Penthrox™) in preference to nitrous oxide analgesia/anaesthesia where clinically appropriate.	Working with patients, staff & communities	23/24		£		Clinical Pharmacy Team	**LTP** 17 **SC** 18.4.2.2 **NZ** 3.4.1
07	Work with anaesthetists and pharmacy to significantly reduce the use of desflurane in surgical procedures to less than 10% of total volatile anaesthetic gas by volume.	Working with patients, staff & communities	23/24		£		Clinical Pharmacy Team	**SC** 18.6 **NZ** 3.4.1
08	Set a target of prescribing at least 50% DPIs for all inhaler types.	Working with patients, staff & communities	23/24		£		Clinical Pharmacy Team	**NZ** 3.4.1
09	Set a goal to reduce MDIs to 25% of all non-salbutamol inhalers by prescribing DPIs and soft mist inhalers, where clinically appropriate	Working with patients, staff & communities	24/25		£		Clinical Pharmacy Team	**IIF** ES-01 **LTP** 17
10	Set a goal of reducing the average emissions from salbutamol inhalers to 11.1kg per inhaler, where clinically appropriate	Working with patients, staff & communities	24/25		£		Clinical Pharmacy Team	**IIF** ES-02 **LTP** 17

Figure 24 Green plan action table for inhalers

Indicative cost:

£ No or low cost

£ Significantly expensive

£ Moderately expensive

Indicative emissions reduction:

Low or incremental reduction

Significant reduction

Moderate reduction

Not applicable

Supply chain and procurement

The NHS is a major purchaser of goods and services, with NHS England alone procuring around £30 billion of goods and services annually. Procurement has major potential social, economic, and environmental impacts both locally and globally.

This includes the power of using local suppliers, the climate performance of equipment and the estate, and preventing modern slavery in supply chains.

ULHT is committed to engage with suppliers to meet the Green Plan and support the sustainable procurement objectives of NHS England wherever practicable.

Procurement and Climate Action

Supply chain emissions represent a huge portion of ULHT's overall carbon footprint. The Trust has baselined the estimated supply chain emissions for 2020/21 utilising the GHG Protocol 'Scope 3' spend-based method. Spend-based emissions change yearly with total spend and will not help measure progress initially. However, they will help ULHT to identify the carbon hotspots to plan for actions.

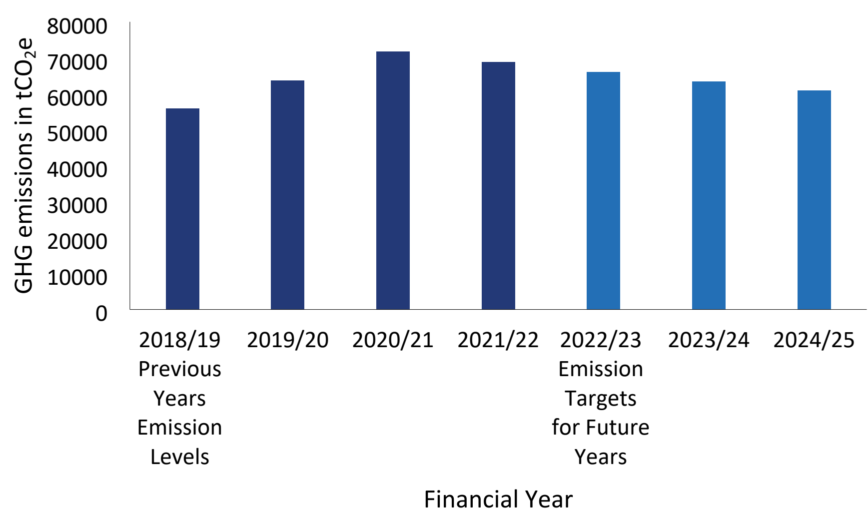


Figure 25 Emissions from the supply chain with reduction trajectory to 2024/25

Supply Chain and Procurement

- Emissions from the supply chain were estimated to be 21,849 tCO2e in 2020/21Emissions from the supply chain were estimated to be 21,849 tCO2e in 2020/21
- A new NHS Sustainable Suppler Framework will be launched in January 2022 and will require all suppliers to publish progress reports and continued carbon emissions reporting by 2030
- An ISO 20400 Sustainable Procurement Strategy would enhance the environmental and social performance of the Trust's supply chain
- Ensure tenders adopt the new social value procurement note PPN 06/20 and carbon management PPN 06/21 in major contracts in April 2022 and 2023 respectively
- Reusable items such as face masks and aprons would reduce waste (as per the Waste section)
- Reclaiming mobility aids and other devices from patients will prevent waste and save money

As a Trust, most items and services are procured through centralised NHS/government frameworks, such as NHS Supply Chain. These centralised frameworks already provide best value through bulk purchasing power and consolidation of orders. The Trust cannot control or influence the sustainability aspects of these routes of procurement and will benefit from the decisions made in how these frameworks operate.

In addition, the Trust is a signatory of the NHS Single Use Plastics Pledge since October 2021 and aims to reduce plastic catering consumables by 50 tonnes during 2021/22.

The NHS, in line with recent government requirements, is mandated to adopt a new social value and environmental standard in the future. A new Sustainable Supplier Framework will be launched in January 2022, and from April 2022, all NHS tenders will include a minimum 10% net zero and social value weighting (as per Policy Procurement Note 06/20).

Grantham Stores. Source: ULHT Library

From April 2023, contracts above £5 million will require suppliers to publish a carbon reduction plan for their direct emissions as a qualifying criterion (as per Policy Procurement Note 06/21).

By 2030, all suppliers will be required to demonstrate progress in-line with the NHS' net zero targets, through published progress reports and continued carbon emissions reporting.

PPN 06/020 & PPN 06/021 are procurement policy notices that relate to Central Government Departments, their Executive Agencies and Non-Departmental Public Bodies. However, ULHT as an organisation is not yet directly in scope.

These additional requirements will enable us to determine more accurately the carbon and social impact of the products and services that the Trust buys, and ensure suppliers are reducing the emissions associated with their operations and products.

In the interim, ULHT will explore ways to reduce single-use plastic items and research how reusable items can be incorporated such as masks and aprons into clinical practice.

Porter. Source: ULHT Library

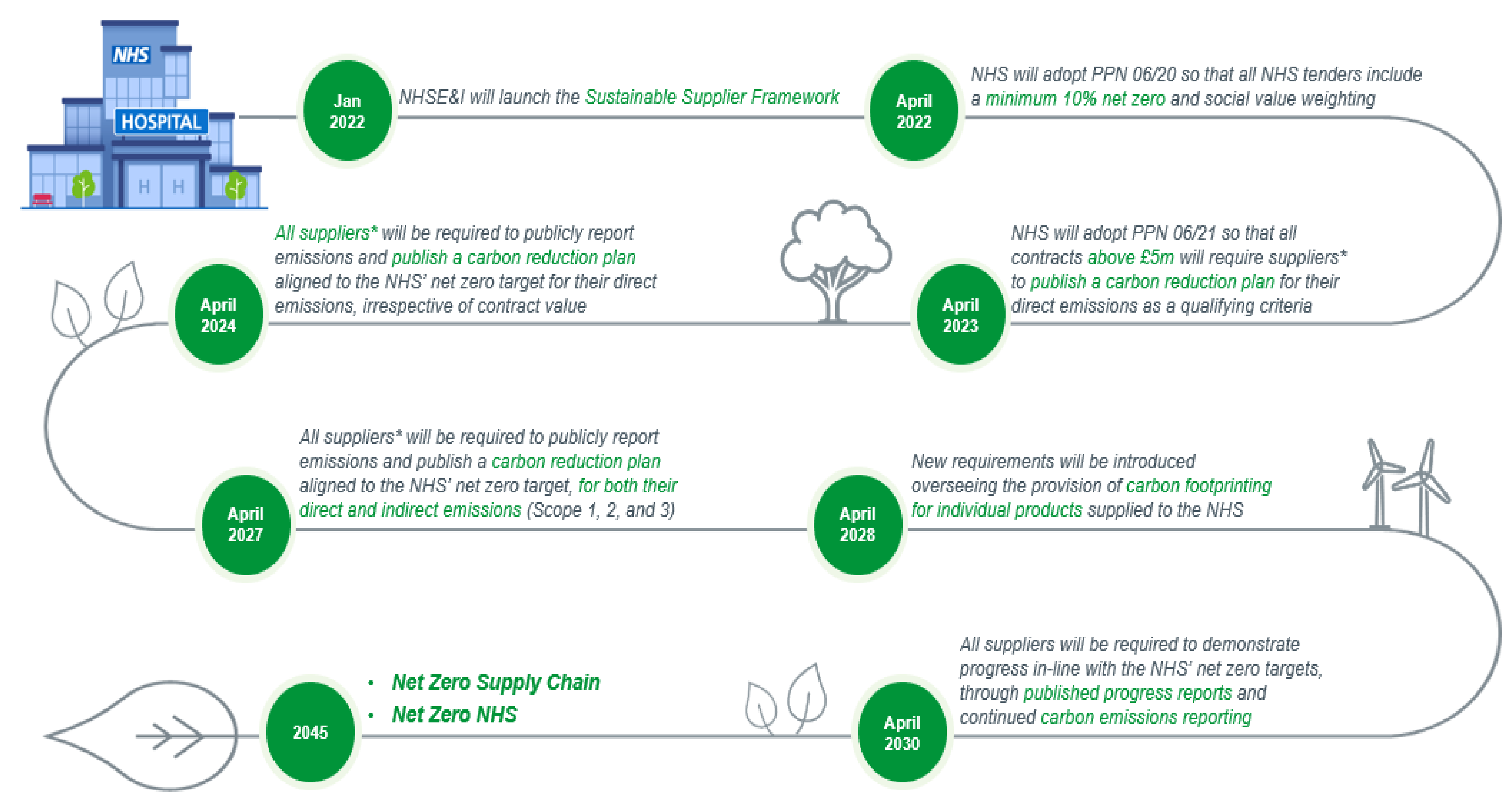


Figure 26 Building net zero into NHS Procurement – shows how NHS England will require all suppliers to provide carbon and social value reporting by 2030

Product retainment and lifecycle extension

Procuring well, ensuring best value for money and social and environmental benefits will remain a core principle for the wider NHS and the Trust.

However, keeping products in service for as long as possible, through maintenance and repair, is fundamental to a circular economy and drives down waste.

Critical care medical products are kept in good working order at the Trust, as per manufacturer's and the Medical and Healthcare Products Regulatory Agency's (MHRA) guidance. Only when an item is no longer supported by the manufacturer, or is beyond economic repair, is disposal considered.

Most 'obsolete' working medical equipment is sent to an auctioneer, where it is sold on, often abroad, for continued use, which has both social and environmental benefits. Equipment that is beyond repair is disposed of through the appropriate waste channels, and components recycled.

Mobility aids, such as walking frames, crutches and walking sticks, are given to outpatients where appropriate. Unfortunately, once issued, these items are no longer under the Trust's control. Though many outpatients will use mobility aids for the long term, many are only used for weeks or months, and there is no way of reclaiming these mobility aids. Ultimately, these items end up in outpatients' domestic waste. Mobility aids are robust pieces of kit, with long service lives.

Reclaiming, cleaning/refurbishing and reissuing mobility aids will negate useful items being scrapped. However, it is cheaper to buy new items than it is to decontaminate and refurbish at present.

Medical equipment. Source: ULHT Library

Anchor trust role

This involves identifying opportunities for regional Small and Medium-sized Enterprises (SMEs), and engaging suppliers to ensure wider community benefits are met.

While the Trust cannot reserve spend locally, proactive steps are taken to support inclusive growth, including a policy on the payment of the Real Living Wage for service suppliers.

NHS England Sustainable Procurement Objectives		
Net Zero	**Modern Slavery**	**Social Value**
Achieve the NHS Supply Chain Net Zero Targets	Eliminate Modern Slavery in the NHS supply chain both domestically and abroad	Ensure NHS procurement is a force for good helping local economies and improving wider determinants of health

Figure 27 Official NHS Sustainable Procurement Objectives Source: website

Lincoln Hospital Main Entrance. Source: ULHT Library

LTP 6.17, 17, 18

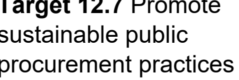
SC 18.6

NZ 3.3, 3.3.1

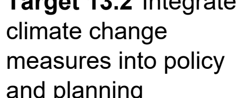
8 DECENT WORK AND ECONOMIC GROWTH

Target 8.3 Promote policies to support job creation and growing enterprises

Target 8.7 End modern slavery, trafficking, and child labour



Target 12.7 Promote sustainable public procurement practices



Target 13.2 Integrate climate change measures into policy and planning

No	ULHT Green Plan Actions	Trust Area	Target Year	Progress	Indicative Cost to Achieve	Indicative Emissions Reduction	Responsible lead/dept.	NHS Req.
01	Review the sustainable procurement approach to find relevant links that enable the Green Plan and work closely with NHS Supply Chain and NHS Improvement to promote their sustainability programmes.	Governance & policy	Ongoing		£		Procurement	**LTP** 6.17, 17
02	Adhere to the requirements of the NHS Sustainable Suppler Framework.	Governance & policy	January 2022		£		Procurement	**SC** 18.6
03	Ensure tenders adopt the new social value procurement note PPN 06/20 and carbon management PPN 06/21 in major contracts from April 2022 and 2023 respectively.	Governance & policy	April 2022		£		Procurement	**NZ** 3.3, 3.3.1
04	Ensure tenders adopt the carbon management PPN 06/21 in major contracts in April 2023.	Governance & policy	April 2023		£		Procurement	**SC** 18.6
05	Ensure the purchase of 100% closed-loop recycled paper.	Core Responsibilities	22/23		£		Estates and Facilities	**SC** 18.6
06	Identify wider social, economic and environmental benefits for the local community and population when considering the purchase and specification of products and services,	Governance & policy	23/24		£		Procurement	**SC** 18.6

	discussed and agreed with the Coordinating Commissioner.							
07	Create a new system for cataloguing and reclaiming mobility aids and other devices from patients.	Governance & policy	23/24		£		Physio and Occupational Therapy	**NZ** 3.3, 3.3.1
08	Engage a key supplier on plans to align their operations and delivery with NHS Net Zero targets over time. Leverage NHS England and NHS Improvement Supplier Engagement Strategy approach for fostering partnerships.	Core responsibilities	23/24		£	✕	Estates and Facilities	**NZ** 3.3, 3.3.1
09	Work with NHS Supply Chain to address Modern Slavery and domestic and international supply chain environmental, and human rights risks, including those linked to PPE.	Procurement	23/24		£	✕	Procurement	**SC** 18.6
10	Explore the creation of an ISO 20400 Sustainable Procurement Strategy.	Procurement	23/24		£		Procurement	**SC** 18.6
11	Work to identify impactful future supply chain emissions reductions opportunities and links to climate adaptation and other Green Plan commitments in procurement specifications and through contract delivery	Procurement	24/25		£	✕	Procurement	**NZ** 3.3, 3.3.1
12	Enable procurement to support Social Value and Anchor Institution NHS aims, e.g., understanding and increasing local, SMEs and social enterprise spend or collaborating with suppliers to promote positive action in equalities or to collaborate on innovation or climate action.	Working with patients, staff & communities	Ongoing		£	✕	Procurement	**LTP** 18

Figure 28 Green plan actions for supply chain management and procurement

Indicative cost:

- £ No or low cost
- £ Significantly expensive
- £ Moderately expensive

Indicative emissions reduction:

- Low or incremental reduction
- Significant reduction
- Moderate reduction
- Not applicable

Food and Nutrition

Food illustrates the links between climate change and public health. The NHS Long Term Plan commits us to promoting plant-forward diets and reducing unhealthy options like sugary drinks on NHS premises. For this reason, the Trust only provides diet drinks in vending machines. Not only will these actions help prevent obesity and non-communicable disease, but they will also play a role in reducing greenhouse gas emissions and environmental impact.

Food production accounts for up to 26% of global greenhouse gas emissions1. Food and livestock production has a huge impact on biodiversity as well, and according to research collected by Our World in Data "of the 28,000 species evaluated to be threatened with extinction on the International Union for Conservation of Nature (IUCN) Red List, agriculture and aquaculture is listed as a threat for 24,000 of them".2

While promoting healthier foods and reducing emissions, the NHS can also source more food from local and regional producers where possible, increasing the positive economic impact for Lincolnshire communities and reducing the emissions associated with food transport.

[1] https://ourworldindata.org/environmental-impacts-of-food

[2] Source: Poore, J., & Nemecek, T. (2018). Reducing food's environmental impacts through producers and consumers. *Science*, 360(6392), 987-992. Via https://ourworldindata.org/environmental-impacts-of-food

ULHT will work to fulfil Long Term Plan priorities for food provision on the premises, promoting plant-forward diets, higher welfare and more sustainable food options, and supporting regional producers wherever possible.

LCH Kitchen staff. Source: ULHT Library

From September 2020 until September 2021, the Trust served 1,124,534 meals (3 meals per day), or on average 93,711 meals per calendar month. In previous waste audits, it has been ascertained that 4.5% of all meals end up as waste.

The Trust offers a wide choice of meals for inpatients, including vegetarian and vegan options and other dietary requirements.

After signing the NHS' Single Use Plastics Pledge, the Trust has planned to work with the NHS Supply all the single-use plastic products from the catalogue and aspire to work with the Trust's supplier to use Vegware products made from plants. ULHT endeavours to eliminate polystyrene, plastic cutlery, and purchase reusable cups in the near future.

The menu itself is changed annually, with food cooked in house at Lincoln County Hospital and Pilgrim Hospital. The menu is currently paper-based, but digital menus will be explored in the future. Menus for staff are made available weekly on staff social media channels.

PBH K f Source: ULHT Lib

LTP 2.18, 17

SC 19.1, 19.2,19.3

NZ 3.3.2

2 ZERO HUNGER

Target 2.2 End all forms of malnutrition (including obesity)

Target 3.4 Reduce mortality from non-communicable diseases and promote mental health

13 CLIMATE ACTION

Target 13.2 Integrate climate change measures into policy and planning

Target 14.4 Sustainable Fishing

No	ULHT Green Plan Actions	Trust Area	Target Year	Pro-gress	Indicative Cost to Achieve	Indicative Emissions Reduction	Responsible lead/dept.	NHS Req.
01	Review food and catering to explore opportunities to push forward Long Term Plan plans to address obesity, benefit ULHT's local area, and reach Net Zero emissions.	Governance & policy	On-going		£		Catering Services	**LTP** 2.18, 17 **SC** 19.1, 19.2 **NZ** 3.3.2
02	Explore a digital meal system for at least one NHS site to enable accurate meal planning and reduce food waste.	Core responsibilities	22/23		£		Estates and Facilities & Catering Services	**NZ** 3.3.2
03	Phase in more Plant-forward diets and other updated NHS requirements and explore greater seasonal menu changes.	Governance & policy	23/24		£		Procurement & Catering Services	**LTP** 2.18
04	Limit sugary drinks sales at Trust facilities and fulfil other updated NHS requirements.	Core Responsibilities	23/24		£		Catering Services	**SC** 19.3
05	Work with NHS Supply Chain to ensure positive impacts from contract management and maintain updates to Government Buying Standards sustainable food criteria.	Procurement	23/24		£		Procurement & Catering Services	**SC** 19.3

06	Work with regional partners to identify opportunities for local and SME food producers.	Procurement	22/23		£		Procurement	**NZ** 3.3.2
07	Ensure all food providers meet or exceed the requirements outlined in Report of the Independent Review of NHS Hospital Food	Core responsibilities	23/24		£		Facilities & Procurement	**SC** 19.3
08	Review internal and NHS strategies for sustainable food procurement, including sustainable fish, elimination of palm oil or limit to RSPC-certified palm oil and Fairtrade items where relevant.	Procurement	23/24		£		Procurement	**LTP** 17
09	Continue to work with patients and partners on the link between food, health and obesity, as well as the emissions impact.	Working with patients, staff & communities	On-going		£		TBC	**LTP** 2.18 **SC** 19.1, 19.2 **NZ** 3.3.2

Figure 29 Table to show green plan actions for food and nutrition

Indicative cost:

£ No or low cost

£ Significantly expensive

£ Moderately expensive

Indicative emissions reduction:

Low or incremental reduction

Significant reduction

Moderate reduction

Not applicable

Adaptation

Climate change will make extreme weather, such as heatwaves, droughts and flooding, more prevalent. Sea-level rise and increased risk of Vector Borne Diseases, such as Lyme Disease, may also impact Lincolnshire's communities. The Pilgrim Hospital site is situated on low level land, which makes flooding a significant risk.

It is therefore important that the Trust examines the potential risks and ensure that buildings, systems and processes are adapted to cope with the possible impacts of increased flooding, heat waves and storm damage. Adaptation planning is an opportunity to ensure a cohesive approach to current and future planning. The process of developing these plans should integrate with the development and refinement of emergency preparedness and business continuity plans.

The changing climate poses risks for vulnerable populations in the community, but also impacts the Trust's estate, its ability to operate and the supply chain.

The Trust already engages with other public authorities and partners in tackling extreme weather events, such as flooding. ULHT will analyse these risks and develop actions for care delivery, estate planning and management, including flood risks across the estate and service area.

Climate change has serious implications for health, wellbeing, livelihoods, and society. Its direct effects result from rising temperatures and changes in the frequency and strength of storms, floods, droughts, and heatwaves — with physical and mental health consequences (The Lancet, 2017)

The NHS Long Term Plan reinforces the requirement to embed resilience and sustainability into the Trust's healthcare services. Climate change adaptation is critical to achieving this. The impacts of climate change on health, services, infrastructure and ULHT's ability to cope with extreme weather events will place significant additional demands on services in the future.

Climate change adaptation in the NHS is about organisational resilience and the prevention of avoidable illness, embracing every opportunity to create a sustainable, healthy and resilient healthcare service. Reducing the Trust's impact on the environment may not only help to mitigate climate change, but reduce the organisational running costs, ensure business continuity, and reduce health inequalities. Above all, it's about ensuring that the NHS and the Trust's buildings, services, staff and patients are prepared for what lies ahead.

United Lincolnshire Hospitals NHS Trust will work with partner organisations and other public sector organisations to develop a climate change adaptation plan to mitigate the consequences of climate change in respect of health and service delivery.

“As climate change accelerates globally, in England we are seeing direct and immediate consequences of heat waves and extreme weather on our patients, the public and the NHS. Adaptation is the process of adjusting our systems and infrastructure to continue to operate effectively while the climate changes. It is critical that the NHS can ensure both continuity of essential services, and a safe environment for patients and staff in even the most challenging times.” - Greener NHS

No	ULHT Green Plan Actions	Trust Area	Target Year	Pro-gress	Indicative Cost to Achieve	Responsible lead/dept.	NHS Req.
01	Appoint a Climate Change Adaptation lead and follow the recommendations of the third Health and Social Care Sector Climate Change Adaptation Report.	Governance & policy	23/24		£	Trust Board	**LTP** 17 **SC** 18.4.2.3 **NZ** 1
02	Embed Climate Change as a strategic risk within the corporate risk register and manage appropriately	Governance & policy	23/24		£	Business Continuity	**SC** 18.4.2.3 **NZ** 1
03	Create an ISO14090 Climate Change Adaptation Plan, including plans for adapting the premises to mitigate climate change and extreme weather risks, using a recognised methodology, that is routinely reviewed considering the changing climate and scientific advancements.	Core responsibilities	23/24		£	Business Continuity	**SC** 18.4.2.3 **NZ** 1
04	Work with NHS Supply Chain to better understand the climate change risks in the supply chain and proactively seek to make the supply chain 'climate-ready'.	Procurement	23/24		£	Procurement	**SC** 18.4.2.3 **NZ** 1
05	Embed and adapt existing health-related contingency planning, such as Flooding Plans to reflect predicted climate change impacts.	Working with patients, staff & communities	23/24		£	Business Continuity	**SC** 18.4.2.3 **NZ** 1

06	Incorporate newly emerging climate-related health care risks into contingency planning, such as the increasing prevalence of Vector Borne Diseases	Working with patients, staff & communities	23/24		£	Business Continuity	**SC** 18.4.2.3 **NZ** 1

Figure 30 Table to show green plan actions for climate adaptation

Conclusion

This Green Plan is a living document and will be regularly reviewed for progress against the action plans. As such, actions and targets may be revised where necessary.

Adequate budgets and resources will be allocated to achieve the Trust's goals and deliver sustainable care. The Trust will look to achieve the 'quick wins' first, although significant investment will be required in future years, especially in making ULHT's buildings 'climate-ready'.

Climate Change poses many threats to the care population and how care is delivered. This Green Plan will enable us to become an adaptable and resilient organisation. It will help steer the direction of travel with other local anchor institutions, bolstering the Trust's ability to provide a continued critical service.

ULHT's dedicated workforce is core to its care provision and delivery of this Green Plan. With the necessary structures in place, it will be the people and service users who will drive the changes to make us a more sustainable organisation. The Trust will continue an open dialogue with all stakeholders to improve the Green Plans and the delivery of care.

For more information, please contact

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This Green Plan was created for United Lincolnshire Hospitals NHS Trust in partnership with Inspired PLC.

Meeting	Trust Board
Date of Meeting	6th September 2022
Item Number	
Integrated Performance Report for July 2022	
Accountable Director	Paul Matthew, Director of Finance & Digital
Presented by	Paul Matthew, Director of Finance & Digital
Author(s)	Sharon Parker, Performance Manager
Report previously considered at	N/A

How the report supports the delivery of the priorities within the Board Assurance Framework	
1a Deliver harm free care	*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 resources	
3c Enhanced data and digital capability	
4a Establish new evidence based models of care	
4b Advancing professional practice with partners	
4c To become 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	• *Limited*

Recommendations/ Decision Required	• *The Board is asked to note the current performance and associated actions/escalations where appropriate*

Patient-centred ◆Respect◆ Excellence ◆Safety◆ Compassion

Executive Summary

Quality

Falls

There has been 2 falls in July resulting in moderate harm and 3 falls resulting in severe harm at the time of reporting. The incidents are currently being validated through the incident management process and the appropriate level of investigation will be instigated. Falls Prevention Ambassador meetings relaunched in July to create a network of engaged staff to provide additional support to the falls quality improvement work being undertaken and facilitate wider and timely sharing of learning at ward level. A Communication plan for delivery of regular falls prevention messages for both staff and patients has been developed. This will support the Focus on Fundamentals programme of work.

Pressure Ulcers

The number of Unstageable PU is 5 for the month of July. The incidents are currently being validated through the incident management process and the appropriate level of investigation will be instigated. Device related damage remains an area of focus. An experience based learning board developed to share findings from a pressure ulcer investigation will be presented as a Patient story at Skin Integrity Group.

Venous Thromboembolism Risk Assessment

Compliance against this metric remains static at 94.41% for the month of July.

Never Events

There has been a further Never Event declared in July pertaining to the wrong site insertion of a JJ stent. This is the third Never Event for this financial year. The Division have undertook a preliminary review of the incident and all immediate actions have been taken.

Medications

For the month of July, the number or incidents reported in relation to omitted or delayed medications is at 26% and 13% for those incidents reported as causing harm, a slight increase for both metrics from the previous month. A Medicines Management project group has now commenced and aims to raise the profile of medicines management and ultimately reduce the number and potential severity of medicines incidents.

Patient Safety Alerts

Of the three National Patient Safety alerts with a due date of July, 2 were completed in time and 1 remains in progress resulting in a compliance of 63%. All CAS alerts are reported through the Patient Safety Group and appropriate actions taken to escalate if overdue.

SHMI

The Trust SHMI is 106.13, a continued decrease in the last three reporting periods. The Trust remains in Band 2 with ‘As expected’. The Trust are currently in the process with their system partners in rolling out the Medical Examiner (ME) service for community deaths. This will enable greater learning on deaths in 30 days post discharge.

eDD

The Trust achieved 90.5% with sending eDDs within 24 hours for July 2022 against a target of 95% with 94.2% being sent anytime within the month. A dashboard has been developed to highlight compliance at both ward and consultant level with each Division now reviewing this metric at their monthly Performance Review Meeting.

Sepsis compliance – based on June data

Screening / IVAB / ED child - Screening compliance for paediatrics in ED was 81.8% with the administration of IVAB paediatrics in ED at 70% for July 2022. Clinical Harm reviews have been undertaken for the three affected children and no harm has been found as a result. Further work is underway within the Emergency Departments.

Operational Performance

At the time of writing this executive summary (8th August 2022), the Trust has 100 positive inpatients. There are 3 patients requiring Intensive Care interventions.

This report covers July's performance, and it should be noted the demands of Wave 5/6 have significantly increased. The Trust moved at pace into the *Recovery* and *Restoration* of services, but increased covid related staff sickness has impacted on this. The teams across the organisation continue to transition to 2022/23 and the recovery of waiting times and return towards pre-Covid access.

A & E and Ambulance Performance

Whilst the summary below pertains to June's data and performance, the proposed revised Urgent Care Constitutional Standards continue to be adopted and run-in shadow form. Performance against these will be described in the supplementary combined operational performance FPEC paper.

4-hour performance deteriorated slightly against June performance of 62.10% being reported at 60.10% in July.

There were 752 12-hr trolley waits, reported via the agreed process in July. This represents an increase of 60 from June. Sub-optimal discharges to meet emergency demand remains the root cause.

Performance against the 15 min triage target demonstrated a deterioration of 3.78%. 78.84% in July verses 82.62% in June. This the lowest recorded compliance in over 12months.

Overall Ambulance conveyances for July were 3756, a decrease of 22 conveyances in June (3778). This represents a 0.59% decrease against June. There were 796 >59minute handover delays recorded in July, an increase of 74 from June, representing a 9.30% increase. Delays experienced at LCH and PHB have seen increased levels of overcrowding in EDs made more difficult whilst continuing to manage pathways with differing levels of infection risk. July demonstrated an increase in >120mins handover delays compared with June, 426 in July compared with 346 in June, representing an 18.78% deterioration. >4hrs handover delays increased. A total of 94 in July compared to 87 in June. This represents a 7.45% increase.

Length of Stay

Non-Elective Length of Stay against the agreed target is not being achieved. Current performance is 4.85 days against an agreed target of 4.5 days The average bed occupancy for July, was 92.47%. The launch of the Integrated Discharge Hubs on 28th June ensures consistent monitoring of all discharge plans for all patients on pathways 1, 2 and 3 are reviewed, with a noted increase of patients being identified as medically optimised patients across the entire week (7days). System Partners are challenged with identifying timely support to facilitate discharge from the acute care setting, Pathway 1 capacity (Domiciliary care) has not been able to meet the demand and is a large contributor to increased LoS. All delays of greater than 24hours are escalated within the System.
Elective Length of Stay increase from 2.79 days in June to 3.11 in July. This increase can be attributed to increased complexity of patients being treated.

Referral to Treatment

It is important to view Referral to Treatment standard in the context of the current National Covid Recovery Agenda, and the move away from a focus on constitutional standards to the expectation of clinical urgency; a clinical risk-based patient selection process as opposed to selection based upon the longest waits. Within this context it is unlikely that there will be complete improvement to statutory RTT performance for some time.

June demonstrated a decrease in performance of 1.62%. June outturn was 50.79%. The Trust reported 6,216 incomplete 52-week breaches for June end of month which is an increase of 924 since May. Whilst the Trust position remains favourable when compared to other regional providers, the position continues to worsen.

The Cancer/Elective Cell continue to meet weekly, with a weekly confirm and challenge meeting with surgical specialities led by senior clinical review and prioritisation cell to ensure capacity across all sites are maximised for the most critical patients. Cancer patients and clinically urgent remain a priority with a continued focus on 62+ day, 104+ days cancer patients and 52+ and 78+ week patients on the 18-week monitoring lists.

At the end of July, the Trust reported 7 patients waiting longer than 104 weeks but none of these waits were associated with a lack of capacity to treat but related to patient choice and complexity. 3 were ULHT patients with the remaining 4 being mutual aid patients from Leicester. NHS organisations have been given the target of clearing all 104 week patients due to complexity by the end of August. Currently, ULHT are forecasting to have 1 patient waiting over 104 weeks that does not fit this criteria and is therefore being reviewed.

Waiting Lists

Overall waiting list size has increased since May. June reported 68,140 compared to May's position of 67,585, an increase of 555. Work continues between Outpatient department and the Clinical Business Units regarding returning better access to our bookable services for primary care and patients' choice.

