Bundle LCHG Board Meeting in Public Session 4 March 2025

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

1 Introduction, Welcome and Chair's Opening Remarks
Chair

2 Public Questions
Chair

2.1 Ward Accreditation
Group Chief Nurse
Burton Ward - Bronze Award
Cardiac Cath Lab - Bronze Award

3 Apologies for Absence
Group Chair

4 Declarations of Interest
Group Chair

5 Minutes of the meeting held on 7th January 2025
Group Chair
Item 5 Public Board Minutes Jan 25

5.1 Matters arising from the previous meeting/action log
Group Chair

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

6.1 Group Model Workstream Update
Group Chief Executive
Item 6.1 LCHG Group Development

7 Patient/Staff Story
Group Chief Nurse

7.1 Celebrating Group Success - Stroke Services
Group Chief Integration Officer
Item 7.1 Celebrating Group Success - Stroke Services
Item 7.1 Stroke QI - TASC Project Board V2

7.2 BREAK

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

8.1 Assurance and Risk Report from the Quality Committee
Chair, Quality Committee
Item 8.1 Quality Committee Upward Report January 2025
Item 8.1 Quality Committee Upward Report February 2025

8.2 Ward Establishment Review
Group Chief Nurse
Item 8.2 Ward Establishment Review Report

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

9.1 Assurance and Risk Report from the People Committee
Chair, People Committee
Item 9.1 People Committee Upward Report January 2025
Item 9.1 People Committee Upward Report February 2025

9.2 Gender Pay Gap Report

Group Chief People Officer

Item 9.2 Front Sheet Gender Pay Gap Action Plan
Item 9.2 GPG_Action_Plan_2025_2028_Overview - 9.1.25
Item 9.2 LCHS Gender Pay Gap Report Cover Sheet - Board
Item 9.2 Lincolnshire_Community_Health_Services_NHS_Trust_Gender_Pay_Gap_Report_2024-25_vers 2
Item 9.2 ULTH Gender Pay Gap Report Cover Sheet - Board
Item 9.2 United_Lincolnshire_Teaching_Hospitals_NHS_Trust_Gender_Pay_Gap_Report_2024-25_vers_2

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

10.1 Assurance and Risk Report from the Finance Committee
Chair, Finance Committee

Item 10.1 Finance Committee Upward Report January 2025v1
Item 10.1 Finance Committee Upward Report February 2025v1

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

11.1 Assurance and Risk Report from the Integration Committee
Chair, Integration Committee

Item 11.1 Integration Committee Upward Report January 2025
Item 11.1 App 1 Integration Committee Health Ineqaulities Update January 2025 FINAL
Item 11.1 App 1a - Health Inequalities Maturity Matrix LCHS
Item 11.1 App 1b - Health Inequalities Maturity Matrix ULTH
Item 11.1 App 2 Integration Committee Update January 2025_v5
Item 11.1 Integration Committee Upward Report February 2025v1
Item 11.1 App Reposition model - V5 Feb 25

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

13 Integrated Performance Report - ULTH/LCHS
Group Chief Integration Officer

Item 13 Front Sheet Trust Board - IPR
Item 13 ULTH IPR Trust Board February 2025
Item 13 Front Sheet Trust Board - IPR
Item 13 LCHS Integrated Performance Report -Jan

14 Risk and Assurance

14.1 Group Risk Management Report
Group Chief Clinical Governance Officer

Item 14.1 LCHG Group Board Risk Report March 2025 v1
Item 14.1 Appendix A Group Board Very High and High Risks March 2025
Item 14.1 Appendix B - ULTH Group Board Very High and High Risks March 2025

14.2 Board Assurance Framework
Group Director of Corporate Affairs

Item 14.2 LCHG BAF 2024-25 Front Cover March 2025
Item 14.2 LCHG BAF 2024-25 25.02.25

14.3 Assurance and Risk Report from the Audit Committee
Chair, Audit Committee

Item 14.3 Audit Committee Upward Report - Jan 25

14.3.1 Audit Committee Terms of Reference and work programme

Item 14.3.1 LCHG Audit and Risk Committee TOR Draft January 2025
Item 14.3.1 LCHG Audit Committee forward reporting schedule 25-26

14.4 Board Forward Planner
Group Director of Corporate Affairs

Item 14.4 DRAFT Board Work Programme 2025-26

15 Any Other Notified Items of Urgent Business

16 The next meeting will be held on Tuesday 6th May 2025

EXCLUSION OF THE PUBLIC

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

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

Minutes of the Public Board in Common Board Meeting

Held on 7 January 2025

Via MS Teams Live Stream

Present

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

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

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

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

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

In attendance:
Mrs Jayne Warner, Group Director of Corporate Affairs
Mrs Karen Willey, Deputy Trust Board Secretary, ULTH
Mrs Rachel Lane, Corporate Administration Manager, LCHS (minutes)
Sister Natalie Beaumont, Greetwell Ward, ULTH (Item 2.1)
Sister Louise Lai, Harrowby Ward, ULTH (Item 2.1)
Matron Sharon Kelham, ULTH (Item 7)
Mrs Sharon Kidd, Patient Experience Manager, ULTH (Item 7)
Professor Alun Roebuck, Senior Consultant Nurse in Cardiology, ULTH (Item 7.2)
Mrs Libby Grooby, Director of Midwifery, ULTH (Item 8.1)
Mrs Emma Upjohn, Head of Midwifery, ULTH (Item 8.1)

001/25	**Item 1 Introduction** The Chair welcomed Board members and members of the public, staff or interested parties who had joined the live stream.
002/25	**Item 2 Public Questions** **Q1 Received from Sue McQuinn** I would like to ask if there are plans for AAA post operative surveillance to be carried out in Grantham at the Community Diagnostic Hub or the hospital? Currently, I understand, AAA screening is done in Grantham but for post operative surveillance patients are required to travel to Pilgrim or Lincoln hospital. The scan & consultation usually take less than 20mins but travelling to Pilgrim, for my partner, makes it into a 3 hour plus round trip, which is both stressful & expensive for us. He's now refusing to go & I imagine he's not the only one who finds these remote appointments daunting. Surely, there must be a way for the AAA surveillance to be carried out in Grantham?
003/25	The Group Chief Integration Officer responded that providing care as close to home as possible was one of the Group's principles and advised that screening programmes came under the remit of the Clinical Support Services Division and

	services were delivered across the County. Where there was a further need for intervention patients were moved to specific specifications to be reviewed and patients were often referred into the Vascular Service at Pilgrim Hospital, Boston. This was a small team and there was insufficient workforce to deliver this service across multiple sites. However it was anticipated that in the future the equipment within the newly established Community Diagnostic Centres (CDCs) could be utilised to expand this service further.
004/25	**Q2 Received from Vi King** Please can I ask why this question keeps getting raised but is still an issue for patients. People getting letters informing them of their appointment after they have attended it. Also getting letters telling them that their appointment has been cancelled by the patient ask they have asked for Grantham but getting sent to Lincoln & Boston. Then receiving messages from a London number telling them of appointments at Lincoln & Pilgrim, again after they have always requested Grantham. The cost of this to the Trust by sending out letters, when the patient has received all in the information on the portal. Please can this be looked into, so that when a patient has requested a certain hospital it can be flagged up on their notes on the system.
006/25	The Group Chief Integration Officer was aware that there were further improvements required in this area, adding that Mrs King was right to raise these questions to hold the organisation to account.
007/25	The Group Chief Integration Officer explained that the organisation did attempt to make contact with all patients requiring short notice appointments by telephone as a safety net. Digital communications were being rolled out and if messages were not accessed within 24 hours, a paper letter was sent out via Royal Mail. The Group Chief Integration Officer expected the use of digital communications to improve experiences and to reduce unnecessary use of postal services and added that all out-patient letters should now be circulated via digital format. With regards to site preferences, if appointments were available earlier at a site, other than that of choice, that would be offered to patients first in order to reduce waiting times.
008/25	The Group Chief Integration Officer also advised that patients would never be contacted via a London telephone number, therefore this would be investigated further.
009/25	**Item 2.1 Ward Accreditation** The Group Chair was pleased to be able to commence the Board meeting with the celebration of achievement of the provision of high quality, safe care through the awarding of ward accreditation.

010/25	Sister Natalie Beaumont from Greetwell Ward at Lincoln County Hospital and Sister Louise Lai from Harrowby Ward at Grantham Hospital were welcomed to the meeting to celebrate their achievements.
011/25	The Group Chief Nurse introduced the team who had successfully achieved the Bronze award as part of the quality accreditation programme. Board members were reminded of the core requirements the departments were required to achieve against a range of quality indicators, in addition to presenting a portfolio of evidence to the Quality Accreditation Panel.
012/25	Sister Lai described some extensive work that had been undertaken on the design of the Ward environment to optimise the care of patients with dementia, recognising the impact that an environment can have in improving the care of these patients. Sister Lai explained that the use of pastel colours for bays and curtains within the Ward aided patient navigation and this had resulted in the reduction of the number of avoidable falls on the Ward and the use of chemical sedation of patients.
013/25	Sister Beaumont presented an example of a project the Ward had undertaken to improve the care of patients with a tracheostomy, this included the introduction of a tracheostomy transfer bag to support and aid discharge of patients from the Ward and was also taken when patients attended other areas of the Hospital for appointments. The introduction of this bag had also made staff members feel more confident when leaving the Ward environment. Sister Beaumont also described the use of electronic whiteboards for patients to improve communication between staff members and patients, who could struggle to communicate due to their condition. This had greatly improved the patient's experience during their time on the Ward.
014/25	The Group Chair thanked Sister Lai and Sister Beaumont for sharing their stories and for their leadership and added that it was clear that patient need had been taken to heart and been responded to in a positive way.
015/25	The Group Chief Executive thanked both Sister Lai and Sister Beaumont for sharing their stories and was able to relate to the dementia aspects including the changes to Ward environment due to her own personal circumstances. The Group Chief Executive commented that the reduction in the use of chemical sedation could only be positive for patients. In terms of adoption and spread, the Group Chief Executive asked both Sisters whether they had shared the improvements made on their Ward areas with other Ward leaders. Sister Beaumont explained that the use of the tracheostomy transfer bag and use of the electronic whiteboard had been shared at a Steering Group meeting, and ward leaders had been keen to take the idea forward in other areas. Sister Lai explained that the work of Harrowby Ward had been shared at Ward meetings and through the Divisions.
016/25	The Group Chair noted the positive comments from Board members and endorsed those on behalf of the whole Board and added that the teams should be proud of their achievements. The Group Chair again thanked Sisters Beaumont and Lai for attending the meeting.

017/25	**Item 3 Apologies for Absence** There were no apologies for absence, however it was noted that the Group Chief Operating Officer would only be present for part of the meeting due to current operational pressures.
018/25	**Item 4 Declarations of Interest** There were no additional Declarations of Interest made.
019/25	**Item 5 Minutes of the meetings held on 5th November 2024** The minutes of the meeting held on Tuesday 5th November 2024 were approved as an accurate record.
020/25	**Item 5.1 Matters Arising from the previous meeting/log** There was one matter arising from the last meeting in relation to the use of Temporary Escalation Spaces. The Group Chief Integration Officer explained that a full hospital protocol was due to be adopted and noted three working examples from other sites which would assist the Group in moving this forward through the appropriate governance and assurance routes.
021/25	The Group Chair thanked the Group Chief Integration Officer for the update, and it was agreed to close this item.
022/25	**Item 6 Chief Executive Horizon Scan** The Group Chief Executive presented the report to the Board, noting that intense operational pressures were being experienced and it was likely that this would continue into the coming weeks. The NHS had seen record numbers of patients and a significant increase in cases of flu, Covid, RSV and norovirus. There had also been several outbreaks within the acute Trust on Ward areas which had reduced the number of beds available and had compounded issues. There had been robust plans in place over the festive period with activity being roughly as anticipated.
023/25	The previous week had seen significant pressure build on the Emergency Department (ED) due to a significant number of unwell patients, acuity, demand and an increase in the numbers of patients waiting for beds in ED. More recently the weather had also compounded the situation further with snow, ice and flooding in the South of the County which had led to the Lincolnshire Resilience Forum (LRF) declaring a major incident, adding to the already challenging situation for the residents of Lincolnshire and the services which supported those patients.
024/25	Several systems in the surrounding areas had already declared critical incidents as a result of what was being experienced, and whilst this had not been done in Lincolnshire, the Group Chief Executive advised that the system was close to this. The Group Chief Executive advised that the Group was doing all it could to maintain patient safety and to continue providing elective care, however the situation was intensifying on an hourly basis.

025/25	The Group Chief Executive was conscious of recent patient experiences within the ED, which would not have been as expected and, as a result of this the Group Chief Executive offered personal apologies to the residents of Lincolnshire. Colleagues were working hard to provide the best services they could at this challenging time, and staff members were thanked for all they continued to do to keep the residents of Lincolnshire and their colleagues safe.
026/25	The Group Chief Executive informed Board members that the 2025/26 National Planning Guidance had not yet been published, however it was broadly known what the direction of travel would be and that there would be three priority areas for the NHS. A plan had also been received in respect of reforming elective care and work was underway on this; the Board would be briefed in due course. There had also recently been an announcement in respect of short-term support for Social Care and the Group would actively contribute to engagement at the appropriate time.
027/25	The Group Chief Executive advised that a full board session had taken place on Wednesday 11 December 2024, for the first time in several years. The Trust Boards of all Lincolnshire provider trusts and Lincolnshire ICB met to continue to strengthen the partnership working and contribution to the improved healthcare of the patients and population of Lincolnshire.
028/25	As a Group, the financial position was off plan with discussions taking place across the system with Regional Finance colleagues and work was underway to bring the Group back on plan by the financial year end.
029/25	Good achievements had been celebrated across the Group in the last few months, including the opening of the new Scotter Ward at John Coupland Hospital, the Group Staff Awards and the official opening of the Skegness CDC.
030/25	The Group Chair thanked the Group Chief Executive for the update on the operational position, which had been challenging for all concerned and took the opportunity to thank the Executive Leadership Team for their continued leadership over recent weeks.
031/25	Mrs Brown offered personal thanks to the Executive Team and commented that it would be extremely difficult to deliver safe patient care in these challenging times, however it was known that this would be at the forefront of all decision making. Mrs Brown commented that the Executives had the support of the Board in this regard.
032/25	Ms Shadlock drew attention to the significant investments for the future services including the new Scotter Ward and the CDCs and offered that this was positive for the population of Lincolnshire.
033/25	The Group Chair took the opportunity to underline the Group Chief Executive's apology to any patient who may not have received the best experience when visiting the ED over the last few weeks. The Board: • **Received the report and noted the significant assurance provided**

034/25	**Item 6.1 CQC Unannounced Assessment Letter** The Group Chief Clinical Governance Officer informed Board members that an unannounced Care Quality Commission (CQC) visit had taken place on 27th November 2024 at Pilgrim Hospital, Boston which focussed on urgent and emergency care pathways, along with a review of medical and surgical wards.
035/25	The CQC had provided feedback noting the well managed flexing and boarding arrangements for patients and good sepsis management within the Emergency Department (ED). There were some areas for potential improvements for both visits, which the Trust were working to address, however no immediate patient safety concerns were reported back to the Trust.
036/25	The Group Chief Clinical Governance Officer advised that evidence had been submitted to the CQC as a result of the visit and a draft report was now awaited. Once received this would be checked for factual accuracy and would then formally be published and submitted to the Board in due course. The Board: • **Received the report and noted the actions taken as described**
037/25	**Item 6.2 Group Development – Next Phase** The Group Chief Executive presented the report to Board members explaining that work to finalise the Group Development Programme Plan had now been completed and the timeline was provided.
038/25	The Group Chief Executive explained that the key enablers required to ensure successful delivery and embedding of the agreed actions and milestones had also now been included within the plan, with communications and engagement and HR and OD support being a requirement across several work streams. Additional capacity would also be sourced as required. The Executive Team would continue to review this monthly and pro-active work was being undertaken with the newly formed Group Leadership Team (GLT) who would deliver the programme and benefits realisation.
039/25	A Board Development Session would be held in the coming weeks to review statutory objectives, the Board Assurance Framework and operating model for the Group.
040/25	Ms Shadlock was pleased to see the communication and engagement and HR support included and to understand the financial constraints attached to this. From a Non-executive Director perspective, it was stressed that it would be important to resource this thoroughly, and a view was expressed that this would pay dividends in achieving the aim.
041/25	Mrs Brown expressed a view that some of the timescales were ambitious given the current challenges being faced and commented that there may be a need for some flexibility around this.

042/25	The Group Chair offered that this was ambitious and well-structured and agreed with the issues raised in respect of timescales and expressed a view that that staff engagement could be more prominent throughout the document.
043/25	The Group Chief Executive acknowledged the comments and agreed that there would need to be some flexibility with the programme which was iterative. In terms of staff engagement, the Group Chief Executive explained that the programme would build on work that had already commenced, including a change in emphasis on the Executive Team being more visible and, moving into care groups thinking about the operating model and the Senior Leadership Team. It was added that this would be important in terms of engagement with wider colleagues and would also become more important when primacy was shifted and for the Group to become more about care in the community in the future.
044/25	The Group Chief People Officer explained that the full engagement plan underpinned the high level objectives which focussed on six engagement lines with several different areas of work that would support this. It was noted that this could be added as an appendix to the Programme Plan as an additional layer of information. The Group Chair looked forward to seeing this work.
045/25	Mr Orrell asked how widely this document had been shared in terms of confidence building within the system and regionally. The Group Chief Executive explained that this had been shared within the Group at high level and not more widely at present, however there was potential for this in due course.
046/25	In terms of benefits realisation, Mrs Buik commented that in terms of tracking performance and reporting being back ended it would be important and part of the narrative for staff and other areas of the system to understand why it had been documented in this way and what, in addition to existing measures, would be needed to understand this fully. The Group Chief Executive responded that benefits realisation would be key to all of this adding that the Executives did not see this as back ended and as the programme work progressed, the benefits realisation would begin to be seen. This was also being seen in terms of the two organisations within the Group working together.
047/25	The Group Chief Executive explained that Executive discussions had also commenced in term of aligning productivity reporting through the Integrated Performance Report using established mechanisms to drive the Group position forward.
048/25	The Group Chief Executive commented that this was a dynamic work programme and work would need to be undertaken which ensured the delivery of safe care for patients. The Board: • **Received the report and approved the Group Development Programme Plan**

049/25	**Item 7 Patient/Staff Story**
050/25	The Group Chief Nurse introduced the item advising that key learning would be described following the presentation and took the opportunity to thank the patient and his wife for sharing their story and for working with the organisation to take the learning forward.
051/25	The Matron for General Surgery, Sharon Kelham and Sharon Kidd, Patient Experience Manager were welcomed to the meeting for this item.
052/25	Board members were presented with the story of William and Joanne, a deaf couple who shared their experiences of being cared for at Pilgrim Hospital, Boston during the Covid pandemic, when William had been admitted to Hospital. The couple shared their emotional story relating to issues they experienced including lack of communication and no interpreter being present, lack of deaf awareness amongst staff members and aspects of the care they experienced. William explained that he felt like he was being ignored during his hospital admission and advised that he had to pay for Wi-Fi and had no television access.
053/25	Matron Kelham expressed a view that this video had been difficult to watch in terms of the poor experiences William had received. However, as a result of the information shared work had been undertaken to look at what could be done to improve the experience of the deaf community upon admission to hospital. Matron Kelham explained that since June 2024 the Trust had used Silent Sounds for sign language interpreting and work had been undertaken with teams to promote this across the organisation. There was now free Wi-Fi available along with a free patient entertainment system which included access to television, games and puzzles. The Digital Team were also reviewing the introduction of subtitles which would also be of high benefit.
054/25	Work was underway on the use of buzzers in ED to alert patients with hearing loss to them being called for treatment and the Patient Experience Manager was also involved in a new project to support patients with autism in ED. The Patient Experience team were also in the process of reviewing sensory packs for all wards and flagging on a patient's SystemOne record to indicate a hearing or sight loss and preferred ways of communication. The use of pictorial menus was also being looked into.
055/25	Matron Kelham was grateful to William and Joanne for sharing their story and for being open and honest and for helping the organisation to improve experiences for other patients.
056/25	The Group Chair thanked Matron Kelham for the story and offered sincere apologies to William and Joanne for the treatment they had received, adding that this was not the type of experience the Board would want for any patient. The Group Chair added that this story had been difficult to hear, however it was valuable in terms of how the organisation could and had learned from this to improve patient experience.
057/25	Strong responses were received from Board members in relation to William and Joanne's story and thanks were offered to the couple for sharing their story so that

	practice could be changed to ensure that others did not experience the same challenges that had been faced.
058/25	Mrs Wells asked what the level of confidence was that there was an awareness of the actions put in place across the organisation. Matron Kelham responded that lessons learned had been shared widely with teams and the Communications team were helping to share this more widely, including via Facebook. There was confidence that experiences would improve, and this would continue to be communicated with teams to ensure that the was ongoing awareness of how to access interpreters.
059/25	The Group Chief Integration Officer commented that there was a common theme within complaint responses which was communication and expressed a view that it was important to address any misunderstandings early to improve the ability to deliver care and understand a patient's own personal journey. There was work underway around personalisation which included making sure patients, carers and residents were communicated with clearly. The Group Chief Integration Officer advised that the newly formed System Personalisation Board was now meeting, and communication and use of new technologies would be discussed. The Group Chief Integration Officer added that it had been a privilege to hear William and Joanne's story, and thanks were extended to the teams for being able to address some of the issues experienced.
060/25	The Group Chief Executive echoed the comments of Board members, adding that it was good to hear of the work that had been undertaken to rectify the situation for patients moving forward and added that the litmus test would be for the patient to return to the hospital to road test the changes that had been made. Matron Kelham agreed and added that William and Joanne were part of the wider deaf community and had friends who had also had negative experiences and it was hoped that the changes made would provide confidence to that community that they had been listened to and their concerns had been acted upon so as to not repeat the experience of William and Joanne.
061/25	The Group Chief Nurse reflected on the comments in respect of wider learning and added that fundamentally the care had shifted for patients, adding that both William and Joanne were willing to work with the organisation further and their video would be shared as part of communications training. This would also be extended to estates and portering members of staff who also interacted with patients. The Group Chief Nurse added that the addition of buzzers in ED would also help. Despite this being a sad story, the Group Chief Nurse expressed a view that it was testament to William and Joanne that they wished to work with the organisation to improve others' experiences.
062/25	The Group Chair thanked colleagues for providing the story and looked forward to seeing William and Joanne work with the organisation further to continue the improvements that had already commenced. The Board: • **Received the Patient/Staff Story**

063/25	**Item 7.1 National Cardiac Audit Programmes National Heart Failure Audit 2023/24 Award** The Chair welcomed Professor Roebuck, Senior Consultant Nurse in Cardiology to the meeting who provided a presentation in respect of an impressive piece of systemwide work that had taken place to transform the care of patients with Heart Failure.
064/25	Professor Roebuck described the comprehensive work that had taken place with patients, primary care, community and acute teams and explained that the Heart Failure service had been redesigned, to develop a new seven day a week, acute and community service, virtual wards, new heart failure beds and new pathways. As a result of this there had been a 13% reduction in admissions, the provision of care closer to home for patients and a reduction of over 1,000 bed days released per annum.
065/25	Professor Roebuck advised that this work had been shared nationally and internationally and had been shortlisted for two national awards.
066/25	The Group Chair thanked Professor Roebuck for the inspirational presentation and took the opportunity to thank him and the teams for all their hard work. There were some core messages within the presentation including how work had been undertaken with Primary Care Networks, what was required moving forward, including being on the front foot in terms of patient pathways.
067/25	The Group Chief Integration Officer thanked Professor Roebuck for the presentation and expressed a view that this was true left shift care and was truly inspirational. It was noted that, bending the health inequalities curve to demonstrate the reduction in veracity of length of stay, and managing residents in the community was key to this and lessons could be learned from the health inequalities map, in terms of the benefits for other services. The Group Chief Integration Officer offered thanks to Professor Roebuck for the work that had been undertaken on this and commented that this could be utilised further as a foundation stone for the left shift approach.
068/25	The Group Chief Medical Officer offered that treating heart failure was difficult to do and expressed a view that what Professor Roebuck and the team had achieved, having a multi-faceted way of treatment for patients along all areas of the pathway and to come out as a national exemplar, had to be celebrated. The Group Chief Medical Officer agreed that this was a good example of left shift working and built foundation blocks for the treatment of patients in their own home and asked what was next to further develop this work.
069/25	Professor Roebuck thanked colleagues for their comments and acknowledged that this had been a team effort. The next project would be around lipidology, which could cause heart attacks and stroke, and a business case would be submitted to the Integrated Care Board (ICB) detailing this work later this month. Diabetes was another area of interest that would be considered in the future.
070/25	The Group Chair thanked Professor Roebuck for attending the meeting adding that this was an exciting opportunity for the future and was encouraged by this. The

	Group Chair offered congratulations for the national recognition and the support of the Board to continue to take this work forward. The Board: • **Received the presentation**
	Item 8 Strategic Aim 1 To Deliver high quality, safe and responsive patient services
071/25	**Item 8.1 Assurance and Risk Report Quality Committee in Common** The Group Chair welcomed the Director of Midwifery to the meeting for this item who would present the CNST elements of the update from the Quality Committee.
072/25	The Chair of the Quality Committee in Common, Mr Connolly, presented the Committee reports following the meetings held on 19th November 2024 and 17th December 2024 and the reports were taken as read. He outlined that the report format had been improved following feedback received and he would welcome comments from colleagues in terms of whether this was helpful, outside of the meeting.
073/25	The Director of Midwifery presented an update on the CNST standards as follows.
074/25	Safety Action 1 - PMRT was fully compliant, despite one missed deadline compliance remained at 95%. The Board had received four quarterly reports with details of all deaths which included reviews and consequent action plans which are available within the January 2025 LCHG Board Reading Room.
075/25	Safety Action 2 – MSDS was complete, and all evidence had been filled.
076/25	Safety Action 3 – TC was on track to achieve; the organisation was required to undertake a QI project which would be launching in February 2025.
077/25	Safety Action 4 – Clinical Workforce. The organisation would be reporting that a six-month audit had been undertaken demonstrating compliance with consultant attendance for the clinical situations listed in the RCOG workforce document. Consultant attendance was reported as 90% compliant which demonstrated that the Trust monitored this indicator. The Trust was compliant with respect of long-term locums, as evidenced from audit.
078/25	From a short-term locum perspective non-compliance would be submitted, due to one Doctor who did not adhere to part A or B or certificate of eligibility therefore this may trigger an evidence review. Progress had been made on a plan which had been submitted for compensatory rest which was fully compliant.
079/25	The Board was updated that full compliance was going to be reported for the neonatal medical workforce. For neonatal nursing, staffing did not meet the required BAPM national standards, as previously reported. The Board had previously received the action plan in response to neonatal nursing workforce. No concerns have been raised by the Board and therefore this action plan was confirmed as being approved.

080/25	Safety Action 5 - Midwifery Workforce has been reported to Board via the bi-annual staffing report. The most recent report updated on progress with the actions being taken in response to the shortfalls. This was ongoing through the business case process.
081/25	Safety Action 6 - SBL v 3 was on track to achieve, MIS year 6 requires that 'trusts should be able to provide a signed declaration from the Executive Medical Director declaring that Saving Babies' Lives Care Bundle, Version 3 would be in place as agreed with the ICB.
082/25	Safety Action 7 – MNVP was on track to achieve, and updates were being upwardly reported. There were no concerns to raise.
083/25	Safety Action 8 – Training compliance had achieved over 90%.
084/25	Safety Action 9 – Floor to Board was also on track to achieve no concerns had been escalated as an organisation, the phasing had been worked through and there had been dedicated time allocated to work as a quad and complete a score survey with regular updates being provided at MNOG. The third phase would be launching shortly with a staff experience group to create conditions for a positive culture and safety. Meetings with the Board Safety Champion were also held regularly.
085/25	Safety Action 10 – MNSI – was also on track to achieve. There had been six cases for MNSI, four had been reported by the legal team to early notification as required. Five had been reported through MNOG, 100% of cases had received duty of candour verbally and in writing.
086/25	The Group Chair thanked the Director of Midwifery for providing the update and commented on the remarkable achievements in respect of compliance achieved.
087/25	Mrs Brown took the opportunity to thank the Director of Midwifery for all her hard work in getting the Trust to this position. In terms of the area of non-compliance she expressed a view that there would be a review, however she expected there to be national support due to the work that had been undertaken in the background. As one of the Board Maternity Safety Champions, alongside the Group Chief Nursing Officer, Mrs Brown advised the Board of regular meetings with the peri-natal leadership team, and formally at bi-monthly intervals through attendance at the Maternity & Neonatal Oversight Group and assured the Board that continued support would be provided to address any issues raised by the team and would obtain further support as needed from the Board as required.
088/25	The Group Chief Integration Officer explained that the Quality Committee upward report from the November meeting referred to the NHSE publication on Temporary Escalation Spaces and she offered that she had met with the ICB, and reporting processes would be introduced to ensure a review of any care delivery issues. This would also be shared with the ICB to ensure a robust mechanism for reporting and sharing of information and would be reported upwardly to the Quality Committee via the Incident Management Report moving forward.

089/25	A gap analysis had also been received at the Quality Committee meeting against the Patient Safety Rights Charter, published by the National Patient Safety Commissioner. The Group Chief Clinical Governance Officer advised Board members that the National Patient Safety Commissioner would be visiting the organisation early next week, who would be reviewing the good work undertaken across the Group.
090/25	As this was the Director of Midwifery's last Board meeting, prior to her retirement, Board members took the opportunity to thank her for all her achievements since commencing in post and she received some good wishes within the meeting chat function. Board members offered the Director of Midwifery their best wishes for the future. The Board: • **Received the assurance reports, noting there were no escalations** • **Received and approved the CNST Standards update**
	Item 9 Strategic Aim 2 To enable our people to lead, work differently, be inclusive, motivated and proud to work within LCHG
091/25	**Item 9.1 Assurance and Risk Report People Committee** Professor Baker provided the assurances received by the People Committee, at the meetings held during November and December 2024 and the reports were taken as read.
092/25	Professor Baker drew colleagues attention to the themes documented within the reports in relation to culture, greater emphasis for colleagues to be involved in training and the reporting structure of sub-committees which was gaining maturity. The emphasis on medical staffing and engagement which were consistent themes was emphasised.
093/25	Professor Baker reminded colleagues that the assurance rating of objective 2b had previously been reduced due to the introduction of new Executive Directors and their portfolios which was taking away the emphasis from some of the core objectives. There would be further consideration of this at the January and February 2025 meetings.
094/25	The Group Chief Clinical Governance Officer referred to the December meeting report where concern had been raised in respect of the documentation of a risk on the Risk Register. Professor Baker would liaise with the Group Chief Clinical Governance Officer outside of the meeting in relation to this.
095/25	The Group Chair referred to conflicting information within the November People Committee report and the Finance Committee report relating to the vacancy control process. The Group Chief People Officer explained that the conflict related to a timing matter where the previous vacancy control measures had not been achieving the required outcomes, hence the change in practice to the deferment of non-essential vacancies. The Board:

	• **Received the assurance reports**
	Item 10 Strategic Aim 3 To ensure services are sustainable, supported by technology and delivered from an improved estate
096/25	**Item 10.1 Assurance and Risk Report from the Finance Committee** The Chair of the Finance Committee, Ms Cecchini, provided the assurances received by the Committee at the meetings held in November and December 2024, the reports were taken as read and the following areas were highlighted.
097/25	A shortened meeting had been held in November where the development of the newly established Group Finance Committee had been considered. At that time, the finance position had been reported as off plan and the Board Assurance Framework (BAF) rating was moved to red from amber.
098/25	At the December meeting the financial position had remained red rated. There had been some assurance and reassurance surrounding the actions being taken to reduce the deficit and return closer to plan. NHS England (NHSE) had been clear on the requirement for the system to achieve financial balance and the action being taken to achieve these included funding being received from the system risk pool which had now been successful, reducing the planning gap, maximising efficiencies and the elective recovery fund. Ms Cecchini explained that the Committee had also been advised of work that had been undertaken with Divisions to understand the recovery actions. The Finance team were undertaking a pay review on productivity to understand the link between the increase in pay and productivity.
099/25	Good assurances had been received in respect of estates for the acute element of the Group however issues remained within LCHS in respect of some ongoing issues relating to NHS Property Services, who were the landlords for most of the community properties. Some capacity issues had also been highlighted within Estates in respect of covering both elements of the Group.
100/25	From a performance perspective there had been good discussion in terms of how the Committee would receive assurance and whilst there had been some improvements, some areas were struggling to deliver according to commissioned or NHS constitutional standards, and discussion had taken place regarding understanding the trajectories for improvements and where services were off track.
101/25	Discharge planning had also been discussed in terms of escalation of internal discharge processes which required more rigour, specifically relating to untimely discharges and a request had been made for this to be escalated to the Board.
102/25	The Group Chief Nurse explained that further work was needed to achieve the required plan and suggested that clinical oversight could be reinforced through the Quality Committee, in terms of those waiting for long periods of time and linking this with patient experience.
103/25	The Group Chief Integration Officer explained that the discharge aspect needed to be escalated due to the size of the risk and level of oversight required. Pathway zero, non-complex discharges, related to ensuring the workforce got into a rhythm of

	watching harm from delayed discharges and had to be improved. The second element related to complex discharges where partner relationships were not as strong as required to hold each organisation to account. A new Discharge Board had been established which the Group Chief Integration Officer would be chairing for the system. An update on discharges would be provided at the next Finance Committee pictorially and if the Committee were content this would be appended to the upward reports so that the Board were also sighted.
104/25	The Group Chair commented that it was good to hear of this new initiative and awaited receipt of the data at the next meeting. The Board: • **Received the assurance report** • **Noted the escalation in respect of discharges and estates** • **Noted the change of rating for strategic objectives 3a and 3g**
105/25	**Item 10.2 Revised Finance Committee Terms of Reference and Workplan** The Group Director of Corporate Affairs presented the revised Finance Committee Terms of Reference and Workplan explaining that this was for noting only. The Board: • **Noted the Terms of Reference and Workplan**
	Item 11 Strategic Aim 4 – To collaborate with our primary care, ICS and external partners to implement new models of care, transform services and grown our culture of research and innovation
106/25	**Item 11.1 Assurance and Risk Report from the Integration Committee** The Chair of the Integration Committee, Mrs Brown provided the assurances received by the Committee at the meeting held in December 2024. A workshop had been held in November to review the focus of the new Committee and what would and would not be in scope, to avoid encroachment on the work of the other Committees. There had been good engagement at the workshop with clear focus including the beginning of some sub-groups that would feed into the Committee.
107/25	At the first meeting in December, the terms of reference for the sub-groups had been received, one remained outstanding which would be presented to the January meeting.
108/25	The BAF had been considered which had been challenging as the strategic objectives were fragmented and work would be undertaken at a forthcoming Board Development Session to discuss this further. Mrs Brown offered that the Committee would struggle to gain any assurance against the objectives prior to the end of the financial year.
109/25	The risk report was reviewed and required further work and would be a key area of discussion at the next meeting in terms of aligning risks to the Committee.

110/25	Overall Mrs Brown expressed a view that there had been good engagement and looked forward to presenting further reports to the Board as the Committee gathered momentum.
111/25	The Group Chair was encouraged from the way these meetings had commenced and added that it was helpful to see what was in and out of scope. The Group Chair was also sympathetic in respect of the BAF and reminded colleagues that this was a year of transition.
112/25	The Group Chief Medical Officer commented that opportunities would arise and there was a clear clinical focus to much of the work that would be undertaken in respect of integration. Mrs Brown agreed and added that the organisation wanted to be clinically led and expressed a view that there would also need to be reassurance that there was good clinical engagement within the sub-groups which would feed into the Committee.
113/25	The Group Chair requested clarity, now the Integration Committee had been established, regarding whether an analysis had been undertaken in terms of transitioning from separate into joint Committees and capturing items for the future. The Group Director of Corporate Affairs responded that this was one of the governance workstream actions and work had commenced to undertake the read across, ensuring all areas had been captured. The Board: • **Received the assurance report**
	Item 12 Strategic Aim 5 – To embed a population health approach to improve physical and mental health outcomes, promote well-being and reduce health inequalities across an entire population
	No items.
114/25	**Item 13 Integrated Performance Reports** The Integrated Performance Reports were taken as read with the Board noting that the reports had been received and reviewed in depth by the Committees. There were three areas the Group Chief Integration Officer wished to highlight to the Board.
115/25	A large piece of work was underway on the redesign of the performance report which would include as much live data as possible and this would be shared with the Board at a Development Session in the future, there would also be a focus on getting the read across working correctly.
116/25	In terms of operational performance, a surge had been seen, earlier than planned in the latter part of November into early December, ED performance had also been impacted however not substantially and the numbers of patients seen were in close comparison to other systems. Type one and type three performance had now been combined and where there were co-located Urgent Treatment Centres this would be incorporated into type one performance.

117/25	In terms of ambulance performance, Lincolnshire was performing well however there was still some work to be done to achieve the required category two performance.
118/25	Referral to Treatment (RTT) standards were sitting at 52% with the guidance ambition to achieve 65% by March 2025. This was a large increase and additional work would be required in terms of the transition within pathways to ensure this was achieved.
119/25	From an LCHS perspective, there were some local targets that were unachievable that required further work. Improvement in alignment of reporting was also required and within future reports detail surrounding any areas of concern would be highlighted at the beginning of the report. The Group Chair agreed that there were some legacy issues in terms of performance and reporting that required a refresh. The Board: • **Received the Integrated Performance Reports noting the moderate assurance**
	Item 14 Risk and Assurance
120/25	**Item 14.1 Group Risk Management Report** The Group Chief Clinical Governance Officer presented the risk report to the Board noting that there was one very high risk to highlight from an LCHS perspective relating to delays in children's speech and language therapy, which had been discussed at the last Quality Committee and a further risk had been reduced relating to treatment room capacity.
121/25	From a ULTH perspective there was one new very high risk relating to financial pressures and the new national profiles for job descriptions; one risk had also been closed relating to the Grantham medical air plant where issues had now been resolved. The Board: • **Accepted the risks as presented noting the significant assurance**
122/25	**Item 14.2 Board Assurance Framework** The Group Director of Corporate Affairs presented the report noting that all assurance Committees had considered the Board Assurance Framework (BAF).
123/25	The Group Director of Corporate Affairs explained that the Finance Committee had moved objective 3a to red in November and objective 3g had been moved from red to amber in December.
124/25	As previously mentioned a Board Development Session would be held in January to consider the 2025/26 Board Assurance Framework and to work through options to make this more effective for Committees to use from April onwards. The Board:

	• **Accepted the Board Assurance Framework and the changes to the assurance ratings for objectives 3a and 3g**
125/25 126/25 127/25	**Item 14.3 Board Committee Membership** The Group Director of Corporate Affairs presented the report which outlined the changes to Committee structures now that appointments had been made into the Group Executive roles and recognised the Non-Executive Director roles and changes. The Group Director of Corporate Affairs explained that there was one omission within the paper relating to the Finance Committee, where it had been agreed that the Group Chief People Officer would attend. Professor Baker sought clarification on when the nominated University Non-Executive Director would be joining the organisation and Committee structure. The Group Director of Corporate Affairs would be seeking a position update from NHSE. The Board: • **Received the report**
128/25	**Item 15 Any Other Notified Items of Urgent Business** No further items were discussed.
129/25	The next scheduled meeting will be held on Tuesday 4 March 2025 via MS Teams live stream.

Voting Members	**7 May 24**	**2 July 2024**	**3 Sept 2024**	**5 Nov 2024**	**7 Jan 2025**							
Elaine Baylis	X	X	X	X	X							
Andrew Morgan	X											
Karen Dunderdale	X	X	A	X	X							
Ian Orrell	X	X	A									
Jim Connolly	X	X	X	X	X							
Gail Shadlock	X	X	X	X	X							
Chris Gibson	X	X										
Philip Baker	A	A	X	X	X							
Neil Herbert	X	X	X	X	X							
Rebecca Brown	X	X	X	X	X							
Dani Cecchini	X	X	X	X	X							
Julie Frake-Harris	X	A										
Colin Farquharson	A	X	A	X	X							

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

Group Chief Executive's Report

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Hospitals NHS Trust

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*4th March 2025*
Item Number	*6*

Group Chief Executive's Report

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

System Overview

a) All parts Lincolnshire health and care system remain busy, but good work continues in order to cope with the ongoing operational pressures. East Midlands Ambulance Service (EMAS) declared a critical incident on 6th January 2025 due to a combination of significant patient demand, pressure within local hospitals and flooding across the East Midlands. System partners took immediate action to help mitigate the risks to the local population and EMAS de-escalated from the critical incident within 48 hours.

b) The 2025/26 priorities and Operational Planning Guidance was issued by NHS England towards the end of January. Work has been ongoing since then to produce the System Operational Plan for 2025/26, which is due to be submitted to NHS England on 27th March 2025. The Lincolnshire system is compliant with the majority of key national operating targets.

c) NHS England published guidance around reforming elective care for patients in early January. This sets out the shared approach to delivering the commitment made to meet the NHS Constitution access standard for elective care by March 2029. Work is ongoing to produce a plan which sets out the proposals to reform elective care.

d) The Lincolnshire system had a Quarterly System Review meeting with NHSE Regional Team on 29th January 2025. The system received positive feedback on continued improvements, alongside an acknowledgement of the challenges faced. A focus remained on the 2024/25 financial position along with the planning for 2025/26.

e) As part of a national engagement programme, the Lincolnshire system has run an engagement exercise with the local public and staff to hear their views, experiences and ideas to help shape the 10-year health plan for England.

f) The Government published the Devolution White Paper in December 2024 which sets out plans to widen and deepen devolution across England, whilst rebuilding and reforming local government. Greater Lincolnshire has been established and will progress through its final political stage which will see the forming of a Combined County Authority (CCA) ahead of the Mayoral election in May 2025. The Group continues to work closely with local councils and Lincolnshire Integrated Care Board (ICB) to support collaborative working for health and social care.

g) Lincolnshire Care Association (LinCA) hosted a visit by NHS England's Chief Nurse for Adult Social Care and Chief Nursing Officer on 9th January 2025. The visit included a meeting with a range of senior leaders from across the Lincolnshire Integrated Care System (ICS). The visit involved discussions about changes required to strengthen collaborative system working.

h) ULTH received the Quarter 4 tiering letter in February, on behalf of the NHS National Elective Recovery and Diagnostic Programmes, which confirmed the organisation has been moved out of tiering for elective and diagnostics. This highlights the considerable amount of work carried out to improve performance and the positive impacts on patient care.

Group overview

a) At month 10, ULTH's YTD financial position is a £33.0m deficit, £24.9m adverse to the planned £8.1m YTD deficit.

b) LCHS's YTD financial position is a £0.3m deficit, £0.2m favourable to the planned £0.5m deficit position.

c) The ULTH CIP YTD has delivered savings of £28.8m, which is £1.9m lower than the planned savings of £30.7m. LCHS CIP YTD has delivered £6.1m, which is £0.7m ahead of plan.

d) On 24th January 2025 I joined The Right Worshipful the Major of Lincoln, Councillor Alan Briggs in the official opening of Lincoln Community Diagnostic Centre (CDC). Approximately £42million has been invested into CDCs in Lincolnshire, of which £23m has been invested into the Lincoln CDC. Along with state-of-the-art elective (planned) diagnostic services, the centre has dedicated training facilities to support the training of future radiographers, directly linking with the Diagnostic Radiography Programme at the University of Lincoln.

e) ULTH presented its Electronic Patient Record (EPR) Business case to the National EPR Team during January. The case was subsequently submitted to the Joint Investment Committee and will now go for final approval during March 2025.

f) Having successfully launched the Martha's Rule, Call for Concern service during December 2024 at Lincoln County Hospital, ULTH has rolled out this service to Pilgrim Hospital, Boston at the beginning of February 2025. The service builds on the existing safeguards already in place in our hospitals to offer a clear and direct way to escalate concerns about a patient's deteriorating condition.

g) On 13th January 2025, ULTH welcomed a visit from the Patient Safety Commissioner for England, Dr Hughes. As part of the visit a detailed update was provided on the progress made with the implementation of the Patient Safety Incident Response Framework (PSIRF), which included how the key Patient Safety Principles had been applied across the Group. Dr Hughes commented on the significant progress made within the Group and took away learning and good practice to share with other Trusts.

h) On 16th January 2025 NHS England's Chief Midwifery Officer visited ULTH along with colleagues from the Regional Chief Nurses' office. The visit included a tour of the maternity unit at Lincoln County Hospital to highlight the improvement journey of the maternity services and how the maternity department was being transformed to improve the care delivered to women, babies and their families. During the visit, members of the maternity team were presented with Chief Midwifery Awards which recognise the significant and outstanding contribution to provide excellent care, leadership and inspiration to their colleagues and patients. Silver awards were presented to Specialist Midwife, Amy Garratt and the Shared Decision Making Council maternity staff, whilst the Gold award was presented to Director of Midwifery, Libby Grooby.

i) The Group welcomed a visit from the Stroke National Steering Group on 29th January 2025, as part of the work for Clinically-Led Workforce and Activity Redesign (CLEAR) for stroke. The CLEAR project is supporting the development of an improved stroke provision for the population of Lincolnshire.

j) Recently, the Group Chair and I met with the Chair and CEO of East Midlands Ambulance Service (EMAS) to continue to strengthen and maintain the positive collaborative relationship between the Group and EMAS.

k) As part of the Group Strategy, and to support the 10 year health plan, the Group is reviewing the way we traditionally provide services to the population of Lincolnshire. A focus will be on population health, with an ambition to

reduce health inequalities within our service transformation, and realigning our clinical services into care groups. This will enable us to deliver care in the right place at the right time for our patients. As a Group we will continue to provide high quality specialist and cancer care and responsive urgent and emergency care, alongside our planned care and community based services. Through a realignment of our services into new Care groups we will look to deliver more of our planned care services in an ‘out of hospital’ model, working with our population and health and social care partners with an ambition to transform clinical pathways, rationalise our estate investing more in community care and reducing reliance on acute services. Our Alliance Care Model will be the way we support this programme of work, with our transformation experts working alongside our clinical and operational teams to prioritise, phase and implement opportunities that will empower our patients and deliver improved health outcomes for our population.

NHS
Lincolnshire Community and Hospitals NHS Group

LCHG Development: Next Phase Delivery Plan Progress Report February 2025

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

Meeting	Public Trust Board
Date of Meeting	Tuesday 4th March 2025
Item Number	*Item 6.1*

Development: Next Phase Delivery Plan Progress Report February 2025

Accountable Director	*Professor Karen Dunderdale, Group Chief Executive*
Presented by	*Professor Karen Dunderdale, Group Chief Executive*
Author(s)	*Professor Karen Dunderdale, Group Chief Executive* *Wendy Booth, Interim Governance Lead*

Recommendations/ Decision Required

The Trust Board is asked to note:

- *Progress against delivery of the group development programme plan;*
- *The actions being taken where tasks / milestones are 'off track' and, where appropriate, agree the proposed revised timescales for completion. [Where revised timescales are agreed by the board, the RAG rating for the specific actions will be changed accordingly and progress reported on the revised timescale thereafter];*
- *The current position in respect of the menopause service* ***(Work Stream 6 refers);***
- *Further details, as requested at an earlier board briefing, on the staff engagement work* ***(Work Stream 6 and Appendix C refer****)*

Executive Summary

Background & Introduction

This report is intended to provide a high level briefing on progress against delivery of the agreed group development programme milestones. Over time, the report will be expanded to include reporting on benefits realisation of the move to group.

Current Position including Issues for Escalation

Overall, good progress has been made on delivery of the agreed programme milestones, although there has been some slippage in some work streams due to external factors outside the control of the group and / or due to internal capacity issues within the relevant teams (both the teams leading the work and the enabling support functions). As envisaged, the communications & engagement and HR & OD teams are facing significant pressures. This will remain under review with additional external capacity sourced as required although work to restructure and strengthen individual executive leadership structures will also assist. External, independent governance expertise and support to the programme also remains in place.

What is also clear from this first (February 2025) review of programme delivery is that, in some instances initially agreed timescales were either too optimistic and / or did not take account of the need for other pieces of work to be completed first. One example of this is the need for approval of the group strategy, vision and values prior to finalising the group visual ID / brand (Work Stream 3 refers).

In all instances where slippage has been encountered, proposed revised timescales have been included.

In respect of other issues requiring escalation, whilst the group has in place a good staff health & well-being offer and this continues to be developed, it has been identified that there is currently insufficient funding for the development of the menopause service (Work Stream 6 refers). This position is currently being urgently reviewed

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

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
Complete the group executive leadership recruitment process including the development of an appropriate induction programme and agreement of the contractual arrangements for the new group executive roles Complete the Fit & Proper Person Test (FPPT) checks for all relevant posts and ensure there are arrangements in place for the audit of "processes, controls and compliance supporting the FPPT assessments", in accordance with the NHSE FPPT Framework	31 August 2024 (initial appointments)	**Partially Complete:** Appointments made to group executive leadership roles; some on an interim basis initially. Contracts yet to be issued – currently being checked. Where roles are currently interim, substantive appointments to be made over the period March – August 2025. Testing of FPPT compliance included in Internal Audit Programme for 2025/26	
Once the executive leadership recruitment process is concluded, formalise the externally-set executive director statutory & regulatory accountability roles (to be reviewed alongside executive portfolios)	30 September 2024	**Complete:** Externally set executive director statutory roles reviewed and formalised to reflect the new leadership structure and shared at board. [**Note:** Schedule to be updated to confirm that the Group Chief Medical Officer is the executive (clinical) lead for medical devices in line with current national guidance]	
Formally approve the overarching group model structure and associated implementation plan including the proposed re-design of the existing directorates to introduce a new Alliance Division as part of an enhanced collaborative operating model, enable each division / directorate to operate on a wider footprint and ensure that clinical leadership remains central to the group model as a key function of group leadership	31 December 2024 **socialise & engage** 4 March 2025 **(board approval)** 1 April 2025 **(implementation)**	Underway - Operating model socialised through the re-launched Group Leadership Team (GLT). Implementation plan in development. On track for approval and implementation by 1 April 2025	
As part of the work to finalise the wider group and directorate structures, agree the division / balance of roles & responsibilities at group and trust level including alignment with Place, supported by the development of a clear Accountability & Performance Management Framework and aligned governance & decision-making processes and arrangements	As above		
Implement the new operating model and leadership structure, Accountability & Performance Management Framework and associated governance arrangements	1 April 2025 **(implementation)** 30 June 2025 **(embedded)**	As above	
Align the group support services and associated policies, processes and arrangements	1 April 2025 **(implementation)** 30 June 2025 **(embedded)**	Underway – some pressures on teams currently	
Once all of the required changes to the trust's operating model including leadership and governance & decision-making arrangements have been made, communicate to staff across the group - to include the development of a simple visual representation of the trust's operating model	1 April 2025	Not yet due – on track	

Work Stream 2: Accountability, Information & Reporting

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
Design, approve and implement an Accountability & Performance Management Framework for the group which: • is aligned to the aims & objectives of the group and strategic partners; • is aligned to the relevant statutory and regulatory standards, requirements and contracts relevant to the trusts and wider group; • flows from ward / patient to board; • is aligned to and supports the board and board committee cycle; • is based on clear metrics with defined performance thresholds reported through a harmonised Integrated Performance Report (IPR) from a group, trust directorate & service perspective; • is balanced across strategy, quality & safety, performance: operational delivery, workforce, finance, governance & risk; • is underpinned by a harmonised accountability & performance review policy & process; • is action focussed in support of delivery and risk mitigation and which reflects best practice as set out in the latest NHSE guidance: 'The Insightful Provider Board'; [**Note:** There is a need to ensure relevant improvement programmes e.g. ULHT Integrated Improvement Plan (IIP) is integral to and not separate from the above process including the alignment of group / trust KPIs]	31 January 2025 **(draft outline)** 28 February 2025 **(socialise)** 3 March 2025 **(approval)** 1 April 2025 **(implementation)** 30 June 2025 **(embedded)**	Aligned PRMs across the group in place from January 2025 Accountability & Performance Management Framework drafted (including a clear process and ratings for escalation / intervention) – to be socialised through GLT and approved by the Group Board in March 2025 and on track to be implemented from 1 April 2025	
Review the BI resource across the group to ensure this remains effective in support of the group Accountability & Performance Management Framework and the accurate, effective and timely reporting on performance and as part of the 'Vision for Information'	20 December 2024 **(Draft Vision)** 31 March 2025 **(Final Vision and Structure Proposal)**	Draft 'Vision for Information drafted Draft team structure developed: • Director of Improvement and Performance job description drafted and due to go out to advert by the end of February 2025 • Director of Digital to be in post from 1 April 2025	

Work Stream 3: Aligned Governance & Decision-Making

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
Board & Committee Governance			
Complete the transition from boards-in-common to a joint or group board (once all appointments have been made to group executive leadership roles and NHSE approval has been received for the appointment of joint or group and trust specific Non-Executive / Associate Non-Executive Directors (NEDs / ANEDs)	30 November 2024 **(complete – joint Trust Board in place)**	**Complete:** Group Board in place. Board Development Programme also in place supported by NHS Providers who have provided some initial observations and recommendations for strengthening the operation of the board – relevant actions incorporated within the group development programme plan. Well Led Assessment also planned for 2025 with NHS Providers support	
Complete the work to align the board business cycle (work plan)	31 December 2024 **(drafted)** 31 January 2024 **(approval)** **3 March 2025 (revised timescale for approval)**	Board business cycle for 2025/26 drafted. Draft shared with Group Chair and Executive Leadership Team for comment. Board business cycle to be shared with the Group Board for approval in March 2025	
Complete the work to transition the remaining board committees (Audit & Risk, People / Workforce, Finance & Performance) to work jointly including the development and approval by the trust board of harmonised terms of reference & work plans and the agreement of any changes to the naming convention for these committees. The development of harmonised terms of reference and work plans for all board committees to include a review of: • delegated authority and matters reserved to the Group Board; • membership (reflecting changes to group leadership structures); • reporting up from sub-groups (reflecting any changes to and / or alignment of those groups) • assurance ratings (ensuring these are aligned and consistent with those within the BAF) • the development of an 'Assurance Map' detailing the areas of oversight covered by each of the board committees; not least to avoid duplication and gaps	31 December 2024 **(harmonisation & approval of terms of reference & work plans & transition to new ways of working for all board committees)** 1 January – 31 March 2025 **(implementation)** **6 May 2025 (final terms of reference & work plans submitted to board)** 30 June 2025 **(arrangements fully embedded)**	Committees are now meeting jointly although arrangements need embedding. Terms of reference and work plans have been agreed but will be refined once final strategic objectives and the board business cycle have been agreed 'Assurance Map' drafted and will be shared with executive committee leads, NED chairs and the Group Board with the final draft set of terms of reference and work plans Work to review and ensure consistency in respect of assurance ratings is yet to be completed – this work is linked to refinements being made to the BAF and review of committee reporting templates which is also underway Review of reporting sub-groups is underway	
Undertake a review of the operation and effectiveness of the Quality Committee nine months on and any required changes to the terms of reference, work plan & associated arrangements. Any learning to be used to inform the transition of the remaining committees to working jointly **[NB.** Independent testing of the operation and effectiveness of all board committees working jointly will be required once embedded. This could be as part of the Internal Audit or planned Well Led Assessment.]	31 October 2024 **(review complete)** 31 January 2025 **(board receipt of & implementation of recommendations)**	Review of Quality Committee undertaken with support from Interim Governance Advisor and recommendations accepted and shared with the Group Board. Some changes made to reporting groups. Arrangements to be reviewed again in 12 months. Learning from the review is being used to inform the transition of the remaining board committees to working jointly	
Develop and seek approval from the trust board of terms of reference and a work plan for the proposed joint Integration Committee and agree the date for these meetings to commence and the required frequency	30 November 2024	Complete but see also comments above on board committees generally on the need for embedding	
Develop a 'board & committee principles framework' to ensure there is collective understanding of joint working principles; that both trusts can continue to make decisions and operate in accordance with the statutory & regulatory requirements that apply to them; and there is continued robust corporate reporting	31 December 2024 6 May 2025 (submitted to board as above)	Drafted but not yet approved – linked to work on finalising terms of reference, work plans and committee templates– to be shared with the Group Board with the final draft set of terms of reference and work plans	
Develop (or make any required changes) to harmonised board & committee templates (report cover / front sheet, agenda, minutes, upward report & action log) and common report writing guidance in light of the move to group and working jointly. As part of the development or updating of the report writing guidance, consider the need for and introduce a programme of report writing training for key staff and develop an exemplar report front / cover sheet	28 February 2025 **(templates & guidance)** 31 March 2025 **(training plan drafted)** **6 May 2025 (submitted to board)**	Underway – upward report templates being strengthened to ensure consistency of approach and that they support and prompt the provision of appropriate assurance to the Group Board from all committees and, in turn, from the groups reporting to the board committees. Action Log also being strengthened.	

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

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
Non-Executive Director (NED) & Associate Non-Executive Director (ANED) Roles			
Complete the review of proposed NED / ANED roles for the group and secure the required internal and external approvals [**Note.** This is required to facilitate a formal move to a joint or group board and joint committees rather than 'in-common' board and committees]	30 September 2024	**Complete** – review of NED / ANED roles complete. Approvals received and arrangements effective from 1 October 2024. Subsequently, NHSE approval is awaited in respect of the appointment of a further NED – who will be a full NED on the ULTH board and an Associate NED on the LCHS board. This additional appointment reflects the award of teaching hospital status to ULTH. It has also since been agreed that the PCN Chief Executive will join the Group Board as an Associate NED	
Board Development			
Once the group executive leadership team is in post and informed by a board skills & knowledge assessment and aligned to the proposed group executive development programme, develop, agree & implement a Joint Board Development Programme. As an outline, a Board Development Programme may typically include: • board development days / time-outs ensuring dedicated time on key topics and priorities including group development and strategy; • information sharing / briefings (e.g. national policy, regulatory changes, learning and good practice from elsewhere); • board training / compliance requirements; • tailored sessions in response to identified development needs (including those identified from the skills & knowledge assessment or arising from the annual review of board effectiveness or any well led or governance review etc.)	From 1 October 2024 onwards	Board Development sessions being undertaken with NHS Providers support Formal programme for 2025/26 being drafted – to ensure appropriate focus on strategy and long term service development, the role of the unitary board, the board's appetite to risk, working with system partners and the board's responsibilities in respect of EDI and health inequalities (NHS Providers Board Effectiveness Survey, November 2024 refers)	
Consider undertaking an annual board maturity assessment which in turn will contribute to any well led assessment and will inform the board development programme for the following year	31 March 2025	Well Led assessment planned with NHS Providers support – timescale TBC	

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

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
Executive Governance			
Design, approve and implement the group executive governance & decision-making structure to include a review and alignment, as appropriate, of the sub-groups reporting up to the Executive Leadership Team (ELT) / Group Leadership Team (GLT). The design of the new structure to ensure: • there are effective & timely governance & decision-making arrangements in place that support operational delivery and meet the needs of the trusts and wider group; • there is appropriate alignment with the proposed Accountability Framework for the group; • the governance & decision-making arrangements in place support the trust and wider group to meet the relevant statutory and regulatory requirements; • there is consistency in how information and assurance is reported up to group executive and board & committee level; • there is a clear separation between management (escalation and decision-making) and assurance meetings; • the structure feeds and supports the new board and committee meeting cycle in a timely way; • there is scope for tailoring arrangements where necessary to specific trust-level risks and needs	31 January 2025 **(draft outline)** 28 February 2025 **(socialise)** 31 March 2025 **(approval)** 1 April 2025 **(implementation)** 30 June 2025 **(embedded)**	Review of executive governance / meeting structures underway through the Executive Leadership Team – discussions held on 7 November and 12 December 2024 and 23 January 2025. Revised structure to be socialised with GLT and finalised by ELT in March 2025.	
As part of the above work, review the terms of reference for the Executive Leadership Team (ELT) & Group Leadership Team (GLT) to ensure that roles & responsibilities are clear and that clinical leadership / input remains central to decision-making across the group	As above	Terms of reference drafted – to be refined as required once executive structures appointed to and executive governance / meeting structures have been agreed	

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

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
Board Reporting Framework (BAF) & Risk Registers			
Phase 1: Complete the work to align the two trust BAFs including a review and alignment of 'assurance ratings' and ensure that each strategic risk is cross-referenced with related risks on the corporate risk registers. **[Note:** Whilst the aligned BAF will reflect risks to the delivery of the strategic objectives which have been agreed for the group and the controls, assurance, gaps and actions may be the same for each organisation, where there are risks which are specific to either ULHT or LCHS, the controls, assurances, gaps and actions to be explicitly referenced for each separate organisation] Phase 2: Consider and agree the 'design' of the aligned BAF for 2025/26 onwards i.e. should the format of the aligned BAF look and feel different for the group? Agree the board committee oversight for each strategic aim & objective Phase 3: Implement the new style BAF	31 October 2024 **(underway)** 21 January 2025 **(Group Board workshop)** 1 April 2024 **implementation of new style BAF)**	Strategic objectives for 2025/26, a revised BAF format and BAF review cycle were agreed by the Group Board in January 2025 Once the risks to the delivery of the strategic objectives and the group risk appetite have been agreed (see below), the new style BAF will be populated and in place from 1 April 2025 although will continue to be refined as the group matures. This work is being supported by the Interim Governance Advisor	
Agree the group risk appetite and ensure this is appropriately referenced within the BAF for each strategic objective	18 March 2025 **(Group Board workshop)**	A board workshop to agree the group risk appetite, supported by NHS Providers, is due to be held on Tuesday, 18 March 2025	
Review and standardise the risk register and approach to risk management and risk reporting across the group including the management of Datix	31 December 2024	**Complete:** A new joint Risk Policy was launched on 1 December 2024. Whilst two separate risk registers remain in place there is a consistent approach to risk management across the group. Testing of the effectiveness of these arrangements will be undertaken as part of the annual internal audit review of risk management which informs the Annual Governance Statement and as part of any Well Led Assessment	
Alignment of Group Meeting Cycle			
Once the work to design and align the board, committee, sub-group and other key trust meetings is complete, develop and update annually a single group meeting schedule (ensuring alignment with the Accountability & Performance Management Framework and performance review meetings)	31 January 2025	Meeting cycle in place. PRMs to be added	

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

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
Document Control & Policy Approvals			
Agree and implement a harmonised and strengthened approach to document control and policy approvals for the group	31 March 2025	A combined document control policy and process is in place although not yet fully embedded. A recent internal audit of these arrangements recognised that the group is still in transition. Further review to be undertaken as part of the group development work programme	
Review of Key Trust Documents & Governing Instruments			
Complete the review, alignment and approval of key documents & governing instruments to reflect the move to group and changes to the operating model to include but not limited to: • Standing Orders • Standing Financial Instructions • Scheme of Delegation & Powers Reserved for the Boards • Division of Responsibilities Schedule between the Group Chair and Chief Executive • Accountability Framework • Fit & Proper Persons Policy & associated processes Other trust documents to be aligned as part of work to implement the directorate structures and align the group support services and to socialise / launch the group brand	31 March 2025	Underway – on track Interim amendment to Standing Orders made to reflect the appointment of a Group Chief Executive and joint Leadership Team, changes to ELT and GLT decision-making and the proposed move to joint board and committees and any changes to voting rights	
Review and update relevant policies, documentation and templates to reflect the move to group and the group brand	31 March 2025	Underway – on track	

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

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
Group Working Agreements			
Review and update the Group Partnership Agreement to reflect the agreed changes to the operating model including the leadership and governance & decision-making arrangements, once finalised and agreed	31 March 2025	On track Date for board re-approval to be schedule	
Review and update the Group Workforce Sharing Agreement to reflect the agreed arrangements for broader staff / staff groups from each trust, as required, to work across the group: such arrangements to maintain the existing employment relationship whilst avoiding the need for honorary contracts or secondment agreements	31 March 2025	On track Date for board re-approval to be scheduled	
Review and update the Group Information & Data Sharing Agreement to reflect changes to the operation of the group and any changes to the requirements for sharing information & data	31 March 2025	On track Date for board re-approval to be scheduled	

Work Stream 4: Communications & Engagement

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
Group Strategy & Group Visual ID / Brand			
Develop and promote the Group Communications & Engagement Strategy	31 March 2025	In development – on track in resect of development of the strategy. Date for board approval TBC	
Develop the Group visual ID / brand ensuring adherence to the NHS Identity Guidelines specifically in respect of partnership branding	**31 January 2025 (original timescale)** **Revised timescale TBC once the group vision & values have been formally approved**	Group visual ID / brand drafted and with the Group Chair and Group Chief Executive for comment. Change proposed to the original timescale for implementation which did not take account of the need to ensure alignment with approval of the group vision and values	
Develop guidelines and supporting suite of templates for the use of the Group visual ID / brand (how and when it should be used including in respect of signage, document design, correspondence etc.)	**As above**	Guidelines and templates being developed – on track in line with revised timescale	
Roll-out / socialise the Group visual ID / brand & supporting guidelines	**As above**	As above	
Internal & External Communication & Engagement Channels			
Merge the external facing social media platforms (e.g. Linked-In, Instagram, Facebook) currently in use within the two trusts to create combined Group social media platforms. **NB.** X (formerly known as Twitter) to remain separate as not possible to merge	31 December 2024 (original timescale) **1 March 2025 (revised timescale)**	Not yet complete – slippage due to external procedural issues with the relevant social media platforms. Revised timescale of 1 March 2025 proposed to complete this work	
Merge the staff closed Facebook group	28 February 2025	Proposal, which takes account of the views of staff within each trust, who wish to retain separate Facebook groups, due to be considered by ELT & GLT in February 2025	
Merge the internal communication & engagement channels (e.g. weekly e-newsletter, team brief / communications cascade) to include the use of the Group visual ID / brand once agreed. **NB.** Group Chief Executive's weekly email already in use across the group	31 January 2025 (original timescale) **1 April 2025 (revised timescale)**	Most communication channels have been merged – those that have not yet been merged are on hold awaiting approval and implementation of the Group visual ID / brand	
Develop and implement a communication & engagement toolkit aimed at ensuring wider awareness of service changes & developments across the group	31 March 2025	Toolkit in development in conjunction with the Patient Experience Team – on track	
Continue the ongoing comms on all aspects of group development and benefits realisation as changes occur including the development of FAQs for staff on changes to 'how things work across the group'. **NB.** Case studies and group wide log of engagement activities being maintained including learning from staff listening events	Ongoing	Ongoing	

Work Stream 4: Communications & Engagement cont'd

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
Group Intranet & Internet			
Create and roll-out a group Intranet (including the migration of ULTH to nhs.net). **[Note:** All staff across the group to have access to the group Intranet from 1 April 2024. Full migration to nhs.net to take up to a year]	30 June 2025	Underway – on track	
Create a single group three URL website which provides information at both a group and individual trust level and which meets accessibility legislation requirements	31 March 2026	Case of Need drafted – timescale for implementation to be confirmed and agreed as part of approval of the Case of Need	
Communications & Engagement Team			
Continue to embed and develop the combined group Communications & Engagement Team building on the implementation of cross-group portfolios from September 2024	30 September 2025	Combined team in place but some changes are proposed as part of the planned restructure therefore arrangements are not yet fully embedded	
Continue to provide communications & engagement support, as required, to the group development programme work streams & SROs e.g. development of group strategy, aims & objectives, values and culture	31 March 2026	Ongoing – pressures on the team to be escalated as they arise. Staff engagement roadshows on the group strategy, vision & values are currently taking up significant communications and engagement team resource	
Continue to embed the merged media monitoring / horizon scanning and escalation process	Ongoing	Ongoing – group wide media monitoring / horizon scanning and reporting to the Group Chief Executive and GLT is in place	

Work Stream 5: HR & Workforce

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
For any consultation process moving staff into group roles from individual trusts, undertake an equality impact assessment in accordance with ACAS best practice	Ongoing	Ongoing process	
Develop a package of individual support for staff who will be affected by the change of the move to group	Ongoing	Arising from the local health & wellbeing survey and outputs from the national staff survey a programme of staff engagement workshops, led by GLT and ELT and covering the group vision, strategy & objectives, group values and behaviour frameworks has been agreed. These workshops are in addition to the existing staff engagement 'Tube Map' & Change Workshops and health & well-being offer in place	
Harmonise contractual policies and processes across the group, working with union colleagues: six priority policies identified and agreed with union colleagues from both trusts in the first instance. Plan and timescale to be agreed for harmonising remaining policies and processes	31 March 2025	Underway – on track	
Harmonise T&Cs – *linked to policy work*	As above	Harmonised Change Management Policy for the group approved	
Harmonise Reward & Recognition including the development of a group Reward & Recognition Policy	31 December 2024	Arrangements harmonised and policy developed. Policy approved w/c 17 February 2025	
Move to a group induction using the following blended approach: • Development of joint induction video • Harmonisation of joint face to face induction	 31 December 2024 31 January 2025 30 June (revised timescale)	Group induction video in place. Plan in place to introduce harmonised face to face induction but this has been delayed due to resource / capacity issues within the team	
Ensure all training, progression, career development opportunities, apprenticeships and support are offered consistently across the group – *linked to policy work and supported by aligned of teams and portfolios*	31 January 2025 **(review of portfolios)**	Ongoing & monitored through Workforce Operational Group	
Ensure portability of staff for cross-site working	1 November 2024 **(interim solution)** 1 April 2025 **(long term solution)**	Interim solution in place. Long term solution being worked up – this work is inked to development of Alliance Division	

Work Stream 6: Organisational Development (OD)

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
Continue to provide ongoing support to those staff most affected by the move to a group model	Ongoing	Engagement 'Tube Map' and Change Workshops in place & ongoing (Appendix C refers). Additional staff engagement roadshows planned as outlined in work stream 5	
Develop proposals for a long term Organisational Development programme to support the transition to group and the new operating model with a focus on: • Directorate leadership development • Executive development • Board development	Ongoing **(Group Board and ELT) Development Programmes)** 31 March 2026 **(Division / Directorate Leadership Programme (The 'Leeds Way') to be embedded**	Board Development sessions are currently being undertaken with NHS Providers support. EDI specific half-day board development session is also being planned with external, expert speakers (authors of *'Too Hot to Handle'*) 12 month ELT Development Programme in place and being supported by Acqua The OD team have commenced the scoping work to support the implementation of the 'Leeds Way'	
Continue to align and develop the group culture including the agreement of one set of group values	31 January 2025 **(outputs & recommendations from 'Better Together' Programme & engagement sessions)** 3 March 2025 **(board approval)**	A report on the 5 new proposed group values is due to be considered by ELT on Thursday, 13 February 2025 with a view to board approval in March 2025 and launch from 1 April 2025	
Continue to develop the staff health & well-being offer across the group including the introduction of menopause support	31 March 2025	The staff health & well-being offer continues to be developed. It has however been identified that there is currently insufficient funding for the development of the menopause service. This is currently being urgently reviewed	

Work Stream 7: Digital

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
Develop a digital strategy, infrastructure & capabilities for the group with a focus on digital transformation and new ways of working to include the following specific actions / milestones:	31 March 2025	Underway – on track in respect of strategy development. Approvals process may take longer	
• undertake an exercise to map the digital systems in place across the group & develop a plan for alignment of systems where feasible to do so e.g. ESR, Datix, Intranet, Document Management System etc.	31 January 2025 **(Map)** 31 March 2025 **(Plan)**	Underway – on track. Update submitted to Digital Oversight Group in February 2025	
• move to a single Microsoft 365 teams platform with the migration of ULTH to the national tenancy	31 March 2025 **(Migration case developed. Delivery Group in place)**	Underway – on track: • Emails: migrated from 24 February 2025 • Teams + Office: migrated from 10 March 2025 The remainder of March 2025 will be utilised for 'problem solving' and 'teething issues	
• move to a single domain / directory login process	31 March 2025 **(Implementation Plan)** 31 October 2025 **(Full Implementation)**	Underway – on track: • Implementation Plan drafted • Supplier (AGEM) to support implementation	
• move to standardised printing & print codes – significant piece of work – workarounds to be simplified in short term	31 March 2026 **(Full Implementation)**	Underway – on track: • Interim arrangements and process in place between ULTH and LCHS to issue codes and provide access to each other's devices	

Work Stream 7: Digital cont'd

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
• transition LCHS from the current AGEM IT support contract to the Group Digital support system	24 January 2025 **(Finalised Plan)** 1 October 2025 **(Full Service Migration – some things may take longer)**	Underway – on track for 1 October 2025 full service migration • Transition plan drafted • Contract signed and in place with supplier (AGEM)	
• create a common identity for the Digital Team (linked to the group brand & associated actions)	31 March 2025	Underway – on track: • Three away days held with the teams • Structures drafted • Director of Digital to be in post from 1 April 2025	
• develop a 'Vision for Information' for the group including a review the Business Intelligence (BI) resource across the group to ensure this remains effective in support of the group Accountability Framework and the accurate, effective and timely reporting on performance	20 December 2024 **(Draft Vision)** 31 March 2025 **(Final Vision and Structure Proposal)**	Draft 'Vision for Information drafted Draft team structure developed: • Director of Improvement and Performance job description drafted and due to go out to advert by the end of February 2025 • Director of Digital to be in post from 1 April 2025	
• move to aligned telecoms	31 March 2025 **(Single telephony team)** 30 May 2025 **(Secured single contract for Telephony Services)**	Underway – on track: • Single team as planned but funding for additional required posts may take longer	
• data hosting	31 March 2025 **(Server Migration Completion)**	Underway – on track: • As of 5 February 2025, all but 6 of the 101 servers have been migrated • Remainder require support from supplier. 5 will be completed by 31 March 2025 and planned with suppliers. 1 planned to be completed in April (currently 20% of migration completed) due to supplier resource issues. There is no risk to the project and group as this work relates to consolidation of the infrastructure	

Work Stream 8: Estates & Facilities

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
Estates Strategy, Service Developments & Transformation			
Develop the Estates Strategy in support of delivery of the agreed group strategic aims & objectives, planned service developments & transformation projects and in support of reducing health inequalities:	31 March 2025 **(commencement of work to develop the strategy)** 2 September 2025 **(board approval)**	Not yet due – no issues or concerns to escalate	
• consider & evaluate the different models for the provision of EFM services across the group to include the option of a wholly owned subsidiary model and present the findings and recommendations for approval to the Group Leadership Team and Trust Board	31 March 2025	Underway – on track. Assessment of options undertaken and currently being evaluated	
• undertake an estates rationalisation review with a focus on decompressing the acute site and agile working and present the findings and recommendations to the Group Leadership Team and Trust Board	30 June 2025	External support to undertake the review being sourced at an estimated cost of £22.5k. Work to be progressed in the 2025/26 financial year	
• continue the programme of ward refurbishments, as funding is available	Ongoing	No funding currently available – programme to be reviewed in new financial year	
• undertake a review of all leases and licences across the group	30 June 2025	Underway – on track although some difficulties have been experienced in obtaining information on leases and licences under the previous shared service	
• produce a visual 'map' of all services and where they sit within the group and ensure this is aligned with each trust's CQC registration / Statement of Purpose'	31 December 2024	**Complete:** 'Map' of services produced and shared with ELT	
• deliver the agreed EFM transformation projects and EFM improvement plans	31 March 2025	Ongoing – on track: no significant issues or concerns to escalate	

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

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
Restructure of EFM			
Complete the restructure of the EFM senior management team and underpinning workforce plans and associated work plans to ensure the two trusts are able to meet and, where necessary, improve compliance with statutory requirements to include the bringing together of the emergency planning and health & safety teams	31 March 2025 (original timescale) **30 June 2025 (revised timescale)**	Deferred to June 2025 due to lack of HR capacity to support the process. Some gaps in the senior management team currently which is also risk	
Equality & Inclusion			
Continue to promote equality & inclusion and reduce workforce inequalities within EFM:	Ongoing	Ongoing	
• develop a single approach to the movement of EFM staff across the group	31 March 2025	Underway but impacted by gaps and capacity issues in the team	
• commission a cultural review of estates services and continue to deliver the improvement actions identified in the facilities services cultural review	31 December 2024 (original timescale) **30 June 2025 (revised timescale)**	Not yet started due to gaps & capacity issues in the team – timescale to be revised / aligned as above	
• align and improve the processes for staff development, on boarding etc. across EFM	31 December 2024 (original timescale) **30 June 2025 (revised timescale)**	Not yet started due to gaps & capacity issues in the team – timescale to be revised / aligned as above	
EFM Governance & Assurance			
Undertake a review of and strengthen the EFM governance structure and associated assurance processes across the group and ensure that the EFM governance structure is appropriately aligned to the wider group governance structures and decision-making arrangements:	30 September 2025	Underway – recruitment to EFM Head of Compliance post underway with interviews scheduled for w/c 17 February 2025 and a number of credible candidates shortlisted	
• align the process for the completion and submission of the annual Premises Assurance Model (PAM) assessment and for delivery of the agreed improvement actions	31 July 2025	Commenced – on track although latest NHSE guidance and assessment tool awaited	
• undertake a review of Approved Persons (APs) for the relevant HTMs and as a key element of the EFM governance & assurance processes	30 September 2025	Not yet due – deadline may be impacted if gaps & capacity issues in the team remain unresolved	
• review, update and align the EFM policies and procedures across the group	31 December 2025	Review of EFM policies & procedures is underway: Fire Policy & Health & Safety Policy currently going through ratification process	

Work Stream 9: Strategy & Planning

Key Tasks / Milestones	Timescales	Current Position including agree remedial actions where progress is 'off track'	RAG
Harmonise the strategy & planning process across the two trusts including the development of a single strategy management policy and strategy group	31 December 2024	**Complete**	
Develop a combined strategy and set of strategic aims & objectives for the group: to include the development of an integrated delivery plan* setting out the programmes and projects to be delivered in Year 1 of the Strategy against the strategic aims, and the associated measures and outcomes [**Note:** The joint Trust Board has agreed to move from 5 to 3 strategic aims – board workshop planed for early 2025 to agree the underpinning strategic aims and linked to the review and alignment of the BAF and agreement of the 'risk appetite' for the group]	31 March 2025 21 January 2025 **(Trust Board workshop)**	Underway – on track Group vision, strategic objectives for 2025/26, a revised BAF format and BAF review cycle were agreed by the Group Board in January 2025 Next steps include agreeing strategy KPIs and monitoring in year delivery against plan	
Harmonise the underpinning strategies e.g. clinical, quality, people, digital etc.	30 June 2025	Once the group strategy has been approved the underpinning enabling strategies and plans will be developed	
Develop a single operational & financial plan for the group including the responsibilities of divisions / directorates for the delivery of the strategic aims & objectives and priorities for the group (linked to the development of the Accountability & Performance Management Framework)	31 March 2025	Underway – currently on track (draft by 28 February 2025 an final by 28 March 2025) although progress may be impacted by delayed planning guidance which, in turn, may impact on budget setting and agreement of priorities for 2025/26	
Develop transformation and improvement programmes to facilitate the delivery of the strategy	31 March 2025	Underway – on track. Productivity & Improvement Group in place reporting to GLT but with reporting from an assurance perspective to the Finance Committee (Productivity) and the Integration Committee (Improvement)	
Develop a common Project Management Office (PMO) approach to enable accurate reporting aligned to the new governance arrangements across the group	31 March 2025	Underway – on track. The group is working with the ICB system and group partners to build our agreed approach of a six stage PMO methodology. Restructuring of teams across the group is underway to build PMO capacity & capability	
Develop a Group Quality Improvement strategy and commence implementation of the Quality Management System (QMS)	31 March 2025	Underway – on track. Work to is underway to develop the QI strategy and plan as a key enabler to the delivery of our productivity and transformation programme. The QI strategy focusses on culture/shared purpose/leadership behaviours and a dosing model for building improvement capability.	

Work Stream 9: Strategy & Planning (cont'd)

Key Tasks / Milestones	Timescales	Current Position including agree remedial actions where progress is 'off track'	RAG
Develop a proposal for primary, community and acute care collaboration (Alliance Model) and a spectrum of integration	31 March 2025	Operating model (including the introduction of an Alliance Division) socialised through the re-launched GLT. Implementation plan in development. On track for implementation by 1 April 2025	
Develop a Partnership Strategy for the group	31 March 2025 (development of strategy) 30 April 2025 (refresh)	The Partnership Strategy for the group has been developed however will be refreshed in line with the group strategy and the creation of an alliance model	
Support development of the Group Sustainability & Green Plan - Phase 1	31 March 2025 (Phase 1) 1 July 2025 (board approval)	Phase 1 - Existing ULTH and LCHS green plans reviewed, workshops completed with high impact areas and biggest areas of opportunity being captured. New plans being drafted, sustainability agenda being embedded in new LCHG Strategy and annual plans. Need to identify SRO for the programme. Board approved Green Plans required in line with statutory guidance by 31 July 2025. Waiting for confirmation from Group Director of Corporate Affairs on requirement for 2 separate plans or a single LCHG plan	
Develop a clinical services and practitioners strategy for the group	31 August 2025	Underway – on track	
Build and shape a new group strategy and planning team with OD support to fully align with required functions	31 August 2025	Underway – on track	

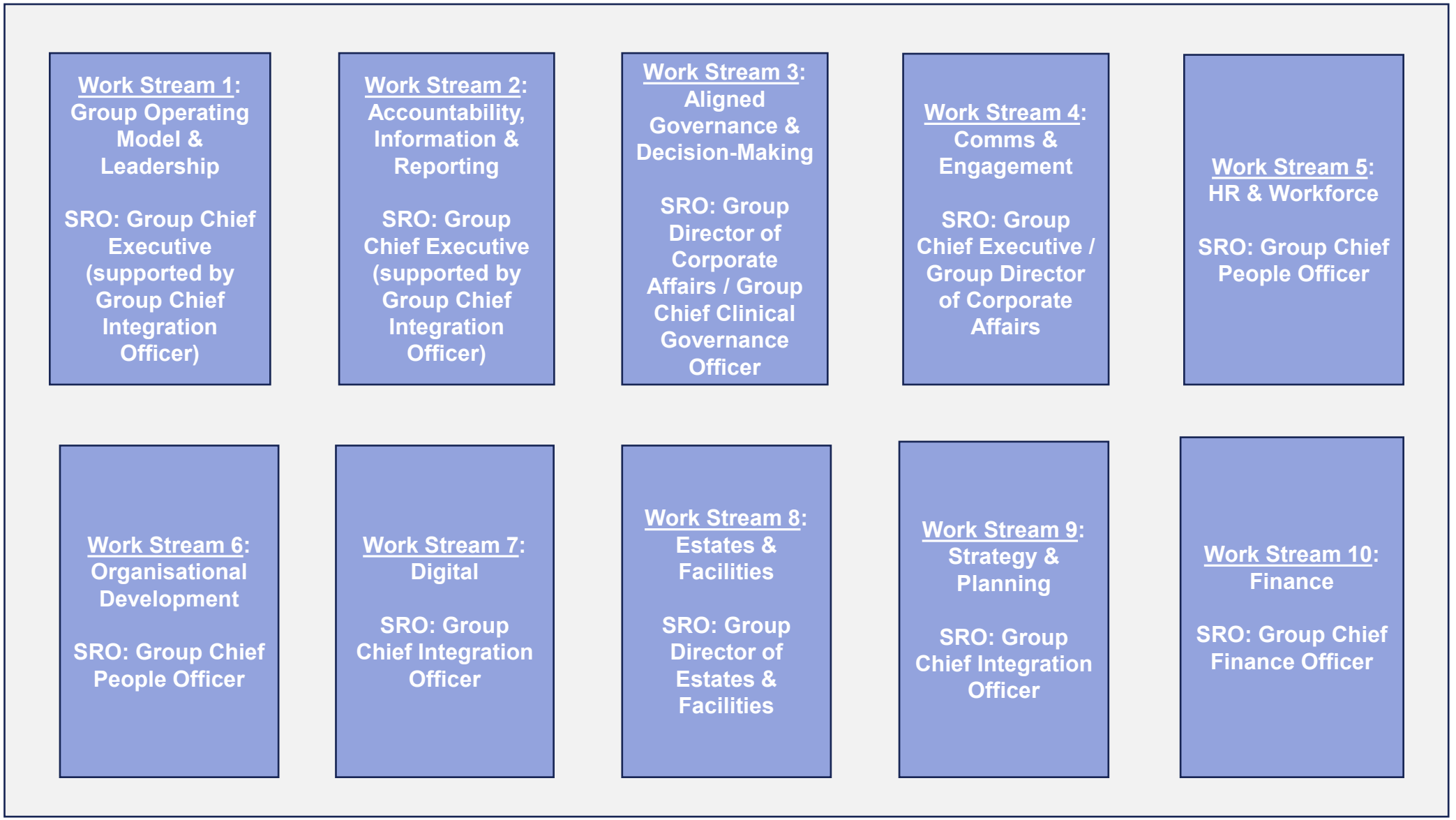
Work Stream 10: Finance

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
Develop the Finance Strategy for the group in support of delivery of the agreed group strategic aims & objectives	30 June 2025 (strategy drafted) 1 July 2025 (board approval)	Currently on track although progress may be impacted by delayed planning guidance which, in turn, may impact on budget setting and agreement of priorities for 2025/26	
Harmonise the financial planning & budget setting processes across the group	31 January 2025	Planning assumptions aligned and consistent although processes not yet fully embedded	
• produce and roll-out a revised budget holder manual	28 February 2025	Single budget holder manual developed and being rolled out	
Develop a single operational & financial plan for the group including the responsibilities of divisions / directorates for the delivery of the strategic aims & objectives and priorities for the group (linked to the development of the Accountability Framework)	31 March 2025 **(see also work stream 9: strategy)**	As above – progress may be impacted by delayed planning guidance although planning assumptions aligned across the group	
Align and strengthen financial reporting ensuring reporting from a group, individual trust and service level perspective and including the development of financial information dashboards reflecting user feedback	31 March 2025	Work to develop new performance metrics & dashboard is underway and on track. Bottom up review of budgets also underway	
Harmonise the business case development, review and approval process ensuring a consistent approach and methodology	31 July 2025	Not yet due but work is underway to align processes across the group	
Apart of the development of the Accountability & Performance Management Framework for the group, align and strengthen the mechanisms for holding divisions / directorates to account for budgetary control, the delivery of financial plans and cost improvements	31 March 2025	As above, work to develop new performance metrics & dashboard is underway and on track. Consistent approach adopted to PRMs from January 2025	
Complete the review, harmonisation and approval of key documents & governing instruments to reflect the move to group and changes to the operating model to include but not limited to: • Standing Financial Instructions • Scheme of Delegation & Powers Reserved for the Boards	31 March 2025	Underway and on track with corporate governance team – no issues or concern to escalate	

Work Stream 10: Finance

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
Harmonise the financial policies and processes across the group	December 2025	Underway – on track. Current financial policies all up to date. Mapping exercise to be undertake to identify those still be aligned and to agree timescales	
Align the Internal Audit arrangements	August 2025	Underway – on track. Internal audit arrangements have been aligned. A joint Audit Committee is in place with auditors working to develop a single report which reports at group and trust level recognising the need to maintain individual organisational sovereignty and accountability	
Review, harmonise and strengthen the financial training offer and culture	June 2025	Underway – on track. First finance roadshow training event being held in February 2025. Budget holder refresher training taking place during February & March 2025	

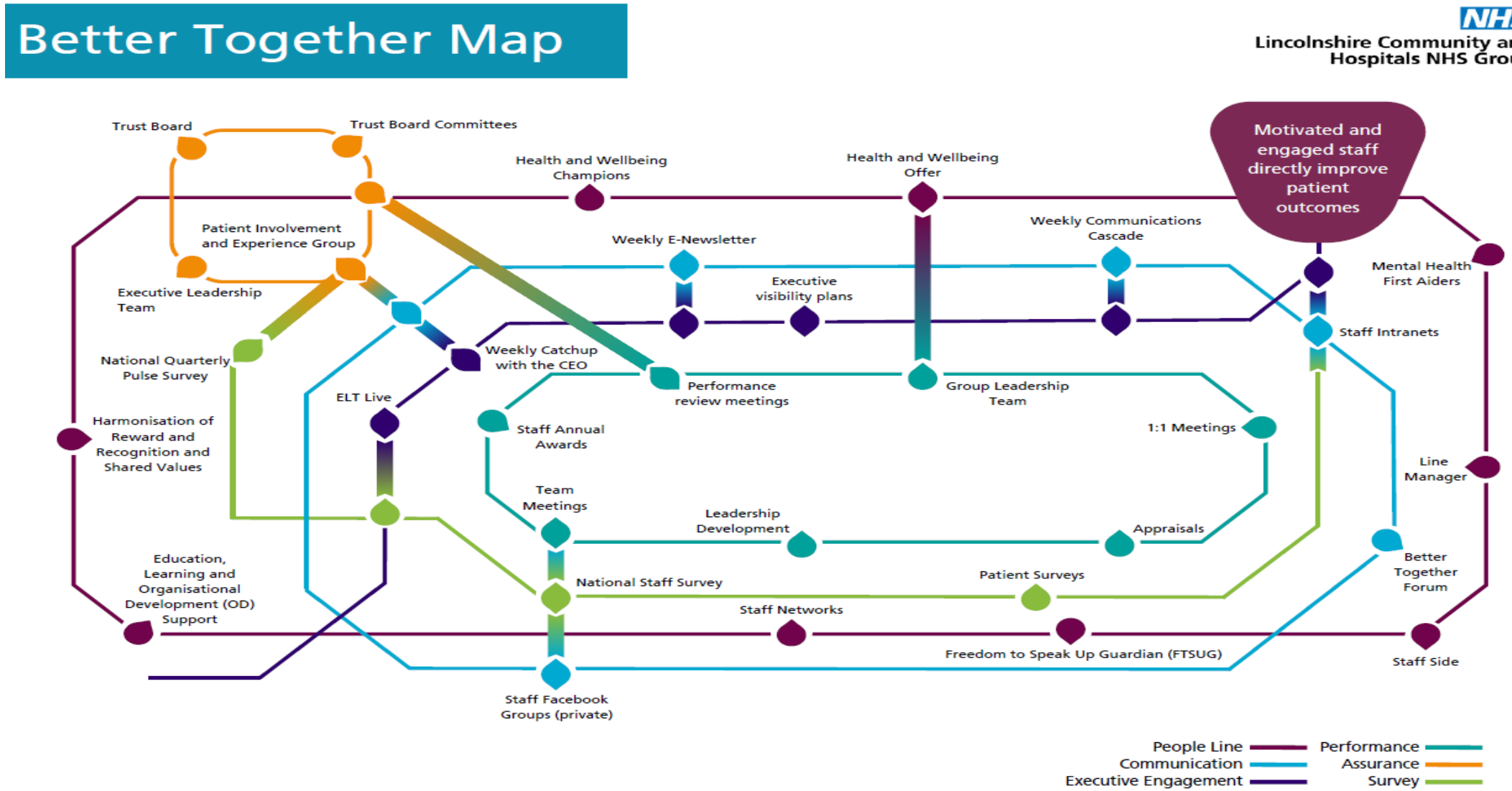
Appendix A: Group Development Programme: Work Streams & SROs



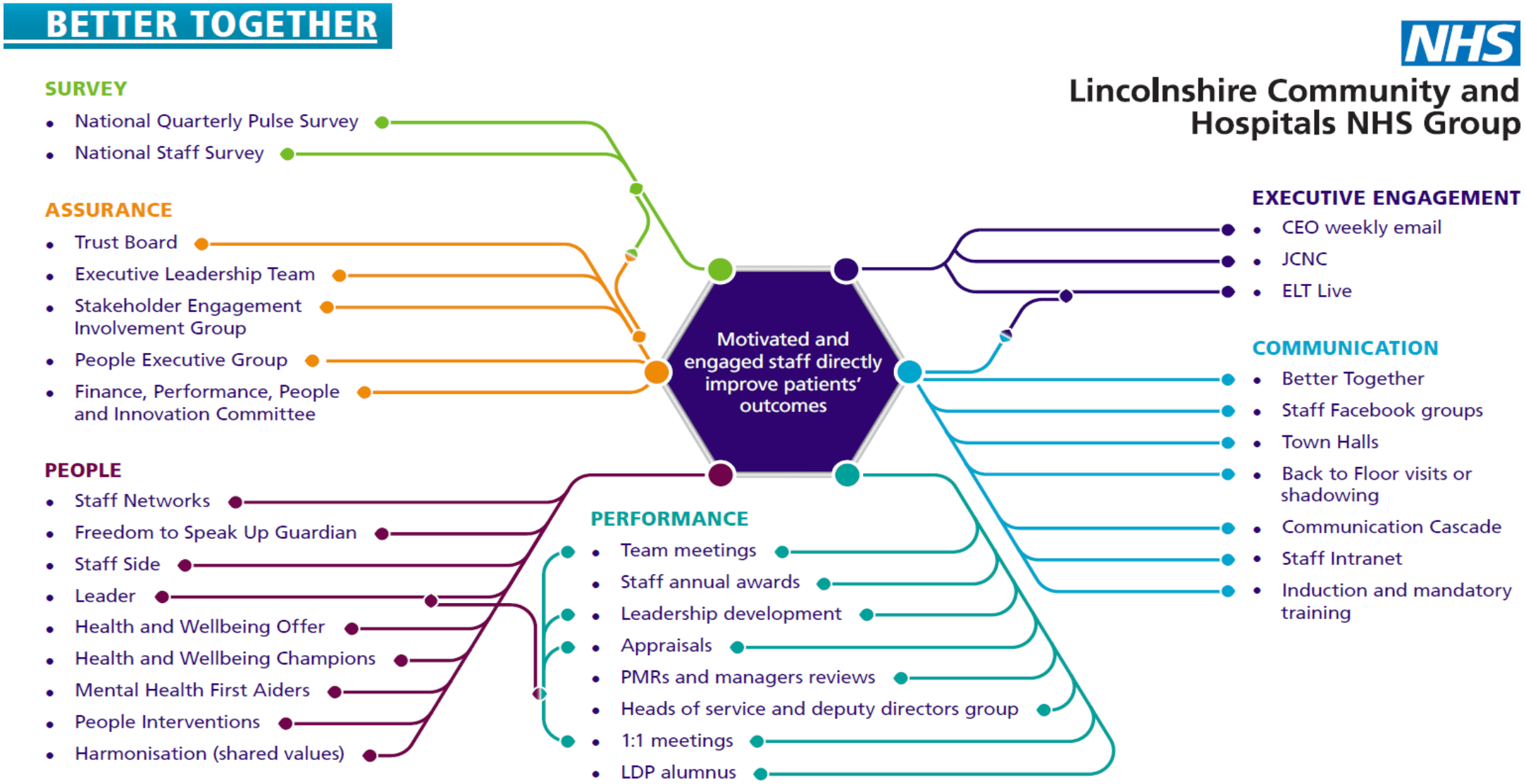
Appendix B: Group Development Programme Delivery RAG Rating

RAG Rating Matrix	
Blue	Completed & embedded
Green	Completed & ongoing and / or not yet fully embedded
Amber	In progress & on track
Red	Not yet completed / significantly behind agreed timescales

Appendix C: Staff Engagement 'Tube Map'



Appendix C: Staff Engagement 'Tube Map'



NHS
Lincolnshire Community and Hospitals NHS Group

Celebrating Group Success
Stroke Services

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

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*4th March 2025*
Item Number	*7.1*

Celebrating Group Success
Stroke Services

Accountable Director	*Daren Fradgley, Group Chief Integration Officer*
Presented by	*Carl Ratcliff, Integration Specialist*
Author(s)	*Carl Ratcliff, Integration Specialist*
Recommendations/ Decision Required	*The Board is asked to:-* • *Receive the update*

How the report supports the delivery of the priorities within the LCHG Board Assurance Framework	*X*
1a Deliver high quality care which is safe, responsive and able to meet the needs of the population	*X*
1b Improve patient experience	*X*
1c Improve clinical outcomes	*X*
1d Deliver clinically led integrated services	*X*
2a Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	*X*
2b To be the employer of choice	*X*
3a Deliver financially sustainable healthcare, making the best use of resources	*X*
3b Drive better decision and impactful action through insight	
3c A modern, clean and fit for purpose environment across the Group	*X*
3d Reduce waits for patients who require urgent and emergency care and diagnostics and ensure we meet all constitutional standards	*X*
3e Reducing unwarranted variation in cancer service delivery and ensure we meet all constitutional standards (ULTH)	
3f Reducing unwarranted variation in planned service delivery and ensure we meet all constitutional standards (ULTH)	*X*
3g Reducing unwarranted variation in community service delivery and ensure we meet all constitutional standards (LCHS)	*X*
4a Establish collaborative models of care with all our partners including Primary Care Network Alliance (PCNA), GPs, health and social care and voluntary sector	*X*
4b Successful delivery of the Acute Services Review	*X*
4c Grow our research and innovation through education, learning and training	
4d Enhanced data and digital capability	*X*

5a Develop a Population Health Management (PHM) and Health Inequalities (HI) approach for our Core20PLUS5 with our ICS	
5b Co-create a personalised care approach to integrate services for our population that are accessible and responsive	*X*
5c Tackle system priorities and service transformation in partnership with our population and communities	*X*
5d Transform key clinical pathways across the group resulting in improved clinical outcomes	*X*

Executive Summary

The Board are provided with an update on a one year project with NHSE where the aim was to improve stroke treatment rates (Thrombolysis)

The slides demonstrate the improvement from 8 to 12% treatment and other areas where patient care was improvement – treatment time halved and time from treatment to ward also improved. Next steps are also noted with a new project with CLEAR / National stroke team to reduce delays in treatment / patient pathways and address staffing challenges.

Thrombolysis in Acute Stroke Collaborative (TASC)

United Lincolnshire Trust – Lincoln Site

4th March 2025


Impact of stroke

Thrombolysis

Thrombolysis in Acute Stroke Collaborative

- A clot busting drug increases individuals of chances of survival with less disability
- Time window – symptom onset less than 4 and half hours
- The quicker it is given the better the patients functional outcomes
- **1.9 million neurons** are lost every minute after stroke.

Our thrombolysis rates were below the national average –

- **2022- 2023 = 8%**
- The team decided to submit an EOI for a National QI project

★ 1 of 6 Trusts selected

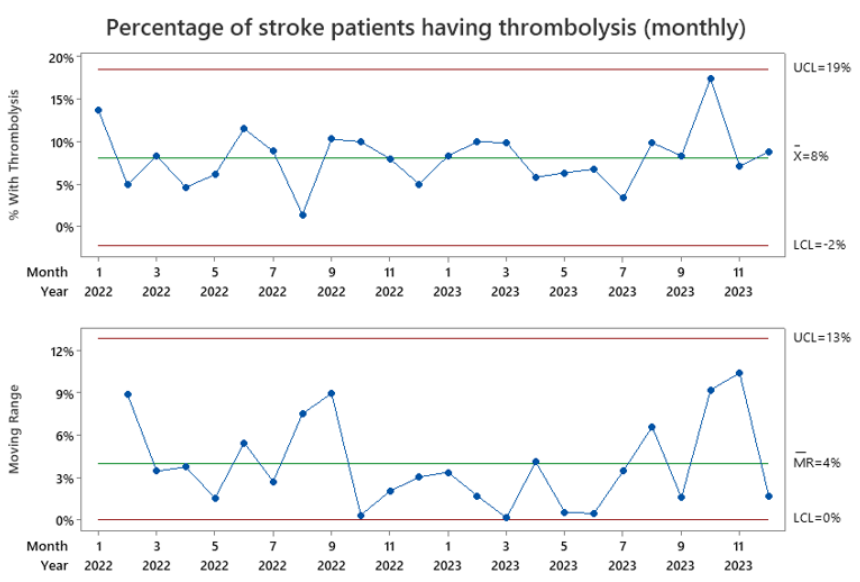
100,000
people have strokes a year. Stroke strikes every five minutes.

Facial weakness
Can the person smile?
Has their mouth or eye drooped?

Arm weakness
Can the person raise both arms?

Speech problems
Can the person speak clearly and understand what you say?

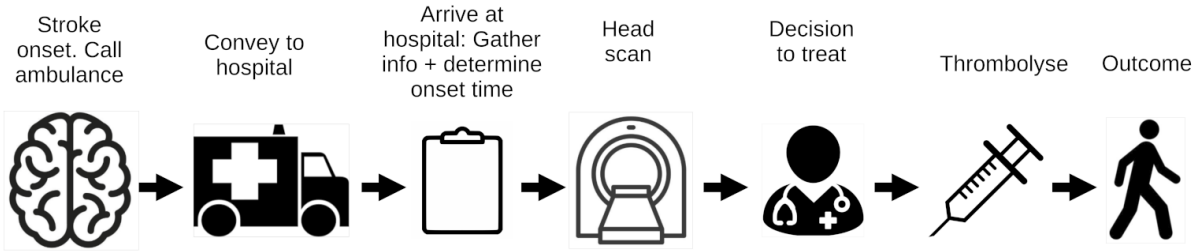
Time to call 999
Stroke is a medical emergency.



	% with thrombolysis
Average	8%
UCL	19%
80% Variation	13.5%
Average MR	4%

Data

Thrombolysis in Acute Stroke Collaborative

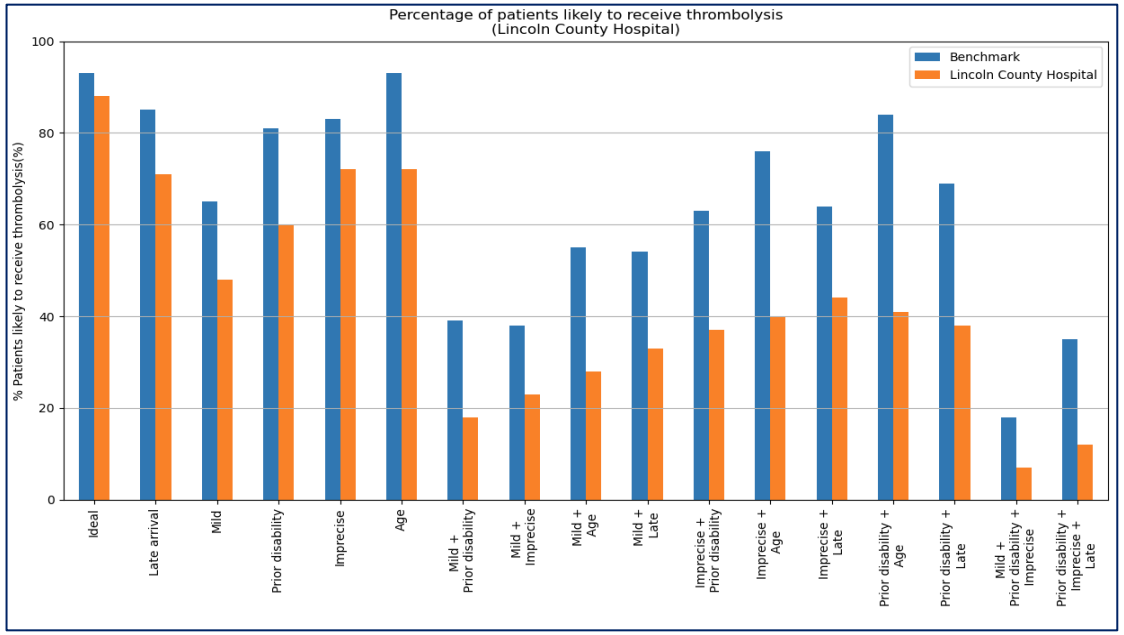


2022 – 2023 data analysed

Patient arrival to **thrombolysis took 75mins on average**

Scan to thrombolysis took **46 mins** on average

Patient characteristics + time frames influence decision making – less likely to thrombolysed 'non-ideal' patients



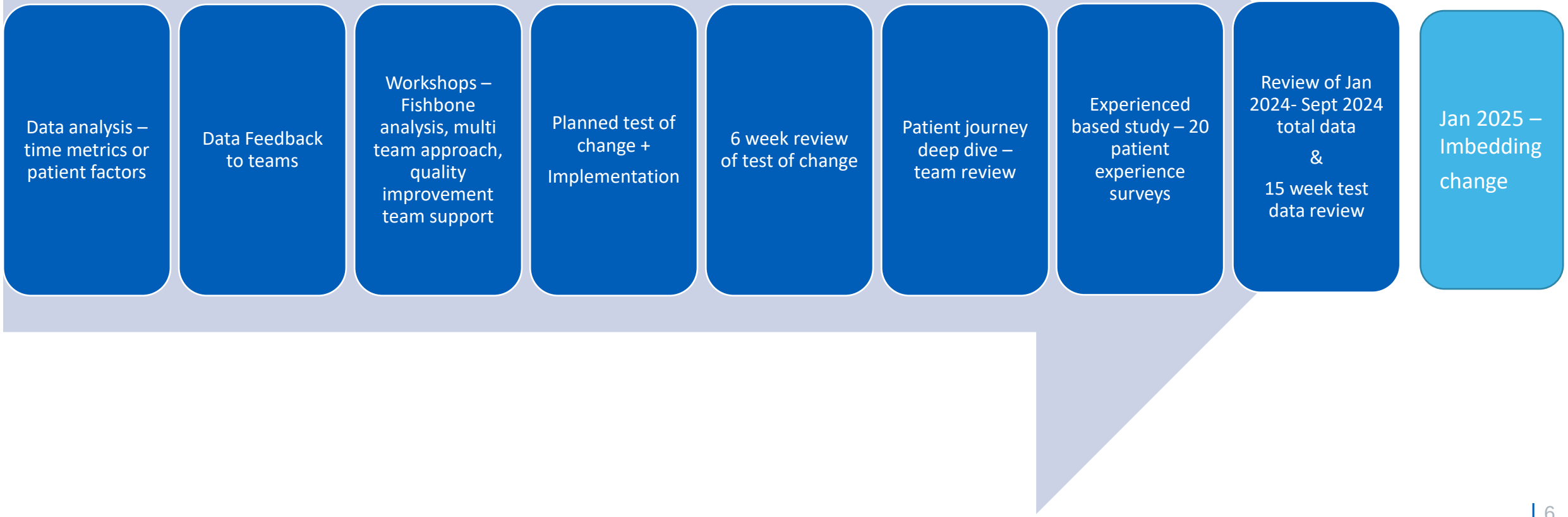
Key observations

Thrombolysis in Acute Stroke Collaborative

- Lincoln Hospital:
  - Modelling predicts a realistic target thrombolysis rate of 17%
  - Less likely to give thrombolysis to patients 'non-ideal' thombolysable characteristics (e.g. milder strokers, patients with prior disability), especially when two or more non-ideal characteristics are present
  - Improving speed will improve outcomes for all patients receiving thrombolysis
  - Possible potential to determine more stroke onset times

Our Journey

Thrombolysis in Acute Stroke Collaborative



Collaboration

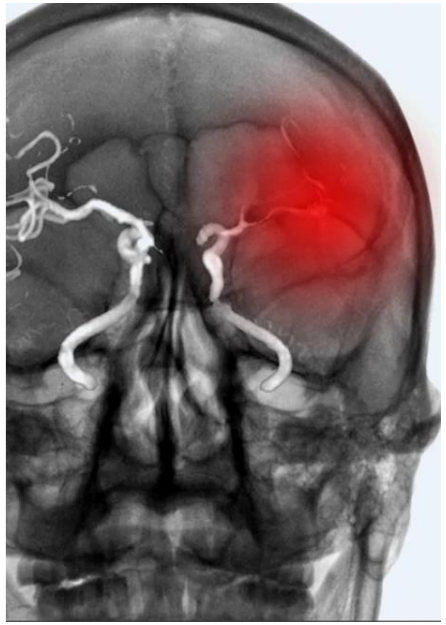
TIME IS BRAIN

Thrombolysis in Acute Stroke Collaborative

- Emergency Department Staff
- Urgent Care Managers
- Ambulance Service
- Radiology Department
- Improvement Team
- Stroke Team

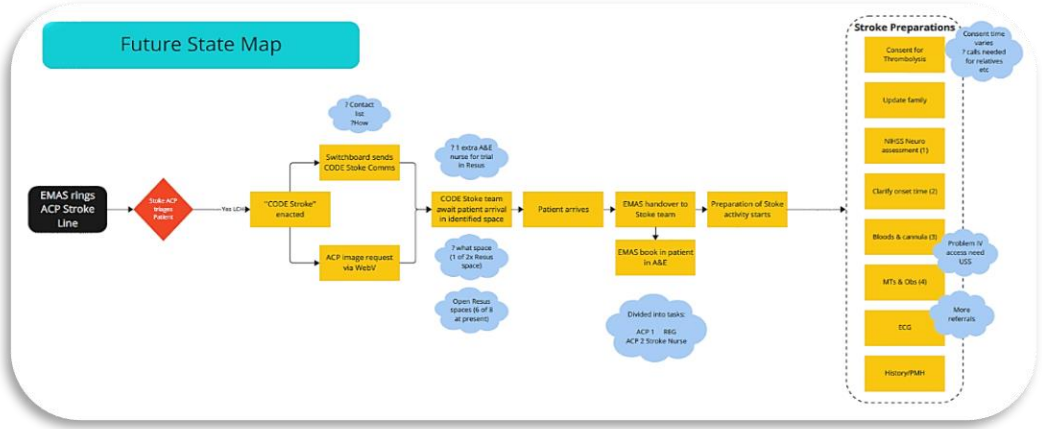
Delays in treatment;

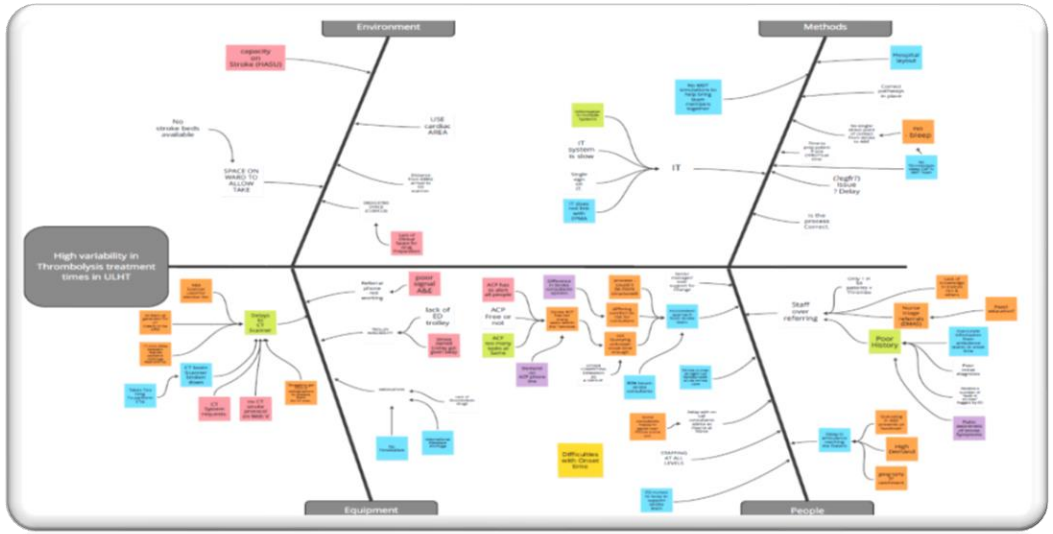
1. One person doing many tasks
2. Communication between departments/ward
3. Space for assessment
4. Waste processes



PIT STOP Approach

CODE STROKE





1. Ambulance service contacts Stroke ACP – deemed potential ‘Code stroke’ patient [candidate for thrombolysis.]
2. Core Team – Stroke Consultant, Stroke ACP, Stroke Registrar, Thrombolysis Nurse
3. Bleep system for pre-alert; Core Stroke Team, ED co-ordinator, Radiology and Ward [ring-fence bed]
4. ED allocate space
5. Speed handover and assessment then straight to scan with crew
6. Thrombolysis bolus now given in CT scanner – infusion can be started if for Thrombectomy transfer or straight to HASU

Test of change 6 weeks then review – Monday to Friday 8-18:00
Process for patient found to be non-stroke [SOL etc] agreed

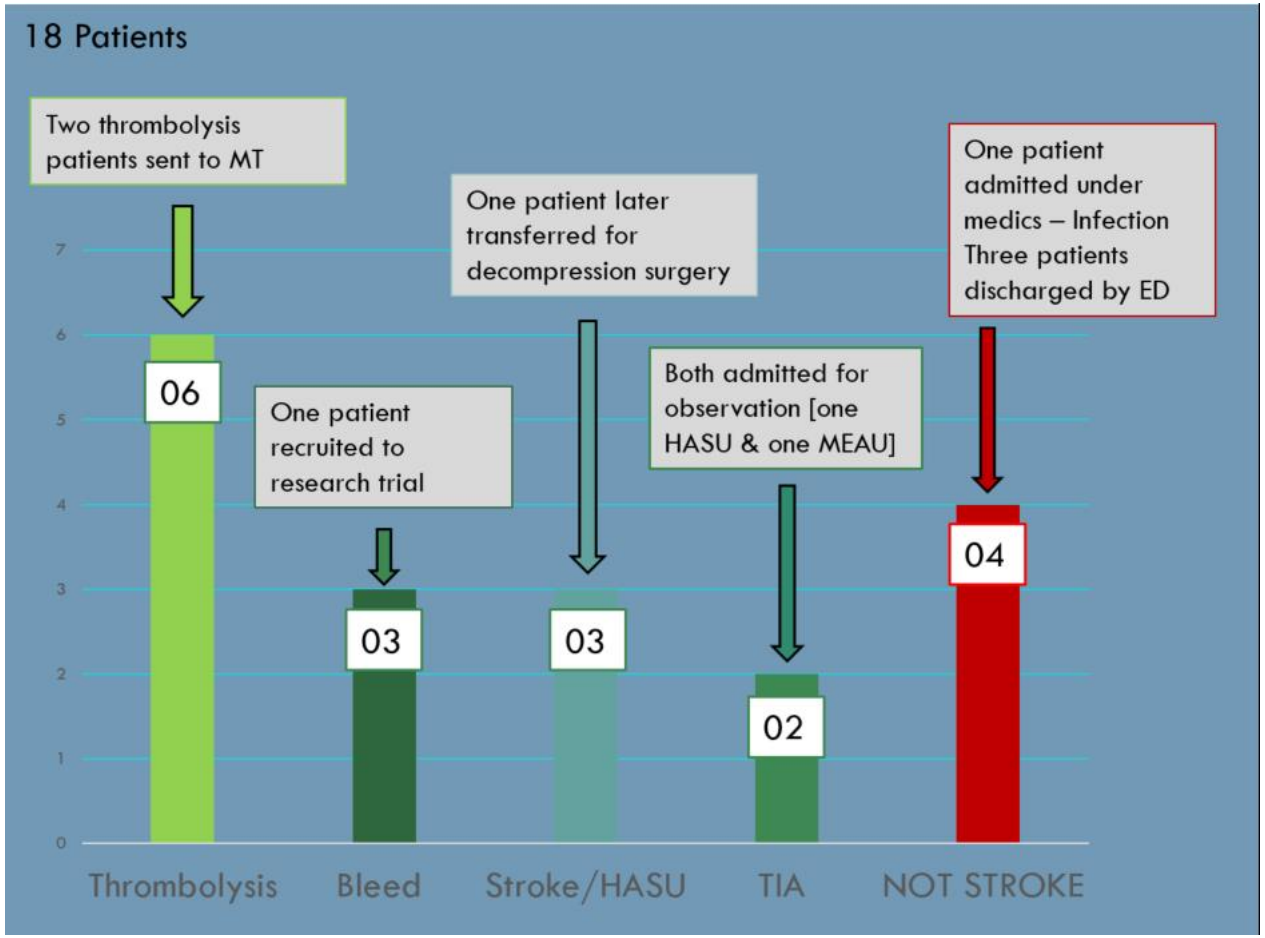
Week 6 – 18 code stroke Alerts – 6 thrombolysed [33%]

Median assessment time to head scan in RESUS = 14 mins [avg 13.8]
Median assessment time to head scan in RAT = 28 mins [avg 26.8]

Door-to-Needle
Median 36 mins
Average 38 mins

50%
[9 out of 18]
Patients scanned in less than 20 minutes

Quicker admission to HASU

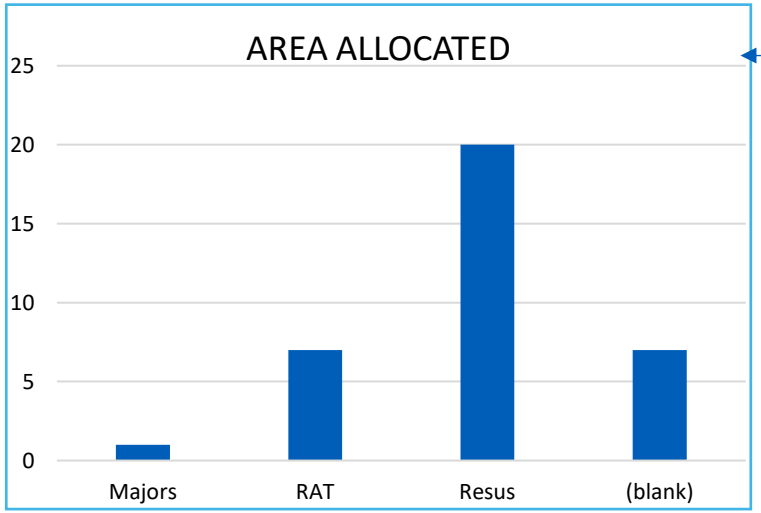


Week 15 - 36 code stroke alerts - 33% thrombolysed

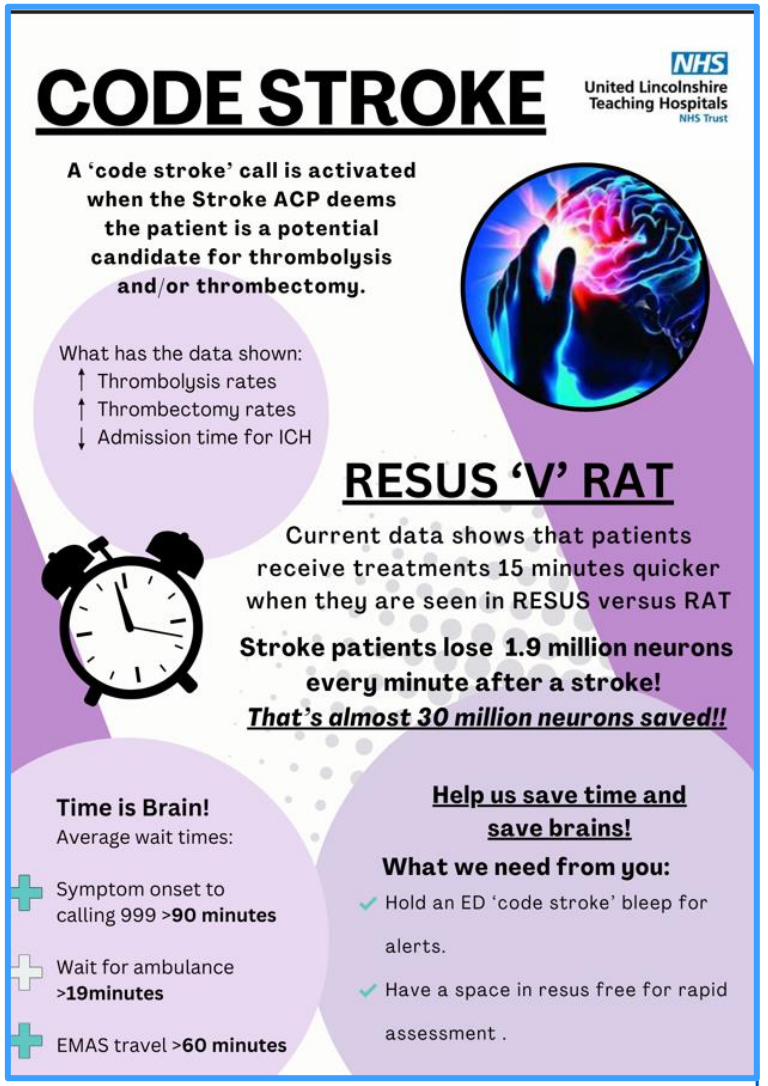
Door-to-Needle
Median 34 mins
Average 36 mins

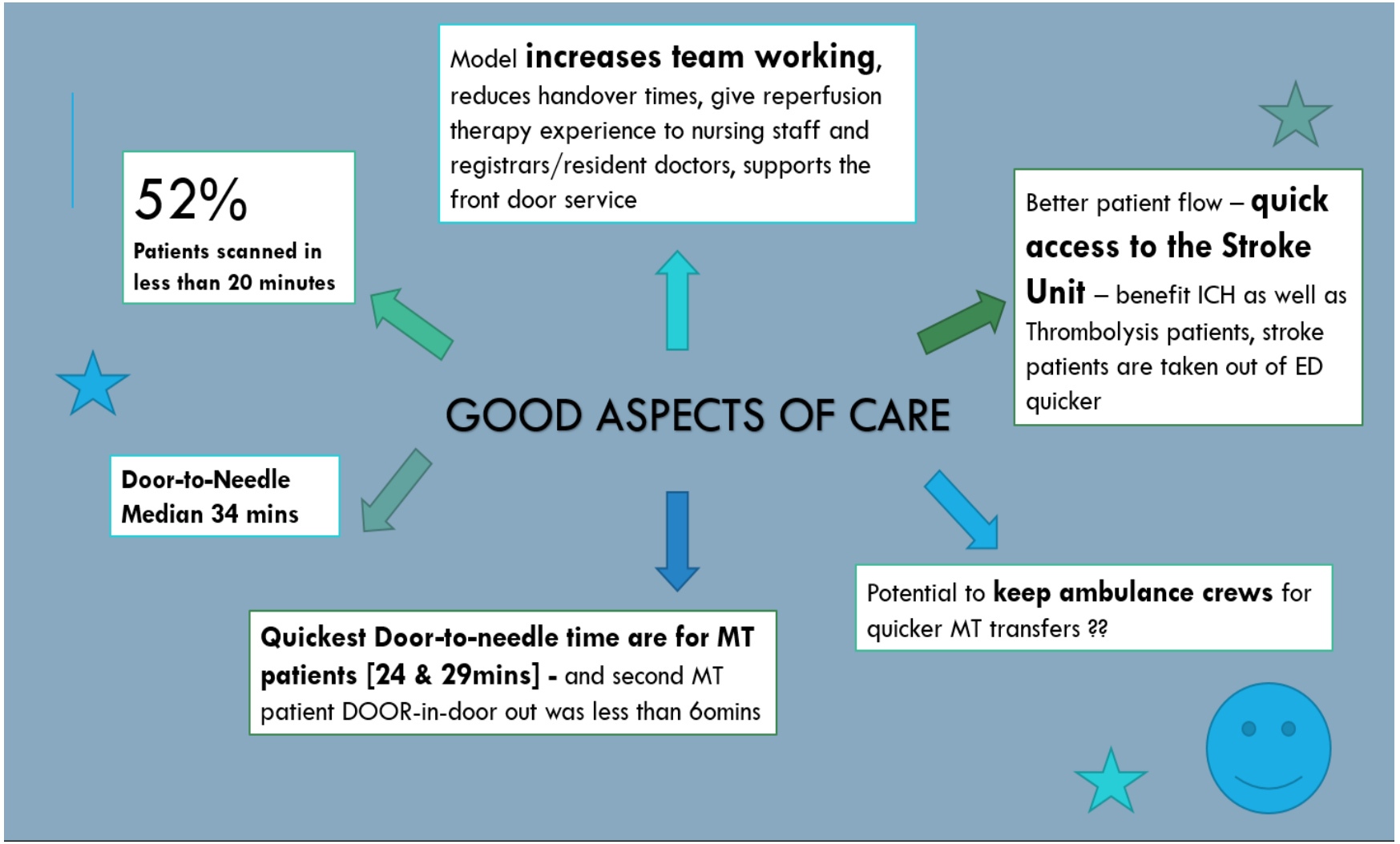
Speed improving further

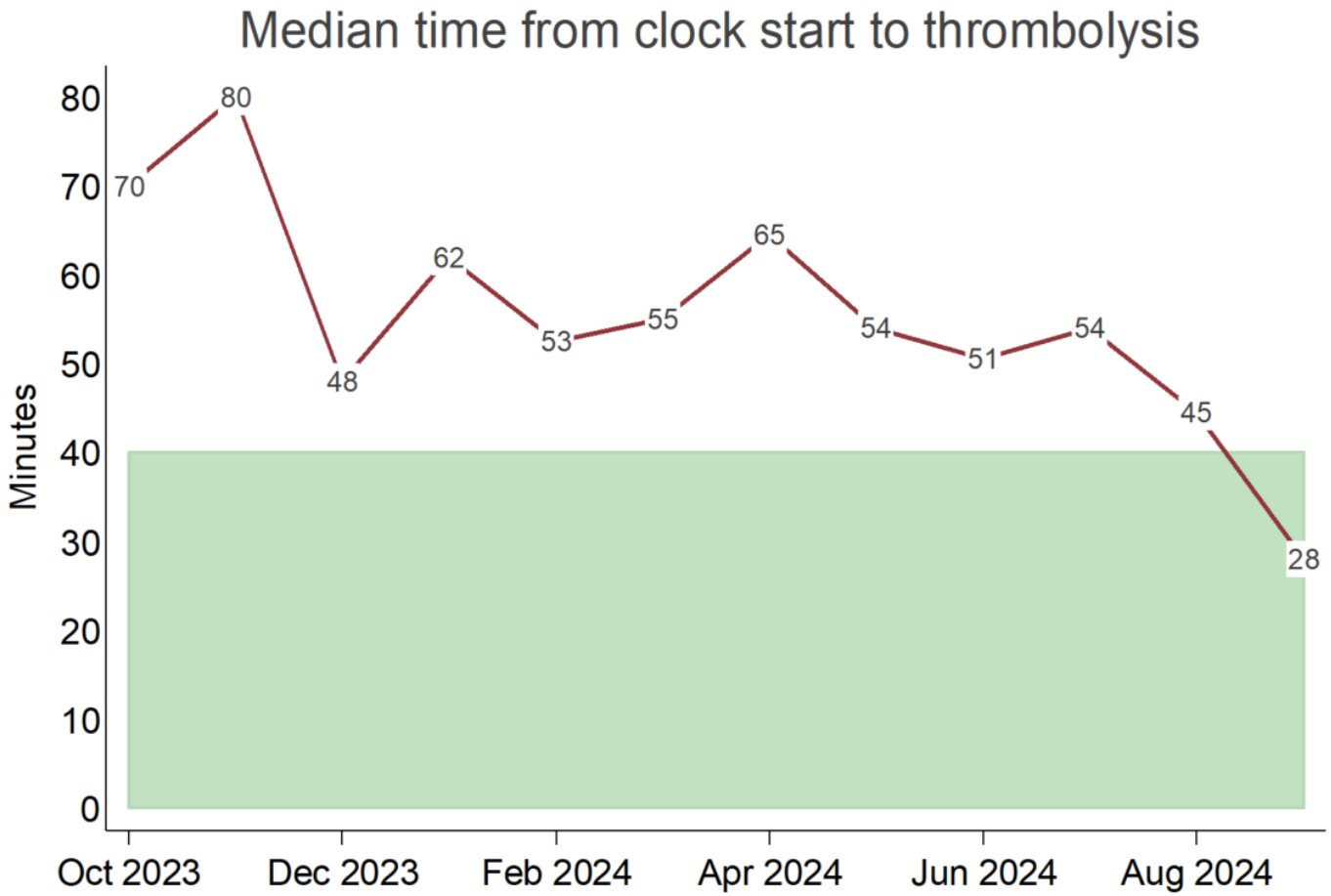
Door to scan - MEDIAN = 19mins
19 patients scanned in less than 20mins [52%]



More Resus allocation




Model **increases team working**, reduces handover times, give reperfusion therapy experience to nursing staff and registrars/resident doctors, supports the front door service
52%
Patients scanned in less than 20 minutes
Better patient flow – **quick access to the Stroke Unit** – benefit ICH as well as Thrombolysis patients, stroke patients are taken out of ED quicker
GOOD ASPECTS OF CARE
Door-to-Needle Median 34 mins
Quickest Door-to-needle time are for MT patients [24 & 29mins] - and second MT patient DOOR-in-door out was less than 60mins
Potential to **keep ambulance crews** for quicker MT transfers ??

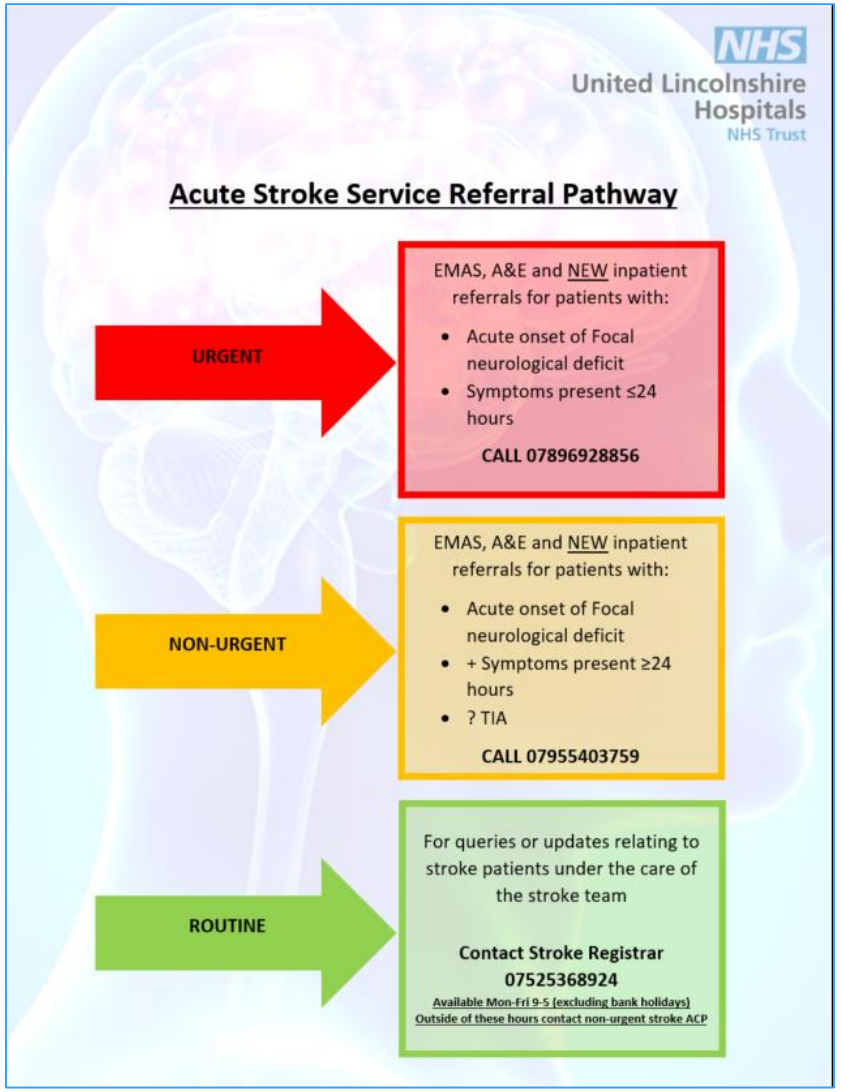


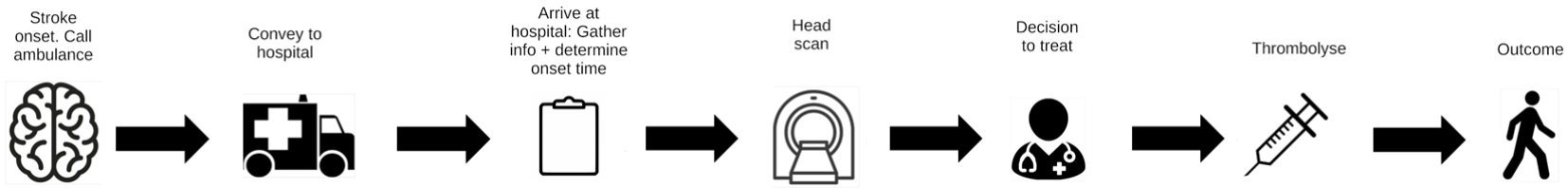
Started our test of change in August, could see treatment times improve in last national audit data

Test of change – shows quicker treatment times

Treatment times halved
75 mins avg to 36 mins

- Inter-professional teaching – teaching sessions with EMAS & ED
- Thrombolysis pathway/decision reviews – monthly Stroke Team meetings
- Plan to implement e-learning to help staff confidently identify stroke symptoms - inpatients
- Poster/Comms in regards to stroke referral pathway





Percentage of stroke patients having thrombolysis (monthly): January 24 – September 24

	% Thrombolysis
Average	11.94%
UCL	21.32%
80% Variation	N/A
Average MR	3.53%

- **On average, approx. 12%** of patients presenting with a stroke will receive thrombolysis per month
- This **may vary** by approx. **+/- 4%** per month
- 80% of variation not calculated as it would not be valid, due to too few data points

Thrombolysis rates increased from 8% to 12%

- Agreed new way of working – SOP created
- Wish to increase service support out-of-hours
- Regular review of the data
- Liaising with university to run training/simulations of the pathway with trainee paramedics & radiographers
- Code stroke posters for ED

Current projects

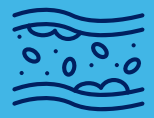
- Pre-hospital Video Triage
- Extended thrombolysis window – CT perfusion
- Rapid TIA Clinics

Thrombolysis in Acute Stroke Collaborative

ULHT stroke service in numbers

Lincolnshire is the **2nd biggest** county in England with Lincoln County Hospital the only site that provides Acute Stroke Care

The East Midlands has the **2nd highest** number of stroke admissions after London (ISDN)



- Thrombolysis rates have increased from **5.1% - 10.1%** (nationally 11.6%)
- Mechanical thrombectomy rates are low at **2.4%** vs 4.0%

39.4% of patients were directly admitted to a stroke unit within 4 hours of arrival to hospital

45.8% of patients spent at least 90% of their time on a specialist stroke unit vs 75.9% nationally

Discharge is delayed by **6.5 days** on average from the point a patient is declared medically fit for discharge

0 in 10 patients receive a six month follow up vs 38.8% nationally

Community caseloads in Lincolnshire for Stroke patients are up to **200** patients **(capacity 160)**

Thank you for listening

Questions

NHS
Lincolnshire Community and Hospitals NHS Group

Quality Committee Upward Report

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

Meeting	*Lincolnshire Community and Hospitals Group Board Meeting*
Date of Meeting	*4 March 2025*
Item Number	*Item 8.1*

Quality Committee Upward Report of the meeting held on 21 January 2025

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

Purpose

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

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

Upward Report

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

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

- Patient Safety Group (PSG) Upward Report
- Update on reporting requirements in relation to the call for concerns SOP
- Update on progress in relation to Pharmacy/Medicines Management
- High Profile Cases Report

The Committee was pleased to note the significant improvement in open Field Safety Notices and Central Alert System actions with action being taken to address those more difficult to close.

The Diabetic ketoacidosis (DKA) group was due to be refocused across the Group to consider the diabetes pathway which would be better progressed through joint working.

Ongoing work in respect of antibiotic usage was noted through the update provided from the Infection Prevention and Control Group with the Antibiotic Steering Group requesting increased ward rounds in respect of antibiotics. The Committee would receive a report on antibiotic usage at a future meeting.

The increase in C-difficile was noted nationally and whilst there had been an increase seen this remained within trajectory, there was a recognition that antibiotic use was a risk to C-difficile.

An update on Call for Concern was received with positive delivery of the pilot at Lincoln County Hospital. Roll out to Pilgrim Hospital was due to take place in February with data collection to take place and report to the Patient Safety Group.

The ongoing work to support the pharmacy team was noted, with support being provided from Executive Directors and the Improvement Team to achieve improvements in service delivery.

The Committee noted that SHMI and HSMR remained as expected.

Assurance in respect of Objective 1b – Improve patient experience

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

- Patient Experience and Involvement Group Upward Report – stood down due to operational pressures
- Safeguarding and Vulnerabilities Oversight Group Upward Report including Children in Care Update
- Patient Experience Deep Dive following publication of the National Urgent and Emergency Care Patient Survey

The Committee noted that due to operational pressures the Patient Experience and Involvement Group had been stood down however received **assurance** through the Patient Experience Deep Dive noting the development of patient involvement across the Group.

The Committee was pleased to note the ongoing work in respect of data collection, specifically utilising the SUPERB dashboard, with both ULTH and LCHS data now included and continued improvements being made.

There was recognition of the triangulation of the data being captured and the keenness of staff to engage with the Patient Panel when undertaking service change and development.

Communication as a key theme continued to be noted in respect of patient experience feedback with the Committee recognising the ‘Hear it Your Way’ training

that had been developed and rolled out to support staff in communicating with patients.

Action was being taken in respect of the outcome of the urgent care survey with a task and finish group being led by the Charge Nurses in ED, supported by the patient experience team to address areas of concern.

The Committee received the Safeguarding and Vulnerabilities Oversight Group Upward Report noting the 2 areas of focus, these being Section 42's and Children Looked After. The Committee noted the focus being given to the Section 42's within the community, primarily resulting from pressure ulcers, with actions in place to ensure appropriate education and escalation.

The Committee noted the delay in the start data for the doctors within the Children Looked After service however received **reassurance** that staff would be in post from 10 February, providing a 5-day service. Ongoing concern was noted in respect of service funding, which would be discussed through the Executive Leadership Team.

Assurance in respect of Objective 1c – Improve clinical outcomes

Due to operational pressures the Committee noted that the Clinical Effectiveness Group had been stood down and noted that, in the absence of evidence otherwise, the position in respect of the assurance rating within the BAF would remain as reported.

Assurance in respect of other areas

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

- Group Board Assurance Framework 2024/25
- Risk Report
- Policy Position Update
- Quarterly Group CQC Progress Update
- Committee Performance Dashboard
- Terms of Reference and Work Programme

Disappointment was noted in respect of the progress related to policy documents, with a recognition that work would take place across the Group to align policy documents where appropriate. The Committee reflected on the benefit of risk rating overdue policy documents with an ambition of ensuring no policy documents were more than a year out of date by the end of the quarter.

The Committee noted the update in respect of the CQC Action Plan recognising that a number of actions had recently been closed with progress continuing to be made on the remining open actions.

Issues where assurance remains outstanding for escalation to the Board

No escalations required.

Items referred to other Committees for Assurance

No items for referral.

Attendance Summary for rolling 12-month period

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

X in attendance
A apologies given
D deputy attended

NHS
Lincolnshire Community and Hospitals NHS Group

Quality Committee Upward Report

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

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*4 March 2025*
Item Number	*Item 8.1*

Quality Committee Upward Report of the meeting held on 18 February 2025

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

Purpose

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

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

Upward Report

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

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

- Patient Safety Group (PSG) Upward Report – to include
- High Profile Cases Report
- Maternity and Neonatal Oversight Group Upward Report
- Temporary Escalation Spaces

The Committee heard that ULTH were reporting five overdue CAS/FSN's. The group would continue to monitor progress whilst recognising the Trust was not an outlier with this.

The Committee were assured that 7 incident investigations remained open expecting open actions to all be closed by Quarter 4.

The Committee were alerted that Pressure Ulcer reporting remains high.

It was noted that the ED long wait report provided significant assurance. Incidents and grading remain comparable to the last report. Lots of work being done at the front door. Longest wait was 66 hours. Most common reasons awaiting AMU/MAU.

The Committee noted the Infection Prevention and Control (IPC) NHSE action plan from the visit. On track to sign off some KPIs in March at IPG. Need to focus on embedding practice changes. Remain an outlier for antimicrobials. Getting engagement with the Divisions and this will provide the stewardship to the change in approach.

The Committee noted the second case of MRSA and sought assurance on whether the actions being taken were the right ones. ULTH are an outlier with this. The Committee asked for assurance on next steps and an action plan to reduce.

LCHS falls team have initiated a task and finish group to review as lack of defined quality management.

The Committee received the Maternity and Neonatal Oversight Group Upward Report and associated appendices. CNST submitted non compliance re safety action 4
100% compliant with duty of candour.
MNSI investigations all up to date on actions.

The Committee were updated in respect of Temporary Escalation Spaces. A dashboard had been implemented of escalation spaces to use at the capacity calls. Patient Safety Partners have walked round with the teams and gave assurance that the report was reflective of what they saw. No corridor care happening in ULTH. Patients are waiting in bed spaces.

The BAF rating for 11 was considered and would remain Green as reported

Assurance in respect of Objective 1b – Improve patient experience

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

- Patient Experience and Involvement Group Upward Report
- Children in Care Update

- Nursing Establishment Review

The Committtee heard that assurance could not be given in terms of the Nursing Establishment Review. This would not be submitted to Board in March. It would now be aimed to submit in September. The Group would seek external support in this. The Committee expressed concern about how they could be assured that current establishment is right. The Committee were advised that the safe staffing report would be updated with monthly quality metrics. The Committee considered the risks and supported the presentation of a paper to Board in respect of this issue.