The recovery plan for ASIs has been developed, including a recovery trajectory. July demonstrated a reduction (815 verses 988 in May) which is above the agreed trajectory of 550. Additional resource has been directed to resolving missing outcomes which is having an adverse effect on the bookings team being able to move the ASIs to open referrals.

DM01

DM01 for July reported a 53.12% compliance against the national target of 99%. A negative variation of 45.88% against the national target but a 0.69% improvement on the June outturn. Whilst the main area of concern remains Echocardiography, DM01 was significantly impacted by the 'heat wave' in terms of service loss and the residual impact of the fire at LCH.

Cancelled Ops

This indicator has not been met since July 2021. The compliance target for this indicator is 0.8%. July demonstrated a 2.87% compliance. A negative variance of 2.07% against the agreed target.

The target for not treated within 28 days of cancellation is zero. July experienced 23 breaches against this standard verses 21 in June.

A review of the effectiveness of the 6:4:2 theatre scheduling meetings continues and ICU capacity as a response to internal and external pressures is improving so it is likely that performance will continue to improve.

Cancer

Trust compliance against the 62day classic treatment standard is 52.47% (against 85.4% target.) This demonstrates an improvement in performance of 6.89% since the last reporting period.

The impact of COVID-19 on the delivery of the cancer pathways remains evident for 31 day and 62-day standards although as per previous statements Cancer pathways remain the highest priority in the recovery of services and the ring-fencing of capacity.

104+ day waiters are reducing in line with the trajectory. There are currently 113 patients waiting >104 days against a target of <10. The current figure is a reduction of 10 patients since the last reporting period.

Workforce

Mandatory Training – Mandatory training rates have remained constant over the past 3 months yet after a slight decreased of 0.5%pts in in June the rate has further decreased this month but remains stable at 89.72%. Issues in recording learning due to IT software have had an impact on courses completion rates. A solution has been looked at since May by the Digital team with little hope for immediate resolution and remains an issue.

Sickness Absence – The trend has increased by 0.02% to 5.28% which is still above the target of 4.5%. Covid absences are continuing to decrease

Extensive work is continuing to get full engagement of using Absence Management System (AMS) Trust wide.in particular to ensure staff report all non- attendance at work through AMS.

Work is continuing to cleanse the Case Manager element of AMS to ensure all open cases can be managed effectively

Monthly, Long Term Absence meeting with SHRBP's, ER Advisers, Divisional Leads and Occ Health are continuing to support staff to return to work where possible

Work has started on People Management Essentials (PME) training, which cover a section on AMS and management responsibilities. Currently undertaken by Medicine and Estates and Facilities, this will continue across all divisions.

The Employee Assistance Programme (EAP) service provides a complete support network that offers expert advice and compassionate guidance 24/7, covering a wide range of issues. We strongly believe in providing an EAP service that offers not only reactive support when someone needs it but also proactive and preventative support to deliver the best possible outcomes.

Staff Appraisals –The WorkPAL contract was decommissioned on 1st of July 2022. Ongoing service pressures and staffing challenges in the Trust have impacted appraisal completion rate over the past 6 months. This month we see an increase from 59.14% to 60.3%.

Staff Turnover – Turnover has remained at over 14.5% for the past 3 months, however this has seen a slight increase for July to 15.062%. Operational pressures, staffing and culture challenges meant that an increasing proportion of staff are looking for other avenues outside the Trust. The OD team offers face to face / Teams exit interviews to gather deeper insights on the reasons for leaving (in addition to ESR / EF3 form results). People Promise Manager is now in post and will look deeper into the reasons for leaving to establish any patterns and where interventions can be put in place to support a reduction in turnover.

Vacancies – We saw a 0.7% reduction in vacancy factor in July, this was due to a significant amount of all round recruitment, with specifically a high number of HCSWs arriving in the Divisions. Provision has been made to increase our International Nursing delivery to address the increase in headcount. Further funding from NHSEI has also been granted to supplement our AHP recruitment.

Finance

The Trust submitted a revised financial plan for 2022/23 of a break-even position; the plan is inclusive of a £29m cost improvement programme.

The Trust delivered a £1.1m deficit in July (£1.1m adverse to a break-even plan) and YTD the Trust has delivered a £6.3m deficit (£6.3m adverse to a break-even plan); CIP savings of £4.4m have been delivered YTD (£2.1m adverse to planned savings of £6.5m).

Capital funding levels for 2022/23, agreed through Trust Board & FPEC, show a plan of c£38.4m; capital expenditure incurred YTD equated to c£3.2m.

The July 2022 cash balance is £63.7m, which is a decrease of £24.6m against the March year-end cash balance of £88.3m.

Paul Matthew
Director of Finance & Digital & (interim) People
August 2022

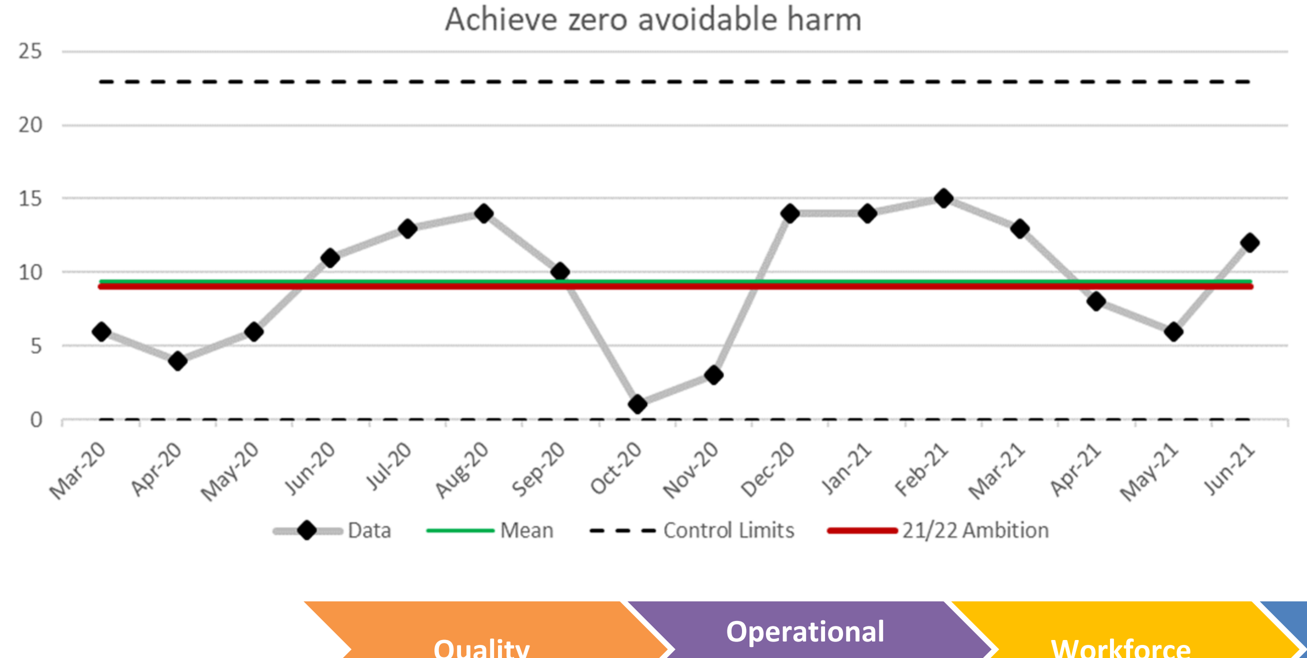
Statistical Process Control Charts

Statistical Process Control (SPC) charts are an analytical tool that plot data over time. They help us understand variation which guides us to make appropriate decisions.

SPC charts look like a traditional run chart but consist of:

- A line graph showing the data across a time series. The data can be in months, weeks, or days- but it is always best to ensure there are at least 15 data points in order to ensure the accurate identification of patterns, trends, anomalies (causes for concern) and random variations.
- A horizontal line showing the Mean. This is the sum of the outcomes, divided by the amount of values. This is used in determining if there is a statistically significant trend or pattern.
- Two horizontal lines either side of the Mean- called the upper and lower control limits. Any data points on the line graph outside these limits, are 'extreme values' and is not within the expected 'normal variation'.
- A horizontal line showing the Target. In order for this target to be achievable, it should sit within the control limits. Any target set that is not within the control limits will not be reached without dramatic changes to the process involved in reaching the outcomes.

An example chart is below:



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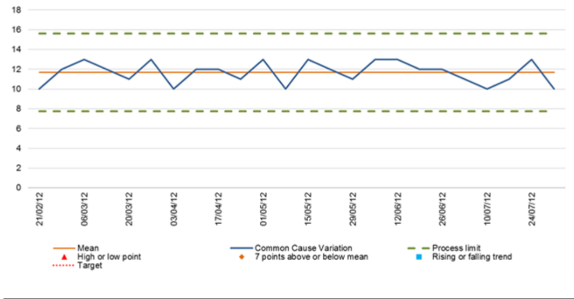
Statistical Process Control Charts

Normal variations in performance across time can occur randomly- without a direct cause, and should not be treated as a concern, or a sign of improvement, and is unlikely to require investigation unless one of the patterns defined below applies.

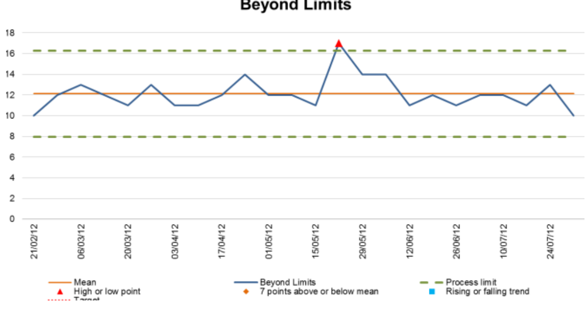
Within an SPC chart there are three different patterns to identify:

- Normal variation – (common cause) fluctuations in data points that sit between the upper and lower control limits
- Extreme values – (special cause) any value on the line graph that falls outside of the control limits. These are very unlikely to occur and where they do, it is likely a reason or handful of reasons outside the control of the process behind the extreme value
- A trend – may be identified where there are 7 consecutive points in either a patter that could be; a downward trend, an upward trend, or a string of data points that are all above, or all below the mean. A trend would indicate that there has been a change in process resulting in a change in outcome

Icons are used throughout this report either complementing or as a substitute for SPC charts. The guidance below describes each icon:



Extreme Values
There is no Icon for this scenario.



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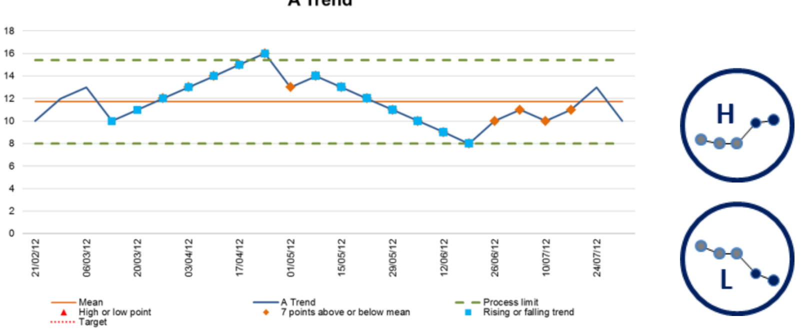
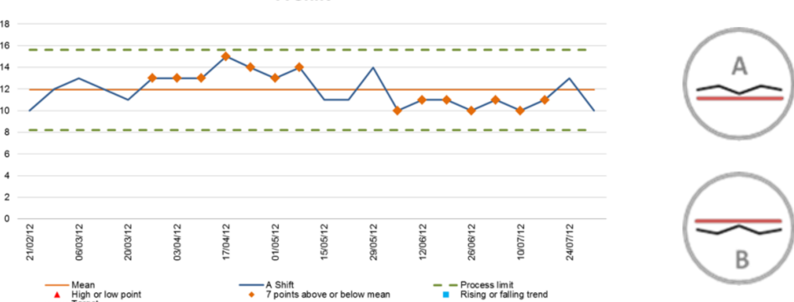
Statistical Process Control Charts

A Trend (upward or downward)



A Trend (a run above or below the mean)



Where a target has been met consistently

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

Where a target has been missed consistently

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

EXECUTIVE SCORECARD

Measure ID	Domain	Measure	Measure Definition	2022/23 Ambition	Tolerance	£'000	May-22	Jun-22	Jul-22	Latest month pass/fail to ambition	Trend variation
1	Patients	Implementation of the SAFER bundle	Non-elective stranded patients with LoS over 7 days as a percentage of total non-elective LoS, just for pathway 0 patients.	10% reduction	2.00%		14.20%	13.28%	12.47%		
2	Patients	SHMI performance	Summary Hospital-level Mortality Indicator. National data published by NHS Digital is for rolling 36 month period ending 5 months prior to current month	105	2 points		4th Quartile (108.32) (102nd of 122)	4th Quartile (106.63) (91st of 121)	3rd Quartile (106.13) (84th of 121)		
3	Patients	Reduction in moderate and severe harm and death incidents	Serious incidents (including Never Events) of harm - Moderate, severe and death.	TBD	TBD		14	9	14		
5	Patients	Reduction in medication incidents leading to moderate & severe harm or death	Total number of Medication incidents reported as causing harm (moderate /severe / death)	TBD	TBD		0	1	2		
6	Patients	Reduction in DKA incidents resulting in moderate & severe harm or death	Total number of DKA incidents reported as causing harm (moderate /severe / death)	TBD	TBD						
7	Patients	Achievement of the IPC BAF	Count of number of red scores, or is average risk score decreasing?	TBD	TBD						
8	Services	Financial Plan	Variance aganst plan	£0	TBD	£'000	-£176.00	-£4,956.00	-£1,149.00		
9	Services	Percentage of patients spending more than 12 hours in department	Number of Patient ED attendances waiting more than 12 hours from arrival to transfer, admission or discharge as a percentage of ED attendances.	1.00%	5.00%		19.16%	18.54%	19.63%		
10	Services	Patients waiting 52 weeks or more	Number of patients waiting 52 weeks or more (RTT pathways)	503	100		5282	6216			
11	Services	28 days faster diagnosis	Number of patients diagnosed within 28 days or less of referral as a percentage of total Cancer pathways.	75.00%	5.00%		58.10%	59.40%			
12	People	Improved vacancy rates	Total vacancy rates including all staff groups.	10.00%	2.00%		10.31%	12.08%	11.35%		
13	People	Appraisal rates and training development **(Appraisal Rates)**	Total appraisal rates including all staff groups.	90.00%	5.00%		57.62%	59.14%	60.30%		
13	People	Appraisal rates and training development **(Core Learning)**	Overall Core learning including all staff groups	95.00%	2.00%		90.26%	89.76%	89.72%		
14	People	Improved Pulse Survey results (Quarterly staff survey)	Improvement in the % of people rating their likelihood of referring the Trust to Friends and Family	TBD	TBD						
15	Partners	Health inequalities and Core20PLUS indicators	Access standards by Ethnicity?	TBD	TBD						
16	Partners	Increased recruitment/academic posts (across the ICS)	Number of posts appointed	10	TBD						
17	Partners	Risk and gain share (provider collaborative)	TBD	TBD	TBD						
18	Partners	Early Warning Discharge Indicators	Non-elective stranded patients with LoS over 7 days as a percentage of total non-elective LoS, for pathway 1-3 patients.	50% reduction	2.00%		76.32%	79.90%	77.99%		

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PERFORMANCE OVERVIEW - QUALITY

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target per month	May-22	Jun-22	Jul-22	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Clostridioides difficile position	Safe	Patients	Director of Nursing	9	6	5	7	22	P	
	MRSA bacteraemia	Safe	Patients	Director of Nursing	0	0	0	0	0	P	
	MSSA bacteraemia cases counts and 12-month rolling rates of hospital-onset, by reporting acute trust and month using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.13	0.07	0.07	0.07		
	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	0.35	0.03	0.01	0.10		
	Catheter Associated Urinary Tract Infection	Safe	Patients	Director of Nursing	1						
	Falls per 1000 bed days resulting in moderate, severe harm & death	Safe	Patients	Director of Nursing	0.19	0.13	0.10	0.17	0.17	P	
	Pressure Ulcers category 3	Safe	Patients	Director of Nursing	4.3	1	1	0	3	P	
	Pressure Ulcers category 4	Safe	Patients	Director of Nursing	1.3	1	2	0	3	P	
	Pressure Ulcers - unstageable	Safe	Patients	Director of Nursing	4.4	7	3	5	17	F	
	Venous Thromboembolism (VTE) Risk Assessment	Safe	Patients	Medical Director	95%	95.16%	94.50%	94.41%	94.86%	F	
	Never Events	Safe	Patients	Director of Nursing	0	1	0	1	3	F	
	Reported medication incidents per 1000 occupied bed days	Safe	Patients	Medical Director	4.3	5.17	5.14	5.74	5.45	P	
	Medication incidents reported as causing harm (low /moderate /severe / death)	Safe	Patients	Medical Director	10.7%	9.9%	10.5%	13.0%	13.58%	F	

PERFORMANCE OVERVIEW - QUALITY

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	May-22	Jun-22	Jul-22	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Patient Safety Alerts responded to by agreed deadline	Safe	Patients	Medical Director	100%	None due	None due	66%		F	
	Hospital Standardised Mortality Ratio - HSMR (basket of 56 diagnosis groups) (rolling year data 3 month time lag)	Effective	Patients	Medical Director	100	92.60	94.47	94.95	94.05	P	
	Summary Hospital Mortality Indicator (SHMI) (rolling year data 6 month time lag)	Effective	Patients	Medical Director	100	108.32	106.63	106.13	107.64	F	
	The Trust participates in all relevant National clinical audits	Effective	Patients	Medical Director	100%	100.00%	100.00%	100.00%	100.00%	P	A
	eDD issued within 24 hours	Effective	Patients	Medical Director	95%	90.20%	90.40%	90.50%	89.93%	F	
	Sepsis screening (bundle) compliance for inpatients (adult)	Safe	Patients	Director of Nursing	90%	93.5%	93.8%		94.01%	P	
	Sepsis screening (bundle) compliance for inpatients (child)	Safe	Patients	Director of Nursing	90%	81.4%	92.3%		86.13%	P	
	IVAB within 1 hour for sepsis for inpatients (adult)	Safe	Patients	Director of Nursing	90%	97.5%	95.4%		97.01%	P	
	IVAB within 1 hour for sepsis for inpatients (child)	Safe	Patients	Director of Nursing	90%	57.1%	100.0%		81.53%	P	
	Sepsis screening (bundle) compliance in A&E (adult)	Safe	Patients	Director of Nursing	90%	89.6%	90.7%		89.24%	P	
	Sepsis screening (bundle) compliance in A&E (child)	Safe	Patients	Director of Nursing	90%	88.5%	81.8%		83.43%	F	
	IVAB within 1 hour for sepsis in A&E (adult)	Safe	Patients	Director of Nursing	90%	91.8%	94.0%		92.70%	P	
	IVAB within 1 hour for sepsis in A&E (child)	Safe	Patients	Director of Nursing	90%	83.3%	70.0%		60.44%	F	
	Rate of stillbirth per 1000 births	Safe	Patients	Director of Nursing	3.80	3.23	3.03	3.28	3.24	P	
Improve Patient Experience	Mixed Sex Accommodation breaches	Caring	Patients	Director of Nursing	0	Submission suspended during Covid					
	Duty of Candour compliance - Verbal	Safe	Patients	Medical Director	100%	96.00%	100.00%		92.67%	F	
	Duty of Candour compliance - Written	Responsive	Patients	Medical Director	100%	84.00%	100.00%		88.67%	F	

Pressure Ulcers - unstageable

Chart data (Data, Mean, Target, Control Limits):

Month	Data
May-21	3
Jun-21	7
Jul-21	6
Aug-21	3
Sep-21	4
Oct-21	3
Nov-21	8
Dec-21	8
Jan-22	8
Feb-22	6
Mar-22	2
Apr-22	2
May-22	7
Jun-22	3
Jul-22	5

Jul-22
5
Variance Type
Metric is currently experiencing Common Cause Variation
Target
4.4
Target Achievement
Metric is consistently failing the target
Executive Lead
Director of Nursing

Background: Pressure Ulcers Unstageable

What the chart tells us: We are currently at 5 incidents against a threshold of 4 per month.

Issues:
The number of incidents has increased by 2 in comparison to June.
One incident was device related from a urinary catheter.
It has been identified that a number of these incidents involved patients declining skin inspection or pressure relieving mattresses, however staff had not fully explained the risks of developing pressure ulcers or existing skin damage deteriorating further.

Actions:
Device related damage remains an area of focus. During July and August, a device related educational bulletin has been shared and is available on the Tissue Viability (TV) intranet page. Further focused work around device related damage will be included as part of the programme for Stop the Pressure ambassador educational day in November.
The Tissue viability team and Safeguarding/Mental Capacity lead are designing pictorial information for patients regarding the risks and potential outcomes from declining care and advice offered. This will help the patients to make an informed choice and to demonstrate actions taken by staff.
The Clinical Nurse Advisor for ARJO will be working with the TV and clinical teams to provide targeted educational support; this will ensure appropriate selection and use of pressure relieving equipment.
An experience based learning board developed to share findings from a pressure ulcer investigation will be presented as a Patient story at Skin Integrity Group.

Mitigations:
Skin Integrity care is reviewed in the weekly ward/dept. leader's assurance and monthly matrons audits.
The monthly Quality Metrics review meeting chaired by the Director of Nursing monitors ward and departments' performance relating to skin integrity.
Quality Matron and Tissue Viability team provide support to areas with increased number of incidents.
The Patient Pressure Ulcer Incident Panel also have sight of any other areas of concern that are not raised through the serious incident process.

Venous Thromboembolism (VTE) Risk Assessment

Jul-22
94.41%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
95%
Target Achievement
Metric is failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
VTE risk assessment performance is just below 95% target, currently at 94.41%.

Issues:
As previously discussed via the VTE and Anti-Coagulation Safety Group.

Actions:
Actions to be proposed, implemented and monitored through the Trust's VTE and Anti-Coagulation Safety Group Meeting, which in turn reports via Deteriorating Patients Group and Patient Safety Group.

Mitigations:
As discussed via the VTE and Anti-Coagulation Safety Group.

Never Events

Chart: Never Events, Jan-21 to Jul-22. Y-axis: 0, 1, 2. Legend: Data, Mean, Target, Control Limits.

Month	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22

Jul-22
1
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0
Target Achievement
Metric is failing the target
Executive Lead
Director of Nursing

Background:
Never Events are deemed to be externally reportable incidents that have been defined by the NHS as 'wholly preventable where nationally available systemic barriers have been locally implemented.

What the chart tells us:
There was 1 Never Event declared in April 2022, 1 declared in May and 1 de3clared in July.

Issues:
The Never Event declared in April 2022 relates to an anaesthetic block performed on the incorrect side.
The Never Event declared in May 2022 relates to a gynaecology surgical procedure.
The Never Event declared in July 2022 involved the wrong site insertion of a JJ stent.

Actions:
All confirmed Never Events are declared as Serious Incidents and have comprehensive investigations, supported by the Risk & Governance team and overseen by the Serious Incident Panel.

Mitigations:
Following the initial review of each incident, immediate actions are implemented to provide mitigation where possible. At the conclusion of the investigation, recommended action plans are agreed with the Serious Incident Panel and monitored through to completion as part of divisional clinical governance arrangements.

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

Legend: Data, Mean, Target, Control Limits

Month	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22

Y-axis: 0%, 5%, 10%, 15%, 20%, 25%, 30%, 35%, 40%

Jul-22
13%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
10.7%
Target Achievement
Metric is failing the target
Executive Lead
Medical Director

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

What the chart tells us:
In the month of July the number of incidents reported was 176. This equates to 5.74 incidents per 1000 bed days. The number of incidents causing some level of harm (low /moderate /severe / death) is 13 % which is above the national average of 11.

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

Actions:
A medicines management project group has been set up to tackle on going medicines incidents. This aims to raise the profile of medicines management and reduce the number and potential severity of medicines incidents.

Mitigations:

Patient Safety Alerts responded to by agreed deadline

120%
100%
80%
60%
40%
20%
0%

Jan-21 Feb-21 Mar-21 Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22

Data | Mean | Target | Control Limits

F

Jul-22
66%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
100%
Target Achievement
The metric has failed to target
Executive Lead
Medical Director

Background:
Percentage of patient safety alerts responded to by an agreed deadline.

What the chart tells us:
There were 3 National Patient Safety Alerts with a due date in July 2022.

2 of these were completed on time, 1 remains in progress.

Issues:
Patient Safety Alerts are compiled by the national team from analysis of reported incidents and contain safety critical actions.

Compliance is monitored through the NHS Central Alerting System (CAS).

Actions:
The Risk & Incident team within Clinical Governance continue to coordinate the Trust response to all CAS alerts.

Mitigations:
Details of all outstanding CAS alerts are now included in monthly Integrated Clinical Governance Reports that are provided to division, CBU and specialty management teams.

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

Chart axis: 95–120; months Jan-21 to Jul-22. Legend: Data, Mean, Target, Control Limits.

Jul-22
106.13
Variance Type
Metric is currently experiencing Common Cause Variation
Target
To remain in "as expected" range
Target Achievement
The metric has consistently failed to target
Executive Lead
Medical Director

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

What the chart tells us:
ULHT SHMI is 106.13; a decrease (improvement) from the last reporting period. The Trust has remained in Band 2 with an 'As expected' value.

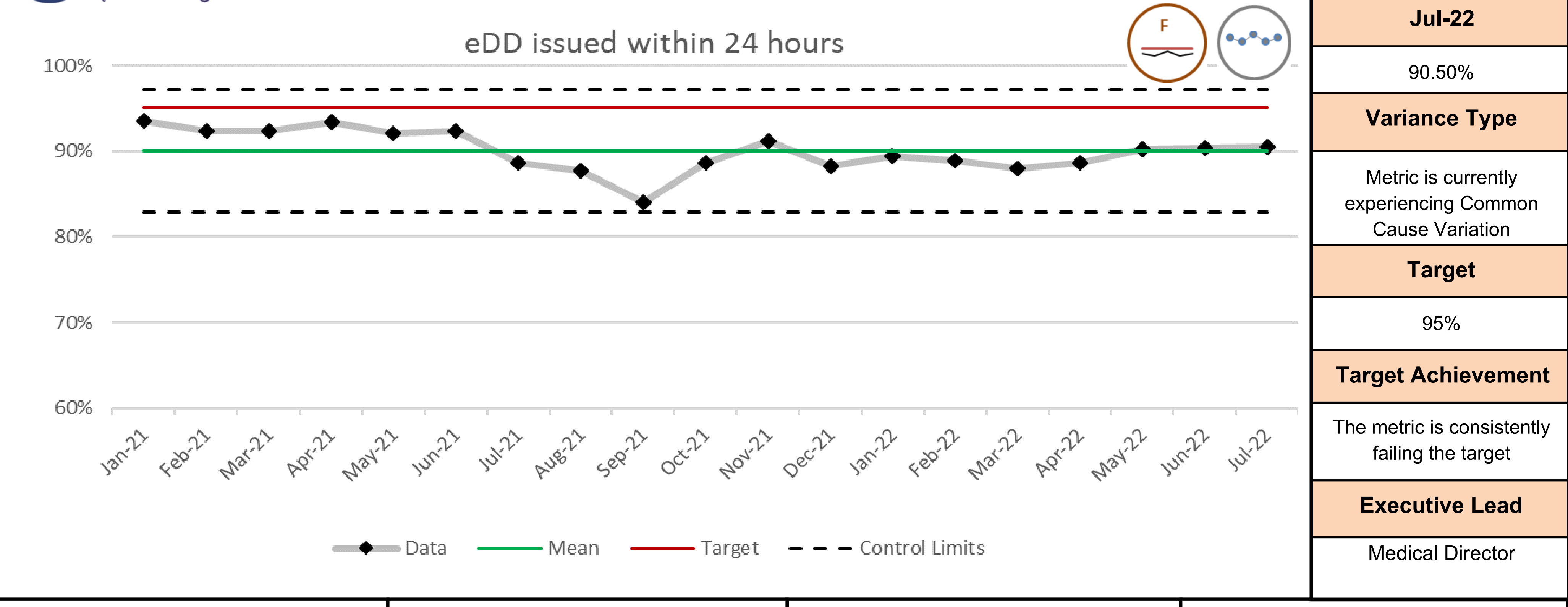
Issues:
The COVID-19 pandemic has impacted on the Trust's SHMI. The data period is reflective from Mar 21 – Feb 22.

There had however been a sustained decrease (i.e. improvement) in the SHMI trajectory seen since March 2022.

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

The Trust are currently in the process with their system partners in rolling out the Medical Examiner (ME) service for community deaths and are currently in the pilot phase. This will enable greater learning on deaths in 30 days post discharge.

Mitigations:
The MEs will commence reviewing all deaths in the community which will enable oversight of deaths in 30 days post discharge of which learning can be identified.
Learning is shared at the Lincolnshire Mortality Collaborative Group which is attended by all system partners.
HSMR is 94.95 - within "as expected" range.



Jul-22
90.50%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
95%
Target Achievement
The metric is consistently failing the target
Executive Lead
Medical Director

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

What the chart tells us:
The Trust is not achieving the 95% target, for July the Trust achieved 90.5% for this standard. The Trust however achieved 94.2% for eDDs sent anytime within the month of July.

Issues:
eDDs not being completed the day prior to the patients discharge.

Actions:
A dashboard has therefore been developed to highlight compliance at both ward and consultant level, which can then help to highlight areas of suboptimal compliance to help focus targeted work to address this.

Mitigations:
Each Division to review their performance at their respective Performance Review Meetings.

Sepsis screening (bundle) compliance in A&E (child)

Chart legend: Data, Mean, Target, Control Limits. Y-axis 40%–110%; X-axis Jan-21 to Jun-22.

Jun-22
81.8%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is consistently failing the target
Executive Lead
Director of Nursing

Background:
Sepsis screening (bundle) compliance in A & E (child).

What the chart tells us:
Screening compliance in ED is 81.8% which is below the 90% target. 176 of 215 patients received screening for sepsis within the hour. This is a decrease on last month.

Issues:
ED has recently seen a large turnover of staff. Staff have reported that they are struggling with the Paediatric workload as a single Paeds Nurse in the ED department.
There is also a marked increase in children attending ED this month as well as those having a higher acuity.

Actions:
Sepsis Practitioners are currently doing increased walk rounds in the department and offering any assistance if needed. Harm reviews are carried out for all delayed / missed screens.
A member of medical team has been identified as a link at Lincoln. A nurse has also been identified as a link nurse. Two nurses in ED have been shown how to pull data so they can observe this throughout month.

Mitigations:
There are ongoing fortnightly Sepsis meetings for ED at present. Issues are discussed at these and action plans are put in place quickly to try and assist the department compliance. Previous action plans are also reviewed at these meetings.
There is also a plan for increased meetings between the link Nurse and Doctor in ED and Sepsis Practitioner.

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

Month	Data
Jan-21	67%
Feb-21	57%
Mar-21	33%
Apr-21	50%
May-21	100%
Jun-21	88%
Jul-21	50%
Aug-21	50%
Sep-21	83%
Oct-21	50%
Nov-21	57%
Dec-21	71%
Jan-22	100%
Feb-22	60%
Mar-22	100%
Apr-22	28%
May-22	83%
Jun-22	70%

Data — Mean — Target — Control Limits

Jun-22
70%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is consistently failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
The data this month shows that the IVAB compliance was 70.0%, which is 7 of 10 patients, and is below the 90% target. There is a decrease against last month.

Issues:
There was 3 patients in ED this month that was delayed in receiving antibiotics. One of these was due to the child being transferred to the ward prior to starting treatment. Paediatric Doctors had requested this as they were busy on the ward and unable to attend ED. There were 2 children where Cannulation was very difficult and antibiotics were delayed due to this.

Actions:
A harm review was completed for all 3 patients and no harm was found. Sepsis training is planned for new Doctors starting in August. Simulation training is to be reintroduced as soon as possible. There will be more training with ED staff about how to fill in/ use the unsure option appropriately.

Mitigations:
Harm reviews completed for the patients. No Harm found. There are ongoing meetings between the Sepsis team and ED which happen every other week. There appears to be more engagement from ED staff, especially those with a Paediatric interest, which is a positive.

OUTSTANDING CARE
personally DELIVERED

PERFORMANCE OVERVIEW – OPERATIONAL PERFORMANCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	May-22	Jun-22	Jul-22	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Improve Patient Experience	% Triage Data Not Recorded	Effective	Patients	Chief Operating Officer	0%	0.06%	0.17%	0.25%	0.14%				
Improve Clinical Outcomes	4hrs or less in A&E Dept	Responsive	Services	Chief Operating Officer	83.12%	63.63%	62.10%	60.10%	62.22%	83.12%			
	12+ Trolley waits	Responsive	Services	Chief Operating Officer	0	680	692	752	2869	0			
	%Triage Achieved under 15 mins	Responsive	Services	Chief Operating Officer	88.5%	84.17%	82.62%	78.84%	82.24%	88.50%			
	52 Week Waiters	Responsive	Services	Chief Operating Officer	0	5292	6216		16,202	0			
	18 week incompletes	Responsive	Services	Chief Operating Officer	84.1%	52.41%	50.79%		51.03%	84.10%			
	Waiting List Size	Responsive	Services	Chief Operating Officer	37,762	67,585	68,140		n/a	n/a			
	62 day classic	Responsive	Services	Chief Operating Officer	85.4%	45.58%	52.47%		48.75%	85.39%			
	2 week wait suspect	Responsive	Services	Chief Operating Officer	93.0%	73.15%	48.96%		62.97%	93.00%			
	2 week wait breast symptomatic	Responsive	Services	Chief Operating Officer	93.0%	22.15%	29.23%		21.66%	93.00%			
	31 day first treatment	Responsive	Services	Chief Operating Officer	96.0%	89.36%	89.76%		90.07%	96.00%			
	31 day subsequent drug treatments	Responsive	Services	Chief Operating Officer	98.0%	97.24%	98.99%		97.78%	98.00%			
	31 day subsequent surgery treatments	Responsive	Services	Chief Operating Officer	94.0%	64.29%	63.64%		66.30%	94.00%			
	31 day subsequent radiotherapy treatments	Responsive	Services	Chief Operating Officer	94.0%	97.22%	98.08%		96.53%	94.00%			
	62 day screening	Responsive	Services	Chief Operating Officer	90.0%	55.56%	72.41%		69.74%	90.00%			

OUTSTANDING CARE
personally DELIVERED

PERFORMANCE OVERVIEW – OPERATIONAL PERFORMANCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	May-22	Jun-22	Jul-22	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Improve Clinical Outcomes	62 day consultant upgrade	Responsive	Services	Chief Operating Officer	85.0%	70.11%	63.95%		66.72%	85.00%	F		
	Diagnostics achieved	Responsive	Services	Chief Operating Officer	99.0%	57.66%	52.43%	53.12%	54.81%	99.00%	F	B	
	Cancelled Operations on the day (non clinical)	Responsive	Services	Chief Operating Officer	0.8%	1.58%	2.17%	2.87%	2.18%	0.80%	F		
	Not treated within 28 days. (Breach)	Responsive	Services	Chief Operating Officer	0	20	21	23	97	0	F	A	
	#NOF 48 hrs	Responsive	Services	Chief Operating Officer	90%	76.71%	78.95%	63.75%	72.84%	90%	F		
	#NOF 36 hrs	Responsive	Services	Chief Operating Officer	TBC	53.42%	68.42%	50.00%	54.24%				
	EMAS Conveyances to ULHT	Responsive	Services	Chief Operating Officer	4,657	4,080	3,778	3,756	3,853	4,657	P		
	EMAS Conveyances Delayed >59 mins	Responsive	Services	Chief Operating Officer	0	748	722	796	771	0	F	A	
	104+ Day Waiters	Responsive	Services	Chief Operating Officer	10	144	123	113	512	40	F	A	
	Average LoS - Elective (not including Daycase)	Effective	Services	Chief Operating Officer	2.80	3.82	2.79	3.11	3.11	2.80	F		
	Average LoS - Non Elective	Effective	Services	Chief Operating Officer	4.50	5.05	5.25	4.85	5.04	4.5	F	A	
	Delayed Transfers of Care	Effective	Services	Chief Operating Officer	3.5%	Submission suspended				3.5%			
	Partial Booking Waiting List	Effective	Services	Chief Operating Officer	4,524	22,856	23,087	23,034	23,135	4,524	F	A	
	Outpatients seen within 15 minutes of appointment	Effective	Services	Chief Operating Officer	70.0%	43.28%	40.07%	33.40%	40.51%	70.00%	F		
	% discharged within 24hrs of PDD	Effective	Services	Chief Operating Officer	45.0%	37.41%	36.85%	42.02%	37.85%	45.00%	F		

% Triage Data Not Recorded

0.8%
0.7%
0.6%
0.5%
0.4%
0.3%
0.2%
0.1%
0.0%

Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22

% Triage Data Not Recorded — Mean — Control Limits — Target

Jul-22
0.25%
Variance Type
Metric is currently experiencing Special Cause Variation – below the mean
Target
0%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Percentage of triage data not recorded.

What the chart tells us:
The recording of triage compliance percentage is 0%.
July reported 025% data not recorded verses 0.17% in June.
July demonstrated a 0.08% negative variation compared with June.
This metric is below target.

Issues:

- Timely inputting of data.
- Manchester Triage trained staff (MTS) to consistently operate two triage streams, especially out of hours but has been less problematic at all three sites.
- Adhoc gaps in the provision of Pre-Hospital Practitioners (PHP) and an increased incidence of only 1 triage stream against the standard of 2 streams.
- Staffing gaps, sickness and skill mix issues
- Increased demand is still cited as a causation factor.

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 and consistent.

Mitigations:

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

%Triage Achieved under 15 mins

Jul-22
78.84%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
88.5%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Percentage of triage achieved under 15 minutes.

What the chart tells us:
The compliance against this target is 88.50%.
July outturn was 78.84% compared to 82.62% in June.
This demonstrated a deterioration in performance of 3.78% compared with June and a 9.66% negative variance against the agreed target.
This is the worst performance thus far and is only 3.29% above the LCL for this metric.
This target has not been met.

Issues:

- Consistent availability of MTS2 trained staff available per shift to ensure 2 triage streams in place 24/7 has deteriorated.
- There is a recording issue for UTC transfers of care to ED that skews that data on occasion.
- Dual department roles. For example, the second triage nurse is also the allocated paediatric trained nurse, whilst reduced is still on occasion, problematic.
- Inability to maintain agreed staffing template, particularly registrants, due high to sickness and agency cancellations at short notice.
- The ability to effectively maintain two triage streams continues to be mainly out of hours but improvement is noted.

Actions:
Most actions are repetitive but remain relevant.
Increased access to MTS2 training.
Increased registrant workforce to support 2 triage streams to be in place via Emergency Department recruitment campaign.
To move to a workforce model with Triage dedicated registrants and remove the dual role component.
The metric forms part of the Emergency Department safety indicators and is monitored/scrutinised at 4 x daily Capacity and Performance Meetings.

Mitigations:
The Senior Nurse Leads maintain oversight and support in periods of either high attendance demand or when the second triage stream is compromised due to duality of role issues.
The confirmation of 2 triage streams is ascertained at the 4 x daily Capacity meetings.
Early escalation and rectification are also managed through the Emergency Department Teams Chat and Staffing Cell.
A twice daily staffing meeting staffing meeting in in operations 7 days a week and a daily staffing forecast is also in place.

4hrs or less in A&E Dept

Jul-22
60.10%
Variance Type
Metric is currently experiencing Special Cause Variation – below the mean
Target
83.12%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

The national 4-hour standard is set at 95%. The agreed trajectory for compliance for ULHT is set at 83.12%. This target has not been reset since April 2021.

What the chart tells us:

The 4-hour transit target performance for July was 60.10% compared to 62.10% in June which is a deterioration of 2.0% and is 23.02% below the agreed target.

Issues:

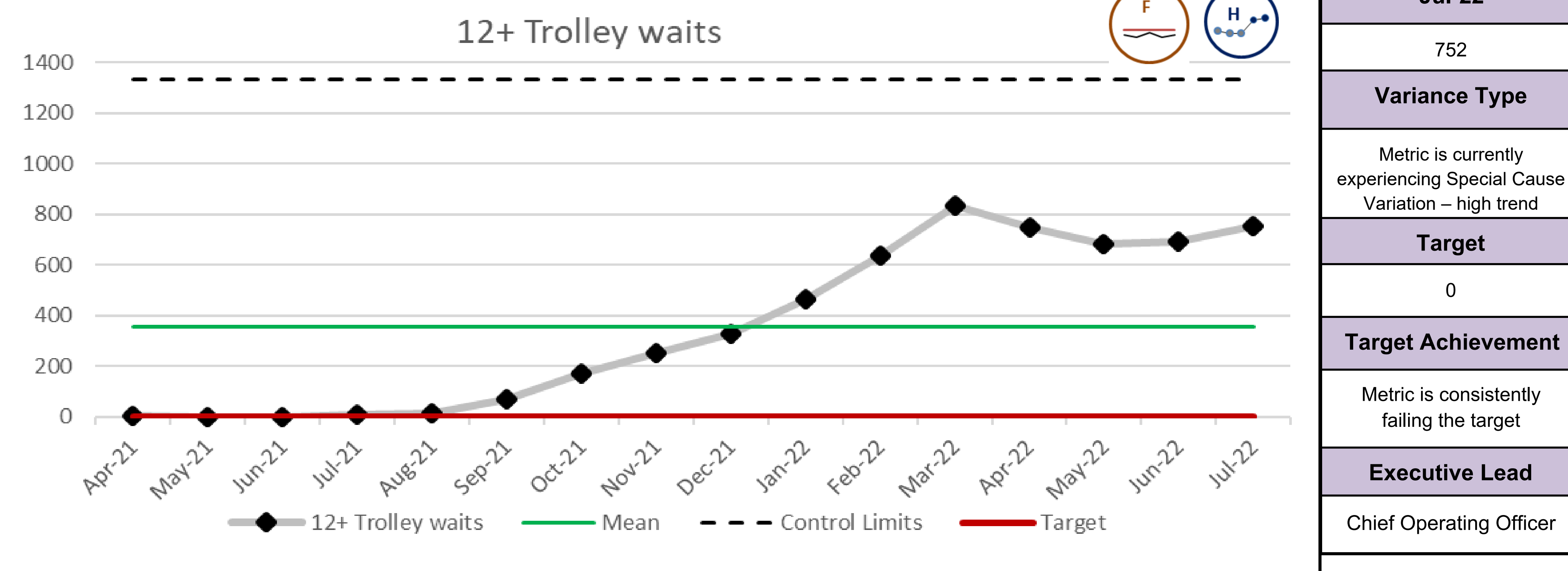
The Emergency Departments saw a 2.80% increase in attendances in July (508 patients) compared to June. 18,162 combined attendances (ED and UTC) in July compared to 17,654 combined attendances in June. Of the 18,162 recorded attendances for type 1 and type 3 across the Trust, type 1 attendances accounted for 12,137 and type 3 accounted for 6,025. This is an increase on type 1across all 3 sites but a decrease in type 3 attendances. An increase of 699 type 1 and a decrease of 141 type 3 attendances
Inadequate daily discharges to meet the admission demand remains an issue leading to extended ED LOS.
Ongoing medical and nursing gaps that were not Emergency Department specific.
Inability to secure consistent 24/7 Discharge Lounge provision due increased registrant staffing gaps.

Actions:

Reducing the burden placed upon the Emergency Departments further will be though the continued expansion of Same Day Emergency Care (SDEC) Services,
maximising the Right to Reside (R2R) information to ensure timely and effective discharges for all pathway zero patients, the System flow and discharge improvement programme, increased pathway 1 (D2A) capacity and the Care Closer to Home programme.

Mitigations:

EMAS continue to enact a targeted admission avoidance process.
The Discharge Lounge at LCH and PHB continues operating, where possible, a 24/7 service provision to release the burden placed on the Emergency Departments in terms of patients awaiting AIR/CIR and transport home. The closure of the Discharge Lounges due to inadequate staffing sits solely with the Chief Operating Officer and the Director of Nursing but can be delegated to Dep Chief Operating Officer/ Gold Commander Out of Hours
Increased CAS and 111 support especially out of hours.
EPIC to Specialty Consultant reviews to ensure DTA applied appropriately.
Clinical Operational Flow Policy adherence and compliance and Full Capacity Protocol activation when OPEL 3 reached.
System Partners attend the ULHT 6pm.



Jul-22
752
Variance Type
Metric is currently experiencing Special Cause Variation – high trend
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
July experienced 752 12-hr trolley wait breaches. This is the unvalidated position. This is an increase of 60 12-hr trolley wait breaches compared to June. This represents an increase of 7.98%. This equates to 6.19% of all type 1 attendances for July.

Issues:
Sub-optimal discharges to meet the known emergency demand.
All reportable 12hr trolleys were either associated with no available beds, patient deterioration or delays in transfer to other care settings. The actual number of 12hr trolleys wait breaches, whilst anticipated against flow predictions, exceeded actual expectations.
July has experienced an increase in incidental positive covid cases and nosocomial transmission, which as restricted the use of several inpatients' beds, impacting further on flow.
July saw a significant increase in the number of new positive covid cases akin to wave 1 and 2 peaks.
To prevent nosocomial transmission, the use of boarding areas as per the Full Capacity Protocol areas has been problematic.

Actions:
The Trust continues to work closely with national regulators in reviewing and reporting these breaches.
Due to the number of 12hrs trolley waits breaches currently, harm reviews are completed by the UEC team, DATIX are completed and escalations to the CCG and NHSE/I are in place.
A daily review of all potential 12hr trolley waits is in place and escalated to all key strategic tactical and operational leads and divisional triumvirates.
System Partners and Regulators remain actively engaged and offer practical support in situational escalations.
A substantial programme of work out of hospital is in place with system partners to reduce delayed discharges which are upwards of 15% of all beds at times.
Internal actions on admission avoidance are focussed on Same Day emergency Care and recent developments have shown a 100% increase in some areas.

Mitigations:
All potential DTA risks are escalated at 8hrs to the Daytime Tactical Lead, out of hours Tactical Lead On Call Manager and CCG Tactical Lead – in and out of hours. Rectification plans are agreed with all CBU teams in hours.
A System agreement remains in place to staff the Discharge Lounges 24/7 to reduce the number of patients in the Emergency Departments that are deemed 'Medically Optimised' that need onward non acute placement/support. This demonstrates a positive impact but due to staffing gaps, there is an increased request to close this facility. Permission to close these areas now sits solely with the Chief Operating Officer and Director of Nursing or delegated officer
A Criteria to Admit Lead has been established ensuring all decisions to admit must be approved by the EPIC (Emergency Physician in Charge) with the relevant On Call Team.

EMAS Conveyances Delayed >59 mins

Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22

Legend: Trajectory; EMAS Conveyances Delayed >59 mins; Mean; Control Limits

Jul-22
796
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Delays in offloading patients following a conveyance has a known impact on the ability of EMAS to respond to outstanding calls. Any delays greater than 59 minutes is reportable to the CCG. There is local and national Ambulance handover delay escalation protocol.

What the chart tells us:
June demonstrated a slight decrease in greater than 59 minutes' handover delays 796 in July compared to 722 in June. This represents a 9.30% increase.
What the chart does not tell us is the increase of >2hrs in July 2022 (426 in July vs 346 in June) and an increase in >4hr delays (94 in July vs 87 in June).
Overall conveyances reduced slightly in July (3,756 vs 3778 in June). This is a 0.59% decrease.

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 de-escalate due to an increased number of patients waiting for admission.

Actions:
All ambulances approaching 30 minutes without a plan to off load is escalated to the Clinical Site Manager and then in hours Tactical Lead to secure a resolution and plans to resolve are feedback to the DOM. Out of hours, the responsibility lies with the Tactical on Call Manager.
Daily messages to EMAS crews to sign post to alternative pathways and reduce conveyances to the acute setting.
Active monitoring of the EMAS inbound screen to ensure the departments are ready to respond.
The rapid handover protocol has now been revisited and agreed. Designated escalation areas have been identified/confirmed to assist in reducing delays in handover.
July saw an increase in formal requests from EMAS to enact the rapid handover protocol and also the newly endorsed immediate handover protocol.

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.

Average LoS - Elective

Month	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22

Legend: Average LoS - Elective, Mean, Control Limits, Target

Jul-22
3.11
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
2.80
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Average length of stay for Elective inpatients

What the chart tells us:
The average LOS for Elective stay has increased from 2.79 days in June to 3.11 days in JUNE. This is an increase of 0.32 days and represents an increase of 10.29%%.
The trajectory for Elective LOS is 2.8 days.

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

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

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

Average LoS - Non Elective

Chart: Average LoS - Non Elective, Apr-21 to Jul-22 (legend: Average LoS - Non Elective; Mean; Control Limits; Target). Y-axis: 3, 4, 5, 6. X-axis: Apr-21, May-21, Jun-21, Jul-21, Aug-21, Sep-21, Oct-21, Nov-21, Dec-21, Jan-22, Feb-22, Mar-22, Apr-22, May-22, Jun-22, Jul-22. Icons: F, A.

Jul-22
4.85
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
4.5
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
The agreed target is 4.5 days verses the actual of 4.85 days in July vs 5.25 in June. This is a decrease of 0.40 days
compared with June
This is a 0.35-day variance against the agreed target.

Issues:
Numbers of stranded and super stranded patients are static in number.
Increasing length of stay of all pathways 1-3. The most significant increase in volume of bed days is Pathway 1 Domiciliary care but since the advent of the joint D2A process and additional funding benefits are being realised but there remains insufficient capacity to meet the increasing demand.
The launch of the Integrated Discharge Hub has gained more traction on moving discharges forward at an improved pace.
Higher acuity of patients requiring a longer period of recovery.
Increased medical outliers and reduced medical staffing leading to delays in senior reviews.
Increased number of positive covid cases requiring a longer length of stay and increased 'contact' patients leading to delayed discharges.
Pathway 0 patient discharging is beginning to show improvement.

Actions:
These actions are repetitive but still appropriate
Focused discharge profile through right to reside data.
Medically optimised patients discussed twice daily 7 days a week with system partners to ensure plans in place and a zero tolerance of >24hrs delay
Use of rapid PCRs to ensure no delay once social care plans are secured.
Maximise use of all community and transitional care beds when onward care provision cannot be secured in a timely manner.
Line by line review of all pathway 0 patients who do not meeting the reason to reside.
System and regional support to re-embedding SAFER via the appointment of System Discharge and Flow specialists.

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

18 Week Incompletes

F B

90%
85%
80%
75%
70%
65%
60%
55%
50%
45%
40%

Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22

Mean — Control Limits — Trajectory — 18 Week Incompletes

Jun-22
50.79%
Variance Type
Metric is currently experiencing Special Cause Variation – below the mean
Target
84.1%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
There is significant backlog of patients on incomplete pathways. June saw RTT performance of 50.79% against a 92% target, which is 1.62% down on May.

Issues:
Performance is currently below trajectory and standard. The five specialties with the highest number of 18 week breaches at the end of the month were:

- ENT – 5651 (increased by 156)
- Gastroenterology – 3633 (increased by 311)
- Dermatology – 3096 (increased by 200)
- Gynaecology – 2585 (decreased by 56)
- General Surgery – 2284 (increased by 66).

Actions:
Planned routine elective work remains challenging. Available capacity is being focussed on cancer, long waiting patients, paediatrics, day cases and patients classified as being P2. Following last month's IPC update relating to vaccination status and isolation for admitted patients, there has now been an update regarding Outpatients. IPC are now supportive of Outpatient areas dropping the 2m rule and all areas will go back to full capacity. This will increase Outpatient capacity by 30-40% in some areas.

Mitigations:
Admitted patient pathways are discussed at the weekly Clinical Prioritisation Cell to determine the clinical appropriateness of patients to be booked for the forthcoming week. Patients are also being assessed for their suitability to be transferred to Independent Sector Providers and offered this choice for treatment.

52 Week Waiters

52 Week Waiters — Mean — Control Limits — Target — Trajectory

Jun-22
6216
Variance Type
Metric is currently experiencing Special Cause Variation – high trend
Target
0
Target Achievement
Metric is consistently failing 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 6216 incomplete 52-week breaches for June. An increase of 924 from May.
The number of 52-week breaches has increased considerably since August.

Issues:
Both the admitted and non-admitted position remains challenging. Current capacity challenges and staffing issues are all impacting on service delivery, which in turn, is detrimentally affecting the 52-week position. Our regional position remains strong. ULHT continue to support regional colleagues with their 104 week waiters and this is being prioritised over our 52 week position.

Actions:
Admitted patients are individually graded and allocated a priority code utilising C2AI.appears to be having a positive effect on the efficiency and effectiveness of this process. All patients waiting more than 52 weeks are required to have a harm review completed. The harm review process is discussed at the Clinical Harms Oversight Group with volumes and severity closely monitored. The in-house monitoring and recording software that was being developed has been identified as unsuitable.

Mitigations:
Non admitted patients continue to be reviewed, utilising all available media.
Patients waiting 78 weeks and above are individually monitored and tracked for their urgency, wait time and priority code where applicable. Recent IPC changes to admitted and Non admitted pathways will support increased activity and a reduction in long waiters.

Waiting List Size

Months	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22

Legend: Trajectory, Mean, Control Limits, Waiting List Size

Y-axis: 30,000 – 90,000

Jun-22
68,140
Variance Type
Metric is currently experiencing Special Cause Variation – high trend
Target
37,762
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
Overall waiting list size has increased from May, with June showing an increase of 555 to 68,140.
The incomplete position for June 2022 has increased by approximately 30,114 more than the reported pre pandemic size in January 2020.

Issues:
Recent extreme weather temperatures have caused service delivery issues, necessitating the cancellation of some elective activity, which will, have a detrimental effect on waiting list size.
The top five specialties showing an increase in total incomplete waiting list size from May are:

- Cardiology + 222
- Gastroenterology + 192
- Dermatology + 165
- General Surgery + 159
- Respiratory Medicine + 146

The five specialties showing the biggest decrease in total incomplete waiting list size from May are:

- Paediatrics – 173
- Community Paediatrics - 136
- ENT - 105
- Nursing Episode - 53
- Gynaecology - 45

The Trust reported 12,604 over 40 week waits, an increase of 718 on May. Patient numbers waiting over 26 weeks increased by 679.

Actions/Mitigations:
The longest waiting patients at 78w+ are monitored and discussed at a weekly PTL meeting and also with system partners at a weekly ICB meeting. Transferring of appropriate admitted patients to ISP's continues. Non admitted patients in the most pressured specialities continue to be transferred out. A contract is currently out to tender to procure an external company to undertake validation of pathways with an anticipated September start.

Diagnostics Achieved

100%
90%
80%
70%
60%
50%
40%
30%

Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22

Trajectory — Diagnostics Achieved — Mean — Control Limits

F B

Jul-22
53.12%
Variance Type
Metric is currently experiencing Special Cause Variation – below the mean
Target
99.00%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Diagnostics achieved in under 6 weeks.

What the chart tells us:
We are currently at 53.12% against the 99.00% target.
CT, MRI, lost capacity and caused breaches due to the fire.

Issues:
CT, MRI have lost capacity due to the LCH fire, All areas have lost capacity due to social distancing, demand is still higher than capacity for some procedures so causing increased backlogs for some specialities and increasing the number of breaches declared each month for those specialities. Although there are breaches in US we are seeing a decline in breaches month on month. Cardiac Echoes have a considerable backlog Audiology have had capacity issues due to sickness and maternity. And the change in the Autism pathway has caused an increase in demand. Back log now being seen for Dexa due to loss of scanner due to fire.

Actions:
Where demand out strips capacity additional resource is being sort, but this is proving difficult to obtain in cardiology echoes. Additional US lists are happening. Additional support is being sought by A plan to extend Mobile scanners is being discussed with finance to aid recovery (CT, MRI). Cardiac echo have an additional 4 locums from June and have reduced slot time to 30 minutes. All areas have completed a recovery trajectory to NHSE.

Mitigations:
All waiting lists are being monitored and where 50% of the waiting list is over 6 weeks we are being asked to complete a clinical validation for each patient, and assign a D code to that patient. Going forward every new referral will have a D code assigned to each patient. This will make sure all patients are seen in clinical urgency. Additional list for ultrasound and echo.

Cancelled Operations on the day (non clinical)

4%
3%
2%
1%
0%

Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22

Cancelled Operations on the day (non clinical) — Mean — Control Limits — Target

Jul-22
2.87%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0.8%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us
July shows an increase to 2.87% for patients who have had their operation cancelled on the day of surgery and therefore remains above the agreed trajectory of 0.8%.

Issues:
The top reasons for same day non-clinical theatre cancellations for July are identified as:

1. No surgeon; followed equally by
2. Adverse weather;
3. Lack of time; and
4. No theatre staff.

Actions:
The heatwave response meant a number of patients were cancelled the day prior to surgery in readiness and operating was undertaken on a priority basis.

Four Eyes are working with the Matrons to look at standardisation of admission processes in order to ensure theatres start on time.

Mitigations:
There have been significant challenges during July with Covid related sickness, particularly within our surgical colleagues, which resulted in a much higher than usual number of cancellations on the day.
In addition, the heatwave caused significant issues due to theatre cooling systems overheating, resulting in a number of cancellations.

Not treated within 28 days. (Breach)

F A

Month	Not treated within 28 days. (Breach)
Apr-21	
May-21	
Jun-21	
Jul-21	
Aug-21	
Sep-21	
Oct-21	
Nov-21	
Dec-21	
Jan-22	
Feb-22	
Mar-22	
Apr-22	
May-22	
Jun-22	
Jul-22	

Y axis: 0, 10, 20, 30, 40, 50, 60

Legend: Not treated within 28 days. (Breach) — Mean — Control Limits — Target

Jul-22
23
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
The number of breaches for July is 23, which is a slight increase from 21 in June.
The agreed target of zero has not been achieved.

Issues:
Absence within our clinical teams has meant reduced theatre capacity during the latter end of July and early August resulting in difficulty in reoffering dates for surgical intervention.

Actions:
The waiting list team within the Surgical Division continue to work alongside the CBUs to reschedule patients who have experienced any on the day non-clinical cancellations.

There has been increased focus on outsourcing patients with the number increasing significantly since July 20th.

Mitigations:
Our Consultancy colleagues, Four Eyes, are supporting implementation of robust procedures for booking patients as well as an improved 642 process and shared learning.

Fracture NOF 48 Hours

110%
100%
90%
80%
70%
60%
50%

Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22

Fracture NOF 48 Hours | Mean | Control Limits | Target

Jul-22
63.75%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Percentage of fracture neck of femur patient's time to theatre within 48 hours.

What the chart tells us:
July performance out turned at 63.75% against the agree target of 90%.

Both sites underperformed with PHB at 70.73% and LCH 56.41% which has led to deterioration in performance.

Issues:
Increase in trauma demand over recent months, particularly during BH weekends in May and June
High vacancy rate in theatres and anaesthetic sickness has limited capacity for additional theatres.
Due to increase in trauma demand and the types of injuries seen, certain procedures have been clinically prioritised ahead of NOF patients.
Delays for NOF's included reduced theatre capacity, patients medically unfit to proceed and the need for specialist surgeon availability due to complexities.
UTAH hub not in place which will support quicker turnaround of diagnostic needs for NOF patients.
This will also help create ring fenced NOF beds.
Loss of Radiology support for additional lists creating trauma backlogs.

Actions:
NOF pathway project ongoing to ensure pathway from EMAS response through to patient discharge post-surgery being fully optimised and responsibilities/protocols are clear.
Forward planning of theatre lists required based on historical peaks in activity seen.
'Golden patient' initiative to be fully implemented.
Ensure robust processes in place to utilise Trust wide trauma capacity and beds.
Additional Specialty Trauma lists identified to Theatre to ensure prioritisation of Theatre staffing ensuring minimal cancellations and backlog of trauma.
Additional trauma lists continue to be identified in periods of high trauma with escalation to Surgical MD when staffing proves challenging.

Mitigations:
Ensure trauma lists are fully optimised.
Reduce 'on the day' change in order of the trauma list where clinically appropriate.
Daily attendance at the trauma meeting by the clinical business unit to improve communication, visibility of current position and increased support for theatre utilisation and extra capacity needed.
Alternative #NOF pathways created on Digby Ward.
Once daily additional CBU review of trauma and plans to ensure capacity maximised for clinical priority.
Reduction in elective lists on Lincoln/Boston sites to accommodate trauma.
Robust Plans for August BH weekend.

Partial Booking Waiting List overdue to followup

F H

35,000
30,000
25,000
20,000
15,000
10,000
5,000
0

Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22

Partial Booking Waiting List — Mean — Control Limits — Trajectory

Jul-22
23,034
Variance Type
Metric is currently experiencing Special Cause Variation – high trend
Target
4,524
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 23,034 against a target of 4,524.
Due to Covid the number of patients overdue significantly increased and has continuously increased since until April 2022. Since then the PBWL has remained reasonably stable with minimal increases and decreases per month.

Issues:
The organisation is continually pressured in a number of areas especially in urgent / emergency care that has taken priority over outpatients. The fluctuating impact of Covid also has an impact on conflicting priorities, increasing demand on resources, sickness levels, staffing issues, space and aligning requirements.

Actions:
Specialities have agreed plans to increase activity for 2022/23 which will improve their PBWL position and reduce patient waits. Outpatients have reviewed and increased waiting area capacity to allow an increase clinic templates. Resource identified to progress Personalised Outpatient Plan including maximising validation, clinical triage, technological solutions and PIFU. Currently, out to procurement for a validation team to review the PBWL patients and prioritisation of patients.

Mitigations:
Supporting organisational priorities in ED and urgent care taking individual outpatient clinics down, if support required across the sites (site/patient flow and theatres) or so a clinician can support the wards or theatres at short notice.

62 Day Classic

Month	62 Day Classic
Apr-21	
...	

Jun-22
52.47%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
85.4%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Percentage of patients to start a first treatment within 62 days of a 2ww GP referral.

What the chart tells us:
We are currently at 52.47% against an 85.4% target.

Issues:
The impact of critical and major incidents on Trust activity and patient pathways.
Pressure on diagnostic services following the fire in Radiology at LCH.
Patient engagement in diagnostic process (reluctance to visit hospitals due to perceived COVID-19 risk, including those waiting for vaccines or the 'effectiveness' period), though this is continuing to reduce. Patients not willing to travel to where our service and / or capacity is. Managing backlogs significantly in excess of pre-COVID levels for Colorectal, Upper GI, Urology, and Lung.
Limited theatre capacity continues to impact cancer pathways across the Trust, with all Specialties vying for additional sessions. Anaesthetic assessment and Pre-op capacity is also limited and impacts the ability to be able to populate lists at short notice.

Actions:
28 Day standard identified as Trust's cancer performance work stream in the Integrated Improvement Program. Recruitment in Oncology is ongoing, working with HR, Holt and Advanta to secure locums, NHS locum or substantive posts. 2 posts have recently been offered and start dates are TBC. There is a significant lack of consultants nationally and very few available from agency.
Endoscopy's review regarding endoscopy staffing is now at the point of recruitment with the intention of increasing administrative support by converting fixed term into substantive posts.
A process is currently being designed 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.
Theatre capacity is improving and will be further alleviated once the new theatres open at GK. 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.

Mitigations:
Grantham Theatres have now returned to undertaking suitable Level 1 colorectal work. Work has commenced on building the new theatres at Grantham and will alleviate capacity issues once up and running.

62 Day Screening

Month	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22

Legend: 62 Day Screening, Mean, Control Limits, Target

Jun-22
72.41%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 72.41% against a 90% target.

Issues:
See issues on previous page – 62 day classic.

Actions:
See actions on previous page – 62 day classic.

Mitigations:
See mitigations on previous page – 62 day classic.

62 Day Consultant Upgrade

Chart: 62 Day Consultant Upgrade (Apr-21 to Jun-22), y-axis 40%–100%. Legend: 62 Day Consultant Upgrade, Mean, Control Limits, Target.

Jun-22
63.95%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
85%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 63.95% against an 85% target.

Issues:
See issues on previous page – 62 day classic.

Actions:
See actions on previous page – 62 day classic.