The Committee received assurances in relation to the looked after children service. As of February 2025 10 PA's of a paediatrician had been provided. The business case to allow this to be maintained was being prepared for approval. Enough sessions were in place to deal with the current capacity coming through the service.

The BAF rating for 1b was considered and would remain Amber as reported.

Assurance in respect of Objective 1c – Improve clinical outcomes

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

- Clinical Effectiveness Group – Chairs Report

The Committee noted that the Group had made some progress with clearing a review of a number of key transfusion policies and consent policies.

The Group had agreed to focus on a review of some of the NCEPOD outstanding actions.

The BAF rating for 1c would remain Green as reported.

Assurance in respect of other areas

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

- Paediatric Cardiology Update
- Group Board Assurance Framework 2024/25
- Risk Report
- Policy Position Update
- Committee Performance Dashboard
- Integrated Improvement Plan – for information
- Terms of Reference and Work Programme
- Medical Examiner Review Backlog

The Committee noted that a time out session in respect of risks on the LCHS Risk Register had been held. This session was used to deep dive into the areas of risk, seek further assurances in some cases and updated risk details and mitigations would then be shared through the usual governance processes and the Board committees.

The Committee noted 3 new patient safety high risks and agreed that assurance around these would be sought through a deep dive at the next meeting.

The Committee were alerted that in Quarter 4 high risk Quality Impact Assessments (QIA) would be brought to the meeting to give committee assurance and oversight. Given the planning and financial risks which were facing the two organisations the QIA will be vital.

The Committee received assurances in respect of Paediatric Cardiology noting that this was a tertiary service supported by ULTH experts. The Committee had been alerted to the fact that a backlog of patients had built up during Covid. A Multi agency approach was in place to address this. The 65 week cohort had now been reduced to zero and the Committee received assurance that the 52 week plus cohort were on trajectory to be addressed by 1 April 2025.

ULTH host the medical examiner office. Historically funded to do all deaths in acute sector. Now include all primary care deaths. Has been no change in funding it is to follow. A backlog has been created. Primary care deaths are the backlog primarily. GPs not as effective to refer. Regional office of ME called a meeting with Trust and ICB. ICB reviewing funding a different service. Backlog is difficult to deal with. May need to seek further funding. Appears on the system risk register. Risk for ULTH is reputational

Progress related to policy documents continued to be an issue, whilst this had not deteriorated there had been no positive progress with the Committee continuing to maintain oversight on a monthly basis. Detailed reporting was provided to allow the Committee to identify Executive ownership of each overdue policy.

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

Issues where assurance remains outstanding for escalation to the Board

No escalations required.

Items referred to other Committees for Assurance

The Committee would seek to triangulate with the people Committee in terms of the issues which were being highlighted which related to communication and values and behaviours and the assurances which could be offered.

Attendance Summary for rolling 12-month period

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

X in attendance
A apologies given
D deputy attended

NHS
Lincolnshire Community and Hospitals NHS Group

LCHG Nursing Establishment Review

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

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*4th March 2025*
Item Number	*8.2*

LCHG Nursing Establishment Review

Accountable Director	*Nerea Odongo, Chief Nursing Officer*
Presented by	*Nerea Odongo, Chief Nursing Officer*
Author(s)	*Nerea Odongo, Chief Nursing Officer* *Nick Mulholland, Deputy Chief Nursing Officer*
Recommendations/ Decision Required	*The Board is asked to:-* *Note the paper and to accept the recommendations set out in points 1 through 5 on page 2*

How the report supports the delivery of the priorities within the LCHG Board Assurance Framework	
1a Deliver high quality care which is safe, responsive and able to meet the needs of the population	*X*
1b Improve patient experience	*X*
1c Improve clinical outcomes	*X*
1d Deliver clinically led integrated services	*X*
2a Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	*X*
2b To be the employer of choice	
3a Deliver financially sustainable healthcare, making the best use of resources	*X*
3b Drive better decision and impactful action through insight	
3c A modern, clean and fit for purpose environment across the Group	
3d Reduce waits for patients who require urgent and emergency care and diagnostics and ensure we meet all constitutional standards	
3e Reducing unwarranted variation in cancer service delivery and ensure we meet all constitutional standards (ULTH)	
3f Reducing unwarranted variation in planned service delivery and ensure we meet all constitutional standards (ULTH)	
3g Reducing unwarranted variation in community service delivery and ensure we meet all constitutional standards (LCHS)	
4a Establish collaborative models of care with all our partners including Primary Care Network Alliance (PCNA), GPs, health and social care and voluntary sector	
4b Successful delivery of the Acute Services Review	
4c Grow our research and innovation through education, learning and training	
4d Enhanced data and digital capability	

5a Develop a Population Health Management (PHM) and Health Inequalities (HI) approach for our Core20PLUS5 with our ICS	
5b Co-create a personalised care approach to integrate services for our population that are accessible and responsive	
5c Tackle system priorities and service transformation in partnership with our population and communities	
5d Transform key clinical pathways across the group resulting in improved clinical outcomes	

Executive Summary

The Safer Nursing Care Tool is an evidence-based tool that enables nurses to assess patient acuity and dependency, incorporating a staffing multiplier to ensure nursing establishments reflect patient needs in acuity/dependency terms.

A data-capture exercise was undertaken across ULTH and LCHS (community hospitals) between November 2024 and January 2025. Whilst this was an annual review for ULTH, this was the first time an establishment review had been conducted for LCHS. The purpose of the exercise was to determine if the existing ward staffing establishments remained sufficient to meet the needs of patients.

On assimilation of the datasets and subsequent interrogation, it has been identified there are significant disparities in how the requirements for data-capture across ward areas has been interpreted. This has resulted in ward establishment assessments deriving results for increases in establishment which are not wholly evidence based. This has predominantly been driven by misinterpretation of patient care levels (appendix a). In addition, where clinical areas have had additional capacity introduced, for example six chairs in MEAU, this increase was considered as part of the establishment review; given this was a material change to the existing capacity base, this increase and demand for additional workforce should have been considered as part of a business case and not the SNCT review.

The Chief Nursing Officer therefore cannot be assured as to the conclusions reached within the establishment review and proposes not to submit the review to the Trust Board in March 2025 as was intended. Instead, the CNO proposes a range of actions and mitigations, as a short-term solution until such time that a repeat establishment review can be carried out in accordance with the SNCT handbook. It is intended the CNO will present a refreshed establishment review to the board in September 2025 at the latest.

In summary, the CNO will:

1. Commission a comprehensive education programme for the use of the safer nursing care tool across LCHG.

2. Embed the Safe Care Tool across ULTH ensuring compliance with the tool is consistently at 85% by August 2025.

3. Introduce validation processes to ensure patient care levels are correctly inputted to support improved use and reliability of the safe care tool.

4. Re-run the SNCT data-collection exercise for presentation at September 2025 Board.

5. Introduce Chief Nursing Officer Safer Staffing Fellows across LCHG to support embedding a sustainable, consistent approach to safer staffing.

The committee and trust board are asked to approve the non-submitting of the Nov-Jan24/25 establishment review and to approve the proposed CNO actions as detailed in points one through five above.

Safer Staffing Education Programme

The latest round of data-collection for the SNCT establishment review has identified gaps in how the care levels associated with the tool are interpreted and captured within the tool. This has resulted in the tool calculating significant uplifts in ward establishments which differ significantly from the professional judgments reached by matrons, lead nurses and divisional nurses.

The recommended uplifts are, in some cases, so excessive, that, if applied, would result in an almost doubling of an existing ward establishment as an example. When considering quality indicators including but not limited to falls, pressure ulcers, medication errors, missed breaks, nursing overtime, compliance with mandatory training and high levels and/or ongoing reliance on temporary staffing, the proposed uplifts appear disproportionate. The chief nurse's office concluded patient care levels had been calculated incorrectly and not in accordance with the SNCT handbook and therefore considers there exists a training need across the organisation in order we better capitalise on the robustness of the SNCT. Given the need for additional training and disparity with the tool outputs and professional judgements, the Chief Nurse cannot be assured as to the reliability of the current ward establishment review.

NHS England have recently relaunched the Community Nursing Safer Staffing Tool (CNSST II) and will be providing associated training materials to help support staff with data entry. However, there is no proposed training for the acute Safer Nursing Care Tool. Therefore, the CNO proposes to utilise the existing NHS England SNCT fellows faculty from across the East Midlands to develop an intensive training programme targeted at the following staff groups:

- Band 7 ward managers
- Divisional Matrons and Lead Nurses
- Divisional Nurses
- Staffing Solutions senior team
- Senior Corporate Nursing team

The programme will be focussed on:

- Understanding safer staffing principles
- How to undertake a robust review of staffing including appropriate assessment of patient care levels including development of a validation process.
- How to use staff multipliers, activity analysis and to carry out staffing assessments

Safe-care Live

The trust uses the Safe-care Module which is licensed by the Allocate Group and works in conjunction with Health Roster to provide information regarding patient acuity and dependency and staffing in real time. Its purpose is to support senior nursing leaders to make professional judgements in relation to staffing numbers and requirements.

This process which builds on the Safer Nursing Care Establishment Review tool, offers an evidence-based approach in how the organisation allocates the workforce resources on a day-to-day basis.

In order the Chief Nurse can be assured the organisation is safely staffed, they will ensure the Safe-care Live tool, is fully embedded mandating it's use across all applicable areas. Safe-care Live data will be used to support daily safe care meetings ensuring the organisation remains safely staffed at all times.

The staffing solutions team are also working to continue to drive down the number of vacancies across the HCSW cohort. Following a recent recruitment campaign, 52 offers were made and accepted bringing the HCSW vacancy down to 122 posts. This is a positive position for Q4 24/25 and will further support the Chief Nurse in ensuring she has substantive staff in post with the correct skill set and competencies to meet the needs of our patients.

Revised process for undertaking the Safer Nursing Care Establishment review:

The Chief Nurse proposes the following process for setting nursing establishments. The process includes several important components and will be supported by a ratified standard operating procedure:

- Using the Safer Nursing Care Tools (SNCT) to assess acuity and dependency, daily for 30 days across all adult wards, acute assessment units, Children and Young Person's inpatient wards undertaken by staff trained in the use of the tool. The tool will also be applied across the Community Hospital inpatient wards within LCHS. The Emergency Departments are progressing a separate business case for safe staffing of the ED department in line with Royal Collage of Emergency Medicine Guidelines.

- The SNCT is repeated twice per year to ensure validity. To note, for this year (January to December 2025) we will undertake a new data collection exercise in May 2025 and then again in November 2025.

- A multi-professional meeting with the ward manager/unit manager, lead nurse, matron, Divisional Director of Nursing, Corporate Lead Nurse for Workforce, Associate Director of Nursing for Quality and Deputy Chief Nurse as well as Finance and Workforce to corroborate the SNCT data with nursing quality indicator outcomes and professional judgement is applied to ensure we are not staffed beyond activity requirement.

We will approach the Safer Staffing Faculty at NHS England to request external validation of our process and methodology for undertaking the SNCT establishment review.

The revised establishment review will be presented to the trust board on 2 September 2025, first having been scrutinised at:

  - Executive Leadership Team – 26th June 2025
  - Group Leadership Team – 4th July 2025

- People Committee – 11th July 2025
- Quality Committee- 15th July 2025

Chief Nursing Officer Safer Staffing Fellowship Programme

The Chief Nursing Officer for England launched a safer staffing fellowship programme with the intention of supporting NHS organisations to embed a sustainable and consistent approach to safer staffing.

Currently, LCHG have no identified Safer Staffing Fellows employed. The CNO intends on supporting two applications for the fellowship programme for 2026 in order the trust can start to build a resilient team of subject matter experts from across both the acute and community setting.

Assurance

The last Safe Staffing Report was submitted to the Board via an upward report from the People Committee on 7 January 2025 and was fully supported. Over the past year, there has been no abnormal variation or significant increase in reported patient harm, providing safety assurance on current staffing levels.

- **Patient Safety and Harm Reduction**: Trust-wide efforts continue to focus on reducing the number of falls and pressure ulcers, ensuring high standards of patient care.
- **Ward Accreditation Progress**: The number of wards achieving accreditation in 2024/25 has increased, successfully meeting our target for the year. Additionally, the accreditation process for community hospital wards has been launched, reinforcing our commitment to quality improvement.
- **Ongoing Quality Monitoring**: Key quality indicators and staffing red flags will continue to be monitored and reported through the Quality and People Committee, ensuring early identification of risks and timely interventions.
- **Workforce Management and Mitigation**:
    - We acknowledge a **10% (122 WTE) vacancy rate** among Health Care Support Workers (HCSWs).
    - Active recruitment is ongoing to fill these roles, and temporary staffing is being used to mitigate the shortfall.
    - The impact is partially mitigated by the over-recruited position of **Internationally Educated Nurses**, who are awaiting their **NMC registration** before fully joining the workforce and through use of temporary staffing.

Conclusion/Recommendations

Given the Chief Nurse has challenged the process by which the most recent safer nursing care tool has been completed, it is appropriate the conclusions and

recommendations from that assessment are not relied upon and therefore not put before the board for consideration.

Although the Chief Nurse is not able to submit a formal ward establishment review to the Board for consideration, remedial action is being taken to introduce safeguards and to bolster assurances that staffing remains safe across LCHG. Optimising the use of Safecare Live with increased daily oversight and scrutiny will ensure clinical areas are appropriately staffed.

The Board can be assured that patient safety remains a priority and the CNO is committed to continue implementation of robust patient harm prevention measures through continuous monitoring and actions to address key risks such as falls and pressure ulcers

People Committee Upward Report

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Hospitals NHS Trust

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*4 March 2025*
Item Number	*9.1*

People Committee Upward Report of the meeting held on 14 January 2025

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

Purpose

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

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

Upward Report

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

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

The Committee received the upward report and performance dashboards noting the ongoing positive meetings and work to calculate metrics consistently across the Group.

Reassurance was offered on the work being undertaken to ensure metrics would be aligned for the 2025/26 year across the Group.

Benchmarking had been considered across the Group in respect of sickness with the Committee noting that the Group was performing better than peers for MSK issues in the past 12 months.

Positive work was noted for the medical workforce programme to be able to track all vacancies and whilst AHP vacancy levels were noted as being high there was a strong pipeline and vacancy control process.

Job Evaluation
The Committee received a verbal update noting the work nationally to consider the job evaluation process and request from NHS England for Committees to be sighted on this to ensure adequate review.

The Committee noted that this had arisen from the band 2 to band 3 job evaluation changes resulting in the development of national guidance to ensure the process for fit for purpose alongside national standards.

There was recognition that the development of the Group would begin to demonstrate any inequalities that may exist with a focus being given to priority policies to support harmonisation across the Group. This was presenting an opportunity to refine local policies and guidance for a consistent approach.

Safer Staffing Nursing and AHP
The Committee received the joint report with **assurance** noting that this was limited for LCHS however triangulation work was being undertaken between safety and staffing gaps.

Work was taking place with the talent academy in respect of apprenticeships to match these against vacancies to progress with no cost pressures. An increase in pressure ulcers was being seen at LCHS however work was taking place through the Patient Safety Group to triangulate staffing gaps.

AHP vacancies within ULTH remained high, driven by the Community Diagnostic Centres however recruitment activity was noted with the Committee receiving limited assurance.

International recruitment was noted in respect of community staffing where the complex nature of community work had resulted in staff moving to work in community wards, as infrastructure was not in place to support autonomous roles. This had resulted in community wards being overstaffed.

Midwifery Bi-annual Staffing Report
The Committee received the report with **assurance** noting that this formed part of the Clinical Negligence Scheme for Trusts (CNST) requirements which considered staffing on a bi-annual basis.

The Committee noted that Birthrate Plus differed from the nursing establishment reviews and considered peaks and troughs in activity with robust escalation processes in place, within maternity services, to ensure appropriate staffing levels were in place.

A required uplift, identified through the review, of 12.1 whole time equivalents was noted by the Committee for the Trust to remain in line with Birthrate Plus. A business case would be developed for consideration through the next round of establishment reviews and, if successful, would be utilised to develop a triage service.

Gender Pay Gap
The Committee received the reports for both LCHS and ULTH noting the statutory requirement for the organisations to report separately however required actions would be aligned across the Group.

The Committee noted improvement across both organisations in the previous year however noted the 14.2% gender pay gap for ULTH, above the 13.1% national median pay gap. LCHS had a gender pay gap position of 8.8%.

There was a 3-year action plan in place covering recruitment, retention and career development to support parity moving forward. It was recognised that the gender pay gap actions linked to both Advisory Appointments Committee (AAC) recruitment, the Equality, Diversity and Inclusion agenda and sexual safety charter.

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

Culture and Leadership Group Upward Report
The Committee received the report noting that due to the timing of the meetings changes had not yet been seen through reporting.

Positive progress was noted in respect of Group harmonisation of policies with the Change Policy agreed in principle which was now going through process and would be a key enabler for the culture work.

The Committee noted that the National Staff Survey results were not yet available however noted the intention for action plans to be consistent across the Group with local ownership of these, monitored through KPIs in cultural metrics.

Freedom to Speak Up Quarterly Report - ULTH
The Committee received the report for ULTH noting the ongoing work to develop a Group report to be received by the Committee with an anticipation that this would contain more analytical data.

The Committee noted the escalation from the Freedom to Speak Up Guardian in respect of the time being taken for actions to be taken when issues were raised. It was noted that this would be addressed through the People Directorate and HR colleagues to support the Guardian in ensuring

actions were taken however it was recognised that this linked to HR cases and the pace of the process.

Education Funding
The Committee received the report noting that the first meeting of the Education Oversight Group was due to take place at the end of January and would report to the Committee in February.

The Committee noted that there were 5 funding streams including the apprenticeship levy, continued professional development (CPD), medication education, tariff for clinical education and Trust funded departmental budgets.

Progress was noted in year against the CPD funding with a plan submitted to NHS England to confirm utilisation of funding in quarter 4. Statutory and mandatory training was noted as a key focus for the Education Oversight Group with KPIs being developed across the Group with a focus on harmonising the education approach.

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

Research, Development and Innovation and University Teaching Hospital Update - ULTH
The Committee received the report noting the improvement in clinical trial recruitment figures compared to the previous year.

Work continued to develop a dashboard to monitor the position of research and innovation with the Committee noting the possible use of PowerBI to identify and collect live data. Collection of information related to publications continued with support from Library Services to identify these. It was noted however that awareness raising was required to ensure publications were issued in recognised journals to achieve the required impact.

The Committee was pleased to note the planning for the System wide expo in May where clinicians would be invited to present work and speaker sessions would be held.

The Committee noted the need to provide focus to the innovation agenda to drive this forward alongside research.

Assurance in respect of other areas

Group Board Assurance Framework 2024/25
The Committee received the Group Board Assurance Framework (BAF) noting the ongoing work to continue to populate the narrative within this.

The Committee noted that due to the Education Oversight Group meeting not having taken place it would not been possible to consider the assurance rating for objective 2b during the February Committee as anticipated. It was

recognised that this meeting would form the foundations of the discussion to consider movement of the assurance rating.

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

Integrated Improvement Plan (ULTH) / Operational Plan (LCHS)
The Committee received the reports noting the content and recognising the increased sickness rates linked to respiratory illness, Covid-19 and flu. This position was being monitored from a People and Executive perspective and it was noted that, in line with increases in staff sickness, there had been an increase in patient admissions with the same illnesses.

Risk Report
The Committee received the joint report with **assurance** noting the ongoing discussions regarding the requirement for the risks to be reviewed and updated.

The Committee noted the need for confirmation to be offered that the risks were being considered and updated through the Risk Register Confirm and Challenge meeting to ensure these were updated appropriately. A meeting would take place with the relevant Executive Directors and Non-Executive Directors regarding review of the risk register.

Update on Fuller and HTA
The Committee received the report noting the current position with the majority of actions reported as green.

It was noted that 98% of all ULTH staff with access to mortuaries had now had an enhanced DBS undertaken with the remaining checks being finalised. For other staff groups work continued to be undertaken to complete relevant checks, with high-risk areas being addressed as a priority.

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

Following review within the People Directorate a number of updates had been provided on those policies being considered for update in line with Group. Trajectories for completion were noted within the report and capacity to address developments of the documents was noted due to the appointment to Deputy Director roles.

Issues where assurance remains outstanding for escalation to the Board

None

Items referred to other Committees for Assurance

No items for referral.

Attendance Summary for rolling 12-month period

Voting Members	F	M	A	M	J	J	A	S	O	N	D	J
Phil Baker, Non-Executive Director, ULTH (Chair)									X	X	X	X
Gail Shadlock, Non-Executive Director, LCHS									X	A	X	X
Claire Low, Group Chief People Officer									X	D	X	X
Colin Farquharson Group Chief Medical Officer									D	X	X	A
Nerea Odongo, Group Chief Nurse									X	X	X	X

X in attendance
A apologies given
D deputy attended

People Committee Upward Report

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Hospitals NHS Trust

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*4 March 2025*
Item Number	*Item 9.1*

People Committee Upward Report of the meeting held on 14 February 2025

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

Purpose

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

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

Upward Report

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

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

The Committee received the upward report and performance dashboards noting the continued challenge of the medical workforce programme with discussion continuing in respect of extra contractual rates.

The focus on the medical workforce had seen a reduction in the agency run rate with actions being effective and moving closer to the CIP target.

The Committee noted the AHP vacancies with ULTH holding less than 100 vacancies for AHP staff, resulting from the work to recruit to CDC positions.

Benchmarking was recognised as a key area for the group to consider with recognition of further work being required in respect of sickness levels for stress, anxiety and depressions to ensure appropriate risk assessments were completed. The group were requested to undertake a deep dive to ensure identification of work related issues was possible.

Safer Staffing Nursing and AHP
The Committee received the joint report with **assurance** noting the recruitment challenges within the paediatric speech and language service with mapping being undertaken to quantify associated levels of harm. Challenges were also noted in respect of children's audiology services with the impact of this not being realised until children were older.

The Committee noted the overall positive vacancy position and the recent offer of 52 Healthcare Support Worker roles which would have a significant impact on vacancy rates and temporary staffing costs.

ULTH Ward Establishment Review
The Committee received the report with **reassurance** noting that the data collection had taken place between November 2024 – January 2025 and had included by acute and community hospital provision.

The Committee noted that there was variation in the data input and as a result there was a **lack of assurance** in respect of the data collection, resulting in the need for a revised data collection to take place.

Action had been taken as a result of the initial data output with support received from NHS England in respect of the need to complete the revised data capture during May. The output of the establishment review would impact the workforce plan for the Group with recognition that this would need to be considered when the data was available. The Group Chief Nurse would consider what additional assurance measures could be provided at the following meeting.

Safer Staffing Medical
The Committee received the report with **assurance** noting the reduction in the use of bank and agency medical staff with increased grip on shift fill rates.

A reduction in vacancies was also noted with substantive roles and the triangulation to risks was requested by the Committee to ensure oversight on risks, staffing position and potential harms. At this time the Committee was reassured that there was no patient harm associated with staffing.

Medical Consultants with signed off job plans
The Committee received the report with **assurance** noting the improved position of job plans with 90% of consultants having these in place at the time

of the meeting. The Committee noted the trajectory of 95% by the end of March with high levels of confidence that the position would be achieved.

The changes to the job planning cycle were noted which had supported the improvements being seen with grip and control required moving forward to maintain the position.

Vacancy Controls 2025/26
The Committee received a verbal update noting the ongoing work in respect of workforce planning and financial challenges for the coming year.

It was recognised that vacancy controls would need to be considered for the coming year with further planning required in respect of the requirement of these.

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

Education Oversight Group Upward Report
The Committee received the report noting that the first meeting had taken place in January 2025 with the group considering its purpose in terms of the meeting and defining the KPIs that were required to develop a dashboard.

The group considered statutory and mandatory compliance across the Group, continuing professional development funding and spend allocation, apprenticeship levy, educational tariff income and medical education.

The Committee noted that as the group matured it would be able to provide greater assurance as well and providing direction to the Committee in respect of areas requiring scrutiny.

Culture and Leadership Group Upward Report
The Committee received the report noting the discussions in respect of Group harmonisation of policies and structures with work taking place to ensure policies were updated appropriately across the Group. The approval of the Group change management policy.

The work undertaken on values was noted with recognition that these had been identified as accountability, collaboration, innovation, compassion and people centred, through staff engagement and would be launched through roadshows across the Group.

Equality, Diversity and Inclusion (EDI) Group Upward Report
The Committee received the report noting that the group was now meeting jointly across LCHG with discussions focusing on the 5 objectives for 2025/26 to ensure these incorporated EDI.

The Committee noted the updates within the report in respect of the outputs from the Equality Delivery System, the gender pay gap position and the updates provided from the staff networks, with no formal escalations noted to the Committee.

National Staff Survey
The Committee received the report noting the high-level data that was presented and recognised the movement in the data offered at this time.

The full results would be released in due course however action had commenced to develop a Group action plan which would support the intended roadshows and engagement activity due to be undertaken in the new financial year.

Guardian of Safe Working Quarterly Report – ULTH
The Committee received the report with **assurance** noting the areas of escalation including further engagement required from clinical and educational supervisors to support exception reporting closure, rest area availability and professional leave for FY2 doctors sitting the MRSA exam.

The Committee noted that whilst action was underway in respect of rest areas this required further oversight and noted the need for action to be taken in respect of the areas escalated.

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

No reports due

Assurance in respect of other areas

Group Board Assurance Framework 2024/25
The Committee received the Group Board Assurance Framework (BAF) noting the updates provided and the intention to consider the assurance rating for objectives 2b.

The Committee recognised that whilst movement was being seen in the assurances being received in a number of areas no changes would be made to assurance ratings at this time.

Integrated Improvement Plan (ULTH) – for information
The Committee received the report for information noting the position presented.

Risk Report
The Committee received the joint report with **assurance** noting that the risks remained static and reflected on the discussions regarding the need to ensure triangulation of risks to the reports offered to the Committee.

Internal Audit Recommendations
The Committee received the report noting the open actions resulting from internal audit recommendations and was pleased to note the positive progress in competing these. Work would be undertaken to address the remaining open actions.

Policy Position Update
The Committee received the report noting the position presented and the ongoing work to review and update policies across the Group with a number due to be ratified in the coming month.

Following review through the Audit Committee a request was made for risk ratings to be applied to the overdue policy documents to ensure that these were addressed in priority order.

Any other business
The Committee was delighted to note that the Talent Academy had been recognised by Buckingham Palace for the contribution to work experience and investment in apprenticeships with an invitation extended to the team to attend the Garden Party at Buckingham Palace on the 14 May.

Issues where assurance remains outstanding for escalation to the Board

None

Items referred to other Committees for Assurance

No items for referral.

Attendance Summary for rolling 12-month period

Voting Members	M	A	M	J	J	A	S	O	N	D	J	F
Phil Baker, Non-Executive Director, ULTH (Chair)								X	X	X	X	X
Gail Shadlock, Non-Executive Director, LCHS								X	A	X	X	A
Claire Low, Group Chief People Officer								X	D	X	X	X
Colin Farquharson Group Chief Medical Officer								D	X	X	A	D
Nerea Odongo, Group Chief Nurse								X	X	X	X	D

X in attendance
A apologies given
D deputy attended

NHS
Lincolnshire Community and Hospitals NHS Group

LCHG Gender Pay Gap Action Plan 2025 - 2028

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

Meeting	*Lincolnshire Community and Hospital Group Board*
Date of Meeting	*4th March 2025*
Item Number	*9.2*

LCHG Gender Pay Gap Action Plan 2025 – 2028

Accountable Director	*Claire Low, Group Chief People Officer*
Presented by	*Claire Low, Group Chief People Officer*
Author(s)	*Kerry Swift, Deputy Director of People*
Recommendations/ Decision Required	*The Board is asked to:-* • *Note the report and approve for publication*

How the report supports the delivery of the priorities within the LCHG Board Assurance Framework	
1a Deliver high quality care which is safe, responsive and able to meet the needs of the population	
1b Improve patient experience	
1c Improve clinical outcomes	
1d Deliver clinically led integrated services	
2a Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	*x*
2b To be the employer of choice	*x*
3a Deliver financially sustainable healthcare, making the best use of resources	
3b Drive better decision and impactful action through insight	
3c A modern, clean and fit for purpose environment across the Group	
3d Reduce waits for patients who require urgent and emergency care and diagnostics and ensure we meet all constitutional standards	
3e Reducing unwarranted variation in cancer service delivery and ensure we meet all constitutional standards (ULTH)	
3f Reducing unwarranted variation in planned service delivery and ensure we meet all constitutional standards (ULTH)	
3g Reducing unwarranted variation in community service delivery and ensure we meet all constitutional standards (LCHS)	
4a Establish collaborative models of care with all our partners including Primary Care Network Alliance (PCNA), GPs, health and social care and voluntary sector	
4b Successful delivery of the Acute Services Review	
4c Grow our research and innovation through education, learning and training	
4d Enhanced data and digital capability	
5a Develop a Population Health Management (PHM) and Health Inequalities (HI) approach for our Core20PLUS5 with our ICS	

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

Lincolnshire Community Hospitals Group (LCHG)
Gender Pay Gap (GPG) Action Plan 2025 - 2028

Task	Actions	Milestones					
		2025/26				2026/27	2027/28
		Q1	Q2	Q3	Q4		
Data and analysis: Expand data and analysis beyond the statutory reporting requirements and prepare for the new pay gap reporting requirements. High Impact Action 3	**Gender Pay Gap (GPG):**						
	Establish feasibility of dashboard to include age factors relating to GPG at a divisional / business unit level.		✸				
	If feasible, create local GPG dashboard.			✸			
	If feasible, commence use of dashboard and use data to inform next annual GPG report,				✸		
	Ethnicity Gender Pay Gap:						
	Prepare for the new Ethnicity Gender Pay Gap reporting (pending publication of national technical guidance).	✸					
	Produce first Ethnicity Gender Pay Gap reports (pending publication of the national technical guidance).		✸				
	Engage with staff networks to analyse Ethnicity Gender Pay Gap reports and develop appropriate actions.			✸			
	Publish first Ethnicity Gender Pay Gap Reports.				✸		
	Disability Gender Pay Gap:						
	Prepare for the new Disability Gender Pay Gap reporting (pending publication of national technical guidance).					✸	
	Produce first Disability Gender Pay Gap reports (pending publication of the national technical guidance).					✸	
	Engage with staff networks to analyse Ethnicity Gender Pay Gap reports and develop appropriate actions.					✸	
	Publish first Disability Gender Pay Gap Reports.					✸	
	Other Gender Pay Gaps:						
	Engage with staff networks to consider feasibility of further pay gap reporting by protected characteristics.						✸
Recruitment, Retention and Career Development: High Impact Action 3	Ensure Lincolnshire Hospitals and Community Group (LCHG) commitment to flexible working promoted at the start of the recruitment journey.	✸					
	Promote Flexible Working Policy across LCHG.		✸				
	Implement the NHS Sexual Safety Charter across LCHG.	✸					
	Promote the Women's Leadership offer through the Talent Academy across LCHG.		✸				
	Promote the award-winning Menopause Service across LCHG.		✸				
	Identify / create, review and update Human Resources (HR) policies where direct gender impact identified.				✸		

	Establish process to routinely analyse exit feedback data by protected group.			✸			
	Launch Reciprocal Mentoring Programme across LCHG	✸					
	Evaluate Reciprocal Mentoring Programme across LCHG				✸		
	Define parameters for LCHG Reciprocal Mentoring Programme to be implemented as business as usual					✸	
Medical Workforce: Mend the Gap Report High Impact Action 3	**Make senior jobs more accessible to women:**						
	Employers should promote a flexible working culture when advertising jobs. They should make clear that reduced hours, flexible working and job-share opportunities are available (unless strong, justifiable reasons exist and are documented for not offering them). They should publish details of their flexible working and job-share policies on their website for all potential employees to access.	✸					
	Talent management and training programmes should be used to develop staff and increase appointment of a more balanced senior workforce, such as Associate Specialist, General Practitioner (GP) Partners, Professors and Consultants.	✸					
	Increase provision of NHS nurseries and other support for childcare, including access for doctors working in primary care, to accommodate out-of-hours and shift working.				✸		
	Facilitate new care models, as suggested in the NHS Long Term Plan, including the use of Artificial Intelligence (AI) and technology to encourage remote working.	✸					
	Promote flexible working to appeal more to men to increase the percentage of men that work Less Than Full Time (LTFT), encouraging more equal sharing of caring responsibilities, reducing the stigma for men and, reducing the number of women obliged to choose LTFT working to accommodate caring responsibilities, particularly in primary care.	✸					
	Implement better retention, re-entering and retraining policies to retain women. Begin with a review of the hurdles that exist and then work to eliminate them.				✸		
	Introduce increased transparency on gender pay gaps:						
	Increase the use of national pay contracts in place of local pay arrangements for hospital doctors.	✸					
	As far as possible to use standard rates for additional paid activity that are consistent and transparent (for example, waiting list initiatives, locum work).	✸					
	Publish medical gender pay gap and action plans, agreed following staff consultation, in trust annual reports.	✸					
	Disaggregate the medical gender pay gap from other professional groups in trust gender pay gap reports.	✸					
	Publish, monitor and report the gender balance of those applying for medical posts, the numbers shortlisted and appointed.				✸		
	Mandate changes to policy on gender pay gaps:						

	Ascertain the requirement to implement locally a national equality scheme based on the Athena Swan programme in Higher Educational Institutions (HEI). If required, develop and deliver on plans to ensure this equality scheme is implemented at LCHG.					✸	
	All candidates who meet the job description requirements will, wherever practicable, be shortlisted for senior medical jobs, clinical academic jobs and GP partnerships.	✸					
	Develop and publish targets for the reduction of the gender pay gap in medicine, to be reported at board level with a mandatory reflective narrative to justify short-term changes; and report on action planning.					✸	
	Review clinical excellence and performance payments and change accordingly:						
	Numbers of men and women eligible for awards, as defined by the Advisory Committee on Clinical Excellence Awards (ACCEA), and in receipt of awards should be reported at medical school, trust board and national level.	✸					
	Both nationally and locally, reward excellence in a gender-neutral way, including the need for LTFT doctors' contribution to be assessed against the proportionate hours they work; and by reviewing domain/ criteria, so additional activity undertaken more frequently by women, such as mentoring, is rewarded equally to that undertaken more frequently by men, such as additional clinical, managerial or research activity.	✸					

Key:

Green – action on target
Amber – action in development
Red – action behind target

✸ - Action delivered / delivery expected

Report to the Board - LCHS Gender Pay Gap Report 2024/25

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Hospitals NHS Trust

Report for the Board meeting on:	*4 March 2025*
Upward Report from the meeting of:	*People Committee*
Date of Meeting:	*14 January 2025*
Item Number	*9.2*

LCHS Gender Pay Gap Report 2024/25

Accountable Director	*Nico Batinica, LCHG Director of People*
Report Prepared by	*Kerry Swift, Deputy Director of People*
Quoracy of meeting met	*n/a*
Items Approved: Gender Pay Gap Report (LCHS)	
Matters highlighted in respect of Risk Register/BAF: None	
Policies/ Procedures/ Guidelines approved/noted by the Group: Not applicable	
Recommendations/Actions Required from the People Committee: The Board is asked to note the report and approve for publication.	

This report contains the LCHS Gender Pay Gap Report for 24-25. This has been approved in January by the People Committee and now requires Board approval prior to publication by 31st March 2025.	
Strategic Objectives	
1a Deliver high quality care which is safe, responsive and able to meet the needs of the population	
1b Improve patient experience	
1c Improve clinical outcomes	
1d Deliver clinically led integrated services	
2a Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	*x*
2b To be the employer of choice	*x*
3a Deliver financially sustainable healthcare, making the best use of resources	
3b Drive better decision and impactful action through insight	
3c A modern, clean and fit for purpose environment across the Group	
3d Reduce waits for patients who require urgent and emergency care and diagnostics and ensure we meet all constitutional standards	
3e Reducing unwarranted variation in cancer service delivery and ensure we meet all constitutional standards (ULHT)	
3f Reducing unwarranted variation in planned service delivery and ensure we meet all constitutional standards (ULHT)	
3g Reducing unwarranted variation in community service delivery and ensure we meet all constitutional standards (LCHS)	
4a Establish collaborative models of care with all our partners including Primary Care Network Alliance (PCNA), GPs, health and social care and voluntary sector	
4b Successful delivery of the Acute Services Review	
4c Grow our research and innovation through education, learning and training	
4d Enhanced data and digital capability	
5a Develop a Population Health Management (PHM) and Health Inequalities (HI) approach for our Core20PLUS5 with our ICS	
5b Co-create a personalised care approach to integrate services for our population that are accessible and responsive	
5c Tackle system priorities and service transformation in partnership with our population and communities	
5d Transform key clinical pathways across the group resulting in improved clinical outcomes	

Lincolnshire Community Health Services NHS Trust

Gender Pay Gap Report 2024 - 2025

Contents

Executive Summary

Headlines

When reporting Gender Pay Gap data, the Trust is working from the data as at previous 31st March, i.e. this report is based on data from 31st March 2024.

In this Trust, women earn 91p for every £1 that men earn when comparing median hourly pay. Women's mean (average) hourly pay was 16.8% lower than men's. This is a 3.8% improvement from last year's gap which was 20.6%.

For women who receive a bonus, they receive £1 for every £1 men receive. In Lincolnshire Community Health Services, bonuses are defined as the Clinical Excellence Awards (CEAs) which are only applicable to consultants in the medical workforce.

At Lincolnshire Community Health Services, women hold 89.2% of the highest paid jobs (the figure was 80.2% last year), and 79.4% of the lowest paid jobs (the figure was 90.6% last year). This is a positive improvement.

There has been an increase of 9% in the number of women holding the highest paid jobs, and an 11.2% decrease in the number of women holding the lowest paid jobs – this was the case as at the 31 March 2024 snapshot date.

Women still hold between 87-89% of the lower middle and upper middle-paid jobs, which has largely remained stable since last year (92-88%).

The median is the generally accepted main indicator across all organisations who take part in Gender Pay Gap reporting. Comparing like-for-like years, i.e. 2024 data, the national gender pay gap in the UK was 13.1%, compared to the Trust's 8.8% gap.

Following the changes in representation at the highest and lowest pay bands in the Trust, the Trust's gender pay gap has significantly improved this year and is below the national median UK pay gap. The national gender pay gap has improved by 1.1%, and LCHS' gap has improved by 7.4%.

When comparing mean (average) hourly pay, women's mean hourly pay is 16.8% lower than men's. This is a continued improvement on last year's data of 20.6%, improving by 3.8%.

National Sources: Gender pay gap in the UK – Office for National Statistics (ons.gov.uk)

This report contains:

- Background to the requirements for Gender Pay Gap Reporting
- Guidance to assist understanding of the indicators and calculations used
- Narrative about the Trust's Gender Pay Gap results, in line with reporting requirements.
- Comparison with previous year's results, which show that the Gender Pay Gap has improved (i.e. reduced).
- A proposed action plan to further reduce the Gender Pay Gap.
- Appendices with all the required data which has been submitted to the Gov.Uk Gender Pay Gap reporting portal, ahead of the 30th of March 2025 deadline.

This report will provide a high level of assurance in terms of compliance with Gender Pay Gap Reporting for People Committee and Trust Board approval.

It will also provide high levels of assurance that the Trust will take action to reduce (improve) the disparity between pay for men and women, providing evidence for High Impact Action 3 of the NHS EDI Improvement Plan.

Please note that to enable internet accessibility, all diagrams and infographics relating to the gender pay gap data are included as appendices at the end of this document.

Background

Employers with 250 or more employees have been required to publish information on the pay gap between male and female employees since 31st March 2017, under the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, which can be found at: The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 (legislation.gov.uk).

Organisations in the public sector, such as NHS Trusts, are required to report against a set of six key indicators, based on data from 31st March each previous year. For example, the "snapshot date" for this report is 31st March 2024. They are then required to publish that data and narrative ("Gender Pay Gap Report") so that employees and members of the public can access it, along with an action plan to address disparities, by 31st March each year. For example, this report is to be published on the Trust's website by 31st March 2025.

Separately from the report, employers are required to upload their data to the HM Government portal by 31st March at the latest. This data upload has been made already in preparation for publication of this report in March.

Private sector employers with 250 or more employees are also required to publish Gender Pay Gap information, albeit with a slightly later publication date of 5th April each year.

In preparing this report, the author has consulted and followed the NHS Employers Gender Pay Gap guide: Addressing-your-gender-pay-gap-guide.pdf (nhsemployers.org) which was co-produced with the Health and Care Women Leaders Network.

Understanding the Gender Pay Gap Calculations

The six key indicators that the Trust is required to report on are:

1. percentage of men and women in each hourly pay quarter (lower, lower middle, upper middle and upper quartile) by number of employees
2. mean (average) gender pay gap using hourly pay
3. median gender pay gap using hourly pay
4. percentage of men and women receiving bonus pay
5. mean (average) gender pay gap using bonus pay
6. median gender pay gap using bonus pay

The data for the report is drawn from the national Electronic Staff Record (ESR) Business Intelligence standard report.

For the purposes of these calculations, pay includes: basic pay, full paid leave, including annual, sick, maternity, paternity, adoption or parental leave, bonus pay, area and other allowances, shift premium pay, pay for piecework.

Pay does not include: overtime pay, expenses (payments made to reimburse expenditure wholly and necessarily incurred in the course of employment, e.g. mileage for use of vehicle), remuneration in lieu of leave, the value of salary sacrifice schemes, benefits in kind (e.g. child-care vouchers), redundancy pay and tax credits.

Bonus pay relates to the Clinical Excellence Awards (CEAs) to Consultants, following the NHS Employers Gender Pay Gap Guide.

The Trust now has eight years' worth of data and the opportunity is taken in this report to indicate trends in that data.

What does median mean?

This is the difference between the hourly pay of the median man and the hourly pay of the median woman. The median for each is the man or woman who is in the middle of a list of hourly pay ordered from highest to lowest paid.

Medians are useful to indicate what the 'typical' situation is. They are not distorted by very high or low hourly pay (or bonuses). However, this means that not all gender pay gap issues will be picked up. They could also fail to pick up as effectively where the gender pay gap issues are most pronounced in the lowest paid or highest paid employees.

And mean?

The mean gender pay gap figure uses hourly pay of all employees to calculate the difference between the mean hourly pay of men, and the mean hourly pay of women. A mean involves adding up all of the numbers and dividing the result by how many numbers were in the list. Very high or very low pay can distort this figure.

About our results

The Trust's Gender Pay Gap has been on a generally decreasing (i.e. improving) trend since reporting began, in line with the national trend both inside and outside of the NHS.

The data sets on which the Trust's Gender Pay Gap report for the current reporting cycle are based can be viewed in appendix 1.

Compared to last year, the median is 7.4% better (smaller gender pay gap), and the average hourly rate has improved by 3.8%. Since 2022 there is an overall improvement.

The trend data from 2017 to 2024 for the median hourly rate and the average hourly rate (mean) are noted as follows:

Reporting Year	**Median Hourly Rate**	**Average Hourly Rate**
2017	11.5%	21.1%
2018	18.9%	21.5%
2019	17.9%	25.5%
2020	13.1%	22.8%
2021	16.4%	26.3%
2022	18.5%	24.3%
2023	16.2%	20.6%
2024	8.8%	16.8%

Trend charts for the Median Hourly Rate and the Average Hourly Rate (mean) are included in appendix 2.

As with previous years, the main driver of the Trust's gender pay gap remains the structure of the NHS workforce, with female colleagues comprising the majority of the lower paid roles and men in higher paid roles including the medical workforce (especially General Practitioners) and Very Senior Management (VSM) roles.

Gender Disparity – Pay Quartiles

79.4% of the workforce in the lowest pay quartile are female. This means that women hold 79.4% of the lowest paid jobs. In comparison, 89.2% of the workforce in the top pay quartile are women. This means that women hold 89.2% of the highest paid jobs, which is disproportionately higher than their representation in the lowest pay quartile (79.4%) and throughout the other pay quartiles (around 87 - 89%).

Further detail relating to the pay quartiles can be located in appendix 1.

Gender Disparity – Mean Salary

The data in Appendix 1 highlights that below the Band 8A Agenda for Change (AfC), the average pay gap percentage between bands does vary with some bands reporting a negative pay gap and others a positive pay gap. The mean pay gap information again varies between bands with both negative and positive values.

From AfC Bands 8A to 9, similar to the previous year, the average pay gap percentage between bands and clinical posts does vary, for example, female General Practitioners (GPs) earn less compared to male GPs, however, when compared female consultants earn more than male consultants.

Gender Disparity – Bonus Pay

Bonus pay relates to the Clinical Excellence Awards (CEAs) which only apply to members of the consultant workforce. Therefore, 100% of women received bonus pay, compared with 100% of men of overall relevant workforce.

For every £1 that a male consultant receives, a female consultant receives the same amount. Therefore, there is no gender disparity with the bonus pay within the Trust.

In relation to the numbers and percentages of employees receiving CEAs (bonus payments) an anomaly in the national gov.uk reporting algorithm has been identified. The national system is set up with the assumption that all employees in an organisation are potentially eligible for a bonus payment. However, as already identified members of the consultant workforce are the only people who are eligible for CEAs. Therefore, the calculation on the gov.uk website where it is recorded that 0.1% female and 0.3% male staff received a bonus payment is actually incorrect, as only members of the consultant workforce should be considered. When recalculated to only include members of the consultant workforce the correct figures are 100% female and 100% male consultants received bonus pay (CEAs). This correct calculation is reflected in the table in appendix 1 below. An action for the coming year is to review this area of the reporting and establish whether accurate reporting on the gov.uk website is possible.

How we will make progress to close the gap

It has been identified where the Trust needs to take action which will be taken forward within the context of the overall Lincolnshire Community Hospitals Group (LCHG) strategic objectives, the LCHG EDI Objectives 2025-2026 and the NHS EDI Improvement Plan.

The Gender Pay Gap action plan will be discussed further with key stakeholders such as the Women's Staff Network and Men's Staff Network.

Appendices:

Appendix 1:

Gender Pay Gap Data on which this report is based.

The mean and median hourly rates for males and females.

Gender	Avg. Hourly Rate	Median Hourly Rate
Male	£22.38	£19.39
Female	£18.62	£17.68
Difference	£3.76	£1.70
Pay Gap %	16.8	8.8

The proportion of male and female staff in each pay quartile.

Quartile	Female	Male	Female %	Male %
1	523	63	89.2	10.8
2	511	76	87.1	12.9
3	524	62	89.4	10.6
4	466	121	79.4	20.6

Mean salary for men and women within each Agenda for Change pay band or grade 2024

	Gender (FTE)		Mean Salary (£)	
Pay Band/Grade	Female	Male	Female	Male
Band 1 & Apprentices	6.63	1.00	£21,880.96	£20,374.80
Band 2	227.90	23.11	£22,369.68	£22,383.00
Band 3	298.02	44.19	£23,766.00	£23,498.45
Band 4	157.57	21.00	£25,773.83	£25,730.10
Band 5	319.27	48.51	£32,341.45	£30,562.76
Band 6	322.65	41.95	£39,111.23	£39,585.84
Band 7	278.21	56.85	£46,713.43	£46,777.11
Band 8A	63.78	27.71	£52,713.49	£53,157.86
Band 8B	17.55	10.00	£60,564.17	£60,882.60
Band 8C	10.00	2.00	£72,561.20	£70,417.00
Band 8D	5.00	1.67	£86,132.00	£89,973.50
Band 9	2.00	-	£99,891.00	-
Director	2.00	1.00	£154,625.00	£131,116.68
Deputy Director	-	1.00	-	£124,535.00

Mean salary for men and women within each Medical Workforce pay band or grade 2024

	Gender (FTE)		Mean Salary (£)	
Pay Band/Grade	Female	Male	Female	Male
General Medical Practitioner	1.90	10.44	£110,183.42	£129,349.82
Consultant	2.30	1.08	£122,154.00	£118,884.00
Associate Specialist	1.65	1.94	£96,350.00	£99,629.67
Foundation Year 2	-	1.00	-	£46,141.00

Bonus payments (Clinical Excellence Awards) for men and women within the medical workforce consultant pay grade 2024:

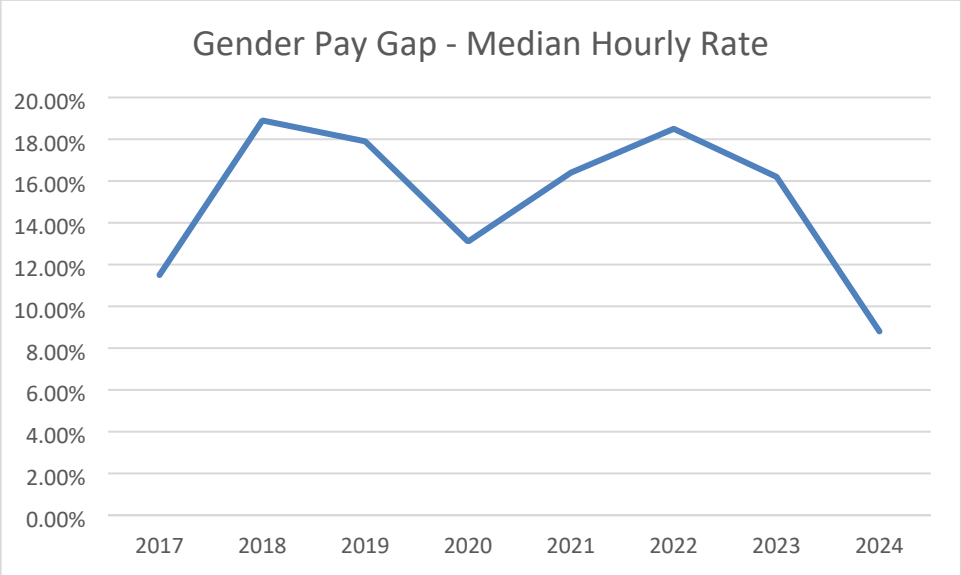
Mean and median bonus payments for males and females.

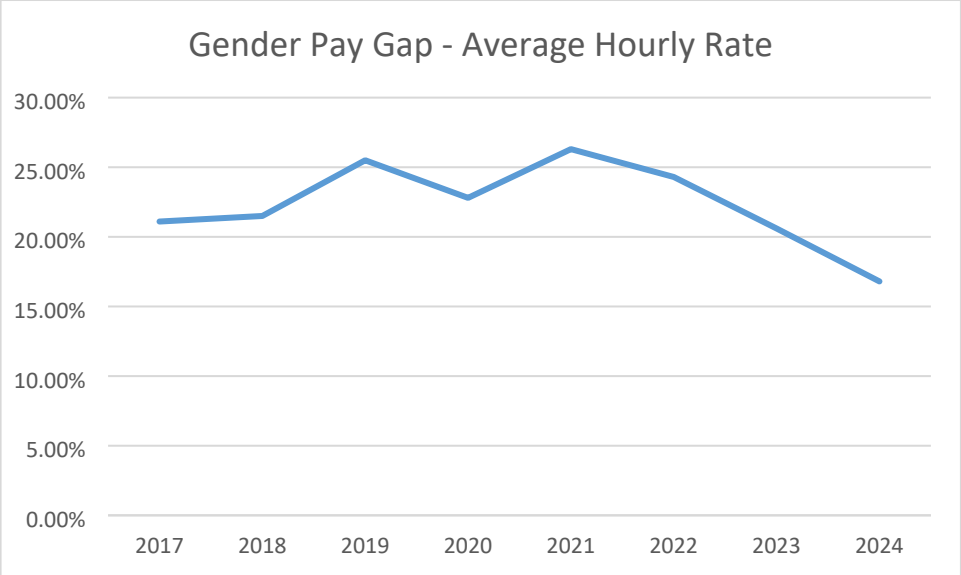
Gender	Avg. Pay	Median Pay
Male	£7,271.25	£7,271.25
Female	£7,271.25	£7,271.25
Difference	£0.00	£0.00
Pay Gap %	0.0	0.0

Table 6. Number of staff receiving bonus.

Gender	Employees Paid Bonus	Total Relevant Employees	%
Female	3	3	100
Male	1	1	100

Appendix 2: – Trend data





Report to the Board - ULTH Gender Pay Gap Report 2024/25

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Hospitals NHS Trust

Report for the Board meeting on:	*4 March 2025*
Upward Report from the meeting of:	*People Committee*
Date of Meeting:	*14 January 2025*
Item Number	*9.2*

ULTH Gender Pay Gap Report 2024/25

Accountable Director	*Nico Batinica, LCHG Director of People*
Report Prepared by	*Kerry Swift, Deputy Director of People*
Quoracy of meeting met	*n/a*
Items Approved: Gender Pay Gap Report (ULTH)	
Matters highlighted in respect of Risk Register/BAF: None	
Policies/ Procedures/ Guidelines approved/noted by the Group: Not applicable	
Recommendations/Actions Required from the People Committee: The Board is asked to note the report and approve for publication.	

This report contains the ULTH Gender Pay Gap Report for 24-25. This has been approved in January by the People Committee and now requires Board approval prior to publication by 31st March 2025.

Strategic Objectives	
1a Deliver high quality care which is safe, responsive and able to meet the needs of the population	
1b Improve patient experience	
1c Improve clinical outcomes	
1d Deliver clinically led integrated services	
2a Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	*x*
2b To be the employer of choice	*x*
3a Deliver financially sustainable healthcare, making the best use of resources	
3b Drive better decision and impactful action through insight	
3c A modern, clean and fit for purpose environment across the Group	
3d Reduce waits for patients who require urgent and emergency care and diagnostics and ensure we meet all constitutional standards	
3e Reducing unwarranted variation in cancer service delivery and ensure we meet all constitutional standards (ULHT)	
3f Reducing unwarranted variation in planned service delivery and ensure we meet all constitutional standards (ULHT)	
3g Reducing unwarranted variation in community service delivery and ensure we meet all constitutional standards (LCHS)	
4a Establish collaborative models of care with all our partners including Primary Care Network Alliance (PCNA), GPs, health and social care and voluntary sector	
4b Successful delivery of the Acute Services Review	
4c Grow our research and innovation through education, learning and training	
4d Enhanced data and digital capability	
5a Develop a Population Health Management (PHM) and Health Inequalities (HI) approach for our Core20PLUS5 with our ICS	
5b Co-create a personalised care approach to integrate services for our population that are accessible and responsive	
5c Tackle system priorities and service transformation in partnership with our population and communities	
5d Transform key clinical pathways across the group resulting in improved clinical outcomes	

United Lincolnshire Teaching Hospitals NHS Trust

Gender Pay Gap Report 2024-2025

Author: Tim Couchman, Head of Equality, Diversity and Inclusion

December 2024

Contents

Executive Summary

Headlines

In line with national guidelines, when reporting Gender Pay Gap data, the Trust is working on the data as at previous 31st March. This means the snapshot date for data in this report is 31 March 2024.

In this Trust, women earn 86p for every £1 that men earn when comparing median hourly pay. This is an improvement on last year's data (85p for every £1).

For women who receive a bonus, they receive £1 for every £1 men receive. In an NHS Acute Trust, bonuses are defined as the Clinical Excellence Awards (CEAs) which are only applicable to consultants in the medical workforce.

At United Lincolnshire Teaching Hospitals NHS Trust, women hold 81.7% of the lowest paid jobs (the figure was 83.5% last year), and 63.8%of the highest paid jobs (the figure was 63.7% last year).

There has been a decrease of 1.8% in the number of women holding the lowest paid jobs, and a slight increase of 0.1% in the number of women holding the highest paid jobs – this was the case as at the 31 March 2024 snapshot date.

Women still hold around 80% of the lower middle and upper middle-paid jobs, which has remained stable since last year.

The median is the generally accepted main indicator across all organisations who take part in Gender Pay Gap reporting. Comparing like-for-like years, i.e. 2024 data, the national gender pay gap in the UK was 13.1%, compared to the Trust's 14.2% gap.

Despite some changes in representation at the highest and lowest pay bands in the Trust, the Trust's gender pay gap continues to improve to be much closer to the national median UK pay gap. The national gender pay gap has improved by 1.1%, and ULHT's gap has improved by 0.4%.

When comparing mean (average) hourly pay, women's mean hourly pay is 27.2% lower than men's. This is a continued improvement on last year's data

of 28.7%, which again was an improvement on the previous year where the data recorded 29.3%.

National Sources:

Gender pay gap in the UK – Office for National Statistics (ons.gov.uk)

This report contains:

- Background to the requirements for Gender Pay Gap Reporting.
- Guidance to assist understanding of the indicators and calculations used.
- Narrative about the Trust's Gender Pay Gap results, in line with reporting requirements – but most importantly, to assist with the Gender Pay Gap Action Plan.
- Comparison with previous year's results, which show that the Gender Pay Gap has improved (i.e. reduced).
- A proposed action plan to further reduce the Gender Pay Gap, incorporating the actions from the Mend the Gap report.
- Appendix with all the required data which has been submitted to the gov.uk Gender Pay Gap reporting portal, ahead of the 30 March 2025 deadline.

This report will provide a high level of assurance in terms of compliance with Gender Pay Gap Reporting, for People Committee and Trust Board approval. It will also provide high levels of assurance that the Trust will take action to reduce (improve) the disparity between pay for men and women, in the form of a detailed action plan. It also provides evidence for High Impact Action 3 of the NHS Equality, Diversity and Inclusion Improvement Plan.

Please note that to enable internet accessibility, all diagrams and infographics relating to the gender pay gap data are included as appendices at the end of this document.

Background

Employers with 250 or more employees have been required to publish information on the pay gap between male and female employees since 31 March 2017, under the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, which can be found at: The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 (legislation.gov.uk).

Organisations in the public sector, such as NHS Trusts, are required to report on the gov.uk Gender Pay Gap website (Search and compare gender pay gap data - Gender pay gap service - GOV.UK), against a set of six key indicators, based on data from 31 March each previous year, for example, the "snapshot date" for this report is 31st March 2024. Organisations are then required to publish the data and a narrative ("Gender Pay Gap Report") so that employees and members of the public can access the data and report, along with an action plan to address disparities, by 31 March each year, for example, this report is to be published on the Trust's website by 31 March 2025 (Gender pay gap reporting - United Lincolnshire Hospitals).

Private sector employers with 250 or more employees are also required to publish Gender Pay Gap information, albeit with a slightly later publication date of 5th April each year.

In preparing this report, the author has consulted and followed the NHS Employers Gender Pay Gap guide: Addressing-your-gender-pay-gap-guide.pdf (nhsemployers.org) which was co-produced with the Health and Care Women Leaders Network.

Understanding the Gender Pay Gap Calculations

The six key indicators that the Trust is required to report on are:

1. percentage of men and women in each hourly pay quarter (lower, lower middle, upper middle and upper quartile) by number of employees.
2. mean (average) gender pay gap using hourly pay.
3. median gender pay gap using hourly pay.
4. percentage of men and women receiving bonus pay.

5. mean (average) gender pay gap using bonus pay.
6. median gender pay gap using bonus pay.

The data for the report is drawn from the national Electronic Staff Record (ESR) Business Intelligence standard report.

For the purposes of these calculations, pay includes: basic pay, full paid leave, including annual, sick, maternity, paternity, adoption or parental leave, bonus pay, area and other allowances, shift premium pay, pay for piecework.

Pay does not include: overtime pay, expenses (payments made to reimburse expenditure wholly and necessarily incurred in the course of employment, e.g. mileage for use of a vehicle), remuneration in lieu of leave, the value of salary sacrifice schemes, benefits in kind (e.g. child-care vouchers), redundancy pay and tax credits.

Bonus pay relates to the Clinical Excellence Awards (CEAs) to consultants, following the NHS Employers Gender Pay Gap Guide.

The Trust now has eight years' worth of data and the opportunity is taken in this report to indicate trends in that data.

What does median mean?

This is the difference between the hourly pay of the median man and the hourly pay of the median woman. The median for each is the man or woman who is in the middle of a list of hourly pay ordered from highest to lowest paid.

Medians are useful to indicate what the 'typical' situation is. They are not distorted by very high or low hourly pay (or bonuses). However, this means that not all gender pay gap issues will be picked up. They could also fail to pick up as effectively where the gender pay gap issues are most pronounced in the lowest paid or highest paid employees.

What is the meaning of mean?

The mean gender pay gap figure uses hourly pay of all employees to calculate the difference between the mean hourly pay of men, and the mean hourly pay of women. A mean involves adding up all the numbers and dividing the result by how many numbers were in the list. Very high or very low pay can distort this figure.

About our results

The Trust's Gender Pay Gap has been on a generally decreasing (i.e. improving) trend since reporting began, in line with the national trend both inside and outside of the NHS.

The data sets on which the Trust's Gender Pay Gap report for the current reporting cycle are based can be viewed in appendix 1.

Compared to last year, the median has improved by 0.4% (smaller gender pay gap), and the average hourly rate (mean) has improved by 1.5%. Since reporting began in 2017-2018, the median has fluctuated and overall there is a very small deterioration of 0.1%.

The trend data from 2017 to 2025 for the median hourly rate and the average hourly rate (mean) are noted as follows:

Reporting Year	Median Hourly Rate	Average Hourly Rate
2017-2018	14.1%	32.8%
2018-2019	15.2%	32.8%
2019-2020	15.3%	31.6%
2020-2021	16.8%	31.4%
2021-2022	14.6%	28.6%
2022-2023	16.8%	29.3%
2023-2024	14.6%	28.7%
2024-2025	14.2%	27.2%

Trend charts for the Median Hourly Rate and the Average Hourly Rate (mean) are included in appendix 2.

As with previous years, the main driver of the Trust's gender pay gap remains the structure of the NHS workforce, with female colleagues comprising the majority of the lower paid roles and men in higher paid roles including the

medical workforce (especially Consultant medical staff) and Very Senior Management (VSM) roles.

Gender Disparity – Pay Quartiles

81.7% of the workforce in the lowest pay quartile are female. This means that women hold 81.7% of the lowest paid jobs. In comparison, 63.8% of the workforce in the top pay quartile are women. This means that women hold 63.8% of the highest paid jobs, which is disproportionately low for their representation in the lowest pay quartile (81.7%) and throughout the other pay quartiles (around 80%).

Further detail relating to the pay quartiles can be located in appendix 1.

Gender Disparity – Mean Salary

The data in Appendix 1 highlights that below Band 8A Agenda for Change (AfC), women are likely to be paid more than men. The reasons why female colleagues are more highly paid in some of the pay bandings is likely to relate to factors like length of time in post, career progression and seniority in the nursing and midwifery workforce. Further investigation and actions are included in the Gender Pay Gap Action Plan.

However, from AfC Bands 8A to 9, similar to the previous year, men are paid more than women. The reasons for this are not evident from the gender pay gap data and may relate to length of service and gaining of higher increments. An action is therefore noted, to explore the reasons for this further.

Across a wide range of medical grades (i.e. consultant, associate specialist, specialty doctors, specialist doctors and specialty registrars) men are paid more than women. This disparity has a specific action in the Gender Pay Gap action plan – to ensure that the “Mend the Gap” report recommendations are implemented at the Trust (NHS EDI Improvement Plan, High Impact Action 3). However, overall, across the medical workforce, women earn +2% more.

Gender Disparity – Bonus Pay

Bonus pay relates to the Clinical Excellence Awards (CEAs) which only apply to members of the consultant workforce.

Historically, Clinical Excellence Awards were an area where gender disparity was evident. In recent years the Trust has transformed its approach to CEAs by ensuring a gender balance on the awarding panel and taking steps to encourage applications from female consultants for the CEAs, and has distributed awards equally in the current reporting cycle. There is now greater equity in terms of equal bonus payments. For every £1 that a male consultant receives, a female consultant receives the same amount.

In relation to the numbers and percentages of employees receiving CEAs (bonus payments) an anomaly in the national gov.uk reporting algorithm has been identified. The national system is set up with the assumption that all employees in an organisation are potentially eligible for a bonus payment. However, as already identified members of the consultant workforce are the only people who are eligible for CEAs. Therefore, the calculation on the gov.uk website where it is recorded that only 1% female and 9.4% male staff received a bonus payment is actually incorrect, as only members of the consultant workforce should be considered. When recalculated to only include members of the consultant workforce the correct figures are 94.4% female and 96.1% male consultants received bonus pay (CEAs). This correct calculation is reflected in the table in appendix 1 below. An action for the coming year is to review this area of the reporting and establish whether accurate reporting on the gov.uk website is possible.

Action Plans for Improvement:

It has been identified where the Trust needs to take action to continue its journey of improvement in relation to Gender Pay Gap. These actions will be taken forward within the context of the overall Lincolnshire Community and Hospitals' Group (LCHG) strategic objectives, the LCHG EDI Objectives 2022-2025, the national Mend the Gap Report (2020) and the national NHS EDI Improvement Plan (2023).

The Gender Pay Gap Action Plan, is proposed for further discussion, including key stakeholders such as the ULHT Women's Staff Network and the Medical Workforce, is included below.

Appendices:

Appendix 1:

Gender Pay Gap data on which this report is based.

The mean and median hourly rates for men and women:

Gender	Avg. Hourly Rate	Median Hourly Rate
Male	£24.60	£18.70
Female	£17.91	£16.05
Difference	£6.69	£2.66
Pay Gap %	27.2	14.2

The proportion of male and female staff in each pay quartile:

Quartile	Female	Male	Female %	Male %
1	1972	443	81.7	18.3
2	2091	491	81.0	19.0
3	1995	504	79.8	20.2
4	1594	905	63.8	36.2

Mean salary for men and women within each Agenda for Change pay band and other pay grades:

	Gender (Fte)		Mean Salary (£)	
Pay Band/Grade	Female	Male	Female	Male
Band 1 & Apprentices	24.23	10.59	£18,920.24	£19,230.59
Band 2	1629.02	412.81	£22,376.13	£22,369.44
Band 3	637.24	158.28	£23,586.04	£23,495.20
Band 4	505.58	127.69	£26,070.00	£26,029.97
Band 5	1536.49	278.20	£30,729.48	£30,150.97
Band 6	822.34	210.70	£38,766.19	£38,128.13
Band 7	516.36	133.46	£46,557.89	£46,096.80
Band 8A	213.25	68.99	£52,874.55	£53,121.84
Band 8B	66.81	26.80	£62,460.86	£65,316.90
Band 8C	28.80	11.00	£75,628.60	£76,264.82
Band 8D	9.00	9.80	£84,993.78	£92,456.10
Band 9	10.10	12.80	£107,345.46	£109,066.97
Director	4.00	3.00	£155,396.00	£192,929.33
Deputy Director		1.00		£177,914.29
General Medical Practitioner	0.11		£125,033.12	
Consultant	94.30	270.52	£111,072.46	£112,889.74
Associate Specialist	2.70	17.79	£107,159.44	£107,328.62
Staff Grade		0.78		£81,493.00
Specialty Doctor	56.97	137.72	£72,628.93	£77,430.21
Specialist	1.87	1.00	£86,967.95	£89,610.00
GPCA/Hospital Practitioner	1.09	0.73	£80,088.25	£68,498.97
Specialty Registrar	96.23	129.65	£50,258.68	£50,657.20
Foundation Year 2	65.80	97.00	£37,303.00	£37,303.00
Foundation Year 1	49.16	47.00	£32,398.00	£32,398.00

Bonus payments (Clinical Excellence Awards) for men and women within the medical workforce consultant pay grades:

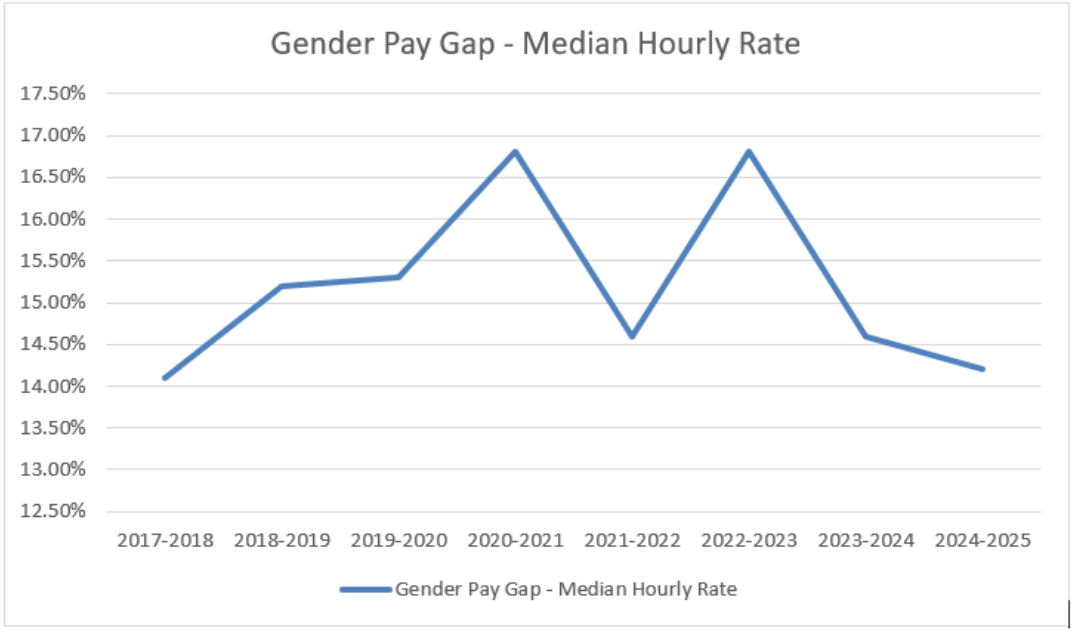
Mean and median bonus payments for men and women:

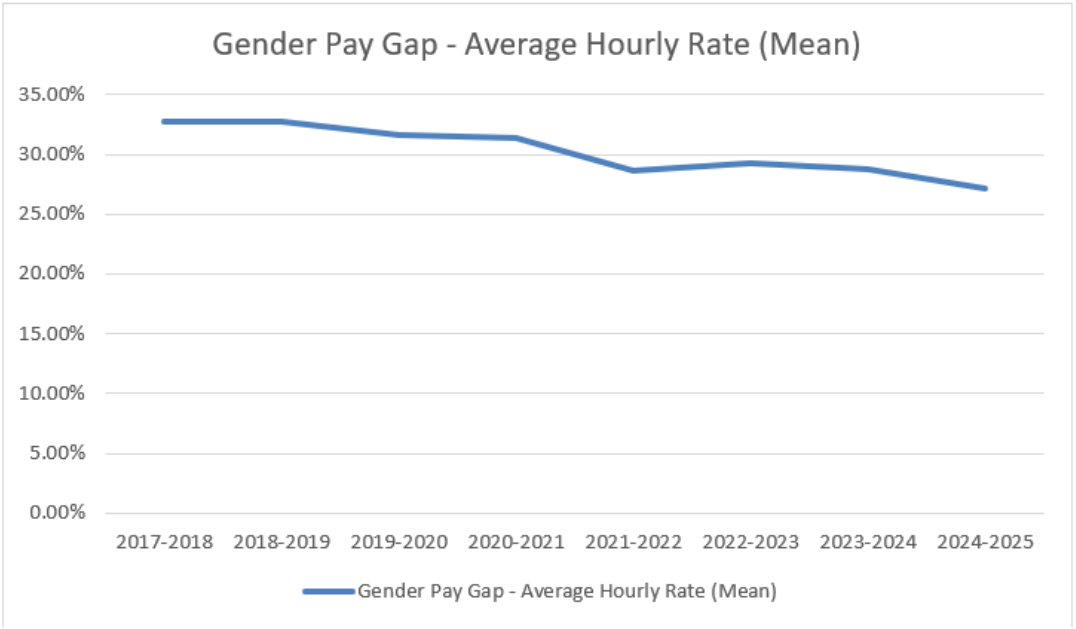
Gender	Avg. Pay	Median Pay
Male	£7,047.27	£4,000.34
Female	£5,220.85	£4,000.34
Difference	£1,826.41	£0.00
Pay Gap %	25.9	0.0

Number of female and male medical staff receiving a bonus payment:

Gender	Employees paid bonus	Total relevant employees	Percentage (%)
Female	89	94.3	94.4%
Male	260	270.52	96.1%

Appendix 2:


Gender Pay Gap - Median Hourly Rate
17.50%
17.00%
16.50%
16.00%
15.50%
15.00%
14.50%
14.00%
13.50%
13.00%
12.50%
2017-2018
2018-2019
2019-2020
2020-2021
2021-2022
2022-2023
2023-2024
2024-2025
Gender Pay Gap - Median Hourly Rate


Gender Pay Gap - Average Hourly Rate (Mean)
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
2017-2018
2018-2019
2019-2020
2020-2021
2021-2022
2022-2023
2023-2024
2024-2025
Gender Pay Gap - Average Hourly Rate (Mean)

NHS
Lincolnshire Community and Hospitals NHS Group

Finance Committee Upward Report

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

Meeting	*Lincolnshire Community and Hospitals Group Board Meeting*
Date of Meeting	*4 March 2025*
Item Number	*Item 10.1*

Finance Committee Upward Report of the meeting held on 23 January 2025

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

Purpose

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

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

Upward Report

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

Finance Report to include CIP and Capital
The Committee received the report noting the Group financial position of a £30.7m deficit, which was adverse to plan and the majority of which was within ULTH.

The Committee noted the cash position which had been managed during December with £6.9m of national cash support secured however the position in January and February remained challenging. Work was being undertaken to work through the position however it was noted that a possible resolution would be through a Public Dividend Capital (PDC) transfer from one of the

other NHS Trusts within the Lincolnshire system. Discussions were taking place within the system and the finance team was diverting efforts to manage the cash position. There was recognition that efforts would be required in future years to raise the profile of the cash position on a monthly basis to support the Group.

An application to the national team for further cash would be made in January however there was recognition that this may not be accepted.

The Committee discussed the forecast outturn revenue position and noted that engagement was taking place with the region and nationally as to the position of this for ULTH with mitigations being developed alongside technical adjustments to improve the position. **No assurance** was received that the Trust would deliver its financial plan, given the pressures discussed and despite the mitigations developed.

The Committee noted that the release date for planning guidance continued to be pushed out however planning had commenced, and the guidance would be overlayed when released in full.

ULTH had accepted a cash settlement of £2.1m from HMRC. This was in respect of a successful legal claim brought by Northumberland Healthcare Trust against HMRC challenging hospital car parking being in scope for VAT. This would be received into the bottom line at £1.5m after fees were paid to the Trust's VAT advisors..

Work was taking place to stabilise workforce expenditure, with vacancy controls in place in respect of substantive recruitment and oversight of bank and agency spend. This was progressing well however a review would be required to ensure delays to recruitment did not have a detrimental impact in the coming year.

The Committee noted the request for, and recommended to the Board, appropriate delegated authority to the Group Chief Finance Officer, Group Integration Officer and Group Chief Operating Officer to approve emergency changes in the capital funds, should additional capital funds become available.

Procurement Report
The Committee received the report noting the improvement in the management of waivers and the increase in value for money, for which independent benchmarking would be sought to identify further opportunities for savings to be achieved.

The Committee noted the introduction of the new procurement legislation which would be presented to the Group Leadership Team with work having already been undertaken with operational teams.

CDC Funding Risk
The Committee received the report noting the concern in respect of pricing for the delivery of services through the Community Diagnostic Centres (CDCs) which was creating a significant financial challenge. This would lead to an income shortfall of circa £3m across the three sites. It was noted that this would need to be addressed through the 2025/26 planning round as a result of the tariff reductions.

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

Estates and Facilities Report
The Committee received the reports noting that this provided an update across the Group. The transition to mobilisation phase on the LCHS estate had taken place however some impact had been experienced due to recent equipment failures and flooding at an LCHS site, for which the Committee commended the Estate Team's actions.

The Committee noted concern in respect of the information provided regarding the LCHS estate with further work being undertaken to confirm the position.

Work remained ongoing in respect of estates utilisation which was a significant piece of work but which could deliver significant improvements in efficiency and usage.

The Committee noted the fire safety issues which had been reported, including a fire enforcement action for County Hospital Louth, work was ongoing with NHS Property Services to resolve the issues.

Compliance issues were also noted at County Hospital Louth in respect of ventilation which could impact on JAG accreditation due to endoscopy services being affected.

Pilgrim ED Highlight Report
The Committee received the report noting the completion dates offered and reflected on the need to ensure that the environment was suitable for use at the point of handover.

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

Operational Performance Report and Committee Performance Dashboard – LCHS/ULTH
The Committee received the reports noting that for ULTH the Urgent and Emergency Care (UEC) combined reporting position had been completed for type 1 and type 3 performance, resulting in the Trust moving to the upper quartile in the region.

12-hour waits continued to cause concern due to flow however the Committee noted that the first round of winter pressures had now passed, with lower occupancy levels being seen and an increase in flow due to the focus on discharge.

Ambulance performance for category 2 standards remained in the mid-40 minutes, despite Lincolnshire being one of the better performing divisions within the East Midlands.

Work was due to commence in respect of streaming at the front door in order to ensure that attendances could be better managed to support resolving urgent ED pressures. Work had also commenced in respect of the Same Day Emergency Care (SDEC) to ensure that this was able to support ED and flow however there were constraints due to limitations of the estate.

In respect of LCHS the Committee noted the performance remained steady with some evidence being seen in respect of attendance avoidance and admissions avoidance. Advanced Care Practitioners were now working in the EMAS Ops centre and had successfully diverted 300 attendances in a month.

Planned care performance continued to see improvements with a number of elective care pathways protected across the winter period with only a small number of operations cancelled in December.

The Committee was pleased to note the eradication of 78-week waits, with those remaining being patient choice. 65-week and 52-week waits were reported at the lowest level in the past 2-years, with a forecast position of 41 patients waiting 65-weeks at the end of January.

Cancer services, for 62-day waits, had seen the highest performance in recent months with Faster Diagnosis Standards in the top quartile for the region and above the set trajectory.

The Committee noted the slight reduction in diagnostic performance with under performance being driven by audiology, Dexa scanning and ultrasound.

The development of the performance reports was noted with the intention to include forward trajectories and key national benchmarks to provider greater oversight of the position across the Group.

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

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

Assurance in respect of Objective 4d Education data and digital capabilities

Information Governance Group Upward Report
The Committee received the report which was taken as read and reflected concerns in respect of the compliance associated with Subject Access Requests and noted the reprimand of the Information Commissioners Officer following a review.

The Committee requested a further update be received in order that an assurance rating could be considered for the objective.

Assurance in respect of other areas

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

The Committee considered the assurance ratings presented within the BAF recognising there were no changes required.

Integrated Improvement Plan (ULTH)/Operational Plan (LCHS)
The Committee received the reports noting the intention to refocus in the 2025/26 year in respect if fewer programmes of work with greater levels of delivery, as the current year programmes of work had been too broad.

The focus moving forward would be on productivity and improvement with a recognition of the need to reduce the duplication currently being seen through this and the performance reports.

The Committee noted the current progress against the programmes of work for both ULTH and LCHS.

Risk Report
The Committee received the report noting that the risks had been considered during the reports presented to the Committee and had been updated accordingly.

CQC Action Plan
The Committee received the report noting the actions for which the Committee held oversight noting the need for cross reference of these to ensure these were being monitored through existing reporting.

Update on Fuller and HTA
The Committee received the report noting that the majority of actions had related to the mortuary with the refurbishment works, which were due to be completed in the near future.

It was noted that some of the actions were reliant on the service provider ensuring these were complete with ongoing discussions taking place to resolve.

The Committee noted the progress in respect of DBS checks, which was overseen by the People Committee, and reflected on the significant progress that had been made in relation to mortuary staff.

Policy Position Update
The Committee received the report noting the position presented and the need for further alignment to ensure these were overseen within the correct directorate.

It was reflected that a number of the overdue policy documents required review to determine if these were required, given how overdue they had become.

Issues where assurance remains outstanding for escalation to the Board

The Committee wished to escalate to the Board the cash position for ULTH and the fire enforcement notice at County Hospital Louth.

Items referred to other Committees for Assurance

No items for referral.

Attendance Summary for rolling 12-month period

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

X in attendance
A apologies given
D deputy attended

NHS
Lincolnshire Community and Hospitals NHS Group

Finance and Performance Committee Upward Report

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

Meeting	*Lincolnshire Community and Hospitals Group Board Meeting*
Date of Meeting	*4 March 2025*
Item Number	*Item 10.1*

Finance Committee Upward Report of the meeting held on 24 February 2025

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

Purpose

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

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

Upward Report

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

Finance Report to include CIP, Capital, CRIG
The Committee received the report noting the Group financial position of a £33.3m deficit, £24.7m adverse to plan with the majority of the deficit within ULTH. In month there had been a delivery of a £3.7m deficit which included a one-off backdated element relating to the band 2 to band 3 back pay.

The Cost Improvement Programme was slightly behind plan by £1.2m, however the run rate was showing improvement year to date.

At month 10, £38.3m capital had been spent against a full year plan of £61m with confidence that the full allocation would be spent, and work was taking place with programme leads to ensure this position.

Positive improvement had been seen in the agency position with a year on year 28% reduction with further work required in the 2025/26 year to support efficiencies.

The Committee noted that the cash position remained challenging with £4m of support received from NHSE in January and temporary support received from LCHS to ULTH. A further request for cash support had been submitted to NHSE in February.

The Committee considered the forecast outturn and noted the discussions, both at regional and national level, with a recognition that the forecast outturn was now anticipated to be circa £29.2m deficit, subject to depreciation adjustments.

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

Estates and Facilities Report
The Committee received the reports noting that whilst this was offered as single Group level report this demonstrated the difference in maturity across the organisations.

The Committee was pleased to note that there had been resolution to the issues raised at County Hospital Louth which had the potential to impact on JAG accreditation and noted that longer term capital investment would be required to resolve issues raised.

Authorised Engineer reports for LCHS were noted as an area of concern with work taking place to address this through the appointment further Authorised Engineers.

Emergency Planning Group Upward Report
The Committee received the report noting that further work was required in respect of lockdown to ensure that this was appropriately in place for the Group.

Significant progress was noted in respect of Business Continuity Plans with continuous testing of plans now in place and the positive position supported by the recent Internal Audit outcome.

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

Operational Performance Report and Committee Performance Dashboard – LCHS/ULTH

The Committee received the performance reports noting that improvements in performance for ULTH had been seen across unscheduled care, 28-day Faster Diagnosis Standard (FDS) in cancer, 62-day waits, and elective waiting lists compared to January 2024.

The Committee noted that there had been zero 78-week waiters for the first time since Covid-19 and only 33 65-week waiters which was the lowest since January during the Covid-19 pandemic. 18-week wait performance was noted as 53.62% and whilst there was not currently a target set against this there was an anticipation that a 60% target would be introduced during 2025/26. Work was taking place to achieve this position by the end of March 2025.

12-hour trolley waits had seen an improvement against the previous year position however it was noted that this was not significant and further work was required, with a focus on discharge to support the front door.

Improvements were noted in DM01 however challenges continued in respect of non-obstetric ultrasound, bone scanning and audiology. Whilst improvements were noted in cancer performance the Committee noted the need to continue with actions to manage and reduce the 62-day backlog.

The Committee recognised the actions being taken in order to improve performance and ensure a positive position entering winter 25/26 and recognised that actions would be taken and embedded across the summer to support this position.

The Committee considered LCHS performance noting ongoing concern in respect of pathways 1 – 3 and the current capacity and funding which was impacting on this. There was a need to realign the capacity across the Group in order to decompress the acute sites and move to a sustainable position.

Performance across LCHS was noted with a number of targets set above national standards, with a need for these to be reviewed to ensure these were attainable. It was recognised that whilst length of stay within community hospitals was 16-days there was a need for review due to the variability across wards and sites.

There was recognition of the increase in community metrics being introduced nationally, including community waiting lists, with local targets due to be set. The Committee noted the referral from the Integration Committee in respect of community waiting lists and performance would now be considered through performance reporting. There were currently no mandated waiting times nationally however these did need to be addressed.

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

Operational Performance Report and Committee Performance Dashboard – LCHS/ULTH

As reported above.

Assurance in respect of Objective 4d Enhanced data and digital capabilities

Information Governance Update
The Committee received the report noting a number of areas of concern including the Subject Access Request (SAR) compliance and the work to develop a dashboard alongside the improvement action plan.

The Committee noted that monthly data did not show fluctuations in the position and therefore weekly reporting had been implemented which provided oversight of the position. Volume and capacity would need to be applied in the context of the team in order to identify an achievable trajectory which would be reported to the Committee.

Group working was noted however there was recognition that both organisations had very different processes meaning it was not yet possible to provide cross cover, there were plans in place to strengthen the team to support compliance.

There was recognition of the challenges faced across the organisation to deliver both patient and staff SARs with positive working between the IG team and HR to ensure staff SARs were progressed.

The Committee noted the other elements of IG including information asset owner identification, linked to the Data Security Protection Toolkit with the Committee requesting further information in respect of the required submission.

Assurance in respect of other areas

Group Board Assurance Framework 2024/25
The Committee received the draft Group Board Assurance Framework (BAF) noting the updates provided and received further verbal updates to the narrative which were requested for inclusion and presentation to the Board.

The Committee noted the discussion regarding objective 4d and the requirements for an assurance rating to be identified with further work required to demonstrate appropriate assurance levels, to enable a rating to be considered.

The Committee noted that there were no changes required to the BAF ratings at this meeting.

Policy Position Update
The Committee received the report noting the position presented.

Following review through the Audit Committee a request was made for risk ratings to be applied to the overdue policy documents to ensure that these were addressed in priority order, with a recognition that there may be a number of policy documents which could be identified as no longer required.

Planning Update
The Committee received the report noting the late release of planning guidance however reflected that work had been undertaken ahead of this resulting in the guidance being overlayed on the work already completed.

The Committee noted that there would be a full Board discussion in respect of planning to consider the detail of the required planning submission which was expected in March.

Integrated Improvement Plan (ULTH)
The Committee received the reports noting the progress to date and that discussions during the course of the meeting had touched on a number of areas within the report.

The Committee reflected on the breadth of the improvement plan and noted the intention for the refocus across the Group in the 2025/26 year.

Risk Report
The Committee received the report noting that the risks had been considered during the reports presented to the Committee and had been updated accordingly.

Internal Audit Recommendations
The Committee received the report noting the open actions resulting from internal audit recommendations and was pleased to note the positive progress in competing these. Work would be undertaken to address the remaining open actions.

Issues where assurance remains outstanding for escalation to the Board

No escalations required.

Items referred to other Committees for Assurance

No items for referral.

Attendance Summary for rolling 12-month period

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

X in attendance
A apologies given
D deputy attended

NHS
Lincolnshire Community and Hospitals NHS Group

Integration Committee Upward Report

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

Meeting	*Lincolnshire Community and Hospitals Group Board Meeting*
Date of Meeting	*4 March 2025*
Item Number	*Item 11.1*

Integration Committee Upward Report of the meeting held on 24 January 2025

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

Purpose

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

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

Upward Report

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

No reports due

Assurance in respect of Objective 3c – A modern, clean and fit for purpose environment across the group

Estates and Facilities Update
The Committee received a verbal update and considered the required reporting to the Committee to ensure that assurance could be provided. It was recognised that reporting would focus on transformational pieces of work and include areas such as capital reporting, new requests for estates development and reports from the Space Group in respect of space utilisation.

The Committee recognised the volume of work associated with space utilisation across the Group and the current work underway to ensure appropriate resource was in place to support the work required.

Development of the estates strategy was noted with a reflection that this need to support and align to the clinical strategy.

Benefits realisation was also considered by the Committee where it was noted that all Committees should receive reports associated with benefits realisation to demonstrate delivery.

Assurance in respect of Objective 4a – Established collaborative models of care with our partners including Primary Care Network Alliance (PCNA)

No reports due

Assurance in respect of Objective 4b – Successful delivery of the Acute Services Review

Stroke Services Review/CLEAR Project – Next Steps
The Committee received the report with **assurance** noting the ongoing work in respect of stroke services and the need to ensure appropriate pathways were in place to support patients.

Work was taking place with CLEAR to support transformational change within the service with the overall aim of reducing length of stay and having clear pathways in place for patients to move from acute to community care at the appropriate time, through decoupling of services.

The Committee noted the complexity of the ongoing work and requested that an update on progress be presented back in June.

Assurance in respect of Objective 4d – Enhanced data and digital capabilities

Electronic Patient Record (EPR) Update
The Committee received the report with **assurance** noting that this continued to progress through the relevant approval routes and cabinet office.

Work was taking place to finalise the contract and the Committee noted the requirements for appropriate engagement with staff in respect of the rollout and delivery of the EPR.

Electronic Document Management System (EDMS) Update
The Committee received the report with **assurance** noting the progress which had been made in respect of costs with the case having been presented to the Finance Committee.

Work had now commenced in respect of the scanning partner and associated equipment required to enable scanning of records both on and off site.

The Committee noted that future updates in respect of digital would be provided through the Digital Group, which was being due to commence meeting jointly from February and would focus on the 4 major projects of EPR for both ULTH and LCHS, national tenant migration for ULTH and EDMS.

Assurance in respect of Objective 5a – Develop a Population Health Management and Health Inequalities approach for our Core20PLUS5 with our ICS

Health Inequalities Mapping Report – appendix 1
The Committee received the report with **assurance** noting the mandatory reporting requirements, with this now forming part of the CQC well led framework. Alongside reporting requirements, the Committee noted the development of a dashboard to monitor and record patients in ED and open 18-week referral to treatment (RTT) figures.

Work was currently taking place with Optum to determine how improvements could be made to reduce health inequalities with positive progress noted in respect of the ENT pilot and identification of actions to reduce DNAs.

Maturity in respect of data capture was developing across the Group and a Health Inequalities Working Group had been established across the system, chaired by the ICB, with the intention of developing a health inequalities map across the county.

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

No reports due

Assurance in respect of Objective 5c – Tackle system priorities and service transformation in partnership with our population and communities

Alliance Operating Model – appendix 2
The Committee received the report with **assurance** noting significant co-ordination required, not only for this to be a delivery model for Group services but also to further develop partnership services.

There was recognition that the naming convention and re-purposing of current structures would be relatively straight forward with the challenges coming from the integration of acute and community teams, due to the consultation requirements. In order to support the work being undertaken a co-ordination group would be established to focus on the internal left-shift and external programmes of work.

Whilst there would be a significant amount of work to be undertaken it was noted that some services may come together prior to transformation taking place due to the length of time that could be taken to achieve transformation of services.

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

No reports due

Assurance in respect of other areas

Board Assurance Framework
The Committee received the report with **limited assurance** noting that, whilst this would remain under review, the 2025/26 BAF would provide clarity of assurance for the Committee, aligned to the new Group objectives.

Risk Register
The Committee received the report with **limited assurance** noting that work continued to appropriately align the risks to the Committee with recognition that the report required further development to reflect those risks, relevant to, but not overseen by the Committee.

The Committee noted that all risks presented, with the exception of one, were relevant for the Committee to receive.

Operational Reporting Group Terms of Reference
The Committee received the terms of reference for the group noting the intention to utilise an existing meeting to deliver day-to-day transformation. The meeting would have a management mode for services as well as an assurance mode that would provide assurance reports to the Committee.

CQC Action Plan
The Committee received the report with **assurance** noting that there were currently no actions relevant to the Committee however this would continue to be offered for information on a quarterly basis.

The Committee noted the proactive work being undertaken in terms of evidence identification with health inequalities linking to the well led domain, which would be reported to the Committee.

Trust Wide Improvement Steering Group Upward Report
The Committee received the report with **assurance** noting the developments of reporting and recognising that the report had previously been offered to the Finance Committee.

It was noted that whilst there would be dual reporting through the group the focus to the Committee would be in respect of transformational change with updates provided to the Finance Committee in respect of the Cost Improvement Programme delivery.

The Committee noted the volume of staff who had been QI trained within ULTH and noted the development of a Group QI training model, ‘QI, lets’ make it better together’, which had been developed by the teams across the Group and was due to be launched imminently.

Issues where assurance remains outstanding for escalation to the Board

No escalations required.

Items referred to other Committees for Assurance

Attendance Summary for rolling 12-month period

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

X in attendance
A apologies given
D deputy attended

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Hospitals NHS Trust

Integration Committee

Health Inequalities Update – January 2025

Authors:

Sameedha Rich-Mahadkar Director of Improvement and Integration

Vicky Holden Associate Director of Partnerships

Emma Townend Interim Health Inequalities Programme Lead NHS Lincolnshire Integrated Care Board

Executive Summary

- **Health Inequalities are the unfair and avoidable differences in people's health across the population**, and between different groups within society. Further context can be found in Appendix 1.
- Lincolnshire and LCHG have committed to address these inequalities through its shared strategic director of travel.
- **ULHT and LCHS are required to submit details of the Health Inequalities programme as part of our annual board reports** and future requirements will include the embedding health inequalities reporting with a quarterly review at Board level.
- Progress during 23/24 across the group included the introduction of a **Health Inequalities Dashboard** (which allows the Trust to monitor and record patients in the Emergency Department and open 18 week wait pathways by a multitude of health inequalities segments, including: age, gender, deprivation, and ethnicity), and the implementation of **Optum's Population Health Management Reporting Suite** which actively supports the Groups ability to identify specific cohorts of the population when undertaking service developments using reports such as CORE20plus5. Other active workstreams underpinned by the health inequalities approach included: ophthalmology , cardiology, and understanding the Lincolnshire population's future need for PET scan provision.
- In order to deliver the Group responsibilities in regards to this agenda, **a Health Inequalities Working Group (HIWG) has been established** which will provide upward reports into the Integrate Committee.
- **A Terms of Reference (TOR) has been produced and can be found in appendix 1**. This clearly describes the roles and responsibilities of the group, membership and governance/accountability arrangements, which include reporting into to LCHG Integration Committee as well as The Health Inequalities Programme Board (ICB and LCC).
- This first update from the group forms the commencement of a regular programme of updates to the committee.
- **Work is already in progress and a full work programme and action plan will be developed by the end of March 2025**.

The committee are asked to note the focus on the areas of work identified including increasing the numbers of Health Inequalities Champions across LCHG to awareness and influence, deploying the Health Equity Assessment Tool (HEAT) across our standard forms and process e.g. EIA/QIA, in line with ICB requirements for this to be included in Business Planning/Business Cases and the plan to improve ethnicity coding across LCHG**.**

The committee are asked to approve the proposed governance structure.

Background, Current Areas of Focus and Governance

Background

- Information on the definition and context of Health Inequalities can be found in appendix 1.
- **Health Inequalities progress is required to be reported formally by both ULTH and LCHS separately as a requirement of our annual board report from 23/24.** Updates shared in the 23/24 report describe progress in both Trusts with the use of HI tools including a HI dashboard and Health Equity Assessment Tool (HEAT), the implementation of the Optum* population health management reporting suite to inform service review/development work and active programmes for ULTH across ophthalmology, cardiology and the development of a new East Midlands PET-CT service. LCHS also have a Health Inequalities Lead in the new Head of Integrated Partnerships Model/Structure.
- **The Health Inequalities Working Group (HIWG) was established in October 2024** in order to support LCHG to move forwards with the Health Inequalities agenda in line with the Joint Forward Plan, ICP Strategy, Joint Health & Wellbeing Strategies and LCHG's own Corporate Strategy. The group acknowledges work completed to date by both individual organisations but also recognised that more focus was required in order to achieve our ambitions in regards to reducing health inequalities across Lincolnshire. The group is still in its infancy stage having met four times since establishment.
- Terms of reference have been developed and can be found in Appendix 2 to this report. These clearly describe the roles and responsibilities of the group, membership and governance/accountability arrangements, which include reporting into to LCHG Integration Committee as well as The Health Inequalities Programme Board (ICB and LCC). **Current membership of the working group includes the ICB Health Inequalities Team, LCHG Strategy and Partnership Team from the Improvement and Integration Directorate Team, The LCHG Patient Experience Team, Divisional/Operational Representatives, Communications and Engagement, ED&I representative, LCHG & ICB Digital/Business Analysts and Public Health Programme Manager from LCC**. Once the LCHG programme has been agreed and implemented there is an intention to extend membership further to include LPFT and the Voluntary Sector. In addition, subject matter experts form across the region are invited to share best practice.
- **This group is responsible for the development of an action plan to address the outcome of the LCHG health inequalities maturity self-assessment** completed in September 2024 – these can be found in Appendix 3 and 4. Some of these actions include improving ethnicity capture across LCHG including postcode data, deploying health inequalities data as standard within improvement/transformation programmes, the completion of Health Literacy Courses by LCHG Patient Experience/Comms leads, rolling out Health Inequalities champions alongside the LCHG Personalisation programme to increase awareness and influence and to embed the HEAT into PDM programmes/project, QI courses and Business Cases.

*Optum were commissioned by NHS England to support 36 ICS's to deliver the PHM programme, including the Lincolnshire ICS.

Current areas of focus

- **Developing a clear programme of work** and reporting process to directly address all areas of improvement identified within the maturity self-assessment to include:
    - Increasing the numbers of Health Inequalities Champions across LCHG to support the agenda.
    - Deploying the Health Equity Assessment Tool (HEAT) across our standard forms and process e.g. EIA/QIA, in line with ICB requirements for this to be included in Business Planning/Business Cases.
    - Developing a plan to improve ethnicity coding across LCHG.
- **Aligning the programme to the 'Reforming elective care for patients**' guidance and main planning guidance in order to support delivery of improvements related to:
    - **Empowering patients and Improving Patient Experience** so that there is more choice and control over when and where they receive their care.
    - **Health Inequalities Improvement –** improve completeness and accuracy of coding and recording practices including ethnicity and housing status coding, undertaking quarterly reviews of waiting list data to better understand areas of health inequalities, **embedding health inequalities reporting with a quarterly review at Board level** and developing and monitoring action plans to reduce health inequalities in access and quality of care.
- The establishment of a communications working group and communications plan with the intention of **increasing knowledge and awareness around the health inequalities agenda** across LCHG including attendance at Clinical Cabinets, establishing regular Executive and all staff messaging approach etc.
- **Supporting delivery of the OP DNA project** which has secured specific funding from the ICB.
- Ensuring appropriate knowledge sharing and connections of work across the wider system.

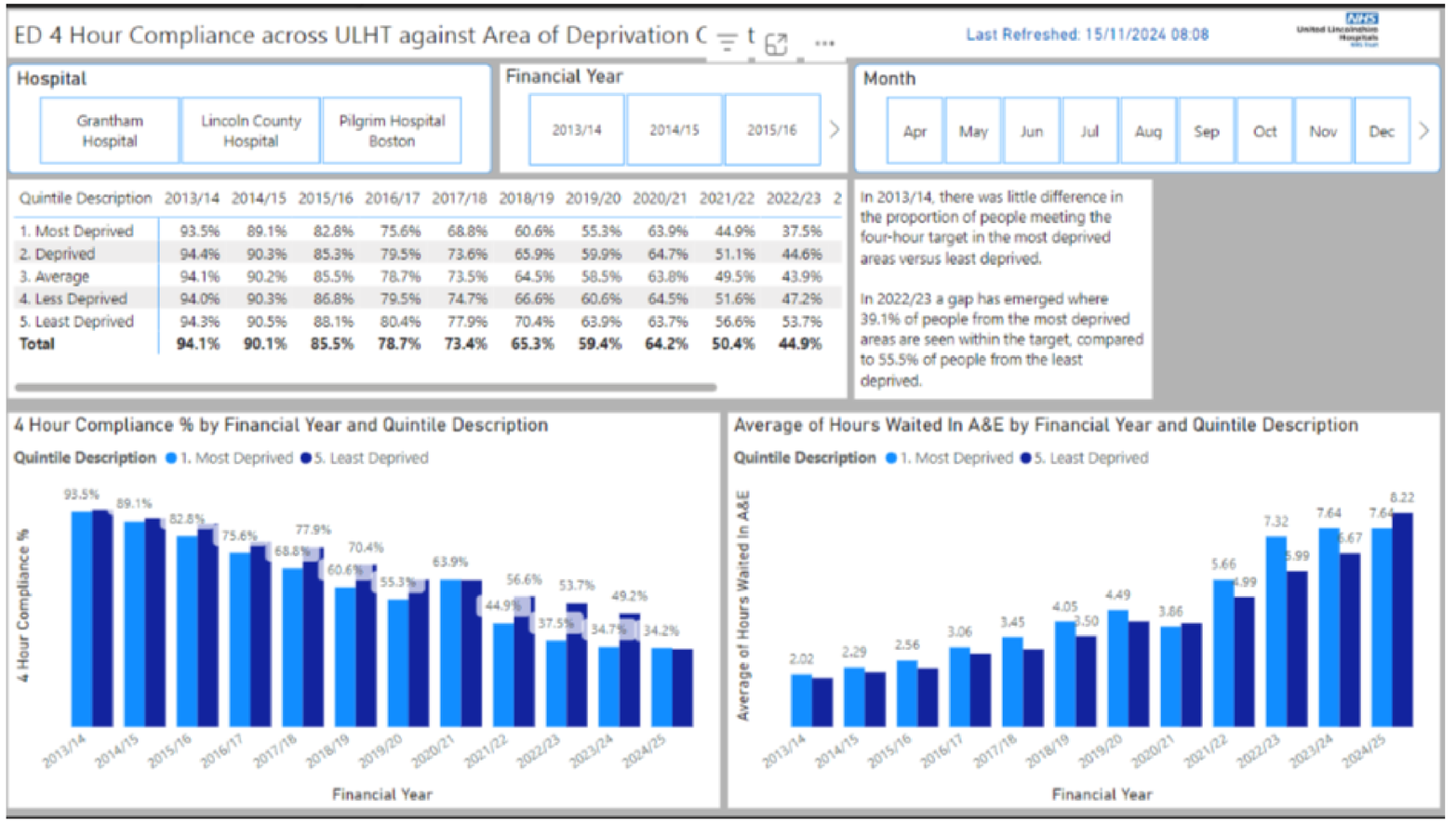
HI Dashboard

ULHT have a Health Inequality Dashboard which has been created for ED and 18 week pathways. This will be integrated with a system dashboard and discussed at the LCHG Health Inequalities Working Group.

For LCHS UTC ethnicity data is already mandated and this is regularly monitored and reported through CSUG (Clinical Systems User Group).

Through the Health Inequalities Working Group, data analysts from across the Group and the ICB are working collaboratively to explore data capture and monitoring and this will be captured within the LCHG action plan.

This will include a plan to increase ethnicity capture and to extend the capability to extend current HI reporting to other protected characteristics as documented within the Equality Act 2014.



Quintile Description	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2
1. Most Deprived	93.5%	89.1%	82.8%	75.6%	68.8%	60.6%	55.3%	63.9%	44.9%	37.5%	
2. Deprived	94.4%	90.3%	85.3%	79.5%	73.6%	65.9%	59.9%	64.7%	51.1%	44.6%	
3. Average	94.1%	90.2%	85.5%	78.7%	73.5%	64.5%	58.5%	63.8%	49.5%	43.9%	
4. Less Deprived	94.0%	90.3%	86.8%	79.5%	74.7%	66.6%	60.6%	64.5%	51.6%	47.2%	
5. Least Deprived	94.3%	90.5%	88.1%	80.4%	77.9%	70.4%	63.9%	63.7%	56.6%	53.7%	
Total	**94.1%**	**90.1%**	**85.5%**	**78.7%**	**73.4%**	**65.3%**	**59.4%**	**64.2%**	**50.4%**	**44.9%**	

Data extracted from ULHT Power Bi report

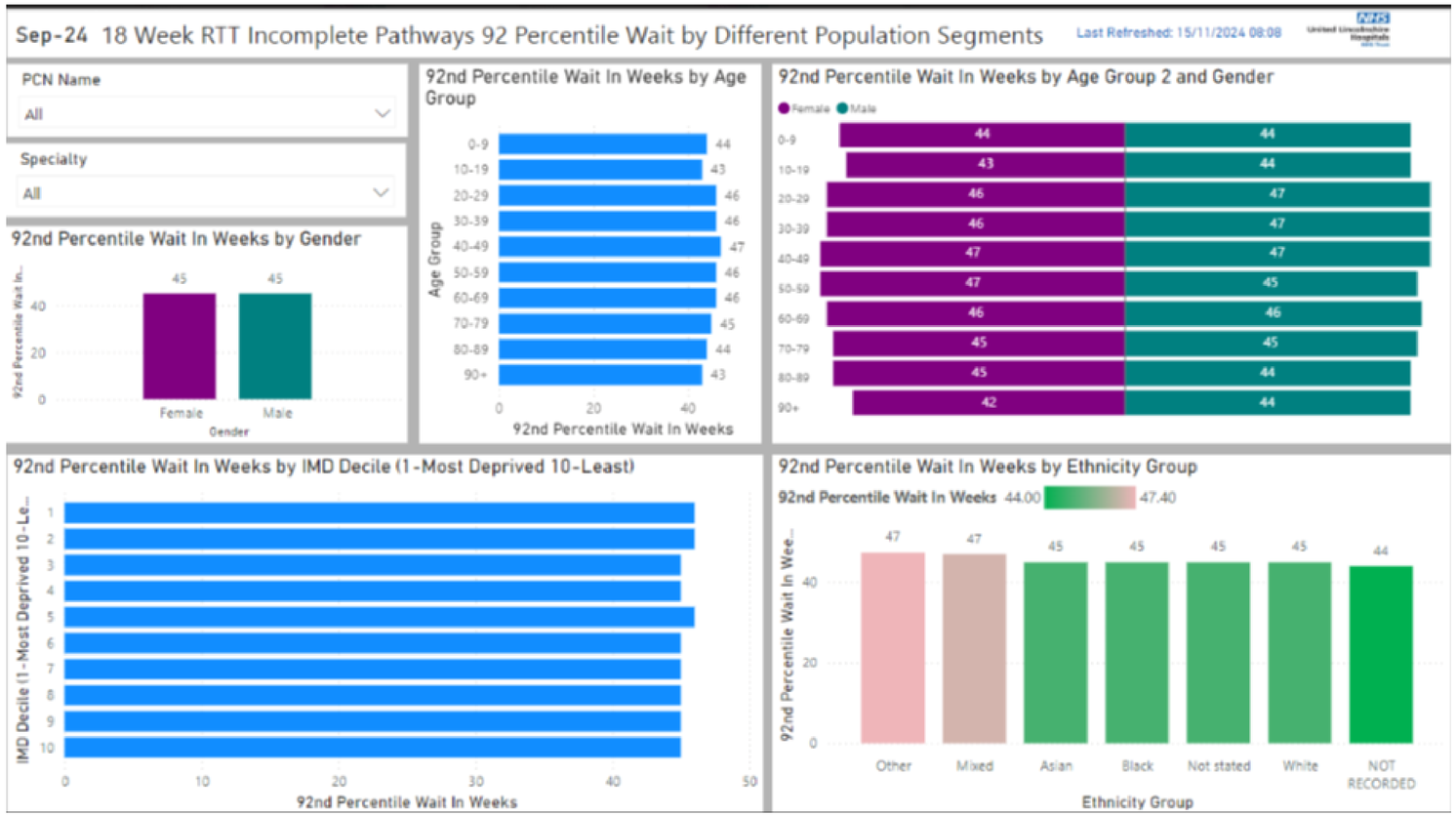
HI Dashboard

ULTH has also developed an analytical tool that brings postcodes and deprivation indices in to a predictor tool to be applied to patient waiting lists that identifies cohorts of patients most likely to miss their appointment.

The tool informs the booking services team to target reminder phone calls and messaging to have the appointment attended or have enough time to reallocate and reduce the rate of missed appointments within the Trust.

A pilot with Ear Nose Throat has provided positive benefits and is being scoped to be implemented across more specialty services.

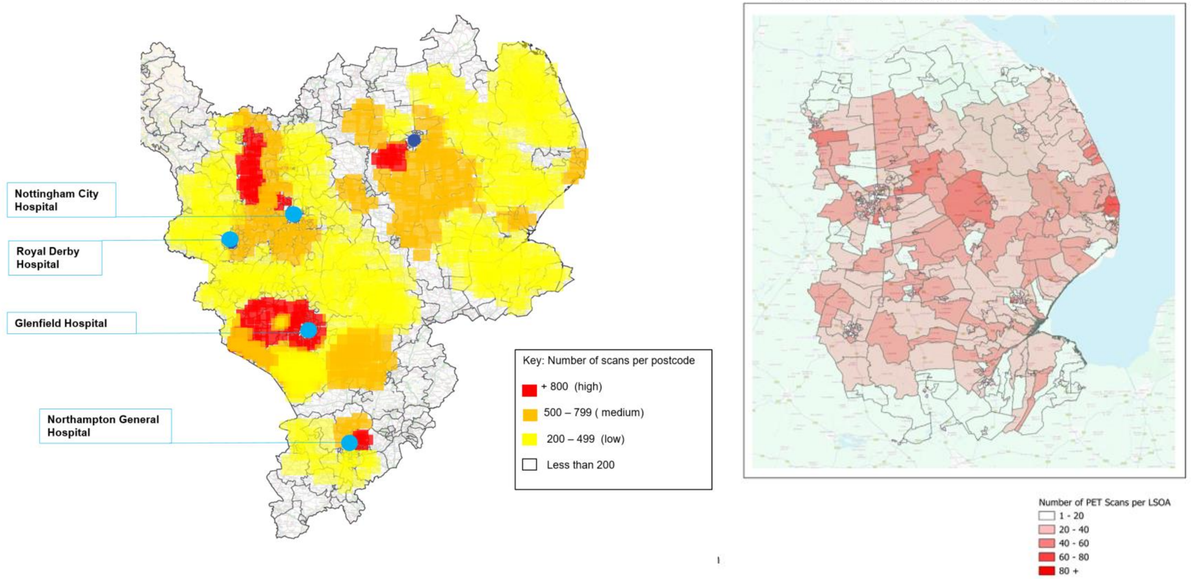
This tool will also be used to capture data related to the OP DNA project which is expected to be funded via ICB Health Inequalities monies and overseen by the ULHT Improvement delivery Team. The Business case for this has just been completed.

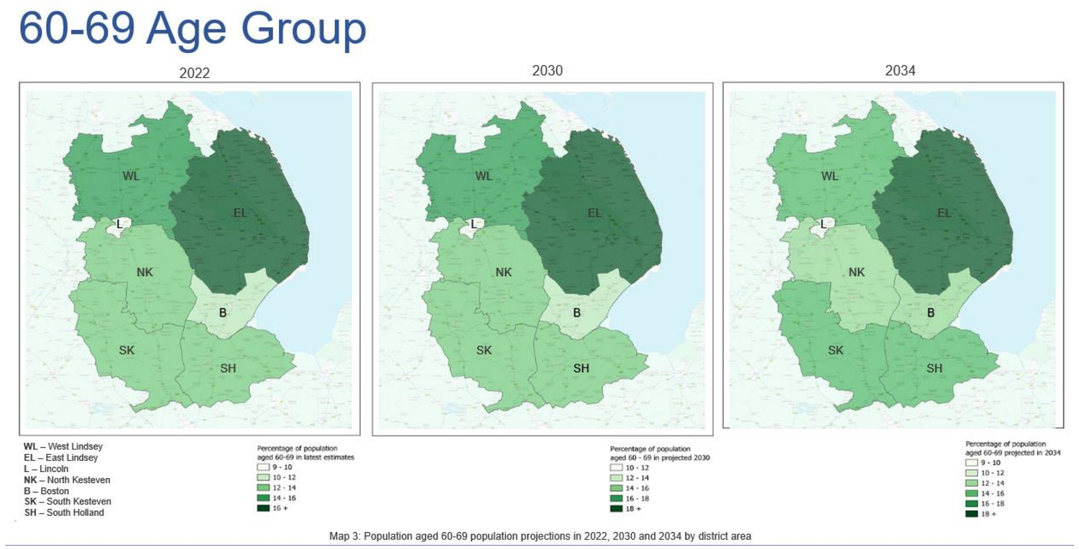


Data extracted from ULHT Power Bi report

Case Study

- PET-CT services across the East Midlands are expected to be re-procured as part of a national process by the commissioners NHS England
- **The East Midlands Acute Provider Collaborative (EMAP) are exploring the opportunities for an NHS led model** in order to improve the provision of services to our population and have established a working group.
- Issues have been identified in current provision with the **equity of access to services and research for patients** across the region and in areas of higher deprivation outside of the main tertiary centres
- **ULHT teams have applied PHM and HI data to review activity and provision across Lincolnshire** and the East Midlands region to support the development of a new clinical model
- This data has explored detailed issues and data for Lincolnshire relating to demand by area/location, areas of deprivation, patient access by deprivation decile (by aligning Lower Layer Super Output Areas (LSOA) data with the Index of Multiple Deprivation), patient demographic age group and forecasting, activity by district and travel times.
- This detailed data will be replicated across the East Midlands and used **to inform the locations of future scanning facilities** and the potential EMAP bid to provide this service.

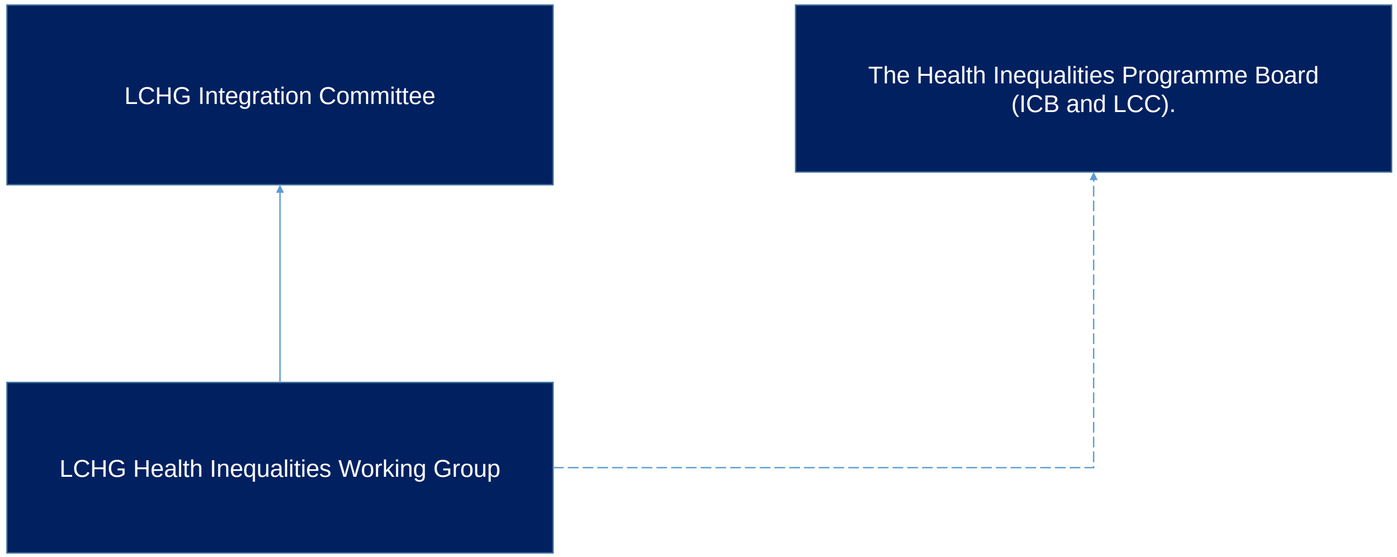




Map 3: Population aged 60-69 population projections in 2022, 2030 and 2034 by district area

Proposed Governance

- It is proposed that the Integration Committee receives a ***quarterly upward report from the group.***
- Progress against specific agreed objectives as part of the LCHG Strategy will also be reported in line with standard IIP reporting.
- A report will also be produced by the Health Inequalities Programme Lead at NHS Lincolnshire Integrated Care Board for The Health Inequalities Programme Board (ICB and LCC).



Next Steps

Next Steps

High level Task	By When
Communications Task and Finish Group to develop and deploy plan to increase awareness and knowledge across LCHG	First meeting 17th January 2025
Health Inequalities Teams to attend ULHT Clinical Cabinets and appropriate LCHS forums	FH January 2025 Others TBC by end March 2025
Progress and deliver ULTH Out patient DNA Business Case and project	Ongoing 2025
Develop full action plan and metrics aligned to outcome of self assessment – identify key areas of focus for 2025/2026	March 2025
Develop Population Health and Inequalities strategic objectives as part of LCHG new Strategy	End March 2025
Next integration Committee upward report	April 2025

Appendices

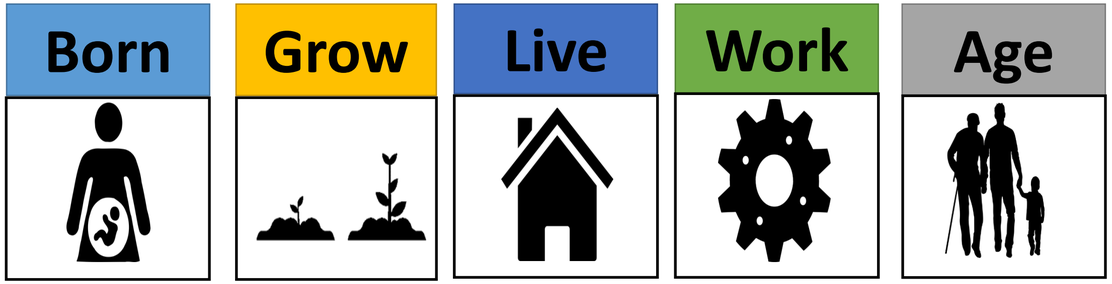
Appendix 1 - Context

What are Health Inequalities?

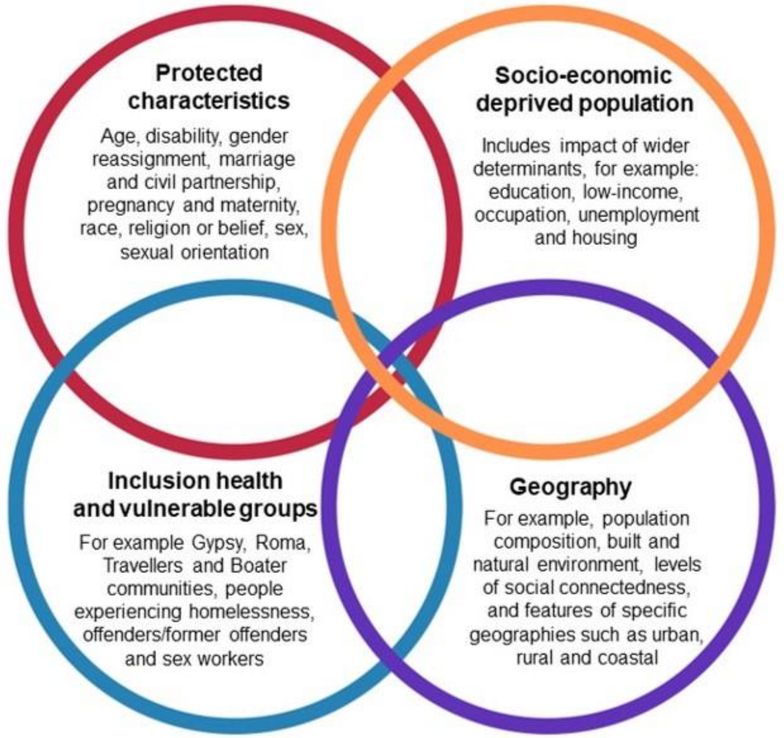
Health Inequalities are the unfair and avoidable differences in people's health across the population, and between different groups within society.

- They do not occur by chance
- They are socially determined by circumstances largely beyond an individual's control.

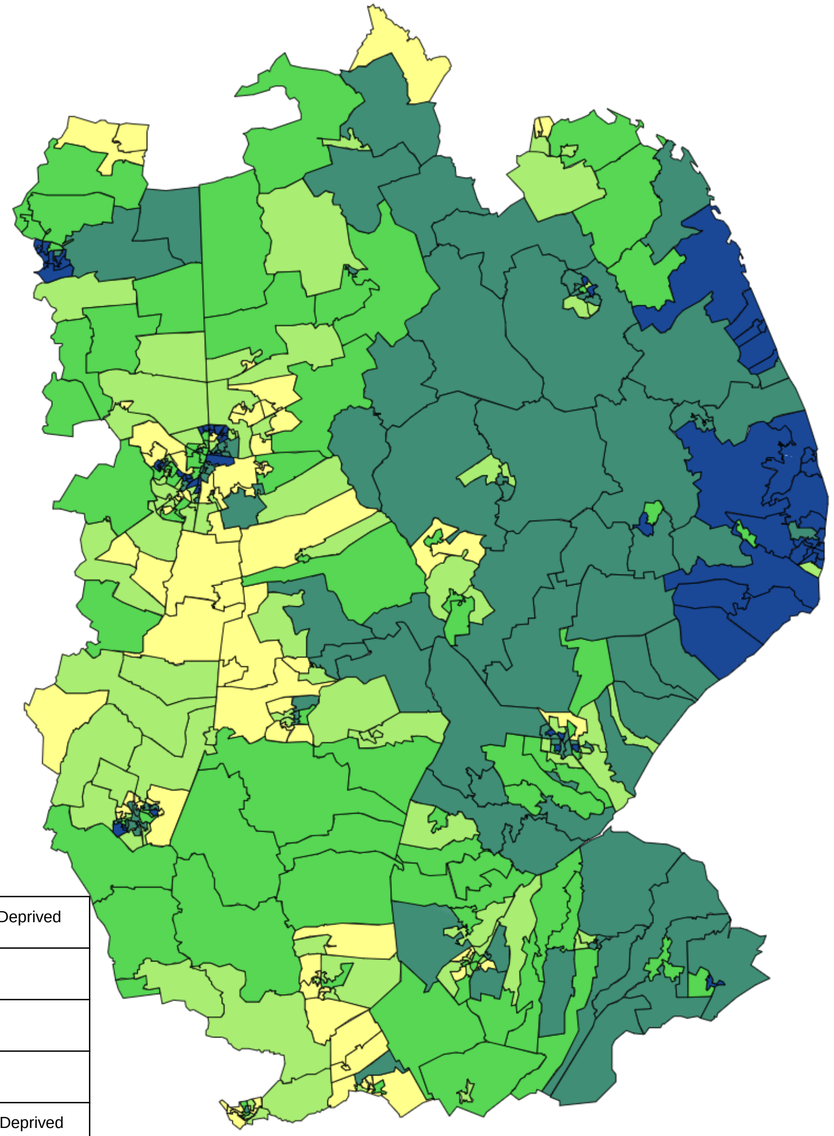
Health Inequalities arise because of conditions in which we are:



People often fall into more than one domain and the effect of overlapping impact is multiplied



Index of Multiple Deprivation in Lincolnshire (2019)



Source: 2019 IMD Rankings

The Index of Multiple Deprivation (IMD) is the official measure of relative deprivation in England. The 2019 IMD is comprised of 7 domains of deprivation which, when combined and appropriately weighted, form the IMD 2019. These domains are:

- Income (22.5%)
- Employment (22.5%)
- Health Deprivation and Disability (13.5%)
- Education, Skills and Training (13.5%)
- Crime (9.3%)
- Barriers to Housing and Services (9.3%)
- Living Environment (9.3%)

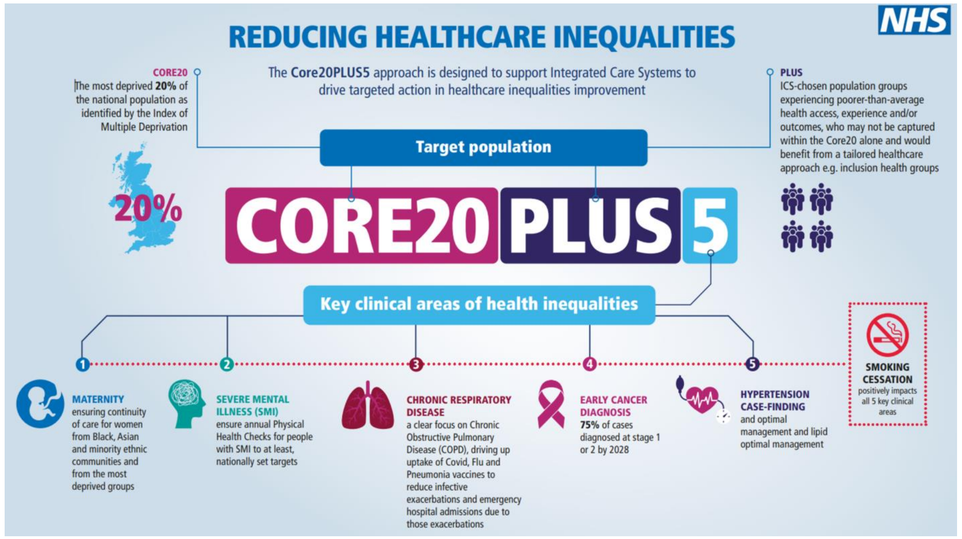
	Life Expectancy		
	Most deprived decile	Least deprived decile	Absolute Gap
Male	73.2	81.9	-8.7
Female	78.4	85.2	-6.8

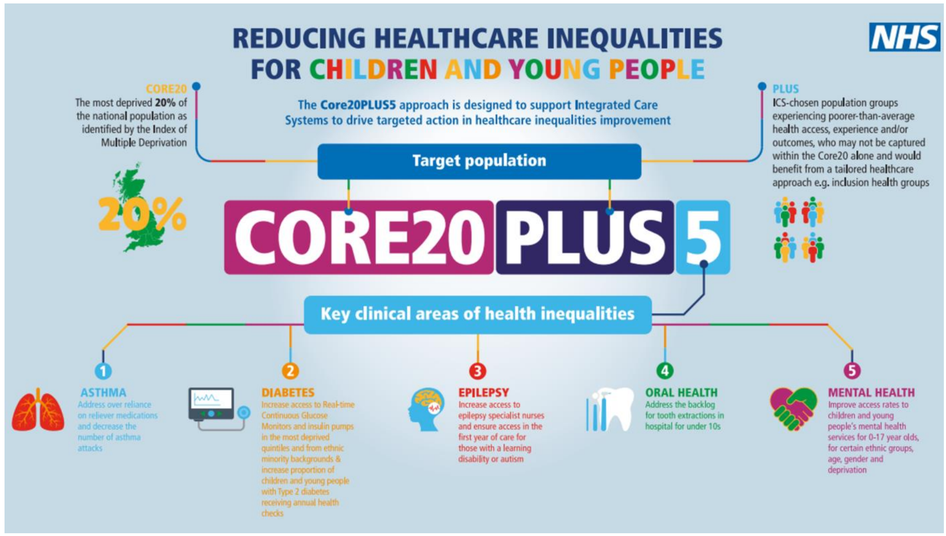
	Healthy Life Expectancy		
	MSOA with lowest HLE	MSOA with highest HLE	Absolute Gap
Male	53.5	69.9	-16.4
Female	56.0	71.0	-15.0

Sources: Male Life Expectancy (OHID Fingertips): 2018-2020 Female Life Expectancy (OHID Fingertips): 2018-2020

Source: ONS Healthy Life Expectancy (2009-2013)

Core20 Plus5





Plus groups for Lincolnshire include:

Adults, Children and Young People – People form Ethnic Backgrounds, People with Eastern European Backgrounds, Carers and those with sensory Impairment

Adults only – Farming Communities, Temporary residents/Gypsy, Roma and Travellers, Military Personnel, Families and veterans, Rural Communities, Coastal Communities and People experiencing Homelessness

C&YP only – Children open to social care, those not in education, those in the justice system, learning disabilities, autism and SEND, care leavers and Children in Care

Key Drivers

Our Vision for Lincolnshire:

To increase life expectancy and quality of life for people living in Lincolnshire and reduce the gap between the healthiest and least healthy populations within our county.

NHS
Lincolnshire Community and Hospitals NHS Group

Strategic Plan 2024/25

PATIENTS	PEOPLE	SERVICES	PARTNERS	POPULATION HEALTH
To deliver high-quality, safe and responsive patient services	To enable our people to lead, work differently, be inclusive, motivated and proud to work within Lincolnshire Community and Hospitals NHS Group (LCHG)	To ensure services are sustainable, supported by technology and delivered from an improved estate	To collaborate with our primary care, ICS and external partners to implement new models of care, transform services and grow our culture of research and innovation	To improve physical and mental health outcomes, promote well-being, and reduce health inequalities across an entire population
Deliver high quality care which is safe, responsive and able to meet the needs of the population Improve patient experience Improve clinical outcomes Deliver clinically led integrated services	Making LCHG the best place to work through delivery of the People Promise To be the employer of choice	Deliver financially sustainable healthcare, making best use of resources Drive better decisions and impactful action through insight A modern, clean and fit for purpose environment across the Group Reduce waits for patients who require urgent and emergency care and ensure we meet all constitutional standards	Successful delivery of the Acute Services Review Grow our research and innovation through education, learning and training Enhanced data and digital capability	Develop a Population Health Management and Health Inequalities approach for our Core20PLUS5 with our ICS Co-create a personalised care approach to integrate services for our population that are accessible and responsive Tackle system priorities and service transformation in partnership with our population and communities Transform key clinical pathways across the group resulting in improved clinical outcomes

Population health and reducing health inequalities one of our current and future strategic aims.

Appendix 2 - Health Inequalities Working Group Terms of Reference

Appendix 3 and 4 - Health Inequalities Maturity Matrix for LCHS and ULTH

NHS
Lincolnshire
Integrated Care Board

Schedule 2N – The Services : Health Inequalities Maturity Matrix

Organisation	**LCHS**
Completed By	**Callum Gray/Nikki Pownall**

This self-assessment matrix is requested from organisations in Lincolnshire to understand their level of maturity in their approach to reducing inequalities in access to, experience of and outcomes from care and treatment, with specific relation to the Services being provided under the Schedule 2N Agreement. Successfully tackling health inequalities will always necessitate close working with other local organisations from the statutory sector and beyond – and the specific actions set out in Schedule 2N should always be rooted in wider systems for partnership working across the local area.

Under each "Best Practice" listed in the tables on pages 2-6 of this document, please use the supporting guidance below to score your organisation by marking an **X** in the relevant box:

1	*Emerging*	None or very little work has been done in this area
2	*Developing*	Some work has been done and/or there is a clear action plan to address this
3	*Maturing*	A lot of work has been done to address this, with a clear action plan to be fully embedded
4	*Embedded*	This work is considered fully complete with ongoing monitoring/review

It would be valuable to understand the context for your score in the "notes/supporting comments" section where local initiatives or intelligence can be listed to build an understanding of the Lincolnshire system picture.

Please complete this matrix and return to licb.healthinequalities@nhs.net by 30th September 2024.

1. Better data and intelligent use of data

		Best Practice	Maturity				Notes/Supporting Comments
			1	*2*	*3*	*4*	
Better data and intelligent use of data	*a.*	Carry out a stocktake to look at data completeness, specifically postcodes for deprivation and ethnicity recording. Include other protected characteristics if appropriate.			**x**		Ethnicity recording regularly monitored and reported through CSUG (Clinical Systems User Group). Postcode data to be included once monitoring mechanism set up
	b.	Carry out a stocktake of analytic skills and availability within the organisation.	**x**				Analytics teams within the trust known, no current recruitment gaps. Pressures currently on team due to trust wide reporting development work however anticipated to complete in March. Increasing capacity and availability
	c.	Identification of Health Inequality priority areas of focus.	**x**				CORE20PLUS5. CORE20 patients are identified through BAU reporting however work still to be done to identify PLUS5 cohorts
	d.	Identification of levels of data compliance that are below required levels and agree action plans.		**x**			Action plans for increasing data capture of ethnicity & postcode are being developed with plans for capture of PLUS groups to follow
	e.	Assess how additional Health Inequalities data can be captured and how it can be used.	**x**				Work to be done on how to capture wider health inequalities data in particular the plus 5 groups - The 'how it can be used' is to be determined. The planned Health Inequalities Working Group will be able to consider this.
	f.	Design data analysis requirements to determine any patterns or trends, which show a link between inequalities or inequity of access and ill physical or mental health.		**x**			Work done in conjunction with LCC on production of Slope Index of inequalities reports to assess links between deprivation and outcomes
	g.	Explore those data issues that are wider than a single organisation (i.e. data completed on referral forms has an impact on the data completeness of waiting lists).	**x**				Issues around S1 shares with GPs and duplicates relating to registered GP practice
	h.	Expand performance report to include ethnicity and deprivation (using IMD 1-5) (once regular reporting in place).			**x**		Health inequalities data to be shown in new performance report due to go live in November
	i.	Implement mandatory postcode and ethnicity data reporting for all service lines.			**x**		UTC ethnicity data is already mandated, current work ongoing review areas with poor recording of ethnicity data

							and being reported through CSUG. This will be captured on Health Inequality dashboards and will be developed through the LCHG Health Inequalities WG.
	j.	A scoping exercise to understand capability to extend current post code, ethnicity recording performance report to other protected characteristics as documented in the Equality Act 2014	**x**				Planned work to review what current protected characteristics are recorded, some are already regularly reported however through service dashboards
	k.	Internal and external reporting should be able to be analysed to provide detail on Health Inequality factors, initially deprivation (IMD score) and ethnicity.		**x**			Current internal reporting to be expanded to all services, scoping required for external reporting

2. Community Engagement

	Best Practice		Maturity				Notes/Supporting Comments
			1	*2*	*3*	*4*	
D	*a.*	Identify the Health Inclusion and Plus groups for the service.		**x**			Work required in regards to the PLUS groups however CORE20 patients are able to be identified through service dashboards
	b.	Ensure Communications and Engagement Teams are focused, and are sighted on the key messages and can engage with those experiencing health inequalities to improve the representation of disadvantaged communities and those with protected characteristics in all consultations, co-production, stakeholder analysis and engagement		**X**			EDI Team engage with communities to reduce inequalities e.g. visiting factories etc The Group has secured a place for a member of the Patient Experience Team to complete 2 ICB funded Health Literacy courses: Health Literacy Awareness Training – 25 Sep 24 Health Literate Organisation Workshop – 29 Oct 24
	c.	Link Health Inequalities work to Population Health Management (PHM)		**x**			Health inequalities work is linked to population health work with the organisation however reporting is still separate
	d.	Encompass the Making every contact count and person centred care to challenge Health Inequalities.	**x**				Scoping required - Personalisation staff and champions in place, as part of a Lincolnshire wide team. The wider programme of work is mature and Personalisation will be a stakeholder on the Health Inequalities Working Group, supporting this work.

	e.	Include local "grassroots" voluntary sector organisations, Primary Care Networks and neighbourhood/integrated place-based teams to ensure their valuable insights into the specific needs of our local communities are captured.	**x**				LCHS has membership attendance at the CCP Steering Groups. Connections are in place between system partners.
	f.	Share learning across organisations.	**x**				Expected to have membership of group to be set up by Chris Craig (ULH)
	g.	Co-produce services and pathways in such a way that do not exclude any disadvantaged communities or those with protected characteristics from accessing or using services, supported by better use of Equality Impact Assessments and data to inform decision making.	**x**				Further scoping required – EQIA processes

Access to and provision of Services

		Best Practice	Maturity				Notes/Supporting Comments
			1	*2*	*3*	*4*	
Access to and provision of services	*a.*	Use the Health Equity Assessment Toolkit (HEAT) and include it in service development, projects and business cases. To assess the impact on Health Inequalities and steps taken to mitigate any detrimental impact. Service changes should be developed with an aim to reduce Health Inequalities.	**x**				HEAT is not currently used widely for business case development
	b.	All service specifications, business cases and service evaluations to outline how services address the inequalities faced by, and improve outcomes for, Lincolnshire's 15% / 20% most deprived communities (120k of the county's population).		**x**			
	c.	Use of communication channels that mitigate against digital exclusion to support a reduction in Health Inequalities. (Consider having digital champions, access to/speed of broadband, how to target virtual/face 2 face offer of appointments, access to and understanding of technology).		**x**			Work around digital inclusion strategy supports these requirements with pillars of the programme being led by LCHS representatives
	d..	Waiting lists – how to communicate effectively with those on the list, how to consider the 'waiting well' e.g., smoking cessation, weight management.		**x**			Patients on a waiting list are assessed as to their fit to wait status and reviews are in place to avoid harm

3. Implementation, monitoring and evaluation

	Best Practice		Maturity				Notes/Supporting Comments
			1	*2*	*3*	*4*	
Implementation, monitoring and evaluation	*a.*	Identify Health Inequality Operational Leads within each organisation.	**X**				No lead currently identified within LCHS
	b.	Agree and finalise Governance arrangements for progress on Health Inequalities.	**X**				Health Inequalities Working Group being established with support from the ICB Health Inequalities team- first meeting scheduled for 16th October 2024 – this group expected to develop and oversee delivery of the LCHG action plan
	c.	Internal and external reporting should be able to be analysed to provide detail on Health Inequality factors, initially deprivation (IMD score) and ethnicity.		**X**			Current internal reporting to be expanded to all services, scoping required for external reporting
	d.	Evaluation of implemented services changes through: • Health Equality Audits, • Learning Academy (working with the University of Lincoln to support and to link into a research project), • Engagement with those accessing services to ensure that what has been done is making a difference.	**X**				

NHS
Lincolnshire
Integrated Care Board

Schedule 2N – The Services : Health Inequalities Maturity Matrix

Organisation	**United Lincolnshire Hospitals NHS Trust**
Completed By	**Matt Powls**

This self-assessment matrix is requested from organisations in Lincolnshire to understand their level of maturity in their approach to reducing inequalities in access to, experience of and outcomes from care and treatment, with specific relation to the Services being provided under the Schedule 2N Agreement. Successfully tackling health inequalities will always necessitate close working with other local organisations from the statutory sector and beyond – and the specific actions set out in Schedule 2N should always be rooted in wider systems for partnership working across the local area.

Under each "Best Practice" listed in the tables on pages 2-6 of this document, please use the supporting guidance below to score your organisation by marking an **X** in the relevant box:

1	*Emerging*	None or very little work has been done in this area
2	*Developing*	Some work has been done and/or there is a clear action plan to address this
3	*Maturing*	A lot of work has been done to address this, with a clear action plan to be fully embedded
4	*Embedded*	This work is considered fully complete with ongoing monitoring/review

It would be valuable to understand the context for your score in the "notes/supporting comments" section where local initiatives or intelligence can be listed to build an understanding of the Lincolnshire system picture.

Please complete this matrix and return to licb.healthinequalities@nhs.net by 30th September 2024.

1. Better data and intelligent use of data

		Best Practice	Maturity				Notes/Supporting Comments
			1	*2*	*3*	*4*	
Better data and intelligent use of data	*a.*	Carry out a stocktake to look at data completeness, specifically postcodes for deprivation and ethnicity recording. Include other protected characteristics if appropriate.		x			Trust Health Inequality Dashboard has been created for ED and 18 week pathways. This will be integrated with a system dashboard and discussed at the LCHG Health Inequalities Working Group. The Trust has also developed an analytical tool that brings postcodes and deprivation indices in to a predictor tool to be applied to patient waiting lists that identifies cohorts of patients most likely to miss their appointment. The tool informs the booking services team to target reminder phone calls and messaging to have the appointment attended or have enough time to reallocate and reduce the rate of missed appointments within the Trust. A pilot with Ear Nose Throat has provided positive benefits and is being scoped to be implemented across more specialty services.
	b.	Carry out a stocktake of analytic skills and availability within the organisation.	x				Analytic team at the Trust are known; capacity/availability to be determined to undertake a stocktake. Definition of Analyst to be considered.
	c.	Identification of Health Inequality priority areas of focus.		x			CORE20PLUS5. PLUS areas for Lincolnshire have been identified: Learning disabilities, autism, alcohol abuse, substance misuse, ethnic minorities, frailty, temporary residents, eastern Europeans, homeless and rural.
	d.	Identification of levels of data compliance that are below required levels and agree action plans.	x				Plan for improving ethnicity capture is ongoing.
	e.	Assess how additional Health Inequalities data can be captured and how it can be used.		x			Access and capture of data is known. Unplanned Care Programme have just secured access to ATHENA which covers all of the population health and demographics and will allow better planning across system and ED with ICS. The 'how it can be used' is to be determined. The planned

							Health Inequalities Working Group will be able to consider this.
	f.	Design data analysis requirements to determine any patterns or trends, which show a link between inequalities or inequity of access and ill physical or mental health.		**x**			Data packs being produced for speciality support programmes, planning and to be deployed within improvement approach as BAU.
	g.	Explore those data issues that are wider than a single organisation (i.e. data completed on referral forms has an impact on the data completeness of waiting lists).	**x**				Data integrity within the Trust and that of external reporting systems such as the NHS Model Health System are being identified and explored to rectify data challenges and provide accurate and timely metrics.
	h.	Expand performance report to include ethnicity and deprivation (using IMD 1-5) (once regular reporting in place).		**x**			Health Inequalities dashboard to support this work, with quarterly reporting to IIP.
	i.	Implement mandatory postcode and ethnicity data reporting for all service lines.		**x**			Ethnicity data to be completed. See 'c' above – this will be captured on Health Inequality dashboards and will be developed through the LCHG Health Inequalities WG.
	j.	A scoping exercise to understand capability to extend current post code, ethnicity recording performance report to other protected characteristics as documented in the Equality Act 2014	**x**				Scoping exercise to be carried out.
	k.	Internal and external reporting should be able to be analysed to provide detail on Health Inequality factors, initially deprivation (IMD score) and ethnicity.		**x**			Analysis for 18 week and 4 hour waits in ED is in place. Other areas/lists to be identified/developed.