Mitigations:
See mitigations on previous page – 62 day classic.

2 Week Wait Suspect

Month	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22

Legend: 2 Week Wait Suspect, Mean, Control Limits, Target

Jun-22
48.96%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
93%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 48.96% against a 93% target.

Issues:
The Trust's 14 Day performance continues to be impacted by the current Breast Service One-Stop appointment alignment issues, with Breast performance being 26.6% - 19% of the Trust's 14 Day breaches were within that tumour site. Of greater concern in June was colorectal performance at 10.9% - colorectal accounted for almost 41% of the Trust's 14 day breaches. The other tumour sites that considerably under-performed include Lung (31.9%), Skin (48.3%) and Gynaecology (54.7%).
Patients not willing to travel to where our service and/or capacity is available.
Nurse Triage / CNP capacity issues in colorectal specialty.

Actions:
The Trust is actively seeking to implement RDC pathways for brain, haematuria and Upper GI at the earliest opportunity. A pathway review for gynaecology and a direct access ultrasound pathway has also been identified as a priority for 2022.
A Locum Respiratory consultant post has been appointed to for 12 months at PHB – start date TBC. There are increased consultant vacancies at LC due to one withdrawal and one resignation. Case of need approved at CRIG in November to increase in consultant workforce to 10-15 consultants.
A Gynae review of specialist nurse workforce and oncology strategy follow up meeting is to be scheduled following the successful initial meeting on 15th July.
These and other key action progress are tracked through the Urgent Care Cancer group chaired by the Medical Director and run with full system partner involvement.

Mitigations:
Agreement in process for Radiology to discharge normal scans on the FReD pathway – to start from August when new staff are in place following model in place at SFH. Work is ongoing to move Spirometry into Community Diagnostic Centres.

Additional weekend Urology clinics continue to be set up to resolve capacity issues. Work is being undertaken with Endoscopy to increase capacity across sites and ensure efficient utilisation of current clinic capacity. Recruitment for CBU booking clerks is underway.

Increasing numbers of skin referrals are set to continue throughout summer – additional weekend clinics in place to mitigate. Case of Need in place to increase waiting room capacity at PHB.

2 Week Wait Breast Symptomatic

Jun-22
29.23%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
93%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Percentage of patients 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 29.23% 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. Reduced clinic throughput due to social distancing / IPC requirements, especially in waiting areas.

Actions:
A comprehensive review of Breast Services and consultant workload is ongoing following the final report issued by NHSI support.

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%.

31 Day First Treatment

Y-axis: 75%, 80%, 85%, 90%, 95%, 100%

X-axis: Apr-21, May-21, Jun-21, Jul-21, Aug-21, Sep-21, Oct-21, Nov-21, Dec-21, Jan-22, Feb-22, Mar-22, Apr-22, May-22, Jun-22

Legend: 31 Day First Treatment, Mean, Control Limits, Target

Jun-22
89.76%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
96%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 89.76% against a 96% target.

Issues:
The failure of the 31 Day standards was primarily attributed to the reduction in theatre capacity).

Actions:
Recruitment in Oncology is ongoing, working with HR, Holt and Advanta to secure locums, NHS locums or substantive posts. 2 posts have recently been offered and start dates are TBC. There is a significant lack of consultants nationally and very few available from agency.
Work has commenced on building the new theatres at Grantham.
For Colorectal, a Deep Dive and pathway analysis is underway, supported by CCG colleagues.

Mitigations:
Theatre capacity is improving and will be further alleviated once the new theatres open at GK. Robotic Lists are progressing well, though proving difficult to populate at short notice if there are cancellations due to pre-op and anaesthetic assessment capacity.

31 Day Subsequent Drug Treatments

(Chart: y-axis 90%–102%; x-axis Mar-21 to May-22. Legend: 31 Day Subsequent Drug Treatments, Mean, Control Limits, Target)

Jun-22
98.08%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
98%
Target Achievement
Metric is failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 98.08% against a 98% target.

Issues:
The inability to deliver the 31 Day standards was primarily attributed to the reduction in theatre capacity. For the subsequent standards the Trust was successful in the Radiotherapy and Drug standards, failing only in the Surgery standard.

Actions:
See actions on previous page – 31 day first treatment.

Mitigations:
See mitigations on previous page – 31 day first treatment.

31 Day Subsequent Surgery Treatments

120%
100%
80%
60%
40%
20%
0%

Mar-21 Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22

31 Day Subsequent Surgery Treatments — Mean — Control Limits — Target

F

Jun-22
63.64%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
94%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 63.64% against a 94% target.

Issues:
The inability to deliver the 31 Day standards was primarily attributed to the reduction in theatre capacity. For the subsequent standards the Trust was successful in the Radiotherapy and Drug standards, failing only in the Surgery standard.

Actions:
See actions on previous page – 31 day first treatment.

Mitigations:
See mitigations on previous page – 31 day first treatment.

104+ Day Waiters

Month	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22

Legend: 104+ Day Waiters; Mean; Control Limits; Target

Jul-22
113
Variance Type
Metric is currently experiencing Common Cause Variation
Target
10
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Number of cancer patients waiting over 104 days.

What the chart tells us:
As of 11th August the 104 Day backlog was at 113 patients. The agreed target is <10.

There are four tumour sites of concern
Colorectal 67 (majority awaiting diagnostics, outpatients and clinical review)
Upper GI 19
Urology 14
Lung 8

Issues:
The impact of critical and major incidents on Trust activity and patient pathways.
Pressure on diagnostic services following the fire in Radiology at LCH.
Patients not willing to travel to where our service and / or capacity is available. Reduced 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, Gynaecology and Lung.
Approximately 24% 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:
28 Day standard identified as Trust's cancer performance work stream in the Integrated Improvement Program.
Recruitment in Oncology is ongoing, working with HR, Holt and Advanta to secure locums, NHS locums or substantive posts. 2 posts have recently been offered and start dates are TBC. There is a significant lack of consultants nationally and very few available from agency.
For Colorectal, a Deep Dive and pathway analysis is underway, supported by ICB and EMCA colleagues.

Mitigations:
Theatre capacity is improving and will be further alleviated once the new theatres open at GK. Robotic Lists are progressing well, though proving difficult to populate at short notice if there are cancellations due to pre-op and anaesthetic assessment capacity.
A process is currently being designed 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.

PERFORMANCE OVERVIEW - WORKFORCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	May-22	Jun-22	Jul-22	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
A Modern and Progressive Workforce	Overall percentage of completed mandatory training	Safe	People	Director of HR & OD	95%	90.26%	89.76%	89.72%	89.75%		F		
	Number of Vacancies	Well-Led	People	Director of HR & OD	12%	10.31%	12.08%	11.35%	11.07%		P		
	Sickness Absence	Well-Led	People	Director of HR & OD	4.5%	5.26%	5.28%	5.28%	5.26%		F		
	Staff Turnover	Well-Led	People	Director of HR & OD	12%	14.58%	14.82%	15.06%	14.78%		F	H	
	Staff Appraisals	Well-Led	People	Director of HR & OD	90%	57.62%	59.14%	60.30%	57.78%		F	B	

Quality | Operational Performance | Workforce | Finance

Overall percentage of completed mandatory training

Jul-22
89.72%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
95%
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of HR & OD

Background:
Overall percentage of completed mandatory training.

What the chart tells us:
Mandatory training shows no increase over the past month however the overall rate can mask poor compliance in some areas.

Issues:
- Protected time for learning continues to be a challenge for staff – especially front line staff.
- Anecdotal feedback reports lack of time to access core learning while on shift and difficulties to access from home devices.
- Issues of proper recording of learning by ESR cited as having an impact on rates
- Core learning suite too large and under review.

Actions:
- The lack of a central learning and development team has been added on the risk register.
- Discussion around protected time for training has not progressed.
- SHRBP's continue to work with their Areas and support compliance.
- Work continues with regards to single contract Bank staff and mandatory training/payment for training.

Mitigations:
Issues of access and recording of learning to be addressed by digital team.

Sickness Absence (Rolling Year %)

5.6%
5.4%
5.2%
5.0%
4.8%
4.6%
4.4%
4.2%
4.0%

Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22

All days lost as a percentage of those available — Mean — Control Limits — Target

Jul-22
5.28%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
4.5%
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of HR & OD

Background:
% of sickness absence rolling year.

What the chart tells us:
The trend has increased by 0.02% to 5.28% which is still above the target of 4.5%.

Issues:

- The COVID absences are re continuing to decrease.
- Stress & Anxiety remains in the top 3 reasons for absence, following cold/flu & Gastro.

Actions:

- Extensive work is continuing to get full engagement of using Absence Management System (AMS) Trust wide.in particular to ensure staff report all non- attendance at work through AMS.
- SHRBP's continue to work closely with the Divisions to ensure reasons for absence are recorded and not left as “blank”.
- Work is continuing to cleanse the Case Manager element of AMS to ensure open cases can be managed effectively
- Monthly, Long Term Absence meeting with SHRBP's, ER Advisers, Divisional Leads and Occ Health to support staff to return to work where possible.
- ER Advisors to focus on Stress and Anxiety with Managers and ensure EAP support.

Mitigations:
Support from Empactis has been given to all Divisions.

Staff Turnover

18%
17%
16%
15%
14%
13%
12%
11%
10%
9%
8%

Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22

Staff Turnover — Mean — Control Limits — Target

F H

Jul-22
15.062%
Variance Type
Metric is currently experiencing Special Cause Variation – high trend
Target
12%
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of HR & OD

Background:
% of turnover over a rolling 12-month period

What the chart tells us:
Turnover rates have stabilised over the past 3 months but still higher than expected as per other partners in the system and Trusts regionally.

Issues:
Analysis of exit survey data shows (completion rate of has steadily dropped over the past 3 months):

- Lack of support from managers, development opportunities, flexible working opportunities and relocations, continues to be one of the main reasons for people leaving.

The reasons are the same month on month.

Actions:

- A Culture and leadership OD manager has been appointed started in July 22.
- A People Promise Manager started in May 22.
- A new suite of leadership and management training is being introduced in June 22. Flexible working clinics offered by OD to all managers.

Mitigations:
See actions

Staff Appraisals

F B

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22

Staff Appraisals — Mean — Control Limits — Target

Jul-22
60.30%
Variance Type
Metric is currently experiencing Special Cause Variation – below the mean
Target
90%
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of HR & OD

Background:
% completion is currently 60.3%.

What the chart tells us:
Operational pressures and staffing challenges continue to impact appraisal completion rates. The completion rate slightly increased in July 22.

Issues:
- Operational pressures are causing an impact on completion.
- Appraisal discussions stood down in previous months still felt in July 22 due to back log
- Staffing issues and increased turnover impact availability of staff to attend appraisals with manager working clinically.

Actions:
- Appraisal completion to be focussed through the divisions regardless of operational pressures Od and HRBPs to continue to prioritise message to divisions
- Appraisal clinics offered by OD to all who require support. Specific focus for Estates and facilities to bring rates up in May 2022 will show in June 22.
- Dedicated appraisal page with resources to support Managers in place end of July 22.
- Appraisal Training to resume

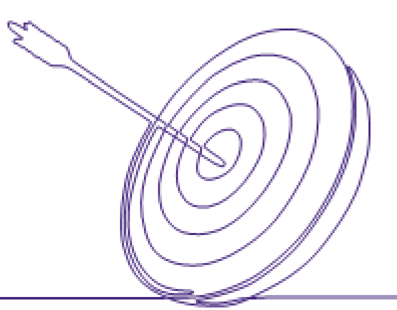
Mitigations:
See actions

Financial Position Month 04 (2022/23)
Finance Report
5 Year Priority – Efficient Use of Resources

OUTSTANDING CARE
personally DELIVERED

Quality | Operational Performance | Workforce | Finance

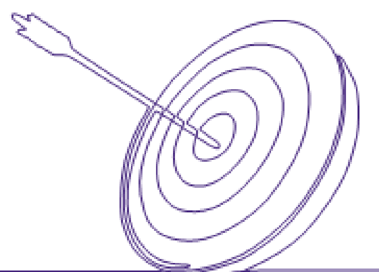
Finance Spotlight Report (Headlines)



	Current Month			Year To Date		
	Plan	Actual	Variance	Plan	Actual	Variance
Patient Care Activities Income	52,456	53,443	987	209,923	210,636	713
Other Operating Income	3,029	3,347	318	11,933	14,016	2,083
Substantive Staff	(29,930)	(29,671)	259	(120,562)	(119,523)	1,039
Agency Staff	(2,097)	(4,861)	(2,764)	(10,717)	(17,585)	(6,868)
Bank Staff	(3,442)	(3,952)	(510)	(12,236)	(15,652)	(3,416)
Apprentice Levy	(358)	(234)	124	(1,346)	(897)	449
Non Pay	(17,475)	(17,274)	201	(68,196)	(68,775)	(579)
Depreciation	(1,599)	(1,522)	77	(6,553)	(6,419)	134
Net Financing	(641)	(592)	49	(2,530)	(2,461)	69
Other Gains / Losses	0	115	115	0	115	115
Surplus / (Deficit)	**(57)**	**(1,201)**	**(1,144)**	**(284)**	**(6,545)**	**(6,261)**
Below Line Adjustments	57	52	(5)	284	213	(71)
Adjusted Surplus / (Deficit)	**0**	**(1,149)**	**(1,149)**	**0**	**(6,333)**	**(6,333)**
Less: Gains	0	(128)	(128)	0	(128)	(128)
Adjusted Surplus / (Deficit) for system achievement	**0**	**(1,277)**	**(1,277)**	**0**	**(6,461)**	**(6,461)**

- The above table shows that the Trust delivered a £1.1m deficit in July (£1.1m adverse to plan) and YTD has delivered a £6.3m deficit (£6.3m adverse to plan). Actual CIP savings of £4.4m have been delivered YTD, such that YTD delivery is £2.1m (32.8%) adverse to plan.
- After removing gains from disposals of £115k, the Trust has delivered £6.5m deficit in relation to system achievement.

Finance Spotlight Report (Key areas of focus - Income)



The Income position is £2.8m favourable YTD to plan; this includes:

- **NHS Patient Care income contract - favourable variance of £0.6m**; this includes over performance of £0.5m re Lincolnshire Variable Drugs (for which there will be an offset in Non Pay) and £0.1m of NHS England prior year income. **£479k of the variable drugs income relates to M1-3 but as the information to assess this has only be available in the current month. Improved information regarding AQP/variable diagnostics is also now available and has impacted on prior months by a further c£140k. This is shown in the respective month for the income and activity analysis but has impacted on the current month income position as it cannot be back-posted in the finance ledger.**

- **Injury cost recovery – favourable variance of £0.1m.**

- **Radiology fire - favourable variance of £1.1m**; the financial plan did not include the I&E impact of the Radiology fire; this favourable income variance offsets an adverse variance of £1.1m in expenditure (mainly in Non Pay in relation to hire of clinical equipment).

- **Bad debt provisions - favourable variance of £0.2m**; this reflects a one off change in month 2 which is offset by an adverse variance of £0.2m in Non Pay.

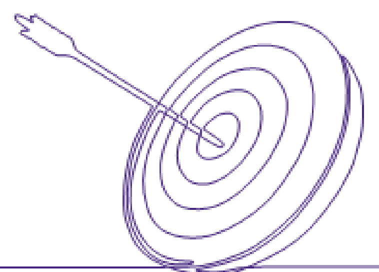
- **Education & Training - favourable variance of £0.2m** (including notional income re the apprenticeship levy); the income variance offsets an adverse variance of £0.2m in Non Pay.

- **Non-Patient Care services - £0.2m favourable to plan.**

- **Pay Recharges - favourable variance of £0.1m**; this favourable income variance offsets an adverse variance of £0.1m in Pay.

- **Various income lines – favourable variance in total of £0.3m.**

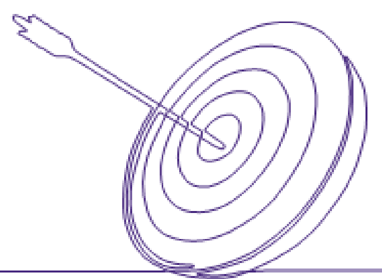
Finance Spotlight Report (Key areas of focus - Pay)



- **The YTD Pay position is £8.8m adverse to plan including under delivery on Pay CIP of £1.3m.**
- Actual Pay expenditure in June of £38.7m was £0.5m higher than £38.2m in June.
- The July Pay position includes £0.5m of non-recurrent technical CIP savings compared to £0.6m in June, and June included £0.4m of Bank Holiday enhancements whereas there were no bank holidays in July; the underlying Pay position has thus moved adversely by £0.8m in comparison to June (driven by higher expenditure on Agency and Bank staffing as well as higher expenditure on substantive staffing).

  - **Substantive pay is £1.5m favourable to plan (driven by £1.1m of technical CIP savings release)**
    - Expenditure of £29.9m in July is £0.1m higher than expenditure of £29.8m in June: while £0.1m less technical CIP savings were released in July than June, the favourable movement of £0.4m expected due to there being no Bank Holidays in July has not been seen in actual expenditure.
  - **Agency pay is £6.9m adverse to plan**
    - Expenditure of £4.9m in July is £0.3m higher than expenditure of £4.6m in June.
    - The YTD efficiency plan assumed savings of £3.6m in Agency Pay, but only £0.2m of savings have been delivered (or £3.4m adverse to plan); the YTD position also reflects higher than planned bed numbers, sickness levels & vacancies.
  - **Bank Pay is £3.4m adverse to plan**
    - Expenditure of £4.0m in July is £0.2m higher than expenditure of £3.8m in June; Bank expenditure (like Agency Pay) reflects higher than planned bed numbers, sickness levels and vacancies.

Finance Spotlight Report
(Key areas of focus - Other)



Non Pay

- Non Pay expenditure in July of £18.8m was £1.6m lower than £20.4m in June; this decrease reflects both changes in activity volumes and the fact that actual invoices received in July were lower than the estimates accrued in June.
- The YTD Non-Pay position is £0.4m adverse to plan including under delivery on CIP of £0.8m.
- The YTD position reflects lower than planned activity levels (including pass-through expenditure), but this under spend has been more than offset by c£1.7m of unplanned expenditure/higher than planned expenditure for which there is an offset within income e.g. £1.1m in relation to the radiology fire and £0.2m re notional apprenticeship levy expenditure.

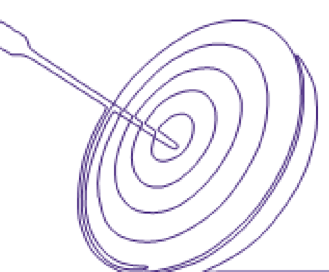
CIP

- The original financial plan assumes that the Trust will deliver CIP savings of £25m (3.6%) in 2022/23; the plan resubmission increased the total CIP savings requirement by £4.0m.
- The financial plan assumed CIP savings delivery of £6.5m by the end of Month 4; actual savings of £4.4m (67.2%) have been delivered, such that YTD delivery is £2.1m (32.8%) adverse to plan.

Capital

- Capital funding levels for 2022/23 agreed through Trust Board & FPEC show a plan of c£38.4m; Capital spend incurred YTD equates to c£3.2m.

Finance Spotlight Report
(Key areas of focus – Other cntd)



Cash

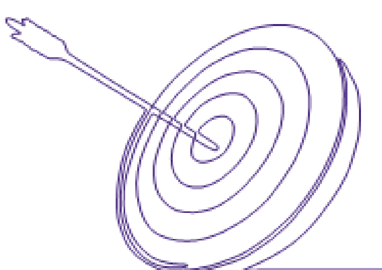
- The July 2022 cash balance is £63.7m which is a decrease of £24.6m against the March year- end cash balance of £88.3m. This is driven by multiple factors, the most significant being the reduction in year end capital creditors from £22.6m to £4.8m and an increase in receivables from £15.5m to £28.3m.

BPPC

- BPPC performance is 82% / 73% by value / volume of invoices paid for July 2022. The YTD performance is 78%/74%, this compares to the full year in 2021/22 of 89%/83%.

  An improvement plan is being developed and is described at appendix 5e. However, the finance system access issues experienced from early August are likely to result in a deterioration of performance in August / September and delays putting improvement actions into effect.

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

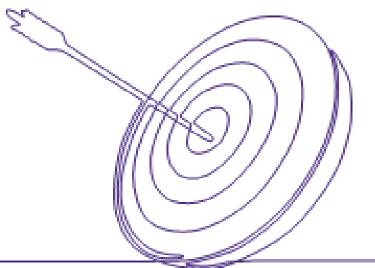
Metric	Rating Boundary			
	1	2	3	4
Capital servicing capacity	2.5	1.75	1.25	<1.25
Liquidity ratio (days)	0	-7	-14	<-14
I&E Margin	1%	0%	-1%	<=-1
I&E margin distance from plan	0%	-1%	-2%	<=-2%
Agency	0%	25%	50%	>=50%

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 two full financial years and the current 2021/22 position are as follows

Finance and use of resources rating	Full Year ending:				Actual
	31/03/2019	31/03/2020	31/03/2021	31/03/2022	JUL 2022
Capital service cover metric	(10.40)	(1.73)	0.06	3.60	0.71
Capital service cover rating	4	4	4	1	4
Liquidity metric	(98.73)	(128.28)	3.71	2.50	(1.28)
Liquidity rating	4	4	1	1	2
I&E margin metric	(19.71%)	(7.62%)	0.38%	0.29%	(2.82%)
I&E margin rating	4	4	2	2	4
Agency metric	77.00%	110.00%	113.00%	120.00%	[illegible]
Agency rating	4	4	4	4	[illegible]
I&E margin: distance from financial plan - metric	(2.80%)	0.70%	n/a	0.01%	(2.82%)
I&E margin: distance from financial plan - rating	4	1	n/a	1	4

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

Balance Sheet



	31-Mar-22	31-Jul-22		31-Mar-23
		Plan	Actual	Forecast
	£000	£000	£000	£000
Intangible assets	7,675	7,015	7,060	6,032
Property, plant and equipment	267,753	271,846	265,861	290,020
Right of use assets	12,751	13,291	12,040	11,374
Receivables	1,848	1,848	1,827	1,848
Total non-current assets	**290,027**	**294,000**	**286,787**	**309,274**
Inventories	6,006	6,006	6,423	6,006
Receivables	15,520	23,421	28,315	24,137
Cash and cash equivalents	88,297	55,538	63,682	49,672
Total current assets	**109,823**	**84,965**	**98,420**	**79,815**
Trade and other payables	(89,017)	(67,976)	(76,729)	(67,436)
Borrowings	(2,381)	(3,290)	(2,583)	(2,855)
Provisions	(8,774)	(8,895)	(8,435)	(2,073)
Other liabilities	(1,130)	(1,130)	(6,581)	(1,130)
Total current liabilities	**(101,302)**	**(81,291)**	**(94,328)**	**(73,494)**
Total assets less current liabilities	**298,548**	**297,674**	**290,880**	**315,595**
Borrowings	(14,264)	(13,921)	(13,390)	(12,087)
Provisions	(3,182)	(3,103)	(3,099)	(3,099)
Other liabilities	(11,572)	(11,404)	(11,404)	(11,069)
Total non-current liabilities	**(29,018)**	**(28,428)**	**(27,893)**	**(26,255)**
Total assets employed	**269,530**	**269,246**	**262,987**	**289,340**
Financed by				
Public dividend capital	704,178	704,180	704,180	724,498
Revaluation reserve	29,294	29,062	29,057	28,593
Other reserves	190	190	190	190
Income and expenditure reserve	(464,131)	(464,186)	(470,440)	(463,940)
Total taxpayers' equity	**269,530**	**269,246**	**262,987**	**289,340**

Note 1: The closing balance sheet for 2021/22 has been restated for the impact of the introduction of IFRS16.

The impact in balance sheet terms is to recognise 'Right of Use' assets with the offset being an increase in Borrowings (£12.83m) and the I&E reserve (£0.13m).

Both the plan and actual for 2022/23 are stated on an IFRS 16 basis.

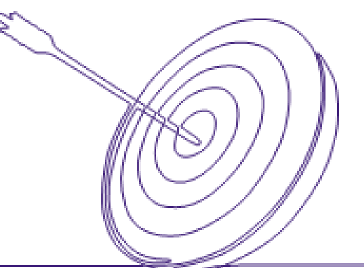
Note 2: Payables, Receivables and Cash have each been impacted by the migration to the new finance system and disruption to BAU processing. The loss of the finance system in mid August is likely to further impact the processing of payables in particular.

Note 3: Trade and other receivables continue to be supressed below pre-pandemic levels and will remain so throughout 2022/23 with the continuation of block contract payments.

Note 4: Trade Payables and other payables remain circa £12-15m higher than would be normally be expected. This being driven in part by the heightened level creditors associated with the remaining finance system 'backlog', but more specifically by the level of Annual leave accrual £8m and other pay accruals £11m. The payables balance of £76m is broadly split between: Staff related creditors £19m, Trade Payables / accruals £36m, Capital creditors £5m and Tax / Superannuation £15m.

Note 5: The level of provisions is anticipated to reduce in year with the settlement of specific payroll provisions.

Cashflow reconciliation – April 2022– March 2023



	31-Mar-22	31-Jul-22		31-Mar-23
		Plan	Actual	Forecast
	£000	£000	£000	£000
Operating surplus / (deficit)	549	2,246	(4,199)	7,034
Depreciation and amortisation	15,736	6,553	6,419	19,192
Impairments and reversals	7,340	-	-	-
Income recognised in respect of capital donations	(27)	-	-	(50)
Amortisation of PFI deferred credit	(503)	(168)	(168)	(503)
(Increase) / decrease in receivables and other assets	11,261	(7,901)	(12,891)	(8,617)
(Increase) / decrease in inventories	504	-	(417)	0
Increase/(decrease) in trade and other payables	9,745	(4,816)	3,029	(7,043)
Increase/(decrease) in other liabilities	(457)	-	5,451	-
Increase / (decrease) in provisions	5,860	72	(382)	(6,754)
Net cash flows from / (used in) operating activities	**50,008**	**(4,014)**	**(3,158)**	**3,259**
Interest received	34	80	229	240
Purchase of intangible assets	(994)	-	-	-
Purchase of property, plant and equipment	(35,132)	(28,029)	(21,075)	(52,411)
Proceeds from sales of property, plant and equipment	148	-	137	137
Net cash flows from / (used in) investing activities	(35,944)	(27,949)	(20,709)	(52,034)
Public dividend capital received	26,610	-	-	20,318
Capital element of finance lease rental payments	-	(757)	(710)	(2,413)
Interest paid	(1)	-	-	-
Interest element of finance lease	-	(38)	(38)	(119)
PDC dividend (paid)/refunded	(6,418)	-	-	(7,224)
Net cash flows from / (used in) financing activities	20,191	(796)	(748)	10,151
Increase / (decrease) in cash and cash equivalents	**34,255**	**(32,759)**	**(24,615)**	**(38,624)**
Cash and cash equivalents at 1 April - brought forward	54,042	88,297	88,297	88,297
Cash and cash equivalents at period end	**88,297**	**55,538**	**63,682**	**49,673**

Note 1: Cash held at 31 July was £63.7m against a plan of £55.5m.

Note 2: Principle reasons for the cash variance to plan of £8.2m are:

- A temporary increase in NHS deferred income which will reverse before the year end.
- The backlog of trade payables associated with the ledger implementation not being reduced as anticipated.
- An increase in the level of prepayments in the first 4 months, this being consistent with prior years.

Note 3: Underlying cash balances remain significantly increased on 2019/20 levels primarily due to:

- The continued block payment regime
- The remaining backlog associated with the implementation of the new finance system.
- Receipt in March 21 of £7.1m to cover future outgoings associated with accrued annual leave.
- Increased levels of provisions to offset risks associated with current litigation and contractual obligations.

Note 4: Despite pressures / risks associated with the in-year financial position, no immediate cash pressures are anticipated. The forecast year end cash position is anticipated to be c£45-50m. Looking into 2023/24, depending upon mitigation of risks and changes in the financial regime, cash balances are likely to reduce.

Meeting	*Trust Board*
Date of Meeting	*6 September 2022*
Item Number	*Item number allocated by admin*
Strategic Risk Report	
Accountable Director	*Karen Dunderdale, Director of Nursing / Deputy Chief Executive*
Presented by	*Karen Dunderdale, Director of Nursing / Deputy Chief Executive*
Author(s)	*Paul White, Head of Risk & Governance*
Report previously considered at	*Separate risk reports to lead committees*

How the report supports the delivery of the priorities within the Board Assurance Framework	
1a Deliver harm free care	*X*
1b Improve patient experience	*X*
1c Improve clinical outcomes	*X*
2a A modern and progressive workforce	*X*
2b Making ULHT the best place to work	*X*
2c Well Led Services	*X*
3a A modern, clean and fit for purpose environment	*X*
3b Efficient use of resources	*X*
3c Enhanced data and digital capability	*X*
4a Establish new evidence based models of care	*X*
4b Advancing professional practice with partners	*X*
4c To become a university hospitals teaching trust	*X*

Risk Assessment	*Not Applicable*
Financial Impact Assessment	*Not Applicable*
Quality Impact Assessment	*Not Applicable*
Equality Impact Assessment	*Not Applicable*
Assurance Level Assessment	*Significant, with some improvement required (based on Internal Audit Report – March 2022)*

Recommendations/ Decision Required	*The Trust Board is invited to review the content of the report.*

Executive Summary

This Strategic Risk Report focuses on the highest priority risks to the Trust's objectives as defined within the Board Assurance Framework (BAF). All references to the risk register concern risks that have previously been reported to the lead assurance committee.

There are 10 quality and safety risks currently rated Very high (20), which cover:

- Delays to planned care pathways for admitted, non-admitted and cancer patients
- Delays to patient handover from ambulances to A&E
- Potential for serious harm from patent falls
- Provision of echocardiograms
- Learning from patient safety events
- Use of hard copy documents for patient records and medication details
- Potential failure of the HDR (high dosage rate) Unit in Radiotherapy – this risk was reviewed at the Risk Register Confirm & Challenge Group in August, where it was agreed that as an equipment replacement project has now been planned for implementation before the end of 2022 the residual risk is now Moderate to Low (the risk register is to be updated to reflect this change)

There are also 12 quality and safety risks with a current rating of High (15-16).

Following PODC approval of the refreshed risk register, there are now 2 Very high workforce risks (scoring 20-25):

- Recruitment and retention within the workforce
- Workforce culture

There are also 3 workforce risks with a current rating of High (15-16).

There are 3 finance, performance and estates risks that are rated Very high (20-25) at present (all have been increased in rating since last month):

- Cost of reliance upon temporary clinical staff
- Potential for a major fire incident and compliance with fire safety standards

There are also 6 finance, performance & estates risks with a current rating of High (15-16).

Details of all active High and Very high risks are provided in Appendix A. Any changes to the risk register that have not yet been presented to the appropriate lead assurance committee are not included in this report.

Clinical Governance business partners will be supporting divisions and directorates this month to update Very high risks that are overdue for review

Purpose
The purpose of this report is to enable the Trust Board to:

- Review the management of significant risks to strategic objectives.
- Evaluate the effectiveness of the Trust's risk management processes.

1. Introduction

1.1 The Trust's risk registers are recorded on the Datix Risk Management System. This report is focussed on those strategic risks with a current rating of very high risk (a score of 20-25). Details of all active Very high and High risks (15-25) are provided in **Appendix A**, organised by strategic objective and current risk rating however a summary of Very high risks is provided below in sections 2.3-2.13. Moderate and Low risks (those with a score of 12 and below) are managed at divisional level.

1.2 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.

1.3 Active risks that have a performance, service continuity and reputation impact as well as a quality of care impact are reported to the Quality Governance Committee as the lead for assurance. In addition, the Finance, Performance & Estates Committee now receives regular updates on progress with managing these risks so as to maintain oversight from a performance and reputation perspective.

1.4 Similarly, the People and Organisational Development Committee receives a regular report on workforce risk as assurance lead, with a summary of Very high workforce risks that have a potential quality and safety impact also being reported to the Quality Governance committee for information.

1.5 This report is an amalgamation of the most recent reports to each of the assurance committees of the Trust Board. Any changes to the risk register that have not yet been reported through the appropriate committee are not included.

2. Trust Risk Profile

2.1 There are 250 active risks recorded on the Trust risk register (2 more than at the time of the last report). There are 16 risks with a current rating of Very high (20-25), an increase of 2; and 21 rated High (15-16), an increase of 4.

2.2 **Table 1** shows the number and proportion of active risks by current 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)
3 (-) (1%)	**40 (-)** (16%)	**170 (-5)** (70%)	**21 (+4)** (7%)	**16 (+2)** (6%)

Strategic objective 1a: Deliver harm free care
Assurance lead: Quality Governance Committee

2.3 There are currently 7 Very high risks and 6 High risks to this objective (an increase of 1). The new High risk relates to the ability of the Trust to implement all aspects of the national Patient Safety Strategy within expected timescales. A summary of the 7 Very high risks is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4877	If there are significant delays within the planned care admitted pathway then patients may experience extended waits for surgery, resulting in failure to meet national standards and potentially reducing the likelihood of a positive clinical outcome for many patients	Very high risk (20)	Planned care recovery plan (Admitted / HVLC / GIRFT) Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions	22/06/2022
4878	If there are significant delays within the planned care non-admitted pathway (outpatients) then patients may experience extended waits for diagnosis and treatment, resulting in failure to meet national standards and potentially reducing the likelihood of a positive clinical outcome for many patients	Very high risk (20)	- Planned care recovery plan (non-admitted / outpatients) - Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions	22/06/2022
4879	If there are significant delays within the planned care cancer pathway then patients may experience extended waits for surgery, resulting in failure to meet national standards and potentially reducing the likelihood of a positive clinical outcome for many patients	Very high risk (20)	- Planned care recovery plan (cancer) - Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions	22/06/2022
4803	If there are substantial delays to patient handovers from ambulances then it could lead to patients being treated in an area that is not appropriate for patient care, resulting in failure to meet the national standard for ambulance handovers which impacts on the wider system and may lead to regulatory action, also potentially reducing the likelihood of a positive clinical outcome and/or causing serious patient harm	Very high risk (20)	- Early intelligence of increasing EMAS demand to allow 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.	23/03/2022

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4622	If the Trust fails to learn lessons when things go wrong with a patient's care, so that changes can be made to policies and procedures, there is an increased likelihood of similar issues arising in future which could result in serious harm, a poor experience or a poor clinical outcome affecting a large number of patients.	Very high risk (20)	- Safety Culture Project, part of Integrated Improvement Plan (IIP) - Prepare for replacement of NRLS and StEIS systems with new Learn From Patient Safety Events (LFPSE) service (previously called PSIMS) - Upgrade current DatixWeb risk management system to Datix CloudIQ	13/06/2022
4789	If there is a significant delay in processing of Echocardiograms, which is impacted by staff shortages and inefficient processes, then it could lead to delayed assessment and treatment for patients, resulting in potential for serious harm and a poor clinical outcome	Very high risk (20)	Review and realignment of systems and processes to ensure that the team efficiency has been optimised. External company (Meridian) engaged for 10 week period to enable a deep dive and improvement plan to be implemented for the service	25/05/2022
4624	If patients in the care of the Trust who are at increased risk of falling are not accurately risk assessed and, where necessary appropriate preventative measures put in place, they may fall and could suffer severe harm as a result.	Very high risk (20)	• Improvement plan implemented by all Divisions, led by QM, monitored through Patient Falls Prevention Steering Group (FPSG). • Introduction and rollout of 'Think Yellow ' falls awareness visual indicators. • Patient story included within FPSG workplan. • Introduction of new falls prevention risk assessment and care plan documentation • Falls prevention training and education framework developed, delivery to commence 2022. • Analyse trends and themes in falls data to inform the need for targeted support and interventions. • Utilisation of Focus on Fundamentals programme • Enhanced care policy and associated processes review. • Revised falls investigation process and documentation. • Overarching action plan for divisional and serious incidents, monitored through FPSG • Business case for dedicated falls team being developed • Collaborative work between Quality and Improvement teams to bring all existing falls prevention work together.	13/06/2022

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4878	If there are significant delays within the planned care non-admitted pathway (outpatients) then patients may experience extended waits for diagnosis and treatment, resulting in failure to meet national standards and potentially reducing the likelihood of a positive clinical outcome for many patients	Very high risk (20)	- Planned care recovery plan (non-admitted / outpatients) - Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions	22/06/2022

Strategic objective 1b: Improve patient experience
Assurance lead: Quality Governance Committee

2.4 There are currently no Very high risks and 4 High risks (an increase of 2) to this objective. The 2 new High risks concern listening to patient voices to understand the quality of their experience and the importance of engaging with patients and families as part of the service design process.

Strategic objective 1c: Improve clinical outcomes
Assurance lead: Quality Governance Committee

2.5 There are currently 3 Very high risks (an increase of 1) and 2 High risks (an increase of 1) to this objective. The new Very high risk concerns the potential for failure of the HDR (high dosage rate) Unit in Radiotherapy; the new High risk relates to radiology support for symptomatic and breast screening services. A summary of the 3 Very high risks is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4828	If 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 reduced likelihood of a positive clinical outcome and possibly causing serious patient harm	Very high risk (20)	Planned introduction of an auditable electronic prescribing system across the Trust.	15/06/2022
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.	21/06/2022

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4979	HDR unit (purchased Sept 2001) was served an end of life notice taking effect from September 2015. This has now been changed to an end of support from the 31st December 2022 which terminates our service as we will not be able to change the radioactive source. The patients will be referred elsewhere and may not be treated within the required time thus decreasing the effectiveness of the treatments. An extension of a week requires 5Gy extra to be treated and decreases the local control of the tumour. Leicester also are currently referring their gynae patients around the region thus further reducing the region's capacity.	Very high risk (20)	The new Physics Lead for brachytherapy is working through the backlog of issues. Additional funding is required for a replacement unit – now agreed and project planned for implementation before the end of 2022. **Risk register to be updated, residual risk is now Moderate to Low.**	27/07/2022

Strategic objective 2a. A modern and progressive workforce
Assurance lead: People & OD Committee

2.6 There are 2 Very high risks and 3 High risks to this objective. The risk register now includes those workforce risks that were recently refreshed and approved by the committee in July 2022. A summary of the 2 Very high risks is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4991	If the Trust is unable to recruit and retain sufficient numbers of staff with the required skills and experience then it may not be possible to provide a full range of services, resulting in widespread disruption with potential delays to diagnosis and treatment and a negative impact on patient experience	Very high risk (20)	1. Focus staff engagement & structuring development pathways. 2. Use of apprenticeship framework to provide a way in to a career in NHS careers. 3. Exploration of new staffing models, including nursing associates and Medical Support Workers. 4. Increase Agency providers across key recruitment areas. 5. Increase capacity in recruitment team to move the service from reactive to proactive. 6. Develop internal agency aspect to recruitment. 7. Reintroduce medical recruitment expertise within Recruitment Team. 8. Build strong relationship with Refugee Doctor project to support MSW recruitment and GMC registered Doctors. 9. Source a third party supplier for Philippines recruitment for hard to recruit AHP roles.	12/07/2022

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4780	Risk of not being able to maintain effective stroke provision across ULHT due to the significant deficit in stroke consultant staffing and nurse staffing. 1 in 4 consultant on-call rota is unsustainable with current staffing levels. Stroke risk summit undertaken 2019. Designated TRUST FRAGILE SERVICE	Very high risk (20)	Monthly review of provision in place. Ongoing recruitment campaigns for vacancies. Expansion of ACP workforce (business case being developed) to increase medical capacity to support consultant workforce.	25/05/2022

Strategic objective 2b. Making ULHT the best place to work
Assurance lead: People & OD Committee

2.7 There are currently 1 Very high risk and 2 High risks (an increase of 2) to this objective. The 2 new High risks relate to compliance with national standards for workforce race and disability equality standards. A summary of the 1 Very high risk is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4990	Poor culture within the Trust resulting in poor behaviours, increased ER cases, turnover, retention issues and ability to recruit and increased sickness absence. ULHT 'Pulse' Survey (quarterly): poor/low uptake; staff survey fatigue; lack of motivation and confidence amongst staff that results are anonymised and are meaningful to ULHT Results affects ULHT standing as an employer of choice and employer brand within NHS - may therefore result in reputational risk and create difficulties when recruiting/attracting talent and retention of workforce locally, regionally and nationally	Very high risk (20)	1. National mandate for NHS organisations to run Pulse Survey every quarter (1,2&4) 2. Comprehensive and robust positioning to complement NHS Staff Survey and part of a wider staff listening and engagement plan 3. You said campaign to drip feed/communicate how staff intelligence is improving working environment and services - now live	12/07/2022

Strategic objective 2c. Well-led services
Assurance lead: Audit Committee

2.8 There are currently no Very high risks or High risks to this objective.

Strategic objective 3a: A modern, clean and fit for purpose environment
Assurance lead: Finance, Performance & Estates Committee

2.9 There are currently 2 Very high risks (an increase of 1) and 1 High risk to this objective. The new Very high risk concerns fire safety standards compliance and has been increased following review by the Fire Safety Group. A summary of the 2 Very high risks is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4648	If a fire occurs on one of the Trust's hospital sites and is not contained (due to issues with fire / smoke detection / alarm systems; compartmentation / containment) it may develop into a major fire resulting in multiple casualties and extensive property damage with subsequent long term consequences for the continuity of services.	Very high risk (20)	- Statutory Fire Safety Improvement Programme based upon risk. - Fire safety protocols development and publication. - Fire drills and evacuation training 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	20/06/2022
4647	If Lincolnshire Fire & Rescue Service (LFRS) carries out an inspection and finds the Trust to be systemically non-compliant with fire safety regulations and standards it could result in regulatory action and sanctions, with the potential for financial penalties and disruption to services if sites are required to close.	Very high risk (20)	- Statutory Fire Safety Improvement Programme based upon risk - LFR involvement and oversight through the FSG - 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 - PPM reporting for FEG and FSG By Estates Teams - All areas of Trust allocated RAG rating for fire using using occupancy profile, escape provision, height above ground and sleeping risk	20/06/2022

Strategic objective 3b: Efficient use of our resources
Assurance lead: Finance, Performance & Estates Committee

2.10 There are currently 1 Very high risk and 3 High risks to this objective. A summary of the 1 Very high risk is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4664	The Trust has an agency cap of c£21m. The Trust is overly reliant upon a large number of temporary agency and locum staff to maintain the safety and continuity of clinical services that will lead to the Trust breaching the agency cap.	Very high risk (20)	Financial Recovery Plan schemes: - recruitment improvement; - medical job planning; - agency cost reduction; - workforce alignment	22/06/2022

Strategic objective 3c: Enhanced data and digital capability
Assurance lead: Finance, Performance & Estates Committee

2.11 There are currently no Very high risks and 2 High risks to this objective.

Strategic objective 4a: Establish new evidence based models of care
Assurance lead: Finance, Performance & Estates Committee

2.12 There are currently no Very high or High risks to this objective.

Strategic objective 4b. To become a University Hospitals Teaching Trust
Assurance lead: People & OD Committee

2.13 There are currently no Very high or High risks to this objective.

3. Conclusions & recommendations

3.1 The most significant risks within the Trust at present relate to:

- the recovery of planned care pathways;
- ambulance handover delays;
- the availability of accurate patient and medicines information;
- patient harm from falls;
- the provision of echocardiograms;
- the ability to learn lessons from previous patient safety incidents;
- fire safety standards and the potential for a major fire;
- the cost of reliance on temporary clinical staff;
- recruitment and retention within the workforce; and
- workforce culture

3.2 Potential failure of the HDR (high dosage rate) Unit in Radiotherapy – this risk was reviewed at the Risk Register Confirm & Challenge Group in August, where it was agreed that as an equipment replacement project has now been planned for implementation before the end of 2022 the residual risk is now Moderate to Low (the risk register is to be updated to reflect this change).

3.3 Several Very high risks were overdue their monthly review at the time of reporting. Clinical Governance business partners will be supporting divisions this month to update risks that are overdue for review.

3.4 The Trust Board is invited to review the content of the report, no further escalations at this time.

Appendix A - All active risks rated 15 - 25

ID	Risk Type	Manager	Handler	Lead Oversight Group	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
Strategic Objective						**1a. Deliver Harm Free Care**																			
4877	Physical or psychological harm	Evans, Simon	Carter, Mr Damian		28/03/2022	20	Risk assessments	Surgery				If there are significant delays within the planned care admitted pathway then patients may experience extended waits for surgery, resulting in failure to meet national standards and and potentially reducing the likelihood of a positive clinical outcome for many patients	National policy: - NHS standards for planned care ULHT policy: - Planned care admitted pathway & booking systems / processes - Clinical Harm Review (CHR) processes ULHT governance: - Lincolnshire System Elective Recovery meeting – Monthly - Integrated Performance Report (IPR) to Trust Board - Monthly - Divisional Performance Review Meeting (PRM) process - Clinical Harm Oversight Group	P2 - surgery within 31 days - currently around 6-7 weeks. Very long waiters	22/06/2022	Extremely likely	High	Very high risk	20	- Planned care recovery plan (Admitted / HVLC / GIRFT) - Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions	Risk lead updated to Head of Operations.	Moderate risk	31/03/2023	31/03/2023	31/07/2022
4878	Physical or psychological harm	Evans, Simon	Carter, Mr Damian		28/03/2022	20	Risk assessments	Clinical Support Services	Outpatients CBU		Trust-wide	If there are significant delays within the planned care non-admitted pathway (outpatients) then patients may experience extended waits for diagnosis and treatment, resulting in failure to meet national standards and and potentially reducing the likelihood of a positive clinical outcome for many patients	National policy: - NHS standards for planned care ULHT policy: - Planned care non-admitted pathway & booking systems / processes (outpatients) - Clinical Harm Review (CHR) processes ULHT governance: - Lincolnshire System Elective Recovery meeting – Monthly - Integrated Performance Report (IPR) to Trust Board - Monthly - Outpatient Recovery Group; Reports through Divisional PRMs (for performance), and FPEC and System Planned Care Group - Clinical Harm Oversight Group	2ww first O/Ps back within national target Urgent 1sts 90% <13 weeks by 31.03.23 Time critical follow ups (452/2657 overdue) – target to eliminate (mainly neurology, cardiology, rheumatology) by 31.03.23 RTT non-admitted: Clear >104wws by 31.03.22 Clear >78wws by 31.03.22 (with few remaining by 30.06.22) Clear >65wws by 30.09.22 Clear >52wws by 31.12.22	22/06/2022	Extremely likely	High	Very high risk	20	- Planned care recovery plan (non-admitted / outpatients) - Specialties to identify and assess any areas of specific risk not addressed through the recovery plan, putting in place necessary mitigating actions	Risk lead updated to Head of Operations.	Moderate risk	31/03/2023	31/03/2023	21/07/2022
4879	Physical or psychological harm	Evans, Simon	Rimmer, Lucy		28/03/2022	20	Risk assessments	Clinical Support Services	Cancer Services CBU	Cancer Centre		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 and potentially reducing the likelihood of a positive clinical outcome for many patients	National policy: - NHS standards for planned care (cancer) ULHT policy: - Cancer care pathway & booking systems / processes - Clinical Harm Review (CHR) processes ULHT governance: - Lincolnshire System Elective Recovery meeting – Monthly - Lincolnshire system RTT Cancer and Diagnostic- Weekly - ULHT Cancer Recovery and Delivery – Weekly - ULHT Clinical Business unit meetings – Weekly - Integrated Performance Report (IPR) to Trust Board - Monthly - Divisional Performance Review Meeting (PRM) process - Clinical Harm Oversight Group	Cancer patients awaiting surgery - all within 31 days New standards: 28 days for first diagnosis; 62 day max wait	22/06/2022	Extremely likely	High	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	This is an initial draft risk register entry that has been discussed by the Risk Register Confirm & Challenge Group. Further detail to be added by lead.	Moderate risk	31/03/2023	31/03/2023	29/07/2022
4803	Physical or psychological harm	Evans, Simon	Skinner, Maxine	Patient Safety Group	16/01/2022	20	Risk assessments	Medicine	Urgent and Emergency Care CBU	Accident and Emergency		If there are substantial delays to patient handovers from ambulances then it could lead to patients being treated in an area that is not appropriate for patient care, resulting in failure to meet the national standard for ambulance handovers which impacts on the wider system and may lead to regulatory action, also potentially reducing the likelihood of a positive clinical outcome and/or causing serious patient harm	ULHT policy & procedure: - All ambulances approaching 30 minutes without a plan to off load are escalated to the Clinical Site Manager and the in hours Tactical Lead to secure a resolution and plans to resolve are fed back to the DOM. - Out of hours, the responsibility lies with the Tactical On Call Manager. - Daily messages to EMAS crews to sign post to alternative pathways and reduce conveyances to the acute setting. - Active monitoring of the EMAS inbound screen to ensure the departments are ready to respond. - The rapid handover protocol has now been revisited and agreed. Designated escalation areas are being identified/confirmed to assist in reducing delays in handover.	- Ambulance handover times: increase of >2hrs in January 2022 (261 in January vs 238 in December) and decrease in >4hr delays (35 in January compared to 39 in December) - Clinical harm reviews / incidents linked to ambulance handover delays: 3 serious harm incidents reported this quarter (under investigation)	23/03/2022	Extremely likely	High	Very high risk	20	- Early intelligence of increasing EMAS demand to allow 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.	January saw formal requests from EMAS to enact the rapid handover protocol. Risk discussed at Risk Register Confirm & Challenge Group 23 March 2022, current rating increased from 16 to 20.	Low risk	30/09/2022	30/06/2022	30/04/2022

Appendix A - All active risks rated 15 - 25

ID	Risk Type	Manager	Handler	Lead Oversight Group	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
4624	Physical or psychological harm	Davies, Angela	Addlesee, Sarah	Patient Falls Steering Group	08/11/2021	16	Aggregation of Incident/Claims & Complaints/PALS	Corporate	Nursing Directorate	Corporate Nursing	Trust-wide	If patients in the care of the Trust who are at increased risk of falling are not accurately risk assessed and, where necessary appropriate preventative measures put in place, they may fall and could suffer severe harm as a result.	National policy: - NICE Clinical Guideline CG161: Assessment and prevention of falls in older people (2013) - PHE Falls and fracture consensus statement: Resource pack (2017) ULHT policy: - Falls Prevention and Management Policy (approved April 2021, due for review March 2023) ULHT governance: - Lead Quality Matron - Weekly Falls Investigation Panel / Training package tiered approach / Weekly spot check audits / Monthly Quality Metrics Dashboard meetings /ward review visits - Patient falls steering group / Nursing, Midwifery & AHP Forum / Quality Governance Committee	Frequency, location and severity of patient falls incidents reported: - The numbers of reported falls incidents are demonstrating an increasing upward trend therefore will not achieve the strategic objective to achieve harm free care. - Operational pressures have resulted in patients having prolonged periods sitting in Emergency Departments whilst waiting assessment and for inpatient beds to become available. This may contribute to an increase in some patients overall frailty level and subsequent deconditioning which increases the vulnerability to an individual falling. - Longer length of stays have demonstrated a correlation to risk of a patient falling whilst in the care of the Trust. Patient falls reported April 2021-March 2022 Total -1916 Moderate harm -22 Severe -12 Death -4 Patient falls reported April 2022-May 2022 Total -344 Moderate harm -7 Severe-4 Death-1	13/06/2022	Extremely likely	High	Very high risk	20	• Improvement plan implemented by all Divisions, led by QM, monitored through Patient Falls Prevention Steering Group (FPSG). • Introduction and rollout of 'Think Yellow ' falls awareness visual indicators. • Patient story included within FPSG workplan. • Introduction of new falls prevention risk assessment and care plan documentation • Falls prevention training and education framework developed, delivery to commence 2022. • Analyse trends and themes in falls data to inform the need for targeted support and interventions. • Utilisation of Focus on Fundamentals programme • Enhanced care policy and associated processes review. • Revised falls investigation process and documentation. • Overarching action plan for divisional and serious incidents ,monitored through FPSG • Business case for dedicated falls team being developed • Collaborative work between Quality and Improvement teams to bring all existing falls prevention work together.	Initial business case for a dedicated falls team resource to be presented to CRIG in June 2022. A Falls QI Project Development and Implementation Group has been established which has multidisciplinary representation from divisional and corporate teams. Dedicated support is being provided by the Improvement Academy. Oversight and monitoring will be provided by FPSG who will receive monthly updates on actions being taken and progress made by the QI group. A schedule of face to face falls prevention and Flojac training commenced in April 2022 delivered within clinical areas by the Quality Matron and Health & Safety teams. Wards identified as having higher falls occurences are being prioritised. The Chief Nursing Information Officer (CNIO) has been working with the Quality Matron team to identify how the identification and handover of patients vulnerable to falling can be improved through the support of digital applications. Falls Prevention Steering Group time out session planned 23/06/22 which will provide an opportunity to review the work programme of the group to ensure all the of the right questions are being asked and the right areas of focus are being looked at effectively.	Low risk	31/12/2021	31/03/2023	31/07/2022
4789	Physical or psychological harm	Evans, Simon	Ratcliff, Carl	Patient Safety Group	16/01/2022	20	Risk assessments	Medicine	Cardiovascular CBU	Cardiology		If there is a significant delay in processing of Echocardiograms, which is impacted by staff shortages and inefficient processes, then it could lead to delayed assessment and treatment for patients, resulting in potential for serious harm, a poor patient experience and a poor clinical outcome	Weekly review and monitoring of OP activity /utilisation data Monthly meeting with CSS to review performance; secure any additional available capacity Escalation through CBU and Divisional governance processes / Planned Care Cancer and Diagnostic System Recovery Cell	DMO1 activity - monthly review Backlog consistently increasing C&A Team remain short-staffed due to vacancies -referrals being late added onto Medway leaving CBU with no visibility of the referrals for the first part of their pathway. - Issues with CBU not having visibility of demand to allow adequate proactive planning of additional clinic sessions. - CBU being unable to accurately forecast activity performance against standards e.g. DM01 -wasted clinic slots	10/08/2022	Extremely likely	High	Very high risk	20	Review and realignment of systems and processes to ensure that the team efficiency has been optimised. External company (Meridian) engaged for 10 week period to enable a deep dive and improvement plan to be implemented for the service	Echo backlog remains high. Meridian re-engaged to support service. Number of measures being undertaken to increase capacity. Progress being reported into planned care board. 10.08.2022- Meridian deep dive completed. Recommendations being reviewed by General Manager. Further options for recovery include R&R package, weekend working, extra rooms being explored by General Manager. ECG Monitoring proposal approved and potentially will have impact on echo waiting list.	Low risk	31/03/2022	31/03/2023	30/06/2022
4622	Patient safety (physical or psychological harm)	Dunderdale, Karen	Helley, Kathryn	Patient Safety Group	09/04/2018	20	Risk assessments	Corporate	Nursing Directorate	Clinical Governance	Trust-wide	If the Trust fails to learn lessons when patient safety incidents occur, so that changes can be made to policies and procedures, there is an increased likelihood of similar incidents occurring in future which could result in serious harm affecting a large number of patients.	National Policy: - NHS National Patient Safety Strategy - NHS National Reporting and Learning System (NRLS) ULHT Policy: - Analysing and Learning from Patient Safety Incidents, Complaints, Claims and Coroners Inquests Policy (approved April 2019, due for review April 2022) ULHT governance: - Trust Board assurance through Quality Governance Committee (QGC) and sub-groups"	- Recurring themes in patient safety incidents, complaints, PALS & claims (e.g. patient falls SIs; pressure ulcer incidents; DKA incidents) - Recurring themes in audits / reviews of risk / incident / complaints / claims management"	13/06/2022	Extremely likely	High	Very high risk	20	- Establishment of Patient Safety Improvement Team - Prepare for replacement of NRLS and StEIS systems with new Learn From Patient Safety Events (LFPSE) service (previoulsy called PSIMS) - Upgrade current DatixWeb risk management system to Datix CloudIQ - Prepare for implementation of new Patient safety Incident Response Framework (PSIRF) in 2022 (replacement for Serious Incident Framework)	- Patient Safety Improvement Team now established within Clinical Governance - Datix CloudIQ has been approved for connection to the new national learning system - Case of need for Datix CloudIQ approved in principle; implementation to be planned Directorate review (May 2022) - agreed that this would remain Very high (20) subject to learning lessons work being completed and evidence that repeated incidents are reducing	Low risk	31/01/2019	31/03/2023	30/07/2022
4979	Physical or psychological harm	Evans, Simon	Cawley, Martin		25/07/2022	20	Risk assessments	Clinical Support Services	Cancer Services CBU	Radiotherapy	Trust-wide	HDR unit (purchased Sept 2001) was served an end of life notice taking effect from September 2015. This has now been changed to an end of support from the 31st December 2022 which terminates our service as we will not be able to change the radioactive source. The patients will be referred elsewhere and may not be treated within the required time thus decreasing the effectiveness of the treatments. See reference Tanderup et al. Radiother Oncol. 2016 Sep;120(3):441-446. An extension of a week requires 5Gy extra to be treated and decreases the local control of the tumour. Leicester also are currently referring their gynae patients around the region thus further reducing the region's capacity.	ULH policy: - Current still on best endeavour contract. The service will stop on the 31st December 2022. - There is agreement in place for neighbouring centres to deliver therapy if required. ULH governance: - Divisional governance arrangements within CSS / Cancer Services / Radiotherapy - Board assurance through Quality Governance Committee - Capital and Revenue Investment Group (CRIG) decision-making processes	Reported incidents of equipment failure (The incidents of a bent check cable and hard disk failure have all been sorted but did result in cancelled theatre sessions.)	24/08/2022	Extremely likely	High	Very high risk	20	The new Physics Lead for brachytherapy is working through the backlog of issues. Additional funding is required for a replacement unit.	A case of need was presented at the March CRIG but was not supported as they were unaware of this as of urgent concern. A Standard Business Justification Case has been requested for the July CRIG. Now agreed and equipment replacement project planned for implementation before the end of 2022. Residual risk is now Moderate to Low. Risk register to be updated with revised score.	Low risk	31/03/2023	31/03/2023	30/11/2022

Appendix A - All active risks rated 15 - 25

ID	Risk Type	Manager	Handler	Lead Oversight Group	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
4646	Physical or psychological harm	Dunderdale, Karen	Gibbins, Donna	Patient Safety 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	05/07/2022	Quite likely	High	High risk	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.	New Specialist Respiratory Unit with adjoining Respiratory ward now open at LCH. Plans for development of the facility at PHB scheduled from Feb / Mar 22. Risk discussed at Risk Register Confirm & Challenge Group on 23 March 2022. Still inconsistencies with timeliness against BTC standards, particularly at Lincoln, and inability to ring-fence beds. Agreed that risk remains high but has reduced. Recommendation for rating to change from 20 to 16.	Low risk	30/09/2022	30/09/2022	28/09/2022
4868	Physical or psychological harm	Farquharson, Colin	Martinez, Francisca	Medicines Quality 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.	1. IV medicines ready to use (pre-prepared in clinical area) kept for 24 hours. 2. To minimise the risk of microbiological contamination and minimise the risk of infection, administration of injections and infusion prepared in a clinical area should be performed immediately after preparation and ideally within 30 minutes of preparation. 3. To minimise the risk of wrong dose/drug/patient errors, the identity of all injectable medicines must be assured. If the preparation (syringe or IV bag) leaves the hands of the person who prepared it and/or the entire injection or infusion process is not under the direct supervision of that person, the syringe or IV bag must be labelled. Infusion Labels must include as a minimum: - the name & dose or strength of the drug and diluent (including units of	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.	15/06/2022	Quite likely	High	High risk	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.	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,	Low risk	30/09/2022	30/09/2022	14/07/2022
4779	Physical or psychological harm	Evans, Simon	Ratcliff, Carl	Clinical Effectiveness 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	29/04/2022	Quite likely	High	High risk	16	defined plans to address backlog for at risk areas	Plans in place to address backlogs across all areas. Significant area of risk for TIA.	Low risk	31/03/2022	30/06/2022	30/05/2022
4790	Service disruption	Evans, Simon	Spendlove, Mrs Clare	Patient Safety Group	16/01/2022	15	Risk assessments	Medicine	Cardiovascular CBU	Cardiology		Major risk to service delivery (cardiology diagnostic tests and reports) due to current system no longer being supported. Supplier only able to support on best endeavours basis. Frequent loss of service resulting in adverse impact on service provision. Urgent replacement of system required	Best endeavours agreement in place with supplier procurement process to be undertaken for replacement system	volume of system failures/ability to reinstate	29/07/2022	Quite likely	High	High risk	16	new system procurement to be expedited	System procurement completed .Implementation plan in place. Risk to be re-assessed once new system has been implemented. Discussed at Risk Register Confirm & Challenge Group 25 May 2022. Agreed that the current level of risk is High and acceptable risk is Low (not Moderate).	Low risk	31/12/2022	31/12/2022	31/08/2022
4935	Service disruption	Farquharson, Colin	Daniels, Mrs Samantha	Patient Safety 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.	06/06/2022	Quite likely	High	High risk	16	Recruit to vacant posts.	Quality Impact Assessment undertaken and LCH ITU reduced to 8 x L3 bed equivalents on a temporary basis. For review	Low risk	31/10/2022		30/06/2022