2. Community Engagement

		Best Practice	Maturity				Notes/Supporting Comments
			1	*2*	*3*	*4*	
Community Engagement	*a.*	Identify the Health Inclusion and Plus groups for the service.		x			Dashboard used to identify the groups
	b.	Ensure Communications and Engagement Teams are focused, and are sighted on the key messages and can engage with those experiencing health inequalities to improve the representation of disadvantaged communities and those with protected characteristics in all consultations, co-production, stakeholder analysis and engagement		x			The Trust has secured a place for a member of the Patient Experience Team to complete 2 ICB funded Health Literacy courses: Health Literacy Awareness Training – **25 Sep 24** Health Literate Organisation Workshop – **29 Oct 24** PIAG group reviews all patient information for readability and accessibility and use the https://newcastlerse.github.io/nhs_readability_react/ tool
	c.	Link Health Inequalities work to Population Health Management (PHM)	x				Health Inequalities Dashboard in development, linked to PHM data.
	d.	Encompass the Making every contact count and person centred care to challenge Health Inequalities.		x			Personalisation staff and champions in place at the Trust, as part of a Lincolnshire wide team. The wider programme of work is mature and Personalisation will be a stakeholder on the Health Inequalities Working Group, supporting this work. At ULHT, increased awareness, education and embed of shared decision making tools is required and that has commenced. Identification of ULHT Executive representation/involvement does need to be confirmed, as well as a Trust governance reporting structure. At the System level, governance is in place, with a Personalisation Board. ULHT representation is sought to attend the System Board. Pre-op clinics have been restructured to be patient centred and move towards a 'one stop' process to reduce the number of attendances at a hospital site, to support this

							Health questionnaires which is the first step in the pre-op process are now being trialled in OP 1st appointment.
	e.	Include local "grassroots" voluntary sector organisations, Primary Care Networks and neighbourhood/integrated place-based teams to ensure their valuable insights into the specific needs of our local communities are captured.	**x**				ULHT has membership attendance at the CCP Steering Groups. Connections are in place between system partners.
	f.	Share learning across organisations.	**x**				Chris Craig setting up Lincolnshire Group, other informal networks exist
	g.	Co-produce services and pathways in such a way that do not exclude any disadvantaged communities or those with protected characteristics from accessing or using services, supported by better use of Equality Impact Assessments and data to inform decision making.			**x**		We have an embedded system for Equality Impact Assessments, as part of our legal duties as a Trust, please see the link to the intranet below: Equality and Health Inequality Impact Assessments (EHIIA) (sharepoint.com) Equality Impact Assessment (sometimes referred to as an Equality Analysis) has been the mechanism to demonstrate due regard in relation to the protected characteristics of the Equality Act 2010. Good practice always sought to ensure Carers (not a protected characteristic) and other groups potentially at risk of disadvantage / discrimination (e.g. migrant community, rural isolation / deprivation etc) were considered as a part of the process. When the health inequality agenda started to emerge, we expanded the EIA to embrace health inequalities (as per the attached link), however, this does not replace the ICB HEAT tool, which should be completed when required. The Patient Experience Group regularly co-produce with the Trust Patient Panel and Patient Improvement Advisory Group.

Access to and provision of Services

	Best Practice		Maturity				Notes/Supporting Comments
			1	*2*	*3*	*4*	
Access to and provision of services	*a.*	Use the Health Equity Assessment Toolkit (HEAT) and include it in service development, projects and business cases. To assess the impact on Health Inequalities and steps taken to mitigate any detrimental impact. Service changes should be developed with an aim to reduce Health Inequalities.		**x**			Requests raised to be embedded into PDM programmes/project, QI courses and Business Cases. Care closer to home and initial discussions are being undertaken to scope OP and Pre-op services delivered in the community which will positively impact health inequalities and improve attendance at appointments and reduce waiting lists.
	b.	All service specifications, business cases and service evaluations to outline how services address the inequalities faced by, and improve outcomes for, Lincolnshire's 15% / 20% most deprived communities (120k of the county's population).			**x**		Social deprivation is considered within the EQIA's as well as within the business needs in the strategic cases for projects. Shape Place Atlas is used to map out social deprivation, transport, local public health issues etc. Social value engine is also used to assist with costing of social issues for economic appraisal. The completion of Health Inequalities considerations for each improvement project or programme of work is detailed within a Quality Impact Assessment (QIA) that is presented at a QIA panel with membership from Nursing, Quality Governance and Inclusion Leads. Social values are formally assessed as part of the procurement process for costs above £1m.
	c.	Use of communication channels that mitigate against digital exclusion to support a reduction in Health Inequalities. (Consider having digital champions, access to/speed of broadband, how to target virtual/face 2 face offer of appointments, access to and understanding of technology).		**x**			Patient Portal for appointment letters – initially digital, text code to access. If not opened by set time will automatically generate a physical letter. Access to free WIFI in hospitals. On Careflow – Accessible Information Standard section, so can register patient's accessibility requirements – measure of how successful this has been is required.

							Use of the NHS readability tool for patient information. Patient appointment letters – new versions co-produced with our Patient Panel. Outpatients Improvement are supporting the process of establishing services as 'directly bookable' within primary care system. This enables visibility to patients and GPs of waiting times for specialty services across the Trust estate in support of patient choice and ownership of their care pathways. Patient Initiated Follow Up is also an embedded process to reduce follow up waiting lists and provide patient choice for those medically appropriate conditions to enable patients to access care when needed. Pre-op have in place face to face and telephone appointments for patients to mitigate against digital exclusion. A digital platform is being developed and digital champions will be aligned both for patients and staff.
	d..	Waiting lists – how to communicate effectively with those on the list, how to consider the 'waiting well' e.g., smoking cessation, weight management.		**x**			From 31 Oct, ULHT will contact patients via text message or letter, depending on their accessibility needs. This communication will trigger a form to be completed either online or via telephone that allows our patients to consider their options to see if they could be seen sooner at a different hospital. The first list of identified eligible patients are adults who have been waiting for over 40 weeks for an Outpatient appointment who do not have an appointment date within the next eight weeks. Tobacco Dependency service not involved with Outpatients waiting lists. Current support is provided to acute inpatients. Smoking Team Action Advice & Refer (STAAR) – support women during pregnancy with free nicotine replacement products, but not part of a waiting list. Will travel to support/engagement with maternity patients

							(children's centres or hospitals). Postal also an option for products. Theatre improvement have a national target to embed the 'waiting well' and have taken forward discussions on how the Trust can contact all patients on the waiting list at 3 month intervals.

3. Implementation, monitoring and evaluation

	Best Practice		Maturity				Notes/Supporting Comments
			1	*2*	*3*	*4*	
Implementation, monitoring and evaluation	*a.*	Identify Health Inequality Operational Leads within each organisation.	**x**				TBC
	b.	Agree and finalise Governance arrangements for progress on Health Inequalities.	**x**				Health Inequalities Working Group being established with support from the ICB Health Inequalities team- first meeting scheduled for 16th October 2024 – this group expected to develop and oversee delivery of the LCHG action plan
	c.	Internal and external reporting should be able to be analysed to provide detail on Health Inequality factors, initially deprivation (IMD score) and ethnicity.	**x**				Health Inequalities Dashboard development is ongoing to enable capture of ethnicity data and ability to drill down into divisional and speciality level data.
	d.	Evaluation of implemented services changes through: • Health Equality Audits, • Learning Academy (working with the University of Lincoln to support and to link into a research project), • Engagement with those accessing services to ensure that what has been done is making a difference.	**x**				For strategic projects and evaluating implemented services we conduct benefits appraisal around 12 months post "go live". If a business case has stated benefits to health inequalities they will be picked up at that stage. Benefits Realisation reports back to CRIG and will assist with supportive action if a project is failing benefits.

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Hospitals NHS Trust

Integration Committee Update

Creation of an Alliance Care Group

24 January 2025

version 5- 17/01/2025

Sameedha Rich-Mahadkar, Vikcy Holden, Nikki Pownall, Alexandra Dudson, Angela Sharp

Executive Summary

- Following the previous update to Integration Committee in December 2025, a further update is shared on emerging thinking in relation to the future landscape for the approach for ‘left shift’ and the Alliance model which is driven through the LCHG Strategy 2025-2030

- The purpose of this paper is to provide an update on creation of an alliance care group through:

    1) Creation of an alliance board
    2) Creation of alliance care group
    3) Development of an alliance delivery plan and key priorities to kick start the work

- This is a large scale, transformation programme – it will be key to build the right approach/framework to identify and support the left shift model in order to support success to ensure we meet the differing needs of our population/services. This will be in line with the overarching LCHG organisational transformational and improvement approach.

- Operationalisation of the approach will be led by Nikki Pownall, the Group Deputy Chief Integration Officer whilst the strategic framework to prioritise and deploy via our transformation and improvement resource will be led by Sameedha Rich-Mahadkar, Director of Improvement and Integration.

Integration Committee are asked to note the assurance on the plans to create the alliance care group and associated transformation and offer feedback on the alliance delivery plans.

1 Creation of an Alliance Care Board

- The Alliance will be a **common organisational agnostic space** which will have the opportunity to scale up collaborations across a range of partners to enable pathway redesign to move care closer to people's home and their communities enabled by digital solutions.

- The purpose of the Alliance is to deliver on the LCHG's strategic aim on populations, by creating a common care group for services across both organisations to be jointly managed. This will help our services adapt to our neighbourhood needs as well as form a robust partnership to meet future demand from changing levels of need, changing funding levels, new legislation and/or policy imperatives, by:

    i. incentivising the achievement of positive outcomes for the benefit of the population's health and wellbeing
    ii. supporting the process of transition to new care, support and wellbeing models delivering improved outcomes for service users
    iii. protecting and promoting service user choice
    iv. ensuring health and care system sustainability through more effectively managing system cost whilst maintaining appropriate quality and service user safety
    v. securing best value for the public sector budget in terms of outcomes per pound spent
    vi. ensuring that integrated health and care services are delivered coherently and that fragmentation of service delivery is minimised by reducing organisational, professional and service boundaries
    vii. directing resources to the right place in order to adequately and sustainably fund the right care for improved patient outcomes

- A task and finish group will be set up by end of January consisting of key stakeholders to agree

    - Collaborative partnership principles, objectives and behaviours for the Alliance
    - Governance mechanisms
    - TOR for the Alliance Care Board and associated membership

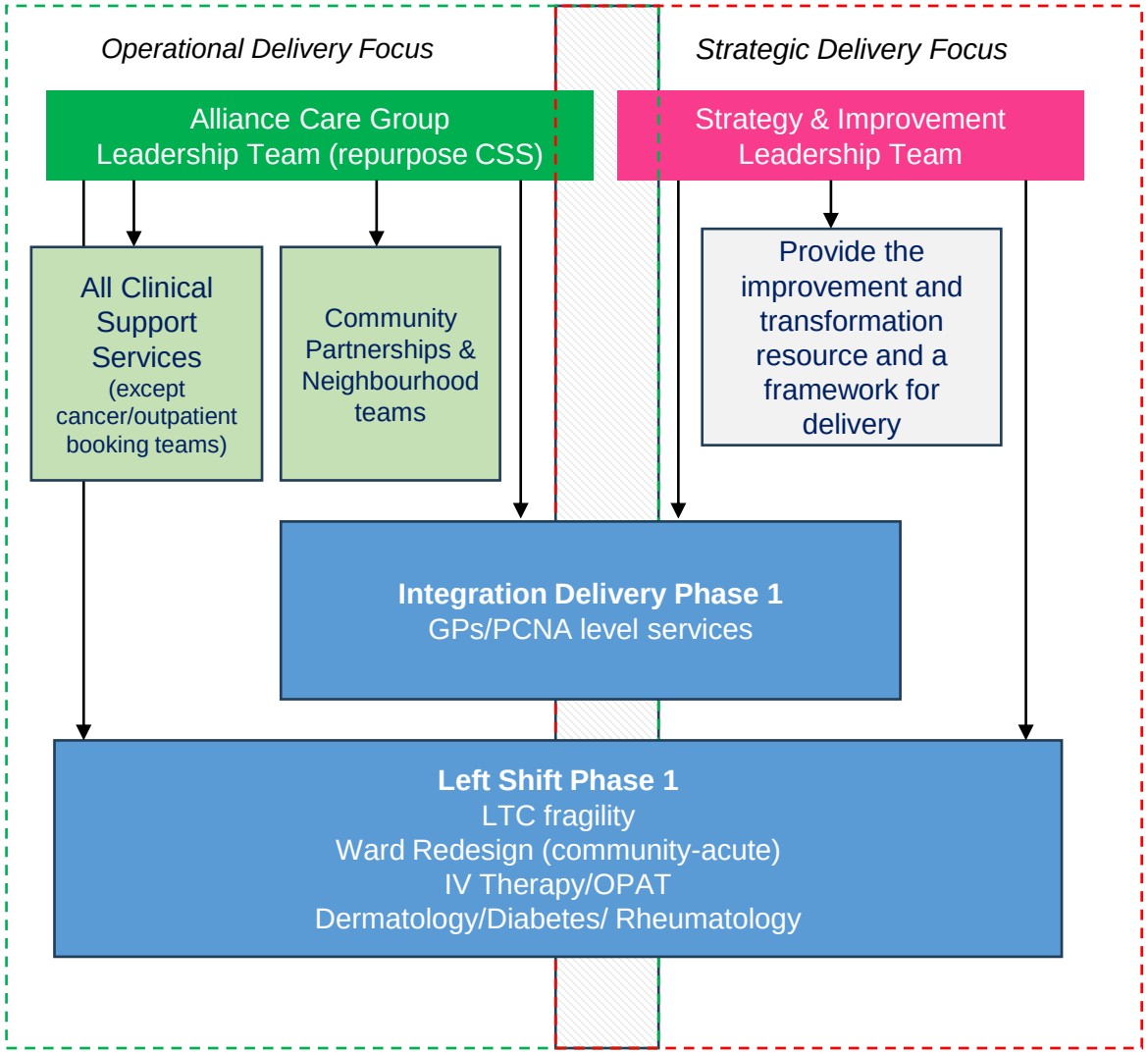
2 Creation of an Alliance Care Group

- We will set up the Alliance Care Group Structure which will include divisional leadership, programme director roles, business and engagement lead, associate director of community (developing into place leadership roles) and heads of integrated partnership (Appendix 3). Recruitment commences February 2025.

- The strategic framework for transformation, improvement and resource to deliver these will be provided by the LCHG Strategy & Improvement team. Depicted in figure to demonstrate the cross team working.

- The Alliance will be set up as a Care Group and as part of commencing Phase 1, we will move all Clinical Support Services except Cancer services and outpatient booking teams from 1st April 2025.

- The Alliance Care Group will align with the LCHG accountability framework to enable delivery of operational services and monitoring of performance through appropriate KPIs by July 2025.



3 Development of an Alliance Delivery Plan

- The Alliance Care Group will focus on 2 key large scale change programmes: internal ‘left shift’ plan- this will be coordinated by operational care group and the external integration programme will be up the partnership leadership in the care group

    - **Internal ‘Left Shift’** which will comprise of pathway redesign through engagement with stakeholders across the group and external partners to move services within a community setting reducing reliance on acute care. Digital, estates will be key enablers to enable these transformations.

    - **External Integration** and partnership opportunities with PCNs, PCNAs, GPs, ICB, volunteer and third party sector. These will include primary and Secondary Care Interface, Early adopter CPP plans on a page, High Intensity Users, Community Nursing with K2, Women's Health Hubs, Weight Management.

- The Alliance Delivery plan will pull together a programme to deliver this, key milestones are highlighted below.

	End of Feb 2025	End of March 2025	End of April 2025	End of Oct 2025	End of March 2026
Internal Left Shift Programme	Socialise key priorities with Care Group and develop the LCHG transformation & improvement framework	Agree overall priorities & phasing. Move CSS services.	Signed off Programme Plan with KPIs with & associated resource for delivery	Prioritised Services on track for delivery	Transformed 5 services through ‘left shift’ with tangible improvements to patient outcomes
External Integration Programme	Engagement with PCNA/PCNs	Agree spectrum of integration opportunities and commence due diligence.	Signed off Programme Plan with KPIs & associated resource for delivery	Agreed Vehicle for Integration with GPs/PCNAs	Successful integration of GPs/PCNA with the LCHG Alliance

Updated Phasing Model & Next Steps

Services that we have identified in GLT (slide 7) – move and transform in place

Review, measure and share successes from the programme as per Quality Improvement methodology

Phase 1

December 2024 – March 2025

- Establish Alliance Care Directorate Structure
- Reassign 2 wards from acute to community
- Release 1 additional ward for community patients via productivity
- Move Clinical Support into the Alliance (excluding cancer services)
- Move Dermatology, Diabetes, Rheumatology, to the Alliance Division
- Redesign/relaunch OPAT service
- Develop Tier 3 Weight Management Service
- Continue to embed population health data into prioritisation and transformation
- Delivery of priorities within the secondary, primary care the interface programme

Phase 2

April 2025 – September 2025

- Redesign Community Nursing via K2 pilot
- Embed Dermatology, Diabetes and Rheumatology into 6 PCN's
- Move Heart failure, CPP, Care Navigation and Neighborhood Teams into Alliance Division
- Work with PCN's to identify priority, needs led service for their population and confirm phase 3 services
- Implement left shift service transformation identified within specialty support and transformation programmes
- Improve primary and secondary care interface scores

Phase 3

October 2025 – March 2026

- Remaining PCN's to have dermatology, Diabetes and Rheumatology embedded
- Phase 3 trance of services transition to Alliance Directorate e.g. Therapies and Rehabilitation, Outpatient Appointment Services, Outpatient Nursing, Screening Services, Paediatrics and appropriate Women's Health services
- Work with PCN's to agree phase 4 services

Phase 4

April 2026 onwards

- Phase 4 of services transition to Alliance base don long term conditions aligned to population health need
- Measure external relationships

Approach to be centred around population health data, PCN priorities and risk stratification via a needs led process and robust framework

What services can we “left shift” to go into the Alliance Care Group?

ULTH				LCHS	
Medicine	**Surgery**	**Family Health**	**CSS**	**Unplanned Care**	**Planned Care**

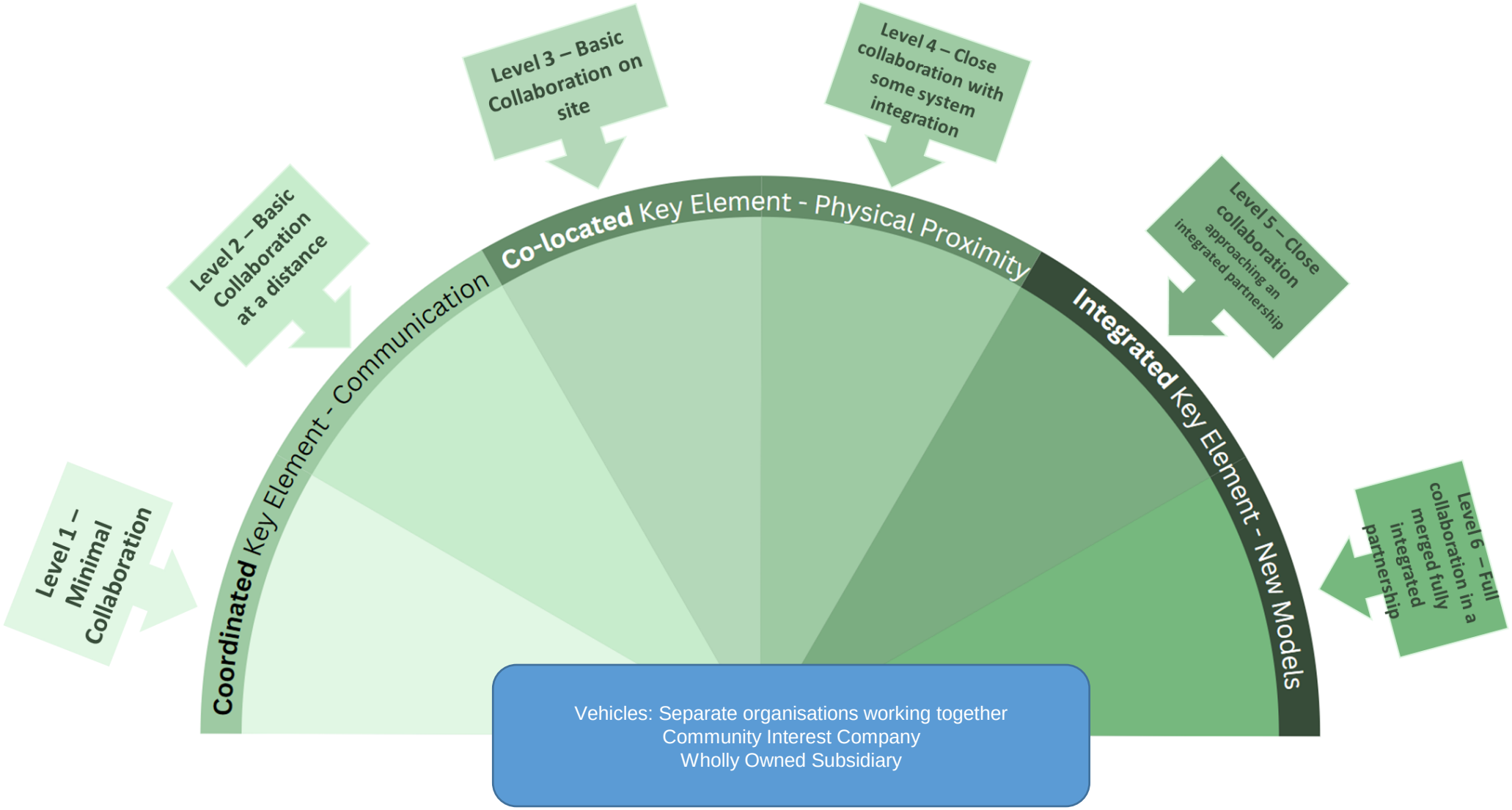
• Diabetes (ONE Diabetes Model)
• Cardiology –
  • Heart Failure
  • Cardiology to outpatients
• Dermatology
• Rheumatology
  • Denosumab access
  • Fibromyalgia
  • Hypermobility
  • Non-inflammatory conditions
* All of the above for peadatrics too
• Nephrology FUPs/ condition specific
• Parkinson’s/frailty
• Dementia
• Neuro outreach (neuro medicine/brain injuries)
• Conversion acute to community
• CMDU
• Respiratory- longitudinal phased
	• Orthotics
	• Max Fax
	• BPA surgery
	• Fracture Clinics
	• Minor ops
	• Ophthalmology (do a proof of concept)
	• Pre- Pre-Ops (community health stratification for planned care)
	• All day case procedures- urology/general surgery daycase
	• Opthamalogy
	• Screening
	• Post treatment monitoring CDCs
	• Pre-op (after decision
		• Community Paeds
		• Gynaecology
		• Gynae-oncology
		• Womens Health Hubs (joint work with ICB)
		•
			• Everything except outpatient booking team and cancer services
			• Chemotherapy at CDC
			• OPAT
			• Endoscopy
			• CSS to keep heam/onc, radiotherapy, chemotherapy/ SAC/Radiotherpay Physics/ Specialist Palliative care
				• Designated stroke beds
				• Designated ortho beds
				• CDC joint appointments for consultations and imaging
				• 2B neuro activity
				• In house pharmacy
					• IV Therapies
					• IV Furosemide
					• Diabetes pathway
					• MS pathway
					• Registered OTs: in-Reach, acute therapy assistant management, MSK PT podiartry
					• Outpatient consultations
					• Joint replacements, ACL repairs
					• Frailty joint job plans with ACPs and frailty follow up clinics
					• Children’s community nurses
					• Children’s therapy services
					• HCOP
					  • Community Geriatricians
					  • Community Falls Service

Current work on-going within the Alliance

Internal Programme	External Programme
• Ward re-designation from acute to community (Alexandra) • OPAT services – progress with SOPS and links into virtual ward, with intention to launch IV Furosemide service by end February 2025. SLA and policies in progress to support and finance models to be developed to support transaction from acute to community • Primary and Secondary Care Interface – system wide documentation circulated across LCHG (5 point behavioural Charter, Ft Note Guidance etc.) and improvements in clear points of contact work. Re-evaluation of self-assessment due end January 2025. • Embedding PHM within LCHG Strategy and approach to planning, speciality strategy development and all improvement/transformation programmes • Identification of 'long list' of specialities/services for 'Alliance' consideration received from GLT (appendix 3)	• Date to be confirmed for Board to Board session between LCHG and PCNA • Tier 3 weigh management service development – Clinical Reference Group (CRG) and system level workshop to be established February 2025 • PCN Priorities received (? Angela/Sarah S) • K2 PCN - Development of Community Nursing/Nursing in the Community and further opportunities in relation to Parkinson's, Diabetes and Respiratory • Meridian/East Lindsey PCNs – agreement to work together on a discrete population/cohort across the 2 PCNs with defined metrics. • Engagement in developments of the Boston Integrated Health and Care Centre

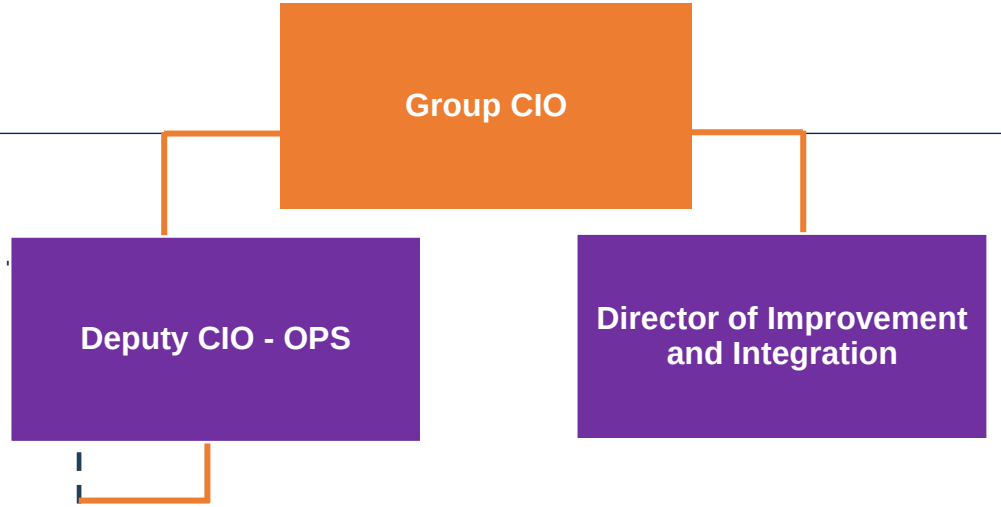
Appendices

Appendix 1 Our Spectrum of Integration Offers to all Partners



Appendix 2- Alliance Care Directorate

Aligned to new Head of Integrated Partnership Roles



Place Leader
Internal Partnerships
LCHG Delivery
Left Shift

Vulnerabilities
Head of Integrated Community Partnership

Health Inequalities
Head of Integrated Community Partnership

Cluster
- First Coastal
- Boston
- Meridian
- East Lindsey

Place Leader
External Partnerships
Neighbourhood, Clusters.
New ways of working

Palliative
Head of Integrated Community Partnership

Cluster
- Four Counties
- South Lincs & Rural
- Spalding

Place Leader
Scalable Partnerships
Enabling Services (structural partnerships)

Complex Frailty
Head of Integrated Community Partnership

Proactive prevention Long term conditions
Head of Integrated Community Partnership

Cluster
- APEX
- Lincoln Healthcare Partnership
- IMP
- Trent
- South Lincoln Healthcare
- K2 – Sleaford
- K2 - Grantham

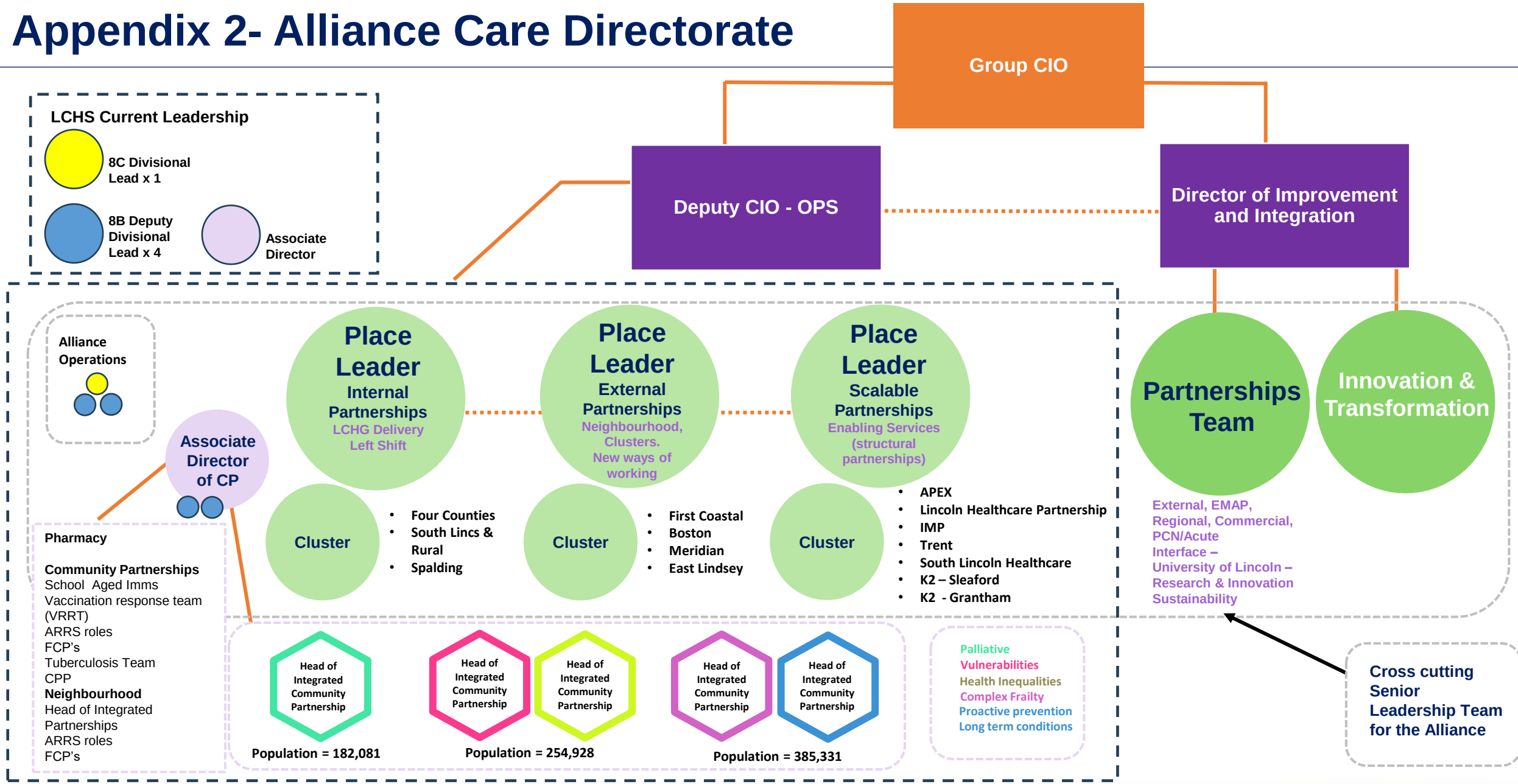
	GP Practices	GP Partners	Number of GPs	Population
Head of Integrated Partnerships - Proactive Prevention & Long Term Conditions - Rebecca McConville				
APEX	4	15	28	47,057
Lincoln Healthcare Partnership	4	5	16	39,330
IMP	9	16	42	72,470
Head of Integrated Partnerships - Complex Frailty - Clare Credland				
Trent	5	4	27	40,345
South Lincoln Healthcare	7	8	19	50,558
K2 - Sleaford	10	14	32	58,798
K2 - Grantham and Rural	6	19	54	76,773
Totals	45	81	218	385331

Head of Integrated Partnerships - Palliative & End of Life - Louise Johnson				
Four Counties	2	10	19	39,332
South Lincs & Rural	9	23	53	98,521
Spalding	2	4	17	44,228
	13	37	89	182081
Totals	13	37	89	182081

Head of Integrated Partnerships - Health Inequalities - Karen Hewinson				
First Coastal	7	10	56	83,320
Boston	6	9	32	78,180
Head of Integrated Partnerships - People with Vulnerabilities - Matthew Fisher				
Meridian	8	12	31	38,917
East Lindsey	4	11	38	54,511
	12	23	69	93428
Totals	25	42	157	254928

Totals				
	GP Practices	GP Partners	Number of GPs	Population
	83	160	464	822,340

Appendix 2- Alliance Care Directorate



NHS
Lincolnshire Community and Hospitals NHS Group

Integration Committee Upward Report

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

Meeting	*Lincolnshire Community and Hospitals Group Board Meeting*
Date of Meeting	*4 March 2025*
Item Number	*Item 11.1*

Integration Committee Upward Report of the meeting held on 25 February 2025

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

Purpose

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

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

Upward Report

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

Focussed Discussion – Alliance Model (appended)
The Committee received the report with **assurance** noting the developments that had taken place since being received at the previous meeting.

The Committee was pleased to note the progress that had been made, particularly in the presentation of the information to ensure this was understood across the Group. There was recognition that the Alliance Model would be in place from the 1 April 2025 with transformation of dermatology, rheumatology, diabetes and 2 acute wards in the first phase, to be completed by July 2025.

There was recognition of the long-term benefits to the population of Lincolnshire in respect of the transformational changes and it was noted that whilst some of the benefits would not be immediately visible there would be movement in operational measures and improved patient outcomes.

Collaborative Out of Hospital Model
The Committee received the report with **assurance** noting the ongoing development of the report and recognised the challenges at this time in producing a report for the Committee as the Alliance Model was not yet established.

There was recognition of reporting that would be required to both the Integration and Finance and Performance Committees however this would develop further as left shift started to take place. It was also noted that the group would report operationally to the Group Leadership Team and assurance to the Committee with a focus within the reports required on service change and transformation.

The Committee noted the escalation in respect of school age immunisations and the current position for LCHS where a decision had been made in respect of not bidding for the service. The Committee supported the decision made recognising the implications financially on the Group.

Assurance in respect of Objective 3c – A modern, clean and fit for purpose environment across the group

No reports due

Assurance in respect of Objective 4a – Established collaborative models of care with our partners including Primary Care Network Alliance (PCNA)

No reports due

Assurance in respect of Objective 4b – Successful delivery of the Acute Services Review

Stroke Update
The Committee received the report with **assurance** noting that this had been presented to the Health Overview Scrutiny Committee to demonstrate the progress in respect of stroke services.

The Committee noted that the update had been received well with a further update requested by HOSC in 6 months. This would provide an opportunity for work to be progressed on the decoupling of the pathways and for the actions following engagement with the CLEAR Programme to commence.

Assurance in respect of Objective 4d – Enhanced data and digital capabilities

Digital Oversight Group Upward Report and Focussed Discussion – Migration Programme Update

The Committee received the upward report with **assurance** noting that this had been the first meeting across the Group with the intention that as the group matured there would be greater focus on joint working.

The group considered the terms of reference and feedback was sought in respect of these.

The Committee noted that there had been some delays associated with programme delivery associated with EPR due to the national funding approval process and the need to divert resource to support the NHS.Net migration for ULTH.

Achievement was noted in the delivery of hybrid mail for ULHT as well as positive progress in respect of EDMS which had been considered through the Finance Committee and was due to be presented to the Board.

Developments in respect of the AI were noted with ULTH having been asked to lead a Clear Note pilot from an NHS perspective, this was being supported.

Recent focus had been on the NHS.Net migration from a digital perspective with the Committee commending the work of the Digital Team in the success of this. It was noted that further migration of Microsoft M365 would be undertaken, and the Committee noted the need to ensure lessons learned needed to be identified and applied to future projects to ensure continued success, specifically in respect of EDMS and EPR.

Assurance in respect of Objective 5a – Develop a Population Health Management and Health Inequalities approach for our Core20PLUS5 with our ICS

No reports due

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

No reports due

Assurance in respect of Objective 5c – Tackle system priorities and service transformation in partnership with our population and communities

No reports due

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

No reports due

Assurance in respect of other areas

111 Activity Update
The Committee received the update noting the position presented and reflected on the work being undertaken, with the support of the Derbyshire ICB as the host commissioner, about the novation of the CAS Service back to LCHS. Discussions remained ongoing.

Staff Story
The Committee received the staff story related to the Emergency Operations Centre (EOC) and senior clinician support from LCHS to support the East Midlands Ambulance Service (EMAS) to support patients in being diverted, where clinically appropriate to urgent care pathways.

The Committee noted the achievement of 69% of patients being managed through urgent care, rather than EMAS which resulted in improved patient outcomes. It was recognised that an ambulance would always be sent where required and if necessary, the category would be increased for the patient following clinical review.

The benefits of the pilot were noted with the Committee recognising the need to identify the total impact of all pilots being undertaken to determine where scaling up was required to continue to support attendance and admission avoidance.

Committee Performance Dashboard
The Committee received the dashboard with **assurance** noting the ongoing work to develop and integrated dashboard for all Committee with the first draft anticipated to be received in March.

The Committee reflected on current performance noting that this would offer insight into areas requiring improvement and transformation and also to demonstrate improvements being made as a result.

Community Waiting List Position
The Committee received the report with **assurance** noting the fortnightly meetings with the ICB with regional meetings now in place.

The Committee noted the risks identified within the paper with the areas of concern mainly being long term conditions however mitigations and daily actions were in place with discussion ongoing with ELT in respect of joining up the pathways across acute and community.

A live dashboard has been developed and benchmarking has taken place against the acute position for 2025/26 to offer a baseline position which was noted as 65% by March 2026. It was noted that there were currently 94 patients waiting less than 18 weeks with an ask that no more than 1% of the total waiting list were waiting beyond 52-weeks. Whilst it was recognised that these were not consultant led services benchmarking was supporting the understanding of the position.

The Committee received the dashboard that had been developed, utilising population health data, to identify longest wait areas. It was recognised that this supported the Group in understanding areas that would have an impact if addressed in respect of waiting lists, with recognition that a reduction in the long-term condition waiting list would have a direct impact on attendances at A&E.

Strategy, Planning and Improvement
The Committee received the upward reports with **assurance** noting the work being undertaken in respect of the reposition model as a result of planning guidance to identify opportunities and those areas already being addressed.

Activity modelling was noted as being based on the outturn of month 8 with key assumptions and productivity being identified with improvement of 2% required on a year-on-year basis.

In respect of planning, the Improvement Steering Group (ISG)had repurposed half of the meeting to focus on the 25/26 plan with discussions focusing on the CIP delivery which was forecast at £40.1m in line with plan.

The LCHS Pillar Programme Board continued to meet and update in respect of productivity and transformation with recognition of the need to ensure that there was triangulation across planning guidance and the 3 measures of health inequalities, which would be included in planning.

The Committee noted the intention of development of the groups, bringing these together across the Group and providing both the backwards look but also the forward view to enable clear sight of productivity ad improvement plans for the coming year.

Risk Register/Risk Mapping
The Committee received the report with **assurance** noting that work had taken place to align risks to the Committee with no very high risks for either LCHS or ULTH and 1 high for LCHS and 5 for ULTH.

The Committee noted the work that had been undertake in respect of mapping and aligning with the report also containing information relating to risk associated with, but not owned, by the Committee.

There was recognition of the mapping work that had been undertaken and the identification of 3 main risks being held in LCHS covering lack of robust plan, activity and waiting list position and oversight of contracts. These risks would be added to the risk register and whilst not owned by the Committee, oversight of these would be provided due to the transformation work associated with the risks.

Board Assurance Framework
The Committee received the report with **assurance** noting that, whilst this would remain under review, the 2025/26 BAF would provide clarity of assurance for the Committee, aligned to the new Group objectives.

Issues where assurance remains outstanding for escalation to the Board

No escalations required.

Items referred to other Committees for Assurance

None.

Attendance Summary for rolling 12-month period

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

X in attendance
A apologies given
D deputy attended

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Hospitals NHS Trust

LCHG 2025-2026

Strategic Drivers – Why are we doing this?

National

3 Big shifts in 10 Year Health Plan*

- NHS England Sickness to Prevention
- NHS England Hospital to Community
- NHS England Digital to Analogue

*10 Year Health Plan due for publish in Spring 2025

5 Mandate Objectives Road to Recovery

- Department of Health & Social Care REFORM to cut Waiting Times
- Department of Health & Social Care REFORM to Improve Primary Care Access
- Department of Health & Social Care REFORM to Improve Urgent & Emergency Care
- Department of Health & Social Care REFORM to The Operating model
- Department of Health & Social Care REFORM to Drive Efficiency and Productivity

4 Objectives Elective Care Reform

- NHS App Empowering Patients
- OPEN Reform Delivery
- Delivering Care in the Right Place
- £ Align funding, performance and Delivery

By March 2026 the % of patients waiting less than 18 weeks for elective treatment will be 65% nationally.

3 Essential Offers – Fuller Report (2022)

- Streamline Access to Care and Advice
- Provide more Proactive, Personalised care
- Help people to stay well for longer MDT Teams

Reforming Elective Care for Patients – January 2025

To meet the 18-week standard and reform elective care by March 2029, we are focusing on:

Empowering Patients

ICB - set a clear local vision for how health inequalities will be reduced as part of elective care reform, and ensure interventions are in place to reduce disparities for groups who face additional waiting list challenges. **March 2025**

Expand the NHS App and Manage Your Referral website to improve information and appointment management on elective care for patients, as well as parents and carers through proxy access – **March 2027**

By the end of **March 2025**, 85% of acute trusts will enable patients to view appointment information via the NHS App

Reforming Delivery

Provide quicker access for patients to common surgical procedures by launching 17 new and expanded surgical hubs by **June 2025**

Deliver significantly improved elective pathways by extending the minimum standards for community diagnostic centres (CDCs) to open 12 hours per day, 7 days a week, delivering same-day tests and consultations, an expanded range of tests, with direct referral from primary and community care, new consulting rooms and at least 10 straight-to-test pathways **March 2026**

New standards for CDCs, particularly increasing direct referrals and rolling out at least 10 straight-to-test pathways **March 2026**

Delivering Care in the Right Place

Ensure both primary care and secondary care are funded to deliver Advice and Guidance, by splitting the existing elective tariff to deliver better Reforming elective care for patients – **January 2025 11 outcomes for patients.**

Ensure PIFU is offered as standard in all appropriate pathways **March 2026**

Set out clear expectations for significant elective care reform to be delivered in at least 5 specialties ENT, gastroenterology, respiratory, urology and cardiology

Work with patients, carers and clinicians to establish a consistent model of 'collective care' approaches, including group appointments and one-stop clinics, **September 2025**

Align funding, performance oversight & delivery standards

Update the Payment Scheme to reflect elective priorities, including with a stronger focus on activity that directly ends a patient's wait for their care, and by developing, testing and introducing relevant tariffs throughout the duration of this plan

Run a capital incentive scheme for providers that improve the most in meeting RTT standards

Put robust arrangements in place to performance manage and deliver elective care targets and standards, including making best use of NHS IMPACT improvement support, national metrics, dashboards and toolkits

Work with system partners to ensure adoption of best practice

Targets

Non-Elective Care

4hr Improve A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours in March 2026.

12hr A higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/25

30 Minutes Improve Category 2 ambulance response times to an average of 30 minutes across 2025/26

15 Minutes Reduce avoidable ambulance conveyances and handover delays by delivering hospital handovers within 15 minutes and improving access to urgent care services at home or within the community

Non-Elective Care

65% 65% RTT by March 2026

92% 92% RTT by March 2029

72% Improve percentage of people waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026, with every trust expected to deliver a minimum 5% improvement

Less than 1% Reduce proportion of people waiting over 52 weeks for treatment to less than 1% of total waiting list by March 2026

Cancer

75% Improve performance against 62-day cancer standards to 75% by March 2026

80% Improve performance against 28-day FDS to 80% by March 2026

Maternity

Improve Safety Improve safety in maternity and neonatal services, delivering the key actions of the “Three Year Delivery Plan”

Targets

Health Inequalities

CORE 20 PLUS5

Reduce inequalities in line with the Core20PLUS5 approach for adults and children and young people

Increase %

Increase the % of patients with hypertension treated according to NICE guidelines

Quality

Fragile Services

Maintain focus on overall quality and safety of services, with a focus on challenged and fragile services

Digital and Data

CYBER Security

All providers achieve and maintain compliance with the NHS Multi-Factor Authentication Policy and act to strengthen their cyber security

Digital Inclusion

All systems mitigate against digital exclusion, including by implementing the framework for NHS action on digital inclusion

85% FDP

Adoption of elective reform Federated Data Platform by 85% of secondary care trusts by March 2026

NHS App

Proactively offer NHS App-first communications to patients, by default through NHS Notify service

EPR

All systems complete planned electronic patient record (EPR) system procurements and upgrades

Finance

£0

Deliver a balanced net system financial position for 2025/26

-30%

Reduce agency expenditure as far as possible, with a minimum 30% reduction on current spending across all systems

Pre COVID Levels

Close the activity/ WTE gap against pre-Covid levels

Efficiency and Productivity

STOP & Improve

Drive improvements in operational and clinical productivity, including stopping lower value activity

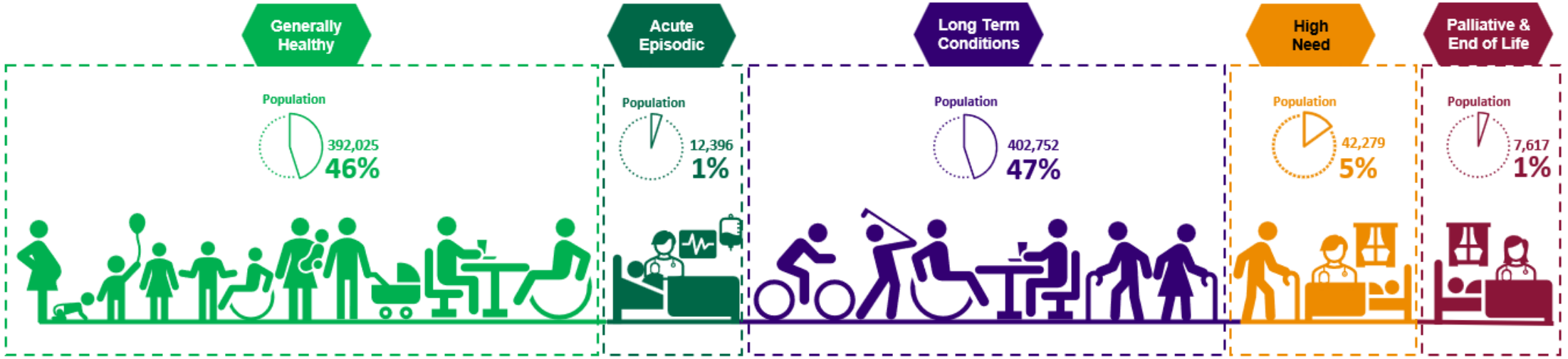
NEW LCHG Strategy, Aims & Objectives

We are Better Together

	PATIENTS	PEOPLE	POPULATION
	Better Care	*Better Opportunities*	*Better Health*
AIMS	Timely, affordable, high-quality care in the right place	Develop, empower and retain great people	Improve population health
OBJECTIVES	**1a** Improve patient safety, patient experience and deliver clinically effective care **1b** Reduce waiting times for our patients **1c** Improve productivity and deliver financial sustainability **1d** Provide modern, clean and fit for purpose care settings	**2a** Enable our people to fulfil their potential through training, development and education **2b** Empower our people to continuously improve and innovate **2c** Nurture compassionate and diverse leadership **2d** Recognising our people through thanks and celebration	**3a** Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services **3b** Move from prescription to prevention, through a population health management & health inequalities approach **3c** Enhance our digital capability and adopt innovations **3d** Drive forward our efficiency and sustainability agenda through our Green Plan

Our Population and Funding

Lincolnshire Population 857,069 Residents



Total Annual Spend £1.3 Billion

- £163m (14%) At Risk , *Children & Maternity age 0-16, Low Risk* — 14%
- £55m (4%) Major, *HIU – 6 or more attendances in year* — 4%
- £712m (53%) Moderate Frailty, *Big Six Disability, Mental health, MSK, Living with Illness* — 53%
- £310m (23%)Severe Frailty, *High Complexity, Dementia* — 23%
- £96m (7%), Cancer, *Non-Cancer* — 7%

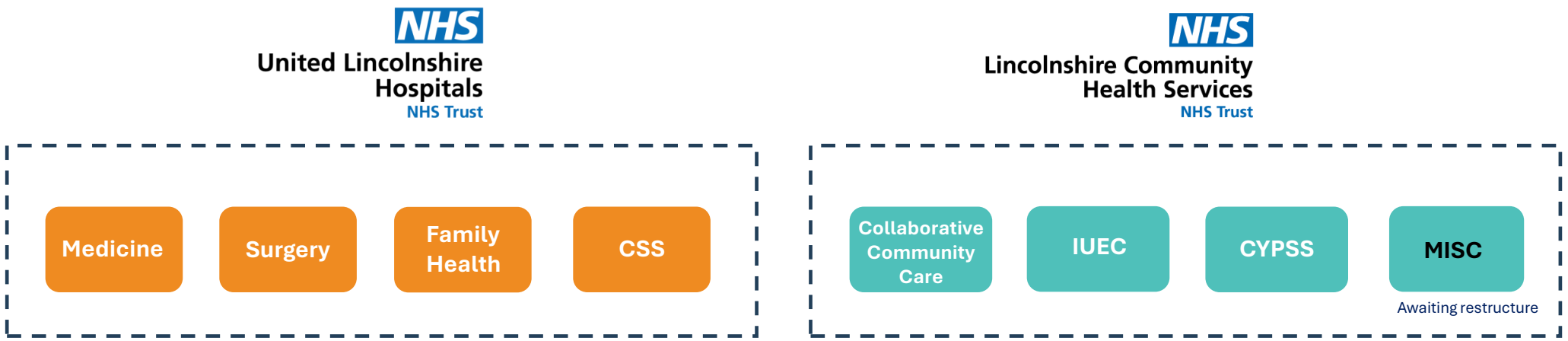
Average spend/resident: £1,559 per resident

Group Model - Established 1st April 2024

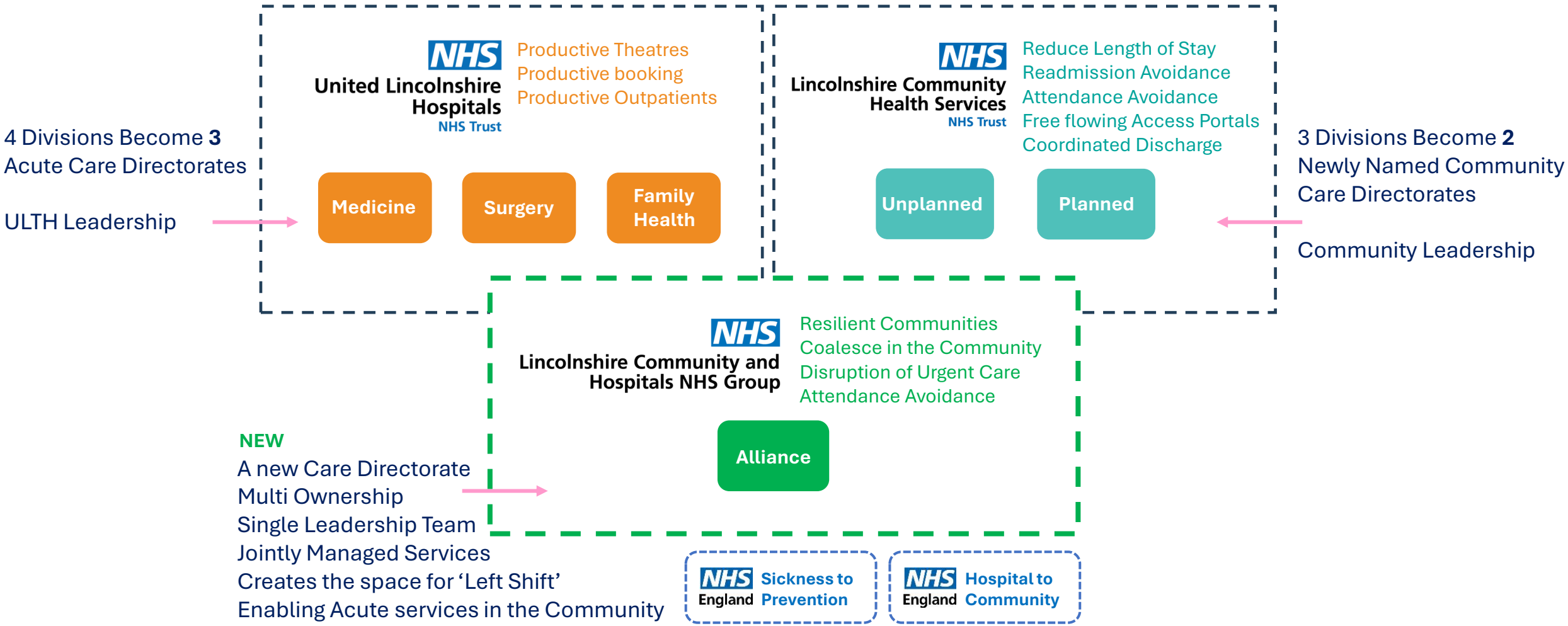
- Remaining Two Separate Legal Organisations
- Coalescing to work ***Better Together*** to deliver:

NHS England Hospital to Community	Acute services nearer to the community and a reduction in length of stay
NHS England Sickness to Prevention	Disruption to urgent care and keeping people out of hospital
NHS England Digital to Analogue	A move to a digitally enabled workforce, empowering patients to manage their appointments and care

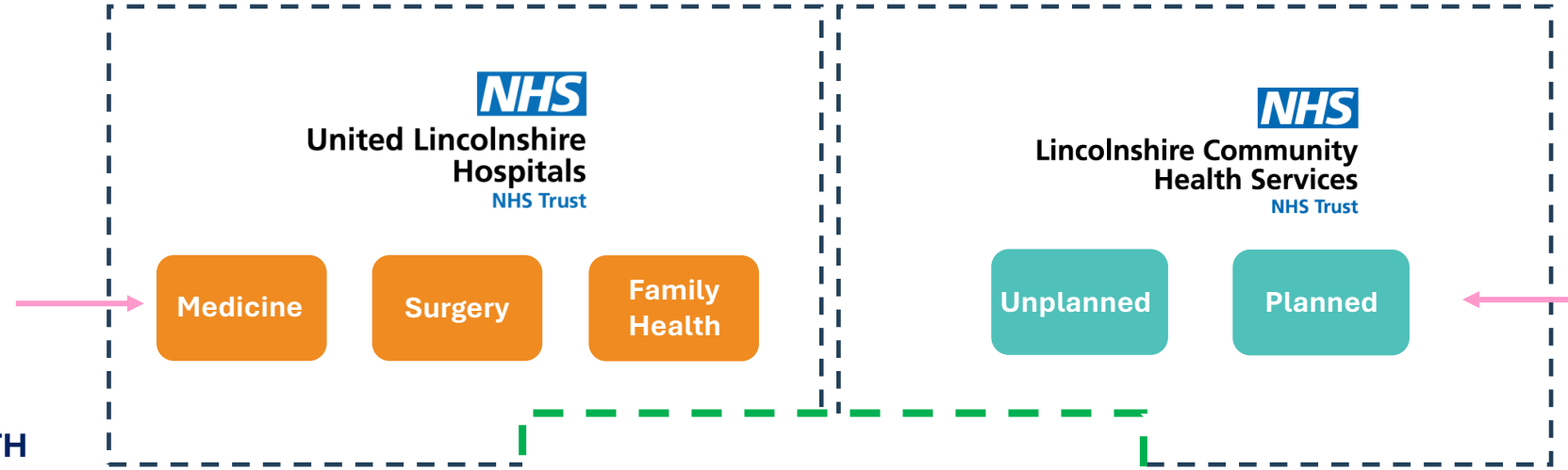
February 2025 – 7 Care Directorates across ULTH and LCHS



The Future – 6 Care Directorates across LCHG



What does this mean for me?



These care directorates stay the same

Your leadership stays the same

You are still employed by ULTH

These care directorates have had a name change

Your leadership will be changing due to vacancies and a new structure

You are still employed by LCHS

These services will move into the Alliance
(excluding Cancer, Outpatients – see next slide)

Your leadership will be changing due to vacancies and a new structure

You are still employed by ULTH

These services will move into the Alliance

Your leadership will be changing due to vacancies and a new structure

You are still employed by LCHS

Alliance – The Integration Space

Resilient Communities
Coalesce in the Community
Disruption of Urgent Care
Attendance Avoidance

Partnerships

Clinical foundation of the Alliance

LCHG - In Our Community Phase 1 - 3

Unplanned **Planned**

Reduce Length of Stay
Readmission Avoidance
Attendance Avoidance
Free flowing Access Portals
Coordinated Discharge

Planned Care

Community Nursing x 11 ICT Teams
Adult Community Therapy
Treatment Rooms

Community Hospitals
Skegness
Spalding
Gainsborough
Louth
Lincoln - **NEW**
Community Hospital Therapy Teams

Children & Young People
Looked after Children
Childrens SALT
Childrens OT
Childrens Physiotherapy
Community Paediatrics (Admin)

Specialist Services
Podiatry
Adult SALT
Post Covid
Respiratory
Parkinson's
MSK
Cardiology
Heart Failure
Stroke
Bowel & Bladder
Lymphedema
INR
Macmillan
Leg Ulcer
Tissue Viability

REGIONAL:
Electronic Assisted Technology Service

Unplanned Care

UTC's
Boston
Lincoln
Spalding
Gainsborough
Louth
Skegness

Response Teams
Urgent Care Response
Home Visiting
Virtual Wards
OPAT
Voice Before You Visit
All Age Respiratory Rapid Response

Coordination Teams
CAS - Clinical Assessment Service
SPA - Operations Centre
PSPA – Palliative
Patient Admin Services (PAS)

Discharge Teams
Transitional Care
Discharge Lounge
Virtual Ward – Step Down
Home First
D2A
Assisted In Reach Team (AIR)

Medical Workforce
Special Equipment
Resus Equipment
IEN

LCHG - In Our Acute Hospitals Phase 1 - 3

Medicine | **Surgery** | **Family Health**

Productive Theatres
Productive Booking
Productive Outpatients

Family Health

Women's Health & Breast Services
Breast
Maternity
Gynaecology

Children & Young Persons
Paediatrics
Community Paediatrics
Neonatology

Medicine

Urgent & Emergency Care
A&E
Acute Medicine
UTC - Grantham

Cardiovascular
Cardiology (Including Cardiac Physiology)
Stroke
Endocrinology
Renal

Speciality Medicine
Neurology
Gastroenterology
Respiratory
Health care of the Older Person

Surgery

General Surgery, Vascular, Head & Neck
General Surgery
Vascular
Head & Neck

Urology, Trauma & Orthopaedics, Ophthalmology
Urology
Trauma & Orthopaedics
Ophthalmology
Orthotics
Urology

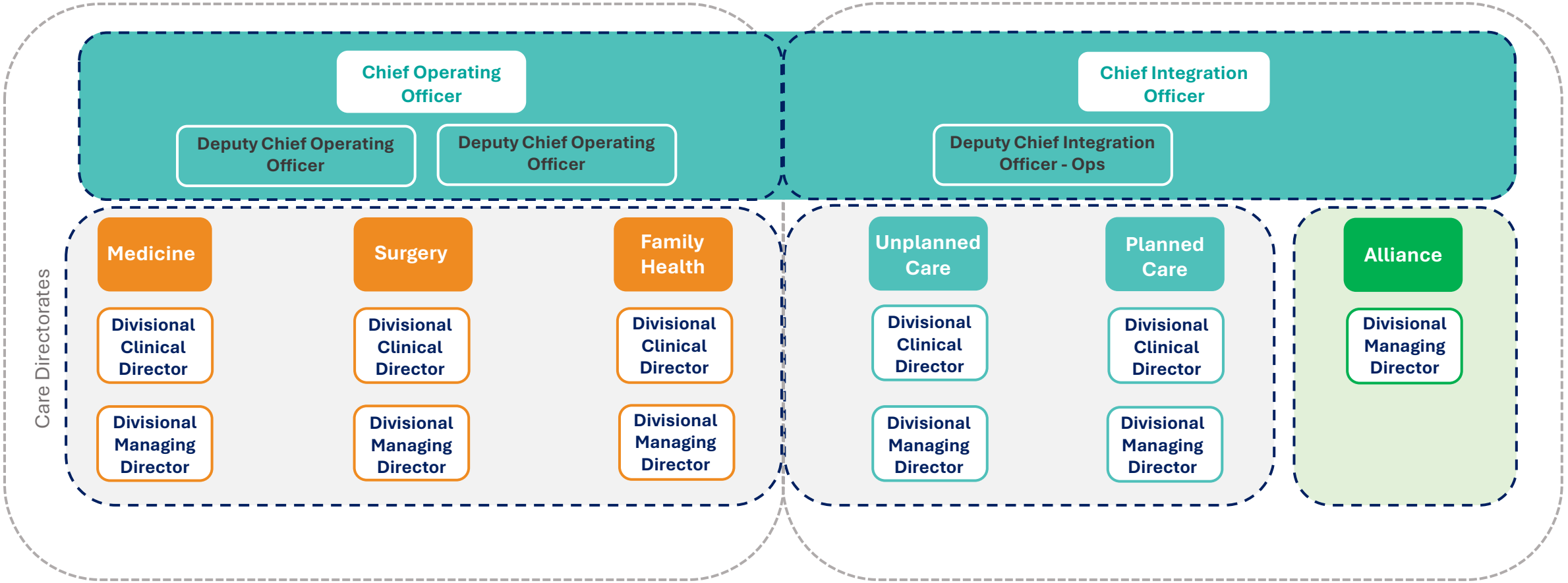
Theatres, Critical Care Anaesthesia
Theatres
Critical Care
Anaesthesia

TBC

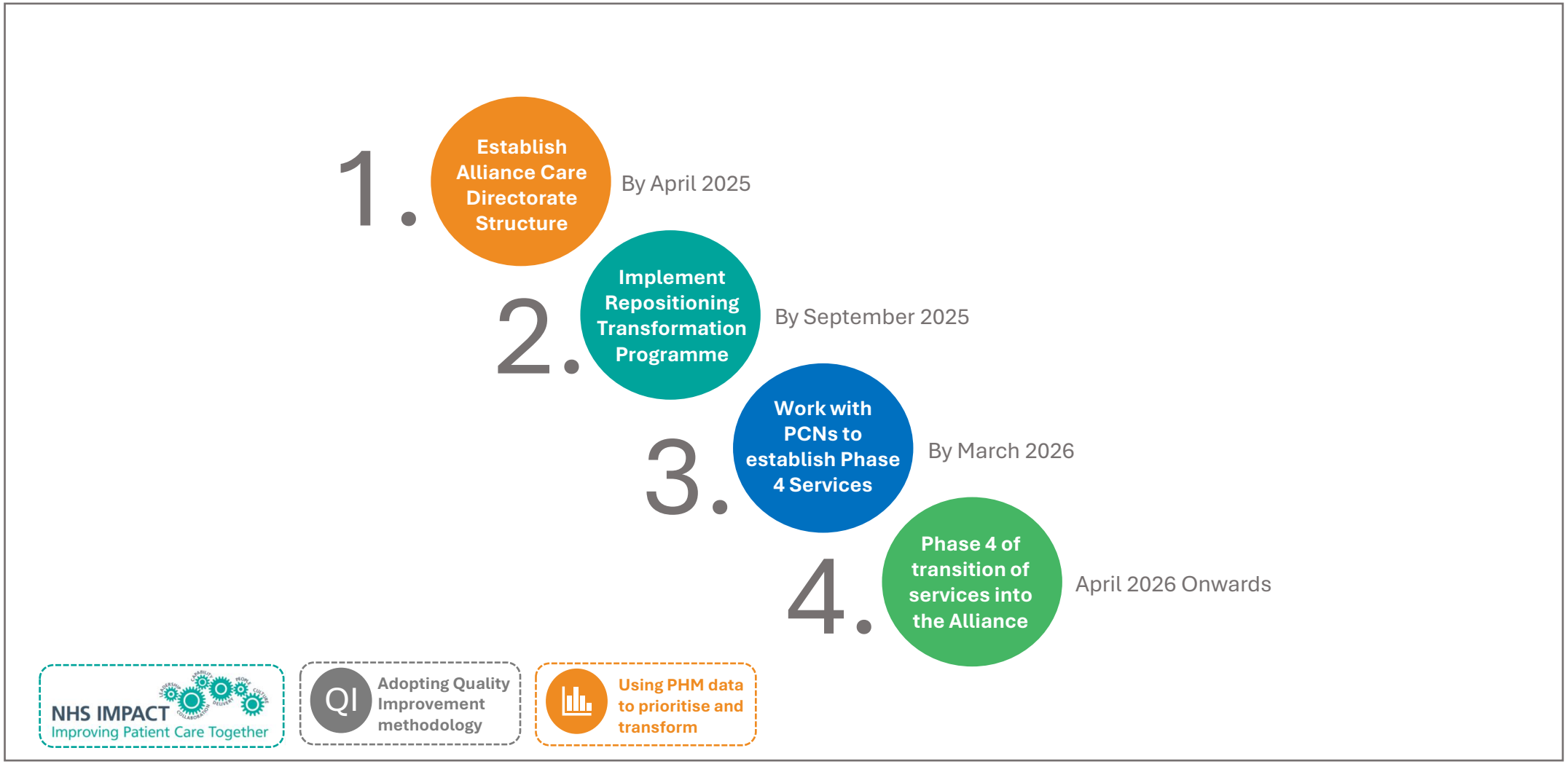
Cancer
Haematology
Oncology
Radiotherapy/Radiotherapy Physics
Cancer centre
Specialist Palliative Care

Outpatients
Outpatient appointments
Services
Outpatient Nursing

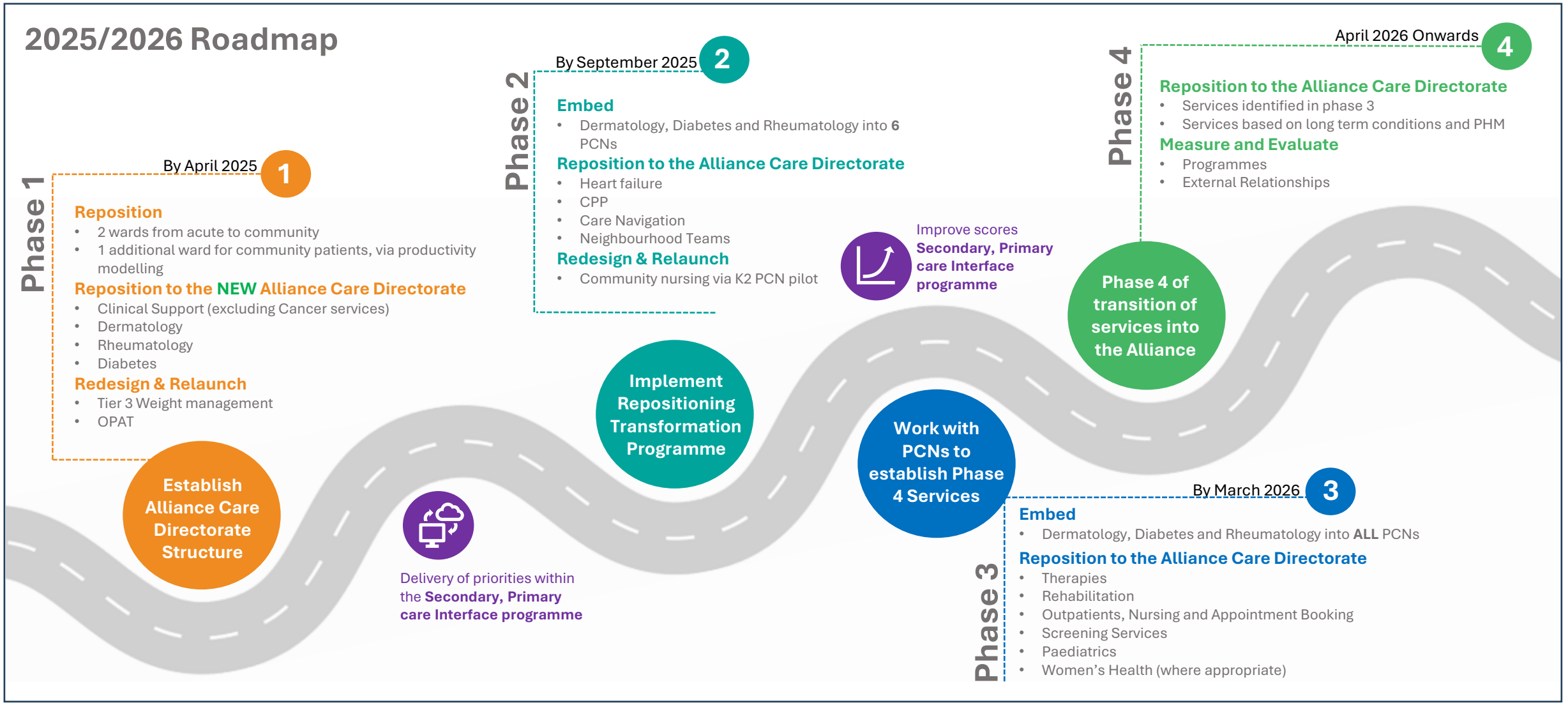
LCHG Operational Leadership Teams



2025/2026 - LCHG 4 Phases of Delivery



2025/2026 Roadmap



Alliance Delivery Plan - Key Milestones

Internal Left Shift Programme

Feb – February 2025
Socialise key priorities with Care Group and develop the LCHG transformation & improvement framework

Mar – March 2025
Agree overall priorities & phasing

Move CSS services

Apr – April 2025
Signed off Programme Plan with KPIs with & associated resource for delivery

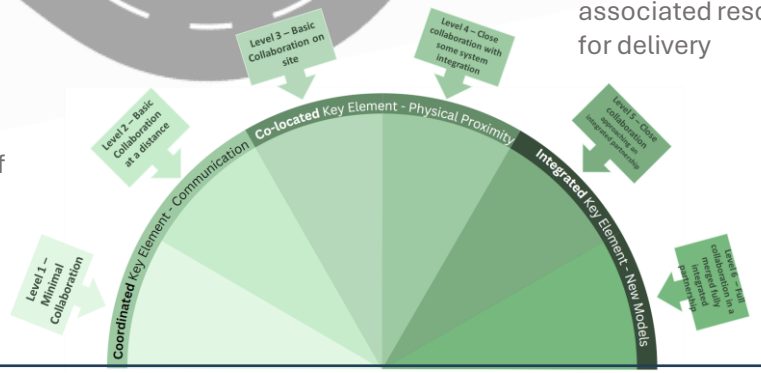
Oct – October 2025
Prioritised Services on track for delivery

Mar – End of March 2026
Transformed 5 services through 'left shift' with tangible improvements to patient outcomes

External Integration Programme

Feb – February 2025
Engagement with PCNA/PCNs

Mar – March 2025
Agree spectrum of integration opportunities and commence due diligence.



Apr – April 2025
Signed off Programme Plan with KPIs & associated resource for delivery

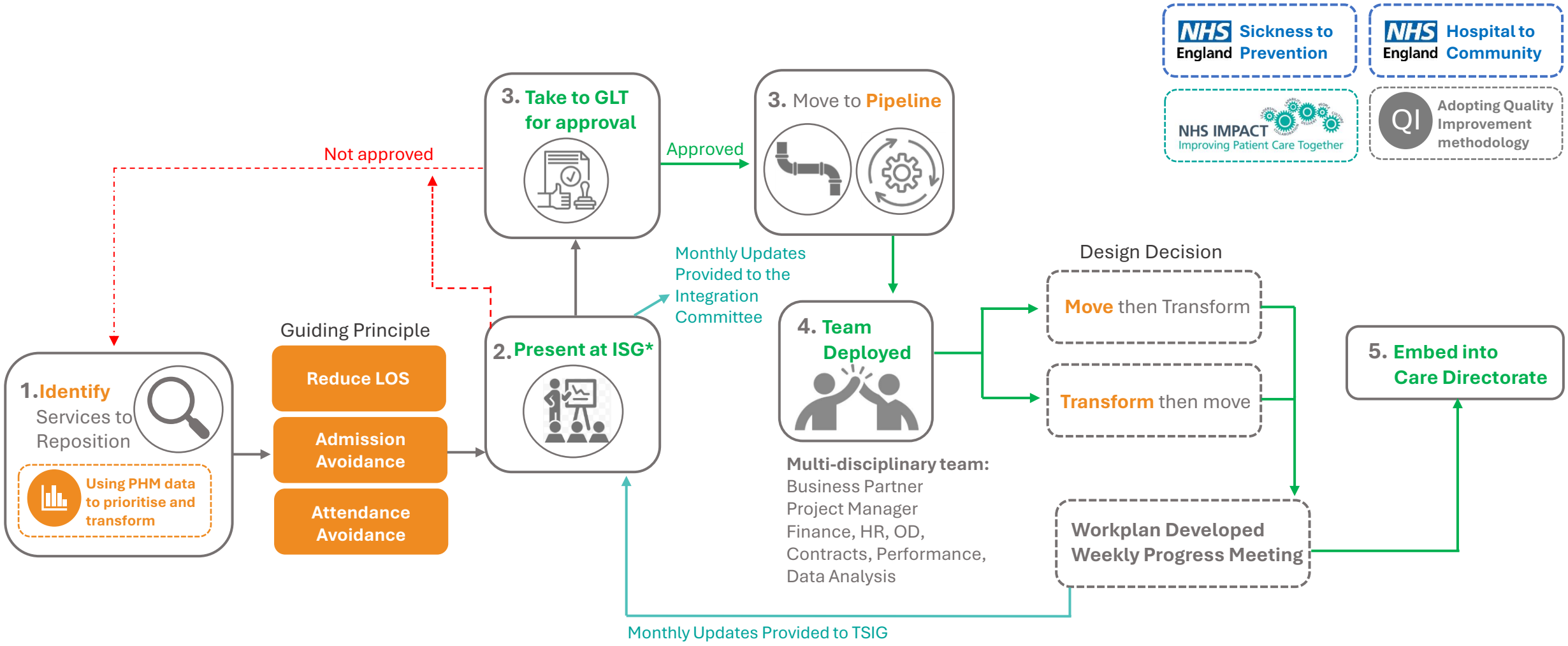
July

Oct – October 2025
Agreed Vehicle for Integration with GPs/PCNAs

Mar – End of March 2026
Successful integration of GPs/PCNA with the LCHG Alliance

July 2025 The Alliance Care Group will align with the LCHG accountability framework to enable delivery of operational services and monitoring of performance through appropriate KPIs

The LCHG Pipeline



* ISG – Improvement Steering Group **(TBC)**

Estates | Partnerships | Digital | Quality & Safety | Finance | People | Sustainability

Current Services in the Pipeline – February 2025

Currently in the Pipeline - Transactional

Reposition – Phase 1

Reposition to Alliance Care Directorate

Community Primary Partnerships
Vaccination response team (VRRT)
Tuberculosis Team
School Aged Imms
Heads of Integrated Partnerships
ARRS roles
Sexual Health

Community Diagnostic Centres
Endoscopy
Respiratory Physiology
Neurophysiology
Audiology
Radiology
Nuclear medicine
Radiation Protection & Radiation Physics
Screening Services
Clinical Engineering

Specialist Services
Dermatology
Rheumatology
Diabetes - Acute
Diabetes – Community

Health Records
Pharmacy

Reposition to Planned Care Directorate
- 2 wards from acute to community
- 1 additional ward for community patients, via productivity modelling

April 2025

Reposition – Phase 3

Reposition to Alliance Care Directorate

Therapies and Rehabilitation
Rehabilitation Medicine
Occupational therapy
Orthotics
Dietetics
Physiotherapy

Outpatients
Outpatient appointments
Services
Outpatient Nursing

Paediatrics
Community Paediatrics

Screening Services
Women's Health (where appropriate)

Sept 2025

NHS
Lincolnshire Community and Hospitals NHS Group

Integrated Performance Report (ULTH)

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

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*4th March 2025*
Item Number	*13*

Integrated Performance Report for January 2025 (ULTH)

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

Recommendations/ Decision Required

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

Key to note:
Quality

- *Medication incidents reported as causing harm has shown deteriorated performance in January at 19.6% against a trajectory of 10.70% compared to 10.9% in December.*
- *Duty of Candour for both verbal and written compliance in December has declined at 94%, compared to 100% in November.*

Performance

- *The year end target for 4 hour performance was established at 78%, with January set at 77.30%. The full UEC combined Type 1, Type 3 (both co-located and separate sites) achieved 73.47% in January.*
- *14.67% of patients (T1 only) exceeded 12 hour wait in department in ED.*
- *Average response time for Cat2 ambulance conveyances in January was approximately 46.49 minutes an increase of 6 minutes compared to December, against a 30 minute target.*
- *Long Waiters - at the end of January, the Trust reported 0 patients waiting longer than 104 weeks; 0 patients waiting over 78 weeks, the first time this has been achieved. 33 patients waiting over 65 weeks, which was better than forecast.*

- *Performance for DM01 in January showed a slight improvement to 67.62%. MRI performance remained strong with the most pressured diagnostics now being Dexa, NOUS and Audiology.*

- *28-day Faster Diagnosis Standard (FDS) in December achieved 79.70% which is a slight deterioration from last month, but is still above the 75% target.*

- *62-day classic treatment performance for December was 68.90%, an improvement from the November position of 66.40%, and is the best performance since pre-Covid.*

- *104+ day waiters increased to 90 as of 12th February compared to 85 as of 8th January, the highest risk specialities are Colorectal, Head & Neck and Prostate.*

- *2 week wait breast symptomatic performance significantly deteriorated in December to 29.00% compared to November position of 83.20%.*

Finance (is now reported for the Group)

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

- *Revenue position - The Group's YTD position is a £33.3m deficit, which is £24.7m adverse to the planned £8.7m YTD deficit. The Group are working with system partners on mitigation actions to improve the financial position.*

- *CIP position - The Group has delivered CIP savings of £34.9m, which is £1.2m adverse to planned CIP savings of £36.1m.*

- *Capital position - The Group has a £93.5m capital programme and the Group has YTD delivered capital expenditure of £58.3m, which is £2.7m lower than planned capital expenditure of £61.0m.*

- *Cash position - The Group's cash balance is £23.5m, which is £12.4m lower than the planned cash balance of £35.9m.*

Workforce

- *Mandatory training for January is 93.53% against a plan of 90%*
- *January sickness rate is 5.26% against Q4 target of 5.50%*
- *Staff AfC appraisals at 78.31% for January against Q4 target 90.00%*
- *Staff turnover at 9.34% for January against Q4 target of 9.00%*
- *Vacancies at 6.10% for January against Q4 target of 4.50%*

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

How the report supports the delivery of the priorities within the LCHG Board Assurance Framework	
1a Deliver high quality care which is safe, responsive and able to meet the needs of the population	X
1b Improve patient experience	X
1c Improve clinical outcomes	X
1d Deliver clinically led integrated services	
2a Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	
2b To be the employer of choice	
3a Deliver financially sustainable healthcare, making the best use of resources	X
3b Drive better decision and impactful action through insight	
3c A modern, clean and fit for purpose environment across the Group	X
3d Reduce waits for patients who require urgent and emergency care and diagnostics and ensure we meet all constitutional standards	X
3e Reducing unwarranted variation in cancer service delivery and ensure we meet all constitutional standards (ULTH)	X
3f Reducing unwarranted variation in planned service delivery and ensure we meet all constitutional standards (ULTH)	X
3g Reducing unwarranted variation in community service delivery and ensure we meet all constitutional standards (LCHS)	X
4a Establish collaborative models of care with all our partners including Primary Care Network Alliance (PCNA), GPs, health and social care and voluntary sector	
4b Successful delivery of the Acute Services Review	
4c Grow our research and innovation through education, learning and training	
4d Enhanced data and digital capability	

5a Develop a Population Health Management (PHM) and Health Inequalities (HI) approach for our Core20PLUS5 with our ICS	
5b Co-create a personalised care approach to integrate services for our population that are accessible and responsive	
5c Tackle system priorities and service transformation in partnership with our population and communities	
5d Transform key clinical pathways across the group resulting in improved clinical outcomes	

Executive Summary

Quality

Falls

There has been 1 fall resulting in moderate harm and 3 falls resulting in severe harm, which is an increase from the previous month. All incidents are under validation to ensure the correct level of review is undertaken. Falls Prevention Steering Group (FPSG) provides oversight and assurance of actions being taken to improve in areas reporting increased numbers of incidents. There are weekly/monthly divisional meetings to establish themes and shared learning from falls to improve practice.

Pressure Ulcers

There have been 39 category 2 and 6 category 3 pressure ulcers in January, an increase from the previous month. Skin Integrity Group (SIG) provides oversight and receives Divisional performance reports, which provide assurance of the improvement actions being taken in areas reporting increased number of incidents. Quality Matron and Tissue Viability team provide support to areas with increased number of incidents.

Medications

Medication incidents reported as causing harm has increased to 19.60% against a trajectory of 10.7%. The majority of incidents are at the point of prescribing and administration of medication and the main error is omitting medicines. Improving medication incidents from omitted medicines is a work stream as part of the new Patient Safety Incident Response Framework (PSIRF) with action planning underway following the completion of the review.

Patient safety Alerts

There were 2 Safety Alerts with a deadline for completion in January, however, neither were completed within the timeframe. Monthly Safety Alerts exception report is now discussed at Patient Safety Group. CAS/FSN Alerts Oversight Group has been implemented which convenes monthly to discuss issues which may arise and prevent the Trust meeting the deadlines and to put plans in place to mitigate.

SHMI

The Trust SHMI has decreased slightly to 107.25 for January but remains within expected limits. Any diagnosis group alerting is subject to a case note review. HSMR is at 98.41 (as expected).

eDD Compliance

eDD Performance continues to be below the 95% target, currently at 90.7%. A dashboard is in place to highlight compliance at both ward and consultant level with each Division now reviewing this metric within their Divisions.

Sepsis compliance – based on December data

The **screening compliance for inpatient child** decreased to 78.6% (target 90%). 48 children out of 61 that had PEWS of 5 or above were screened for sepsis within 60 minutes. No Harm was found in the harm reviews completed as the children had a viral illness or non-infective cause for illness / raised PEWS.

IVAB ED Children – The administration of IVAB for children in ED decreased to 68% (target 90%). 17 children out of 25 were treated with IV antibiotics within the 60 minute timeframe. Harm reviews were completed for all children with delayed treatment and no harm was found.

IVAB Inpatient Children – The administration of IVAB for inpatients remains at 100%.

VTE

There is no VTE data published as there is ongoing work with the VTE Specialist Nurse and Information Services to ensure the VTE data is accurately reflected due to the data being extricated from multiple systems.

Duty of Candour (DoC) – December Data

DoC compliance in December for verbal and written was 94%. Dedicated members of the Incident Team have been aligned to Divisions to improve compliance.

Operational Performance

This report evaluates the performance metrics observed during the month of January 2025.

In January, there was a notable increase in attendance across the Urgent and Emergency Care (UEC) pathways, reflecting a 7.38% rise compared to the average attendance recorded during January for the years 2022, 2023, and 2024. Furthermore, an upward trend in patient acuity was observed, with 16% of patients scoring 4 or higher on the National Early Warning Score (NEWS) during their initial assessments.

The paediatrics department reported significant seasonal variation, with attendance in the emergency department (ED) rising by 11.23% in comparison to the average attendance for January across the years 2022, 2023, and 2024, which corresponds to an increase of 158 patients. Seasonal infections continue to exert pressure on our services. By the conclusion of January, the Trust had documented 22 PCR confirmed inpatients with positive COVID-19 test results, which represents a decrease of 49 cases compared to the previous year.

Throughout the month, a total of 1,148 flu tests were administered, indicating a 186% increase relative to January 2024. Of these tests, 237 yielded positive results, resulting in a positivity rate of 21%. In comparison, among the 1,101 patients tested for respiratory syncytial virus (RSV), 56 were found to be positive, leading to a positivity rate of 5%. Additionally, the month of January witnessed a 144.67% increase in the number of RSV tests conducted in comparison to the previous year.

A & E and Ambulance Performance

The annual performance target for the 4-hour wait time has been established at 78%, with monthly progress assessments conducted. In January 2025, the trust recorded a performance rate of 73.47%, signifying a 2.06% improvement compared to December 2024 and a 3.66% increase to January 2024.
The (SPC) chart included in the report delineates the performance targets for the 2023/24 and 2024/25 fiscal years, focusing on Type 1 and Type 3 activities.
It is important to note that there has been a change in the reporting of metrics related to Type 1 and Type 3 activities at the Lincoln and Pilgrim Hospital sites. The following information is based on these updated principles and has been applied retrospectively to ensure fair comparisons in the narrative.

Significant improvements have been observed in Type 1 performance, with the Lincoln Emergency Department demonstrating an increase from 55.48% to 60.95%. Similarly, the Pilgrim Emergency Department experienced a rise from 57.58% to 57.97%. Overall, Type 1 performance achieved an increase of 3.28%, culminating in a final performance rate of 59.65%.

In response to the ongoing challenges faced within the Urgent and Emergency Care (UEC) pathways, the Emergency Department has prioritized efforts to reduce the duration of patient stays within the department. Unfortunately, 14.67% of patients exceeded the 12-hour

benchmark (Type 1 only); this figure indicates a 2.44% decrease compared to December 2024, equating to an additional 180 patients surpassing this threshold.

In January, the average mean response time for Category 2 cases was approximately 46.49 minutes, reflecting a decrease of 6 minutes compared to December 2024 and remaining above the targeted 30 minutes. It is noteworthy that the overall mean response time for Category 2 cases includes instances in which patients did not attend (ULTH), despite their postcodes falling within the designated catchment area. The Statistical Process Control (SPC) chart included in the report illustrates the frequency of patient handovers exceeding 59 minutes; however, it does not provide data regarding the number of presentations during the same period or the acuity of patients upon arrival. Notably, more than 23% of patients recorded a score of 4 or higher on the National Early Warning Score (NEWS) at the initial observations documented on the (WEBV) system. Specifically, 28% of paediatric patients arriving via the East Midlands Ambulance Service (EMAS) scored 4 or greater, while the percentage for adult patients was 22.83%.

Fractured Neck of Femur 48hr Pathway (#NOF)
After a significant improvement in October 23 #NOFs going to theatre within 48 hours has continued to perform well. After a significant drop in performance to 40.45% in November driven by increased and sustained UEC pressures and demand, performance improved in December. January saw a slight reduction in performance to 58.76%. This has largely been driven by increased Trauma demand and reduced theatre staffing.

Length of Stay
In January, the Non-Elective Length of Stay experienced a reduction of 0.07 days compared to December 2024, with the current performance level recorded at 4.59 days, which surpasses the maximum threshold by 0.09 days. The average bed occupancy rate, with respect to "Core General and Administrative," stood at 95.05%. To maintain safe and efficient operational flow within acute care settings, an average of 22 escalation beds or boarding spaces has been allocated, resulting in an occupancy to escalation ratio of 93.14%, which does not comply with the national standard of less than 92%. Additionally, approximately 44 beds have been earmarked for elective patient flow at Grantham. Excluding this facility from the metrics indicates that the core occupancy would result in 97.42%, while the core plus escalation occupancy would yield 95.43%.
In September 2024, System Partners initiated the “Discharge Sprint” and the “System Sprint” to address the challenges associated with providing timely assistance for discharges from the acute care setting for Pathways 0, 1, 2, and 3. These efforts will persist through November, while a monthly program of MADE will continue throughout the remainder of 2024 and extend into 2025.

The identification of timely support to facilitate discharges from the acute care setting for pathways 1 to 3 continues to present substantial challenges for System Partners. Furthermore, the Trust has reinstated the involvement of SAFER practitioners to enhance education and improve compliance related to the recording and monitoring of the percentage of discharges occurring within 24 hours of the predicted

discharge date (PDD). January's performance metrics reveal a decline in results, which stand at 38.65%. This marks a drop from September's notable achievement of 41.30%, highlighting a shift in performance over the past few months

Referral to Treatment
December performance showed a third consecutive month of improvement, reporting a performance of 53.32%. The Trust continues to report patients waiting over 104, 78, 65 & 52 weeks. At the end of December, the Trust reported zero patients waiting longer than 104 weeks. The trust exited December with 0 patient waiting more than 78 weeks, the first time this has been achieved. The trust exited December with 33 patients waiting over 65 weeks which was better than forecast and ULTH is 1 of 2 trusts in the region that performed better than trajectory.

The trust was an early adopter of the Further Faster programme which is a national initiative to reduce patients waiting over 52 weeks. In December the Trust reported 1,543 patients waiting over 52 weeks which demonstrates a fourth consecutive month of improvement.

Waiting Lists
Nationally, we are seeing increased focus on total waiting list size. Whilst the trust has made huge improvements in reducing long waiting patients, total waiting list size has remained relatively static at 72-75k since November 2022. December saw another reduction in waiting list size, dropping to 70,628

As of 2^{9th} January 2025, ASI sat at 980. Whilst this is higher than the agreed trajectory of 550, the number fluctuates week on week and is a significant improvement overall. Additional resource has been directed to resolving missing outcomes which is having a positive effect on the bookings team being able to move the ASIs to open referrals.

DM01
The report for DM01 in January showed a slight improvement, increasing from 65.66% in December to 67.62%. MRI performance remained strong with the most pressured diagnostics now being Dexa, NOUS and Audiology with Nous being the main contributor to the reduction in performance.

Cancelled Ops
January outturn for cancelled operations on the day Improved from 1.95% in December to 1.58%. Lack of time and lack of theatre staff were again the main reasons for cancellations, but January continued to see on the day cancellations due to bed pressure. This is a reflection of the demand on UEC that has been seen nationally
28-day Faster Diagnosis Standard (FDS) for December sat at 79.7% This is a slight deterioration but is still above the 75% target.

Included in the 1.58% of on the day cancellations, 35 patients were not treated within the 28-day standard. Despite the reduction in cancellations, the 35 is a deterioration and continues to be driven by the pressure to date long waiters and Cancer patients.

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

Cancer

31 day performance for December improved to 93.1%

62-day classic performance for December improved to 71.8% and is the best performance since pre-Covid

104+ day waiters decreased to 73 at the end of December compared to 85 at the end of November. The highest risk specialities are colorectal, head & Neck and prostate. The divisions are working hard to resolve but are facing challenges from a high number of complex and disengaged patients.

Workforce

Mandatory Training – Our January 2025 Core Learning Rate is 93.53% against a Target of 90.00%. This is a slight decrease in compliance when compared to last month, although we are exceeding our overall target. Compliance will continue to be monitored in line with our 2024/25 target to ensure that we remain in line with our overall trajectory.

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

Work continues to ensure that all areas and individuals are given the time to complete core learning modules, with focussed support being offered to those with low compliance (50% and less).

Sickness Absence – Our January 2025 Sickness Rate is 5.26% against a Q4 Target of 5.50%. This is within trajectory and has met the end of year target. December 2024 saw an increase in short term absences related to Cold & Flu, which has continued into January 2025.

Sickness absence rates have remained stable so far within 2024/25. We are continuing to work towards further reducing our vacancy level and are hopeful this continued improvement will impact positively on our colleague's health and wellbeing throughout 2024/25.

There is a continued focus on supporting managers and leaders in absence processes and supporting our people to attend the work environment will be delivered through the mandated 'People Management Essentials' training.

Staff Appraisals – Our January 2025 appraisal rate is measured against a Q4 Target of 90.00%, and in month we have achieved a Trust wide position of 80.04%. This is a slight decrease when compared to the previous month and remains just outside of target. It is the Agenda for Change appraisals which require the focus in order to ensure that the year-end target is able to be achieved by 31 March 2025.

Work continues to educate leaders on the process required to update ESR, including the use of 'how to' guides/sessions and utilising reporting to identify areas of low completion. Our Education, Learning & OD Team are developing an approach which will support specific teams where compliance rates are less than 50% in the same way we did with Core Learning. It is expected that this will see further improvements.

Staff Turnover – Our January 2025 Turnover Rate is 9.34% against a Q4 Target of 9.00%. This is within trajectory and 0.34% from meeting the end of year target.

Operational pressures, staffing and culture are continued challenges. With the introduction of the Equality, Diversity & Inclusion Group, Culture & Leadership Group, Education Oversight Group, and the refresh of the Workforce Strategy Group across Lincolnshire Community Hospitals Group (LCHG) there are additional platforms where retention of staff can be considered through various workforce lenses.

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

Vacancies – Our January 2025 Vacancy Rate is 6.10% against a Q4 Target of 4.50%. This is within trajectory and within 2% of meeting the end of year target.

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

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

Finance

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

Revenue position - The Group's YTD position is a £33.3m deficit, which is £24.7m adverse to the planned £8.7m YTD deficit. The Group are working with system partners on mitigation actions to improve the financial position.

CIP position - The Group has delivered CIP savings of £34.9m, which is £1.2m adverse to planned CIP savings of £36.1m.

Capital position - The Group has a £93.5m capital programme and the Group has YTD delivered capital expenditure of £58.3m, which is £2.7m lower than planned capital expenditure of £61.0m.

Cash position - The Group's cash balance is £23.5m, which is £12.4m lower than the planned cash balance of £35.9m.

	Group performance			LCHS performance			ULTH performance		
Month 10 Position	Year To Date			Year To Date			Year To Date		
	Plan £m	Actual £m	Var. £m	Plan £m	Actual £m	Var. £m	Plan £m	Actual £m	Var. £m
Surplus / (Deficit)	(8.7)	(33.3)	(24.7)	(0.5)	(0.3)	0.2	(8.1)	(33.0)	(24.9)
CIP Delivery	36.1	34.9	(1.2)	5.4	6.1	0.7	30.7	28.8	(1.9)
Capital Spend	61.0	58.3	2.7	2.6	4.2	(1.6)	58.4	54.1	4.3
Agency Spend	(16.0)	(21.1)	(5.1)	(2.2)	(1.4)	0.8	(13.7)	(19.6)	(5.9)
Cash Balance	35.9	23.5	(12.4)	25.0	9.0	(16.0)	10.9	14.5	3.6

Daren Fradgley
Group Chief Integration Officer
February 2024

Key to Variation and Assurance Icons and SPC Dots

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

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

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

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

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

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

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

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

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

OUTSTANDING CARE personally DELIVERED

Performance Overview - Quality

NHS United Lincolnshire Teaching Hospitals NHS Trust

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Nov-24	Dec-24	Jan-25	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Clostridioides difficile position	Safe	Patients	Director of Nursing	9	11	8	11	84	?	
	MRSA bacteraemia	Safe	Patients	Director of Nursing	0	0	1	0	2	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	0.03	0.01	0.01	0.01		
	E. coli bacteraemia cases counts and 12-month rolling rates, by reporting acute trust and month using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.04	0.04	0.02	0.04		
	Catheter Associated Urinary Tract Infection	Safe	Patients	Director of Nursing	1	Data Not Available	Data Not Available	Data Not Available			
	Falls per 1000 bed days resulting in moderate, severe harm & death	Safe	Patients	Director of Nursing	0.19	0.09	0.08	0.11	0.13	P	
	Pressure Ulcers category 3	Safe	Patients	Director of Nursing	4.3	1	5	6	42	?	
	Pressure Ulcers category 4	Safe	Patients	Director of Nursing	1.3	0	1	0	4	P	
	Venous Thromboembolism (VTE) Risk Assessment	Safe	Patients	Medical Director	95.00%	96.61%	Data Not Available	Data Not Available	95.78%	P	H
	Never Events	Safe	Patients	Director of Nursing	0	0	0	0	2	P	
	Reported medication incidents per 1000 occupied bed days	Safe	Patients	Medical Director	4.30	3.81	4.35	5.07	4.70	P	

OUTSTANDING CARE personally DELIVERED

Performance Overview - Quality

NHS United Lincolnshire Teaching Hospitals NHS Trust

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Nov-24	Dec-24	Jan-25	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Medication incidents reported as causing harm (low /moderate /severe / death)	Safe	Patients	Medical Director	10.70%	17.60%	10.90%	19.60%	13.73%	F	
	Patient Safety Alerts responded to by agreed deadline	Safe	Patients	Medical Director	100.00%	0.00%	None due	0.00%	38.88%	F	
	Hospital Standardised Mortality Ratio - HSMR (basket of 56 diagnosis groups) (rolling year data 3 month time lag)	Effective	Patients	Medical Director	100	95.75	96.92	98.41	N/A		
	Summary Hospital Mortality Indicator (SHMI) (rolling year data 5 month time lag)	Effective	Patients	Medical Director	100	106.09	107.95	107.29	N/A		
	The Trust participates in all relevant National clinical audits	Effective	Patients	Medical Director	100.00%	100.00%	100.00%	100.00%	100.00%	P	H
	eDD issued within 24 hours	Effective	Patients	Medical Director	95.00%	90.40%	90.50%	90.70%	90.87%	F	
	Sepsis screening (bundle) compliance for inpatients (adult)	Safe	Patients	Director of Nursing	90.00%	94.08%	91.38%	Data Not Available	92.29%	P	
	Sepsis screening (bundle) compliance for inpatients (child)	Safe	Patients	Director of Nursing	90.00%	88.09%	78.60%	Data Not Available	80.29%	F	
	IVAB within 1 hour for sepsis for inpatients (adult)	Safe	Patients	Director of Nursing	90.00%	95.23%	98.93%	Data Not Available	96.68%	P	
	IVAB within 1 hour for sepsis for inpatients (child)	Safe	Patients	Director of Nursing	90.00%	100.00%	100.00%	Data Not Available	83.46%	P	
	Sepsis screening (bundle) compliance in A&E (adult)	Safe	Patients	Director of Nursing	90.00%	92.00%	95.24%	Data Not Available	92.48%	P	

OUTSTANDING CARE personally DELIVERED

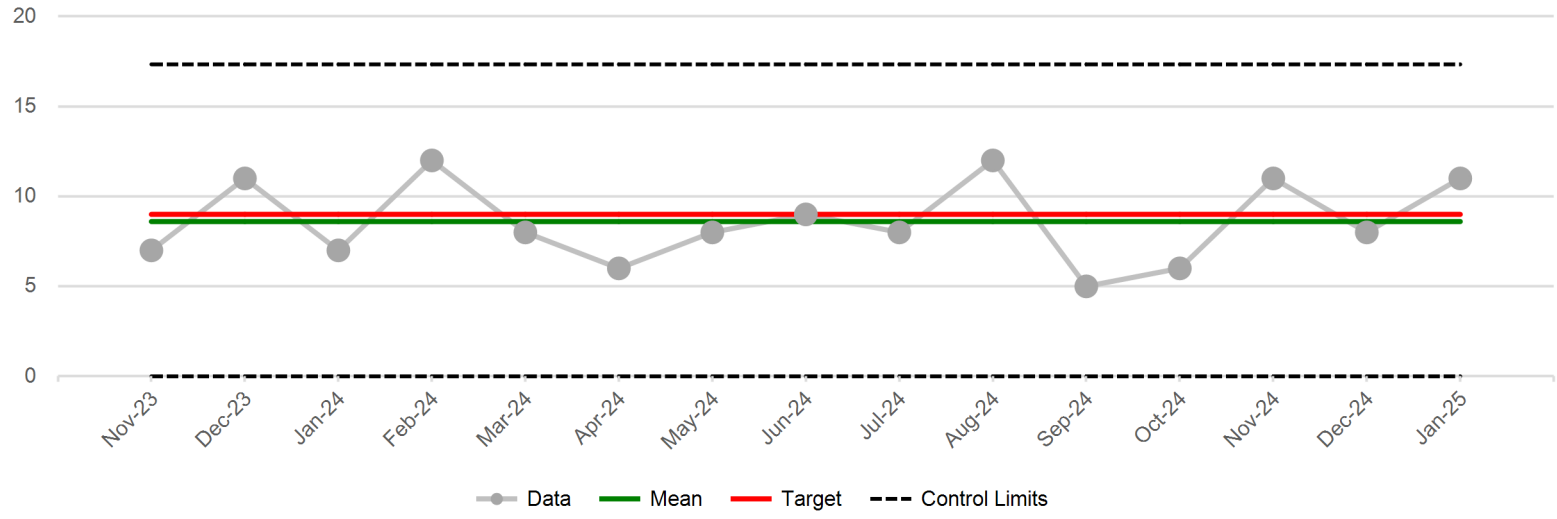
Performance Overview - Quality

NHS United Lincolnshire Teaching Hospitals NHS Trust

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Nov-24	Dec-24	Jan-25	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Sepsis screening (bundle) compliance in A&E (child)	Safe	Patients	Director of Nursing	90.00%	93.70%	91.20%	Data Not Available	92.99%	P	
	IVAB within 1 hour for sepsis in A&E (adult)	Safe	Patients	Director of Nursing	90.00%	93.26%	94.01%	Data Not Available	94.69%	P	
	IVAB within 1 hour for sepsis in A&E (child)	Safe	Patients	Director of Nursing	90.00%	75.00%	68.00%	Data Not Available	72.87%	F	
	Rate of stillbirth per 1000 births	Safe	Patients	Director of Nursing	3.80	2.93	3.15	3.16	2.75	P	
Improve Patient Experience	Mixed Sex Accommodation breaches	Caring	Patients	Director of Nursing	0	Submission Suspended	Submission Suspended	Submission Suspended			
	Duty of Candour compliance - Verbal	Safe	Patients	Medical Director	100.00%	100.00%	94.00%	Data Not Available	93.56%	F	
	Duty of Candour compliance - Written	Responsive	Patients	Medical Director	100.00%	100.00%	94.00%	Data Not Available	90.89%	F	

Performance Overview - Quality

Clostridioides difficile position



Jan-25
11
Variance Type
Common cause variation
Target
9
Achievement
Variation indicates inconsistently passing and falling short of the target
Executive Lead
Director of Nursing

Background:
Clostridioides difficile position.

What the chart tells us:
There has been an increase in cases and this is the picture nationally.

Issues:
More sicker and complex patients and relapses of the disease.
Sporadic patients rather than outbreaks.

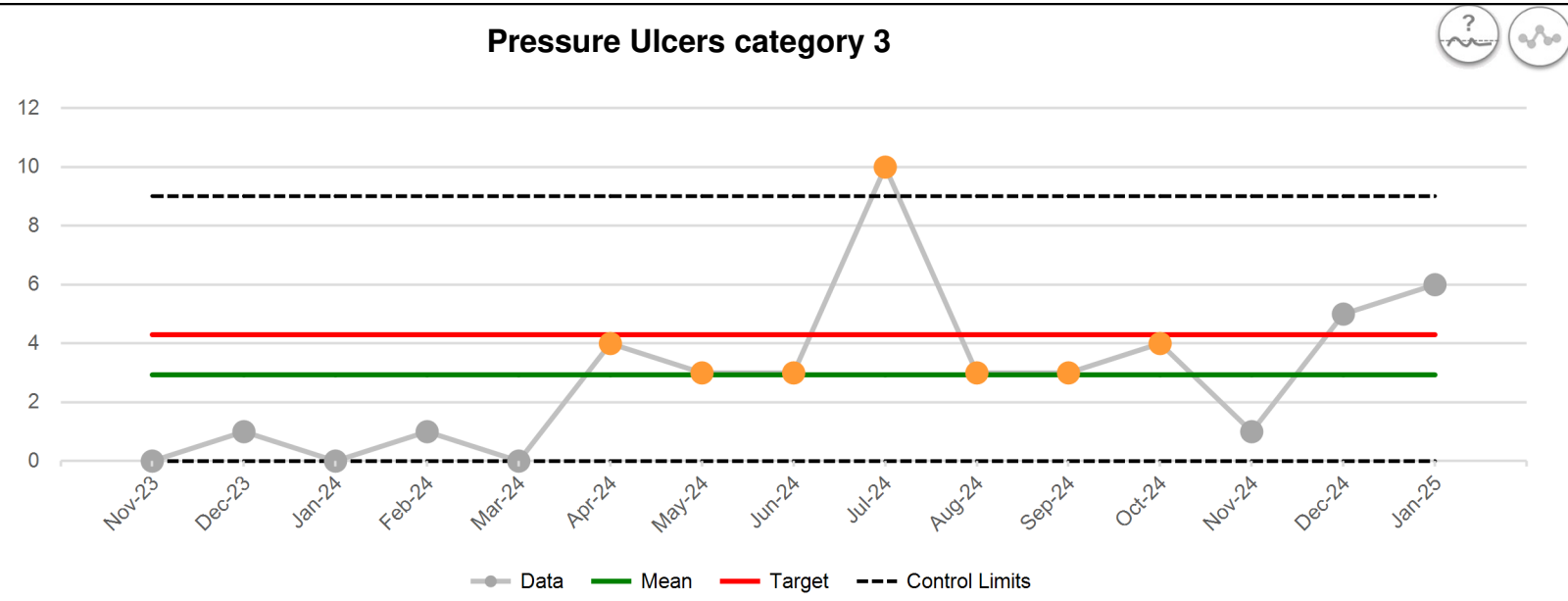
Actions:
Weekly CDI wardrounds with Consultant Microbiologist and review of patients.

Mitigations:
Prompt isolation of patients with diarrhoea and cleaning with Tistel Fuse to destroy the spores.

OUTSTANDING CARE personally DELIVERED

Performance Overview - Quality

NHS United Lincolnshire Teaching Hospitals NHS Trust



Jan-25
6
Variance Type
Common cause variation
Target
4.3
Achievement
Variation indicates inconsistently passing and falling short of the target
Executive Lead
Director of Nursing

Background:
Category 3
Pressure Ulcers

What the chart tells us:
The Trust recorded 6 Category 3 incidents against a target of 4.3 per month.

Issues:
The number of Category 3 incidents in January have increased by 1 from December 2024. All the Category 3 incidents this month would have previously been classified as unstageable.

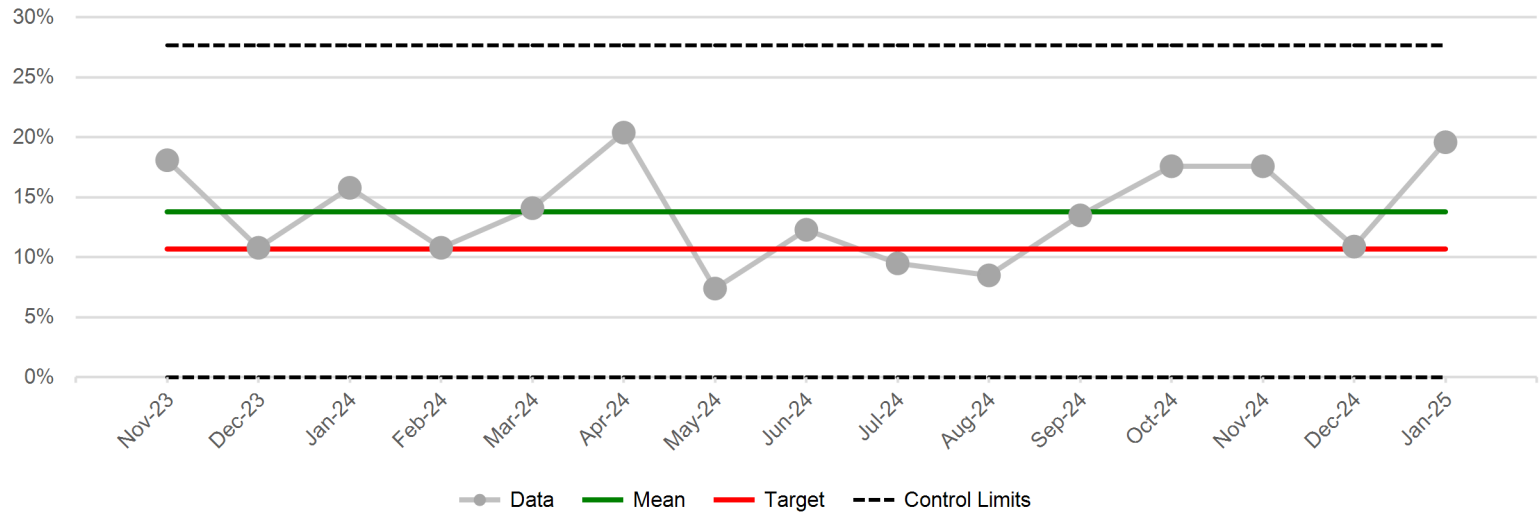
Themes identified as continued areas for improvement are:
• Ensuring clinical teams assess all patients pressure areas including those under devices or dressings

Actions:
All Category 3 incidents will be reviewed at the weekly Pressure Ulcer Support and Supervision Panel meeting.
The Tissue Viability and Quality Matron Team undertake a detailed review of these incidents to identify any additional learning.
Utilise Tissue Viability Matters Information and Learning (TVMIL) educational forums to improve staff knowledge regarding the potential risks associated with medical devices and what to observe for.
Embed the requirement to follow patient's specialist management plans put in place to prevent skin deterioration and seek advice where needed.

Mitigations:
Quality Matron and Tissue Viability team provide support to areas with increased number of incidents.

Performance Overview - Quality

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



Jan-25
19.60%
Variance Type
Common cause variation
Target
10.70%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Medical Director

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

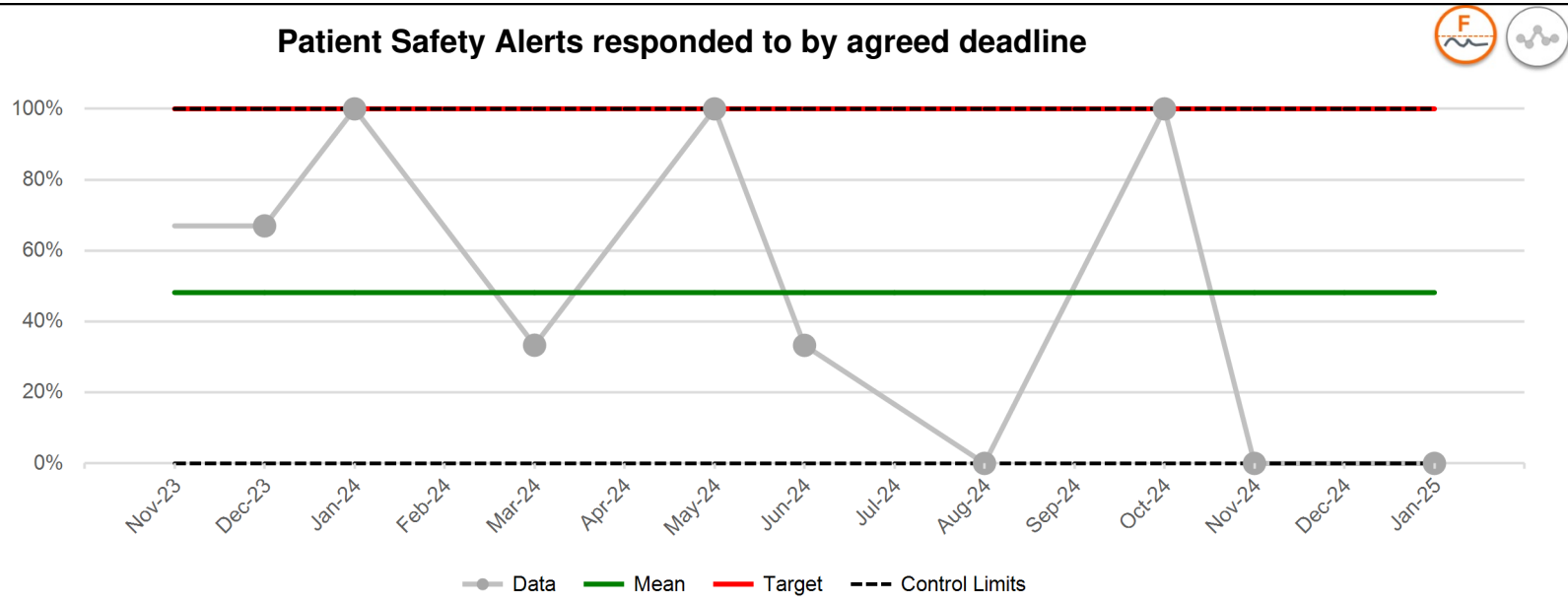
What the chart tells us:
In the month of January the number of medication incidents reported was 183. This equates to 5.07 incidents per 1000 bed days. The number of incidents causing some level of harm (low /moderate /severe / death) is 19.6% which is above the national average of 11%.

Issues:
The majority of incidents are at the point of prescribing and administration of medication and the main errors are omitting medicines and incorrect dose prescribed.

Actions:
Improving medication incidents from omitted medicines is a work stream as part of the Patient Safety Incident Response Framework (PSIRF). Additionally medication incidents are escalated through medicines quality group. Pharmacy support is offered to areas where it has been identified through the data that there may be need for additional training or support.

Mitigations:

Performance Overview - Quality



Jan-25
0.00%
Variance Type
Common cause variation
Target
100.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Medical Director

Background:
Patient safety alerts responded to by agreed deadline.

What the chart tells us:
There were 2 Safety Alerts with a deadline for completion in January, neither were completed within timeframe. Deviances continue to be seen in compliance.

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

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

Patient Safety Alerts are recorded on the DatixIQ Alerts module, compliance is monitored on dashboards by Risk & Datix Team and Leads with overall responsibility for the alerts and escalated where appropriate.

CAS/FSN Alerts Oversight Group meetings held monthly – outstanding actions monitored and escalation when appropriate. Meetings held with appropriate Leads when new Alerts received to ensure actions are assigned to relevant Trust leads and are completed within deadlines.

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

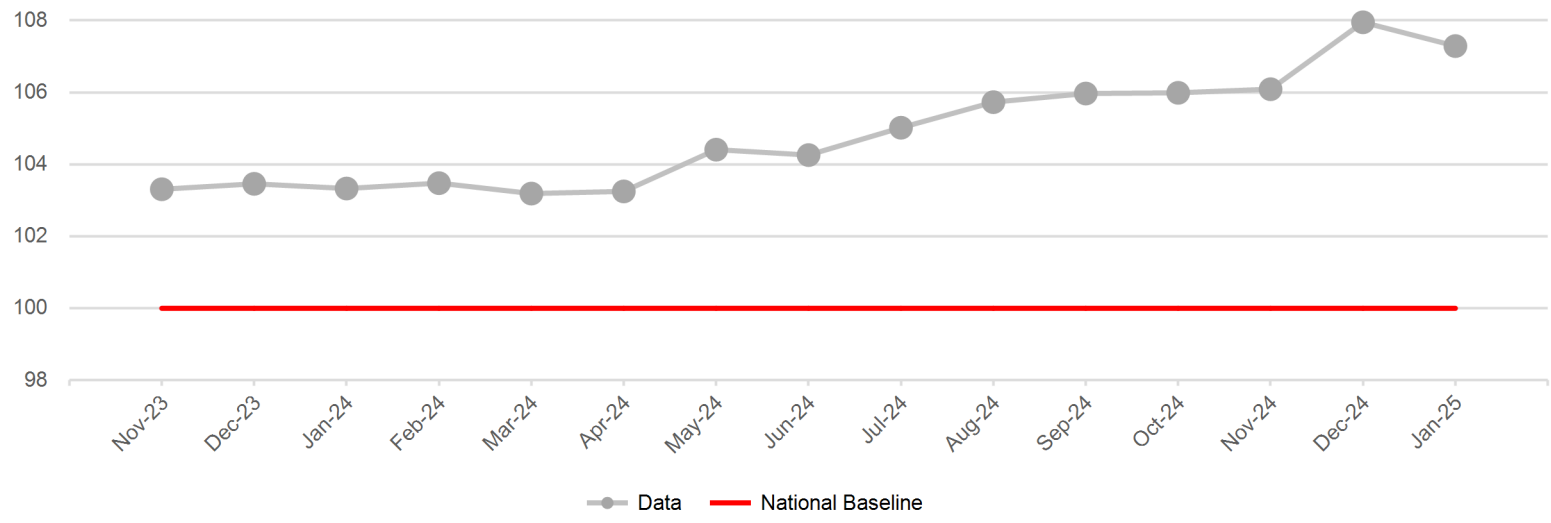
A CAS/FSN Alerts Oversight Group convenes monthly to discuss issues which may arise and prevent the Trust meeting the deadlines and to put plans in place to mitigate.

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

Performance Overview - Quality

United Lincolnshire Teaching Hospitals NHS Trust

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



Jan-25
107.29
Variance Type
Target
To remain in 'as expected' range
Achievement
Executive Lead
Medical Director

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

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

Issues:
The data includes deaths within 30 days. Legislation came into effect from 9 September 2024 for all deaths in Lincolnshire to be reviewed by an ME.

The SHMI methodology has currently changed and the data is being reviewed to understand the impact of these changes.

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

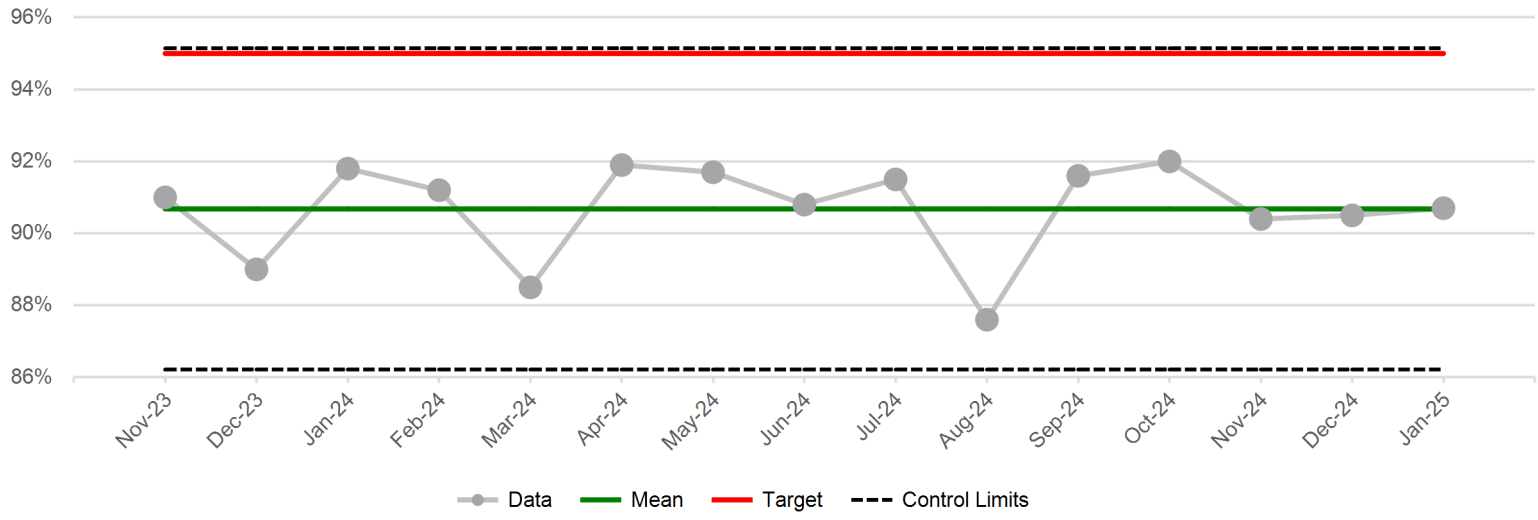
Mortality reviews are discussed at either Speciality Governance or M&Ms to aid learning.

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

HSMR is 98.41

Performance Overview - Quality

eDD issued within 24 hours



Jan-25
90.70%
Variance Type
Common cause variation
Target
95.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Medical Director

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

What the chart tells us:
eDD Performance continues to be below the 95% target, currently at 90.70%.

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

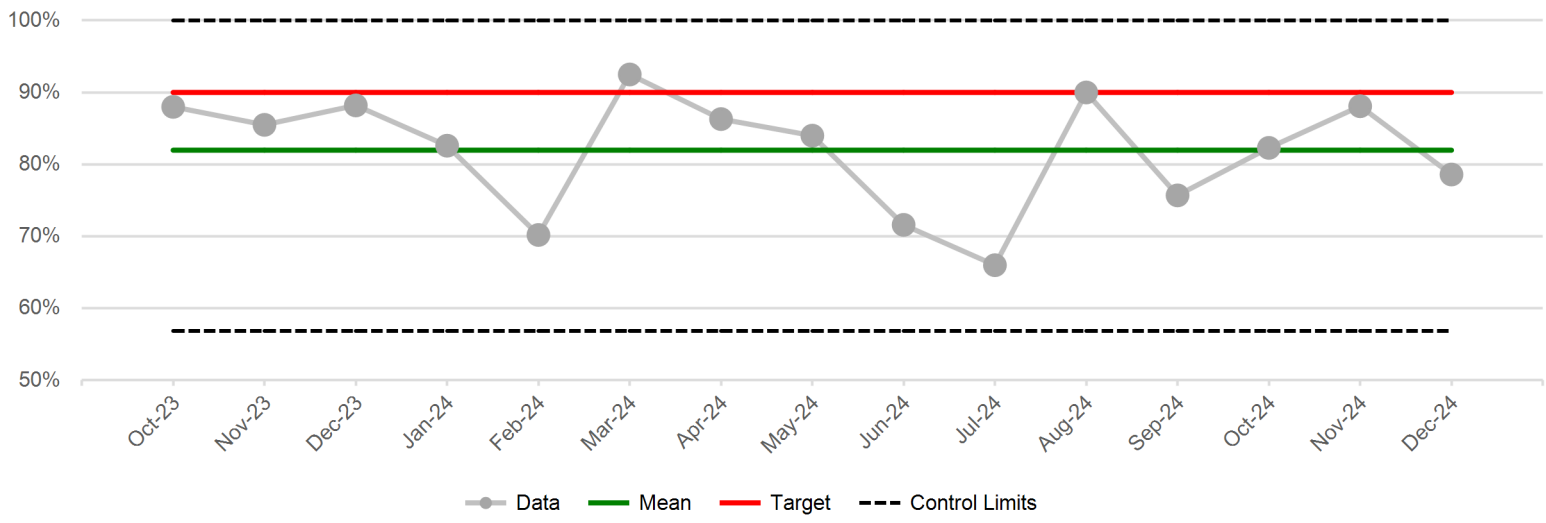
No Narrative owner

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

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

Performance Overview - Quality

Sepsis screening (bundle) compliance for inpatients (child)



Dec-24
78.60%
Variance Type
Common cause variation
Target
90.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of Nursing

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

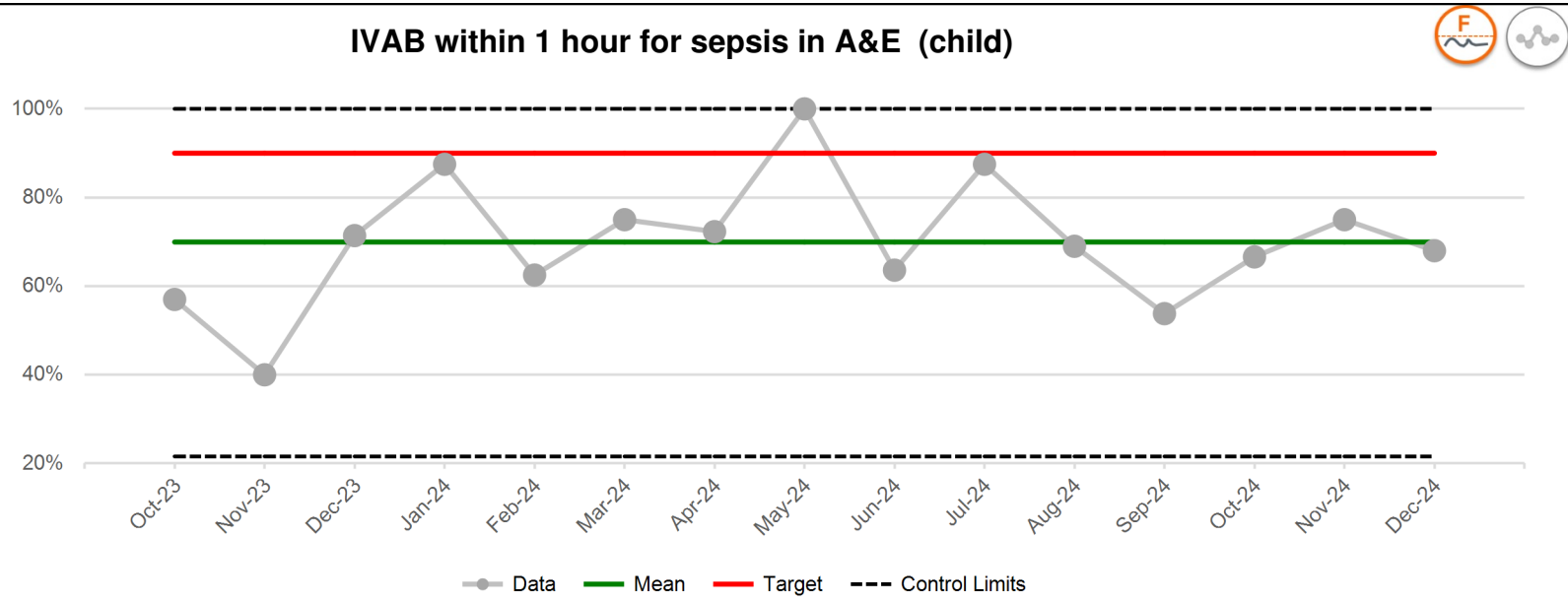
What the chart tells us:
The Sepsis screening compliance this month was 78.60%, which is below the 90% target. 48 of 61 patients were screened within the 60-minute timeframe.

Issues:
There were 13 patients this month with delayed sepsis screening. Themes were mainly that screens were being added to the system when patient scored but they were not being completed.
- Observations taken by students are not being escalated to or dealt with by supervisors in a timely manner.
- One screen was completed at 80 minutes – non-infective screen.

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

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

Performance Overview - Quality



Dec-24
68.00%
Variance Type
Common cause variation
Target
90.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of Nursing

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

What the chart tells us:
The compliance for administration of IVAB within one hour was 68.00%, which is well below the 90% standard. 17 out of 25 patients received their antibiotics within a timely manner.

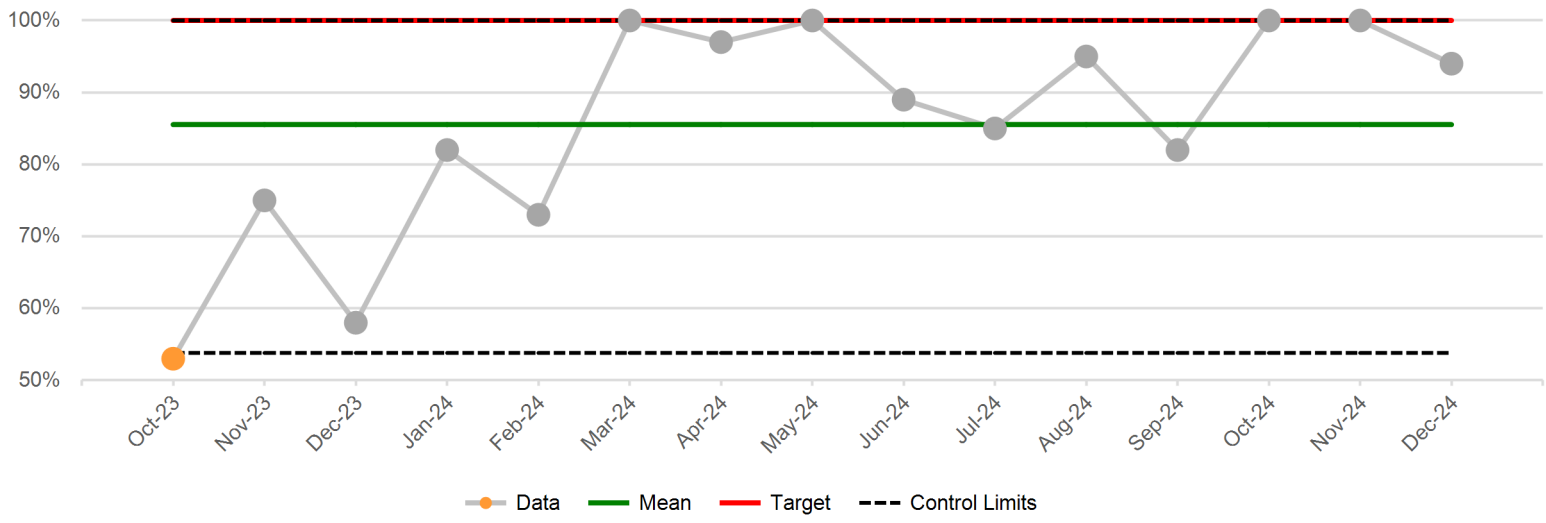
Issues:
There were 8 patients this month with delayed Sepsis treatment. All 8 patients were on one site.
Themes for delays were found to be:
- 1 autistic child difficult to examine and cannulate, 1 child difficult to cannulate.
- 3 x long delays between prescribing and administering – reason not documented.
-Difficulty obtaining IV access
- 2 x delay in decision as waiting for paediatric review
- 1 cannula tissued and had to be resited

Actions:
Themes escalated to ED manager, Sepsis link nurses and Consultant. Paediatric teams are planning some joint training with ED team.
Staff are reviewing notes.
There has been a lack of engagement from ED staff at compliance focus group meetings. Thus has been escalated

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

Performance Overview - Quality

Duty of Candour compliance - Verbal



Dec-24
94.00%
Variance Type
Common cause variation
Target
100.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Medical Director

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

What the chart tells us:
Compliance remains consistently high.

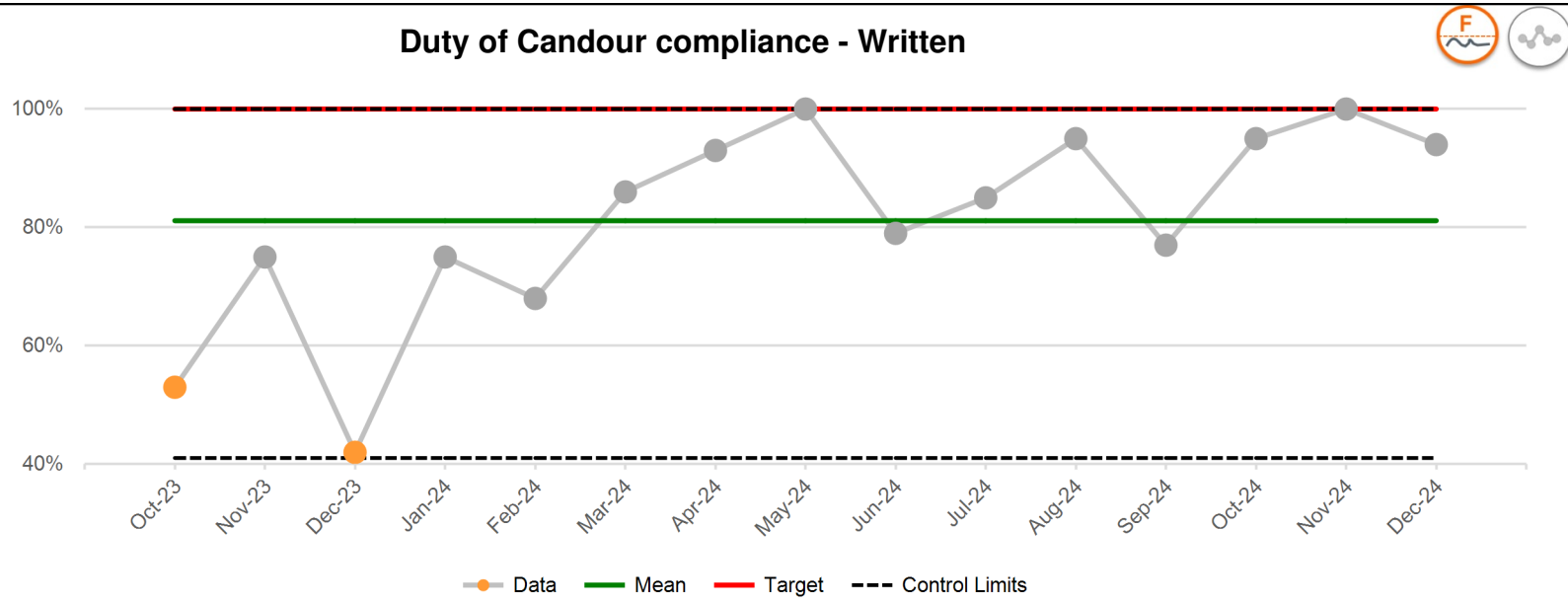
Issues:
From March 2024, a new parameter in DatixIQ has been used to monitor Duty of Candour compliance to ensure accuracy of data. This enables the incident team to ensure the grading of harm is accurate to enable the Duty of Candour regulation to be triggered.

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

Weekly tracking in progress by the incident team.

Mitigations:
Dedicated members of the incident team have been aligned to divisions which has improved compliance.

Performance Overview - Quality



Dec-24
94.00%
Variance Type
Common cause variation
Target
100.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Medical Director

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

What the chart tells us:
Compliance remains consistently high.

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

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

Weekly tracking in progress by the incident team.

Mitigations:
Dedicated members of the incident team have been aligned to divisions which has improved compliance.

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Teaching Hospitals NHS Trust

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Nov-24	Dec-24	Jan-25	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Patient Experience	% Triage Data Not Recorded	Effective	Patients	Chief Operating Officer	0.00%	0.30%	0.36%	0.38%	0.29%	0.00%	F	
Improve Clinical Outcomes	4hrs or less in A&E Dept	Responsive	Services	Chief Operating Officer	77.30%	72.87%	71.41%	73.47%	72.96%	75.78%	F	
	12+ Trolley waits	Responsive	Services	Chief Operating Officer	0	874	1,049	1,317	9,941	0	F	
	%Triage Achieved under 15 mins	Responsive	Services	Chief Operating Officer	88.50%	76.22%	73.75%	74.96%	79.40%	88.50%	F	
	52 Week Waiters	Responsive	Services	Chief Operating Officer	2,027	1,944	1,543		24,548	18,243	F	L
	65 Week Waiters	Responsive	Services	Chief Operating Officer	0	120	53		2,955	0	F	L
	18 week incompletes	Responsive	Services	Chief Operating Officer	84.10%	52.64%	53.32%		51.99%	84.10%	F	H
	Waiting List Size	Responsive	Services	Chief Operating Officer	58,965	70,940	70,628		N/A	N/A	F	
	28 days faster diagnosis	Responsive	Services	Chief Operating Officer	75.00%	80.50%	79.70%		78.44%	75.00%	P	
	62 day classic	Responsive	Services	Chief Operating Officer	85.39%	66.40%	68.90%		62.16%	85.39%	F	H
	2 week wait suspect	Responsive	Services	Chief Operating Officer	93.00%	75.30%	83.60%		75.70%	93.00%	F	

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Teaching Hospitals NHS Trust

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Nov-24	Dec-24	Jan-25	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Clinical Outcomes	2 week wait breast symptomatic	Responsive	Services	Chief Operating Officer	93.00%	83.20%	29.00%		62.97%	93.00%	F	
	31 day first treatment	Responsive	Services	Chief Operating Officer	96.00%	91.80%	93.80%		91.52%	96.00%	F	
	31 day subsequent drug treatments	Responsive	Services	Chief Operating Officer	98.00%	94.60%	96.40%		91.06%	98.00%	F	
	31 day subsequent surgery treatments	Responsive	Services	Chief Operating Officer	94.00%	70.20%	81.80%		77.28%	94.00%	F	
	31 day subsequent radiotherapy treatments	Responsive	Services	Chief Operating Officer	94.00%	85.70%	90.00%		88.21%	94.00%	F	
	62 day screening	Responsive	Services	Chief Operating Officer	90.00%	66.70%	58.80%		66.90%	90.00%	F	
	62 day consultant upgrade	Responsive	Services	Chief Operating Officer	85.00%	70.50%	78.20%		71.31%	85.00%	F	
	Diagnostics achieved	Responsive	Services	Chief Operating Officer	99.00%	73.91%	65.66%	67.62%	71.86%	99.00%	F	
	Cancelled Operations on the day (non clinical)	Responsive	Services	Chief Operating Officer	0.80%	1.14%	1.95%	1.58%	1.78%	0.80%	F	
	Not treated within 28 days. (Breach)	Responsive	Services	Chief Operating Officer	0	21	24	35	318	0	F	
	#NOF 48 hrs	Responsive	Services	Chief Operating Officer	90.00%	40.45%	63.29%	58.76%	67.09%	90.00%	F	

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Teaching Hospitals NHS Trust

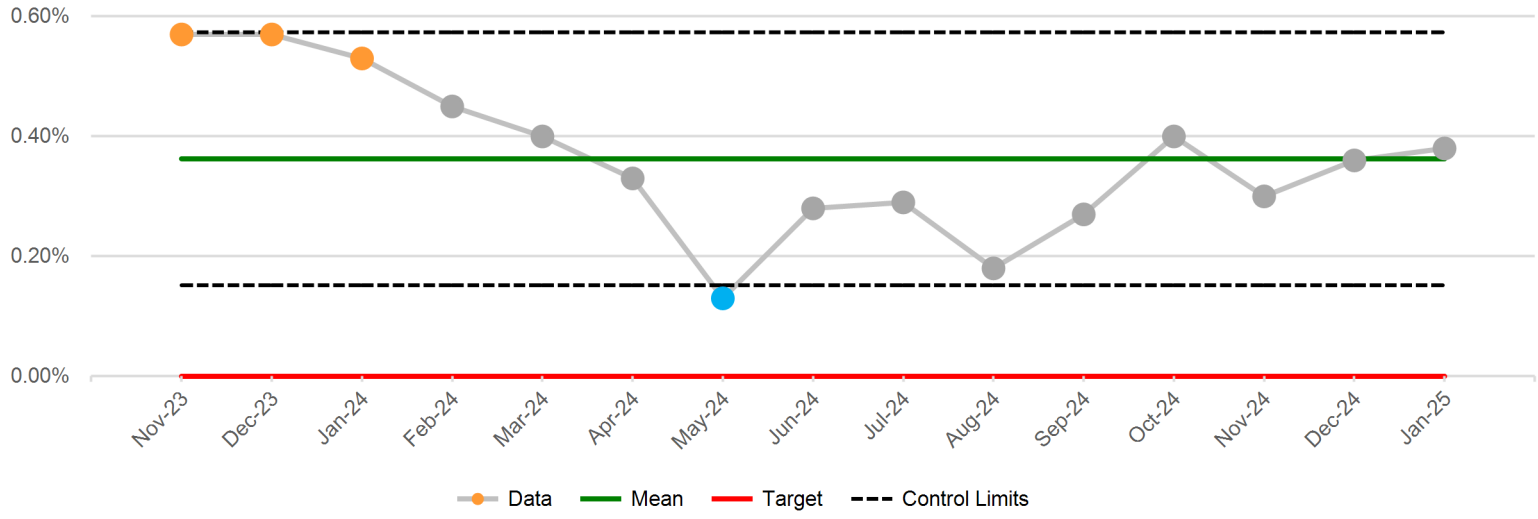
5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Nov-24	Dec-24	Jan-25	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Clinical Outcomes	#NOF 36 hrs	Responsive	Services	Chief Operating Officer	TBC	25.84%	41.77%	40.21%	41.09%			L
	EMAS Conveyances to ULHT	Responsive	Services	Chief Operating Officer	4,657	4,645	4,687	4,556	4,666	4,657	P	
	EMAS Conveyances Delayed >59 mins	Responsive	Services	Chief Operating Officer	0	670	978	1,085	555	0	F	H
	104+ Day Waiters	Responsive	Services	Chief Operating Officer	10	72	85	90	645	100	F	H
	Average LoS - Elective (not including Daycase)	Effective	Services	Chief Operating Officer	2.80	2.28	2.54	2.82	2.67	2.80	P	
	Average LoS - Non Elective	Effective	Services	Chief Operating Officer	4.50	4.39	4.52	4.59	4.69	4.50	F	
	Delayed Transfers of Care	Effective	Services	Chief Operating Officer	3.50%	Submission suspended	Submission suspended	Submission suspended				
	Partial Booking Waiting List	Effective	Services	Chief Operating Officer	4,524	33,164	34,684	34,661	32,585	4,524	F	H
	% discharged within 24hrs of PDD	Effective	Services	Chief Operating Officer	45.00%	38.71%	38.43%	38.65%	38.90%	45.00%	F	

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Teaching Hospitals NHS Trust

% Triage Data Not Recorded



Jan-25
0.38%
Variance Type
Common cause variation
Target
0.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
Percentage of triage data not recorded.