Appendix A - All active risks rated 15 - 25

ID	Risk Type	Manager	Handler	Lead Oversight Group	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
4958	Physical or psychological harm	Dunderdale, Karen	Helley, Kathryn	Patient Safety Group	30/06/2022	12	Risk assessments	Corporate	Nursing Directorate	Clinical Governance	Trust-wide	The Trust may not be able to fully and effectively implement the requirements of the National Patient Safety Strategy, resulting in potential missed opportunities to significantly improve patient safety and possible non-compliance with national standards	National policy: - NHS Pateint Safety Strategy: Safer culture, safer systems, safer patients ULHT policy: - Patient Safety Improvement Team (Clinical Governance) - Patient Safety Specialists ULHT governance: - Patient Safety Group (lead) / Quality Governance Committee (assurance)	Frequency and severity of patient safety incidents reported. Monitoring implementation of the National Patient Safety Strategy.	27/06/2022	Quite likely	High	High risk	16	Patient Safety Strategy implementation plans, including: - Preparations for introduction of the new national Patient Safety Incident Response Framework (PSIRF) - Upgrade to Datix CloudIQ to enable information upload to the new national Learning from Patient Safety Events (LFPSE) system - Recruitment and induction of Patient Safety Partners (PSPs)	As a result of delays to the procurement of Datix Cloud IQ, along with an estimated implementation timeline of 6 months to upgrade the system, there is now an increased likelihood of not being ready to integrate with the LFPSE system by the April 2023 due date. Rating increased from 12 to 16.	Low risk	31/03/2023	31/03/2023	30/09/2022
Strategic Objective						**1b. Improve patient experience**																			
4629	Reputation	Davies, Angela	Negus, Jennie	Patient Experience Group	09/04/2018	12	Risk assessments	Corporate	Nursing Directorate	Corporate Nursing	Trust-wide	If we do not listen to the voices of our patients, carers and families through not seeking out, hearing and appreciating their experiences and then acting on them, we will fail in our ambition to deliver patient centred care.	• Patient & Carer Experience Plan and associated workplan. • Patient experience metrics and reporting (FFT, Care Opinion, PALS & Complaints, Healthwatch data, compliments all of which are triangulated through SUPERB); • National survey reports (inpatient, UEC, Maternity, NCPES, CYP). • Patient Experience Group - rolling programme of divisional assurance reporting. • Patient Experience upward reports to Quality Governance Committee through agreed reporting schedule. • Monthly Patient Panela dn expert reference groups reporting upwards to Patient Experience Group. • Patient Stories at Trust Board. • PLACE annual inspections and internal PLACE Lite visits. • Ward and department assurance visits as part of Quality Accreditation programme. • Carers Policy • Care of the Dying Patient and Care after Death procedures and guidelines. • Visiting Procedures. • Policy for the Development of Written Patient Information. • Complaints & PALs Policy	Patient feedback; volume and theme: • PALs & complaints • FFT • Care Opinion • National and local surveys • Healthwatch data • Patient Panels and expert reference groups • Patient feedback through ward assurance and Quality Accreditation programme • Patient stories • Triangulated data through SUPERB	16/06/2022	Quite likely	High	High risk	16	• Continue delivery of Patient Experience Training programme. • Support teams to use SUPERB and Envoy (FFT) dashboards to access their data and intelligence. • Continue to promote & spread Academy of FAB NHS Stuff to share and celebrate achievements, motivate, and energise teams • Develop Patient and Carer Experience Plan workplan. • Deliver IIP project improving communication and engagement with patients. • Explore development of further Expert Reference Groups. • Continue to develop Patient Panel. • Continue current work to embed patient voice and experience within QSIR programmes. • Strengthen divisional assurance reporting to spotlight actions taken as a result of feedback received including o Patient stories o You said, we did o Learning & improvement o Adoption of 'What Matters to You' • Develop new database to record patient experience activity and initiatives. • Analyse trends and themes in patient experience data to inform the need for targeted support and interventions by Patient Experience Team. • Consolidate and support the FAB Experience Champions network to support local actions and improvements.	• Training programme running weekly March – June and then monthly thereafter. >110 staff attended to dat. • Academy of FAB NHS team scheduled to visit in July to highlight ULHT as part of 2022 Fab Change Day. • Patient and Carer Experience Plan due to June PEG, workplan to be developed on approval. • Continue to deliver IIP project improving communication and engagement with patients. • Settle and embed Expert Reference Groups: o Sensory Loss o Breast Mastalgia o Cancer – first meeting end May 22 o Dementia Carers – out to advert • Patient Panel continues to develop & their story shared with Trust Board in May. • Divisional assurance reporting template refreshed and circulated. • Additional Patient Experience Manager commenced in March 2022. • FAB Experience Champions network meetings scheduled. Rating increased from 12 to 16.	Low risk	30/09/2019	31/03/2023	30/09/2022
4980	Reputation	Davies, Angela	Negus, Jennie	Patient Experience Group	25/07/2022	16	Patient Surveys	Corporate	Nursing Directorate	Patient Experience	Trust-wide	Patient engagement can inform service design and evaluation as well as enhance its delivery and governance. It is the process of building the involvement of patients, families and carers, supporting their active involvement in order to enhance their care, care experience, safety, quality and patient-centredness. If we do not build the expectation to engage with our patients then we will not achieve patient centred care and if we do not reach out to 'hard to reach' groups our intelligence will fail to be diverse and inclusive.	• IIP project driving delivery of engagement and communication with patients and public. Reaching Out objective within this focuses on hard to reach groups. • Patient Panel meets monthly. • Expert reference groups in development: o Sensory loss group established o Breast Mastalgia group established o Cancer group established (first meeting May 2022) o Dementia Carers group in development • Patient Experience Training • Stakeholder involvement at Patient Experience Group: o Healthwatch o Carers First o Young Carers o Maternity Voices • Monthly reports from Healthwatch with feedback and queries. • Continued implementation of 'What Matters to you' initiative	• IIP milestone reports including Reaching Out objective. • Patient Panel evaluations. • Upward reports to Patient Experience Group • Expert reference groups evaluations will be undertaken. • Patient Experience Training requires a staff pledge on completion; these are being analysed and themes collated. • Stakeholder feedback and engagement at Patient Experience Group • Evaluations and outputs from implantation of 'What Matters to You' initiative through QSIRv	16/06/2022	Quite likely	High	High risk	16	• Deliver against IIP milestones. • Reaching out project objectives targeting hard to reach communities: o Mental Health o Learning Disabilities & Autism o Traveller community o Children and Young People o BAME & Easter European groups o LGBQT+ Older People: • Scoping development of further Expert Reference Groups. • Seeking to secure Neonatal Voices representative and involvement. • Launch of Cohort 2 QSIRv What Matters to You.	• IIP milestone plan to be updated following communication of Year 3 priorities. • Reaching out project: o Mental Health – links established with MH colleagues, options being explored to reach in to seek feedback and engagement. o Learning Disabilities & ASD – new ULHT LD nurse in post; exploring means for working with existing experts by experience. o Traveller community – link established with development team and community nursing. o Children and Young People – Youth Panel and Expert Family groups being explored. o BAME & Easter European groups – links being explored within communities. o LGBQT+ - links established with ED&I lead to scope. o Older People: o Launch of Dementia Carers Expert Reference Group planned for July 2022 o Proposal for Virtual Ward Expert Reference group being considered by CCG colleagues	Low risk	31/03/2023	31/03/2023	31/10/2022
4701	Reputation	Grooby, Mrs Libby	Upjohn, Emma		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.	13/04/2022	Reasonably likely	Extreme	High risk	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.	Staff engagement sessions to communicate refurb plans. Issues dealt with by Estates & Facilities as they occur. 13/04/2022: Mitigation plan - full board approval to progress the business case. Require monitoring of staff surveys. CQC report demonstrates unsuitable for use - amended to 3 impact and 5 occurrence = 15	Low risk	31/03/2025	31/03/2025	30/09/2022

Appendix A - All active risks rated 15 - 25

ID	Risk Type	Manager	Handler	Lead Oversight Group	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
4724	Physical or psychological harm	Lalloo, Yavenuscha	Cooper, Mrs Anita		13/01/2022	20	Risk assessments	Clinical Support Services	Therapies and Rehabilitation CBU		Trust-wide	If Therapies and Rehabilitation service provision is not sufficient to deliver 7 day service provision, then once COVID funding ends it will leave 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.	22/03/2022	Extremely likely	Medium	High risk	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.	Business cases completed for all areas.	Low risk	30/11/2021	31/03/2023	30/06/2022
Strategic Objective						**1c. Improve clinical outcomes**																			
4731	Physical or psychological harm	Evans, Simon	Parkin, Mr Lee	Medical Records Group	13/01/2022	20	Risk assessments	Clinical Support Services	Outpatients CBU	Choice, Access and Booking	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 June 2022) - Trust Board assurance via Finance, Performance & Estates Committee (FPEC); lead Information Governance Group / Medical Records Group - CSS Division	Internal audit of medical records management processes - reliance upon hard copy patient records; patients may have multiple sets of records. Reported incidents involving availability of patient records issues.	21/06/2022	Extremely likely	High	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.	OBC for EPR is being produced in line with NHSE/I guidance. Hoping to have Board sign off and funding in early 2022, with project start 2nd quarter 2022. To discuss / agree interim approach. Reviewed by Risk Register Confirm & Challenge Group, 26 Jan 22. Rating increased to 20, risk lead changed to Prof lead for Outpatients. Oversight to be via Digital Hospital Group. 120522 - Review of policy is underway – sent to h/recs managers for amendments before being sent for sign off to Lee and via the CRG	Low risk	30/06/2018	31/03/2023	21/07/2022
4828	Physical or psychological harm	Farquharson, Colin	Costello, Mr Colin	Medicines Quality Group	17/01/2022	20	Risk assessments	Clinical Support Services	Pharmacy CBU	Pharmacy	Trust-wide	If information about patient medication is not accurate, up to date and available when required by Pharmacists then it could lead to delays or errors in prescribing and administration, resulting in a widespread impact on quality of care, potentially reducing the likelihood of a positive clinical outcome and/or causing serious patient harm	National policy: - NICE Guideline NG5: Medicines optimisation, etc. ULHT policy: - Policy for Medicines Management: Sections 1-8 (various approval / review dates) ULHT governance: - Trust Board assurance via Quality Governance Committee (QGC) / Medicines Quality Group (MQG)	Medication incident analysis Audit / review of medicines management processes - the Trust currently uses a manual prescribing process across all sites, which is inefficient and restricts the timely availability of patient information when required by Pharmacists.	15/06/2022	Extremely likely	High	Very high risk	20	Planned introduction of an auditable electronic prescribing system across the Trust.	Funding approved for Electronic Prescribing and Medicines Administration (EPMA). Project plan has been developed, implementation from Oct / Nov 21. Reviewed at Risk Register Confirm & Challenge Group 26 Jan 22. Rating increased to 20. 17/5/22 No change	Low risk	31/03/2022	30/09/2022	13/09/2022
4905	Physical or psychological harm	Cooper, Mrs Anita	Bradley, Mrs Lesley		22/04/2022	12	Workforce Metrics, Risk assessments, Aggregation of Incident/Claims & Complaints/PALS	Clinical Support Services	Therapies and Rehabilitation CBU		Lincoln County Hospital	If we have insufficient staffing, or required level of experience and skill, the risk is patients will not receive assessment and rehabilitation leading to poor clinical outcome. Reduced flow on acute wards, delayed discharges, delayed referral to response times. Patient reviews delayed for botox treatment.	Recruitment and retention strategies to fill vacancies. Bank staff. Requests to Locum Agencies. Skill mix Roster management. SQD data. Daily review of ward systems eg WebV. Prioritisation guidelines.	Patient complaints. Fewer discharges at the weekend. Site escalation. Vacancy rates. Roster fill rates. Waiting lists for spasticity service.	27/07/2022	Extremely likely	Medium	High risk	15	Getting locums and bank staff in place. Good use of relocation allowance. Actively managing the waiting lists and dealing with urgent cases to avoid harm eg telephone contact with patients. Case of need for GDH orthopaedic staffing. Case of need for rehabilitation consultant post. Case of need for upper GI dietician. Case of need for Neuro Psychology staff on Ashby. Case of need for OT staff at PHB and LCH in ITU. Over recruitment of band 5s in dietetics. Competency frameworks and preceptorship.	130622 Looking at staffing vacancies and looking at line by line post analysis.	Moderate risk	30/06/2023		15/08/2022
4819	Regulatory compliance	Cooper, Mrs Anita	Clark, Paul		16/01/2022	20	Risk assessments	Clinical Support Services	Diagnostics CBU	Radiology		Lack of radiology support for the symptomatic and breast screening services. unable to cover the required clinics needed to deal with the symptomatic demand and screening demand. Backlog of 220 2ww and 5000 breast screening. just able to support current 2WW demand difficult to reduce the backlog.	Diagnostics clinical governance arrangements / CSS Division Exploring overseas recruitment Secured additional breast screening support for 12 months-mobile van and agency staffing. Providing overtime shifts 7 days to help provide additional capacity.	Monitoring radiology 2ww performance/ screening round length	27/07/2022	Extremely likely	Medium	High risk	15	continued recruitment of radiologists, mammographers, consultant mammographer and the use of locums when available, working closely with family health to maximise capacity via weekly capacity meeting. Working with outsourcing companies and additional Locums to provide extra screening capacity to try and shorten the current screening round length.	NHSE have raised concerns around the screening round length and have asked for a plan to reduce back to 36 months, Looking for locums, NHS England raised concerns about backlog. 290622 Have additional international and UK mamographers. Now 21 days backlog. due to staff leaving due to retirement and moving jobs this has caused the risk score to be increased to 15 as there has been a drop in capacity.	Low risk	30/09/2022	30/09/2022	15/08/2022
Strategic Objective						**2a. A modern and progressive workforce**																			

Appendix A - All active risks rated 15 - 25

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4991	Service disruption	Matthew, Mr Paul	Low, Claire	People and OD Committee	19/05/2022	20	Workforce Metrics	Corporate	People and Organisational Development	Recruitment	Trust-wide	If the Trust is unable to recruit and retain sufficient numbers of staff with the required skills and experience then it may not be possible to provide a full range of services, resulting in widespread disruption with potential delays to diagnosis and treatment and a negative impact on patient experience	ULHT policy: - Workforce planning processes - Recruitment & Selection Policy & Procedure - Rota management systems & processes - Locum temporary staffing arrangements - Workforce management information - Core learning / Core+ programmes? ULHT governance: - Trust Board assurance through People & OD Committee / lead Workforce Strategy Group - Divisional workforce governance arrangements	Vacancies & turnover rate. Staff survey results relating to job satisfaction / retention. Core learning compliance rates?	12/07/2022	Extremely likely (5)	4 (High)	Very high risk	20	1. Focus staff engagement & structuring development pathways. 2. Use of apprenticeship framework to provide a way in to a career in NHS careers. 3. Exploration of new staffing models, including nursing associates and Medical Support Workers. 4. Increase Agency providers across key recruitment areas. 5. Increase capacity in recruitment team to move the service from reactive to proactive. 6. Develop internal agency aspect to recruitment. 7. Reintroduce medical recruitment expertise within Recruitment Team. 8. Build strong relationship with Refugee Doctor project to support MSW recruitment and GMC registered Doctors. 9. Source a third party supplier for Philippines recruitment for hard to recruit AHP roles.	1.New to care recruitment being extensively used for HCSW role with 14 appointed & a further 40 offered. 2.Nursing associate recruitment embedded 3. Medical Support Worker role now looking to be embedded as business as usual. 4. Agency providers increased to a minimum of three for key roles, rather than 1 previously. 5.Restructure process started within wider HR team will result in significant greater capacity for recruitment activities and overall oversight and proactivity. 6.Restructure process started, to introduce internal agency aspect to ULHT recruitment. 7.Medical recruitment expertise aspect being reintroduced via restructure, support already in place via agency staff. 8.Relationship with LRDP now embedded, GMC registered Drs and MSWs recruited. 9. Agreement reached with third party supplier to support Philippines recruitment for difficult to recruit AHP roles. 3 recruits in progress	Low risk	31/03/2023	31/03/2023	31/08/2022
4780	Service disruption	Ratcliff, Carl	Ratcliff, Carl	Workforce Strategy Group	16/01/2022	20	Risk assessments	Medicine	Cardiovascular CBU	Stroke	Trust-wide	Risk of not being able to maintain effective stroke provision across ULHT due to the significant deficit in stroke consultant staffing and nurse staffing. 1 in 4 consultant on-call rota is unsustainable with current staffing levels. Stroke risk summit undertaken 2019. Designated TRUST FRAGILE SERVICE	Ongoing recruitment activity to attract perm and locum resources. No success with overseas or local tertiary centre recruitment Temporary Service change during COVID has consolidated to a single site hyper-acute service- approved by Executives in December 2019 Protocol in place for access to Thrombolysis Trolley on each site. Acute Care Practitioners (ACP's) appointed and undergoing Masters Level Education and Training currently. Integrated into Cardiology ACP Workforce to ensure supported management & education. Business case being developed to secure funding for ACP workforce	monthly service review in place primarily assessed on rota gaps / ability to maintian services across both sites	25/05/2022	Quite likely	Extreme	Very high risk	20	Monthly review of provision in place ongoing recruitment campaigns for vacancies expansion of ACP workforce (business case beig developed) to increase medical capacity to support consultant workforce	ongoing deficit in Stroke Consultant staffing. Recruitment to substantive posts unsuccessful. Only 2 substantive consultants out of 6 in post. National Market shortage .Increased reliance on agency locums with significant financial impact Increased pressure on current workforce as service demands have not reduced ASR consultation adding pressure due to lack of uncertainty on outcome. Increase in staff turnover due to service instability daily ward round commitments amended to every other day to create capacity. Review update on 28.04.2022- Risk level increased to 20; only 1 substantive stroke consultant in place. Further risk summit undertaken in April 2022. Discussed at Risk Register Confirm & Challenge Group 25 May 2022. Agreed with current rating.	Moderate risk	31/03/2022	31/03/2023	30/06/2022
4741	Service disruption	Farquharson, Colin	Sanz Torres, Aurora A	Workforce Strategy Group	13/01/2022	20	Risk assessments	Clinical Support Services	Cancer Services CBU	Oncology	Trust-wide	Oncology is considered to be a fragile service due to consultant oncologist gaps. Tumour sites at risk (Medical oncology) - renal, breast, upper and lower GI, CUP, ovary/gynae, skin, testicular, lung Clinical oncology - head and neck, skin, upper GI (RT only). Lack of cover for leadership roles (Chemotherapy lead)	Cancer services operational management processes & clinical governance arrangements Medical staff recruitment processes Agency / locum arrangements	Monitoring tumour site performance data	27/07/2022	Quite likely	High	High risk	16	Need to undertake a workforce review, oncology still a fragile service, continuing to work with HR to source consultants	Raised at Cancer delivery and performance (CCG present). CSM spoken with Advanta re requirements. 220622 Agency Clinical oncologists recruited. So improved cover for Head and neck and melanoma.	Low risk	31/03/2022	31/03/2023	15/08/2022
Strategic Objective						**2b. Making ULHT the best place to work**																			
4990	Service disruption	Matthew, Mr Paul	Low, Claire	People and OD Committee	19/05/2022	20	Risk assessment	Corporate	People and Organisational Development	Culture and OD	Trust-wide	Poor culture within the Trust resulting in poor behaviours, increased ER cases, turnover, retention issues and ability to recruit and increased sickness absence. ULHT 'Pulse' Survey (quarterly): poor/low uptake; staff survey fatigue; lack of motivation and confidence amongst staff that results are anonymised and are meaningful to ULHT Results affects ULHT standing as an employer of choice and employer brand within NHS - may therefore result in reputational risk and create difficulties when recruiting/attracting talent and retention of workforce locally, regionally and nationally	1. National and local lessons learnt for engaging staff effectively with surveys 2. Dedicated 'staff experience/engagement' role proposed to lead programme of work (including corporate and local action planning)	1. Pulse Staff Survey response rate (quarterly) 2. NHS Staff Survey response rate (annual)	12/07/2022	Extremely likely (5)	4 (High)	Very high risk	20	1. National mandate for NHS organisations to run Pulse Survey every quarter (1,2&4) 2. Comprehensive and robust positioning to complement NHS Staff Survey and part of a wider staff listening and engagement plan 3. You said campaign to drip feed/communicate how staff intelligence is improving working environment and services - now live	1. Pulse Staff Survey - Q2 (July'22) 2. Reset approach (communication, engagement of and management) for sign off - ELT (June'22) 3. Local action planning process - now live 4. 7 Big Ticket Priorities proposed following NHS Staff Survey	Low risk	31/03/2023	31/03/2023	31/08/2022

Appendix A - All active risks rated 15 - 25

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4992	Reputational risk	Matthew, Mr Paul	Low, Claire	People and OD Committee	19/05/2022	16	Risk assessment	Corporate	People and Organisational Development	Equality, Diversity and Inclusion	Trust-wide	WRES (Workforce Race Equality Standard): low compliance/ limited improvement and action to address indicators i.e. increase senior representation and better lived experience of BAME staff working in ULHT. Risk is this results in low number of applications for vacancies which then remain unfilled (difficulty attracting talent); poor turnover rates (difficulty in retaining talent) and a poor employer brand locally, regionally, nationally and overseas. This will impact on the culture of the organisation and the ability to recruit with increased turnover. Wider risk with regards to broader protected characteristics linked to the delivery of the EDI objectives.	1. Lincolnshire Belonging Strategy (improving equity of lived experience and representation across Lincolnshire system) 2. Appointment of People Promise Manager (12 month fixed term) 3. Robust monitoring of EDI incidents/concerns 4. Equitable and EQIA 'tested' HR processes (for recruitment, reward and performance)	1. NHS Staff Survey 2. 'Pulse Check' Staff Survey 3. No. EDI/Race incidents reported 4. No. of EDI/Race related concerns reported 5. BAME staff retention % (leave within first 3, 6 and 12 months) 6. BAME senior representation	12/07/2022	Quite likely (4)	4 (High)	High risk	16	1. Robust governance and assurance for ULHT direction of travel for EDI 2. Reset ULHT strategic direction for EDI (EDI objectives 2022-25) 3. Active WRES Action Plan 4. Anti-Racism strategy and delivery plan 5. Zero tolerance stance - for racist behaviour including banter 6. Improved senior level BAME representation 7. Reset Trust values (highlighting civility@work and ULHT commitment to inclusion)	1. EDI Group and regular reporting established (for assurance) 2. Anti racism strategy and delivery plan socialised with stakeholders and live 3. NHS Staff Survey results - deep dive and analysis of lived experience of staff with protected characteristics 4. Draft EDI objectives 2022-25 - socialised and ready for sign off (end June) 5. ULHT workstream lead - addressing BAME disciplinary gap (Lincs Belonging Strategy) 6. People Promise Manager successfully appointed from end May'22	Low risk	31/03/2023	31/03/2023	31/10/2022
4993	Reputational risk	Matthew, Mr Paul	Low, Claire	People and OD Committee	19/05/2022	16	Risk assessment	Corporate	People and Organisational Development	Equality, Diversity and Inclusion	Trust-wide	WDES: (Workforce Disability Equality Standard): limited awareness and implementation of reasonable adjustments and other forms of support which results in limited equality and equity of opportunity for staff classifed as having a 'disability'; impedes Trust's ambitions to create an inclusive culture and foster belonging; difficulties in attracting as well as retaining talent	1. Appointment of People Promise Manager (12 month fixed term) 2. Robust monitoring of EDI incidents/concerns 3. Equitable and EQIA 'tested' HR processes (for recruitment, reward and performance) 4. Dedicated OH service	1. Measurement of lived experience of disabled staff at ULHT via - NHS Staff Survey 2. No. EDI/disabilty related incidents reported 3. No. of EDI/disability related concerns reported	12/07/2022	Quite likely (4)	4 (High)	High risk	16	1. Governance and assurance for delivery of WDES action plan 2. Review of appropriate datasets to measure risk 3. Introduction of WDES annual report	1. WDES action plan prioritised for engagement, development and delivery 2. July 2022: ULHT review datasets, declaration rates (from 1/7/22 ULHT required to submit metrics and narrative data via the DCF online platform by Aug'22). 3. End October 2022: deadline for ULHT to publish WDES 2022 annual report (include metrics report and WDES action plan)	Low risk	31/03/2023	31/03/2023	31/10/2022
Strategic Objective						**3a. A modern, clean and fit for purpose environment**																			
4648	Physical or psychological harm	Evans, Simon	Davey, Keiron	Fire Safety Group	15/12/2021	20	Risk assessments	Corporate	Estates and Facilities	Fire and Security	Trust-wide	If a fire occurs on one of the Trust's hospital sites and is not contained (due to issues with fire / smoke detection / alarm systems; compartmentation / containment) it may develop into a major fire resulting in multiple casualties and extensive property damage with subsequent long term consequences for the continuity of services.	National policy: - Regulatory Reform (Fire Safety) Order 2005 - NHS Fire safety Health Technical Memoranda (HTM 05-01 / 05-02 / 05-03) ULH policy: - Fire Policy (approved April 2019, due for review April 2022): # Personal Emergency Evacuation Plans (PEEPs), approved April 2017 - Fire safety training (Core Learning, annual) / Fire Warden training / Fire specialist training - Major Incident Plan - Estates Planned Preventative Maintenance (PPM) programme ULH governance: - Trust Board assurance through Finance, Performance & Estates Committee (FPEC) / lead Fire Safety Group (including divisional clinical representation & regulator attendance) / Fire Engineering Group - All areas within the Trust estate are individually risk rated for fire safety (based on occupancy, dependency, height, means of escape), which informs audit / monitoring activity - Local fire safety issues register (generated from local fire risk assessments) - tasks allocated to Estates / local managers, etc. as appropriate; tracked and monitored by Fire Safety Team, validation by Fire & Rescue Service - Weekly fire safety team meetings concerning risk assessments and risk register - Capital risk programme for fire - Reporting of local fire safety incidents (Datix) generated through audit programme - Authorising Engineer for Fire - Health & Safety Committee & site-based H&S committees	Results of fire safety audits & risk assessments, currently indicate: - Fire Risk assessments within Maternity Tower block Lincoln indicating substantial breaches of compartmentation requirements - Fire risk assessments indicate lack of compartmentation within some sleeping risk areas - Age of fire alarm systems at all 3 sites (beyond industry recommendations) - No compartmentation reviews undertaken to provide assurance of existing compliance (all 3 sites) - Concerns with networking of fire alarm system at Pilgrim (to notify Site Duty Manager / Switchboard of alarm activation) Reported fire safety incidents (including unwanted fire signals / false alarms). Fire safety mandatory training compliance rates.	20/06/2022	Quite likely	Extreme	Very high risk	20	- Statutory Fire Safety Improvement Programme based upon risk. - 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. - Capital investment programme for Fire Safety being implemented on the basis of risk. - 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	Rating increased on review to 20 - combustible storage in common areas frequently found (including life lobbys); emerging lessons learned from recent arson incident at LCH (including spread of smoke beyond the room of origin). Actions undertaken recently - IR1s issued to local managers and owners of storage risk, including escalation to senior managers. Setting up task & finish group to look at storage issues. Reviewed all fire risk assessments in Diagnostics across all 3 sites; other FRAs for public areas have also been reviewed. Reviewed all external security patrols and implemented alterations to routes to ensure possible higher risk areas are also patrolled. New tagging points added to patrol routes. Implementation of further required actions continues to progress.	Moderate risk	31/03/2022	31/12/2022	31/07/2022

Appendix A - All active risks rated 15 - 25

ID	Risk Type	Manager	Handler	Lead Oversight Group	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
4647	Reputation	Evans, Simon	Davey, Keiron	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	20/06/2022	Extremely likely	High	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 - PPM reporting for FEG and FSG By Estates Teams - Fire safety team weekly Risk assessment confirm and challenge reviews by Fire safety team - All areas of Trust allocated RAG rating for fire using using occupancy profile, escape provision, height above ground and sleeping risk - Higher rated residual risks from risk assessments being incorporated into risk register	LFR previously served ULH with an Enforcement notice and action plan (since removed) in which the storage of items within corridors was highlighted: "Article 14(2) Emergency Routes and Exits There are combustible materials and items that pose an ignition risk are located on escape routes within the hospital. It required that Corridors and stairways that form part of an escape route should be kept clear of obstruction and hazard free at all times. Items that maybe a source of fuel or pose an ignition risk should not normally be located on any corridor or stairway that will be used as an escape route." In light of identified storage issues and subsequent non-compliance with these requirements, there is now a high potential for immediate enforcement notice with a view to prosecution in accordance with the regulator's compliance code. Task & finish group set up to address storage issues at local and at senior levels. Fire Safety Advisors working with local managers; IR1s reported when storage issues are identified, with escalation to divisional leads where necessary.	Low risk	30/06/2022	31/03/2024	31/07/2022
4858	Service disruption	Parkhill, Michael	Whitehead, Mr Stuart	Water Safety Group	10/02/2022	25	Risk assessments	Corporate	Estates and Facilities	Estates	Pilgrim Hospital, Boston	If there is a critical failure of the water supply to one of the Trust's hospital sites then it could lead to unplanned closure of all or part of the hospital, resulting in significant diruption 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.	10/02/2022	Reasonably likely	Extreme	High risk	15	Regular inspection, automatic meter reading and telemetry for the incoming water main at Pilgrim Hospital. Install additional supply to provide resilience.	Scheme of work and design currently being produced.	Low risk	30/10/2020	31/03/2023	30/06/2022
Strategic Objective						**3b. Efficient use of our resources**																			
4664	Finances	Matthew, Mr Paul	Young, Jonathan		11/01/2022	20	Risk assessments	Corporate	Finance and Digital	Finance	Trust-wide	The Trust has an agency cap of c£21m. The Trust is overly reliant upon a large number of temporary agency and locum staff to maintain the safety and continuity of clinical services that will lead to the Trust breaching the agency cap.	National policy: - Agency spending cap set by Government ULHT policy: - Financial plan set out the Trust limits in respect of temporary staffing spend - Annual budget setting process cascades and apportions the Trust temporary staffing spend limits to the Divisions and Directorates. - Monthly financial management & monitoring arrangements are in place to identify variation temporary staffing financial plans at all levels of expenditure from department up to Trust. - Key financial controls for the use of the break glass agency usage are in place. - Specific staff group temporary staff spend is provided to dedicated Medical and Nursing workforce oversight groups. - Financial review meetings held monthly with each Division to understand and challenge usage of temporary staffing. - Plan for every post information has been embedded to support temporary staff usage forecasts ULHT governance: - The establishment of the Improvement Steering Group will provide general oversight of Trust wide agency reduction schemes - Board assurance through Finance, Performance and Estates Committee (FPEC)	The Trust is monitored externally against an agency cap through the monthly finance return to NHSE/I The Trust monitors internally against its financial plan inclusive of specific targets for agency and bank spend by staff group The cross Trust workstreams are reported to the Improvement Steering Group The Divisional workstreams are reported to the relevant Financial Review Meeting (FRM)	22/06/2022	Extremely likely	High	Very high risk	20	Financial Recovery Plan schemes: - recruitment improvement; - medical job planning; - agency cost reduction; - workforce alignment	The Trust has exited the 21/22 financial year with an agency spend of c£44m. This has in part been driven by COVID pressures and a large number of escalation beds open increasing the requirement for temporary staff. The Trust has agreed an ambitious CIP programme that is heavily focused on agency reductions through the recruitment of staff and reducing the number of NEL beds required. This will take time to embed. Reviewed at RRC&CG - score increased from 16 to 20.	Moderate risk	31/03/2022	31/03/2023	31/03/2022

Appendix A - All active risks rated 15 - 25

ID	Risk Type	Manager	Handler	Lead Oversight Group	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
4665	Finances	Matthew, Mr Paul	Young, Jonathan	Financial Turnaround Group	11/01/2022	20	Risk assessments	Corporate	Finance and Digital	Finance	Trust-wide	The Trust has a £25m CIP target for 22/23. If the Trust fails to deliver The CIP Plan it will have a significant adverse impact on the ability of the Trust and the Lincolnshire ICS to achieve their financial plans.	National policy: - NHS annual budget setting and monitoring processes ULHT policy: - Detailed Financial plan inclusive of the establishments and embedding of the 3 T's; Transactional, Targeted and Transformational. - Alignment of the Trust financial improvement opportunities with system partners to develop an integrated financial plan inclusive of CIP. (Transformational) - Establishment of the service framework to prioritise Speciality improvement reviews. (Transformational) - Establishment of a suite of cross cutting schemes aligned to the Trust Improvement Strategy. (Targeted) - Divisional CIP targets allocated as part of the budget setting process from 1st April. (Transactional) ULHT governance: - Detailed CIP reporting via the CIP tracker supported by QIA process - Programme Management Office (PMO) & dedicated Programme Manager. - Introduction of the Improvement Steering Group to monitor, challenge and hold accountable for the Targeted and Transformational Schemes - Refresh of the FRMs to monitor, challenge and hold accountable for the Transactional Schemes	The Trust is monitored externally against the Trust CIP target through the monthly finance return to NHSE/I The Trust monitors internally against its CIP targets inclusive of specific Divisional and Scheme targets Divisional focus against Transactional schemes is reviewed at the relevant FRM Trust focus against Targeted and Transformational schemes is reviewed at the Improvement Steering Group	22/06/2022	Quite likely	High	High risk	16	- Refresh of the CIP framework and training to all stakeholders. - Increased CIP governance & monitoring arrangements introduced. - Alignment with the Trust IIP and System objectives - CIP is embedded as part of the Trust Improvement Strategy not seen as a separate workstream.	The Trust has delivered its CIP plan for the past 3 years, albeit a reduced requirement during the 2 financial years that cover COVID. The Trust is embedding a new Improvement framework with CIP included within it and is also working with system partners to make financial improvements due to pathway changes. This will take time to embed and alongside the operational pressures, specifically; sickness, excess beds open, rising acuity of patients and continuing rising demand at the front door of the acute Trust is putting at risk in year delivery of the CIP target. Reviewed at RRC&CG - agreed score of 16.	Low risk	31/03/2023	31/03/2023	30/09/2022
4957	Finances	Young, Jonathan	Young, Jonathan		28/06/2022	16	Professional Guidance	Corporate	Finance and Digital	Finance	Trust-wide	The lack of ability of the Trust to eradicate / reduce the costs that were introduced as a consequence of COVID. The national planning assumption is that all COVID costs incurred in Acute settings in relation to COVID will cease from 1st June 2022 aligned to the anticipated reduction in COVID patients to extremely low levels.	National policy: - Government financial planning assumptions due to COVID ULHT policy: - Financial plan set out the Trust Budget allocations in respect of COVID spend - Annual budget setting process cascades and apportions the Trust COVID budgets to the Divisions and Directorates (phased April - May 2022 / 2 months only). ULHT governance: - Monthly financial management & monitoring arrangements are in place to identify variation of COVID spend to financial plans at all levels of expenditure from department up to Trust. - Financial review meetings held monthly with each Division to understand and challenge of COVID services impacts on the cost base. - The Planning and Recovery Steering group will provide oversight of the COVID costs.	The Trust is monitored externally against the COVID impacts through the monthly finance return to NHSE/I The Trust monitors internally against its financial plan inclusive of specific COVID costs into FPEC and onto Trust Board Divisional focus against specific COVID costs is reviewed at the relevant FRM.	22/06/2022	Quite likely	High	High risk	16	Alignment of the Directorate and Divisional budgets to the national strategy for the removal of COVID costs from 1st June 20222. By exception reporting of all COVID costs not removed from financial positions.	The Trust incurred c£13m of direct costs in relation to COVID with a further indirect cost e.g. staff sickness. The national expectation is that the costs of COVID cease from 1st June 2022. This is a significant risk to the delivery of the Trust financial position as the costs have become embedded in the Trust way of working in number of services. E.g. Housekeeping services to improve IPC.	Moderate risk	31/03/2023	31/03/2023	30/09/2022
4384	Finances	Matthew, Mr Paul	Young, Jonathan		24/09/2018	20	Risk assessments	Corporate	Finance and Digital	Finance	Trust-wide	If there is a substantial unplanned reduction in the Trust's income, or missed opportunities to generate income, it could have a significant adverse impact on the Trust ability to achieve the annual financial plan. Failure to deliver the nationally activity targets of 104% of 19/20 planned activity will result in a clawback of an element of the ERF allocation made to Lincolnshire.	National policy: - NHS financial planning and monitoring processes ULHT policy: - Trust and System Financial Plans built from the bottom up Trust Divisional Demand and Capacity Plans. - The Trust national activity submission was aligned to the delivery of 104% activity targets for planned care PODs ULHT governance: - Internal weekly internal Planning and Restoration meetings to review progress - Improved counting and coding, including data capture and missing outcome reductions. - Shared risk and gain share agreements for the Lincolnshire ICS.	The Trust is monitored externally against the Trust activity target through the monthly activity returns. The Trust monitors internally against its activity targets inclusive of specific Divisional and Specialty plans and targets. The Lincolnshire ICS is monitored externally against the system activity target through the monthly activity returns.	22/06/2022	Quite likely	High	High risk	16	Collective ownership across the Lincolnshire ICS of the restoration and recovery of the planned care pathways leading to improved activity delivery. Trust focus to restore services to pre-COVID levels and then stretch to 104%.	The Trust and the Lincolnshire ICS ability to achieve the 104% activity target is a concern. 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 104% activity target. Reviewed at RRC&CG - agreed current score as 16.	Moderate risk	31/03/2023	31/03/2023	31/12/2021
Strategic Objective						**3c. Enhanced data and digital capability**																			
4641	Service disruption	Humber, Michael	Gay, Nigel	Digital Hospital Group	23/11/2021	16	Risk assessments	Corporate	Finance and Digital	Digital Services (ICT)	Trust-wide	If the Trust's digital infrastructure or systems experience an unplanned outage then the availability of essential information for multiple clinical and corporate services may be disrupted for a prolonged period of time, resulting in a significant impact on patient care, productivity and costs	National policy: - NHS Digital Data Security Protection Toolkit (DSPT) and Guidance ULHT policy: - Telecoms infrastructure maintenance arrangements - ICT hardware & software upgrade programme - Corporate and local business continuity plans for loss of access to ICT systems & system recovery ULHT governance: - Digital Hospital Group / Information Governance Group (IGG), accountable to the Finance, Performance & Estates Committee (FPEC) - 5 year capital plan -	- Network performance monitoring - Digital Services reported issues / incidents - Monitoring delivery of digital capital programme - Horizon scanning across the global digital market / supply chain to identify availability issues	19/05/2022	Quite likely	High	High risk	16	- Prioritisation of available capital and revenue resources to essential projects through the business case approval process. - Working with suppliers and application vendors to understand upgrade and support roadmaps. - Assurance mechanisms in place with key suppliers for business continuity purposes - Comprehensive risk assessments to be completed for local service / site specific vulnerabilities so that appropriate action can be taken to manage those risks. - Contingency plans - data centres protected from overheating, fire and flood / water damage risks: Portable air con units kept on site for when needed. Estates work has addressed some leakage issues at Pilgrim. Fire retardant systems in all data centre rooms, routinely serviced by Estates.	Risk reviewed, description amended to reflect broader range of threats to the digital infrastructure. Current score increased to 16. Have purchased a significant number of Radios, to allow communication in the event of failure. We've completed a Network Core Switch replacement at Pilgrim new Data (DC3) at Pilgrim to provide resilience at site backup across site has been improved. Recovery Vault is in the process of implementation The Metro-Cluster is in the process of implementation.	Low risk	31/03/2023	31/03/2023	18/08/2022

Appendix A - All active risks rated 15 - 25

ID	Risk Type	Manager	Handler	Lead Oversight Group	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
4661	Reputation	Warner, Jayne	Warner, Jayne	Information Governance Group	10/01/2022	20	Risk assessments	Corporate	Trust Headquarters	Corporate Secretary		If the required data protection / privacy impact assessment process is not followed consistently at the start of a system change project, then results may not be available to inform decision-making and system development resulting in an increased likelihood of a future data breach that could expose the Trust to regulatory action by the Information Commissioner's Office (ICO)	National policy: - Data Protection Act 2018 - NHS Digital Data Security & Protection Toolkit ULHT policy: - Information Governance Policy (approved May 2018, due for review May 2021) & supporting appendices ULHT governance: - Trust Board assurance via Finance, Performance & Estates Committee (FPEC); lead Information Governance Group - Senior Information Risk Owner (SIRO) / Caldicott Guardian / Data Protection Officer (DPO) / Chief Information Officer (CIO) roles	Internal audit review of data protection / PIA processes	24/03/2022	Quite likely	High	High risk	16	Review of the data protection / privacy impact assessment process and governance, to include education and communication to raise staff awareness of the required process.	Process and documentation reviewed and updated; these are now GDPR compliant. Further action required to address governance issues. Reference to DPIAs in Data Security and Awareness mandatory training. Long standing issue of IG not being made aware of new systems or changes in processes that require assessment under Data Protection legislation. Educating staff across the Trust is required. Changes to legislation due to Brexit means that any data leaving the UK has greater risks associated. If a DPIA is not conducted then this could have an impact on availability of that data.	Low risk	31/03/2022	31/01/2023	30/06/2022

Meeting	*Trust Board*
Date of Meeting	*6 September 2022*
Item Number	*Item 13.2*
Board Assurance Framework (BAF) 2022/23	
Accountable Director	*Andrew Morgan Chief Executive*
Presented by	*Jayne Warner, Trust Secretary*
Author(s)	*Karen Willey, Deputy Trust Secretary*
Report previously considered at	*N/A*

How the report supports the delivery of the priorities within the Board Assurance Framework	
1a Deliver harm free care	*X*
1b Improve patient experience	*X*
1c Improve clinical outcomes	*X*
2a A modern and progressive workforce	*X*
2b Making ULHT the best place to work	*X*
2c Well Led Services	*X*
3a A modern, clean and fit for purpose environment	*X*
3b Efficient use of resources	*X*
3c Enhanced data and digital capability	*X*
4a Establish new evidence based models of care	*X*
4b Becoming a university hospitals teaching trust	*X*

Risk Assessment	*Objectives within BAF referenced to Risk Register*
Financial Impact Assessment	*N/A*
Quality Impact Assessment	*N/A*
Equality Impact Assessment	*N/A*
Assurance Level Assessment	*Insert assurance level* • *Moderate*

Recommendations/ Decision Required	• *Board to consider assurances provided in respect of Trust objectives noting that framework has been reviewed through committee structure*

Patient-centred ◆Respect◆ Excellence ◆Safety◆ Compassion

Executive Summary

The relevant objectives of the 2022/23 BAF were presented to all Committees during August, with the exception of the People and Organisational Development Committee, which did not meet, and the Board are asked to note the updates provided within the BAF.

Assurance ratings have been provided for all objectives including the new 2022/23 objectives 3d, 3e and 3f. Assurance ratings provided have been confirmed by the Committees.

Updates provided to the Committees and offered to the Board are identified by green text.

Red text has been presented in the Board Assurance Framework to demonstrate items proposed for removal, which no longer feature as a project/priority within the year 3 IIP. Through the detailed review process the changes will be confirmed.

The following assurance ratings have been identified:

Objective		Rating at start of 2022/23	Previous month (July)	Assurance Rating (August)
1a	Deliver harm free care	Green	Green	Green
1b	Improve patient experience	Amber	Amber	Amber
1c	Improve clinical outcomes	Amber	Green	Green
2a	A modern and progressive workforce	Red	Red	Red
2b	Making ULHT the best place to work	Red	Red	Red
2c	Well led services	Amber	Amber	Amber
3a	A modern, clean and fit for purpose environment	Amber	Amber	Amber
3b	Efficient use of resources	Amber	Red	Red

3c	Enhanced data and digital capability	Amber	Amber	Amber
3d	Improving cancer services access	N/A	N/A	Red
3e	Reduce waits for patients who require planned care and diagnostics to constitutional standards	N/A	N/A	Amber
3f	Urgent Care	N/A	N/A	Red
4a	Establish new evidence-based models of care	Amber	Amber	Amber
4b	Becoming a University Hospitals Teaching Trust	Red	Red	Red
4c	Successful delivery of the Acute Services Review	N/A	Green	Green

United Lincolnshire Hospitals NHS Trust
Board Assurance Framework (BAF) 2022/23 - August 2022

Strategic Objective	Board Committee
Patients: To deliver high quality, safe and responsive **patient** services, shaped by best practice and our communities	Quality Governance Committee
People: To enable our **people** to lead, work differently and to feel valued, motivated and proud to work at ULHT	People and Organisational Development Committee
Services: To ensure that **services** are sustainable, supported by technology and delivered from an improved estate	Finance, Performance and Estates Committee
Partners: To implement new integrated models of care with our **partners** to improve Lincolnshire's health and well-being	Trust Board

Assurance Rating Key:	
Red	Effective controls may not be in place and/or appropriate assurances are not available to the Board
Amber	Effective controls are thought to be in place but assurances are uncertain and/or possibly insufficient
Green	Effective controls are definitely in place and Board are satisfied that appropriate assurances are available

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
SO1	**To deliver high quality, safe and responsive patient services, shaped by best practice and our communities**												
						Developing a Safety Culture - Programme of work in place to implement the requirements of the National Patient Safety Strategy (culture and systems) Human Factors faculty in place and face to face training restarted. Commencing next steps of cultural work with external agency. Pascale survey work continues to be undertaken. Safe to Say Campaign launched. (PSG)	Further work required in conjunction with People and OD to develop the Just Culture framework.	To be considered as part of the Trust Culture and Leadership Programme	Safety Culture Surveys Action plans from focus groups and Pascal survey findings. Regular update reports to the Patient Safety Group and upwardly reported to QGC and through TLT. Theatre Safety Group reporting progress against a Quality Improvement plan to PSG.	Other divisions due to commence upward reporting to PSG from July 2022.	Where possible, safety conversations have been taking place with staff.		
						Robust Quality Governance Committee, which is a sub-group of the Trust Board, in operation with appropriate reporting from sub-groups. (CG)	None identified.	Not applicable	Upward reports from QGC sub-groups 6 month review of sub-group function Annual review of QGC takes place.	None identified	Not applicable		
						Effective sub-group structure and reporting to QGC in place (CG)	None identified.	Not applicable	Sub-Group upward reports to QGC	None identified.	Not applicable		

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
						IPC policies and procedures are in place in line with the requirements of The Health and Social Care Act (2008). Code of Practice on the prevention and control of infections and related guidance "Hygiene Code" IPCG will retain oversight of the relevant IIP programme of work. (IPCG)	Policies not in line with the requirements of the Hygiene Code and some have not been reviewed and updated.	Planned programme of IPC policy development and update in line with Hygiene Code requirements.	IPC programmes of surveillance and audit are in place to monitor policy requirements. Divisional audit processes with progress and exception reporting to IPCG, IPC Site meetings and IPC related Divisional forums. Associated action and development plan documentation. Very good progress with monthly IPC ratification. Work on decontamination and other estates- related policies. This will lead to compliance of policy aspects of the Hygiene Code	Some aspects of reporting require further development.	Reporting to and monitoring by IPCG and other related forums, e.g. Site meetings.		
						Process in place to monitor delivery of and compliance with The Health and Social Care Act (2008). Code of Practice on the prevention and control of infections and related guidance (IPCG). Infection Prevention and Control BAF in place and reviewed monthly IPCG will retain oversight of the relevant IIP programme of work. (IPCG)	Non-compliance with some aspects of the Hygiene Code.	Premises and facilities Premises Assurance Model (PAM) - 21/22 - take forward as a sub project led by (E&F). Gap Analysis to be compiled and presented quarterly to the IPCG and QGC. IPC policies have been updated / developed / written in line with the timetable. •Estates and Facilities/Decontamination Lead has made good progress with estates and facilities work and is awaiting a place on a specialist decontamination course. • Good progress with achieving and sustaining standards of environmental cleanliness. Potential to remain at amber due to infrastructure concerns & requirement to achieve Very good progress with work to achieve compliance with new National Standards of Cleanliness directive and this continues to be taken forward via a Task and Finish Group with monthly monitoring by the IPCG • Provision of suitable hand hygiene facilities work under the remit of ward enhancement, capital and tap replacement programmes.	IPC programmes of surveillance and audit are in place to monitor policy requirements. Divisional audit processes with progress and exception reporting to IPCG, IPC Site meetings and IPC related Divisional forums. Associated action and development plan documentation	Some aspects of reporting require further development.	Reporting to and monitoring by IPCG and other related forums, e.g. Site meetings.		

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
1a	Deliver high quality care which is safe, responsive and able to meet the needs of the population	Director of Nursing/Medical Director	Failure to manage demand safely Failure to provide safe care Failure to provide timely care Failure to use medical devices and equipment safely Failure to use medicines safely Failure to control the spread of infections Failure to safeguard vulnerable adults and children Failure to manage blood and blood products safely Failure to manage radiation safely Failure to deliver planned improvements to quality and safety of care Failure to provide a safe hospital environment Failure to maintain the integrity and availability of patient information Failure to prevent Nosocomial spread of Covid-19	4558 4480 4142 4353 4146 4556 4481	CQC Safe	Monthly mortality report in place to track achievement of SHMI/Mortality targets (Maintaining our HSMR and improving our SHMI) reporting in to monthly mortality group and upwardly to PSG. Training has been delivered to approximately 40 members of staff to undertake SJR's. Bespoke training and support offered from the Mortality team to the Divisions. (PSG)	Gaps in the number of structured judgement reviews undertaken - this is not across all Divisions, good practice exists and is demonstrated through the mortality group. Impact of Covid-19 on coding triangles	Following the success in UTOO for ACP's contributing to the SJR reviews, further training is going to be rolled out to the MDT.	National Clinical Audits Dr Foster alerts HSMR and SHMI data Medical Examiner screening compliance and feedback Dr Foster data on depth of coding. Dr Foster data is now available.	Gap identified in the ability to draw learning from SJR's due to ongoing delays with completion	Local data sources are used where possible. Gaps in learning mitigated by ME process and escalation of concerns via incident management processes.	Quality Governance Committee	Green
						Robust policies and procedures for incident investigations, harm reviews and assurance of learning (PSG)	Clinical harm review processes not all documented & aligned with incident reporting Recognition of a skills gap for investigations at different levels of the organisation	Implementation of a Clinical Harm Delivery Group reporting into the Clinical Harm Oversight Group which is a sub-group of QGC. Appointment of a Clinical Harm and Mortality Manager Investigation training will be addressed as part of the implementation of the PSIRF and National Patient Safety Strategy. Plan to refocus PRM with a specific focus on quality and safety.	Incident Management Report Quarterly harm report to PSG Bi-weekly executive level Serious Incident meeting Learning to Improve Newsletters Patient Safety Briefings Divisional Integrated Governance reports Strong divisional reporting to MORALs	Divisional reporting to PSG has commenced although this is not yet embedded.	Divisions present focussed pieces of work to PSG on issues that arise based on the data received. There is strong Divisional representation at PSG each month.		
						Process in place to ensure safe use of surgical procedures (NatSIPs/LocSIPs) (PSG)	Lack of assurance regarding progress of implementing NatSIPs/LocSIPs within the Trust although progress is now being made within all four Divisions. Operational pressures continues to impact on delivery.	Individual Divisional meetings now in place; quarterly reporting to PSG Additional support provided to medicine from the Patient Safety Improvement Team	Audit of compliance	Audit of compliance not currently in place - under development at present.	Review will occur through the Divisional meetings with quarterly reporting to PSG. Links now in place with the Clinical Audit team to progress.		
						Medicines Quality Group in place with a focus on reducing medication errors 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 and MMT&FG will retain oversight of the relevant IIP programme of work, including DKA. (MQG & MMT&FG)	Lack of e-prescribing leading to increase in patient safety incidents due to medication errors Gaps identified within the recent internal audit undertaken by Grant Thornton	Replacement of manual prescribing processes with an electronic prescribing system; improvements to medication storage facilities; strengthening of Pharmacy involvement in discharge processes. Medical Director led Medicines Management Task & Finish Group convened to ensure the required pace and progress of delivery of the Improving the Safety of Medicines Management IIP. Divisional representation at the Task & Finish Group confirmed as Divisional Clinical Director or Divisional Nurse. Action / Delivery Group also in place and meeting fortnightly to progress actions and reporting to the Task & Finish Group.	Upward Report from the Medicines Quality Group to QGC Routine analysis and reporting of medication incidents and outcomes from medicines audits in to Medicines Quality Group	Medicines Quality Group have not been receiving reports regarding progress with the medicines management IIP; there has been a lack of Divisional attendance at the Medicines Quality Group	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		

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						Maternity & Neonatal Oversight Group (MNOG) in place to have oversight of the quality of maternity & neonatal services and to provide assurance that these services are safe and in line with the National Safety Ambition / Transformation programme. MNOG will retain oversight of the implemention of the relevant IIP programme of work. (MNOG)	Issues with the environment. Ongoing difficulties with the Maternity Medway system which has the potential to impact on compliance with the CNST Year 4 Safety Actions.	External independent input in to SI process. Thematic review of SIs and complaints undertaken - recommendations being progressed as part of the Maternity & Neonatal Improvement Plan. Improvements to the environment to be completed as part of planned ward refurbishment. Team to continue to liaise with E&F to resolve and immediate issues as they arise ensuring escalation where delays are encountered. Issues with the Medway system being progressed at local and system level.	Monthly Maternity & Neonatal Assurance Report. Maternity & Neonatal Improvement Plan. Executive & NED Safety Champions in place and work closely with local Safety Champions. NHSE/I appointed MIA in place and supporting the Trust - monthly reports of progress to MNOG. Validation of the implementation & embedding of the Ockenden IEAs has been provided by the regional maternity team. There is a process in place for ongoing testing through supported site visits.	Additional assurance required in respect of training compliance (recovery of women following GA) - trajectory agreed.	Monitoring of compliance against trajectory for recovery training occurs through MNOG.		
						Appropriate policies and procedures in place to recognise and treat the deteriorating patient, reported to deteriorating patient group and upwardly to PSG and QGC. Deteriorating Patient Group set up as a sub group of the Patient Safety Group to identify actions taken to improve; has its own sub-groups covering NIV; AKI; sepsis; VTE;DKA (Ensuring early detection and treatment of deteriorating patients) (PSG)	Number of incidents occurring regarding lack of recognition of the deteriorating patient Maturity of some of the sub-groups of DPG not yet realised Observation policy has now been reviewed and is out for approval.	Observation policy ready to go to next NMAAF Fluid management policy approved by DPG/PSG and awaiting approval at NMAAF Deteriorating Patient Group set up as a sub group of the Patient Safety Group to identify actions taken to improve; has its own sub-groups covering NIV; AKI; sepsis; VTE; DKA	Audit of response to triage, NEWS, MEWS and PEWS Sepsis Six compliance data Audit of compliance for all cardiac arrests Upward reports into DPG from all areas	Identified at PSG that further work is required to breakdown incident categories pertaining to the deteriorating patient.	Deep dive commissioned at PSG for presentation to the April meeting.		
						Ensuring a robust safeguarding framework is in place to protect vulnerable patients and staff (Ensuring a robust safeguarding framework is in a place to protect vulnerable patients and staff) (SVOG)	New funding needed to continue restraint training delivery. Business case being developed in conjunction with conflict resolution team and will be presented to QGC within next 2 months. Further work has taken place with LPFT to consider a joint approach to training - awaiting options paper from LPFT	Updated policy & training in use of chemical restraint / sedation; strengthening of pathways & training to support patients with mental health issues	Upward reporting from Mental Health/ Learning Disability and Autism Oversight Group	No active Restraint training available within the trust	Small business case paper being submitted for funding decision at the end of March 2022 - if successful plan to start training delivering in July 2022. Adhoc session being delivered to Security providers to ensure appropriately trained Datix being monitored by safeguarding team to ensure review of any restraint incidents		

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						Appropriate policies in place to ensure CAS alerts and Field Safety Notices are implemented as appropriate. (PSG)	Gap in current policy identified meaning that not all responses from divisions are received / recorded. Improvement demonstrated in the number of overdue alerts	New group meeting to address CAS/FSN policy implementation with key stakeholders. Any relevant alerts are also discussed at gold as appropriate.	Quarterly report to PSG with escalation to QGC as necessary. Compliance included in the integrated governance report for Divisions.				
						Appropriate policies and procedures in place to reduce the prevalence of pressure ulcers, including a Skin Integrity Group (NMAAF)							
						Formal governance processes in place within divisions, including regular meetings and reporting, supported by a central governance team Formal role description and network in place for Clinical Governance Leads(CG)	Training provision for Divisional Clinical Governance Leads	Role based TNA being devised for Clinical Governance leads	Minutes of Divisional Clinical Governance meetings with upward reporting within the Division Divisional Integrated Governance Report Support Offer in place from the central CG team for the Divisions	Minutes demonstrate some Divisional Clinical Governance meetings need strengthening	Implementation of standard ToR, agendas and reporting		
						Robust process in place to monitor delivery against the CQC Must Do and Should Do actions and regulatory notices (Delivering on all CQC Must Do actions and regulatory notices) (CG)			Monthly report to QGC and Trust Board on Must and Should dos				
						Patient Experience Group, which is a sub-group of the Quality Governance Committee, in place meeting monthly Robust Complaints and PALS process in place (PEG)	Patient Experience Group reinstated in its new format and ToR, the group needs to develop its maturity Meeting stood down due to operational pressures. The group meets monthly, has developed a work reporting plan Papers reviewed and Chair's report provided. Any risks to quality and safety are discussed at the relevant cell meeting, e.g., quality cell and issues escalated to gold as appropriate. Quality Impact Assessments undertaken as part of the response to operational pressures are discussed at the quality cell.		Upward reports to QGC monthly and responds to feedback Review of ToR in July 2021. Quarterly Complaints reports identifying themes and trends presented at the Patient Experience Group Patient Experience Group upward report	Divisional assurance reports to PEG providing limited assurance; further work needed to improve this. Will be monitored through PEG.	Head of Pt Experience revising divisional assurance report template and have discussions with divisional clinical leads re: requirements for the reports. Template approved through PEG Nov 21		

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1b	Improve patient experience	Director of Nursing	Failure to provide a caring, compassionate service to patients and their families Failure to provide a suitable quality of hospital environment	3688 4081	CQC Caring	Patient Experience & Carer plan 2019-2023 (PEG)	Number of objectives in the plan paused due to Covid Pandemic; this means the plan need a full review.	Objectives being reviewed with updated timeframes going forward for inclusion in the IIP and other improvement plans at Directorate level. Patient & Carers Experience Plan to be reviewed by end Sept 21 and present to Oct PEG	Patient Experience & Carer Plan progress report to Patient Experience Group and IIP Support and Challenge meetings with monthly highlight reports.	Limited assurance until the plan is reviewed.	Plan is being reviewed with a draft final date of end of January 22.	Quality Governance Committee	Amber
						Quality Accreditation and assurance programme which includes section on patient experience. (PEG)	Lack of alignment of findings in accreditation data to patient experience plans. Ward / Dept review visits paused due to operational pressures	Head of pt experience to have access to accreditation data. Deep dives into areas of concern as identified in quality meetings and accreditation reports. Update reports to PEG and QGC as required. Matrons audits continue to take place. Any risks to quality and safety identified are discussed at the quality cell and issues escalated to gold as appropriate.	Reports to PEG and upwardly to QGC	Ward / Dept review Visits are cancelled when the organisation is in surge. However, weekly spot checks and matron audits continue.	Scheduled review visits for the year. Pt Experience team to have sight of hotspots / concerns and can in-reach to provide support.		
						Redesign our communication and engagement approaches to broaden and maximise involvement with patients and carers (PEG)	Reaching out project (Hard to Reach groups) still in development; diversity of current patient representatives and panel members is narrow; 15 new panel members recruited; contact still to be made with some community groups. Experts by Experience group slow to gain traction and engagement.	Patient Panel has agenda and representatives that attend Patient Experience group to feedback and ensure continuity of messaging Sensory Loss group upwardly reports to Patient Panel.	Upward reports and minutes to the Patient Experience Group IIP reporting to Support & Challenge group.	Diversity of patient engagement and involvement.	CCG exploring dev of a Health Inequalities cell to combine efforts in reaching out. Date not yet secured. ULHT Experts by Experience project progressing with Mastalgia Expert ref group (ERG)established, Cancer Board recruiting 2022 discussions continue with Gastro & CYP (Expert Families).		
						Care after death / last offices Procedure & Guidelines Sharing information with relatives Visiting Procedure Patient information (PEG)	Inconsistency in applying end of life visiting exceptions.	Exceptions guidance re-issued. Monitor through complaints & PALs.	Report to PEG through complaints & PALs reports; upward reports from Visiting Review working group. Visiting experience section within complaints & PALs reports.		Complaints/PALs reports to include visiting concerns; div ass reports to include visiting related issues. Visiting review indicates inconsistency in EoL visiting; criteria and process being strengthened. Request to ME's to ask relatives about visiting experience at EoL.		
						Inclusion Strategy in place (PEG)	Lack of diversity in patient feedback and engagement	Equality, Diversity and Inclusion Lead is member of Patient Experience Group.	EDI 1/4rly report to PEG;	EDI Reports not being received by PEG	Head of Pt Experience to discuss with EDI lead to agree a way forward. Head of Pt Experience & EDI lead meeting to agree a way forward. Links to Reaching Out IIP project.		

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						Robust process in place for annual PLACE inspection accompanied by PLACE LITE (PEG)	PLACE Lite Process needs to be embedded as Business as Usual	PLACE Lite visits are being scheduled for the year across the organisation.	PLACE report to go to Patient Experience Group quarterly and upwardly reported to QGC	National PLACE programme currently paused due to pandemic;	PLACE Lite continues & reports to PEG.		
						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 including the embedding of the SAFER bundle.							
1c	Improve clinical outcomes	Medical Director	Failure to provide effective and timely diagnosis and treatment that deliver positive patient outcomes	4558	CQC Responsive CQC Effective	Clinical Effectiveness Group in place as a sub group of QGC and meets monthly (CEG). CEG works to an annual work programme and standard agenda to ensure that all business is covered appropriately. Upward reports are received from reporting groups. Quality of reporting into CEG has improved and is increasingly robust.	Issued identified with ensuring appropriate clinical engagement at the meetings.	Review of Terms of Reference to be undertaken. Invites to speakers to come direct from Mr Simpson as Chair of the Group in future.	Effective upward reporting to QGC from reporting groups.	Divisional reports still in their infancy.	Verbal updates provided by divisional representatives at the group.	Quality Governance Committee	Green
						Getting it Right First Time Programme in place with upward reports to CEG and QGC. Agreement in place recommencement of the of the GIRFT Programme (CEG)	Recognition that the Trust has made the decision that the GIRFT programme will be restricted to those areas relating to high volume, low complexity (HVLC) and areas seeking to focus on elective recovery.	Quarterly reports to Clinical Effectiveness Group GIRFT team in place to support divisions and ensure that appropriate activity takes place.	Upward reports to QGC and its sub-groups KPIs in the integrated governance report Process in place for feedback to divisions	Current reporting has tended to focus on process rather than improved outcomes.	Request from CEG for future reports to show improved outcomes as a result of GIRFT activity.		
						Clinical Audit Group in place and meets monthly (CAG) with quarterly reports to QGC (CEG)	There are outstanding actions from local audits Due to operational pressures, quoracy has been an issue.	Audit Leads present compliance with their local audit plan and actions. Support being provided from central team to close outstanding overdue actions Job role description for Clinical Audit Leads has been developed and workshops planned with leads, led by the Medical Director.	Reports generated for Clinical Audit group and CEG detailing status of local audits and number of open actions	Clinical Audit Leads may not attend to present their updates meaning that reporting to QGC is not as up to date as expected.	Rolling attendance in progress and names of Clinical Audit Leads not attending will be escalated to the Triumvirate Meeting to take place with Medical Director and Audit Leads to discuss role and expectations, however attendance has been impacted by operational pressures.		
						National and Local Audit programme in place and agreed (CEG) - signed off by QGC. Improved reporting to CEG regarding outcomes from clinical audit (CEG)	None identified.	Not applicable	Reports from the National Audit Programmes including outlier status where identified as such Relevant internal audit reports Reports identify where practice has improved but also where it has not improved.	None identified	Not applicable		

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						Process for monitoring the implementation of NICE guidance and national publications in place and upwardly reported through QGC (CEG)	There are sometimes delays in the completion of the gap analysis for the Clinical Guidelines.	Process in place for escalation if required within the Clinical Divisions.	Reports on compliance with NICE / Tas demonstrating improved compliance.	None identified	Not applicable		
						Process in place for taking part in the Patient Related Outcome Measures (PROMs) project (CEG)	None identified.	Not applicable	Quarterly reports to CEG and upwardly reported to QGC	Business Units not sighted on their performance due to national reporting being stood down during COVID-19	National reports to be presented at Governance Meetings once produced		
						Process in place for implementing requirements of the CQUIN scheme.	Plans not fully formed for implementation of 2022/23 CQUINs	CQUIN delivery group commenced again.	Quarterly reports to CEG and upwardly reported to QGC	Some gaps identified in reporting processes.	Being dealt with via the CQUIN delivery group		
						Quarterly Learning Lessons Newsletter in place at both Division and Trust wide level (CEG)	Staff may not access emails to review newsletters	Programme of work commencing regarding wide ranging mechanisms for learning lessons across the Trust.	Evidnce of newsletters shared is available.				
SO2	**To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT**												
						NHS people plan & system people plan & five themes:- - Looking after our people - Belonging in the NHS - New ways of working & delivering care - Growing for the future - Leadership and Lifelong Learning (from 2022/23)	Awaiting sign off of system people plan (delivery plan reviewed and objectives agreed annually in Q4)	System People Team System Workforce Cell	System PP - Each 'pillar assigned system lead Progress/assurance reported to People Board (quarterly) Reported progress on the implementation of the NHS People Plan and the Lincolnshire System Workforce Plan Setting priorities 22-23 - away day (18/03)		Presentation of system progression and oversight being delivered to PODC on 15th March 2022. A day planning session has been held for the 22/23 priorities which are being presented at the next People Board for signoff in April 2022. The proposals and objectives for 22/23 were approved by People Board in April and a further time out is planned with the system leads to agree next steps/KPI's etc. A further time out was held with agreement made on top 3 priorities and how the delivery against these will be measured.		
						Workforce planning and workforce plans	Overall vacancy rate declining but increasing for clinical roles.	IIP Project - Embed robust workforce planning and development of new roles	Workforce plans submitted for H2 2021/22 Operational Planning. Recruitment plans are in place. Divisional Recruitment Pipeline Reports are refreshed regularly for each division.	Some areas remain hard to fill and therefore difficult to fully mitigate risk. Challenges in obtaining meaningful information from Trac, due to Recruitment team capacity issues.	Regular reviews take place with Divisions through workforce analyses and a plan for every post; alternatives and workforce mix are considered and where national workforce shortages identified then focus is on overseas recruitment. Current workforce planning being undertaken in conjunction with our SHRBP and finance colleagues. Draft narrative have been prepared to support the workforce requirements for the Trust, further work is required to align to activity demand and capacity before the final submission date. We continue to work closely with Strategy & Planning team and discussions with services, via service leads and Managing Directors. Working towards triangulation between workforce, finance and activity and weekly technical meetings have been established to bring teams together to interrogate		

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											teams together to interrogate the data. Deep dive into plan for every position with the Divisions, particularly for medical recruitment, which will be built into the plan. First draft to be prepared for Tuesday 7th June, for a 13th June submission. The workforce plan was submitted as per the above deadline and work now begins in terms of how we as a Trust measure the deliverables set against the plan with HR/Finance and Planning.		
			Vacancy rates rises Turnover increases			Recruitment to agreed roles - plan for every post		Pipeline report shows future vacancy position International nurse recruitment & cohort recruitment	Internal Audit - Recruitment follow up Performance Dashboard developed offering accurate and timely information to all appropriate managers and staff		Recruitment deep dive continues with the support of the new Head of Recruitment. Additional resource has also been brought into the recruitment team with NLAG providing additional training support. Support is being received from NHSI/E and additional capacity has now been recruited to support the cohort recruitment of HCSW. A review of the process around how we recruit consultants to the Trust has also commenced. Additional training has been provided for the Recruitment team from NLAG and training from TRAC is due to take place in April. Additional training has been completed by the Recruitment team with support from NLAG. Work continues to 'relaunch' recruitment processes with a dedicated recruitment calendar of activity being produced alongside the launch of new recruitment standards and processes to improve the employment journey with a new recruitment landing page currently being created.		