What the chart tells us:
January reported a non-validated position of 0.38% of data not recorded versus the target of 0%. To note, 65% of those without a triage recorded “did not wait” to be seen or diverted to UTC. Of those who did not wait to be seen they waited an average of 65 minutes.

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

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

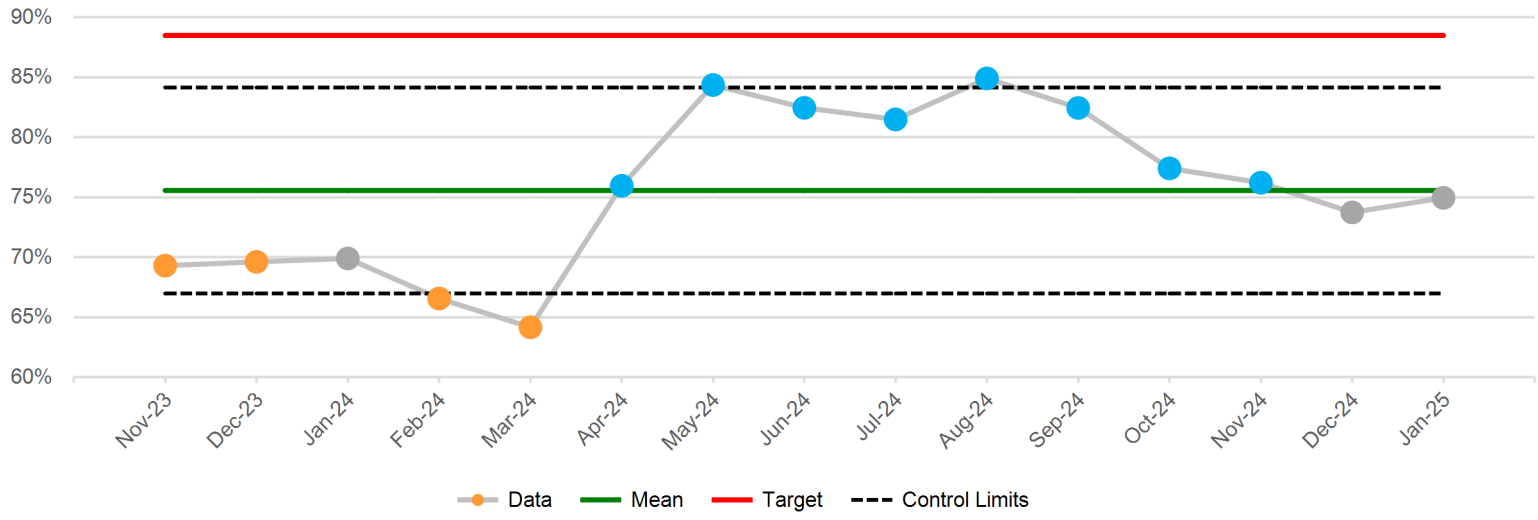
Mitigations:
- Earlier identification of recording delays via 3 x daily Capacity and performance meetings and confirmation via bespoke UEC daily updates.
- Increased nursing workforce following a targeted recruitment campaign has been successful and supernumerary period, has, in the main come to an end.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

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Teaching Hospitals NHS Trust

%Triage Achieved under 15 mins



Jan-25
74.96%
Variance Type
Common cause variation
Target
88.50%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
Percentage of triage achieved under 15 minutes.

What the chart tells us:
January's outturn was 74.96%, compared to 73.75% in December (validated). This represents a negative variance of 13.54% from the target of 88.50%. January's performance shows a 5.05% improvement compared to the same month in 2024.

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

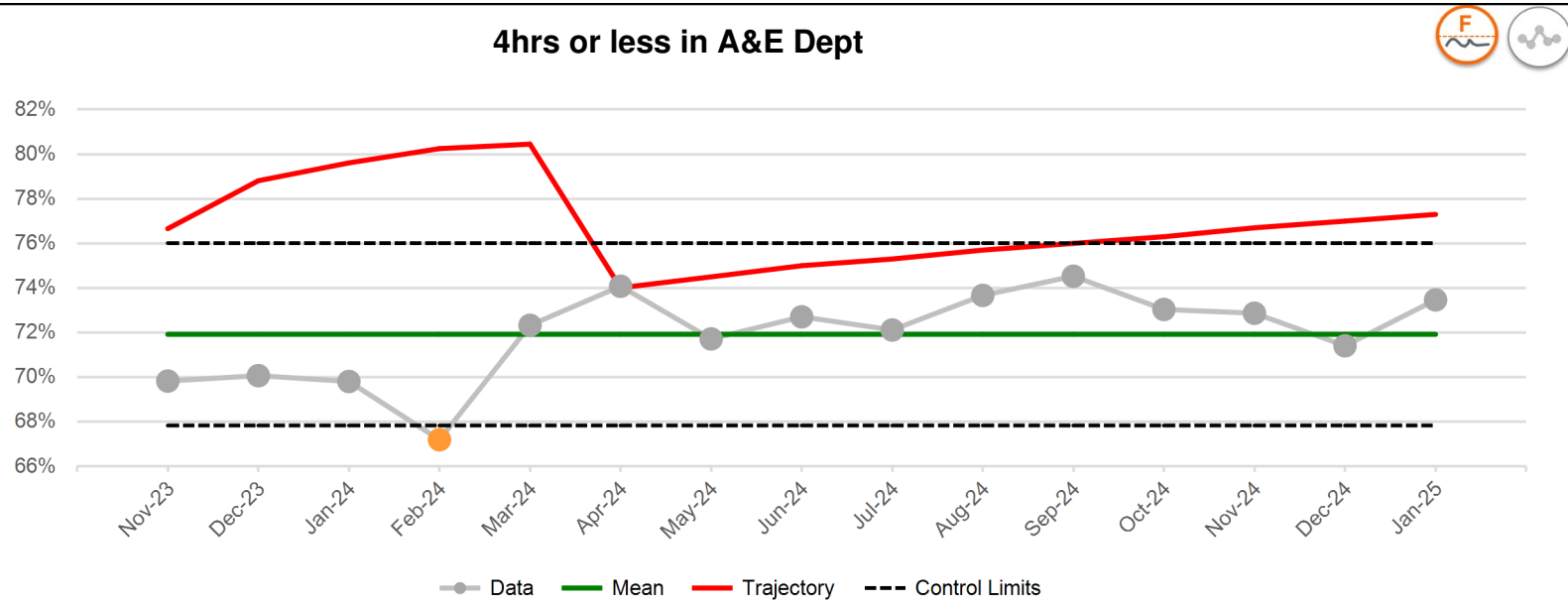
Actions:
Increased access to MTS2 training.
Increased registrant workforce to support 2 triage streams to be in place via Emergency Department recruitment campaign.
To move to a workforce model with Triage dedicated registrants and remove the dual role component.
The metric forms part of the Emergency Department safety indicators and is monitored/scrutinised at 4 x daily Capacity and Performance Meetings
New escalation process in place
UEC Sprint commenced also in August 2024.

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

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Teaching Hospitals NHS Trust



Jan-25
73.47%
Variance Type
Common cause variation
Trajectory
77.30%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
The 24/25 target has been set at 78% with a rolling trajectory by month to achieve by year end.

What the chart tells us:
The 4-hour transit performance for Type 1/3 combined was recorded at 73.47%, representing an improvement over December's performance of 71.41%. It is important to note that the chart does not account for the increased volume and acuity of presentations to the department.

Issues:
In January 2025, Type 1 witnessed an average daily patient volume of 503, reflecting a decrease from the 555 patients attended to in December 2024. ED encountered a deficiency in discharges from the wards, with an average of 32 fewer patient discharges per day than necessary to meet the demand. This led to extended wait times for inpatient beds during the night. Additionally, delayed identification of patients eligible for prolonged stays in the ED was noted, with over 60% of patients being identified only after 4 pm daily. Furthermore, the closure of beds on the wards due to COVID19, Influenza and RSV impacted the availability of resources for movement and cleaning, thereby affecting timely movements.

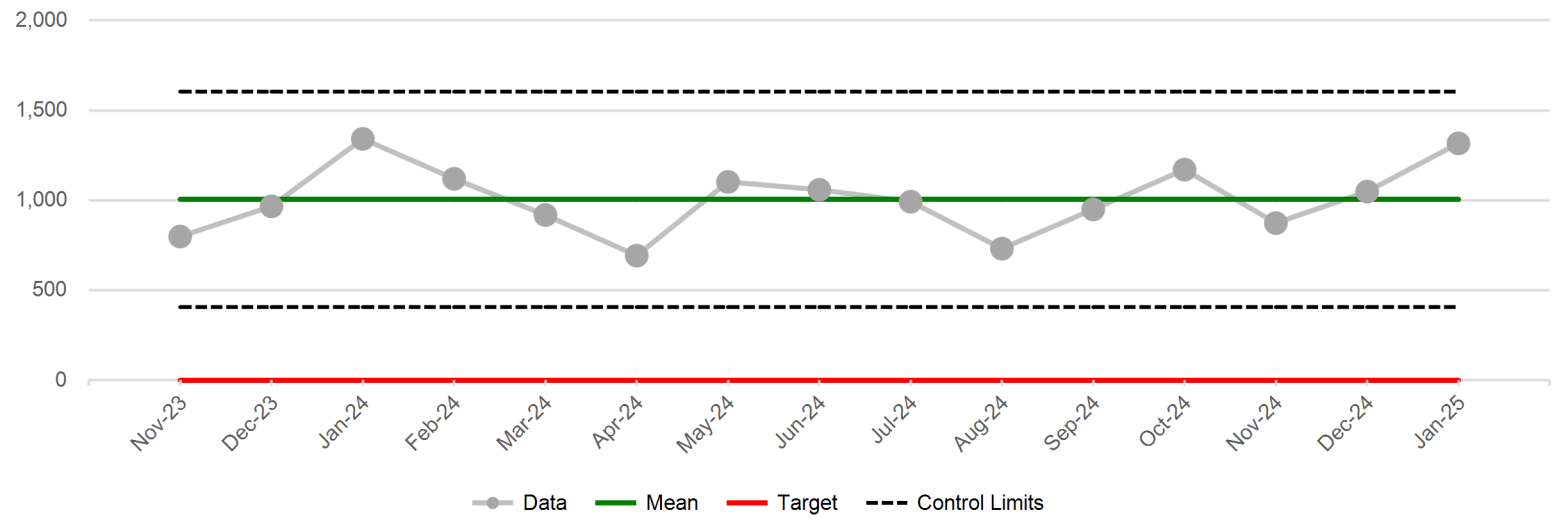
Type 3 (All locations) observed an average of 382 daily patients, representing a 11.16% decrease to the preceding month.

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

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

Performance Overview - Operational Performance

12+ Trolley waits



Jan-25
1,317
Variance Type
Common cause variation
Target
0
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
January experienced 1317 breaches, an increase from 1049 in December, marking a decline of 26% (268 more patients). The 1317 breaches accounted for 8.5% of all type 1 attendances.
Additionally, the chart did not capture the adhoc internal decisions made to prioritise total time in the Emergency Department, aimed at minimising exposure risk and mortality rate.

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

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

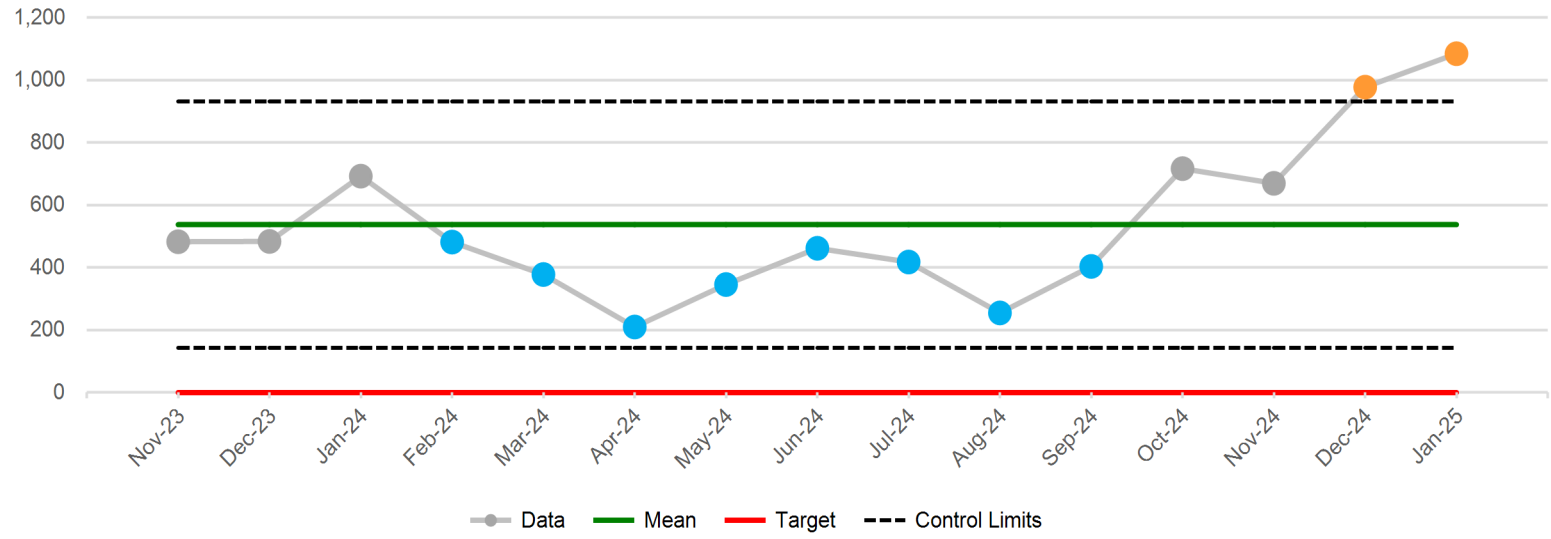
Mitigations:
A System agreement remains in place to staff the Discharge Lounges 24/7 to reduce the number of patients in the Emergency Departments that are deemed 'Medically Optimised' that need onward non acute placement/support.
A Criteria to Admit Lead has been established ensuring all decisions to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

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Teaching Hospitals NHS Trust

EMAS Conveyances Delayed >59 mins



Jan-25
1,085
Variance Type
Special cause variation - cause for concern (Indicator where high is a concern)
Target
0
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
In January, the performance of ambulance handovers exhibited a further decline. A total of 1085 arrivals were recorded within a 59-minute timeframe, in contrast to the 693 arrivals documented in January 2024. Arrivals exceeding 59 minutes accounted for 24% of all handovers in January. Furthermore, 22.99% of patients arriving were already scoring above 4 on (NEWS) at the time of presentation.

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

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

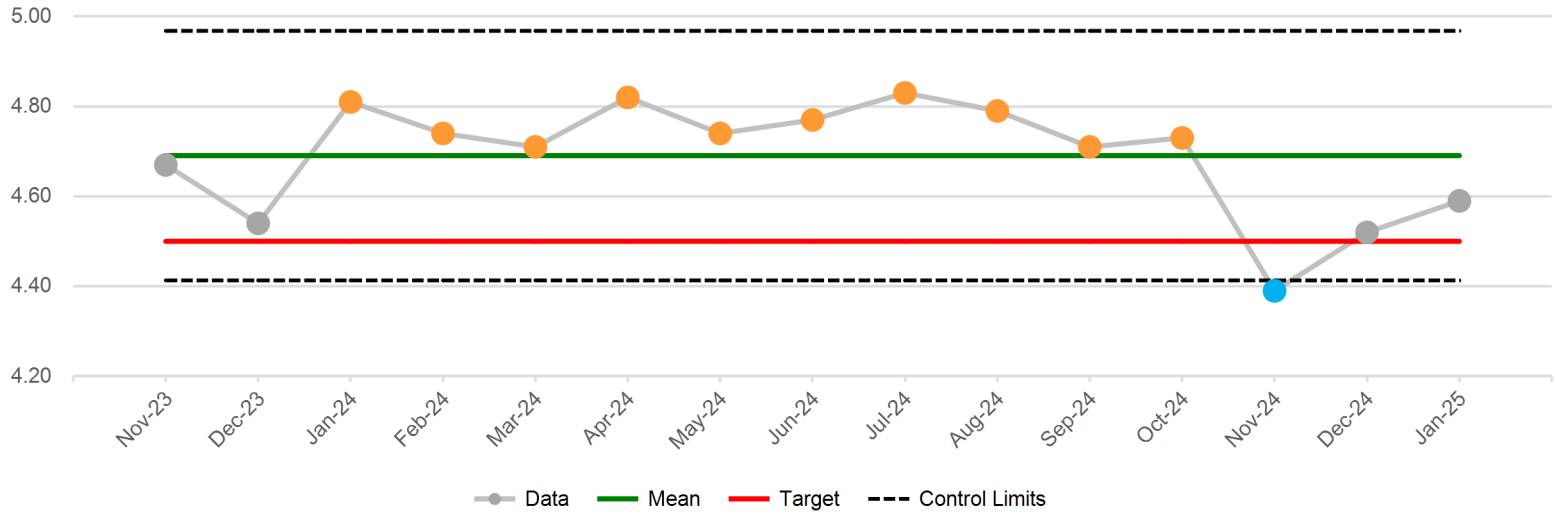
Mitigations:
Early intelligence of increasing EMAS demand has allowed for planning and preparedness to receive and escalate.
Contact points throughout the day and night with the Clinical Site Manager and Tactical Lead (in and out of hours) to appreciate EMAS on scene (active calls) and calls waiting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

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Teaching Hospitals NHS Trust

Average LoS - Non Elective



Jan-25
4.59
Variance Type
Common cause variation
Target
4.50
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
January outturn of 4.59 is a decline 0.07 days and a 0.09-day negative variance against the agreed target.
What the chart doesn't tell us is the change by pathway:
Pathway 0 (0.5) more days
Pathway 1 (2.9) less days
Pathway 2 (1.6) less days
Pathway 3 (0.4) less days

Issues:
In January, there was a decrease in performance in the number of super-stranded patients, with the daily average increasing to 141 from 129. This is replicated with the number of stranded patients (14 days) increasing from 220 daily to 233. Weekend discharges consistently remained lower than weekdays, with a 39.80% reduction and an average of 53 less patients discharged. This reduction in weekend discharges presents a challenge in meeting the capacity and demand for emergency admissions.

The Transfer of Care Hub continues to gain traction in moving discharges forward at an improved pace. There is a higher acuity of patients requiring a longer period of recovery.

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

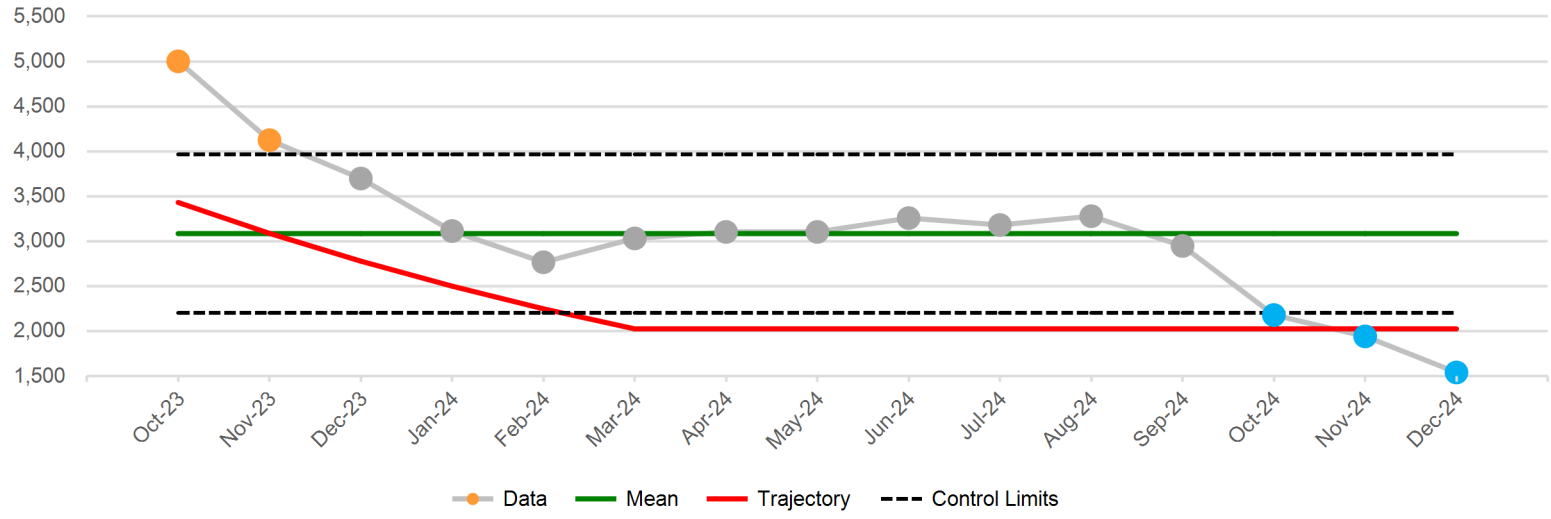
Mitigations:
Divisional Leads are providing support for addressing delays in patient discharges. Efforts to streamline corporate and divisional meetings are underway to prioritise the increase of daily discharges
An automated daily site update notification is now distributed at 6 AM to notify Key Leaders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

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Teaching Hospitals NHS Trust

52 Week Waiters



Dec-24
1,543
Variance Type
Special cause variation - improvement (Indicator where low is good)
Trajectory
2,027
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
The Trust reported 1,543 incomplete 52-week breaches for December 2024, a decrease of 401 from November's 1,944.

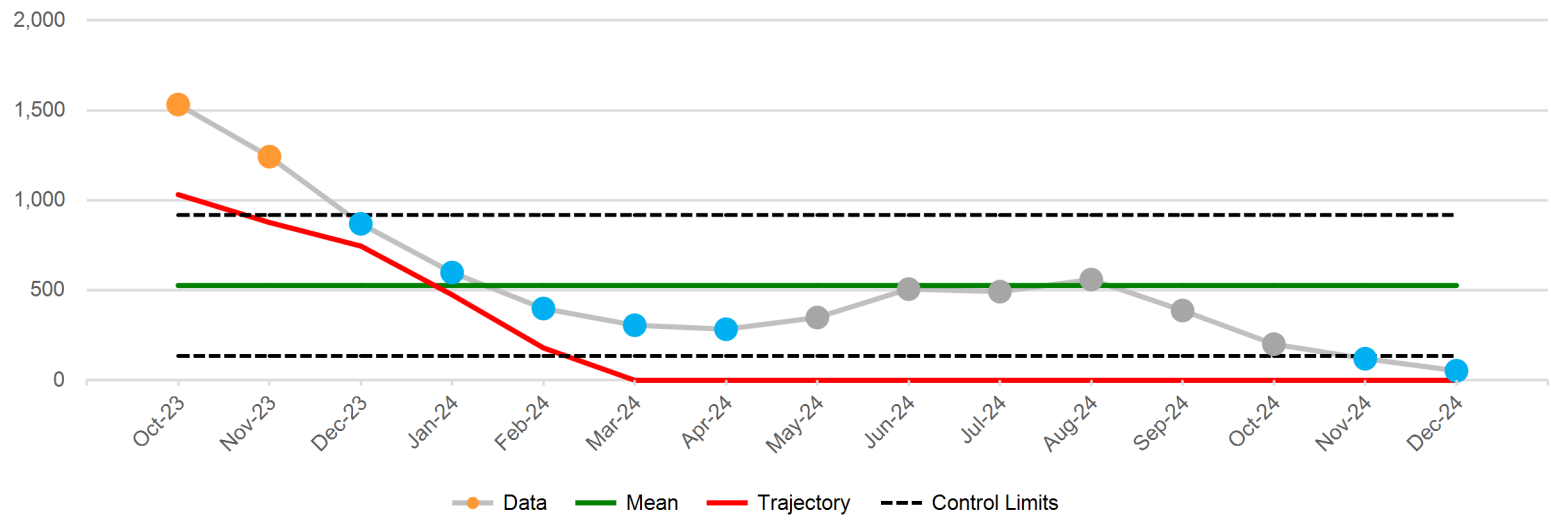
Issues:
As shown above, 52 week waiters are positively performing against trajectory, with a decrease in numbers from last month. Both admitted and non-admitted patients sit within this wait band, however, the most significant pressure is in the non-admitted pathways. ENT continues to be the specialty under greatest pressure, which together with audiology, accounts for 41.22% of patients in this wait band. An increase of 4.95% from last month.

Actions:
Max Fax is now back on track, therefore insourcing finished on the 14th December. The last additional Audiology clinic was held on 5th January. Insourcing for additional ENT clinics continues throughout February and has now been extended until the end of March. The additional clinics have reduced both total waiting list size and long waiters.

Mitigations:
ULTH 52 week position in current data (W/E 29th December '24) ranks 2nd for this metric within the Midlands region (11 Providers).

Performance Overview - Operational Performance

65 Week Waiters



Dec-24
53
Variance Type
Special cause variation - improvement (Indicator where low is good)
Trajectory
0
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
The Trust reported 53 incomplete 65-week breaches for December 2024, a decrease of 67 from November's 120.

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

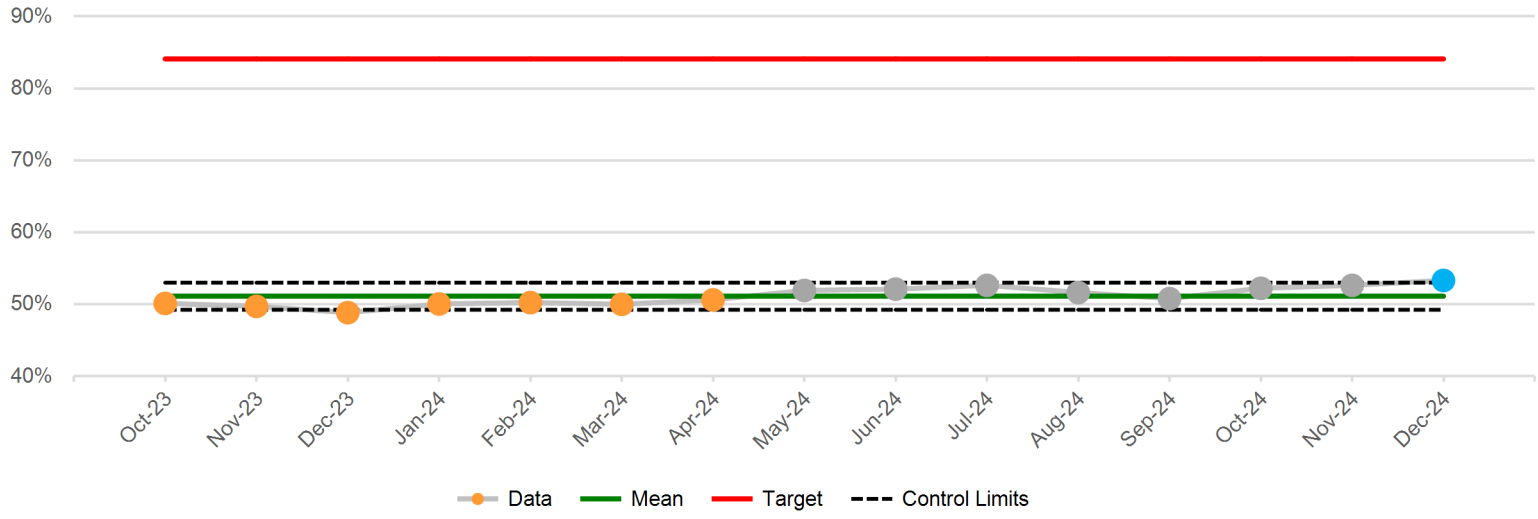
Actions:
Incomplete patient pathways are discussed with individual specialities weekly, through PTL meetings.
This meeting is currently focusing on patients in the 65w cohort for the current month. Due to the high volume of patients, this is being held twice a week.

Mitigations:
ORIG supports the delivery of Outpatient improvements for non-admitted pathways, to ensure Outpatient capacity is fully utilised and efficiency schemes are implemented and well used.
Current data (W/E 29th December '24) ranks ULTH 3rd for 65w cohort metrics within the Midlands region (11 Providers).

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Teaching Hospitals NHS Trust



Dec-24
53.32%
Variance Type
Special cause variation - improvement (Indicator where high is good)
Target
84.10%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
There is significant backlog of patients on incomplete pathways. December 2024 saw RTT performance of 53.32% against an 84.1% target, which is 0.68% up from November.

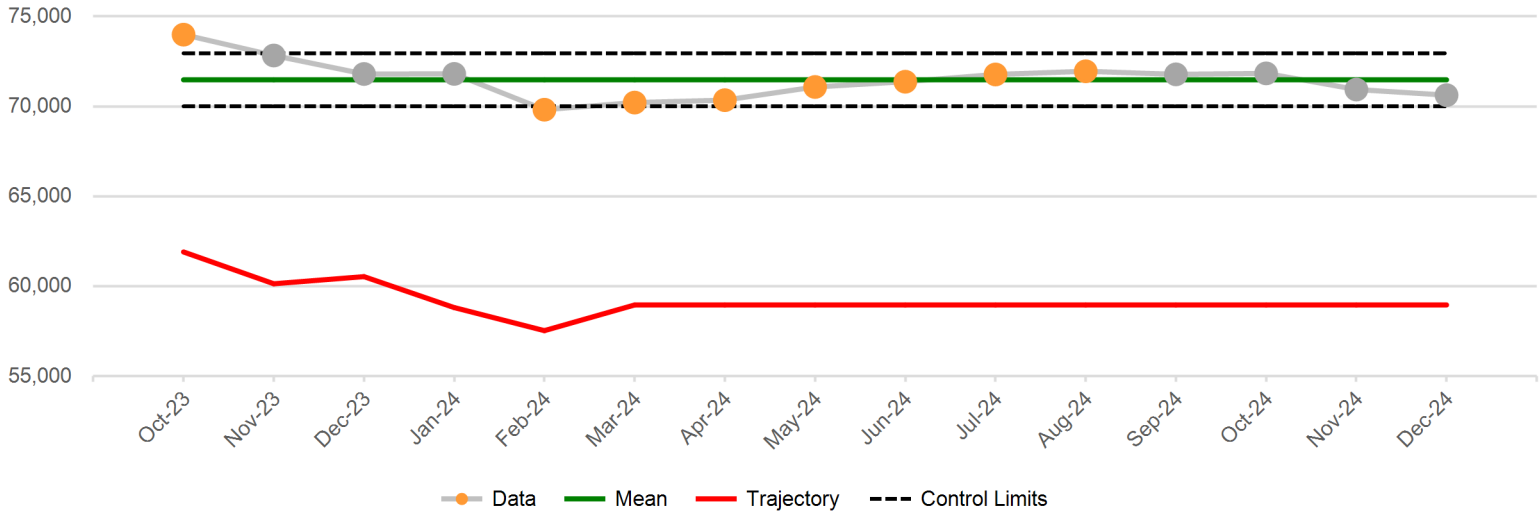
Issues:
Performance is currently below trajectory and standard. The five specialties with the highest number of 18 week breaches at the end of the month were:
ENT– 5,778(decreased by 249)
Gynaecology – 2,860 (increased by 18)
Ophthalmology – 2,701 (decreased by 4)
Gastroenterology – 2,566 (decreased by 180)
T&O–2,128 (increased by 188).

Actions:
Priority remains focussed on clinically urgent and Cancer patients. National focus is on patients that are waiting 65 weeks and over, with the target to achieve zero by the end of the current month. Resource is targeted at patients who have the potential to be >65 weeks.
Schemes to address the backlog include;
1. Outpatient utilisation
2. Tertiary capacity
3. Outsourcing/Insourcing
4. Use of ISPs
5. Reducing missing outcomes

Mitigations:
Improvement programmes established to support delivery of actions and maintain focus on recovery. HVLC/Theatre Productivity to ensure best use of theatres and compliance with HVLC procedures. Focus is also on capturing all activity. Clinical prioritisation, focusing on clinical priority of patients using theatres. Current data (W/E 29th December '24) ranks ULTH 8th for RTT performance metrics within the Midlands region (11 Providers).

Performance Overview - Operational Performance

Waiting List Size



Dec-24
70,628
Variance Type
Common cause variation
Trajectory
58,965
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
Overall waiting list size has decreased from November, with December showing a decrease of 312 to 70,628.
This is more than double the pre-pandemic level reported in January 2020.

Issues:
Following the backlog increase from the pandemic, there have been additional pressures that have affected capacity, including urgent care pressures.
The five specialties with the largest waiting lists are;
ENT – 9,602
Ophthalmology – 6,008
Gastroenterology – 5,927
Gynaecology – 5,767
Trauma & Orthopaedics 5,556

Actions:
Improvement programmes as described above for RTT performance. An internal review of ENT pathways is being undertaken to standardise in line with GIRFT recommendations. Approval has been agreed to invest in a substantive internal validation team. Half to be recruited this financial year with the remainder in the next financial year. Recruitment continues for the remaining vacant posts.

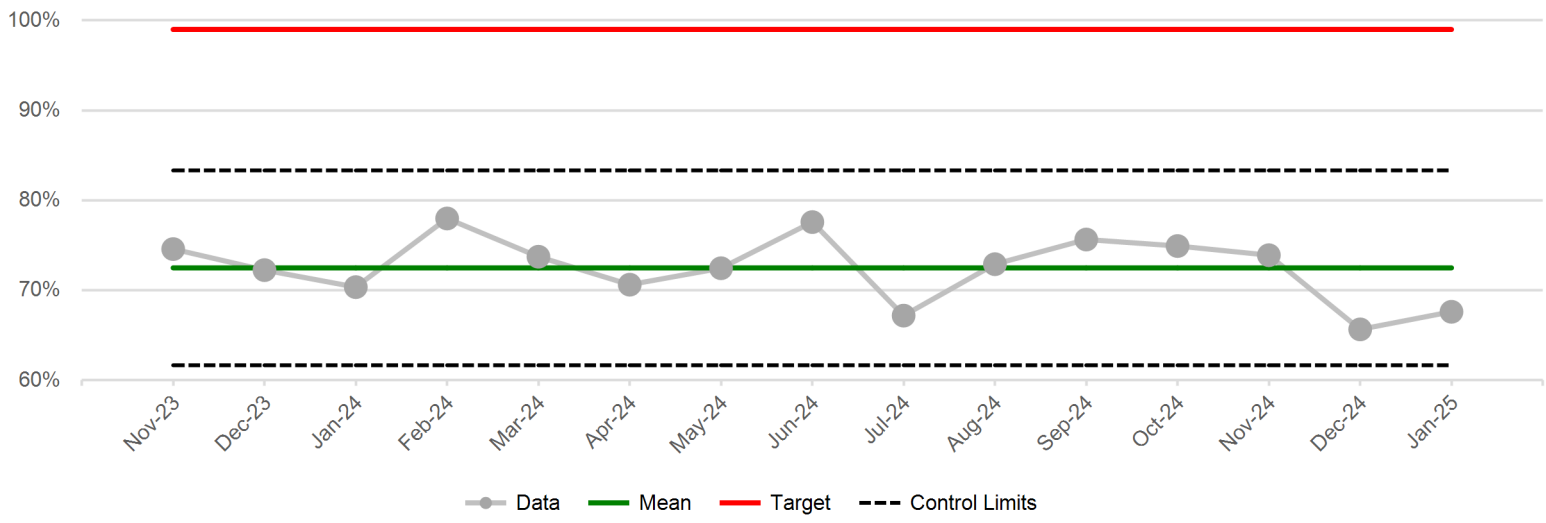
Mitigations:
The number of patients waiting over 78 weeks has remained the same as last month. Current data (W/E 29th December '24) ranks ULTH 3rd for this metric within the Midlands region (11 Providers)

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

Performance Overview - Operational Performance

United Lincolnshire Teaching Hospitals NHS Trust

Diagnostics achieved



Jan-25
67.62%
Variance Type
Common cause variation
Target
99.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
Diagnostics achieved in under 6 weeks.

What the chart tells us:
DM01 for January was 67.62% against the 99.00% target.

Issues:
The majority of diagnostic breaches sit in Ultrasound, and Audiology. A full recovery trajectory has been submitted and is being monitored closely.
Reduction in the waiting list will reduce the overall percentage of the DM01.
The long waiters demand is stopping any Audiology recovery.

Actions:
Radiology are working to their recovery plans.
Dexa has experienced significant sickness and vacancies. In the process of reprofiling staffing and training there should be an increase in performance in January 2025.
Ultrasound are using agency where possible and additional shifts.

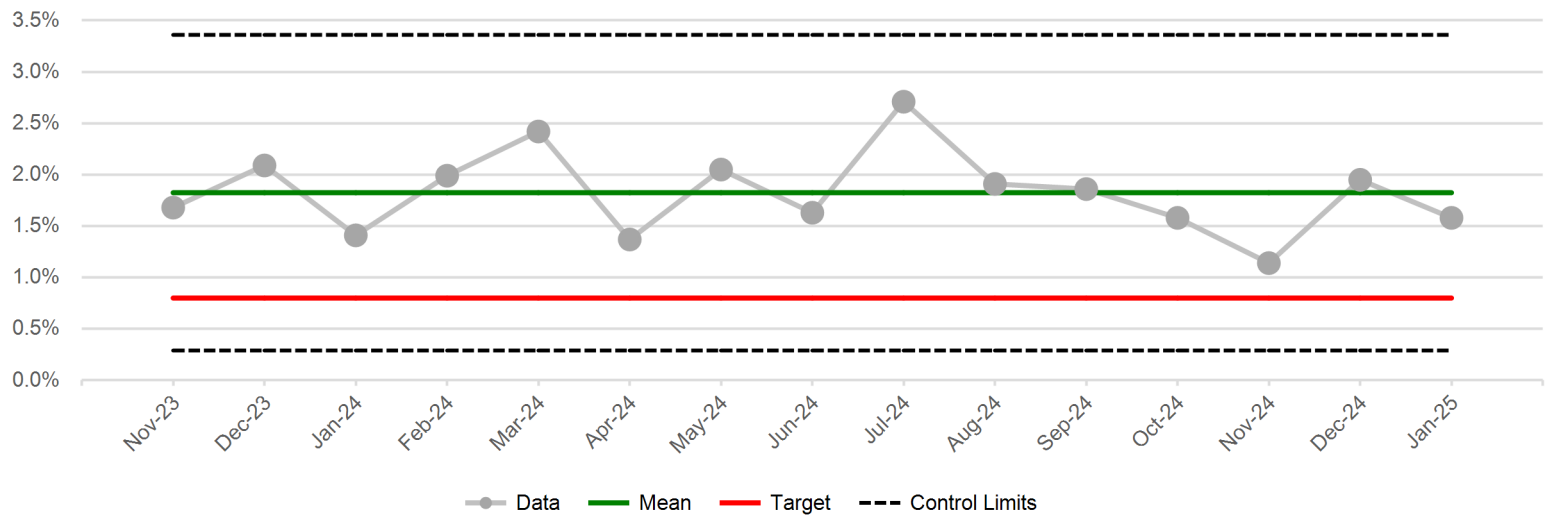
Mitigations:
Patients are being seen in clinical priority.

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Teaching Hospitals NHS Trust

Cancelled Operations on the day (non clinical)



Jan-25
1.58%
Variance Type
Common cause variation
Target
0.80%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
There has been a reduction in the number of non-clinical cancellations in January to 1.58%, from 1.95% in December, which remains over the 0.80% target.

Issues:
Top 3 issues were:

- Lack of time
- Bed Capacity
- Surgeon Unavailable

Actions:
52% of our lists started late in January which identifies that we need to undertake some focused work around reducing these. We are working closely with our colleagues to improve communication and actions required to enable these reductions.

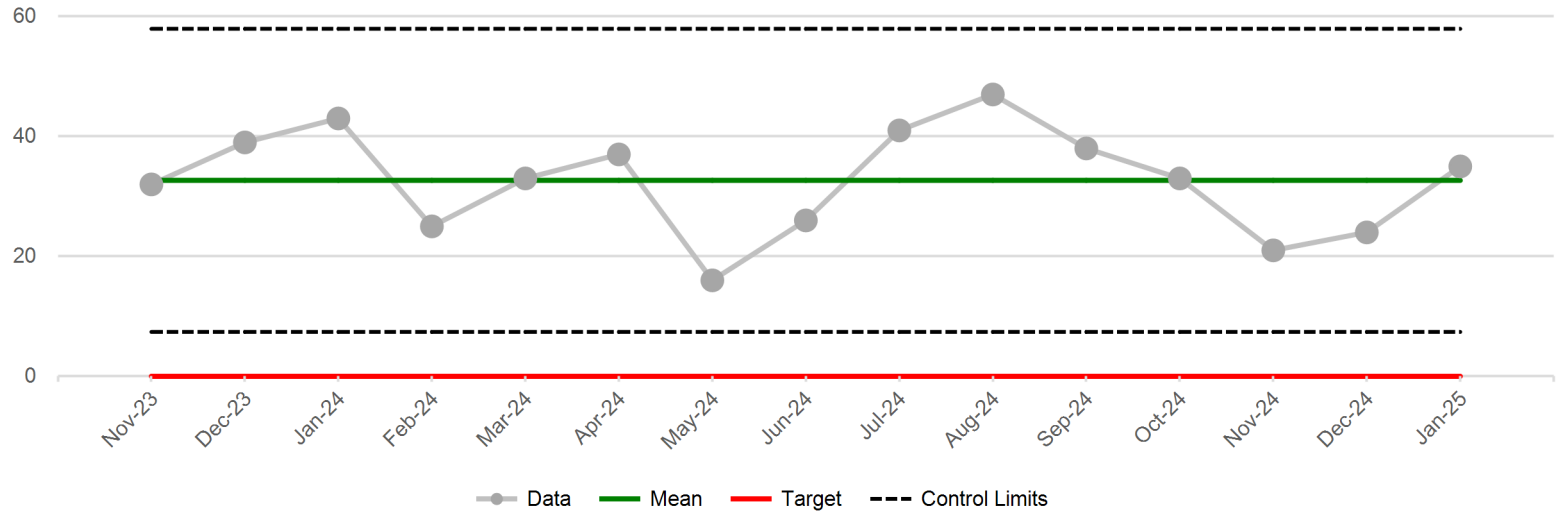
Increased focus is ongoing within teams to address both COTD and late starts.

Mitigations:
Continued issues around capacity pressures meant increased cancellations due to bed availability. Most of these were on the Boston site and are indicative of Ward 2B being used to outlie patients. A high number of orthopaedic trauma patients created further cancellations due to delayed treatment.

Sickness within our surgical teams was a problem in January although efforts were made to find short notice backfill.

Performance Overview - Operational Performance

Not treated within 28 days. (Breach)



Jan-25
35
Variance Type
Common cause variation
Target
0
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
Breaches have increased further in January to 35, compared to 24 in December.

Issues:
Recruitment of waiting list staffing now completed, and training is ongoing.

The focus on long waiters and the trauma backlog have both had an impact on elective lists at Boston and Lincoln and has made rebooking patients more challenging.

Actions:
Focus to remain on improved utilisation on our lists using 642. All areas undertaking pre meets with clear actions being monitored daily within the waiting list and specialty teams.

Implementation of standby patients will maintain improved list utilisation when there are cancellations on the day and provide an ability to reduce these breach patients.

Mitigations:
The implementation of average timings for surgical procedures started on 2nd December. AQUA theatre planner went live on 15th January and is being scrutinised to understand timings further in line with averages.

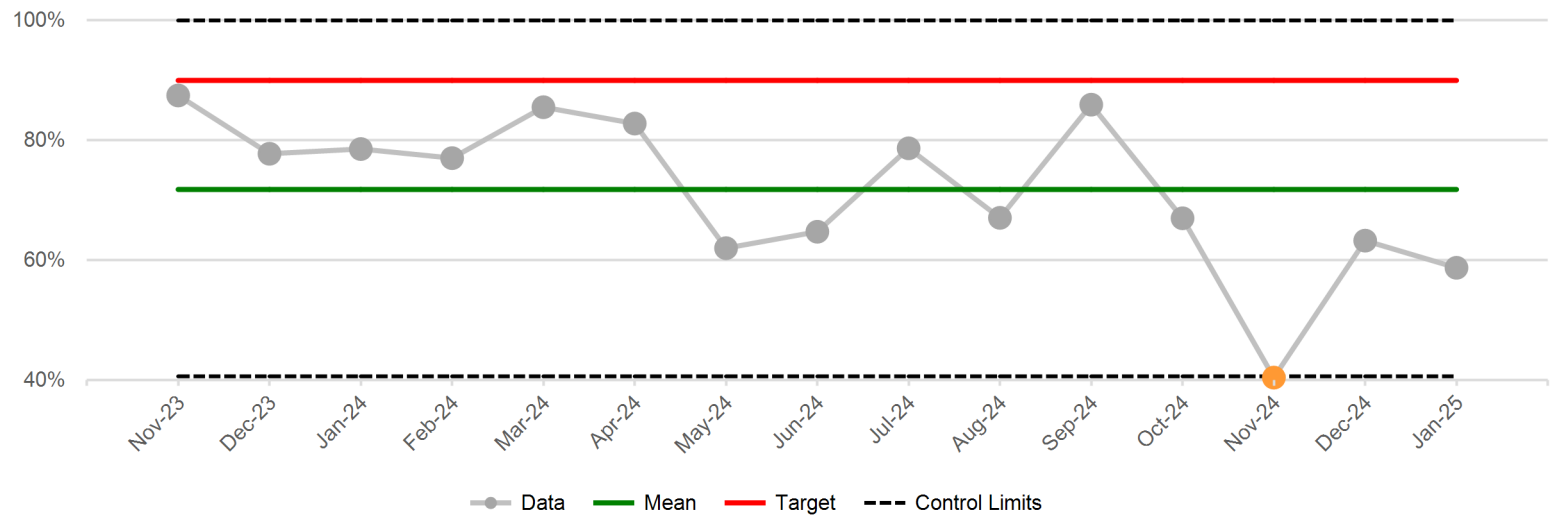
Improvements in theatre utilisation have been identified through 642 and the CBU pre meets will improve ability to redate our patients.

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Teaching Hospitals NHS Trust

#NOF 48 hrs



Jan-25
58.76%
Variance Type
Common cause variation
Target
90.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
The average percentage across both sites for January was 58.76%.

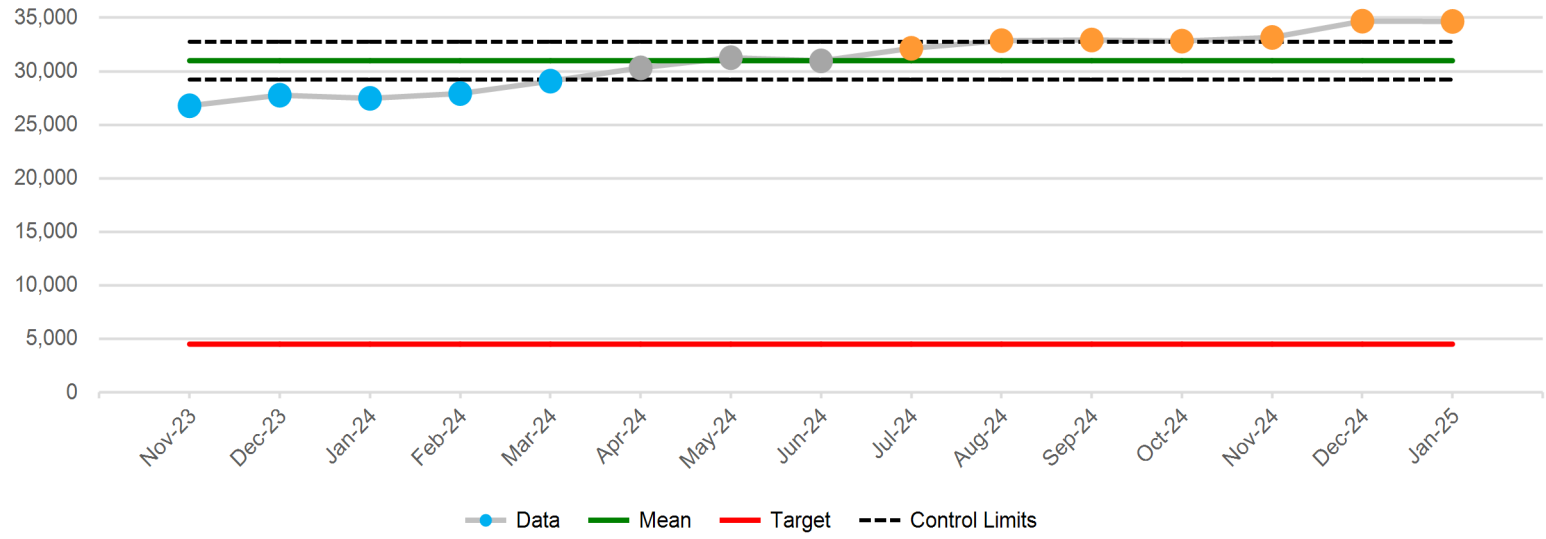
Issues:
- Lack of theatre space to accommodate Femur fractures.
- ULHT continue to have a high demand of trauma patients admitted with one trauma list planned daily on both sites.
- Lack of theatre staff to provide additional trauma capacity.
- ULHT breaching the NHFD best practice tariff for femur fractures.
- Patients not being medically fit for surgery
- Awaiting specialist surgeon
- Delays for MRI and CT scan prior to surgery

Actions:
- 'Golden patient' initiative to be fully implemented.
- Additional Trauma lists to be planned on both sites
- Review of additional trauma lists through job planning process to see if additional trauma lists can be available for Femur fractures to avoid breaches.
- Trauma coordinator team to ensure that femur fractures are listed on the trauma list to avoid breaches.
- Daily Trauma huddles via MS teams with the trauma coordinators and the CBU to discuss extra theatre capacity on all sites
- Aqua to be accessed daily by the trauma coordinators to see what capacity is available
- Trauma coordinators to identify suitable patients that could be operated on at Grantham and Louth

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

Performance Overview - Operational Performance

Partial Booking Waiting List



Jan-25
34,661
Variance Type
Special cause variation - cause for concern (Indicator where high is a concern)
Target
4,524
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
Currently at 34,661 against a target of 4,524. During Covid the number of patients overdue significantly increased and the trend has seen a steady increase since, an exception being Aug 23 – Nov 23. More recently Oct 24 saw a slight decrease on previous months, however this has increased and remained steady from Nov 24.

Issues:
The organisation has several competing priorities. The current focus is on the long waiting patients (> 65 weeks), potential cancer patients and additional outpatient 'hot clinics' to alleviate winter pressures on UEC. The current PBWL demand outweighs the current capacity which is being impacted by available capacity, rooms and resources.

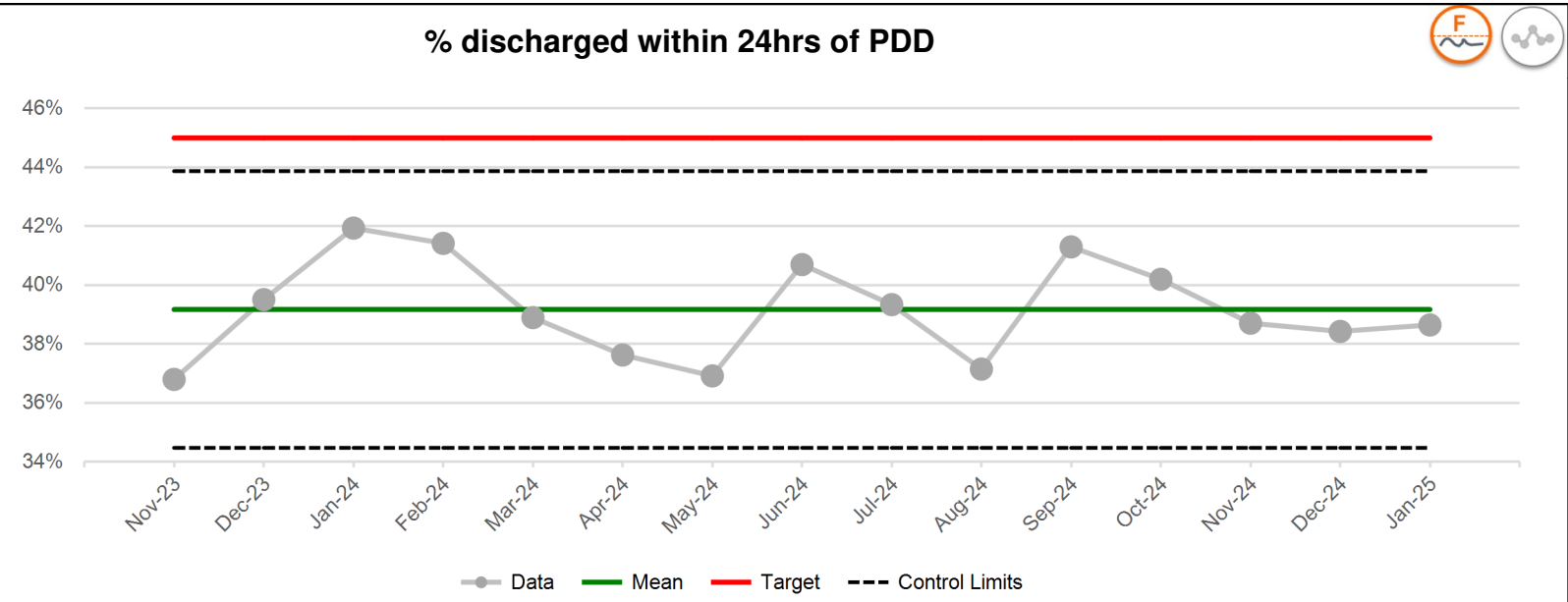
Actions:
Regular Outpatient Waiting Lists (OWL) meeting with speciality CBU's to improve focus, and discussions continue regarding reduction of non-tariff f/ups. PIFU uptake continues to be an area of focus for specialties. The 642 process is currently being rolled out to improve capacity and vacant slots. Clinic Scheduler x 2 in post and digital room booking system at initial project phase (projected go live Q1 2025/26) to improve clinic utilisation and maximise capacity.

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

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Teaching Hospitals NHS Trust



Jan-25
38.65%
Variance Type
Common cause variation
Target
45.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
% discharged within 24 hrs of PDD.

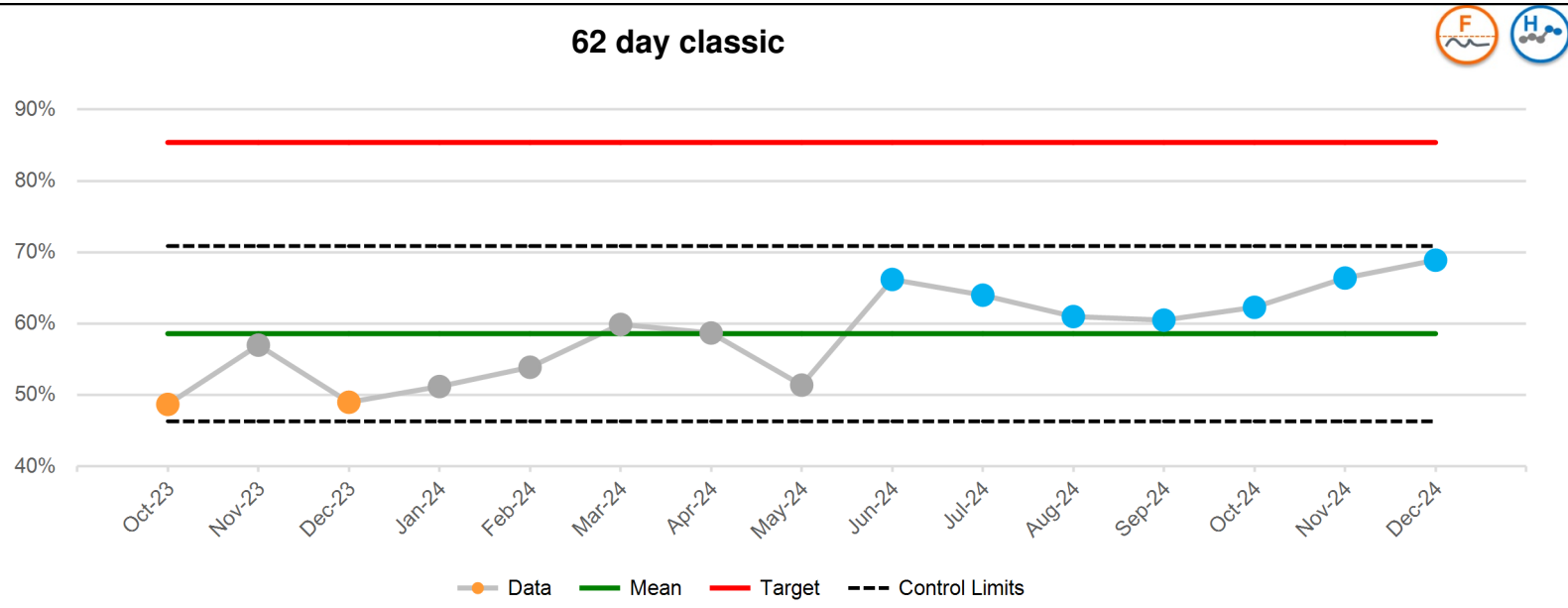
What the chart tells us:
The current performance metrics reveal a decline in January's results, which stand at 38.65%. This marks a drop from September's notable achievement of 41.30%, highlighting a shift in performance over the past few months.

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

Actions:
Ongoing weekly monitoring is being conducted, and any identified areas of concern are being brought to the attention of ward sisters and matrons to ensure performance enhancement. In July, a new project was launched in collaboration with the SAFER practitioners to address daily issues pertaining to wards with incomplete fields or patients who are due for discharge and those exceeding their target date.

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

Performance Overview - Operational Performance



Dec-24
68.90%
Variance Type
Special cause variation - improvement (Indicator where high is good)
Target
85.39%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 68.90% against a 85.39% target.

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

Please also see Issues on accompanying pages.

Actions:
Oncology Fragile Service – A piece of work on right-sizing the Oncology service workforce is ongoing and posts are out to advert.
Robotic Lists are progressing well, though proving difficult to populate at short notice if there are cancellations due to the lack of trained staff within theatres, pre-op and anaesthetics. Tumour site specialties are working with TACC to ensure the best possible utilisation of lists, including a process for last minute cancellations. Additional slots for cancer specialties to increase from 2 to 3 slots per day starting from July.
Performance – Intensive Support Meetings continue to take place twice weekly to understand and resolve the themes and issues in 62 day performance in a number of tumour site specialties. Deep Dives are being undertaken by each CBU to understand how diagnostic turnaround times for positive cancers can be improved as this will be key to achieving the NHSE target of 70% by March '24.
Please also see Actions on accompanying pages.

Mitigations:
A process is now in place to ensure the Pre-Diagnosis CNS is made aware of patients who are likely to be non-compliant or in need of support at the time of receipt of referral to allow for early intervention and a more efficient journey on the cancer pathway.

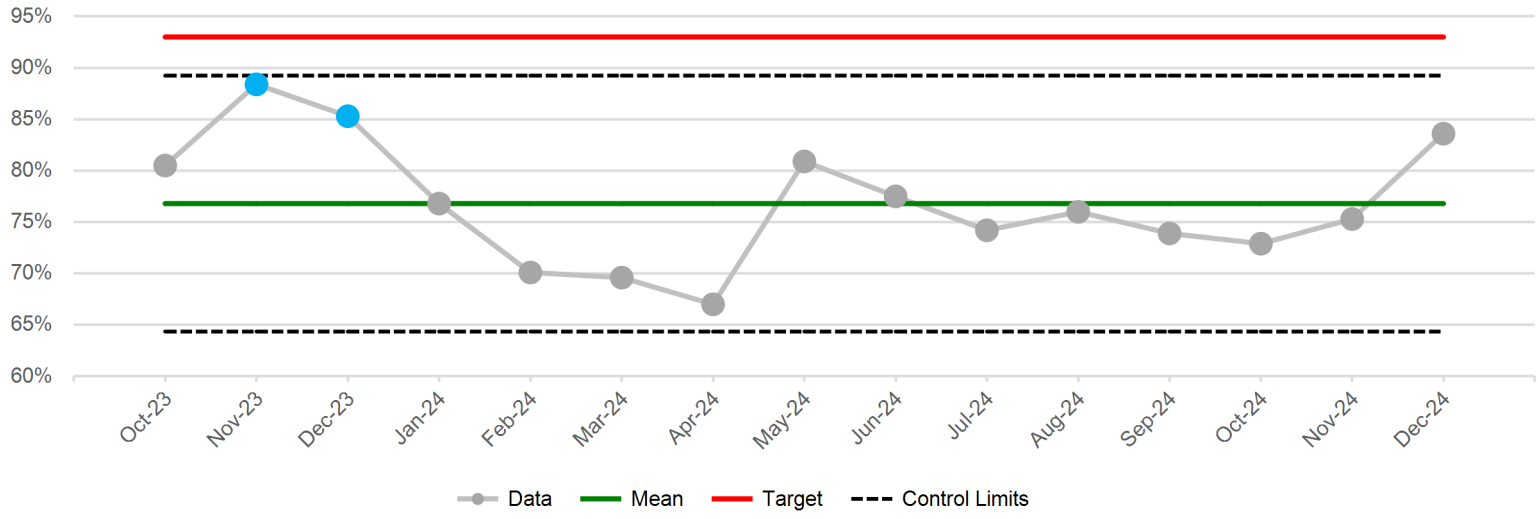
Please also see Mitigations on accompanying pages.

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Teaching Hospitals NHS Trust

2 week wait suspect



Dec-24
83.60%
Variance Type
Common cause variation
Target
93.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 83.60% against a 93% target.

Issues:
Patients not willing to travel to where our service and/or capacity is available.
The Trust's 14-day performance remains affected by the ongoing alignment issues in Breast Service One-Stop appointments, due to clinician sickness Breast accounted for 47.37% of the Trust's 14 day breaches. We should see an improvement by February performance.
Additionally, Skin tumour site accounted for 26.07% of the Trust's 14-day breaches in December.

Actions:
The Radiology Recruitment Strategy and intensive support meetings are in place to address the fragile Breast Service One-Stop appointment alignment issues. Respiratory Consultant capacity is ongoing as well as the BC for an increase in consultant workforce to 10-15 consultants. 2 x Lung Cancer CNS posts (funding until March 25) for risk stratification to reduce unnecessary CT scans demand on consultant triage are now established. The Lung Rapid Access pathway will now include CT referrals to accurately reflect performance and has recently been implemented. We have seen the impact of this in improved FDS performance since May. UGI Triage CNS has started in post and further job planning underway. Gastro admin team are now cross referencing USC referrals while the CBU work towards sustainable solutions to managing the start of the UGI USC referrals. Processes – SOPs relating to DNAs, multiple cancellations and Escalation's are currently being developed and taken through CBU Governance processes for approval.

Mitigations:
Haematology is in fragile services due to vacancy/capacity. Issues with inappropriate referrals and GP engagement continue to be escalated and supported by the ICB and Cancer Navigators will be able to streamline this process. Delays in the booking and utilisation of appointment slots which continue to be addressed with C&A and the Divisions.
In Gynae, the urgent PMB pathway progress and impact is being monitored. An HRT programme of work is underway with support from ICB colleagues.

The process to ensure the Pre-Diagnosis CNS is made aware of patients who are likely to be non-compliant or in need of support at the time of receipt of referral to allow for early intervention / support is currently being reviewed.

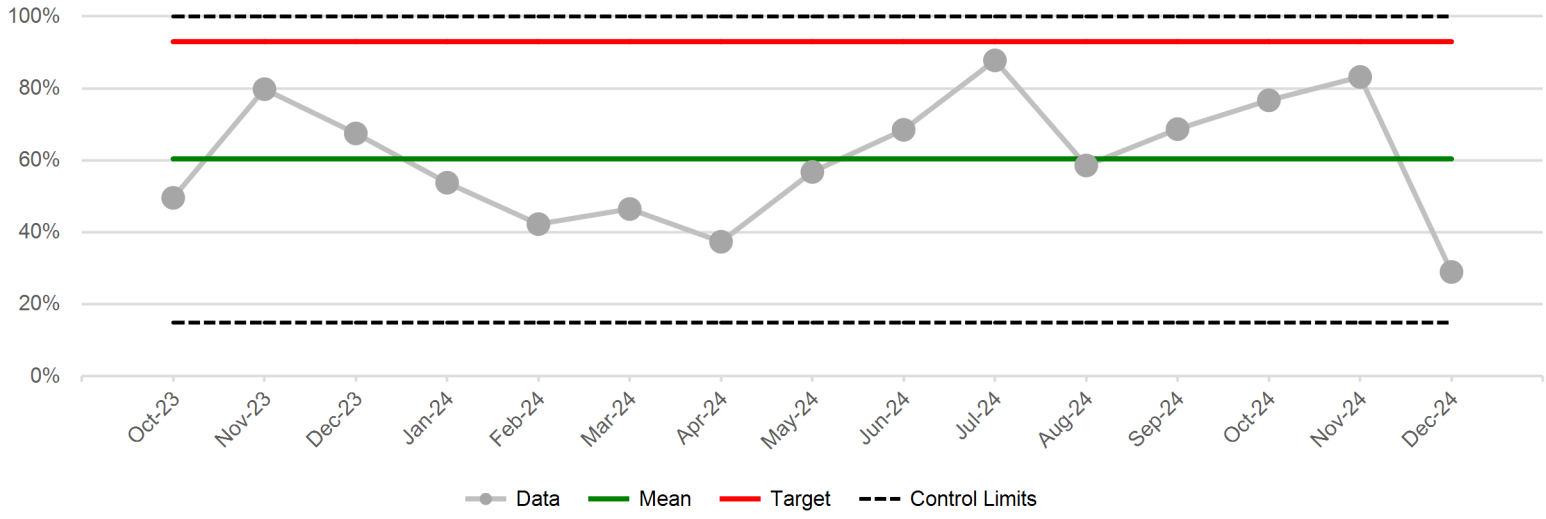
Please also see Mitigations on accompanying pages.

Performance Overview - Operational Performance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Teaching Hospitals NHS Trust

2 week wait breast symptomatic



Dec-24
29.00%
Variance Type
Common cause variation
Target
93.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
Percentage of patients 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 29.00% against a 93% target.

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

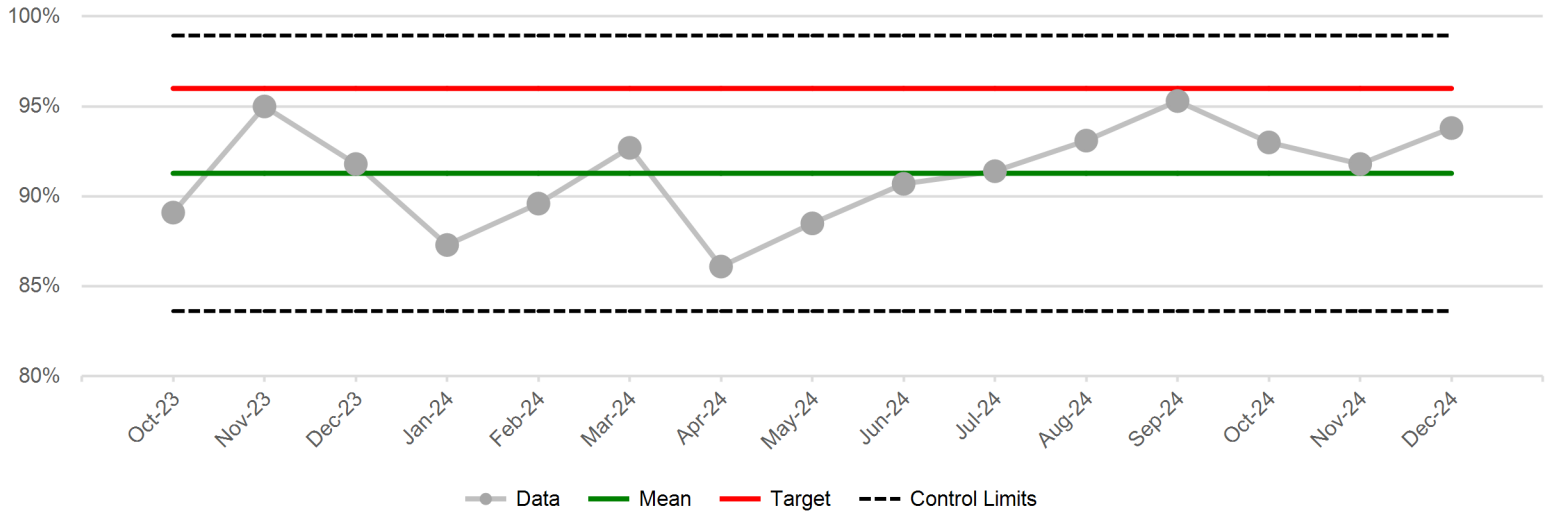
Actions:
A comprehensive review of Breast Services and consultant workload is ongoing.

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

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

Performance Overview - Operational Performance

31 day first treatment



Dec-24
93.80%
Variance Type
Common cause variation
Target
96.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 93.80% against a 96% target.

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

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

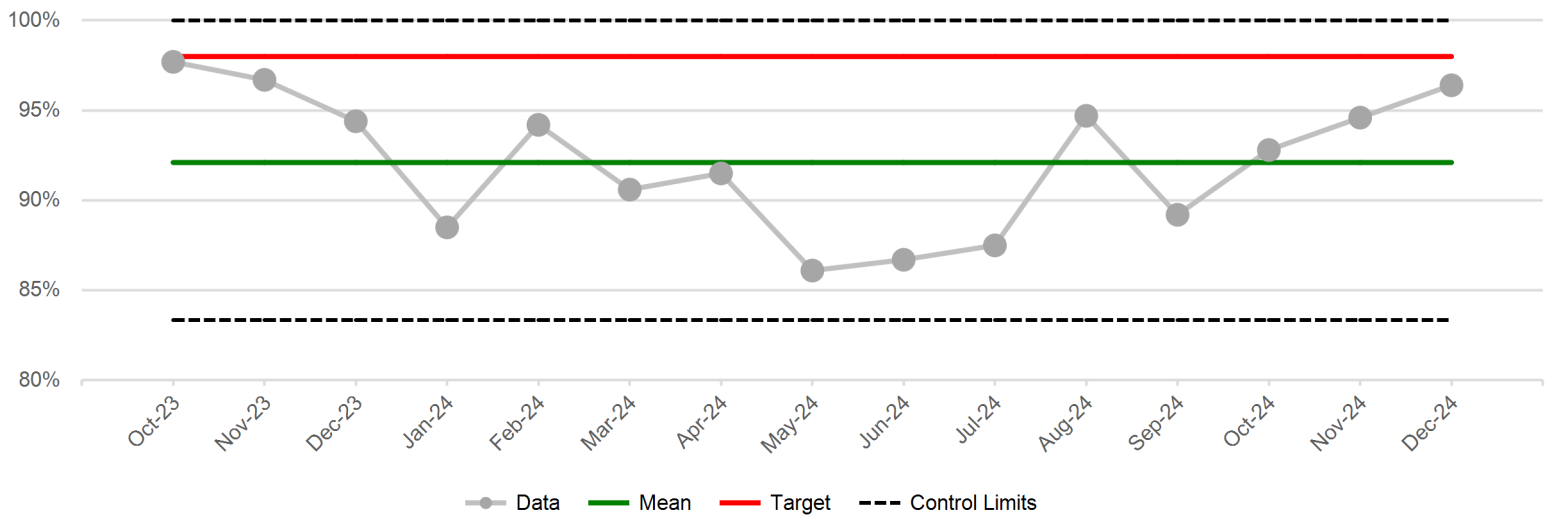
Mitigations:
Robotic Lists are progressing well, though proving difficult to populate at short notice if there are cancellations due to pre-op and anaesthetic assessment capacity. Tumour site specialties are working with TACC to ensure the best possible utilisation of lists, including a process for last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

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Teaching Hospitals NHS Trust

31 day subsequent drug treatments



Dec-24
96.40%
Variance Type
Common cause variation
Target
98.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 96.40% against a 98% target.

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

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

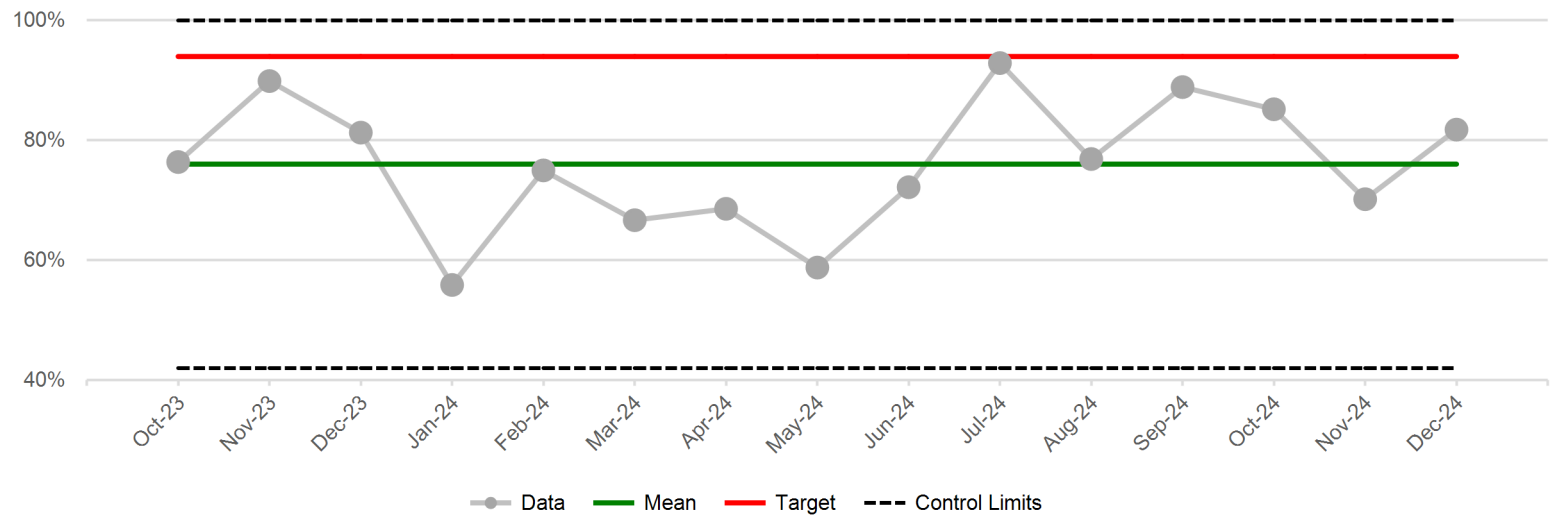
Mitigations:

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Teaching Hospitals NHS Trust

31 day subsequent surgery treatments



Dec-24
81.80%
Variance Type
Common cause variation
Target
94.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 81.80% against a 94% target.

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

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

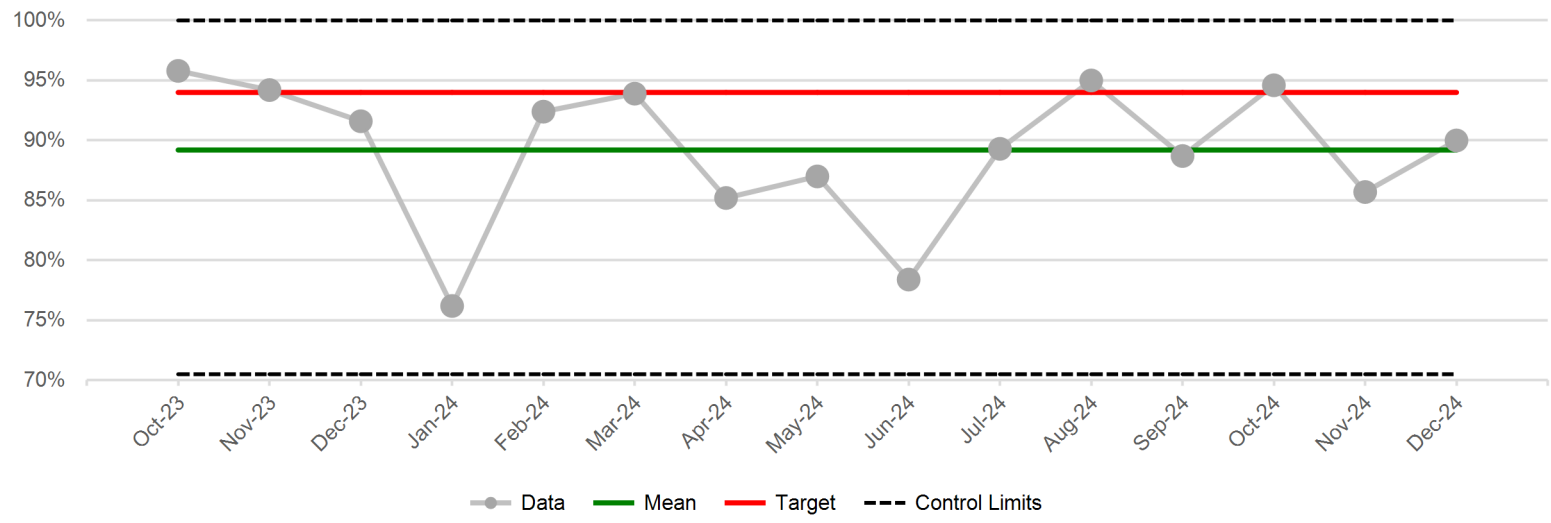
Mitigations:
In Dermatology, a Minor Op Clinic process review, alongside SpDr training, is underway to increase capacity. A training plan for Skin Surgery nurses to support with head and neck lesions is being developed.
In Head and Neck, an ENT consultant has recently commenced in post and further recruitment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

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Teaching Hospitals NHS Trust

31 day subsequent radiotherapy treatments



Dec-24
90.00%
Variance Type
Common cause variation
Target
94.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 90.00% against a 94% target.

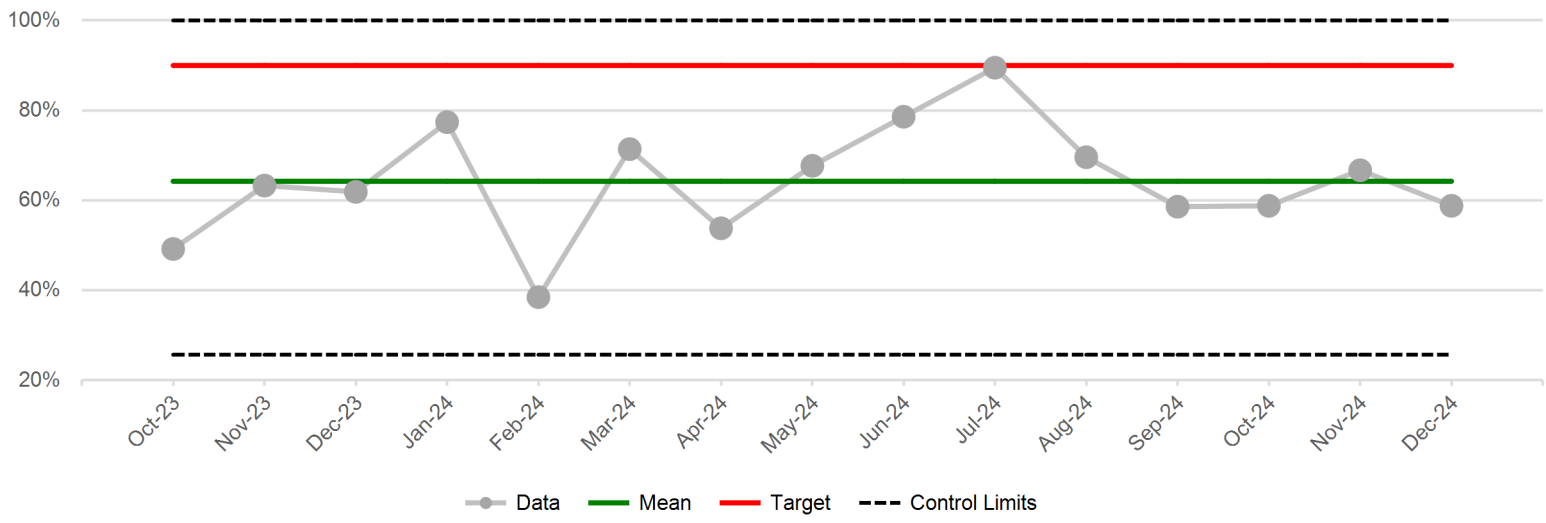
Issues:
Radiotherapy – Recent Linac breakdowns have resulted in delayed treatment start dates.

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

Mitigations:

Performance Overview - Operational Performance

62 day screening



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

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

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

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

Please also see Issues on accompanying pages.

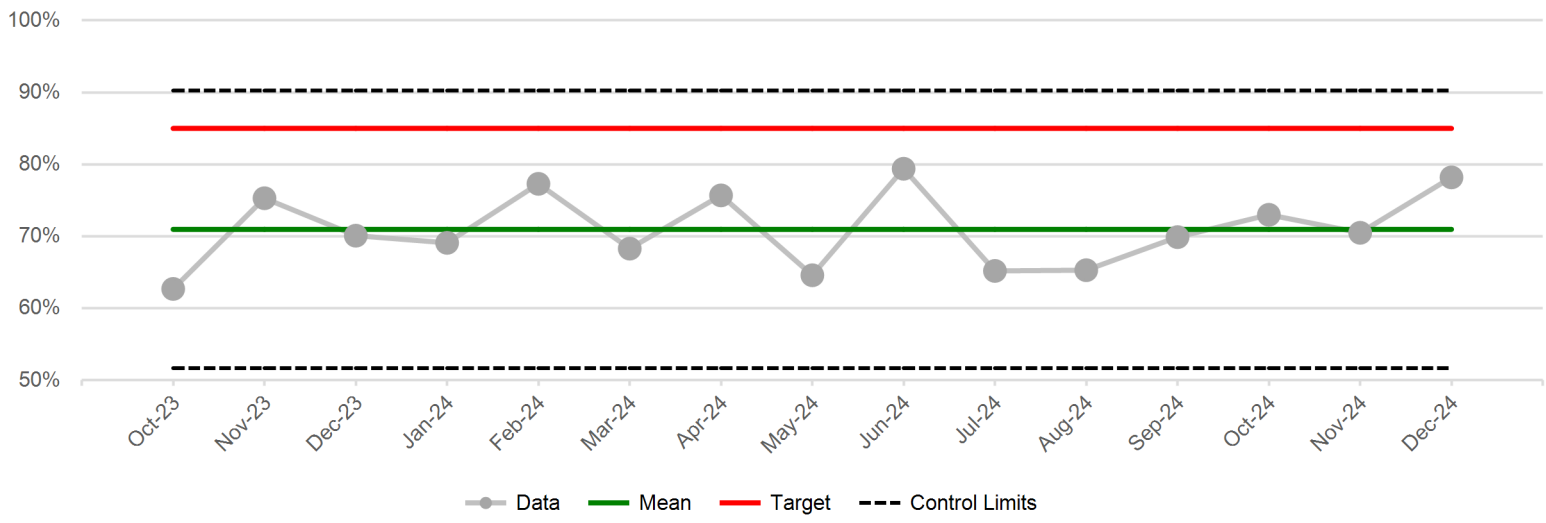
Actions:
Oncology Fragile Service – A piece of work on right-sizing the Oncology service workforce is ongoing and posts are out to advert.
Robotic Lists are progressing well, though proving difficult to populate at short notice if there are cancellations due to the lack of trained staff within theatres,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

Please also see Actions on accompanying pages.

Mitigations:
Please also see Mitigations on accompanying pages.

Performance Overview - Operational Performance

62 day consultant upgrade



Dec-24
78.20%
Variance Type
Common cause variation
Target
85.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 78.20% against an 85% target.

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

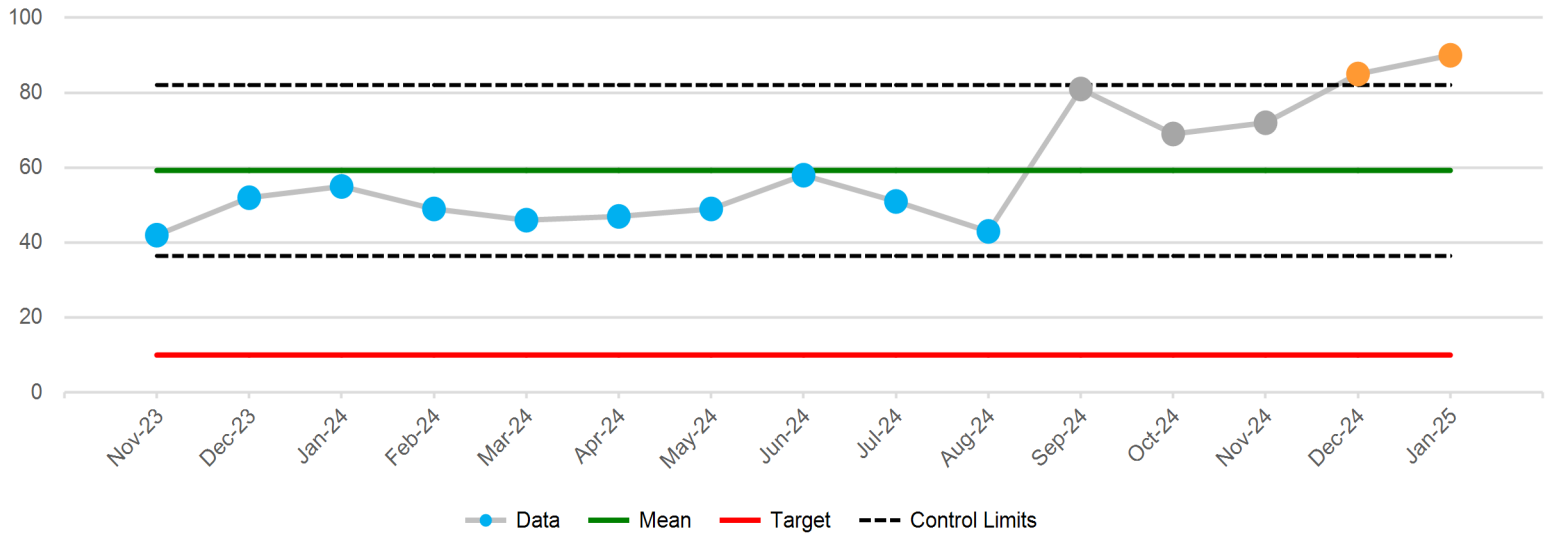
Actions:
Oncology Fragile Service – A piece of work on right-sizing the Oncology service workforce is ongoing and posts are out to advert.
Robotic Lists are progressing well, though proving difficult to populate at short notice if there are cancellations due to the lack of trained staff within theatres,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

Please also see Actions on accompanying pages.

Mitigations:
Please also see Mitigations on accompanying pages.

Performance Overview - Operational Performance

104+ Day Waiters



Jan-25
90
Variance Type
Special cause variation - cause for concern (Indicator where high is a concern)
Target
10
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
Number of cancer patients waiting over 104 days.

What the chart tells us:
As of 12th February the 104 Day backlog is at 90 patients.
There are 5 main tumour sites of concern:-

Colorectal 33
Upper GI 15
Lung 13
Head and Neck 12
Urology 10

Issues:
The impact of ongoing pathway, staffing and capacity challenges.
Patients not willing to travel to where our service and / or capacity is available.
Reduced OP, diagnostic and theatre capacity across the Trust, all Specialties vying for additional sessions.
Managing backlogs significantly in excess of pre-COVID levels for Colorectal, Upper GI, Urology, Head & Neck, Gynaecology, and Lung.
Approximately 25.56% of these patients require support from the Pre-Diagnosis CNS as they have mental or social care needs that have the potential to significantly impact on the length of their pathway.

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

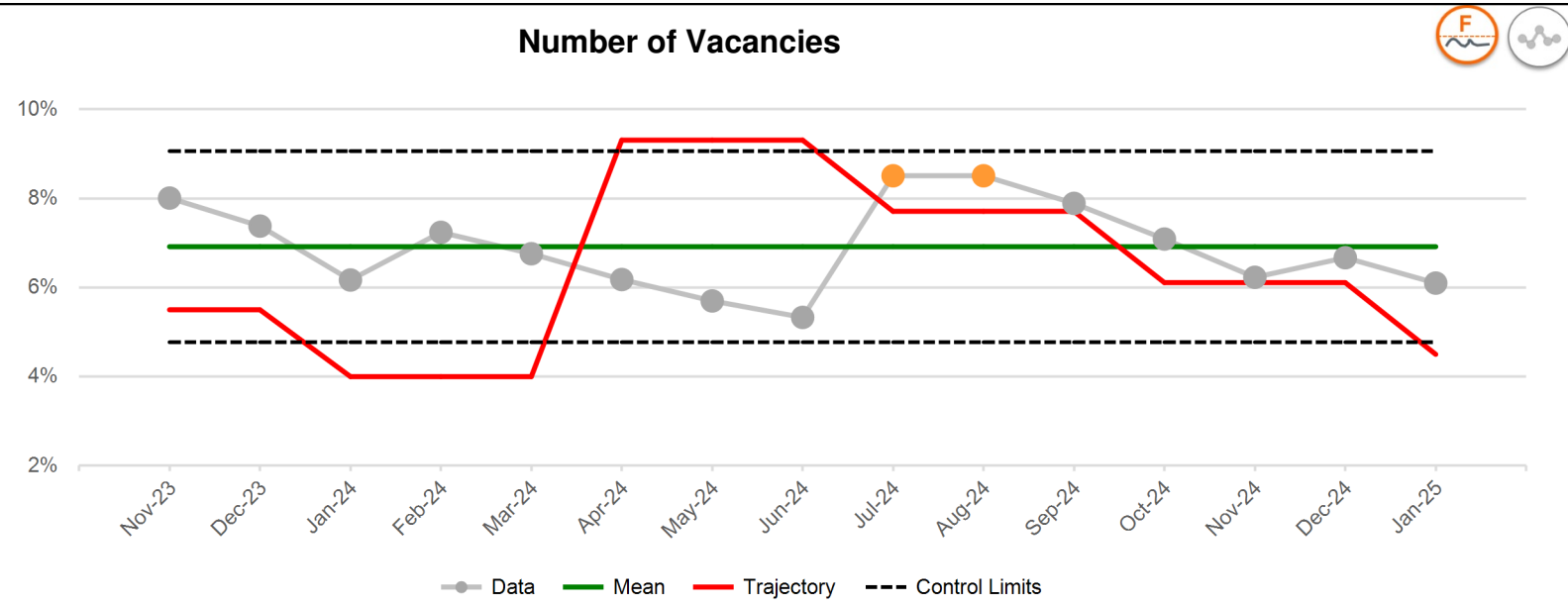
Please also see Actions on accompanying pages.

Mitigations:
Please also see Mitigations on accompanying pages.

Performance Overview - Workforce

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Nov-24	Dec-24	Jan-25	YTD	YTD Trajectory	Pass/Fail	Trend Variation
A Modern and Progressive Workforce	Overall percentage of completed mandatory training	Safe	People	Director of HR & OD	90.00%	93.55%	93.69%	93.53%	93.68%	90.00%	P	
	Number of Vacancies	Well-Led	People	Director of HR & OD	4.50%	6.23%	6.67%	6.10%	6.82%	7.39%	F	
	Sickness Absence	Well-Led	People	Director of HR & OD	5.50%	5.23%	5.24%	5.26%	5.32%	5.51%	P	L
	Staff Turnover	Well-Led	People	Director of HR & OD	9.00%	9.65%	9.54%	9.34%	9.93%	11.23%	P	L
	Staff Appraisals	Well-Led	People	Director of HR & OD	90.00%	79.76%	80.10%	78.31%	78.41%	82.06%	F	H

Performance Overview - Workforce



Jan-25
6.10%
Variance Type
Common cause variation
Trajectory
4.50%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of HR & OD

Background:
January 2025 reported Vacancy Rate is 6.10% against a Q4 target of 4.50%.

What the chart tells us:
That we are not within the Q4 target for although we are within 2% of year-end target.

Issues:
• The increase in vacancy rate is due to the budgets being finalised and translating into reporting.

• AHP recruitment remains an area of focus in response to the implementation of Community Diagnostic Centres.

Actions:
• Work is in progress to review our overall establishment with our Divisional Teams as we further develop Workforce Plans in response to the Long-Term Workforce Plan.

• Continued focus within key roles where the vacancy rate is largest. our Community Diagnostic Centres across Lincolnshire.

Mitigations:
• Ongoing work to ensure compliance with Vacancy Rate targets, and to ensure that our establishment levels remain in line with our overall Workforce Plan.

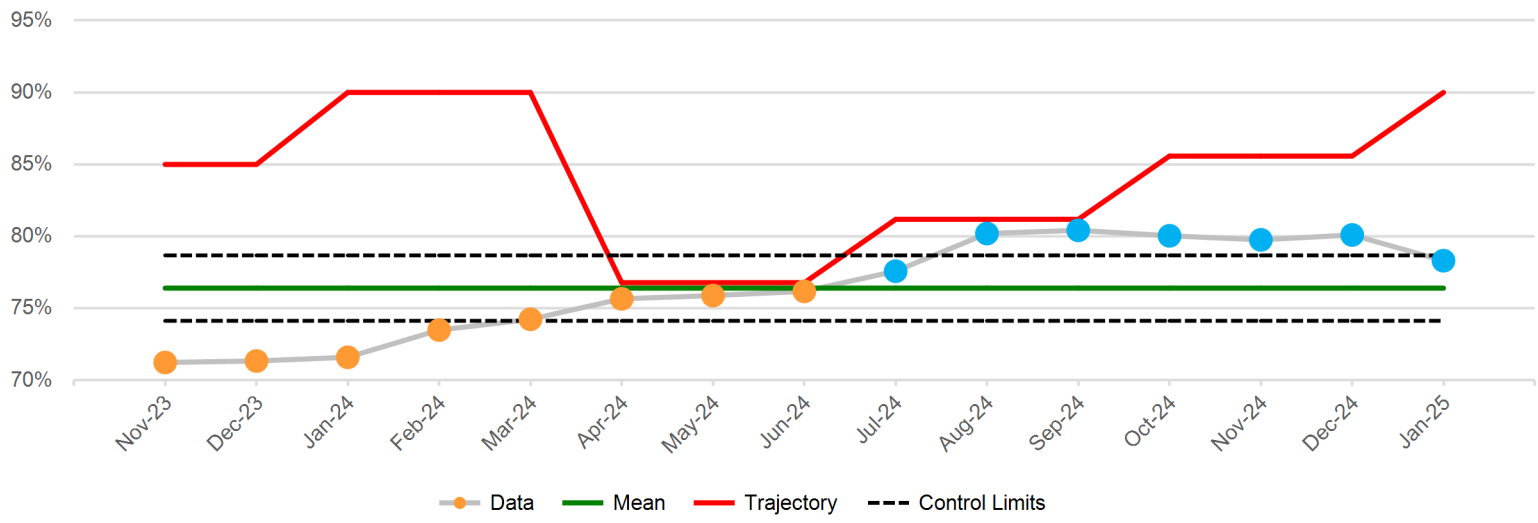
• Our Recruitment Team have supported closing the gap between the Establishment and the number of Staff In Post.

OUTSTANDING CARE personally DELIVERED

Performance Overview - Workforce

NHS United Lincolnshire Teaching Hospitals NHS Trust

Staff Appraisals



Jan-25
78.31%
Variance Type
Special cause variation - improvement (Indicator where high is good)
Trajectory
90.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of HR & OD

Background:
Completion is currently 78.31% for Agenda for Change staff which is outside of the Q4 target of 90.00%.

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

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

Actions:
- Launched 90 minute appraisal 'how to' sessions to improve overall compliance.
- Ensuring that all completed appraisals have been captured in ESR.
- Raising awareness of the importance of an appraisal with a focus on areas of low compliance.
- Paper approved by our Executive Leadership Team with approval given to move to an annual cycle in line with other Trust Reporting and Planning.
- Contacting staff and team managers who are <50.00% for compliance.

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

NHS
Lincolnshire Community and Hospitals NHS Group

LCHS Integrated Performance Report (January Data)

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

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*4th March 2025*
Item Number	*13*

LCHS Integrated Performance Report (January data)

Accountable Director	*Daren Fradgley, Group Chief Integration Officer*
Presented by	*Daren Fradgley, Group Chief Integration Officer*
Author(s)	*Ben Storer, Patient Level Insight Lead LCHS*
Recommendations/ Decision Required	*The Board is asked to:-* • *Note the report*

How the report supports the delivery of the priorities within the LCHG Board Assurance Framework	
1a Deliver high quality care which is safe, responsive and able to meet the needs of the population	*x*
1b Improve patient experience	*x*
1c Improve clinical outcomes	*x*
1d Deliver clinically led integrated services	
2a Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	*x*
2b To be the employer of choice	*x*
3a Deliver financially sustainable healthcare, making the best use of resources	*x*
3b Drive better decision and impactful action through insight	*x*
3c A modern, clean and fit for purpose environment across the Group	
3d Reduce waits for patients who require urgent and emergency care and diagnostics and ensure we meet all constitutional standards	
3e Reducing unwarranted variation in cancer service delivery and ensure we meet all constitutional standards (ULTH)	
3f Reducing unwarranted variation in planned service delivery and ensure we meet all constitutional standards (ULTH)	
3g Reducing unwarranted variation in community service delivery and ensure we meet all constitutional standards (LCHS)	*x*
4a Establish collaborative models of care with all our partners including Primary Care Network Alliance (PCNA), GPs, health and social care and voluntary sector	
4b Successful delivery of the Acute Services Review	
4c Grow our research and innovation through education, learning and training	
4d Enhanced data and digital capability	*x*

5a Develop a Population Health Management (PHM) and Health Inequalities (HI) approach for our Core20PLUS5 with our ICS	
5b Co-create a personalised care approach to integrate services for our population that are accessible and responsive	
5c Tackle system priorities and service transformation in partnership with our population and communities	
5d Transform key clinical pathways across the group resulting in improved clinical outcomes	

Executive Summary

Performance up until the end of January is set out in the report. The Quality Committee and Finance, Performance, People, and Innovation Committee reviewed January performance in their February meetings.

We have not yet received the data for "Care Hours per Patient Day (CHPPD)". As a result, the KPI data for (CHPPD). January is currently missing from this report.

The number of metrics in each cell in the SPC grid is as follows:

		SPC Variation		
		Special Cause Improvement	No Variation	Special Cause Deterioration
Target Capability	Consistently Capable	2	9	0
	Inconsistently Capable	1	13	2
	Not Capable	1	2	0
	No Target	1	18	1

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

1. Home Visiting

   There is an expectation that the compliance will increase for February as we begin to recover from staffing challenges.

2. Ethnicity recording in A&E data sets.

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

3. Patient Incidents

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

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

Upgrade and redevelopment of the Datix system to Datix IQ is currently being explored to bring LCHS in line with ULHT partners.

3 indicators are showing special cause deterioration currently:

1. Ops Centre Calls: Abandoned
   New starters are becoming embedded into their roles which is showing benefits.
   Emails increased to nearly 8000 contacts for January – a 9.7% increase on December.
   Focus next month to look at how we can improve the abandonment rate as well as the priority SLA.

2. Community Hospital Discharge Summaries
   Community Hospitals are seeking further support for Patient Flow which would improve resilience around this process.

3.Virtual wards

   FBI are supporting the virtual ward team, cross referencing the different reporting that currently takes place (e.g., NHSE, SHREWD and internal reports) to make sure that the data is consistent and that all virtual wards are included in all our reporting.

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

1. Patient Incidents per 1000 WTE;
2. GU Patients seen within 2 working days;
3. Staff Turnover;
4. Agency Expenditure
5. Transitional Care Activity

Lincolnshire Community Health Services NHS Trust

INTEGRATED PERFORMANCE REPORT

January 2025 Performance Data

Contents

SPC Scorecard

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

Executive Summary

Safe

X Total LCHS Patient Medication Incidents has increased this month from 30 in December to 44 in January

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

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

✓ MRSA compliance achieving target.

✓ Patient Incidents Community Rate per 1000 WTE decreased from 229.03 in December to 226.25 in January and is above the benchmark of 193.86

Caring

X FFT scores not achieving 95% target.

✓ Complaints have decreased from previous month.

X Compliments decreased from previous month.

Responsive

X Discharge Summaries – Community Hospitals, not achieving target.

✓ Discharge Summaries – Urgent Treatment Centres achieving target.

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

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

✓ 15-minute Ambulance Handover is achieving 95% target.

X Urgent Community Response is not achieving the 97% target for 2-hour response compliance.

X Ops Centre Calls Answered in Timescale is not achieving 90% target.

X Ops Centre Calls Abandoned is not achieving 8% target.

Effective

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

✓ Environmental Cleanliness achieving target.

✓ Bed Occupancy rate achieving 90% while the target is at 85%.

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

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

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

Well-Led

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

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

✓Staff Turnover is within the 15% target.

✓ Year to date agency expenditure is within plan.

✓ Month 10 Trust's YTD deficit is a £0.2M favourable variance to plan.

✓ Overall efficiency (CIP) ahead of plan.

X Cash balances are £16.46M, behind the original plan

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

✓ Capital expenditure is ahead of plan.

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

✓ Training Compliance is achieving the 90% target.

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

X Long-Term Sickness Absence is not achieving 3% target.

.

Medicine-related Incidents

Background

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

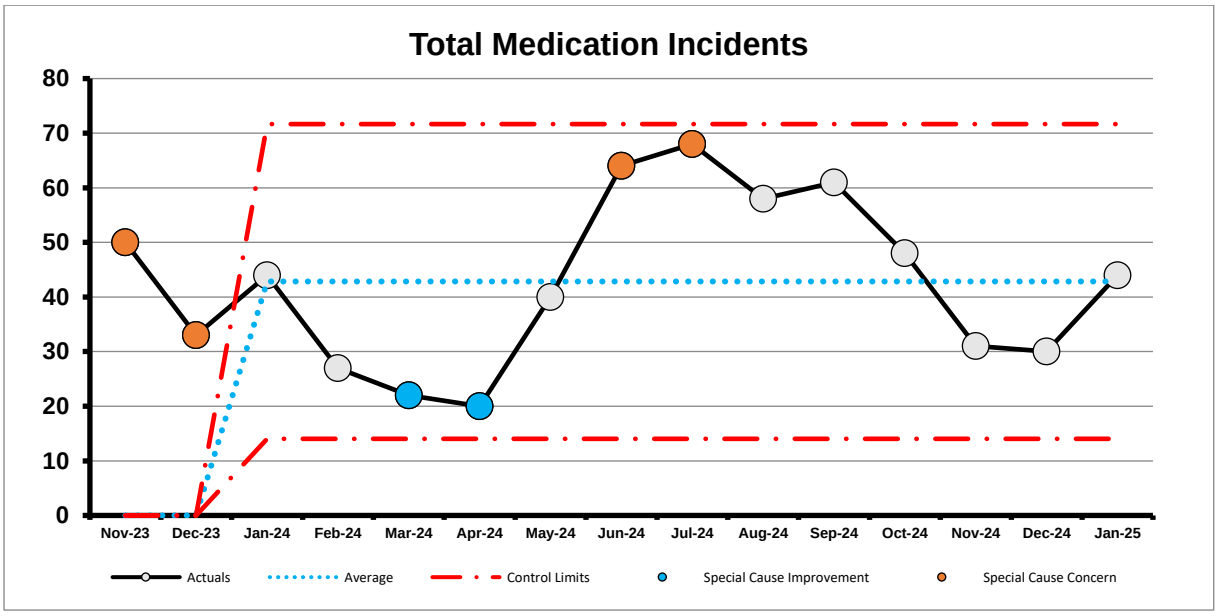
A medicine-related incident can pose a threat to the patient as well as the organisation. The member of staff who made the error can also be affected. Broadly speaking, medicine-related incidents encompass prescribing, preparation, dispensing, administration, and monitoring.

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

Benchmark / Target

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

Current Performance



Narrative

In LCHS, Co-operative pharmacy is the contracted pharmacy service provider to our community hospitals. There is an emerging theme around administration of time critical medication. To mitigate this, the in-house medicines management pharmacy team supported the community hospitals and the contracted pharmacy service provider to develop and implement processes to ensure that time critical medications are administered within a defined time frame. Work has commenced to strengthen the guidance within the medicines policy and introducing fit for purpose audits within community hospitals that will track practice. Clinical staff have been encouraged to complete a Datix whenever time critical medications are administered outside the defined time frame. This has led to a significant increase in the number of incidents reported in June & July when compared to previous months. Administration of time Critical medicine incidents will continue to be tracked to ensure that improvement is embedded & sustained. Examples of time critical medicines include antiparkinsons, psychotropics, blood thinners such as warfarin and antiepileptics.

The inhouse pharmacy team has worked closely with the effective practice facilitator to ensure that time critical medicines are covered in the medicines management training.

LCHS have employed an Associate Chief Pharmacist who is also the trusts medicines safety officer. Part of this role entails improving the reporting and learning from medication incidents. He has been attending various steering groups reiterating and reinforcing the importance of encouraging staff to report medicines related incidents. He also supports teams with action plans ensuring that learning is cascaded and used to improve practice.

SPC

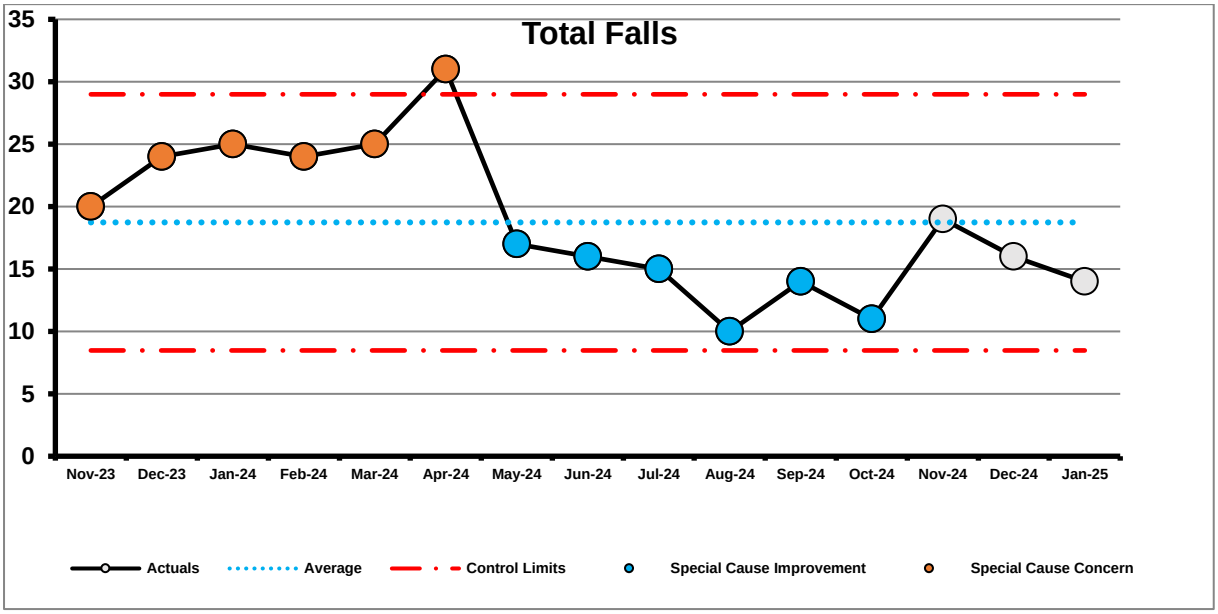
SPC shows that the Trust's total medication incidents have not varied significantly in the period.

Total Trust Falls

Background

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

Current Performance



Narrative

We see a month with about average falls. To strengthen personalised falls care planning templates on S1 are in the process of being reviewed to facilitate this.

SPC

SPC shows that the Trust's total falls have not varied significantly in the period. Showing common cause no variation, sitting below the average and above the lower control limit.

Falls in Community Hospitals

Background

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

Falls are categorised and captured as the following: -

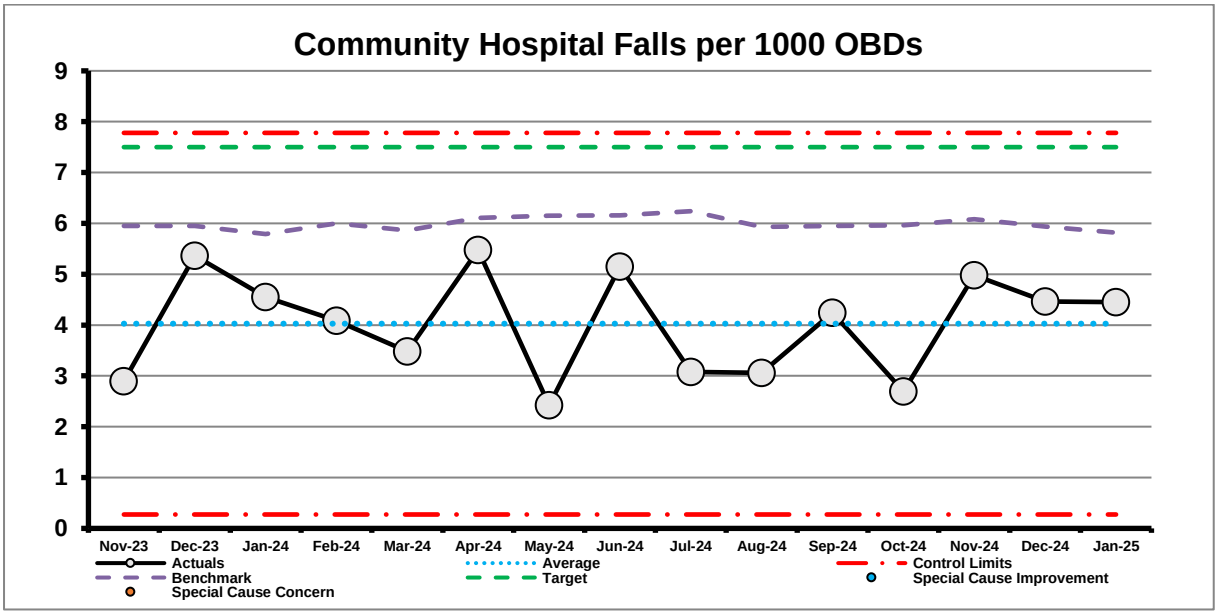
- Fall from a height / bed / chair (these falls tend to result in the highest level of injury of harm
- Slip / trip / fall on level ground.
- Supported lower to ground/ bed / chair / other (many of these are during direct patient care or therapeutic interventions)

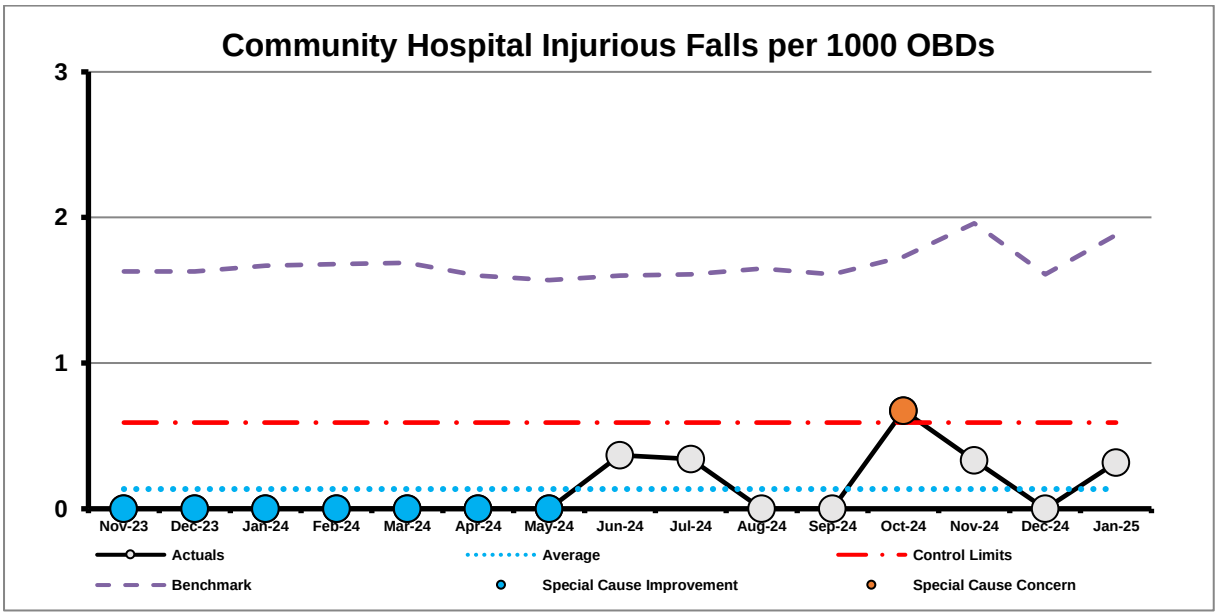
Benchmark / Target

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

The latest available monthly benchmark for all Community Hospital falls is 5.82. The latest monthly benchmark of injurious falls is 1.88.

Current Performance





Narrative

Falls with harm within control limits

SPC

Community Hospital Falls per 1000 OBDs

SPC shows the Community falls per 1000 OBDs have not varied over the period.

Community Hospital Injurious Falls per 1000 OBDs

SPC for Community Hospital Injurious falls per 1000 OBDs shows common cause no variation for January 2025.

MRSA Screening

Background

The Trust undertakes targeted MRSA colonisation screening for inpatients and surgical patients in line with the DH “Implementation of modified admission MRSA screening guidance for NHS (2014)”.

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

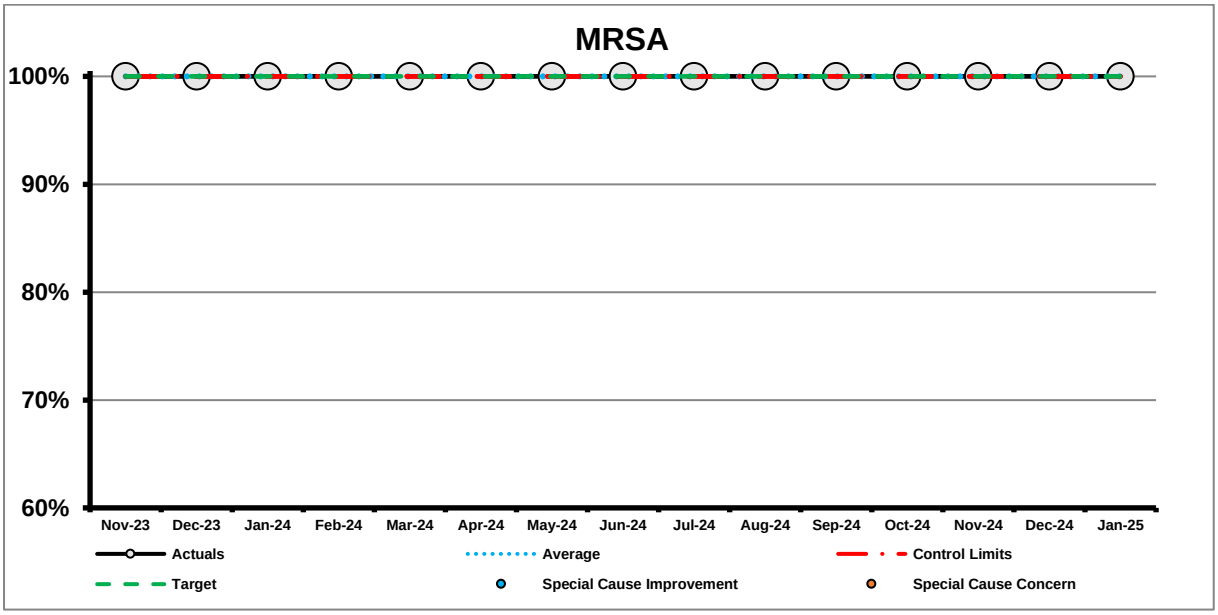
Across LCHS those patients known to be previously MRSA positive or from high-risk groups are identified on admission/or at pre-admission screening and

necessary infection prevention risk management strategies applied.

Benchmark / Target

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

Current Performance



Narrative

Of the 162 patients admitted across all sites, 9 patients were eligible for MRSA screening, of which all 9 were screened.

SPC

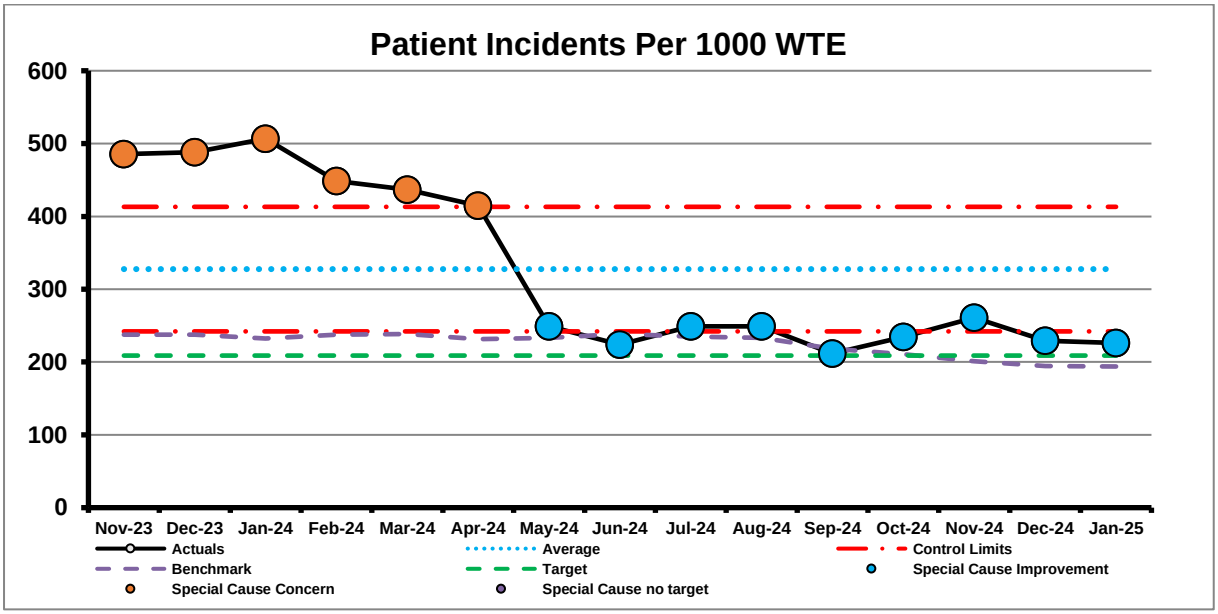
SPC shows MRSA screening compliance has not varied over the period.

Patient Incidents

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

Benchmarking / Target
LCHS has been consistently a high reporter of incidents using the Datix system.
The latest available 6 monthly average numbers of incidents per 1,000 WTE staff in the Community Trust Benchmarking group was 193.86.

Current Performance



Narrative

- The graph shows LCHS patient safety incidents per 1000 WTE from 1 November 2023 to 31 January 2025. The sharp decrease is because as of May'24, only patient safety incidents related to LCHS are being reported on the divisional dashboards and therefore the benchmarking chart that is being submitted into Quality Committee was re-aligned. The benchmarking data is always available on the 10th of each month, and it will therefore be added to the graph retrospectively every month.
- At the time of reporting:
  - CYPSS & IUEC are meeting trajectory around overdue Datix. The remaining divisions are taking actions to realign to trajectory by weekly quality review meetings with leadership oversight.
  - Duty of a candour continues to be tracked weekly. There continues to be improvement in the timeliness of Duty of Candour compliance.
  - There are zero Never Event investigations ongoing, nor have any been declared.

Actions

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

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

Upgrade and redevelopment of the Datix system to Datix IQ is currently being explored to bring LCHS in line with ULHT partners.

SPC
Patient Incident SPC has shown special cause improvement since May 2024.

Community Pressure Ulcers – Rate per 1,000 contacts

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

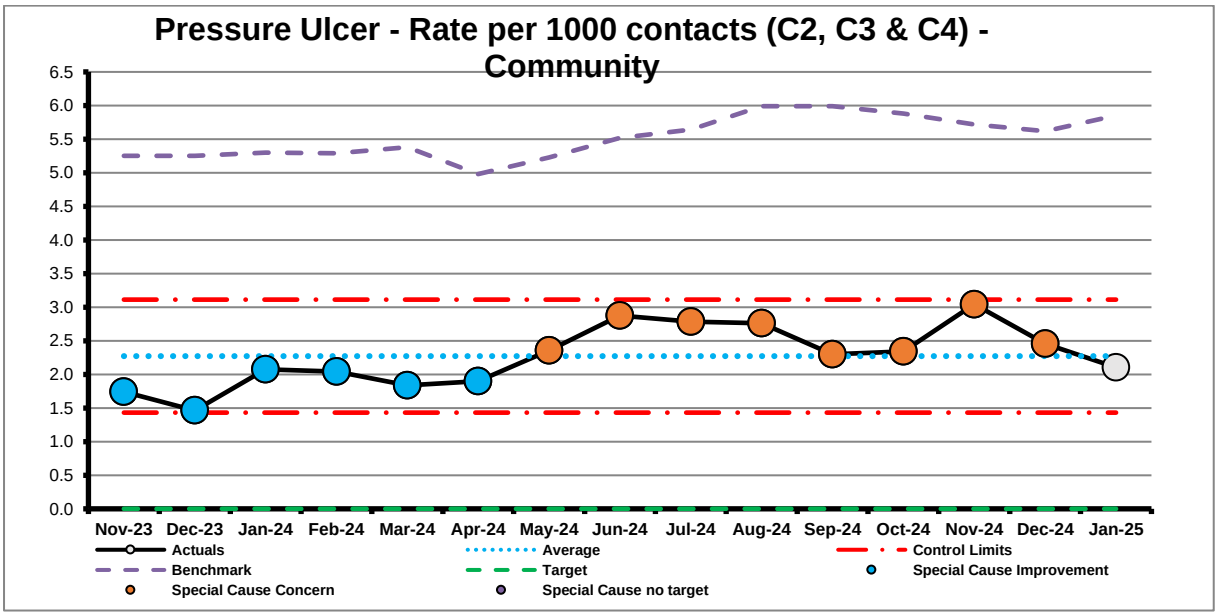
Reduction in patient harm related to pressure damage is the highest priority objective for the Lincolnshire Safeguarding Adults Board.

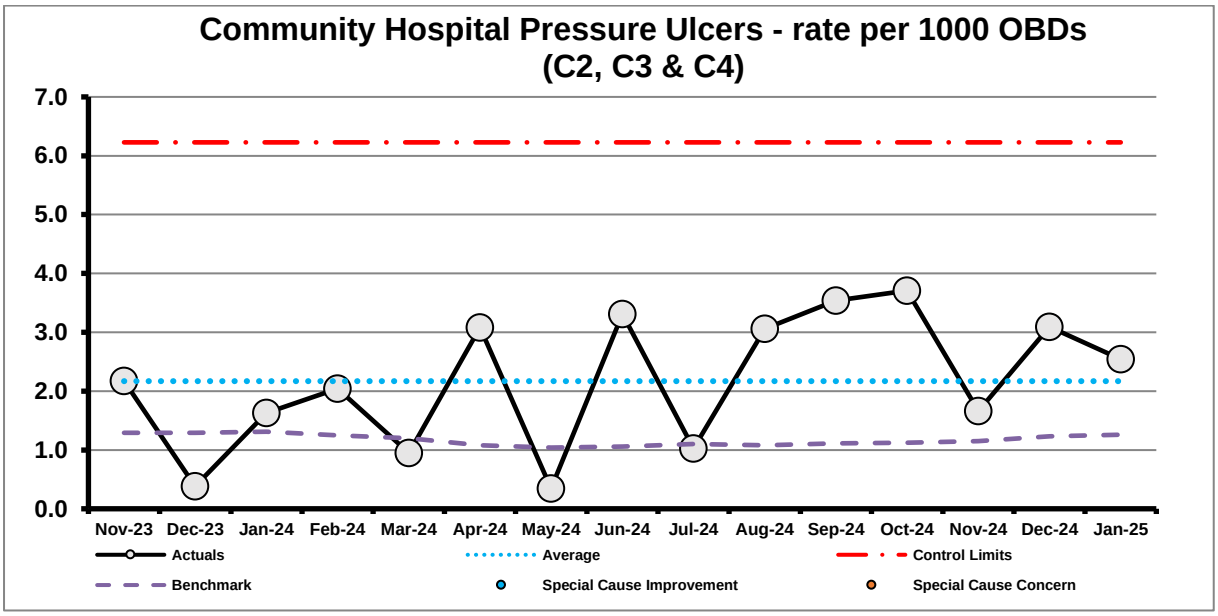
The Lincolnshire System Quality Group have agreed their first quality priority to be pressure damage – eradication of harm, standardising and improving care.

Benchmark
Benchmarking will continue to be calculated in community teams by 1,000 patient contacts – currently the national benchmark is 5.85.

Community Hospital benchmarking is calculated by 1000 Occupied Bed Days (OBDs) – currently the national benchmarking rate is 1.26.

Current Performance





Narrative for Community:

Awaiting Clinical Narrative and data update

Narrative for Community Hospitals:

Since the change to reporting standards a new average needs to be established. Community Hospitals continues on the same trajectory as previous months.

SPC

Pressure Ulcers - rate per 1000 contacts (C2, C3 & C4) – Community
SPC for Pressure Ulcer rate/1000 there has been a slight decrease for this reporting month of January and is now common cause no variation.

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

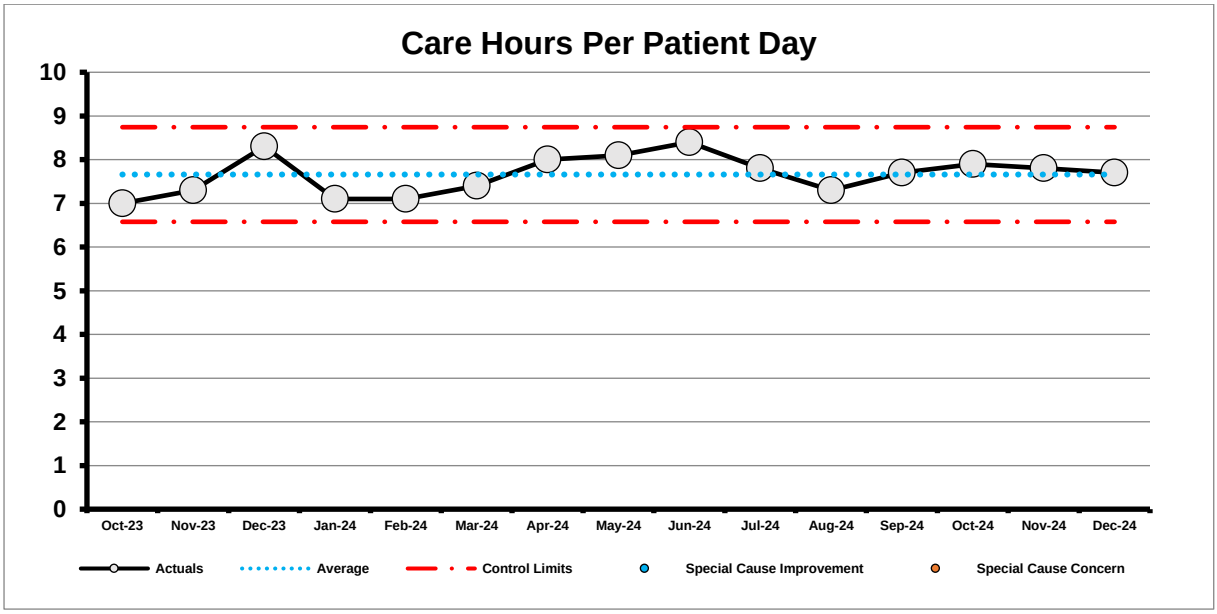
Care Hours Per Patient Day (CHPPD)

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

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

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

Current Performance



Narrative

Awaiting Clinical Narrative and data update

SPC

Care hours per patient day shows no significant variation over the period, and is within the control limits.

Patient Facing Time

The process for capturing the data to report PFT and the relevancy of the metric is under review.

Discharge Summaries

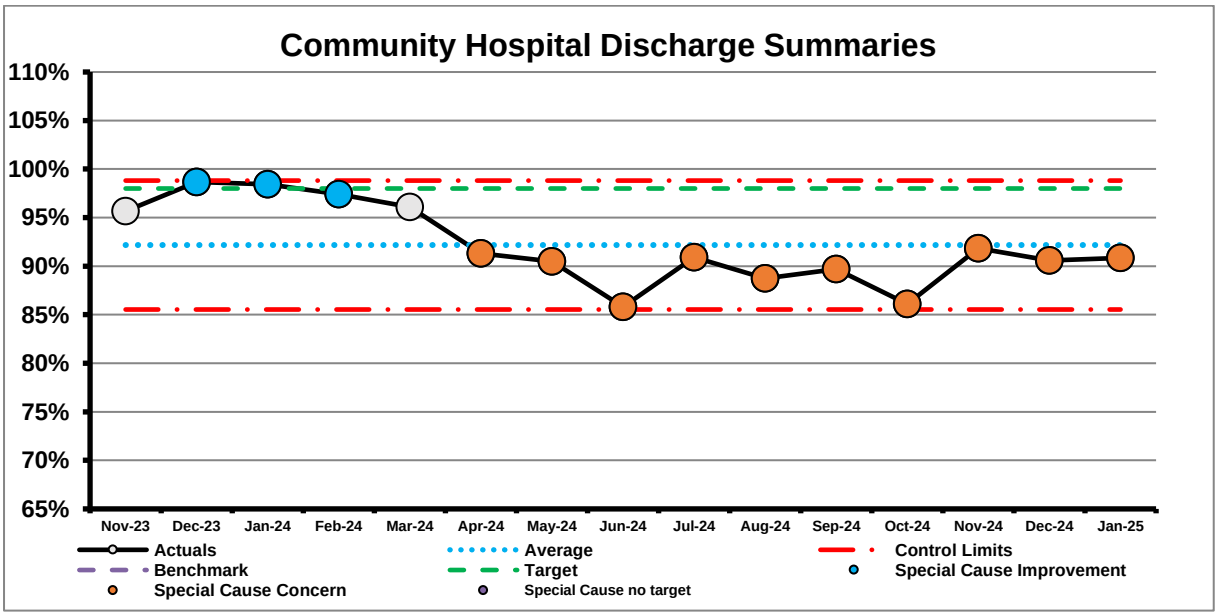
Background

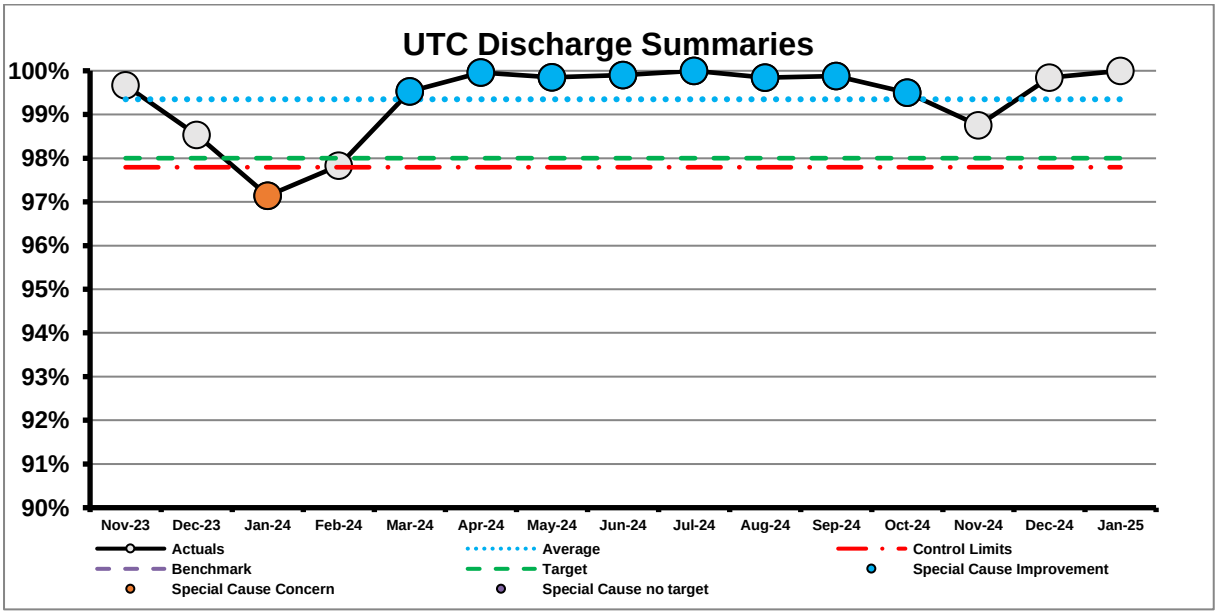
It is a requirement of the Quality Schedule part 6 to the NHS Standard Contract that discharge summaries issued by the ward doctor are issued from Community Hospitals to the patients GP within 24 hours of discharge. As the Trust medical staff currently work Monday to Friday this performance measure is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

Benchmark / Target

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

Current Performance





Narrative

Community Hospitals

Working as an MDT the Community Hospitals are seeking to address this with clearer ownership of responsibilities in the process. Community Hospitals are seeking further support for Patient Flow which would improve resilience around this process.

Urgent Treatment Centres

'The UTC's have achieved 100% of all discharge's summaries sent to the GP, this mean 100% of patients were kept safe and onward letter sent to GPs on time. This is an excellent achievement to ensure the people of Lincolnshire are safe''.

SPC

Discharge Summaries - Community Hospitals
SPC Community Hospital Discharge Summaries has shown special cause concern since April 2024 and is sitting slightly below the average.

Discharge Summaries – Urgent Treatment Centres
UTC Discharge Summaries has shown no variation in the period.

Overdue & Reported Datix

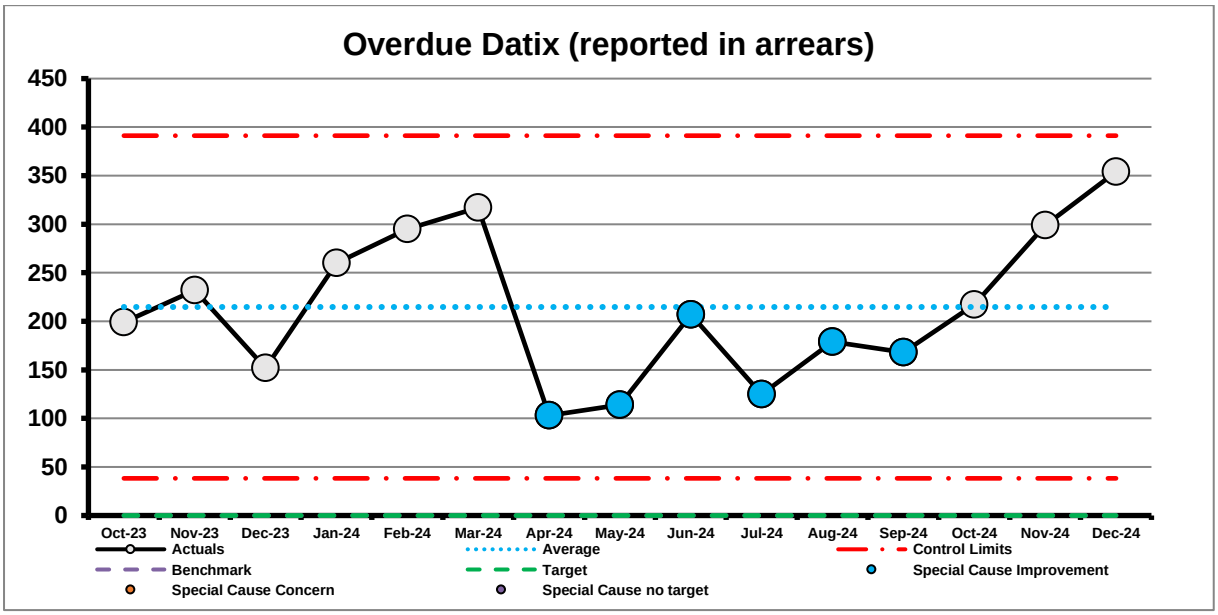
Background
When a Datix is raised to alert or escalate an incident (IR1 form) – it is imperative that the details are reviewed and considered in terms of any immediate actions that have or should be taken particularly regarding patient and staff safety.

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

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

Datix are reported as at the end of the preceding month (i.e., below is the position for November 2024). Reported Datix are reported at the end of the reporting month.

Current Performance



Narrative

The timescale covering the period between an incident being reported to it being reviewed and finally approved is one calendar month. An incident is marked overdue if it has not been finally approved within 31 days of the incident being reported.

Historically a target of 10% of all reported incidents has been used as the tolerance threshold.

CYPSS & IUEC divisions are meeting trajectory around overdue Datix.
The other divisions are taking actions to realign to trajectory by weekly quality review meetings with leadership oversight.

Within Community nursing there are a number of 'overdue Datix' that are pending approval ('Being Approved') because they are awaiting steering group (PUs) and thematic review (Medicines) validation. These numbers are consistent each month however relate to different events awaiting the monthly review which happens after PSG in the reporting cycle. These events are reviewed at steering group and then closed.
Within Community Hospitals overdue Datix marked as 'Awaiting final approval' have been fully investigated by the clinical team and are awaiting final sign off by Clinical Service Lead. Community Hospitals and

services have agreed on a timeline of 2-3 months to close the oldest outstanding Datix reports within the division.

SPC

The SPC for Overdue Datix has not varied over the period.

Children in Care (reported one month in arrears)

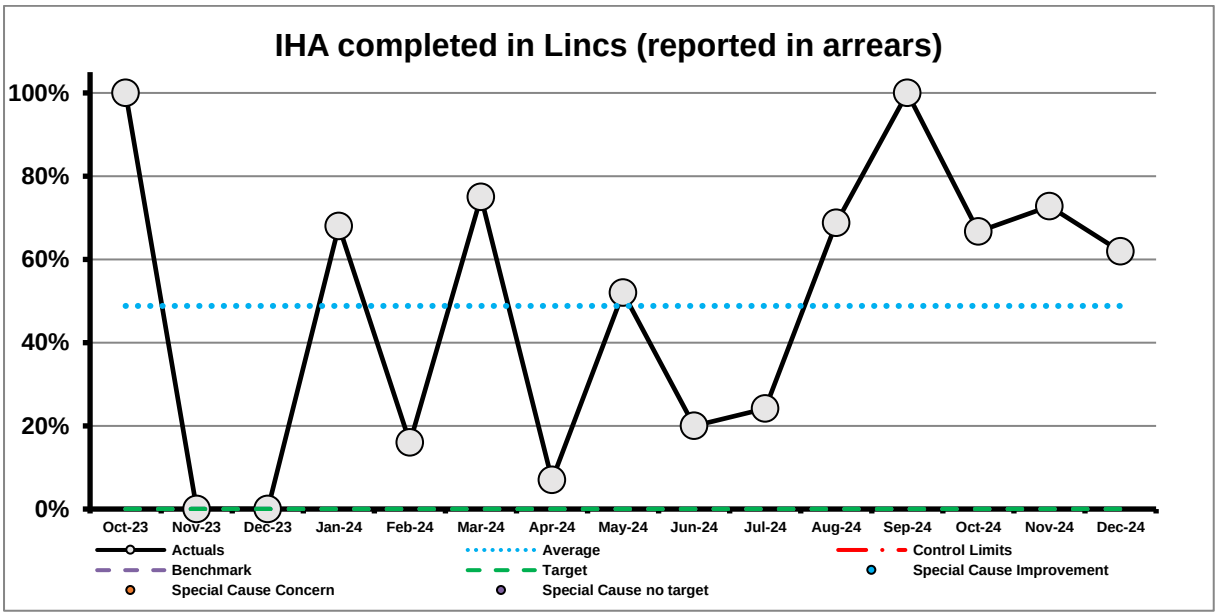
Background

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

Benchmarking / Target

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

Current Performance



Narrative

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

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

In December, 21 children entered care in Lincolnshire, and 13 received an initial health assessment within 20 working days of them becoming looked after.

SPC

The SPC for IHA Performance is above average in December.