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2a	A modern and progressive workforce	Director of People and Organisational Development	Sickness absence rises Under-investment in education & learning Failure to engage organisation in continuous improvement Failure to transform the medical & nursing workforce	4362	CQC Safe CQC Responsive CQC Effective	Focus on retention of staff - creating positive working environment and intergration of People Promise 'themes' System retention role established (8B - 12 month) Temp/12 month fixed term People Promise Manager appointed (Liz Smith - ULHT) from end May 2022	IIP projects on hold	IIP Projects Appraisal - deep dive - Dec21 Mandatory training - currently in scope for reset Talent management - on hold	Regional Midlands Talent Board Model Employer ambition appraisal/mandatory training compliance	Appraisal and training compliance levels not at expected level		People and Organisational Development Committee	Red

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						Embed continuous improvement methodology across the Trust		Training in continuous improvement for staff - To be discussed following review of development offer (on hold)					
						Reducing sickness absence	Sickness absence rate higher than average	Embedding of AMS	Sickness/absence data Turnover rates Vacancy rates	Various reports (Sitrep, Gold, STP) unable to offer absolute assurance due to both the national picture and the Critical level the Trust is operating under.	The reports are run daily and any abnormalities are considered in the context of the national and regional position. The pandemic and the critical incidents the Trust is in has impacted on usual trends. AMS data is reviewed regularly and reported into Divisions on accuracy. Data currently for absence is inline with national reporting. AMS Project is being relaunched with a training roll-out plan and SHRBP support. The AMS project has been relaunched and additional capacity identified. Training has started to be rolled out with divisions and a position paper is currently being prepared. Reporting will start to feature as part of the Workforce Cell meetings and monthly one to ones with key HR staff. Work continues to highlight absence stats through the PRM meetings via the SHRBP's and AMS have presented an overview of the reporting functionality to HR and Trust executives which will move forward in terms of deep dives into the data available.		
						Ensuring access to the personal and professional development that enables people to deliver outstanding care and ensures ULHT becomes known as a learning organisation Establish ULHT Education and Learning service (pending P&OD restructure)	IIP projects in early stage of delivery	IIP projects - education and learning Subject area/work programme under review. Work underway to 'scope' requirements, including interface with Education	Reported progress on the implementation of the NHS People Plan and the Lincolnshire System Workforce Plan NB New indicators being developed for the 21/22 financial year System LEAD (Learning, Education and Development) Board to provide system oversight (agreed)				

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						Creation of robust Workforce Plan • Values based recruitment and retention • Maximising talent management opportunities • Create an environment where there is investment in training and a drive towards a career escalator culture – 'earn and learn'			Improved vacancy rates				
						Improve the consistency and quality of leadership through:- • Improved mandatory training compliance • Improved appraisals rates using the WorkPal system • Developing clear communication mechanisms within teams and departments			Appraisal rates and training development				
						Providing a stable and sustainable workforce by:- • Ensuring we have the right roles in the right place through strong workforce planning • Reducing vacancy rates and ensuring that posts are filled through a positive and values recruitment approach • Reducing our agency staffing levels/spend • Strengthening the Medical Workforce Job Planning processes							
						NHS People Plan & System People Plan & five themes:- - Looking after our people - Belonging in the NHS - New ways of working & delivering care Growing for the future	Awaiting sign off of system people plan Delivery of IIP projects in early stage of delivery	People Plan - in draft System EDI Strategy underway 5 pillar -leads confirmed (ULHT Lead for leadership and lifelong learning)			Linked to delivery of the system People Plan agenda as above.		
						Reset and alignment of Trust values & staff charter (with safe culture) Reset ULH Culture & Leadership	Comprehensive follow up and prioritisation of NSS results - key areas of concern identified for action 7 point action plan presented and agreed to ELT/TLT	Leading Together Forum - regular bi-monthly leadership event Delivery Plan and actions to be confirmed further to results of Leadership Survey LTF Forward Plan Leadership SkillsLAB - essentials in management and leadership for existing managers	Culture and Leadership Programme Group upward report	Delivery of agreed output	Improved function of group and reporting to be in place for November report		

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2b	Making ULHT the best place to work	Director of People and Organisational Development	Further decline in demand Weak structure (to support delivery) Lack of resource and expertise Failure to address examples bullying & poor behaviour Lack of investment or engagement in leadership & management training Perceived lack of listening to staff voice Under-investing in staff engagement with wellbeing programme Failure to respond to GMC survey Ineffectiveness of key roles Staff networks not strong	4083	CQC Well Led	Effective communication mechanisms with our staff - ELT Live, managers cascade, intranet etc.		Reviewing the way in which we communicate with staff and involve them in shaping our plans	Staff survey feedback - engagement score, recommend as place to work			People and Organisational Development Committee	Red
						Leadership & Management training. (Improving the consistency and quality of leadership and line management across ULHT) Leadership SkillsLab - launched June'22		Leadership SkillsLab - launched June'22	Pulse surveys - " Have your say" Number of staff attending leadership courses		Proposal to be shared with ELT (Dec'21): gradual introduction of L&M activities NB. L&M apprenticeship on going		
						Lincs Belonging Strategy EDI Delivery Plan 2022-25	EDI Group (report to PODC) live from Dec 2021 Reset of ULHT EDI objectives 22-25 (PSED) from Jun'22	EDI Group membership reset - to ensure representation and coverage	Council of Staff Networks Internal Audit - Equality, Diversity and Inclusion NHS NNSS	WRES/ WDES	WRES action plan WDES action plan WRES/WDES and Internal Audit actions being monitored through Committee. The Trust has committed to implement and embed the Leading Inclusively with Cultural Intelligence (CQ) programme across the Trust and develop a social movement of intentionally inclusive leaders. A launch event has been held for CQ and masterclass sessions now created for members of the Trust leadership team to enrole. Work continues for the creation of a dedicated intranet website and members page.		
						Staff networks	Some staff networks stronger than others	Continued work to embed the networks and provide them with effective support Following recruitment of new SN Chairs - agree Universal Terms of Reference Support groups in developing strategic objectives for the next 12 months	Protect our staff from bullying, violence and harassment - measure through National Staff Survey		Governance for EDI Recruitment process for SN Chair/VC - Feb'22		

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						Demonstrate that we care and are concerned about staff health and wellbeing		EAP implementation from May'22	System Health & Wellbeing Board Linc People Board	OH KPIS to be agreed (for reporting to PODC) System Hub activity Wellbeing activity (upward report to PODC)	Commence reporting from 2022		
						Focus on junior doctor experience key roles:- - Freedom to speak up Guardian - Guardian of safe working - Well-being Guardian		Junior doctor forum	Dedicated resource in place for GOSW and FTSUG. Trust Chair has taken role of Well being Guardian. Reports being provided from GOSW and FTSUG. JNR doctor survey findings being seen at Committee. GOSW and FTSUG invited in person to Committee		Junior Dr Survey results (alignment with NNSS21 findings)		
						Embed a compassionate leadership approach through our Culture & Leadership Programme			Improved Pulse survey results				
2c	Well led services	Chief Executive	Current risk register configuration not fully reflective of organisations risk profile Current systems and processes for policy management are inadequate resulting in failure to review out of date or policies which are not fit for purpose	4277 4389	CQC Well Lead	Delivery of risk management training programmes 4 sessions during Oct / Nov 21 Risk Register Confirm and Challenge Group ToRs Upgrade to datix system Full Risk Register review	Updated Policy and Strategy document for approval at December 21 Risk Register Confirm and Challenge meeting - Meeting Cancelled Covid pressures	Consider at January meeting	Third party assessment of well led domains Internal Audit assessments Risk Management HOIA Opinion received and Audit Committee considered in June noting 'partial assurance with improvement required can be given on the overall adequacy and effectiveness of the Trust's framework of governance, risk management and control. Completeness of risk registers Annual Governance Statement			Audit Committee	Amber
						Shared Decision making framework			Number of Shared decision making councils in place	8 councils established. Target for 2021 was 6			

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						Implementing a robust policy management system Additional resource identified for policy management post Reports on status by division and Directorate Updated Policy on Policies Published Guidance on intranet re policy management reviewed and updated	Move of policies in to SharePoint reliant on progress with Trust intranet. Timeline delayed through Covid Review of Divisional policy status reports not progressed due to covid pressures	Review of document management processes New document management system - SharePoint Reports generated form existing system All policies aligned to division and directorates Single process for all polices clinical and corporate	Fortnightly ELT report monitoring actions. Quarterly report to Audit Committee including data on in date policies CQC Report - Well Led Domain				
						Ensure system alignment with improvement activity							
SO3	**To ensure that services are sustainable, supported by technology and delivered from an improved estate**												
3a	A modern, clean and fit for purpose environment	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)	3720 3520 3688 4403 3690	CQC Safe	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.	Interim case for £9.6M of CIR continues in to 2021/22. Will reflect priority areas in the Estates Strategy 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.	Capital Delivery Group Highlight Reports Compliance report to Finance, Performance and Estates Committee Updates on progress above linked to the estates strategy.	Infrastructure case has tackled £9.6M of the overall £100m+ backlog in first year. Future years will at most tackle £20m of backlog in any given year	Estates improvement and Estates Group review compliance and key statutory areas. Progress against Estates Strategy/Delivery Plan and IIP Delivery of 2021/22 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.	Finance, Performance and Estates Committee	**Amber**
						Continual improvement towards meeting PLACE assessment outcomes	PLACE assessments have been suspended and delayed for a period during COVID	Use of PLACE Light assessments and other intelligence reports.	PLACE Light Assessments	PLACE/Light do not provide as deep an assurance review as PLACE with limited input.	Combination of PLACE Light and other intelligence (IPC Group/Compliance Reports and Capital Delivery Group) will help triangulate areas of concern and response.		
						Review and improve the quality and value for money of Facility services including catering and housekeeping	Value for Money schemes have been delayed during COVID		MiC4C cleaning inspections Staff and user surveys 6 Facet Surveys	6 Facet Survey are not recent and require updating. 6 facet survey review commencing in Jan 22. Specification drafted for full 6 facet survey with tender process to start in Jan 22	IPC Cell/Group and upward reporting of cleanliness is reported through to QGC. Water Safety and Fire Safety Groups will report through alongside Health and Safety Groups to relevant sub-committees and provide a more comprehensive view offering assurance were it is possible and describing improvement where it is not. The appointment of Authorised engineers in key statutory areas will give responsible person/Executive arms length oversight of assurance gaps to fill. Review of 6 Facet Surveys will commence as part of HIP Bid (Referral in Estates Strategy)		

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						Continued progress on improving infrastructure to meet statutory Health and Safety compliance	H&S Committee Previously not run with quoracy. However now reviewed with ToR agreed and Quorate with staffside representation	Water/Fire safety meetings are in place and review of controls are part of external validation from authorised engineers. Health and Safety Committee new terms of reference approved and now chaired by Chief Operating Officer/Director of Estates and Facilities. Upward reporting to Finance, Performance and Estates Committee Med gas, Critical ventilation, Water safety group, electrical safety group, medical gas group have all been established and include the relevant authorising engineers in attendance. These groups monitor and manage risks and report upwards any exceptions or points of escalation.	Reports from authorised engineers Response times to urgent estates requests Estates led condition inspections of the environment Response times for reactive estates repair requests Progress towards removal of enforcement notices Health and Safety Committee upward report				
						Implement Year 1 of our Estates Strategy							
						CIP - Refresh of the CIP framework and training to all stakeholders. Increased CIP governance & monitoring arrangements introduced. Alignment with the Trust IIP and System objectives CIP is embedded as part of the Trust Improvement Strategy not seen as a separate workstream.	Operational ownership and delivery of efficiency schemes Detailed delivery plans supported by clear timelines and metrics	Divisional FPAM to provide oversight of Transactional CIP reporting upward into PRMs, Trust wide oversight for Targeted and Transformational schemes in the Improvement Steering Group, System oversight of organisational cross cutting schemes.	Delivery of the Trust CIP target	Ability of clinical and operational colleagues to engage due to service pressures. Evidence of system and Trust schemes to reduce the operational pressures and beds numbers in the Trust. Traction in year to produce cost out from cross cutting targeted and transformational schemes	Divisional - Progress is being reviewed monthly with Divisions through FPAMs. Trust wide improvement schemes - Progress is being reviewed monthly with Exec, Divisional and Corporate teams through the Improvement Steering Group. System wide - Progress is being reviewed monthly with system partners including Exec, Operational and Corporate teams through various forums.		
			Not identifying and then delivering the required £29m CIP of schemes The Trust is overly reliant upon	4382 (CIP) - Risk rating 16		Inflation - The Trust is working to actively manage its contracts and to flag excess inflation due to market conditions as part of the national collection process in relation to this spend area	Impact of unstable market conditions led to the Trust forecasting excess inflation of £5.8m in its 2022/23 financial plan, primarily in relation to Utility costs but also impacts in other non-pay contracts. As prices continue to rise may be unable to mitigate these cost increases.	Financial plan set out the Trust expectation in respect of inflation aligned to the national allocations Annual budget setting process cascades and apportions the Trust inflation allocation to Divisions and Directorates. Monthly financial management & monitoring arrangements are in place to identify variation of excess inflation against financial plans at all levels of expenditure from department up to Trust. The Trust actively manages its external contracts to ensure value for money.	The Trust is monitored externally against the inflation impacts through the monthly finance return to NHSE/I The Trust monitors internally against its financial plan inclusive of specific inflation forecasts Divisional focus against specific contracts (e.g. Utilities) is reviewed at the relevant FPAM	Forward view of market conditions.	Internally through FPAMs and upwards into FPEC. Externally through greater dialogue with suppliers and proactive contract management		

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3b	Efficient use of our resources	Director of Finance and Digital	a large number of temporary agency and locum staff to maintain the safety and continuity of clinical services. The national impact of rising inflation (specifically utilities) in excess of the levels assumed in the 22/23 financial settlements The lack of ability of the Trust to eradicate / reduce the costs that were introduced as a consequence of COVID. Failure to deliver the nationally activity targets of 104% of 19/20 planned activity will result in a clawback of an element of the ERF allocation made to Lincolnshire. Substantial unplanned reduction in the Trust's income, or missed opportunities to generate income	rating 16 4383 (Reliance on agency) - Risk rating 20 TBC (Inflation impact) - Risk rating 6 4384 (ERF Clawback) - Risk rating 16 TBC (COVID costs) - Risk rating 16	CQC Well Led CQC Use of Resources	Agency - Financial Recovery Plan schemes: Recruitment improvement; Medical job planning; Agency price reduction; Workforce alignment	Reliance on temporary staff to maintain services, at increased cost Management within staff departments and groups to funded levels. Maximisation of below cap framework rates Rapid ability to on-board temporary staff to substantive contracts	Proposed centralised agency & bank team. Workforce Groups to provide grip Improvement Steering Group to provide oversight	Delivery of the planned agency reduction target.	Granular detailed plan for every post plans. Rotal and job plan sign off in a timely manner Large scale recruitment plans to mitigate vacancies.	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 FPAM The staff areas of key focus - Medical and Nursing are reported through their Workforce Groups	Finance, Performance and Estates Committee	Red
						ERF clawback - Collective ownership across the Lincolnshire ICS of the restoration and recovery of the planned care pathways leading to improved activity delivery. Trust focus to restore services to pre-COVID levels and then stretch to 104%.	Maximisation of the Trust Resources - Theatre and Outpatient productivity. Impact of the COVID patients and flow on availability of beds to provide capacity. Ability to recruit and retain staff to deliver the capacity.	Internal weekly internal Planning and Restoration meetings to review progress Improved counting and coding, including data capture and missing outcome reductions. Shared risk and gain share agreements for the Lincolnshire ICS.	Delivery of the 104% target	The operational pressures, specifically; sickness, excess beds open, rising acuity of patients and continuing rising demand at the front door of the acute Trust is putting at risk in year delivery of the 104% activity target.	The Trust is monitored externally against the Trust activity target through the monthly activity returns The Trust monitors internally against its activity targets inclusive of specific Divisional and Specialty plans and targets The Lincolnshire ICS is monitored externally against the system activity target through the monthly activity returns		
						COVID costs - The lack of ability of the Trust to eradicate / reduce the costs that were introduced as a consequence of COVID.	The national expectation is that the costs of COVID cease from 1st June 2022. This is a significant risk to the delivery of the Trust financial position as the costs have become embedded in the Trust way of working in number of services. E.g. Housekeeping services to improve IPC.	Financial plan set out the Trust Budget allocations in respect of COVID spend Annual budget setting process cascades and apportions the Trust COVID budgets to the Divisions and Directorates (phased April - May 2022 / 2 months only). Monthly financial management & monitoring arrangements are in place to identify variation of COVID spend to financial plans at all levels of expenditure from department up to Trust. Financial review meetings held monthly with each Division to understand and challenge of COVID services impacts on the cost base. The Planning and Recovery Steering group will provide oversight of the COVID costs.	Cease or approved COVID costs continuation as part of the Trust investment prioritisation process.	Correlation between the response to COVID and the new cost base. Ability to remove COVID costs at pace. Prevalence of COVID patients in the Trust.	The Trust is monitored externally against the COVID impacts through the monthly finance return to NHSE/I The Trust monitors internally against its financial plan inclusive of specific COVID costs into FPEC and onto Trust Board Divisional focus against specific COVID costs is reviewed at the relevant FPAM.		

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3c	Enhanced data and digital capability	Director of Finance and Digital	Approval of OBC for Electronic Health Record is delayed or unsuccessful Major Cyber Security Attack Critical Infrastructure failure		CQC Responsive	Improve utilisation of the Care Portal with increased availability of information -	Cyber Security and enhancing core infrastructure to ensure network resilience. .	Digital Services Steering Group Digital Hospital Group Operational Excellence Programme Outpatient Redesign Group	Number of staff using care portal		EMAS, GPs, mental health, community, social care and care homes data now also available within the Care Portal.	Finance, Performance and Estates Committee	**Amber**
						Development and approval of Electronic Patient Record OBC		Digital Services Steering Group Digital Hospital Group e-HR Programme Steering Group	Delivery of OBC		EPR OBC to be approved by Frontline Digitalisation NHSE/I OBC requirements (including financial) being worked through with Frontline Digitalisation NHSE/I OBC going to Aug FPEC and Sept Board		
						Undertake review of business intelligence platform to better support decision making			Delivering improved information and reports Implement a refreshed IPR	IPR refresh for 22/23. Completed for Jan 2022	Steady implementation of PowerBI through specific bespoke dashboards and requests.		
						Implement robotic process automation	Lack of expert knowledge available within and to the Trust (experts in short supply nationally) Business case development on hold due to capacity issues						
						Improve end user utilisation of electronic systems	Business case for additional staff under development						
						Complete roll out of Data Quality kite mark			Ensuring every IPR metric has an associated Data Quality Kite Mark	Information improvements aligned to reporting needs of Covid-19.	A number of metrics have had a review and these are awaiting formal sign off. They will then appear in the IPR. Remaining metrics have a work plan and deadlines associated with completion.		

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3d	Improving cancer services access	Chief Operating Officer				Improve access for patients be reducing unwarranted variation in service delivery through transformation of Cancer Care	Recovery post COVID and risk of further waves Specialty strategies not in place	Requirement for specialty strategies now part of strategy deployment and will commence Q1 22/23 Cancer Improvement Board	Percentage of patients waiting 52 weeks or more 28 Day Faster Diagnostics			Finance, Performance and Estates Committee	Red
						Recovery Support Plans							
3e	Reduce waits for patients who require planned care and diagnostics to constitutional standards	Chief Operating Officer				Improve access for patients be reducing unwarranted variation in service delivery through transformation of Planned Care	Recovery post COVID and risk of further waves Specialty strategies not in place Elective Theatre Programme Transformation team not yet established.	Requirement for specialty strategies now part of strategy deployment and will commence Q1 22/23 Outpatient Improvement Group	Percentage of patients waiting 52 weeks or more 28 Day Faster Diagnostics		Reporting via FPEC/Improvement Steering Group (ISG) which commences on 20/06/22. Programme Manager recruited and due to start in June 2022.	Finance, Performance and Estates Committee	Amber
						Recovery Support Plans			Delivery against 62 day combined standard Urgent Treatment (P2) turnaround time Deliver outpatient activity non face to face		Reporting via FPEC/Improvement Steering Group (ISG) which commences on 20/06/22. Programme Manager recruited and due to start in June 2022.		
						Pre op Assessment Modernisation	Engagement exercise required to seek further views regarding the proposed revised model	Pre assessment project group	IIP report to FPEC - monthly				
3f	Urgent Care	Chief Operating Officer				Improve access for patients be reducing unwarranted variation in service delivery through transformation of Urgent Care	Recovery post COVID and risk of further waves Specialty strategies not in place	Urgent and Emergency Care Board.	Improvement against strategic metrics % of patients in Emergency Department >12 hrs (Total Time)		Reporting via FPEC/Improvement Steering Group (ISG) which commences on 20/06/22. Programme Manager recruited and due to start in June 2022.	Finance, Performance and Estates Committee	Red
						Recovery Support Plans							

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SO4	**To implement new integrated models of care with our partners to improve Lincolnshire's health and well-being**												
4a	Establish collaborative models of care with our partners	Director of Improvement and Integration	Failure of specialty teams to design and adopt new pathways of care Failure to support system working Failure to design and implement improvement methodology Operational pressures and other planning priorities puts an added constraint on time, capacity and headspace to engage with the ICS agenda. Thus, being unable to fully support system working and play an active role in the development of the Provider Collaborative. Challenge to get wider organisation and partner engaged in enhancing our collective roles as Anchor institutions		CQC Caring CQC Responsive CQC Well Led	Supporting the implementation of new models of care across a range of specialties	Specialty strategies not in place	Requirement for specialty strategies now part of strategy deployment and will commence Q1 22/23	Reports -ELT / TLT -Committees -Board -System	No plan of how the speciality strategies will be developed	New Improvement programme framework aligned to the CIP framework is being developed. Draft Heat Map is almost complete to support the identification of priority specialities for service reviews by July 2022.	Finance, Performance and Estates Committee	**Amber**
						Implementing the Outstanding Care Together Programme to support the Organisation to focus on high priority improvements in 22/23- (1) continued improvements in patient safety and experience (2) reduce long waiting times for treatment (3)make our people feel valued and supported by improving our culture and leadership	Embedding and sustaining cultural change when we remain operationally challenged with staffing issues etc. Ability to demonstrate quick impact on the cultural change due to various interventions as part of our Outstanding Care Together programme will be limited (as these are multi year/multi factorial projects)	ELT/TLT oversight Board / system reporting	Updated IIP reported at relevant Board Committees	Impact of Outstanding Care together programme on any of the key deliverables	Outstanding care together programme is being refreshed as part of the IIP year 3 refresh		
						Lead the Lincolnshire ICS and Provider Collaborative as an Anchor Institution and play an increasing leadership role within the East Midlands Acute Services Collaborative	Governance arrangements for Provider Collaborative, Integrated Care Board still in development Clarity on accountability of partners in integration/risk and gain ULHT anchor organisation plan not yet in place Wider regional governance to provide East Midlands oversight of population need and outcomes not yet finalised (via East Midlands Acute Provider Collaborative (EMAP)) ULHT have not embedded a culture of contributing towards population health across the whole organisation and a further understanding of health inequalities and mitigating actions.	Map key stakeholders and priorities for a partnership strategy focussing on addressing health inequalities and prevention Board and senior leadership team sessions on understanding the new ICS landscape and ULHT role within this Scope what a good effective partnership look like. Stakeholder mapping & engagement plan. Develop appropriate comms for the Lincolnshire ICS and our provider collaborative Agreements to support the development of the Provider Collaborative have been designed and shared. The Provider Collaborative is undertaking a stock take of services.	ULHT anchor institution plan Risk and Gain share (provider collaborative) Early Warning Discharge Indicators/development a common set of agreed metrics for flow and discharge across the system ICB delegation agreement ULHT Partnership Strategy	A better understanding of effective partnerships and what good looks like Clarity around role/accountability of partners within the Provider Collaborative Clarity around system improvement plan and provider collaborative plan and what outcomes each seeks to achieve Shared understanding and implications of the early warning discharge indicators, risk and gain share agreement within ULHT	Part of the refreshed IIP Reporting processes Regular updates to ELT/TLT/TB on Provider Collaborative, Health Inequalities, EMAP and our ICS		

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4b	Becoming a University Hospitals Teaching Trust	Director of Improvement and Integration	Failure to develop research and innovation programme Failure to develop relationship with university of Lincoln and University of Nottingham Failure to become member of university hospital association		CQC Caring CQC Responsive CQC Well Led	Developing a business case to support achievement of University Hospital Teaching Trust Status	R&I Team require investment and growth to create sustainable department	The case of need was approved at CRIG (September 2021) and now needs to return to CRIG as FBC. R&I team working closely with Strategic Projects to develop full business case for the growth of R&I department.	Progress with application for University Hospital Trust status R&I Team reporting in to ULHT Hospital Steering group as key stakeholder. Upward report to P&OD Committee	Further understanding of the costs involved to increase size of R&I department and also to develop an R&I facility	R&I team reworking business case with a phased approach	People and Organisational Development Committee	Red
						Shared understanding and implications of the UHA guidance and identify realtionship management of key stakeholders nationally (DH, UHA) Agree contract with UOL, R&I team to Increase the number of Clinical Academic posts	With the criteria change in June 2021 we are no require to demonstrated increase clinical academics by 20 and RCF funding worth £200k within the last 2yrs Furher clarification and implications of the changed guidance on univ hospital status required. Funding for Clinical Academic posts and split with UOL to be agreed	Working through the potential options presented by the Medicine Clinical Academics pilot and understanding whether this can be deployed across other divisions. Monthly meetings with ULHT and Uni of Lincoln to discuss funding position	Contract agreed with UOL for Clinical acandemic posts Increase in numbers of Clinical Academic posts RD&I Strategy and implementation plan agreed by Trust Board Upward reporting and approval sought through TLT/ELT	Unknown financial commitment for the Trust	Monthly meetings with ULHT and Uni of Lincoln to discuss funding position		
						Improve the training environment for students	Understanding of our offer of the facilities required for a functioning clinical academic department	Revision of the library and training facilities to ensure that facilities are fit for purpose for all staff who will require access to training facilities, library, ICT equipemtnto be able to perform their role. This will be aligned to the UHA Guidance, and will incldue those within UGME/PGME and access for Clinical Academics.	GMC training survey Stock check against checklist Internal Audit - Education Funding	Unkown timescales of completion	Universtity Teaching Hospital Status working group has been renewed with more drive, ensuring representation from key stakeholders and clear milestones for delivery		
						Developing a joint ressearch strategy with the University of Lincoln	A joint MOU is in place at a Lincolnshire System level as agreed in April 2022, and the Steering Group and ELT has agreed that this should be used as the overarching MOU, with a local version between ULHT and UoL created as we move forward and understand the finer details of the partnership. Draft priorities based on initial dialogue with vice dean of the medical school has been created, further work to develop UOL strategy is being undertaken.	Working closely with the University of Lincoln, monthly meetings. Through these meetings have completed first draft of the Joint Strategy.	RD&I Strategy and implementation plan agreed by Trust Board	Drafts in place which broadly cover joint research and teaching approach across the organisations, unable to outline in strategy financial commitment	Monthly meetings with ULHT and Uni of Lincoln and through ULHT Steering Group		
						Develop a portfolio of evidence to apply for membership to the University Hospitals Association	Evidence bound by UHA requirements	Portfolio of evidence is being captured and is available on the shared drive Identified leads to liase with UHA CEO (Medical Director, ULHT and System Clinical Director/Chair PCN, Lincolnshire ICS)	Roadmap developed to identify required evidence for portfolio	Clear understanding of rigidity of UHA requirements	Discussions being held to clearly identify opportunity for movement within guidance and steps being taken for a name change application		

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						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 Scientistis/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	HRBP at ULHT is part of the Steering Group to assist with working through the contractual issues The project team now also includes a HRBP from UoL and has a dedicated project resource aligned.	ULHT healthcare roles plan Increased recruitment/academic posts (across ICS)	The change to the UHA Guidance (20xClinical Academics) is a challenge	Working closely with University of Lincoln to develop plans for recruitment of Clinical Acadmic posts with a view to maximising existing research relationships where possible. Having a project lead at UoL has further supported the partnership approach and ability to co-create solutions and gather evidence for the UHA - specifically with regard to Clinical Academic recruitment.		
4c	Successful delivery of the Acute Services Review		Limited capacity to hold regular scheduled ASR meetings with ULHT Divisional Teams due to ongoing operational pressures (Level 4, Major Incident etc).		CQC safe, CQC responsive, CQC well led	Develop a ULHT clinical service strategy with focus on fragile services in order to provide sustainable and safe services for the future Identify the key services to focus on for Clinical Service Review (taking into account CIP, benchmarking, GIRFT and other core data) Engage with services to develop plans as to how best to approach a clinical review, Engaging with the Integrated Care Board to take ASR implementation work forward. First Implementation Oversight Group meeting scheduled for September	Heat maps now drafted, with service reviews linked with improvement and clinical strategy development Divisional IIPs need to be completed to ensure links into fragile services/clinical service strategy Identify resources to implement ASR outcomes	Process being developed to identify services for review. This includes the development of a HEAT Tool to identify areas where services are not meeting targets, such as RTT, Cancer, Finance data. Initial discussions with divisions have been had with a view to ensure that the services most needing priority review are identified. Programme management support being identified via Provider Collaborative to help deliver ASR phase 1 Individual work streams to be established	Heatmap of fragility Plan for development of a clinical service strategy Health inequalities and core25 PLUS indicators Early Warning Discharge Indicators Rigorous engagement, both for feedback from the ASR review and further implementation	Evidence available but working on a process to bring together the information for services to aid the identification of the Top 5 areas for focus in 2022/23.	Part of the refreshed IIP Reporting processes HEAT Map for identification of services being created within Strategy & Planning Publish ULHT clinical service strategy end of 2022/23 Working with Divisions to identify ASR implementation requirements	Finance, Performance and Estates Committee	Green

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The Trust Board has assigned each strategic objective of the 2021/22 Strategy to a lead assurance Committee. Outcomes under each strategic objective are aligned to a lead Committee or reserved for review by the Trust Board.

The process for routine reviews and update of the BAF is as follows:

- The corporate risk register is maintained by the Lead Executive, in accordance with the Risk Management Policy
- The BAF is updated with any changes to those corporate risks recorded within it; the Trust Board decides which corporate risks are significant enough to warrant inclusion on the BAF, based on recommendations from Committees
- The lead assurance Committee (or Trust Board, where applicable) reviews the management of risks to each required outcome (as part of their regular work programme), through evaluation of reports and risk assessments provided at Committee by Executive Leads
- The lead Committee identifies any gaps in controls or assurance and ensures there are appropriate plans in place to address them
- The lead Committee decides on an assurance rating for each required outcome, based on evidence provided in identified sources of assurance

To facilitate this process, each Committee will receive regular reports from specialist groups, Executive leads and other sources which provide management information and analysis of relevant key risk, to enable the Committee to make a judgement as to the level of assurance that can be provided to the Board. All reports to the Committees should first have been reviewed and approved by the Executive Lead.

When deciding on the assurance rating for each outcome the following key should be used:

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