Environmental Cleanliness

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

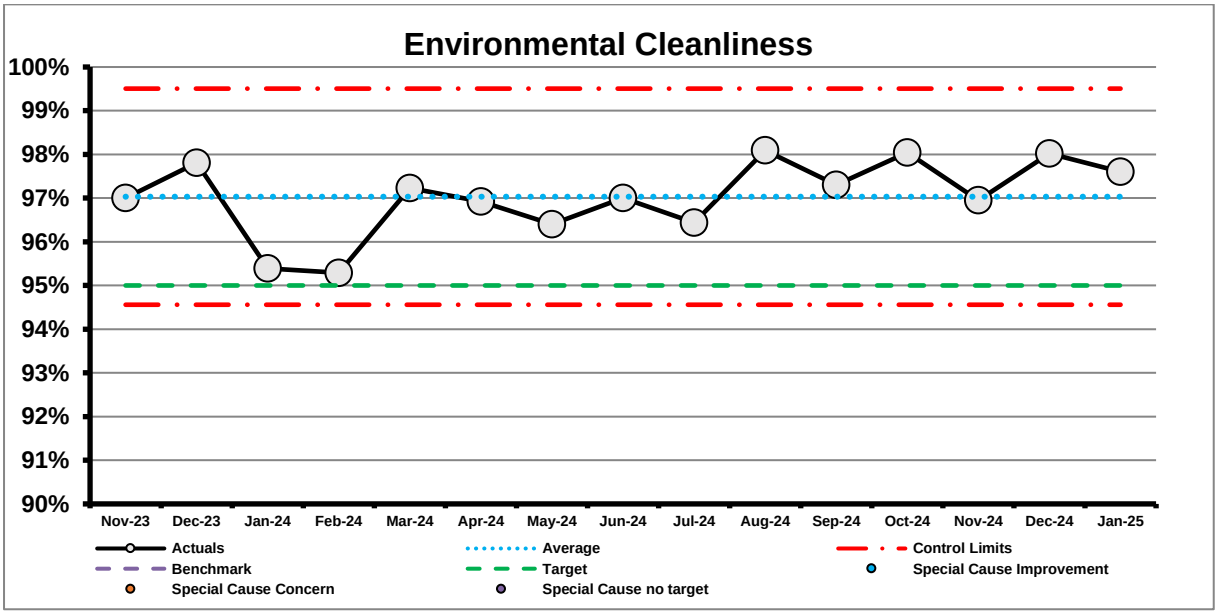
The requirements of the new National Standards of Healthcare Cleanliness that were published at the end of April 2021 have been rolled out across all LCHS community premises by OCS as well as being adopted by NHSPS and the in-house teams at the hospital sites.

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

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

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

Current Performance



Narrative
LCHS reported 97.6% compliance of cleanliness audits and has achieved the 95% target every month. Visible improvements in the cleaning standards across all the community premises are being sustained. During the quarter, all sites achieved scores that would rate them as either 4 or 5 stars, in accordance with the new Healthcare cleaning standards.

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

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

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

Community Hospital Bed Occupancy

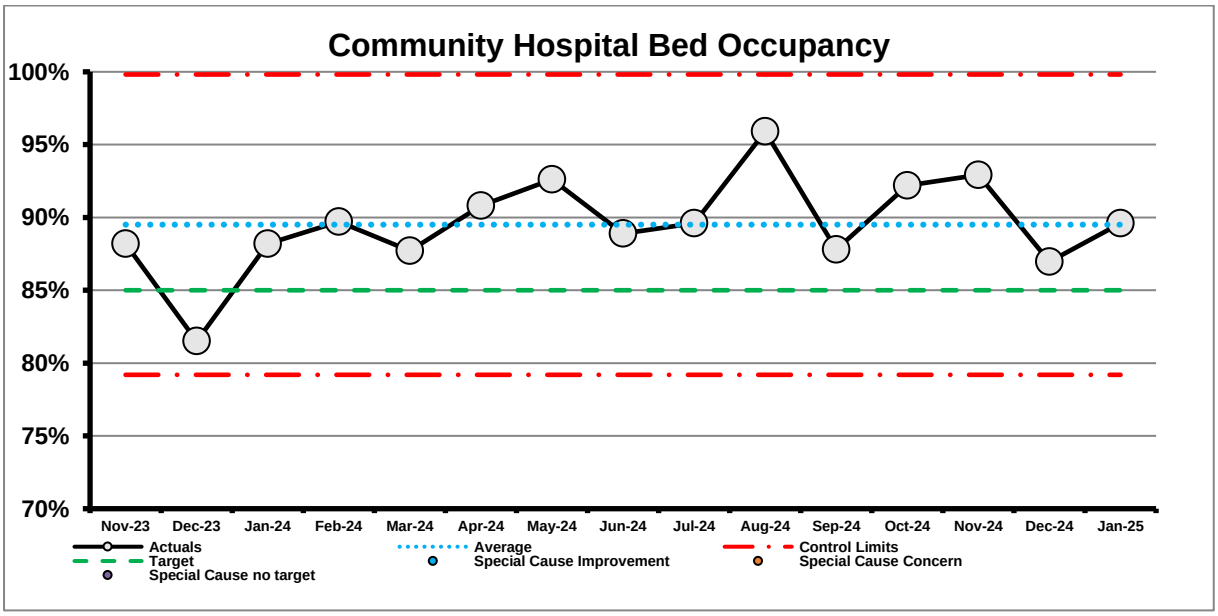
Background

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

Benchmark/Target

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

Current Performance



Narrative

In reality for January all beds were filled at all times but because of the delay in a patient arriving post acceptance some beds are empty at midnight but do have names against them. In addition to this the occupancy of palliative care beds remains less than that of rehab beds. In future months we hope to report these figures separately.

SPC

SPC shows the Community Hospital bed occupancy performance has not varied over the period and continues to be above the target of 85%.

Average Length of Stay

Background

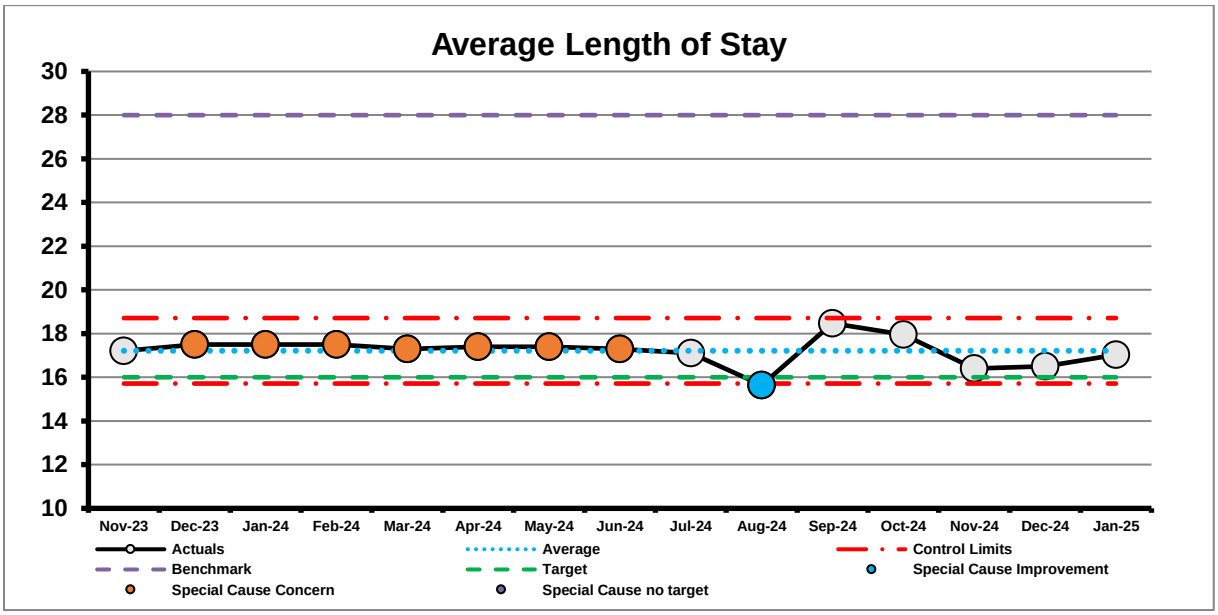
This measure is defined as the difference in days between the date the patient was discharged from the hospital, and the date they were admitted. The average time in hospital in days for all the patients who underwent a procedure in an NHS trust is then calculated (NHS Digital, 2018).

Benchmark/ Target

NHS National Benchmark for Average Length of Stay is currently 28 days.

Target length of stay is 16 days.

Current Performance



Narrative

Continues at the long run average.

SPC

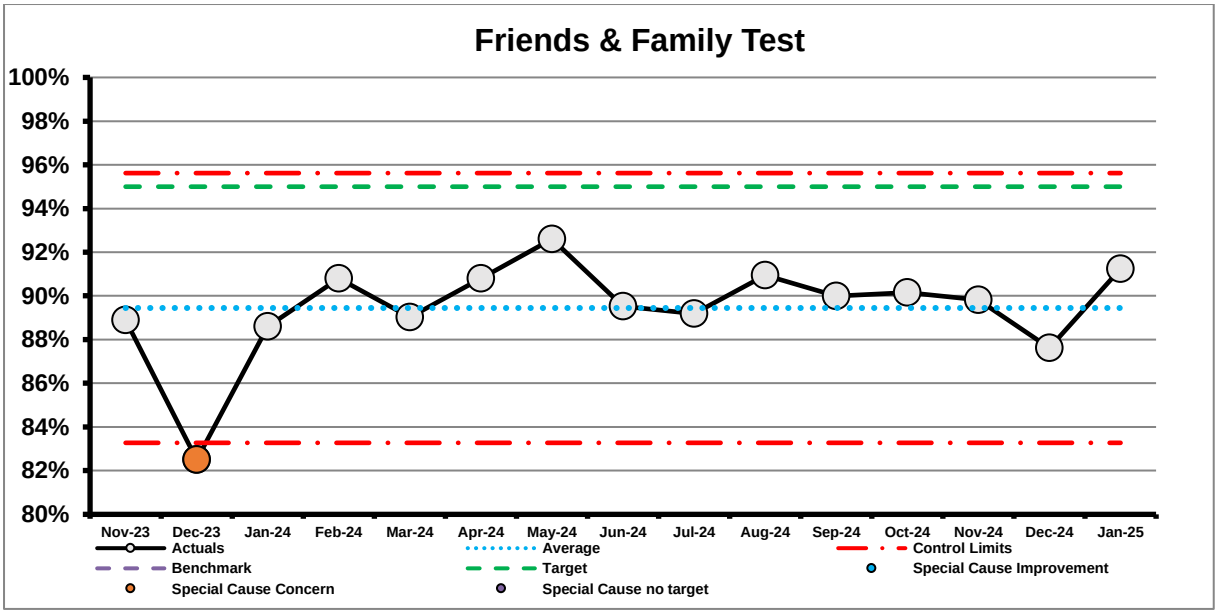
Average length of stay SPC shows it has not varied significantly in the period and sits upon the average line.

Friends and Family Test

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

Benchmark / Target
The LCHS Target is 95% of service users recommend our services.

Current Performance



Narrative

FFT figures for January (91.24%) shows an increase on last month's performance activity (87.62%).

11 FFT QR codes have been generated with bespoke alignment to the community nursing teams for patient engagement and feedback. The Patient Experience Support Officer is working within each of the 11 community nursing teams for an enrichment data collation experience. The FFT intelligence acquired will formulate a 'you said we did' feedback method - which will be incorporated into the weekly bulletin, screensaver, team meetings and QSG for dissemination.

Actions

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

SPC

SPC shows that Friends and Family performance has shown no variation in the period.

Compliments

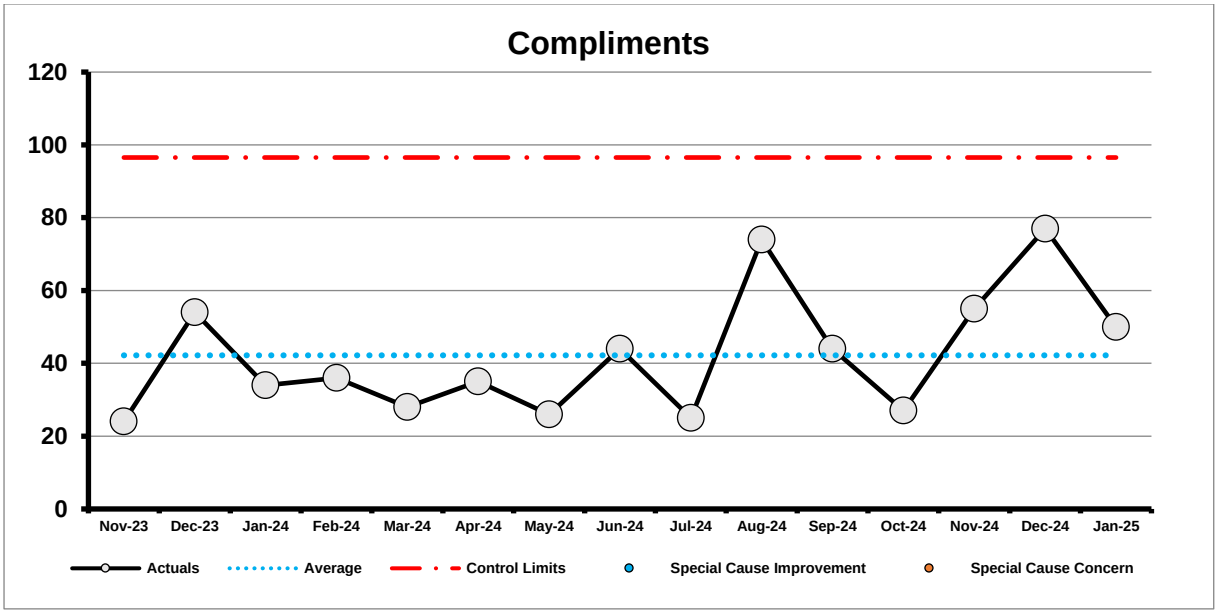
Background

Compliments are received by the Trust through services directly which are then shared with the PALS, Complaints and Claims Team, through NHS Choices, Healthwatch, alternative partners or directly into PALS. Work continues to accurately capture the compliments received by the Trust.

Benchmark / Target

There is no available benchmarking. A proposed target of 50 compliments each month across the Trust is currently being discussed with divisions.

Current activity



Narrative

There seems to be a slight increase in January with 50 recorded. These are mainly Community Hospitals (21) Childrens and Specialist Services (12), Collaborative CC (6) and Urgent Care (9). The pals and complaints team also received 2 this month.

SPC

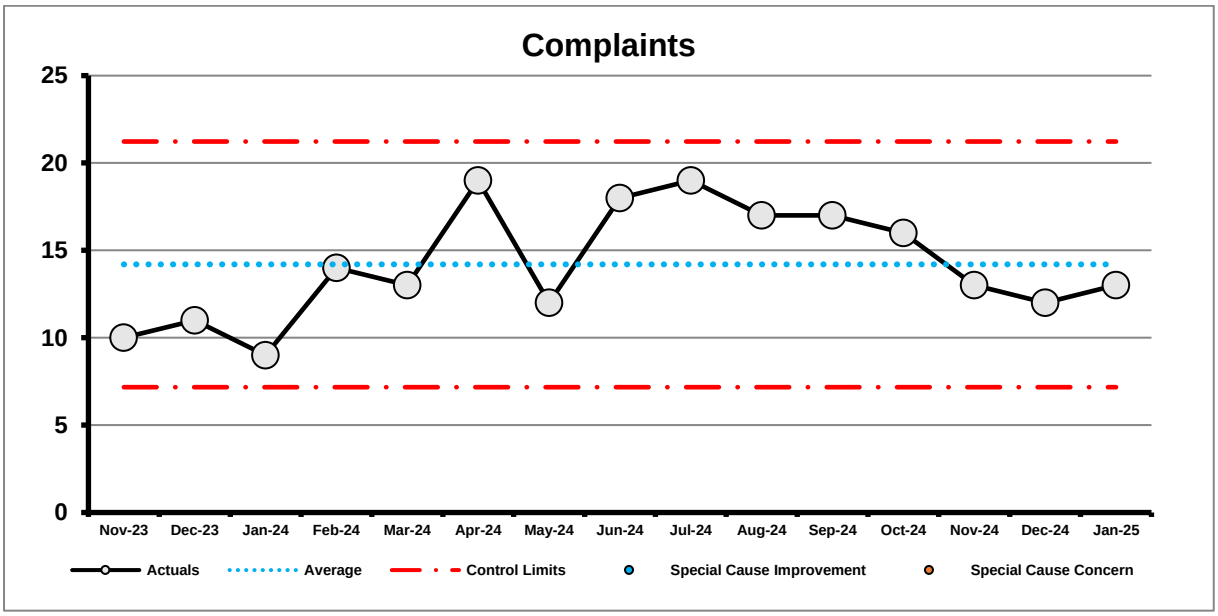
SPC shows that compliments have not varied significantly.

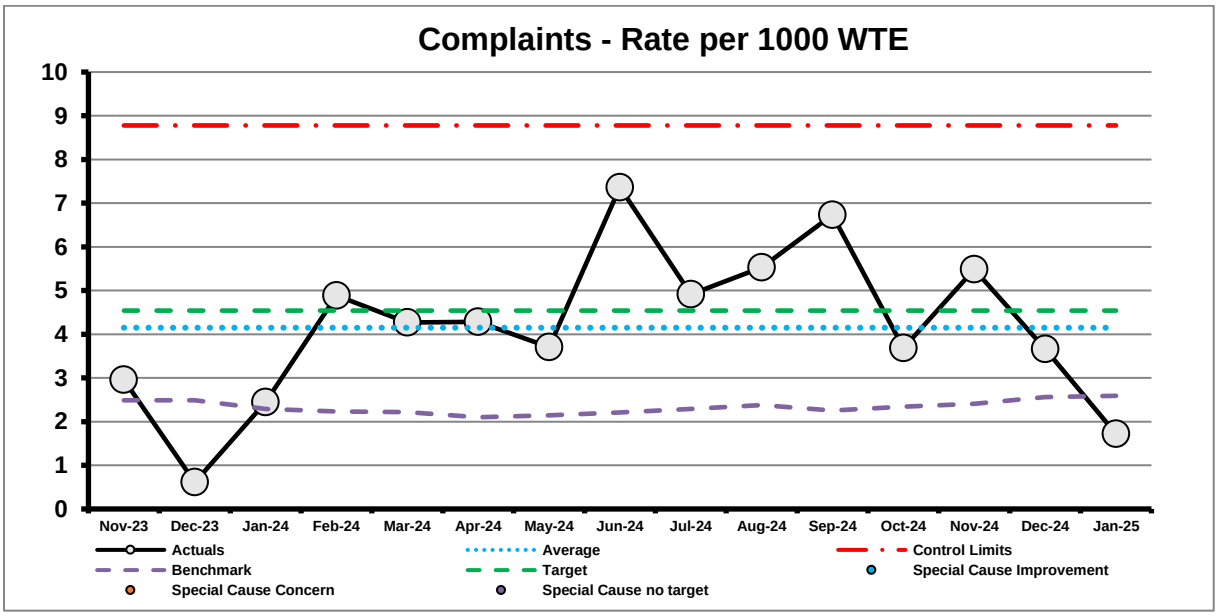
Complaints

Benchmark / Target

LCHS is benchmarked by the number of complaints reported per 1,000 WTE budgeted staff.

Current Performance





Narrative

As a Trust we are keen to resolve any complaints or issues concerning contact that patients or family members have with our services.

We are currently working with divisions to streamline the complaints process; we have implemented a complaint handler for each complaint who will work more closely with the investigator of the complaint. Significant work will take place over the coming months to improve the flow of the complaint

process across the Trust and align the complaints process with colleagues at ULHT. Discussions are being held with the divisions to gain feedback before implementing a new process.

Actions

The complaints team are continuing to improve the complaints process. There will be more changes to the current process over the next few months and talks have started with some of the divisions regarding the planned new process.

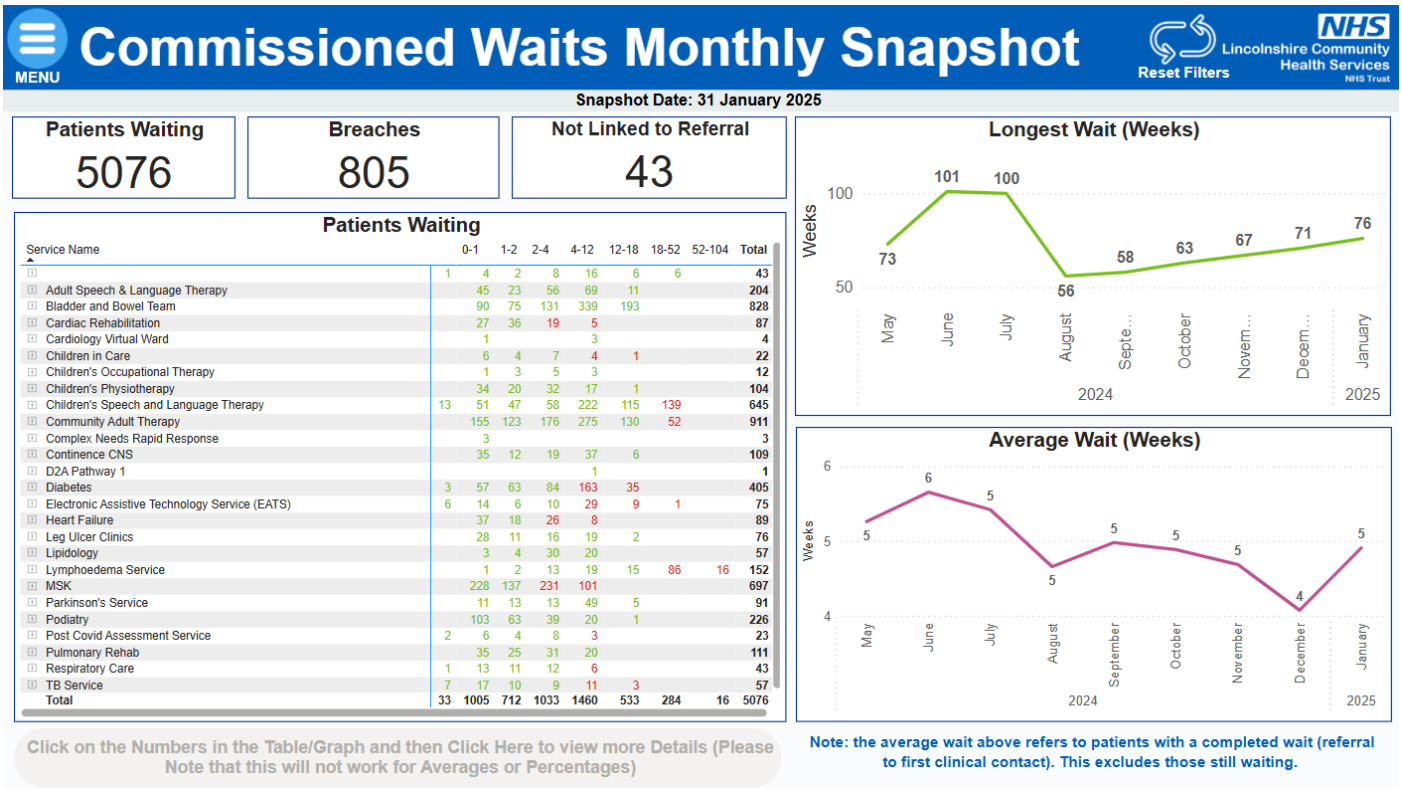
SPC

SPC for complaints has not varied significantly in the period. Complaints rate per 1000 WTE has also not varied significantly in the period.

LCHS Commissioned Waits

Background

LCHS Commissioned waits are the agreed target waits set out by each service level agreement and therefore not all services will be aligned to an 18 week wait target.



Narrative

This is the current LCHS Commissioned Wait position based on the data for those services using the clock, and where the clock has not been paused. It has been agreed across the Trust for waits to be recorded using the 18 Week Wait function on SystmOne. However, each individual service will be working and recording Harm reviews within their own commissioned wait KPIs which maybe outside the 18 weeks.

Despite the NHS Operating Framework and NHS Constitution setting out rules and definitions for consultant-led waiting times, as a non-consultant-led trust, the NHS framework allows the use of the clock to make clinically sound decisions locally about applying them, in collaboration between clinicians, providers, commissioners and the patient.

All services have now implemented this process, recording referral to initial contact.

Lymphoedema has seen an increase in urgent referrals which has meant that those referred and triaged as routine must unfortunately wait longer. Safe waiting advice and safety netting is in place. Essity are kindly providing clinics to help bring the waiting list down. The service has submitted a Case of Need and a Business Case to expand capacity and are awaiting an outcome to inform future delivery. There has been a possible opportunity to expand clinics to Sleaford and work has begun with a view to procuring the clinic space and equipment required.

The agreed target waits for those services currently utilising the clock are outlined below.

Service	**Target Wait**
Adult Speech and Language Therapy	18 Weeks
Bladder and Bowel	6 Weeks

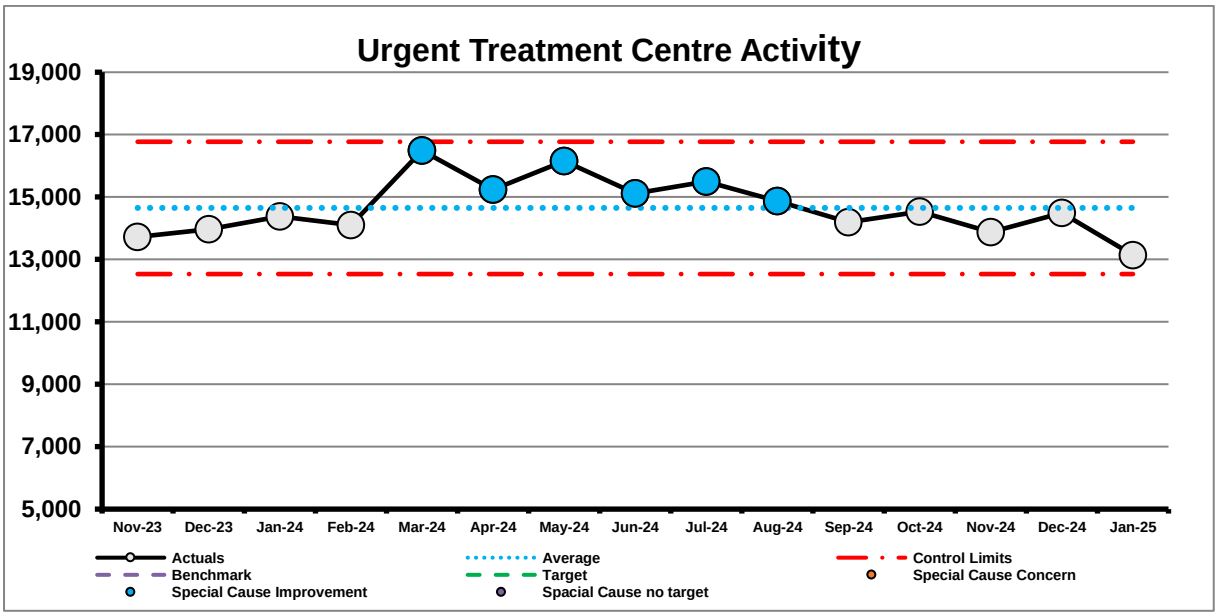
Cardiac Rehabilitation	10 Working Days
Child Therapy	18 Weeks
Children in Care	20 Working Days
CNS Continence	18 Weeks
Diabetes	4 Weeks
Electronic Assistive Technology Service	6 Weeks
Heart Failure	2 Weeks
Musculoskeletal Physiotherapy	15 Working Days
Parkinson’s	18 Weeks
Podiatry	18 Weeks
Post Covid	6 Weeks
Pulmonary Rehab	10 Weeks
Complex Needs Rapid Response	18 Weeks
Respiratory (CCM, Oxygen, Physiotherapy)	4 Weeks
TB	6 Weeks

The function of the clock is to provide a true wait for those patients with a new referral awaiting an initial clinical contact and should not be confused with the Waiting Lists on SystmOne which will run alongside the clock. The Waiting Lists show the position of the patients wait but does not take into consideration where the patient has been offered an appointment they have refused and cannot be paused for any reason. This is likely to have a negative impact on the services performance.

Urgent Treatment Centre Activity

Background

This metric measures UTC activity across the Trust. Note that all LCHS Minor Injury Units (MIUs) have now transitioned to Urgent Treatment Centres, in line with national requirements. Activity from June 2021 onwards excludes Peterborough UTC after the cessation of this contract. The figures also exclude the support that LCHS provided to United Lincolnshire Hospitals at Grantham (running a UTC from July 2020 – June 2021).



Narrative

The above data shows the footfall in January 2025 is slightly down on the December 2024 data but remains within expected activity ranges. We are continuing to monitor when the peak in footfall arrives at UTC's and monitoring whether GP collective action is having impacts on the UTC footfall. We expect to see a rise in footfall over the winter period due to the respiratory infections presenting at UTCs as nationally predicted.

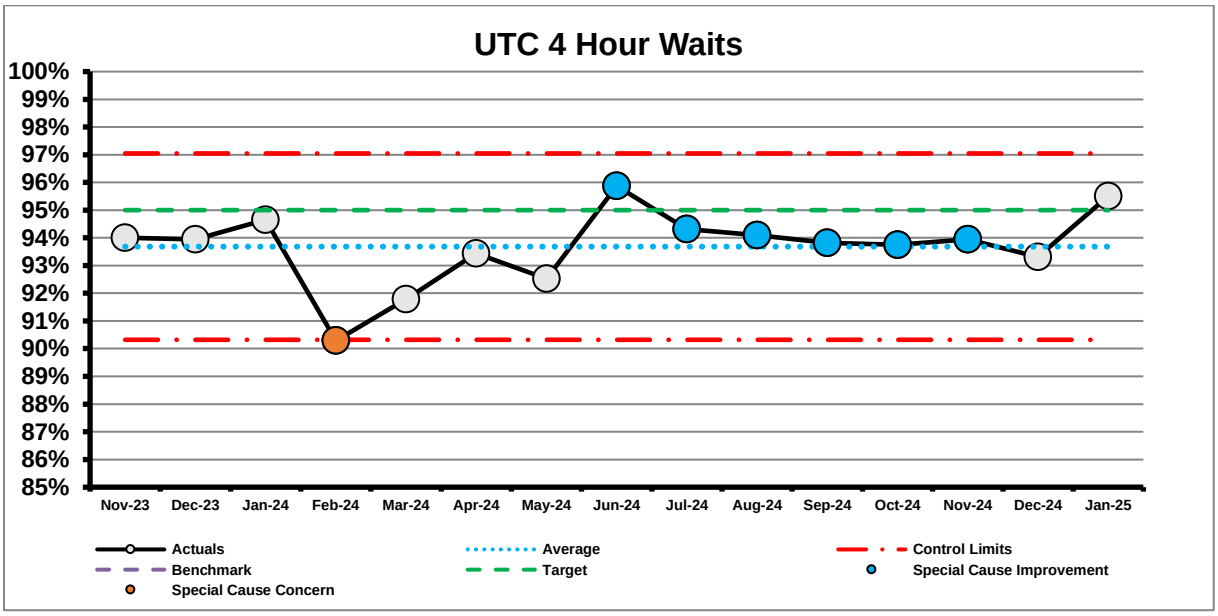
SPC

UTC activity has not varied significantly since September 2024.

UTC 4 Hour Waits

Background

The Quality Schedule requires the Trust to achieve a target of 95% of UTC attendances where the Service User was admitted, transferred, or discharged within 4 hours of their arrival at an A & E department.



Narrative

January 2025 shows an increase in performance of 2.19% with 4-hour waits 95.5% compared to December 2024 93.3%. The performance is now above our target of 95% for the first time since June 2024

It is the time to departure at our co-located sites, in particular Lincoln UTC and Boston UTC, that has the most significant impact on overall performance with delays for speciality referrals, access to x-ray and those patients requiring acute admission continue to be an ongoing challenge as we support our acute partners who also face pressures around bed availability. The issue around speciality waits, orthopaedic, bloods and x-rays have been escalated back into the group and work continues to resolve these issues.

Although the UTC 4-Hour Wait performance data shows that we have been inconsistent in achieving the 95% target, it is important to consider the UTC activity. We are working closely with our system partners to raise performance to above 76% across the system by validating breaches daily, identifying potential breaches early in the patient journey and improving pathways into specialities. As this work continues, we anticipate that this improvement will become more consistent and sustained.

The demand for UTC services continues and reflects the hard work around pathways and system partnership working. We are now focusing on our workforce modelling for the future to ensure we continue to drive all areas of performance.

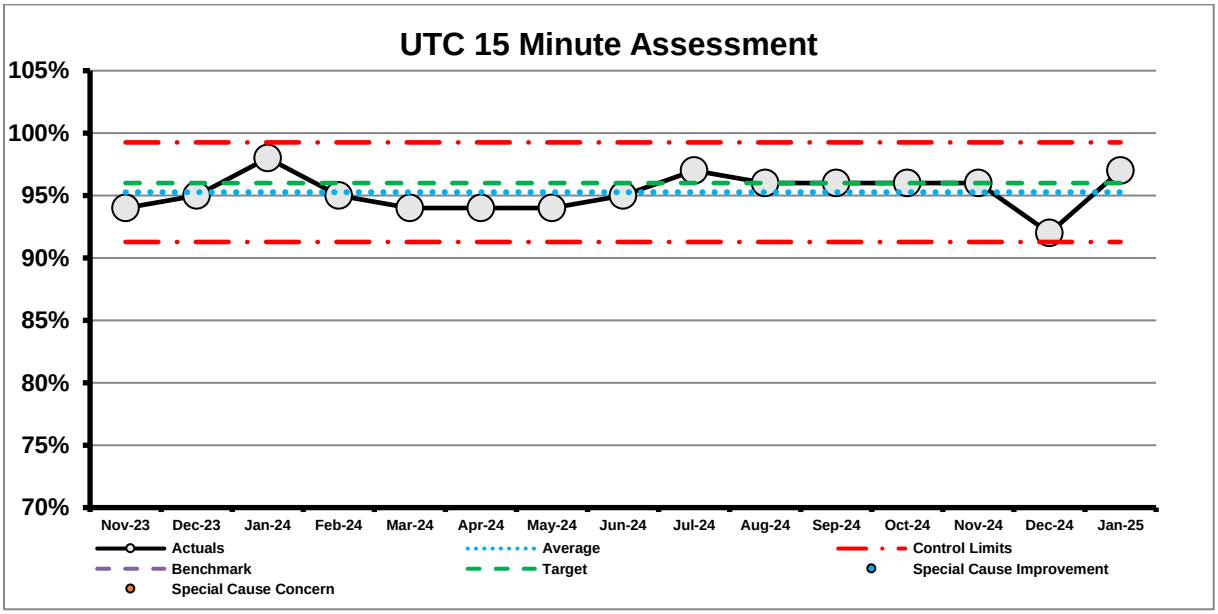
SPC

UTC 4-Hour Wait performance has not varied significantly over the period. UTC 4-Hour Wait performance is inconsistently capable of achieving the 95% target. The target is missed more often than not.

UTC 15-Minute Assessment

Background

Urgent Treatment Centre specifications state that patients who walk-into a UTC should be clinically assessed within 15 minutes of arrival. Following a 2019/20 CQC visit it was agreed that the Trust would ensure that all patients attending A&E (for then Urgent Care Streaming services), regardless of which method of transport they used to arrive, should be assessed within 15 minutes.



Narrative

15-minute assessment has improved by 5% to 97%. This coincides with a slight decrease in UTC attendances but also reflects the ongoing hard work of the UTC staff following a difficult December which had a high level of sick leave.

Work continues ensuring that the success achieved in the past few months continues and remains sustainable. This month 97% of UTC patients were triaged within 15 minutes against a target of 95%.

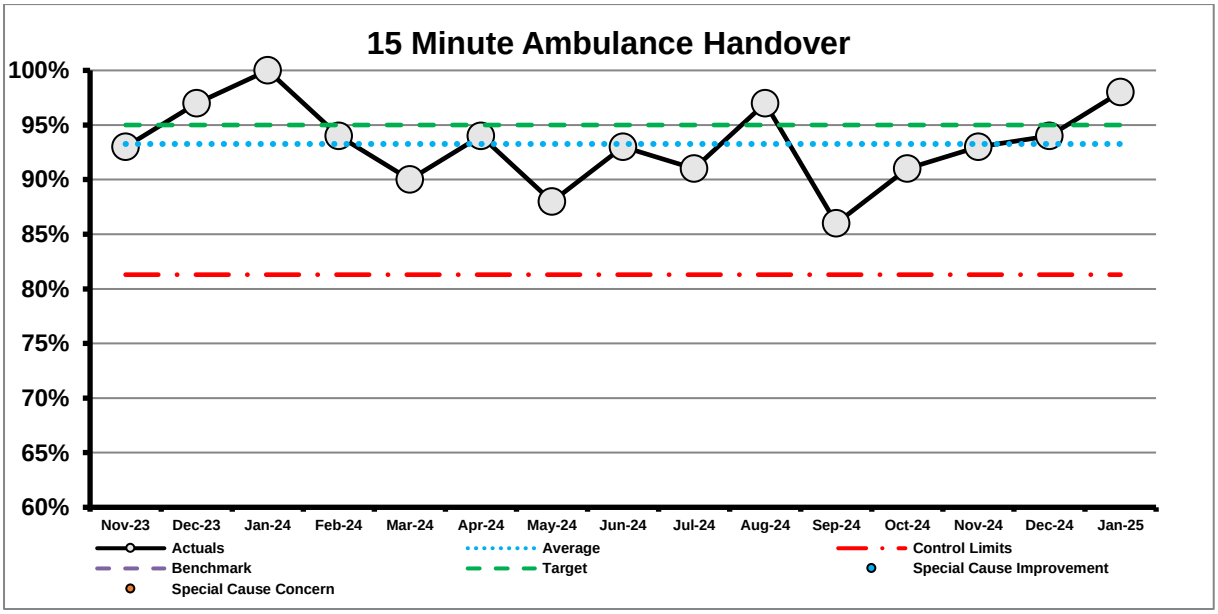
SPC

UTC 15-minute assessment has shown significant improvement since December 2024. Teams continue to focus efforts to ensure that the months performance is sustained.

15-Minute Ambulance Handover

Background

The NHS standard contract requires that handovers between ambulances and A & E must take place within 15 minutes with no patient waiting more than 30 minutes. Locally the 95% target is used to indicate and highlight where this is not delivered.



Narrative

15-minute Ambulance Handover performance has continued to improve with a 4% increase since last reporting period. 98% in January 2025 compared to 94% December 2024. We continue to work closely and meet regularly with EMAS partners to enhance admission avoidance pathways.

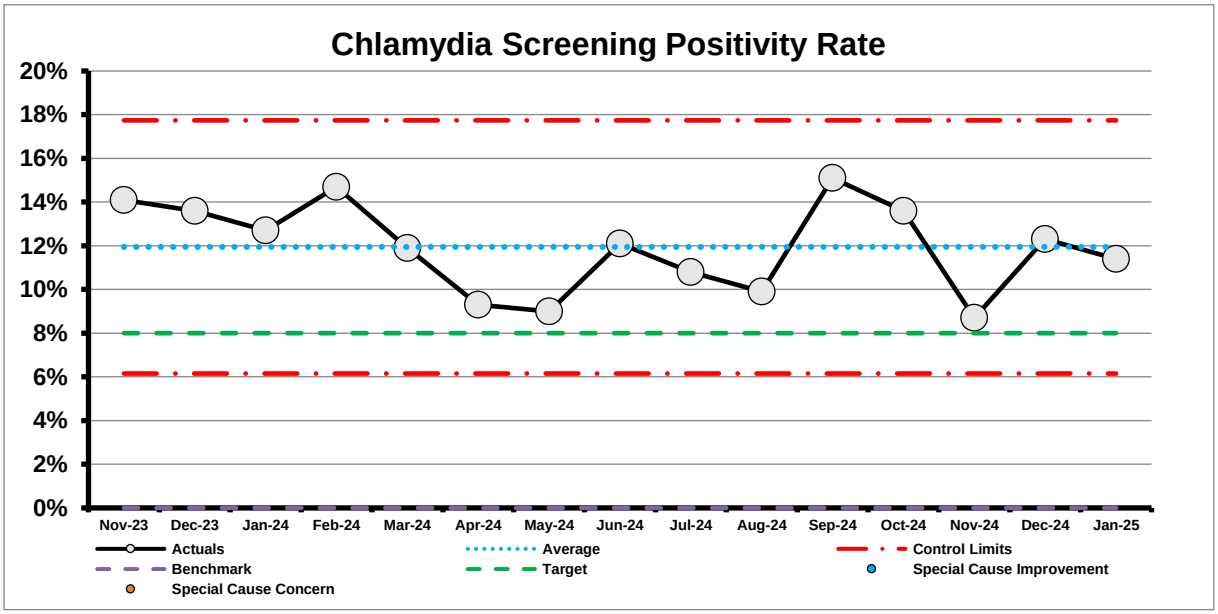
SPC

Although 15-minute Ambulance Handover has inconsistently been capable of achieving the 95% target over the last 12 months, performance is continuing in an upward trajectory.

Chlamydia Screening Positivity Rate

Background

The Trust is commissioned with a positivity target of 8% of young adults aged 15-24 years who have accepted a screen, and to ensure that 80% of the GU patients are seen or assessed within 2 working days of first contacting the LiSH service. Both these measures have historically had financial service credits (penalties) attached in achieving the target, although these have been suspended in the Covid-19 response period and no confirmation has been made with regards to reinstatement.



Narrative

Positive screening rates have continued to exceed the target rate.

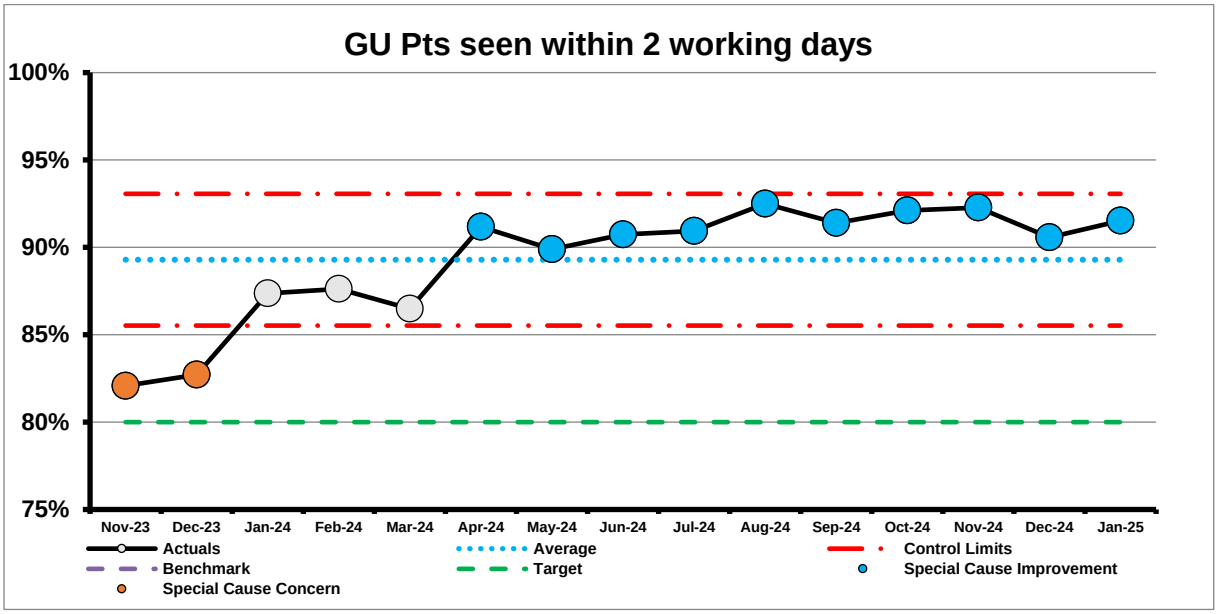
Actions

To continue developing and raising awareness of the service within the younger population.

SPC

Chlamydia screening positivity rates are consistently capable of achieving the 8% target but are expected to achieve the target more often than not, as they have in each of the last 15-months.

GU Patients seen or assessed within 2 working days



Narrative

Performance levels and activity are stable for GU clients seen within two working days.

Actions

Discussions continue to understand how the team can further improve on this level of performance.

SPC

GU patients seen within 2 working days shows special cause improvement since April 2024. This measure is consistently capable of achieving the 80% target.

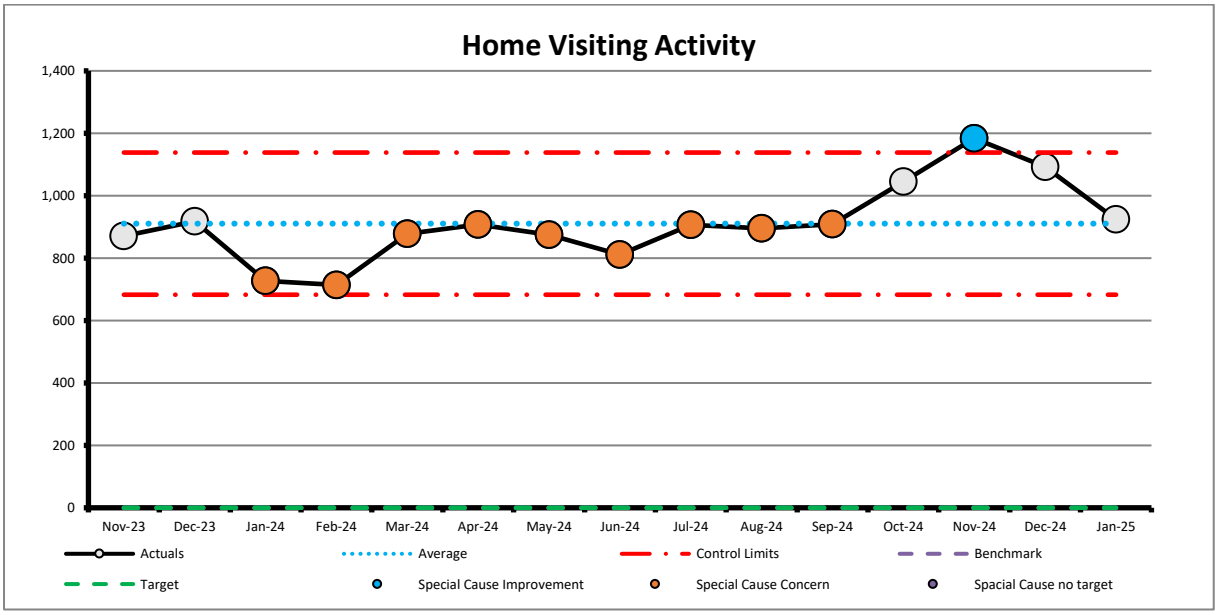
Home Visiting Report

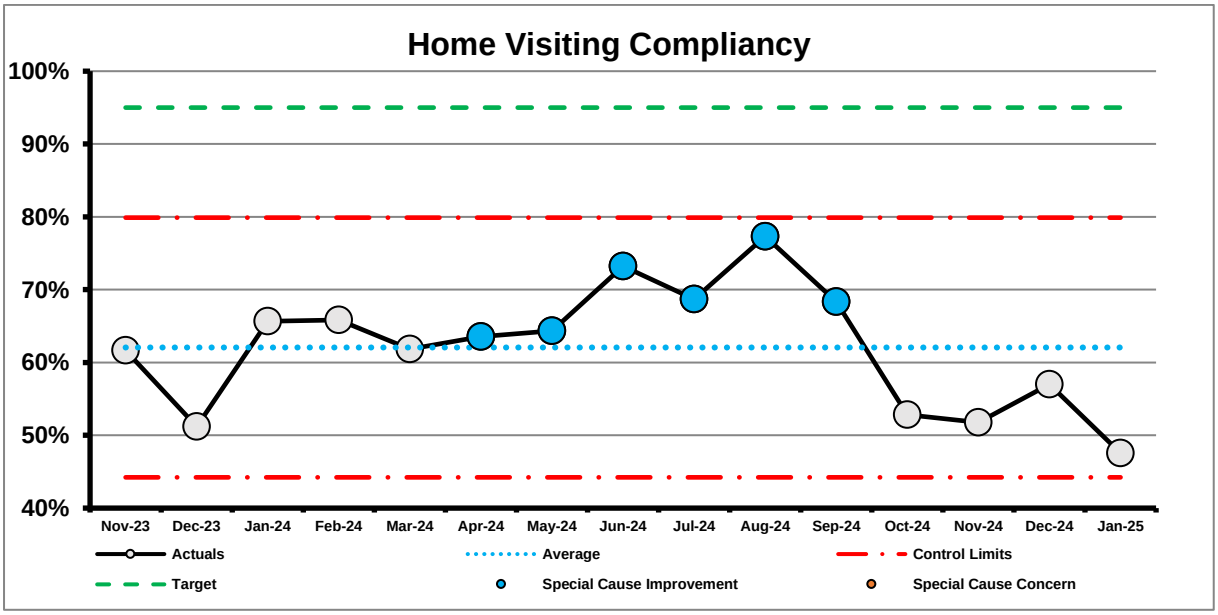
Background

Patients are offered a face-to-face consultation most appropriate to meet their needs and, where applicable, in the patient's home.

Patients are Lincolnshire citizens who become LCHS patients when triaged and accepted by the Home Visiting / Integrated Urgent Care Team and can be accessed via the 111 Service, CAS, and referrals from Community Teams.

The Service avoids admission to Emergency Departments, prevents ambulance call outs and provides reassurance for patients when GP surgeries are closed.





Narrative

The compliance for the activity seen (923 visits) during January is on par with similar performing months. The service has faced staffing challenges alongside an increased need for a 2-hour response (880 visits). There is an expectation that the compliance will increase for February as we begin to recover from staffing challenges.

SPC

Home Visiting activity has not varied significantly over the period.

Compliance has also not varied significantly over the period.

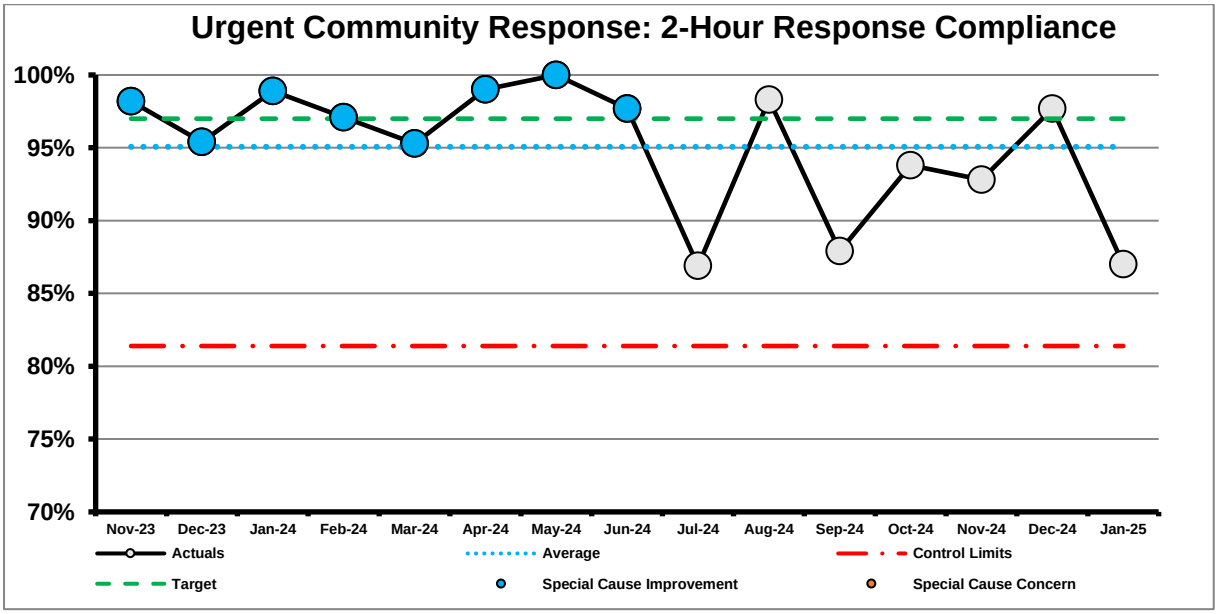
Urgent Community Response

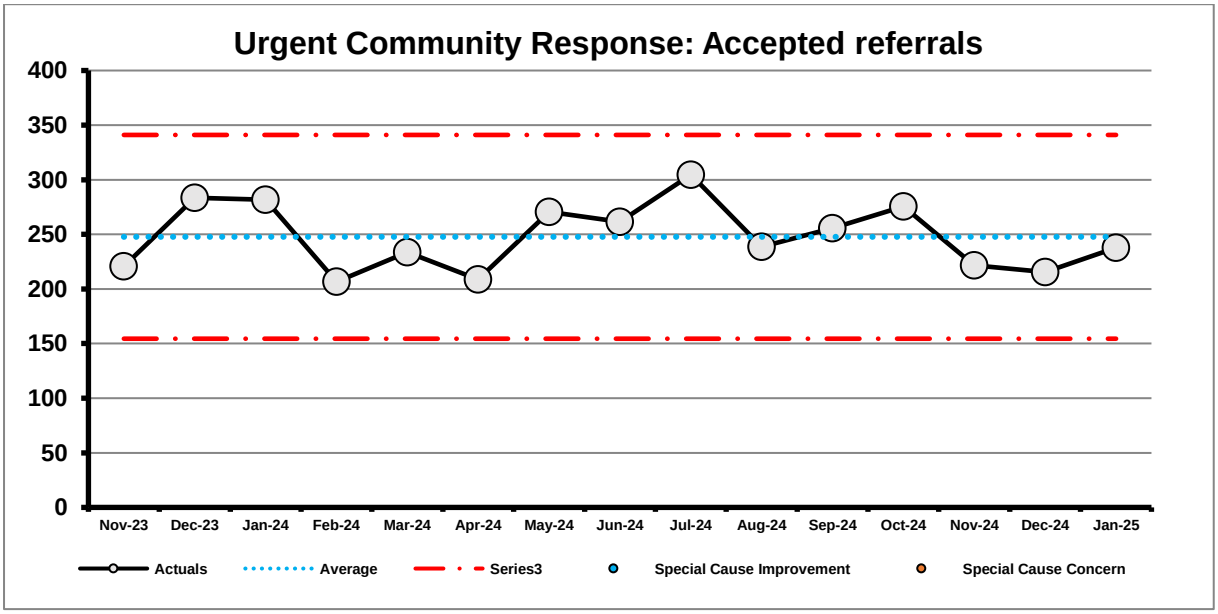
Background

Urgent Community Response is a nationally directed service. The Urgent Community Response Team receives referrals from a variety of sources to support urgent response care services.

The target for each referral is to respond and reach the patient within 2 hours.

It is a collaborative service working closely with Lincolnshire County Council and Social Care.





Narrative

Slight increase in accepted referrals received to UCR this month, bringing rate of referrals to just below average. Members of the UCR team are actively going out to community teams to showcase UCR with the aim of increasing referral rates. The 2-hour compliance has dipped this month due to staff gaps (which are

now recruited to) and increased sickness across the IUEC division. The service continues to showcase capabilities at countywide events and will work alongside CAS, Home visiting and EMAS to identify cases appropriate for a UCR response.

SPC

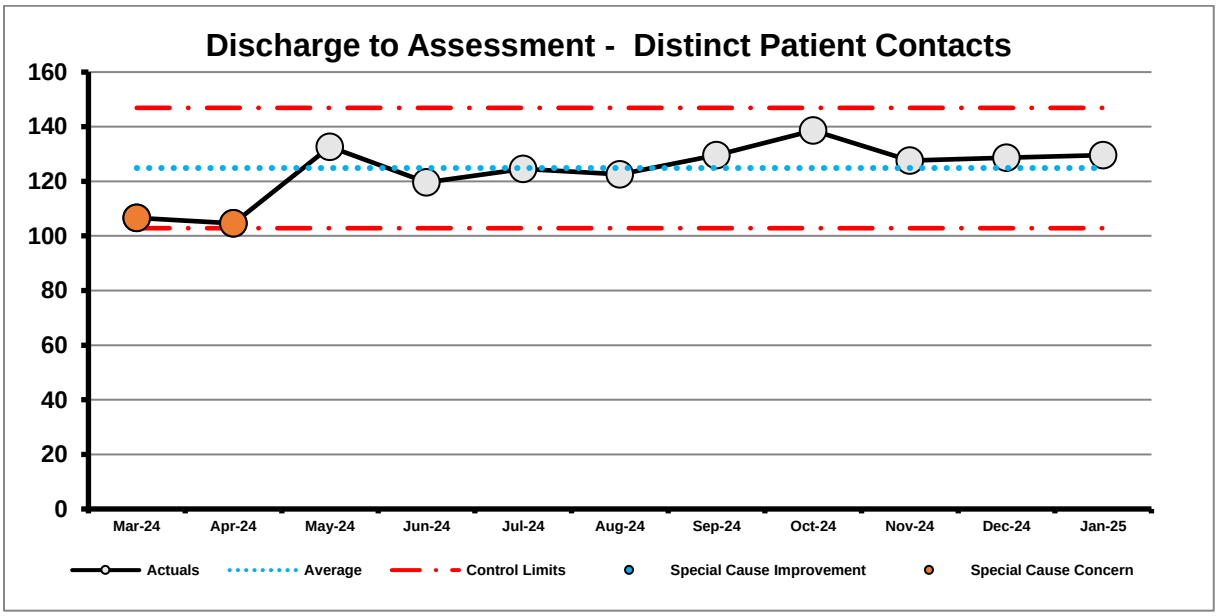
The 2-hour response rate has not varied significantly over the period. This measure is inconsistently capable of achieving the 97% target and is expected to miss the target more often than not. The number of accepted referrals for Urgent Community Response has not varied significantly over the period.

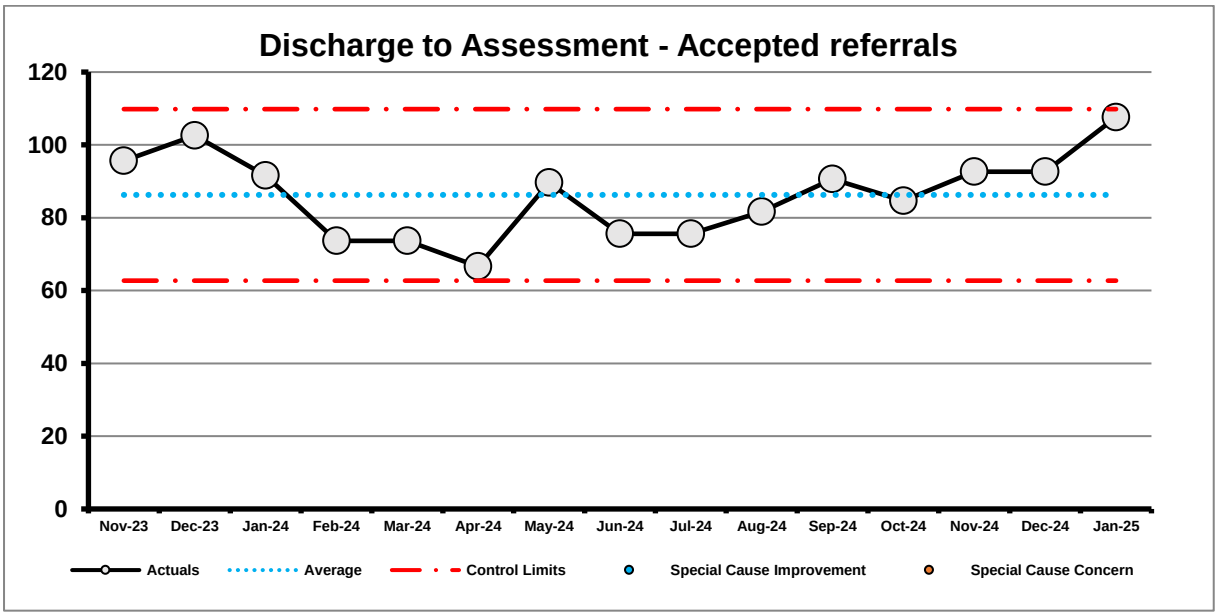
Discharge To Assessment

Background

The Discharge to Assessment programme has been introduced to expedite patients to leave acute care and return to their own home for reablement.

The service works closely with Adult Social Care and supports patients with a wide range of needs.





Narrative

The number of referrals accepted into the Pathway 1 D2A has continued to rise.

Continued work with the ULTH Front Door Therapy Service and LCC HBRS service has supported this work, in addition to trialling new ways of working between the D2A and LCHS community hospital teams.

Actions

Further collaboration with the HBRS reablement service; agreed to re-commence weekly meetings to discuss hybrid packages of support. Through these meetings the teams can share feedback and updates but also discuss and agree alterations to the hybrid offer to best suit service user requirements.

Work between D2A and ULTH Front Door Therapy (FDT) continues, with SystmOne access granted to the FDT team. Once e-learning training is completed, agreed for practical support from the D2A team for the use of SystmOne and to build in a pathway to support both timely discharges and service user experience.

Recent recruitment has been successful for B5 and B6 therapy posts, and the new B4 practitioner posts. Should all recruits commence in post as planned, D2A will be at establishment with regard to current AHP vacancies.

SPC

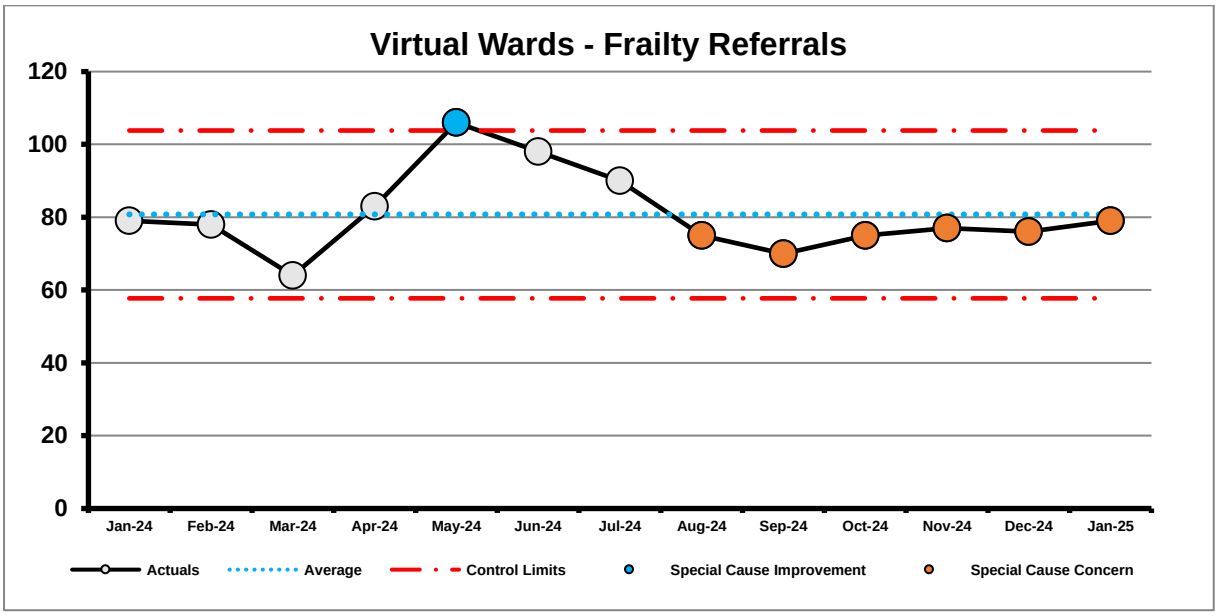
The number of distinct patient contacts has not varied significantly over the period and remains above average.

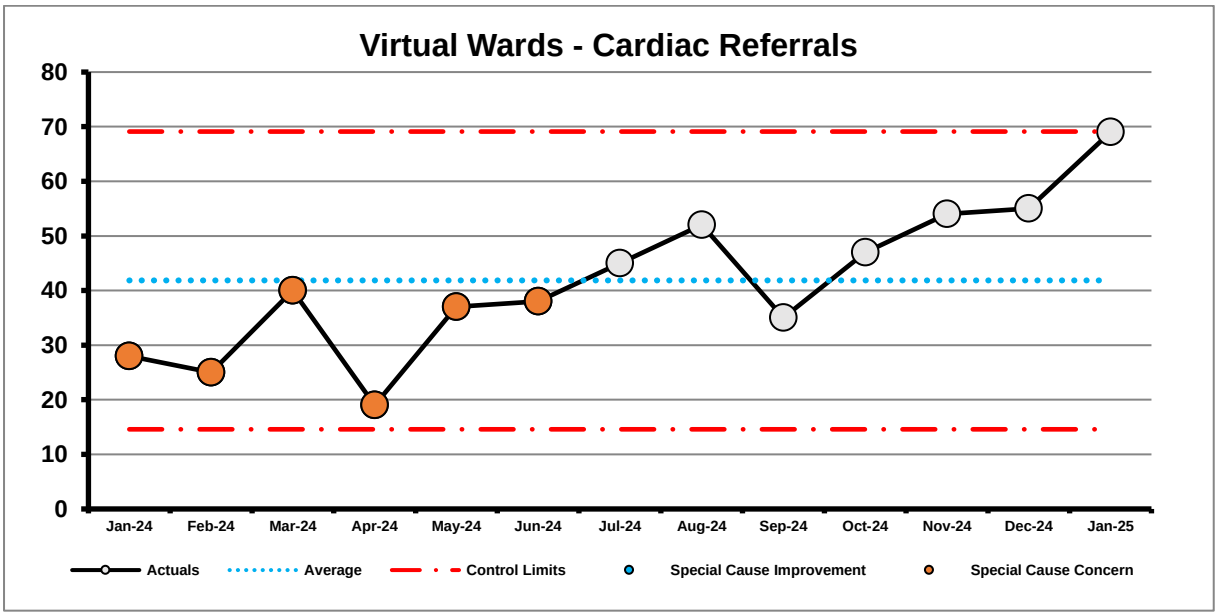
The number of D2A accepted referrals has not varied significantly and remains above average.

Virtual Wards

Background

The Trust's current virtual ward offering includes frailty, cardiology and respiratory. The service closely collaborates with ULHT, and patients are cared for in the community, with guidance from ULHT consultants.





Narrative

Reporting continues to encompass frailty, respiratory and cardiology virtual wards. OPAT & SDEC data is being progressed with ULHT. FBI are supporting the virtual ward team, cross referencing the different reporting that currently takes place (e.g., NHSE, SHREWD and internal reports) to make sure that the data is consistent and that all virtual wards are included in all our reporting.

SPC

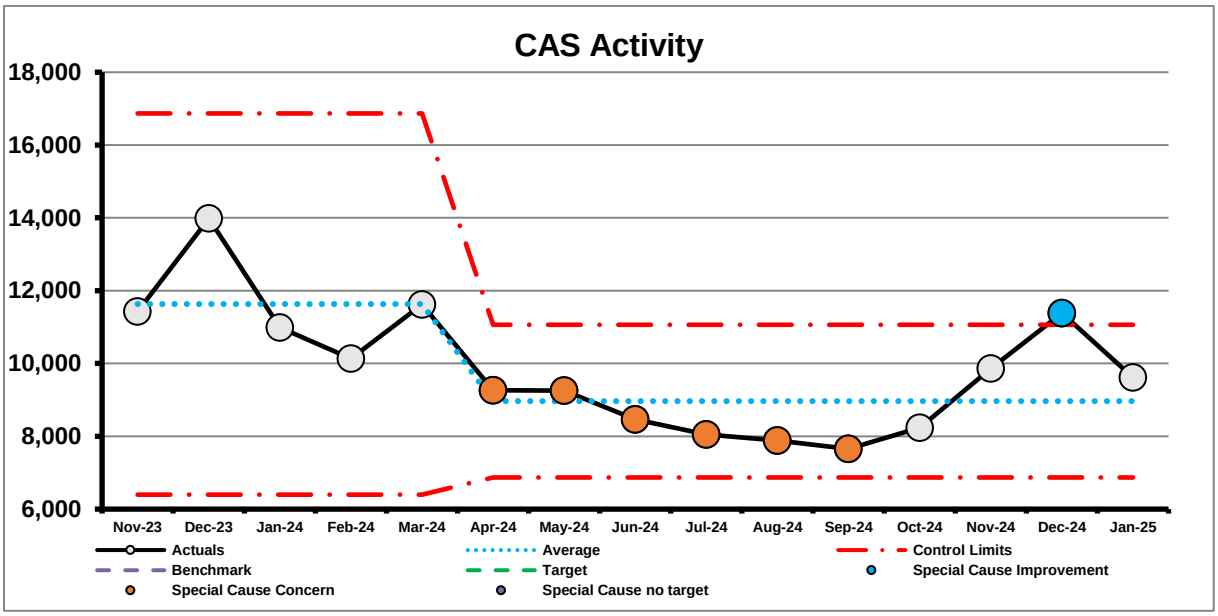
The number of referrals to the frailty virtual ward now shows special cause concern since July 2024.

The number of referrals to the cardiology virtual ward has not varied significantly over the period.

CAS Activity

Background

The CAS was initially commissioned as a proof of concept and commissioners asked providers to collaborate to develop an Alliance Agreement. The service has since demonstrated significant positive system impacts in supporting and reducing A&E attendances. This is now an integral part of the LCHS and Lincolnshire System Integrated Urgent Care offer.



Narrative

There appears to be a difference of around 1000 or 10% in cases reported on Power BI compared to Systm1 again this month. Concerns are ongoing regarding data discrepancies. Following the 111 contract changes in April (which equated to a loss of approximately 100 calls per day into CAS), activity had been consistently falling until September when cases began to rise significantly. January referrals have dipped a little from December but are still higher than the average post DHU contract changes.

There has been significant work within CAS to ensure we are using the established resource and increasing utilisation. This has included various projects.

· Ongoing pilot of CAS physically basing themselves within EMAS EOC which to date has avoided the dispatch of 117 ambulances. The ICB have requested that we increase input to 7 days a week over winter due to the success of the project so far.

· CAS for Care Homes successful relaunch (impact of which can be seen in increased referral numbers throughout October and November)

· Healthcare SPA went live 14.10.24

· Same Day Access Pilot went live 18.11.24.

There are ongoing discussions with the ICB regarding the return of interim dispositions and ED validations from DHU to CAS following significant concerns about DHU's performance and patient safety/experience with the new pathway. This may mean pausing some of the ongoing pilots discussed above but this is yet to be confirmed.

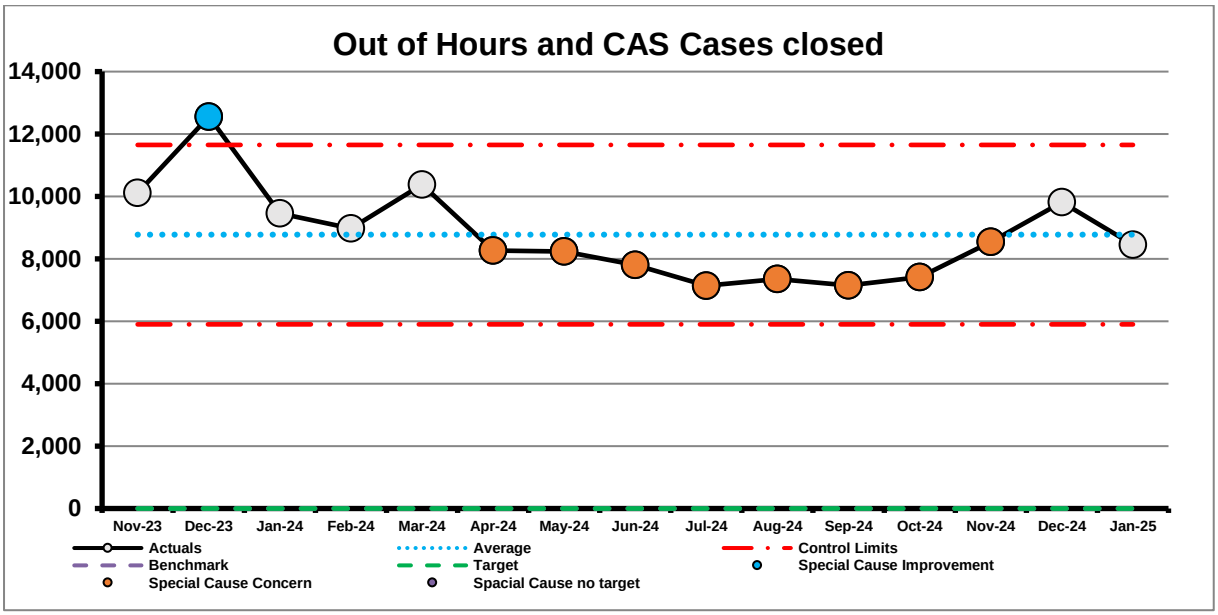
SPC

CAS activity has shown special cause concern since June 2024, this, however, seems to have recovered to lower range of average.

OOH and CAS Cases Closed

Background

LCHS on average has around double the attendances of ULHT's type 1 attendances. This includes Out of Hours services and CAS.



Narrative

This metric shows the combined number of cases closed within the Stamford Out of Hours and CAS services and is directly correlated to the level of activity seen within those services (additional narrative is featured within the CAS activity). April saw a significant decrease due to the change in the DHU contract and the reduction in call volume to CAS and therefore a decrease in booked appointments. Some concern around data for CAS/OOH not pulling correctly from Systm1 into PowerBI and the FBI continue to investigate this. November and December saw a significant increase in cases closed which is in direct correlation with the higher activity seen within CAS.

Ongoing discussions were being held as to the value of this data being included within FFPIC reporting due to Grantham OOH no longer being included.

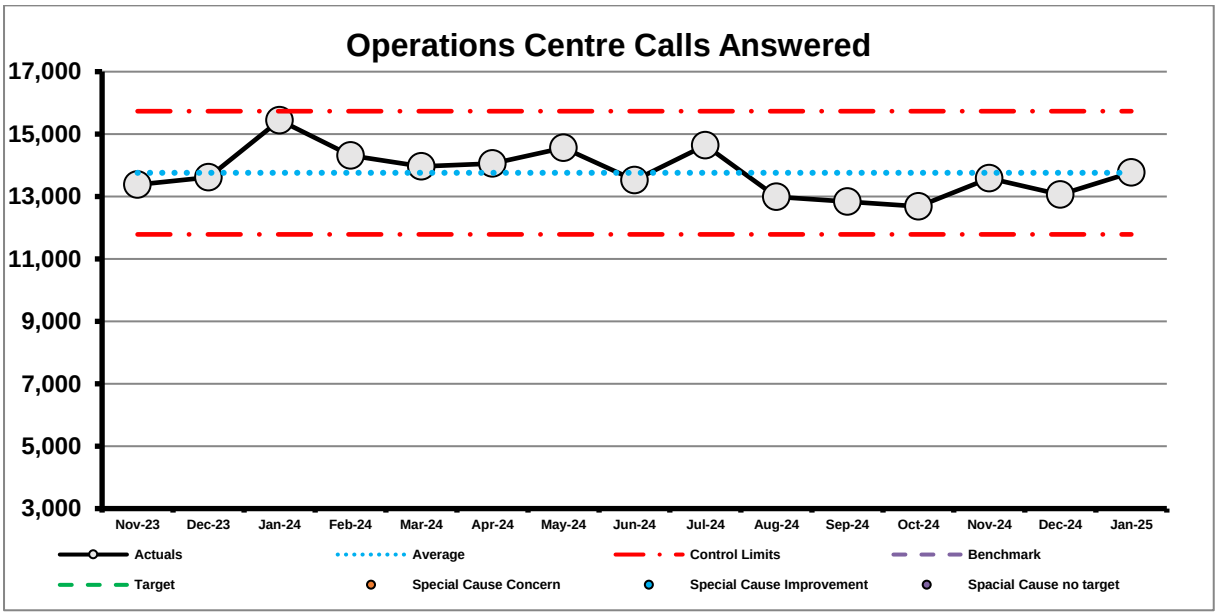
SPC

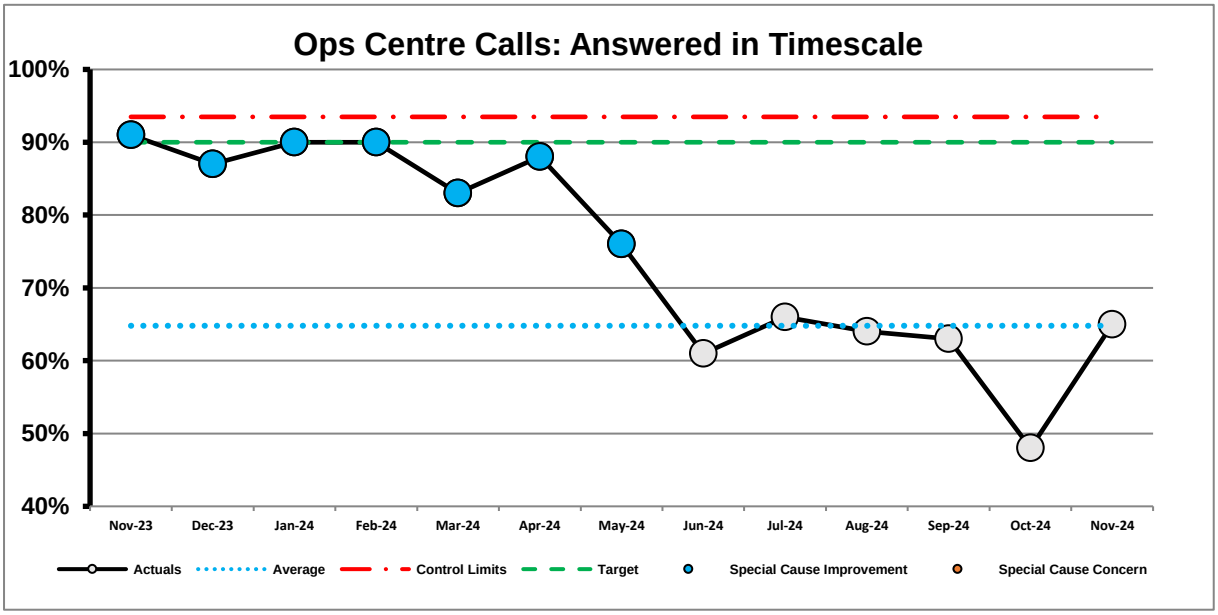
OOH & CAS Cases Closed has not varied significantly in the period.

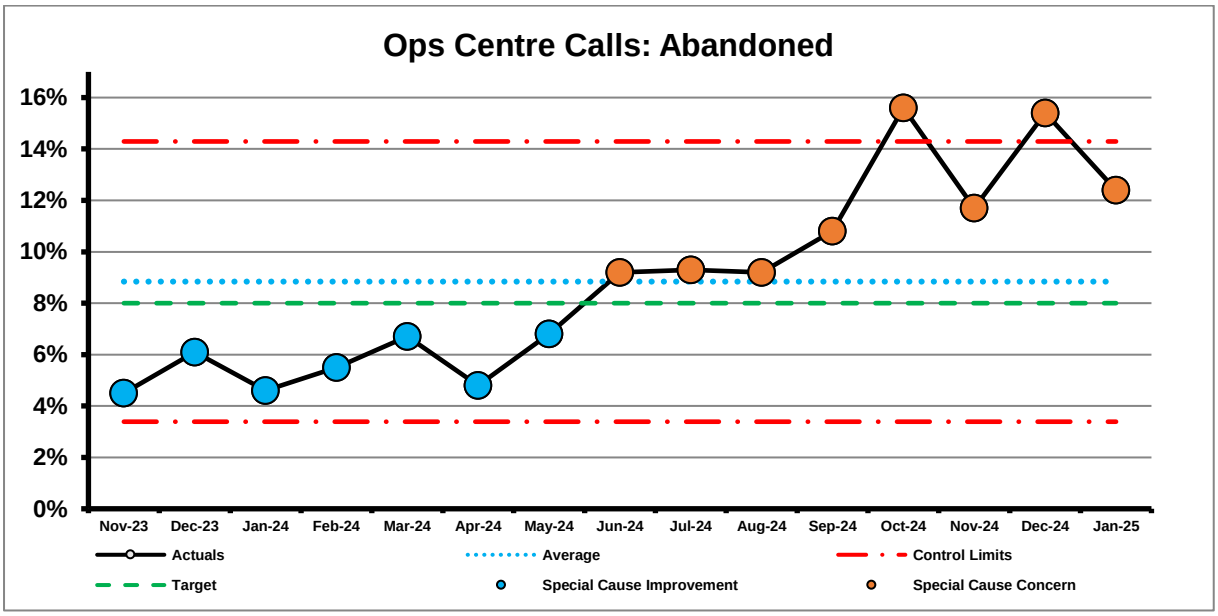
Operation Centre Calls Metrics

Background

The Operations Centre was opened in December 2016 and provides a 24/7 multi-disciplinary team for LCHS. It was developed on the principle of a 'one call does it all' model and is a critical service that holds the Trust's services together e.g., community nursing, community hospitals, urgent care, transitional care, and our Clinical Assessment Service.







Narrative

January saw 17,597 calls come through the Ops Centre, of those calls coming through we saw an increase in answered calls of 5.4% (706 additional calls answered).

We saw a slight drop in Priority calls being answered within the SLA (68% within SLA) although Standard calls were above the SLA and achieved a strong month (86% within SLA) abandonment rate reduced to 12.4% whilst all email contacts achieved the SLA. (100% within SLA)

New starters are becoming embedded into their roles which is showing benefits.

Emails increased to nearly 8000 contacts for January – a 9.7% increase on December.

Focus next month to look at how we can improve the abandonment rate as well as the priority SLA.

SPC

The number of calls answered within the Ops Centre has not varied significantly since December 2023.

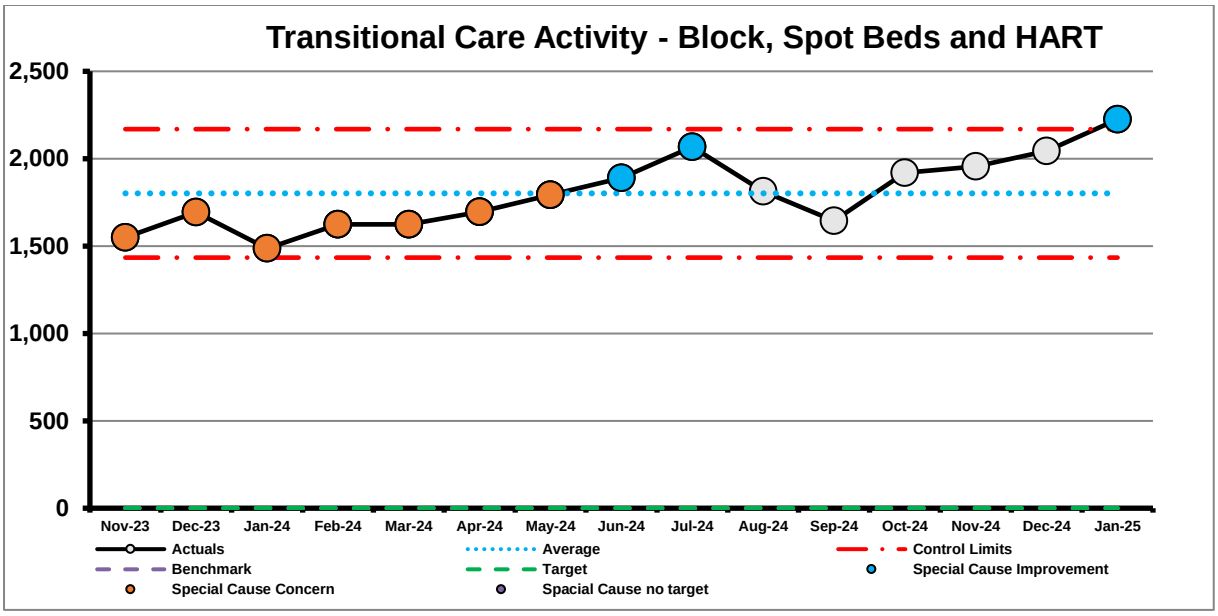
Ops Centre Calls Abandoned shows special cause concern since June 2024. It is inconsistently capable of achieving the 8% target but achieves target more often than not.

Ops Centre Calls Answered within Timescale – This is no longer being reported but remains on the report for the time being as a reference point. New Measures for the Operations centre are to be included in the April report for March data in April report.

Transitional Care Activity

Background

LCHS has a now established and commissioned a Hospital Avoidance Response Team (HART) service, via Age UK to focus on admission avoidance and reduction of Delayed Transfers of Care (DToC). The HART service has demonstrated some excellent quality outcomes, as well as consistently achieving their targets around the number of cases managed each month. HART continue to achieve their monthly key performance indicators and work as a key system partner.



Narrative

Use of transitional care resource has continued to rise: January has marked the highest usage since November 2023.

Use of spot purchase bed stock remains high, reflecting the system ask to increase bed stock.

Actions

Our Commissioned service HART's productivity is being regularly scrutinised as it remains below the contracted levels within both the core contract and the additional winter funding. The core contract has been extended to 31st March 2026, to mirror the system ask around the 'Intermediate Care Review'.

There has been a request from the system to increase spot purchase beds to a maximum of 18 – consideration is being given to how to manage this within safe parameters, alongside the contract managers in LCC.

SPC

Transitional care activity has remained high since June 2024.

Transitional care activity has shown special cause improvement in January 2025.

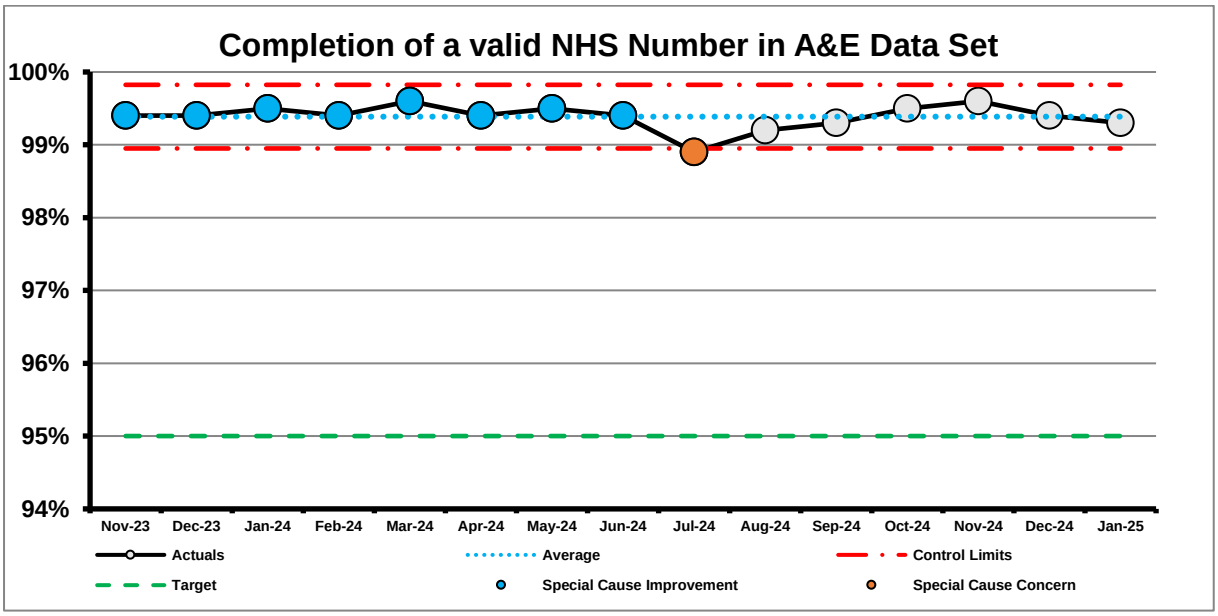
Completion of a Valid NHS Number in A&E Data Set

Background

The Data Quality Dashboards are a national resource to support the improvement and completeness of data flows by reporting on the validity of key data items in Secondary Uses Service (SUS) in accordance with published data standards. The information is provided by The Health and Social Care Information Centre and the areas applicable to LCHS are:

- Accident and emergency

The dashboards are reviewed against the national attainment and any data items that fall below the national attainment rate are highlighted for consideration and action planning.



Narrative

The latest available data demonstrates the completion of a valid NHS number for A&E Data Sets. The Trust maintains a high level of compliance – above 98% since April 2021. This is higher than the national average. Remarkably, July's figure would normally show concern, but this must be seen in context against the outstanding figures across the rest of the year.

Actions

The completions of NHS numbers within the A&E datasets continue to be raised with services, to ensure issues around data quality are addressed. The data system used is linked to the NHS Spine. Patients with no NHS number are not registered with a GP.

SPC

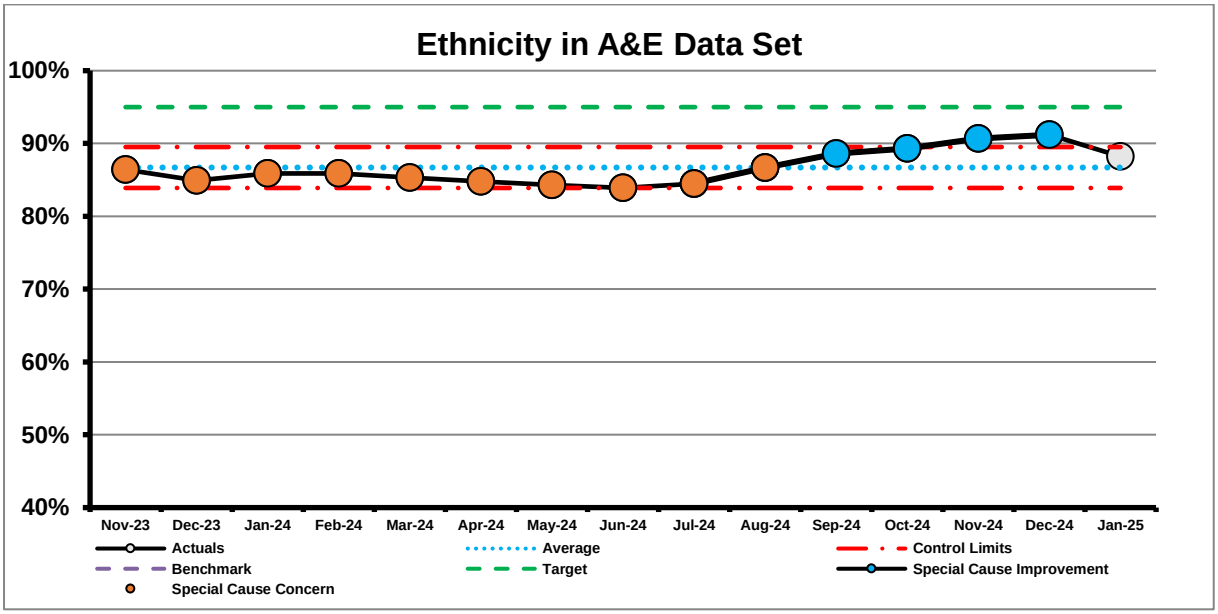
Completion of a valid NHS number for A&E datasets has not varied significantly since June 2024 and is consistently capable of achieving the 95% target.

Completion of Ethnicity in A&E data set

Background

The Data Quality Dashboards are a national resource to support the improvement and completeness of data flows by reporting on the validity of key data items in Secondary Uses Service (SUS) in accordance with published data standards. The information is provided by The Health and Social Care Information Centre and the areas applicable to LCHS are:

- Accident and emergency



Narrative

As reported previously changes to this process were being made to stop using local codes for ethnicity not stated and remove old codes.

Issues have been identified where SystmOne doesn't export patient's ethnicity if the data is not something added by the user onto the system. This has caused problems with us being unable to pull our ethnicity activity from within the extract. The months during July and August where we reported 100%, were due to a miscommunication between ourselves and NHS England during the validation period, where we were advised to reset blank ethnic codes. Since discovering these inaccuracies, we have resubmitted our activity and it is now reflected on a new download from SUS.

The increase from 67% to 87% is through a process developed to download an extra patient dataset from SystmOne which reports on Ethnicity for all patients. Following this validation process, 87% is a more reflective position on actual completion. Further work is still required with our UTC colleagues to continue to work towards improving the collating of our ethnicity data at the point of source.

We have initiated a new Data Quality system "RINSE" introduced to support managers to monitor and manage who hasn't completed ethnicity population. The FBI team continue to with digital health to ensure that any SOPs or training emphasis' the importance of completing the data.

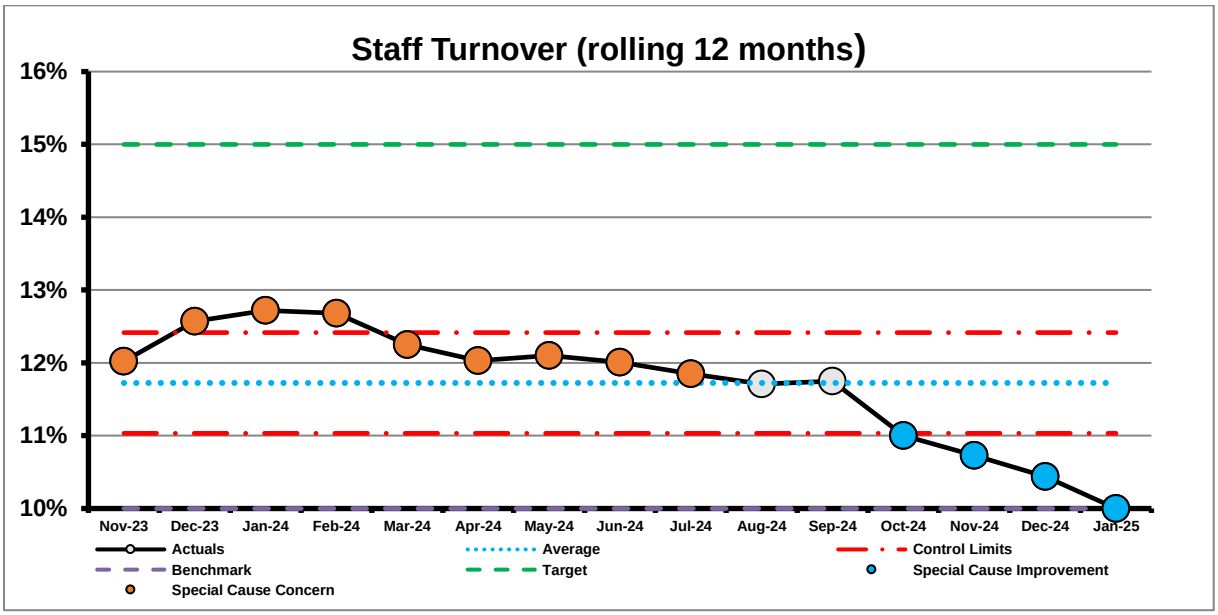
SPC

Ethnicity in A&E dataset has not varied significantly in the period. This metric is not capable of achieving the 95% target without further redesign. Use of the new Data Quality system "RINSE" is expected to drive up performance to the 95% target between November 2024 and March 2025.

Staff Turnover (Rolling 12 months)

Background

The Quality Schedule requires data on staff turnover to be shared with commissioners as well as being an important barometer of service stability, sustainability, and staff satisfaction.



Narrative

The graph above shows the total staff turnover, with rolling 12-monthly turnover lower than the average at 9.92% for the period. The “target” level of 15% represents a ceiling to stay within. A healthy level of staff turnover is positive for refreshing the workforce and securing new or additional talent into the organisation, however rising turnover would be indicative of potential staff dissatisfaction and impacts on service delivery.

Actions

Staff turnover is managed by leaders at local levels with supportive frameworks to enable staff to maintain health and wellbeing, freedom to speak up and engage with changes to their service delivery.

SPC

Staff turnover has shown special cause improvement since September 2024 and is consistently capable of achieving the 15% target.

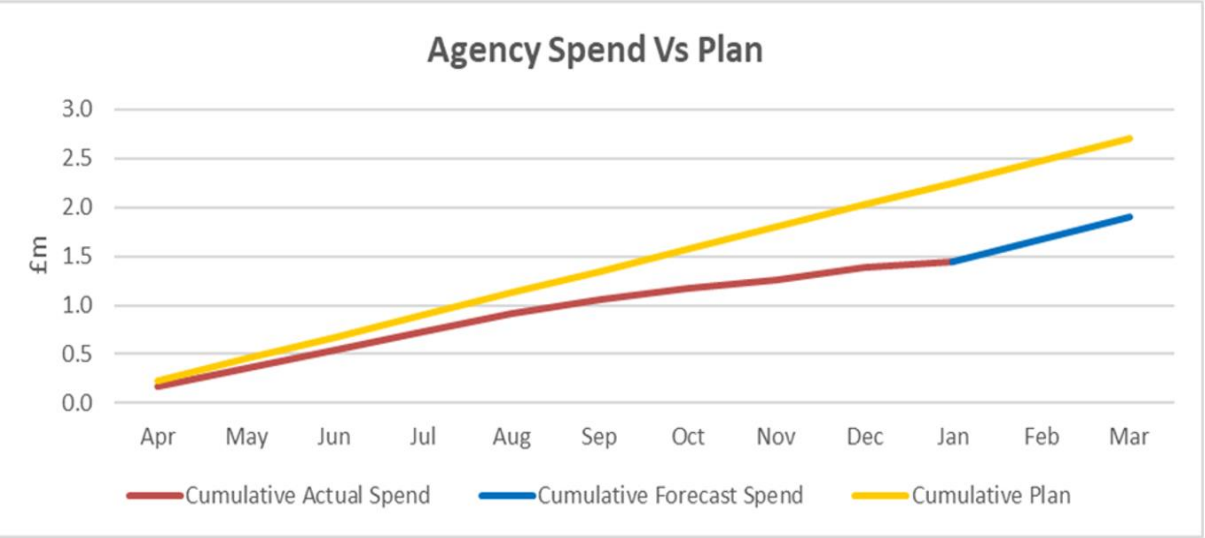
Financial Performance Summary

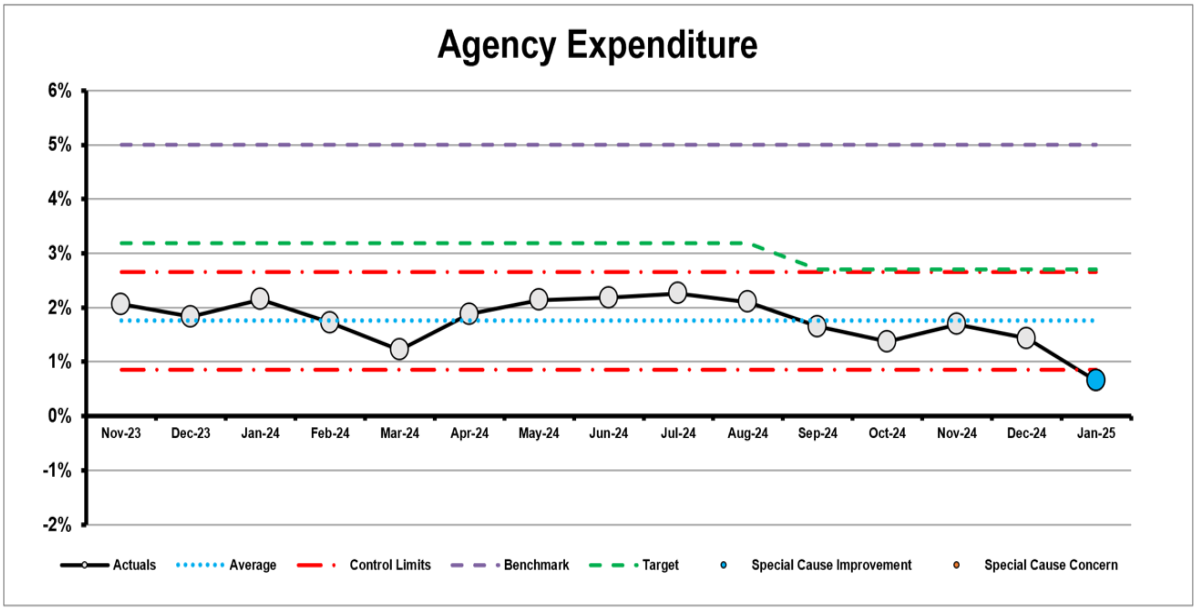
Financial Summary Table (Month 10)	
Description	**Narrative**
Position in January	£653k surplus
Position YTD	£297k deficit
Position FOT	Breakeven
CIP in January	£966k against plan of £797k
CIP YTD	£6.089m against plan of £5.437m
CIP FOT	£7.401m against plan of £7.030m
Agency in January	£57k against plan of £225k
Agency YTD	£1.448m against plan of £2.250m
Agency FOT	£1.898m against plan of £2.700m
Capital in January	£54k against plan of £0
Capital YTD	£4.183m against plan of £2.580m
Capital FOT	£5.339m against plan of £5.386m
Cash	£9.040m against forecast plan of £25.5m

Agency Expenditure

Background

For both 2023/24 and 2024/25 there is an agency ceiling at Lincolnshire System level rather than organisational level. The Trust planned for a 3.19% agency level in 2023/24 and is planning for a 2.70% agency in level in 2024/25 as its contribution to achieving the system agency ceiling.





Narrative

- M10 agency spend was £57k compared to £225k plan, this was a highly favourable result in month.
- YTD agency spend (at M10) is £1.448m which is £802k lower than plan, noting that this excludes the benefit of £143k accrual release (M3) and £169k accrual release (M8) relating to prior year invoicing to show a true comparison. This is in line with expected CIP savings for agency.
- In respect of the split of Agency spend:
    - Collaborative Community Care - £798k (66%)
    - UEC Collaborative - £330k (33%)
    - Agency Nursing represented 54% of Agency costs YTD

SPC

Agency expenditure has shown special cause improvement in January 2025. It is inconsistently capable of achieving the 2.7% target but expected to achieve target more often than not.

Efficiencies Plan (CIP)

Background

This information represents year-to-date delivery against the planned Cost Improvement Plan (CIP).

	Aspyre	Plan Month 10 £000	Actual Month 10 £000	Variance Month 10 £000	Plan YTD £000	Actual YTD £000	Variance YTD £000	Annual Plan £000	Forecast £000	Variance £000	Overall Delivery of Savings RAG
Interest - GBS Bank Account		£108	£88	-£21	£1,083	£1,134	£51	£1,300	£1,274	-£26	R
LCHS income to cover initiatives without System support		£97	£97	£0	£966	£966	£0	£1,159	£1,159	£0	NR
Procurement		£43	£3	-£40	£202	£189	-£13	£300	£249	-£51	R
Non-Pay Savings		£18	£18	£0	£89	£228	£139	£140	£272	£132	R/NR
Estates Savings		£23	£21	-£2	£105	£90	-£15	£150	£131	-£19	R/NR
Delay to POCT Project		£25	£42	£17	£75	£250	£175	£125	£333	£208	NR
Continence products		£8	£0	-£8	£54	£21	-£33	£70	£37	-£33	R
Service Redesign		£178	£163	-£15	£914	£879	-£34	£1,177	£1,177	£0	R
Agency Reduction	✓	£125	£168	£43	£848	£804	-£44	£1,100	£1,054	-£46	R
Use of ULHT GP cover overnight		£11	£12	£1	£66	£116	£51	£127	£139	£12	R
POCT and FBI posts removed		£10	£10	£0	£70	£70	£0	£107	£90	-£17	R
Vacancy Savings (additional 1%)		£110	£48	-£62	£772	£447	-£325	£992	£543	-£449	NR
Bank and Overtime Reduction		£9	£17	£8	£66	£77	£11	£105	£125	£20	NR
Unidentified Gap		£32	£0	-£32	£128	£0	-£128	£178	£0	-£178	R/NR
Technical CIP		£0	£281	£281	£0	£818	£818	£0	£818	£818	NR
2024-25 CIP Programme		**£797**	**£966**	**£169**	**£5,437**	**£6,089**	**£653**	**£7,030**	**£7,401**	**£371**	

Narrative

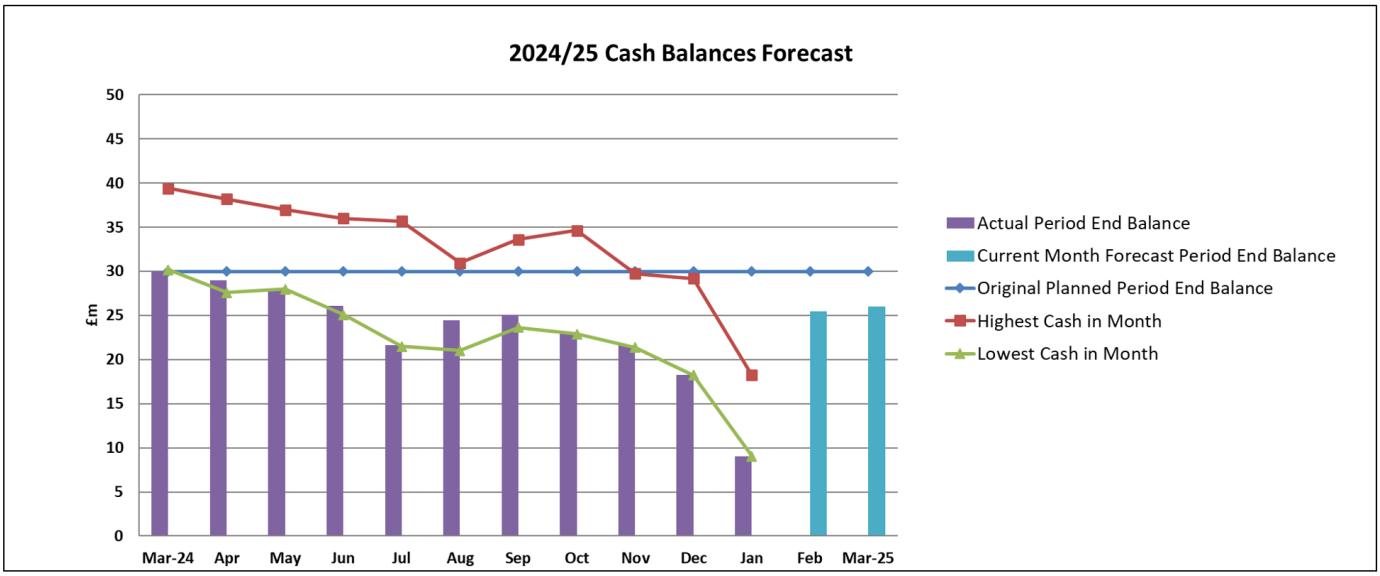
- M10 YTD £653k ahead of plan, due to technical CIP release in month 8 and month10.
- Full year forecast increased from £7.0m to £7.4m due to Technical CIP releases.
- No red rates initiatives.
- M10 delivery £169k favourable due to technical CIP release (GRN £75k, dilapidation provision review £206k) also a low month for agency spend.
- Ongoing monitoring on status of delivery as H2 CIP increases significantly working with leads.

Cash Balances

Background

This metric tracks the Trust performance of cash balances against planned levels of cash at each month end. Management of cash is important to ensure the Trust can adequately meet its liabilities to stakeholders. As part of the interim financial arrangements in place for Covid-19, a formal plan for cash was not mandated or collected but providers manage cash positions to remain stable.

Cash Balances for 2024/25 are as below:



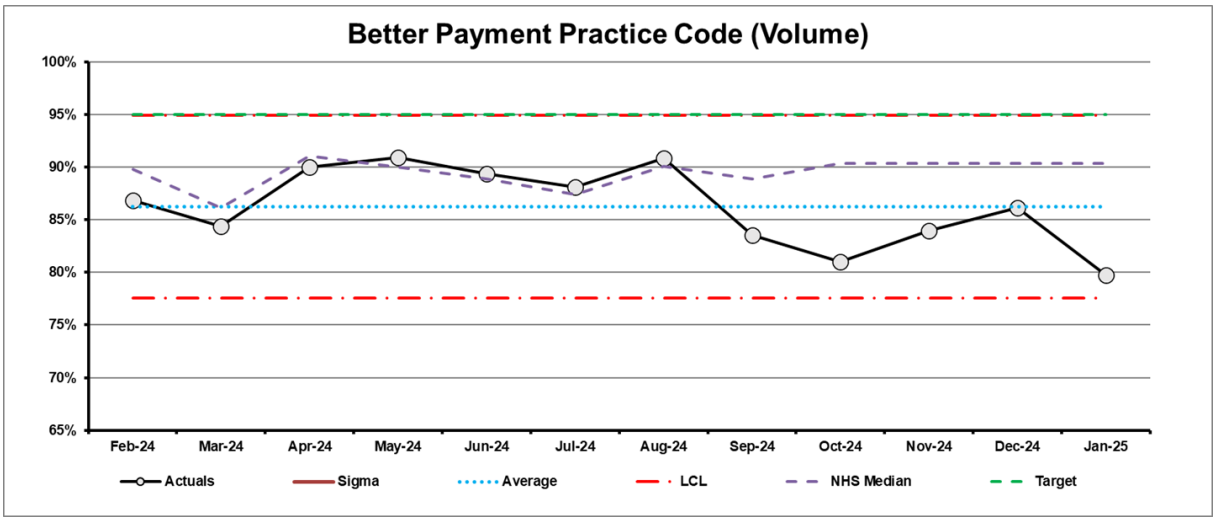
Narrative

- The LCHS cash balance for M10 was £9.04m, £16.46m below original planned balance, this is lower than forecast due to the delay os the pay award funding (£2.4m) and delay of receipt of M10 ICB income to support Group cash position (£14m). This will be paid prior to year end.
- c£1m prior year estates invoices relating to revaluation of Johnson site in Spalding paid in M4.
- Phasing of I&E plan, with a deficit of £0.8m YTD, also contributing to deterioration in cash position

Better Payment Practice Code

Background

This metric represents the performance of our invoices paid within the agreed terms. The target Better Payment Practice Code (BPPC) is 95%.



Narrative

- BPPC by number of invoices for January at 80%, down 6% versus prior month and below the target of 95% (noting that BPPC by value of invoices is close to target at 92%).

- The NHSE Median has not yet been released, so estimated at the same as prior month at 90%. There has been an improvement in month, and there remains a focus within the Finance team on improving the turnaround.

- Finance are reviewing ASD access, and training members of staff to pick up the monitoring of BPPC, so that there is a renewed focus on achieving 95% working closely with ULTH accounts payable team to understand areas of concern and agreed actions to address.

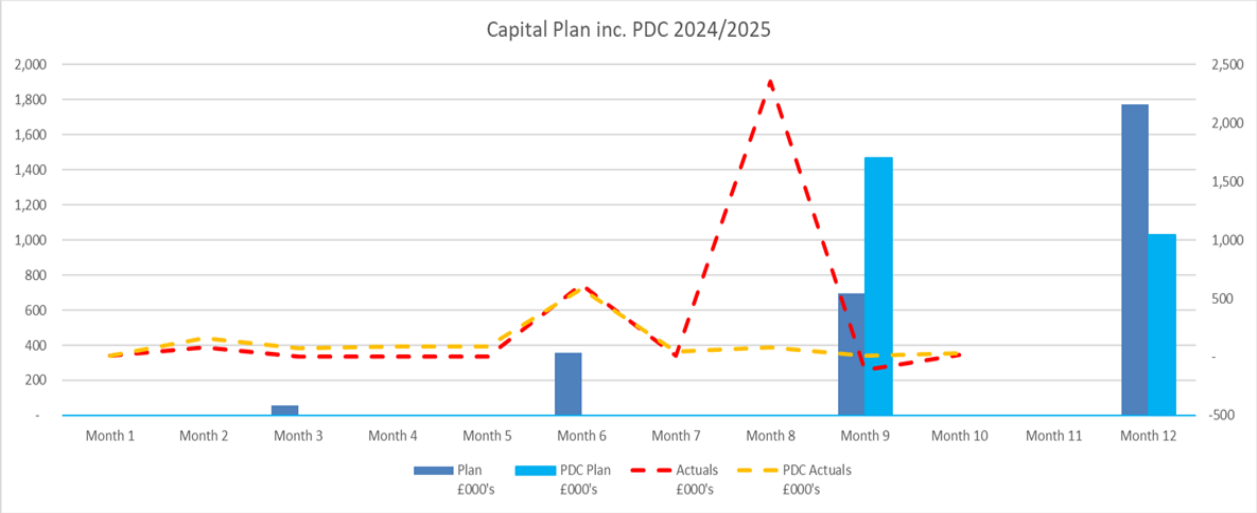
SPC

Monthly Better Payment Practice Performance by volume has not varied significantly over the period. This metric is inconsistently capable of achieving the 95% target and is expected to miss the target more often than not.

Cumulative Capital Expenditure Plan vs Actual (£000)

Background

This metric tracks year-to-date expenditure of the Trust Capital Programme against plan. Capital Expenditure includes investment in maintaining, replacing, and transforming the Trust asset base. The Trust has a capital plan of £2m for 2024/25.



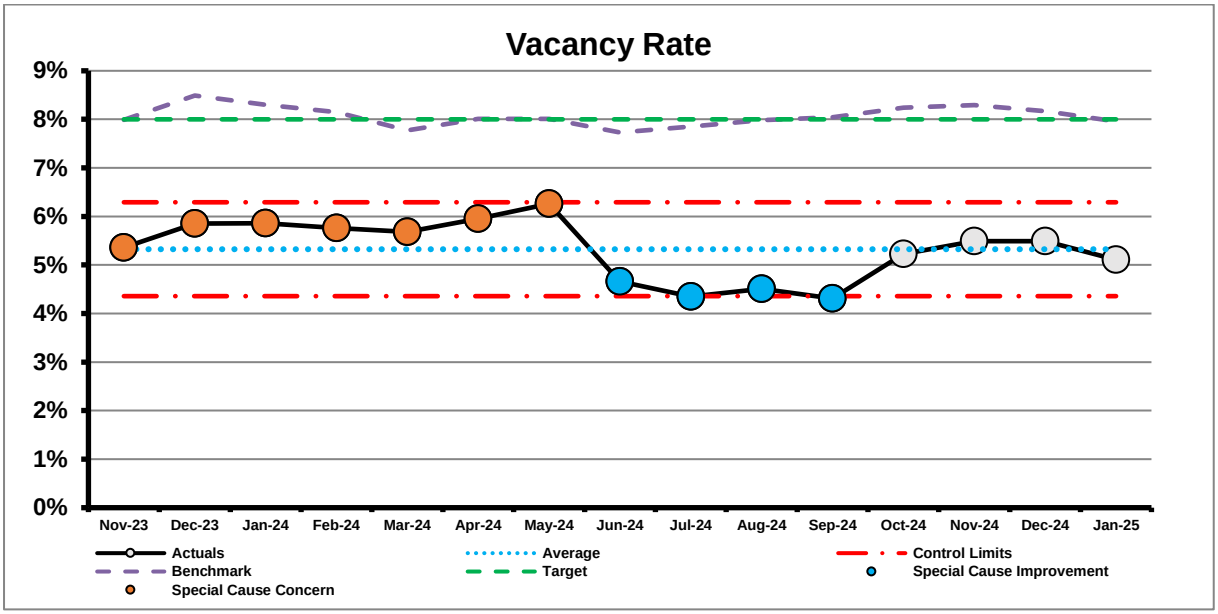
Narrative

- The LCHS capital plan for the financial year totals c£5.386m, £2.086m of capital allocation, £2.5m of PDC and £800k of IFRS16 funding.
- Year-to-date capital spend up to M10 equated to £4.183m.
- The Plan assumed that capital spend would be incurred in M9 (£1.0m) and M12 (£1.1m) with spend phased towards the end of the year to allow plans to be fully developed.
- There is a YTD overspend (£1.602m), and expected overspend full year (£960k), following an initial review of possible mitigations this relates to increases in leases captured in M8 (£2.4m).
- The year to date spend has been incurred in the following areas (bracketed numbers are full year plan)
    - Information Management & Technology - £0k (£650k)
    - Estates investment schemes - £10k (£816k)
    - Clinical Equipment schemes - £247k (£620k)
    - IFRS16 - £2.733m (£800k)
    - PDC – £1.184m (£2.5m)
    -

Vacancy Rate

Background

The Vacancy Rate target for LCHS is 8%.



Narrative

Following the TUPE transfer of the Mass Vaccination Centre staff into LCHS from the ICB, this affected the Trust vacancy rate bringing this artificially lower whilst work was undertaken to align the budgets and establishment. This work has now been completed and the budget/finance system and ESR have been fully balanced.

Actions

On target – the Trust has a low overall vacancy rate compared to both the 8% target and the national benchmark figure. The national benchmark figure is published by the NHS Benchmarking Network's community indicators project monthly.

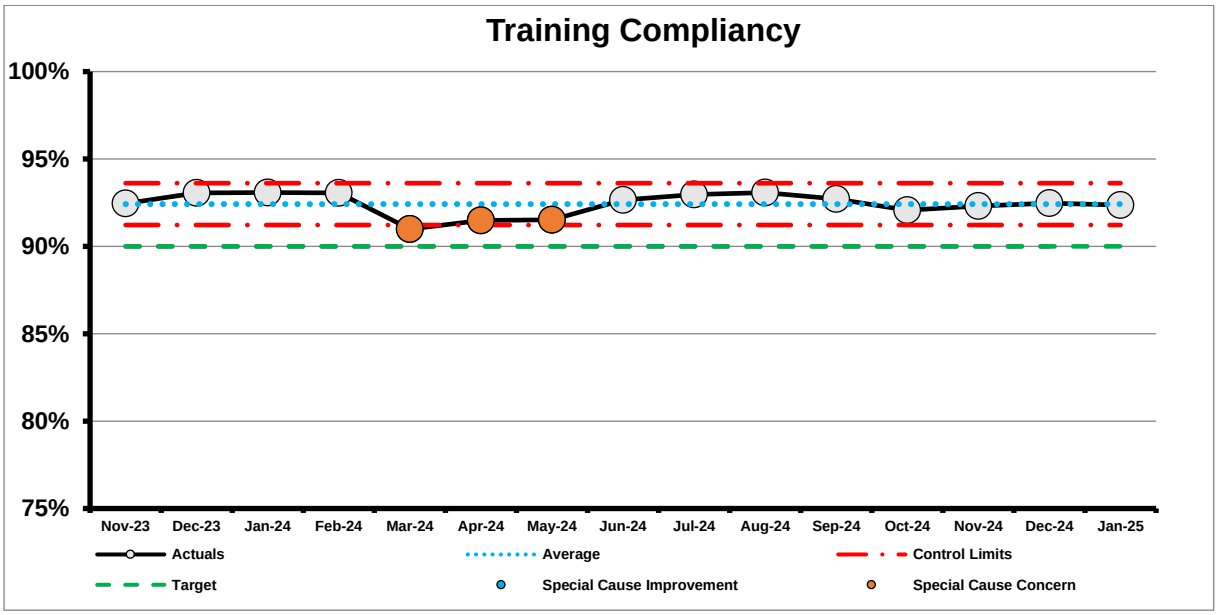
SPC

The vacancy rate has not varied significantly in the period and is consistently capable of achieving the 8% target.

Training Compliancy

Background

The national benchmark for Training Compliance is 90%. In November 2022, the Trust Board approved the recommendation to reduce the target to match this. This new target of 90% is reflected within the data below.



Overall mandatory compliance as of 31st January 2025:

The overall mandatory training compliance rate which includes all core and role specific modules has decreased very slightly to 92.36% which exceeds the local and national target of 90%.

Core mandatory training compliance (requirements for all staff):

Overall compliance for the core mandatory modules has increased very slightly to 95.43% which exceeds the national/local target of 90%.

The eLearning module remains live on ESR for staff to access at a time of their choice and support those returning to work from long term absence to update. The dates for 25-26 Mandatory season, Apr-Jun, have now be advertised for people to book on ESR.

Most divisions/directorates have overall compliance remaining above the national/local target of 90% except for IUEC and Operational Leadership who remain under target.

Children's, Young People's, and Specialist Services	94.15%	↓
Collaborative Community Care	91.87%	↓
Corporate Services	96.10%	↑
Integrated Urgent and Emergency Care	88.35%	↑
Operational Business Services	98.30%	↑
Operational Leadership	82.22%	↑
System	94.31%	↓

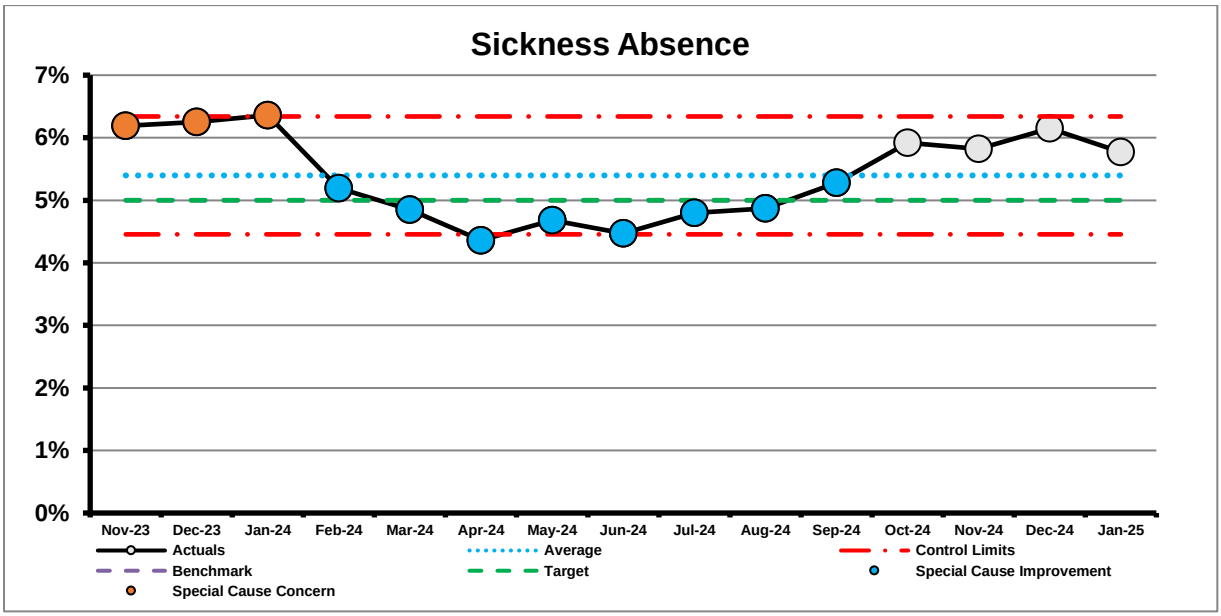
SPC

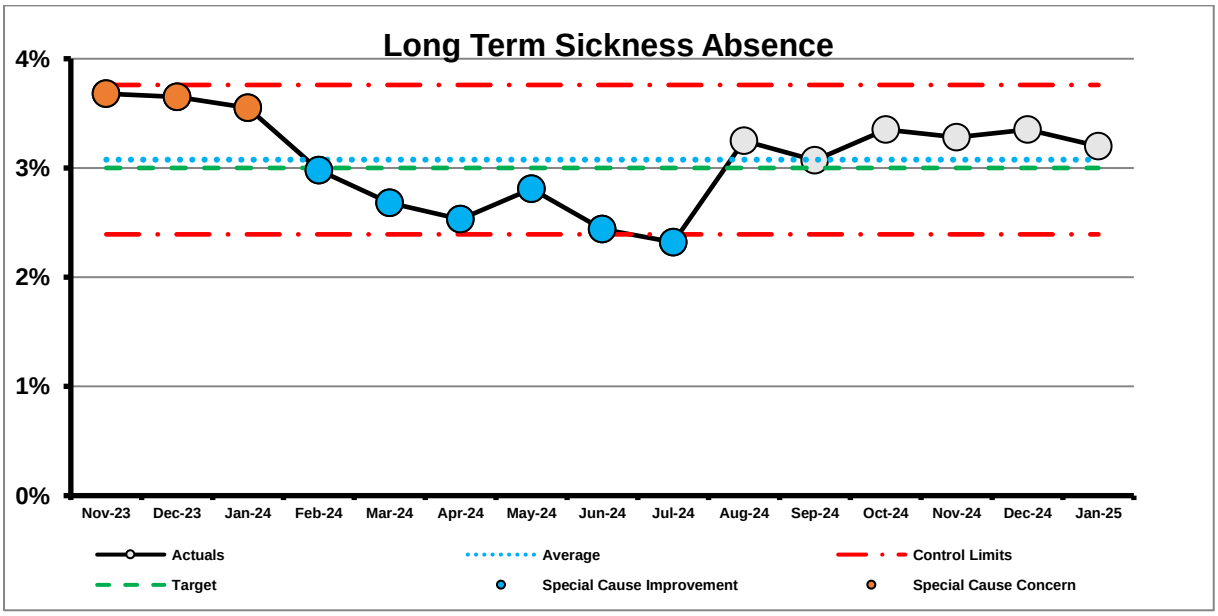
Mandatory Training compliance has not varied significantly since March 2024. The measure is consistently capable of achieving the 90% target.

Sickness Absence

Background

The Trust target for total sickness absence is 5%.





Narrative

The overall sickness levels in January have decreased to 5.77%, compared with 6.15% in December. However, this still remains above the agreed target of 5%.

For overall sickness absence, there are four areas which are above target as of January: Operational Business Services (8.02%), Integrated Urgent and Emergency Care (7.47%), Collaborative Community Care (5.79%) and Children's Young People and Specialist Services (5.12%).

The top three reasons accounting for overall sickness absence in January were anxiety, stress and depression, cold/cough/flu and gastrointestinal problems, which is consistent with previous months.

Long Term

The long-term sickness level in January has seen a slight increase to 3.2% from 3.35% in December, although this remains above the agreed target of 3%.

In relation to long term absence, there are three areas above target: Operational Business Services (5.22%), Integrated Urgent and Emergency Care (4.1%) and Children's Young People and Specialist Services (3.10%).

The top three reasons for long term sickness absence for January were: anxiety, stress and depression, injury/fracture and other musculoskeletal problems – which are the same as in December.

Short Term

The short-term sickness level in January has also decreased to 2.57% from 2.8% in December, although this remains above the 2% target.

In respect of short-term sickness, there are four areas who remain above target: Integrated Urgent and Emergency Care (3.37%), Collaborative Community Care (3.01%), Operational Business Services (2.8%) and Children's Young People and Specialist Services (2.02%).

The top three reasons for short term sickness absence in January were: cold/cough/flu, gastrointestinal problems and anxiety/stress/depression. These are the same top 3 as the previous month, although are in a different order.

Actions

- The Workforce Strategy Group is focussing on sickness absence including the number of return-to-work meetings taking place to support staff as well as consideration of the timescales for the various stage sickness absence meetings and whether these happen. This includes where warnings are being issued/not issued and whether this is appropriate, to ensure that the absence policy is being followed in all areas. Divisional leads and HR Business Partners have worked together to hold a number of sickness absence summits with leaders with a focus on different levels of leader's responsibilities and what support is available.

- The HR team continue to offer leaders coaching, advice and guidance in the appropriate and timely management of absence in line with the Your Attendance Matters policy and a number of bespoke attendance management workshops have been held with leaders. HR are encouraging managers to hold early wellbeing conversations with individuals to identify health and wellbeing support, adjustments, and flexible arrangements as appropriate, to support individuals to remain in work and/or return to work and to reduce the number of absence cases becoming long term.

- The HR team work proactively with managers to ensure there is timely support in place for those on long term sick and to facilitate successful return to works. The HR Advisors provide monthly reporting and work with Deputy Divisional Leads and CTLs to discuss the monthly KPI reports including but not limited to absence to highlight absences and trends and discuss actions.

- A comprehensive health and wellbeing offer remains in place, relating to support for mental health and wider wellbeing which is aligned to best practice.

SPC

Overall sickness rate has not varied significantly in the period and is inconsistently capable of achieving the 5% target. The target is expected to be missed more often than achieved.

Long-Term Sickness Absence has not varied significantly since July 2024 and is inconsistently capable of achieving the 3% target. The target is expected to be missed more often than achieved.

Workforce Dashboard

January 2024

Division	FTE Budgeted	FTE Actual	FTE Vacant	Vacancy Rate	Annual Turnover Rate	Monthly Turnover Rate	Total Absence Rate	Short Term Absence Rate	Long Term Absence Rate	Training Compliance Rate	Appraisals Rate	Supervision Rate
Children's, Young People's and Specialist Services	550.81	507.46	43.35	7.87%	8.43%	0.71%	5.12%	2.02%	3.10%	94.15%	95.73%	91.14%
Collaborative Community Care	759.80	773.18	-13.38	-1.76%	8.41%	0.44%	5.79%	3.01%	2.78%	91.87%	87.04%	81.75%
Corporate Services	225.33	213.29	12.04	5.34%	20.39%	1.64%	4.09%	1.09%	3.00%	96.10%	98.96%	84.44%
Integrated Urgent & Emergency Care	435.17	364.56	70.61	16.23%	5.96%	0.77%	7.47%	3.37%	4.10%	88.35%	96.73%	93.10%
Operational Business Services	111.44	109.10	2.34	2.10%	11.12%		8.02%	2.80%	5.22%	98.30%	97.17%	
Operations	14.90	10.18	4.72	31.68%	49.12%	19.65%	0.60%	0.60%		82.22%	100.00%	71.43%
System	19.00	30.48	-11.48	-60.42%	29.75%	2.19%	1.30%	1.30%		94.31%	84.62%	100.00%
Total	**2,116.45**	**2,008.26**	**108.19**	**5.11%**	**9.92%**	**0.80%**	**5.77%**	**2.57%**	**3.20%**	**92.36%**	**92.89%**	**86.98%**

Corporate Services

Division	FTE Budgeted	FTE Actual	FTE Vacant	Vacancy Rate	Annual Turnover Rate	Monthly Turnover Rate	Total Absence Rate	Short Term Absence Rate	Long Term Absence Rate	Training Compliance Rate	Appraisals Rate	Supervision Rate
Corporate Services	225.33	213.29	12.04	5.34%	20.39%	1.64%	4.09%	1.09%	3.00%	96.10%	98.96%	84.44%
Chief Exec	20.95	10.45	10.50	50.10%	51.66%		13.33%	2.78%	10.55%	95.63%	100.00%	
Finance & Business Intelligence	55.40	49.53	5.87	10.59%	26.65%	2.02%	2.33%	0.31%	2.02%	97.08%	97.44%	
Medical Directorate	21.25	25.79	-4.54	-21.35%	13.57%	5.82%	3.36%	0.87%	2.49%	92.89%	95.24%	77.78%
People & Innovation	84.77	90.44	-5.67	-6.69%	14.82%	1.11%	2.91%	1.13%	1.79%	95.78%	100.00%	100.00%
Quality	42.96	37.08	5.88	13.69%	21.57%		7.30%	1.75%	5.54%	98.24%	100.00%	88.00%
Total	**225.33**	**213.29**	**12.04**	**5.34%**	**20.39%**	**1.64%**	**4.09%**	**1.09%**	**3.00%**	**96.10%**	**98.96%**	**84.44%**

NHS
Lincolnshire Community and Hospitals NHS Group

Group Board Risk Report

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

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*4 March 2025*
Item Number	*14.1*

Risk Report

Accountable Director	*Kathryn Helley, Group Chief Clinical Governance Officer*
Presented by	*Kathryn Helley, Group Chief Clinical Governance Officer*
Author(s)	*Helen Shelton, Group Deputy Chief Clinical Governance Officer* *Lorna Adlington, Head of Patient Safety and Quality Governance, LCHS* *Sarah Davy, Risk and Datix Manager, ULTH* *Rachael Turner, Risk & Datix Facilitator*
Recommendations/ Decision Required	*The Group Board are invited to review the content of the report. There are no further escalations at this time.*

How the report supports the delivery of the priorities within the LCHG Board Assurance Framework	
1a Deliver high quality care which is safe, responsive and able to meet the needs of the population	*X*
1b Improve patient experience	*X*
1c Improve clinical outcomes	*X*
1d Deliver clinically led integrated services	*X*
2a Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	*X*
2b To be the employer of choice	*X*
3a Deliver financially sustainable healthcare, making the best use of resources	*X*
3b Drive better decision and impactful action through insight	*X*
3c A modern, clean and fit for purpose environment across the Group	*X*
3d Reduce waits for patients who require urgent and emergency care and diagnostics and ensure we meet all constitutional standards	*X*
3e Reducing unwarranted variation in cancer service delivery and ensure we meet all constitutional standards (ULTH)	*X*
3f Reducing unwarranted variation in planned service delivery and ensure we meet all constitutional standards (ULTH)	*X*
3g Reducing unwarranted variation in community service delivery and ensure we meet all constitutional standards (LCHS)	*X*

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

Executive Summary

From the 1st December 2024, the Group Risk Policy was launched which sees full alignment across both organisations of the risk profiles against each of the strategic objectives. The following report includes information pertaining to risks scoring 15 – 25 which are in relation to the highest risks across the Group.

As of 10th February 2025, there are 747 (129 LCHS and ULTH 618) risks recorded on the Group risk registers.

LCHS

The are 2 Very High risks (20 - 25) reported to the Quality Committee, this remains static from the previous reporting period. These relate to:

- 403 - Children SLT Therapy Treatment Delays
- 395 - TB Demand and Capacity

There are no Very High risks (20-25) reported to the Finance, People and Integration Committees this month.

ULTH

The are 9 Very High risks (20-25) reported to the Quality Committee this month, remaining stable from last month's reporting period, these relate to:

- 4731 - Reliance on paper medical records
- 4828 - Reliance on manual prescribing processes
- 4879 - Recovery of planned care cancer pathways
- 4947 – NICE Medicines reconciliation compliance
- 5016 - Patient flow through Emergency Departments
- 5100 - Quality and safety risk from inability to deliver epilepsy pathways within Acute Paediatrics that meet National standards
- 5101 - Delivery of paediatric epilepsy pathways-community
- 5143 - Removal of lift in H Block PHB affecting service delivery to patient records
- 5450 - Risk of Gastro service not being viable due to current fragility of consultant workforce

There are 5 Very High risks (20-25) reported to the People Committee this month, remaining stable from the previous reporting period:

- 4844 - Staffing levels requiring an increase in Pharmacy to be able to provide a seven-day service.
- 4948 - Pharmacy workload demands
- 4996 - Consultant workforce capacity (Haematology)
- 4997 - Service configuration (Haematology)
- 5447 - Cancellation of elective lists due to lack of theatre staff

There are 4 Very High risks (20-25) reported to the Finance Committee this month, a reduction of three from the last reporting period, these relate to:

- 4664 - Exceeding the agency cap due to the cost of reliance upon temporary clinical staff
- 4665 - Failure to meet 24/25 CIP

- 5020 - Reliance on agency / locum medical staff in Urgent & Emergency Care
- 5277 - Risk of additional financial pressures from possible application of national profiles to existing Job Descriptions.

The following risks was presented at Risk Register Confirm and Challenge in December and validated for a reduction in score:

- 4647 - Compliance with fire safety standards, assessed by Lincolnshire Fire and Rescue Service – **risk presented at December RRC&C meeting and validated for a decrease in score to 3x4:12 (Moderate risk) previously 5x4:20 Very High risk**
- 4648 - Potential for a major fire-**risk presented at December RRC&C meeting and validated for a decrease in score to 4x4:16 (High Risk) previously 5x4=20 Very High risk.**

The following risk has now been aligned to Integration Committee:

- 4657 - SARs Compliance and access to Health records in accordance with statuary requirements

There is 1 Very High risk (20-25) reported to the Integration Committee this month, this relates to:

- 4657 - SARs Compliance and access to Health records in accordance with statuary requirements

Purpose

The purpose of this report is to enable the Group Board to review the management of significant risks to strategic objectives and consider the overall extent of risk exposure within the Group at this time.

1. Introduction

1.1 The Group's risk registers are recorded on Datix. This report is focussed on significant risks to each objective, those with a current rating of Very High risk (a score of 20-25).

1.2 Full details of all active Very High and High risks (those with a current risk score of 15-25) are included in **Appendix A (LCHS) and Appendix B (ULTH)**, and a summary of Very High risks is provided in Section 2 below. Moderate and Low risks (those with a score of 12 and below) are overseen at divisional level.

1.3 The Risk Register Confirm and Challenge Group continues to meet on a monthly basis, reviewing all High and Very high risks as well as receiving presentations from clinical and corporate business areas on a rotational basis to enable constructive feedback to be provided.

2. Group Risk Profile

2.1 There are 747 (LCHS 129 and ULTH 618) active and approved risks reported to lead committees in February 2025.

2.2 LCHS

There are 2 risks with a current rating of Very High risk (20-25) and 13 rated High risk (15-16) reported to lead committees. **Table 1** below shows the number of active risks by current risk rating and proportion of the overall Trust risk profile:

Very low (1-3)	**Low** (4-6)	**Moderate** (8-12)	**High** (15-16)	**Very high** (20-25)
4 (3%)	**35** (27%)	**75** (58%)	**13** (10%)	**2** (2%)

2.3 ULTH

There are 19 risks with a current rating of Very High risk (20-25) and 65 rated High risk (15-16) reported to lead committees this month. **Table 1** below shows the number of active risks by current risk rating and proportion of the overall Trust risk profile:

Very low (1-3)	**Low** (4-6)	**Moderate** (8-12)	**High** (15-16)	**Very high** (20-25)
54 (+1) (9%)	**153 (+12)** (25%)	**327 (+9)** (53%)	**65 (+4)** (10%)	**19 (-2)** (3%)

Strategic objective 1a: Deliver high quality care which is safe, responsive and able to meet the needs of the population

2.4 **LCHS**

There are 2 Very High risks, remaining stable from the previous reporting period and 5 High risks recorded in relation to this objective. A summary of the Very High risks is provided below:

Risk ID	Title	Risk score	Division	Progress Update	Date of latest review
403	Children SLT Therapy Treatment Delays	20	Children, Young People, and Specialist Services	A further staff member (1 x B6 WTE) has resigned. A business case has been written to be shared with the ICB. Referrals are 188% higher in 2023/24 than in 2019 Waiting times are breaching the 18 week wait requirement with follow up and therapy waits over a year. There is a decrease of staff morale & staff retention – from fully staffed at the end of 2023 to 4.3 WTE vacancies, staff citing service challenges as reason for exit.	29/01/2025
395	TB demand and capacity	20	Community Partnerships	ARAP site at maximum capacity 200 residents - assessed as 16% with LTBI - 9 referrals sent to TB team from PCN allocated as camp health team. TB team unable to meet demand - escalated to ICB and plan in place for PCN/TB nurse specialist within ICB HPT to support TB team although RED/RED drugs are unobtainable for pts using this mitigation. ICB aware. Paper waiting to be submitted for review at the investment panel on 24/01/25. People with LTBI are not being case managed in line with NICE guidance, this includes HSCW working within the system who are known to have latent TB and may become ill or pose a risk to patients, other staff and the wider public.	23/01/2025

2.5 **ULTH**

There are 7 Very High risks, remaining stable and 23 High risks recorded in relation to this objective. A summary of the Very High risks is provided below:

ID	Title	Risk level (current)	Division	Progress update	Date of latest risk review
4879	Recovery of planned care cancer pathways	Very high risk (20-25)	Clinical Support Services	The Cancer right-sizing Business Case for Haematology and Oncology was prioritised by CSS Division and submitted in line with the Trust's programme for 25/26, aligned to the health System process. Next step for review via this process is 19 December 2024. It was also presented to Cancer Board on 29 November 2024 as part of the governance process.	21/01/2025
4947	NICE medicines reconciliation targets	Very high risk (20-25)	Clinical Support Services	RCEM/ED pharmacy case developed and submitted for winter pressures funding- this was	09/01/2025

ID	Title	Risk level (current)	Division	Progress update	Date of latest risk review
				unsuccessful. The case will be resubmitted for the next financial year (25/26).	
5016	Patient Flow Through Emergency Departments	Very high risk (20-25)	Medicine	UEC refresh continues to focus on ED performance and tasks to improve performance delivery. Flow impacts on ED space, capacity and impedes performance. Striving to attain 78%, however due to demand impairments within the department delivery will probably not be achievable. Improvements being seen due to work being undertaken. 4 hour standard has improved over last couple of weeks but risk needs to remain at current level.	04/02/2025
5100	Quality and safety risk from inability to deliver epilepsy pathways within Acute Paediatrics that meet National standards	Very high risk (20-25)	Family Health	Business case has been submitted to PMO office, still awaiting outcome from CRIG. Using bank B5 nurses to support some of this work, which adds to cost pressures and not sustainable.	21/01/2025
5101	Delivery of paediatric epilepsy pathways-community	Very high risk (20-25)	Family Health	Business case has been submitted to PMO office, awaiting date for presentation to CRIG. If business case approved, risk can be reduced. Risk to be raised as part of PRM process.	29/01/2025
5143	Removal of lift in H Block PHB affecting service delivery to patient records	Very high risk (20-25)	Clinical Support Services	Work has started and is ongoing, working with Estates to ensure any works have minimal disruption to the service. On track for works to be completed by end March 2025.	31/01/2025
5450	Risk of Gastro service not being viable due to current fragility of Consultant workforce	Very high risk (20-25)	Medicine	An additional consultant has started at Pilgrim with another possible for late 2025. Workforce business case has been submitted. Risk remains in fragile position, currently awaiting feedback from Trust/ICB.	04/02/2025

Strategic objective 1b: Improve patient experience

2.6 **LCHS**
There are no Very High risks and no High risks recorded in relation to this objective.

2.7 **ULTH**
There are no Very High risks, remaining stable and 4 High risks, remaining stable since the last reporting period.

Strategic objective 1c: Improve clinical outcomes

2.8 **LCHS**
There are no Very High risks and no High risks recorded in relation to this objective.

2.9 **ULTH**

There are 2 Very High risks, remaining stable and 6 High risks, an increase of 1, in relation to this objective. A summary of the Very High risks is provided below:

ID	Title	Risk level (current)	Division	Progress update	Date of latest risk review
4828	Reliance on manual prescribing processes	Very high risk (20-25)	Clinical Support Services	Outpatients – Product Manager job description review for banding – will be appointed once completed and funds for post agreed. Paediatrics – mitigations in place to accept minimal risk to Paediatrics, no plans to employ full time Paediatrician for EPMA.	24/01/2025
4731	Reliance on paper medical records	Very high risk (20-25)	Corporate	Until EDMS in in place and ePR alongside it, this remains a risk as there is a potential for information not all in one place. An example of this is that we no longer file blood results in the notes but refer to WebV. Therefore, it is not always feasible to add to the paper notes and a reliance on the clinician to check all digital solutions.	15/01/2025

Strategic objective 1d: Deliver clinically led integrated services

2.10 **LCHS**

There are no Very High risks and no High risks recorded in relation to this objective.

2.11 **ULTH**

There are no Very High risks and no High risks recorded in relation to this objective.

Strategic objective 2a. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise

2.12 **LCHS**

There are no Very High risks and no High risks recorded in relation to this objective.

2.13 **ULTH**

There are 5 Very High risks, remaining stable, and 17 High risks, an increase of 1, in relation to this objective. A summary of the Very High risks is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date added to register and latest review:
4844	The ability to provide a seven day a week pharmacy service requires a level of staffing above the current levels. Benchmarking has taken place against peer Trusts for staffing levels. Until this is funded the seven day a week service is unobtainable and this puts patients at risk.	Very high risk (20)	Pharmacy supply a limited Saturday and Sunday morning service with staff working beyond their contracted hours. An on-call pharmacist is available for EMERGENCY items only. A Business Case has been submitted to CSS CBU. Work continues to help recruit to hard to fill posts, pipeline talent attraction and Recruitment and Retention premia principles being explored for the hard to recruit to posts.	**Date added to the Trust Register:** **19/01/2022** **Date of latest review:** **30/01/2025**
4996	Staffing - insufficient consultant workforce to meet demand. Particular areas of concern: 1. Lymphoma tumour site cover 2. Haemostasis/haemophilia (single consultant Trust wide) 3. Pilgrim Consultant cover 4. Clinical governance lead 5. HoS/clinical lead	Very high risk (20)	Workforce review - Now Completed July 2023 Refresher of Fragile Services Paper - NB there is a National shortage of Haematology consultants - Now completed September 2023 * Recruitment of further substantive consultants - December 2024	**Date added to the Trust Register:** **22/08/2022** **Date of latest review:** **20/01/2025**
4997	Service configuration - single consultant covering both sites during weekend so cover limited if critically unwell patients on both sites	Very high risk (20)	Workforce review - Now Completed July 2023 Refresher of Fragile Services Paper - NB there is a National shortage of Haematology consultants - Now completed September 2023 *Recruitment of further substantive consultants - December 2024	**Date added to the Trust Register:** **22/08/2022** **Date of latest review:** **20/01/2025**
5447	Nurse staffing in theatres does not support current activity. There is a risk of elective lists being cancelled due to lack of theatre staff. Business case has been written to source funding. Currently in a difficult position. The off framework is going to stop soon with an impact that will possibly cancel lists. Lengthy discussions have been had to support Theatres. Break Glass agency workers are starting to be put in place but we are still very short. ODP has been approved but no back fill.	Very high risk (20)	Establishment review Business case for funding in process to apply for funding with staffing workshop planned for September. Project group commenced at Lincoln to introduce activity manager to try to support planning and management of deficits.	**Date added to the Trust Register:** **05/06/2024** **Date of latest review:** **07/01/2025**

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date added to register and latest review:
4948	Workload demands within Pharmacy persistently exceed current staffing capacity which leads to longer working hours (inc weekends), work related stress resulting in serious and potentially long-term effects on staff health and wellbeing. Adding to this with additional workload demands with insufficient staffing, or required level of experience and skill, the risk is patients will not be reviewed by a pharmacist leading to poorer clinical outcomes, reduced flow on acute wards, delayed discharges and increased risk of omitted medicines. For staff the risk is long term absence. This may result in the failure to meet the national and local targets for KPIs	Very high risk (20)	Review current provision and identify gaps in service to inform business cases for change to support 7 day working (working with Surgery and Medicine Divisions as appropriate). Skill mix requires review due to complexity of patients.. Pragmatic management of workload & provision of management support. On-going exploration of recruitment options. Wellbeing team supporting staff - regular visits organised	**Date added to the Trust Register:** **17/06/2022** **Date of latest review:** **30/01/2025**

Strategic objective 2b. To be the employer of choice

2.14 **LCHS**

There are no Very High risks and no High risks recorded in relation to this objective.

2.15 **ULTH**

There are no Very High risks and no High risks recorded in relation to this objective.

Strategic objective 3a: Deliver financially sustainable healthcare, making the best use of resources

2.16 **LCHS**

There is no Very High risk and 3 High risks recorded in relation to this objective.

2.17 **ULTH**

There are 4 Very High risks (20-25) and 1 High risk (15-16), both remaining stable, recorded in relation to this objective. A summary of the Very High risks is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
5020	If there is a continued reliance on bank and agency staff for medical workforce in Urgent & Emergency Care there is a risk that there is not sufficient fill rate for medical rotas both ward / department fill and on call shifts which will impact on patient safety and have a negative impact on the CBU budget	Very high risk (20)	Robust recruitment plan International recruitment Medical Workforce Management Project. Work remains ongoing.	04/02/2025

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4664	The Trust is overly reliant upon a large number of temporary agency and locum staff to maintain the safety and continuity of clinical services.	Very high risk (20)	Financial Recovery Plan schemes: - recruitment improvement; - medical job planning; - agency cost reduction; - workforce alignment	20/01/2025
4665	The Trust has a £40.1m Financial improvement target for 24/25. If the Trust fails to deliver the CIP Plan, this will have a significant adverse impact on the ability of the Trust and the Lincolnshire ICS to deliver its breakeven financial plan for the year. This represents a 5% target which is greater than any financial improvement the trust has delivered in previous years. In addition to this target, invest to save investments required to deliver the savings plan will need to be funded via more CIP identification/ delivery. Failure to deliver the CIP plan will have an adverse impact on the trusts ability to decrease its underlying deficit and build towards a sustainable pipeline of cost improvement for the future.	Very high risk (20)	Training & Support offered to all Divisions and stakeholders through CIP planning workshops. Increased CIP governance & monitoring arrangements introduced. Alignment with the Trust Strategy and System objectives CIP is embedded as part of the Trust Improvement Strategy not seen as a separate annual work stream. Development of future programme of cost improvement. Continual exploration of new opportunities.	20/01/2025
5277	Risk of additional financial pressure to the Trust from the possible application of national profiles to existing job descriptions for a number of Band 2 and Band 3 roles and the potential wider impact of any decision.	Very high risk (20)	Band 2 staff who requested Band 3 now being paid Band 3 and backdated payment paid in January No longer a risk and is now part of the overall financial position. Risk to be presented at February Risk Register Confirm and Challenge for closure - details of this as part of the current financial position will be included in Risk 4665	20/01/2025

Strategic objective 3b: Drive better decision and impactful action through insight

2.18 **LCHS**

There are no Very High risks and no High risks recorded in relation to this objective.

2.19 **ULTH**

There are no Very High risks and no High risks recorded in relation to this objective.

Strategic objective 3c: A modern, clean and fit for purpose environment across the Group

2.20 **LCHS**

There are no Very High risks and 4 High risks recorded in relation to this objective.

2.21 **ULTH**

There are no Very High risks (20-25), a reduction of 2, and 9 High risks (15-16), an increase of 1, recorded in relation to this objective.

Updates since the last report

Following the last report the following changes were agreed and validated:

- 4647 - Compliance with fire safety standards, assessed by Lincolnshire Fire and Rescue Service – **risk presented at December RRC&C meeting and validated for a decrease in score to 3x4:12 (Moderate risk) previously 5x4:20 Very High risk**
- 4648 - Potential for a major fire-**risk presented at December RRC&C meeting and validated for a decrease in score to 4x4:16 (High Risk) previously 5x4=20 Very High risk.**

Strategic objective 3d: Reduce waits for patients who require urgent and emergency care and diagnostics and ensure we meet all constitutional standards

2.22 **LCHS**

There are no Very High risks and no High risks recorded in relation to this objective.

2.23 **ULTH**

There are no Very High risks and no High risks recorded in relation to this objective.

Strategic objective 3e: Reducing unwarranted variation in cancer service delivery and ensure we meet all constitutional standards (ULTH)

2.24 There are no Very High risks and no High risks recorded in relation to this objective.

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

2.25 There are no Very High risks and no High risks recorded in relation to this objective.

Strategic objective 3g – Reducing unwarranted variation in community service delivery and ensure we meet all constitutional standards (LCHS)

2.26 There are no Very High risks and no High risks recorded in relation to this objective.

Strategic objective 4a: Establish collaborative models of care with all our partners Including Primary Care Network Alliance (PCNA), GPs, health and social care and voluntary sector

2.27 **LCHS**

There are no Very High risks and no High risks recorded in relation to this objective.

2.28 **ULTH**

There are no Very High risks and no High risks recorded in relation to this objective.

Strategic objective 4b: Successful delivery of the Acute Services Review

2.29 **LCHS**
There are no Very High risks and no High risks recorded in relation to this objective.

2.30 **ULTH**
There are no Very High risks and no High risks recorded in relation to this objective.

Strategic objective 4c. Grow our research and innovation through education, learning and training

2.31 **LCHS**
There are no Very High risks and no High risks recorded in relation to this objective.

2.32 **ULTH**
There are no Very High risks and 1 High risks an increase in 1 recorded in relation to this objective.

Strategic objective 4d: Enhanced data and digital capability

2.33 **LCHS**
There are no Very High risks and no High risks recorded in relation to this objective.

2.34 **ULTH**
There is 1 approved Very High risk (20-25), remaining stable, and 4 High risks (15-16), a reduction of 1, recorded in relation to this objective. A summary of the Very High risk is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4657	If the Trust does not comply with Subject Access Requests (SARs) and Access to Health Records provisions in accordance with statutory requirements specified legislation, then it could lead to complaints to the Trust and Information Commissioner's Office (ICO). This could result in regulatory action and possibly financial penalties. Inconsistent levels of expertise outside of the IG team regarding SAR requirements. Lack of technical tools to carry out a search of emails / systems to identify personal information held. Potential financial implications."	Very high risk (20)	Current active communications with ICO- regulator. Changes to processes are being constantly discussed and implemented. Resource needs being discussed and temporarily increased to support. Monitored through the IGG in DP KPI report. Head of IG leading on work to review and improve. Working in a more digital way where feasible. Workforce change is required which will be a much longer process. Early identifications of chasers and urgent requests to reduce the likelihood of complaints.	29/01/2025

Strategic objective 5a - Develop a Population Health Management (PHM) and Health Inequalities (HI) approach for our Core20PLUS5 with our ICS

2.35 **LCHS**
There are no Very High risks and no High risks recorded in relation to this objective.

2.36 **ULTH**
There are no Very High risks and no High risks recorded in relation to this objective.

Strategic objective 5b: Co-create a personalised care approach to integrate services for our population that are accessible and responsive

2.37 **LCHS**
There are no Very High risks and 1 high risk recorded in relation to this objective.

2.38 **ULTH**
There are no Very High risks and no High risks recorded in relation to this objective.

Strategic objective 5c: Tackle system priorities and service transformation in partnership with our population and communities.

2.39 **LCHS**
There are no Very High risks and no High risks recorded in relation to this objective.

2.40 **ULTH**
There are no Very High risks and no High risks recorded in relation to this objective.

Strategic objective 5d: Transform key clinical pathways across the group resulting in improved clinical outcomes.

2.41 **LCHS**
There are no Very High risks and no High risks recorded in relation to this objective.

2.42 **ULTH**
There are no Very High risks and no High risks recorded in relation to this objective.

.

3.0 Conclusions

3.1 As of 10th February 2025, there are 747 (129 LCHS and ULTH 618) risks recorded on the Group risk registers.

3.2 **LCHS**

The are 2 Very High risks (20 - 25) reported to the Quality Committee this reporting period:

403 - Children SLT Therapy Treatment
395 - TB Demand and Capacity

There are no Very High risks (20-25) reported to the Finance, People and Integration Committees this reporting period.

3.3 **ULTH**

There are 9 Very High risks (20-25) reported to the Quality Committee this reporting period:

- 4731 - Reliance on paper medical records
- 4828 - Reliance on manual prescribing processes
- 4879 - Recovery of planned care cancer pathways
- 4947 – NICE Medicines reconciliation compliance
- 5016 - Patient flow through Emergency Departments
- 5100 - Quality and safety risk from inability to deliver epilepsy pathways within Acute Paediatrics that meet National standards
- 5101 - Delivery of paediatric epilepsy pathways-community
- 5143 - Removal of lift in H Block PHB affecting service delivery to patient records
- 5450 - Risk of Gastro service not being viable due to current fragility of consultant workforce

There are 5 Very High risks (20-25) reported to the People Committee this reporting period:

4844 - Staffing levels requiring an increase in Pharmacy to be able to provide a seven-day service.
4948 - Pharmacy workload demands
4996 - Consultant workforce capacity (Haematology)
4997 - Service configuration (Haematology)
5447 - Cancellation of elective lists due to lack of theatre staff

There are 4 Very High risks (20-25) reported to the Finance Committee this reporting period:

- 4664 - Exceeding the agency cap due to the cost of reliance upon temporary clinical staff
- 4665 - Failure to meet 24/25 CIP
- 5020 - Reliance on agency / locum medical staff in Urgent & Emergency Care
- 5277 - Risk of additional financial pressures from possible application of national profiles to existing Job Descriptions.

There is 1 Very High risk (20-25) reported to the Integration Committee this reporting period:

- 4657 - SARs Compliance and access to Health records in accordance with statuary requirements

3.4 The Group Board is invited to review the content of the report. There are no further escalations at this time.

Appendix A - LCHS High and Very High Risks (15 - 25)

ID	Group Risk Type	Risk Lead	Committee Responsible	Opened	Rating (initial)	Division	Service	Title	There is a risk that:	Caused by:	Resulting in	Controls in place	Likelihood (current)	Consequence (current)	Risk level (current)	Rating (current)	Updates by reviewers	Risk level (Target)
403	Physical or Psychological Harm	Griffiths, Claire	Quality Committee (Lead assurance committee)	13/09/2022	9	Children, Young People, and Specialist Services	Children's Therapy	Children SLT Therapy Treatment Delays	Children & young people will not receive the speech and language support they require to meet their social, emotional, educational, and health needs in a timeframe appropriate for their development.	Demand has increased nationally & regionally for SLT support overwhelming commissioned capacity. Referrals 188% higher in 2023/24 than in 2019.	Untreated speech, language, and communication needs (SLCN), which leads to: Children 6-11 times more likely to be behind educationally & more likely to be excluded from schools; 60-70% of young offenders reported to have poor language skills; 81% children with emotional behaviours problems have SLCN; SLCN children are twice as likely to be unemployed as an adult due to poor cognitive & social outcomes increasing lifelong health inequalities. Reputational damage from increased complaints & appeals to MPs & press	1. Advice and activities are given the patient's family and/or educational setting, ensuring they are safe to wait. 2. An appropriate skill mix is used, for example assessments are carried out by SLT and most therapy blocks completed by SLTAs. 3. Mix of face to face and virtual sessions 4. Increased the referral acceptance criteria: focused on highly complex patients only	Extremely likely (5) >90% chance	Severe (4)	Very High Risk (20-25)	20	20/01/2025 Discussed at CYPSS Quality SMT 16/01/25: noted that one more staff member (1 x B6 WTE) had handed in their resignation. No change to score. 17/12/2024 Discussed at CYPSS divisional Quality Scrutiny Group 16/12/24: Business case has been written up on the ICB template and is awaiting further sign off. No change to score. 29/11/2024 Discussed at RRCC 27/11/24: agreed to increase the score from L4 x C4 = 16 score to L5 x C4 = 20. 14/11/2024 Discussed with DDL KJK 14/11/24: Propose to increase the score from L4 x C4 = 16 score to L5 x C4 = 20, based on the below narrative: • Referrals 188% higher in 2023/24 than in 2019 (average 354 / month 12/23-04/24) • Waiting times breaching the 18 week wait requirement – follow up and therapy waits over a year. • Decrease of staff morale & staff retention – from fully staffed at the end of 2023 to 4.3 WTE vacancies, staff citing service challenges as reason • Service working in OPEL 4 since Sep'23 and activating BCP, with no plans to reinstate lower level referrals • Oct'23 50+% lower-level needs CYP on the caseload not eligible for a service under the OPEL 4 threshold • Increase in concerns and complaints (from 2.1	Low Risk (4-6)
395	Physical or Psychological Harm	Humphreys, Julie	Quality Committee (Lead assurance committee), Trust Leadership Team	09/07/2020	9	Community Partnerships	Tuberculosis Adult Services	TB Demand and Capacity	Demand is exceeding capacity within the TB service in particular managing the LTBI referrals which have increased significantly. People with LTBI are not being case managed in line with NICE guidance, this includes HSCW working within the system who are known to have latent TB and may become ill or pose a risk to patients, other staff and the wider public.	Current commissioned staffing model doesn't match the increased activity. Additional staff currently recruited at cost pressure. HSCW employees with known latent TB are not being treated or managed in accordance with NICE. Some LTBI have inadvertently started taking prescribed medication without being case managed. Administrative support has been reduced = 1 WTE at Band 2managed	Rise of active TB, MDRTB, hospital admissions, deaths, risk to public health. Impact to patients' mental, social, economic & physical health. Impact on staff wellbeing, retention of specialist TB nurses. No capacity to respond to TB outbreaks - most recent and ongoing in Boston leading to operating an unplanned 7 day service. Staff unable to timely review/update service SOPs / NICE compliance. LTBI employees not being managed. Potential Regulatory enforcement action. Increased waits	1. Placed on fragile services register. 2. Paper to SLT / ELT for approval to request further investment from ICB. 3. Review of case management and option to move to nurse-led model with enhanced technology. 4. Running service at cost pressure and through loan of TB nurse from another division has led to ability to case managed active TB cases, community LTBI cases (excludes employees with LTBI) 5. Video Supported Treatment was introduced that provides case managers assurance that doses were not missed in the absence of support, but this still lacks the prompt and support elements. 6. Prioritisation of TB and MDR TB management. System LTBI employees not beginning treatment as no capacity to case manage. 7. Additional CTL post agreed for CDRT (VRRT funded)	Extremely likely (5) >90% chance	Severe (4)	Very High Risk (20-25)	20	23/01/2025 ARAP site with max capacity 200 residents - assessed as 16% with LTBI - 9 referrals sent to TB team from PCN allocated as camp health team. TB team unable to meet demand - escalated to ICB and plan in place for PCN/TB nurse specialist within ICB HPT to support TB team although RED/RED drugs are unobtainable for pts using this mitigation. ICB aware. 21/01/2025 Discussed at CDRT Quality Scrutiny Group 15/01/2025: paper waiting to be submitted for review at the investment panel on 24/01/25. Score remains the same. 10/01/2025 Discussed at CDRT Quality Scrutiny Group 11/12/24: business paper submitted for seals of approval as part of the governance process. Once these are in place, the paper can be submitted to the ICB. No change to score. 02/12/2024 Discussed at CDRT Quality Scrutiny Group 13/11/24: No change to score. 11/10/2024 Operations Delivery Group (ODG) reviewed the risk and requested a higher risk rating, placement on the system risk register and agreed this is a system risk relating the employees working in LCHS / system who have LTBI and are untreated. There are now 117 employees (data to Sept 24) who have been referred with LTBI (57 to LCHS and Apr - Sept 60 further referred to OH from DoH). In addition the TB service with their existing case load (active TB	Very Low Risk (1-3)

681	Regulatory Compliance	Griffiths, Claire	Quality Committee (Lead assurance committee)	05/02/2024	20	Children, Young People, and Specialist Services	Children in Care	Children in Care - unable to meet IHA and RHA timescales	There is a risk that there is insufficient capacity within the children in care service to meet the current demand for Initial Health Assessments (IHAs) and Review Health Assessments (RHAs). Initial Health Assessment is required within 20 days of a child coming into care. Review Health Assessments are required annually for children over 5 years of age, and twice yearly for children under the age of 5 years.	At the end of 2023 there were 728 children in the care of Lincolnshire County Council, this number continues to increase year on year (increased by 7% from the previous year alone and 18% over the last 5 years). The introduction of the National Transfer Scheme in November 2021 has also triggered a significant rise in Unaccompanied Asylum-Seeking Children receiving support from the service. The number of children and young people placed into Lincolnshire by external authorities also continues to rise significantly putting additional pressure on the team (22% increase over the last 5 years). The current budget for the Children in Care Service has not been reviewed for several years and is no longer sufficient to meet this increasing demand.	This means there is a significant increase in the number of children in care in Lincolnshire resulting in an increased demand for IHA and RHAs. These assessments are statutory and the service will be unable to meet the timescales these should be completed within. This will impact on the health needs of children in care living in Lincolnshire and delay access to care they may require. The reputation of the service will also be affected if they are unable to meet these statutory assessment timescales. Service user and carer feedback will also be impacted as children have to wait longer than expected for these assessments.	The number of children under the care of Lincolnshire County Council continues to grow year on year increasing the demand for IHA and RHA assessments. The service has only been able to offer the amount of IHA appointments needed to meet this demand at significant cost pressure to LCHS. LCHS are unable to continue to cover this additional financial support needed from 01.04.24. An options appraisal has been completed to identify the increase in funding to meet the increased demand for IHA and RHAs, this is attached to the record.	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16	17/12/2024 Discussed at CYPSS Quality Scrutiny Group 16/12/24: outcome of business case awaited. No change to score. 23/11/2024 Discussed at CYPSS Quality SMT 21/11/24: reduced concerns this month because there have been fewer referrals combined with increased availability from the doctors; however this is normal activity fluctuation consistent with last year's around the same time. Temporary doctor starting in Jan'25. No change to score. 17/10/2024 Discussed at CYPSS Quality SMT 17/10/24: no change to score. 20/09/2024 Discussed at CYPSS Quality SMT 19/09/24: update from Director of Safeguarding CF was acknolwedged. No change to score. 28/08/2024 Paper presented to ELT (27.08.2024) agreement given for overspend to be increased as per Option 2 - If the service were to recruit a substantive Specialist Paediatric Doctor from September 2024, the projected overspend for 2024/25 would be: £90,020. Five months bank paediatrician (£26,320) and seven months Specialist Doctor (£63,700). Service will now open discussion with ULHT family health to procure a senior paediatrician at the earliest opportunity 19/08/2024 Discussed at CYPSS Quality SMT 15/08/24: Overspend to be officially agreed; paper to be submitted to ELT with regards to overspend	Very Low Risk (1-3)
714	Physical or Psychological Harm	Brunton, Michael	Quality Committee (Lead assurance committee)	16/05/2024	16	Collaborative Community Care		Delivery of pressure ulcer care in the community	Patients are not always receiving the correct level of care for pressure ulcers within community nursing settings	Variability in the delivery of care for pressure ulcers across community Lack of consistent senior clinical case review Variable clinical skill set of team members in delivering pressure ulcer care	Deterioration in pressure ulcers Increasing referrals for S42 safeguarding responses Poor patient and family/carer experience ICB/CQC oversight of pressure ulcer care	Daily BeSafe reviews of patient care Service action plan to improve pressure ulcer care implemented ICB oversight Educational training plan for all community clinicians initiated Assurance programme commenced Monthly thematic review of pressure ulcers highlighting themes and risks in care	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16	05/11/2024 - Keeping current score, we are seeing improvements but this is not consistent across all of the county. Data evidencing this is being shown in QA audit processes. 08/10/2024 - Made improvements using data collected from weekly audits, increase in Purpose T, Obs, and using the safe guarding checklist. Need to look at patients with convenience issues. Seen a reduction in Cat 4 PU's. Further suspected S42. Score to remain the same currently. We have moved the Consequence score in the target risk matrix table as this will always stay the same and likelihood will move after mitigations. 10/09/2024 Increase in Cat 2's in the month. Cat 3's have now gone up due to unstagables are now included in Cat 3. No reduction in score at this time. 23/08/2024 Whilst there are some improvements can be seen in assurance standards there is insufficient progress against the action plan for this risk to be confident that a reduction in score is currently warranted 25/07/2024 This has 2 workstreams ongoing. 1 for immediate actions in relation to current increase in S42's in specific teams. 2 is for overall improvement to PU care across all teams. Current weekly meetings being held and auditing of teams has started. A3 thinking has been completed with some areas which has supported development of quality improvement	Moderate Risk (8-12)
695	Service Disruption	Brunton, Michael	Quality Committee (Lead assurance committee)	12/03/2024	16	Collaborative Community Care		Lack of District Nurse Specialist Practice qualified staff in community nursing affecting the quality of care	Community nursing teams fail to provide high quality care due to reduced levels of District Nurse Qualified staff within the team structure	Lack of value placed upon the importance of the DNSPQ qualification within community nursing teams Failure to reimburse staff undertaking the role relevant to their responsibilities and thereby retaining them Failure to train sufficient number of DNSPQ qualified staff Lack of standard use of the Enhanced Practitioner role in community nursing teams and defined role Lack of qualified DN	Insufficient levels of qualified DNSPQ support for junior members of teams Lack of oversight for complex case management. Identified theme in case of patient harm Reduced safe management of caseload sizes in community nursing teams Lack of professional support and guidance for team development	BSAFE initiated for daily oversight of safe care BSAFE audits by CSL level staff Reallocation of qualified DNSPQ staff to teams with low levels to aid safety Identification of new assessors for DNSPQ trainees Allocation of trainers to training places for increased trajectory of DNSPQ training Recovery trajectory and commitment to model of care for excellence to be submitted to ELT as part of a wider strategy for service	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16	05/11/2024 - Increasing DNSPQ mentors and 6 people currently going through this process. 08/10/2024 - Update in 715 as these are linked. 10/09/2024 Still awaiting ELT conversation on proposed changes to CN structure. 23/08/2024 No change in the level of score currently. ELT conversation on business case for community nursing to be had 25/07/2024 Paper finalised which has been writen by Angie Davies and Michael Brunton. This has been shared with new Director of Nursing and Exec. Possibility of going to ELT either Aug/Sept 2024. This paper is proposing the need to increase DN speciality to band 7 and aligned with QNI caseload recommendation. 30/05/2024 New risk agreed at Risk Register Confirm & Challenge Group 29/05/2024	Low Risk (4-6)

715	Physical or Psychological Harm	Brunton, Michael	Quality Committee (Lead assurance committee)	16/05/2024	16	Collaborative Community Care		There is a risk that the Community nursing lacks capacity and skill set to meet community demand	The community nursing service is unable to meet the demand of patients within Lincolnshire	Increased demand for service of 8% Care unit allocation above the maximum of 15 care units daily Case load levels above 150 max levels Reduced numbers of DNSPQ qualified staff	Variance in care delivery Ineffective case load management Poor patient experience Reduced complex caseload efficiency Task based service provision with a lack of holistic care planning	Daily BSafe - escalation/oversight review Twice daily matron led safety huddles Re allocation of senior resource to at risk areas Operational oversight of risk daily Service evaluation of DNSPQ role Support from UCR and CYPSS services to aid meeting unplanned demand when required	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16	05/11/2024 - No change currently 08/10/2024 - paper has gone to ELT and has been backed by the board, awaiting information on if/how this can be financed to increase capacity and value DNSPQ workforce. 6 now DNSPQ students started in September. 6 practice teachers are now on the course. [10/09/2024 No change 23/08/2024 No change in score as capacity continues to not meet demand for service 25/07/2024 Paper evidencing need for increase in registered staff in Community Nursing has been finalised and share with new Director of Nursing and other Excs. This paper should go to ELT in Aug/Sept 2024. The establishment gap has been modelled on QNI 80/20 ratio. 30/05/2024 New risk agreed at Risk Register Confirm & Challenge Group 29/05/2024	Low Risk (4-6)
495	Physical or Psychological Harm	Parkin, Hayley	Integration Committee (Lead assurance committee)			Collaborative Community Care	Treatment room	Treatment room clinics do not have capacity to meet demand	The Treatment Room clinics are working off contracted specification High service demand beyond contracted obligation Patient safety risk as patients with complex wound management needs are being seen in clinics staffed and set up for minor wounds The clinics are underfunded (-250K initial investment needed)	Gap in service provision for ambulatory patients who have Tier 2 and 3 wounds. GP practices which opted out of the Treatment Room DCA have also been referring patients who do not meet criteria. Proposed GP IA likely to exacerbate this problem	Time restrictions on patient assessment timeslots Risk of delayed healing/inappropriate care Non clinic staff being pulled in to assist The capacity of the clinics is impacting on wider services such as IUEC and community nursing covering gaps in demand No budget to expand the service to meet need Cost pressure to LCHS	Initial service review carried out and shared with the ICB to highlight the gap in service and patient risk No guidance from the ICB around future service specifications See attached risk assessment. 28/02/24: Full in-depth service review carried out in relation to demand, capacity and cost of the service Meetings with ICB to discuss IA impact	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16	03/12/2024 - Risk too to RRC&C and score reduction agreed. 05/11/2024 - Plan in place for stabilising Treatment Rooms and staffing across the county. This has reduced likelihood to 4. 08/10/2024 - No change in score, LCHS has now started to provide TR for K2 PCN due to them serving notice as part of GP collective action. 10/09/2024 Score to stay the same, this is due to the GP Collective Action and the risk of more areas needing support with Treatment Rooms. Clinic Space an issue in Skegness, Boston, Mablethorpe. Type of things being seen in clinics is not what we are comissioned for. Work on going with ICB on being funded appropriately. K2 have served notice and	Very Low Risk (1-3)
444	Finances	Taylor , James	Finance Committee (Lead assurance committee)		15	Corporate	Finance	Failure to deliver financial plan 24/25 - Cost	The Trust fails to deliver breakeven duty aspect of its financial plan by failing to contain costs within planned levels	Service pressures, continued pressure in the system and level of demand being experienced, and/or failure to manage performance effectively or unforeseen events; Inflationary 'cost of living pressures	Reputational damage including reduction in the SOF rating and/or lack of financial sustainability going forward, and a failure to meet statutory financial duties.	1. Financial plan and budgets approved, including the capital plan 2. Financial control system 3. Executive oversight at TLT, through to FPPIC. 4. Monthly capital group meeting internal to LCHS 5. Monitored at PMR, monthly via FPPIC and , monthly contract meetings with Commissioners. LCHS aligned to system plan but maintaining own business and governance assurance. 6. Cost of living increase pressures funding influenced at Lincolnshire system and national levels.	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16	25/11/2024 Costs continue to be tightly controlled. Greater grip and control implementation by association as part of LCHG group financial recovery plan. 17/10/2024 Maintain current score. Delivery of plan contingent on delivering 25% reduction in run rate spend on overtime, required to mitigate cost pressures associated with apprentices and international nurses 04/09/2024 Score reviewed at Risk Register Confirm and Challenge meeting 28/08/24 and agreed to increase likelihood to 4 and decrease consequence to the same, overall increase from L3 x C5 = 15 to final score L4 x C4 = 16. 23/07/2024 Monthly update. No change 20/05/2024 Decisions regarding cost pressures need to be made by ELT. 14/05/2024 Risk decrease from 12 in December 2023 to 6. Risk updated on 29/04/2024 with Mike Pockett.'' At the start of the year there is a lot of people involved in bringing a quality efficiency program to be delivered. There were risks that didn't happen and as the year has gone on a lot of changes have happened because of financial benefits so the risk reduced. 9 months worth of efficiency financial measure allowed a more informed view of were the organisation is going for the next few months. 27/04/2024 Retrospective decrease of score noted	Low Risk (4-6)
754	Physical or Psychological Harm	Chaytor, Sarah	Finance Committee (Lead assurance committee), Health and Safety Committee (Accountable for)		15	Corporate	Quality	Moving and Handling	Clinical staff are inadequately trained in moving and handling	Poor compliance with expected standards. Training content currently being re evaluated. As a consequence there has been a pause in delivery. Cohort of staff requiring training being reviewed	Risk of injury to staff and patients. Potential for claims and complaints. There will be a disruption to the planned training schedule (impact presently being evaluated)	Mutual support request to ULHT. Internal sources of alternate training support being identified. Reviewing training schedule and package. Action plan in place to increase attendance when training is reinstated. Engagement with operational colleagues to confirm appropriate staff requiring training.	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16	05/11/2024 Discussed at Risk Register Confirm and Challenge 30/10/24: agreed as new risk scoring L4 x C4 = 16.	Very Low Risk (1-3)

651	Finances	Bassi, Sangeeta	Finance Committee (Lead assurance committee)		12	Medical	Medicines Management	Contracted Pharmacy Service - Co-op	Despite Co-op winning the tender for the contracted pharmacy service for LCHS from April 2023 (medicines supply and clinical pharmacy service), the contract is still unsigned 6 months later (it was signed in the beginning of 2024). Due to oversights during the procurement process, there is a requirement to go out to tender again at the end of March 2026 (ULTH Procurement JB).	Co-op have not signed the new contract & have requested to re-negotiate the spec & KPIs, despite bidding for and winning against these versions. Management costs have significantly increased.	LCHS not receiving a comprehensive pharmacy service in line with the new spec/CV. KPIs/audits for the clinical pharmacy service have not been agreed thus reporting/assurance is limited. Cost pressure.	Co-op continue to provide the pharmacy service against the previous spec, KPIs. Controls include: - Quarterly CD checks via Co-op - Monthly Chart Checker audits via Co-op - Safe and Secure Handling of Medicines/CD audits continue to be led by LCHS MMT on a quarterly basis - All medicines related incidents reviewed by Divisional Senior Pharmacy Technicians and by LCHS pharmacist Mitigating actions: - LCHS have chased and now (from October 2023) have in place monthly operational meetings with Co-op pharmacist lead (Claire Rogers) to discuss any issues of concern e.g., relating to patient safety - Snapshot audit completed (October 2023) in relation to discharge delays associated with	Extremely likely (5) >90% chance	Moderate (3)	High Risk (15-16)	15	15/11/2024 Discussed at risk summit with DDMD SB and QPIL AM 15/11/24: As part of planning for 2025/26, a case of need has been presented at CRIG and ELT in relation to taking the clinical pharmacy services in house. No change to score. 05/11/2024 Discussed at Risk Register Confirm and Challenge 30/10/24: agreed to increase the score from L4 x C3=12 to L5 x C3 = 15. 18/10/2024 Discussed at risk summit with DDMD SB and QPIL AM 18/10/24: priority of need not agreed by Finance in relation to funding (JT 03/10/24). 10/10/2024 Discussed at risk summit with Deputy Director of Medical Directorate SB: Risk to patient safety and quality of service (as evidenced by staff survey and recent evaluation of service) was discussed at Community SLT 19/09/2024, along with a proof of concept paper for a community hospital pharmacist - not approved due to funding. DDMD SB to discuss further with finance. This issue has been escalated to the Quality Committee through the upwards Patient Safety Group report in Aug'24. Propose to increase the score from L4 x C3=12 to L5 x C3 = 15 - for approval at RRCC Oct'24. 20/09/2024 Risk to patient safety and quality of service (as evidenced by staff survey and recent evaluation of service) was discussed at Community SLT 19/09/2024, along with a proof of concept paper for a community hospital pharmacist - not approved	
649	Regulatory Compliance	Smith, Alan	Finance Committee (Lead assurance committee), Health and Safety Committee (Accountable for)		15	Corporate	Estates	Fire Safety Core Risk	There is a risk of harm to building occupants (including patients)caused by fire. There is a risk that the Trust cannot demonstrate statutory compliance in accordance with the Regulatory Reform (Fire Safety) Order 2005 (RRO).	Inadequate fire protection systems, maintenance, training and procedures	Loss of facilities, services and injuries to patients and staff.	1. LCHS Fire Safety Operational Meeting 2. Planned Preventative Maintenance PPM 3. Fire Risk Assessments 4. Fire Safety Training 5. Fire protection system tests 5. Fire Emergency Plans 6. Yearly Fire audit 7. Appointed Authorising Engineer (AE) for Fire 8. Inpatient Fire evacuation plans and tests 9. Test Fire drills.	Reasonably likely (3) 31-70% chance	Extreme (5)	High Risk (15-16)	15	11/10/2024 After a conversation with Mike Parkhill this risk has been moved to Alan Smith with Mike having overall responsibility for the risk. 10/09/2024 Fire updates are being presented at H&S committee and the action plan is still being worked through. No Change to score currently. 16/08/2024 The Group fire team continue to work against the FRA action plan and the risk score will be reviewed once this is complete. No change to score currently. 09/07/2024 Risk continues to be monitored. No change to score. 05/06/2024 LCHS Fire Safety meeting took place in June to support the wider dissemination of information. The plan to review all fire risk assessments was also shared. No change to score. 10/05/2024 No change to score and it continues to be monitored and reviewed. 25/04/2024 Fire officer working across the LCHS estate supporting with risk assessments, training and support. Feedback is good from operations teams on support and information provided. 14/03/2024 A new fire officer has been recruited into the ULHT team and is now working with LCHS on supporting with renewing the fire risk assessments. 09/01/2024 ULHT are supporting LCHS with all elements of fire safety. Also a recruitment process has	Low Risk (4-6)
390	Physical or Psychological Harm	Smith, Alan	Finance Committee (Lead assurance committee), Health and Safety Committee (Accountable for)		10	Corporate	Estates	John Coupland Hospital Theatres ventilation	Patient safety/ infection control / loss of service and disrupted service to patients	Theatre one - The plant in JCH theatre 1 is running inconsistently resulting in temperatures being close to or over the limit of 22c and humidity at times being close to or breaching the limit of 60.	Creating a patient safety risk if not effectively monitored, theatre lists have had to be cancelled for patient safety at short notice, a risk to service delivery and LCHS reputation.	1. PPMs and recording undertaken by NHSPS. 2. Yearly survey reports on high risk equipment (theatres) undertaken by NHSPS. 3. Monitoring of compliance undertaken by Estates Shared Service. 4. Compliance information reported into LCHS Safety and Compliance Group (SACG) monthly and Health and Safety Committee Quarterly. 5. Weekly maintenance checks are being undertaken by NHSPS.	Reasonably likely (3) 31-70% chance	Extreme (5)	High Risk (15-16)	15	11/10/2024 After a conversation with Mike Parkhill this risk has been moved to Alan Smith with Mike having overall responsibility for the risk. 12/09/2024 Local meetings have taken place with the project team and the work is still planned for start in the middle of October. No change to risk score and continues to be monitored. 16/08/2024 Project has now began to replace the air handling units. This is being planned for the middle of October. The risk can be reviewed completely when the work has been completed. Risk will continue to be monitored in the interim. 09/07/2024 Project kick off meeting is set for July to start the work at JCH. No change to risk score currently. 06/06/2024 NHSPS Update: the AHUs have been awarded to the contractor and the Finance decision support docs have been signed. Contract due to be signed and then lead time for the clinics to know when to mobilise once a pre start meeting has occurred. 10/05/2024 Risk reviewed and no change to score 25/04/2024 Risk reviewed and no change to score. Still awaiting update from NHSPS on procurement response. 27/03/2024 NHSPS Update. the design has been approved and it is currently out to procurement. Procurement due to complete in April. No change to score currently.	Very Low Risk (1-3)

391	Physical or Psychological Harm	Smith, Alan	Finance Committee (Lead assurance committee), Health and Safety Committee (Accountable for)		20	Corporate	Estates	John Coupland Hospital Water Safety	Water supply to patients, staff and visitors has been contaminated;	The regulatory routine maintenance of the landlord (NHSPS) being ineffective;	Risk of harm from Legionella and other waterborne pathogens	1. Joint Water Safety Group 2. NHSPS planned maintenance regime 3. Infection Control Group. 4. Appointed Authorising Engineer (AE) for water 5. NHSPS is undertaking flushing of outlets. 6. Water sampling - with all results being sent to the Trust AE and Estates Shared Services 7. Estates shared service and AE follow up actions required on high count outlets. 8. Any positive counts have a filter fitted immediately	Reasonably likely (3) 31-70% chance	Extreme (5)	High Risk (15-16)	15	11/10/2024 After a conversation with Mike Parkhill this risk has been moved to Alan Smith with Mike having overall responsibility for the risk. 16/08/2024 NHSPS Update: Scotter ward decant is planned for September. Once the ward is empty the suspect pipework will be isolated and removed. This will eradicate the issue and the risk can be reviewed. 06/06/2024 NHSPS Update: positive counts low in the palliative suite in Scotter Ward. Recently thermally disinfected and awaiting the re sampling results. LCHS Update: seeking additional support from the group water safety team. 10/05/2024 NHSPS Update. All bacteria counts are zero and now awaiting new test results post the flushes that have taken place. Filters fitted on any outlet that previously returned a count to protect staff and patients. 27/03/2024 NHSPS Update. All identified dead legs have been removed and a chemical flush has been booked w/c 25th March. Filters are on positive outlet, changed monthly and documented.	Moderate Risk (8-12)
393	Physical or Psychological Harm	Smith, Alan	Finance Committee (Lead assurance committee), Health and Safety Committee (Accountable for)		20	Corporate	Estates	Skegness Hospital Water Safety	Water supply to patients, staff and visitors has been contaminated;	The regulatory routine maintenance of the landlord (NHSPS) being ineffective	Risk of harm from Legionella and other waterborne pathogens	1. Infection Control Group 2. NHSPS planned maintenance regime 3. Appointed Authorising Engineer (AE) for water 4. NHSPS is undertaking flushing of outlets. 5. Water sampling - with all results being sent to the Trust AE and Estates Shared Services 6. Estates shared service and AE follow up actions required on high count outlets. 7. Any positive counts have a filter fitted immediately	Reasonably likely (3) 31-70% chance	Extreme (5)	High Risk (15-16)	15	11/10/2024 After a conversation with Mike Parkhill this risk has been moved to Alan Smith with Mike having overall responsibility for the risk. 16/08/2024 Awaiting results from NHSPS. No change to score and risk continues to be monitored. 22/07/2024 NHSPS Update: SG 27 pipework has been replaced. Chemical disinfection run and resampling has taken place. Awaiting results. Still twice daily flushing is taking place with filters replaced every 30 days. 06/06/2024 NHSPS Update: Room SG 26/27 (open space)continues to return high counts even after thermal disinfections. Adjoining room clear. Decision taken to replace pipework due to possible biofilm build up. This work has started. Will arrange resampling after works. Filter fitted and flushed twice daily UTC Small counts still present. Plans to move part of the boiler room closer to UTC to increase return flow and water temps. Planned for July. Filters fitted and flushed daily. 10/05/2024 NHSPS Update - 2 Outlets are still displaying significant counts after flushes have taken place. pipework to now be removed and replaced. Work has already commenced on this. UTC still returning small counts. Flushes planned. All outlets with counts returning have got filters fitted to reduce risks to staff and patients	Moderate Risk (8-12)
719	Physical or Psychological Harm	Mckee, Nat	Quality Committee (Lead assurance committee)	10/06/2024	6	Integrated Urgent & Emergency Care	Clinical Assessment Service (CAS)	Impact of DHU Contract Changes on CAS Model	That patients will come to harm or experience delays to their care due to clinical validation by external partners.	Regional agreement with no input from Lincs ICB. New contract for clinical validations of all interim dispositions and ED validation to DHU from CAS. Loss of approx 100 CAS calls per day	System impact will be significant (increased EMAS attendance, increased demand for ED). Reputational impact. Poor patient experience. Barrier to care. Potential for reduction in funding for CAS; reduction in booked appointments, unneeded attendance to UTCs, attendance to inappropriate UTC (non-collocated), reduced referrals to community services. Reduced staff morale.	Support and regular updates to staff Close monitoring of staffing levels Data monitoring Monitoring of Datix. CAS clinician sitting in EOC pilot. Conversations with ICB Dynamic redistribution of skill mix	Reasonably likely (3) 31-70% chance	Extreme (5)	High Risk (15-16)	15	29/11/2024 Discussed at RRCC 27/11/24 and agreed to increase the score from L3 x C3 = 9 to L3 x C5 = 15, based on new available evidence from incidents that the consequence score should be higher as detailed in narrative from 22/11/24. 22/11/2024 Risk updated by DL NMcK and DDL LA following request at RRCC to review the risk's consequence score; agreed consequence should be changed from 3 to 5. This is based on the high risk patients being inappropriately booked into the UTCs: •Complex pregnant patient with palpitations & dizziness post fall down the stairs •Patient with history of collapse who then collapsed in the UTC •Patient with severe chest pain who then had episode of asystole in the department •5/52 old baby with hx of sepsis •42wk old child with head injury post submersion in water For review at the Risk Register Confirm and Challenge meeting Nov'24	Low Risk (4-6)

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
2a. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	5447	691	Service disruption	Capon, Mrs Catherine	Rojas, Mrs Wendy	Workforce Strategy Group	05/06/2024	16	Surgery	Theatres, Anaesthesia and Critical Care CBU	Theatres		Nurse staffing in theatres does not support current activity, resulting in patient cancellations and delays. There is a risk of elective lists being cancelled due to lack of theatre staff. Business case has been written to source funding. Currently in a difficult position. The off framework is going to stop soon with an impact that will possibly cancel lists. Lengthy discussions have been had to support Theatres. Break Glass agency workers are starting to be put in place but we are still very short. ODP has been approved but no back fill.	AFPP guidelines for staffing in perioperative setting Daily review of staffing/lists Daily prioritisation of patients Use of agency staff	Incident reporting Review of staffing/cancellations	07/01/2025	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Establishment review Business case for funding in process to apply for funding with staffing workshop planned for September. Project group commenced at Lincoln to introduce activity manager to try to support planning and management of deficits.	[07/01/2025 10:42:07 Nicola Cornish] Risk reviewed by Wendy Rojas - no further progress. [28/11/2024 10:06:10 Nicola Cornish] Task and finish group now established to look at theatre workforce. [21/10/2024 13:06:13 Nicola Cornish] Business Case is ongoing and risk of cancellation remains very high. Long line agency was agreed but with limited fill. Sourced International nurses and CV's received - awaiting completion of interviews. [11/09/2024 14:23:33 Nicola Cornish] Risk reviewed, no change. [29/08/2024 08:44:21 Nicola Cornish] Off framework has stopped. Limited availability of agency staff but now agreed that we can source long line agency bookings. Theatre staffing workshop in September to support business case. Project group commenced at Lincoln to introduce activity manager to try to support planning and management of deficits. [30/07/2024 08:56:34 Nicola Cornish] Case of need has been completed and is awaiting a date to be presented to CRIG. [26/06/2024 14:08:26 Rachael Turner] Risk presented at RRC&C meeting 26/06/24. Business case has been written to source funding. Currently in a difficult position. The off framework is going to stop soon with an impact that will possibly cancel lists. Lengthy discussions have been had to support Theatres. Break Glass agency workers are starting to be put in place but we are still very short. ODP has been approved but no back fill. Risk requires updates to reflect current position. Risk validated at 5x4:20 Very High Risk. [05/06/2024 09:53:31 Nicola Cornish] New high risk, to be presented at June RRC&C meeting for approval.	8	30/06/2025		07/02/2025
4d. Enhanced data and digital capability	4657	7	Reputation	Warner, Jayne	Hobday, Fiona	Digital Hospital Group	10/01/2022	12	Corporate	Trust Headquarters	Information Governance	Trust-wide	If the Trust does not comply with Subject Access Requests (SARs) and Access to Health Records provisions in accordance with statutory requirements specified legislation, then it could lead to complaints to the Trust and Information Commissioner's Office (ICO). This could result in regulatory action and possibly financial penalties. Inconsistent levels of expertise outside IG team regarding SAR requirements. Lack of technical tools to carry out a search of emails / systems to identify personal information held. Implementation of digital systems which don't include a disclosure process. Potential financial implications.	ULHT policy in place. Monitoring through IGG and at exec level. Temporary additional resource has been put in place to oversee. Proposal made to ELT and IGG regarding process which has removed reliance on clinical staff to review all cases. Increased training provided to team. 18/11/24- Procured new solution to better manage requests.	Monthly reporting completed. Compliance rate is monitored by the Supervisor and reports taken to IGG in our KPI report. Volume of ICO complaints and Trust complaints received.	29/01/2025	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Current active communications with ICO-regulator. Changes to processes are being constantly discussed and implemented. Resource needs being discussed and temporarily increased to support. Monitored through the IGG in DP KPI report. Head of IG leading on work to review and improve. Working in a more digital way where feasible. Workforce change is required which will be a much longer process. Early identifications of chasers and urgent requests to reduce the likelihood of complaints.	[29/01/2025 12:39:05 Rachael Turner] Risk discussed as part of the Deep Dive at Risk Confirm and Challenge meeting. Given that we are subject to ICO working with us, risk to remain at current level. [09/01/2025 15:39:47 Fiona Hobday] Trust have been issued with a reprimand by ICO- published Dec 24. Resource borrowed from central IG to support Disclosure Team for 3 days per week. Investigations as to what support LCHS team may be able to offer. [18/11/2024 14:41:01 Fiona Hobday] x2 new staff joining team in November. Pilot of new system carried out successfully. Full roll out scheduled for Dec 1st. [22/10/2024 09:27:29 Fiona Hobday] Issues with system to extract data for staff SARs- leading to delays. x2 staff resigned in service (1 remaining staff member)- x2 appointed to Disclosure Team following recruitment- expect to start in Nov. [10/09/2024 09:01:56 Fiona Hobday] Update from Sept IGG- plan and trajectory for improvement to be developed for closer monitoring at IGG. Discussion as to what has led to recent compliance drop- staffing matters to be managed. [02/09/2024 12:00:37 Fiona Hobday] New system has been built in UAT and signed off. Live system is ready and initial training scheduled Sept 24. Soft go live currently planned for Oct and full go live in Nov. Capacity issues remain- working through process to seek approval to recruit. [01/08/2024 15:33:56 Fiona Hobday] *Still awaiting outcome from ICO	6	29/12/2023	30/04/2025	28/02/2025
2a. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	4996	39	Physical or psychological harm	Lynch, Diane	Chester-Buckley, Sarah	Outpatient Improvement Group	22/08/2022	16	Clinical Support Services	Cancer Services CBU	Haematology (Cancer Services)	Trust-wide	As a result of lack of investment for Haematology workforce historically there is insufficient workforce and to meet increasing demand of the service (and we have recruited posts at risk above budget) which would lead to additional stress and burn out causing the remaining staff to leave and the service to collapse which would also lead to significant patient harm. Patients would need to be referred to other neighbouring Trusts which in turn would cause other Trusts to collapse. Particular areas of concern are Clinical Governance Lead and Head of Service for Haematology.	CG lead duties shared between consultants but no one wishes to take on role (Clinical Governance Lead to commence post in April 2025) Introduction of nurse-led clinics to manage demand. Fixed term Locum Consultants / High cost agency above budget to support service. Ad-hoc additional clinics outside of consultant job plan Workforce review completed Refresher of Fragile Services Paper completed (NB there is a National shortage of Haematology consultants) Additional unfunded ST3+ for Haematologist started in August 2022	New referrals and PBWL show ongoing capacity issues. RTT and cancer performance below target. Increased PA's for substantive consultants. Outcome from Staff Survey results Financial constraints of group Monitoring of outpatient appointments Datix incidents / Clinical Harm reviews / Complaints / PALS	20/01/2025	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Recruitment of further substantive consultants - Sarah Chester-Buckley April 2025 Cancer Services paper written awaiting CRIG invitation - Sarah Chester-Buckley - February 2025	[20/01/2025 10:33:40 Gemma Staples] Business case now not going to CRIG, needs to be taken through Divisional PRM for funding, awaiting next meeting. [19/12/2024 11:38:08 Gemma Staples] Cancer Services paper written awaiting CRIG invitation [18/11/2024 12:37:44 Gemma Staples] Business case submitted and proceeding to next stage of the process within the Trust. [18/10/2024 10:36:47 Gemma Staples] CoN written to be submitted on 31st October 2024 to ensure this is included in the planning round 2025/26. [20/09/2024 10:49:48 Gemma Staples] Attended ELT, asked to produce new Business Case for Cancer Services to be presented at CRIG asap to ensure the staffing requirement is put into planning for 2025/2026. [28/08/2024 14:45:28 Rachael Turner] Risk presented at RRC&C meeting 28/08/2024. Risk validated. [22/08/2024 08:39:24 Gemma Staples] Risk remains the same as previous update as awaiting ELT on the 28th August 2024. [05/08/2024 09:33:36 Gemma Staples] Following the deep dive in April, it was asked that risk 4996 & 4740 be reviewed to see if if these are one risk under different facets or if it is two distinct risks with similar mitigations. SCB - both risks have been reviewed and merged into one risk. 4996 will be the active risk and 4740 will be the closed risk. Both risks will be taken to August RRC&C meeting for agreement. [24/07/2024 11:46:17 Gemma Staples] Paper to be presented in August to ELT regarding staffing levels to seek approval to go over budget for patient safety. [28/06/2024 14:35:02 Gemma Staples] Risk reviewed. Haematology rightsizing paper will not be considered for funding until 2025/2026. Risk remains the same. [29/05/2024 09:01:54 Gemma Staples] Risk reviewed, ICB investment panel not to fund the Right Sizing Business Case in 2024/2025. A reduced Business case has been put forward for funding to the SDF panel.	8	30/09/2023	01/04/2025	20/02/2025

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
3a. Deliver financially sustainable healthcare, making best use of resources	4665	14	Finances		Young, Jonathan	Sargeant, Paula		11/01/2022	20	Corporate	Finance and Digital	Finance	Trust-wide	The Trust has a £40.1m Financial improvement target for 24/25. If the Trust fails to deliver the CIP Plan, this will have a significant adverse impact on the ability of the Trust and the Lincolnshire ICS to deliver its breakeven financial plan for the year. This represents a 5% target which is greater than any financial improvement the trust has delivered in previous years. In addition to this target, invest to save investments required to deliver the savings plan will need to be funded via more CIP identification/ delivery. Failure to deliver the CIP plan will have an adverse impact on the trusts ability to decrease its underlying deficit and build towards a sustainable pipeline of cost improvement for the future.	National policy: - NHS annual budget setting and monitoring processes ULHT policy: - Detailed Financial plan inclusive of the establishments and embedding of the 3 T's; Transactional, Targeted and Transformational. - Alignment of the Trust financial improvement opportunities with system partners to develop an integrated financial recovery plan aligned to CIP. - Development of Divisional Schemes assured through FPAMS (Transactional) - Establishment of future looking programme to develop schemes for a sustainable cost improvement programme for the future. (Transformational) - Establishment of a suite of cross cutting schemes aligned to the Trust Improvement Strategy. (Targeted) - Divisional CIP targets allocated as part of the budget setting process. ULHT governance: - Detailed CIP reporting via the CIP tracker supported by QIA process at Improvement Steering Group (ISG) - Programme Management Office (PMO) monitors full programme & dedicated Head of Financial Improvement. - Introduction of the Trust wide Improvement Steering Group to monitor, challenge and hold accountable for the Targeted and Transformational Schemes. - FPAMs to monitor, challenge and hold accountable for the Transactional Schemes	The Trust is monitored externally against the Trust CIP target through the monthly finance return to NHSE/I. For 2024/25 the Trust continues to be monitored twice a month on the FRP by the ICB and system Improvement Director. To exit NOF3, into NOF2, the system must deliver against the FRP plan for 2 consecutive quarters and ULHT is held to account to deliver their element of this £40.1m FYE. The Trust monitors internally against its CIP targets inclusive of specific Divisional and targeted scheme targets through the Improvement Steering group and Finance, Performance and Activity meetings. (FPAM's). Scrutiny & oversight will be	20/01/2025	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	and stakeholders through CIP planning workshops. - Increased CIP governance & monitoring arrangements introduced. - Alignment with the Trust Strategy and System objectives - CIP is embedded as part of the Trust Improvement Strategy not seen as a separate annual work stream. - Development of future programme of cost improvement. - Continual exploration of new opportunities.	[20/01/2025 09:33:25 Rachael Turner] The current forecast for 2024-25 is £36.7m; inclusive of executive led mitigations, set to deliver in quarter 4. Divisions have submitted a list of measures which will reduce the run rate of spend in the last quarter of the year for consideration. These measures are considered higher risk, and some may impact other performance metrics, therefore, consideration is required by the Group Leadership team and QIA's will be required. [20/12/2024 15:49:56 Rachael Turner] Executive colleagues have held urgent Budget Review Meetings with all clinical divisions to understand what can be safely paused, delayed, stopped in the final quarter of the financial year to support the overall position of the trust. The Corporate directorates and Estates and Facilities meetings will be held in early January 25. Increased focus is been applied in all areas to support the delivery of this. [19/11/2024 09:11:00 Rachael Turner] Risk of Delivery remains high with a direct impact on the financial position of the trust. Mitigating actions required at pace to improve delivery. List of potential mitigations compiled and senior finance team meeting with relevant Execs in W/C 18/11/24 to establish impact expected for 2024/25 and appetite for options proposed. To include a deep dive into areas of CIP not delivering for this financial year. [23/10/2024 11:04:51 Nicola Cornish] Improvement Steering Group met on the 10th to review actions to move each scheme from RED to Amber and Amber to Green. Actions are in the process of being costed to revise the initial finance forecast with a Programme led forecast. Actions stepped up on the Medical Workforce Programme which currently remains RED on the financial RAG rating due to time taken to embed controls across the organisation. [20/09/2024 09:23:11 Rachael Turner] Risk remains high risk with a forecast of £35.2m presented to ELT and FPEC on the 19th Sept 24 against the £40.1m CIP	4	31/03/2023	31/03/2024	20/02/2025
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5101	487	Physical or psychological harm		Rivett, Kate	Herath, Dr Durga	Clinical Effectiveness Group	14/03/2023	20	Family Health	Children and Young Persons CBU	Children's Community Services	Trust-wide	Quality and safety risk from inability to deliver epilepsy pathways within Community Paediatrics that meet National standards due to resourcing and capacity factors.	1. Single Consultant Paediatrician (DH) is currently managing all children with Epilepsy alongside a single specialist epilepsy nurse; 2. Wider consultant body supporting the care of children who are prescribed 2 antiepileptics in the absence of a consultant paediatrician with expertise in epilepsy; 3.Single Consultant Paediatrician is developing individualized care plans for each patient to optimise management of condition; 4. Liaison with ICB and regional network to support development and improvement of local services	1. Audit of compliance with NICE guideline NG217 - Epilepsies in Children, Young People and Adults and NICE quality standard QS27 - Epilepsy in Children and Young People;	29/01/2025	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	1. Business case is being produced to enable establishment of fully funded epilepsy service 2. Agreement for spending has been obtained, moving forward. 3. Appointing 2 x epilepsy nurses. 4. Epilepsy workshop with ICB	[29/01/2025 13:03:36 Rachael Turner] Risk discussed as part of the RRC&C Deep Dive, risk score to remain at current level. If the business case is approved we can recruit and reduce the risk, if not the risk level will remain or increase with no additional resource. This risk to be raised as part of PRM process. [22/01/2025 13:37:02 Nicola Cornish] No progress, still awaiting outcome from CRIG. Using bank B5 nurses to support some of this work, but this is adding to cost pressures so not sustainable. [09/12/2024 13:21:53 Nicola Cornish] Business case has been submitted to PMO office, awaiting date for presentation to CRIG. [11/11/2024 15:06:06 Nicola Cornish] Business case has been completed, and the service has been added to the investment tracker for 2025/26. [14/10/2024 14:01:56 Nicola Cornish] Draft business case completed and submitted to Finance. Liaising with ICB regarding funding priorities for 2025/26. [09/09/2024 14:48:10 Nicola Cornish] No further progress. Received an outlier notice, action plan developed for delivering improvements - seeking approval from ICB for funding for a Band 6 epilepsy specialist nurse post as part of this. [13/08/2024 11:52:26 Nicola Cornish] Risk reviewed, no change. Regular meetings with ICB continue and commencing conversations with NUH about delivery of tertiary element. [16/07/2024 14:49:26 Nicola Cornish] No change to risk; Business case currently being developed to support increase in team size; Regular meetings in place with ICB to support improvements to epilepsy service; Service benchmarking against Epilepsy Deliverables to help better understand gaps. [18/06/2024 13:27:13 Nicola Cornish] Business case development is progressing. [21/05/2024 13:14:53 Nicola Cornish] Risk reviewed, no further progress. [16/04/2024 13:56:12 Nicola Cornish] Risk reviewed, no change [20/02/2024 13:08:27 Nicola Cornish] No change. Business case meeting is being	8	14/03/2024	16/02/2024	21/02/2025
3a. Deliver financially sustainable healthcare, making best use of resources	4664	5	Finances		Young, Jonathan	Picken, David		11/01/2022	20	Corporate	Finance and Digital	Finance	Trust-wide	The Trust is overly reliant upon a large number of temporary agency and locum staff to maintain the safety and continuity of clinical services.	ULHT policy: - Financial plan set out the Trust limits in respect of temporary staffing spend - Financial plan for agency expenditure is based upon developed savings plans in relation to agency staffing; acknowledges the progress made in 2023/24 in relation to real reductions in actual agency expenditure - Monthly financial management & FRP monitoring arrangements are in place to identify variation; agency expenditure reduction is a major part of the FRP and as such is heavily monitored. - Key financial controls for the use of the break glass agency usage are in place. - Specific staff group temporary staff spend is provided to dedicated Medical and Nursing workforce oversight groups. - Financial review meetings held monthly with each Division to understand and challenge usage of temporary staffing. - Plan for every post information has been embedded to support temporary staff usage forecasts ULHT governance: - The establishment of the Improvement Steering Group will provide general oversight of Trust wide agency reduction schemes - Board assurance through Finance, Performance and Estates Committee (FPEC)	The Trust is monitored externally against an agency cap through the monthly finance return to NHSE/I The Trust monitors internally against its financial plan inclusive of specific targets for agency and bank spend by staff group The cross Trust workstreams are reported to the Improvement Steering Group The Divisional workstreams are reported to the relevant Finance, People & Activity Meeting (FPAM)	20/01/2025	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Financial Recovery Plan schemes: - recruitment improvement; - medical job planning; - agency cost reduction; - workforce alignment	[20/01/2025 09:36:33 Rachael Turner] In 2024/25, the Trust's financial plan requires the Trust to make a similar level of reduction to agency expenditure as made in 2023/24. In 2024/25, the focus of the programme is to reduce agency expenditure in relation to medical and dental (M&D) staffing, whereas in 2023/24 the focus was upon reducing agency expenditure in relation to registered nursing and midwifery. The 2024/25 financial plan includes a total agency plan of £14.9m and the expenditure profile in the plan requires agency expenditure to reduce: • From £7.3m in the first financial quarter of the year. • To £3.5m in the second financial quarter of the year. • To £2.3m in the third financial quarter of the year. • To £1.8m in the final quarter of the year. Agency expenditure YTD of £18.0m is £5.0m higher than planned agency expenditure of £13.1m driven by M&D agency expenditure being higher than planned; expenditure of £18.0m YTD is, though, £6.4m lower than expenditure of £24.4m in the same period last financial year. The adverse agency pay position is part of a larger adverse movement to plan in the overall pay position, which in turn is a major driver of the adverse movement to plan in the overall financial position. The agency pay position will therefore be of considerable concern to both our ICS and our regulator, and both will expect/require the Trust to take actions at the scale required to address the adverse impact of the pay position on the overall financial position.	8	31/03/2023	31/03/2024	20/02/2025

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
1c. Improve clinical outcomes	4828	31	Physical or psychological harm	Farquharson, Colin	Costello, Mr Colin	Digital Hospital Group, Patient Safety Group		17/01/2022	20	Clinical Support Services	Pharmacy CBU	Pharmacy	Trust-wide	As a result of Maternity, Paediatrics, Outpatients and ICU using manual prescribing processes which are inefficient and restrict the timely availability of patient information when required by Pharmacists this could lead to delays or errors in prescribing and administration, resulting in a widespread impact on quality of care, potentially reducing the likelihood of a positive clinical outcome and/or causing serious patient harm. EPMA rolled out across the Trust - Outpatients, ICU, Paediatrics and Maternity were removed from scope. • Outpatients module installed as part of ePMA, due to the COVID19 delays, reconfiguration of services and complexities with the nature of outpatient prescribing, it was agreed by the ePMA Steering group to defer this to either EPR or a later optimisation piece of work. • EMIS solution does not support the British National Formulary (BNF) for paediatrics. • Maternity was removed from scope at their request due to them pursuing a new digital solution of their own that would have its own prescribing feature. • The ePMA software is not suitable for ICU for very complex infusions, there was a different project - metavision which is an ICU specific ePMA, this was stopped due to safety concerns.	National policy: - NICE Guideline NG5: Medicines optimisation, etc. ULHT policy: - Policy for Medicines Management: Sections 1-8 (various approval / review dates) ULHT governance: - Trust Board assurance via Quality Governance Committee (QGC) / Medicines Quality Group (MQG)	Medication incident analysis Audit / review of medicines management processes	24/01/2025	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Maternity : Pursuing new digital system which would have own prescribing feature - Badgernet? - Lorraine Brooks - May 2025 ICU : Suitable software for very complex infusions being sought - Lead? - May 2025 Outpatients : Outpatients module installed as part of EPMA, due to COVID delays, reconfiguration of services and complexities with nature of outpatient prescribing agreed by EPMA Steering Group to defer to either the EPR or later optimisation piece of work - Lead to be confirmed once in post - May 2025	[24/01/2025 08:53:20 Lisa Hansford] No further update [24/12/2024 08:25:27 Lisa Hansford] No further update [25/11/2024 10:46:08 Sarah Davy] Outpatients - Product Manager JD is undergoing review for banding and will be appointed once completed. Funds for post have been agreed. [25/11/2024 10:41:10 Sarah Davy] Kate Rivett confirmed that there are mitigations in place where they would accept the minimal risk to Paediatrics. No plans to employ full time Paediatrician for EPMA [29/10/2024 10:20:16 Lisa Hansford] Risk to be agreed at MOpS on 12th November, then will need presenting at confirm and challenge in December. [26/09/2024 12:15:50 Gemma Staples] As EPMA is now rolled out, risk to be presented at October RRC&C to seek approval of closure. The areas that are still manually prescribing are to add individual risks for their divisions if required. [09/09/2024 12:40:05 Gemma Staples] Risk to go to RRC&C to agree closure of this risk. A new risk has been created for manually prescribing in Outpatient and Maternity (Risk ID 5509) and this will also be taken to RRC&C for approval. [29/08/2024 07:51:18 Lisa Hansford] No further update [29/07/2024 11:58:02 Gemma Staples] AS to confirm if Maternity / Outpatients are in scope for EPR tender process. [10/07/2024 15:22:31 Gemma Staples] 03/07/2024 – Lisa Hansford has asked Ahtisham to review this risk to decide if to close this risk and create a new risk for outpatients / maternity as they are still manually prescribing – awaiting update [11/06/2024 09:59:34 Gemma Staples] Risk reviewed and confirmed to be reassigned to Digital Team. Rachel Turner to discuss with Digital Team and confirm who to assign as the handler. [09/05/2024 08:56:06 Gemma Staples] Risk reviewed and remains the same. [04/04/2024 08:54:58 Lisa Hansford] no update [07/03/2024 14:08:02 Lisa Hansford] Although epma has now been fully rolled	4	31/12/2023	30/06/2025	24/02/2025
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	4947	27	Physical or psychological harm	Sakthivel, Mr Kulandaivel	Saddick, Ahtisham	Clinical Effectiveness Group		17/06/2022	20	Clinical Support Services	Pharmacy CBU			There is an issue in which the Trust is failing to meet NICE medicines reconciliation targets on a consistent basis and not being able to review discharges. This is caused by lack of pharmacy resource. Resulting in potential for patient harm due to incorrect or delayed medication, financial implications due to increased length of stay or unnecessary supply and risk of continuation of errors onto the discharge letter and further more into the community.	NICE guidance NG5 states that in an acute setting, that we should accurately list all of the patient's medicines (including prescribed, over-the-counter and complementary medicines) and carry out medicines reconciliation within 24 hours or sooner if clinically necessary, when the person moves from one care setting to another – for example, if they are admitted to hospital.	We conduct monthly medicines reconciliation audits, which consistently have shown us failing to meet NICE targets and we are operating significantly below the national average. This audit is presented at the MQG.	10/02/2025	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	There are many options but we are utilising these; - We have prioritised pharmacist and technician cover to acute admission areas as patient turnover is highest on these areas and gives us to best opportunity to conduct a medicines reconciliation under 24 hours - We prioritise patients which have stayed in the longest and have critical medication where known. Prioritisation of the highest risk patients decreases the risk of harm - No ward visits are divided as much as possible. A partial mitigation for medication error reduction is incorporation of discharge functionality within EMIS (the link and seamless transition of medication from inpatient to discharge). This will reduce prescription errors into the discharge medication. Discharge functionality is not available currently within EMIS. To significantly reduce this risk requires additional ward based pharmacy staff cover across 7 days.	[10/02/2025 09:29:49 Lisa Hansford] Full business case was submitted in November and medicines reconciliation data collection process is under review. [09/01/2025 14:55:34 Lisa Hansford] No update [16/12/2024 10:27:27 Lisa Hansford] No further update [12/11/2024 14:24:12 Lisa Hansford] RCEM/ED pharmacy case developed and submitted for winter pressures funding- this was unsuccessful. The case will be resubmitted for the next financial year (25/26) [17/10/2024 09:41:28 Lisa Hansford] no further update [19/09/2024 12:57:45 Lisa Hansford] no further update, risk remains the same [20/08/2024 09:27:39 Lisa Hansford] no further update [17/07/2024 09:50:43 Lisa Hansford] risk reduction plan updated as follows: A partial mitigation for medication error reduction is incorporation of discharge functionality within EMIS (the link and seamless transition of medication from inpatient to discharge). This will reduce prescription errors into the discharge medication. Discharge functionality is not available currently within EMIS. [10/07/2024 11:05:06 Lisa Hansford] Risk reviewed and remains the same [11/06/2024 10:39:16 Lisa Hansford] risk reviewed and remains the same [09/05/2024 08:53:19 Gemma Staples] Risk reviewed and remains the same. [04/04/2024 08:45:37 Lisa Hansford] No further update [07/03/2024 14:18:16 Lisa Hansford] no further update [17/01/2024 12:05:07 Gemma] No further update [29/12/2023 13:53:23 Lisa Hansford] No further update [19/12/2023 13:26:38 Lisa-Marie Moore] phase 2 pharmacy improvement plan in development. meeting with MD 18/12 to discuss prioritisation of business cases [07/11/2023 14:13:38 Lisa Hansford] Update- DMS implementation has been affected as a consequence of low medicines reconciliation figures. Pharmacists	8	30/06/2023	30/04/2025	10/03/2025
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5016	22	Physical or psychological harm	Hamer, Fiona	Lentz, Blanche			02/09/2022	25	Medicine	Urgent and Emergency Care CBU	Accident and Emergency	Trust-wide	If there is not sufficient flow through the Trusts Emergency Departments, due to demand outstripping capacity and insufficient availability of beds in the hospitals leading to overcrowding; this may result in increased likelihood of long waits in the departments for patients, and an increase in the potential for patient harm, delays in care, poor patient and staff experience and impact on the reputation of the Trust .	Medical SDEC currently working 08:00 - 20:00 24 hour UTC co-located with ED at Pilgrim and Lincoln 'Are you sitting comfortably' scheme 4 x Daily Capacity meetings (08:00, 12:00, 15:00, 18:00) Clinical Operational Flow Policy Full Capacity Protocol National Criterial 2 Admit flowchart embedded in the ED's Introduction of "Pit stop" model. The development of a CDU in October 2024 will enable some flow from the emergency department to home for patients requiring treatment to discharge. This will be monitored through UEC improvement work to ensure area is fit for purpose. If CDU is utilised to enable ambulances to offload before 2 hours this will effect the flow through CDU.	ED Risk Tool - updated 4 times daily with an overview of the department Capacity Meetings to dynamically risk assess Monthly scorecard to track performance from both harm and constitutional standards Matrons Dashboard Datix Number of harm reviews	04/02/2025	Quite likely (4) 71-90% chance	Extreme (5)	Very high risk (20-25)	20	Ongoing work in place for long lengths of stay. There is a discharge work progress team in place. 78% performance project currently in place which is supported by the improvement team. Safer Programme in place and SOP is being delivered for Operational meetings in the aim to process discharges and improve flow. Ongoing Care and Comfort project in place to mitigate both harm and risks.	[04/02/2025 15:35:52 Rachael Turner] Risk currently remains, we are seeing improvements due to work that's being undertaken. our 4 hour standard has improved over last couple of weeks but still needs to remain at current level. [07/01/2025 15:06:23 Rachael Turner] UEC refresh continues to focus on ED performance and tasks to improve performance delivery. Flow impacts on ED space,capacity and impedes performance. Striving to attain 78%, however due to demand impairments within the department delivery will probably not be achievable. [03/12/2024 13:47:06 Rachael Turner] Following discussion at the Risk Confirm and Challenge meeting it has been agreed that this risk sits as a joint risk between Urgent and Emergency Care and Ops. From an Emergency Care perspective there is a UEC refresh project taking place, this involves a whole refresh of UEC. Performance is currently between 70-76%. An update from an Ops perspective to be provided. [13/11/2024 11:21:35 Rachael Turner] UEC improvement plan and discharge improvement plan are currently in process to reduce admissions where viable i.e. signpost to SDEC, Hot Clinics, ETC. The Discharge element is focussing on reduction in length of stay and implementing criteria led discharge to facilitate reduction in length of stay. Both projects should support improvement in flow and to attain 78% performance. Risk score currently remains. [11/11/2024 14:59:29 Rachael Turner] Risk reviewed, no further update. [02/10/2024 12:03:02 Rachael Turner] There is a new COO lead project in place around patient flow this looks not only at ED but also Ops for Wards and Discharge planning. Risk remains at the same level. [03/09/2024 15:04:06 Rachael Turner] Risk reviewed, remains in same position. Mitigation is in place to manage but needs to remain at current risk level. [09/08/2024 14:34:14 Rachael Turner] Risk reviewed. Meeting booked with new interim COO to look at support within Ops. Risk score remains.	10	02/09/2023	31/03/2024	04/03/2025

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
2a. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	4948	50	Physical or psychological harm	Cooper, Mrs Anita	Walker, Helen	Health and Safety Group, Medicines Quality Group, Patient Safety Group	17/06/2022	20	Clinical Support Services	Pharmacy CBU			Workload demands within Pharmacy persistently exceed current staffing capacity which leads to longer working hours (inc weekends), work related stress resulting in serious and potentially long-term effects on staff health and wellbeing. Adding to this with additional workload demands with insufficient staffing, or required level of experience and skill, the risk is patients will not be reviewed by a pharmacist leading to poorer clinical outcomes, reduced flow on acute wards, delayed discharges and increased risk of omitted medicines. For staff the risk is long term absence. This may result in the failure to meet the national and local targets for KPIs	Business Continuity Plans on ward coverage when staffing low	Sickness rates/vacancy rates and staff turnover - highlight that retention is problematic at current. Staff survey highlights issues low staff morale within the department. Medicines reconciliation, datix incidents and omitted doses highlight that the trust is underperforming and not meeting targets at current	30/01/2025	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Review current provision and identify gaps in service to inform business cases for change to support 7 day working (working with Surgery and Medicine Divisions as appropriate). Skill mix requires review due to complexity of patients.. Pragmatic management of workload & provision of management support. On-going exploration of recruitment options. Wellbeing team supporting staff - regular visits organised	[30/01/2025 16:08:30 Lisa Hansford] no further update [30/12/2024 08:35:51 Lisa Hansford] No further update [29/11/2024 10:18:44 Lisa Hansford] No further update [29/10/2024 10:21:55 Lisa Hansford] Full business case in development. [30/09/2024 13:45:19 Gemma Staples] Risk reviewed and remains the same [05/09/2024 14:06:45 Lisa Hansford] no further update [09/08/2024 16:25:26 Lisa Hansford] risk remains the same [10/07/2024 11:02:53 Lisa Hansford] Risk reviewed and remains the same [11/06/2024 10:37:25 Lisa Hansford] Risk reviewed and remains the same [09/05/2024 08:51:41 Gemma Staples] Risk reviewed and remains the same. [04/04/2024 08:44:22 Lisa Hansford] No further update [07/03/2024 14:16:19 Lisa Hansford] Current trial at Lincoln having a more comprehensive stock list on wards, focussing on TTo's and non stock item requests to manage work load. This is a back word in terms of patient safety and does not pharmacy strategy. This risk remains moderate as this approach is reactive and does not solve the issues. [13/02/2024 16:38:34 Gemma] Risk reviewed and no change [17/01/2024 12:04:24 Gemma] No further update [21/12/2023 13:30:51 Divisional Dashboards] Lisa- Marie Moore: Ongoing challenges. Demonstrable workload increase particularly on weekends across all sites. Phase 2 work plan development to review pharmacy workforce [27/11/2023 14:55:44 Rachael Turner] Risk remains with staffing challenges, no update. [26/09/2023 14:08:09 Rachel Thackray] Staffing vacancies still remain a challenge [03/08/2023 14:48:27 Lisa-Marie Moore] No further updates [27/06/2023 09:47:53 Alex Measures] Discussed in risk register review meeting- no further updates [01/06/2023 14:17:03 Lisa-Marie Moore] No change since previous entry	8	30/06/2023	30/10/2023	03/03/2025
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5100		Physical or psychological harm	Rivett, Kate	Herath, Dr Durga	Clinical Effectiveness Group	14/03/2023	20	Family Health	Children and Young Persons CBU	Paediatric Medicine	Trust-wide	Quality and safety risk from inability to deliver epilepsy pathways within Acute Paediatrics that meet National standards due to resourcing and capacity factors.	1. Single Consultant Paediatrician (DH) is currently managing all children with Epilepsy alongside a single specialist epilepsy nurse; 2. Wider consultant body supporting the care of children who are prescribed 2 antiepileptics in the absence of a consultant paediatrician with expertise in epilepsy; 3.Single Consultant Paediatrician is developing individualized care plans for each patient to optimise management of condition; 4. Liaison with ICB and regional network to support development and improvement of local services	1. Audit of compliance with NICE guideline NG217 - Epilepsies in Children, Young People and Adults and NICE quality standard QS27 - Epilepsy in Children and Young People;	21/01/2025	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	1. Multi-professional working group tasked with delivering improvements that will support achievement of audit compliance.	[22/01/2025 13:38:13 Nicola Cornish] No progress, still awaiting outcome from CRIG. Using bank B5 nurses to support some of this work, but this is adding to cost pressures so not sustainable. [09/12/2024 13:20:30 Nicola Cornish] Business case has been submitted to PMO office, awaiting date for presentation to CRIG. [11/11/2024 15:04:28 Nicola Cornish] Business case has been completed, and the service has been added to the investment tracker for 2025/26. [14/10/2024 13:59:49 Nicola Cornish] Draft businness case completed and submitted to Finance. Liaising with ICB regarding funding priorities for 2025/26. [09/09/2024 14:47:00 Nicola Cornish] No further progress. Received an outlier notice, action plan developed for delivering improvements - seeking approval from ICB for funding for a Band 6 epilepsy specialist nurse post as part of this. [12/08/2024 14:25:12 Nicola Cornish] Risk reviewed, no change. Regular meetings with ICB continue and commencing conversations with NUH about delivery of tertiary element. [08/07/2024 12:48:00 Kate Rivett] 08/07/2024 - KR 1. Risk reviewed at Risk Register Review meeting; 2. No change to risk; 3. Business case currently being developed to support increase in team size; 4. Regular meetings in place with ICB to support improvements to epilepsy service; 5. Service benchmarking against Epilepsy Deliverables to help better understand gaps. [10/06/2024 15:10:51 Nicola Cornish] No change [21/05/2024 13:15:59 Nicola Cornish] Risk reviewed, no further progress. [09/04/2024 11:24:36 Nicola Cornish] A business case is being developed for expanding the epilepsy nursing team. [13/03/2024 09:12:22 Nicola Cornish] Benchmarking has been completed - initial	8	14/03/2024		21/02/2025
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	4879	28	Physical or psychological harm	Carter, Mr Damian	Lynch, Diane	Clinical Support Services	28/03/2022	20	Cancer Services CBU	Oncology	Trust-wide	As a result of National long waits post COVID there may be significant delays within the cancer pathway and as a consequence patients may experience extended waits for diagnosis and surgery which would lead to a failure in meeting national standards and potentially reducing the likelihood of a positive clinical outcome for many patients.	National policy: - NHS standards for planned care (cancer) ULHT policy: - Cancer care pathway & booking systems / processes - Clinical Harm Review (CHR) processes ULHT governance: - LincoInshire System Elective Recovery meeting – Monthly - LincoInshire system RTT Cancer and Diagnostic- Weekly - ULHT Cancer Recovery and Delivery – Weekly - ULHT Clinical Business unit meetings – Weekly - Integrated Performance Report (IPR) to Trust Board - Monthly - Divisional Performance Review Meeting (PRM) process - Clinical Harm Oversight Group Intensive support meetings in association with the ICB - 2/52 Cancer Delivery and recovery - 2/52 Cancer Board - Monthly	Cancer patients awaiting surgery - all within 31 days New standards: 28 days for first diagnosis; 62 day max wait Diagnostic standard less than 6 weeks	21/01/2025	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Recovery trajectory of 62+ waits to 0 – Damian Carter – March 2025 Through the intensive support process, specialties to identify and assess any areas of specific risk not addressed through the recovery trajectory, putting in place necessary mitigating actions – Damian Carter – March 2025	[21/01/2025 14:40:00 Gemma Staples] 21/01/2025 The Cancer right-sizing Business Case for Haematology and Oncology was prioritised by CSS Division and submitted in line with the Trust's programme for 25/26, aligned to the health System process. Next step for review via this process is 19 December 2024. It was also presented to Cancer Board on 29 November 2024 as part of the governance process. Expecting response on the rightsizing case from Execs via CSS PRM on 31/01/2025. [11/12/2024 11:47:31 Gemma Staples] The Cancer right-sizing Business Case for Haematology and Oncology was prioritised by CSS Division and submitted in line with the Trust's programme for 25/26, aligned to the health System process. Next step for review via this process is 19 December 2024. It was also presented to Cancer Board on 29 November 2024 as part of the governance process. [11/11/2024 13:18:53 Gemma Staples] Risk reviewed and remains the same. No further update. [04/10/2024 14:49:53 Gemma Staples] Following ELT meeting case of need to be written for presentation at CRIG and ICB investment panel to include Oncology and Haematology workforce. The DOF requested this case to be managed via the 25/26 planning cycle. [16/09/2024 12:38:28 Gemma Staples] DL and Cancer leadership team presented impact assessment to ELT 27/08/2024. More work for the division to do to secure substantive funding for 25/26. Approval given to retain 20 posts across Haem/Onc that have been recruited 'at risk' and above establishment with prior approval in 2023 from CEO and COO. [22/08/2024 15:09:20 Gemma Staples] Impact assessment / QIA for potential removal of 16 wte posts approved 'at risk' by Execs in 2023 deferred date for ELT to 27/08/2024. Being presented by DI and the Cancer leadership team. [24/07/2024 08:15:32 Gemma Staples] 23/07/2024 Funding is not available in 24/25. DL to take impact assessment/QIA to ELT 31 July 2024.	8	31/03/2023	31/03/2023	21/02/2025

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
3a. Deliver financially sustainable healthcare, making best use of resources	5020	6	Finances	Hamer, Fiona	Lentz, Blanche	WORK		02/09/2022	20	Medicine	Urgent and Emergency Care CBU			If there is a continued reliance on bank and agency staff for medical workforce in Urgent & Emergency Care there is a risk that there is not sufficient fill rate for medical rotas both ward / department fill and on call shifts which will impact on patient safety and have a negative impact on the CBU budget	Robust medical plan for every post meetings Close working with temporary medical staffing team Daily management of any gaps to support minimum staffing levels Fundamental overview of tier 1 and tier 2 docs in medicine and ED based on RCP safer staffing levels. Introduction of BMA rate cards This will reduce once output on medical workforce plan is in place, not due to come online in this review period.	Plan for every post meetings Budget reports	04/02/2025	Quite likely (4) 71-90% chance	Extreme (5)	Very high risk (20-25)	20	Robust recruitment plan International recruitment Medical Workforce Management Project	[04/02/2025 15:39:31 Rachael Turner] Risk currently remains, we still haven't filled the Tier 2 rota so work remains ongoing. [07/01/2025 15:10:44 Rachael Turner] No change, we need to clarify what posts we need to recruit to to facilitate reduction in agency and locum spend to dovetail with the implementation of the rota in April. [03/12/2024 16:57:16 Rachael Turner] No changes with scoring, rota finalised and working with Tier 2 team to potentially implement annualised rota in April 25. [13/11/2024 11:36:06 Rachael Turner] Options appraisal for the Tier 2 rota sent to Quadumvirate for approval planned to implement rota 1st April 2025 subject to approval. [28/10/2024 11:02:45 Rachael Turner] This remains very high as we are still in process of recruiting and finalising the tier 2 rota to ensure the correct provision. Hoping to have a resolution and start date by end of November. Recruitment continues for consultant posts. [03/09/2024 15:05:32 Rachael Turner] We are recruiting but are not yet in post. Extra shifts are being put out to bank. Still in same position currently, will review next month for possible reduction. [09/08/2024 14:35:27 Rachael Turner] Risk remains, working towards reduction. No change to risk score. [02/07/2024 16:11:12 Rachael Turner] The recruitment is going well from tier 2 and consultant perspective but it is the tier two costing that remains an issue. This is discussed regularly at TSSG & Divisional Financial Efficiency Group. [06/06/2024 11:52:13 Rachael Turner] This is being monitored by TSSG and ongoing recruitment and retention plans as a CBU. [10/05/2024 12:04:33 Rachael Turner] Risk reviewed.Ongoing challenge. For ED T2 workforce rota implementation going through job planning process. Acute	10	02/09/2023		04/03/2025
1c. Improve clinical outcomes	4731	33	Physical or psychological harm	Landon, Caroline	Landon, Caroline	Patient Safety Group		13/01/2022	20	Corporate	Operations	Operations	Trust-wide	If patient records are not complete, accurate, up to date and available when needed by clinicians then it could have a widespread impact on clinical services throughout the Trust, potentially resulting in delayed diagnosis and treatment, adversely affecting patient experience and reducing the likelihood of a positive clinical outcome.	- Clinical Records Management Policy (approved June 2021, due for review December 2023) - Trust Board assurance via Finance, Performance & Estates Committee (FPEC); lead Information Governance Group / Clinical Records Group - Now led by Deputy Medical Director.	Internal audit of medical records management processes - reliance upon hard copy patient records; patients may have multiple sets of records. Reported incidents involving availability of patient records issues.	15/01/2025	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Design and delivery of the Electronic Document Management System (EDMS) project, incorporating Electronic Patient records (EPR). Interim strategy required to reduce the risk whilst hard copy records remain in use.	[15/01/2025 13:34:44 Rachael Turner] Risk reviewed, until electronic patient records is in place this risk will remain at the current level with no current change to risk scoring. [28/10/2024 11:14:13 Rachael Turner] Risk reviewed, no change to current scoring. [12/09/2024 20:14:05 Rachael Turner] Risk reviewed, remains unchanged, no change to risk score. [20/08/2024 16:20:51 Rachael Turner] Risk reviewed, risk score remains accurate until EDMS is in place. [16/07/2024 12:40:46 Rachael Turner] Risk reviewed, no further updates. Risk score to remain. [26/06/2024 09:09:01 Rachael Turner] Until EDMS in in place and ePR alongside it this remains a risk as there is a potential for information not all in one place. An example of this is that we no longer file blood results in the notes but refer to WebV. Therefore it is not always feasible to add to the paper notes and a reliance on the clinician to check all digital solutions. [26/04/2024 10:19:13 Gemma Staples] Lee Parkin met with Paul Dunning. Medical directors office to review if patient clinical information is stored on an electronic system is it necessary to add to paper notes, await update. This risk will significantly reduce one EDMS (digital records) introduced. [25/04/2024 14:08:17 Gemma Staples] Following a review of the risk with Colin Farquharson it was agreed that the risk sit under COO instead of Outpatients CBU. Risk now updated. [26/03/2024 09:33:18 Laura Kearney] CSS Interim GM, Lee Parkin, met with Paul Dunning, Medical Directors Office. Paul is of the opinion that any medical information held om electronic systems is not required to be printed and added into paper based notes, reducing reliance on such notes and therefore reducing the risk. Mr Dunning will take this suggestion to the Medical Director team to	4	30/06/2018	31/03/2025	15/02/2025
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5143	63	Service disruption	Lynch, Diane	Parkin, Mr Lee	Group, Information Governance Group, Outpatient Improvement Group, Patient Safety		13/04/2023	25	Clinical Support Services	Outpatients CBU	Choice, Access and Booking	Pilgrim Hospital, Boston	As a result of the demolition of H Block it removed facilities and amenities that the Health Record Teams (also Porters & Secretaries) utilised. The risk is that staff are now having to use dumbwaiters to transport notes between the main library and outpatient clinics with additional manual handling requirements, the impact on the staff has meant an increase in staff injuries, an increase in staff turnover with multiple vacancies and low staff morale. The impact on staff has meant to change to processes, an increase in workload and a more physically demanding role. Additional concerns are that the notes are being delayed to clinic which could cause the potential for appointments to be cancelled and also there is an IG issue with notes being transported in dumbwaiters that open in patient areas. With no lift to support the department if any large items fail i.e printer or racking, replacement items will be unable to be delivered.	There is addition of dumb waiter(x2). Health & Safety risk assessment on the dumbwaiters limits the capacity to two boxes in the coding dumbwaiter and with the upgrade to the dumbwaiter in Health record the limit has been increased to 4 boxes. Process in place to ensure notes are either with a member of staff or in lockable storage areas. Quality Impact Assessment completed Risk presented every month to PRM with an update Health and Safety guidance delivered to Team on regular basis	Patient cancellation, waiting times and waiting list increase for patients due to patient notes being unavailable or delayed. Staff survey results. Staff sickness/injury through Occupational Health and ESR.	31/01/2025	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	New lift is planned to be commissioned in 2025 and at that point the risk will diminish. Dumb waiters upgrade completed, working with some minor changes in process needed to maximise use. Schedule of works received showing completion by March 2025. Initial work started, staff moved around to accommodate works. Working with Estates to ensure any works have minimal disruption to the service.	[31/01/2025 16:41:15 Gemma Staples] Risk remains the same. Work has started and is ongoing, working with Estates to ensure any works have minimal disruption to the service. On track for works to be completed by end March 2025. Requests for extra support elsewhere due to Health and Safety risks, have had to be declined due to staffing and the lift issues in the main library. [20/12/2024 14:20:37 Gemma Staples] Work has started and is ongoing, working with Estates to ensure any works have minimal disruption to the service. On track for works to be completed by end March 2025. [25/11/2024 14:47:23 Gemma Staples] Schedule of works received showing completion by 31st March 2024; initial work has started and staff have been moved around to accommodate works; working with estates to limit disruption whilst works take place. [30/10/2024 16:08:46 Gemma Staples] Dumb waiter upgrade completed and working with some minor changes in process needed to maximise use. Awaiting schedule of works for main lift from estates, however it is indicated further delays in implementation, due date now March 2025. [17/10/2024 12:00:04 Laura Kearney] Estimation for lift installation has been extended to March 2025. [25/09/2024 10:19:53 Gemma Staples] Upgrade of dumbwaiter completed awaiting impact of this before mitigation is taken into account and risk to be reviewed. Meeting to review progress and timelines for lift installation arranged for end of September 2024. [02/09/2024 09:46:56 Gemma Staples] Working together with estates team. The dumb waiter is currently being upgraded and causing the team additional issues but we were aware of the issues and agreed that these will be mitigated as far as they can be whilst the works are progressing on the dumb waiter.	1	31/03/2025		03/03/2025

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
3a. Deliver financially sustainable healthcare, making best use of resources	5277	469	Finances	Young, Jonathan	Treasure, Vanessa			09/10/2023	12	Corporate	Finance and Digital	Finance	Trust-wide	Risk of additional financial pressure to the Trust from the possible application of national profiles to existing job descriptions for a number of Band 2 and Band 3 roles and the potential wider impact of any decision.	Initial high level financial risk modelling undertaken by finance. Proformas completed by divisional lead/lead nurse, supported by DHoHR and DHoF to capturing: • how many posts required at each level across each teams • how many current employees currently match the Band 2 profile and Band 3 profiles. Deputy Director of Nursing and Assistant Director of Nursing to review/challenge and agree proposals.	Potential worst case scenario of £3.2m has been calculated. Feedback has been given regarding the need to ensure other band 2 & 3 roles are considered and the possible impact of decisions for those already in a number of band 3 roles."	20/01/2025	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Following proposals being reviewed and challenged, discussions will take place with HR regarding the change process and following this the true cost impact will be calculated. Confirmed high level costing if backdated to August 2021 is £692,517, a significant reduction to the previous anticipated £3.2m financial impact. Possible application and impact of the national profiles for Band 2 and Band 3 roles are currently being consulted through staff side.	[20/01/2025 09:41:20 Rachael Turner] The Band 2's who want to be band 3's are now being paid band 3 and the backdated part has been agreed and is to be paid in January. Therefore, it is no longer a risk but a done deal and is now part of the overall financial position. This risk will be presented at February Risk Register Confirm and Challenge for closure and details of this as part of the current financial position will be included in Risk 4665 [19/12/2024 11:20:07 Rachael Turner] The risk is we have upgraded all band 2's who wanted to move to a band 3 in November and will be actioning back pay as per Hr and union agreement in January. [27/11/2024 13:43:00 Rachael Turner] Risk presented at Risk Confirm and Challenge, risk validated for increase in score 5x4:20 [18/11/2024 14:40:08 Rachael Turner] Payment for those moving to a Band 3 will start in November, so all band 2's wishing to take up the role of the band 3 will be paid a band 3 in November, backdated pay has still not yet been finalised. [13/11/2024 11:57:12 Rachael Turner] Risk to be presented at RRC&C in November for increase in score. [23/10/2024 11:01:47 Nicola Cornish] The Band 2 to 3 has moved significantly, ELT / Board agreed to move ALL band 2's to band 3 with the exception of staff members whom may rejected it. This has now been recalculated to include all approximately 1,000 people: 1 Financial impact recurrently is Part year 2024/25 £1,127,500 and Full year 2025/26 ongoing of £2,706,000. 2 Back pay not yet agreed but costed at £3,559,803. Therefore, I think this risk needs to move to, highly likely as the comms have gone out about it and severity high.	4	09/10/2025		20/02/2025
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5450	659	Physical or psychological harm	Mooney, Mrs Katy	Highfield, Kimmi			05/06/2024	12	Medicine	Specialty Medicine CBU	Gastroenterology	Trust-wide	The capacity of the Gastroenterology Consultant workforce is reducing due to individuals wishing to take resign, retire or partially retire and return with reduce job planned activity. This is impacting the inpatient and outpatient activities of the service. However, as the drive to resign/retire/reduce job planned activity focuses on removal of all inpatient and on-call activity as a 'must' the primary impact is being felt in these area's. If the Consultant Medical workforce for Gastroenterology depletes further and/or does not recruit to vacancies within the workforce, the service will not be able to maintain a two site Gastroenterology inpatient cover, outpatient/ cancer performance and Upper GI Bleed On Call service.	-Recruitment - full time Gastroenterology gaps are out with Agency and on TRAC for NHS Locums. The Business Unit manage the gaps proactively and will put out a variation of gaps (for example, ward cover only) to seek cover for the gaps in the service. -When on-call bleed rota not covered at one site calls are diverted to the other, however this mitigation provides a lower level of service. -Management of UGI Guidelines policy. -Guidelines on Management of Upper Gastro-Intestinal Bleeding (UGIB)	Workforce gaps Capacity of the service Cover of rota's (inpatient ward cover and on-call bleed cover)	04/02/2025	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Explore recruiting to Hepatology specialist posts with ERCP and EUS included. -Robust recruitment plan to cover establishment gaps, including non substantive workforce. -Single site on-call cover in place-currently covering both sites to mitigate for gaps. -Development of clinical service strategy for Gastroenterology by end of 2024/25 financial year. -Paper to go to executive detailing short fall and asking for support with further mitigation- by close of play September 2024.	[04/02/2025 14:42:02 Rachael Turner] Risk reviewed, risk remains in fragile position currently still awaiting feedback from Trust/ICB. [08/01/2025 12:17:07 Charles Smith] Risk reviewed - No substantial update to current provision. No feedback from Trust/ICB on next steps re: investment cases [10/12/2024 14:52:10 Rachael Turner] Risk reviewed, one more consultant has started at Pilgrim with another possible for late 2025. Workforce business case has been submitted. Risk score remains and unchanged. [22/11/2024 10:23:18 Rachael Turner] Guidelines on Management of Upper Gastro-Intestinal Bleeding (UGIB) is currently under review. Controls for this risk have been updated. [18/11/2024 07:58:41 Charles Smith] Risk ongoing - Service sustainability paper drafted for ELT in October 2024. Awaiting formal outcome, further deterioration has led to further options appraisal going forward. This has been signed off by Medicine CD and to be shares with exec. Large workforce CoN supported at initial 2025/26 investment priorities process. SBIC being drafted for 22/11 deadline. [07/10/2024 13:08:56 Rachael Turner] Gastroenterology : Service Sustainability Impact Assessment document which demonstrates the current position of this risk has been added as evidence of Very High Risk Score in supporting documents. Risk currently remains at same level. [25/09/2024 13:05:15 Rachael Turner] Risk presented at RRC&C meeting 25/09/2024. Risk validated as a 5x4:20 Very High Risk. [04/09/2024 12:22:35 Rachael Turner] Risk reviewed. Due to fragile service with 17 whole time equivalent workforce (15 on which are in post), however 5 of these have retired and returned on outpatient only. This leads to increasing pressure of specific parts of the service, most notably the inpatient service. This leads pressure to on-call rota bleed rota. Gastro also has a significant challenge to long waiters and in unlikely to meet the	8	05/06/2025		04/03/2025
2a. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	4997	41	Service disruption	Lynch, Diane	Chester-Buckley, Sarah	Patient Safety Group		22/08/2022	16	Clinical Support Services	Cancer Services CBU	Haematology (Cancer Services)		As a result of current Consultant staffing and on-call arrangements there is a single consultant covering both sites during weekend so cover limited if critically unwell patients on both sites which could lead to potential patient harm, delays in care/discharge.	Middle Grade cover in Oncology & Haematology over and above budget therefore using high cost agency. VC ward rounds are taking place if face to face ward rounds are not possible. Workforce review completed Refresher of Fragile Services Paper completed (NB there is a National shortage of Haematology consultants) Additional unfunded ST3+ for Haematologist started in August 2022	Datix incidents Complaints and PALS Outcome from Staff Survey results Financial constraints of group	20/01/2025	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Cancer Services paper written awaiting CRIG invitation - Sarah Chester-Buckley - February 2025 Recruitment of further substantive consultants - Sarah Chester-Buckley - April 2025	[20/01/2025 10:33:21 Gemma Staples] Business case now not going to CRIG, needs to be taken through Divisional PRM for funding, awaiting next meeting. [19/12/2024 11:34:12 Gemma Staples] Cancer Services paper written, awaiting CRIG invitation [18/11/2024 12:37:17 Gemma Staples] Business case submitted and proceeding to next stage of the process within the Trust. [18/10/2024 10:35:59 Gemma Staples] CoN written to be submitted on 31st October 2024 to ensure this is included in the planning round 2025/26. [20/09/2024 10:49:24 Gemma Staples] Attended ELT, asked to produce new Business Case for Cancer Services to be presented at CRIG asap to ensure the staffing requirement is put into planning for 2025/2026. [22/08/2024 08:38:53 Gemma Staples] Risk remains the same as previous update as awaiting ELT on the 28th August 2024. [24/07/2024 11:45:27 Gemma Staples] Paper to be presented in August to ELT regarding staffing levels to seek approval to go over budget for patient safety. [28/06/2024 14:34:29 Gemma Staples] Risk reviewed. Haematology rightsizing paper will not be considered for funding until 2025/2026. Risk remains the same. [29/05/2024 09:00:34 Gemma Staples] Risk reviewed, ICB investment panel not to fund the Right Sizing Business Case in 2024/2025. A reduced Business case has been put forward for funding to the SDF panel. [23/04/2024 13:05:45 Gemma Staples] Risk reviewed and still awaiting outcome of ICB investment panel [25/03/2024 10:06:21 Gemma Staples] Haematology rightsizing SJBC presented at ICB investment panel on 15th March, still awaiting outcome. [26/02/2024 16:53:12 Gemma] Risk reviewed and ongoing [31/01/2024 14:32:33 Gemma] Risk reviewed and ongoing [18/01/2024 11:09:19 Gemma] Haematology rightsizing paper taken to TLT and approved, now needs to go to the Board and ICB investment panel.	8	01/04/2023	01/04/2023	20/02/2025

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
2a. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	4844	38	Service disruption	Lynch, Diane	Costello, Mr Colin	Medicines Quality Group	19/01/2022	20	Clinical Support Services	Pharmacy CBU	Pharmacy		The ability to provide a seven day a week pharmacy service requires a level of staffing above the current levels. Benchmarking has taken place against peer Trusts for staffing levels. Until this is funded the seven day a week service is unobtainable and this puts patients at risk.	Service planning & annual budget setting processes: Pharmacy / CSS Division	Staffing levels / budget benchmarked against other similar trusts. Reported medication incidents occurring out of hours.	30/01/2025	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Pharmacy supply a limited Saturday and Sunday morning service with staff working beyond their contracted hours. An on-call pharmacist is available for EMERGENCY items only. A Business Case is due to be submitted to CSS CBU to resolve the issue of current workload on Saturday and Sunday mornings, however this will not address the risk associated with being unable to provide clinical services to the wards which will require a separate business case. Work continues to help recruit too hard to fill posts, pipeline talent attraction and Recruitment and Retention premia principles being explored for the hard to recruit to posts.	[30/01/2025 16:02:34 Lisa Hansford] No further update. [30/12/2024 08:32:18 Lisa Hansford] No further update December CRIG meeting was stood down. [29/11/2024 10:17:21 Lisa Hansford] No further update [29/10/2024 10:16:49 Lisa Hansford] Weekend supply business case going to CRIG November. Case of need for ED pharmacy cover also going to November CRIG. Full business case still in development. [30/09/2024 13:37:45 Gemma Staples] Risk reviewed and remains the same. [05/09/2024 14:05:09 Lisa Hansford] No further update [09/08/2024 16:24:38 Lisa Hansford] risk remains the same [10/07/2024 11:08:48 Lisa Hansford] risk remains the same [11/06/2024 10:38:30 Lisa Hansford] Risk reviewed and remains the same [09/05/2024 08:55:00 Gemma Staples] Risk reviewed and remains the same. [04/04/2024 08:49:00 Lisa Hansford] no update [07/03/2024 14:20:29 Lisa Hansford] no update [13/02/2024 11:52:19 Gemma] Risk reviewed, no further update. [17/01/2024 12:06:01 Gemma] No further update [19/12/2023 13:27:34 Lisa-Marie Moore] Meeting with MD 18/12 to discuss business cases Pharmacy phase 2 improvement plan in progress [28/11/2023 12:09:20 Rachael Turner] Risk score remains, no further update. [30/10/2023 12:40:52 Rachael Turner] No changes, risk ongoing. No further updates at this time. [26/09/2023 14:05:31 Rachel Thackray] No changes as yet made, meeting to take place with Medical Director [03/08/2023 14:49:28 Lisa-Marie Moore] No further updates [27/06/2023 09:47:18 Alex Measures] Discussed in risk register review meeting- no further updates	4	29/10/2021	28/04/2023	03/03/2025
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5200	283	Physical or psychological harm	Rivett, Kate	Coghill, Piper	Children & Young Persons Oversight Group	30/06/2023	8	Family Health	Children and Young Persons CBU	Paediatric Cardiology		As a result of a backlog Paediatric Cardiology clinic appointments patients are at risk of undiagnosed cardiac conditions, lack of follow up within appropriate timeframes and subsequent delay in treatment, which could lead to life limiting outcomes or death. RTT Target is 18 weeks, best practice is to be seen within 6-8 weeks to ensure the risk of life limiting conditions and death is significantly reduced and treatment can be undertaken when necessary by appropriate clinician.	-Manage clinics follow up and new patients based on demand with flexibility to swap between either based on waiting times and outcomes -Additional clinics at Boston and Lincoln -Escalated to ELT regarding waiting list -Cardiology meetings monthly with Leicester -Cancellation list in place to ensure clinic is filled and prioritise patients who are overdue and chasing an appointment	-Number of patients awaiting an appointment -Audits -Staff feedback -Next of kin feedback -Incidents -Complaints/PALS	29/01/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	-Continuing to support Paediatric Consultant undertaking PEC training to gain Cardiology experience -Ongoing discussions with ELT regarding plan to address clinic backlogs -Review undertaken by East Midlands Congenital Heart Services; awaiting outcome -Source space to facilitate ECHO clinics -Recruited additional Paediatrician at PHB, support being given to upskill to deliver Cardiology clinics	[29/01/2025 13:09:13 Rachael Turner] Risk discussed at Risk Register Confirm and Challenge as part of the Deep Dive, harm reviews need to be undertaken. Until then the risk to remain at current level. [27/11/2024 13:51:27 Nicola Cornish] Discussed at Risk Register Confirm & Challenge meeting on 27th November. Region-wide issue which executive team are fully sighted on. Approved increase in score to 4x4=16. [07/11/2024 09:51:37 Rachael Turner] Updated risk description due to external review by East Mids Congenital Heart Services - awaiting outcome of report. Risk score increased due to number of patients waiting appointments-risk to be presented at Risk Confirm and Challenge in November for increase in score [07/11/2024 09:33:20 Sarah Davy] Review undertaken by East Midlands Congenital Heart Services; awaiting outcome to review actions and risk score [07/11/2024 09:19:57 Sarah Davy] (current 60 ww for new appointments - 216 new referrals waiting; 1116 follow ups - 307 which are overdue). [09/09/2024 15:49:14 Nicola Cornish] No change, awaiting review feedback and also job planning. Need to look at other options for delivering clinics to make them more efficient eg overbooking, ad hoc extra clinics when funding available etc. [10/06/2024 15:28:01 Nicola Cornish] Need to review what the current backlog is. An independent external review of cardiology service was done last week, awaiting feedback. Recruitment ongoing for locum consultant post at Boston who will completed spin training in cardiology. Intention is to put additional clinics on to reduce backlog. ULHT also feed in to regional dashboard held by EMCHN as this is a regional issue. [09/04/2024 11:07:37 Nicola Cornish] A proposal is being developed to engage a short term locum cardiology consultant to help clear the backlog of patient review. A virtual case review is also being done for all patients on the waiting list to identify and remove any patients that no longer need to be seen.	8	30/06/2024	30/06/2025	29/04/2025
4c. Grow our research and innovation through education, learning and training	5160	56	Reputation	Dunderdale, Karen	Rich-Mahadkar, Sameedha		21/04/2023	16	Corporate				If we don't deliver against our ambition of becoming a University Hospital Trust, this could negatively impact our organisational reputation.	Achievement of Teaching Hospital Status New Clinical Academic Oversight Group established to oversee development and agreement of MOU and recruitment Regular discussions between Executive leads from ULHT and UoL regarding financial arrangements Working closely with University of Lincoln to define and agree future collaborations Working with Research and Innovation teams and reporting into R&I groups to maintain oversight	Executive scorecard - number of clinical academics in post and number of collaborations that are developed to support research grants	04/02/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Continued discussions between ULHT and UoL to agree first tranche of specialities aligned to substantive consultant gaps via medical workforce improvement programme Executive leads to finalise research, financial agreements and HR approach Application for Teaching Hospital Status as interim step - now completed. Maintain oversight of UHA requirements as we align for a future application	[04/02/2025 13:39:08 Rachael Turner] A financial model for CA funding has been provisionally agreed by the CFO. A long list of potential specialities for recruitment has been developed and is being verified via the Medical Workforce Improvement Programme. HR workstreams continue to develop appropriate documents/processes to support recruitment. A final list of specialities to recruit first CA tranche will be agreed with UoL to align with their areas of research expertise. Proposal to reduce the risk score due to the mitigation that securing Teaching Hospital status has from a reputational perspective, new risk score proposed: 4x3:12 Moderate Risk. This risk will be presented at RRC&C meeting in February to validate risk score reduction. [19/09/2024 17:16:16 Rachael Turner] United Lincolnshire Hospitals NHS Trust has been awarded teaching hospital status as of September 2024. The Trust has started the roll out of adopting our new name of United Lincolnshire Teaching Hospitals NHS Trust (ULTH). [26/06/2024 09:13:16 Rachael Turner] Risk reviewed-new control now in place to mitigate this risk-New Clinical Academic Oversight Group established to oversee development and agreement of MOU and recruitment. Risk score to remain. [18/10/2023 11:52:17 Rachael Turner] An application for Teaching Hospital Status is to be submitted to the DHSC as an interim step to recognise ULHT's significant teaching commitment. We anticipate that this will be approved before the end of 23/24 financial year. An MOU and financial model is being developed and agreed between ULHT and UoL which will support our requirement to recruit clinical academics and regular meetings are in the diary to conclude this work.	8	31/03/2025		04/05/2025

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5002	535	Service disruption	Farquharson, Colin	Edwards, Mrs Jill	Clinical Effectiveness Group, Palliative/End of Life Care Oversight Group		23/08/2022	16	Clinical Support Services	Cancer Services CBU	Specialist Palliative Care	Trust-wide	As a result of the Trust not being consistently compliant with NICE Quality Standards for PEOL and commissioning guidance for specialist palliative care (SPC) due to staffing resource there is a risk of lack of identification of palliative need, delays to assessment, patients not achieving preferred place of care/death across the Trust resulting in serious physical and psychological patient and family harm, with a poor patient experience of care and service. This could lead to Regulatory action.	National Policy - NICE Quality Standard (QS13) End of life care for adults - NICE Guideline (NG142) End of life care for adults: service delivery - NICE - Care of dying adults in the last days of life Quality standard Published: 2 March 2017 - Ambitions for Palliative and End of Life Care: A national framework for local action 2021-2026 - 'One Chance to Get it Right: improving people's experience of care in the last few days and hours of life' Leadership Alliance for the Care of Dying People. June 2014. - 'Every Moment Counts' A narrative for person centred co-ordinated care for people near the end of life (VOICES) - Commissioning guidance for Specialist Palliative Care (2016). Local Strategy - Palliative and End of Life Care (PEOL) strategy for Linconshire - PEOL Re-Design for PEOL services Lincolnshire - ULH Strategy for PEOL ULH Governance - SPC Governance/ CSS CBU/ Cancer Services/ SPC - NACEL report Daily caseload review and triage of caseload using PEOL OPEL reporting measures with sitrep for escalation of risks Daily palliative huddle with key partners to support demand Working as one team across sites to provide pan trust cover Senior leadership for direct support to PEOL at ULHT by addition of deputy lead nurse for PEOL Workforce plan to identify gaps in alignment with national policy and guidance completed	Frequency of referrals outside SPC referral criteria Frequency of referrals that require more information for triage Datix incident / HPF's Complaints/concerns Frequency of patients died/discharged before seen Frequency of patients dying outside Preferred place of death Frequency of first assessment (over 24hrs) from service KPI's. SPC workforce review including staffing deficits and skills gap analysis Daily OPEL level Frequency of support needed by teams from SPC	27/11/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Business Case to be developed - Sarah Chester-Buckley Ongoing training for PEOL champions. Event planned - Jill Edwards - March 2025 Development of SPC SOP & business continuity plan - Jill Edwards - March 2025	[27/11/2024 16:55:04 Gemma Staples] business case in final draft and going through process for submission to CRIG. CSS looking at funding additional consultant (10 PA's). Long term CNS absence has increased delays and need for additional clinical support for Deputy Lead Nurse to cover. [19/08/2024 11:08:04 Gemma Staples] Business case continues to be developed. Developing standard for what current team can provide with available resources based on commissioning guidance and deficit to support prioritisation. Previous challenges continue and increased due to further staffing deficit. Risk managed with deputy lead nurse cover but this can only be sustained for a short period of time. Remains high risk. [17/07/2024 09:38:11 Gemma Staples] This risk is linked to 5475 (the regulatory risk). [25/04/2024 11:33:45 Gemma Staples] Risk reviewed and remains the same. A regulatory risk is being drafted and will be taken to the division for approval and will be taken back to RRC&C. Macmillan in reach role support has been reduced from 5 days to approx 3 days per week. Ongoing conversations with LCHS and options appraisal being completed. [31/01/2024 12:36:56 Rachael Turner] Risk discussed at RRC&C meeting 31/01/2024 for increase in score. Not meeting KPI and significant delays to patients receiving care and direct patient harm. We cannot see people within 24 hours, this is currently at a week. 30% of discharges discharged with no further referral provided. Risk of patient harm due to workforce, we are working at between 5-13% currently at 1.8. There is no MDT. Currently no resource for change. Risk score reviewed and validated: 4x4:16 High risk. Also risk of regulatory action, new risk to be created to cover this. [08/12/2023 13:25:40 Gemma] Risk discussed at SPC Governance identified not able to meet KPI of 75% of referrals assessed within 24hours. This is evidence that the risk has increased and therefore would like to be considered as a high risk.	4	30/12/2024		27/02/2025
2a. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	4862	44	Service disruption	Mooney, Mrs Katy	Smith, Charles	WORK		22/02/2022	16	Medicine	Specialty Medicine CBU	Respiratory Medicine	Trust-wide	Consultant staffing within Respiratory Medicine at Lincoln and Boston Hospital. Currently there are only 3 Substantive consultants in place at LCH and 2 at PHB. We have a vacancy of 5 across the three sites. Various gaps are covered with Adhoc Locum. The main current risk is to the inpatient cover at Pilgrim Hospital. With only x2 Consultants over there, when we have 1 on annual leave, the risk that the other could be either sick or covid contact is extremely high. We have supported this with clinicians going over from LCH, however due to a further resignation at LCH, this is proving more difficult This combined risk on Medical staffing has now impacted the Secretarial team at LCH. There is currently 0 secretaries at work at LCH due to sickness in the team. This is mitigated through support from Agency / Other specialties supporting. We do not have the substantive staff nor the locum or agency bookings, to cover all functions of our Resp Medical Team. Inpatient risk of high acuity patients without specialist input. Outpatient risk of high activity of 2ww referrals on top of high volume OP workload, delayed pathway progress / commencing treatment such as chemotherapy. Due to lists / skillset required, there is not the ability within the organisation to cross cover between sites leading to Grantham particularly being most at risk.	Due to the severity of the risk: Currently: x 5 Consultant Gaps in Resp The impact this is having on the current workforce is stretching the team and leading to added pressure on the workforce. We are working with agency teams to work 'differently' for example Locum consultants supporting with on call work / remote clinics to release the burden on the current clinical team in respiratory. OD support in place also, along with weekly catch up meetings with the teams to explain the current state of play. The CBU continue to proactively manage workforce. Rotas are stable but continue to be challenged with gaps.	Staff Survey Results. Data Analysis through HR around recruitment and retention. Measured through Performance for patients (although this is not directly attributed towards the recruitment and retention, the longer wait times cause anxiety and unwarranted stress for the consultants in post)	10/12/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Close working with Agency to try and recruit agency locums to temporarily fill gaps. Working with Advanta / Medical Resourcing to recruit long term and improve retention of current staff. Additional funding applied for from Cancer alliance/ICB for Gastro and Resp to allow for additional Gen Med Locum to reduce burden on current workforce. Remote working in place to support outpatients where possible. Agency spend supporting out of hours workload - for example, covering the substantive consultants on calls to allow them to focus on Cancer work instead of on call - supporting patient care.	[10/12/2024 14:48:18 Rachael Turner] Business case has now been completed and submitted for investment for 25/26. No current change at this time. [12/09/2024 14:12:18 Rachael Turner] Workforce review is underway, however this is still fragile, likely to be a business case for workforce consultants in near future due to THLC (Targeted Lung Health Check). [31/07/2024 13:09:17 Rachael Turner] Risk presented as part of the Deep Dive at RRC&C meeting 31/07/2024. Service remains fragile. Risk to remain at current score of 16. [30/07/2024 13:09:24 Charles Smith] Respiratory Medicine workforce review underway. Cons and ACP.10 Cons now, 7 NHSLocum/Ag. Continue to manage pro-actively but service remains fragile. [09/05/2024 14:35:19 Rachael Turner] There is going to be a clinical strategy review for Respiratory. This will require significant financial investment and currently we are restricted. Risk remains the same. ACP work will continue. [14/11/2023 14:43:19 Rachael Turner] There are 3 substantive consultants but the risks remains the same and we rely heavily on bank and agency. Score remains. Nodule ACP role, this is a permanent role, has been developed and recruited but she is still back filling the plural. [30/08/2023 09:30:26 Carl Ratcliff] Expect to be at 10 consultants at end of Nov and will review risk again in 1/12 [24/04/2023 12:25:14 Carl Ratcliff] Have recruited to Consultant ACP post in nodules to support team - will start in 1/12 Using additional external support to deliver extra capacity for OPD to allow delivery of 78ww and reduce risk for delivery of 2ww urgent work [24/02/2023 13:48:15 David Marsh] Recruitment in progress, 5 substantive consultants in post (3 x Lincoln, 2 Boston). Agency locums in place covering a variety of roles/sites. New NHS Trust Locum Respiratory Consultant from overseas started in January at Lincoln. Now working independently. Division	4	30/12/2022	03/06/2024	10/03/2025
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5142	65	Physical or psychological harm	Thomson, Cheryl	Lentz, Blanche			12/04/2023	20	Medicine	Urgent and Emergency Care CBU	Accident and Emergency	Trust-wide	Within Lincoln and Pilgrim Emergency Departments there is a risk that, given increases in demand/footfall, the current staffing template for middle grade doctors overnight may not provide assurance to maintain patient safety.	Utilisation of on-call Consultant to support dependant on holistic risk. Specialty support and signposting to other directorates and providers. Full capacity protocol and boarding.	4 hour target/12 hour breaches. Time to first assessment. Decision to admit.	07/01/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	ED Rota and workforce review with new rotas to provide effective cover overnight in all areas at all grades. New rota templates signed off by finance, to be implemented Q3 2023. Recruitment ongoing.	[07/01/2025 15:08:23 Rachael Turner] No change, however nearly at resolution for tier 2 rota timeline anticipated for the 17th Jan to implement for the 1st April 2025. [03/10/2024 09:15:45 Rachael Turner] Risk reviewed, no change. [02/07/2024 16:05:28 Rachael Turner] Tier 2 programme still ongoing, in the phase of implementation. Workshops in place to work with tier two cohort to proceed to job planning. Timeline to be completed by Q4. [15/04/2024 11:01:21 Rachael Turner] Further delay due to job planning from medical workforce. Now expected Q3/Q4 24/25. CBU Team looking at mitigations including removal of some shifts to improve uptake across 24 hour period. [05/03/2024 15:45:12 Rachael Turner] Consultation has now ended. Expected go live date Q3/Q4, this should have gone live last October. Update to be provided in June. [09/01/2024 15:09:37 Rachael Turner] Risk remains the same. Increased winter slippage funding that lets us have extra middle grade shifts. Consultation due end of Feb/ March. [17/10/2023 10:11:32 Rachael Turner] This remain the same due the consultation in place. This remains to go out to bank and agency until staff are recruited. [26/09/2023 14:46:05 Charles Smith] Tier 2 MG consultation extended and ongoing. Mitigation via locum/bank until then. [30/08/2023 11:24:12 Carl Ratcliff] will review post meeting with exec on 30th August 2023 with action plan in place to manage more of the ED risk [15/08/2023 11:15:38 Helen Hartley] This will align into the medical workforce tier 2 recruitment process as per risk 5020 Also links into overcrowding piece. [19/07/2023 15:54:10 Helen Hartley] This has been looked at and updated, remains and will review next month [13/06/2023 11:09:55 Helen Hartley] Risk reviewed, level remains the same.	9	31/08/2023	01/11/2023	07/04/2025

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5267	485	Physical or psychological harm	Ratcliff, Carl	Marsh, David			26/09/2023	16	Medicine	Cardiovascular CBU	Cardiology		If there is a continued delay in processing of Cardiac MRIs, which is impacted by workforce limitations and an existing backlog of scans, then it could lead to delayed assessment and treatment for patients, resulting in potential for serious harm, a poor patient experience and a poor clinical outcomes. Cardiac MRI backlog was recorded at 125 11th September, this went down to 72 2nd October, this backlog continues to be monitored.	1.Outsourcing some CMR reporting to Medica - they will be reporting ten studies per week for the foreseeable future, which is around one third of our current reporting workload. At cost. 2.Undertaking additional reporting sessions - this will help significantly with the reporting backlog but not solve causal factors. At cost.	Size of reporting backlog (number/time required) Average time for reporting of scans from date of imaging	12/12/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	1. Work with imaging colleagues to develop/review need for additional imaging consultant with CMR included in Skill-set. 2. Continue to mitigate proactively at cost via current controls.	[12/12/2024 14:49:24 Rachael Turner] As of Monday 9th December: •There are 266 CMR scans awaiting reporting • The oldest scan awaiting reporting is from 30.09.24 (70 days) With regard to current reporting 'performance', the number of reports per operator over the last week was: • Houghton 26 • Andrews 5 • Disbrow-Carpenter 2 (supervised reports) • Kylintireas 0 [30/09/2024 11:07:44 Rachael Turner] Current backlog has increased to 194 which were waiting to be reported. The oldest scan is from the 8th August. Business case is still going ahead. Currently waiting to see if we need to go through CRIG process. [21/06/2024 13:51:51 Rachael Turner] We had reduced this, however we now have another backlog. A plan is in place but the reports must be done by a Cardiologist trained in Cardiac MRI. Lack of resource as a business unit, currently looking at working up a business case but this is in the very early stages. [18/03/2024 10:38:56 Rachael Turner] Reporting is massively reduced. As of last Monday there were just three to report. Longest wait was two days. This risk will be chased so that it can be agreed for a reduction and presented at RRC&C. [15/01/2024 14:28:44 Rachael Turner] There is no significant backlog. Weekly check of performance has been provided as evidence. This risk will need approval at Division in order to be reduced in score. If agreed this will go to Risk Confirm and Challenge for a reduction in score. [25/10/2023 11:12:43 Rachael Turner] Risk discussed at RRC&C meeting 25/10/2023, risk validated as 4x4:16 High Risk.	3	01/07/2024		12/03/2025
1c. Improve clinical outcomes	4855	207	Physical or psychological harm	Hallion, Simon	Chantry, Chris			10/02/2022	16	Family Health	Women's Health and Breast CBU	Breast Services		Risk of harm to patients through delayed diagnosis of breast cancer and increased waits to treat confirmed cancers. Further risk of delays due to shortages in Pathology and Oncology staff. Risk of staff fatigue through additional clinics. Reputational risk to trust due to poor performance.	Service level agreement with Path Links Cancer MDT Weekly Breast capacity meetings New Cancer Remote Monitoring Administrator and tracking spreadsheet in place Escalation process for converting unused oncology appointments allocated to other specialties into Breast oncology appointments where possible.	Volume of referrals and clinic capacity. 2ww performance / average wait time for first appointments. 62 day performance. MDT staffing levels / absence rates.	29/01/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Additional capacity and exploration of creating capacity through redesign of clinic facilities, etc.	[29/01/2025 13:57:28 Gemma Staples] Risk presented at Risk Register Confirm & Challenge Meeting held on 29/01/2025 and the request for an increase of the scoring was agreed and approved. Risk amended from 3x4(12) to 4x4(16) [10/01/2025 11:51:41 Nicola Cornish] Wait times for diagnosis remain acceptable due to staff undertaking increased weekend working currently to maintain current position, however this risks staff burnout. There is an increase wait for treatment due to Oncology input and commencement of radiotherapy/chemotherapy treatment. There are also some delays in receiving histology results and Radiology appointments for pre-operative work up requirements identified at MDT discussion (Magseed insertion). A rightsizing case has been written to add c.1000 slots to the service to meet current and predicted demand. This is currently awaiting approval through the Trust's 25/26 planning round – failure to fund the uplift will remove the current agency support and we will lose the additional capacity. The ICB cancer team have identified this as their priority risk – Risk ID001 on the corporate ICB cancer risk register. Increase in likelihood to Quite Likely - to be presented to RRC&C in January for approval of High risk score. [01/11/2024 10:01:08 Nicola Cornish] Increased wait for treatment due to oncology capacity but positive working with oncology to improve this. [20/08/2024 12:43:10 Nicola Cornish] Working with oncology around improving processes for booking appointments for treatment. Oncology recruitment underway. Improved diagnosis timescale has increased pressure on treatment timescales, although there appears to be less negative patient feedback currently. [10/05/2024 11:58:41 Nicola Cornish] Diagnosis performance is good but delays still with patients who require oncology appointment. Cancer Remote Monitoring	4	31/12/2021 29/12/2023		29/04/2025
1c. Improve clinical outcomes	4928	89	Service disruption	Mooney, Mrs Katy Marsh, David				28/04/2022	16	Medicine	Cardiovascular CBU	Cardiology		As a result of a current backlog of Cardiology services this could result in a risk of delays to patient care/harm, service restrictions, delays in discharge and site escalation pressures. Cardiology outpatients are delayed due to catching up on backlog post Covid 19 and demand exceeding capacity. This is also exacerbated if patients need cardiology tests and results reporting on prior to their initial outpatient appointment e.g. Holter Monitor/24 Tape. The current longest wait is between 52 & 65 weeks, although the backlog this is a priority for the Division and the waits are reducing.	additional clinics/lists (cost pressure) additional staffing where feasible to increase capacity (cost pressure) Job planning exercises are completed	weekly monitoring of RTT and PBWL Datix incidents weekly meetings with planned care managers Reported to NHSE	06/02/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	-Weekly waiting list meeting -Weekly RTT meeting For both of these we make plans for all patients that are 45 weeks and over. This will be ongoing. -Review in place for all our pathways-this is continually at present so we can re-design with the correct cohorts.	[06/02/2025 11:46:54 Rachael Turner] Risk reviewed, description and controls updated to reflect current position. A year ago we were appointing at 42 weeks, we are now at 33, after this first appointment the diagnostic pathway begins but this can have delays. We are improving our percentage slowly and work remains ongoing in the reduction plan. [09/01/2025 12:26:47 Rachael Turner] Risk reviewed, no current change. Risk score to remain. [30/09/2024 11:11:54 Rachael Turner] Delays occur due to waiting for diagnostic tests for ECG monitors to come through. Currently 17 waiting for 52 weeks and above. This continues to be monitored. [21/06/2024 13:54:54 Rachael Turner] We have reduced the backlog. The Cardiology waiting list is in a much better position and we are monitoring ourselves against P Codes. We are utilising our capacity as best as we can by booking 6 weeks ahead. RTT continues to improve but routine patients are being appointed at 14 weeks. We have in excess of over 3000 follow ups. [18/03/2024 10:44:23 Rachael Turner] Risk reviewed, waiting lists have reduced down significantly, booking up to six weeks ahead. Those on the list are being reviewed for priority and whether they require to be seen. 3563 are now currently on the waiting list. RTT position 52.54%. Risk to be looked at to be reviewed for a reduction in score. [15/01/2024 14:33:03 Rachael Turner] Waiting lists are coming down with regular monitoring and validation. We have now adopted a 6 4 2 process for booking our waiting list slots. Performance is reported through Governance PRM every month. Risk Reduction plan reviewed and updated. [16/10/2023 16:34:58 Rachael Turner] The Cardiology waiting list has been extensively validated and has been reduced. Our biggest backlog on the waiting list is loop recorders and we are holding a three day "loopathon" 14-16th November where 96 patients will be treated.	8	15/01/2025 01/03/2024		06/05/2025

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	4779	61	Physical or psychological harm	Landon, Caroline	Marsh, David			16/01/2022	20	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	09/01/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	-Virtual clinics in place for substantive consultants, where long overdue follow ups are giving priority. Overdue was standing at 989 patients, this was reported in October 2023. With industrial action, this will have had an impact. Trajectory of how we continue to reduce to be provided.	[09/01/2025 12:23:04 Rachael Turner] TIA continues to improve and a new pathway is being put in place. For stroke virtual clinics are in place, locum consultant is in place to cover ward discharges returning for the month of Jan. TIA 47 follow ups, but only 1 is over due. For Gen Med (stroke) patients waiting to be seen for clinic is currently just over 400. These patients will be seen through Jan/Feb. Risk score to currently remain. [02/09/2024 11:20:05 Rachael Turner] Follow ups are improving for TIA and stroke. Patients are being reviewed virtually and from Friday we are including validation on Partial Booking Waiting List. 659 patients currently waiting this is split between stroke and TIA. [21/06/2024 13:48:45 Rachael Turner] This remains the same. This has reduced but still a concern. Trying to mitigate through virtual clinics but lack of consultants in post makes this a challenge. [18/03/2024 10:35:28 Rachael Turner] PBWL reduced to half due to carrying out virtual clinics. Work remains ongoing. [15/01/2024 14:24:35 Rachael Turner] Risk reviewed, controls in place and risk reduction plan updated. Virtual clinics currently in place to provide follow ups for long overdue patients. [13/12/2023 19:05:30 Rachael Turner] No current update, meeting to be had to combine with Risk 4780 and 4778. Due to staffing working capacity this will be done in January 24. [27/09/2023 11:31:18 Rachael Turner] Risk discussed at RRC&C as part of the Deep Dive. Since Covid this risk has moved on, this needs to be reviewed and possibly combined with risk ID 4780 and 4778. [30/08/2023 11:19:10 Carl Ratcliff] to review with COO as may be able to remove given lower COVID demand [23/07/2023 12:57:33 Carl Ratcliff] Proposal been constructed to allow better use of LCH beds - await feedback from Execs on next steps	4	31/03/2022	29/12/2023	09/04/2025
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5520	753	Physical or psychological harm	Landon, Caroline	Hunter, Sarah			11/10/2024	16	Medicine	Cardiovascular CBU	Stroke	Trust-wide	As a result of ULHT not having a Thrombectomy centre, we have to transport patients to Nottingham. There is a risk of transfer delays for patients with acute neurological presentation suspected to be a stroke having access to a designated thrombectomy centre for consideration of mechanical Thrombectomy. This could lead to more brain cell death, increase risk to life and ultimately poor functional outcomes/severe disability. On occasions delays have been so long the offer of intervention has been withdrawn.	Attempts to streamline pathway to hold crew bring patient to Lincoln for further transfer to Nottingham however not often successful due to pathway delays. [current acute pathway QI project] Escalating to operation centre as soon as Ambulance requested for transfer if original crew already stood down/handed over. Explored option of increasing category allocated to Stroke transfers [Currently CAT2] so far despite regional engagement Ambulance service unable to re-categorise.	Regional meetings - Integrated Stroke Delivery Network M&M meetings [local & regional] Datix incidents reported.	03/02/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Action 1. Continue to work to streamline pathway to avoid transfer delays. Consultant Stroke Practitioner & Stroke ACP lead responsible for streamlined internal pathway – current QI project till December [Code thrombolysis/Stroke] Action 2. Develop internal processes to escalate transfer delays more quickly. Stroke CBU/Acute team to liaise with Operations department for clear escalation process. Action 3. Ongoing communications/meetings with Ambulance service. Consultant stroke Practitioner liaising with ISDN & Ambulance service [Claire] ongoing Action 4. Look to the future to develop local thrombectomy centre to ensure fair access to emergency stroke treatments for the people of Lincolnshire, reducing long-term disability, dependence of health & social services, overall reducing the socio-economic burden of stroke. – Executive responsibility for service allocation?	[03/02/2025 11:05:07 Rachael Turner] Risk reviewed, work remains ongoing with no change to risk scoring. [27/11/2024 13:02:18 Rachael Turner] Risk presented at Risk Register Confirm and Challenge 27/11/24. Risk validated 4x4:16 High Risk. [11/10/2024 12:34:10 Rachael Turner] Risk to be presented for validation at November Risk Register Confirm and Challenge meeting.	8	11/10/2025		03/05/2025
4d. Enhanced data and digital capability	4641	18	Service disruption	Humber, Michael	Gay, Nigel	Emergency Planning Group		23/11/2021	16	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	24/12/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	- Prioritisation of available capital and revenue resources to essential projects through the business case approval process. - Working with suppliers and application vendors to understand upgrade and support roadmaps. - Assurance mechanisms in place with key suppliers for business continuity purposes - Comprehensive risk assessments to be completed for local service / site specific vulnerabilities so that appropriate action can be taken to manage those risks. - Contingency plans - data centres protected from overheating, fire and flood / water damage risks: Portable air con units kept on site for when needed. Estates work has addressed some leakage issues at Pilgrim. Fire retardant systems in all data centre rooms, routinely serviced by Estates.	[27/01/2025 09:42:07 Rachael Turner] Work is continuing to commission the two new locations at Lincoln and a suitable location has now been confirmed and work has started on build of the new data centre at Pilgrim Hospital. Work is also planned next year 25/26 to develop new second rooms at Louth and Grantham as well as refresh the current spaces. A contract has been awarded to replace fibre cabling on Trust sites, this will run new fibre to the new data centre starting at Lincoln during Q4 24/25, work will follow on other sites, as the new locations come on line. [19/09/2024 16:37:07 Rachael Turner] Work is continuing to commission the two new locations at Lincoln and also to locate a suitable location for a new development at Pilgrim. Work is also planned next year to develop new second rooms at Louth and Grantham as well as refresh the current spaces. Work is also ongoing to provide connectivity resilience from the new facilities on the Lincoln Site to provide connectivity from both rooms to the site edge distribution cabinets and also look at the power supplies in these cabinets. [19/06/2024 14:27:38 Rachael Turner] The Lincoln two new rooms have been delivered and have been handed over. Work is now continuing to connect the rooms into the existing building infrastructure and also start to migrate out of the old spaces. This will be an ongoing process for Q2 - Q4 of this year. [21/03/2024 11:59:38 Rachael Turner] The new Lincoln comms rooms are now largely complete and almost at the point of supplier handover, this will allow commissioning to take place during Q1/Q2 24/25. The second new comms environment at Pilgrim Hospital has been procured and will be implemented during FY 24/25. [21/03/2024 11:58:08 Rachael Turner] Propose no update to current risk score but forward view is once of reducing risk, particularly when these new facilities are onboarded. [20/12/2023 09:39:41 Rachael Turner] Risk reviewed, no current change. Risk	4	31/03/2023	31/03/2023	24/03/2025

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
2a. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	4439	49	Service disruption		Low, Claire	Gates, Karen	WORK	16/11/2018	20	Corporate	People and Organisational Development	Operational HR		If there is large-scale industrial action amongst Trust employees then it could lead to a significant proportion of the workforce being temporarily unavailable for work, resulting in widespread disruption to services affecting a large number of patients	1).Workforce plans & rota management procedures. 2).Temporary staffing arrangements. 3).Business Continuity Policy with associated procedures & guidelines. 4).Local service-specific business continuity plans & recovery procedures. 5).Executive oversight (Chief Operating Officer) through Emergency Planning Group.	1.Frequency of industrial action events. 2.Publicised staff polls / surveys by professional bodies on possible industrial action. 3. When there is industrial action we can monitor percentage rate of strike which will allow us to identify whether there is an increase.	05/02/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Industrial relations action plan & engagement mechanisms and arrangements with Staff Side representatives.	[05/02/2025 11:10:04 Rachael Turner] Risk reviewed. Part of pay deals in place for Consultants and SAS and resident doctors, the industrial action would stop. Part of the settlements is a reform of the Doctors Dentist Pay Review Body (DDRB) and how they operate as this impacts their recommendations to Gov't for pay awards If DDRB delivers on that review and it goes through, the risk should then become low. However, if they don't reform as part of the settlement, the BMA have openly said we are at risk of restarting industrial action for Consultants and SAS doctors. Due to current risk position, risk to be presented as part of the Deep Dive and recommended for a reduction in score to 3x4:12 Moderate Risk. [08/01/2025 10:51:05 Rachael Turner] There have been no further notifications regarding industrial action. Due to mitigation in place risk to be put forward for the February RRC&C meeting for reduction in score to 3x4:12 Moderate risk. [04/12/2024 11:28:29 Rachael Turner] This risk will be reviewed at the beginning of Jan, looking at the likelihood score and consider a presenting at Jan Risk Confirm and Challenge for a reduction in score, providing there has been no further notifications. [04/10/2024 11:52:48 Rachael Turner] As of Sept 24 the BMA Junior Doctors Committee accepted the Governments pay offer, this is expected to reduce the impact of strike action for this staff group. However, there remains a risk that other staff groups may take industrial action for this reason the risk remains at present. Risk score to remain at current level and will be regularly monitored. [09/07/2024 11:14:55 Rachael Turner] Risk reviewed, there has been no current change. Risk score remains at 16. Recent Junior Doctor and Consult strike recently went according to plan with appropriate support in place. [26/03/2024 13:23:38 Gemma Staples] Risk reviewed at RRC&C today and agreed	4	31/03/2025	31/03/2023	05/05/2025
2a. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	5251	53	Reputation		Low, Claire	MacDonald, Damian		06/09/2023	16	Corporate	People and Organisational Development	Organisation Development	Trust-wide	If the Trust doesn't have an effective approach to employee appraisals then it could have a negative impact on morale and lead to poor performance, inappropriate behaviours, reduced productivity, non-compliance with policy, increased turnover.	1. Dedicated page for Staff Appraisals on the Intranet with a wealth of easily accessible information that sets out the process, principles, benefits, fact-sheets 2. Leading an Effective Appraisal 2-hour virtual workshop available to all managers to support them in developing their skills and confidence to undertake staff appraisals 3. Creation of an Appraisal and Career Discussion form that is simple but allows for discussion on performance, professional relationships, career and development goals, and wellbeing. It also allows for performance and development objectives to be set, an overall assessment of performance to be made and a check on completion of mandatory training to be undertaken. There are also forms to support managers to undertake regular 1:1 'check-ins' and to undertake mid-year reviews 4. Trust governance: Board assurance through People and OD Committee 5. A current development of the appraisal cycle is underway as a result of best practice learning from LCHS.	1. Compliance rates reported at Divisional and Trust level in a variety of forums monthly. 2. Turnover rates.	05/02/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	1. Creation of a Task and Finish Group to undertake a scoping/review exercise to understand current issues and barriers to completion 2. Findings of Task and Finish Group to be used to inform and develop an Improvement Action Plan 3. Complete Improvement Action Plan when drafted - to be monitored through Workforce Strategy and OD Group and reported up to People and OD Committee 4. Ensure detailed scrutiny takes place at FPAM with Divisions - Learning and Development Coordinator to provide more detailed monthly slides as part of FPAM reporting"	[05/02/2025 11:13:32 Rachael Turner] Introduction of appraisal window - paper review in January 25 - needs GLT, working with Comms 5 month window to get appraisals undertaken. Work with areas who didn't manage it so when ready for 26/27 Q1 we will be square and ready to go. Adequate system in place. Agree with moderate reduction to risk. This risk will be presented as part of the Deep Dive at RRC&C in February with a recommendation for reduction in score to 3x4:12 Moderate Risk. [08/01/2025 10:57:14 Rachael Turner] Due to plans that are currently in place around the Group model and turnover rates continue to reduce. Mitigation as place including business as usual through FPAM process. Introduction of appraisal window will re-train staff and will support transition to a dedicated compliance window which will be closely monitored. Risk to be presented at RRC&C in February for reduction in score to 3x4:12 Moderate Risk [04/12/2024 11:25:17 Rachael Turner] As of Quarter 3 there is an appraisal rate target of 85.58% and as a collective our Trust is 81.15% as of month 7 which is outside of target but within tolerance levels. Its agenda for change staff where improvements need to be made. We have continued focus through FPAM meetings and offers of support through People Directorate with a focus on targeted areas with the least compliance rates. This risk will be reviewed at the beginning of Jan to see if the risk is ready for a reduction in score. [04/10/2024 12:03:17 Rachael Turner] 1. Appraisal rate has improved within 24/25 we have seen a seven and half percent Trust wide improvement since March 24 and as of Quarter 2 of 24/25 are exceeding our trajectory. 2. Further improvement is required within the Agenda For Change staff groups, this is monitored through FPAM. Recommendation is to monitor risk score when we get to the end of Quarter three. If we continue to meet trajectory we will consider a reduction in risk score. [09/07/2024 11:21:35 Rachael Turner] Risk reviewed. Approval from ELT to move	8	31/03/2025	31/03/2025	05/05/2025
3c. A modern, clean and fit for purpose environment across the Group	4725	466	Physical or psychological harm	Taylor, Ruth	Taylor, Ruth	Health and Safety Group		13/01/2022	20	Clinical Support Services	Therapies and Rehabilitation CBU	Rehabilitation	Lincoln County Hospital	If essential repairs and maintenance requirements at Lincoln County Hospital Occupational Therapy Department are not addressed then it may lead to accidents and injury resulting in potentially serious harm to staff, patients and visitors. There is a security risk to the building.	Legislation: - Health & Safety at Work Act 1974 -Management of Health & Safety at Work Regulations 1992 associated guidance. ULH policy: - Health & Safety Policy & related guidance - Health & safety training (Induction, Core Learning, Core Plus Learning and CPD) - Estates Planned Preventative Maintenance (PPM) / testing - Occupational Health services ULH governance: - Health & Safety Committee / site-based H&S Forums; accountable to Trust Board through Finance, Performance & Estates Committee (FPEC)	IPC flo scores, monitoring of incidents, staff satisfaction concerns, complaints / PALS Tracking of Estates work requests - The Department has a significant amount of outstanding jobs including, leaking windows, leaking roof tiles, carpeted areas, unsanitary toilet/shower & changing facilities, repeatedly broken toilets. Inability to monitor temperatures due to inappropriate fitting of radiator covers, swelling and uneven floor services following leaks.	04/02/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Daily & Weekly IPC checks, Staff well being checks, frequent monitoring of safety issues. Escalation to H&S Team via audit process. Monthly updates to MICAD system, Escalation via IPC FLO audit process.	[04/02/2025 19:23:10 Gemma Staples] Risk remains the same – OT team now moved to PT dept – however rehabilitation medicine, neuro outreach and therapy Leads remain utilising the space. The deterioration of the building continues to be an issue, all previously identified issues remain. Most recently heating system has broken and advised by estates team that this is not cost effective to repair. Mobile heaters have been provided however on cold days temperatures remain low. Staff frequently wearing coats to keep warm. Staff priorities to utilise heaters to heat patient clinic areas. Divisional leadership team members have visited the department more recently. Estates team continue to source alternative accommodation however team are required to provide capacity and demand data before an alternative can be sourced. Re housed OT team and existing Physiotherapy teams continue to share space. [04/11/2024 11:02:36 Gemma Staples] We are currently looking at alternatives to the current establishment - we are being included in looking at the provision of outpatient off site. We are also looking at Therapy only options. [05/08/2024 11:06:56 Gemma Staples] Still awaiting on Estates to block off the corridors. We are working with Estates & Strategies to to look at service provision across therapies and rehab medicine to look at provision on and off site. There have been requests to Estates that have been declined due to cost and this is knock on effect on staffing. [07/05/2024 11:15:24 Gemma Staples] OT have moved into Physio now and Rehab Medicine are moving into the better part of the dept on 9/05/2024. The riskiest corridor will then be secured and locked and the other corridor will be storage only and limited access. Staff are reporting an impact on wellbeing capacity to do their job. There is ongoing lack of office space to be able to do none clinical work effectively and lack of space to accommodate lunch breaks. There is a clear drive for us to consider off site premises with the support of the Estates team.	4	31/03/2022	31/03/2023	02/05/2025

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
3c. A modern, clean and fit for purpose environment across the Group	5104	8	Regulatory compliance	Farquharson, Colin	Rinaldi, Dr Ciro	Estates Infrastructure and Environment Group		16/03/2023	10	Clinical Support Services	Path Links (Pathology)	Mortuary (Pathology)	Trust-wide	As a result of the HTA's concerns relating to the fabric and capacity of the Trusts mortuary service and the delay in timescales by which the Trust is able to refurbish these following the HTA inspection in May 2022. There is a risk that The HTA as the regulator could impose conditions on our licence to store the body of a deceased person within the Trusts mortuary facilities.	- HTA undertook an unannounced inspection during October/November 2024. This visit centred on the Lincoln site which was mid-refurbishment. No significant concerns were identified from HTA inspectors. -HTA oversight group has been established-meeting to manage the action plan. -Papers have been to CRIG for initial funding to establish planning and building work. This has been approved. -Draft business case has been developed and approved. -Initial concerns have been addressed from Lincoln site. -The Trust currently has two Titan units (temporary additional mortuary capacity) which provides additional capacity in the event of winter pressure peaks in demand and also in the event of equipment failure, although the Boston refurbishment has enabled the Titan unit at Boston to be no longer needed. -The Trust has a memorandum of understanding with Hull University Teaching Hospitals to support with the storage of bariatric bodies that require longer storage (freezer capacity).	ULHT Improvement action plan HTA Governance Group	25/11/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Risk reduction plan to assure HTA during March 2023 that risk was controlled as a result of above mitigations in place to address their immediate concerns over the Trusts mortuary estate. HTA have confirmed their acceptance of the Trust's plans to mitigate and have closed down their inspection process as complete. HTA unannounced on site inspection during October and November did not identify any significant concerns. Escalation of concerns to designated individual with respect to the Lincoln refurbishment process and security disparities in terms of alarm, CCTV and swipe card controls. Improvements made with alarm now fitted to Titan unit. CCTV repositioning has not been included in refurbishment plans Additional levels of swipe access not included as part of the refurbishment plans Refurbishment completion at Lincoln will result in this risk reducing in terms of likelihood	[25/11/2024 16:16:31 Gemma Staples] HTA undertook an unannounced inspection during October/November 2024. This visit centred on the Lincoln site which was mid-refurbishment. No significant concerns were identified from HTA inspectors. [22/08/2024 08:04:09 Gemma Staples] The HTA have recently confirmed to all Trusts about the greater powers of enforcement now granted which includes the ability to visit and inspect Trust's mortuary facilities unannounced. Plans are in place to review evidence required to ensure this would be available in such a situation and that this is of good quality. [17/05/2024 10:54:44 Gemma Staples] Risk remains the same as work is ongoing [01/02/2024 16:05:12 Gemma] Business Case has been approved at Trust Board and work has commenced on the Trustwide Mortuary Project [19/10/2023 15:50:44 Ciro Rinaldi] -HTA oversight group has been established-meeting to manage the action plan. -Papers have been to CRIG for initial funding to establish planning and building work. This has been approved. -Draft business case has been developed and approved. -Initial concerns have been addressed from Lincoln site. -The Trust currently has two Titan units (temporary additional mortuary capacity) which provides additional capacity in the event of winter pressure peaks in demand and also in the event of equipment failure. -The Trust has a memorandum of understanding with Hull University Teaching Hospitals to support with the storage of bariatric bodies that require longer storage (freezer capacity). [19/10/2023 07:47:27 Jeremy Daws] ELT provided with an update that plans approved, and building work scheduled to commence October 2023. At recent weekly mortuary refurbishment meeting, building commencement	20	31/03/2024	01/01/2025	25/02/2025
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5533	754	Physical or psychological harm	Mooney, Mrs Katy	Hunter, Sarah			07/11/2024	16	Medicine	Cardiovascular CBU	Stroke	Trust-wide	As a result of being unable to provide specialist assessment and investigation to people whom have had a suspected TIA within 24 hours [in line with guidelines] this may result in subsequent stroke due to a delay in intervention/treatment. Stroke may cause lifelong disability or death.	Reviewing patients as soon as we can in clinic and arranging investigations to coincide with clinic appointment [limited to imaging slots allocated per day] We convey ambulance referrals to have patients reviewed in ED by ACP team, if adequate space was provided for rapid TIA review there could be hospital avoidance [better patient experience/reduce cost and better patient flow]	Audit delays from referral to physical review in TIA clinic – Stroke Co-ordinator/service manager Recent data provided by Vascular team reports delays to carotid Doppler scans being performed, creating less benefit from surgical intervention which may result in no intervention being completed Datix review of hospital admissions with stroke symptoms post TIA clinic referral and not yet seen	03/02/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Allocate appropriate facilities for rapid TIA clinic – recommend similar set up to NOTTINGHAM or alternative – SOP attached. Area to assess patients perform clinic plus access to imaging [carotid dopplers & Head imaging in a timely manner- SDEC approach] Responsible divisional/service managers	[03/02/2025 11:22:54 Rachael Turner] The new TIA Pathway is currently in process, this pathway will streamline the service and will meet the need for patients to be seen within 24 hours. [27/11/2024 13:11:28 Rachael Turner] Risk presented at Risk Confirm and Challenge 27/11/2024. Risk validated as 4x4:16. Risk controls and reduction plan to be strengthened with current position.	8	07/11/2025		03/05/2025
2a. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	5469	697	Service disruption	Rinaldi, Dr Ciro	Chabiani, Manish			21/06/2024	16	Corporate	Medical Director's Office	Medical Education	Trust-wide	As a result of Pharmacy struggling to budget and recruit into the role whilst there are budgetary provisions on the medical education side there is a risk that without adequate educators we would fail to deliver the curriculum across the entire clinical years for years 3,4 & 5 which would lead failure of our contractual requirements and this would bring into question our newly gained status as a teaching hospital.	We are currently liasing with the Pharmacy department around the appointment of a part time prescribing skills lead. This would be a 50/50 appointment shared with the pharmacy team	Meeting reviews.	18/12/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Increase the workforce, investment into staff and education	[18/12/2024 11:06:27 Rachael Turner] Risk presented at Risk Register Confirm & Challenge 18/12/2024 this will be reduced following recruitment has taken place. Risk score to remain until established post. [26/11/2024 14:59:10 Rachael Turner] We have nearly come to an agreement with LCHS regarding a shared appointment. This is a now a low risk and may not require to be on the register. This risk will be presented at Risk Register Confirm and Challenge in December for a reduction in score. [31/07/2024 13:24:09 Rachael Turner] Risk presented at RRC&C meeting 31/07/2024. Risk validated as a High risk score 4x4:16 High risk.	8	21/06/2025		18/03/2025

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
4d. Enhanced data and digital capability	4658	17	Reputation	Warner, Jayne	Willey, Karen	Digital Hospital Group		10/01/2022	20	Corporate	Trust Headquarters	Corporate Secretary	Trust-wide	If the Trust does not have a defined records management framework/ strategy it runs the risk of not meeting national best practice and not making informed decisions in relation to Digital programmes of work. This could result in a breach of regulations and ULHT finding it difficult to meet national enquires that could lead to regulatory action and financial penalties. This risk has increased due to ongoing national enquiries and the move to a more digital way of records mgmt which whilst positive heightens the need to manage legacy and ensure expert RM support for future decision making.	The Trust has policies in place. Trust DPIA template included aspects on records mgmt and retention.	FOI compliance gives an indication of the Trusts position as compliance is linked to good records management. Reports of unmanaged records found in Trust locations.	29/01/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Requires a strategic decision from the Trust regarding a Records management lifecycle and level of expertise to advise and guide on future projects and developments. Needs to link into 365, ePR and EDMS Programme. 365 cannot be delivered with dedicated Records SME resource.	[29/01/2025 12:42:38 Rachael Turner] Risk discussed as part of the Deep Dive at Risk Confirm and Challenge meeting. This has started to escalated as its an area where we do not have a dedicated resources. Do to changes as a Trust there have been issues raises where records management issues have been identified. We are looking at how we can provide this resource, EPR being one of these resources. Currently score to remain at current level. [16/01/2025 10:50:39 Rachael Turner] Risk reviewed, consideration of Records Management resource taking place through development of Executive structures. [22/10/2024 09:20:44 Fiona Hobday] Still awaiting answer from Digital re money for resource. Move to national tenant has began- no SME to support. Project to procure scanning provider has started- no SME to support. EMDS project reaching contract award- no SME for any implementation. [10/09/2024 09:06:00 Fiona Hobday] Sept IGG- as part of risk review HofIG raised urgency for Trust to resolve RM SME resource due to key strategic projects. HofIG is currently supporting as much as possible- but is not current in field. Outstanding action for Digital to confirm funding in various project pots to inform discussion as to resource and where roles may sit. Final decision made re move to national 365 tenant adds to urgency to resolve this role. [27/06/2024 17:20:09 Fiona Hobday] *Need to resolve SME for RM is increasing and potential impact of not having one in post, e.g. EDMS procurement, 365 move. *No update from Digital re funding available from various projects. *Head of IG raised with new CRG Chair re issue of no clinical records SME. [23/04/2024 09:19:54 Fiona Hobday] Little progress: *Corporate- Action with Digital to identify all available funding in different project pots so Trust can look at options for RM roles.	4	28/06/2024	31/03/2025	29/04/2025
2a. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	4741	42	Service disruption	Lynch, Diane	Chester-Buckley, Sarah			13/01/2022	20	Clinical Support Services	Cancer Services CBU	Oncology	Trust-wide	As a result of lack of investment for Oncology workforce historically there is insufficient workforce to meet demand of the service (and we have recruited posts at risk above budget) which would lead to additional stress and burn out causing the remaining staff to leave. We are heavily reliant on high cost agency covering vacant posts due to the national shortage of Oncologists. If the service was to stop for specific tumour sites this would lead to significant patient harm whereby patients would have to travel following referral to neighbouring Trusts for radiotherapy and chemotherapy treatment, which in turn would put further pressure on other Trusts who could potentially collapse. Oncology is considered to be a fragile service due to consultant oncologist gaps. Demand vastly exceeds the capacity, requiring an increase in establishment. Oncology Consultants do not have capacity to review patients as required for their treatment which has a knock on effect on Pharmacy services. Tumour sites at risk (Medical oncology) - renal, breast, upper and lower GI, CUP, ovary/gynae, skin, testicular, lung, urology, HPB Clinical oncology - head and neck, skin, breast, Urology, Including testicular, upper GI (RT only). Due to only consultant covering Sarcoma retiring we will no longer have consultant cover for sarcoma from July 23. Particular areas of concern are Chemotherapy Lead. The workload is also unmanageable for current staffing levels of Middle grade/ACP workforce therefore adding to the fragility of the Oncology Service. Currently unfunded for LCH OAU. SPA time not able to be adequately given	Medical staff recruitment processes Agency / locum arrangements Extra clinics offered Unable to cover sarcoma due to no capacity/specialisation so this is now picked up by NUH Job plans continuing to be reviewed Recruited at risk over and above budget to support service Support offered through on-call consultant, this is not adequate due to their workload.	Monitoring tumour site performance data Datix incidents Complaints and PALS Outcome from Staff Survey results Financial constraints of group	20/01/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Need to undertake a fragile service review (Sarah Chester-Buckley - December 2024)	[20/01/2025 10:33:02 Gemma Staples] Business case now not going to CRIG, needs to be taken through Divisional PRM for funding, awaiting next meeting. [18/10/2024 10:37:20 Gemma Staples] CoN written to be submitted on 31st October 2024 to ensure this is included in the planning round 2025/26. [23/09/2024 09:58:14 Gemma Staples] Following the CSS Confirm & Challenge meeting it was agreed to combine this risk with 5180. [24/07/2024 11:38:27 Gemma Staples] Clinical Lead appointed due to start August 2024. SACT Lead appointed to, HR checks in progress, therefore no start date as yet. [23/04/2024 13:04:41 Gemma Staples] Risk reviewed and no further update [05/04/2024 10:41:51 Gemma Staples] Risk reviewed. No further update [05/04/2024 10:38:06 Gemma Staples] Consultant Oncologist workforce capacity [18/01/2024 11:26:42 Gemma] Oncology rightsizing paper currently being written. [14/09/2023 16:04:46 Rose Roberts] Ongoing [28/06/2023 14:43:05 Rachael Turner] Following this risk being discussed at RRC&C meeting, the question was raised around the number of patients currently waiting to be seen (including overdue) These are as follows: Oncology PBWL numbers as at 29/5/23: Lincoln County Hospital: Overdue: Clinical - 171 Medical – 55 Total number of patients on PBWL (including overdue): Clinical – 2169	4	31/03/2023	31/03/2023	18/04/2025
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5488	738	Physical or psychological harm	Rivett, Kate	Flatman, Deborah			12/07/2024	16	Family Health	Children and Young Persons CBU	Children's Community Services	Community	Patient safety risk from inadequate staffing Levels resulting in lack of capacity to safely manage the Children's Community Nursing Caseload. Potential for unrecognised deterioration due to lack of timely visits, increased hospital admissions due to inability to manage effectively in the community, plus increased length of stay due to inability to facilitate timely discharge into community. There is also a risk to staff health and wellbeing as a result of unmanageable workload.	Weekly Senior children's community nurse safety huddles to monitor staffing levels. Weekly CYP Senior Team huddle for escalation of situation Clinical governance reporting. Merged Boston CCN Patient caseload into Lincoln & Grantham CCN teams creating a North and South team due to lack of Boston Team Leader oversight & unsafe staffing > 75% CCN deficit. Approx 50 patients transferred to Grantham & 32 transferred to Lincoln. only 0.8wte Boston CCN available to Grantham. No Boston CCNs available to support Lincoln. Merger was to ensure Caseload oversight & review of Boston BCYP patients.	commenced submission of IR1s	21/01/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	CCNs from all x3 Teams regularly cross-cover and provide support to managing the county-wide caseload. There is UEC funding within the CCN budgets to recruit more CCNs	[22/01/2025 13:54:28 Nicola Cornish] This still remains an issue. 2 new staff are still completing their induction period and recruitment remains ongoing. There are 2WTE vacancies at Lincoln with 2 shortlisted candidates to be interviewed, 2.2WTE vacancies at Boston with 2 shortlisted candidates to be interviewed, and 1.43WTE vacancies at Grantham currently out to advert. [30/10/2024 14:50:31 Nicola Cornish] Discussed at Risk Register Confirm & Challenge meeting on 30th October 2024. The updated risk description was approved with a score of 16. [28/08/2024 14:35:58 Nicola Cornish] Risk discussed at Risk Register Confirm & Challenge meeting on 28th August. Not approved - need to update the risk description to include more detail about the impact on patients to justify high risk score. NC to work with KR to update. [16/07/2024 13:57:49 Nicola Cornish] New risk discussed with Kate Rivett. Agreed that proposed scoring of 16 is appropriate and Kate will present this to Risk Register Confirm & Challenge meeting for approval.	6	31/01/2025		21/04/2025

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5306	713	Physical or psychological harm	Cooper, Mrs Anita	Rambani, Reena	Maternity & Neonatal Oversight Group	28/08/2024	20	Clinical Support Services	Path Links (Pathology)	Microbiology (Pathology)		As a result of the inadequate resource of Microbiologists provided via the service contracted from NLAG, there is inadequate specialist input to ULH for complex cases or reviews on the correct use of high risk treatments used. This would lead to patient care being unsafe and can result in harm including death. It would also lead to extended hospital stays, readmissions, poor bed flow affecting access to Acute NHS care, increased morbidity and increases risk of antimicrobial resistance as a Public Health threat which harms our patients further. There are severe restrictions to prescribers accessing Microbiologist Specialist advice as it is now limited to Consultant level only that can access. This is resulting in patients being managed without the specialist required input, including for complex cases. Due to lack of Microbiologist capacity there is no pro-active input either in the form of Microbiologists undertaking regular ward rounds in high risk areas, no offer of call-backs, no Microbiologists delivering educational sessions, poor input in revising antimicrobial guidelines and no Microbiologist action on trends in a timely manner.	Currently being directed through Consultant Antimicrobial Pharmacist within own working hours and remit. Being flagged at various forums. Regular communication and reminders about availability of Antimicrobial team and guidelines and any resources available	Through antimicrobial consumption and surveillance Audit results Specialist time input from Antimicrobial Team Survey Pending Infection prevention & control surveillance and audits	31/01/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Trust to consider Antimicrobial Nurses - initiative put forward by ASSG and supported by MQG - as a matter of urgency Trust to review Microbiologist contracting - as a matter of urgency ASSG formally writing to clinical Directors (including ICB Medical Director) with this concern Antimicrobial Guidelines being revised to make them specific to ULHT rather than shared with NLAG as they are now.	[31/01/2025 15:31:36 Gemma Staples] We recently advertised three substantive posts and successfully filled one. The remaining two positions will be re-advertised. So the risk still remains , as it is. [18/10/2024 13:44:29 Reena Rambani] The restriction to calls from "Consultants and GPs only" were lifted end of August when a new locum Consultant Microbiology, Dr Rashmi Dube joined the team as NHS locum for 6 months.The three substantive Consultant Microbiology posts have been advertised and closing date is 31st October.Also another new locum Consultant Microbiology, Dr Milind Khare, has joined the department this week. Having said that, the risk due to staff shortage continues in Microbiology department due to planned leave of multiple colleagues for the next few weeks [28/08/2024 14:11:06 Nicola Cornish] Risk discussed at Risk Register Confirm & Challenge meeting on 28th August. Risk description updated to reflect that Microbiology is a service contracted from NLAG. Agreed score of 16 (Severity 4, Likelihood 4). [15/07/2024 12:45:42 Gemma Staples] Risk reviewed and details amended. Risk 5305 is a Reputational risk scoring a 12 and this risk is regarding the Patient safety risk. Risk to be presented by Bal at RRC&C in August 2024 for approval. [13/06/2024 14:21:57 Gemma Staples] Risk reviewed and assigned to Pathology - Bal to present at the next RRC&C meeting.	4	30/11/2025	01/06/2025	30/04/2025
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	4868	64	Physical or psychological harm	Farquharson, Colin	Martinez, Francisca	Maternity & Neonatal Oversight Group	01/03/2022	16	Clinical Support Services	Pharmacy CBU	Pharmacy		Preparation of Drugs for Lower Segment Caesarean Section (LSCS). 1. Medicines at risk of tampering as prepared in advance and left unattended. 2. Risk of microbiological contamination of the preparations. 3. Risk of wrong dose/drug/patient errors. Breach of Medicines Act: Regulation 3 of the Human Medicines Regulations 2021 permits doctors to prepare medicines for administration. The expectation would be that preparation would be in compliance with current best practice and governance expectations. Regulation 214 permits parenteral administration of medicines by or in accordance with the directions of and appropriate practitioner. This practice would constitute a risk to the patient and falls outside of expected governance arrangements detailed in Advice Note for Chief Pharmacists March 2017 NHS Pharmaceutical Quality Assurance Committee which defines acceptable practice as: administration immediately after (within 30 minutes) preparation and completed within 24 hours. It is noted the Trust Injectable Medicines Policy is in compliance with this expectation.	No current processes in place to minimise risk Policies do not support this practice	Incidents involving advance preparation of intravenous medication in clinical areas. Audits of compliance with standards / policy - The current labelling does not comply with national recommendation. Not all labels include the recommend identity (no dose/strength as per pictures). Also, no preparation date/time always included. There is no documented procedure stating the process to follow to ensure that the medicines prepared are discarded.	09/01/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	1. Use of tamper proof boxes/trays being purchased. 2. The only control to prevent the risk is to prepare the injections prior to administration (within 30 minutes) as per guidance (National and Trust). 3. If the practice is to continue, the prepared products should be labelled to include the recommended information. A procedure should be developed indicating the process to follow to ensure the medicines drawn up are discarded at the end of the day.	[09/01/2025 14:22:58 Lisa Hansford] No update [10/10/2024 10:10:14 Lisa Hansford] No further update [10/07/2024 11:13:39 Lisa Hansford] no further update [04/04/2024 09:02:51 Lisa Hansford] NO FURTHER UPDATE [29/12/2023 13:33:55 Lisa Hansford] No further update [26/09/2023 14:17:01 Rachel Thackray] Meeting to take place to review progress [20/07/2023 10:43:27 Lisa-Marie Moore] narrative updated to reflect conversation between Fran Martinez and Regional QA about breaching medicines act regulation 3 [27/06/2023 09:45:38 Alex Measures] Discussed in risk register review meeting- no further updates [01/06/2023 14:26:57 Lisa-Marie Moore] Risk assessment resent to anaesthetists - to discuss at next MQG. If no further progress to discuss with CQC [04/05/2023 14:26:40 Lisa Hansford] needs to go back to MQG [29/03/2023 10:16:01 Maddy Ward] This risk needs to go to MOpS for escalation to medicines quality group. [21/02/2023 08:53:55 Paul White] Note from Risk Register Confirm & Challenge Group - risk to be reviewed from Family Health perspective, including current rating and where responsibility for the risk should belong. [05/01/2023 14:08:19 Lisa-Marie Moore] To be raised again at MQG and action to be taken agreed Following a Datix (ref no: 255637), it has been identified that intravenous medication required for a Lower Segment Caesarean Section (LSCS) is being prepared in advance of the procedure in case of an emergency. The Lead Obstetric Anaesthetist has discussed the practice with the team and the consensus is that for safety the drugs need to be prepared in advance for potential emergencies. The team has sourced tamper proof drug trays to store the drugs once prepared. This risk assessment has been done for Pilgrim Hospital,	4	30/09/2022	31/03/2023	09/04/2025
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	4935	58	Service disruption	Farquharson, Colin	Sewell, Chris	Workforce Strategy Group	26/05/2022	16	Surgery	Theatres, Anaesthesia and Critical Care CBU	Critical Care		Insufficient medical staffing in Intensive Care Units at Lincoln and Boston. Uncovered shifts may result in Unit being decompressed. Medical staff asked to work extra hours compromising workforce directive. Unsafe cover in Unit when doctors are called to attend patients in A&E. Could result in harm to both patients and staff (in terms of wellbeing/morale).	Locums to recruit. Recruitment adverts out. Staff are being paid in TOIL in order to mitigate the financial risk to staff. Rotas are set and monitored -a Consultant formulates the rota and identifies gaps which cannot be covered in advance. Agency requests. Escalation to Divisional Triumvirate when gaps cannot be filled. Escalations are made to the medical director re payment agreements in accordance with NHSE/I policy. Business Continuity Plans are in place for both sites.	Rotas (gaps). Agency spend - financial risk. Number of Datix incidents recorded.	11/09/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Recruit to vacant posts.	[11/09/2024 14:27:43 Nicola Cornish] Risk reviewed, no change. [14/06/2024 13:17:32 Nicola Cornish] The JD has now been approved and the consultant post is currently out to advert. [28/05/2024 14:47:03 Nicola Cornish] No further update [23/04/2024 14:15:23 Nicola Cornish] No change. ICU oversight group continues with x 3 workstreams. Have x 3 TACCP's in post [18/11/2023 21:05:16 Nicola Cornish] No change to risk score. Have an ICU oversight group with x 3 workstreams one of which is workforce. Meets weekly to look at recruitment and medical workforce. We have recruited trainee ACCP's which won't solve current issues but is future planning. [15/06/2023 09:32:33 Wendy Rojas] No change to risk status.beds capped at x8 L3 [18/04/2023 13:52:46 Caroline Donaldson] No change in risk status. Bed base number remains at x8 Level 3 beds. [09/01/2023 14:27:52 Caroline Donaldson] No change in status - still remains an issue. Bed base numbers remain reduced at x8 Level 3 beds. [29/11/2022 15:16:01 Caroline Donaldson] 17/11/2022 Discussed at TACC CBU governance meeting. Still remains an issue. [19/10/2022 15:22:43 Caroline Donaldson] 19/10/2022 CBU are looking to request an escalated rate for recruitment. Paper is currently in progress to request. Confirmed by S Daniels. Quality Impact Assessment undertaken and LCH ITU reduced to 8 x L3 bed equivalents on a temporary basis. For review Update 25.7.22 - substantive advert closes 8th August 2022. Locum advert is closed but awaiting shortlisting. Awaiting confirmation of interview date but looking like 27.9.22. Escalated to Medical Director and COO re decision to continue L3 equivalent reduction at current time.	4	31/10/2022		11/12/2024

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
1b. Improve patient experience	5495	725	Physical or psychological harm		Grooby, Mrs Libby	Bond, Rachel	Estates Infrastructure and Environment Group, Patient Experience Group	07/08/2024	16	Family Health	Women's Health and Breast CBU	Obstetrics	Lincoln County Hospital	Lack of adequate provision for appropriate clinical care of bereaved families within Obstetrics at Lincoln County Hospital. There is a risk of psychological harm due to hearing labouring women and crying babies, and having to share facilities with mothers and their new-borns.	Have allocated a room on labour ward to care for the women, which is not within the centre of the labour ward and has its own en-suite facilities. Women not to be moved to Nettleham ward at any point during their admission.	Incident reports PMRT reviews Patient complaints	24/01/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Specific bereavement facilities to be included as part of proposed redevelopment of labour ward - unknown timeframe.	[24/01/2025 10:32:31 Nicola Cornish] Discussions are still ongoing with Facilities on how the room can be sound-proofed. [09/12/2024 14:36:27 Nicola Cornish] There are plans to move forward with changing one of the labour ward rooms into a designated area for bereaved families. Talks currently underway with specialist bereavement Midwife, inpatient Matron and HOM of how to move forward with this plan. [25/09/2024 13:22:59 Nicola Cornish] Discussed at RR Confirm & Challenge meeting on 25th September 2024. Panel queried scoring of 16 - Gemma Rayner explained that this issue is a common finding in every PRMT review at Lincoln whereas it is not found at Boston. Significant patient complaints regarding psychological harm - one patient described it as torture. Scoring of 16 approved. [07/08/2024 10:27:39 Nicola Cornish] Plan to enhance facilities in a designated room on labour ward to improve patient experience with current confinements.	4	07/08/2025		24/04/2025
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5515	737	Service disruption		Grooby, Mrs Libby	Sant, Manjusha		25/09/2024	16	Family Health	Women's Health and Breast CBU	Obstetrics		Due to increasing demand for Elective Caesarean Section (El LSCS) exceeding the capacity of the current dedicated El LSCS lists, the maternity service is having to perform El LSCS outside of the planned pathways using both the emergency medical and theatre teams. As a result, there is a risk of severe harm or death to mother and baby should a second emergency arise whilst the second emergency team is performing an elective procedure. Currently there are dedicated El LSCS list on a Tuesday and Thursday morning at the Lincoln site and all day Wednesdays. On average Lincoln performs 2-3 El LSCS every day Monday - Friday. At Boston there are 4 on a Wednesday and 2 on a Friday.	Elective section activity is managed on a daily basis and cancellations made where required. Additional emergency team called in when required.	Any delayed, cancelled LSCS or when the 2nd theatre is opened are reported on Datix	24/01/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Exploring with theatres the ability to provide further El LSCS lists across both sites.	[24/01/2025 10:29:29 Nicola Cornish] Risk reviewed, no change. [30/10/2024 14:44:18 Nicola Cornish] Discussed at Risk Register Confirm & Challenge meeting on 30th October 2024. Panel approved the score but requested mitigations described are reflected in the Datix record. ULHT is not an outlier in terms of our ElCS rate. [25/09/2024 13:24:51 Nicola Cornish] New risk agreed by Libby Grooby. To be added to agenda for October RRC&C meeting for approval.	2	30/09/2025		24/04/2025
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	4843	57	Physical or psychological harm		Landon, Caroline	Landon, Caroline	Medicines Quality Group	19/01/2022	20	Corporate	Operations	Operations		As a result of a lack of Immunologist within the Trust, Screening, management and review mechanisms of patients requiring or in receipt of Intravenous Immunoglobulin (IVIg) is inadequate. The Clinicians prescribing Immunoglobulin are not able to receive advice from an Immunologist and as a result patients could receive incorrect treatment. Patients are receiving Immunoglobulin for longer than they should be.	National policy: - NICE Guideline NG5: Medicines optimisation, etc. ULHT policy: - Policy for Medicines Management: Sections 1-8 (various approval / review dates) ULHT governance: - Trust Board assurance via Quality Governance Committee (QGC) / Medicines Quality Group (MQG) Antimicrobial and High Cost Drugs Management Pharmacist undertaking administrative functions to ensure all referrals are screened and are done so in a timely manner.	Reported incidents involving use of Intravenous Immunoglobulin (IVIg)	15/01/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Employ an immunologist or have a local agreement with another Trust to have immunologist support - Colin Farquharson - End of December 2024 Shared Care arrangements and prescribing accountabilities to be reviewed - Colin Farquharson - End of December 2024	[15/01/2025 13:41:06 Rachael Turner] Risk reviewed, due to being able to seek advise from other colleagues at Nottingham and it not being a clinical requirement this likelihood score to be reduced. Therefore risk score to be reduced to 2x4:8 Moderate. this risk to be presented at February RRC&C meeting. [02/09/2024 17:26:56 Gemma Staples] Risk agreed to sit under COO - now amended [24/07/2024 11:19:33 Gemma Staples] Sarah Chester-Buckley has spoken with Consultant Haematologist Charlotte Kallmeyer regarding this risk. Haematologists are able to prescribe Immunoglobulins without the input of a Immunologist. Previously the Trust employed an Immunologist for a small number of PAs, this is not required for the Haematology service as patients can be discussed with colleagues at Hull / Nottingham. [22/07/2024 12:54:39 the reporter] 22/07/2024 - Risk reviewed ad reworded with Fran. To discuss risk with Sarah Chester-Buckley. [09/07/2024 09:17:09 Gemma Staples] Incident reviewed and requires review on the incident. Gemma to meet with Fran to update the risk. [26/06/2024 09:36:19 Gemma Staples] Colin suggested this should still sit under CCS still under Haematology instead of Pharmacy as they are more likely to be administering the care. Now amended [04/04/2024 08:50:30 Lisa Hansford] no progress [29/12/2023 13:42:16 Lisa Hansford] No further update [26/09/2023 14:14:06 Rachel Thackray] Progress ongoing with regard to shared care [27/06/2023 09:45:04 Alex Measures] Discussed in risk register review meeting- no further updates [26/06/2023 13:55:27 Lisa Hansford] Risk discussed with Paul Dunning. Sue Leo to give PD list of patients that this effects. PD to review information and discussed with NHSE again.	4	01/10/2021	31/07/2023	15/04/2025
3c. A modern, clean and fit for purpose environment across the Group	5334	533	Physical or psychological harm		Grooby, Mrs Libby	Carr, Katy		26/01/2024	15	Family Health	Women's Health and Breast CBU	Obstetrics	Pilgrim Hospital, Boston	There is no second theatre within the confines of the labour ward within which to undertake any theatre based procedures when Theatre 8 is already in use. In time critical scenarios the increased time taken to transfer to Theatre 1 on ground floor and commence surgical management may impact on the health and/or wellbeing outcomes for mother and/or baby. There is a patient experience risk due to a lack of privacy and dignity for women when transferring to ground floor theatres through public corridors. There is also a potential for an increase in Caesarean Section rate as clinicians attempt to avoid late labour transfers.	Multi-professional discussions in relation to plans of care. Out of hours – on call maternity manager available for support. Dedicated theatre available in ground floor theatre. Close monitoring of labour ward activity. Publication of Standard Operating Procedure (SoP) Labour Ward Manager / Matron / Labour Ward Obstetric Lead to have an awareness of all theatre cases. Visible management and Leadership/active on call support to teams PMA support	Closely monitor all cases where woman transferred to theatre before or following birth – daily Medway report for scrutiny. Regular review of Incident reporting system.	24/01/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	To inform teams of the risk controls in place. Coordinate Estates to undertake the works on Theatre 8a to minimise disruption as soon as practicably possible.	[24/01/2025 10:34:50 Nicola Cornish] This issue is ongoing and will remain the same until the refurbishment programme has been completed. Continue to receive patient feedback about poor experience of being moved through corridors. [09/12/2024 10:11:00 Nicola Cornish] Risk reviewed by Emma Upjohn - no further progress, still awaiting trust board decision regarding refurbishment plans for the whole maternity unit at Pilgrim. [25/09/2024 13:09:11 Nicola Cornish] Discussed at RR Confirm & Challenge meeting on 25th September. Acknowledged the mitigations in place and requested that data on incident numbers/harm occurring is included in progress updates. [09/07/2024 16:09:21 Nicola Cornish] This is ongoing, it is being be picked up as part of overall refurb at Pilgrim. [04/04/2024 10:33:53 Nicola Cornish] Risk reviewed, no change. [31/01/2024 13:01:35 Rachael Turner] Risk discussed at RRC&C meeting 31/01/2024. Need to know frequency when this is happening. Agreed currently that this sits at a 4x4: 16 High Risk. Link to be added around regulations.	6	01/01/2025		24/04/2025

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
4d. Enhanced data and digital capability	5245	19	Service disruption	Young, Jonathan	Humber, Michael			30/08/2023	20	Corporate	Finance and Digital	Digital Services (ICT)	Trust-wide	The Trusts disaster recovery capabilities are limited. In the event of a major incident affecting the primary data centre/site the ability to restore services elsewhere is limited. This would affect the availability and data integrity of tier 1 clinical and corporate systems, leading to extended unavailability and reliance on Business Continuity Plans. In addition there is a risk of significant data loss in the event that recent backups are unavailable or compromised.	-Business Continuity Plans which the Trust is planning to exercise of a regular basis via Emergency Response. -Annual SIRO approved incident response exercise. -Protections that reduce the likelihood of various disasters, including environmental and technical controls: A number of improvements have been made in this area. We now have a dedicated ""stretched"" Metro cluster between Lincoln and Boston. We also have Standard clusters at each site which have increased capacity. -Immutable Backup system introduced to ensure organisational data is held securely and available for recovery, this includes off site cloud storage for critical data	-Annual SIRO approved incident response exercise. -Incidents reported via Datix these are backed up via an RCA and lessons learned.	20/01/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Whilst some systems still need to transition fully with VLAN/IP changes we do have new systems and system upgrades migrating to the new solution. Enabling Tech programme in place to improve the Trust Foundations from which the Digital Services will run. This requires completion prior to remobilisation of EPR. Trajectory for this is 2025/26.	[27/01/2025 09:44:28 Rachael Turner] In addition to the implementation of Rubrik, the Trust uses resilience direct to store important procedural documentation, BCP and contact lists such that in the event of system loss, recovery and build documentation can be pulled from this cloud resource. Development of the overall Digital Services BIA and BCP has progressed significantly and will be presented to the relevant Trust committees/groups in reasonable time. [19/09/2024 16:39:50 Rachael Turner] This risk is linked to risk 575. In that we have commissioned the Rubrik product that manages our backup processes and also keeps an immutable copy in the cloud which allows restoration to anywhere. This system is being refined with Operations to prioritise systems into P1, P2,etc for DR instances and provide a plan for recovery if a complete or partial lose of infrastructure is felt. [14/08/2024 21:12:12 Rachael Turner] Work has been ongoing for a while to purchase and install a new backup and recovery tool. This is now in place and has been commissioned, it provides both on site and cloud capability and also immutable capability. This provides for a much more hardened and capable solution if ever required in anger. We are also able to preform full recovery testing. Work now continues with the Operations team to identify critical systems first to apply the solution to. [17/05/2024 10:42:15 Rachael Turner] Implementation of Rubrick continues. Risk score currently remains. [30/01/2024 11:04:10 Rachael Turner] Risk reviewed. Risk controls and reduction plan updated. Risk score to remain. [20/12/2023 09:22:32 Rachael Turner] In the process of implementing Rubrick, which will support disaster recovery and cloud back up. [30/08/2023 16:06:58 Rachael Turner] Risk discussed at RRC&C meeting	10	30/08/2024		20/04/2025
3c. A modern, clean and fit for purpose environment across the Group	5272	455	Physical or psychological harm	Mooney, Mrs Katy	Miller, Mrs Sally			06/10/2023	12	Medicine	Cardiovascular CBU	Cardiology	Lincoln County Hospital	Lincoln cardiac catheter lab is not connected to the emergency power supply at Lincoln County Hospital. There is currently emergency power to safely abort procedures, however without being connected to an uninterrupted power supply we could potentially be unable to offer a PPCI service (primary percutaneous cardiac intervention). There is a risk if any patient undergoing a procedure at a time of a power cut that loss of power could result in serious harm or death or possible implications around infection.	Temporary electrical fix via Estates-UPS-however there have been mechanical failures which has required Estates to manually to change it over. Estates had a third party assess the UPS switch-this needs to be re-wired but are currently awaiting a date for this to be carried out. Both of the Cath Labs will need re-wiring. Estates have stated they cannot provide power in the event of national grid power outage. Business Continuity Plan Cath Lab-short term power cut would look at utilising Thrombolysis. Prolonged power outage we would need to request mutual aid from those that offer PPI in neighbouring organisations.	Monthly audit internally (Cath Lab) Incidents of power outage raised on Datix.	02/12/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Job has been raised with Estates-this may be tied in with Lab replacement. Request to Estates to provide sufficient power to Cath Lab during a power outage has been made. Estates are currently working on solutions for this.	[02/12/2024 09:10:52 Rachael Turner] Both labs were tested this morning (29th November) simulating a power cut. Lab 2 worked as planned. During the simulated power cut screening was provided by the 3 phase UPS. When power was restored by estates lab2 reverted back to normal operation. In Lab1 the simulation was repeated. Cath lab 1 did not perform as expected. During the simulated power cut the machine did not switch over to the UPS as expected. The power supply was struck in what Siemens call emergency by-pass. This is the same situation that happened during the last proper power cut where the pacemaker case had to be stopped mid case. There is an automatic switch in the circuit that is supposed to detect a loss in power and then switch over to 3 phase UPS. It is our understanding is that it is this automatic switch that has caused the failure. We are currently waiting on estates to give a time when the work can be carried out. [27/11/2024 13:36:30 Rachael Turner] Risk presented at Risk Confirm and Challenge, risk validated for increase in score 4x4:16 High Risk. [13/11/2024 10:56:53 Rachael Turner] Incidents raised relating to this are: 23069 & 23237 [13/11/2024 10:26:28 Rachael Turner] Risk reviewed. Controls and risk reduction plan updated. There was recently an incident where a patient was on the table where a national grid power cut occurred. Although there was no harm caused to the patient there is an increased risk of infection due to the patient having to be re-opened to continue with the procedure. With these incidents increasing there is a increased risk of severe harm or death to patients. With previous mitigation	1	31/12/2023		02/03/2025
1c. Improve clinical outcomes	5154	88	Regulatory compliance	Simpson, Mr Andrew	Hansford, Lisa			17/04/2023	16	Corporate			Trust-wide	The Trust currently does not have a Medicines Management or Intravenous Drug Training package on ESR. Previous Medicines management training was removed when the ESR software was changed. Usually all new nurses will be required to complete the medicines management training as part of the mandatory training. This is to support them to be able to administer medicines to patients. Without a robust Medicines management training package staff will not have access to the r Medicines Management training that has previously been available, which is not in line with Trust standards. This could potentially lead to harm to our patients from medication incidents, we will not be adhering to CG174, NG29, SG1 and QAPPS minimising injectables risk. Risk of breaching CQC regulation 12: Safe care and treatment also	All staff will have had undertaken some level of medicines management as part of their professional qualification, however standards are inconsistent and not aligned to trust standards. National (CG174, NG29,SG1) and Local policies and guidance indicate that training should be available to staff to support in administration and safe medicines management. Additionally won't be compliant with QAPPS in relation to minimising injectable medicines risks. CQC regulation 12: Safe care and treatment all indicated training should be available. None currently in place in the Trust. There are new staff that have comenced employment with the organisation that cannot access the trust medicines management training and ward and department leads require a decision to be made as to whether or not these staff can administer medication.	Reported incidents, Staff feedback on training and support available in staff surveys. Inspection feedback	09/01/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	The Medication Safety Team have written the Medicines Management, Controlled drugs training and the Drug Administration Programme. These training documents are also to be supported by the nationally recognised eLearning for health IV therapy passport. These training packages are under review by MOpS group before they can go through the governance process. The governance process is likely to take a number of months. There is then the added task of getting the training packages put onto ESR and mapped to the correct staff. ESR team is severly understaffed which may delay the process further. As an interim measure to reduce this risk level, once the training packages have been through the relevant governance processess, there could be the option to add the training power points to the Trust intranet. This would not be mapped to staff members, however we could signpost staff to this and local training completion records could be kept by the ward/department leads.	[09/01/2025 14:34:06 Lisa Hansford] Awaiting Medicines management and controlled drug training packages to be added to ESR. The IV therapy passport is now on ESR. [10/10/2024 10:14:02 Lisa Hansford] Awaiting packages to be uploaded to ESR [10/07/2024 11:11:57 Lisa Hansford] no further update [04/04/2024 09:01:18 Lisa Hansford] Still awaiting this package to be uploaded to ESR [29/12/2023 12:57:50 Lisa Hansford] Awaiting education and training team to upload to ESR [06/12/2023 14:55:35 Gemma] Training packs signed off through governance process Awaiting update from Education and Training team when these will be uploaded to ESR. Delay in this due to vacancy in their team [07/09/2023 14:09:00 Lisa Hansford] 7.9.23 Signed off by APPG and will go to NMAFF on 8.9.23 for final ratification [13/06/2023 12:46:40 Lisa Hansford] Training packages to be signed of by MOpS by 20th June. Then will continue through the governance process before they can go on ESR [04/05/2023 14:24:40 Lisa Hansford] No update as waiting to go through MOpS process [26/04/2023 11:14:07 Rachael Turner] Risk validated at RRC&C Meeting 26/04/2023 as a score of 16 High Risk. Risk to go to Medicines Quality Group to expedite risk.	8	31/03/2025		09/04/2025

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
2a. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	5563	782	Physical or psychological harm	Mooney, Mrs Katy	Smith, Charles			19/12/2024	16	Medicine	Specialty Medicine CBU	Neurology	Trust-wide	As a result of impending retirement of 50% of the substantive workforce in Apr 2025 and a challenging national recruitment environment; there is a risk that the trust's Neurology service will cease to function sustainably. This would lead to a risk of harm to patients via delayed outpatient appointments, delayed inpatient reviews and an inability of the service to meet it's demands. Prior to the impending retirement, the Neurology service is already in a situation whereby substantive capacity does not meet recurrent demands on the service At present Neurology has 5485 overdue patients on its PBWL, 44% of which (2415) are overdue by more than 1 year. At this time there is no clinical capacity (for all the reasons highlighted in this report) for any clinical validation of this backlog and no available administrative resource for a data cleanse. It may be some of these patients no longer require follow-up, are now under the care of other centres or represent duplicates. Upon review of current demand and the loss of capacity approaching in the service, it has been estimated that if no additional capacity or mitigations are possible the PBWL could approach 12000 patients by the end of the 2025/26 financial year with roughly 8500 of these being overdue.	Agency workforce already in place to supplement establishment that is not right-sized to service demands JDs being sent to Royal college for recruitment of substantive vacancies (with interim 6mo locum) One of retiring consultants has agreed to do x2 monthly weekend clinics for 6mo to support Botox FUs who have no alternative treatment provider.	-Substantive workforce against establishment -Size of PBWL -NEW backlog/Booking timeframes	29/01/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Action 1. Working group convened to discuss plans for service as current model not appropriate. Have met twice as of 19/12. Action 2. Discussions to take place with contracting team/ICB re: discussion of service model for Lincolnshire. Action 3. Meetings taken place with NUH to discuss interim measures for balancing workload/pt cohorts.	[29/01/2025 13:25:15 Rachael Turner] Risk presented at RRC&C meeting 29/01/2025. Current backlog of 5000 patients but this is with a full workforce. Agency workforce is in place and we are going out to advert. There will be no provision for new patients for Botox. Initial discussion has been had with ICB. Neurology is a difficult area to recruit. Risk validated at 4x4: 16 High Risk	8	19/12/2025		19/03/2025
3c. A modern, clean and fit for purpose environment across the Group	5136	10	Physical or psychological harm	Parkhill, Michael	Davies, Chris	Health and Safety Group		28/03/2023	20	Corporate	Estates and Facilities	Estates	Trust-wide	Following monitoring for Nitrous Oxide levels in Pilgrim and Lincoln (Theatre and Maternity Units), it was identified that in a number of locations, staff were exposed to higher levels of nitrous oxide where levels exceed the Workplace Exposure Limit (WEL) OF 100 ppm (8hr time weighted average (TWA)).	Following notification the following actions were undertaken: Pilgrim Hospital – Labour Ward: Estates staff checked the supply ventilation from the Air Handling Unit (AHU) to the Supply Grilles within the labour rooms. At the time of inspection, the Estates staff identified the dampers restricting airflow were not adjusted correctly. This was addressed and airflow checks were undertaken. Typical air change rates were around 6 air changes per hour (ACH) – current guidance is a minimum of 10 ACH, however the ventilation systems are circa. 1960 and the guidance is not retrospective. Following the actions undertaken, resampling commenced 15th March (15 sample tubes), 13 were within WEL limits, but 2 sample results were recorded at 255 and 407 ppm (8 h TWA) in Rooms 2/2a and Room 3, respectively and exceeded WEL limits. Estates are reviewing the current system to look at increasing air changes by upgrading the supply fans / changing pulleys / upgrading filter media or a combination of factors. Further works to increase ventilation has been completed and whilst not HTM03 compliant by design - supply ventilation has been increased to reduce the risk of WEL exceedance. Lincoln Hospital - Labour Ward: Estates staff found the ventilation system had been isolated (approximately 10 years ago). Following discussions with Estates members, the ventilation system had failed and was deemed beyond economical repair and a decision had been made not to replace (no one is aware of why this was made or by whom). Estates plan to reinstate the ventilation, where feasible, which will likely include partial refurbishment and deep clean of existing systems. N.B the use of sampling tubes to monitor Nitrous oxide levels can be highly time and place dependent, the person with the sampling equipment and their activities, can indicate exposure levels that are as a result of human error, not as a failing of the environment. As such G210 analysers specifically designed for highly accurate measurement and verification of the quality of piped N2O and O2 gases, are being sourced.	-COSHH assessments and training. -Health Safety Environmental and Welfare Operational Audit programme. -Direct involvement with Occupational Health. -Datix incident reporting.	21/01/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	The issues identified with exposure levels are not unique to ULHT, as with most NHS Trusts investment is required to upgrade Ventilation to comply with HTM 03-01. NHSEI issued guidance on the 2nd March 2023 for NHS Trusts to follow. Noting where ventilation is insufficient, human factors are critical in reducing staff exposure, such as: 1. Providing clear instructions to patients on correct use of equipment being used, including exhaling into the rebreather mask or out through the mouthpiece 2. Staff positioning relative to exhaust N2O and the direction of ventilation flow 3. Turning gas and air off when not in use 4. Unplugging regulators from outlets when not in use 5. Monitoring the condition of equipment for leakages. These factors can't directly be influenced by Estates and require the support and influence of Clinical Leads and Occupational Health. ULHT Health and Safety Team have recently implemented software to assist with COSHH assessments and training. The Team provide support with the Health Safety Environmental and Welfare Operational Audit programme. Occupational Health have been directly	[21/01/2025 12:15:52 Rachael Turner] Lincoln we are looking at getting more monitoring equipment. There is a licence issue with getting the data onto our Trust computers. Update required around ventilation. [17/09/2024 08:44:20 Rachael Turner] We continue to monitor Datix in regards with Occupational ill health. Zero Datix have been received around Nitrous Oxide [17/09/2024 08:43:11 Rachael Turner] The ventilation systems are still not functioning as expected, work with a consultant is currently in place and exploring alternative ventilation options. [25/06/2024 09:13:33 Rachael Turner] Discussion to be had with Health and Safety Team for update and to share this risk. Chris Davies will discuss this next week. [20/03/2024 14:46:36 Rachael Turner] Update from Health and Safety: PHB indicates no staff exposure exceeding values for nitrous oxide Workplace Exposure Limit. LCH does refer to x1 member of staff carried out on 29.08.2023 values cause for concern, the following day the values were no cause for concern. To date I am unaware of any referral to Occ Health relating to this employee. The work to provide a safe of work/ protocol was completed with Maternity Leads and the Cadmus system is available for department leads to provide local monitoring. It would be prudent to reduce the risk bearing in mind that this subject remains on the Maternity agenda (National Survey). The two most recent reports carried out on 30th May 2023 for PHB and 6th September 2023 LCH have been attached to this risk. Estates will undertake some further air change monitoring to ascertain if any further work is needed on the ventilation at LCH, we may then need to think about re-testing	10	28/03/2024		21/04/2025
1b. Improve patient experience	5234	510	Service disruption	Lynch, Diane	Biddulph, Victoria			25/08/2023	15	Clinical Support Services	Diagnostics CBU	Neurophysiology		No clinic space at Pilgrim Hospital resulting in only ad-hoc provision of outpatient nerve conduction testing at the hospital. Previous clinical space was taken from the service due to ED/UTC projects with temporary agreement for clinic room (agreed in 2020) ending in October 2022 with PHB physiologist retirement. No EEG or EMG service provided at PHB currently. No Inpatient provision for testing at PHB. Inpatients requiring tests have to be transferred by hospital transport to Lincoln County for testing. Current risk is not being able to restart the service. At the moment, this is an unequitable health offering.	Adhoc bookings of space available within Outpatients at PHB. Booked where and when possible.Recruitment of new overseas Physiologist has been undertaken and completed. The staff member is fully trained and ready to start clinics in PHB when appropriate, permanent space is provided. Space must meet IPC requirements.	Waiting times, travel times, Patient Feedback, IP LOS impacted by the service being unavailable on site.	29/11/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Adhoc sessions being booked for Outpatient provision where space can be found. No plan for IP on site.	[29/11/2024 14:16:09 Gemma Staples] Meeting was held on the 27/11/2024 with Family Health and the risks were discussed and Simon Hallion escalated to estates stating the urgency to get this resolved. Handler amended to Victoria Biddulph. [03/09/2024 12:06:05 Gemma Staples] This has been escalated to Estates asking for an update and a quote. Email sent on the 7 of august. [17/06/2024 10:08:42 Gemma Staples] It has been agreed - we are waiting for Estates to confirm the costs and dates for the enabling works. IPC have reviewed and are happy with the plan [19/03/2024 10:38:03 Gemma Staples] In January we submitted a change of use form to Estates, chased this in February and March and to date have not had a response. [31/01/2024 11:37:43 Rachael Turner] Risk discussed as part of the Deep Dive at RRC&C meeting 31/01/2024. Risk score reviewed and updated to 4x4:16 High risk. [11/12/2023 13:05:50 Gemma] Risk reviewed. No change [13/09/2023 12:20:09 Maddy Ward] From an estates point of view, there is no plan to restart the service. This has been passed to project manager in estates to review clinical space (chased today). A suitable sized, permanent room is required. Started space request in September 2022 and meeting in July 2023. There has not yet been a date given for a clinical space review.	3	26/08/2024		28/02/2025

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	4746	121	Physical or psychological harm	Lacey, Mark	Knapp, Chris	Clinical Effectiveness Group, Outpatient Improvement Group	14/01/2022	20	Surgery	Urology, Trauma and Orthopaedics, and Ophthalmology CBU	Ophthalmology		Overdue patients on the Trust-wide Ophthalmology Partial Booking Waiting List who wait for longer than the expected wait time specified by clinician. This may result in deterioration of eye condition.	Ophthalmology / Surgery Division clinical governance arrangements Outpatient / PBWL management processes The e-Outcomes Out-Patient clinic system has had an additional field added to record these required appointments which will be greater than 6 weeks.	Monitoring Ophthalmology PBWL Clinical harm reviews / reported incidents due to appointment delays	07/10/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Need to ensure future sustainability once recovered.	[08/10/2024 12:59:55 Nicola Cornish] 07/10/2024 - Leanne Chamberlain no changes [04/09/2024 16:16:00 Nicola Cornish] Discussed at Ophthalmology Governance meeting on 4th September. Agreed that scoring should increase to Very High. Recruitment to vacant posts within the establishment is ongoing and working with the ICB to review how stable glaucoma patients can be managed in the community to free up clinic capacity to review patients with higher clinical urgency. Explore options for holding extra clinics at the weekend if clinicians are willing to participate. Also need to review how existing clinics are utilised to enable trainees to see patients where appropriate. Review other strategies within each sub-specialty eg medical retina could switch to longer acting injections such as Eylea HD that require less frequent review, although this needs agreement with Pharmacy as it is not a pre-filled injection. [28/08/2024 13:38:12 Nicola Cornish] NC to work with LC to action this and present any changes to next meeting for approval. [28/08/2024 13:37:28 Nicola Cornish] Risk discussed at Risk Register Confirm & Challenge meeting on 28th August. Panel felt that scoring should be reconsidered as the likelihood appears to have increased due to the increase in patients on the PBWL. The mitigations in place also need to be described in more detail and risk reduction plan to include discussion with LCHS about what support they could provide. [27/08/2024 15:14:20 Nicola Cornish] There are currently 5000 patients on PBWL, which is a significant increase from 4000 patients when the risk was first raised, despite the mitigations in place. All patients on the PBWL are being reassessed and prioritised so they are seen in order of clinical need rather than date order. Further vacancies have cancelled out the additional capacity that had previously been created by engagement of a locum doctor to focus exclusively on the PBWL. Recruitment requires the job description to be agreed by Royal College of	4	31/07/2021	30/06/2022	07/01/2025
2a. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	5422	684	Service disruption	Costello, Mr Colin	Martinez, Francisca	Medicines Quality Group	28/08/2024	16	Clinical Support Services	Pharmacy CBU	Pharmacy		As a result of Chemotherapy prescriptions not being prescribed in a timely manner this impacts on staff health and wellbeing due to additional stress to staff. There have been a significant number of near miss incidents. This causes an ineffective service leading to a reduction of capacity to make chemotherapy and significant time is wasted by pharmacy staff ensuring correct processes have been followed. Products have to be wasted regularly and remade, causing a loss to the Trust of approximately £100k per month.	Pharmacy staff working increased hours to complete late chemotherapy orders. Chemotherapy Prescribing Policy Cancer Services CBU has discussed the timely prescribing of chemotherapy with their Oncology and Haematology consultants. All consultants aim to prescribe 48 hours ahead of dosing with chemo.	Near misses/incidents Staff health and wellbeing Staff concerns Delays on chemotherapy appointments Chemotherapy waste	29/11/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Agreement to be sought and implemented by CSS, cancer and pharmacy - Sarah Chester Buckley - End of December 2024 - completed	[18/12/2024 16:46:51 Gemma Staples] Risk is being monitored to see if Consultants are prescribing with the 48 hours notice and escalate if not. [18/12/2024 15:43:01 Gemma Staples] Cancer Services CBU has discussed the timely prescribing of chemotherapy with their Oncology and Haematology consultants. All consultants aim to prescribe 48 hours ahead of dosing with chemo. [29/11/2024 10:13:46 Lisa Hansford] No further update [28/08/2024 14:25:03 Nicola Cornish] Risk discussed at Risk Register Confirm & Challenge meeting on 28th August. Revised risk description relating to service description was approved. [01/08/2024 08:53:01 Gemma Staples] Risk updated by Fran and will be taken to RRC&C in August. [10/07/2024 09:05:11 Gemma Staples] Risk discussed at RRC&C (26/06/2024) and it was agreed to accept the risk as active but more work needed to be done on it and to look at whether it was a patient safety risk rather than service disruption. Once updated this is to be taken back to RRC&C.	4	09/04/2025		28/02/2025
2a. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	5093	40	Service disruption	Costello, Mr Colin	Baines, Andrew	Workforce Strategy Group	16/02/2023	20	Clinical Support Services	Pharmacy CBU	Pharmacy	Trust-wide	As a result of a long term sickness absence within the invoicing team and a capability issue within the purchasing team (therefore both teams are a staff member reduced) there is a risk that any further absence due to sickness or leave will mean the remaining staff member doesn't have the capacity to do the work of all 3 sites which would impact staff wellbeing and also impact drug ordering and invoice payment and there is a Trust target to pay invoices within 30 days with any further absence, we would not be able to meet this.	Band 7 covering the Band 3 gap when needed We have two members of staff who are trained and substantive part time staff but also able to provide bank support (though their availability to work is not guaranteed)	Staff Survey Staff Feedback Staff sickness Finance performance on invoice payment Workload	03/01/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	A further case of need will be prepared to identify workforce requirements to better support the day to day management of the team and also shortages and stock management across the Trust - Andrew Baines - July 2025	[03/01/2025 10:35:48 Lisa Hansford] Capability process complete. 1xB3 vacancy and long term sickness in invoicing team is ongoing. Awaiting outcome of banding exercise on new post associated with biosimilars with the hope of creating B4 role. In the interim reliant on B7 covering any B3 gaps. Office capacity is only sufficient for four members of staff at any one time. [04/10/2024 10:24:54 Gemma Staples] Recruitment recently completed for 0.8 WTE band 3 purchase clerk and 0.2 WTE band 3 purchase clerk maternity leave cover; 1.0 WTE band 3 purchase clerk currently on redeployment pathway following capability pathway – no longer working in the purchasing office. This means currently we have 2 purchasers actively working in the role Monday-Friday and so risk currently elevated if either of them is on leave or off sick. Recruitment to the third post will commence following outcome of redeployment. Band 7 senior procurement technician can backfill gaps in the short term. 0.64 WTE part time band 2 invoice clerk is on a long term sickness absence. This means we currently have 2 0.6 WTE part time invoice clerks actively working in the role and so risk currently elevated if either of them is on leave or off sick. Finance KPIs continue to be met at this time – continuing to monitor. [26/06/2024 10:59:16 Gemma Staples] Risk reviewed Description / Controls & Risk reduction plan have been reworded as agreed at the recent Pharmacy Summit follow up meeting. [19/06/2024 14:35:10 Gemma Staples] CSS have funded the additional vacancies and we have partially recruited into the positions but we have still got 3 days where we have a gap so still need to do more recruitment. We also have maternity leave imminently which will impact staff. Time will be required for new starters to provide adequate training. [27/03/2024 09:51:29 Rachael Turner] Risk presented at RRC&C meeting 26/03/2024. Agreed to be reduced to a 4x4: 16 High Risk. [11/03/2024 09:59:03 Lisa Hansford] Invoicing is in a much improved position and	4	16/02/2024	16/02/2024	03/04/2025

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5095	59	Physical or psychological harm		Capon, Mrs Catherine	Chamberlain, Liz (Elizabeth)		24/02/2023	16	Surgery	Surgery CBU	Vascular Surgery	Pilgrim Hospital, Boston	Due to increased demand for PICC services there is a risk that within the current establishment there is a significant delay to patients. This can delay treatment, hinder flow and cause poorer outcomes for patients. 8 years ago, venous access within the Trust was classed as central lines (internal jugular insertion) and cannulas. Peripheral central catheters (PICC) were undertaken occasionally for oncology patients and portacaths and Hickman lines were done in theatre, as they still are. The vascular ACPs started to learn how to insert picc PICC lines starting from one morning clinic on a Tuesday (supported by the Consultants). The needs for PICC increased and we went to two full day clinics in a week. They were only inserting in pilgrim at that time. It was then determined that Total Parental Nutrition (TPN) needed to be given centrally and not peripherally, and the work load increased two fold. A business case was successful for a 1.0 WTE band 6 venous access nurse to take on the clinics as the work load for the ACPs was also increasing. The Royal College of Radiologists state that a PICC line should be inserted with 72 hours. However, due to the varied nature of why a line is required particulary for urgent cases this has been deemed locally as 24 hours.	At present there is one 1.0 WTE VAN (band 6) and two 22.5 hours HCSW (band 2) covering: - Lincoln clinics (in patient only) Monday (up to and including 6 patients) and a Wednesday out/in patients - Pilgrim clinics Tuesday and Thursday, both in and outpatients - All clinics have slots for up to 6 patients, however, many late referrals are received and the clinic can increase to anything up to 12 patients. This means that the VAN goes home late most nights that incurs overtime payment. This additional activity is driven through urgent care pathways and is reliant upon a stretched team to meet this demand. As services enter a a post COVID climate there has been a recognised increase in complexity of presentations due to non-presentation at an earlier point. Case of Need has been written with final finance input outstanding to then go to CRIG ACPs are trained in this procedure but should not be relied upon as takes away from other core duties and is not a sustainable. Interventional Radiology is picking up some activity although this exposes patients to radiation and is not a sustainable option. This also require anaesthetics and theatre resources.	Volume of requests against number of staff and time taken to acquire IR1 submissions - started to see an increase in incidents being reported.	05/12/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Business case established with final finance input outstanding to then go to CRIG 6 month secondment for a PICC nurse has been advertised and will require training Give consideration to training of a wider network of clinicians associated with their individual service needs	[05/12/2024 10:30:15 Nicola Cornish] Discussed at speciality governance meeting on 5th December. Still waiting for business case to be considered at CRIG. [29/10/2024 14:25:18 Nicola Cornish] The business case is still waiting approval. The secondment has been extended for a further 6 months. [29/10/2024 08:53:09 Nicola Cornish] Risk reviewed, no change. [27/06/2024 10:31:25 Nicola Cornish] Business case needs to be put in to the new template and then seals of approval sought. [31/05/2024 12:07:02 Nicola Cornish] Business case needs to be reviewed before presentation to CRIG. Looking at funding sources across other divisions as it is a Trust wide service. 6 month secondment has been extended to end of March 2025. [28/05/2024 14:48:51 Nicola Cornish] No further update [23/10/2023 11:25:05 Nicola Cornish] Extended secondment until end of March 2024, approval and QIA for business case are ongoing [03/05/2023 10:26:45 Rachael Turner] Following further quantitative data provided this risk has now been validated as an active risk for the trust register. [26/04/2023 11:26:50 Rachael Turner] Risk needs to return to RRC&C once we have the quantitative data confirmed. Needs to look at where this risk sits as possibly more appropriate with CSS. This will be re-presented in the May RRC&C meeting. [25/04/2023 10:06:15 Chris Sewell] Due to unforeseen circumstances and long term absence the service has had to rely on the ACP and Interventional Radiology options as outlined in the risk controls. It is anticipated that they will return at the beginning of May. This has led to an increase in IR1s.	1	01/06/2023		05/03/2025
3c. A modern, clean and fit for purpose environment across the Group	4648	2	Physical or psychological harm		Landon, Caroline	Davey, Keiron	Emergency Planning Group, Health and Safety Group	15/12/2021	20	Corporate	Estates and Facilities	Fire and Security	Trust-wide	If a fire occurs on one of the Trust's hospital sites and is not contained (due to issues with fire / smoke detection / alarm systems; compartmentation / containment) it may develop into a major fire resulting in multiple casualties and extensive property damage with subsequent long term consequences for the continuity of services. Low level of attendance/completion of fire safety training also contributes to this risk as there there may be significant non-adherence to fire safety policy and procedures which could lead to potential of a major fire.	National policy: - Regulatory Reform (Fire Safety) Order 2005 - NHS Fire safety Health Technical Memoranda (HTM 05-01 / 05-02 / 05-03) ULH policy: - Fire Policy (approved by FEG / FSG Sept 2022 - awaiting final approval / signature to be HTM compliant): # Personal Emergency Evacuation Plans (PEEPs), approved April 2017 - Fire safety training (Core Learning, annual) / Fire Warden training / Fire specialist training - review / protocol in draft, TNA in draft for Fire Safety Team review - Major Incident Plan - Estates Planned Preventative Maintenance (PPM) programme ULH governance: - Trust Board assurance through Finance, Performance & Estates Committee (FPEC) / lead Fire Safety Group (including divisional clinical representation & regulator attendance) / Fire Engineering Group - All areas within the Trust estate are individually risk rated for fire safety (based on occupancy, dependency, height, means of escape), which informs audit / monitoring activity - Local fire safety issues register (generated from local fire risk assessments) - tasks allocated to Estates / local managers, etc. as appropriate; tracked and monitored by Fire Safety Team, validation by Fire & Rescue Service - Weekly fire safety team meetings concerning risk assessments and risk register - Capital risk programme for fire - Reporting of local fire safety incidents (Datix) generated through audit programme - Authorising Engineer for Fire - Health & Safety Committee & site-based H&S committees	Results of fire safety audits & risk assessments, currently indicate: - Fire Risk assessments within Maternity Tower block Lincoln indicating substantial breaches of compartmentation requirements - Fire risk assessments indicate lack of compartmentation within some sleeping risk areas - Age of fire alarm systems at all 3 sites (beyond industry recommendations) - No compartmentation reviews undertaken to provide assurance of existing compliance (all 3 sites) - Concerns with networking of fire alarm system at Pilgrim (to notify Site Duty Manager / Switchboard of alarm activation) Reported fire safety incidents (including unwanted fire signals / false alarms)	18/12/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	- Capital investment programme for Fire Safety being implemented on the basis of risk - costed budget plan for FEG submission Sept 2022. - Trust-wide replacement programme for fire detectors. - Fire Doors, Fire/Smoke Dampers and Fire Compartment Barriers above ceilings in Pilgrim, Lincoln and Grantham require improvements to ensure compliant fire protection. - Fire safety protocols development and publication. - Fire drills and evacuation training for staff. - Fire Risk assessments being undertaken on basis of inherent risk priority; areas of increased residual risk to be added to the risk register for specific action required - Local weekly fire safety checks undertaken with reporting for FEG and FSG. Areas not providing assurance receive Fire safety snapshot audit. - Staff training including bespoke training for higher risk areas - Planned preventative maintenance programme by Estates	[18/12/2024 11:16:34 Rachael Turner] Risk presented at Risk Confirm and Challenge 18/12/2024, risk validated for reduction in score of 4x4:16 High Risk. [05/12/2024 12:49:00 Rachael Turner] Risk mitigation currently in place includes fire door mapping work is now complete. 22 new fire doors are currently being installed across the Trust. An additional 21 have been ordered and a further 74 doors are being sent out for costings with the intention to be installed within this financial year. We have a fire safety trainer to competently inspect all fire doors. An additional 6 estate joiners have also been allocated a course for fire door inspection. Capital works for compartmentation remedials and replacement across all three sites continues to make good progress with work being targeted on the basis of risk. Fire Warden numbers across the Trust continue to rise. Due to these mitigations risk proposed for a reduction in score to 4x4:16. [07/11/2024 12:44:43 Rachael Turner] Risk discussed at Fire Safety Group due to current mitigation in place request for risk to reduced to 4x4:16 High Risk. This risk will be presented at RRC&C meeting in December to validate reduction in score. [28/10/2024 11:25:19 Rachael Turner] Risk reviewed, no current change from previous update. Risk score remains. [17/09/2024 08:59:59 Rachael Turner] Work continues with capital based upon risk. Fire door mapping work is completed. Discussions are in place around maintenance on fire doors. [13/08/2024 18:09:19 Rachael Turner] Risk updated to incorporate low level of attendance/completion of fire safety training as this will contribute to a risk of major fire- risk 4674: Low levels of attendance/completion of fire safety training to be closed as all details are now contained within this risk. [13/08/2024 17:54:00 Rachael Turner] Work on Fire door mapping has concluded for all sites. capital compartmentation works continues across all 3 sites on a risk basis.	10	31/03/2022	31/03/2025	18/03/2025
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	4646	66	Physical or psychological harm		Dunderdale, Karen	Gibbins, Donna	Clinical Effectiveness Group	14/12/2021	20	Medicine	Specialty Medicine CBU	Respiratory Medicine	Trust-wide	If the Trust is not consistently compliant with with NICE Guidelines and BTS / GIRFT standards to support the recognition of type 2 respiratory failure then there may be delays to the provision of treatment using Non-Invasive Ventilation (NIV), resulting in serious and potentially life-threatening patient harm.	National policy: - NICE Guideline NG115 - COPD in Over-16s: diagnosis and management - NICE Quality Standard QS10 - COPD in Adults - British Thoracic Society (BTS) / Get It Right First Time (GIRFT) standards for NIV ULHT policy: - Guidelines and Care Pathway for commencing Non-invasive Ventilation (NIV) in the non-ITU setting - NIV-trained clinical staff - Dedicated NIV beds (Respiratory wards) ULHT governance: - Medicine Division clinical governance arrangements / Specialty Medicine CBU / Respiratory Medicine - Trust Board assurance through Quality Governance Committee (QGC) / lead Patient Safety Group (PSG) / NIV Group and Integrated Improvement Plan (IIP) / Improving Respiratory Services Programme	- Frequency and severity of patient safety incidents involving delayed NIV - recent history of rare but serious harm incidents - Total elapsed time from Type 2 Respiratory Failure (T2RF) suspicion to commencement of NIV <120mins - not being met at LCH or PHB as of Dec 21 - Start time for NIV <60mins from Arterial Blood Gas (ABG) - not being met at LCH or PHB as of Dec 21 - NIV progress for all patients to be reviewed (once NIV commenced) < 4hours - not being met at LCH as of Dec 21 update: There is a NIV audit captured monthly which determines both trust wide compliance and site specific- this is shared through PRM and available for cabinet and CBU governance meetings	04/02/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Delivery of the NIV Pathway project as part of the Improving Respiratory Service Programme within the Integrated Improvement Plan (IIP): 1. Understand the Trust-wide demand and capacity for Acute and Non Acute NIV. 2. Provision of ring-fenced beds for NIV. 3. Develop Trust-wide Model and Pathway for Acute and Non Acute NIV To meet BTS/GIRFT Standards. 4. Provision of NIV service (ED) which meets the BTS Quality Standards. 5. To have a trained workforce with the skills required to meet the needs of the patients and BTS standards. 6. Governance Process for NIV Demonstrating a Safe Service where Lessons are Learnt.	[04/02/2025 14:39:07 Rachael Turner] We have made no more progression with engagement through ED, however we are re-reviewing KPIs against national standards for NIV. Also reviewing dashboard to identify gaps in knowledge in ED. [27/11/2024 12:16:28 Rachael Turner] NIV provision being reviewed with the implementation of a study day for staff in ED at band 6 and 7, this will be followed by a competence pack whereby staff will be required to set up 5 NIV and be signed off by staff on respiratory. The NIV in a non itu setting SOP is being reviewed to consider options for commencement of NIV in ED. There continues to be significant issues with failure to recognise type 2 respiratory failure in ED and refer patients. Education continues as part of the study day and relationship with ED. A daily communications in place with escalations whereby the ringfenced bed is not available for immediate action which is successful to ensure the pathway is not compromised. [31/07/2024 13:04:42 Rachael Turner] Risk discussed as part of the Deep Dive at RRC&C meeting 31/07/24. We are currently not in a position to reduce currently. We continue to have NIV Dashboard and targets where we have an annual review. We are currently not delivering to the standard. The education in recognising type 2 respiratory is still an issue, it is not consistent due to changes in workforce and operational pressures. Meeting booked with ED on 14th August and we continue to review the SOP. Incidents are also increasing around NIV. Risk score to remain. [18/07/2024 11:48:19 Donna Gibbins] Risk remains at 16, lack of equitable services at PHB against BTS at pilgrim. Additionally, the monthly NIV dashboard continues to report themes and concerns in relation to education in ED. Concerns relating to NIV being started in ED which is currently outside of policy. A review of the NIV policy which is due in August 24 is underway, involving ED colleagues. Incidents in relation to NIV being commenced in ED which has been incorrectly set up and SJR's with concerns in relation to ringfenced provision. Mitigations of	4	30/09/2022	31/12/2024	04/05/2025

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
1c. Improve clinical outcomes	4866	87	Service disruption		Costello, Mr Colin	Saddick, Ahtisham	Medicines Quality Group	01/03/2022	15	Clinical Support Services	Pharmacy CBU	Pharmacy		Recruitment of ULHT pharmacy technicians to ward-based clinical pharmacy roles affects the balance of the pharmacy workforce and impacts on the core pharmacy service provided	Pharmacy should be fully involved in the development and implementation of these roles. The Chief Pharmacist is accountable for the professional management of these roles, however there is not a clear understanding of the supervision and development framework for the new roles.	Monitoring of Pharmacy Technician performance	09/01/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	To develop a robust supervision, training and development framework for the new pharmacy technicians roles. 1. To undertake a quality impact assessment to evaluate the potential impact on pharmacy services. 2. To develop a robust NVQ apprenticeship training scheme to train band 2/3 staff to band 4/5 roles both on the wards and in pharmacy services to achieve a sustainable pharmacy technician workforce in order to support all pharmacy technician roles.	[09/01/2025 14:20:31 Lisa Hansford] No update. [10/10/2024 10:09:29 Lisa Hansford] No further update [10/07/2024 11:22:38 Lisa Hansford] no further update [04/04/2024 09:06:25 Lisa Hansford] No further update [29/12/2023 13:54:44 Lisa Hansford] No further update [07/11/2023 14:12:59 Lisa Hansford] Update- Variable ward based technician support is being provided for clinical pharmacy cover for admission areas. Risk is ongoing as there is still the possibility of staff movement to WBT roles therefore leaving gaps in core services [26/09/2023 14:15:54 Rachel Thackray] Risk remains, awaiting further update [07/09/2023 14:11:26 Lisa Hansford] 7.9.23 no further updates [27/06/2023 09:45:21 Alex Measures] Discussed in risk register review meeting- no further updates [01/06/2023 14:31:32 Lisa-Marie Moore] Discussion with CSS Division on how techs could be used to support pharmacy [28/03/2023 15:04:33 Rachael Turner] Risk proposed to be increased to a 16, this will be presented at RRC&C meeting 29th March. [20/12/2022 14:39:34 Alex Measures] no further updates Scheduled project due to commence March 2021, monthly reports will be provided. Monthly ward based technician meetings are addressing the training issue. 150622 ongoing, losing another technician to wards.	16	30/11/2021	28/04/2023	09/04/2025
2a. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	5467	695	Service disruption		Babu, Suresh	Chablani, Manish	Clinical Effectiveness Group, Infection Prevention and Control Group	21/06/2024	16	Corporate	Medical Director's Office	Medical Education	Lincoln County Hospital	As a result of the respiratory teaching at Lincoln currently being delivered by a locum consultant (via bank), who has previously indicated they wish to retire and as there are no consultant job planned or capacity. This could result in the Trust failing our contractual requirements which would bring into question our newly gained status as a teaching hospital.	No controls in place at the moment. This risk has been escalated up to the head of Respiratory by Dr Babu DME as per Dr Chablani's request.	Workforce	18/12/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Increase the workforce, include undergraduate teaching as a part of the job plan of a few consultants to share the workload and provide resiliance. Investment into staff and education	[18/12/2024 11:28:22 Rachael Turner] Risk presented to Risk Register Confirm and Challenge 18/12/2024. Until post filled this risk will remain at current level. [26/11/2024 15:03:32 Rachael Turner] Another locum consultant has been appointed to this position for the next year. This is now a low risk. This risk will be presented at December Risk Confirm and Challenge to validate reduction in score. [31/07/2024 13:21:11 Rachael Turner] Risk presented at RRC&C meeting 31/07/2024. Risk validated as a High risk score 4x4:16 High risk.	8	21/06/2025		18/03/2025
2a. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	5466	698	Service disruption		Babu, Suresh	Chablani, Manish	Clinical Effectiveness Group, Infection Prevention and Control Group	21/06/2024	16	Corporate	Medical Director's Office	Medical Education	Trust-wide	As a result of the current Paediatrics teaching fellow leaving in September at the end of this academic year, there is a need for a departmental plan to ensure training is in place for a new teaching fellow ready for the students starting in March 2025. Without this the Trust would be unable to deliver the required teaching in Paediatrics. This could lead to the Trust failing on our contractual requirements and this would bring into question our newly gained status as a teaching hospital.	No controls in place at the moment. This risk has been flagged up to the head of Paediatric service by the modules leads, Dr Broodbank and Dr Herath.	Workforce	26/11/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Increase the workforce, include undergraduate teaching as a part of the job plan of a few consultants to share the workload and provide resiliance. Investment into staff and education	[26/11/2024 15:06:27 Rachael Turner] Interviews are taking place in the next couple of weeks. This is still a risk until an appointment is made. [31/07/2024 13:25:41 Rachael Turner] Risk presented at RRC&C meeting 31/07/2024. Risk validated as a High risk score 4x4:16 High risk.	8	21/06/2025		26/02/2025
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5491	701	Physical or psychological harm		Parkhill, Michael	Davies, Chris	Clinical Effectiveness Group, Infection Prevention and Control Group	18/07/2024	16	Corporate	Estates and Facilities	Estates	Trust-wide	As a result of wards and departments not following the Change of Use Policy this has resulted in rooms being used for clinical treatments in which ventilation requirements are inadequate. This could lead to patients harm and patients contracting Hospital acquired infections.	Change of Use Policy Space Management Policy-this was approved by H&S Committee IPC Action Plan to review all current areas that are being used inappropriately.	IPC Action Plan. Datix incidents raised.	19/11/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	IPC Action Plan has been developed and carried out identifying all areas where treatment rooms are being used with inadequate ventilation. Estates Actions: •Estates to progress a ventilation compliance review upon Trust approved Capital Funding. •If mechanical ventilation is present – discuss / request Estates feasibility to increase air changes for treatment rooms found to have less than 10 air changes. •Estates to progress environmental infrastructure remedial work upon Trust approved funding. Clinical Division Actions •Where treatments rooms are not up to standard, the relevant Clinicians to be informed by the Divisions so that they can perform their own assessment of risk / responsibility. IPC will support risk assessments. •Red rated treatment rooms to be a priority for relocation to a safer environment. The IPC action plan where areas identified	[19/11/2024 12:16:52 Rachael Turner] Risk action plan remains ongoing. Estates and capital are working towards replacement. A meeting is booked on the 9th December to discuss capital funding. A new ventilation safety group has been put together, chaired by head of estates. Audits and actions are being produced to find solutions for all ventilation issues. Validation reports are available for all critical plants. [31/07/2024 13:53:50 Rachael Turner] Risk presented at RRC&C meeting 31/07/2024. Risk validated at 4x4:16 High Risk. [22/07/2024 15:33:13 Rachael Turner] Treatment room action plan updated version uploaded with feedback from CSS.	8	18/07/2025		19/02/2025

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
2a. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	5468	696	Service disruption		Babu, Suresh	Chablani, Manish		21/06/2024	16	Corporate	Medical Director's Office	Medical Education	Trust-wide	As a result of failing to provide the curriculum requirements for clinic based specialties across the board but especially Dermatology, ENT Ophthalmology and Rheumatology. This has resulted in clinics being overbooked and the patient numbers not being reduced to allow for teaching the medical students. Which could lead to failing on our contractual requirements and this would bring into question our newly gained status as a teaching hospital.	None at the moment. Dr Chablani has written to the Clinical Leads asking them to support with reduced patient numbers in teaching clinics and for the clinical and attachment leads to work closely together to ensure a balance between service provision and teaching but is yet to get reassurance or a formal response.	Work around appropriate remuneration with Business Units and recognising the need to release clinicians to deliver teaching. Reduce patients in clinics - balancing waiting lists alongside teaching opportunities	26/11/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Increase the workforce, investment into staff and education	[26/11/2024 15:08:57 Rachael Turner] A meeting with Dermatology has taken place and this is no longer a risk in Dermatology. Further meetings are planned over the next few weeks with ENT and Ophthalmology [31/07/2024 13:22:46 Rachael Turner] Risk presented at RRC&C meeting 31/07/2024. Risk validated as a High risk score 4x4:16 High risk.	8	21/06/2025		26/02/2025
1c. Improve clinical outcomes	4778	94	Physical or psychological harm	Mooney, Mrs Katy	Marsh, David	Patient Safety Group		16/01/2022	15	Medicine	Cardiovascular CBU	Stroke		Risk of failure to meet best practice standards for stroke patients due to lack of timely access to community rehabilitation services. Length of stay for patients is set at 10 working days. Currently all processes for moving patients on from stroke unit for rehab is going over which is having an effect on patients rehab causing potential patient harm, service delays and burn out for staff. This is having an effect of staff morale and performance where they feel they are not delivering the service that they would like to.	LCHS provides Lincolnshire Community Stroke Services with a broadened access criteria post 100 day challenge. This is offering some increased access to stroke rehab in the community. One year seconded band 6 OT is currently covering Lincoln Stroke Unit 2 days. Her remit is to identify and facilitate timely discharge from acute to community. This service has KPI's to measure this. -Teams Groups with LCH to facilitate handover. -Joint email to narrow where referrals are directed and sent. -Reviewing prioritise lists everyday to decide appropriate pathways for patients. This is carried out every morning at 08:30. -Joint assessment with OT and PT to increase effectiveness and reduce time to decide which pathway is best for the patient. -Pathways currently in place are HomeFirst, ABI referral pathway --Working with CHC to create meeting of discussion for patients to trust each other within our assessments.	SNNAP data scores . Service provision not in top quartile	03/12/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Stroke pathway development project on place. Close partnership working within community to expedite discharges into the community	[03/12/2024 10:49:59 Rachael Turner] Nothing has changed other than working on contributing to uplift staffing linked to the Navenby stroke expansion, as part of a business case. [02/09/2024 11:21:16 Rachael Turner] Risk remains ongoing. No current change to risk score. [26/06/2024 15:03:44 Rachael Turner] Risk presented at June RRC&C meeting. Risk validated at 4X4: 16 High Risk score. [10/05/2024 14:02:56 Rachael Turner] Risk reviewed. Update to risk description and controls to reflect current status of the service. Risk score reviewed with a potential increase of score to 15. This will be sent to both CSS and Medicine Governance to be agreed before being presented at Risk Confirm and Challenge for validation of score change. [15/04/2024 14:28:03 Rachael Turner] We are currently communication with LCH for beds for community, however there is a funding gap, this is being costed and looking at next steps. There is also work going on in the background for referrals to community hospitals and what they will accept. [25/01/2024 10:51:13 Rachael Turner] Work remains ongoing-working with community for rehab. Risk remains. Stroke Implementation Group currently in place for improvements. [30/10/2023 15:39:47 Rachael Turner] Stroke monthly board has been established, looking at all areas in patient pathway. This will be looked at as a part of this board. [25/07/2023 09:38:47 Bev Vertigan] No further development with ASR. Working group meets monthly to review areas of SNAP. [14/03/2023 10:12:54 Charles Smith] Continuation - Update the same as previous, dependant on Stroke ASR work. [22/11/2022 15:31:56 Milena Casswell] 22/11/22 Update – Continue to work with community to ensure timely discharge, perfect week planned as part of ASR	6	31/03/2025	28/02/2023	03/03/2025
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5564	783	Physical or psychological harm		Landon, Caroline	Anderton, Kerry		19/12/2024	16	Medicine	Urgent and Emergency Care CBU	Hospital at night	Trust-wide	As a result of staffing not being uplifted for Hospital Out of Hours along with gaining more wards this has resulted in an increase in patients along with an increase in acuity. This has led to patients waiting for longer than they should do to be reviewed and for essential medications and fluids to be prescribed. This could result into an increase in patient mortality leading to increase length of stay, a reduction in bed flow and a negative effect of patient experience. This risk also has an effect on staff with reduced morale and increased levels of stress due to pressures.	-All clinical task requests are triaged by Hospital Out of Hours clinical coordinator who can advise the nurses on interim measures while they are waiting for their patient to be reviewed and give safety netting advice. -Tasks are then triaged again by the clinician receiving them. -Any tasks left at the end of shift are handed back to day staff. - Staffing levels currently have at both Lincoln & Boston: 1 ACP, 1 Clinical Coordinator and 1 Clinical Support Worker. -Medical staffing at Lincoln: 1 dedicated Hospital Out Of Hours F1 Doctor -Medical staffing Boston: 1 Trauma and Ortho Doctor, 1 Surgical Doctor, 1 Medical Doctor-these are not however dedicated to Out Of Hours so may not be readily available-these also clerk on Admissions Units and A&E.	-Datix Incidents -Audit Nerve Centre -Regional Hospital Out of Hours Network KPI's	29/01/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	To increase the number of clinicians in the Team by 1 extra member of staff per night-a Doctor or ACP-unfortunately there is no current source of funding for a Business Case. Currently looking into this but this is reliant on buy in from Medicine. This is an ongoing piece of work.	[29/01/2025 13:41:22 Rachael Turner] Risk presented at RRC&C meeting 29/01/2025. Risk score validated at 4x4:16 High Risk.	8	19/12/2025		29/04/2025
3a. Deliver financially sustainable healthcare, making best use of resources	5389	559	Finances		Landon, Caroline	Hodgkins, Mr James		19/02/2024	20	Corporate		Hospital at night		Risk of overspend due to current service provision being unfunded. Also overspend due to increased sickness leading to a higher requirement for bank, agency and Overtime. Increased insurance due to increased litigation. Due to patient complaints and safety aspects.	Monthly budget reviews, and recognised overspend.	Datix, through finance reviews.	19/12/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Case of Need to be heard by CRIG on the 26th March 2024, following which a business case to be submitted.	[19/12/2024 13:05:31 Rachael Turner] There is currently no source of funding so Business Case cannot be heard. Finances are being looked currently looking at the overspend. Money is still left in staffing budget but this due to current staff not being yet at the top of their band. [17/09/2024 10:24:21 Rachael Turner] Risk remains with no change at present. [14/06/2024 11:12:21 Rachael Turner] Risk reviewed, no change at present. Risk score remains the same. [28/02/2024 11:50:14 Rachael Turner] Risk presented at RRC&C meeting 28/02/2024. Risk validated as a 4x4:16 High risk.	6	19/02/2025		19/03/2025

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
4d. Enhanced data and digital capability	5519	739	Physical or psychological harm	Humber, Michael	Evans, Thomas	Clinical Effectiveness Group		08/10/2024	16	Corporate	Finance and Digital	Digital Services (ICT)	Trust-wide	As a result of the lack of an established Digital Clinical Risk Management system (Health IT system), processes and resource resulting in non-compliance with the Digital Clinical Safety Standards DCB0129 and DCB0160 (the Standards mandated by NHSE to ensure the safe manufacture, development, deployment, and use of Health IT Systems) this could lead to patient safety incidents involving digital systems, resulting in or contributing to patient harm or death. An informal 'best endeavours' approach has previously been taken and digital clinical systems have been deployed that have not fully met the Standards. The Standards also mandate an approach to Clinical Risk Management which continues for the entire lifecycle of the Health IT system, not just prior to initial deployment. Under the standards, the CRMS must have proactive and reactive elements to effectively manage post deployment patient safety concerns / incidents and this element has also previously not existed within at the Trust in any formal way with a lack of formal governance and assurance for clinical safety.	•Previously no defined lead for digital clinical safety established in the Trust. The CNIO has voluntarily taken the lead on Digital Clinical Safety (Trained CSO) within their substantive role, although clinical safety responsibility not outlined in job description / role and responsibilities. However, no resource for non-project/non funded DCSO work = risk •Digital Clinical Safety Officer (DCSO) post recruited into May 2024, as part of EPR programme (not revenue funded = risk). 1 further DCSO post has been included in the resource model for EPR implementation (>2025 funding) however, given the large volume of current in-flight Health IT System projects and legacy systems outside of EPR, this is not an adequate resource. •Digital Clinical Safety Policy now in the organisation (approved at DHG and Corp Gov – awaiting publication on the intranet) •Draft Clinical Risk Management System developed by new DCSO and awaiting Clinical Governance review before formal approval at DHG •Further development of required structures and governance standards to meet/comply with National standards and strengthen our position underway. •Digital Clinical Safety processes / awareness will require significant 'socialisation' to ensure they are effectively embedded. This will include clinical safety training for clinical / digital / operational colleagues as appropriate to their role.	•Number of digital systems without full compliance with the Standards i.e Clinical Risk Management File, Clinical Risk Management Plan, Clinical Safety Case Report, Hazard Logs etc. •Lack of digital clinical safety resource and no policy or standard within the Trust prior to recently created and published policy. •Known new and upcoming digital projects are tracked, and activities aligned to new policy and the National standards. •Previous deployments will require review and a post deployment safety assessment and remain subject to further clinical safety activities under the National standards and guidance	04/02/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Action 1. Develop and strengthen Digital Clinical Safety Function - will require funding for permanent staff including administrative resource to administer / manage the CRMS. Action 2. Continue to work towards meeting the National standards, all new projects will have the Digital Clinical Safety Standards applied. Action 3. Further development of the new CRMS, embedding of associated processes and improved digital clinical safety literacy among digital, clinical, and operational teams. Action 4. Review of previous projects and live systems, deployed under previous arrangements to ensure a clinical safety review is applied under the new standards. Action 5. Ensure effective application of Digital Clinical Risk Management activities through regular audits	[04/02/2025 12:47:33 Rachael Turner] Whilst making significant progress with developing and implementing the digital Clinical Risk Management System (CRMS) and CRM service, significant challenges remain which impact our ability to undertake and apply the identified mitigating actions / risk controls to effectively manage this risk (see actions review comments). At the time of first registering this risk, the score reflected our known position in terms of organisational compliance with DCB0160 / DCB0129. We now need to reconsider this rating taking into account the following: • The planned implementation of the Electronic Patient Record (EPR) - the largest Health IT deployment our organisation has ever seen. • Potential wider clinical use of M365 applications to support patient care pathways as part of our migration to the national shared tenant and Group working. • The large number of digital Health IT solutions planned for deployment across the organisation in addition to the EPR programme. • The planned deployment of Health IT Systems incorporating the use of artificial Intelligence / clinical decision making functionality. • Conflicting/changing priorities with limited resource to undertake meaningful Clinical Risk Management on Digital/Health IT projects and the risk of patient harms occurring as a consequence of this. On this basis, the severity score for this risk needs to be revised upwards from severe (4) to extreme (5), resulting in a Risk Rating of 20. [30/10/2024 13:44:35 Rachael Turner] Risk presented at RRC&C meeting 30/10/2024. Risk validated at 4x4:16 High Risk score.	12	08/10/2025		04/03/2025
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5227	439	Regulatory compliance	Lynch, Diane	Hughes, Robert	Clinical Effectiveness Group		02/08/2023	12	Clinical Support Services	Path Links (Pathology)	Mortuary (Pathology)	Trust-wide	Due to the limited security measures in place there is significant risk of unauthorised entry into the Trust's mortuary departments and/or temporary body stores. The risk is based on the following security gaps: Lincoln: Temporary body store: No Swipecard access but locked with key In the event of a break in, not only would the dignity of patients be compromised but there is a high probability that damage could be inflicted on patients either deliberately or as a consequence of a failure in the control of the environment. The scenario is reportable to both CQC and HTA as regulators. In addition, criminal investigations would be initiated. As regulators, CQC and HTA can issues fines, sanctions or even revoke the licence to operate mortuaries. It would be highly likely that complaints and claims from families of the deceased would ensue having lasting reputational damage to the Trust.	24 hour site security: Walkarounds in place, with security tags fitted to exterior of mortuary buildings; additional security patrols at night CCTV: On entrance to Mortuary departments and the temporary body stores (inside also) Access Control: Swipecard access to main mortuary departments (governed by SOPs). No swipecard access to Temporary body stores, this is key operated locks only. Single key set only accessible by mortuary staff held in the mortuary which is access controlled. Alarm system: All 3 sites main mortuaries have intruder alarm that is connected to the Switchboard. The Titan temporary body store also now has an intruder alarm. Boston: Temporary Body store: Not currently in use, following completion of refurbishment at Boston. Access is via a locked gated yard.	The frequency and extended use of the temporary body store at Lincoln has increased the risk.	25/11/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Significant progress has been made in reducing identified security gaps, but risk remains. Assess security vulnerability (on the back of recent incident at NLAG/DPoW) with NLAG/ULHT/Police review of security (Meeting held during July to understand findings and discuss next steps. Actions in response need to be agreed, to be tabled at HTA Governance meeting)	[25/11/2024 16:11:34 Gemma Staples] Boston Temporary Body store is not currently in use, following completion of refurbishment at Boston. Access is via a locked gated yard. Meeting held in July with NLAG/ULHT/Police review of security to understand findings and discuss next steps. Actions in response have been discussed at the HTA Governance Meeting and the recommendations made in the report have been ratified by the group. The HTA DI will progress this with facilities and security teams. [02/08/2024 12:17:24 Gemma Staples] All 3 sites main mortuaries have intruder alarm that is connected to the Switchboard. The Titan temporary body store also now has an intruder alarm. Significant progress has been made. We are now awaiting clarity on the timescales for removing the Titan Unit at Lincoln (when refurb completed) and the outcome of the police led review [24/04/2024 13:12:25 Nicola Cornish] Discussed at RRC&C on 24/04/24. Likelihood has increased due to longer use of the temporary units but the severity has also increased due to the current acute focus on mortuary security following well publicised local and national incidents. Agreed to increase in score to 16 (4x4). [03/04/2024 16:03:33 Jeremy Daws] As a result of the refurbishment programme of work taking longer than first planned (Paper to ELT submitted) and the demolition of B Store to enable refurbishment work at Lincoln, the use of the Temporary Body Store at Lincoln has increased and will be in use for much longer than first planned (?End of September 2024). There has been a security near miss incident at Boston which was reported to the HTA.	6	02/08/2024	01/01/2025	25/02/2025
2a. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	4780	74	Service disruption	Mooney, Mrs Katy	Hunter, Sarah			16/01/2022	20	Medicine	Cardiovascular CBU	Stroke	Trust-wide	As a result of a significant deficit in stroke consultants levels due to staff leaving/ retiring and stroke service struggling to recruit substantive consultants there is a risk of not being able to maintain effective stroke provision across ULTH. From April 2025 the stroke service will have only one Substantive Consultant, upcoming retirement could result in no substantive Consultant Stroke Physicians in 2028-2029 if continue to not recruit. Reliance on Locum consultants is costly and causes instability in the rota. Locum/Agency/Bank reliance results in limited medical training & supervision for resident doctors, Registrars, ACPs and students – limiting staffing pool for the future & reduces staff experience/satisfaction.	•Utilising a regular pool of locum consultants •Consultant advert out •Attended recruitment drive at medical conference November 2024 •Consultant ACP post •Liaising with Integrated stroke delivery network [ISDN] for possible regional solutions	Datix/incidents/SJR/SI Rota Gaps Budget/costing	09/01/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Action 1. Convert locum contacts to Bank where possible Action 2. Continue to advertise for consultant stroke physicians Action 3. Continue to liaise with Integrated stroke delivery network [ISDN] for possible regional solutions ?regional rota Action 4. Further consultant stroke practitioner post & support Stroke registrars to become stroke consultants. Action 5. Redesigned stroke pathway.	[29/01/2025 13:49:21 Rachael Turner] Risk presented at RRC&C meeting 29/01/25. Risk validated for increase i score 4x4:16 High Risk. [09/01/2025 12:18:33 Rachael Turner] Risk being presented for increase in score at RRC&C this month. [18/12/2024 12:42:46 Rachael Turner] Risk reviewed-substantive consultant leaving early next year, we are struggling to recruit substantive consultants. Our substantive/clinical lead may retire soon. There is a future risk of no consultant physician substantive workforce. There is a risk of not being able to maintain effective stroke provision across ULTH 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. Risk score to be reviewed for increase in score of 4x4:16 High Risk, risk to be presented at Risk Confirm and Challenge in January. [02/09/2024 11:17:55 Rachael Turner] Consultant staffing remains ongoing, issues remain with recruitment. Advert is out but currently no applicants. [21/06/2024 13:47:29 Rachael Turner] From a medical perspective we remain fragile where we can only plan from a month by month basis as we still only have 3 consultants in post where we require 6. [10/06/2024 15:56:54 Rachael Turner] Stroke staffing now resolved from a nursing perspective, staffed to demand and ongoing training with all registrants. [18/03/2024 10:48:50 Rachael Turner] Risk reviewed, advert went out but received no applicants. Risk currently remains. [15/01/2024 14:41:21 Rachael Turner] Consultant staffing remains ongoing, rolling advert for locum consultants with no applicants as yet. Substantive consultant has just been re-advertised, this has a AAC booked for the 26th March. Still heavily reliant on agency locums. Risk reduction plan reviewed and updated to	8	31/03/2022	01/07/2024	09/04/2025

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
2a. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	5427	699	Service disruption		Babu, Suresh	Chablani, Manish		30/04/2024	16	Corporate	Medical Director's Office	Medical Education		Student report discrepancy in teaching between Lincoln and Boston site especially in HCOL and stroke where there is only one educator. To mitigate this , we plan to employ Teaching Fellows so they can offer similar amount of teaching on both sides.	We have appointed Teaching Fellow in Stroke and shortly will do so in HCOL.	Workforce	26/11/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Increase the workforce, investment into staff and education	[26/11/2024 15:13:38 Rachael Turner] There are barriers within the Business Unit in terms of the JD/funding for the Specialty Teaching Fellow, which is delaying the appointment to this post. This should be a joint risk which sits with the Business Unit as we are unable to move forwards with this from an undergraduate perspective. [31/07/2024 13:26:57 Rachael Turner] Risk presented at RRC&C meeting 31/07/2024. Risk validated as a High risk score 4x4:16 High risk. [10/06/2024 15:43:27 Gemma Staples] Request for the handler to be amended from Catherine Wormington to Dr Maish Chablani. [29/05/2024 13:48:30 Gemma Staples] No attendance to present so deferred to June RRC&C meeting	4	30/04/2025	30/04/2025	26/02/2025
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5403	712	Regulatory compliance		Cooper, Mrs Anita	Cragg, James		28/08/2024	15	Clinical Support Services	Path Links (Pathology)	Microbiology (Pathology)	Pilgrim Hospital, Boston	As a result of the breakdown of the Microbiology Class A Waste Autoclave (since 11 December 2023) the Trust does not meet HSE Regulatory Compliance (this stipulates that Category A and B wastes are inactivated on-site before final disposal because they may contain high concentrations of biological agents and pose an increased risk of exposure) which could lead to financial penalties to the Trust. As a result, the current failure has led to business continuity plan enactment which necessitates diversion of this work to Scunthorpe which causes a direct impact on patient care. This is affecting ULHT / NLAG and 81 ICB Surgeries and patient flow as patients are waiting longer for a diagnosis which could have a negative impact on their outcome In addition; without the ability to inactivate Category B waste onsite via the autoclave at Boston, waste is going out in a higher category stream at increased cost to the Trust. We are sending approximately 250 lower respiratory samples (sputum, bronchial lavage and pleural fluid) to Scunthorpe each week. Half of these samples will be subject to a 24 hour delay in the reporting of culture findings. Due the additional pressure on the Scunthorpe laboratory, they have needed to redistribute work to ourselves to compensate. This comprises of approximately 250 bacteriology swab samples (throat swabs, ear swabs, eye swabs and wound swabs) sent to Boston each week. These samples are also subject to a 24 hour delay in the reporting of culture findings. So, in summary, we can state that approximately 125 lower respiratory samples and 250 bacteriology swabs per week are subjected to delayed reporting by 24 hours. This has a considerable clinical impact as there is a delay to clinicians receiving reports that may (a) instigate a course of antibiotic treatment, (b) modify a course of antibiotic treatment, (c) allow for the cessation of a course of antibiotic treatment. This is likely to increase length of stay, contribute to poorer outcomes for patients in general and increase infection prevention issues (as there will be delayed diagnoses of such things as multiply resistant bacterial infections and pulmonary tuberculosis).	Ceased processing of respiratory samples as the Trust have no method of making waste from these tests safe prior to disposal. Business Continuity Plan diversion of this work to Scunthorpe Using Taxis but this is incurring a cost to ULHT Staff working additional hours at Scunthorpe Two units were moved to Boston from Lincoln as part of the transfer of microbiology service in 2009, one of the units failed and has been out of use for 10+ years. The second unit has been supported by E&F onsite at Boston with LTE servicing and repairing when required.	Audit KPI's Datix Incidents Complaints / PALS	29/11/2024	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Specification to be completed and sent to E&F – James Cragg/Michael Jewsbury to submit by 30/07/2024 BCP to be reviewed – James Cragg/Michael Jewsbury reviewed 30/07/2024 LEBBS – Lincolnshire Charity Bikes to be contacted regarding Monday to Friday support - James Cragg - Pending response 02/08/24-06/08/24 Apply for derogation once specification / plan is in place – James Cragg and Michael Jewsbury - 16/08/2024 Purchase and installation of new Autoclave Unit - Chris Davies - 30/01/2025	[29/11/2024 16:15:24 Gemma Staples] Derogation application pending ULHT security team site plan and risk assessment for work around. ULHT team confirmed purchase and installation of a replacement today after E&F approval, spec confirmed pending . [28/08/2024 14:13:41 Rachael Turner] Risk presented at RRC&C meeting 28/08/2024. Risk validated at a 5x3: 15 High Risk. [19/08/2024 10:12:54 Gemma Staples] Update from James Cragg: Working through Derogation application, met with ULHT team actions below: Meeting Andy Miles/Keiron Davey/Joseph Pearson apologies. Action Email ULHT DGSA for consulation/report, Updated H&S Risk assessment for waste derogation, Porters training, Pathology staff training, Keiron advised Threat risk assessment - Gareth Holder - storage of waste below removal. Site visits organised for W/C 19/08/2024, two suppliers attending. [06/08/2024 12:02:09 Gemma Staples] Update: Discussions taken place with E&F to look at alternative options. Quoted £50k for 3 years for a van to go to Scunthorpe and back. LEBS - Lincolnshire Charity Bikes Lead contacted and is going to respond with what actions they can support with our request for additional support Monday - Friday. Antenatal department is potentially looking at a case in ULHT Charitable funds as although LEBS is a charity there are costs associated with this so some funds from NLAG & ULH Charitable funds may be a way to do this. [29/05/2024 13:47:47 Gemma Staples] No attendance to present so deferred to June RRC&C meeting [02/05/2024 10:41:24 Gemma Staples] Additional information has been added to the risk detail and this will go to May RRC&C meeting for approval.	6	13/03/2025		28/02/2025
3c. A modern, clean and fit for purpose environment across the Group	4858	12	Service disruption		Parkhill, Michael	Whitehead, Mr Stuart	Emergency Planning Group, Estates Infrastructure and Environment Group	10/02/2022	25	Corporate	Estates and Facilities	Estates	Trust-wide	If there is a critical failure of the water supply to one of the Trust's hospital sites then it could lead to unplanned closure of all or part of the hospital, resulting in significant disruption to multiple services affecting a large number of patients, visitors and staff	Estates Infrastructure and Environment Committee (EIEC). Estates risk governance & compliance monitoring process. Emergency Planning Group / Major Incident Plan and departmental business continuity plans.	Surveys of water supply infrastructure - Pilgrim Hospital is served by only one incoming water main. This is in very poor condition and has burst on several occasions causing loss of supply to the site.	21/01/2025	Reasonably likely (3) 31-70% chance	Extreme (5)	High risk (15-16)	15	Regular inspection, automatic meter reading and telemetry for the incoming water main at all sites. Keeping components on site and regular contractors on stand by. Regular stock levels for emergency fixes. Recently undertaken a survey that looks at the condition of infrastructure. Future survey work will be taking place with Aquawave (Anglian Water) who will do a survey of all the pipework Trust-wide. Pilgrim/Watertank replacement has concluded.	[21/01/2025 12:06:29 Rachael Turner] There is year end capital money available to carry out surveys for all sites this will give a better understanding or risks involved. [17/09/2024 08:35:28 Rachael Turner] We are still trying to identifying appropriate funding for this survey but are still awaiting feedback. Risk score remains the same. [25/06/2024 09:06:05 Rachael Turner] Survey work is ongoing, update to be provided by Paul. [20/03/2024 15:07:19 Rachael Turner] Recently undertaken a survey that looks at the condition of infrastructure. Future survey work will be taking place with Aquawave (Anglian Water) who will do a survey of all the pipework Trust-wide. Pilgrim/Watertank replacement has concluded. [19/03/2024 10:22:50 Rachael Turner] Risk reviewed. Risk reduction plan updated. Risk score remains. [29/01/2024 19:38:32 Rachael Turner] 2 x feeds to site, one at the Hospital Exit Road, adjoining Sibsey Road & one coming in from the start of Castle Road, the access road to Progress Living. I have 2 water storage tanks, Capacity per tank is 243m³/243,000L, This is potable quality water & will supply the hospital for approx. 20 hours. [21/10/2022 09:06:00 Walter Thompson] Scheme for replacement of critical water tanks - Pilgrim HB- is being developed for the capital plan 22/23 Scheme of work and design currently being produced.	5	30/10/2020	31/03/2023	21/04/2025
2a. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	5381	560	Service disruption		Landon, Caroline	Hodgkins, Mr James		09/02/2024	15	Corporate	Operations	Operations		Discharge Lounge (DL) has insufficient substantive workforce to meet current service demands. Significant RN and HCSW WTE shortfall. No B7 manager in place. B6 jnr sister post is unfunded secondment. No ward clerk. Insufficient housekeeping hours. This means that DL cannot staff each shift witihin budget and relys on temporary workforce and inpatient ward support. RNs and HCSWs act as ward clerk and Housekeeper. The risks are:- service is not well led on every shift contributing to delays, failed discharges, reduced patient capacity and turnover, reduced patient flow impacting on front door, omissions in care, omissions in documentation, errors, patient safety incidents, poor staff wellbeing, Poor patient notes and careflow management, poor patient experience. Improvement to practice very challenged to implement due to temporary staffing. Unable to function within current budget. Reputational damage. Inability to meet CQC requirement from 2021 audit.	Each shift has substantive, bank or ward swap nurse in charge. Staffing issues on the day managed by ops matron. Shifts go to bank and then to agency. Dynamic risk assessment; capping capacity or refusing complex patients. Strategic on call sign off required to close discharge lounge due to staffing. Orientation of temporary staff; Induction materials. limited support and advice from operations centre. RNs and HCSWs complete meal and refreshment service. RNs and HCSWs complete cleaning required outside of 2hrs allocated Housekeeper time. RNs and HCSWs complete ward clerk duties.	Healthroster, Workforce safeguard spreadsheet, 8a lead audit, flo audit, datix, PALS feedback and complaints, e-mail feedback, monthly budget, CQC assurance summary, DL patient flow dashboard, daily delays escalation, complaints, PALS feedback, TSSG, Confirm and challenge process. Sickness rates.	24/01/2025	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	1)Recruiting RNs against potential agency savings as part of TSSG. 2)Case of need in progress to fund appropriate establishment to meet demand.	[24/01/2025 14:12:16 Rachael Turner] Risk reviewed, no change risk score remains at current position. [25/06/2024 17:05:43 Rachael Turner] Risk reviewed, no change, risk score remains. [28/02/2024 11:51:43 Rachael Turner] Risk presented at RRC&C meeting 28/02/2024. Risk validated at 5x3: 15 High Risk.	4	09/02/2025		24/04/2025

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
1c. Improve clinical outcomes	4840	329	Physical or psychological harm		Costello, Mr Colin	Baines, Andrew		19/01/2022	15	Clinical Support Services	Pharmacy CBU	Pharmacy	Trust-wide	As a result of National shortages of medications there is a risk that there will be a potential impact on patient treatment unless we can source suitable alternatives which may include unlicensed imports (this is licensed in the country of origin but not UK licensed). The shortages can impact multiple wards / divisions. Use of unlicensed products is associated with an increased administrative burden for Pharmacy and Clinicians. There is a risk within unlicensed products where not labelled in English so Pharmacy manage an over labelling process.	National policy: - NICE Guideline NG5: Medicines optimisation, etc. ULHT policy: - Policy for Medicines Management: Sections 1-8 (various approval / review dates) ULHT governance: - Trust Board assurance via Quality Governance Committee (QGC) / Medicines Quality Group (MQG) - Purchasing for Safety - Unlicensed Medicines Policy Medicines Shortage Notification (MSN) tracker completed regularly assessing each medication - (This goes to the MQG and is attached to the risk)	Monitoring medication stock levels / reported shortages Shortage tracker	29/11/2024	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Continue to monitor and assess medication shortages and alternatives – Andrew Baines - Ongoing	[29/11/2024 10:11:09 Lisa Hansford] No further update [28/08/2024 13:58:20 Rachael Turner] Risk presented at RRC&C meeting August 2024. There are no concerns of the quality and safety of the drugs. Due to the complexity of this risk it has been requested to develop an Overarching Medication risk for the Trust and then Pharmacy to provide individual risk assessments for each drug. Governance to support. Following this we can agree the risk score. Risk to remain open at current score until this risk is developed. [09/08/2024 12:32:47 Gemma Staples] Following discussion at PSG it was asked that Pharmacy review the scoring due to the risk of serious harm to patients due to some of the drug shortages. Risk reviewed and request made for this to be increased to a 5x4(20). Increase in scoring to be presented at August RRC&C meeting for agreement. [26/06/2024 15:32:16 Rachael Turner] Risk presented at June RRC&C meeting. Risk score validated for an increase in score 5x3: 15. [19/06/2024 14:22:14 Gemma Staples] Request for risk to be increased to 5 likelihood and 4 Severity. Trended upwards in number of shortages since 2020. We are averaging 13 per month currently we are on 74 for 2024. We got to 118 total in 2023. The complexity and potential risk associated with MSNs appears to be increasing, with a growing requirement to scope the use of unlicensed imported medication – this is a more complex process in terms of risk assessment, engagement with clinicians, order receipt and stock management as such lines need to be held in quarantine to undergo a formal sign off by a member of pharmacy before being able to be put into use. [04/04/2024 09:07:26 Lisa Hansford] No further update [29/12/2023 14:09:12 Lisa Hansford] No further update [26/09/2023 14:31:35 Rachel Thackray] Supply outside of pharmacy control, mitigation in place. Improved internal risk assessment process for new drugs. [27/06/2023 09:42:07 Alex Measures] Discussed in risk register review meeting-	6	01/12/2021	31/05/2023	28/02/2025
1b. Improve patient experience	4701	85	Reputation		Grooby, Mrs Libby	Upjohn, Emma	Patient Experience Group	13/01/2022	15	Family Health	Women's Health and Breast CBU	Obstetrics	Trust-wide	If the quality and condition of the hospital environment and facilities used within Maternity services are poor then it may have a negative impact on patient experience and staff morale resulting in loss of confidence in the Trust and damage to reputation; there is also an increased infection risk	- Trust procedures for capital investment and Estates project management - Corporate oversight through Estates Investment & Environment Group / Finance, Performance & Estates Committee (FPEC)	Patient & staff feedback on the environment in Maternity services. Audits of infection prevention & control compliance. Reported health & safety and IPC incidents.	24/01/2025	Reasonably likely (3) 31-70% chance	Extreme (5)	High risk (15-16)	15	Plans for refurbishment of Maternity units on both sites, estimated timescales 3-5 years for LCH, PHB to be confirmed. Full Business Case required. Maternity shared decision council looking at simple solutions for improving working lives of staff.	[24/01/2025 12:32:05 Nicola Cornish] no change, will remain ongoing until refurb programme is complete. [24/10/2024 15:12:06 Nicola Cornish] Risk reviewed, no change. [25/09/2024 13:13:56 Nicola Cornish] Discussed at RR Confirm & Challenge meeting on 25th September 2024. Risk severity was scored as 5 when initially added but ward has since relocated and some issues addressed so consideration to be given to reducing this to 4. Bring back to next meeting for approval. [09/07/2024 16:06:45 Nicola Cornish] This is ongoing, business cases have been developed for both sites and it is anticipated that work will commence on the Lincoln site before the end of this year. [04/04/2024 10:32:18 Nicola Cornish] No change, awaiting trust board decision regarding the architect plans. [23/01/2024 16:04:20 Nicola Cornish] The team are continuing to work with architects to develop plans, which are expected to be submitted to the Trust board for approval by 31st March. [17/10/2023 09:30:32 Nicola Cornish] Nettleham have moved to Langton, in process of issuing purchase orders for design team and healthcare planners have visited Pilgrim. Meetings to schedule accommodation. [04/07/2023 09:11:47 Alex Measures] Risk reviewed 03/07/2023- Nettleham has decanted to 1st Floor to allow for works to commence as per plan. [04/04/2023 12:45:23 Jasmine Kent] Predicted date for decanting Nettleham to Langton 02/05/2023. While awaiting funding for refurbishment of Nettleham. Drain work at Pilgrim site is scheduled. [23/01/2023 17:04:59 Jasmine Kent] Included within capital allocation bids for next financial year. Agreement from trust board that works will take place in next financial year. Staff engagement sessions to communicate refurb plans. Issues dealt with by	6	31/03/2025	31/03/2025	24/04/2025
2a. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	4905	48	Physical or psychological harm		Cooper, Mrs Anita	Taylor, Ruth		22/04/2022	12	Clinical Support Services	Therapies and Rehabilitation CBU		Trust-wide	As a result of having insufficient staffing, or required level of experience and skill, the risk is patients will not receive assessment and rehabilitation leading to poor clinical outcome. Reduced flow on Ashby and the acute wards, delayed discharges, delayed referral to response times. Increase in avoidable harm i.e. deconditioning. Patient reviews delayed. Lack of specialist service area resource impacting on long term social value outcomes. Lack of consistency of provision across Lincolnshire footprint. Existing staff stretched to cover additional beds. Increased stress and sick leave on substantive staff.	Recruitment and retention strategies being work through. Therapies and rehab right sizing and service review. Improved joint working with LCHS and system colleagues. Clear therapies and rehab strategy to include CIPP and CON. Working with finance on establishment and nominal role review. Plan in place for sustainable medical workforce rehab medicine. Development team established for therapies. Neuro psych posts recruited too, therapies at front door service substantive funding in place.	Patient complaints. Monitoring of flow at front and back door. Site escalation. Vacancy rate monitoring. Roster fill rates. Waiting list numbers of frequency of follow ups. Staff absence. Staff survey and feedback.	04/02/2025	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Good use of relocation and workforce development resources. Actively managing and reviewing the waiting lists to include RAG rating, use of TC/VC, PIFU and discharge . Case of need strategy in place linked to wider system work. Development team in place. Competency frameworks and preceptorship processes being developed. Joint working with LCHS including new joint system posts. Clear strategy in place to include capacity and demand management, workforce management and development - Ruth Taylor Lead to all above with completion dates as March 2025	[04/02/2025 11:33:00 Gemma Staples] Risk remains the same with a deteriorating picture currently on Ashby therapy and OT at PHB. [04/11/2024 11:14:51 Gemma Staples] Risk reviewed and remains the same [20/08/2024 09:21:14 Gemma Staples] Risk reviewed and will be reviewing progress monthly as is part of our workstream plan. [07/05/2024 11:37:33 Gemma Staples] The position remains the same however we are looking at capacity and demand reviews. We have also looked at were there is a known risk and been able to recruit to those areas against the matched establishment. Potential challenges to putting forward cases of need in the current financial restrictions and processes. [05/02/2024 11:25:33 Gemma] We are in the process of working on Therapy Strategy document and models of care document which will review current position against future planning. There is a safer staffing template for OT and Physio. Dietetics team to review use of this. [08/09/2023 14:19:33 Maddy Ward] We have made some progress in terms of recruitment but level of risk to remain the same. Grantham site is fully staffed and risk is not relevant to Grantham. [23/06/2023 14:12:17 Rose Roberts] Been asked to put in a case of need for RSU on both sites. Will be reviewed by RT to see if the risk needs to be separated out. [09/05/2023 15:14:15 Sara Blackbourn] Addition of escalation beds. Front door pilot. Referral criteria review. [10/03/2023 13:46:14 Rose Roberts] One member of staff has returned but another member is on maternity leave and there is no cover for her. Across all the services continue to be flexible and look at the skill mix to allow to deliver the best service we can. [13/01/2023 12:54:24 Lesley Bradley] 13/01/2023 Continue to review staffing levels, vacancies and reasons for sickness on a monthly basis [15/12/2022 09:55:40 Alex Measures] still looking at models of how to measure	9	30/09/2023	18/12/2023	02/05/2025

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5535	784	Physical or psychological harm	Mooney, Mrs Katy	Hunter, Sarah			07/11/2024	15	Medicine	Cardiovascular CBU	Stroke	Lincoln County Hospital	Acute Stroke patients have no access to clinical psychology services in line with the National Clinical Guideline for Stroke 2023 which stipulates psychological care should be provided by stroke services across acute and community settings. Services for people with stroke should have a comprehensive approach to delivering psychological care that includes specialist clinical psychology/neuropsychology input within the multidisciplinary team and should include specialist clinical psychology/neuropsychology provision for severe or persistent symptoms of emotional disturbance, mood or cognition. This could result in patients not being able to engage fully with therapy leading to longer rehabilitation periods, increasing lengths of stay. It could also affect staff due to adverse behaviour by patients due to cognitive impairment.	There is currently no commissioned post for this service within the acute service there is limited provision in the community.	SSNAP data & Datix	29/01/2025	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Commission post and recruit to post, currently lies with CBU Proposal for additional ward space	[29/01/2025 13:45:12 Rachael Turner] Risk presented at RRC&C meeting 29/01/2025.Risk validated 5x3:15 High Risk. [05/12/2024 16:28:00 Rachael Turner] Risk description updated to reflect guidelines and negative impact to patients and staff. This risk to be agreed at Stroke and Cardiovascular CBU Governance, once agreed this will be presented at Risk Confirm and Challenge in January. [27/11/2024 13:21:18 Rachael Turner] Risk presented at Risk Confirm and Challenge 27/11/2024, risk requested to be re-worded with details of what that guidelines, once updated this will be returned.	6	07/11/2025		29/04/2025
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5196	309	Regulatory compliance	Costello, Mr Colin	Hansford, Lisa			20/06/2023	15	Clinical Support Services	Pharmacy CBU	Pharmacy		As a result of regular audits not being completed, the standards for medicines storage are likely to fall below the required standards. Medicines storage and temperature monitoring was raised by CQC during the last inspection, as 'must do' actions. Some of these audits have legal implications such as the controlled drugs audits and safe and secure medicines storage. As we have had the same 'must do' action since 2018 with no improvement, there is possibility without full assurance they could impose improvement notices. Due to a shortage in staffing, Pharmacy department are unable to complete the annual medicines management and temperature monitoring audits for all clinical areas that store medication. The organisation is required to be compliant with both the RPS Guidance for the safe and secure handling of medicines and the Health Building Note (HBN 14-02).	The matrons and quality matrons complete ward assurance audits that include some medicines management questions.	Review of incomplete audits, highlights that there are ongoing issues with timely completion of medicines management audits due to the lack available staff to complete these. Datix incidents reported indicate ongoing issues with medicines management.	06/12/2024	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Business Case to be completed to improve Pharmacy staffing - Ahtisham Saddick - September 2025	[06/12/2024 17:41:52 Lisa Hansford] No further update [04/09/2024 14:09:01 Gemma Staples] Lisa Hansford reviewed the risk and updated details and felt the risk should stay as a 5x3. [21/08/2024 16:34:29 Gemma Staples] A request for a decrease to go to September RRC&C meeting from a 5x3 to a 4x2 [10/07/2024 11:21:47 Lisa Hansford] no further update [04/04/2024 09:05:12 Lisa Hansford] No further update, still not in a position to be able to complete the safe and secure medicines storage audits due to staffing. [29/12/2023 12:55:51 Lisa Hansford] No further update [26/09/2023 14:53:17 Rachel Thackray] No further update [07/09/2023 14:10:05 Lisa Hansford] 7.9.23 no further update	4	20/06/2024		06/03/2025
2a. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	4762	47	Service disruption	Capon, Mrs Catherine	Rojas, Mrs Wendy	Nursing, Midwifery and AHP Forum, WORK		14/01/2022	15	Surgery	Theatres, Anaesthesia and Critical Care CBU	Critical Care	Lincoln County Hospital	Issues with maintaining nurse staffing levels/skill to establishment in ICU at Lincoln.	Nursing workforce planning arrangements. Nurse recruitment / retention processes. Clinical Governance arrangements in Critical Care / Surgery Division.	Staffing vacancy rate within ICU nursing	11/09/2024	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Review of current recruitment strategy. Advertisement for vacant posts.	[11/09/2024 14:26:31 Nicola Cornish] Risk reviewed, no change. [14/06/2024 13:15:32 Nicola Cornish] All substantive posts have now been recruited to but the staff are not yet not fully skilled yet. Additional funding for the clinical educator continues in order to support staff development. [09/05/2024 12:15:19 Nicola Cornish] Risk reviewed as felt needed to stay at 15 due to increased capacity in ICU, increased vacancy and poor skill mix. As of 8th May we currently have 8.91 wte vacancy at Lincoln and 0 vacancy at PHB. We are interviewing this month and hope to fill all vacancies. Skill mix will remain an issue but we have recruited some nurses with critical care experience. It will be several months before skill issues improve. We continue to have an additional clinical educator funded by the network. [26/03/2024 13:42:01 Gemma Staples] Risk reviewed at RCC&C today and it was agreed that the risk be reviewed and updated to include capacity aswell as skill and to look at if this is a service disruption risk. Once reviewed then the risk scoring should be looked at based on this. The risk scoring is to be left as it is and to be brought back to the next RRC&C meeting in April 2024. [09/02/2024 10:12:46 Nicola Cornish] Recruitment successful and minimal vacancy however due to the number of new starters skill mix remains an issue. I have reduced the risk this month as our position is improving. We have received network funding which will enable us to continue with additional clinical educators on both units. [18/11/2023 21:08:13 Nicola Cornish] No change to risk score. Part of ICU workforce group that meets weekly. Minimal vacancy across both sites but skill mix remains diluted. Additional clinical education support on both sites and additional funding from network to support training and development. [25/10/2023 11:21:03 Rachael Turner] Risk reviewed at RRC&C still a high risk,	6	30/06/2021	30/09/2022	11/12/2024
3c. A modern, clean and fit for purpose environment across the Group	4830	11	Service disruption	Cooper, Mrs Anita	Myers, Joseph	Estates Infrastructure and Environment Group, Medicines Quality Group		17/01/2022	15	Clinical Support Services	Pharmacy CBU	Pharmacy	Pilgrim Hospital, Boston	The area above Pharmacy at Pilgrim Hospital contains estates plant and pipes that are prone to blockage and overflow, which could cause extensive damage to medicines; computer equipment and aseptic facilities that disrupts service continuity.	ULHT policy: - Estates maintenance / repair arrangements - Business continuity plans ULHT governance: - Trust Board assurance via Quality Governance Committee (QGC) / Medicines Quality Group (MQG) / Pharmacy CBU / CSS Division	Reported incidents of service disruption	20/12/2024	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Discussions with Estates to identify potential solutions to the blockage / overflow issues. Contingency plan - medicines and equipment are moved to a temporary location in the event of overflow into Pharmacy. 7.9.23 there are no ongoing conversations with estates. JM will open up discussions again with estates and facilities	[20/12/2024 13:09:07 Gemma Staples] Update from Estates - Russell Fordham is looking into this and will provide a further update, but the feasibility of moving services is very unlikely. [10/10/2024 09:55:21 Lisa Hansford] further leak 07.10.24 – we have had to switch off lighting to an area of pharmacy. Thankfully leak started whilst we were on site otherwise could have destroyed lots of stock, including some on shortage list (KCl) – minimal loss due to quick response: [10/07/2024 11:31:17 Lisa Hansford] no further update [04/04/2024 09:21:11 Lisa Hansford] No further update, all leaks reported to estates [29/12/2023 12:17:18 Lisa Hansford] Leak in dispensary w/c 18th December and stock had to be moved to prevent damage. [26/09/2023 14:12:47 Rachel Thackray] No further update [07/09/2023 14:20:37 Lisa Hansford] 7.9.23 no further update [01/08/2023 14:22:43 Rachael Turner] Risk discussed as RRC&C in July, risk approved to an increase in score to 5x3: 15 High Risk [27/06/2023 09:21:08 Alex Measures] meeting raised risk level to 15 Colin Costello to meet with Paul Dunning on Monday to get exec approval [01/06/2023 14:33:41 Lisa-Marie Moore] Risk ongoing no further update [29/03/2023 11:22:00 Maddy Ward] Discussed at Pharmacy Risk Register Review meeting today and risk is ongoing, no further update. [20/12/2022 14:16:17 Alex Measures] no updates - risk likely to increase in future reviewed 01/07/21 - ongoing, increase likelihood to likely 150622 ongoing. Shut down aseptic facility at PHB and put in a modular unit at PHB as consequence. Colin considers the risk level should be increased, to be discussed at confirm and challenge meeting next week.	6	30/09/2021	31/03/2022	20/03/2025

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population	5169	60	Physical or psychological harm	Mooney, Mrs Katy	Hunter, Sarah		09/05/2023	15	Clinical Support Services	Therapies and Rehabilitation CBU		Lincoln County Hospital	Approx 15-20 Stroke outliers at any time on the LCH site. Therefore not on the stroke unit and not receiving specialist stroke therapy at the frequency and duration required by SSNAP. Outlier patients are not cohorted on site and can be on any ward therefore Stroke staff cannot go and review and advise. Stroke patient on other non stroke ward will not be assessed as a priority as they are not medically optimised and ready for discharge. Current staffing levels are for the 28 bedded Stroke unit only. If a stroke patient is seen o a non stroke ward this is to the detriment of another patient on that ward. Increased staff stress. General wards do not have the treatment facilities that Stroke patients need.	Stroke Therapy Team review all outliers at the cost of not seeing the Stroke ward patients as much. Stroke team will advise general ward based therapy team. Minimal basic Stroke assessment and treatment skills for general ward therapy staff. Proposal to implement Trusted Assessor Stroke Assessment.	Datixes M&H injury to staff and patient	05/02/2025	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Moving of Stroke specialist therapy staff from PHB to LCH Robust stroke training plan for general ward staff Attendance at Stroke Board to influence change and need for cohorting of outliers Review of Stroke staffing in line with latest staffing levels needed 16/10/23 funding transferred to LCH budget to help support staffing and recruitment has started	[05/02/2025 10:03:18 Gemma Staples] This risk is ongoing, work continues to expand the stroke bed base and the workforce proposal will be in line with the additional beds and national guidelines for therapy staffing levels, unfortunately due to the need for a ward refurbishment and business case approval the predicted completion date is December 2026 [and this may be optimistic.] [04/11/2024 13:21:24 Gemma Staples] We have been working with finance to look at the uplift of staffing against the current staffing guidelines as part of a wider business case linked to the Stroke Estates. [05/08/2024 11:15:56 Gemma Staples] We are currently involved in a review of Estates. Meeting to take regarding plans. Trying to get a Consultant / AHP job description matched to try and support the staffing issues on the Stroke Unit. We have a joint band 6 OT post with LCHS focussing on flow and discharge. Ongoing work with LCHS to enhance the pathway in order to meet standards required. Ongoing discussions with finance & ICB around additional staffing. [07/05/2024 11:25:01 Gemma Staples] Increased staffing - additional full time band 6 Physio and a rotational band 6. x 2 Band 6 OT's increase. Extra x1 band 4. Currently collecting data on Stroke and Neurological outliers to consider an outlier team. [05/02/2024 11:11:38 Gemma] Risk reviewed and is still ongoing [16/10/2023 11:12:34 Sean East] 16/10/23 funding transferred to LCH budget to help support staffing and recruitment has started [08/09/2023 14:20:40 Maddy Ward] Consultation in progress currently with the intention to move some money across to Lincoln. This links in with joint working with LCHS. [23/06/2023 14:13:54 Rose Roberts] No change, went to C&C recently and level agreed. [07/06/2023 12:45:33 Rachael Turner] Risk discussed at RRC&C meeting 07/06/2023.	8	13/05/2024		05/05/2025
1b. Improve patient experience	4724	86	Physical or psychological harm	Lynch, Diane	Taylor, Ruth	Patient Experience Group	13/01/2022	20	Clinical Support Services	Therapies and Rehabilitation CBU		Lincoln County Hospital	If Therapies and Rehabilitation service provision is not sufficient to deliver 7 day service provision, it leaves services without cover at a weekend or with inadequate cover during the week, leading to delayed patient flow; delayed discharge; extended length of stay; impacting on patient experience with potential for serious harm. This includes the neuropsychology cover on Ashby, SLT cover for inpatients, and therapy cover on ITU.	ULH policy: - Service planning & budget setting processes - Business case decision making processes ULH governance: - Capital & Revenue Investment Group (CRIG) management of business case process - CSS Division, CBU / speciality governance arrangements	Level of cover at weekends. Length of stay, patient flow, delayed discharges. Level of funding - Some 7 day funding, but limited to orthopaedics at LCH, minimal service. Inadequate for level of service demand.	04/02/2025	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Review current provision and identify gaps in service to inform business cases for change (working with Surgery and Medicine Divisions as appropriate). Skill mix requires review due to complexity of patients. Prioritisation tool helps to identify patients with greatest acuity or importance which will directly impact patient flow and current bed situation.	[04/02/2025 11:41:42 Gemma Staples] Remains the same until we have completed the current work around right sizing with budgets and staff. Closer scrutiny and management of rosters since December 24 has shown better results leading to the use of bank staff at weekends to boost services. [04/11/2024 11:04:16 Gemma Staples] We have been working with finance to look at the uplift of staffing against the current staffing guidelines as part of a wider business case linked to the Stroke Estates. [05/08/2024 11:07:48 Gemma Staples] Risk reviewed and remains the same. [07/05/2024 11:16:36 Gemma Staples] Risk reviewed and remains the same. Increased extra ward cover at Lincoln. [05/02/2024 11:06:18 Gemma] Risk reviewed and ongoing. [06/12/2023 13:09:39 Gemma] Conversations are currently happening in regards to appropriate staffing levels for ICU for Therapy Services. Further update to follow [25/10/2023 15:07:18 Rachael Turner] Business case being undertaken by CSS, needs to go through approval process. [08/09/2023 14:14:43 Maddy Ward] Reviewed at quarterly risk register review meeting. Risk is ongoing at present. [23/06/2023 14:07:53 Rose Roberts] Recruited into the Neuro psychology post. Increase risk in consultant cover - sickness and resignation. potential to have to stop admissions. [10/03/2023 13:43:06 Rose Roberts] Awaiting nhse results. Neuro psychology bid waiting to go to CRIG [13/01/2023 12:51:48 Lesley Bradley] 13/1/23 NHSE reviewed Ashby ward this month-await recommendations for staffing levels [15/12/2022 09:53:21 Alex Measures] No update [30/11/2022 10:04:52 Rose Roberts] Neuropsychology bid is still awaiting CRIG approval as CRIG has been stood down.	4	05/01/2024 13/02/2025	31/03/2023	02/05/2025
3c. A modern, clean and fit for purpose environment across the Group	5383	615	Regulatory compliance	Cooper, Mrs Anita	Rigby, Lauren	Estates Strategy Group, Health and Safety Group	13/02/2024	15	Clinical Support Services	Cancer Services CBU	Haematology (Cancer Services)	Pilgrim Hospital, Boston	As a result of the treatment room not being compliant with HBN 00-03 procedures are being performed in an area that is not compliant, Adhoc and urgent bone marrow biopsies and intrathecal chemotherapy will still be performed in this room which would lead to an infection risk to patients.	Room is being decluttered Estates have reviewed, still awaiting if they can increase the air exchanges and how much this would cost. Larger organisation piece of work being undertaken Regular bone marrow biopsy clinics have been moved to outpatient department Venesections have been confirmed by the lead Estates Nurse can continue Risk assessment and precautions have been circulated to staff to adhere to for adhoc and urgent bone marrow biopsies and intrathecal chemo.	Datix incidents Complaints / PALS Assessment against regulations	24/01/2025	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Estates job logged to see if can increase air exchange to 10 - Stuart Whitehead - December 2024 Wider organisational piece of work - Karen Bailey - December 2024	[24/01/2025 10:04:54 Gemma Staples] Risk remains the same as we are currently awaiting on Estates. [08/10/2024 10:11:18 Gemma Staples] Venesections can remain, we have moved BM biopsies out, urgent is undertaken with risk assessment, still awaiting works to make the room right. [26/07/2024 10:59:13 Gemma Staples] Estates have been out to look at the room and we are awaiting a quote to see if they can undertake the work. [23/04/2024 13:12:50 Gemma Staples] BM biopsies moved, Karen Bailey confirmed venesections do not require the air exchanges, only IT chemo will be administered in this room being discussed with IT lead and pharmacy lead around options. [26/03/2024 16:04:11 Gemma Staples] Risk reviewed at the RRC&C today. Update: Suggested at last RRC&C meeting that Estates have one overarching risk but list each identified areas under this risk. Rachel Turner has met with Chris in Estates as this is one area of about 11 areas across all divisions where procedures are taking place without correct ventilation. Chris has a list of areas of which he is asking each area to review and look at areas to see what we can deal with now and then look at what is left. It was agreed that this risk be left on until the overarching risk has been added [13/03/2024 11:15:52 Gemma] Update: We have moved the bone marrow biopsies out. We are waiting to have a meeting with the lead nurse on the ventilation project to understand if venesections can continue in there but at present they are weekly. We also do not yet have another identified area for IT chemo but this is far and few between. [28/02/2024 11:41:30 Rachael Turner] Risk presented at RRC&C, we need to establish if any procedures are happening in this room as this would be a patient safety risk. Once established this will be re-presented in March.	3	13/02/2025	13/02/2025	24/04/2025

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	Lead Oversight Group	Reportable to	Opened	Rating (inherent)	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
2a. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	5439	714	Service disruption		Costello, Mr Colin	Saddick, Ahtisham		14/05/2024	20	Clinical Support Services	Pharmacy CBU	Pharmacy	Trust-wide	As a result of weekend workload (dispensing and checking of medication) exceeds staffing capacity on all sites, which leads to colleagues staying late and workplace stress. This results in serious and long-term effects on staff health and wellbeing. The Working Time Regulations (1998) state that breaks are mandatory but under current working structures, the weekend team are staying late to complete the workload. Therefore the Trusts is failing to comply with the legal requirements of rest periods as the weekend team feel undertaking breaks will compound on late finishes. A key improvement theme from the pharmacy staff survey identifies service resilience and quality- It is felt that weekend understaffing and negativity is leading to stress, burnout, dissatisfaction and low morale. There is the possibility that goodwill of staff will cease therefore the weekend dispensary team will finish on time and not stay late. The consequence is the workload will become unsafe for one on-call pharmacist. Without adequate staffing, the wellbeing of the pharmacy team would be compromised, as they will continue to work extended hours without breaks. This situation poses a high risk in terms of patient safety as errors occur due to fatigue. Additionally, regulatory compliance issues with the Care Quality Commission (CQC) would arise, further jeopardising the quality-of-service delivery.	Staff working voluntary overtime to complete workload Case of need and Business case developed and approved at CSS Business meeting	Late finishes (data from healthroaster and time sheets) Items dispensed on a weekend - workload Near misses/error recording systems Staff surveys discussing welling Staff concerns regarding lack of breaks / late finishes Staff sickness	29/11/2024	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Case of need and Business Case to seek approval from CRIG - Ahtisham Saddick - November 2024 A proposal is being developed which will review workforce allocation and suggest a new way of working on the weekends. This will discuss an increase in staffing resource and will form the basis of the CoN/BC – Ahtisham Saddick – End of July 2025	[29/11/2024 10:09:34 Lisa Hansford] Case of need and Business Case to seek approval from CRIG - Ahtisham Saddick - November 2024 A proposal is being developed which will review workforce allocation and suggest a new way of working on the weekends. This will discuss an increase in staffing resource and will form the basis of the CoN/BC – [28/08/2024 14:20:51 Nicola Cornish] Risk discussed at Risk Register Confirm & Challenge meeting on 28th August. Likelihood score of 5 agreed because it is happening every weekend but severity approved at 3. Case of need timescale needs to be amended as this is already written. [29/07/2024 12:13:26 Gemma Staples] The pharmacy service currently operates as a half a day service on the weekend, this is not a service which has been separately funded. Five-day cover was expanded with existing staffing resource to include an additional two half days for Lincoln and Pilgrim sites and one additional half a day for Grantham; this has created further clinical cover gaps during the working week. [29/05/2024 12:44:11 Nicola Cornish] Discussed at RRC&C meeting on 29/05/24 - not approved, need to articulate the mitigations and risk reduction plans more fully, also need to review scoring to consider the level of harm to staff and how often it is happening at this level. Look at whether there is any incident data to demonstrate patient harm that would support a Very High score.	3	14/05/2025	31/07/2025	28/02/2025

NHS
Lincolnshire Community and Hospitals NHS Group

Board Assurance Framework 2024/25

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

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*4 March 2025*
Item Number	*Item 14.2*

Lincolnshire Community and Hospitals Group Board Assurance Framework 2024/25

Accountable Director	*Professor Karen Dunderdale, Group Chief Executive*
Presented by	*Jayne Warner, Group Director of Corporate Affairs*
Author(s)	*Karen Willey, Deputy Trust Secretary, ULTH*
Recommendations/ Decision Required	*The Board is asked to:-* • *Consider the Board Assurance Framework for 2024-25*

How the report supports the delivery of the priorities within the LCHG Board Assurance Framework	
1a Deliver high quality care which is safe, responsive and able to meet the needs of the population	*X*
1b Improve patient experience	*X*
1c Improve clinical outcomes	*X*
1d Deliver clinically led integrated services	*X*
2a Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	*X*
2b To be the employer of choice	*X*
3a Deliver financially sustainable healthcare, making the best use of resources	*X*
3b Drive better decision and impactful action through insight	*X*
3c A modern, clean and fit for purpose environment across the Group	*X*
3d Reduce waits for patients who require urgent and emergency care and diagnostics and ensure we meet all constitutional standards	*X*
3e Reducing unwarranted variation in cancer service delivery and ensure we meet all constitutional standards (ULTH)	*X*
3f Reducing unwarranted variation in planned service delivery and ensure we meet all constitutional standards (ULTH)	*X*
3g Reducing unwarranted variation in community service delivery and ensure we meet all constitutional standards (LCHS)	*X*
4a Establish collaborative models of care with all our partners including Primary Care Network Alliance (PCNA), GPs, health and social care and voluntary sector	*X*
4b Successful delivery of the Acute Services Review	*X*
4c Grow our research and innovation through education, learning and training	*X*

4d Enhanced data and digital capability	*X*
5a Develop a Population Health Management (PHM) and Health Inequalities (HI) approach for our Core20PLUS5 with our ICS	*X*
5b Co-create a personalised care approach to integrate services for our population that are accessible and responsive	*X*
5c Tackle system priorities and service transformation in partnership with our population and communities	*X*
5d Transform key clinical pathways across the group resulting in improved clinical outcomes	*X*

Executive Summary

The Board Assurance Framework (BAF) enables the Board to maintain effective oversight of its strategic objectives with assurance being provided by the relevant Committees. The development of the Lincolnshire Community and Hospitals Group (LCHG) BAF is being completed alongside the development of the 2024/25 Strategy for the Group.

The 2024/25 framework has been further populated and developed following the approval of the 2024/25 Strategy and the Integrated Improvement Plan (ULHT) and Operational Plan (LCHS).

All Committees have received the BAF during the months of January and February, including the Audit Committee in January.

Monthly review and update of the BAF is being undertaken routinely which will enable the Committees to consider the content and assurance ratings with bi-monthly reporting to the Board. Reporting to the Audit Committee will continue on a quarterly basis.

Following review through the Committees there are no proposed changes to the ratings presented. The Board is asked to confirm the ratings.

Lincolnshire Community and Hospitals Group
Board Assurance Framework (BAF) 2024/25

Strategic Aims	Board Committee
Patients - To deliver high, quality, safe and responsive patient services	Quality Committee
People - To enable our people to lead, work differently, be inclusive, motivated and proud to work within LCHG	People Committee
Services - To ensure services are sustainable, supported by technology and delivered from an improved estate	Finance Committee / Integration Committee
Partners - To collaborate with our primary care, ICS and external partners to implement new models of care, transform services and grow our culture of research and innovation	Integration Committee
Population Health - To embed a population health approach to improve physical and mental health outcomes, promote well-being, and reduce health inequalities across an entire population	Integration Committee

Assurance Rating Key:	
Red	Effective controls may not be in place and/or appropriate assurances are not available to the Board
Amber	Effective controls are thought to be in place but assurances are uncertain and/or possibly insufficient
Green	Effective controls are definitely in place and Board are satisfied that appropriate assurances are available

Objective alignment
Lincolnshire Community Health Services NHS Trust objectives
United Lincolnshire Teaching Hospitals NHS Trust objective

Ref	Objective	Executive Lead	Linked programmes in Integrated Improvement Plan/Operational Plan	Linked projects in Integrated Improvement Plan/Operational Plan	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating										
SA1 To deliver high, quality, safe and responsive patient services																									
1a	Deliver high quality care which is safe, responsive and able to meet the needs of the population	Group Chief Nurse/Group Chief Medical Officer	1. Improve medical devices and use of in practice	1.1. Develop in house maintenance programme 1.2. Review contracts for medical supplies and medical device management 1.3. Support implementation of Point of Care (POC) testing at Urgent Treatment Centres 1.4. Modernising and innovating use of technology to improve quality of patient care 1.5. Virtual Ward Programme Support											Quality Committee									
			2. Wound care and improvement management	2.1. Implement the National wound care strategy for pressure damage 2.2. Implement the National wound care strategy for leg ulcers 2.3. Introduction of a digital application	1. Lack of resources 2. Lack of skills and capability 3. Leadership capacity 4. External partnerships and ways of working 5. Patients and public behaviours 6. Mindset of leaders 7. National releases on best practice	395 495 681 403 714 695 715		Skin Integrity Group (SIG) established as a sub group of the Patient Safety Group to provide oversight, monitoring and accountability of the ongoing improvement work around prevention of pressure ulcers and the wider skin integrity programme of work. Skin Integrity management policies, procedures and pathways in place.	Following National changes in pressure ulcer categorisation in April 2024, all ulcers previously categorised as Unstageable will now be classified as a minimum of Category 3 ulcers, and therefore an increase in Category 3 and 4 incidents is expected and has been observed.	Weekly Pressure Ulcer Assurance meetings with the community nursing teams with safeguarding support. Thematic review of all Category 3 and 4 incidents completed monthly and presented into QSG and SIG.	Skin Integrity care is reviewed in the weekly ward/service leader's assurance and monthly Matrons audits for CoHo and CoNu. The monthly Quality Metrics review meeting monitors ward and services performance relating to skin integrity. Skin Integrity Group (SIG) provides oversight and receives Divisional performance reports, which provide assurance of the improvement actions being taken in areas reporting increased number of incidents. Skin Integrity incidents are analysed to identify themes and trends which are reported through SIG and improvement actions identified. Overarching action plan for incidents, themes and improvement actions is in place and monitored through Skin Integrity Group	Work progressing on live data stream identifying all current pressure ulcer in the community. Requirement to triangulate oversight for complex wound with increase specialist support and confirm and challenge process.	Continued Observation of Section 42 incidents across community services. Safeguarding referrals monitored monthly by safeguarding team and via SVOG. Quarterly update reports to PSIRF				G	G	G	G	G	G	G	G	G
			3. Improve medicines related safety	3.1. Develop the pharmacy strategy, including gases and workforce																					

			4. Strengthen LCHS Patient Safety Culture	4.1. Embed the Just Culture principals and a full programme of training as part of the PSIRF response. 4.2. Strengthen a learning culture across LCHS through the introduction of the Patient Safety Incident Response Framework. 4.3. Recruitment of Patient Safety Partners																						
			5. Strengthen Effective Practice	5.1. Develop clear nursing competencies, from band 2-6, aligned to clinical pathways and best practice within community nursing and community hospitals 5.2.Expand our current research portfolio 5.3. Aim to be top recruiter in GP trials in East Midlands in 2023 5.4. Start participating in commercial trials 5.5. Work with the Medicine Management Team on medicines related research 5.6. Modernising and innovating use of technology to improve quality of patient care 5.7. Develop workforce plans for clinical services across the organisation 5.8. Support the delivery the clinical and professional workforce models in line with the Lincolnshire ACP strategy with regards to job plan implementation, workforce modelling and 3-5 year workforce training plans 5.9. Implement a Ward Accreditation Framework over the next 2 years to include all clinical teams in a phased approach																						
								Primary: 1. Clinical Strategy 2023-28 and linked reporting of delivery 2. Integrated Care System (ICS) Strategy 3. Integrated Care Board 5-year joint forward plan 4. Trust Leadership Team (TLT) reports 5. LCHS Operational Plan reports 6. Lincolnshire Long Term Plan 7. Quality Team/ Patient Experience and Involvement leads. Funding identified for new B7 Patient Experience Manager for LCHS. This is the sole establishment and Patient Experience now a Group managed model. 8. Complaints, Patient Advice and Liaison (PALS), and Claims Team. Data now included within SUPERB dashboard. 9. System Communications and Engagement Team 10. Volunteering Services Team. Voluntary Services now	1. System Engagement Team not currently in place and timeline not confirmed. 2. Data - not connected Datix/ Business Intelligence/ System 1 Head of Patient Experience & Patient Experience Data Insight Manager need LCHS systems access. Group approach to Patient Panel explored & agreed separate ULHT & LCHS Patient Panels that come together 1/4rly. Draft ToR and plan prepared with aim to commence recruitment in Jan 25 and launch April 25.	1. System CEOs meeting to progress decisions. 2. FBI developed rollout plan for datix being pulled into the data warehouse. 3. FBI developed rollout plan for Systemone data linkage to datix incidents/ complaints/ claims. PEIG Task & Finish Group established to lead Group modelling, planning and working.	1.1 Recruitment and delivery of System Statutory Engagement Team resource and plan 2.1 LCHS involvement plan, feedback, improvement and delivery of plan (including national patient surveys) 3.1 LCHS experience plan, feedback, improvement and delivery of plan 3.2 Improved service design, access and experience 3.3 LCHG plan in development that will include ULHT priorities, LCHS priorities and collaborative priorities. Self assessment completed by PEIG Task & Finish Group. Timetable is for this to be approved at Feb 24 PEIG and QGC for		New template for divisional assurance reports developed and scheduled reports received at PEIG. SUPERB now includes LCHS data, monthly reports and infographics received at PEIG and circulated. To identify service level champions / leads to work in partnership with Patient Experience Team.	Quality Committee												

1b	Improve patient experience	Group Chief Nurse	1. Grow People Engagement	1.1. Co-produce an LCHS statutory engagement plan and trajectory for informing decision-making and service delivery collaboratively across the group	1. Lack of System Engagement and Comms Team/ recruitment to team/ External partnerships and ways of working 2. Inadequate resources to deliver against objective/ programmes 3. Mindset, ownership and behaviour of leaders 4. Quality improvement approach and toolkit 5. System working interdependencies 6. Patients and public behaviours 7. Lack of capacity, capability and/or skills 8. Staff health and wellbeing	468 - Complaints		a Group managed model. 11. Triumvirate weekly complaints, incidents and claims reviews 12. Divisional monthly operational plan reporting. Divisions have now commenced Patient Experience Group meetings. 13. Quality Assurance Groups Secondary: 1. LCHG Patient Experience & Involvement Group (PEIG) 2. Clinical Safety and Effectiveness Group (CSEG) 3. Strategy and Planning Group (SPG) 4. Quality and Risk Committee (QRC) 5. Audit Committee 6. Trust Leadership Team (TLT) 7. Performance Management Reviews (PMRs) Tertiary: 1. Care Quality Commission Engagement and Assessment 2. Healthwatch monthly reports 3. Patient-Led Assessments of Care Environment (PLACE) Report 4. NHS Resolution reporting 5. Audit - internal/ external 6. Patient and Public feedback/ surveys/ NHS Choices Aiming to promote Care Opinion as a source. Data now included within SUPERB dashboard 7. Volunteering placement evaluations/ take up of opportunities 8. Complaints and Claims benchmarking data 9. Friends and Family Test data. New tender exercise across LCHS, ULTH, LPFT commenced. Current contract extended by 6 months			launch April 25.						G	A	A	A	A	A	A	A
1c	Improve clinical outcomes	Group Chief Nurse/Group Chief Medical Officer	1. Quality Assurance and Accreditation Programme	1.1 Develop a quality assurance assessment methodology 1.2 Develop a quality accreditation programme				Weekly assurance within Community hospitals with monthly overnight. Monthly oversight commenced in community nursing	Monthly senior review in CoHo with developing weekly review in CoNu. Defined therapy assurance and assurance for specialist services.	Quality team support and leadership in building programme	Monthly assurance meetings overseeing divisional performance and quality improvement plans	Increased senior assurance in Coho and other services where model not yet built	Bi monthly quality assurance oversight aiding continued development of the model and harm free care certification building accreditation process	Quality Committee			G	G	G	G	G	G	G	G	G
			2. In collaboration develop a quality dashboard and infrastructure to provide best evidence to demonstrate quality of care	2.1. Develop an overarching infrastructure to ensure quality improvement and performance can be continually monitored, evidenced and understood from ward to Board ensuring that evidence can easily be collated for CQC assessments																			
			3. Improve People Involvement	3.1. Develop a programme of assurance with effectiveness of clinical procedural documents																			
			1. Review and transformation of Intermediate Pathways of Care Review	1.1. Working with system partners to review priority pathways for looked after children in Lincolnshire 1.2. Links to system Intermediate Care Review. This is currently paused so will be picked up again once this has been reinstated. 1.3. Maximising the use, occupancy and pathways in to our Community Hospitals and Transitional Care Beds- review of the Integrated Discharge Hub CLOSED IN YEAR - NOW BAU																			

1d	Deliver clinically led integrated services	Group Chief Nurse/Group Chief Medical Officer	2. Frailty Pathways	2.1. Community Hospitals being recognised as Frailty specialists within our Lincolnshire system 2.2. Adult Community Therapy Frailty Rebranding 2.3. Delivering a population health needs based service that maximises the potential of our estate from Archer Assessment Unit										Integration Committee												
			3. Childrens Services Transformation	3.1. Child to adult transition of services - Business Cases and Case for Change being prepared nationally - where do these children go - for example Asthma - there is no adult service for this																						
			4. Palliative Pathways	4.1. Review the palliative pathways across LCHS to meet the needs of all palliative patients and their families.																						
SA2 To enable our people to lead, work differently, be inclusive, motivated and proud to work within LCHG																										
2a	Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	Group Chief People Officer	1. Workforce Planning	1. Work Planning Solution - Implement the KPMG strategic workforce planner	1. Lack of resources 2. Lack of skills and capability 3. Leadership capacity/capability 4. External partnerships and ways of working 5. Mindset of leaders and staff 6. Staff health and wellbeing 7. Further Industrial Relations 8. National/Region directives	442 Recruitment 470 Staffing levels		Primary: 1 Integrated Care System (ICS) Strategy 2. Integrated Care Board 5-year joint forward plan 3. LCHS People Strategy 2023-28 4. Clinical Strategy 2023-28 5. People Strategy Group 6. LCHS Operational Plans 7. Divisional delivery plans 8. Action Plans (eg Workforce Race Equality Scheme/Workforce Disability Equality Scheme) 9. Equality Diversity and Inclusion Lead/ Freedom to speak up guardian (FTSUG) /Staff Networks/ Health and Wellbeing Lead and Champions 10. Mental Health First Aid Champions 11. Swartz Rounds 12. Staff Networks 13. NHSE EDI Improvement Plan/6 High Impact Actions Secondary: 1. People Executive Group (PEG) 2. Finance, People, Performance and Investment Committee (FFPIC) 3. Lincolnshire People Board 4. Audit Committee 5. Equality, Diversity and Inclusion Group 6. Trust Well-Being Guardian 7. Lincolnshire People Plan 2024/25 8. Executive Leadership Team 9. Transformation Delivery Group (TDG) 10. Stakeholder Engagement and Involvement Group (SEIG) 11. Performance Management Reviews (PMRs) 12. Transformation Delivery Group (TDG) 13. Trust Leadership Team (TLT) 14. Quality and Risk Committee (Q&RC) 15. Lincolnshire People Hub 16. Lincolnshire Integrated Care Board 17. Lincolnshire Health and Care Collaborative Delivery Board 18. Strategic Delivery Plan (SDP) Programme Board Tertiary: 1. Audit 2. NHS National Staff Survey 3. Regional People Board	1. 10 Year NHSE Workforce Plan	1. 10 Year NHSE Workforce Plan	1. Delivery of the LCHS People Strategy 2024/25 Action Plan 2. Standard People Metrics (Sickness/Turnover/MT /Vacancy/agency spend etc) better than LCHS targets and benchmarking 3. NHS National Staff Survey results above average in all People Promise areas 4. Delivery of the Lincs People Plan 23/24 and improved system people metrics (sickness, staff survey, turnover, agency spend etc) 5. Efficient use of Apprentice Levy funds 6. Improved NHS Freedom to Speak Up Guardian (FTSUG) Index score 7. National Quarterly Pulse Survey (Quarter 1, Quarter 2 and Quarter 4) above benchmarking 8. Improved Workforce Race Equality Scheme (WRES) and Workforce Disability Equality Scheme (WDES) Data 9. Corporate Benchmarking in the lowest quartile for People Functions 10. Delivery of NHSE EDI Improvement Action Plan 11. Sub Groups now in place across the Group (LCHG) which will include oversight of workforce planning as required. These commenced in Q3 of 2024/25 and include: Workforce Strategy Group (WSG), Education Oversight Group (EOG), Culture & Leadership (CLG) and Equality, Diversity & Inclusion Group (EDIG). Each will be attended by key stakeholders and consider workforce planning and other key workforce aspects as relevant to the meeting	None identified	None identified	People Committee			G	G	G	G	G	G	G	G	G	
			2. Inclusion	2.1 Reduce total pay gaps - race, disability, gender 2.2 Inclusive Recruitment Processes																						
			3. Pipeline	3.1 Group Bank 3.2 Apprenticeships 3.3 Wider Workforce																						
			4. Flexibility	4.1. Enabling a flexibility by default approach																						
			5. Retention	5.1 Support better retention																						
			6. Civility and respect	6.1 Allyship 6.2 Reduce bullying and harassment																						

			7. Health and Wellbeing	7.1 Research into staff self-care/role of leadership				4. NHSE EDI Improvement Plan/6 High Impact Actions 5. CQC 6. System Improvement Director 7. NHS People Plan 8. National/Regional Benchmarking			and will report into the People Committee on a monthly basis. 12. People Quality & Governance Manager attends the monthly Strategic Workforce Planning meetings to represent LCHS, and the Head of Workforce Plannign & reporting to represent ULTH as part of the wider Group Model. 13. As part of the LCHG Workforce Strategy Group meeting there is regular inclusion of benchmarking data for workforce included - this commenced within the meeting in January 2025.															
			8. Leadership and Talent	8.1 Leadership Development 8.2 Inclusive Talent Development																						
			9. Workforce Transformation	9.1 New ways of working 9.2 Develop New Roles and Skills																						
2b	To be the employer of choice	Group Chief People Officer	1-9 highlighted above in 2a	1-9 highlighted above in 2a	1. Lack of resources 2. Lack of skills and capability 3. Leadership capacity/capability 4. External partnerships and ways of working 5. Mindset of leaders and staff 6. Staff health and wellbeing 7. Further Industrial Relations 8. National/Region directives	442 Recruitment 470 Staffing levels		Primary: 1 Integrated Care System (ICS) Strategy 2. Integrated Care Board 5-year joint forward plan 3. LCHS People Strategy 2023-28 4. Clinical Strategy 2023-28 5. People Strategy Group 6. LCHS Operational Plans 7. Divisional delivery plans 8. Action Plans (eg Workforce Race Equality Scheme/Workforce Disability Equality Scheme) 9. Equality Diversity and Inclusion Lead/ Freedom to speak up guardian (FTSUG) /Staff Networks/ Health and Wellbeing Lead and Champions 10. Mental Health First Aid Champions 11. Swartz Rounds 12. Staff Networks 13. NHSE EDI Improvement Plan/6 High Impact Actions Secondary: 1. People Executive Group (PEG) 2. Finance, People, Performance and Investment Committee (FPPIC) 3. Lincolnshire People Board 4. Audit Committee 5. Equality, Diversity and Inclusion Group 6. Trust Well-Being Guardian 7. Lincolnshire People Plan 24/25 8. Executive Leadership Team (ELT) 9. Stakeholder Engagement and Involvement Group (SEIG) 10. Performance Management Reviews (PMRs) 11. Transformation Delivery Group (TDG) 12. Trust Leadership Team (TLT) 13. Quality and Risk Committee (Q&RC) 14. Lincolnshire People Hub 15. Lincolnshire Integrated Care Board 16. Lincolnshire Health and Care Collaborative Delivery Board 17. Strategic Delivery Plan (SDP) Programme Board Tertiary: 1. Audit	1. 10 Year NHSE Workforce Plan	1. 10 Year NHSE Workforce Plan				People Committee			G	G	G	G	A	A	A	A	A	

								2. NHS National Staff Survey 3. Regional People Board 4. NHSE EDI Improvement Plan/6 HIAs 5. CQC 6. System Improvement Director 7. NHS People Plan 8. National/Regional Benchmarking						
SA3 To ensure services are sustainable, supported by technology and delivered from an improved estate														
			1. Develop foundational insight	1.1. Develop regular integrated portfolio analysis 1.2 Develop and embed a multi-level performance management framework and conditions for a performance and improvement culture	1.Mindset and behaviour of leaders 2.Lack of capacity 3.Lack of skills and capability 4.Leadership capacity and capability 5.A poor internal reputation 6.National guidance changes 7.System finance/data requests	528 Breakeven Duty - Cost Control 529 Efficiency Requirement 530 System Risk and Gain Share - Financial Risk 532 Non attainment of capital plan		Primary: 1. Integrated Care System (ICS) Strategy 2. Integrated Care Board 5-year joint forward plan 3. Finance and Business Intelligence (FBI) Strategy 2023-28 4. FBI Strategy update on current year plan 5. Finance reporting to Finance Performance, People and Innovation Committee (FPPIC) 6. Trust Leadership Team (TLT) reports 7. LCHS Operational Plan reports 8. Clinical Strategy 2023-28 9. Chief Clinical Digital Information Officer (CCDIO) 10. Lincolnshire Long Term Plan 11. Strategic Delivery Plan as part of the Recovery Support Programme 12. NHSE Planning Guidance Secondary: 1. LCHS Finance Performance, People and Investment Committee (FPPIC) 2. Quality and Risk Committee (Q&RC) 3. LCHS Trust Leadership Team (TLT) 4. Transformation Delivery Group (TDG) 5. Data Quality Group 6. Capital Investment Group 7. LCHS private board 8. Performance Management Reviews (PMR) 9. Lincolnshire Integrated Care Board 10. Lincolnshire Health and Care Collaborative Delivery Board 11. Strategic Delivery Plan (SDP) Programme Board 12. System Financial Assurance Group 13. System Financial Leaders Group (FLG) 14. System Digital, Data and Technology (DDAT) Tertiary: 1. Internal audit – Standard Financial Controls Annual Audit 2. External audit – Annual Independent Audit and Opinion on Financial Statements 3. Benchmarking data 4. National Oversight Framework rating 5. Clinical audit reports 6. National best practice data and reports 7. CQC rating 8. National Oversight Framework (NOF) rating quarterly letter	Skills and capability to use tools and frameworks	Programme of knowledge and skills development for FBI and stakeholder partners. Formal finance training sessions re-established.	1. Delivery of the financial plan measured through reporting and variances to planned performance 2. Deliver the required operating budget alongside leaders feeling engaged, informed and empowered to drive their service efficiency agenda 3. Delivery of the FBI Strategy plan 2023-24 4. National Oversight Framework (NOF) rating (annual and quarterly)		Variation from financial plan agreed with system and regulator (system control total allocated). CIP plan fully identified, although through significant NR action and in year mitigations.	

3a	Deliver financially sustainable healthcare, making best use of resources	Group Chief Finance Officer	2. Produce a multi-year financial plan including the key service transformation priorities	2.1 Develop frameworks to identify, scope and prioritise tactical, operational and transformational efficiency opportunities	1.Mindset and behaviour of leaders 2.Lack of capacity 3.Lack of skills and capability 4.Leadership capacity and capability 5.A poor internal reputation 6.National guidance changes 7.System finance/data requests	528 Breakeven Duty - Cost Control 529 Efficiency Requirement 530 System Risk and Gain Share - Financial Risk 532 Non attainment of capital plan		Primary: 1. Integrated Care System (ICS) Strategy 2. Integrated Care Board 5-year joint forward plan 3. Finance and Business Intelligence (FBI) Strategy 2023-28 4. FBI Strategy update on current year plan 5. Finance reporting to Finance Performance, People and Innovation Committee (FPPIC) 6. Trust Leadership Team (TLT) reports 7. LCHS Operational Plan reports 8. Clinical Strategy 2023-28 9. Chief Clinical Digital Information Officer (CCDIO) 10. Lincolnshire Long Term Plan 11. Strategic Delivery Plan as part of the Recovery Support Programme 12. NHSE Planning Guidance Secondary: 1. LCHS Finance Performance, People and Investment Committee (FPPIC) 2. Quality and Risk Committee (Q&RC) 3. LCHS Trust Leadership Team (TLT) 4. Transformation Delivery Group (TDG) 5. Data Quality Group 6. Capital Investment Group 7. LCHS private board 8. Performance Management Reviews (PMR) 9. Lincolnshire Integrated Care Board 10. Lincolnshire Health and Care Collaborative Delivery Board 11. Strategic Delivery Plan (SDP) Programme Board 12. System Financial Assurance Group 13. System Financial Leaders Group (FLG) 14. System Digital, Data and Technology (DDAT) Tertiary: 1. Internal audit – Standard Financial Controls Annual Audit 2. External audit – Annual Independent Audit and Opinion on Financial Statements 3. Benchmarking data 4. National Oversight Framework rating 5. Clinical audit reports 6. National best practice data and reports 7. CQC rating 8. National Oversight Framework (NOF) rating quarterly letter	Skills and capability to use tools and frameworks	Programme of knowledge and skills development for FBI and stakeholder partners	1. Delivery of the financial plan measured through reporting and variances to planned performance 2. Deliver the required operating budget alongside leaders feeling engaged, informed and empowered to drive their service efficiency agenda 3. Delivery of the FBI Strategy plan 2023-24 4. National Oversight Framework (NOF) rating (annual and quarterly)			Finance Committee			A	G	G	G	G	G	G	G

			3. Deliver a multi-year financial plan including the key service transformation priorities	3.1 Support to deliver the operational efficiency initiatives and the strategic transformation/new operating models	1. Mindset and behaviour of leaders 2. Lack of capacity 3. Lack of skills and capability 4. Leadership capacity and capability 5. A poor internal reputation	529 Efficiency requirement 530 System Risk and Gain Share - Financial Risk		Primary: 1. Integrated Care System (ICS) Strategy 2. Integrated Care Board 5-year joint forward plan 3. Finance and Business Intelligence (FBI) Strategy 2023-28 4. FBI Strategy update on current year plan 5. Finance reporting to Finance Performance, People and Innovation Committee (FPPIC) 6. Trust Leadership Team (TLT) reports 7. LCHS Operational Plan reports 8. Clinical Strategy 2023-28 9. Chief Clinical Digital Information Officer (CCDIO) 10. Lincolnshire Long Term Plan 11. Strategic Delivery Plan as part of the Recovery Support Programme 12. NHSE Planning Guidance Secondary: 1. LCHS Finance Performance, People and Investment Committee (FPPIC) 2. Quality and Risk Committee (Q&RC) 3. LCHS Trust Leadership Team (TLT) 4. LCHS Strategy and Planning Group (SDP) 5. Transformation Delivery Group (TDG) 6. Performance Management Reviews (PMR) 7. Lincolnshire Integrated Care Board 8. Lincolnshire Health and Care Collaborative Delivery Board 9. Strategic Delivery Plan (SDP) Programme Board 10. System Financial Leaders Group (FLG) Tertiary: 1. Internal audit 2. External audit 3. Benchmarking data 4. Partnership satisfaction ratings 5. Clinical audit reports 6. National best practice data and reports 7. CQC rating 8. National Oversight Framework (NOF) rating quarterly letter	Strategic business partnering approach well-established	Embedding FBI structure and new ways of working. Agreed to implement post investment evaluations into 25/26 FPC agenda.	1. Partner satisfaction ratings with FBI (internal) 2. Delivery of the Finance and Business Intelligence (FBI) Strategy plan 2023-24 3. National Oversight Framework (NOF) rating (annual and quarterly)														
				1.1 Use integrated portfolio analysis to inform strategic				Primary: 1. Integrated Care System (ICS) Strategy 2. Integrated Care Board 5-year joint forward plan 3. Finance and Business Intelligence (FBI) Strategy 2023-28 4. FBI Strategy update on current year plan 5. Finance reporting to Finance Performance, People and Innovation Committee (FPPIC) 6. Trust Leadership Team (TLT) reports 7. LCHS Operational Plan reports 8. Clinical Strategy 2023-28 9. Chief Clinical Digital Information Officer (CCDIO) 10. Lincolnshire Long Term Plan 11. Strategic Delivery Plan as part of the Recovery Support Programme 12. NHSE Planning Guidance Secondary: 1. LCHS Finance Performance,	Strategic business partnering approach well-established	Embedding FBI structure and new ways of working	1. Partner satisfaction ratings with FBI (internal) 2. Delivery of the Finance and Business Intelligence (FBI) Strategy plan 2023-24 3. National Oversight Framework (NOF) rating (annual and quarterly)														

3b	Drive better decisions and impactful action through insight		1. Drive change, insight and direction	and tactical decision making and prioritise opportunities 1.2 Drive change, insight and direction through a business partnering approach and culture 1.3 Use performance management framework to identify key areas to maximise performance, and swiftly address areas of underperformance to ensure tangible better outcomes for patients	1. Mindset and behaviour of leaders 2. Lack of capacity 3. Lack of skills and capability 4. Leadership capacity and capability 5. A poor internal reputation	529 Efficiency requirement 530 System Risk and Gain Share - Financial Risk		People and Investment Committee (FPPIC) 2. Quality and Risk Committee (Q&RC) 3. LCHS Trust Leadership Team (TLT) 4. LCHS Strategy and Planning Group (SDP) 5. Transformation Delivery Group (TDG) 6. Performance Management Reviews (PMR) 7. Lincolnshire Integrated Care Board 8. Lincolnshire Health and Care Collaborative Delivery Board 9. Strategic Delivery Plan (SDP) Programme Board 10. System Financial Leaders Group (FLG) 11. System Digital and Data Team (DDAT) Tertiary: 1. Internal audit 2. External audit 3. Benchmarking data 4. Partnership satisfaction ratings 5. Clinical audit reports 6. National best practice data and reports 7. CQC rating 8. National Oversight Framework (NOF) rating quarterly letter							Finance Committee			G	G	G	G	G	G	G	G	G								
3c	A modern, clean and fit for purpose environment across the Group	Group Chief Estates and Facilities Officer	1. Safe and Sustainable Foundations (Estates and Transformation)	1.1. Driving the efficiency of our estate 1.2. Transparency in our Estates Utilisation	1. Lack of resources 2. Lack of skills and capability 3. Leadership capacity 4. External partnerships and ways of working 5. Patients and public behaviours 6. Mindset of leaders 7. Staff health and wellbeing 8. Patient and public engagement	454 NHSPS Water Supply 460 Cost of estate 461 NHSPS Maintenance of LCHS estate 483 JCH Theatre Ventilation 473 NHSPS property ventilation 551 JCH Water Purity 552 Skegness Hospital Water Purity		Primary: 1. Estates and Transformation Strategy 2. Clinical Strategy 3. Lincolnshire Long Term Plan 4. LCHS Operational Plan 5. Integrated Care System (ICS) Strategy 6. Integrated Care Board 5-year joint forward plan 7. Strategic Delivery Plan as part of the Recovery Support Programme 8. LCHS Green Plan 9. NHS Lincolnshire Green Plan Secondary: 2. Estates Delivery Group 4. Health and Safety Committee 5. Finance, Performance, People and Investment Committee (FPPIC) 6. Audit Committee 7. Estates Shared Service Programme Group (ESSPG) 9. Lincolnshire Strategic Infrastructure and Investment Group 10. Transformation Delivery Group (TDG) 11. Trust Leadership Team (TLT) 12. Performance Management Reviews (PMRs) 13. Quality and Risk Committee (Q&RC) 14. Capital Investment Group 15. Lincolnshire System Operational Estates Group 16. Lincolnshire Greener NHS Group Tertiary: 1. Estates Returns Information Collection (ERIC) Return 2. Patient-Led Assessments of Care Environment (PLACE) Report 5. Internal Audit 6. Health and Safety Executive Standards 7. CQC rating 8. Benchmarking data 9. Healthcare Information and Management Systems Society Assessment (HIMSS)	1. Fully developed Estates dashboard 2. Fully developed 3rd party compliance dashboard 3. No Authoring Engineers reports handed over from ESS ro ULTH E&F Team	1. Programme of AE audits being planned & additional resources being scoped to support the audit process & actions arising from said audits.	1. Delivery of the Estates and Transformation Improvement Plan 24/25 2. Delivery of the LCHS Green Plan action plan 24/25 3. Increased compliance and safety 5. Delivery of LCHS Capital Plan 24/25 6. Greater utilisation of Estate	Lack of assurance relating to statutory compliance of the estate. No Authorising Engineer audits being undertaken. Former LPFT Shared Service handed over very little in terms of assuarnce.	LCHS Estates now being managed by ULHT Estates & Facilities Services following termination of shared service agreement. Group Chief Estates & Facilities Officer. ULHT Safety Groups being reviewed to include LCHS Estate. Performance meetings being held with NHSPS. Group Estates & Facilities structure being developed to provide capacity to effectively manage the estate and maximise potential going forward. Further Authorising Engineers audit on fire safety being undertaken in November 2024 to ascertain what level of improvement has been made since the last audit and actions taken by ULTH Fire safety Team. Safety Groups being established across the Group to commence January 2025 which have oversight of all risks, e.g. fire safety, electrical safety, water safety, medical gas management etc. Health & Safety Committee in Common to launched in April 2025, Terms of Reference currently being finalised. Premises Assurance Model completed and tabled at FPPIC which shows significant areas in improvement required - action plans being developed. integration & improvements plans monitored through E&F SMT.	Finance Committee / Integration Committee			R	R	R	R	R	R	R	R	R								

3d	Reduce waits for patients who require urgent care and diagnostics to constitutional standards	Group Chief Operating Officer												Finance Committee			A	A	A	A	A	A	A	A	A	
3g	Reducing unwarranted variation in community service delivery and ensure we meet all constitutional standards	Group Chief Operating Officer				ID681 Children in care, ID403childrens SLT, ID397 Lymphoedema staff workspace, ID409 lymphoedema service capacity	referral to treatment(18 week wait)	1. Planned care group oversight, 2. Weekly community SLT 3. GLT/PRM 4. ELT 5. FPEC 6. CWL system meeting (external), 7. regional CWL group	Live community waiting list available on power BI with agreed waiting list policy supporting completion of records	Programme of specilaity deep dives with audit programme initiated	Audit against waiting list policy adherence			Finance Committee			R	R	R	R	R	R	A	A	A	
SA4 To collaborate with our primary care, ICS and external partners to implement new models of care, transform services and grow our culture of research and innovation																										
4a	Establish collaborative models of care with all our partners including Primary Care network Alliance (PCNA), GPs, health and social care and voluntary sector	Group Chief Integration Officer	1. Community Primary Partnerships	1.1 Neighbourhood Working 1.2 Tobacco Dependence Team move 1.3 First Costal Development								New Group objective. Assurance and governance reporting against this TBC.		Integration Committee			R	G	G	G	G	G	G	G	G	
			2. Support and provider leadership to the ICS operating framework and governance	2.1 Paly an active role in the governance structures of the ICS	1.Mindset and behaviour of leaders 2.Lack of capacity 3.Lack of skills and capability 4.Leadership capacity and capability 5.Commissioning practices 6.A poor external reputation"	444, 481, 504, 526, 530 - TO BE CHECKED AGAINST DATIX		1. Integrated Care System (ICS) Strategy 2. Integrated Care Board 5-year joint forward plan 3. Lincolnshire Long Term Plan 4. LCHS IIP 5. Clinical Strategy 2023-28 6. NHS England Planning Guidance 7.Performance Management Reviews (PMR) 8.Lincolnshire Leaders Board 9.Better Lives Lincolnshire Leadership Team 10.System joint committees 11.System Financial Leaders Group (FLG) 12.Quarterly System Review Meeting (QSRM) 13.National Oversight Framework (NOF) rating (annual and quarterly 14.Internal audit 15.External audit	No up to date survey of partner views	CIO once in post to take a view on whether (and when) to conduct a survey of partner views.	1.Delivery of the FBI Strategy plan 2024-25 2.National Oversight Framework (NOF) rating (currently out to consultation) 3.LCHS representation on system boards, committees and groups 4.Compliance with system mechanisms e.g. Risk/Gain Share 5.LCHS delivery of its elements of system projects	Partner satisfaction ratings New Group objective. Assurance and governance reporting against this TBC.	CIO once in post to take a view on whether (and when) to conduct a survey of partner views.													
			3. Play an active role in collaborations that make a difference	3.1 Play and active role as a key partner in the Lincolnshire Health and Care Collaborative 3.2 Work in partnership to identify and deliver initiatives that can only succeed in collaboration	1.Mindset and behaviour of leaders 2.Lack of capacity 3.Lack of skills and capability 4.Leadership capacity and capability 5.Commissioning practices 6.A poor external reputation"	444, 481, 504, 526, 530 - TO BE CHECKED AGAINST DATIX		1. Integrated Care System (ICS) Strategy 2. Integrated Care Board 5-year joint forward plan 3. Lincolnshire Long Term Plan 4. LCHS IIP 5. Clinical Strategy 2023-28 6. NHS England Planning Guidance 7.Performance Management Reviews (PMR) 8.Lincolnshire Leaders Board 9.Better Lives Lincolnshire Leadership Team 10.System joint committees 11.System Financial Leaders Group (FLG) 12.Quarterly System Review Meeting (QSRM) 13.National Oversight Framework (NOF) rating (annual and quarterly 14.Internal audit 15.External audit	No up to date survey of partner views	CIO once in post to take a view on whether (and when) to conduct a survey of partner views.	1.Delivery of the FBI Strategy plan 2024-25 2.National Oversight Framework (NOF) rating (currently out to consultation) 3.LCHS representation on system boards, committees and groups 4.Compliance with system mechanisms e.g. Risk/Gain Share 5.LCHS delivery of its elements of system projects	Partner satisfaction ratings New Group objective. Assurance and governance reporting against this TBC.	CIO once in post to take a view on whether (and when) to conduct a survey of partner views.													
4b	Successful delivery of the Acute Services Review	Group Chief Integration Officer												Integration Committee			A	A	A	A	A	A	A	A	A	

4c	Grow our research and innovation through education, learning and training	Group Chief Integration Officer													People Committee (To move to: Transformation and Integration Committee)											
4d	Enhanced data and digital capability	Group Chief Integration Officer	1. Care Closer to Home (Digital)	1.1. Technology Enabled Transformation	1. Lack of resources 2. Lack of skills and capability 3. Leadership capacity 4. External partnerships and ways of working 5. Patients and public behaviours 6. Mindset of leaders 7. Staff health and wellbeing 8. Patient and public engagement	430 Cyber Security 553 Migration from network drives to SharePoint		Primary: 1. Digital Health Strategy Secondary: 1. Digital Strategy Group (DSG) 2. Digital Executive Group (DEG) 3. Finance, Performance, People and Investment Committee (FPPIC) 4. System Digital, Data and Technology Board (DDaT) 5. Transformation Delivery Group (TDG) 6. Trust Leadership Team (TLT) 7. Performance Management Reviews (PMRs) 8. Capital Investment Group Tertiary: 1. Annual Network and Security Penetration Test (DSPT) 2. Data Security and Protection Toolkit 3. Internal Audit 4. Benchmarking data 5. Healthcare Information and Management Systems Society Assessment (HIMSS)	1. Patient Digital Literacy Information 2. Workforce Digital Literacy Information 3. Fully developed Estates dashboard	1. Creation of a patient co-design group 2. Trust wide Digital skills training needs analysis 3. Programme of work around information into the dashboard and further training for staff	1. Delivery of the Digital Health Strategy 23/24 Action Plan 2. Improved use of digital technologies 3. Delivery of LCHS Capital Plan 23/24 4. Greater uptake of digital services from the public			Finance Committee / Integration Committee			G	G	G	G	G	G	G	G	G	
			2. Safe and Sustainable Foundations (Digital)	2.1. Safe Practice 2.2. Technology Optimisation					1. Fully developed 3rd party compliance dashboard	1. Programme of work to share compliance data across organisations into a dashboard														
			1. Change Ready Workforce (Digital)	1.1. Digital Ready Workforce 1.2. Digital Leadership					1. Patient Digital Literacy Information 2. Workforce Digital Literacy Information	1. Creation of a patient co-design group 2. Trust wide Digital skills training needs analysis														
SA5 To embed a population health approach to improve physical and mental health outcomes, promote well-being, and reduce health inequalities across an entire population																									
5a	Develop a Population Health Management (PHM) and Health Inequalities (HI) approach for our Core20PLUS5 with our ICS	Group Chief Nurse/Group Chief Medical Officer	1. Develop foundational insight	1.1 Develop the Population Health Management (PHM) and Health Inequalities (HI) approach	1.Mindset and behaviour of leaders 2.Lack of capacity 3.Lack of skills and capability 4.Leadership capacity and capability 5.A poor internal reputation 6.National guidance changes 7.System finance/data requests			Primary: 1. Integrated Care System (ICS) Strategy 2. Integrated Care Board 5-year joint forward plan 3. Finance and Business Intelligence (FBI) Strategy 2023-28 4. FBI Strategy update on current year plan 5. Trust Leadership Team (TLT) reports 6. LCHS Operational Plan reports 7. Clinical Strategy 2023-28 8. Chief Clinical Digital Information Officer (CCDIO) 9. Lincolnshire Long Term Plan 10. Strategic Delivery Plan as part of the Recovery Support Programme 11. NHSE Planning Guidance Secondary: 1. LCHS Finance Performance, People and Investment Committee (FPPIC) 2. Quality and Risk Committee (Q&RC) 3. LCHS Trust Leadership Team (TLT) 4. Transformation Delivery Group (TDG) 5. Data Quality Group 6. Performance Management Reviews (PMR) 7. Lincolnshire Integrated Care Board 8. Lincolnshire Health and Care Collaborative Delivery Board 9. System Digital, Data and Technology (DDAT) Tertiary: 1. Benchmarking data 2. Clinical audit reports 3. National best practice data and reports 4. CQC rating	Skills and capability to use tools and frameworks	Programme of knowledge and skills development for FBI and stakeholder partners		New Group objective. Assurance and governance reporting against this TBC.		Integration Committee			R	G	G	G	G	G	G	G	G	

5b	Co-create a personalised care approach to integrate services for our population that are accessible and responsive	Group Chief Nurse/Group Chief Medical Officer												Integration Committee												
5c	Tackle system priorities and service transformation in partnership with our population and communities	Group Chief Integration Officer										New Group objective. Assurance and governance reporting against this TBC.		Integration Committee			R	R	R	R	R	R	R	R	R	
			1.1. Care Closer to Home (Estates and Transformation)	1.1. Supporting Models of Care 1.2. Driving Integrated Working	1. Lack of resources 2. Lack of skills and capability 3. Leadership capacity 4. External partnerships and ways of working 5. Patients and public behaviours 6. Mindset of leaders 7. Staff health and wellbeing 8. Patient and public engagement	430 Cyber Security 454 NHSPS Water Supply 460 Cost of estate 461 NHSPS Maintenance of LCHS estate 483 JCH Theatre Ventilation 473 NHSPS property ventilation 551 JCH Water Purity 552 Skegness Hospital Water Purity 553 Migration from network drives to SharePoint		Primary: 1. Digital Health Strategy 2. Estates and Transformation Strategy 3. Clinical Strategy 4. Lincolnshire Long Term Plan 5. LCHS Operational Plan 6. Integrated Care System (ICS) Strategy 7. Integrated Care Board 5-year joint forward plan 8. Strategic Delivery Plan as part of the Recovery Support Programme 9. LCHS Green Plan 10. NHS Lincolnshire Green Plan Secondary: 1. Digital Strategy Group (DSG) 2. Estates Delivery Group 3. Digital Executive Group (DEG) 4. Health and Safety Committee 5. Finance, Performance, People and Investment Committee 6. Audit Committee (FPPIC) 7. Estates Shared Service Programme Group (ESSPG) 8. System Digital, Data and Technology Board (DDaT) 9. Lincolnshire Strategic Infrastructure and Investment Group 10. Transformation Delivery Group (TDG) 11. Trust Leadership Team (TLT) 12. Performance Management Reviews (PMRs) 13. Quality and Risk Committee (Q&RC) 14. Capital Investment Group 15. Lincolnshire System Operational Estates Group 16. Lincolnshire Greener NHS Group Tertiary: 1. Estates Returns Information Collection (ERIC) Return 2. Patient-Led Assessments of Care Environment (PLACE) Report 3. Annual Network and Security Penetration Test (DSPT) 4. Data Security and Protection Toolkit 5. Internal Audit 6. Health and Safety Executive Standards 7. CQC rating 8. Benchmarking data 9. Healthcare Information and Management Systems Society Assessment (HIMSS)	1. Patient Digital Literacy Information 2. Workforce Digital Literacy Information 3. Fully developed Estates dashboard	1. Creation of a patient co-design group 2. Trust wide Digital skills training needs analysis 3. Programme of work around information into the dashboard and further training for staff	1. Digital Health Strategy 23/24 Action Plan 2. Estates and Transformation Strategy 23/24 Action Plan 3. Delivery of the LCHS Green Plan action plan 23/24 4. Improved use of digital technologies 5. Improved Cyber security reporting and oversight 6. Increased compliance and safety 7. Robust signed off Service Level Agreements (SLAs) for the Estates Shared Service 8. Delivery of LCHS Capital Plan 23/24 9. Greater uptake of digital services from the public											

5d	Transform key clinical pathways across the group resulting in improved clinical outcomes	Group Chief Integration Officer/Group Chief Medical Director	2. Transforming Nursing in the Community	2.1. Reviewing existing and ensuring the right longer term Skin Integrity (incl. Lymphoedema) services for Lincolnshire 2.2. Reviewing the Community Nursing offer- what does "good Community Nursing look like" (the catalogue) Specialist Service criteria, including but not limited to: - Proactive care provisions - Catheters - IV Therapy, INR - Skin Integrity, Lymphoedema - Community Nursing Safer Staffing 2.3 Voice Before You Visit Service Evaluation										Integration Committee												
			3. Transforming Community Hospitals	3.1. Rebranding / Standardisation of Community Hospital offer - Discharge hub - Proactive care provisions - Correct bed distribution																						
			4. Children's Services Transformation	4.1. Childrens hub in Lincolnshire 4.2. Children's services reviews - ALL LCHS Children's services 4.2.1. Children In Care 4.3. Children's services reviews - ALL LCHS Children's services 4.3.1. Childrens Therapy - SALT																						
			5. Development of Community Neurology Services	5.1. One community Neuro team with the scope of maximising the capability of existing Community Neuro Nursing and Therapy Services - currently at ULHT and LCHS - Community Outreach and Parkinson's																						
			6. Transforming Operations Centre	6.1. Transformation of One Front Door including Ops Centre, CAS, Home Visiting and UCR including triage and dispatch																						
			7. IUEC Pathways	7.1. Initial unplanned pathways, response project 7.2. UTC Review - outcomes and recommendations 7.3. Virtual Wards																						
			8. Seasonal Planning Reviews - Winter Schemes	8..1. Seasonal Planning Reviews - Development																						
			9. Agile Workstream	9.1. Continence Re-model of service 9.2. TB & SAIS - **CLOSED IN YEAR - MOVED TO LVHIT** 9.3. LISH - **CLOSED IN YEAR - COMPLETE** 9.4. NLISH - **CLOSED IN YEAR - MOVED TO BAU**																						

Lincolnshire Community and Hospitals Group
Board Assurance Framework (BAF) 2024/25

Strategic Aims	Board Committee
Patients - To deliver high, quality, safe and responsive patient services	Quality Committee
People - To enable our people to lead, work differently, be inclusive, motivated and proud to work within LCHG	People and Organisational Development Committee
Services - To ensure services are sustainable, supported by technology and delivered from an improved estate	Finance, Performance and Estates Committee / Finance, Performance, People and Innovation Committee
Partners - To collaborate with our primary care, ICS and external partners to implement new models of care, transform services and grow our culture of research and innovation	Transformation and Integration Committee
Population Health - To embed a population health approach to improve physical and mental health outcomes, promote well-being, and reduce health inequalities across an entire population	Quality Committee / Transformation and Integration Committee

Assurance Rating Key:	
Red	Effective controls may not be in place and/or appropriate assurances are not available to the Board
Amber	Effective controls are thought to be in place but assurances are uncertain and/or possibly insufficient
Green	Effective controls are definitely in place and Board are satisfied that appropriate assurances are available

Objective alignment
Lincolnshire Community Health Services NHS Trust objectives
United Lincolnshire Teaching Hospitals NHS Trust objective

Ref	Objective	Executive Lead	Linked programmes in Integrated Improvement Plan/Operational Plan	Linked projects in Integrated Improvement Plan/Operational Plan	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
SA1 To deliver high, quality, safe and responsive patient services															
								Medicines Quality Group in place with a focus on improving medication safety / appropriate prescribing / appropriate management of drugs and controlled drugs Robust medicines management policies and procedures in place Improving the safety of medicines management / review of Pharmacy model and service are key projects within the IIP. Improvement actions reflect the challenges identified from a number of sources e.g. CQC, internal audit. MQG will retain oversight of the relevant IIP programme of work through divisional upward reports Electronic prescribing has been rolled out to areas where this was planned, although some challenges are being identified post-rollout	Gaps identified within internal audits undertaken by Grant Thornton Lack of adherence to Medicines management policy and procedures (i.e. Controlled Drugs processes as evidenced by regular audit work programmes) Lack of 7 day clinical pharmacy service and specific specialty specific gaps in service (i.e. Emergency Departments, Childrens and young persons, as identified by Neonatal ODN Network visit in June 2024) Some medicines management policies are overdue / past their review dates Medicines reconciliation compliance is poor and has remained an outlier during 2023/2024	Replacement of manual prescribing processes with an electronic prescribing system; improvements to medication storage facilities; strengthening of Pharmacy involvement in discharge processes. Divisional Upward Report template to be developed to ensure divisional assurances are provided against actions/improvement work linked to Grant Thornton and CQC now that Medicines Management Action Task and Finish Group has closed	Upward Report from the Medicines Quality Group to PSG Routine analysis and reporting of medication incidents and outcomes from medicines audits in to Medicines Quality Group Omitted doses audit Controlled Drugs Audit Prescribing Quality reports Robust Divisional reporting and attendance into MQG monthly Internal Audit report Upward reporting from other groups	Lack of upward reporting from the Medical Gases, Sedation Group Pharmacy audits only occurring in areas they are providing a clinical service to. Some gaps in other groups not reporting to MQG / or concerns in respect of effectiveness (i.e. Drugs and Therapeutics Group, Patient Group Directive (PGD))	Divisional representation at Medicines Quality Group reinforced by Medical Director and Director of Nursing and template for divisional reporting of BAU medication safety activities in to Medicines Quality Group developed and in place		
								Appropriate policies and procedures in place to recognise and treat the deteriorating patient, reported to deteriorating patient group and upwardly to PSG and QGC. Deteriorating Patient Group set up as a sub group of the Patient Safety Group to identify actions taken to improve; has its own sub-groups covering AKI; sepsis (Ensuring early detection and treatment of deteriorating patients) (PSG)	Maturity of some of the sub-groups of DPG not yet realised. This will be considered as part of the review of DPG.	Observation policy ready to go to next NMAAF Fluid management policy approved by DPG/PSG and awaiting approval at NMAAF Work taking place across the Group to support Deteriorating Patient agenda. Development of DPG across Group Chair now appointed as the Deputy Medical Director. First meeting undertaken in November to review terms of reference / workplan and subgroups. First upward report submitted to QC in January 2025	Audit of response to triage, NEWS, MEWS and PEWS Sepsis Six compliance data Audit of compliance for all cardiac arrests Upward reports into DPG from all areas Number of incidents occurring regarding lack of recognition of the deteriorating patient Robust upward reports received monthly into PSG	Fluid Management group has not been meeting and therefore concerns through PSG have been raised. Reporting not being received by PSG from DPG due to vacancy	First upward report to QC in Janaury 2025- group TOR require review and workplan to be agreed.		

1a	Deliver high quality care which is safe, responsive and able to meet the needs of the population	Group Chief Nurse/Group Chief Medical Officer			Failure to provide safe care Failure to provide timely care Failure to use medical devices and equipment safely Failure to use medicines safely Failure to manage blood and blood products safely Failure to manage radiation safely Failure to deliver planned improvements to quality and safety of care Failure to respond to patient safety alerts appropriately	5101 4947 5016 5100 4879 5143 5450 5002 5142 5267 4779 5488 5306 4868 4935 5515 4843 5423 4746 5095 4646 5491 5227 5403 5196 5169		Implementation and oversight of national patient safety strategy (culture and systems) Human Factors Faculty	Development of Safety Culture review process in conjunction with People and OD	Working group established to review and propose framework to be utilised	Patient Safety Board Development session held - June 2024 6 monthly gap analysis against National Patient Safety Strategy reporting in to PSG and upwardly to Quality Committee Safety Culture review process From Q2 Group Patient Safety report triangulating across multiple key stakeholders to consider patient safety culture and future plans of work, to report to PSG and QC quarterly	Working group outputs not yet available due to group in infancy	Initial meeting held in October, verbal updated expected at November PSG. Clarification on project lead required. Commenced recruitment process for TTT for Human Factors cohort for Jan/Feb 2025.	Quality Committee			G	G	G	G	G	G	G	G	G
									Appropriate policies in place to ensure CAS alerts and Field Safety Notices are implemented as appropriate. One central monitoring process now in place. Monthly Group Oversight Meeting for CAS and FSN alerts Strengthen oversight of designated Executive and Patient Safety Specialist on recovering CAS alerts and final sign off (PSG)	CAS and FSN Group policy	Development of CAS and FSN Group Policy commenced, expected completion December 2024	Quarterly report to PSG with escalation to QC as necessary and monthly exception report to PSG. Compliance included in the integrated governance report for Divisions.	None identified	None identified									
									Robust process in place to monitor delivery against the CQC Must Do and Should Do actions and regulatory notices (Delivering on all CQC Must Do actions and regulatory notices). Includes regular meetings with divisions, CQC action plan which goes to relevant committees, TLT, etc. Regular executive challenge meetings on delivery. Escalation routes into PRM and TLT. (CG)	No gaps identified.	Not applicable.	Monthly reporting to sub-committees with the relevant extract of the action plan. CYC and TLT receive monthly reports. QGC receive quarterly update on the entire plan. Quarterly updates Trust Board. Feedback to CQC on achievements at monthly engagement meeting. CQC assurance data.	CQC assurance data not yet complete. CQC assurance data not yet shared with committees. Output from PRM is not clear. Escalations not always acted upon promptly.	Use of exec led meeting to pick up escalations which may not occur via other routes. Additional resource identified for compliance team to support with sourcing levels of assurance.									
									Skin Integrity Group (SIG) established as a sub group of the Patient Safety Group to provide oversight, monitoring and accountability of the ongoing improvement work around prevention of pressure ulcers and the wider skin integrity programme of work. Skin Integrity management policies, procedures and pathways in place.	Following National changes in pressure ulcer categorisation in April 2024, all ulcers previously categorised as Unstageable will now be classified as a minimum of Category 3 ulcers, and therefore an increase in Category 3 and 4 incidents is expected and has been observed.	Weekly Pressure Ulcer Support and Supervision panel with Quality, Tissue Viability and Safeguarding team representation reviews all Category 3 and 4 pressure ulcers against the safeguarding adults protocol for all pressure ulcers and raising a safeguarding concern guidance.	Skin Integrity care is reviewed in the weekly ward/dept. leader's assurance and monthly Matrons audits. The monthly Quality Metrics review meeting monitors ward and departments' performance relating to skin integrity. Skin Integrity Group (SIG) provides oversight and receives Divisional performance reports, which provide assurance of the improvement actions being taken in areas reporting increased number of incidents. Skin Integrity incidents are analysed to identify themes and trends which are reported through SIG and	No gaps identified.	Not applicable.									

											improvement actions identified. Overarching action plan for incidents, themes and improvement actions is in place and monitored through Skin Integrity Group																				
1b	Improve patient experience	Group Chief Nurse				5495 5234 4701 4724		Patient and Carer Experience (PACE) plan 2022 - 2025 The PACE Delivery Plan is actioned and embedded over the life of the delivery plan. (PEIG)	PACE plan due for review in 2025. Patient Experience Team capacity to support both ULHT & LCHS imperatives.	LCHG plan in development that will include ULHT priorities, LCHS priorities and collaborative priorities. Self assessment completed by PEIG Task & Finish Group. Timetable is for this to be approved at Feb 24 PEIG and QGC for launch April 25. Funding identified for LCHS Patient Experience Manager - aiming for recruitment in January 2025	Patient Experience & Carer Plan progress report to Patient Experience & Involvement Group (PEIG) as per schedule. PEIG Task & Finish Group upward reports provided to PEIG re: progress and actions.	There are no assurance gaps identified.	Not applicable	Quality Committee			G	A	A	A	A	A	A	A	A
								Enhance patient experience by learning from patient feedback and demonstrating our values and behaviours in the delivery of care with a specific focus on discharge of patients. (PEIG)	National surveys evidence overall poor experiences in relation to discharge and UEC with a number of questions being benchmarked as worse than others Trusts. Patient Experience Team working with divisions to support improvements including a deep dive triangulation across data sources and real time surveying.	Amalgamated national survey action plan in place to identify Trust wide improvement focus; the current plan is cumbersome for divisional engagement so will be managed by Patient Experience Team and collective focus across all divisions to be linked to targets within each benchmarked quartile: 'upper' - cleanliness and food, 'about the same' - individual needs met and information, 'bottom' - moving wards at night and sleep. Rolling out of new suite of communication and patient experience training including Hearing it Your Way and at induction. Patient Experience Team working with Discharge and UEC teams staff facilitating real time surveying to enable improvements and developments	New template for divisional assurance reports developed and scheduled reports received at PEIG. SUPERB now includes LCHS data, monthly reports and infographics received at PEIG and circulated.	Engagement capacity within discharge and UEC teams to lead patient experience improvement initiatives and developments.	To identify service level champions / leads to work in partnership with Patient Experience Team.											
								Maternity & Neonatal Oversight Group (MNOG) in place to have oversight of the quality of maternity & neonatal services and to provide assurance that these services are safe and in line with the National Safety Ambition / Transformation programme. Thematic review of SIs and complaints undertaken - recommendations being progressed as part of the Maternity & Neonatal Improvement Plan. External independent input in to SI process. MNOG will retain oversight of the implementation of the relevant IIP programme of work. (MNOG)	Issues with the environment. Ongoing difficulties with the Maternity Medway system which has the potential to impact on compliance with the CNST Year 4 Safety Actions.	Improvements to the environment to be completed as part of planned ward refurbishment. Team to continue to liaise with E&F to resolve and immediate issues as they arise ensuring escalation where delays are encountered. Issues with the Medway system being progressed at local and system level.	Monthly Maternity & Neonatal Assurance Report. Maternity & Neonatal Improvement Plan. Executive & NED Safety Champions in place and work closely with local Safety Champions. NHSE/I appointed MIA in place and supporting the Trust - monthly reports of progress to MNOG. Validation of the implementation & embedding of the Ockenden IEAs has been provided by the regional maternity team. There is a process in place for ongoing testing through supported site visits. Training compliance data.	None Identified	Not applicable.											

1c	Improve clinical outcomes	Group Chief Nurse/Group Chief Medical Officer				4828 4731 4928 5154 4866 4778 4840		Ensure we provide clinically safe services, through an increased number of Diamond Award Accredited Wards / Departments (PEIG)	there are no identified Control gaps	Not applicable	monthly Quality metrics dashboard meeting with all clinical areas. Diamond award applications received and supported by corporate nursing team. Diamond Award Panel chaired by DoN/DepDoN. Award presented by Trust Chair. Metric included with the IIP, and measured Quarterly.	None Identified	Not applicable	Quality Committee			G	G	G	G	G	G	G	G	G
								Getting it Right First Time Programme in place with upward reports to CEG and onward reporting to QGC. (CEG)	Reports currently tend to focus on the process of GIRFT. Further work needed to demonstrate changes in practice as a result of GIRFT work.	Quarterly reports to Clinical Effectiveness Group with a request to focus on specific areas each quarter to see improvements GIRFT team in place to support divisions and ensure that appropriate activity takes place.	Upward reports to CEG and onward reporting to QC KPIs in the integrated governance report Process in place for feedback to divisions Reporting through IIP to QC	Reporting has begun to focus on outcomes but this is not yet well embedded.	Request from CEG for future reports to show improved outcomes as a result of GIRFT activity.												
								Clinical Effectiveness Group in place as a sub group of QC and meets monthly CEG works to an annual work programme and standard agenda to ensure that all business is covered appropriately. Upward reports are received from reporting groups inc: Human Tissue Authority Group Transfusion Committee Organ Donation Group Adjustment to policy and procedures Group Mortality Groups VTE Group Radiation Protection Committee NATSSIP/LOCSIP Group Research Groups Role of CEG is to Improve clinical effectiveness through increased compliance with national and local standards. Quality of reporting into CEG has improved and is increasingly robust. (CEG)	Acknowledged that there is good engagement from nursing and AHPs, however work continues to encourage engagement from medics. Leads of the reporting groups attend CEG on a quarterly basis to present upward report	Invites to speakers to come direct from Mr Simpson as Chair of the Group in future. Mr Simpson to continue as Chair of the Group whilst appointment of Deputy Medical Director concluded and will commence in role of CEG chair Increasing engagement with leads of reporting groups	Effective upward reporting to QGC from reporting groups. Regular reports received from Divisions providing assurance that they understand their position with respect to clinical effectiveness	No gaps identified.	Not applicable.												
								Clinical Audit Group in place and meets monthly (CAG) with monthly upward reports to CEG Refocus of CAG to focus on the learning from audit. (CEG)	There are outstanding actions from local audits ULHT and LCHS Groups being considered as a single meeting to strengthen learning and assurance	ToR currently being reviewed as new Chair in place for CAG	Upward report to CEG confirming status of clinical and associated actions and shared learning	No gaps identified.	Not applicable.												
								National and Local Audit programme in place and agreed which is signed off by QC. Improved reporting to CEG regarding outcomes from clinical audit. Reports and process in place for any areas where the Trust is identified as an outlier. (CEG)	None identified.	Not applicable	All National Audits presented to CEG with associated action plan Internal Audits undertake review of Clinical Audit Programme on a scheduled basis	None identified	Not applicable												
								Process for monitoring the implementation of NICE guidance and national publications in place and upwardly reported through QC (CEG)	There are sometimes delays in the completion of the gap analysis for the Clinical Guidelines.	Process in place for escalation if required within the Clinical Divisions.	Reports on compliance with NICE / TAs demonstrating improved compliance.	None identified	Not applicable												
								Process in place for taking part in the Patient Related Outcome Measures (PROMs) project. (CEG)	None identified.	Not applicable	Quarterly reports to CEG and upwardly reported to QGC Outcome measures report published annually and shared with CEG														

								Specialised services quality dashboards (SSQD) Process in place for identifying outliers through Model Hospital. Clinical leads for outlying areas present updates to CEG quarterly. (CEG)	No gaps identified.	Not applicable.	Quarterly reports to CEG and upwardly reported to QGC. Action plans developed for all required areas.	No gaps identified.	Not applicable.	
								Process in place for monitoring of and implementation of NCEPOD requirements. (CEG)	None identified.	Not applicable	Quarterly reports to CEG on progress.	Some outstanding baseline assessments. Some overdue actions identified.	Work taking place with divisional leads to address.	
								Monthly MorALS meeting chaired by the Deputy Medical Director and attended by a representative of the Triumvirate for each division. Monthly reporting to CEG (CEG)	Timeliness of completion of SJRs	Process being developed for M&M meetings.	Dr Foster alerts HSMR and SHMI data Medical Examiner screening compliance and feedback Compliance with SJR completion reported through PRMs Divisional updates art MORaLs by the Triumvirates	None Identified	Not applicable	
1d	Deliver clinically led integrated services	Group Chief Nurse/Group Chief Medical Officer												Integration Committee
SA2 To enable our people to lead, work differently, be inclusive, motivated and proud to work within LCHG														
			Medical Workforce Programme (Medical Staffing Project)	Medical Workforce Programme - Medical Staffing Project with focus on: a) Plan for Every Post b) NHSE Workforce Productivity Tool c) Reporting				Workforce planning and workforce plans. Recruitment to agreed roles - plan for every post, for Agenda for Change, Medical and Dental Workforce People Planning & Transformation Team are in post, with Senior Lead (Director of People & OD) overseeing functions. Strong working relationships to utilise Divisional Heads of HR, Finance and Improvement Team to monitor compliance against KPIs set out within the IIP. This is established and regular reviews are now in place. Reported through to the Workforce Strategy Group and then included within the highlight report for People & OD Committee highlight report to Board.	None identified	None identified	Workforce plans submitted for 2024/25 Operational Planning. Recruitment plans are in place. Divisional Recruitment Pipeline Reports are refreshed regularly for each division working with each of the SHRBP's and are reporting through to FPAM in terms of pipeline linked to reducing agency spend. Medical Workforce Programme reports into ISG on a monthly basis following monthly Steering Group chaired by SRO. Comprehensive review of project plan has been undertaken to ensure the Plan for Every Post' progress is fully reflective and able to provide upward level of assurance on deliverables within 2024/25.	Currently Medical & Dental vacancies are not managed by Position Number	Continued progress with refreshed approach to 'Plan for Every Post' being developed as part of the Medical Staffing Project within the Medical workforce Programme. Reported at Medical Workforce Steering Group and ISG on a monthly basis. It is expected that this will be a key enabler to supporting the Trust in reducing temporary staffing spend within this staff group. Divisional roll out of the refreshed Plan for Every Post process has commenced, with the largest Divisions being the priority. This has now been rolled out across all four clinical Divisions for Medical & Dental staff. People Quality & Governance Manager attends the monthly Strategic Workforce Planning meetings to represent LCHS, and the Head of Workforce Plannign & reporting to represent ULTH as part of the wider Group Model.	

							Focus on retention of staff - creating positive working environment and integration of People Promise 'themes' System retention role established and in place for 2023/24. People Promise Y1 work complete with funding for Y2 agreed, this has now ended and is incorporated into the BAU for the Education, Learning & OD Team. Education and Learning Team in place and actively working to improve compliance with Statutory and Mandatory Training. Organisational Development Team in place and actively working to improve completion rates for Appraisals. Maintain a link between the Education, Learning & OD Team and their work that supports the approach to Just Culture & Leadership through the Culture & Leadership Group (CLG). Maintain a 'golden thread' of Civility& Respect, Compassionate Leadership and Just Culture throughout all interactions and developments.	Reward, Recognition & Engagement Officer is now in place and will take on some of the ongoing work with regards to the People Promise now that the Fixed Term Contract for the People Promise Manager has come to an end as at October 2024. Consideration to the concept of group appraisals and appraisal lite to form part of the review of people policies and procedures.	<u>Turnover (retention):</u>Turnover has continued to improve over the last 12 months and is on track to deliver against the 2024/25 KPI set out within the IIP. To further support this, work has begun to understand how we develop exit data to gather insights for 'reasons for leaving' and support our staff to remain working <u>Statutory & Mandatory Training:</u> Reported into LCHG Education Oversight Group (monthly) and within Divisional FPAM (monthly) with areas<50% compliance highlighted. Support offered to Divisional Teams by Head of HR and Education, Learning & OD (ELOD) Team to improve in these areas to ensure that staff are compliant with mandatory training, and where issues identified are supported as required. All staff are now being contacted with regards to their compliance rates where thy are <90% and not just those who are <50% compliance so as to ensure we can sustain our improved position. <u>Appraisals</u>**:** Workforce Strategy Group to discuss group appraisal and appraisal lite Ongoing discussions are in place with agenda items on Workforce Strategy Group as required. Focus on those areas where there are <50% compliance to encourage improved compliance rates, ensuring that where support to record is required this is offered.	Workforce Strategy Group upward report to People Committee including scorecard analytics i.e. appraisal, statutory and mandatory training.	<u>Mandatory Training</u> compliance has improved and continue to be on target for full year effect. <u>Appraisal</u> compliance levels have improved and continue to be on target for full year effect.	To be monitored through the Workforce Strategy Group and FPAM meetings and will feature in the highlight report to PODC. Phased targeted approach in 2024/25 KPIs as featured in the Integrated Improvement Plan. As of Quarter 3 within 2024/25 there will be a new: 1) LCHG Education Oversight Group commenced which will oversee key aspects of education and learning with key stakeholders across the Group. This will report into People Committee on a monthly basis. 2) LCHG Culture & Leadership Group (CLG) commenced which will oversee key aspects of culture and leadership with key stakeholders across the Group. This will report into People Committee on a monthly basis. As part of the LCHG Workforce Strategy Group meeting there is regular inclusion of benchmarking data for workforce included - this commenced within the meeting in January 2025.
							Reducing sickness absence - Absence Management System	Manager call back compliance and return to work interview	Compliance with use of AMS being addressed through People Management Essential Training and AMS training from HRBPs Early Occupational Health led interventions are being explored for top two reasons for sickness absence. Absence reported at Divisional FPAMs with areas of concern highlighted (eg: CBU and Staff Group information) to support targeted action if required.	Sickness/absence data with detailed report available for Head of HR use to support targeted actions with Divisions. Deep dive by Workforce Strategy and OD Group into absence data Internal Audit Report Actions Report via FPAM (monthly), Workforce & OD Group (monthly) and into PODC via Scorecard.	Various reports through Heads of HR to Divisions. Output from Workforce Strategy Group deep dive into absence data.	Work continues with the completion of the audit actions and work/training with the departmental managers and HR. To be monitored through the Workforce Strategy Group and FPAM meetings and will feature in the highlight report to PODC. Phased targeted approach in 24/25 KPI's as featured in the Integrated Improvement Plan. A deep dive is being undertaken of the full utilisation of the AMS management system as early indications show improvement is needed aligned to Health and Wellbeing initiatives. As part of the LCHG Workforce Strategy Group meeting there is regular inclusion of benchmarking data for workforce included - this commenced within the meeting in January 2025.

Ensuring access to the personal and professional development that enables people to deliver outstanding care and ensures ULHT becomes known as a learning organisation Establish ULHT Education and Learning service Promote benefits and opportunities of Apprenticeships	None identified	None identified	Workforce Strategy Group Finance, People & Activity Meeting and People Committee data Workforce Strategy Group upward report to People Committee including scorecard analytics i.e. appraisal, statutory and mandatory training Sub Groups now in place across the Group (LCHG) which will include oversight of workforce planning as required. These commenced in Q3 of 2024/25 and include: Workforce Strategy Group (WSG), Education Oversight Group (EOG), Culture & Leadership (CLG) and Equality, Diversity & Inclusion Group (EDIG). Each will be attended by key stakeholders and consider workforce planning and other key workforce aspects as relevant to the meeting and will report into the People Committee on a monthly basis. Mandatory Training compliance have improved and continue to be on target for full year effect, and this is reported via FPAM each month. Appraisal compliance levels have improved and continue to be on target for full year effect, and this is reported via FPAM each month.	None identified	None identified
Improve the consistency and quality of leadership through:- a) Reset leadership development offer and support (Leadership SkillsLab and PME) b) Improved mandatory training compliance c) Improved appraisals rates using the WorkPal system d) Developing clear communication mechanisms within teams and departments. Better Together Programme for multi disciplinary senior leaders across the Organisation is in place across LCHG. Maintain a link between the Education, Learning & OD Team and their work that supports the approach to Just Culture & Leadership through the Culture & Leadership Group (CLG). Maintain a 'golden thread' of Civility& Respect, Compassionate Leadership and Just Culture throughout all interactions and developments.	Education, Learning & OD Team in place with ELOD certified experts with a mission to "engage and develop our people, champion differences and nurturing relationships to embrace a culture of civility and respect. Becoming the employer of choice"	Dedicated capacity and project leadership identified for Culture and Leadership Programme.	Workforce Strategy Group Finance, People & Activity Meeting and People Committee data Sub Groups now in place across the Group (LCHG) which will include oversight of workforce planning as required. These commenced in Q3 of 2024/25 and include: Workforce Strategy Group (WSG), Education Oversight Group (EOG), Culture & Leadership (CLG) and Equality, Diversity & Inclusion Group (EDIG). Each will be attended by key stakeholders and consider workforce planning and other key workforce aspects as relevant to the meeting and will report into the People Committee on a monthly basis.	None identified	None identified

2a	Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	Group Chief People Officer				4844 4996 4997 5447		Proactively support staff to remain well and at work, however should the need arise, supporting them through illness and their return to work Staff Vaccination Programme Health and wellbeing Programme for staff.	2024/25 5.5% sickness absence target Continue to fill vacancies within the HR department to support Divisions with sickness management.	Continue to fill vacancies within the HR department to support Divisions with sickness management. Now at a fully recruited position within HR. Standardised absence reporting via FPAM, with Divisional HR Teams also having access to Division/CBU/Specialty level specific data to support the active management and monitoring of absence with Divisional colleagues. Staff are signposted to Health & Wellbeing services as a matter of routine through regular communications and in response to specific incidents/needs across the Trust (eg: Employee Assistance Programme).	Health and wellbeing Manager and Health and Wellbeing Group/Wellbeing Champions Upward reporting to WSODG from H&WB Group Board level HWB Guardian change enacted Vaccination Programme updates through Workforce Strategy Group Compliance rates continue to be monitored via the People Committee Scorecard for the below: 1) Rolling 12mths Sickness Absence rate 2) Return to Work compliance 3) Flu vaccination rate 4) Occupational Health referral data	None Identified	None Identified	People Committee			G	G	G	G	G	G	G	G	G
								Vacancy levels below 4.5% across the Trust by 31st March 2025. Aligned to the plan for every post, recruitment plans for each division and aligned to the workforce submission plan for 24/25.	Changes in budgeted establishment as a result of approved (System and Interval) investments which increase establishment, thus widening the vacancy gap.	Regular monitoring of monthly reports and tracking of changes with clear rationale.	Key Performance indicators have been identified as part of the IIP and will be monitored through the scorecard at Workforce Operational and Strategy Group. Pastoral care award received for recruitment and on-boarding of international nurses Compliance rates continue to be monitored via the People Committee Scorecard for the below: 1) Vacancy rate (Trust wide and by specific staff groups) 2) Recruitment KPIs	None Identified	None Identified											
								Reduce our staff turnover rate to 9.00% across the Trust by 31st March 2025	9.00% turnover rate yet to be embedded as BAU in all staff groups	Aligned to the continued work under the People Promise Manager role and plans for 24/25 to continue to improve work life balance, flexible working requests, flexible retirement/retire and return options. People Promise Mgr funding identified for Yr2. To be embedded as business as usual at the end of Year Two funding for the Group.	Key Performance indicators have been identified as part of the IIP and will be monitored through the scorecard at Workforce Strategy Group Pastoral care award received for recruitment and on-boarding of international nurses Compliance rates continue to be monitored via the People Committee Scorecard for the below: 1) Turnover rate 2) Flexible Working agreement rates	None Identified	None Identified											

Reset ULH Culture and Leadership through delivery and implementation of Culture and Leadership Programme and Restorative and Just Culture Programme. Cultural deep dives, specific / ad hoc pieces of OD work with individual areas, as identified that requires support / help and associated action plans agreed and owned by Clinical/Management teams. Working in conjunction with HRBP's and OD Business Partners for a joined up approach to tackle culture challenges. The OD, Education and Development Directorate was restructured as part of the redesign piece of work within People & OD Directorate and investment made to increase the workforce. Maintain a 'golden thread' of Civility& Respect, Compassionate Leadership and Just Culture throughout all interactions and developments.	Culture shift takes time to be embedded however improvements continue to be recognised in engagement scores in the National Staff Survey results. Very strong performing staff networks now in place and being recognised nationally for awards. Investment in wellbeing manager leading the wellbeing work across the Trust under Occupational Health offering direct support for staff who may require it in addition to the Employee Assistance Programme available. Increase in the number of staff reaching out to FTSU guardian is a positive reflection of the effectiveness of the FTSU processes.	Leading Together Forum - regular bi-monthly leadership event Delivery Plan and actions to be confirmed further to results of Leadership Survey LTF Forward Plan Leadership SkillsLAB - essentials in management and leadership for existing managers. Comprehensive follow up and prioritisation of NSS results - key areas of concern identified for action 7 point action plan presented and agreed by ELT and shared with Group Leadership Team. Restorative Just and Learning Culture project team has been formed with a full roll out now being undertaken.	Culture and Leadership Group and System People Board Culture and Leadership Programme Group upward report NSS results (Feb 2023/Feb 2024) Themes from cultural deep dives presented to People Committee. Patient complaints and compliments data. staff complaints data. FTSU data. External stakeholders feedback. Just and Learning Steering Group offer a highlight report to People Committee. Culture and Leadership Group offer a highlight report to People Committee. Staff Networks and their effectiveness is measured through the EDI action plan.	None identified	None identified
Support Divisions to achieve and maintain 90.00% of our people having completed all relevant statutory and mandatory training by 31st March 2025. Trust aligned to National Core Skills Training Framework Mandatory Training Governance Group in place. Manager reports re: training compliance MTTG used as Gateway to core learning Mapping of core training on more individual basis.	Dedicated Education Department now in place as part of the restructure. Aligned to the People Promise continued work for 24/25. Updates to ESR system to allow better monitoring and reporting. Consideration of appraisal lite and group appraisal now embedded. Further work required aligned to the Quarterly Pulse survey and promotion of this. 90.00% compliance yet to be embedded as BAU.	HRBP support in each Division and Directorate supporting the promotion of mandatory training and appraisals, using reported data to show progress. New Appraisal paperwork embedded. Recommendations captured through the National Staff Survey.	Workforce Operational Group training report Upward reporting to People and OD Committee CQC Monthly reporting Individual core training matrix on ESR. Additional monthly assurance offered to CQC through governance team regular meetings Education Oversight Group (EOG) is now in place and meets monthly with upward report to People Committee. Monitored through the Workforce Strategy Group and FPAM meetings and will feature in the highlight report to PODC. Phased targeted approach in 24/25 KPI's as featured in the Integrated Improvement Plan has been implemented	None identified	None identified
Support our Divisions to provide all staff with an appraisal and clear objectives by 90.00% of our staff having an 'in-date' appraisal within 2024/25.	90.00% compliance yet to be embedded as BAU.	HRBP support in each Division and Directorate supporting the promotion of mandatory training and appraisals, using reported data to show progress. New Appraisal paperwork embedded. Recommendations captured through the National Staff Survey.	Workforce Operational Group reports Upward reporting to People and OD Committee CQC Monthly reporting Education Oversight Group (EOG) is now in place and meets monthly with upward report to People Committee.	None identified	None identified

								55% of our staff recommending ULHT as a place to work.	NSS results show a requirement to improve this recommendation	Annual NSS. Pulse surveys staff feedback through Facebook, exit interviews, Attractive recruitment campaigns and packages; Retention strategy being developed. Attrition rates monitored	Workforce Operational Group reports Upward reporting to People and OD Committee CQC Monthly reporting National Awards e.g. Pastoral Care Award received for IEN recruitment.	Sub-Group meetings within the People Directorate are not yet in place	As of Quarter 3 within 2024/25 there will be a new LCHG Education Oversight Group (EOG) commence which will oversee key aspects of education and learning with key stakeholders across the Group. This will report into People Committee on a monthly basis.												
								53% of our staff recommending ULHT as a place to receive care	NSS results show a requirement to improve this recommendation	Further work required aligned to the Quarterly Pulse survey and promotion of this. Annual NSS. Patient feedback. National recognition for improvements in service delivery and care Eg. Maternity Service Improvements.	Workforce Operational Group Reports Upward reporting to People and OD Committee CQC Monthly reporting Recognition certificate and letter received for the 2022 National Staff Survey Patient Experience Group Staff satisfaction reports Education Oversight Group (EOG) and Culture & Leadership Group (CLG) are now in place and meets monthly with upward report to People Committee.	None identified	None identified												
			Education, Training & Development	Aligns to Integrated Improvement Plan at Trust Level and Divisional Level where there are in year plans within the People Objective with regards to developing staff and teams.	Capacity to release staff due to operational pressures to attend relevant training and development sessions.			Embedding continuous learning and personal development culture across the Trust	Dedicated Talent Academy Team who support wider access to apprenticeship programmes which support the ongoing development of current staff, and the attraction of new staff to the Trust. Education, Learning & Organisational Development Team who support the Trust to meet the regulatory areas of compliance, such as Mandatory Training, and also support ongoing learning which is bespoke to the needs of the Trust. For Medical Workforce, Clinicians are able to access the training provided by the Talent Academy. There is a gap in how this is reviewed and monitored within the Chief Medical Officer portfolio. This is an area of focus for 2024/25 to ensure that there is a robust mechanism for oversight and assurance.	Reported via People & OD Committee for regulatory needs/compliance. Updates provided within FPAM at Divisional Level with regards to attendance and engagement with: 1) People Management Essentials Training, 2) Just Culture Briefings and 3) 50% or less compliance for Mandatory Training Close working between Education, Learning & OD Team with regards to the co-ordination of the METIP and TNA so that this is aligned to the wider needs of Workforce Planning.	People & OD Committee Workforce Strategy & OD Group Nursing & AHP Transformation Group Education Oversight Group (EOG) and Culture & Leadership Group (CLG) are now in place and meets monthly with upward report to People Committee.	None Identified, although regularly reviewed to consider platforms which are best placed to provide further insights and levels of assurance for Education, Training & Development.	Working closely with key roles and groups to better understand the needs of the organisation and staff. Collaborative working by ensuring that key functions are included as part of ad hoc or standing agendas for the regular review and discussion about kept areas within education, training and development. For example: Education is now a key area of focus with a regular slot on the Workforce, Strategy Group. On a monthly basis.												
2b	To be the employer of choice	Group Chief People Officer				4948		Embed continuous improvement methodology across the Trust	Embedding and sustaining cultural improvement change when the ability of the ULHT teams to engage is limited or constrained when we are operationally challenged. Ability to demonstrate quick impact on the cultural change due to various interventions will be limited (as these are multi year/multi factorial projects).	Improvement Academy now report all training & associated activity to embed continuous improvement through Improvement Steering Group for oversight and escalations. Working with each improvement programme and Divisions to develop identify and align improvement plans.	Internal training reports produced by Improvement academy. Improvement programmes identifying personalised training needs for ULHT staff. Divisions training plan (aligned to the IIP) presented at FPAM.	Information is reported to ISG - Low uptake of our various training offers despite general and targeted comms through various platforms. Services are struggling to release staff for QI training due to pressures. Plan for a QI relaunch in the new financial year. Use of virtual training option via MS Teams. Sub-Group meetings within the People Directorate are not yet in place	Weekly meetings with Improvement Academy to increase offer with more agile training methods to meet the needs of the varied staff. Developing communications & engagement strategy for on-going awareness of Improvement Academy to enable improvement culture change (not just limited to sending email updates but being creative and being on site on wards to talk about quality improvement) As of Quarter 3 within 2024/25 there will be a new LCHG Equality, Diversity & Inclusion Group (EDIG) commence which will oversee key aspects of equality, diversity and inclusion with key stakeholders across the Group. This will report into People Committee on a bi-monthly basis.	People Committee			G	G	G	A	A	A	A	A	A

			Medical Workforce Programme (Medical Staffing Project)					Compliance with National agency utilisation target of 3.7% agency and locum workforce	None identified		FRP and ISG	None identified	None identified												
								Lincs Belonging Strategy EDI Delivery Plan 2022-25	None identified		Council of Staff Networks Internal Audit - Equality, Diversity and Inclusion NHS NSS EDI/EDS objectives	None identified	None identified												
SA3 To ensure services are sustainable, supported by technology and delivered from an improved estate																									
					ERF - Failure to deliver the ERF target of 113% of 19/20 planned activity will result in a potential clawback of an element of the ERF allocation made to Lincolnshire and non delivery against the ERF gain share CIP scheme for ULHT.			1.1 ERF clawback - Collective ownership across the Lincolnshire ICS of the planned care pathways leading to improved activity delivery. 1.2 Trust focus to deliver 113% of activity	1.1 Maximisation of the Trust Resources - Theatre and Outpatient productivity. 1.2 Ability to recruit and retain staff to deliver the capacity. 1.2 Production of an activity delivery plan.	1.1 Improved counting and coding, focus in this area including data capture and missing outcome reductions. 1.1 Shared risk and gain share agreements for the Lincolnshire ICS. 1.2 Divisional ownership and reporting 1.2 Reporting by POD and Specialty against the delivery plan	1.1 & 1.2 Delivery of the 113% target - phased trajectory.	1.1 & 1.2 The operational pressures, specifically; sickness, excess beds open, rising acuity of patients and continuing rising demand at the front door of the acute Trust is putting at risk in year delivery of the 113% ERF activity target.	1.1 The Lincolnshire ICS is monitored externally against the system activity target through the monthly activity returns 1.2 The Trust is monitored externally against the Trust activity target through the monthly activity returns 1.2 The Trust monitors internally against its activity targets inclusive of specific Divisional and Specialty plans and targets												
3a	Deliver financially sustainable healthcare, making best use of resources	Group Chief Finance Officer			Capital - Capital investment levels are significant and require delivery in 'live' environments. Robust planning is required to ensure that delivery of the agreed schemes takes place within the financial year to avoid any under-investment in our services.	5020 4664	CQC Well Led CQC Use of Resources	2.1 Three key capital groups; MDCG, DHG and Estates, are in existence to understand the issues and provide mitigations, alongside escalation where required. Escalation should be via Capital Delivery Group (CDG) and CRIG which links in the risk impacts of the requirement. Upward reporting from CDG/CRIG to GLT, FPEC and Trust Board is in place. 2.2 From a clinical divisional perspective, investment priorities continue to be identified and these are being reviewed and prioritised based on risk. 2.3 Lincolnshire does have an agreed Capital SOP that will be utilised if/where required in terms of risk management across all provider organisations. 2.4 ULHT has a rolling 5 year capital programme analysis that details the level of investment required across the organisation with financial estimates included. Financial assessments include; Medical Device equipment replacement cost, 6-Facet Survey within Estates and CIR calculations. 2.5 Business cases are produced for future investment that include capital requirements.	2.1 & 2.2 Difficult to compare Estate, Digital and Medical Equipment risks when allocating capital resources. 2.1 & 2.2 & 2.5 Robust timeframes for operational delivery of schemes required. Financial consequences (Capital & Revenue) if operational delivery is outside of agreed plans. 2.5 Capacity to produce business cases to access external funds. 2.1 - 2.5 Impact of IFRS16 (Right of Use Assets) agreements. 2.1 & 2.5 Contractor 'contracts' and transfer of risk away from ULHT.	2.1 & 2.2 & 2.3 & 2.5 Open and transparent discussion around proposed scheme deliverability to manage risks identified with Estates, Digital and Medical Devices. Presentations to FPEC and Trust Board to engage senior leaders in the proposed capital programme together with the risks that remain. Further discussion with Lincolnshire partners to ensure all opportunities are understood and awareness of shared risks. 2.5 Robust business case process with all key stakeholders involved in the support and approval of cases. Business Case (Green book & Local requirements) training roll out across the Trust and partners. 2.1 & 2.2 & 2.4 & 2.5 Risk rating pre & post investment required in all investment requests. 2.1 & 2.5 Key stakeholders involved in agreement of leases (IFRS16) aware that Finance need to be involved in all discussions to assess the implications of agreements proposed.	2.3 & 2.4 & 2.5 Capital Programme approval process ahead of the financial year - FPEC / Trust Board development session / Trust Board. 2.1 Capital Delivery Group (CDG) fortnightly monitoring of scheme delivery. Upwardly reported on a monthly basis to FPEC and Trust Board. 2.5 CRIG approval process for business cases. Upward reporting into GLT for final agreement. 2.5 Benefits realisation group review and upward reporting into CRIG, GLT and FPEC. 2.4 Development of a 5 year capital programme cross referenced to risk register.	2.5 Benefits identified in business cases not being fully delivered. Need to ensure greater accountability of delivery and learning lessons if ambitions were not achieved. 2.1 Control process for timeline changes for scheme delivery needs to be implemented.	2.4 Multi-year capital requirements prioritised to assess 'need' versus 'affordability'. Mitigations discussed and agreed at the key capital groups and escalation where required. Capital programme to be 'managed' within Lincolnshire therefore ability to 'pause' schemes if impact of 'new' scheme is greater is possible. 2.4 6-Facet survey completed and details being assessed to feed into a revised and more robustly prioritised multi-year capital planning requirement. 2.3 & 2.4 & 2.5 Discussions continue with NHSE regarding the level of capital limits (CDEL) applied to Lincolnshire and the need for this to be reviewed and increased as part of national calculations. As it stands, the national limits are lower than the level that would be investable based on 'local' available resources.	Finance Committee			A	A	A	A	A	R	R	R	R

					Cash - Deficits in the last 3 years have depleted cash reserves. Factoring in the 2024/25 deficit plan with additional delivery risks alongside a large capital programme means that the availability of cash to meet Pay and Non pay obligations is at substantially increased risk unless carefully managed.			3.1 Cashflow Monthly Projection to 30 June 2025 3.2 Daily cashflow projected 3 months ahead 3.3 Monthly reporting to FPEC 3.4 Access to cash support via NHSE subject to formal Board approval and application process 3.5 Facility to move cash around Lincolnshire System utilising NHSE cash support process	3.1, 3.2 & 3.3 Cash forecasting dependent upon accurate capital, CIP and I&E projections and certainty of delivery. 3.4 Cash support above the level of the I&E deficit is subject to more rigorous challenge through the business case process. May not be approved. 3.5 Transfer of cash between Lincolnshire bodies requires formal agreement by both parties. 3.5 Process to enable cash transfer between NHS bodies requires the repayment of PDC by the donor and issuing of PDC to the recipient (ULHT). LCHS has very limited PDC that can be repaid which in turn restricts the ability to transfer cash within LCHG.	3.1, 3.2 & 3.3 Capital, CIP & I&E risks are separately identified with mitigations. 3.5 System discussions to facilitate moving of cash.	3.1 - 3.5 Cash and working capital reporting to FPEC	3.1 - 3.5 Underlying Capital, I&E projections / timelines are best assessments at a point in time.	3.1 - 3.5 Ongoing review	
					CIP - Not delivering the identified required £40.1m of CIP schemes			4.1 Delivery of CIP Schemes 4.2 Medical Recruitment improvement 4.3 Medical job planning 4.4 Agency price reduction 4.5 Workforce alignment 4.6 Service Reviews process and transformational programmes of work 4.7 Budget compliance	4.1 & 4.6 Maximisation of resources to deliver CIP 4.2 Reliance on temporary staff to maintain services, at premium cost 4.3 Management within staff departments and groups to funded levels. 4.4 Maximisation of below cap framework rates 4.5 Rapid ability to on-board temporary staff to substantive contracts 4.7 Manage divisions to contain costs within budgetary envelope.	4.4 Embedding of centralised agency & bank team. 4.1 , 4.2 , 4.3 & 4.4 Workforce Groups / Delivery programmes to provide grip 4.1 & 4.6 Improvement Steering Group to provide oversight across the group 4.5 Overseas & local recruitment support fragile services and substantive staff aligned to fragile areas 4.1 & 4.7Continuous Non-Clinical Agency sign off process & Vacancy control process	4.1 - 4.6 Delivery of the planned agency reduction target, supported by substantive recruitment to vacancies 4.7 Budget compliance reported to FPAM's	4.3 Granular detailed plan for every post plans 4.2 & 4.7 Rota and job plan sign off in a timely manner	4.1 -4.5 The Trust monitors internally against its financial plan inclusive of specific targets for agency and bank spend by staff group 4.1 & 4.6 The Trust CIP workstreams are reported to the Improvement Steering Group 4.1 & 4.7 The Divisional cut of the workstreams are reported to the relevant FPAM 4.7 The staff areas of key focus - Medical and Nursing are reported through their Workforce Groups 4.1 Fortnightly FRP Board assurance with Lincolnshire ICB CIP plan now fully identified and overall financial poisition for 24/25 agreed with ICB and regulator.	
3b	Drive better decisions and impactful action through insight							Provide our people with real-time data to support high quality care delivery to all clinical staff			Agreed to implement post investment evaluations into 25/26 FPC agenda.			Finance Committee
								Continual improvement towards meeting PLACE assessment outcomes	None	N/A	PLACE Light Assessments PLACE Full assessments completed annually PLACE Steering Group monitors action plans following audits			

3c	A modern, clean and fit for purpose environment across the Group	Group Chief Estates and Facilities Officer			Longer term impact on supplier services (including raw materials) who are supporting the improvement, development, and maintenance of our environments. Availability of funding to support the necessary improvement of environments (capital and revenue)	4648 4647 5415	CQC Safe	Review and improve the quality and value for money of Facility services including catering and housekeeping	Review of catering services currently being undertaken		MiC4C cleaning inspections Staff and user surveys Catering project plan Cleanliness is reported through IPC Group to QGC. Water Safety and Fire Safety Fire Safety, confined spaces, working at heights, electrical safety, security management, lift safety and medical gases report to the Health & safety Committee via an upwards report.			Finance Committee / Integration Committee			A	A	A	A	A	A	A	A	A
								Develop business cases to demonstrate capital requirement in line with Estates Strategy	Business Cases require level of capital development that cannot be rectified in any single year.	Estates Strategy sets out a framework of responding to issues and management of risk. Capital Delivery Group has oversight of the delivery of key capital schemes. External Specialist Advisor working jointly NHSE & ULHT providing external guidance and validation. Use of the premises assurance model PAM will help identify gaps and subsequent actions or schemes of improvements.	Capital Delivery Group Highlight Reports Compliance report to Finance, Performance and Estates Committee Updates on progress above linked to the estates strategy. PAM Quarterly internal review and annual submission. Up to date 6 facet survey completed in 2024, high & significant being identified to place on the risk register.	Funding gap when considering the full £100m+ backlog in first year. Future years will at most tackle £20m of backlog in any given year	Statutory compliance and actions from AE (Authorised Engineers) reports monitored through safety groups which report into the Health & Safety Committee. Progress against Estates Strategy/Delivery Plan and IIP via sub groups upward reports. Delivery of 2024/25 Capital Programme will continue to ensure progress against remaining backlog of critical infrastructure. Capital Delivery Group will monitor the delivery of key capital programmes and ensure robust programme governance. Combination of PLACE Light and other intelligence (IPC Group/Compliance Reports and Capital Delivery Group) will help triangulate areas of concern and response.													
								Continued progress on improving infrastructure to meet statutory Health and Safety compliance		Water/Fire safety meetings are in place and review of controls are part of external validation from authorised engineers. Health and Safety Committee new terms of reference approved and now chaired by Group Chief Estates and Facilities officer. Upward reporting to Finance, Performance and Estates Committee Medical gas, ventilation, Water safety group, electrical safety group, confined spaces group, Lift Safety group and Asbestos Working Group have all been established and include the relevant authorising engineers in attendance. These groups monitor and manage risks and report upwards any exceptions or points of escalation.	Reports from authorised engineers Response times to urgent estates requests Estates led condition inspections of the environment Response times for reactive estates repair requests Action tracker managed by Fire Safety group which monitors progress against fire safety actions previously held under prohibition notices Health and Safety Committee upward report British Safety Council	Improvement needed in closing AE audit actions. Review of infrastructure risks currently being undertaken which will result in additional risks being placed on the Trust Risk Register which accurately reflects the quality and risks being carried by the current estate.	Monthly meeting held by Head of Compliance to drive improvement in compilation of actions from AE audits. Upwards reports to include more detail relating to progress being made to close AE audit actions. Site Estates Managers present performance data to SMT on a monthly basis .													
								Estates Strategy currently being refreshed	Funding gaps between overall plan of replacement vs available funding. Availability of Suppliers and Changes in market forces. Availability of raw materials and specialist components to replace/repair etc.	Business Case Development and preparation pre-empting available capital to maximise available. Use of procurement framework and liaison with NHSE to coordinate bids and larger schemes	Estates Group Upward Report													
								Refurbishment of 8 theatres, across our sites	Funding stream			Theatre strategy Group												
								Support capacity maximisation ensuring modernisation and utilisation of space, including that leased off the main acute sites			Revised Space Management Policy developed.	Revised Space Management Policy needs embedding.												

								Reduce our net carbon footprint		Trust Green Plan. CEF business case to bring investment in energy related improvements at Pilgrim			Weekly CEF Project board established to manage PSDS4 application for grant funding (decesion expected May 2025), detailed designs being worked up by preferred partner (FP Hurley). Heat Decarbonisation Plans being developed - to be complted by March 2025.													
								Develop Health Master Plans to better algin wards																		
3d	Reduce waits for patients who require urgent care and diagnostics to constitutional standards	Group Chief Operating Officer						3x daily internal capacity meetings to improve discharge and flow and trouble shoot operational issues at the front door Project 76 meetings with Group/ICB stakeholders in place with weekly deep dives into divisional actions plans across both organisations and weekly project review with system partners Group Discharge Board in place (from 10/04/2024) Daily ICB UEC call to escalate issues across the system and provide support to unblock pressure areas Group UEC Board established reflecting 5 Pillars of Improvement System Urgent Care Partnership Board.	Internal professional standards not embedded Medical and Nursing WFP not reflective of 24/7 UEC service requirements Lack of understanding at ward level re SAFER leading to poor implementation Assessment areas not substantively funded Capacity Team unable to provide adequate cover 24/7 due to WFP	5 Pillars / Workstreams reflecting key cross system programs of work. Progress of the above measured through the Group UEC Board Monitoring of performance at Tiering Meetings with NHSE, although these have now been stepped back to fortnightly as UEC has moved from Tier 2 to Tier 3 External reviews including GRFT have identified gaps in services which have been included in actions plans within the relevant specialties/divisions	Improvement against 3 key metrics as agreed with NHSE and monitored via Tier 2 meetings : % of patients in Emergency Department >12 hrs (Total Time) 4 hour Type 1 performance Cat 2 Mean EMAS performance Updates full suite of metrics to ELT, TLT and Board. Updates provided to Group UEC Board and UEC System Partnership Board	Pathway 0 patients discharge is being effectively planned from the point of admission All PW1-3 capacity is used on a daily basis Escalation policy is not fit for purpose and not used to define triggers and actions form divisions and support services. Process and deployment of Full Capacity Protocol not clear and not used effectively as not aligned to Escalation Policy. Specialist teams are attending ED within 30 mins of request in line with IP standards	Weekly Group UEC Board from January 2024 through which x 5 pillars of cross LCHS/ULHT work are monitored Daily 76% EAS meetings taking place to monitor in-day delivery against the standard EAS discussed at every capacity meeting Daily Breach understanding is circulated along with performance MTD, previous day and in-day progress Revised capacity meetings implemented from Sept 2023 and led by COO Office x 4 days a week and Divisions 1 day a week. Full capacity protocol including +1 and +2 on wards has been updated and implemented from September 2023.	Finance Committee							A	A	A	A	A	
								Maximisation of capacity and efficiencies to reduce waiting times in ED Support discharge processes, ensuring services are provided within timeframes which are safe and responsive, enabling a reduction in length of stay/bed occupancy and increased flow			Trajectories for all specialties in place, weekly position statements offered to ELT and TLT New board has a suite of metrics to measure improvements and focus divisional leadership teams on discharge target actions to ensure patients are bale to return to their usual place of residence or most fitting place of care sooner		Further rollout of SAFER will be supported by 4 B6 nurses to support discharge and flow out of wards and improve "pull" from ED. New Group Discharge Board set up to pull together workstreams that focus on discharge and flow, including SAFER principles, criteria led discharge and divisional flow targets													
								Development of plans for seven day working, across all of our services			Requires scoping and costing for all support and direct care services															
								Daily reporting of all three metrics (62 day backlog, FDS and 62 day performance) Weekly Intensive Support meetings to review all 3 metrics and position of patients on the cancer PTL Monthly cancer recovery meeting System Cancer Improvement Board Weekly ICB/Group oversight through Planned Care and Cancer catch up	Capacity v demand across all tumour site pathways not completed Insufficient oversight of system partners contribution (e.g. primary care testing and workups)	Cancer Leadership Group Deep Dive Workshops (e.g. Colorectal) Intensive Support Meetings (Trust and ICS)	Cancer board assurance and performance reports Routine Performance and pathway data provided by Sommerset system Cancer Intensive Support Meetings Cancer Intensive Support Meetings Monthly Trust Board reporting for planned care and cancer	Process information below the cancer stages are not always captured Some digital systems are not linked and not all wait information is recorded e.g. MIME system	Trajectories in place agreed with all tumour sites, to achieve a reduction in number patients >62 days, achievement FDS 75% March and reduction in patients >104 days. Tool developed to identify optimum ptl sizes for FDS/62 days for each tumour site. This allows us to identify key pressure areas and focus support													
3e	Reducing unwarranted variation in cancer service delivery and ensure we meet all constitutional	Group Chief Operating Officer					Cancer Standards 62 day, 14 day and 28 Day	Achievement of FDS, 104 and 62 week performance trajectory	Capacity to deliver Faster Diagnosis (FDs) for all services		Weekly system elective and cancer recovery meetings 3x weekly cancer meetings for all T Sites led by Deputy COO, Urgent Care and Cancer and ICB Cancer lead		Due to sustained improvement, NHSE de-escalated cancer from Tiering in December 2023.	Finance Committee							A	A	A	A	A	

	meet all constitutional standards						and 28 Day FDS	Maximisation of capacity and efficiencies to reduce waiting times and support discharge processes, ensuring services are provided within timeframes which are safe and responsive, enabling a reduction in length of stay/bed occupancy			Trajectories for all specialties in place, weekly position statements offered to ELT and TLT RAPs at Tumour Site level available from March through which performance will be monitored		Focused piece of work in place to review Navigator role in terms of WF capacity and capability has been undertaken with a training program in place and supported PTLs as a result. Additional support from external ICB funded cancer specialist to further refine the PTL process and provide on the job coaching and training of the cancer team. Breast are developing a sustainability plan to be taken through CRIG in Q4 that will provide a backdrop for continuous achievement of all 3 cancer targets. Number of capacity increasing BCs have been agreed by CRIG and others dependent upon slippage. Each tumour site has worked through mitigations and impact.													
3f	Reducing unwarranted variation in planned service delivery and ensure we meet all constitutional standards	Group Chief Operating Officer		Outpatient Recovery and Improvement Group (ORIG) Productive Theatres Group (PTOG) Medical Workforce Programme	Hybrid Mail		Referral to Treatment (18week wait) Standards Diagnostic 6week (DM01)	Internal assurance process through ISG and corporate into ELT, GLT and FPEC Planned Care & Diagnostic Board	Inconsistent approach to validation Clinic slot utilisation driven by DNAs and last minute cancellations Theatre utilisation, including; 1. Preop 2. Estate utilisation 3. Late starts/early finishes 4. Day case rates 5. On the day cancellations Gaps in Job planned and delivered activity for Admitted & Non-Admitted Workforce gaps, particularly in theatres	Improvement programmes driving workstreams to address control measures. These include; 1. Outpatient letter project to reduce variation of clinic template letters, ensuring patients receive timely and accurate information 2. Hybrid mail project to digitalise and streamline Outpatient correspondence 3. Use of PIFU to reduce unnecessary follow up 4. Preop focused workstream to increase access to preop and build a prospective service 5. GIRFT workstreams focused on compliance with BADS identified day case procedures and unexpected conversion to Inpatients 6. 6-4-2 Processes in Outpatients and Theatres to ensure clinics/lists fully utilised 7. Look Back Wednesday to address unexpected changes to theatre lists impacting utilisation 8. Ongoing work to match job plans with clinic session	Performance Data Planned Care Improvement and Performance Reporting Integrated Improvement Plan Highlight and Status Reports GIRFT Reports and Model Hospital Regional Performance Packs	Escalations & issues through ISG when required Limited Diagnostic reporting/assurance	Reporting through Improvement Steering Group & FC Diagnostic reporting tools and process currently being developed	Finance Committee							A	A	A	A	A	
								HVLC/GIRFT Programme - Theatre productivity and efficiency	Ability of the ULHT teams to engage in the programme Emergency pressures resulting in elective cancellations Culture mindset change takes time.	Full robust Theatre programme with focus on KPIs now meeting weekly to oversee and drive changes	Theatre dashboard has been created and reviewed by operational teams for booking & scheduling - aim for 90% 6-4-2/scheduling now in place and now has a Senior Leader attendance rota. Weekly Capacity meetings held to ensure theatre utilisation	Increased in NEL demand may impact staffing levels, elective bed capacity, and therefore could impact on elective activity. KPIs potentially impacted: OTD cancellations and actual utilisation against planned levels	Reporting through Improvement Steering Group/FPEC/HVLC													
								Maximisation of capacity and efficiencies to reduce and eliminate 78 week, 65 week waits across all specialties and moves to ambition of reducing 52 week to 700 by end of Q4 2023/2024			Trajectories for all specialties in place, weekly position statements offered to ELT and TLT Weekly planned care update meeting															

SA4 To collaborate with our primary care, ICS and external partners to implement new models of care, transform services and grow our culture of research and innovation																										
4a	Establish collaborative models of care with all our partners including Primary Care network Alliance (PCNA), GPs, health and social care and voluntary sector	Group Chief Integration Officer						Lead the Lincolnshire ICS and Provider Collaborative as an Anchor Institution and play an increasing leadership role within the East Midlands Acute Services Collaborative	Governance arrangements for Provider Collaborative, Integrated Care Board still in development Clarity on accountability of partners in integration/risk and gain Lincolnshire ICS anchor organisation plan not yet in place Wider regional governance to provide East Midlands oversight of population need and outcomes not yet finalised (via East Midlands Acute Provider Collaborative (EMAP)) ULHT have not embedded a culture of contributing towards population health across the whole organisation and a further understanding of health inequalities and mitigating actions.	Map key stakeholders and priorities for a partnership strategy focussing on addressing health inequalities and prevention Board and senior leadership team sessions on understanding the new ICS landscape and ULHT role within this Lincolnshire System Anchor Workshops underway to align areas of focus and develop system Anchor Plan - looking to agree priorities and exploring opportunities associated with Greater Lincolnshire devolution EMAP Governance structure now agreed, EMAP Managing Director in post and will be hosted by ULHT. ULHT engagement in 3 EMAP work programmes. EMAP MOU approved by board. Scope what a good effective partnership look like. Stakeholder mapping & engagement plan. Develop appropriate comms for the Lincolnshire ICS and our provider collaborative Agreements to support the development of the Provider Collaborative have been designed and shared. The Provider Collaborative is undertaking a stock take of services.	ULHT Green Plan Risk and Gain share (provider collaborative) Early Warning Discharge Indicators/development a common set of agreed metrics for flow and discharge across the system ICB delegation agreement ULHT Partnership Strategy EMAP governance structures/MOU	Green Pan under-delivery A better understanding of effective partnerships and what good looks like Clarity around role/accountability of partners within the Provider Collaborative Clarity around system improvement plan and provider collaborative plan and what outcomes each seeks to achieve Shared understanding and implications of the early warning discharge indicators, risk and gain share agreement within ULHT	Green Plan assurance - governance and PMO plan Part of the refreshed IIP Reporting processes Regular updates to ELT/TLT/TB on Provider Collaborative, Health Inequalities, EMAP and our ICS Evidence and intelligence gathered from Service Reviews, Business Planning, Population Health and all other aspects of work will be pulled into this strategy to support the wider considerations of partnership working and future opportunities (commercial and non-commercial) Group Clinical Franework to be included within new LCHG Organisational Strategy.	Integration Committee												
								A Joint Forward Plan (JFP) by June 2023 and continued utilisation of Joint Strategic Needs Assessment (JSNA), population health data from Optum and the health and wellbeing strategy, to influence our collective approach	JFP completed February 2024 and shared with Board	JFP triangulation with IIP Year 5	JFP completed and considered in Chief Executives Group and formally to the Board	JFP triangulation within new Group Strategy	Year 5 IIP will include JFP triangulation for Boards prior to sign to off, April 2024 New group Strategy includes triangulation to JFP.													
								Joint working with system partners, maximising care homes, virtual wards and admission avoidance schemes, such as the frailty programme	Investment Business Cases not yet in place (SDEC frailty assessment, ED Paed Hub, Community Child Nurse, Rapid Assessment and Triage (RAT), Hospital at Night, SAFER)	Business Cases being presented to CRIG in July	Business Cases Shared Performance Dashboard - frequent attenders	Business Cases in development Dashboard in development	Business Cases being presented to CRIG in July Joint work with Optum to create dashboard													
								Play an increasing leadership role within the East Midlands Acute Provider Collaborative to develop key partnerships	EMAP work programmes establishing - outcomes/deliverables not yet agreed	Programme Boards in place with monthly meetings underway Highlight reports being overseen by monthly EMAP executive meetings EMAP updates to ELT/TLT	EMAP executive meeting minutes EMAP Quarterly reports	Impact of EMAP programmes	Verbal updates at EMAP exec meetings and ULHT representation at EMAP programme groups, quarterly EMAP updates via IIP													
4b	Successful delivery of the Acute Services Review	Group Chief Integration Officer						Develop a ULHT clinical service strategy with focus on fragile services in order to provide sustainable and safe services for the future Identify the key services to focus on for Clinical Service Review (taking into account CIP, benchmarking, GIRFT and other core data)	Divisional IIPs need to be completed to ensure links into fragile services/clinical service strategy Identify resources to implement ASR outcomes	First and second cohort of specialty reviews underway and on track Programme management support being identified via Provider Collaborative to help deliver ASR phase 1 Individual work streams to be established Clinical Strategy engagement period has successfully concluded - 1st draft document has been socialised for feedback from key stakeholders. Group Strategy (to include clincial framework) with new strategic aims and objectives in final draft and will be shared with ELT on 27th February and Trust Board on 3rd March 2025	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 Group Clincial framework to be incorporated into new Group Strategy from April 2025. ASR- Work continues to improve the Single Lincolnshire Stroke Service supported by the Stroke Model of Care and appropriate staffing to meet the needs of the service and the estates development at Lincoln County Hospital. The consolidated stroke service is in place at Lincoln hospital, work continues to reduce the current 18-day average length of stay (LOS) of patients to the required 10 days workign with the national CLEAR project team	Integration Committee												

4c	Grow our research and innovation through education, learning and training	Group Chief Integration Officer						Shared understanding and implications of the UHA guidance and identify relationship management of key stakeholders nationally (DH, UHA) Agree contract with UOL, R&I team to Increase the number of Clinical Academic posts	Funding for Clinical Academic posts and split with UOL to be agreed although current proposal to target substantive vacancies with high agency/bank spend has provisionally been agreed by GCMO and CFO. Short list currenlty being agreed via TSSG for discussion with UoL.	Monthly meetings with ULHT and Uni of Lincoln to discuss funding position and agree MOU. Clinical Academic Oversight Group to oversee recruitment of clinical academic model, recruitment and delivery. Group meetings being held to support discussion on performance and any adjustments to job plans Meetings with ULHT and UOL finance/contracting teams to finalise financial model and MOU based on principles of the Selby report produced early 2024. Current proposal to target substantive vacancies with high agency/bank spend has provisionally been agreed by GCMO and CFO. Short list currenlty being agreed via TSSG for discussion with UoL	Contract agreed with UOL for Clinical academic posts. UoL and ULHT have draft contracts and offer letters ready for use. Increase in numbers of Clinical Academic posts - agreed to prioritise on clinical specialities where there are workforce gaps/high agency spend to mitigate ULHT cost pressure RD&I Strategy and implementation plan agreed by Trust Board Upward reporting and approval sought through TLT/ELT/PODC	Unknown financial commitment for the Trust in relation to the clinical academic roles until the financial model is completed and recruitment commences.	Monthly meetings with ULHT and Uni of Lincoln Financial best case, most likely and worst case models reviewed by ELT and shared with Board in March 2024 to agree risk appetite Proposed model to target substantive vacancies with high agency/bank spend will mitigate costs to ULTH Exploring all opportunities across ULHT and UoL to mitigate the financial risk through additional income generation, wider socio-economic impact	People Committee (To move to: Integration Committee)			R	R	R	R	R	R	R	R	R	
								The training and support environment for students and clinical academics will be in place. ULHT Library and training facilities improvements are now complete.	Lack of a model for research training and support for new clinical academics as they start to be employed No current agreement between ULHT/UoL in relation to clinical academic accommodation and resources model	Clinical Academic Model financial model and contract will include facilities and resource provision. Exploratory work underway to understand package of support e.g. via clinical rails unit, UoL and Joint Research Office	Clinical academic financial model once complete GMC training survey Stock check against checklist Internal Audit - Education Funding	Clinical Academic financial model not yet agreed	A new R&I group has been set up being led by Director of R&I/Deputy Medical Director, this will provide more oversight and rigor in developing an R&I agenda with representation from key stakeholders and clear milestones for delivery															
								Develop a joint research strategy with the UoL by September 2023, which identified shared research focus areas which is needed to meet UHA requirements	A joint MOU is in place at a Lincolnshire System level as agreed in April 2022, and the Steering Group and ELT has agreed that this should be used as the overarching MOU A draft ULHT/UOL MOU has been prepared but this has not been signed off as ideally it will need be combined with the final clinical academic model into a shared contract. Draft priorities based on initial dialogue with vice dean of the medical school has been created, further work to develop UOL strategy is being undertaken.	Working closely with the University of Lincoln, monthly meetings. Through these meetings have completed first draft of the Joint Strategy. There is an existing ULHT R&I Strategy in place and a new version will be developed for 24/25 as the current one is it its final year. The Lincolnshire ICS have commenced work on a system wide R&I strategy - UHLT Director of R&I is engaged with this process. As ULHT are not currently in a position to apply for UHA status due to the lack of clinical academics employed, the shared Strategy is not required currently. However it will need to be in place ahead of a UHA application.	RD&I Strategy and implementation plan agreed by Trust Board	Clinical Academic Model is required to support shared Strategy development UoL have refreshed their Research Strategy and as at end Oct 2022 ULHT are awaiting a copy of this to then align to joint strategy between the two organisations.	Monthly meetings with ULHT and Uni of Lincoln and through ULHT Steering Group Shared Strategy is a requirement for UHA application and not Teaching Hospital Status														
								Develop a strong professional relationship with the University of Lincoln and the Medical School and jointly create a strategy with a focus on developing rural healthcare, medical/nursing/AHPs/Clinical Scientists/R&I staff education and other healthcare roles	Evidence bound by UHA requirements Clear plan/strategy on development of medical/nursing/SHPs/Clinical scientists/R&I staff education roles	A new R&I group has been set up, being led by Director of R&I/Deputy Medical Director. We continue active stakeholder management with Medical Director of ICS and UOL VC.	ULHT healthcare roles plan Increased recruitment/academic posts (across ICS)	The change to the UHA Guidance (20xClinical Academics) is a challenge. Received further feedback from UHA and need to have at least 20 clinical academics remain unchanged.	Working closely with University of Lincoln to develop plans for recruitment of Clinical Academic posts with a view to maximising existing research relationships where possible. Two potential candidates have been identified for the Clinical Academic recruitment.														
								Successfully recruit 6 Clinical Academics within the first year of agreement of the UoL/ULHT model	Agreed clinical academic financial model	A financial model for the appointment of clinical academics is in development that describes a timeline to achieve the required 6% of medical workforce for UHA status	Working group Meetings, ULHT/UOL Exec meetings and R&I meetings	The financial model is not yet agreed which is delaying appointment of clinical academic roles Identified early adopter Clinical Academic roles once model agreed	Ongoing meetings between ULHT and UoL, commissioned working group developing final proposal which will be used to inform the financial model and MOU. Update to Trust Board shared in March 2024 to agree risk appetite and next steps.														

4d	Enhanced data and digital capability	Group Chief Integration Officer				4657		Development and approval of Electronic Patient Record OBC	Regional and National approval of OBC Affordability of OBC	Digital Services Steering Group Digital Hospital Group e-HR Programme Steering Group Capital, Revenue and Investment Group Engagement with regional colleagues	Delivery of OBC Agreement of funding	Regional feedback on OBC	OBC approved by Frontline Digitalisation ePR Investment Board (EPRIB) on 19th July 2023. OBC approved by JIC on 28th July 2023. OBC approved by Cabinet Office Commercial Spend Controls Process on 3rd Oct 2023. ITT published 6th October 2023 with bid submission deadline on 29th November 2023 but only three bid submissions received with non of them being fully compliant. After listening to the market and involving all parties (including legal), changes have been made to the ITT, including provide increased flexibility in the approach to T&Cs and updating the wording of one of the Mandatory Compliance Questions. ITT republished 29th February 2024 with bid submission	Finance Committee / Integration Committee
								Upgrade of our technological infrastructure to support technology advancements	Insufficient cap/rev to replace aging technology Insufficient capacity to deliver purchased equipment	Technical Design Authority Digital Hospital Group Information Governance Group (for cyber / info security)	Digital Maturity Assessment		Looking to procure a Technical / Implementation Partner to provide capacity as and when required Enabling infrastructure funded via FD (EPR) rollout going to plan.	
								Enhance our organisational digital capability and skills through training	Insufficient capacity to create and deliver training materials	Digital Hospital Group			Looking to procure a Technical / Implementation Partner to provide capacity as and when required This is now well underway with 2 comms centres purchased in 23/24 and will be commissioned in 24/25, wireless network being upgraded	
SA5 To embed a population health approach to improve physical and mental health outcomes, promote well-being, and reduce health inequalities across an entire population														
5a	Develop a Population Health Management (PHM) and Health Inequalities (HI) approach for our Core20PLUS5 with our ICS	Group Chief Nurse/Group Chief Medical Officer						Gain a greater understanding of the Lincolnshire population and support a reduction in health inequalities	Core20PLUS dashboard not yet developed	Development of Core20PLUS dashboard by June 2023	Core20PLUS dashboard	Core20PLUS dashboard not yet developed	Dashboard in place for A&E and 18 weeks, plans for further expansion being overseen by Health Inequalities Working Group.	Integration Committee
5b	Co-create a personalised care approach to integrate services for our population that are accessible and responsive	Group Chief Nurse/Group Chief Medical Officer						Embed personalisation and Population Health Management across our improvement and transformation programmes Increase the number of personalisation Champions acroos the group PEG Patient Panels			Health Ineqaulities working group PEG/Patient Panels			Integration Committee
5c	Tackle system priorities and service transformation in partnership with our population and communities	Group Chief Integration Officer						Build a Partnership strategy to support improvements in safe and sustainable care, and harness benefits for the population of Lincolnshire		Associate Director of Partnerships started in post May 2023 Board development sessions 5th December 2023 and August 2024 Partnership work is already underway across the organisation and is not being delayed by the lack of formal strategy e.g opportunities emerging for the speciality review programme		Partnership Plan completed - will be reviewed and updated in line with new Group Strategy	Work is underway to align the plan with the new Group Strtagey and emerging work around the Alliance	Integration Committee

5d	Transform key clinical pathways across the group resulting in improved clinical outcomes	Group Chief Integration Officer/Group Chief Medical Director	OP and UEC Improvement Programmes Speciality Support programme EMAP clinical programmes		Readiness of Primary Care to support pathway transformation			ISG EMAP Executive Meetings/Upward reports	Alliance Steering Group tba	Executive Meeting 10th February 2025 to map Steering group and Corporate support for transformation programmes	IC upward reports EMAP Executive Meeting upward reports to ELT			Integration Committee												

NHS
Lincolnshire Community and Hospitals NHS Group

Group Audit Committee Upward Report

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

Meeting	*Lincolnshire Community and Hospitals Group Board Meeting*
Date of Meeting	*4 March 2025*
Item Number	

Group Audit Committee Upward Report of the meeting held on 31st January 2025

Accountable Director	*Neil Herbert, Audit Committee Chair*
Presented by	*Neil Herbert, Audit Committee Chair*
Author(s)	*Jayne Warner, Director of Corporate Affairs*
Recommendations/ Decision Required	*The Board is asked to:-* • *Note the upward report*

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

This assurance Committee meets quarterly and takes scheduled reports according to an established work programme, for both Lincolnshire Community Health Services NHS Trust (LCHS) and United Lincolnshire Teaching Hospitals NHS Trust (ULTH). The Committee worked to the 2024/25 objectives for the Lincolnshire Community and Hospitals NHS Group (LCHG).

External Audit

The Committee noted that the External Audit engagement letters had been signed for both organisations allowing the year end audit work to commence. The External Audit team had provided a joint report for both organisations into Committee.

The Committee were advised that the initial planning stage was underway, focussing on resourcing the audits, key dates, planning, and establishing key contacts.

Document deliverables and update queries had been sent to both Trusts, and several calls had been held to discuss emerging accounting issues and general audit logistics. The planning and risk assessment activities were aimed at understanding the entity, with a particular focus on controls in February.

The Committee noted that efforts were being made to ensure efficiency by coordinating activities across the Lincolnshire trusts where possible. Early testing was being maximised to meet the final audit stage from early April to June 2025.

The Committee noted the changes within the Finance Teams in each organisation but that the team were prepared and an internal timeline was in place.

Internal Audit

The Committee received the Internal Audit Progress Report for both organisations noting that one audit report had been finalised for LCHS and two reports for ULTH. There were a number of other reports at final stages of completion awaiting issue.

The Audit Committee were advised of progress against the rest of the Audit Programme for the year for both Trusts. The Committee recognised the need to maintain the traction which had been achieved with the audit plans and to ensure that finalised reports were being issued at the earliest opportunity.

The position with audit recommendations and the audit plan were noted. The Committee were concerned with progress being made against plan and the need for proactive engagement. Internal Audit recommendations continued to be closely monitored.

Local Counter Fraud Specialist Progress Reports

The Committee noted the progress report which had been aligned for both organisations to avoid duplication.

It was confirmed for the Committee that the role of Counter Fraud Champion in both Trusts would be best served by one Champion going forward. This would be the Deputy Director of Finance James Taylor.

Compliance Report

The Committee received the quarterly compliance report which was being developed to reflect compliance across both organisations.

It was noted that the levels of waivers remained stable after an increase had been seen earlier in the year.

The report had been updated to include details of the formal reprimand from the Information Commissioner's Office (ICO) related to compliance with subject access requests. The Information Governance Group and the Finance Committee had raised further questions about the level of assurance regarding improvements in this area. The Group Director of Corporate Affairs had met with Ms Cecchini and Mrs Buik, Associate Non-Executive Director to discuss these areas in detail and agreed on a way forward for the next Finance Committee meeting.

Policies Update

The Committee received the quarterly update on the policy position. It was noted that the position remained poor. The Committee noted the actions being taken by

the Executive to address the areas of concern but asked for assurance on when traction would be seen in delivering improvement. It was noted that compliance was now being monitored through all Committees not just Audit Committee.

Executives continued to receive monthly updates, and performance data was being challenged through Performance Review Meetings (PRMs). Committee Chairs shared their experiences and challenges with policy management, emphasising the need for risk assessments and clear ownership.

The Group Director of Corporate Affairs explained that a significant piece of work had been done to align policies and to ensure they were up to date. However, the volume of policies and the need for clinical teams to address clinical policies posed challenges. The Committee discussed the importance of risk assessments for policies and the need for executive leads to take ownership of policies within their portfolios. The Group Director of Corporate Affairs agreed to request a risk assessment of all outstanding policies.

Board Assurance Framework and Risk Register

The Committee reviewed the BAF and Risk Register confirming that each remain fit for purpose recognising the challenges which Committees were experiencing with the 24/25 format. This was being addressed in the new format being developed for 25/26.

Group Audit and Risk Committee
Terms of Reference

1. Authority

The Audit and Risk Committee is established by the Trust Boards of both Lincolnshire Community Health Services NHS Trust and United Lincolnshire Teaching Hospitals NHS Trust and in line with the powers set out in bothTrust's Standing Orders.

The Audit and Risk Committee holds only those powers as delegated in these Terms of Reference as determined by the Group Board.

The Standing Orders and Standing Financial Instructions of both Trust's, as far as they are applicable, shall apply to the Committee and any of its established groups.

The Committee is authorised by both Trust Board's to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the committee. The Committee is authorised by both governing bodies to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

2. Purpose of the Committee

The Audit and Risk Committee exists to scrutinise the robustness of and provide assurance to the Group Board that there is an effective system of governance and control for risk, the accounting policies and the accounts of the organisation, the planned activity and results of both internal and external audit and assurances relating to the corporate governance requirements for the organisation.

3. Membership

The members of the Committee are:

- Non-Executive Director (Chair)
- Non-Executive Director (Quality Committee Chair)
- Non-Executive Director (Finance and Performance Committee Chair)
- Non-Executive Director (People Committee Chair)
- Non Executive Director (Integration Committee Chair)

The following roles will be routine attendees at the Committee:

- Group Chief Finance Officer
- Group Director of Corporate Affairs (Company Secretary)
- Representative from Internal Audit
- Representative from External Audit
- Counter Fraud Representative (at least twice annually)
- Group Deputy Chief Finance Officer
- Chief Clinical Governance Officer

- Associate Non-Executive Director

The Accountable Officer should discuss at least annually with the committee the process for assurance that supports the governance statement and should attend the committee when it considers the draft annual governance statement and the annual report and accounts.

Executive Directors/ Senior Managers may be invited to attend when the committee is discussing areas of risk or operation that are the responsibility of that director/manager.

Members will be expected to conduct business in line with the Trust values and objectives. Members of, and those attending, the Committee shall behave in accordance with the Trust Standing Orders and Standards of Business Conduct Policy.

Members must demonstrate the equality and diversity implications of decisions they make.

4. Attendance and Quorum

The Committee will be quorate when three of the five Non-Executive Director members are present.

5. Frequency

The committee will not meet less than five times per year. At least once a year the committee will meet privately with the internal and external auditors.

6. Specific Duties

The Audit and Risk Committee will:

Integrated governance, risk management and internal control:

- Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisations activities (clinical and non-clinical), that supports the achievement of the organisations objectives
- Review the adequacy and effectiveness of all risk related disclosure statements (in particular the annual governance statement) together with any accompanying head of internal audit opinion, external audit opinion or other appropriate independent assurances, prior to submission to the Trust Board
- Review the adequacy and effectiveness of the underlying assurance processes that indicate the degree of achievement of the organisation's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- Review the adequacy and effectiveness of the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications including the NHS Code of Governance and NHS Provider Licence

- Review the adequacy and effectiveness of the policies and procedures for all work related to counter fraud, bribery and corruption as required by NHSCFA

Internal Audit:

- Consider the provision of the internal audit service and the costs involved.
- Review and approve the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework.
- Consider the major findings of internal audit work (and management response) and ensuring coordination between the internal and external auditors to optimise the use of audit resources.
- Ensure that the internal audit function is adequately resourced and has appropriate standing within the organisation.
- Monitor the effectiveness of internal audit and carry out an annual review.

External Audit:

- The Committee shall review and monitor the external auditors independence and objectivity and the effectiveness of the audit process. In particular the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work
- Consider the appointment and performance of external auditors, as far as the rules governing the appointment permit (and make recommendations to the Trust Board when appropriate).
- Discuss and agree with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan.
- Discuss with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee.
- Review all external audit reports, including the report to those charged with governance (before its submission to the Trust Board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

Other Assurance Functions:

- The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation. Including but not limited to any reviews by DHSC arm's length bodies or regulators/inspectors for example, the CQC, NHS Resolution, Royal Colleges, accreditation bodies etc.
- The Committee will review the work of other committees within the organisation whose work can provide relevant assurance to the audit committee's own areas of responsibility.
- The Committee will satisfy itself on the assurance that can be gained from the clinical audit function through its review of the work of the Quality Committee.

Counter Fraud:

- The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud, bribery and corruption that meet NHSCFA's standards and shall review the outcomes of work in these areas.

- The Committee will refer any suspicions of fraud, bribery and corruption to the NHSCFA.

Management:

- The Committee shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.
- The Committee may request specific reports from individual functions within the organisation

Financial Reporting:

- The Committee shall monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance.
- The Committee will ensure that the systems for financial reporting to the governing body, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.
- The Committee shall review the annual report and financial statements before submission to the Trust Board focussing particularly on
    - The wording in the annual governance statement and other disclosures relevant to the terms of reference of the committee.
    - Changes in and compliance with, accounting policies, practices and estimation techniques
    - Unadjusted misstatements in the financial statements
    - Significant judgements in preparation of the financial statements
    - Significant adjustments resulting from the audit
    - Letters of representation
    - Explanations for significant variances

Raising Concerns:

- The Committee shall review the effectiveness of the arrangements in place for allowing staff and contractors to raise (in confidence) concerns about possible improprieties in financial, clinical safety or workforce matters and ensure that any concerns are investigated proportionately and independently and in line with relevant policies.

Governance Regulatory Compliance

- The Committee shall review the organisation's reporting on compliance with the NHS provider licence, NHS Code of Governance and the Fit and Proper Persons Test
- The Committee shall satisfy itself that the organisation's policy, systems and processes for the management of conflicts (including gifts and hospitality and bribery) are effective including receiving reports relating to non compliance with the policy and procedures relating to conflicts of interest.

7. Administrative support

The Committee will operate using a work plan to inform its core agenda. The agenda will be agreed with the Chair prior to the meeting.

Agendas and supporting papers will be circulated no later than 7 days in advance of meetings. Any items to be placed on the agenda are to be submitted no later than 8 working days in advance of the meeting. Items which miss the deadline for inclusion on the agenda may be added with permission from the Chair.

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

8. Accountability and Reporting Arrangements

The Chair of the Committee shall report to the Board after each meeting and provide a report on how it has discharged it's responsibilities, escalating any concerns where necessary.

The Committee shall report at least annually to the Trust Board on its work in support of the annual governance statement, specifically commenting on:

- The fitness for purpose of the Board Assurance Framework
- The completeness and embeddedness of risk management in the organisation
- The integration of governance arrangements
- The appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a functioning business
- The robustness of the processes behind the quality accounts

The annual report should also describe how the committee has fulfilled its terms of reference and give details of any significant issues that the committee has considered in relation to the financial statements and how they were addressed.

9. Monitoring effectiveness and Compliance with Terms of Reference

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

10. Review of Terms of Reference

The Terms of Reference for the Committee will be reviewed annually by the Committee and submitted to the Trust board for approval.

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

Approved:
Approved by:
Next Review Date:

United Lincolnshire Teaching Hospitals NHS Trust/ Lincolnshire Community Healthcare Services NHS Group Audit Committee Forward Reporting Schedule 2025/2026

Agenda Item	Lead	Apr	May	July	Oct	Jan
Governance						
Review the board assurance framework	Dir of CA	x		x	x	x
Review the risk management system	CCGO	x		x	x	x
Note business of other committees and review inter-relationships	Non Exec Chairs	x		x	x	x
Review draft Annual Governance Statement	Dir of CA	x	x			x
Receive other sources of assurance	Dir of CA	x		x	x	x
Review Fit and Proper Person Test	Dir of CA	x				
Review the draft Annual Report	Dir of CA	x	x			x
Review the Quality Account	CCGO	Delegated to Quality Committee for assurance				
Review whistle blowing arrangements	Dir of CA	Delegated to People Committee and Board for assurance				
Review arrangements for cyber security	CIO	Delegated to Finance and Performance Committee				
Review other reports and policies as appropriate	Dir of CA	x		x	x	x
Review clinical audit	CCGO	Delegated to Quality Governance Committee for assurance				
Financial Focus						
Agree annual accounts and annual report timetable and plans	CFO/ Dir of CA					x
Review of annual report and accounts progress	CFO/ Dir of CA	x				
Review of Audited Annual Accounts and Financial Statements (including external audit opinion)	CFO		x			
Review risks and controls around financial management	CFO			x		x
Review changes to standing orders, standing financial instructions/ prime financial policies and changes to accounting policies	CFO/ Dir of CA	x		x		x
Review losses and special payments	CFO	x		x	x	x
Review waiving of standing orders	CFO	x		x	x	x
Internal/ Exernal Audit						
Review and approve the annual internal audit plan	CFO	x				
Review and approve internal audit terms of reference	CFO	x				
Review the effectiveness of internal audit	CFO				x	
Receive internal audit progress reports	Internal Audit	x		x	x	x
Receive Head of Internal Audit Opinion	Internal Audit		x			
Agreement of external audit plans and fee	CFO	x				
Review the effectiveness of external audit	CFO				x	
Review external audit progress reports	External Audit	x		x	x	x
Receive External Audit annual governance report	External Audit			x		
Receive external auditors Annual Audit letter	External Audit			x		
Counter Fraud and Security						
Review annual reports on counter fraud activity	LCFS		x			
Review Annual Counter fraud work programmes	LCFS	x				
Receive Counter fraud progress reports	LCFS	X		X	X	x
Review organisations self review against NHSCFA standards	LCFS		x			
Review effectiveness of those carrying out Counter fraud activity	CFO				x	
General						
Review the terms of reference	Dir of CA	X		X	X	x
Review the Committee effectiveness	Dir of CA					x
Develop improvement plan based on review of effectiveness	Dir of CA	x				
Produce Annual Report for Trust Board	Dir of CA			x		
Private meeting with Internal /External Auditors	Chair	x				
Other activites						
Policies	Dir of CA					

Lincolnshire Community and Hospitals NHS Group
Board Work Programme 2025/26

Agenda Item	Lead	Person Responsible	Committee Oversight	Mar	May	Jul	Sep	Nov	Jan	Mar	Purpose of Report	Action
Business Items												
Public Questions	Group Chair	Group Director of Corporate Affairs	N/A	X	X	X	X	X	X	X		
Ward Accreditation	Group Chief Nurse		N/A	X	X	X	X	X	X	X		Assurance
Declarations of Interest	Group Chair	Group Director of Corporate Affairs	N/A	X	X	X	X	X	X	X	To note any conflicts of interest on specific agenda items or any changes to Directors' Interests	Assurance
Annual Declaration of Board Interests	Group Chair	Group Director of Corporate Affairs	N/A		X						To review and note any changes to the Register of Directors' Interests	Assurance
Fit and Proper Person Annual Declaration	Group Chair	Group Director of Corporate Affairs	Audit & Risk Committee		X						To receive assurance that all board members remain compliant with the Fit & Proper Person requirements	Assurance
Minutes of the previous meeting	Group Chair	Group Director of Corporate Affairs	N/A	X	X	X	X	X	X	X	To approve and / or amend the minutes of the previous meeting ensuring an accurate corporate record of the meeting is maintained	Approval
Matters arising from the previous meeting/action log	Group Chair	Group Director of Corporate Affairs	N/A	X	X	X	X	X	X	X	To ensure all agreed board actions are completed	Assurance
Group Chief Executive Horizon Scan	Group Chief Executive	Executive Business Manager	N/A	X	X	X	X	X	X	X	To brief the boards on local and national topical matters, risk issues & mitigations and good news & communication updates	
Group Workstreams Report	Group Chief Executive		N/A	X	X	X	X	X	X	X	To receive regular updates on the delivery of the expected benefits of moving to a Group model and the integration of clinical and corporate services	
Celebrating Group Success	Group Director of Corporate Affairs	Deputy Trust Secretary	N/A	X	X	X	X	X	X	X	To hear from Clinical Teams and give clinical teams access to the Board	
Patient/staff Story	Group Chief Nurse	Associate Director of Communications and Engagement	N/A	X	X	X	X	X	X	X	To receive direct feedback on the experience of both patients and staff	
Patients												
Strategic Aim 1 - High quality, timely care in the right place												
Assurance and Risk Report from the Quality Committee	Chair of Quality Committee	Deputy Trust Secretary	Quality Committee	X	X	X	X	X	X	X	To note the matters considered by the committee and the issues which the committees wish to escalate to the Trust Board and to agree any actions required	Assurance
Quality Committee Annual Report	Chair of Quality Committee	Deputy Trust Secretary	Quality Committee		X						To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Assurance
Quality Committee ToR and Work Programme	Chair of Quality Committee	Deputy Trust Secretary	Quality Committee		X						To approve the changes to board committee terms of reference and work plans following annual review.	Approval
Safeguarding Annual Report	Group Chief Nurse	Group Director of Safeguarding and Patient Experience	Quality Committee			X					To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Assurance
Infection Prevention and Control Annual Report	Group Chief Nurse	Deputy Director of Infection Prevention and Control	Quality Committee			X					To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Assurance
Complaints Annual Report	Group Chief Clinical Governance Officer	Deputy Group Chief Clinical Governance Officer	Quality Committee			X					To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Assurance
Patient Experience Annual Report	Group Chief Nurse	Group Director of Safeguarding and Patient Experience	Quality Committee			X					To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Assurance
Assurance and Risk Report from the Finance Committee	Chair of Finance Committee	Deputy Trust Secretary	Finance Committee	X	X	X	X	X	X	X	To note the matters considered by the committee and the issues which the committees wish to escalate to the Trust Board and to agree any actions required	Assurance
Finance Committee Annual Report	Chair of Finance Committee	Deputy Trust Secretary	Finance Committee		X						To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Assurance
Finance Committee ToR and Work Programme	Chair of Finance Committee	Deputy Trust Secretary	Finance Committee					X			To approve the changes to board committee terms of reference and work plans following annual review.	Approval
Financial Plan	Group Chief Finance Officer		Finance Committee								To approve the Financial Plan	Approval
Capital Plan	Group Chief Finance Officer		Finance Committee								To approve the Capital Plan	Approval
Contract Award Reports	Group Chief Finance Officer	Deputy Director of Procurement	Finance Committee	X	X	X	X	X	X	X	To approve relevant Contract Awards in accordance with the Trusts' Schemes of Delegation	Approval
Emergency Preparedness Annual Report and EPRR Core Standards	Group Chief Estates and Facilities Officer	Emergency Planning and Business Continuity Manager	Finance Committee			X					To receive and approve the Trusts' annual submission to NHSE on EPRR including any required improvement actions	Assurance
People												
Strategic Aim 2 - Attract and retain talent, build a strong culture												
Assurance and Risk Report from the People Committee	Chair of People Committee	Deputy Trust Secretary	People Committee	X	X	X	X	X	X	X	To note the matters considered by the committee and the issues which the committees wish to escalate to the Trust Board and to agree any actions required	Assurance
People Committee Annual Report	Chair of People Committee	Deputy Trust Secretary	People Committee		X						To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Assurance
People Committee ToR and Work Programme	Chair of People Committee	Deputy Trust Secretary	People Committee					X			To approve the changes to board committee terms of reference and work plans following annual review.	Approval
Gender Pay Gap Report	Group Chief People Officer	Director of People	People Committee	X						X	To receive the Gender Pay Gap Report	Assurance
Ward Establishment Review	Group Chief Nurse	Deputy Director of Nursing and Midwifery	People Committee	X						X	To approve the outcome of the review of safe staffing and any recommended changes to the establishment	Approval
Responsible Officer Revalidation Report	Group Chief Medical Director	Deputy Medical Director	People Committee				X					
National Staff Survey Results	Group Chief People Officer	Director of People	People Committee		X					X	To receive the results from the annual staff survey & note the planned improvement actions and monitoring arrangements	Assurance
FTSU Annual Report	Group Director of Corporate Affairs	FTSU Guardians	People Committee		X						To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Assurance
Equality Delivery System Report	Group Chief People Officer	Director of People	People Committee		X					X	To approve the annual EDS submission	Approval
Workforce Race Equality Standard (WRES) Report and Action Plan	Group Chief People Officer	Director of People	People Committee				X				To approve the annual WDES submission	Approval
Workforce Disability Equality Standard (WDES) Report and Action Plan	Group Chief People Officer	Director of People	People Committee				X				To approve the annual WDES submission	Approval
Population Health												
Strategic Aim 3 - Adapting to neighbourhood health needs												
Assurance and Risk Report from the Integration Committee	Chair of Integration Committee	Deputy Trust Secretary	Integration Committee	X	X	X	X	X	X	X	To note the matters considered by the committee and the issues which the committees wish to escalate to the Trust Board and to agree any actions required	Assurance
Integration Committee Annual Report	Chair of Integration Committee	Deputy Trust Secretary	Integration Committee		X						To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Assurance
Integration Committee ToR and Work Programme	Chair of Integration Committee	Deputy Trust Secretary	Integration Committee						X		To approve the changes to board committee terms of reference and work plans following annual review.	Approval
Risk and Assurance												
Integrated Performance Report	Group Chief Integration Officer	Associate Director of Performance and Information	Finance Committee	X	X	X	X	X	X	X	To brief the boards on key performance metrics & priorities, risks to delivery & mitigations	Assurance
Group Risk Management Report	Group Chief Clinical Governance Officer	Deputy Group Chief Clinical Governance Officer	Audit & Risk Committee	X	X	X	X	X	X	X	To receive assurance in relation to the management & mitigation of the risks to the achievement of the Trusts' strategic objectives and ensure that the BAF is reflective of the Trusts' current risk profile	Assurance
Board Assurance Framework	Group Director of Corporate Affairs	Deputy Trust Secretary	Audit & Risk Committee	X	X	X	X	X	X	X	To receive assurance in relation to the management & mitigation of the risks to the achievement of the Trusts' strategic objectives and ensure that the BAF is reflective of the Trusts' current risk profile	Assurance
Strategic Objectives	Group Chief Integration Officer	Director of Strategy and Planning		X						X	To approve the Group Vision, Strategy & Objectives	Approval
Assurance and Risk Report from the Audit Committee	Chair of Audit Committee	Group Director of Corporate Affairs	Audit & Risk Committee	X	X		X	X		X	To note the matters considered by the committees-in-common and the issues which the committees wish to escalate to the Trust Board and to agree any actions required	Assurance
Audit Committee Annual Report	Chair of Audit Committee	Group Director of Corporate Affairs	Audit & Risk Committee			X					To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Assurance
Audit Committee ToR and Work Programme	Chair of Audit Committee	Group Director of Corporate Affairs	Audit & Risk Committee	X						X	To approve the changes to board committee terms of reference and work plans following annual review.	Approval
NHS Provider Licence Self Certification	Chair of Audit Committee	Group Director of Corporate Affairs	Audit & Risk Committee		X						To agree the annual Trust Board self certification of compliance with the NHS Provider Licence	Approval
Year End Accounts and Annual Report	Chair of Audit Committee	Group Chief Finance Officer/ Group Director of Corporate Affairs	Audit & Risk Committee		X						To approve and adopt the Annual Report & Accounts	Approval
End of meeting												
Board Work Programme	Group Director of Corporate Affairs	Deputy Trust Secretary	N/A	X	X	X	X	X	X	X	To ensure the boards' consideration of all relevant items of business and, in turn, continued compliance with their statutory and regulatory requirements	Assurance
Any other notified items of urgent business	Group Chair	Group Director of Corporate Affairs	N/A	X	X	X	X	X	X	X		